weight, waist, insulin resistance, and triglycerides and increases in HDL cholesterol and adiponectin levels.

New trials are currently evaluating the potential of rimonabant in the prevention of diabetes in overweight/obese patients with impaired glucose tolerance (prediabetes) (‘RAPSODY’) or in the management of insulin-treated patients with type 2 diabetes (‘ARPEGGIO’). Finally, the ongoing ‘CRESCENDO’ (Comprehensive Rimonabant Evaluation Study of Cardiovascular ENDpoints and Outcomes) study will assess whether rimonabant 20 mg can reduce the risk of major cardiovascular events in 17 000 abdominally obese patients with clustering risk factors (at least half with type 2 diabetes) followed for 5 years.

Rimonabant 20 mg is recognized in Europe as an adjunct to diet and exercise for the treatment of obese patients (BMI ≥30 kg/m²) or overweight patients (BMI >27 kg/m²) with associated risk factor(s), such as type 2 diabetes or dyslipidaemia. Furthermore, half of the observed improvements on HbA1c, as well as HDL cholesterol and triglycerides, was recognized to occur beyond weight loss, in agreement with direct peripheral metabolic effects. Even if we agree that lifestyle intervention is essential, the potential role of rimonabant, a drug targeting multiple cardiometabolic risk factors, in overweight/obese patients with type 2 diabetes and high-risk cardiovascular disease deserves consideration.

References


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Rimonabant as an adjunct therapy in overweight/obese patients with type 2 diabetes: reply

Thank you for forwarding the letter of the distinguished colleagues, Andre Scheen and Luc Van Gaal, and the opportunity to respond.

The potential of rimonabant, the first representative of a new class of drugs, the CB1-receptor blocker, to induce weight loss and beneficial metabolic effects in support of a healthier lifestyle are undoubtedly impressive (references 3 and 4 of the letter). Guidelines, however, are to be based on available evidence in the form of published, full papers at the time they are consented. In view of this pre-condition, we regret that the rimonabant data in patients with diabetes were published after the complex work of the guideline-producing process had been terminated. Moreover, some of these data are still available in the abstract format only (reference 5 of the letter).

When time comes to update the Joint ESC/EASD Guidelines on Diabetes, Prediabetes and Cardiovascular Diseases, we certainly foresee the need to consider also the state of affair in terms of rimonabant. By that time, it would be rather helpful if the weight-reducing and metabolic effects in high-risk patients with type 2 diabetes could be shown to indeed translate into a reduction of major cardiovascular events or appropriate surrogate markers.

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