



Member, International Committee of Diabetes Magazines, International Diabetes Federation

Diabetes Watch

A publication of the PHILIPPINE DIABETES ASSOCIATION, INC.

YEAR XIII, NO. 1

JANUARY - JUNE, 1996

Congress OKs Diabetes Commission

Introduced by Senators Gonzales, Webb, Flavier, Coseteng, Romulo, Roco, Magsaysay, and Shahani, the Act shall be known as the "National Diabetes Act of 1996".

There will be created a National Commission on Diabetes, composed of nine members - a diabetologist, a research and education oriented physician, an epidemiologist, a diabetes-oriented nutritionist, a social scientist, an NGO engaged in diabetes prevention and control, an academican, and a diabetic with a diabetes-oriented service record. The Under-Secretary for Public Health Services shall be the *ex-officio* Chairman of the Commission. All of the commissioners shall be appointed by the President of the Philippines. The rules and regulations shall be set up by the Secretary of Health. The Commission shall be attached to the Department of Health for administrative, technical and budgetary purposes.

The Commission shall assess the social and economic impact of the disease, evaluate the adequacy of national resources devoted to prevention and control, and formulate a National Diabetes and Control Program. The program shall develop strategies to prevent diabetes and its complications, screening programs for early

(Continued on page 11)

PDA HOLDS MIDYEAR CONVENTION IN BACOLOD

10th Diabetes Workshop to precede confab

PROGRAMME

5th Mid-Year Convention
July 21, 1996

- 0830 Opening Ceremonies
0840 Plenary Lecture
"Is Diabetes Preventable?"
Speaker: Dr. Augusto D. Litonjua
Chairperson: Dr. Mary Arne Lim-Abraham

SYMPOSIUM I: NEW DEVELOPMENTS IN DIABETES: A SNEAK PREVIEW

- 0940 Proposed New Classification for Diabetes (ADA)
Speaker: Dr. Roberto Mirasol
1000 New OHA: The Thiazolidinediones
Speaker: Dr. Josephine C. Raboca
1030 Coffee Break
1100 The Non-Invasive Glucose Meter
Speaker: Dr. Laura Trajano-Acamapado
1120 The Role of the Podiatrist in the care of the Diabetic Foot
Speaker: Mr. Tye Lee Tze, Singapore
1200 Lunch Symposium, BMS

SYMPOSIUM II: MANAGEMENT PROBLEMS IN DIABETES

- 1330 Alternative Therapies in Diabetes Mellitus
Speaker: Dr. Alfonso T. Lagaya
1400 Management Problems in Insulin Therapy
Panel: Dr. Lina C. Lantion-Ang
Dr. Ruby T. Go
Dr. Elizabeth Paz Pacheco
1430 Coffee Break
1500 Diet Therapy in DM Nephropathy
Speaker: Miss Socorro T. Balderamos, RND
1530 Management Problems in Very Young Children
Speaker: Dr. Siok Soan C. Cua

LAY PROGRAM

- 0800 Welcome Remarks
0805 Lecture on Diabetes/Overview
Dr. Elwyn Fernando
0820 Complications
Dr. Rino Sobrepeña
0835 Exercise
0910 Coffee Break
1010 Lecture on Diet
Mrs. Socorro T. Balderamos
1025 Lecture & Demo on Foot Care
Ms. Rea Oarja
1040 Open Forum

The Philippine Diabetes Association will hold its 5th Mid-Year Convention on July 21, 1996 at the L'Fisher Hotel in Bacolod City. It will feature the Plenary Lecture "Is Diabetes Preventable?" Symposia topics include New Developments in Diabetes featuring the newer oral hypoglycemic agents, a proposed new classification for diabetes, the non-invasive blood glucose meter and new developments in wound care. The Symposium on Management Problems in Diabetes will include alternative therapies in diabetes, insulin therapy, diet therapy, diabetic nephropathy, and management of diabetes in very young children.

There will be a simultaneous session for the lay members which will include working sessions on diabetes complications, exercise, diet and foot care.

The coordinators for the 5th Mid-Year Convention are Dr. Ma. Teresa Plata-Que, Mrs. Susan B. Trinidad, Mrs. Estrella R. Dysanco and Mr. Cesar Rupert F. Ocampo.

The 10th Diabetes Workshop will be held on July 18-20, 1996 at the L'Fisher Hotel in Bacolod City. There has been innovation in the content and conduct of the course. It will feature more interactive

(Continued on page 2)

DIABETES AWARENESS WEEK STARTS JULY 28

Preventing the occurrence of diabetes in every community through proper education is a goal everyone can help achieve. On July 28 - August 3, 1996, the Diabetes Center in cooperation with the Philip-

pine Diabetes Association and DIACARE plans to involve individuals, civic and religious organizations and the media in spreading the word.

The kick-off activity for

(Continued on page 3)

10th DIABETES WORKSHOP

July 18-20, 1996
L'Fisher Hotel, Bacolod City

DAY 1:

Session 1: 8:00 AM - 12:00 Noon

EPIDEMIOLOGY/OVERVIEW

- Dr. Ma. Teresa Plata-Que

PSYCHOSOCIAL ASPECTS OF DIABETES MELLITUS

- Dr. Roberto C. Mirasol

MEDICAL NUTRITION THERAPY IN DIABETES MELLITUS

- Dr. Joselynn S. Afel-Quimpo

Session 2: 1:30 PM - 5:00 PM

EXERCISE AND DIABETES MELLITUS

- Dr. Rosa Allyn G. Sy

ORAL HYPOGLYCEMIC AGENTS AND INSULIN REGIMENS

- Dr. Elizabeth Paz-Pacheco

DAY 2:

Session 3: 8:00 AM - 12:00 Noon

CASE PROBLEMS IN INSULIN THERAPY

- Dr. Cynthia Halli-Manabat

ACUTE COMPLICATIONS OF DIABETES MELLITUS

Hypoglycemic

Diabetic Ketoacidosis/Nonketotic Hyperosmolar Coma

- Dr. Lina C. Lantion-Ang

Session 4: 1:30 PM - 5:00 PM

GESTATIONAL AND PREGESTATIONAL DIABETES MELLITUS

- Dr. Mary Anne Lim-Abraham

MANAGEMENT OF DIABETES MELLITUS IN SURGERY

- Dr. Ruby T. Go

DAY 3:

Session 5: 8:00 AM - 11:30 AM

DIABETIC FOOT

- Dr. Ma. Teresa Plata-Que

CHRONIC COMPLICATIONS:

Peripheral Vascular Disease/Atherosclerosis

Dyslipidemia in Diabetes Mellitus

- Dr. Tommy Ty-Willing

Session 6: 1:00 PM - 5:00 PM

CHRONIC COMPLICATIONS:

Retinopathy and Nephropathy

Hypertension in Diabetes Mellitus

- Dr. Elizabeth Paz-Pacheco

CHRONIC COMPLICATION

Neuropathy

- Dr. Augusto D. Litonjua

Convention, workshop...

(From page 1)

participation oriented to their medical practice and allow the registrants opportunities to share their more difficult clinic cases. The emphasis will be on innovative treatment techniques and proven medical management strategies. The coordinators for the 10th Workshop are Drs. Rosa Allyn Sy, Roberto C. Mirasol and Mr. Angelo C. Lagman in coordination with the members and officers of the PDA Chapter of Negros Occidental under the presidency of Dr. Marian Joyce G. Co.

The Diabetes Workshop was initiated in 1992 and has been held in Legaspi, Cebu, Manila, Davao, Baguio, Iloilo, Cagayan de Oro, Bulacan, and Lucena City.

Acute diabetic...

(From page 11)

able to manage the stress caused by such events as infection, surgery etc. much better thereby preventing the occurrence of these acute metabolic complications. Remember, as always, an ounce of prevention is worth a pound of cure. Think about it!

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Everything you always wanted to know about DIABETES...

(but were afraid to ask!)

ROBERTO MIRASOL, M.D.
Endocrinologist
Rizal Medical Center

To drink or not to drink is a dilemma often faced by people with diabetes. People may find pleasure in an occasional drink or often times they find themselves in social occasions where alcohol is being served. *What do I do? Is it good for me? What will happen to my sugars?* These are some of the questions often asked by patients. We will attempt to answer these questions to correct any misconceptions on alcohol. Cheers!!!

Can I take alcohol? While there is no evidence that an occasional drink is harmful to people whose diabetes is in

good control, it is important to be aware of the effects of alcohol in the management of diabetes. Read on.

Does alcohol have any nutritional value? Except for beer, alcohol has no nutritional value. It provides no carbohydrate, protein or fat. It cannot be used therefore as a substitute for food. Alcohol is high in calories, however. When used it can add calories to your meal plan. Beer contains carbohydrate. A bottle of beer contains approximately the same amount as a slice of bread. This should be counted in your meal plan.

What effect does alcohol have on my blood glucose?

Alcohol can lower your blood sugar and produce an insulin reaction or a hypoglycemia. When consumed, alcohol is absorbed directly from the stomach into the blood stream and carried to the liver where it is broken down. While the liver is processing alcohol, its ability to release glucose when needed by the body is completely blocked. This can result in a hypoglycemic reaction.

What can I do to prevent a hypo reaction? The best way is to abstain from alcohol. But if you cannot do this, it is important to eat while drinking. Food in the stomach slows down the absorption of alcohol into the blood stream and reduces the amount of alcohol reaching the liver at any one time.

But my doctor told me that alcohol will increase my blood sugar? That is correct. Some liquors such as sweet wines, liqueurs and cordials contain

large quantities of concentrated sugar. These should be avoided since this will increase the blood sugar. Use low calorie brands of alcohol ("lite" beer or *Cali 10*). When drinking mixed drinks, hard liquor such as gin, rum, whiskey or vodka should be mixed with water, soda or sugar free mixers.

How much alcohol am I allowed to take? You should take alcohol upon consultation with your physician. Use alcohol only if your blood sugar is in good control and limit your consumption to two drinks per week.

Will I have to change my insulin dose or omit my medications when drinking? Do not adjust your insulin or omit medications to accommodate for alcohol intake.

Most important is to inform your friends of the possibility of an insulin reaction. Otherwise they may confuse an insulin reaction with intoxication and fail to provide help if needed.

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Diabetes awareness...

(From page 1)

this event will be a motorcade starting from the participants' respective hospitals to Glorietta Quad in Makati City. It will be led by our famous mascot Busy Buddy, a hummingbird which was adopted by the International Diabetes Federation as an international symbol.

At the Glorietta, a Mass

will be officiated by a guest priest, a dance exercise demonstration will be participated in by selected patients and health practitioners.

During the week, television and radio interviews, blood glucose testings, lectures on diabetes and free clinics will be held daily in the participating hospitals.

Provincial chapters will have the same activities for the duration of the celebration.

"Doctor, shouldn't I change my medicine? It doesn't seem to work anymore. *Baka na-iimuna na ako sa* (beep)"

Before you conclude that the recent increases in your blood sugar levels is due to ineffectivity (or failure) of your medicine - THINK AGAIN. Think of other, certainly more common, reasons to explain your high blood sugar levels.

Dietary noncompliance and weight gain. You've been on your 1400 calorie per day diet for so long, you've lapsed into complacency, and allowed yourself a small jigger of liquor or a tiny bite of cake once too often.

Exercise. Because the rainy season is back, you find yourself cancelling your after dinner walks and acting the "couch potato" again.

Technique of Self-

WHAT'S NEXT??

--when tablets no longer work--

CYNTHIA HALILI-MANABAT, MD, PhD
Endocrinologist,
U.P. College of Medicine

Monitoring of Blood Glucose (SMBG). When was the last time you calibrated your machine? Are you using expired strips? Are you meticulous about the timing and procedure?

Illness or infection. Do you have a non-healing, infected wound? If you've had fever and cough the last few days, have you had your lungs checked? Is there any pain on urination or itchiness in your groin? Any illness or infection constitutes a stress situation wherein your

body automatically copes by producing increased amounts of contra-insulin hormones. That is why blood sugars tend to go up during an illness.

Drugs. If you are asthmatic or have severe arthritic pains, has your doctor been giving you corticosteroids? Are you taking diuretics for hypertension? Some medicines like steroids, thiazides, beta-blockers and nicotinic acid, may have hyperglycemic effects.

Noncompliance. Have you

been taking the prescribed number of tablets, at the right time and frequency? Sometimes, when money is tight - or simply because you forget - do you skip your lunch time or evening dose?

Inappropriate selection of medication. Could your doctor have made a mistake in labelling you non-insulin dependent (NIDDM) when in fact, you are insulin-dependent (IDDM)? If you initially had ketonuria (ketone bodies in the urine), weight loss or are underweight, with an initial FBS greater than 300 mg%, there is a chance that you actually have IDDM and not NIDDM.

But let's say you've eliminated all these possibilities, do we then label you as a "Secondary Drug Failure"? This means that

(Continued on page 5)

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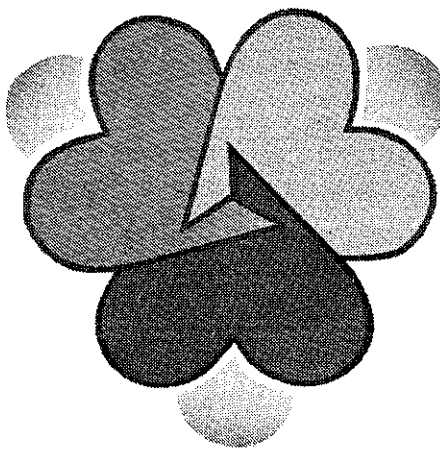
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CARDIOPROTECTION

- LOWERS LIPID AND TRIGLYCERIDE LEVELS
- NO HYPERINSULINEMIA

(Continued from page 4)

although your medicine initially was effective in controlling your blood sugar levels, it is no longer able to bring it down to normal even, when given at the maximum recommended dose. At this point, we say "the drug has failed."

What happens next?

1. Add another drug. If you are taking one kind of drug, say glyburide, which belongs to a class of drugs known as sulfonylureas (SU), there is not much sense in shifting to another drug in the same class, say gliclazide. Most SUs (especially the newer second generation SUs) are equally efficacious in lowering blood sugar. Besides, they have the same mechanism of action anyway. What your doctor can do though, is to add on another drug from a different class, say metformin or an alpha-glucosidase inhibitor.

2. Combine tablets and insulin. Another approach would be to add insulin to your present regimen. Usually an intermediate-acting or long-acting insulin preparation is given as a bedtime injection. Other schedules are possible: single morning injection, 1 or more injections of short-acting insulin, etc.

3. Switch to insulin. One other approach would be to stop taking the tablets completely and switch to insulin injections alone (Insulin Monotherapy). Again the regimens one can choose from are numerous. One can inject once, twice, thrice, four times a day. One can use intermediate or long-acting insulin alone or in combination with short-acting insulins. It is essential however, that you monitor your blood sugar levels more frequently once you start

using insulin. The doses of insulin and tablets will have to be adjusted depending on your SMBG results, your food intake and daily activities.

Re-emphasize diet, exercise and weight loss. Hand in hand with the above three options, we also encourage you to reinstitute and strictly adhere to your meal plan (see your dietician again!), follow the prescribed exercise program and renew your attempts at weight loss (if you are overweight).

What happens when the blood sugar goes down? Can I go back to taking tablets alone?

In many cases, YES. Most notably, if the rise in the blood sugar were due to a temporary condition, like stress, illness, infection, drugs, lack of exercise and dietary non-compliance. Once the doctor is able to control the blood sugar, he can try weaning you off insulin and shifting you back to tablets alone.

However, in those cases where the hyperglycemia was due to misdiagnosis of the IDDM patient as NIDDM, then obviously, insulin therapy here is lifetime. There are also patients which initially present as NIDDM, but later, gradually progress into IDDM because of "exhaustion of the beta cells". These patients will also require insulin for life.

Certainly, for these cases of apparent "secondary drug failures," the management of the diabetic becomes truly challenging. But only by paying close attention to all the four aspects of diabetes management (diet, exercise, medication, patient education) can you hope to achieve optimal blood sugar control and sustain a healthy and fruitful life.

MA IMELDA Q. CARDINO, M.S.F.N.
Dietitian Educator
Diabetes Educational Clinic
Makati Medical Center

DIET NOTES

International Congress of Dietetics

The International Congress of Dietetics was held for the first time in the Philippines last February 18 - 23, 1996 at the Philippine International Convention Center. The Twelfth Congress was co-hosted by the Nutritionist-Dietitians' Association of the Philippines (NDAP). The Philippine delegation took pride in the fact that there were many local studies presented in this Congress. Some notes on the Congress proceedings are mentioned in this article.

"Changing Food Intake Patterns and Diet-Related

Diseases"

Kraisid Tontisirin, et. al. (Thailand)

Rapid socio-economic development by westernization of practices even in food selection and lifestyle has been noted. Experiences from Thailand and China showed higher incidence of obesity, hypertension, diabetes mellitus, heart diseases, and stroke which are largely attributed to drastic changes in personal and family lifestyles involving food intake patterns. The eating pattern has shifted from traditional Asian diet (cereal-based

(Continued on page 8)

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CAMP COPE — An awakening...

C.V. HALILI, JR.
Camp Administrator

As early as noontime of Friday, May 3, campers were seen waiting for the bus that would take them to Los Baños, the site of the 3-day 1st Camp COPE (Children overcoming problems everywhere). The bus finally came at 2:30 P.M. and arrived at the campsite at 4:30 unloading 18 excited, nervous, apprehensive campers; 8 perhaps more nervous counselors; nurses, dieticians, physical therapist, and physicians.

The campers were grouped into 4 teams, later to be called: "Mixed Nuts"; "Tropang Trumpo"; "Bubble Gang"; and "Oki, doki, doc", all popular TV sitcoms. Each team had 2 counselors and a nurse assigned to it, full-time. Just before sunset, a leisurely walk around the campsite to enjoy the scenery for which the place is known for was enjoyed by the whole group. It was also an opportunity to put to use, a learning process called "Teachable moments" - a practical down-to-earth manner of showing the diabetics how to cope.

The first dinner was by a campfire, with parlor games all designed to help "break the ice." At this time, more doctors started arriving from Manila. They were to form the Healthcare Team. Representatives of sponsoring drug firms also started showing up, in groups. After dinner, indoor games and learning activities called "rap sessions" were held. At around 10:00, with great hesitancy, "lights out" was called. Although everyone felt like they had already com-

pleted the 3 day camp, it was only the end of day 1.

Saturday started as early as 5:30 A.M. for some of the counselors and staffers. The wake-up bell was rung at 6:00, quickly followed by blood glucose monitoring, urine tests, and insulins. After breakfast, the group trooped to the swimming pool for a 2-hour dip. Those who opted to stay behind played lawn games.

The rest of Saturday was a flurry of activities, including the eating of ice cream (believe it or not!), under the ever watchful eyes of the Healthcare

Team. To top the day, another campfire dinner, this time in costumes. After another indoor rap session, it was lights-out for the campers, but not for the counselors and staffers who stayed on for another hour and a half for assessment meeting. Finally, Sunday, the big day. Even breakfast was special, made even more special by the appetite-whetting outdoor aerobics. Then, everyone went to Mass, held at a nearby chapel. Once back at the camp, everyone started preparing for the coming big event - graduation time.

It was an event marked by mixed feelings. There was a lot of merry-making. Tears were also shed, as sentimental songs were rendered. Certificates were awarded to all campers and staffers who "survived" the camp. Special merit certificates were given to those who did exceedingly well during the 3 days.

And as the campers chanted over and over: "Camp Cope, Camp Cope, babalik

The JDF — Summer Camps...

MA TERESA PLATA-QUE
Endocrinologist
National Kidney Center

Summer camps for children with diabetes? This is not something new. The first summer camp for juvenile diabetics was spearheaded by Dr. Lourdes Mabanta at the Jesuit Seminary in Novaliches as far back as 1982. This made our country the first ASEAN nation to start such a project. In 1983, the same group spon-

sored another summer camp at a resort in Pansol, Laguna. During this camp, some parents realized the need for an organization which would help and monitor the needs of diabetic children. Thus was born the Juvenile Diabetes Foundation in September 30, 1983, with 25 concerned parents of diabetic children and Atty. Godofredo Mabunga at the helm. A moving spirit behind the new organization was Dr. Ricardo Fernando who had been involved in the care of juvenile diabetics as early as the 70's.

The Foundation became the complementary arm of clinics that doctors established to support the diabetic and his family in terms of education through summer camps, mini camps, fora and symposia. Since then the JDF has been holding annual summer camps held in various places through the generosity of many bene-

kami" the 1st Camp came to an end.

factors. The weeklong camp is held during the Holy Week and the children, numbering from 30-80 are left by their parents during Holy Monday and fetched during Holy Saturday. A feedback session awaits the parents at the first convenient time the week after camp. Through the years camps have been held in places such as Tanay, Rizal, Balayan, Batangas, Nueva Ecija and the latest one was held in Bataan. The weeklong camp is enlivened by children's games, lectures, group interactions, counselling, exercise sessions, etc. Blood sugars are checked 4x daily and children are taught to overcome their fears about their condition especially with needle pricks. Professionals helping out during the camp include diabetologist, dieticians, nurse educators, the indefatigable Mrs. Baby Dysangco, JDF's President and the ever loyal Ate Ve. Representatives from the various pharmaceutical companies also lend a helping hand all throughout the week.

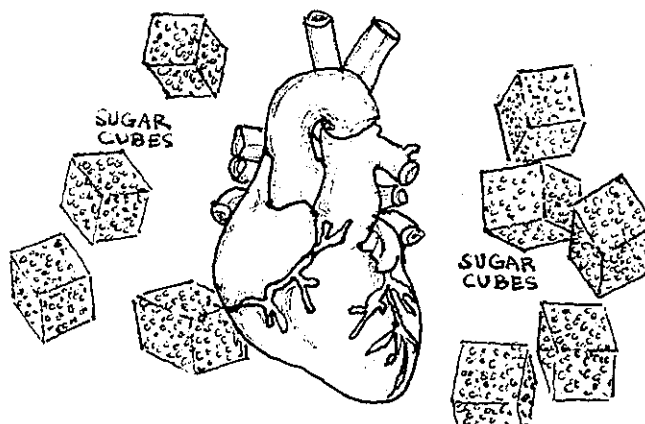
In recent years parallel camps have been held in Cebu and our juveniles went international when they joined the international camps held in Japan, Australia and Hawaii. These camps have widened the panoramas of our children and doctors alike and it has inspired another vision and that is to play host to an ASEAN camp in 1997. This is certainly a challenging undertaking which the JDF is eagerly preparing for.

A pervading goal during the camp is for these children, many of whom will lose contact after camp, to be embraced by hope and warmth so that they will be able to transcend the mortal realities of their diabetic condition.

SUMMER CAMPS FOR YOUNG DIABETICS

DIABETES MELLITUS: RISK FACTOR FOR HEART DISEASE

LINA C. LANTION-ANG, MD,
Endocrinologist
Polymedic General Hospital



Diabetes mellitus is prominent among the risk factors for atherosclerosis and coronary artery disease. Atherosclerosis in the diabetic occurs prematurely at an accelerated phase, it affects younger patients, it progresses with age, it is quite severe and it is the most serious complication and commonest cause of death in diabetics. The normal female protection against atherosclerosis is lost in diabetics of all ages.

Aside from hyperglycemia, several mechanisms have been involved for this diabetes associated risk. Included are alterations in thrombosis (platelet function and clotting factors) in NIDDM patients, diabetic microangiopathy which may cause rigidity and impaired function in small vessels of the myocardium and vasculature and a clustering of cardiovascular risk factors commonly seen in diabetics notably dyslipidemia, obesity and hypertension. A possible diabetes specific cardiomyopathy has been reported.

In diabetes, the prothrombotic factors can be divided into factors that increase resistance to blood flow such as increased blood viscosity, increased rbc aggregability, decreased rbc deformability and platelet abnormalities. Factors promoting or favoring a hypercoagulable state include increased levels of fibrinogen, increased levels of factor VIII and elevated PAI-I levels. These are factors that affect blood vessel wall physiology.

Looking at microangiopathy in type I DM, aside from hyperglycemia, the increased risk of coronary artery disease is to a significant extent, the consequence of impaired renal function or diabetic nephropathy. The controversy as to

whether control of hyperglycemia can prevent the dreaded microvascular complications of diabetes (nephropathy, retinopathy, and neuropathy) was laid to rest with the convincing results of the Diabetes Control and Complications Trial on type I diabetics who were intensively treated with exogenous insulin to approach near normoglycemia. In this monumental study, the risk of developing all the triopathies was significantly reduced in both the primary prevention and secondary intervention groups. Cardiovascular events were not significantly increased, alleviating the fear that exogenous insulin therapy is atherogenic.

As to macroangiopathy in the non-insulin dependent diabetic; so much discussion has evolved around multiple cardiovascular risk factors notably dyslipidemia. Lipid abnormalities in diabetics as reported in western literature can be summarized as slightly elevated to normal total cholesterol, elevated triglycerides, and decreased HDL-C. In Fili-

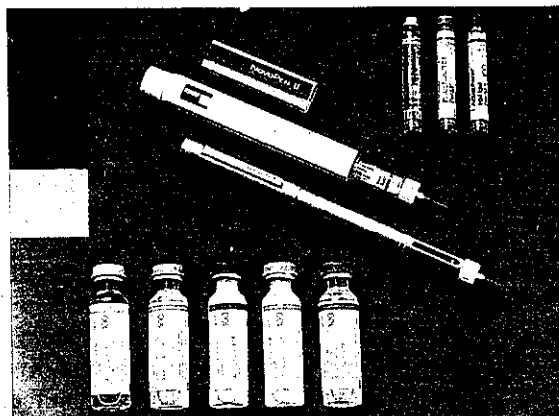
pinos, Dr. Augusto D. Litonjua found the following lipid profiles among 2,000 untreated NIDDM patients: Only 26% exhibited elevated triglycerides, 74% exhibited normal levels, total cholesterol was increased in a few patients but normal in a great majority and the low HDL-C levels are in agreement with the Western figures. It is speculated that the low triglyceride levels maybe related to the fact that fewer NIDDM patients in the Philippines, particularly male patients are obese.

Dyslipidemia is closely related to the high incidence of coronary vascular disease seen in the diabetic. Chronic hyperglycemia has been suggested to cause macrovascular atherogenesis by generation of advanced glycosylation products. Recall that lipoproteins are necessary in transporting triglyceride and cholesterol in the plasma and therefore are necessary physiological molecules. These lipoproteins however are vulnerable to glycosylation in a hyperglycemic environment and it is this modified lipoprotein that

is quite atherogenic. A very good example is modified LDL or oxidized LDL. The added factor of defective insulin action and declining insulin secretion in type II DM lead to increased production of triglyceride risk VLDL as a result of defective lipoprotein lipase activity. Lipoprotein lipase activity is dependent on insulin action. The message to be conveyed here is that poor diabetes control worsens dyslipidemia. There are many risk factors other than hyperlipidemia that can contribute to atherosclerosis in diabetes; hypertension, obesity, sedentary lifestyle, age and a previous history of coronary vascular disease. Under any of these circumstances, diabetes control is the primary concern. Weight reduction, exercise and dietary restrictions are indicated first, and if there is improvement no further action is required. Only if the patient fails to respond are other measures considered.

Because of the high incidence of vascular disease in diabetes, lipid targets should be stricter than in the non-diabetic: Triglycerides should be below 2 mmol/L, cholesterol less than 5.5 mmol/L and HDL-C above 1.1 mmol/L. Efforts to lower lipids should be taken early even when diabetes control is not fully attained because of the increased risk of coronary vascular disease in diabetics as compared to non-diabetics with the same lipid level. Diabetics who have not had any cardiovascular event but with multiple and correctable risk factors deserve aggressive treatment. There is more to just blood sugars, lipids, obesity and hypertension that make the diabetic more prone to coronary vascular disease. The dream is a complete cure, but for the moment, we strive for what is correctable.

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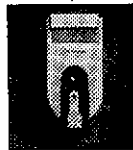
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Diet notes... (From page 5)

and low fat) towards a more westernized diet of increased consumption of animal products, fats, and sugars as well as decreased intake of complex carbohydrates such as rice, etc. Careful monitoring of these changes, suitable behavior modification, and promotion of appropriate eating patterns and physical activities are recommended.

"Atherogenesis and Dietary Fats"

Conrado Dayrit, M.D. (Philippines)

The fundamental cause of atherogenesis remains unclear. Genetic influences are assuming a greater role in identifying those who are atherosclerosis-prone and those who are not. The various risk factors (aging, hypertension, diabetes mellitus, smoking, dietary fats, obesity, dyslipoproteinemia, stress, and physical inactivity) appear to play roles of varying importance predominantly in the atherosclerosis-prone segment. Definitely animal fat sources are taboo. Some vegetable fat sources still remain controversial. Use of artificially hydrogenated fats are questionable (such as margarines).

"Role of Monounsaturated Fatty Acids in Nutrition for Patients with Non-Insulin Dependent Diabetes Mellitus (NIDDM)"

Abhimanyu Garg, M.D. (USA)

Most NIDDM patients are obese in the USA. Hence, there is a consensus about restricting total calorie intake to effect weight loss to better manage the diabetes. Although there is no controversy about decreasing the saturated fat (mostly animal fat) in the diet,

the total calorie contributed by fat remains controversial. Some experts suggest replacing the saturated fat calorie with carbohydrate but the author disagrees. Hence, he conducted a research wherein the total calorie from fat is about 40% but this is contributed by olive oil. He claims that the diet is more palatable and more acceptable. He further claims that his patients showed better dietary compliance and therefore had better glucose control.

"Nutrition for Recovery After Exercise"

Louise Burke (Australia)

Training programs of athletes often involve 2 or 3 daily exercise sessions. Many competitions require repeated performance trials (that is, competitions staged as tournaments, multiday events, events staged with heats and finals). Recovery time may span 2 to 24 hours, and will involve a number of physiological processes, including:

1. recovery of body fuel stores, particularly body carbohydrate reserves
2. replacement of fluid and electrolytes lost as sweat
3. repair, regeneration, adaptation of body tissues in response to the exercise stimulus and damage.

Nutritional strategies to optimize these processes have become a recent focus of exercise science. Food intake must enhance rehydration and re-synthesis of body glycogen stores. Effective athlete education must not only include scientific support but also practical issues such as the athlete's ability to ingest food and fluid in the post-exercise period.

"Interrelating Obesity Factors in Greek Women"

Antigone Panetsou-Oreopoulou

(Greece)

The purpose of the study is to identify the more predominant factors interrelated with obesity in order to come up with better management of the condition. Seventy-five women were surveyed and the results follow, starting with the highest number of responses:

1. faulty eating habits
2. faulty communication patterns
3. weight and food obsession
4. negative self-concept
5. family dysfunction
6. problematic sexual identity
7. anxiety
8. physical inactivity
9. depression

Obesity problems among Greek women are affected by several factors, mostly psychological, so that management should not be by dietary manipulation alone.

"Metabolic Effects of Increased Meal Frequency in NIDDM After Consumption of a Low Glycemic Index Food"

Evangelia Manglana-Katsilambros, et. al. (Greece)

The aim of the study was to find out whether the postprandial blood glucose and/or insulin levels in NIDDM subjects are affected by meal frequency if the food consumed is low in glycemic index. The same amount of the boiled beans (50 gms) were given to 8 patients ingested on 2 occasions under the same fasting conditions. The bean was given as a single meal on the first occasion and then as 3 equal meals at 2-hour intervals. Plasma glucose and plasma insulin levels were obtained. Results showed that the NIDDM subjects showed a slightly, but significantly

higher, glycemic response in the case of those given more frequent meals.

"Role of Sweeteners in Diet Management"

Nancy Wellman (USA)

Artificial sweeteners, when used in moderation, are not an independent risk factor in the development of any particular disease, except in rare cases of inborn errors of metabolism. The other forms of sweeteners available in the market were reviewed:

1. fructose - This has the same calorie content as any other sugar so it offers no advantage in this respect. Although some foods require less fructose than sucrose for sweetening, when consumed in amounts greater than 50 gm/day, diarrhea may result.

2. Sorbitol and Mannitol - These are sugar alcohols or polyols. They produce a low glycemic response and therefore are used as substitute sweeteners in many food products including confectioneries and beverages. When consumed in excess of 30 gm, abdominal discomfort and diarrhea may result.

3. Acesulfame Potassium - This is 2,000 times sweeter than sugar. This is heat stable and therefore may be used in cooking. The acceptable daily intake (ADI) for adults is 15 mg/kg of body weight.

4. Sucralose, Alitame, and Cyclamates - These non-nutritive sweeteners have been shown to be safe for human consumption although they have not yet been approved by the USFDA.

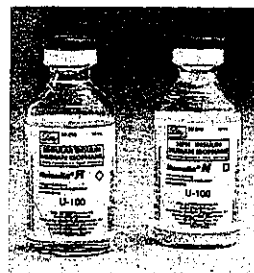
The other common kinds of artificial sweeteners like saccharine and aspartame are not mentioned in this article because much has been written about them already.

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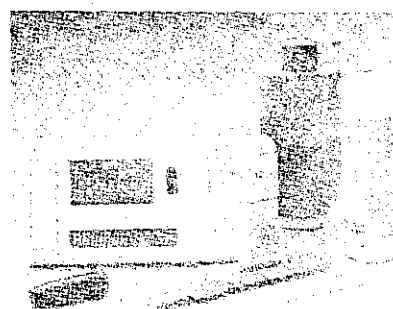
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DIABETES GOLF

The Diabetes Center (Philippine Center for Diabetes Education Foundation, Inc.) recently concluded the well attended Diabetes Foundation Golf Classic last Wednesday, June 5, 1996. The participating golfers were led by no less than the First Lady, Amelita M. Ramos at the Canlubang Golf and Country Club. On hand to witness the tee-off were Dr. Augusto D. Litonjua, president of the Diabetes Center; Mrs. Lovely Romulo, Mrs. Remy Fournier and Dr. Tommy Ty-Willing with special guest, Mrs. Susan Flavier.

Emerging as over-all champion among the thirty teams participating in the scramble format golf fest was the team from the Transfarm & Company, Inc. composed of Gerry Romualdez, Victor Romualdez, Willie Capulong, Toll Zara and Col. Conrado Gueron. Class A champion was the team from the Philippine Charity Sweepstakes Office, with the team from AMSPEC bagging the runner-up trophy. The PAGCOR team earned the Class B championship, while the Far East Bank and Trust Co. team was the Class B runner-up.

Major sponsors of the event were PAGCOR, International Container Terminal Services, Inc. and the Philippine

DIABETES EDUCATORS TRAINING COURSE

The 6th training course for diabetes educators will be held on July 22-27, 1996 at the Makati Medical Center by the Diabetes Center.

For this year, there will be seven teams and 2 nurses who will complete the course.

The participants will be conferred the title of Assistant Diabetes Educator.

A total of 31 teams have been trained by the Center since it started in 1993. The team consists of physician, nurse and dietician. They have pledged to set up educational clinics in their respective communities and in turn train physician, nurse and dietician for their respective provinces.

This course is carried out twice a year. The 7th course is slated for the last week of October this year.

Charity Sweepstakes Office. The highlight of the affair was the raffle of Philippine Airline business class tickets to international destinations like the U.S. and Hongkong.

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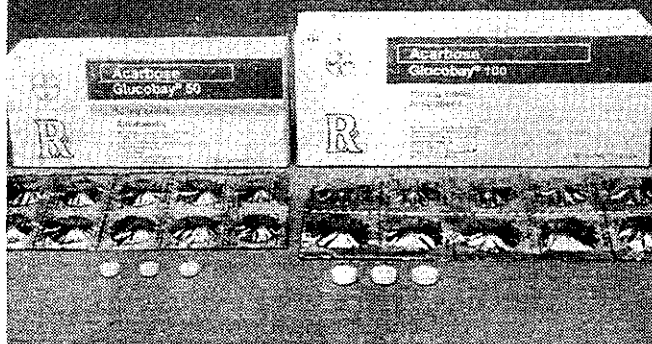
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SIDE EFFECTS: Commonly flatulence and bloating, rarely diarrhea and abdominal pain. Patients may suffer more intense intestinal side effects if they do not follow their prescribed diet. In case of an increase in liver enzymes without any symptoms, Glucobay treatment should be stopped.
INTERACTIONS: Cane sugar (sucrose) and sugar-free foods can easily cause abdominal pain and diarrhea during Glucobay treatment, because of increased fermentation of carbohydrates in the colon. Anilids, cholestyramine, mineral adsorbents and medicine containing digestive enzymes should be avoided since they may reduce the effectiveness of Acarbose. Glucobay (Acarbose) in combination with sulphonylureas or insulin may potentiate the hypoglycemic effects of these drugs. However, when administered alone, Glucobay does not cause hypoglycemia.
DOSAGE/ADMINISTRATION: Unless prescribed otherwise, 1 tablet Glucobay 50mg, three times a day during the initial phase. Later 1 tablet Glucobay 100mg, three times a day, maximum daily dosage, 2 tablets Glucobay 100mg three times a day. The dose can be increased after initial phase of 1-2 weeks (or later, if necessary). Glucobay tablet should be taken after the first mouthful of each main meal.
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Diabetes commission...

(From page 1)

detection, investigate epidemiology and various aspects of the disease, evaluate current measures employed in prevention and control, and establish mechanisms to reduce the socio-economic impact of the diabetes on affected individuals and families. It shall also study granting of incentives and support for organizations for diabetes, establish coordinated health systems for dealing with diabetes and its complications, study the participation of local government units alongside with NGO's and the systematic utilization of public and private resources including legislation to achieve the objectives thus far enumerated.

The Diabetes Prevention and Control Program shall be implemented by the Office of Public Health of the Department of Health.

ment of Health.

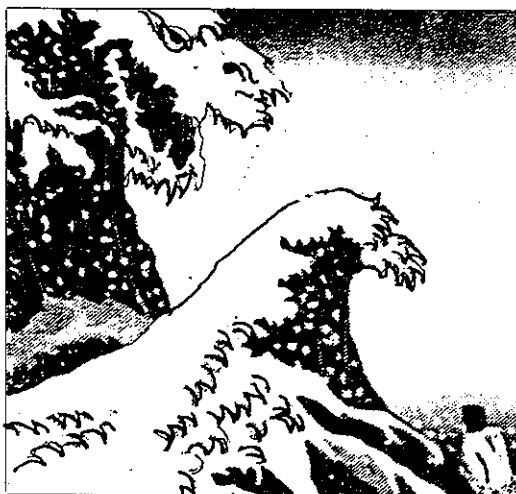
After one year of work, the Commission shall submit its report and cease to be. It shall be reconstituted as the Oversight Committee attached to the Department of Health and shall review and evaluate the implementation of the Prevention and Control program. The Committee shall cease to exist after five years and all of its functions shall devolve to the Department of Health.

Acute diabetic...

(From page 12)

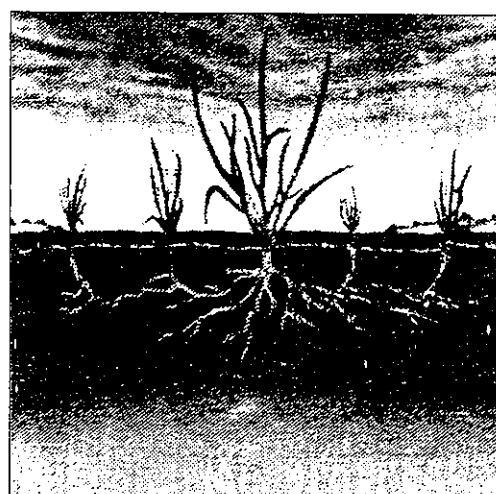
or tablets), eating the right food, exercising, monitoring blood sugar at home and basically leading a healthy lifestyle so that blood sugar would always be in good control - not high and not too low either. When blood sugar is adequately controlled, one is

(Continued on page 2)



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EDITORIAL COMMENT

LAURA TRAJANO-ACAMPADO, MD
Endocrinologist
UP-PGH Medical Center

ACUTE METABOLIC COMPLICATIONS

Can you recognize them?

Diabetes mellitus is a disease manifested by hyperglycemia. Chronic complications involving different organs of the body occur when blood sugar is uncontrolled. Many of us are already aware of the chronic complications of diabetes involving the eyes (retinopathy), kidneys (nephropathy), nerves (neuropathy) and the heart and blood vessels (coronary artery disease, peripheral vascular disease and stroke). However, aside from these complications, it is also very important to be aware of the acute metabolic complications of diabetes since these are life threatening and need immediate medical attention. The three most commonly encountered acute complications of diabetes are hypoglycemia, diabetic ketoacidosis and hyperosmolar coma.

Hypoglycemia

Hypoglycemia occurs when blood sugar becomes very low as a result of poor intake, increased metabolic demands or as a complication of treatment with insulin or oral hypoglycemic agents. Early warning signals of low blood sugar include dizziness, light-headedness, cold sweats, tremors and hunger. Later on, patients may present with behavioral and sensorial changes and subsequently coma and even convulsions if uncorrected. Unfortunately, some patients especially those with neuropathy, do not experience the early warning signs. These patients would usually be found already unconscious. These patients

are said to have "hypoglycemia unawareness."

It is important that these early warning signals be picked up so that treatment may be given immediately. If the patient is still conscious with the above symptoms, he may be given candy or any sugar containing beverage such as coke or juice so that blood sugar can be raised as soon as possible after which the patient must be fed. However, if the patient is already unconscious, never force any food or drink because this will just cause the patient to choke on the food or drink resulting in more complications. Unconscious patients are best treated with intravenous glucose or glucagon if available.

Diabetic Ketoacidosis

DKA or diabetic ketoacidosis occurs more often in insulin dependent diabetics although it may also occur in people with non-insulin-dependent diabetes mellitus. It usually occurs because of a deficiency of insulin coupled with a rise in another hormone called glucagon which has effects opposite to that of insulin. It is usually caused by cessation of insulin injections or by the presence of precipitating factors such as infection, surgery, trauma and other stress situations. The metabolic abnormalities include hyperglycemia, ketone body formation and acidosis.

In the early stages, patients present with anorexia, nausea, vomiting and increased urine output. Abdominal pain may be present which may sometimes result in

unnecessary abdominal surgery. If left untreated, this may result in alteration in consciousness and ultimately frank coma. Patients usually manifest with shallow, rapid breathing (Kussmaul respiration) and signs of dehydration.

In the early phase DKA can be managed outside the hospital with administration of insulin, increase in oral fluid intake and correction of precipitating factors such as infection. In the later stages, admission to a hospital is required. Management essentially includes hydration, administration of insulin and correction of other metabolic abnormalities and precipitating factors.

Hyperosmolar Coma

Hyperosmolar nonketotic diabetic coma is usually a complication of non-insulin-dependent diabetes mellitus. It is characterized by hyperglycemia and profound dehydration without ketoacidosis. The precipitating factors include infection, stroke, surgery, trauma and use of medication that increase blood sugar or urine output. Commonly, the patient is an elderly person who develops an infection or a stroke which worsens hyperglycemia and prevents adequate fluid intake.

Clinically, patients present with very high blood sugar, hyperosmolarity, volume depletion with central nervous system signs ranging from clouded sensorium to coma. Seizures may also occur.

Management usually requires admission to the hospital because the problem is usually picked up when the



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patient is already profoundly dehydrated and blood sugar is already very high. The essentials of treatment are similar to that of DKA: hydration, administration of insulin, correction of other metabolic abnormalities and recognition and correction of precipitating factors such as infection.

Conclusion

It is indeed very important to recognize the acute complications of diabetes, preferably in their early stages, so that the appropriate medical intervention may be instituted. But the buck does not stop with recognition and appropriate intervention. The most important part still remains to be PREVENTION. These complications can be prevented by taking one's medications regularly (whether it be insulin

(Continued on page 11)