View from an Expert Bonus Content: ENDOCRINOLOGY

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Hi, everyone. I'm Jennifer Green. I'm an endocrinologist at Duke University Medical Center in North Carolina. Thank you for rejoining us after viewing the live MLI program presented at the World Congress of Insulin Resistance, Diabetes, and Cardiovascular Disease. I'm looking forward to sharing with you some brief views and key takeaways from really an endocrinologist perspective.

If you've listened to the full program, I hope that you took away from our conversation the fact that risk reduction is a shared responsibility, and that even though endocrinologists perhaps have not thought of themselves as making major interventions to reduce the risk of cardiovascular complications or progressive kidney disease, the time has come to revisit that approach.

As an endocrinologist who's been in practice for a long time, I can remember that for many years when we identified that a person with diabetes had albuminuria, essentially, we put them in an ACE or ARB and made sure that their blood pressure was well controlled but really didn't have much to offer beyond that. Of course, there's been a tremendous amount of new evidence resulting in new guidelines and new expanded pillars of care for the person with chronic kidney disease, and in particular, people with type 2 diabetes and chronic kidney disease.

If we think about those major pillars, again, it's the ACEs and ARBs, the SGLT2 inhibitors, nonsteroidal MRA therapy, and now the GLP-1 receptor agonists. Now, sometimes the response that we get to discussing these pillars of care is that it doesn't seem feasible, or it can be overwhelming to think about prescribing all of those pillars of care to an individual person with type 2 diabetes and chronic kidney disease, and that is understandable.

The pillars do not necessarily mean that everyone needs to be on all of those medicines, and in fact, the American Diabetes Association's recently revised standards of care for the management of people with type 2 diabetes, which was just published for the year 2025, actually recommends that for people with type 2 diabetes and chronic kidney disease that they be treated with an ACE or ARB, and then either an SGLT2 inhibitor or a GLP-1 receptor agonist with evidence of outcomes benefit in that population, so we do not necessarily need to treat everyone with all four pillars.

The other thing that is very encouraging and may make the prescription of all the components of care more feasible is the fact that, number one, the government, Medicare, has now been able to negotiate prices for lower prices for these medications. There will be limits on out-of-pocket spending by Medicare recipients, and then many of these drugs are going to be available in generic formulations in the near future. Of course, ACEs and ARBs, which are the foundation of therapy for chronic kidney disease, have been available at relatively low cost for a very long time.

Before I close, I'd also like to mention that there have been many questions about populations of people with chronic kidney disease who thus far have really not been included in the major CKD outcomes trials, for example, people with type 1 diabetes, people who are on dialysis already, and people who have had kidney transplantations. It is clear that those are major gaps in our understanding of the effects of these newer therapies in people who are at risk for progressive kidney disease and cardiovascular complications.

The good news is there's certainly great awareness that we need more information, and there are certainly small studies, which are ongoing now, to assess the effect of these newer medicines in these populations. To some extent, they may be very much focused on safety, but again, I think that the field is evolving very quickly, and we should have more information available soon to inform the care of those populations. Thank you again for joining this short view from an endocrinologist, and we hope to see you again soon.