



Feast for Mind, Body & Soul

HOLD
Hypertension Obesity Lipid Diabetes
Update

Cardio Metabolic Range

Homo-16 D

(Vitamin D3 1000 IU + ALA 100 mg + Pyridoxine HCL 3 mg + Methylcobalamin 1500 mcg + Folic Acid 1.5 mg Tablets)

Homo-16 PG

(Pregabalin 75 mg (SR) + Nortriptyline 10.mg + Methylcobalamin 1500 mcg Tablets)

Homo-16 N

(Methylcobalamin 1500 mcg + ALA 100 mg + Folic Acid 1.5 mg + Pyridoxine HCL 3 mg Tablets)

Homo-16 LC

(L-Carnitine 500 mg + Mecobalamin 1500 mcg + Folic Acid 1.5 mg Tablets)

Telfirst AM

(Telmisartan 40 mg + Amlodipine 5 mg Tablets)

Telfirst-CT $\frac{6.25}{12.5}$

(Telmisartan 40 mg + CTDN 6.25/12.5 mg Tablets)

Telfirst 20/40/80

(Telmisartan 20 / 40 / 80 mg Tablets)

Telfirst-M $\frac{25}{50}$

(Telmisartan 40 mg + Metoprolol Succinate 25/50 mg (ER) Tablets)

Telfirst-H

(Telmisartan 40 mg + HCTZ 12.5 mg Tablets)

For the use of Registered Medical Practitioner Only.

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Bulletin

• An initiative by •



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Dimensions in Diabetes

For a disease afflicting more than 54 crore people in the World, more than 10.1 crore with T2DM in India (& 13.6 crore prediabetes), diabetes is not a multidimensional, multi morbid, multi-billion-dollar, multi-National problem only, but to quote Prof. Paul Zimmet, diabetes is likely to overwhelm some health budgets/systems.

To elaborate upon the dimensions in diabetes, one may stick to clinical & therapeutic stance of ABC Control (HbA1c, BP, Cholesterol) or the recent cardio-renal-metabolic dimensions OR the academic diabetes diversities viewpoint (looking at T1DM through insulin antibodies, GAD antibodies, HLA typing, genetic risk score, C pep assay) & deep dissecting into T2DM via insulin antibodies, GAD status, T2DM Genetic risk score, C pep levels & following these parameters over time to align management with precision diagnosis, treatment & prognostication.

I look at chiefly 3 dimensions of diabetes- from stakeholder point of view. Physician-Patient or Person with Diabetes PWD- policymakers or the State & extending this to the Global Health Organizations. Physician seeks early diagnosis (pre diabetes & new Diabetes), early detection of comorbidities / complications & improve quality of life of PWD. HCPs also look at issues like lifestyle modification (healthy diet, weight watching & control, staying away from alcohol & tobacco, stress management, sleep health etc). Asymptomatic nature of diabetes remains a challenge in Dx prediabetes or diabetes. Diabetes definitely kills softly-but mostly cruelly!!

Patient has not only a physical ailment, but a lifelong responsibility nay burden of dietary discipline, restraint on foods fond, managing physical exercise/ work / family time & expenditure (prescriptions, clinic visits, investigations & hospitalization if needed). Diabetes distress is a very crucial dimension in this space. Sexual dysfunction in diabetes is very prevalent & undisclosed dimension mostly. I am chiefly discussing T2DM (& T1DM has its own set of problem dimensions of patient-parents-family environment disturbances, psychological problem set & clearly large expense burden if on insulin pump).

Diabetes remains a killer every few minutes in our country & for the 10.1 crore diagnosed there are more who remain undiagnosed- threatening as future bomb on lives. Diabetes adversely affects physical efficiency (if not intellectual!) & Both absenteeism & presenteeism is more in PWD (absent from work or present but suboptimal performance). The economic burden of diabetes is very high (~trillion dollars for USA) in our country (since we have a large diabetes related expense on hospitalization & complication treatment). The prevalence of diabetes in youth (age<20 years) is increasing in India & these patients are more likely to need insulin, more likely to develop complications.

There is an association & future risk dimension to diabetes as well. The famous/ well publicized nephro, neuro, retinopathy & cardiovascular, cerebrovascular & peripheral vascular disease & complications are well known. Off last few years, more associations of diabetes (MASLD with future dark shadows of NASH, Liver cirrhosis & hepatocellular carcinoma) or increased risk of heart failure (increased epicardial fat, fatty kidney, fatty pancreas) increased risk of gastrointestinal cancers, depression- all have future dimension of diabetes.

To summarize, diabetes has dimensions encompassing the PWD-their family members, HCPs caring for diabetes & their health systems/ institutions & Policy makers/Government which looks at economic supports, prevention protocols. The dimensions pertain to the present as well as future! Though diagnosed by a (ridiculously simple & inexpensive) blood sugar test, diabetes has a number of dimensions for all stakeholders & people at large as well!!

Abbreviations:

Dx: Diagnosis, **MASLD:** Metabolic dysfunction-associated Steatotic Liver Disease, **NASH:** Nonalcoholic steatohepatitis, **GAD antibodies:** Glutamic Acid Decarboxylase, **HLA:** Human Leukocyte Antigen



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Can Statins reduce the risk of stroke in patients with atrial fibrillation?

Every year, around 800,000 individuals experience new or recurrent strokes, with most of these being new cases. Approximately 87% are ischemic, 10% reflect intracranial hemorrhage (ICH), and 3% are subarachnoid hemorrhage (SAH). Despite a general decrease in stroke incidence during the past 30 years, it is projected that by 2030, an additional 3.4 million adults will have had a stroke.

A region-wide study in more than 50,000 patients with atrial fibrillation has found reduced risks of stroke and transient ischaemic attack in those who started statins within a year of diagnosis compared with those who did not. Taking statins for many years was even more protective against stroke than short-term use.

Atrial fibrillation is the most common heart rhythm disorder, affecting more than 40 million people worldwide. Patients with the condition have a five times greater risk of stroke than their peers. Anticoagulant medication is recommended to prevent strokes in those with atrial fibrillation but does not completely eliminate risk. Statin therapy is widely prescribed to lower blood cholesterol and reduce the likelihood of heart attack and stroke. However, the benefit of statins for stroke prevention in patients with atrial fibrillation has been unclear.

Studies have been executed to evaluate the association between statin use and the incidence of stroke and transient ischaemic attack in patients with atrial fibrillation.

The use of Statin is associated with a 17% reduced risk of ischaemic stroke or systemic embolism. Also, the intervention of statins exhibited 7% reduced risk of hemorrhagic stroke and 15% reduced risk of transient ischaemic attack.

The long-term statin use was associated with greater protection than short-term use. Patients using statins for six years or longer had a 43% lower risk of ischaemic stroke and 44% reduced likelihood of hemorrhagic stroke.

Established data supports the use of statins to prevent stroke and transient ischaemic attack in patients with new-onset atrial fibrillation. The findings have important clinical implications particularly given that in atrial fibrillation patients, ischaemic strokes are often fatal or disabling, and have a high risk of recurrence.