



Member, International Committee of Diabetes Magazines, International Diabetes Federation

# DiabetesWatch

A publication of the PHILIPPINE DIABETES ASSOCIATION, INC.

Vol. VIII, No. 1

May 2, 1991

## ***PDA Hails Laurel Bill to Establish Diabetes Commission***

The Philippine Diabetes Association (PDA) hailed Senate Bill No. 1803 sponsored by Sen. Sotero Laurel, proposing to establish a Diabetes Commission to study the problem of diabetes in the Philippines.

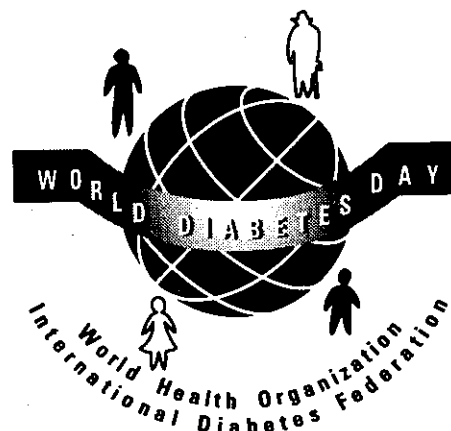
With the growing number of diabetics in this developing country come increasing incidences of heart disease, hypertension, strokes, blindness, kidney disease, disabling nerve problems, amputations, and infections of all sorts led by pulmonary tuberculosis.

Since the local disease prevalence hits hardest at the ages 40-60 (approximately 20% prevalence) the effect on the nation's economy is inestimable. Absenteeism, sick leaves, inefficiency at work, early morbidity and mortality - these plague both employees and employers in industry and all sectors of our economy.

The last national survey which was conducted by the then Ministry of Health led by Drs. Jesus Azurin and Virginia Basaca Sevilla gave a national prevalence rates of 8-11% in urban populations. Western experience has shown that the number of diabetics doubles every 15 years.

A reassessment coupled with programs of detection, prevention and control, need to be instituted on a nation-

*(Continued on page 6)*



## **WORLD DIABETES DAY SET FOR JUNE 27**

The International Diabetes Federation (IDF) and the World Health Organization (WHO) announce the first ever World Diabetes Day. World Diabetes Day, officially recognized as 27 June 1991, represents the efforts of people in every part of the world united against diabetes. The goal of this unprecedented event is to enhance diabetes research and care throughout the world by increasing national and international awareness of the increasing seriousness and magnitude of this problem and its associated complications.

Most importantly, World Diabetes Day is not simply a one day event. It is an awareness campaign, with programs spanning many months and covering many countries and regions. Global attention is sought on all days leading up to World Diabetes Day in order to create timeless awareness.

Around the world, there are activities, publications and programs to promote the ideals and the goals of World Diabetes Day.

The IDF characterizes World Diabetes Day as a "multi-faceted and global awareness campaign that must continue in the spirit of international solidarity until diabetes has come to its end."

Among the activities being planned by the Philippine Diabetes Association (PDA), in cooperation with the two major sponsors of the Day, Boehringer Mannheim and Novo-Nordisk, are: posters in public places for the educational campaign, spot interviews of Philippine diabetologists to be aired over the radio, blood glucose testings by the PDA chapters nationwide and by selected hospitals in the Metro Manila area, culminating in the annual convention of the PDA in December of this year.

## **PDA Seeks New Logo; Launches Contest for Design**

The Board of Directors of the Philippine Diabetes Association in a recent meeting decided to change the association's logo to reflect its current role in diabetes care.

A contest has been launched to select the logo that will best depict the purposes of the PDA, which is the physician-family relationship that will cope with the management of the diabetic patient through education, proper diet, appropriate physical activity and the use of hypoglycemic medications. The design should include the name, Philippine Diabetes Association, and the year 1958.

The contest is open to all members of the PDA, both professional and lay. All entries should be submitted on or before 15 November 1991 to the offices of the PDA at Room 309, Polymedic General Hospital, E. de los Santos Avenue, Mandaluyong, Metro Manila. The announcement of the winners will be made at the Annual Convention of the PDA in December of this year.

Winners will be categorized into first, second and third, and will be awarded cash prizes of P5,000, P2,000 and P1,000, respectively. The entry should be done in a form suitable for reproduction, and should be

*(Continued on page 3)*

**Purpose:**

This is an intensive course on different aspects of diabetes mellitus, its pathogenesis, its treatment by diet, exercise, oral hypoglycemic agents and the insulins, how to deal with the acute and chronic complications attendant to the disease, and the special situations which the physician is faced with in the care of the patient with diabetes.

It is intended to upgrade the physician's expertise in the management of diabetes mellitus. Thus, it can be considered as a postgraduate course for general practitioners and as a refresher course for internists. Its target attendees are physicians who will form the memberships of the PDA chapters and who will patronize the Diabetes Educational Clinics of the chapters.

*... to upgrade the physician's expertise in the management of diabetes ...*

## The PDA's DIABETES WORKSHOP

**Sponsoring Organizations:**

This course is sponsored by the mother society, the Philippines Diabetes Association (PDA), and her chapters. Selected pharmaceutical companies have been invited to provide the transportation expenses of the lecturers, as well as, to sponsor a day in the course where they will provide one lunch and two snacks for each registrant. In turn the

cooperating pharmaceutical company may set up a booth in the premises, and a streamer in the lecture hall on the day they are sponsors to. Ethical promotion will be observed throughout.

**Format:**

The course is designed for three days, in order that learning can be more leisurely, as well as, to encourage discussions after each lecture.

The morning sessions will be purely didactic.

The afternoon sessions will reinforce the morning didactics through group discussions, workshops, case presentations and wet clinics. Homeworks may also be assigned.

A team of two diabetologists will take charge of each day - as morning lecturers and as discussant/preceptor for the afternoon activities.

**Venue:**

The site of the course will be decided by the PDA in consultation with the PDA chapter. It will be a clean, quiet and comfortable place, but should be inexpensive. It is desirable that all out-of-town participants should be billeted in the same place to encourage camaraderie.

**Registrants:**

The optimum number of participants shall be a minimum of 40 and a maximum of

60. Any physician may register. Pre-registration shall be encouraged - through the PDA or through the host chapter/s.

Registration fees are set at: Non-PDA member = P500.00; PDA member = P300.00. The registration fee is higher for non-PDA member to encourage his membership to the PDA chapter.

The registration fee shall be the responsibility of the registrant, to whom the official receipt will be addressed. Pharmaceutical companies are prohibited from sponsoring the registration fee, so that the spirit of give (registration fee) and take (the postgraduate course) will be engendered in the participant who takes financial responsibility for his learning.

The president of the host chapter and the president of the next host chapter (who will be invited to attend the course so that he can see first hand how the course is conducted, and therefore, suggest minor modifications to suit his community) will be exempted from the registration fees.

**Certificate:**

A certificate of attendance will be given each participant who will be present physically in all three days of the course. For this purpose, a daily attendance sheet will be provided.

**Handouts:**

A syllabus will be provided each participant. Other handouts may be given as the circumstances will allow. These will be part of the registration fee.

**Other Aspects:**

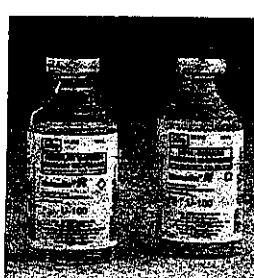
Free lodging may be provided for by the PDA to out-of-town participants. This will  
(Continued on page 3)

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**FIGHT DIABETES - Be a member of PDA**

## 87 Complete Cebu Workshop

Eighty seven participants completed the Second Diabetes-Workshop of the Philippine Diabetes Association (PDA) which was held April 12 to 14 in Cebu City at the Sundowner Centrepoint Hotel.

The faculty was composed of Drs. Lynn Anel-Quimpo,

Lina Lantion-Ang, Mary Anne Lim-Abrahan, Araceli Panelo, Ruby T. Go and Augusto D. Litonjua.

The breakdown of the eighty seven participants according to place of practice follows: Cebu 58, Dumaguete City 13, Tagbilaran City 6, Ozamis City 3,

Suikijor 3, Tacloban City 2, Iloilo City 1, and Davao City 1.

Arrangements for the Second Workshop were made possible by the PDA Chapter of Cebu composed of: Dr. Marian Denopol, president and her various committees - Dr. Erlinda Po and Dr. Tessie Lamoste, secretariat; Dr. Allan Sy, finance; Dr. Vicente Rodriguez and Dr. Roy Ycong, accommodations; and Dr. Pura Dominguito, overall coordinator for transportation.

The Third DiabetesWorkshop will be held in Davao City sometime in August, 1991. Acting as coordinator is Dr. Edna Tecaro, president of the Davao Chapter, PDA. The Davao Workshop will also include the members of the Cagayan de Oro and Zamboanga chapters.

*The PDA's . . . from page 2*

be in the form of dormitory style accommodation.

Contests, satellite lectures, and other activities - sponsored by cooperating pharmaceutical companies - will be allowed, so long as the PDA is informed, and as long as, the general format of the course will not be disrupted.

An evaluation process will be conducted at the end of the course - to give participant reaction to the course. The evaluation will be course-oriented, and not individual-oriented.

*PDA Seeks . . . from page 1*

submitted in no more than 3 colors. The Board of Directors will act as judge, and none of them may submit entries.

## 2nd DiabetesWorkshop Participants

April 12-14, 1991

Sundowner Centrepoint Hotel  
Cebu City

- |                            |                             |
|----------------------------|-----------------------------|
| 1. Adenir, Dalilah         | 45. Lao, Lily               |
| 2. Agudo, Ramon            | 46. Lim, Joy                |
| 3. Araneta, Grace          | 47. Lim-Juan, Erlinda       |
| 4. Arco, Roy               | 48. Loberanes, Ma. Luisa    |
| 5. Atillo, Eduardo         | 49. Macavinta, Eden         |
| 6. Atillo, Pablo, Jr.      | 50. Manulat, Francisca      |
| 7. Aurelia, Fidencio       | 51. Maape, Pepita           |
| 8. Bacareza, Manuel        | 52. Mendez, Raul            |
| 9. Baclayon, Uriel         | 53. Moleta, Elizabeth       |
| 10. Baculao, Elma          | 54. Nerves, Christine       |
| 11. Balo, Juanito          | 55. Nonato, Ronald          |
| 12. Bayani, Ayn Vincent    | 56. Ogan, Judith            |
| 13. Barcenas, Emmanuel     | 57. Oliver, Silahis         |
| 14. Cadiz, Clarita         | 58. Ong, Marie Daisy Lou    |
| 15. Canete, Rosalia        | 59. Ong, Teresita           |
| 16. Caparuzo, Rosalia      | 60. Onglatco, Emily         |
| 17. Casinilio, Herbetina   | 61. Pama, Manuel            |
| 18. Cativo, Rosenda        | 62. Paradel, Virginia       |
| 19. Celestial, Lea         | 63. Patindol, Lilirosa      |
| 20. Ceniza, Maritoni       | 64. Pepito, Galileo         |
| 21. Co, Marlon             | 65. Po, Erlinda             |
| 22. Cuenco, Marissa        | 66. Puracan, Cecilia        |
| 23. Codoy, Ethelda         | 67. Quevenco, Julia         |
| 24. Cortes, Redempta       | 68. Retana, Evelyn          |
| 25. Dano, Fay              | 69. Ricamora, Ma. Filipinas |
| 26. De Jesus, Noel         | 70. Rodriguez, Vicente      |
| 27. Denopol, Marian        | 71. Rosario, Gaudiosa       |
| 28. Desquitado, Sharee Ann | 72. Sta. Ana, Cynthia       |
| 29. Diaz, Lilia            | 73. Sepe, Enriqueta         |
| 30. Dimaculangan, Ophelia  | 74. Suico, Obdulia          |
| 31. Dominguito, Pura       | 75. Sy, Alan                |
| 32. Dungog, Renan          | 76. Sy, Jacqueline          |
| 33. Enad, Raul             | 77. Sy, Eleuteria           |
| 34. Eskao, Elizabeth       | 78. Tagimacruz, Fe          |
| 35. Estillore, Daisy       | 79. Tamayo, Joseph          |
| 36. Fernandez, Agnes       | 80. Tecarro, Edna           |
| 37. Fernandez, Esperanza   | 81. Tio, Helen              |
| 38. Fernando, Judith       | 82. Velez Jo, Estrelita     |
| 39. Fiel, Vivienne         | 83. Yap, Araceli            |
| 40. Gallego, Lourdes       | 84. Ybanez, Teresito, Jr.   |
| 41. Go, Jill               | 85. Ycong, Roy              |
| 42. Kuan, Arlene           | 86. Yu, Estefanio           |
| 43. Kwan, Cecilia          | 87. Zerna, Abrahan          |
| 44. Lamoste, Teresita      |                             |

## GLIPIZIDE MINIDIAB

MINIDIAB pharmacokinetics are more advantageous than those of other sulfonylureas

| Drugs          | Time (hr) to peak effect | Half-life, T 1/2 (hr) | Duration of action (hr) | Metabolites          | Overall excretion            |
|----------------|--------------------------|-----------------------|-------------------------|----------------------|------------------------------|
| Chlorpropamide | 8-10                     | 30-60                 | 22-65                   | 4 (active)           | 100% in 10-14 days           |
| Glibenclamide  | 2-5                      | 10-16                 | 16-24                   | 6 (partially active) | 59% in 1 day, 95% in 5 days  |
| Gliclazide     | 2-6                      | 10-12                 | 4-24                    | 8 (inactive)         | 98% by renal route in 48 hr  |
| Glipizide      | 1.0-2.5                  | 2.4-4                 | 6-24                    | 4 (inactive)         | 97% in 1 day, 100% in 3 days |

• "Glipizide evoked a more pronounced and more rapid increase of plasma insulin and correspondingly greater and faster blood glucose reduction than did glibenclamide."

• Thus, likelihood of hypoglycemia is minimized "As glipizide (Minidiab) is rapidly eliminated, and as there is no evidence that its metabolites are significantly active, the risk of long-lasting hypoglycemia should be small when using glipizide. In contrast, glibenclamide has provoked serious, and even fatal hypoglycemia in several cases; it is possible that this risk is increased in patients with renal insufficiency due to accumulation of an active polar metabolite. A similar risk is well recognized in the case of chlorpropamide."

**FIGHT DIABETES** - Be a member of PDA

## Three experts discuss the complexities of fat metabolism . . .

Heart disease is one of the leading causes of death in the world. It is related to several predisposing factors namely: smoking, high blood pressure, diabetes and high blood cholesterol.

Cheeseburgers, steaks, eggs and other dairy products, rich in fats and cholesterol that may be deposited in the blood vessel wall can cause atherosclerosis (hardening of the arteries). When vessels are clogged up by these deposits, they result in heart attacks, strokes and gangrene of the legs.

Lipids (cholesterol and triglyceride) are sources of fat found in plant and animal foods. They are absorbed in the intestinal tract and trans-

## UNDERSTANDING LIPIDS

RUBY T. GO, MD  
Endocrinologist  
Chinese General Hospital

ported in the form of lipoproteins (lipids and proteins) to the liver and the peripheral organs. There are different forms of lipoproteins: the low density lipoprotein (LDL), the very low density lipoprotein (VLDL), the high density lipoprotein (HDL) and chylomicrons. Most of the blood cholesterol in human is carried by LDL and most of the blood

triglyceride by VLDL and chylomicrons.

Cholesterol is an important constituent of cell membrane. It also serves as a precursor of certain hormones (steroid) and bile acids. Dietary cholesterol contributes to the pool of cholesterol in the body. As mentioned above, it is transported predominantly by LDL (often referred to as bad cholesterol) from the liver to the peripheral tissues for membrane and hormone production and may be deposited in the vessel wall causing hardening and blockage of the arteries. A small amount is carried by HDL from the peripheral tissues back to the liver (reverse cholesterol transport). Thus, the so-called good cholesterol, HDL facilitates the removal of cholesterol from the peripheral cells (especially the lining of the blood vessel).

There are certain factors which affect the level of blood cholesterol in the body. Smoking, uncontrolled diabetes, excessive dietary fat, liver and kidney disease can lead to elevation of LDL and lowering of HDL. Women in general have higher HDL (good cholesterol) because of estrogen. This partly accounts for the lower incidence of heart disease in women before menopause (cessation of menstruation) compared to men. Regular

exercise and avoidance of alcohol can increase HDL.

Triglyceride provides an efficient storage form of energy. It is mainly transported in the blood in the form of chylomicrons and VLDL and cleared from the plasma by mechanisms that involve the liver. When dietary intake of fat decreases and is replaced by carbohydrates (glucose), the liver increases its production of fatty acid which is derived from glucose. The fatty acid is in turn converted to triglyceride and secreted into the blood stream. Thus, a high carbohydrate diet can significantly elevate blood triglyceride level. In the same manner, uncontrolled diabetes can lead to high triglyceride level.

Disorders affecting lipids may be primary (genetically transmitted) or secondary (due to some other diseases mentioned previously). It may be due to inability of the body to metabolize the fat (genetically predetermined) or due to excessive dietary intake. Modest elevation in blood lipid levels can be controlled with diet, weight loss (in overweight individuals) and exercise. A change in diet may lower the blood cholesterol by 10-15%. The more severe cases require medications in addition to diet.

Patients with lipid disorders generally have no symptoms until complications arise such as heart disease or stroke, a stage at which the damage is often irreversible. Because of this, a baseline lipid profile is recommended in most individuals above the age of forty. In those with a strong family history of lipid disorder or

### FAT FACTS AT YOUR FINGERTIPS

**atherosclerosis**—also called "hardening of the arteries," it is caused by high blood cholesterol, diabetes, high blood pressure, and smoking. It leads to narrowing of arteries and reduced blood flow, causing heart attacks and stroke.

**high density lipoprotein (HDL) cholesterol**—also called "good cholesterol," these particles help take cholesterol to the liver, where it is broken down. HDL cholesterol protects against heart disease. Desirable level: more than 45 mg/dl.

**lipids**—a broad class of compounds that are not soluble in water. Fat and cholesterol are both considered lipids. High levels of lipids is called hyperlipidemia.

**lipoproteins**—particles of protein that carry cholesterol and triglycerides through the blood.

**low density lipoprotein (LDL) cholesterol**—also called "bad cholesterol," these are the particles that carry cholesterol to ar-

tery walls and are responsible for atherosclerosis. Desirable level: less than 130 mg/dl.

**saturated fats**—fats found in animal food, including meats and dairy products, and some vegetable products, such as palm and coconut oils. Foods rich in saturated fats raise blood cholesterol.

**triglycerides**—fats found in animal foods that are used as a source of energy. High levels signal uncontrolled diabetes or other fat disorders. Desirable level: less than 200 mg/ml.

**total cholesterol**—a waxy substance produced by the body and present in foods from animals. High levels can lead to atherosclerosis. Desirable levels are less than 200 mg/dl.

**unsaturated fats**—fats primary in fish and in vegetable foods like cooking oils, margarine, and peanuts. Unsaturated fats, which include monounsaturated and polyunsaturated fats, tend to reduce blood cholesterol.

Reprinted from *Diabetes Forecast*: January, 1989, page 25

(Continued on page 5)

*Understanding . . . from page 4*

vascular complications, screening should be done at an earlier age, usually above twenty.

A baseline blood cholesterol and triglyceride is often sufficient; however, in those with mild elevation of blood cholesterol, a complete lipoprotein profile is necessary to determine whether the mild elevation is due to HDL (good cholesterol) especially in athletes or LDL (bad cholesterol). Elevation of HDL does not require any treatment and in fact is protective against heart disease.

High blood cholesterol is a major risk factor for heart disease. Both patient compliance and physician guidance are necessary for optimum success in the control of lipid disorders and prevention of vascular complications.

## Lowering the high lipids in the blood

Hyperlipidemia (high blood lipids) occurs in about one third of all diabetic patients. The co-occurrence of hyperlipidemia with diabetes mellitus is related to the critical role of insulin in the production and removal of lipids. Dietary indiscretion is a major cause of hyperlipidemia while the coexistence of inherited familial hyperlipidemia with diabetes mellitus is also a possibility.

Proper dietary modification, optimal blood sugar control and weight reduction may be all that are needed to normalize lipids. Even in the presence of severe hyperlipidemia, the

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Endocrinologist  
St. Luke's Medical Center

amount of lipid-lowering drug required is reduced, thus minimizing the drug expenses and the risk of side effects.

Dietary control not only helps in lowering lipids but also in improving glucose control and reducing weight. The intake of foods rich in cholesterol and saturated fats should be decreased, mainly, dairy products such as whole milk, cheese, and butter; egg yolk; organ meat including liver, pancreas, brain, and kidney;

lard, and visible animal fat; palm and coconut oil (two vegetable oil high in saturated fats). For instance, one egg contains about 250 mg of cholesterol, an amount almost approaching the total daily allowance for cholesterol of 300 mg/day, so that no more than 3 eggs per week should be consumed. Good alternative food sources that are low in fat and cholesterol include skim or non-fat milk, margarine, yogurt, and egg whites. Lean cuts of beef are allowed in moderation while processed meat (i.e. hot-dog, bacon, ham) should be eliminated. Consumption of

(Continued on page 6)

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**Lowering . . . from page 5**

fish and poultry (i.e. chicken, turkey minus the skin) as protein sources is permissible, however, they should not be fried in saturated fats (i.e. animal fat, lard, palm oil) nor covered with fat-rich sauces. If oil is needed for cooking, corn, soybean, peanut or olive oils are preferred. Cooking methods with the use of little or no fat including steaming, baking, boiling, or grilling should be used. Meat to be roasted or baked should be placed on a rack so that fat can drain. Vegetables, soybean products, cereals, pastas are encouraged within the limits of caloric requirement per day.

A weight loss program should be initiated for overweight and obese individuals (those greater than 10% of their ideal body weight). Weight reduction through calorie restriction and exercise

will usually cause marked reduction in cholesterol and triglycerides plus elevation of HDL (good cholesterol). A recent study found an equal rise in HDL in subjects who lost similar amounts of weight either by dietary restriction or by exercise, suggesting that exercise mainly raises HDL, but the possible beneficial effects of this increase have been questioned because it was in HDL<sub>3</sub> rather than HDL<sub>2</sub>, the subfraction thought to be protective. Patients are therefore not encouraged to take alcohol in order to raise HDL. Smoking cessation is another effective method to elevate HDL.

If after 3 to 6 months of conservative therapy, the desired level of cholesterol (<200 mg%) or LDL (<130 mg%) has not been reached, drug therapy is started. Each group of drugs has specific

action, some agents work very effectively to reduce the level of one type of lipid while exacerbating another. It is therefore essential to tailor the selection of drug to the specific type of hyperlipidemia. Furthermore, all currently available lipid-lowering drugs, may be associated with side effects which underscores the need for continuous follow-up with your physicians. Despite the potential side effects of lipid-lowering drugs, correction of abnormally elevated blood lipids to prevent complications or death from heart attack, stroke, gangrene, pancreatitis, and others, far outweighs the risks. Be familiar with the features and possible untoward effects of the lipid-lowering drug you are taking.

## Fat Substitutes

Excerpted from an article by Maisie Vanriet, *Diabetes Dialogue*, Spring 1991, page 53.

If wishes came true, all foods would taste great, be easy to prepare and have no effect on your body except to provide nutrients. Now comes news that almost sin-free fat substitutes are on their way to the grocery stores.

A new fat substitute is made from protein, in this case egg white and milk proteins. It has been specially formulated to have rich smooth taste normally associated with fats and to provide only between 1 or 2

*(Continued on page 8)*

**PDA hails . . . from page 1**

wide basis to be able to prevent the sequelae of this silent

killer. Highly professional non-political moves may yet save the future from the consequences of neglect.

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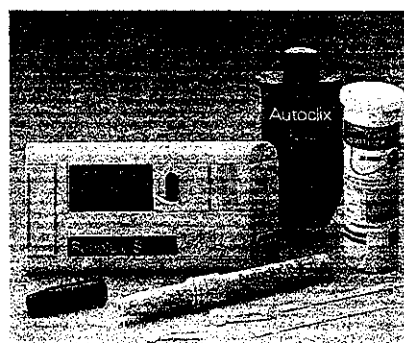
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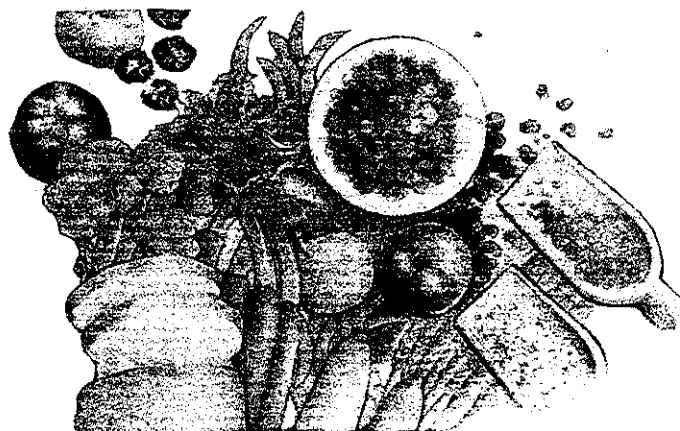


Sometime ago, simple carbohydrate (like fruits and fruit juices) was recommended limited in the case of hyperglycemic individuals. Rice, rootcrops, corn, and other so-called complex carbohydrates were recommended as a major source of energy or calorie. Simple carbohydrate, therefore, may be considered as the "less good carbohydrate" and the complex ones as the "better carbohydrate."

Now it is the cholesterol in focus: the "good" vs. the "bad." Actually even the so-called "bad" cholesterol serves a good purpose, too, as explained by Dr. Ruby Go in her article. In other words, it is not TOTALLY "bad" because some of it is also necessary for one's total well-being. Besides, a zero "bad" cholesterol dietary consumption is possible only if you become a strict vegetarian. Hence, a moderate intake of a variety of foods is really the basic rule.

There is a substance, though, that has been said to reduce the total "bad" cholesterol (the LDL or the low density lipoprotein): the omega-3 fatty acid, a kind of polyunsaturated fatty acid. Rich sources are tuna ("tulingan"), salmon, eel ("palos"), mackerel ("tangigue"), sardine ("tawilis" or "tamban"), and others. To gain the possible benefits of omega-3 fatty acids, fish must be eaten at least three times weekly. Fish supplements like cod liver oil, primrose oil, and similar products are not recommended because they contribute to the total fat intake. It therefore adds up to calorie taken daily. For those watching their weight, this is important.

Although the topics being discussed are mainly fat, cholesterol, and triglyceride, a kind of carbohydrate has to be



## GOOD CHOLESTEROL VS BAD CHOLESTEROL

MA. IMELDA Q. CARDINO, RND, MSFN  
Teaching Dietician, Diabetes Educational Clinic,  
Makati Medical Center

mentioned. Simple carbohydrate (such as sugar and other sweets) contribute to both high blood sugar and high blood triglyceride levels, contribute so much calories and practically nothing else nutrient-wise, and as a source of extra calories add up to weight. Complex carbohydrates are recommended most especially if they come from whole grain cereals. Dietary fiber (such as those found in oat bran, barley, oatmeal, beans like mongo and kidney bean) lowers blood sugar and LDL-cholesterol. Fiber, however, should not be thought of as a cure-all. Diet must still be reduced in total fat content and sources of saturated fat must be kept at a minimum even if you eat a high fiber diet.

A minimal alcohol intake may have some benefits (if your diabetes is well controlled) but high alcohol ingestion has many undesirable effects:

it contributes to high blood pressure, stroke, and some forms of cancer; it causes formation of triglyceride (because excess calorie may be stored as triglyceride); and it may interfere with triglyceride removal from the blood stream.

Here are some dietary tips to manage elevated "bad" cholesterol:

**\*\* Serve fish more often.** Lessen the intake of red meat like beef and pork. Serve white meat of chicken (breast).

**\*\* Serve legumes, like monggo, kadyos, kidney beans, and others two to three times weekly.** If your uric acid is elevated but you are not hypersensitive (your joint pain, for example, is not immediately felt if you eat legumes), limit these foods to **ONE CUP COOKED WEEKLY:**

**\*\* Trim-off the visible fat of meat BEFORE cooking** (chicken skin, fatty portions of beef

and pork, etc.)

**\*\* Avoid deep-fat frying.** Deep-fat fried foods have high content of fat because a lot of fat has been absorbed by the food. For example, if you deep-fat fry in corn oil, the cholesterol is low but the fat content is still high.

**\*\* Boiling, steaming, broiling, and baking are the recommended methods of cooking.** Cooking equipment like greaseless pans, the microwave oven, the pressure cooker, and the turbo-broiler would be a great help.

**\*\* A food low in fat is not necessarily low in cholesterol.** For example, a hard-cooked egg is low in fat but still high in cholesterol unless you eat the eggwhite alone.

**\*\* Some amount of fat may be used to improve palatability of the diet.** For instance, olive oil may be added to the vinegar and spices dressing for fresh vegetable salad. Mazola margarine may be added to steamed vegetables in limited amounts to improve its taste.

**\*\* If possible, boil soup stock a meal in advance.** Cool and refrigerate. Skim-off the fat that solidifies on top before reheating and adding the desired ingredients.

**\*\* On the average, about six matchbox pieces of lean meat, fish or poultry are recommended daily.** Some medical conditions, however, might require the increase or decrease of protein foods.

**\*\* Not only the diet would play an important role in increasing the "good" cholesterol and decreasing the "bad" cholesterol.** Diet is only a certain part of the total picture. The picture must be complete: exercise, weight control, absence of smoking, and stress management. Remember: look at the **TOTAL PICTURE**, not just the part where you want to focus your attention to.



## DiabetesWatch

A publication of the  
PHILIPPINE  
DIABETES  
ASSOCIATION, INC.  
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### Report from Cebu:

### Diabetes Educational Clinic Census of the SACRED HEART HOSPITAL

| Month          | Total Number<br>of Patients | Followed-up<br>Visit | New Patients |
|----------------|-----------------------------|----------------------|--------------|
| July 1988      | 34                          | 14                   | 20           |
| August 1988    | 19                          | 14                   | 5            |
| September 1988 | 9                           | 6                    | 3            |
| October 1988   | 11                          | 6                    | 5            |
| November 1988  | 6                           | 2                    | 4            |
| December 1988  | 10                          | 7                    | 3            |
| January 1989   | 17                          | 8                    | 9            |
| February 1989  | 20                          | 14                   | 6            |
| March 1989     | 15                          | 11                   | 4            |
| April 1989     | 28                          | 26                   | 2            |
| May 1989       | 58                          | 42                   | 16           |
| June 1989      | 33                          | 17                   | 16           |
| July 1989      | 33                          | 20                   | 13           |
| August 1989    | 54                          | 38                   | 16           |
| September 1989 | 43                          | 36                   | 7            |
| October 1989   | 53                          | 43                   | 10           |
| November 1989  | 29                          | 24                   | 5            |
| December 1989  | 23                          | 19                   | 4            |
| January 1990   | 41                          | 33                   | 8            |
| February 1990  | 50                          | 40                   | 10           |
| March 1990     | 50                          | 38                   | 12           |
| April 1990     | 42                          | 38                   | 4            |
| May 1990       | 27                          | 24                   | 3            |
| June 1990      | 32                          | 24                   | 8            |
| July 1990      | 58                          | 43                   | 15           |
| August 1990    | 43                          | 34                   | 9            |
| September 1990 | 45                          | 42                   | 3            |

Average number of patients every month = 30-35

Average of new patients every month = 6-8

New insulin dependent = 4

Old insulin dependent = 2

Total number of followed-up patients from July 1988 to September 1990 = 679

Total number of new patients from July 1988 to September 1990 = 228

## Training Course for Diabetes Epidemiology

Dr. Takeshi Kuyuzo, chairman of the Japan-US Diabetes Epidemiology training course announces the holding of a course on August 21-28, 1991 at the Jichi Medical School, with address at 1-3311 Yakushiji, Minami-Kawachimachi, Kawahi-gun, Tochigi, Japan. Invited to apply are young researchers or students interested in diabetes epidemiology with English capability. A total number of 20-30 trainees from Japan and other Asian countries will be selected.

Tuition, accommodation and meals will be free. However, transportation to the meeting site is not covered by the course, although special travel grants will be considered on request for a limited num-

*Fat . . . from page 6*

calories/gram. All currently available fats provide 9 calories/gram. The product cannot be used if the food must be fried, baked or heated to high temperature. Possible uses include salad dressings, frozen desserts and whipped toppings.

ber of overseas students.

The course will have lectures and workshops in small groups. The course is an educational component of the World Health Organization multinational project for childhood diabetes.

Persons with diabetes, however, should proceed with caution before embracing fat substitutes, even though this product offers a lower calorie alternative. Even companies that manufacture fat substitutes point out that nutrition education remains most important in the battle to reduce dietary fat. Achieving a total dietary intake of 30% or less will do more for a person with diabetes than the ad-

dition of anyone food ever could.

With artificial sweeteners perhaps we expected a bit of miracle; something that would improve our diets without too much effort. This time let's try to remember there are no miracle foods, only miracle meal plans. Ones that are nutritionally balanced, moderate in amounts and used by motivated people.

### Acknowledgment

The illustrations that were used in this issue were lifted from Diabetes Dialogue, Spring 1991 issue.