SLACPT NEWS

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SLACPT THEME 2025-2026

Personalized Medicine : Shaping the Future of Prescribing

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President's Message



Dear Colleagues and Friends,

I am delighted to share with you that ClinPharm 2026, the biennial conference of SLACPT, was successfully held on 6th and 7th August 2026. This year, the National Medicines Regulatory Authority (NMRA) joined us as a collaborator, which helped to increase the visibility of the conference. The plenaries and symposia were of a high standard and were well received by the attendees, particularly as they addressed areas highly relevant to the safe use of medicines but not widely discussed.

The lectures will be uploaded to our website and YouTube channel, and I invite all of you to share them widely.

I am also happy to share that the Ministry of Health has commenced work on the job description for Specialists in Clinical Pharmacology who will be attached to the Ministry. This is a welcome development and a positive step towards greater recognition of Clinical Pharmacology as a subspecialty.

We have completed most of the activities planned for this year and are now entering the final quarter of this Council's tenure. The AGM will be held on 14th December, from 12.00 pm at the Department of Pharmacology, Faculty of Medicine, University of Colombo. Please keep the date and time free and attend the AGM.

With best wishes,

Professor Chandanie Wanigatunge
President, SLACPT

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Cover Story

From treating diseases to treating individuals

Why do two patients with the same disease, receiving the same medicine at the same dose, sometimes experience very different outcomes? One may respond remarkably well, another may obtain little benefit, while a third develops an adverse reaction. The answer lies in the remarkable biological and clinical diversity between individuals.

Precision and personalised medicine is changing how we think about prescribing. Rather than relying solely on a “one-size-fits-all” approach, it brings together genetics, biomarkers, clinical characteristics, lifestyle, patient preferences and increasingly, artificial intelligence and big data, to identify the most appropriate treatment for an individual patient.

Pharmacogenomics is already demonstrating this potential. Genetic variation can influence the effectiveness and safety of commonly prescribed medicines, including statins, clopidogrel and warfarin. In the future, such information may increasingly help clinicians select the right medicine or dose before treatment begins.
But personalised medicine is about more than genes and technology. The patient must remain at its centre. Treatment success should reflect not only laboratory values and disease control, but also quality of life, functional outcomes and what matters most to patients and their families.

For Sri Lanka, the opportunities are significant, but so are the challenges. Genetic testing, advanced biomarkers and AI-supported technologies bring questions of affordability, accessibility and equity. Locally generated evidence, stronger pharmacovigilance, appropriate research and greater professional expertise will therefore be essential.

Personalised medicine should not replace rational prescribing, it should make it better. The challenge ahead is to combine robust population evidence with the unique characteristics and priorities of each patient.
The future of prescribing is ultimately about a simple principle: the right treatment, for the right patient, at the right time delivering meaningful benefit with the least possible harm

From Precision to Personalised Medicine: A Pharmacological Journey

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Department of Pharmacology, Faculty of Medicine, University of Ruhuna

Modern medicine has traditionally relied on evidence derived from populations. Clinical trials identify treatments that work for groups of patients with a particular disease. However, clinicians know that patients with the same diagnosis may respond very differently to the same medicine. Genetic variation, age, comorbidities, organ function, concomitant medicines, lifestyle and patient preferences can all influence treatment response.

Precision and personalised medicine seeks to address this variability by incorporating individual patient characteristics into decisions about prevention, diagnosis and treatment.

Moving beyond "one-size-fits-all"

Personalised medicine uses advances in genomics, biomarkers, data science and artificial intelligence (AI) to understand differences between patients. However, greater individualisation also creates challenges for rational prescribing.

Modern evidence is largely based on population-level clinical trials. As patients are divided into increasingly smaller biological subgroups, evidence may become less certain and treatments may become more expensive. Therefore, personalised medicine should not replace rational prescribing. Instead, population-level evidence should be combined with information about the individual patient, while maintaining consideration of efficacy, safety, cost and equity.

Pharmacogenomics: tailoring treatment to genetic variation

Pharmacogenomics is one of the most promising components of personalised medicine. Genetic differences can influence drug metabolism, transport and drug targets, resulting in differences in efficacy and adverse effects.

Examples include SLCO1B1 variants associated with statin-related myopathy, CYP2C19 variants influencing response to clopidogrel, and CYP2C9/VKORC1 variation affecting warfarin dose requirements.

For Sri Lanka, the challenge is translating this knowledge into clinical practice. Cost, access to genetic testing, limited outcome-based evidence and clinician awareness remain important considerations. A practical approach may be targeted pharmacogenomic testing in selected clinical situations, supported by local research.



AI and big data

Personalised medicine is not limited to genetics. Healthcare now generates enormous amounts of information through electronic health records, laboratory investigations, imaging, genomic data, wearable devices and lifestyle information. AI can analyse these complex datasets and potentially support diagnosis, drug discovery, treatment selection and personalised therapeutics.

However, technological capability must be balanced against concerns regarding data quality, privacy, bias, transparency and accountability. AI should support—not replace—clinical judgement.

The patient remains at the centre

Personalisation should not mean simply matching a drug to a genetic profile. It must also consider what matters to the patient.

Clinical outcomes such as laboratory values or disease control may not fully capture treatment success. In childhood epilepsy, for example, seizure control alone may not reflect developmental, psychological, social and quality-of-life outcomes. Patient and caregiver priorities therefore need to be incorporated into therapeutic decisions.

This principle applies across medicine: the best treatment is not necessarily the one producing the greatest change in a single biological measure, but the one that provides meaningful benefit to the individual patient.

The importance of local evidence

Precision medicine needs evidence that reflects the population in which it will be used. Investigator-initiated and phase 4 clinical research can provide valuable information about real-world effectiveness, safety, adherence, feasibility, acceptability and cost. This is particularly important in countries such as Sri Lanka, where patient characteristics and healthcare-system constraints may differ from those in large international trials.

Strengthening locally generated evidence should therefore be an important component of developing personalised medicine in Sri Lanka.

Pharmacovigilance remains essential

As treatment becomes more individualised, monitoring safety becomes increasingly important. Pharmacovigilance needs to move beyond a predominantly reactive approach towards proactive identification of safety signals using real-world data.

Clinicians have an important role through recognition and reporting of adverse drug reactions. Better safety data will ultimately allow treatment to become both more effective and safer.

Equity must not be forgotten

Advanced genomic testing, biomarkers and AI-supported technologies can be expensive. If access is determined primarily by ability to pay, precision medicine could widen existing healthcare inequalities.

For Sri Lanka, the emphasis should therefore be on evidence-based, clinically meaningful and affordable precision medicine. Technologies should be introduced where there is convincing evidence that they improve patient outcomes.

The future of prescribing

The prescription of the future may incorporate:

Genetic and pharmacogenomic information
Biomarkers
Previous treatment response
Comorbidities and concomitant medicines
Patient-reported outcomes
Lifestyle and environmental factors
Real-world safety data
AI-supported decision-making
Patient preferences and treatment goals



Yet the fundamental objective remains simple:
To provide the right treatment for the right patient at the right time, with the greatest meaningful benefit and the least acceptable harm.

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Conclusion

Precision and personalised medicine represent an important evolution in clinical pharmacology. Pharmacogenomics, AI, big data, biomarkers, real-world evidence and patient-centred outcomes provide new opportunities to individualise treatment.
However, personalised medicine should not replace rational prescribing. Rather, it should make rational prescribing more individualised, contextual and patient-centred.
For Sri Lanka, the way forward is to develop local research, strengthen pharmacovigilance, build expertise and introduce technologies where they demonstrate genuine clinical value.
The future of prescribing will therefore require a balance between population-level evidence and individual patient needs—ensuring that advances in technology ultimately translate into safer, more effective and more meaningful care.

References

ClinPharm 2026: Proceedings of the 6th Biennial Academic Sessions. Sri Lanka Association of Clinical Pharmacology and Therapeutics.

ClinPharm 2026 - Sixth Biennial Academic Sessions of Sri Lanka Association of Clinical Pharmacology and Therapeutics

ClinPharm 2026, the Biennial Scientific Conference of the Sri Lanka Association of Clinical Pharmacology and Therapeutics (SLACPT), was held on 6–7 August 2026 at the Academic Centre, Postgraduate Institute of Medicine (PGIM), Colombo, in collaboration with the National Medicines Regulatory Authority (NMRA). The conference was conducted under the theme "Personalised Medicine: Shaping the Future of Prescribing."



The conference focused on the evolving role of personalised medicine in clinical practice, particularly the integration of pharmacogenomics, artificial intelligence, big data, pharmacovigilance and evidence-based prescribing. The scientific programme brought together local and international experts through plenary lectures, symposia, oral presentations and poster presentations, with particular attention to translating emerging scientific advances into practical and contextually appropriate prescribing in Sri Lanka.

The conference provided a valuable platform for Sri Lankan clinical pharmacology and therapeutics research, with oral and poster presentations

Overall, ClinPharm 2026 highlighted the changing landscape of clinical pharmacology from conventional rational prescribing towards increasingly individualised, data-informed and patient-centred therapeutics. The proceedings demonstrate the importance of combining advances in precision medicine with pharmacovigilance, regulatory science, clinical research and consideration of local healthcare realities to improve the safe, effective and rational use of medicines in Sri Lanka.

SLACPT Presidential Induction 2025/2026 and the Inauguration Ceremony - ClinPharm 2026

The inauguration ceremony of ClinPharm 2026, the Biennial Scientific Conference of the Sri Lanka Association of Clinical Pharmacology and Therapeutics (SLACPT), was held on 6 August 2026 at the Academic Centre of the Postgraduate Institute of Medicine, Colombo. The conference was conducted under the theme “Personalised Medicine: Shaping the Future of Prescribing.”

The formal proceedings included the welcome address by Professor Shalini Sri Ranganathan, President-Elect of SLACPT, followed by the induction of the President, Professor Chandanie Wanigatunge, and her Presidential Address. The Past President’s Medal was also presented to Professor Priyadarshani Galappatthy, Immediate Past President, in recognition of her service to the Association.

The addresses by the Guest of Honour and Chief Guest highlighted the growing importance of personalised medicine, pharmacogenomics, data-driven healthcare and patient-centred prescribing. The inauguration was followed by the SLACPT Oration 2026, delivered by Professor Roshini Murugupillai on “Optimising Antiepileptic Therapy in Childhood Epilepsy: An Outcomes-Based Clinical Pharmacology Approach.”














ClinPharm 2026
6TH BIENNIAL ACADEMIC SESSIONS
ClinPharm 2026
"Personalised Medicine: Shaping the Future of Prescribing"
6TH & 7TH AUGUST 2026
Auditorium, Academic Centre,
PGIM, Colombo, Sri Lanka
In Collaboration with
National Medicines Regulatory Authority
NMRA










ClinPharm 2026







Address by the Chief Guest, Professor Selvanayagam Nirthanan





Address by the Guest of Honour, Emeritus Professor Gita Fernando

During the ceremony, Professor Chandanie Wanigatunge was inducted as President of the Sri Lanka Association of Clinical Pharmacology and Therapeutics for 2025/2026.









Induction of the President of the SLACPT 2025/2026, Professor Chandanie Wanigatunge





Presidential Address by Professor Chandanie Wanigatunge

The occasion also provided an opportunity to acknowledge the contribution of the outgoing leadership. The Past President's Medal was presented to Professor Priyadarshani Galappatthy, Immediate Past President, in recognition of her service to the Association.

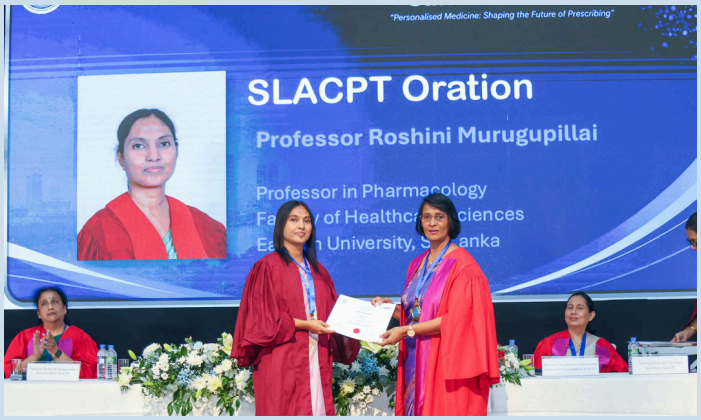




Award of Past President's Medal to Immediate Past President, Professor Priyadarshani Galappatthy









Professor Roshini Murugupillai delivered the SLACPT Oration on "Optimizing Antiepileptic Therapy in Childhood Epilepsy: An Outcome based Clinical Pharmacological Approach"

The ceremony represented both a celebration of the Association's continuing journey and a transition towards its next phase of leadership, providing an appropriate opening to a conference centred on the future of clinical pharmacology and therapeutics.













ClinPharm 2026

Shaping the Future of Prescribing Through Personalised Medicine

From “one-size-fits-all” to individualised prescribing

A major message emerging from ClinPharm 2026 was that personalised medicine offers considerable promise, but its implementation requires careful consideration of evidence, cost, equity and the realities of healthcare systems.

The discussions highlighted the importance of maintaining randomised evidence, population-level considerations, cost-effectiveness and health equity while developing more individualised approaches to treatment. This conference emphasised that the future need not be a choice between rational prescribing and personalised medicine; rather, rational prescribing itself may need to evolve within a precision-medicine framework.

This perspective is particularly relevant to Sri Lanka, where personalised medicine is still developing. The Chief Guest's message highlighted opportunities arising from pharmacogenomics, biomarker-guided therapy and data-driven decision-making, while also recognising challenges related to access, cost, infrastructure, workforce development and interdisciplinary collaboration.

AI, big data and the next generation of therapeutics

The opening plenary of the conference looked beyond genomics to the rapidly expanding role of artificial intelligence and big data.

This plenary on “AI, Big Data and Personalised Therapeutics: Transforming Modern Medicine” examined the potential of integrating genomic and multi-omic information with medical imaging, electronic health records, wearable-device data and lifestyle information. Such integration may enable increasingly sophisticated approaches to drug discovery and personalised therapeutics. At the same time, the speaker emphasised that ethical, technical and operational challenges must be addressed, with clinicians retaining an essential role in ensuring that these technologies are used safely, effectively and equitably.

Thus, the conference presented AI not simply as a technological innovation, but as a developing component of clinical decision-making that will require appropriate human oversight, evidence and responsible implementation.

Pharmacogenomics: from evidence to action

One of the most directly relevant sessions to the conference theme was “From Evidence to Action: Implementing Pharmacogenomics in Sri Lanka.”

The speaker described clinically relevant genetic variation affecting drug metabolism, transport and pharmacodynamic targets, with examples involving SLCO1B1 and statin-associated myopathy, CYP2C19 and clopidogrel response, and CYP2C9/VKORC1 variation and warfarin dosing.

These examples demonstrate how genetic variability can contribute to differences in therapeutic response and adverse effects.

Importantly, the discussion moved beyond scientific discovery towards implementation. Limited access to testing, cost, insufficient outcome-based evidence and gaps in clinician awareness were identified as barriers. Targeted testing in selected high-risk situations, population-specific prescribing guidance, integration into clinical workflows, research and education were identified as potential pathways towards implementation.

Pharmacovigilance: moving from reaction to prevention

Patient safety was another prominent theme. The symposium “Pharmacovigilance: From Signals to Safety” addressed both the current state and future direction of pharmacovigilance in Sri Lanka.

The sessions highlighted the importance of strengthening adverse drug reaction reporting and moving from predominantly reactive pharmacovigilance towards proactive safety monitoring. Practical aspects of adverse drug reaction assessment, causality evaluation and regulatory decision-making were also discussed, including the role of the NMRA's Pharmacovigilance Division.

The session on drug reactions further emphasised the clinical challenge of determining whether a medicine is genuinely responsible for a patient's symptoms, particularly in the presence of polypharmacy, comorbidities and alternative explanations.

Prescribing across the life course

Personalised prescribing was also examined through the lens of age and physiological development. The symposium “Prescribing Across the Ages: Challenges When Resources are Limited” addressed neonatal, adolescent and geriatric therapeutics.

The discussions highlighted how the same prescribing principles cannot simply be applied uniformly across the life course. Neonates present challenges related to immature physiology, dosing uncertainty and off-label medicine use. Adolescents require consideration of developmental, psychosocial and adherence-related factors, while older adults present complex problems related to multimorbidity, frailty, polypharmacy, drug interactions and treatment burden.

This reinforced an important message of ClinPharm 2026: personalisation is not synonymous with genomics alone; it also means understanding the individual patient, their age, physiology, circumstances, preferences and treatment goals.

Translating research into local clinical practice

The conference provided an important platform for Sri Lankan clinical research. The programme included five oral presentations and eight poster presentations, covering diverse topics including dengue management, medicine regulation, medication adherence, clinical pharmacy services in hypertension, antibiotic consumption, adverse drug reactions, paracetamol overdose, self-medication, antiseizure medicines, complementary and alternative medicine, drug interactions and medication adherence in cirrhosis.

Several presentations demonstrated the practical nature of clinical pharmacology research. The oral presentation on clinical pharmacy services and blood pressure control, for example, explored whether pharmacist-led medication reconciliation and counselling could improve hypertension care. Other work addressed antibiotic consumption using the WHO AWaRe framework, medication adherence, dengue treatment practices and medicine regulatory processes.

The poster programme further demonstrated the breadth of clinical pharmacology—from individual adverse drug reactions and drug-induced neurological complications to overdose, self-medication, antiseizure medication safety and complex drug–drug interactions.

Regulation, evidence and emerging health products

The final symposium, “Borderline Products: Science, Regulation and Practice,” broadened the discussion beyond conventional medicines. Nutrition supplements, vitamins, nutraceuticals and other emerging health products increasingly occupy a space between food and medicine, creating challenges for scientific substantiation, classification and regulation.

The sessions emphasised the importance of credible evidence for health claims, clear regulatory pathways, collaboration between regulators and industry, digitalisation, regulatory harmonisation and proportionate post-market surveillance.

This was particularly pertinent to the overarching theme of rational prescribing: individualised and preventive healthcare can only be effective when the products and interventions offered to patients are supported by reliable evidence and appropriate regulatory oversight.

Looking towards the future

Taken together, the ClinPharm 2026 proceedings portray a discipline at an important point of transition. Clinical pharmacology is expanding beyond traditional questions of drug efficacy and adverse effects towards a broader model incorporating genomic information, AI, real-world data, pharmacovigilance, patient-centred outcomes and health-system considerations.

At the same time, the proceedings caution against viewing technological advancement as an end in itself. Personalised medicine must remain grounded in evidence, affordability, equity, patient preferences and local healthcare priorities. The Chief Guest's message particularly emphasised the opportunity for Sri Lanka to develop a model of personalised medicine that is evidence-based and contextually relevant, rather than simply replicating approaches developed elsewhere.

ClinPharm 2026 therefore served not only as a forum for presenting scientific advances, but also as a platform for considering how these advances can be translated into everyday prescribing. Its central message can be summarised simply: the future of prescribing will be increasingly personalised, data-informed and technology-enabled—but it must remain clinically grounded, scientifically rigorous and centred on the patient.

Source: ClinPharm 2026 Book of Proceedings, Sri Lanka Association of Clinical Pharmacology and Therapeutics, in collaboration with the National Medicines Regulatory Authority.

Highlights from ClinPharm 2026

Plenary 1 - AI, Big Data and Personalised Therapeutics: Transforming Modern Medicine - Delivered by Dr Nirmala Wijekoon







Symposium 1 - Pharmacovigilance: From Signals to Safety

Speakers:
Professor Rohini Fernandopulle - Pharmacovigilance in Sri Lanka: Current to Future
Ms. D. D. Udeshika Wijerathna - When an Adverse Drug Reaction occurs: Practical aspects of Pharmacovigilance
Dr. Rajiva de Silva - “Drug Reactions”- Is the drug the culprit?













Plenary 2 - Challenges and opportunities of investigator-initiated phase 4 clinical trials - Delivered by Professor Jithangi Wanigasinghe







Plenary 3 - From Evidence to Action: Implementing Pharmacogenomics in Sri Lanka - Delivered by Professor Priyanga Ranasinghe







Symposium 2 - Prescribing Across the Ages: Challenges when resources are limited

Speakers
Professor Nishani Lucas - Challenges in Neonatal Therapeutics
Dr Navoda Atapattu - Challenges in Prescribing for Adolescents
Dr Maheshi Wijayabandara - Challenges in Prescribing for the Elderly

















Symposium 3 - Borderline Products: Science, Regulation and Practice

Speakers:
Dr. Renuka Jayatissa - Advancing Scientific Evidence and Claims Validation: Ensuring Credibility, Compliance, and Consumer Trust
Ms. Wasana Welipitiya - Navigating Industry and Regulatory Bottlenecks: Strategies for Efficient Product Development and Market Access
Mr. Arjuna Pathmaperuma - Addressing Classification Challenges in Emerging Health and Consumer Products: Regulatory and Practical Perspectives













Free Paper Session - Oral Presentations

















Free Paper Session - Poster Presentations

















ClinPharm 2026 - Award Ceremony





Best Oral Presentation



Best Poster Presentation



SLACPT Inter Medical Faculty Pharmacology Quiz 2025 Champions

SLACPT Inter Medical Faculty Pharmacology Quiz 2026 Champions




Runners-Up
University of Peradeniya
DKHY Dassanayake
SMPD Samaraweera
DSDP Hettithantri
HBIP Wijesinghe


ClinPharm 2026
"Personalised Medicine: Shaping the Future of Prescribing"
Runners-Up
University of Colombo
Samagra Abeysena
Ashvni Chandrakumar
Jeyasharan Jeiyaseelan


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ClinPharm 2026
6TH & 7TH AUGUST 2026
Auditorium, Academic Centre,
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National Medicines Regulatory Authority

ClinPharm 2026 was successfully completed as a comprehensive academic forum for advancing clinical pharmacology and therapeutics in Sri Lanka. The conference brought together contemporary developments in personalised medicine with locally relevant research, clinical experience and regulatory perspectives, promoting knowledge exchange, collaboration and evidence-based, safe, rational and increasingly individualised prescribing.

Special appreciation is extended to the National Medicines Regulatory Authority (NMRA), the collaborative partner of SLACPT, for its valuable support and contribution to the successful conduct of ClinPharm 2026. The partnership brought together academic, clinical and regulatory perspectives and strengthened the conference's focus on medicine safety, pharmacovigilance and responsible medicines use.

The success of ClinPharm 2026 was made possible through the dedication of the SLACPT Council, Scientific Committee, Abstract Review Committee and judges, technical and administrative support staff, members of the SLACPT and the entire pharmacology academic family across the country. Their collective commitment and contribution made ClinPharm 2026 a successful celebration of academic excellence, scientific integrity and the advancement of clinical pharmacology and therapeutics in Sri Lanka.

GLP-1–Based Therapies in Sri Lanka: Where Are We Now?

Mendis SA
Department of Pharmacology, Faculty of Medicine, University of Ruhuna

The rapid global rise of GLP-1–based therapies has begun to make its mark on clinical practice in Sri Lanka. Drugs such as semaglutide and tirzepatide have moved beyond their traditional role in diabetes management and are increasingly being discussed in the context of obesity, metabolic disease and weight management.

The important question for Sri Lankan clinicians is no longer whether these medicines are available, but rather which products are accessible, how they are being used, and whether their use is occurring within an appropriate evidence-based and regulated framework.

From diabetes treatment to metabolic medicine

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) improve glucose-dependent insulin secretion, suppress glucagon secretion, delay gastric emptying and reduce appetite. Their effects on body weight have transformed the therapeutic landscape of both type 2 diabetes and obesity [1].

The newer generation of drugs has expanded this further. Semaglutide is a GLP-1 receptor agonist, while tirzepatide is a dual GIP/GLP-1 receptor agonist. Internationally, semaglutide and tirzepatide have demonstrated substantially greater weight reduction than earlier GLP-1 agents.

This evolution is particularly relevant to Sri Lanka, where diabetes, obesity, cardiovascular disease and metabolic-associated fatty liver disease constitute an increasing clinical burden.

What products are available in Sri Lanka?

The Sri Lankan landscape appears to include several GLP-1–based products, although availability in the market should not automatically be equated with current NMRA registration or consistent pharmacy supply.

Dulaglutide, semaglutide, liraglutide and tirzepatide have all been discussed in recent Sri Lankan professional publications [2].
Semeglutide tablets are available in Sri Lanka, registered under NMRA which is marketed by a local manufacturer [3].

Importantly, however, clinicians should distinguish between registration, commercial availability, actual stock at a particular pharmacy and medicines being brought into the country through personal-import mechanisms. The NMRA states that medicines that are not registered or are unavailable in Sri Lanka can, under specified circumstances, be imported for personal use with appropriate documentation and a personal-user authorisation.

The arrival of obesity pharmacotherapy in Sri Lanka

Perhaps the most significant development is that GLP-1–based therapy is no longer being discussed solely as a diabetes intervention.

The National Guideline on Obesity Management – 2025 explicitly includes GLP-1 receptor agonists and dual GIP/GLP-1 receptor agonists among pharmacological options for adults with appropriate BMI categories or obesity-related metabolic complications when lifestyle intervention alone is insufficient [4]. The guideline is intended for use across Sri Lanka, including primary care, NCD clinics, endocrinology and bariatric services.

This represents an important conceptual change. Obesity is increasingly being approached as a chronic metabolic disease requiring long-term management rather than simply as a consequence of lifestyle choices.

How extensively are these medicines being prescribed?

This is perhaps the most difficult question to answer.

There do not appear to be publicly available national Sri Lankan data quantifying prescriptions or consumption of individual GLP-1–based medicines. Consequently, it would be inappropriate to state that a particular number or percentage of Sri Lankan patients are receiving semaglutide or tirzepatide.

Nevertheless, several indicators suggest that use is increasing.

First, these medicines are being incorporated into Sri Lankan professional discussions and obesity-management guidance.

Second, there is growing evidence of private-sector clinical use, particularly in endocrinology and weight-management settings. For example, Sri Lankan private clinical services are now publicly advertising physician-supervised tirzepatide-based weight-management programmes.

Third, consumer interest appears substantial. Recent Sri Lankan online discussions specifically refer to commonly available labels being used for weight reduction, with individuals discussing obtaining these medicines through private medical practitioners. These reports are anecdotal and cannot be interpreted as prescription-volume data, but they do demonstrate considerable public awareness and demand,

The affordability issue

The cost of these medicines is likely to be one of the strongest determinants of their use in Sri Lanka.

Unlike metformin, sulfonylureas and many other established diabetes medicines, GLP-1–based therapies remain relatively expensive and are generally accessed through the private sector. Anecdotal reports from Sri Lankan users suggest monthly costs ranging from tens of thousands of rupees to well over LKR 100,000 depending on the drug, dose and source. Such figures should not be interpreted as official Sri Lankan retail prices, but they illustrate the economic barrier to long-term treatment.

This creates an important equity issue. A therapy that may be clinically appropriate for a patient with obesity and diabetes may nevertheless be financially unsustainable for long-term use.

The problem of informal supply

The increasing popularity of GLP-1 medicines also creates a potential patient-safety problem.

Social-media discussions indicate that some Sri Lankan patients seek these medicines outside conventional medical channels. There have also been recent reports raising concerns about some labels circulating through informal channels without reliable cold-chain assurance. These reports have not been independently established as representing the entire market, but they highlight a genuine concern with injectable biological medicines.

Where does Sri Lanka stand?

The current picture can therefore be summarised as follows:

GLP-1–based therapy has arrived in Sri Lanka, but the market is still evolving.

There is documented availability and professional discussion of dulaglutide, liraglutide, semaglutide and tirzepatide, with semaglutide and tirzepatide attracting particularly strong interest because of their effects on body weight.

However, we currently lack robust national prescription or utilisation data that would allow us to say how many Sri Lankan patients are receiving these medicines, what proportion receive them for diabetes versus obesity, or how rapidly prescribing is increasing.

Conclusion

The GLP-1 era has clearly reached Sri Lanka. Dulaglutide, liraglutide, semaglutide and tirzepatide are now part of the local clinical conversation, while semaglutide and tirzepatide are generating particular interest because of their weight-loss effects. Sri Lanka's 2025 obesity guideline formally recognises GLP-1 and dual GIP/GLP-1 therapies as options within appropriate obesity management.

The increasing demand, private-sector availability and substantial cost suggest that these medicines are becoming increasingly visible in clinical practice, but their true penetration into Sri Lankan medicine remains to be measured.

For Sri Lankan clinicians, the priority should therefore be neither enthusiasm nor resistance, but appropriate patient selection, evidence-based prescribing, reliable product sourcing and careful long-term follow-up.

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Intravenous Fluid Therapy: Safe and Appropriate Use

Based on the Guidelines of the Australian Commission on Safety and Quality in Health Care 2026

Intravenous (IV) fluid therapy is among the most frequently used interventions in acute clinical care. It is often perceived as a simple prescription choose a fluid, specify a volume and rate, and commence an infusion. Yet IV fluids are a complex, high-risk clinical therapy that can cause significant harm when they are prescribed, administered or continued without a clear clinical indication.

The Guidance for Intravenous Fluid Therapy: Principles for Safe, Appropriate and Sustainable Use provides a useful framework for changing this approach. Its central message is straightforward: IV fluids should be prescribed with the same care and attention as any other medicine.

Start with a clinical question

Before prescribing an IV fluid, clinicians should ask: Why does this patient need IV fluid?

IV fluids may be required for resuscitation, replacement of ongoing losses, maintenance or hydration, or as a vehicle for administering medicines when the oral or enteral route is unsuitable. However, IV therapy should not be initiated simply because a patient is admitted to hospital, is fasting, or is unable to maintain oral intake temporarily.

The first consideration should be whether oral intake can adequately meet the patient's requirements. When IV therapy is being considered for medicine administration, an effective and safe oral alternative should also be considered.



Once the need for IV therapy has been established, the indication or clinical intent should be clearly defined. Is the purpose resuscitation, replacement, maintenance, hydration or medication administration? The answer should determine the type, volume, rate and duration of therapy.

Individualise the prescription

There is no single IV fluid regimen suitable for every patient. Fluid requirements depend on the patient's haemodynamic status, ongoing losses, electrolyte concentrations, renal function, cardiac and respiratory disease, age, weight, pregnancy and other comorbidities. Oral or enteral intake, IV medicines, nutrition and blood products must also be considered as part of the patient's total fluid and electrolyte balance.

This is particularly important in patients at increased risk of fluid-related complications. Children are more susceptible to electrolyte disturbances, particularly hyponatraemia, and hypotonic fluids should generally be avoided in routine situations. Patients undergoing surgery require careful attention to both fluid deficit and fluid overload. Pregnancy increases susceptibility to fluid overload, while older adults and patients with cardiac or renal disease often require more cautious and individualised therapy.

The message is therefore clear: fluid therapy should be patient-specific rather than protocol-driven by default.

Choosing the right fluid

Understanding the basic properties of IV fluids remains essential.

Crystalloids contain electrolytes and/or glucose and can be broadly considered according to tonicity and electrolyte composition. Balanced crystalloids more closely approximate plasma electrolyte composition, whereas unbalanced solutions such as 0.9% sodium chloride contain a higher chloride concentration. Large volumes of 0.9% sodium chloride may contribute to hyperchloraemia and metabolic acidosis.

The guidance notes that commonly used isotonic crystalloids—including balanced solutions and 0.9% sodium chloride—may be appropriate for short-term therapy in clinically stable patients without major ongoing losses, electrolyte disturbances or significant comorbidities. Where larger volumes or prolonged therapy are anticipated, balanced crystalloids may be preferred because of their lower chloride content and reduced risk of metabolic disturbance.

Glucose-containing solutions have different clinical roles and should not be considered substitutes for resuscitation fluids. Once glucose is metabolised, these solutions behave as free water and do not provide effective intravascular volume expansion. They may also contribute to hyponatraemia.

Colloids have a limited role in routine IV fluid therapy, and synthetic colloids such as hydroxyethyl starch are associated with safety concerns and are restricted or not recommended in many settings.

Prescribe deliberately and document clearly

One of the most important practical recommendations is that IV fluid prescriptions should contain sufficient information to communicate the clinical plan.

The prescription should specify:
Fluid type
Volume and rate
Clinical indication or goal
Intended duration, where appropriate
Monitoring requirements
Criteria for reassessment,
Criteria for modification or cessation



Poor documentation creates a particular problem during weekends, overnight periods and transitions of care.

When the indication and stopping criteria are unclear, IV fluids can simply continue because nobody has actively decided to stop them. This phenomenon, continuation by default, is one of the recurring problems identified in IV fluid prescribing.

Review: "Does the patient still need it?"

Starting an IV infusion should never be regarded as the end of the prescribing decision.
IV fluid therapy requires ongoing reassessment. The patient's clinical response, fluid status, laboratory parameters and potential adverse effects should be reviewed. Particular attention should be paid to fluid overload, electrolyte abnormalities and complications related to IV access.
At every review, clinicians should make an active decision:
Continue – Adjust – or Stop.

If IV therapy is no longer required, it should be stopped promptly. Where clinically appropriate, patients should be transitioned to oral hydration and oral medicines, and unnecessary IV access devices should be removed.
This simple approach has implications not only for patient safety but also for patient comfort and responsible use of healthcare resources.

Safe administration matters

Correct prescribing is only one part of safe IV therapy.
Administration requires attention to the correct fluid, correct patient, correct dose, correct time and correct route, together with appropriate labelling, infection prevention and management of vascular access. The guidance also highlights the value of infusion pumps, where possible, to improve accuracy and control of infusion rates.
When IV fluids are used to administer medicines, compatibility becomes particularly important. Clinicians should consider compatibility between the medicine and fluid, the IV container or bag, and the giving set, as well as the total volume of fluid contributed by multiple IV medicines.

IV fluid therapy is a team responsibility

Safe fluid management cannot be achieved by the prescriber alone.
Prescribers determine the indication, goals and stopping criteria and lead the transition from IV to oral therapy. Nurses and midwives monitor clinical response, fluid balance and IV access sites and play a central role in safe administration. Pharmacists contribute to medicines safety, compatibility advice, electrolyte monitoring and IV-to-oral transition. Senior clinicians provide oversight and clinical governance.
Patients should also be involved in decisions about IV therapy wherever possible. Good communication ensures that the clinical team shares a common understanding of why IV fluids are being given and when they should be stopped.

A culture of stewardship

The guidance places IV fluid therapy within the broader concept of clinical governance and stewardship.
Healthcare organisations can improve practice by establishing systems for regular review, providing education and prescribing tools, monitoring IV fluid-related incidents and supporting multidisciplinary review. Electronic clinical decision support and real-time monitoring systems may also help standardise practice and improve oversight where such technology is available.

For clinicians, however, the most important change may be cultural rather than technological: IV fluids should no longer be regarded as a benign background therapy. They are medicines—and should be prescribed, monitored and discontinued accordingly.

A practical message for clinical practice

The principles can be condensed into six simple actions:

1. Confirm the need – Can the patient meet their requirements orally or enterally?
2. Define the goal – Is the purpose resuscitation, replacement, maintenance, hydration or medicine administration?
3. Select appropriately – Consider the patient's clinical condition, fluid status, electrolytes, comorbidities and the properties of the available fluid.
4. Prescribe clearly – Specify fluid, volume, rate, indication, duration and monitoring requirements.
5. Review regularly – Assess response, fluid balance, laboratory parameters and complications.
6. Stop or switch promptly – When IV therapy is no longer required, transition to oral therapy where appropriate and remove unnecessary IV access.

These principles reflect the core message of the guidance: start appropriate IV fluids only when there is a clear clinical indication, stop them when they are no longer required, and modify therapy according to the patient's response.

Conclusion

IV fluid therapy may be routine, but it should never be automatic. Every bag of fluid represents a clinical intervention with potential benefits and potential harms.

Ask why. Choose carefully. Prescribe clearly. Review regularly. Stop promptly.

This shift from routine administration to deliberate, individualised and continually reviewed therapy is central to safer IV fluid use and to better clinical pharmacology practice.

Reference

Australian Commission on Safety and Quality in Health Care. Intravenous fluid therapy: Principles for safe, appropriate and sustainable use. Sydney: ACSQHC; 2026

Drug Information Summary

Chlorthalidone

Generic name: Chlorthalidone
Drug class: Thiazide-like diuretic
Route: Oral
Main clinical uses: Hypertension; oedema associated with congestive heart failure, cirrhosis, renal disease and some drug-related fluid retention.

Introduction

Chlorthalidone is a long-acting oral diuretic with antihypertensive activity. According to the current FDA prescribing information, chlorthalidone is indicated for the treatment of hypertension in adults. Reduction of blood pressure decreases the risk of fatal and non-fatal cardiovascular events, particularly stroke and myocardial infarction.

Chlorthalidone may be used alone or in combination with other antihypertensive medicines. The FDA label emphasizes that hypertension management should form part of comprehensive cardiovascular risk reduction, including appropriate management of lipids and diabetes, smoking cessation, exercise and dietary sodium restriction.

Mechanism of action

Chlorthalidone is described as a long-acting oral diuretic. It increases the urinary excretion of sodium and chloride, with its principal site of action appearing to be the cortical diluting segment of the ascending limb of the loop of Henle.

Its diuretic effect produces reductions in extracellular fluid volume, plasma volume and cardiac output, with reductions in total exchangeable sodium. Sodium and water depletion are considered to contribute to its antihypertensive effect.

The diuretic effect begins at a mean of approximately 2.6 hours after administration and may continue for up to 72 hours. The FDA label notes dose-related reductions in serum potassium and increases in serum uric acid and blood glucose, together with possible reductions in serum sodium and chloride.

Dosage and administration

The recommended adult starting dose is:
12.5 mg or 25 mg orally once daily
The dose may be doubled after 2–4 weeks, according to individual patient response.
The maximum recommended dose is 100 mg once daily.
Doses above 100 mg daily generally do not provide additional effectiveness.
Therapy should be initiated with the lowest possible dose.

Important safety considerations

1. Acute kidney injury

Chlorthalidone can cause hypovolaemia, which may precipitate acute kidney injury. Patients with chronic kidney disease, heart failure or volume depletion may be at particular risk.

Kidney function should therefore be monitored periodically. The FDA label recommends considering withholding or discontinuing treatment when a clinically significant deterioration in kidney function develops during therapy.

2. Electrolyte disturbances
Chlorthalidone may cause:
Hypokalaemia
Hyponatraemia
Hypochloraemic alkalosis
Hypomagnesaemia
Hypokalaemia is dose-dependent. Hypomagnesaemia may contribute to hypokalaemia that is difficult to correct despite potassium replacement.
Serum electrolytes should be assessed before treatment and monitored periodically during therapy.

3. Metabolic effects
Chlorthalidone may:
Increase blood glucose and alter diabetes control
Alter requirements for antidiabetic medication
Increase serum cholesterol and triglycerides
Increase serum uric acid
Precipitate or exacerbate gout in susceptible individuals
Increase serum calcium because of reduced urinary calcium excretion
The increase in serum uric acid is dose-related. Blood glucose and lipid concentrations should be monitored, while calcium monitoring is advised in patients with hypercalcaemia receiving chlorthalidone.

Adverse drug reactions
Electrolyte abnormalities and metabolic disturbances are the most frequently expected adverse drug reactions associated with thiazide-like diuretics.
Other adverse reactions reported with chlorthalidone include:
Gastrointestinal: anorexia, gastric irritation, nausea, vomiting, abdominal cramping, diarrhoea, constipation, cholestatic jaundice and pancreatitis.
Neurological: dizziness, paraesthesia and headache.
Haematological: leukopenia, agranulocytosis, thrombocytopenia and aplastic anaemia.
Dermatological/hypersensitivity: purpura, photosensitivity, rash, urticaria, cutaneous vasculitis and toxic epidermal necrolysis.
Cardiovascular: orthostatic hypotension.
Other reported reactions include muscle spasm, weakness, restlessness, impotence and xanthopsia.

Clinically important drug interactions

Lithium

Chlorthalidone reduces renal clearance of lithium and can consequently increase the risk of lithium toxicity. Serum lithium concentrations should be monitored when the medicines are used concomitantly.

Antidiabetic medicines

Insulin requirements may increase, decrease or remain unchanged. Patients receiving oral hypoglycaemic agents may require dose adjustment.

Tubocurarine

Chlorthalidone may increase responsiveness to tubocurarine.

Norepinephrine

Chlorthalidone may decrease arterial responsiveness to norepinephrine, although the FDA label states that this reduction is not sufficient to preclude its therapeutic effectiveness.

Special populations

Pregnancy

Available observational data and reports over several decades have not identified a drug-associated risk of major birth defects or miscarriage. However, adverse fetal or neonatal outcomes, including jaundice, thrombocytopenia, hypoglycaemia and electrolyte abnormalities, have been reported with maternal use of thiazide diuretics.

The FDA label states that chlorthalidone should not be used as first-line therapy for hypertension during pregnancy and advises counselling regarding potential fetal risk.

Lactation

Chlorthalidone is present in human milk. Because of the potential for accumulation and serious adverse reactions in the breastfed infant, including jaundice, thrombocytopenia, hyperglycaemia and electrolyte abnormalities, the FDA label advises that breastfeeding is not recommended during treatment.

Paediatric patients

Safety and effectiveness in children have not been established.

Older adults

Dose selection should be cautious and generally begin at the lower end of the dosing range. Particular attention should be given to renal function because chlorthalidone is substantially excreted by the kidneys and older adults are more likely to have impaired renal function.

Hepatic impairment

Changes in fluid and electrolyte balance may precipitate hepatic coma in patients with impaired hepatic function or progressive liver disease.

Contraindications

Chlorthalidone is contraindicated in:

Anuria

Hypersensitivity to chlorthalidone or other sulfonamide-derived drugs

Pharmacokinetic highlights

Approximately 75% of chlorthalidone is plasma-protein bound, with about 58% bound to albumin. The drug has a relatively long plasma half-life of approximately 40–60 hours. Chlorthalidone is eliminated primarily as unchanged drug in the urine.

Overdose

Acute overdose may produce:

Nausea, Weakness, Dizziness, Electrolyte disturbances

There is no specific antidote. The FDA label describes supportive treatment, including gastric lavage and, where necessary, intravenous dextrose-saline with potassium administered cautiously.

Key messages for clinical practice

Chlorthalidone remains an important long-acting oral diuretic for adult hypertension. Its prolonged diuretic activity is accompanied by clinically important risks of electrolyte and metabolic disturbances.

When prescribing chlorthalidone, clinicians should particularly consider:

1. Start low and titrate according to response, with the FDA-recommended starting dose of 12.5 or 25 mg once daily.
2. Monitor renal function, particularly in patients with chronic kidney disease, heart failure or volume depletion.
3. Monitor serum electrolytes, especially potassium, sodium and magnesium.
4. Consider metabolic effects, including hyperglycaemia, dyslipidaemia and hyperuricaemia.
5. Exercise caution in patients with gout or hyperuricaemia.
6. Monitor patients receiving lithium because of the increased risk of lithium toxicity.
7. Consider the specific recommendations for pregnancy, lactation, older adults and hepatic impairment.
8. Educate patients regarding symptoms suggestive of potassium depletion, including excessive thirst, fatigue, drowsiness, restlessness, muscle pain or cramps, nausea, vomiting and increased heart rate or pulse.

Source

U.S. Food and Drug Administration. Chlorthalidone tablets, for oral use. Full Prescribing Information. Revised March 2025.

Drug Information Summary

Ranolazine

Generic name: Ranolazine
Drug class: Add-on antianginal
Route: Oral
Main clinical uses: Stable angina

Introduction

Ranolazine is an antianginal medicine indicated in adults as add-on therapy for the symptomatic treatment of stable angina pectoris in patients who are inadequately controlled by, or intolerant to, first-line antianginal therapies such as beta-blockers and/or calcium antagonists.

Unlike conventional antianginal agents that primarily act through changes in heart rate, blood pressure or vascular tone, ranolazine's antianginal effects are considered to be related to modulation of intracellular ionic balance during myocardial ischaemia. Importantly, the product information notes that its effects do not depend upon reductions in heart rate, blood pressure or vasodilation.

Mechanism of action

The precise mechanism of action of ranolazine is largely unknown. It may exert antianginal effects through inhibition of the late sodium current (late INa) in cardiac cells.

Inhibition of the late sodium current reduces intracellular sodium accumulation and consequently reduces intracellular calcium overload. This is expected to improve myocardial relaxation and reduce left ventricular diastolic stiffness during ischaemia.

These effects occur without clinically important reductions in heart rate or blood pressure. Controlled studies reported mean reductions in heart rate of less than 2 beats/minute and systolic blood pressure of less than 3 mmHg.

Indication

Ranolazine is indicated for:

Add-on symptomatic treatment of stable angina pectoris in adults who are inadequately controlled or intolerant to first-line antianginal therapy.

The product information specifically identifies beta-blockers and/or calcium antagonists as examples of first-line antianginal therapies.

Dosage and administration

Ranolazine is available as prolonged-release tablets containing 375 mg, 500 mg and 750 mg.

Recommended adult regimen

Initial dose: 375 mg twice daily

After 2–4 weeks: increase to 500 mg twice daily

Depending on clinical response, the dose may be increased to a maximum of 750 mg twice daily.

If treatment-related adverse effects such as dizziness, nausea or vomiting occur, the dose may be reduced to 500 mg or 375 mg twice daily.
If adverse effects persist despite dose reduction, treatment should be discontinued.
Dose titration should be undertaken cautiously in patients receiving moderate CYP3A4 or P-glycoprotein inhibitors and in patients with renal or hepatic impairment.

Administration
Ranalozine prolonged-release tablets should be swallowed whole and should not be crushed, broken or chewed. They may be taken with or without food.

Contraindications
Ranolazine is contraindicated in patients with:
Hypersensitivity to ranolazine or any of the excipients
Severe renal impairment — creatinine clearance <30 mL/min
Moderate or severe hepatic impairment
Concomitant use of potent CYP3A4 inhibitors, including itraconazole, ketoconazole, voriconazole, posaconazole, HIV protease inhibitors, clarithromycin, telithromycin and nefazodone
Concomitant use of Class Ia antiarrhythmics, such as quinidine, or Class III antiarrhythmics, such as dofetilide or sotalol, other than amiodarone.

Important safety considerations
1. QT interval prolongation
One of the most clinically important considerations with ranolazine is its effect on cardiac repolarisation.
Ranolazine blocks the IKr potassium current and prolongs the QTc interval in a dose- and plasma concentration-dependent manner. The product information estimates an increase of approximately 2–7 ms across the plasma concentration range associated with 500–1000 mg twice-daily dosing.
Caution is therefore advised in patients with:
Congenital or familial long-QT syndrome
Known acquired QT prolongation
Concomitant medicines that prolong the QT interval
Co-administration with other QT-prolonging medicines may theoretically increase the risk of ventricular arrhythmias. Examples listed in the product information include certain antihistamines, antiarrhythmics, erythromycin and tricyclic antidepressants.

2. Renal impairment
Renal function should be checked regularly during treatment, particularly because renal function tends to decline with age.
Careful dose titration is recommended in mild to moderate renal impairment (creatinine clearance 30–80 mL/min), whereas ranolazine is contraindicated when creatinine clearance is below 30 mL/min.
Exposure to ranolazine is increased in renal impairment, with the product information reporting approximately 1.7- to 2-fold higher AUC in subjects with renal impairment compared with those with normal renal function.

3. Hepatic impairment
Dose titration should be undertaken cautiously in mild hepatic impairment.
Ranolazine is contraindicated in moderate or severe hepatic impairment. Exposure is increased in moderate hepatic impairment, and QT prolongation is more pronounced in this population.

4. Elderly and low body weight
Caution is required when titrating ranolazine in older adults and patients weighing ≤60 kg, because adverse events and/or drug exposure may be increased.
Patients aged ≥75 years experienced adverse events more frequently than younger patients in the reported data.

5. Heart failure
Dose titration should be undertaken cautiously in patients with moderate to severe congestive heart failure (NYHA class III–IV). These patients may have increased ranolazine exposure.

Important drug interactions
Ranolazine has several clinically important pharmacokinetic interactions.
CYP3A4 inhibitors
Ranolazine is a CYP3A4 substrate. CYP3A4 inhibitors increase ranolazine plasma concentrations and may increase dose-related adverse effects.
Potent CYP3A4 inhibitors are contraindicated. Ketoconazole, for example, increased ranolazine exposure by approximately 3.0–3.9-fold.

Moderate CYP3A4 inhibitors, including:
Diltiazem
Erythromycin
Fluconazole
require careful dose titration, and down-titration of ranolazine may be necessary.

P-glycoprotein inhibitors
Ranolazine is also a P-glycoprotein substrate. P-gp inhibitors such as verapamil and ciclosporin increase ranolazine concentrations, requiring careful dose titration.

CYP3A4 inducers
CYP3A4 inducers can markedly reduce ranolazine exposure and may result in loss of efficacy.

Rifampicin decreased steady-state ranolazine concentrations by approximately 95%. Ranolazine should therefore not be used with CYP3A4 inducers such as rifampicin, phenytoin, phenobarbital, carbamazepine or St John's Wort.

Effects on other medicines

Ranolazine can inhibit P-gp and CYP3A4 and may therefore increase concentrations of their substrates.

Clinically important examples include:

Simvastatin: Ranolazine approximately doubled simvastatin exposure. The product information recommends limiting simvastatin to 20 mg once daily in patients receiving ranolazine.

Metoprolol: Ranolazine 750 mg twice daily increased metoprolol plasma concentrations by approximately 1.8-fold. Lower doses of metoprolol or other CYP2D6 substrates may therefore be required.

Digoxin: Ranolazine increased plasma digoxin concentrations by approximately 1.5-fold. Digoxin concentrations should be monitored when ranolazine is initiated or discontinued.

Tacrolimus and other narrow-therapeutic-index CYP3A4 substrates: Tacrolimus concentrations may increase, and blood concentrations should be monitored with appropriate dose adjustment. Similar precautions apply to ciclosporin, sirolimus and everolimus.

Metformin: Ranolazine increased metformin exposure by approximately 1.4-fold with ranolazine 500 mg twice daily and 1.8-fold with 1000 mg twice daily. Other OCT2 substrates may also be affected.

Adverse drug reactions

Adverse effects are generally mild to moderate and often develop within the first two weeks of treatment.

Common adverse effects

Dizziness
Headache
Constipation
Nausea
Vomiting
Asthenia

Other reported adverse effects

Uncommon adverse effects include:

Hypotension
Postural dizziness
Syncope
Somnolence
Tremor
Paraesthesia
Blurred vision and diplopia
Vertigo
Dyspnoea
Abdominal discomfort and dyspepsia
Peripheral oedema

Muscle cramps
Increased serum creatinine and urea
QTc prolongation
Rare adverse reactions include acute renal failure, urinary retention, pancreatitis, angioedema, allergic dermatitis, urticaria, erectile dysfunction and elevated hepatic enzymes.

The frequency of adverse events is generally higher among elderly patients, patients with renal impairment and those with low body weight.
Effects on driving and use of machines
No dedicated studies assessing the effect of ranolazine on driving or operating machinery have been performed.
However, ranolazine may cause dizziness, blurred vision, diplopia, confusion, impaired coordination and hallucination, which may affect the ability to drive or operate machinery.

Pregnancy and lactation

- Pregnancy

There are limited data on ranolazine use during pregnancy. Animal studies have demonstrated embryo toxicity, while the potential risk in humans remains unknown.
The product information states that ranolazine should not be used during pregnancy unless clearly necessary.

- Breast-feeding

It is not known whether ranolazine is excreted into human breast milk. Animal data demonstrate excretion into milk, and a risk to the breastfed infant cannot be excluded.
Ranolazine should not be used during breast-feeding.

- Fertility

Animal reproductive studies showed no adverse effects on fertility; however, the effect of ranolazine on human fertility is unknown.

Use in children

The safety and efficacy of ranolazine in children below 18 years have not been established, and no paediatric data are available.

Pharmacokinetic highlights

Following oral administration, peak plasma concentrations are generally reached within 2–6 hours, and steady state is usually achieved within approximately three days of twice-daily dosing.
Food does not affect the rate or extent of ranolazine absorption.
Approximately 62% of ranolazine is bound to plasma proteins. The drug undergoes extensive metabolism, predominantly through CYP3A4, with a contribution from CYP2D6. Less than 5% of the dose is excreted unchanged in urine and faeces.
The terminal half-life following oral administration at steady state is approximately 7 hours.

Overdose
In high-dose studies, overdose was associated with an increased incidence of:
Dizziness
Nausea
Vomiting
Diplopia
Lethargy
Syncope
Management is symptomatic and supportive, with close monitoring of the patient.
Approximately 62% of ranolazine is protein-bound, making complete clearance by haemodialysis unlikely.

Key messages for clinical practice

- Ranolazine is a useful add-on option for symptomatic management of stable angina when first-line antianginal therapy is inadequate or not tolerated.

When prescribing ranolazine, clinicians should particularly remember:
Start at 375 mg twice daily and titrate after 2–4 weeks according to response and tolerability.
The recommended maximum dose is 750 mg twice daily.

- Tablets should be swallowed whole and should not be crushed or chewed.

QTc prolongation is dose- and concentration-dependent; consider the patient's QT interval and concomitant QT-prolonging medicines.

- Check renal function regularly, particularly in older adults.

Avoid ranolazine in severe renal impairment and moderate/severe hepatic impairment.

- Check for CYP3A4 and P-gp interactions before prescribing.

Potent CYP3A4 inhibitors and CYP3A4 inducers should be avoided as specified in the product information.
Remember important interactions with simvastatin, digoxin, metoprolol, tacrolimus and metformin.

- Dizziness, nausea, constipation and headache are among the more frequent adverse effects.

Use caution in older patients, those weighing ≤60 kg, and those with NYHA class III–IV heart failure.
Ranolazine should not be used during breast-feeding and should only be used during pregnancy when clearly necessary.

Source

European Medicines Agency. Ranolazine prolonged-release tablets. Summary of Product Characteristics.

SLACPT Pharmacology MCQ course

SLACPT MCQ course targeting the MD selection examinations was meticulously organised by Dr Asanka Eriyawa and Dr Supun Wedasinghe, for the second time for the year 2026 . This course was conducted for two days, 12th September 2026 and 20th September 2026 as an online programme.

MCQ Course Targeting MD Selection Exams Organized by the

SRI LANKA ASSOCIATION OF CLINICAL PHARMACOLOGY & THERAPEUTICS (SLACPT)

12th & 19th September 2026

12th September 2026		
09.00 – 10.30 AM	Basic Pharmacology	Prof. Roshini Murugupillai
10.45 AM – 12.15 PM	Respiratory and Autonomic Nervous System Pharmacology	Dr Ruwanthi Jayasekara
01.00 PM – 02.30 PM	Pharmacology of Gastrointestinal and liver diseases	Prof Anuradha Dissanayake
02.45 PM - 04.15 PM	Antidiabetic Agents and other Drugs in Endocrine Disorders	Dr Gayana Amiyangoda
19th September 2026		
09.00 AM – 10.30 AM	Prescribing in Rheumatology	Dr Sujeevani Kurukulasuriya
10.45 AM – 12.15 PM	Pharmacology of Anti Infectives	Dr Sahan Mendis
01.00 PM – 02.30 PM	Cardiovascular Pharmacology	Dr. Solith Senanayake
02.45 PM - 04.15 PM	Pharmacology in Special Populations	Prof Shalini Sri Ranganathan

IUPHAR General Assembly and the World Congress 2026

International Union of Basic and Clinical Pharmacology (IUPHAR) General Assembly was held on Wednesday, July 15, 2026. SLACPT Immediate Past President, Professor Priyadarshani Galappatthy, participated in the assembly, representing the SLACPT.

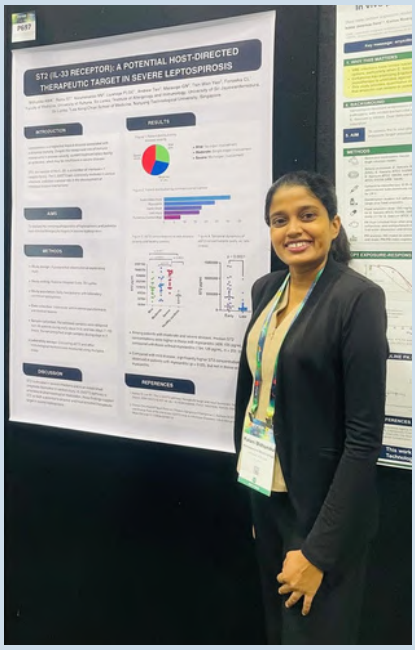


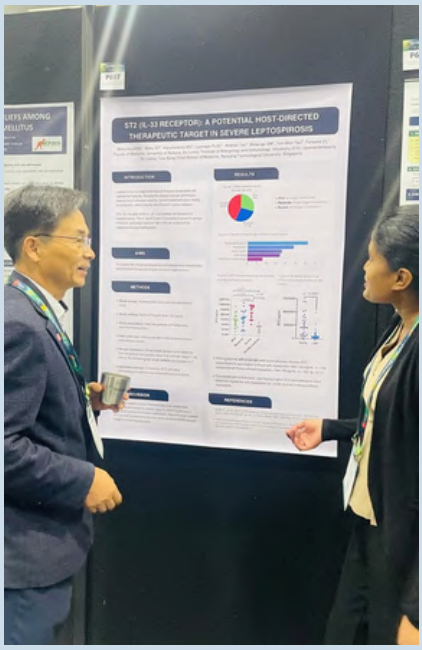


Dr. Kalani Mithunika, a lecturer in Pharmacology at the Faculty of Medicine, University of Ruhuna attended the 20th World Congress of Basic and Clinical Pharmacology (WCP 2026) in Melbourne, Australia, representing the SLACPT.

Dr Mithunika presented a poster titled “ST2 (IL-33 receptor): a potential host-directed therapeutic target in severe leptospirosis” at the WCP 2026.

She has been awarded the IUPHAR support opportunity to attend this World Congress.





SLACPT upcoming events

SLACPT/SLCIM Joint CME Webinar – October 2026

Next SLACPT joint CME webinar will be conducted in collaboration with Sri Lanka College of Paediatricians in October 2026

SLACPT Annual General Meeting - December 2026

The Annual General Meeting of the Sri Lanka Association of Clinical Pharmacology and Therapeutics will be held on 14 December 2026 from 12.00 PM onwards at the Department of Pharmacology, Faculty of Medicine, University of Colombo.

SLACPT NEWS

The Official Newsletter of
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SLACPT welcomes suggestions from readers towards improving the image of the Association and the newsletter.

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