

Semaglutide: Real World Results, Realistic Recommendations

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In less than a decade, semaglutide has become one of the most frequently used drugs worldwide. This is testimony to not only the burden of obesity that we face, but the benefits of semaglutide as well.¹ Along with other glucagon-like peptide 1 receptor agonists (GLP1RA) and dual receptor agonists, semaglutide has proven its weight-lowering and pleiotropic effects. Clinical trials and real world studies have demonstrated the efficacy, safety and tolerability of the molecule. Many Asian countries have also been a part of the semaglutide clinical trial programme.²

National level research, however, is needed to supplement the findings of global studies. Each country has a unique nutrimental phenotype, characterized by a specific pattern of adiposity, metabolic dysfunction and nutritional preferences.³ This may impact not only the health status, but also one's response to therapeutic interventions. Specific dietary choices, gut microbiome, comorbid conditions and concomitant medications, as well as financial constraints and social opinions may influence efficacy and tolerability of these drugs.

With this in mind, the publication by Jabeen et al from Islamabad⁴ offers much-needed evidence regarding the suitability of semaglutide in Pakistan, and South Asia. The authors share their retrospective experience of using the drug in adults living with type 2 diabetes. They highlight the strengths of semaglutide-good glucose control, weight loss and lack of hypoglycaemia.

At the same time, their data reveals an obstacle to metabolic control. This is the high rate of discontinuation, or poor persistence with suggested therapy. This, however, can be converted into an opportunity for better health. Talking to our patients, and their caregivers, about the long term benefits of sustained semaglutide use may help in enhancing adherence. The BLACK mnemonic (benefits, limitations, potential adverse events, cost, knowledge required take the drug) is a useful tool which helps ensure complete and comprehensive medication counselling.⁵

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Explaining simple ways of mitigating GLP1RA-associated side effects, especially using GLP1RA-friendly nutrition, helps improve adherence to therapy.⁶ The cost of therapy has come down markedly, thus enhancing acceptance of semaglutide in Pakistan, and beyond.⁷ Injection technique must not be neglected: appropriate care must be taken to minimize local site reactions.

It is important to remind ourselves that pharmacological support is just one pillar of diabetes or obesity management. The other pillars, including behavioural therapy, diet, exercise and monitoring, are equally important.⁸ Just as the Minar-e- Pakistan has a five-pointed star base, we suggest a five- star 'magical M' foundation for metabolic health. These are mind styling (behavioural therapy), meal planning (medical nutritional therapy), movement (exercise, physical activity), modern medication (evidence-based therapy), and monitoring. This concept helps our patients understand the importance of all these factors in creating strong, and sustainable health.

If we are able to institute these 5Ms in a timely manner, we can ensure independence from dysfunction, from disease, and from disability. The Islamabad data encourage us to do better in terms of metabolic health. We should be able to use modern medication such as the GLP1RA, as per standard of care, to manage diabetes, and associated conditions. We should also share our experiences, both positive and challenging, with our colleagues. This facilitates sharing of best practices, and contributes to acceptance of appropriate therapy in the community at large. This is what the Journal of Pakistan Medical Association endeavours to do, through its pages. Once again, we commend Jabeen et al for their efforts to improve diabetes care in Pakistan.⁴

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