Member, International Committee of Diabetes Magazines, International Diabetes Federation

DiabetesWatch

A publication of the PHILIPPINE DIABETES ASSOCIATION, INC.

VOL. IX, No. 2 September 2, 1992

First Servier Lecture in Diabetes

The First Servier Lecture in Diabetes will be delivered by Prof. John R. Turtle of the University of Sydney Australia on the evening of December 9 at the Hotel Intercontinental. Dr. Turtle will speak on new aspects of the management of diabetes mellitus.

World Diabetes Day 1992

World Diabetes Day 1992 and in years to come will officially be 14 November, the birthdate of Frederick Banting. The announcement came after the IDF received official notice from Director-General Hiroshi Nakajima that WHO would again co-sponsor World Diabetes Day in 1992.

In many countries World Diabetes Day activities have been planned for different dates, and

(Continued on Page 2)

PDA Advisory No. 3

Since the control of the elevated blood sugar remains the single most important objective in the management of diabetes mellitus, recent knowledge has added some more laboratory aids to ensure lasting control of the sugar levels in the blood. Patients are advised to consult with their physicians on the need of these in their particular cases.

Glycated hemoglobin, or glycosylated hemoglobin, or HbA1 - this comprises a series of minor components of the red cell protein, hemoglobin, to which sugars (glucose) have combined. The level of HbA1 reflects the integrated levels of the blood sugar, and therefore the average blood sugar concentration over the preceding 6-8 weeks. Thus, the HbA1 gives an indication of the control of the patient in between clinic visits.

Fructosamine - Other proteins in the blood may combine with glucose like hemoglobin. Notably so with the serum protein, albumin. Unlike hemoglobin, however, which stays in the red cells for about 6-8 weeks, albumin stays for a shorter duration in the blood. Thus, the combination of albumin with glucose - or the 'fructosamine reaction' - provides a measure of short term (1-2 weeks) integrated blood sugar control.

The above two lab aids cannot substitute for single blood glucose measurements, and are used as adjuncts to the fasting and postprandial blood sugar determinations.

1992 Annual Convention

The annual convention of the PDA will be held on December 10 (Thursday) at the Nikko Manila Garden Hotel in Makati. Guest will be Dr. John Karam, noted diabetologist from the University of California, San Francisco. The convention will be a whole-day affair.

Fellowship in Diabetes

The Department of Diabetes and Endocrinology, Lidcombe Hospital, Sydney, Australia is inviting application for the position of postgraduate fellow in diabetes for 1993. The aim of the fellowship program is to provide an opportunity to facilitate the development of diabetes education and research in Southeast Asian countries.

Application should be forwarded to:

(Continued on Page 4)

More than 250 doctors, nurses, dieticians and patients attended the first mid-year convention of the Association in Cebu City last July 10. Guest speaker was Prof. Gerald Reaven, who is shown receiving a plaque and other gifts from Dr. Litonjua. The occasion was held at the Cebu Midtown Hotel, and the sponsoring chapter was headed by Dr. Marian Denopol, president; Dr. Pura B. Dominguito, vice president; Dr. Erlinda Po, secretary; Dr. Alan T. Sy, treasurer; and Mrs. Eleuteria Reyes, PRO. Other members of the board include Dr. Fay Dano and Dr. Elma Baculao. Sponsor of Prof. Reaven's trip was Farmitalia Carlo Erba.

The National Headquarters of the Association was inaugurated recently. Located at Unit 25 of the Facilities Center, 548 Shaw Boulevard in Mandaluyong, the unit will now serve as meeting place of the Board of Directors and will serve as the repository of the records of the Association. Shown cutting the ribbon at the inauguration rites is Dr. Gonzalo Austria, past president, and assisted by two other past presidents, Dr. Herminio Gemar (left) and Dr. Aurora Cinco-Villegas (right). At the back (l to r) are Mr. Lito Tomas of Boehringer Mannheim; Dr. Litonjua, PDA president; and Mr. Tony Ancheta of Boots Pharmaceutical and current Board member.

From the IDF:

The San Jose Declaration

Education in Diabetes A Right and An Obligation

The San Jose Declaration has been adopted by the International Diabetes Federation

Education is a fundamental component of the treatment of diabetes. Patients and professional education allows the proper implementation of general dietary and therapeutic procedures. This promotes the final goals of treatment; the day to day well-being of the person with diabetes and the preservation of life with the least risk of developing long-term problems.

It is a right of every person with diabetes to be fully informed on the nature and management of the disorder; and it is the obligation of communities and of the nations, to supply the means for the achievement of this right.

There is an increasing and absolute need for the provision of education in diabetes in all countries, most particularly in developing countries. This need is largely unfulfilled. The material resources required for these educational activities are limited, relative to the benefits derived from such actions. Human resources are, however, available.

It is important and urgent that all governmental and non-governmental organizations with an interest in health and, particularly, diabetes take responsibility for the promotion of an increase in educational activities in diabetes. Such actions should include:

-The organization of seminars, short courses and workshops for health care professionals.

-The establishment of training centres as a regional resource.

-The provision of training fellowships.

-The organization of continuing educational activities for people with diabetes and their families.

-The strengthening of teaching of diabetes in all university programs related to health sciences, and also at the level of public education.

-The promotion of educational activities for communities.

The achievement of the goals stated in this declaration will make a major contribution to the improvement of the quality of life of people with diabetes in every country of the world. We call upon governments to take action now.

World Diabetes... *(From Page 1)* many inspiring events have already been held in 1992. World Diabetes Day is an ongoing phenomenon, and the date of recognition is left to the discretion of individual countries and organizations.

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CHAPTER NEWS

FROM BAGUIO-BENGUET

1. Diabetes Clinic every Thursday morning with an average of 6 patients a day.
2. Diabetes Education to laymen Hospital Week Celebration May 7, 1992.
3. Lecture on the "Role of the Nurse in Diabetes Management" Attendance - 58 nurses June 25, 1992.
4. Community Screening on Diabetes, Barangay Dontogan, Green Valley, Baguio City.
5. Two physicians and one nurse attended the Workshop on Diabetes held in San Fernando, La Union.

Schedule of Activities:

1. To send one physician and one nurse to the 4th Workshop on Diabetes in Quezon City.
2. Diabetes Screening at the Baguio Public Market last week of October 1992.
3. Coordinating for a Radio program on Information Dissemination about Diabetes.

FROM CAGAYAN

Diabetes Educational Clinic Census
of the CAGAYAN VALLEY REGIONAL HOSPITAL

Month	Total No. of Patients	Followed-up Visits	New Patients
July 1991	5	2	3
August 1991	11	5	6
September 1991	6	4	2
October 1991	15	9	6
November 1991	12	8	4
December 1991	10	7	3
January 1992	18	10	8
February 1992	15	9	6
March 1992	14	10	4
April 1992	14	11	3
May 1992	8	5	3
June 1992	18	10	8

Average No. of Patients every month = 12-14
Average No. Of New Patients every month = 3-5
Total No. of Patients followed-up from July 1991 to June 1992 = 90
Total No. of New Patients from July 1991 to June 1992 = 52


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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 3days

- "Glipizide evoked a more pronounced and more rapid increase of plasma insulin and correspondingly greater and faster blood glucose reduction than did glibenclamide."
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AFES launches regional study on Diabetes and Pregnancy

A core group representing the member countries of ASEAN has completed a study protocol that should answer some questions on diabetes and pregnancy, such as, the incidence of increased blood sugar in pregnant women, the outcome of a standard protocol for dealing with diabetes in pregnancy, and a long-term follow-up on the offsprings of mothers who were diabetic during their pregnancy. Composing the core group are: Dr. Boedisantoso R. of Indonesia, Prof. Annuar Zaini of Malaysia, Dr. Kek Lee Phin of Singapore and Dr. Samantha Serirat of Thailand. Chairman of the group for the period, 1991-1992 was Dr. Augusto D. Litonjua.

The Philippine Group to oversee the project nation-wide has been formed with Drs. Natividad Puertollano and Virgilio Castro as obstetricians-perinatologists; Dr. Carmelita F. Domingo, Dr. Dolores Sy and Dr. Sioksuan Chan-Cua as pediatricians; and Dr. Litonjua and Dr. Honolina S. Gomez, as diabetologists.

Institutional study groups are now being established all over the Philippines, and the objective is to come up with a management protocol that will do away with most of the complications of diabetes affecting the mother and her child.

●

RP Doctors Participate in 6th AFES Convention

Physicians from the Philippines comprised the third biggest foreign delegation who attended the 6th Congress of the ASEAN Federation of Endocrine Societies (AFES). This was held last July 2-5 in Jakarta, Indonesia.

Symposium lecturers were: Dr. Mary Anne Lim-Abrahan who spoke on 'Mortality of Thyroid Cancer;' Dr. Ricardo Fernando, 'Microalbuminuria and Incipient Nephropathy;' and Dr. Augusto D. Litonjua, 'Overview of Gestational Diabetes.'

Chosen symposium chairman were Drs. Fernando and Litonjua, whereas Dr. Lina Lantion-Ang served as plenary lecture co-chairman. Chairing the free communications sessions were Dr. Mary Anne Lim-Abrahan and Dr. Rolando Jardeleza.

Drs. Carmelita F. Domingo and Sioksuan Chan-Cua presented papers, while Dr. Domingo and Drs. Minnie Sy-Enriquez and Fe Hilado had poster presentations.

A completed study protocol on Diabetes and Pregnancy was presented by Dr. Litonjua to the Congress. On the planning stage was another cooperative protocol on a tumor registry of thyroid cancer. Data are being prepared for the 7th Congress which will be held in late November, 1993 in Kuala Lumpur, Malaysia.

-L. C. Lantion-Ang, M.D.

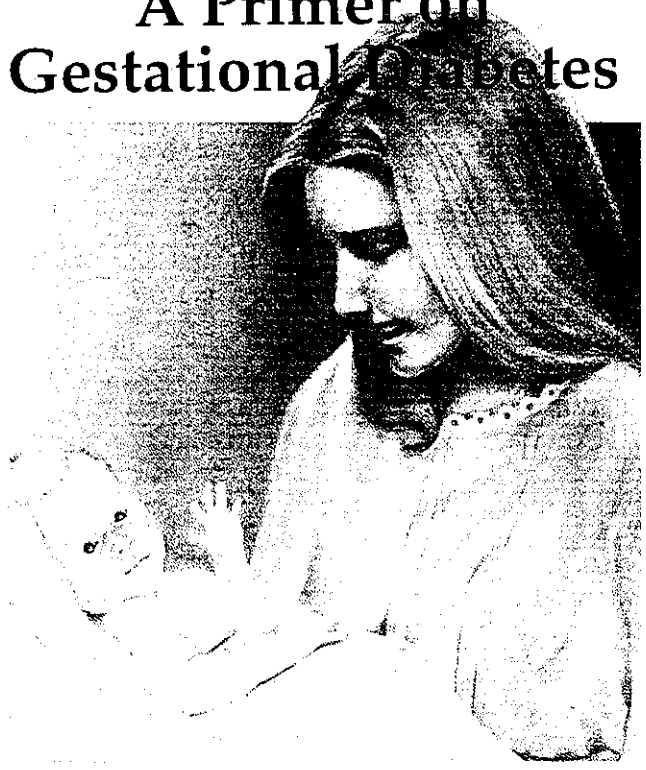
Fellowship... *(From Page 1)*

Dr. Jeff Flack, Director
Diabetes Centre,
Lidcombe Hospital
PO Box 247, Lidcombe
NSW 2141, Australia
FAX 61 2 6465978,
or 61 2 7492430.

A monthly stipend of $A500 will be awarded the fellow. The one-year fellowship will begin in January, 1993.

Application forms are available at the National Headquarters of the Philippine Diabetes Association.

A Primer on Gestational Diabetes



What is Gestational Diabetes?

Gestational diabetes is the diagnosis given when high blood sugar is first detected during pregnancy. This is in contrast to the term, Pregestational Diabetes, where a woman known to have diabetes becomes pregnant. In both cases, the elevated blood sugar can do harm to the mother and her baby.

Who are prone to develop gestational diabetes?

Women with a family history of diabetes, or who are overweight, have a greater chance of acquiring gestational diabetes, although it can occur in women with no risk factors for this disorder. Gestational diabetes usually recurs with subsequent pregnancies.

What may happen to the baby?

High blood sugar levels can affect the baby in many ways. It is important to realize, however, that these problems can be prevented by maintaining normal blood sugar levels - thus, close cooperation with the physician is necessary.

One possible outcome of gestational diabetes is large babies. The reason for this is that the mother's sugar crosses the placenta to the baby, and the baby's pancreas will respond by producing extra insulin. This extra insulin that the baby produces causes the baby to grow bigger.

Because the baby has been making extra insulin inside the mother's womb, it is hard to stop this insulin production quickly after the baby is born. The result of this is that the baby goes through a type of sugar withrawal at birth. This withrawal occurs because the baby has become accustomed to high blood sugar levels. This may cause the baby's blood sugar to drop dangerously low to cause serious problems in the newborn.

Other blood chemistries may be affected while the baby's organs adjust the first few days after birth. Yellowing of the skin (jaundice) is a common occurrence which pediatricians are able to cope with successfully.

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Untreated GDM can lead to problems for both mother and child.

WHY WORRY ABOUT GESTATIONAL DIABETES?

Janice T. Radak
Reprinted from Diabetes Forecast
April 1991

You are 28 weeks pregnant and your obstetrician has just informed you that you have gestational diabetes mellitus (GDM). Should you be concerned?

According to a group of nearly 300 health-care professionals who attended a special conference on this topic, the answer is yes. While the experts disagree on exactly what issues are of most concern to you, they all agree that gestational diabetes is a condition that needs immediate attention-both for the long-term health of your baby as well as the implications for your own long-term health.

What is Gestational Diabetes?

Gestational diabetes is defined as carbohydrate intolerance of variable severity with onset or first recognition during pregnancy. In other words, pregnant women with no personal history of diabetes who have higher-than-expected blood-glucose levels are diagnosed as having gestational diabetes.

This form of diabetes was identified as a serious condition when the first international workshop, sponsored by the American Diabetes Association, was convened in 1979. A second ADA - sponsored workshop made treatment recommendations in 1984. And this past November, ADA's Third International Workshop Conference on Gestational Diabetes Mellitus was held and revised treatment recommendations are pending.

Gestational diabetes affects about 3 percent of all pregnancies. At the first workshop, the late Norbert Freinkel, M.D., considered an authority on gestational diabetes, predicted there would be an average of 100,000 cases of gestational diabetes each year in the United States alone. As programs for the detection and treatment of gestational diabetes are more widely implemented throughout the United States and abroad, that prediction is being fulfilled.

Janice T. Radak is Managing Editor of Forecast. This article is based on information presented at the Third International Conference on Gestational Diabetes Mellitus, November 8-10, 1990, in Chicago.

While the exact causes of this condition are unknown, several key players in its development have been identified. First and foremost are the hormones created by the placenta (the organ that provides nourishment to the baby while it is developing inside the mother). These hormones help the baby develop. Unfortunately, these same hormones also block the action of the mother's insulin, and this can lead to insulin resistance. Because of these hormones and other factors, all pregnant women have some form of insulin resistance. As a result, the mother's body may require up to nearly three times as much insulin as usual. So even a non-diabetic mom's pancreas is working overtime.

But gestational diabetes develops when the mother's body cannot compensate for the combination of insulin resistance and increased need for insulin. In other words, the mother's pancreas cannot produce all of the insulin her body requires for pregnancy. You know the rest of the story: Without the insulin, glucose cannot leave the blood and be converted to energy. Glucose build-up in the blood leads to hyperglycemia (high blood-glucose levels) is the hallmark of all types (type I, type II, as well as gestational) of diabetes.

Usually, gestational diabetes disappears after pregnancy, and blood-glucose values return to normal. However, approximately 35 to 50 percent of all women with gestational diabetes will go on to develop diabetes, usually type II (non-insulin-dependent), usually within eight years.

The American Diabetes Association recommends that all women be screened for gestational diabetes between the 24th and 28th weeks of pregnancy-the test usually occurs during the fourth month. That's because it is at this time that the placenta begins to produce the vast quantities of hormones that lead to insulin resistance, the need for more insulin, and finally, gestational diabetes.

Who Is At Risk?

Like other types of diabetes, this form can strike any pregnant woman-but certain factors put some women at higher-than-average risk. Those factors include:

-Higher maternal age: How old are you at the time of the pregnancy? Older mothers are at greater risk.

-Obesity: Were you more than twenty percent over ideal weight before you became pregnant? Women who start their pregnancies overweight are at higher risk.

-Family history: Does non-insulin-dependent diabetes run in your family? Did your mother or sister have an infant weighing more than nine pounds? If so, you may be at higher risk.

-Ethnicity: Does your ethnic background place you at higher risk for type II diabetes? For example, Hispanics and Blacks are at increased risk for non-insulin-dependent diabetes. Researchers are now finding that the same is true for gestational diabetes.

-Previous obstetrical history: Did you have gestational diabetes in an earlier pregnancy? Have you had a baby weighing more than 9 pounds?

Treating Gestational Diabetes

Unlike the other two types of diabetes, where the individual has time -a lifetime- to learn about the ins and outs of meal planning, blood-glucose control, and various health concerns associated with the disorder, women with gestational diabetes have very little time. That's because treatment begins immediately to help create the best possible environment for the health of the developing baby.

Treatment plans are designed to keep blood-glucose levels within ranges that are considered acceptable for pregnant women who do NOT have gestational diabetes. Treatment plans always include special meal plans and may also require daily or weekly blood-glucose testing, scheduled exercise, and/or insulin injections. Women with gestational diabetes work closely with their heath-care teams so that treatment plans can be changed as the pregnancy progresses.

Treatment plans focus on keeping blood glucose in line because glucose and other nutrients cross the placenta-but insulin does not. So, mom's high blood glucose can pass through

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Why worry...

(From Page 5)

the placenta, giving her developing baby high blood glucose. In response, the baby's pancreas produces the extra insulin it needs to process all the glucose.

This can lead to macrosomic or "fat" babies. Macrosomia develops because the extra insulin stimulates the baby to lay down extra layers of fat in order to use all the glucose mom sends across the placenta. Macrosomic babies face health problems of their own, including difficult deliveries. Because of the extra insulin produced by the baby's pancreas, newborns are also at higher risk for problems such as respiratory distress (breathing difficulties), and neonatal hypoglycemia (very low blood glucose). Information presented at the recent workshop also suggests that these babies may be at increased risk for childhood obesity and type II diabetes.

Gestational diabetes treatment helps the mother by preventing the symptoms of hyperglycemia-excessive thirst and urination. And keeping blood glucose in line also helps reduce the risk for toxemia (pregnancy-induced high blood pressure) and swelling, and can help prevent urinary tract infections. Plus, large babies are not easy to deliver, so keeping the baby from becoming macrosomic helps mom, too.

Why Worry About GDM?

Is gestational diabetes something to worry about? There are two sides of this question to consider: One is more immediate and says you should be concerned about gestational diabetes because it is a disease. And left untreated, this disease may cause harm to your developing baby.

The other side is more long-range and says you should be concerned about gestational diabetes because its appearance means you (the mother) are at increased risk of developing non-insulin-dependent diabetes later in life.

So, what should an expectant mother with gestational diabetes do? Should she worry about gestational diabetes?

Most certainly, gestational diabetes is a condition to be concerned about. But the good news is that you can control it. And, working with your health-care team, you can translate that concern into concrete steps to help ensure a healthy environment for your baby.

And if your gestational diabetes disappears, all the better. But, having developed this form of disease, you and your health-care team now know, you are at increased risk for developing type II diabetes later in life. And knowing this means you can take the steps now that may help you prevent diabetes later.

Gestational diabetes is a serious condition that deserves your attention. Yes, you should be concerned. And if your concern turns to worry, be sure to talk with your health-care team. Pregnancy is not an easy experience. And gestational diabetes doesn't exactly help.

But gestational diabetes doesn't have to hurt, either.

A Primer on...

(From Page 4)

In very rare cases, the baby's blood chemistry and mineral levels can be so abnormal that they cause the baby to die before birth (stillbirth). Thus, as a form of precaution, doctors induce labor a few weeks early to deliver the baby by caesarean section. Early termination of the pregnancy artificially can be avoided by good control of the blood sugar.

Is the baby born of diabetic woman also diabetic?

The baby born of a diabetic mother is more likely to have low blood sugar at birth. Thus, at birth, the baby is not diabetic. There is a risk of developing diabetes later on in life.

What can happen to the mother?

Some women with gestational diabetes develop too much amniotic fluid in the uterus. This can cause early labor because the extra fluid stretches the uterus. If the labor is not stopped, the baby can be born prematurely.

A large baby can also prolong labor as the baby may have a hard time fitting through the birth canal. Birth injury can be a result to the baby.

Any woman with high blood sugar has a greater chance of developing infections, especially in the vagina, urinary bladder and the kidneys. A frequent examination of the urine may make for early diagnosis and treatment.

After pregnancy, what?

While the blood sugar levels of the mother are followed after delivery, an oral glucose tolerance test is mandatory 6 weeks after delivery if the single blood sugar tests are normal. In the great majority of women with gestational diabetes, the diabetes disappears after delivery, although it may recur with the next pregnancy.

Blood sugar screens during pregnancy:

All women who become pregnant should now be screened for the presence of high blood sugar. The ASEAN Study Group on Diabetes in Pregnancy has now protocolized the procedure for such screen and eventual diagnosis. It is hoped that there will be universal acceptance of this method.

— A.. D. Litonjua, M.D. adapted in parts from L. Jovanovic, D.L. Jornsay and A. E. Cuckles: Gestational Diabetes, published by Boehringer Mannheim Diagnostic.

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(Continued on Page 8)

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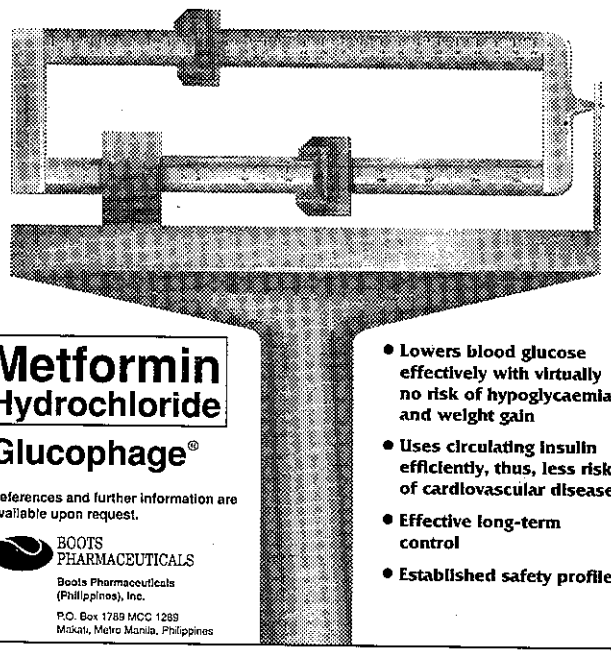

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(From Page 7)

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To be continued in next issue.

Second Regional Training Course for Diabetes Educators Held in Cebu City

The second regional training course for diabetes educators was held at Villa Kan-Irag in Cebu City last July 11 and 12. Faculty was composed of Dr. May Anne Lim-Abrahan, Dr. Allan Hernandez, Dr. A.D. Litonjua, Mrs. Emy Cardino and Mrs. Susan Trinidad.

Thirteen teams attended the Course, each team being composed of a physician, a nurse and a dietician.

Attendees were: *Southern Islands Medical Center, Cebu:* Dr. Liza Ma. Yap, Ms. Jacqueline Pesebre, Mrs. Astrid Falsis.

Mandaue City Health Office, Cebu: Dr. Obdulia Suico, Ms. Thelma Suico, Ms. Florita Olandria.

Sacred Heart Hospital, Cebu City: Dr. Helen Tio, Ms. Tessie Cerna, Ms. Visa Jutba.

St. Vincent General Hospital, Cebu City: Dr. Stela Dano, Ms. Janet Ramos, Ms. Girlie Dangcalan.

Metro Cebu Community Hospital, Cebu City: Dr. Ronald Rubio, Ms. Edna Cadavedo, Ms. Erlidan Taboada.

Cebu City Medical Center, Cebu City: Dr. Fe Lynn Rodriguez, Ms. Babelina Pepito, Ms. Rosalina Uy.

Puerto Princesa Hospital, Palawan: Dr. Josefina Goh, Ms. Rosita Herrera, Ms. Belinda Bontogon.

Rizal Memorial District Hospital, Dapitan City: Dr. Ferdinand de Guzman, Mr. Preciosa Adasa, Ms. Leticia Villanueva.

Bohol: Dr. Audrey Ramiro, Ms. Eufemia Betonio, Ms. Barilou Virtudazo.

Ormoc District Hospital, Ormoc City: Dr. Ramon Agudo, Ms. Myrna Filomeno, Ms. Susan Penserga.

Bacolod City: Dr. Marian Joyce Go, Ms. Jonna Guance, Ms. Trini Mugemulta.

Misamis Occidental Provincial Hospital, Oroquieta City: Dr. Iraa Marie Yape, Ms. Rosanna Mahinay, Ms. Agnes Omega.

MHARS General Hospital, Ozamis City: Dr. Margarita Cortes, Ms. Karen Sy, Ms. Flor Magtuba.

World Diabetes...

(From Page 2)

The IDF encourages all Member Associations to participate in this important diabetes awareness raising campaign, at any time they feel it is appropriate for their area.

IDF-WPR

DiabetesWatch

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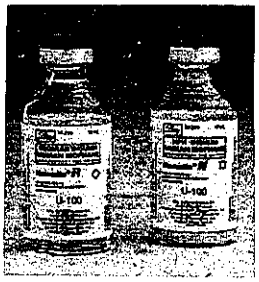

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