



Six forces reshaping the future of care

Global breakthroughs. Real-world impact.
What it means for general practice.



The Clinical Briefing

A researcher-level digest of what is changing in medicine — the global frontier, and what it means at the Australian coalface.

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FROM MY DESK

Dr Reguram Sandrasegaram, Frankston

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.

p-tau217: A NEW ERA IN ALZHEIMER'S DISEASE DETECTION AND CARE

Earlier detection. Greater certainty. Better outcomes.

Plasma p-tau217 is transforming how we detect, diagnose and manage Alzheimer's disease in primary care.

WHAT IS p-tau217?

p-tau217 is a phosphorylated tau protein fragment released into the blood when tau pathology is present in the brain.



WHY p-tau217 MATTERS



DETECTS EARLY

Changes occur years before symptoms.



HIGH ACCURACY

Strong correlation with brain amyloid and tau pathology.



BLOOD BASED

Minimally invasive, scalable and cost-effective.



CHANGES CARE

Enables earlier intervention and better planning.

THE CLINICAL JOURNEY: WHERE p-tau217 FITS

1

AT RISK



- Age >60
- Family history
- APOE ε4
- Cardiometabolic risk factors

2

INITIAL ASSESSMENT



- Cognitive screen
- Functional assessment
- Risk factor review
- Consider p-tau217

3

p-tau217 BLOOD TEST



- Simple blood test
- Result in days
- Helps clarify probability

4

FURTHER EVALUATION



- Abnormal p-tau217
- Consider amyloid PET or CSF testing
- Specialist referral

5

PERSONALISED MANAGEMENT



- Risk reduction
- Symptom monitoring
- Treatment options
- Future planning

EVIDENCE AT A GLANCE



EXCELLENT DIAGNOSTIC PERFORMANCE
AUC ~0.90 for detecting Alzheimer's pathology.



DETECTS PATHOLOGY YEARS EARLY
p-tau217 rises in preclinical stages, before symptoms.



PROGNOSTIC VALUE
Higher levels predict faster cognitive decline.



MONITORING POTENTIAL
Levels change over time, reflecting disease activity and response to therapy.

WHAT THIS MEANS FOR GENERAL PRACTICE



MORE CONFIDENCE IN DECISION MAKING
Helps determine who needs further investigation and who can be reassured.



EARLIER INTERVENTION
Opportunities for risk reduction and access to emerging disease-modifying therapies.



BETTER PATIENT AND FAMILY PLANNING
Provides clarity, allows for timely discussions and future planning.



EFFICIENT USE OF RESOURCES
Reduces unnecessary imaging and focuses specialist referrals where needed.



STAY INFORMED
The science is evolving rapidly. Stay across emerging guidelines and access.



THE p-tau217 DIFFERENCE

p-tau217 brings Alzheimer's detection into a new era — earlier, simpler and more actionable than ever before.



Detect earlier



Act sooner



Personalise care



Improve outcomes



Empower patients and families

The future of Alzheimer's care starts with a simple blood test.

p-tau217. A small test. A life-changing difference.

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.

03

PRECISION CARDIOLOGY

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.

Lp(a): THE LAST LIPID FRONTIER

Elevated Lp(a) is an independent, causal risk factor for atherosclerotic cardiovascular disease.

MECHANISM • RISK • FUTURE THERAPIES

1
GENETICALLY DETERMINED

Lp(a) levels are largely inherited and stable across life.

Lp(a)
Plasma concentration varies up to ~100-fold between individuals.

2
PRO-ATHEROGENIC & PRO-THROMBOTIC

Lp(a) promotes plaque build-up and increases clotting potential through multiple pathways.

- Enters arterial wall and promotes lipid accumulation and inflammation
- Carries oxidised phospholipids
- Interferes with fibrinolysis ("clot breakdown")

3
ACCELERATES ATHEROSCLEROSIS

Results in earlier, faster and more extensive plaque progression.

Risk is independent of LDL-C and traditional risk factors.

4
INCREASED RISK OF EVENTS

Higher Lp(a) = higher risk of heart attack, stroke and aortic stenosis.

- ~1.5–2x higher CVD risk with Lp(a) >125 nmol/L
- Associated with aortic valve stenosis (calcific)
- Affects ~20–25% of the population at high levels

5
THE FUTURE: TARGETED THERAPIES

RNA and antisense therapies are designed to dramatically lower Lp(a).

Emerging therapies in phase 2/3

- siRNA therapies (e.g. olpasiran, SLN360) ↓ Lp(a) up to 90–95%
- Antisense (e.g. pelacarsen) ↓ Lp(a) up to 80–90%
- Long-acting, infrequent dosing high durable effect
- Trials are underway to see if lowering Lp(a) reduces CVD events.

For the first time, ‘your Lp(a) is high’ may soon be followed by something other than a shrug. Measure once in adulthood (especially with premature or familial CVD) and act on the overall risk.

— Dr Regu —

RECOVER • REBALANCE • REVIVE

Key point: Lp(a) is not modified by diet or exercise.

Measure it once. Identify high-risk patients. The treatment era is arriving.

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

what actually matters on Monday

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.

ONCOLOGY

mRNA BEYOND VACCINES: A NEW ERA IN CANCER CARE

From prevention to personalised therapy. mRNA is unlocking a new generation of cancer treatments.

HOW mRNA THERAPIES WORK

- mRNA DELIVERY**
Lipid nanoparticle (LNP) delivers mRNA into the cell.
- PROTEIN PRODUCTION**
Cell reads the mRNA and produces the therapeutic protein/antigen.
- IMMUNE ACTIVATION**
Immune system recognises the antigen and mounts a targeted response against cancer cells.

THE mRNA ONCOLOGY PIPELINE

- 1 PREVENTION**
Cancer vaccines to prevent recurrence or new cancers.
EXAMPLES: HPV mRNA vaccines, Shared neoantigen vaccines, High-risk individual vaccines.
- 2 EARLY DETECTION**
mRNA to improve early detection and monitoring.
EXAMPLES: mRNA biomarkers in blood, Multi-cancer early detection (MCED), Minimal residual disease monitoring.
- 3 PERSONALISED THERAPY**
Custom mRNA vaccines and therapies tailored to the patient.
EXAMPLES: Personalised neoantigen mRNA vaccines, mRNA + checkpoint inhibitors, mRNA + adoptive cell therapy.
- 4 CANCER TREATMENT**
mRNA to directly treat or reprogram tumours.
EXAMPLES: mRNA-encoded oncolytic proteins, mRNA for targeted cytokines, mRNA for tumour suppressor restoration.

WHAT THE EVIDENCE SHOWS

- RAPID PROGRESS**
>1,000 mRNA oncology clinical trials underway globally (2024).
- STRONG SAFETY PROFILE**
mRNA does not enter the nucleus or alter human DNA.
- BROAD POTENTIAL**
Solid tumours, haematological cancers and rare tumours all in scope.

WHAT THIS MEANS FOR GENERAL PRACTICE

- MORE OPTIONS AHEAD**
mRNA therapies will expand treatment choices across many cancers.
- EARLIER REFERRAL, BETTER OUTCOMES**
Awareness of clinical trials and emerging therapies is key.
- PERSONALISED IS THE FUTURE**
Treatments tailored to tumour biology and the individual.
- COLLABORATION MATTERS**
GPs remain central to survivorship care, symptom management and coordination.
- STAY INFORMED**
An exciting and fast-moving field — continued education is essential.

mRNA is no longer just about vaccines.
It is becoming a platform for the future of oncology.

More precise More personalised More effective More hope for patients

The next decade in oncology will be written in mRNA.
The journey has already begun.

— Dr Regu —
RECOVER. REBALANCE. REVIVE.

New science. New hope. Real impact for patients.
Staying ahead so you can care with confidence.

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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.

05

GENOMIC MEDICINE

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.

GENOMIC MEDICINE | CRISPR GOES BESPOKE
From rare diseases to common conditions — gene editing enters a new era.

CRISPR-Cas9 is a precise gene editing tool that can add, remove or correct DNA sequence.

WHY IT MATTERS

- Unprecedented precision**
Edits at the DNA level
- One-time potential**
Therapeutic effect may be long lasting
- Broad applicability**
From rare genetic disorders to common diseases
- Rapid innovation**
New tools and delivery systems expanding what's possible

HOW CRISPR-Cas9 WORKS

- TARGET IDENTIFICATION**
Guide RNA is designed to match the target DNA.
- CAS9 BINDING**
Cas9 and guide RNA bind to the target site.
- DNA CUT**
Cas9 makes a precise double-strand break.
- CELL REPAIR**
The cell repairs the break using natural mechanisms.
- GENE EDITED**
Gene is corrected, disrupted or replaced as intended.

CURRENT & NEAR-TERM APPLICATIONS

- Rare genetic disorders**
e.g. sickle cell disease, TTR amyloidosis
- Blood disorders**
e.g. β -thalassaemia, haemophilia
- Liver diseases**
e.g. PCSK9, AAT deficiency
- Eye diseases**
e.g. inherited retinal dystrophy, AMD
- Cancer immunotherapy**
e.g. CAR-T cell enhancement

THE FUTURE

- In vivo editing**
Delivering editors directly inside the body
- Safer, more precise tools**
Base editors, prime editors, and novel systems
- Expansion beyond rare disease**
Cardiometabolic, neurodegenerative and more

Dr Regu — RECOVER · REBALANCE · REVIVE

Precision today. Cures for tomorrow. Science. Innovation. Hope.

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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.

06

AI IN PRACTICE

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 AT THE COALFACE OF GENERAL PRACTICE

From admin burden to clinical partner — AI is here, and it's changing how we work.

WHAT'S HAPPENING NOW

- AI SCRIBES ARE MAINSTREAM**
Real-time note taking, summarisation and letter drafting inside the consult.
- BETTER DECISIONS, FASTER**
Clinical decision support at the point of care, drawn from trusted sources.
- PRIVACY & SAFETY FIRST**
Australian privacy laws apply. Always check data handling and storage.
- RAPID ADOPTION**
Surveys show >60% of GPs are trialling AI tools in 2025.

AI won't replace GPs. But GPs who use AI will replace GPs who don't.

AI TAKES CARE OF THE BUSYWORK SO YOU CAN FOCUS ON WHAT MATTERS MOST — YOUR PATIENTS.

OPPORTUNITIES FOR GENERAL PRACTICE

- CLINICAL EFFICIENCY**
Less time on notes and admin, more time in front of patients.
- QUALITY & SAFETY**
Fewer missed steps, better guideline adherence, reduced cognitive load.
- PATIENT EXPERIENCE**
Shorter waits, clearer communication, and more personalised care.
- PRACTICE PRODUCTIVITY**
Streamlined workflows and better team efficiency.

RISKS TO MANAGE

- INACCURACY**
AI can make mistakes. You're always the final decision-maker.
- BIAS & HALLUCINATIONS**
Check outputs, especially for uncommon conditions.
- DATA PRIVACY**
Use tools that store data securely in Australia where possible.
- OVER-RELIANCE**
AI supports your judgement, it doesn't replace it.

HOW AI HELPS ACROSS THE GP WORKFLOW

- BEFORE THE CONSULT**
 - Triage assistance
 - Patient summaries
 - Background checks
- DURING THE CONSULT**
 - Scribe & summarise
 - Decision support
 - Drug & interaction checks
- AFTER THE CONSULT**
 - Notes & letters
 - Referrals
 - Care plans
- PATIENT FOLLOW-UP**
 - SMS/recall drafting
 - Results explanations
 - Education materials
- PRACTICE MANAGEMENT**
 - Template creation
 - Data insights
 - Workflow automation

Start small. Choose one trusted tool. Test it. Build confidence. **Make AI your ally — not a distraction.**



AI should amplify the art of medicine — not replace it. Human connection remains the heart of healing.

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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.

07

CLOSER TO HOME

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.

AUSTRALIA 2026: THE CHANGES SHAPING GENERAL PRACTICE

Policy, funding and regulation shifts delivering real impact at the coalface.

A STRONGER HEALTH SYSTEM, CLOSER TO HOME

1 PBS REFORMS
\$25 PBS co-payment cap

- Applies to most PBS medicines from 1 Jan 2026
- Reduces out-of-pocket costs and improves adherence
- Supports up to 20 million prescriptions a year

2 LIVING GUIDELINES
Therapeutic Guidelines go 'living'

- Continuously updated online
- Faster access to new evidence
- Built for busy clinicians

3 VACCINATION EXPANSION
Shingrix (zoster)

- Now funded for all adults aged 65 and over
- Also for 18–64 year olds with increased risk conditions

4 WORKFORCE INVESTMENT
More GPs for the future

- 306 additional GP training places from 2026
- Rural pipeline and retention strengthened
- GP registrars = stronger communities

5 REGULATION & SAFETY FOCUS
TGA priorities sharpened

Medicinal cannabis quality & ad claims

Vapes & nicotine products crackdown

Weight-loss medicines promotion under scrutiny

Melatonin & other 'low-risk' products

What this means:

- Expect increased compliance oversight
- Evidence-based promotion only
- Patient safety comes first

WHAT THIS MEANS ON MONDAY MORNING

More affordable prescriptions for more patients

Greater role for pharmacists in care delivery

Up-to-date guidance at the point of care

Stronger oversight protects patients and clinicians

Continued investment in Australia's primary care future

— Dr Regu —
RECOVER, REBALANCE, REVIVE.

Evidence-based. Australian-focused. GP-practical.
Bringing global advances home to the Australian coalface.

The Clinical Briefing | Issue 01 • June 2026

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

what actually matters on Monday

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.