



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.

Item Code : M09226



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SINSAN PHARMACEUTICALS PVT. LTD.



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Should sodium-glucose cotransporter-2 inhibitors be first-line glucose lowering treatment for patients with type 2 diabetes?

The recent guidelines have given greater emphasis on reducing the risk of developing heart and kidney problems and protecting these organs from damage. The recommendations focus on proper choice of medications, generally SGLT2 inhibitors or GLP-1 receptor agonists for people with atherosclerotic cardiovascular disease (ASCVD), and/or those with high risk for heart and kidney disease, heart failure, and chronic kidney disease. Today, more than ever before, there are medications that lower glucose levels and assist in the prevention or management of other conditions like obesity, hypertension, heart failure medication, social determinants of health, and lipid management along with glycemic control.

With the use of SGLT2 inhibitors playing a role in protecting the health of kidneys, the levels of kidney function for which it is recommended were lowered.

SGLT2 inhibitors are preferred as first line therapy specifically in Diabetes-related Heart Failure and Chronic Kidney Diseases. The Cardioprotective benefits of SGLT2 inhibitors have been observed and FDA has approved HF Benefits of Dapagliflozin and Empagliflozin and thus have recommended these molecules for management of T2DM with Heart Failure.

SGLT2 inhibitors are also beneficial in Diabetes-related CKD patients where eGFR is less than 60, as they assist in reducing the CKD progression. Canagliflozin and Dapagliflozin both have FDA Approval for renal benefits seen in similar patients.

SGLT2 inhibitors are insulin-independent with no risk for hypoglycemia and weight gain. Also, in majority of the cases, gliflozins work immediately without having a need for titration.

Beginning a therapy with SGLT2 Inhibitors would have an objective of decreasing the long-term complications and making the use of pleiotropic benefits of SGLT2 Inhibitors in special population.

In patients with T2DM, SGLT2i as first-line treatment may be associated with decreased events of heart failure hospitalization, acute coronary syndrome, and all-cause mortality, compared with metformin as first-line treatment making it cardio-centric by reducing the CV events while decreasing HbA1c without increasing hypoglycemia.

But at the same time, there is no data that beginning metformin as a first-line therapy is harmful. For most patients, metformin is affordable, well understood, safe, prescribed with confidence, and possibly beneficial for the heart.

If that intervention is not enough based on HbA1c, or if an SGLT2 inhibitor is required for CV or renal reasons independent of HbA1c, then we can begin the SGLT2 inhibitor after a few months of metformin.

Concluding, SGLT2 Inhibitors should be considered as first line treatment in Type 2 Diabetes patients with High-Risk conditions like ASCVD, HF and CKD, but in patients where only optimum glycemic goal is the primary objective, Metformin can remain the first choice of drug.



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Sulphonyl Ureas: Still a Supermolecule

Sulphonylureas, the secretagogue are the widely used molecules for management of T2DM. As suggested by many previous guidelines, they are preferred as first line therapy. The use is effective and vast in India, as Sulphonylureas are very reasonably priced and very efficacious in controlling and reducing the elevated blood glucose levels.

Various guidelines for effective diabetes management suggest use of sulphonylureas in those patients where the reduction of HbA1c was the primary goal. ADA 2022, suggests use of Sulphonylureas as first line therapy specifically in patients where cost of therapy is a concern.

But with advent of Newer Molecules which include SGLT2i, DDP4i etc. in some patient cases, Sulphonylureas have taken a back seat.

Sulphonylureas, are effective enough to reduce HbA1c by 1.5-2 % when given to patients.

The maximum dose approved specifically for Glimepiride is 1-8 mg, so it can be once or even twice a day. But when given twice, care have to be taken to effectively manage hypoglycemia. Many complain about hypoglycemia, as a side effect associated with Glimepiride or other Sulphonylureas, but it has to be understood that Sulphonylureas function by stimulating the β -Cell to release insulin, irrespective of the blood glucose levels, as it is a glucose dependent molecule conversely to new molecules like DPP4i.

Also, β -Cells have a specific lifespan. For initial 5-6 years the β -cell population is very robust, but by 8 years the exhaustion starts. Thus, the role here is of the prescribers, dose titration is the key to this.

When Sulphonylureas are prescribed, it should be considered that β -cell deterioration and resistance is bound to happen in a span of years. The only solution to this is effective dose titration.

In patients with low eGFR, adjusting the dose and setting the right frequency will assist the patients to get the optimum glucose levels.

Also, in patients with uncontrolled T2DM and CKD, avoiding the molecule would be better as the excretion of Glimepiride is through Kidney. In patients with Renal failure, short acting sulphonylureas like Gliclazide could be a better choice of treatment in combination with Pioglitazone and Linagliptin.

The new recommendations consider the pleiotropic effects and thus according to different patient conditions have suggested use of new agents, but Sulphonylureas are supermolecules when it comes to efficacy and should be placed as first line therapy where the primary goal is to reduce blood glucose levels.

To conclude, Sulphonylureas are ancient molecules with established evidences of efficacy, can be combined easily with other antidiabetic agents to maintain glycemic goals and they definitely could be the choice of treatment for T2DM while considering the additional patient specific factors like cost and access.