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Managing Diabetes During Hajj

A Dietitian's Practical Guide

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Navigating Diabetes and Foot Care during Hajj

Dr Shakeel Ahmed

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The pilgrimage of Hajj represents one of the largest mass gatherings in the world, bringing together millions of Muslims in Makkah, Saudi Arabia. While spiritually rewarding, Hajj poses significant physical and environmental challenges, especially for individuals living with Diabetes Mellitus. Proper diabetes care during Hajj is therefore essential to ensure a safe and healthy pilgrimage experi-

Hajj rituals involve prolonged walking, exposure to extreme heat, overcrowding, and disruption of daily routines. Pilgrims may walk several kilometres daily and stay in tents under temperatures that can exceed 45°C. These conditions can significantly affect blood glucose control, making individuals with diabetes more vulnerable to complications. Additionally, the change in diet, irregular meal timings, and increased physical activity can further destabilize glycaemic levels. A study suggested the scope of foot problem is given below.

This observational study conducted during the Hajj 2013 in Makkah assessed foot injuries among 197 pilgrims (31% diabetics) who sought care at mobile clinics in Mina, revealing that both diabetic and non-diabetic individuals are at high risk of foot trauma and subsequent infection due to prolonged barefoot walking on hot surfaces and extensive physical activity; the most common injuries were blisters (34%) and erythema (25%), while callosities were significantly more frequent in diabetics, highlighting their increased vulnerability, and the study emphasizes preventive strategies such as properly fitting

protective footwear, adherence to diet and medications, and targeted education on foot hygiene before and during Hajj to reduce complications and improve foot care outcomes.

Foot problems are common among Umrah pilgrims, affecting about 46% of participants, mainly as sprains, strains, and muscle pain due to prolonged walking and crowded conditions. Despite this high prevalence, very few pilgrims seek medical care or use preventive measures. Factors like lower education and chronic diseases increase the risk. The study emphasizes the need for better awareness, preventive practices, and early medical attention to improve pilgrims' safety and experience.

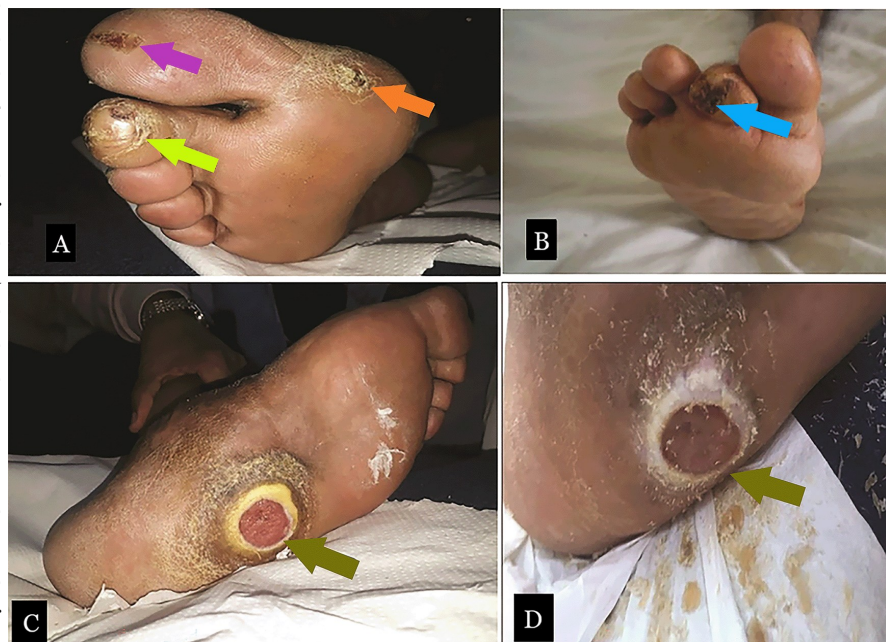
Several acute complications may arise during Hajj. Hyperglycaemia can occur due to missed medications, infections, or dehydration, potentially leading to serious conditions such as diabetic ketoacidosis or hyperosmolar

hyperglycaemic state. On the other hand, hypoglycaemia is also common due to increased physical exertion and delayed meals. This dual risk makes careful monitoring of blood glucose levels essential throughout the pilgrimage.

Forty-three diabetic patients planning to perform pilgrimage were included in the study. Post-pilgrimage clinical exams revealed hyperkeratosis (96.8%) and superficial fungal infections

(61.3%) as the most common podiatric lesions. Foot ulcers attributed to trauma from walking were found in 7% of patients.

Our data showed a significant association between foot ulcer risk and lower total cholesterol ($p=0.02$), HDL cholesterol ($p=0.02$), LDL cholesterol ($p=0.01$), as well as higher triglyceride levels ($p=0.04$) only in univariate analysis. Other diabetes-related risk factors did not show significant correlations.

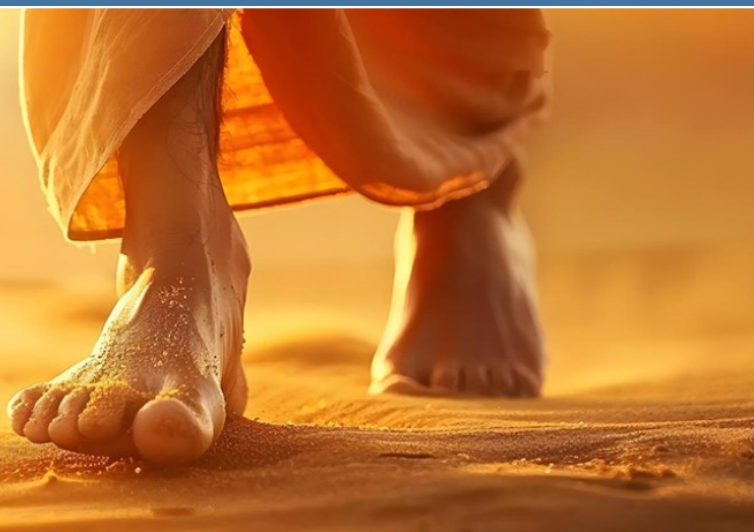


Podiatric lesions in three diabetic patients during the Hajj pilgrimage. Patient 1 (A) presented an ulceration in the big toe (purple arrow), second toe (green arrow), and next to the first metatarsal (orange arrow). Patient 2 (B) had dry gangrene in the second toe. Foot ulcer before (C) and after (D) debridement in patient 3.



Diabetic Foot Care for Pilgrims

Walking Barefoot on the Path of Devotion



The Hajj pilgrimage is one of the five pillars of Islam. Every practicing Muslim is bound by faith to do it at least once in his life if he is physically and financially capable. During the journey to Mecca for Hajj, pilgrims perform a series of religious rituals, including barefoot circuits around the holy mosque - Tawaf - and walk between two hills, Safa and Marwah, for long hours. They are also required to spend five days in tents in the Mina Valley where sanitation is very basic, in a hot climate, where the average temperatures can reach 45 °C in the summer.

The global prevalence of diabetes mellitus is estimated at 10.5% and this prevalence increases with age. Given that approximately 2 million Muslims perform the pilgrimage each year, many of them are aged 60 and above, it was projected that the number of pilgrims with diabetes could surpass 340,000 annually.

Diabetes mellitus is characterized by various complications, including retinopathy, neuropathy, nephropathy, and an increased risk of cardiovascular diseases. Diabetes complications affecting the lower limbs are common, complex, and costly. People with diabetes are exposed to a range of complications during the pilgrimage, with diabetic foot reported once to be one of the most common causes of admissions in two pilgrimage site hospitals. However, few studies have studied the podiatry risk in pilgrims with diabetes. Foot-related problems are another major concern for diabetic pilgrims. Long-distance walking, inappropriate footwear, and hot ground surfaces increase the risk of blisters, burns, and infections. Individuals with diabetic neuropathy or peripheral vascular disease are particularly at risk, as they may not feel minor injuries that can later progress into severe complications. Proper foot care, including wearing

comfortable shoes and avoiding barefoot walking, is crucial.

Environmental factors during Hajj also contribute to health risks. High temperatures can lead to dehydration, electrolyte imbalance, and heat stroke, especially in patients with diabetic nephropathy. Moreover, infections such as respiratory illnesses and gastrointestinal disturbances are common due to overcrowding and can worsen glycaemic control. Language barriers and limited access to healthcare facilities may further delay timely medical intervention. Pre-Hajj preparation plays a vital role in minimizing risks. Pilgrims with diabetes should consult healthcare professionals well in advance to assess their fitness for travel and develop an individualized management plan. This includes reviewing medications, adjusting insulin doses, and ensuring optimal control of blood glucose, blood pressure, and renal function. Carrying sufficient medical supplies, in-

cluding insulin, glucose monitoring devices, and an emergency kit, is essential.

Education is another key component of diabetes management during Hajj. Patients should be aware of "sick day rules," recognize symptoms of hypo- and hyperglycaemia, and know when to seek medical help. They should also carry identification indicating their diabetic status and inform group leaders about their condition. Proper storage of insulin, especially in hot climates, is equally important to maintain its effectiveness.

In conclusion, Hajj presents unique challenges for individuals with diabetes due to physical exertion, environmental stress, and disruption of routine. However, with proper planning, education, and medical support, these risks can be effectively managed. Healthcare professionals play a crucial role in pre-Hajj counselling and ongoing support, enabling diabetic pilgrims to perform their religious duties safely while maintaining optimal health.

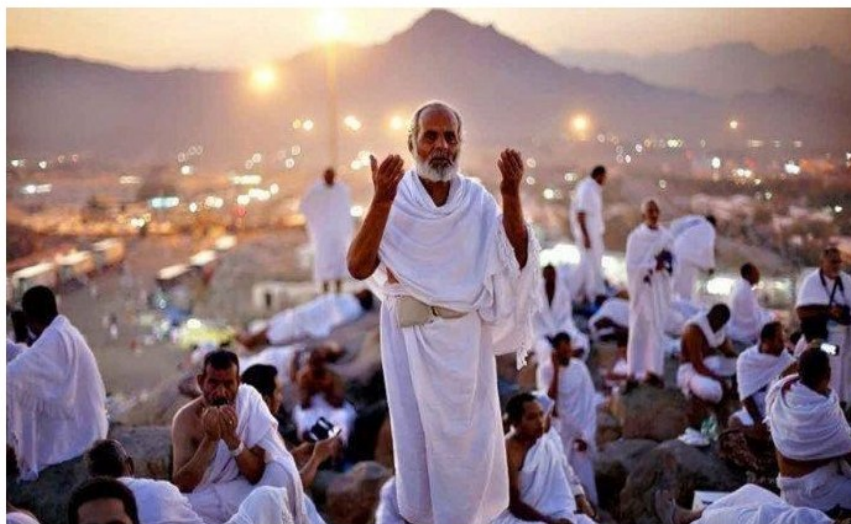


Diabetes And Hajj

Courtesy of:
**Ministry Of
Health
Kingdom of
Saudi Arabia**

Before you travel to perform Hajj:

1. Visit a physician to discuss with the diabetic patient about his ability to perform Hajj, as well as about continuing taking medication during the Hajj period. It is possible to reduce doses for the presence of high effort such as long walks.
2. Take care to carry a detailed medical report on the health condition, it is allowed to bring syringes (if any) in case of travel by plane.
3. Make sure to put a bracelet around the wrist or carry an identification card stating that the person has diabetes and treatment type, so that the necessary assistance can be provided when needed.
4. Bring a sufficient amount of medications and syringes, make sure to take the necessary vaccinations before traveling.
5. Make sure to take a glucometer to measure the rate of blood glucose daily and regularly, especially when you feel the blood glucose level imbalance.
6. Accompanying a companion familiar with the patient's condition.
7. Carry a candy bar or juice and snacks to use in case of flight delays and emergencies.
8. If there is an insulin pump and travel by plane, sufficient information should be obtained about the possibility of its use.
9. **Traveling Bag Contents:**
It is advisable to allocate a bag dedicated to diabetes equipment, as it includes:
Medical report.
10. Identification card for the person and his illness.
11. Adequate amount of insulin and medications.
12. Glucagon injection syringe (Glucagon Emergency Kit).
13. Glucometer and its accessories.
14. Umbrella.
15. Sweets or juice and a snack.
16. Notebook and pen to write down any notes or changes for doctor's review after return.



Health guidelines for people with diabetes during Hajj:

Make sure to inform the nearby person at the place of residence and the campaign doctor of having diabetes, as well as informing the companions of ways to treat high and low blood glucose level.



- Ensure that the diet is followed according to the professional's instructions.
- Ensure that insulin is cooled during transportation and storage, by placing it in a suitable case or refrigerator at the place of residence.
- Carry candy or juice in case of Low blood glucose level.
- Take care to carry the glucagon syringe (after the doctor's recommendation) to be used in case of low blood glucose level. During the Hajj, be sure to wear comfortable socks to protect the feet from any sores, avoid walking barefoot.



- It is advisable not to perform Tawaf and Sa'i until after taking adequate treatment and food, to prevent a low blood glucose level in the body.
- Make sure to drink water in appropriate quantities and frequently.
- Avoid overcrowding and sun's heat as much as possible.
- Temporary cessation of the continuation of performing the rituals in case of symptoms of Low blood glucose level.
- Use your own electrical shaving machine rather than the razor to avoid wounds and inflammation as much as possible.
- Maintain basic and light meals during travel and perform pilgrimage "Hajj" to reduce exposure to very low blood glucose levels.
- Be sure to take some disinfectants to treat skin inflammations when it occurs.

- If there are complications (e.g., skin infections and ulcers) consult a doctor.
- Carefully trim nails.
- Drying the feet well, especially between the fingers, using a cotton towel after ablution.
- Be sure to check your feet thoroughly twice a day and moisturize the feet thoroughly to avoid ulcers and cracks in the foot.
- See the nearest health center or hospital when needed.
- Washing hands with soap and water (unscented) frequently, especially before eating and after using the bathroom
- Use hand sanitizers (unscented) in crowded places.
- Do not touch your eyes with your hands, especially when in crowded places.
- Eat well-cooked food in places that are as clean as possible.
- Take care of the etiquette of coughing and sneezing using elbows or wipes and get rid of them.
- Wear a mask especially in crowded places.
- **After returning from Hajj:**
See your doctor to rearrange your insulin doses and medications if needed and discuss any changes or complications during Hajj.
- Not to neglect the following cases:
- Any health problem (such as: High fever, flu).
- Sensation of any complications.



Various rituals during Hajj



Diabetes Care During Hajj

Diabetes mellitus affects over 463 million individuals worldwide. Religious activities such as the Hajj pilgrimage have a major impact on patients with diabetes mellitus, including increasing the risk of hyperglycaemia and hypoglycaemia. This increased risk is due to dietary changes and intense physical activity during pilgrimage while being on antidiabetic medications. Approximately 20% of the pilgrims with underlying illnesses who visit Mecca are diabetic, and complications, such as diabetic ketoacidosis, nonketotic hyperosmolar state, and fatigue/unconsciousness due to hypoglycaemia, have been observed among these patients. Diabetic patients are also at a high risk for foot complications and infections. To avoid any aggra-

vation of the diabetes, a complete biochemical evaluation of the patient must be conducted before Hajj, and the patients must be provided contextualized educational guidance to avert these potential health challenges. This counselling should include the importance of carrying with them at all time their relevant medical history, summaries of the current treatment regimen and emergency snacks. In addition, to reduce the risk of hypoglycaemia, the dosage of insulin should be reduced in selected patients by 20% and that of sulfonylurea should be reduced as needed. Basal insulin and glucagon-like peptide 1 receptor agonists are associated with fewer complications and can be preferentially

The Hajj pilgrimage poses certain challenges to those persons living with diabetes.

A comprehensive pre-pilgrimage medical checkup in combination with focussed health education is necessary to ensure a safe pilgrimage.

Appropriate attention must be paid to diet, glucose monitoring, dose titration, maintenance of fluid balance and foot hygiene.

Understanding these aspects of diabetes care will help ensure a fulfilling pilgrimage for the believers who undertake the Hajj.

prescribed. Those patients with type 1 diabetes can continue with the use of insulin pump with suitable education prior to Hajj. For the prevention of foot problems, the use of padded socks and well-fitting shoes is recommended along with an insistence on not walking barefoot. After Hajj, the patient must be followed up, and necessary investigations must be made along with readjustment of insulin dosage in those patients for whom it was reduced. Until the pandemic situation abates, all diabetic patients should avoid making the Hajj journey.

Risk stratification table for persons with diabetes wishing to go on Hajj

Parameter	Low risk	Moderate	High risk	Very high risk
Glycaemia related	<7.0 Good control; No h/o hypoglycaemia	7.0-8.5 Fair control; No h/o severe hypoglycaemia	>8.5 Poor control; h/o recent episodes of severe hypoglycaemia, DKA	Recurrent hypoglycaemic episodes along with hypoglycaemic unawareness
Therapy related	Sensitizers, DPP4 inhibitors, GLP1RA	Modern sulfonylureas, SGLT2i, Basal, premixed, co-formulation insulin analogues	Glibenclamide, Premixed human insulin, basal bolus insulin	Premixed human insulin, basal bolus insulin
Diabetes complication related	No acute or chronic complication, no risk factors for acute complication	Foot ulcer in remote past, Chronic microvascular or macrovascular complication but under control	Recent/active episode of foot ulcer, Recent/acute exacerbation of chronic complication; severe sensory neuropathy, Foot ulcer in remote past	chronic kidney disease requiring dialysis, Acute myocardial infarction or stroke within last 6 months or presence of advanced macrovascular and microvascular complications, Patients with heart failure or unstable angina, Patients with peripheral vascular disease and recurrent foot ulcers
ADL	Optimal	Near optimal	Impaired	Severely impaired
Self-care capacity	Good self-care; good social support	Good social support during Hajj	Poor self-care/ social support during Hajj	Poor self-care/ social support during Hajj
Recommendation for Hajj	May perform	Can Perform	Postpone until medical state improves	Not recommended

Preparing for Hajj

Checklist of items to be carried:

Blood glucose monitoring device, band aids and extra batteries for the glucometer along with sufficient quantity of all medications.

If on insulin, sufficient amount of insulin stored in a pouch with cooling pad in it.

Thermally insulated flask for storing insulin in a cool and dry environment or 'cool wallets'

Diabetes identification and a copy of the treatment regimen and medical record, which needs to be carried on the person at all times

Sugary foods and beverages

Masks, umbrella, good-fitting shoes, cotton socks and non-scented hand sanitizer.

Hajj Pilgrimage

Pre-Hajj

Parameter	Low risk	Moderate	High risk	Very high risk
Glycemia related	<7.0 Good control; No h/o hypoglycaemia	7.0-8.5 Fair control; No h/o severe hypoglycaemia	>8.5 Poor control; h/o recent episodes of severe hypoglycaemia, Diabetic Ketoacidosis (DKA)	Recurrent hypoglycaemic episodes along with hypoglycaemic unawareness
Therapy related	Sensitizers, Dipeptidyl-peptidase 4 (DPP4) inhibitors GLP-1 Receptor Agonists (GLP1RA)	Modern sulfonylureas, Sodium-glucose Cotransporter 2 Inhibitors (SGLT2i) Basal, premixed, co-formulation insulin analogues	Glibenclamide Premixed human insulin, basal bolus insulin	Premixed human insulin, basal bolus insulin
Diabetes complication related	No acute or chronic complication, no risk factors for acute complication	Foot ulcer in remote past. Chronic microvascular or macrovascular complication but under control	Recent/active episode of foot ulcer Recent/acute exacerbation of chronic complication; severe sensory neuropathy Foot ulcer in remote past	Chronic kidney disease requiring dialysis Acute myocardial infarction or stroke within last 6 months or advanced macrovascular and microvascular complications Heart failure or unstable angina Peripheral vascular disease and recurrent foot ulcers
Activities Daily Living	Optimal	Near optimal	Impaired	Severely impaired
Self - care capacity	Good self-care; good social support	Good social support during Hajj	Poor self - care/ social support during Hajj	Poor self - care/ social support during Hajj
Recommendation	May perform	Can Perform	Postpone until medical state improves	Not recommended

During Hajj

Patient Profile	Adjustments needed
Type 1 diabetics	Combination of basal and rapid-acting insulin analogues 20% dosage reduction of short and intermediate-acting insulin Continuation of Insulin Pump therapy Once daily premixed dosage of 0.1-0.2 U/kg/day can be split into a pre-breakfast and pre-dinner dose Frequent monitoring of blood glucose levels
Type 2 diabetics	Metformin if GFR is above 30mls/min/1.73m ² Can be combined with SGLT2 to reduce the risk of hypoglycemia
Foot problems	Use of padded socks, shoes and prophylactic antibiotics Use of motored vehicles/ wheelchairs for travelling long distances
Kidney disorders	Dose reduction of diuretics, especially thiazide diuretics to prevent the risk of hyperglycemia
Cardiovascular conditions	Regular glucose monitoring to prevent hypoglycemia

Pre - Hajj education

- Insulin use and dosage
- Self-monitoring and administration
- Insulin storage and injection techniques
- Use of insulin pumps in a hygienic environment
- Nutrition counseling
- Prevention of hypoglycemia through the intake of carbohydrates when symptoms are faced
- Infection prevention through hygiene maintenance and distancing

Post Hajj

Follow-up considerations

- Complete biochemical investigation and foot examination
- Dose adjustment of the patient at 10 to 14 days post-arrival to comply with reduced activity levels and optimal environments
- Treatment of diagnosed ulcers/ infections along with rest and hydration

Dietary Considerations During Hajj

Regular meals must be encouraged in patients as well as between-meal snacks. In case of irregular meals, patients can be advised to consume nuts, fruits and dairy products, which are readily available at Mecca. They must be instructed to avoid sugary drinks unless responding to hypoglycaemia.

Eating one to two dates, which are easily available at pilgrim locations, or a high carbohydrate drink/ meal is recommended in response to symptoms of hypoglycaemia or in situations where a meal is skipped or delayed. Before Tawaf and Sai, it is advisable to consume complex carbohydrates and dates, if required, because they can be

carried inside the mosque. Tight glycaemic control must not be attempted during Hajj journey because hyperglycaemia has less severe consequences than hypoglycaemia during Hajj, with the latter having the potential to be fatal. (Full article can be viewed by clicking the link.
https://adisjournals.figshare.com/articles/figure/Diabetes_Care_During_Hajj/13050551)



Managing Diabetes During Hajj: A Dietitian's Perspective

Rabbiya Tirmizi

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For many of us, Hajj is a once-in-a-lifetime journey, one that we wait for with deep emotion and spiritual longing. But alongside that spiritual preparation, there's also a physical reality that we often underestimate, especially for people with diabetes.

The intense heat, long walking distances, and irregular meal timings can disrupt blood glucose levels. According to the International Diabetes Federation (IDF) and the American Diabetes Association (ADA), proper planning, balanced nutrition, and regular self-monitoring are essential to ensure a safe and healthy pilgrimage.

Regular blood glucose monitoring plays a crucial role during Hajj. Checking sugar levels before and after meals, and around physically demanding rituals like Tawaf and Sa'i, helps detect fluctuations early. Both low and high blood sugar levels can be dangerous. Hypoglycemia (below 70 mg/dL) may cause sweating, dizziness, and weakness, and should be treated immediately with fast-acting glucose such as dates or juice, followed by re-checking after 15 minutes. On the other hand, hyperglycemia (above 130 mg/dL fasting or 180 mg/dL after meals) can lead to dehydration and fatigue, especially in hot weather, and requires hydration, medication adherence, and medical attention if severe.

Dietary control remains central to diabetes management. Foods commonly consumed during Hajj, such as white rice and refined flour products, can raise blood sugar quickly and should be taken in moderation. Balanced meals that include whole grains, protein, and fiber

Challenges During Hajj

- Long walking distances
- Irregular meals
- Heat & dehydration
- Risk of hypo/hyperglycemia

Dietary Guidelines

Balanced Meals: Whole grains, lean protein, healthy fats
Smart Carbs: Prefer low GI foods, avoid sugary drinks
Hydration: Drink water frequently
Snacks: Nuts, roasted chickpeas, fruits

Warning Signs

Hypoglycemia: Sweating, dizziness, confusion
Hyperglycemia: Thirst, fatigue, blurred vision

Practical Tips

- Do not skip meals
- Monitor glucose regularly
- Carry medicines & snacks
- Wear comfortable footwear

Key Message for Practitioners

Pre-travel counseling and individualized diet planning are essential for safe Hajj in people with diabetes.

along with fresh salads help maintain stable glucose levels. Fried and heavy foods should be avoided in favor of lighter options like fruits, lentils, and grilled items. Maintaining a simple meal pattern with regular snacks can prevent sudden drops in blood sugar.

Hydration is equally important. Drinking 2.5 to 3 liters of water daily helps

prevent dehydration, which can worsen blood sugar control. Sugary drinks should be avoided, and caffeinated beverages limited.

Foot care and emergency preparedness are also essential. Pilgrims should wear comfortable footwear, inspect their feet daily, and carry a diabetes kit with a glucometer, medications, and quick sources of sugar

such as dates or juice, along with an identification card stating, "I have diabetes."

In conclusion, with proper preparation, mindful eating, regular monitoring, and adequate hydration, individuals with diabetes can safely perform Hajj.

Prevention, awareness, and preparedness are the keys to a safe and fulfilling jour-



**BY: Rabbiya Tirmizi, Dietitian CDE,
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Managing Diabetes During Hajj

A Dietitian's Practical Guide



Hajj is a deeply spiritual journey, but it is also physically demanding. Long walking hours, extreme heat, irregular meals, and fatigue can affect blood sugar levels. If you are living with diabetes, preparation, awareness, and balance are essential for a safe and fulfilling experience.

Monitor Your Blood Sugar

- Before & after meals
 - Before Tawaf/Sā'i
 - After long walks

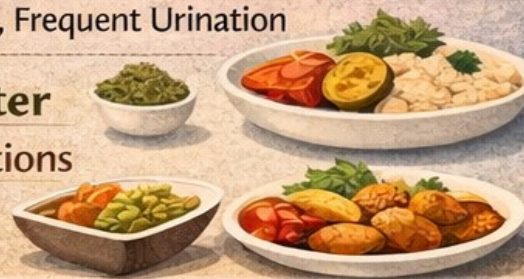


High Sugar (Hyperglycemia) in mg/dl

- Above 130 fasting | 180 after meals | 250 + Risky
- SYMPTOMS:**
- Thirst, Fatigue, Frequent Urination

Drink Water

- Take medications
- Seek Help



Low Sugar (Hypoglycemia)

Below 70 mg/dL (Severe <54 mg/dL)

SYMPTOMS:

- Sweating, Shaking, Dizziness, Weakness

- ✓ Take 3 dates or ½ cup juice
- ✓ Rest & Recheck after 15 minutes



Eat Smart, Stay Balanced

- Limit white rice & naan
- Always combine with protein (dal, chicken, fish)
- Add salad (fiber helps control sugar)
- Avoid Fried & heavy foods



Simple Daily Eating Pattern

- Breakfast: Oats/Roti + Egg/Yogurt
- Lunch: Roti/Rice + Protein + Salad
- Dinner: Light Meal (Dal, Vegetables)
- Snacks: Fruit, Nuts, Chana
- Bedtime: Milk or Light Snack



Stay Hydrated

- Drink 2.5-3 Liters of water daily
- Limit Tea/Coffee • No Sugary Drinks



Always Carry Your Diabetes Kit

- Glucometer • Medicines • Insulin
- Dates / Juice • Water
- ID Card: "I have diabetes"



Final Message:

Your health is part of your worship.

With preparation, balanced diet, hydration, and regular monitoring, you can perform Hajj safely.





Saving Limbs Starts in Primary Care: Don't Miss the Infected Diabetic Foot

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Abstract:

Diabetic foot infections (DFIs) are a leading cause of preventable amputations in Pakistan, where delayed presentation and limited resources remain common challenges. Early recognition and timely intervention in primary care can significantly reduce morbidity and healthcare burden. This article provides a concise, guideline-aligned approach for primary care physicians, focusing on early diagnosis, severity classification, rational antibiotic use, and timely referral. Emphasis is placed on antimicrobial stewardship and practical prevention strategies relevant to everyday clinical practice.

Introduction

Diabetes prevalence in Pakistan continues to rise, with foot complications representing a major cause of disability and healthcare utilization. Most amputations are preceded by a preventable sequence: minor trauma → ulcer → infection → delayed treatment.¹ Diabetic foot infections are among the leading causes of non-traumatic lower limb amputations worldwide.

Primary care physicians are at the front line of this trajectory.

Early identification and structured management of diabetic foot infections can interrupt disease progression and significantly reduce limb loss.

Examination reveals:

- 2 cm plantar ulcer
- Mild surrounding erythema (~1 cm) and warmth
- Minimal discharge
- No pain (due to neuropathy)
- No systemic features

This is consistent with a mild diabetic foot infection.²

Initial Management:

- Clean and dress the wound

- Offload pressure
- Initiate oral antibiotics
- Optimize glycemic control, as hyperglycemia impairs immune function and delays wound healing
- Arrange review within 48–72 hours

Early intervention at this stage can be limb-saving.

Recognizing Infection

Diabetic foot infections are clinical diagnoses.²

Infection should be suspected when ≥ 2 of the following are present:

- Erythema
- Warmth
- Swelling
- Tenderness (may be absent)
- Purulent discharge

Clinical Pearls:

- Pain is often absent due to neuropathy
- Fever is an unreliable early sign
- Even small ulcers may harbor deep infection.

Clinical Scenario

A 58-year-old man with poorly controlled type 2 diabetes presents with a 10-day history of a small wound on the sole of his foot.

Severity Classification

Severity	Features	Management
Mild	Local infection ≤ 2 cm	Outpatient care
Moderate	>2 cm or deeper tissue involvement	Refer or co-manage
Severe	Systemic toxicity	Urgent hospital care



Management decisions, including antibiotic choice and need for referral, should be guided primarily by infection severity.

Initial Management in Primary Care

Clinical Assessment:

- Ulcer size, depth, and location
- Peripheral pulses and perfusion
- Neuropathy assessment
- Probe-to-bone test (if trained)

A positive probe-to-bone test strongly suggests osteomyelitis and warrants referral.²

Suspected osteomyelitis requires specialist evaluation; prolonged empirical antibiotic therapy without confirmation should be avoided.

The presence of ischemia significantly impairs antibiotic delivery and wound healing; vascular assessment and early referral are essential in such cases.

Investigations (if available):

- Blood glucose / HbA1c
- CBC ± CRP
- Plain X-ray if bone involvement suspected

Superficial wound swabs should be avoided, as they often reflect colonizing organisms rather than true pathogens.

Wound Care:

- Irrigate with normal saline
- Debride necrotic tissue (if trained)
- Apply clean dressing
- Offload pressure

Antibiotic Therapy

When to Treat:

- ✓ Only when clinical infection is present
- ∅ Do NOT treat uninfected ulcers

Not all diabetic foot ulcers are infected; antibiotics should never be initiated based on ulcer presence alone without clinical signs of infection.

Uninfected ulcers must not be treated with antibiotics, as this promotes antimicrobial resistance without clinical benefit.³

MRSA risk should be considered in patients with prior MRSA infection, recent hospitalization, recent antibiotic use, or recurrent infections. Routine empiric coverage for *Pseudomonas aeruginosa* is not recommended unless specific risk factors are present.

Empiric Antibiotic Recommendations (Primary Care):

Clinical Scenario	Recommended Antibiotics
Mild (no MRSA risk)	Amoxicillin-clavulanate OR Cephalexin
Mild (MRSA risk)	Doxycycline OR TMP-SMX
Moderate infection	Broader coverage (gram-negative ± anaerobes); refer/co-manage
Severe infection	Urgent hospital referral (IV therapy required)

Whenever possible, antibiotic therapy should be adjusted based on culture and sensitivity results to enable targeted therapy and reduce unnecessary broad-spectrum antibiotic use.

Quick Primary Care Approach

Suspect infection → ≥2 clinical signs → classify severity → mild: oral antibiotics + wound care → review in 48–72 hours → no improvement or red flags: refer.

When to Refer (Red Flags)

- Suspected osteomyelitis
- Moderate or severe infection
- Systemic features (fever, sepsis)
- Ischemia or absent pulses

- Failure to improve within 48–72 hours
- Extensive tissue involvement or necrosis
- Severe pain out of proportion to clinical findings (possible deep or necrotizing infection)

Common Pitfalls

- Treating uninfected ulcers with antibiotics
- Overuse of broad-spectrum agents
- Relying on superficial wound swabs
- Missing ischemia
- Failure to arrange timely follow-up

Prevention

Preventive care remains the most effective strategy.

- Patient Education:
- Daily foot inspection
- Proper hygiene
- Avoid barefoot walk-

- ing Early reporting of wounds
- Primary Care Role:
- Routine foot examination
- Glycemic optimization
- Footwear counseling

Conclusion

Most diabetic amputations are preventable. The critical window for intervention lies in early recognition and appropriate management in primary care. A structured approach—clinical diagnosis, rational antibiotic use, close follow-up, and timely referral—can significantly reduce limb loss.² Saving limbs starts with vigilant primary care.

Key Practice Points

- Examine feet routinely in all diabetic patients

- Diagnose infection clinically
- Avoid antibiotics in uninfected ulcers
- Reassess within 48–72 hours
- Refer early when red flags are present

References (Vancouver Style)

1. World Health Organization. Global report on diabetes. Geneva: WHO; 2023.
2. Lipsky BA, Senneville E, Abbas ZG, et al. Guidelines on the diagnosis and treatment of diabetic foot infections. Clin Infect Dis. 2023;76:e123–e145.
3. Abbas ZG, Armstrong DG. Antimicrobial stewardship in diabetic foot infections. Lancet Infect Dis. 2024;24(2):e45–e56.
4. Senneville E, Lipsky BA. Diabetic foot infection: current concepts and management. Nat Rev Endocrinol. 2023;19(6):345–358.
5. International Working Group on the Diabetic Foot (IWGDF). Guidelines on the prevention and management of diabetic foot disease. 2023.



Aztreonam–Avibactam:

From Mechanistic Synergy to Microbiology-Guided Clinical Use;

(expected to be available in Pakistan)

Dr Ifra Nasir
 Infectious Diseases Fellow at
 SKMCH&RC Lahore

The combination of aztreonam and avibactam represents a mechanistically robust strategy to overcome the therapeutic challenge posed by metallo-β-lactamase (MBL)–producing Gram-negative pathogens. By inhibiting co-produced serine β-lactamases, avibactam effectively preserves aztreonam activity, providing a compelling basis for synergistic in vivo efficacy when administered concurrently. This approach is particularly pertinent in high-burden settings such as Pakistan, where NDM-producing Enterobacterales are endemic and treatment options are severely constrained.

However, translating this pharmacological synergy into consistent clinical benefit requires careful consideration of PK/PD optimization, infection source control, and timely microbiological confirmation. Importantly, current evidence remains largely observational, and variability in local diagnostic and susceptibility testing capacity may further influence outcomes. Thus, while AZT–AVI is an important addition to the armamentarium against extensively drug-resistant pathogens, its use should remain judicious and guided by antimicrobial stewardship until more definitive clinical data are available. Availability of standardized susceptibility testing methods, including aztreonam–avibactam discs, will be crucial to support targeted and evidence-based use in routine practice. Use AZT–AVI early when MBL is suspected, give both drugs together via extended infusion, adjust for renal function, and always com-

Aztreonam/avibactam

(brand name Emblaveo) is a combination antibiotic approved for treating serious Gram-negative infections with limited treatment options, such as complicated intra-abdominal infections (cIAI), hospital-acquired pneumonia (HAP), and complicated urinary tract infections (cUTI).

It pairs a monobactam antibiotic with a beta lactamase inhibitor to combat multidrug-resistant pathogens

Medical Conditions Treated:

- Complicated Intra-abdominal Infections (cIAI): Approved for use with metronidazole in adults.
- Hospital-acquired Pneumonia (HAP)/Ventilator-associated Pneumonia (VAP): Approved for treating serious aerobic Gram-negative infections in these settings.
- Complicated Urinary Tract Infections (cUTI): Includes pyelonephritis.

How It Works:

Aztreonam/avibactam is designed to treat infections caused by multidrug-resistant (MDR) bacteria, particularly metallo-(β)-lactamases (MBLs). Aztreonam binds to penicillin-binding protein 3 (PBP3) to inhibit cell wall synthesis, while avibactam protects it from degradation.

Side Effects and Safety:

Common Side Effects: The safety profile is similar to its individual components, commonly including diarrhea, elevated liver enzymes, anemia, nausea, vomiting, and skin reactions.

Serious Risks: Potential for allergic reactions (rash, hives) and liver injury.

Administration:

It is administered intravenously (IV) over a 3-hour period.

Approval and Availability:

Europe: Approved in 2024 (as Emblaveo) for cIAI, HAP/VAP, and cUTI.

United States: Approved by the FDA in February 2025 for cIAI.



Modulating the Microbiome: A New Frontier in Diabetic Foot Ulcer Healing

By PCDA Editorial Team



Highlights

- 1 Topical probiotics in soybean concentrate show promising healing outcomes in DFUs
- 2 Early studies report high rates of complete wound closure
- 3 Recent randomized controlled trial (2026) expected to provide stronger evidence

4 Not yet recommended for routine use—standard care remains essential

Key Message for Practitioners

- 1 Continue standard DFU care as the foundation of treatment
- 2 Topical probiotics may be considered investigational

adjuncts

3 Await stronger RCT evidence before routine adoption

4 Focus on infection control and offloading for optimal outcomes

Overview

Diabetic foot ulcers remain a major clinical burden. Emerging therapies targeting the wound

microbiome have shown promise, including topical probiotics in soybean-based formulations.

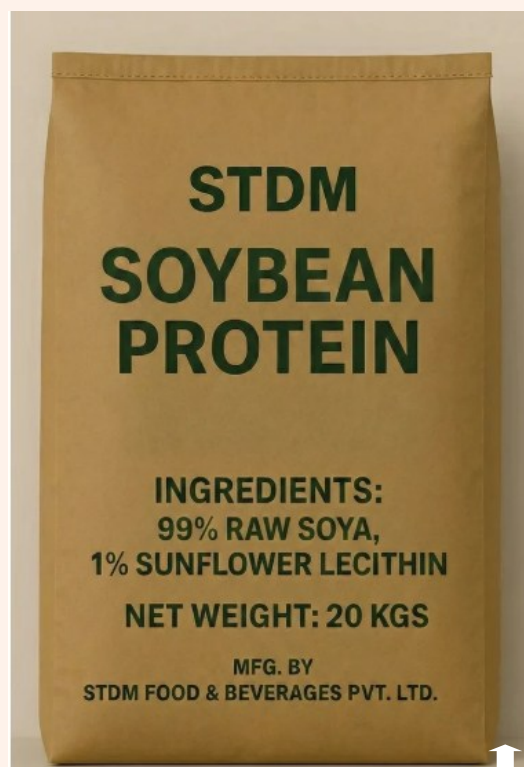
What Does the Evidence Say?

Preliminary studies suggest improved healing rates and reduced

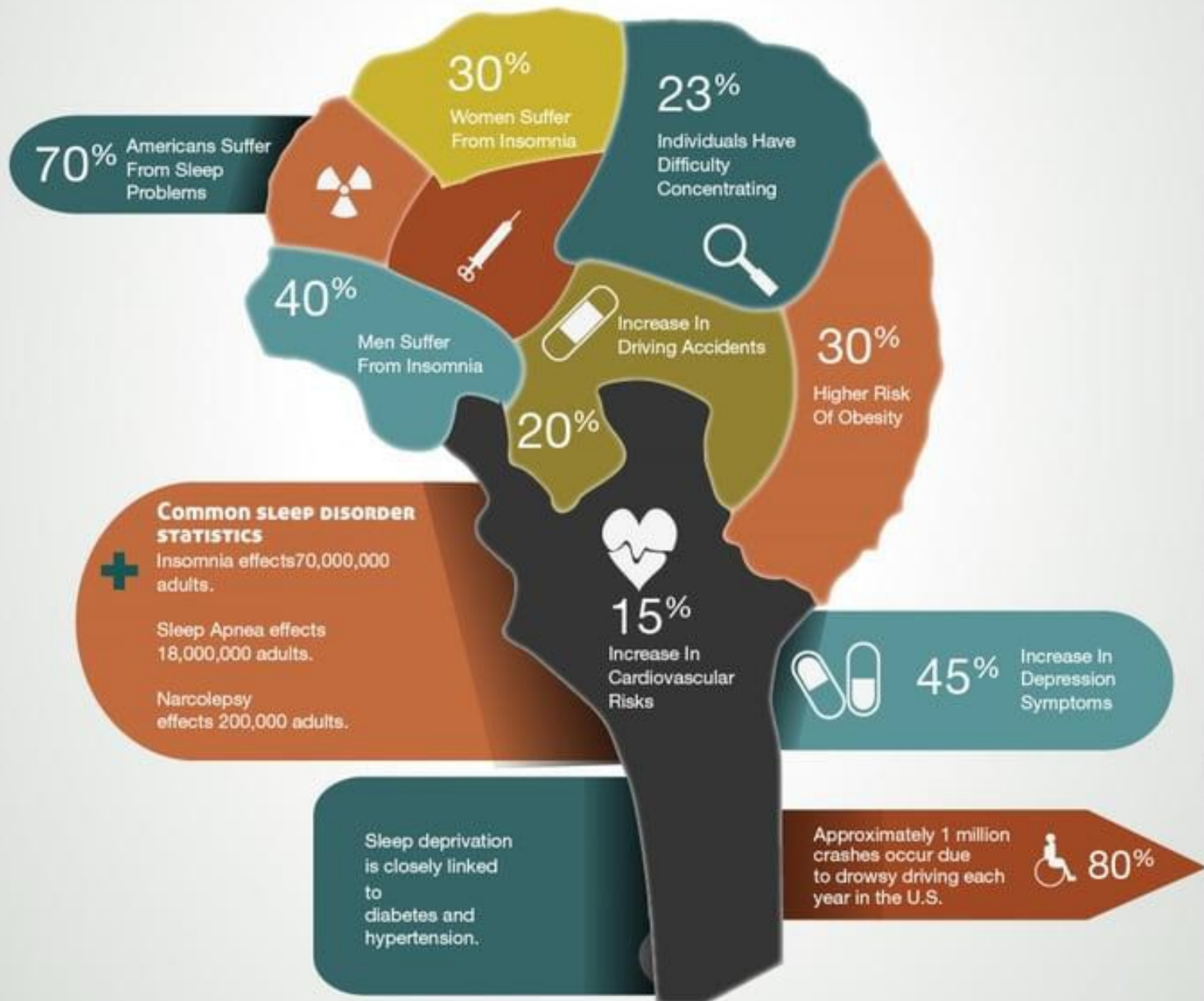
healing time. A recent randomized controlled trial aims to validate these findings.

Conclusion

Topical probiotics represent an innovative approach but require further validation before routine clinical use.



SLEEP DEPRIVATION FACTS & DANGERS



By:

Dr. Khaleeq Warsi

MBBS (MD), MSc, CSQIL (Harvard) Healthcare Quality and Patient Safety Advisor
Healthsine, Resourcing Health, Vancouver, Canada

Head of Canada Chapter pf PCDA





Sleep

The Most Underrated Pillar of Health



The Brain's Overnight Reset

During sleep, the brain carries out essential work. It processes information from the day, organizes memories, and resets emotional responses. This nightly reset helps improve focus, learning, and decision-making. When sleep is insufficient, the brain becomes less efficient. Concentration declines, thinking slows, and decision-making becomes less reliable. Over time, this can affect performance at school, work, and daily life.

Sleep and Emotional Balance

One of the most noticeable effects of poor sleep is irritability. After a restless night, people often feel more sensitive, impatient, or overwhelmed. Small challenges can feel larger than they actually are.

Sleep plays a key role in regulating the emotional centers of the brain. With adequate rest, we are better able to manage stress and respond calmly. Without it, emotional reactions become stronger while our ability to control them weakens. In this way, sleep acts as a form of **emotional first aid**, helping the mind recover from daily stress and maintain stability.



CLEAN UP YOUR SLEEP HYGIENE

13 simple tricks, will help you get a good nights sleep.



1. Go to bed and get up at the same time every day, including on the weekends and during vacations.



2. If you can't fall asleep or wake up and can't get back to sleep, get out of bed, read, sketch, or do another calming activity in low light.



3. Make sure your bedroom is quiet, dark, relaxing, and at a comfortable temperature.



4. Remove electronic devices, such as TVs, computers, and smart phones, from the bedroom.



5. Use your bed only for sleep and sex.



6. Exercise, being physically active during the day can help you fall asleep more easily and sleep more deeply at night.



7. Keep a sleep diary, experiment and figure out what works best for you.



8. Limit exposure to bright light in the evenings, turn off electronic devices at least 30-60 minutes before bedtime.



9. Establish a relaxing bedtime routine.



10. Don't eat a large meal before bedtime. If you are hungry at night, eat a light, healthy snack.



11. Avoid consuming caffeine in the late afternoon or evening.

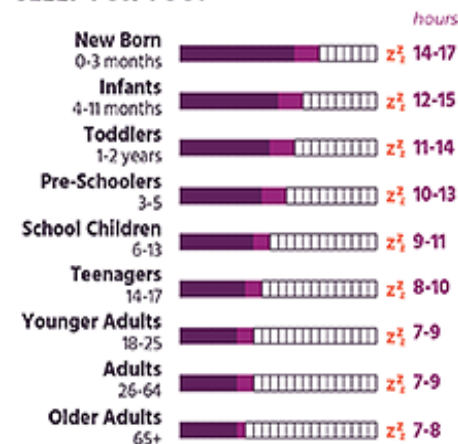


12. Avoid consuming alcohol, nicotine and THC before bedtime.



13. Reduce your fluid intake before bedtime.

WHAT'S THE RIGHT AMOUNT OF SLEEP FOR YOU?



Above are the current evidence-based recommendations for each age group, use this as a guide for how many hours of sleep you need to feel your best.

Sleep Hygiene. Retrieved from <https://www.sleepfoundation.org/articles/sleep-hygiene>
 Basics About Sleep: Tips For Better Sleep (2016, July15). Retrieved from https://www.cdc.gov/sleep/about_sleep/sleep_hygiene.html

co-created by **opticnerve**
 marykelley.com & alpinistastudio.com

Restoring the Body Term Health

Sleep is also a critical time for physical restoration. During deep sleep, the body repairs tissues, rebuilds energy stores, and releases important hormones that support growth and recovery.

The immune system becomes more effective, helping the body fight infections and heal.

When sleep is regularly disrupted, these processes are incomplete. Over time, this may lead to fatigue, reduced immunity, and increased strain on overall health.

Metabolism, Hormones, and Long-

Sleep helps regulate appetite, metabolism, and hormonal balance. Poor sleep can increase hunger, reduce energy efficiency, and disrupt normal body rhythms.

Long-term sleep deprivation has been linked to a higher risk of conditions such as heart disease, diabetes, obesity, and mental health disorders. These risks highlight that sleep is not just about daily comfort—it is a key factor in long-term health.

More Than Just Rest

Sleep should not be viewed as a passive break from daily ac-

tivity. It is an active and essential part of maintaining health. Alongside nutrition and physical activity, sleep forms a core pillar of well-being.

Even with a healthy diet and regular exercise, neglecting sleep can undermine overall health. Sleep allows the body and mind to fully benefit from the efforts made during the day.

A Prevention-First Perspective

From a preventive health standpoint, sleep is one of the most accessible and powerful tools available. It requires no cost, yet its benefits extend across physical, mental, and emotional health.

Prioritizing sleep can improve resilience, enhance daily functioning, and reduce the risk of long-term health problems. In contrast, consistently poor sleep can gradually weaken these same areas.

Final Thought

Sleep may be quiet and often overlooked, but its impact is profound. It restores the body, stabilizes emotions, and sharpens the mind.

Recognizing sleep as a necessity rather than a luxury is an important step toward better health. Protecting sleep is not simply about avoiding tiredness—it is about building a stronger, healthier, and more balanced life.





By:
Dr. Muhammad Saleem Khan
 Head of AJK/GB Region PCDA
 Pakistan

نیند کیوں رات بھر نہیں آتی

بے خوابی Lack of sleep is commonly caused by stress, poor sleep hygiene (irregular schedules, screens), and an uncomfortable environment. Other major factors include caffeine/alcohol consumption, medical issues (pain, apnea), and mental health conditions like anxiety or depression. It often stems from a combination of lifestyle choices and underlying health conditions

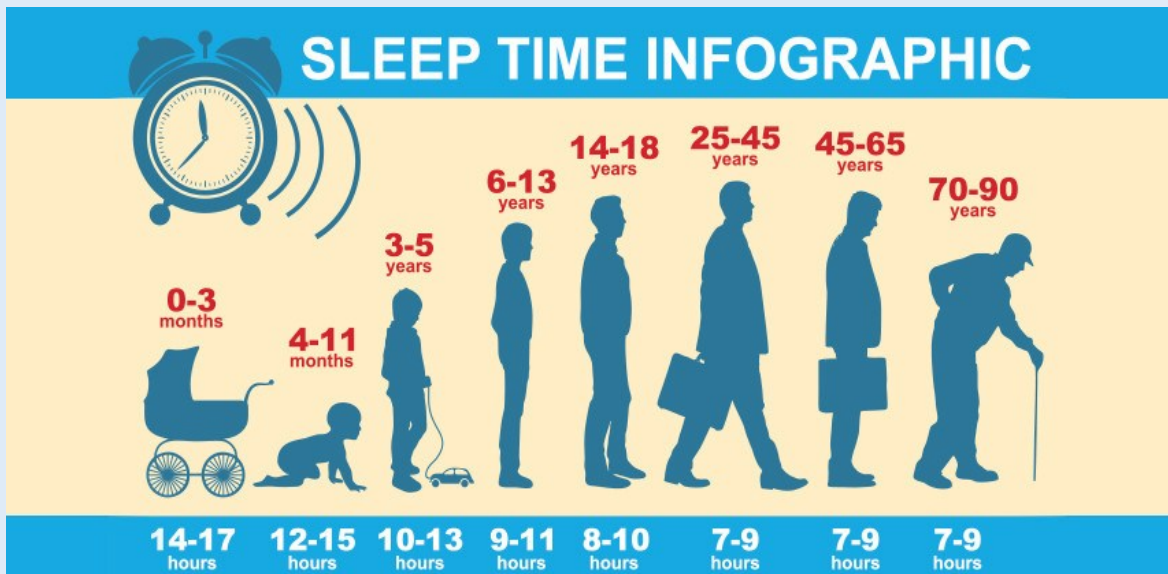
Common Causes of Lack of Sleep:

- Psychological Stress:** Worry about work, health, finances, or family can keep the mind active and trigger a "fight or flight" response, causing hyperarousal.
- Poor Sleep Hygiene:** Inconsistent bedtimes, taking long daytime naps, using digital devices (phones/TV) before bed, or working/eating in bed.
- Lifestyle Choices:** Consuming caffeine, alcohol, or nicotine, especially late in the day.
- Environmental Factors:** A bedroom that is too loud, bright, or uncomfortable.
- Medical Conditions:** Chronic pain, restless legs syndrome, allergies, asthma, acid reflux, and sleep disorders like sleep apnea.
- Mental Health Disorders:** Anxiety, depression, and PTSD.
- Circadian Rhythm Disruptions:** Jet lag, rotating shift work, or an irregular schedule.
- Medications:** Some drugs, including certain antidepressants, steroids, and blood pressure meds, can affect sleep.

To promote prevention and management of sleep disorders and highlight the importance of healthy sleep for overall health, World Sleep Day was initiated in 2008 by the World Sleep Day Committee of the World Sleep Society to celebrate sleep and encourage action on important sleep-related issues.

Sleep is a fundamental biological necessity that profoundly impacts our long-term health. Why it's so vital? Because:

- It is essential for bodily repair and function. During sleep, your body and brain actively work to repair tissues, consolidate memories, regulate hormones, and clear out toxins that build up during waking hours. For instance, a single night of poor sleep can disrupt hormones like ghrelin and leptin, increasing cravings and impacting metabolism.
- It boosts our immune system: Adequate sleep strengthens your immune system, helping your body fight off illnesses and infections. Just one night of insufficient sleep can significantly reduce the activity of natural killer cells, which are crucial for combating cancer. Chronic sleep deprivation can also lead to increased inflammation,



- tion, a precursor to many chronic diseases.
- It protects against chronic diseases: Insufficient or irregular sleep is linked to a higher risk of developing a range of serious health conditions, including type 2 diabetes, heart disease, high blood pressure, obesity, and even certain cancers. Consistent sleep, ideally 7-9 hours for adults, is as crucial as diet and exercise in mitigating these risks.
- It ensures cognitive and mental well-being: Sleep is critical for brain functions like learning, memory consolidation, emotional regulation, and decision-making. Chronic poor sleep is associated with mood disorders, cognitive impairment, and an increased risk of neurodegenerative diseases like Alzheimer's.

Conclusion:

Sleep isn't just about feeling rested; it's about giving your body and mind the essential time they need to maintain optimal function, repair themselves, and protect against disease. It's truly a non-negotiable part of staying healthy in the long run.

Sleep Deprivation: Guide for a Better Night's Rest



صحت افزاء نیند کے لئے 10 تجاویز:

1. سونے اور جاگنے کا باقاعدہ وقت مقرر کریں۔
2. اگر آپ کو دن میں نیند لینے کی عادت ہے تو دن میں 45 منٹ سے زیادہ نہ کریں۔
3. سونے سے 4 گھنٹے پہلے سکریٹ نوشی اور تمباکو خوری سے پرہیز کریں۔
4. سونے سے 6 گھنٹے پہلے کیفین کے استعمال سے پرہیز کریں (کافی، چائے، بہت سے سافٹ ڈرنکس، کوکو)۔
5. سونے سے 4 گھنٹے پہلے ثقیل، مسالہ دار اور زیادہ میٹھی غذاؤں سے پرہیز کریں، سونے سے پہلے ہلکے ناشتے میں کوئی حرج نہیں۔
6. جسمانی سرگرمی میں مشغول ہوں، لیکن سونے کے وقت سے پہلے نہیں۔
7. آرام دہ بستر کا استعمال کریں۔
8. سونے کے لیے کمرے کا درجہ حرارت مناسب رکھیں اور کمرے کو ہوادار بنائیں۔
9. تمام اضافی شور اور روشنی کو ختم کریں۔ بہتر ہے کہ اپنے موبائل فون کو سائیلنٹ کر دیں۔
10. بستر صرف سونے کے لئے استعمال کریں۔ کام اور عام آرام کے لیے بستر کے استعمال سے پرہیز کریں۔

PCDA holds Meta Connect Singapore Session on Chronic Disease Management

Report: Dr. Ahmad Shahzad

Primary Care Diabetes Association (PCDA) Pakistan and Lyallpur Diabetes Foundation (LDF) Faisalabad organized “Meta Connect Singapore Session” on 24th. March 2026 at Furoma Hotel, Singapore.

The session was moderated by Dr. Ahmad Shahzad, Head of PCDA Central Region. This clinical meeting was attended by leading clinicians from Pakistan.



Agenda and Proceedings:

1. Welcome & Opening:

The session began with a Holy Quran recitation

2. Opening Remarks:

Dr. Ahmad Shahzad set the scientific context emphasizing the focus of Primary Care Diabetes Association (PCDA) Pakistan and Lyallpur Diabetes Foundation (LDF), Faisalabad, on improving diabetes care in primary settings.

3. First Presentation:

Pathophysiology of Diabetic Complications – presented by Dr Ahmad Shahzad. The talk highlighted

mechanisms of diabetic complications relevant to primary care in Pakistan.

4. Beyond Monotherapy

Dr. Aiman Malik discussed modern therapies in type 2 diabetes management. Diabetes in CKD – Dr. Sohail Anjum explored safer therapeutic options for diabetic kidney disease. Paradigm Shift – Dr. Gen Tassarwar Hussain spoke on managing acid peptic disease. Cost vs Care – Dr. Ahmad Shahzad analyzed cost effectiveness in chronic disease treatment adherence.

5. Panel Discussion: – Expert panel led by Dr. Muhammad

Naeem and Dr. Ghazala Khalid, Prof Dr Hafiz Rauf discussed Breaking Barriers in Chronic Disease Management, integrating diabetes, renal, and GI care.

6. Q&A Session: Dr. Ahmad Shahzad facilitated a question-and-answer segment, encouraging dialogue on primary care diabetes management relevant to PCDA and LDF, Faisalabad initiatives.

Key Emphasis:

The session highlighted the mission of Primary Care Diabetes Association (PCDA) Pakistan to enhance diabetes care in primary healthcare settings in Pakistan. Lyallpur Diabetes

Foundation (LDF), Faisalabad, was noted for its role in promoting diabetes awareness and management in the community, with leading clinicians from Pakistan sharing experiences.

Collaboration between PCDA, LDF, and Singapore experts was stressed for improving primary care diabetes programs.

Action Items:

PCDA and LDF to implement discussed strategies in primary care diabetes programs in Faisalabad.

Follow-up on collaborative initiatives with Singapore partners for diabetes education and research.



Glimpses of the Meta Connect Singapore





HbA1c: When the Marker Lies

Posted By: Dr. Hira Baqai
 Head of Women Wing of PCDA Pakistan

People can be labelled prediabetic or diabetic based on HbA1c when the issue is actually iron deficiency or altered red blood cell biology. What HbA1c is supposed to tell us? HbA1c measures the percentage of haemoglobin that has glucose attached to it.

It assumes:

- * Red blood cells live ~120 days
- * Haemoglobin structure is normal
- * Cell turnover is stable
- ✓ Under those conditions, it reflects average blood glucose over 2–3 months

What anaemia does to that assumption

Anaemia is not just “low haemoglobin”

It is altered red blood cell biology

Depending on the type, you can get:

- * Reduced production
- * Abnormal cell size and structure
- * Altered lifespan (often prolonged in iron deficiency)
- * Ineffective turnover
- ✓ The entire foundation of HbA1c becomes unstable

Iron deficiency anaemia (most common scenario)

Key mechanism: prolonged red cell lifespan

When iron is low:

- * New red blood cell production slows
- * Existing cells stay in circulation longer
- * Cells are often smaller (microcytic) and metabolically stressed
- ✓ These older cells are exposed to glucose for longer
- ✓ More glucose binds to haemoglobin over time
- ✓ HbA1c rises without any real increase in blood glucose

The result

You can see:

- * “Prediabetic” HbA1c
- * Or even “diabetic range” HbA1c
- ✓ In someone whose actual glucose control is normal

There is more going on than just lifespan

1. Increased glycation under oxidative stress

Iron deficiency increases oxidative stress

This accelerates glycation reactions independently of glucose levels

2. Altered haemoglobin structure

Changes in haemoglobin can make it more prone to glycation

3. Inflammation crossover

If inflammation is present (very common), glycation increases further

Other anaemias behave differently (important)

- * Iron deficiency anaemia → HbA1c tends to be falsely HIGH
- * B12 or folate deficiency → can also falsely raise HbA1c (impaired turnover)
- * Haemolytic anaemia → falsely LOW HbA1c (cells destroyed too quickly)
- ✓ Same test
- ✓ Completely different meanings depending on red cell biology

This is the clinical trap

Someone presents with:

- * Fatigue
- * Hair loss

- * Breathlessness
- * Low ferritin or borderline haemoglobin

HbA1c comes back elevated

They get labelled prediabetic

- ✓ Instead of addressing iron deficiency

What happens when you correct the iron

This is where it gets interesting:

- * Iron is replenished
- * Red blood cell turnover

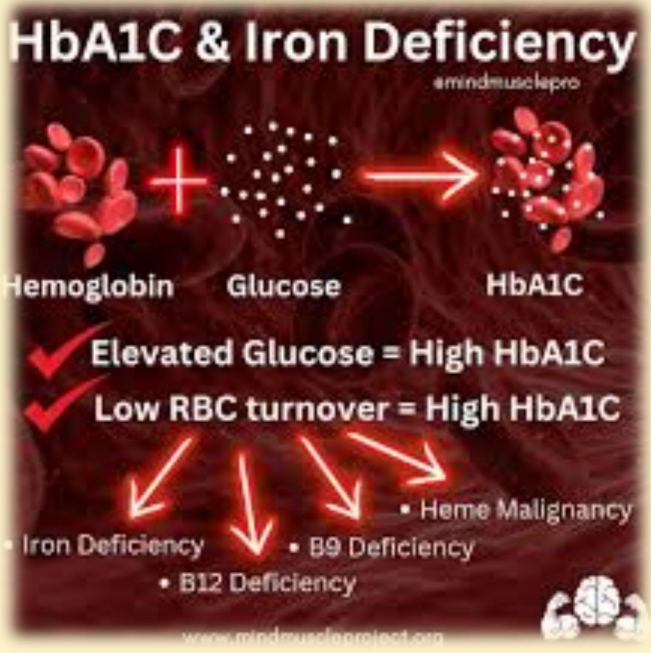
tion

- * Recent blood loss
- * B12 or folate issues

What to use instead (while correcting anaemia)

If you actually want glucose insight:

- * Fasting glucose
- * Fasting insulin
- * HOMA IR
- * Continuous glucose monitoring if needed
- ✓ These reflect real time



physiology, not red cell lifespan

HbA1c is not a glucose test.

It is a red blood cell test that assumes normal biology.

If the red

normalises

- * Younger cells replace older ones
- ✓ HbA1c often drops
- ✓ Even with no change in diet or glucose intake

When HbA1c should NOT be trusted

Be cautious if there is:

- * Ferritin < 50 or clearly depleted iron stores
- * Anaemia or borderline haemoglobin
- * Chronic illness or inflam-

blood cell is abnormal

- ✓ the result is distorted

Iron deficiency can falsely elevate HbA1c because red blood cells live longer and accumulate more glucose over time, making it look like poor sugar control when the real issue is impaired red cell turnover, not elevated blood glucose.





Dr. Nazeer Soomro, Head of Jacobabad Chapter of PCDA Pakistan arranges Free Medical Camp on every Sunday in Jacobabad. During these camps not only general public is screened for diabetes and other NCDs but the diagnosed diabetic patients are provided medicines and blood sugar testing devices.





An update for the readers of PFN-Online readers

What is Mpox?

By: Dr. Syed Riaz Ali Shah

Mpox (formerly known as monkeypox) is a viral illness caused by the monkeypox virus. It is a zoonotic disease, meaning it can spread from animals to humans, as well as between people through close physical contact.

The disease typically causes a fever followed by a distinctive rash that can be painful or itchy. While most cases are mild and resolve within 2 to 4 weeks, the virus can cause severe illness, particularly in children, pregnant women, and people with weakened immune systems.

Key Symptoms

Symptoms usually appear within 1 to 21 days after exposure.

Early Phase: Fever, intense headache, muscle aches, back pain, and low energy.

Swollen Lymph Nodes: A key feature that distinguishes mpox from smallpox.

The Rash: Often starts on the face or genitals and spreads to other parts of the body. It progresses from flat spots to painful, fluid-filled blisters that eventually scab over and fall off.

health emergency of international concern due to an upsurge of cases in the Democratic Republic of the Congo and other African countries. This current outbreak is primarily driven by "Clade I," a strain considered more severe than the "Clade II" strain that caused the global outbreak in 2022.

Availability: Widely available in the U.S. and Europe at travel clinics and pharmacies for at-risk groups.

Usage: Preferred for most adults, including those with weakened immune systems or pregnancy.

2. LC16m8:

Type: A "3rd generation"

vaccine widely approved for use in children (1 year and older).

3. ACAM2000:

Type: A "2nd generation" live-replicating vaccine.

Schedule: A single-dose given by rapidly pricking the skin 15 times.

Usage: Authorized for mpox in the U.S. but often kept as a backup for emergency stockpiles due to higher side-effect risks (like myocarditis).

4. OrthopoxVac: Produced in Russia and registered for use against orthopoxviruses.

Vaccine Effectiveness

Full Protection: Protection is highest about two weeks after the second dose of JYNNEOS (72–92% effective) or four weeks after a single LC16m8 dose.

Waning Immunity: Recent 2026 data suggests protection may begin to fade within 6–12 months, leading to ongoing research into the need for future booster shots.

Post-Exposure: If you've been exposed, getting vaccinated within 4 days can prevent the disease, and within 14 days can reduce symptom severity. [1, 2, 3, 4].

Cost and Access

In many regions, including the U.S. and parts of South Asia like Pakistan, vaccines are provided free of charge to eligible high-risk individ-

The first case of Monkeypox in Pakistan was reported in the Islamabad Capital Territory on April 21, 2023. A 25-year-old Pakistani man who had just returned from Saudi Arabia was found to have an infection. Following the notification from National Institute of Health (NIH), health authorities in Pakistan were placed on high alert on May 23, 2022 due to the possibility of a Monkeypox outbreak in the country, given the virus' emergence in non-endemic countries like the US and the UK.

Since those first cases were discovered in Pakistan in April 2023, a total of 11 cases have been documented, including 1 fatality. Pakistan confirmed its first Monkeypox case of the current year on August 16, 2024.

Vaccines:

live-attenuated vaccine that can replicate at the injection site but is highly weakened.

Schedule: A single-dose vaccine administered via a "bifurcated needle" (lightly pricking the skin multiple times).

Availability: Primarily used in Japan and through WHO Emergency Use Listing for international responses, including recent deliveries to Madagascar and DRC.

Usage: Currently the only

As of early 2026, four primary vaccines are used globally to protect against mpox.

1. JYNNEOS (also known as MVA-BN, Imvanex, or Imvamune):

Type: A non-replicating "3rd generation" vaccine that cannot cause infection.

Schedule: Administered as two doses given 28 days apart.

Transmission and Prevention

Animal-to-Human: Contact with infected animals like rodents or primates through bites, scratches, or handling wild game.

Human-to-Human: Close skin-to-skin contact (including sexual contact), touching contaminated materials (bedding, clothing), or prolonged face-to-face contact.

Prevention: Vaccination is recommended for those at high risk. Frequent hand-washing and avoiding contact with symptomatic individuals or wild animals in endemic areas are also crucial.

Global Situation (2024–2026)

In August 2024, the World Health Organization (WHO) declared mpox a public



The Brain Behind Metformin: A Discovery That Changes Everything

A New Perspective on Metformin

Update posted by Dr. Altaf Ahmed Cheema

For more than 60 years, Metformin has been prescribed to hundreds of millions of people with Type 2 Diabetes. While clinicians knew it was effective, the exact mechanism behind its action remained only partially understood. Researchers at Baylor College of Medicine have now uncovered a crucial aspect of this mystery. Their findings, published in Science Advances, suggest that metformin works directly through the brain, revealing a previously unidentified mechanism.

The study focuses on a protein called Rap1 located in the Ventromedial Hypothalamus, a key control center for whole-body metabolism.

When metformin reaches the VMH, it switches off Rap1, which activates a group of neurons known as SF1 neurons. These neurons then signal the body to reduce blood glucose levels. In experiments, mice genetically engineered without Rap1 in this brain region

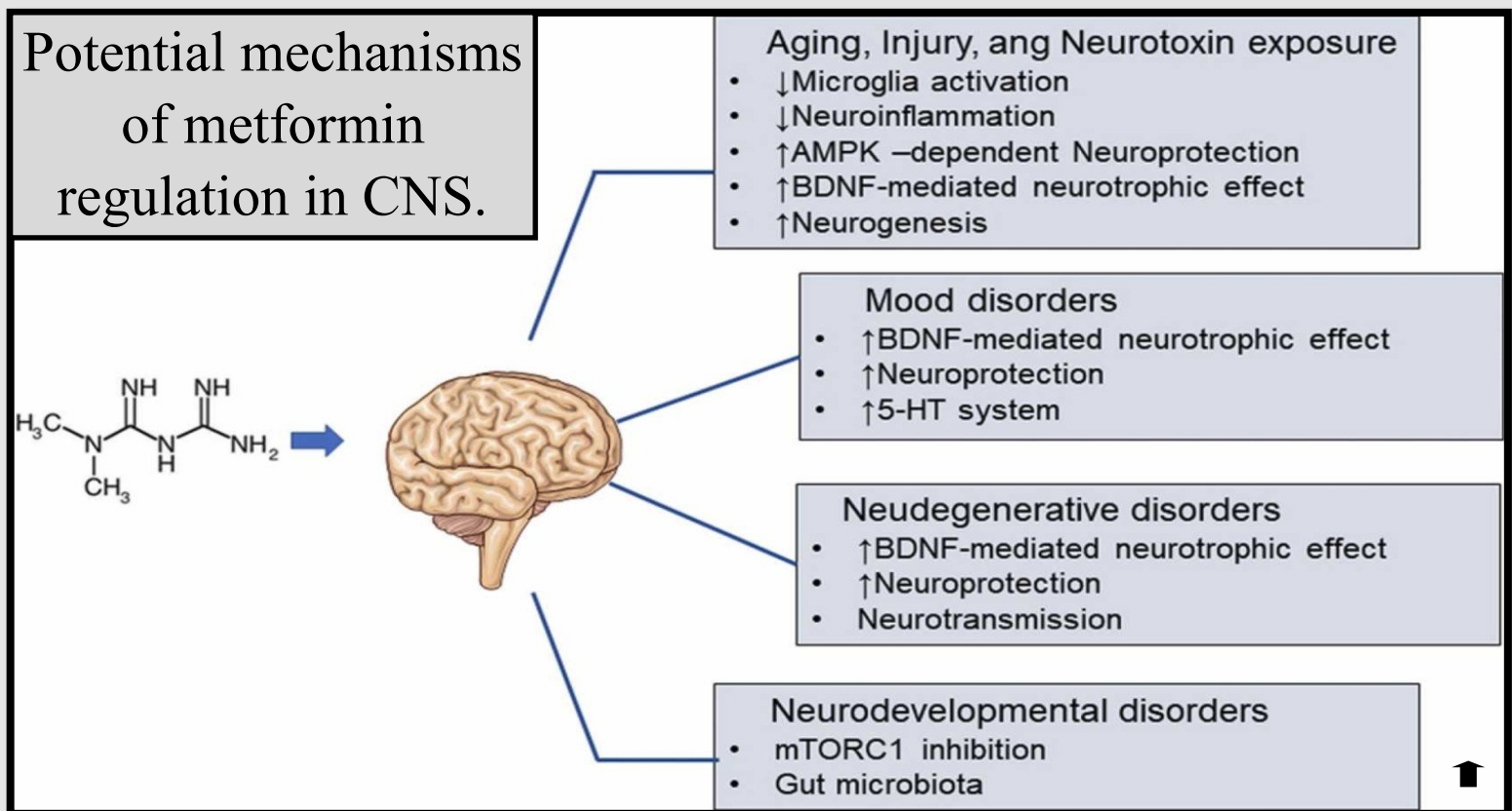
showed a striking result: metformin stopped working entirely, even when the mice were on a high-fat diet. Interestingly, other diabetes treatments, such as insulin and GLP-1 receptor agonists, continued to function normally, suggesting that this brain pathway is unique to metformin.

Another remarkable finding was the brain's extreme sensitivity to the drug. While the liver and intestines require relatively high drug

concentrations to respond, the brain reacted to thousands of times lower than typical oral doses. These insights reshape decades of understanding. Metformin may not simply act through the liver or gut as traditionally believed, it has likely been influencing the brain's metabolic control systems all along. □

metformin's other reported benefits, including potential effects on brain aging and longevity. Human studies are still required to confirm these mechanisms, but the discovery opens the door to more precise and targeted diabetes therapies in the future.

Reference:
Lin et al. (2025). Low-dose metformin requires brain Rap1 for its antidiabetic action. Science Advances.



Posted by Dr. Nauman Rizwan

FDA Approves First Once-Weekly Basal Insulin for Type 2 Diabetes

Awikli® (insulin icodec-abae) 700 units/mL – Approved March 26, 2026 as an adjunct to diet and exercise

SECTION 1 – FDA Approval Highlights



First and only once-weekly basal insulin for adults with type 2 diabetes

- Major shift from daily to weekly dosing
- Approval restricted to type 2 diabetes due to hypoglycemia safety concerns in type 1
- Prior FDA review led to refocusing exclusively on type 2 diabetes population

SECTION 2 – Mechanism of Action



Ultra-long-acting basal insulin with half-life enabling stable glucose control over 7 days

- Provides continuous insulin exposure with a single weekly injection
- Designed for steady-state levels with less day-to-day fluctuation than daily basal insulin
- Requires loading/adjustment strategies during initiation.



SECTION 3 – Clinical Evidence



ONWARDS phase 3 program (≈2,680 patients across 4 key trials)

- Compared to daily basal insulin (e.g., glargine U100) with oral agents, GLP-1 RAs, or prandial insulin
- Demonstrated noninferiority or superiority in HbA1c reduction
- Effective in both insulin-naïve and insulin-experienced patients.

SECTION 4 – Hypoglycemia Profile



Slightly higher rates of clinically significant or severe hypoglycemia in some trials (not statistically significant overall)

- ONWARDS 1 example: 0.30 vs 0.16 events per patient-year vs glargine
- Long duration makes hypoglycemia more prolonged if it occurs.

SECTION 5 – Clinical Advantages

Significant improvement in adherence due to once-weekly dosing

- Aligns well with weekly GLP-1 receptor agonists or dual incretin therapies
- Reduces injection burden (52 injections/year vs 365)
- Especially useful in patients with poor compliance or injection fatigue.



SECTION 6 – Patient Selection & Practical Considerations



Best for stable, predictable lifestyles

- Less suitable for highly active patients with fluctuating insulin sensitivity
- Caution in elderly, frail, or high hypoglycemia-risk patients
- Dose adjustments slower due to long pharmacokinetics
- Strong recommendation for continuous glucose monitoring (CGM) and intensive patient education.



Evolution of Insulins

Insulin has evolved over 100 years from crude animal extracts in the 1920s to highly purified recombinant human insulin in the 1980s, and finally to modern analog insulins. This evolution has focused on improving purity, reducing allergic reactions, and engineering molecules to mimic natural pancreatic insulin secretion more closely, resulting in rapid-acting and long-acting formulations for better glycemic control

Key Stages in Insulin Evolution

Discovery and Early Use (1920s–1930s):

Extracted from animal (bovine/porcine) pancreas. While life-saving, these preparations were short-acting and contained impurities causing allergic reactions.

Purification and Stabilization (1940s–1960s):

Development of NPH (Neutral Protamine Hagedorn) and Lente insulins provided longer-acting options. Techniques like gel filtration improved purity.

Human Insulin Production (1970s–1980s):

The American Chemical Society notes that in 1978, sci-

entists used recombinant DNA technology to engineer E. coli bacteria to produce synthetic human insulin, providing a more consistent, non-animal source.

Insulin Analogs (1990s–Present):

Researchers began altering the amino acid sequence of human insulin to create "designer" insulins with improved pharmacokinetic profiles.

*** Rapid-Acting Analogs** (Lispro, Aspart, Glulisine): Modified to absorb faster and peak earlier, allowing for better mealtime glucose management.

*** Long-Acting Analogs** (Glargine, Detemir, Degludec): Engineered to provide a stable, "peakless" basal level of insulin over 24 hours or longer.

IDF estimates that globally 537 million adults currently live with diabetes. For those who can access and afford insulin, it is a literal lifesaver, saving tens of millions of lives over the past 100 years. But what's fascinating is that this gamechanger keeps changing. Scientific advances in fields like synthetic biology (for recombinant DNA) and materials chemistry (for microneedle delivery) have elevated the healing prospect of insulin. The rich story of biochemical inventions continues as scientists seek to perfect their miracle drug.

Evolution of Delivery Systems

Provided continuous subcutaneous insulin infusion (CSII).

Smart Pens & Automated Delivery:

Currently used, including closed-loop systems ("artificial pancreas")

The goal of this ongoing evolution is to better match physiological insulin secretion, reducing the risk of hypoglycemia and improving the quality of life for people with diabetes.

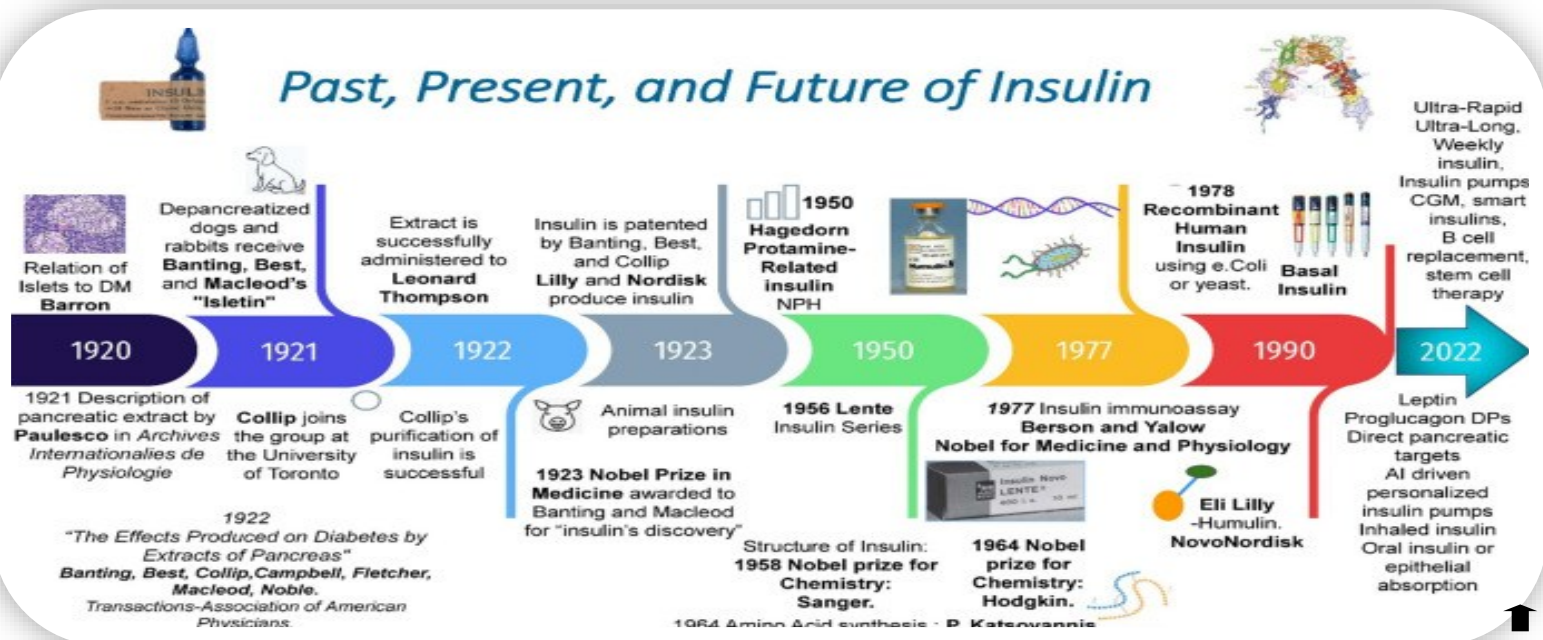
Syringes:

Original method, improved with finer, plastic syringes over time.

Pens:

Introduced for greater convenience and dosing accuracy.

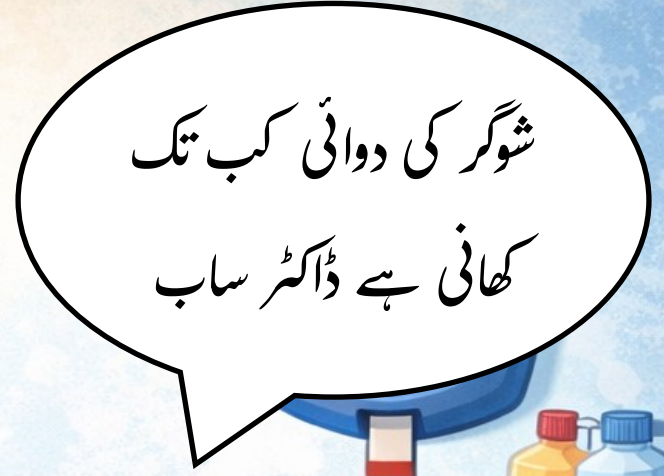
Pumps:



آج کا کارٹون

KHAN CLINIC

Dr. Riasat Ali Khan



آج کی نظم

ذیابیطیس کے

مریض کو ڈاکٹر

کی نصیحت



مریض آیا تھکا ہوا، کچھ فکر کے آثار لیے

کہنے لگا ڈاکٹر سے، دل میں کئی سوال لیے

ڈاکٹر مسکرایا نرمی سے، بولا سنو مریض عزیز

شوگر کوئی دشمن نہیں، بس مانگے تھوڑی سی تمیز

میٹھا کم اور احتیاط زیادہ، یہ پہلا اصول ہے

چلنا پھرنا روز کا معمول، صحت کا یہ پھول ہے

دوائی وقت پہ لینا تم، مت کرنا اس میں دیر کبھی

پرہیز کو عادت کر لو، یہ بات سمجھ لو ابھی

چاول، روٹی ناپ کے کھاؤ، سبزی کو ترجیح دو

پھل بھی لیکن سوچ سمجھ کر، میٹھے کم ہی چنؤ

پانی زیادہ پینا لازم، چائے کم اور سادہ رکھو

ٹینشن سے بھی دور رہو تم، دل کو ذرا کشادہ رکھو

مریض نے سر ہلایا، آنکھوں میں [امید لیے

کہنے لگا شکریہ ڈاکٹر، اب جینے کے ارادے لیے

ڈاکٹر بولا یاد رکھو، صحت ہے تمہاری دولت

اپنی عادت بدل لو، یہی ہے شاخ کی نصیحت

ڈاکٹر شاخ یوسفی

Proud of You !
Dr. Khalid Hussain

Head of Rahim Yar Khan chapter of
PCDA Pakistan



ڈاکٹر خالد حسین مزاری
(ماہر امراض ویاہٹس و بلڈ پریشر)

فیاض الحق
ڈیپٹنٹ ڈائریکٹر CCD ضلع رحیم یار خان

امس پی شفقت عطا
ڈیپٹنٹ سربراہ CCD ہالپور

آراو (RO) سی سی ڈی جناب شفقت ندیم عطا اور
ڈی او (DO) سی سی ڈی جناب فیاض الحق کی خصوصی کاوش سے

معروف ماہر امراض ڈاکٹر خالد حسین مزاری نے سٹیڈیکل ونگ کا چارج سنبھال لیا ڈیپٹنٹ سربراہ پریشر



ڈاکٹر خالد حسین مزاری کی مہارت اور تجربہ اب ادارے کی میڈیکل سروسز کو نئی بلندیوں پر لے جائے گا
عوامی و سماجی حلقوں نے ڈاکٹر خالد حسین مزاری کی تعیناتی کو ادارے کے لیے ایک نیک شگون قرار دیا
بہترین چیک اپ اور معیاری علاج کی فوری فراہمی۔ سی سی ڈی فیملی کے لیے اب صحت کی سہولیات مزید بہتر اور قریب سے



* بڑی خبر: صحت کے میدان میں ایک نئے دور کا آغاز * ارجمت یار خان کے عوام اور سی سی ڈی کے جوانوں کے لیے خوشخبری! شہر کے
ماہر ناز اور عالمی سطح کے تعلیم یافتہ معالج * ڈاکٹر خالد حسین مزاری (MBBS US, Dip Diab UK) نے سی سی ڈی
(CCD) رحیم یار خان کی میڈیکل ونگ کا چارج سنبھال لیا ہے۔ یہاں تعیناتی * آراو (RO) سی سی ڈی جناب شفقت ندیم عطا اور
ڈی او (DO) سی سی ڈی جناب فیاض الحق کی خصوصی کاوشوں اور گہری دلچسپی کے باعث ممکن ہوئی ہے، تاکہ ادارے کے ملازمین کو
بہترین طبی سہولیات میسر آسکیں۔ اب سی سی



ڈی کے بہادر جوانوں اور ان کے خاندانوں کو
ڈاکٹر خالد حسین مزاری کی
میڈیکل سروسز کو نئی بلندیوں پر
مہارت: شوگر
(Hypertension)
چیک اپ اور معیاری علاج کی
لے اب صحت کی سہولیات
سنبھالنے کے بعد میڈیا سے
کہا کہ ان کی اولین ترجیح سی
فیملی کو جدید ترین طبی سہولیات
کے اہلکار اور ان کے اہل خانہ کو
لے بہترین اور معیاری سروسز
میڈیکل ونگ کے اندر ہی میسر ہوں گی۔ عوامی حلقوں نے ڈاکٹر خالد حسین مزاری کی تعیناتی کو
ادارے کے لیے ایک نیک شگون قرار دیتے ہوئے امید ظاہر کی ہے کہ ان کی زیر نگرانی میڈیکل ونگ کی
کارکردگی میں نمایاں بہتری آئے گی۔



ڈیپٹنٹ
میڈیکل سروسز سہارن پور
سیکرٹری سہارن پور





صحیح کے میڈیکل میں ایک نئے دروازے کا آغاز!

معروف تعلیم یافتہ معالج PCDA رحیم یار خان کے پریزیڈنٹ ڈاکٹر خالد حسین مزاری نے سی سی ڈی میڈیکل ونگ کا چارج سنبھال لیا



افسران بالا کے مقرر ہیں جنہوں نے ان پر اعتماد کیا اور وہ اپنی تمام تر پیشہ ورانہ صلاحیتیں ادا کرنے کے لیے جہازوں کی خدمت و تندرستی کے لیے اہل خاندان کو علاج معالجے کی بہترین اور جدید ترین سہولیات ان کی ویڈیو پر فراہم کرنا ہے۔ ڈاکٹر خالد حسین مزاری، جو کہ (پولیس) اور ڈیپٹیمانڈ ڈیپارٹمنٹ (پولیس) میں بین الاقوامی استاد کے ساتھ ساتھ ایک باوقار فرد اور باہرین کا کہنا ہے کہ ایک ماہر فرینٹ کی موجودگی سے اب فوس کے جانوں کو شکر اور بلڈ پریشر جیسے موزی امراض کے خلاف بروقت اور معیاری علاج سمیرا کے گارجم یار خان، معروف میڈیکل ونگ کا چارج سنبھال لیا۔ آراء و شفقت عدیم عطا اور ڈی ایف ایف کی کوشش سے ادارے میں سبھی سہولیات کے نئے باب کا آغاز ہے۔ "رحیم یار خان (معاہدہ خصوصی)" رحیم یار خان کے ماہر ماہر امراض پیشہ و بلڈ پریشر ڈاکٹر خالد حسین مزاری نے سی سی ڈی



تحریرو کا دانش مرزا عدنان انکلاؤں کی صحت و تندرستی کے لیے وقت

داریں سنبھالیں ڈاکٹر خالد حسین مزاری کی تینتی آراوی سی سی ڈی جناب شفقت عدیم عطا اور ڈی ایف ایف کی سی سی ڈی جناب فیاض کی خصوصی دیکھی اور رابطہ کوشش کا نتیجہ ہے جس کا مقصد ادارے کے جانوں اور ان کے اہل خاندان کو علاج معالجے کی بہترین اور جدید ترین سہولیات ان کی ویڈیو پر فراہم کرنا ہے۔ ڈاکٹر خالد حسین مزاری، جو کہ (پولیس) اور ڈیپٹیمانڈ ڈیپارٹمنٹ (پولیس) میں بین الاقوامی استاد کے ساتھ ساتھ ایک باوقار فرد اور باہرین کا کہنا ہے کہ ایک ماہر فرینٹ کی موجودگی سے اب فوس کے جانوں کو شکر اور بلڈ پریشر جیسے موزی امراض کے خلاف بروقت اور معیاری علاج سمیرا کے گارجم یار خان، معروف میڈیکل ونگ کا چارج سنبھال لیا۔ آراء و شفقت عدیم عطا اور ڈی ایف ایف کی کوشش سے ادارے میں سبھی سہولیات کے نئے باب کا آغاز ہے۔ "رحیم یار خان (معاہدہ خصوصی)" رحیم یار خان کے ماہر ماہر امراض پیشہ و بلڈ پریشر ڈاکٹر خالد حسین مزاری نے سی سی ڈی



رحیم یار خان کے عوام اور سی سی ڈی کے جانوں کے لیے خوشخبری! شکر کے ماہر اور عالمی سطح پر تعلیم یافتہ معالج ڈاکٹر خالد حسین مزاری (Diab Dip US, MBBS) میڈیکل ونگ کی سربراہی پر فرائض ادا کر رہے ہیں۔ شکر (UK) سی سی ڈی (CCD) رحیم یار خان کی میڈیکل ونگ کا چارج سنبھال لیا ہے۔ فرینٹ - مزاج - بہترین چیک اپ اور معیاری علاج کی فوری فراہمی - سی سی ڈی (DO) سی سی ڈی جناب فیاض کی خصوصی کوشش اور گہری دیکھی کے باعث ممکن ہوئی ہے تاکہ ادارے کے ملازمین کو بہترین سہولیات سمیرا آسکس سب سی سی ڈی



داریں سنبھالیں ڈاکٹر خالد حسین مزاری نے سی سی ڈی میڈیکل ونگ کا چارج سنبھال لیا

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DEFENSIVE MEDICINE

Posted by: **Muhammed Maimoon Ishtiaq**

1. Stop apologising for petty mistakes. What's done is done.
2. Prioritise your 'peace' over 'being liked'.
3. Stop "Being a nice doctor drama" and treat the the patients the way you like. Do your best. Polite to patient & neutral with families. Avoid detailed answers to both.
4. Don't give long explanations. 'Yes' or 'no' matters alot more than theories & hypothesis.
5. Treat the patients you feel comfortable to treat. Don't narrow your coronaries by falling into traps of 'life saving heroics' in patients of fussy attendants or protocol patients.
6. Don't waste too much time on one patient, others will suffer.
7. Avoid visits of non-medical high ups like ministers or bureaucrats or similar entities. If you couldn't and get stuck in a conversation, Look them back in the eyes and give answers in medical jargons that will confuse them. Break their confidence by saying these words, sir you don't know what is acetaminophen? They will naturally avoid you & prey upon someone 'weaker & obedient'.
8. Don't allow anyone to make your video. It's dangerous as we all know already.
9. You can't save every patient. Let others do their job too.
10. People will call you arrogant but finally you have started 'respecting yourself'.

If you need respect , respecting yourself is the first step.

Editor's Note

MAINTAINING PROFESSIONAL BOUNDARIES

While Delivering Compassionate Care

In today's demanding healthcare environment, maintaining a balance between empathy and professional boundaries is essential for effective, ethical, and sustainable medical practice.

KEY PRINCIPLES

Strive for Excellence, Not Perfection: Learn from setbacks and move forward.

Balance Compassion with Boundaries: Be empathetic while avoiding overextension.

Communicate Clearly: Provide simple, understandable explanations.

Practice Within Your Scope: Refer or collaborate when needed.

Manage Time Wisely: Ensure fair attention to all patients.

Maintain Professional Interactions: Stay respectful and composed.

Protect Privacy: Ensure confidentiality and avoid unauthorized recordings.

Accept Limits of Medicine: Focus on best possible care.

Foster Mutual Respect: Integrity builds professional respect.

KEY MESSAGE

Effective medical practice requires a balance between compassion and boundaries. Clear communication, ethical conduct, and self-care enable clinicians to deliver high-quality care while protecting their own well-being.





مرسلہ : ڈاکٹر آفتاب احمد خاں - کراچی چیپٹر

کون سا فائبر قبض، کولیسٹرول اور ٹرائگلسرائیڈ کے لیے بہتر ہے؟

1. Soluble Fiber

مطلب:

ایسا فائبر جو پانی میں گھل جاتا ہے اور جیل جیسا مادہ بنا لیتا ہے۔ ڈائریا کو کنٹرول کرنے میں مدد دیتا ہے یہ ہاضمے کو بہتر کرتا ہے۔ کولیسٹرول اور شوگر کو کنٹرول کرنے میں مدد دیتا ہے۔

مثالیں:



جئی (Oats)



اسی



لوبیا / پھلیاں
کھٹے پھل

سیب



دالیں



اسپنول



خوراک میں 60-70 فیصد شامل کریں

2. Insoluble Fiber

مطلب:

ایسا فائبر جو پانی میں نہیں گھلتا۔ یہ آنتوں کی حرکت بہتر کرتا ہے اور قبض سے بچانے میں مدد دیتا ہے۔

مثالیں:



سبزیاں



گاجر



کھیرا

پھلوں کے چھلکے

پتوں والی سبزیاں

گندم کا چوکر

سبزیاں

کھیرا

بند گو بھی



خوراک میں 20-30 فیصد شامل کریں

دونوں فائبرز ہماری صحت کے لیے بہت ضروری ہیں لیکن شرط یہ ہے

کہ یہ صحیح مقدار میں لیں



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.

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SCAN FOR THE MEMBERSHIP OF

PCDA



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DEW

