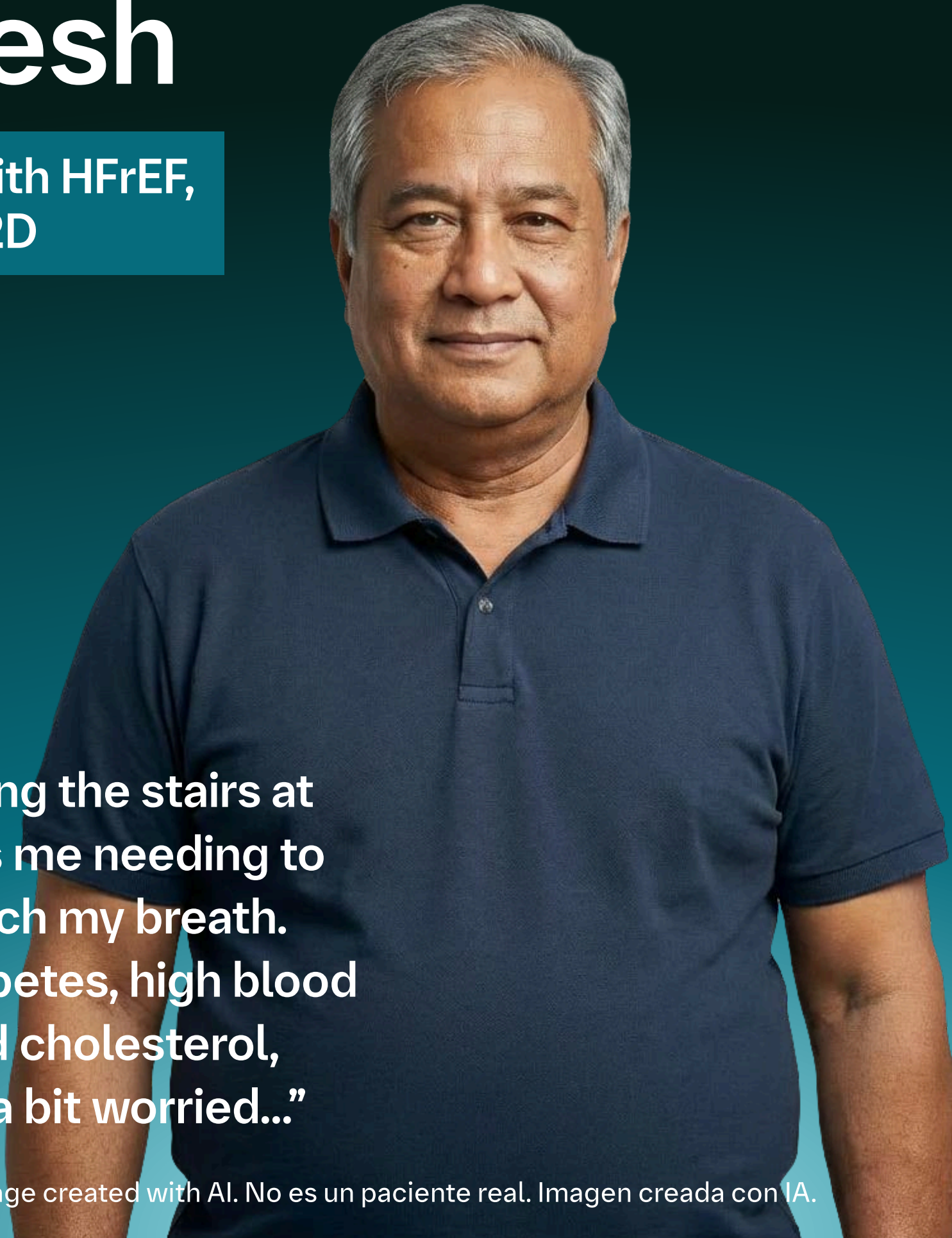


Meet Ramesh

A patient with HFrEF, CKD and T2D

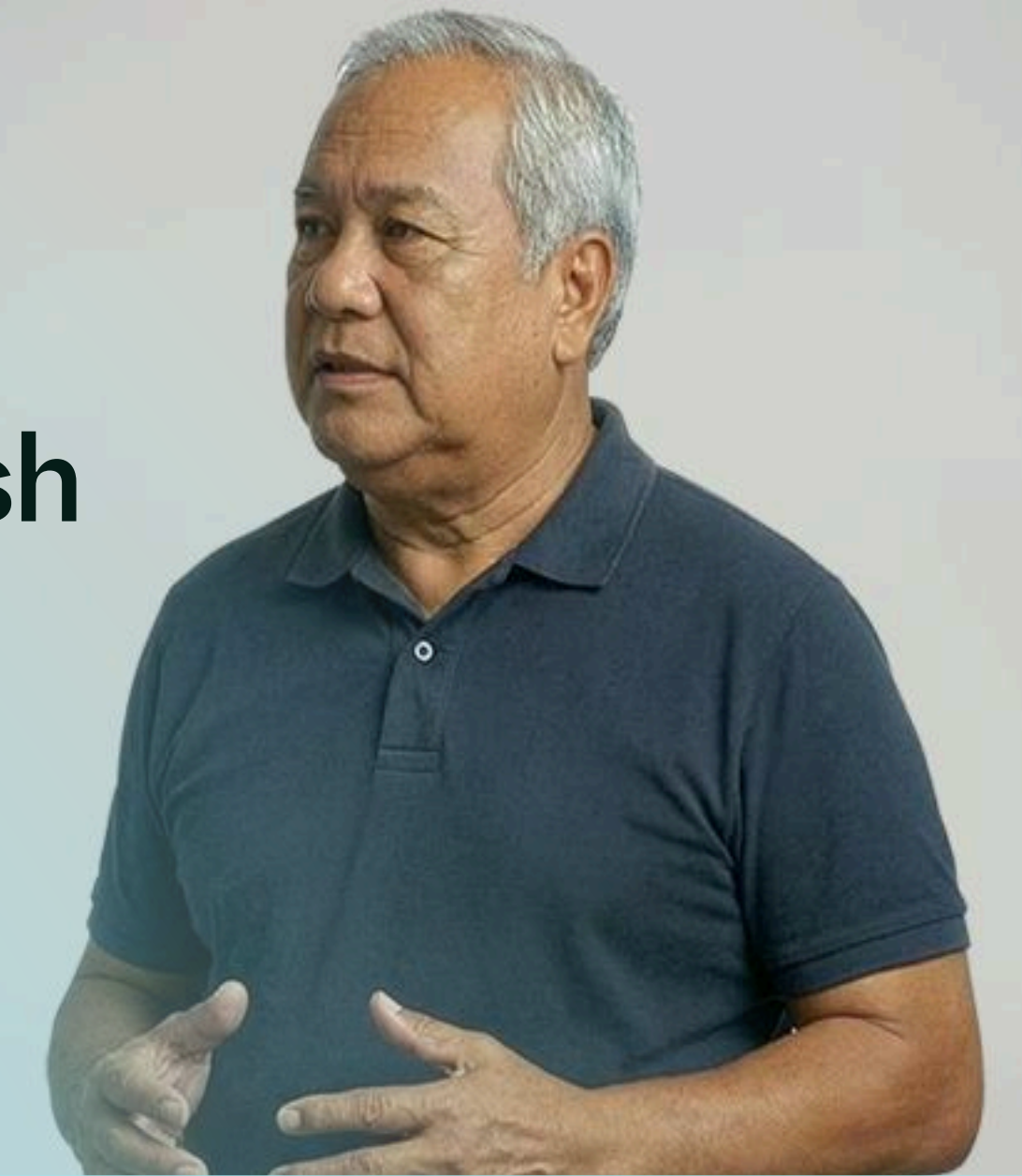


“Even climbing the stairs at home leaves me needing to stop and catch my breath. With my diabetes, high blood pressure and cholesterol, I am feeling a bit worried...”

Not a real patient. Image created with AI. No es un paciente real. Imagen creada con IA.

Hear from Ramesh

 Play video



See topics



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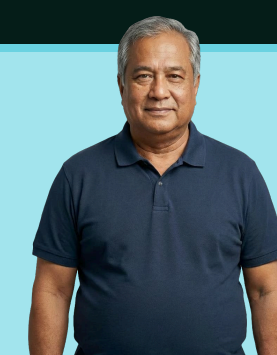
Susan

A patient with HFpEF



Ramesh

A patient with HFrEF, CKD and T2D

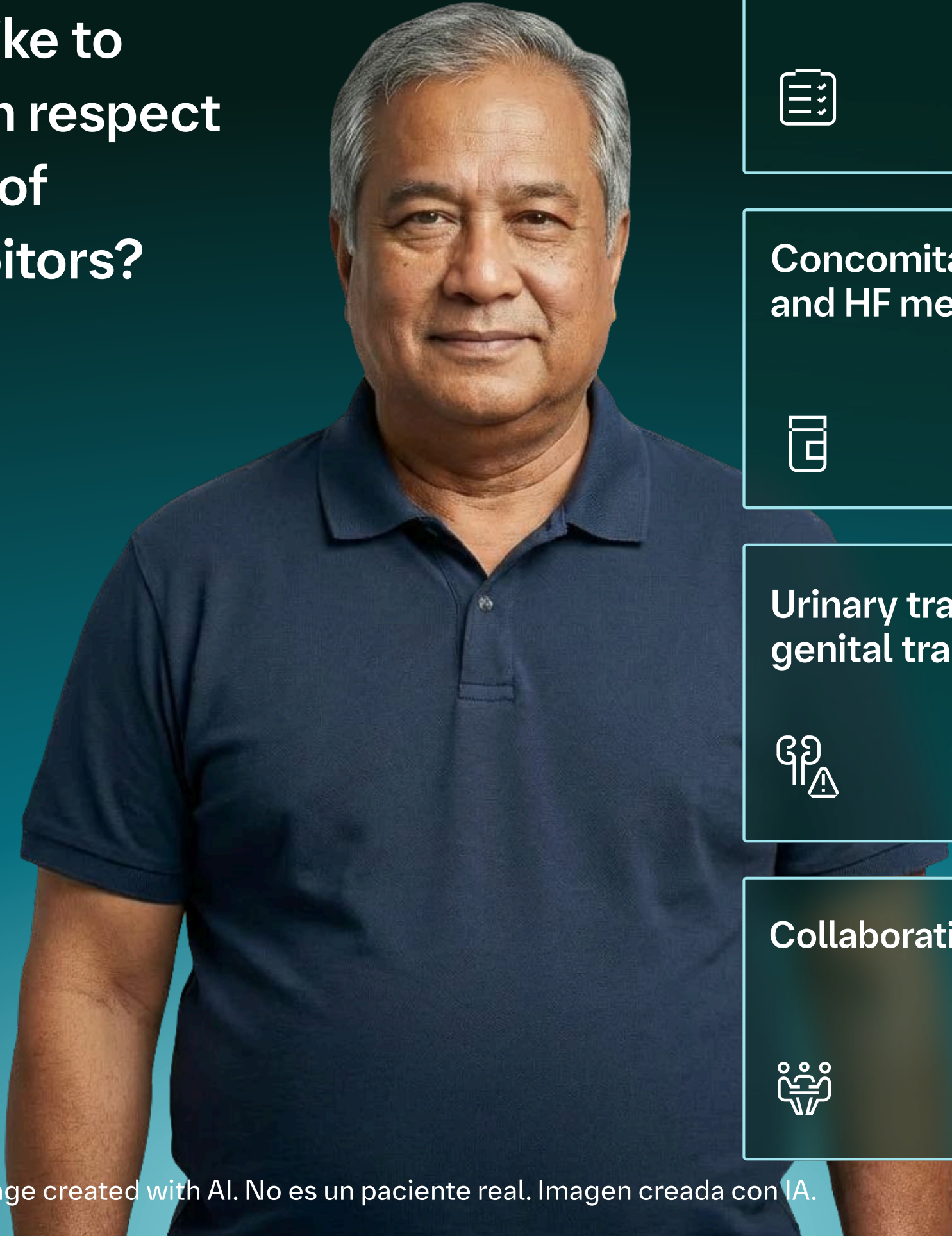


Jerry

A patient with acute decompensated heart failure




Which aspect of Ramesh's management would you like to explore with respect to initiation of SGLT2 inhibitors?



Guideline implementation for HFrEF





Elderly patients





Dosing





Concomitant diabetes and HF medications



Kidney dysfunction



eGFR dip




Urinary tract infections/ genital tract infections




Hypotension


Video



When to stop, pause and restart treatment




Collaborating with Primary Care



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Susan
A patient with HFpEF





Ramesh
A patient with HFrEF, CKD and T2D



Jerry
A patient with acute decompensated heart failure







What treatment(s) would be suitable for this patient?



Guideline implementation for HFrEF



Elderly patients



Dosing



Concomitant diabetes and HF medications



Kidney dysfunction



eGFR dip



Urinary tract infections/ genital tract infections



Hypotension



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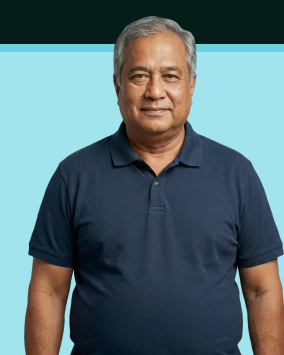
Susan

A patient with HFpEF



Ramesh

A patient with HFrEF, CKD and T2D



Jerry

A patient with acute decompensated heart failure



SGLT2 inhibitors are recommended as foundational therapy across the heart failure LVEF spectrum^{1,2}

ESC recommendations¹

	Class*	Level†
An ACEi is recommended for patients with HFrEF to reduce the risk of HHF and death	I	A
A beta-blocker is recommended for patients with stable HFrEF to reduce the risk of HHF and death	I	A
An MRA is recommended for patients with HFrEF to reduce the risk of HHF and death	I	A
Dapagliflozin or empagliflozin is recommended for patients with HFrEF to reduce the risk of HHF and death	I	A
Sacubitril/valsartan is recommended as a replacement for an ACEi in patients with HFrEF to reduce the risk of HHF and death	I	B

ESC recommendations²

	Class*	Level†
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFmrEF to reduce the risk of HHF or CV death	I	A

ESC recommendations²

	Class*	Level†
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFpEF to reduce the risk of HHF or CV death	I	A

*Class of recommendation. †Level of evidence.
 ACEi, angiotensin-converting enzyme inhibitor; CV, cardiovascular; ESC, European Society of Cardiology; HFmrEF, heart failure with mildly reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HHF, hospitalisation for heart failure; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist; SGLT2, sodium-glucose co-transporter-2.
 1. McDonagh TA et al. *Eur Heart J* 2021;42:3599; 2. McDonagh TA et al. *Eur Heart J* 2023;44:3627



Guideline implementation for HFrEF

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Kidney dysfunction

eGFR dip

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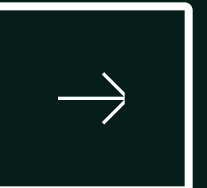
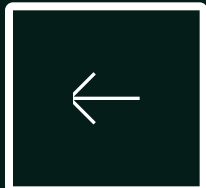
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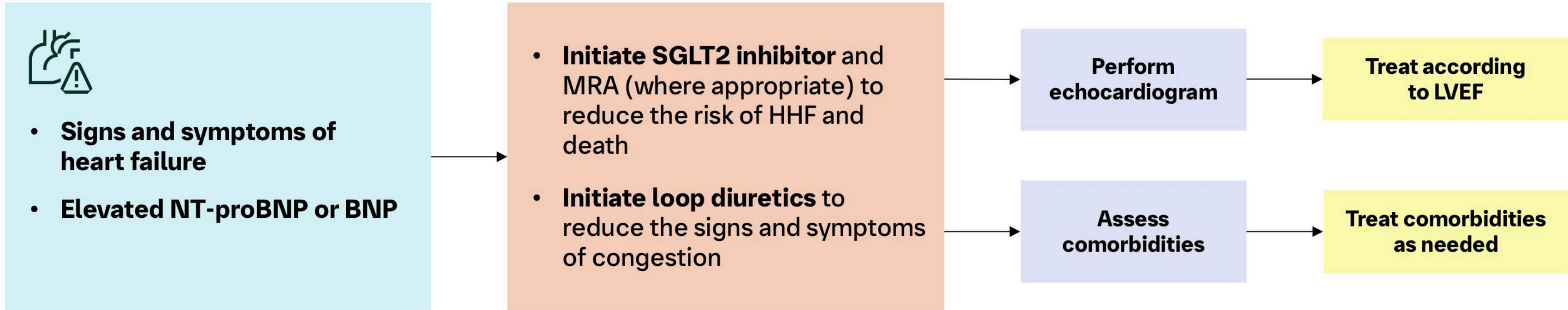
Jerry
 A patient with acute decompensated heart failure



SGLT2 inhibitors are recommended for heart failure, regardless of LVEF¹⁻³

Clinical consensus statement on the use of LVEF for the diagnosis and management of heart failure (ESC-HFA, HFSA, JHFS)

Proposed treatment initiation pathway for heart failure irrespective of LVEF



- Patients with new-onset chronic heart failure waiting for an echocardiogram are at high risk of events¹
- If a long wait is expected, SGLT2 inhibitors should be started in all patients with heart failure without delay¹
 - If congestion is present, SGLT2 inhibitors should be started with diuretics¹

BNP, B-type natriuretic peptide; ESC-HFA, European Society of Cardiology–Heart Failure Association; HFSA, Heart Failure Society of America; HHF, hospitalisation for heart failure; JHFS, Japanese Heart Failure Society; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist; NT-proBNP, N-terminal pro-B-type natriuretic peptide; SGLT2, sodium-glucose co-transporter-2
 1. Rosano GMC et al. *Eur J Heart Fail* 2025; doi: 10.1002/ejhf.3646; 2. McDonagh TA et al. *Eur Heart J* 2021;42:3599; 3. McDonagh TA et al. *Eur Heart J* 2023;44:3627



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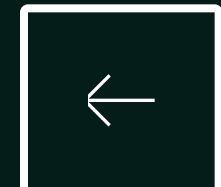
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A patient with HFpEF


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How do you approach the use of SGLT2 inhibitors in elderly patients with heart failure?




Guideline implementation for HFrEF 

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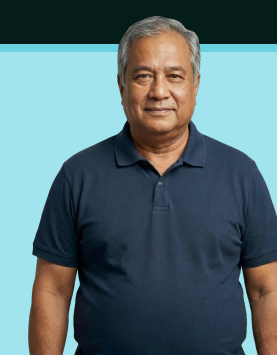
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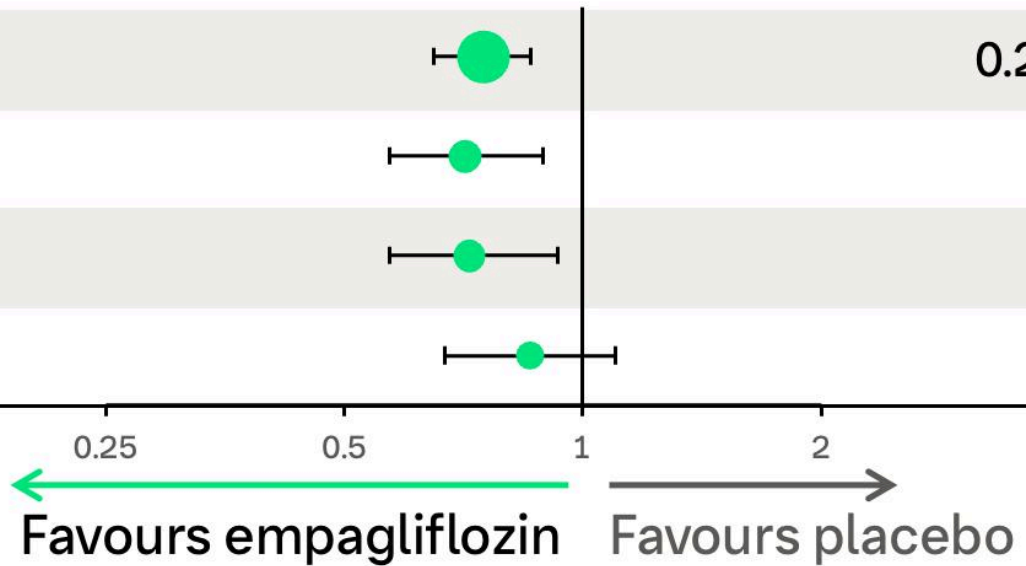


Empagliflozin improves outcomes compared with placebo in patients with HFrEF across the spectrum of age

EMPEROR-Reduced (LVEF ≤40%): impact of age on CV death or HHF



Endpoint	Empagliflozin		Placebo		Hazard ratio (95% CI)	p-value for trend
	n/N	Events/100 PY	n/N	Events/100 PY		
CV death or first HHF						
All patients	361/1863	15.8	462/1867	21.0	0.75 (0.65, 0.86)	0.25
<65 years	128/675	15.7	193/740	22.6	0.71 (0.57, 0.89)	
65 to <75 years	118/685	13.7	140/631	18.4	0.72 (0.57, 0.93)	
≥75 years	115/503	18.9	129/496	22.0	0.86 (0.67, 1.10)	



CV, cardiovascular; HFrEF, heart failure with reduced ejection fraction; HHF, hospitalisation for heart failure; LVEF, left ventricular ejection fraction; PY, patient-years; Filippatos G et al. Eur J Heart Fail 2022;24:2297
Figure adapted from: Filippatos G et al. 2022



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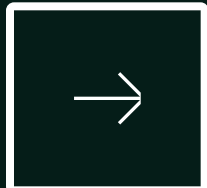
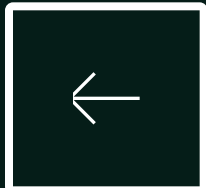
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Empagliflozin has a consistent safety profile in patients with HFrEF across the spectrum of age

EMPEROR-Reduced (LVEF ≤40%): impact of age on CV death or HHF

Category of AEs, n (%)	<65 years		65 to <75 years		≥75 years							
	Placebo	Empagliflozin	Placebo	Empagliflozin	Placebo	Empagliflozin						
	n=739	IR per 100 PY	n=675	IR per 100 PY	n=628	IR per 100 PY	n=685	IR per 100 PY	n=496	IR per 100 PY	n=503	IR per 100 PY
Patients with any AEs	558 (75.5)	158.3	493 (73.0)	136.4	501 (79.8)	156.1	525 (76.6)	148.5	404 (81.5)	195.1	402 (79.9)	169.2
AE leading to drug discontinuation	113 (15.3)	12.6	92 (13.6)	11.2	101 (16.1)	13.1	115 (16.8)	13.6	114 (23.0)	19.8	115 (22.9)	19.4
Serious AE	340 (46.0)	53.5	249 (36.9)	38.3	302 (48.1)	53.5	289 (42.2)	44.1	254 (51.2)	59.9	234 (46.5)	51.4
Hypotension	63 (8.5)	7.5	64 (9.5)	8.3	45 (7.2)	6.0	60 (8.8)	7.5	55 (11.1)	10.3	52 (10.3)	9.2
Acute renal failure	78 (10.6)	9.2	57 (8.4)	7.2	60 (9.6)	8.2	68 (9.9)	8.4	54 (10.9)	9.8	50 (9.9)	8.9
Confirmed hypoglycaemic event*	18 (2.4)	2.0	10 (1.5)	1.2	5 (0.8)	0.7	12 (1.8)	1.4	5 (1.0)	0.9	5 (1.0)	0.8
Volume depletion	70 (9.5)	8.4	66 (9.8)	8.6	52 (8.3)	7.0	68 (9.9)	8.5	62 (12.5)	11.8	63 (12.5)	11.3
Urinary tract infection	24 (3.9)	2.7	13 (1.9)	1.6	21 (3.3)	2.8	29 (4.2)	3.5	27 (5.4)	4.7	27 (5.4)	4.7
Genital tract infection	7 (0.9)	0.78	10 (1.5)	1.23	2 (0.3)	0.26	10 (1.5)	1.19	3 (0.6)	0.57	11 (2.2)	1.87
Hyperkalaemia	35 (4.7)	4.0	30 (4.4)	3.8	41 (6.5)	5.5	42 (6.1)	5.2	39 (7.9)	7.1	29 (5.8)	5.0
Hypokalaemia	12 (1.6)	1.4	16 (2.4)	2.0	11 (1.8)	1.4	10 (1.5)	1.2	5 (1.0)	0.9	7 (1.4)	1.2

No clinically relevant differences in AEs between empagliflozin and placebo across the age groups

*Hypoglycaemic AEs with plasma glucose ≤70 mg/dl or requiring assistance
 AE, adverse event; CV, cardiovascular; HHF, hospitalisation for heart failure; IR, incidence rate; LVEF, left ventricular ejection fraction; PY, patient-years; SGLT2, sodium-glucose co-transporter-2
 Filippatos G et al. Eur J Heart Fail 2022;24:2297
 Table adapted from: Filippatos G et al. 2022



Guideline implementation for HFrEF



Elderly patients



Dosing



Concomitant diabetes and HF medications



Kidney dysfunction



eGFR dip



Urinary tract infections/ genital tract infections



Hypotension



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A patient with HFrEF, CKD and T2D



Jerry

A patient with acute decompensated heart failure



What are the practical benefits of empagliflozin's dosing approach in patients with heart failure?



Guideline implementation for HFrEF

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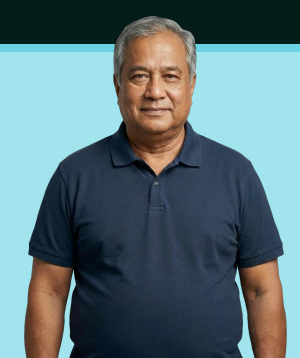
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Jerry

A patient with acute decompensated heart failure



SGLT2 inhibitors are initiated at a single, fixed dose without the need for titration

-  Single dose^{1,2} 
-  Once daily^{1,2} 
-  No titration^{1,2} 
-  With or without food^{1,2} 
-  Any time of day but regularly^{1,2} 



Early benefits with SGLT2 inhibitors³

The **beneficial effects of SGLT2 inhibitors occurred early after randomisation** in clinical trials and were associated with improvements in QoL and symptoms³

Due to the benefits observed, irrespective of LVEF or background heart failure therapy, **early administration of SGLT2 inhibitors is recommended³**

 Pharmacokinetics of SGLT2 inhibitors are not influenced by co-administration with a wide range of drugs*^{1,2}

*Other heart failure/CV medications also do not need to be adjusted when initiating SGLT2 inhibitors in most patients with heart failure^{1,2}
 CV, cardiovascular; LVEF, left ventricular ejection fraction; QoL, quality of life; SGLT2, sodium-glucose co-transporter-2
 1. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 2. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 3. Metra M et al. *Eur J Heart Fail* 2023;25:1115



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How would you manage this patient's concomitant medications?




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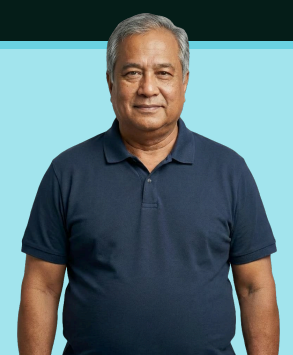
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SGLT2 inhibitors rarely cause hypoglycaemia when used alongside most antidiabetic medications*1,2



Overview of the management of SUs, repaglinide or insulin

- A lower dose of insulin or SU may be required to reduce the risk of hypoglycaemia when used in combination with SGLT2 inhibitors^{1,2}

History of hypoglycaemia

Reduce dose of hypoglycaemic agent³

SUs, repaglinide or insulin

Possible risk of hypoglycaemia – verify eGFR and HbA1c³

eGFR <45 ml/min/1.73 m² or HbA1c ≥7.5%

Verify possible hypoglycaemia by self-monitored blood glucose
 • If so, reduce dose of hypoglycaemic agent³

HbA1c <7.5%

Reduce dose of hypoglycaemic agent³

Patients without diabetes

SGLT2 inhibitors did not lower HbA1c and were not associated with an increased risk of hypoglycaemia^{4,5}

SGLT2 inhibitors have been shown to reduce the risk of new-onset T2D in adults with prediabetes and heart failure or CKD⁶

Hypoglycaemia is defined as a measurable glucose concentration <70 mg/dl (3.9 mmol/l)⁷

*Empagliflozin and dapagliflozin; very common (≥10) adverse events when used either with SU or insulin

eGFR, estimated glomerular filtration rate; HbA1c, glycated haemoglobin; SGLT2, sodium-glucose co-transporter-2; SU, sulphonylurea

1. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 2. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 3. Giaccari A et al. *Int J Cardiol* 2022;351:66; 4. Anker SD et al. *Circulation* 2021;143:337; 5. Petrie MC et al. *JAMA* 2020;323:1353; 6. Mori Y et al. *J Clin Endocrinol Metab* 2022;108:221; 7. ElSayed NA et al. *Diabetes Care* 2023;46:S97



Guideline implementation for HFrEF



Elderly patients



Dosing



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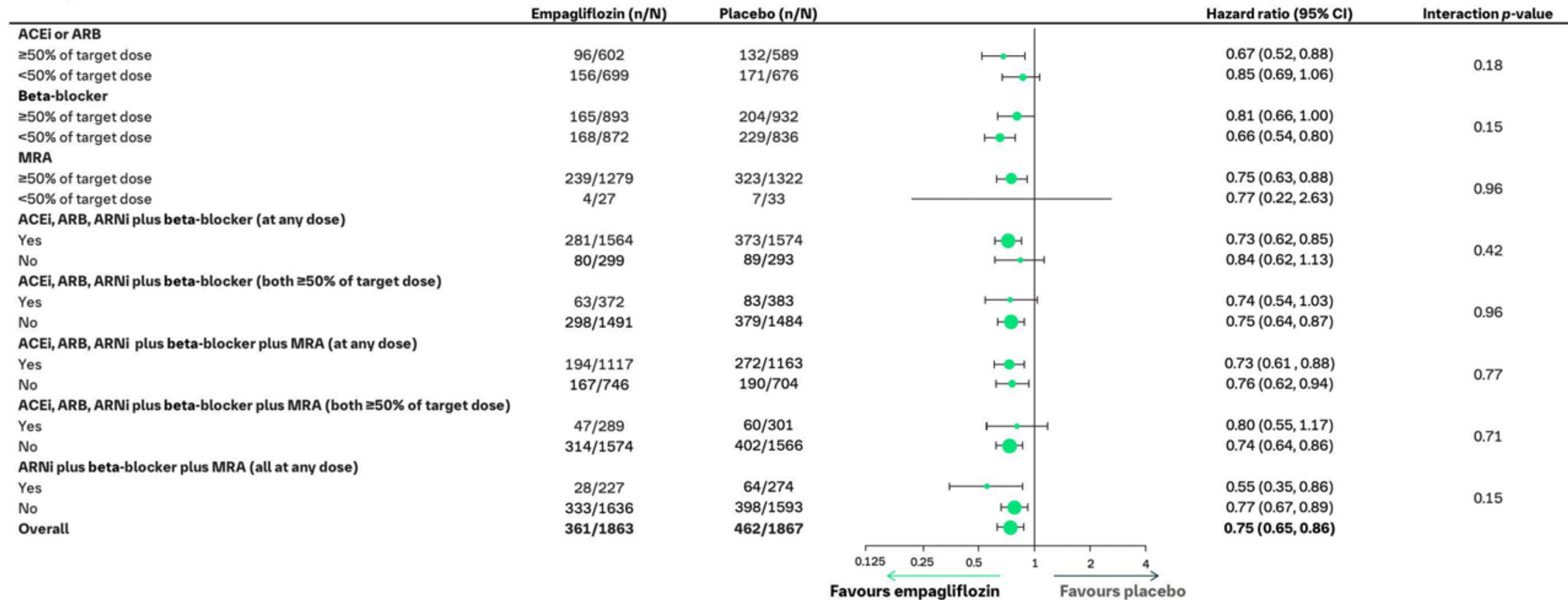
Jerry

A patient with acute decompensated heart failure



Concomitant heart failure medications

For patients with HFrEF, SGLT2 inhibitors can be used with **any combination of the other foundational therapies**^{1,2}



ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker; ARNi, angiotensin receptor–neprilysin inhibitor; HFrEF, heart failure with reduced ejection fraction; MRA, mineralocorticoid receptor antagonist; SGLT2, sodium-glucose co-transporter-2
 1. McDonagh TA et al. *Eur Heart J* 2023;44:3627; 2. Verma S et al. *Lancet Diabetes Endocrinol* 2022;10:35
 Figure adapted from: Verma S et al. 2022



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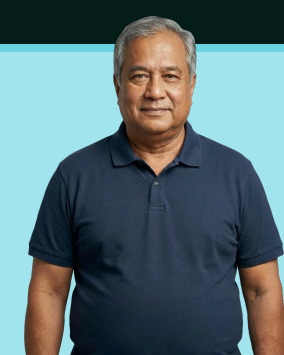
Susan

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Jerry

A patient with acute decompensated heart failure




How would you manage this patient with CKD?




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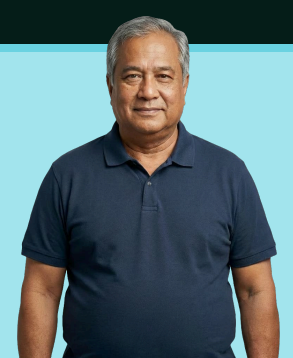
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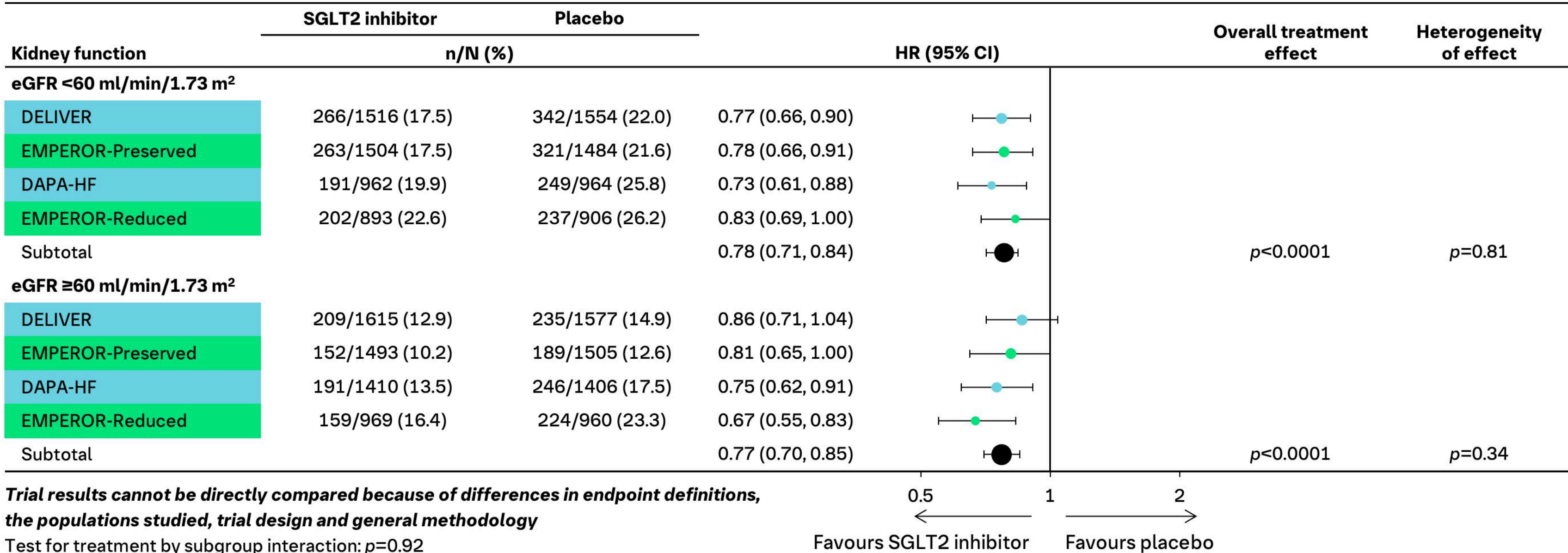
Jerry

A patient with acute decompensated heart failure



SGLT2 inhibitors improve outcomes in patients with heart failure across the spectrum of kidney function

CV death or first HHF



Trial results cannot be directly compared because of differences in endpoint definitions, the populations studied, trial design and general methodology

Test for treatment by subgroup interaction: p=0.92

CV, cardiovascular; DAPA-HF, Dapagliflozin and Prevention of Adverse Outcomes in Heart Failure; eGFR, estimated glomerular filtration rate; HHF, hospitalisation for heart failure; LVEF, left ventricular ejection fraction; SGLT2, sodium-glucose co-transporter-2
 Vaduganathan M et al. Lancet 2022;400:757
 Figure adapted from: Vaduganathan M et al. 2022



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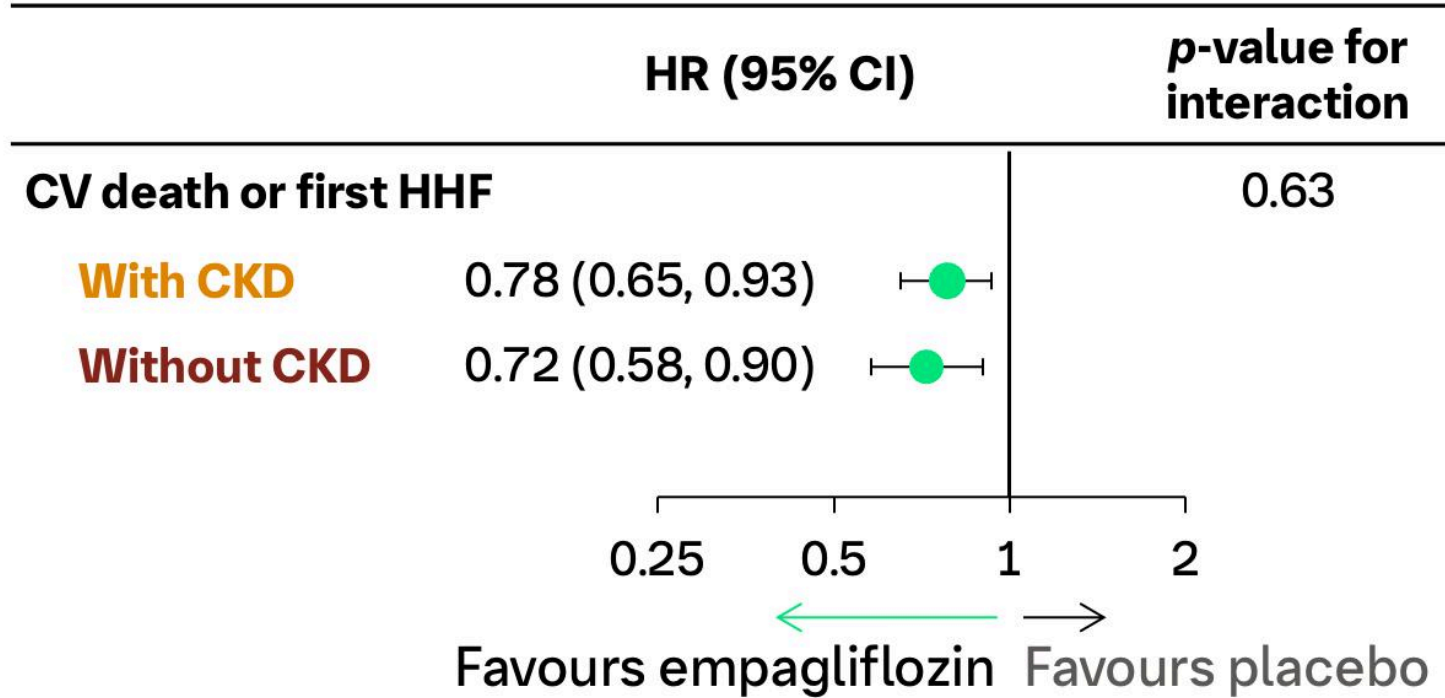
Ramesh
 A patient with HFrEF, CKD and T2D

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Empagliflozin is consistently effective and has a similar safety profile in patients with or without CKD*

EMPEROR-Reduced¹



		Empagliflozin		Placebo	
		n/N (%)	IR/100 PY	n/N (%)	IR/100 PY
Any AEs	No prevalent CKD	632/879 (71.9)	130.7	636/865 (73.5)	140.9
	Prevalent CKD	787/981 (80.2)	168.7	825/995 (82.9)	193.7
Serious AE	No prevalent CKD	310/879 (35.3)	35.6	381/865 (44.0)	48.6
	Prevalent CKD	462/981 (47.1)	52.1	513/995 (51.6)	61.2
AE leading to discontinuation	No prevalent CKD	124/879 (14.1)	11.5	116/865 (13.4)	11.0
	Prevalent CKD	198/981 (20.2)	16.9	210/995 (21.1)	17.8
Acute renal failure	No prevalent CKD	52/879 (5.9)	5.0	62/865 (7.2)	6.1
	Prevalent CKD	123/981 (12.5)	11.2	130/995 (13.1)	11.7
Volume depletion	No prevalent CKD	81/879 (9.2)	7.9	74/865 (8.6)	7.4
	Prevalent CKD	116/981 (11.8)	10.5	110/995 (11.1)	10.1
Urinary tract infection	No prevalent CKD	32/879 (3.6)	3.0	30/865 (3.5)	2.9
	Prevalent CKD	58/981 (5.9)	5.1	53/995 (5.3)	4.6
Bone fracture	No prevalent CKD	15/879 (1.7)	1.4	13/865 (1.5)	1.2
	Prevalent CKD	30/981 (3.1)	2.6	29/995 (2.9)	2.5
Confirmed hypoglycaemia†	No prevalent CKD	11/879 (1.3)	1.0	9/865 (1.0)	0.9
	Prevalent CKD	16/981 (1.6)	1.4	19/995 (1.9)	1.6
Genital infection	No prevalent CKD	15/879 (1.7)	1.4	7/865 (0.8)	0.7
	Prevalent CKD	16/981 (1.6)	1.4	5/995 (0.5)	0.4

Empagliflozin 10 mg is indicated for the treatment of adults with CKD²
 *CKD was defined by the presence of at least one of the following at baseline: eGFR <60 ml/min/1.73 m² or UACR >300 mg/g¹; †Plasma glucose ≤70 mg/dL or requiring assistance¹
 AE, adverse event; CV, cardiovascular; eGFR, estimated glomerular filtration rate; HHF, hospitalisation for heart failure; IR, incidence rate; PY, patient-years; UACR, urine albumin-to-creatinine ratio
 1. Zannad F et al. *Circulation* 2021;143:310; 2. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026
 Table adapted from: Zannad F et al. 2021



Guideline implementation for HFrEF

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Collaborating with Primary Care

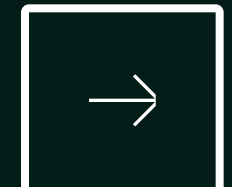
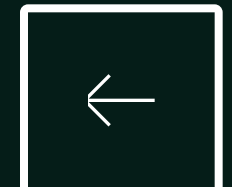
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Summary

Susan
 A patient with HFpEF


Ramesh
 A patient with HFrEF, CKD and T2D

Jerry
 A patient with acute decompensated heart failure




Your patient's eGFR has shown a slight dip. What do you do?



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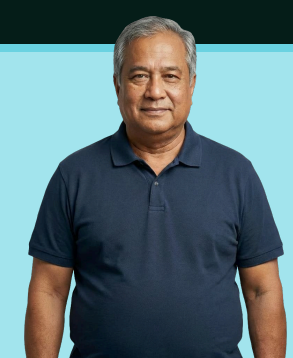
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Unnecessary fear of worsening kidney function is a leading cause of insufficient dosing of GDMT in general¹



A transient eGFR decrease* after initiation of SGLT2 inhibitors may be expected and...^{2,3}






- **Is reversible and not associated with untoward heart failure, mortality or kidney events^{2,3}**
- Does not equal AKI or kidney failure^{2,4}
- Should not lead to concerns among clinicians^{2,3}



Regardless of treatment, an eGFR decrease >30% should prompt clinical assessment and elimination of nephrotoxic factors^{2,3}

*Average decrease in eGFR: EMPEROR-Reduced² -3.5 ml/min/1.73 m² (95% CI -3.9, -3.1) at Week 4; DAPA-HF³ -3.1 ml/min/1.73 m² at Day 14
AKI, acute kidney injury; DAPA-HF, Dapagliflozin and Prevention of Adverse Outcomes in Heart Failure; eGFR, estimated glomerular filtration rate; GDMT, guideline-directed medical therapy; SGLT2, sodium-glucose co-transporter-2
1. Metra M et al. *Eur J Heart Fail* 2023;25:1115; 2. Zannad F et al. *Eur J Heart Fail* 2022;24:1829; 3. Adamson C et al. *Circulation* 2022;146:438; 4. Palevsky PM et al. *Am J Kidney Dis* 2013;61:649



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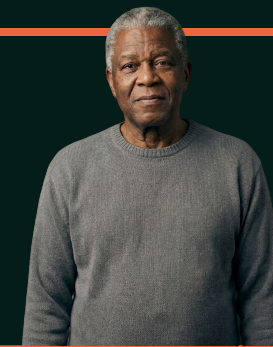
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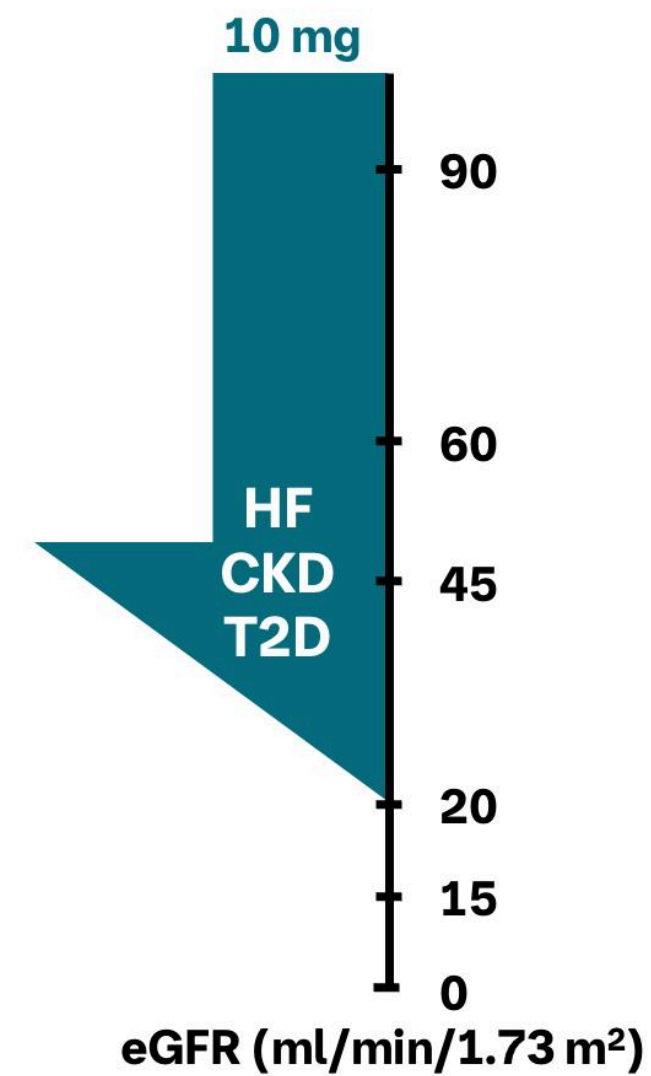
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Empagliflozin can be initiated with an eGFR as low as 20 ml/min/1.73 m²

For **heart failure**, **CKD**, or **T2D**, the recommended daily dose is 10 mg* in patients with eGFR \geq 20 ml/min/1.73 m²

Due to limited experience, it is **not recommended to initiate** treatment with empagliflozin in patients with an eGFR $<$ 20 ml/min/1.73 m²



Label recommendations for assessment of renal function:

- Prior to empagliflozin initiation and periodically during treatment, i.e. at least yearly
- Prior to initiation of any concomitant medicinal product that may have a negative impact on renal function

*Please see the summary of product characteristics for dosing details
eGFR, estimated glomerular filtration rate
Jardiance® (empagliflozin) summary of product characteristics. Apr 2026



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Your patient has developed a urinary tract infection/genital tract infection. What do you advise them?




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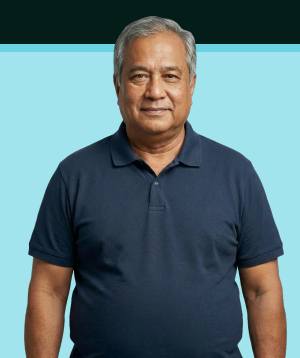
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Infections are often mild, responsive to treatment and do not usually require SGLT2 inhibitor discontinuation¹

Similar rates (<6%) of genital tract infections are observed with different SGLT2 inhibitors^{2,3}

Complicated genital tract infections are uncommon^{*4,5}

Urinary tract infection rates were **generally comparable between SGLT2 inhibitor treatment and placebo groups**^{†2,3}

How to manage¹:

Genital tract infections

- Raise awareness** at initiation of SGLT2 inhibitor treatment to manage expectations and promote early intervention¹
- Provide practical hygiene advice** to patients (and their partners) to prevent infections¹
- Topical treatments or appropriate oral treatments** can be used for mild to moderate infections¹

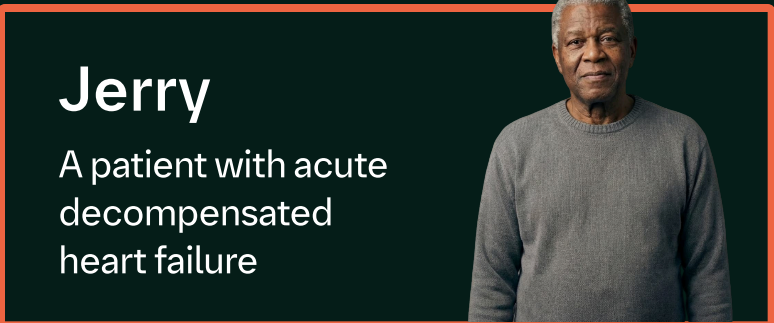
Urinary tract infections

- Encourage** patients to maintain good personal **hygiene** to reduce the risk of urinary tract infections¹
- Treat with **standard oral antibiotics**¹
- In patients with complicated urinary tract infections (including pyelonephritis and urosepsis), **temporary interruption of treatment should be considered**^{2,3}

*Evidence from empagliflozin trials; †The overall frequency of urinary tract infection reported as adverse event was similar in patients treated with empagliflozin 25 mg and placebo (7.0% and 7.2%) and higher in empagliflozin 10 mg (8.8%); urinary tract infections were more frequently reported for dapagliflozin 10 mg compared to placebo (4.7% versus 3.5%, respectively)^{2,3}
 SGLT2, sodium-glucose co-transporter-2
 1. Wilding J et al. *Diabetes Ther* 2018;9:1757; 2. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 3. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 4. Packer M et al. *N Engl J Med* 2020;383:1413; 5. Anker SD et al. *N Engl J Med* 2021;385:1451



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Your patient develops hypotension. What do you do?



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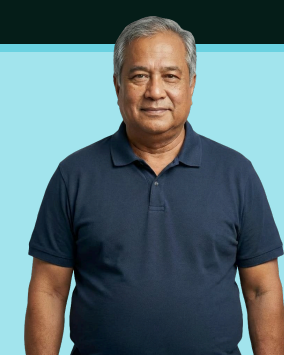
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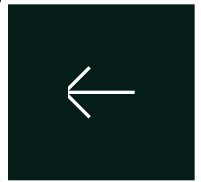
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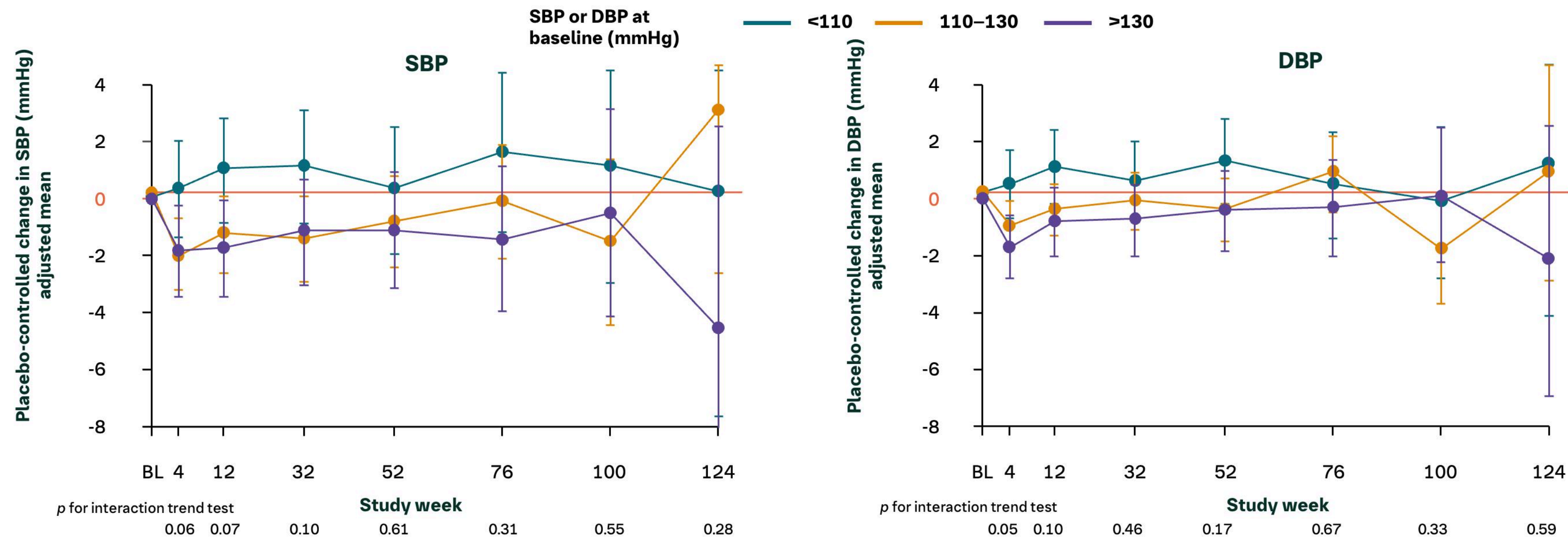
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EMPEROR-Reduced: BP lowering with SGLT2 inhibitors and placebo was primarily observed in those with a higher baseline SBP

Placebo-corrected change in BP from baseline in patients treated with empagliflozin



Between-group differences were of borderline significance after 4 and 12 weeks but were not significant at later time points

BL, baseline; BP, blood pressure; DBP, diastolic blood pressure; SBP, systolic blood pressure; SGLT2, sodium-glucose co-transporter-2
 Böhm M et al. *J Am Coll Cardiol* 2021;78:1337
 Figure adapted from: Böhm M et al. 2021



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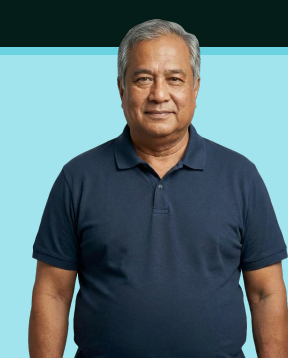
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When to pause SGLT2 inhibitor therapy

SGLT2 inhibitors should be paused in patients:



- If they have an acute **serious medical illness** (e.g. sepsis)^{1,2}
- If they have a condition that leads to **volume depletion or dehydration**, e.g. unable to eat and drink normally, persistent vomiting^{1,2}



- Patients who are **not eating and drinking** should **discontinue SGLT2 inhibitors and only restart when normal eating and drinking are resumed**^{1,2}

– If a patient is to undergo a prolonged period of fasting, additional precautions apply³:

Ensure dose stabilisation prior to the fasting period

Increase fluid intake during non-fasting hours, if applicable



- Treatment should be interrupted at least 72 hours before all major surgeries^{2,4}
- In patients with diabetes, blood glucose may be higher than usual – blood sugar should be checked more regularly until their levels are within range and **have stabilised**^{5,6}

Restart SGLT2 inhibitor therapy once the patient's condition has stabilised and blood ketone levels have returned to normal^{1,2}

SGLT2, sodium-glucose co-transporter-2

1. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 2. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 3. Hassanein M et al. *Diabetes Res Clin Pract* 2020;169:108465; 4. Mazer C et al. *Curr Opin Cardiol* 2020;35:178; 5. Sreedharan R et al. *Perioper Med (Lond)* 2023;12:13; 6. Sudhakaran S & Surani SR. *Surg Res Pract* 2015;2015:284063



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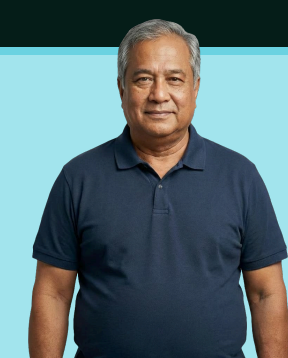
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How can you collaborate with your Primary Care colleagues to support ongoing care for your patients with heart failure?




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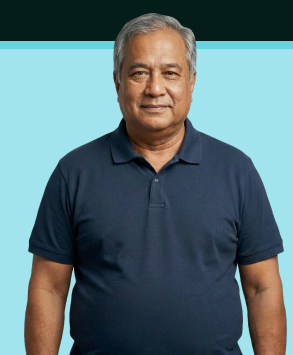
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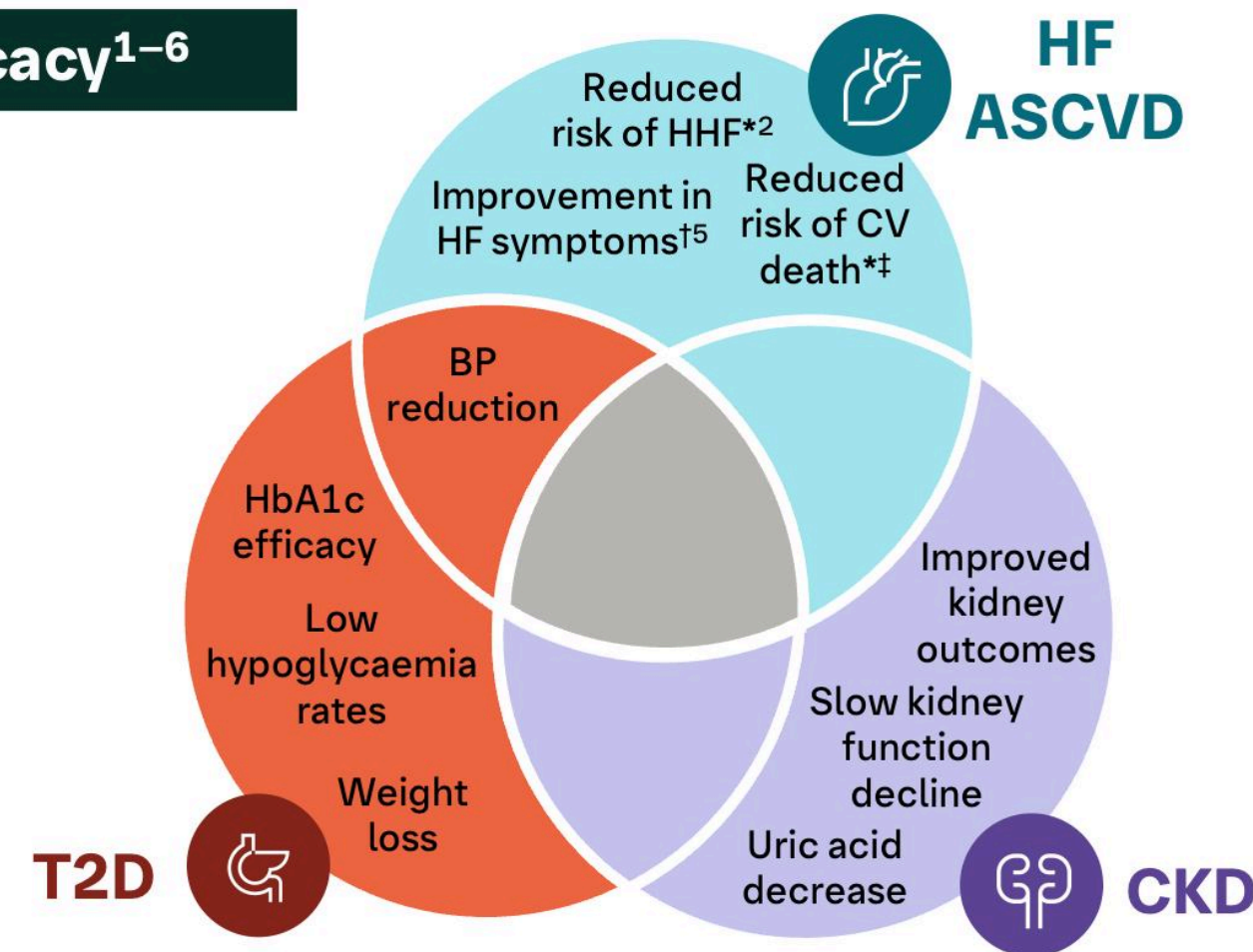
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International guidelines increasingly and strongly recommend the use of SGLT2 inhibitors for their benefits across the cardio, renal and metabolic spectrum¹⁻¹⁵

Efficacy¹⁻⁶



International CKD, HF and T2D guidelines recommend the use of SGLT2 inhibitors as early as **foundational therapy**

HF ASCVD
ESC⁷⁻⁹
AHA/ACC/HFSA¹⁰
CCS/CHFS¹¹

T2D
ADA-EASD¹²
ADA¹³

CKD
ADA-KDIGO¹⁴
ADA-EASD¹²
ADA¹³
KDIGO¹⁵

*In people with T2D and ASCVD or multiple risk factors for ASCVD (as reported in EMPA-REG OUTCOME,² CANVAS Programme³ and DECLARE-TIMI 58⁴); [†]Improvements in KCCQ symptom scores⁵; [‡]Significant reductions in the risk of CV death were observed only with empagliflozin in the EMPA-REG OUTCOME² trial. Empagliflozin is indicated to reduce the risk of CV death in people with T2D and established CV disease in the EU^{2,6}
ACC, American College of Cardiology; ADA, American Diabetes Association; AHA, American Heart Association; ASCVD, atherosclerotic cardiovascular disease; BP, blood pressure; CCS, Canadian Cardiovascular Society; CHFS, Canadian Heart Failure Society; CV, cardiovascular; EASD, European Association for the Study of Diabetes; ESC, European Society of Cardiology; EU, European Union; HbA1c, glycated haemoglobin; HFSA, Heart Failure Society of America; KCCQ, Kansas City Cardiomyopathy Questionnaire; KDIGO, Kidney Disease: Improving Global Outcomes; SGLT2, sodium-glucose co-transporter-2
1. Scheen AJ. *Curr Diab Rep* 2016;16:92; 2. Zinman B et al. *N Engl J Med* 2015;373:2117; 3. Neal B et al. *N Engl J Med* 2017;377:644; 4. Wiviott SD et al. *N Engl J Med* 2019;380:347; 5. Butler J et al. *Eur Heart J* 2021;42:1203; 6. Jardiance* (empagliflozin) summary of product characteristics. Apr 2026; 7. McDonagh TA et al. *Eur Heart J* 2023;44:3627; 8. McDonagh TA et al. *Eur Heart J* 2021;42:3599; 9. Marx M et al. *Eur Heart J* 2023;44:4043; 10. Heidenreich PA et al. *Circulation* 2022;145:e895; 11. McDonald M et al. *Can J Cardiol* 2021;37:531; 12. Davies MJ et al. *Diabetes Care* 2022;45:2753; 13. American Diabetes Association. *Diabetes Care* 2026;49:S1; 14. de Boer IH et al. *Diabetes Care* 2022;45:3075; 15. Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. *Kidney Int* 2024;105(Suppl. 4S):S117



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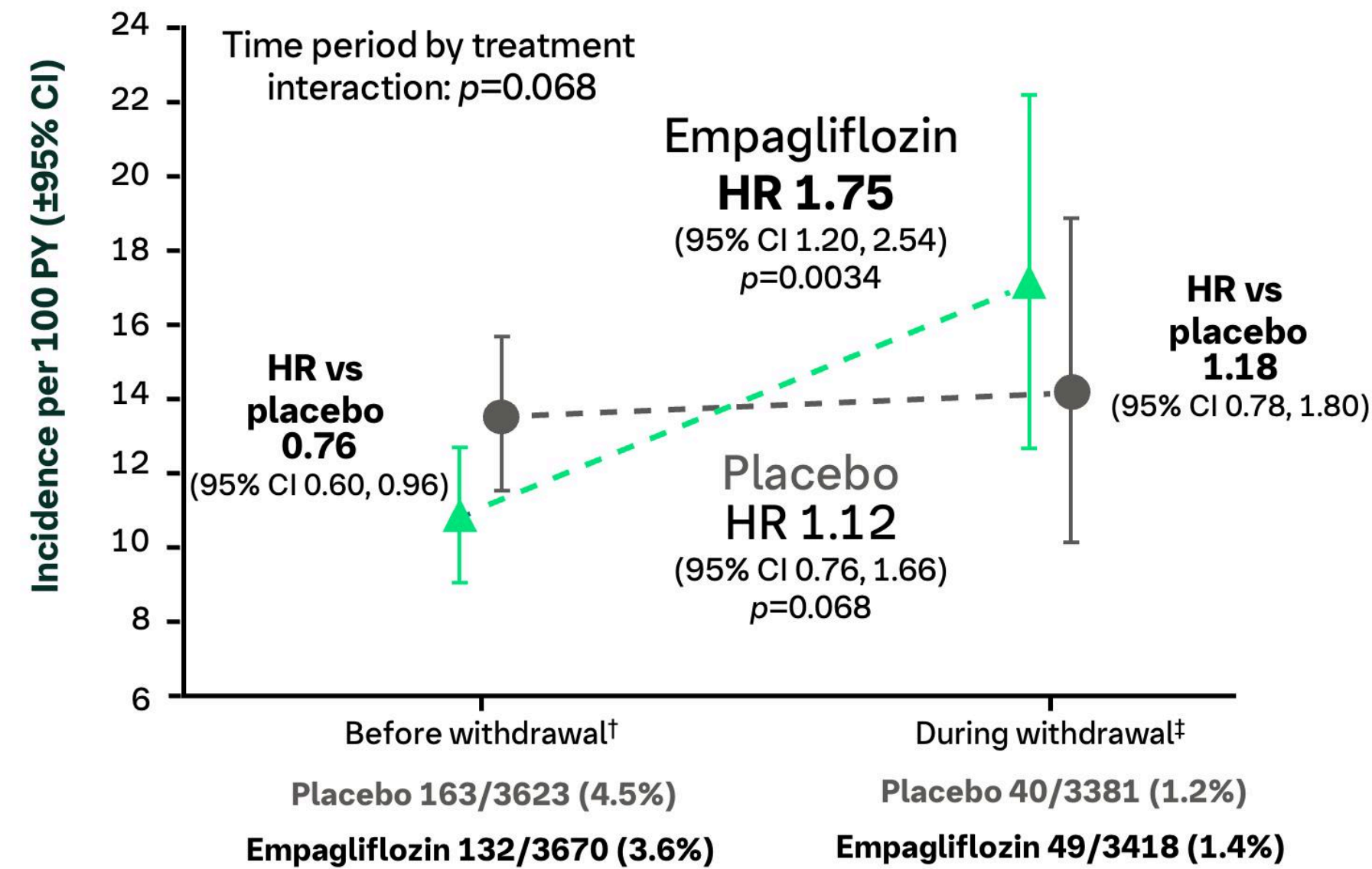
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Why is continuation of therapy important?

Discontinuation of empagliflozin translated into increased clinical events in EMPEROR-Pooled*



75% RR

Withdrawal of empagliflozin increased the risk of CV death or first HFrEF during the 30-day period versus on treatment (HR 1.75)

*Pooled analysis of the EMPEROR-Reduced (patients with heart failure and LVEF ≤40%) and EMPEROR-Preserved (patients with heart failure and LVEF >40%) trials; †From 90 days before start of closeout up to planned end of double-blind treatment; ‡During 30-day withdrawal period
 CV, cardiovascular; HFrEF, hospitalisation for heart failure; LVEF, left ventricular ejection fraction; PY, patient-years; RR, relative risk
 Packer M et al. *Circulation* 2023;148:1011
 Figure adapted from: Packer M et al. 2023



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