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Diabetes Watch

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YEAR XIII, NO. 2

JULY - DECEMBER, 1996

PDA's Eleventh Diabetes Workshop

Since 1992, the Philippines Diabetes Association has committed to provide service by helping participants acquire a high level of expertise and proficiency in the care of their diabetes patients.

The 11th Diabetes Workshop will be held on Nov. 22 to 24, 1996 at Star Plaza Hotel, Dagupan City. The comprehensive curriculum of the present workshop that started in Bacolod City last July, 1996 is a whole new innovative course. It is more interactive, participation oriented sessions which allow the registrants opportunities for greater learnings and furthermore they can share their difficulties in clinic cases. The emphasis will be on innovative treatment techniques and proven medical strategies which will surely clarify doubts of all participants in the treatment of their

(Continued on page 4)

5th SERVIER LECTURE

Professor Philip Home, a noted diabetologist from Newcastle upon Tyne, UK will be this year's lecturer for the 5th Servier Lecture on Diabetes Mellitus.

Professor Home, also the Chairman of the International Diabetes Federation in Europe will deliver a lecture on "What is Diabetes Anyway?"

The lecture will be held at the Century Park Hotel Grand Ballroom on December 2, 1996 at 7:00 p.m.

This is a joint undertaking of the Diabetes Center, Philippine Diabetes Association and Les Laboratoires Servier.

Joint Confab with Endocrine Society is PDA's Final Event for 1996

In a flashback to a previous practice, the Philippine Diabetes Association (PDA) and the Philippine Society of Endocrinology and Metabolism (PSEM) will again unite forces for a joint annual convention on December 2-4, 1996 at the Century Park Hotel to close out a fruitful year. Foreign and local

experts will grace the occasion to update the locals' knowledge of diabetes and endocrinology.

Dr. Mary Anne Lim-Abraham, president of PDA and Dr. Lina Lantion-Ang, president of PSEM promise a program (reproduced below) that is both invigorating and educational.

The 5th Midyear Convention of the Philippine Diabetes Association last July 21 was a big success. Hosted by the Negros Occidental Chapter working hand in hand with the PDA Organization Committee, the meeting attracted 130 physicians, 25 paramedical per-

(Continued on page 7)

December 2, 1996 (Monday)

PDA Lay Convention

December 3, 1996

Morning Session:

Registration

Opening Ceremonies

Session 1: Moderator: Ma. TERESA PLATA-QUE, MD

Autonomic Dysfunction in Diabetes Mellitus

PHILLIP A. LOW, USA
Insulin Therapy Revisited
PHILIP D. HOME, UK

Open Forum

Session 2: Moderator: JOSELYNNA S. ANEL-QUIMPO, MD

Symposium: Endocrine Diseases And Pregnancy

Diabetes Mellitus
AUGUSTO D. LITONJUA, MD
Thyroid Diseases
MARY ANNE LIM-ABRAHAN, MD

MD

Perinatal Monitoring of Mothers with Endocrine Disorders

PILAR LAGMAN-DY, MD
Neonatal Care of Infants of Mothers with Endocrine Disorders
LORNA RAMOS-ABAD, MD

Open Forum

Lunch Satellite Symposium (Otsuka Pharmaceuticals)

"Diabetic Neuropathy: New Insights", PHILLIP A. LOW

"Cilostazol - A New Concept in DPN", MIKIHIRO KEHARA

Afternoon Session:

Session 3: Moderator: ROBERTO C. MIRASOL, MD

Diabetes And Hypertension: An Unholy Alliance

JULIANA CHAN, HONG KONG
Lipid And The Diabetic Kidney
KAREN S. LAM, HONG KONG

PROGRAM

"A FRESH LOOK BEYOND OLD FACTS"

Open Forum

Coffee Break

Session 4: Moderator: TOMMY S. TY WILLING, MD

The Major Atherogenic Lipid In NIDDM: Triglyceride or Cholesterol?

Introduction
Dyslipidemia And Cardiovascular Disease In NIDDM

RAMON S. ABARQUEZ, JR., MD

Triglyceride- The Major Atherogenic Lipid In NIDDM

CLIVE S. COCKRAM, HONGKONG

Cholesterol- The Major Atherogenic Lipid in NIDDM

NELSON S. ABELARDO, MD

Discussion- Moderator
RAMON S. ABARQUEZ, JR., MD

Summing Up
CLIVE S. COCKRAM

NELSON S. ABELARDO

Votation

PSEM Business Meeting
INVESTITURE: DIPLOMATES IN ENDOCRINOLOGY

Dinner Satellite Symposium (Hoechst MARION ROUSSEL)

"Glimipiride in the Treatment of NIDDM"

GERHARD SACHSE, GERMANY

December 4, 1996 (Wednesday)

Morning Session:

Session 5: Moderator: LINA C. LANTION-ANG, MD

Hormone Replacement Therapy in Post Menopausal Women

Case Presentation: VERONICA RACHO, MD

Grand Rounds: Discussants

Osteoporosis in Post Menopausal Women
EDWARD LIM, MD

Gynecology

CONCEPCION ILAO, MD

Endocrinology

RUBY T. GO, MD

Open Forum

Coffee Break

Session 6: Moderator: CYNTHIA CHUA-HO, MD

Genetic Screening for Metabolic Problems

CARMENCITA PADILLA, MD

Open Forum

Lunch Satellite Symposium (Bayer Philippines)

"Should IGT Subjects Be Treated Or Not?"

JEAN-LOUIS CHIASSON, CANADA

Afternoon Session:

Session 7: Moderator: ROSA ALLYN G. SY, MD

Visceral Obesity and NIDDM
JULIANA CHAN

Open Forum

Session 8: Moderator: RICARDO E. FERNANDO, MD

Meet The Professors: Insulin Resistance

PHILIP D. HOME
JULIANA CHAN
GERHARD SACHSE

JEAN-LOUIS CHIASSON

Coffee Break

Session 9: Moderator: ELIZABETH PAZ-PACHECO, MD

New Aspects in the Treatment of NIDDM

GERHARD SACHSE
Erectile Dysfunction in the Diabetic

ALEX FOK, SINGAPORE

Open Forum

PDA Business Meeting

1996 DIABETES AWARENESS WEEK



Mabuti pa ang langgam, alam (the tagalog for 'good for the ants, they know better') was the theme of the 1996 Diabetes Awareness Week. Picture shows Senator Gloria Macapagal-Arroyo delivering the launching speech for the Week at the Glorietta, Ayala Center, Makati City last July 28, before a big crowd. Activities during the Week, included news items on diabetes published in major Manila dailies, free clinics in selected barangays, radio and TV appearances of the members of the Medical Bureau of the Diabetes Center, and several weeklong lectures to civic oriented groups and religious societies. The activities were replicated in places in the country where the chapters of the PDA and the teaching teams of the Diabetes Center are located.

FIRST NATIONAL ASSEMBLY OF DIABETES TRAINORS

The Diabetes Center will hold its 1st National Assembly of Diabetes Trainors on December 2, 1996 at 8:00 a.m. - 2:00 p.m. at the Century Park Sheraton Hotel, Ballroom B.

The purpose of this assembly is to gather all the Center's trainors and update them on the latest in Diabetes Education. A total of 44 teams composed of MD, RN and RND nationwide, including one team from Sumber Waras Hospital in Jakarta, have been trained in the Center.

Dr. Rosa Allyn Sy, endocrinologist from Cardinal Santos Memorial Hospital will talk on the latest on IDDM, Dr. Joseph Regalado a pediatrician-psychologist also from Cardinal Santos, will focus on the Psychosocial Aspect of Care for Young Diabetics. Ms. Janet Lloyd, a podiatrist from International Diabetes Institute, Melbourne, Australia will talk on the Care of the Feet and Proper Assessment and Management of Foot Problems. The participants will be taken

through actual process of how the patient must care for his feet and skin to avoid the complications feared by most diabetic patients.

The highlight of the affair will be the conferment of the title "Associate Diabetes Trainor" for those who have trained 500 patients in their hospital or community.

The candidates are:
Davao Doctors Hospital - Marie Ann Co-Villegas, M.D., Nanette Gaurano, R.N., Lilibeth Ancheta, R.N.D.; Far Eastern University-NRMF Medical Foundation Hospital - Trinidad Madrigal, M.D., Mercedes Legarda, R.N.; Philippine General Hospital, Lizaflor Ibay, R.N., Emelita Ong, R.N.D.; Albay Provincial Hospital - Lina delos Reyes-Asido, M.D., Merlyn L. Bernal, R.N., Blessila S. Bermas, R.N.D.; Davao Medical Center - Roy Ferrer, M.D., Herminilda Vargas, R.N., Alma Basbaño, R.N.D.; Saint Thomas Diabetes Center - Rosalyn Almazan, R.N.

7th Training Course for Diabetes Trainors

The 7th Training Course for Diabetes Trainors was held last October 21-26, 1996 at the Makati Medical Center by the Diabetes Center.

The following were conferred the title of Assistant Diabetes Trainor:

Our Lady of Lourdes Hospital, Camarines Norte - Paul Luis G. Palencia, M.D., Nancy R. Licup, R.N., Ma. Bella A. Abilgos, R.N.D.; Coalition of Services of the Elderly Inc. (COSE), Cubao, Quezon City - Doris Mariebel D. Camagay, M.D., Susan L. Gentolia, R.N., Emmeline L. Verzosa, R.N.D.; Western Visayas Medical Center, Iloilo City - Noel B. Camique, M.D., Digna O. Gil, R.N., Noemi S. Clement, R.N.D.; Cavite Integrated Provincial Health Office, Trece Martires City - Emerita B. Velasquez, M.D., Teresita A. Perey, R.N., Cora A. Molod, R.N.D.; Cotabato regional

Five Delegates to International Youth Camp

The Diabetes Center sponsored 5 delegates to join the 1996 International Camp for Youth with Diabetes to be held in Victoria, Australia from November 23-30, 1996 at Lion's Village Licola.

Playing host is the International Association of Lions Club in Australia. The purpose of this camp is to discuss ways to help young people throughout the world with their care of diabetes.

Participating in the camp are young diabetics Emmanuel Zabala, Zennia Mascariñas and Patricia Marañon together with Dra. Cynthia Halili-Manabat and Myra Flor Aquino, teaching nurse.

The foregoing people were involved in the Diabetes Center's Camp COPE.

Hospital, Cotabato City -

(Continued on page 3)

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ROBERTO MIRASOL, M.D.
Endocrinologist
Rizal Medical Center

Everything you always wanted to know about DIABETES... (but were afraid to ask!)

The Diabetes Control and Complications Trial is an interesting study which showed that when people with diabetes keep their blood glucose in the normal range, the diabetics can prevent the serious complications that can affect their eyes, kidneys, feet and legs. It is therefore important for people with diabetes to know all they can about their disease and how to take care of themselves. Blood glucose monitoring is one way by which a person with diabetes can understand and learn how to make changes with their diabetes treatment program. Self blood glucose monitoring is a very important tool to help you better manage your diabetes.

What is self blood glucose monitoring (SBGM)? How do I do it?

Self blood glucose monitoring (SBGM) is a method of determining your blood glucose levels using a drop of blood. It used to be a difficult procedure but with the new generation of meters, blood glucose determination is quite easy. You puncture the skin on the side of your fingertip, apply a drop of blood to test pads on a reagent strip, wait for a specified time, blot the pads (newer meters skip this step), and read against a color chart or insert in a meter for a reading. It takes from 12 seconds to two minutes to do a test and at a precise moment you know your blood sugar.

Should I monitor my blood sugar?

It is a general rule that most people with diabetes should do self blood glucose testing. Remember that it is your goal to keep you blood

sugars to as near normal as possible. SBGM is a reasonable feed back. The only disadvantage is the expense incurred in purchasing a unit. If this a problem then you can visually read your strips (DON'T CUT STRIPS!), or you may use urine testing. A urine test cannot show you what your exact blood glucose level is because it is only an indirect indication of whether your blood glucose is normal or high. Urine tests also are dependent on the kidney threshold for spilling sugar into the urine. This is usually not accurate in the elderly and in pregnancy.

What are the advantages?

The advantages are: 1) it is reasonably accurate 2) blood glucose can be determined at any time 3) convenient 4) high blood glucose and low blood glucose can be determined immediately 5) when you keep your blood glucose in the range suggested by your doctor then you may avoid developing serious complications 6) it can

7th Training...

(Continued from page 2)

Ebenezer N. Demetillo, M.D., Luzviminda A. Montejó, R.N., Florence L. Galangam, R.N.D.; Marinduque Provincial Hospital, Boac, Marinduque - Edgardo J. Marquez, M.D., Esthie S. Miciano, R.N., Maribeth M. Madla, R.N.D.; San Miguel Corporation, Pasig City - Theodore S. Neric, M.D., Lorlyn Y. Capistrano, R.N., Margarita Maria G. Gatchalian, R.N.D.

The 8th Training Course is slated for June or July next year.

help you learn more about your diabetes.

How do I begin?

It takes commitment to start SBGM. This will require you to do something everyday to help you take care of your diabetes. If your doctor has not suggested SBGM to you, ask him about it. Tell him you are interested to keep your diabetes in control.

SBGM is only for people who are using insulin. Why should I use it?

It is true that those who are on insulin will benefit most from SBGM, but diabetics who

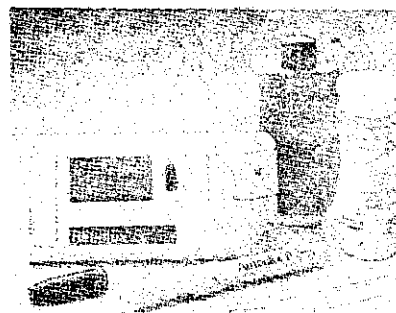
are on oral tablets may also use SBGM to keep track of their blood sugars. The difference perhaps will be on the frequency of determination of blood sugars. Those who are on insulin will require more blood glucose testing than those on oral tablets.

What is the best meter in the market?

There are a lot of meters available and choose one which is reasonably priced, easy to handle and not prone to technical problems. Be sure also that the meter you buy has technical support available in case of malfunction.

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Tips for Diabetes Educators:

EFFECTIVE AUDIO-VISUAL AIDS

SUSAN BERNAL-TRINIDAD, RN
Nurse Educator
Makati Medical Center

Audio-visual (A-V) aids are very important in teaching a diabetic client. Most of us in the medical world have used these in achieving objectives and skill, knowledge, and attitude. Be it in the form of printed text, transparencies, slides, tape-slide programmes, film and video, or even a computer-interactive system.

All of the above can be very beneficial in transferring information. However, the use of such aids should be well supervised by an educator. Effective educators should always be reminded that these have their place only in the context of a broader education of the diabetic in his or her disorder and in its management.

In choosing the appropriate visual aid, one should identify what a particular group needs and the objective should be clearly defined because you can already evaluate the usefulness of the A-V aid (old-fashioned term) if it can help in achieving the objectives in knowledge, skill and attitude.

We should also remember that in choosing an appropriate A-V aid, we should consider its content whether it is simple and concise. There are lots of prepackaged programmes with cluttered mass of information or details which the group does not need.

An important tip is that one should NEVER use an A-V aid if he/she is not familiar with the aid. Simply because you may be very conscious with what you are trying to impart and will keep on looking at your aid trying to decipher what's on it. More importantly, audience contact will be lost during the process. Eye contact is very important to gauge whether you have been understood or not. Plus sincerity counts a lot. Your audience can

feel if you are true to what you are saying if you can look straight into their eyes.

A-V aid should be well understood by the client. No "ABSTRACTS" please! It should be well-defined and not too technical.

ALWAYS update your materials. Outdated ones may lose your credibility. Plus worn-out materials may not help them, too.

And so to the educators, here are the Ten Audio-Visual Commandments taken from the Teaching Letter prepared by the Diabetes Education Study Group of the European Association for the Study of Diabetes (EASD):

-Don't use A-V to escape talking to the patient.

-Don't use any A-V aid or programme which fails on educational criteria.

-Don't use aids or programmes which fail on technical criteria unless they are educationally outstanding.

-Don't use outdated or worn-out material.

-Don't fill the patients head with useless information.

-Don't desert the learner - most A-V materials need the interaction of a "tutor".

-Don't let the A-V materials force the patient into a passive role.

-Don't misdirect the material, e.g. Type I material for Type II patients, young material for old patients.

-Don't let the A-V material frighten your patients.

-Don't make or use programmes designed for an Einstein.

Diabetes Workshop...

(Continued from page 1)

diabetes patients. The coordinators for the 11th workshop are Dr. Rosa Allyn G. Sy, Robert C. Mirasol and Mr. Angelo C. Lagman in coordination with the officers and members of the PDA Chapter of Pangasinan and DDVMH Diabetes Club.

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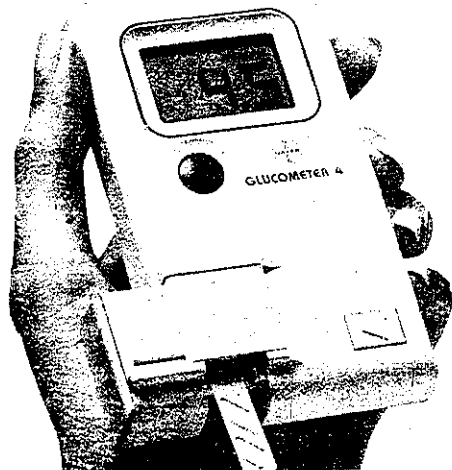
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FIND OUT !! ARE ALL SUGAR SUBSTITUTES ALIKE ?

MARY ANNE LIM-ABRAHAN, MD
President,
Philippine Diabetes Association

Sucrose (table sugar), is a disaccharide composed of glucose and fructose. It was the major sweetener used in the first half of the century. There are two types of consumers of high intake of added sugars : those who add sugars to a reasonably balanced diet, and those who tend to substitute certain sugar-rich foods for more nutritionally desirable foods, like substituting soft drinks for milk or fruit.

Not all sweeteners are alike, nor do they have the same effect on blood sugar. Some sweeteners contain calories (nutritive sweeteners) which must be counted in the meal plan. They may also affect blood glucose and therefore have to be avoided. These include carob, chocolate, glucose (dextrose), honey, maltose, molasses, sucrose (table sugar, brown sugar, confectioner's sugar), and syrups (corn syrup, high fructose syrups).

Other sweeteners contain few calories and have no effect on blood glucose and may be used by persons with diabetes. This include acesulfame potassium (Sunette, Sweet One, or Swiss Sweet), saccharin (Sucaryl, Sweet'n Low) and aspartame (Nutrasweet, Equal). These are the non-nutritive sweeteners.

Other sweeteners fall somewhere in between and contain calories and therefore have to be used sparingly. They do not affect blood glucose unless used in huge amounts (fructose, lactose and sugar alcohols-sorbitol).

The non-nutritive sweeteners that can be used in cooking and baking include saccharin and acesulfame K. Aspartame is used most frequently in frozen products and as a tabletop sweetener. It is available in granulated, powder and tablet

forms.

People generally worry about the safety of the non-nutritive sweeteners. Saccharin was initially banned by the US FDA but because of intense public opposition (1977) its use was permitted. In 1991 the ban was lifted. However the consumer warning will still remain on the label. Human studies did not support any association between saccharin and human bladder cancer.

Aspartame is approved for use in pregnancy and childhood. It carries a warning that reads: Phenylketonurics: contains phenylalanine. Phenylalanine, together with aspartic acid and methanol are the breakdown products of aspartame. Phenylalanine is found in common foods like fish, beef, milk and rice. Aspartic acid is found in huge amounts in beef and milk, while methanol is usually found in juices like orange, apple, grape and tomato.

Sugar substitutes, because of their intense sweetness have also been studied with regard to their plaque forming potential and the incidence of dental caries. There is theoretically a decrease in plaque metabolism resulting in subsequent decrease in the incidence of caries and periodontal diseases. Since aspartame is not a carbohydrate, it does not promote caries by lowering pH.

The acceptable daily intake (ADI) is a conservative upper limit on the amount of a substance that can safely be consumed on a chronic or lifetime basis. The ADI for saccharin is 500 mg for children and 1,000 mg for adults. A packet of saccharin contains 14-20 mg saccharin. Therefore adults can safely take in 50-70

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Hypertension is frequently associated with diabetes. In fact, it occurs twice as often among diabetics than in a non-diabetic group. Hypertension in diabetes may be any of four different forms. First, it may be part of kidney disease, which is a major complication of diabetes. Second, it can be part of what is called essential (or primary) hypertension, that is, with no known cause. In other cases, patients can present with isolated systolic hypertension (e.g. blood pressures of 160-200/70-80, as a result of blocking of arteries) or hypertension in the lying position with subsequent hypotension upon arising (due to nerve complication). It is also important to note that in diabetics, like the general population, surgically curable causes of hypertension have to be identified.

There are currently very interesting researches on hypertension associated with kidney disease. Studies on the

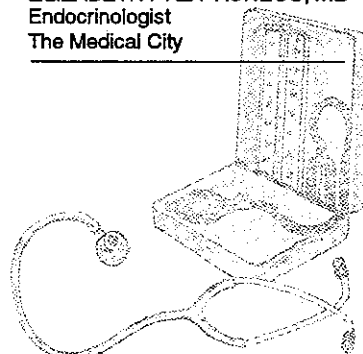
natural history of kidney disease in Type I Diabetes (or Insulin Dependent Diabetes), reveal that only one-third of them will develop diabetic kidney disease and subsequently hypertension. On the other hand, the patients with Type II Diabetes (or Non-Insulin Dependent Diabetes), the prevalence of hypertension is about 40% after about 20 years of high blood sugars.

In both conditions, the earliest clinical manifestation of kidney disease is the presence of albumin in the urine, initially as microalbumin (smaller particles of protein). At this time, there is a mild increase in blood pressure, not necessarily reaching hypertensive levels. If untreated, the kidney disease progresses to renal failure.

There are a variety of ways to prevent progression of kidney disease among diabetic patients. The Diabetes Control and Complications Trial conducted in the United States

HIGH BLOOD PRESSURE IN DIABETES

ELIZABETH PAZ-PACHECO, MD
Endocrinologist
The Medical City



proved that good glucose control (blood sugars of around 150 mg/dl) resulted in fewer complications after an observation period of nine years. Trials that limited dietary protein intake to about one-third to one-half of their usual allowance also showed retardation of progression of urinary protein excretion. Finally, control of blood pressure has been shown to play an important

role in protecting the kidney.

Important consideration for hypertensive diabetics is in order, because of the unique interrelationship between hypertension, glucose and cholesterol. The first approach always consists of behavioral modification. A diet consisting of high fiber, low fat and low salt is prescribed. Regular exercise consisting of at least 3 sessions per week on non-con-

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INTERACTIONS: Certain sugar (sucrose) and sugar alcohols can easily cause abdominal pain and diarrhea during Glucobay treatment because of increased fermentation of carbohydrates in the colon. Antacids, cholestyramine, intestinal 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.
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secutive days provides clear benefits.

When these steps fail, the use of drugs becomes necessary. The Joint National Committee of the United States suggested a few years ago that the first line of drugs should either be diuretics or beta-blockers. On the other hand, the World Health Organization and the International Society of Hypertension had a somewhat different opinion. The latter groups recommend the choice from any of the following five classes of drugs: diuretics, beta-blockers, angiotensin-converting enzyme (ACE) inhibitors, calcium antagonists and alpha-1 blockers, chosen because of their favorable efficacy, tolerability and safety. Each of these different classes of drugs has unique properties that make one class preferred over the other. Commonly used drugs such as diuretics and beta blockers, which although not absolutely prohibited, have shown clear

disadvantages, as they result in worsening of blood sugars and cholesterol levels. Calcium antagonists, ACE inhibitors and alpha-1 blockers are generally preferred because of their lack of adverse effect on the sugar and cholesterol levels. ACE inhibitors appear to be particularly important in the setting of diabetic kidney disease, even in its early stages, as these drugs retard deterioration of the kidneys. Calcium antagonists as verapamil and diltiazem have also been shown to be safe and decrease urinary protein excretion. The calcium antagonists of the dihydropyridine type, such as nifedipine, however, have been shown to increase urinary protein excretion. It's effective control of blood pressure, however, has allowed it to be utilized in cases where control is not achieved by the other agents. Alpha-1 blockers share the properties of ACE inhibitors and calcium antagonists. They are, however, more prone

to cause a drop in blood pressure to below normal levels. The non-thiazide diuretic indapamide and the serotonin-2 antagonist ketanserin are also effective and safe.

Based on this characteristics, ACE inhibitors and calcium antagonists (except nifedipine) are the preferred first line of drugs for hypertension in diabetes. Importantly, these agents may be used among normal or mildly hypertensive diabetics with albumin in the urine. For patients who need a diuretic, indapamide is a satisfactory choice. Thiazide or loop diuretics should probably be avoided. Long-acting alpha-1 blockers are reasonable alternatives.

The advances in research in this area have certainly improved our understanding of the mechanisms of hypertension and kidney disease in diabetes and have allowed recommendation of more appropriate drugs in this special setting.

Diabetes Epidemic...

(Continued from page 10)

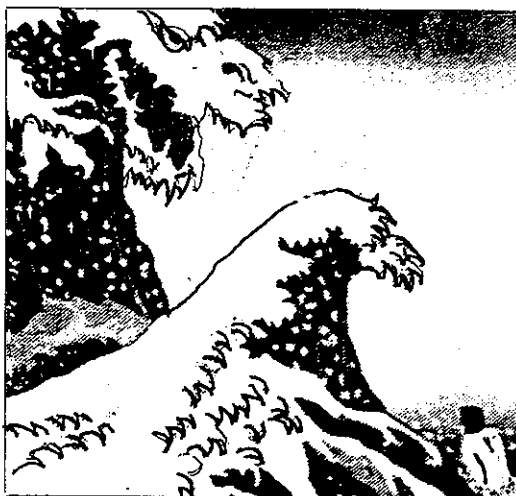
economic recovery onward to the year 2000, we are faced with the consequences of rapid modernization, that of increasing prevalence of diabetes, as have been experienced by other nations who have achieved economic stability ahead of us. Thus diabetes must be a top public health priority. The government must think ahead and lay the groundwork for its prevention and cure before its complications will cause a huge burden to our society and negate the gains that we have painstakingly put in place.

Joint Confab...

(Continued from page 1)

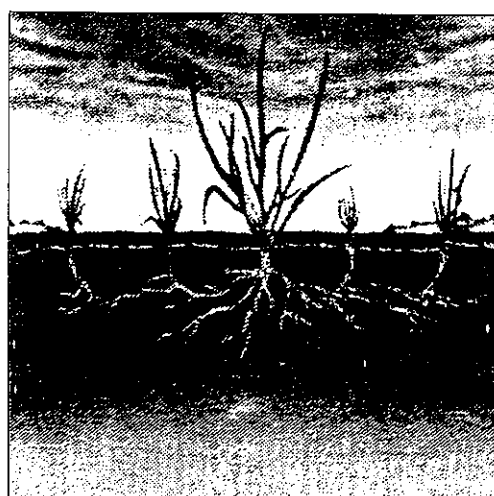
sonnel and 134 lay persons.

Through the able leadership and preparation of Dr. Joyce Co, Dr. Angel Araneta and the PDA Negros Occidental Chapter Organizing Committee the sessions flowed smoothly with good audience participation. What added to the enjoyment of the guests were delicious Bacolod cuisine and superb Negrense hospitality.



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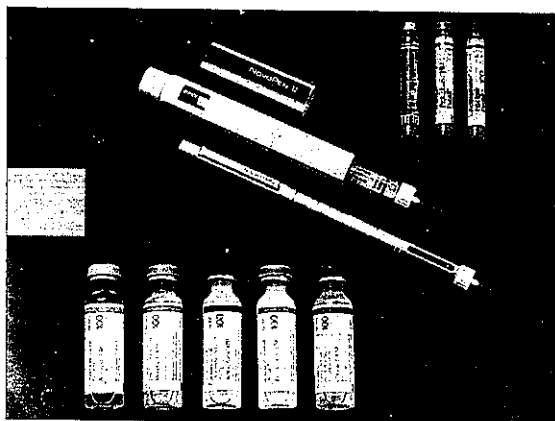
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Tips for the diabetic:

?? TRAVELLING ??

MA. TERESA P. QUE, MD
Endocrinologist
National Kidney Center

Being a diabetic does not mean having to stay cooped up at home. Many diabetics enjoy an active life and travel is one of the many pleasant activities which can be enjoyed. However, one must not go unprepared when one travels so there are some basic things to remember before you set off.

If you are taking a bus home to the province and especially if the travel is long do not forget to bring snacks with you so as to be prepared for meal delays. These may be a sandwich, crackers or fruit. Do not forget to take your medication on time as always. Plan for your trip and prepare your needs at least one week before depending on how long you intend to be gone. Bring double the supplies you will need for the time you will spend so that in case you get stranded you will have plenty of stocks. Bring your tablets or insulin, syringes and blood monitoring equipment.

If you are bringing your car, you should take it to a nearby service station to get it checked out and tuned up. Rushing preparations the day before is a sure prescription for forgetting a lot of things with sometimes disastrous results. If you are going on a long drive and you are using insulin be sure you have about 15 grams of carbohydrate every hour to guard against a low blood sugar reaction and insulin reaction. A small piece of fruit such as a banana, apple or orange, two large sugar cubes, a small box of raisins or two crackers will provide about the right amount of carbohydrate. Don't keep your insulin anywhere in the car especially if the weather is too hot. Keeping your insulin inside

styropore packs can protect your insulin from frosting or deteriorating. If you have motion sickness you can take medication prior to the trip. Consult your doctor about this.

If you are already 50 years old or more or depending on your state of health bringing along a companion is a wise idea. Be sure that at least one companion knows about your diabetes and what to do in case of an emergency. If you are going abroad it would be good to have your doctor's certification in your wallet or have a diabetes I.D. A Filipino singer while on tour abroad had a hypoglycemic reaction and was mistaken to be a drug addict. It's a good thing he had companions knowledgeable about his diabetes or else he would have landed in jail.

Visit your doctor for a pre-vacation check-up on your fitness to travel. Tell your doctor about your vacation plans and discuss whether your diabetes or other health problems may interfere with these plans. Be realistic. If neuropathy affects, your feet for example, a five day walking tour might not be a good idea. Having too many activities crammed over a few days can cause stress and upset your blood glucose control so be sure to have plenty of rest in between activities. Discuss what sort of adjustments in your diabetes management program (food/medication/exercise) you will have to make during your trip to keep your blood glucose under control. Ask your doctor for a list of diabetes centers, with addresses and phone numbers near your vacation sites.

Traveling by plane is the usual mode of transport when

(Continued on page 9)

Diabetes Screening...

(Continued from page 12)

plasma glucose levels, as recommended. There is a difference. Blood, as you all know, is that red viscous liquid you get after doing a finger prick. Plasma, on the other hand, is the yellowish fluid that is obtained after blood cells have been removed. It is usually obtained from a venipuncture, rather than a finger prick. Blood glucose levels are generally 15-20% lower than plasma glucose levels. Therefore, the screenings being done at the present time utilize a method that is really not recommended by most diabetes experts and has not been validated as reliable (for screening purposes) by scientific investigations.

They do however serve a purpose. If only to identify individuals who need to be tested further to confirm the diagnosis of diabetes.

The key word here is **SCREENING**, not diagnosis. We do these tests only to identify individuals who are likely to be diagnosed with diabetes. It is important to remember

that a positive screening test is NOT evidence of diabetes. As such, individuals with a positive screening test must be referred to a physician for follow up testing for a diagnosis to be made.

And hence, we condemn the practice of making the diagnosis of "Diabetes" during screenings, based on one elevated blood glucose value. And certainly, we discourage the practice of giving "starter doses" of antidiabetic medicine during such screenings. The treatment of diabetes is best left to the physician (and his health care team), in his office, after confirmatory tests have been conducted, and where the different tools of management, including diet and exercise, can be better explained.

Blood glucose screening should be recognized for what it is. A red light, a warning that should alert the asymptomatic individual to submit himself for further diagnostic testing. Nothing more. To ascribe more to it would be to commit a great disservice to our patients.

Are all sugar...

(Continued from page 5)

packets/day while children may take 25-30 packets/day. The ADI for aspartame in adults is 97 packets of equal, 20 cans of 12 oz. diet soda and 34 6 oz. powdered drinks. The ADI for children is one third that of adults.

So how many calories can be saved by using low calorie products? The average savings for diet soda (145 calories), dry mix fruit drink/lemonade (80 calories), coffee (31 calories), hot chocolate mix (60 calories), 1teaspoon of sugar (14 calories). SUGAR-FREE anyone?

tion during the long flight put only one half as much air as you normally would. Cabin pressure in high altitude flight is lower than pressure on the ground so you won't need as much pressure inside the bottle to balance the insulin you draw. Discuss changes in your insulin dose with your doctor if there will be changes in time zones.

Travelling...

(Continued from page 8)

you leave for other countries. When you make your flight reservations, reserve a special meal which is suited for the diabetic diet. Inform the air carrier should you need any assistance upon your arrival at the airport or if you prefer certain seats. Pack light or use a luggage cart and put your medications especially your insulin in your carry-on luggage. Avoid storing insulin in baggage which can get very hot or cold such as the car boot and airline baggage compartments. Wear loose comfortable clothing and shoes. Drink extra water during the flight to avoid dehydration. Avoid fruit juices and regular softdrinks which can send your blood glucose soaring. Avoid alcohol which can cause your blood sugar levels to drop.

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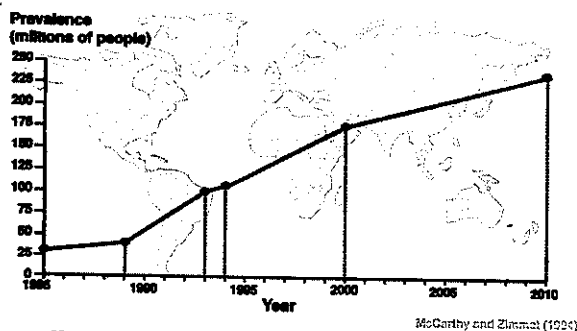
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THELMA D. CRISOSTOMO, M.D.
Endocrinologist
Makati Medical Center

DIABETES' EPIDEMIC THREAT!

Estimates of global prevalence



Diabetes mellitus is a major global public health problem which has reached epidemic proportions in some parts of the world especially in non Caucasian populations particularly among Asians and peoples in the Pacific region. The estimated number of 80 million sufferers in 1990 is expected to double by the year 2000 and the major part of the increase will occur in developing countries.

Diabetes mellitus is appropriately classified into two major clinical forms, Insulin Dependent Diabetes Mellitus (IDDM) and Non Insulin Dependent Diabetes Mellitus (NIDDM). NIDDM is the most frequent form of diabetes in all parts of the world. It accounts for approximately 80-90% of diabetes in developed countries and nearly 100% in many developing populations.

Certain ethnic groups in the developing world which have experienced rapid modernization of lifestyle during the latter part of the 20th century demonstrate the greatest susceptibility to NIDDM. Diabetes mellitus results from the collision of our hunter-gatherer genes with the modern 20th century lifestyle. This process also has been labelled as coca-colonization by the late Arthur Koestler.

What is an epidemic? This is a term used to describe the occurrence in a community of a disease occurring at a greater frequency than usually expected. This clearly applies to NIDDM, for its occurrence will continue to escalate over the next decade and its complications will pose as one of the major threats to health throughout the world at huge economic and social costs to society.

Among Pima Indians in Arizona, diabetes used to be a very rare disease in the 1920's

but has affected almost 50% of its population in these last few years. Among Nauruans in Micronesia, the rapid modernization in that area brought about 40% of their population becoming diabetics. The same is true among Melanesians in Papua, New Guinea where 37% of their population are diabetics and among Australians aborigines too. 16% of Chinese and Indian migrants living in Mauritius have been affected by this illness. Compare this to the low incidence among their compatriots who have not left rural areas in China and India.

In the Philippines, the diabetes statistics available were those done 13 years ago (1983) by the Ministry of Health. During that period, 1982-1983, 4.17% of the whole population was affected by diabetes and it was higher in urban areas at 6.8% than in rural areas 2.5%. We expect these figures to have doubled during this period.

The pattern of NIDDM frequency in developing and newly industrialized and migrant populations strongly suggests that factors inherent in Western lifestyles are involved and that diabetes is a lifestyle disease. The following are major behavioral, environmental and social risk factors that may predispose to diabetes: Age, diet, obesity, physical inactivity, degree of modernization, intrauterine environment and stress.

Genetic factors play an important role in diabetes. The

marked susceptibility to NIDDM of traditional populations have been explained in terms of the Thrifty Genotype Hypothesis. Our hunter-gatherer ancestors in the centuries past who were subjected to cycles of feast and famine developed thrifty genes with maximum efficiency to store food and energy. In these modern times, in rapidly developing countries, where famine is rare and food is in abundance, the thrifty genes become a disadvantage because very efficient storage of energy will eventually result in obesity and diabetes.

Diet has long been believed to play a role in the development of diabetes. One recent study in the USA concluded that the consumption of 40 grams of fat or more per day was associated with a sixfold increased risk for diabetes. The hunter-gatherers in the past centuries had a simple diet which consisted of 15-20% fat, 70% complex carbohydrates and 15-20% proteins. In contrast the diet of the present day Western man contains 40% fat and 20% simple sugars, with the complex carbohydrates reduced to 25-30%. Clinical studies increasingly suggest the hypothesis that the high fat low carbohydrate diet prevalent in Westernized societies today are contributing to the obesity and diabetes seen in these groups.

Obesity act as a predisposing factor in those individuals with genetic susceptibility,

particularly those with upper body obesity. They should be specifically targeted in any programme aimed at prevention of NIDDM. Centralized distribution of body fat has been shown to be associated with the later development of NIDDM in a wide range of ethnic groups such as Nauruans, Native Americans, Asian Indians and Mexican Americans.

Profound physical inactivity is associated with the development of diabetes. The prevalence may be two times as high in those with lower degrees of physical activity.

Many studies demonstrate higher occurrence of diabetes in city environments than in rural areas in developing countries. Possible explanations for these are: change in lifestyle and physical activity, more refined diet in urban areas and greater occurrence of obesity.

There are evidences that the environment in the mother's womb during conception may influence the risk of developing diabetes among offsprings. Diabetes occurs more frequently in offspring of diabetic pregnancies than the offsprings of woman who were non diabetics at the time of delivery.

Having presented the risk factors in diabetes, the question now is, can we prevent diabetes?

Short term studies indicate that diabetes is preventable with appropriate diet composition consisting of high fiber and low fat, minimizing simple sugars, together with weight reduction for those who are obese and increased physical activity will improved utilization of glucose, reduce blood pressure and correct cholesterol and triglyceride abnormalities.

As we gear our nation to
(Continued on page 7)

DIABETES AND PREGNANCY:

6. When should I be checked for diabetes?

Ideally screening is done on the 1st visit to the doctor. If you have the following, visit your doctor right away: (+) family history of diabetes, obesity, sugar in the urine, random blood sugar over 120 mg/dl, frequent miscarriages, history of stillbirth, big babies, and increased amount of amniotic fluid.

7. What treatment should I receive?

Initially you will be observed with diet alone. Tablets are not allowed to be taken during pregnancy because of their harmful effects on the baby. Insulin injection may become necessary in some patients.

Severe dieting may compromise fetal nutrition. Optimal weight gain during pregnancy is within 20 to 30 pounds. Home monitoring of blood sugar is highly recommended for excellent control of blood sugar.

Some questions answered

LEILANI B. MERCADO-ASIS, MD, PhD
Endocrinologist
Faculty of Medicine and Surgery
University of Santo Tomas

1. Why did I develop diabetes?

Pregnancy-induced diabetes may occur in patients who have the following: (+) family history of diabetes, obesity, age over 30, and concomitant medications like steroids.

2. Why can diabetes develop in a genetically predisposed pregnant patient?

The placenta becomes a factory of the different hormones like human chorionic somatotropin, progesterone, and estrogen which increase in proportion to placental size. These hormones are anti-insulin resulting in decreased sensitivity of the body to insulin action. Furthermore, pregnancy *per se* is a stress which can induce increase in blood sugar.

3. What happens if I do not control my blood sugar?

Maternal blood sugar freely crosses the placenta and goes to the baby. The baby is eventually fed with excess

sugar resulting in an increase in its size. The resultant concentrated amniotic fluid attracts more water resulting in an increase in its amount. This increase in the uterine contents induces difficult delivery that may require cesarian section, premature labor and even death of the baby.

4. Will my baby be safe?

If blood sugar during pregnancy is controlled well, the baby is safe. However, if uncontrolled, in addition to the No. 3 sequela, the increase in the blood sugar of the baby induces hypersecretion of insulin from its pancreas. Once the umbilical cord is ligated, the supply of the sugar from the mother is

stopped, but hyperinsulinemia in the baby remains which may cause serious decrease in the baby's blood sugar (hypoglycemia). Hypoglycemia is bad for the baby's brain and may lead to convulsion.

5. What happens to my diabetes after delivery?

As the placenta becomes old (end of third trimester), the anti-insulin hormones decrease. Pregnancy-induced diabetes starts to resolve during labor and may be completely gone during delivery and 6 weeks thereafter. In some patients, it may persist, so that follow-up with your doctor is important.

In NIDDM
Management

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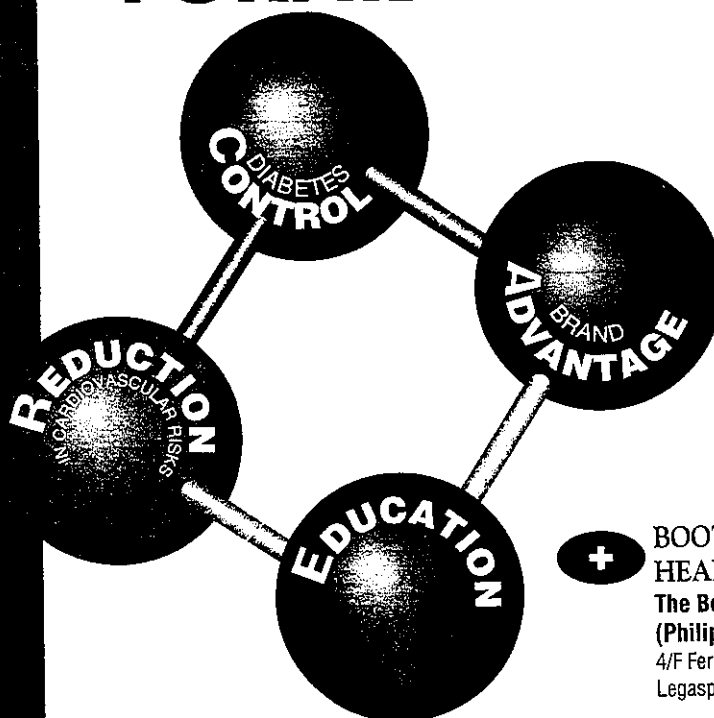
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EDITORIAL COMMENT

CYNTHIA HALILI-MANABAT, MD, PhD
Endocrinologist
UP College of Medicine

"DIABETES SCREENING"...

What it should be about?

You've seen it being done in hospital lobbies, during medical missions, special diabetes events, conventions and seminars. Now it's being done even in malls and shopping centers! Free blood sugar testing. What is it all about? Why do it at all?

Diabetes mellitus is a chronic, life long disease characterized by high blood glucose (sugar) and other metabolic disturbances. It is associated with severe cardiovascular, neurologic, ocular and renal complications. Although symptoms of diabetes may include weight loss, thirst, frequent urination and blurred vision, in the early stages of the disease, the patient is often asymptomatic.

Glucose testing is part and parcel of a Diabetes Screening Program that aims to identify such people who have no symptoms of diabetes but who are likely to have the disease anyway. The rationale for screening here is to identify asymptomatic individuals be-

fore their diabetes becomes debilitating, and thereby prevent the occurrence of the many complications, including death.

Who should be screened? Although most screening programs are open to the general public, the likelihood of identifying an asymptomatic individual with diabetes is much greater if certain high-risk groups are tested. These include:

(a) Individuals with a family history of diabetes (parents, brothers, or sisters with diabetes)

(b) Those who are obese, or more than 20% above their desired body weight. (A simple way to calculate your desired body weight is to subtract 100 from your height in cm, and this will give you your desired weight in kg. Ex: Height = 162 cm $162 - 100 = 62$. Therefore, desired body weight is 62 kg.)

(c) Age more than 45 years.

(d) Hypertension, hypercholesterolemia (choles-

terol greater than 240 mg/dl), hypertriglyceridemia (triglycerides greater than 250 mg/dl)

(e) In women, delivery of babies over 8 lbs.

If you belong to any of these categories, it is essential that you be tested for diabetes at least every 3 years.

How should screening be done? The screening test of choice is a fasting plasma glucose test (American Diabetes Association Position Statement 1995). Fasting is defined as no consumption of food or beverage (other than water) for at least 10 hours before testing (not necessarily NPO after midnight). A plasma glucose level greater than 115 mg/dl is suspect and indicates the need for further diagnostic testing.

Plasma glucose testing may also be performed on individuals who have taken food shortly before the test. These are called "random" plasma glucose measurements. In which case, a random plasma glucose greater than 160 mg/dl should be considered posi-



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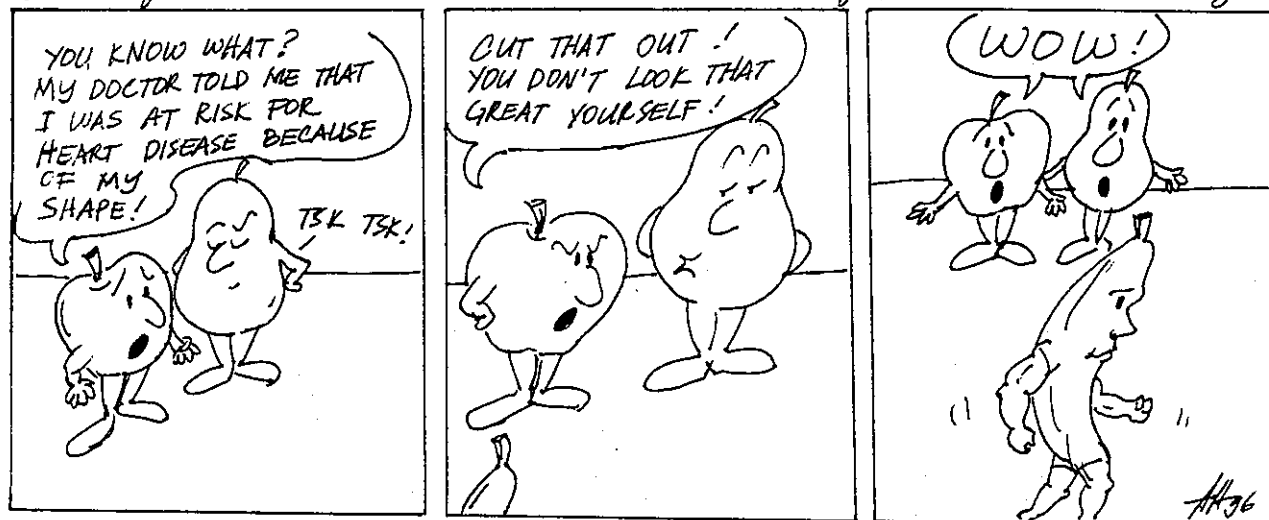
tive and the patient referred for further testing.

However, what almost all free screening tests measure are blood glucose levels, not

(Continued on page 9)

The lighter side of Diabetes

By: Dr. Allan Hernandez



Woe to the man who is shaped like an apple - all sorts of complications he'll surely be able.