We provide an up-to-date meta-analysis of trials showing the benefits of SGLT2i for the reduction of cardiorenal mor- bidity and mortality in individuals living with HF or CKD and we reappraise the comparison of SGLT2i in people with T2D as well.Additionally, the significant but modest reduction in non-fatal MI of 10% with SGLT2i remains not significantly different from the 6%-point estimate reduction associated with GLP-1 RA, which itself is not significant.In the current analy- sis, however, the risk reduction associated with SGLT2iWe believe, therefore, that the existing CCS guidelines recommending use of an SGLT2i in adults with CKD (UACR>20 mg/mmol, eGFR>=25 mL/min/1.73m2) to reduce the composite of a significant decline in eGFR, progression to end-stage kidney disease or death due to kid- ney disease, all-cause and CV mortality, non-fatal MI, and hospitalization for HF remain largely unchanged although a slightly lower eGFR of 20 mL/min/1.73m2 would be con- sidered reasonable.Finally, it is impor- tant to note that the prior CCS cardiorenal guideline com- mittee did not feel that recommendations regarding either HF or CKD protection using GLP1-RA were warranted in the absence of published, dedicated trials in these popula- tions.The EMPA-Kidney trial is unique in adding informa- tion to participants with CKD defined by an eGFR of at least 20 mL/min/1.73m2 but less than 45 mL/min/1.73m2 of body-surface area, or who had an eGFR of at least 45 mL/min/1.73m2 but less than 90 mL/min/1.73m2 with a urinary albumin-to-creatinine ratio (with albumin mea- sured in milligrams and creatinine measured in grams) of at least 200.The effect on the combined outcome of CV mortality or HF hospitaliza- tion also remained unchanged (25% reduction) despite the data from two additional trials (DELIVER and EMPULSE, Fig.