Translating scientific progress into meaningful benefits



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After a relatively quiet summer, we are reminded of the pace of diabetes research and clinical innovation once again. The arrival of once-weekly insulin in the UK represents one of the most significant advances in insulin therapy for many years, with the potential to reduce treatment burden and improve acceptance of insulin. In October 2026, the MHRA authorised insulin efsitora alfa, and NICE subsequently recommended its use for certain adults with type 2 diabetes, making the UK one of the first countries to adopt a once-weekly insulin option. Pam Brown discusses the practicalities in her latest *Diabetes Distilled* summary.

The annual meeting of the European Association for the Study of Diabetes (EASD) in Milan also provided a timely reminder of the energy, ambition and breadth of activity within the field. Bringing together researchers and healthcare professionals from around the world, the conference showcased a wealth of new data, fresh perspectives and lively debate on some of the most pressing challenges in diabetes care. We highlight some of the key themes and developments emerging from the meeting in our conference report.

Of course, important questions remain about implementation, access and long-term outcomes; scientific progress must ultimately translate into meaningful benefits for people living with diabetes. Evidence-informed guidelines are key to this implementation, and currently within the UK we are getting to grips with the update NICE NG28 guidance published earlier this year. You may recall our previous summary of this update. A key highlight of the EASD conference was the launch of the updated American Diabetes Association and EASD's joint consensus report on type 2 diabetes management, summarised here. It marks a significant shift from a predominantly glucose-centric approach to a more holistic model of diabetes care, placing equal emphasis on weight management, cardiovascular and kidney protection, lifestyle behaviours and overall quality of life. Notably, the consensus advocates earlier use of SGLT2 inhibitors and GLP-1-based therapies, potentially from diagnosis, to prevent complications and improve long-term outcomes, while positioning type 2 diabetes within the broader context of associated long-term conditions and multimorbidity.

The inclusion of metabolic dysfunction-associated steatotic liver disease (MASLD) within the guidance is helpful and reflects growing recognition that liver disease is a common and clinically important complication of type 2 diabetes. The consensus highlights the strong links between obesity, insulin resistance, type 2 diabetes and progressive liver disease, and now incorporates MASLD and metabolic dysfunction-associated steatohepatitis (MASH) into routine diabetes assessment and management. It recommends that GLP-1-based therapies should be preferred in people with obesity, MASLD and type 2 diabetes, while tirzepatide or pioglitazone may also be considered.

Expanding use of incretin therapies and SGLT2 inhibitors

SGLT2 inhibitors and GLP-1-based therapies have become the cornerstone of management for many people with type 2 diabetes, reflecting their proven benefits on cardiovascular, kidney and metabolic outcomes that extend well beyond glucose lowering. As the use of GLP-1 receptor agonists and tirzepatide continues to expand, gastrointestinal side-effects remain one of the principal challenges to treatment persistence, highlighting the importance of careful counselling, gradual dose titration and proactive management of symptoms. David Morris's practical review provides clinicians with valuable strategies to anticipate, minimise and manage symptoms, helping to improve treatment persistence and outcomes.

It is also timely to have updated Pam Brown's How-to guide on using SGLT2 inhibitors

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safely and effectively. Awareness of diabetic ketoacidosis (DKA) remains critical, and the article emphasises the importance of recognising that SGLT2 inhibitor-associated DKA may occur with normal glucose levels (euglycaemic DKA). While the risk of DKA with SGLT2 inhibitors is low, its potentially life-threatening nature means that sick-day guidance, symptom awareness, temporary discontinuation during acute illness or before surgery, and advice on ketone testing during acute illness should be a part of routine and ongoing patient education from initiation onwards.

A recent study, reviewed in *Diabetes Distilled*, adds important real-world evidence to our understanding of DKA risk with SGLT2 inhibitors. Although the absolute risk was low, at 2.43 events per 1000 person-years, DKA occurred throughout treatment and not just during the early months after initiation, reinforcing the need for ongoing vigilance and education.

A focus on preventing complications

A key indication for initiation of an SGLT2 inhibitor is chronic kidney disease (CKD), and we know that urinary albumin:creatinine ratio (uACR) is often a more sensitive marker of early kidney damage than estimated glomerular filtration rate (eGFR), yet it remains the least frequently completed diabetes care process. This commentary from Kidney Research UK serves as a timely reminder that early detection of CKD relies on measuring both eGFR and uACR, and calls on primary care teams to prioritise uACR testing in people at risk in order to facilitate earlier intervention and improve renal and cardiovascular outcomes.

Despite the growing prominence of SGLT2 inhibitors and GLP-1 receptor agonists, statin therapy continues to underpin cardiovascular risk reduction and remains a fundamental component of care. Evidence in *Diabetes Distilled* that statins are effective for primary cardiovascular prevention in selected older adults, reducing major cardiovascular events by nearly one-third, is reassuring although, as with SGLT2 inhibitors and GLP-1 receptor agonists, decisions to initiate treatment should be individualised through shared decision-making, balancing cardiovascular benefit against frailty, comorbidity, treatment burden and the priorities of each individual.

At the other end of the age spectrum, a more assertive and proactive approach is usually required. Women with a history of gestational diabetes, for example, should be considered at high cardio-kidney-metabolic risk. This quality improvement project demonstrates how a simple, structured primary care pathway can transform follow-up after gestational diabetes, improving surveillance for both type 2 diabetes and cardiovascular risk factors, whilst supporting a more proactive and preventative approach to women's health.

However, in an era of increasingly advanced therapies and technologies, and more intensive and proactive management strategies, we must balance the pursuit of improved clinical outcomes with an understanding of the psychological, social and practical realities that influence a person's ability to achieve them. In this commentary, Emmanuel Ekpor and colleagues challenge us to ensure that clinical targets inform person-centred care rather than becoming measures of success or failure. The article is a valuable reminder that language and communication are as important as the metrics themselves, and that the person, not the number on the screen, should always be at the centre of every consultation. The way we discuss HbA_{1c}, weight and other metrics can either empower people or inadvertently reinforce stigma.

As the post-summer lull gives way to a busy and exciting period, there is certainly no shortage of topics demanding our attention. I hope you enjoy this packed issue, and I shall look forward to catching up with those of you attending the PCDO Society National Conference in Birmingham on 18–19 November.