

Diabetes Digest

July 2026

Mental Health and Psychological Well-Being in Diabetes

Semaglutide and Diabetic Retinopathy:
An Evidence-Based Review

ٹائپ 1 ذیابیطس میں ہنی مون فیز: تشخیص،
اہمیت اور حقیقت

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OF PAKISTAN



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Editor: Dr. Faiza Rauf & Ms Amna Mansoor

Welcome to the July 2026 issue of Diabetes Digest. This edition continues to highlight our collective efforts in advancing diabetes prevention, awareness, and care across Pakistan. Through ongoing initiatives, community engagement, and collaborative partnerships, we remain committed to improving health outcomes and strengthening support systems for individuals living with diabetes. We hope this issue provides valuable insights, inspiration, and a deeper understanding of the impactful work being carried out across the country.

"انسان کو اپنی زندگی میں شعور اور توازن پیدا کرنا چاہیے، یہی اصل کامیابی ہے۔"

— بانو قدسیہ

All Enquiries: Diabetic Association of Pakistan

📍 5-E/3, Nazimabad, Karachi-74600.

☎ +92-21-36616890, 36680959, 36613578

✉ dapkhi@cyber.net.pk, dapkarachi@gmail.com

🌐 www.dap.org.pk

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DAP MONTHLY HIGHLIGHTS

Successful Cataract Surgery Initiative

During July 2026, the Diabetic Association of Pakistan (DAP), with the generous support of the Jeco Foundation, successfully conducted a series of cataract surgeries for deserving patients. The initiative aimed to restore vision and improve the quality of life of individuals suffering from cataracts, particularly those living with diabetes who are at a higher risk of developing vision-related complications.

The surgical procedures were carried out by experienced ophthalmic

professionals, ensuring high standards of patient care and safety throughout the process. The program enabled numerous patients to receive sight-restoring treatment that might otherwise have remained beyond their financial reach.

The Diabetic Association of Pakistan extends its sincere gratitude to the Jeco Foundation for its continued commitment to supporting initiatives that improve the health and well-being of the community. Such collaborations play a vital role in expanding access to essential healthcare services for vulnerable populations.

DAP remains committed to its mission of preventing diabetes-related complications and enhancing patients' quality of life through comprehensive healthcare services and community partnerships. The schedule for the next cataract surgery program will be announced soon, Insha'Allah.

Promoting Ethical Excellence in the Workplace

The Diabetic Association of Pakistan (DAP) continues to strengthen its organizational values by promoting professionalism, integrity, and ethical responsibility among its team members. As part of this commitment, DAP recently organized an Office Ethics Awareness Session conducted by the organization's Sharia Advisor.

The session was attended by respected doctors and staff members and focused on the importance of maintaining ethical standards in the workplace. Key topics included professionalism, mutual respect, accountability, honesty, and responsible conduct while performing professional duties.





During the session, participants discussed how strong ethical values, guided by Islamic principles, play a vital role in creating a positive, respectful, and supportive work environment. The discussion emphasized that ethical practices not only improve teamwork and organizational culture but also contribute to delivering better healthcare services and compassionate patient care.

Such initiatives reflect DAP's ongoing commitment to nurturing a culture of excellence, responsibility, and integrity. By investing in awareness and professional development, DAP aims to empower its team members to uphold the highest standards of service and dedication in fulfilling its mission of improving the lives of people affected by diabetes.

Office Ethics Awareness Session

The Diabetic Association of Pakistan successfully organized an Office Ethics Awareness Session to reinforce the importance of ethical

conduct, professional integrity, workplace discipline, and mutual respect among its employees. The session aimed to strengthen the organization's commitment to maintaining a positive, responsible, and professional work environment.

The session was delivered by Mufti Farrukh Ahmed, who shared insightful guidance on the significance of honesty, accountability, respect, and ethical decision-making in the workplace. Through his engaging

discussion, participants were encouraged to uphold high moral values and demonstrate professionalism in their daily responsibilities.

The interactive session provided employees with an opportunity to reflect on the role of ethics in fostering teamwork, trust, and organizational excellence. It also emphasized the importance of maintaining respectful relationships with colleagues while contributing positively to the overall work culture.

The Diabetic Association of Pakistan extends its sincere appreciation to all staff members for their enthusiastic participation and commitment to promoting an ethical, disciplined, and respectful workplace. Such initiatives reflect the organization's continued dedication to professional development and the cultivation of a strong ethical culture.



Undiagnosed Diabetes has Critical Consequences

Author: Dr Sumair Ishtiaq

CONFIRMED undiagnosed diabetes has been found associated with a higher risk of cardiovascular and renal outcomes. The unconfirmed undiagnosed phenotype shared a similar cardiovascular disease (CVD) risk with confirmed diabetes, but had a 50pc lower risk of treated diabetes, with a stronger association observed for isolated fasting plasma glucose (FPG) elevation than for isolated 2-h postload glucose (2-hPG).

Current diagnostic criteria emphasize hemoglobin A1c (HbA1c) as a practical indicator of long-term glycaemia, reducing reliance on the oral glucose tolerance test (OGTT), except in specific settings, such as gestational diabetes mellitus (GDM). In the absence of classic symptoms, diabetes can be diagnosed using FPG, 2-hPG or HbA1c, provided that two abnormal results are confirmed either concurrently or at separate time points. Given the often-prolonged asymptomatic phase of hyperglycemia, early detection is essential, as undiagnosed diabetes is associated with an increased risk of complications.

Guidelines recommend confirming an isolated abnormal glucose value with a second test, whereas concurrent abnormalities in two indices are sufficient for diagnosis. Some studies, however, have used single-sample definitions to estimate undiagnosed diabetes. Data from the Na-

tional Health and Nutrition Examination Survey (NHANES) show a decline in confirmed undiagnosed diabetes in American adults from 19.3% in 1988 to 9.5% in 2020. However, in other regions, including Asia and Africa, the trend is moving in the opposite direction. Despite the high burden of undiagnosed diabetes, evidence on the prognostic significance of confirmed versus unconfirmed undiagnosed diabetes is limited.

A study at Shahid Beheshti University of Medical Sciences in the Iranian capital of Tehran recently evaluated the prognostic performance of a single-sample confirmatory definition of undiagnosed diabetes, and examined the association between baseline diabetes status and subsequent outcomes. The study comprised 6,712 participants aged ≥ 30 years.

The study defined “no diabetes” as FPG levels $<7\text{mmol/L}$ (126mg/dL) and 2-hPG $<11.1\text{mmol/L}$ ($<200\text{mg/dL}$). Unconfirmed undiagnosed diabetes was defined by elevated levels of either $\text{FPG} \geq 7\text{mmol/L}$ or $2\text{-h PG} \geq 11.1\text{mmol/L}$, but not both, whereas confirmed undiagnosed diabetes was defined as having elevated levels of both $\text{FPG} \geq 7\text{mmol/L}$ and $2\text{-h PG} \geq 11.1\text{mmol/L}$. Participants who reported the use of glucose-lowering medications were considered “treated diabetes” cases.

In the CVD sample, 3.6% subjects had confirmed and 3.3% had unconfirmed undiagnosed diabetes. The mean levels of FPG and 2-hPG were

significantly higher in the confirmed undiagnosed group than in the unconfirmed group. Compared to individuals without diabetes, those with unconfirmed undiagnosed and confirmed undiagnosed diabetes had a significantly higher risk of developing treated diabetes. For incident chronic kidney disease (CKD), participants with confirmed undiagnosed diabetes had a significantly higher risk, whereas no significant association was observed among those with unconfirmed undiagnosed diabetes. For incident hypertension, participants with unconfirmed undiagnosed diabetes had a significantly higher risk, whereas the association among those with confirmed undiagnosed diabetes was not significant. Compared to individuals without diabetes, participants with isolated elevation of FPG and those with isolated elevation of 2-hPG had a significantly higher risk of developing treated diabetes.

On the basis of these and several other findings, the population-based study concluded that confirmed undiagnosed diabetes, defined by concurrent elevations in FPG and 2-hPG levels, was associated with increased risks of treated diabetes, CKD and incident first and hard CVD events. Compared with confirmed undiagnosed diabetes, the unconfirmed undiagnosed phenotype conferred a similar risk for incident first CVD, but was accompanied by an approximately 50pc lower risk of progression to treated diabetes. Finally, the excess risk of



first and hard CVD events appeared to be driven primarily by isolated elevation of FPG rather than isolated elevation of 2-hPG; noticeably, the CVD risk associated with isolated FPG elevation was comparable with that observed in confirmed undiagnosed diabetes.

Diabetes and Gum Disease

Author: Muhammad Ali Siddiqui

What is Diabetes?

Diabetes is a long-term disease that cannot be cured, but it can be controlled. It includes different types such as Type 1, Type 2, Gestational Diabetes, and MODY. In diabetes, the body does not make enough insulin or cannot use it properly, causing high blood sugar (hyperglycaemia).

High blood sugar can damage many parts of the body, including the:

- Kidneys

- Heart
- Eyes
- Nerves
- Feet
- Teeth and gums

Diabetes can be managed by:

- Eating a healthy diet
- Exercising regularly
- Taking medicines or insulin
- Checking blood sugar and HbA1c levels regularly

Why Are People with Diabetes More Likely to Get Gum Disease?

People with diabetes have a higher chance of developing periodontitis (serious gum disease). Healthy teeth are held in place by the gums and supporting bone. When bacteria collect on teeth, they form dental plaque. If plaque is not removed, it can damage the gums and bone, making teeth loose.

People with diabetes are more likely to get infections because:

- They usually develop more dental plaque.
- High blood sugar changes the bacteria in the mouth.
- It damages collagen (supporting tissue).
- It reduces blood supply to the gums, making healing slower.

How to Prevent Gum Disease in Diabetes

You can lower the risk of periodontitis by:

- Keeping diabetes under good control.
- Brushing and flossing regularly.
- Visiting the dentist for regular cleanings.
- Treating cavities, tartar, and early gum disease before it becomes severe.

Signs of Gum Disease

Common symptoms include:

- Loose teeth

- Bleeding gums while brushing or chewing
- Swollen or infected gums
- Bad breath

Treatment Options

Treatment depends on how severe the gum disease is.

It may include:

- Professional periodontal (gum) treatment if the disease is not very advanced.
- Removing badly damaged teeth and replacing them with a removable denture.
- Removing damaged teeth and placing a dental bridge if enough healthy teeth remain.
- Using BAX basal implants, which are designed to reduce bacterial attachment.

Dental Implants and Diabetes

Traditional dental implants may not be the best choice for people with diabetes because they heal more slowly and have a higher risk of infection. This can increase the chance that the implant will fail.

For this reason, dentists may recommend BAX basal implants instead.

BAX Basal Implants for Diabetic Patients

BAX basal implants have a smooth surface and are fixed into the strong outer layer of bone (cortical bone). Because bacteria do not easily stick to them, the risk of peri-implantitis (infection around the implant) is very low.

Studies by the International Implant Foundation on nearly 10,000 patients showed that BAX basal implants had similar success rates in

both diabetic and non-diabetic patients.

Even with basal implants, diabetes should be well controlled before treatment, as people with diabetes can still develop other oral health problems.

Source: <https://anveli.dental/diabetes-and-dental-implant/>



Diabetes and Gum Disease

Protect Your Smile by Controlling Your Blood Sugar



1. What is Diabetes?

- High blood sugar damages teeth and gums.
- Diabetes can be controlled with healthy eating, exercise, medication, and regular HbA1c checks.



2. Why Does Diabetes Affect Gums?

- More dental plaque
- Slower healing
- Reduced blood supply
- Higher infection risk

3. Warning Signs

 Bleeding gums
  Swollen gums
  Loose teeth
  Bad breath

4. Prevention

- ✓ Control blood sugar
- ✓ Brush twice daily
- ✓ Floss every day
- ✓ Visit your dentist regularly

5. Treatment Options

 Professional gum treatment
  Dental bridge or denture
  BAX Basal Implants for selected diabetic patients



Maintaining good blood sugar control is the best way to protect your gums and improve treatment success.



Semaglutide and Diabetic Retinopathy: A Narrative Review of Current Evidence

Dr. Faiza Rauf

Editor, DAP Digest

Abstract

Semaglutide, a glucagon-like peptide-1 receptor agonist (GLP-1 RA), has emerged as one of the most effective therapies for the management of type 2 diabetes mellitus (T2DM), offering significant improvements in glycemic control, weight reduction, and cardiovascular outcomes. However, concerns regarding diabetic retinopathy (DR) were raised following the SUSTAIN-6 cardiovascular outcomes trial, which reported a higher incidence of retinopathy complications among semaglutide-treated patients. Subsequent studies have provided conflicting findings, suggesting that the observed risk is likely related to rapid glycemic improvement rather than a direct toxic effect of semaglutide on retinal tissue. This narrative review summarizes the available evidence, explores the proposed mechanisms, identifies high-risk patient populations, and discusses current clinical recommendations for minimizing ocular complications while maximizing therapeutic benefits.

Keywords: Semaglutide, GLP-1 receptor agonists, diabetic retinopathy, type 2 diabetes mellitus, SUSTAIN-6, HbA1c.

Introduction

Diabetic retinopathy remains one of the leading causes of preventable blindness among working-age adults worldwide. Chronic hyperglycemia results in progressive retinal microvascular damage, eventually leading to visual impairment if left untreated. Tight glycemic control has consistently been shown to reduce the long-term risk of diabetic retinopathy progression.

Semaglutide has revolutionized diabetes management by producing substantial reductions in HbA1c and body weight while lowering cardiovascular risk. Nevertheless, reports of worsening diabetic retinopathy shortly after treatment initiation generated concern among clinicians and patients. Determining whether semaglutide directly contributes to retinal injury or whether this phenomenon reflects rapid glucose normalization is critical for evidence-based clinical practice.

Pathophysiology of Diabetic Retinopathy

Diabetic retinopathy develops through prolonged exposure to hyperglycemia, oxidative stress, inflammation, endothelial dysfunction, and retinal ischemia. These processes lead to:

- Capillary basement membrane thickening
- Pericyte loss
- Increased vascular permeability
- Retinal microaneurysm formation
- Neovascularization in advanced disease

The progression from non-proliferative diabetic retinopathy (NPDR) to proliferative diabetic retinopathy (PDR) is influenced by glycemic control, duration of diabetes, hypertension, dyslipidemia, and renal disease.

Semaglutide:

Mechanism of Action

Semaglutide is a long-acting GLP-1 receptor agonist that enhances glucose-dependent insulin secretion, suppresses glucagon release, delays gastric emptying, and promotes satiety. Clinical trials have demonstrated HbA1c reductions of approximately 1–2% with clinically meaningful weight loss and cardiovascular benefits.

These metabolic improvements make semaglutide an attractive treatment option for patients with T2DM and obesity.

Clinical Evidence Linking Semaglutide and Retinopathy

The SUSTAIN-6 Trial

The SUSTAIN-6 cardiovascular outcomes trial first reported an increased rate of diabetic retinopathy complications among patients receiving semaglutide compared with placebo.

Importantly, further analysis showed that affected patients generally had:

- Pre-existing diabetic retinopathy
- Long-standing diabetes
- High baseline HbA1c
- Concurrent insulin therapy

- Rapid reductions in HbA1c following treatment initiation

These observations suggested that patient characteristics rather than direct retinal toxicity explained the findings.

Evidence from Subsequent Studies

Several randomized controlled trials, observational studies, and meta-analyses published after SUSTAIN-6 have not demonstrated a consistent increase in diabetic retinopathy risk associated with semaglutide.

Most investigators concluded that the transient worsening observed in susceptible patients represents the well-recognized phenomenon of early worsening of diabetic retinopathy, previously described after intensive insulin therapy.

Current evidence therefore supports the hypothesis that rapid improvement in glycemic control, rather than semaglutide itself, is the primary contributor.

Proposed Mechanisms

Several mechanisms have been proposed:

1. Rapid HbA1c Reduction

The most widely accepted explanation is rapid normalization of blood glucose, resulting in temporary retinal vascular instability.

2. Early Worsening Phenomenon

Historical studies including the Diabetes Control and Complications Trial (DCCT) demonstrated similar transient worsening following intensive glucose-lowering therapy.

3. Direct Drug Effect

Experimental evidence has not demonstrated direct retinal toxicity from semaglutide, and GLP-1 receptors within retinal tissue may even possess anti-inflammatory and neuroprotective properties.

Patients at Increased Risk

Closer ophthalmologic monitoring should be considered for patients with:

- Moderate or severe diabetic retinopathy
- HbA1c greater than 9–10%
- Long duration of diabetes
- Insulin-treated diabetes
- Chronic kidney disease
- Rapid anticipated HbA1c reduction

Patients without baseline retinopathy appear to have a very low risk of developing vision-threatening complications after semaglutide initiation.

Clinical Recommendations

Healthcare professionals should adopt a multidisciplinary approach.

Recommendations include:

- Perform a comprehensive dilated retinal examination before initiating semaglutide in high-risk patients.
- Optimize blood pressure and lipid control.
- Avoid unnecessarily rapid reductions in HbA1c where clinically feasible.
- Arrange ophthalmology follow-up during the first 3–6 months after therapy initiation.

- Educate patients regarding symptoms requiring urgent ophthalmic assessment, including blurred vision, floaters, flashes, or sudden visual loss.

Future Perspectives

The ongoing FOCUS Trial is specifically evaluating the long-term effects of semaglutide on diabetic retinopathy progression. Its findings are expected to provide more definitive evidence regarding retinal safety and may influence future diabetes management guidelines.

Conclusion

Current evidence does not support semaglutide as a direct cause of diabetic retinopathy. Instead, transient worsening appears primarily related to rapid glycemic improvement in patients with pre-existing retinal disease and poor baseline glycemic control. Appropriate patient selection, baseline ophthalmologic assessment, and gradual optimization of glycemic control where appropriate, and close follow-up remain essential components of safe semaglutide therapy.

Overall, the substantial metabolic and cardiovascular benefits of semaglutide continue to outweigh its potential ocular risks in appropriately monitored patients.

Semaglutide and Diabetic Retinopathy

A Narrative Review of Current Evidence



SUMMARY	
WHAT IS SEMAGLUTIDE? A GLP-1 receptor agonist that improves HbA1c, promotes weight loss, and reduces cardiovascular risk in type 2 diabetes.	CONCERN RAISED SUSTAIN-6 trial reported higher rate of diabetic retinopathy complications. Further studies suggest this is due to rapid glycemic improvement, not a direct toxic effect.
PROPOSED MECHANISMS - Rapid HbA1c reduction causing temporary retinal instability - Early worsening phenomenon seen with intensive therapy - No evidence of direct retinal toxicity; possible protective retinal effects	PATIENTS AT INCREASED RISK - Pre-existing moderate/severe DR - HbA1c >9–10% - Long duration of diabetes - Insulin treatment - Chronic kidney disease - Rapid expected HbA1c reduction
CLINICAL RECOMMENDATIONS - Baseline dilated retinal exam in high-risk patients - Optimize blood pressure and lipid control - Avoid rapid HbA1c reductions where possible - Ophthalmology follow-up in 3–6 months - Educate patients about warning symptoms	
KEY TAKEAWAY Semaglutide is not a direct cause of diabetic retinopathy. Transient worsening is mainly due to rapid glycemic improvement in susceptible patients. With appropriate monitoring, the metabolic and cardiovascular benefits outweigh potential ocular risks.	FUTURE PERSPECTIVE The ongoing FOCUS Trial will provide more definitive evidence on the long-term effects of semaglutide on diabetic retinopathy progression and guide future clinical practice.

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The Impact of Diabetes on Mental Health and Well-Being

Author: Amna Mansoor
Editor, DAP Digest

Diabetes and mental health affect each other in many ways:

- Stress can cause blood sugar to rise or fall unpredictably,

making diabetes harder to control.

- Depression may reduce motivation, energy, and interest in self-care, leading people to skip medications, appointments, healthy eating, exercise, or blood sugar monitoring.
- Anxiety and low blood sugar (hypoglycemia) can feel very similar because both can cause shaking, sweating, a racing heart, and nervousness.
- Some psychiatric medications can cause weight gain, making diabetes management more difficult.

Diabetes-related distress

Managing diabetes every day can be emotionally exhausting. This is called diabetes distress, which is different from clinical depression.

People with diabetes may feel:

- Overwhelmed by constant self-management.
- Frustrated with blood sugar fluctuations.
- Guilty when their diabetes is not well controlled.
- Burned out from monitoring, medications, and lifestyle changes.

The CDC estimates that about one-third to one-half of people with diabetes experience diabetes distress within an 18-month period.

Mental health conditions are more common in diabetes

Compared with people without diabetes:

- People with diabetes are 2–3 times more likely to experience depression.
- They are about 20% more likely to develop anxiety.
- Eating disorders are also more common, especially in people with type 1 diabetes.

Other factors that affect both

Mental health and diabetes are also influenced by:

- Financial stress from the cost of diabetes care.
- Social support.
- Access to healthcare.
- Discrimination and other social barriers.
- Work, family, and environmental stressors.

How to manage both diabetes and mental health

Helpful strategies include:

- Work with your doctor and diabetes educator.
- Talk openly about symptoms of anxiety, depression, or burnout.
- Stay physically active, as exercise benefits both blood sugar and mood.
- Follow your diabetes treatment plan and avoid skipping insulin or medications.
- Practice stress-management techniques such as mindfulness, relaxation exercises, or spending time with supportive family and friends.
- Seek counseling or psychological therapy if emotional symptoms persist.

Recommendations for healthcare professionals

Healthcare providers should:

- Regular psychological assessment should be incorporated into diabetes care to identify depression, anxiety, and diabetes-related distress.

- Recognize that poor diabetes control may sometimes be related to emotional difficulties rather than lack of motivation.
- Avoid blaming or shaming patients.
- Validate the emotional burden of living with diabetes.
- Refer patients to mental health professionals when appropriate.

Prediabetes and mental health

People with serious mental health conditions have a higher risk of developing:

- Prediabetes
- Type 2 diabetes
- Obesity
- Heart disease

Healthy lifestyle changes—such as regular physical activity, nutritious eating, and stress reduction—can help prevent diabetes while also improving mental well-being.

Key takeaway

The relationship between diabetes and mental health is bidirectional:

- Mental health problems (such as depression, anxiety, and chronic stress) can make diabetes harder to manage.
- Living with diabetes can itself contribute to depression, anxiety, and diabetes-related distress.

Treating both conditions together generally leads to better blood sugar control, improved quality of life, and better overall health outcomes.

Source

<https://www.health.state.mn.us/diseases/diabetes/about/mentalhealth.html>

People with diabetes experience higher rates of mental health issues

Increased symptoms of **depression** affect **one in four adults with diabetes** with rates ranging from 21.3% in adults with type 1 diabetes to 27% in adults with type 2 diabetes.²

18-45%³ of people with diabetes exhibit **diabetes distress** – a condition where the emotional burden and stresses of living with diabetes manifests in physical ways such as fatigue, tension and burnout.

Adults with diabetes have been found to have **elevated rates of anxiety symptoms** and conditions including generalized anxiety disorder (GAD) and anxiety symptoms that are specific to the experience of living with diabetes or diabetes complications (e.g. fear of needles, fear of hypoglycemia).⁴

ٹائپ 1 ذیابیطس اور ہنی مون فیز: وقتی بہتری یا ایک خوش فہمی؟

تحریر: ہانا نور

بعض اوقات ٹائپ 1 ذیابیطس میں سب سے بڑی غلط فہمی اس وقت پیدا ہوتی ہے، جب سب کچھ پہلے سے بہتر نظر آنے لگتا ہے۔ خون میں گلوکوز کی سطح پہلے کے مقابلے میں زیادہ متوازن دکھائی دیتی ہے، انسولین کی ضرورت بھی کم محسوس ہونے لگتی ہے، تو اکثر والدین یہ سوچنے لگتے ہیں کہ شاید اب ٹائپ 1 ذیابیطس ختم ہو رہی ہے۔ یہی وہ مرحلہ ہے جہاں خوشی کے ساتھ ساتھ درست معلومات بھی اتنی ہی ضروری ہو جاتی ہیں، کیونکہ ہر وقتی بہتری مکمل صحت کی علامت نہیں ہوتی۔ ٹائپ 1 ذیابیطس میں اس کیفیت کو ہنی مون فیز کہا جاتا ہے، جسے سمجھنا ہر اس فرد کے لیے ضروری ہے جو ٹائپ 1 ذیابیطس کے ساتھ زندگی گزار رہا ہے یا کسی ایسے بچے کی دیکھ بھال کر رہا ہے۔

آخر ہنی مون فیز ہوتا کیا ہے؟

ہنی مون فیز ٹائپ 1 ذیابیطس کی تشخیص کے بعد آنے والا ایک عارضی مرحلہ ہوتا ہے۔ جب انسولین کا علاج شروع کیا ختم جاتا ہے تو لیبلے میں موجود کچھ پینا خلیات، جو مکمل طور پر نہیں ہوئے ہوتے، وقتی طور پر دوبارہ محدود مقدار میں انسولین بنانا شروع کر دیتے ہیں۔ اس کی وجہ سے خون میں گلوکوز نسبتاً بہتر رہتا ہے اور جسم کو باہر سے دی جانے والی انسولین کی ضرورت بھی پہلے کے مقابلے میں کم ہو سکتی ہے۔ یہ بہتری اس بات کی علامت نہیں کہ ٹائپ 1 ذیابیطس ختم ہو گئی ہے، بلکہ یہ بیماری کے قدرتی سفر کا ایک عارضی مرحلہ ہے۔

یہ مرحلہ کب شروع ہوتا ہے اور کتنی دیر تک رہ سکتا ہے؟

ہنی مون فیز عام طور پر انسولین شروع کرنے کے چند ہفتوں یا چند مہینوں کے اندر شروع ہو سکتا ہے۔ ہر فرد میں اس کی مدت مختلف ہوتی ہے۔ بعض افراد میں یہ صرف چند ہفتے رہتا ہے، جبکہ کچھ میں کئی ماہ یا ایک سال سے زیادہ بھی جاری رہ سکتا ہے۔ اس کا انحصار عمر، تشخیص کے وقت لیبلے کی باقی ماندہ کارکردگی، بروقت علاج اور دیگر عوامل پر ہوتا ہے۔

والدین کو غلط فہمی کیوں ہوتی ہے؟

جب بچے کے خون میں گلوکوز کی سطح پہلے کے مقابلے میں بہتر ہونے لگتی ہے اور انسولین کی ضرورت عارضی طور پر کم محسوس ہوتی ہے، تو اکثر والدین خوش ہو کر یہ سمجھ لیتے ہیں کہ اب انسولین کی ضرورت ختم ہونے والی ہے۔ بعض اوقات وہ دوسروں کو بھی یہی بتانے لگتے ہیں کہ "اب ہمارا بچہ ٹھیک ہو گیا

ہے۔" حالانکہ حقیقت یہ ہے کہ یہ بہتری عارضی ہوتی ہے اور ٹائپ 1 ذیابیطس ختم نہیں ہوتی۔ یہی وہ سوچ ہے جو بعد میں مشکلات پیدا کر سکتی ہے، کیونکہ حقیقت میں بیماری ختم نہیں ہوتی بلکہ وقتی طور پر نسبتاً قابو میں نظر آتی ہے۔

کیا اس دوران انسولین بند کر دینی چاہیے؟

اس سوال کا جواب واضح طور پر نہیں ہے ہنی مون فیز کے دوران بھی انسولین ڈاکٹر کی ہدایت کے مطابق جاری رکھنا ضروری ہے۔ اگر اپنی مرضی سے انسولین بند کر دی جائے یا بار بار خوراک چھوڑ دی جائے تو خون میں گلوکوز دوبارہ خطرناک حد تک بڑھ سکتی ہے اور ڈائابٹک کیٹو ایسڈوسس جیسی جان لیوا پیچیدگی پیدا ہو سکتی ہے۔ ضرورت صرف اتنی ہوتی ہے کہ ڈاکٹر یا ذیابیطس کی دیکھ بھال کرنے والی ٹیم خون میں گلوکوز کے ریکارڈ کو دیکھتے ہوئے انسولین کی مقدار میں مناسب تبدیلی کرے۔

عام غلط فہمیاں... اور اصل حقیقت

ہنی مون فیز کے بارے میں بہت سی ایسی باتیں عام ہیں جو والدین کو الجھن میں ڈال دیتی ہیں۔ آئیے چند اہم غلط فہمیوں اور ان کی حقیقت کو سمجھتے ہیں

غلط فہمی: ہنی مون فیز شروع ہو گیا ہے، اس کا مطلب ہے کہ ٹائپ 1 ذیابیطس ختم ہو رہی ہے۔

حقیقت: ہنی مون فیز صرف ایک عارضی مرحلہ ہے۔ اس دوران جسم کچھ عرصے تک محدود مقدار میں انسولین بناتا رہتا ہے، لیکن یہ کیفیت مستقل نہیں رہتی۔

غلط فہمی: اگر گلوکوز کی سطح بہتر ہے تو انسولین بند کر دینی چاہیے۔

حقیقت: انسولین کی ضرورت کم ضرور ہو سکتی ہے، لیکن اپنی مرضی سے انسولین بند کرنا خطرناک ثابت ہو سکتا ہے۔

انسولین کی مقدار میں ہر تبدیلی اپنے ڈاکٹر اور ذیابیطس کے معلم کی ہدایت کے مطابق ہونی چاہیے

غلط فہمی: ہر بچے میں ہنی مون فیز آتا ہے۔

حقیقت: ایسا ضروری نہیں۔ بعض افراد میں یہ مرحلہ آتا ہے، بعض میں نہیں، اور اگر آج بھی جائے تو اس کی مدت اور شدت ہر فرد میں مختلف ہو سکتی ہے۔

غلط فہمی: ہنی مون فیز جتنا زیادہ رہے، اتنا ہی بہتر ہے۔

حقیقت: اس مرحلے کا دورانیہ ہر فرد میں مختلف ہوتا ہے اور اس کی مدت کو بڑھانے کا کوئی ثابت شدہ طریقہ موجود نہیں۔ اصل توجہ خون میں گلوکوز کو متوازن رکھنے اور باقاعدہ فالو اپ پر ہونی چاہیے۔

والدین کے لیے چند اہم باتیں:

ہنی مون فیز خوشی کا مرحلہ ضرور ہو سکتا ہے، لیکن اس کے ساتھ احتیاط بھی اتنی ہی ضروری ہے۔

اگر خون میں گلوکوز کی ریڈنگ بہتر آنے لگے یا انسولین کی ضرورت کم محسوس ہو تو اسے علاج کے خاتمے کی علامت نہ سمجھیں۔ گلوکوز کی باقاعدہ نگرانی جاری رکھیں، انسولین کی خوراک میں اپنی طرف سے تبدیلی نہ کریں اور ہر نئی صورتحال میں اپنے ڈاکٹر اور ذیابیطس کے معلم رابطہ کریں۔ بروقت رہنمائی نہ صرف گلوکوز کو متوازن رکھنے میں مدد دیتی ہے بلکہ مستقبل میں غیر ضروری پیچیدگیوں سے بچانے میں بھی اہم کردار ادا کرتی ہے۔

اختتام:

ہنی مون فیز ٹائپ 1 ذیابیطس کے سفر کا ایک عارضی مگر اہم مرحلہ ہے۔ اس دوران وقتی بہتری والدین کے لیے امید کا باعث ضرور بنتی ہے، لیکن یہی وقت درست معلومات اور محتاط فیصلوں کا بھی ہوتا ہے۔ اگر اس مرحلے کو صحیح انداز میں سمجھا جائے تو نہ صرف غیر ضروری غلط فہمیوں سے بچا جاسکتا ہے بلکہ ٹائپ 1 ذیابیطس کے ساتھ ایک بہتر اور متوازن زندگی گزارنے میں بھی مدد ملتی ہے۔ یاد رکھیں، ہنی مون فیز علاج کے اختتام کا نہیں، بلکہ مسلسل نگہداشت اور بہتر منصوبہ بندی کا ایک نیا مرحلہ ہے۔



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