

We provide an up-to-date meta-analysis of trials showing the benefits of SGLT2i for the reduction of cardiorenal morbidity 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 analysis, however, the risk reduction associated with SGLT2i. We believe, therefore, that the existing CCS guidelines recommending use of an SGLT2i in adults with CKD (UACR >20 mg/mmol, eGFR \geq 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 kidney 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 considered reasonable. Finally, it is important to note that the prior CCS cardiorenal guideline committee 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 populations. The EMPA-Kidney trial is unique in adding information 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 measured in milligrams and creatinine measured in grams) of at least 200. The effect on the combined outcome of CV mortality or HF hospitalization also remained unchanged (25% reduction) despite the data from two additional trials (DELIVER and EMPULSE, Fig.