

# **PRESENTATIONS**

By

National Speakers

## 34- Shall we be treating all women with HRT? Hormone replacement therapies, Metabolic and cardiovascular effects.

*Prof. A.H. Aamir  
Consultant Endocrinologist,  
Professor of Medicines,  
Head of Department of Endocrinology,  
Hayatabad Medical Complex, Peshawar.*

Menopause affects every woman and it usually occurs at a median age of 51 years. As large number of women is reaching midlife, it is likely that physicians will come across a stage where HRT may need to be considered for their patient.

Menopause has Physical, Psychological, Uro-genital tract, Cardiovascular, Skeletal effects. Estrogens also have effects on carbohydrate homeostasis, fatty liver and atherosclerosis. Postmenopausal women with hyper-androgenemia have elevated risks for NIDDM-Risk and CHD.

Most of these effects are reversible with replacement of Estrogens. Women health initiative study (WHI) initially showed an increased cardiovascular risk with HRT increased risk of VTE, stroke, MI Risk appears to be higher in initial years of treatment, followed by decline in risk.

Recent re-analyses of WHI results suggested that the association between HRT and cardiovascular risk is influenced by factors such as age and time since menopause

- Reduced CV risk in women <10 years post-menopause.
- WHI population included older women with other CV risk factors.

Risks of stroke should be balanced against benefits, such as decreased risk of hip fracture. Treatment with HRT needs to be individualized in the light of recent International menopausal society recommendations.

## 35- Characteristics of Fasting and Ramadan-specific diabetes education trends in people with diabetes (CARE)

*Prof. Yakoob Ahmedani  
Consultant Physician & Diabetologist,  
Professor of Medicines, Baqai Medical University,  
Deputy Director BIDE, Karachi - Pakistan.*

**Objectives:** To observe the characteristics of fasting, trends of Ramadan-specific diabetes education and implementation of diabetes management recommendations in fasting patients with diabetes during Ramadan.

**Methodology:** This observational study was conducted in 7 countries. Inclusion of patients for the study began immediately after the end of Ramadan (August) of Muslim year 1435 (i.e., 2014) until December 2014. Standardized questionnaire-based, face-to-face interview was conducted on one-to-one basis. An identical questionnaire was used in each country. Data was analyzed using Statistical Package for Social Sciences (SPSS), version 17.0.

**Results:** A total of 6610 patients with diabetes (260 patients with type 1 and 6350 patients with type 2) participated in the survey. Ramadan-specific diabetes education was received by 3142 (47.5%) patients, drug dosage and timings were altered in 4371 (66.1%) and dietary advice was received by 4636 (70.1%) patients with diabetes before Ramadan. For analysis, patients were identified in two groups; Group A (Received Ramadan-specific diabetes education) and Group B (Did not receive Ramadan-specific diabetes education). Frequency of symptomatic hypoglycemia and hyperglycemia was not significantly different in the two groups ( $p > 0.05$ ), however, the frequency of severe hypoglycemia and hyperglycemia were less ( $p < 0.0001$ ) in Group A compared to Group B. Group A was also significantly better ( $p < 0.0001$ ) in following Ramadan-specific diabetes management recommendations.

**Conclusion:** The findings of our study suggest that patients who received Ramadan-specific diabetes education had lesser severe acute complications of diabetes during Ramadan. Ramadan-specific diabetes management recommendations are still not completely implemented.

**KEY WORDS:** Ramadan, Education, Diabetes, Fasting.

## 36- For how long should I take Metformin? PCOS: A Metabolic Conundrum

*Prof. Tasnim Ahsan  
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Convenor of the Faculty of Endocrinology,  
College of Physicians & Surgeons of Pakistan,  
Ex Executive Director and Head of Department of Medicine,  
Jinnah Post Graduate Medical Centre, Karachi - Pakistan.*

Patients with metabolic obesity and PCOS are at a higher risk of cardiovascular disease (CVD), endometrial and other cancers, as well as subfertility. These patients also have insulin resistance and are set up for early onset Diabetes Mellitus (DM). PCOS is an imprecise label, which may hold many different disease entities underneath its umbrage. The classical PCOS patient with metabolic obesity and Insulin resistance, lends herself best to Metformin intervention. It is one of the oldest drugs for DM and has a safety record of decades; it offers many other benefits apart from its glucose lowering effect. Most importantly it has a cardio-protective effect in DM, CVD being the basis of most complications of DM.

Metformin suppresses the hepatic production of glucose, decreases intestinal glucose absorption and improves glucose uptake and utilization; has platelet anti-aggregation effect, reduces the rate of formation of advanced glycation end products and decreases the cellular oxidative reaction. The distinct anti-oxidant action explains its vascular protective effect. It thus has a favorable effect on Insulin resistance and reducing body weight.

Continuation of Metformin in PCOS throughout pregnancy has been shown to reduce the risk of miscarriage, GDM, Gestational hypertension and a non-significant decrease in pre-eclampsia. There is likely a beneficial effect on foetal overweight in women who have taken Metformin throughout pregnancy.

## 37- Postpartum management of Diabetes Mellitus

*Prof. Nazli Hussain  
Consultant Obstetrician & Gynecologist,  
Prof. of Obstetrics & Gynecology, Civil Hospital,  
Dow University of Health Science, Karachi.*

Postpartum period is an important period in the life of a couple. With stress of pregnancy over, joy of newborn, increasing family participation, its time that couple should be given ample advice about certain important aspects.

In our routine practice, we fail to impress upon woman the importance of health dietary choices, importance of regulating body mass index, contraceptive measures to avoid further pregnancies unless the desired body mass index is achieved, importance of breast feeding in regulating body mass index and development of type 2 diabetes mellitus.

The talk will focus on postpartum management of both IDDM and gestational diabetes mellitus. It aims to highlight the importance of continued care in postpartum period of women with GDM. Cardiovascular, metabolic risks of women with GDM will be discussed. Neonatal effects of GDM, along with long term effects of GDM in later life will also be discussed. Also discussed will be role of gynecologists in our set up in decreasing the incidence of GDM in subsequent pregnancies. Screening modalities for subsequent development of type 2 diabetes mellitus in above group of women will also be discussed. Emphasis will be laid on decreasing the cardiovascular, metabolic risks in future for this group of women.

## 38- Biochemical Assessment of Metabolic Bone Diseases: It's not always Vitamin-D deficiency!

*Dr. Ayesha Habib,  
Associate Professor & Section Head Clinical Chemistry  
Department of Pathology & Laboratory Medicine  
Aga Khan University, Karachi.*

Several factors influence the choice of a method for the measurement of MBD depending upon the locally available equipment, methodology, expertise and knowledge for the interpretation of the results and the type of information required. Biochemical measurements are often required to distinguish between the various causes of osteopenia, identifying people at risk, the prediction of bone loss and the selection of groups for treatment, particularly for osteoporosis, parathyroid dysfunction etc.

Measurement of serum calcium, 25-hydroxyvitamin D (25OHD), and plasma iPTH concentrations, although readily available, are of limited value in assessing MBD when used individually. Simultaneous testing with markers relevant to MBD improves diagnostic yield, as interpretation can be made together with clinical history and examination. They are also economical both in terms of time and money for both patients and physicians. Bone health screening panels (BHSPs) variably utilize combinations of blood tests to screen, diagnose, and monitor MBDs in clinical practice. These panels facilitate answering the potential clinical questions that a physician asks when investigating MBDs.

Vitamin D deficiency and insufficiency has an important role in the interpretation of diagnostic tests. A significant number of patients presents with biochemical variables that do not fit the classic description of primary and secondary disorders of hormone secretion and may present a diagnostic dilemma. Use of indices and multidimensional nomogram to enhance diagnostic accuracy in atypical cases is recommended. There is a dire need to identify the other defects in areas with endemic vitamin D deficiency due to its implications on osteoporosis.

## 39- Screening for Gestational Diabetes Mellitus

*Dr. Shabeen Naz MBBS, MCPS, FICS, FCPS, PhD, DCPS (HCSM),  
Prof. of Obstetrics & Gynecology,  
Isra University,  
Karachi - Pakistan.*

Gestational diabetes is increasing worldwide with an increase in prevalence by two-to-three-folds. It is diagnosed in 2-18% of pregnant women worldwide. Diagnosis of gestational diabetes (GDM) carries a lifetime risk of progression to type 2 diabetes in up to 60% and develops in about one-half of all women who have GDM. Identification of women at higher risk of progression to diabetes allows timely introduction of measures to delay or prevent type 2 diabetes onset. In 2015 IDF Atlas, it is estimated that 21 million women develop gestational diabetes out of which 1 in 7 births are affected by gestational diabetes. Women who have been previously diagnosed as GDM are at higher risk of developing diabetes in subsequent pregnancies and type 2 diabetes later in life. Babies born to mothers with gestational diabetes also have a higher risk of developing type 2 diabetes in their teens or early adulthood. Instead of Risk stratification universal screening is essential in all pregnant women. Tight glycemic targets are required for optimal maternal and fetal outcome.

## 40- Anemia In Pregnancy Consequences For Mother & Offspring

*Prof. Sadaqat Jabeen-MBBS, FCPS  
Post Fellowship in Fetal Medicines,  
Head Department of Obstetrics &Gynaecology,  
Lady Reading Hospital, Peshawar.*

Anemia is one of the most common medical disorders occurring in pregnancy. The prevalence ranges from 12-60% in different regions of the world. It is a cause of serious concern as it is associated with significantly high rates of maternal and fetal morbidity and mortality. According to WHO about 40% of maternal deaths are associated with it. The maternal complications range from simple fatigue to cardiac failure & even death. Other complications are high incidence of infection, PPH, thrombo embolism, anesthetic problems etc. Its fetal complications are pre-term birth, IUGA & many more. About 90-95% cases, the cause is iron deficiency followed by folic acid deficiency & hemoglobinopathies. In our society thalassemia is also becoming an increasing cause. The aim of management is to find out the cause and then to treat it. Systemic approach of history, examination and step wise investigation can lead to find out its causes. The nutritional deficiencies need administration of iron or folic acid. Blood transfusion has limited role in specific indications. Iron & folic acid prophylaxis during pregnancy is very helpful in reducing the incidences of anemia.

## 41- To prevent future dismay, start healthy eating today

*Dr. Fayza Khan M.Sc. (Nutrition)  
Registered Clinical Dietitian,  
The Kidney Centre Post Graduate Training Institute,  
Karachi - Pakistan.*

Unhealthy diets and physical inactivity are among leading cause of obesity, therefore successful preventive and control mechanisms for obesity in the country are warranted particularly through whole society approach. Creating an environment that supports the population in developing countries and sustaining healthy eating and physical activity habits is a challenge for the policy makers.

In order to improve health outcomes, individuals with obesity will need to practice healthy eating and daily exercise and these behaviors must be sustained. Among all the variety of interventions, weight loss and adopting a healthier eating pattern is perhaps one of the most critical for preventing onset as well as progression of diabetes. Indeed numerous research studies have demonstrated the positive impact of dietary treatment in experimental conditions for prevention and treatment of obesity and diabetes .Making a few simple changes in the lifestyle now may help people avoid the serious health complications of diabetes down the road, such as nerve, kidney and heart damage. Dietitians should translate the approaches most suited for the individual patients in day today practice to help them achieve optimal health outcomes. Understanding the concept of a balanced diet is essential, by excluding or strictly limiting a particular food group, essential nutrients intake may be compromised. Instead, variety and portion control as part of an overall healthy-eating plan is the key to maintain good health.

## 42- Medical Management of Diabetes in Pregnancy

*Dr. Musarrat Riaz FCPS (Med), FCPS (Endo),  
Assistant Professor,  
Consultant Endocrinologist,  
Baqai Institute of Diabetology & Endocrinology (BIDE),  
Baqai Medical University (BMU),  
Karachi - Pakistan.*

The prevalence of diabetes in pregnancy including gestational diabetes mellitus (GDM) has been increasing worldwide. Most cases of GDM can be managed by lifestyle measures alone, including careful attention to dietary principles and regular exercise during pregnancy. Pharmacologic agents are recommended if lifestyle interventions alone fail to control glucose levels. Blood glucose is monitored before and two hours after meals. The recommended glycemic targets for patients with GDM are Fasting blood glucose  $\leq$  95 mg/dl; or 2h post-prandial  $\leq$  120 mg/dl. If MNT and lifestyle changes are not sufficient to maintain the blood glucose at the recommended targets within 1-2 weeks, the initiation of insulin is recommended. Insulin is the recommended first line of treatment if glycemic targets are exceeded, although there is increasing evidence that oral agents (metformin or glyburide) may also be safe in this situation. Typically, 50% of the total daily dose is used for basal requirements and 50% for prandial requirements (divided into three doses), with frequent adjustment to dosing until glycemic targets are reached. Women with pregestational diabetes should have a baseline ophthalmology exam in the first trimester and then be monitored every trimester as indicated by degree of retinopathy. The requirement for insulin usually ends with delivery, however women with GDM remain at increased risk of developing diabetes in subsequent pregnancies or later in life, and appropriate counselling and advice should be provided and long-term monitoring are needed.

Metformin therapy has been shown to be beneficial for long term complications of PCOS, by reducing the risk of DM, cancer, CVD; recently it has been reported to have beneficial effects on neuro-degenerative disorders also. A case can be made for indefinite Metformin therapy in PCOS, as long as obesity and high Insulin levels persist.

### **43- Diabetic Foot Infections. "Role of Radionuclide Imaging in the Diagnosis of Diabetic Foot Infections"**

*Dr. Shabana Saeed,  
Pakistan.*

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### **44- Lifestyle Intervention trials in women with Gestational Diabetes Mellitus**

*Dr. Romaina Iqbal  
Associate Professor,  
Aga Khan University, Karachi - Pakistan.*

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### **45- Pregnancy Complicated with Hypertension**

*Dr. Bashir Hanif  
Consultant Cardiologist,  
Medical Director/Chief of Cardiology/Director Interventional Cardiology,  
Tabba Heart Institute, Karachi, Pakistan.*

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### **46- How to transform junk food into healthy items (smart cooking video)**

*Mrs. Rabia Saqib*

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### **47- Diabetic Foot Infections (Case Discussion)**

*Dr. Zahid Miyan  
Assistant Professor of Medicine,  
Baqai Medical University, Consultant Diabetologist & Endocrinologist,  
Baqai Institute of Diabetology & Endocrinology, Karachi - Pakistan.*

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### **48- Weight Gain: A precursor of Gestational Diabetes Mellitus**

*Dr. Rubina Sohail. MCPS (OB/GYN), DCPS-HPE  
Consultant Obstetrician and Gynaecologist, Professor of Obstetrics and Gynaecology,  
Services Institute of Medical Sciences/Services Hospital Lahore.*

## 49- I am too young to be unfit: Managing hypogonadotropic hypogonadal male fertility

*Dr. Rehman Khan, U.K.*

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## 50- Correlating stones, moans & groans: Medical Treatment of parathyroid disorders

**1. Dr. S. Abbas Raza**

*Consultant Diabetologist & Endocrinologist,  
Shaikat Khanum Trust Hospital, Lahore - Pakistan.*

**2. Prof. Zaman Shaikh**

*Consultant Diabetologist & Endocrinologist,  
Dean Faculty of Medicine, Sir Syed Medical College ,  
Director Sir Syed Institute of Diabetology and Endocrinology, Karachi - Pakistan.*

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## 51- Diagnostic approach towards cushing syndrome

**1. Dr. Khurram Shahid**

*Consultant Diabetologist & Endocrinologist*

**2. Dr. Aisha Sheikh,**

*Consultant Diabetologist & Endocrinologist,  
Agha Khan University Hospital, Karachi - Pakistan.*

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## 52- Snapshots of endocrine disorders

**1. Dr. Hameed Farooqi**

*Consultant Physician, Diabetologist & Endocrinologist, Former Medical Director,  
Joslin Diabetes Center Florida, USA*

**2. Dr. Osama Ishtiaq. FCPS, FACE (US),**

*Consultant Diabetologist & Endocrinologist Shifa International Hospital, Islamabad,  
Professor of Medicine, Shifa College of Medicine, Islamabad - Pakistan.*

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## 53- How and When to treat short Stature?

**1. Prof. Jamal Raza**

*Director, Professor of Pediatrics, Pediatric Endocrinologist,  
National Institute of Child Health, Karachi - Pakistan.*

**2. Dr. Khadija Nuzhat**

*Consultant Pediatrician, Consultant Pediatric Endocrinologist,  
Agha Khan University Hospital, Karachi - Pakistan.*