

Prevention First

September'26, Issue-37, Volume-2, Total Pages-50 In-charge: Dr. Shahid Akhter

Prof. Abdul
Basit
Awarded

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Editorial

Continuing the Journey of Prevention, Education & Collaboration

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It gives me immense pleasure to welcome our readers to the **37th issue of PFN-Online**, the official monthly online newsletter of the Primary Care Diabetes Association (PCDA) Pakistan.

The publication of our 36th issue—the 3rd Anniversary Special Issue of PFN-Online was a particularly memorable milestone. Reaching three years of uninterrupted monthly publication has been possible only through the continued encouragement, trust, and active participation of our members, colleagues, contributors, and readers.

On this occasion, I would like to extend my **heartfelt gratitude to all those who contributed articles, messages, photographs, reports, and other valuable material** to the 3rd Anniversary Issue. Your contributions not only enriched the special issue but also reflected the diversity, dedication, and professional commitment of the PCDA family. Every article, message, report, and expression of goodwill added meaning to this important milestone and helped us celebrate the journey of PFN-Online.

I would also like to express my sincere appreciation to the distinguished **Editorial Board of PFN-Online** for their continued commitment, valuable time, editorial guidance, and tireless efforts. Behind every issue is a considerable amount of work—from planning and soliciting content to reviewing, editing, designing, compiling, and finally bringing the issue to our readers. The consistency and quality of PFN-Online are a reflection of this collective effort.

Over the past three years, PFN-Online has evolved into more than simply a newsletter. It has become a platform for **sharing knowledge, highlighting PCDA activities, recognizing professional contributions, promoting diabetes prevention, and connecting our members across Pakistan and beyond**. Through its pages, we continue to share experiences from our chapters, regions, wings, educational programs, screening activities, CMEs, community initiatives, and professional achievements.

As we enter our **fourth year**, our commitment remains firmly aligned with the PCDA vision of **“Prevention First.”** We hope to make PFN-Online even more informative, engaging, inclusive, and relevant to healthcare professionals working in primary care and diabetes care.

Let us continue this journey together—with knowledge, collaboration, compassion, and an unwavering commitment to preventing diabetes and improving the lives of people living with diabetes.

My sincere thanks to every member of the Editorial Board, and every reader who has supported PFN-Online throughout this journey.

Let us move forward together into another year of **learning, sharing, inspiring, and transforming lives through Prevention First.**

Dr. Shahid Akhter

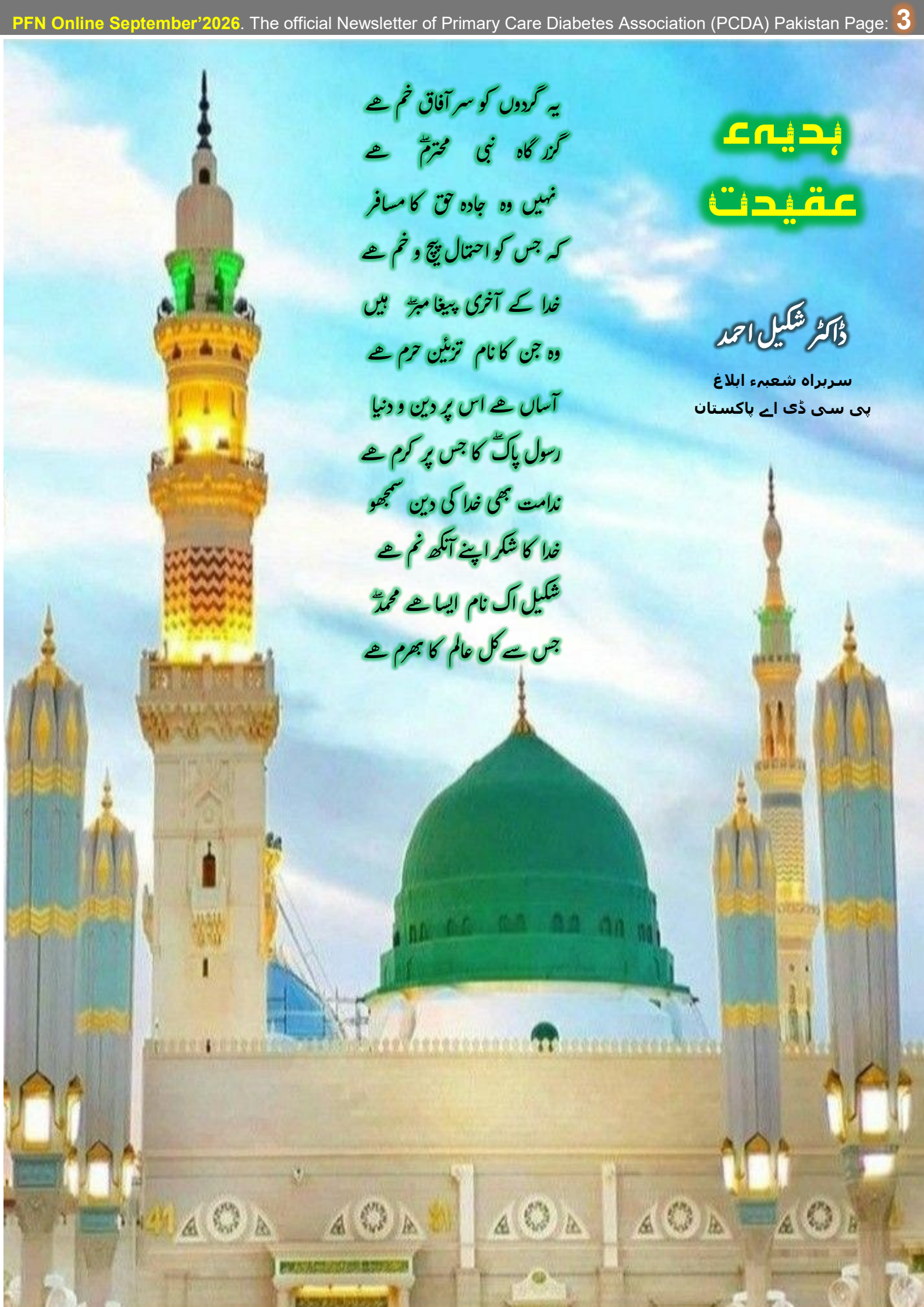
In-charge, PFN-Online

ہدیہ عقیدت

ڈاکٹر شکیل احمد

سربراہ شعبہ ابلاغ
پی سی ڈی اے پاکستان

یہ گردوں کو سر آفاق خم ہے
گزر گاہ نبی محترمؐ ہے
نہیں وہ جاہد حق کا مسافر
کہ جس کو احتمال پیچ و خم ہے
خدا کے آخری پیغامبرؐ ہیں
وہ جن کا نام تزئین حرم ہے
آساں ہے اس پر دین و دنیا
رسول پاکؐ کا جس پر کرم ہے
ندامت بھی خدا کی دین سمجھو
خدا کا شکر اپنے آنکھ نم ہے
شکیل اک نام ایسا ہے محمدؐ
جس سے کل عالم کا بھرم ہے



PCDA Strengthens Primary Care Skills in Diabetic Foot Management

Interactive Educational Session on:

“How to Manage Diabetic Foot at Primary Care”

North Karachi | 11 September 2026



In line with its commitment to strengthening diabetes care at the primary healthcare level, PCDA Pakistan organized an engaging educational lecture for primary care physicians on “How to Manage Diabetic Foot at Primary Care” on 11 September 2026 at Essa Laboratory, North Karachi Branch.

The session was arranged by Dr. Shakeel Ahmed on behalf of PCDA Pakistan and brought together physicians from North Karachi and surrounding areas for an interactive learning experience focused on one of the most important and potentially preventable complications of diabetes.

From Knowledge to Practical Skills

The educational session emphasized the crucial role of primary care physicians in the early identification, assessment, prevention, and initial management of diabetic foot problems. The discussion covered practical aspects of diabetic foot care, including:

- ♦ Early identification of high-risk feet
- ♦ Systematic diabetic foot examination
- ♦ Assessment of diabetic foot wounds and ulcers
- ♦ Basic principles of wound care and hygiene
- ♦ Recognition of infection and warning signs
- ♦ Importance of off-loading and pressure reduction
- ♦ Patient education and self-care
- ♦ Timely referral of complicated or high-risk cases



The interactive nature of the session enabled participants to discuss real-world clinical situations and challenges frequently encountered in primary care practice.

KEY HIGHLIGHTS

Educational Lecture: “How to Manage Diabetic Foot at Primary Care”

Date: 11 September 2026

Venue: Essa Laboratory, North Karachi Branch

Organized by: PCDA Pakistan

Arranged by: Dr. Shakeel Ahmed

Participants: Primary Care Physicians from North Karachi and surrounding areas

Format: Interactive clinical learning session



Participants Gain Confidence

The participating physicians appreciated the practical and clinically relevant approach of the session. At the conclusion of the program, participants expressed that the lecture had updated their knowledge and enhanced their confidence in assessing and managing diabetic foot problems at the primary care level.

The participants also expressed interest in continuing this type of skills-based learning through future PCDA educational activities. A particular interest was shown in organizing a practical workshop on “Wound Hygiene”, with greater emphasis on hands-on wound-care techniques and appropriate dressing practices.

Such follow-up workshops can further bridge the gap between theoretical knowledge and practical clinical skills, enabling physicians to provide safer and more effective care to people with diabetes.

Looking Beyond the Lecture

Diabetic foot complications often begin with seemingly minor problems that can progress rapidly when not recognized and managed appropriately. Empowering primary care physicians with the right knowledge and practical skills can therefore play a vital role in preventing ulcers, reducing infections, preserving limbs, and improving the quality of life of people living with diabetes.



PCDA Pakistan remains committed to taking diabetes education beyond conventional academic settings and bringing practical, accessible and clinically relevant learning opportunities to healthcare professionals in their communities.

The North Karachi session is an encouraging example of how focused educational initiatives can help strengthen the frontline response to diabetic foot disease.



PCDA Prevention First

Prevention First — Because Diabetes Is Better Prevented Than Suffered.

Through continued physician education, early screening, patient awareness, appropriate foot care, and timely intervention, PCDA Pakistan is working to make prevention and complication avoidance an integral part of diabetes care.

Educate • Empower • Prevent • Preserve Limbs





Heartiest congratulations to

Prof. Abdul Basit

on being honored with the Distinguished

Health Researcher Award

**at the 3rd National Health Awards,
organized by the Ministry of National Health
Services and Health Asia.**

**A truly proud and well-deserved moment
for his family, colleagues, and entire team.**

*This recognition reflects his outstanding and
lifelong contributions to
health research and diabetes care.*





HEARTIEST CONGRATULATIONS



Heartiest Congratulations
to

Prof. Abdul Basit

on being awarded the **Honorary Fellow of the
College of Physicians and Surgeons (CPSP)***

in recognition of his outstanding contributions
to healthcare and diabetes services across Pakistan.

A truly remarkable and well-deserved achievement!



Director
Indus Diabetes &
Endocrinology Centre IHNN



Secretary General
Diabetes Association of Pakistan



Chairman
Health RAB



President
Diabetes in Asia Study
Group

*Your leadership and dedication
continue to inspire us all.*



Obesity, Metabolism & Diabetes

The Triple Epidemic



PCDA PAKISTAN

cordially invites you to attend

DIABETES PAKISTAN 2026

4th International Conference of Diabetes & Related Complications



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FRIDAY - SATURDAY



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WHY ATTEND?



Global faculty from
UK, UAE &
Saudi Arabia



National leaders in
Diabetes, Endocrinology
& Cardiology



Hands-on
pre-conference
workshops



Scientific sessions
case-based
discussions

Poster presentations
& networking

KEY SCIENTIFIC THEMES



Primary Care
Diabetes



Obesity
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Diabetic
Foot



Technology In
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The secrets of the world's most prescribed diabetes drug are finally being unlocked.

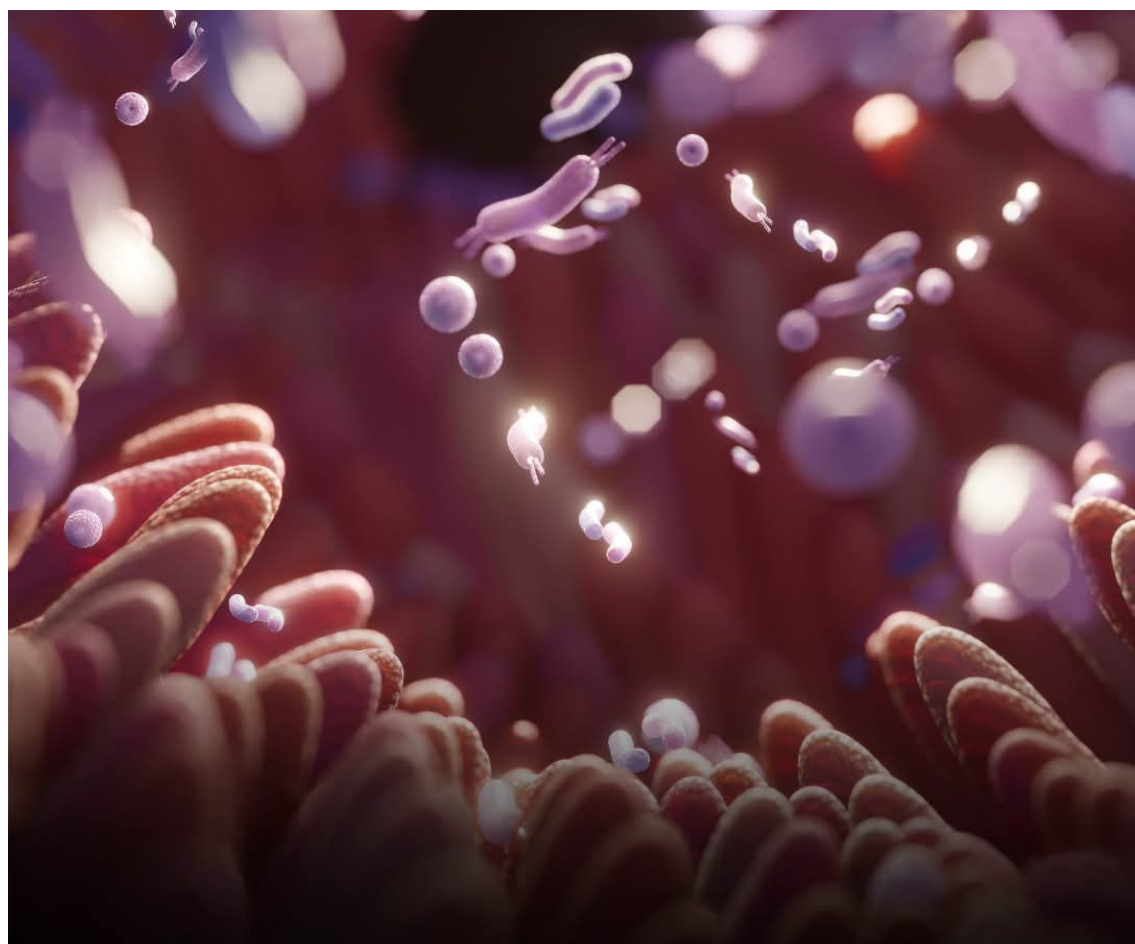
Posted by: **Dr. Altaf Ahmed Cheema (Lahore Chapter)**

For over 60 years, metformin has served as the first-line defense against type 2 diabetes, helping millions manage blood sugar levels worldwide.

Yet, despite its widespread use, scientists never fully understood the precise mechanism behind its therapeutic power. Recent groundbreaking studies have shattered long-held beliefs that metformin primarily targets the liver. In 2026, researchers at Northwestern University revealed that the drug acts directly on the gut, forcing intestinal cells to consume excess glucose and pull it out of the bloodstream.

Concurrently, a pioneering study from the Baylor College of Medicine published in Science Advances has uncovered a previously hidden brain-based pathway. Researchers found that even minuscule doses of metformin can suppress a protein called Rap1 in the hypothalamus, activating key neurons that regulate blood sugar levels. Unveiling these multifaceted gut and brain mechanisms not only explains the drug's profound efficacy but also opens the door to next-generation, highly targeted diabetes treatments and potential anti-aging therapeutics.

source: Lin, H. Y., Lu, W., & Fukuda, M. (2025). Low-dose metformin requires brain Rap1 for its antidiabetic action. Science Advances



**POPULAR DRUG
METFORMIN TRANSFORMS
YOUR GUT INTO A SUGAR
SINK**

The Pause Before the Prescription



Diagnostic and Antibiotic Stewardship in the Diabetes Clinic

Reported By:

Dr. Ifra Nasir

PCDA Lahore Chapter

Dr. Ifra Nasir, Infectious Diseases Fellow; Dr. Faisal Sultan, Consultant in Infectious Diseases; Dr. Summiya Nizamuddin, Consultant Microbiologist

In one minute

Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore, Pakistan

Ask what a positive culture would change before you send it. Do not treat bacteriuria without urinary symptoms. Diagnose foot infection by looking, not by swabbing. Give the narrowest agent that fits, at a dose adjusted for renal function, with a stop date and a review point.

Most antibiotic decisions in diabetes are made in a ten-minute consultation

Bacterial antimicrobial resistance was associated with 4.95 million deaths worldwide in 2019 and directly attributable to 1.27 million, with the heaviest burden falling on low- and middle-income countries, and projections show the toll continuing to rise to 2050.^{1,2} We tend to picture that problem in an intensive care unit, with a carbapenem-resistant organism on the report. But much of that pressure builds far earlier, in rooms like the one you will be sitting in on Monday morning, with a queue outside, a patient who wants to feel better, and a prescription pad.

Outpatient prescribing carries much of that weight. In a study of 2016 prescription records from 32 public primary healthcare centres in Punjab, 79.2 per cent of outpatient prescriptions contained an antimicrobial, and only 16.4 per cent of outpatient antimicrobial use met the study's criteria for appropriate prescribing.³ These data are not nationally representative, but they illustrate the scale of the stewardship challenge in our own setting.

People living with diabetes feel this more than most. They come back more often with fever, with a foot that will not heal, with burning on passing urine. A patient may accumulate repeated antibiotic courses over years of care. Each course may shift the organisms that patient carries, and that shift can matter on the day they are seriously ill. Stewardship in the diabetes clinic is not a hospital habit borrowed for the newsletter. It is a form of long-term care for someone you will still be seeing in ten years.

Diagnostic stewardship comes before antibiotic stewardship

Stewardship starts with the test, not the drug. The right test, in the right patient, at the right moment, with some idea of what each result will lead to. A test sent without that thought is not neutral: it produces a result, and a result produces a prescription, often by a different doctor, days later, on the phone.

Ask what a positive report would change. If the honest answer is nothing, do not send it. If it would change the antibiotic, collect it properly and, wherever feasible, before the first dose, since prior therapy can reduce yield. If treatment has already started, an indicated culture should still be sent when the result could influence what you do next.

The most useful pause in the consultation is the one before you sign the culture request.

The urine culture is the commonest trap in diabetes

Asymptomatic bacteriuria is common in people with diabetes, particularly women, and the Infectious Diseases Society of America recommends against screening for it or treating it in non-pregnant adults with diabetes.⁴ Treatment has not been shown to reduce subsequent symptomatic urinary infection, including pyelonephritis. It still carries real harms: adverse drug effects, *Clostridioides difficile* infection, and the selection of antimicrobial resistance that matters the next time that patient is ill.

Cloudy urine, strong-smelling urine, and pyuria on dipstick are not indications to treat.

Pyuria alone does not diagnose urinary tract infection, although its absence makes bacterial infection less likely in many clinical contexts. Culture and treatment should be reserved for a clinically compatible urinary syndrome, once alternative explanations have been considered. Frequency may be osmotic diuresis from hyperglycaemia. Urgency may be long-standing and neuropathic. Dysuria in a woman may be vulvovaginitis or candidiasis. Once a compatible syndrome is present, the decision to culture is guided by severity, recurrence, prior resistant isolates, recent antibiotic exposure, renal or urological abnormality, and local guidance.

The recognised exceptions, in which screening and treatment are recommended, are pregnancy and the period before an endoscopic urological procedure associated with mucosal trauma.⁴ The objection raised in clinic is that autonomic neuropathy, incomplete emptying, and prior instrumentation make bacteriuria more likely here. That is exactly right, and it is why the discipline matters: the higher the background colonisation, the more often a reflex culture returns something, and the more often that something is treated for no gain.

The foot: look first, swab last

Diabetes-related foot infection is a clinical diagnosis, made on local or systemic signs of inflammation and graded clinically.⁵ A culture report does not make the diagnosis, and an ulcer that is not clinically infected does not need antibiotics, however alarming the organism on the form. Every chronic wound is colonised. Treating colonisation converts a wound-care problem into a resistance problem and leaves the ulcer exactly where it was.

When culture is indicated, the specimen decides the value of the result.

Superficial swabs of an undebried ulcer correlate poorly with deep tissue and over-report skin flora and contaminants; tissue obtained by curettage or biopsy after cleansing and debridement is far more informative.^{5,6} C-reactive protein, ESR, or procalcitonin may help when the clinical examination for soft tissue infection is equivocal or difficult to interpret; where osteomyelitis is suspected, they belong alongside the probe-to-bone test and plain radiographs rather than on their own.⁵ Antibiotics are only one part of the work: healing also depends on debridement, pressure offloading, vascular assessment, wound care, and metabolic management.

Coughs, colds, and a rising blood sugar

Most acute cough, coryza, and sore throat is viral, and diabetes does not change that. What diabetes changes is the threshold for review, for safety-netting, and for looking harder at the patient who looks unwell. Hyperglycaemia during an intercurrent illness tells you something is going on, but it is not specific to bacterial infection, and it is a reason to tighten glucose monitoring rather than to add an antibiotic. A clear plan for review is usually worth more to that patient than an empiric prescription.

When an antibiotic is genuinely indicated

Aim for the narrowest agent that adequately covers the likely pathogens, judged by syndrome and severity, local resistance patterns, the patient's previous cultures, recent antibiotic exposure, allergy, renal function, and risk of complications. The WHO AWaRe framework is a helpful lens here: it classifies agents such as amoxicillin, co-amoxiclav, nitrofurantoin, and doxycycline as Access, and third-generation cephalosporins, fluoroquinolones, and macrolides as Watch, whose use should be more selective.⁷ It is a stewardship and monitoring tool, not a substitute for diagnosis-specific guidance: not every Access drug is right, and not every Watch drug is wrong. A longitudinal hospital survey in Lahore found that 70.3 per cent of patients received at least one inappropriate antimicrobial, with cephalosporins extensively and frequently inappropriately prescribed.⁸

Fluoroquinolones deserve particular thought in this clinic. Beyond tendinopathy, peripheral neuropathy, aortic events, and QT prolongation, they carry a metabolic hazard specific to our patients. In a population-based observational cohort of more than 78,000 patients with diabetes, oral fluoroquinolone use was associated with higher rates of both hyperglycaemia and hypoglycaemia severe enough to need emergency care or admission, with moxifloxacin carrying the highest risk and the hypoglycaemia risk greater in those on insulin.⁹ This is association rather than proof of causation, and it does not make fluoroquinolones forbidden. It does mean that in a patient on a sulfonylurea or insulin, particularly with renal impairment, the risk deserves a moment's thought and a word to the patient.

Check the dose against renal function, and write a duration on every prescription.

Chronic kidney disease is common in long-standing diabetes, and doses should not be assumed. For many uncomplicated community infections, evidence-based shorter courses work and reduce exposure, but duration remains syndrome-specific and should be extended only where severity, inadequate source control, complications, or a slow response justify it. An unwritten duration almost always becomes a longer one.

The 48 to 72 hour question

De-escalation sounds like a hospital word, but the logic is the same in clinic. If you sent a culture, somebody must look at it, and the plan should change when the report allows something narrower or nothing at all. If you sent nothing and the patient is no better, the right response is to revisit the diagnosis rather than to widen the spectrum. Fixing that review point at the time of prescribing, whether a call or a visit, is what turns an empiric decision into a reviewed one.

Refer the same day, do not prescribe and wait

Suspected sepsis. Diabetic ketoacidosis or hyperosmolar state. Rapidly progressive or crepitant soft-tissue infection. A foot infection complicated by extensive gangrene, suspected deep abscess, necrotising features, or severe limb ischaemia. Pyelonephritis with vomiting or haemodynamic compromise. Any patient unable to tolerate oral treatment. Exposed or probe-detectable bone should prompt assessment for osteomyelitis and timely specialist referral rather than emergency transfer on its own. Recognising these quickly is as much a part of good antibiotic practice as withholding an unnecessary course.

A quick reference for the consultation

Ian clinic	Skip	Do instead
Bacteriuria, no symptoms	Culture and antibiotics	Leave it alone; look for another cause of the symptom that prompted the test
Cloudy urine or pyuria alone	Treating the dipstick	Ask for a compatible urinary syndrome first
Ulcer with no inflamma-	Swab and treat	Wound care, offloading, vascular
Foot infection needing culture	Surface swab of an un-debrided ulcer	Curettage or tissue after cleansing and debridement
Cough, coryza, high sugars	Empiric antibiotic for the sugar reading	Tighter glucose monitoring and a stated review point
An antibiotic is indicated	Broadest agent to hand	Narrowest agent that covers the likely pathogens, with a stop date

Five habits worth carrying into Monday's clinic

1. Ask what a positive result would change before ordering any culture. If nothing, do not send it.
2. Collect indicated cultures before the first dose where feasible, and from the right site.
3. Do not treat asymptomatic bacteriuria in a non-pregnant patient with diabetes, however impressive the report.
4. Diagnose foot infection clinically, and sample deep tissue after debridement rather than swabbing the surface.
5. Write the indication, the renally adjusted dose, and the stop date on every antibiotic prescription.

None of this needs new technology or a formal stewardship committee. It needs a pause between the symptom and the specimen, and another between the specimen and the prescription. In a specialty where we see the same faces for years, those two pauses compound quietly in the patient's favour. The antibiotic you did not give today is the one that still works on the day they truly need it.

This is a narrative practice commentary written for general practitioners and diabetologists seeing patients in the outpatient clinic. It is not a comprehensive infection management guideline, and empiric choices should always be checked against local antibiograms and national or institutional prescribing guidance.

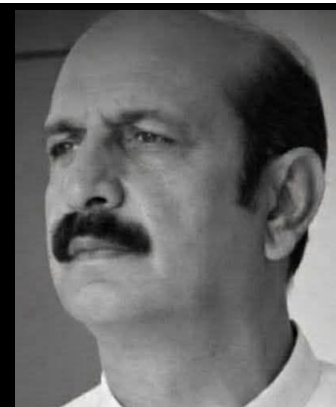
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Obituary

إِنَّا لِلَّهِ وَإِنَّا إِلَيْهِ رَاجِعُونَ

The younger brother of Dr. Shehzad Tahir,
Head of Islamabad Chapter, PCDA Pakistan,
Mr. SHAHID MEHMOOD
passed away recently in Saudi Arabia



Team PCDA and PFN-Online extend their heartfelt condolences to Dr. Shehzad Tahir and his bereaved family on this great loss. May Allah Almighty forgive the departed soul, grant him the highest place in Jannat-ul-Firdous, shower him with His infinite mercy, and grant the family strength, patience, and courage to bear this irreparable loss.

Ameen!

The Fire We Keep Ignoring



By:

Dr. Aftab Ahmed Khan
Family Physician and Public Health Expert



For decades, public debate has focused on nicotine. As physicians, we know the greatest danger begins when tobacco burns. That distinction is more than a matter of scientific precision. It lies at the heart of why smoking remains one of Pakistan's leading preventable causes of disease and premature death.

Every day, physicians treat patients living with chronic obstructive pulmonary disease, cardiovascular disease, stroke and multiple forms of cancer linked to years of smoking. While nicotine is the substance that sustains addiction, it is the smoke produced through the combustion of tobacco that exposes smokers to the overwhelming majority of the toxic chemicals responsible for smoking-related disease.

When a cigarette burns, it of more than 7,000 chemicals known to cause cancer. Over 7,000 chemicals identified as harmful to human health. Every inhalation carries tar, carbon monoxide and numerous toxic compounds deep into the lungs, where they damage tissue, impair blood circulation and increase the risk of disease throughout the body. This understanding has shaped decades of medical research and tobacco control efforts worldwide.

creates a complex mixture of chemicals, including dozens of known carcinogens and many other harmful or potentially harmful compounds. Every inhalation carries carbon monoxide and numerous toxic compounds deep into the lungs, where they damage tissue, impair blood circulation and increase the risk of disease throughout the body. This understanding has shaped decades of medical research and tobacco control efforts worldwide.

Smokers

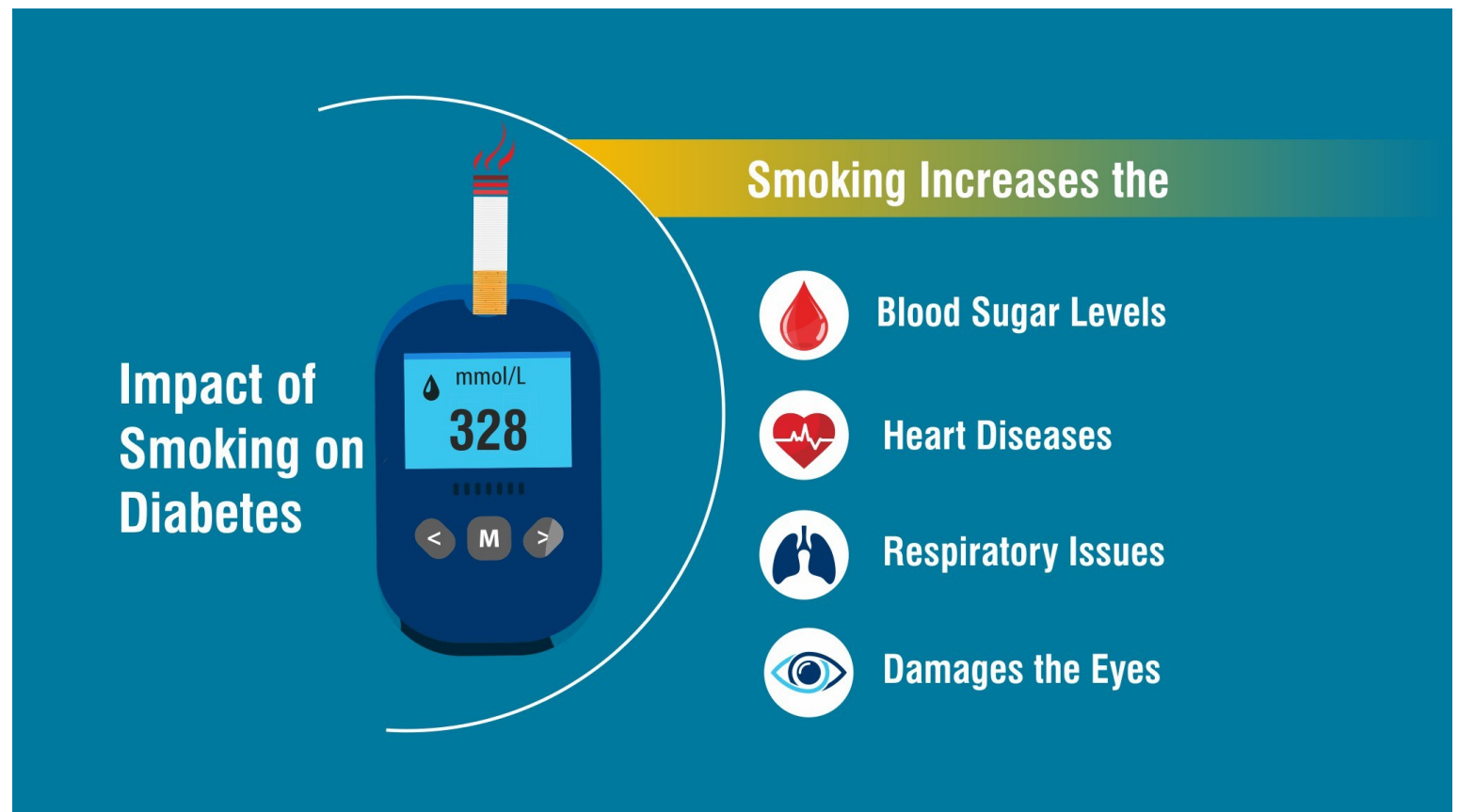
have a 30% to 50% higher likelihood of developing type 2 diabetes than non-smokers, and the more cigarettes you smoke, the higher that risk climbs.

Smoking also makes managing blood sugar levels much harder in people with diabetes.

It is also why physicians have consistently urged smokers to quit. Medical science commonly emphasizes the principle that "prevention is better than cure," and the most effective way to prevent the health risks associated with smoking is to stop smoking altogether.

Yet medical science also recognizes the reality that quitting is not easy. Nicotine dependence is a chronic condition, and many smokers make repeated attempts to quit before they succeed. Some never do. As clinicians, we meet patients who understand the risks, genuinely want to stop and have tried multiple times, yet continue smoking because addiction is rarely overcome through willpower alone.

clinical question. If an adult smoker cannot or will not quit despite repeated efforts, can reducing exposure to the toxic products created by combustion reduce the health risks associated with continued smoking? An increasing body of scientific evidence suggests the answer deserves careful consideration. While no nicotine product should be considered risk free, scientific assessments increasingly distinguish between the risks associated with combustible cigarettes and those associated with smoke-free alternatives because the ab-



It is in these circumstances that tobacco harm reduction enters the conversation. Harm reduction is neither a new nor a controversial principle in public health. We encourage seatbelts even though the safest journey is one without a road accident.

We provide clean needles to reduce the spread of blood-borne diseases. We prescribe methadone to reduce the harms associated with opioid dependence. In each case, the objective is not to endorse a harmful behaviour but to reduce the harm when eliminating that behaviour immediately is not possible.

The same principle applies to smoking. Tobacco harm reduction begins with a simple

sense of combustion significantly reduces exposure to many of the toxic substances found in cigarette smoke.

This distinction should not be misunderstood. Tobacco harm reduction is not intended for young people, non-smokers or former smokers. Nor should it replace smoking cessation, which remains the best possible outcome for every smoker. Rather, it offers another evidence-based approach for adults who would otherwise continue smoking combustible cigarettes.

Recognising relative risk does not weaken tobacco control. It strengthens by aligning public health advice with scientific evidence.

Several countries, including Sweden, the United Kingdom and Japan, have incorporated harm reduction into broader tobacco control strategies while maintaining strong youth protections and encouraging smoking cessation. Their approaches differ, but they share a willingness to evaluate emerging evidence and adapt policy accordingly. Pakistan need not replicate another country's model, but it should be willing to engage with the same scientific questions rather than dismiss them outright.

As physicians, our responsibility extends beyond treating disease. It includes helping patients understand risk accurately. Oversimplifying complex issues may make public messaging easier, but it can also leave adult smokers believing there are no important differences in risk between products that involve combustion and those that do not. Patients deserve information that reflects the best available evidence, enabling them to make informed decisions in consultation with healthcare professionals.

Protecting young people should remain a priority, with stronger measures to ensure that underage individuals do not have access to tobacco and nicotine products. Efforts should focus on preventing underage use and ensuring these products remain out of reach of young people. There is also a need to strengthen the training of general physicians in smoking risk assessment and establish smoking cessation clinics at the town level, ensuring that professional quitting support is accessible to smokers across the country.

Smoking has never been a simple public health chal-



lenge and there are no simple solutions. Prevention, cessation support, regulation and public education will always remain the foundation of tobacco control. But science has also taught us that understanding risk requires nuance.

As physicians, our duty is not to simplify evidence until it fits familiar narratives. It is to communicate that evidence honestly, help patients make informed decisions and remain open to approaches that have the potential to reduce disease and save lives. That is how medicine has always progressed and it is how it should continue to do so.





How should clinicians manage gastrointestinal adverse effects with GLP-1-based therapy?

Dr. Faryal Tariq Masood

Consultant Diabetologist and Endocrinologist
BIDE, OMI, DHA and Saddar hospitals
Coordinator PCDA Women Forum,
Wing of PCDA Pakistan



For clinicians, GI adverse effects (AEs) are usually predictable, dose related and most prominent during initiation /escalation. A 2026 cardiovascular -kidney metabolic guide line also recommends slower escalation and longer intervals between doses.

Key Points:

- GI AEs common class effect; usually mild/moderate, transient
- Educate early; diet/behavior modification first-line
- “Start low, go slow”; pause or de-escalate if needed
- Symptom-directed meds (antiemetics, prokinetics, loperamide, stool softeners)

Consider dose reduction/switch; rule out pancreatobiliary disease

For GLP-1-based therapy, GI adverse effects are common but usually manageable with education, dietary measures, and careful titration. Here is a concise, stepwise approach based on current consensus guidance and recent research.

General principles Frequency/severity

GLP1RAs commonly cause **nausea, vomiting, diarrhea, constipation, and abdominal discomfort**, which are typically mild–moderate and transient.

1 - Systematic reviews in obesity populations show **class-wide increases** in nausea, vomiting, diarrhea, and constipation vs placebo, contributing to discontinuation.

2 Patient education & lifestyle Before and at initiation, counsel patients that GI AEs are expected and usually self limited, and review:

Eating behavior: eat slowly; smaller, more frequent meals; stop when full; avoid eating when not hungry; avoid lying down or vigorous activity soon after meals; avoid eating close to bedtime.

Food composition: prefer easy-to-digest, low fat foods; avoid sweet, spicy, canned foods and heavy sauces; use oven/boiling instead of frying.

Hydration: increase fluids (small, frequent sips of water/clear drinks).

Monitoring: keep a food diary to identify triggers.

3 Dose initiation and titration - Use **“start low and go slow”**: begin at the lowest available dose and titrate only as tolerated. If GIAEs occur during up titration, clinicians may: - Extend the current dose for 2–4 additional weeks. - Avoid further escalation while symptoms persist.

Step back to the prior tolerated dose, then re escalate more gradually (using multidose pens when possible). - Accept a **maintenance dose below the label maximum** if that is the best tolerated.

For severe/persistent AEs, temporarily **withhold the GLP1 RA** until resolution, then restart at a lower dose.

4. Symptom-specific management

Nausea - Non pharmacologic: crackers, apples, mint, ginger products; avoid strong smells. If persistent: **domperidone 10–20 mg PO three to four times daily** preferred over metoclopramide in older adults to reduce extrapyramidal risk; cinitapride is an alternative where available. If antiemetics are still required >1 month at maintenance dose, consider GLP1RA dose reduction.

Vomiting - Emphasize hydration and very small, frequent meals. Use the same antiemetic/prokinetic strategy as for nausea. - For notable severity (dizziness, confusion, fatigue), manage per standard vomiting protocols; IV fluids may rarely be required.

Diarrhea - Hydration (water, lemon, small amounts of bicarbonate solution); avoid sports drinks, dairy, coffee, alcohol, soft drinks, very hot/cold foods. Temporarily reduce high fiber foods, then re introduce once symptoms improve; use simple foods (broth, rice, carrots, very ripe peeled fruit). If persistent, consider **probiotics and loperamide**. In patients on **metformin**, GLP1 RAs may exacerbate diarrhea; reducing metformin dose can help.

Burps- are sulphur burps that may have a taste or smell of sulfur or rotten eggs,” Typically, they occur with the breakdown of sulfur-rich foods like proteins and cruciferous vegetables.”Further assessment into the scientific factors contributing to sulfur burps is warranted. GLP-1 use is associated with sulfur burps as they mimic hormones that slow gastric emptying.“This delay prolongs food contact with bacteria, enhancing fermentation of sulfur-containing substrates and hydrogen sulfide production,”

Reduce intake of sulfur-rich foods, eggs, broccoli, [garlic](#), and avoid carbonated drinks “Eat smaller, frequent meals, stay hydrated, and take remedies like [simethicone](#), or antacids.”

Take Sulfur Burp Concerns Seriously

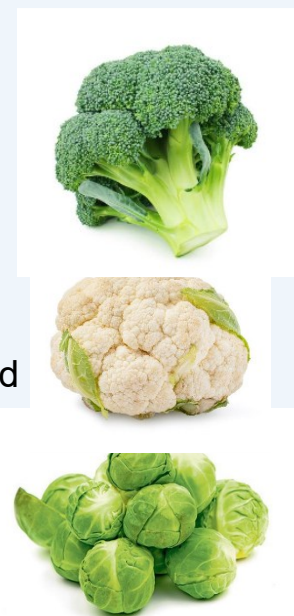
Don't ignore a discussion of symptoms and frequency of sulfur burps. “It is important to ask so we don't miss other digestive disease like acid reflux or hernias that may also cause sulfur burps. Avoid using cruciferous vegetables.

Constipation - Increase physical activity, water, and dietary fiber; use stool softeners if needed. Consider GLP1RA **dose reduction** if constipation worsens or is prolonged.

Abdominal pain / red flags - Mild cramping is common and managed with the above measures.

5. Rare pancreatobiliary complications (gallbladder events, acute pancreatitis). Sudden, severe, or persistent upper abdominal pain radiating to the back, with or without vomiting, warrants prompt evaluation for pancreatitis and gallbladder disease and **immediate drug discontinuation if pancreatitis is suspected** per product labeling for liraglutide, tirzepatide.

When to switch or stop - If bothersome GI AEs persist despite optimized lifestyle measures, titration adjustments, and symptomatic therapy, consider **switching to another GLP1RA**, starting again at the lowest dose. For semaglutide, switching between oral and SC formulations may improve tolerability in some patients.



Key reference:

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Journal of Clinical Medicine. 2023;12(1):145.

DOI: 10.3390/jcm12010145.

Diabetes & Mental Well-being: The Hidden Burden

Report:

Dr. Hira Sabih Baqai

Head of PCDA-Women Forum



The PCDA Women Wing successfully conducted its third podcast session today, focusing on an important yet often overlooked aspect of diabetes care: “Diabetes and Mental Well-being — The Hidden Burden.”



The session featured

Dr Majid Ali Abidi, Professor of Psychiatry & Director, The Brain Clinic Karachi,

in an insightful conversation moderated by Dr Hira Sabih Baqai, Head PCDA Women Wing.

The discussion highlighted the emotional and psychological challenges faced by people living with diabetes, including diabetes distress, anxiety, depression, treatment fatigue and the fear of complications. The speakers emphasized that mental health is an integral part of diabetes management and that healthcare professionals need to recognize and address psychological well-being alongside physical health.

The session was held live on Facebook and provided an engaging platform for awareness, professional learning and meaningful discussion. It reinforced a key message: effective dia-

betes care is not only about controlling blood sugar, but also about caring for the person behind the disease.

The PCDA Women Wing remains committed to creating awareness and promoting a holistic, patient-centred approach to diabetes care.

Ischemic Diabetic Foot

“An Emerging Challenge”



Dr. Shakeel Ahmed
Head of Diabetic Foot Wing
of PCDA Pakistan

Diabetes mellitus has become one of the most significant public health challenge in Pakistan. According to the International Diabetes Federation (IDF), Pakistan is among the countries with the highest burden of diabetes worldwide. Along with poor glycemic control, diabetes leads to several chronic complications, among which diabetic foot disease is one of the most devastating. Diabetic foot ulcers (DFUs) are responsible for prolonged hospitalization, disability, reduced quality of life, and lower **limb amputations**.

A particularly dangerous form of diabetic foot disease is the ischemic diabetic foot, where inadequate blood supply to the lower limbs prevents wound healing and significantly increases the risk of gangrene and amputation. In Pakistan, delayed diagnosis, lack of awareness, inadequate vascular services, and poor foot care practices contribute to the increasing burden of ischemic diabetic foot disease. This article discusses the epidemiology, causes, clinical presentation, diagnosis, management, and current situation of ischemic diabetic foot in Pakistan.

Understanding Ischemic Diabetic Foot

An ischemic diabetic foot occurs when blood flow to the foot is severely reduced due to peripheral arterial disease (PAD). The arteries supplying blood to the legs become narrowed or blocked by atherosclerosis, resulting in inadequate oxygen and nutrient delivery to tissues.

In diabetic patients, ischemia often coexists with neuropathy and infection, creating a complex clinical situation. Reduced blood flow impairs wound healing, increases susceptibility to infection, and substantially raises the risk of amputation.

Burden of Diabetes in Pakistan

Pakistan has witnessed a dramatic rise in diabetes prevalence over the last two decades. The IDF Diabetes Atlas estimates that over 33 million adults in Pakistan are living with diabetes, making Pakistan one of the countries with the highest diabetes prevalence globally.

Several factors contribute to this growing epidemic:

- a. Urbanization
- b. Sedentary lifestyle
- c. Obesity
- d. Unhealthy dietary habits
- e. Genetic predisposition
- f. Delayed diagnosis

As the number of people with diabetes increases, the incidence of diabetic foot complications, including ischemic foot disease, also rises.

Diabetes accelerates atherosclerosis through:

- a. Chronic hyperglycemia
- b. Endothelial dysfunction
- c. Inflammation
- d. Dyslipidemia
- e. Increased platelet aggregation

Diabetic patients often develop diffuse and distal arterial disease involving:

- a. Tibial arteries
- b. Peroneal arteries



Peripheral Arterial Disease in Diabetes

Peripheral arterial disease is significantly more common among people with diabetes than in the general population.

- c. Dorsalis pedis artery
- d. Plantar arteries

This pattern differs from non-diabetic PAD and makes revascularization more challenging.

Epidemiology of Ischemic Diabetic Foot

International studies suggest that peripheral arterial disease is present in approximately 20–50% of patients with diabetic foot ulcers. Studies from Pakistan indicate that a significant proportion of diabetic foot ulcer patients present with ischemic changes at tertiary care centers. Research from the Baqai Institute of Diabetology and Endocrinology (BIDE) and other diabetic foot clinics has highlighted the high prevalence of PAD among Pakistani diabetic foot patients.

Unfortunately, many patients present late with:

- a. Non-healing ulcers
- b. Gangrene
- c. Critical limb ischemia
- d. Severe infections

Such delayed presentation contributes to increased amputation rates.

Risk Factors for Ischemic Diabetic Foot

Several factors increase the risk of ischemic diabetic foot:

Non-Modifiable Factors

- a. Increasing age
- b. Male gender
- c. Long duration of diabetes
- d. Family history of vascular disease

Modifiable Factors

- a. Poor glycemic control
- b. Smoking
- c. Hypertension
- d. Dyslipidemia
- e. Obesity
- e. Physical inactivity
- f. Chronic kidney disease

Smoking remains one of the strongest predictors of peripheral arterial disease and lower-limb amputation.

Pathophysiology

The development of ischemic diabetic foot involves multiple mechanisms:

Atherosclerosis

Chronic hyperglycemia damages blood vessel walls and accelerates plaque formation.

Endothelial Dysfunction

Diabetes impairs nitric oxide production, re-

ducing vasodilation and blood flow.

Microvascular Dysfunction

Small vessel disease further compromises tissue perfusion.

Hypercoagulability

Diabetes increases blood clotting tendencies, worsening arterial obstruction.

Inflammation

Persistent inflammation contributes to vascular injury and progression of arterial disease. The combined effect is reduced tissue oxygenation and impaired wound healing.

Clinical Presentation

Patients with ischemic diabetic foot may present with:



Symptoms

- a. pain while walking (intermittent claudication)

- b. Rest pain, especially at night
- c. Cold feet
- d. Delayed wound healing
- e. Non-healing ulcers
- g. Black discoloration of toes
- h. Gangrene

Signs

- a. Absent foot pulses
- b. Cool skin temperature
- c. Pale or bluish skin
- e. Thin, shiny skin
- f. Loss of hair on legs
- g. Delayed capillary refill
- h. Tissue necrosis

Because diabetic neuropathy may mask pain, many patients remain unaware of severe ischemia until advanced disease develops.

Critical Limb-Threatening Ischemia

Critical Limb-Threatening Ischemia (CLTI) represents the most severe stage of PAD.

It is characterized by:

- a. Ischemic rest pain
- b. Non-healing wounds
- c. Gangrene
- d. Severe reduction in blood flow

Without timely intervention, major amputation may become unavoidable.

Diagnosis

Clinical Examination

A thorough vascular assessment should include:

- a. Pulse examination
- b. Skin inspection
- c. Temperature assessment
- d. Capillary refill evaluation

Ankle-Brachial Index (ABI)

ABI is a simple, non-invasive test used to detect PAD.

Interpretation:

- a. 1.0–1.4: Normal
- b. 0.91–0.99: Borderline
- c. <0.90: Peripheral arterial disease
- d. <0.40: Severe ischemia

Toe Pressure Measurements

Useful when ABI is falsely elevated due to

arterial calcification.

Doppler Ultrasound

Helps identify arterial stenosis and occlusions.

CT Angiography

Provides detailed visualization of lower-limb vessels.

MR Angiography

Alternative imaging modality for vascular assessment.

Digital Subtraction Angiography

Gold standard for vascular imaging and intervention planning.

Management requires a multidisciplinary approach involving:

- a. Diabetologists
- b. Vascular surgeons
- c. Interventional radiologists
- d. Podiatrists
- e. Wound care specialists
- f. Diabetes educators

Management

Medical Management

Glycemic Control

Optimal glucose control improves wound healing and reduces complications.

Antiplatelet Therapy

Commonly used agents include:

- a. Aspirin
- b. Clopidogrel
- c. celistazole is the recomended drug

Lipid-Lowering Therapy

Statins reduce cardiovascular risk and slow atherosclerotic progression.

Blood Pressure Control

ACE inhibitors and ARBs are frequently used.

Smoking Cessation

Smoking cessation is essential to improve vascular outcomes.

Wound Care

Effective wound management includes:

- a. Debridement when appropriate
- b. Infection control
- c. Moist wound healing
- d. Pressure offloading
- e. Regular monitoring

However, aggressive debridement should be avoided in severely ischemic limbs until vascular status has been assessed.

Revascularization

Revascularization is often limb-saving.

Endovascular Procedures

These include:

- a. Balloon angioplasty
- b. Stenting
- c. Atherectomy

Advantages:

- a. Minimally invasive
- b. Shorter recovery
- c. Suitable for high-risk patients

Surgical Bypass

Used when extensive arterial disease is present.

Common bypass procedures include:

- a. Femoropopliteal bypass
- b. Distal bypass grafting
- c. Successful revascularization significantly improves ulcer healing and limb salvage rates.

Infection Control

Infection frequently coexists with ischemia.

Management includes:

- a. Culture-guided antibiotics
- b. Surgical drainage when needed
- c. Removal of necrotic tissue
- d. Osteomyelitis management

Failure to control infection can rapidly lead to limb loss.

Amputation

Despite advances in care, some patients require amputation.

Indications include:

- a. Extensive gangrene
- b. Uncontrolled infection
- c. Unsalvageable limb
- d. Severe tissue destruction

The goal is always to preserve maximum limb function while ensuring patient survival.

Situation in Pakistan

Pakistan faces several challenges in managing ischemic diabetic foot:

Late Presentation

Many patients seek medical attention only after ulceration or gangrene develops.

Limited Awareness

Knowledge regarding foot care and vascular disease remains inadequate among patients.

Shortage of Specialized Centers

Dedicated diabetic foot and vascular services are available mainly in large urban centers.

Economic Constraints

Many patients cannot afford advanced imaging or revascularization procedures.

High Prevalence of Risk Factors

Smoking, hypertension, obesity, and uncontrolled diabetes remain widespread.

These factors contribute to increased rates of disability and amputation.

Role of PCDA Diabetes & Foot Care Center-BIDE and Specialized Foot Clinic.

The PCDA-DFCC & (BIDE) has played a leading role in diabetic foot care in Pakistan.

Major contributions include:

Establishment of specialized foot clinics

- a. Professional training programs
- b. Public awareness campaigns
- c. Multidisciplinary foot care services
- c. Research on diabetic foot disease

It has been now established that early intervention and structured diabetic foot programs can significantly reduce amputation rates.

PCDA Diabetic Foot Care at Gulistan-e-johar is an emerging foot care center where we are managing

- a. Diabetic foot ulcers
- b. Public awareness Campaign
- c. Research on DFUs
- d. Diabetic Foot training for Primary cares

Prevention

Prevention remains the most cost-effective strategy.

Patient Education

Patients should be educated regarding:

- a. Daily foot inspection
- b. Proper footwear
- c. Nail care
- d. Early reporting of foot problems

Regular Screening

All diabetic patients should undergo annual foot examinations.
High-risk patients require more frequent assessments.

Risk Factor Modification

- a.Smoking cessation
- b.Blood pressure control
- c.Lipid management
- d..Weight reduction
- e.Regular physical activity

Detection of PAD

Routine pulse examination and ABI measurement can identify vascular disease before ulceration occurs.

Future Directions

To reduce the burden of ischemic diabetic foot in Pakistan, the following measures are needed:

- a.National diabetic foot programs
- b..Increased availability of vascular services
- c.dTraining of healthcare professionals
- d.Expansion of multidisciplinary foot clinics
- e.Public awareness campaigns
- f.Integration of diabetic foot screening into primary care

Improved access to revascularization procedures

Investment in preventive care can significantly reduce amputations and healthcare costs.

limb amputation in Pakistan. The growing diabetes epidemic, combined with delayed diagnosis and limited access to specialized care, has created a significant healthcare challenge. Peripheral arterial disease plays a central role in the development of non-healing ulcers and limb-threatening ischemia. Early detection, comprehensive vascular assessment, multidisciplinary management, and timely revascularization are critical for limb preservation. Strengthening diabetic foot services, improving patient education, and promoting preventive strategies can substantially reduce the burden of ischemic diabetic foot and improve outcomes for millions of people living with diabetes in Pakistan.

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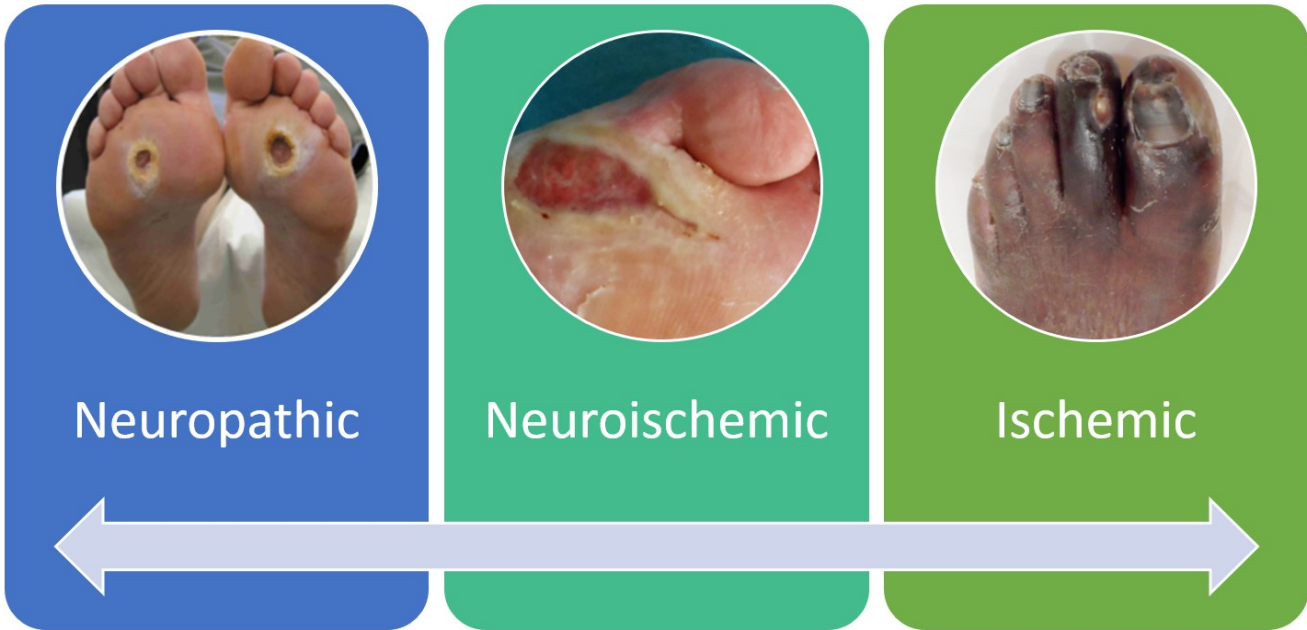
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Ischemic diabetic foot is a major cause of disability, hospitalization, and lower-

The Brutal Truths We Ignore on Our Weight-Loss Journey



By:

Rabbiya Tirmizi
Head of Diet & Education(DEW)
Wing of PCDA Pakistan



Evidence-based lessons every dietitian wishes more people knew before starting their weight-loss journey.

"I've tried every diet, but nothing works."

As a dietitian, this is one of the most common statements I hear in my clinic. Often, the issue isn't a lack of willpower or finding the "perfect" diet. It's that we often overlook the simple, evidence-based truths that truly determine long-term success.

Social media is flooded with quick fixes, detox drinks, fat-burning supplements, and influencers promising dramatic transformations. At the same time, well-meaning family and friends continue to advise us to "skip dinner", "stop eating rice", or "switch to desi ghee because it's healthier." While these suggestions may sound convincing, many are based on myths rather than science.

The truth is that sustainable weight loss isn't about eliminating your favorite foods or following restrictive diets. It's about understanding how your body works, recognizing habits that quietly sabotage your progress, and making realistic changes you can maintain for life.

For us in Pakistan, this journey comes with unique challenges. Our love for parathas, biryani, halwa puri, sweet chai, bakery biscuits, rusks, family daawats, weddings, and generous hospitality is part of our culture. The goal isn't to give up these traditions it's to learn how to enjoy them wisely.

Here are some evidence-based truths every Pakistani should know.



Truth #1:

Healthy Foods Can Still Lead to Weight Gain and Desi Doesn't Always Mean Healthy

One of the biggest myths I hear is, "Doctor, I don't eat junk food. I only eat homemade food." Homemade meals are usually healthier than fast food because they contain fewer additives and you control the ingredients. However, homemade doesn't automatically mean low in calories.

A breakfast of several rusks dipped in sweet milk tea, halwa puri on weekends, or aloo parathas cooked with generous amounts of oil or desi ghee may provide more calories than many people realize. Likewise, almonds, walnuts, dates, honey, peanut butter, olive oil and desi ghee are nutritious foods, but they are also calorie-dense. Eating large portions simply because they are "healthy" can still contribute to weight gain.

Eating healthy doesn't always mean low calories or weight loss.



Healthy eating focuses on food quality, nutrient density, and overall bodily function, whereas weight management primarily relies on energy balance and portion control. Eating nutritious whole foods supports long-term wellness, but weight change ultimately depends on consuming fewer calories than you burn, regardless of food quality.

Dietitian's Tip: Healthy eating and weight management are not the same thing. Quality matters for health, while portion size matters for weight.

Truth #2

Chai-Time Calories Count



Many people proudly tell me they eat only two meals a day. Yet, during the consultation, they casually mention three or four cups of sweet chai, a few rusks, bakery biscuits, nimco, pakoras or "just one" samosa in the evening.

These small snacks may seem harmless individually, but together they can contribute several hundred extra calories every day without making you feel full.

Dietitian's Tip:

Before reaching for another biscuit with tea, ask yourself, "Am I hungry, or is this simply a habit?"

Truth #3

Protein Is the Missing Piece on Most Plates

A common Pakistani meal is heavy on cha-pati or rice but light on protein. Protein helps preserve muscle during weight loss, improves satiety, and supports healthy ageing.

Good protein sources include eggs, chicken, fish, lean meat, yoghurt, milk, paneer, lentils, beans and soy products.

Many people consider peanut butter or nuts to be protein foods. While they do contain protein, they are primarily sources of healthy fats and should not replace higher-quality protein foods.

Dietitian's Tip:

Try to include a source of protein every time you eat even at breakfast or at snack time.

Eating Full Plates... Still Missing Protein?



Truth #4

Stop Blaming Rice



Rice has unfairly become the villain of many weight-loss plans. The reality is that no single food causes obesity.

Weight gain occurs when we consistently consume more calories than we burn not because we ate rice, roti or fruit.

Instead of eliminating carbohydrates, focus on balanced portions and pair them with vegetables and protein.

Dietitian's Tip:

Half your plate should contain vegetables, one-quarter lean protein, and one-quarter whole grains or starchy foods.

Truth #5

Exercise Cannot Outrun a Poor Diet

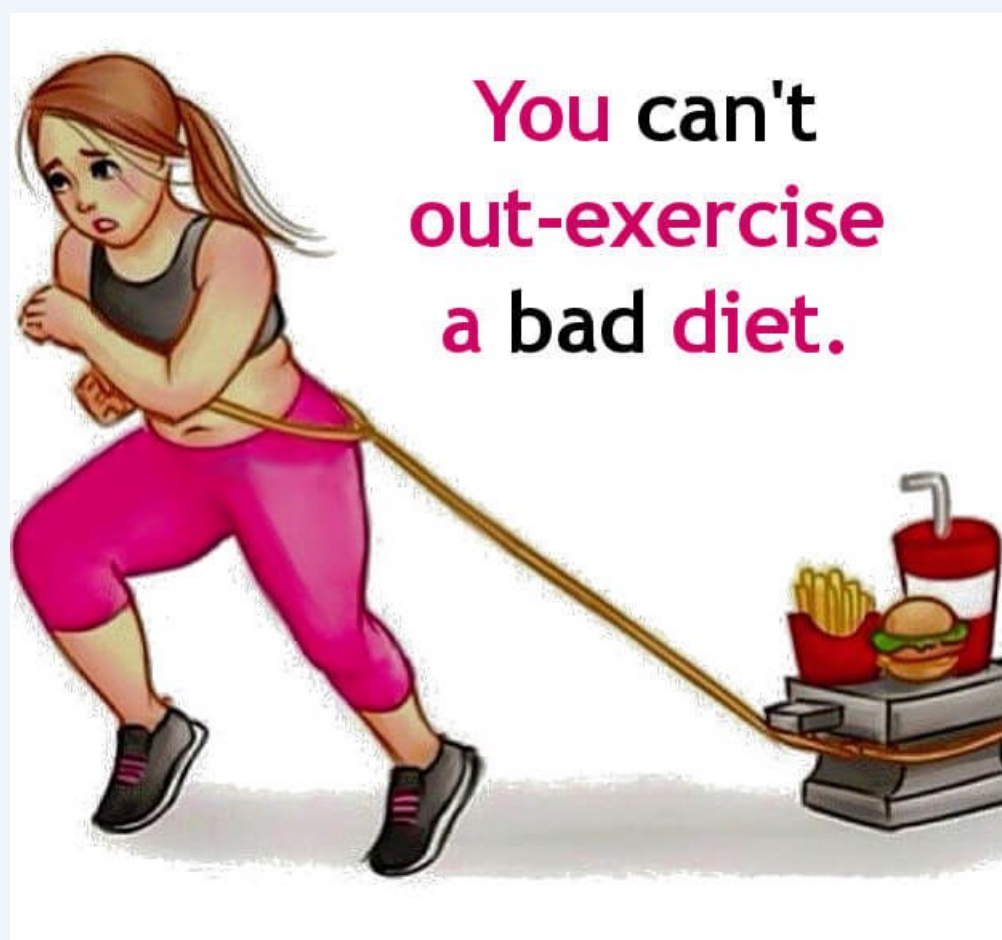
Many people spend an hour walking or at the gym and then reward themselves with fast food or dessert because they believe they have "earned it."

Unfortunately, it's much easier to consume calories than to burn them.

Exercise is essential for heart health, stronger muscles, better mental health and improved fitness, but nutrition plays the biggest role in weight management.

Dietitian's Tip:

Think of exercise as a way to improve your health not as punishment for eating.



Truth #6

Don't Fear Strength Training



Many women worry that lifting weights will make them bulky. In reality, women naturally have much lower testosterone levels than men, making it difficult to build large amounts of muscle.

Strength training helps preserve muscle during weight loss, improves metabolism, strengthens bones and keeps us independent as we age.

Dietitian's Tip:

Aim for at least two strength-training sessions each week alongside regular physical activity.

Truth #7

Planning Beats Willpower

Healthy eating decisions are *rarely* made when you're already hungry.

After a long day at work, it's much easier to order shawarma, pizza or fried chicken than prepare dinner from scratch.



Planning meals, carrying healthy snacks and keeping nutritious ingredients at home reduces impulsive food choices.

Dietitian's Tip:

Your future self will thank you for preparing meals before hunger makes the decisions for you.

Truth #8

Our Environment Shapes Our Choices



VS



If chocolates, sugary drinks and crisps are always within reach, resisting them requires constant willpower.

Similarly, spending time with people who encourage active lifestyles often makes healthy habits easier.

Our environment influences our behavior far more than we realize.

Dietitian's Tip:

Make healthy choice the easy choice by keeping fruit visible and less nutritious snacks out of sight.

Truth #9

Hospitality Shouldn't Cost You Your Health



Food is central to Pakistani culture. Whether it's Eid, weddings, birthdays or family dinners, refusing food can sometimes feel impolite.

You don't need to avoid social events. Instead, enjoy smaller portions, eat slowly, choose your favorite dishes rather than everything on the buffet, and politely decline second helpings.

Dietitian's Tip:

Remember, respecting your health is never disrespectful to your host.

Truth #10

The Scale Doesn't Tell the Whole Story



Your weight naturally fluctuates because of water retention, hormones, sodium intake and digestion.

Instead of becoming discouraged by daily changes, look for trends over several weeks and celebrate other achievements like improved energy, better blood sugar, stronger muscles, lower blood pressure or clothes fitting more comfortably.

Dietitian's Tip:

Health is measured by much more than a number on the scale.

Truth #11

Children Learn by Watching Us

Children copy what they see, not what they hear.

When they regularly see parents eating vegetables, drinking water, cooking balanced meals and enjoying physical activity, these habits become normal for them too.



Dietitian's Tip:

Healthy families are created through everyday actions, not lectures.

Truth #11

There Are No Miracle Foods or Shortcuts

Whether it's detox teas, apple cider vinegar, herbal powders, fat burners or the latest diet trending on social media, there is no substitute for healthy eating, regular physical activity, quality sleep and consistency.

Even medications for weight management work best alongside lifestyle changes they do not replace them.

The Bottom Line



Weight loss isn't about giving up biryani forever, refusing every piece of mithai or never enjoying a cup of chai again. It's about learning balance.

Science consistently shows that the most successful people are not those who follow the strictest diets they are the ones who build habits they can maintain for years.

As dietitians, we don't believe in perfection. We believe in progress.

So instead of asking, "What's the fastest way to lose weight?" ask, "What healthy habits can I still be practicing five years from now?"

Because sustainable weight loss isn't achieved through temporary diets it is achieved through lifelong habits.

Remember these simple principles:

- Eat balanced meals rich in protein, vegetables and whole grains.
- Watch portion sizes, even with healthy foods.
- Limit sugary drinks and frequent tea-time snacks.
- Stay physically active and include strength training.
- Plan meals instead of relying on willpower.
- Sleep well, manage stress and stay hydrated.
- Enjoy traditional Pakistani foods in moderation not guilt.

The greatest transformation isn't simply losing kilograms; it's gaining a healthier body, a healthier relationship with food and a healthier future. That's a journey worth taking.

The Ghost Tablet-

Is your medicine still working?

The Mistry of the empty pill shell

Have you ever seen a pill in your stool and thought, "Wait... did my medicine even work?"

Did it make you worry that it just passed right through?

Let's crack this mystery and find why you sometimes see a whole tablet in your stool — and what it really means for your diabetes treatment

What Patients Notice:

Some patients taking antidiabetic tablets — most often extended-release metformin — notice something in the toilet that looks like the tablet they swallowed earlier that day. It may look almost unchanged: same shape, same color, sometimes even the printed marking still visible.

The natural reaction is to assume the tablet passed through the body without being absorbed, and that the dose was wasted. This is understandable, but in most cases it is not correct. What patients are seeing is a well-known and expected finding called a "ghost tablet" or "ghost shell." It is a normal part of how many extended-release medicines are designed to work, not a sign that the medicine has failed.



Hashir Mubeen
DEW-PCDA

WHAT IS A GHOST PILL?

@MEMORYPHARMSTUDY



Ghost pills, also called ghost tablets or ghost capsules, are the **empty shells** of certain extended-release (ER) or controlled-release (CR) medications. These drugs use a non-digestible shell or matrix that slowly releases medication as it moves through the GI tract.

Once the drug is absorbed, the **empty shell** may come out looking almost identical to the original tablet or capsule—like a "ghost." Even though they are harmless, they often **confuse** patients and can lead to unnecessary **worry** or **nonadherence**.



Why This Happens: The Science in Simple Terms

Many extended-release antidiabetic tablets — commonly labeled ER, XR, or SR — are not built to dissolve completely like ordinary tablets. Instead, the active drug is mixed into a matrix, usually made from a slow-release material such as hydroxypropyl methylcellulose (HPMC).

A simple way to picture this is a tea bag. The tea leaves are the medicine. The mesh bag is the matrix. When you steep the bag in hot water, the flavor slowly moves out through the mesh over several minutes. The bag itself does not dissolve — it stays behind once the tea has been released.

The tablet works in a similar, controlled way:

1. Once swallowed, the matrix absorbs fluid in the stomach and softens slightly.

- As the tablet travels through the intestines over several hours, the drug slowly moves out through tiny channels in the matrix.
 - By the time the tablet reaches the end of the digestive tract, most or all of the drug has already been released and absorbed.
 - What remains — the swollen, empty matrix — is passed out of the body. This is the “ghost tablet.”
- In short: the tablet you see is the leftover framework, not the unused medicine.

Myth vs. Fact

Myth	Fact
Seeing the tablet means none of the drug was absorbed.	The drug is released gradually during the several hours the tablet travels through the gut, not all at once at the end.
This means the tablet is defective or low	This is a designed and expected feature of extended-release formulations, not a manufacturing fault.
An extra tablet should be taken to make up for it.	Taking an extra dose is not recommended. It does not correct anything and can increase the risk of side effects.
This happens with all diabetes medicines.	It is specifically linked to extended-release formulations. Ordinary immediate-release tablets should break down and should not be seen intact in stool.

When This Is Usually Not a Concern

This finding is generally not something to worry about when:

- The medicine is an extended-release formulation (ER, XR, or SR).
- Blood sugar readings and HbA1c results remain within the range advised by the treating doctor.
- There is no ongoing diarrhea or unusually fast bowel movements.
- It happens occasionally rather than with every single dose.

When to Speak to a Pharmacist or Doctor

There are specific situations where this finding should be discussed rather than ignored:

- Blood sugar control is worsening — for example, rising fasting or post-meal readings, or an increasing HbA1c.
- The medicine is an immediate-release tablet, not extended-release, and it is still appearing intact.
- There is a history of chronic diarrhea, bowel surgery, or inflammatory bowel disease, which can speed up transit through the gut and reduce absorption.
- The tablet has been crushed, split, or chewed. This breaks the controlled-release design and should not be done unless a pharmacist has specifically advised that it is safe for that particular medicine.
- Symptoms of poor sugar control are present, such as excess thirst, frequent urination, or unusual tiredness.

If any of these apply, the medicine or dose should not be changed independently. It is best to raise the concern so it can be reviewed properly, sometimes alongside blood sugar records or lab results.

Practical Guidance for Patients

- Swallow extended-release tablets whole, with a full glass of water. Do not crush, chew, or split them unless specifically advised.
- Take doses with food if instructed, as this can support steady absorption and reduce stomach discomfort.

- Do not take an extra dose after noticing a ghost tablet.
- Use blood sugar readings, not what is seen in stool, as the real indicator of whether treatment is working.
- Continue the medicine as prescribed. Stopping it due to concern about “wasted” doses carries far more risk than the ghost tablet itself.
- Mention this finding at the next visit if it happens repeatedly, so it can be reviewed and explained clearly.

A ghost tablet is best understood as the leftover framework of an extended-release medicine, similar to an empty tea bag after the tea has already been released. It reflects how the medicine is designed to release its dose gradually over several hours, not a failure of treatment.

Any concerns about blood sugar control, unusual bowel symptoms, or tablets that should not behave this way are worth discussing with a pharmacist, rather than making assumptions based on appearance alone.

1. Extended Release (ER) Tablet



2. Controlled Release (CR) Tablet



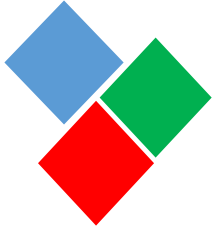
3. Enteric-Coated Tablet



**“Tablet type matters.
Do not treat every
tablet the same.”**

4. Buccal Tablet





معصوم شوہر

جھوٹ میں ڈوبی ایک سچی تحریر



سن 2005ء میں ہماری شادی ناہید سید سے ہوئی—یا یوں کہہ لیجیے کہ امیرن بیگم سے ہوئی۔

الحمد للہ، 2025ء میں شادی کے پورے بیس سال مکمل ہو گئے، لیکن ہمیں آج تک یہ سمجھ نہیں آئی کہ امیرن بیگم سے مراد کیا ہے۔

ہم نے ایک دن مؤدبانہ عرض کیا:

”بیگم! اگر امیرن کے ساتھ سے بیگم ہٹا دیا جائے تو یہ نام کچھ مذکر سا معلوم ہوتا ہے—امیرالدین!“

بیگم نے فوراً تصحیح فرمائی:

”یہ امیرالدین نہیں، امیرن بیگم ہے! جب میں پیدا ہوئی تو ہم

بہت امیر تھے، اس لیے والدین نے خوش ہو کر میرا نام امیرن

بیگم رکھ دیا۔“ ہم نے پوچھا:

”پھر ناہید کیسے بن گئیں؟“

ایک ٹھنڈی آہ بھر کر بولیں:

”جوں جوں ہم بڑے ہوئے، نہ جانے کس کی نظر لگ گئی۔

نہ ملک آگے بڑھا، نہ گھر کی معیشت اور نہ ہی ہمارا قد!“

”امیری سے غریبی تک کا یہ سفر خاصا تکلیف دہ تھا۔

میں راتوں کو نیند سے اٹھ کر چیختی تھی: نہیں... نہیں...“

میں غریبن بیگم نہیں بننا چاہتی!“

ہم نے ہمدردی سے پوچھا:

”پھر گھر والے آپ کو ڈاکٹر کے پاس نہیں لے گئے؟“

بولیں:

”لے جا کر کیا کرتے؟ ڈاکٹر کے پاس بخار، کھانسی اور بلڈ پریشر کا علاج ہوتا ہے—غربت کا نہیں!“

اور ویسے بھی ڈاکٹر کی فیس سن کر باقی گھر والوں کے بھی امیرن سے غریبن بننے کا خطرہ تھا!“



ڈاکٹر خلیق وارثی

سرے (وینکوور)

برٹش کولمبیا، کینیڈا

ڈاکٹر خلیق وارثی

پی سی ڈی اے

کے تاسیسی ارکان

میں شامل ہیں۔

انکی اس تحریر کی

نیوز لیٹر میں اشاعت کا مقصد پی سی ڈی

اے کے دوستوں کی علمی تحقیقی اور ادبی

صلاحیتوں کو اجاگر کر کے انکی حوصلہ افزائی

کرنا ہے۔

”سبحان اللہ! کیا ڈالٹھ ہے! بیگم، آج تو کمال ہی کردیا!“ بیگم نے حیرت سے ہماری طرف دیکھا، مگر کچھ نہیں بولیں۔ ہم نے دوسرا لقمہ لیا:

”واہ! ایسی دال تو فائو اسٹار ہوٹل میں بھی نہیں مل سکتی!“ تیسرے لقمے پر ہمارے اندر کا فوڈ بلاگر بھی جاگ اٹھا: ”دال کی ساخت متوازن، خوشبو لاجواب، مرچیں نپی تلی اور نمک عالمی معیار کے عین مطابق ہے!“ چوتھا لقمہ لیتے ہوئے ہم نے جذباتی انداز میں کہا:

”بیگم! آج احساس ہوا کہ میں نے کسی عام خاتون سے نہیں بلکہ ایک بین الاقوامی شیف سے شادی کی ہے۔ تمہارے ہاتھوں میں تو جادو ہے!“

بیگم خاموشی سے ہمیں گھورتی رہیں۔ ہم سمجھے کہ بیس سال بعد تعریف سن کر جذبات سے مغلوب ہو گئی ہیں، اس لیے آخری وار بھی کردیا: ”اگر تم یہ دال کسی ریسٹورنٹ میں پیش کرو تو لوگ پلڈیٹیں چاٹ کر واپس کریں!“ یہ سنتے ہی بیگم اٹھیں، باورچی خانے میں گئیں اور بیلن لے آئیں۔

ہم خوش ہوئے کہ شاید اب تازہ روٹیاں بھی ملیں گی۔ مگر اگلے ہی لمحے — دھڑام!

بیلن سیدھا ہمارے سر پر اترا۔ ہم نے سر پکڑ کر پوچھا:

”ارے امیرن بیگم! یہ کیا کردیا؟ مولوی صاحب نے تو کہا تھا کہ تعریف کرنے سے محبت بڑھتی ہے!“ بیگم غصے سے بولیں:

”بیس سال سے میرے ہاتھ کا کھانا کھا رہے ہو، کبھی دو لفظ تعریف کے نہیں کہے... اور آج ذرا سی دال پڑوسن نے کیا بھیج دی، تمہارے اندر کا شاعر، عاشق، فوڈ بلاگر اور بین الاقوامی نقاد — سب ایک ساتھ جاگ اٹھے!“

ہم نے سر سہلاتے ہوئے دھیرے سے کہا:

”مولوی صاحب نے تعریف کا اجر تو بتایا تھا... مگر یہ نہیں بتایا کہ کھانا کس نے بنایا ہے، پہلے اس کی تصدیق بھی کر لینی چاہیے!“

بیگم نے بیلن دوبارہ اٹھاتے ہوئے پوچھا:

”کوئی آخری خواہش؟“

ہم نے فوراً کہا:

”جی... پڑوسن کو دال کی پلیٹ واپس میں خود دے آتا ہوں!“

بیگم بولیں:

”اب پلیٹ بھی واپس ہوگی، دال بھی واپس ہوگی — اور اگر مزید تعریف کی تو تم بھی اسی کے ساتھ واپس ہو جاؤ گے!“

اس دن ہمیں ازدواجی زندگی کے دو اہم اصول معلوم ہوئے:

پہلا: بیوی کے کھانے کی تعریف ضرور کریں۔

دوسرا: تعریف کرنے سے پہلے یہ ضرور معلوم کر لیں کہ کھانا واقعی بیوی نے ہی بنایا ہے! اور تیسرا اصول، جو بیس سال کی تحقیق کا نچوڑ ہے:

بیوی کے ہاتھ میں بیلن ہو تو منطق، شاعری اور مولوی صاحب کا حوالہ — تینوں بے اثر ہو جاتے ہیں!

”آخر کار گھر والوں نے کافی سوچ بچار کے بعد میرے مسلسل بولے جانے والے لفظ نہیں سے آخری نوٹ بنایا، اس کی جگہ دال لگائی، اور یوں میں ناہید کھلانے لگی۔“

ہم نے پوچھا: ”نام کی یہ تبدیلی سرکاری گزٹ میں ہوئی تھی یا باورچی خانے میں؟“

فرمایا: ”مزید تحقیق کی تو دال کے ساتھ بیلن بھی شامل ہو سکتا ہے!“

ہم نے فوراً موضوع بدل دیا۔

جہاں تک سید ہونے کا تعلق ہے، اس پر تحقیق کرنا ہم نے مناسب نہیں سمجھا۔ سندھ میں رولت یہ ہے کہ کوئی کھوکھرا پار کے راستے سندھ آیا ہو، حیدرآباد کے اسٹیشن پر اترا ہو یا وہیں پیدا ہوا ہو — اگر نام کے ساتھ سید لکھا ہے تو بس سید ہے! زیادہ سوال کرنے والا خود اپنے شجرہ نسب کے ساتھ گھر سے باہر پایا جاسکتا ہے۔

ہماری بیگم حیدرآبادی بھی ہیں، لیکن بھارتی نہیں، سندھی حیدرآبادی۔ گانا بھی اچھا گالیتی ہیں، مگر شادی کے بعد زیادہ تر ہماری زندگی میں سر کے بجائے تال کا انتظام کرتی رہی ہیں۔

”سال“ سے ہماری مراد وہ آوازیں ہیں جو کبھی چچ، کبھی پلیٹ اور کبھی بیلن کے میز سے نکلنے پر پیدا ہوتی ہیں۔ ادھر ہمارے والدین نے ہماری تربیت میں تقریباً ہر چیز شامل کی — بڑوں کا احترام، چھوٹوں سے محبت، ممان نوازی اور وقت کی پابندی — مگر ایک بنیادی سبق دینا بھول گئے:

بیوی کی، سہمی نہ سہی، کبھی کبھار جھوٹی تعریف ضرور کر دینی چاہیے۔

چنانچہ شادی کے بیس سال میں ہم نے کبھی بیگم کے کھانے کی تعریف نہیں کی۔

کھانا سامنے آتا، ہم خاموشی سے کھاتے اور اٹھ جاتے۔ ہمارا انداز ایسا ہوتا جیسے کھانا نہیں کھایا بلکہ کسی سرکاری دفتر میں ایک ضروری فائل نمٹا کر آئے ہوں۔

بیگم کبھی پوچھتیں: ”کھانا کیسا بنا ہے؟“

ہم جواب دیتے: ”ٹھیک ہے۔“ یہ ٹھیک ہے ہماری طرف سے فائو اسٹار ریٹنگ ہوتی تھی، مگر بیگم اسے تو بین سمجھتی تھیں۔

ایک جمعہ ہم مسجد گئے۔ مولوی صاحب نے خطبے میں فرمایا: ”بھائیو! اپنی بیوی کی خوبیوں اور اس کے ہاتھ کے کھانے کی تعریف کیا کریں۔ اس سے محبت بڑھتی ہے، گھر کا ماحول خوشگوار رہتا ہے اور سالن میں نمک کم بھی ہو تو محسوس نہیں ہوتا۔“ ہمیں محسوس ہوا کہ مولوی صاحب براہ راست ہمیں ہی مخاطب کر رہے ہیں۔ ہم نے وہیں پکا ارادہ کر لیا کہ آج گھر جاکر بیگم کی ایسی تعریف کریں گے کہ گزشتہ بیس سال کا خسارہ ایک ہی دن میں پورا ہو جائے۔ گھر پہنچے تو بیگم نے دال، چاول اور اچار سامنے رکھ دیا۔ ہم نے پہلا لقمہ منہ میں ڈالا، آنکھیں بند کیں اور وجد میں آکر بولے:



Head of Multan Chapter of PCDA, Dr. Irfan Shaukat talks on Insulin Resistance

Dr. Irfan Shaukat, Head of the Multan Chapter of the Primary Care Diabetes Association (PCDA) Pakistan, delivered an informative and highly interactive session on **Insulin Resistance** at a Hotel Ramada Multan



Talking to the primary care physicians of Multan and the surrounding areas, he said “The syndromes of insulin resistance actually make up a broad clinical spectrum, which includes obesity, glucose intolerance, diabetes, and the metabolic syndrome, as well as an extreme insulin-resistant state. Many of these disorders are associated with various endocrine, metabolic, and genetic conditions.

These syndromes may also be associated with immunologic diseases and may exhibit distinct phenotypic characteristics. The metabolic syndrome—a state of insulin-resistance that is also known as either syndrome X or the dysmetabolic syndrome—has drawn the greatest attention because of its public health importance.”

Dr. Irfan told the audience that obesity-related insulin resistance or metabolic syndrome is typically characterized by central adiposity, glucose intolerance, dyslipidemia, and hypertension. Prevalence of hypertension rises with exacerbation of stages of impaired glucose metabolism; however, it seems that only in the early stages of impaired insulin metabolism do hyperglycemia and hyperinsulinemia appear to be significant contributors to the presence of hypertension. Other features may include acanthosis nigricans, polycystic ovary syndrome, and the metabolic dysfunction-associated steatotic liver disease, previously known as non-alcoholic fatty liver disease.

There are other forms of insulin resistance, including those with unique phenotypes such as lipodystrophy, and those due to insulin receptor dysfunction (type A and type B syndromes) with different amounts or patterns of fat distribution.

Dr. Irfan reminded that no single laboratory test is used to diagnose insulin resistance syndrome. Diagnosis is based on clinical findings corroborated with laboratory tests. Individual patients are screened based on the presence of comorbid conditions. Laboratory tests include the plasma glucose level, the fasting insulin level, and a lipid profile, among others.



Dr. Irfan Shaukat said that treatment involves pharmacologic therapy to reduce insulin resistance, along with surgical management of underlying causes if appropriate. Comorbid conditions should be evaluated and addressed; this is generally feasible on an outpatient basis, though some patients will require admission.

The metabolic syndrome requires aggressive control of cardiovascular and metabolic risk factors. Modifications of diet and activity are recommended. Medications that reduce insulin resistance (insulin-sensitizing and antihyperglycemic effects) include metformin, the thiazolidinediones, sodium-glucose cotransporter-2 (SGLT2) inhibitors, glucagon-like peptide-1 (GLP-1) receptor agonists, and the dual glucose-dependent insulinotropic polypeptide (GIP)/GLP-1 receptor agonists.

Dr. Irfan Shaukat specially focused the role of GLP1 receptor agonists in the management of the metabolic syndrome. He said that These agents are incretin mimetics. They are analogues of human glucagon-like peptide-1 (GLP-1), and they act as GLP-1 receptor agonists to increase insulin secretion in the presence of elevated blood glucose. These agents delay gastric emptying to decrease postprandial glucose, and they also decrease glucagon secretion.



GLP1 receptor agonists are incretin mimetic agents that elicits GLP-1 receptor agonist activity. These activates the GLP-1 receptor by stimulating G-protein in pancreatic beta cells. These also increases intracellular cyclic AMP, leading to insulin release in the presence of elevated glucose concentrations. GLP1 receptor agonists like Semaglutide, produces weight loss and, hence, an increase in insulin sensitivity.

Summarizing the topic Dr. Irfan Shaukat said that the GLP1 receptor agonists help in Weight Reduction by curbing appetite, leading to weight loss. Losing visceral fat—the fat stored around organs—makes cells more sensitive to insulin. Secondly they reduce Inflammation and help lower chronic, low-grade inflammation that blocks normal insulin signals.

And also they produce better Liver Health by reducing fat stored in the liver, which restores healthy metabolic function.

Free Diabetes, Fatty Liver, Obesity & Metabolic Diseases Screening Camp Held in Toba Tek Singh



Dr. Mutayyaba Asad Aman

Under the umbrella of the **Primary Care Diabetes Association (PCDA) Pakistan** and the **Liver & Diabetes Foundation (LDF)**, a comprehensive **One-Day Free Screening Camp for Diabetes, Fatty Liver Disease, Obesity, and Metabolic Diseases** was successfully organized at **Aman Hospital, Toba Tek Singh**, on **Monday, August 31, 2026**.

The camp was organized by **Dr. Mutayyaba Asad Aman**, 2nd Year Postgraduate Resident in Diploma in Diabetes and Assistant Professor of Medical Physiology at Aman Hospital. Dr. Mutayyaba is an active member of **PCDA Pakistan** and an **Executive Member of LDF**.

The initiative was aimed at providing accessible, preventive, and comprehensive screening services to the local community, particularly individuals who may otherwise have limited access to specialized diagnostic facilities.

Comprehensive Free Screening Services

More than **40 patients and visitors** benefited from the screening camp. Participants underwent comprehensive assessment for **diabetes, obesity, metabolic disorders, fatty liver disease, and associated complications**.

A range of essential investigations and clinical assessments were provided **completely free of cost**, including:

- **HbA1c** for assessment of long-term glycemic control and identification of undiagnosed diabetes or prediabetes]
- **Fasting Lipid Profile** for cardiovascular and metabolic risk assessment



- **Complete Blood Count (CBC)**
- **Liver Function Tests (LFTs)** for assessment of hepatic health
- **Blood Pressure Monitoring.**

- **Random Plasma Glucose (RPG)**
- **Body Mass Index (BMI)** assessment for identification and stratification of obesity-related risk

All laboratory investigations required for screening and **high-risk stratification** were provided free of charge through established laboratory facilities. This enabled participants to receive a more comprehensive assessment without the financial burden that often prevents people in underserved communities from seeking timely healthcare.

Following the screening and assessment, all participants were provided with **free medical consultation**, counselling, and **available medicines free of cost**, ensuring that the camp extended beyond diagnosis to appropriate medical guidance and initial management.

Introduction of Free Diabetic Neuropathy Screening

A particularly noteworthy feature of the camp was the provision of **free diabetic peripheral neuropathy screening using a biothesiometer**.



In the district of **Toba Tek Singh**, Dr. Mu-tayyaba Majeed/Aman has taken the initiative to introduce this important facility, utilizing modern technology designed to improve the assessment of peripheral sensory function and help identify patients at increased risk of diabetic foot complications.

Early detection of diabetic neuropathy is an important component of diabetic foot prevention. Identifying patients with impaired sensation at an early stage provides an opportunity for timely education, risk stratification, appropriate foot-care advice, and preventive interventions before serious complications such as **foot ulcers and limb-threatening infections** develop.

The initiative therefore reflects the core philosophy of **prevention, early detection, and timely intervention** in diabetes care.

Free Assessment for Fatty Liver and Liver Fibrosis Risk

The camp also incorporated assessment of patients at increased risk of metabolic liver disease. **High-risk patients fulfilling the relevant FIB-4 criteria** were offered further liver assessment completely free of cost.

2D Shear Wave Elastography was performed by highly qualified professional radiologists to assess liver stiffness and assist in the evaluation of patients at risk of significant liver fibrosis. This service provided an important opportunity for early identification and further risk stratification of individuals with suspected metabolic dysfunction-associated fatty liver disease.

Promoting Prevention and Early Detection

The screening camp represented a holistic approach to metabolic health by bringing together screening for **diabetes, obesity, dyslipidemia, hypertension, liver disease, and diabetic complications** under one initiative.

Such integrated screening is particularly valuable because these conditions frequently coexist and collectively contribute to an increased risk of cardiovascular disease, chronic kidney disease, liver disease, diabetic foot complications, and other long-term health problems.

By providing investigations, consultation, counselling, neuropathy assessment, liver assessment, and available medicines **free of cost**, the initiative helped reduce some of the financial and accessibility barriers faced by people living in peripheral and underserved communities.



A Collaborative Model for Community Healthcare

The successful organization of this camp demonstrates the value of collaboration between professional healthcare organizations, dedicated healthcare professionals, hospitals, laboratories, and diagnostic services.

The initiative reflects the shared commitment of **PCDA Pakistan and LDF** toward promoting **prevention, early detection, risk stratification, patient education, and accessible quality healthcare**.

The organizers expressed their hope that similar collaborative initiatives will continue and expand in the future, creating more opportunities to provide preventive and specialized healthcare services to underserved populations in peripheral areas of **Central Punjab**.



Overall, the free screening camp at Aman Hospital, Toba Tek Singh, was a commendable and meaningful community health initiative. It not only provided much-needed diagnostic and clinical services at no cost but also emphasized an important message:

Early detection, prevention, education, and timely intervention can significantly reduce the burden of diabetes and its associated complications.

The initiative stands as a positive example of how professional organizations and committed healthcare providers can work together to **empower communities, promote preventive healthcare, and improve the quality of life of people living in underserved areas.**



PRIMARY CARE DIABETES ASSOCIATION PAKISTAN

Prevention First, Care Always



NOTIFICATION

The Executive Committee and Central Cabinet of PCDA Pakistan, following a series of discussions and after obtaining the consent of the concerned office-bearers, have approved the following designations

1



Dr. Farasat Ali Shah

former Head of the Khyber Pakhtunkhwa (KPK) Region of PCDA Pakistan, has been designated as a **Member of the Supreme Council** of PCDA Pakistan.

2



Prof. Dr. Arshad Hussain

Head of the Peshawar Chapter of PCDA Pakistan, has been designated as the new **Head of the Khyber Pakhtunkhwa (KPK) Region** of PCDA Pakistan.



The above designations have been duly approved by the **Supreme Council** and the **Executive Committee** of PCDA Pakistan.



These designations shall take effect immediately



All Regional Heads, Chapter Heads, Heads of Wings, and relevant committees are hereby informed of these **designations** and are requested to extend their full cooperation to the newly appointed office-bearers.



We congratulate **Dr. Farasat Ali Shah** and **Prof. Dr. Arshad Hussain** on their new responsibilities and wish them every success in their respective roles.

Dr. Riasat Ali Khan
(President)
PCDA Pakistan



Dr. Shahid Akhter
(General Secretary)
PCDA Pakistan

One Day Symposia on

Type 1 DM **and Beyond**

Exploring the Future of T1DM Care in Pakistan

{CME accredited event}



Date:
Wednesday,
September 23, 2026



Venue:
Auditorium, Fourth Floor,
Northwest Hospital Peshawar

Join us for an informative symposium organized in collaboration
with the **CDIC (Changing Diabetes in Children)**.

This event aims to enhance understanding and management
of T1DM among healthcare professionals in Pakistan.

Highlights of the Symposium



Insightful Talks:

Learn about the latest
standards of care for T1DM.



CDIC Implementation:

Discover how CDIC is making
a difference for patients
locally.



Interactive Session:

Engage in discussions on
insulin therapy, its different
regimes, and carbohydrate
counting.

This event is designed for:



Family
Physicians



Physicians



Paediatricians



Diabetic
Nurses



Educators



Pharmacists



Don't miss this opportunity

for professional development and to enhance
your knowledge in diabetes care!

Eagerly look forward to welcoming you.

Dr Arshad Hussain

PCDA Lead KPK
CDIC lead KPK

Mazdutide, a dual agonist targeting GLP-1R and GCGR, mitigates diabetes-associated cognitive dysfunction

Reports:

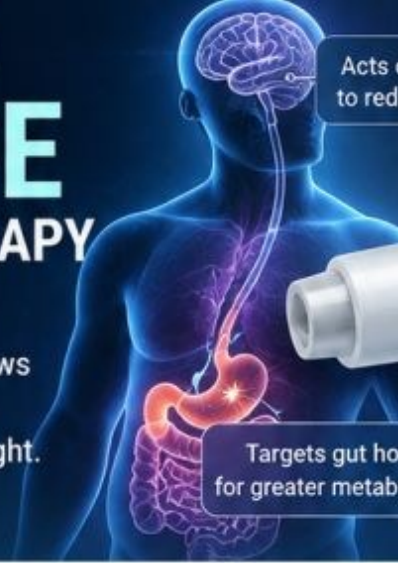
Dr. Hira Sabih Baqai-Head of PCDA-Women's Forum

A NEW ERA IN OBESITY TREATMENT

MAZDUTIDE

A PROMISING NEW THERAPY FOR OBESITY

A Phase 2 randomized, multicenter trial shows significant and sustained weight loss with mazdutide in adults with obesity or overweight.



Published in
THE LANCET
Diabetes & Endocrinology
August 21, 2026

Mazdutide
Once weekly

A NOVEL MULTI-AGONIST

- ✓ Targets GLP-1 receptors
- ✓ Targets glucagon receptors
- ✓ Potential dual metabolic and weight-reducing effects



Reduces appetite
Helps you feel fuller for longer



Significant weight loss
Clinically meaningful results



Improves metabolic parameters
Potential benefits beyond weight loss



Cardiometabolic potential
May improve cardiometabolic risk factors

THE STUDY

-  **Design**
Phase 2, randomized, multicenter, double-blind, placebo-controlled
-  **Population**
Adults with obesity or overweight (without diabetes)
-  **Intervention**
Mazdutide (various doses) vs. placebo (subcutaneous, once weekly)
-  **Duration**
48 weeks
-  **Primary outcome**
Change in body weight from baseline

KEY RESULTS

MEAN PERCENTAGE CHANGE IN BODY WEIGHT AT 48 WEEKS

Group	Mean Percentage Change in Body Weight at 48 Weeks
Placebo	-2.1%
Mazdutide (1 mg)	-8.6%
Mazdutide (3 mg)	-14.2%
Mazdutide (6 mg)	-17.8%

 Dose-dependent weight loss with durable effects over 48 weeks.

SAFETY PROFILE

-  **Generally well tolerated**
Adverse events were mostly mild to moderate.
-  **Most common side effects**
 - Nausea
 - Vomiting
 - Diarrhea
 - Decreased appetite
-  **Low discontinuation rates**
Due to adverse events.

WHY IT MATTERS

- ✓ Addresses a major global health challenge
- ✓ Offers a new potential option in the evolving landscape of anti-obesity therapies
- ✓ May provide additional metabolic benefits through multi-agonist activity
- ✓ Supports the future development of next-generation incretin-based treatments



MORE THAN WEIGHT LOSS
A step toward better metabolic health and a healthier future.

Source: [Authors]. Mazdutide in adults with obesity or overweight: a Phase 2 randomized, multicenter trial. The Lancet Diabetes & Endocrinology. Published online August 21, 2026. doi: 10.1016/S2213-8587(26)xxxx-x

INNOVATION TODAY
FOR A HEALTHIER TOMORROW

Prevention First Newsletter-Online

Dear Readers;

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

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

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

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

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

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

Articles, pictures or any other material for PFN-Online can be directly sent to any member of the Publications Committee and the Editorial Board.

Or E-mail to: preventionfirstnewsletter@gmail.com and pcda.pak@hotmail.com

In charge PFN-Online

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