

Prevention First

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Dr. Syed Fasih A Hashmi

Email: preventionfirstnews-
letter@gmail.com

Web: [https://pcdapak.org/
newsletter/](https://pcdapak.org/newsletter/)

Postal Address:

PCDA House

E-1. Naveed Banglows,

Block-17 Gulistan-e-Jauher

Karachi.

Contacts:

pcda.pak@gmail.com Tel:

02134020106, 3107777232



Head Of AJK/GB region of
PCDA Pakistan,
Dr. Muhammad Saleem Khan
receiving Prestigious Honors from
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PCDA Pakistan Congratulates PAFP on the Resounding Success of the Primary Care Summit in Bhurban



The Primary Care Diabetes Association (PCDA) Pakistan has extended its heartfelt congratulations to the Pakistan Academy of Family Physicians (PAFP) on the successful organization of the **Primary Care Summit**, held in Hotel PC Bhurban. The well-attended scientific gathering brought together hundreds of Primary Care Physicians (PCPs) from across Pakistan, reaffirming the growing commitment of the country's primary healthcare community towards continuous professional development and excellence in patient care.

On behalf of the Central Cabinet of PCDA Pakistan, the President Dr. Riasat Ali Khan congratulated the leadership and organizing committee of PAFP for hosting an outstanding academic event that provided an excellent platform for learning, collaboration, and the exchange of clinical experience among healthcare professionals.

The summit featured a comprehensive scientific program encompassing a broad spectrum of topics relevant to contemporary primary care practice. Expert speakers and experienced clinicians delivered evidence-based lectures, interactive discussions, and practical updates on the diagnosis, management, and prevention of common medical conditions encountered by

family physicians and general practitioners. The academic sessions emphasized the importance of adopting current clinical guidelines, strengthening preventive healthcare, and promoting patient-centered care in everyday practice.





The enthusiastic participation of hundreds of primary care physicians from different provinces reflected the increasing recognition of lifelong learning as an essential component of quality healthcare delivery. Such national forums not only enhance the clinical competence of healthcare professionals but also foster professional networking, interdisciplinary collaboration, and the sharing of best practices that ultimately benefit patients and communities alike.

Dr. Riasat Ali Khan reiterated that capacity building of primary care physicians remains one of the cornerstones of improving healthcare outcomes in Pakistan. As diabetes and other non-communicable diseases continue to impose a significant burden on the healthcare system, empowering frontline healthcare providers through high-quality scientific education is more important than ever.

"PCDA Pakistan firmly believes that strengthening primary care is the foundation of a healthier nation. We wholeheartedly support all professional organizations that are working diligently to enhance the standards of clinical practice, promote evidence-based medicine, and build the capacity of healthcare professionals across Pakistan. The success of the PAFP Primary Care Summit is a commendable milestone in this direction, and we congratulate the entire PAFP team for their remarkable achievement."

PCDA Pakistan reaffirmed its commitment to working alongside national medical organizations, academic institutions, and healthcare societies in promoting continuing medical education, collaborative learning, and multidisciplinary initiatives aimed at improving the quality of primary healthcare services throughout the country.

PCDA also expressed its appreciation to the distinguished faculty members, organizers, sponsors, and all participating physicians whose collective efforts made the Primary Care Summit a memorable and academically enriching event. PCDA Pakistan looks forward to future opportunities for collaboration with PAFP and other professional bodies in advancing medical education and strengthening primary healthcare for the benefit of the people of Pakistan.



STEP-PCDA Take “Health Across Communities” to a Local Church in Karachi

Report: **Zavareena Safra D'souza**
STEP-PCDA

Continuing its mission of taking diabetes prevention and early detection to communities at the grassroots level, the Primary Care Diabetes Association (PCDA) Pakistan, with the active support of its student wing, the Student Taskforce for Education & Public Health (STEP), organized a Free Diabetes Screening and Podiatric Health Campaign under the title “Health Across Communities” at Our Lady of Fatima Church (Parish Hall), Randle Road, Karachi.

The community outreach activity was held on Sunday, 12 July 2026, from 7:00 PM to 9:00 PM, following the Evening Mass, enabling members of the local community to conveniently benefit



from free diabetes-related healthcare services.

The campaign aimed to promote diabetes prevention, early detection, patient education, and awareness of diabetic foot health. Visitors were offered free diabetes screening, podiatric and foot health assessments, diabetes education, and expert clinical consultations.

A team of experienced PCDA physicians comprising Dr. Riasat Ali Khan, Dr. Fareeduddin, Dr. Muhammed Iqbal Batavia, and Dr. Shahid Akhter provided free clinical consultations to people attending the camp. The doctors assessed participants, offered individualised medical advice, and guided those requiring further evaluation or follow-up care.

The STEP volunteers played a pivotal role in the smooth and successful conduct of the campaign.

Zavareena Safra D'souza (organizer), Sanjna Bai, Abeera Athar, Tahir Iqbal, Bareera Khan

actively participated in screening camp visitors, guiding participants through the various stages of the campaign, and distributing diabetes education and awareness material.

With enthusiasm and dedication, the STEP team engaged with community members and reinforced important messages regarding healthy lifestyles, regular diabetes screening, early diagnosis, and the prevention of diabetes-related complications. Their active participation highlighted the important role of young healthcare volunteers in community health education and preventive care.

Special emphasis was placed on foot health and the early recognition of podiatric problems, highlighting the importance of regular foot assessment and preventive care among people living with diabetes. Participants were also counselled on the significance of timely medical consultation and appropriate preventive healthcare beyond the clinic walls. The "Health Across Communities" campaign demonstrated PCDA Pakistan's commitment to extending preventive healthcare beyond the clinic walls and reaching diverse sections of society. The collaboration between experienced young STEP volunteers rebuilding a better-informed and more health-conscious community. Through such grassroots initiatives, PCDA Pakistan continues to advance its "Prevention First" philosophy, strengthening diabetes awareness, promoting early detection, and bringing essential healthcare education and services closer to communities across Pakistan.



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Yet Another Camp by STEP-PCDA

Reports: Muhammad Hamza (Chapter Head, STEP-PCDA UMD C Chapter)



Karachi, July 12th, 2026 The Student Taskforce for Education and Public Health STEP-PCDA, the youth wing Primary Care Diabetes Association PCDA Pakistan, successfully organized a Diabetes Awareness and Screening Camp on Sunday 12th July 2026, at the Diabetes Care Centre & Foot Clinic, Nazimabad, on Sunday, July 12th, 2026 under the series of Health Across Communities.

The camp brought together over 50 patients who came to benefit from free diabetes screening, consultation, and awareness services offered at the centre. The event began with an awareness session delivered by Dr. Fareed Uddin, Dr. Aamer Hafeez, and Dr. Irfan Safi, who spoke on the importance of early detection of diabetes and the need for consistent patient education in managing the condition.

Following the session, the camp conducted clinical screening services for the attendees, which included Random Blood Sugar (RBS) testing, Blood Pressure monitoring, and BMI assessments.





Free personalized medical consultation was provided by the same panel of experts who led the awareness session, Dr. Fareed Uddin, Dr. Aamer Hafeez, and Dr. Irfan Safi. As with previous camps, foot assessment and preventive podiatric care remained a specialized focus, with guidance provided on foot hygiene, early detection of diabetes-related complications that could lead to diabetic foot ulcers, and advice on appropriate footwear for patients at risk. Based on individual assessments, doctors recommended further testing where needed, and free sample medications were provided to attendees in partnership with the pharmaceutical company Ferozsons Laboratories.

In addition, free vouchers for In Body fat analyzer tests were distributed among attendees, allowing them to access detailed body composition analysis as part of their overall health assessment.

Ferozsons Laboratories contributed by equipping the camp with the necessary medications needed to support community wellness.

We extend our sincere appreciation to all medical professionals, volunteers, partners and contributors, whose combined efforts and dedication made this camp a success.

The event was led by Saud Abbasi, Director Outreach and Campaigns, and managed by Muhammad Hamza. Working alongside them were volunteers Hussainah and Fatima Naseem, who ensured a smooth experience for the attendees, managing participant flow and every other aspect of the camp from registration to clinical screenings.

PCDA Congratulates Dr. Muhammad Saleem Khan on Receiving Prestigious Honors from Pakistan Army Medical Leadership

Report: Dr. Shakeel Ahmed

The Primary Care Diabetes Association (PCDA) Pakistan proudly congratulates Dr. Muhammad Saleem, Head of the AJK/GB Region of PCDA Pakistan, on being honored by the senior leadership of the Pakistan Army Medical Corps in recognition of his outstanding academic and professional contributions to postgraduate medical education.

Dr. Muhammad Saleem, who has been serving with distinction at the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Physicians, London for many years, is widely respected for his commitment to maintaining the highest standards of medical education and clinical excellence.

In addition to his international academic responsibilities, he also serves as an examiner for the prestigious MRCP(UK) PACES Examination conducted at the Pak Emirates Military Hospital, Rawalpindi, where he plays a significant role in assessing and mentoring the next generation of physicians.



A proud moment for PCDA Pakistan. On 23 June 2026, Dr. Muhammad Saleem, Head of the AJK/GB Region of PCDA Pakistan, was honored by Lieutenant General Fawad, Director General Medicine, Pakistan Army, and by the Commandant of Pak Emirates Military Hospital. The honors were bestowed in appreciation of his dedicated services, professional excellence, and invaluable contributions to postgraduate medical training and the successful conduct of the MRCP(UK) PACES examinations in Pakistan.



On behalf of the Central Cabinet and members of PCDA Pakistan, Dr. Shahid Akhter, General Secretary of PCDA Pakistan, extended his heartfelt congratulations to Dr. Muhammad Saleem on this well-deserved recognition. He described the honors as a reflection of Dr. Saleem's unwavering dedication to medical education, professional integrity, and academic leadership. Dr. Shahid Akhter expressed confidence that Dr. Saleem's vast international experience, exceptional teaching abilities, and extensive expertise in postgraduate medical assessment will continue to strengthen the educational mission of PCDA Pakistan. He noted that the Association looks forward to benefiting from Dr. Saleem's guidance in designing advanced academic activities, structured clinical training programs, and capacity-building initiatives aimed at enhancing the knowledge, clinical skills, and professional competence of primary care physicians across Pakistan.

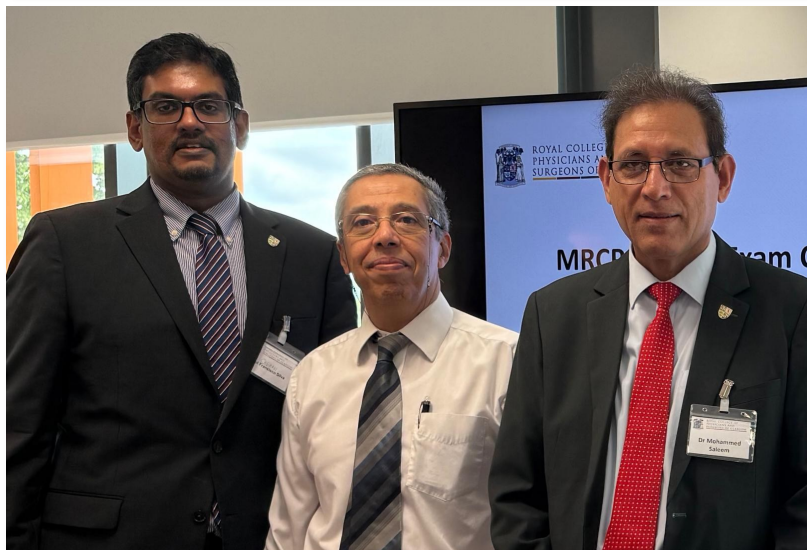


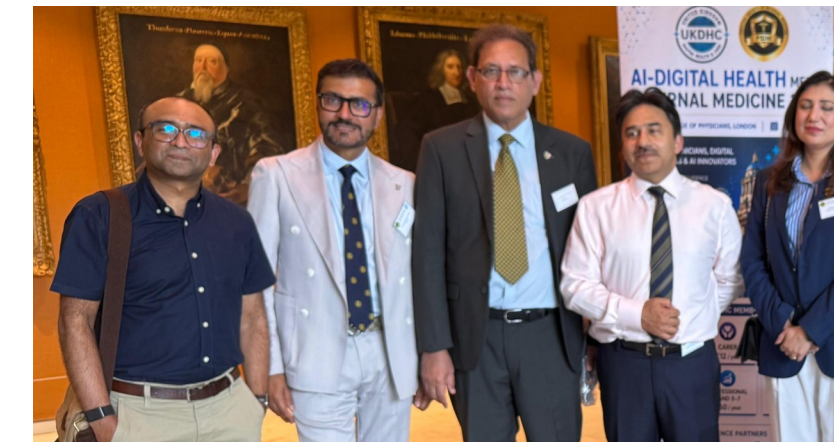
Dr. Shahid Akhter further remarked that strengthening the capabilities of primary care physicians remains one of the core objectives of PCDA Pakistan, as high-quality primary care is fundamental to improving diabetes prevention, early diagnosis, and comprehensive management throughout the country. Experienced physician-educators such as Dr. Muhammad Saleem represent a valuable national asset whose contributions will continue to inspire excellence in medical education and ultimately improve the quality of care for people living with diabetes.

The entire PCDA family extends its sincere congratulations to Dr. Muhammad Saleem on this distinguished achievement and wishes him continued success in his national and international academic endeavors.



*MRCP UK PACES Exams at Sandwell General Hospital
Birmingham. Being honoured with Sign of Royal College of Physicians
and Surgeons of Glasgow*





Why a Balanced Diet Matters for Better Blood Sugar Control

When you are living with diabetes, healthy eating is not about giving up your favourite foods it's about making balanced choices. Every food group provides unique nutrients that work together to maintain healthy blood glucose levels, support body functions, and reduce the risk of diabetes-related complications. Rather than focusing on restrictions, aim to build meals that include a variety of foods in the right proportions.

Cereals and Whole Grains, Your Body's Fuel

Carbohydrates are the body's main source of energy and the preferred fuel for the brain and muscles. Instead of avoiding carbohydrates, choose whole grains such as whole wheat, oats, brown rice, barley, and millets. They are rich in dietary fibre, B vitamins, magnesium, and antioxidants. Fibre slows the absorption of glucose into the bloodstream, helping prevent sharp blood sugar spikes while improving satiety and insulin sensitivity. Regular consumption of whole grains has also been associated with a lower risk of type 2 diabetes and cardiovascular disease.



Fruits, Nature's Sweetness with Powerful Nutrition

Many people with diabetes avoid fruits because they contain natural sugars. However, whole fruits are very different from sweets and sugary drinks. They provide fibre, vitamin C, potassium, folate, and antioxidants that slow sugar absorption and support heart health.

Rabbiya Tirmizi

Dietitian/ Nutritionist, CDE
Head of Diet & Education Wing
(DEW)-PCDA



Vegetables, Fill Half Your Plate

Non-starchy vegetables such as spinach, broccoli, cauliflower, cabbage, cucumber, tomatoes, carrots, and okra are naturally low in calories but rich in fibre, vitamins, minerals, and antioxidants. Their fibre helps maintain steady blood glucose levels, while antioxidants reduce inflammation and oxidative stress, both of which contribute to insulin resistance. Filling half your plate with colourful vegetables is one of the simplest ways to improve both blood sugar control and overall health.

Fruits also satisfy our natural desire for something sweet, making healthy eating more enjoyable and sustainable. Replacing sugary desserts with an apple, guava, orange, pear, or berries allows you to enjoy sweetness while nourishing your body. Regular fruit intake has been associated with a lower risk of type 2 diabetes and better overall health.

Meat, Poultry, Fish, Eggs, Beans and Lentils, Building a Strong Body

Protein foods help build and repair body tissues, preserve muscle mass, and support immunity. Including lean meat, poultry, fish, eggs, beans, chickpeas, or lentils in meals slows digestion and reduces post-meal blood glucose fluctuations. Beans and lentils also provide fibre, while fish contributes heart-healthy omega-3 fatty acids. Maintaining muscle mass improves insulin sensitivity because muscles are the body's largest site for glucose uptake.



Milk and Dairy, More Than Strong Bones

Milk and unsweetened yoghurt provide high-quality protein, calcium, vitamin B12, and vitamin D, all of which support healthy bones, muscles, and nerves. Their protein content also promotes fullness and may help moderate blood glucose after meals. Vitamin D deserves special attention because it plays a role in normal insulin secretion and insulin sensitivity. Vitamin D deficiency is common among people with diabetes and has been associated with poorer glycaemic control. Maintaining adequate vitamin D levels through fortified dairy products, safe sun exposure, or supplementation when prescribed may support healthy glucose metabolism as part of comprehensive diabetes care.

Healthy Fats, Choose Wisely



Healthy fats from nuts, seeds, olive oil, canola oil, and avocados support heart health and help the body absorb fat-soluble vitamins. At the same time, limit foods high in saturated fats, trans fats, and added sugars, including sugary drinks and highly processed snacks, as they can worsen blood glucose control and increase cardiovascular risk.

A balanced plate that includes all food groups provides the nutrients needed for healthy blood glucose levels, improved insulin sensitivity, healthy weight, and overall well-being. Remember, nutrition is never one-size-fits-all. Your age, lifestyle, medications, and medical conditions all influence your dietary needs. Consulting a **Dietitian** can help you understand your individual nutritional requirements and develop a meal plan that fits your lifestyle and culture. Medical Nutrition Therapy delivered by a dietitian has been shown to improve HbA1c, support weight management, and reduce diabetes-related complications. With the right guidance, healthy eating becomes enjoyable, sustainable, and one of the most powerful tools for living well with diabetes.

Memories from the Past

In Conversation with Professor M. Zaman Shaikh



**Professor
M. Zaman Shaikh**
MBBS, FCPS, MRCP
(UK), FRCP
MSc (Diabetes & Endo-
crinology), University of
Glasgow
Director, Sir Syed Insti-
tute of Diabetes & En-
docrinology (SSIDE)
Professor of
Medicine & Head of De-
partment,
Sir Syed College of
Medical Sciences, Kara-
chi

Prof. Zaman Shaikh is a mentor of Primary Care Diabetes Association Pakistan who always guided and encouraged the newborn Association since its inception. This Interview was recorded by Dr. Shahid Akhter in a hotel of San Francisco USA on 9 June, 2019 during **79th Scientific Sessions of American Diabetes Association**. Late Dr. Syed Mansoor Ali (Then President PCDA Pakistan) and Dr. Fareeduddin (Then Vice President PCDA Pakistan) were also present during the interview.



The interview can be watched at https://youtu.be/sRMzUua2Yis?si=Pykh_pQHUW6NEB1-

Dr. Shahid Akhter: Sir, please tell us about the beginning of your journey, including your schooling, graduation, postgraduate training, research work, and professional career.

Professor M. Zaman Shaikh: I was born on 1 July 1953 in Karachi and received my primary education at NJV High School on Bunder Road (now M.A. Jinnah Road), Karachi, which was one of the most renowned schools in the city at that time. After completing Class 7, my family moved to Gambat, my hometown, where I completed my matriculation from Murad High School in 1968.

I then moved to Hyderabad and completed my Intermediate education at Sachal Sarmast Science College, Tilak Chari, Hyderabad. Subsequently, I gained admission to Liaquat Medical College, Jamshoro, from where I graduated in 1978. I completed my house job at the National Institute of Child Health (NICH), Karachi.

After my house job, I joined the Pakistan Army Medical Corps (AMC) as a Captain and served from 1979 to 1981. That period remains one of the most rewarding phases of my professional life, as I gained invaluable experience during my military service. After leaving the Army, I joined the Government of Sindh as a Resident Medical Officer (RMO) in November 1981, and it was there that my journey toward postgraduate education truly began.

During my Army service, I was posted at CMH Rahwali, Gujranwala, under the guidance of a distinguished teacher, Maj Gen (R) Zaheeruddin (then Colonel Zaheeruddin), who strongly encouraged me to pursue postgraduate training. In fact, this was already my heartfelt ambition. Although many of my friends advised me to appear in the CSS examination, which was highly popular among fresh graduates at that time, and despite having the advantage of a special quota for the Civil Service, I chose to remain in academics. While a career in the Civil Service offered greater comfort and required comparatively less struggle than pursuing FCPS, my passion lay in medicine and education.

To make a long story short, I passed FCPS Part II in 1988 and was subsequently offered the position of Assistant Professor at Peoples Medical College, Nawabshah. A year later, I

proceeded to the United Kingdom on deputation to pursue an MSc in Endocrinology and Diabetology at the University of Glasgow.

The MSc programme was designed to be completed over three years. However, after two years, I decided to simultaneously appear for the MRCP Part II examination because I had been exempted from MRCP Part I on account of already having passed FCPS Part II from CPSP. As a result, I earned both postgraduate qualifications in 1991 and returned to Pakistan. Six years later, I was awarded the FRCP. At that time, this was considered a notable achievement because obtaining the FRCP usually required at least ten years after MRCP qualification, whereas I achieved it within six years.

I chose Endocrinology as my subspecialty after considerable discussion with family and friends. Looking back, I believe it was a passion that was already within me. At that time, endocrine disorders were generally considered rare, and most physicians preferred specialties such as Cardiology and Gastroenterology. I deliberately chose a less crowded field that I believed would become increasingly important. Even then, I observed that diabetes and endocrine disorders were becoming more common and were often misdiagnosed or inadequately managed.

While in Glasgow, I lived with my family—my parents, my wife, and our three children. Their unwavering support and prayers were a constant source of strength. On the day of every examination, my parents would spend the entire duration of the exam in prayer. Their faith in me motivated me to work even harder.

I was also fortunate to have supportive friends from Scotland, England, China, India, and various Arab countries. By then, I had invested so much time, effort, and sacrifice into my education that failure was simply not an option. Some friends used to joke that if I failed after such hard work, I would collapse from shock.

Although my family and home were in Glasgow, I often stayed overnight in my office to study in a calm and quiet environment. Many nights were spent with cheese, bananas, milk, and large amounts of coffee to keep me awake and focused. I would tell my family that I was on night duty. Some friends encouraged me to enjoy the attractions and entertainment that

Glasgow had to offer. However, I believed that enjoyment required both

time and money, and I felt that my time and resources belonged to my family, my children, and most importantly, my studies. In truth, that dedication itself became my source of satisfaction.

From the very beginning, my goal was to obtain these prestigious qualifications and then dedicate myself to serving people living with diabetes and endocrine disorders. I bow my head humbly before Almighty Allah, who fulfilled all my goals, aspirations, and ambitions, and blessed me with far more than I ever deserved or asked for.

Dr. Shahid Akhter: Are you satisfied with the standard of care for people with diabetes in Pakistan? Is the government healthcare system performing according to international stand-

ards?

Professor M. Zaman Shaikh: Not at all. At the government level, we are not doing enough to prevent or control diabetes. In reality, there is no well-defined system. Diabetes is an expensive disease. Patients often have to pay consultation fees from their own pockets, ranging from a few hundred to several thousand rupees. Then come the costs of investigations, medications, management of comorbidities, and screening for complications.

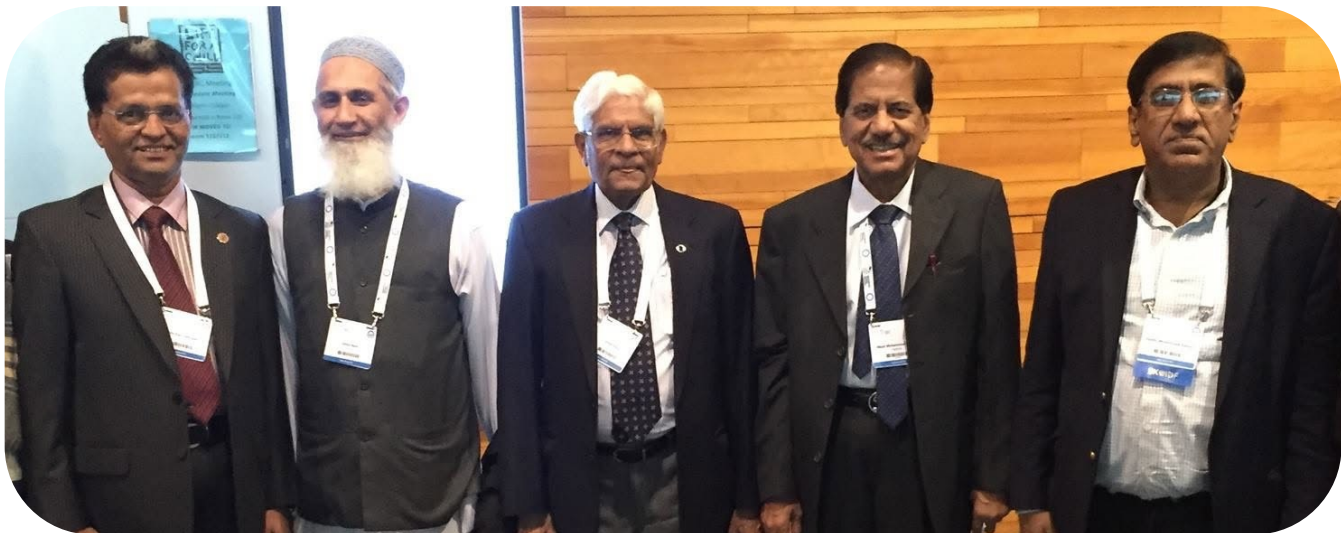
For a person earning Rs. 16,000 to 18,000 per month, how is it possible to bear these expenses? There is no comprehensive health insur-

ance system and very limited support for low-income patients.

Furthermore,

there is no properly functioning primary, secondary, and tertiary healthcare structure for diabetes care. Complicated cases often remain at the primary care level, while uncomplicated cases may directly seek care from tertiary specialists. Patients who cannot afford treatment are left at the mercy of charitable organizations or, unfortunately, quacks.

There are also insufficient efforts from the government to curb quackery, which is particularly common in diabetes and endocrine disorders. Health has never been a true national priority. There is a lack of vision, passion, commitment, and long-term policy planning. Instead, ad hoc decision-making prevails. Corruption has damaged many of our institutions and systems.





I remember that during the early 1970s, one of my Pakistani friends who held US nationality visited me at Civil Hospital Karachi. He was amazed by the quality of free healthcare and nutritious meals provided to all patients without discrimination. Similar facilities existed at Liaquat Medical College when I was a student. Sadly, much of that system has deteriorated over time.

During my tenure at Dow University of Health Sciences, we organized three international diabetes conferences. At one of these events, the Governor of Sindh attended as Chief Guest. We proposed the establishment of diabetes centres at the taluka level throughout the province. Our estimates showed that each centre could be established at a relatively modest cost. We even suggested that if the government could not fund the initiative directly, it could facilitate partnerships through the pharmaceutical industry. The Governor appreciated the proposal and expressed support, but unfortunately I do not know what became of it afterward.

Dr. Shahid Akhter: What is the contribution and role of Primary Care Physicians (PCPs) in the management of people with diabetes?

Professor M. Zaman Shaikh: The role of Primary Care Physicians is crucial and pivotal in diabetes management, particularly for under-

privileged patients. They are the frontline force in the fight against diabetes and represent the very foundation of healthcare delivery.

There is no doubt that PCPs work extremely hard and remain highly committed to their patients. However, they are often overwhelmed by heavy patient loads and limited consultation time. As a result, they may not be able to provide comprehensive diabetes education to every patient.

A physician who identifies as a diabetologist should ideally establish a support system within the clinic. For example, a trained nurse who also functions as a diabetes educator and dietitian can provide individualized counseling regarding diet, exercise, medication adherence, self-monitoring of blood glucose, insulin storage, and injection techniques.

In my experience, female educators are often particularly effective in this role. A PCP cannot perform all these tasks alone. By employing a trained diabetes educator, physicians can improve the quality of care, increase patient satisfaction, and ultimately strengthen their professional reputation while managing a larger patient population more efficiently.



One of the mentors of PCDA Pakistan, Professor M. Zaman Shaikh is Consultant Endocrinologist and Diabetologist at Karachi. After passing MBBS from LMC Jamshoro, he passed FCPS in 1988 and proceeded to UK, from where he acquired MSc in Endocrinology and Diabetes from University of Glasgow as well as MRCP. He was awarded FRCP at Glasgow only 6 years after passing his MRCP. Till his retirement, he served Dow University of Health Sciences (Ojha Campus) Karachi as Professor of Medicine and Head of Department. He established National Institute of Diabetes and Endocrinology, and served there as director. He also started MSc program in Diabetes and Endocrinology for doctors, a two-year diploma, recognized by PMDC.

At present, he is working as Professor of Medicine and Head of Department, as well as Director of Sir Syed Institute of Diabetes and Endocrinology, at Sir Syed College of Medical Sciences, Karachi. He has experience teaching and working at University of Glasgow, Royal Infirmary Glasgow, DMC, Dow University, JPMC Karachi, Chandka Medical College Larkana, Peoples Medical College Nawabshah and he is a senior examiner for FCPS Exams (Medicine & Endocrinology) at College of Physicians and Surgeons of Pakistan and of MD examination at different universities.

He is observer of International Diabetes Federation (IDF) General Council, from Pakistan. He is Founder Member of Diabetes in Asia Study Group (DASG) from Pakistan. He is also Executive Committee Member of Middle East North Africa (MENA) region of IDF.

He is on Editorial Board of International Journal of Andrology (From China) and Chief Adviser and Adjuvant Professor at Sindh Institute of Endocrinology and Diabetes (SIED), at LUMHS, Jamshoro, where also guided and helped commencing 2-yr. M.Sc program in Diabetes and Endocrinology for the benefit of junior doctors from interior of Sindh. is President of Heath Times Academy. He is a member of UK Diabetes, Caledonian Society of Endocrinology, Scotland and AACE, among other organizations.

This "Lifetime Achievement Award" was presented to him during 8th. International Biennial PCDA Symposium 2024, held in Karachi



PCDA has successfully organized numerous symposia and academic activities. In future events, I would recommend inviting senior government officials, including ministers and secretaries, as chief guests. Such forums provide an excellent opportunity to present challenges, discuss practical solutions, and advocate for policy changes.

Government officials have a responsibility to address healthcare concerns, and if approached constructively, they may respond positively. We stand with PCDA in these efforts and will support the organization whenever possible.

Dr. Shahid Akhter: How can senior professionals help PCDA achieve its goals?

Professor M. Zaman Shaikh: It is always a matter of pride for us to contribute to PCDA's academic activities. One area that deserves particular attention is research.

Dr. Shahid Akhter: How do you see PCDA working for the betterment of diabetes care in Pakistan?

Professor M. Zaman Shaikh: There are several organizations representing family physicians in Pakistan, but most are not specifically focused on diabetes. PCDA is innovative, unique, and pioneering in its commitment to diabetes care at the primary healthcare level.

The members of PCDA are hardworking and dedicated. Many of them have been my students, and I take great pride in their achievements. The organization has already made valuable contributions, although there remains considerable potential for further growth and impact.

Dr. Shahid Akhter: What more should PCDA do?

Professor M. Zaman Shaikh: PCDA should actively engage with government stakeholders. We, as seniors, are willing to support these efforts through whatever professional contacts and influence we possess.

I am aware that PCDA has established a Research Committee and has already initiated some important work. Research is essential for generating local evidence and guiding future policy and clinical practice.

All of us seniors are ready and willing to support PCDA in research, training, mentorship, and academic development. Together, we can contribute significantly to improving diabetes care in Pakistan.

Dr. Shahid Akhter: Thank you, Professor Zaman Shaikh, for taking time out of your busy schedule to share your experiences, insights, and wisdom with us. The entire PCDA family is grateful for your continued guidance, encouragement, and unwavering support. We wish you continued health, success, and many more years of service to the people of Pakistan.

Thank you once again.

Obesity, Metabolism & Diabetes

The Triple Epidemic

DIABETES

PAKISTAN 2026

International Conference of Diabetes & Related Complications


30-31 OCTOBER 2026
 FRIDAY - SATURDAY

SERENA HOTEL
 FAISALABAD, PAKISTAN

IN COLLABORATION WITH

Layallpur Diabetes
FoundationPrimary Care Diabetes
Association
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Internal MedicineFaisalabad Medical
UniversityPak Korea Nutrition
CenterPakistan Academy of
Family PhysiciansPakistan Academy of
Family Physicians

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WHY ATTEND?

Global faculty from
UK, UAE &
Saudi ArabiaNational leaders in
Diabetes, Endocrinology
& CardiologyHands-on
pre-conference
workshopsScientific sessions &
expert panel
discussionsPoster presentations
& networking

KEY SCIENTIFIC THEMES

Primary Care
DiabetesObesity
ManagementDiabetic
FootTechnology in
Diabetes &
Cardiovascular
Prevention

OFFICIAL INVITATION & REGISTRATION

Opening Soon170-B Sadar Bazar Iqbal Chowk
GM Abad Faisalabad.

0313-5991457



diabetes.pakfsd@gmail.com


www.lyallpurdiabetesfoundation.org
www.ldf.com.pk



The Theme For World Diabetes Day 2026-27 announced

Early Action on Diabetes



Early action on diabetes is the theme for World Diabetes Day 2026-27. The campaign focus for 14 November is early diagnosis and risk reduction. Early action accelerates access to care, reduces the risk of diabetes and leads to better health for all.

1 in 9

adults are currently living with diabetes worldwide.

**635
million**

adults are at high risk of type 2 diabetes.

**Up to
50%**

of people with type 2 diabetes already have complications at the time of diagnosis.

**Get Ready to
celebrate with**

**PCDA
PAKISTAN**

Safe Disposal of Used Needles and Syringes: A Guide for People Living with Diabetes

Written By:

Muhammad Saud Abbasi

Surgical Technologist,

Certified Assistant Podiatrist,

Director of Outreach & Campaigns

at STEP-PCDA

Diabetes is one of the most common chronic diseases worldwide, and millions of people rely on insulin injections and other injectable medications to manage their blood sugar levels effectively. For many individuals living with diabetes, administering injections at home has become a routine part of daily life. However, while much attention is given to the proper use of insulin and blood glucose monitoring, an equally important aspect of diabetes management is often overlooked: the safe disposal of used needles, syringes, lancets, and other sharps.

Improper disposal of these items can pose serious health and environmental risks. Used needles and syringes can cause accidental injuries, spread infections, and create hazards for family members, sanitation workers, healthcare providers, and the community at large. Therefore, every person with diabetes should understand the importance of safe sharps disposal and follow recommended guidelines to protect themselves and others.

Why Safe Needle Disposal Matters

A used needle may appear harmless after an injection, but it can still carry blood and other bodily fluids. If another person is accidentally pricked by a contaminated needle, there is a risk of transmission of blood-borne infections such as Hepatitis B, Hepatitis C, and HIV. Children are particularly vulnerable because they may unknowingly handle discarded needles out of curiosity. Likewise, waste collectors and sanitation workers often suffer accidental needle-stick injuries when sharps are mixed with household garbage.

Improper disposal can also contribute to environmental pollution. When medical waste enters the regular waste stream, it creates challenges for waste management systems and increases the risk of contamination.

What Are Sharps?

The term “sharps” refers to medical devices capable of puncturing or cutting the skin.

For people living with diabetes, common sharps include:

- (1) Insulin syringes
- (2) Pen needles
- (3) Lancets used for blood glucose testing
- (4) Continuous glucose monitoring insertion needles
- (5) Infusion sets – tubing systems with a needle used to deliver drugs to the body.
- (6) Connection needles/sets – needles that connect to a tube used to transfer fluids in and out of the body.

These items should always be treated as potentially hazardous after use.



Common Mistakes in Needle Disposal



Many people unknowingly dispose of used needles in unsafe ways. Some common mistakes include:

- (1) Throwing loose needles directly into household trash.
- (2) Disposing of needles in plastic shopping bags.
- (3) Flushing needles down toilets or drains.
- (4) Attempting to bend, break, or cut used needles.
- (5) Leaving used syringes exposed on tables, beds, or countertops.
- (6) Reusing disposable needles multiple times.

These practices significantly increase the risk

of injury and infection.

Risks Associated with Improper Disposal

The dangers of unsafe disposal extend beyond the individual patient.

Needle-Stick Injuries

Accidental needle-stick injuries are among the most common consequences of improper disposal. Such injuries can occur at home, in workplaces, during waste collection, or in healthcare settings.

Risk of Infection

Although not every needle-stick injury results in infection, exposure to contaminated blood can potentially transmit serious diseases.

Harm to Children and Family Members

Improperly discarded sharps can be found and handled by children or other household members, leading to preventable injuries.

Environmental Impact

Medical waste disposed of with regular garbage may contaminate the environment and complicate waste treatment processes.

How to Dispose of Used Needles Safely

The safest method is to place used sharps immediately into a puncture-resistant sharps container after use.

An ideal sharps container should be:

- (1) Made of strong plastic.
- (2) Leak-resistant.
- (3) Puncture-proof.
- (4) Equipped with a secure lid.
- (5) Clearly labeled.

Commercial sharps containers are available at pharmacies and medical supply stores. However, if a commercial container is not available, a thick plastic household container with a secure

Importance of Safe Sharps Disposal

Used needles and other sharps are dangerous to people and pets if not disposed of safely because they can injure people and spread infections that cause serious health conditions. The most common infections are:

- 1) Hepatitis B (HBV),
- 2) Hepatitis C (HCV), and
- 3) Human Immunodeficiency Virus (HIV).

Safe sharps disposal is important whether you are at home, at work, at school, traveling, or in other public places such as hotels, parks, and restaurants.

Never place loose needles and other sharps (those that are not place

Important Steps After Every Injection

- (1) Do not leave the needle exposed after use.
- (2) Place the needle or syringe directly into the sharps container.
- (3) Keep the container out of reach of children and pets.
- (4) Store the container in a safe and dry location.
- (5) Do not overfill the container.

Experts generally recommend replacing the container when it becomes approximately three-quarters full.

Should Needles Be Recapped?

Recapping a needle after use increases the risk of accidental injury. Therefore, routine recapping should be avoided whenever possible. If recapping is absolutely necessary, it should

be performed with extreme caution according to healthcare professional guidance.

Disposal of Lancets

Lancets used for blood glucose monitoring are also considered sharps. Although they are smaller than insulin needles, they can still cause injuries and should be disposed of in the same sharps container.

Many people mistakenly throw lancets into household trash, which is unsafe and should be avoided.

What to Do When the Sharps Container Is Full

Once the sharps container reaches the recommended fill level:

- (1) Close and seal the lid securely.
- (2) Do not attempt to empty the contents.
- (3) Follow local regulations regarding disposal.
- (4) Return the container to designated collection centers if such services are available.
- (5) Seek guidance from healthcare providers or local authorities regarding approved disposal methods.

Since disposal regulations vary by region, patients should familiarize themselves with local recommendations.



Safety During Travel

People with diabetes who travel frequently should plan for safe sharps disposal in advance.

Carry a portable sharps container while traveling. Never leave used needles in hotel rooms, public places, vehicles, or luggage pockets. If traveling by air, carry diabetes supplies according to airline regulations and keep medical documentation available if required.

They should be aware of:

- (1) Proper sharps disposal methods.
- (2) Risks associated with needle-stick injuries.
- (3) Emergency procedures following an accidental injury.
- (4) Safe storage of diabetes supplies.

Education and awareness among family members can significantly reduce preventable accidents.

Building Safe Habits

What to Do After an Accidental Needle-Stick Injury

If someone is accidentally pricked by a used needle:

- (1) Wash the affected area immediately with soap and water.
- (2) Do not squeeze the wound excessively.
- (3) Seek medical advice as soon as possible.
- (4) Inform healthcare professionals about the source of the needle if known.

Prompt medical evaluation is important to determine whether further testing or treatment is needed.

Role of Family Members and Caregivers

Family members and caregivers play an important role in maintaining a safe environment.



Safe sharps disposal should become a routine part of diabetes self-management, just like taking medications, monitoring blood glucose, and maintaining a healthy lifestyle. Developing these habits protects not only the patient but also family members, healthcare workers, sanitation staff, and the wider community.

A few seconds spent disposing of a needle correctly can prevent serious injuries and potential infections. Therefore, every person living with diabetes should make safe sharps disposal a priority and encourage others to do the same.

Remember, managing diabetes is not limited to controlling blood sugar levels. Responsible handling and disposal of used needles, syringes, and lancets is also an essential part of living safely and protecting public health.

PREVENTION FIRST

PRIMARY CARE DIABETES ASSOCIATION |
ANTIMICROBIAL STEWARDSHIP

The Prescription That Shapes Tomorrow's Resistance

An Infectious Diseases Perspective on Antimicrobial Stewardship for Primary Care in Diabetes

**Dr Ifra Nasir, MBBS (AIMC),
FCPS (Medicine), MRCP (UK) Parts 1 & 2**

*Infectious Diseases Fellow, Shaukat Khanum Memorial Cancer
Hospital and Research Centre, Lahore, Pakistan*



Muhammad Rehan Khan, Pharm-D, MPhil (Pharmacology), MS (Health Management and Innovation) *Manager, Health Informatics and Medication Safety, Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore, Pakistan*

Corresponding author: Dr Ifra Nasir

Case in Practice

A 58-year-old man with type 2 diabetes is admitted with community-acquired pneumonia and started on ceftriaxone and azithromycin. By day five he is afebrile, off oxygen, and eating well. His inflammatory markers are falling, and discharge is planned. By every measure that matters, he has recovered.

“Should we continue antibiotics for another five days, just to be safe?”

It is a reasonable question. He has diabetes, he was unwell, and caution feels safe. The temptation is to add a few more days, to treat the discomfort of stopping rather than any sign of ongoing infection. Six questions stand between that instinct and the answer.*

Stewardship Begins Before the Infectious Diseases Consultation

As infectious diseases physicians, we are often consulted late. By the time we arrive, the cultures already grow resistant organisms, and the choices have narrowed to a handful of last-line agents. But the decisions that shaped that resistance were rarely ours. They were made earlier, in the places where most antibiotics are actually prescribed: the clinic, the diabetes practice, the emergency department. Antimicrobial resistance was directly responsible for an estimated 1.27 million deaths worldwide in 2019 and associated with nearly 5 million deaths¹, and the prescriptions that drive it are written far more often in primary care than in any specialist unit. That places the primary care clinician, not the specialist, at the centre of this story.

Your patients with diabetes sit squarely at the heart of it. They are prescribed antibiotics more frequently over the course of their care, and they are among the patients in whom careful prescribing matters most and in whom reflexive prescribing is most common. Stewardship, then, is not a hospital committee or a specialist service. In low- and middle-income settings such as ours, where access, affordability, and resistance pressures collide, it begins with the very first antibiotic prescription, wherever that prescription is written².

Why Every Antibiotic Prescription Deserves a Second Thought

Every antibiotic prescription is more than a decision to start treatment. It is a series of decisions that should be revisited as the patient's condition evolves. Before continuing an antibiotic, every clinician can pause and ask six simple questions³.

Six Questions Every Antibiotic Prescription Must Answer

1. Does this patient truly have a bacterial infection?

The most overused antibiotic is the one given for an infection that was never there. Nowhere is this clearer than in diabetes, where asymptomatic bacteriuria, bacteria in the urine without any symptoms, is common, and a positive urine culture is too often read as a call to treat. Current

guidance is explicit: diabetes alone is not a reason to screen for or to treat asymptomatic bacteriuria⁴. A culture describes the bladder. It does not, by itself, diagnose disease.

Take-home message: *Treat the patient, not the culture.*

2. Am I using the narrowest effective antibiotic?

Broad-spectrum antibiotics, the ones that cover many organisms at once, make sense when a patient is unwell and the cause is unknown. The problem is starting them and never looking back. Once the cultures are back and the patient is improving, de-escalation means tailoring therapy to what you now know: switching to a narrower drug that matches the organism, and stopping any antibiotic that is no longer needed once the culture results are in³. A patient placed on broad cover for a diabetic foot infection rarely needs that breadth once they settle and the culture names the organism.

Take-home message: *Broad-spectrum therapy should always have an exit strategy.*

3. What has changed after 48 to 72 hours?

By two or three days, most of what should reshape a prescription has arrived: the fever curve, the cultures, the patient's trajectory. This is the "antibiotic timeout"³, a deliberate pause to ask whether the diagnosis still holds and whether the drug still fits. De-escalation is safe to consider once three things line up: the patient is improving (stable observations, settling fever, falling markers), reliable culture and susceptibility results are back, and, where it applies, the source of infection has been dealt with. The 48 to 72 hour mark is usually when all three become visible, which is why it is the natural moment for the antibiotic timeout. A patient with diabetes and cellulitis who is clearly improving may be ready to step down to a narrower antibiotic; one who is not may need a different diagnosis, not a broader drug.

Take-home message: *Every antibiotic deserves a reassessment.*

4. Can I stop sooner?

Here we return to our patient. Much of what we were taught about antibiotic duration is tradition, not evidence. The point holds across infection types: a randomised trial in intra-abdominal infection found that a short, fixed course sufficed once the source was controlled⁵, and the pneumonia guidelines support stopping at clinical stability rather than at an arbitrary day count⁶. The instinct to extend therapy because a patient has diabetes rarely survives contact with the data.

Take-home message: *The calendar should not determine antibiotic duration. Clinical recovery should.*

5. Can treatment continue orally?

A patient who is afebrile, improving, and able to swallow seldom needs an injectable antibiotic. In hospital this means switching early from a drip to tablets, which is appropriate for many clinically stable patients, including those with community-acquired pneumonia, while removing the cannula, the cost, and often the reason to stay admitted⁶. The same logic reaches into the clinic: when an oral antibiotic will do the job, an injection adds little but inconvenience and expense. The route should follow the patient's condition, not habit.

Take-home message: *When a patient can take tablets, intravenous therapy has usually done its job.*

6. Is today's dose still the right dose?

The right drug at the wrong dose is still the wrong therapy. In diabetes this cuts both ways. Reduced kidney function, common in long-standing diabetes, means some antibiotics need a lower dose and others are best avoided, yet kidney function is not fixed. It dips during acute illness and recovers afterward, so a dose that was correct at the start may be wrong a few days later. Weight matters too for drugs dosed by size. The dose, like the diagnosis, deserves to be revisited.

Take-home message: *The right antibiotic at the wrong dose is still inappropriate therapy.*

Before You Continue the Antibiotic

Pause for 30 seconds and ask yourself:

- ☐ Does my patient still have a bacterial infection?
- ☐ Am I using the narrowest effective antibiotic?
- ☐ Have new clinical or microbiological data changed my plan?
- ☐ Can treatment be shortened?
- ☐ Can therapy continue orally?
- ☐ Is today's dose still appropriate?

Every prescription deserves a second thought.

Practice Pitfalls: Common Stewardship Errors

- ☐ Treating laboratory results instead of patients.
- ☐ Continuing broad-spectrum therapy after culture results return.
- ☐ Prescribing antibiotics "just in case."
- ☐ Extending treatment out of habit rather than evidence.
- ☐ Missing opportunities to switch from injection to tablets.

Returning to Our Patient

Our patient with diabetes and pneumonia was afebrile, eating, and walking by day five, with inflammatory markers already falling on ceftriaxone and azithromycin. He had responded. For community-acquired pneumonia, guidelines support stopping once a patient reaches clinical stability and has had a long enough course, which for most patients is around five days⁶. His diabetes did not change that. To prescribe another five days would have treated our anxiety, not his infection, adding cost, the risk of side effects, and another nudge toward resistance, with no benefit in return. Five days were enough because he had recovered, and recovery, not the calendar, is the signal to stop.

Every Prescription Leaves a Legacy

Few advances have reshaped medicine as profoundly as antibiotics. Surgery, chemotherapy, transplantation, and the care of premature infants all rest on the assumption that infection can be treated. That assumption is no longer safe. Antimicrobial resistance has become one of the defining health threats of our era, already among the leading causes of death worldwide¹. The World Health Organization places it among the gravest global threats to public health². We do not need to look abroad for the consequences. Since 2016, Pakistan has experienced an outbreak of extensively drug-resistant typhoid, resistant to ceftriaxone, which during the outbreak left azithromycin and the carbapenems among the remaining effective treatment options, turning an infection that was once routinely cured by oral antibiotics into one that can defeat first-line therapy⁷. Resistance is not the product of any single failure. It is the cumulative result of millions of individual prescribing decisions, each reasonable on its own, each nudging bacteria a little further toward adapting, until, multiplied across clinics and countries, the microbial world is reshaped. This is why stewardship cannot be delegated to a committee or a guideline alone. It lives in the ordinary choices clinicians make every day.

It is also worth saying plainly what stewardship is not. It is not rationing, and it is not the withholding of treatment from patients who need it. It is the discipline of giving the right drug, at the right dose, for the right duration, which is simply good medicine. Our recovering patient with pneumonia did not need five more days. He needed a clinician willing to ask whether the prescription still served him. **Every prescription shapes tomorrow's resistance.**

** The patient described is an illustrative composite and does not represent an identifiable individual.*

Acknowledgement

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How Breathing Exercises Help in the Primary Care Management of Diabetes

Yogi Wajahat
Corporate Wellness Trainer
Executive Member DEW (Diet & Education Wing) PCDA

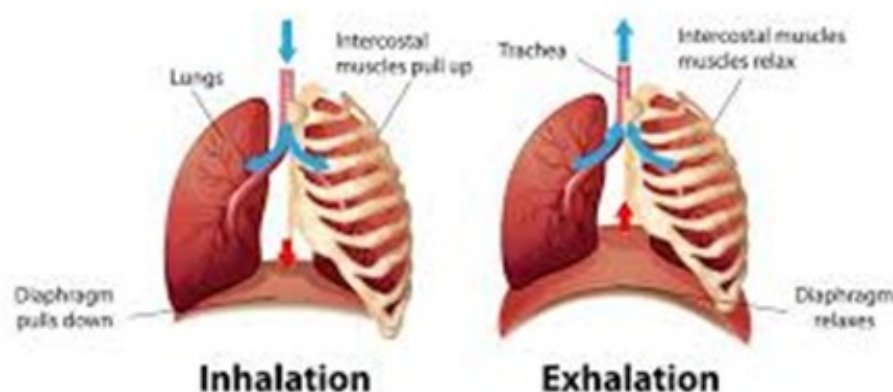


Diabetes mellitus is one of the leading chronic diseases worldwide. While pharmacological treatment remains essential, lifestyle interventions play a crucial role in improving outcomes. Among these interventions, breathing exercises have gained attention due to their beneficial effects on both physical and mental health.

Stress is a recognized contributor to poor glycemic control. Elevated levels of stress hormones such as cortisol and adrenaline can increase blood glucose levels and worsen insulin resistance. Breathing exercises offer a practical method for managing stress and promoting physiological balance.

Physiological Effects of Breathing Exercises

THE DIAPHRAGM FUNCTIONS IN BREATHING



Controlled breathing techniques stimulate the parasympathetic nervous system, commonly known as the "rest-and-digest" response. This reduces sympathetic overactivity, lowers heart rate, and decreases blood pressure.

Deep diaphragmatic breathing improves oxygen delivery to tissues and enhances cellular metabolism. Slow breathing practices may also improve heart rate variability, an indicator of healthy autonomic nervous system function. Better autonomic regulation has been linked with improved metabolic control in people with diabetes.

Impact on Blood Glucose Control

Although breathing exercises do not directly replace physical activity or medication, they may indirectly support glycemic control by reducing stress-related hyperglycemia. Several studies have

demonstrated that regular practice of yogic breathing techniques can lead to modest reductions in fasting blood glucose and HbA1c levels when combined with standard diabetes care. Stress reduction achieved through breathing exercises may decrease cortisol secretion, thereby reducing insulin resistance and improving glucose utilization.

Psychological Benefits

People living with diabetes frequently experience anxiety, depression, and emotional distress related to disease management. Breathing exercises promote relaxation, improve mood, and enhance emotional resilience.

Improved mental well-being often translates into better adherence to medication, dietary recommendations, and physical activity programs, resulting in more effective diabetes self-management.

Practical Recommendations for Primary Care

Primary care practitioners can encourage patients to practice simple breathing exercises for 10–20 minutes daily. Common techniques include:

- Diaphragmatic (abdominal) breathing

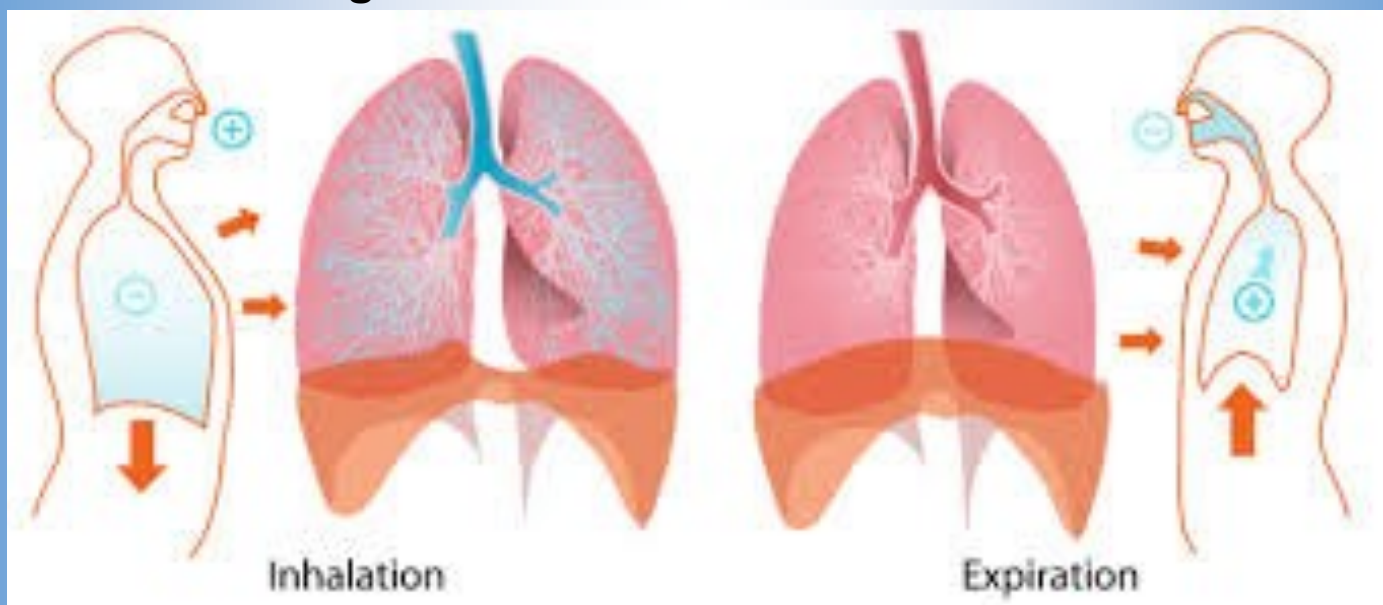
Deep slow breathing

These techniques can be safely practiced by most patients and require no special equipment.

Diaphragmatic (Abdominal) Breathing:

Sit or lie comfortably with one hand on your chest and the other on your abdomen. Inhale slowly through your nose, allowing your abdomen to rise while keeping your chest relatively still. Exhale gently through your nose or mouth, letting your abdomen fall. Continue for 5–10 minutes, focusing on slow, deep, and relaxed breathing.

Deep Slow Breathing:



Sit upright in a comfortable position. Inhale slowly through your nose for about 4–5 seconds, allowing your lungs to fill completely. Pause briefly, then exhale gently through your nose or mouth for 5–6 seconds. Maintain a smooth, steady rhythm without strain. Practice for 5–10 minutes to promote relaxation and reduce stress.

Heat-Smart Diabetes Care -

What you must know this Summer

Blood glucose monitoring, hydration and medication safety — a primary care guide

Summer is here — and for people living with diabetes, the heat brings more than just discomfort. Rising temperatures can quietly disrupt blood glucose levels, damage medications, and in serious cases, trigger a medical emergency. The good news is that with a little awareness and some simple habits, most heat-related problems are entirely preventable. As a pharmacist, I want to walk you through what you really need to know this season.

Why heat hits harder when you have diabetes

When the body gets too warm, it cools itself down by sweating and sending more blood to the skin. For many people with diabetes — particularly those with nerve damage (neuropathy) or poor circulation — this system does not work as well as it should. The result is that the body struggles to cool itself, and the risk of overheating rises faster than it would for someone without diabetes.



Hashir Mubeen
Executive member
DEW (Diet And
Education Wing)
PCDA Pakistan



Heat also makes you sweat more and lose fluid faster. When you become dehydrated, blood glucose tends to rise — and when glucose is high, the kidneys try to flush it out, causing even more fluid loss. This cycle can escalate quickly. In severe cases, dehydration can precipitate a dangerous condition called hyperosmolar hyperglycaemic state (HHS), more common in type 2 diabe-

tes. In people who rely on insulin, heat-related illness, vomiting, or missed doses can increase the risk of diabetic ketoacidosis (DKA) — driven by insulin deficiency, not dehydration alone. Both are medical emergencies requiring urgent hospital treatment.

glucose first before assuming it is just the weather. If readings are unexpectedly low or high, or you are unable to keep fluids down, contact your healthcare provider early rather than waiting.

SUN SAFETY FOR THOSE WITH DIABETES



Heat can make blood glucose unpredictable

One of the trickier aspects of hot weather is that it can push glucose levels in either direction. Some people find their levels creep up as they become less active and more dehydrated. Others — particularly those on insulin — may find that heat speeds up how quickly insulin is absorbed from an injection site, leading to unexpected **low blood glucose (hypoglycaemia)**.

This matters because the symptoms of hypoglycaemia — dizziness, sweating, confusion, and weakness — overlap almost exactly with the signs of heat exhaustion. If you are feeling unwell in the heat, **always check your blood**

Your medicines need protection too

Insulin is the obvious one — but it is far from the only medicine that needs extra care in the heat.

Insulin must be kept out of direct sunlight and away from high temperatures at all times. Unopened vials and pens should be refrigerated between 2–8°C. Once in use, most insulins can be stored at room temperature (generally below 25–30°C) for around 28 to 42 days, depending on the specific product — always check the label or ask your pharmacist. Here is something many people do not realise: **heat-damaged insulin can look completely normal** — no cloudiness, no change in colour —

but still have lost much of its effectiveness. If your insulin has been left in a hot car, a bag in direct sun, or anywhere it may have overheated, discard it and start a fresh supply. Do not take the risk. In areas with unreliable electricity, keep unopened insulin in a cool, damp cloth wrap or a clay pot with water as a short-term measure until proper refrigeration is available.

Beyond insulin, several other medicines deserve attention in hot weather.

vomiting or unable to keep fluids down, contact your provider before continuing it.

Diuretics and blood pressure medicines can worsen fluid loss and cause dizziness on standing.

Some **antihistamines and antidepressants** with anticholinergic effects reduce the body's ability to sweat, raising heat stroke risk.

GLP-1 receptor agonists like semaglutide and li-



SGLT2 inhibitors such as dapagliflozin and empagliflozin already cause extra fluid and glucose loss through urine — in the heat, this compounds dehydration and can, rarely, trigger a form of DKA even when blood glucose appears near-normal. Warning signs include nausea, vomiting, rapid breathing, or feeling very unwell despite a seemingly normal glucose reading — seek medical help promptly if these develop.

Metformin should be used with caution in severe dehydration or heat illness, as impaired kidney function in these situations can rarely increase the risk of lactic acidosis — if you are

raglutide are just as temperature-sensitive as insulin and need the same careful storage. If you are unwell, vomiting, or unable to keep fluids down, follow your sick-day guidance and reach out to your healthcare provider early. If unsure about any of your medicines, your pharmacist is the best person to ask.



Staying hydrated — the right way

Drinking enough water is the single most effective thing you can do to protect yourself in the heat — but there are a few things worth knowing. Do not wait until you are thirsty; thirst is already a sign of mild dehydration. A simple and reliable guide is the colour of your urine — pale straw is where you want to be; dark yellow means drink more.

For most people, water is the best choice. If you have been sweating heavily, vomiting, or have had diarrhoea, an **oral rehydration solution** is better than a sports drink, which can carry more sugar than you need. One important note: if you have kidney disease or heart failure, you should not simply increase your fluids without checking with your doctor or pharmacist first — extra fluid can be harmful in these conditions.

Simple things that make a big difference

Check your blood glucose more often than usual during hot weather, especially if you are outdoors, travelling, or have been more active. Wear loose, light clothing, a wide-brimmed hat, and sunscreen, and plan outdoor activities for the cooler parts of the morning or evening. Never leave your insulin, glucose meter, or any medication inside a parked car — temperatures inside a vehicle can reach dangerous levels within minutes.

If you have diabetic neuropathy, **always wear shoes outdoors** — reduced sensation in the feet means you may not feel a burn from hot pavement, sand, or tarmac until real damage has been done. Keep fast-acting glucose, water, and someone's contact number with you whenever you head out.

Knowing when to act

Heat exhaustion — heavy sweating, weakness, dizziness, headache, nausea, cramps — is a warning that the body is struggling. Move to a cool place, rest, and drink fluids. This usually resolves with prompt action.

Heat stroke is different — it is a medical emergency. If someone becomes **confused, loses consciousness, has a seizure, or stops sweating despite extreme heat**, call for emergency help immediately and begin active cooling — remove excess clothing, apply cool water to the skin, and fan the person while waiting for help to arrive. Do not wait to see if it passes. Heat stroke can cause permanent organ damage or death if treatment is delayed.

Hot weather should not stop anyone with diabetes from living fully and staying active. It just asks for a little more preparation.

Keep your medicines safe, keep yourself hydrated, check your glucose, know the warning signs — and if you are ever unsure about how the heat might be affecting your medications, do not hesitate to speak to your pharmacist. That is exactly what we are here for.



Avoid Keeping your diabetes medicines, Insulins or GLP's in a hot vehicle



PCDA
Pakistan

Member of
International
Diabetes
Federation
(IDF)

Cordially Invites you to

IDF Congress 2027

Singapore 10-12 April 2027

- 3-day congress
- 9 programme streams
- 7 parallel sessions
- 110 hours of scientific sessions
- 200 leading international speakers
- 1000 e-posters
- An expected 17 CME credits
- 5000 sq exhibition with diabetes spotlight

After extensive and thoughtful consideration of the evolving regional context in the Gulf and the wider Middle East, and its potential implications for international participation and global gatherings, the International Diabetes Federation (IDF) has made the difficult decision to postpone the IDF Congress in Qatar.

The IDF Congress 2027 will now take place in **Singapore from 10-12 April 2027**.

This decision reflects our responsibility to ensure a safe, accessible, and rewarding experience for all participants, partners, speakers, exhibitors, and stakeholders across the international diabetes community.



Registration

July 2026:
Registration opens

31 October 2026:
Early rate deadline



Abstracts

15 June - 15 August 2026:
Abstract submission

21 October 2026:
Abstract selection notification

Review of the First Podcast Session – "ECG Made Easy"



By. Dr. Hira Sabih Baqai
Head of PCDA Women's Forum



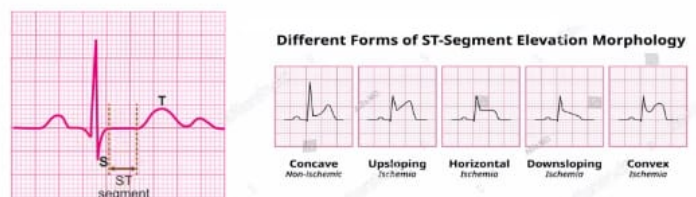
The first session of the PCDA Women Wing Podcast Series, "ECG Made Easy," was successfully conducted on 16th June 2026 with an overwhelming response from healthcare professionals.

With cardiovascular diseases on the rise and an increasing number of cardiac emergencies presenting in both outpatient departments (OPDs) and emergency rooms, the ability to accurately interpret an ECG has become an essential clinical skill for every practicing physician. Early recognition of ECG abnormalities enables timely diagnosis, appropriate referral, and improved patient outcomes. Keeping this need in mind, the PCDA Women Wing organized this educational session to help refresh and strengthen the ECG interpretation skills of practicing doctors.

The session was expertly moderated by Dr. Hira Baqai, Head of the PCDA Women Wing, who welcomed the participants and highlighted the importance of continuous medical education in improving patient care.

The guest speaker, Dr. Asad Baqai, Consultant Cardiologist, delivered an engaging and highly informative lecture. He explained the fundamental principles of ECG interpretation in a simple, practical, and easy-to-understand manner. The session covered the essential basics of ECG reading, helping participants clear many of the common misconceptions and confusions encountered in daily clinical practice. His interactive teaching style made complex concepts easier to grasp and encouraged active participation from the audience.

ST SEGMENT MORPHOLOGY



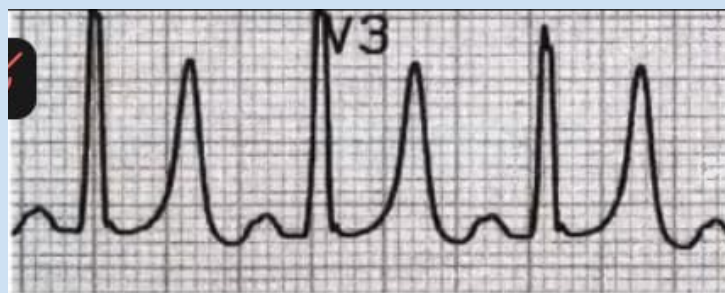
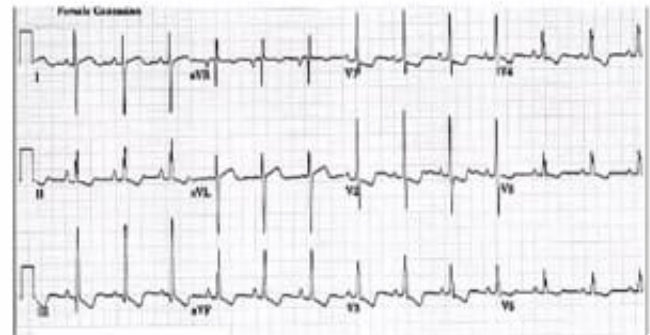
The webinar was attended by a large number of doctors from various specialties, reflecting the growing interest in strengthening clinical skills related to cardiovascular care. Participants appreciated the practical approach of the session and found it highly relevant to their day-to-day practice.

QRS complex height abnormalities

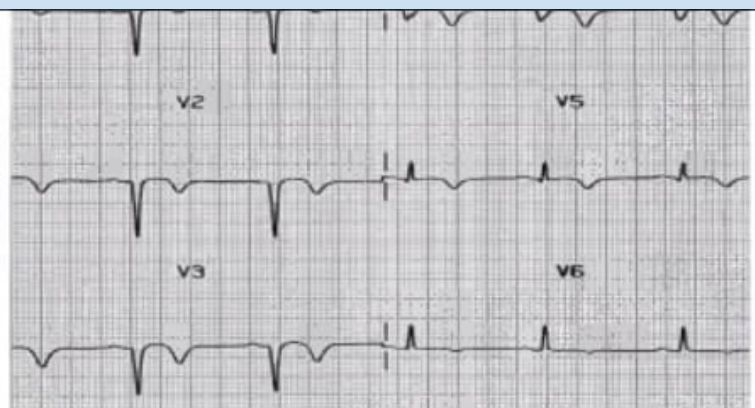
RIGHT VENTRICULAR HYPERTROPHY

R WAVE IN V1 > 7 mm or R/S Ratio > 1

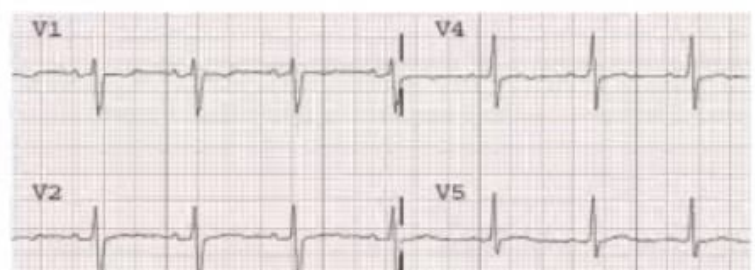
S WAVE IN V5 OR V6 > 7 mm or R/S Ratio < 1



Biphasic T waves



Flattened T waves



The successful completion of this inaugural podcast session marks the beginning of an educational initiative by the PCDA Women Wing aimed at enhancing the knowledge and confidence of healthcare professionals through regular academic activities. We extend our sincere gratitude to Dr. Asad Baqai for sharing his expertise and to all the participants for making the session a great success.

Prevention First Newsletter-Online

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