

Real-world effectiveness of remogliflozin versus liraglutide in obese T2DM to evaluate glycemic control and bodyweight



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Biography

Anand Shankar has been practising as a diabetologist in patna, Bihar, since 2006. He has his own clinic at makhania kuan road, and also consults at ruban memorial hospital (patliputra colony). Anand Shankar received training in diabetology from 2004-2006 as a clinical assistant in the department of diabetology, apollo diabetes centre, Apollo hospital and at Dr.V Seshiah diabetes care and research institute, chennai. For two years prior to this training, he gained experience as a senior resident in the department of internal medicine at Dr. Ram Manohar lohia hospital, India.



Abstract

Objective: Newer AHAs for T2DM, including sodium glucose co-transporter 2 (SGLT2) inhibitors and glucagon-like peptide-1 receptor agonists (GLP1RAs), have been shown to be effective for glycemic control and to promote weight loss, which may contribute to the cardiovascular benefits seen with some of these agents [1,2]. Remogliflozin is the new SGLT2i which has approved in India.

Aim: Real-world effectiveness of remogliflozin 100 mg BD versus liraglutide 0.6 mg/day was examined in obese and uncontrolled patients with Type II diabetes.

Methods: A single center, retrospective observational study conducted for 24 weeks in a real-world setting. Dose of remogliflozin was 100mg BD and liraglutide was 0.6 mg/day. All patients received remogliflozin or liraglutide in addition to their existing antidiabetic therapy except dipeptidyl peptidase-4 inhibitors and insulin. HbA1c, Weight and BMI were evaluated at baseline and after 24 weeks of therapy.

Results: A total of 60 patients with 42 (70%) females, 18 (30%) males, overweight (91.71 ± 14.19 kg), obese (35.6 ± 5.04 kg/m²) and uncontrolled (HbA1c $8.2 \pm 0.8\%$) patients with T2DM. Mean HbA1c and rate of achieving HbA1c <7% was similar at 6 months with remogliflozin (N=45) ($P < 0.05$) and liraglutide (N=15) ($P < 0.05$). At 24 weeks, patients who continued liraglutide had a non-significant mean weight loss of 2.73 ± 0.62 kg which was 2.69 ± 1.02 kg with remogliflozin and non-significant decrease in BMI was found in both the arm (-1.15 ± 0.6 kg/m² with remogliflozin and -1.21 ± 0.8 kg/m² with liraglutide). Patients were less likely to discontinue or switch with remogliflozin than liraglutide, and were more likely to add-on because of cost effectiveness.

Discussion: There is a progressive decline in β -cell function in T2DM requiring treatment adjustment. Co-morbidities such as obesity, cardiovascular diseases and patient factors like financial capabilities, compliance needs to be taken into consideration while individualizing therapy. Low dose liraglutide (0.6 mg/dl) once a day and remogliflozin 100 mg BD improved glycemic control and decrease in weight in almost similar fashion, in obese uncontrolled longstanding type 2 diabetes. Patients in the remogliflozin compare to liraglutide were more likely to be adherent to treatment and less likely to discontinue or switch treatment.

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