NEJM | Clinician

WEEK OF
May 18th

Emerging Lipid Biomarkers and Cardiovascular Risk

CHRISTOPHER W. GOODMAN, M.D.
REVIEWING: JAMA NETWORK OPEN
MAY 12

Clinical Takeaway: Adding apolipoprotein B and lipoprotein(a) to the PREVENT risk calculator did not meaningfully improve ASCVD prediction.

Context

Elevations in lipoprotein(a) (Lp[a]) and apolipoprotein B (apoB) have been linked to excess cardiovascular risk. Recently published lipid guidelines recommend using these biomarkers to guide risk stratification and tailor treatment decisions, but there is limited evidence to support their practical role in clinical decision-making.

In this study, researchers pooled three large U.S.-based cohorts to identify ~10,000 adults (mean age, 48 years) without cardiovascular disease at baseline; they then examined whether integrating Lp(a) and apoB into the PREVENT base model improves the prediction of atherosclerotic cardiovascular disease (ASCVD). Median follow-up was 21 years, and ~1100 ASCVD events occurred.

Key Results

- When added to the PREVENT risk calculator, neither biomarker improved the accuracy of ASCVD risk prediction.
- Neither biomarker improved net reclassification — a measure of how often patients are correctly moved across guideline risk thresholds (e.g., ASCVD risk of 5%, 7.5%, 20%) — in adults aged 40 and older.

Comment

These results call into question the routine use of these new lipid biomarkers. While apoB and Lp(a) do not materially improve population-level risk prediction when added to PREVENT, they may still have value in individual risk refinement and decision-making in specific scenarios — for example, when estimated cardiovascular risk is close to a treatment threshold or when a patient is particularly hesitant about starting a statin. I've been hesitant to incorporate these biomarkers into my practice because of limited evidence to guide their use, and based on these results, I'm going to remain highly selective with their use.

Tang R, et al. Traditional and emerging lipid markers for cardiovascular risk assessment in young vs older adults. JAMA Netw Open 2026 Apr; 9:e265199. DOI: 10.1001/jamanetworkopen.2026.5199.

Updated Surviving Sepsis Guidelines

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WEEK OF May 25th

PATRICIA KRITEK, M.D. | REVIEWING: CRITICAL CARE MEDICINE | MAY 15

Clinical Takeaway: The newest guidelines shift to a more nuanced, patient-centered approach and away from strict targets for all patients.

An overview of Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2026

Background

This is the fifth update to the guidelines, which were previously updated in 2021. The recommendations, from the Society of Critical Care Medicine and the European Society of Intensive Care Medicine, are based on best available evidence (assessed by the GRADE approach) as well as cost, equity, feasibility, and patient values.

Key Recommendations

- In screening for sepsis, favor tools such as systemic inflammatory response syndrome (SIRS) criteria and modified Early Warning Score (MEWS) over the quick Sequential Organ Failure Assessment (qSOFA), which is less sensitive.
- Administer fluids before vasopressors for persistent hypotension; the groups conditionally recommend an initial fluid bolus of 30 ml/kg. However, patients in unstable shock can receive fluids and vasopressors together. (The groups acknowledge that debate on vasopressor timing continues.)
- Resuscitate to a mean arterial pressure of 65 mm Hg for adults <65 years of age. Some evidence suggests the target may be lower (60–65 mm Hg) for adults 65 years of age or older.
- Order blood cultures before antibiotics. Administer antibiotics within 1 hour for patients in shock or for those with definite or probable sepsis. However, for more stable patients or those with less certainty of the diagnosis, waiting up to 3 hours is reasonable.
- Consider active fluid removal (i.e., diuresis or ultrafiltration) after the initial phase of resuscitation.

Comment

This update reflects a transition to more patient-centered treatment and a movement away from strict “one size fits all” recommendations for patients with sepsis. The guidelines highlight ongoing uncertainty regarding initial resuscitation, methods used to guide resuscitation, and timing of antibiotics, because of conflicting results or a paucity of convincing evidence. They also strike more of a balance between antimicrobial stewardship and early, broad administration of antibiotics. Despite the many new recommendations, we should be able to implement them relatively easily, as they are mostly small tweaks to care as opposed to major changes

Prescott HC, et al. Surviving Sepsis campaign: International guidelines for management of sepsis and septic shock 2026. Crit Care Med 2026 Apr; 54:725. DOI: 10.1097/CCM.0000000000007075.

Randomized Trial Supports Semaglutide for Alcohol Use Disorder

CHRISTOPHER W. GOODMAN, M.D.
REVIEWING: LANCET
MAY 20

Clinical Takeaway: This small study provides the strongest evidence to date that a GLP-1 agonist can reduce harmful alcohol use.

Context

Observational evidence has suggested that glucagon-like peptide-1 (GLP-1) agonists might improve outcomes for patients with alcohol use disorder. The mechanism is thought to involve the brain's reward system, which is involved in addictive behavior and, it turns out, is chock-full of GLP-1 receptors. Now, randomized trial data are beginning to emerge.

In this study, researchers randomized ≈100 treatment-seeking patients with alcohol use disorder and obesity to once-weekly semaglutide (titrated to 2.4 mg) or placebo for 26 weeks. All participants received cognitive behavioral therapy; most met diagnostic criteria for severe alcohol use disorder.

Key Results

- Heavy drinking decreased from 17 days per month at baseline to 13 with placebo and 10 with semaglutide — a significant 3-day difference.
- Days without any alcohol use in the past month increased from 9 at baseline to 11 with placebo and 12 with semaglutide, though this difference was not significant (P=0.051).
- Side effects with semaglutide were common (>50% of patients).

Comment

This study was relatively small, and many patients likely knew they were taking semaglutide rather than placebo, due to side effects and weight reduction. Nevertheless, I'm convinced that GLP-1s deserve serious consideration as treatment options for alcohol use disorder. We should still favor standard first-line therapies, such as naltrexone and acamprosate, given their robust clinical evidence, lower cost, and real-world experience, but GLP-1 agonists might be reasonable second-line options. The changes in this study might appear modest, but are better than those seen in trials of FDA-approved medications for alcohol use disorder — and another effective option is no small thing.

Klausen MK, et al. Once-weekly semaglutide versus placebo in patients with alcohol use disorder and comorbid obesity: A randomised, double-blind, placebo-controlled trial. Lancet 2026 May 2; 407:1687.

How Common Are CV Risk Enhancers?

SARAH E. POST, M.D.
REVIEWING: JOURNAL OF GENERAL INTERNAL MEDICINE
MAY 15

Clinical Takeaway: More than three quarters of U.S. adults have at least one.

Context

The 2026 lipid guidelines from the American College of Cardiology and the American Heart Association reaffirm the recommendation to consider risk-enhancing factors as part of cardiovascular risk assessment, especially for patients at borderline risk. In this National Health and Nutrition Examination Survey analysis from 2015 to 2020, researchers evaluated data from 3000 adults aged 40 to 75 without known atherosclerotic cardiovascular disease (ASCVD) to estimate the prevalence of nine risk enhancers: family history of premature ASCVD, chronic kidney disease, metabolic syndrome, rheumatoid arthritis, early menopause, elevated high-sensitivity C-reactive protein (hsCRP), and three lipid measures (high non-HDL cholesterol, LDL cholesterol, or triglycerides).

Key Results

- Overall, risk enhancers were common: The estimated population prevalence of at least one risk enhancer was 77%, and 28% had three or more.
- In individuals with borderline risk (10-year ASCVD risk: 5%–7.4%, per the standard definition at the time the analysis was done), the results were similar: 80% had any risk enhancer, and 30% had 3 or more.
- Elevated hsCRP and metabolic syndrome were the most common risk enhancers (≈50%).

Comment

Risk enhancers are incredibly common among U.S. patients, which raises the question of whether they add much value for risk stratification. We still don't know how individual risk enhancers improve risk prediction beyond what standard calculators offer. Personally, I rely on PREVENT to decide when to discuss lipid-lowering therapy, and I may point out someone's personal risk enhancers as part of an individualized discussion. But for patients in the borderline category who are uncertain about medication, I favor coronary artery calcium scoring to tip the balance: the guideline provides a clear framework for incorporating these results into treatment decisions.

Wilson LM, et al. Prevalence of atherosclerotic cardiovascular disease risk-enhancing factors and their association with primary prevention statin use. J Gen Intern Med 2026 Apr 20; [e-pub]. DOI: 10.1007/s11606-026-10423-5

Endovascular Therapy for Patients with Post-Thrombotic Syndrome

PAUL S. MUELLER, M.D., M.P.H., M.A.C.P.
REVIEWING: NEW ENGLAND JOURNAL OF MEDICINE
MAY 12

Clinical Takeaway: Endovascular therapy improved disease severity and quality of life at 6 months.

Context

Post-thrombotic syndrome after acute lower-extremity deep venous thrombosis (DVT) is characterized by persistent symptoms and signs of chronic venous insufficiency such as pain, pruritus, edema, and ulceration. This syndrome is especially common and severe after proximal DVT, particularly with iliac-vein obstruction. To find out whether targeted treatment would improve outcomes in these patients, researchers randomized 225 adults with moderate-to-severe post-thrombotic syndrome and image-confirmed iliac-vein obstruction to endovascular therapy (iliac-vein stent and recommendation for ≥6 months of anticoagulants and aspirin) or to no endovascular therapy. Both groups received standard care (e.g., knee-high compression stockings, anticoagulation according to risk for recurrent DVT).

Key Results

- The primary outcome was the change in the 30-point Venous Clinical Severity Score (mean score at baseline, 12). At 6 months, the mean score had decreased by 4 points in the endovascular-therapy group and by 2 points in the no–endovascular-therapy group — a modest but statistically significant difference.
- Measures of quality-of-life were significantly better with endovascular therapy.
- Bleeding, however, was significantly more common in the endovascular-therapy group (12% vs. 4% of patients), which received more-potent antithrombotic therapy (antiplatelet use: 71% vs. 21%).

Comment

These results may not apply to endovascular therapy performed by less-experienced operators, and follow-up beyond 6 months is needed. Nevertheless, based on these findings, I will consider referring more of my patients with severe post-thrombotic syndrome and evidence of iliac-vein obstruction for consideration of possible endovascular therapy.

Vedantham S, et al. Endovascular therapy for post-thrombotic syndrome — A randomized trial. N Engl J Med 2026 Apr 13; [e-pub]. DOI: 10.1056/NEJMoa2519001.

Sitting with Patients at the Bedside

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WEEK OF June 1st

DANIEL D. DRESSLER, M.D., M.SC., M.H.M., M.A.C.P.
REVIEWING: JOURNAL OF HOSPITAL MEDICINE
MAY 26

Clinical Takeaway: Taking a minute to pull up a chair goes a long way with hospitalized patients.

Context

Clinicians caring for hospitalized patients generally stand at the bedside during patient encounters, which some believe will save time and improve clinical efficiency. In a recent publication in the series, “Things We Do For No Reason™,” authors review the published literature that addresses this common practice.

Key Findings

- Several studies report patients’ preference for clinicians to sit during interactions at the bedside
- In a small randomized trial, patient perception of physician communication was significantly improved for direct-care hospitalists who sat at the bedside compared with those who stood.
- Multiple studies show that sitting at the bedside does not increase visit duration compared with standing and that patients perceive their clinical encounters as longer when physicians are seated.

Comment

It’s time to abandon standing at the bedside — and its false association with improved efficiency. I go out of my way to sit, or sometimes kneel, at the bedside (though I avoid sitting on the edge of the bed for purposes of infection control and patient privacy). For the same amount of time as a standing encounter, sitting can help patients feel more heard and acknowledged. Some unpublished data even suggest that formal patient satisfaction scores can improve when physicians sit at the bedside. It’s sometimes inconvenient to sit when I need to drag a chair across the room, but it’s almost always worth it.

Updated Guidance on Metabolic Dysfunction–Associated Liver Disease

JEFFREY KOHLWES, M.D., M.P.H.
REVIEWING: CLINICAL GASTROENTEROLOGY & HEPATOLOGY
MAY 27

Clinical Takeaway: The new recommendations focus on screening and treatment within the primary care setting.

An overview of the 2026 Updated Global Consensus Recommendations for Risk Stratification, Treatment Initiation, and Response Monitoring in Metabolic Dysfunction–Associated Steatotic Liver Disease

Background

Metabolic dysfunction–associated steatotic liver disease (MASLD) is increasingly diagnosed and managed in primary care settings, thanks to rapid improvements in noninvasive tests for fibrosis and the recent approval of semaglutide and resmetirom for treatment. In response to these changes, a multidisciplinary international panel has released updated consensus recommendations on MASLD; their work was partially supported by companies that manufacture resmetirom and MASLD diagnostic tests.* Both the panel and the American Diabetes Association (ADA) focus on MASLD-associated advanced liver fibrosis, which is now considered the primary driver of mortality in MASLD.

Key Recommendations

Risk Stratification

- Patients with type 2 diabetes, obesity, or both are at risk for MASLD-associated advanced liver fibrosis and should undergo risk stratification, preferably using noninvasive tests rather than liver biopsy.
- The fibrosis-4 (FIB-4) index is the preferred tool for risk assessment.
- Patients with a FIB-4 score ≥1.3 (or ≥2.0 for age ≥65) should undergo confirmatory testing using either vibration-controlled transient elastography (VCTE) or the proprietary Enhanced Liver Fibrosis (ELF) blood test. Those found to have stage F2 or greater fibrosis, defined as liver stiffness ≥10 kPa on VCTE or an ELF score ≥9.8, should be referred to a specialist.

Treatment

- Lifestyle modification remains first-line treatment for all patients with steatosis.
- Pharmacologic therapy is recommended for patients with MASLD and F2 or F3 fibrosis (VCTE 10–15 kPa or ELF 9.8–10.5). It can also be considered in select patients with

lower fibrosis scores (VCTE 8–10 kPa or ELF 9.2–9.8) depending on their cardiometabolic risk. It is not indicated for patients with cirrhosis.
- Shared decision-making is recommended when choosing between semaglutide and resmetirom. Patients with a suboptimal response to either agent may benefit from addition of the alternate agent.

Monitoring for Treatment Response

- VCTE or ELF should be repeated after 12 to 16 months of optimized therapy. Results suggestive of disease progression (a ≥30% increase in liver stiffness or a ≥0.5-point increase in ELF) should be confirmed with a different noninvasive test to ensure accuracy.

Comment

These screening recommendations generally align with current ADA guidance and provide a practical framework for using FIB-4 in primary care settings. However, industry sponsorship should be acknowledged as a potential source of bias, especially in terms of treatment recommendations. Although I agree with the panel's emphasis on shared decision-making, particularly in the absence of head-to-head trials, I think semaglutide should be the preferred initial treatment for most patients because it has a higher rate of MASLD resolution and broader cardiometabolic benefits than resmetirom. Given that MASLD management is rapidly evolving, I often comanage the care of these patients with hepatologists.

*Many of the guideline authors also have personal financial ties to these companies and to the maker of semaglutide.

Younossi ZM, et al. Updated global consensus recommendations for risk stratification, treatment initiation, and response monitoring in metabolic dysfunction-associated steatotic liver disease. Clin Gastroenterol Hepatol 2026 Apr 6; [e-pub]. DOI: 10.1016/j.cgh.2026.03.030.

The Roadmap for MASLD: From Risk Stratification to Management Action

STEP 1: IDENTIFICATION & INITIAL RISK STRATIFICATION

Who to Screen for High-Risk MASLD

- Type 2 Diabetes
- Medically Complicated Obesity
- Persistent Liver Enzyme Elevation

The First-Line Tool: FIB-4 Index

Score < 1.3 (or < 2.0 for age ≥65): **Low Risk**
Maintain in Primary Care; Retest in 1-3 years based on Cardiometabolic Risks (CMRs)

Score ≥ 1.3 (or ≥ 2.0 for age ≥65): **High Risk**
Progression to Step 2 Testing (VCTE or ELF)

STEP 2: STAGING-TO-ACTION THRESHOLDS

	VCTE LSM (kPa)	ELF Score	
Probable Cirrhosis	> 20.0	≥ 11.3	**Specialist referral** for cirrhosis care; No resmetirom or semaglutide
Advanced Fibrosis	15.0 – 20.0	10.5 – 11.3	**Use 2nd NIT to exclude cirrhosis;** if excluded, treat as MASH (F2-F3).
MASH F2–F3	10.0 – 15.0	9.8 – 10.5	**Refer to specialist;** Lifestyle intervention + eligible for resmetirom or semaglutide
At Risk	8.0 – 10.0	9.2*– 9.8	**Clinical judgement based on CMRs;** Treat as MASH (F2-F3)
Low Risk	VCTE LSM < 8.0	ELF Score < 9.2*	**Primary care management;** Lifestyle intervention + Retest in 1-3 years based on CMRs

* Some regional protocols may utilize a lower threshold of 9.0

MANAGEMENT GOALS

Weight Loss Targets

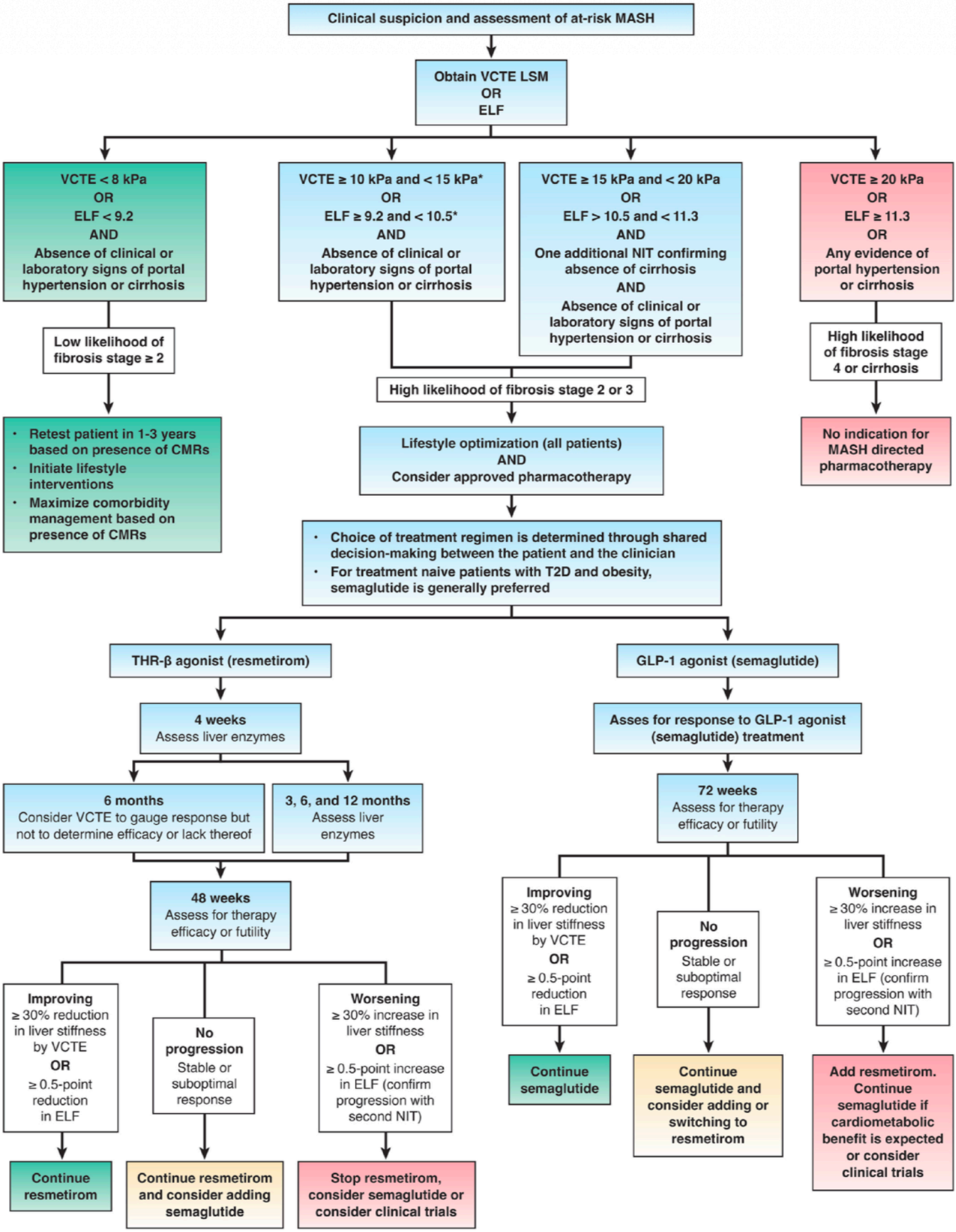
Improeve all pathologic features of MASH including fibrosis

Mediterranean Dietary Pattern

Increase fruits, vegetables, legumes, nuts, olive oil. Strictly limit ultra-processed foods, saturated fats, added fructose.

Physical Activity & Lifestyle

150-300 min/week moderate-intensity (or 75-150 min vigorous) exercise. Resistance exercise 2-3 days a week. Smoking cessation. Total alcohol avoidance in advanced disease.



*VCTE between 8-10 kPa and ELF between 9-9.2 are reasonable cut-points to initiate treatment in selected patients

Figure 2. Algorithm for use of ELF, VCTE, and medications.

Can We Still Trust Single-Dose Fosfomycin for Uncomplicated UTI?

GEORGE SAKOULAS, M.D.
REVIEWING: LANCET
MAY 27

Clinical Takeaway: New trial results favor short-course nitrofurantoin instead.

Context

Nitrofurantoin and fosfomycin are both guideline-recommended for the management of uncomplicated urinary tract infection (UTI), but a previous randomized trial showed that single-dose fosfomycin was less effective than nitrofurantoin. Now, we have a second randomized trial comparing the two agents as well as pivmecillinam, which was only recently approved in the United States but is also guideline-recommended.

The open-label, multicenter trial involved 720 **women** in Spain (median age, 48) presenting to primary care with symptoms of uncomplicated UTI and dipstick testing positive for nitrites or leukocyte esterase.

Key Results
Rates of complete symptom resolution at day 7 were as follows:

74% with nitrofurantoin (100 mg three times daily for 5 days)
- 70% with pivmecillinam (400 mg three times daily for 3 days)
- 67% for two-dose fosfomycin (3 g, 24 hours apart)
- 59% for single-dose fosfomycin (3 g)

Only the difference between nitrofurantoin and single-dose fosfomycin was statistically significant. However, the difference between pivmecillinam and single-dose fosfomycin was also clinically meaningful, according to the authors' predefined threshold.

Adverse events were mild and generally similar across treatments.

Comment

Like most clinicians, I already had less confidence in single-dose fosfomycin than in short-course nitrofurantoin, and these findings reinforce that view. Of note, the study used broad inclusion criteria, so some participants may not have had true bacterial UTIs. In addition, the study fell short of its recruitment goals, but I still trust the results, given their similarity to the previous trial and everyday clinical experience. Taken together, these findings support choosing short-course nitrofurantoin over single-dose fosfomycin for uncomplicated UTI, at least until we better define optimal fosfomycin dosing.

Llor C, et al. Clinical and bacteriological effectiveness of three different short-course antibiotic regimens and single-dose fosfomycin for uncomplicated lower urinary tract infections in women (SCOUT): A pragmatic, multicentre, open-label, randomised clinical trial. Lancet 2026 Apr 25; 407:1603. DOI: 10.1016/S0140-6736(25)02171-3.

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WEEK OF June 8th

Early Transition to Oral Antibiotics after Hospitalization for Serious Infection

NEIL H. WINAWER, M.D., S.F.H.M.

REVIEWING: CLINICAL INFECTIOUS DISEASES
JUNE 3

Clinical Takeaway: Oral therapy reduced treatment-related complications while maintaining efficacy comparable to that of prolonged IV therapy.

Context

Landmark trials have established the efficacy of early transition from intravenous (IV) to oral antibiotics for many challenging infections

But unlike outpatient parenteral antimicrobial therapy (OPAT) programs, complex outpatient antimicrobial with oral agent (COpAT) programs have not been widely adopted. To provide further evidence, researchers conducted a pragmatic trial across five hospitals, randomizing adults needing at least 2 weeks of antibiotics after discharge for serious infections (other than central nervous system infections) to receive early transition to oral therapy or continued IV therapy. The early-oral group received a high-bioavailability antibiotic regimen beginning at randomization or, in patients with bacteremia, when blood cultures were negative for 48 to 72 hours.

Most infections were bone/joint (73%) or endovascular (14%), and nearly half were bacteremic. The early-oral group transitioned to oral therapy at a median of 4 days and received oral agents on 89% of treatment days (vs. 39% in the IV-only group). Both groups received treatment for about 6 weeks.

Key Results

- The trial was stopped after enrolling 90 patients, when additional enrollment was considered unlikely to change findings.
- Early oral therapy significantly reduced adverse events, driven largely by elimination of line complications (occurring in 25% of the IV-only group and none of the early-oral group).
- Therapeutic efficacy was similar in the two groups.

Comment

These findings reinforce established evidence for hastening transition to oral antibiotics, even for our patients with challenging infections. When reliable oral options and outpatient monitoring are available, earlier transition should be actively considered as standard practice rather than the exception.

Juskowich JJ, et al. Using the Comparing Oral versus Parenteral Antimicrobial Therapy (COPAT) clinical trial to influence institutional practice transformation towards earlier transition to oral antibiotics. Clin Infect Dis 2026 Apr 30; 82:e674. DOI: 10.1093/cid/ciaf707.

Breaking the Unfractionated Heparin Habit in Acute VTE

AARON J. CALDERON, M.D., F.A.C.P., S.F.H.M.
REVIEWING: JOURNAL OF HOSPITAL MEDICINE
JUNE 3

Clinical Takeaway: For patients who initially require nonoral treatment, it's time to change our default to low-molecular-weight heparin.

Context

Direct oral anticoagulants can be initiated immediately in many patients with low- to moderate-risk acute venous thromboembolism (VTE). But for patients who initially require nonoral treatment, many clinicians continue to choose unfractionated heparin (UFH) despite strong evidence favoring low-molecular-weight heparin (LMWH). Much of this preference stems from the longstanding belief that UFH works faster and is more potent because it's intravenous. Clinicians also value the drug's familiarity and easy reversibility, particularly if advanced therapies might be needed. Now, a "Things We Do for No Reason" report revisits the evidence supporting LMWH as the preferred parenteral option for most patients.

Key Points

- LMWH achieves therapeutic anticoagulation more predictably and more quickly (3–5 hours) than UFH, which can take at least twice as long.
- LMWH is associated with lower rates of major bleeding, recurrent VTE, and heparin-induced thrombocytopenia than UFH.
- LMWH requires less frequent monitoring, reduces nurses' workload, and is associated with a shorter length of stay than UFH.
- Importantly, emerging evidence is challenging the assumption that patients with possible or expected clinical deterioration must begin on UFH. Two recent studies show that even patients who later require escalation to systemic thrombolysis or catheter-directed interventions can generally be managed safely after initial LMWH therapy.
- UFH should be reserved for patients who have severe renal impairment, a high risk of bleeding, or a strong likelihood of needing immediate reversal.

Comment

We should stop reflexively choosing UFH and instead lean on the abundant evidence. For most patients with VTE who require a nonoral initial anticoagulant, I would choose LMWH, even when I'm concerned that escalated therapy might be needed; a recent guideline supports this approach. UFH still has a role, but it should be the exception, not the default.

Saklawi Y, et al. Things we do for no reason™: Routine use of unfractionated heparin for initial anticoagulation in venous thromboembolism. J Hosp Med 2026 Apr 20; [e-pub]. DOI: 10.1002/jhm.70331.

How Helpful Are Continuous Glucose Monitors for Type 2 Diabetes?

MOLLY S. BRETT, M.D.
REVIEWING: LANCET: DIABETES & ENDOCRINOLOGY
MAY 27

Clinical Takeaway: In a randomized trial, patients using CGMs had greater improvement in HbA1c levels.

Context

Recent guidelines from the American Diabetes Association (ADA) recommend expanded use of continuous glucose monitors (CGMs) in patients with type 2 diabetes. However, the real-world benefits of CGM use in this population remain uncertain.

In this open-label, industry-supported trial, researchers recruited 300 patients with type 2 diabetes (mean age, 61; mean diabetes duration, 17 years) from the U.K. At baseline, participants were taking basal insulin plus various other antidiabetes drugs, including sodium–glucose cotransporter-2 inhibitors, glucagon-like peptide-1 receptor agonists, and metformin. Patients were randomized to CGM use or self-monitoring of blood glucose in two phases: A self-management phase (weeks 1–16) that involved self-titration of basal insulin, and a clinician-supported phase (weeks 17–32) where additional therapies could be initiated. At baseline, patients in both groups had mean glycosylated hemoglobin (HbA1c) levels of 8.8%.

Key Results

- Mean HbA1c in the control group decreased to 8.7% and 8.3% at 16 and 32 weeks, respectively. In the CGM group, decreases were greater — to 8.0% and 7.8% at 16 and 32 weeks, respectively.
- Mean total daily insulin doses did not differ by group during the study, but participants in the CGM group were significantly more likely to initiate prandial insulin.
- Two instances of severe hypoglycemia occurred in the control group versus none in the CGM group.

Comment

This study supports ADA recommendations for expanded use of CGMs in patients with type 2 diabetes, and it mirrors my clinical experience: With real-time data about their blood sugar, many patients make lifestyle adjustments and are more open to medication changes. Commercial insurance coverage remains a barrier for obtaining CGMs, particularly for patients who use basal but not prandial insulin.

Wilmot EG, et al. Continuous glucose monitoring versus self-monitoring of blood glucose in individuals with type 2 diabetes: A randomised, multicentre, open-label, superiority trial. Lancet Diabetes Endocrinol 2026 Jun; 14:463. DOI: 10.1016/S2213-8587(26)00076-8.