This conference was developed by the PCDO Society in conjunction with OmniaMed Communications. The sponsoring pharmaceutical, device, training and educational companies contributed financial support towards this event but had no input into the conference agenda, speaker selection or presentations, with the exception of the symposium sessions, for which the respective sponsoring companies were fully responsible.

Conference over coffee: Diabetes and obesity management in multimorbidity and frailty

The 2026 London Conference of the Primary Care Diabetes & Obesity Society took place on Wednesday 1 July at the Royal College of General Practitioners. Aligned with the newly updated NICE NG28 guidance, the programme focused on early intervention, multidisciplinary collaboration with the Integrated Neighbourhood Team, and practical strategies that empower individuals to self-manage their conditions and achieve better long-term health. In this short report, Pam Brown summarises the key take-home points from the final two sessions of the conference.

Diabetes and obesity management in complexity – Physical health

Hannah Beba, Consultant Pharmacist, West Yorkshire Health & Care Partnership

Philip Newland-Jones, Consultant Pharmacist, University Hospital Southampton NHS Foundation Trust

- Diabetes and obesity drive a connected, multi-organ cluster: cardio–kidney–metabolic (CKM) syndrome.
  - Visceral adiposity and insulin resistance are the drivers.
  - Affects four organ domains – chronic kidney disease (CKD), cardiovascular disease (CVD), metabolic dysfunction-associated steatotic liver disease/steatohepatitis (MASLD/MASH) and obstructive sleep apnoea (OSA).
- Multimorbidity is the rule, not the exception.
  - In people with type 2 diabetes:
    - Approximately 40% have CKD.
    - Up to 70% have MASLD.
    - 2–4-times higher mortality risk.
  - In people with obesity, more than two in three have sleep-related breathing disorders.
- Modern pharmacology has multi-organ effects: see *Table 1*.
- The evidence base is large and recent:
  - 2019 to 2025 – an avalanche of practice-changing trials (see *Table 2*). Guidelines struggle to keep up, so understanding the trials is important for day-to-day decisions.
- Layered cardiorenal protection framework:
  - Foundation: RAAS blockade (ACE inhibitor or ARB) to maximum tolerated dose; blood pressure <130/80 mmHg, glycaemic and lifestyle optimisation.
  - SGLT2 inhibitor: foundational in all with albuminuric CKD; recommended by NICE for all with type 2 diabetes.
    - 39% lower risk of kidney/CVD composite in DAPA-CKD, 28% reduction in EMPA-KIDNEY and 30% reduction in CREDENCE (diabetic nephropathy only).
  - Finerenone (non-steroidal MRA): add on to RAAS inhibitor +/– SGLT2 inhibitor in type 2 diabetes with diabetic nephropathy.

Table 1. Pharmacotherapies with multi-organ benefits. Adapted from session slides.

Drug class	Representative agents	Multi-organ benefit (key trial)	NICE/UK positioning
GLP-1 receptor agonist	Semaglutide, dulaglutide, liraglutide	**Weight**; **glycaemia**; **CVD** (SELECT); **CKD** (FLOW); **MASH** (ESSENCE)	TA875 (obesity); NG28; CVD and MASH indications emerging
GIP/GLP-1 receptor agonist	Tirzepatide	**Weight**; **glycaemia**; **OSA** (SURMOUNT-OSA); **HFpEF** (SUMMIT)	TA1026 (obesity); NG28
SGLT2 inhibitor	Dapagliflozin, empagliflozin	**CKD progression** (DAPA-CKD, EMPA-KIDNEY); **HF**; **CVD**	TA775 (CKD); NG28; HF guidance – foundational
Non-steroidal MRA	Finerenone	**Kidney and CVD outcomes in type 2 diabetes and CKD** (FIDELIO, FIGARO); **HF**	TA877 – add-on to RAAS inhibitor ± SGLT2 inhibitor
Foundational protection	ACEi/ARB, statin ± ezetimibe, PCSK9 target medicines, antiplatelets	**Blood pressure**; **albuminuria**; **LDL cholesterol**; **atherothrombotic risk**	NG28, NG203, CG181 – treat to target

CKD=chronic kidney disease; CVD=cardiovascular disease; HF=heart failure; HFpEF=heart failure with preserved ejection fraction; LDL=low-density lipoprotein; MASH=metabolic dysfunction-associated steatohepatitis; OSA=obstructive sleep apnoea.

Table 2. Practice-changing trials in 2019–2025.

Year	Trial(s)	Message
2019	CREDENCE	SGLT2 inhibitors protective in diabetic kidney disease
2020	DAPA-CKD	SGLT2 inhibitors protective in CKD beyond diabetes
2021	FIDELIO, FIGARO	Finerenone provides kidney and cardiovascular benefits
2022	EMPA-KIDNEY	SGLT2 inhibitors effective across broad range of CKD
2023	SELECT, STEP-HFpEF	Incretins: Obesity management as cardiovascular protection
2024	FLOW, SURMOUNT-OSA	Incretins: Kidney and sleep milestones
2025	ESSENCE, SUMMIT	Incretins: MASH and HFpEF outcomes

Year reflects primary publication/topline read-out.
CKD=chronic kidney disease; HFpEF=heart failure with preserved ejection fraction; MASH=metabolic dysfunction-associated steatohepatitis.

  - 13–18% reduction in composite outcome with finerenone in FIDELIO-DKD and FIGARO-DKD trials.
- ➤ GLP-1 receptor agonist: semaglutide has shown cardiovascular, kidney and mortality benefits:
  - FLOW trial: 24% reduction in kidney events in people with type 2 diabetes and CKD.
- ➤ Sequencing, monitoring and deprescribing are core pharmacist roles.
- ➤ Expect an initial eGFR "dip" when starting RAASi/SGLT2i/finerenone. Not a reason to stop the drugs.
- ➤ Monitor potassium carefully if prescribing finerenone.

- Weight management and the cardiovascular framework:
  - ➤ Secondary prevention backbone is lipid-lowering therapy to ESC LDL targets (Mach et al, 2025):
    - Statin +/– ezetimibe/bempedoic acid/inclisiran/PCSK9 inhibitor.
  - ➤ Antiplatelets.
  - ➤ ACE inhibitor/ARB.
  - ➤ Blood pressure control.
  - ➤ Cardiac rehabilitation.
  - ➤ SGLT2 inhibitor.
  - ➤ GLP-1 receptor agonist: **SELECT trial established obesity as a modifiable cardiovascular risk factor and its treatment as secondary prevention**.
    - Semaglutide 2.4 mg versus placebo in 17 604 adults with BMI ≥27 kg/m^2, no diabetes, over 40 months.
    - 20% relative risk reduction in major adverse cardiovascular events (MACE); benefit largely uncoupled from weight loss magnitude (those losing <5% had same benefit as >5%).
  - ➤ Tirzepatide: SUMMIT trial showed fewer cardiovascular deaths/heart failure events in obesity-related HFpEF.
- MASLD starts as a silent disease; progresses to MASH/fibrosis; increased CVD risk.
  - ➤ Stratify risk: Fib-4, ELF, transient elastography scan. Identify significant fibrosis (≥F2).
  - ➤ Weight loss ≥10% resolves steatohepatitis in around 90%; regresses fibrosis in around 45% (Vilar-Gomez et al, 2015).
  - ➤ Statins are safe and indicated. Optimise glycaemia, blood pressure and lipids
  - ➤ ESSENCE trial: 62.9% steatosis resolution in semaglutide 2.4 mg recipients versus 34.3% with placebo. 36.8% vs 22.4% fibrosis improvement.
    - Clinical outcomes to 240 weeks' evaluated in ESSENCE 2 – results expected in 2029.
- Obstructive sleep apnoea:
  - ➤ SURMOUNT-OSA 1 and 2 trials: tirzepatide 10–15 mg evaluated in people with moderate/severe OSA and obesity; with/without continuous positive airways pressure (CPAP).
    - 52 weeks: 50–63% reduction in apnoea/hypopnoea ratio versus placebo.
    - 43–51% met disease resolution criteria.
    - Reductions in blood pressure and hsCRP also seen.
- Safety, monitoring and deprescribing:
  - ➤ SGLT2 inhibitors: euglycaemic diabetic ketoacidosis risk (sick day rules); mycotic infections; volume depletion; initial eGFR dip; prescribe for protective considerations.
  - ➤ Finerenone: hyperkalaemia risk (potassium monitoring at baseline and 4 weeks); initiate if eGFR is ≥25 mL/min/1.73 m^2 and potassium ≤5.0 mmol/L; sequence after SGLT2 inhibitor, (mitigates hyperkalaemia risk).
  - ➤ GLP-1 receptor agonists and tirzepatide: gastrointestinal intolerance (titrate slowly); pancreatitis risk; avoid in pregnancy; withhold around sedation/anaesthesia.
  - ➤ Polypharmacy and equity: de-escalate sulfonylureas/insulin as incretins and SGLT2 inhibitors are optimised (reduce hypoglycaemia); shared decision-making and structured medication review, apply an equality lens.

Key steps to deliver effective care across all domains

- Treat the drivers – visceral fat and insulin resistance. Aim for sustained weight loss and cardiometabolic control.
- Lay foundational protection early.
- Layer disease-modifying agents by indication and residual risk.
- Treat to target: LDL-cholesterol, blood pressure, HbA_{1c}, weight.

- Think absolute risk and the whole person.
- Own the follow-through: monitoring, titration, deprescribing.

Type 2 diabetes and frailty

The frailty arm of NG28 – a multimorbidity-focused case discussion

Hannah Beba, Consultant Pharmacist, West Yorkshire Health & Care Partnership

- Frailty is more prevalent and develops earlier in people with type 2 diabetes compared to those without.
- Most frail older adults with diabetes live with multiple long-term conditions – heart failure, chronic kidney disease, cardiovascular disease, cognitive impairment.
  - ➤ The resulting polypharmacy, hypoglycaemia and adverse drug events drive falls, admissions and reduced quality of life.
  - ➤ Function, independence and harm avoidance may matter more than glycaemic or end-organ targets.
- This is reflected in the frailty arm of the NICE NG28 guideline – but treat the person, not the algorithm.
  - ➤ Offer modified-release metformin as the first line; add SGLT2 inhibitor only if safe (consider volume depletion, hypotension risks).
  - ➤ If metformin MR unsuitable, consider whether SGLT2 inhibitor monotherapy is safe; otherwise, consider DDP-4 inhibitor monotherapy.
  - ➤ GLP-1 receptor agonists and tirzepatide are permitted, but individualise and offer if relevant indication.
    - Weight loss includes lean mass loss – protect muscle and function.
  - ➤ When several conditions compete, use shared decision-making.
    - Prioritise which to treat; consider treatment burden and potential harm.
    - Aim for function, independence, symptom control and quality of life.
    - Aim for smallest effective number of medicines at lowest effective dose.
- NICE's NG28 cardiorenal shift is based on cardiovascular, heart failure and renal randomised controlled trials:
  - ➤ People with multiple long-term conditions (especially severe frailty, dementia, care home residence) were under-represented.
  - ➤ Some trials demonstrated persistent benefit in older/frail. For example, in DELIVER, dapagliflozin reduced heart failure admissions and cardiovascular death across the frailty strata; most frail gained largest absolute benefit and quality of life improvement.
    - But harm scales too, hence caution with SGLT2 inhibitors.
  - ➤ Relax targets: Sulfonylureas and insulin drive hypoglycaemia and harm; favour low-hypo-risk agents (e.g. DPP-4 inhibitors); increased mortality in ACCORD trial with intensive control (long-duration type 2 diabetes).

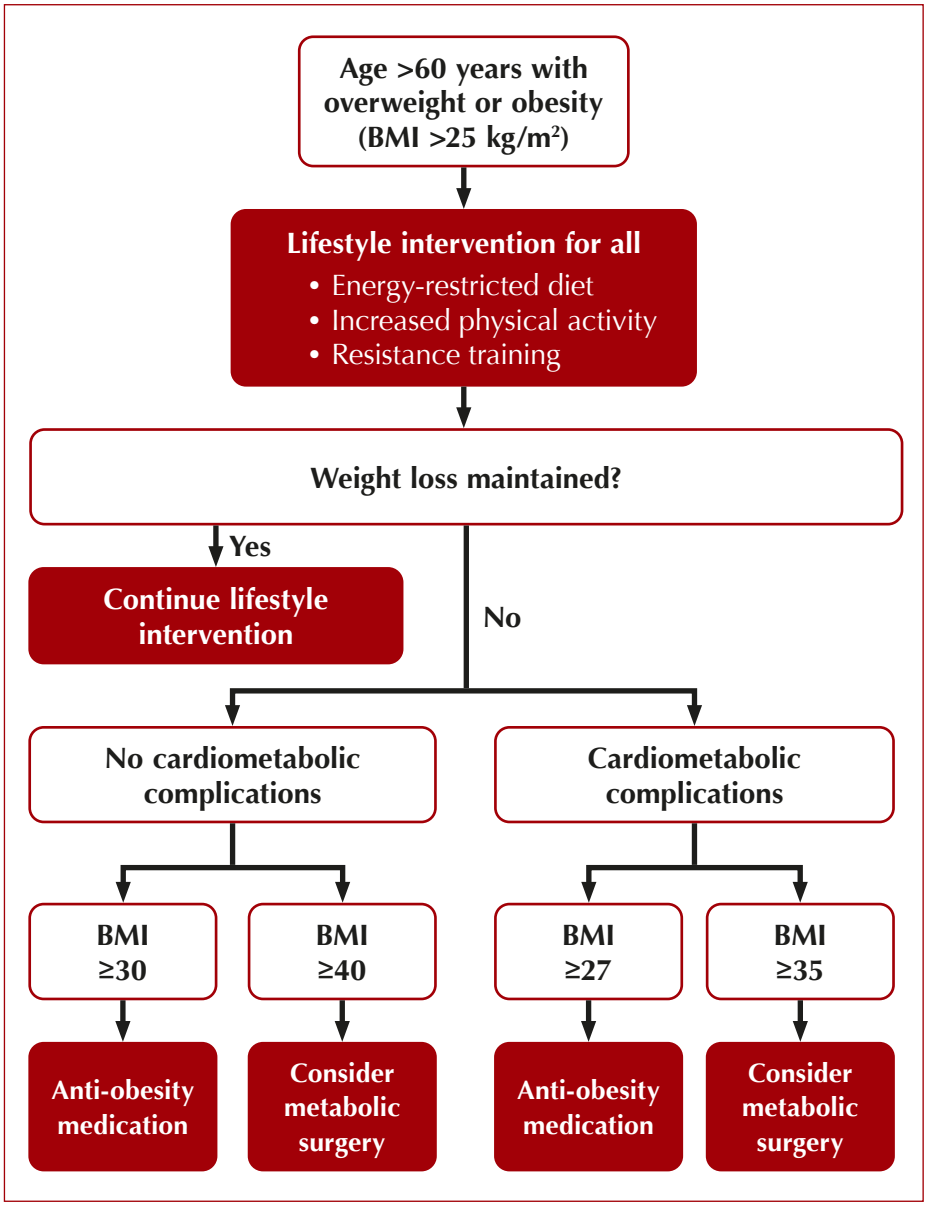

Figure 1. When to consider lifestyle intervention, pharmacological therapy, and metabolic surgery in older adults with overweight and obesity (Henney et al, 2025).

- Note, the right medicine for the disease can be the wrong medicine for the person.

NICE resources

- NG28: Type 2 diabetes in adults
- NG56: Multimorbidity
- NG197: Shared decision making

Obesity management in the frail patient population

Satish Durgam, GPwER diabetes, obesity and metabolic health, London

- Improving care for older people living with frailty or multiple long-term conditions is a priority in the 10 Year Health Plan for England.
- Sarcopenic obesity: defined as increased adipose tissue with concurrent decline in muscle mass (quality and/or quality) and function.
  - Poses a major health risk.
- Geriatric assessment of older adults with obesity helps identify those at risk, so that tailored nutrition and activity can be recommended and appropriateness of medication can be considered (Dewar, 2025):
  - Cognitive function – mini mental score/three-item recall.
  - Functional status – hand grip strength, activities of daily living (ADL).
  - Mobility/balance – falls, challenges in walking/rising from chair.
  - Psychosocial assessment – PHQ-9/GAD-7 questionnaires.
  - Social determinants of health – consider housing, food insecurity, transportation.
- Obesity paradox – overweight and obesity seem protective against disease and mortality in older adults – but this is not a reason not to manage obesity.
- Tailored and personalised weight loss intervention is recommended for older adults with obesity, weight maintenance for those with overweight but no comorbidities.
- Key approaches (Dewar, 2025):
  - Consider the risks and benefits of treatment alongside the person's priorities.
  - Prioritise independence and quality of life – not weight reduction alone.
  - Use waist circumference, grip strength and gait speed to detect sarcopenic obesity.
  - Optimise protein intake and calorie consumption to prevent falls.
  - Communication is important – avoid stigmatisation, which is common.
  - Use a tailored, personalised approach considering racial, ethnic and systemic disparities.
- There is a need (often unmet) to consider the cumulative weight-promoting effects of medications:
  - Diabetes medications.
  - Beta-blockers.
  - Antidepressants.
  - Atypical antipsychotics.
  - Corticosteroids.
  - Anticonvulsants.
  - Neuropathic pain medications.
  - First-generation antihistamines.
- When to consider lifestyle, pharmacological and surgical interventions: see *Figure 1* on previous page (Henney et al, 2025).

Useful review

- Brown MB (2026) Take a personalised approach to weight management for older adults with obesity. *Drugs Ther Perspect* **42**: 56–60

References

Dewar S (2025) A geriatrician's approach to managing the complex older adult with obesity. *Obesity (Silver Spring)* **33**(Suppl 1): 41–56

Henney AE, Wilding JPH, Alam U, Cuthbertson DJ (2025) Obesity pharmacotherapy in older adults: A narrative review of evidence. *Int J Obes (Lond)* **49**: 369–80

Mach F, Koskinas KC, Roeters van Lennep JE et al (2025) 2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias. *Eur Heart J* **46**: 4359–78

Vilar-Gomez E, Martinez-Perez Y, Calzadilla-Bertot L et al (2015) Weight loss through lifestyle modification significantly reduces features of nonalcoholic steatohepatitis. *Gastroenterology* **149**: 367–78

Author: Pam Brown, GP, Swansea.

Citation: Brown P (2026) Conference over coffee: Diabetes and obesity management in multimorbidity and frailty. *Diabetes & Primary Care* **28**: [Early view publication]