

PES Endocrine Monthly Round-Up

September 2026



Editor's Perspective

September's selection covers five areas of routine practice: the updated ADA/EASD consensus on type 1 diabetes in adults, a Society for Endocrinology position statement on non-medical androgen use, the effect of GLP-1 receptor agonists on body composition, ketoacidosis during SGLT2 inhibitor treatment, and serious adverse events after short courses of oral corticosteroids in type 2 diabetes. Three of the five concern the safety of widely used treatments.

Research Highlights

1. The Management of Type 1 Diabetes in Adults: Updated 2026 ADA/EASD Consensus Report

Guideline Focus: Joint ADA and EASD update of the 2021 consensus report, with expanded coverage of technology, complications, obesity and cardiovascular risk.

Key Messages:

- Adults with suspected type 1 diabetes should have islet autoantibodies measured, with C-peptide considered if these are negative. Teplizumab may benefit people with stage 2 disease.
- Continuous glucose monitoring is preferred, and automated insulin delivery is described as the optimal method of insulin delivery when used consistently. Suggested targets are time in range above 70%, time below range below 4% and HbA1c below 53 mmol/mol, individualised.
- No adjunctive therapy is routinely recommended. SGLT inhibitors increase the risk of ketoacidosis.

Clinical Takeaway: The report recommends automated insulin delivery where feasible and is intended to be adapted to different resource settings.

2. Management of Non-Medical Androgen Use: A Position Statement by the Society for Endocrinology

Guideline Focus: A clinical framework rather than a formal guideline, as the authors consider the evidence insufficient for graded recommendations.

Key Messages:

- Undisclosed androgen use should be considered in unexplained secondary hypogonadism, erythrocytosis, low HDL cholesterol or suppressed LH. A single suppressed LH identified androgen use in approximately 89% of cases.
- Most men recover HPG axis function within about 12 months of stopping, although spermatogenesis may take up to three years. Haemoglobin and haematocrit should be checked twice yearly.

- Symptoms often persist after biochemical recovery and are more strongly associated with psychiatric comorbidity than with testosterone. Routine use of hCG, SERMs and aromatase inhibitors is not recommended.

Clinical Takeaway: Counselling should cover recovery over months to years and assessment of mood. The evidence base is largely observational.

3. The Impact of GLP-1 Receptor Agonists on Body Composition in Individuals with Overweight and Obesity: A Systematic Review and Meta-Analysis

Study Design: Meta-analysis of three RCTs of liraglutide and dulaglutide in adults without type 2 diabetes, with body composition measured by DXA.

Key Findings:

- Compared with control, treatment reduced lean mass by 0.78 kg (95% CI -1.39 to -0.16) and fat mass by 3.43 kg (95% CI -5.94 to -0.93).
- Waist circumference fell by 3.65 cm. Differences in visceral and subcutaneous fat were not statistically significant.

Clinical Takeaway: Lean tissue accounted for roughly a fifth of the tissue lost. Lean mass is not a direct measure of muscle, and strength and physical function were not assessed. Semaglutide and tirzepatide were not included.

4. Ketoacidosis with SGLT2 Inhibitors in Routine Clinical Practice of Type 2 Diabetes: Scandinavian Cohort and Nested Case–Control Study

Study Design: Nationwide register study from Sweden, Denmark and Norway of 282,282 adults with type 2 diabetes treated with SGLT2 inhibitors.

Key Findings:

- The incidence of ketoacidosis was 2.43 per 1000 person-years. Risk was highest in the first 180 days but persisted throughout treatment.
- The strongest risk factors were HbA1c ≥ 83 mmol/mol (OR 15.4), malnutrition (OR 10.5), previous ketoacidosis (OR 10.4), BMI below 20 kg/m² (OR 10.0) and recent hypoglycaemia (OR 5.2). Infection was the most common precipitating event.
- Compared with GLP-1 receptor agonists, SGLT2 inhibitor use was associated with approximately double the risk (HR 2.11).

Clinical Takeaway: The authors recommend assessing risk throughout treatment and advising patients to pause the drug during acute illness, surgery and stress.

5. Oral Corticosteroid Bursts and Risk of Serious Adverse Events in Adults With Type 2 Diabetes

Study Design: Self-controlled case series of 36,048 adults with type 2 diabetes in Taiwan who received oral corticosteroid courses of 14 days or less.

Key Findings:

- In the 6 to 30 days after starting treatment, risk increased for gastrointestinal bleeding (IRR 1.71), pneumonia (IRR 2.06) and heart failure (IRR 1.87).
- From 31 to 90 days, risk remained increased for gastrointestinal bleeding (IRR 1.26) and fracture (IRR 1.42). There was no association with the negative control outcome.

Clinical Takeaway: The authors advise careful risk–benefit assessment when prescribing short steroid courses in type 2 diabetes. Absolute risks were not reported.

For Further Reading

The management of type 1 diabetes in adults: the updated 2026 consensus report by the ADA and EASD: <https://doi.org/10.2337/dci26-0122>

Management of non-medical androgen use: a position statement by the Society for Endocrinology: <https://doi.org/10.1530/EC-26-0361>

The impact of GLP-1 receptor agonists on body composition in individuals with overweight and obesity: a systematic review and meta-analysis: <https://doi.org/10.3390/jcm15176818>

Ketoacidosis with SGLT2 inhibitors in routine clinical practice of type 2 diabetes: Scandinavian cohort and nested case–control study: [https://doi.org/10.1016/S2213-8587\(26\)00162-2](https://doi.org/10.1016/S2213-8587(26)00162-2)

Oral corticosteroid bursts and risk of serious adverse events in adults with type 2 diabetes: <https://doi.org/10.1001/jamanetworkopen.2026.35604>

Closing Note

Several items this month show that treatment risks are not confined to the start of therapy or to high doses. Ketoacidosis risk with SGLT2 inhibitors persisted beyond the first months, harms followed steroid courses of a few days, and symptoms after androgen withdrawal often outlasted biochemical recovery.

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