Optimización Terapéutica en Diabéticos con Cardiopatía Isquémica
Papel de los ar-GLP1

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Conflict of interest:

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- **Diabetes en Cardiología**
- **Fármacos para control glucometabólico para cardiólogos**
- **Ar-GLP1 en Cardiopatía Isquémica – semaglutida oral**
- **Ar-GLP1 en la estrategia de optimización terapéutica**

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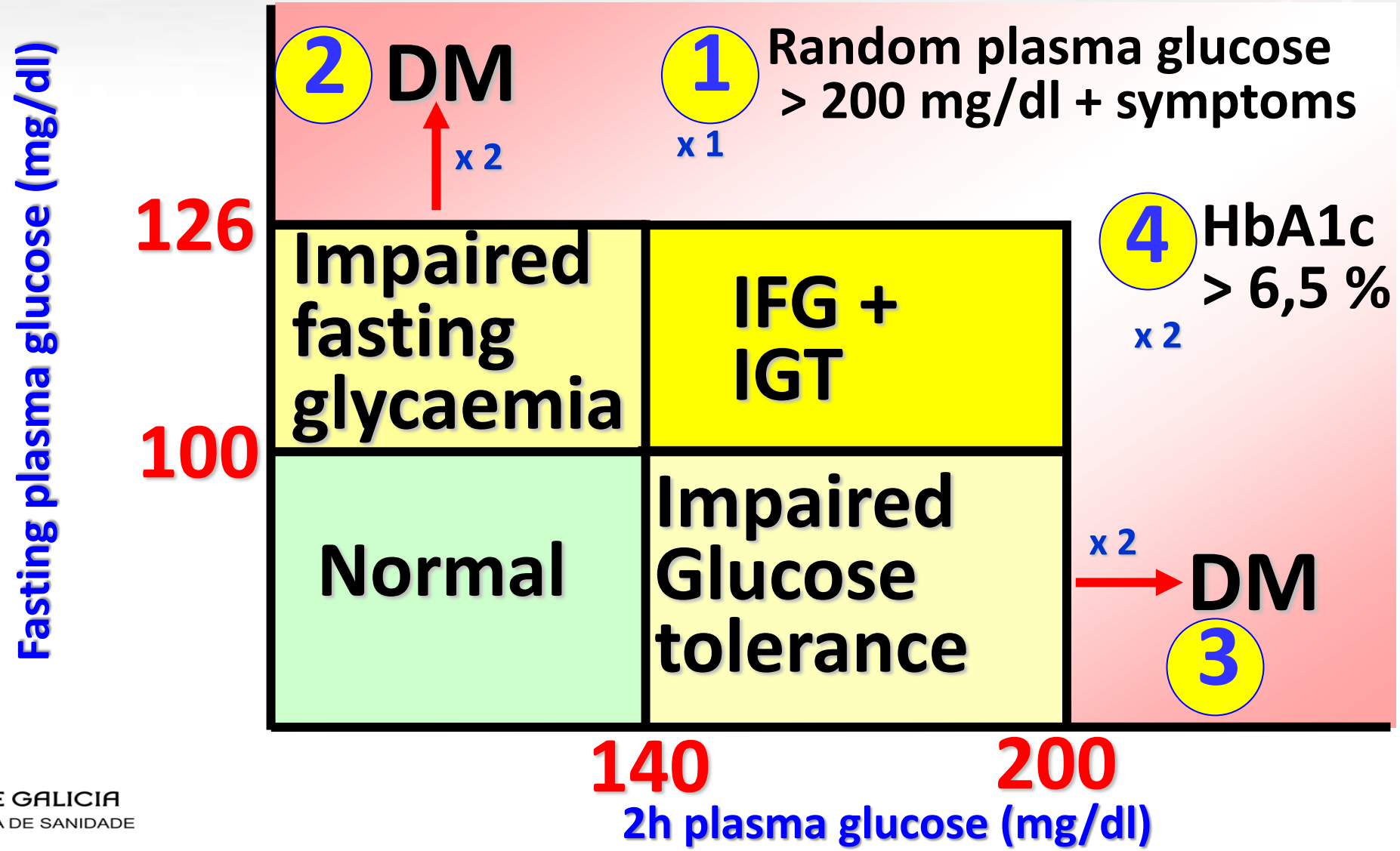
T2DM and Pre-diabetes

ADA



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T2D and CV Disease in Spain. An Epidemiological Perspective

Diabetes + IHD → **30-35% IHD PATIENTS WITH T2D** [1]

Diabetes + HF → **27-47% HF PATIENTS WITH T2D** [2]

Diabetes + AF → **24-34% AF PATIENTS WITH T2D** [3]

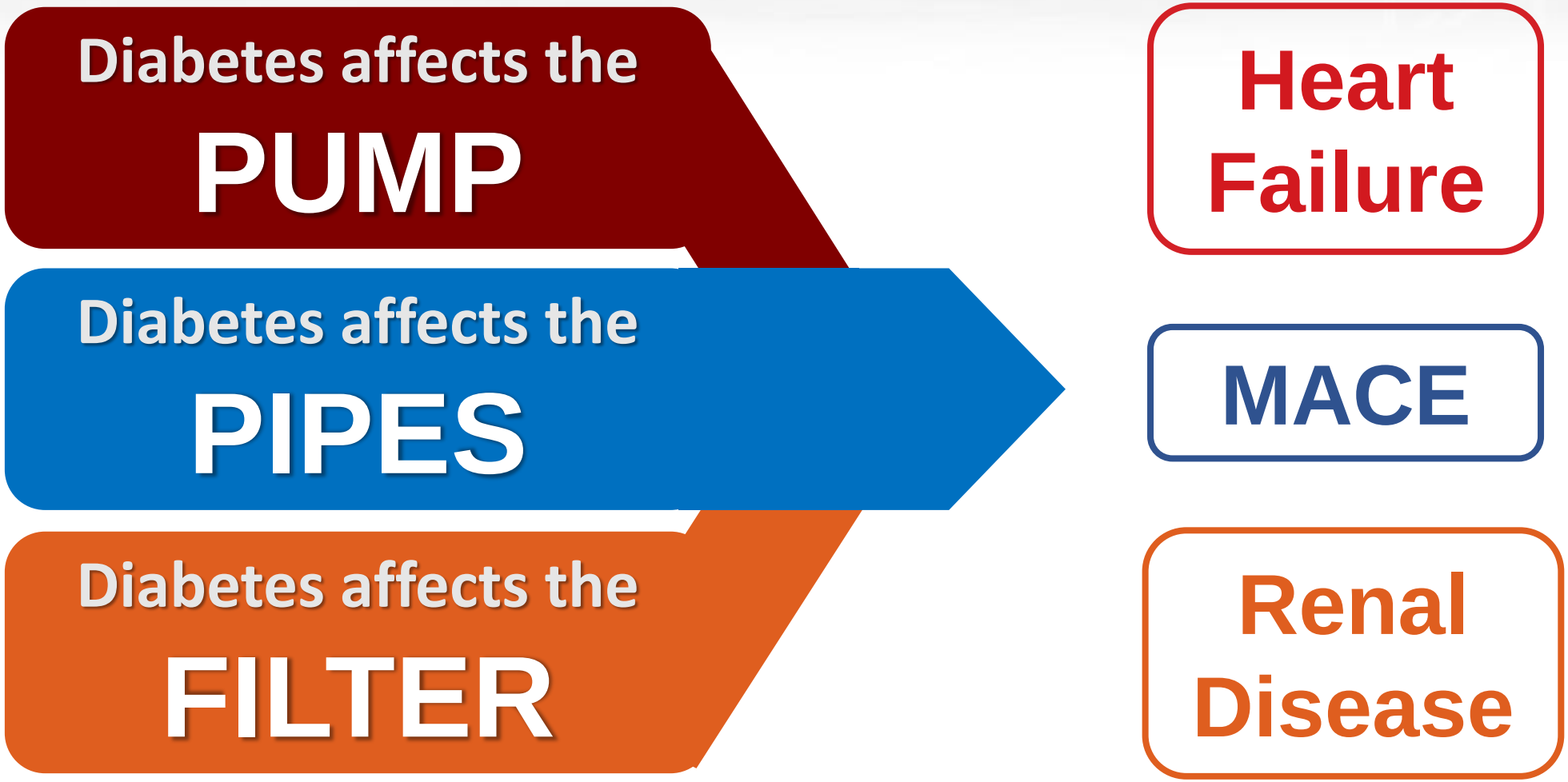
± 20% DIAGNOSIS AT TIME OF ADMISSION

Redondo A et al. Rev Esp Cardiol 2015;68:777-84
Galvao C et al. Rev Esp Cardiol 2017; 70:425-32
Otero F et al. Rev Esp Cardiol 2010; 63:1371-6
Galve E et al. Rev Esp Cardiol 2016;69:931-8.

Varela A et al. Heart 2005; 91:489-94
Otero F et al. Rev Esp Cardiol 2007; 60:373-83
Agra R et al. Cardiol J 2017; epub ahead of print
Gómez-Otero et al. Rev Esp Cardiol 2017;70:338-46

Rodríguez-Mañero M et al. Rev Esp Cardiol. 2014;67:890–7
Carnero L et al. Rev Esp Cardiol. 2017;70:872–86
Rodríguez-Mañero M et al. Inter J Cardiol 2017; 243: 211–5

Cardiovascular-Renal Spectrum of Diabetes



MACE, major adverse cardiovascular events (non-fatal stroke, non-fatal myocardial infarction, and cardiovascular death).
Verma S et al. Lancet. 2019;393:3-5.

Diabetes and NSTEMI. Prognostic Implications

CardioCHUS-HUSJ Registry

	MORTALIDAD CV				MORTALIDAD TOTAL			
	GRACE < 140	p	GRACE≥140	p	GRACE < 140	p	GRACE≥140	p
Mujeres	0,70 (0,48-1,00)	0,05	0,71 (0,54-0,92)	0,01	0,57 (0,42-0,77)	<0,01	0,61 (0,49-0,77)	<0,01
Diabetes *mellitus*	1,77 (1,29-2,44)	0,01	1,63 (1,28-2,01)	0,01	1,63 (1,26-2,11)	<0,01	1,50 (1,22-1,82)	<0,01
EC previa	1,08 (0,76-1,50)	0,61	1,40 (1,09-1,79)	0,01	1,07 (0,81-1,41)	0,06	1,33 (1,08-1,64)	<0,01
IC previa	2,25 (1,16-4,37)	0,02	2,25 (1,59-3,17)	0,01	1,66 (0,92-3,02)	0,10	2,02 (1,50-2,72)	<0,01
TFG < 60 ml/min/1,72 m^2	1,51 (1,00-1,86)	0,03	1,50 (1,09-1,79)	0,01	1,51 (1,12-2,04)	<0,01	1,50 (1,22-1,84)	<0,01
Bloqueadores beta al alta	0,75 (0,53-1,06)	0,11	0,73 (0,57-0,92)	0,01	0,62 (0,48-0,82)	<0,01	0,71 (0,58-0,86)	<0,01
IECA/ARA-II al alta	1,00 (0,70-1,45)	0,99	0,85 (0,66-1,09)	0,19	0,93 (0,70-1,24)	0,63	0,83 (0,67-1,02)	0,08
Coronariografía en 24 h	1,37 (1,00-1,86)	0,05	0,79 (0,63-0,97)	0,04	1,22 (0,98-1,68)	0,06	0,86 (0,71-1,05)	0,15

Alvarez B, …, Gonzalez-Juanatey JR . Rev Esp Cardiol 2020 73: 35-42.

New treatment paradigm in T2D

GlucoCentric Aproach

HbA_{1c} as the central focus

(CV) Events Reduction Approach

Multifactorial Intervention

The *pillars* of CV Protection in T2D in 2022

LDL-C lowering Statins Ezetimibe PCSK9i	**Blood Pressure** ACEi ARAB	**Triglyceride Lowering** EPA	**GLP-1RA** **SGLT2i**	**Life-style Changes**

OPTIMAL CV RISK REDUCTION IN DIABETIC PATIENTS IS ACHIEVED THROUGH TARGETING MULTIPLE RISK FACTORS

Lifestyle Changes

Lipids	**Lipid lowering** LDL < 55 / <70 or < 100 mg/dL (1.8 mmol/L); lifestyle, statin, ezetimibe, PCSK9i
Blood pressure	**Target of <130/80 (140–130/90–80) mmHg** ACEi/ARB, BB
Antithrombotics	**Antiplatelet use** ASA (75–162 mg/day), DAPT
Glucose	**HbA_{1c} target individualised; generally ~7%** Lifestyle modification, then metformin/SGLT2i/GLP1a

ARB, angiotensin receptor blocker; BB, beta blocker; CV, cardiovascular; DAPT, dual antiplatelet therapy; GLP1a, glucagon-like peptide 1a; SGLT2i, sodium glucose transport protein 2 inhibitor.

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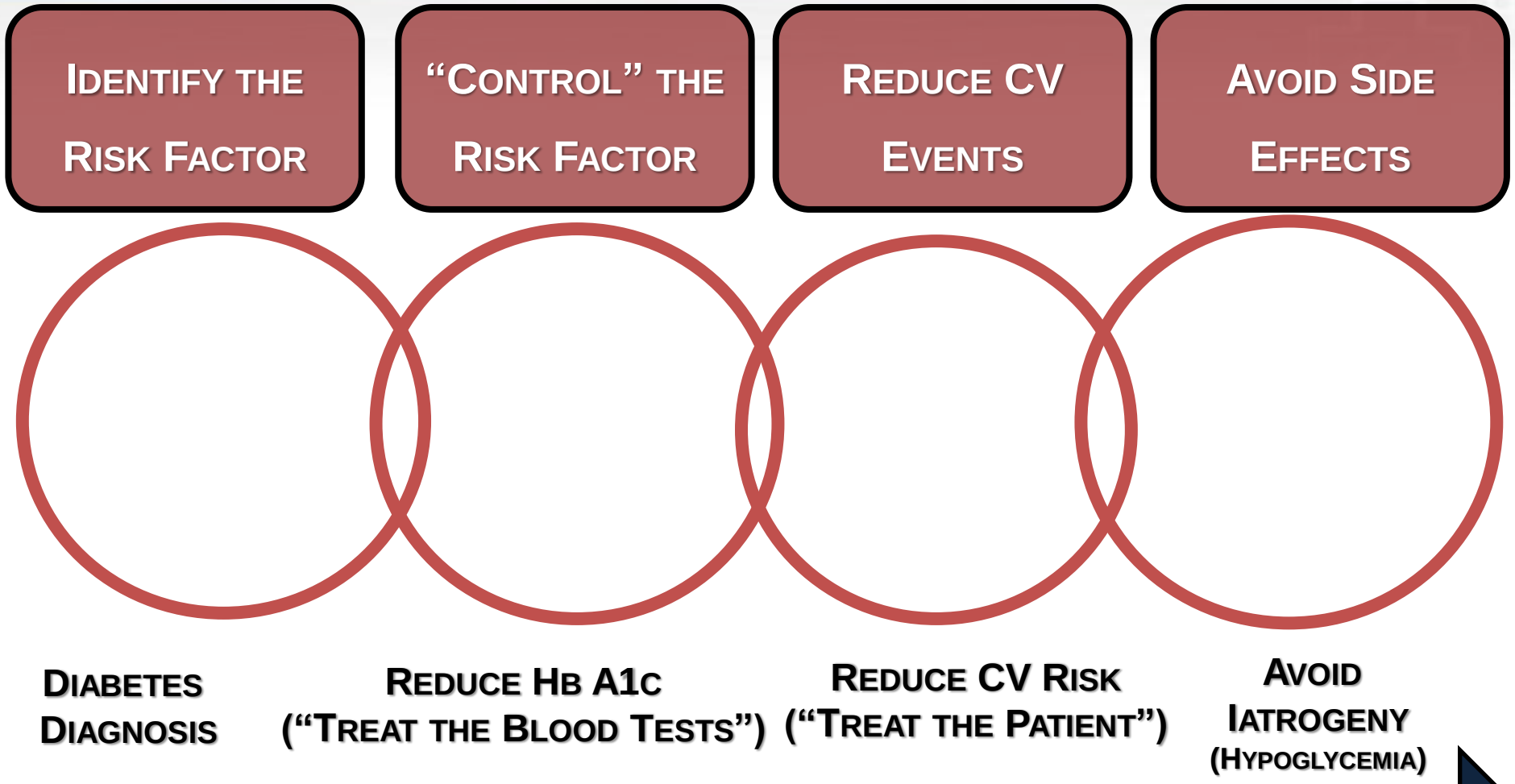
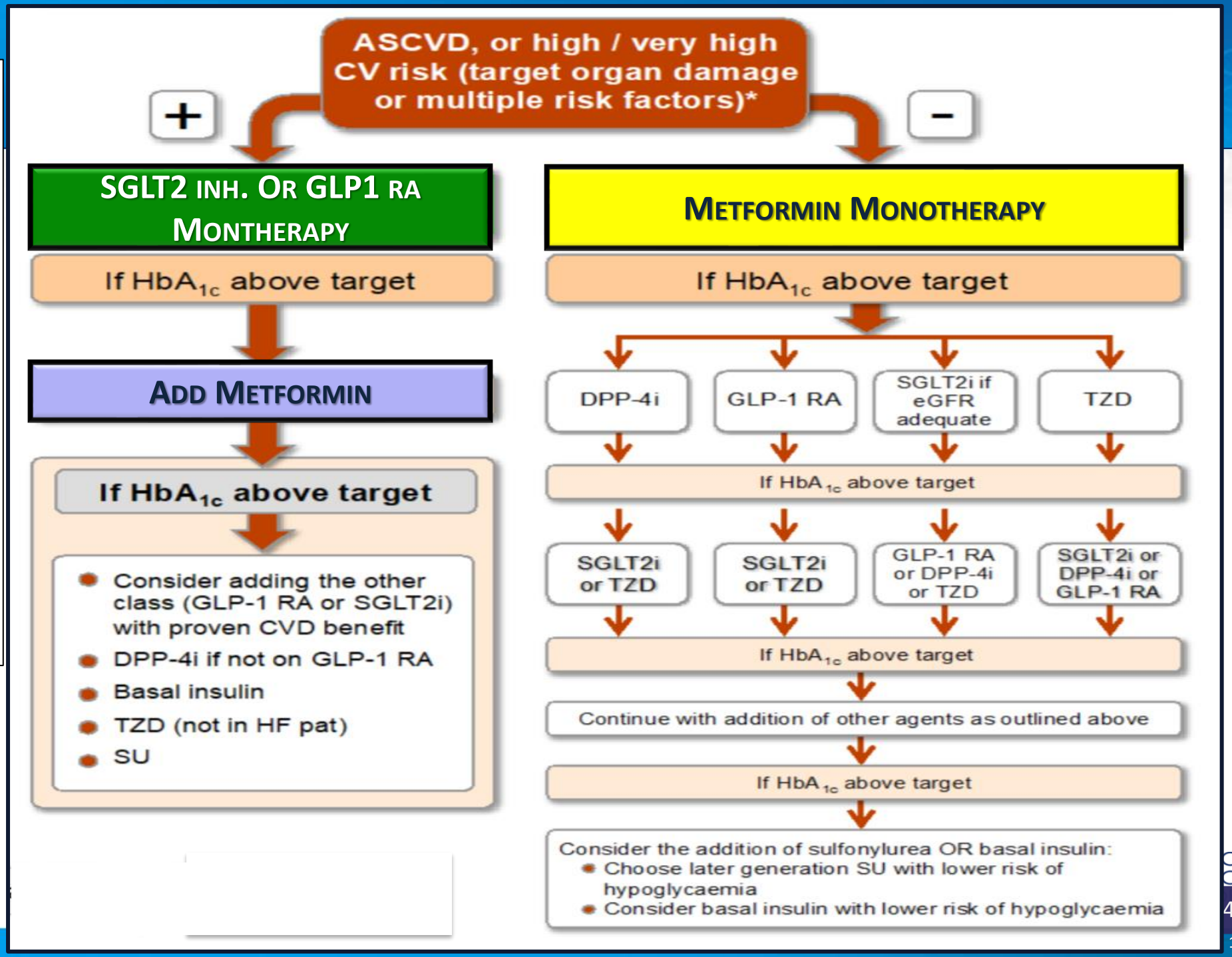
The "Virtuous Chain" of Cardiovascular Protection In Diabetes

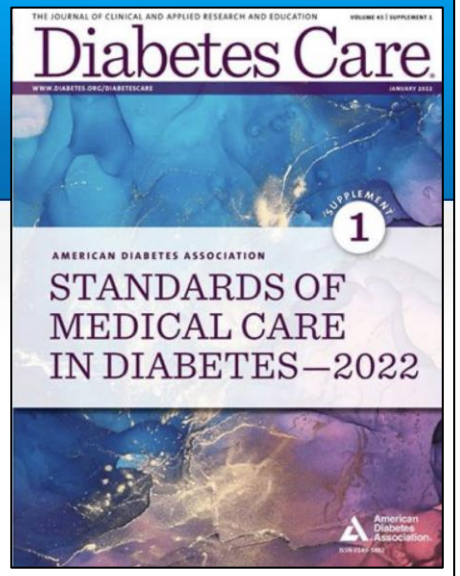


T2DM Treatment algorithm.

Type 2 DM – Drug naive patients.

ESC-2019





PHARMACOLOGIC TREATMENT OF HYPERGLYCEMIA IN ADULTS WITH TYPE 2 DIABETES

FIRST-LINE THERAPY depends on comorbidities, patient-centered treatment factors, including cost and access considerations, and management needs and generally includes metformin and comprehensive lifestyle modification^

TO AVOID THERAPEUTIC INERTIA REASSESS AND MODIFY TREATMENT REGULARLY (3–6 MONTHS)

ASCVD/INDICATORS OF HIGH RISK, HF, CKD†

RECOMMEND INDEPENDENTLY OF BASELINE A1C, INDIVIDUALIZED A1C TARGET, OR METFORMIN USE‡

+ASCVD/INDICATORS OF HIGH RISK*

EITHER/OR

- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1]

IF A1C ABOVE TARGET

- For patients on a GLP-1 RA, consider incorporating SGLT2i with proven CVD benefit and vice versa[1]
- TZD[2]

+HF*

SGLT2i with proven benefit in this population[1]

+CKD**

CKD and albuminuria (e.g., ≥200 mg/g creatinine)

CKD without albuminuria (e.g., eGFR <60 mL/min/1.73 m²)

PREFERABLY

SGLT2i with primary evidence of reducing CKD progression

OR

SGLT2i with evidence of reducing CKD progression in CVOTs

OR

GLP-1 RA with proven CVD benefit[1] if SGLT2i not tolerated or contraindicated

For patients with CKD (e.g., eGFR <60 mL/min/1.73 m²) without albuminuria, recommend the following to decrease cardiovascular risk

EITHER/OR

- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1]

If A1C above target, for patients on SGLT2i, consider incorporating a GLP-1 RA and vice versa

If A1C remains above target, consider treatment intensification based on comorbidities, patient-centered treatment factors, and management needs

NONE

Incorporate agents that provide adequate EFFICACY to achieve and maintain glycemic goals

Higher glycemic efficacy therapy: GLP-1 RA; insulin; combination approaches (Table 9.2)

- **Consider additional comorbidities, patient-centered treatment factors, and management needs in choice of therapy, as below:**

MINIMIZE HYPOGLYCEMIA

No/low inherent risk of hypoglycemia: DPP-4i, GLP-1 RA, SGLT2i, TZD

For SU or basal insulin, consider agents with lower risk of hypoglycemia[3,4]

IF A1C ABOVE TARGET

Incorporate additional agents based on comorbidities, patient-centered treatment factors, and management needs

MINIMIZE WEIGHT GAIN/ PROMOTE WEIGHT LOSS

PREFERABLY

GLP-1 RA with good efficacy for weight loss

OR

SGLT2i

IF A1C ABOVE TARGET

For patients on a GLP-1 RA, consider incorporating SGLT2i and vice versa

- If GLP-1 RA not tolerated or indicated, consider DPP-4i (weight neutral)

Incorporate additional agents based on comorbidities, patient-centered treatment factors, and management needs

CONSIDER COST AND ACCESS

Available in generic form at lower cost:

- Certain insulins: consider insulin available at the lowest acquisition cost
- SU
- TZD

IF A1C ABOVE TARGET

Incorporate additional agents based on comorbidities, patient-centered treatment factors, and management needs

1. Proven benefit refers to label indication (see Table 9.2)
2. Low dose may be better tolerated though less well studied for CVD effects
3. Choose later generation SU to lower risk of hypoglycemia
4. Risk of hypoglycemia: degludec / glargine U-300 < glargine U-100 / detemir < NPH insulin
5. Consider country- and region-specific cost of drugs

^For adults with overweight or obesity, lifestyle modification to achieve and maintain ≥5% weight loss and ≥150 min/week of moderate- to vigorous-intensity physical activity is recommended (See Section 5: Facilitating Behavior Change and Well-being to Improve Health Outcomes).
†Actioned whenever these become new clinical considerations regardless of background glucose-lowering medications.
‡Most patients enrolled in the relevant trials were on metformin at baseline as glucose-lowering therapy.
*Refer to Section 10: Cardiovascular Disease and Risk Management.
**Refer to Section 11: Chronic Kidney Disease and Risk Management and specific medication label for eGFR criteria.

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GLP-1 Receptor Agonists

CV Outcome Trials

ELIXA

LEADER

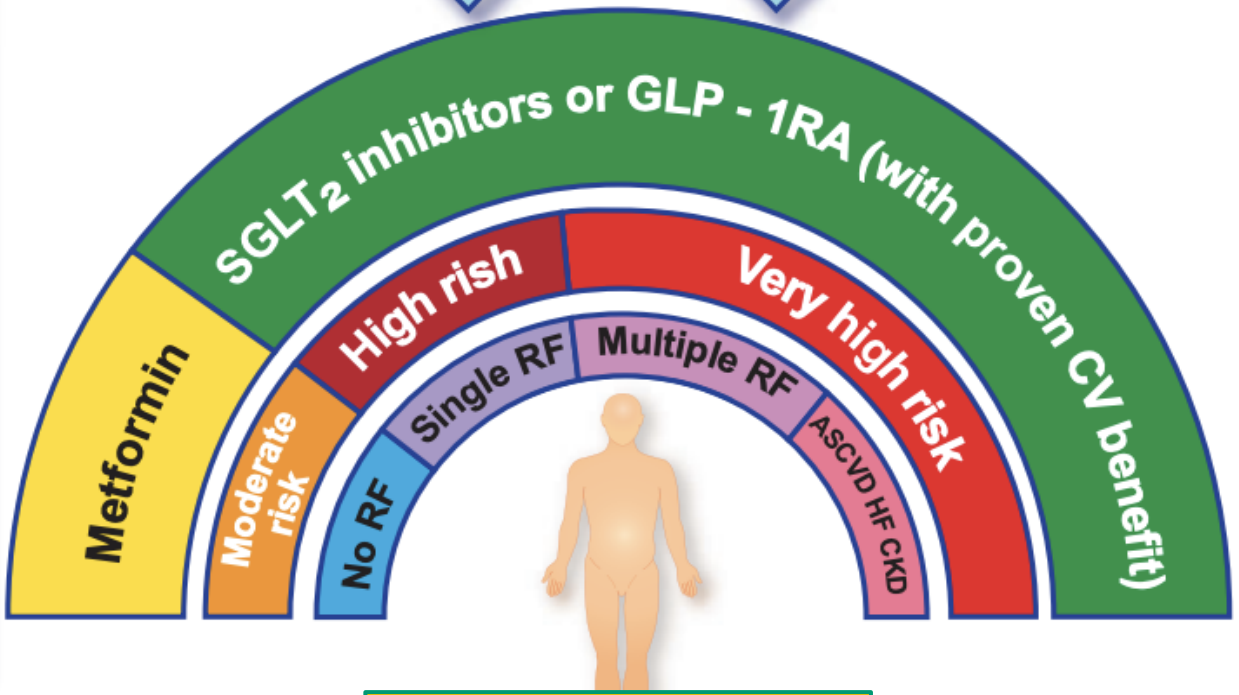
SUSTAIN-6

EXSCEL

HARMONY

REWIND

PIONEER-6



SGLT2 Inhibitors

CV Outcome Trials

EMPA REG OUTCOME

CANVAS Programme

DECLARE TIMI 58

VERTIS CV

Renal Trials

CREDENCE

DAPA CKD

HF Trials

DAPA HF

EMPEROR- Reduced

DIABETES

Very high risk	Patients with DM and establised CVD or other target organ damage or three or more major risk factors or early onset T1DM of long duration (>20 years)
High risk	Patients with DM duration ≥10 years without target organ damage plus any other additional risk factor
Moderate risk	Young patients (T1DM aged <35 years or T2DM aged <50 years) with DM duration <10 years, without other risk factors

EHJ 2020

Evidence GLP-1 RAs have beneficial effects on CV outcomes on atherothrombotic events

	EMPA-REG OUTCOME[1] (empagliflozin)	CANVAS Program[2,3] (canagliflozin)	DECLARE-TIMI 58[4] (dapagliflozin)	ELIXA[5] (lixisenatide)	LEADER[6] (liraglutide)	EXSCEL[7] (exenatide)	SUSTAIN-6[8] (inject. semaglutide)	Harmony Outcomes[9] (albiglutide)	PIONEER 6 (oral semaglutide)[10]	REWIND (dulaglutide)[11]
3P-MACE	**HR 0.86 (95% CI 0.74, 0.99) *p*=0.04**	**HR 0.86 (95% CI 0.75, 0.97) *p*=0.02†**	HR 0.93 (95% CI 0.84, 1.03) *p*=0.17	HR 1.02 (4P-MACE) (95% CI 0.89, 1.17) *p*=0.81	**HR 0.87 (95% CI 0.78, 0.97) *p*=0.01**	HR 0.91 (95% CI 0.83, 1.00) *p*=0.06	**HR 0.74 (95% CI 0.58, 0.95) *p*=0.02§**	**HR 0.78 (95% CI 0.68, 0.90) *p*=0.0006**	HR 0.79 (95% CI 0.57, 1.11) *p*=0.17	**HR 0.88 (95% CI 0.79, 0.99) *p*=0.026**
CV death*	**HR 0.62 (95% CI 0.49, 0.77) *p*<0.001***	HR 0.87 (95% CI 0.72, 1.06)‡	HR 0.98 (95% CI 0.82, 1.17)‡	HR 0.98 (95% CI 0.78, 1.22) *p*=0.85*	**HR 0.78 (95% CI 0.66, 0.93) *p*=0.007***	HR 0.88 (95% CI 0.76, 1.02)‡	HR 0.98 (95% CI 0.65, 1.48) *p*=0.92*	HR 0.93 (95% CI 0.73, 1.19) *p*=0.578*	**HR 0.49 (95% CI 0.27, 0.92)‡**	HR 0.91 (95% CI 0.78, 1.06) *p*=0.21*
HHF	**HR 0.65 (95% CI 0.50, 0.85) *p*=0.002***	**HR 0.67 (95% CI 0.52, 0.87)‡**	**HR 0.73 (95% CI 0.61, 0.88)‡**	HR 0.96 (95% CI 0.75, 1.23) *p*=0.75*	HR 0.87 (95% CI 0.73, 1.05) *p*=0.14*	HR 0.94 (95% CI 0.78, 1.13)‡	HR 1.11 (95% CI 0.77, 1.61) *p*=0.57*	NR	HR 0.86 (95% CI 0.48, 1.55)‡	HR 0.93 (95% CI 0.77, 1.12) *p*=0.46*
CV death or HHF	**HR 0.66 (95% CI 0.55, 0.79) *p*<0.001***	**HR 0.78 (95% CI 0.67, 0.91) *p*=0.002***	**HR 0.83 (95% CI 0.73, 0.95) *p*=0.005***	NR	NR	NR	NR	HR 0.85 (95% CI 0.70, 1.04) *p*=0.113*	NR	NR
Non-fatal stroke	HR 1.24 (95% CI 0.92, 1.67) *p*=0.16*	HR 0.90 (95% CI 0.71, 1.15)‡	HR 1.01 (95% CI 0.84, 1.21)‡	HR 1.12 (95% CI 0.79, 1.58) *p*=0.54*	HR 0.89 (95% CI 0.72, 1.11) *p*=0.30*	HR 0.85 (95% CI 0.70, 1.03)‡,††	**HR 0.61 (95% CI 0.38, 0.99) *p*=0.04***	NR	HR 0.74 (95% CI 0.35, 1.57)‡	**HR 0.76 (95% CI 0.61, 0.95) *p*=0.017***
Non-fatal MI	HR 0.87 (95% CI 0.70, 1.09) *p*=0.23*	HR 0.89 (95% CI 0.73, 1.09)‡	HR 0.89 (95% CI 0.77, 1.01)‡	HR 1.03 (95% CI 0.87, 1.22) *p*=0.71*	HR 0.88 (95% CI 0.75, 1.03) *p*=0.11*	HR 0.97 (95% CI 0.85, 1.10)‡,††	HR 0.74 (95% CI 0.51, 1.08) *p*=0.12*	**HR 0.75 (95% CI 0.61, 0.90) *p*=0.003***	HR 1.18 (95% CI 0.73, 1.90)‡	HR 0.96 (95% CI 0.79, 1.16) *p*=0.65*

1. Zinman B *et al*. *N Engl J Med* 2015;373:2117; 2. Neal B *et al*. *N Engl J Med* 2017;377:644; 3. Radholm K *et al*. *Circulation* 2018;138:458; 4. Wiviott S *et al*. *N Engl J Med* 2019;380:347; 5. Pfeffer MA *et al*. *N Engl J Med* 2015;373:2247; 6. Marso SP *et al*. *N Engl J Med* 2016;375:311; 7. Holman RR *et al*. *N Engl J Med* 2017;377:1228; 8. Marso SP *et al*. *N Engl J Med* 2016;375:1834; 9. Hernandez AF *et al*. *Lancet* 2018;392:1519; 10. Husain M *et al*. *N Engl J Med* 2019;381:841; 11. Gerstein H *et al*. *Diabetes Obesity Metab* 2018;20:42

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Semaglutida oral y resultados cardiovasculares en pacientes con DM2: características basales del estudio PIONEER 6[1]

- **84,7%** pacientes con DM2 ≥ 50 años con ECV establecida y ERC
- **32,3** IMC
- **66** años edad media
- **74** ml/min/1,73m² TFGe

Características basales clínicas y demográficas seleccionadas de los pacientes*

Características	Rybelsus® (N = 1591)	Placebo (N = 1592)	Total (N = 3183)
Edad-años	66±7	66±7	66±7
Sexo femenino - n° (%)	507 (31,9)	500 (31,4)	1007 (31,6)
Peso corporal - kg	91,0±21,4	90,8±21,0	90,9±21,2
Índice de masa corporal	32,3±6,6	32,3±6,4	32,3±6,5
Diabetes tipo 2			
Duración-años	14,7±8,5	15,1±8,5	14,9±8,5
Hemoglobina glicada - %	8,2±1,6	8,2±1,6	8,2±1,6
Hemoglobina glicada - mmol/mol	66±17	66±18	66±18
Estrato del riesgo cardiovascular - n° (%)			
Edad ≥50 años y ECV establecida o enfermedad renal crónica	1350 (84,9)	1345 (84,5)	2695 (84,7)
Edad ≥60 años y únicamente factores de riesgo cardiovascular	241 (15,1)	247 (15,5)	488 (15,3)
Factores de riesgo cardiovascular			
Presión arterial - mm Hg			
Sistólica	135±18	136±18	136±18
Diastólica	76±10	76±10	76±10
Colesterol LDL			
Media geométrica - mg/dl	77	79	78
Coeficiente de variación - %	44,9	41,2	43,1
Fumador - n° (%)	184 (11,6)	165 (10,4)	349 (11,0)
TFG estimada			
Media - ml/min/1,73 m²	74±21	74±21	74±21
Distribución - n° (%)			
≥90 ml/min/1,73 m²	464 (29,2)	455 (28,6)	919 (28,9)
60 a <90 ml/min/1,73 m²	686 (43,1)	703 (44,2)	1389 (43,6)
30 a <60 ml/min/1,73 m²	418 (26,3)	409 (25,7)	827 (26,0)
<30 ml/min/1,73 m²	16 (1,0)	13 (0,8)	29 (0,9)
Datos no disponibles	7 (0,4)	12 (0,8)	19 (0,6)

*Los valores más-menos son medias ±DE. Los porcentajes pueden no sumar 100 debido al redondeo. Para convertir los valores de colesterol de lipoproteínas de baja densidad (LDL) a milimoles por litro, multiplique por 0,02586. ECV significa enfermedad cardiovascular, y TFG tasa de filtración glomerular. En Bain et al. se ofrecen más datos basales resumidos. DM2: diabetes mellitus tipo 2; ECV: enfermedad cardiovascular; ERC: enferemedad renal crónica; IMC: índice de masa corporal; TFGe: tasa de filtración glomerular estimada; LDL: lipoproteínas de alta densidad; TFG: tasa de filtración glomerular.

1. Husain M, et al. N Engl J Med. 2019 Aug 29;381(9):841-851. doi: 10.1056/NEJMoa1901118.

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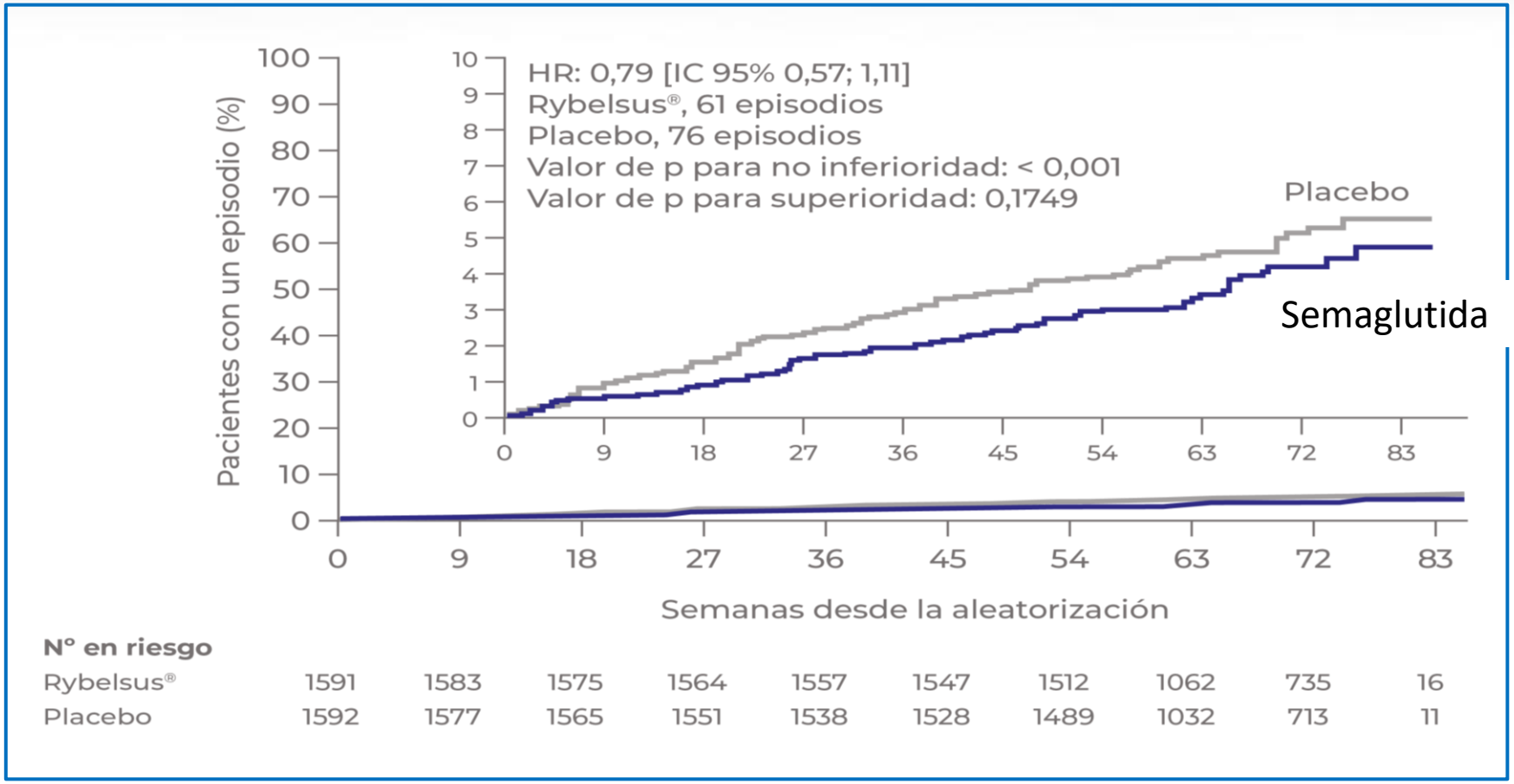
Semaglutida oral y resultados cardiovasculares en pacientes con DM2: estudio PIONEER 6[1]

Resultados cardiovasculares



El ensayo incluyó un periodo de observación previsto de 109 semanas para todos los pacientes (un periodo de tratamiento de 104 semanas con un período de seguimiento de 5 semanas). DM2: diabetes mellitus tipo 2; HR: hazard ratio; IC: intervalo de confianza.

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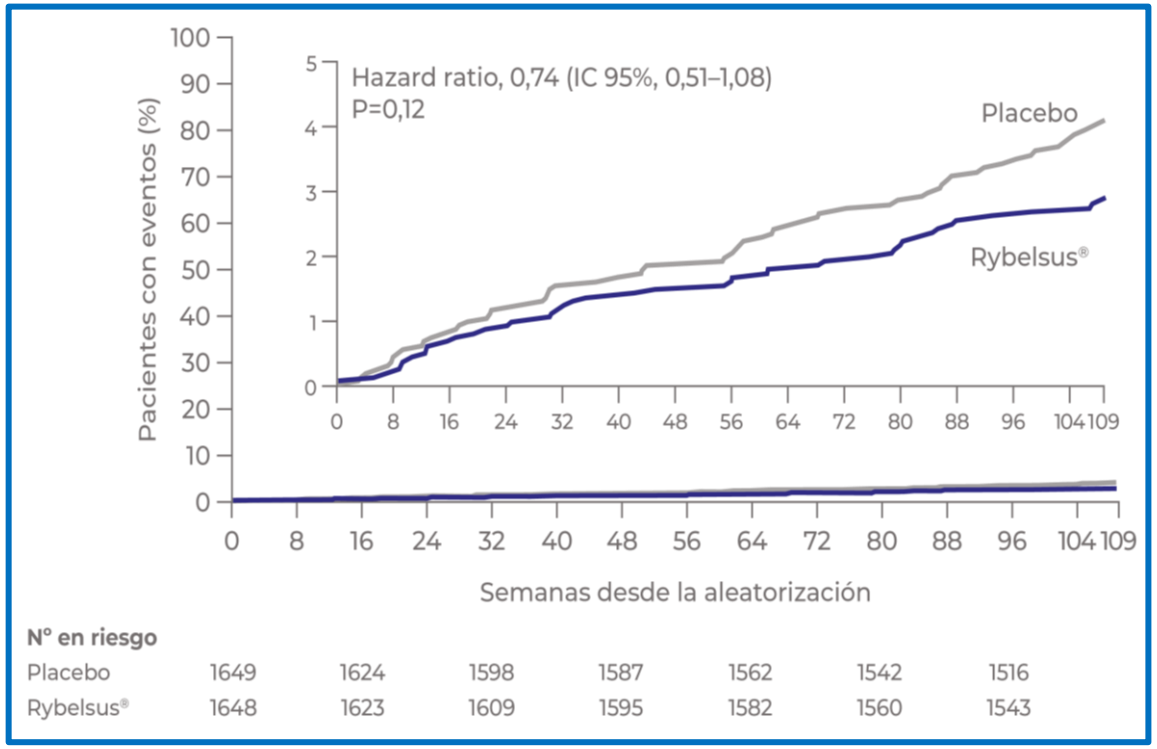
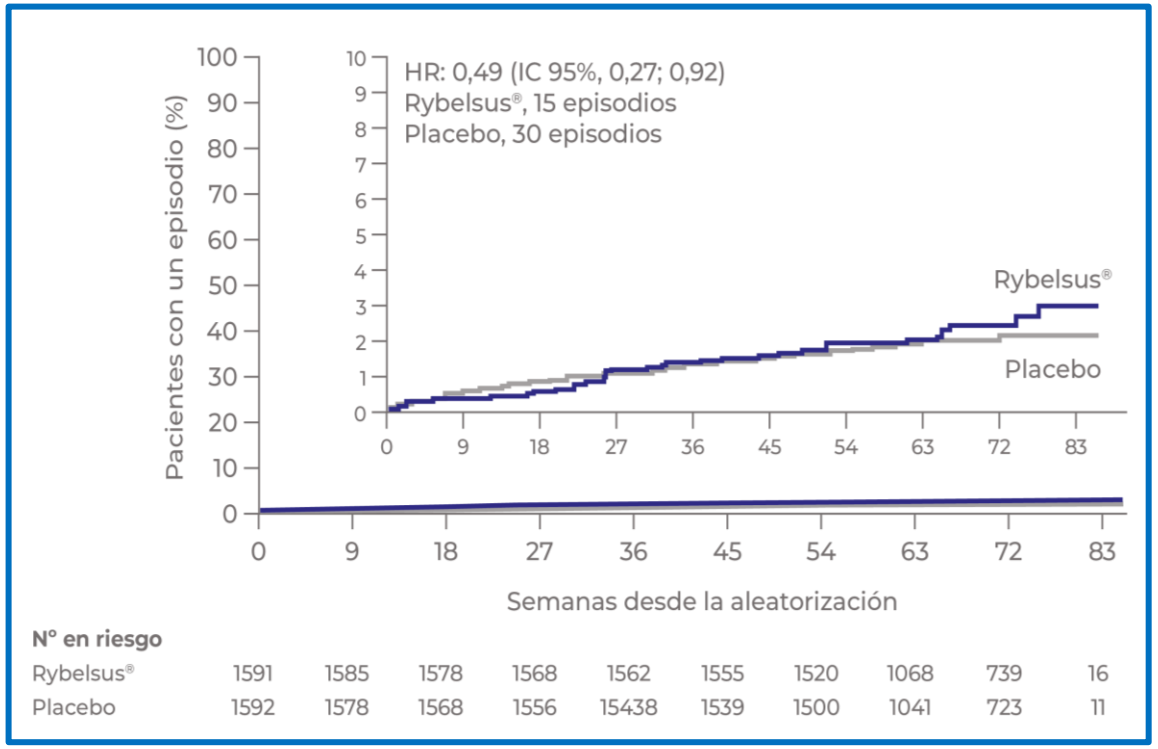
Semaglutida oral y resultados cardiovasculares en pacientes con DM2: estudio PIONEER 6[1]

Infarto de miocardio no mortal



Muerte cardiovascular



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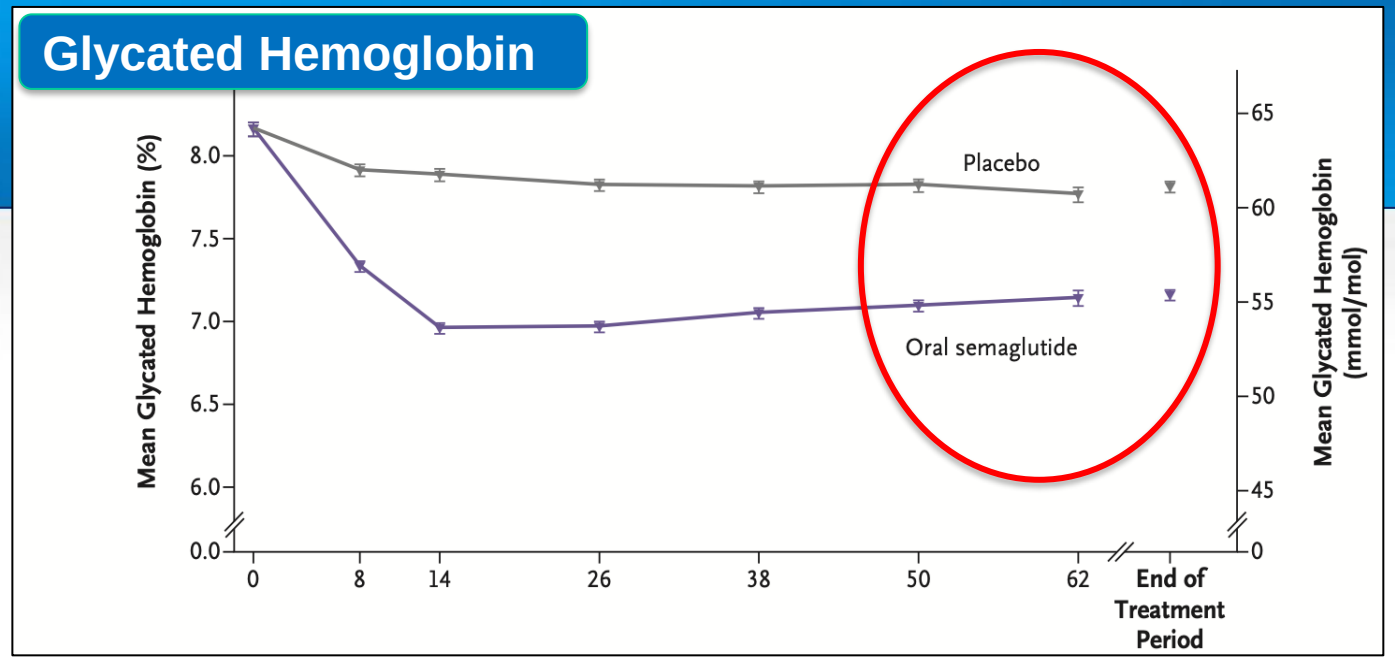
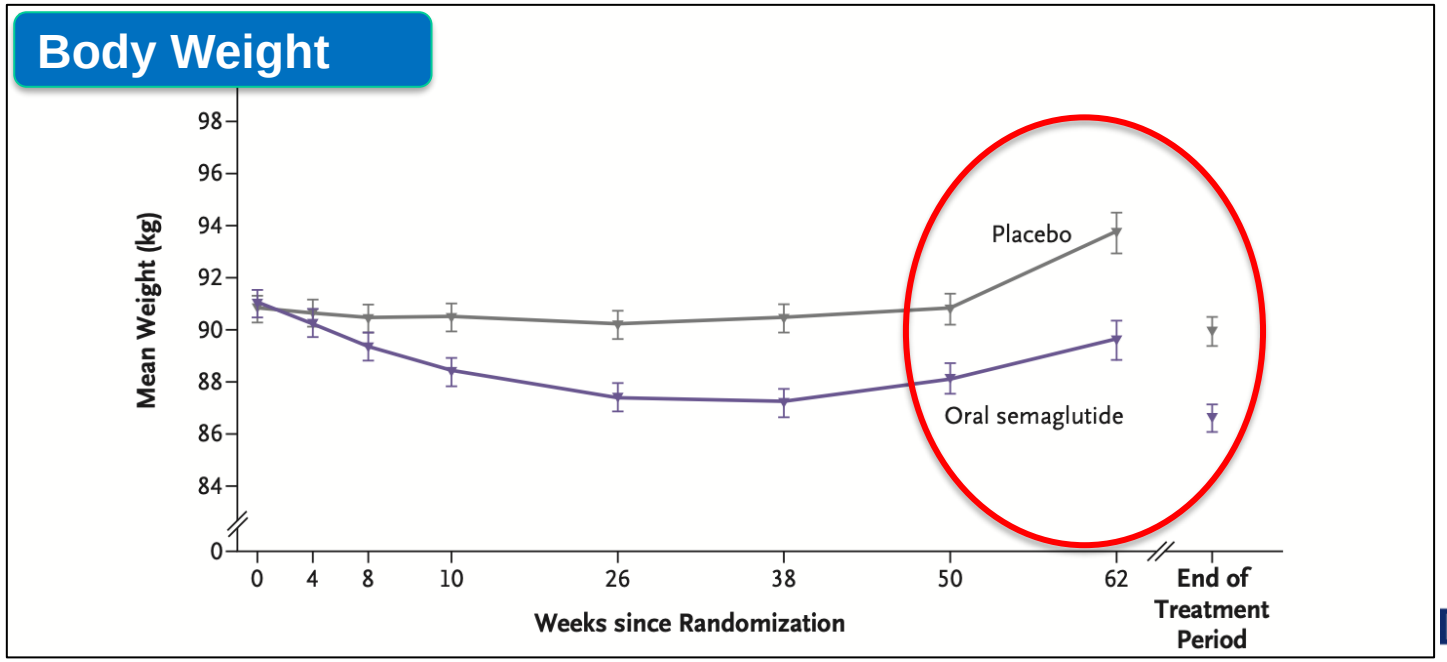
Oral semaglutide and Cardiovascular Outcomes in Patients with T2D. PIONEER 6 Trial

Glycated Hemoglobin



Body Weight



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Husain M, et al. New Engl J Med 2019; 381: 841-851.

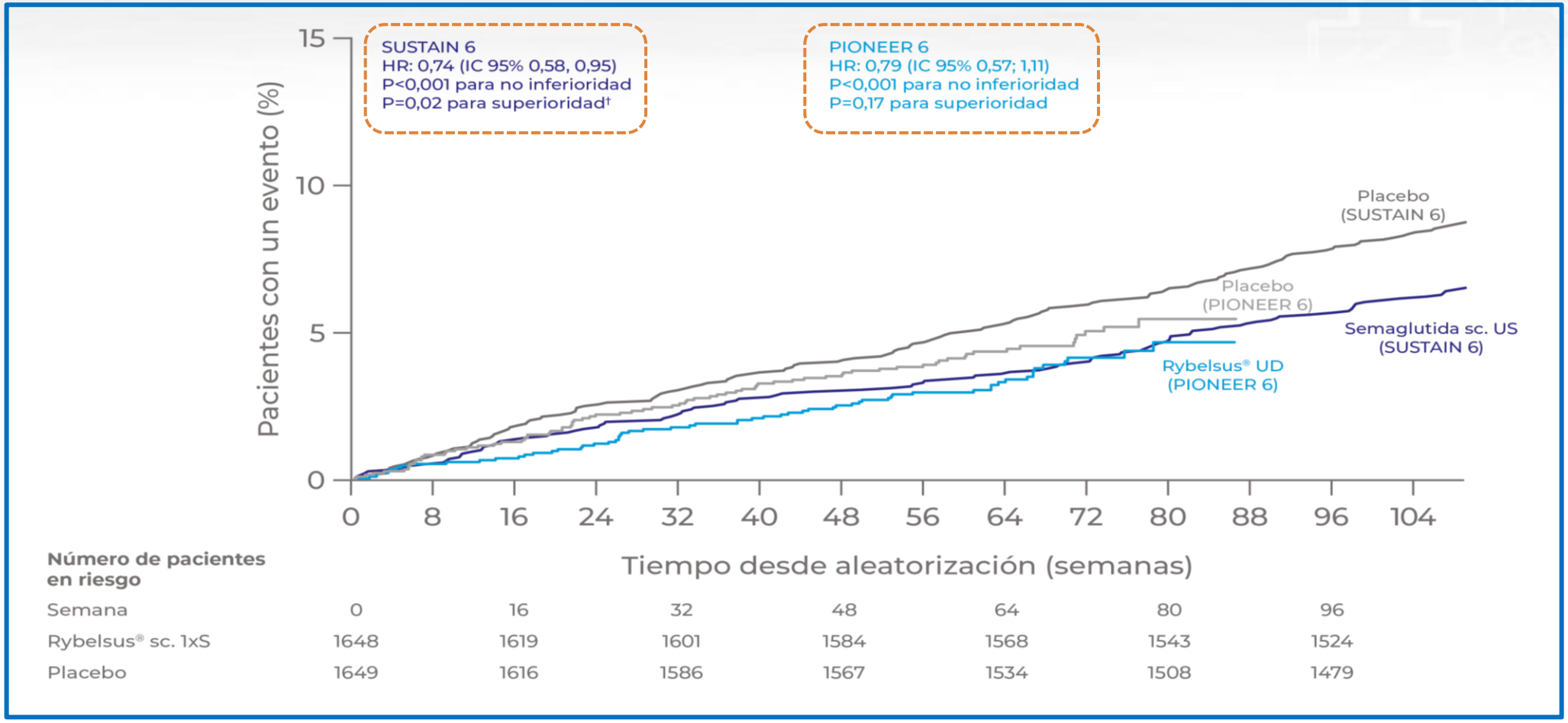
Semaglutida oral y resultados cardiovasculares en pacientes con DM2: acontecimientos adversos observados en el estudio PIONEER 6[1]

Acontecimiento adversos (durante el periodo de tratamiento a menos que se especifique lo contrario)

Evento	Rybelsus® (N = 1591)	Placebo (N = 1592)
	Número de pacientes (porcentaje)	
Acontecimiento adverso que conduce a la interrupción permanente de semaglutida oral o de placebo	184 (11,6)	104 (6,5)
Según el sistema de clasificación por órgano†		
Trastornos gastrointestinales	108 (6,8)	26 (1,6)
Trastornos del metabolismo y la nutrición	19 (1,2)	7 (0,4)
Trastornos del sistema nervioso	17 (1,1)	13 (0,8)
Acontecimiento adverso grave	301 (18,9)	358 (22,5)
Que conlleven a la interrupción permanente de semaglutida oral o de placebo	41 (2,6)	48 (3,0)
Acontecimientos adversos de especial interés		
Enfermedad renal aguda‡	32 (2,0)	37 (2,3)
Pancreatitis aguda‡	1 (0,1)	3 (0,2)
Retinopatía o complicaciones relacionadas§¶	113 (7,1)	101 (6,3)
Hipoglucemia grave§	23 (1,4)	13 (0,8)
Neoplasias malignas‡¶‖	41 (2,6)	48 (3,0)

1. Husain M, et al. N Engl J Med. 2019 Aug 29;381(9):841-851. doi: 10.1056/NEJMoa1901118.

Incidencia acumulada del tiempo hasta la primera aparición de AAG con semaglutida vs. placebo en los estudios SUSTAIN 6 y PIONEER 6[1]



Número de pacientes en riesgo

Semana	0	16	32	48	64	80	96
Rybelsus® sc. 1xS	1648	1619	1601	1584	1568	1543	1524
Placebo	1649	1616	1586	1567	1534	1508	1479

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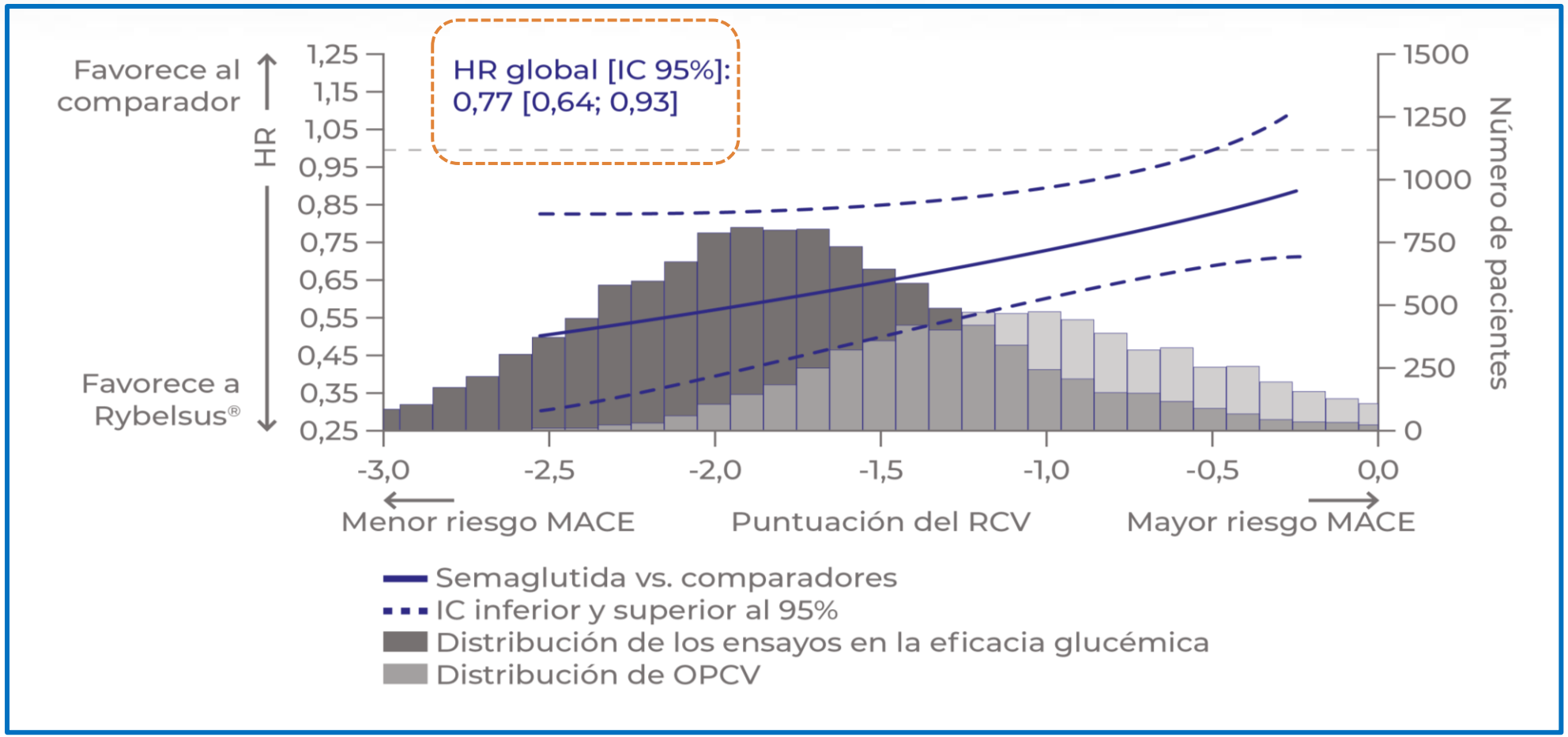
1. Husain M, et al. Diabetes Obes Metab. 2020 Mar;22(3):442-451. doi: 10.1111/dom.13955.

SERVIZO GALEGO de SAÚDE

Efectos de semaglutida en el RCV: estudio SUSTAIN y PIONEER[1]

Riesgo relativo de MACE según el ECV basal y la distribución de sujetos



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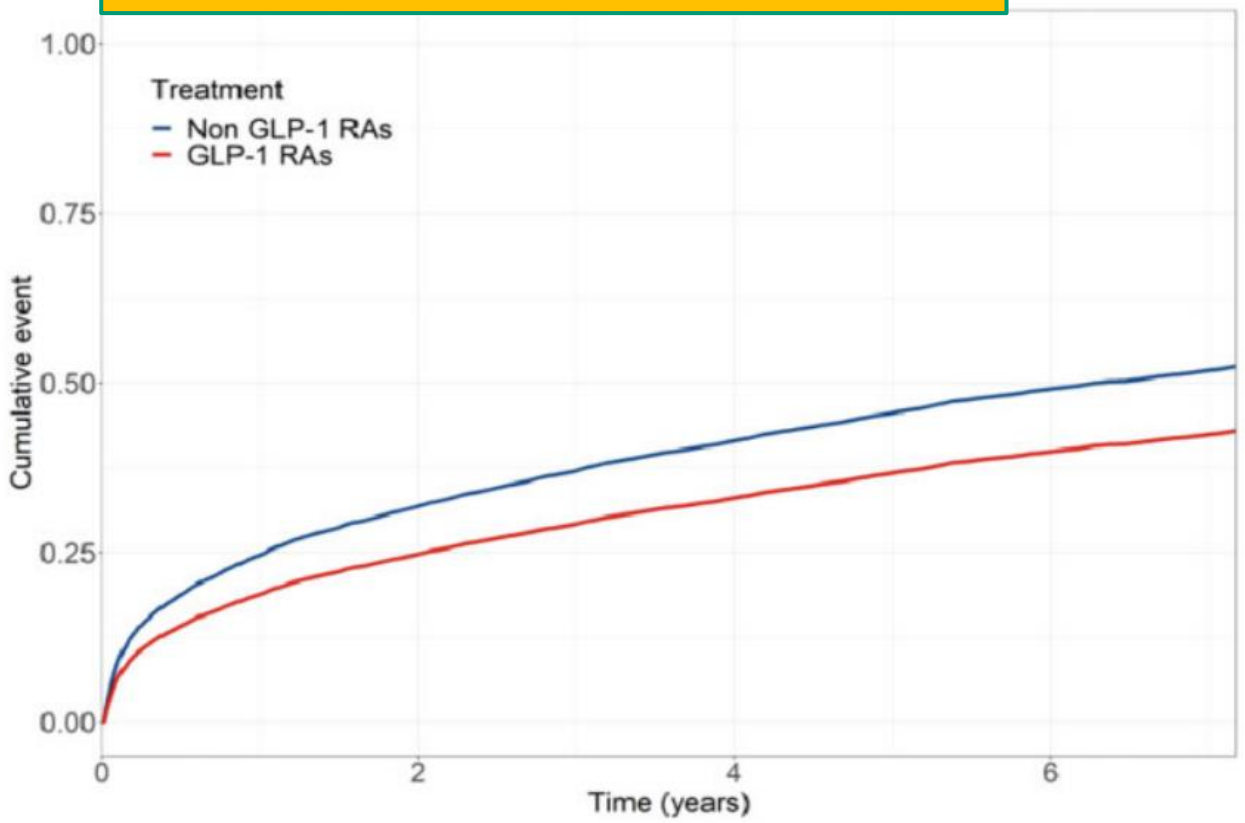
1. Husain M, et al. Cardiovasc Diabetol. 2020 Sep 30;19(1):156. doi: 10.1186/s12933-020-01106-4.

GLP1 receptor agonists and the risk of CV events in diabetic patients with an Acute Myocardial Infarction. SWEDEHEART.

3P-MACE

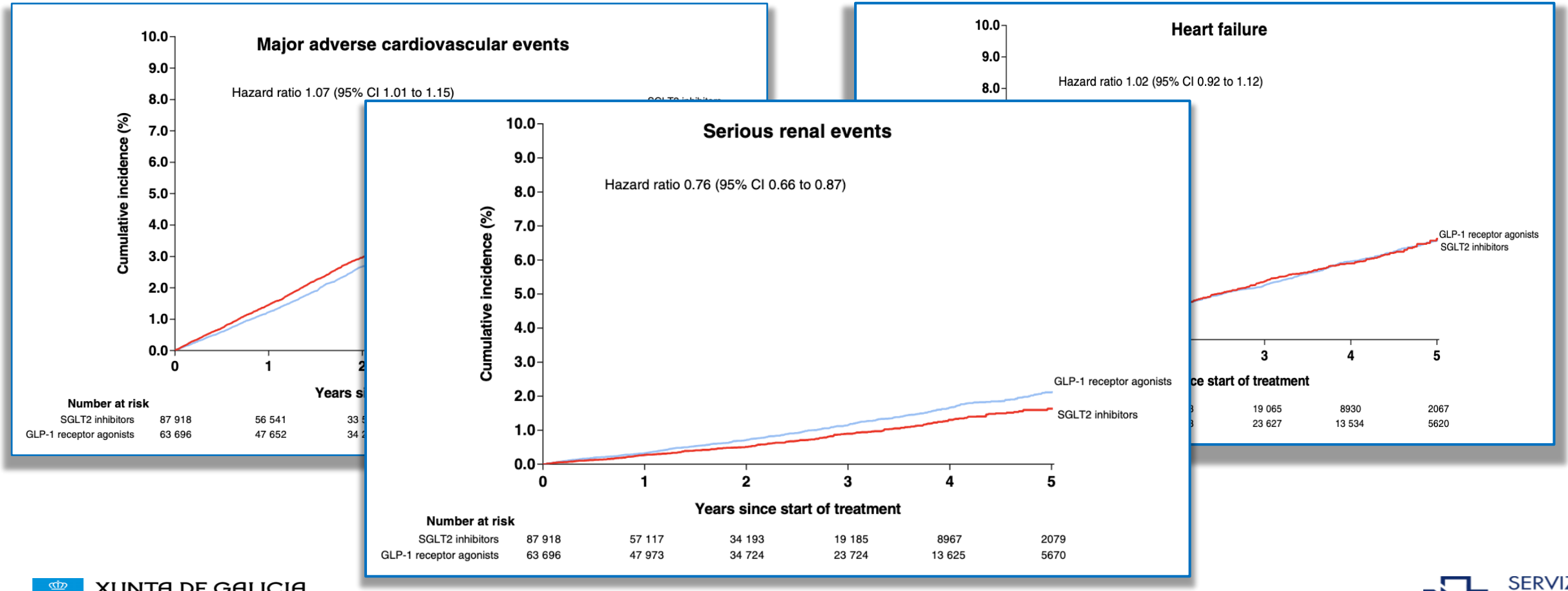
MACE: Cumulative incidence (adjusted)



Trevisan M, et al. EHJ Cardiovasc Pharm 2021; 7: 337-104-111.

The comparative cardiovascular and renal effectiveness of SGLT2i and GLP1-ra : *A Scandinavian cohort study*

A cohort study of nationwide registers from Sweden,Denmark, and Norway, including *87 525* new users of SGLT2 inhibitors and 63 921new users of GLP-1 receptor agonists, was conducted using data from 2013-2018



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Ueda P et al. Diabetes Obes Metab 2022;24:473–485

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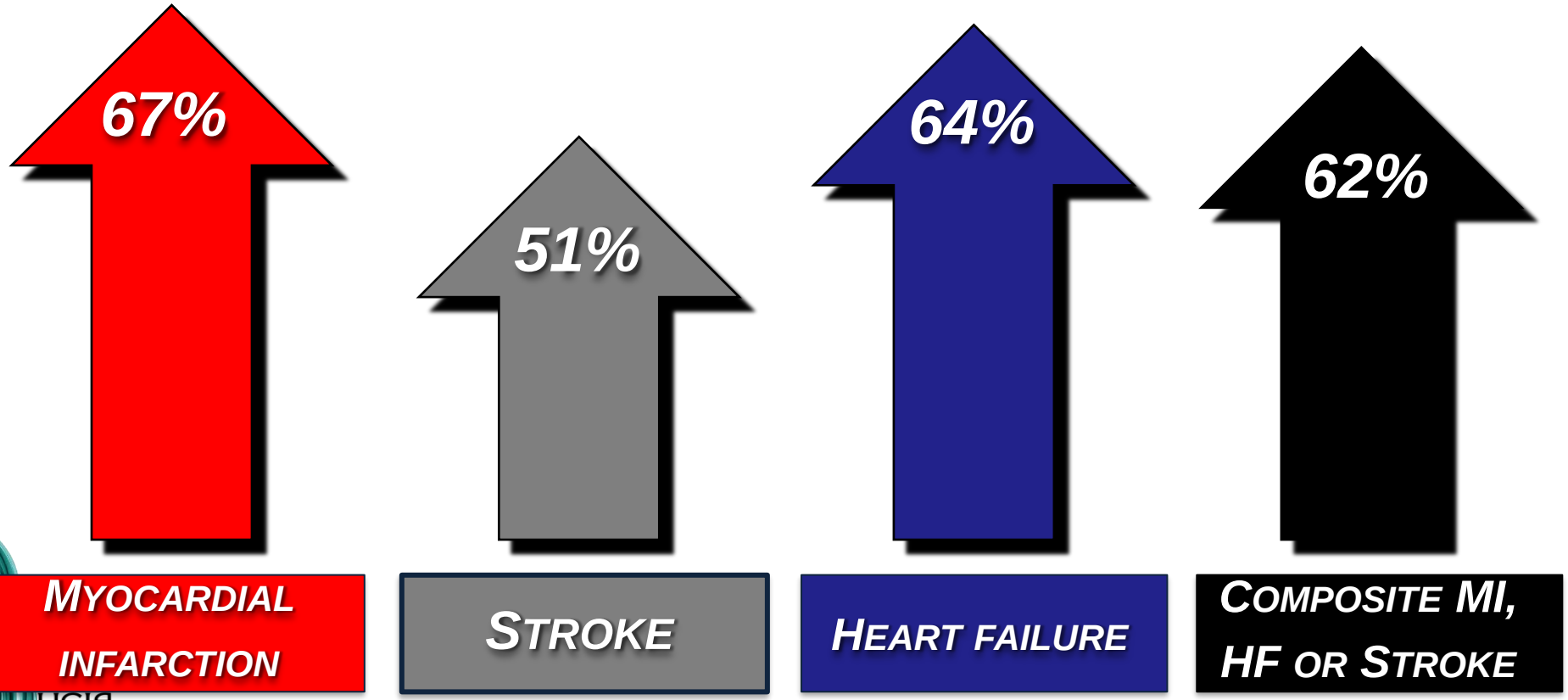
- Diabetes en Cardiología
- Fármacos para control glucometabólico para cardiólogos
- **Ar-GLP1 en Cardiopatía Isquémica – semaglutida oral**
- Ar-GLP1 en la estrategia de optimización terapéutica

Delayed Interventions is associated with and increased risk of Complications

Percent Increase in CV Events in Patients with a 1-year delay in receiving intensive therapy and HbA1c >7% vs <7% *retrospective UK Study



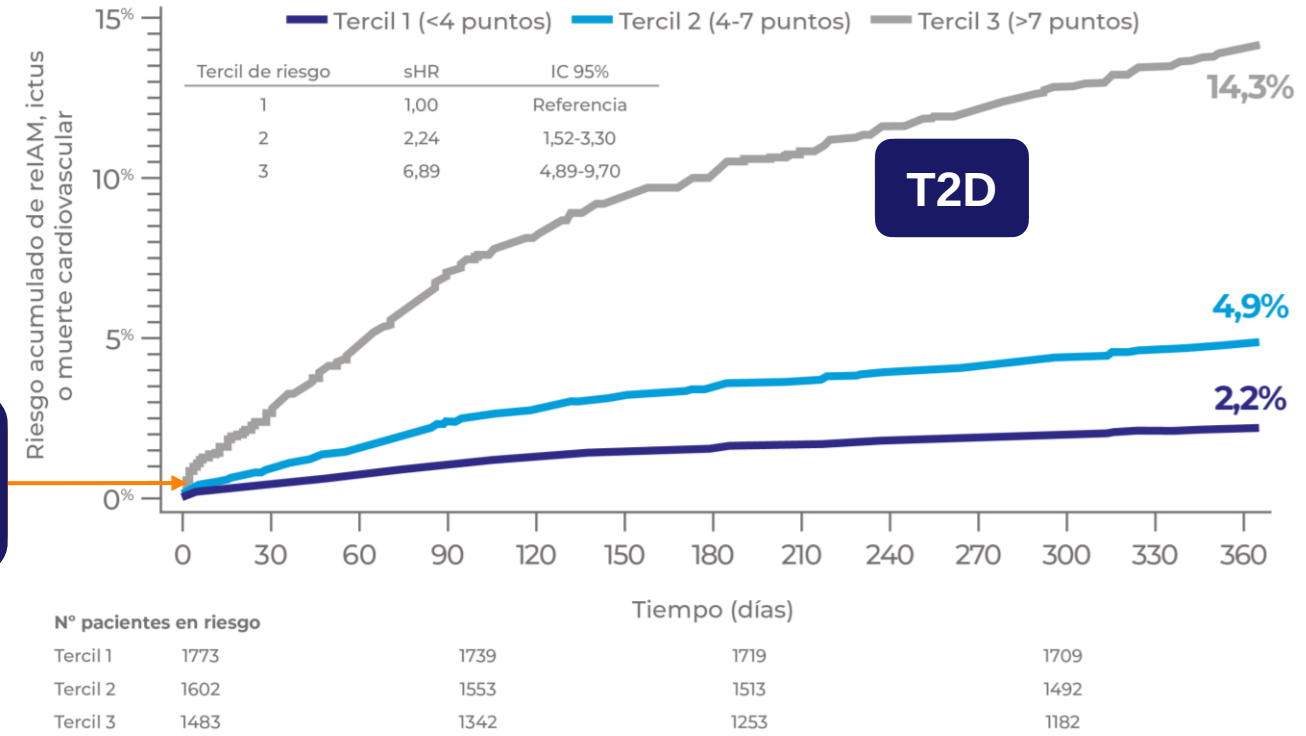
Paul SK, et al. Cardiovasc Diabetol 2015; 14: 100.

IAM, ictus o muerte CV tras un SCA: registro CardioCHUS

Desde el alta hospitalaria hasta el primer año[1]

Riesgo acumulado de IAM, ictus, o muerte CV

Estratificación riesgo en hospital



T2D

SUSTAIN 6
RRR < 26%;
14.3-3.82 = 10.48%

IAM: infarto agudo de miocardio; CV: cardiovascular; SCA: síndrome coronario agudo; HR: hazard ratio; IC: intervalo de confianza.

1. Abu-Assi E, et al. Rev Esp Cardiol (Engl Ed). 2016 Jan;69(1):11-8. doi: 10.1016/j.rec.2015.06.015. Epub 2015 Sep 3.

Clinical CV Phenotypes and the patterns of future events in patients with T2D

iSGLT2 VS aGLP1

CARDIOVASCULAR PHENOTYPE

STROKE

ISCHEMIC HEART DISEASE

PHERIPHERAL ARTERY DISEASE

HEART FAILURE

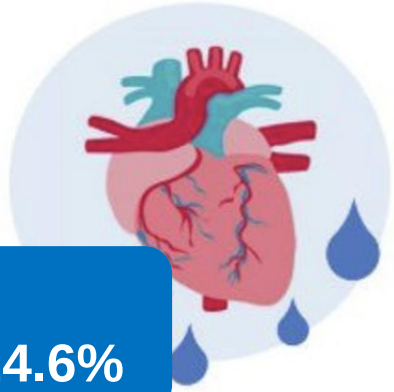
ABSOLUTE 5-YEAR RISK OF NEXT EVENT

Heart failure: 3.2%
Atherothrombotic event: 20.6%

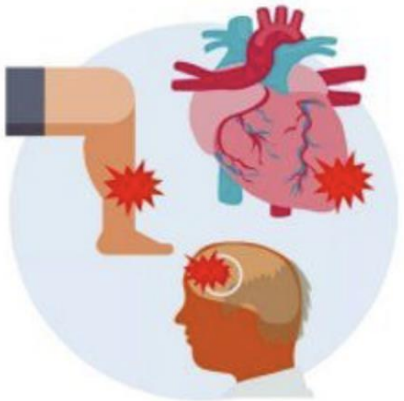
Heart Failure: 10.6%
Atherothrombotic event: 24.6%

Heart failure: 4.4%
Atherothrombotic event: 15.9%

Heart failure: 17.9%
Atherothrombotic event: 15.8%



VS



Malik, M.E., Andersson, C., Blanche, P. *et al. Clin Res Cardiol* (2022). https://doi.org/10.1007/s00392-022-02016-z

MACE

Superiority

Heart Failure Hospitalization

Mostly neutral except for albiglutdie

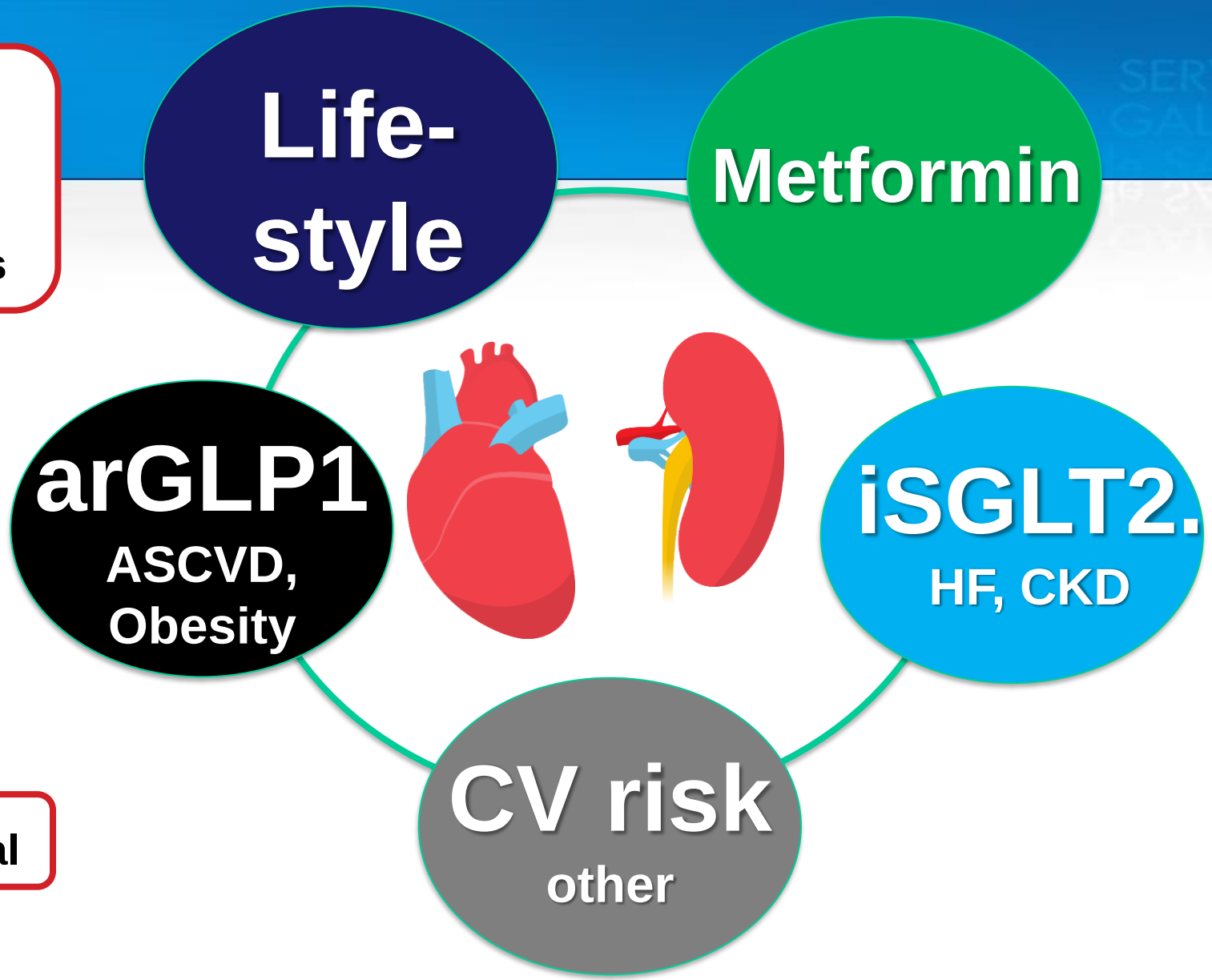
Proven Renal Benefit

Mostly albuminuria

These are complementary therapies acting on distinct patho-physiological pathways

The mechanisms of action are independent and additive

The benefits are incremental

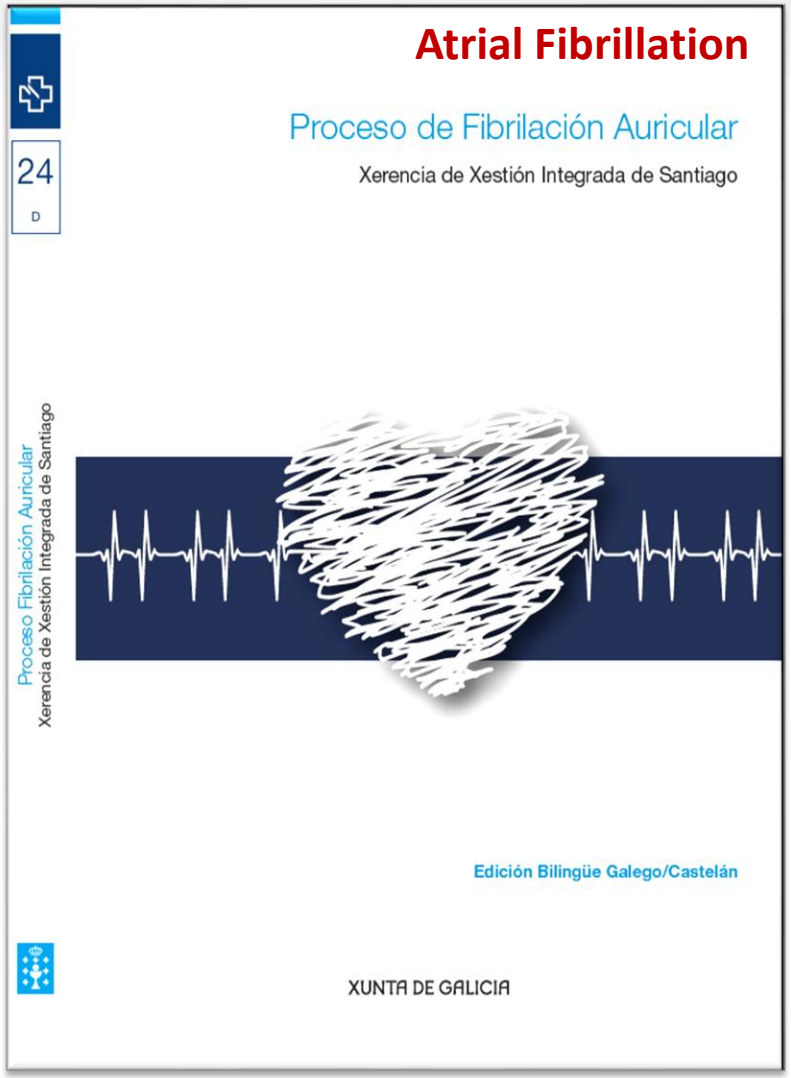


The goal is to optimize the management as possible as quickly as possible

Integrated Patient-care Pathway

Heart Failure

Atrial Fibrillation



Ischemic Heart Disease

CONSELLERÍA DE SANIDADE

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PROCESO ASISTENCIAL DE CARDIOPATÍA ISQUÉMICA. PARTIENDO DEL SCA

Hospitalización

- Diagnóstico y Estratificación Riesgo -GRACE
- Reperfusión - PPCI
- Tratamiento Médico Óptimo / Transición terapias orales

Paciente SCA

Hospitalización Extendida / Seguimiento

Proceso del ALTA / Transición de Cuidados

- Características Informe de Alta
- Objetivos de Control (lípidos, TA, Diabetes, etc)
- Integración Asistencial (Enfermería)
- INDICADORES DE CALIDAD DEL PROCESO Y DE RESULTADOS EN SALUD

TRANSICIÓN DE CUIDADOS

Escenario I: **Programa de Rehabilitación Cardíaca**

Escenario Alternativo: **Integración del Seguimiento AP / Enfermería**

E-Consulta: **Atención Primaria***

TELEA: **Seguimiento Remoto**

CONTINUIDAD ASISTENCIAL
(Enfermera/Médico/Paciente/Cuidador)

1-3 meses

6 meses

1 año

Anual

- **CONTROLES:**
  - **Clínico**
  - **Analítico**
  - **ECG**
  - **Otras Pruebas de AP**

CANAL RÁPIDO – e-consulta

Seguimiento TELEMEDICINA / PRESENCIAL

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CardioCHUS

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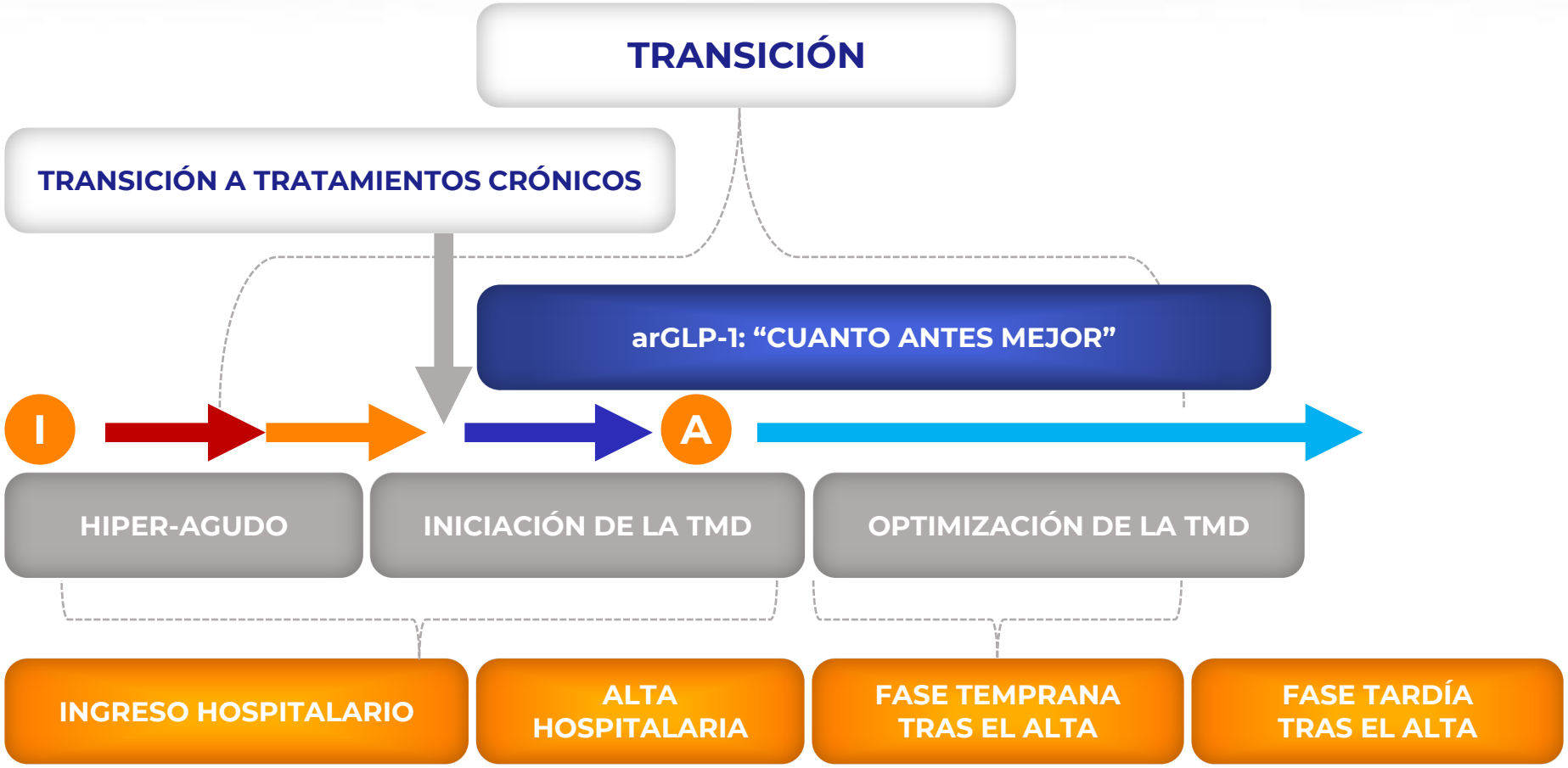
Abordaje del paciente con cardiopatía isquémica: El desafío



XUNTA DE GALICIA
CONSELLERÍA DE SANIDADE

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arGLP-1: agonista del receptor de glucagón tipo 1; TMD: terapia médica dirigida mediante las guías.

- **Diabetes en Cardiología**
- **Fármacos para control glucometabólico para cardiólogos**
- **Ar-GLP1 en Cardiopatía Isquémica – semaglutida oral**
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