

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/medical-industry-feature/peer-perspectives-diabetes-treatment-guidelines-and-addressing-cv-risk/10389/>

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Peer Perspectives: Diabetes Treatment Guidelines & Addressing CV Risk

ReachMD Announcer:

Welcome to this medical industry feature, titled “Peer Perspectives: Diabetes Treatment Guidelines and Addressing CV Risk” sponsored by Novo Nordisk. This program is intended for U.S. physicians. Important safety information is provided throughout this transcript. To view the full [prescribing information](#), including boxed warning, visit [Victozapro.com](https://victoza.com).

Announcer:

INDICATIONS AND LIMITATIONS OF USE: Victoza® (liraglutide) injection 1.2 mg or 1.8 mg is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus, and to reduce the risk of major adverse cardiovascular, CV death, nonfatal myocardial infarction or nonfatal stroke in adults with type 2 diabetes mellitus and established CV disease. Victoza® is not a substitute for insulin and should not be used in patients with type 1 diabetes mellitus or diabetic ketoacidosis. Concurrent use with prandial insulin has not been studied.

IMPORTANT SAFETY INFORMATION:

WARNING: Risk of thyroid C-cell tumors. Liraglutide causes dose-dependent and treatment duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including thyroid medullary thyroid carcinoma, MTC, in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors has not been determined. Victoza® is contraindicated in patients with a personal or family history of MTC, and in patients with multiple endocrine neoplasia syndrome type 2 (MEN-2). Counsel patients regarding the potential risk for MTC with the use of Victoza® and inform them of symptoms of thyroid tumors; for example, a mass in the neck, dysphagia, dyspnea, persistent hoarseness. Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with Victoza®.

Dr. Anderson:

Well, we've got a lot of guidelines. I think the ones most primary care providers follow is American Diabetes Association (ADA), and American Association of Clinical Endocrinologists (AACE). And you know, there is always this argument back and forth that they really agree much more than they disagree. Of course, we talked earlier about the AACE guidelines, the GLP-1 receptor agonist at the top, but now it is no longer, do you have type 2 diabetes? It's, do you have type 2 diabetes and if you have cardiovascular disease and you fall into the parameters that the trials were done on, it's now you need to be thinking about how you get to goal and the different medications. I think slowly but surely it's percolating into the primary care communities.

Dr. D'Agostino:

Prior to 2017, treatment guidelines for diabetes standards of care did not provide recommendations or management algorithms that could impact cardiovascular risk in addition to glycemic control.¹

But cardiovascular risk has been on our radar for much longer, especially since it was as far back as 2008 that the FDA mandated that all drug manufacturers of diabetes medications perform cardiovascular outcome trials or CVOTs to ensure that type 2 diabetes treatments did not show an unacceptable increase in the risk of CV events.²

Melissa Magwire:

Due to the results of these CVOTs, the ADA and AACE have both updated their guidelines to include sections that touch on how to treat

patients with type 2 diabetes that may benefit from medications that also address CV risk.^{2,3}

Dr. Anderson:

Every healthcare professional who works with adults with type 2 diabetes has a slightly unique approach to treatment. That is why guidelines from various organizations and associations are helpful, so that we can use evidence-based research to make informed treatment decisions.

Dr. Baron:

For those of us who work with a lot of patients with diabetes; in my practice, it's about 50%, we pay close attention to all of the new information that is released, including clinical data results. We don't necessarily sit and wait for updated guidelines to be released before trying the new approach.

Dr. Anderson:

Really, it's only in the last few years that many of our colleagues are truly understanding that some of the anti-hyperglycemic agents we have been prescribing, may offer cardiovascular risk reduction, as well.²

Melissa Magwire:

As more data becomes available, about the link between type 2 diabetes and cardiovascular disease, healthcare professionals are looking more closely at treatments that address both, such as Victoza®.⁴

We all know that cardiologists follow goals, ACC guidelines, but are you now finding that your colleagues are paying more attention to ADA and AACE because of the emphasis on cardiovascular disease now?

Dr. D'Agostino:

Absolutely. We're paying more attention to ADA and AACE guidelines and, again not just getting to goal, but how you get to goal is very important. The drugs that you use are paramount. You don't just want to get the A1c down to 7, you want to use the right drugs to get there.

Dr. Baron:

Even before the results of the results of the LEADER CVOT were released, I prescribed Victoza® for a number of my adult patients with type 2 diabetes for glycemic control, and I liked that it had the additional benefit of weight reduction. Then, when the data came out and the label was updated to include reducing the risk of major adverse cardiovascular events for adults with type 2 diabetes and established CVD, there was even more rationale to continue prescribing a GLP-1 receptor agonist like Victoza®.⁴

Dr. D'Agostino:

I actually used the results of the LEADER trial when talking to my patients about the cardiovascular risk reduction of Victoza®.⁴

Some patients don't understand why I want to switch treatments if their A1c is under control, but I bring up Victoza® and we discussed the connection between type 2 diabetes and cardiovascular disease. I believe an educated patient is a motivated patient.⁵

Melissa Magwire:

The ADA has an algorithm for treating type 2 diabetes, but some of that is left to the discretion of the healthcare professional. Now in the guidelines, there is more specific direction when it comes to cardiovascular risk, and with the reduction of CV risk addressed in the Victoza® label, it is the top of mind when discussing treatment options with patients.^{2,4}

We've been saying that a long time about collaborative care and diabetes should be, but I can tell you that, since this has come out, the LEADER data, I've actually found it more of an emphasis on having to work together and pulling in the cardiologist, and pulling in the primary care, and actually for the first time really building a team that is having to cross-talk, because we now have a common goal that we can all have a piece of.

Announcer:

IMPORTANT SAFETY INFORMATION CONTINUED:

CONTRAINDICATIONS: Victoza® is contraindicated in patients with a personal or family history of MTC or in patients with MEN-2, and in patients with a prior serious hypersensitivity reaction to Victoza® or any of the product components. Serious hypersensitivity reactions, including anaphylactic reactions and angioedema have been reported with Victoza®.

WARNINGS AND PRECAUTIONS:

Risk of thyroid C-cell tumors: Patients should be referred to an endocrinologist for further evaluation if serum calcitonin is measured and found to be elevated, or thyroid nodules are noted on physical examination or neck imaging.

Pancreatitis: Acute pancreatitis, including fatal and nonfatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza® postmarketing. Observe patients carefully for signs and symptoms of pancreatitis; persistent severe abdominal pain, sometimes radiating to the back with or without vomiting. If pancreatitis is suspected, discontinue Victoza® promptly. And if pancreatitis is confirmed, do not restart. Victoza® has been studied in a limited number of patients with a history of pancreatitis. It is unknown if patients with a history of pancreatitis are at a higher risk for development of pancreatitis on Victoza®.

Never share a Victoza® pen between patients, even if the needle is changed. Pen-sharing poses a risk for transmission of blood-borne pathogens.

Hypoglycemia: When Victoza® is used with an insulin secretagogue; for example, a sulfonylurea or insulin, serious hypoglycemia can occur. Consider lowering the dose of the insulin secretagogue or insulin to reduce the risk of hypoglycemia.

Renal Impairment: Acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis, have been reported postmarketing, usually in association with nausea, vomiting, diarrhea, or dehydration. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment.

Hypersensitivity Reactions: Serious hypersensitivity reactions; for example, anaphylaxis and angioedema, have been reported postmarketing. If symptoms of hypersensitivity reactions occur, patients must stop taking Victoza®. Treat promptly per standard of care and monitor until signs and symptoms resolve. Do not use in patients with a previous hypersensitivity reaction to Victoza®. Anaphylaxis and angioedema have been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of anaphylaxis or angioedema with another GLP receptor agonist because it is unknown whether such patients will be predisposed to these reactions with Victoza®.

Acute Gallbladder Disease: In the LEADER trial, 3.1% of Victoza® versus 1.9% of placebo-treated patients reported an acute event of gallbladder disease, such as cholelithiasis or cholecystitis. The majority of events required hospitalization or cholecystectomy. If cholelithiasis is suspected, gallbladder studies and appropriate clinical follow-up are indicated.

Adverse Reactions: The most common adverse reactions reported in greater than or equal to 5% of patients treated with Victoza®, and more commonly than in patients treated with placebo are nausea, diarrhea, headache, vomiting, decreased appetite, dyspepsia, and constipation. Immunogenicity-related events, including urticaria, were more common among Victoza®-treated patients 0.8% than among comparator-treated patients 0.4% in clinical trials.

Drug Interactions: Victoza® causes a delay of gastric emptying and has the potential to impact the absorption of concomitantly-administered oral medications. Caution should be exercised when oral medications are concomitantly administered with Victoza®.

Use in specific populations. Victoza® has not been studied in patients with type 2 diabetes below 18 years of age and is not recommended for use in pediatric patients. Victoza® slows gastric emptying. Victoza® has not been studied in patients with pre-existing gastroparesis. Victoza® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

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References:

1. American Diabetes Association. Standards of medical care in diabetes-2017. *Diabetes Care*. 2017;40(suppl 1):S1-S135.
2. American Diabetes Association. Standards of medical care in diabetes—2019. *Diabetes Care*. 2019;41(suppl 1):S1-S172.
3. Garber AJ, Abrahamson MJ, Barzilay JI, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the comprehensive type 2 diabetes management algorithm—2018 executive summary. *Endocr Pract*. 2018;24(1):91-120.
4. Victoza [package insert]. Plainsboro, NJ: Novo Nordisk Inc; August 2017.
5. Low Wang CC, Hess CN, Hiatt WR, Goldfine AB. Clinical update: cardiovascular disease in diabetes mellitus. Atherosclerotic cardiovascular disease and heart failure in type 2 diabetes mellitus-mechanisms, management, and clinical considerations. *Circulation*. 2016;133:2459-2502.