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DiabetesWatch

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Vol. VIII, No. 2

September 2, 1991

FOUR PROJECTS HIGHLIGHT PDA-DRUG FIRMS' TIE-UP

1. Novo-Nordisk's Diabetes Award

Novo Nordisk A/S, in cooperation with the Philippine Diabetes Association, Philippine Society of Endocrinology and Metabolism, Philippine Society of Pediatric Metabolism and Endocrinology, and the Institute for the Study of Diabetes, has launched the Diabetes Award for young physicians in order to:

1. recognize and honor young physicians (under 45 years of age) who have excelled in the field of diabetology.

2. provide incentive to physicians for them to continue the noble task of serving the Filipino diabetics, and

3. to serve as inspiration to all physicians to follow the awardee's achievements.

The Award will be given to

(Continued on page 2)

2. FICE's Diabetes Dialogue

Farmitalia Carlo Erba, with Excerpta Medica, will publish the quarterly Diabetes Dialogue, in cooperation with the PDA. The Dialogue will contain 2 or 3 interviews with international, or regional, or local experts in diabetes, plus summaries of recent works on diabetes. It will also carry a colored sample menu for the diabetic, plus announcements of meetings in the region and the world.

Each issue will have a physician-member of the PDA's Board of Directors as consultant, and he will have the added responsibility of answering questions fielded in, plus, framing twenty questions for 3 CME credits of the physician-responder.

(Continued on page 2)

3. Servier's Lecture on Diabetes

Les Laboratoires Servier will deposit an initial ₱150,000 in a trust fund whose earnings will serve as honorarium for a lecturer of international renown who will be selected by a committee composed of the Presidents of the PDA and the Philippine Center for Diabetes Education Foundation, Inc. (PhilCeDEF), the chairman of the Medical Bureau of PhilCeDEF, the regional director of Les Laboratoires Servier, the medical director of Med Asia and two other designated diabetologists. Med Asia, the local subsidiary of Les Laboratoires Servier will shoulder the transportation and accommodation expenses of the Lecturer. The lecture will be held on the evening preceeding the annual convention of the PDA.

4. Regional Training Course for Nurses and Dieticians

The PDA, together with Boehringer Mannheim and Eli Lilly, will hold regional training courses for nurses and dieticians of the chapters of PDA. The setting up of this course will answer the need of the chapters to re-train their personnel, as well as, to train the personnel of chapters to be organized.

Thus, with the regional training course, the PDA's DiabetesWorkshop can really be exclusively for physicians.

Targetted for the October training course to be held in San Fernando, La Union are the personnel of the chapters of Ilocos Norte, Pangasinan, Baguio City, as well as the soon to be organized chapters of Ilocos Sur and La Union.

PDA Annual Convention Set for December 3

Australian Diabetes Expert is Main Speaker

Dr. Ruby T. Go and Mr. Meneleo Hernandez, Jr., Convention Co-Chairpersons, announce that the 1991 Annual Convention of the Philippine Diabetes Association (PDA) will be held on Tuesday, December 3 at the Nikko Manila Garden Hotel. The whole day convention will feature the morning program

for physicians, and the afternoon program for both physicians and lay members.

Dr. Jeff Flack, Director of the Diabetes Centre, Lidcombe Hospital, New South Wales, Australia will be the main speaker. He will talk on the recent concepts of the pathogenesis of diabetic complications in the morning, and on

the latest trends in diabetes care in the afternoon.

The morning session will also have leading Filipino physicians talk on the various complications of diabetes in their specialties: Dr. Dy Bun Yok, cardiology; Dr. Romeo Espiritu, ophthalmology; Dr. Jose Garcia, nephrologist; and

(Continued on page 3)

Logo contest ends November 15

The on-going contest for the new logo of the Philippine Diabetes Association will end the middle of November. The winner will be announced during the annual convention on December 3. Cash prizes of ₱5,000 for the first prize, ₱2,000 for the second prize

(Continued on page 3)

46 Complete Davao Workshop

Of the 68 who registered for the 3rd DiabetesWorkshop held in Davao City last August 11-13, 1991, 46 were given certificates of completion. Their names are printed elsewhere on this page.

24 were from Davao City, 7 from Davao del Norte, 1 from Davao del Sur, 1 from Butuan City and 2 from General Santos City. The other attendees came from Cotabato City — 5, Cagayan de Oro City — 2, Cebu City — 2, Surigao del Sur — 1 and Dagupan City — 1.

Co-sponsors of the Workshop were: Ames, Becton-Dickinson, Boehringer Mannheim, Boots Co., Bristol Myer Squibb, Eli Lilly, Farmitalia Carlo Erba, Hoechst-Zuellig, Novo Nordisk, Pfizer, Servier/Med Asia, and Wyeth Suaco. The Workshop was held in

Venee's Hotel in the district of Matina, Davao City. Lecturers were: Dr. Lina Lantion-Ang, Dr. Joselynn Anel-Quimpo, Dr. Araceli Panelo, Dr. Mary Anne Lim Abrahan, Dr. Ruby T. Go and Dr. A. D. Litonjua.

The 4th Workshop will be held in San Fernando, La Union early next year and will have Dr. Jennifer Wi as coordinator. Expected to participate are the chapters of Ilocos Norte, Pangasinan, Baguio City and the soon to be formed chapters of Ilocos Sur and La Union.

Novo Nordisk's

... (From page 1)

that physician who has excelled in diabetes education and/or research, and/or community service related to diabetes for no less than four years.

3rd DiabetesWorkShop

August 11-13, 1991

Venee's Hotel, Matina, Davao City

Participants

- | | |
|--------------------------------|-----------------------------|
| 1. Abear, Juan, Jr. M. | 24. Luague, Norma M. |
| 2. Adarna, Alicia C. | 25. Macadato, Bai Tarjata |
| 3. Adlaon, Zaida H. | 26. Maglana, Marilou P. |
| 4. Alquiza, Mila | 27. Magno, Hansel Jr. |
| 5. Arguillas, Marilyn | 28. Montenegro, Virginia R. |
| 6. Asuelo, Virgilio M. | 29. Montague, Ciriaco M. |
| 7. Avellanosa, Amancio, Jr. G. | 30. Moreno, Ramon |
| 8. Barez, Yvette | 31. Pableo, Grace |
| 9. Bautista, Chyrl Tan | 32. Padiila, Prospero |
| 10. Bisnar, Luisa Llanes | 33. Ramas, Joon |
| 11. Canonoy, Teresita M. | 34. Rivera, Ramon |
| 12. Caoagdan, Emilio S. | 35. Samtani, Hargoon |
| 13. De Castro, Froilan T. | 36. Sarmiento, Richio T. |
| 14. Deocampo, Rosario M. | 37. Sarmiento, Melo Jane A. |
| 15. Dizor, Emily Calvo | 38. Sta. Cruz, Judith |
| 16. Durban, Evangeline | 39. Tan, Erlinda |
| 17. Evidente, Ma. Cleo E. | 40. Tanopo, Helen H. |
| 18. Fernandez, Rico Hector D. | 41. Tecarro, Edna S. |
| 19. Francisco, Juanito D. | 42. Torre, Arisfina M. |
| 20. Galang, Daniel B. | 43. Torres, Ma. Luz C. |
| 21. Galupo, Wilhelmina F. | 44. Villegas, Edilberto B. |
| 22. Gatmin, Judy Ann S. | 45. Viola, Danilo J. |
| 23. Homez, Edgardo C. | 46. Wi, Jennifer M. |

The Award will consist of a cash prize of ₱100,000.00, medical textbooks or journal subscription worth ₱10,000.00 and a plaque of recognition.

FICE's ... (From page 1)

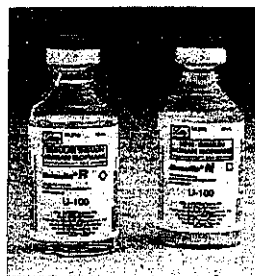
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DIACARE Formally Inaugurated

The Diabetic Care and Assistance Foundation of the Philippines held its formal inauguration last April 13, 1991 at the Makati Sports Club. Angeli Pangilinan-Valenciano, wife of diabetic superstar Gary Valenciano, gave an inspirational talk on "How it is living with a diabetic and how the family can help in diabetes management." Secretary Alfredo R.A. Bengzon of the Department of Health was the keynote speaker who spoke about the current state of diabetes in the Philippines. He committed the support of the department (and its wide network down to the barangay level) especially to the information campaign of the foundation.

Inducted by Secretary Bengzon as officers were the following: Joby G. Belmonte — President; Assunta Ancheta —

Vice President; Cecille Maranon — Secretary; Raul V. Gamban — Treasurer; Rosalinda Torres, Zenaida Saquing, Emmanuel B. Zabala and Atty. Ramon Ledesma — Board of Directors.

The foundation has the following objectives:

- to bring together all diabetics, parents, friends and concerned individuals or companies who wish to help the foundation;
- to fund an organized educational and out-reach program to further improve diabetes management of those afflicted members;
- to disseminate information regarding the latest developments in the management, control and cure of diabetes; and
- to offer assistance when needed to its members whenever possible.

Logo Contest . . .

(From page 1)

and ₱1,000 for the third prize will be awarded on the same day.

The entries should be in a form suitable for printing, and in color, and should be submitted to the office of the PDA, Room 309, Polymedic General Hospital, EDSA, Mandaluyong, Metro Manila.

The logo should depict the aim of the PDA which is primarily diabetes care for the individual, family and community.

Annual Convention . . .

(From page 1)

Dr. Leonor Cabral-Lim, neurologist. Topics in the afternoon include dietary tips by Ms. Annela Orbeta-Heytens, foot care by Ms. Merle Victorino, and sick day guidelines by Dr. Ricardo Fernando.

FIGHT DIABETES Support the PDA

Juvenile Diabetes Reunion on November 17

All juvenile diabetics will have an Annual Reunion and Christmas Program on Sunday, November 17, 1991 at the Quezon City Charismatic Renewal Center at 55 Scout Santiago St., Quezon City.

Features of the day will be a series of lectures for both patients and students by members of the staff of the Institute for Studies on Diabetes.

There will be a Christmas program to be followed by the annual meeting of The Juvenile Diabetes Foundation.

Plans for next year's summer camp for diabetic children will be discussed during the meeting.



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COCONUT OIL



Good or Bad?

CONRADO S. DAYRIT, M.D.*
Cardiologist, Pharmacologist

Question: Is it true that coconut oil has plenty of cholesterol which is bad for the heart?

Answer: No. Coconut oil has practically no cholesterol. Its cholesterol content varies from 0 to 14 parts per million (ppm). Soybean oil contains 18 ppm, corn oil 50 ppm; animal and dairy fats like lard and butter contain 3,500 and 3,150 ppm, respectively.

Regarding the second part of the question, that of cholesterol in foods being bad for the heart: This is now seriously questioned and the US Food and Drug Administration has prohibited the placing of "No Cholesterol" label in food products. The cholesterol in the body is mostly synthesized by the body itself. Dietary or preformed cholesterol in foods contributes very little to serum cholesterol. Some people, in fact, eat several eggs a day (egg yolk is rich in cholesterol) and their serum cholesterol is not affected. The synthesis of cholesterol by the body is regulated by one's own genes

and persons with high cholesterol inherit this predisposition from their parents. In such predisposed persons (young to middle-age males and women after menopause) eating of dairy and animal fats, which are saturated, has been shown to be more harmful than preformed cholesterol.

Question: So — does not coconut oil contain these bad saturated fats that produce atherosclerosis and coronary heart disease?

Answer: No. Coconut oil fats, though saturated, are predominantly *medium chain* triglycerides (MCTs) which are only 6-12 carbon atoms long. Animal and dairy fats contrariwise contain saturated *long chain* triglycerides (LCTs), 16-20 carbon atoms in length. MCTs should be differentiated from LCTs because, while both are saturated, they differ diametrically in their absorption, transport, metabolism and effects on the body. Simply put, MCTs are readily digested, rapidly carried to the liver

where, like carbohydrates, they are speedily and almost totally converted to energy, without need for insulin. MCTs are not elongated to LCTs and are not deposited as fat. They are not converted to cholesterol in the body nor are they transported in the blood by the low density lipoproteins (VLDL and LDL). Very recent evidence even suggests that coconut oil may have the beneficial effect of increasing HDL which carry the cholesterol from the peripheral tissues back to the liver for excretion. (HDL or high density lipoproteins are like "garbage disposal units" for cholesterol and should be increased, if low). Hence, coconut oil is more of an energy food in contrast to LCT-containing fats and oils whose fatty acids are only partially (30%) oxidized to energy and whose excess is deposited as cholesterol and in fat depots. Therefore, saturated fats are not all the same. There are the cholesterologenic LCTs and the energy-rich MCTs.

Question: If corn and soybean oils are rich in polyunsaturated fatty acids (PUFAs) that are

said to lower serum cholesterol, should we not use only these oils?

Answer: Yes, we should use some corn or soybean oil because PUFAs, especially linoleic acid, are essential fatty acids, needed by the body like vitamins. But PUFAs liberate free-radicals and in large amounts can hasten ageing and have been shown in many animal studies to act as mutagens (i.e. affect chromosomes) and promote cancer. The U.S. Surgeon General, following the advice of top cardiologists, advises that PUFAs in the diet should not exceed 10% of total daily caloric requirement or 1/3 of total fats.

Question: If butter is bad, is it better to take margarine made from corn oil?

Answer: In making margarine from corn oil or from any PUFA containing oils, the liquid oil has to be partially hydrogenated to make it more solid. Hydrogenation converts PUFAs to either saturated LCTs or to isomeric trans-fatty acids, both of which raise cholesterol and lower HDL.

Question: What fats can one take, therefore?

Answer: In general, one's diet should not be too rich in fats — 10 to 20% is good. Coconut oil is "neutral" (i.e. does not affect cholesterol), energy-rich and is a good oil to supply the basic needs for cooking. PUFAs, being essential, should be included in the diet in small amounts. Fish oils are also good for reasons not covered in this article and should be included. Animal and dairy fats in small amounts are not bad. The advice therefore is: Take a mixture of various fats, and keep total fat and calorie intake low — 1,500 to 2,500 calories depending on one's physical activity and body size.

*Vice President, Medical Affairs, United Laboratories
Emeritus Professor, College of Medicine, University of the Philippines

Recently, there has been an upsurge of interest in the use of fish oils for the prevention of coronary artery disease, the most common form of heart disease to affect the diabetic patient. The interest originated from observations which saw an inverse relationship between fish diets and coronary artery disease — the more one adheres to a fish diet, the less one is prone to heart attack.

Fish have a special type of fat content — the omega-3 fatty acids which are highly polyunsaturated (5 or 6 double bonds). In comparison, the chief fatty acid of vegetable oil, linoleic acid, contains only two double (or unsaturated) bonds. Thus, the desirable property of fish oils (see Diabetes Watch, last issue). However, the use of commercial fish oil supplements is not the way to avail of oils which contain beneficial poly-unsaturated fatty acids which lower cholesterol in the blood.

In the November-December 1989 issue of Clinical Diabetes, Dr. Sidika Kasim, Director of the Lipid Program at Wayne State University in Michigan, USA lists the undesirable effects associated with fish oil supplementation:

1. **Weight gain** — a fish oil capsule contains about 10 K calories, so that the recommended dose of 8-30 capsules/day can mean a weight gain of 8-30 lbs/year.

2. **Excess cholesterol intake** — some fish oil supplements contain about 7 mg cholesterol/capsule to provide an additional 50-200 mg cholesterol/day. The recommended daily intake of cholesterol is only 300 mg. So the fish oil supplement leaves little else cholesterol to come from the other food items of the diet.

3. **Worsening of blood sugar control** — several studies are cited wherein increases in the

and now . . .

FISH OILS



AUGUSTO D. LITONJUA, M.D.
President, PDA

fasting blood sugars, post meal blood sugars and glycosylated hemoglobin values have been observed during fish oil supplementation. It seems that the liver is stimulated by the fish oil supplement to increase its output of sugar into the blood.

4. **Bleeding tendencies** — fish oils, by altering the function of the blood elements (platelets) responsible for clotting, cause prolongation of bleeding time and easy bruisability. Eskimos, who have a high intake of dietary fish, have a 2 fold increased risk of developing bleeding strokes (cerebral hemorrhage).

In the August, 1990 issue of Diabetes Care, Dr. T.J. Hendra, et al, carried out the first big scale controlled study on fish oil supplement. The fish oil supplement was used in 80 NIDDM subjects. Triglyceride, but not cholesterol levels decreased, with deleterious effects on a clotting factor (Factor VII) and in blood glucose levels and in LDL-cholesterol values. Thus, the authors conclude that fish oil in the dosage used (10 g/day) "cannot be recommended to NIDDM subjects as an aid to reducing cardio-vascular risk."

In another study utilizing a smaller group of diabetics, this time IDDMs, as reported in the July 1990 issue of Diabetes

Care, Dr. T.A. Mori, et al, conclude:

— "however, in view of this hypercholesterolemic effect and evidence that suggests that LDL apolipoprotein B (protein linked to fat substances) may be a risk factor for coronary heart disease, these findings raise questions regarding the safety of fish oils in patients with IDDM."

In our country, fish oils are marketed as PROCARD and SQUALENE. We do not recommend these products for use by diabetic patients in the light of the foregoing studies. On the other hand, if one wants to avail of the benefits of fish oils, he should just include fish in his diet more often (See DiabetesWatch, Vol. VIII, No. 1).

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	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."

NON-INSULIN DEPENDENT DIABETES MELLITUS

Is it "mild diabetes?"

TOMMY TY-WILLING, M.D.
Diabetologist
Metropolitan Hospital

"... don't worry, you won't need insulin ... your diabetes is only mild"

— overheard at a Diabetes Clinic.

The idea that non-insulin dependent diabetes (NIDDM, Type 2) is "milder" than the insulin-dependent diabetes (IDDM, Type 1) is deep-seated. In his classic paper on long term control and the development of complications, Jean Pirart equates "mild diabetes" to that which is "without chronic insulin dependence." Similarly, in his original description of the distressing syndrome of diabetic neuropathic cachexia, Max Ellenberg records that "... the diabetes was mild ... patients were controlled with diet and oral agents." The implication seems to be that because some degree of pancreatic insulin secretion persists, Type 2 diabetics can survive without insulin being injected, and must therefore have "milder disease" than their Type 1 counterparts. From a strictly pathological viewpoint, this may be true; but in terms of natural history and prognosis, the concept has grave flaws. It has become increasingly realized that the two major "types" of diabetes mellitus are different etiolo-

gically and have differing long-term implications. It is therefore difficult to validly compare them in terms of "mildness" or "severity."

1. EYE DISEASE

If it is carefully looked for, retinopathy is very common in NIDDM. Pirart found that after 10 years duration of diabetes, background retinopathy was present in 19% of NIDDM patients with "good" control, and 51% of those with "poor control."

It is interesting that though background retinopathy is common, proliferation is unusual in NIDDM. In contrast, however, exudative maculopathy (edema in the macula) is more common. It can cause considerable visual disturbance and is a significant therapeutic problem.

2. NEPHROPATHY (Kidney Disease)

End-stage renal failure due to diabetic glomerulosclerosis is unusual in NIDDM, but this is probably because patients succumb to macrovascular disease before significant nephropathy becomes evident. Nevertheless, lesser degrees of nephropathy are also important, as a recent study from Denmark strongly suggests. In

this survey, 12.5% of 609 NIDDM patients were shown to have microalbuminuria or minute traces of protein in the urine. Of the group with urinary albumin levels between 30 and 140 mcg/min, 22% later developed overt or gross proteinuria, and the overall 10 year mortality (from diagnosis of microalbuminuria) was 148% higher than those with normal primary albumin excretion.

3. NEUROPATHY (Nerve Disease)

Asymptomatic peripheral neuropathy is very common, but cannot be considered a problem to the patient. Specific forms of neuropathy, however, may cause very distressing symptoms which are hard to treat — for example diabetic amyotrophy, diabetic neuropathic cachexia, painful peripheral neuropathy, and autonomic neuropathy.

The fully developed syndrome of painful neuropathy causes sleep loss, depression and considerable debility — often with some loss of weight. A more florid example of this weight loss occurs in the rare, but dramatic, syndrome of "diabetic neuropathic cachexia." Here, severe (and usually painful) neuropathy is

accompanied by weight loss and cachexia which is so marked that patients are usually investigated for malabsorption and/or malignancy before the correct diagnosis is made.

Though treatment of these painful neuropathic syndromes is difficult, they are fortunately usually self-limiting. The same is unfortunately not true of autonomic neuropathy, which may cause many distressing complaints including diarrhea, sweating, postural hypotension and impotence. The latter problem is particularly distressing and common. A survey from Scotland has shown that a staggering 35.6% of 216 male NIDDM (aged 35-39 years) had partial or complete failure of erection of at least 6 months duration.

4. MACROVASCULAR DISEASE (Big Blood Vessel Disease)

The major cause of premature death and disability amongst NIDDM is, however, large vessel disease — ischemic heart disease, cerebrovascular disease, and peripheral vascular disease. As well as occurring more frequently in NIDDM, these diseases are more severe. The overall mortality risk of NIDDM is about 2.2 to 2.4 times that of age and sex-

(Continued on page 7)

(from page 6)

matched non-diabetic patients. Peripheral vascular disease rarely features as a certified cause of death; but in terms of morbidity (including hospitalizations, health costs, debility and loss of work), the costs of lower limb ischemia, gangrene and ulceration, are huge.

Myocardial infarction (MI) is a particular manifestation of diabetic large vessel disease, which has attracted a good deal of attention lately. The mortality rate of MI is generally double the non-diabetic figure, (34% vs. 18%), Oswald and colleagues also demonstrated an increasing mortality risk with glycated haemoglobin (HbA_1) level, when this was measured in all patients admitted with MI's. The mortality was 23% in those with an HbA_1 of $< 7.5\%$, 33% when HbA_1 was 7.5-8.5%, and 63% when HbA_1 was $> 8.5\%$. They also estimated that 5.3% of all patients with MI have undiagnosed NIDDM.

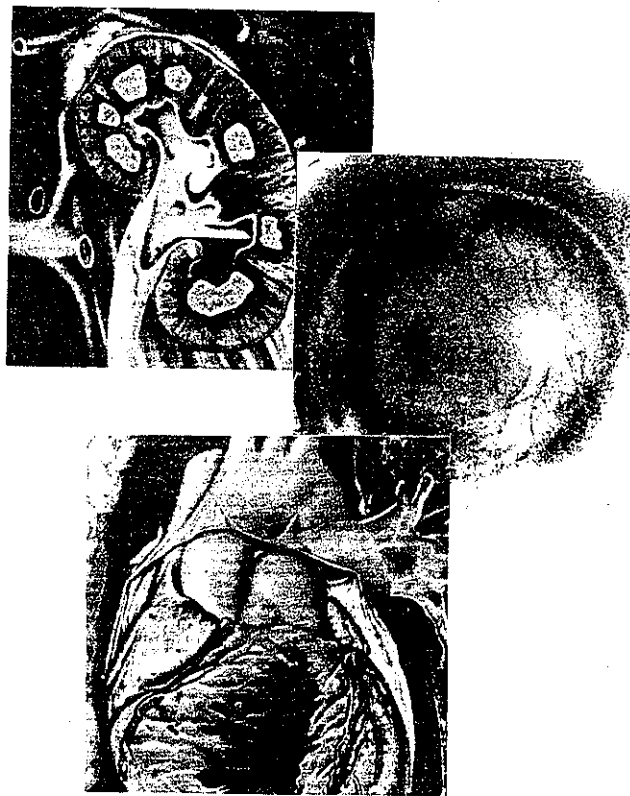
The reasons for the greatly increased rate and severity of atheromatous disease is complex, but there is no doubt that NIDDM patients as a group suffer more from obesity and hyperlipidemia than their non-diabetic counterparts. The same is probably true for hypertension.

5. ACUTE COMPLICATIONS

Although ketoacidosis is not generally a problem of NIDDM, hyperosmolar non-ketotic coma is a not uncommon emergency. Hyperosmolar coma probably accounts for at least 10% of all hyperglycemic emergencies, and the mortality is very high — in the order of 40 to 70%.

A neglected acute complication of NIDDM is sulfonylurea — induced hypoglycemia (low blood sugar). This is particularly common when potent

Diabetes a risk factor for vascular damage



“second-generation” sulfonylureas are used in the elderly and/or those with renal insufficiency. A Scandinavian survey of 57 episodes showed that hypoglycemia was prolonged (12-72 hours) in 24, and fatal in 10.

There can be no doubt that NIDDM may lead to, or increase the risk of, a number of serious and debilitating conditions. Can we continue to consider it as a “mild” form of diabetes mellitus? Certainly, many of its sufferers can not agree — for example, those blind with cataracts, those whose freedom and self-respect have been destroyed by amputation, those whose potency is permanently lost, those whose nights are disturbed by

the shooting pains of painful neuropathy, and the relatives of a middle-aged NIDDM man recently demised from myocardial infarction.

WHAT CAN BE DONE?

Diabetes is common, and NIDDM is the commonest subgroup. There are probably some two million non-insulin dependent diabetics requiring care in the Philippines, with more undiagnosed. The number being referred to diabetic specialists is also steadily increasing as diagnostic awareness spreads. Present diabetic services, in terms of manpower and clinic time available, are unable to adequately cope with the problem; and there is little doubt that the care of NIDDM is a major failure of the health

services of most if not all, countries. We are all aware of the overweight, sedentary hyperlipidemic, 50 years old who smokes 20/day and has recently been diagnosed diabetic — with no symptoms and a mildly raised HbA_1 level. The greatest service that we can do is to concentrate our energies on this patient's weight and smoking, rather than immediately confuse him with the tricks of the diabetic trade. Moreover, we should remember that there is little evidence that long-term mild to moderately elevated HbA_1 levels in NIDDM patients, significantly worsens the outcome. The same is certainly not true of hypertension, smoking, obesity and hyperlipidemia.

This is not to deny the value of sensible diabetic treatment, but patients must be taught to realize that they are not “all right as long as I take the tablets.” The use of sulfonylureas and insulin must be careful, preferably with avoidance in the overweight. The organization of care is of prime importance, and problem patients (e.g. those with complications or those likely to need insulin) should receive most attention. Consideration should be given to “shared care.”

Above all, from the very start we must impress upon our newly diagnosed NIDDM patients that their disease is potentially serious, and not the “mild” condition we have been pretending it to be for far too long.

“... although you don't need insulin, your diabetes may well seriously affect the duration and quality of your life. Together we must try to keep the risks at a minimum.”

— overheard at a Diabetes Clinic?

Reprint:

Dental Tips for Diabetics

• Controlling your blood glucose is the most important step you can take to prevent tooth and gum problems. People with diabetes, especially those whose blood glucose levels are poorly controlled, are more likely to get gum infections than nondiabetics. A severe gum infection can also make it more difficult to control your diabetes. Once such an infection starts in a person with diabetes, it takes longer to heal. If the infection lasts for a long time, the diabetic person may lose teeth.

• Much of what you eat requires good teeth for chewing, so it is extremely important to try to preserve your teeth. Because the bone surrounding the teeth may sometimes be damaged by infection, dentures may not always fit properly and may not be perfect substitutes for your natural teeth.

• Taking good care of your gums and teeth is another important measure. Use a soft-bristle brush between the gums and the teeth in a vibrating motion. Place the rubber tip on the toothbrush between the teeth and move it in a circle.

• If you notice that your gums bleed while you are eating or brushing your teeth, see a dentist to determine if you have a beginning infection. You should also notify your dentist if you notice other abnormal changes in your mouth, such as patches of whitish-colored skin.

• Have a dental checkup every 6 months. Be sure to tell your dentist that you have diabetes and ask him or her to demonstrate procedures that will help you maintain healthy teeth and gums.



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DiabetesWatch

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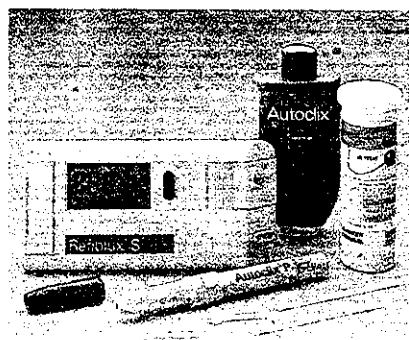
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