



همایش سراسری دیابت مشهد

**مقدم شما اساتید و میهمانان ارجمند را
گرامی میداریم.**





کلینیک تخصصی
دیابت

پارسیان

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تلفن: ۰۵۱۳۲۵۲۴۴۵ ، ۰۵۱۳۲۵۲۴۴۵

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مشهد، چهارراه لشکر به
سمت چهارراه بیسیم
پلاک ۲۲۸، کلینیک
تخصصی دیابت پارسیان



کلینیک تخصصی
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پارسیان

Diabetologist point of view:

Shared decision Making

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How it was: We said , They did



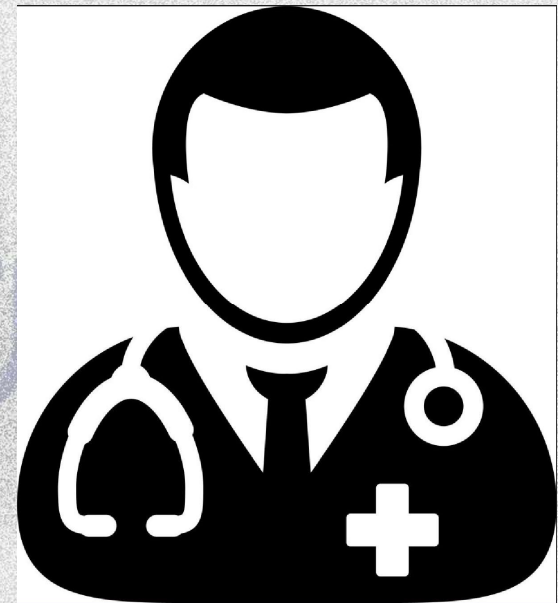
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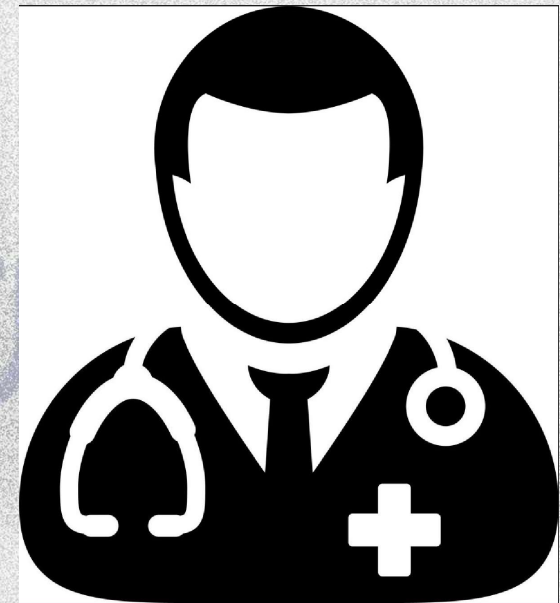
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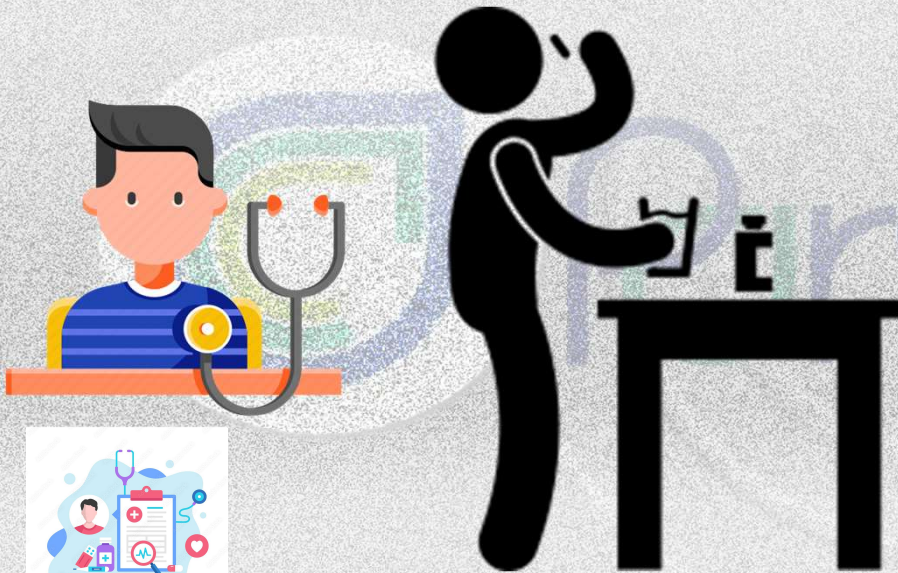
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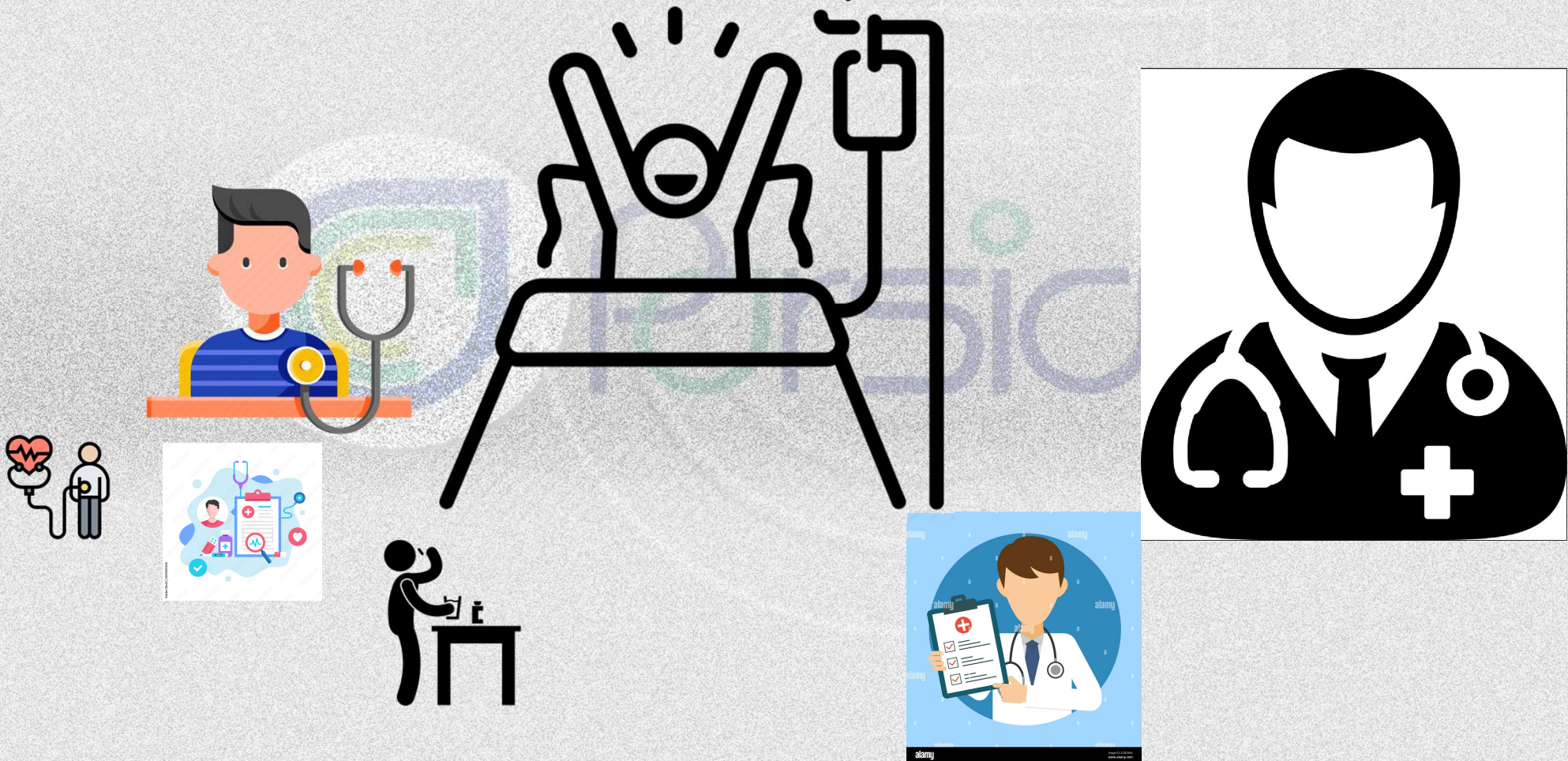
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How it was: We said , They did



How it was: We said , They did



How it was: We said , They did



How it was: We said , They did



How it was: We said , They did



Today, the internet has made everyone an 'expert'

Please do not confuse your Google search with my medical degree



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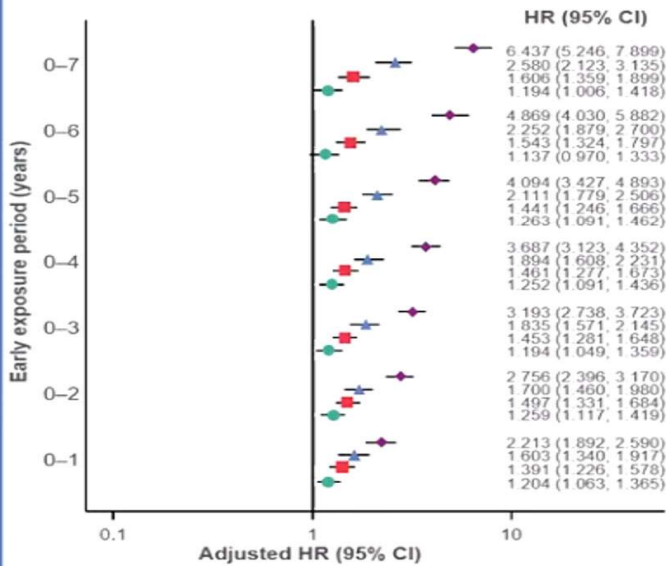


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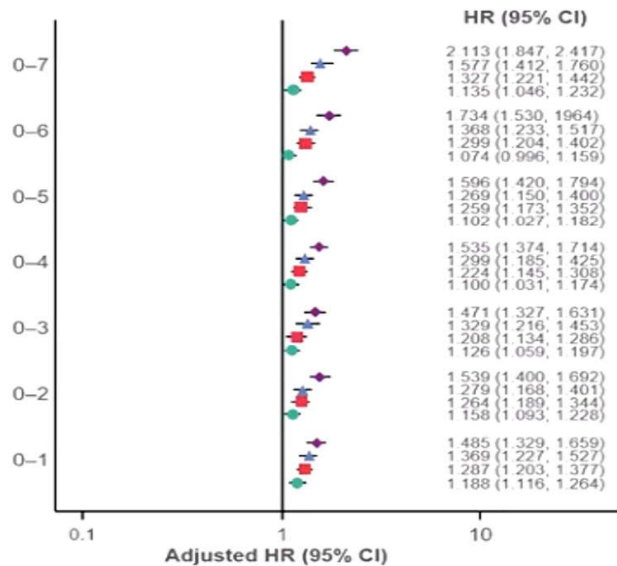


Early and intensive glycaemic control is crucial because dysglycaemia increases the risk of complications early in the course of T2D

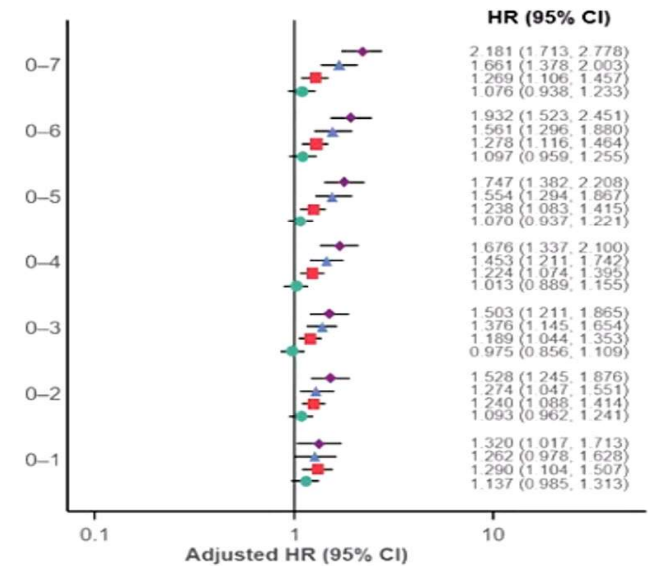
Microvascular events



Macrovascular events



Mortality



● HbA1c 6.5% to <7.0% (48 to <53 mmol/mol) ■ HbA1c 7.0% to <8.0% (53 to <64 mmol/mol) ▲ HbA1c 8.0% to <9.0% (64 to <75 mmol/mol) ◆ HbA1c 9.0% (>75 mmol/mol)

HbA1c, glycaemic management, T2D, type 2 diabetes
 Laiteerapong N et al. *Diabetes Care* 2019;42:416



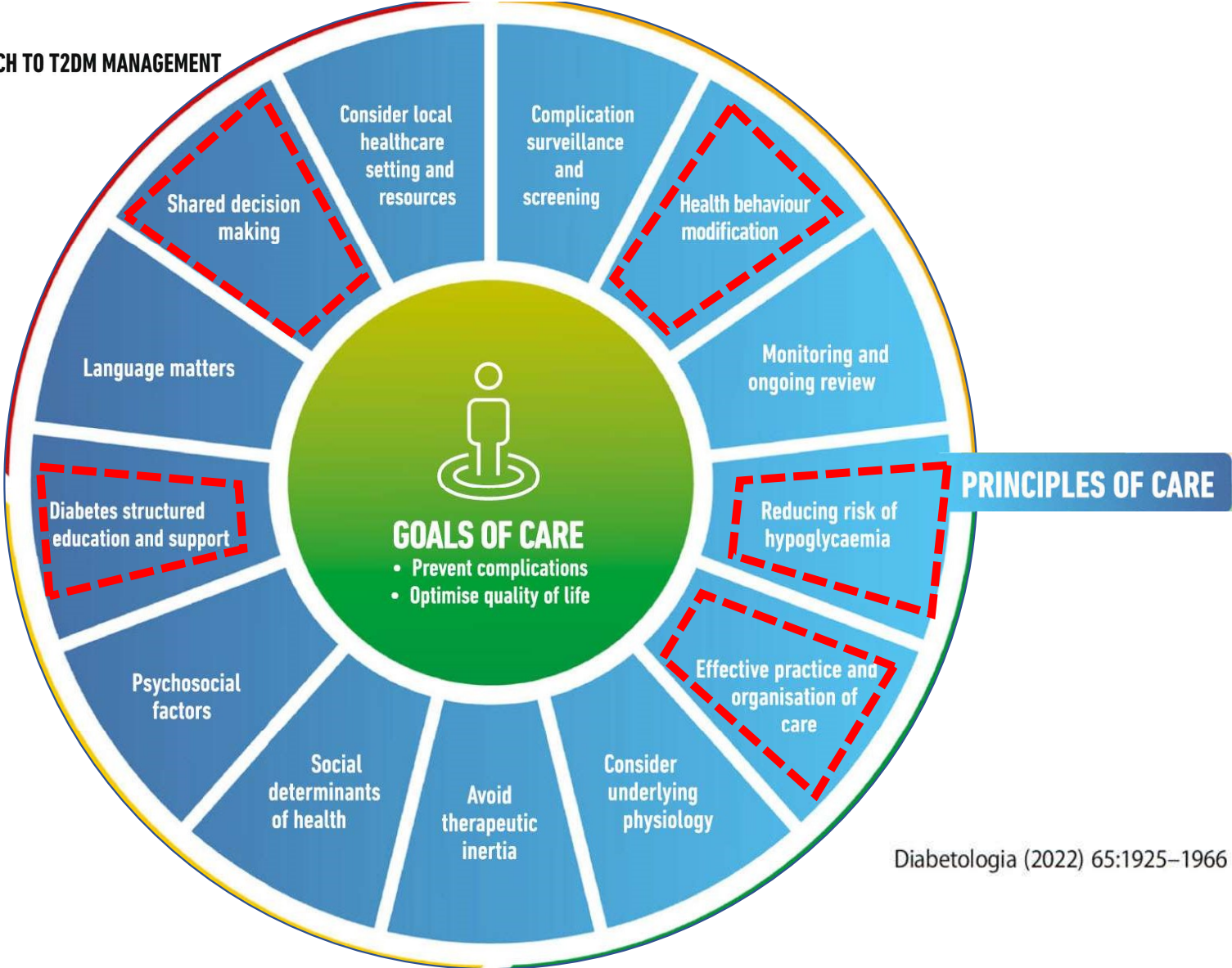
HOLISTIC PERSON-CENTRED APPROACH TO T2DM MANAGEMENT

Diabetologia (2022) 65:1925–1966

HOLISTIC PERSON-CENTRED APPROACH TO T2DM MANAGEMENT

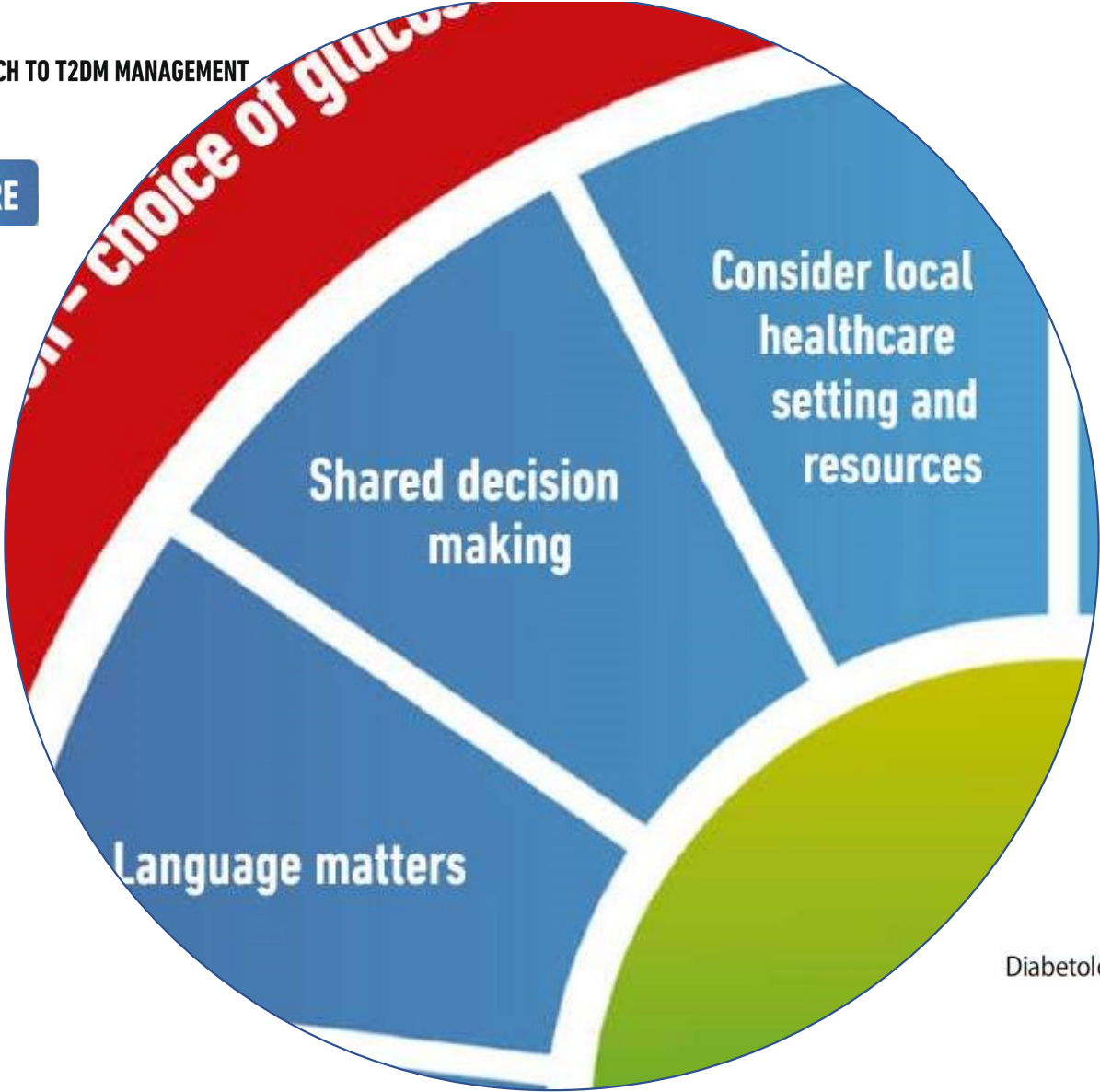


HOLISTIC PERSON-CENTRED APPROACH TO T2DM MANAGEMENT



HOLISTIC PERSON-CENTRED APPROACH TO T2DM MANAGEMENT

PRINCIPLES OF CARE



person with diabetes, the family or support group and health care team together formulate the management plan, which includes lifestyle management (see Section 5, “Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes”).

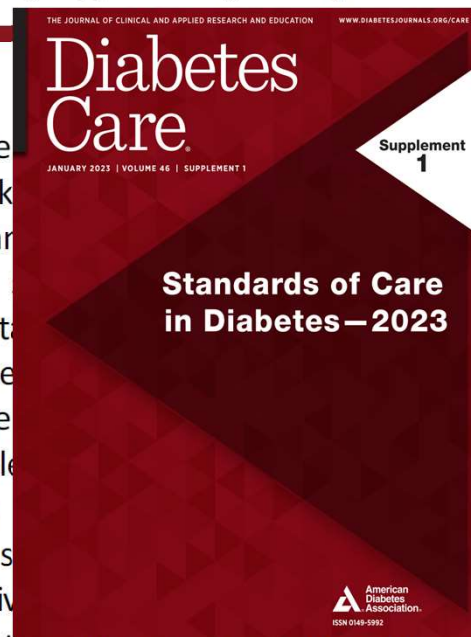
The goals of treatment for diabetes are to prevent or delay complications and optimize quality of life (Fig. 4.1).

Treatment goals and plans should be created with people with diabetes based on their individual preferences, values, and goals. This individualized management plan should take into account the person’s age, cognitive abilities, school/work schedule and conditions, health beliefs, support systems, eating patterns, physical activity, social situation, financial concerns, cultural factors, literacy and nu-

niques should be used to support the person’s self-management efforts, including providing education on problem-solving skills for all aspects of diabetes management.

Health care professional communication with people with diabetes and families should acknowledge that multiple factors impact glycemic management but also emphasize that collaboratively developed treatment plans and a healthy lifestyle can significantly improve disease outcomes and well-being (4–8). Thus, the goal of communication between health care professionals and people with diabetes is to establish a collaborative relationship and to assess and address self-management barriers without blaming people with diabetes for “noncompliance” or “nonadherence” when the outcomes of

diabetes take decision-making evaluation, and in diabetes nonjudgmental periodic lapse minimize the supporting problem Empathizing techniques, situations, reflecting what the person said, can help facilitate communication. Perceptions of people with diabetes about their own ability, or self-efficacy, to self-manage diabetes constitute one important psychosocial factor related to improved diabetes self-management and treatment outcomes in diabetes (10–12) and should be a target of ongoing assessment, edu-



person with diabetes, the family or support group and health care team together formulate the management plan, which includes lifestyle management (see Section 5, "Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes").

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Treatment goals and plans should be created with people with diabetes based on their individual preferences, values, and goals. This individualized management plan should take into account the person's age, cognitive abilities, school/work schedule and conditions, health beliefs, support systems, eating patterns, physical activity, social situation, financial concerns, cultural factors, literacy and nu-

niques should be used to support the person's self-management efforts, including providing education on problem-solving skills for all aspects of diabetes management.

Health care providers should collaborate with people with diabetes to create treatment goals and plans based on their individual preferences, values, and goals. This individualized management plan should take into account the person's age, cognitive abilities, school/work schedule and conditions, health beliefs, support systems, eating patterns, physical activity, social situation, financial concerns, cultural factors, literacy and nu-

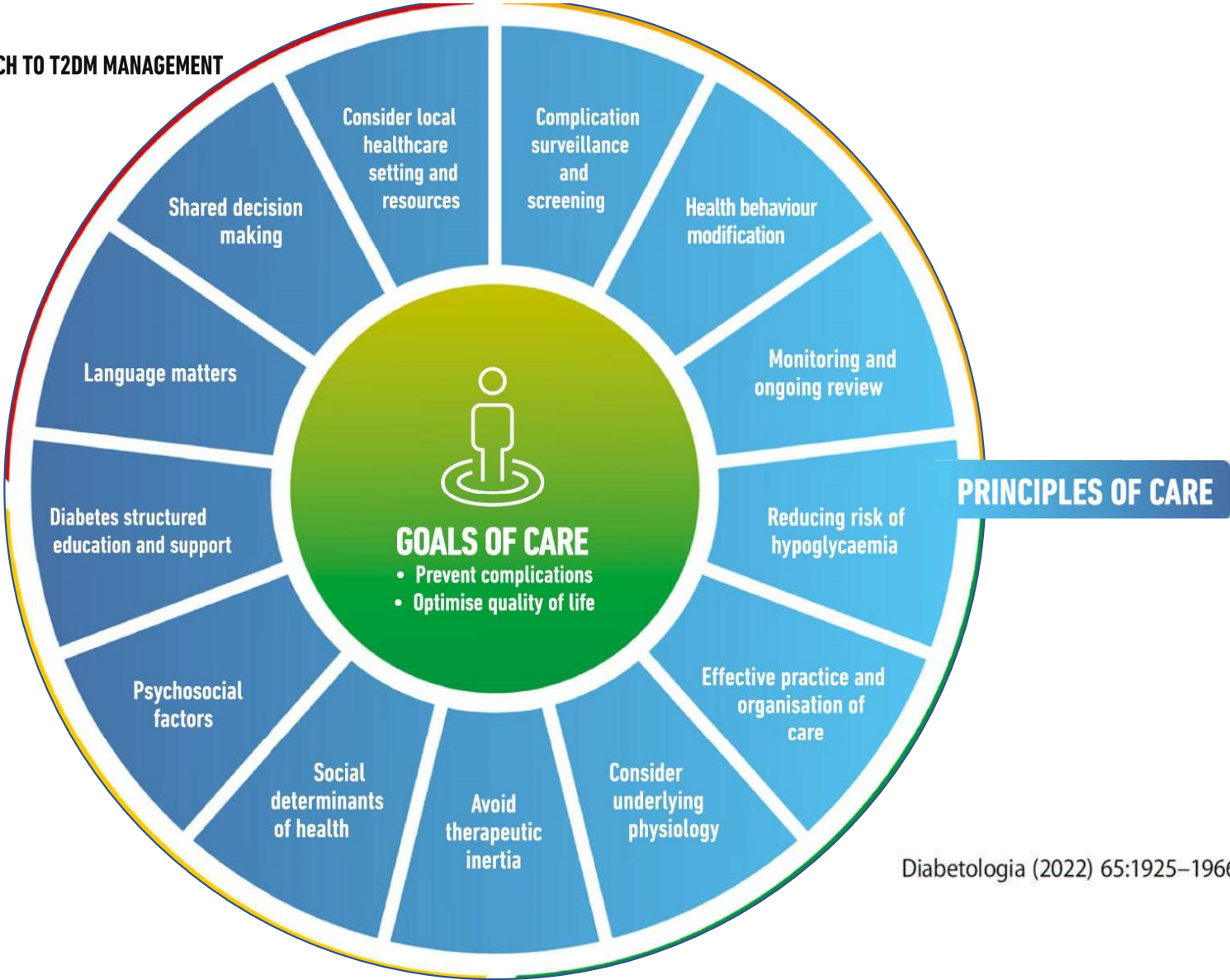
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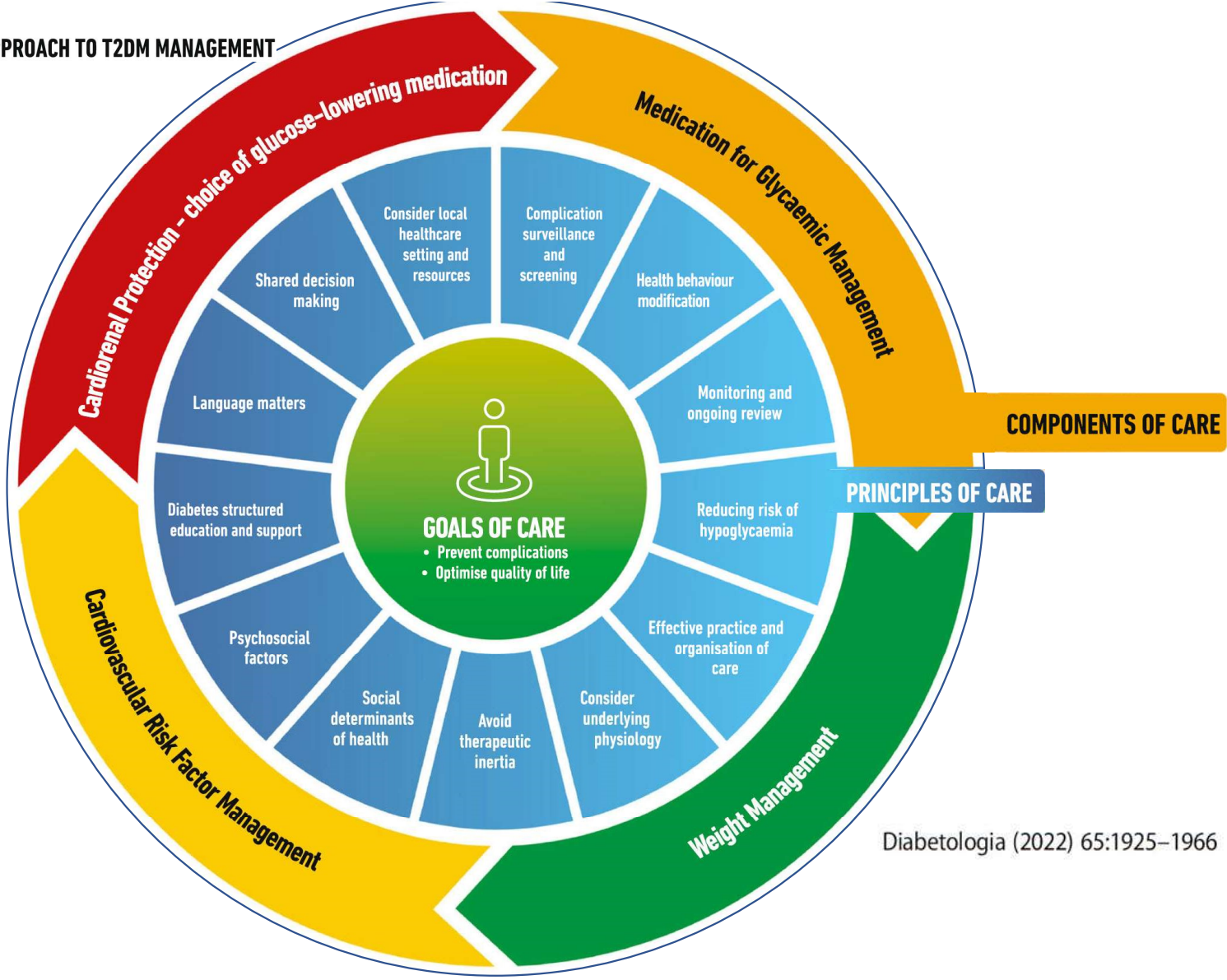
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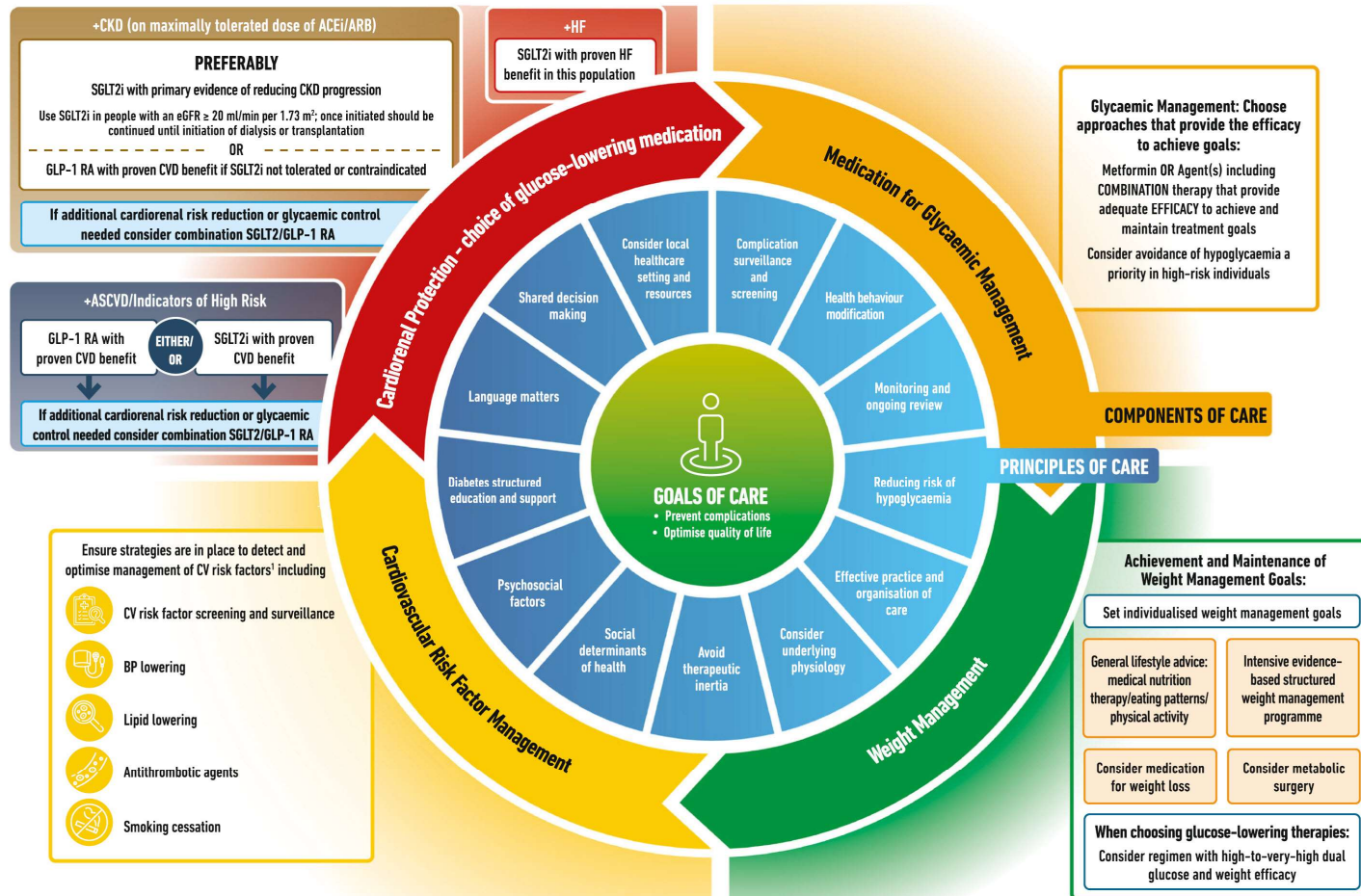
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1 = American Diabetes Association Professional Practice Committee. 10. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes-2022. Diabetes Care. 2022 Jan 1;45(Suppl 1):S144-74.
 ACEi, Angiotensin-Converting Enzyme Inhibitor; ARB, Angiotensin Receptor Blockers; ASCVD, Atherosclerotic Cardiovascular Disease; BP, Blood Pressure; CKD, Chronic Kidney Disease; CV, Cardiovascular; eGFR, Estimated Glomerular Filtration Rate; GLP-1 RA, Glucagon-Like Peptide-1 Receptor Agonist; HF, Heart Failure; SGLT2i, Sodium-Glucose Cotransporter-2 Inhibitor; T2D, Type 2 Diabetes.

Fig. 4 Holistic person-centred approach to T2DM management

Shared decision making^{1,2}

- Open discussion integrating the medical issues at hand and the patient's preferences and context to arrive at a course of action
- Both the patient and clinician share responsibility for the final decision



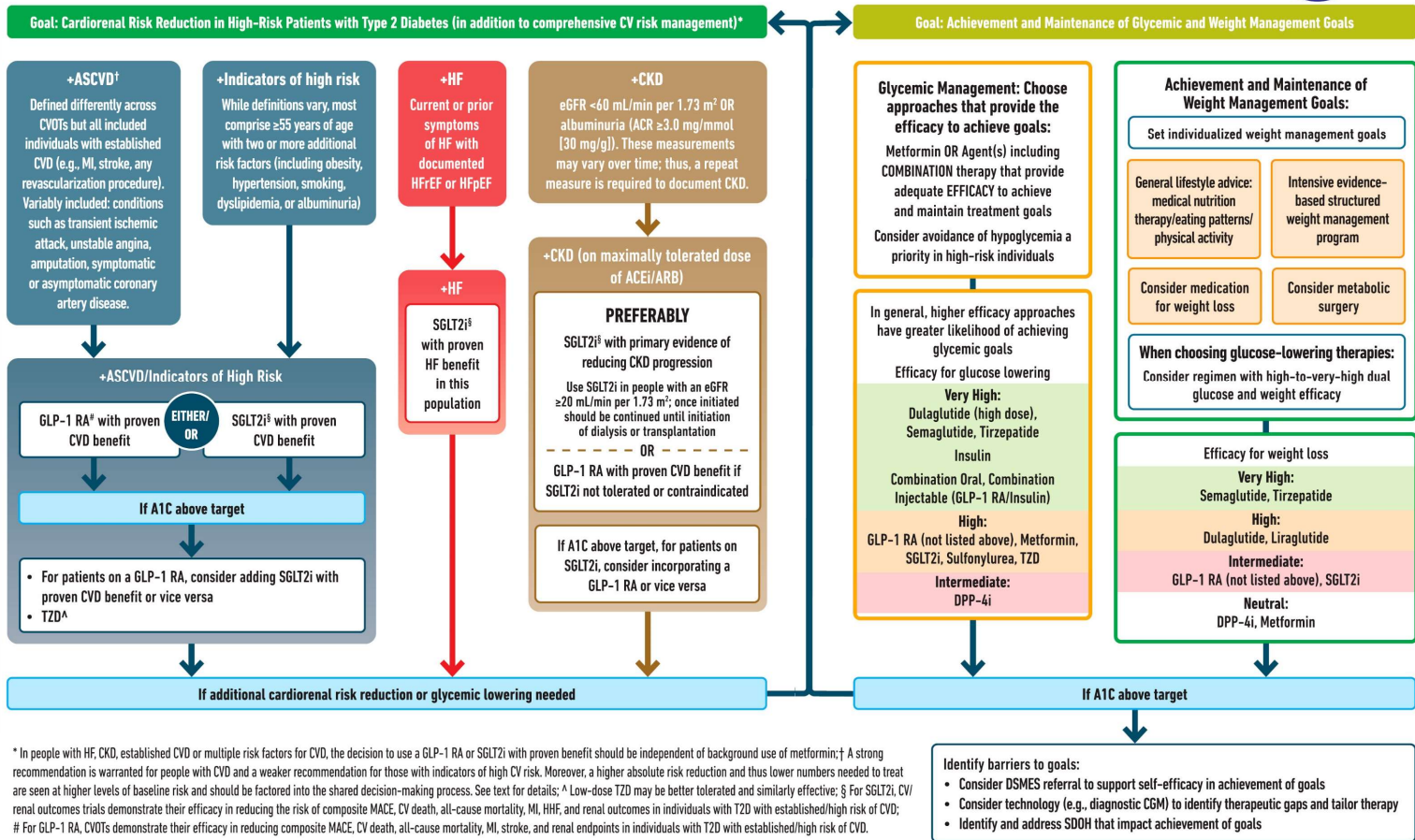
Photo by Cytonn Photography on Unsplash

1. Charles C *et al.* *Soc Sci Med* 1997;44:681; 2. Charles C *et al.* *Soc Sci Med* 1999;49:651



USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES

HEALTHY LIFESTYLE BEHAVIORS; DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES); SOCIAL DETERMINANTS OF HEALTH (SDOH)



* In people with HF, CKD, established CVD or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin; † A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details; ^ Low-dose TZD may be better tolerated and similarly effective; § For SGLT2i, CV/renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HFrEF, and renal outcomes in individuals with T2D with established/high risk of CVD; # For GLP-1 RA, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and renal endpoints in individuals with T2D with established/high risk of CVD.

Figure 9.3—Use of glucose-lowering medications in the management of type 2 diabetes. ACEi, angiotensin-converting enzyme inhibitor; ACR, albumin-to-creatinine ratio; ARB, angiotensin receptor blocker; ASCVD, atherosclerotic cardiovascular disease; CGM, continuous glucose monitoring; CKD, chronic kidney disease; CV, cardiovascular; CVD, cardiovascular disease; CVOT, cardiovascular outcomes trial; DPP-4i, dipeptidyl peptidase 4 inhibitor; eGFR, estimated glomerular filtration rate; GLP-1 RA, glucagon-like peptide 1 receptor agonist; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HHF, hospitalization for heart failure; MACE, major adverse cardiovascular events; MI, myocardial infarction; SDOH, social determinants of health; SGLT2i, sodium-glucose cotransporter 2 inhibitor; TZD, type 2 diabetes; TZD, thiazolidinedione. Adapted from Davies et al. (45).

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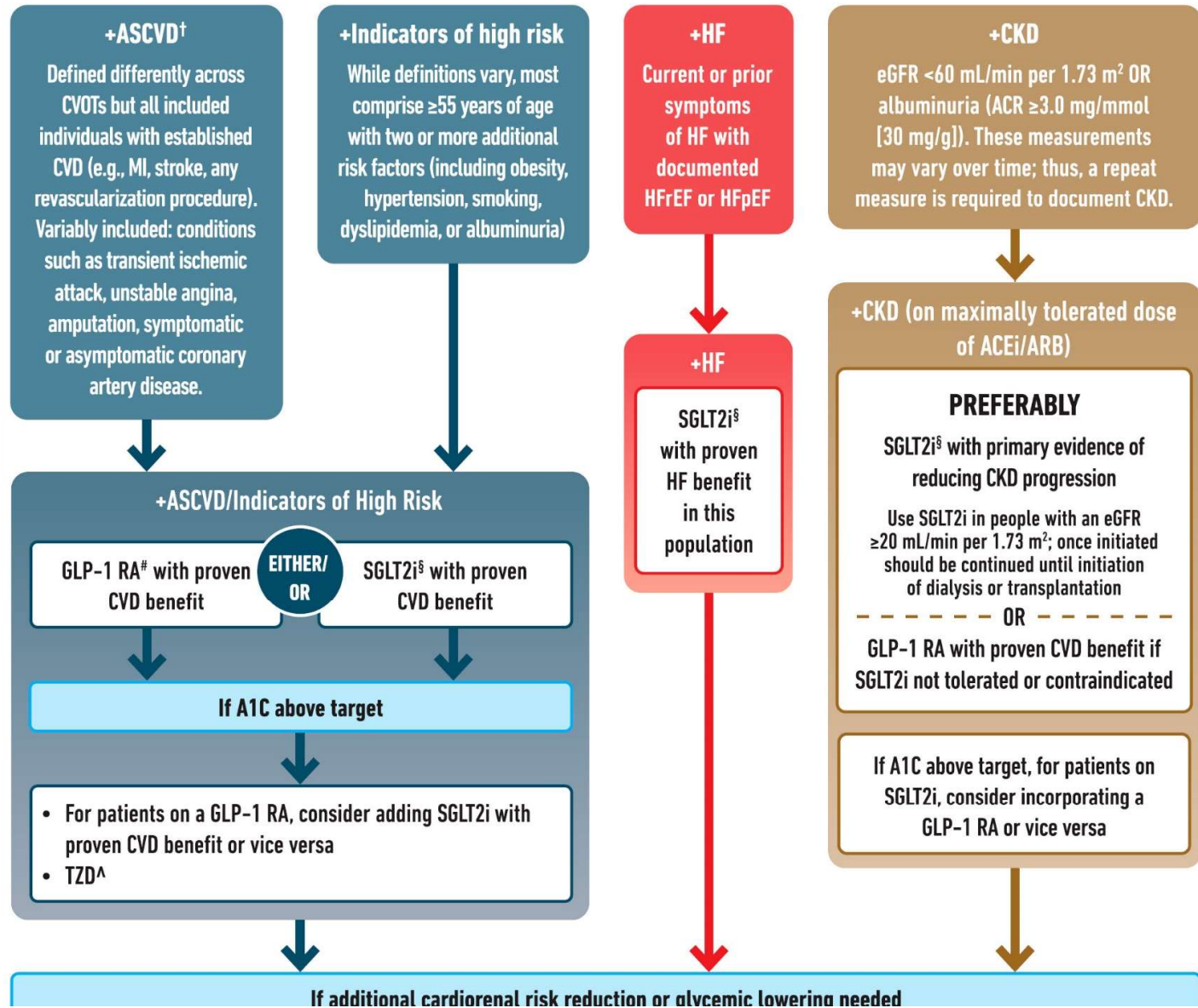
Photo by iStockphoto.com on iStockphoto.com
© Charles C. et al. / Doc 501 Med 1995-09-03

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Photo by iStock/Photography on Unsplash
1. Chavakis C et al. *Doc* 2019; 19(1):44-51. 2. Chavakis C et al. *Doc* 2019; 19(1):44-51



Type 2 Diabetes (in addition to comprehensive CV risk management)*

Goal: Achievement and Maintenance of Glycemic and Weight Management Goals

+HF
Current or prior symptoms of HF with documented HFrEF or HFpEF

+CKD
eGFR <60 mL/min per 1.73 m² OR albuminuria (ACR ≥3.0 mg/mmol [30 mg/g]). These measurements may vary over time; thus, a repeat measure is required to document CKD.

+HF
SGLT2i^s with proven HF benefit in this population

+CKD (on maximally tolerated dose of ACEi/ARB)

PREFERABLY
SGLT2i^s with primary evidence of reducing CKD progression
Use SGLT2i in people with an eGFR ≥20 mL/min per 1.73 m²; once initiated should be continued until initiation of dialysis or transplantation

----- OR -----
GLP-1 RA with proven CVD benefit if SGLT2i not tolerated or contraindicated

If A1C above target, for patients on SGLT2i, consider incorporating a GLP-1 RA or vice versa

Glycemic Management: Choose approaches that provide the efficacy to achieve goals:
Metformin OR Agent(s) including COMBINATION therapy that provide adequate EFFICACY to achieve and maintain treatment goals
Consider avoidance of hypoglycemia a priority in high-risk individuals

In general, higher efficacy approaches have greater likelihood of achieving glycemic goals

Efficacy for glucose lowering

Very High:
Dulaglutide (high dose), Semaglutide, Tirzepatide

Insulin
Combination Oral, Combination Injectable (GLP-1 RA/Insulin)

High:
GLP-1 RA (not listed above), Metformin, SGLT2i, Sulfonylurea, TZD

Intermediate:
DPP-4i

Achievement and Maintenance of Weight Management Goals:

Set individualized weight management goals

General lifestyle advice: medical nutrition therapy/eating patterns/physical activity

Intensive evidence-based structured weight management program

Consider medication for weight loss

Consider metabolic surgery

When choosing glucose-lowering therapies:
Consider regimen with high-to-very-high dual glucose and weight efficacy

Efficacy for weight loss

Very High:
Semaglutide, Tirzepatide

High:
Dulaglutide, Liraglutide

Intermediate:
GLP-1 RA (not listed above), SGLT2i

Neutral:
DPP-4i, Metformin

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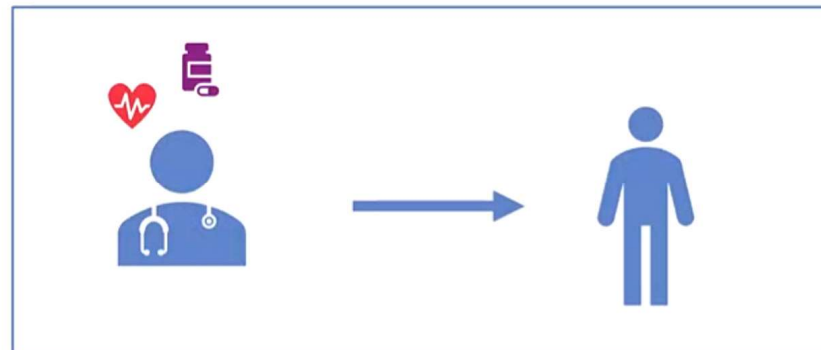


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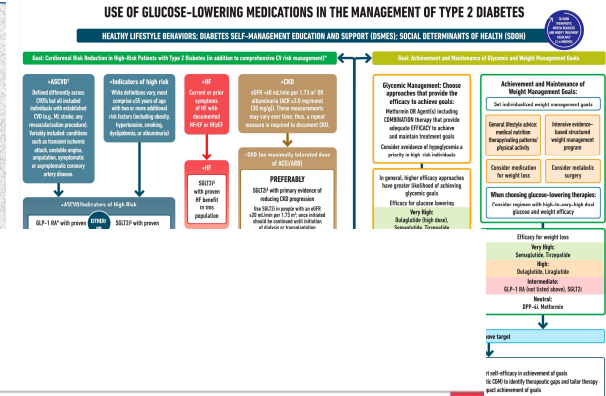
1. Charles C et al. Soc Sci Med 1997;44:681; 2. Charles C et al. Soc Sci Med 1999;49:651

The parental model^{1,2}

- Clinician reviews the medical situation and decides on the course of action
- **How does this differ from shared decision making?**
- The clinician makes decisions based entirely on the medical situation at hand
- There is no involvement of patient values or preferences, only minimal patient participation to satisfy legal requirements for informed consent



1. Charles C et al. Soc Sci Med 1997;44:681; 2. Charles C et al. Soc Sci Med 1999;49:651



non-receptor Diabetic ASCVD, atherosclerotic cardiovascular morbidity, atherosclerotic cardiovascular morbidity, HF, hospitalization for heart failure, MACE, morbidity. Adapted from Davies et al. (40).

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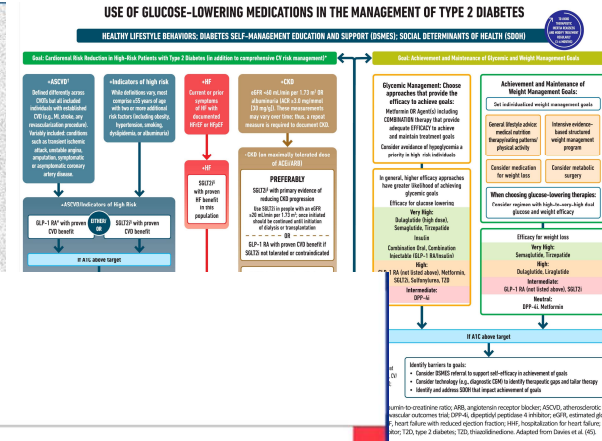
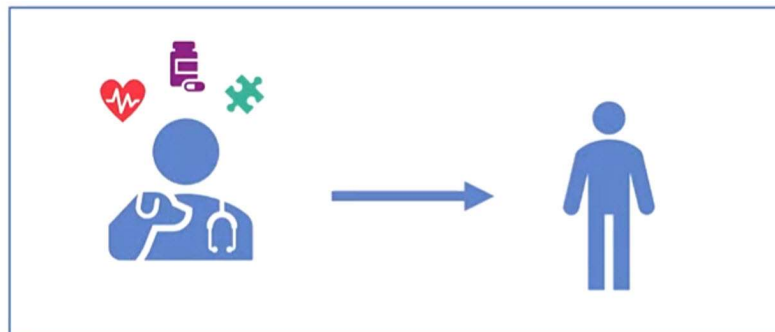
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Clinician as best-agent decision making

- Clinician makes decision about treatment course but takes into consideration or assumes to know the patient's values and preferences
- **How does this differ from shared decision making?**
- There is no exchange of preference. Clinician makes the final decision but seeks to understand and incorporate the patient's values into the decision-making process



Shared decision making^{1,2}

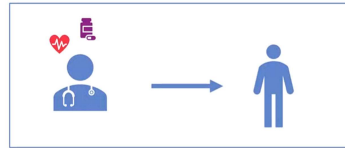
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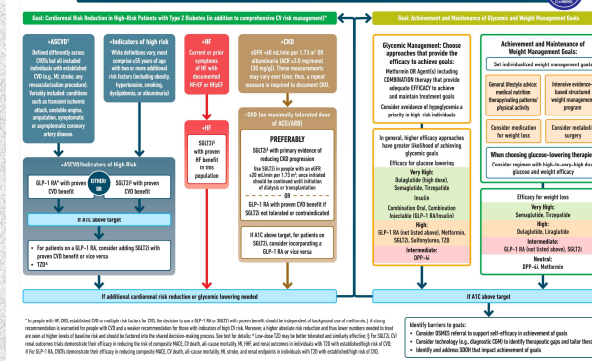


Figure 9-3—Use of glucose-lowering medications in the management of type 2 diabetes. ACEI, angiotensin-converting enzyme inhibitor; ARJ, albumin-to-creatinine ratio; ARB, angiotensin receptor blocker; ASCVD, atherosclerotic cardiovascular disease; CVD, cardiovascular disease; DPP-4, dipeptidyl peptidase-4 inhibitor; GLP-1 RA, glucagon-like peptide-1 receptor agonist; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; HFrEF, hospitalization for heart failure; MAAC, major adverse cardiovascular events; NA, nonarteriole; NIDDM, noninsulin-dependent diabetes mellitus; SGLT2i, sodium-glucose cotransporter 2 inhibitor; T2D, type 2 diabetes; T2DM, type 2 diabetes mellitus. Adapted from Davies et al.¹⁰

COST!

Clinician as best-agent decision making

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Economic burden of Diabetic nephropathy

Based on a US study conducted between 1999 and 2002

DM ,
no nephropathy
a mean annual
medical cost of
USD 4,573

DM ,
with clinical
nephropathy
mean annual
costs 49% higher
(USD 6,826)

DM ,
with ESRD
not on dialysis
mean annual
costs of USD
10,322,

*those on
dialysis this
increased
28900*

25% of DM
related inpatient

DM is
responsible for

costs are a
Considerable
CVD

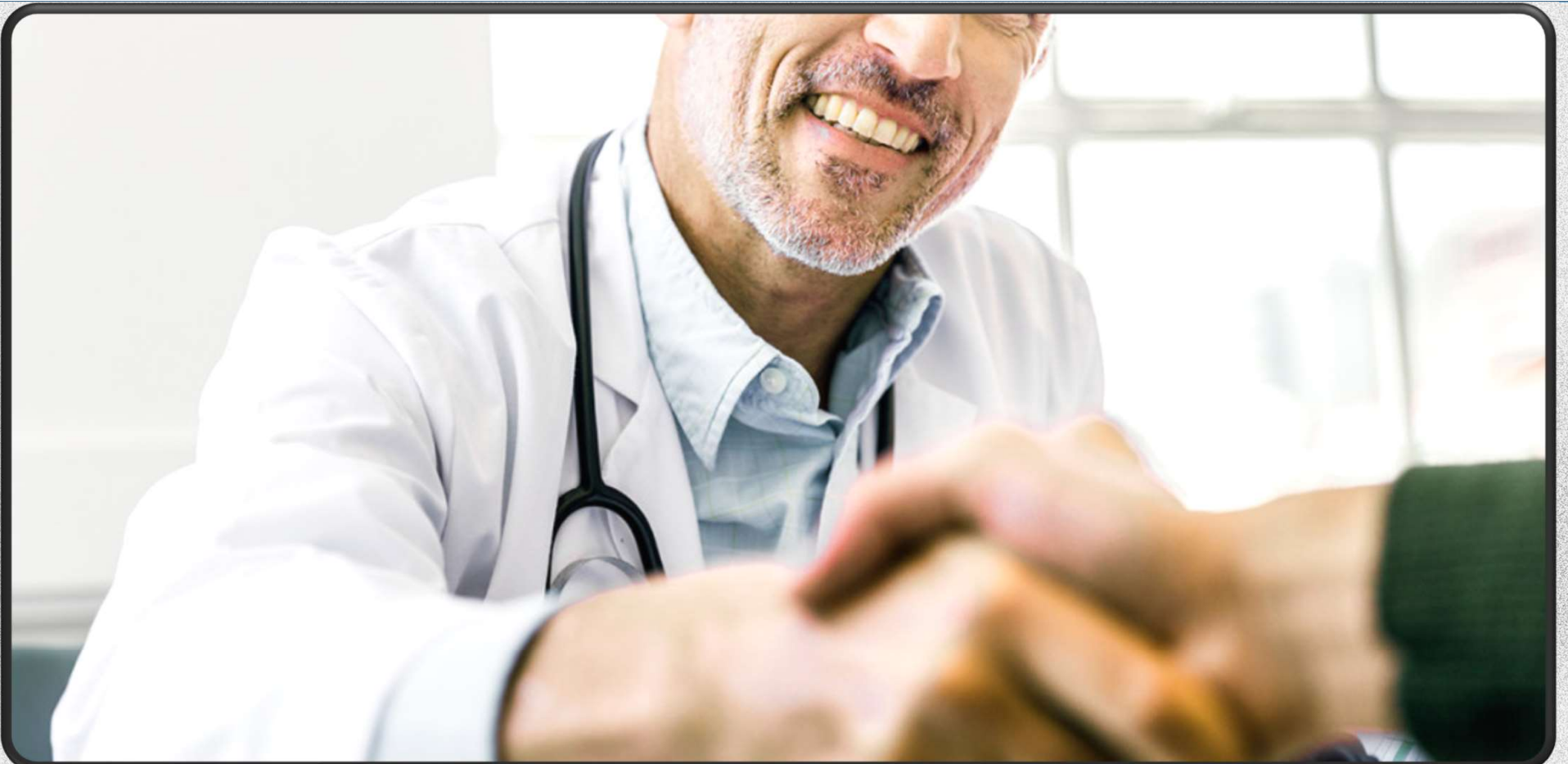
More than
25% of
All CVD
expenditure.

What Dose It Mean?

14% of
of physician

office visits in

Costs of DM are not
All simple and direct



The shared decision making is about supporting patients in making healthcare decisions in cases where there is more than one reasonable option.



Thank You
For Your
Attention