NEWSLETTER 3

Top 10 Take-Home Messages of the 2026 CKM Guideline

From staging and PREVENT risk to guideline-directed therapy across the spectrum

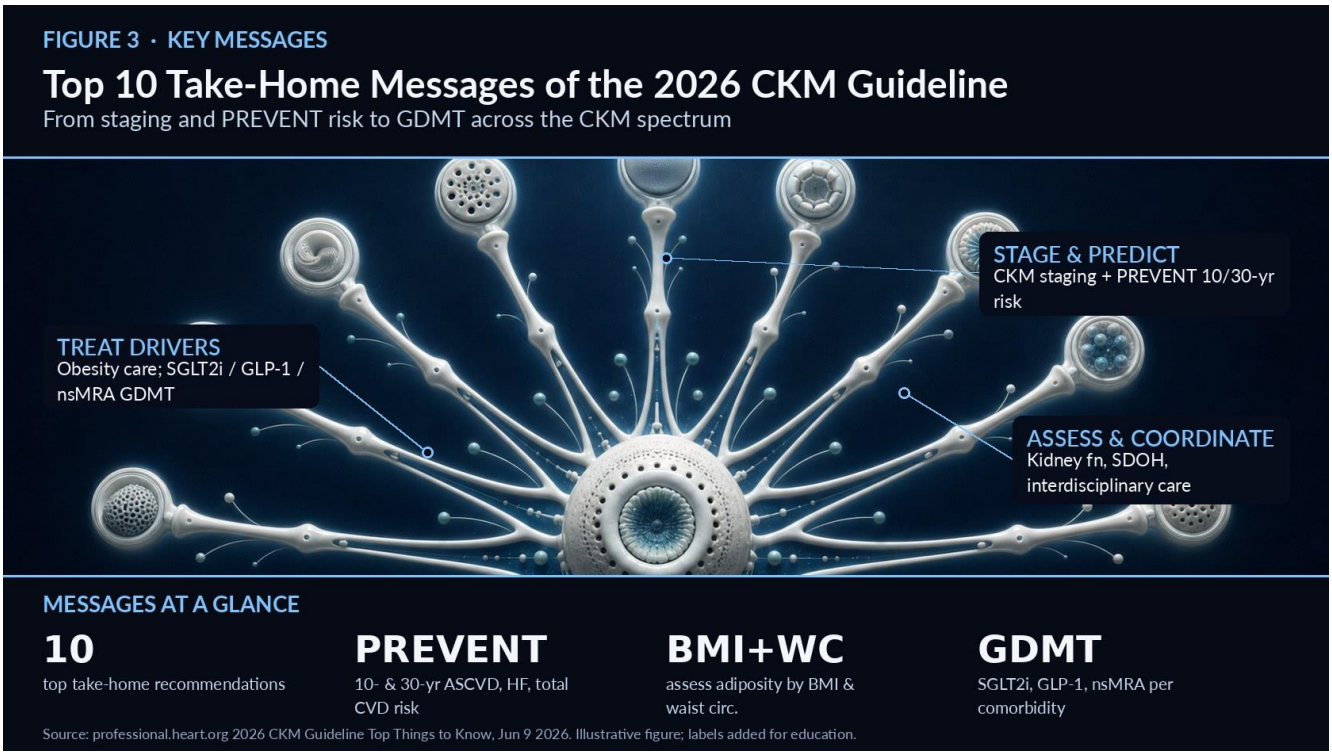

Figure 3. Top 10 Take-Home Messages of the 2026 CKM Guideline — mechanism overview (illustrative; labels added for education).

The guideline's companion "Top Things to Know" distils the document into ten clinically actionable messages that map neatly onto a workflow of stage, predict, assess, coordinate, and treat.[1]

Messages 1–2 establish the foundation: CKM staging is recommended for youths and adults, and in Stages 0–3 risk should be quantified using the PREVENT equations, which estimate 10- and 30-year risk for atherosclerotic cardiovascular disease, heart failure, and total cardiovascular disease.[1]

Messages 3–5 address systematic evaluation: routinely assess metabolic risk factors and kidney function—with selected assessment for pre-heart-failure, MASLD, and obstructive sleep apnoea—screen and address social determinants of health, and deliver interdisciplinary care anchored by a CKM coordination point person.[1]

Message 6 reframes adiposity: assess overweight/obesity and abdominal adiposity using both BMI and waist circumference, and support lifestyle modification with adjunctive obesity pharmacotherapy and metabolic/bariatric surgery when indicated.[1]

Messages 7–8 define pharmacotherapy: in type 2 diabetes with or at risk for cardiovascular disease, use cardioprotective antihyperglycaemic therapy (SGLT2 inhibitors, GLP-1-based therapy, or both); use both eGFR and UACR to characterise CKD, with RAS inhibitors plus SGLT2 inhibitors first-line and a nonsteroidal MRA or GLP-1 therapy added if albuminuria persists.[1]

Taken together, the ten messages function as an implementation blueprint rather than a list of ideals. They move in a logical sequence—stage the patient, predict risk with PREVENT, assess metabolic and kidney parameters plus social needs, coordinate an interdisciplinary team, and then treat with organ-protective agents matched to comorbidities.[1] Because each message maps to a concrete clinical action, a hospital can convert them almost directly into order sets, dashboards, and quality metrics—exactly the kind of structured workflow that closes the gap between guideline publication and bedside practice.[2]

Messages 9–10 extend care into established disease: in ASCVD, emphasise CKM comorbidities including obesity treatment and kidney-protective agents; in HFrEF use RAS inhibitor/ARNI plus SGLT2 inhibitor within quadruple therapy, and in HFmrEF/HFpEF use SGLT2 inhibitors first-line, add GLP-1 therapy for obesity, and consider nonsteroidal MRAs in patients with type 2 diabetes and CKD.[1] Together the messages give clinicians and administrators a concise checklist for auditing whether CKM patients are receiving the full spectrum of evidence-based, organ-protective care.[2,3]

References

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