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.