The Importance of Early Glycemic and Weight Control in T2D

The Challenge

Persistent elevation of HbA1c (≥6.5%), for even 1 year postdiagnosis, is associated with **increased long-term risk of diabetes complications** vs. HbA1c <6.5%[a,1]

Up to 74% of adults with T2D globally have an **HbA1c ≥7%**[b,2-4]

>50% of adults with T2D in the USA **remain untreated** 1 year postdiagnosis[5]



Second-line glucose-lowering therapies are typically only initiated **4.6-6.9 years** after T2D diagnosis[c,6]



>85% of adults with diabetes globally live with overweight or obesity[d,7,8]

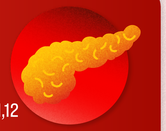


Higher BMI is generally associated with a **higher HbA1c**[e,2]



Excess weight, particularly visceral adiposity, can lead to **hyperglycemia** due to **increased insulin resistance** and reduced **β-cell function**[9,10]

≥50% of β-cell function may already be lost by the time of T2D onset[11,12]



The Opportunity

Early and **intensive** glycemic control **can reduce the risk of long-term complications** in patients with T2D[13,14]

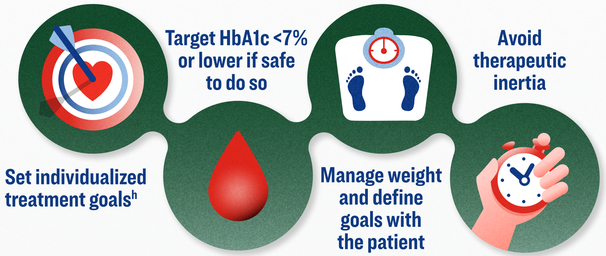
Long-term **legacy benefits of early HbA1c reduction**[f,14]: *(10 years post-trial period)*

- ↓**24%** **Microvascular disease**
- ↓**15%** **Myocardial infarction**
- ↓**13%** **All-cause mortailty**



- **Weight reduction** in adults with overweight/obesity and T2D **reduces HbA1c**[g,15]
- **5%-7%** weight reduction helps to improve obesity-related complications[16]
- Sustained reductions of **>10%** confer additional benefits[16]

The 2026 ADA Standards of Care call for a holistic, person-centered approach to care that addresses **glycemic control** and **weight management**[16,17]



Summary

Early and intensive control of HbA1c and weight in T2D management can improve long-term outcomes associated with T2D[13,14,16]

[a]10-year follow-up from the Diabetes and Aging study (1997-2013; average follow-up: 13.0 years; N=34,737) reported increased risk of microvascular and macrovascular events 10 years postdiagnosis for those with elevated HbA1c (mean HbA1c ≥6.5%) 1 year postdiagnosis vs. those with early HbA1c control. [b]Data from 5 European countries, USA, Australia, and Brazil. [c]Reported by the DISCOVER program, comprising two similar 3-year, prospective, observational studies (NCT02322762 and NCT02226822; N=15,992). [d]Data from 8 European countries and the USA. [e]Data from a retrospective database study with data from 6 countries (N=1,456,898); patients with T2D and BMI ≥30 kg/m^2 were more likely to have HbA1c ≥7% than individuals with BMI <30 kg/m^2. [f]10-year data from the post-trial monitoring study of UKPDS (2008; N=4209). Data are for participants who received intensive therapy with sulfonylurea or insulin. [g]Observational analysis of participants with overweight or obesity and T2D in the Look AHEAD study (NCT00017953; N=5145). [h]Goals should be based on individual patient characteristics and comorbidities, with treatment choices considering impact on weight, hypoglycemia, cardiovascular and kidney protection, and MASLD.

ADA=American Diabetes Association; BMI=Body Mass Index; HbA1c=Glycated Hemoglobin; MASLD=Metabolic Dysfunction-Associated Steatotic Liver Disease; T2D=Type 2 Diabetes; UKPDS=UK Prospective Diabetes Study.

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