Congress Interviews

EMJ is delighted to present this exclusive interview series from the European Association for the Study of Diabetes (EASD) Annual Meeting 2026, featuring interviews with EASD President Francesco Giorgino, Vice President Miriam Cnop, Board Member Lena Eliasson, Rising Star awardee Nick Thomas, and leading researcher Décio L. Eizirik. This collection explores the latest advances in diabetes research and care, from precision medicine, early detection, and prevention of Type 1 and Type 2 diabetes, to emerging immunotherapies, stem cell-derived β cell replacement, and the mechanisms underpinning β cell dysfunction, while highlighting the challenges of translating scientific discoveries into improved patient outcomes and the EASD's role in advancing global collaboration, research, and education.

Featuring: Francesco Giorgino, Nick Thomas, Miriam Cnop, Lena Eliasson, and Décio L. Eizirik



Francesco Giorgino

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Q1 With the European Association for the Study of Diabetes (EASD) Annual Meeting 2026 marking your first meeting as President, what would you highlight as the key scientific and clinical messages emerging from this year's meeting so far? How do these reflect the direction you previously envisioned for the EASD after last year's congress?

First of all, I would say that we are working in continuity. Although I became President this year, I served as Senior Vice President for the previous 3 years, and together we have been building a project that we are now executing slowly but consistently. This project, which I am also trying to reinforce, aims for the EASD to become the reference society for diabetes worldwide. To do this, we are looking at the contributions, needs, and specific circumstances of regions outside Europe that are heavily affected by this disease. We have established, and are now further developing, the EASD Global Council, a committee with members from all regions of the world.

Diabetes is a very heterogeneous disease, and we need to address that by learning more about its heterogeneity. We need to see whether there is room for precision medicine, identifying the drugs best suited to specific types of the disease. We also need to implement the guidelines and

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clinical messages that we develop through consensus documents, often together with other learned societies. This requires not only research, discussion, and writing the relevant documents, but also spreading them, especially where they are less well known. This is called implementation science, and we are making an effort in that direction. We are also still learning how to do this, as the EASD has not traditionally been used to these types of processes.

Another important area I would like to highlight is research. We want to go beyond supporting people who carry out research and carry out research ourselves. We have chosen a very important topic: recent-onset Type 2 diabetes (T2D). This could be extended to pre-diabetes, but our first focus is people who have received a recent diagnosis of T2D. We know that these individuals in Europe are not receiving the best possible management, especially given the new medications available. The recent consensus document on the management of T2D, developed jointly with the American Diabetes Association (ADA), also states that new therapies should be introduced very early in the course of the disease.

We think a project is needed to map how T2D is diagnosed and treated in Europe, and to see whether there are problems with identification or misclassification. For example, some people with autoimmune diabetes may be incorrectly diagnosed with T2D, because they have not been tested for autoantibodies. There are many situations where we could do better, so we would like to improve diagnostic accuracy and overcome clinical inertia in the early use of effective medications.

This research also aims to show that T2D could even be reversed if it is detected early and treated intensively. This has been shown to be possible with new therapies, as well as with other approaches such as bariatric surgery or marked dietary restriction. I think it is time to change the paradigm of management and be more intensive early on. Of course, we need evidence for that and a very strong case. Ultimately, we hope to influence current policies and even how diabetes is perceived at the EU level.

Q2 We are still in a period of rapid advances in diabetes treatment, from new approaches to glucose and weight management to therapies targeting cardiovascular, kidney, or liver complications. Are there any standout developments being discussed at this year's meeting in your opinion, and how might they influence clinical practice going forward?

We have known for some time that glucagon-like peptide-1–based therapies and sodium/glucose cotransporter 2 (SGLT2) inhibitors can help prevent and delay the progression of cardiorenal disease. This is well established, though it is not always implemented widely.

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However, for metabolic liver disease, namely MASLD and metabolic dysfunction–associated steatohepatitis, there is a lot of emphasis at the meeting. We now know more than ever about these two diseases, and we have tools that have been shown to potentially reduce the burden of the disease, such as glucagon-like peptide-1 receptor agonists and resmetirom. Other drugs may follow, especially dual agonists that include glucagon agonism, so this is a very interesting area to follow.

We are working on this together with the European Association for the Study of the Liver (EASL). Liver disease is also given clear recognition in the ADA–EASD consensus on the management of T2D, which we will present



on Friday. The consensus lists all the comorbidities and clinical conditions that should be carefully assessed in every individual with T2D. It ranks liver disease alongside atherosclerotic cardiovascular disease, heart failure, and chronic kidney disease.

The message, essentially, is that we need to look at the liver as closely as we look at the heart, the blood vessels, and the kidneys. This is also important for clinical diabetologists, who need to know more about the liver, how to screen for liver disease, and how to monitor patients appropriately.

Q3 The EASD's previous President, Chantal Mathieu, Department of Chronic Diseases and Metabolism, KU Leuven, Belgium, who EMJ had the privilege of interviewing last year, expected that there may be a key focus on early detection and screening in Type 1 diabetes (T1D) at the EASD Annual Meeting 2026. What are the most significant developments in T1D being presented this year?

Over the years, the work of Anette-Gabriele Ziegler, Institute of Diabetes Research, Helmholtz Munich, German Research Center for Environmental Health, Neuherberg, Germany, has shown how people progress from being unaffected to being fully affected. This covers the different stages of T1D, the significance of biomarkers, especially autoantibodies, and how they can be very useful. As she has shown, they can help prevent adverse outcomes at T1D diagnosis, such as diabetic ketoacidosis, and they can also identify a suitable window for intervention with disease-modifying therapies. I think this is very exciting. Also, teplizumab is currently approved in the USA, but not yet fully available in Europe; we hope this will change as soon as possible. Additionally, we are hoping that the other drugs in development will live up to their promise and prove as effective as teplizumab.

Q4 Precision medicine has been an increasingly prominent theme across recent EASD meetings, with a number of sessions dedicated to the topic this year. Which developments or discussions are you particularly looking forward to, and what do you hope attendees will take away from them?

I am very interested in seeing the data on different phenotypes of T2D, including different ages at onset and disease trajectories. I think we should evaluate these more carefully, especially in people with early-onset T2D, who will be exposed to an adverse metabolic environment for a longer part of their lives. We need to consider whether these individuals require a different approach, perhaps even more intensive than the one we now consider for most people with T2D.

AI also has an important role in complementing the stratification of patient risk. Precision medicine could be supported by carefully assessing multiple variables to produce rankings or scores that help us understand whether an individual is likely to be a progressor or a non-progressor. This is something we are also doing as part of the research project I mentioned earlier.

AI can be used for very specific purposes, such as assessing vascular changes in the retina to stage retinopathy, which is already available. It can also be used for multidimensional assessment, considering not only biological and clinical variables, but also social and environmental variables that can affect how diabetes manifests, how the phenotype develops, and how the disease progresses over time. We need

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very powerful tools, such as AI-based platforms, to bring all this information together and build more accurate models to predict what will happen to an individual.

Q5 The EASD brings together researchers and HCPs from across the world, but the challenges of diabetes care vary considerably between regions. How is the EASD working to continue to strengthen its global role, and what discussions at this year's meeting are particularly relevant to improving equity in diabetes research and care globally?

We are keen to highlight the Global Council, a new committee we created only 2 years ago. Its members come from different regions of the world, and they can provide very relevant suggestions and work with the EASD to develop our initiatives. For example, they can spread the word about research grant opportunities, travel fellowships for young investigators, and the medical education platforms, such as e-learning, that we make freely available to everyone.

First of all, I would highlight this as an example of closer collaboration and exchange of expertise in both directions. On the one hand, our initiatives become better known outside Europe. On the other hand, the specific problems, needs, and achievements of diabetes communities outside Europe can inform the EASD's activities. It is really a two-way exchange.

We are also developing tools that we hope will be useful for a very wide audience. One, which I mentioned in my presidential address, is a paper on diabetes registries developed by members of the Global Council. The paper sets out the features of a diabetes registry: how it should be built and run, which modules are essential, and how it could be further upgraded to collect data that inform not only clinical care but also research.

That is one example, and I can announce that work is ongoing on additional documents for a broad audience. We think that through these initiatives, we can contribute to better cooperation and help everyone speak the same language.

Q6 Planning for the EASD Annual Meeting takes place well in advance. How is planning progressing for next year's congress in Budapest, Hungary, and are there any emerging themes that you are already expecting to shape the programme?

I think it is too early to talk about emerging themes. We have already made a great effort to identify what is most relevant for this meeting, and, once it is over, we will see which topics are best developed further in the next edition. The Scientific Programme Committee for 2027 is already at work. We chose the country, city, and venue a long time ago, and some activities to define next year's programme are already starting. I am sure that some of the highlights of this meeting will carry over to the next one.

Q7 As you're still in the early stages of your presidency, what would you most like to achieve for the EASD in the remainder of your tenure, and what lasting impact would you hope to have on the organisation and the wider diabetes community?

I hope we can do even more to support research and to generate new information that is truly relevant to diabetes pathophysiology and treatment. I hope we can improve the standard of care through better education and a range of educational activities shared as widely as possible. I also hope that we can engage more effectively with the EU to draw more attention to diabetes at that level. Finally, I hope we can work more consistently on a model where knowledge is translated into good clinical practice, as this is where there is still a large gap to fill.