General information

Venue
Courtyard by Marriott St. Petersburg Center West Pushkin
33, Kanoneskaya St.
190121 - St. Petersburg
Russian Federation

Language
The official language of this live educational symposium is English.

Scientific secretariat
EXCEMED – Excellence in Medical Education
Salita di San Nicola da Tolentino, 1/b
00187 Rome, Italy
Specialist Medical Advisor: Giuseppina Anguissola Beretta

EXCEMED is a Swiss Foundation with headquarters in
14, Rue du Rhône, 1204 Geneva, Switzerland

Organising secretariat
Meridiano Congress International
Via Sapri, 6 - 00185 Rome (Italy)

Main contacts
Project Manager: Dorina Monaco
Email: dorina.monaco@organizing-secretariat.com
Congress Manager: Concetta Di Palma
Email: concetta.dipalma@meridiano.it
Tel: +39 06 88595 226
Fax: +39 06 88595 234

Register to EXCEMED website:
www.excedmed.org

follow us on twitter
EXCEMED/Cardio
www.twitter.com/EXCEMED/Cardio
Background and Aim of the conference

Type 2 diabetes and its related chronic complications are an increasing problem in many Eastern and developing countries. Thyroid diseases are also very common in these areas as a result of iodine deficiency and genetic factors. Treating these chronic diseases in medical daily care needs to focus on the importance of improving medical education based on international guidelines and standards of care. In chronic diseases such as Diabetes and Thyroid diseases, patients’ adherence to treatment and changes in lifestyle is crucial to good patient outcomes. Improving communications strategies between healthcare professionals and patients is clearly linked to positive outcomes of care including patient satisfaction, health status, adherence to treatment and changes in lifestyle. EXCEMED has organized a dedicated meeting for healthcare professionals involved in the management of diabetes and thyroid diseases. The meeting will review significant and most recent research achievements and relevant clinical aspects for clinical practice.

Learning objectives

Participants will receive up-to-date knowledge about clinical management of diabetes and thyroid diseases. They will have the chance to participate in an innovative workshop on the skills required to communicate with patients who have chronic diseases.

This meeting will help participants to:

• Diagnose and manage pre-diabetes
• Diagnose and manage subclinical thyroid diseases
• Understand current standards for managing special conditions such as thyroid disorders and diabetes in pregnancy and clinical associations of diabetes and thyroid diseases
• Understand medical communication skills so as to increase the patient’s understanding of the disease affecting them and the need for compliance with treatment

Target audience

Endocrinologists, diabetologists and all healthcare professional’s involved in managing Diabetes and Thyroid diseases

Accreditation

The ’EXCEMED - Excellence in Medical Education’ (or) ‘Diabetes and thyroid disorders in clinical practice today’ is accredited by the European Accreditation Council for Continuing Medical Education (EACCME) to provide the following CME activity for medical specialists. The EACCME is an institution of the European Union of Medical Specialists (UEMS), www.uems.net. The ‘Diabetes and thyroid disorders in clinical practice today’ is designated for up to 3 hours of European external CME credits. Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity. Through an agreement between the European Union of Medical Specialists and the American Medical Association, physicians may convert EACCME credits to an equivalent number of AMA PRA Category 1 Credits™. Information on the process to convert EACCME credit to AMA credit can be found at www.ama-assn.org/go/internationalcme. Live educational activities, occurring outside of Canada, recognized by the UEMS-EACCME for ECMEC credits are deemed to be Accredited Group Learning Activities (Section 1) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

EXCEMED adheres to the principles of the Good CME Practice group (gCMEp)
Diabetes and thyroid disorders in clinical practice today

Scientific Organizer

**Paolo Pozzilli**
Dept. Endocrinology and Diabetes,  
University Campus Bio-Medico of Rome, Italy  
Centre of Diabetes,  
St. Bartholomew’s and The London School of Medicine  
Queen Mary University of London, UK

---

Share your opinion with us

We are always looking for ways to bring our educational activities to the next level and meet your needs as a healthcare practitioner. You will be asked to answer a post-event online survey after this event to find out if the experience met your educational expectations. Your views also help us tailor future initiatives. **Thank you for taking the time to participate!**

---

Faculty members

**Bernadette Biondi**  
Department of Clinical Medicine and Surgery  
University of Naples Federico II  
Naples, Italy

**Raffaella Buzzetti**  
Sapienza University of Rome  
Rome, Italy

**Mahmoud Ibrahim**  
EDC, Center for Diabetes Education  
American Diabetes Association, Middle East & North Africa  
Atlanta, GA, USA

**George J. Kahaly**  
Endocrine outpatient clinic  
Gutenberg University Medical Center  
Mainz, Germany

**Peter Andreas Kopp**  
Division of Endocrinology, Metabolism and Molecular Medicine  
Northwestern University  
Robert H. Lurie Comprehensive Cancer Center  
Chicago, IL, USA

**Roberto Negro**  
Department of Endocrinology  
Fazzi Hospital  
Lecce, Italy

**Paolo Pozzilli**  
Dept. Endocrinology and Diabetes,  
University Campus Bio-Medico of Rome, Italy  
Centre of Diabetes,  
St. Bartholomew’s and The London School of Medicine  
Queen Mary University of London, UK

**Salman Razvi**  
Queen Elizabeth Hospital  
Gateshead, UK

**Daniel Schmid**  
Infinity S.r.l.  
Rome, Italy

**Eberhard Standl**  
Munich Diabetes Research Group e.V. at Helmholtz Centre  
Munich, Germany
### Scientific programme
#### Saturday 25 April 2015

**Session I**  
**Thyroid and diabetes: from pathogenesis to pathophysiology**

**Chairman:** Paolo Pozzilli, Italy

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 08:25 | Welcome and opening  
P. Pozzilli, Italy |
| 08:30 | L1 Pre diabetes  
M. Ibrahim, USA |
| 08:55 | L2 Subclinical hypothyroidism  
S. Razvi, UK |

**Session II**  
**Thyroid and diabetes: clinical aspects**

**Chairman:** Eberhard Standl, Germany

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 09:20 | L3 Type 2 diabetes, metabolic syndrome and thyroid diseases  
P. Pozzilli, Italy |
| 09:45 | L4 Autoimmune thyroid disease and diabetes  
G. Kahaly, Germany |
| 10:10 | L5 Latent Autoimmune Diabetes of Adults (LADA)  
R. Buzzetti, Italy |
| 10:35 | L6 Cardiovascular involvement in autoimmune hyperthyroidism  
B. Biondi, Italy |
| 11:00 | Coffee break |

**Session III**  
**Management according to evidence-based medicine**

**Chairman:** G. Kahaly, Germany

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 11:20 | L7 Thyroid diseases in pregnancy  
R. Negro, Italy |
| 11:45 | L8 An update on guidelines for the treatment of thyroid cancer  
P. Kopp, USA |

**Session VI**  
**Improve medical communication strategies**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 12:10 | L9 How to reach compliance of diabetes patients to treatment  
D. Schmid, Italy |
| 12:30 | WS Communication in practice  
Videos depicting the “unsuccessful stories” of some patients-doctors relationship will be shown. After every video story, participants will be invited to review the “successful” management of the example situation. After every discussion a video will show an ideal doctor-patient interaction. This will offer a positive model to reinforce messages previously delivered and it will provide inspiration for the right communication and the proper emotional approach. |
| 13:30 | Conclusion remarks  
P. Pozzilli, Italy |
| 13:45 | Lunch |

**Legend:**  
L: Lecture - WS: Workshop
Disclosure of faculty relationships

EXCEMED adheres to guidelines of the European Accreditation Council for Continuing Medical Education (EACCME®) and all other professional organizations, as applicable, which state that programmes awarding continuing education credits must be balanced, independent, objective, and scientifically rigorous. Investigative and other uses for pharmaceutical agents, medical devices, and other products (other than those uses indicated in approved product labeling/package insert for the product) may be presented in the programme (which may reflect clinical experience, the professional literature or other clinical sources known to the presenter). We ask all presenters to provide participants with information about relationships with pharmaceutical or medical equipment companies that may have relevance to their lectures. This policy is not intended to exclude faculty who have relationships with such companies; it is only intended to inform participants of any potential conflicts so that participants may form their own judgements, based on full disclosure of the facts. Further, all opinions and recommendations presented during the programme and all programme-related materials neither imply an endorsement nor a recommendation on the part of EXCEMED. All presentations represent solely the independent views of the presenters/authors.

The following faculty provided information regarding significant commercial relationships and/or discussions of investigational or non-EMEA/FDA approved (off-label) uses of drugs:

RaffaellaBuzzetti  Declared no potential conflict of interest.
MahmoudIbrahim  Declared no potential conflict of interest.
George J. Kahaly  Declared no potential conflict of interest.
Peter Andreas Kopp  Declared no potential conflict of interest.
Roberto Negro  Declared no potential conflict of interest.
Paolo Pozzilli  Declared receipt of grants and contracts; honoraria or consultation fees.
Salman Razvi  Declared no potential conflict of interest.
Daniel Schmid  Declared receipt of grants and contracts.
Eberhard Standl  Declared receipt of honoraria or consultation fees from Merck Serono, Bayer, Sanofi, Astra Zeneca, Labstyle, Wockhart.

The following faculty have provided no information regarding significant relationship with commercial supporters and/or discussion of investigational or non-EMEA/FDA approved (off-label) uses of drugs as of 9 April, 2015.

Bernadette Biondi
Abstracts
Pre diabetes should be considered as a major health issue. Its prevalence is actually dependent on the definition used. According to the latest ADA standards of care 2015, Current diagnostic criteria for the diagnosis of diabetes, one of the following criteria is needed for the diagnosis of Diabetes: A1C ≥6.5% or fasting plasma glucose (FPG) ≥126 mg/dL (7.0 mmol/L), or 2-hour plasma glucose ≥200 mg/dL (11.1 mmol/L) during an OGTT or a random plasma glucose ≥200 mg/dL (11.1 mmol/L).

These criteria relate to patients with or without the classic symptoms of hyperglycemia or hyperglycemic crisis. Patients with pre diabetes are those individuals whose glucose levels did not meet the criteria for diabetes, but were too high to be considered normal. These persons were defined as having impaired fasting glucose (IFG) or impaired glucose tolerance (IGT). IFG: fasting plasma glucose (FPG) levels of 100–125 mg/dL (5.6–6.9 mmol/L). IGT: 2-hour plasma glucose (2-h PG) in the 75-g oral glucose tolerance test (OGTT) of 140–199 mg/dL (7.8–11.0 mmol/L).

The number of people living with pre diabetes worldwide is expected to increase from 316 million in 2013 to 471 million by 2035. Prevalence estimates in the Middle East (6.7–17.7%), Africa (7.3–13.2%), and South and East Asia (2.7–19%) are similar, but in some pockets exceed rates in Europe (5.1–9.9%) and the U.S. (13.5%).

Pre diabetes has been linked to a significant increase in the risk of developing macrovascular complications and possibly microvascular complications as well. Consequently there is a great need for wide screening programs using either the ADA or WHO screening criteria. Generally, the high risk groups are people over 45 years of age or overweight individuals if they have at least one additional risk factor. The list also includes family history of diabetes, high risk ethnic groups, a history of gestational diabetes, polycystic ovarian syndrome, CVD, hypertension, dyslipidemia, physical inactivity, and signs of insulin resistance, such as acanthosis nigricans along with moderate or severe obesity.

Should the results of the screening tests prove to be normal, these tests may be repeated at three year intervals. The Task Force on Diabetes and Cardiovascular Diseases of the European Society of Cardiology and the European Association for the Study of Diabetes (ESC-EASD) guidelines advocate a two-step approach for pre diabetes screening: 1. identifying at-risk individuals utilizing cost-efficient tools that include demographic and clinical characteristics and previous laboratory exams or a questionnaire such as the Finnish Diabetes Risk Assessment (FINDRISK) tool, and 2. glucose testing of a subgroup identified as high risk during the first step.

The management of pre diabetes should start very early even before childbirth. Treatment of overweight and obesity, which are key factors, should include lifestyle changes along with the possibility of using some medication such as Metformin and GLP1 agonists. Bariatric surgery may be a good choice in cases of morbid obesity.
The main objective of this presentation is to explore and discuss consequences of subclinical hypothyroidism (SCH) particularly in relation to cardiovascular (CV) disease and its impact on different age groups. SCH has been postulated as a cardiovascular (CV) risk factor for more than 40 years. There are several observational studies that have shown an association between SCH and CV disease. Despite this, no randomised controlled trial has ever been performed that has investigated whether treating SCH may reduce CV risk. This is even more important as SCH is common – with prevalence rates of 10 – 16% in the elderly and in women. Critical issues to discuss are: What are the consequences of a raised TSH on CV disease? Are the effects of SCH similar across all age groups? And treatment of SCH and national and international guidelines. SCH is a common condition and has a significant impact on CV health. However, there may be important differences between younger and older age groups that should be borne in mind particularly when considering treatment.
Type 2 diabetes (T2D) is not just disglycaemia. In diabetic patients, a complex interplay of pathological mechanisms operates involving multiple organs. Management of this complexity is difficult because such interplay differs in each patient. Of particular relevance is the association of T2D with metabolic syndrome which implies that additional pathophysiological factors need to be addressed to define personalized therapies. Moreover, the association of T2D with autoimmune thyroid diseases with or without metabolic syndrome is a common feature that is often associated with LADA. In therapies for T2D safety is the first factor a physician should consider; secondly, given the complexity of alterations worsening morbidity and mortality in T2D, a Multifactorial Approach is needed. Finally, the actual cardio-metabolic risk of each patient should always be stated so that a reliable objective can be gained with Therapy. So Safety, Multifactorial Approach and reduction of Risk are the three ingredients to achieve the best therapy for diabetes, abbreviated as SMART which is also the most important quality for every physician involved in the management of type 2 when achieving the highest standard of care.
Type 1 diabetes mellitus is an autoimmune disorder caused by an inflammatory destruction of pancreatic tissue. Several studies revealed characteristics of the pathologic process and found susceptibility genes for type 1 diabetes and/or autoimmune endocrine in general, and thyroid in special, diseases, respectively. In recent years, the annual incidence of type 1 diabetes mellitus has constantly increased in most parts of the world. Especially in industrializing nations it is still rapidly increasing. Type 1 diabetes is frequently accompanied by additional autoimmune endocrine (i.e. autoimmune thyroid disorders e.g. Hashimoto’s thyroiditis and/or Graves’ disease) and non-endocrine diseases. A familial clustering can be found, which suggests a genetic predisposition. Currently, there are several various hypotheses pertaining to the cause of pancreatic autoimmunity, but a complete explanation of the origin of type 1 diabetes or autoimmune endocrine diseases in general has not yet been found. Patients with type 1 diabetes are at a higher risk of developing additional endocrine autoimmune diseases. Such an autoimmune polyglandular syndrome shows several characteristic features that are different from monoglandular autoimmune diseases, suggesting a sub-classification of these patients. Recently, genetic research focusing on autoimmune endocrinopathies revealed a multitude of potential autoantigens that can be found in patients with an autoimmune polyglandular syndrome. Therefore the origin and pathogenesis of type 1 diabetes within the scope of the autoimmune polyglandular syndrome should be considered to be one of the various phenotypes of an endocrine autoimmunity predisposing to different endocrinopathies or autoimmune diseases, respectively.
Latent autoimmune diabetes in adults (LADA) is a recognized diabetes entity, with a prevalence ranging from 2% to 12% of all cases of diabetes, with a wide regional variation. LADA is a form of autoimmune diabetes with a later age of onset and a slower progression towards insulin dependence than is seen in the majority of people with type 1 diabetes. Classified, nevertheless, as a variation of type 1 diabetes, LADA is characterized by the presence of at least one type of islet cell specific autoantibody – most people with LADA show the presence of autoantibodies directed against glutamic acid decarboxylase (GADA), fewer against the protein tyrosine phosphatase IA-2. In the earlier stages of the disease people affected by LADA are often wrongly diagnosed as having developed type 2 diabetes, as a result of the concomitant insulin resistance state and the absence of clinical information on GADA and other antibodies. More importantly, people with LADA misdiagnosed as having type 2 diabetes are wrongly treated as though they have type 2 diabetes. Consistent evidence shows the importance, in terms of clinical outcome, of early initiation of insulin therapy in LADA, and avoiding the use of secretagogues like sulphonylurea typically used for the treatment of type 2 diabetes. Moreover, recent data suggests a possible role for incretin-based therapy in the treatment of LADA, especially in the early stages of the disease when some beta-cell reserve is still preserved.
Hyperthyroidism is a common endocrine disorder that produces important clinical consequences for the cardiovascular system. In areas of iodine sufficiency, the most common cause of hyperthyroidism is Graves’ disease (GD). In recent studies, an increased cardiovascular mortality has been associated with overt and subclinical hyperthyroidism. Recent data on hyperthyroid patients with GD suggest that these findings might be the effect of both thyroid hormone excess and specific autoimmunity per se. A specific autoimmune cardiovascular involvement (cardiac valve disease, pulmonary arterial hypertension, dilated cardiomyopathy, peripartum cardiomyopathy) has been demonstrated in patients with autoimmune hyperthyroidism, suggesting that some cardiovascular risk factors might play a role in determining this negative cardiovascular outcome in GD.

Prompt and effective recognition of cardiac manifestations in GD patients with hyperthyroidism is therefore crucial as cardiovascular complications account for most of the deaths in hyperthyroid patients. Graves’ disease should be considered in patients with pulmonary hypertension, dilated cardiomyopathy, and peripartum cardiomyopathy of unknown etiology. Physicians should also consider the possibility of antiphospholipid syndrome and/or myxomatous cardiac valve involvement in patients with GD and a history of stroke and arterial or venous thrombosis. Doppler echocardiography is a useful technique to assess cardiovascular complications in hyperthyroid GD patients with cardiac symptoms. Its use is justified in symptomatic patients as it allows assessment of potential autoimmune cardiovascular involvement.

Correction of overt and subclinical hyperthyroidism should be the first step in improving the prognosis of hyperthyroid patients with cardiovascular complications.

The etiology of hyperthyroidism must be established to enable correct treatment of the disease and of the related cardiovascular complications.
Undiagnosed and untreated thyroid disease in pregnancy are associated with an increased risk of maternal and neonatal adverse events. The spectrum of such complications varies widely depending on the severity of maternal disease. A clear association between overt hypothyroidism and miscarriage and reduced intelligence quotient in the progeny has been demonstrated, while less clear is this association in cases of subclinical hypothyroidism. Overt hyperthyroidism induces complications as well, in particular miscarriage, and hypertension, sometimes associated with fetal/neonatal hyperthyroidism.

Replacement treatment with Levothyroxine is suggested by the main scientific societies, either for overt or for subclinical hypothyroidism. Treatment with anti-thyroid drugs is also suggested in case of overt hyperthyroidism, but is not recommended for subclinical hyperthyroidism. For subclinical hyperthyroidism Propylthiouracil is the drug of choice for the first trimester, and Methimazole for the second and the third trimester. A satisfactory control of thyroid disease (hyper- or hypothyroidism) ensures a healthy pregnancy period without serious complications for the mother and the newborn.
Differentiated thyroid cancer (DTC), which includes papillary and follicular cancer, accounts for the vast majority (>90%) of all thyroid cancers. In the United States, approximately 63,000 new cases of thyroid cancer were diagnosed in 2014. The yearly incidence has significantly increased from 4.9 per 100,000 in 1975 to 14.3 per 100,000 in 2009. Medullary thyroid cancer (MTC), occurring sporadically or in the context of multiple endocrine neoplasia type 2 (MEN2) and anaplastic thyroid cancer (ATC) are less common forms of thyroid cancer. Guidelines by the American Thyroid Association published in 2009 and in preparation for publication in 2015, and annually updated guidelines by the National Comprehensive Cancer Network (NCCN) provide the clinician with a framework for the treatment of DTC, MTC and ATC. Following this presentation learners will be able to recognize the increasing incidence of DTC, implement an ultrasound stratification model for the indication of fine-needle aspiration and describe the Bethesda cytology system and molecular markers for patients with indeterminate cytology. Learners will also be able to apply a differentiated approach to radioiodine remnant ablation and therapy, apply appropriate surveillance for patients with DTC and describe new therapies for patients with advanced metastatic papillary, follicular and medullary thyroid cancer.
In this presentation, we will explore how taking care of the therapeutic relationship with the patient can help physicians in creating better and faster compliance.

Nowadays we must consider the psychosocial impact of the diseases on the lives of patients and their families. Coping effectively with the stresses related to living with the disease and having to manage these on a daily basis is not simply a consequence of education. Clearly, knowledge is a prerequisite, but in no way a guarantee.

To understand patients’ behavior, we need to take into account various psychological and social factors. Behavioral research findings underscore the role of attitudes and illness beliefs as determinants of patients’ health behaviors. Thus, learning to understand the patient’s perspective will help health care professionals communicate more effectively and tailor the treatment to the needs of the individual.

We will in depth analyze what empathy means, and how an empathetic approach can facilitate the understanding of the patient’s point of view, fears and doubts. This will lead to awareness of our own barriers to Active Listening, and how they can be removed to foster a sharing environment where the patient feels welcomed and acknowledged.

We will also discuss the importance of versatility in communication, as one of the most crucial keys to the patient’s adherence and compliance to the therapy is the feeling of a personalized approach and treatment.

The speech will end with a participative game. Educational videos featuring examples of Doctor-patient communication in diabetes, will reinforce tips and tricks for reading patient signs and creating the right flow of communication.

In the training of doctors, too often the psychological aspects play a secondary role. Yet, the motivational, cognitive and relational care is vital in helping patients with chronic diseases.
Improving the patient’s life through medical education

www.excemed.org