Voice of Primary Care Diabetes Association (PCDA) Pakistan-*Member of IDF*

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In-charge:

Dr. Shahid Akhter



DEW-PCDA:

- Educate
- Empower
- Prevent



DEW

DIET AND EDUCATION WING

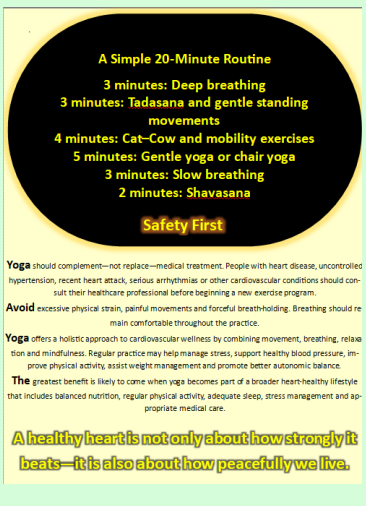
(A project by PCDA)

"DEW-PCDA Champions Preventive Healthcare Through Lifestyle Education".....Yogi Wajahat









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Web:
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Postal Address:
PCDA House
E-1 Naveed Banglows,
Block-17 Gulistan-e-Jauher
Karachi.

Contacts:
pcda.pak@gmail.com Tel:
0213 402 0106, 3107777232

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Editorial

Welcome to the October 2026 issue of *PFN-Online*. Continuing our commitment to *Prevention First*, this issue brings together valuable insights, professional experiences, and practical guidance on diabetes care, cardiovascular health, patient safety, and public health.

Our highlights include the **4th STEEP Health Symposium in Larkana**, an educational session on hypertension, and an online course on cardio-renal protection in type 2 diabetes. Contributions on metabolic health, cardiovascular wellness, emergency surgical care, nutrition education, oral health, hand hygiene, and the responsible use of antibiotics emphasize the importance of a comprehensive, multidisciplinary approach to healthcare.

We are also delighted to feature **Dr. Hira Sabih Baqai's interview in FLARE magazine**, celebrating the voices and contributions of healthcare professionals. Articles on the meaning behind a prescription and the challenges of politics and uncertainty add further depth and diversity to this issue.

We sincerely thank all our authors, contributors, and editorial team members for sharing their knowledge and supporting the mission of PCDA Pakistan. Your contributions strengthen our collective efforts to educate healthcare professionals, empower patients, and promote healthier communities.

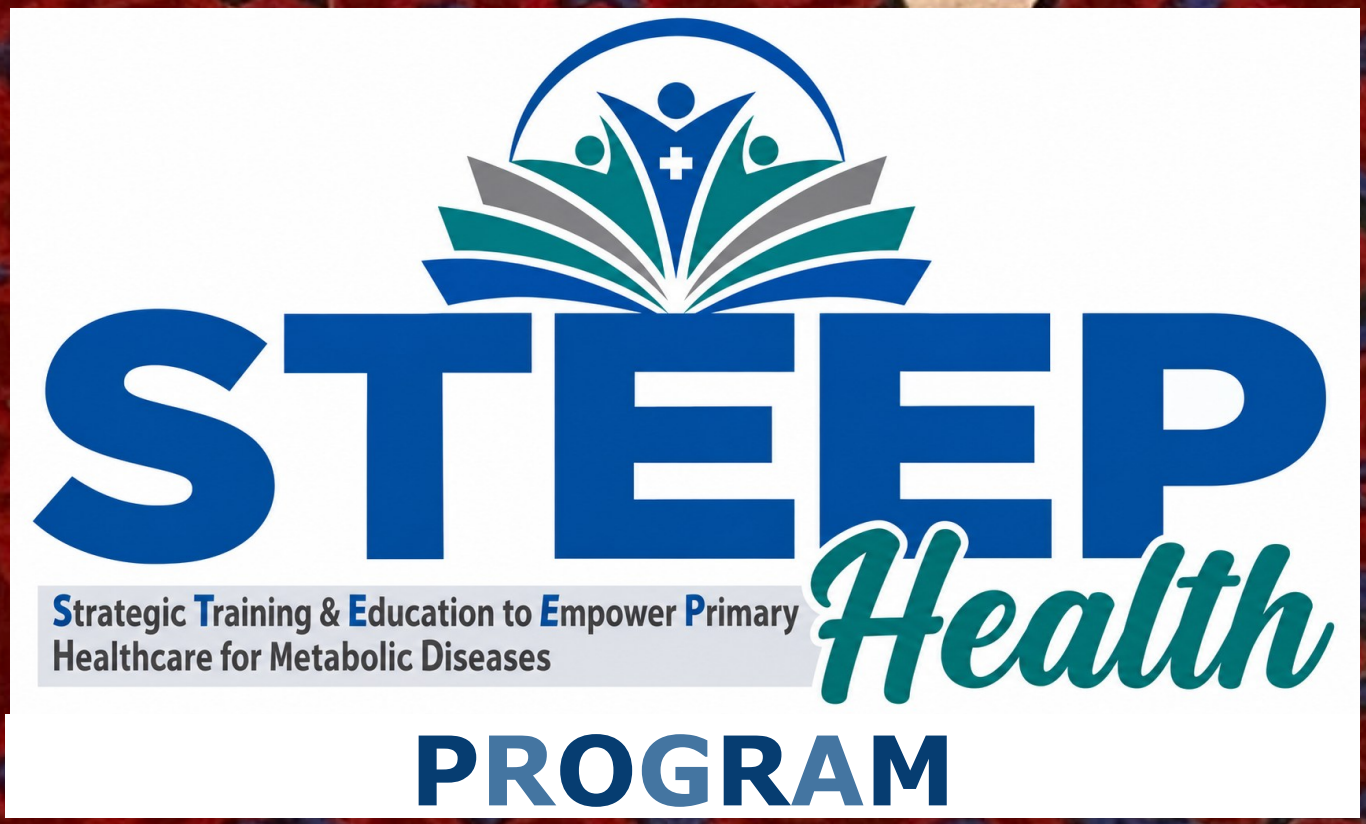
As we move forward, let us continue to place prevention at the heart of healthcare and translate knowledge into meaningful action.

Happy Reading!

4th.Symposium

Under

PCDA's



Larkana

27th September 2026

From Evidence to Practice:

PCPs Gather in Larkana for Scientific Learning on Diabetes, Obesity, Metabolic Health, and Diabetic Foot Care

Hands-On Learning and Evidence-Based Insights for Better Healthcare

LARKANA, September 27, 2026: The fourth symposium under the **STEEP Health Program** was held on Sunday, September 27, 2026, from 8:00 to 11:00 pm at RT Serene Hotel, Larkana. Organised through a collaboration between **B&F and the Primary Care Diabetes Association (PCDA) Pakistan**, the scientific programme brought together more than 100 primary care physicians from Larkana and its surrounding areas for an evening of continuing medical education focused on contemporary approaches to diabetes and metabolic health.

Strengthening Primary Care of Diabetes Through Continuing Medical Education

The participation of more than 100 primary care physicians from Larkana and neighbouring areas reflected the importance of accessible, clinically relevant educational opportunities for frontline healthcare professionals.

With diabetes frequently accompanied by obesity, fatty liver disease, cardiovascular risk factors, and other metabolic complications, primary care physicians play a central role in early identification, risk assessment, treatment selection, patient education, and continuity of care.

By bringing these interconnected topics together in a single scientific programme, the Larkana symposium provided a platform for professional learning across several important dimensions of contemporary diabetes care. The inclusion of diabetic foot prevention and communication strategies also highlighted the need to integrate complication prevention and patient engagement into routine clinical practice.

The collaboration between B&F and PCDA Pakistan further demonstrated the value of partnerships in facilitating continuing medical education and supporting the professional development of primary care physicians.

The fourth STEEP Health Program in Larkana represented another opportunity to strengthen clinical knowledge and encourage the application of evidence-based approaches in everyday practice. By addressing diabetes alongside obesity, liver disease, therapeutic advances, and diabetic foot care, the programme reinforced the importance of viewing metabolic health as an interconnected clinical priority.

As diabetes care continues to evolve, strengthening the knowledge and skills of primary care physicians remains essential to improving early diagnosis, individualising treatment, preventing complications, and enhancing the quality of life of people living with diabetes.

Through continued educational initiatives and collaborative engagement, programmes such as STEEP can contribute to building a more informed, confident, and capable primary care workforce—supporting the shared goal of better diabetes care and improved health outcomes.

4th STEEP Health Symposium featured six expert-led scientific sessions addressing the interconnected challenges of diabetes, metabolic dysfunction-associated fatty liver disease, obesity, diabetic foot complications, and the evolving pharmacological management of type 2 diabetes. The programme emphasised the importance of evidence-based decision-making, early recognition of metabolic complications, and strengthening the capacity of primary care physicians to deliver comprehensive, patient-centred care.

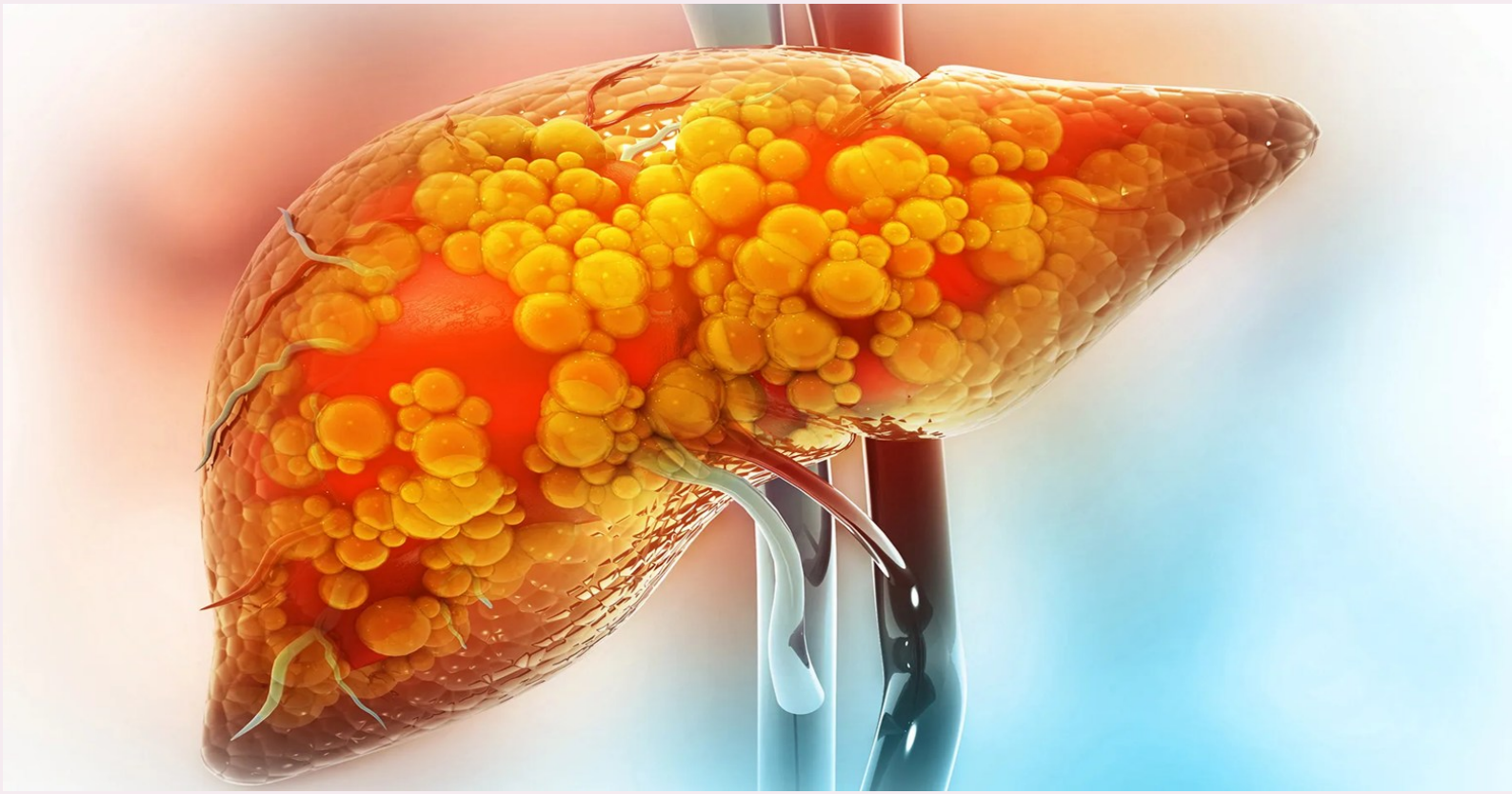
Six Scientific Sessions

Address Key Priorities in Diabetes Care

The scientific programme covered a broad spectrum of clinical issues, reflecting the growing need for an integrated approach to diabetes management in primary care.

1. **MAFLD and MASH in Diabetes**: Why Primary Care Can't Ignore the Liver:
   Speaker: Dr. Iftikhar Ali Shah

Dr. Iftikhar Ali Shah addressed metabolic dysfunction-associated fatty liver disease (MAFLD) and metabolic dysfunction-associated steatohepatitis (MASH) in people living with diabetes. His session highlighted the clinical importance of recognising liver involvement as part of the broader metabolic disease spectrum. The topic reinforced the need for primary care physicians to maintain awareness of liver-related complications while assessing and managing patients with diabetes and associated metabolic risk factors.



2. Obesity as a Key Driver of Metabolic Disorders:

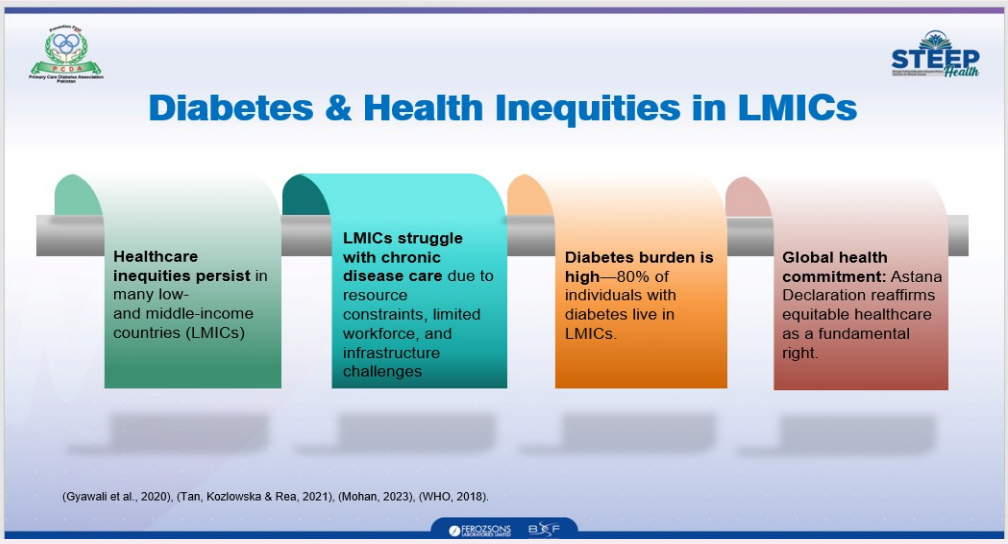


Speaker: Dr. Hakim Ali Abro

Focusing on obesity as a major contributor to metabolic dysfunction, Dr. Hakim Ali Abro explored its relationship with diabetes and other metabolic disorders. The session highlighted the importance of recognising obesity as a significant clinical concern requiring proactive assessment and appropriate management, alongside attention to associated metabolic risk factors. It also underscored the value of addressing weight management as an integral component of comprehensive diabetes care.

3. Understanding Diabetes:
A Window into Metabolic Disorders

Speaker: Dr. Shahid Akhter



Dr. Shahid Akhter presented diabetes as an important window into the wider spectrum of metabolic disorders. His session focused on understanding diabetes beyond elevated blood glucose, drawing attention to the interconnected metabolic abnormalities that influence disease progression and associated complications.

The presentation reinforced the importance of a comprehensive clinical perspective in primary care, encouraging physicians to consider the broader metabolic health of their patients rather than focusing exclusively on glycaemic control.

4. Saving Limbs, Changing Lives:
Communication Strategy in Diabetic Foot Care

Speaker: Dr. Shakeel Ahmed

Highlighting the importance of diabetic foot care, Dr. Shakeel Ahmed addressed communication strategies that can help improve awareness, prevention, and early intervention. His session emphasised the role of effective communication between healthcare professionals and patients in promoting foot-care practices, recognising warning signs, and encouraging timely medical consultation.

Dr. Shakeel's presentation reinforced the principle that diabetic foot complications require a proactive, multidisciplinary approach, with patient education and early recognition playing essential roles in reducing the risk of ulcers, infections, and lower-limb amputations.



Managing a Diabetic Foot Ulcer (DFU) at the primary care level focuses on early recognition, halting tissue destruction, controlling infection, and arranging prompt specialist care considering Risk Factors , Physical Exam , Wound Evaluation and Red Flags (Urgent Referral) .



5. Oral and Injectable Options for Type 2 Diabetes

Speaker: Dr. Riasat Ali Khan

Dr. Riasat Ali Khan discussed oral and injectable treatment options for type 2 diabetes, addressing an important aspect of everyday clinical practice. The session focused on the range of pharmacological approaches available to support individualised diabetes management.

The discussion highlighted the importance of selecting appropriate treatment according to patients' clinical needs, treatment goals, comorbidities, and individual circumstances. For primary care physicians, familiarity with available therapeutic options remains essential to optimising diabetes control and supporting long-term patient outcomes.

6. GLP-1 Receptor Agonists: A Pathway to Comprehen sive Metabolic Care, with Evidence



Speaker: Dr. Fareeduddin

Dr. Fareeduddin explored the role of glucagon-like peptide-1 receptor agonists (GLP-1 RAs) in contemporary diabetes management and broader metabolic care. The session examined this therapeutic class within the context of evidence-based clinical decision-making and the increasing emphasis on addressing multiple metabolic risk factors in patients with type 2 diabetes.

The presentation highlighted the importance of understanding the evidence supporting newer therapeutic options and considering their appropriate place in individualised treatment strategies.

Note: Due to some technical problems, pictures of this symposium are not included.

Dr. Irfan Shaukat on Diuretic Therapy of Hypertension



Chistian Distt Bahawalnagar, 15 September 2026.

The combination of the potassium-sparing diuretic spironolactone and the loop diuretic frusemide is a widely used, synergistic treatment for managing severe fluid retention and swelling. By acting on different parts of the kidneys, these two medications complement each other to maximize fluid removal while stabilizing critical electrolyte levels.

Dr. Irfan Shaukat who is the head of Multan chapter of PCDA Pakistan was talking to a gatering of Primary Care Physicians of Chishtian and the adjacent villages. He said that "When used together, these drugs provide a "dual-action" approach to fluid clearance by its synergistic diuretic effect and Potassium Balancing, Frusemide is highly effective but causes the body to lose potassium, which can lead to dangerously low levels (hypokalemia). Spironolactone blocks the hormone aldosterone, which causes the kidneys to retain potassium (potassium-sparing). Pairing them protects the body from extreme potassium fluctuations.

Primary Care Physicians typically prescribe this combination to manage refractory edema (fluid retention that doesn't respond to a single diuretic) caused by Liver Cirrhosis with Ascites, Congestive Heart Failure (CHF) and Nephrotic Syndrome



Metabolic Health:

The Foundation of Long Term Well-Being



Dr. Shakeel Ahmed
Media Secretary & Head of Diabetic Foot Group of PCDA Pakistan

Metabolic health is a foundation part of overall health, yet it is often overlooked until a problem develops. The body's metabolism involves a complex network of processes that convert food into energy, regulate blood sugar, manage fats, maintain blood pressure, and support the functioning of organs and tissues. Good metabolic health means these processes are working effectively and are maintained within healthy ranges.

Metabolic health is not simply about body weight or appearance. A person can have a higher or lower body weight and still have varying degrees of metabolic health. Likewise, feeling healthy does not necessarily mean that blood sugar, cholesterol, blood pressure, or other metabolic markers are within desirable ranges. Understanding these factors can help people make informed choices that support health throughout life.

What Is Metabolic Health?

Metabolic health refers to how well the body regulates essential physiological processes, particularly those involving energy and nutrients. Several measurable factors are commonly used to assess metabolic health, including blood glucose, blood pressure, blood lipids, waist circumference, and insulin regulation.



Blood glucose is especially important because glucose provides energy for cells. The hormone insulin helps move glucose from the bloodstream into cells. When the body becomes less responsive to insulin—a condition known as insulin resistance—the pancreas may need to produce more insulin to maintain normal blood glucose levels. Over time, this can contribute to prediabetes and type 2 diabetes.

Blood lipids are another important component. Cholesterol and triglycerides are essential substances, but abnormal levels can increase the risk of cardiovascular disease. Blood pressure also matters because persistently elevated pressure places additional strain on blood vessels and the heart.

These factors are interconnected. For example, insulin resistance can occur alongside high blood pressure, abnormal cholesterol levels, and increased abdominal fat. This clustering of metabolic problems is commonly associated with metabolic syndrome.

Why Metabolic Health Matters

Poor metabolic health can develop gradually and may remain unnoticed for years. Some metabolic conditions produce few or no obvious symptoms during their early stages. For this reason, regular health assessments can be valuable even for people who feel well.

Long-term metabolic problems are associated with an increased risk of conditions such as type 2 diabetes, cardiovascular disease, fatty liver disease, and kidney disease. Maintaining healthy metabolic function can therefore contribute not only to daily well-being but also to reducing the risk of chronic disease.

Metabolic health also influences energy balance and physical performance. The body needs a reliable supply of energy to support movement, concentration, immune function, tissue repair, and other activities. Sleep, nutrition, physical activity, stress, genetics, medications, and other factors can all influence metabolic processes.

The Role of Nutrition

Nutrition is one of the most important factors affecting metabolic health. A balanced eating pattern can provide the body with essential nutrients while helping regulate blood glucose and energy intake.

Whole or minimally processed foods can form the foundation of a metabolic-health-conscious diet. Vegetables, fruits, legumes, whole grains, nuts, seeds, fish, eggs, and other nutrient-dense foods provide combinations of fiber, vitamins, minerals, protein, and healthy fats.

Dietary fiber is particularly useful because it can slow the absorption of carbohydrates, support digestive health, and contribute to feelings of fullness. Foods rich in fiber include beans, lentils, vegetables, fruits, oats, and whole grains.

Protein is also important because it supports muscles and other tissues and can help with satiety. Healthy sources can include fish, poultry, eggs, beans, lentils, yogurt, nuts, and seeds.

At the same time, frequently consuming large amounts of highly processed foods, sugary beverages, and foods high in added sugars can make maintaining healthy metabolic markers more difficult. The overall dietary pattern generally matters more than any single food.

Physical Activity and Metabolism

Regular physical activity is another cornerstone of metabolic health. Muscles use glucose for energy, and physical activity can improve the body's ability to use glucose efficiently.

Both aerobic exercise and resistance training can provide metabolic benefits. Activities such as brisk walking, cycling, swimming, and dancing can improve cardiovascular fitness. Resistance exercises, including weight training and body-weight exercises, can help build and maintain muscle.

Importantly, physical activity does not have to mean intense exercise every day. Consistency is often more practical and sustainable. Breaking up long periods of sitting with short periods of movement can also be beneficial.

For people who are new to exercise, gradually increasing activity may be more realistic than immediately adopting a demanding program. Individuals with medical conditions or significant limitations should discuss appropriate exercise with a healthcare professional.



Sleep and Metabolic Health

Sleep is sometimes neglected in discussions about metabolism, but it plays an important role in overall physiological health. Poor sleep or insufficient sleep can affect appetite regulation, energy levels, glucose metabolism, and other biological processes.

Adults generally benefit from getting adequate, regular sleep, although individual needs vary. Maintaining consistent sleep and wake times, creating a comfortable sleeping environment, and limiting stimulating activities close to bedtime can support better sleep habits.

Persistent problems such as loud snoring, repeated nighttime awakenings, or excessive daytime sleepiness may warrant medical evaluation because sleep disorders can affect health.

Stress and Metabolic Function

Stress is another factor that can influence metabolic health. During periods of stress, the body releases hormones that help it respond to perceived challenges. Short-term stress responses are normal, but persistent psychological stress can affect sleep, eating patterns, physical activity, and other behaviors.

Stress management does not require eliminating every source of stress. Instead, useful strategies may include regular physical activity, adequate sleep, social connection, relaxation practices, hobbies, and professional support when necessary.

Mental and physical health are closely connected. A sustainable approach to metabolic health should therefore consider emotional well-being rather than focusing exclusively on food, weight, or laboratory results.

Weight Is Only One Part of the Picture

Body weight is often treated as the main indicator of metabolic health, but it is only one measure. Waist circumference can provide additional information about abdominal fat, while blood pressure and laboratory tests can reveal aspects of metabolic function that cannot be determined from appearance alone.

It is possible for someone with a higher body weight to have some healthy metabolic markers, while another person with a lower body weight may have elevated blood glucose or cholesterol. This is why health assessment should consider multiple factors rather than relying on weight alone.

The goal should be to improve health-related behaviors and measurable risk factors rather than pursuing a particular appearance.

Monitoring Metabolic Health

Healthcare professionals can assess metabolic health through routine measurements and laboratory tests. Depending on a person's age, medical history, family history, and risk factors, assessments may include blood pressure measurement, blood glucose or HbA1c testing, cholesterol testing, and evaluation of waist circumference or other relevant measures.

Regular screening can help identify problems at an earlier stage. Prediabetes, for example, can often be detected through blood testing before diabetes develops. Early identification provides an opportunity to address risk factors and discuss appropriate treatment or monitoring with a healthcare professional.

People with a family history of diabetes or cardiovascular disease, previous abnormal test results, or other risk factors may need more frequent assessment.

Building Sustainable Habits

Improving metabolic health does not necessarily require dramatic lifestyle changes. Small, sustainable habits can accumulate over time. Someone might begin by adding more vegetables to meals, replacing sugary drinks with water, taking a daily walk, establishing a consistent sleep schedule, or reducing prolonged sitting.

Another important principle is avoiding an all-or-nothing approach. A healthy lifestyle does not require perfect eating or exercise every day. Occasional indulgences or missed workouts do not erase progress. What matters most is the overall pattern maintained over months and years.

Extreme diets, unnecessary supplements, or rapid weight-loss programs are not required for good metabolic health. In some circumstances, medications may be appropriate, particularly when lifestyle measures alone are insufficient. Treatment decisions should be individualized and discussed with qualified healthcare professionals.

The Bigger Picture

Metabolic health is shaped by many factors, including genetics, age, environment, socioeconomic circumstances, medical conditions, medications, diet, physical activity, sleep, and stress. This means that improving metabolic health should not be viewed as a matter of willpower alone.

A comprehensive approach focuses on several areas simultaneously: nutritious food, regular movement, adequate sleep, stress management, preventive healthcare, and appropriate treatment when needed. These factors work together to support the body's ability to regulate energy and maintain healthy physiological function.

Conclusion

Metabolic health provides an important window into how effectively the body manages energy, blood sugar, fats, and other essential processes. It is closely connected with the risk of chronic diseases and with overall quality of life.

The good news is that many aspects of metabolic health can be supported through everyday habits. Eating a balanced diet, staying physically active, getting adequate sleep, managing stress, avoiding tobacco, and attending appropriate health screenings can all contribute to better long-term health.

Ultimately, metabolic health is not about achieving perfection or meeting a particular body shape. It is about creating sustainable conditions in which the body can function effectively. By paying attention to multiple health indicators and making realistic, consistent lifestyle choices, people can take meaningful steps toward protecting their health for the future.

A comprehensive approach focuses on several areas simultaneously: nutritious food, regular movement, adequate sleep, stress management, preventive healthcare, and appropriate treatment when needed. These factors work together to support the body's ability to regulate energy and maintain healthy physiological function.

PCDA Pakistan, South Region, Organizes Online Course on Cardio-renal Protection in Type 2 Diabetes

Academic Initiative Focuses on Implementing the 2026 Consensus for Improved Cardiovascular and Kidney Health

Reported by: **Dr. Abdul Samad Memon**
Head of South Region PCDA Pakistan



MIRPURKHAS, October 13, 2026: The Primary Care Diabetes Association Pakistan (PCDA), Mirpurkhas – South Region, organised an academic course programme on *"Implementing the 2026 Consensus for Cardiorenal Protection in Patients with Type 2 Diabetes"* in collaboration with PharmEvo Pharma on Tuesday, October 13, 2026. The programme was held at Food Cravings, Mirpurkhas, bringing an educational opportunity to healthcare professionals focused on contemporary approaches to diabetes management and the prevention of cardiovascular and kidney complications.

The activity was coordinated under the leadership of **Dr Abdul Samad Memon, Head of the South Region Chapter of PCDA Pakistan**, who also served as the session moderator. The programme featured **Dr Sarwat Anjum, Consultant Endocrinologist and Assistant Professor at MMC&H, ISU, Mirpurkhas**, as the facilitator.

Emphasis on Comprehensive Diabetes Management

The course focused on the implementation of the 2026 consensus recommendations for cardiorenal protection in patients with type 2 diabetes. The subject highlights an important dimension of modern diabetes care: the need to address cardiovascular and kidney health alongside blood glucose control. People living with type 2 diabetes are at increased risk of developing cardiovascular disease and chronic kidney disease. Therefore, comprehensive management requires healthcare professionals to consider these risks as part of an integrated treatment strategy rather than concentrating exclusively on glycaemic targets.



The programme's central theme was the practical implementation of contemporary consensus recommendations in clinical practice. By focusing on cardiorenal protection, the course aimed to support healthcare professionals in strengthening their understanding of approaches that can help reduce diabetes-related complications and improve long-term patient outcomes.

Expert Facilitation and Academic Moderation

Dr Sarwat Anjum, Consultant Endocrinologist and Assistant Professor at MMC&H, ISU, Mirpurkhas, served as the programme facilitator. Her role was to guide the academic session on the implementation of the 2026 consensus for cardiorenal protection in type 2 diabetes.

Dr Abdul Samad Memon, Family Physician and Diabetologist, moderated the programme. As Head of the PCDA Pakistan South Region Chapter, he has been instrumental in coordinating academic activities aimed at supporting continuing medical education and strengthening diabetes care among healthcare professionals in the region.

The collaboration between PCDA Pakistan and PharmEvo Pharma reflected a shared interest in facilitating educational opportunities for healthcare professionals and promoting awareness of evolving approaches to diabetes management.





Digital Learning and Certification

The programme incorporated an online course format, requiring participants to bring an Android mobile phone with an active internet package and a valid email address. These requirements enabled participants to access the digital learning platform and complete the course.
Participants were informed that certificates would be awarded upon successful completion of the programme, providing an additional incentive for engagement with the educational activity.
The integration of digital learning into professional education offers healthcare professionals an opportunity to engage with structured educational content and contemporary clinical recommendations. Such initiatives can help extend access to learning opportunities and encourage the continuing professional development of primary care practitioners and other healthcare providers.

Strengthening Primary Care Diabetes Education

PCDA Pakistan works to advance diabetes prevention, early detection, patient education, and the professional development of healthcare providers, with a particular emphasis on strengthening diabetes care at the primary care level.
The Mirpurkhas programme reflected the importance of continuing medical education in an area of diabetes management that increasingly requires an integrated approach. Cardiovascular and kidney complications contribute substantially to the burden of diabetes, making risk assessment, appropriate



treatment planning, and coordinated long-term care important considerations for clinicians.
By organising educational programmes on emerging clinical recommendations, PCDA's regional chapters can help connect healthcare professionals with relevant academic discussions and encourage the application of evidence-based approaches in everyday practice.
The collaboration with PharmEvo Pharma also demonstrated the role that academic and industry partnerships can play in supporting professional education, while maintaining a focus on the clinical needs of people living with diabetes.



A Step Towards Better Diabetes Outcomes

The course programme in Mirpurkhas underscored the importance of keeping healthcare professionals informed about contemporary approaches to the management of type 2 diabetes and its associated complications. All 30 participants successfully completed the online course and received certificates of completion from the European Academy of CME, UK.



Yoga and Heart Health:



A Natural Approach to Cardiovascular Wellness

By: **Yogi Wajahat (DEW-PCDA)**

Heart disease is one of the leading health challenges worldwide. High blood pressure, obesity, diabetes, high cholesterol, physical inactivity, poor sleep and chronic stress can all increase the risk of cardiovascular problems. Along with medical care and a healthy lifestyle, yoga can be a valuable complementary approach to maintaining heart health.

Yoga is more than physical exercise. It combines body postures (asanas), breathing techniques (pranayama), relaxation and meditation. This combination may positively influence several factors that are important for cardiovascular health.



How Yoga Supports Heart Health

1 Helps Manage Blood Pressure:

High blood pressure makes the heart work harder and places additional stress on blood vessels. Regular, gentle yoga practice may help promote relaxation and improve blood-pressure regulation. Slow breathing and relaxation techniques can reduce excessive sympathetic nervous-system activity—the body's "fight-or-flight" response—and encourage a calmer physiological state. Over time, this may contribute to healthier blood-pressure levels.

2 Reduces Stress:

Chronic psychological stress can increase heart rate and blood pressure and may negatively affect sleep, eating habits and overall health.

Yoga encourages awareness of breathing and body sensations, helping practitioners develop a calmer response to stress. Meditation and relaxation at the end of a yoga session can further support mental and emotional well-being.

3 Supports Healthy Heart Rate and Autonomic Balance



The autonomic nervous system regulates important functions such as heart rate and blood pressure. Yoga breathing and meditation may encourage better balance between sympathetic and parasympathetic activity.

Slow, controlled breathing can be particularly useful for developing better respiratory control and promoting relaxation.

4 Improves Physical Activity and Weight Management

Being physically inactive and carrying excess body weight are important cardiovascular risk factors. Yoga provides a form of physical activity that can improve flexibility, balance, mobility and muscular endurance.



More active forms of yoga can also increase energy expenditure. When combined with appropriate nutrition and regular walking or aerobic exercise, yoga may support healthy weight management and metabolic health.

5 Supports Vascular Health

Healthy blood vessels are essential for efficient circulation. Regular physical activity and stress reduction may support vascular function.

Yoga's combination of movement, breathing and relaxation may therefore contribute to better overall cardiovascular function.

Heart-Friendly Yoga Exercises

1. Sukhasana with Deep Breathing



Sit comfortably with the spine upright. Relax the shoulders and breathe slowly through the nose.

Allow the abdomen and ribs to expand naturally during inhalation and relax during exhalation. Practice for 3–5 minutes.

2. Tadasana — Mountain Pose

Stand comfortably with the feet apart.

Lengthen the spine, relax the shoulders and breathe naturally. Hold for 20–30 seconds and repeat several times.



3. Cat–Cow Movement



Come onto the hands and knees. Slowly move between gentle spinal extension and rounding while coordinating movement with breathing. Repeat 8–10 times.

4. Nadi Shodhana



Practice gentle alternate-nostril breathing for 3–5 minutes. The breathing should remain comfortable and relaxed.

Avoid forceful breathing or prolonged breath retention.

5. Chair Yoga

Chair-based yoga is particularly useful for older adults or people with limited mobility. Gentle seated movements, shoulder rotations, ankle movements and coordinated arm-and-breath exercises can provide accessible physical activity.







Finish the session with 5–10 minutes of relaxation. Lie comfortably or sit with support, close the eyes and allow the breathing to become natural

6. Shavasana



A Simple 20-Minute Routine

3 minutes: Deep breathing
3 minutes: Tadasana and gentle standing movements
4 minutes: Cat–Cow and mobility exercises
5 minutes: Gentle yoga or chair yoga
3 minutes: Slow breathing
2 minutes: Shavasana

Safety First

Yoga should complement—not replace—medical treatment. People with heart disease, uncontrolled hypertension, recent heart attack, serious arrhythmias or other cardiovascular conditions should consult their healthcare professional before beginning a new exercise program.

Avoid excessive physical strain, painful movements and forceful breath-holding. Breathing should remain comfortable throughout the practice.

Yoga offers a holistic approach to cardiovascular wellness by combining movement, breathing, relaxation and mindfulness. Regular practice may help manage stress, support healthy blood pressure, improve physical activity, assist weight management and promote better autonomic balance.

The greatest benefit is likely to come when yoga becomes part of a broader heart-healthy lifestyle that includes balanced nutrition, regular physical activity, adequate sleep, stress management and appropriate medical care.

A healthy heart is not only about how strongly it beats—it is also about how peacefully we live.

Poorly managed diabetes can damage vital organs

Dr Hira Sabih Baqai,
Head, PCDA Women's Forum



PCDA WOMEN'S FORUM
EMPOWER • LEAD • INSPIRE

Dr Hira Sabih Baqai, Head of the PCDA Women's Forum, shared her views with Flare Magazine on diabetes care, women's leadership, professional education, and the PCDA Women's Forum's initiatives during an interview. She also thanked the magazine for the opportunity to spotlight efforts to improve diabetes and metabolic health in Pakistan.

Flare: Dr. Hira, could you introduce yourself to our readers?

Dr. Hira: I am Dr. Hira Sabih Baqai, Consultant Diabetologist and Endocrinologist, with special interests in diabetes, obesity, thyroid disorders and PCOS. I also have the honour of serving as Head of the PCDA Women's Forum.

I believe healthcare is not only about treating disease but also about prevention, education, awareness and empowering people to make informed health decisions. Through my clinical and professional work, I aim to contribute to better diabetes and metabolic health in Pakistan.

Flare: What is PCDA, and why is primary-care diabetes important?

Dr. Hira: PCDA—the Primary Care Diabetes Association—is a non-governmental, non-profit organisation dedicated to improving diabetes care in Pakistan through education, advocacy, research, prevention and capacity building.

Founded by the late Dr. Syed Mansoor Ali, PCDA was built on the recognition that primary-care physicians play a vital role in addressing Pakistan's growing diabetes burden. Today, it has expanded to more than 50 cities and towns through 65 chapters across five regions.

Prof. Abdul Basit has also been a valued mentor and patron, providing guidance and support to PCDA's mission. PCDA is a member association of the International Diabetes Federation (IDF), reflecting its commitment to diabetes education, prevention and professional development.

Flare: What are PCDA's major initiatives?

Dr. Hira: PCDA has developed several initiatives addressing diabetes care, education and professional development. The PCDA Women's Forum empowers women healthcare professionals through education, leadership, research, advocacy and community outreach, while also addressing women-specific metabolic and endocrine health issues.

DEW (Diet & Education Wing) promotes evidence-based nutrition, diabetes prevention and practical lifestyle strategies for healthier living and better diabetes outcomes.

STEP (Student Taskforce for Education and Prevention) engages medical students and young healthcare professionals in diabetes education, awareness and prevention, helping develop future public-health ambassadors. The Diabetic Foot Group focuses on education, early recognition, prevention and appropriate management of diabetic foot disease to reduce preventable complications and amputations.

PCDA's Podcast Series provides accessible, evidence-based discussions on diabetes, metabolic health and clinical practice, bringing experts together for healthcare professionals and the wider community. Its nationwide regional chapter network conducts educational sessions, screening activities, awareness programmes, community initiatives and professional meetings, taking diabetes education closer to the people.

Flare: How does PCDA use digital platforms for education and outreach?

Dr. Hira: Communication and education are central to PCDA's mission. Its monthly newsletter, "Prevention First," highlights chapter activities, clinical updates, research, educational articles, awareness initiatives and upcoming events.

PCDA's official website provides information about its leadership, chapters, research, seminars, projects and educational resources. Its social-media platforms further extend this outreach through health messages, campaign materials, event updates, podcasts and educational content.

Flare: What are the major challenges in preventing and controlling the growing burden of diabetes?

Dr. Hira: Pakistan faces a significant and growing diabetes burden driven by changing lifestyles, physical inactivity, unhealthy diets, obesity, stress and inadequate sleep.

A major challenge is that many people remain undiagnosed until complications develop. Limited awareness, inadequate screening and unequal access to quality healthcare further compound the problem.

We must move beyond a treatment-focused model and prioritise prevention, early detection, risk reduction and long-term management. This requires collaboration among healthcare professionals, communities, policymakers, educational institutions and the media.

Flare: How can the government help prevent diabetes? What policies are needed?

Dr. Hira: Diabetes prevention should be a national public-health priority. We need stronger screening and risk-assessment programmes through primary healthcare, better food labelling, healthier nutrition policies and measures to reduce excessive consumption of sugar-sweetened beverages and highly processed foods.

> I believe healthcare goes beyond treatment to include prevention, education and empowerment. Through my clinical and professional work, I strive to improve diabetes and metabolic health in Pakistan

Flare: Can AI contribute to diabetes prevention and management?

Dr. Hira: Absolutely, Artificial Intelligence (AI) can help identify people at high risk, analyse glucose and health data, recognise patterns, support clinical decision-making and enable more personalised care.

Combined with continuous glucose monitoring, digital health platforms and smart devices, AI can also encourage patients to take a more active role in managing their health.

However, AI should support—not replace—healthcare professionals. Its use must be guided by safeguards for privacy, accuracy, data security, ethics and accessibility. Technology is most valuable when it strengthens, rather than replaces, the patient–healthcare professional relationship.

Flare: What challenges do female doctors face, and how can the PCDA Women's Forum support them?

Dr. Hira: Female doctors often balance demanding careers with family responsibilities and societal expectations, while facing fewer opportunities for leadership, mentorship, research, networking and professional recognition.

The PCDA Women's Forum aims to provide a supportive platform where women healthcare professionals can learn, collaborate, lead and serve.

Flare:What is your vision for the PCDA Women's Forum?

Dr. Hira: My vision is to build a strong, dynamic and recognised network of women physicians across Pakistan.

I want every member to feel valued and empowered to contribute. We aim to create opportunities for continuous learning, professional growth, leadership, research, collaboration and community service.

Most importantly, the Forum should be a platform where women physicians support one another, share knowledge and collectively contribute to improving diabetes and metabolic health.

Through collective action, we can strengthen women's role in healthcare and contribute to a healthier Pakistan.

Flare:Finally, what message would you like to give the public about diabetes?

Dr. Hira: Diabetes is much more than high blood sugar. If poorly managed, it can affect the heart, kidneys, eyes, nerves and overall quality of life.

However, many risk factors are modifiable, and early action can make a meaningful difference.

My message is simple: Know your risk. Get screened. Stay active. Eat wisely. Maintain a healthy weight and seek timely medical advice.

We should not wait for symptoms or complications before taking action. Through awareness, education, early detection and collective effort, we can change the trajectory of diabetes in Pakistan.


World Health Organization
75
HEALTH FOR ALL
STEP-PCDA
Accelerate action together
STUDENT TASKFORCE FOR EDUCATION & PUBLIC HEALTH
SAVE LIVES Clean Your Hands
Hand Hygiene
By: Mahnoor Tariq
#HandHygiene
#CleanYourHands
#InfectionPrevention

Hand hygiene:

First step to prevent from every disease





By:

Mahnoor Tariq

Student Taskforce for Education and Public Health (STEP-PCDA)

In the previous issue of Prevention First Newsletter, I discussed *SSI: Prevention, woundcare in Patients with Diabetes*. In this issue I want to discuss the most basic and most important step to prevent any disease which is hand hygiene.

I will focus on sterilization, disinfection, autoclave, because we often forget that infection control starts from our hands. Hands are the main source of carrying germs from one source to another. During my clinical posting in OR I have seen that before starting any surgical procedure we follow proper surgical hand scrub for 5 minutes. But outside OT, I have seen people ignore hand washing and get infections. When patients are shifted from OR or discharged after any procedure they often do not care about their wound management. They do not follow hand hygiene and this is the main cause where infection starts. Hand hygiene is not just for OT staff. It is for everyone. A Doctor, a Nurse, OT Staff and even the patient's family. This is more important for patients whose immune system is weak, like children, geriatric patients, HIV, Cancer and Diabetes patients.

I saw in my posting that diabetic patients get infection very fast. Their sugar level is high and healing is slow. If we touch them with unwashed hands, we are giving them infection.

In **WHO guidelines** there are 5 moments of hand hygiene, which we try to follow:
Before touching the patient, before any clean procedure, after body fluid exposure, after touching the patient, and after touching patient surroundings.

Know the 5 Moments for Hand Hygiene

in aged care



1 **BEFORE** touching a person



2 **BEFORE** any procedure



3 **IMMEDIATELY AFTER** a procedure, or bodily fluid exposure



4 **AFTER** touching a person



5 **AFTER** touching a person's surroundings

The best part is, hand hygiene is very basic and simple. Just 30 seconds of proper hand washing can stop infection. Honestly, these steps take less than a minute but they can prevent almost every hospital infection.

Steps of Hand Washing:

1. Wet hands with water and apply soap.
2. Rub palms together.
3. Rub back of each hand with palm of other hand.
4. Rub between fingers and thumbs.
5. Rub fingertips on palms to clean nails.
6. Rinse hands with water.
7. Dry with clean towel or tissue.

This whole process will take approx 30 to 40 seconds. Hand washing with soap and water is best when hands are visibly dirty. But hand sanitizer also useful when water is not available. In wards and OR, we use alcohol based sanitizer. It is quick and kills 99.9% germs in 20 seconds.



RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

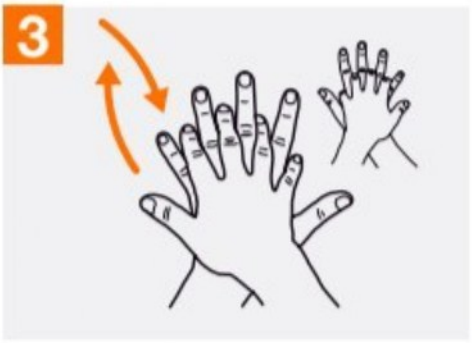
Duration of the entire procedure: 20-30 seconds



Apply a palmful of the product in a cupped hand, covering all surfaces;



Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



Palm to palm with fingers interlaced;



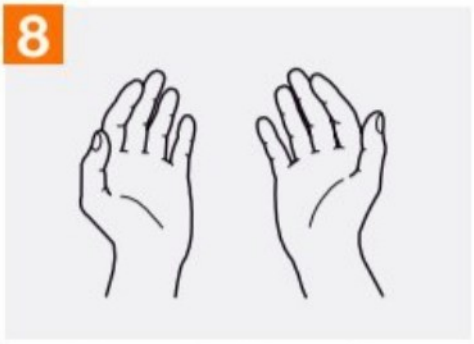
Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

As surgical technology students, we should make it a habit. Not just in OT, but everywhere we should follow hand hygiene. And we should also teach patient's attendants to wash hands before touching the patient and how to take care of their wound. Because at the end:

Prevention does not start with big machines or expensive antibiotics. It starts with our own hands.

Reference: *All information and visual materials used in this newsletter are adapted from authentic resources published by the World Health Organization (WHO) and the Aged Care Quality and Safety Commission (Australian Government).*
Fig. 1: 5 Moments for Hand Hygiene — adapted from Aged Care Quality and Safety Commission / WHO.
Fig. 2: How to Handwash — World Health Organization (2009).
Fig. 3: How to Handrub — World Health Organization (2009).
Fig. 4: World Hand Hygiene Day Campaign — World Health Organization (2023).

NAVIGATING EMERGENCY SURGICAL INTERVENTIONS IN PATIENTS WITH UNCONTROLLED DIABETES

RECOGNIZING DIABETIC KETOACIDOSIS (DKA) AND HYPEROSMOLAR HYPERGLYCEMIC STATE (HHS) IN THE OPERATING ROOM



Written by:
FATIMA NASEEM
STEP-PCDA

Uncontrolled diabetes can lead to serious metabolic emergencies such as diabetic ketoacidosis (DKA) and hyperosmolar hyperglycemic state (HHS). These conditions are particularly important in patients requiring surgery because they can rapidly worsen and increase perioperative risk.

Emergency surgery presents an additional challenge because there may be limited time for metabolic optimization. Surgical stress, infection, acute illness, dehydration and missed insulin doses can contribute to worsening hyperglycemia and precipitate metabolic emergencies.

Early recognition and prompt management are therefore essential when an unstable patient with diabetes requires urgent surgical care.

WHAT IS UNCONTROLLED DIABETES?

Uncontrolled diabetes occurs when the body does not have enough effective insulin or cannot use insulin properly.Uncontrolled diabetes can lead to serious metabolic emergencies such as diabetic ketoacidosis (DKA) and hyperosmolar hyperglycemic state (HHS). These conditions are particularly important in patients requiring surgery because they can rapidly worsen and increase perioperative risk.

Type 1 Diabetes: The body stops making insulin.
Type 2 Diabetes: The body cannot use insulin effectively.

When diabetes becomes poorly controlled, patients may develop serious complications, including DKA and HHS.



WHY IT MATTERS

DKA and **HHS** are not simply "**high blood sugar**"
They can produce severe dehydration, electrolyte disturbances, hemodynamic instability and neurological complications that make anesthesia and emergency surgery considerably more challenging.

WHY CAN EMERGENCY SURGERY TRIGGER A CRISIS?

Surgical Stress
Surgery increases stress hormones, which can raise blood glucose and contribute to DKA or HHS.

Missed or Altered Insulin
Patients may be unable to eat before surgery, while insulin doses may be missed or changed. This can contribute to DKA.

Infection or Acute Illness
Underlying infection and acute illness can increase metabolic stress and worsen glycemic control.

Limited Time for Optimization
Unlike elective procedures, emergency surgery may not allow enough time to correct severe metabolic abnormalities before intervention.

TWO METABOLIC EMERGENCIES ONE SURGICAL CHALLENGE

DIABETIC KETOACIDOSIS (DKA)?

DKA occurs when there is inadequate effective insulin, resulting in hyperglycemia, ketone production and metabolic acidosis. Your literature-review notes describe blood glucose above 200 mg/dL together with ketones and acidosis, including pH below 7.3 or bicarbonate below 18

Common Triggers :
- Insufficient insulin
- Missed insulin doses
- Infection
- Acute illness
- Emergency surgery
- Increased stress hormones during surgery or illness

Warning Signs
- Excessive thirst and urination
- Nausea and vomiting
- Abdominal pain
- Fast breathing
- Fatigue and weakness

Diagnosis:
- Blood glucose
- Blood or urine ketones
- Blood gases and bicarbonate
- Electrolytes

HYPEROSMOLAR HYPERGLYCEMIC STATE (HHS)?

HHS is characterized by very high blood glucose, severe dehydration and increased blood concentration/osmolality, with little or no ketone production.

Common Triggers
- Severe lack of insulin
- Inadequate fluid intake
- Infection
- Acute illness

Warning Signs
- Very high blood glucose
- Severe dehydration
- Confusion Drowsiness
- Less vomiting than typically seen with DKA

Diagnosis
- Very high blood glucose
- Increased blood osmolality Low or absent ketones Major

FEATURE	DKA	HHS
Glucose	High	Very high
Ketones	Present / High	Low / Absent
Acidosis	Present	Not prominent
Dehydration	Moderate	Severe
Mental Status	Alert to drowsy	Confused, drowsy, may progress to coma
Common Presentation	Nausea, vomiting, abdominal pain, fast breathing	Severe dehydration, confusion, weakness

SGLT2 INHIBITORS

DKA may occur with relatively normal blood glucose in patients taking SGLT2 inhibitors.

Major Complications:
- Severe dehydration
- Potassium and other electrolyte abnormalities
- Brain swelling
- Increased postoperative risk in some patients

When Metabolic Emergency Meets Emergency Surgery

surgery itself can worsen metabolic instability through stress responses, while fasting, altered insulin administration, infection, and the urgency of the procedure can make management more difficult.

Why Are DKA and HHS Dangerous During Surgery?

- **Severe Dehydration -**

Can contribute to low blood pressure and Instability during anesthesia

- **Electrolyte Disturbances -**

Abnormal potassium and other electrolyte levels can create significant perioperative concerns.

- **Metabolic Acidosis -**

Acidosis can complicate the patient's physiologic status during surgery.



- **Neurological Changes -**
Confusion and altered mental status may complicate assessment and postoperative recovery.

- **Poor Healing and Infection Risk -**
Poor glycemic control can negatively affect wound healing and increase infection risk.



EARLY RECOGNITION CAN CHANGE THE COURSE OF PERIOPERATIVE MANAGEMENT

Recognizing the Warning Signs in the Operating Room

- **Clinical Warning Signs -**
* Nausea or vomiting
* Abdominal pain
* Fast or deep breathing
* Confusion or drowsiness
* Delayed or abnormal recovery from anesthesia

- **Vital-Sign Changes -**
* * Low blood pressure
* Tachycardia
* Fever
* Abnormal breathing

- **Laboratory Red Flags -**
* Elevated blood glucose
* Ketones
* Low bicarbonate or pH
* Potassium abnormalities
* Increased osmolality in HHS

Immediate Priorities:
Stabilize, Monitor and Treat

Management requires rapid assessment, correction of physiologic abnormalities and close monitoring throughout the perioperative period

- **Airway and Breathing -**
Assess airway and respiratory status , Provide oxygen when needed , monitor abnormal or rapid breathing

- **Circulation -**
Assess blood pressure and pulse , recognize that significant dehydration may contribute to instability.

- **IV Fluid Replacement -**
Begin fluid replacement early according to the clinical situation and management protocol monitor the patient's response closely

- **Insulin Management -**
Insulin therapy is used to address hyperglycemia ongoing glucose monitoring is essential during treatment.

- **Electrolyte Management -**
Monitor potassium, sodium, bicarbonate, and other relevant electrolytes , potassium requires particular attention during insulin treatment.

- **Continuous Monitoring -**

Include:
- Blood glucose
- Blood gases when indicated
- Electrolytes
- Ketones
- Urine output
- Vital signs



In hyperglycemic emergencies, close monitoring is as important as initial treatment

Beyond the Emergency: The Role of the Surgical Team

- **Surgeon -**
Consider the patient's metabolic condition when planning surgical timing, remain alert to infection and wound-related complications

- **Anesthesia Team -**
Monitor blood glucose before, during and after surgery , manage fluids and insulin monitor vital signs and metabolic stability.

- **Surgical Technologist-**
Help maintain a sterile environment , support the surgical team during emergency cases.Remain prepared for the demands of rapidly evolving intraoperative situations

- **Nursing Staff -**
Support timely medication administration.Monitor the patient before and after surgery.

Prevention Starts Before the Operating Room

- **Glucose Optimization -**
Monitor and address significant hyperglycemia , continue or adjust diabetes treatment according to the clinical protocol.

- **Preoperative Assessment -**
Review diabetes type and medications , assess recent glycemic control , identify previous DKA or hypoglycemia, check for insulin pumps or CGM use

- **Communication-**
Ensure clear coordination between surgical, anesthesia, nursing and other relevant teams.



KEY TAKEAWAY

Emergency surgery in a patient with uncontrolled diabetes requires more than managing the surgical condition alone. Recognizing the warning signs of DKA and HHS, identifying dehydration and metabolic abnormalities, and ensuring close communication and monitoring can support safer perioperative care



Obituary

Team PCDA Pakistan and PFN-Online deeply mourn the passing of Dr. Syed Ajaz Hussain Kazmi of the Gujranwala Chapter.

We extend our heartfelt condolences to his family, colleagues, friends, and the entire PCDA community. May Allah Almighty grant the departed soul eternal peace and give the bereaved family strength and patience to bear this irreparable loss.

Inna Lillahi Wa Inna Ilaihi Raji'un

Obesity, Metabolism & Diabetes

The Triple Epidemic

Prevention First
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Primary Care Diabetes Association Pakistan

PCDA PAKISTAN

cordially invites you to attend

DIABETES PAKISTAN 2026

4th International Conference of Diabetes & Related Complications

30-31 OCTOBER 2026
FRIDAY - SATURDAY

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IN COLLABORATION WITH

- Lyallpur Diabetes Foundation
- Primary Care Diabetes Association Pakistan
- Pakistan Society of Internal Medicine
- Faisalabad Medical University
- Pak Korea Nutrition Center
- Pakistan Academy of Family Physicians
- Pakistan Academy of Family Physicians



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Dr. Naila Shahid

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

KEY SCIENTIFIC THEMES

- Primary Care Diabetes
- Obesity Management
- Diabetic Foot
- Technology In Diabetes & Cardiovascular Prevention

OFFICIAL INVITATION & REGISTRATION

Opening Soon

170-B Sadar Bazar Iqbal Chowk
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Pre Conference Symposium

SALIM HABIB EDUCATION COMPLEX
A Project of The Salim Habib Education Foundation

4th Diabetes Pakistan Annual International Conference 2026
Pre Conference Symposium

District Toba Tek Singh in collaboration with
Women Medical Forum & Saleem Habib Educational Complex
under leadership of
Patron - in - Chief Prof. Dr. Aamir Shaukat
Dean Post Graduate Medical Sciences, Director Department of Internal Medicine Faisalabad Medical University.

President Women Wing Prof. Dr. Hooria Aamir,
Dean Basic & Allied Medical Sciences
&
President LDF Dr. Ahmed Shahzad

Invite you to the symposium

Diabesity: Insulin Resistance, PMOS And Women Metabolic Health....
Bridging The Gaps from Primary to Tertiary Level

On ***15th October, Thursday*** at ***09:15 am to 11:45 pm***
at
Auditorium Salim Habib Educational Complex Toba Tek Singh

Organized by
Dr. Mutayyaba Majeed
LDF ,PCDA , Faisalabad

Sponsored by

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Pre Conference Symposium

WOMEN MEDICAL FORUM
TOBA TEK SINGH
EST. 2025

SALIM HABIB EDUCATION COMPLEX
A Project of The Salim Habib Education Foundation

4th Diabetes Pakistan Annual International Conference 2026
Pre Conference Symposium

15th Oct 2026
09:15 PM to 11:45 PM
Auditorium Salim Habib Educational Complex Toba Tek Singh

The Chief Guest
Prof. Dr. Aamir Shaukat

Moderator
Dr. Mutayyaba Majeed
M.B.B.S.M.PHIL.C.H.P.E. Dip.Diabetes
Assistant Professor, IMC, Faisalabad
Consultant Diabetologist & Endocrinologist

Agenda

Time	Speaker	Topic
9:15 am - 9:30 am		Recitation of Holy Quran & National Anthem
9:30 am - 9:45 am	Prof. Dr. Aamir Shaukat	Recent evidence based approach to management of obesity, metabolic syndrome, PMOS: The paradigm shift
9:45 am - 10:00 am	Dr. Ahmed Shahzad	Prevention of NON-Communicable Diseases & the legacy of Lyallpur Diabetes Foundation
10:00 am - 10:15 am	Dr. Usman Musharraf	Initiation of insuline in GDM & Type 2 diabeties Mellitus
10:15 am - 10:30 am	Prof. Dr. Hooria Aamir	Holistic approach to mental wellness in Metabolic stress and diseases
10:30 am - 10:45 am	Dr. Mutayyaba Majeed	Question Answers session and Lucky Draw
10:45 am - 11:00 am	Mr. Muhammad Rashid Bodla	Vote of thanks by Principal & Director of Saleem Habib Educational Complex
11:00 am - 11:30 am	Prof. Dr. Amir Shaukat	Shield Distribution and Closing Remarks

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Pre Conference Symposium

WOMEN MEDICAL FORUM
TOBA TEK SINGH
EST. 2025

SALIM HABIB EDUCATION COMPLEX
A Project of The Salim Habib Education Foundation

4th Diabetes Pakistan Annual International Conference 2026
Pre Conference Symposium

15th Oct 2026 | 09:15 AM to 11:45 AM | Auditorium Salim Habib Educational Complex Toba Tek Singh



Patron-in-Chief & Speaker

Prof. Amir Shoukat
MBBS, MRCP(UK), FCPS(med), FRCP(UK), Pro Vice Chancellar FMU
Dean & HOD of Medicine & Allied Specialities
Dean Post Graduadate Medical Science

Moderator



Dr.Mutayyaba Majeed
M.B.B.S.M.PHIL.C.H.P.E. Dip.Diabetes
Assistant Professor, IMC, Faisalabad
Consultant Diabetologist & Endocrinologist

Speakers



Dr. Ahmed Shahzad
Consultant Diabetologist
President Lyallpur Diabetes Foundation



Dr. M. Usman Musharraf
Consultant Endocrinologist
F.M.U. Faisalabad



Prof. Dr. Hooria Aamir
Dean, Faculty of Basic Medical Sciences

Panelists



Dr. Ijaz Anwar
General Secretary L.D.F. Faisalabad



Dr. Muhammad Irfan
M.B.B.S. F.C.P.S.
Associate Professor Medicine ,F.M.U.



Dr. Zaheer Ahmed
Consultant Neurologist
F.M.U. Faisalabad



Dr. Muhammad Tariq
Consultant Diabetologist and Physician



Dr. M. Yousaf Ikram
Consultantant Diabetologist



Dr. Tayyaba Rasool
Consultantant Gynaecologist



Dr. Amina Ijaz Warraich
Consultant Gynaecologist



Dr. Uzma Khalid
Consultant Dermatologist



Dr. Ambreen Zaigham
Consultant Dermatologist

Guest Of Honour



Dr. Myra Hafeez
Consultant Family Physician



Dr. Bisma Safdar
Consultant Pediatrician



Dr. Ayesha Mehmood
Consultant Gynaecologist



Dr. Zainab Fatima
Consultant Opthalmologist



Dr. Somiya Sarwar
Consultantant Gynaecologist



Dr. Gul Fatima
Consultant Nephrologist

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Prevention First

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Primary Care Diabetes Association Pakistan

TWO UPCOMING PROJECTS

Diabetic Foot Group (DFG) — PCDA Pakistan

Under the supervision of

Dr. Shakeel Ahmed

PROJECT 1

WOUND HYGIENE COURSE

4 Weeks

A structured educational course on wound hygiene and diabetic wound care.

Target audience:
Doctors / Healthcare Professionals

Sponsor: Pharmevo®



PROJECT 2

URDU DIABETIC FOOT BOOK

Patient-education book on diabetic foot care, written in simple Urdu.

Inauguration:
14 November 2026

Sponsor: Pharmevo®



PCDA — Prevention First

The Colour of a Prescription

Using the WHO AWaRe Classification and Antibiotic Book in primary diabetes care



Co-Authors:
Dr Faisal Sultan, Dr Salman Saleem, Mr Rehan Khan Niazi, Dr Muhammad Arslan and Mariam Nawaz

Corresponding Author:
Dr Ifra Nasir

It is the last hour of a Thursday clinic. A 58-year-old man with type 2 diabetes sits down with three days of cough, a blocked nose and a low-grade fever. His sugars have crept up. He has a wedding to attend on Sunday and asks, politely but firmly, for "a strong one". The pen drifts towards cefixime.



Nothing about that moment feels like a global health decision, but it is one. Multiplied across thousands of clinics, it contributes to the selection pressure that affects future treatment, for this man and for those who come after him.

The World Health Organization has given us a simple tool for that moment. It is worth learning to read.

In one minute:

- WHO's AWaRe classification groups antibiotics into Access, Watch and Reserve according to their resistance potential and stewardship priority, and separately lists certain products and fixed-dose combinations it does not recommend. It is updated every two years; the most recent edition was published in September 2025.
- The WHO AWaRe Antibiotic Book (2022) turns the classification into practical guidance on drug, dose, route and duration for more than 30 common infections, and it identifies when no antibiotic is needed.
- UN Member States have committed to aim, by 2030, for Access antibiotics to make up at least 70% of overall human antibiotic use globally.4 This is a population-level consumption target, not a rule for each patient.
- An Access antibiotic can still be the wrong prescription, and a prescription without adequate diagnostic information cannot be reliably assessed. Local outpatient data from Multan illustrate both points.

A traffic light for antibiotics

Since 2017, WHO has grouped antibiotics by their resistance potential and stewardship priority, not only by what they kill.1 The groups describe the role an antibiotic should play. They do not, by themselves, tell you whether a particular patient needs one.



Access (green). Access antibiotics have a narrow spectrum of activity, a lower potential for selecting resistance, and a lower cost.3 For sore throat, mild pneumonia, lower urinary tract infection and cellulitis in primary care, the book's first-choice options are all Access antibiotics.3 The group includes amoxicillin, amoxicillin-clavulanic acid, cefalexin, cloxacillin, doxycycline, nitrofurantoin, sulfamethoxazole-trimethoprim and metronidazole.6

Watch (amber). Watch antibiotics have higher resistance potential and are the main targets for stewardship and monitoring. Many familiar prescriptions sit here: cefixime, cefuroxime, ceftriaxone, ciprofloxacin, levofloxacin, moxifloxacin, azithromycin and clarithromycin.6 For some syndromes, a Watch antibiotic is the recommended first choice. They should never be the reflex.

Reserve (red). Reserve antibiotics are last-resort options for confirmed or suspected multidrug-resistant infection.3 Linezolid, colistin and ceftazidime-avibactam belong here.6 Their use generally requires specialist assessment and a defined indication.

Not Recommended. Separately, WHO lists certain products and fixed-dose combinations as Not Recommended. Examples include cefixime with clavulanic acid, cefixime with ofloxacin, amoxicillin with cloxacillin, cefpodoxime with clavulanic acid, and levofloxacin with ornidazole.6 Many of us will recognise these names from local pharmacy shelves, which is exactly why they deserve a second look.

The book that turns colour into a prescription

A classification tells you what a drug is. It does not tell you what to write. That gap is what the WHO AWaRe Antibiotic Book was designed to close. The 2022 edition gives concise, evidence-based recommendations for 34 common infections in adults and children, in primary care and in hospital.

The book that turns colour into a prescription

A classification tells you what a drug is. It does not tell you what to write. That gap is what the WHO AWaRe Antibiotic Book was designed to close. The 2022 edition gives concise, evidence-based recommendations for 34 common infections in adults and children, in primary care and in hospital.

Three features make it especially useful for general practice:

- It treats "no antibiotic" as a genuine treatment option: where the preferred approach is to observe and wait, it recommends symptomatic treatment without antibiotics.
- It encourages treatment for the shortest acceptable duration and, in hospital, an early switch from intravenous to oral therapy.
- It is written with primary care firmly in mind, because that is where most antibiotic prescribing takes place.

Its recommendations are a starting point. They still need to be matched to the patient in front of you and to local resistance patterns.

Three questions before every prescription

1. Does this patient need an antibiotic?
2. What syndrome am I treating, and how severe is it?
3. Which agent, dose and duration fit this patient and local resistance?

What it looks like in the diabetes clinic

Table 1. Where AWaRe points for common primary care presentations

Presentation	Where AWaRe points	Check first
Common cold or acute bronchitis in a clinically stable patient	No antibiotic; symptomatic care with safety-netting[3]	Features of pneumonia: breathlessness, fast breathing, low oxygen saturation, focal chest signs
Sore throat	Usually no antibiotic. If group A streptococcal infection is likely on clinical assessment or confirmed on testing: amoxicillin or phenoxymethylpenicillin (Access)[3]	Penicillin allergy; signs of peritonsillar abscess or airway compromise need urgent review
Mild community-acquired pneumonia, suitable for home treatment	Amoxicillin (Access);[3] for adults, 1 g every 8 hours for 5 days[7]	Confirm mild severity and ability to take oral treatment; hypoxia, confusion or unstable glucose warrants hospital assessment
Symptomatic uncomplicated lower urinary tract infection (cystitis) in a nonpregnant woman, without fever, flank pain or systemic features	Nitrofurantoin, or sulfamethoxazole-trimethoprim if local susceptibility supports its use (Access)[3]	Renal function and prior culture results; nitrofurantoin is not suitable for pyelonephritis. UTI in men and in pregnancy needs its own assessment. Diabetes alone does not make a UTI complicated, and is not a reason to treat asymptomatic bacteriuria[8]
Mild nonpurulent cellulitis	Cefalexin or amoxicillin-clavulanic acid (Access)[3]	An abscess needs drainage; on the foot, examine for depth, ulceration and ischaemia[9]

Note: Antibiotic colours follow the AWaRe classification;[1,6] treatment choices follow the WHO AWaRe Antibiotic Book.[2,3] These are starting points, not fixed rules. The final choice also depends on allergy, severity, renal function, pregnancy, local susceptibility and the clinical setting. Common Watch substitutions seen in practice include azithromycin or cefixime for colds and sore throats, and ciprofloxacin or cefixime for cystitis.

Watch antibiotics have their place. For mild to moderate acute pyelonephritis, the WHO Antibiotics Portal lists ciprofloxacin as a first choice.[6] That is not a licence for reflex empiric fluoroquinolones. Send a urine culture before starting treatment, and weigh severity, previous resistant isolates and local susceptibility. A patient who is vomiting, septic, dehydrated or losing control of their glucose needs urgent hospital assessment. The aim is the right colour for the right infection, not the banishment of Watch drugs.

Where diabetes changes the decision

Diabetes does not, by itself, justify an antibiotic, nor a move from Access to Watch. It does change what needs checking.

- **Sick days.** Any febrile illness, viral or bacterial, can push glucose up. Advise more frequent glucose monitoring, adequate fluids and the clinic's sick day plan for medicines. Patients who are vomiting, cannot keep fluids down or have persistently high readings need prompt review, including assessment for ketosis where relevant.
- **Urine.** Bacteriuria without urinary symptoms is common in people with diabetes. Diabetes alone is not an indication to screen for or treat asymptomatic bacteriuria; assess separately in pregnancy or before an endourological procedure involving mucosal trauma.[8] Treat the symptoms, not the urine report.
- **Feet.** Examine the foot of any patient with diabetes who reports redness, swelling or a wound, and assess foot perfusion. First decide whether the wound is clinically infected: an ulcer without signs of infection does not need antibiotics. Mild, superficial infection can often be managed in clinic, with early planned review. Severe infection, including any infection with signs of systemic illness, needs urgent hospital assessment. Moderate infection complicated by extensive gangrene, necrotising infection, a suspected deep abscess, compartment syndrome or severe ischaemia needs urgent surgical assessment.[9]

Access is not the same as appropriate

It would be comforting to think that switching to green drugs solves the problem. Local data suggest otherwise.

In a point prevalence survey of 1,208 patients attending the outpatient departments of two hospitals in Multan in 2023 and 2024, about one in three received an antibiotic.[5] Of the 532 antibiotics prescribed, 65.2% were Access agents, with amoxicillin-clavulanic acid the most common.[5] Only 41 of 532 prescriptions (7.7%) could be documented as guideline-compliant; 191 were classified as inappropriate, while 300 lacked sufficient diagnostic information for assessment.[5] Among the 232 prescriptions that could be assessed, 41 (17.7%) were appropriate. The 7.7% figure therefore reflects documented compliance across all prescriptions; it does not mean that the remaining 92.3% were shown to be inappropriate. Sore throat, cough and nasal congestion, which are mostly viral, accounted for much of the prescribing.[5]

The missing documentation is a finding in itself: a prescription without a recorded diagnosis cannot be shown to be right. The lesson is uncomfortable but useful. The colour of the drug matters less than whether an antibiotic was justified in the first place. A green antibiotic given for a cold is still the wrong prescription.

Three habits to borrow from the book

1. **Name the infection before naming the drug.**
Write the diagnosis and its severity in the notes. If the note says only "fever" or "cough", the prescription has no anchor. The book is organised by infection for good reason: the diagnosis is what makes the choice defensible.

2. **First decide whether an antibiotic is needed; then choose the narrowest suitable agent.** Once an antibiotic is clearly needed, pick the narrowest agent that fits the likely pathogen and the patient. When a Watch antibiotic is the right choice, one line in the notes explaining why is enough.

3. **Write the stop date.** Most outpatient infections in the book are treated with short courses. A course without an end date quietly becomes a longer one.

Keep the book within easy reach. The full PDF, the 2025 classification and the WHO Antibiotics Portal are all free to download from WHO's website. A search function on a phone is often faster than memory at the end of a long clinic.

Back to Thursday



On examination, our patient was alert and well hydrated. His temperature was 37.8 °C, his breathing was unhurried, his oxygen saturation was normal and his chest was clear. There was no tonsillar exudate, sinus tenderness or other focal sign. His glucose was higher than usual, but he was eating and drinking. The working diagnosis was an uncomplicated upper respiratory tract infection, most likely viral.

The most useful prescription was therefore not an antibiotic. It was an explanation of why an infection can raise blood glucose, a sick day plan for monitoring his sugars and managing his medicines, and clear reasons to come back: breathlessness, chest pain, confusion, vomiting, persistently high glucose readings, fever that persists or worsens, or any new focal symptom. The cefixime stayed in the pharmacy. That is what stewardship looks like from the clinic chair: a few seconds of thought, a colour on a chart, and a decision that looks after both this patient and the ones who come after him.

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Sugar Feeds Germs:

What Every Person With Diabetes Should Know About Antibiotics Use

Better glycemic control & responsible antibiotic use can help protect from difficult-to-treat infections

Antimicrobial Resistance: The Bigger Picture

Hashir Mubeen
Diet & Education Wing of PCDA Pakistan



Antimicrobial resistance (AMR) occurs when bacteria change in ways that stop medicines from working against them.
It is one of the major health threats of

Our time, and the numbers show how serious it has become.

- **Older adults are the most affected.** Between 1990 and 2021, AMR deaths in adults aged 70 years and older rose by more than 80%.
- **South Asia, including Pakistan, is expected to carry the highest burden** of AMR deaths in the coming decades.
- **Antibiotic choice matters.** At the 2024 United Nations General Assembly, countries committed to ensuring that at least 70% of human antibiotic use comes from the WHO "Access" group (narrower-spectrum antibiotics with a lower potential for resistance) by 2030. A 2025 WHO report found that only about one in three reporting countries and territories was meeting this target, with the broader-spectrum "Watch" antibiotics still widely used.

Why this matters for people with diabetes.According to the IDF Diabetes Atlas 2025, Pakistan has the highest diabetes prevalence among adults in the world, at roughly three in ten adults. Diabetes makes infections more likely, and antibiotics are used often. With so much at stake, using antibiotics wisely is something every person with diabetes can contribute to. The rest of this article explains how.

Living with diabetes means paying a little extra attention when you become unwell. High blood glucose can affect the body's response to infection, while diabetes-related nerve damage and poor circulation can make injuries—especially on the feet—harder to notice and slower to heal.
At the same time, antibiotics are powerful medicines that should be used carefully. Having diabetes does not mean that every infection needs an antibiotic, and having symptoms does not mean you should choose one yourself.

The safest approach is simple:

> If you think you have an infection, get assessed by a doctor or other qualified healthcare professional before starting an antibiotic.

Why infections need extra attention in diabetes?

When blood glucose is persistently high, several aspects of the body's immune response can be affected. Diabetes can also cause nerve damage and circulation problems, particularly in the feet.
This means a small cut, blister or wound may go unnoticed.
A wound that initially looks minor can become more serious if infection develops.
That is why people with diabetes should make daily foot checks part of their routine. Look for cuts, blisters, redness, swelling, cracks, changes in colour, discharge or other unusual changes.
If you notice a wound or signs that it may be infected, do not try to treat it yourself with leftover antibiotics or medicines recommended by someone else. Get it assessed.

Don't start an antibiotic on your own

A common misconception is:

"I have diabetes, so if I develop an infection, I should start an antibiotic quickly."

The reality is more complicated.
Different infections require different approaches. Some illnesses are caused by bacteria, while others are caused by viruses or other organisms.
Even when a bacterial infection is present, the appropriate antibiotic depends on the infection, its severity, the likely or identified bacteria, previous antibiotic exposure, allergies, kidney function, other medicines and local resistance patterns.
This is why the decision to prescribe an antibiotic should be made after appropriate clinical assessment.



Do not start an antibiotic simply because:

⇒ You have a fever.
⇒ You have a cough or sore throat.
⇒ A wound looks red.
⇒ A urine report mentions bacteria.
⇒ Someone with similar symptoms took the same antibiotic.
⇒ You have leftover tablets from a previous illness.
⇒ Someone recommends an antibiotic without examining you.

These situations may require medical assessment—but they do not give you enough information to safely select an antibiotic yourself.

A laboratory report is not a prescription

Modern tests can detect bacteria, but a laboratory result must be interpreted in the context of the patient's symptoms and clinical examination.

For example, bacteria may sometimes be found in urine without causing symptoms. Similarly, bacteria can be present on a chronic wound without the wound necessarily having a clinical infection.
This is one reason why a positive test result should not automatically lead to self-treatment with an antibiotic. Your healthcare professional will decide whether the finding represents an infection that requires treatment.

Your diabetic foot needs professional assessment

Foot problems deserve particular attention in diabetes.
A diabetic foot ulcer is not automatically an infection, and the presence of bacteria on a wound does not by itself establish infection. The IWGDF/IDSA guideline recommends diagnosing diabetic foot infection clinically and assessing its severity before treatment decisions are made.
If infection is suspected, the healthcare professional may need to assess the wound, circulation, nerves, severity of infection and other factors. In some situations, appropriate specimens may also be required to help guide treatment.
Do not put an antibiotic cream on a wound or start antibiotic tablets simply because you have diabetes and have developed a foot ulcer.
Instead:
Get the wound assessed.
Early professional assessment can help identify problems before they become more serious.

Antibiotics can affect your diabetes treatment too

Antibiotics are not harmless medicines.
Some can cause side effects, interact with other medicines or affect blood glucose.
For example, systemic fluoroquinolone antibiotics such as ciprofloxacin and levofloxacin can cause significant changes in blood glucose, including potentially serious hypoglycaemia. This is particularly important for people with diabetes who are taking glucose-lowering medicines.
Other antibiotics can interact with certain diabetes medicines as well.
Therefore, whenever a healthcare professional prescribes an antibiotic, **tell them about all the medicines you take for diabetes and any other medicines or supplements you use.**
Your pharmacist can also help check for potential interactions.

Being sick can change your blood glucose



An infection or other illness can itself make blood glucose harder to control.
You may eat less, drink less, become dehydrated or experience changes in your usual glucose levels.
Some medicines used during illness can also affect blood glucose.
If you become unwell:
Continue monitoring your blood glucose as advised.
Follow your individual sick-day plan if you have one.
Drink fluids if you are able to do so.
Seek medical advice if your glucose levels are persistently very high or very low, or if you are vomiting, becoming dehydrated or unable to take food or fluids normally.
Do not stop or change your diabetes medicines on your own.
If you are unsure what to do with your diabetes medicines during an illness, contact your doctor or pharmacist.

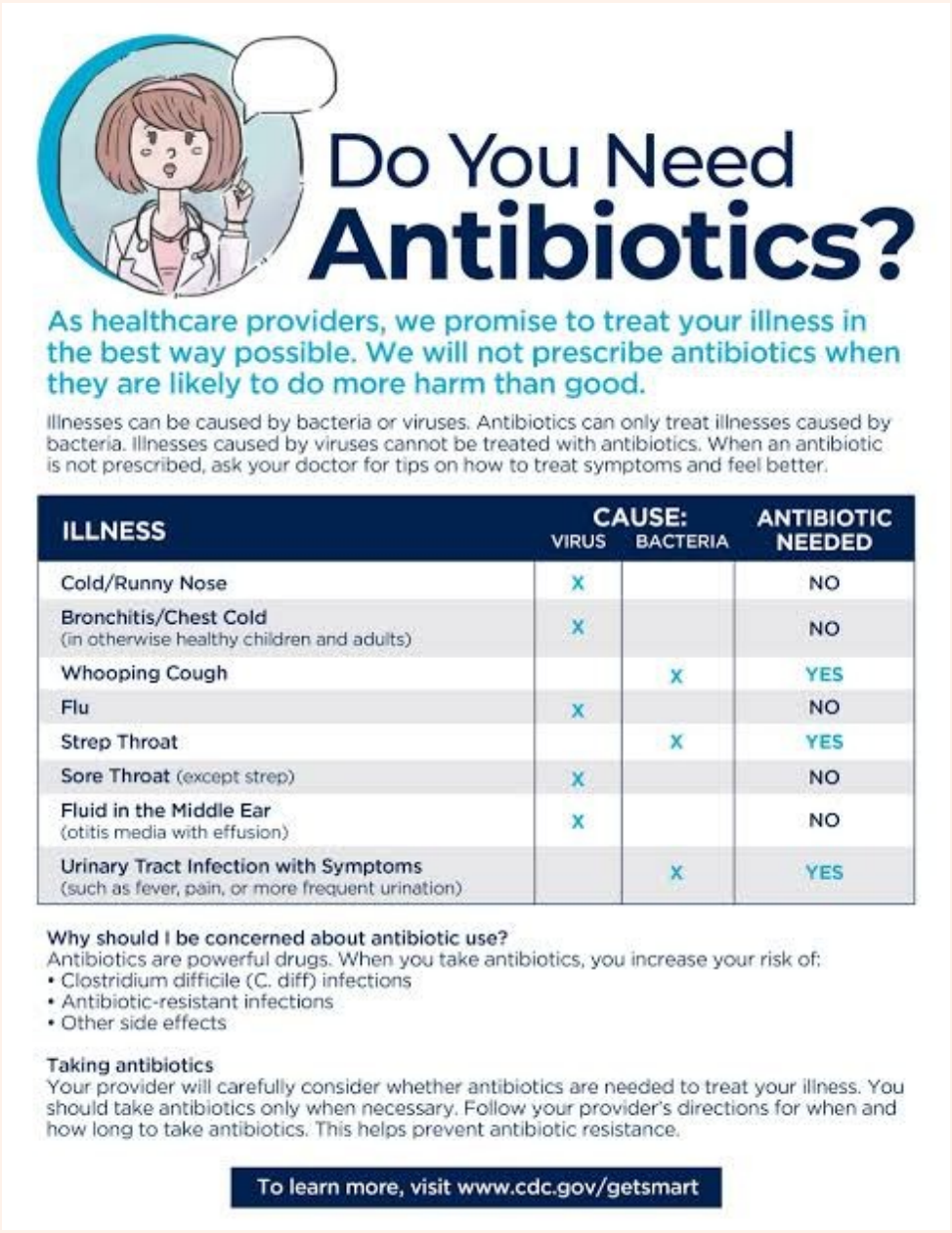
Antibiotics do not work against every infection

Fever, cough, sore throat or feeling generally unwell does not automatically mean that an antibiotic is needed. Many common infections are caused by viruses, against which antibiotics do not work.

Taking an antibiotic when it is not appropriate can expose you to unnecessary adverse effects and contributes to antimicrobial resistance—the ability of microorganisms to survive medicines that would previously have killed or controlled them.

That does not mean you should refuse an antibiotic when a healthcare professional determines that you genuinely need one.

Responsible antibiotic use means neither overusing nor avoiding antibiotics—it means using them when appropriately prescribed.



Do You Need Antibiotics?

As healthcare providers, we promise to treat your illness in the best way possible. We will not prescribe antibiotics when they are likely to do more harm than good.

Illnesses can be caused by bacteria or viruses. Antibiotics can only treat illnesses caused by bacteria. Illnesses caused by viruses cannot be treated with antibiotics. When an antibiotic is not prescribed, ask your doctor for tips on how to treat symptoms and feel better.

ILLNESS	CAUSE: VIRUS	CAUSE: BACTERIA	ANTIBIOTIC NEEDED
Cold/Runny Nose	X		NO
Bronchitis/Chest Cold (in otherwise healthy children and adults)	X		NO
Whooping Cough		X	YES
Flu	X		NO
Strep Throat		X	YES
Sore Throat (except strep)	X		NO
Fluid in the Middle Ear (otitis media with effusion)	X		NO
Urinary Tract Infection with Symptoms (such as fever, pain, or more frequent urination)		X	YES

Why should I be concerned about antibiotic use?
Antibiotics are powerful drugs. When you take antibiotics, you increase your risk of:
- Clostridium difficile (C. diff) infections
- Antibiotic-resistant infections
- Other side effects

Taking antibiotics
Your provider will carefully consider whether antibiotics are needed to treat your illness. You should take antibiotics only when necessary. Follow your provider's directions for when and how long to take antibiotics. This helps prevent antibiotic resistance.

To learn more, visit www.cdc.gov/getsmart

Never borrow or reuse antibiotics

An antibiotic prescribed for another person—or for an illness you had in the past—may not be appropriate for your current problem.

The same symptoms can have different causes, and the correct treatment can differ from one infection to another.

So:

Don't use someone else's antibiotic.
Don't use leftover antibiotics.
Don't buy an antibiotic simply because you have taken it before.
Don't recommend your antibiotic to another person.

And if an antibiotic has been prescribed for you, take it exactly as directed by your healthcare professional. If you experience problems or are unsure about the treatment, speak to your doctor or pharmacist rather than changing it yourself.

What can you do to protect yourself?

Good infection care begins before an antibiotic is ever needed.

Keep your blood glucose well managed

Follow your diabetes treatment plan and attend your recommended check-ups.

Check your feet every day

Look carefully for injuries, blisters, redness, swelling, cracks or wounds—especially if you have reduced sensation in your feet.

Don't ignore wounds

A small wound can deserve prompt attention in a person with diabetes, even when it does not look serious.

Keep recommended vaccinations up to date

Ask your healthcare professional which vaccinations are recommended for you. Vaccination is an important part of preventing certain infections in people living with diabetes.

Get assessed when you are unwell

If you think you have an infection, **seek professional medical advice rather than trying to identify and treat it yourself.**

Tell your healthcare professional about your diabetes

Whenever you are prescribed a medicine for an infection, make sure your doctor and pharmacist know about your diabetes medicines and other medications.

The message to remember



Diabetes does not mean that you need antibiotics more often. It means that infections deserve appropriate attention.
Don't diagnose the infection yourself.
Don't choose the antibiotic yourself.
Don't use leftover or someone else's antibiotics.
Don't assume that a positive laboratory report automatically means you need an antibiotic.
Instead, **get properly assessed by a healthcare professional and follow the treatment plan provided for you.**
And while you are waiting for medical advice, don't ignore your diabetes: monitor your blood glucose, look after your feet and seek help promptly if you become significantly unwell.

Protect yourself. Protect your feet. Protect your antibiotics

The right antibiotic, for the right patient, at the right time—starts with the right clinical assessment.

Beyond the Diet Chart:

Making Nutrition Education Work in Everyday Life



Dr. Hira Iftikhar
Member DEW-PCDA
Lecturer
Institute of Home Sciences
University of Agriculture
Faisalabad

"Doctor, what should I eat?" is a familiar question in diabetes care. Yet the answer often arrives as a list of restrictions: avoid sugar, reduce rice, stop sweets and lose weight. Patients may leave knowing what to avoid but still unsure how to prepare breakfast, share a family meal or choose food at a wedding.
Nutrition education should help people make these everyday decisions with understanding and confidence. A diet chart can guide a patient, but its value depends on whether the advice is understood, affordable and practical.

Begin with the Person Behind the Plate

Before giving dietary advice, we need to understand how a person actually eats. Who buys and prepares the food? What is the household budget? Are meals affected by work, caregiving or irregular schedules? Which foods does the family enjoy?

These questions make education relevant. Advice built around unfamiliar ingredients or expensive "health foods" may be difficult to follow. In Pakistan, teaching can begin with familiar foods such as roti, rice, daal, chickpeas, vegetables, eggs and plain yoghurt.
Individualised nutrition care should also consider medication, activity, preferences and other health conditions. The American Diabetes Association emphasises personalised eating plans and practical tools, supported by a qualified dietitian.

Turn Advice into Skills

"Eat a balanced diet" sounds helpful, but what does it look like on a plate?
The diabetes plate method offers a simple starting point: fill half a plate with non-starchy vegetables, one-quarter with lean protein and one-quarter with carbohydrate foods. Water or an unsweetened drink can accompany the meal. [2]
This approach can be demonstrated using a familiar lunch: a generous serving of vegetables or salad, chicken or fish, and an appropriate portion of roti or rice. Daal and chickpeas also deserve attention because they provide both protein and carbohydrate; they should be considered within the overall meal.

The aim is to help patients recognize portions and build meals, rather than simply memorise food lists.



Replace Food Myths with Clear Explanations

Nutrition education should create space for questions that patients may hesitate to ask.
Does diabetes mean never eating fruit? Is honey different from sugar? Can "sugar-free" biscuits be eaten freely?
Useful teaching explains that carbohydrate comes from several foods, including grains, fruit, milk and pulses—not only sweets. Whole fruit can fit into a meal plan, while fruit juice raises blood glucose more quickly. Packaged foods should be assessed by portion size and total carbohydrate, rather than a reassuring claim on the front of the packet. [2]
Using actual food packets, household utensils and meal photographs can make these discussions easier to understand.

Check Understanding Kindly

Asking "Do you understand?" often produces a polite "yes". A more useful approach is to invite the patient to explain the advice in their own words:

"Using the foods available at home, how would you put together tomorrow's lunch?"
This is the teach-back method. It allows the healthcare professional to check whether the explanation was clear and address misunderstandings. It should feel like a conversation, not an examination. [3]

Include the Family and Set One Achievable Goal

Food decisions rarely belong to one person alone. With the patient's consent, involving the family member who cooks or shops can help translate advice into daily practice.

Instead of giving several instructions at once, agree on one achievable change: replacing a daily sugary drink with water, adding vegetables to lunch or measuring the usual rice serving. At follow-up, ask what worked and what made the change difficult.

The patient who struggles with a plan may need a more workable plan—not another lecture.

Make Education a Continuing Conversation

Nutrition education belongs in clinics, schools, workplaces and community programmes. Universities and professional associations can support practical activities such as meal-building demonstrations, label-reading exercises and affordable food comparisons.

For primary care teams, each visit offers an opportunity to reinforce a skill, answer a question and review progress. Referral for individualised nutrition care strengthens this process.

PCDA's "Prevention First" vision offers a valuable direction: equip people to make informed decisions before poor dietary habits become established, and continue supporting those already living with diabetes.

The success of nutrition education is reflected in what a person can do afterwards: choose a suitable meal, understand a portion, question a misleading claim and make a realistic change at home.

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HEARTFELT CONDOLENCES

Team PCDA Pakistan and PFN-Online are deeply saddened by the tragic and untimely passing of the **younger sister of Dr. Pawan Kumar, Joint Secretary of PCDA Pakistan**, in a road accident in Karachi.

We extend our heartfelt condolences to Dr. Pawan Kumar and his entire family during this profoundly painful time. The sudden loss of a beloved family member is an immense sorrow, and we can only imagine the grief the family is enduring.

Our thoughts and sympathies are with the bereaved family as they navigate this difficult period. May they find strength, comfort, and courage in the love and support of those around them. May the departed soul rest in eternal peace, and may her cherished memories continue to live on in the hearts of all who knew and loved her.

With deepest sympathy and heartfelt condolences,
Team PCDA Pakistan & PFN-Online

Healthy Teeth, Healthy Life:

Managing Diabetes and Oral Health



Diabetes mellitus is a chronic metabolic disorder characterized by elevated blood glucose levels due to insufficient insulin production (Type 1 Diabetes) or insulin resistance (Type 2 Diabetes). The long-term complications of diabetes are well-documented, affecting various organs and systems, including the cardiovascular system, kidneys, eyes, and nerves. However, one of the less frequently discussed complications is the impact of diabetes on oral health.

Diabetic patients are at a higher risk of developing various oral lesions, which can significantly affect their quality of life and overall health. This article explores the relationship between oral lesions and diabetes, focusing on the types of lesions, their clinical features, and the importance of early detection and management. Diabetes profoundly affects oral health due to its impact on immune response, vascular health, and tissue repair mechanisms. Hyperglycemia, a hallmark of diabetes, can lead to an increased risk of infections, delayed wound healing, and altered inflammatory responses, all of which contribute to the development of oral lesions. Additionally, diabetic patients often experience xerostomia (dry mouth), which can exacerbate oral health issues by reducing the protective effects of saliva.

Periodontal disease, including gingivitis and periodontitis, is one of the most common oral complications in diabetic patients. It is characterized by inflammation of the gums and supporting structures of the teeth. Symptoms include red, swollen, bleeding gums, receding gum lines, and, in severe cases, tooth loss. Diabetic patients are more susceptible to periodontal disease due to impaired immune response and poor wound healing. Oral candidiasis, or thrush, is a fungal infection caused by Candida species.

1	Mouth dryness and burning (xerostomia)
2	Oral acetone smells in poorly controlled patients
3	Brittle teeth
4	Dental caries
5	Recurrent oral infections, e.g. oral candida
6	Mouth ulcerations
7	Altered taste sensation
8	Delayed healing of mucous membranes
9	Teeth disposition and misalignment
10	Periodontitis
11	Gingivitis



Diabetic patients are more prone to this infection due to elevated glucose levels in saliva and a compromised immune system. White, creamy lesions on the tongue, inner cheeks, and sometimes the roof of the mouth, gums, and tonsils. The lesions may be painful and can cause a burning sensation. Xerostomia (Dry Mouth) is a common condition in diabetic patients, often resulting from dehydration, medication side effects, or diabetic neuropathy affecting salivary glands. Dryness in the mouth, difficulty swallowing, a burning sensation in the oral cavity, and an increased risk of dental caries and oral infections.

Burning Mouth Syndrome (BMS):

A burning sensation in the mouth characterizes BMS without an identifiable cause. It is more common in diabetic patients, possibly due to neuropathy or hormonal changes. Persistent burning or scalding sensation on the tongue, lips, gums, or entire mouth, often accompanied by dry mouth and altered taste.

Oral lichen planus is an inflammatory condition that affects the mucous membranes inside the mouth. It is considered an autoimmune disorder, and its prevalence may be higher in diabetic patients. White, lacy patches on the mucous membranes of the mouth, sometimes accompanied by painful sores or ulcers.

Diabetic patients are at an increased risk of dental caries due to higher glucose levels in saliva and reduced salivary flow. Cavities or decay in the teeth often lead to pain, sensitivity, and infection if left untreated. The pathophysiology of oral lesions in diabetes is multifactorial. Hyperglycemia leads to the glycation of proteins, which impairs the function of immune cells, such as neutrophils, and increases the susceptibility to infections. Additionally, diabetes-associated microvascular changes reduce blood flow to oral tissues, delaying healing and promoting the development of lesions. Xerostomia further exacerbates these issues by reducing the natural cleansing and protective effects of saliva.



Managing oral lesions in diabetic patients:

Managing oral lesions in diabetic patients requires a multidisciplinary approach that involves regular monitoring of blood glucose levels, maintaining good oral hygiene, and routine dental check-ups.

Key strategies include:

1-Glycemic Control: Effective management of blood glucose levels is crucial in reducing the risk of oral lesions. Diabetic patients should work closely with their healthcare providers to achieve and maintain target blood glucose levels.

2-Oral Hygiene: Patients should be educated on the importance of maintaining good oral hygiene practices, including regular brushing, flossing, and using antiseptic mouthwashes.

3-Regular Dental Visits: Routine dental check-ups are essential for early detection and management of oral lesions. Dentists can provide professional cleaning, diagnose early signs of oral disease, and offer appropriate treatments.

4-Management of Xerostomia: Diabetic patients suffering from dry mouth should be encouraged to stay hydrated, use saliva substitutes, and avoid substances that exacerbate dry mouth, such as tobacco and alcohol.

5-Antifungal Therapy: Antifungal medications may be prescribed for patients with oral candidiasis, and underlying diabetes should be carefully managed to prevent a recurrence.

6-Smoking Cessation: Smoking cessation is significant for diabetic patients, as smoking further increases the risk of periodontal disease and oral cancer

Diabetes significantly increases the risk of various oral lesions, which can have a profound impact on a patient's overall health and quality of life. Understanding the relationship between diabetes and oral health is crucial for the early detection and management of these lesions. By maintaining good glycemic control, practicing excellent oral hygiene, and seeking regular dental care, diabetic patients can minimize their risk of developing oral complications and ensure better long-term outcomes.

UK prevalence has doubled in 20 years, and 5% of the population is affected, but probably at least



50% of diabetics with mild or early disease pass unrecognized. By 2025, the UK incidence will be 8%, a level already attained in the United States. World incidence is rising as populations become urbanized, eat a more Western diet, and become Obese. There are two main clinical types. Type 1 diabetes ('insulin-dependent) accounts for 10% of cases. Symptoms typically appear before the age of 25, and the disease is usually severe with thirst, polyuria, hunger, loss of weight, and susceptibility to infection. The cause is the failure of secretion of insulin after autoimmune destruction of the pancreatic islets, and insulin replacement is the treatment. Type 2 ('maturity onset') accounts for 90% of cases. Patients are typically older than middle age and obese. The onset is insidious, often with deterioration of vision or pruritus or, sometimes, thirst, polyuria, and fatigue.



However, many cases are asymptomatic. The cause is end-organ resistance to insulin, and the disease can be controlled by dietary restriction and, if necessary, oral hypoglycaemic drugs. The current epidemic of childhood obesity seems likely to lead to the onset of this variety of diabetes early in life.

In practice, the division between these two types is some Complications of diabetes mellitus that can affect dental management

⇒ Susceptibility to infection, particularly candidosis and mucormycosis
⇒ Hypoglycaemic coma
⇒ Diabetic coma
⇒ Ischaemic heart disease
⇒ Acceleration of periodontal disease if control is poor
⇒ Dry mouth secondary to polyuria and dehydration
⇒ Oral lichenoid reactions due to oral hypoglycaemic drugs
⇒ Delayed healing
⇒ Sialadenosis

Principles of Dental Management of diabetics

⇒ Time treatment to avoid disturbance of routine insulin administration or meals
⇒ Use local anesthesia for routine dentistry – the amount of adrenaline (epinephrine) in local anesthetic solutions has no significant effect on the blood sugar
⇒ Sedation can be given if required
⇒ Deal with any diabetic complications.
⇒ Manage hypoglycaemic coma
⇒ General anesthesia requires special precautions In terms of dental management, it is usually said that the greatest problems are with 'uncontrolled' diabetes. However, 'uncontrolled' applies to several diabetic states. At one extreme, there is the mild, unrecognized, and therefore untreated diabetes. On the other hand, there is the treated diabetic whose disease is difficult to control ('brittle diabetes') or has been mismanaged. This last group is the one most likely to have oral complications and present difficulties in dental management. Type 2 diabetics with good dietary or oral hypoglycaemic drug control can be treated as non-diabetic patients. In type 1 diabetes, well-controlled patients are similarly very low risk. However, hypoglycaemic coma may be precipitated by dental treatment that delays a normal meal or unbalances food intake and insulin. This can cause an emergency in dental surgery. Treatment should therefore be so timed as to avoid these risks – ideally, soon after the patient's breakfast. Many patients now have their glucose monitors and can check the level immediately before treatment and when signs suggest the onset of Hypoglycemia. Diabetic (hyperglycaemic) coma is a complication of poorly controlled diabetes mellitus and is much less likely to be seen. Patients with recurrent candidosis or severe periodontitis without cause can be relatively easily tested in a dental setting using urine dipsticks to detect glycosuria, enabling confident referral to their medical
⇒ practitioner.

Reports
Dr. Javeria Salman
Head of Hyderabad-2 Chapter of
PCDA Pakistan

Gynae Department Civil Hospital Hyderabad

in collaboration with

PCDA Hyderabad

Prevention First
PCDA
Primary Care Diabetes Association Pakistan

The Role of GLP-1/GIP Therapy (Tirzepatide) in Managing Weight & PCOS-Related Challenges



Date: Monday, 28 September 2026

Time: 11:30 AM – 12:30 PM

Speaker: Dr. Javeria Salman
Diabetologist and Family Physician

Venue: Gynae Department
Civil Hospital Hyderabad











Key Highlights

Understanding PCOS & PMOS
Pathophysiology, diagnosis and clinical challenges

Obesity & Metabolic Health
Impact on reproductive, metabolic and long-term outcomes

Role of GLP-1/GIP Therapy (Tirzepatide)
Evidence, benefits and clinical use in weight management and PCOS

Updated Management Approaches
Lifestyle modification, pharmacological and multidisciplinary care

Interactive Discussion
Active participation and clinical perspectives



A productive academic session promoting evidence-based, multidisciplinary care for women with PCOS and metabolic health challenges.

گوشۂ ظرافت

سیاست اور مخمصہ

جھوٹ میں لپٹی ایک سچی تحریر



کہتے ہیں *ضرورت ایجاد کی ماں ہے*۔ اب یہ ہم پر منحصر ہے کہ اس ایجاد کو انسانیت کی خدمت میں استعمال کریں، سیاست کی نذر کریں یا واٹس ایپ یونیورسٹی میں داخلہ لے کر اس پر پی ایچ ڈی شروع کر دیں۔

پاکستانیوں کا بنیادی مخمصہ یہ ہے کہ وہ دنیا کے کسی بھی کونے میں جا بسیں—ریاست کو ٹیکس دیں یا نہ دیں، ملکی حالات سے واقف ہوں یا نہ ہوں—لیکن سیاست ضرور کریں گے۔ بلکہ بعض حضرات تو وطن سے جتنا دور ہوتے جاتے ہیں، ملکی سیاست کے اتنے ہی قریب آتے جاتے ہیں!

چند روز پہلے ہم نے اپنے سسرالی واٹس ایپ گروپ میں ایک ویڈیو شیئر کی، جس میں ایک بندر بجلی کے کھمبے پر چڑھا بیٹھا تھا۔ نیچے ہم نے بطورِ دانش ور لکھ دیا:

کسی کے اوپر تک پہنچ جانے کا مطلب یہ نہیں کہ وہ آپ کے مسائل بھی حل کر دے گا، یہ دیکھنا زیادہ ضروری ہے کہ اوپر پہنچنے والا اس کام کا اہل بھی ہے یا نہیں۔

ہمیں امید تھی کہ لوگ بندر دیکھیں گے، مسکرائیں گے اور آگے بڑھ جائیں گے۔ مگر پاکستانی خاندان میں ایک بندر بھی غیر سیاسی نہیں رہ سکتا! ہمارے ایک بھانجے—جنہیں ہم محبت سے "بھائی لوگ" کہتے ہیں—نے فوراً تبصرہ کر دیا: "جنہوں نے اوپر چڑھایا تھا، انہی نے بعد میں پنجرے میں بند کر دیا!" بات تو سچی تھی، مگر بات تھی رسوائی کی!

ہماری بیگم، جو نظریاتی طور پر پکی یوتھیا اور انتظامی طور پر گروپ ایڈمن ہیں، انہوں نے جمہوری روایات کی پاسداری کرتے ہوئے بھانجے کو فوراً گروپ سے نکال دیا۔ یوں آزادیٔ اظہار کا باب بند ہوا اور ایڈمن پاور کا نیا باب کھل گیا! آج کل ہم واٹس ایپ یونیورسٹی میں Conflict Resolution پڑھا رہے ہیں۔ بیگم ہم سے دس سال چھوٹی ہیں، لہٰذا ہم نے عمر، تجربے اور شوہرانہ اعتماد کا فائدہ اٹھاتے ہوئے انہیں Response اور Reaction کا فرق سمجھایا۔ ہم نے عرض کیا:

"ردِ عمل وہ ہوتا ہے جو آپ نے بھانجے کو نکال کر دیا، اور جواب وہ ہوگا جب آپ اسے واپس شامل کر کے کہیں گی کہ آئندہ سچ بولنے سے پہلے ایڈمن سے اجازت لینا ضروری ہے!"



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

نیوزلیٹر میں اشاعت کا مقصد پی سی ڈی اے کے دوستوں کی علمی تحقیقی اور ادبی صلاحیتوں کو اجاگر کر کے انکی حوصلہ



سیاست اور معاشرے پر

طنز و مزاح سے بھرپور کالم

کچھ مذاکرات ہوئے، چند غیرعلانیہ ضمانتیں دی گئیں، فریقین نے اپنے اپنے مؤقف میں لچک دکھائی اور یوں معاملہ رَفع دفع ہوگیا۔ بھانجا واپس آگیا، البتہ اب وہ ہر پیغام بھیجنے سے پہلے یہ دیکھ لیتا ہے کہ ایڈمن آن لائن تو نہیں۔

پٹواریوں کو فی الحال ایک طرف رکھیے، "بھائی لوگ" اور "یوتھیے" دونوں ہی اپنے اپنے مخمصے میں گرفتار ہیں۔ ایک کے رہنما نے پردیس کو مستقل پتہ بنالیا، جبکہ دوسرے کے رہنما نے جیل کو سیاسی ہیڈ آفس بنا رکھا ہے۔

بھائی" کو قوم تقریباً بھول چکی ہے، سوائے ان چند وفاداروں کے جو اب بھی واپسی کے ایسے منتظر ہیں جیسے بچپن میں گرمیوں کی چھٹیوں کا انتظار کیا کرتے تھے۔

دوسری طرف یوتھیے اس امید پر زندہ ہیں کہ ایک دن جیل کے تالے کھلیں گے، دروازے کھلیں گے اور انقلاب کم از کم واٹس ایپ اسٹیٹس تک ضرور پہنچے گا۔

اب آیئے، ایک خود ساختہ پروفیسر کی حیثیت سے ہم آپ کو سمجھاتے ہیں کہ مخمصہ آخر ہوتا کیا ہے؟ یہ سبق بھی ہمیں واٹس ایپ یونیورسٹی ہی سے ملا ہے، جہاں نہ داخلے کی شرط ہے، نہ حاضری کی پابندی، نہ تحقیق کی ضرورت—صرف فارورڈ کا بٹن دبانا آنا چاہیے۔ ایک شاگرد اپنے استاد سے الجھ پڑا۔ اسے "مخمصے" کا مطلب سمجھ نہیں آرہا تھا۔ استاد نے لغت، فلسفہ اور مثالوں سے بہت سمجھایا، مگر شاگرد مطمئن نہ ہوا۔

آخر استاد نے کہا: "بیٹا، میں تمہیں ایک واقعہ سناتا ہوں۔ شاید اس کے بعد تمہیں مخمصہ سمجھ آجائے۔ لیکن یاد رکھنا، یہ واقعہ مکمل طور پر واٹس ایپی ہے؛ اس کا حقیقت، طبّی سائنس اور عقلِ سلیم سے کوئی تعلق نہیں!"

استاد نے کہنا شروع کیا: "کراچی کی ایک سڑک پر ایک باپ اور بیٹا موٹر سائیکل پر جارہے تھے۔ ان کے آگے ایک ٹرک تھا، جس پر فولادی چادریں لدی ہوئی تھیں۔ اچانک ایک چادر اڑی اور ایسی قیامت ڈھائی کہ دونوں کے سر دھڑ سے جدا ہوگئے۔ لوگ دونوں کو اٹھا کر ایک غیرمعمولی سرجن کے پاس لے گئے۔ سات گھنٹے کے طویل آپریشن کے بعد ڈاکٹر نے دونوں کے سر دوبارہ جوڑ دیے۔ آپریشن کامیاب رہا، مریض بھی زندہ بچ گئے—

لیکن جلدی میں باپ کا سر بیٹے کے دھڑ پر اور بیٹے کا سر باپ کے دھڑ پر لگا دیا گیا!" شاگرد کی آنکھیں کھلی کی کھلی رہ گئیں۔ استاد نے بات جاری رکھی: "دو ماہ بعد دونوں گھر پہنچے تو خاندان میں ایسا آئینی بحران پیدا ہوا جس کے سامنے پاکستان کے تمام سیاسی بحران معمولی دکھائی دینے لگے۔

بہو پریشان کہ شوہر کے سر کے ساتھ رہے یا شوہر کے دھڑ کے ساتھ؟ شوہر کا سر اپنی جگہ موجود تھا، مگر دھڑ سسر کا تھا۔ دوسری طرف ساس کی مشکل یہ تھی کہ شوہر کا سر ایک طرف تھا اور شوہر کا دھڑ دوسری طرف! بیٹا اپنی بیوی کا ہاتھ پکڑنا چاہتا تو وہ فوراً کہتی: 'مجھے ابا جان کے ہاتھوں سے شرم آتی ہے!' سسر اپنی اہلیہ کے قریب جانے سے گھبراتے، کیونکہ چہرہ ان کا تھا مگر دھڑ صاحبزادے کا! موٹر سائیکل پر جانے کا مرحلہ آتا تو نیا بحران کھڑا ہوجاتا: بہو شوہر کے دھڑ کے پیچھے بیٹھے یا شوہر کے سر کے؟ اور اگر درمیان میں ٹریفک پولیس روک لے تو شناختی کارڈ کس کا دکھایا جائے؟

بینک والے الگ پریشان، نادرا والے الگ حیران، اور خاندان کے وکیل نے تو فائل دیکھتے ہی چھٹی کی درخواست دے دی! آخر کسی بزرگ نے مشورہ دیا: 'دونوں اپنی اپنی بیویوں کو طلاق دے کر دوبارہ نکاح کرلیں، مسئلہ حل ہوجائے گا۔' مگر فوراً نیا سوال اٹھا: ماں طلاق شوہر کے سر سے لے یا اس کے دھڑ سے؟ اور بہو طلاق شوہر کے سر سے مانگے یا سسر کے دھڑ سے؟ اگر سر نے طلاق دے دی اور دھڑ نے انکار کردیا تو فیصلہ کون سا معتبر ہوگا؟ اور اگر دھڑ نے دستخط کردیے مگر سر نے کہا کہ مجھے تو خبر ہی نہیں، تو عدالت کس کی بات مانے گی؟" شاگرد نے دونوں ہاتھوں سے اپنا سر پکڑ لیا اور بولا: "استاد جی، میرا دماغ بند ہوگیا ہے۔ مجھے کچھ سمجھ نہیں آرہا کہ کون کس کا شوہر ہے، کون کس کا بیٹا ہے اور طلاق کس سے لینی ہے!" استاد مسکرائے اور فرمایا:

"بیٹا، بس تمہاری یہی کیفیت مخمصہ کہلاتی ہے!" پاکستان کی سیاست بھی کچھ ایسی ہی سرجری کا نتیجہ معلوم ہوتی ہے۔ اس کا سر جمہوریت کا اور دھڑ اسٹیبلشمنٹ کا ہے۔ زبان آئین کی بات کرتی ہے، ہاتھ کسی اور کے اشارے پر حرکت کرتے ہیں، پاؤں عوام کے ووٹوں سے چلتے ہیں اور منزل کا فیصلہ کہیں اور ہوتا ہے۔ سر الگ کریں تو مصیبت، دھڑ الگ کریں تو مصیبت۔ سر حکم دیتا ہے مگر دھڑ نہیں مانتا، اور دھڑ حرکت کرتا ہے تو سر کہتا ہے: "مجھے تو معلوم ہی نہیں تھا!"

عوام ہر الیکشن میں یہی سوچ کر ووٹ دیتے ہیں کہ شاید اس مرتبہ سر اور دھڑ ایک ہی شخص کے نکلیں، مگر نتیجہ آنے کے بعد پتا چلتا ہے کہ آپریشن تھیٹر وہی تھا، سرجن بھی وہی تھے، صرف مریضوں کے نام بدل گئے ہیں۔

یہی ہماری سیاست ہے، یہی ہمارا المیہ، اور یہی ہمارا قومی مخمصہ:

جمہوریت کو بچائیں تو اختیار ناراض، اختیار کو بچائیں تو جمہوریت ناراض—اور دونوں کو خوش رکھنے کی کوشش کریں تو عوام برباد!

Prevention First Newsletter-Online

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