the HORIZON

VOLUME 4, ISSUE 5, MAY 2026

DEAN'S DESK

DEAN OF FACULTY OF INTERNATIONAL STUDENTS
DR. ALEKSANDER ALEKSANDEROVICH STENKO

Dear students, we at Grodno State Medical University strive to provide students with top-quality education, but that's not it. GRSMU is also a hub for Scientific, Cultural, and Sports related activities. We wholeheartedly acknowledge that International students are an integral part of our university, and we take immense pride in that. Grodno State Medical University is glad to work with students from different countries and provide them with a stage to represent their nation and culture.

GRSMU celebrates its uniqueness in diversity, for in its true essence our university is a junction where students from various backgrounds and cultures come together as one big family. GRSMU has always encouraged students to explore further and beyond in every field they try their hands at. I hope that you like the novel concept of 'The Horizon' - a magazine that serves as a platform for the students to voice their opinions, share their takes and present their points of view.

'**The Horizon**' is a medium of extended communication where we can learn a lot from one another.
I highly appreciate this initiative and personally support it. I look forward to reading the interesting blogs written by you.

WELCOME TO THE HORIZON

DR. MEHUL H. SADADIWALA, FOUNDER, CLASS OF 2023

“We all have fascinating stories to share!” For the longest time, I have had this idea of starting a magazine. But not just any conventional magazine, one that shall serve as a platform for the students and alumni of International faculty at Grodno State Medical University to share their stories. A platform that enables students to share their takes on various curricular and extracurricular aspects of medicine. Thus, the idea of ‘**The Horizon’**, came to life.

‘The Horizon’ will be a creative intersection where students can freely give commentaries about Lifestyle, Culture, Productivity tips, and more. Throughout the years, many individuals at GrSMU have inculcated valuable skills and gained experience with a fair share of success in various disciplines. Maybe you run a successful YouTube channel or an educational website, or maybe you are a successful student-researcher or an educator, and so much more. 'The Horizon' enables students to share their personal experiences. The insights that you share will encourage other students to take further strides and explore future possibilities.

‘The Horizon’ is supported directly by the Dean of the International Faculty, and it will operate under the supervision of the International Students' Scientific Committee. Students from 1st to 6th year, and even graduates, can submit their blogs to this magazine. The articles should directly or indirectly revolve around student life to share knowledge and the collective growth of students.

For inquiries and submissions.
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EDITOR'S DESK

"I am Iba Shareef, a final year Medical student at Grodno State Medical University. Over the years, I have watched The Horizon grow, and I am honored to step into the role of editor-in-chief of The Horizon's Spring issue 2026. It is a great pleasure to work alongside our gifted writers and our Horizon team to make this issue engaging, informative, and stimulating.

I warmly invite you all to share your insights and enjoy the blogs, where you may learn, reflect, grow, and connect through curiosity and a shared passion for the future of medicine."

IBA SHAREEF,
EDITOR, APR-JUN 2026

MISHRA VAIBHAV RAKESHKUMAR,
EDITOR, APR-JUN 2026

"Myself, Vaibhav Mishra, a 4th year student in Grodno State Medical University. I am deeply honoured to be entrusted with the role of Editor-in-Chief of this year's Spring issue. This is a privilege and a responsibility — to shape a publication that reflects our academic rigor, clinical curiosity, and commitment to compassionate care. I look this as a magazine that educates and inspires. I envision pages that foster critical thinking, celebrate interdisciplinary collaboration, amplify trainee voices, and promote wellness and professionalism. Together with contributors and readers, I aim to create a lasting resource that nurtures learning, sparks meaningful discussion, and strengthens our community."

And a message to our dearest readers, we would like to invite you all, students and alumni, to share with us the blogs that directly or indirectly revolve around student life, to share knowledge and experiences that has had an impact on your growth within and outside the bounds of our university.

Concluding, let us alter the limitations of our individual efforts and collectively explore limitless Horizons.

Cover Credits

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THE HORIZON
MAY 2026

THE SKINNY FAT TRAP: WHY ASIANS AND SOUTH ASIANS FACE A HIDDEN METABOLIC CRISIS

You might look slim in clothes and see a normal number on the scale, yet struggle with a soft belly, low energy, and surprising health test results. This is "skinny fat"—technically called normal-weight obesity or metabolically obese normal weight. For people of Asian and South Asian descent, this isn't just an aesthetic concern; it's a deeply rooted biological predisposition with serious consequences.

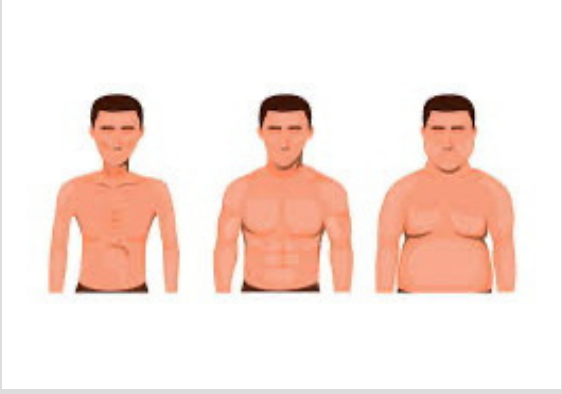
WRITTEN BY
H.M.HESHAN C. SENANAYAKE
CLASS OF 2026

1. THE EVOLUTIONARY PARADOX: WHY ASIANS ARE PRONE TO SKINNY FAT

The story begins thousands of years ago. South Asia (India, Pakistan, Bangladesh, Sri Lanka) and East Asia (China, Japan, Korea) endured cycles of famine, seasonal food scarcity, and infectious diseases. Populations that could store fat efficiently during times of plenty—while preserving muscle to reduce caloric needs—had a survival advantage.

This led to what researchers call the "thrifty gene" hypothesis (Neel, 1962), refined for Asians as the "low BMI – high adiposity" phenotype. Evolution favoured individuals who deposited fat viscerally rather than subcutaneously. Visceral fat is metabolically active, releases inflammatory cytokines, and is an efficient energy reserve during starvation.

Simultaneously, these populations developed a genetic tendency for lower baseline lean mass. A landmark study showed that even when matched for height and weight, Asians have 3–5% less skeletal muscle mass than Caucasians. This was adaptive: less muscle requires fewer calories to maintain, a benefit during food scarcity.



2. HOW MUCH LEAN MUSCLE? ASIAN VS. NON-ASIAN COMPARISON

How significant is the difference?
A meta-analysis by the International Council for Standardization in Anthropometry found that at the same body mass index (BMI) of 23 kg/m^2:
· White/Caucasian individuals: Average 74–76% lean mass (of total body weight), 22–24% fat.
· East Asians: Average 71–73% lean mass, 26–28% fat.
· South Asians: Average 68–70% lean mass, 29–32% fat.

More starkly, a DEXA scan study of healthy young adults found that South Asians had 8–10% less appendicular skeletal muscle (arm and leg muscle) than age-matched whites with the same BMI (Lear et al., 2007). This means a 70 kg Asian man may have 4–5 kg less muscle than a 70 kg white man, while carrying the same or more fat mass—the perfect skinny fat profile.

3. THE DISADVANTAGES OF SKINNY FAT

Skinny fat is not harmless. The primary dangers include:· Hidden inflammation: Visceral fat secretes IL-6 and TNF-alpha, leading to chronic low-grade inflammation.
· Low resting metabolic rate: Muscle burns calories at rest. Less muscle means a slower metabolism, making weight gain inevitable over time.
· Poor physical function: Reduced muscle mass correlates with lower grip strength, fatigue, and eventually sarcopenia (age-related muscle loss) starting as early as the 30s.

· Cardiovascular risk: Normal-weight obese individuals have higher triglyceride/HDL ratios and small, dense LDL particles—a pattern more dangerous than simple obesity.

4. THE DIABETES CONNECTION: AN ASIAN EPIDEMIC

This is the most critical link. Asians and South Asians develop type 2 diabetes at two to four times the rate of whites at the same BMI. Why? Skinny fat explains it.

Because muscle is the body's primary site for glucose disposal (up to 80% of post-meal glucose is taken up by muscle), having less muscle means a reduced "sink" for blood sugar. Simultaneously, visceral fat releases free fatty acids that cause muscle insulin resistance. The result: a double hit.

A groundbreaking study in Diabetologia followed 4,000 Asian Indians and found that for every 1% increase in body fat percentage at normal BMI, diabetes risk rose by 12% (Snehalatha et al., 2003). Another study concluded that the Asian phenotype is essentially "metabolically obese" from birth, with pancreatic beta cells working harder to compensate until they fail.

5. HOW TO FIND IF YOU HAVE SKINNY FAT

You don't need expensive labs initially.
Check these signs:

1. BMI 18.5–23 (Asian normal range) BUT waist circumference >80 cm (31.5 inches) for women, >90 cm (35.5 inches) for men.
2. Waist-to-hip ratio >0.85 (women) or >0.90 (men).
3. Soft, pinchable belly despite slim arms/legs.
4. Home scales with bioelectrical impedance – look for body fat % >25% (men) or >32% (women) even with normal weight.
5. Blood markers (if available): Fasting glucose 5.6–6.9 mmol/L, triglycerides >1.7 mmol/L, HDL <1.0 mmol/L (men) or <1.3 mmol/L (women).

6. WHAT TO DO: HOW TO LOSE SKINNY FAT

The goal is NOT crash dieting (which loses muscle and worsens the problem). The goal is body recomposition: lose visceral fat while gaining muscle. What to Eat & Meal Frequency

· Protein at every meal: 1.6–2.2 g per kg of body weight. For a 60 kg person: 100–130 g protein daily. Sources: eggs, fish, chicken, paneer, tofu, lentils (combine with grains to complete amino acids).

· Meal frequency: 3 main meals + 1 post-workout snack. Avoid grazing (keeps insulin high). Consider time-restricted eating (eat all meals within 10 hours) to lower insulin levels.

· Carbohydrates: Replace white rice/roti with complex carbs – brown rice, quinoa, millets (ragi, jowar). Limit to 1 cup cooked per meal.

· Fats: Ghee, coconut oil, nuts, avocados. Avoid seed oils and trans fats.

What Exercises to Do

Resistance training is non-negotiable. Cardio alone will not fix skinny fat.

· Strength training 3–4x/week: Squats, deadlifts, push-ups, pull-ups, rows. Focus on progressive overload (increase weight/reps each week).
· High-Intensity Interval Training (HIIT) 1–2x/week: 20 seconds sprint / 40 seconds rest, repeated 8 times. HIIT specifically reduces visceral fat.
· Daily steps: 8,000–10,000 steps on non-training days to maintain NEAT (non-exercise activity thermogenesis).
Sleep 7–8 hours: Sleep deprivation raises cortisol, which promotes visceral fat storage.
· Stress management: High stress = high cortisol = skinny fat worsens. Try 10 minutes of deep breathing or meditation daily.
· Hydration: 2–3 liters water daily. Dehydration lowers metabolic rate.

What to Avoid

· Chronic calorie restriction: Eating <1,200 calories/day will strip muscle.
· Long-duration steady-state cardio (e.g., 1-hour jogging daily): This burns muscle without targeting visceral fat effectively.
· Sugary beverages, packaged snacks, white bread/rice: These spike insulin and promote visceral fat.
· Skipping meals: Leads to muscle breakdown and later overeating.

FINAL TAKEWAY

Skinny fat is not a body type—it is a metabolic state. The good news is that with consistent strength training and protein-focused nutrition, you can reverse it within 3–6 months, dramatically lowering your diabetes risk and transforming your energy, strength, and longevity.

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REJECTION SENSITIVITY : THE THING I CAN NAME BUT CANNOT TAME

"When your brain plays tricks on you-and "no" feels deeper than personal"

WRITTEN BY
ABARRANE LOURAIN FERNANDO
CLASS OF 2026

INTRODUCTION

Rejection Sensitive Dysphoria (RSD) is common in neurodivergent people. It amplifies rejection into devastation and makes letting go a battle. Every word, every action, every perceived thought gets picked apart-until everything feels like rejection. Ever felt completely unseen by the people you thought were your people ? That sting of being ignored can feel like a quiet devastation ? You're not "too much." You're not faking it. Your brain is just wired a little differently.

DIVING DEEPER

There's actually a name for what you're going through: Rejection Sensitive Dysphoria. Most people just call it RSD.

You'll hear it discussed most in ADHD and autism circles. Dr. Dodson, who's spent his career studying this, believes that an overwhelming 99% of people with ADHD face RSD at some stage in their lives [1] and later It was estimated that anywhere from 34% to 70% of adults with ADHD experience emotional dysregulation. [2]

RSD is most famous for its link to ADHD -but it doesn't stop there. Researchers reviewing 75 studies found it's also common in anxiety, depression, borderline personality disorder, and body dysmorphic disorder. [1]

Here's a rough breakdown of the symptoms:

1. Intense emotional pain - A reaction that feels far bigger than the trigger.
2.Avoidance behavior -Steering clear of situations where rejection might happen.
3. Hypervigilance - Constantly scanning for signs of disapproval.
4. Low self-esteem - A persistent sense of not being good enough.
5. Social isolation -Withdrawing to protect yourself from being hurt.
6. Perfectionism - Trying to be flawless so no one can criticise you.
7. Defensive reactions - Snapping back quickly when feeling attacked or dismissed.

What's listed here is only a glimpse. But it speaks volumes about how neurodivergent brains experience the world. These reactions aren't overreactions-they're intense, mentally agonizing processes wired into the brain itself. Like I mentioned earlier, RSD is deeply connected to ADHD and/or autism. That said, even depression can trigger it. And who knows-many of us might be walking around with undiagnosed ADHD in the first place.

Now consider this-what if the person battling RSD is also the one in medical school, training to save lives?

Medical school alone can make anyone feel those symptoms. Add RSD as your little bonus, and suddenly life feels like a minefield

When rejection consumes you, the books don't get opened. And for a future doctor, unread pages today can mean lost lives tomorrow. And it's not just a feeling. Emotional lability and chronic stress have been solidly linked to impaired cognition. [3] Your brain literally struggles to learn when it's drowning in emotion.

So what can you actually do when RSD hits? [1]

1. Write it out. Putting your thoughts on paper can stop them from spiraling

2. Accept your emotions-no judgment. You feel what you feel. That doesn't make you weak or broken.

3. Regulate your nervous system. Calming the amygdala is key-try music, talking to someone you trust, prayer, or exercise. There's no universal fix; just find your thing.

4. Progressive Muscle Relaxation (PMR). Tense and slowly relax each muscle group, starting at your feet and working up.

5. Guided meditation. A short session can shift your entire state.
You might be curious-wait, isn't there any medication for this? The answer is yes. But let's not forget, as doctors-in-training, we always encourage patients to try lifestyle changes first. After all, nothing heals the body quite like the body itself.

That said, here's the rundown:

Back in the 1960s, Dr. Peter Wenderdiscovered that Monoamine Oxidase Inhibitors (MAOIs) could potentially improve not just focus and attention, but also emotional dysregulation. The downside?

MAOIs demand a strict diet-straying from it can lead to dangerous reactions. [4]

More recently, Dr. Dodson has highlighted newer option: alpha-agonists like clonidine and guanfacine.

But like we said earlier-don't rush to meds just yet.

There's a strange irony in it: we're training to heal others, yet we have no definitive cure for what's happening inside our own minds.

I should be honest-this blog was born from my own story. I've lived through RSD, and in many ways, I still do. No formal diagnosis sits on my file, but those symptoms? I know them intimately. I've cried until exhaustion, felt my world collapse inward, turned away from loved ones, and vanished inside my feelings. What pulled me through was a mix of stubborn friendships - the stubborn kind that doesn't let you drown and music that met me in the silence when I couldn't explain what I was feeling. I'm not at 100%, maybe I never will be. But I've learned this much: when I fall, I know how to land.

If something here resonated, pass it along to someone who needs to hear it. Because keeping it all inside? That only turns today's emotions into tomorrow's chronic stress.

CONCLUSION

The key takeaway is that RSD isn't a disease. It's just proof that your brain works differently-and beautifully so. Everyone's wired in their own way, and we're all still figuring out who we are. You're the lead in your movie called Life. It comes down to understanding yourself and reaching out for support. Stay encouraged. Keep going.

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[3] : Influence of Stress and Emotions in the Learning Process: The Example of COVID-19 on University Students: A Narrative Review. PMCID: PMC10298416 PMID: 37372905
[4] : Blog from amenclinics

THE STORIES WE CARRY: HOW OUR BRAINS WRITE THE SCRIPTS FOR OUR FUTURE

We all carry stories from our past. They are physical pathways in our brains, maintained by the Default Mode Network. They become predictions through predictive processing, and they are strengthened by principle of neuroplasticity. But, the most beautiful truth is, we are not the sum of our past experiences. We are the authors of our future stories, if we choose to pick up the pen.

WRITTEN BY
NIMNADI DISSANAYAKE
CLASS OF 2031

INTRODUCTION

Imagine a student sitting in an examination hall. The paper is in front of him, but his hands are trembling. He has studied well but a voice inside him whispers, "You're going to fail. You always do."

Now imagine someone who has just met a wonderful person. There is chemistry, laughter, connection. But a voice inside says, "Don't get too close. The last time you trusted someone, it ended in pain."

Or picture an entrepreneur with a brilliant new idea. He has the skills, the passion, the plan. But the memory of his previous business crashing down holds him back. "Why try again? You already know how this ends."

What do these three people have in common? They are all carrying stories written by their past experiences. These scripts run automatically, shaping how they see themselves, how they make decisions, and ultimately, how they step into the future. But why does the brain do this? And can these scripts ever be rewritten?

The answers lie in three fascinating scientific discoveries.

THE BRAIN'S STORYTELLER: THE DEFAULT MODE NETWORK

To understand why we carry past stories into the future, we must first look at what happens in our brains when we are doing nothing at all. In 2001, neuroscientist Marcus Raichle made a surprising discovery. He found that even when the brain is at rest, it remains highly active. A specific network of brain regions lights up, constantly working. Raichle named this the Default Mode Network, or DMN.

So what does the DMN do when we are resting? It tells stories. It retrieves memories from the past, connects them to our sense of self, and imagines future scenarios. This is why, when you lie in bed at night, your mind drifts to old conversations, past failures, and worries about tomorrow. The DMN is weaving your narrative.

For the student who has failed exams before, their DMN is constantly replaying those memories, the feeling of disappointment, the weight of failure. And then it projects those memories forward, painting a vivid picture of failure in the next exam. The student is not choosing to think this way. Their brain is simply doing what it has been trained to do: using the past to predict the future.

THE PREDICTION ENGINE: KARL FRISTON'S FREE-ENERGY PRINCIPLE

If the DMN is the storyteller, neuroscientist Karl Friston has given us a deeper understanding of why the brain tells these stories. Friston proposed that the brain is fundamentally a prediction engine. Its main job is to predict what will happen next so that we can survive and thrive.

Every moment, your brain is making guesses: What will I see when I turn the corner? How will this conversation go? Will I succeed or fail? These predictions are based on past experiences. When predictions match reality, the brain relaxes. When they don't, it experiences what Friston calls "prediction error" a signal that notify something is wrong.

Here is the problem: when a person has repeated failures, their brain's predictions become fixed. The brain learns to expect failure. And because the brain is designed to avoid prediction errors, it begins to avoid situations where failure might occur. The student avoids studying properly because they know they will fail anyway. The person avoids new relationships because they know it will end badly. The entrepreneur avoids starting again because they know the outcome.

The brain is not being pessimistic. It is being efficient. It is using the data it has to protect you from future pain. But in doing so, it traps you in a loop where the past dictates the future.

HOW SCRIPTS BECOME HARDWIRED: DONALD HEBB'S NEUROPLASTICITY

So how do these scripts become so powerful that they feel impossible to break? This is where the work of Donald Hebb comes in. In 1949, Hebb proposed a simple but revolutionary idea: neurons that fire together, wire together.

What this means is that every time we think a thought, feel an emotion, or have an experience, specific pathways in our brain are activated. If the same pathway is activated repeatedly, it becomes stronger like a path through a forest that becomes more defined the more it is walked. Eventually, that pathway becomes the brain's default route.

When a student fails an exam, specific neural pathways are activated those associated with disappointment, fear, and self-doubt. If this happens again and again, those pathways grow stronger. Eventually, even the thought of an exam automatically activates the fear pathway. The student does not choose to be afraid. Their brain has physically wired itself to respond that way.

But here is the hopeful part: Hebb's principle works both ways. If negative scripts can be wired into the brain, positive ones can be wired too. Neuroplasticity the brain's ability to change throughout life means we are not prisoners of our past. With new experiences, we can slowly build new pathways. We can rewrite the script.

REWRITING THE SCRIPT: FROM PRISONERS TO AUTHORS

Let us return to our three characters.

The student who has failed before can begin to rewrite their script by creating small successes, perhaps mastering one chapter at a time, allowing the brain to experience a new prediction: "I can do this." Each small success strengthens a new neural pathway, slowly weakening the old one.

The person afraid of new relationships can start by building trust in small, safe ways by allowing the brain to gather new data that not all relationships end in pain. Over time, the prediction engine updates its model.

The entrepreneur can begin again, but this time with awareness that the fear they feel is not a sign of inevitable failure it is simply an old script playing in their brain. With each small step forward, they are carving a new path.

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THE DEBT DIAGNOSIS (MONEY & MEDICAL STUDENTS)

We came to medical school to help people. We want to heal the sick, save lives, and make a difference. That is our real goal. But there is one topic most of us avoid: money.We pretend that doctors should not care about money. We think talking about salaries or debt makes us look greedy.So we stay silent. We learn complicated science but we never learn how to manage our own finances.This silence is a problem. It hurts our mental health. It changes the doctors we become. And it is time to break it.

WRITTEN BY
MNM SABRAN
CLASS OF 2026

THE HEAVY WEIGHT OF DEBT

Most medical students graduate with around $200,000 in student loans. According to the Education Data Initiative, the average debt for 2023 graduates was $202,453. About 70% of medical students, per AAMC data, graduate with some student debt.

This debt grows while we study. It grows while we sleep, with interest adding up every day. One analysis notes that with interest, this debt can balloon to $300,000 over the life of the loan. By the time we finish residency (four to seven years after medical school), that $200,000 can turn into $300,000 or more.

We feel this stress. We worry about rent and credit card bills. Research shows that students with high debt are nearly 1.5 times more likely to report symptoms of burnout. One study found that medical students are 40% more likely to be burned out and 20% more likely to be depressed compared to people their age who are not in medical school. But we rarely talk about this in the lecture hall.

SMALL EXPENSES ADD UP

You might think medical school only costs tuition. That is wrong. Here are some extra costs every student faces:

- A stethoscope: $150–$500
- Board exam fees(Step 1 & Step 2):over $1,200
- Question banks (UWorld, Kaplan): $200–$500
- Travel for away hospital rotations: A study in the journal BMC Medical Education found the average cost of an away rotation is $958. For some specialties like neurosurgery, it can exceed $2,500 per rotation. Other sources estimate this can be as high as $5,000.
- Residency interview costs: Students can spend $400 to $3,000 on applications and travel. Even with new AAMC fee structures, applying to 30 programs costs $330, and applying to more than 30 can quickly add up.

DEBT CHANGES OUR CAREER DREAMS

Here is the scariest part. The more debt we have, the less free we feel to choose our specialty. Research consistently shows that medical students with high debt burdens are significantly more likely to choose higher-compensation specialties like dermatology, radiology, or anesthesiology, while avoiding lower-paying but critically needed fields like primary care, pediatrics, or infectious disease.

When debt forces our choices, patients lose. Communities lose. And we lose the chance to follow our true passion.

WHAT WE CAN DO RIGHT NOW

We cannot fix all these problems overnight. But we can start small.

1. Talk about money openly. Stop hiding your finances. Share your worries with trusted friends.

2. Learn basic money skills. Studies confirm that medical students and residents have significant financial literacy deficits—that is a problem. Ask your school to teach real finance: how to pay back loans, what a credit score is, and how to budget in clinical years.

3. Use trusted resources. Start with The White Coat Investor, a finance guide written specifically for medical students and doctors by a practicing emergency physician.

4. Help each other. Upperclassmen should share tips on cheap rotations and budget spreadsheets. Schools should offer emergency grants for exam fees.

YOU CAN BE A HEALER AND STILL CARE ABOUT MONEY

Some people will say: "Real doctors don't worry about money." That sounds noble, but it is unrealistic. When you cannot pay your rent, you cannot focus on patients. When you are drowning in debt, you burn out faster. When you feel trapped, you make decisions you later regret.

Caring about money does not make you selfish. It makes you human. And a financially stable doctor is a better doctor—less stressed, and able to choose a public health job that helps many people.

LET'S STOP PRETENDING

So let's do something different. Let's talk about salaries. Let's ask about loan repayment. Let's help the student next to us who cannot afford this month's rent.

Money is not dirty. It is not unprofessional. It is just a tool. And learning to use it is just as important as learning to use a stethoscope.

Let's break the silence. Your future self will thank you. And so will your patients.

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