FROM MY DESK

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A quick word before you dive in. I and my AI read a fair bit of this so you don't have to, and this first issue pulls together the developments from the past year that I think will actually touch our consulting rooms — not the press - release noise, but the things a patient will ask about or a guideline will quietly change under us.

You'll find six shifts, plus a word on AI, each finished with a short **Dr Regu's Take** — the bit I'd scribble in the margin for a colleague. It's meant to be read with a coffee in ten minutes.

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01 The incretin era stopped being about weight

Oral GLP-1s have arrived — but the real shift is incretins quietly becoming whole-body cardiometabolic drugs.

Oral

First GLP-1 pill for weight — taken any time, no food rules.

Whole-body

Triple agonists move weight, BP, lipids, knee pain and apnoea.

CV + kidney

Now co-primary goals alongside HbA1c in the 2026 standards.

What really caught my attention this year wasn't another impressive weight-loss graph. It was the arrival of a GLP-1 tablet that patients can simply take with their morning coffee — no injections, no fasting windows, no complicated timing.
For years, one of the biggest barriers to these medications has been the needle. Many patients were interested but reluctant to inject themselves. That conversation may be about to change.

In April, the FDA approved orforglipron (Foundayo), and other oral GLP-1 medications are not far behind. For many patients, a tablet feels more familiar, less intimidating and easier to fit into everyday life.

But the bigger story isn't the tablet itself. It's what these drugs are becoming.

The latest studies on newer agents such as retatrutide show benefits extending well beyond weight loss. We're seeing improvements in blood pressure, triglycerides, fatty liver disease, sleep apnoea and even obesity-related joint pain. Increasingly, these medicines are looking less like weight-loss treatments and more like comprehensive cardiometabolic therapies.

The diabetes guidelines are reflecting that shift too. The conversation is no longer just about lowering HbA1c. Cardiovascular protection, kidney protection and long-term health outcomes are moving centre stage.

The question many patients are already asking is:
"Doctor, is there a tablet version now?"
The answer is yes — but with some important caveats.

These medications are still relatively new, they're not currently PBS-listed for obesity, and we don't yet have the same long-term outcome data that we have for some of the injectable agents.
In my view, the biggest challenge over the next few years won't be whether these medications work. We already know they do. The real discussion will be around affordability, access and who stands to benefit the most.

We're no longer treating a number on the scales — we're treating the whole cardiometabolic mess that walks in with it.

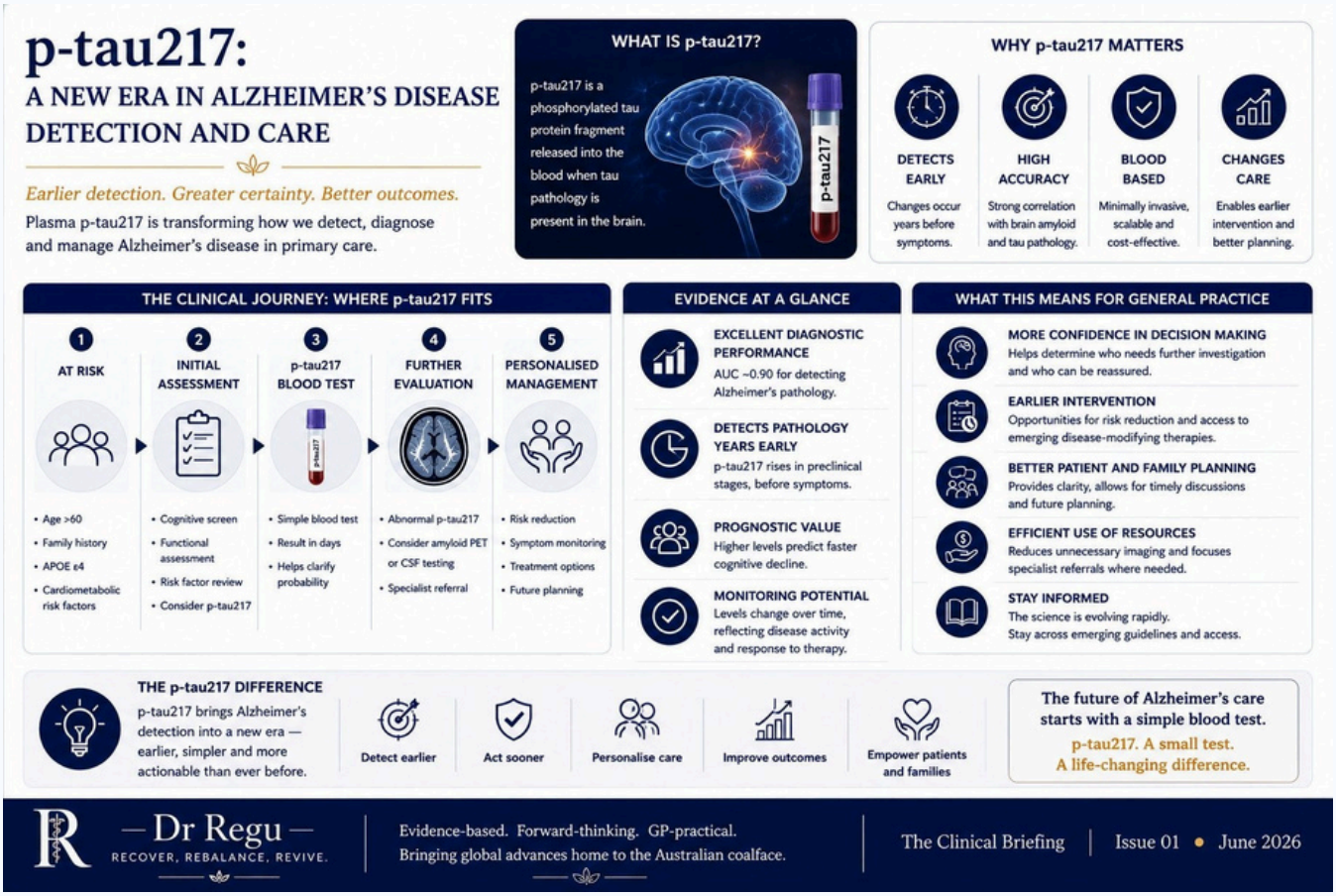
DR REGU'S TAKE

what actually matters on Monday

The incretins are now about far more than weight loss. When starting one, look beyond the scales and monitor blood pressure, HbA1c, lipids and renal function. Discuss gastrointestinal side effects early and titrate slowly — many patients who struggle have simply escalated too quickly. The new oral agents are promising, but access, affordability and long-term outcomes will determine their place in everyday practice. Above all, don't forget the fundamentals: review medications, encourage resistance exercise and adequate protein intake, and focus on health rather than dress size. The tablets may grab the headlines, but improving long-term health is the real story.

02 Alzheimer's becomes something you can act on

Modest disease-modifying drugs, a blood test that moves diagnosis upstream — and an honest debate about how much it means.



Earlier Detection, New Possibilities

For decades, confirming Alzheimer's disease often required specialist assessment, advanced imaging or invasive testing. That landscape is beginning to change. Blood biomarkers such as plasma p-tau217 can identify Alzheimer's pathology years before symptoms become obvious and are showing impressive diagnostic accuracy in clinical studies.

At the same time, disease-modifying therapies such as lecanemab and donanemab have demonstrated the ability to slow cognitive decline in selected patients with early Alzheimer's disease. While the benefits are modest and treatment requires careful patient selection and monitoring, they represent an important shift from purely supportive care towards targeted intervention.

Together, these advances suggest a future where Alzheimer's disease may be recognised earlier, diagnosed more accurately and managed more proactively than ever before.

DR REGU'S TAKE

what actually matters on Monday

The headline isn't the infusions. For most patients, eligibility, cost and monitoring requirements will keep these treatments largely specialist-led for now.

The more practical development is p-tau217. Use it when the result is likely to change management, referral or future planning — not as a screening test for the anxious-but-well.

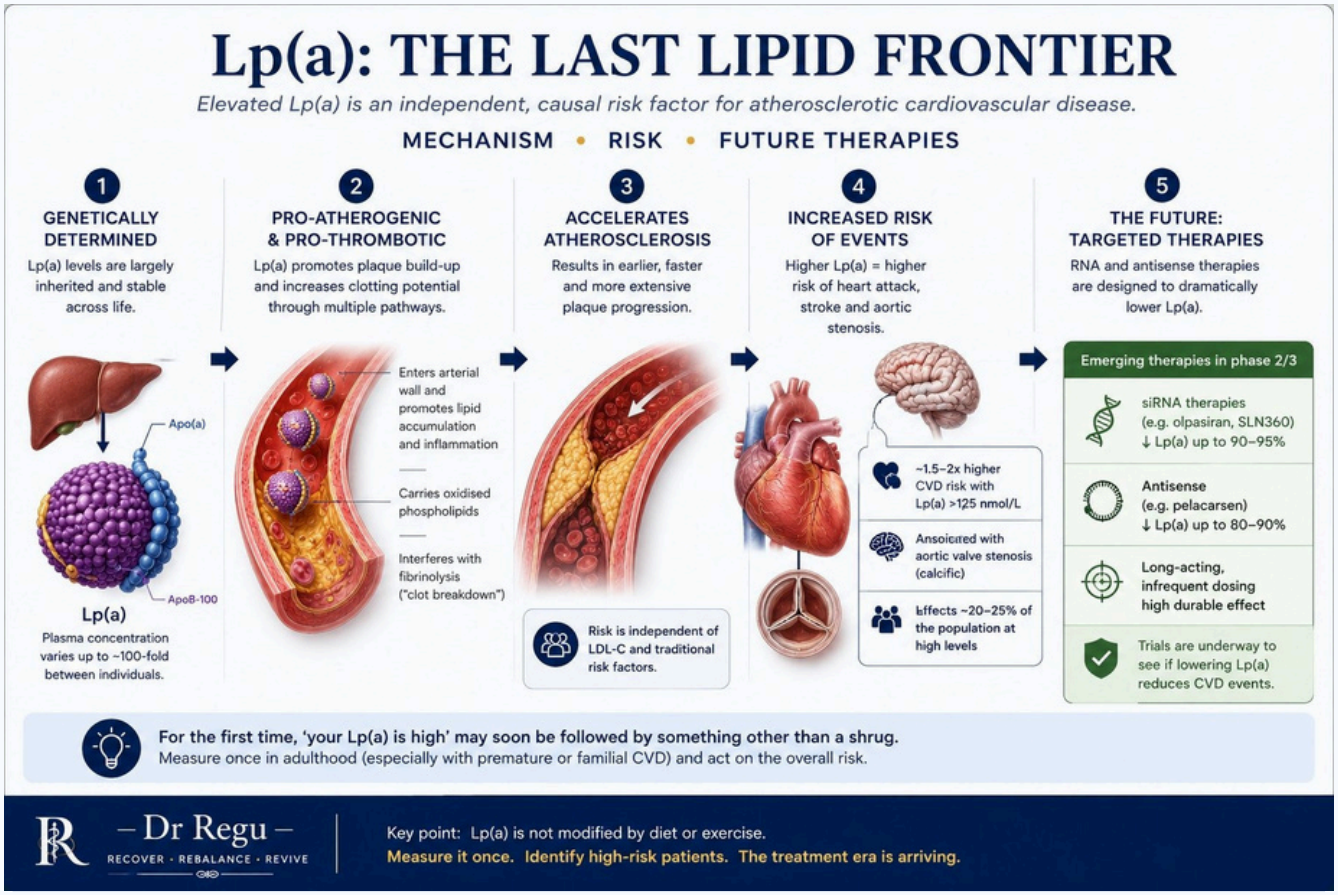
And don't overlook the basics. Blood pressure control, exercise, good sleep, treating hearing loss, addressing depression and maintaining social connection remain some of the most effective tools we have for protecting brain health.

Sometimes the biggest advances aren't the newest drugs, but doing the fundamentals well.

PRECISION CARDIOLOGY

03 Lp(a): the inherited risk we can finally treat

One in five of your patients carry it, most have never been tested — and the 'nothing to offer' excuse is running out.



The Last Lipid Frontier

Around one in five adults carries an elevated lipoprotein(a) [Lp(a)] — a genetically determined risk factor for heart attack, stroke and aortic valve disease. Unlike LDL cholesterol, Lp(a) is largely unaffected by diet, exercise or most conventional lipid-lowering therapies, and until recently there was little reason to measure it because there was little we could do about it.

That is beginning to change. A new generation of targeted therapies, including lepodisiran, pelacarsen, olpasiran and zerlasiran, can reduce Lp(a) levels by 60–95%, with major outcome trials now underway. While we await those results, the most important step is recognising who carries this hidden risk factor.

Because Lp(a) is genetically determined and remains relatively stable throughout life, it usually only needs to be measured once. Patients with premature cardiovascular disease, a strong family history, or cardiovascular risk that seems disproportionate to traditional factors are often the people most likely to benefit from testing.

DR REGU'S TAKE

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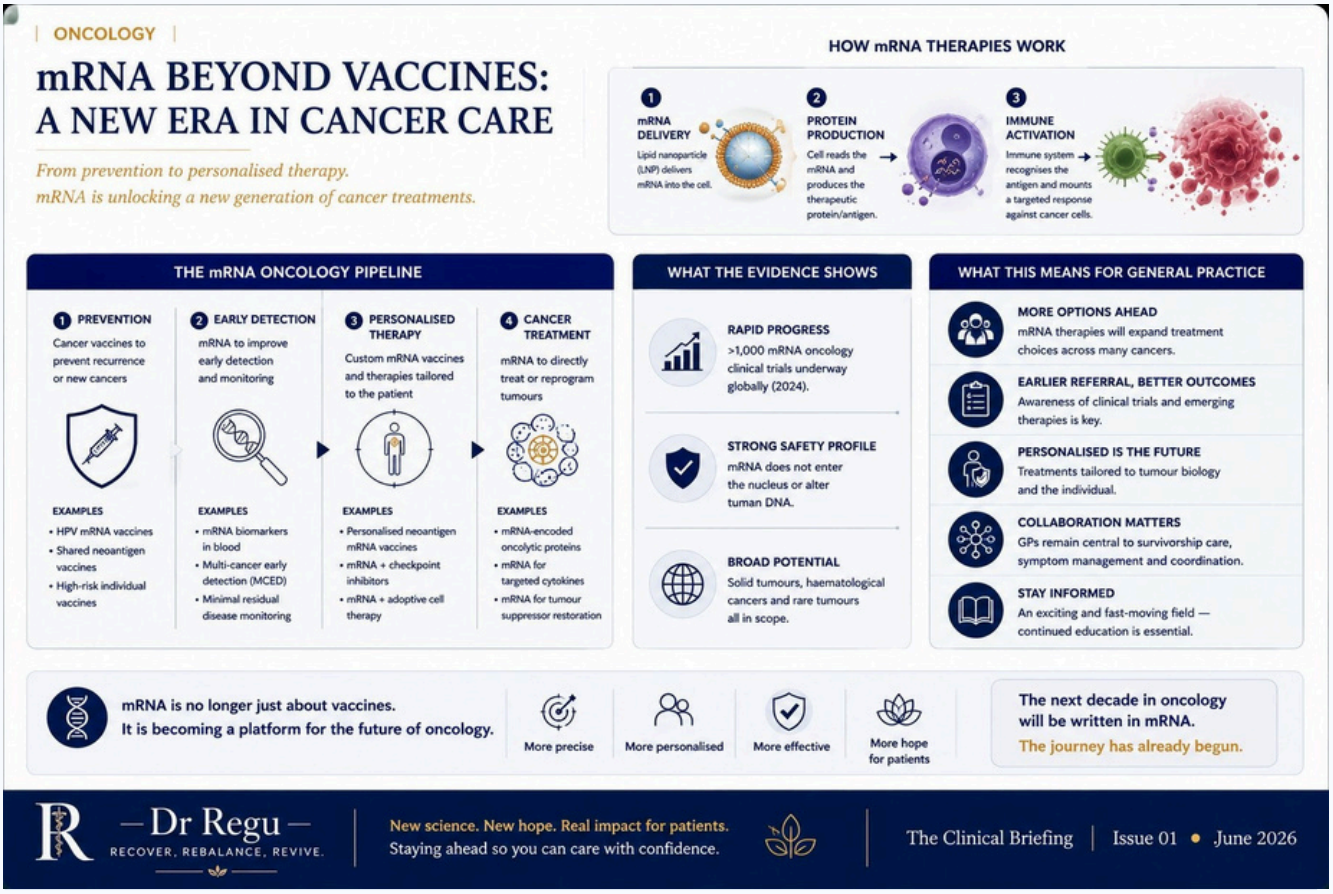
You don't need to wait for the new drugs to change your practice — you need to start measuring. Check Lp(a) once in adults with premature or familial cardiovascular disease, unexplained progression, or a striking family history. It reframes the whole risk conversation: a high result isn't a reason to shrug, it's a reason to be more aggressive with everything you can already modify — LDL to target, blood pressure, smoking, the lot. Tell patients plainly that diet and exercise won't shift the Lp(a) number itself, so they don't waste energy blaming themselves, and flag that targeted therapies are coming. Document it once, act on the total risk, and you've future-proofed that patient for the day the outcome trials report.

PERSONALISED ONCOLOGY

04 Personalised mRNA vaccines grow up

Sequence the tumour, build a bespoke vaccine against it — and this year the durable data started to arrive.



Personalised Cancer Vaccines Move Closer to Reality

For years, the phrase "cancer vaccine" generated more excitement than results. That may finally be changing.

The concept is remarkably simple. Scientists analyse a patient's tumour, identify the mutations that make it unique, and create a personalised mRNA vaccine designed to help the immune system recognise and attack those cancer cells.

Early results are encouraging. In high-risk melanoma, adding the personalised vaccine mRNA-4157 to pembrolizumab significantly reduced the risk of recurrence. In pancreatic cancer, some patients developed durable tumour-specific immune responses that persisted for years after treatment.

These therapies remain firmly in the specialist domain, but they matter to general practice because patients will increasingly hear about them and ask questions. More importantly, the success of personalised cancer treatment depends on something we influence every day: early diagnosis. The earlier a cancer is detected, the greater the opportunity for targeted and personalised treatment.

DR REGU'S TAKE

what actually matters on Monday

This won't change your prescribing, but it will change your conversations. Expect patients to ask about "cancer vaccines" and be ready to explain that these are personalised, tumour-specific treatments, not preventive vaccines, and for now remain largely confined to specialist centres and clinical trials.

Where we add the greatest value is upstream. Keep doing the unglamorous but life-saving work of screening, recognising red-flag symptoms and referring early, because personalised therapies work best when cancers are caught sooner.

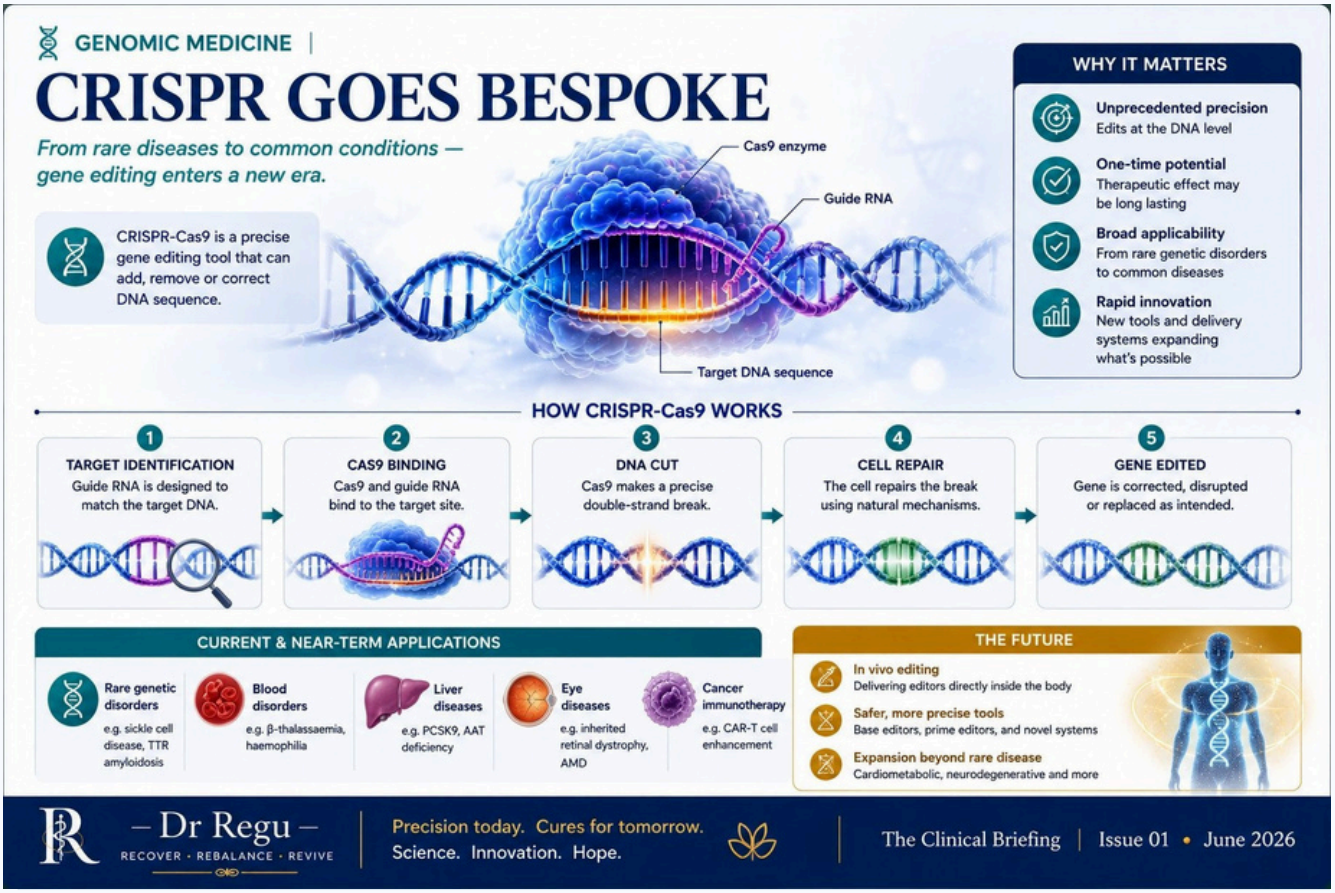
And don't forget survivorship. As more patients live longer with advanced treatments, much of the ongoing coordination, symptom management and shared care will fall to general practice.

The science is exciting. Our job is to help patients reach it in time.

GENOMIC MEDICINE

05 CRISPR goes bespoke

From a decade of headlines to a treatment with a price tag and real patients — arriving one rare disease at a time.



CRISPR Moves from Headlines to Patients

For years, CRISPR was one of those technologies that always seemed to be "just around the corner." It isn't anymore. The first approved CRISPR therapy, Casgevy, is now being used to treat patients with sickle cell disease and beta-thalassaemia, offering the possibility of long-term disease control for conditions that previously relied largely on supportive care.

What is perhaps even more remarkable is the rise of highly personalised gene-editing treatments. In 2025, a child with an extremely rare genetic disorder received a custom-designed CRISPR therapy created specifically for that individual. While these "n-of-1" treatments remain exceptional, they offer a glimpse of where medicine may be heading.

For now, gene editing remains firmly within specialist centres. However, the technology is rapidly expanding beyond rare diseases, with researchers already exploring applications in conditions such as familial hypercholesterolaemia. As public awareness grows, patients will increasingly turn to their GP with questions about what gene editing can — and cannot — achieve.

DR REGU'S TAKE

what actually matters on Monday

You won't be ordering CRISPR, but you'll be the first person families ask about it. The useful things to hold: these are somatic edits (the patient, not their future children), they are transformative but eye-wateringly expensive and centre-based, and they are real now for sickle cell and thalassaemia. Keep your antennae up for the inherited conditions in your own caseload — the families with sickle cell, thalassaemia, familial hypercholesterolaemia — because they're the ones for whom referral pathways will open first. Manage expectations gently: 'bespoke' and 'available to everyone' aren't the same thing yet. And resist the hype in both directions — this is neither a miracle for all nor a gimmick. It's a genuinely new tool.

AI IN PRACTICE

06 AI arrives — first a scribe, then a second opinion

The most immediately useful thing to reach our desks in years — provided you stay the author and the safety net.

AI Arrives in the Consulting Room

Artificial intelligence is no longer a future concept in general practice. For many clinicians, it has arrived first as an AI scribe, reducing documentation time and helping reclaim attention for patients. Early studies suggest these tools can increase direct patient-facing time, and adoption has accelerated rapidly across primary care.

But AI's role is expanding beyond note-taking. New systems are beginning to assist with clinical documentation, information retrieval and decision support, raising important questions about privacy, bias, transparency and governance.

While the potential benefits are significant, AI remains a tool rather than a clinician. It can generate fluent and convincing outputs, but it does not understand the information it produces. Human oversight remains essential.

DR REGU'S TAKE

what actually matters on Monday

The biggest mistake is assuming AI is right because it sounds confident. It isn't. A simple transcription error — "lithium" becoming "sodium" — can completely change the meaning of a consultation.

Use AI to save time, reduce admin and improve workflow, but never outsource clinical judgement. Read every letter, every referral and every note before it leaves your desk.

The technology will keep improving. Our responsibility for patient safety won't change.

CLOSER TO HOME

07 The local changes that reach your room

All the global science matters less to your Monday than a handful of Australian rule changes — and 2026 brought several.

What Matters for Australian General Practice

If you're sitting in general practice on Monday morning, a handful of local changes may have more impact on your week than any global medical breakthrough.

The biggest headline is affordability. From 1 January 2026, the maximum PBS co-payment fell from $31.60 to $25 for Medicare card holders, while the concessional co-payment remains frozen at $7.70 until 2030. For many patients, that is a meaningful reduction in cost and a genuine opportunity to improve medication adherence.

Therapeutic Guidelines have also moved further towards a living, continuously updated model, making it more important than ever to rely on current online guidance rather than printed editions. Meanwhile, the TGA has identified medicinal cannabis, vaping products, weight-loss medicines and melatonin as areas of increased regulatory focus.

Other changes worth watching include expanded GP training positions, broader pharmacist prescribing initiatives in several jurisdictions, ongoing MyMedicare reforms, and wider access to funded vaccination programs for eligible at-risk groups.

None of these changes are as glamorous as gene editing or cancer vaccines, but they are far more likely to affect the patients walking into your consulting room this week.

DR REGU'S TAKE

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The PBS co-payment reduction is probably the most immediately useful change here. Every GP has patients who stretch prescriptions, delay repeats or skip medicines because of cost. A cheaper script won't solve everything, but it removes one barrier.

The other lesson is simple: check your sources. Guidelines, PBS restrictions and prescribing rules are changing faster than many of us realise. The days of relying on an old handbook on the shelf are rapidly disappearing.

Sources & further reading

Tapanylinktoopentheoriginalsource.Selectedprimary references for each section.

01 METABOLIC MEDICINE

→ FDA novel drug approvals 2026

02 NEUROLOGY

→ Alzheimer's 2026 forecast (BrightFocus)

03 PRECISION CARDIOLOGY

→ Lipoprotein(a) feature (ACC)

04 PERSONALISED ONCOLOGY

→ Pancreatic mRNA vaccine (MSK)

05 GENOMIC MEDICINE

→ New drug approvals tracker (Drugs.com)

06 AI IN PRACTICE

→ Generative AI in general practice (BJGP)

07 CLOSER TO HOME

→ PBS co-payments (health.gov.au)

→ TGA compliance priorities (newsGP)

→ Therapeutic Guidelines (living updates)

About this briefing. Compiled by Dr Reguram Sandrasegaram for educational use across the practice. It summarises developments to mid-June 2026 from regulators, peer-reviewed journals and professional colleges. It is not a clinical directive; verify PBS criteria at pbs.gov.au and prescribing details against current product information and Therapeutic Guidelines before acting. British English throughout.