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Original article

## The impact of canagliflozin on the risk of neuropathy events: a post-hoc exploratory analysis of the CREDESCENCE trial<sup>A</sup>

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## ABSTRACT

*Aim.* - Canagliflozin reduces the risk, and progression, of diabetic kidney disease. We hypothesized that it may improve the microvascular complication of neuropathy.

*Methods.* - The CREDENCE trial randomized participants with type 2 diabetes and kidney disease to canagliflozin 100mg daily or placebo. Neuropathy events were defined post-hoc as any reported adverse event consistent with a peripheral or autonomic neuropathy event. The effect of canagliflozin and predictors of neuropathy events were estimated using Cox regression analysis. In sensitivity analyses the endpoint was restricted to sensorimotor polyneuropathy, diabetic neuropathy, and non-autonomic neuropathy events.

*Results.* - Almost half (48.8%) of the 4401 participants had a diagnosis of neuropathy at baseline. Over a median of 2.45 years of follow up, 657 people experienced a neuropathy event (63.2 per 1000 patient-years). Independent factors associated with higher risk of experiencing neuropathy events were non-white race, younger age, higher glycated haemoglobin and lower estimated glomerular filtration rate. The incidence of neuropathy events was similar in people randomized to canagliflozin and placebo (334/2202 vs. 323/2199; HR 1.04, 95% CI 0.89 to 1.21,  $P = 0.66$ ). Canagliflozin had no impact on sensorimotor polyneuropathy (HR 0.93, 95% CI 0.69 to 1.25,  $P = 0.63$ ), diabetic neuropathy (HR 0.91, 95% CI 0.68 to 1.22,  $P = 0.52$ ), or non-autonomic neuropathy (HR 1.03, 95% CI 0.87 to 1.21,  $P = 0.77$ ). The lack of effect on neuropathy events was consistent in subgroup analyses.

*Conclusion.* - Canagliflozin did not affect the risk of neuropathy events in the CREDENCE trial. Future large randomized studies with prespecified neuropathy endpoints are required to determine the impact of sodium glucose cotransporter 2 inhibitors on diabetic neuropathy.

Trial registration: ClinicalTrials.gov number, NCT02065791

### Keywords

Adverse event; Diabetic kidney disease; Diabetic neuropathy; Randomized Controlled Trial; Sodium Glucose Co-transporter Inhibitors

## INTRODUCTION

Neuropathy affects up to half of all people with type 2 diabetes mellitus (T2DM) [1]. It most commonly presents with distal pain and sensory loss from sensorimotor polyneuropathy, followed by postural hypotension or erectile dysfunction from autonomic neuropathy, however, other nerve pathologies such as carpal tunnel syndrome, medication toxicity and inflammatory neuropathies are also more common in people with T2DM [2]. The high prevalence of non-diabetic neuropathy in T2DM may be due to a higher burden of comorbidity and medication use, immunomodulatory effects of hyperglycaemia, or the interplay of neuropathic insults [3]. People with both T2DM and chronic kidney disease (CKD) experience accelerated nerve injury, perhaps due to the combination of hyperglycaemia, hyperkalaemia, uremic toxins, and atherosclerotic vasculopathy [4]. The symptoms of neuropathy, namely pain, paraesthesia and postural hypotension reduce quality of life and increase the risk of foot ulcers, falls and fractures [2, 5]. Neuropathies, especially diabetic neuropathy, may not be reversible and prevention is crucial.

Sodium-glucose co-transporter-2 (SGLT2) inhibitors reduce the risk of cardiovascular disease [6] and slow progression of CKD [7], however their impact on neuropathy is not well understood. Animal models suggest that SGLT2 inhibitors may be neuroprotective [8-10], through glucose-lowering or glucose-independent mechanisms such as shifting metabolism from glucose to fat oxidation, anti-inflammatory effects, and reducing oxidative stress [11, 12], and a small randomized study found evidence of improvement in cardiac autonomic function when empagliflozin was administered following acute myocardial infarction [13]. To explore the hypothesis that SGLT2 inhibitors may reduce the incidence or progression of peripheral neuropathy, we conducted an exploratory analysis of the Canagliflozin and Renal

Events in Diabetes with Established Nephropathy Clinical Evaluation (CREDENCE) trial to determine if treatment with canagliflozin resulted in fewer neuropathy events in those with T2DM and diabetic kidney disease.

## METHODS

The CREDENCE trial was a multicentre, randomized, double-blind, placebo-controlled trial designed to assess the effects of the SGLT2 inhibitor canagliflozin on renal outcomes in patients with T2DM with diabetic kidney disease (estimated glomerular filtration rate (GFR) of 30 to < 90 ml/min/1.73m<sup>2</sup> and urine albumin to creatinine ratio of > 300 to 5000 mg/g)[14, 15]. The trial randomized 4401 participants from 690 sites in 34 countries in a 1:1 ratio to receive either canagliflozin 100mg daily orally or placebo.

### **Neuropathy adverse events**

The primary endpoint for this analysis was the first occurrence of an adverse event (AE) related to neuropathy in all trial participants (with or without neuropathy at baseline). In the CREDENCE trial, all AEs (including serious AEs) occurring after randomization were assigned a single Medical Dictionary for Regulatory Activities (MedDRA) code from pre-specified lists by site investigators. Two clinicians blinded to treatment allocation (JL and CX) independently categorized MedDRA terms indicative of a neuropathy (of any cause) according to the terms used in the Toronto Classification prior to the analyses being performed [2]. This analysis was post-hoc and AEs were categorized following data-lock. Reviewers were aware of the primary trial results but were blinded to treatment allocation relating to AEs or the participants experiencing them.

The MedDRA terms used to define neuropathy AEs are listed in the table S1 (see

supplementary materials associated with this article on line). The adverse events identified in this fashion were considered to be surrogate indicators of the presence or severity of neuropathy. The resulting list of terms defined 'neuropathy AE' for the primary analysis. Subsets (or clusters) of terms within this list were selected a priori to define more specific endpoints as events consistent with a) 'diabetic neuropathy', b) 'sensorimotor polyneuropathy', or c) 'autonomic neuropathy'. These definitions were used for sensitivity analysis. Discrepancies were resolved by review by a third clinician (AK).

### **Statistical analysis**

Continuous data are presented as the mean  $\pm$  SD or median (interquartile limits) as appropriate. Categorical variables are expressed as numbers and percentages. All analyses were conducted according to intention-to-treat principles. For the primary analysis and comparison of baseline characteristics, a two-sided *P*-value of  $< 0.05$  was considered statistically significant. However, we also chose to quantify the risk from multiple testing in the multivariable model and in the subgroup analyses using adjusted two-sided *P*-value thresholds calculated according to the Holm-Bonferroni correction [16]. Given the exploratory nature of this analysis, a family-wise error rate of 0.1 was chosen (i.e. an overall 10% chance of a false positive) and applied separately to the multivariable analysis and to the subgroup analyses (as a whole). We have chosen to present unadjusted *p*-values and, where relevant, to indicate where a significant result did not also meet adjusted significance thresholds.

### *Prediction model construction*

Potential risk factors for neuropathy events were pre-selected on the basis of known associations with neuropathy and biological plausibility [17]. Baseline sociodemographic factors were age, sex and race. Baseline clinical factors were history of neuropathy, history of

retinopathy, history of cardiovascular disease (coronary artery disease, cerebrovascular disease, or peripheral vascular disease), duration of diabetes, body mass index (BMI), systolic blood pressure (SBP), glycated haemoglobin (HbA1c), urine albumin to creatinine ratio (UACR) and estimated glomerular filtration rate (eGFR) measured by the Chronic Kidney Disease Epidemiology Collaboration formula, serum triglycerides, low-density lipoprotein cholesterol (LDL-C), high-density lipoprotein cholesterol (HDL-C), total cholesterol, and baseline use of the following medications: metformin, sulphonylureas, glucagon-like peptide-1 (GLP-1) receptor agonist, insulin, statin, antithrombotic agent. The effect of these variables was examined by fitting a multivariable Cox model (stratified by eGFR at baseline) assessing time to neuropathy AE and a predefined set of possible risk factors (as listed above). Continuous variables were not categorized. Cholesterol was removed from consideration owing to a strong association with LDL-C. The proportional hazard assumption was checked by visual assessment of the log cumulative-hazard functions and by Kolmogorov-type Supremum test. As there was evidence of a time dependent hazard ratio for age, an interaction term between age and follow-up time was included in the final model. In a post-hoc analysis, the relationship between continuous parameters identified as associated with neuropathy was further explored within the multivariable model by treating the parameter of interest as a restricted cubic spline, with knots at the 10<sup>th</sup>, 50<sup>th</sup> and 90<sup>th</sup> centile. The hazard ratio, adjusted for covariates, for neuropathy events by baseline parameter was plotted over the central 90% of the distribution (i.e. from the 5<sup>th</sup> centile to 95<sup>th</sup> centile).

#### *Effect of canagliflozin on neuropathy*

The primary outcome and pre-specified sensitivity analyses ('diabetic neuropathy events', 'sensorimotor polyneuropathy events', and 'neuropathy events excluding autonomic

neuropathy events' (table S1; see supplementary materials associated with this article on line) were performed using a Cox proportional-hazards model stratified by eGFR at baseline. The sensitivity analysis of 'neuropathy events excluding autonomic neuropathy events' was chosen as some autonomic symptoms, such as orthostatic hypotension, may be indistinguishable from symptoms of hypovolemia, a potential side effect of canagliflozin. Pre-specified subgroup analyses were undertaken by age, sex, race, history of neuropathy, history of retinopathy, duration of diabetes, and baseline parameters: body mass index (BMI), SBP, HbA1c, UACR, and eGFR. Subgroup analyses were performed to assess the heterogeneity of treatment effects by tests for the interaction between canagliflozin and the subgroup in stratified Cox proportional-hazards models. Statistical analyses were performed using SAS Enterprise Guide 7.15 (SAS Inc, Cary, NC) and Stata/IC 15.1 (StataCorp, College Station, TX).

## RESULTS

### **Baseline characteristics and neuropathy events**

Of 4401 participants, the mean age was  $63.0 \pm 9.2$  years, mean duration of diabetes was  $15.8 \pm 8.6$  years, mean HbA1c was  $8.3 \pm 1.3\%$ , and 2147 (48.8%) had a diagnosis of neuropathy at baseline (Table I). Those with neuropathy at baseline were more likely to be female, white race, with a longer duration of diabetes, higher cholesterol and UACR; and were more likely to have co-morbid heart failure, retinopathy, or cardiovascular or peripheral vascular disease. Over a median of 2.62 years (range 0.02 to 4.53) of follow-up, 657 participants experienced at least one neuropathy AE (63.2 per 1000 patient-years) (Table II; table S2: see supplementary materials associated with this article on line). The



most common MedDRA terms for neuropathy events were (in order of frequency) diabetic neuropathy, pain in extremity, diabetic foot, postural dizziness, orthostatic hypotension and peripheral neuropathy, which collectively accounted for 63% of analyzed neuropathy AEs (table S3; see supplementary materials associated with this article on line).

### **Primary outcome, sensitivity analyses and subgroup analyses**

Rates of neuropathy events were similar in people randomized to canagliflozin and placebo (334/2202 in the canagliflozin arm, 323/2199 in the placebo arm; HR 1.03, 95% CI 0.89 to 1.21,  $P = 0.66$ ) (Table II, Figure 1). The results were similar for the pre-specified sensitivity analyses, with no difference in AE related to non-autonomic neuropathy (279/2202 versus 271/2199, HR 1.03, 95% CI 0.87 to 1.21,  $P = 0.77$ ), sensorimotor polyneuropathy (84/2202 versus 90/2199, HR 0.93, 95% CI 0.69 to 1.25,  $P = 0.63$ ), or diabetic neuropathy (84/2202 versus 92/2199, HR 0.91, 95% CI 0.68 to 1.22,  $P = 0.52$ ). After adjustment for multiple comparisons, the effect of canagliflozin on neuropathy events was similar across all tested subgroups, including those with and without neuropathy at baseline (Figure 2; table S4: see supplementary materials associated with this article on line ).

### **Predictors of neuropathy events**

Factors associated with a higher risk of neuropathy events in multivariable analysis were Black, Asian, or other non-white race, younger age, higher glycated haemoglobin or lower eGFR (Table III). Weak associations between neuropathy events and baseline use of insulin or statin, and serum potassium did not meet significance thresholds adjusted for multiple comparisons (table S5; see supplementary materials associated with this article on line). The relationship between risk of neuropathy, baseline HbA1c, and baseline eGFR is presented in Figure S1; see supplementary materials associated with this article on line.

## DISCUSSION

This exploratory study is the first to examine the effect of an SGLT2 inhibitor on neuropathy events in a randomized cohort to our knowledge and found no effect on the risk of neuropathy events, including in a range of important subgroups. Multivariable analysis showed non-white race, younger age, lower baseline eGFR and higher glycated haemoglobin to be independently associated with neuropathy events. The lack of observed effect of SGLT2 inhibitors on neuropathy is in contrast to their clear benefit on renal and cardiovascular outcomes and suggests that other treatment approaches may be required to improve neuropathy risk.

Current treatment guidelines for T2DM are based on studies that have focused on macrovascular outcomes with – until recently – few studies focusing primarily on microvascular outcomes [18]. Despite the high prevalence and disabling nature of neuropathy in T2DM, treatments capable of altering its natural history are lacking [19]. A meta-analysis of key studies on the intensity of glycaemic control suggests that, in contrast to albuminuria progression, more intensive glucose control does not reduce the incidence of neuropathy [20]. There has been little attention paid to neuropathy outcomes in recent trials of novel glucose lowering agents [21]. The TECOS study of sitagliptin vs. placebo reported an incidence of new diabetic neuropathy of 4.1% and 3.8%, respectively (suggesting no impact of sitagliptin, although formal statistical analysis was not provided) [22]; a rate similar to the 4.0% seen in the present study. Only two small randomized studies have examined the effect of GLP-1RA on neuropathy in humans, both finding no evidence of a beneficial effect on symptoms or signs of neuropathy [23, 24]. Overall, the limited evidence available is not encouraging and neuropathy remains the only micro- or macrovascular complication of

diabetes for which there is no evidence-based disease-modifying treatment.

In contrast to the clinical studies, pre-clinical studies suggest that SGLT2 inhibitors may be neuroprotective, with a reduction in sensory nerve hypersensitivity [9], preservation of motor nerve conduction velocity[8] and reduction in sympathetic nervous system activity [25, 26]. This disconnect highlights the growing understanding of diabetic neuropathy as a complex disease resulting from multiple interacting causal pathways which may be challenging to replicate in pre-clinical studies. While hyperglycaemia is a risk factor for the development of neuropathy in both type 1 and type 2 DM, it is clearly one factor among many, particularly in T2DM, where (in contrast to type 1 DM) improved glycaemic control has not been shown to improve neuropathy outcomes [20]. This, in itself, supplies one possible explanation for the lack of efficacy of SGLT2 inhibitors in the present study. However, the between-group difference in glycaemic control was modest (mean glycated haemoglobin being lower in the canagliflozin arm by 0.25%), thus providing little scope for the assessment of the relationship between improved glycaemic control and neuropathy. In addition to glycaemic control, observational studies in both type 1 and type 2 DM have highlighted the potential importance of vascular risk factors, including higher BMI, hypertension, history of cardiovascular disease, smoking and triglyceride level, as independent risk factors for the development of neuropathy [27, 28].

The present study identified the expected associations between lower eGFR and higher glycated haemoglobin, and neuropathy events. Younger age was associated with a higher risk. Cohort studies have demonstrated a similar incidence of neuropathy in younger and older people with T2DM, and that neuropathy is common at diagnosis; new onset retinopathy has been found to associate with younger age [29]. This mirrors previously described phenotypic differences between younger and older people with T2DM, reflected

in varying incidence for cardiovascular and kidney disease versus neuropathic and retinal complications [30]. We also found that white participants had a higher prevalence of neuropathy at baseline, yet participants of non-white ethnicity were at higher risk of neuropathy events during the trial, independent of other risk factors for neuropathy. The relative prevalence of diabetic (or other) peripheral neuropathy among different racial or ethnic groups has not been well described. A cross-sectional study of 266 participants in the United Kingdom found a lower prevalence of diabetic neuropathy in South Asians compared to whites [31], while a larger cross-sectional UK study of 15,692 participants found lower rates of neuropathy in South Asians compared to white Caucasians but a higher prevalence of neuropathic pain [32]. However, two studies from the United States have not found differences in the prevalence of neuropathy between white, black, and Hispanic Americans [33, 34]. The reasons for the higher risks in non-white participants in the present study are unclear, but may reflect racial inequities in the access to diabetes care and subsequent effects on glycaemic control and kidney and cardiovascular outcomes [35].

Interestingly, a baseline history of neuropathy was not associated with an increased risk for a neuropathy event in this study and the rates of neuropathy events were similar in those with and without such a baseline history. The baseline diagnosis was derived from medical history provided to the investigator, rather than by dedicated clinical or neurophysiological assessment, and the accuracy of routine physician assessment of a history of peripheral neuropathy is questionable, with evidence that only one third of patients with a mild-moderate neuropathy are correctly identified as so by their physician [36]. This inaccuracy may be compounded by differential access to care and diagnosis between racial groups and countries, which may contribute to the discrepancy between the higher prevalence of a history of neuropathy at baseline in white participants and the

observed increased risk of neuropathy events in non-white participants seen in this study. Nevertheless, in the absence of dedicated neurological assessment we are unable to determine to what extent misclassification at baseline history or in the attribution of AE to neuropathy may have affected to our findings.

The apparent lack of effect of an SGLT2 inhibitor on neuropathy, in addition to a lack of effect of retinopathy [37, 38], reflects the growing awareness of the heterogeneous pathophysiological pathways contributing to 'microvascular' disease in those with diabetes, such that the goals of treatment are not simply glycaemic control. Indeed, in contrast to T1DM, meta-analysis of a number of large scale randomized studies in people with T2DM, has shown intensive glycaemic control has only a modest effect on neurophysiological parameters and no significant effect on clinical neuropathy [39]. This stands in contrast to nephropathy and retinopathy, where intensive glycaemic control does appear to have a modest impact.[39] The primary results of the CREDENCE study emphasize the independence of microvascular disease and glycaemic control, with robust and early reductions in nephropathy with SGLT2 inhibition despite an average difference in glycated haemoglobin of only 0.25% [15]. Likewise, despite reduction in nephropathy events, SGLT2 inhibitors do not appear to affect the incidence of diabetic retinopathy, and semaglutide (a glucagon-like peptide-1 receptor agonist) may increase the risk [37, 40, 41]. Fundamentally, the divergence in efficacy of the various glucose-lowering agents on neuropathy, retinopathy and nephropathy challenges the practice of grouping these complications together under the label of 'microvascular disease'. Animal studies show important differences in the pattern of glucose metabolism in the retina, kidney and nerve, along with distinct pathophysiological mechanisms, including lipid metabolism and mitochondrial function, mediating damage in those with T2DM [42]. This results in distinct natural histories and

emphasizes the need to pursue novel therapies targeting these separate pathways.

The strengths of this study include its multi-centre randomized design, large size with diverse countries and racial groups, and the blinded assessment of adverse events. The primary limitation of this study is the reliance on adverse events coded per MedDRA rather than the gold standard of a dedicated assessment of neuropathy by standardized clinical and/or neurophysiological criteria [2], although given the significant cost and burden for participants, such assessments may be difficult to implement in a large randomized trial [43]. Administrative codes can reliably detect severe neuropathy in epidemiological research [44] and adverse events related to neuropathy have been used as a neuropathy endpoint in other clinical trials [45]. Recognizing that neuropathy in diabetes is heterogenous, we used a broad definition of neuropathy in this analysis. However, it is plausible that SGLT2 inhibitors have a specific effect on a subtype of neuropathy, which our analysis would have less power to detect. Other limitations include that this was a post-hoc analysis and the study was terminated early at a median of 2.6 years for overall efficacy for the primary endpoint, which may well be too early to detect a difference in neuropathy events, especially without dedicated neurological testing.

In conclusion, this post-hoc exploratory analysis of the CREDENCE randomized trial suggests that canagliflozin does not affect the risk of neuropathy events in patients with type 2 diabetes and albuminuric kidney disease. Non-white race, younger age, lower baseline eGFR and higher glycosylated haemoglobin were independently associated with neuropathy events. The findings need to be replicated in other studies and could reflect insufficient duration of treatment for a benefit to be observed but do suggest a need for dedicated studies, using well-validated neurological endpoints, of treatments to prevent or slow the progression of diabetic neuropathy. Such an endeavour could be aided by a better

understanding of the distinct pathophysiology that drives neuropathy independently of other diabetic complications.

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#### **Author contributions**

Design and oversight of the CREDENCE study was provided by VP, MJ, CP, RA, GB, DMC, DdZ, HJLH, AL, BN, DCW, HZ, BZ, KWM. MJ, BS and CA conceptualized the present study. Adverse event terminology was categorized by JL, AK and CX. The analysis was designed by BS and AK, with expert review and revision provided by GLDT. Statistical analysis was performed by JL, AK, TY and BS. Figures were produced by AK and BS. The manuscript was drafted by JL, AK, TY and BS and interpretation of the analysis provided by CA, AVK, RA, GB, DMC, DdZ, BN, DCW, BZ, KWM, VP and MJ. The manuscript was revised by BS with critical review from CA, CP, AVK, RA, GB, DMC, DdZ, HJLH, BN, DCW, BZ, AL, KWM, VP and MJ. All authors had full access to the data on request and JL, AK and BS verified all the data in the study. All authors reviewed the manuscript and have agreed to publication of the final version.

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### **Data sharing**

Data from this study is available in the public domain via the Yale University Open Data Access Project (<http://yoda.yale.edu/>). This includes deidentified individual participant data, data definition specification, annotated case report form, protocol with amendments and primary statistical analysis plan.

### **Appendix supplementary material**

Supplementary materials (Fig. S1 and Tables S1-S2-S3-S4-S5, and Appendix) associated with this article can be found at <http://www.sciencedirect.com> at doi . . .

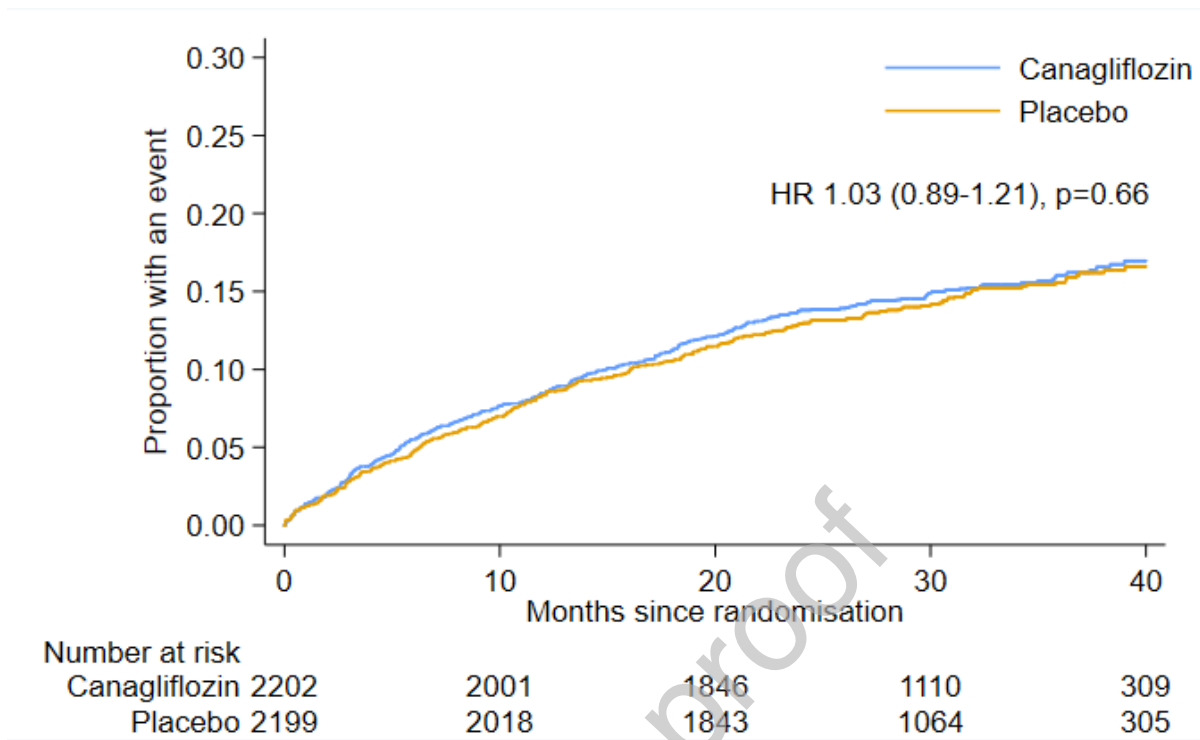


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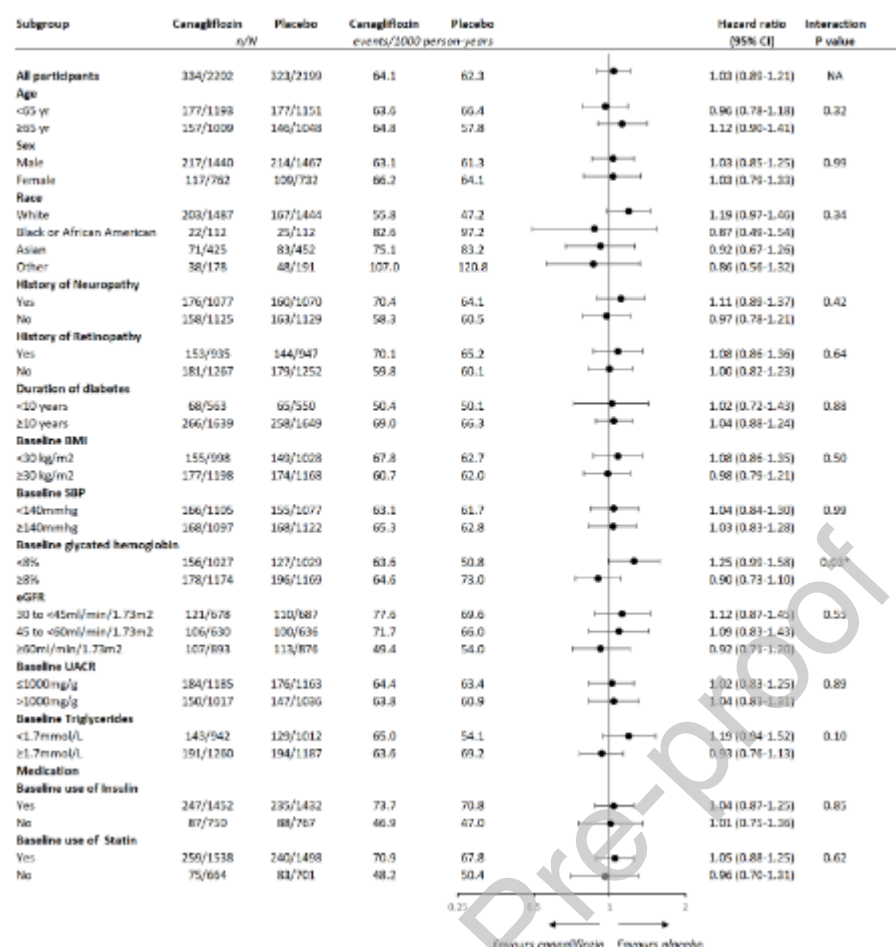
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**Figure 1** Time to first neuropathy events

Kaplan-Meier curve for neuropathy adverse events. Hazard ratio from Cox-regression.



**Figure 2** Subgroup analysis of effect of canagliflozin on neuropathy. P-values are for interaction between treatment group and subgroup in Cox-proportional hazards analysis of time to neuropathy event. BMI, body mass index; CI, confidence interval; eGFR, estimated glomerular filtration rate; UACR, urine albumin-to-creatinine ratio. \* indicates p-values that did not remain statistically significant after adjustment for multiple testing (Table S4; see supplementary materials associated with this article on line).

**Table I** Demographic and clinical characteristics of participants with or without neuropathy at baseline

Characteristic	No known neuropathy at	Prevalent neuropathy	P-value	All participants
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	baseline			
	(N=2254)	(N=2147)		(N=4401)
Age-- yr.	63.1±9.4	63.0±9.0	0.65	63.0±9.2
Female sex--no. (%)	694 (30.8)	800(37.3)	< 0.0001	1494 (33.9)
Race or ethnic group--no. (%)			0.0002	
White	1447 (64.2)	1484 (69.1)		2931 (66.6)
Black	104 (4.6)	120 (5.6)		224 (5.1)
Asian	500 (22.2)	377 (17.6)		877 (19.9)
Other	203 (9.0)	166 (7.7)		369 (8.4)
Current smoker--no. (%)	322 (14.3)	317 (14.8)	0.65	639 (14.5)
Hypertension--no. (%)	2172 (96.4)	2088 (97.3)	0.094	4260 (96.8)
Heart Failure--no. (%)	221 (9.8)	431 (20.1)	< 0.0001	652 (14.8)
Duration of diabetes--yr.	15.1±8.7	16.5±8.5	< 0.0001	15.8±8.6
Cardiovascular--no. (%)	946 (42.0)	1274 (59.3)	< 0.0001	2220 (50.4)
Amputation--no. (%)	60 (2.7)	174 (8.1)	< 0.0001	234 (5.3)
Peripheral vascular disease--no. (%)	343 (15.2)	703 (32.7)	< 0.0001	1046 (23.8)
Retinopathy--no. (%)	681 (30.2)	1201 (55.9)	< 0.0001	1882 (42.8)
Body-mass index	31.4±6.2	31.3±6.1	0.65	31.3±6.2
Blood pressure--mmHg				
Systolic	139.8±15.7	140.2±15.5	0.44	140.0±15.6
Diastolic	78.3±9.4	78.3±9.3	0.82	78.3±9.4
Glycated haemoglobin--%	8.2±1.3	8.3±1.3	0.057	8.3±1.3
Total Cholesterol(mmol/L)	4.6±1.2	4.8±1.4	< 0.0001	4.7±1.3
Triglycerides (mmol/L)	2.2±1.5	2.3±1.8	0.33	2.2±1.6
HDL-C(mmol/L)	1.1±0.3	1.2±0.4	0.14	1.1±0.3
LDL-C(mmol/L)	2.4±1.0	2.6±1.1	< 0.0001	2.5±1.1
Estimated GFR -- ml/min/1.73m <sup>2</sup>	56.2±18.3	56.2±18.2	0.94	56.2±18.2
Median urinary albumin-to-creatinine ratio – mg/g (IQL)	877 (449-1722)	964 (483-1971)	0.0007	927 (463-1833)

**Table II** Primary outcome and sensitivity analyses

	<b>Canagliflozin</b> <i>no. of participants with event/ total no. of participants</i>	<b>Placebo</b>	<b>Canagliflozin</b> <i>event rate/1000 patient years</i>	<b>Placebo</b>	<b>Hazard Ratio</b> HR (95% CI)	<b>P value</b>
<b>Neuropathy events</b>						
All neuropathy events	334/2202	323/2199	64.1	62.3	1.03(0.89-1.21)	0.66
Sensorimotor polyneuropathy events	84/2202	90/2199	14.9	16.1	0.93(0.69-1.25)	0.63
Diabetic neuropathy events	84/2202	92/2199	14.9	16.5	0.91(0.68-1.22)	0.52
Neuropathy events excluding autonomic neuropathy events	279/2202	271/2199	52.5	51.3	1.03(0.87-1.21)	0.77

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**Table III** Multivariable model of risk of first occurrence of neuropathy event

Multivariable Cox-regression model of predictors of first neuropathy event. The model was stratified by baseline eGFR group and included an age by time interaction to maintain proportional hazards. Randomized allocation was not included in the model. \* indicates p-values that did not remain significant after adjustment for multiple testing (see Supplementary Table 4).

<b>Variable</b>	<b>Hazard ratio (95% confidence interval)</b>	<b>P-value</b>
Age (per 5 years)	0.87 (0.81 to 0.93)	< 0.001
Sex (ref=Male)	1.03 (0.87 to 1.23)	0.712
Race (ref=White)		
Asian	1.45 (1.18 to 1.79)	< 0.001
Black	1.59 (1.16 to 2.17)	0.004
Other	1.96 (1.53 to 2.51)	< 0.001
History of Neuropathy	1.12 (0.95 to 1.31)	0.185
History of Retinopathy	1.03 (0.87 to 1.21)	0.764
Systolic blood pressure (per 5 mmHg)	1.003 (0.978 to 1.028)	0.836
Glycated haemoglobin (%)	1.10 (1.03 to 1.17)	0.002
Body mass index (kg/m <sup>2</sup> )	1.003 (0.990 to 1.017)	0.635
Duration of diabetes (years)	1.007 (0.998 to 1.017)	0.144
Smoker	1.16 (0.94 to 1.44)	0.175
History of cardiovascular disease	1.04 (0.88 to 1.24)	0.641
Urine albumin-to-creatinine ratio (per 10 mg/mmol)	0.994 (0.989 to 1.000)	0.054
Low density lipoprotein-cholesterol (mmol/l)	0.97 (0.89 to 1.05)	0.424
High density lipoprotein-cholesterol (mmol/l)	0.85 (0.66 to 1.11)	0.227
Triglycerides (mmol/l)	0.998 (0.948 to 1.050)	0.932
Estimated glomerular filtration rate (ml/min/1.73m <sup>2</sup> )	0.986 (0.979 to 0.994)	< 0.001
Insulin use	1.26 (1.02 to 1.57)	0.034*
Glucagon-like peptide-1 agonist use	1.13 (0.79 to 1.60)	0.505
Metformin use	1.12 (0.94 to 1.33)	0.216
Sulphonylurea use	0.99 (0.81 to 1.21)	0.897
Statin use	1.28 (1.06 to 1.56)	0.011*
Anti-thrombotic use	1.003 (0.843 to 1.194)	0.971
Potassium (mmol/l)	0.85 (0.73 to 0.99)	0.036*