Sir,

We thank Mundra for a detailed analysis of our paper, and for his attempt to improve the impact of our findings.

In our study, 152 subjects were on plain Vildagliptin while 148 were on a fixed dose combination of vildagliptin and metformin. The uptitration of the dose was based on the glycemic control achieved. There was no protocol followed for the uptitration of the dosages.

A significant drop was reported in both the groups (on vildagliptin as well as vildagliptin and metformin combination). The baseline fasting plasma glucose in plain and combination groups was 195.61 ± 57.91 and 194.26 ± 54.56 mg% respectively, which came down to 121.84 ± 27.52 and 128.11 ± 32.33 mg% respectively. Also, the baseline postprandial glucose in plain and combination of 287.43 ± 85.62 and 287.77 ± 69.94 mg% came down to 165.60 ± 34.00 and 178.67 ± 39.65 mg% respectively. The HbA1c changes were significant: Values of 9.04 ± 1.45 and 8.99 ± 1.12% came down to levels of 7.61 ± 1.04 and 7.69 ± 0.99% respectively.

Dipeptidyl peptidase (DPP)-4 inhibitors are generally weight-neutral, although modest weight loss has been observed with the DPP-4 inhibitor, vildagliptin, in patients with relatively low baseline glycemia. The weight neutrality of vildagliptin likely results in part from its intrinsically low risk for hypoglycemia. Recent studies point to additional potential mechanisms. One study found that drug-naïve patients randomized to vildagliptin exhibited significantly lower chylomicron lipid and apolipoprotein levels than placebo patients, suggesting that vildagliptin may inhibit intestinal fat extraction. Another trial found that patients randomized to vildagliptin versus placebo experienced paradoxical postprandial increases in markers of fatty acid mobilization and oxidation, in conjunction with increased sympathetic stimulation. Elaboration of these and other pathways could further clarify the origins of the favorable weight profile of vildagliptin.

Adverse event reporting was only kept for hypoglycaemia, which was not observed during the trial period in any of the group.

We agree with Dr. Mundra that we definitely need more randomized trials to further elucidate the role of DPP-IV inhibitors and their benefit in terms of cardiac, lipids and insulin sensitivity.

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Diabetes awareness through religious leaders

Sir,

Type 2 diabetes is escalating at an alarming rate in the Indian Subcontinent and in many other developing countries. But the condition is largely preventable. Many developed countries have been able to arrest this epidemic. Finland is a shining example. In this subcontinent, religious leaders...
can play an effective role in creating mass awareness for prevention of type 2 DM and other Non Communicable Diseases (NCDs). Bangladesh is a secular country and more than 88% of its population are Muslims. We have several meetings with religious and opinion leaders like the Chief Imam of large Mosques and Principals of the Govt, accredited Madrasas in Bangladesh. They all agreed to help our mission for prevention of diabetes and other NCDs. The Imams also helped us to compose a religious sermon (Khutba) for Friday congregation. We have already appealed to the Imams for distributing it to different Mosques. We are also taking the help of our Affiliated Associations (almost one at each of the 64 districts) to persuade the Imams of the district headquarters to use this at Friday sermon. We also contacted Priests of Churches, Hindu Temples (Ram Krishna Mission), and Buddhist Temples (Buddha Bihar) for assistance. They all have agreed to help us. Govt. of Bangladesh is now in the process of finalizing a draft for the National Policy for Prevention of type 2 DM. The Govt. is also considering religious leaders as a part of the policy: We seek your help for disseminating this through your esteem Journal. We have the English version of this Khutba which we are glad to share with anybody who may like to use it.

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