medeasy
REVIEW

MONTHLY PHYSICIAN-ONLY
DIGITAL MEDICAL REVIEW

SEPTEMBER 2026
ISSUE 01

MEDICINE, REIMAGINED

Evidence. Innovation. Impact. Better care for every patient.



MEDICINE, REIMAGINED

15 developments changing clinical medicine in 2026

The key innovations, therapies, and breakthroughs shaping the future of patient care.

THE PEPTIDE REVOLUTION

Retatrutide and Beyond

The next wave of multi-agonist therapies for obesity and metabolic disease.

DAPAGLIFLOZIN

The Diabetes Drug That Outgrew Diabetes

Cardiorenal protection and outcomes that matter most for patients.

CONTENTS

SEPTEMBER 2026 • ISSUE 01

Editor's Letter 03
A note from the editor

Medicine, Reimagined 04
15 developments changing clinical medicine in 2026

The Peptide Revolution 07
Retatrutide and beyond

Dapagliflozin: The Diabetes Drug That Outgrew Diabetes 10
Cardiorenal protection and outcomes that matter

Evidence Update: 4 Papers Worth Knowing 12
Neurology, oncology, ID, and geriatrics

Clinical Discovery: Is BMI Losing Its Grip? 15
Looking beyond BMI for better risk stratification

Practice Changer: Stage 1 Hypertension 17
New perspectives for early identification and management

Future Medicine: Beyond the Statin 19
Next-generation lipid-lowering therapies

Tech Check: Can Your Wearable Really Save Your Life? 21
What the evidence says—and what it can't

Medeasy Picks 23
ABG Basics + ECG Basics

References / Disclosures / Closing 24
Endnotes and disclosures

medeasy
REVIEW

INSTITUTIONAL NOTE
FROM THE MEDEASY REVIEW TEAM

Medeasy Review is created exclusively for doctors.

Our mission is to cut through the noise and deliver what truly matters—trusted evidence, focused insights, and practical takeaways that improve patient care.

We rigorously curate the latest advances so you can save time, stay ahead, and focus on what you do best.

Thank you for being part of the Medeasy physician community.

EVIDENCE FIRST
We prioritize high-quality, peer-reviewed evidence.

CLINICALLY USEFUL
Every insight is chosen for real-world relevance.

PHYSICIAN TO PHYSICIAN
Written by doctors, for doctors.

INDEPENDENT & TRUSTED
Editorial integrity is at the core of all we do.

info@medeasy.ph

www.medeasy.ph

EDITOR'S LETTER

Dear Colleagues,

Welcome to the very first issue of **Medeasy Review.**

In a world of information overload, our goal is simple: bring you what matters most—reliable evidence, clear insights, and practical takeaways you can use today.

Each month, we'll do the hard work of curating the latest advances, so you can focus on what you do best—caring for your patients.

Thank you for being part of this journey.

Warm regards,
Medeasy Review Team

IN THIS ISSUE

Latest Evidence.
Curated research across neurology, cardiology, endocrinology, ID, and more.

Clinical Impact.
Actionable insights and practical perspectives you can apply in real-world practice.

Broader Perspective.
From emerging science to health tech, we explore what's shaping the future of medicine.

Handpicked for You.
Essential reads, tools, and resources from the Medeasy Library.

medeasy
REVIEW



WHY MEDEASY REVIEW?
Because your time is precious. We translate complex science into clear, trusted, and clinically relevant content—so you can make better decisions, faster.

OUR PROMISE
Evidence first.
Practically useful.
Written by doctors, for doctors.

STAY CONNECTED

info@medeasy.ph
medeasy.ph
/medeasy.ph
@medeasy.ph



medeasy REVIEW

MEDICINE, REIMAGINED



15 developments changing clinical medicine in 2026

Breakthroughs across therapeutics, diagnostics, and technology are reshaping how we prevent, detect, and treat disease. Here are 15 developments that deserve your attention.



01

Next-Generation Obesity Therapies

Dual- and triple-agonist incretin therapies are delivering unprecedented weight loss and metabolic benefits—beyond GLP-1 alone.

CLINICAL IMPACT
Potential to transform the management of obesity and cardiometabolic risk.



02

Gene Editing Moves Closer to the Clinic

CRISPR-based therapies are advancing through late-stage trials for inherited and acquired diseases.

CLINICAL IMPACT
One-time treatments may offer durable, potentially curative outcomes.



03

AI-Augmented Diagnostics

AI tools are improving accuracy and speed in imaging, ECG interpretation, pathology, and risk prediction.

CLINICAL IMPACT
Earlier detection, fewer misses, and more confident clinical decisions.



04

mRNA Platform Expands Beyond Vaccines

mRNA technology is entering trials for cancer therapeutics, rare diseases, and chronic conditions.

CLINICAL IMPACT
A versatile platform with potential across a wide range of diseases.

MEDICINE IS EVOLVING. SO ARE WE.
From the lab bench to the bedside, these innovations reflect a future where medicine is more precise, more personalized, and more patient-centered.

OUR COMMITMENT
To keep you informed, inspired, and equipped to deliver the best care.

MEDICINE, REIMAGINED

15 Developments Changing Clinical Medicine in 2026

05–10 | From Detection to Precision





05 Wearables Move from Wellness to Clinical Value

New-generation wearables can reliably detect AFib, sleep apnea, blood pressure trends, and even early signs of heart failure.

WHAT THIS MEANS

Earlier detection and continuous monitoring enable proactive, preventive care.

06 Genomic Risk Scores Enter Routine Practice

Polygenic risk scores help identify patients at higher risk for complex diseases, guiding earlier screening and personalized prevention.

WHAT THIS MEANS

Prevention becomes more precise, personalized, and actionable.





07 Alzheimer's Disease Biomarkers Enable Earlier Intervention

Blood-based biomarkers and advanced imaging allow detection of Alzheimer's pathology years before symptoms become evident.

WHAT THIS MEANS

Early diagnosis opens the door to timely, disease-modifying therapies.

08 CKD Therapies Slow Progression Like Never Before

SGLT2 inhibitors and non-steroidal MRAs show superior outcomes in slowing CKD progression and reducing cardiovascular risk.

WHAT THIS MEANS

Better renal and CV outcomes with earlier, guideline-directed therapy.





09 Targeted Cancer Therapies Continue to Transform Care

Next-generation inhibitors and antibody–drug conjugates deliver better outcomes with fewer side effects across multiple cancers.

WHAT THIS MEANS

More options, more precision, better survival.

10 Rapid & Point-of-Care Diagnostics Reach a New Era

Highly accurate, multiplex tests bring lab-quality results to the clinic—improving decisions and patient outcomes in real time.

WHAT THIS MEANS

Faster answers. Better decisions. Improved outcomes.

medeasy REVIEW

MEDICINE, REIMAGINED

15 Developments Changing Clinical Medicine in 2026

11–15 | From Metabolism to Outcomes

11 | New Dual & Triple Agonists Redefine Obesity Treatment

Agents like retatrutide show unprecedented weight loss and cardiometabolic benefits by targeting multiple pathways (GLP-1, GIP, glucagon)—pushing beyond the limits of current therapies.

WHAT THIS MEANS

A new era of obesity care with greater efficacy and broader metabolic impact.



12 | Gut & Microbiome Therapies Move from Hype to Hope

Microbiome modulation, fecal microbiota transplantation (FMT), and next-gen probiotics are showing real promise across GI, metabolic, immunologic, and even neuropsychiatric conditions.

WHAT THIS MEANS

Personalized microbiome interventions may unlock new treatment frontiers.

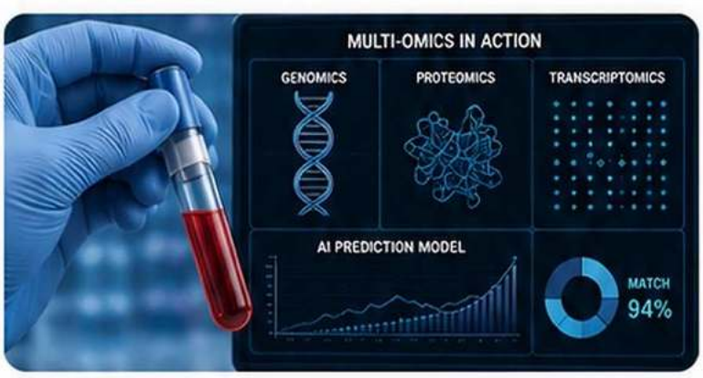


13 | Liquid Biopsy & Multi-Omics Accelerate Precision Oncology

Combinations of liquid biopsy, genomics, proteomics, and AI analytics are improving early detection, resistance monitoring, and therapy matching in real time.

WHAT THIS MEANS

More precise treatment choices and better outcomes with fewer delays.



14 | Heart Failure Care Enters a New Standard

SGLT2 inhibitors, ARNI, device therapy, and digital monitoring are now standard pillars—dramatically improving survival, reducing hospitalizations, and enhancing quality of life.

WHAT THIS MEANS

Better outcomes across the entire heart failure journey—from prevention to advanced care.



15 | ELEVATE: Pioneering CV Outcome Data in Type 2 Diabetes

The ELEVATE trial shows a 42% relative risk reduction in major cardiovascular events with an oral GLP-1 receptor agonist—marking a major leap forward for oral incretin therapy.

WHAT THIS MEANS

Oral GLP-1 therapy moves closer to becoming a first-line option for cardiometabolic protection.



medeasy REVIEW

CLINICAL DISCOVERY

The Peptide Revolution

Retatrutide

A Potential Next Frontier in Obesity Therapy

Retatrutide is an investigational triple-hormone receptor agonist (GIP, GLP-1, and glucagon) showing unprecedented weight loss in early studies—potentially a new frontier in obesity management.



TARGET	Obesity and overweight with comorbidities
MECHANISM	Triple agonist: GIP + GLP-1 + Glucagon receptors
DEVELOPMENT STATUS	Phase 3 (TRIUMPH-1) results reported (May 2026)

HOW DOES IT WORK?

GIP Agonism
- Enhances insulin secretion
- Improves glucose control
- May reduce fat mass

+

GLP-1 Agonism
- Reduces appetite
- Slows gastric emptying
- Improves glycemic control

+

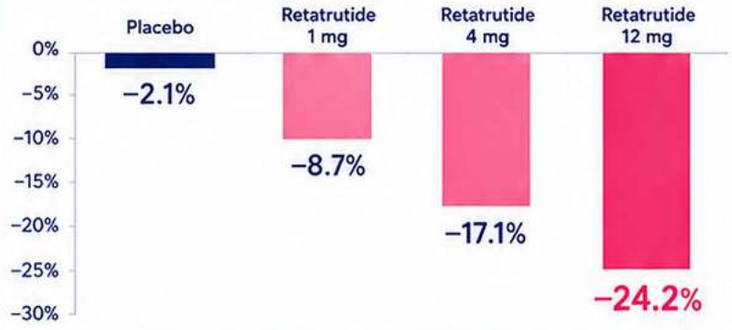
Glucagon Agonism
- Increases energy expenditure
- Promotes fat oxidation
- Helps preserve lean mass

=

Greater weight loss and metabolic benefits than GLP-1 alone

PHASE 2 RESULTS (BREAKWATER-1 STUDY)

Mean % body weight change at 48 weeks (vs placebo)



Up to 24.2% mean weight loss at 48 weeks wass observed with retatrutide 12 mg in phase 2.

Primary endpoint: Percent change in body weight from baseline.
Results are least-squares mean vs placebo.

ADDITIONAL BENEFITS OBSERVED (PHASE 2)

Improved Glycemic Control
Significant reductions in HbA1c (up to −2.2%) in participants with T2D.

Better Lipid Profile
Reductions in triglycerides, ApoB, and non-HDL cholesterol.

Blood Pressure Reduction
Modest but meaningful decreases in systolic and diastolic BP.

Favorable Body Composition
Greater fat mass loss with preservation of lean muscle mass.

KEY TAKEAWAYS

- Retatrutide showed up to 24.2% mean weight loss at 48 weeks in phase 2—unprecedented in its class.
- Triple-hormone mechanism may deliver superior metabolic benefits beyond GLP-1 agonists.
- Phase 3 TRIUMPH-1 (12 mg) achieved 28.3% mean weight loss at 80 weeks (topline results, May 2026).
- Long-term efficacy, safety, and cardiovascular outcomes continue to be evaluated.

SAFETY PROFILE (PHASE 2 & 3)

Adverse events were mostly gastrointestinal (nausea, vomiting, diarrhea) and generally mild to moderate.

Discontinuation due to adverse events was low (−8% in phase 2; 6.1% in phase 3).

> "Retatrutide may redefine the future of obesity pharmacotherapy—we are just at the beginning of the peptide era."

References: Jastreboff AM, Kaplan LM, Frias JP, et al. Triple-Hormone-Receptor Agonist Retatrutide for Obesity — A Phase 2 Trial. N Engl J Med. 2023;389:514-526. doi:10.1056/NEJMoa2301972.
Lilly press release. Retatrutide (TRIUMPH-1) topline results. May 6, 2026.

medeasy REVIEW

THE PEPTIDE REVOLUTION

Retatrutide: From Promise to Proof.

The Next Standard in Metabolic Medicine.

Retatrutide (GLP-1/GIP/glucagon tri-agonist) is the most advanced multi-agonist peptide in clinical development—designed to deliver superior and sustained improvements across weight, glycemic control, lipids, and cardiometabolic risk.

ONE MOLECULE. THREE PATHWAYS.

Synergistic activation for transformative outcomes.

GLP-1
Slows gastric emptying, increases satiety, and enhances insulin secretion.

GIP
Enhances insulin secretion, improves lipid metabolism, and supports adipose remodeling.

GLUCAGON
Increases energy expenditure, reduces hepatic fat, and supports lean mass.

Greater efficacy. Broader impact. Lasting change.

CLINICAL EVIDENCE: RETATRUTIDE DELIVERS

PHASE 2 OBESITY TRIAL

48 WEEKS

UP TO **24.2%**
MEAN BODY WEIGHT REDUCTION

Surpassing all GLP-1 and dual GIP/GLP-1 therapies studied to date at 48 weeks.

PHASE 3 (TRIUMPH-1)

80 WEEKS

UP TO **28.3%**
MEAN BODY WEIGHT REDUCTION

With 12 mg retatrutide—achieving unprecedented and durable weight loss at 80 weeks.

PHASE 3 (TRANSCEND-T2D-1)

40 WEEKS

UP TO **2.0%**
A1C REDUCTION

UP TO **16.8%**
MEAN BODY WEIGHT REDUCTION AT 40 WEEKS

In adults with type 2 diabetes, on stable background therapy.

> Retatrutide represents a new standard with the potential to transform how we treat obesity and type 2 diabetes.

Jastreboff AM, et al. N Engl J Med. 2023;389:514-526.
Frias JP, et al. N Engl J Med. 2023;388:514-526.
Garvey WT, et al. N Engl J Med. 2024;391:145-156.
Press releases, Eli Lilly and Company, June 2024.

KEY BENEFITS

UNPRECEDENTED WEIGHT LOSS
Up to 28.3% mean body weight reduction at 80 weeks.

SUPERIOR GLYCEMIC CONTROL
Up to 2.0% A1C reduction and up to 16.8% weight reduction at 40 weeks in T2D.

FAVORABLE CARDIOMETABOLIC PROFILE
Significant improvements in blood pressure, lipids, liver fat, and inflammatory markers.

WELL TOLERATED
Mostly mild to moderate GI adverse events, with low discontinuation rate.

DURABLE & SUSTAINED
Benefits continued to improve through 80 weeks with no evidence of plateau.

SAFETY PROFILE

MOST COMMON ADVERSE EVENTS
Nausea, diarrhea, constipation, vomiting, and decreased appetite.

MOSTLY MILD TO MODERATE
Typically occur during dose escalation and decline over time.

LOW DISCONTINUATION RATE
Comparable to other incretin-based therapies in clinical trials.

INVESTIGATIONAL USE ONLY
Retatrutide is investigational and not yet approved for any indication. Ongoing Phase 3 trials are evaluating long-term outcomes and safety.

CLINICAL TAKEAWAY

Retatrutide's unique triple-agonist activity delivers additive and synergistic benefits across weight, glycemia, and multiple metabolic pathways—positioning it as the most promising next-generation therapy for metabolic disease.

LOOKING AHEAD

Ongoing Phase 3 outcome trials are underway to assess cardiovascular, renal, and long-term safety outcomes.
Retatrutide could set a new bar for what's achievable in metabolic health.

THE PEPTIDE REVOLUTION IS HERE.
Better biology. Better outcomes.
Better futures for our patients.

At Medeasy, we bring you the science that shapes tomorrow's care—today.

medeasy REVIEW

THE PEPTIDE REVOLUTION

How Retatrutide Works. Where It Acts. Why It Matters.

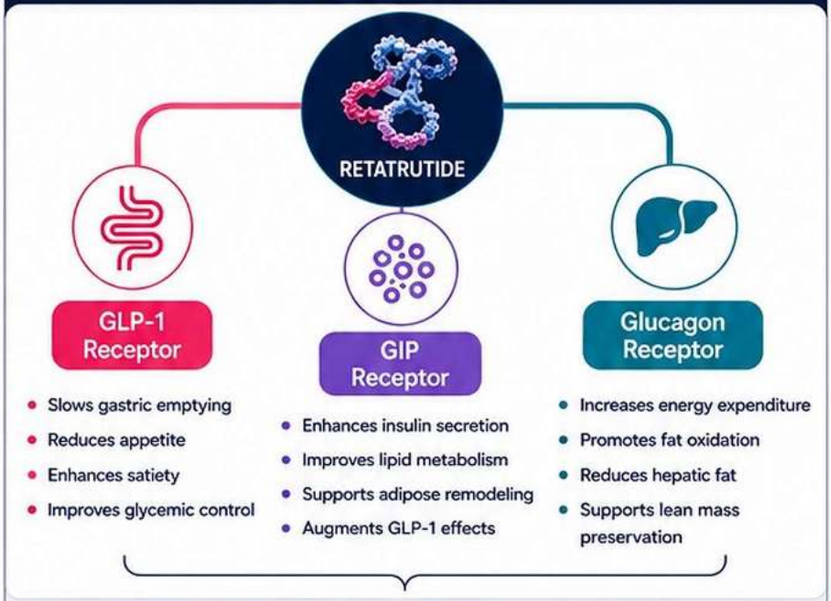
Retatrutide is the first and only peptide in clinical development designed to activate three key metabolic pathways simultaneously—GLP-1, GIP, and glucagon. This unique triple agonism drives powerful, complementary effects across multiple organs and systems.

ONE MOLECULE. MULTIPLE BENEFITS. TRANSFORMATIVE POTENTIAL.

By targeting the biology of obesity and type 2 diabetes at multiple levels, retatrutide offers the potential for unmatched clinical impact.

THE SCIENCE: TRIPLE-AGONIST MECHANISM

Retatrutide engages three receptors to deliver synergistic, complementary metabolic effects.



- Slows gastric emptying
- Reduces appetite
- Enhances satiety
- Improves glycemic control

- Enhances insulin secretion
- Improves lipid metabolism
- Supports adipose remodeling
- Augments GLP-1 effects

- Increases energy expenditure
- Promotes fat oxidation
- Reduces hepatic fat
- Supports lean mass preservation

Complementary pathways. Synergistic effects. Superior and durable outcomes.

WHO MIGHT BENEFIT?

Retatrutide is being studied in a broad range of patients.

- Adults with obesity (BMI ≥30 kg/m²)
- Adults with overweight (BMI ≥27 kg/m²) with weight-related comorbidities
- Adults with type 2 diabetes
- Patients seeking significant and sustained metabolic improvements

HOW IT WAS STUDIED (INVESTIGATIONAL)

Retatrutide was administered as a once-weekly subcutaneous injection in clinical trials of obesity and type 2 diabetes.

TRIAL DESIGN

Phase 2 and Phase 3 randomized, double-blind, placebo-controlled trials.

DOSING APPROACH

Doses were escalated per trial protocols up to 12 mg once weekly.

DOSES STUDIED

Trials evaluated dose levels up to 12 mg once weekly (most studied).

Dose escalation schedules varied by study. Please refer to individual trial protocols and local prescribing information when/if approved.

Retatrutide is investigational and not approved for any indication.

KEY BENEFITS OBSERVED ACROSS CLINICAL STUDIES

SUBSTANTIAL WEIGHT REDUCTION
Up to 28.3% mean body weight reduction at 80 weeks (Phase 3, TRIUMPH-1).

EXCELLENT GLYCEMIC IMPROVEMENT
Up to 2.0% A1C reduction and up to 16.8% mean body weight reduction in T2D at 40 weeks (Phase 3, TRANSCEND-T2D-1).

CARDIOMETABOLIC RISK FACTORS
Improvements in blood pressure, lipids, liver fat, and inflammatory markers.

METABOLIC HEALTH
Improved insulin sensitivity, body composition, and overall metabolic profile.

SAFETY PROFILE: WHAT WE KNOW

MOST COMMON ADVERSE EVENTS

Gastrointestinal: Nausea, diarrhea, constipation, vomiting, decreased appetite.

Mostly mild to moderate: Typically occur during dose escalation and decline over time.

Low discontinuation rate: Comparable to other incretin-based therapies.

No new safety signals identified to date in Phase 2 or Phase 3 trials.

Ongoing Phase 3 trials continue to evaluate long-term safety.

> “Retatrutide’s triple-agonist mechanism addresses the complexity of obesity and type 2 diabetes at multiple biological levels—delivering transformative potential for patients.”

Medeasy Review Team
EVIDENCE. INSIGHT. IMPACT.

CLINICAL TAKEAWAY

By activating GLP-1, GIP, and glucagon pathways, retatrutide represents a new era in metabolic medicine—with the potential to set a new standard for the treatment of obesity and type 2 diabetes.

LOOKING AHEAD

Phase 3 outcomes will clarify the long-term cardiovascular, renal, and metabolic benefits and define the ultimate role of retatrutide in clinical practice.

medeasy REVIEW

Dapagliflozin

Expanding Benefits Beyond Glycemic Control.

Dapagliflozin demonstrates broad cardiorenal benefits across a spectrum of patients, including those without diabetes.



CLASS
SGLT2 inhibitor

APPROVED USE
T2DM, HFrEF, CKD, HFpEF*
**Country-specific approval may vary*

DOSE
10 mg once daily
With or without food

PRIMARY ACTION
Inhibits SGLT2 in the proximal tubule
↑ Urinary glucose excretion and natriuresis

KEY BENEFIT AREAS
- Cardiovascular
- Renal
- Metabolic

EVIDENCE HIGHLIGHTS

Heart Failure with Reduced EF

Reduced worsening HF or CV death

DAPA-HF
4,744 patients

26%
RRR vs placebo

N Engl J Med 2019; 381:1995–2008.

Chronic Kidney Disease

Slowed kidney function decline and reduced renal failure

DAPA-CKD
4,304 patients

39%
RRR in sustained ≥50% eGFR decline, ESKD, or renal/CV death

N Engl J Med 2020; 383:1436–1446.

Heart Failure with Preserved EF

Reduced worsening HF or CV death

DELIVER
6,263 patients

18%
RRR vs placebo

N Engl J Med 2022; 387:1089–1098.

Chronic Kidney Disease (Non-diabetic)

Benefit consistent in patients without diabetes

DAPA-CKD
(Non-diabetic subgroup)
1,398 patients (32%)

50%
RRR in primary renal composite outcome

N Engl J Med 2020; 383:1436–1446.

KEY TAKEAWAY

- Dapagliflozin provides robust benefit in HF (HFrEF and HFpEF) and CKD.
- Benefits are consistent regardless of diabetes status.
- Early initiation and long-term use are key to maximizing outcomes.
- Well tolerated with a favorable safety profile.

PRACTICAL TIP

Consider dapagliflozin for appropriate patients with HF or CKD, regardless of diabetes status, when clinically indicated and unless contraindicated.

PATIENT BENEFITS

- Protects heart and kidneys
- Reduces risk of hospitalization
- Improves quality of life

SAFETY SUMMARY

- Generally well tolerated
- Most common AEs: genital mycotic infections, volume depletion
- Monitor volume status and renal function
- Rare but serious: ketoacidosis, Fournier gangrene

> Dapagliflozin: more than glucose control—clinically meaningful benefit for the heart and kidneys.

Scan for latest clinical updates on dapagliflozin and related evidence.

medeasy REVIEW

INTERESTING MEDICINES

Inclisiran & Evolocumab: Different Paths. Same Goal.

Powerful LDL-C lowering. Different levels of outcomes evidence.

Two innovative therapies that reduce cholesterol—but through completely different mechanisms.

TWO MECHANISMS. ONE OUTCOME: LOWER LDL-C.

INCLISIRAN (siRNA THERAPY)

Small interfering RNA (siRNA) that silences PCSK9 production in the liver.

Less PCSK9 made.
More LDL receptors.
Lower LDL-C.

EVOLOCUMAB (PCSK9 MONOCLONAL ANTIBODY)

Monoclonal antibody that binds circulating PCSK9 and prevents it from degrading LDL receptors.

PCSK9 is blocked.
More LDL receptors.
Lower LDL-C.

LDL-C

POWERFUL LDL-C LOWERING. DIFFERENT LEVELS OF OUTCOMES EVIDENCE.

INCLISIRAN: ORION PROGRAM

~50% LDL-C REDUCTION vs. placebo

SUSTAINED WITH TWICE-YEARLY DOSING

- **ORION-10 & ORION-11:** Consistent ~50% LDL-C reduction at 18 months.
- **ORION-4 (CV outcomes trial):** Designed to evaluate the effect on major cardiovascular events. *Results are not yet available (readout expected in 2027).*
- Twice-yearly dosing after initial and 3-month dose offers long-term adherence advantage.

EVOLOCUMAB: FOURIER TRIAL

~60% LDL-C REDUCTION vs. placebo

PROVEN CV RISK REDUCTION IN HIGH-RISK PATIENTS

- **FOURIER Trial:** 15% relative risk reduction in major adverse cardiovascular events.
- Consistent benefit across key secondary outcomes including MI, stroke, and revascularization.
- Benefit seen on top of statin therapy.

AT A GLANCE COMPARISON

	INCLISIRAN	EVOLOCUMAB
MECHANISM	Inhibits PCSK9 production (siRNA)	Binds PCSK9 and prevents LDL receptor degradation
ADMINISTRATION	Subcutaneous injection every 6 months	Subcutaneous injection every 2–4 weeks
LDL-C REDUCTION	~50%	~60%
OUTCOMES DATA	CV outcomes trial ongoing (ORION-4)*	FOURIER: 15% RRR in major CV events
BEST FOR	Patients who prefer twice-yearly dosing	Patients needing greater LDL-C lowering or faster intensification

*ORION-4 (inclisiran) and VICTORION-2-PREVENT (inclisiran) are ongoing. Primary results are expected in 2027.

WHO CAN BENEFIT?

- Patients with atherosclerotic cardiovascular disease (ASCVD) who need additional LDL-C lowering.
- Patients with familial hypercholesterolemia (HeFH or HoFH).
- Patients who are statin-intolerant or need non-statin options.
- Patients who value less frequent dosing (inclisiran every 6 months).

SAFETY PROFILE

- **Inclisiran:** Most common adverse event – injection site reactions.
- **Evolocumab:** Most common adverse event – nasopharyngitis, injection site reactions.
- Both therapies are generally well tolerated.
- Low rates of muscle-related side effects.

CLINICAL TAKEAWAY

Inclisiran and evolocumab are both game-changing therapies that lower LDL-C substantially and reduce CV risk.

Choose the right path for the right patient.
Same goal: protect the heart and save lives.

DIFFERENT PATHWAYS. STRONGER OUTCOMES.
Evidence-based choices today for a healthier tomorrow.

At Medeasy, we bring you the science that shapes tomorrow's care—today.

medeasy REVIEW

EVIDENCE UPDATE

PAPERS WORTH KNOWING.

Fresh evidence from major journals—insights that matter for your patients today.

Key late-summer 2026 studies every clinician should know.

1 STAREE Trial

Statin Therapy in Healthy Older Adults Reduces Major Cardiovascular Events

Published in NEJM

N Engl J Med 2026; published Aug 28, 2026.

KEY RESULT

30%

Relative reduction in major cardiovascular events with atorvastatin 40 mg vs placebo in adults ≥70 years (median follow-up 5.9 years).

CLINICAL TAKEAWAY

In healthy older adults without CVD, atorvastatin lowered major CV events but did not improve disability-free survival. Discuss benefits and values with patients.

2 AIR-STEMI Trial

Complete Revascularization Guided by Physiology Improves Outcomes

Published in NEJM

N Engl J Med 2026; published Aug 29, 2026.

KEY RESULT

38%

Reduction in the composite of death, MI, stroke/TIA, or ischemia-driven revascularization with physiology-guided complete revascularization in STEMI with multivessel disease.

CLINICAL TAKEAWAY

Physiology-guided complete revascularization may help identify which nonculprit lesions should be treated in eligible STEMI patients with multivessel disease.

3 PREMIUM Trial

Immediate Aspirin Omission After STEMI Failed Noninferiority vs DAPT

Published in NEJM

N Engl J Med 2026; published Aug 29, 2026.

KEY RESULT

NONINFERIORITY NOT MET

Immediate aspirin omission after primary PCI was not noninferior to standard DAPT with prasugrel plus aspirin for death, stroke, or MI at 12 months (11.0% vs 8.5%; HR 1.34; 95% CI 1.02–1.75).

CLINICAL TAKEAWAY

Upfront aspirin omission with prasugrel after STEMI is not supported by current evidence. Continue standard DAPT unless a clear indication to de-escalate.

4 CARDIO-TTRansform Trial

Eplontersen in Transthyretin Amyloidosis Cardiomyopathy Did Not Meet Primary Endpoint

Published in NEJM

N Engl J Med 2026; published Aug 28, 2026.

KEY RESULT

PRIMARY ENDPOINT NOT MET

Eplontersen did not reduce the hierarchical composite of cardiovascular death or recurrent cardiovascular clinical events vs placebo at 140 weeks (rate ratio 0.89; 95% CI 0.73–1.09; P=0.28), despite substantial TTR reduction.

CLINICAL TAKEAWAY

TTR lowering alone may not translate into clinical benefit in ATTR-CM. Ongoing trials and longer follow-up remain essential.

WHAT THIS MEANS FOR PRACTICE

PREVENT EARLY

Evidence supports earlier risk modification—even before disease is established.

USE THE RIGHT STRATEGY

Physiology-guided revascularization and guideline-directed therapies can improve outcomes.

EXPAND EVIDENCE-BASED OPTIONS

New data strengthen our tools across CV, HF, and kidney disease.

TREAT THE WHOLE PATIENT

Consider comorbidities and patient preferences to achieve meaningful, patient-centered care.

Science moves forward.
Our commitment remains the same:
better evidence, better decisions, better outcomes for every patient.

Stay curious.
Stay updated.
Keep learning.
Keep caring.
— Medeasy Review Team

EVIDENCE UPDATE

PAPERS WORTH KNOWING.

Fresh evidence from NEJM and major journals—insights that matter for your patients today.

Breaking science published in *NEJM*, July 8, 2026.

5 ELEVATE Trial

PHASE 3

Ensartinib vs Placebo in ALK-Positive NSCLC After Complete Resection

N Engl J Med 2026; online July 8, 2026.

274 Patients
Stage IB (≥4 cm) to IIIA ALK+ NSCLC

Randomized
Ensartinib 225 mg once daily vs Placebo

Treatment
Up to 24 months (double-blind)

Primary Endpoint
Disease-free Survival (DFS) in Stage II–IIIB

KEY RESULTS (24-MONTH DFS)

Primary Analysis Stage II–IIIB Population

DFS at 24 Months

86.4% Ensartinib | 53.5% Placebo

HR 0.20
95% CI 0.11–0.38; P<0.001

Overall Population (All Randomized Patients)

DFS at 24 Months

87.3% Ensartinib | 57.2% Placebo

HR 0.20
95% CI 0.10–0.37; P<0.001

SAFETY (OVERALL POPULATION)

Grade ≥3 Adverse Events

35.8% Ensartinib | 18.2% Placebo

Most Common Grade ≥3 AE

Rash (16.4% vs 0.7%)

CLINICAL TAKEAWAY

Ensartinib for up to 2 years after complete resection significantly improves disease-free survival in patients with ALK-positive NSCLC, with manageable safety. Overall survival data are not yet mature.

ClinicalTrials.gov Identifier: NCT05341583

WHAT THIS MEANS FOR PRACTICE

PREVENT RECURRENCE
Adjuvant ensartinib significantly reduces recurrence risk in resected ALK+ NSCLC.

SELECT APPROPRIATELY
Consider for patients with stage IB (≥4 cm) to IIIA ALK+ NSCLC after complete resection.

MANAGE SAFETY
Monitor for rash and other AEs; most are manageable with appropriate care.

CONTINUE FOLLOW-UP
Continue standard surveillance; overall survival benefit is awaited.

Science moves forward.
Our commitment remains the same:
better evidence, better decisions, better outcomes for every patient.

Stay curious.
Stay updated.
Keep learning.
Keep caring.
— Medeasy Review Team

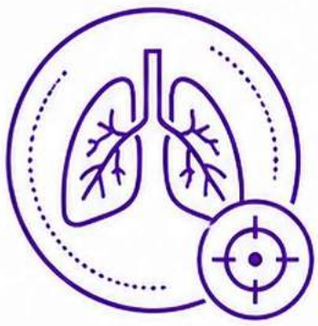
medeasy REVIEW

THERAPEUTIC REVIEW

ELEVATE: Deep Dive

A closer look at the phase 3 evidence for adjuvant ensartinib in ALK-positive NSCLC

The ELEVATE trial demonstrated a significant improvement in disease-free survival with ensartinib versus placebo after complete resection of ALK-positive non–small-cell lung cancer. The primary analysis focused on patients with stage II–IIIB disease, with disease-free survival also evaluated in the overall stage IB–IIIB population.



PRIMARY ENDPOINT

Disease-Free Survival — Stage II–IIIB Population

24-MONTH DFS

86.4% Ensartinib

53.5% Placebo

HR 0.20

95% CI 0.11–0.38

P<0.001

At 24 months, ensartinib significantly reduced the risk of disease recurrence or death versus placebo.

KEY SECONDARY ENDPOINT

Disease-Free Survival — Overall Stage IB–IIIB Population

87.3% Ensartinib

57.2% Placebo

HR 0.20

95% CI 0.10–0.37

P<0.001

SAFETY SUMMARY

GRADE ≥3 ADVERSE EVENTS

35.8% Ensartinib

18.2% Placebo

Rash was the most common grade ≥3 adverse event reported with ensartinib.

WHAT WE KNOW SO FAR

OVERALL SURVIVAL
Overall survival data remain immature.

SUBGROUP ANALYSES
The DFS benefit was generally consistent across prespecified patient subgroups.

FOLLOW-UP
Longer follow-up is needed to determine whether the DFS benefit translates into an overall survival advantage.

CLINICAL PERSPECTIVE

ELEVATE provides compelling phase 3 evidence that adjuvant ensartinib can substantially improve disease-free survival following complete resection of ALK-positive NSCLC. The magnitude of benefit is clinically important, but overall survival remains immature and longer follow-up is required.

WHAT THIS MEANS FOR PRACTICE

TARGET ALK EARLY
Test for ALK rearrangements in resected NSCLC.

DISCUSS ADJUVANT THERAPY
Consider ensartinib after surgery and adjuvant chemotherapy when appropriate.

MONITOR SAFETY
Watch for rash and treatment-related adverse events during therapy.

FOLLOW LONGER
Continue surveillance while awaiting mature overall survival data.

> Stronger evidence.
> Earlier intervention.
> Better outcomes for our patients.

— Medeasy Review Team

medeasy REVIEW

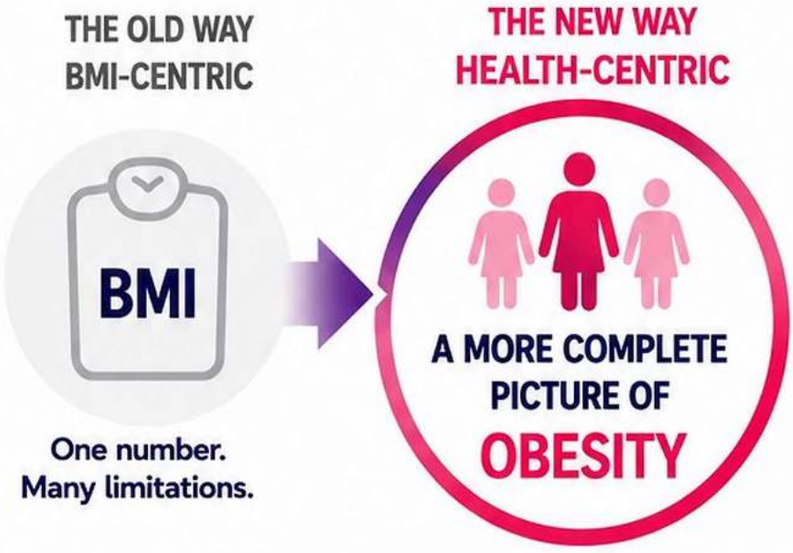
CLINICAL DISCOVERY

Beyond BMI: A New Diagnostic Era for Obesity

Moving from Size Alone to Health Impact

Obesity is more than a number on the scale. The latest evidence shows that health risk depends on how much fat we carry, where it is stored, and the impact it has on our organs and daily function.

THE PARADIGM SHIFT



The goal: identify individuals at risk earlier, personalize treatment, and improve outcomes across the obesity care journey.

WHAT REALLY MATTERS

1. ADIPOSITY

How much fat is in the body

Total body fat matters, not just body weight.

2. FAT DISTRIBUTION

Where fat is located

Visceral and ectopic fat drive higher cardiometabolic risk.

3. HEALTH IMPACT

How it affects organs and function

Metabolic, cardiovascular, and functional consequences determine risk.

WHAT THIS CHANGES IN PRACTICE

1. SCREEN BROADLY, ASSESS DEEPLY

Use BMI to screen, but look deeper to understand risk.

2. PERSONALIZE TREATMENT

Target the right pathway for the right patient at the right time.

3. IMPROVE OUTCOMES

Better identification and tailored care lead to better long-term results.

> **Obesity care is evolving.** By looking beyond BMI and focusing on **what truly matters—fat, function, and health impact**—we can change the trajectory of disease and improve lives.

Stay curious.
Stay updated.
Keep learning.
Keep caring.

— Medeasy Review Team

References:

1. Wilding JPH, Batterham RL, Calanna S, et al. The new diagnostic era for obesity, Nat Rev Endocrinol. 2026;22:453–470.
2. Rubino F, Abrahamsson N, Davies M, et al. EASO Framework for the definition and diagnosis of obesity. Obes Facts. 2024;17:321–344.

medeasy REVIEW

CLINICAL DISCOVERY

Beyond BMI

A Practical Approach to Modern Obesity Care

BMI remains useful, but it does not tell the whole story. Assessing body composition and fat distribution helps identify risk earlier, personalize treatment, and improve outcomes.



WHY BEYOND BMI?

- BMI cannot distinguish muscle from fat.
- Visceral fat is more strongly linked to cardiometabolic risk.
- People with "normal" BMI can still have high risk (normal-weight obesity).
- Use multiple measures for a more complete assessment

WAIST-TO-HEIGHT RATIO (WtHR)

A Simple Marker of Abdominal Adiposity

$$\text{Waist-to-Height Ratio (WtHR)} = \frac{\text{Waist circumference (cm)}}{\text{Height (cm)}}$$

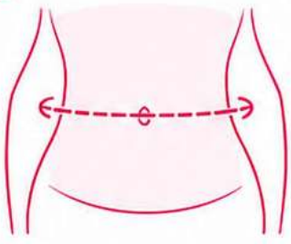
WtHR	INTERPRETATION & RISK
< 0.50	Generally associated with lower cardiometabolic risk.
> 0.50	Suggests increased abdominal adiposity and cardiometabolic risk. Interpret together with BMI, comorbidities, physical function, and overall clinical assessment.

WtHR is applicable across ages, sexes, and ethnicities. A single cutoff of >0.50 works well for most adults.

References: Ashwell M, Gunn P, Gibson S. Waist-to-height ratio is a screening tool for height-related cardiometabolic risk factors: systematic review and meta-analysis. Lancet Diabetes Endocrinol. 2012;0(0):000–000.

HOW TO MEASURE WAIST

1. Use a non-stretchable measuring tape.
2. Measure at the midpoint between the lower margin of the last palpable rib and the top of the iliac crest.
3. Ensure the tape is horizontal and snug but not compressing the skin.
4. Take the measurement at the end of a normal expiration.
5. Record to the nearest 0.1 cm.



Measurement site: Midpoint between lower rib and iliac crest

A PRACTICAL APPROACH IN CLINICAL PRACTICE

1. **SCREEN** — Assess BMI, waist circumference, and WtHR in all adults.
2. **STRATIFY RISK** — Identify patients with increased WtHR (>0.50) even if BMI is "normal".
3. **LOOK FOR RISKS** — Check blood pressure, glucose, lipids, and other cardiometabolic factors.
4. **PERSONALIZE CARE** — Combine lifestyle interventions with appropriate therapy.
5. **MONITOR & FOLLOW-UP** — Track WtHR and metabolic markers, not just weight or BMI.

> "Obesity is more than weight. Look beyond BMI. Measure what matters."

Small changes in assessment can lead to big differences in outcomes.

- Measure simply.
- Interpret holistically.
- Treat comprehensively.

For full prescribing information, please refer to the latest product monograph.

Scan for the latest obesity management guidelines and resources.

#healthcaremadeeasy

Reference: Busetto L, Dicker D, Frühbeck G, et al. A new framework for the diagnosis, staging and management of obesity in adults. Nat Med. 2024;30:2395–2399. doi:10.1038/s41591-024-03095-3.

medeasy REVIEW

PRACTICE CHANGER

Stage 1 Hypertension

Treat Early. Treat Smart. Protect for Life.

A small rise in blood pressure today can lead to big problems tomorrow. Detect early, manage wisely, and prevent cardiovascular disease.

WHY IT MATTERS

EARLY IS BETTER
Risk of heart attack, stroke, and kidney disease starts rising at this stage.

TREATMENT WORKS
Lifestyle change and medication can lower BP, reduce risk, and improve long-term outcomes.

HIGH PREVALENCE
Affects ~1 in 3 adults worldwide. Many are undiagnosed or untreated.

PREVENT, DON'T REACT
Prevent progression to Stage 2 and avoid complications.

WHAT IS STAGE 1 HYPERTENSION?

Persistent elevation in blood pressure above normal but below Stage 2.

SYSTOLIC		DIASTOLIC
130–139 mmHg	OR	80–89 mmHg

Confirm with accurate, repeated BP measurements.
Use home BP monitoring (HBPM) when appropriate.

EVALUATE TOTAL CARDIOVASCULAR RISK

Use risk calculators (e.g., PREVENT) to guide decisions.
Consider age, comorbidities, and organ damage.

- Age
- Diabetes / Prediabetes
- CKD
- Established CVD
- Other risk factors

APPROACH TO MANAGEMENT IN STAGE 1 HYPERTENSION

RISK / CLINICAL PROFILE	WHAT TO DO	WHEN TO START MEDICATION
PREVENT 10-YEAR RISK <7.5% (No CVD, CKD, DM, or target organ damage)	LIFESTYLE MODIFICATION Implement lifestyle changes and reassess in 3–6 months.	If BP remains ≥130/80 mmHg after 3–6 months, consider medication.
PREVENT 10-YEAR RISK ≥7.5% OR (With CVD, CKD, DM, or target organ damage)	LIFESTYLE + MEDICATION Start pharmacologic therapy along with lifestyle modification.	Start medication now. Do not delay if risk is high or target organ damage is present.

BP GOAL FOR MOST ADULTS: <130/80 mmHg
Individualize based on patient factors and tolerance.

LIFESTYLE FIRST, ALWAYS

WEIGHT MANAGEMENT
For patients with excess weight, even ~5% weight loss can help lower BP.

BE PHYSICALLY ACTIVE
150 minutes moderate-intensity exercise per week.

EAT HEART-HEALTHY
DASH diet: more fruits, vegetables, whole grains, lean protein.

REDUCE SODIUM
Aim for ≤2,300 mg sodium/day, ideally toward 1,500 mg/day.

QUIT SMOKING
Eliminate tobacco use.

MANAGE STRESS
Adequate sleep, relaxation, mindfulness.

FIRST-LINE MEDICATION OPTIONS

ACE INHIBITORS
e.g., enalapril, lisinopril

ARBs
e.g., losartan, telmisartan

CALCIUM CHANNEL BLOCKERS
(Long-acting dihydropyridine)
e.g., amlodipine

THIAZIDE-TYPE DIURETICS
e.g., chlorthalidone, indapamide

Choose based on patient factors, comorbidities, tolerability, and accessibility.

COMBINATION THERAPY
Consider early combination in high-risk patients for better BP control and outcomes.

> Stage 1 hypertension today can become a crisis tomorrow. **Act early. Treat appropriately.** Keep your patient's future pressure-free.

YOUR ACTION PLAN

- ☑ Measure BP accurately
- ☑ Assess total cardiovascular risk (PREVENT ≥7.5%)
- ☑ Start lifestyle changes
- ☑ Start medication when indicated
- ☑ Monitor and follow up

REFERENCES:
1. American Heart Association. 2025 AHA/ACC/AANP/APHA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. Circulation. 2025.
2. Muntner P, Carey RM, Gidding S, et al. 2025 International Society of Hypertension Global Hypertension Practice Guidelines. Hypertension. 2025.

medeasy REVIEW

PRACTICE CHANGER

Stage 1 Hypertension: Pathway to Control

Confirm with accurate, repeated BP measurements.

Use home BP monitoring (HBPM) when appropriate.

Good control saves lives. Use accurate monitoring, the right combinations, and don't miss secondary causes.

THE STEPWISE PATHWAY

1 START RIGHT

Begin with **LIFESTYLE MODIFICATION** for all patients.

Start medication if:

- PREVENT 10-year risk ≥7.5%
  or
- CVD, CKD, or diabetes
  or
- BP remains ≥130/80 mmHg after 3–6 months of lifestyle therapy.

2 COMBINE EARLY

If BP not at goal in 4–6 weeks, optimize treatment.

Use **SINGLE-PILL COMBINATION THERAPY** whenever possible.

(Better adherence, fewer pills, greater BP reduction.)

3 TITRATE & FOLLOW UP

Adjust dose or add medication every 4–6 weeks until goal.

- Reinforce lifestyle at every visit.
- Monitor for efficacy, adherence, and side effects.

4 GOAL

<130/80 mmHg

Individualize based on patient factors and tolerance.

ACCURATE BP MEASUREMENT MATTERS

PREPARE
Rest 5 minutes. No caffeine, exercise, or smoking for 30 minutes.

POSITION
Back supported, feet flat, arm supported at heart level, cuff on bare arm.

MEASURE
Use a validated device. Take 2–3 readings, 1 minute apart, and average.

CONFIRM AT HOME
HBPM: measure morning and evening for 7 days (discard day 1), average the rest.

Office BP ≥130/80 mmHg → Home BP ≥130/80 mmHg

Indicates hypertension

WHEN BP REMAINS UNCONTROLLED

Consider resistant hypertension if BP remains above goal despite:

- ☑ 3 medications of different classes (one should be a diuretic)
- ☑ Adequate doses
- ☑ Good adherence
- ☑ Lifestyle optimization

Evaluate for secondary causes and optimize therapy.

EVALUATE FOR SECONDARY CAUSES

RENAL PARENCHYMAL DISEASE
CKD, proteinuria, post-AKI.

RENOVASCULAR DISEASE
Renal artery stenosis, especially in older adults or flash pulmonary edema.

THYROID DISORDERS
Hypo- or hyperthyroidism.

OBSTRUCTIVE SLEEP APNEA
Snoring, daytime sleepiness.

PRIMARY ALDOSTERONISM
Hypokalemia, resistant HTN.

MEDICATIONS / SUBSTANCES
NSAIDs, steroids, OCPs, sympathomimetics, excess alcohol.

A NEW OPTION FOR SELECT PATIENTS

RENAL DENERVATION

For patients with uncontrolled hypertension despite optimized medical therapy.

- Adjunct therapy, not a replacement for medications.
- Shown to reduce BP in appropriate patients.
- Consider in specialized centers with experienced operators.

> Early action and consistent follow-up turn Stage 1 hypertension into **heart and kidney protection** for the long run.

YOUR ACTION PLAN

- ☑ Diagnose accurately and confirm with HBPM
- ☑ Assess total cardiovascular risk (PREVENT ≥7.5%)
- ☑ Start lifestyle changes for all
- ☑ Start medication when indicated
- ☑ Combine early, titrate, and follow up
- ☑ Goal for most adults: <130/80 mmHg

REFERENCES:

1. American Heart Association. 2025 AHA/ACC/AANP/APHA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. Circulation. 2025.
2. Carey RM, Whelton PK, Gidding S, et al. 2025 International Society of Hypertension Global Hypertension Practice Guidelines. Hypertension. 2025.

FUTURE MEDICINE

Lipids Reimagined

Beyond LDL-C. Toward True Risk Reduction.

The 2026 ACC/AHA dyslipidemia guideline shifts the focus from LDL-C alone to a broader, more personalized strategy for preventing first and recurrent cardiovascular events.

WHAT'S NEW IN THE 2026 ACC/AHA DYSLIPIDEMIA GUIDELINE

Lp(a)	PREVENT-ASCVD	LDL-C Goals	ApoB	CAC
Measure once in a lifetime	Use for risk estimation	Renewed treatment goals	Consider selectively	Use to reclassify risk and guide therapy
Elevated Lp(a) is independent and causal risk.	Better prediction across age, race, and risk factors.	Lower is better. Aim lower for higher risk.	ApoB helps identify higher atherogenic particle burden.	CAC informs risk and the intensity of therapy.

UPDATED RISK-BASED APPROACH

RISK CATEGORY	APPROXIMATE PREVENT-ASCVD 10-YEAR RISK	PRACTICAL TREATMENT APPROACH
High risk	>=10%	Treat aggressively; LDL-C goal <70 mg/dL and >=50% reduction from baseline
Intermediate risk	5% to <10%	Consider statin therapy; aim LDL-C <100 mg/dL
Borderline risk	3% to <5%	Use risk enhancers, ApoB, Lp(a), and CAC to guide intensity
Low risk	<3%	Emphasize lifestyle and long-term prevention

In patients with ASCVD at very high risk, the LDL-C target is <55 mg/dL.

A. Lp(a): THE HIDDEN RISK

- Inherited, relatively stable over life, independent of LDL-C.
- Elevated when >=125 nmol/L (>=50 mg/dL).
- Associated with higher ASCVD risk.

B. ApoB: COUNT WHAT MATTERS

- ApoB reflects the number of atherogenic particles.
- Helps refine risk when triglycerides are high, LDL-C is low, or risk appears discordant.

C. CAC: SEEING IS BELIEVING

- Coronary artery calcium helps refine risk.
- Guides whether to start or intensify statin therapy in uncertain cases.

D. MANAGING RESIDUAL RISK

- Elevated triglycerides remain a risk factor.
- Inflammation contributes to residual risk.
- Metabolic health matters.
- Lifestyle remains foundational.

THERAPEUTIC CHECKLIST

- Measure Lp(a) once
- Estimate risk with PREVENT-ASCVD
- Set LDL-C goal based on risk
- Start statin and intensify if needed
- Reassess, reinforce lifestyle, and monitor long-term

> It's not just about lowering LDL-C. It's about lowering risk, closing gaps, and preventing what matters.

KEY TAKEAWAYS

- [x] Measure Lp(a) once in a lifetime.
- [x] Use PREVENT-ASCVD, ApoB, and CAC to personalize risk.
- [x] Aim for lower LDL-C and address residual risk.
- [x] Better lipid management today means fewer events tomorrow.

Reference: Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia. Circulation. 2026;153:e1154-e1276. doi:10.1161/CIR.0000000000001423.

medeasy REVIEW

PRACTICE CHANGER

Type 2 Diabetes in 2026:

Treat the Patient, Not Just the A1C.

The 2026 ADA Standards of Care shift the focus from glucose numbers to outcomes that matter most—cardiorenal protection, weight management, and long-term well-being.

WHAT'S NEW IN THE 2026 ADA STANDARDS OF CARE

OUTCOME-FOCUSED
Treat to reduce CVD, kidney disease, HF, and mortality.

EARLY RISK REDUCTION
Use SGLT2i or GLP-1 RA early in people at risk—independent of baseline A1C.

WEIGHT MANAGEMENT
Medications with weight benefit are prioritized.

PERSONALIZED CARE
Consider patient preferences, access, and affordability.

SIMPLIFY & SUPPORT
Simplify therapy, reduce burden, and address SDOH.

A1C GOAL: INDIVIDUALIZE

For many nonpregnant adults:

<7%

is a reasonable goal.

Consider higher or lower goals based on:

- Life expectancy
- Comorbidities
- Risk of hypoglycemia
- Disease duration
- Patient preferences & treatment burden

Shared decision-making is essential.

THE 2026 ADA PERSON-CENTERED T2D CARE PATHWAY

1. ASSESS THE PERSON
Medical history, risk of hypoglycemia, weight, CKD, HF, ASCVD, and patient goals & preferences.

2. IDENTIFY THE DOMINANT CLINICAL NEED
(Treat irrespective of baseline A1C)

ASCVD
(MI, stroke, PAD)
USE GLP-1 RA AND/OR SGLT2i
with demonstrated cardiovascular benefit.

HEART FAILURE
(HFrEF or HFpEF)
PREFER SGLT2i
to reduce HF hospitalization and CV death.

CHRONIC KIDNEY DISEASE
(eGFR & albuminuria)
PREFER SGLT2i or GLP-1 RA
with demonstrated kidney benefit.
- eGFR 20–60 and/or albuminuria
- If eGFR <30: GLP-1 RA preferred for glycemic management.

OBESITY
(overweight/obesity)
PREFER GLP-1 RA
(high efficacy) for meaningful weight loss and metabolic benefit.

NONE OF THE ABOVE
Low risk and no compelling indication.
Focus on lifestyle, metabolic control, and prevention.

3. THEN OPTIMIZE GLYCEMIA
Add, adjust, or intensify therapy to achieve individualized A1C goal while minimizing hypoglycemia and side effects.

KEY CLINICAL PEARLS

CARDIORENAL BENEFITS ARE INDEPENDENT OF A1C
SGLT2i and GLP-1 RA reduce major CV events, HF hospitalization, CKD progression, and all-cause mortality.

COMBINATION THERAPY MAY BE NEEDED
Use complementary mechanisms (e.g., SGLT2i + GLP-1 RA) to achieve glycemic goals and protect organs.

MINIMIZE HYPOGLYCEMIA
Choose agents with low hypoglycemia risk, especially in older adults or those with limited life expectancy.

ADDRESS LIFESTYLE AND SDOH
Nutrition, physical activity, sleep, mental health, and social determinants are essential to outcomes.

> Great diabetes care in 2026 is about improving lives, not just lowering numbers.

KEY TAKEAWAYS

1. Address the patient's dominant risk (ASCVD, HF, CKD, or obesity).
2. Use SGLT2i for HF and CKD; GLP-1 RA and/or SGLT2i for ASCVD.
3. Individualize A1C goals and therapy based on the whole patient.
4. Prioritize weight benefit and minimize hypoglycemia.
5. Partner with patients—shared decisions lead to better outcomes.

REFERENCES:
1. American Diabetes Association. 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026. Diabetes Care. 2026;49(Suppl 1):S183–S215.
2. American Diabetes Association. 6. Glycemic Goals and Hypoglycemia: Standards of Care in Diabetes—2026. Diabetes Care. 2026;49(Suppl 1):S132–S151.

medeasy REVIEW

TECH CHECK

Your Watch Found AF. Now What?

Wearables are transforming AF detection. The 2026 guidance is clear: a watch alert is a **STARTING POINT**— not a diagnosis.

WHY IT MATTERS

EARLIER DETECTION
Find AF sooner—when treatment works best.

PREVENT STROKE
Timely diagnosis + anticoagulation saves lives.

IMPROVE QUALITY OF LIFE
Better symptom control, more energy, better daily function.

LOWER MEDICATION NEEDS
Weight loss and risk-factor control can reduce the need for medications.

LONG-TERM VALUE
Prevents complications and reduces healthcare costs over time.

> "Wearables can help find AF earlier, but smart action confirms it and improves outcomes."

THE 5-STEP PATHWAY: FROM ALERT TO ACTION

1 WATCH ALERT
Your device detects a possible irregular rhythm or AF.
This is NOT a clinical diagnosis.

2 REVIEW TRACING
Review the tracing from your device. Check for adequate signal quality and duration.
Poor-quality data needs repeat.

3 CONFIRM WITH CLINICIAN
Confirm AF with a medical-grade ECG or rhythm strip (single-lead or 12-lead).
Let your clinician confirm.

4 ASSESS STROKE RISK
Evaluate stroke risk (e.g., CHA_2DS_2-VASc) and bleeding risk. Review symptoms and comorbidities.
Risk drives therapy, not the alert alone.

5 ACT
Start or adjust treatment based on confirmed AF and risk assessment.
Anticoagulation, rate/rhythm control, lifestyle & follow-up.

KEY THINGS TO KNOW

Not all irregular rhythms are AF.
Premature beats or artifact can trigger alerts.

False positives happen.
Ask your patient to remain still and repeat if needed.

Clinical context matters.
Symptoms, duration, and overall risk guide decisions.

Shared decisions work best.
Discuss options, risks, and preferences with your patient.

AF BURDEN: THE NEXT FRONTIER

WHAT IS AF BURDEN?

AF burden is the total amount of time a patient is in AF during a given period, measured by wearables or monitors.



WHY IT MATTERS

- Evidence is growing that higher burden may be associated with worse outcomes.
- Burden adds important context alongside stroke risk, symptoms, and clinical factors.
- Guidelines are evolving—optimal thresholds and how to use burden are still being defined.

The latest evidence: treat the patient, not just the numbers. Combine AF burden with risk profile, symptoms, and patient goals.

> "A watch can raise the flag, but good medicine leads the way."

KEY TAKEAWAYS

1. Wearables help detect AF earlier—but alerts are not diagnoses.
2. Confirm AF with ECG or rhythm strip before labeling.
3. Assess stroke risk and symptoms—these drive therapy.
4. Consider AF burden to guide management intensity.
5. Partner with patients for long-term success.

REFERENCES:
1. January CT, et al. 2026 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation. Circulation. 2026.
2. Hindricks G, et al. 2026 ESC Guidelines for the management of atrial fibrillation. Eur Heart J. 2026.

medeasy REVIEW

TECH CHECK

Your Smartwatch Measures Blood Pressure. How Much Can You Trust the Number?

Smartwatches and gadgets are getting smarter.
But the number on your wrist is an **ESTIMATE**,
not a direct measurement.
Here's how they work—and what that means.

THE BIG PICTURE

Smartwatch BP = EARLY WARNING / TREND

Great for awareness and tracking changes over time.

Validated Upper-Arm Cuff = CONFIRMATION FOR CLINICAL DECISIONS

Use for diagnosis, treatment decisions, and monitoring control.

HOW DOES YOUR SMARTWATCH GET BLOOD PRESSURE?

SMARTWATCH / CUFFLESS DEVICE

ESTIMATES BLOOD PRESSURE

1. **LED LIGHT** — Green light shines into the skin and blood vessels.
2. **PULSE SIGNAL (PPG)** — Sensors detect tiny changes in blood volume with each heartbeat.
3. **ALGORITHM** — The device's algorithm uses the signal + personal data (age, sex, height, weight, etc.) and previous calibrations* to estimate BP.
4. **ESTIMATED BP DISPLAYED** — The result is an ESTIMATE, not a direct measurement of arterial pressure.

* Many devices need periodic calibration with a real cuff because accuracy can drift over time.

UPPER-ARM CUFF (GOLD STANDARD)

MEASURES BLOOD PRESSURE

1. **CUFF INFLATES** — Cuff inflates and stops blood flow in the artery temporarily.
2. **PRESSURE OSCILLATIONS** — As the cuff slowly deflates, the device detects pressure oscillations in the artery.
3. **CALCULATION** — The monitor calculates systolic and diastolic pressure based on validated physical principles.
4. **MEASURED BP (MORE ACCURATE)** — This is a DIRECT measurement and the current clinical standard.

WHY SMARTWATCH BP NUMBERS CAN BE OFF

- **Not directly measuring pressure** — Built from indirect signals and algorithms—not artery compression.
- **Movement & wrist position** — Talking, walking, or poor positioning changes the signal.
- **Wrist anatomy & vascular differences** — Skin tone, vessel depth, and stiffness vary between people.
- **Calibration & algorithm limitations** — Many models lack independent validation across diverse populations.
- **Situation & physiology** — Exercise, stress, caffeine, recent meals, cold hands, or full bladder can affect readings.

HOW CLOSE ARE THEY?

TYPICAL DIFFERENCE vs CUFF?

NO FIXED NUMBER

Accuracy varies by device, person & situation.

Even a precise **138/86** may be meaningfully different from a validated cuff reading.

There is no universal "normal" difference. What matters is accuracy for YOU.

WHAT CAN YOU USE IT FOR?

- **Spotting possible high or low BP** — Use as an early alert.
- **Tracking trends over time** — Look for consistent patterns, not single readings.
- **Motivating lifestyle changes** — Great for engagement and accountability.
- **Monitoring response to treatment as a supplement** — Still confirm with a cuff.

WHAT YOU SHOULD NOT DO

- Do not diagnose hypertension from watch readings.
- Do not start, stop, or change medication based on watch BP.
- Do not use it alone to confirm BP control.

> "Think of your smartwatch as a **SMOKE ALARM**, not a **THERMOMETER**. It alerts you—your cuff tells you the truth."

BOTTOM LINE FOR CLINICAL PRACTICE

- Treat smartwatch/cuffless BP as a SIGNAL, not a diagnosis.
- Always confirm with a VALIDATED UPPER-ARM CUFF.
- Use the whole picture: BP, symptoms, risk factors, and clinical judgment.



KEY REMINDER
When in doubt, cuff it out.
Measure right. Treat right.

REFERENCES:
1. Sharman JE, et al. AHA Scientific Statement on the Use of Cuffless Blood Pressure Measuring Devices. Circulation. 2025;152:e000–e000.
2. Whelton PK, et al. 2025 AHA/ACC Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure. Circulation. 2025;151:e000–e000.
3. Bohm M, et al. ESH Clinical Practice Guidelines for the Management of Arterial Hypertension. Eur Heart J. 2024.

medeasy REVIEW

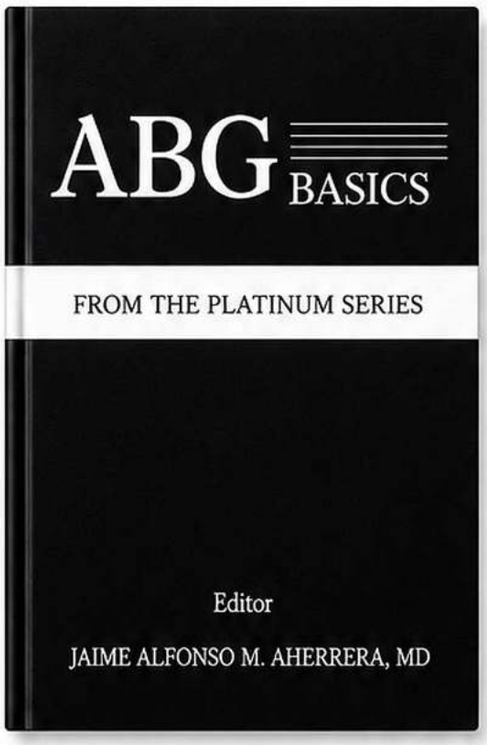
MEDEASY PICKS

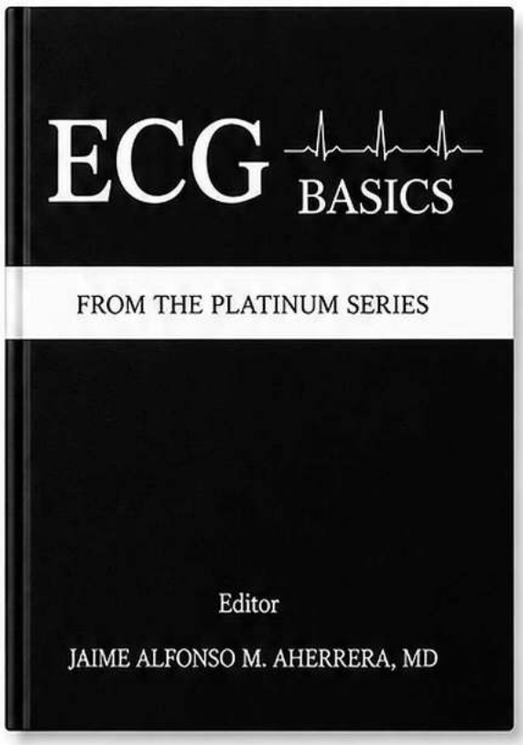
FREE DOWNLOAD
For all doctors

LIMITED-TIME ACCESS
Grab yours now!

Tools for Everyday Clinical Excellence

Knowledge at your fingertips. Download these quick-reference guides designed by clinicians, for clinicians.





ABG BASICS

A practical guide to arterial blood gas interpretation made simple.

- **Practical & Focused** — Key concepts you use every day.
- **Clinical First** — Built around real-world scenarios.
- **Easy to Understand** — Clear explanations. Better retention.
- **Quick Reference** — At the point of care, when you need it most.

ECG BASICS

A practical guide to ECG interpretation in everyday clinical practice.

- **Systematic Approach** — Clear 6-step ECG method.
- **High-Yield Focus** — Normal vs. abnormal made easy.
- **Arrhythmias Made Simple** — Understand patterns with confidence.
- **Must-Know Patterns** — High-yield patterns you must know.
- **Practice Strips** — Practice with explanations included.

GET THE MEDEASY PH APP

Your clinical companion. Anywhere, anytime.

- Earn rewards with every activity
- Access trusted medical content
- Track your points and rewards
- Built for doctors, by doctors

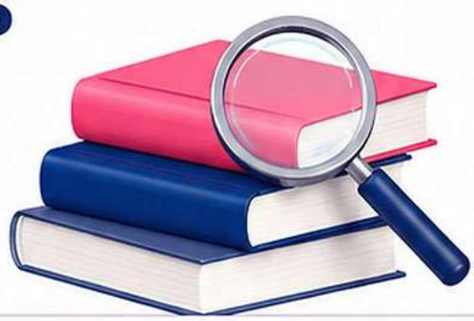
SCAN TO DOWNLOAD MEDEASY PH

GET IT ON Google Play

Download on the App Store

medeasy REVIEW

References & Sources



Primary publications and official guidelines used across Issue 01. Sources are grouped by topic so readers can trace the evidence quickly.

PEPTIDES & METABOLIC THERAPY

01 **Jastreboff AM, Kaplan LM, Frías JP, et al. Triple-Hormone-Receptor Agonist Retatrutide for Obesity - A Phase 2 Trial.**
N Engl J Med. 2023;389:514-526. doi:10.1056/NEJMoa2301972

02 **Eli Lilly and Company. Retatrutide (TRIUMPH-1) Phase 3 topline results in adults with obesity or overweight and a weight-related comorbidity.**
Press release. May 21, 2026. Company topline source.

EVIDENCE UPDATE - 2026

08 **Zoungas S, Wolfe R, Moran C, et al. Atorvastatin, Cardiovascular Events, and Disability-free Survival in Older Adults (STAREE).**
N Engl J Med. Published Aug 28, 2026. doi:10.1056/NEJMoa2607314

09 **Complete Revascularization Guided by Functional Coronary Angiography in STEMI (AIR-STEMI).**
N Engl J Med. Published Aug 29, 2026. doi:10.1056/NEJMoa2605373

10 **Takahashi K, Kozuma K, Morino Y, et al. Aspirin Omission at the Time of Primary Percutaneous Coronary Intervention in STEMI (PREMIUM).**
N Engl J Med. Published Aug 29, 2026. doi:10.1056/NEJMoa2606997

11 **Fontana M, Masri A, Solomon SD, et al. Eplontersen for Transthyretin Amyloid Cardiomyopathy (CARDIO-TTRansform).**
N Engl J Med. Published Aug 28, 2026. doi:10.1056/NEJMoa2608510

GUIDELINES 2025-2026

14 **2025 AHA/ACC multisociety guideline for the prevention, detection, evaluation, and management of high blood pressure in adults.**
Circulation. 2025. doi:10.1161/CIR.0000000000001356

15 **Blumenthal RS, et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia.**
Circulation. 2026;153:e1154-e1276. doi:10.1161/CIR.0000000000001423

16 **American Diabetes Association Professional Practice Committee. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2026.**
Diabetes Care. 2026;49(Suppl 1). doi:10.2337/dc26-S010

17 **2023 ACC/AHA/ACCP/HRS Guideline for the Diagnosis and Management of Atrial Fibrillation.**
Circulation. 2024;149:e1-e156. doi:10.1161/CIR.0000000000001193

CARDIORENAL THERAPEUTICS

03 **McMurray JJV, Solomon SD, Inzucchi SE, et al. Dapagliflozin in Patients with Heart Failure and Reduced Ejection Fraction.**
N Engl J Med. 2019;381:1995-2008. doi:10.1056/NEJMoa1911303

04 **Heerspink HJL, Stefánsson BV, Correa-Rotter R, et al. Dapagliflozin in Patients with Chronic Kidney Disease.**
N Engl J Med. 2020;383:1436-1446. doi:10.1056/NEJMoa2024816

05 **Solomon SD, McMurray JJV, Claggett B, et al. Dapagliflozin in Heart Failure with Mildly Reduced or Preserved Ejection Fraction.**
N Engl J Med. 2022;387:1089-1098. doi:10.1056/NEJMoa2206286

06 **Ray KK, Wright RS, Kallend D, et al. Two Phase 3 Trials of Inclisiran in Patients with Elevated LDL Cholesterol.**
N Engl J Med. 2020;382:1507-1519. doi:10.1056/NEJMoa1912387

07 **Sabatine MS, Giugliano RP, Keech AC, et al. Evolocumab and Clinical Outcomes in Patients with Cardiovascular Disease.**
N Engl J Med. 2017;376:1713-1722. doi:10.1056/NEJMoa1615664

ONCOLOGY & OBESITY FRAMEWORK

12 **Yue D, Huang M, Song P, et al. Ensartinib in Resected ALK-Positive Non-Small-Cell Lung Cancer (ELEVATE).**
N Engl J Med. 2026;395:151-161. doi:10.1056/NEJMoa2518990

13 **Busetto L, Dicker D, Frühbeck G, et al. A new framework for the diagnosis, staging and management of obesity in adults.**
Nat Med. 2024;30:2395-2399. doi:10.1038/s41591-024-03095-3

REFERENCE NOTE

For brevity, this page lists the principal primary studies and guideline sources. Full prescribing information, supplementary appendices, and country-specific regulatory documents should be consulted when relevant.

DISCLAIMER

Medeasy Review is intended for licensed healthcare professionals for educational purposes only. It does not replace clinical judgment, current guidelines, local regulations, or product information.

DISCLOSURES & PUBLICATION INFORMATION



Medeasy Review is committed to delivering independent, evidence-based, and engaging clinical content that supports better decisions and better outcomes.
Transparency and trust are at the core of everything we do.

EDITORIAL INDEPENDENCE

Medeasy Review's content is planned, written, edited, and published independently by the Medeasy Review Team.

Our editorial decisions are not influenced by any sponsor, advertiser, or commercial interest.

CONFLICT OF INTEREST

The Medeasy Review Team declares no relevant financial relationships or conflicts of interest related to the content in this issue.

Where potential conflicts exist (authors, advisors, or experts), they are disclosed transparently.

NO SPONSORED EDITORIAL CONTENT

This issue of Medeasy Review contains no sponsored editorial content.

All articles are developed without commercial influence.

DISCLAIMER

FOR EDUCATIONAL PURPOSES ONLY

Medeasy Review is intended for licensed healthcare professionals only.

The content in this publication is for general informational and educational purposes and does not replace professional judgment, diagnosis, or treatment.

Readers should always consult the latest product information, clinical guidelines, and local regulations before applying any information in practice.

The authors, editors, and publisher are not responsible for any injury or damage arising from the use of information contained in this publication.

> "Evidence informs. Experience guides. Compassion connects. Together, we care better."

ABOUT MEDEASY REVIEW

Medeasy Review is a monthly clinical publication for doctors.

Our mission is to make high-quality medical knowledge easy to access, easy to understand, and easy to apply — so we can improve outcomes, one patient at a time.

FREQUENCY
Monthly

AUDIENCE
Licensed Physicians

PUBLISHER
NVI Health Tech Corp. (Medeasy PH)

BASED IN
Philippines

CONTACT & CONNECT

Website
www.medeasy.ph

Email
info@medeasy.ph

Facebook
facebook.com/medeasy.ph

Instagram
@medeasy.ph

LinkedIn
Medeasy PH

SCAN TO DOWNLOAD THE MEDEASY APP

Download on the App Store

GET IT ON Google Play

medeasy
#HealthcareMadeEasy

Thank you for being part of our community.
Your commitment to learning inspires us every day.
Let's keep learning. Let's keep caring. Let's keep making a difference.