EASD 2026 highlights: Updated type 2 diabetes consensus, incretins and beyond, and reversing the diabetes epidemic

The 62nd Annual Meeting of the European Association for the Study of Diabetes (EASD) was held in Milan between 28 September and 2 October 2026. In addition to data on new and developmental therapies for diabetes and weight management, highlights from the meeting included an update to the EASD and American Diabetes Association's joint consensus report on type 2 diabetes management. In this short report, we outline the key messages from the meeting.

ADA/EASD consensus report updated for 2026

Four years after the EASD and American Diabetes Association last updated their joint consensus report on management of hyperglycaemia in type 2 diabetes, a 2026 update was announced at the meeting and simultaneously published in *Diabetes Care* and *Diabetologia*.

The updated consensus takes a broader view than previously, focusing beyond hyperglycaemia to cover proactive, holistic management of type 2 diabetes, its complications and associated multiple long-term conditions. Among the proactive approaches recommended are:

- Earlier use of SGLT2 inhibitors and GLP-1-based therapies to modify disease and reduce complication risk, with particular attention to tailoring therapy towards the individual's own cardiovascular, renal and liver risk.
- More prominent focus on monitoring and treating conditions that can coexist with type 2 diabetes, such as heart failure, metabolic dysfunction-associated steatotic liver disease (MASLD), obstructive sleep apnoea, mental health conditions such as anxiety and depression, and periodontal health. The recommendations extend beyond the eye, foot and kidney complications that are already typically monitored.

The consensus statement includes an updated algorithm on the use of glucose-lowering medications in the management of type 2 diabetes. Alongside nutrition and other behavioural interventions, the recommendations also include an updated 24-hour framework that organises and promotes healthy behaviours across a full day.

The changes are reviewed in greater detail in our At a glance factsheet.

Retatrutide for obesity and type 2 diabetes management: TRIUMPH-2 study

Retatrutide is a triple agonist of GIP, GLP-1 and glucagon, currently in development. Results from the phase 3 TRIUMPH-2 study of retatrutide in people with obesity and type 2 diabetes were presented at the meeting, showing significant reductions in weight, HbA_{1c} and other cardiometabolic risk factors.

A total of 1152 adults with a BMI ≥27 kg/m^2 and HbA_{1c} 48–91 mmol/mol despite treatment with up to three oral glucose-lowering agents were randomised to one of three doses of retatrutide or placebo. After 80 weeks of treatment, according to the treatment-regimen estimand (assessing effects regardless of whether treatment was discontinued or interrupted, or whether other obesity medications were used), mean body weight fell by 11.9%, 16.8% and 18.8% with retatrutide 4 mg, 9 mg and 12 mg, respectively, and by 5.1% with placebo (P<0.001 for all comparisons with placebo). These are greater reductions than have generally been seen with GLP-1 and GIP/GLP-1 agonists in trials conducted in people with type 2 diabetes, although direct comparisons have not been made.

Mean HbA_{1c} also fell by 15.1, 16.4 and 15.8 mmol/mol with the three doses of retatrutide, compared with a reduction of 4.9 mmol/mol with placebo. This was accompanied by improvements in blood pressure, lipid profile, eGFR, uACR and C-reactive protein levels, as well as self-reported physical functioning scores.

Adverse effects occurred in 79–85% of retatrutide recipients versus 79% of placebo recipients, and the safety profile was similar to other incretin-based therapies: most commonly gastrointestinal in nature (although diarrhoea was more frequent than in comparable studies of other incretins). All cases of pancreatitis occurred in retatrutide recipients, whereas severe gallbladder and biliary tract disorders were reported with similar frequencies across all four study arms, including placebo. Treatment discontinuation due to adverse events was more common with higher doses of retatrutide.

The study was simultaneously published in *The Lancet*.

Survodutide in people with obesity and type 2 diabetes: SYNCHRONIZE-2

Survodutide is a dual agonist of GLP-1 and glucagon, currently in development. Results from the SYNCHRONIZE-2

study, presented at the meeting, showed significant reductions in weight – up to 13.1% at the highest dose – and HbA_{1c} compared with placebo in people with obesity and type 2 diabetes.

In this phase 3 trial, 752 adults with type 2 diabetes and a BMI ≥27 kg/m^2 were randomised to survodutide 3.6 mg or 6.0 mg. After 72 weeks of treatment, according to the treatment-regimen estimand, mean body weight had fallen by 8.2% and 9.8% in the survodutide 3.6 mg and 6.0 mg groups, respectively, versus 3.9% with placebo. Overall, 57.6%, 64.5% and 35.1% of the groups achieved the co-primary endpoint of weight reduction of at least 5%. Mean HbA_{1c} fell by 9.8 and 8.7 mmol/mol in the survodutide groups, versus 2.2 mmol/mol with placebo.

The most commonly reported adverse events with survodutide were gastrointestinal events, and 18% of survodutide recipients discontinued treatment due to gastrointestinal events, compared with 1.2% of placebo recipients. This high discontinuation rate was likely because the study protocol allowed only limited flexibility to manage adverse events; discontinuations mostly occurred during dose escalation.

Results from the cardiovascular outcomes trial of survodutide (SYNCHRONIZE-CVOT) are expected later this year.

The study was simultaneously published in the *New England Journal of Medicine*.

Amylin agonist petrelintide for obesity management

Data from the phase 2 ZUPREME-1 study showed that petrelintide, a long-acting amylin analogue being developed for long-term treatment of obesity, led to weight loss of up to 10% in people with obesity but no type 2 diabetes. Weight loss was lower than with the newer incretin-based therapies but came with fewer side-effects.

A total of 485 people were randomised to one of five doses of petrelintide (1.0–9.0 mg per week) or placebo for 42 weeks, including a dose-escalation period. Data were presented for the efficacy estimand, representing the efficacy if all randomised participants had remained on study intervention (with possible dose interruptions and/or dose modifications) for the study period.

Mean percentage body weight at 42 weeks fell by 8.7%, 9.2%, 10.7%, 10.5% and 10.2% with petrelintide 1.0 mg, 2.5 mg, 5.0 mg, 7.0 mg and 9.0 mg, respectively, compared with a weight loss of 1.7% in the placebo group. Improvements in blood pressure, C-reactive protein and lipid profiles were also observed.

The most common adverse event with petrelintide was nausea, occurring in 20% of recipients (all doses pooled) versus 6% of placebo recipients. Vomiting was infrequent with petrelintide (3% vs 6% with placebo), and there were similar rates of diarrhoea (7% vs 7%) and constipation (7% vs 4%) between the groups. Overall, 18 serious adverse events were reported during the trial, with similar incidences in the petrelintide and placebo groups, and with no apparent association with dose or treatment group. Only 1.5% of participants discontinued petrelintide due to gastrointestinal adverse events, whilst 2.2% required dose reduction for this reason.

The study was simultaneously published in *The Lancet Diabetes & Endocrinology*.

Trevogrumab: selective myostatin inhibition helps preserve lean mass during and after weight loss with semaglutide

Trevogrumab, a developmental agent that inhibits myostatin (a myokine that inhibits muscle growth), was shown to reduce lean mass loss during treatment with semaglutide by 50% compared with semaglutide and placebo in a phase 2 study presented at the meeting.

Lean mass was assessed using dual-energy X-ray absorptiometry. In part A of the study, 599 participants were treated for 26 weeks with semaglutide plus trevogrumab 200 mg or 400 mg, or with semaglutide plus placebo. There then followed a semaglutide-withdrawal period, when participants received trevogrumab 400 mg or placebo for an additional 26 weeks.

At 26 weeks, lean mass had fallen by 6.6% in the placebo group. In contrast, it fell by 3.4% and 3.9% with trevogrumab 200 mg and 400 mg. After semaglutide discontinuation, lean mass fell by 2.4% in placebo recipients over the subsequent 26 weeks, whereas it increased by 0.4% in trevogrumab recipients.

In part B of the study, 376 participants were treated with semaglutide for 52 weeks and randomised to concomitant treatment with placebo or lower doses of trevogrumab (25 mg or 75 mg). In addition to assessing lean mass, an exploratory MRI substudy assessed muscle volume directly in 76 individuals.

After 52 weeks, compared with a lean mass loss of 7.3% with placebo, lean mass fell by 5.8% with trevogrumab 25 mg (difference not significant) and by 4.2% with trevogrumab 75 mg (difference significant). In the MRI substudy evaluating thigh muscle volume, co-treatment with trevogrumab reduced muscle loss by 69–72% compared with semaglutide plus placebo.

All doses of trevogrumab were generally well tolerated, with a safety profile comparable to semaglutide plus placebo.

The authors concluded that selective myostatin inhibition may help improve body composition during pharmacological weight loss, with an acceptable safety profile. Whether this muscle preservation translates into long-term improvements in physical function, metabolic health or clinical outcomes requires further investigation, however.

Structured diet and physical activity programme reverses early-onset type 2 diabetes in 50% of participants

Data from the RESET for Remission study in the UK and Canada showed that around half of early-onset type 2

diabetes cases could be put into remission using a combination of a low-energy liquid diet and a structured exercise programme.

The dietary intervention comprised 2 weeks of total diet replacement (TDR) providing 800–900 kcal/day, followed by 10 weeks of the same caloric intake but switching to one food-based meal per day alongside TDR. The exercise intervention comprised twice-weekly supervised exercise sessions (aerobic and resistance) and once-weekly independent exercise for 12 weeks. Both interventions were then followed by a weight-maintenance diet and independent exercise (weeks 13–24). Participants stopped all glucose- and blood pressure-lowering medication at study start.

In total, 96 participants with type 2 diabetes onset at age 18–45 years were randomised to intervention or usual care, and 86 attended final assessments. Remission at 24 weeks occurred in 54% of the intervention group versus 4% of the control group (adjusted odds ratio 21.6). On average, the intervention group lost 7.5 kg more than controls by week 24 (7.0% of initial body weight), of which 6.6 kg was fat mass.

Most of the intervention group experienced at least one adverse event (86% vs 13%), mainly the early effects of the low-energy diet (e.g. constipation, headache, dizziness, fatigue), which resolved. No severe adverse events occurred.

Other remission trials, including DiRECT, have not included structured exercise in their interventions, as it was thought that this would increase hunger. The present intervention, however, aimed to achieve remission whilst also minimising loss of lean mass and muscle, which may have important implications for long-term metabolic health, physical function and disease trajectory. However, such outcomes require longer-term study in real-world populations.

The authors concluded that combining structured aerobic and resistance exercise with a low-energy diet has potential to deliver substantial and holistic health and wellbeing benefits alongside diabetes remission in people with early-onset type 2 diabetes. The approach may be particularly valuable in women of childbearing potential, for whom weight-loss medications present extra risks.

The study was simultaneously published in *The Lancet Regional Health – Americas*.

Mauritius shows signs of reversing type 2 diabetes epidemic

Research presented at the meeting suggests that Mauritius is the first country in the world to prove it is reversing the type 2 diabetes epidemic using the gold-standard testing method of the 2-hour oral glucose tolerance test (OGTT) recommended by the World Health Organization.

Mauritius is similar to many other island nations that have seen obesity and type 2 diabetes surge since the 1980s. However, it has closely monitored the rise via seven cross-sectional surveys conducted since 1987. These surveys suggest that prevalence of type 2 diabetes rose from 14.7% in 1987 to a peak of 23.3% in 2009, but have since begun to reverse, falling to 19.9% in 2021.

The authors attribute Mauritius's success to a number of multisectoral approaches, including:

1. Prevention: creating an action plan; policy (including advocacy and legislation); risk factor screening (including mobile clinics) for non-communicable diseases (NCDs); and community engagement and participation (including national action plans for nutrition, physical activity, and tobacco control).
2. A national integrated NCD action plan: a roadmap to improve health and wellbeing across the life course.
3. A national service framework for NCDs: a policy set to define standards of care for NCDs within a service protocol with appropriate quality standards. Public sector health services are free of charge, including essential medicines.

The study was simultaneously published in *The Lancet Diabetes & Endocrinology*.

News in brief

Eloralintide and tirzepatide: Combined amylin/GIP/GLP-1 agonism

Results from a phase 2b trial suggest that EloraTZP, a combination of eloralintide, a developmental amylin receptor agonist, with the GIP/GLP-1 agonist tirzepatide, led to significant weight and HbA_{1c} reductions in people living with obesity and type 2 diabetes.

A total of 367 participants were randomised to four doses of EloraTZP, or to three doses of eloralintide alone or tirzepatide 15 mg alone for 48 weeks. According to the efficacy estimand, at the highest dose of EloraTZP (eloralintide 9 mg + tirzepatide 15 mg), the mean weight loss was 23.3% and the average reduction in HbA_{1c} was 31.7 mmol/mol, compared with reductions of 14.8% and 26.2 mmol/mol with tirzepatide 15 mg alone.

Adverse events were more common with the combined therapy than the individual agents.

Type 2 diabetes and cancer incidence

Cancer incidence remains higher in people with type 2 diabetes, with the gap widening in recent years, according to population-level data from Denmark. Overall cancer incidence was 12% higher among men and 22% higher among women with type 2 diabetes compared with those without diabetes in 2010–2022. The corresponding differences in 1996–2009 were 9% and 15%.

The higher cancer incidence was particularly evident for obesity-related cancers, which were 45% higher in men and 30% higher in women compared to those without diabetes in 2010–2022; corresponding differences in 1996–2009 were 34% and 23%, respectively.

The results underline the importance of considering cancer prevention and early detection alongside other established aspects of diabetes care, particularly for common cancers such as colorectal and post-menopausal breast cancer.

Orforglipron non-inferior to insulin glargine for cardiovascular outcomes

Results from the phase 3 ACHIEVE-4 study comparing cardiovascular outcomes with the oral GLP-1 receptor agonist orforglipron showed non-inferiority compared with insulin glargine in people with type 2 diabetes at high cardiovascular risk.

A total of 2749 adults with type 2 diabetes and established cardiovascular or chronic kidney disease were randomised to orforglipron or insulin glargine, in addition to their previous therapy with up to three oral diabetes medications. Over a median follow-up of 2 years, the primary endpoint (a composite of cardiovascular death, non-fatal myocardial infarction, non-fatal stroke or hospitalisation for unstable angina) occurred in 4.2% of orforglipron recipients versus 5.0% of glargine recipients (hazard ratio 0.84; 95% confidence interval 0.59–1.20; $P<0.0001$ for non-inferiority).

Gastrointestinal events were more common with orforglipron, whilst hypoglycaemia was more common with glargine. The authors conclude that their findings support orforglipron as a potential once-daily, oral treatment option with established cardiovascular safety in people with type 2 diabetes and increased cardiovascular risk.

The results were simultaneously published in *The Lancet*.

Neurodiversity is common in people with early-onset type 2 diabetes

People with neurodiversity, particularly autism and attention deficit/hyperactivity disorder (ADHD), may be more likely to be diagnosed with type 2 diabetes at younger ages, with a particularly high prevalence in those diagnosed with type 2 diabetes before the age of 20 years, according to data from the TriNetX US collaborative network on 4.2 million individuals newly diagnosed with type 2 diabetes.

ADHD was over twice as prevalent among people diagnosed with type 2 diabetes before the age of 20 compared to similarly aged individuals without diabetes (14.4% vs 6.9%). Similarly, autism was more than three times as prevalent (5.72% vs 1.79%), and dyslexia and dyspraxia were also more common.

Although the observational design means the study cannot establish causality, the authors propose several factors that might contribute to this association, including lower levels of physical activity, sleep difficulties, medication use, mental health conditions and barriers to accessing healthcare. Factors earlier in life may also play a role; for example, maternal diabetes has been associated with neurodevelopmental outcomes and later cardiometabolic risk in children.

The results also underscore the importance of considering the needs of neurodivergent people when planning clinical services and support for those with early-onset type 2 diabetes.

Previous gestational diabetes linked to more severe and earlier development of type 2 diabetes

Research from Denmark suggests that women with a history of gestational diabetes (GDM) develop type 2 diabetes almost 13 years earlier on average than those without GDM and are twice as likely to have more advanced disease requiring insulin treatment within the first two years after type 2 diabetes diagnosis.

Type 2 diabetes registry data were used to compare 173 women with a history of GDM versus 2965 with no prior GDM. In the GDM group, type 2 diabetes was diagnosed at a median age of 43.5 years, compared with 56.3 years in those without a history of GDM, and women with previous GDM had a 2-fold higher prevalence of insulin treatment (10.4% vs 5.2%) and lower fasting levels of serum C-peptide (median 1068 pmol/L vs 1195 pmol/L), indicating lower insulin production.

However, BMI, HbA_{1c} and fasting plasma glucose were found to be similar between the groups, and the prevalence of nephropathy, neuropathy and cardiovascular disease were comparable.

These findings underscore the importance of enhanced monitoring and follow-up strategies for women with a prior GDM diagnosis.