Prevention First
Newsletter Online July 2024

In this Issue:

Start National Diabetes Prevention Program urgently

PCDA is on the right path of prevention first-"Small steps build great things"

An interview with Dr. Zakir Alavi—-Interviewer: Dr. Shahid Akhter

Dr. Shahid Akhter: Thank you very much for giving us time for this interview. In the beginning our readers would like to know about your personality, your childhood, your education etc.

Dr. Zakir Alavi: I was born in Karachi, studied in St. Paul's English High School Saddar, did my intermediate education from Adam Jee Science College. I did my medical graduation from Sindh Medical College Karachi, then House Job in medicine and surgery from Jinnah Hospital Karachi. In medicine I got opportunity to learn from Prof. S. M. Rabb. That was really a great learning experience. After the end of my house job in 1987, I went to Ireland for the training in medicine and did my MRCP, wor ked in the field of endocrinology. I lived and worked in Ireland till 1997 and came back to Pakistan. Then I joined Jinnah Medical & Dental College Hospital Karachi as Assistant Professor of Medicine. I worked there from 1998 till 2004, after which I joined Liaqat General Hospital Karachi as consultant endocrinologist and later on as Head of the Dept. of Endocrinology. I worked there till 2010, at which time I joined PPL (Pakistan Petroleum Ltd) as Senior Manager of Medical Services. I retired from there in 2020. I'm currently working in Medicare Hospital, South City Hospital and Medilink.

Dr. Shahid Akhter: Are you satisfied with the standards of care of the people with diabetes in Pakistan? Is government health care system performing its functions according to the international standards?

Dr. Zakir Alavi: Really very important question and very difficult to answer too. The answer is NO! I'm not satisfied with the current health care status of the country because in fact there is no existing system. Everybody is doing what he wish. Nobody is following any clear recommendations. And that's because the awareness of the new recommendation has not disseminated properly. In recent years the situation is improving only because of the individual efforts by the consultants working in the hospitals and institutions; and also because of the primary care physicians individually harmonizing the recommendation on a very small scale. Nobody is following any clear cut practicing guidelines. Unfortunately a lot of hearsay and presumed health remedies are getting mixed up in main line medicine; and a lot of doctors, unfortunately, are advising people to take such alternate steps as medicines, not necessarily drugs, but certain things in diets. There are a lot of misconcepts about diets. Remember I'm not saying that the physicians are wrong, may be that person believes that these remedies are useful, and that belief is established because of marketing by the individuals who are selling alternative medicines either through Youtube or social media, giving you wrong messages. A lot of misinformation by the social media; and those things need to brought forward and explained to all that do not believe on everything which you hear or see on social media. It is important to analyze and verify any such claim. Anybody can make a video or write an article or make a domain or web page and write down whatever they want. These could be wrong things. Not only they take away these things they take away the opportunity of the proper medical care, but sometimes they actually propagate care and drugs and supplements which may end up in doing harm. That's what I'm afraid of. Thus I am not satisfied with the system. There should be an organized system. , for which people, like you (PCDA) and other associations are doing. Trying to make sure that not only is proper knowledge given but there is also a harmonization and uniformity in recommendations so that the physician or the general practitioners do not get conflicting messages.

Dr. Shahid Akhter: How can this be changed?

Dr. Zakir Alavi: I think first of all, senior family physicians and the senior teaching professors at the medical institution should come forward. They are well aware of the current happenings round the globe e.g. what are the latest recommendations. I'm sure the awareness level is good but practicing these guidelines is a different thing. There is a gap between knowledge and practice. The first step towards the improvement

can be that seniors start practicing what they know. Secondly these awareness programs like PCDA is conducting, can help a lot. And I think that widening the scope of such CMEs is needed. It is heartening to see that many other associations are now conducting CMEs. The only fear is that probably everybody is not saying the same thing. If there are conflicting messages then there is trouble. So as you said the government is responsible for managing all these. After all its government's job to bring uniformity, widen the reach of these programs nationwide. Only governments can do this through their regularity bodies like PMC, HCC, CPS and others. What we can do is to continue what we are doing, as much as we can. And same time create pressure on the governments to start organizing things, and start dissipating the knowledge not just about how to manage the diseases but about how to prevent these. Prevention is very difficult for the small associations as they can cover small areas. Governments should start National Prevention Program say for example for Diabetes. It has to be started by the central government then spread to the provinces. In smaller countries with smaller population small NGOs can do a lot, but Pakistan is a big country with about 200 million population.

Dr. Shahid Akhter: Do you believe in Public-Private partnership in improving our health care system?

Dr. Zakir Alavi: Can be done but not in the sense of constructing buildings and the infra structure. Governments have to initiate it first. They have to set up the infrastructure and then they can involve private sector within that structure. What the private sector can do is to join and enforce it.

Dr. Shahid Akhter: International guidelines are based on the meta analysis of the clinical trials done in the western countries and USA etc. Are these guidelines as such applicable to our population. Isn't it better that to have our own guidelines?

Dr. Zakir Alavi: International guidelines are very important for updating medical knowledge. These guidelines are based on very huge data related not only to management ant treatment but to prevent the disease. They are not only about pharmacotherapy but other modes of therapy like lifestyle modifications and psychotherapy etc. Putting all that data is not easy, thus guidelines and algorithm are made. When new data comes, the guidelines are changed. Ideally speaking local guidelines are the best. You are right the European guidelines are not exactly applicable to our population. However we can't have local guidelines until you have the local data. There is deficiency and paucity of locally collected data and registries. However what we can do is to follow these guidelines e.g. in diabetes ADA, EASD, IDF and AACE etc are very regularly updating their guidelines. We can modify them a little bit to suit our circumstances. Such guidelines can be the initial effort. Pakistan Endocrine Society has published guidelines for the management of T2DM; and another set of guidelines is coming soon. Remember guidelines are not absolute rules. Guidelines just provide you available options and approaches to start managing the disease. Propagation require support from pharmaceutical industry as we are very much dependant on them. And that's a good thing. However at the same time none of us really know about guidelines for the prevention of disease. How much we are propagating that. And unfortunately that is very important. There are few guidelines in disease prevention. The guidelines for the management of the disease do contain few things for prevention, not detailed. Especially in my domain there are no clear cut guidelines for the prevention of diabetes. They contain suggestion about life style changes for the individuals, but it is very difficult to implement life style changes at national level.

Like implementing suggestion for diet at national level, as in Denmark they have national Dietary guidelines for healthy eating. And there are clear cut guidelines applicable not only to general public but at institution levels. They provide healthy food based on the guidelines, to the school children regularly. In businesses and in other institutions they are following the guidelines. At least they have set their guidelines. People there sit together, think and make plans to decide what diet is healthy for their nation.

We can modify these model guidelines according to our scenario. Like good quality protein is not affordable for the majority of our people. Our diet is carbohydrate rich. And unfortunately we can't get away from it, because non-carbohydrate food is expensive. Carbohydrate food is cheap like wheat and rice. You go to any school and check their snacks, all contain more carbohydrates and less protein.

Dr. Shahid Akhter: What role doctors in general and diabetologist and their organizations in particular can play in making and implementing such guidelines?

Dr. Zakir Alavi: We are not in position of implementing the guidelines. Only governments can do that. We can just suggest and give our expert opinion. The suggestion should then be validated and implicated. The dietary guidelines should be based on these suggestions coming from experts.

Dr. Shahid Akhter: DAP and other associations have demanded banning the carbonated drinks in educational institutions. What happened to those expert's suggestions?

Zakir Alavi : That is being applied by many schools voluntarily. My suggestion is a little bit different. Instead of banning a single item, make and implement proper dietary guidelines. So we can tell them what not to eat, but also what to eat. Suggest alternative food which is acceptable to the children, which is delicious and tasty, and liked by all the children. National Diet plan should be made keeping in mind our resources, accessibility, sustainability and comprehensiveness. The suggested diet plan should provide all food components and overcome all common deficiency states of the children.

Shahid Akhter: Do you see a lack of good relationship between primary care physicians and the consultants. Is the trust deficit responsible for the deterioration of the system?

Dr. Zakir Alavi: The primary care physicians have much improved and updated their knowledge because of the tremendous efforts made the doctors associations like PCDA. But still there is a gap between the knowledge of the PCPs and the consultants. And that knowledge gap is acceptable and understandable. A family physician is not required to have highest detailed knowledge of a single subject, whereas a consultant is dealing with a single subject. His job is to make sure that the basic care or the primary care of the patient, which is about 90%, is done properly. However our problem with the family physician level, and may also be at consultant level, is that we do not know our limitations. We do not accept that this is beyond me. You find a lot of referral from primary care Family physicians to the secondary and tertiary care consultant surgeons, but you don't find much referral in medicine. This can be only done by increasing the awareness level.

Everyone should know his limitations and not to cross them. This applies to the consultant even. Although he may have knowledge of managing primary problems of the patients, yet he should refer the patient back to the referring family physician. I admit that referring back is rare at consultant level. May be they don't refer the patient only because they don't want to lose them. I think , if they know that the level of the disease in a patient is at a level where he shouldn't treat him ,majority of the Family physicians will be happily lose the patient if they are sure doing so is in favor of the patient. If this type of awareness is there, this is the right way of referral. I'm sure most doctors want to care their patients, and they will certainly refer the patient if they know their limitations. There is a trust deficit between Family physicians and the consultants. A specialist is not a superior doctor. A specialist is a doctor who knows a single disease. He may be superior in that disease but inferior in all other fields. Thus no doctor is inferior or superior. They are simply different types of doctors. Unfortunately in our system it is very much apparent and very much made aware by our specialists. Our specialists should make sure a family physician is not made to feel inferior.

Dr. Shahid Akhter: How can the family physicians upgrade and improve their standards of care of the patients?

Dr. Zakir Alavi: One important thing is the trust of the patients. During last 30 or 40 years time, level of knowledge and the standard of medical practice at family physician level had gone down tremendously. General public lost trust in their family physicians. So a lot of harm was done to the relationship between public and the family physician. People only went to the family physician when they could not afford the specialist. However things are changing back as they were in 60s and 70s, when a family physician was a priority doctor they went to. They were reluctant enough to go to the consultants. They didn't trust the specialist. They felt that they have no relationship with the specialist; while the family physician was the person they had relationship with, they could trust their family physician not only because the family physician took the best decision for their care, but they trusted him as the most knowledgeable person. And that is gradually coming back with the improving medical care by the family physicians as they improved their knowledge. I think if they continue down this path we will do well. However they if still continue in this segment where doctors have become mere 'drug pushers' and agents for drug sellers. Sorry to say that. My father was a family physician and I know about the relationship a family physician has with the patient. I have myself seen that level of trust of the patient. We lost this in 90s and this is gradually improving again only because of the efforts you people and many other organizations are doing for the improvement of knowledge. If the knowledge improves this trust increases.

Dr. Shahid Akhter: Are you satisfied with way PCDA is working?

Dr. Zakir Alavi: PCDA is doing an excellent job. I appreciate them because there are few organization which talk about '***prevention first***' and then about the treatment. PCDA has always emphasized on prevention. I have seen so many active societies in this country but PCDA is doing the best in conducting the awareness sessions, camps and what not. *I think you are on the right path*. You should do all that including the guidelines. *Small steps build great things*. What PCDA needs now is to widen itself. More members in the core section of the organization. I know many of you people are very aggressive and energetic, and spend your time in improving the knowledge of the primary care physicians about diabetes. Still a lot has to be done because the public is huge; thus you need ten times more members. My suggestion to PCDA is to travel to less visited and neglected areas of Karachi e.g. Liaqatabad, Baldia, Lyari and metroville area. Karachi is as big as a province. There are a lot of physicians who are not still involved in the learning process.

Dr. Shahid Akhter: Your message to PCDA?

Dr. Zakir Alavi: My message is that if you want to make changes first change yourself. Start practicing the guidelines they are given out. A lot of family physicians face difficulties in their practice. Just help out them. Implement the guidelines on yourself first, even if you don't have the disease. Feel the pain of a patient who is taking injections three times a day. Use empathy with them. And that empathetic relationship has to be understood while making policies at higher level. I think main function of PCDA should be to dissipate knowledge widely to family physicians.

DR. Shahid Akhter: Thank you very much Dr. Zakir for giving your precious time for PREVENTION FIRST N EWSLETTER and guiding PCDA with your valuable suggestions. Thanks Again!

“Thyroid Storm” during pregnancy

Report By: Dr. Syed Farasat Tirmazi, Mansehra KPK

(This poster was presented by Dr. Yasir Mughal in ENDO 2024 symposium. Dr. Farasat is Co-Author of this poster)

Deciphering The Enigma: A Case Report On New-onset Graves Disease Presenting As Thyroid Storm In The First Trimester Of Pregnancy, Managed In The Intensive Care Setting

Yasir Mughal MD1,2, Syed Farasat Ali Shah MBBS1,2, Apoorv Tiwari MD1,2, Abhishek Vadher MD1,2, Abed Dabaja MD1,2, Sujata Kambhatla MD1,2

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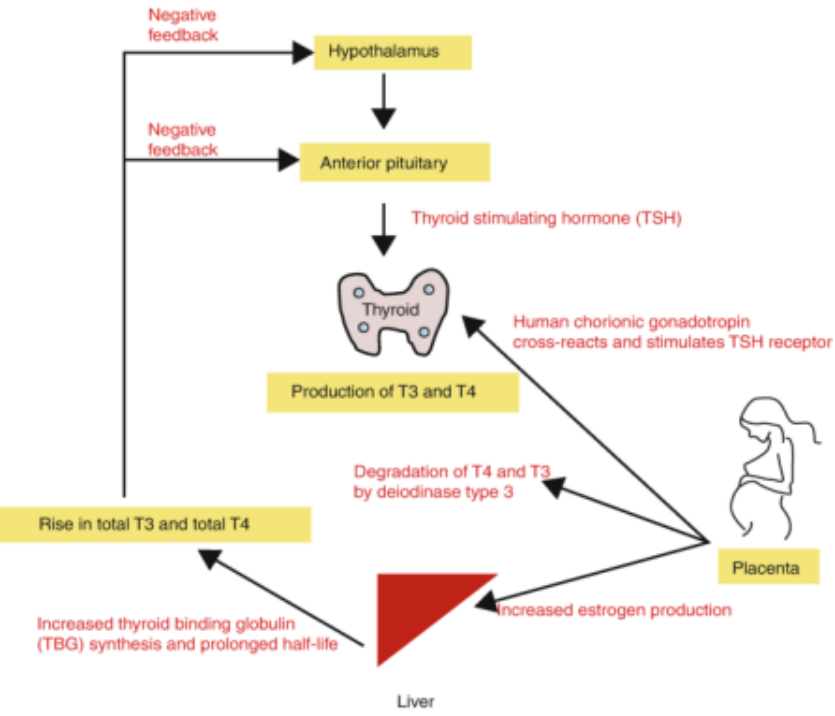
Introduction:

Graves' disease, an autoimmune disorder causing hyperthyroidism, presents unique challenges during pregnancy, particularly when it manifests as a thyroid storm. Thyroid storm is a critical endocrine emergency characterized by an acute and severe exacerbation of hyperthyroid symptoms. This condition demands prompt diagnosis and aggressive treatment to avert severe maternal and fetal complications.

Clinical significance:

Pregnant women should undergo regular thyroid disorder screenings, particularly if their resting HR surpasses 100/min. Should a thyroid storm occur, prompt and vigorous treatment is crucial to avert further worsening of the condition. Despite limited research opportunities, evidence based guidelines are crucial for optimizing care and reducing maternal fetal complications and mortality.

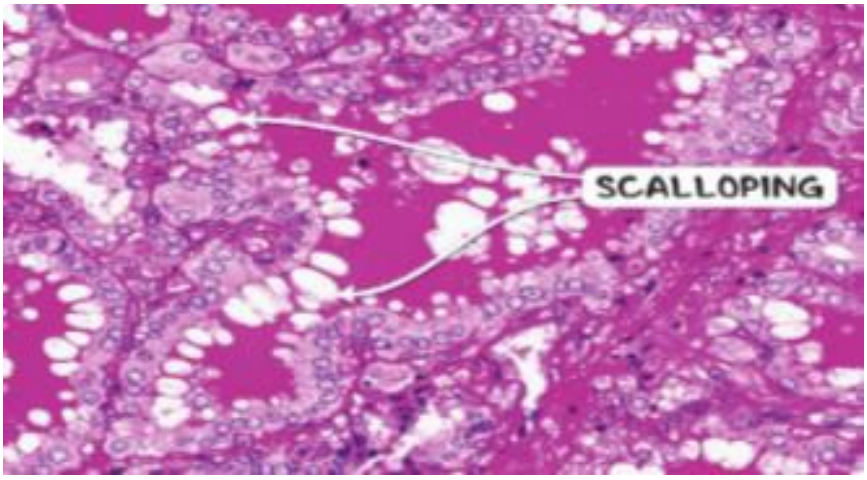


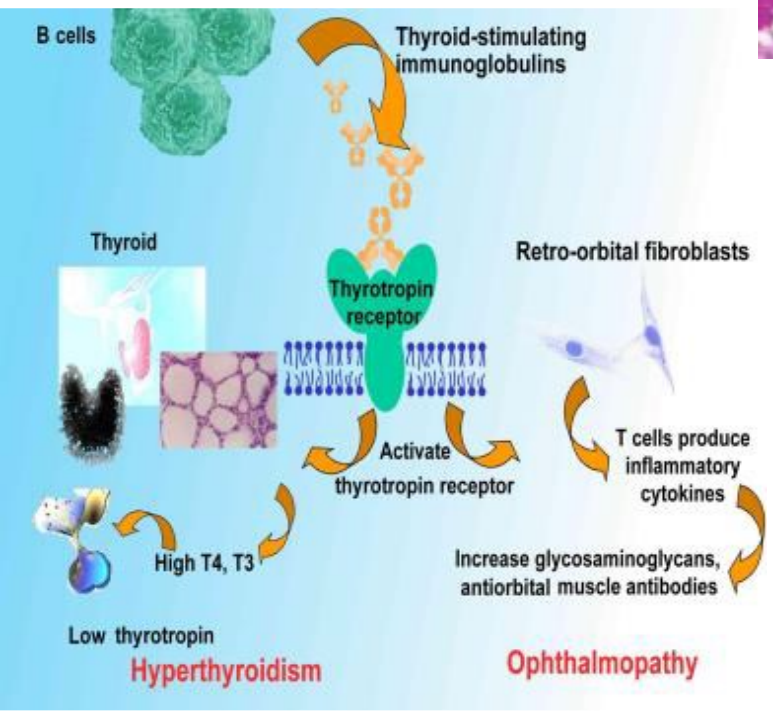
Case description:

27-year-old African American woman gravida 1 para 0 at 9 weeks gestation with no significant PMH whopresented with palpitations, agitation, and fever.On examination, she was febrile, tachycardic, and tremors in hands, with mild bilateral exophthalmos. Thyroid function tests revealed markedly elevated free thyroxine and suppressed thyroid-stimulating hormone levels and normocytic anemia. Thyroid ultrasound confirmed diffuse thyroid enlargement with increased vascularity, consistent with Graves' disease. Pelvic ultrasound estimated the gestational age at 9 weeks and 2 days, with a β-hCG level of 135,037 mIU/mL. An electrocardiogram revealed sinus tachycardia, and a complete metabolic panel indicated mild hypokalemia. The thyroid Stimulation Immunoglobulin and Thyrotropin receptor antibodies were tested positive. The Burch-Warsofsky point score of 45, supported the diagnosis of thyroid storm. The patient received intensive care treatment including intravenous fluids, hydrocortisone, beta-blockers, Lugol’s iodine, propylthiouracil, and potassium replacement. Following treatment, thyroid function stabilized within 48 hours, and hyperthyroid symptoms resolved. The patient was transitioned to floor and ultimately discharged on oral labetalol and propylthiouracil after 4 days.

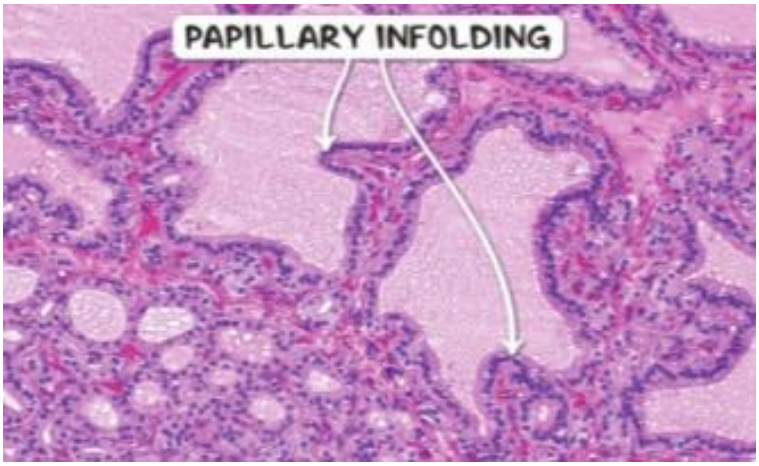
Discussion/Conclusion:

Hyperthyroidism in pregnancy primarily arises from Graves' disease or hCG-induced hyperthyroidism. Thyroid storm, often triggered by acute stressors, can stem from various causes, including uncontrolled hyperthyroidism and pregnancy-related factors like anemia. Free T4 levels may not accurately reflect thyroid storm severity in pregnant individuals. TRAbs are confirmatory in 96-97% Graves' disease, while Doppler ultrasound aids in diagnosis. Thyroid storm is diagnosed clinically. Tools like the Burch-Wartofsky Point Scale (BWPS) aid in diagnosis and severity assessment, though not validated for pregnancy. BWPS has high sensitivity but low specificity.





Thyroid storm are at increased risk for cardiomyopathy and heart failure, presenting as pulmonary edema and pleural effusion. Tachyarrhythmias like Afib and SVT can cause diastolic dysfunction, and severe vascular issues, such as arterial aneurysmal rupture, may occur. Thyroid storm management in ICU involves continuous cardiac and fetal monitoring. Initial measures include securing access, oxygen therapy, and, if needed, intubation. Crystalloids are administered for fluid resuscitation, correcting electrolyte imbalances and administering thiamine empirically. Temperature management targets euthermia with cooling and acetaminophen is preferred Pregnant women should undergo regular thyroid disorder screenings, particularly if their resting HR surpasses 100/min. Should a thyroid storm occur, prompt and vigorous treatment is crucial to avert further worsening of the condition.



Thana Bula Khan: Screening Camp under SEED Project

Report by: Dr. Qazi Mujahid

On a very hot Sunday of 17 July'24, a PCDA team of doctors comprised of Dr. Fareeduddin, Dr. Shakeel Ahmed, Dr. Shahid Akhter, Dr. Qazi Mujahid and Dr. Naresh Kumar visited Thana Bula Khan, a small town near Kirthar National Park in Sindh. A team of STEP headed by Saud Abbassi and volunteers from Pharmevo were part of the team. The camp was organized by Dr. Manghan Lal, head of PCDA chapter of Thana Bula Khan, in Taluka District Hospital.

About 200 villagers from the nearby villages attended the camp where they were screened for diabetes, pre-diabetes, hypertension and other common diseases. After taking careful history, examination and lab tests, data was collected on the specifically designed forms by the expert team of STEP volunteers. The data collecting system is designed by Dr. Fareeduddin and Mr. Umair Ahmad of DUHS, School of public Health.

The program was 28th of the SEED series, in which PCDA & PharmEvo have pledged to screen outreach areas of Pakistan to create awareness about defeating diabetes along with nurturing the nature by projecting plantation drive throughout Pakistan. The only objective of both parties is to make a better & healthier Pakistan in order to reduce the burden of the most important metabolic disorder which is spreading like a fire i.e. Diabetes. Members at PCDA & PharmEvo were thoughtfully design a nationwide campaign to equip the nation with preventive measures to halt this epidemic. This unique partnership has only one agenda to screen almost 1 Milllion Pakistanis in a year in order to diagnose diabetic patients as early as possible along with making the environment healthier through plantation at multiple sites of Pakistan.

In the beginning of the camp, an awareness session was conducted for the attending patients during which Dr. Shahid Akhter, Dr. Shakeel Ahmed and Dr. Naresh Kumar addressed the audience in Urdu and Sindhi languages; and gave them tips for good control of diabetes and how to prevent the complications. They were then screened and their data collected by STEP volunteers. Later the patients were examined by the doctors who advised them the subsequent treatment.

Later in the office of Medical Superintendent Dr. a Ajruk ceremony was held during which Ajraks were awarded to all the guests. Dr.Manghan paid special thanks to PCDA team and Pharmevo for this outreach program.


NISE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Dr. VEERU MAL
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Dr. ASAR MAL
Dr. VERSI MAL
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Dr. HEMAN KUMAR
Dr. ASHOK KUMAR

STEP PCDA

Forthcoming Camp under SEED project of PCDA

Badin Chapter

Obituary

All members and friends of Primary Care Diabetes Association (PCDA) Pakistan express their feeling of regrets and sorrow on the sad news of demise of Prof. Akhter Hussain, president of International Diabetes Federation (IDF).

Prof. Hussain was a long-serving volunteer and contributor to the activities of IDF, with over 30 years of experience in diabetes research and education. Originally from Bangladesh, he pursued post-graduate and doctoral studies in the US and Norway and went on to hold senior cancer research and epidemiology positions in Norway, Brazil and Bangladesh.

He served for many years as Professor of Medicine in Global Health at NORD University in Norway. In recognition of his contribution to diabetes, Prof Hussain received the Bangladesh National Award in Diabetes in 2011 and 2012.

A passionate champion for the diabetes cause, Prof Hussain's contributions to the field of diabetes were invaluable and his absence will be deeply felt by all who had the privilege of knowing him.

A Triumph in Public Health:

PCDA and STEP Facilitate Groundbreaking PhD Research

By: Dr. Syed Omair Adil

Primary Care Diabetes Association (PCDA) of Pakistan and its student wing "Students Taskforce for Education and Public Health" (STEP), proudly announce that a monumental PhD research project has reached its successful completion. The research, conducted by Syed Omair Adil, a dedicated faculty member from the School of Public Health at Dow University of Health Sciences (DUHS), and completed at University Sains Malaysia (USM), aimed to screen apparently healthy individuals in Karachi, Pakistan, for metabolic syndrome and assess their risk of cardiovascular disease (CVD) over the next 8-10 years.

Community Engagement and Data Collection

The success of this research project is deeply rooted in the exceptional community engagement and logistical support provided by PCDA and STEP. The organizations played a pivotal role in facilitating data collection through the organization of screening camps across various regions of Karachi. These camps were strategically set up in diverse locations, ranging from slum areas to posh neighborhoods, ensuring comprehensive coverage of the city's population.

The screening camps were hosted in numerous community sections, including mosques, madrasahs, universities, hospitals, and factories. This diverse outreach enabled the research team to gather data from a wide cross-section of Karachi's populace, making the findings robust and representative.

Free Consultation and Assessments

At each screening camp, participants received free consultations along with nutritional and anthropometric assessments. Moreover, a free laboratory screening from Dow Laboratory was also performed. This initiative not only facilitated data collection for the research but also provided immediate health benefits to the community. The comprehensive assessments conducted during these camps included measurements of height, weight, body mass index (BMI), blood pressure, and other relevant health indicators. These evaluations were crucial in identifying individuals at risk of metabolic syndrome and CVD.

Supervisory and Field Support

The research was overseen by Prof. Kamarul Imran Musa and Dr. Asiful Islam from Universiti Sains Malaysia, who provided critical guidance and support throughout the project. Additionally, Prof. Kashif Shafique from the School of Public Health at DUHS played a significant role as the field supervisor, ensuring the smooth execution of the study on the ground. The collaboration between these academic leaders and the field team was instrumental in the project's success.

The Role of STEP Students

The contribution of STEP students was invaluable, showcasing their dedication and resilience. These students worked tirelessly to collect data under challenging conditions, including hot and cloudy weather. Their commitment and hard work were crucial in reaching the target of screening a number of individuals, highlighting the importance of community and student involvement in public health research.

Research Findings and Academic Success

The primary objective of the study was to screen apparently healthy individuals in Karachi for metabolic syndrome and assess their risk of developing CVD over the next 8-10 years. The findings showed that one-third of the healthy individuals were diagnosed with metabolic syndrome. A higher BMI, current smoking, areca nut use, and low physical activity were significant factors. Furthermore, BMI, waist circumference (WC), waist to height ratio (WHtR), and visceral adiposity index (VAI) were the most important anthropometric predictors for metabolic syndrome in apparently healthy individuals of Pakistan, while body shape index was found to be the weakest indicator. CVD risk was calculated among individuals with newly diagnosed metabolic syndrome using the Framingham Risk Score (FRS) and Globorisk Score. The FRS and Globorisk scores are particularly relevant in predicting

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Prevalence of undiagnosed metabolic syndrome using three different definitions and identifying associated risk factors among apparently healthy adults in Karachi, Pakistan: a cross-sectional survey in the year 2022

Syed Omair Adil,[1,2] Kamarul Imran Musa,[1] Fareed Uddin,[3] Asima Khan,[4] Irfanullah Khan,[5,6] Areebah Shakeel,[7] Kashif Shafique,[2] and Md Asiful Islam[8]

CVD risk as these scores include key metabolic syndrome-related risk factors like blood pressure, cholesterol levels, and age. The outcome of both CVD risk scores predicted moderate-to-high risk of CVD in 10-years in almost half of the newly diagnosed patients with metabolic syndrome. In particular, the risk of development of CVD in 10 -years in newly diagnosed metabolic syndrome is higher with increasing age, in male gender, and current smokers.

This groundbreaking research has not only culminated in the successful completion of a PhD thesis but has also led to the publication of three papers in high-impact, peer-reviewed journals. These publications underscore the academic rigor and significance of the study, contributing valuable insights to the field of public health and epidemiology.

Acknowledgment and Future Directions

The collaboration between academic institutions and community organizations exemplifies the power of collective effort in advancing public health research. As the findings of this study continue to inform public health strategies and interventions, PCDA and STEP are proud to have played a key role in this journey. The data collected through their screening camps have been pivotal in advancing our understanding of metabolic syndrome and CVD risk in Karachi, paving the way for future research and public health initiatives.

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PMID: 37876536

Role of anthropometric indices as a screening tool for predicting metabolic syndrome among apparently healthy individuals of Karachi, Pakistan

Syed Omair Adil,[1,2,*] Kamarul Imran Musa,[1] Fareed Uddin,[3] Kashif Shafique,[2] Asima Khan,[4] and Md Asiful Islam[5,*]

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PMCID: PMC10518264
PMID: 37753441

Risk Assessment for Cardiovascular Disease Using the Framingham Risk Score and Globorisk Score Among Newly Diagnosed Metabolic Syndrome Patients

Syed Omair Adil,[1,2] Fareed Uddin,[3] Kamarul Imran Musa,[1] Asima Khan,[4] Areebah Shakeel,[5] Kashif Shafique,[2] and Md Asiful Islam[6]

Glimpses of some of the camps arranged by PCDA and STEP

Dr. Abdul Rauf reports from Lahore Chapter

ذیابیطس کے متعلق شعور اجاگر کرنے کیلئے آگاہی تقریب

ڈاکٹر الطاف احمد چیمہ، ڈاکٹر طاہر رسول، ڈاکٹر عبدالرؤف و دیگر نے شرکت کی

لاہور (پ ر) ذیابیطس (شوگر) کے متعلق شعور اجاگر کرنے کیلئے آگاہی تقریب کا انعقاد، سکریننگ ٹیسٹ بھی کئے گئے۔ ذیابیطس (شوگر) ایک موذی مرض ہے، پاکستان میں اس کا تناسب دنیا میں بلند ترین سطح پر ہے، ایک تحقیق کے مطابق 30 برس سے زائد عمر کا ہر 4 میں سے ایک پاکستانی شوگر کے مرض میں مبتلا ہے اور اکثر کو اس کا علم ہی نہیں، ان حقائق کے پیش نظر PCDA(DOCTORSCONPAFP) اور PCDA Lahore نے مشترکہ طور پر ایک نجی ادارے TTLAB لاہور کے تعاون سے شوگر آگاہی تقریب کا انعقاد کیا جس میں ڈاکٹر الطاف احمد چیمہ، ڈاکٹر طاہر رسول، ڈاکٹر عبدالرؤف، ڈاکٹر منظور جنجوعہ اور ڈاکٹر معاذ نے اپنے ہیلتھ اسٹنس کے ساتھ پرعزم شرکت کی۔ نجی ادارے کے تمام 30 افراد سے زیادہ عمر کے افراد کے شوگر کا سکریننگ RBG ٹیسٹ کیا گیا اور بعض کا HbAIC بھی کیا گیا۔ اس ادارے کے تمام افراد کو جمع کر کے شوگر آگاہی لیکچر دیا گیا، اور اس کے بعد سوالات اور جوابات کے طویل سلسلے میں ڈاکٹروں کے پورے پینل نے پرجوش حصہ لیا۔ ذیابیطس کے ماہرین نے جسمانی ورزش اور صحت مند غذا کی افادیت اور شوگر پر اس کے مثبت اثرات پر ایک تفصیلی بحث کی۔ فاسٹ فوڈ اور کولڈ ڈرنکس کے مضر اثرات اور ان سے بچاؤ پر زور دیا۔ نجی ادارے کے تمام سٹاف اور ذمہ داران احمد لطیف نے دورہ کرنے والی ٹیم کا شکریہ ادا کیا اور اس قسم کی تقاریب بار بار منعقد کرنے کے عزم کا اظہار کیا۔

30 برس سے زائد عمر کے ہر 4 میں سے ایک پاکستانی شوگر کا مریض

DOCTORSCONPAFP اور PCDA کی نجی ادارے TTLAB لاہور کے تعاون سے ذیابیطس سے متعلق آگاہی تقریب

ڈاکٹر الطاف چیمہ، ڈاکٹر طاہر رسول، ڈاکٹر عبدالرؤف، ڈاکٹر منظور، ڈاکٹر معاذ نے ورزش اور صحت مند غذا کی افادیت پر روشنی ڈالی

لاہور (ہیلتھ رپورٹر) ذیابیطس (شوگر) کے متعلق شعور اجاگر کرنے کیلئے آگاہی تقریب کا انعقاد، سکریننگ ٹیسٹ بھی کئے گئے۔ تفصیلات کے مطابق ذیابیطس (شوگر) ایک موذی مرض ہے، پاکستان میں اس کا تناسب دنیا میں بلند ترین سطح پر ہے، ایک تحقیق کے مطابق 30 برس سے زائد عمر کا ہر 4 میں سے ایک پاکستانی شوگر کے مرض میں مبتلا ہے اور اکثر کو اس کا علم ہی نہیں، ان حقائق کے پیش نظر (DOCTORSCONPAFP) اور PCDA Lahore نے مشترکہ طور پر ایک نجی ادارے TTLAB لاہور کے تعاون سے شوگر آگاہی تقریب کا انعقاد کیا جس میں ڈاکٹر الطاف احمد چیمہ، ڈاکٹر طاہر رسول، ڈاکٹر عبدالرؤف، ڈاکٹر منظور جنجوعہ اور ڈاکٹر معاذ نے اپنے ہیلتھ اسٹنس کے ساتھ پرعزم شرکت کی۔ اس موقع نجی ادارے کے تمام 30 افراد سے زیادہ عمر کے افراد کے شوگر کا سکریننگ RBG ٹیسٹ کیا (صفحہ 4 پر بقیہ نمبر 6)

نئی بات شوگر 6

گیا اور بعض کا HbAIC بھی کیا گیا، اس ادارے کے تمام افراد کو جمع کر کے شوگر آگاہی لیکچر دیا گیا، اور اس کے بعد سوالات اور جوابات کے طویل سلسلے میں ڈاکٹروں کے پورے پینل نے پرجوش حصہ لیا۔ ذیابیطس کے ماہرین نے جسمانی ورزش اور صحت مند غذا کی افادیت اور شوگر پر اس کے مثبت اثرات پر ایک تفصیلی بحث کی۔ فاسٹ فوڈ اور کولڈ ڈرنکس کے مضر اثرات اور ان سے بچاؤ پر زور دیا۔ نجی ادارے کے تمام سٹاف اور ذمہ داران احمد لطیف نے دورہ کرنے والی ٹیم کا شکریہ ادا کیا اور اس قسم کی تقاریب بار بار منعقد کرنے کے عزم کا اظہار کیا۔

شوگر کے حوالے سے آگاہی تقریب کے موقع پر ڈاکٹر الطاف چیمہ، ڈاکٹر طاہر رسول، ڈاکٹر عبدالرؤف و دیگر کا گروپ فوٹو

ذیابیطس سے متعلق شعور اجاگر کرنے کیلئے آگاہی تقریب، سکریننگ ٹیسٹ کیے گئے

ماہرین نے جسمانی ورزش، صحت مند غذا کی افادیت، شوگر پر اس کے مثبت اثرات پر ایک تفصیلی بحث کی

لاہور (نیوز رپورٹر) ذیابیطس (شوگر) کے متعلق جنجوعہ اور ڈاکٹر معاذ نے اپنے ہیلتھ اسٹنس کے

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Prof. Dr. Khalid Amin
Prof. Dr. Amir Hussain
Prof. Dr. Shahid Rasool
Prof. Dr. Masood Ahmad
Prof. Dr. Shahid Abbass
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Non Physician Group:
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Shabbir Chawla
Haji Riaz Sheikh
Tariq Sattar
Mirza Aslam Baig
Engg. Faizan

PCDAians attending ADA 2024 Orlando

Latest from ADA'24……..reports Dr. Riasat Ali Khan

STEP trials show heart failure benefit with or without diabetes, could transform HFpEF treatment

Two trials of the of glucagon-like peptide-1 (GLP-1) receptor agonist semaglutide show similar improvement in heart failure (HF) symptoms and weight loss in patients with a BMI >30 who have heart failure with preserved ejection fraction (HFpEF) with or without diabetes. HFpEF is the most common phenotype of HF in the world and is increasingly common as obesity grows more common, noted Mikhail N. Kosiborod, MD, the Ben McAllister Endowed Chair in Cardiovascular Research, Saint Luke's Health System and Professor of Medicine, University of Missouri-Kansas City.

The initial results of STEP-HFpEF (HFpEF patients without diabetes) and STEP-HFpEF-DM (HFpEF patients with diabetes), showed a combined Kansas City Cardiomyopathy Questionnaire Clinical Summary Score (KCCQ-CSS) improvement of 7.5 points and body weight reduction of 8.4 percent versus placebo over 52 weeks. **The STEP-HFpEF and STEP-HFpEF-DM Trials—Targeting Obesity to Treat Heart Failure**

STEP-HFpEF-DM evaluated the effects of semaglutide in 616 patients by three categories of baseline A1C: <6.5 percent, 6.5 percent-–< 7.5 percent, and ≥7.5 percent. Patients had a median A1C at baseline of 6.8 percent and a mean BMI of about 38. Most patients, 59.7 percent, were 65–75 years old, 44.3 percent were female, and 84.3 percent were white.

"There was no impact of baseline A1C on KCCQ benefits," said Melanie J. Davies, CBE, MB, ChB, MD, FRCP, FRCGP, FMedSci, Professor of Diabetes Medicine, University of Leicester, Leicester, United Kingdom. "And the same observation applies to body weight advantages."

Baseline A1C likewise had no effect on improvements in six-minute walk distance, C-reactive protein high-sensitivity (hsCRP), or N-terminal prohormone of brain natriuretic peptide (NTproBNP).

The overall reduction in A1C with semaglutide was 0.8 percent, Dr. Davies reported, with increasing reductions as baseline A1C increased. Patients in the semaglutide arm were less likely to initiate any diabetes medication and more likely to discontinue any diabetes medication. There were numerically fewer hypoglycemic events in the semaglutide arm.

"Semaglutide significantly reduced A1C, but its HF benefits are likely driven by mechanisms beyond glycemia, including both weight loss-related and weight loss-independent effects," Dr. Davies said.

The mechanisms by which semaglutide benefits HF are not clear. While semaglutide has similar HFpEF benefits regardless of diabetes, the mean weight loss in STEP-HFpEF was 10.7 percent compared to 6.4 percent in STEP-HFpEF-DM, nearly 40 percent lower.

"There is something more than weight loss at work," said Javed Butler, MD, MPH, MBA, President, Baylor Scott and White Research Institute, the Maxwell A. and Gayle H. Clampitt Endowed Chair, Baylor Scott and White Health, and Distinguished Professor of Medicine, University of Mississippi.

There were other differences as well. Patients with higher baseline NTproBNP benefited more than those with lower levels. Those with New York Heart Association (NYHA) Functional Classification III or IV HF showed greater benefit than those with NYHA Class II. Patients with atrial fibrillation had greater benefits than those without. Patients on loop diuretics showed greater benefit than those not on the agents.

Semaglutide lowered NTproBNP versus placebo regardless of weight lost during the trial. And while numbers were small, semaglutide showed longer time to first HF event and time to first HF event or CV death.

Better understanding of the mechanisms of action for semaglutide are needed, but the more important message is that the drug can treat HF patients today.

"We are in a war with HF," said Subodh Verma, MD, PhD, FRCSC, Professor and Cardiac Surgeon, University of Toronto, Canada Research Chair in CV Surgery, and Chair of the CardioLink Trials Platform, St. Michael's Hospital, Toronto, Canada. "It represents a recalcitrant burden and we have very few options. Between 80–90 percent of HFpEF is co-existent with obesity, an area in which we have had no previous tools."

The STEP-HFpEF program is poised to transform clinical practice, Dr. Verma continued. The magnitude of benefit is large and includes all KCCQ domains. The trial was not designed to evaluate clinical events, but the data show major reductions in time to first HF and/or CV death.

Semaglutide benefits both male and female patients with greater benefits in women. The drug also triggers early improvement in NYHA class. Analysis of both female benefit and NYHA improvements were published simultaneously in the *Journal of the American College of Cardiology*.

Latest from ADA

The NEW ENGLAND JOURNAL of MEDICINE

RESEARCH SUMMARY

Semaglutide in Patients with Heart Failure with Preserved Ejection Fraction and Obesity

Kosiborod MN et al. DOI: 10.1056/NEJMoa2306963

CLINICAL PROBLEM

Patients with heart failure with preserved ejection fraction often have obesity, a condition that is associated with a greater burden of heart failure–related symptoms, worse functional capacity, and more impaired quality of life. Whether therapies that target obesity in such patients can alleviate symptoms and physical limitations is unknown.

CLINICAL TRIAL

Design: A multinational, double-blind, randomized, placebo-controlled trial evaluated whether treatment with semaglutide — a glucagon-like peptide 1 receptor agonist approved for long-term weight management — would reduce heart failure–related symptoms and improve physical function, in addition to inducing weight loss, in adults with heart failure with preserved ejection fraction and obesity.

Intervention: 529 patients with a body-mass index of ≥30 were assigned to receive subcutaneous semaglutide (2.4 mg) or placebo once weekly for 52 weeks. The dual primary end points were the change in the Kansas City Cardiomyopathy Questionnaire clinical summary score (KCCQ-CSS), which quantifies heart failure–related symptoms and physical function, and the change in body weight from baseline to week 52.

RESULTS

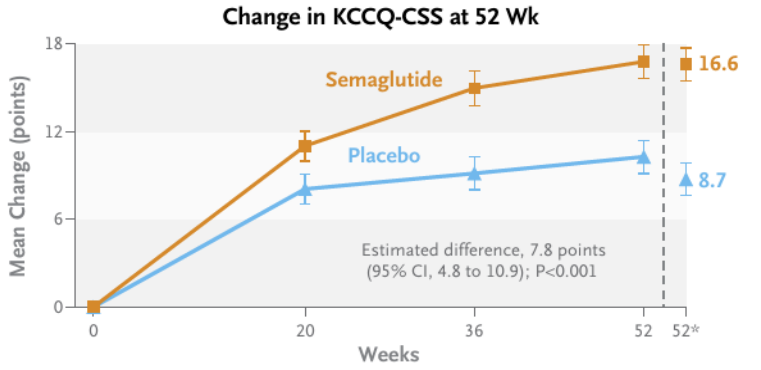
Efficacy: The mean change in KCCQ-CSS and the mean percentage change in body weight were significantly greater with semaglutide than with placebo.

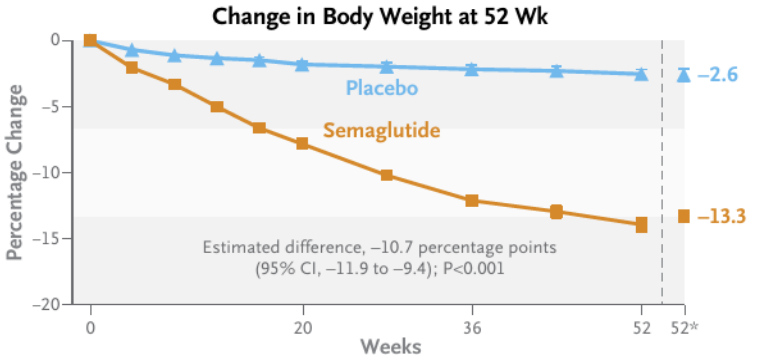
Safety: Serious adverse events occurred less often with semaglutide than with placebo, primarily because fewer cardiac disorders occurred in the semaglutide group. Adverse events leading to treatment discontinuation were more common with semaglutide.

LIMITATIONS AND REMAINING QUESTIONS

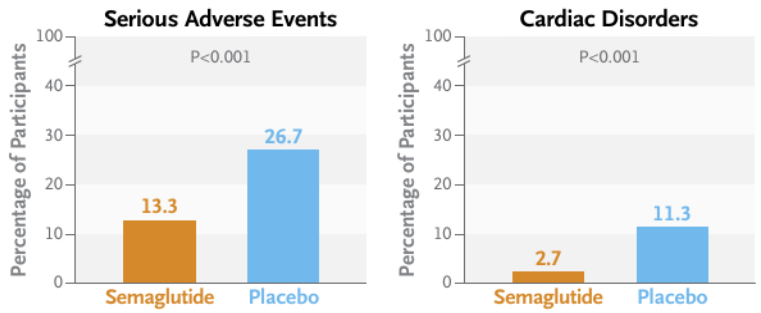
- The number of non-White trial participants was low.
- The trial was not sufficiently powered to evaluate the effects of semaglutide on clinical events, such as hospitalization for heart failure.
- Whether the observed effects of semaglutide would last beyond 1 year is unknown.

Links: Full Article | NEJM Quick Take | Editorial





Week 52 data are based on ANCOVA and imputation of missing data.



CONCLUSIONS

In adults with heart failure with preserved ejection fraction and obesity, once-weekly treatment with semaglutide was associated with greater reductions in heart failure–related symptoms and physical limitations and greater weight loss than placebo over 52 weeks.

Debate: What Should Be Priority in Managing Early Diabetes?

Latest from ADA

Nancy A. Melville July 02, 2024 ORLANDO, Florida

What to prioritize first in managing early diabetes?

That was the question debated on an expert panel at the American Diabetes Association (ADA) 84th Scientific Sessions, with impassioned responses ranging from a plea to "treat obesity first," to a James Carville–inspired counterpoint of "it's the glucose, stupid."

With a focus on preventing complications and inducing remission rounding out the four positions argued, Session Moderator Ravi Retnakaran, MD, of the University of Toronto, in Toronto, Ontario, Canada, noted that the options reflect the tricky choices clinicians treating patients with diabetes are pressed to make on a daily basis.

"In clinical decision-making [for early diabetes], we are faced with weighing each of these variables for the individual patient, and while all are good options, strong arguments can be made for prioritizing each — with the potential of each choice to influence or improve all of the others," Retnakaran told Medscape Medical News.

Which to Prioritize First?

Making the obesity first argument, Ania M. Jastreboff, MD, PhD, an associate professor and director of the Yale Obesity Research Center at Yale School of Medicine, in New Haven, Connecticut, noted the striking statistic that nearly 90% of people with type 2 diabetes have overweight or obesity and discussed the ever-expanding data showing the benefits of drugs including glucagon-like peptide 1 (GLP-1) receptor agonists not just in weight loss but also in kidney, cardiovascular, and, as presented at the meeting, even sleep apnea improvement.

She contrasted the experiences of two patients with obesity: One treated for the obesity upon type 2 diagnosis — who had a quick normalization of lipids and hypertension soon after the obesity treatment — and the other presenting after 10 years with type 2 diabetes — who was on therapy for hypertension and hyperlipidemia but not for obesity and whose diseases were not as easily treated by that point.

"Why are we treating all the downstream effects and we're not treating the disease that is potentially the root cause of all these other diseases?" Jastreboff said.

Complications?

Arguing in favor of focusing on complications, Roopa Mehta, MD, PhD, with the Department of Endocrinology and Metabolism at INCMNSZ, Mexico City, Mexico, made the case that stakes don't get any higher in diabetes than when it comes the looming threat of potentially fatal complications.

Acute myocardial infarction, stroke, amputation, and end-stage renal disease are all on the list of unwanted outcomes and need to be considered even in the earliest stages, as data show early onset type 2 diabetes is linked to life expectancy.

"The main goal of management has always been to prevent complications," she noted. Citing ADA guidelines, Mehta underscored the benefits of first- and second-line therapy of metformin, sodium-glucose cotransporter 2 (SGLT2) inhibitors, and GLP-1 receptor agonists for most patients.

Remission?

Discussing the priority of putting patients into disease remission, Roy Taylor, MD, a professor of medicine and metabolism at Newcastle University and Newcastle Hospitals NHS in Newcastle upon Tyne, England, and author of the book Life Without Diabetes, focused on an evidence-based alternative to achieving remission — a nonpharmacologic approach that avoids costly and sometimes inaccessible drugs.

In the intervention, described in the DiRECT randomized trial and subsequently in the UK National Health Service Type 2 Diabetes Path to Remission Program, patients with overweight or obesity were placed on a highly restrictive diet of just 800-900 calories a day for 12-20 weeks, followed by maintenance for 12 months, and they not only achieved weight loss but also achieved diabetes remission, in some cases long-term.

Acknowledging that "this is not for everyone," Taylor asserted that "we have to realize there is a substantial minority of people who want to be healthy but who don't want to be medicalized," he said.

"They want their health, and they can do extremely well."

Glucose?

In taking his self-titled "it's the glucose, stupid" stand, David M. Nathan, MD, of the Diabetes Center, Massachusetts General Hospital, Harvard Medical School, in Boston, cited extensive evidence showing that early intensive blood glucose control with treatment including sulfonylureas, insulin, or metformin significantly reduced the risk for complications in type 2 diabetes 15 or more years later, including renal failure, blindness, amputation, and myocardial infarctions, in addition to a reduction in diabetes-related death.

"In many of these studies, you saw the benefit even in the setting of weight-gain," Nathan underscored.

He further noted the "sobering" findings of the Look AHEAD study, which had to be stopped due to futility when an intensive lifestyle/weight loss intervention showed no significant benefits in terms of cardiovascular disease in people with type 2 diabetes at a median follow-up of 9.6 years.

Ultimately, "diabetes, type 1 and type 2, remains a glucocentric disease," Nathan asserted.

"Hyperglycemia is the only universal link between all forms of diabetes and mortality, and the long-term complications of diabetes are intimately associated with hyperglycemia."

…….contiued

Latest from ADA

Tackling the Caveats

The ensuing panel discussion did not fail to deliver in delving into key areas of contention, particularly in terms of GLP-1 treatment.

Regarding a lack of data on the potential long-term effects of GLP-1s: "Yes, there are a huge number of studies [on GLP-1 receptor agonists], but they are, in general, over short periods of time and driven by pharma, who get in and get out as quickly as they can and have little in the way of interest to do comparative effectiveness studies," Nathan argued.

"Meanwhile, this is like the crack cocaine of medications — patients have to stay on it for a lifetime or they will regain the weight — are you concerned at all about a lifetime of exposure to GLP-1 [drugs]?" he asked the panel.

Jastreboff responded that the first GLP-1 receptor agonist medications were approved in 2005, nearly 20 years ago, by the US Food and Drug Administration.

"Do I think we need long-term lifetime data? Absolutely," she said. "We need to do our due diligence, we need to be careful, we need to monitor patients, and when and if there are signals, we need to follow them."

What about the notorious gastrointestinal side effects of the drugs? "A majority of them are mitigated by slow uptitration," Jastreboff noted.

"If patients have nausea, I do not go up [in dose]. I invite patients to tell me if they're having vomiting because I don't want anybody to have it, and I can count on one hand how many of my patients do."

Mehta added the concern that as the drugs' popularity soars, "a lot of doctors don't know when they need to put the brakes on [weight coming off too quickly]."

She underscored that "we are not treating obesity for weight loss or for cosmetic reasons — this is about optimizing health."

Jastreboff noted that in her practice, "I downtitrate if they're losing weight too quickly."

"If the patient is losing more than 1% per week of their body weight, then I slow down to make sure they're getting the nutrients that they need, that they have enough energy to exercise, and that they're prioritizing protein and fruits and vegetables in their diet."

"We just need to go slow, and yes, we need to follow them long term," she said.

Chiming in from the audience, Julio Rosenstock, MD, a recognized thought-leader in type 2 diabetes, offered his own take on the issues, describing Taylor's very low–calorie diet suggestion as "not realistic" and Nathan's glucose-first argument to be "stuck in the past."

Based on modern-day evidence, "there is no reason on earth to start [diabetes treatment] with only metformin," asserted Rosenstock, who is director of the Velocity Clinical Research center at Medical City and clinical professor of medicine at the University of Texas Southwestern Medical Center, Dallas.

"We need to start at the very least with metformin and a sodium-glucose cotransporter 2 (SGLT2) inhibitor from day 1, and then, if it's affordable and there is access, with a GLP-1 receptor agonist," he said.

"There is nothing better these days than those agents that consistently have shown a reduction of cardiovascular events and slowing of kidney disease progression."

Overall, however, "I think you are all right," he added, a sentiment shared by most.

Noting that the discussion as a whole represents a virtual sea change from the evidence-based options that would have been discussed only a decade ago, Retnakaran summed up his take-home message: "Stay tuned."

"You could easily see things changing in the next decade to come as we get more data and evidence to support what we ultimately should prioritize an early type 2 diabetes, so this is an exciting time."

Short Updates: Ctrl+Click for details

The inhaled insulin Afrezza combined with a long-acting basal analog offers a non-inferior insulin treatment option for people with type 1 diabetes, new phase 4 data suggest.

Using fixed-ratio insulin combinations (FRC) can reduce side effects such as nausea in treating diabetes

Cannabis users may have a "healthier inflammatory cytokine profile, better insulin sensitivity, and higher levels of physical activity than nonusers," all of which can be linked to a potentially lower risk for diabetes, ongoing research suggested.

Use of continuous glucose monitoring (CGM) and automated insulin delivery (AID) systems doesn't guarantee achievement of A1c targets or avoidance of severe hypoglycemia in people with type 1 diabetes (T1D), new survey data suggested.

Achieving target glucose and lipid levels reduces the risk for diabetic retinopathy (DR) and other adverse health outcomes in people with diabetes, but all are associated with a greater risk of developing age-related macular degeneration (AMD), new research suggested.

The old, generic cholesterol drug fenofibrate has shown potential for slowing the progression of diabetic retinopathy in people with early retinal changes, with the potential to reduce the need for retinal laser or intravitreal injection treatment, new trial data suggest.

Chat of the Month

PCDA Members (We All Friends)
Abdul, AGP, Ameer, Aqeel, Bashir, Dr. Rajoo Jacobabad, Dure, Ganesh, Ghazal Raza Dr., Ghotki Sindh, GSK Aya..

PCDA Syed Ishtiaq Ahmed Fatmi Karachi
Fasting is defined as no calories intake for 8 hours . Please guide me what is the maximum fasting permissible for doing fasting blood sugar
11:57 AM

PCDA Sagheeruddin Turbat
> **PCDA Syed Ishtiaq Ahmed Fatmi Karachi**
> Fasting is defined as no calories intake for 8 hours . Please guide me what is the maximum fasting permissible for doing fasting blood...

Sir, a minimum of 8 to 12 hours more than that time frame is not significant due to gluconeognesis and beta oxidation
12:13 PM

Just to encourage academic posts on PCDA groups

PCDA Nauman Rizwan
> **PCDA Syed Ishtiaq Ahmed Fatmi Karachi**
> Fasting is defined as no calories intake for 8 hours . Please guide me what is the maximum fasting permissible for doing fasting...

Today's recommendation is 10 hrs
1:45 PM

PCDA Kanwal Fayyaz Karachi
> **PCDA Sagheeruddin Turbat**
> Sir, a minimum of 8 to 12 hours more than that time frame is not significant due to gluconeognesis and beta oxidation

8 hrs especially in pregnancy and who can't do fasting easily
1:47 PM

PCDA Syed Ishtiaq Ahmed Fatmi Karachi
> **PCDA Sagheeruddin Turbat**
> Sir, a minimum of 8 to 12 hours more than that time frame is not significant due to gluconeognesis and beta oxidation

What is the maximum fasting allowed for fbs .this is my question
3:05 PM

PCDA Sagheeruddin Turbat
> **PCDA Syed Ishtiaq Ahmed Fatmi Karachi**
> What is the maximum fasting allowed for fbs .this is my question

12 hours
3:06 PM

After 12 hours, the body started gluconeogensis and beta oxidation process to compensate low blood glucose levels and then false result
3:09 PM

Dr. Nazir Soomro reports from Jacobabad Chapter

Free distribution of blood sugar strips to pathology laboratory Civil hospital Jacobabad for free Blood Sugar testing of diabetic patients on 8.7.24

Monthly Online Newsletter of PCDA
(Primary Care Diabetes Association Pakistan)

Prevention First Newsletter-Online

1st. Anniversary Edition
August 2024

پریوینشن فرسٹ نیوز لیٹر آن لائن

کا بارھواں شمارہ (سالگرہ ایڈیشن)

15 اگست 2024 کو شائع ہوگا۔

جس میں محترم قارئین کے تبصرے، آرا اور تجاویز شامل کی جائیں گی۔

اپنی تحریریں (اُردو یا انگریزی) یکم اگست 2024 سے قبل ادارتی بورڈ کے کسی بھی رکن کو بھیجی جاسکتی ہیں

Publications Secretary:
03332391743
Chief Editor:
03218222680

Dr. Shafqat Mirza's advice for the elderly

Kindly take some time to-read and save some where to read it again and again .
A letter from orthopedic doctor to all the elderly (60-100 yers and above…)
I don't advocate determination of bone density anymore, because the elderly will definitely have osteoporosis, and with the increase of age, the degree of osteoporosis will definitely become more and more serious, and the risk of fracture is bound to get bigger.
There is a formula:

The risk of fracture= external damage force/ bone density.

The elderly are prone to fractures because the denominator value (bone density) is getting smaller and smaller, so the risk of fractures will definitely increase.
Therefore, the most important measure for the elderly to prevent fractures is to do everything possible to prevent accidental injuries.

How to reduce accidental injuries?

There are the twelve major characters of the so-called secret that I summed up, which is:
"Be careful, be careful, be careful again"!
Specific measures include:
1. Never stand on a chair or stool to get something, even a low stool.
2. Try not to go out on rainy days.
3. Take special care when bathing or using the toilet, to prevent slipping.
4. The most important, especially for women - don't wear underwear in bathroom, taking support of wall or other things... The commonest cause of slipping and fracture of hip joint... After bath, come back to your changing room.. Sit comfortably on either a chair or on your bed and then put on underwear..
5. While going to toilet, ensure that bathroom floor is dry and not slippery.. Use only commode.. and at the same time, fix a hand rest to hold on to while getting up from the commode seat... same is true while taking a bath sitting on bath stool.
6. Be sure to clean up the clutter on the floor of the house before going to bed, and take double care when floor is wet...
7. When getting up in the middle of the night, sit on the bed for 3-4 minutes before standing up; be sure to turn on the light first, and then get up.
8. At least in night or even during day time (if feasible), please, please do not close toilet door from inside.. If possible, have an alarm bell fitted in toilet, and press it to summon help from family members etc in case of any emergency...
9. Seniors must sit on a chair or a bed to wear pants etc.
10. In the event of a fall, you must stretch out your hands to get support from the ground. It is better to fracture the forearm and wrist than to fracture the femoral neck at the hip joint.
11. I strongly advocate exercise, at least walk, to the extent possible for you..
12. Especially for women.. be very, very serious to keep your weight in permissible limits... Diet control is the most important key... Eating leftovers, common behavior of women... just get away from it... feed leftovers to stray cows... keeping your weight in control is absolutely in your head and your mind, " always better to stop eating with half stomach full, rather than eat till have a satiety for having full stomach.
Regarding increasing bone mass, I also advocate dietary supplements rather than medicinal supplements.
The other is to do outdoor activities properly, because sun exposure (under UV light) converts the cholesterol in the skin into vitamin D.
It is beneficial to promote intestinal absorption of calcium and osteoblast activity has the effect of delaying osteoporosis.
Pay special attention to the non-slip floor of the bathroom. When going up the stairs, use the handrails and don't fall. Everyone, take care.*
Therefore, the elderly must pay attention to anti-skid and anti-fall measures.
One fall will cost ten years of life. Because all the bones and muscles are destroyed. So, be careful.
Avoid standing for too long

Dr. Shehzad Tahir reports from Islamabad

Head of Islamabad chapter of PCDA addressed to a clinical meeting in a restaurant of Islamabad. HCPs from the twin cities attended the meeting and participated in a very academic discussion. The topic of the session was "Benefits of early Insulinization in the management of T_2DM. Speaker Dr. Shehzad Tahir talked about the rationale for early initiation of insulin. He said it is based on evidence demonstrating multifaceted benefits, including overcoming the glucotoxic effects of hyperglycemia, thereby facilitating "β-cell rest," and preserving β-cell mass and function, while also improving insulin sensitivity.

Clinical inertia, noncompliance, and adverse effects often result in prolonged glycemic burden for individuals with T2DM receiving OADs.[8] There is too often a delay in advancing therapy when glycemic control is inadequate, with insulin supplementation being commenced when complications are already evident due to the inability to achieve target glycemic control. However, the timing of introduction and the choice of insulin remain inconsistent owing, in large part, to the heterogeneous nature of T2DM, but also to the unwillingness of the person with diabetes—and often the caregiver—to commence insulin therapy, which presents both a behavioral (lifestyle) and a therapeutic challenge.

Dr. Shehzad in the end thanked the audience and the sponsor of the program.

Prof. Zaman Sheikh organizing talks on radio FM-100

Reported By: **Dr. Riasat Ali Khan (**President Elect PCDA)

PCDA Lifetime Achievement Award winner Prof Zaman Sheikh is organizing one radio program series on Fm100 from the platform of PSIM, sponsored by Scilife. This is a one year program with weekly 30 min sessions for the public.

This program will be in urdu, and will be broadcasted live on Facebook and YouTube simultaneously. This program is planned to conduct weekly every Tuesday from 12.30 to 1.00 pm., started from 9th. July'24. There are 52 topics with 52 speakers.

Primary Care Diabetes Association has in principle extended its full support for this program and assured utmost cooperation to the honorable Prof. Zaman Sheikh and Prof. Jawed Akram; and many speakers are invited from PCDA. This one year series of talks on FM radio is in line with the prime objective of PCDA to spread awareness about diabetes among common people. FM radio channels are the best media to access the majority of the Pakistanis.

First talk delivered by Prof. Javed Akram, Patron of the program on "Overview and Burden of Diabetes.": 9th. July 2024. Following are the reputed speakers from all over Pakistan (in alphabetic order):

1. Prof. Abdul Basit
2. Prof. Aftab Mohsin (Sen. VP)
3. Prof. A. H. Aamir
4. Dr. Aisha Sheikh
5. Prof. Akhter Baloch
6. Dr. Ali Asghar
7. Dr. Asima Khan
8. Prof. Aziz-ur-Rehman (Sen. VP)
9. Prof. Bikha Ram Devrajani
10. Prof. Ejaz Vohra
11. Dr. Faisal Masood Qureshi
12. Miss Faiza Ayub
13. Dr. Farah Naz Farooq
14. Dr. Fareed-ud-din
15. Dr. Faryal Tariq
16. Dr. Ibrar Ahmed
17. Dr. Imtiaz Hassan
18. Prof. Irshad Ahmed khoso
19. Prof. Jaida Manzoor
20. Dr. Jamal Zafar
21. Prof. Jameel Ahmed
22. Prof. Kareem Kammeruddin
23. Prof. Khadija Irfan Khawaja
24. Prof. Khalid Usman
25. Prof. Masroor Ahmed
26. Prof. M. Zaman Shaikh
27. Prof. Munir Azhar Chaudary
28. Dr. Nabeel Chaudary
29. Dr. Najum F. Mehmudi
30. Prof. Najmul Islam
31. Dr. Osama Ishtiaq
32. Prof. Qamar Masood
33. Dr. Riasat Ali Khan
34. Prof. Saeed A. Mahar
35. Prof. Sajid Abaidullah
36. Prof. Sajid Abbas Jafari
37. Prof. Shabeen Naz Masood
38. Prof. Shabnam Naveed Korejo
39. Dr. Shafat Khatoon
40. Dr. Shahid Akhter
41. Dr. Shakeel Ahmed
42. Dr. Shehla Akram
43. Dr. shehla Naseem
44. Dr. Sobia Sabir
45. Dr. Somia Iqtadar (Gen. Sec)
46. Dr. Syed Abbas Raza
47. Prof. Tariq Waseem (Sen VP)
48. Dr. Urooj Lal Rehman
48. Dr. V. M. Lohano
50. Prof. Yaqoob Ahmadani
51. Dr. Zahid Miyan
52. Dr. Zeeshan Ali Junejo

The topics will soon be allotted to worthy speakers.

Dr. Pawan Kumar (Joint Secreatary PCDA) reports

FDA Approves Faricimab PFS (Vabysmo) for Leading Causes of Vision Loss

Patients with age-related macular degeneration, diabetic macular edema, and macular edema following retinal vein occlusion can use Vabysmo (Faricimab-svoa) as a prefilled syringe (PFS).

The drug was previously available in vial for doctors to use and will continue to be made available in both formats. Faricimab is the first and only bispecific antibody that can be used for the treatment of the eye. Retinal drying in wet AMD, DME, and RVO as well as quick improvements in vision have been shown to occur in patients using this medication.

Faricimab has previously demonstrated the ability to target and inhibit 2 different signaling pathways that are linked to vision-threatening retinal conditions. This includes angiopoietin-2 and vascular endothelial growth factor-A, both of which are thought to destabilize blood vessels, which leads to vision loss due to the new leaky blood vessels that form and the inflammation that increases in the process. Faricimab is aimed at stabilizing blood vessels in the eyes.

Faricimab was first approved by the FDA in its vial form in 2022.[2] The 2022 approval was based on the TENAYA and LUCERNE studies that were identical, randomized, multicenter, double-masked phase 3 studies that compared faricimab with aflibercept in 1329 patients who lived with wet AMD. Faricimab was able to meet the primary end point of average change in best-corrected visual acuity (BCVA). The studies both found that faricimab given every 4 months consistently improved BCVA at a rate that was not inferior to aflibercept given every 2 months. The BCVA gains were +5.8 and +6.6 letters for faricimab compared with +5.1 and +6.6 letters in the aflibercept arms in each respective study.

Regarding safety, the most common adverse events included cataract (15%) adverse reactions and conjunctival hemorrhage (8%), though these were not the only possible adverse events reported. Faricimab can cause endophthalmitis or separation of layers of the retina. A temporary increase in pressure in the eye is possible about 60 minutes after the injection. Serious problems related to blood clots, such as a heart attack, have been reported, but they were not common, occurring in 7 of 664 patients with wet AMD, 64 of 1262 patients with DME, and 7 of 641 patients with RVO treated with faricimab. Health care providers should discontinue use of the treatment if their patients develop retinal vasculitis or RVO.

While many retina specialists are already using Vabysmo as a first-line treatment, this new offering should make it even simpler to administer, thereby enhancing the treatment experience for both physicians and patients.

Vabysmo is administered by intravitreal injection. Warnings and precautions associated with Vabysmo include endophthalmitis and retinal detachments, increases in intraocular pressure, and potential risk of arterial thromboembolic events.

Common adverse reactions include cataract and conjunctival hemorrhage.

Dr. M. Irfan Sheikh from Multan Chapter

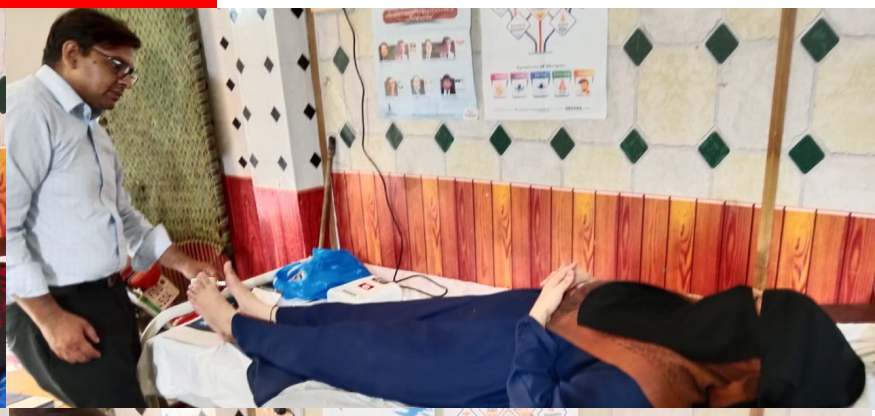
No Text Report sent

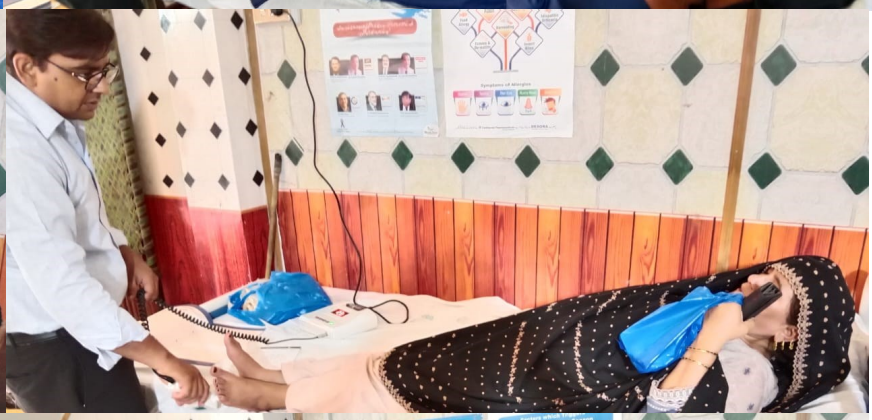
Dr. Sohail Shaukat from Sahiwal Chapter

No Text Report sent

Dr.Imranullah from Tandianwala Chapter

No Text Report sent





Prevention First Newsletter-Online

Dear Readers;

Prevention First Newsletter is the official newsletter issued by the Publications Committee of PCDA (Primary Care Diabetes Association Pakistan). The paper version is printed on the occasion of every mega event by PCDA Pakistan.

Prevention First Newsletter has limited circulation, to be circulated among members only.

PFN-Online is the online version of Prevention First Newsletter, which is published to the social media groups of PCDA Pakistan on the 15th. day of every month.

PFN-Online publishes the reports and photographs of the activities of PCDA and its chapters across the country.

Reports of only those events are included in PFN-Online which are managed under the platform of PCDA. Better choose and send the pictures with name or logo of PCDA.

The Publications Committee and the Editorial Board of Prevention First Newsletter, have right to accept or reject any material sent for publication.

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