

The 2026 ADA/EASD consensus: Why early SGLT2/GLP-1 works

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The joint ADA and EASD consensus on type 2 diabetes now treats glucose as one target among several. The 2026 report, published in *Diabetologia* and *Diabetes Care*, advocates starting an SGLT2 inhibitor, a GLP-1-based therapy or both early, potentially from diagnosis, for organ protection.¹

KEY TAKEAWAYS

- **The Pivot:** The 2026 ADA and EASD consensus moves type 2 diabetes care from managing glucose to holistic, organ-protective care, with early SGLT2 inhibitor or GLP-1-based therapy, potentially from diagnosis.
- **The Data:** Early combination of both classes should be considered with cardiovascular, kidney or heart failure disease, weight targets are as essential as glycaemic ones, and insulin should start as basal only, usually after GLP-1-based therapy.
- **The Action:** Review whether patients with cardiovascular, kidney or liver disease are on a proven-benefit SGLT2 inhibitor or GLP-1-based therapy, prioritise by absolute risk where access is limited, and pair weight loss with protein and resistance exercise advice.

The consensus has been published since 2006 and was last updated in 2022. A 16-member writing group with equal representation from both organisations, co-chaired by Professor Melanie Davies for EASD and Professor John Buse for ADA, searched PubMed for randomised trials, systematic reviews and meta-analyses published between 1 May 2022 and 31 December 2025. Evidence was appraised with GRADE-informed methods, the draft went to public comment at the ADA meeting in New Orleans in 2026, and the report then underwent external peer review before approval by both societies.¹

The authors say this update broadens the focus from managing hyperglycaemia to the holistic management of type 2 diabetes and its associated multiple long-term conditions, from heart, kidney and liver disease to sleep apnoea and mental health. Fundamental care includes healthy eating, 24-hour physical behaviours, psychological support and weight management, delivered with diabetes self-management education and support. The report says these behaviours are "foundational, not adjunctive."¹

What Changes in Prescribing

The biggest shift is in sequencing. The report states that SGLT2 inhibitors and GLP-1-based therapy, which here includes tirzepatide, confer cardiovascular benefits independent of metformin and should be first-line therapeutic considerations. Most people with type 2 diabetes would benefit from early introduction of an SGLT2 inhibitor, a GLP-1-based therapy or

both, potentially from diagnosis, alongside education and health behaviour interventions. The authors argue this targets glucose without hypoglycaemia risk, weight and organ protection together, and helps avoid clinical inertia.¹

For people with established cardiovascular disease, the report recommends a GLP-1-based therapy with proven benefit to reduce major adverse cardiovascular events and all-cause mortality, or an SGLT2 inhibitor with proven benefit. Because benefits may be additive, combination therapy could be considered in people at high risk or with established cardiovascular or kidney disease irrespective of HbA1c, and early combination should be considered in people with concurrent cardiovascular, kidney and heart failure disease. We have covered the evidence for combining the two classes before.¹

In chronic kidney disease, an SGLT2 inhibitor with proven benefit should be started regardless of albuminuria and continued until kidney replacement therapy, a GLP-1-based therapy should be added, with semaglutide indicated to slow CKD progression, and a non-steroidal mineralocorticoid receptor antagonist should be used when urine albumin-to-creatinine ratio exceeds 3.0 mg/mmol. For people with obesity, type 2 diabetes and MASLD, a GLP-1-based therapy is recommended, and tirzepatide or a GLP-1 receptor agonist could be prioritised in obstructive sleep apnoea.¹

Weight is now a formal target. Weight targets "achieved by any means" are described as being as essential as glycaemic targets, agents with weight-lowering effects should be preferred in people with overweight or obesity, and metabolic surgery could be considered at a BMI of 30 or above and should be considered at 35 or above (27.5 and 32.5 for people of Asian ancestry). Intensive lifestyle therapy aiming for 10% or greater weight loss is suggested with the possibility of remission. If insulin is needed, it should start as basal insulin only, usually after GLP-1-based therapy, while keeping SGLT2 inhibitors, and sulfonylureas should be stopped.¹

Targets, Access and Caveats

Targets are largely unchanged. A reasonable HbA1c for most adults with enough life expectancy to see microvascular benefit is around 48 to 53 mmol/mol (6.5% to 7%) or lower, with 48 mmol/mol or lower for people managed with lifestyle alone or drugs that do not cause hypoglycaemia, and for early-onset disease diagnosed before age 40. Continuous glucose monitoring targets a time in range above 70%. Blood pressure should be below 130/80 mm Hg, with a systolic goal under 120 mm Hg encouraged in high-risk people, and statins are recommended for most people over 40.¹

Behaviour gets specific numbers. The "five S's" are standing, stepping, sweating, strengthening and sleep, with a minimum of 150 minutes a week of moderate-to-vigorous aerobic activity and resistance exercise 2 to 3 times a week. The report cites body composition analyses, including SURMOUNT-1, suggesting about 25% to 40% of weight lost with GLP-1-based therapies reflects lean mass loss, while noting other studies report figures nearer 15%. It advises protein guidance and resistance exercise for anyone losing substantial weight, and caution about potent agents in frail people.¹

Cost and access are acknowledged as limits. The authors point to the classes now being on the WHO essential medicines list and to prices easing as patents expire, but they say that where resources are short the highest-risk groups should be prioritised, using absolute rather than relative risk reductions. In lower-risk people, such as those with minimal

hyperglycaemia, limited excess weight and no organ damage, a more stepwise approach may be appropriate. Certainty is also lower in people with cardiovascular risk factors but no established disease, because some outcome trials enrolled only established disease.¹

Other caveats follow. The recommendations reflect the values and preferences of the writing group, and the authors acknowledge limitations in the evidence base, including thin data in younger and older people, women and different racial and ethnic groups, though they say that is not a reason to withhold treatment. They call current remission definitions based on glycaemic thresholds "inherently simplistic" and suggest the broader concept of type 2 diabetes modification. The activity was funded by ADA and EASD, and the authors report extensive relationships with pharmaceutical companies in the disclosures at the end of the paper.¹

CLINICAL IMPLICATIONS

The practical message is about timing. For most people with type 2 diabetes, waiting for metformin to fail before adding an SGLT2 inhibitor or GLP-1-based therapy is no longer the default the authors support. That matters most for those with established cardiovascular, kidney or liver disease, where the report is direct about which classes to use, and for early-onset disease, which it describes as deteriorating faster.

The report is also candid that this approach depends on access. Where these drugs cost too much, the authors say to prioritise people with the highest absolute risk, which is a more defensible rule than treating everyone alike. Metformin, DPP-4 inhibitors, pioglitazone and sulfonylureas keep a place for people who cannot take newer agents, and the report notes the evidence on them has not changed.

The cautions are specific. Evidence is weaker in people with risk factors but no established disease, lean mass loss with weight reduction needs active management, and frail or older patients may need adjusted choices. Clinicians should read the full recommendations alongside local guidance and national licences, because the report says drug choice should follow country-specific indications.

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2. Presented at: European Association for the Study of Diabetes (EASD) Annual Meeting; September 28-October 2, 2026; Milan, Italy (session in London Hall, October 2, 2026).

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