

### 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/heart-matters/complication-centric-diabetes-care-obesity-cardiometabolic-risk/57033/>

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www.reachmd.com  
info@reachmd.com  
(866) 423-7849

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## Complication-Centric Diabetes Care: Addressing Obesity and Cardiometabolic Risk

### Announcer:

This is *Heart Matters* on ReachMD. On this episode, Dr. Scott Isaacs will discuss how we can integrate weight management and cardiometabolic risk reduction into diabetes care. He's the Immediate Past President of the American Association of Clinical Endocrinology and an Associate Professor of Medicine at Emory University School of Medicine. Let's hear from Dr. Isaacs now.

### Dr. Isaacs:

It's important when you're making therapeutic decisions for patients to think about how all their risk factors intersect—hypertension, dyslipidemia, glucose, and weight. And so the AACE diabetes algorithm is built around the concept that excess adiposity drives insulin resistance, and this contributes directly to these risk factors—to dyslipidemia, hypertension, and ASCVD risk, but also to steatotic liver disease, sleep apnea, and then, of course, glycemic dysfunction.

So as a result, the therapeutic decision should begin with identifying these comorbidities and then selecting specific medications that can help the comorbidities as well. For example, SGLT2 inhibitors are prioritized for patients who have heart failure or CKD, while GLP-1 receptor agonists or dual agonists should be favored if obesity, ASCVD risk, MASLD, or sleep apnea are the major issues.

And so it's important to think about obesity pharmacotherapy as disease-modifying rather than just a cosmetic treatment, because weight loss can improve all of these comorbidities—glycemia, blood pressure, lipids, MASLD, sleep apnea, et cetera. So when we're treating diabetes, we really want to think about the complication-centric approach and trying to treat these comorbidities at the same time.

There are some practical implementation strategies that you can use in a busy practice. The first visit should have a checklist that includes the A1C, blood pressure, lipid panel, BMI, waist-based adiposity assessment such as the waist to height ratio, smoking status, CKD markers such as albuminuria and eGFR, and screening for MASLD risk with the FIB-4. And by identifying the comorbidities and complications, that can allow a protocol-driven treatment and treat the underlying conditions as well as diabetes at the same time.

In addition to that, you want to do follow-ups at three months because you want to avoid therapeutic inertia. So you want to have either in-person visits or virtual visits to intensify care. If patients have not reached the goal, you want to increase the doses or add on medications until patients reach the goal.

And also, using team-based care can improve implementation, with pharmacists, advanced practice providers, nurse practitioners, and PAs who can assist with blood pressure and lipid management, and also trying to involve dietitians and behavioral health professionals to support the lifestyle and obesity management.

### Announcer:

That was Dr. Scott Isaacs discussing how a complication-centric approach to diabetes management can help address cardiometabolic comorbidities. To access this and other episodes in our series, visit *Heart Matters* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!