American Heart Association.

Top Take-Home Messages
for Endocrinology and Diabetology Clinicians

Adapted from: 2026 AHA/ACC/ADA/ASN Guideline for the Prevention, Detection, Evaluation and Management of Cardiovascular-Kidney-Metabolic Syndrome

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1. **Among patients with T2D, provide support for healthy lifestyle and weight management.**

   Among individuals with type 2 diabetes (T2D), healthy lifestyle changes, including a balanced, heart-healthy diet and regular physical activity, have favorable effects on weight, glycemic control and metabolic risk factors. Weight management, supported through lifestyle modification and adjunctive pharmacotherapy and/or metabolic and bariatric surgery, is associated with further cardiometabolic benefits. Glucagon-like peptide-1 (GLP-1)-based therapies can also be considered in patients who have undergone metabolic and bariatric surgery (MBS) and have regained a significant amount of weight (≥25% or more of total lost weight). Healthy lifestyle and weight management should be a key focus of care for T2D. *(Section 5.5.1)*

2. **Among patients with T2D, perform regular testing for CKM risk factors and achieve collective risk factor control to reduce the risk of cardiovascular disease and mortality.**

   T2D is one criterion for Cardiovascular-Kidney-Metabolic (CKM) Syndrome Stage 2. T2D is commonly associated with additional comorbidities, including hypertension, dyslipidemia and chronic kidney disease (CKD). Yearly testing for these metabolic risk factors and CKD (with both estimated glomerular filtration rate (GFR) and urine albumin-to-creatinine ratio (UACR)) are recommended for timely identification and management of these conditions. Collectively controlling these risk factors with a combination of lifestyle modification and targeted pharmacotherapy reduces the risk for cardiovascular events, kidney events and overall mortality. *(Section 3.1.1)*

3. **A PREVENT-HF risk estimate ≥5% is concerning for short-term risk for heart failure in patients with prediabetes or T2D.**

   Heart failure (HF) is becoming a leading manifestation of cardiovascular disease (CVD) among patients with T2D. For individuals with a 10-year PREVENT-HF risk of ≥5%, in the absence of symptomatic clinical HF, clinical HF, testing with cardiac

biomarkers can be beneficial (natriuretic peptides with or without high-sensitivity troponin). If cardiac biomarkers are elevated, coordinated preventive care is advised with risk factor optimization and possible further evaluation with cardiac imaging. *(Section 3.1)*

4. **Among patients with T2D without CVD, a PREVENT-CVD 10-yr estimate ≥7.5% indicates increased risk for CVD and supports prioritization of cardioprotective antihyperglycemic therapies.**

   Individuals with T2D meet the diagnostic criteria for CKM syndrome stage 2. Clinical trials demonstrate cardiovascular benefits of cardioprotective antihyperglycemic therapies (GLP-1-based agent or sodium glucose cotransporter 2 inhibitors (SGLT2i)) in high-risk patients with T2D. Therefore, in patients with T2D without CVD but with a PREVENT-CVD 10-yr estimate ≥7.5% or age >50 years with other risk factors, a GLP-1-based agent or an SGLT2i is recommended to reduce CVD events and cardiovascular mortality. The choice of agent should be guided by presence of comorbidities such as CKD, pre-HF, obesity, severe hyperglycemia and metabolic dysfunction-associated steatotic liver disease (MASLD). *(Section 5.5.1)*

5. **In individuals with T2D and HF or CKD (with eGFR ≥20 mL/min/1.73 m^2), prioritize use of an SGLT2i as the 1st-line cardioprotective antihyperglycemic therapy.**

   Multiple large randomized clinical trials demonstrate the benefits of SGLT2i to reduce risks of HF hospitalization and cardiovascular mortality, and to reduce the loss of kidney function. *(Section 6.3.3)*

6. **Consider addition of a GLP-1 RA or finerenone in patients with T2D and CKD who have persistent albuminuria despite 1st-line kidney protective therapies (RASi and SGLT2i).**

   Both the GLP-1 RA semaglutide 1 mg SQ Qwk and the nonsteroidal mineralocorticoid receptor antagonist (nsMRA) finerenone 10 or 20 mg QD have been demonstrated to reduce risk for cardiovascular and kidney outcomes (loss of kidney function, kidney failure) in individuals with CKD (eGFR <60 mL/min/1.73 m^2). Among patients with T2D, CKD and persistent albuminuria on 1st line therapies, the addition of a GLP-1 RA or nsMRA is recommended, with an initiation threshold of UACR ≥30 mg/g for finerenone and UACR ≥100 mg/g for semaglutide. The choice of agent can be guided by additional clinical comorbidities, with obesity, uncontrolled diabetes and MASLD favoring the use of GLP-1 RA therapy. *(Section 5.5.4)*

7. **Consider the addition of GLP-1-based therapy to SGLT2i therapy among patients with T2D, HFpEF and obesity or other CKM comorbidities.**

   Evidence from clinical trials demonstrates that among patients with T2D, obesity and heart failure preserved ejection fraction (HFpEF), the use of GLP-1-based therapy includes clinical outcomes. In the absence of obesity, poor glycemic control, other CKM comorbidities, or MASLD may be other reasons for considering the additional use of GLP-1-based therapy among patients with T2D and HFpEF. *(Section 6.3.2)*

8. **Use a cardioprotective antihyperglycemic therapy among all patients with T2D and ASCVD.**

   Among patients with T2D and atherosclerotic cardiovascular disease (ASCVD), multiple clinical trials demonstrate that SGLT2i and GLP-1-based therapy both significantly reduce the risk of major adverse cardiovascular events and cardiovascular mortality, in addition to other beneficial effects on CKM risk profiles. Therefore, use of at least one of these agents is recommended among all individuals with T2D and ASCVD. *(Section 6.2.2)*

9. **Consider combination therapy with both GLP-1-based therapy and an SGLT2i in patients with T2D with ASCVD, increased predicted CVD risk or multiple CKM risk factors, to reduce the risk of cardiovascular events beyond that conferred by a single cardioprotective antihyperglycemic agent.**

   Combination therapy with a GLP-1-based therapy with proven benefit and an SGLT2i has been examined in real-world studies and demonstrates benefits beyond a single one of agents in patients with T2D at high CVD risk. In clinical trials, the benefits of each agent are the same among individuals who are and who are not taking the other agent. Use of combination GLP-1-based therapy and SGLT2i can be considered in high-risk patients with T2D to improve CKM risk factor control and cardiovascular and kidney outcomes. *(Section 6.2)*

10. **GLP-1-based therapies can be considered in patients who have undergone MBS and have regained a significant amount of weight (≥25% or more of total lost weight).**

    Patients undergoing MBS often experience significant weight loss, but approximately 10% of those who have undergone bypass surgery and 30% undergoing sleeve gastrectomy have less than 20% total body weight loss, and weight regain after the 12-18 month nadir is common. GLP-1-based therapies have been shown to mitigate post-surgical weight regain in observational studies and can be useful in the management of comorbidities. *(Section 5.4.4)*