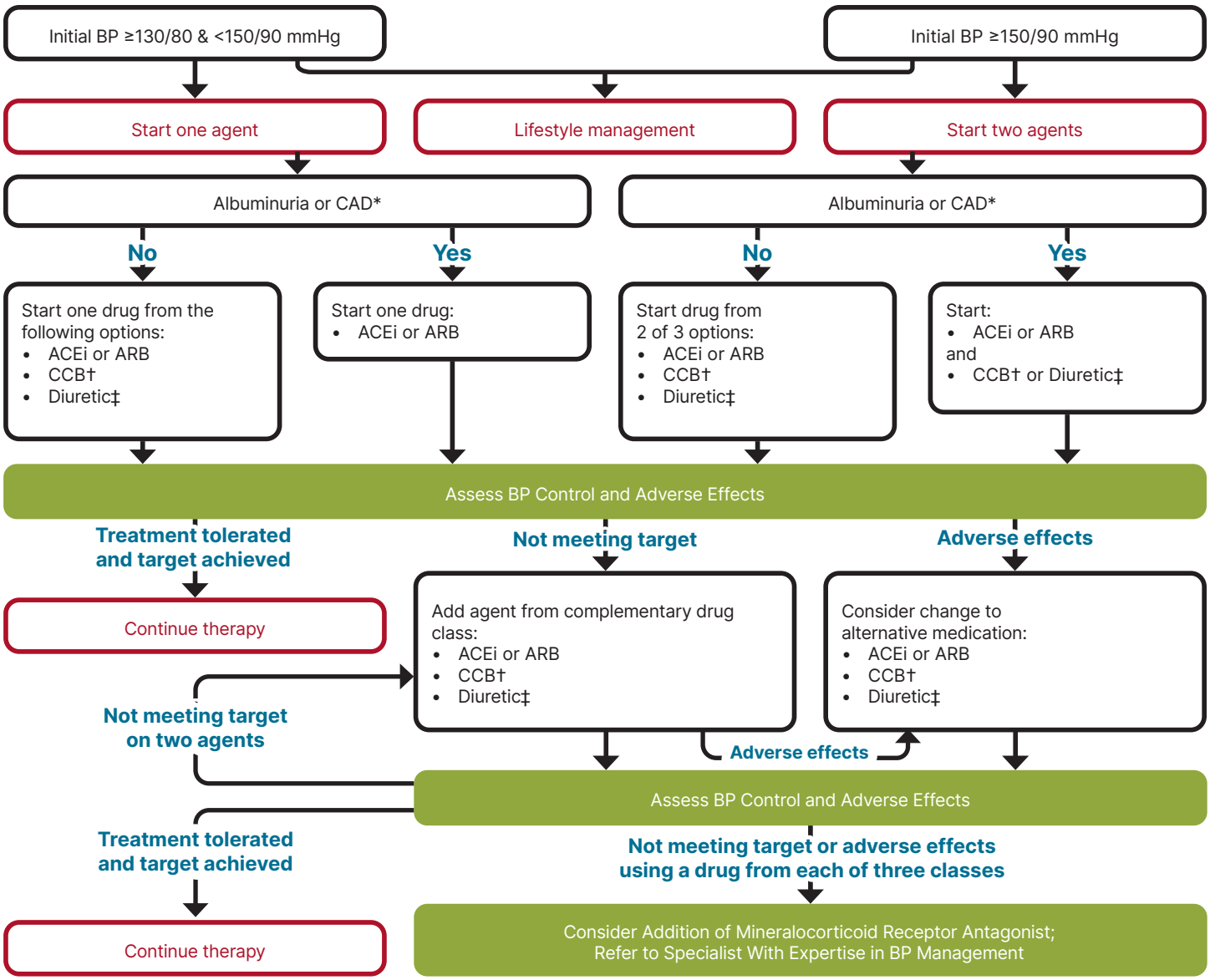
Section 10:

Cardiovascular Disease and Risk Management

Atherosclerotic cardiovascular disease (ASCVD), encompassing coronary heart disease, cerebrovascular disease, and peripheral artery disease (PAD) presumed to be of atherosclerotic origin, is the primary cause of morbidity and mortality in individuals with diabetes, leading to significant health care costs. Managing multiple risk factors simultaneously can prevent or slow the progression of ASCVD. Heart failure is another major cause of morbidity and mortality from cardiovascular disease.

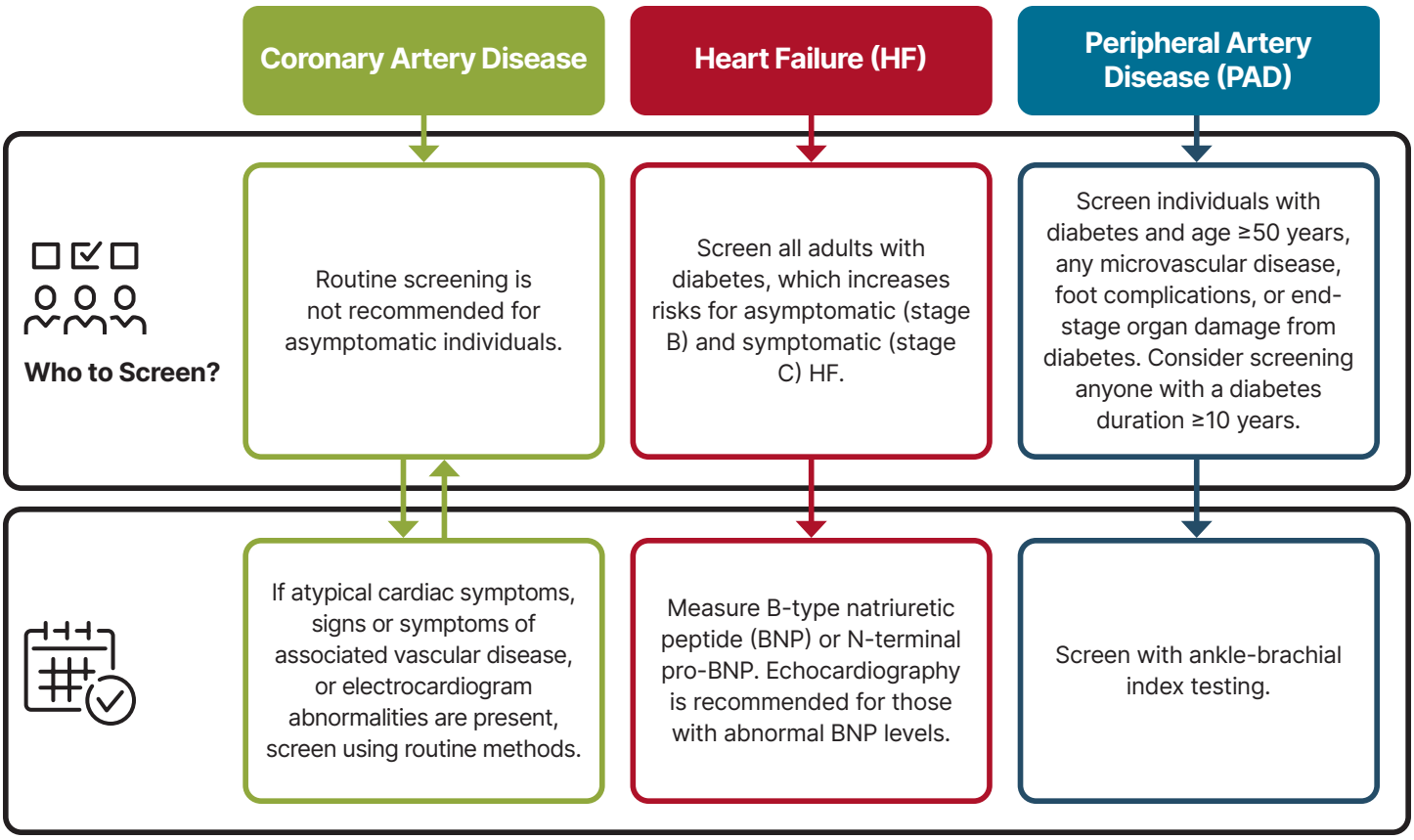
Recommendations for the Treatment of Confirmed Hypertension in Nonpregnant People With Diabetes



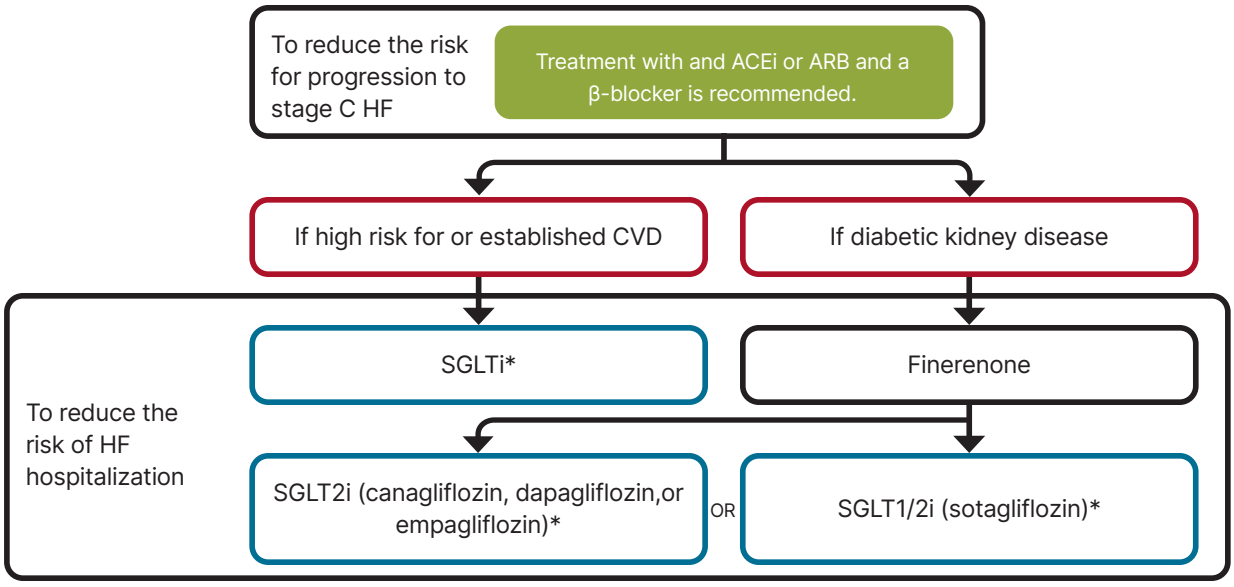
*An ACE inhibitor (ACEi) or angiotensin receptor blocker (ARB) is suggested to treat hypertension for people with coronary artery disease (CAD) or urine albumin-to-creatinine ratio (UACR) 30–299 mg/g creatinine and strongly recommended for individuals with UACR ≥300 mg/g creatinine. †Dihydropyridine calcium channel blocker (CCB). ‡Thiazide-like diuretic; long-acting agents shown to reduce cardiovascular events, such as chlorthalidone and indapamide, are preferred. BP, blood pressure. Adapted from de Boer IH, Bangalore S, Benetos A, et al. Diabetes and hypertension: a position statement by the American Diabetes Association. Diabetes Care 2017;40:1273–1284.

Suggested citation: American Diabetes Association Primary Care Advisory Group. 10. Cardiovascular disease and risk management: *Standards of Care in Diabetes—2024* abridged for primary care professionals. Clin Diabetes 2024;42:209–211 (doi: 10.2337/cd24-a010).

Screening for Asymptomatic Cardiovascular Disease (CVD)



Treatment of Stage B HF in People With Diabetes



*People with type 1 diabetes, ketosis-prone type 2 diabetes, or on a ketogenic diet require education on the signs and symptoms of ketoacidosis, risk management strategies, and ketone monitoring while taking an SGLTi. SGLTi, sodium–glucose cotransporter inhibitor; drugs in this class include the SGLT2 inhibitors canagliflozin, dapagliflozin, and empagliflozin and the SGLT1/2 inhibitor sotagliflozin.

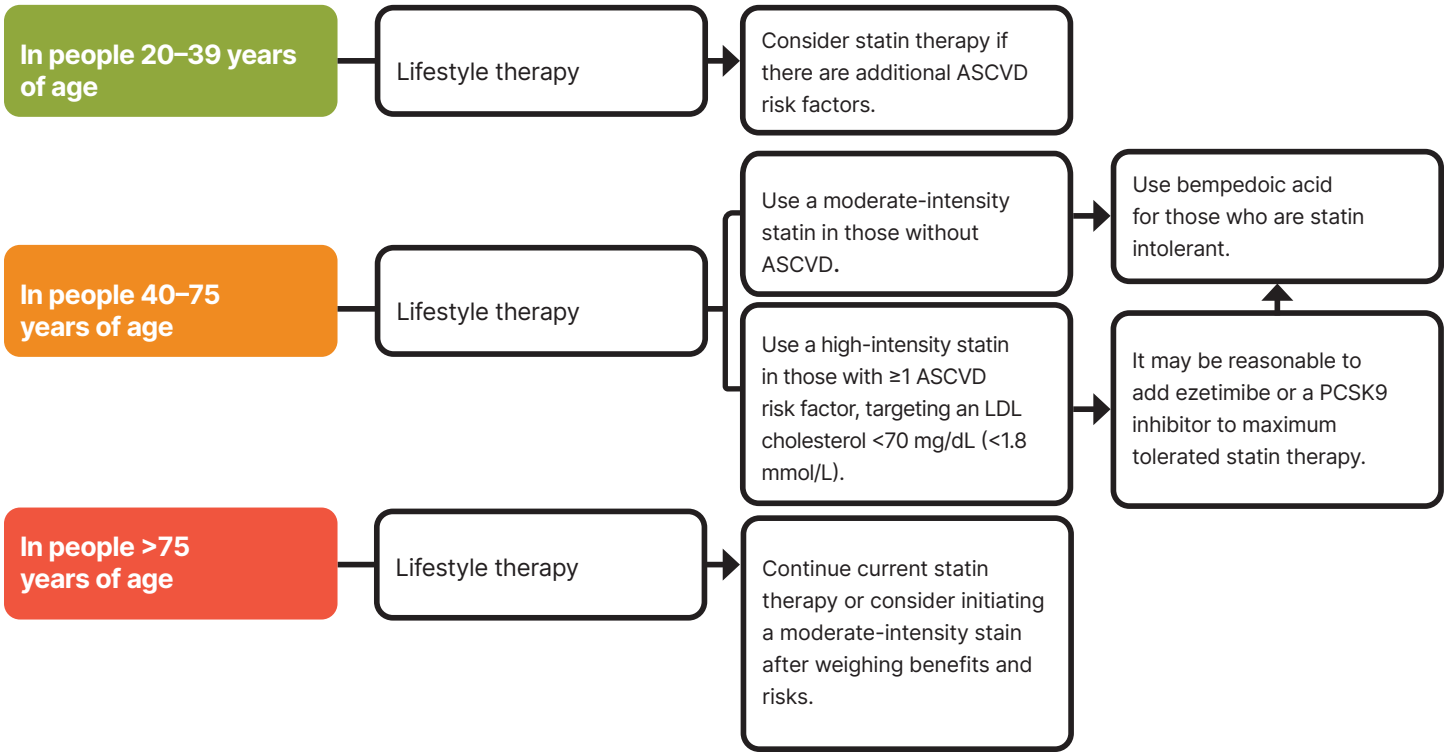
How often should you check lipids?

- For people with prediabetes or diabetes not on lipid-lowering therapy, check at diagnosis and at least annually thereafter.
- Check lipids at initiation of lipid-lowering therapy, 4–12 weeks after initiation or dose changes, and annually thereafter.

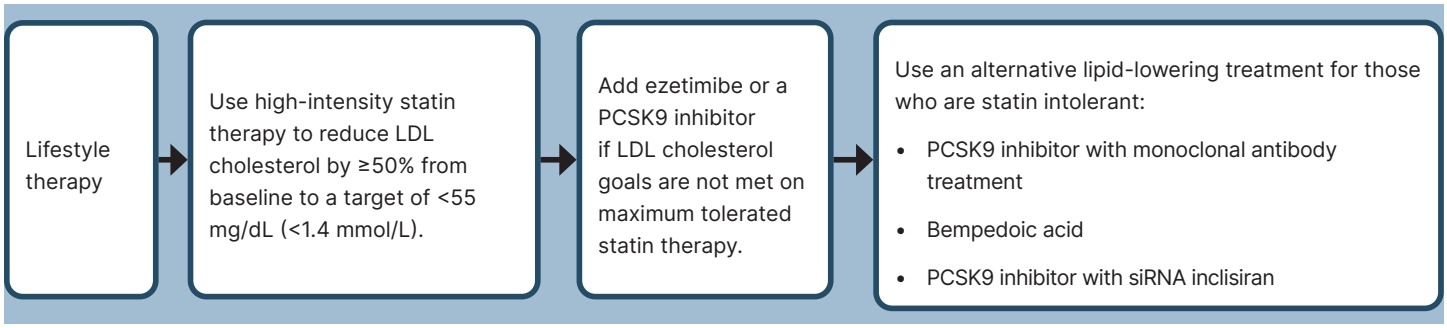
Statin Therapy Potency Chart

High-intensity statin therapy (lowers LDL cholesterol by ≥50%)	**Moderate-intensity statin therapy** (lowers LDL cholesterol by 30-49%)
Atorvastatin (40–80 mg)	Atorvastatin (10–20 mg)
Rosuvastatin (20–40 mg)	Rosuvastatin (5–10 mg)
	Simvastatin (20–0 mg)
	Pravastatin (40–80 mg)
	Lovastatin (40 mg)
	Fluvastatin XL (80 mg)
	Pitavastatin (1–4 mg)
Once-daily dosing. XL, extended release.	

Lipid Management for Primary Prevention of Atherosclerotic Cardiovascular Disease (ASCVD) Events in People with Diabetes



Lipid Management for Secondary Prevention of ASCVD Events in People With Diabetes of All Ages



PCSK9, proprotein convertase subtilisin/kexin type 9.