Member, International Committee of Diabetes Magazines, International Diabetes Federation

DiabetesWatch

A publication of the PHILIPPINE DIABETES ASSOCIATION, INC.

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PDA'S TWELFTH, THIRTEENTH DIABETESWORKSHOP & 6TH MIDYEAR CONVENTION

The 12th Diabetes Workshop was held in Casablanca Hotel, Legaspi City April 7-9, 1997. A record breaking number of participants totalling 175 registered for the course. The 12th Workshop was held in cooperation with the PDA Chapters of Albay, Sorsogon and Camarines Sur together with the PAFP Bicol Region. This workshop saw the birth of two (2) new chapters namely Masbate and Camarines Norte and the reactivation of the Sorsogon Chapter. Catanduanes sent a delegate to observe with the hope of forming a chapter in the near future.

The 13th Diabetes Workshop will be held on August 21-23, 1997 at the Grand Men Seng Hotel in Davao City. The topics include: Overview, Screening Diagnosis and Classification of Diabetes Mellitus, Dr. Edith Arceo-Dalisay; Medical Nutrition Therapy in Diabetes Mellitus, Mrs. Sanirose Orbeta; Exercise and Diabetes Mellitus, Dr. Rosa Allyn G. Sy; Oral Agents and Insulin Therapy, Dr. Laura Trajano-Acampado; Insulin Administration and Monitoring Diabetes Control, Dr. Susan T. Yu-Gan; Diabetes and Pregnancy, Dr. Mary Anne Lim-Abrahan; Management of Diabetes Mellitus, Dr. Ruby T. Go; Psychosocial Aspects of Diabetes Mellitus, Dr. Roberto C. Mirasol; Acute Complications of Diabetes Mellitus, Dr. Lina C. Lantion-Ang; Peripheral Vascular Disease/ Diabetic Foot Care, Dr. Ma. Teresa Plata-Que; Atherosclerosis / Dyslipidemia in Diabetes Mellitus, Dr. Tommy S. Ty Willing; Retinopathy, Nephropathy and Hypertension in Diabetes Mellitus, Dr. Elizabeth Paz-Pacheco; Neuropathy in Diabetes Mellitus, Dr. Augusto D. Litonjua.

Following the interesting and successful inclusion of a hands-on experience in Medical Nutrition Therapy where participants will guesstimate' the carbohydrate content of the food tray given to them during the last workshop, we have incorporated this method in the 13th Workshop. Another new innovation for the 13th Workshop is the inclusion of a workshop for Para-Medical Personnel. This will be held on August 22, 1997 at 1:00-5:00 PM.

The 6th Midyear Convention with the theme: "Issues in Diabetes Care" will be on August 24, 1997 at the Grand Men Seng Hotel, Davao City. The issues that will be addressed during this convention include: Drug Therapy in Diabetes: A Look

(Continued on page 9)

8th TRAINING COURSE FOR DIABETES EDUCATORS

The 8th Intensive Training Course For Diabetes Educators of the Diabetes Center was held June 30 to July 5, 1997 at the Makati Medical Center.

Participants to the course who were conferred the title, Assistant Diabetes Educators, included: **Bicol Medical Center** - Teodora Doris Figueras, M.D., Henrietta Blacer, R.N., Ma. Carmen Blincow, R.N.D.; **Holy Child Hospital, Dumaguete** - Edna Alcantara, M.D., Maricar Cadalso, R.N., Gilda Belmonte, R.N.D.; **John F. Cotton Hospital** - Bernadette Balmores, R.N., Teresita Sicangco, R.N., Elisa Valdecantos, R.N.D.; **Provincial Health Office-Virac** - Lilian Olfindo, M.D., Aurora Manlagnit, R.N., Justina Torrecampo, R.N.D.; **San Miguel Corporation** - Reynaldo Mariano, M.D., Melvin Cabaysa, M.D., Gloria Rivera, R.N.; **Tondo Medical Center** -

(Continued on page 9)

DIABETES CENTER SPONSORS OPERATION:SILIP-MATA

From July 27 to August 2, 1997, the Philippine Center for Diabetes Education Foundation, Inc. (Diabetes Center), in cooperation with the Philippine Academy of Ophthalmology and the Philippine Diabetes Association, will be holding Operation: Silip Mata. On scheduled days, diabetic patients may avail of free fundoscopic (eye) examinations and consultations at the diabetes education clinic affiliated with the Diabetes Center nearest them.

Fundoscopic examinations detect the presence of diabetic retinopathy, the most common cause of blindness among diabetic patients. It is recommended that diabetic patients have a fundoscopic examination done at least annually to monitor the development and progression of diabetic retinopathy.

(Continued on page 14)

Medical Bureau Staff with First Lady Mrs. Amelita Ramos

Your President Speaks . . .

Lina C. Lantion-Ang, M.D.
PDA, President

WORKING TOGETHER....

Let us work together to DISSEMINATE DIABETES AWARENESS in the Philippines. This is a global appeal considering the magnitude of the problem Diabetes Mellitus has become.

This year the present PDA Board has decided to reactivate the various PDA chapters in the country to help disseminate Diabetes Awareness in their respective areas. They will act as the local working group in the preparation of various PDA activities such as the PDA Workshops, Mid-Year Convention and other activities pertinent to Diabetes Awareness.

We welcome the new PDA Chapters of Camarines Norte and Masbate, as well as the joint collaborative efforts of the various medical societies and the Philippine Academy of Family Physicians in encouraging its member physicians to attend the PDA Workshops. Newly introduced to the workshop this year is the actual measurement of food portions and "guesstimates" of the carbohydrate content of a prepared meal by participating physicians.

There is now a growing concern among the members of the Diabetes Health Team in the provinces to update themselves on Diabetes Education and Management. In response to this request, the PDA, working with its local chapter in Davao City, will conduct a half-day interactive session on selected topics on Diabetes Mellitus for Dieticians and Nurses on August 22, 1987 during the 6th Mid-Year PDA Convention (CME units will be provided). A separate half-day lay session will also be conducted for PDA lay members.

The Diabetes Watch will continue as our venue for more Diabetes information. We welcome Dr. Rosa Allyn Sy and Dr. Patricia "Tish" Gatbonton to the Editorial Board. Dr. Augusto D. Litonjua is now Editor-in-Chief, Emeritus.

Our friends from the pharmaceutical industries have always been supportive of all the PDA activities and we will always be grateful to them for their continued commitment to Diabetes Care.

Team work is the key to a successful Diabetes Awareness Program.

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DIABETES FAIR AT THE GLORIETTA

The increasing number of diabetics worldwide confirms a diabetes epidemic. Our country is not an exemption. Our target is to increase awareness among the people so diabetes can be prevented.

As part of our program in celebrating the Diabetes Awareness Week, a Diabetes Fair is slated at Glorietta on the 27th of July from 11:00 am to 4:00 pm. This fair is highlighted by various educational booths and materials geared towards the education of everyone regarding Diabetes Mellitus, with emphasis on prevention of both the disease and the complications from among those who have it. There will be simultaneous testing of blood sugar during the duration of the fair and checking of the feet for any possible problems related to Diabetes.

Spearheading this activity are the Diabetes Center chaired by the First Lady Amelita M. Ramos and the Philippine Diabetes Association in cooperation with the various pharmaceutical companies.

Other activities include a week-long eye screening program, dance contest and a mini-program.

For details, please contact Diabetes Center at tel. no. 893-6070.

MEANDERINGS . . . .

Augusto D. Litonjua, M.D.

BRING BACK THE ANIMAL INSULINS?

The discovery of insulin in 1921 is traditionally ascribed to a group of Canadian scientists: Banting and Best, Collip and Macleod. Other workers also claim credit for the discovery of the blood sugar lowering substance from the pancreas: Zulzer of Germany, Paulesco of Romania and Kleiner of the US. But history narrates that is was the extract made by Banting and Best that was first injected into Leonard Thompson, a 14 year old boy dying from diabetes. History also tells us however, that Banting and Best's preparation did not cause the blood sugar of Thompson to drop. Even so, these trials led to the insulin era when thereafter countless lives would be saved.

In modern experience, products of new techniques become cheaper and more widely available in the years after their first introduction. However, the same is not true for insulin. It remains very expensive and not universally available for those who need it. Reports from the World Health Organization and International Diabetes Federation show that many from around the world are still dying from lack of insulin.

Why?

Prejudice — the mistaken notions that insulin is addictive and that its use connotes that its user is near death still pervade certain societies, and deters many diabetics from using it when oral medications fail.

Ignorance — many doctors think that insulin should not be used in NIDDM (non-insulin dependent diabetes mellitus) because its name implies that it is not insulin deficiency that causes sugar to rise in the patient's blood. This, despite published reports that the addition of insulin to present regimens will improve blood sugar control. Also, it is not accepted that what may be NIDDM now may eventually be IDDM (insulin dependent diabetes mellitus) in the future, unmasked by the years.

However, it is the cost of insulin — the most important factor — that makes it unreachable by the majority. Insulin use has graduated from the animal insulins (pork and bovine) to "human" insulin — and prevent it from being marketed below the cost of animal insulins. It seems that the "better" the insulin we aim for, the more expensive it will become. For example, another insulin is in the offing — readily absorbable from its injection site, obviating the need to wait for 30-40 minutes before eating. A vast improvement indeed, but at what cost?

How then do we bring down the costs of insulin, so that its use would truly be widespread among those who need it?

1. Removing taxes can significantly lower the cost of insulin. Approximately more than half of the price of an insulin vial is due to the taxes the insulin importer has to pay the government. In countries where there are no taxes on insulin — as in Singapore or Malaysia — insulin is considerably much cheaper than in the Philippines.

2. Government subsidy to charity institutions or non-profit foundations may also ameliorate the situation, although this does not seem feasible because of the several stumbling blocks to its implementation. Will the recipients be truly deserving?

3. Use expired but still potent insulins. At the moment, an Australian institution managed by Ron Raab sends out unused insulins to many parts of the world. Some of our Philippine institutions also use them — with safe success. Insulin distribution in our country is still faulty and could stand improvement.

4. Perhaps we could even bring back the animal insulins, if made available at significantly cheaper prices. For years these insulins saved many lives. The only

(Continued on page 14)

Roberto C. Mirasol, M.D.
Endocrinologist
St. Luke's Medical Center

Everything you always wanted to know about DIABETES...

(but were afraid to ask!)

What's new in diabetes? is a question often asked by patients in the clinic. To keep you up to date in recent developments in the diabetes field, this issue of the Diabetes Watch will tackle some of the landmark and recent studies that have changed the way it is being managed.

What was the Diabetes Control and Complications Trial (DCCT)?

The DCCT is a ten-year randomized controlled trial which addressed the relationship between glycemic control and microvascular complications. This study demonstrated that good blood glucose control significantly reduced the development of complications in people with diabetes. Specifically, it reduced risk of retinopathy (eye disease) by as much as 34-76%. Nephropathy (kidney disease) was likewise reduced by 39-60%, and clinical neuropathy risk by as much as 60%. In other words METABOLIC CONTROL MATTERS!

The DCCT studied Type I individuals, could it's conclusions apply as well to most of us who have Type II diabetes?

As we await the United Kingdom Diabetes Prospective Study, most physicians caring for people with diabetes suggest that tight control for many people with Type II diabetes will have similar beneficial results for decreasing risks of complications. There is growing evidence that there are common mechanisms by which glucose causes these complications.

What is the Diabetes Prevention Trial - 1 (DPT - 1)?

The DPT - 1 is a randomized controlled clinical trial designed to determine if it is possible to prevent or delay the onset of Type I diabetes, in persons predicted to be at risk for this disease. The study aims to look at the effectiveness of giving low doses of long acting insulin administered twice daily coupled with periodic intervals of intensified insulin treatment. So far the results have been very good and answers may be forthcoming in the near future.

What is the rationale for doing this study?

There is a need to prevent diabetes because of its unacceptable morbidity and mortality. Likewise, the financial burden to society is astronomical. We are also now able to predict type I diabetes by the use of immune markers and metabolic parameters (loss of first phase insulin secretion). Finally, there is potential for cure.

What about the DPT - 2?

This is again a randomized controlled trial looking at parenteral antigens and oral antigens. This trial will test whether taking a capsule containing beta cell materials, such as insulin or other products, will reduce the chances of developing Type I individuals.

These are studies in Type I individuals, how about for Type 2?

The Diabetes Prevention Program (DPP) is one such study. It is one of the largest diabetes trials in the US today. Its objective is to prevent or delay the onset of Type II diabetes in people who are at high risk of developing the disease. This study will look at intensive lifestyle modification; use of metformin or troglitazone (believed to improve insulin sensitivity) in preventing the onset of Type 2. The study hopes to enroll 4000 patients with impaired glucose tolerance over six years. We eagerly await the results of all these studies.

We welcome your comments, suggestions and questions. Please fax at 531-1278.

PHILIPPINE DIABETES ASSOCIATION/ PHILIPPINE SOCIETY OF ENDOCRINOLOGY AND METABOLISM JOINT ANNUAL CONVENTION

The joint annual convention of the PDA/PSEM will be on December 9-10,1997, at the Century Park Sheraton. The theme is Current Issues in Endocrinology and Diabetes: From Molecular to Clinical. Foreign and local speakers will focus on Type I Diabetes Mellitus; Unfolding Realities in Type II Diabetes Mellitus; Nutrition in the Diabetes Health Care Delivery; and Intervention in Diabetes: A look in the Future.

We look forward to seeing there.

DIABETES AWARENESS WEEK 1997 DANCE CONTEST

Come July, we will once gain celebrate Diabetes Awareness Week. As has been customary, we will have a grand kick-off activity at the Glorietta on July 27, Sunday. One of the highlights of the program will be a dance contest which is open to all patients and healthcare professionals from all participating hospitals. Cash prizes await the winners. Special prizes will also be given away. So come and join the fun and show-off your "hidden" talents. But remember, the dance routine and movements must not be too strenous and must be suited to diabetics. That shouldn't be too difficult, right? Deadline for submission of group and dance entries is on June 15, 1997. Several hospitals have already enlisted. Don't be left behind!

Other activities include a week-long eye screening program and a mini-program.

For details, please call the Philippine Center for Diabetes Education Foundation, Inc. (Diabetes Center) at tel. no. 893-6070.

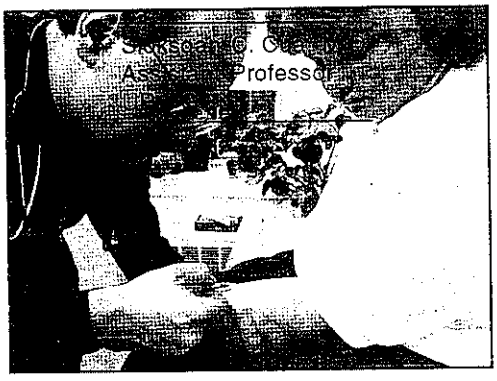
9th CONGRESS OF THE ASEAN FEDERATION OF ENDOCRINE SOCIETIES

This early, the 9th congress of the ASEAN Federation of Endocrine Societies, in Singapore from December 3-6, 1997, has generated a lot of interest. The congress, to be held at the Shangri-La Hotel, has for its theme Advances in ASEAN Endocrinology. The symposia will feature speakers from the ASEAN region who will share their understanding of the endocrine or lipid problems in their countries. State-of the-art lectures feature world renowned speakers. Plenary sessions will include lectures on Mechanisms of Insulin Action by Ronald C. Kahn; New Hope for Diabetes Management by George Alberti among others.

A pre-congress Laboratory Endocrinology Workshop will be held at the National University of Singapore Training and Education Centre on December 2, 1997.

A stimulating and educational time is promised for all. See you in Singapore!

DIABETES MELLITUS IN CHILDREN AND ADOLESCENTS



Can children have diabetes mellitus?

This is a common question. The answer is "Yes." Diabetes mellitus is seen in children. Most of them have insulin-dependent mellitus (IDDM); they have an insulin deficiency and will require exogenous insulin for survival. Nowadays, there is a rising incidence of non-insulin-dependent diabetes mellitus (NIDDM) among young obese patients because of changing eating habits and lifestyles.

What is the age range of these diabetes children?

The age ranges from infancy to adolescence. Locally, the youngest patient with IDDM is an infant. The age of onset of diabetes among the Filipino children is usually between 6 to 15 years; they are the school-aged children who are susceptible to viral infections, or adolescents approaching puberty.

What are the clinical manifestations or clues suggesting diabetes?

The diabetic child has frequent urination (polyuria). If a previously toilet-trained child again bed-wets, it may be a warning sign for parents to investigate. Generally, there is significant weight loss. A school-aged child may become inattentive and irritable. School performance may deteriorate. An adolescent girl often complains of itchiness at the vulvovaginal area; she may have frequent urinary tract infections. Quite often, these symptoms are "ignored" or the parents unaware, so no medical consultation is made until the patient becomes seriously ill. In some instances, the child may develop severe abdominal pain and an operation is considered for an "acute abdomen", but then the blood sugar is found to be very high! Another common scenario: a child is noted to have depressed sensorium or coma, with difficulty in breathing. In other words, the child has a serious complication of insulin-dependent diabetes mellitus - diabetic ketoacidosis (DKA)! DKA is a medical emergency. 25% or more children may have DKA as the initial presentation of diabetes mellitus. They are usually rushed to the emergency room, then admitted to the intensive care unit (ICU). The frequency of coma as a presenting feature in children less than 2 years old is much higher than those older than 15 years.

If an obese child has "unexplained" weight loss, particularly when associated with frequent urination, and increased water intake (polydipsia), the parents should seek medical consultation. A review of nutritional history can provide information regarding the caloric intake. Blood glucose determination may be needed to document hyperglycemia. If the fasting blood glucose level is greater than 140 mg/dl (>7.7 mmol/L) or random blood glucose is greater than 200 mg/dl (>11 mmol/L) in at least two occasions, a diagnosis of diabetes mellitus can be made.

MANAGEMENT

For IDDM patients, insulin injection is required. Education consists of teaching the parents or bigger children how to administer injections, monitor blood or urine sugar, understand the disease and possible complications. The nutritionist can help the parents to provide adequate amount of calories to the child without causing high blood sugars.

For the NIDDM or maturity - onset diabetes in the young (MODY) patients, dietary modification with reduced oily food and simple sugar intake is important. The right amount of exercise also helps control weight. Oral hypoglycemic agents may be needed when diet fails to achieve good glucose control.

The approach to management depends on the patient's age. The caloric requirement as well as the activity level of each age group varies. The management has to be "individualized"! The involvement of parents is very crucial to good glucose control. Home blood glucose monitoring can provide important information and help in adjustment of insulin dosage.

SOME TIPS FOR THE PARENTS WITH DIABETIC CHILDREN

1. Maintain a consistent, appropriate diabetes regimen for your child.
2. Things work smoothly when each parent carries some of the burden of a young child's diabetes care.
3. Encourage every member in the family to eat the same healthy meals.
4. Think of the diabetes regimen as a daily habit that can bring a healthy lifestyle to everyone in the family.
5. Try exercising together as a family, perhaps by walking or biking once a week.
6. You can still provide the sense of trust for your little child with diabetes by cuddling and showing lots of warmth after each finger prick and insulin injection.
7. Young children often can't express their fear verbally, but they can act them out through ordinary play. You may give your little child with diabetes a doll or teddy bear, and syringe without needle; let the child play at injecting these figures and then provide comfort after the injection.
8. Praise; don't blame. Do use many positives with your child. Say "You're great," or "You're brave!"
9. When a child is cooperative during a finger stick or injection, you may give a "star" or sticker as a reward.
10. Remember, a young child can get used to the diabetes treatment regimen. It will be easier when you are able to explain things more fully as the years go on.

References:
- L Rosin, *Family Matters.* Diabetes Forecast. Feb 97.
- L Siminerio, *On Kids, Injections, and Maintaining Trust.* Diabetes Forecast, Sept 96.

THE PSYCHOSOCIAL ASPECT OF CARE OF THE YOUNG DIABETIC

Joseph A. Regalado, M.D., M.A.
Philippine Psychological Research & Training House, Inc.
Cardinal Santos Medical Center

The advent of the holistic approach in the practice of medicine has enhanced the efficacy of modern therapeutics. Understanding the psychosocial implications of a disease on the life of the patient and on the corresponding treatment process is invaluable to both the patient and the doctor. These implications cannot be ignored especially when dealing with ailments affecting the youth as in the case of diabetes mellitus. The etiology, epidemiology, clinical presentations, complications and treatment modalities in diabetes in the young have been thoroughly expounded. A doctor's armamentarium can only be strengthened when the psychosocial aspect of care is incorporated in its therapy.

Everyone involved in the comprehensive care of these diabetics should keep in mind that there are 3 basic emotional needs of a child, namely: affection, approval and acceptance. These needs have to be satisfied for the child to maintain a sense of well-being in health. When sick, the child feels a loss of his sense of self, completeness, freedom and control. Illness means loss of playtime, school time, sleep and the comfortable alertness needed for activities he would otherwise have enjoyably spent his time in. He is hampered by the limitations imposed by both the disease and the impositions of treatment. While ill, the continued satisfaction of emotional needs should be ensured to maintain as much of a sense of wholeness as possible. This ensures the patient will accept his illness and thus cooperate in its management.

For a child with diabetes, the most difficult emotional problems arise after the diagnosis is made. The older the child, the more complicated the situation becomes. More than just having to deal with the medical management, the child also has to adjust to the changes the illness will impose on the life he has lived thus far. For the very young, adjustment may be minimal and only at the beginning. As a child grows, he develops a natural urge for autonomy and freedom. A lifetime illness such as IDDM is thus conceived inimical to this process of personal evolution and development. In the older age group, the conflict is more marked. Breaking old habits is difficult and can only be achieved by real self-determination. A greater emotional upheaval is expected in adolescents. Given the characteristic impulsiveness of teenagers, resistance from the point of accepting the illness once diagnosed to the pain of the insulin shots is not unexpected. Psychological support is critical for this age group.

With food preference being a learned behavior, the

(Continued on page 12)

DEALING WITH DIABETES: A PATIENT'S VIEW

Patricia Ann Marañon

Life was going smoothly. As a kid, I was enjoying myself, looking forward to the future. Then suddenly, I am diagnosed diabetic. I was just eleven. I was frightened and confused. I realized that no pills could cure me, and that diabetes was going to be with me for the rest of my life. I often was lonely and wondered: Will I be able to do the things I used to do? Will I still be able to eat chocolate and ice cream like other kids my age? Will people think differently of me now? Will I get complications?

Why me? I asked myself that question a thousand times. I was hoping that everything was just a bad dream, so I could wake up and escape it. But it was real...and awful. For anyone diagnosed with Type I Diabetes, the biggest hurdle is often the discomfort of daily blood glucose testing and insulin injections. Suddenly, my body required the attention it never needed before. My lifestyle now included a regimen I didn't really want. I couldn't envision the future as clearly as I once could.

I reached the rebellious age of puberty. I wanted to have friends and go to parties and enjoy social eating. There came a point when I denied the seriousness of my diabetes. It was tempting to deny the necessity of following all the diabetes care instructions such as monitoring my diet and

(Continued on page 8)

SOME NUTRITIONAL TIPS FOR THE INSULIN-DEPENDENT DIABETIC

Maria Imelda Q. Cardiño
Diabetes Educational Clinic
Makati Medical Center

Food intake of the insulin- dependent diabetic must be sufficient, best taken at regular times (since insulin is usually given 15 before meals) and frequency is (that is: breakfast, lunch, supper and about 3 snacks daily). The bedtime snack is particularly important to prevent low blood sugar reaction at dawn. It is recommended that this snack contains some protein source if the food allowances would permit them. Some suggestions follow:

MAIZ CON HIELO - Use kernel corn, and you may or may not add artificial sweetener.

EN MAMI SOUP - Use chicken and add vegetables.

AO WITH BEATEN EGG WHITES - Perk up with add shredded vegeand fresh kalamansi.

ED SAGO/GULAMAN with or without artificial sweetener).

OVEN-GRILLED BEEF BALLS - Use lean ground beef, add some minced carrots, chopped parsley and spices.

ICED FRESH KALAMANSI JUICE (with or skim milk, canned whole

(Continued page 14)

Dealing with...

(From page 7)

blood glucose levels.

As I matured, I realized that there were more people with bigger problems than me. Everyone is given a challenge in this world and each person should deal with it in his or her own way. It was up to me to be responsible, to deal with my diabetes. I needed to be brave, to accept and confront my illness or face the consequences, which were scary.

Finally, I saw that my diabetes taught me discipline and responsibility. It brought on an inspiration to fight for and celebrate life. Diabetes is about coping - not running away.

There are a lot of little ways that can make coping easier:

- Maintain a positive self image. The fact that you are dealing with a chronic illness is a courageous thing !
- Set goals and aim to reach them. Engage in activities such as sports. Whatever it is, give it a try.
- Be as involved as possible in your health care. Learn all you can about diabetes, ask questions, read books to keep yourself updated.
- Pat yourself on the back each time you achieve something like having a normal glucose level after a blood test .
- Do not drift. Get on with school, work, hobbies and social events.

I say to those of you who have diabetes like me: you have a bright and long future. Prepare for it. Go on. You'll not only appear in control of your life, you'll feel in control too! Then you'll realize that coping with diabetes isn't a big deal after all.

8th Training...

(From page 1)

Cristina Acuesta, M.D., Juliet Pereda, R.N., and Noemi Mercado, R.N.D.

At the closing ceremonies, the guests were inspired by the talk given by Dr. Rodolfo Carungin, Philippine College of Physicians President.

The faculty of the 8th course were Dr. Augusto D. Litonjua, Dr. Mary Anne Lim-Abrahan, Dr. Lina Lantion-Ang, Dr. Cynthia Manabat, Dr. Roberto Mirasol, Dr. Ruby Go, Dr. Rosa Allyn Sy, Dr. Tommy Ty Willing, Dr. Elizabeth Pacheco, Dr. Josephine Raboca, Dr. Laura Acampado, Dr. Gail Magtolis, Mrs. Susan Trinidad, R.N., Mrs. Imelda Cardino, R.N.D.

To date, we already have trained 52 Diabetes teams nationwide. The 9th training course is slated for October this year.

PDA's Twelfth...

(From page 1)

into the Future by Dr. Ruby T. Go; Intensive Therapy in NIDDM: Is it Worth the Risk by Dr. Susan T. Yu-Gan; Diabetes Prevention Programs by Dr. Ricardo E. Fernando; Endothelial Cell Dysfunction in Diabetes Mellitus by Dr. Mary Anne Lim-Abrahan; Impaired Glucose Tolerance by Dr. Araceli A. Panelo; Diabetes Education: The Role of Empowerment by Dr. Elwyn V. Fernando.

These dual events promise 4 days of interesting, thought provoking discussions amidst the cool scenic spots in Davao City.

For further details please contact PDA Secretariat at Unit 25, Facilities Centre 548 Shaw Blvd., Mandaluyong City. Tel/ Fax No. 531-1278.

CAMP COPE '97... A SEQUEL

C.V. Halili, Jr.
Camp Administrator

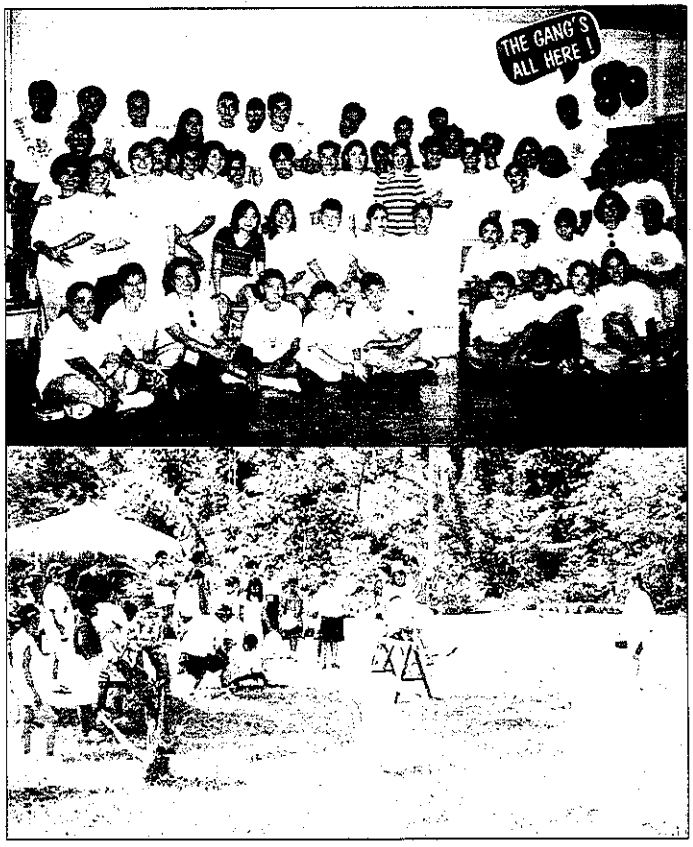
Like a block-buster movie, the successful Camp Cope of May 1996 at the Boy Scouts Jamboree in Los Baños had a sequel...Camp Cope '97. This time, it was held at the Girl Scouts of the Philippines in Tagaytay City. Plans for this follow-up camp were drawn as early as the last day of the first camp. The only unresolved issues were the inclusive dates, which was soon settled; and the number of participants, this took longer to resolve.

Anyway on Thursday, April 10, a big air-con bus unloaded at the campsite: 22 campers (10 girls and 12 boys); physicians; nurses; dietitians; an exercise instructor; Counselors-in-training and Counselors, the last two groups juvenile diabetics themselves. The introduction of counselors-in-training was a new, important feature in this year's camp, they were the "spark plugs" and role models.

Though this year's camp was a day longer than last year's, the general feeling was that there was still not enough time. Perusing the schedule, it is easy to see why. On **Day 1** alone, the activities included a trip to a mini-zoo, horseback riding, bicycling, a trip to mushroom burger and a camp-fire dinner!

Day 2 saw exercises, trekking, indoor and outdoor games, swimming in a resort club pool (!), arts and crafts, "rap sessions," and outdoor movies.

Day 3 was essentially a repeat of Day 2, except that instead of movies, there was a Pajama party, videoke and disco.



Campers and Counselors have lots of fun.

Day 4 was subdued, as it was the last day. A Mass celebrated had parents and friends of the campers in attendance. This was followed by tree-planting by sponsors and other participating companies.

The culminating activities included a group presentation by the campers and their new found friends...the Counselors-in-training and the Counselors. The finale: an awarding ceremony recognizing those participants who gave their best during the four wonderful, fun-filled days.

While boarding the different family cars that would take them home, the campers let out a familiar chant: *"Camp Cope, Camp Cope, babalik kami!"*

So, it looks as if we can safely say: STAR WARS TRILOGY, EAT YOUR HEART OUT!

First ASEAN Juvenile Diabetes Camp

Dr. Ricardo E. Fernando
Institute for Studies of Diabetes Foundation, Inc.

Delegates from Indonesia, Malaysia, the Philippines and Thailand came together for an unforgettable first ASEAN Juvenile Diabetes Camp sponsored by the Juvenile Diabetes Foundation at the Jardin ni Lola (Home of the JDF), Mabiga, Hermosa, Bataan, from June 1-7, 1997

The invitation was extended to juvenile diabetes from 12-19 years old and to doctors, nurses, dieticians, educators and parents from member countries. Originally coursed through veteran members of AFES, the information gradually filtered down to country doctors and other health workers who gathered the children together and brought them all to Manila.

Characterized by non-stop camp activities including mountain climbing, swimming in a new pool, indoor and outdoor sports and games and painting; the only missing part of the original program was basketball because a typhoon and floods swept one whole court and its goals away.

Climaxing the weeks events were cultural presentations made possible by children from all four countries. Adults participated actively to make the whole celebration very lively.

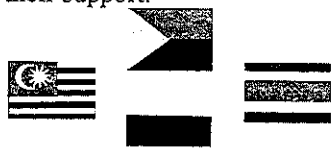
Initial apprehension over food immediately dissipated when the foreign delegates took to Filipino food minus pork/beef, depending upon a Muslim or Buddhist background. The most remarkable feature of the whole week was a show of deep love and concern among the various participants for each other - a feat that their adult counterparts could easily learn from.

Lectures were educational, and presented in attractive ways by professionals from the ISD and the Philippine Center for Diabetes Education. Participating lecturers included Dr. Araceli Panelo, Dr. Edith Dalisay, Dr. Richard Elwyn Fernando, Dr. Rosa Sy, Dr. Roberto Mirasol, Dr. Edmund Ofilada and Dr. Norie Calma.

The total program was planned months in advance by a group led by Drs. Elizabeth Fernando and Rosa Sy and a panel of senior physicians. The execution of the plans was efficiently carried out through the energetic efforts of Archie Entienza, RN diabetes educator and president of the Association of Diabetes Nurse Educators of the Philippines.

Behind the project was a finance committee led by Mrs. Elenita Nolasco, with Mrs. Estrella Dysangco and the whole board of the JDFPI. Kitchen staff led by Mrs. Elizabeth Fernando and a sprinkling of dieticians from St. Luke's Medical Center provided meals that were ideal, yet tasty. The campers kept talking about their good fortune in finding wonderful food in the Philippines.

The board members of the JDFPI were also there to lend their support.



The Psychosocial...

(From page 7)

lack of exposure to certain types of food (otherwise considered contraindicated) is as good as saying that such food "does not exist" or has no existential value to a child. There will certainly be no craving for the food, at most, they will only be curious. The same cannot be said for older children and adolescents. Taste biases would have long been established, and with appetites that long to be satisfied, diet restrictions mean nothing more than deprivation!

Invariably, one is predisposed to eat in the presence of other factors: appetizing food, the enticing company of people eating or about to eat, a suitable ambiance, the temporal suggestion for consumptive behavior (by force of habit) and the absence of any alternative worthwhile activity. These factors underscore the important role family members, friends, teachers, classmates, and others in the immediate environment play in the life of the patient. Their support for the diabetic child should not be limited to moral and economic support, but in the modification of the factors so-mentioned. Their support may make a difference in compliance to prescriptions—life can then be fully enjoyed without ignoring for one moment that one is a diabetic. If the proper conditions are not in place however, the patient will exhibit rebellious behavior: stealing or eating prohibited food or hiding restricted food items under pillows, the bed, or in closets, drawers, etc.

When insulin is administered there is no denying the pain the child feels, but it is imperative to make him realize the need for it. At any age, pain is universally unacceptable, and only the tolerance for it evolves with time. The insulin shots are more painful than they really are for as long as the child has not completely accepted the illness. Because the dosage is dependent on monitored glucose levels and food intake, the shots are construed as punishment for what seemed to be a pleasurable experience. Resistance, if not hostility, becomes an inevitable reaction in this condition. He may deliberately miss his shots, cheat on his monitoring results or even miss his glucose monitoring all together.

People who handle young diabetics should bear in mind that they too have different reactions to illness, just as older patients. Unlike other illnesses that present dramatically at the onset, the young patient may easily deny the illness to himself, at least during apparently asymptomatic intervals. Reassurance helps the child to get over this important initial reaction. Other observable reactions are anxiety, hostility, regression or depression, each needs to be dealt with differently. These reactions may not be mutually exclusive, and the best possible approach is one that is individualized to the type of patient and specific situation with which a doctor is confronted. The care-giver has to project himself as considerate and reassuring to the anxious. He has to be authoritative to the hostile, but firm and maternal to the regressed and depressed. There are four approaches that may be utilized: patient-oriented, consultee-oriented, situation-

(Continued on page 13)

The Psychosocial...

(From page 12)

oriented and eclectic.

Aside from the patient's reactions, one should also keep stock of the many ways family members may react to the illness: disbelief/denial; depression; anxiety; anger or hostility. With disbelief or denial, they may not act on or follow the doctor's orders with dispatch. They may claim the condition is "impossible". They may deny florid signs and symptoms and attribute them to other conditions. They may even resort to doctor-shopping, in the hope that someone will say "an error was committed." The care-giver has to be informative, objective and approachable. When depressed, the family may lack zest and enthusiasm. They follow orders passively. They barely ask for information and accept what they were told. In this case, one has to be firm but patiently reassuring. Familial anxiety may be manifested by a battery of queries and expressions of fear and uncertainty. The family is overly alarmed and cautious. Their physician should be maternal, reassuring and directing. Those who are angry and hostile must be handled with a manner of respectable authority. Considering that the illness is a lifetime affliction, the psychological reactions of both the diabetic child and his family have to be continuously monitored.

The non-medical approaches in the management of IDDM like diet holidays and group activities are ways of coping with the psychological dimension of the illness. Diet holidays provide welcome breaks to dietary restrictions along with corresponding dosage adjustments of insulin and other medications. It is like a breather from a "monotony of the tongue." Joining associations of young diabetics with activities like summer camps, group discussions and group projects that instill togetherness and foster friendship should be encouraged. The sharing of common experiences strengthens each diabetic emotionally and provides each one a better perspective on his illness and his person. This kind of company helps re-establish the sense of well being of the affected child. Difficult attitude changes and behavior modification maybe achieved in this milieu.

The psychological demands of the young diabetic can be summarized as follows: they need to wholly accept the disease; understand the limitations it imposes and available alternatives; to feel his parents, siblings and friends unconditional love for and acceptance of him; and to realize he remains in control of his life and his future.

The initial affective shock may be compounded when fear of complications is immediately instilled. That the patient understand his illness and the management strategy to maintain a healthy life style cannot be over-emphasized. It is necessary that the patient accept the illness as soon as the diagnosis is made so his cooperation in management may be ensured. In dealing with the young, emphasis should not be overly focused on lifestyle restraints which will sound more like deprivation and punishment, but on options (as to diet and activities) and the huge possibilities (as to the fulfillment of his dreams and ambitions) that remain open despite his diabetes.

Some Nutritional...

(From page 8)

without artificial sweetener) and LIGHT HAM SANDWICH - Steam the light ham or other light meat products. One may or may not use light mayonnaise. Some mustard may be added on the whole wheat or rye bread and add fresh tomato slices, lettuce, and cucumber.

Exercise is important for toning muscles and general well-being. However, one must not exercise at the time the action of insulin is at its peak. Avoid injecting at the site that will be used extensively in the exercise. It would be wise to know the blood sugar level before exercise. For longer duration exercises (1 hour or longer), a more filling snack may be necessary. Since it is difficult to give all the guidelines here, it would be better to consult the health professional caring for you.

Be reminded that some source of sugar must be taken along just in case hypoglycemia (low blood sugar) occurs. Candy and juice with sugar (as in brik packs) is easy to carry.

Green, leafy vegetables play an important role because they are good sources of vitamins and minerals. They should be taken with meals.

Fruits high in fiber are the better choices. They are also best taken with major meals like breakfast, lunch and dinner. Some examples are fresh guava, datiles, suha and guayabano.

Main courses must be lean (the fatty portion should be trimmed off). As much as possible, use vegetable oil for cooking but try to keep the amount used to a minimum. Hence, the use of non-stick pans are suggested. Grillers, roasters, ovens, turbo-broilers are also good equipment for cooking. Steamers may also be considered.

Remember that since individuals have different needs, it is best to see a diabetes educator for guidelines more attuned to one's requirements.

Bring Back...

(From page 3)

acceptable reason for the importation of "human" insulin — not truly derived from the human pancreas, but manufactured by a technology that copies the human insulin molecule accurately — is that it will not cause allergy. But this is not a truly significant improvement. There seems to be a worldwide movement a foot towards bringing back animal insulins.

This meandering mind would like to finally focus on the need for cheaper insulins so that its benefits could truly benefit all diabetic mankind. This is as a plea to government and the pharmaceutical industry to come up with a solution.

Diabetes Center...

(From page 1)

Diabetic retinopathy, like all the other complications of diabetes, may be prevented by good blood sugar control. Good blood pressure control is also essential.

Other activities include a week-long eye screening program, dance contest and a mini-program.

For details, please contact Diabetes Center at tel. no. 893-6070.

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Note: In controlled studies, gemfibrozil caused a significant elevation of plasma levels of HDL cholesterol. Increases in this lipoprotein fraction have been associated with lowering of the risk of death from coronary heart disease.
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Gemfibrozil should be used with caution in patients receiving anticoagulants. The dosage of the anticoagulant should be reduced by one-half (depending on the individual case) to maintain prothrombin time at the desired levels to prevent bleeding complications. Frequent prothrombin determinations are advisable until the prothrombin level is stabilized.
Contraindications:
Gemfibrozil is contraindicated in patients with hepatic or renal dysfunction.
Usage in Pregnancy:
Safety has not been established.
Usage in Nursing Mothers:
Breast feeding should not occur during therapy with gemfibrozil.
Side Effects:
Gastrointestinal complaints were the most frequently reported adverse reactions but were usually not severe enough to necessitate cessation of therapy.
Drug Interaction:
Should be used with caution in patients receiving anticoagulants (see Warnings).
Overdosage:
Overdosage with gemfibrozil-symptomatic and supportive measures should be taken.
Dosage and administration:
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EDITORIAL

Rosa Allyn Sy, M.D.

On behalf of the Board Members of the Philippine Diabetes Association and the staff of Diabetes Watch, we welcome you to the first issue for 1997.

The staff has envisioned a newsletter that will deliver information, updates and news about diabetes, the PDA and its activities around a central, cohesive theme.

For our maiden issue, we felt it timely to focus attention on various aspects of Insulin Dependent Diabetes Mellitus (IDDM), an entity that is often misdiagnosed and unrecognized. We hope that by focusing on IDDM we can educate more health care providers and by doing so, save more of our children and our youth. This is our response to the appeal made both by our PDA president and by Lorna Mellor and Dr. Martin Silnik, co-convenors of the IDF Consultative Section on Childhood and Adolescent Diabetes whose article appeared in the IDF Bulletin in September 1996. The authors invite us to imagine how diabetes has affected these children's lives and to increase awareness of the special problems they face by focusing on the psychosocial aspects of coping with the disease as well as camping experience. We have tried to emulate that focus with this issue.

Other prominent changes in the format include in every issue a column by the current president of the Philippine Diabetes Association, Dr. Lina Lantion-Ang and another by Editor Emeritus Dr. Augusto Litonjua—a pioneer member of the PDA.

We would also like to solicit and encourage greater participation from the different PDA chapters, other members of the diabetes team—our nurses and dietitians. Most of all, we would like to hear from our patients themselves and their families.

We believe that with your cooperation and commitment, Diabetes Watch can be an important tool to achieve our goal of disseminating information and educating as many people as we can about diabetes.

Let us work together against diabetes.

Philippine Diabetes Association, Inc.

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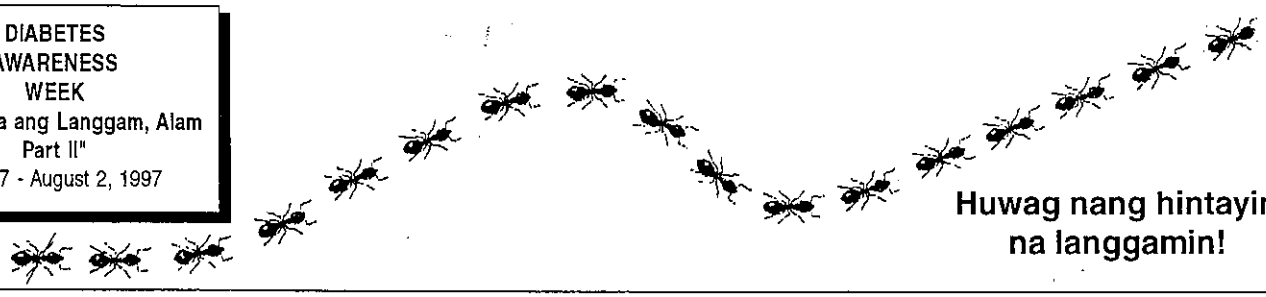
The Lighter Side of Diabetes

By: Dr. Allan Hernandez

An exercise a day keeps the doctor away. (Or at least thrice on weekdays and once on a weekend.)

DIABETES AWARENESS WEEK
"Mabuti pa ang Langgam, Alam Part II"
July 27 - August 2, 1997



Huwag nang hintayin na langgamin!