Manejo integral de DM y outcomes

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Conflictos de interés

- Conferencista: Astra Zeneca, Abbott Nutrición, Novartis Oncology, Novo Nordisk, Merck Sharp & Dohme, Roche, Glaxo SmithKline, Sanofi Aventis, Bayer, Boehringer Ingelheim, Janssen
- Advisory Board: Novartis Oncology, Sanofi Aventis, Astra Zeneca, Novo Nordisk, Stendhal, Pfizer, Janssen
- Investigación clínica: Astra Zeneca, Novartis Pharma Logistics Inc., Merck Sharp & Dohme, Glaxo SmithKline, Organon, Boehringer Ingelheim, Roche, Novo Nordisk

Agenda

- Más allá de un enfoque glucocéntrico
- Metas glicémicas
- Metas presión arterial
- Metas lipídicas
- Otros aspectos de cuidados
- Atención multifactorial

DE DÓNDE VIENE LAS METAS DE CONTROL GLICÉMICO?

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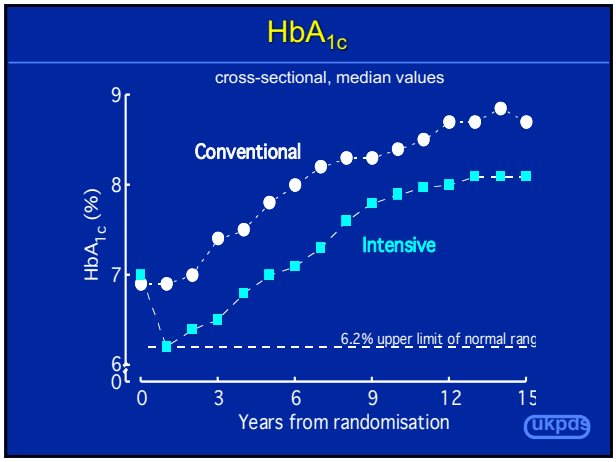

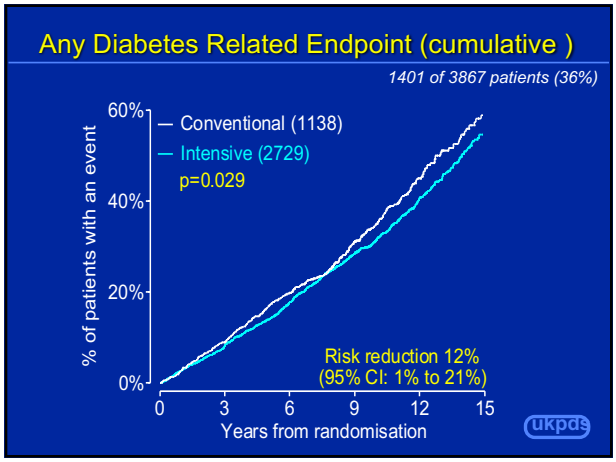

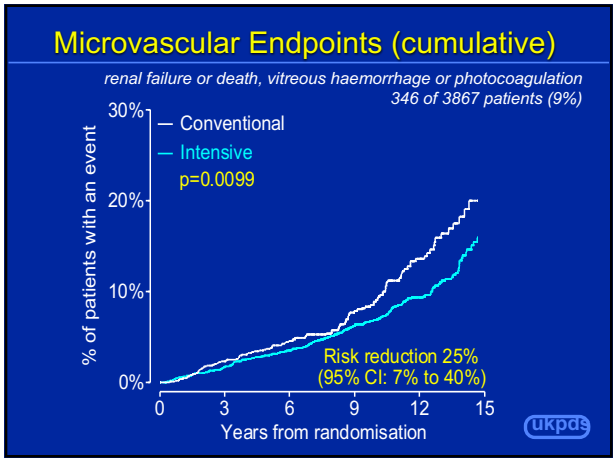

CONCEPTO DE MEMORIA METABÓLICO O EFECTO LEGADO

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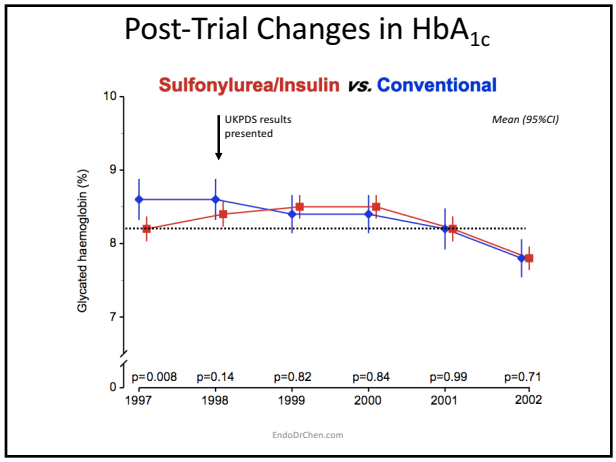
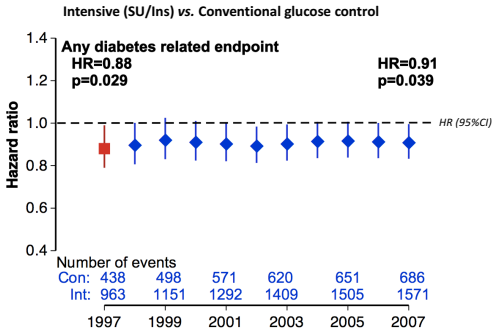


Any Diabetes Related Endpoint Hazard Ratio



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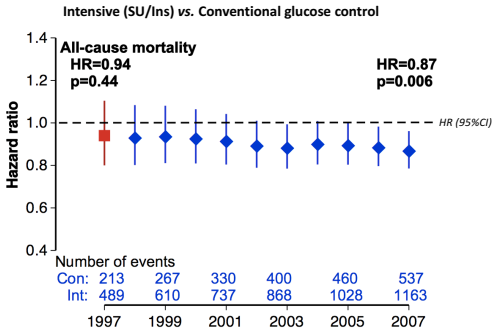
All-cause Mortality Hazard Ratio



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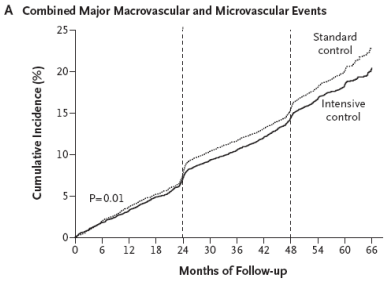
ADVANCE



No. at Risk

Intensive	5570	5457	5369	5256	5100	4957	4867	4756	4599	4044	1883	447
Standard	5569	5448	5342	5240	5065	4903	4808	4703	4545	3992	1921	470

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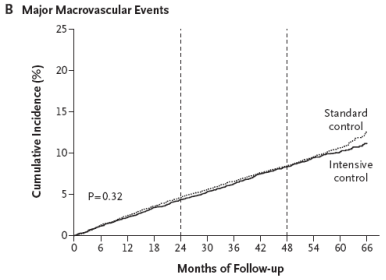
The ADVANCE Collaborative Group. N Engl J Med. 2008;358:2560-2572

ADVANCE



No. at Risk

Intensive	5570	5494	5428	5338	5256	5176	5097	5005	4927	4396	2071	486
Standard	5569	5486	5413	5330	5237	5163	5084	4995	4922	4385	2108	509

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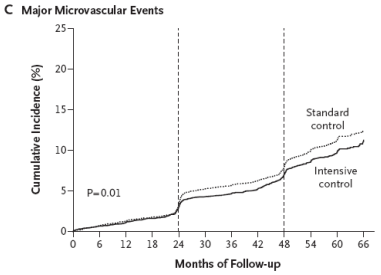
The ADVANCE Collaborative Group. N Engl J Med. 2008;358:2560-2572

ADVANCE



No. at Risk

Intensive	5571	5495	5430	5358	5233	5120	5055	4968	4824	4258	1992	473
Standard	5569	5498	5431	5353	5207	5069	4995	4911	4764	4204	2024	494

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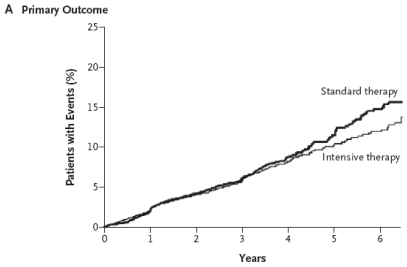
The ADVANCE Collaborative Group. N Engl J Med. 2008;358:2560-2572

ACCORD



No. at Risk

Intensive therapy	5128	4843	4390	2839	1337	475	448
Standard therapy	5123	4827	4262	2702	1186	440	395

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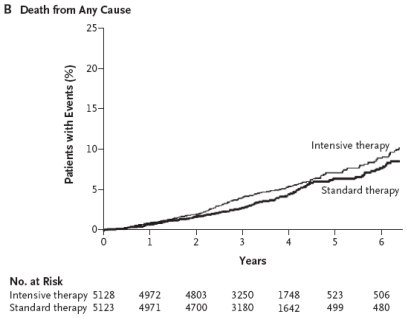
The ACCORD Study Group. N Engl J Med. 2008;358:2545-2559

ACCORD



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The ACCORD Study Group. N Engl J Med. 2008;358:2545-2559

VADT

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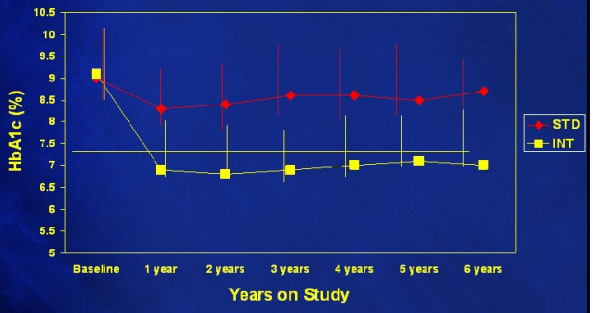
Median HbA1c +/- IQR



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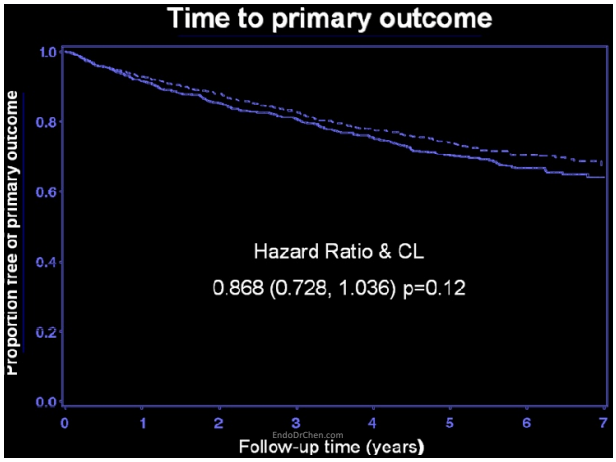

Predictors of CV Death

(There is no treatment effect and there are no interactions).

Variable	Hazard Ratio	HR Lower CL	HR Upper CL	P-Value
Prior CV event	3.116	1.744	5.567	0.0001
Age/10 yr.	2.090	1.518	2.877	<.0001
HDL/10 mg	0.699	0.536	0.910	0.0079
Baseline HbA1c/1%	1.213	1.038	1.417	0.0150
Severe HypoX	4.042	1.449	11.276	0.0076

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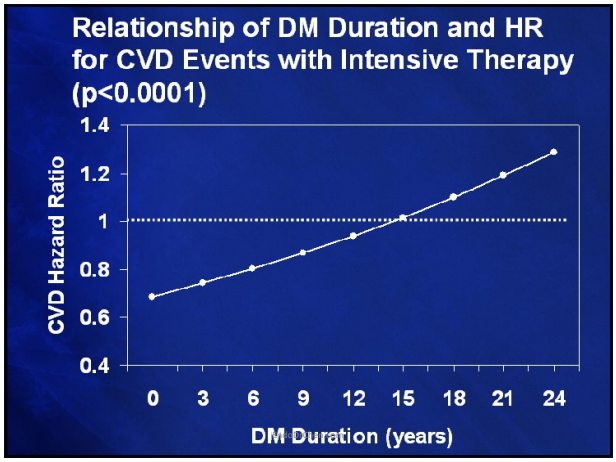

Impact of Intensive Therapy for Diabetes: Summary of Major Clinical Trials

Study	Microvasc		CVD		Mortality	
UKPDS	↓	↓	↔	↓	↔	↓
DCCT / EDIC*	↓	↓	↔	↓	↔	↔
ACCORD	↓		↔		↑	
ADVANCE	↓		↔		↔	
VADT	↓		↔		↔	

Kendall DM, Buggerstaff KM © International Diabetes Center 2009

UK Prospective Diabetes Study (UKPDS) Group. *Lancet* 1998;352:854.
Holman RR et al. *N Engl J Med*. 2008;359:1577. DCCT Research Group. N Engl J Med 1993;329:977.
Nathan DM et al. *N Engl J Med*. 2005;353:2643. Gerstein HC et al. *N Engl J Med*. 2008;358:2545.
Patel A et al. N Engl J Med 2008;358:2560. Duckworth W et al. N Engl J Med 2009;360:129. (erratum: Moritz T. *N Engl J Med* 2009;361:1024)

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Initial Trial
Long Term Follow-up
* in T1DM

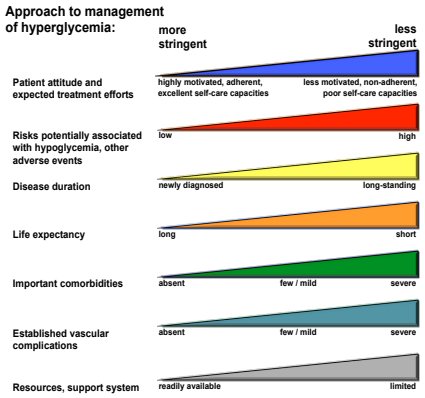

Figure 1

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***Diabetes Care*, *Diabetologia*. 19 April 2012 [Epub ahead of print]**
(Adapted with permission from: Ismail-Beigi F, et al. *Ann Intern Med* 2011;154:554)

CÓMO HA EVOLUCIONADO EL CONCEPTO DE DIABETES Y RIESGO CARDIOVASCULAR?

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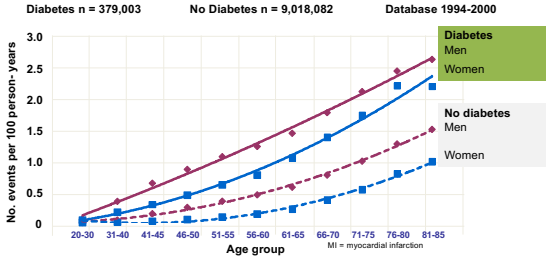
Absolute Risk of MI is Higher in Patients with DM



All lines fitted according to a polynomial equation; R^2= 0.99–1.00 for each

Booth GL, et al. *Lancet* 2006;368:29-36.

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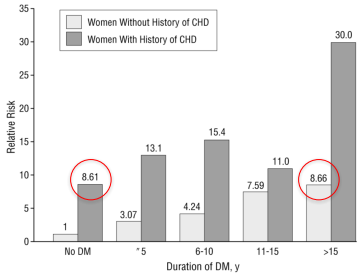
T2DM for > 15 Years Duration Confers a Similar Risk of Fatal CHD as Prior CHD and No Diabetes



20 year follow-up of 121,046 women aged 30 to 55 years in Nurses' Health Study

Hu F, et al. Arch Intern Med. 2001;161:1717-1723.

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Jackson Heart Study: HR ajustados

Outcome	N	Events	Unadjusted HR (95% CI)	Model 1 HR (95% CI)	Model 2 HR (95% CI)
Incident stroke					
No diabetes or CKD	2235	26	1.00 (reference)	1.00 (reference)	1.00 (reference)
Diabetes but no CKD	431	17	3.23 (1.75 to 5.97)	1.94 (0.96 to 3.93)	1.83 (0.90 to 3.74)
CKD but no diabetes	238	9	3.65 (1.70 to 7.82)	2.43 (1.02 to 5.74)	1.91 (0.80 to 4.55)
Diabetes and CKD	184	19	10.33 (5.70 to 18.73)	7.41 (3.87 to 14.18)	6.23 (3.22 to 12.09)
Incident coronary heart disease					
No diabetes or CKD	2186	39	1.00 (reference)	1.00 (reference)	1.00 (reference)
Diabetes but no CKD	409	17	2.23 (1.26 to 3.95)	1.59 (0.84 to 3.03)	1.36 (0.74 to 2.60)
CKD but no diabetes	215	9	2.44 (1.18 to 5.05)	1.65 (0.73 to 3.75)	1.32 (0.58 to 3.00)
Diabetes and CKD	162	16	5.90 (3.30 to 10.56)	4.32 (2.33 to 8.04)	3.33 (1.79 to 6.20)
Cardiovascular mortality					
No diabetes or CKD	2297	30	1.00 (reference)	1.00 (reference)	1.00 (reference)
Diabetes but no CKD	456	16	2.52 (1.37 to 4.62)	2.06 (1.03 to 4.20)	1.90 (0.94 to 3.84)
CKD but no diabetes	257	22	7.00 (4.04 to 12.13)	5.04 (2.70 to 9.40)	4.22 (2.24 to 7.97)
Diabetes and CKD	201	30	13.38 (7.45 to 20.56)	7.46 (4.15 to 13.43)	6.44 (3.53 to 11.78)

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Afkarian M. Clin J Am Soc Nephrol. 2016;11: early on line.

HIPERTENSIÓN ARTERIAL

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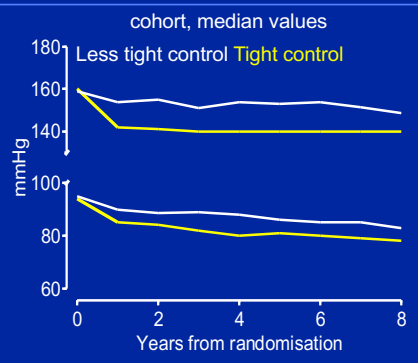
Blood Pressure : Tight vs Less Tight Control



Blood Pressure Control Study

in 1148 Type 2 diabetic patients
a tight blood pressure control policy which achieved
blood pressure of 144 / 82 mmHg gave reduced risk for

any diabetes-related endpoint	24%	p=0.0046
diabetes-related deaths	32%	p=0.019
Stroke	44%	p=0.013
microvascular disease	37%	p=0.0092
heart failure	56%	p=0.0043
retinopathy progression	34%	p=0.0038
deterioration of vision	47%	p=0.0036

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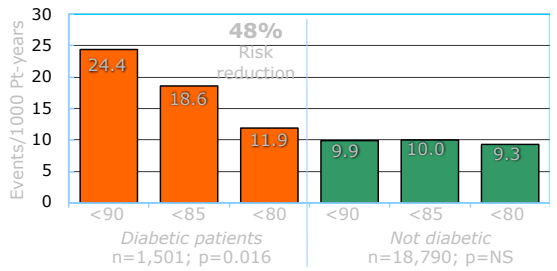
UKPDS. BMJ. 1998;317:713

HOT: Cardiovascular events in diabetics and not diabetic patients, effect of diastolic goal at 4 years



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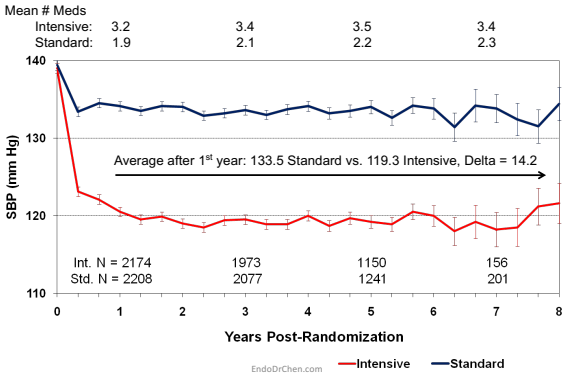
Hansson L, et al. Lancet. 1998;351:1755-1762.

Systolic Pressures (mean ± 95% CI)



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Primary & Secondary Outcomes

	Intensive Events (%/yr)	Standard Events (%/yr)	HR (95% CI)	P
Primary	208 (1.87)	237 (2.09)	0.88 (0.73-1.06)	0.20
Total Mortality	150 (1.28)	144 (1.19)	1.07 (0.85-1.35)	0.55
Cardiovascular Deaths	60 (0.52)	58 (0.49)	1.06 (0.74-1.52)	0.74
Nonfatal MI	126 (1.13)	146 (1.28)	0.87 (0.68-1.10)	0.25
Nonfatal Stroke	34 (0.30)	55 (0.47)	0.63 (0.41-0.96)	0.03
Total Stroke	36 (0.32)	62 (0.53)	0.59 (0.39-0.89)	0.01

Also examined Fatal/Nonfatal HF (HR=0.94, p=0.67), a composite of fatal coronary events, nonfatal MI and unstable angina (HR=0.94, p=0.50) and a composite of the primary outcome, revascularization and unstable angina (HR=0.95, p=0.40)

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Adverse Events

	Intensive N (%)	Standard N (%)	P
Serious AE	77 (3.3)	30 (1.3)	<0.0001
Hypotension	17 (0.7)	1 (0.04)	<0.0001
Syncope	12 (0.5)	5 (0.2)	0.10
Bradycardia or Arrhythmia	12 (0.5)	3 (0.1)	0.02
Hyperkalemia	9 (0.4)	1 (0.04)	0.01
Renal Failure	5 (0.2)	1 (0.04)	0.12
eGFR ever <30 mL/min/1.73m^2	99 (4.2)	52 (2.2)	<0.001
Any Dialysis or ESRD	59 (2.5)	58 (2.4)	0.93
Dizziness on Standing†	217 (44)	188 (40)	0.36

† Symptom experienced over past 30 days from HRQL sample of N=969 participants assessed at 12, 36, and 48 months post-randomization

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Recommendations: Hypertension/ Blood Pressure Control (2)

Systolic Targets:

- **People with diabetes and hypertension should be treated to a systolic blood pressure goal of <140 mmHg. A**
- **Lower systolic targets, such as <130 mmHg, may be appropriate for certain individuals, such as younger patients, if it can be achieved without undue treatment burden. C**

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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Recommendations: Hypertension/ Blood Pressure Control (3)

Diastolic Targets:

- **Patients with diabetes should be treated to a diastolic blood pressure <90 mmHg. A**
- **Lower diastolic targets, such as <80 mmHg, may be appropriate for certain individuals, such as younger patients, if it can be achieved without undue treatment burden. B**

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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Recommendations: Hypertension/ Blood Pressure Control (6)

Treatment (3):

- **Pharmacological therapy for patients with diabetes and HTN includes:**
  - **either an ACE inhibitor or angiotensin II receptor blocker B**
  - **if one class is not tolerated, substitute the other C**
- **Multiple drug therapy (two or more agents at maximal doses) generally required to achieve BP targets. B**

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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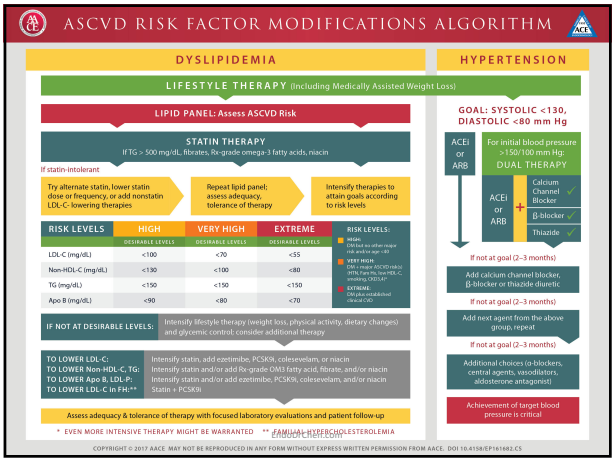

Guías HTA ACC 2017

Recommendations for Treatment of Hypertension in Patients With DM
References that support recommendations are summarized in Online Data Supplements 46 and 47 and Systematic Review Report.

COR	LOE	Recommendations
I	SBP: B-R[SR] DBP: C-EO	**1. In adults with DM and hypertension, antihypertensive drug treatment should be initiated at a BP of 130/80 mm Hg or higher with a treatment goal of less than 130/80 mm Hg (1-8).**
I	A[SR]	**2. In adults with DM and hypertension, all first-line classes of antihypertensive agents (i.e., diuretics, ACE inhibitors, ARBs, and CCBs) are useful and effective (1, 9, 10).**
IIb	B-NR	**3. In adults with DM and hypertension, ACE inhibitors or ARBs may be considered in the presence of albuminuria (11, 12).**

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Whelton PK. JACC. 2017; online Nov 14

MANEJO DE DISLIPIDEMIA

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CARDS Criterios de eligibilidad

- Diabetes tipo 2
- Masculinos o femeninos
- 40-75 años
- Sin historia clínica de enfermedad coronaria, cerebrovascular o enfermedad vascular periférica
- LDL-C ≤4.14 mmol/L (≤160 mg/dL)
- TG ≤6.78 mmol/L (≤600 mg/dL)
- Uno de:
  - Hipertensión definido como uso de terapia antihipertensiva o PAS ≥140 mm Hg o PAD ≥90 mm Hg
  - Retinopatía
  - Microalbuminuria o macroalbuminuria
  - Tabaquismo activo

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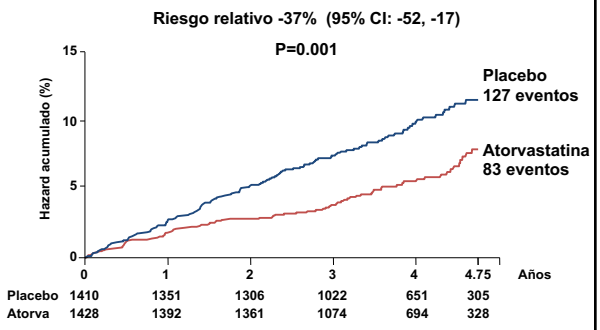
Riesgo acumulado para el punto final primario



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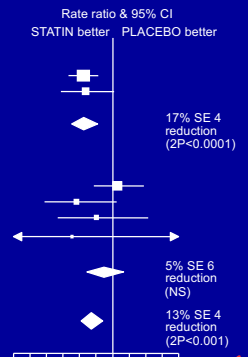
SIMVASTATIN: CAUSE-SPECIFIC MORTALITY

Cause of death	SIMVASTATIN (10269)	PLACEBO (10267)
Vascular		
Coronary	587	707
Other vascular	194	230
ANY VASCULAR	781 (7.6%)	937 (9.1%)
Non-vascular		
Neoplastic	359	345
Respiratory	90	114
Other medical	82	90
Non-medical	16	21
NON-VASCULAR	547 (5.3%)	570 (5.6%)
ALL CAUSES	1328 (12.9%)	1507 (14.7%)



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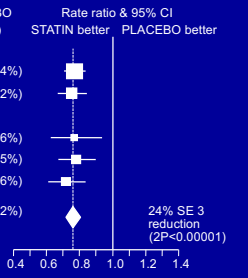
SIMVASTATIN: MAJOR VASCULAR EVENT by PRIOR DISEASE

	SIMVASTATIN (10269)	PLACEBO (10267)
Previous MI	999 (23.5%)	1250 (29.4%)
Other CHD (not MI)	460 (18.9%)	591 (24.2%)
No prior CHD		
CVD	172 (18.7%)	212 (23.6%)
PVD	327 (24.7%)	420 (30.5%)
Diabetes	276 (13.8%)	367 (18.6%)
ALL PATIENTS	2033 (19.8%)	2585 (25.2%)



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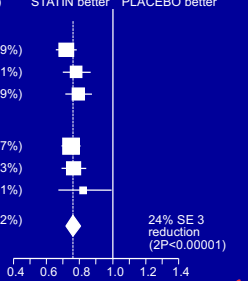
SIMVASTATIN: MAJOR VASCULAR EVENT by HDL CHOLESTEROL & TRIGLYCERIDES

Lipid levels at entry	SIMVASTATIN (10269)	PLACEBO (10267)
HDL cholesterol (mmol/l)		
< 0.9 (35 mg/dl)	818 (22.6%)	1064 (29.9%)
≥ 0.9 < 1.1	560 (20.0%)	720 (25.1%)
≥ 1.1 (43 mg/dl)	655 (17.0%)	801 (20.9%)
Triglycerides (mmol/l)		
< 2.0 (177 mg/dl)	1101 (18.3%)	1432 (23.7%)
≥ 2.0 < 4.0	743 (21.6%)	939 (27.3%)
≥ 4.0 (354 mg/dl)	189 (23.2%)	214 (27.1%)
ALL PATIENTS	2033 (19.8%)	2585 (25.2%)



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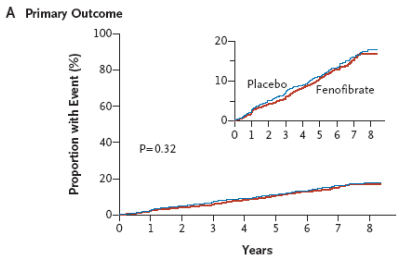
ACCORD-lipidos



No. at Risk									
Fenofibrate	2765	2644	2565	2485	1981	1160	412	249	137
Placebo	2753	2634	2528	2442	1979	1161	395	245	131

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Prevención primaria

Pacientes con diabetes y LDL-C 70-189 mg/dL (edad 40-75 años) sin ASCVD

→ Estatinas intensidad moderada

→ Estatinas a alta intensidad si riesgo a 10 años de ASCVCD ≥7.5% *

* Estimado usando Pooled Cohort Risk Assessment Equations

Stone NJ, et al. *J Am Coll Cardiol*. 2013: doi:10.1016/j.jacc.2013.11.002. Available at: http://content.onlinejacc.org/article.aspx?articleid=1770217. Accessed November 13, 2013.

Recommendations for Statin Treatment in People with Diabetes

Age	Risk Factors	Statin Intensity*
<40 years	None	None
	ASCVD risk factor(s)**	Moderate or high
	ASCVD	High
40–75 years	None	Moderate
	ASCVD risk factors	High
	ACS & LDL >50 who can't tolerate high dose statin	Moderate + ezetimibe
>75 years	None	Moderate
	ASCVD risk factors	Moderate or high
	ASCVD	High
	ACS & LDL >50 who can't tolerate high dose statin	Moderate + ezetimibe

* In addition to lifestyle therapy. ** ASCVD risk factors include LDL cholesterol ≥100 mg/dL (2.6 mmol/L), high blood pressure, smoking, overweight and obesity, and family history of premature ASCVD.

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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Recommendations: Lipid Management (5)

- **Combination therapy (statin/fibrate) doesn't improve ASCVD outcomes and is generally not recommended A. Consider therapy with statin and fenofibrate for men with *both* trigs ≥204 mg/dL (2.3 mmol/L) and HDL ≤34 mg/dL (0.9 mmol/L). B**
- **Combination therapy (statin/niacin) hasn't demonstrated additional CV benefit over statins alone, may raise risk of stroke & is not generally recommended. A**
- **Statin therapy is contraindicated in pregnancy. B**

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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High- and Moderate-Intensity Statin Therapy*

High Intensity Statin Therapy	Moderate-Intensity Statin Therapy
Lowers LDL by ≥50%	Lowers LDL by 30 - <50%
Atorvastatin 40-80 mg	Atorvastatin 10-20 mg
Rosuvastatin 20-40 mg	Rosuvastatin 5-10 mg
	Simvastatin 20-40 mg
	Pravastatin 40-80 mg
	Lovastatin 40 mg
	Fluvastatin XL 80 mg
	Pitavastatin 2-4 mg

* Once-daily dosing

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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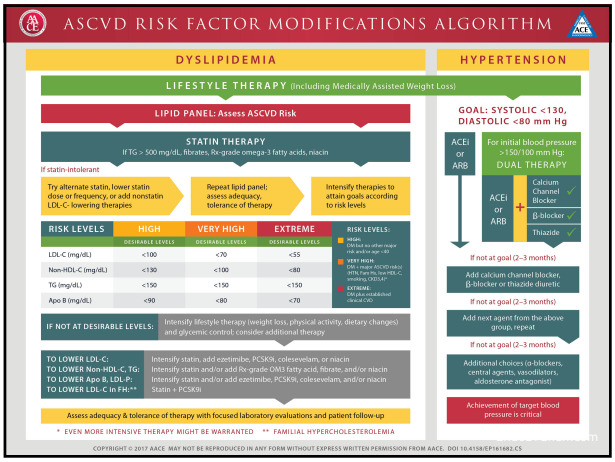

ANTIAGREGANTES PLAQUETARIOS

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Recommendations: Antiplatelet Agents

Consider aspirin therapy (75–162 mg/day) C

- As a primary prevention strategy in those with type 1 or type 2 diabetes at increased cardiovascular risk (10-year risk >10%)
- Includes most men or women with diabetes age ≥50 years who have at least one additional major risk factor, including:
  - Family history of premature ASCVD
  - Hypertension
  - Smoking
  - Dyslipidemia
  - Albuminuria

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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Recommendations: Antiplatelet Agents (2)

- Aspirin is not recommended for ASCVD prevention for adults with DM at low ASCVD risk, since potential adverse effects from bleeding likely offset potential benefits. C
  - Low risk: 10-year CVD risk <5%, such as in men or women with diabetes aged <50 years with no major additional ASCVD risk factors)
- In patients with diabetes <50 years of age with multiple other risk factors (e.g., 10-year risk 5–10%), clinical judgment is required. E

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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Recommendations: Antiplatelet Agents (3)

- Use aspirin therapy (75–162 mg/day) as secondary prevention in those with diabetes and history of ASCVD. A
- For patients w/ ASCVD & aspirin allergy, clopidogrel (75 mg/day) should be used. B
- Dual antiplatelet therapy is reasonable for up to a year after an acute coronary syndrome. B

American Diabetes Association.

American Diabetes Association Standards of Medical Care in Diabetes. Cardiovascular disease and risk management. *Diabetes Care* 2016; 39 (Suppl. 1): S60-S71

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ENFERMEDAD PERIODONTAL

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J Clin Periodontol 2013; 40 (Suppl. 14): S106–S112 doi: 10.1111/jcpe.12077

Journal of Clinical Periodontology

Diabetes and periodontal diseases: consensus report of the Joint EFP/AAP Workshop on Periodontitis and Systemic Diseases

Iain L. C. Chapple[1], Robert Genco[2] and on behalf of working group 2 of the joint EFP/AAP workshop*

[1]Periodontal Research Group & MRC Centre for Immune Regulation, University of Birmingham School of Dentistry, Birmingham, UK; [2]University at Buffalo, Oral Biology and Microbiology and Immunology, Buffalo, NY, USA

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Enfemerdad periodontal

- Es la condición inflamatorio crónica más frecuente en el mundo
- 50% de los adultos tienen periodontitis
- 60% de los mayores de 65 años
- Periodontitis severa afecta 10-15% de la población
- Iniciado por bacterias, la reacción inflamatoria sistémica viene de la invasión

EndoDrChen.com
Chapple ILC. J Clin Periodontol. 2013;40:S106

Periodontitis

- Asociación entre periodontitis y control glicémico e incluso con casos nuevos de DM
- Tratamiento de la enfermedad periodontal puede reducir hba1c en 0.36% en promedio
  - Se desconoce si esto se mantiene a largo plazo
- Tratamiento consiste en debridación mecánica y cuidados ambulatorios. No se recomiendan antibióticos.

EndoDrChen.com
Chapple ILC. J Clin Periodontol. 2013;40:S106

Fisiopatología

- Flora bacteriana de la enfermedad periodontal es similar en pacientes diabéticos y no diabéticos
- El problema es por lo tanto del huésped y no de la flora bacteriana

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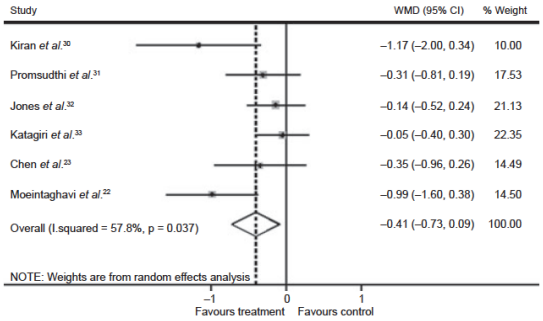
Katagiri S. J Diabet Invest. 2013;4:320

Metanálisis tratamiento periodontal



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Liew AKC. Aust J Dent. 2013;58:350-357

Algunas consideraciones

- Se considera uno de los posibles focos causantes de la inflamación observado en el paciente diabético
- Varios ensayos clínicos corriendo evaluando el impacto en riesgo cardiovascular a través de la reducción de inflamación

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PATOLOGÍA REUMÁTICA

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Patologías reumáticas

- Hombro congelado
- Ruptura del manguito rotador
- Contractura de Dupuytren
- Dedo en gatillo
- Queiroartropatía
- Daño del tendón de Aquiles
- Fascitis plantar

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Abate M. Diab Metab Synd Obes: Targets and Therapy. 2013;6:197

Queiroartropatía

- Limitación no dolorosa de la movilidad de manos y dedos
- Piel engrosada y cerosa
- Contracturas fijas en flexión de las articulaciones pequeñas de las manos
- Disminución en fuerza de prensión
- Descrito en adolescentes con DM-1 y adultos con DM-2

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Abate M. Diab Metab Synd Obes: Targets and Therapy. 2013;6:197

Queiroartropatía

- Calcificaciones arteriales en radiografía simple
- Signo del rezador o de la mesa
- Es marcador de otras complicaciones microvasculares
- Efecto de la hiperglicemia sobre el colágeno
- Anormalidades microvasculares que llevan a hipoxia, liberación de radicales libres y producción de factores de crecimiento

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Abate M. Diab Metab Synd Obes: Targets and Therapy. 2013;6:197

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Queiroartropatía y DCCT/EDIC

- Datos a 30 años
- Factores de riesgo:
  - Mayor edad (52.3 vs 50.8 años)
  - Mujeres (53 vs 38%)
  - Mayor hba1c (8.0 vs 7.8%)
  - Mayor duración de DM (31.2 vs 28.9 años)
- 12% hombro congelado, STC 8%, dedo en gatillo 6% y signo de rezador 6%, contractura de Dupuytren 1%

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DCCT/EDIC. ADA 2013.

DESPUÉS DE HABER REVISADO TODAS LAS COMPLICACIONES EN DM, LO ESENCIAL ES INTERVENCIÓN MULTIFACTORIAL

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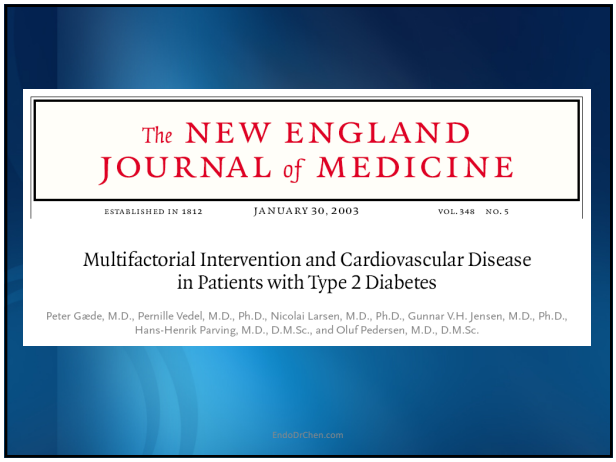
The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812
JANUARY 30, 2003
VOL. 348 NO. 5
Multifactorial Intervention and Cardiovascular Disease in Patients with Type 2 Diabetes
Peter Gæde, M.D., Pernille Vedel, M.D., Ph.D., Nicolai Larsen, M.D., Ph.D., Gunnar V.H. Jensen, M.D., Ph.D., Hans-Henrik Parving, M.D., D.M.Sc., and Oluf Pedersen, M.D., D.M.Sc.
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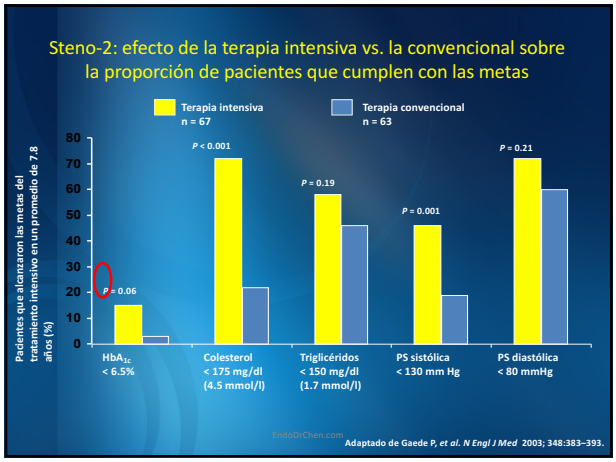
Steno-2: efecto de la terapia intensiva vs. la convencional sobre la proporción de pacientes que cumplen con las metas
Terapia intensiva n = 67
Terapia convencional n = 63
Pacientes que alcanzaron las metas del tratamiento intensivo en un promedio de 7.8 años (%)
80
70
60
50
40
30
20
10
0
P = 0.06
P < 0.001
P = 0.19
P = 0.001
P = 0.21
HbA1c < 6.5%
Colesterol < 175 mg/dl (4.5 mmol/l)
Triglicéridos < 150 mg/dl (1.7 mmol/l)
PS sistólica < 130 mm Hg
PS diastólica < 80 mmHg
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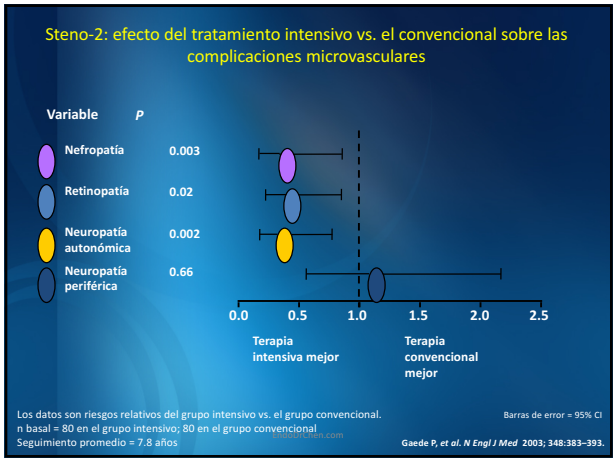
Adaptado de Gaede P, et al. N Engl J Med 2003; 348:383–393.


Steno-2: efecto del tratamiento intensivo vs. el convencional sobre las complicaciones microvasculares
Variable
P
Nefropatía
0.003
Retinopatía
0.02
Neuropatía autonómica
0.002
Neuropatía periférica
0.66
0.0
0.5
1.0
1.5
2.0
2.5
Terapia intensiva mejor
Terapia convencional mejor
Los datos son riesgos relativos del grupo intensivo vs. el grupo convencional.
n basal = 80 en el grupo intensivo; 80 en el grupo convencional
Seguimiento promedio = 7.8 años
Barras de error = 95% CI
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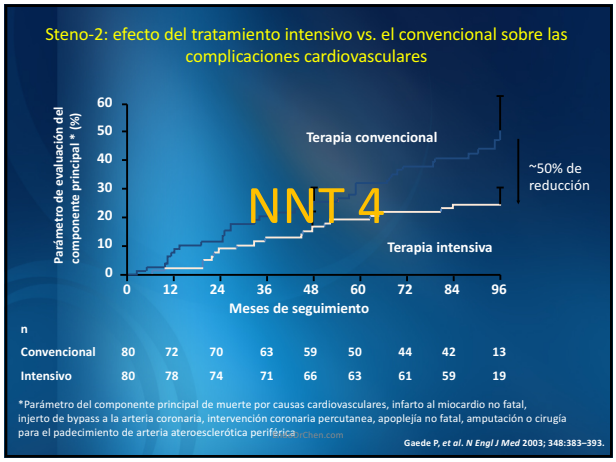
Gaede P, et al. N Engl J Med 2003; 348:383–393.



Conclusiones

- Manejo de hipertensión y dislipidemia son esenciales para prevención de mortalidad y complicaciones cardiovasculares
- Estatinas en mayores de 40 años de edad según su riesgo
- Meta de presión <140/90 para la mayoría de la población
- AAS en pacientes >50 años con factores de riesgo adicionales

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PREGUNTAS…
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