

Will the Innovations in Diabetes and Dyslipidemia Affect Our Practice in 2020?

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In 2019, new guidelines on arrhythmia, coronary syndrome, diabetes mellitus, hyperlipidemia and pulmonary embolism were published. Innovations and changes in these areas will already affect the practice of cardiologists in 2020. In this article we aimed to focus on these changes and innovations with main lines in diabetes mellitus and hiperlipidemia.

While the miracle drug of diabetes mellitus was the first drug of choice for metformin years, it was emphasized that the use of SGLT-2 inhibitors and GLP1-RAs agents should be the first choice because it reduces adverse cardiovascular events. It has not been recommended for the first time to measure carotid intima-media thickness, which we have been using for years to estimate cardiovascular risk. Microalbuminuria, a cardiovascular risk marker and renal dysfunction marker, has been recommended to be routinely evaluated in diabetic patients. Reducing HbA1c to less than 7% to prevent microvascular complications and this target value should be individualized. It has been proposed to focus on the more flexible HbA1c target in the elderly and the lower HbA1c targets in the young. It was stated that SGTL2 inhibitors should be the first choice drugs in patients with heart failure because they reduce the risk of heart failure and reduce hospitalization in patients with heart failure. however, saxagliptin, a DPP4 inhibitor, has not been recommended for use in patients with heart failure. Since atrial fibrillation is common in diabetic patients, screening of diabetic patients over 65 years of age for atrial fibrillation has been recommended. Mediterranean diet and exercise were recommended in diabetic patients, and the discontinuation of micronutrient use frequently consumed by diabetic patients was emphasized.

The SCORE method for estimating total cardiovascular risk is presented in two different ways for low and high risk regions in the European population. Targeted LDL-C levels in the very high and high risk groups were further lowered. With the prolonga-

tion of life expectancy, the age limit of 65 on SCORE cards has been increased to 70. The cholesterol band of 8 mmol/L was removed. HDL-C measurements were added to SCORE conditions and SCORE cards have been modified for young individuals. LDL-C target of 70 mg/dl in the very high risk group was reduced to 55 mg/dl and LDL-C target of 100 mg/dl in the high risk group was reduced to 70 mg/dl. It has been advocated that the target LDL-C level may be below 40 mg/dl in patients with recurrent cardiovascular events within 2 years despite receiving maximum statin therapy. The use of ezetimibe and PCSK-9 inhibitors was recommended in patients whose target value could not be achieved despite maximum statin therapy. Diet and exercise have also been an important cornerstone of treatment in both diabetes and hyperlipidemia guidelines. Particular emphasis was given to smoking cessation and alcohol restriction.

Although new agents for diabetes control seem to facilitate the work of cardiologists, unfortunately lowering target cholesterol levels will make physicians difficult. Although new diabetic agents are more expensive, they may reduce the financial burden of countries on diabetic patients in the future. Applying tighter lipid-lowering therapy in patients at a time of deterioration of antihyperlipidemic agents of the media and social networks will be quite a challenge for cardiologists. Increasing the number of drugs to achieve the targets during a period of low compliance with polypharmacy may further reduce patient compliance. Therefore, a more integrated relationship should be established between the patient and physician. The family of the patient should be included in this relationship if necessary [1,2].

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Conflict of Interest

None.

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