

# **NOVIDADES**

## **DAS GUIDELINES DA ESC 2023**

### **Doença Cardiovascular e Diabetes**

Beatriz Andrade

# 2023 ESC Guidelines for the management of cardiovascular disease in patients with diabetes

Developed by the task force on the management of cardiovascular disease in patients with diabetes of the European Society of Cardiology (ESC)

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# What is new?

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
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### Cardiovascular risk assessment in diabetes—Section 4

In patients with T2DM without symptomatic ASCVD or severe TOD, it is recommended to estimate 10-year CVD risk via SCORE2-Diabetes.	I	B
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### Antithrombotic therapy in patients with diabetes—Section 5.6

Clopidogrel 75 mg o.d. following appropriate loading (e.g. 600 mg or at least 5 days already on maintenance therapy) is recommended in addition to ASA for 6 months following coronary stenting in patients with CCS, irrespective of stent type, unless a shorter duration is indicated due to the risk or occurrence of life-threatening bleeding.	I	A
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In patients with diabetes and ACS treated with DAPT who are undergoing CABG and do not require long-term OAC therapy, resuming a P2Y <sub>12</sub> receptor inhibitor as soon as deemed safe after surgery and continuing it up to 12 months is recommended.	I	C
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Adding very low-dose rivaroxaban to low-dose ASA for long-term prevention of serious vascular events should be considered in patients with diabetes and CCS or symptomatic PAD without high bleeding risk.	IIa	B
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### Heart failure and diabetes—Section 7

#### Evaluation for heart failure in diabetes

If HF is suspected, it is recommended to measure BNP/NT-proBNP.	I	B
Systematic survey for HF symptoms and/or signs of HF is recommended at each clinical encounter in all patients with diabetes.	I	C

#### Diagnostic tests in all patients with suspected heart failure

12-lead ECG is recommended.	I	C
Trans thoracic echocardiography is recommended.	I	C
Chest radiography (X-ray) is recommended.	I	C
Routine blood tests for comorbidities are recommended, including full blood count, urea, creatinine and electrolytes, thyroid function, lipids, and iron status (ferritin and TSAT).	I	C

#### Pharmacological treatment indicated in patients with NYHA class II–IV) and diabetes

SGLT2 inhibitors (dapagliflozin, empagliflozin, or sotagliflozin) are recommended in all patients with HF-EF and T2DM to reduce the risk of HF hospitalization and CV death.	I	A
An intensive strategy of early initiation of evidence-based treatment (SGLT2 inhibitors, ARNI/ACE-Is, beta-blockers, and MRAs), with rapid up-titration to trial-defined target doses starting before discharge and with frequent follow-up visits in the first 6 weeks following a HF hospitalization is recommended to reduce re-admissions or mortality.	I	A

### Lipids and diabetes—Section 5.5

A PCSK9 inhibitor is recommended in patients at very high CV risk, with persistently high LDL-C levels despite treatment with a maximum tolerated dose, in combination with ezetimibe, when a statin-based regimen is not tolerated at any dose after re-challenge). A PCSK9 inhibitor should be considered.	I	A
A PCSK9 inhibitor should be considered when a statin-based regimen is not tolerated at any dose after re-challenge).	IIa	B

### Chronic kidney disease and diabetes—Section 9

Intensive LDL-C lowering with statins or a statin/ezetimibe combination is recommended.	I	A
A SGLT2 inhibitor (canagliflozin, empagliflozin, or dapagliflozin) is recommended in patients with T2DM and CKD with an eGFR $\geq 20$ mL/min/1.73 m <sup>2</sup> to reduce the risk of CVD and kidney failure.	I	A
Finerenone is recommended in addition to an ACE-I or ARB in patients with T2DM and eGFR $> 60$ mL/min/1.73 m <sup>2</sup> with a UACR $\geq 30$ mg/mmol ( $\geq 300$ mg/g) or eGFR 25–60 mL/min/1.73 m <sup>2</sup> and UACR $\geq 3$ mg/mmol ( $\geq 30$ mg/g) to reduce CV events and kidney failure.	I	A
Low-dose ASA (75–100 mg o.d.) is recommended in patients with CKD and ASCVD.	I	A

# Diabetes – Diagnóstico



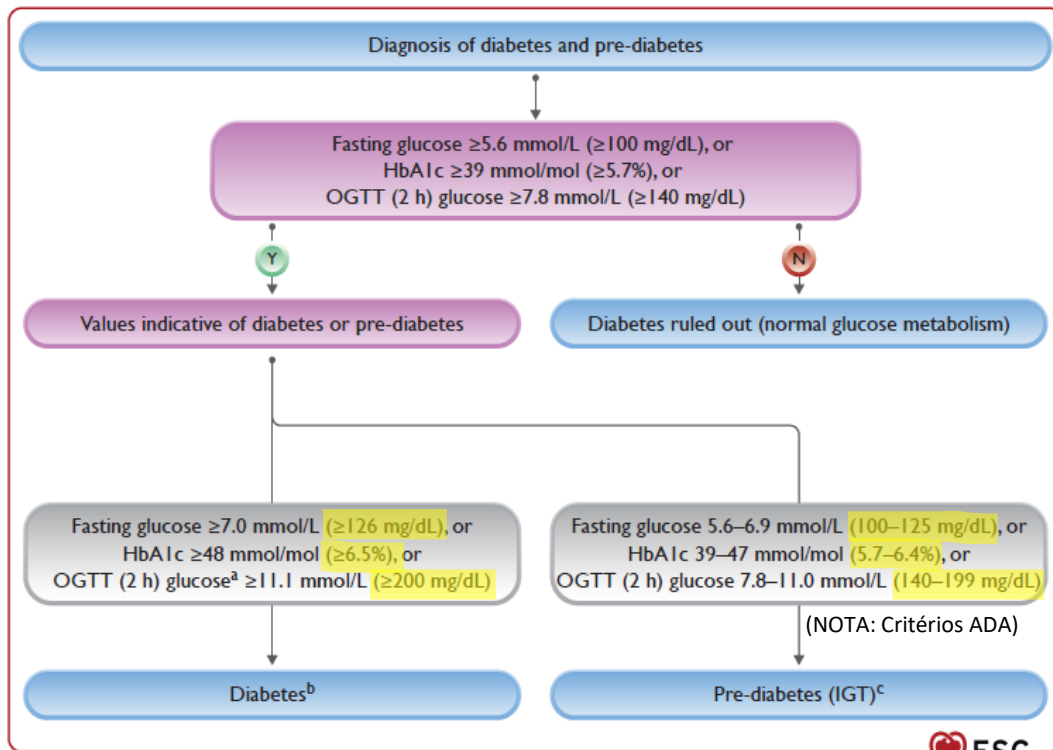
Uma pandemia silenciosa...

- **537 milhões** de indivíduos em todo o mundo em 2021 (prevalência de 10,5%)

- espera-se que esse número aumente para **783 milhões de casos até 2045** (12,2%)

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Screening for diabetes is recommended in all individuals with CVD, <sup>c</sup> using fasting glucose and/or HbA1c <sup>5-7,36,37,39</sup>	I	A
It is recommended that the diagnosis of diabetes is based on HbA1c and/or fasting plasma glucose, or on an OGTT if still in doubt. <sup>d-5-8,10,11</sup>	I	B

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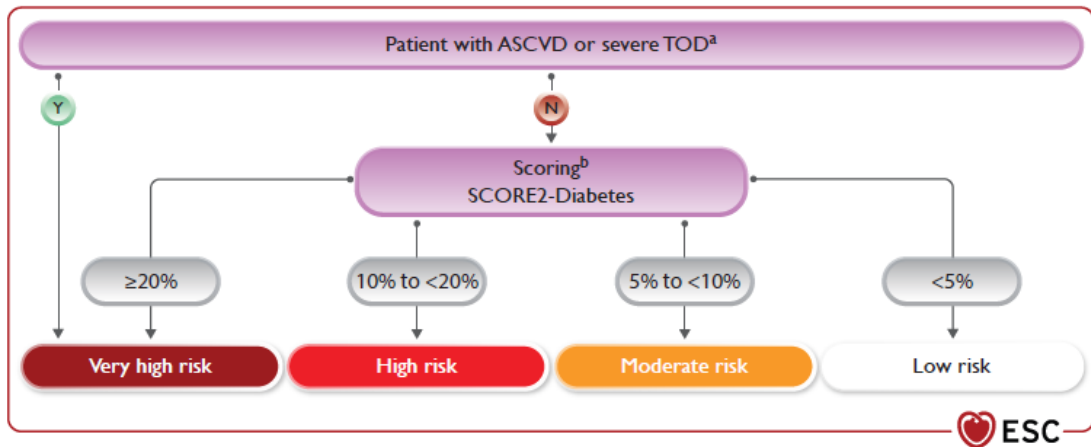


b\* Se sintomas, 1 teste é suficiente; se assintomático, são necessários 2 testes alterados

# Avaliação do Risco CV na Diabetes



Para os doentes com DMT2 sem doença cardiovascular estabelecida ou lesão de órgão alvo, introduz-se um novo score de risco CV: **SCORE2-Diabetes**



Recommendations to assess cardiovascular risk in patients with diabetes	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended to screen patients with diabetes for the presence of severe TOD. <sup>c,43,44</sup>	I	A
It is recommended to assess medical history and the presence of symptoms suggestive of ASCVD in patients with diabetes. <sup>53-55</sup>	I	B
In patients with T2DM without symptomatic ASCVD or severe TOD, <sup>c</sup> it is recommended to estimate 10-year CVD risk via SCORE2-Diabetes. <sup>d,50</sup>	I	B

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**FRCV convencionais**  
(idade, tabagismo, PAS, colesterol total e HDL)



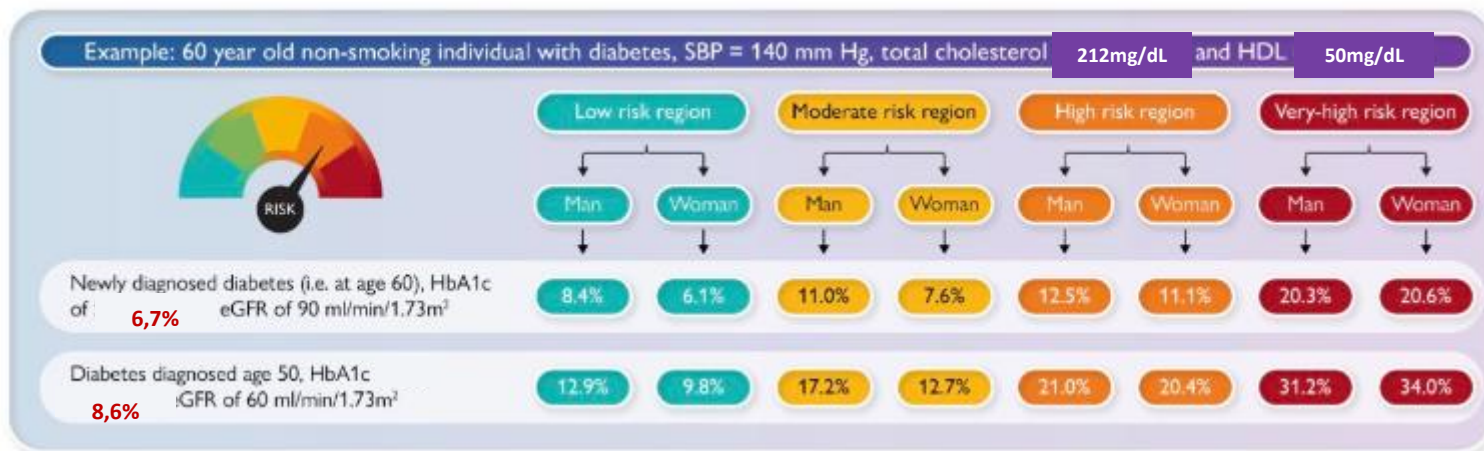
**Diabetes**  
(idade no diagnóstico, HbA1c e TFG)



# Avaliação do Risco CV na Diabetes



Para os doentes com DMT2 sem doença cardiovascular estabelecida ou lesão de órgão alvo, introduz-se um novo score de risco CV: **SCORE2-Diabetes**



# Estilo de Vida

**Recommendation Table 3** — Recommendations for reducing weight in patients with type 2 diabetes with or without cardiovascular disease

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended that individuals living with overweight or obesity aim to reduce weight and increase physical exercise to improve metabolic control and overall CVD risk profile. <sup>56,79</sup>	I	A
Glucose-lowering medications with effects on weight loss (e.g. GLP-1 RAs) should be considered in patients with overweight or obesity to reduce weight. <sup>67</sup>	Ila	B
Bariatric surgery should be considered for high and very high risk patients with BMI $\geq 35$ kg/m <sup>2</sup> ( $\geq$ Class II <sup>c</sup> ) when repetitive and structured efforts of lifestyle changes combined with weight-reducing medications do not result in maintained weight loss. <sup>73-77</sup>	Ila	B

**Recommendation Table 5** — Recommendations for physical activity/exercise in patients with type 2 diabetes with or without cardiovascular disease

Recommendation	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended to increase any physical activity (e.g. 10 min daily walking) in all patients with T2DM with and without CVD. Optimal is a weekly activity of 150 min of moderate intensity or 75 min of vigorous endurance intensity. <sup>97,98</sup>	I	A
It is recommended to adapt exercise interventions to T2DM-associated comorbidities, e.g. frailty, neuropathy, or retinopathy. <sup>108,115</sup>	I	B
It is recommended to introduce structured exercise training in patients with T2DM and established CVD, e.g. CAD, HFpEF, HFmrEF, HFrEF, or AF to improve metabolic control, exercise capacity and quality of life, and to reduce CV events. <sup>108,115,116</sup>	I	B
It is recommended to perform resistance exercise in addition to endurance exercise at least twice a week. <sup>115,117</sup>	I	B

**Recommendation Table 4** — Recommendations for nutrition in patients with type 2 diabetes with or without cardiovascular disease

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended to adopt a Mediterranean or plant-based diet with high unsaturated fat content to lower cardiovascular risk. <sup>82,85</sup>	I	A



**Recommendation Table 6** — Recommendations for smoking cessation in patients with type 2 diabetes with or without cardiovascular disease

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended to stop smoking to reduce cardiovascular risk. <sup>118-120</sup>	I	A
Nicotine replacement therapy, varenicline, and bupropion, as well as individual or telephone counselling, should be considered to improve smoking cessation success rate. <sup>121</sup>	Ila	B



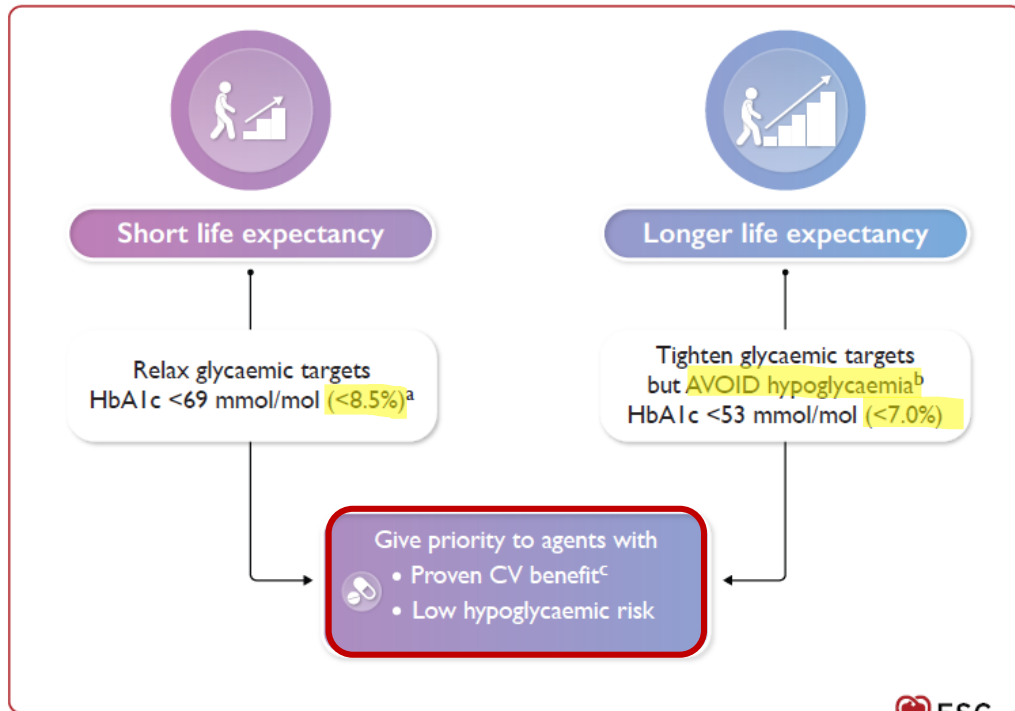
# Alvos Glicémicos



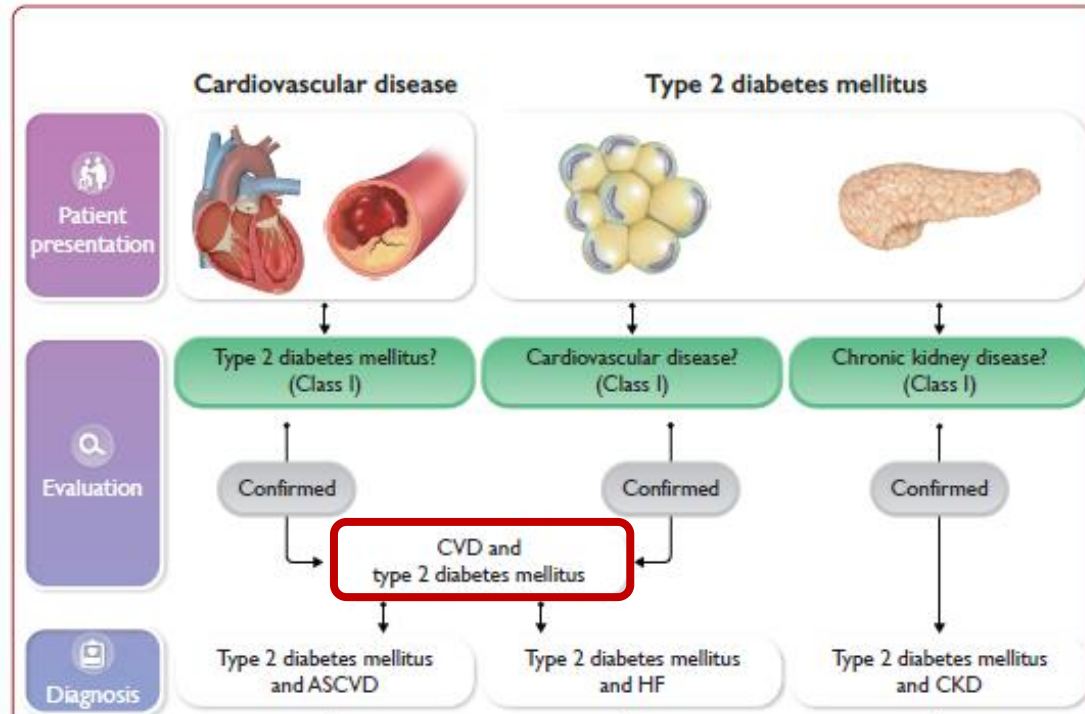
- Alvos personalizados
- Exposição à **hipoglicémia** < 1% (i.e. <15min/dia) em indivíduos com elevado risco CV

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended to apply <b>tight glycaemic control</b> (HbA1c <7%) to reduce microvascular complications. <sup>126–128,133</sup>	<b>I</b>	<b>A</b>
It is recommended to <b>avoid hypoglycaemia</b> , particularly in patients with CVD. <sup>134–137,147</sup>	<b>I</b>	<b>B</b>
It is recommended to <b>individualize HbA1c targets</b> according to comorbidities, diabetes duration, and life expectancy. <sup>134,137</sup>	<b>I</b>	<b>C</b>
<b>Tight glycaemic control</b> should be considered for reducing CAD in the long term, preferably using agents with proven CV benefit. <sup>c,129–132</sup>	<b>IIa</b>	<b>B</b>

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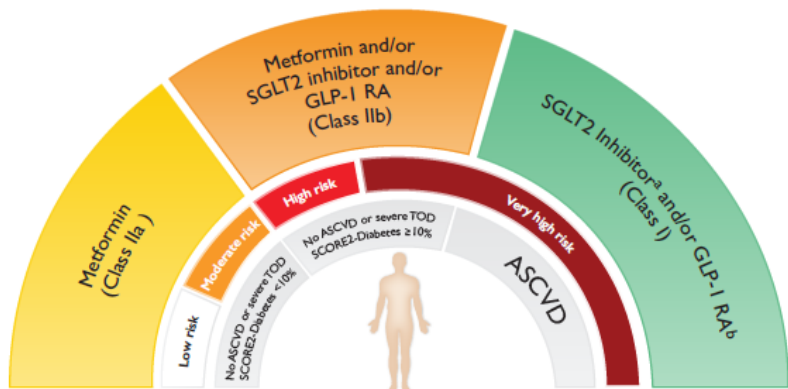
# Diabetes e Doença CV



# Diabetes e Doença CV



**iSGLT2 E aGLP1** para reduzir o risco cardiovascular, independentemente do controlo glicémico!



Risk assessment for patients with type 2 diabetes based on the presence of ASCVD/severe TOD and 10-year CVD risk estimation via SCORE2-Diabetes

To reduce CV risk independent of glucose control<sup>a</sup>

GLP-1 RA<sup>b</sup>  
(Class I)

SGLT2 inhibitor<sup>c</sup>  
(Class I)

Independent of HbA1c

Independent of concomitant glucose-lowering medication

For additional glucose control

Glucose-lowering agents with suggested CV benefit

Metformin  
(Class IIa)

Pioglitazone<sup>d</sup>  
(Class IIb)

Glucose-lowering agents with proven CV safety

DPP-4 inhibitors (sitagliptin, alogliptin, linagliptin)<sup>e</sup>

Ertugliflozin<sup>f</sup>

Sulfonylureas (glimepiride or gliclazide)

Insulin glargine or insulin degludec

Other GLP-1 RAs (lixisenatide, exenatide ER, oral semaglutide)

# Diabetes e Doença CV

**Recommendation Table 8** — Recommendations for glucose-lowering treatment for patients with type 2 diabetes and atherosclerotic cardiovascular disease to reduce cardiovascular risk

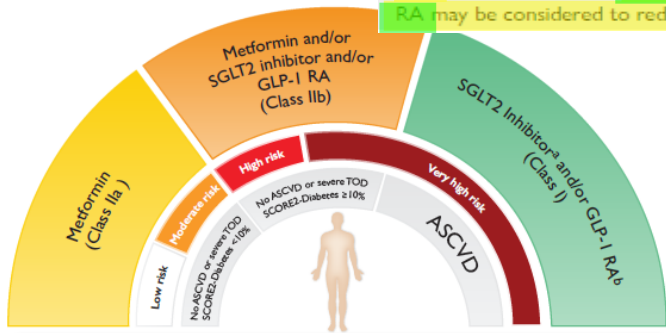
Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended to prioritize the use of glucose-lowering agents with proven CV benefits <sup>cd</sup> followed by agents with proven CV safety <sup>e</sup> over agents without proven CV benefit or proven CV safety.	I	C
<b>Sodium–glucose co-transporter-2 inhibitors</b>		
SGLT2 inhibitors with proven CV benefit <sup>c</sup> are recommended in patients with T2DM and ASCVD to reduce CV events, independent of baseline or target HbA1c and independent of concomitant glucose-lowering medication. <sup>71,150–152,155,189</sup>	I	A
<b>Glucagon-like peptide-1 receptor agonists</b>		
GLP-1 RAs with proven CV benefit <sup>d</sup> are recommended in patients with T2DM and ASCVD to reduce CV events, independent of baseline or target HbA1c and independent of concomitant glucose-lowering medication. <sup>70,72,161,163,164</sup>	I	A
<b>Other glucose-lowering medications to reduce cardiovascular risk</b>		
If additional glucose control is needed, metformin should be considered in patients with T2DM and ASCVD.	IIa	C
If additional glucose control is needed, pioglitazone may be considered in patients with T2DM and ASCVD without HF. <sup>165</sup>	IIb	B



**Recommendation Table 9** — Recommendation for glucose-lowering treatment for patients with type 2 diabetes without atherosclerotic cardiovascular disease or severe target-organ damage to reduce cardiovascular risk

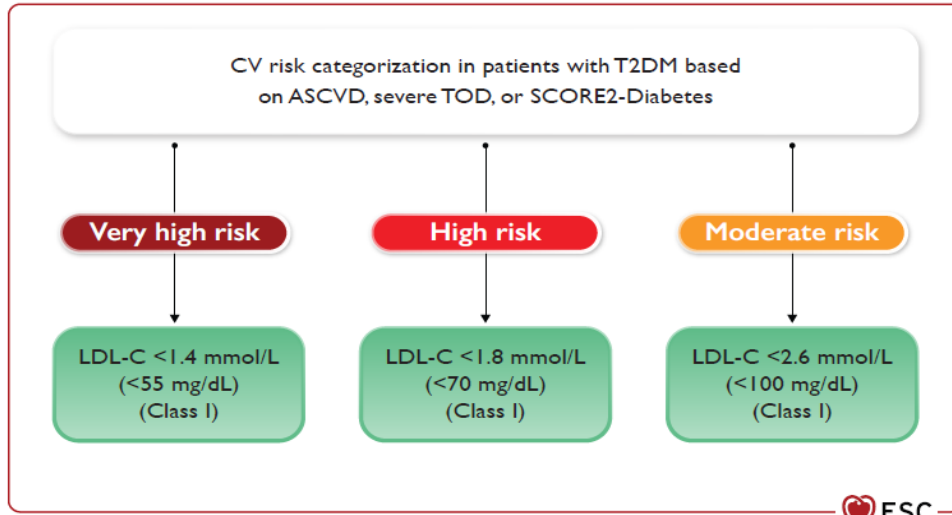
Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
In patients with T2DM without ASCVD or severe TOD <sup>c</sup> at low or moderate risk, treatment with metformin should be considered to reduce CV risk. <sup>183</sup>	IIa	C
In patients with T2DM without ASCVD or severe TOD <sup>c</sup> at high or very high risk, treatment with metformin may be considered to reduce CV risk.	IIb	C
In patients with T2DM without ASCVD or severe TOD <sup>c</sup> but with a calculated 10-year CVD risk <sup>d</sup> ≥10%, treatment with a SGLT2 inhibitor or GLP-1 RA may be considered to reduce CV risk. <sup>155,164</sup>	IIb	C

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Risk assessment for patients with type 2 diabetes based on the presence of ASCVD/severe TOD and 10-year CVD risk estimation via SCORE2-Diabetes

# Diabetes e Dislipidémia



**NEW!**

## Lipid-lowering treatment

<p>Statin are recommended as the first-choice</p> <p>LDL-C-lowering treatment in patients with diabetes and above-target LDL-C levels. Administration of statins is defined based on the CV risk profile of the patients and the recommended LDL-C (or non-HDL-C) target levels.<sup>247-249</sup></p>	I	A
<p>A PCSK9 inhibitor is recommended in patients at very high CV risk, with persistently high LDL-C levels above target despite treatment with a maximum tolerated statin dose, in combination with ezetimibe, or in patients with statin intolerance.<sup>267,268</sup></p>	I	A
<p>If the target LDL-C is not reached with statins, combination therapy with ezetimibe is recommended.<sup>259,260</sup></p>	I	B
<p>If a statin-based regimen is not tolerated at any dosage (even after re-challenge), a PCSK9 inhibitor added to ezetimibe should be considered.<sup>287,288</sup></p>	IIa	B
<p>If a statin-based regimen is not tolerated at any dosage (even after re-challenge), ezetimibe should be considered.<sup>259,260</sup></p>	IIa	C
<p>High-dose icosapent ethyl (2 g b.i.d.) may be considered in combination with a statin in patients with hypertriglyceridaemia.<sup>c 274</sup></p>	IIb	B

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Recommendations	Class <sup>a</sup>	Level <sup>b</sup>		
<b>Lipid targets</b>				
In patients with T2DM at moderate CV risk, an LDL-C target of <2.6 mmol/L (<100 mg/dL) is recommended. <sup>248,249</sup>	I	A	In patients with T2DM at very high CV risk, an LDL-C target of <1.4 mmol/L (<55 mg/dL) and LDL-C reduction of at least 50% is recommended. <sup>248,249</sup>	I B
In patients with T2DM at high CV risk, an LDL-C target of <1.8 mmol/L (<70 mg/dL) and LDL-C reduction of at least 50% is recommended. <sup>248,249</sup>	I	A	In patients with T2DM, a secondary goal of a non-HDL-C target of <2.2 mmol/L (<85 mg/dL) in very high CV risk patients and <2.6 mmol/L (<100 mg/dL) in high CV risk patients is recommended. <sup>283-285</sup>	I B

# Diabetes e HTA

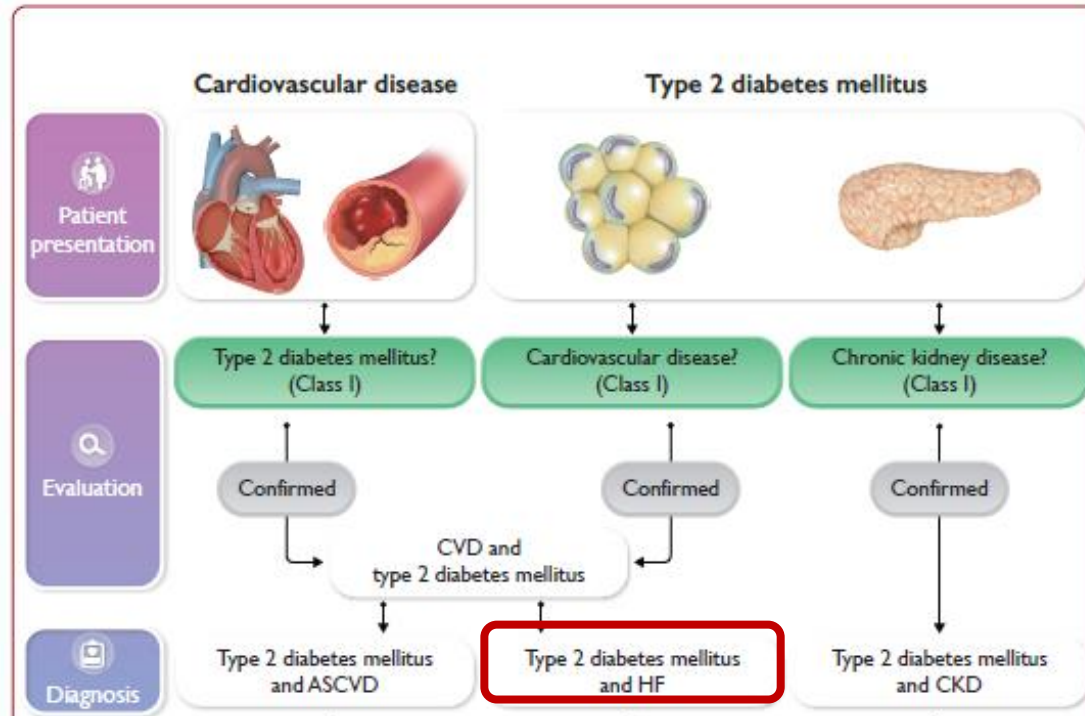


Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
<b>Screening for hypertension</b>		
Regular BP measurements <sup>c</sup> are recommended in all patients with diabetes to detect and treat hypertension to reduce CV risk. <sup>193,232,233</sup>	<b>I</b>	<b>A</b>
<b>Treatment targets</b>		
Anti-hypertensive drug treatment is recommended for people with diabetes when office BP is $\geq 140/90$ mmHg. <sup>196,202,234,235</sup>	<b>I</b>	<b>A</b>
It is recommended to treat hypertension in patients with diabetes in an individualized manner. The BP goal is to target SBP to 130 mmHg and $<130$ mmHg if tolerated, but not $<120$ mmHg. In older people (age $>65$ years), it is recommended to target SBP to 130-139 mmHg. <sup>196,236-238</sup>	<b>I</b>	<b>A</b>
An on-treatment SBP target of $<130$ mmHg may be considered in patients with diabetes at particularly high risk of a cerebrovascular event to further reduce their risk of stroke. <sup>194-198,239,240</sup>	<b>Iib</b>	<b>B</b>

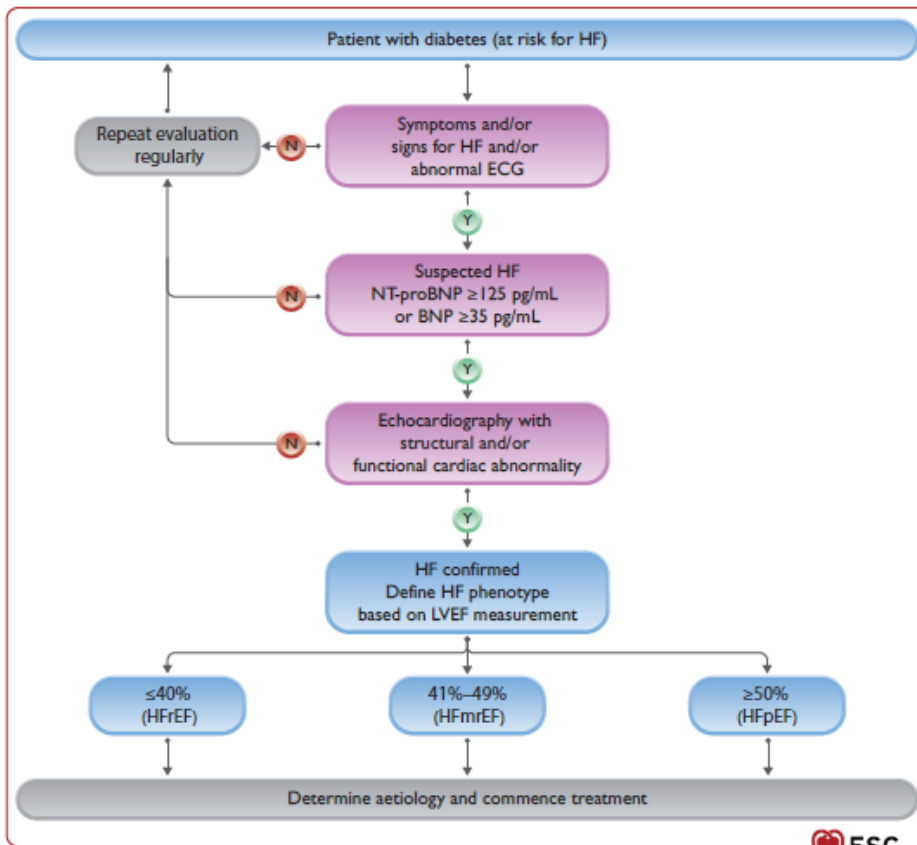
<b>Treatment and evaluation</b>		
Lifestyle changes (weight loss if overweight, physical activity, alcohol restriction, sodium restriction, increased consumption of vegetables, using low-fat dairy products) are recommended in patients with diabetes and hypertension. <sup>205-207,210</sup>	<b>I</b>	<b>A</b>
It is recommended to initiate treatment with a combination of a RAS inhibitor and a CCB or thiazide/thiazide-like diuretic. <sup>196,213-216,218,241</sup>	<b>I</b>	<b>A</b>
Home BP self-monitoring should be considered in patients with diabetes on anti-hypertensive treatments to check that BP is appropriately controlled. <sup>242</sup>	<b>Ila</b>	<b>B</b>
24 h ambulatory blood pressure monitoring should be considered to assess abnormal 24 h BP patterns, including nocturnal hypertension and reduced or reversed nocturnal BP dipping, and to adjust anti-hypertensive treatment. <sup>243</sup>	<b>Ila</b>	<b>B</b>

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# Diabetes e Insuficiência Cardíaca



# Diabetes e Insuficiência Cardíaca

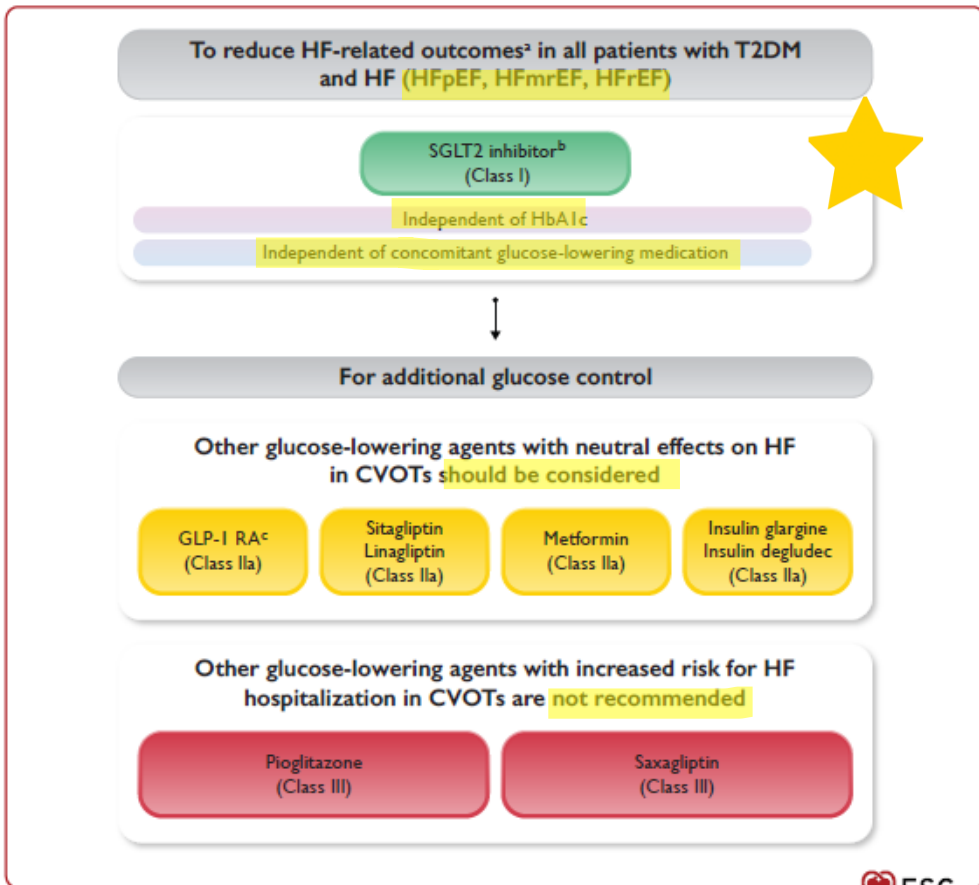


Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
<b>Evaluating for heart failure</b>		
If HF is suspected, it is recommended to measure BNP/NT-proBNP. <sup>4B5</sup>	I	B
Systematic survey for HF symptoms and/or signs of HF is recommended at each clinical encounter in all patients with diabetes.	I	C
<b>Diagnostic tests in all patients with suspected heart failure</b>		
12-lead ECG is recommended.	I	C
Transthoracic echocardiography is recommended.	I	C
Chest radiography (X-ray) is recommended.	I	C
Routine blood tests for comorbidities are recommended, including full blood count, urea, creatinine and electrolytes, thyroid function, lipids, and iron status (ferritin and TSAT).	I	C

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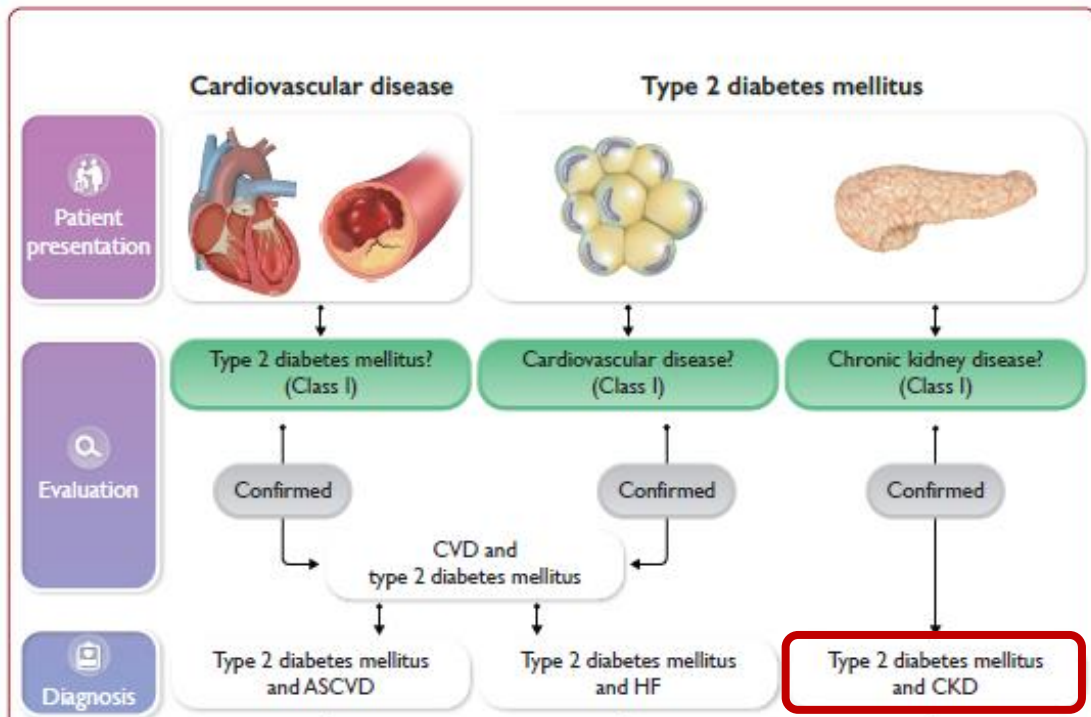


# Diabetes e Insuficiência Cardíaca



Recommendations for the pharmacological treatment indicated in patients with HFrEF (NYHA class II–IV) and diabetes			
IC FEF	SGLT2 inhibitors (dapagliflozin, empagliflozin, or sotagliflozin <sup>c</sup> ) are recommended in all patients with HFrEF and T2DM to reduce the risk of HF hospitalization and CV death. <sup>189,491,494,497</sup>	I	A
	Sacubitril/valsartan or an ACE-I is recommended in all patients with HFrEF and diabetes to reduce the risk of HF hospitalization and death. <sup>471,501,502,527</sup>	I	A
	Beta-blockers <sup>d</sup> are recommended in patients with HFrEF and diabetes to reduce the risk of HF hospitalization and death. <sup>509–512,528</sup>	I	A
	MRAs <sup>e</sup> are recommended in patients with HFrEF and diabetes to reduce the risk of HF hospitalization and death. <sup>507,529</sup>	I	A
Recommendations		Class <sup>a</sup>	Level <sup>b</sup>
IC FEF	Empagliflozin or dapagliflozin are recommended in patients with T2DM and LVEF >40% (HFmrEF and HFpEF) to reduce the risk of HF hospitalization or CV death. <sup>530–533</sup>	I	A
	Diuretics are recommended in patients with HFpEF or HFmrEF and diabetes with signs and/or symptoms of fluid congestion to improve symptoms, exercise capacity, and HF hospitalization. <sup>520</sup>	I	C

# Diabetes e DRC



# Diabetes e DRC

## Treatment of patients with T2DM and CKD<sup>a</sup>

To reduce cardiovascular risk

Statin-based regimen  
(Class I)

To reduce kidney failure risk

ACE-I or ARB  
(Class I)

To reduce cardiovascular and kidney failure risk

**SGLT2 inhibitor<sup>b</sup>**  
(Class I)

BP control  
(Class I)

**Finerenone**  
(Class I)

For additional glucose control

Glucose-lowering medications with suggested cardiovascular benefit

GLP-I RA

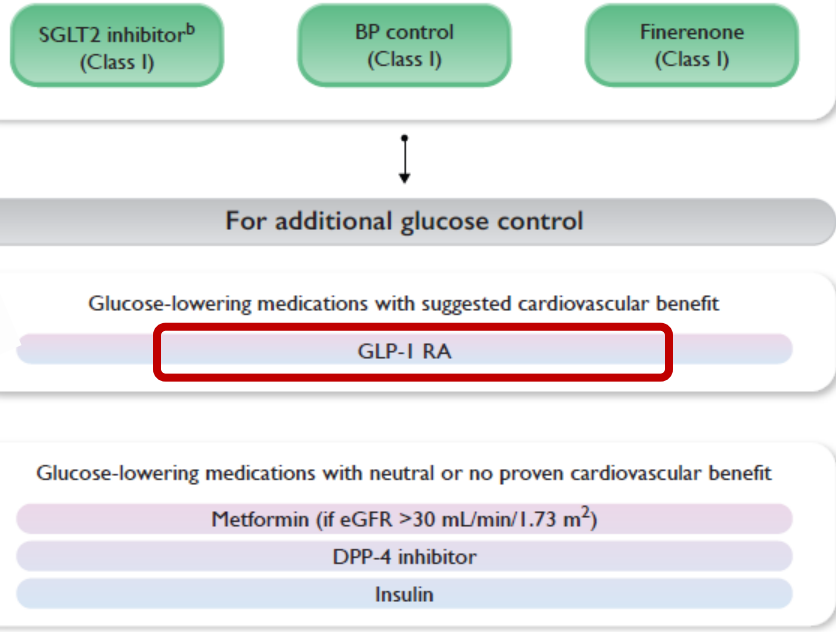
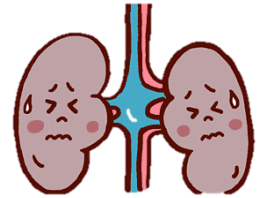


**Recommendation Table 24** — Recommendations for patients with chronic kidney disease and diabetes

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Intensive LDL-C lowering with statins or a statin/ezetimibe combination is recommended. <sup>C,697,698</sup>	I	A
A BP target of $\leq 130/80$ mmHg is recommended to reduce risk of CVD and albuminuria. <sup>196</sup>	I	A
Personalized HbA1c targets 6.5–8.0% (48–64 mmol/mol) are recommended, with a target $<7.0\%$ ( $<53$ mmol/mol) to reduce microvascular complications, wherever possible. <sup>132,133</sup>	I	A
The maximum tolerated dose of an ACE-I or ARB is recommended. <sup>705–709</sup>	I	A
A SGLT2 inhibitor (canagliflozin, empagliflozin, or dapagliflozin) <sup>d</sup> is recommended in patients with T2DM and CKD with an eGFR $\geq 20$ mL/min/1.73 m <sup>2</sup> to reduce the risk of CVD and kidney failure. <sup>150,153,542,543,711,714,715</sup>	I	A
Finerenone is recommended in addition to an ACE-I or ARB in patients with T2DM and eGFR $>60$ mL/min/1.73 m <sup>2</sup> with a UACR $\geq 30$ mg/mmol ( $\geq 300$ mg/g), or eGFR 25–60 mL/min/1.73 m <sup>2</sup> and UACR $\geq 3$ mg/mmol ( $\geq 30$ mg/g) to reduce CV events and kidney failure. <sup>718–720</sup>	I	A

UACR, urinary albumin-to-creatinine ratio.

# Diabetes e DRC



**NEW!**

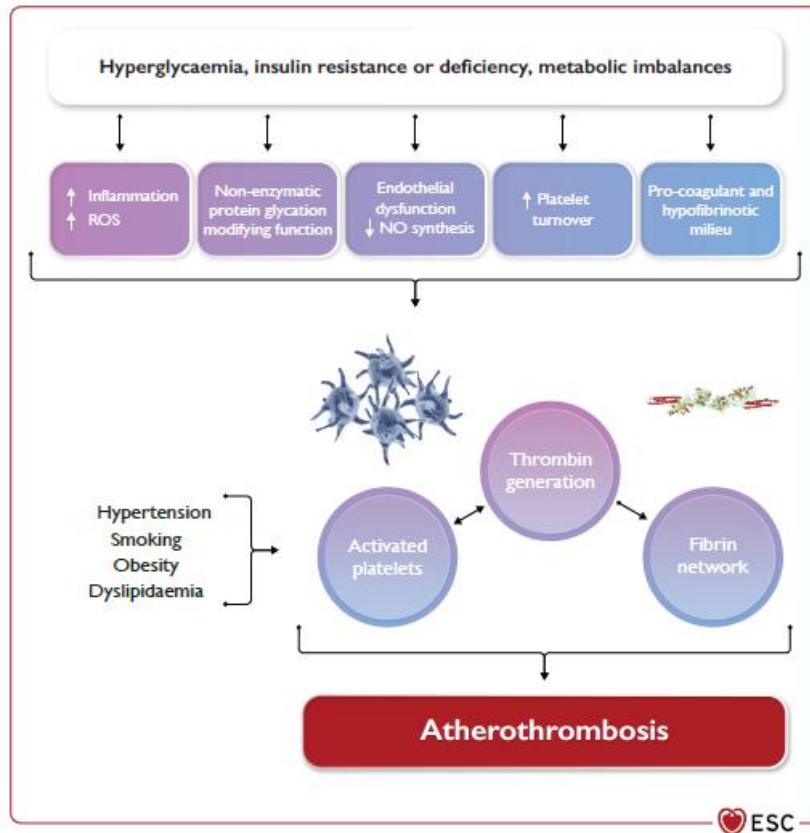
A GLP-1 RA is recommended at eGFR >15 mL/min/1.73 m <sup>2</sup> to achieve adequate glycaemic control, due to low risk of hypoglycaemia and beneficial effects on weight, CV risk, and albuminuria. <sup>164</sup>	I	A
Low-dose ASA (75–100 mg o.d.) is recommended in patients with CKD and ASCVD. <sup>325,735</sup>	I	A
It is recommended that patients with diabetes are routinely screened for kidney disease by assessing eGFR defined by CKD-EPI and UACR. <sup>43,678,745</sup>	I	B
Treatment with intensive medical or an initial invasive strategy is recommended in people with CKD, diabetes, and stable moderate or severe CAD, due to similar outcomes. <sup>e,740,746</sup>	I	B

# Terapêutica antitrombótica na diabetes

**Recommendation Table 12 — Recommendations for patients with diabetes without a history of symptomatic atherosclerotic cardiovascular disease or revascularization**

Recommendation	Class <sup>a</sup>	Level <sup>b</sup>
In adults with T2DM without a history of symptomatic ASCVD or revascularization, <u>ASA (75–100 mg o.d.)</u> may be considered to prevent the first severe vascular event <sup>c</sup> in the absence of clear contraindications. <sup>c,292,293</sup>	<b>IIb</b>	<b>A</b>

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# Diabetes Mellitus tipo 1

**Recommendation Table 26** — Recommendations for patients with type 1 diabetes

Recommendation	Class <sup>a</sup>	Level <sup>b</sup>
In patients with T1DM, it is recommended that adjustment of glucose-lowering medication follows principles of patient self-management under the guidance of the diabetes healthcare multidisciplinary team.	I	C
Avoiding hypoglycaemic episodes is recommended, particularly in those with established CVD. <sup>780-782</sup>	I	C
Statins should be considered for LDL-C lowering in adults older than 40 years with T1DM without a history of CVD to reduce CV risk. <sup>787</sup>	IIa	B
Statins should be considered for use in adults younger than 40 years with T1DM and other risk factors of CVD or microvascular end-organ damage or 10-year CVD risk $\geq 10\%$ to reduce CVD risk. <sup>787,788</sup>	IIa	B
The use of the Scottish/Swedish risk prediction model may be considered to estimate 10-year CVD risk in patients with T1DM. <sup>793</sup>	IIb	B

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A DM tipo 1 acarreta um aumento 3x na mortalidade, que se repercute na perda de 11 anos de EMV. A **morte de causa cardiovascular engloba 30-44% de todas as mortes!**



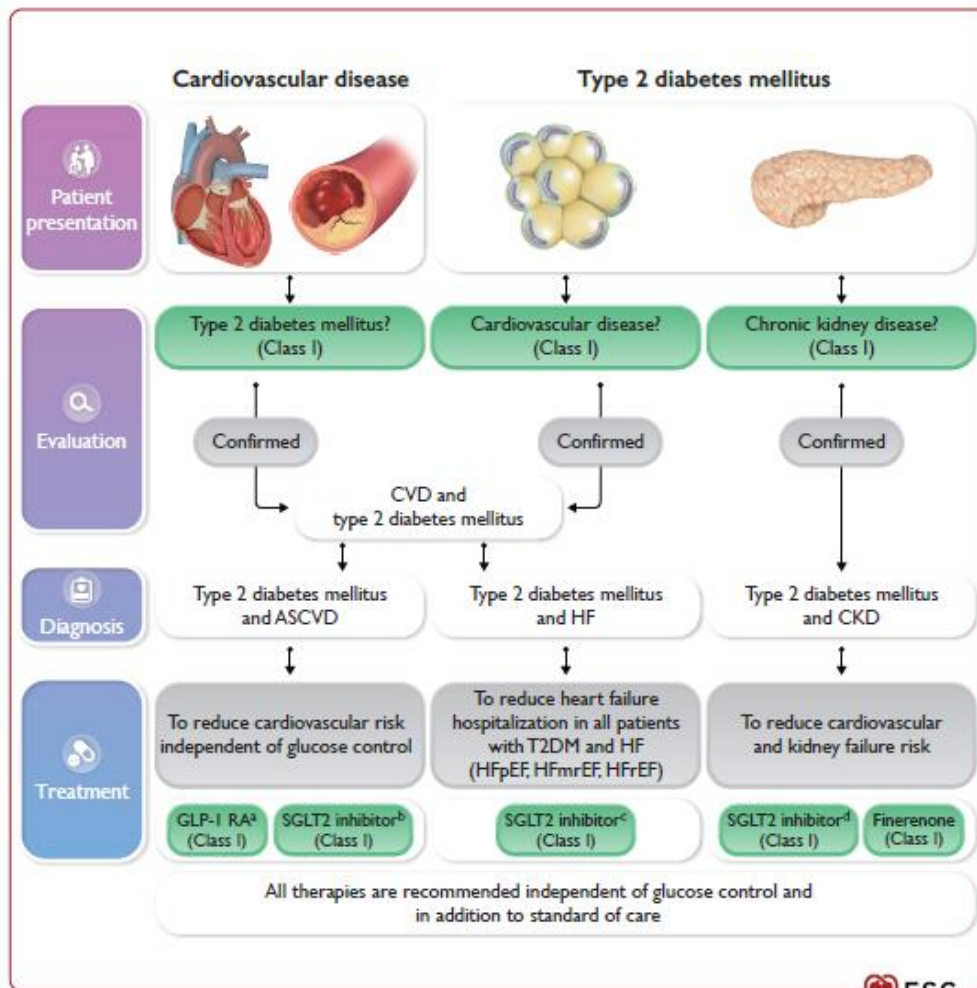
Importância do controlo da diabetes e FRCV!

- ✓ Estratificação de risco CV mais difícil e com menos evidência
- ✓ Importância da idade de início da doença

PA alvo 120/80mmHg  
 Estatina em prevenção primária

# Conclusão

- Rastreio sistemático da **diabetes** (DMT2) em doentes com **doença cardiovascular aterosclerótica** (DCV) e vice versa
- Novo score de cálculo de RCV a 10 anos em doentes com **DMT2 sem DCV ou lesão de órgão alvo (SCORE2-DIABETES)**
- Tratamento diferenciado da diabetes em doentes com DCV
  - **aGLP1** e **iSGLT2**
- Tratamento da insuficiência cardíaca e doença renal crónica em doentes com DMT2
- Gestão interdisciplinar, *patient-centered*



# NOVIDADES

## DAS GUIDELINES DA ESC 2023

### Doença Cardiovascular e Diabetes