NOVEMBER 2026 | ISSUE 03

Medeasy Review

EVIDENCE FOR A BRIGHTER PRACTICE

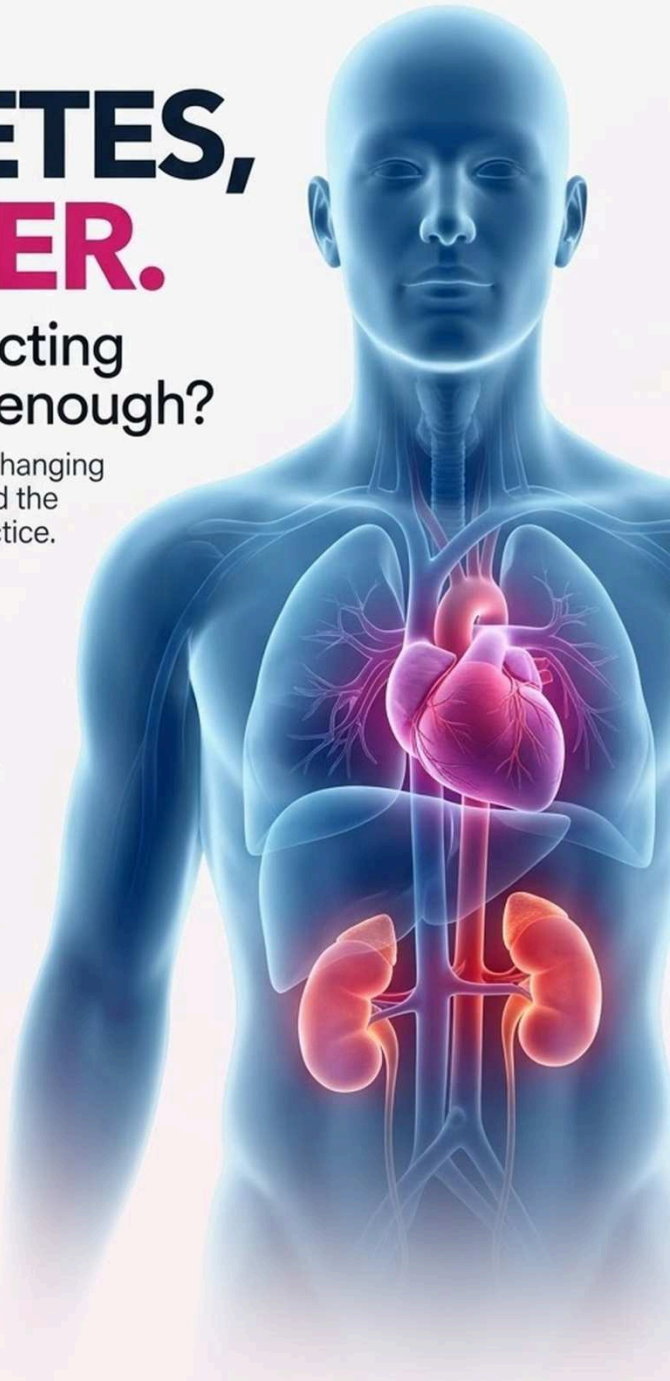
CLINICAL
PRACTICAL
FORWARD-LOOKING

SPECIAL FEATURE

DIABETES, EARLIER.

Are we protecting organs soon enough?

The newest evidence, a changing treatment philosophy, and the realities of Philippine practice.



SEPTIC SHOCK
Fluids or earlier vasopressors?

COPD BEYOND INHALERS
The evidence for biologics

ANTIBIOTIC RESISTANCE
The Philippine perspective

AI IN EYE CARE
Screening versus real outcomes

A MEDEASY PUBLICATION

medeasy+
Healthcare made easy

EDITOR'S NOTE

From Evidence to Better Decisions

Dear Colleagues,

The hardest question in medicine is often not whether a study produced a significant result. It is whether that result should change the decision we make for the patient in front of us.

In this November issue of Medeasy Review, we examine that challenge across several areas of clinical practice.

Our main feature explores the evolving approach to type 2 diabetes, asking whether earlier organ-protective treatment can be meaningfully integrated into Philippine healthcare. We also revisit fluid and vasopressor strategies in septic shock, evaluate emerging biologic therapies for COPD, and examine what local antimicrobial resistance data mean for prescribing decisions.

Beyond new treatments, we consider an equally important question: are we identifying the right patients, using the right evidence, and measuring outcomes that truly matter?

New evidence deserves attention. But better care requires interpretation, clinical judgment, and an understanding of the healthcare setting in which decisions are made.

Thank you for being part of the Medeasy physician community.

Warm regards,
Medeasy Review Editorial Team

> *"The value of evidence lies not only in what it shows, but in the decisions it helps us make.*

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EVIDENCE UPDATE

PAPERS WORTH KNOWING

New studies. Different outcomes. Better clinical questions.

01 PREVENTIVE MEDICINE

DAN-RSV: Does Vaccination Prevent Hospitalization?

70.3%

ESTIMATED EFFECTIVENESS AGAINST RSV-RELATED HOSPITALIZATION

95% CI 49.7–83.2

THE STUDY

Pragmatic, open-label trial: 513,358 adults randomized to RSVpreF or no vaccination in Denmark and Spain over two winter seasons.

KEY RESULT

RSV-related respiratory hospitalization: 0.16 vs 0.55 events per 1,000 person-years.

CLINICAL PERSPECTIVE

The absolute reduction was 0.39 events per 1,000 person-years. Consider patient risk, local eligibility and access.

Lassen et al. NEJM Evidence (Aug 29, 2026). doi:10.1056/EVIDoa2600272.

02 ONCOLOGY / SCREENING

NHS-Galleri: Does Earlier Detection Improve Outcomes?

1.03

INCIDENCE RATE RATIO FOR STAGE III–IV CANCERS

95% CI 0.92–1.14 | P=0.63

THE STUDY

Randomized study of 142,250 participants aged 50–77: multicancer blood testing plus usual care versus usual care.

KEY RESULT

Stage III–IV incidence across 12 prespecified cancers was not significantly lower after three rounds.

CLINICAL PERSPECTIVE

The primary late-stage cancer endpoint was neutral. Better detection alone does not prove better patient outcomes.

Sasieni et al. N Engl J Med (Sep 22, 2026). doi:10.1056/NEJMoa2505723.

THE MEDEASY TAKE

Relative effects, absolute outcomes, and study limitations must be interpreted together before evidence changes clinical practice.

EVIDENCE UPDATE

PAPERS WORTH KNOWING

Different specialties. Important advances. Questions that remain.

03 PEDIATRIC HEMATOLOGY

Blinatumomab: Replacing Selected Chemotherapy Cycles

83.0% vs 70.3%

ESTIMATED 4-YEAR EVENT-FREE SURVIVAL

HR 0.51 (95% CI 0.35–0.73)

THE STUDY

709 children with newly diagnosed high-risk B-cell ALL were randomized after consolidation: two cycles of blinatumomab replaced two chemotherapy cycles.

KEY RESULT

Estimated 4-year EFS: 83.0% vs 70.3% (HR 0.51). Interim analysis; median follow-up 2.9 years.

CLINICAL PERSPECTIVE

Only two selected chemotherapy cycles were replaced. EFS improved, but neurotoxic events were more frequent (12.0% vs 3.2%).

Schrappe et al. N Engl J Med (2026);395:1075–89. doi:10.1056/NEJMoa2604166.

04 NEUROLOGY / SLEEP MEDICINE

Oveporexton: An Orexin-Based Approach to Narcolepsy Type 1

+14.3 to +19.8 min

MEAN CHANGE IN MWT SLEEP LATENCY

Active-treatment groups at week 12

THE STUDY

Two placebo-controlled phase 3 trials enrolled 168 and 105 people with narcolepsy type 1.

KEY RESULT

MWT sleep-latency change: +14.3 to +19.8 minutes with oveporexton vs −0.4 to −0.8 with placebo (12 weeks).

CLINICAL PERSPECTIVE

Wakefulness and cataplexy improved. Urinary frequency and transient insomnia were common; long-term safety remains uncertain.

Dauvilliers et al. N Engl J Med (2026);395:1166–79. doi:10.1056/NEJMoa2601598.

THE MEDEASY TAKE

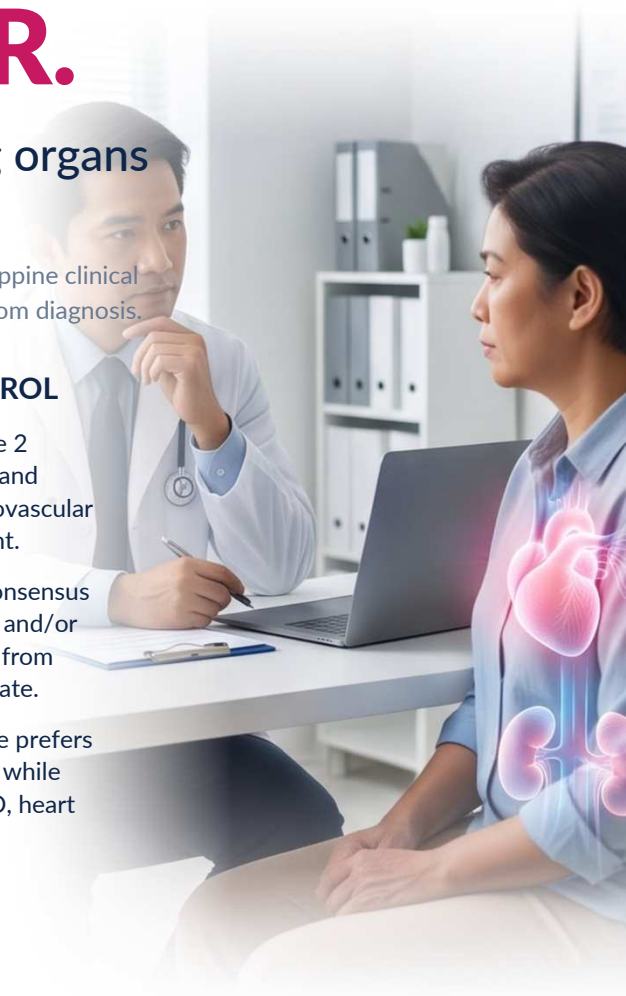
New therapies deserve attention, but outcomes and safety determine clinical value.

MAIN FEATURE / DIABETES 2026

DIABETES, EARLIER.

Are we protecting organs soon enough?

New international evidence. Philippine clinical realities. Decisions that matter from diagnosis.



BEYOND GLUCOSE CONTROL

HbA1c remains essential, but type 2 diabetes also threatens the heart and kidneys. Care must address cardiovascular risk, heart failure, CKD, and weight.

The October 2026 ADA/EASD consensus advocates earlier SGLT2 inhibitor and/or GLP-1-based therapy, potentially from diagnosis when clinically appropriate.

Philippine PCEDM/DOH guidance prefers metformin initially when suitable, while individualizing therapy for ASCVD, heart failure, and CKD.

THE CLINICAL QUESTION

How early should we act—and for whom?

01 What the new 2026 evidence changes
02 Where global and Philippine guidance differ
03 Making treatment realistic for Filipino patients

SOURCES 1. Davies MJ, et al. ADA/EASD 2026 Consensus Report. Diabetes Care. doi:10.2337/dci26-0141 2. PCEDM. Outpatient T2DM Management CPG, Part 2b. DOH Guidelines Platform. 2026.

MAIN FEATURE / DIABETES 2026

WHAT REALLY CHANGES IN 2026?

Earlier intervention. Broader goals. More individualized decisions.

AN EVOLUTION, NOT A REVERSAL

The 2022 ADA/EASD consensus already supported SGLT2 inhibitors and GLP-1 receptor agonists with proven cardiovascular or kidney benefits in selected patients, independent of HbA1c or metformin use. The 2026 update emphasizes earlier, risk-led treatment and holistic care for people living with type 2 diabetes.

THREE IMPORTANT DEVELOPMENTS

01

ORGAN PROTECTION MOVES EARLIER

Consider proven organ-protective therapies early in patients with ASCVD, heart failure, CKD, or other relevant risk—even at diagnosis when indicated.

Clinical implication: Assess organ risk early, not only HbA1c.

02

COMBINATION THERAPY: SELECTIVE USE

An SGLT2 inhibitor plus GLP-1-based therapy may be considered in selected patients with CVD, CKD, or heart failure. Evidence is agent- and outcome-specific.

Clinical implication: Combination treatment is not universal.

03

BROADER GOALS BEYOND HbA1c

Weight, heart and kidney health, liver disease, physical activity, sleep, psychological well-being, and personal priorities matter alongside glucose control.

Clinical implication: Set goals beyond one laboratory number.

WHAT HAS NOT CHANGED?

HbA1c targets and lifestyle care remain important. Metformin continues to be useful, accessible, and affordable when appropriate. Drug selection still requires shared decisions about benefits, tolerability, safety, and cost.

THE MEDEASY TAKE

The 2026 message is about timing and patient selection—not using every newer drug for every person with diabetes.

SOURCES 1. Davies MJ, et al. ADA/EASD Consensus Report. Diabetes Care. 2026. doi:10.2337/dci26-0141.
2. Davies MJ, et al. ADA/EASD Consensus Report. Diabetes Care. 2022. doi:10.2337/dci22-0034.

MAIN FEATURE / DIABETES 2026

SAME GOAL. DIFFERENT STARTING POINTS.

ADA/EASD 2026 versus Philippine PCEDM guidance

Both address glucose control and organ protection. The difference lies mainly in treatment emphasis and sequencing, not conflicting clinical goals.

01 WHERE DOES TREATMENT BEGIN?

ADA/EASD 2026

Early SGLT2 inhibitor and/or GLP-1-based therapy may be appropriate, potentially at diagnosis, when clinical risks and evidence support it. Metformin need not precede indicated organ protection.

PHILIPPINE PCEDM

Metformin is preferred initially when tolerated. Initial therapy can be individualized for contraindications or a profile that includes CHF, ASCVD or CKD.

02 WHEN DOES ORGAN PROTECTION TAKE PRIORITY?

ADA/EASD 2026

For relevant cardiovascular or kidney disease, prioritize therapies with demonstrated outcomes. Earlier SGLT2/GLP-1 combination therapy may be considered in selected higher-risk patients.

PHILIPPINE PCEDM

Recommends SGLT2 inhibitors in T2DM with CKD at eGFR ≥20 mL/min/1.73 m^2, and supports SGLT2 therapy in heart failure and GLP-1 RAs in selected profiles.

03 HOW DO COST AND ACCESS SHAPE DECISIONS?

ADA/EASD 2026

Includes affordability, access to care, patient preferences and social determinants when individualizing evidence-based treatment.

PHILIPPINE PCEDM

Includes resource-limited treatment options and patient-centered selection. Access constraints do not negate indications for beneficial therapies.

THE PHILIPPINE PRACTICE CHECK

- Screen for ASCVD, heart failure and CKD; check eGFR and urine albumin.
- Check contraindications, affordability, likely adherence and follow-up.
- Choose drugs with outcome evidence that matches the patient profile.

THE MEDEASY TAKE

These are not competing treatment philosophies. Start with organ risk and clinical indications, then make evidence-based care feasible for the Filipino patient.

SOURCES 1. Davies MJ, et al. ADA/EASD consensus. Diabetes Care. 2026. doi:10.2337/dci26-0141.
2. PCEDM. Outpatient T2DM Guidelines, Part 2b. DOH Guidelines Platform. 2026.

MAIN FEATURE / DIABETES 2026

THREE PATIENTS. THREE DIFFERENT PRIORITIES.

HbA1c alone cannot determine treatment priorities. These fictional Philippine outpatient cases show how organ disease, clinical risk, and access influence care.

01 NEWLY DIAGNOSED · LIMITED BUDGET

Age 47 | HbA1c 7.4% | eGFR 93

No known ASCVD, heart failure or CKD.

CLINICAL PRIORITY

Set an individualized glucose goal and assess overall cardio-kidney risk.

EVIDENCE-INFORMED APPROACH

Metformin is reasonable initially if tolerated and suitable, with lifestyle support and follow-up.

PH REALITY · Choose an affordable regimen the patient can maintain.

02 CKD WITH NEAR-TARGET HbA1c

Age 62 | HbA1c 6.9% | eGFR 42 | UACR 220 mg/g

Established CKD; currently taking metformin.

CLINICAL PRIORITY

Slow kidney decline and reduce cardiovascular risk, not merely HbA1c.

EVIDENCE-INFORMED APPROACH

Consider an SGLT2 inhibitor with proven kidney benefit; review renal status and precautions.

PH REALITY · Check access, tolerability and capacity for follow-up.

03 PREVIOUS MI AND OBESITY

Age 57 | HbA1c 7.8% | BMI 31 kg/m²

Prior myocardial infarction and ongoing ASCVD risk.

CLINICAL PRIORITY

Reduce recurrent CV events while addressing glycemia and weight.

EVIDENCE-INFORMED APPROACH

Consider GLP-1-based therapy with proven CV benefit alongside secondary prevention.

PH REALITY · Match evidence, tolerability and affordability to lasting treatment.

THE MEDEASY TAKE

Treatment priorities depend on more than HbA1c.

Sources: ADA/EASD 2026 consensus (doi:10.2337/dci26-0141); PCEDM/DOH Philippine T2DM CPG, 2026.
Illustrative cases only; not individualized prescribing instructions.

MAIN FEATURE / DIABETES 2026

FROM EVIDENCE TO EVERYDAY PRACTICE

Five decisions that make diabetes care better.

A practical framework for choosing, sustaining, and reassessing treatment.

01

IDENTIFY THE DOMINANT RISK

Assess ASCVD, heart failure, CKD, weight, eGFR, and UACR alongside HbA1c to identify organ risk.

CLINICAL PEARL HbA1c alone does not define cardio-kidney risk.

02

CHOOSE TREATMENT FOR THE OUTCOME

Prioritize agents with demonstrated cardiovascular or kidney benefits when indicated. Metformin remains valuable when appropriate and accessible.

03

PRESCRIBE WITH SAFETY IN MIND

Review kidney function, contraindications, and interactions. Discuss SGLT2-related volume depletion and ketoacidosis, plus GLP-1 gastrointestinal effects.

04

MAKE THE PLAN SUSTAINABLE

Discuss cost, availability, monitoring, patient preferences, and realistic follow-up. Choose a regimen the patient can maintain.

CLINICAL PEARL Benefits depend on access, adherence, and treatment persistence.

05

REASSESS AND ADJUST

Monitor glycemia, tolerability, adherence, cardiovascular risk factors, and kidney parameters as appropriate. Adjust therapy as priorities change.

WHAT REMAINS UNCERTAIN?

Optimal sequencing and additive long-term benefits in some subgroups; equitable access and persistence in practice.

THE MEDEASY TAKE

Protect the patient, not just the HbA1c. Recognize risk early, use proven therapy when appropriate, and keep care sustainable.

SOURCES 1. Davies MJ, et al. ADA/EASD Consensus. Diabetes Care. 2026. doi:10.2337/dci26-0141.
2. PCEDM. Outpatient T2DM Management CPG, Part 2b. DOH Guidelines Platform. 2026.

EVIDENCE SYNTHESIS / CRITICAL CARE

SEPTIC SHOCK: HAVE WE BEEN GIVING TOO MUCH FLUID?



Early vasopressors, fluid volumes, and the evidence behind better resuscitation decisions.

THE QUESTION BEHIND THE BOLUS

Initial fluids remain essential. The harder question is whether another bolus will improve perfusion or increase fluid-related harm.

ARISE FLUIDS tested earlier vasopressors with less IV fluid against later vasopressors with more fluid in early septic shock.

ARISE FLUIDS | 963 PATIENTS ANALYZED

76 vs 76

DAYS ALIVE AND OUT OF HOSPITAL

Primary endpoint at day 90; difference 0.0 days (95% CI -2.7 to 2.7).

0.6% vs 5.0%

PULMONARY EDEMA

Lower in the early-vasopressor arm; secondary safety finding, not proof of survival benefit.

2026 SURVIVING SEPSIS CAMPAIGN

Conditionally suggests at least 30 mL/kg IV crystalloid in the first 3 hours for sepsis-induced hypoperfusion or septic shock (low-certainty evidence), with frequent reassessment. Unstable patients may need concurrent vasopressors.

THE MEDEASY TAKE

Less fluid is not automatically better.

Reassess perfusion and select fluids or vasopressors for the patient.

1. ARISE FLUIDS Investigators. N Engl J Med. 2026;395:1387-98. doi:10.1056/NEJMoa2516225.
2. Surviving Sepsis Campaign. Intensive Care Med. 2026;52:863-936. doi:10.1007/s00134-026-08361-1.

EVIDENCE SYNTHESIS / SEPTIC SHOCK

THREE TRIALS. THREE DIFFERENT CONTEXTS.

Different resuscitation phases, interventions, and endpoints.

Neutral primary results do not establish clinical equivalence.

01 / CLOVERS

2023 | EARLY ED HYPOTENSION | n=1,563

14.0% vs 14.9%

Death before discharge home by day 90

After 1–3 L initial IV fluid; restrictive vs liberal strategy.

Difference −0.9 pp (95% CI −4.4 to 2.6); P=0.61.

02 / CLASSIC

2022 | ICU SEPTIC SHOCK | n=1,554

42.3% vs 42.1%

All-cause mortality by day 90

After initial IV fluids; restrictive vs standard ICU strategy.

Adjusted difference +0.1 pp (95% CI −4.7 to 4.9); P=0.96.

03 / ARISE FLUIDS

2026 | EARLY ED SEPTIC SHOCK | n=963 ITT

76 vs 76 days

Days alive and out of hospital through day 90

Earlier vasopressors with less fluid vs later with more fluid.

Median difference 0.0 days (95% CI −2.7 to 2.7); P=1.00.

THE MEDEASY TAKE

Three neutral results do not prove equivalence.

Timing, populations, and endpoint choice shape what we can conclude.

1. CLOVERS Investigators. N Engl J Med. 2023;388:499-510. doi:10.1056/NEJMoa2212663.
2. Meyhoff TS, et al. N Engl J Med. 2022;386:2459-2470. doi:10.1056/NEJMoa2202707.
3. ARISE FLUIDS Investigators. N Engl J Med. 2026;395:1387-1398. doi:10.1056/NEJMoa2516225.

WHY THREE NEUTRAL RESULTS DON'T END THE DEBATE

Different starting lines, fluid exposure windows, and endpoints.

01 / WHERE THE STRATEGIES BEGAN

ARISE FLUIDS

ED · early shock

Early ED septic shock; less fluid and earlier vasopressors during a 6-24 h protocol.

CLOVERS

ED · after fluids

Hypotension despite 1-3 L IV fluid; randomized within 4 h of meeting criteria.

CLASSIC

ICU · after fluids

ICU septic shock after at least 1 L of IV fluid.

02 / FLUID EXPOSURE WAS NOT IDENTICAL

Between-group differences shown below come from different observation periods.

ARISE FLUIDS

1,108 mL less

First 24 h; median difference.

CLOVERS

2,134 mL less

24-h protocol; difference in medians.

CLASSIC

1,798 vs 3,811 mL

Cumulative ICU IV fluid through day 90.

03 / THE PRIMARY ENDPOINTS

ARISE FLUIDS

Days alive and out of hospital by day 90

CLOVERS

Death before discharge home by day 90

CLASSIC

All-cause death by day 90

04 / WHY CAUTION IS NEEDED

Strategy, not a single dose
Fluid and vasopressors were bundled.

Open-label decisions
Unblinded and flexible protocols.

No equivalence test
Does not establish equivalence.

Context matters
Patient fluid needs differ.

THE MEDEASY TAKE

Neutral is not equivalent. No single fluid strategy is proven best for every patient.

1. ARISE FLUIDS. NEJM 2026;395:1387-98. doi:10.1056/NEJMoa2516225.
2. CLOVERS. NEJM 2023;388:499-510. doi:10.1056/NEJMoa2212663.
3. Meyhoff TS, et al. NEJM 2022;386:2459-70. doi:10.1056/NEJMoa2202707.

EVIDENCE SYNTHESIS / SEPTIC SHOCK

THE NEXT LITER?
OR THE NEXT VASOPRESSOR?

Five bedside decisions to balance perfusion and fluid-related harm.

01

BEGIN RESUSCITATION PROMPTLY

The SSC conditionally suggests at least 30 mL/kg IV crystalloid within 3 h for sepsis-induced hypoperfusion or shock. Individualize and reassess.

CLINICAL PEARL Reassess during fluid administration.

02

ASK WHETHER MORE FLUID WILL HELP

Assess perfusion and fluid responsiveness. Use passive leg raising with stroke-volume assessment or other dynamic measures when feasible.

CLINICAL PEARL Hypotension alone does not prove fluid responsiveness.

03

DO NOT DELAY NEEDED VASOPRESSORS

If hypotension persists after initial fluids, use norepinephrine. In unstable shock, concurrent fluids and vasopressors may be warranted. Initial MAP target: about 65 mmHg.

CLINICAL PEARL Peripheral initiation requires monitoring and trained care.

04

REASSESS PERFUSION, NOT JUST MAP

Review mentation, capillary refill, urine output, MAP and lactate trends. An adequate pressure does not necessarily mean adequate tissue perfusion.

CLINICAL PEARL Do not give repeated fluids solely to normalize lactate.

05

WATCH FOR FLUID-RELATED HARM

Before more boluses, review oxygen needs, respiratory status, congestion and fluid balance. Weigh likely benefit against overload risk.

CLINICAL PEARL Avoid both under-resuscitation and fluid accumulation.

THE PHILIPPINE PRACTICE CHECK

Where advanced monitoring is limited, repeat bedside assessment. Vasopressors require trained staff, monitoring and escalation. Give prompt antimicrobials and pursue source control.

THE MEDEASY TAKE

Restore perfusion, not a preset fluid volume. Neither restrictive fluids nor extra boluses are universally superior. Reassess repeatedly, then individualize the balance of fluids and vasopressors.

PRIMARY SOURCES

Prescott HC, et al. Surviving Sepsis Campaign 2026. *Intensive Care Med.* 2026;52:863-936. doi:10.1007/s00134-026-08361-1.

ARISE FLUIDS Investigators. *N Engl J Med.* 2026;395:1387-1398. doi:10.1056/NEJMoa2516225.

THERAPEUTIC REVIEW / PULMONOLOGY

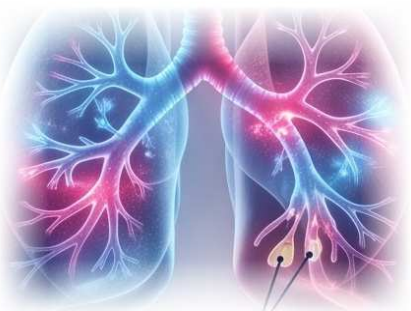
COPD BEYOND INHALERS

Can biologics reach more patients?

IL-33 inhibition may extend exacerbation prevention beyond eosinophil-selected trials, but important questions remain.

WHY LOOK BEYOND INHALERS?

Moderate or severe exacerbations persist in some patients despite optimized maintenance inhaled therapy. Biologics are being studied as add-on prevention for selected patients.



TARGETING IL-33

Tozorakimab is an investigational antibody against interleukin-33. OBERON and TITANIA did not require a blood-eosinophil threshold for enrollment.

TWO REPLICATE PHASE 3 TRIALS

Former smokers | Primary endpoint | 52 weeks

OBERON

29%

RELATIVE RATE REDUCTION

RR 0.71 | 95% CI 0.57-0.88
1.34 vs 1.90 events/yr

TITANIA

34%

RELATIVE RATE REDUCTION

RR 0.66 | 95% CI 0.55-0.80
1.37 vs 2.07 events/yr

WHAT THE FINDINGS MEAN

Both trials found fewer moderate or severe exacerbations in former smokers, with statistically significant results also in the overall current/former-smoker populations. This does not establish equal benefit across eosinophil subgroups or improved survival.

THE MEDEASY TAKE

Broader eligibility for study is not proof of benefit for every COPD phenotype. Efficacy, safety, and patient selection still matter.

Sciurba FC, et al. N Engl J Med. 2026. doi:10.1056/NEJMoa2606998.
Funded by AstraZeneca. Tozorakimab remained investigational at this review.

THERAPEUTIC REVIEW / PULMONOLOGY

DIFFERENT TARGETS. DIFFERENT EVIDENCE.

Why COPD biologic trials cannot be ranked by headline percentages.

01 DUPILUMAB

RR 0.70 / 0.66

IL-4 / IL-13 | BOREAS + NOTUS

Blood eosinophils ≥300 cells/µL, chronic bronchitis, and exacerbation risk despite optimized inhaled treatment.

Fewer exacerbations and improved FEV1 versus placebo.

95% CIs: 0.58–0.86 (BOREAS); 0.54–0.82 (NOTUS).

02 MEPOLIZUMAB

RR 0.79

IL-5 | MATINEE

Blood eosinophils ≥300 cells/µL and prior exacerbations despite triple inhaled therapy.

0.80 vs 1.01 events/year; no significant QoL or symptom difference.

95% CI: 0.66–0.94 (MATINEE).

03 TOZORAKIMAB

RR 0.71 / 0.66

IL-33 | OBERON + TITANIA

Former smokers were the primary-analysis populations; no minimum eosinophil count was required for enrollment.

Fewer exacerbations vs placebo; subgroup equivalence is unproven. Investigational therapy.

95% CIs: 0.57–0.88 (OBERON); 0.55–0.80 (TITANIA).

WHY THE NUMBERS CANNOT BE RANKED

Different entry criteria, inflammatory phenotypes, background treatment and smoking status limit cross-trial comparisons. These are separate placebo-controlled trials, not head-to-head evidence.

MEDEASY TAKE Match proven outcomes to the patient—not the headline rate ratio.

SOURCES BOREAS: NEJMoa2303951 · NOTUS: NEJMoa2401304 · MATINEE: NEJMoa2413181
OBERON/TITANIA: NEJMoa2606998 | Trials funded by respective manufacturers.

THERAPEUTIC REVIEW / PULMONOLOGY

COPD BIOLOGICS: WHO IS THE RIGHT PATIENT?

From trial eligibility to careful clinical adoption.

01 OPTIMIZE BEFORE ESCALATING

Confirm COPD with spirometry; review exacerbation history, inhaler technique, adherence, and appropriate maintenance therapy. Address smoking, vaccination, pulmonary rehabilitation, and comorbidities.

Clinical pearl: Recurrent exacerbations—not dyspnea alone—drive biologic assessment.

02 MATCH THE PATIENT TO THE EVIDENCE

DUPILUMAB	Eosinophils ≥300 cells/µL, chronic bronchitis, and exacerbations despite triple therapy.
MEPOLIZUMAB	Eosinophils ≥300 cells/µL and exacerbations despite triple therapy; chronic bronchitis not mandatory.
TOZORAKIMAB	Investigational IL-33 blocker; no minimum eosinophil count at enrollment. Benefit across all phenotypes is unproven.

03 REASSESS SAFETY & PATIENT-RELEVANT BENEFIT

Review agent-specific warnings and adverse effects; monitor exacerbations, function, and tolerability. There is no universal 4–6-month stopping rule. Reassess continuation according to response, safety, and specialist guidance.

04 PROSPERO: LONGER-TERM EVIDENCE

RR 0.79 95% CI 0.61–1.01 | P=0.0587

At up to 104 weeks, the former-smoker primary endpoint (severe COPD exacerbations) was not statistically significant. An overall-population result was nominally significant; it is not confirmatory after a missed primary endpoint.

CHEST 2026 · Sponsor-reported conference results; preliminary.

PHILIPPINE PRACTICE CHECK

Check Philippine FDA indication, access, cost, and follow-up. Global approval does not establish local approval.

THE MEDEASY TAKE

Select patients by exacerbation history and trial criteria. Prioritize safety and outcomes, not headline percentages.

SOURCES GOLD 2026 · Sciurba et al., NEJM 2026 (NEJMoa2606998) · AstraZeneca CHEST 2026 release (sponsor report; preliminary).

PHILIPPINE CLINICAL FOCUS / AMR

ANTIBIOTIC RESISTANCE: THE PHILIPPINE REALITY

What should surveillance change in prescribing?

Choosing empiric antibiotics requires a balance: treat serious infection promptly while avoiding unnecessary broad-spectrum exposure.

Philippine ARSP reports national resistance estimates and trends. Its **2025 report** is available, but these findings cannot substitute for individual clinical assessment.

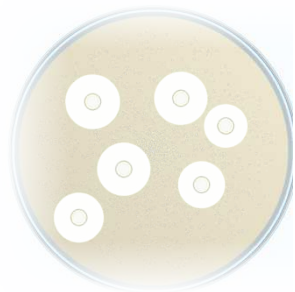


ILLUSTRATION ONLY

NATIONAL SIGNAL. LOCAL DECISION.

Before acting on any reported resistance percentage, ask four questions:

01 ORGANISM + ANTIBIOTIC

Resistance is specific to a bacterial species and the agent tested; "Gram-negative resistance" alone is not a prescribing rule.

02 SPECIMEN + SYNDROME

Urine, blood, and respiratory isolates reflect different clinical situations. Distinguish infection from colonization.

03 WHO WAS CULTURED?

Surveillance samples may overrepresent hospitalized patients or those more likely to undergo testing.

04 LOCAL CONTEXT

Use a current local antibiogram where available; also review severity, prior cultures, and antibiotic exposure.

ESBL IS A CLINICAL QUESTION, NOT A BLANKET ORDER

ESBL-producing *E. coli* and *K. pneumoniae* can narrow treatment options, but drug selection depends on the site and severity of infection, susceptibility results, and current guidance. **Carbapenems are not automatic for every ESBL isolate.**

THE MEDEASY TAKE

Surveillance should improve precision, not widen coverage by default. Culture when indicated; reassess empiric therapy and narrow or stop treatment as evidence allows.

SOURCES 1. RITM/DOH. ARSP 2025 Annual Report Data Summary. 2. WHO. GLASS Manual, 2023.
3. IDSA. Guidance on antimicrobial-resistant Gram-negative infections, 2024.

PHILIPPINE CLINICAL FOCUS / ANTIMICROBIAL RESISTANCE

THE NUMBERS BEHIND PHILIPPINE AMR

Six resistance signals from Philippine sentinel surveillance.

ARSP 2025 155,138 infections analyzed 28 sentinel sites
Percentages below = resistant isolates / isolates tested for that specific antibiotic.

01 E. coli

Escherichia coli

All reported E. coli infections: n=17,248

45.90%
Ciprofloxacin

38.99%
Ceftriaxone

02 K. pneumoniae

Klebsiella pneumoniae

All reported K. pneumoniae infections: n=20,732

17.41%
Meropenem

35.40%
Piperacillin/tazobactam

03 A. baumannii

Acinetobacter baumannii

All reported A. baumannii infections: n=8,207

44.23%
Meropenem

Substantial carbapenem resistance in tested isolates; interpret within the infection setting.

04 S. pneumoniae

Streptococcus pneumoniae

All reported S. pneumoniae infections: n=439

1.55%
Penicillin resistance
NON-MENINGITIS breakpoint

Do not apply this percentage to suspected pneumococcal meningitis.

HOW TO READ THE NUMBERS

Organism totals are **not** antibiotic-specific testing denominators. Sentinel sampling, selective cultures, and laboratory access may bias estimates.

THE MEDEASY TAKE

High resistance deserves attention; low resistance matters too. **Use local antibiograms and individual cultures when available, not national figures alone.**

SOURCE DOH-RITM. ARSP 2025 Annual Report (published July 2026).
Figures 89 (p64), 108 (p79), 143 (p108), and 8 (p15).

PHILIPPINE CLINICAL FOCUS / ANTIMICROBIAL STEWARDSHIP

FROM RESISTANCE DATA TO BETTER PRESCRIBING

Five decisions that make antibiotic treatment more precise.

ARSP 2025 informs risk; local data and the patient guide treatment.

01 ESTABLISH THE CLINICAL INDICATION

Assess whether bacterial infection requires treatment. Distinguish infection from colonization, contamination, and noninfectious illness.

Asymptomatic bacteriuria: usually no treatment; key exceptions include pregnancy and certain urologic procedures.

02 OBTAIN APPROPRIATE MICROBIOLOGY

Collect syndrome-appropriate cultures before antibiotics when feasible, without materially delaying care for sepsis or other serious infection.

Well-collected specimens can enable targeted therapy and avoid unnecessary broad coverage.

03 SELECT EMPIRIC THERAPY INTELLIGENTLY

Consider source, severity, prior cultures, recent antibiotics, resistance risks, and the current facility antibiogram.

National ARSP estimates complement, but do not replace, a local antibiogram.

04 REASSESS AND REFINE

Review the diagnosis, cultures, susceptibility, and clinical response. Continue, narrow, change, or stop therapy when appropriate.

A 48–72-hour review is useful; reassess sooner whenever new findings warrant.

05 OPTIMIZE DURATION AND ROUTE

Use syndrome-appropriate dosing and duration. Consider oral step-down when stable, with source control and an active oral option.

Antibiotic resistance alone does not mandate a longer course.

THE PHILIPPINE PRACTICE CHECK

Use facility guidance and local antibiograms where available. Prioritize cultures in serious infections and seek expert input for complex resistance.

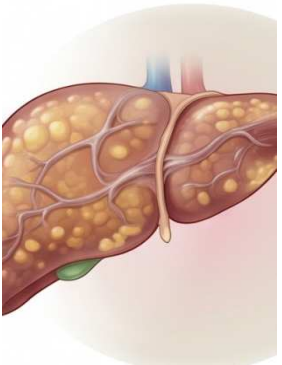
THE MEDEASY TAKE

The best antibiotic is not always the broadest. Treat promptly when indicated, then refine using response and microbiology.

SOURCES DOH-RITM ARSP 2025 (2026); DOH AO 2023-0011; CDC Stewardship (2019); IDSA ASB (2019).

PRACTICE CHANGER / METABOLIC LIVER DISEASE

THE FATTY LIVER TRAP WHAT NORMAL LIVER ENZYMES CAN MISS



Why routine liver panels can miss progressive liver disease in patients with metabolic risk.

THE FALSE REASSURANCE OF NORMAL ALT

Normal ALT does not exclude MASLD or advanced fibrosis. Assessment should reflect metabolic risk and appropriate noninvasive tests, rather than aminotransferase values alone.

STEATOSIS IS NOT FIBROSIS

Steatosis indicates hepatic fat; it does not establish MASH or fibrosis stage. Fibrosis reflects scarring and is a major predictor of liver-related outcomes. Ultrasound may identify steatosis but cannot reliably stage fibrosis.

WHO SHOULD BE ASSESSED?

01 TYPE 2 DIABETES
Assess with FIB-4 even if ALT is normal.

02 METABOLIC RISK
Obesity and other cardiometabolic factors.

03 LIVER FINDINGS
Steatosis or persistently raised enzymes.

THE FIRST STEP: FIB-4

Age • AST • ALT • Platelet count

<1.3 Lower risk in most adults
1.3–2.67 Further assessment
>2.67 High risk; refer

Age >65: use ~2.0 as the initial threshold.
Age <35: accuracy is limited.

FIB-4 is not diagnostic; a low score may miss disease in some high-risk patients.

THE PHILIPPINE PRACTICE CHECK

Use routine laboratory results for FIB-4; plan elastography or referral according to risk, availability and cost.

THE MEDEASY TAKE

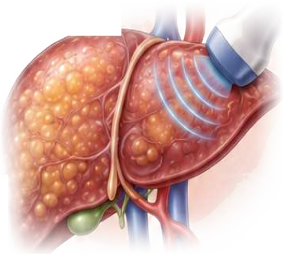
Normal ALT is not a fibrosis clearance certificate. Assess the patient's metabolic risk, then use appropriate noninvasive testing.

Sources: ADA, Standards of Care in Diabetes 2026 (doi:10.2337/dc26-S004); EASL–EASD–EASO MASLD Guideline, J Hepatol 2024 (doi:10.1016/j.jhep.2024.04.031).

PRACTICE CHANGER / METABOLIC LIVER DISEASE

FROM RISK SCORE TO REFERRAL

What to do after FIB-4—and when liver stiffness changes the decision.



01 INTERPRET FIB-4 IN CONTEXT

A first-line assessment of advanced fibrosis risk

< 1.3

LOWER RISK

Continue metabolic care and reassess. In type 2 diabetes, repeat FIB-4 about every 1–2 years.

1.3–2.67

FURTHER TESTING

Obtain VCTE; consider ELF if VCTE is unavailable. Interpret with patient risk and age.

> 2.67

HIGHER RISK

Consider direct hepatology referral to assess fibrosis risk and other liver conditions.

Age ≥65: use 2.0 as the initial FIB-4 threshold. **Age <35:** FIB-4 performs poorly; clinical risk can justify other assessment.

02 WHEN ELASTOGRAPHY HELPS

Vibration-controlled transient elastography (VCTE) adds liver stiffness measurement; it does not establish a histological stage.

< 8 kPa

Lower probability of advanced fibrosis. Continue risk-factor management and periodic follow-up.

≥ 8 kPa

Greater risk of advanced fibrosis. Arrange further evaluation and specialist referral; not diagnostic of F2–F4.

03 KNOW WHEN SCORES MISLEAD

Acute illness can distort FIB-4; inflammation, congestion and cholestasis may increase liver stiffness. Persistent enzyme elevation, discordant tests or clinical red flags warrant further evaluation.

THE PHILIPPINE PRACTICE CHECK

Start with available labs. Arrange VCTE/ELF when indicated; prioritize referral if risk is high or tests disagree.

THE MEDEASY TAKE

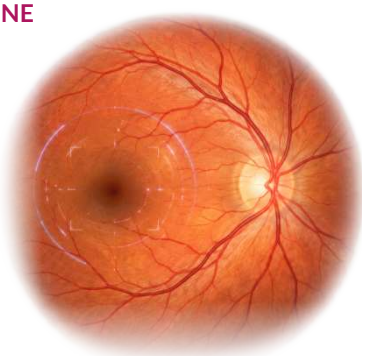
FIB-4 is a triage tool, not a final diagnosis. Normal ALT and low scores do not eliminate clinical judgment.

Sources: ADA Standards of Care 2026, Sec. 4; EASL–EASD–EASO MASLD CPG 2024.

TECH CHECK / OPHTHALMOLOGY & DIGITAL MEDICINE

AI IN EYE CARE

BETTER SCREENING—OR SIMPLY FEWER REFERRALS?



AI-assisted diabetic retinal screening is promising. But do abnormal findings lead to completed follow-up and care?

TWO STUDIES. TWO DIFFERENT OUTCOMES.

ACCESS 2024 | RANDOMIZED

100% vs 22%

Diabetic eye-exam completion

81/81 vs 18/82 participants; ages 8–21 years.

64% (16/25)

AI-positive: completed follow-up

REAL-WORLD 2026 | COHORT

95.7%

Definitive AI screening result

245/256 adults received a usable non-dilated result.

44.7% (34/76)

AI-positive: documented internal review

THE REFERRAL GAP IS THE CLINICAL TEST

Screening completion is not treatment completion. In the 2026 study, follow-up outside the institution was **not captured**. These studies differ in design and patient populations; neither established long-term prevention of vision loss.

Clinical safeguard: Positive or ungradable screens still require an appropriate eye-care pathway; retinal photography does not replace comprehensive assessment.

PHILIPPINE PRACTICE CHECK

Validate local device approval, operator training, image quality and patient privacy. Fund a dependable ophthalmology referral and follow-up process—not just camera access.

THE MEDEASY TAKE

AI can close the screening gap without closing the care gap. Judge programs by completed referrals, treatment access and meaningful visual outcomes.

SOURCES 1. Wolf RM et al. Nat Commun. 2024;15:421. doi:10.1038/s41467-023-44676-z.
2. Gil O et al. Br J Ophthalmol. 2026. doi:10.1136/bjo-2025-328991. 3. ADA Standards 2026.

TECH CHECK / OPHTHALMOLOGY & DIGITAL MEDICINE

BEYOND ACCURACY: THE PHILIPPINE TEST



When AI screening reaches Filipino patients, missed disease and referral pathways matter as much as headline accuracy.

01 / WHAT THE METRICS MEAN

SENSITIVITY

Among eyes with referable disease, how often does AI flag them? Lower sensitivity means more missed cases.

SPECIFICITY

Among eyes without referable disease, how often does AI correctly classify them as negative?

GLOBAL META-ANALYSIS | 2026

96.2%

Pooled AI sensitivity for referable retinopathy

28 diagnostic-accuracy studies. Not a head-to-head device comparison.

02 / THE PHILIPPINE VALIDATION

Retrospective study (La Union, 2026): 284 eyes from 142 people with diabetes; one AI system, graded against retina-specialist assessments.

79.03%
SENSITIVITY

96.50%
SPECIFICITY

Eye-level results for referable DR. The local study and global synthesis involve different devices and populations; the percentages cannot be ranked directly.

03 / BEFORE ADOPTING AI SCREENING

01 VALIDATION
Validate the specific device for your patients and setting.

02 IMAGE QUALITY
Plan for ungradable images or an inconclusive result.

03 REFERRAL PATHWAY
Track positive screens and completed specialist referrals.

04 PRIVACY & REGULATION
Check Philippine FDA rules and protect retinal image data.

PHILIPPINE PRACTICE CHECK

Track ungradable images, referral completion and audited diagnostic performance—not accuracy claims alone.

THE MEDEASY TAKE

Validation is local; benefit is clinical. A screening result matters only when it leads to appropriate care.

SOURCES 1. Chen KY et al. npj Digit Med. 2026;9:400. doi:10.1038/s41746-026-02627-0.
2. Eduardo MKDG, Pajarillo JR. Acta Med Philipp. 2026;60(17). Retrospective validation.

CLINICAL BRIEFS / NOVEMBER 2026

TWO STUDIES. TWO CLINICAL LESSONS.

When evidence is neutral—or a treatment is still experimental—clinical interpretation matters.

01

MATERNAL HEALTH / ALLERGY

CAN MATERNAL DIET PREVENT INFANT FOOD ALLERGY?

7.8%
vs 8.4%

THE STUDY. PrEggNut randomized 2,137 women with familial allergy risk to higher or standard egg/peanut intake during pregnancy and lactation.

KEY RESULT. Infant egg/peanut allergy at 1 year: **7.8% vs 8.4%** (RR 0.93; 95% CI 0.69–1.26; P=0.65). No significant reduction.

MEDEASY TAKE High maternal intake did not lower infant allergy risk. This does not imply allergen avoidance.

02

OPHTHALMOLOGY / INNOVATION

OPTOGENETICS: A SIGNAL OF RESTORED LIGHT SENSITIVITY

7 / 10
Increased light sensitivity

THE STUDY. PIONEER was an open-label phase 1 safety study (n=10) in advanced retinitis pigmentosa using an intravitreal ChrimsonR vector and light-stimulating goggles.

KEY RESULT. Seven showed increased light sensitivity; six met a meaningful threshold not prespecified in the protocol. This was **not** restoration of normal vision.

SAFETY. There were 34 ocular adverse events in nine participants, including one severe transient central retinal artery occlusion.

MEDEASY TAKE An encouraging biological signal; functional benefit and long-term safety remain uncertain.

SOURCES 1. Palmer DJ, et al. *N Engl J Med.* 2026;395:1090–1099. doi:10.1056/NEJMoa2605659.
2. Sahel JA, et al. *N Engl J Med.* 2026;395:1399–1408. doi:10.1056/NEJMoa2602215.
DISCLOSURE: PIONEER was funded by GenSight Biologics. This article is independent editorial content.

PRACTICAL INSIGHTS / MEDEASY PICKS

MONDAY MORNING MEDICINE

Six Questions Before Your First Patient

Six practical decisions from this issue, grounded in evidence and patient context.

01 WHAT IS THE PATIENT'S DOMINANT RISK?

DIABETES | P06–P10

Assess ASCVD, heart failure and CKD before choosing therapy. Prioritize treatments with proven organ benefits when indicated, alongside glycemic goals and affordability.

02 WILL ANOTHER FLUID BOLUS HELP?

SEPTIC SHOCK | P11–P14

After initial resuscitation, reassess perfusion and fluid responsiveness. Use vasopressors when indicated rather than reflexively giving more fluid.

03 DOES THE PATIENT MATCH THE TRIAL POPULATION?

COPD BIOLOGICS | P15–P17

Check exacerbation history, optimized inhaled therapy and eosinophil profile. Different trial populations cannot establish a biologic ranking.

04 WHAT DOES LOCAL RESISTANCE TELL US?

ANTIMICROBIAL STEWARDSHIP | P18–P20

Use infection severity, prior microbiology and a reliable local antibiogram to guide empiric therapy. Reassess when culture results and clinical response are known.

05 COULD NORMAL ALT BE MISLEADING?

METABOLIC LIVER DISEASE | P21–P22

Normal ALT does not exclude advanced fibrosis. Consider FIB-4 in at-risk adults, interpret it by age, and investigate further when indicated.

06 WHO CLOSES THE REFERRAL LOOP?

AI IN EYE CARE | P23–P24

Track ungradable images, positive AI screens and specialist follow-up. A completed screening test is not the same as completed clinical care.

THE MEDEASY EVIDENCE FILTER

Before changing practice, ask:
01 Is the outcome meaningful?
02 Does the evidence fit my patient?
03 Can care be delivered safely here?

THE MEDEASY TAKE

Evidence informs the choice. Patient risk, clinical judgment and access guide the next step.

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