

Addressing the Continuum of Dysglycaemia and Vascular Complications in Prediabetes and Type 2 Diabetes: Need for Early and Intensive Treatment

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Abstract: The onset of type 2 diabetes increases the risk of vascular complications and death. We know now that that this risk begins long before the diabetes diagnosis. Prediabetes and type 2 diabetes are not separate entities in practice and exist within a continuum of dysglycaemia and vascular risk that increases in severity over time. This excess risk requires early intervention with lifestyle therapy supported with pharmacologic antidiabetic therapy, intensified promptly where necessary throughout the duration of the diabetes continuum. Metformin is an evidence-based treatment for preventing prediabetes and improves cardiovascular outcomes in people with type 2 diabetes from diagnosis onwards. Newer agents (SGLT2 inhibitors and GLP-1 agonists) are appropriate for people presenting with type 2 diabetes and significant cardiovascular comorbidity. Additional therapies should be used without delay to achieve patients' individualised HbA1c goals and to minimise cardiovascular risk.

Keywords: prediabetes, type 2 diabetes, diabetes complications, antidiabetic therapy

Introduction

The publication of the Diabetes Control and Complications Trial in 1993 proved conclusively that long-term hyperglycaemia in the setting of type 1 diabetes was associated with cardiorenal complications with the potential to reduce greatly both the quantity and quality of patients' lives.¹ This was also the first randomised trial to prove that intensive vs standard control of blood glucose reduced the risk of diabetes complications. The results of the UK Prospective diabetes Study (UKPDS) in 1998 showed that intensive glucose management per se (compared with diet-based treatment only) delivered significant reductions in long-term microvascular complications in people with type 2 diabetes,² with significant cardiovascular outcome benefits observed in patients randomised to metformin vs the diet intervention.³ These landmark trials, together with epidemiological associations of hyperglycaemia and adverse clinical outcomes, underpinned the design of diabetes management algorithms intended to preserve long-term health among people with diabetes.

Current management recommendations for type 2 diabetes include individualised HbA1c goals based on age, comorbidities, patient preferences, risk of adverse effects of treatment, and other factors.^{4,5} A general recommendation to reduce HbA1c to <7.0% for most non-pregnant adults reflects observations that the risk of diabetes complications begins to increase more steeply above this level of HbA1c, although there is no lower cut-off for HbA1c that negates the risk of complications.^{6,7} Concepts of "prediabetes", "intermediate hyperglycaemia", or "non-diabetic hyperglycaemia" have evolved to characterise the substantial population with markers of blood glucose that are elevated, but insufficiently

to trigger the diagnosis of type 2 diabetes. In practice, there is growing recognition that the boundary between prediabetic states and clinical type 2 diabetes is arbitrary, in that it does not mark a starting point for increased risk of diabetes-associated complications.⁸ In this article, we review the evidence that prediabetes and diagnosed type 2 diabetes represent a continuum of vascular risk that should be managed early and continuously.

Clinical Relevance of the Diabetes Continuum Glycaemic Control

Individuals at risk of developing type 2 diabetes demonstrate a progressive increase in indices of glycaemia. The development of insulin resistance at this time prompts increased secretion of insulin to maintain blood glucose near normal levels, despite a concurrent progressive decline in pancreatic β -cell function.⁹ Increases in fasting glucose and post-load glucose and HbA1c occur during this period that can prompt a diagnosis of prediabetes according to criteria provided by expert societies (the diagnostic cut-offs used to diagnose prediabetes and type 2 diabetes are summarised in Table 1).^{10,11} Interestingly, there is evidence that men tend to present with prediabetes driven by elevation of fasting glucose (impaired fasting glucose; IFG), driven by increased hepatic glucose output and blunted first-phase insulin secretion, while women tend to present with elevation of post-load glucose (impaired glucose tolerance; IGT), driven by insulin resistance in the periphery.¹² Systematic reviews have associated changes in the gut microbiome with insulin resistance, prediabetes and type 2 diabetes, with some evaluations of probiotics demonstrating improvements in glycaemic control.^{13–15} These associations are variable, however, and this approach remains in the arena of research. Further study will be needed in this area before targeted modulation of the gut microbiome joins the evidence-based interventions for managing the diabetes continuum that are described later in this article.

Any form of prediabetes markedly increases the risk of developing subsequent type 2 diabetes. For example, up to 8 years of longitudinal follow-up of a cohort in Sweden showed that IFG and impaired glucose tolerance (IGT) increased the risk of developing type 2 diabetes by about 2-fold and 5-fold, respectively, compared with normoglycemic subjects, with a higher risk still for subjects with combined IFG and IGT.¹⁶ A meta-analysis of observational studies showed that IGT and IFG (American Diabetes Association [ADA] criteria) increased the 5-year risk of type 2 diabetes by about 3–5-fold, with a higher risk of about 7–8-fold associated with elevated HbA1c.¹⁷

Eventually, β -cell function declines to a point where it is no longer possible to maintain the level of insulin secretion needed to overcome insulin resistance: blood glucose increases further and clinical type 2 diabetes becomes established.⁹ It is important to note that these diagnoses are categorical, in that only a small increase in the level of hyperglycaemia is required to progress from any category of prediabetes to clinical type 2 diabetes. In addition, the impairments in insulin sensitivity and β -cell function begin long before diabetes is diagnosed: for example, data from the UKPDS suggested that β -cell function had been declining for as much as 12 years before the initiation of the trial, on average, in this population

Table 1 Diagnosis of Prediabetes and Type 2 Diabetes

	Type of Measurement			
	Fasting Plasma Glucose	Post-OGTT Glucose ^a	HbA1c	Random Glucose
Prediabetes:				
Impaired fasting glucose:	5.7–6.9 mmol/L (100–125 mg/dL) ^b	–	–	–
Impaired glucose tolerance:	–	7.8–11.0 mmol/L (140–199 mg/dL)	–	–
Elevated HbA1c	–	–	5.7–6.4% (39–47 mmol/mol) ^c	–
Type 2 diabetes:	≥7.0 mmol/L (≥126 mg/dL)	≥11.1 mmol/L (≥200 mg/dL)	≥6.5% (≥47 mmol/mol)	≥11.1 mmol/L (≥200 mg/dL)

Notes: ^aGlucose values following a standard, 75 g oral glucose tolerance test; ^blower cut-off value = 6.1 mmol/L (110 mg/dL) according to World Health Organization criteria; ^cor increase in HbA1c of ≥10% according to American Diabetes Association criteria. Data from these studies.^{10,11}

Abbreviation: OGTT, oral glucose tolerance test.

with newly-diagnosed type 2 diabetes.¹⁸ Finally, the magnitude of increases in blood glucose in people with prediabetes or early type 2 diabetes is not sufficient to produce symptoms of hyperglycaemia and prediabetes and type 2 diabetes often go undiagnosed. For example, more than 8/10 people with prediabetes in the USA do not know they have the condition¹⁹ and surveys of community-based populations have discovered substantial proportions of people with previously undiagnosed diabetes.^{20–23}

Vascular Complications

The increase in the risk of major adverse cardiovascular events in people with vs without type 2 diabetes has been understood for decades.⁶ Although mortality rates in people with diabetes have been falling in recent years, likely due to increased medical management of cardiovascular risk factors and cardiac events, the magnitude of the excess mortality in people with vs without diabetes has remained constant over time.²⁴ This section will therefore focus on the less well-understood relationships between prediabetes and adverse vascular outcomes.

Observational studies^{25–28} and systematic reviews^{29–31} have demonstrated an increased risk of adverse macrovascular complications, including all-cause mortality, reminiscent of type 2 diabetes in populations with IFG and/or IGT, although it should be noted that such associations have not been seen in all studies.³² Figure 1 shows an example of the associations of prediabetes diagnosed as IFG, IGT and elevated HbA1c with a range of adverse macrovascular outcomes from a recent systematic review: prediabetes, however diagnosed, increased the risks of all-cause and cardiovascular death, cardiovascular events, coronary heart disease events, and stroke.³⁰

To some extent, the excess cardiovascular risk associated with prediabetes may be mediated by classical cardiovascular risk factors associated with insulin resistance and the metabolic syndrome.^{33–36} Women tend to demonstrate more adverse classical cardiovascular risk profiles during conversion from prediabetes to type 2 diabetes, compared with men.³⁷ Endothelial dysfunction has been observed in people with prediabetes and this increases the risk of subsequent conversion to type 2 diabetes.³⁸ Although endothelial dysfunction has been associated with insulin resistance,^{39,40} evaluations of interventions designed to ameliorate insulin resistance, such as diet and exercise, have been mixed.^{41–43} Treatment with metformin has been shown to improve coronary endothelial function in people with prediabetes and pre-existing coronary artery disease.⁴⁴ Accelerated atherosclerosis has also been observed in people with prediabetes, as measured by carotid intima-media-thickness,^{45,46} a validated surrogate measure of the overall burden of atherosclerosis⁴⁷

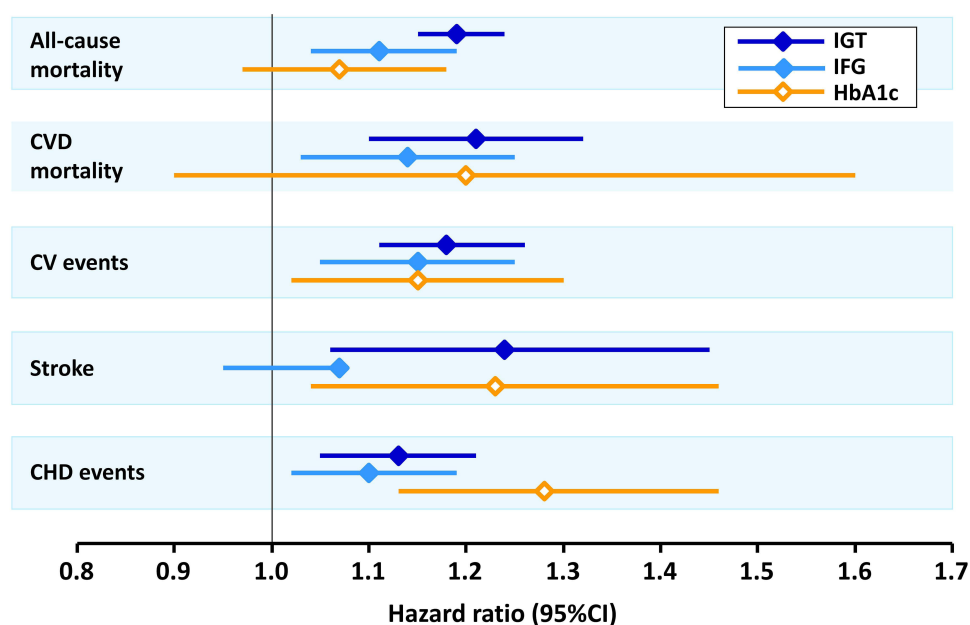


Figure 1 Associations between different definitions of prediabetic states and adverse macrovascular outcomes from a systematic review.

Notes: Definitions of prediabetic states shown here were according to American Diabetes Association criteria. Data from Gujral et al.³⁰

Abbreviations: CHD, coronary heart disease; CVD, cardiovascular disease; IFG, impaired fasting glucose; IGT, impaired glucose tolerance.

and a powerful predictor of cardiovascular risk.⁴⁸ Heart failure is now recognised as the most commonly occurring cardiorenal complication of type 2 diabetes.^{49,50} Observational studies or systematic reviews have^{51,52} or have not^{30,32} demonstrated strong associations of incident heart failure with prediabetes. Other analyses suggested more adverse outcomes from pre-existing heart failure in populations with vs without prediabetes.^{53–55} The excess risk of cardiovascular disease associated with type 2 diabetes is markedly greater for women vs men; although current data suggest that women with IGT, but not IFG, may be at higher risk of adverse cardiovascular outcomes.³⁷

A number of studies have demonstrated a higher risk of microvascular changes in people with vs without prediabetes. Adverse microvascular changes in the eye have included abnormalities in retinal arteriolar structure or function,^{56–59} macular thinning,⁶⁰ or impaired retinal function.⁶¹ A diagnosis of prediabetes was associated with a higher risk of diagnosis of retinopathy in a retrospective study in a primary care population.⁶² Again, it should be noted that not all studies have associated significant adverse microvascular findings in the eye with prediabetes.⁶³ Similarly, prediabetes has been associated with dysfunction of the kidney.^{30,62,64–72} Evidence of neuropathy or microvascular dysfunction has been found in people with vs without prediabetes in skin,⁵⁶ the heart,^{73,74} and in sensory nerves.⁷⁵ Other studies showed trends to adverse changes in nerve function, rather than overt neuropathy, in people with prediabetes.^{76–79} Prediabetes has also been associated with loss of brain volume and other potentially adverse ultrastructural changes.^{80,81} In general, the severity of these adverse changes in people with prediabetes was intermediate between those with normoglycaemia and type 2 diabetes.⁸²

Intervening in the Diabetes Continuum

The data summarised above show that the insidious and largely undiagnosed and untreated progression of hyperglycaemia in the setting of prediabetes (and undiagnosed type 2 diabetes) can persist for a decade or more, leaving the vascular system exposed to an increased risk of vascular and cardiac complications similar to those observed in people with established type 2 diabetes. **Figure 2** summarises key principles in the management of the diabetes continuum, which are described below.

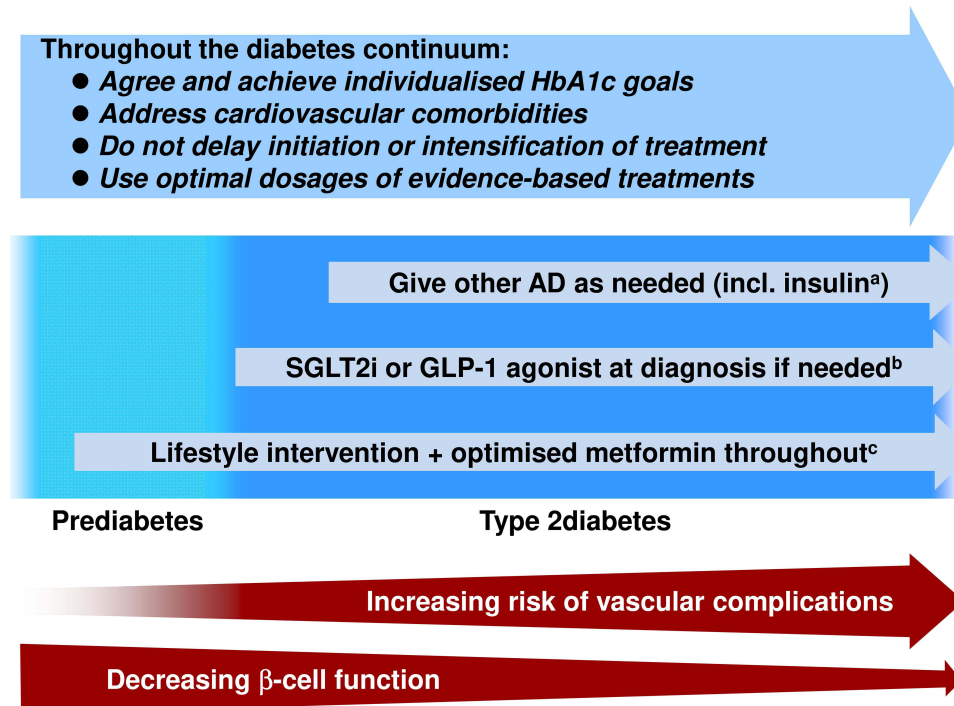


Figure 2 Schematic representation of key goals in managing the diabetes continuum.

Notes: ^aUse with caution in combination with SGLT2 inhibitor or sulfonylurea to minimise risk of hypoglycaemia; ^bpatients with established cardiovascular disease or heart failure at presentation (see text); ^cfor selected people with prediabetes (see text⁹⁴) and/or at diagnosis of type 2 diabetes consistent with joint guidance from the American Diabetes Association/European Association for the study of Diabetes.⁴

Abbreviation: AD, antidiabetic drug.

Intervene Early to Optimise Long-Term Outcomes – Prediabetes

Early intervention is important for interrupting this process and optimising long-term outcomes. Lifestyle intervention remains the foundation treatment for all stages of the diabetes continuum and all subjects with prediabetes or established diabetes should be encouraged to improve their diets and increase their level of physical activity. Two landmark randomised studies in subjects with IGT, the Diabetes Prevention Program (DPP, USA)⁸³ and the Diabetes Prevention Study (DPS, Finland)⁸⁴ showed that an intensive lifestyle intervention (≥ 150 min/week of moderate exercise and improved diet aimed at facilitating weight loss) reduced the risk of developing diabetes by 58% over 3 years, compared with standard lifestyle advice. The DaQing study, a cluster randomised trial in subjects with IGT in China, showed that, either exercise or diet plus exercise reduced significantly the 6-year risk of diabetes.⁸⁵ The benefit for diabetes prevention persisted long after the end of the randomised trials, with lower incidences of diabetes for former intervention vs former control groups after 25 years (DPP),^{86–88} 13 years (DPS),⁸⁹ and 30 years (DaQing).⁹⁰ Importantly, the diabetes prevention intervention in the DaQing study (for pooled diet and exercise groups vs control) resulted in a significantly reduced risk of cardiovascular events, microvascular events, and mortality after 30 years of follow-up.⁹⁰ Long-term follow up to the DPP did not produce sufficient events to demonstrate significant outcomes benefits for individual study interventions, but diabetes prevention per se in the overall population was associated with improved cardiovascular and microvascular outcomes.⁸⁶ Finally, we focused on these three studies here because of their long-term follow-up programmes; many other studies have demonstrated the benefits of lifestyle interventions in people with prediabetes, and these are reviewed elsewhere.⁹¹

Many patients cannot, or will not, comply with lifestyle interventions, however, and pharmacologic interventions also have the potential to prevent/delay the onset of type 2 diabetes.⁹¹ Metformin has the largest clinical evidence base for use in prediabetes and had been granted a therapeutic indication for this purpose in 67 countries in 2017.^{92,93} Metformin reduced the incidence of diabetes by 31% vs standard lifestyle advice in the DPP, but was similarly effective to the intensive lifestyle intervention in this trial (see above) in younger, heavier, and more hyperglycaemic subjects.⁸³ Guidelines or expert opinion in Europe and the USA support the use of metformin in this population, and also in women at risk of type 2 diabetes through prior gestational diabetes (Table 2).^{94–96}

The DPP did not demonstrate clinical outcomes benefits for any individual study arm, as described above. However, a real-world analysis has shown that the use of metformin in people with prediabetes was associated with a significantly lower ($p < 0.001$) incidence of new cardiovascular disease for people with BMI ≥ 35 kg/m² (21%) vs < 35 kg/m² (28%), which is consistent with current guidance in this area.⁹⁷

Table 2 European and US Guidance on the Use of Metformin to Prevent or Delay the Onset of Type 2 Diabetes

	Overview of Recommendations on Pharmacologic Diabetes Prevention
ADA (2023) ⁹⁴	Consider adding metformin to lifestyle intervention especially for subjects with: <ul style="list-style-type: none"> • BMI ≥ 35 kg/m², • Age 25–59 years • Fasting glucose > 6.1 mmol/L (110 mg/dL) • HbA1c $> 6.0\%$ • Prior history of gestational diabetes
NICE (2020) ⁹⁶	Consider metformin (+ lifestyle intervention) for people whose HbA1c is rising despite lifestyle intervention, or where the patient is unable to undertake a lifestyle intervention – especially if BMI is ≥ 35 kg/m ² Discontinue after 6–12 months if there is no improvement in glycaemia Also consider orlistat for weight loss if BMI ≥ 28 kg/m ²
European expert group (2010) ⁹⁵	Consider metformin or acarbose for diabetes prevention in people with IGT Consider orlistat for obese subjects
ESC (2019) ¹⁰¹	Consider lifestyle changes to reduce the risk of new-onset diabetes and cardiovascular risk only, with no advice on pharmacological intervention in people with prediabetes

Note: All recommendations on metformin assume an absence of contraindications and concurrent application of a lifestyle intervention.

Abbreviations: ADA, American Diabetes Association; EASD, European Society for the Study of Diabetes; ESC, European Society of Cardiology; NICE, National Institute of Health and Care Excellence.

Intervene Early to Optimise Long-Term Outcomes – Type 2 Diabetes

The primary randomisation of the UKPDS included allocation of 753 people with newly diagnosed type 2 diabetes to receive 10 years of intensive glycaemic management with metformin or to the diet control arm.³ Randomisation to metformin was associated with clinically and statistically significant reductions in mortality and endpoints related to cardiovascular disease that were greater than those expected from improved glycaemic control alone.³ Intensive glycaemic management with sulfonylurea or insulin in the UKPDS significantly reduced microvascular endpoints in a larger population of 3867 patients, without significant cardiovascular benefit.²

Patients returned to the care of their usual physicians at the end of the randomised phase of the UKPDS, and average HbA1c quickly became similar between the two groups.⁹⁸ A further 10 years of epidemiological follow-up of these patients showed that the cardiovascular benefit of metformin was still evident for patients who did vs did not receive randomised treatment with metformin, with fewer macrovascular events and lower mortality.⁹⁸ Cardiovascular benefits were also evident at this time for people who had formerly been randomised to sulfonylurea/insulin vs those who did not, including significantly lower rates of all-cause mortality and myocardial infarction.⁹⁸ Thus, early and intensive intervention to control glycaemia can provide long-term reductions in mortality and cardiovascular events over and above those seen during initial short-term treatment. These “legacy benefits” of intensive glycaemic control applied early were not observed in populations with more advanced diabetes after intensification of blood glucose control.⁹⁹

The cardiovascular protection observed with metformin in newly diagnosed type 2 diabetes patients in the UKPDS supports initiation of pharmacologic antidiabetic pharmacotherapy with this agent, and this remains consistent with the recommendation of the joint guideline from the ADA and European Association for the Study of Diabetes where patients do not have pre-existing heart failure or cardiovascular or renal dysfunction.⁴ European Society of Cardiology guidance includes metformin as a first-line management option.¹⁰⁰ Metformin can be combined with any other glucose-lowering treatment. Both guidelines agree that patients with new type 2 diabetes and established cardiovascular disease should be considered for treatment with a GLP-1 agonist, and patients with heart failure or chronic kidney disease should be considered for a SGLT2 inhibitor.

Long Term Diabetes Management

Starting with Metformin

Antidiabetic treatments must also be given at an effective dose. For example, the DPP employed a target dose of metformin of 1750 mg/day for diabetes prevention⁸³ and the median dose of metformin, the most common first pharmacologic antidiabetic therapy, in the UKPDS was 2550 mg/day.¹ Randomised trials and many observational studies indicate cardiovascular benefit with metformin at all stages of type 2 diabetes (reviewed elsewhere).^{101,102} These are important considerations, because in the clinical experience of the authors, metformin is often under dosed, especially in prediabetes. A range of tablet strengths facilitates titration of metformin, and in the authors’ experience, use of a 750 mg metformin tablet facilitates achievement of a dose of 1500 mg for prediabetes, and the 1000 mg XR tablet facilitates achievement of the maximum dosage of 2000 mg/day.

Metformin is generally safe and well tolerated by most patients if initiated and titrated appropriately, including in people with prediabetes, and an extended-release formulation has been shown to have better gastrointestinal tolerability than the older, immediate-release version.^{103,104} It is important to monitor patients carefully for the existence or appearance of contraindications to metformin that might increase the risk of lactic acidosis. In addition, the presence of significant cardiovascular comorbidities at diagnosis may require additional use of a GLP-1 agonist or SGLT2 inhibitor, as described above.

Countering Clinical Inertia Over the Longer Term

“Clinical inertia” describes the situation where a patient who requires initiation or intensification of therapy does not receive it, or receives it only after an unnecessary delay.^{105–107} People who are at all stages of the diabetes continuum are at risk from therapeutic inertia, from under treatment of prediabetes, via delayed antidiabetes treatment on type 2 diabetes diagnosis, to reluctance to initiate insulin late in the course of diabetes.^{105–107} The result is unnecessary exposure of people with prediabetes or diabetes to long-term hyperglycaemia and increased risk of diabetes complications.

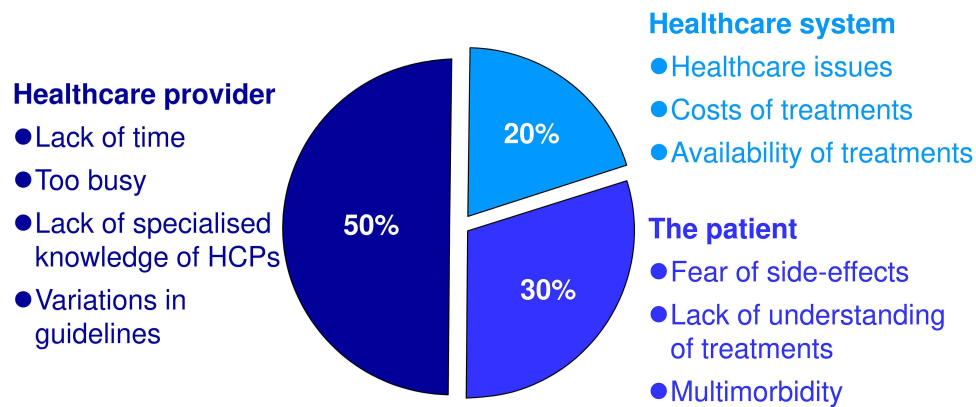


Figure 3 Principal sources of therapeutic inertia: contributions from the healthcare system, healthcare providers, and the patients themselves.

Notes: Data from Khunti S, Khunti K, Seidu S.¹⁰⁵ Percentages shown are the relative contributions of each domain to the overall problem of clinical inertia in the opinion of the authors of reference.¹⁰⁵

Three key sources of clinical inertia have been identified, relating to the patient (estimated as contributing 30% of the problem), health-care providers (50% of the problem) and the health-care system itself (30% of the problem).^{105–107} Multiple factors are at play within each of these areas and these are summarised in Figure 3.¹⁰⁵ Clearly, different factors are likely to impact the care of each individual patient. This, in turn, emphasises the key importance of individualised patient care in order to understand and overcome barriers to effective and timely delivery of care. Therapeutic inertia has been described as “the enemy of therapeutic success in the management of diabetes and its complications”.¹⁰⁷ Avoiding clinical inertia by prompt application of required treatments (or intensification of treatments) holds the key to improving long-term outcomes at all stages of the continuum of dysglycaemia.

Conclusions

Prediabetes and type 2 diabetes are not separate entities: in practice, they exist as a continuum of dysglycaemia and increasing vascular risk. Indeed, multiple studies have now demonstrated that the increased risk of vascular complications usually associated with type 2 diabetes is evident in people with early forms of dysglycaemia that are commonly described as prediabetes. This adverse process may continue for more than a decade before a formal diagnosis of type 2 diabetes is reached. There is an opportunity here to intervene early and intensively with lifestyle intervention and evidence-based pharmacologic therapies. Metformin is supported evidence-based treatment for prediabetes in a defined subgroup of subjects and has been shown to improve long-term outcomes at all stages of diabetes. GLP-1 agonists and SGLT2 inhibitors are also available for people presenting with type 2 diabetes and established cardiovascular comorbidities. The same approach must be maintained later in the course of the continuum, with prompt and effective intensification of treatment, without undue delay and unnecessary exposure of the patient to hyperglycaemia.

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