30th Annual Hypertension, Diabetes & Dyslipidemia Conference
Day 1 Review – Jan Basile, MD

What Have We Learned – Day 1

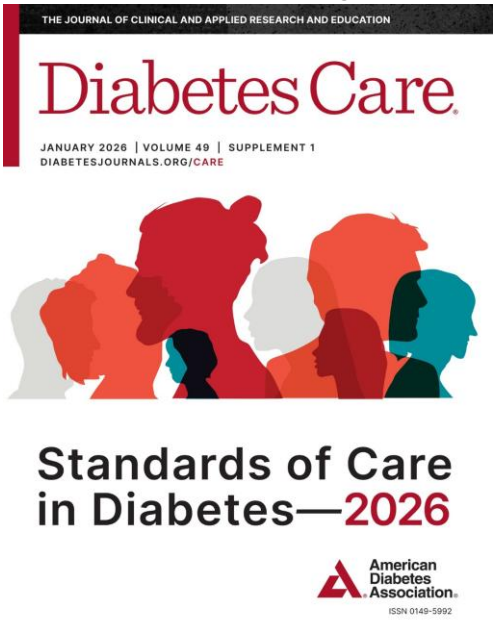
30th Annual Conference on Hypertension Diabetes, and Dyslipidemia

Hyatt Regency Hotel
Savannah, Georgia
June 3-5, 2026

CONTINUING EDUCATION COMPANY

1

Day 1-Focus on Diabetes
Dr. Low Wang spoke on "Standards of Care in Diabetes-Highlights from the ADA Standards of Care and the AACE T2D Consensus Algorithm"

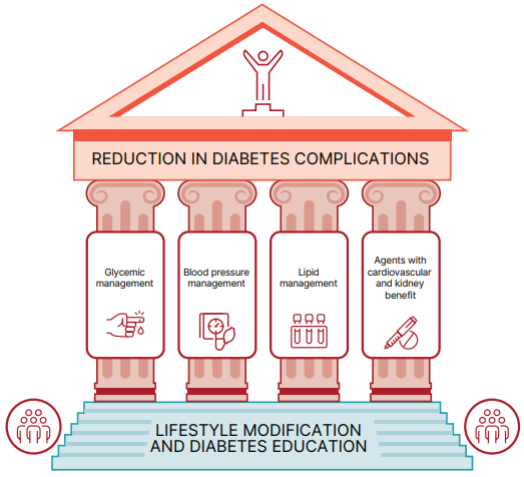


Diabetes Care 2026;49(Supplement 1).

2

Day 1-Focus on Diabetes
Dr. Low Wang spoke on "Standards of Care in Diabetes-Highlights from the ADA Standards and the AACE T2D Consensus Algorithm"

Section 10. CVD and Risk Management



Multifactorial Approach to Reduction in Risk of Diabetes Complications

Diabetes Care 2026;49(Suppl 1):S216-S245.

3

Day 1-Focus on Diabetes
Dr. Low Wang spoke on "Standards of Care in Diabetes-Highlights from the ADA Standards and the AACE T2D Consensus Algorithm"

- Maintain a high index of suspicion for type 1 diabetes in adults with presumed type 2 diabetes, especially in lean patients, those with rapid progression of their diabetes, those who develop ketosis, or those having a poor response to oral Rx.
- Continuous glucose monitoring (CGM) should be considered early and broadly in diabetes care; time-in-range ≥ 70% is now a major therapeutic goal.
- For diabetes with hypertension, target BP <130/80 mmHg; and in those with high CV or kidney risk, consider targeting a SBP < 120 mmHg, if tolerated.
- ACE inhibitor or ARB therapy in those with diabetes remains first-line only when albuminuria or established ASCVD is present. Otherwise, a thiazide-type diuretic or CCB can be used. Initial Single Pill combination Rx is recommended when BP is > 150/90 mmHg, while the ACC/AHA 2025 threshold is 140/90 mm Hg.
- LDL-C goals in those with diabetes are aggressive: ≥ 50% LDL reduction and LDL < 70 mg/dL for high-risk primary prevention and < 55 mg/dL for secondary prevention.

4

Day 1-Focus on Diabetes
Dr. Low Wang spoke on "Standards of Care in Diabetes-Highlights from the ADA Standards and the AACE T2D Consensus Algorithm"

- GLP-1 receptor agonists and SGLT2 inhibitors are foundational therapies for patients with ASCVD, CKD, HF, obesity, or MASLD/MASH risk.
- Metformin, approved in 1995, while often used, is no longer the default first-line therapy. It has no known beneficial effects on CV or renal outcomes.
- Rapid A1c reduction with GLP-1 therapies may transiently worsen diabetic retinopathy; assess retinal status before intensification with a GLP-1RA or dual GLP-1RA/GIP incretin.
- Euglycemic DKA is increasingly important, particularly with SGLT2 inhibitors—when using an SGLT2i, a normal glucose does not exclude DKA.
- Before elective surgery, preoperative diabetes optimization now includes targets of an A1c < 8% and/or CGM time-in-range > 50%.
- Management of diabetes now extends beyond glucose control to comprehensive cardio-kidney-metabolic risk reduction.

5

Day 1-Focus on Diabetes
Dr. Wysham spoke on "Diabetes and MASLD-Evaluation and Treatment" "

- A New nomenclature was developed during the summer of 2023 for NAFLD
- NAFLD was renamed by an international consensus group to reduce the stigma associated with alcohol and to also facilitate a shift towards prevention, proactive case finding, and early identification of progressive liver fibrosis.
- NAFLD is now called MASLD (Metabolic dysfunction–Associated Steatotic Liver Disease) suspected in those with obesity, type 2 diabetes, hypertension, and dyslipidemia; insulin resistance is a common underlying feature. It is the liver manifestation of the metabolic syndrome.
- In addition, MASH, Metabolic dysfunction–Associated SteatoHepatitis, replaces NASH, or non-alcoholic steatohepatitis.

6

Day 1-Focus on Diabetes
Dr. Wysham spoke on "Diabetes and MASLD-Evaluation and Treatment" "

- Approximately 70–80% of patients with type 2 diabetes have MASLD; primary care clinicians should actively screen high-risk patients.
- Progression from steatosis to MASH and cirrhosis is strongly associated with diabetes, insulin resistance, and obesity.
- Patients with MASLD and diabetes have substantially increased CV, cancer, and all-cause mortality risk—CV risk reduction is essential.
- This requires aggressive management of obesity, lipids, blood pressure, and CKD risk.
- Weight loss remains first-line therapy; sustained 7–10% weight reduction can significantly improve steatohepatitis and fibrosis.

7

Day 1-Focus on Diabetes
Dr. Wysham spoke on "Diabetes and MASLD-Evaluation and Treatment" "

- Lifestyle modification with the mediterranean diet, calorie restriction, brewed coffee up to 3 cups per day, resistance training, and avoidance of excess fructose are core lifestyle interventions.
- Do not overlook MASLD in rural primary care settings—early recognition and fibrosis identification may prevent cirrhosis and liver cancer.
- LFTs often can miss patients with liver fibrosis. Do not rely on LFTs for ruling out a diagnosis of MASLD.
- Standard B-mode ultrasound "is not recommended as a tool to identify hepatic steatosis" due to its low sensitivity so do not order it for this indication.

8

Day 1-Focus on Diabetes
Dr. Wysham spoke on "Diabetes and MASLD-Evaluation and Treatment" "

- In primary care settings, patients with risk factors for MASLD should be screened using the Fibrosis-4 (FIB 4) index, because of its excellent negative predictive value as a screening test.
- Obtainable by "fib4" on EPIC, the calculation of the FIB-4 index involves knowing the patient's age, aspartate aminotransferase (AST), alanine aminotransferase (ALT), and platelet count.
- The FIB-4 predicts long-term outcome and fibrosis in those with MASLD.
- The FIB-4 is used best in patients 35 to 65 years of age.
- Patients with a FIB-4 score ≥ 1.3 (or ≥ 2.0 for age ≥ 65) should undergo confirmatory testing using either vibration-controlled transient elastography (VCTE) or the proprietary Enhanced Liver Fibrosis (ELF) blood test. Those found to have stage F2 or greater fibrosis, defined as liver stiffness ≥ 10 kPa on VCTE or an ELF score ≥ 9.8, should be referred to a Liver specialist.

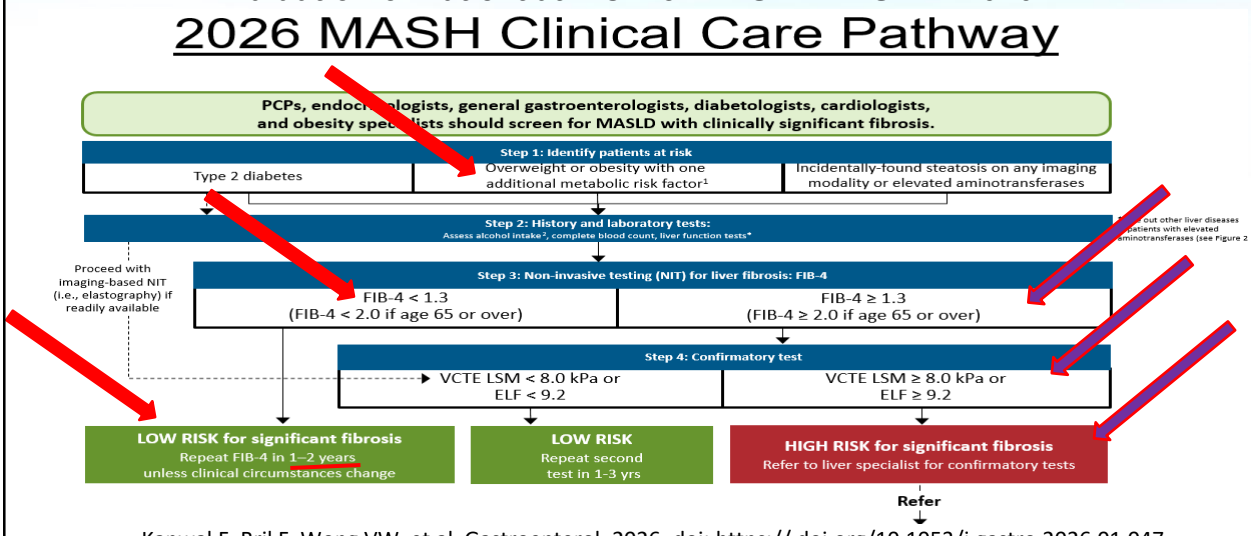
Day 1-Focus on Diabetes
Dr. Wysham spoke on "Diabetes and MASLD-Evaluation and Treatment" "

- Pharmacologic therapy with either one of 2 FDA approved agents-semaglutide (lower in cost) or resmetirom as a shared-decision is recommended for patients with MASLD and F2 or F3 fibrosis (VCTE 10–15 kPa or ELF 9.8–10.5). They can also be considered in select patients with lower fibrosis scores (VCTE 8–10 kPa or ELF 9.2–9.8) depending on their cardiometabolic risk. Neither drug is indicated for patients with cirrhosis.
- Resmitirom (Rezdiffra) when given at 80 mg (< 100 kg weight) or 100 mg (≥ 100 kg body weight), has favorable effects on MASH and at least regression of 1 stage of liver fibrosis.
- Adverse events are mostly GI including diarrhea and nausea. It has a neutral effect on body weight, insulin resistance, and TFT's. Cost is $47,000 per yr.
- Other pharmacologic agents, not FDA approved, but studied for MASH improvement include tirzepatide (SYNERGY-NASH study), pioglitazone at doses of 15-30 mg (diabetes), and the SGLT2i dapagliflozin.

Day 1-Focus on Diabetes

Dr. Wysham spoke on "Diabetes and MASLD-Evaluation and Treatment"

Evaluation of Patient at Risk for MASLD/MASH in 2026



Kanwal F, Bril F, Wong VW, et al. Gastroenterol. 2026; doi: https:// doi.org/10.1053/j.gastro.2026.01.047

11

Day 1-Focus on Diabetes

Dr. Low Wang spoke on "Navigating GLP-1RA and SGLT2i Use in Your Patients with Diabetes and Obesity"

- Type 2 diabetes is driven by insulin resistance, beta-cell dysfunction, and impaired incretin response; obesity is central to disease progression and the main driver of metabolic risk.
- Use the CKM (cardiovascular-kidney-metabolic) syndrome framework to integrate obesity, diabetes, CKD, HF, and ASCVD risk into one treatment strategy.
- SGLT2 inhibitors are preferred when any form of heart failure or CKD; GLP-1 receptor agonists are preferred for obesity, ASVD, and MASLD risk reduction.
- In high-risk patients with ASCVD, CKD, or HF, combination GLP-1RA plus SGLT2i therapy may provide additive cardiovascular and renal protection.
- Weight management (Stage 1) should be treated as a primary therapeutic target rather than a secondary consequence of glycemic control.

12

Day 1-Focus on Diabetes

Dr. Low Wang spoke on "Navigating GLP-1RA and SGLT2i Use in Your Patients with Diabetes and Obesity"

Stages of CKM Syndrome

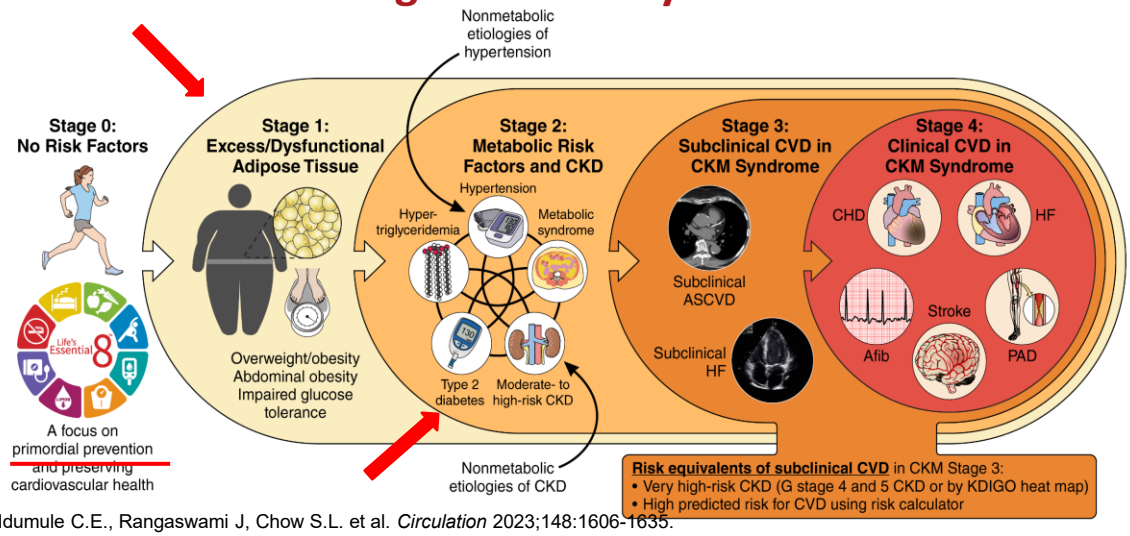


Fig 1. Ndumule C.E., Rangaswami J, Chow S.L. et al. *Circulation* 2023;148:1606-1635.

13

Day 1-Focus on Diabetes

Dr. Low Wang spoke on "Navigating GLP-1RA and SGLT2i Use in Your Patients with Diabetes and Obesity"

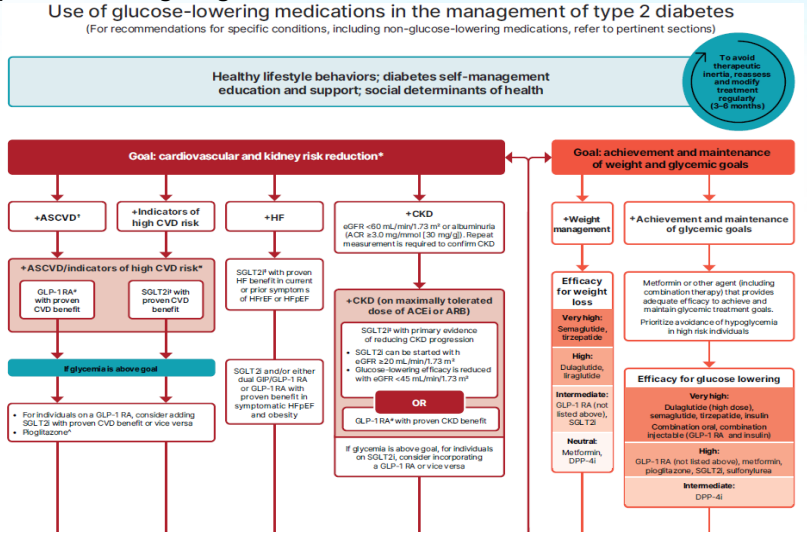


***Fig 9.4.Standards of Care in Diabetes - 2026. Diabetes Care* 2026;49(Suppl. 1):S183-215**

14

Choosing between SGLT2i vs GLP-1RA

Clinical Profile	Priority	Clinical Rationale
Patient has CKD (eGFR >/= 20)	SGLT2i	Reduces HF hospitalizations, slows kidney decline.
Patient has Heart Failure	SGLT2i	Cornerstone of GDMT regardless of diabetes status.
Patient has Severe Obesity (BMI >/= 35)	GLP-1RA	Induces >10% intentional weight loss.
Patient has HbA1c >/= 9% or high insulin dose	GLP-1RA	Superior glycemic control.
Patient has ASCVD / Multiple Comorbidities	Synergy: Combine SGLT2i + GLP-1RA	Maximum absolute risk reduction.

Rule: Co-utilize Metformin with either agent if HbA1c >/= 7.5% to achieve targets with minimal side effects.

Graphic prepared with help of Notebook LM AI using AHA CKM advisory as reference document.

Ndumele CE, et al. *Circ* 2023;148:1606-1635

15

Comparison of GLP-1RA and GIP/GLP-1RAs

Generic	Brand	Approved Indications	Dosing Frequency	Titration Frequency	Adult Dose Range	Pediatric Dose Range	Age	~ A1c Decrease	~ Weight Loss	Clinical Outcomes
Semaglutide	Ozempic	Type 2 diabetes, CV (US) and CKD risk reduction	Once weekly	Every 4 weeks	0.25 mg to 2 mg		18+	+ + +	+ +	
Semaglutide, oral	Rybelsus	Type 2 diabetes, CV risk reduction (US)	Once daily	Every 30 days	3 to 14 mg (R1), or 1.5 to 9 mg (R2)		18+	+ +	+ +	
Liraglutide	Victoza	Type 2 diabetes, CV risk reduction	Once daily	Every 1 week	0.6 mg to 1.8 mg	0.6 mg to 1.8 mg	10+	+ +	+	
Dulaglutide	Trulicity	Type 2 diabetes, CV risk reduction	Once weekly	After 1 week, then every 4 weeks	0.75 mg to 4.5 mg	0.75 mg to 1.5 mg	10+	+ +	+	
Tirzepatide	Mounjaro	Type 2 diabetes	Once weekly	Every 4 weeks	2.5 mg to 15 mg		18+	+ + + +	+ + + +	
Exenatide	generic	Type 2 diabetes	Twice daily	After 4 weeks	5 mcg bid to 10 mcg bid		18+	+	+	
Tirzepatide	Zepbound	Overweight and obesity, Sleep apnea in obesity (US)	Once weekly	Every 4 weeks	2.5 mg to 15 mg		18+		+ + + +	
Semaglutide, injection	Wegovy	Overweight and obesity, CV risk reduction, MASH (US)	Once weekly	Every 4 weeks	0.25 mg to 2.4 mg	0.25 mg to 2.4 mg	12+		+ + +	
Semaglutide, oral	Wegovy	Overweight and obesity, CV risk reduction	Once daily	Every 30 days	1.5 to 25 mg		18+		+ + +	
Liraglutide	Saxenda	Overweight and obesity	Once daily	Every 1 week	0.6 mg to 3 mg	0.6 mg to 3 mg	12+		+ +	

Clinical Outcomes Icon Legend

FDA approved for CV benefit · CV benefit · FDA approved for kidney benefit · Kidney benefit · MASH · FDA approved for MASH · FDA approved for sleep apnea · Peripheral artery disease

Prescribers Letter -July 2025.

16

Monitoring Disease Progression in Chronic Kidney Disease: 2026 ADA Standards of Care

- Low risk (if no other markers of kidney disease, no CKD)
- Moderately increased risk
- High risk
- Very high risk

on:
- GFR (G)
- Albuminuria (A)

GFR categories (mL/min/1.73 m²) Description and range				Albuminuria categories Description and range		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-299 mg/g 3-29 mg/mmol	≥300 mg/g ≥30 mg/mmol
	G1	Normal or high	≥90	Screen 1	Treat 1	Treat and refer 2
	G2	Mildly decreased	60-89	Screen 1	Treat 1	Treat and refer 2
	G3a	Mildly to moderately decreased	45-59	Treat 1	Treat 2	Treat and refer 3
	G3b	Moderately to severely decreased	30-44	Treat 2	Treat and refer 3	Treat and refer 3
	G4	Severely decreased	15-29	Treat and refer 3	Treat and refer 3	Treat and refer 4+
	G5	Kidney failure	<15	Treat and refer 4+	Treat and refer 4+	Treat and refer 4+

Numbers indicate guide to the frequency of monitoring (# of times per year)

Routinely order:

- **eGFR**
- **Albuminuria w Alb/Creat**

- Recognize that small fluctuations in GFR are common and are not necessarily indicative of progression.
- Repeat measurement at 3 months to make dx and over q 3-6 months to properly follow changes in UACR.

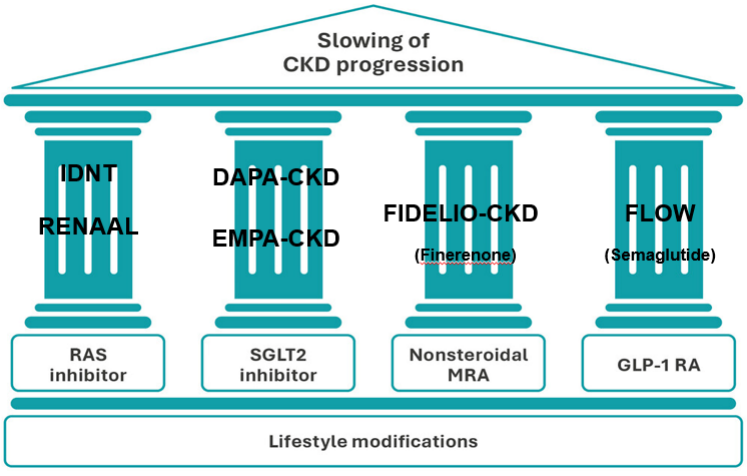
Figure 11.1Diabetes Care. 2026;49(Supplement_1):S246-S260. doi:10.2337/dc26-S011

17

Day 1-Focus on Diabetes

Dr. Low Wang spoke on "Navigating GLP-1RA and SGLT2i Use in Your Patients with Diabetes and Obesity"

TREATMENT TO REDUCE CV and RENAL RISK IN DIABETIC KIDNEY DISEASE



Zannad F. et al. *Jnl of Int Med*, Volume: 297, Issue: 5, Pages: 460-478, 31 December 2024, DOI:(10.1111/joim.20050).

18

Day 1-Focus on Diabetes

Dr. Wysham spoke on "Addressing Obesity in Diabetes: Why Weight?"

- Obesity is a complex, chronic, relapsing, and progressive "neuro-metabolic" disease of fat mass regulation that involves the neuroendocrine regulation of appetite—it is not simply a lifestyle failure. Obesity independently worsens insulin resistance, CV risk, fatty liver disease, and diabetes progression.
- The body defends a "set point" of fat mass through hormonal and neurological mechanisms. The body's defense of the set point is called metabolic adaptation. As we gain weight, this "set point" is redefined at a higher level which the body defends. Accordingly, it is hard to lose weight on your own.
- Effective obesity treatments (GLP-1 RAs, GLP-1RA/GIP, bariatric surgery, etc.) lower the defended fat mass "set point". This is how and why these drugs and surgery work and why drugs need to be continued at some dose to continue to keep the set point lowered.

19

Day 1-Focus on Diabetes

Dr. Wysham spoke on "Addressing Obesity in Diabetes: Why Weight?"

- Weight reduction should be considered a primary therapeutic endpoint in diabetes management, not simply an adjunct to glucose lowering.
- Even modest sustained weight loss of 5% improves glycemia, blood pressure, lipids, mobility, sleep apnea, and quality of life but more weight loss improves these areas to an even greater extent.
- Lifestyle therapy remains foundational: nutrition counseling, physical activity with resistance exercises, sleep optimization, and behavioral support are essential for durable success.
- GLP-1 receptor agonists and dual-incretin therapies provide clinically meaningful weight reduction and should be considered early in appropriate patients.

20

Day 1-Focus on Diabetes

Dr. Wysham spoke on "Addressing Obesity in Diabetes: Why Weight?"

- Patients with type 1 diabetes often have obesity and insulin resistance like T2D; obesity treatment principles should still be applied to them.
- Weight stigma and therapeutic inertia remain major barriers to effective obesity care and should be actively addressed in clinical practice.
- Primary care clinicians should routinely discuss obesity as a treatable chronic medical condition using non-judgmental, person-centered language.
- Monitor for muscle loss, nutritional compromise, gallbladder disease, GI intolerance, and hypoglycemic risk when initiating weight-loss pharmacotherapy.
- Early aggressive management of obesity may reduce progression of diabetes complications, MASLD, CKD, and CV disease.

21

Day 1-Focus on Diabetes

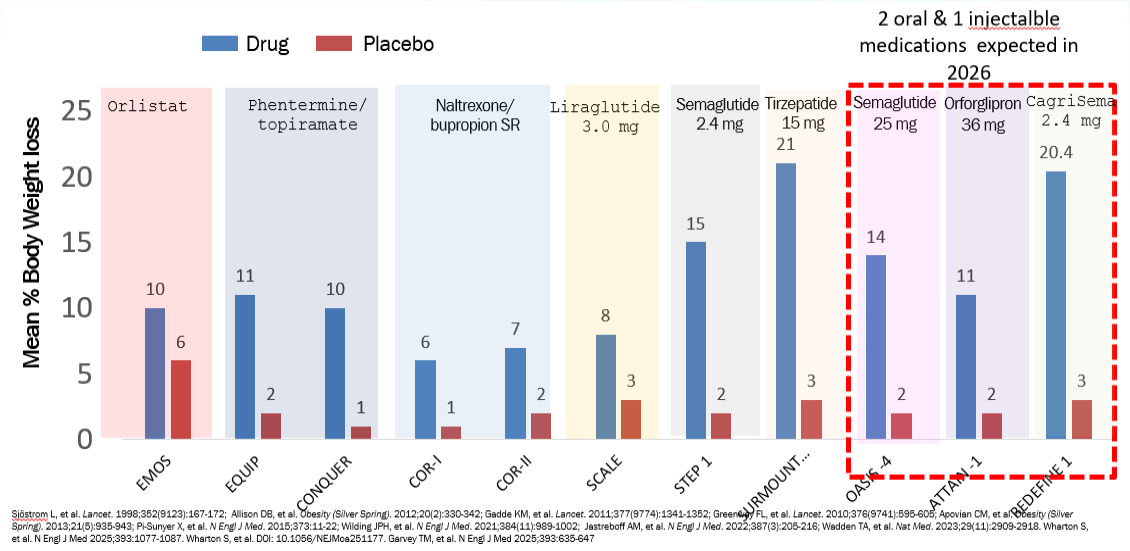
Dr. Wysham spoke on "Addressing Obesity in Diabetes: Why Weight?"

- Current and upcoming medications appear to be highly effective at reaching > 15% weight loss.
- Next-generation therapies including triple agonists like Retatrutide, amylin agonists, and small molecule oral GLP-1RA agents like orforglipron are expanding the options for further weight loss and metabolic control in the future.
- Public health measures are desperately needed to tackle the obesity problem.

22

Day 1-Focus on Diabetes

Dr. Wysham spoke on "Addressing Obesity in Diabetes: Why Weight?"



Sjöstrom L, et al. *Lancet*. 1998;352(9123):167-172; Allison DB, et al. *Obesity (Silver Spring)*. 2012;20(2):330-342; Gadde KM, et al. *Lancet*. 2011;377(9774):1341-1352; Greenway FL, et al. *Lancet*. 2010;376(9741):595-605; Apovian CM, et al. *Obesity (Silver Spring)*. 2013;21(5):935-943; Pi-Sunyer X, et al. *N Engl J Med*. 2015;373:11-22; Wilding JPH, et al. *N Engl J Med*. 2021;384(11):989-1002; Jastreboff AM, et al. *N Engl J Med*. 2022;387(3):205-216; Wadden TA, et al. *Nat Med*. 2023;29(11):2909-2918. Wharton S, et al. N Engl J Med 2025;393:1077-1087. Wharton S, et al. DOI: 10.1056/NEJMoa251177. Garvey TM, et al. N Engl J Med 2025;393:635-647

23

Summary of Obesity Medications

	Mechanism of Action	Typical Maintenance Dose	Mean Weight Loss*	≥5% of Initial Weight*	≥10% of Initial Weight*	Key Points
Phentermine	Norepinephrine release	8-37.5mg daily	~5%	X	X	Approved for short-term use, lowest cost
Orlistat (Xenical)	Lipase inhibitor	60mg TID (OTC) 120 mg TID (Rx)	3-4%	~21%	~12%	Available over-the-counter, GI side effects
Naltrexone ER/ Bupropion ER (Contrave)	Opioid antagonist/ antidepressant (dopamine)	16 mg/180 mg BID	5-6%	35%	20%	Intermediate in effectiveness and side effects
Liraglutide (Saxenda)	GLP-1 Receptor Agonist	3.0 mg daily	6-7%	36%	23%	Intermediate effectiveness and side effects, ?CVD benefit, high cost
****Phentermine/ Topiramate ER** (Qsymia)	Sympathomimetic/ GABA	7.5-15mg/46-92 mg daily	8-11%	41-49%	30-41%	Effective, intermediate side effects
Semaglutide (Wegovy)	GLP-1 Receptor Agonist	2.4 mg weekly	6-14%	40-55%	37-57%	Very effective, intermediate in side effects, high cost
Tirzepatide (Zepbound)	GLP-1/GIP Receptor Agonist	15 mg weekly	10-20%	83-90%	65-85%	Most effective. Intermediate in side effects, high cost
Setmelanotide (IMCIVREE)	MC4 receptor agonist	1-3 mg SC daily				For patients with genetically confirmed POMC, PCSK1, or LEPR deficiency

** Now generic

*placebo subtracted

24