Gestione del paziente cardiopatico ischemico cronico con diabete mellito

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

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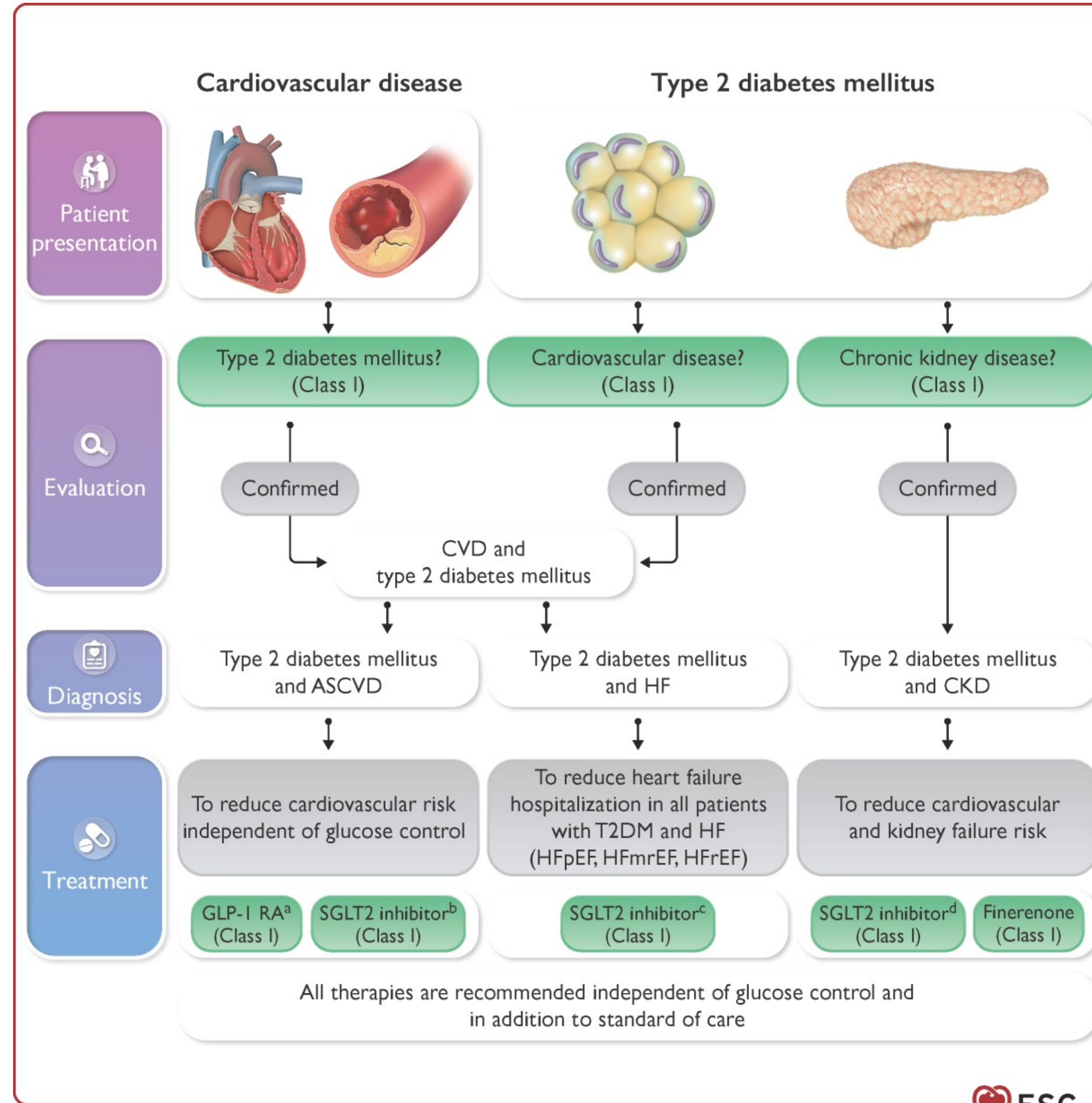
Figure 1

Management of cardiovascular disease in patients with type 2 diabetes: clinical approach and key recommendations



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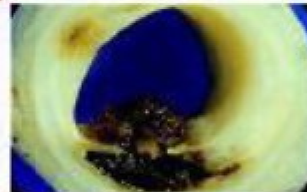
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad192)

Principles for multifactorial management of people with diabetes

Life style modification

- Glycaemic control
- Antiplatelet therapy
- Blood pressure control
- Lipid control



www.escardio.org/guidelines

Full text: European Heart Journal 2013;34(39):3035-3087
Summary: ESC web site & Diabetologia 2013;56(12)

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Recommendations for smoking cessation in patients with type 2 diabetes with or without cardiovascular disease

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Recommendations	Class	Level
It is recommended to stop smoking to reduce cardiovascular risk.	I	A
Nicotine replacement therapy, varenicline, and bupropion, as well as individual or telephone counselling, should be considered to improve smoking cessation success rate.	IIa	B

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Recommendations for nutrition in patients with type 2 diabetes with or without cardiovascular disease

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Recommendation	Class	Level
It is recommended to adopt a Mediterranean or plant-based diet with high unsaturated fat content to lower cardiovascular risk.	I	A
Recommendations	**Class**	**Level**
Increasing physical activity and exercise in patients with diabetes		
It is recommended to adapt exercise interventions to T2DM-associated comorbidities, e.g. frailty, neuropathy, or retinopathy.	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.	I	B
Recommendations	**Class**	**Level**
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.	I	A

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Recommendations for reducing weight in patients with type 2 diabetes with or without cardiovascular disease

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Recommendations	Class	Level
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.	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.	IIa	B
Bariatric surgery should be considered for high and very high risk patients with BMI ≥35 kg/m^2 (≥Class II) when repetitive and structured efforts of lifestyle changes combined with weight-reducing medications do not result in maintained weight loss.	IIa	B

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Recommendations for blood pressure management in patients with diabetes (1)

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Recommendations	Class	Level
Screening for hypertension		
Regular BP measurements are recommended in all patients with diabetes to detect and treat hypertension to reduce CV risk.	I	A
Treatment targets		
Anti-hypertensive drug treatment is recommended for people with diabetes when office BP is ≥140/90 mmHg.	I	A
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.	I	A

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Figure 3

Cardiovascular risk categories in patients with type 2 diabetes

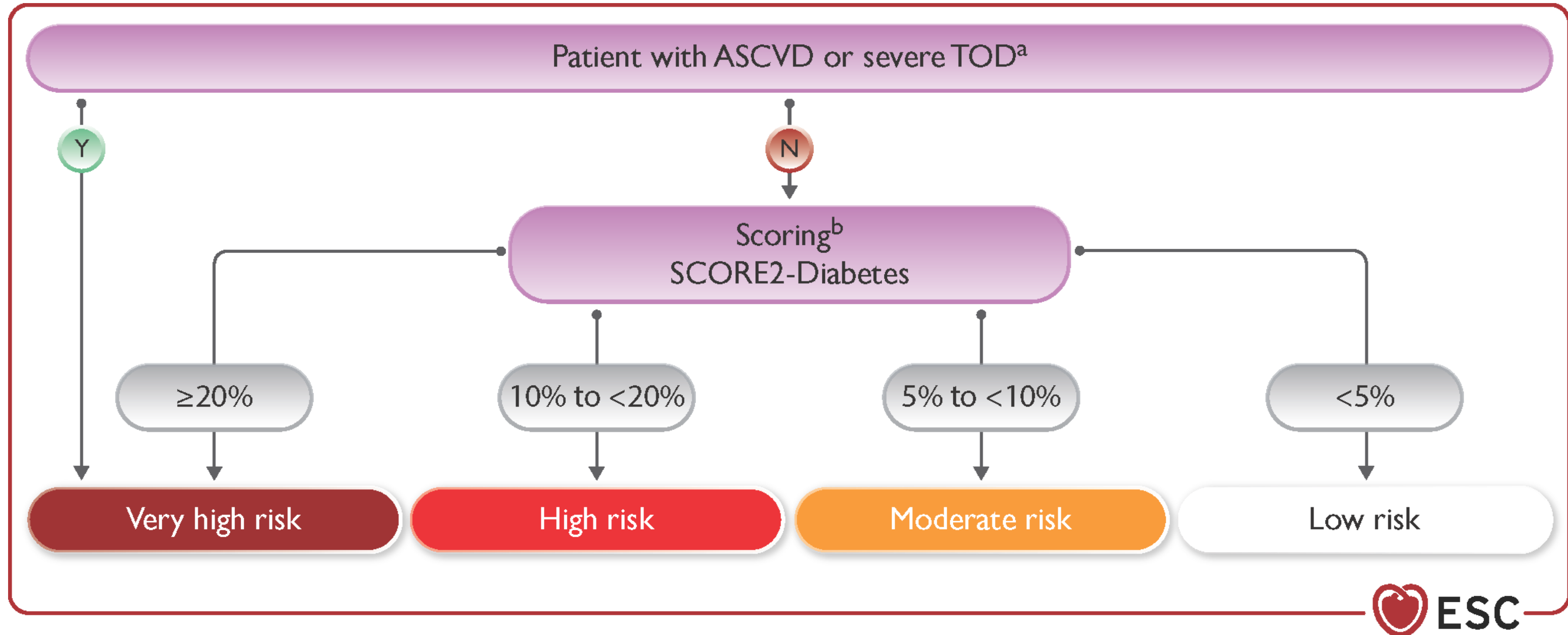

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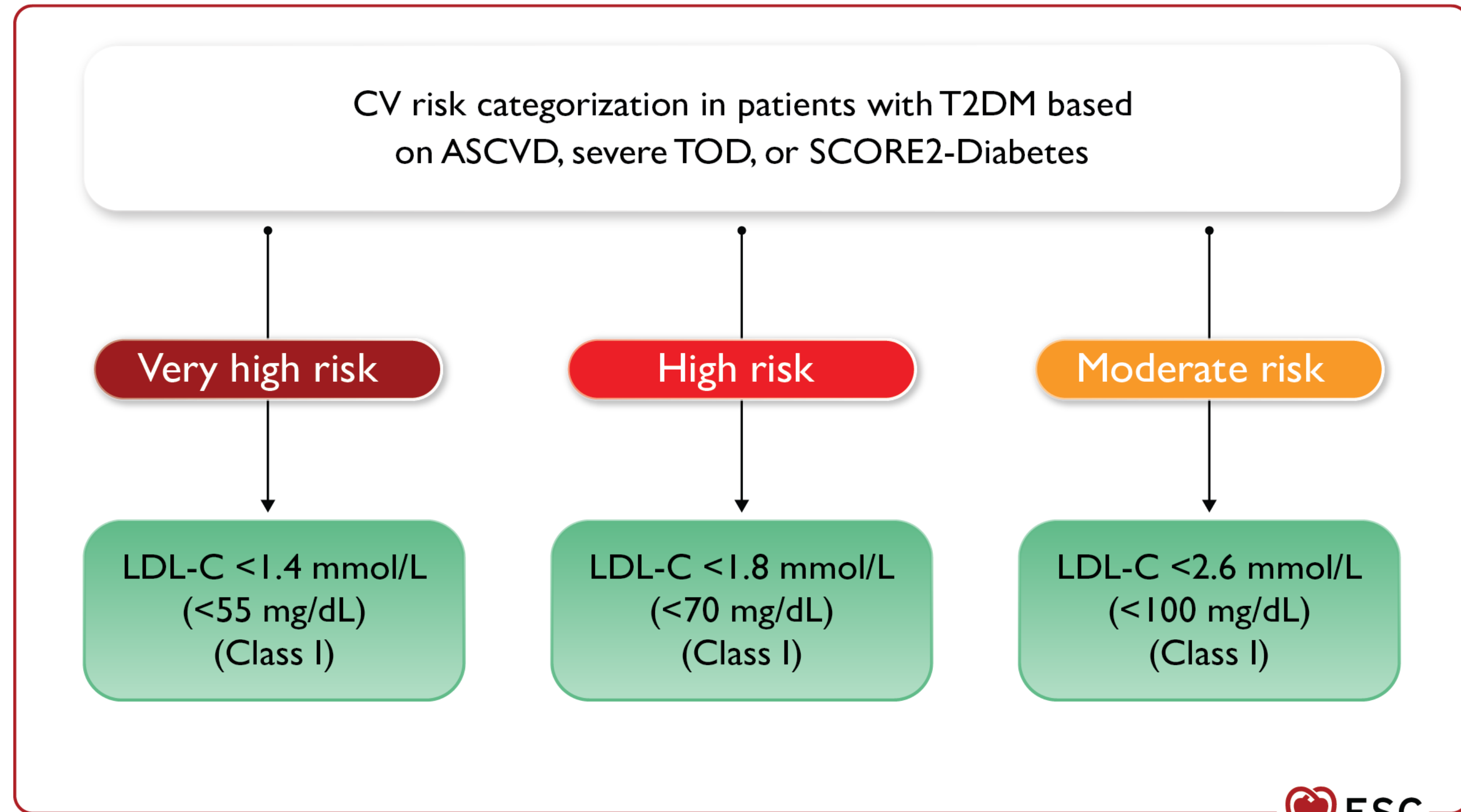
Figure 10

Recommended low-density lipoprotein-cholesterol targets by cardiovascular risk categories in patients with type 2 diabetes



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Recommendations for the management of dyslipidaemia in patients with diabetes (2)

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Recommendations	Class	Level
Lipid-lowering treatment		
Statins are recommended as the first-choice 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.	I	A
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.	I	A
If the target LDL-C is not reached with statins, combination therapy with ezetimibe is recommended.	I	B

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Recommendations for the management of dyslipidaemia in patients with diabetes (3)

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Recommendations	Class	Level
Lipid-lowering treatment (continued)		
If a statin-based regimen is not tolerated at any dosage (even after re-challenge), a PCSK9 inhibitor added to ezetimibe should be considered.	IIa	B
If a statin-based regimen is not tolerated at any dosage (even after re-challenge), ezetimibe should be considered.	IIa	C
High-dose icosapent ethyl (2 g b.i.d.) may be considered in combination with a statin in patients with hypertriglyceridaemia.	IIb	B

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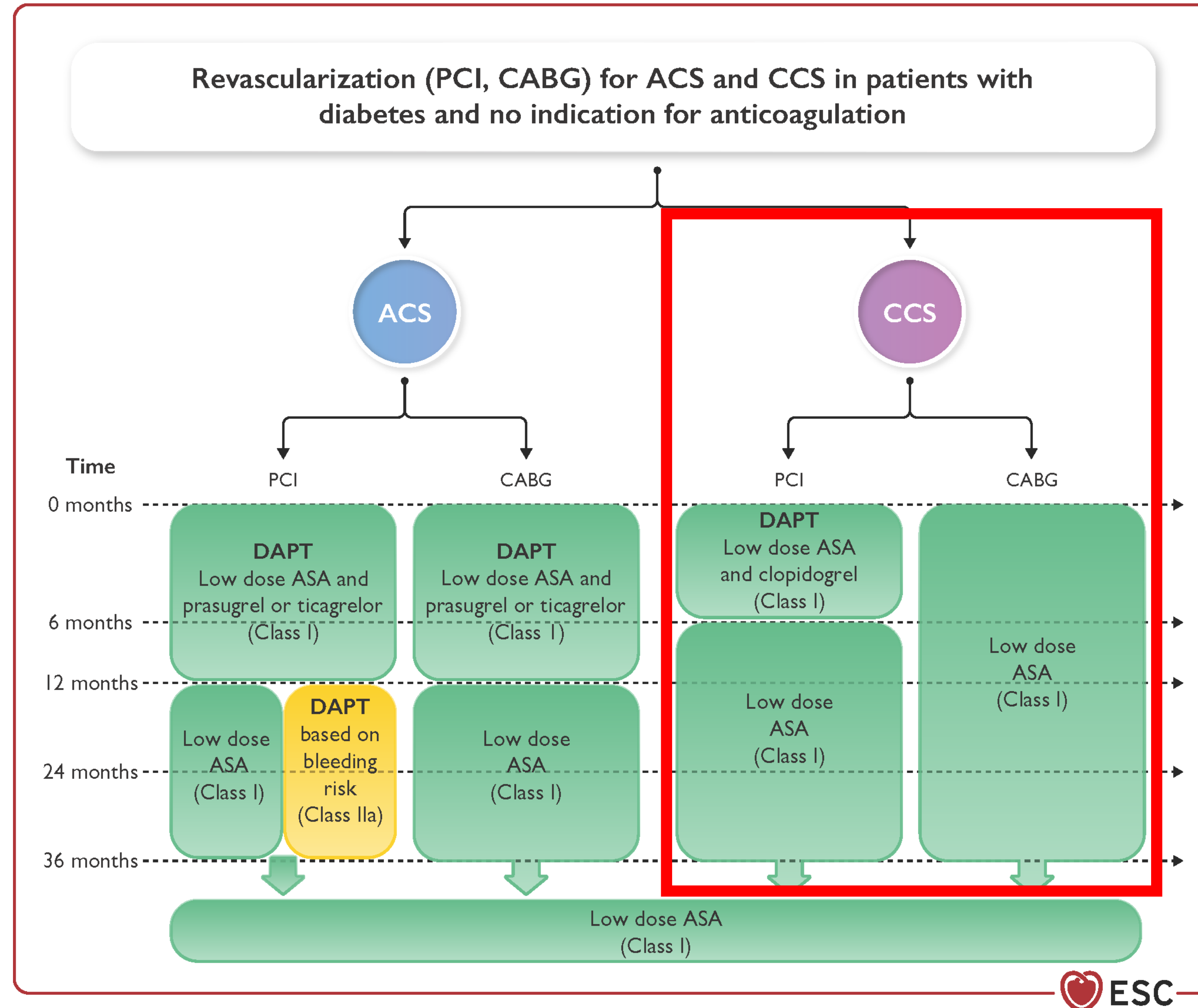
Figure 12

Recommendations for antiplatelet therapy in patients with diabetes with acute or chronic coronary syndrome undergoing percutaneous coronary intervention or coronary artery bypass grafting without indications for long-term oral anticoagulation



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Management of coronary artery disease in patients with diabetes		
Myocardial revascularization in CCS is recommended when angina persists despite treatment with anti-anginal drugs or in patients with a documented large area of ischaemia (>10% LV).	I	A

Recommendations for antithrombotic therapy in patients with diabetes and ACS or CCS and/or post-PCI requiring long-term oral anticoagulation (1)

Recommendations	Class	Level
In patients with AF and receiving antiplatelet therapy, eligible for anticoagulation, and without a contraindication, NOACs are recommended in preference to a VKA.	I	A
In patients with ACS or CCS and diabetes undergoing coronary stent implantation and having an indication for anticoagulation, triple therapy with low-dose ASA, clopidogrel, and an OAC is recommended for at least 1 week, followed by dual therapy with an OAC and a single, oral, antiplatelet agent.	I	A

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Recommendations for antithrombotic therapy in patients with diabetes and ACS or CCS and/or post-PCI requiring long-term oral anticoagulation (2)

Recommendations	Class	Level
In patients with ACS or CCS and diabetes undergoing coronary stent implantation and having an indication for anticoagulation, prolonging triple therapy with low-dose ASA, clopidogrel, and an OAC should be considered up to 1 month if the thrombotic risk outweighs the bleeding risk in the individual patient.	IIa	C
In patients with ACS or CCS and diabetes undergoing coronary stent implantation and having an indication for anticoagulation, prolonging triple therapy with low-dose ASA, clopidogrel, and an OAC up to 3 months may be considered if the thrombotic risk outweighs the bleeding risk in the individual patient.	IIb	C

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Recommendations for gastric protection in patients with diabetes taking antithrombotic drugs

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Recommendations	Class	Level
When antithrombotic drugs are used in combination, proton pump inhibitors are recommended to prevent gastrointestinal bleeding.	I	A
When a single antiplatelet or anticoagulant drug is used, proton pump inhibitors should be considered to prevent gastrointestinal bleeding, considering the bleeding risk of the individual patient.	IIa	A
When clopidogrel is used, omeprazole and esomeprazole are not recommended for gastric protection.	III	B

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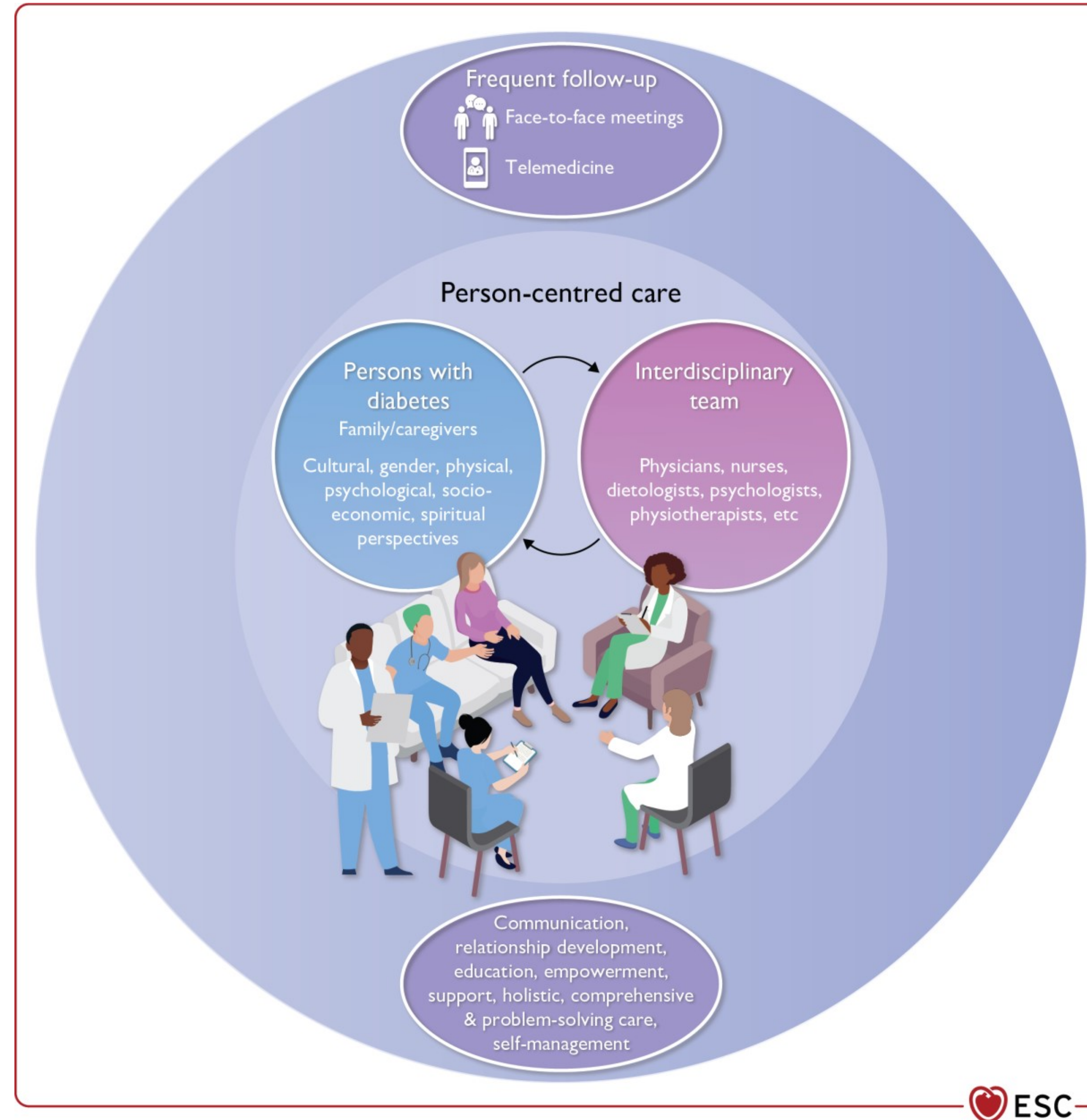
Figure 21

Person-centred care approach for patients with diabetes with or without cardiovascular disease



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