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Cardiologist and diabetologist crosstalk

The prevalence of Type 2 diabetes is consistently increasing, and the leading cause of death among diabetic patients continues to be cardiovascular diseases. Statistics show that coronary artery disease (CAD) accounts for 30% of deaths in the diabetic population. More than two-thirds of diabetic patients, 65 years and older, die because of vascular problems. Silent ischaemia is more prevalent in diabetic patients as compared to non-diabetic patients. The use of traditional therapies for glycaemic control has not shown a significant reduction in macrovascular complications of diabetes or mortality.

In the midst of all this lies an issue of paramount importance - the interdisciplinary crosstalk between the Cardiologist and the Diabetologist. As the awareness of the cardiovascular complexity of the diabetic patient increases, so does the realisation that there is a need to move towards a complete multidisciplinary approach with diabetologists and cardiologists working together.

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The use of novel glucose-lowering drugs (GLDs) is also being emphasised as they offer a new approach to handle the problem of Type 2 diabetes and are believed to have a positive impact in reducing CV morbidity and mortality. Some of these new anti-diabetic agents have demonstrated an impressive impact on cardiovascular outcomes.

However, whenever a new clinical management approach is proposed or recommended, there are always some concerns, doubts, and questions regarding the treatment. With respect to the GLDs, the primary area of concern is related to the economic sustainability of using these expensive molecules as long-term therapy because the unitary cost of new molecules is much higher compared to traditional molecules.

But GLDs are believed to have the potential to revolutionise the treatment of diabetes as well as reduce major adverse cardiovascular events (MACE) and mortality. It is this potential of GLDs that has also sparked interest among cardiologists. The only issue is their applicability and cost-benefit in everyday clinical practice.

Landmark cardiovascular trials can be used as the starting point to evaluate the positive and negative aspects of GLDs. The goal is to ensure that cardiologists become confident with the new GLDs and learn how to exploit their positive impact while diabetologists start considering outcomes beyond glycaemic control and focus on long-term results.

There is no doubt that the new GLDs can be powerful tools in the management of Type 2 diabetes but since diabetes is a major risk factor for cardiovascular disease, it is imperative that this new weapon is used through the combined management efforts of cardiologists and diabetologists. As the burden of patients with Type 2 diabetes and cardiovascular disease increases, the need for a multidisciplinary approach to managing these patients also increases. If these healthcare providers want to fully exploit the power of new pharmacological strategies, they need to do it together.

Source: ICJ Heart & Vasculature
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