New anti-diabetic agents: major advances with unanswered questions

Pierre Sabouret1,*, Pier Paolo Bocchino2 and Giuseppe Biondi-Zoccai3,4

1Heart Institute and ACTION Group, Pitié-Salpêtrière, Sorbonne University, 47-83 Boulevard de l’Hôpital, 75013, Paris, France
2Division of Cardiology, Department of Medical Sciences, University of Turin, “Città della Salute e della Scienza” hospital, 10100, Turin, Italy
3Department of Medical-Surgical Sciences and Biotechnologies, Sapienza University of Rome, 04100, Latina, Italy
4Mediterranea Cardiocentro, 80100, Napoli, Italy

*Correspondence: cardiology.sabouret@gmail.com (Pierre Sabouret)

DOI: 10.31083/j.rcm.2020.04.220

This is an open access article under the CC BY 4.0 license (https://creativecommons.org/licenses/by/4.0/).

Keywords
Diabetes mellitus; SGLT2i; GLP1-RA; heart failure; chronic kidney disease

During the latest European Society of Cardiology (ESC) congress, impressive results have been reported regarding the clinical benefits of sodium-glucose cotransporter 2 inhibitors (SGLT2i) in heart failure with reduced ejection fraction (HFrEF) in the EMPagliflozin outcomeTrial in Patients With chronic heArt Failure With Reduced Ejection Fraction (EMPEROR-Reduced) and Dapagliflozin on the Incidence of Worsening Heart Failure or Cardiovascular Death in Patients With Chronic Heart Failure (DAPA-HF) trials (McMurray et al., 2019; Packer et al., 2020). A meta-analysis addressing the combined 8474 patients from both trials showed a 13% relative risk reduction (RRR) of total mortality (HR [hazard ratio], 0.87; 95% CI [confidence interval], 0.77-0.98), a 14% RRR of cardiovascular death (HR, 0.86; 95% CI, 0.76-0.98), a 25% RRR of cardiovascular death or hospitalizations for heart failure (HR, 0.75; 95% CI, 0.68-0.84) and a 38% RRR of the composite renal endpoint (HR, 0.62; 95% CI, 0.53-0.73) in the treatment group compared to placebo at a median follow-up time of 16 months in EMPEROR-Reduced and 18 months in DAPA-HF (Zinman et al., 2020).

After the encouraging results from Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes (EMPAREG-OUTCOME) and Dapagliflozin Effect on Cardiovascular Events-Thrombolysis in Myocardial Infarction 58 (DECLARE-TIMI 58) trials in diabetic patients with HFREF (Kato et al., 2019; Zinman et al., 2015), EMPEROR-Reduced and DAPA-HF demonstrated that the magnitude of benefits were similar in both diabetic and non-diabetic HFREF patients, thus underlining that SGLT2i benefits are not only mediated by the anti-diabetic pharmacological properties of these drugs but other biological mechanisms are at work (Murray et al., 2019; Packer et al., 2020). Notwithstanding, these results should not obscure the clinical efficacy of glucagon-like peptide-1 receptor agonists (GLP1-RA), which come as another emerging class of anti-diabetic drugs (Gerstein et al., 2019; Marso et al., 2016b,a).

Despite promising data from randomized controlled trials (RCT) on SGLT2i and GLP1-RA, some issues remain unresolved. Indeed, even if these drugs have proven cardioprotective effects, the underlying mechanisms of action are not yet perfectly understood. The class effect also remains uncertain due to the pharmacological differences among individual drugs and the heterogeneity of the results from RCTs. Moreover, it is still debated which class provides the greatest prevention against ischemic events. Indeed, only 3 RCTs, namely EMPAREG-OUTCOME, Liraglutide Effect and Action in Diabetes: Evaluation of Cardiovascular Outcome Results (LEADER) and Peptide Innovation for Early Diabetes Treatment (PIONEER-6) demonstrated a reduction of cardiovascular mortality in the treatment group compared to optimal medical therapy, whereas all the RCTs showed no difference in non-fatal myocardial infarction rates between groups (Husain et al., 2019; Marso et al., 2016a; Zinman et al., 2015). As for stroke, only dulaglutide was proven to reduce stroke rates in the Dulaglutide and cardiovascular outcomes in type 2 diabetes (REWIND) trial (Gerstein et al., 2019), but this effect was not observed in other GLP1-RA or SGLT2i trials. In REWIND, 58 (3.2%) stroke events were reported in the dulaglutide group (n = 4949) compared to 205 (4.1%) in the placebo group (n = 4952) with a hazard ratio (HR) of 0.76 (95% CI 0.62-0.94; P = 0.010). Ischemic stroke rates were decreased by 25% (HR 0.75, 95% CI 0.59-0.94, P = 0.012) with no impact on hemorrhagic stroke (HR 1.05, 95% CI 0.55-1.99; P = 0.89) (Gerstein et al., 2020).

Concerning the renal outcomes, RCTs on individual SGLT2i and GLP1-RA molecules demonstrated their protective role against worsening renal function, likely due to an increase of natriuresis and glycosuria, reduced proteinuria, decrease in glomerular
Fig. 1. Overview of the effects of SGLT2i (A) and GLP1-RA (B) on heart, kidney and metabolic pathways. GLP1-RA, glucagon-like peptide-1 receptor agonists; HBA1c, glycated haemoglobin; HDL, high-density lipoprotein; SGLT2, sodium-glucose cotransporter 2.

oxidative stress leading to an improved glomerular renal function (Gerstein et al., 2019; Kato et al., 2019; Marso et al., 2016a, b; Zinman et al., 2015). However, which drug class should be considered for first-line antidiabetic therapy in patients with chronic kidney disease is still a matter of debate as the most protective agents against worsening renal function are still argued.

Lastly, whether a combination therapy with these agents is effective on cardiovascular and/or renal outcomes in diabetic and non-diabetic patients is yet to be assessed in clinical trials (Table 1) and, should it be proved true, their safety and cost-effectiveness will eventually need to be confirmed by post-marketing analyses. Of note, retinopathy complications (vitreous hemorrhage, blind-
ness or conditions requiring treatment with an intrartreal agent or photocoagulation) may be higher with GLP1-RA as reported for semaglutide compared to placebo in the Trial to Evaluate Cardiovascular and Other Long-term Outcomes with Semaglutide in Subjects with Type 2 Diabetes (SUSTAIN 6) (HR 1.76, 95% CI 1.11-2.78; \( P = 0.02 \)) (Huang and Lee, 2020; Marso et al., 2016a).

Future studies are warranted to better assess the pharmacological properties, efficacy and safety of SGLT2i and GLP1-RA in order to optimize the management of both diabetic patients and non-diabetic individuals with heart failure against a background of optimal medical treatment (Cosentino et al., 2020; Di Lullo et al., 2020).

Author contributions

Pierre Sabouret and Giuseppe Biondi Zoccai conceived the study. Pierre Sabouret and Pier Paolo Bocchino did the literary search and wrote the first draft of the manuscript. All authors critically reviewed the manuscript. All authors read and approved its final version.

Acknowledgment

There are no acknowledgments to disclose.

Funding

None.

Conflict of Interest

Dr. Sabouret reports consulting or lecture fees from Amgen, AstraZeneca, Bayer, Bristol-Myers Squibb, Novartis, Pfizer, Servier, Vifor, Sanofi Regeneron, outside the submitted work. Dr. Biondi-Zoccai has consulted for InnovHeart, Milan, Medtrivial, Rome, and Replycare, Rome, all in Italy, outside the submitted work. Dr. Bocchino has no conflicts of interest to declare.

Table 1. Trials evaluating the combination of GLP1RA with SGLT2i.

<table>
<thead>
<tr>
<th>Study</th>
<th>DURATION 8</th>
<th>DECREASE</th>
<th>EXANDA</th>
<th>RESILIENT</th>
<th>NCT03018665</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2017-004709-42</td>
<td>NCT03361098</td>
<td>NCT03007329</td>
<td>NCT03419624</td>
<td>NCT03018665</td>
</tr>
<tr>
<td>Treatment group</td>
<td>Exenatide QW + Dapagliflozin</td>
<td>Exenatide BID + Dapagliflozin</td>
<td>Exenatide QW + Dapagliflozin</td>
<td>Exenatide QW + Dapagliflozin</td>
<td>Exenatide + Metformin</td>
</tr>
<tr>
<td>Comparator group</td>
<td>Placebo + Dapagliflozin</td>
<td>Placebo + Dapagliflozin</td>
<td>Placebo + Dapagliflozin</td>
<td>Placebo + Dapagliflozin</td>
<td>BIAsp30 + Metformin</td>
</tr>
<tr>
<td>Patient’s Characteristics</td>
<td>HbA1c 8-12% BMI &gt; 30 kg/m²</td>
<td>HbA1c 7-10% BMI 30-40 kg/m²</td>
<td>HbA1c 6.5-11% BMI ≥ 25 kg/m²</td>
<td>HbA1c 8-11% BMI ≥ 20 kg/m²</td>
<td>HbA1c 8-14% BMI ≥ 24-40 kg/m²</td>
</tr>
<tr>
<td>Primary endpoints</td>
<td>Changes in HbA1c</td>
<td>Differences in neuronal activity in central reward and satiety activity in response to food</td>
<td>Change in hepatic lipid content</td>
<td>Differences in weight and HbA1c</td>
<td>Rate of Inducing Diabetes + Change of Rate of Maintaining Diabetes</td>
</tr>
<tr>
<td>Status</td>
<td>Recruiting</td>
<td>Recruiting</td>
<td>Ongoing</td>
<td>Recruiting</td>
<td>Remission</td>
</tr>
</tbody>
</table>

T2 : Type 2; HbA1c : glycosylated Hemoglobin; IR : insulin resistance.

References


Husain, M., Birkenfeld, A. L., Donsmark, M., Dungan, K., Eliaschewitz, F. G., Franco, D. R., Jeppesen, O. K., Lingvay, I., Mosenson, O., Ped-


