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CARDIOMETAB - THE HEART OF DIABETES

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People with type 2 diabetes mellitus (T2DM), prediabetes and insulin resistance are more likely to develop myocardial infarction and stroke and have also associated lipid abnormalities, hypertension and chronic vascular inflammation, that are themselves significant cardiovascular risk factors. It is a certainty that the most common cause of death in patients with T2DM is due to a cardiovascular disease (CVD). Pre-diabetes and diabetes do not confer the same risk for the different entities of CVD, therefore an individualized assessment for major adverse cardiovascular events (MACE) is mandatory. The definition of MACE is non-fatal myocardial infarction, nonfatal stroke and cardiovascular death. Hypertension occurs in more than two thirds of patients with T2DM and is associated with a further marked increase of cardiovascular risk. Arterial hypertension (AH) commonly occurs in conjunction with insulin resistance. Activation of the renin–angiotensin–aldosterone system (RAAS) and consequent elevations of angiotensin II and aldosterone contributes to increased hepatic glucose release and decreased insulin sensitivity. Moreover, hyperglycaemia also increases serum aldosterone levels. Accordingly, in addition to blood pressure (BP) lowering, RAAS blockade might also serve as an effective strategy to control impaired glucose and insulin tolerance. Up to date most of the antidiabetic drugs proved to improve insulin sensitivity, glycaemic control, hypertension, dyslipidemia and microalbuminuria in T2DM. Emerging, antihypertensive agents (angiotensin receptor blockers (ARBs) or ACE inhibitors (ACEIs)) may reduce the incidence of new-onset diabetes in hypertensive patients. As BP control is an important strategy for preventing cardiovascular and renal complications in T2DM treatment guidelines include disease-specific BP targets, that demand a multifactorial approach, which includes control of glycemia, lipids, BP and body weight.