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UKPDS: There is Hope for a Better Quality of Life in Type 2 DM

Diabetes is a chronic illness that requires daily care and monitoring. The publication of the large, 10-year randomized prospective study, DCCT, done in several centers in the U.S.A. in 1993 marked a significant change in the total outlook of diabetes care and management. In the absence of data amongst type 2 DM, the results of the DCCT were applied and extrapolated to this group of patients. Since then, practicing endocrinologists and diabetologists have always believed that

tight glycemic control can lead to risk reduction of diabetes complications in type 2 diabetics.

In the recent EASD annual convention held in Barcelona, Spain last September 7 -12, 1998, Professor Robert Turner finally released their multi-center trial of type 2 diabetic patients. The United Kingdom Prospective Diabetes Study (UKPDS) is a 20-year randomized prospective trial involving

Rosa Allyn G. Sy, MD
Cardinal Santos Medical Center

23 centers in the United Kingdom. The primary aim of the study is to determine whether tight glucose control can reduce diabetes complications. The study also looked into the effects of tight blood pressure control on the morbidity of type 2 DM.

Subjects included in the BLOOD GLUCOSE CONTROL STUDY were recruited from 1977 to 1991. A total of

7616 newly diagnosed type 2 DM were referred. Only 5102 were recruited; 2514 subjects were excluded. The study ended in September 1997. Characteristics of patients included are as follows: 59% male, 41% female, age 25-65 years with a mean age of 53 years, mean BMI 28kg/m², median FPG 11.5 mmol/L and HgbA1C 9.5. All 5102 newly diagnosed type 2 diabetes were initially placed on diet therapy. They were subsequently classi-

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That was the slogan of the recently concluded Diabetes Awareness Week celebration that ran from July 26 till August 1, 1998.

As in the previous years, the concept of ants being attracted to urine of affected individuals was used to promote awareness among the people.

Preventing its occurrence through proper education is a goal that the Diabetes Center in cooperation with the Philippine Diabetes Association, Diacare and its satellite clinics would like to achieve through its awareness program.

The kick-off activities in Glorietta started with a motorcade from the participant's respective hospitals to Glorietta in Makati City.

At the Glorietta, a mass was officiated by Rev. Fr. Armand Robleza. The program proper followed this where the

DIABETES AWARENESS WEEK "Ants in Your Pants?"

Susan B. Trinidad, RN
Jose Carlos S. Miranda, MD
Makati Medical Center



Senator Robert Jaworski receives a token of appreciation from Dr. Augusto D. Litonjua while Dr. Lina Lantion-Ang looks on.

keynote speaker - Sen. Robert Jaworski - captured the audience with his presence and in-

spiring message for the diabetics. A dance contest for diabetics was participated in by 9 hos-

pitals in Metro Manila including one group from Pampanga.

Air Force General Hospital won the first prize of P8,000.00 and a trophy. The second prize went to Philippine General Hospital and third prize to Perpetual Help Medical Center of Laguna.

During the weeklong activities, Operation: Silip-Mata and Operation: Bantay-Paa were conducted in 64 Diabetes Satellite Clinics nationwide.

In the "Silip Mata" activity, visual acuity and funduscopic examinations were done. Of the 64 participating Diabetes Clinics, 33 have already submitted the results. A total of 849 patients were evaluated. Last year, the number of patients seen for the same activity was 566.

In the "Bantay Paa" activity, checking for nerve damage

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Your President Speaks...



Lina C. Lantion-Ang, MD
PDA, President

Unburdening Diabetes Complications

To a diabetic patient, the reward for good metabolic control is a life FREE of diabetic complications. This is the message that is now heard all over the world after the results of the UKPDS on Type 2 patients were reported to the Medical

World in Barcelona, Spain on September 10 - 11, 1998.

A similarly joyous occasion took place in the United States in 1993 when the results of the DCCT were also reported. Both monumental studies have proven beyond reason-

able doubt that Retinopathy, Neuropathy, Nephropathy and the macrovascular complications of diabetes mellitus can be significantly reduced or even prevented provided good metabolic control is achieved and maintained at all times.

This means discipline, commitment and continuous diabetes education for the diabetic patient, his family and the diabetes health care team.

This approach unburdens all aspects of Diabetes Care and brings in renewed Hope for the diabetic patient.

Yes, Juan dela Cruz, there is a better quality of life after the UKPDS... there is a better quality of life after the DCCT.

Happy Holidays!

LOCAL CLINIC GETS INTERNATIONAL HONORS

The Diabetes Foot Clinic of the East Avenue Medical Center was one of five centers worldwide chosen for the 1998 Roche Boehringer Mannheim-Lilly Amputation Prevention International Awards. The award for the research project, "Routine Foot Screening in the Preventive Care of the Diabetic Foot", which will be conducted by Dr. Ma. Teresa Plata-Que and Mrs. Aurora Urbano was announced at the meeting of the European Association for the Study of Diabetes (EASD) in Barcelona, Spain last September, 1998.

Diabetes...

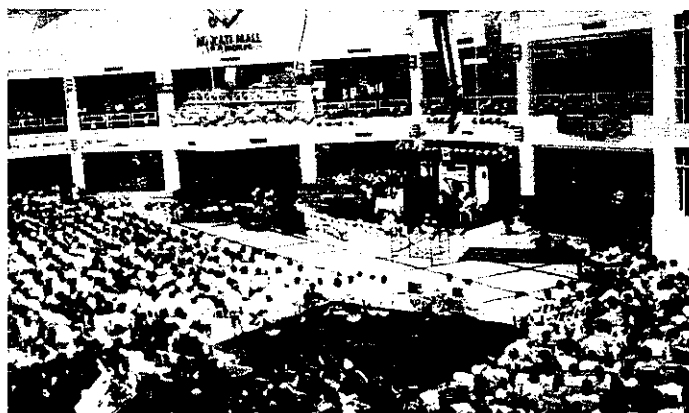
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and blood vessel problems helped us detect the high-risk foot. This was done with the aid of monofilament and biothesiometer testing. Partial reports from 31 Diabetes Clinics yielded 894 patients for Bantay-Paa Screening.

We will present the findings as soon as possible, once all the

results are complete. The center would like to remind the other participating diabetes clinics to submit the forms.

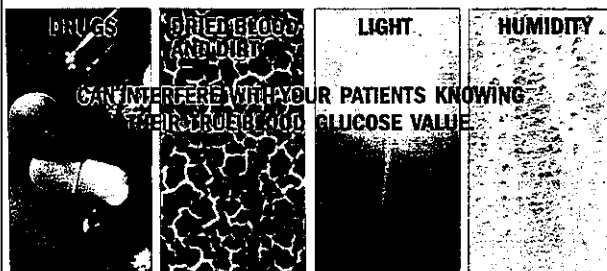
The center would like to acknowledge the following for their support in this endeavor: The Philippine Academy of Ophthalmology, The Department of Ophthalmology of various participating hospitals/centers, Centramed-Greenline, Otsuka Pharmaceuticals, and Eli Lilly.



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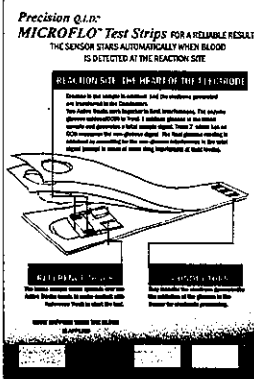
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MEANDERINGS.....



Augusto D. Litonjua, MD
Editor Emeritus

That cheap drug called Aspirin!

In 1893, Herman Dresser introduced acetylsalicylic acid into medicine, as an antipyretic (against fever) and analgesic (against pain). The drug gained such prominence for its effectivity that the brand name, Aspirin, is permissively used as a generic term. It is probably the only drug that is privileged to do so.

However, through the years, aspirin has been found to have other uses than alleviating fever and pain. At the scientific centenary celebrations for acetylsalicylic acid held during the European Congress of Cardiology in Stockholm, Sweden, international experts emphasized the therapeutic value of the

drug of the century in the treatment and prevention of heart diseases. It is now regarded that low dosages of aspirin can be given as prevention against heart attacks. Aspirin has become essential in the treatment of acute diseases of the coronary vessels -- those vessels that nourish the heart muscles and whose blockage result in heart attacks. Several clinical studies of patients with chest pains (angina pectoris) said to be a precursor to infarction, have shown that aspirin can lower the rate of deaths and heart attacks by about 50%. Thus, aspirin has become accepted worldwide by major cardiologic societies as the gold standard in the treatment of acute heart attacks, even if other remedies, such as drugs which dissolve the blood clot in the blocked coronary vessels, are available.

To top it all, aspirin is one of the cheapest drugs in the market!

Now, come the findings that in type 2 diabetes mellitus:

1. There is an increase in the levels of many substances

or factors in diabetes which cause the blood to clot inside the blood vessels.

2. That the platelets -- a constituent of the blood that causes clotting -- readily come together to cause clot formation and release a substance that further enhances blood clot formations.

3. That there is a decreased property of the blood of diabetic patients to lyse or destroy the clotted blood -- what is known as 'decreased fibrinolytic activity.'

Three reputable studies in the United States showed that using aspirin in diabetic patients can lower the incidence of diseases associated with clot formation in the blood vessels. Thus, the recommendation that diabetic patients be given enteric-coated aspirin in the dose of 75 to 325 mg/day is made by the American Diabetes Association. This is a small price to pay -- if one can prevent a heart attack. Therefore, patients should ask their physicians if they are at high risk for a cardiac event, and if a little aspirin a day can drive the heart attack away.

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UKPDS...

(from page 1)

fied according to their FPG level. Those with FPG <6.0 mmol/L and were asymptomatic were continued on diet therapy, those with FPG of >15 mmol/L were considered diet failure and those whose FPG falls between 6.1 - 15 mmol/L were randomized to the main randomization group.

Of the 4209 subjects included in the main randomization group, 3867 were entered into the main glucose control group that was further subdivided to the conventional therapy group and the intensive therapy group. 342 were as-

signed to the metformin group. These patients were followed-up for a period of 6-20 years, median of 10 years. The main glucose control study showed that intensive glucose control policy which maintained a lowered HgA1c by nearly 0.9% over a median follow-up period of 10 years from diagnosis of type 2 DM showed a reduction in risk for any diabetes-related endpoints by 12%, microvascular endpoints by 25%, MI by 16%, albuminuria at 12 years by 33%, cataract extraction by 24%, and retinopathy at 12 years by 21%. When epidemiological relationships of macrovascular and microvascular

(Continued on page 8)

North and South Celebrate Diabetes Awareness Week

The distance from nor the absence of flights to Manila did not deter the people of Dumaguete City from celebrating Diabetes Awareness Week. A mass and a motorcade highlighted the opening. Dr. Edna V. Alcantara and friends from the pharmaceuticals went to far flung areas, Bais City, Dauin Health Center, and Siaton Dis-

trict Hospital to provide free clinics and lectures on diabetes. One session was held under an acacia tree!

Operation Silip Mata was held on July 29 at Silliman University Medical Center and at Holy Child Hospital.

The celebration ended with a bang, with no less than Dr. Augusto D. Litonjua giving a

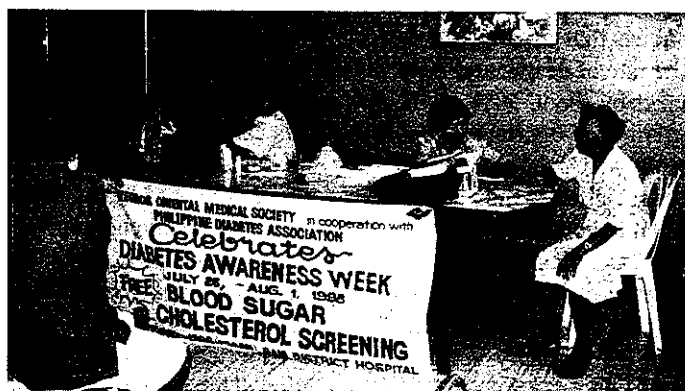
lecture on "Updates in the Management of Type 2 Diabetes Mellitus and Diabetic Neuropathy" to the Negros Oriental Medical Society and Philippine Academy of Family Physicians.

Dr. Josefa C. Yanga, president of PDA Bulacan Chapter reports on her busy year. She says, "My primary aim was to treat and teach; 9 towns were

under my responsibility. I had to go back and forth for months!" The first patients were from Buklod, Malolos. A core group of 20 patients underwent rigid diabetes education. Others were taught basic footcare and shown a film using the Carville Method.

Scientific meetings brought

(Continued on page 5)



Free clinic and lecturette at Siaton headed by Dr. E. Alcantara.



The team of Operation: Silip Mata, Bulacan chapter headed by Dr. J. Yanga.

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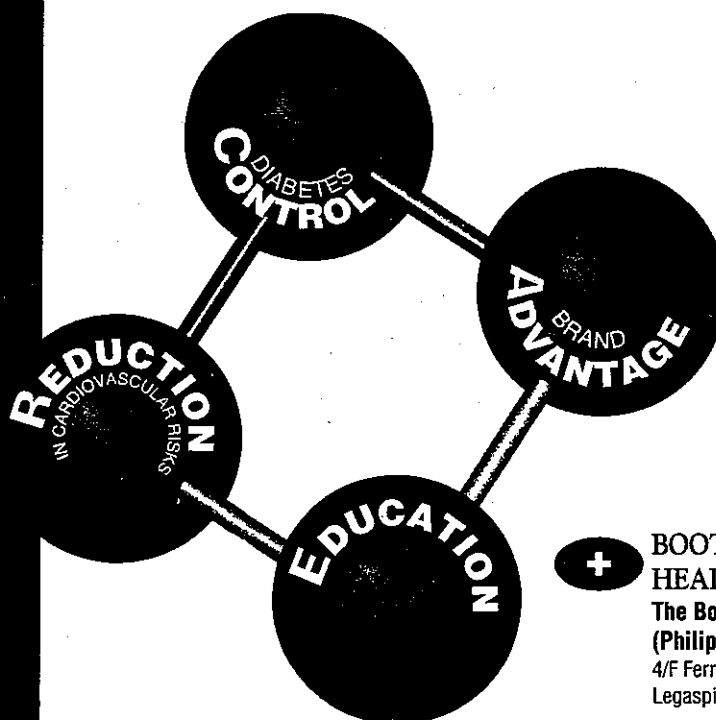
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Diabetes Camping Association

The Second International Conference of the Diabetes Camping Association (DCA) was held in Nashville, Indiana this year. Two camp leaders—Dr. Roberto Mirasol from Camp COPE (Children Overcoming diabetes Problems Everywhere) and Dr. Elizabeth Fernando from the Juvenile Diabetes Foundation summer camp attended the conference. This year's conference theme was "Bridging to Excellence". This reflects the concerns of camp leaders all over the world to provide consistent excellence in all programs that specialize in children with diabetes.

The DCA has been established to emphasize camping

programs that cater to children with diabetes. The concept is that our programs are camps (a program centered in outdoor activities based on fun) for children (that all programs should be child appropriate and child centered) with diabetes (that although diabetes is what brings us together, it is only a part of that child). With this in mind, the DCA hopes to reach out to all interested in camping programs to provide the best possible medical care for children attending camps for diabetics.

In conjunction with the conference, the first general membership meeting was held and Dr. Roberto Mirasol was elected member of the board of directors.

North...

(from page 4)

the best and prominent lecturers. Drs. Litonjua, Fernando, Lantion-Ang, Panelo, and Elwyn Fernando came and their topics kept us up to date.

Local governments and various civic organizations (Sorooptimists, Kiwanis, Rotary Club, Labong Lions, Fil-Asia Diabetic Foundation, and Juvenile Foundation) joined the battle against diabetes.

In Meycauyan, Mr. Dan Daez, a diabetic and former mayor, approached Mayor Edgardo Nolasco to put up a health program for diabetes. A survey in 26 towns was done. Training of all DSW staff, midwives, nurses, and Municipal Health Officers was conducted under the PDA.

The Resolution (98-10)

(Continued on page 10)

PHILIPPINE COLLEGE OF DIABETES EDUCATORS

The Philippine College of Diabetes Educators will be launched during the 3rd National Assembly of Diabetes Educators at the Century Park Hotel. The purpose of the college is to professionalize Diabetes Educators thru a Certification Program. All qualified health professionals can earn the title "FELLOW IN DIABETES EDUCATION". For details, please write The Philippine College of Diabetes Educators at Room 366 Makati Medical Center, Amorsolo St., Makati City.

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Atherosclerosis and Diabetes

Cynthia Halili-Manabat, MD, PhD
UP College of Medicine

Macrovascular disease, an accelerated disorder of the large blood vessels, is responsible for 80% of the mortality in diabetic adults. Put another way, 8 out of 10 diabetic patients will die either of a heart attack, stroke or gangrene.

The effects of diabetes on the large vessels are largely seen at three major sites of the cardiovascular system; the coronary (heart), cerebral (brain) and peripheral arteries (legs and feet), and the predominant large vessel disturbance is that of atherosclerosis. Atherosclerosis is a complex process that involves deposition of fat and cholesterol in the lining of the blood vessels, thickening and proliferation of smooth muscle cells in the walls of the blood vessels, and calcification of the vessel walls - all consequently leading to a decrease in blood flow.

Atherosclerosis occurs in the diabetic patient at an earlier age and with greater frequency than it does in nondiabetic individuals. Early detection is therefore crucial so that appropriate treatment can be introduced before major complications occur.

Why is there are increased risk of atherosclerosis among diabetics? The cause is multifactorial.

Hyperglycemia (high blood sugar levels). There is some evidence, especially among Type 1 diabetics, to suggest that the degree of cardiovascular disorder is proportional to the severity of hyperglycemia. And yet, there are diabetic patients (especially Type 2), who have severe arterial disease but with only moderate degrees of glucose intolerance. In addition, researchers have shown that good glucose control does not always guarantee protection from development of large vessel disorders. Part of the explanation may be that other factors contributory to atherosclerosis, such as high lipid lev-

els, sticky platelets or fibrinogen levels, are also dependent on the level of diabetic control. It therefore makes good sense to aim for as good blood glucose control as possible.

Hyperlipidemia. We sometimes forget that diabetes is not only a disorder of carbohydrate metabolism, but also fat metabolism as well and that these lipid (fat) abnormalities also contribute to accelerated atherosclerosis.

Characteristically, diabetics have high triglyceride levels, with low HDL (good cholesterol) and high LDL (bad cholesterol) levels. This lipid profile is the result of a combination of altered synthesis, catabolism and clearance.

All diabetic patients should be screened for hyperlipidemia during their first medical visit by measuring a fasting lipid profile, including triglyceride, total cholesterol, HDL cholesterol and LDL cholesterol. This table defines acceptable, borderline and high-risk lipid levels for adults. Patients without evidence of large vessel disease in the borderline or high-risk category should be treated aggressively.

Risk for Adult Diabetic patients	Cholesterol (mg/dl)	HDL cholesterol	LDL cholesterol	Triglyceride
Acceptable	<200		<130	<200
Borderline	200-239		130-159	200-399
High	>240	<35	>160	>400

The most common abnormality among diabetics is an elevated triglyceride level. In many cases, this can be lowered by

good blood glucose control. Optimum nutrition is the first line of defense. Recommendations include a moderate increase in monounsaturated fat intake, with <10% of calories from saturated and polyunsaturated fats and a more moderate intake of carbohydrates. Addition of triglyceride and/or cholesterol lowering drugs may also be indicated.

Hypertension. The combination of raised blood pressure and diabetes is a serious situation. The presence of hypertension in diabetes is associated with reduced survival, the predominant cause of death being myocardial infarction ("heart attack") in 40% of cases. Therefore, treatment of hypertension in all patients with diabetes should be emphasized. The goal for BP control is <130/85 mmHg.

Initial management of the hypertensive diabetic should include advice on lifestyle, the patient being encouraged to reduce excessive weight, to modify diet by reducing salt and fat intake and to limit alcohol consumption. Pharmacologic treatment may be necessary. Initial treatment may include an ACE inhibitor, cal-

cium channel blocker, and alpha-adrenergic blocker or beta-blocker and diuretic in low doses.

Obesity. In the past it was

thought that obesity per se was not necessarily associated with increased cardiovascular risk unless other factors like hypertension or diabetes were present. Recently, we have become aware that an unfavorable fat distribution may be an independent indicator of risk. We call this type of fat distribution central adiposity or android obesity or apple shaped obesity, where there is increased underlying visceral fat. The waist-hip circumference ratio (WHR) is > 0.9 in men and > 0.75 in women.

Cigarette Smoking. Of all the risk factors, cigarette smoking should be the one that is most readily reversible. In fact, the benefits of stopping smoking in diabetics may even exceed therapeutic measures aimed at controlling hypertension and hyperlipidemia! Strokes and heart attacks occur more frequently and with greater severity among smokers. But it is in the peripheral arterial disease of the legs where the effect of smoking is most evident. Intermittent claudication (pain in the legs while walking), ulceration of the foot and lower limb amputation are all strongly associated with a combination of cigarette smoking and diabetes. Active efforts should therefore be made by all physicians to assist their smoking patients in discontinuing cigarette smoking - including enrollment in smoking cessation programs, behavioral modification and use of nicotine patches.

Atherosclerosis contributes significantly to premature death and morbidity in diabetes. Therefore detection of cardiovascular risk factors significantly contributing to the development of macrovascular disease, including hypertension, hyperlipidemia, obesity and cigarette smoking should be an important part of the management of all diabetic patients.

Cold sweats, shaky hands, weakness, hunger, and dizziness - sometimes experienced by diabetics on insulin or anti-diabetic medications - may suggest hypoglycemia (low blood sugar). Others complain of blurred vision, numbness, and sleepiness. All these symptoms may easily be relieved with intake of sugar in any form - softdrinks, juices or plain water with sugar. In some patients especially those with diabetes of long duration, hypoglycemia may present with signs and symptoms related to a lack of sugar in the brain - confusion, irritability, restlessness and in severe cases, coma without any preceding typical external signs of hypoglycemia.

When hypoglycemia occurs, catecholamines, a stress hormone is secreted in the body. These substances cause palpitations or fast heartbeat, sweat-

HYPOGLYCEMIA UNAWARENESS

Ruby T. Go, MD
Chinese General Hospital

ing, tremors or nervousness. At the same time, they stimulate glucose production by the liver through breakdown of glycogen (stored glucose in the liver). Another hormone, glucagon, secreted by the pancreas, also stimulates the breakdown of glycogen in the liver. Secretion of these hormones leads to an increase in the level of sugar in the blood. In severe cases of hypoglycemia, the blood sugar may remain low especially in case of severe insulin overdose. Other hormones may come into play at a later time, about two to three hours after the onset of hypoglycemia. These are the cortisol and growth hormone,

which also promote sugar production from sources other than glycogen in the liver. If hypoglycemia persists for a long period of time, inspite of all these stress hormones, brain damage may occur.

Why do some patients experience the typical signs and symptoms of hypoglycemia when their sugar starts to drop and others do not?

In the first few years of diabetes, the response of stress hormone to hypoglycemia is usually sufficient and blood sugar may return to normal by itself. At the same time, the external signs experienced by the patient will warn the patient of

the presence of hypoglycemia which will prompt him to take measures to correct it, by intake of sugar or food. However, when neuropathy, a vascular complication of diabetes, develops, the stress hormone response becomes impaired and may totally disappear. Without these hormones, the patient does not experience the warning signs and cannot take the necessary measures to correct the hypoglycemia. The body will not recover from hypoglycemia without intake of sugar because the breakdown of glycogen from the liver to produce sugar will not take place. Brain damage may occur in severe cases of hypoglycemia and death may ensue.

Neuropathy occurs frequently in patients with poorly controlled diabetes. Damage and changes in the nerves caused

(Continued on page 8)

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INTERACTIONS: Cane sugar (sucrose) and sugary foods 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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UKPDS...

(from page 3)

complications to glycemic control were analyzed, a 1% change of HgbA1c showed a much more significant risk reduction.

The UKPDS also looked into the effects of tight BP control on diabetes complications; whether the BP control group can reduce the morbidity and the mortality in type 2 DM and whether captopril or beta-blockers can decrease the BP of diabetic patients. In this arm of the study, 1148 type 2 diabetics, who had the disease for 2 years with a mean age of 56 years, mean BMI of 29kg/m², BP 160/94 were included. 55% of the subjects were male and 45% were female. The results showed that a tight BP control (144/82) can reduce risk of any diabetes-related endpoints by 24%, diabetes-related death by 32%, MI by 21%, stroke by 44%, microvascular endpoints by 37%, and heart failure by 56%. Epidemiological rela-

tionships of the macrovascular and microvascular complications to BP control when a decrement of 10 mmHg systolic BP was achieved showed a risk reduction in both the micro as well as the macrovascular complications of elevated BP. The study likewise showed that captopril and beta-blockers are equally effective in lowering the BP of diabetic patients.

In summary, UKPDS has confirmed the belief of most practicing endocrinologists and diabetologists, that intensive blood glucose control reduces the risk of diabetes complications particularly microvascular complications. And that based on epidemiological analysis, tight BP control on the other hand can reduce both the macrovascular and the microvascular complications. Furthermore, it also showed that blood glucose and blood pressure are independent risk factors for microvascular and macrovascular complications. Based on this large prospective

(Continued on page 14)



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Hypoglycemia...

(from page 7)

by long duration of hyperglycemia (high blood sugar) will lead to **HYPOGLYCEMIA UN-AWARENESS** - a lack of symptoms of hypoglycemia when the blood sugar starts to drop. Most of these patients experience only the effects of low sugar in the brain - confusion, restlessness, drowsiness or coma and are often brought to the emergency room for treatment.

Good control of diabetes with near normal blood sugar levels is generally the goal of treatment in any diabetic. However, this is often accompanied by episodes of hypoglycemia.

This does not pose any real danger as long as the patient experiences the symptoms of hypoglycemia and can take measures to correct it. But in patients with hypoglycemia unawareness, the risk of unrecognized hypoglycemia and its consequences including brain damage far outweighs the benefit of tight control. In these patients who are unable to recognize the onset of hypoglycemia, the danger of brain damage is real when hypoglycemia is not corrected. Hence, the goals of therapy will be different in this group of patients - no longer tight control, more of amelioration of symptoms of high

(Continued on page 14)

The source of this proverb does not say why the man had no feet. It is possible that he had no feet because of a congenital anomaly. Or he could have lost his feet because of diabetes.

The foot is affected in diabetes because the interplay of a long duration of diabetes and poor glucose control leads to the complications of nerve damage, poor circulation and infection. Most of the time, a diabetic patient develops foot ulcers because the ability to feel noxious stimuli is impaired. Some patients have walked on thumbtacks or had foreign bodies in their shoes without realizing it. Fever or chills will later alert them to the presence of an infected wound on their foot. Very often surgeons are aggressive in recommending amputation (usually below the knee) because they believe it is less

"I cried because I had no shoes until I saw a man who had no feet."

Ma. Teresa Plata-Que, MD
East Avenue Medical Center

expensive and inconvenient to the patient. Amputation also saves them the tedious work of having to care for slowly healing wounds. However, lower extremity amputation is stressful for patients, often elderly, who lose their independence once they lose a limb. The risk of dying within 5 years also goes up for patients after lower extremity amputation. The noted playwright George Bernard Shaw said, "I marvel that society would pay a surgeon a large sum of money to remove a person's leg but nothing to save it."

In developed countries

podiatrists or foot specialists care for foot problems in diabetic patients. The majority would have foot ulcers, so proper wound care is an essential part of the practice of a podiatrist. Wound care specialist nurses also help care for the slow healing ulcers of diabetic patients. We have no podiatrists in our country, but we do have a handful of nurses who are trained in the problems of the diabetic foot. We hope that many more nurses can be trained in the future. Their expertise will include identifying patients who have high-risk feet, callus debridement,

wound care, and footcare education. These nurses will be part of the physician and podiatrist (a specialist who makes special shoes and appliances for the diabetic foot) team.

Since the foot examination is the most neglected part of a clinic visit, patients should ask their doctors to take a look at their feet. A foot screening should include testing for sensation and this can be done using a monofilament, anylon filament, designed to deliver a 10 gm pressure load. The inability to perceive the monofilament means there is loss of the protective sensation in a patient's foot and has an increased risk of ulceration. The circulation in the feet can be evaluated by feeling for the pulses, and looking for other signs of ischemia such as loss

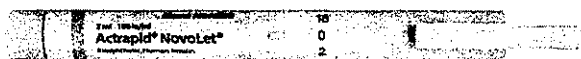
(Continued on page 11)

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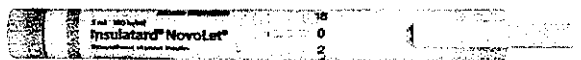
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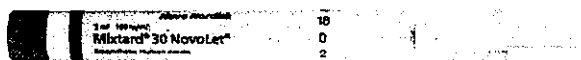
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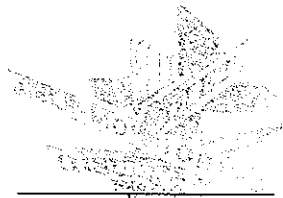


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Roberto C. Mirasol, MD
St. Luke's Medical Center

Everything you always wanted to know about **DIABETES...**

(but were afraid to ask!)

This issue of Diabetes Watch will tackle one of the most controversial and talked about topics in diabetes today - that of impotence or the more p.c. (politically correct) term - erectile dysfunction.

What is erectile dysfunction?

Erectile dysfunction (ED) is the inability to achieve or maintain an erection suitable for sexual intercourse in 50% of attempts. So the occasional failure to achieve erection is not necessarily erectile dysfunction. The problem must be chronic and persistent.

What are the causes of erectile dysfunction?

Most common cause of erectile dysfunction is vascular disease and diabetes. Other causes include spinal cord injury, following radical surgery, those on medications, other endocrine problems and psychological causes.

Do I need to see a doctor first?

An initial evaluation is needed by your doctor to determine possible causes of ED. This usually will include a detailed sexual history including presentation, nature and degree of erection problem, sexual ex-

perience, performance and medical history. Physical examination soon follows.

Is there hope for me?

There is hope of course. You need to control your blood sugars. The blood pressure must be controlled as well. Avoid beta-blockers in the treatment of hypertension because it may cause E.D.

Does Vitamin E work for ED?

No.

What are my options?

Several options are available for you. Your doctor will recommend one that is suitable.

What is external vacuum therapy?

Placing the penis in a vacuum chamber or cylinder that draws blood into the erectile bodies produces erection. A ring is positioned in the base of the penis to maintain rigidity. It is cumbersome and uncomfortable to some.

How about surgical methods?

With the advent of newer drugs surgery is becoming less popular. The more common ones are the semi-rigid implants and fluffy inflatable implants.

These are quite expensive.

I heard about penile injection therapy and the use of pellets. What are the advantages and disadvantages?

Both these methods are effective. The setback is that they are invasive. There is pain in the injection and directly at the urethra. They will not interfere with other medications being taken.

What about Viagra?

Viagra is an oral agent and found to be very effective in treating E.D. It comes in three

strengths - 25mg, 50 mg and 100 mg. Its side effects are headache, flushing, upset stomach and visual changes. It is not recommended for people taking nitroglycerin or nitrates of any form because it may cause a dangerous drop in blood pressure. Check with your doctor before taking the medication.

We have answered some of your frequently asked questions. We know you have more. Fax your questions to PDA office at 531-1278.

North...

(from page 5)

signed on February 25, 1998 set into motion the bimonthly clinics. Local government provided

strips, meters and medicines.

Diabetes Awareness Week was sponsored by Mayor Eduardo Alarilla with a motorcade, T-shirts, and snacks.

Thanks to all who helped!

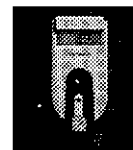
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I cried...

(from page 9)

of hair, shiny skin, thickened nails, dependent rubor and blanching on elevation of the feet. Intermittent claudication, pain experienced in the calf muscle after walking, is also a sign of poor circulation. The lack of feeling coupled with poor circulation in the feet can lead to wounds or ulcer formation. These can invite bacteria resulting in a severe infection which may lead to gangrene and even amputation.

Identification of high-risk feet, footcare education and regular surveillance can save many a foot from the surgeon's saw.

Here are some important tips to remember in caring for your feet:

To avoid injury because of poor sensation in the feet.

- Never walk barefoot.
- Do not wear pointy-toed shoes.
- Inspect your feet everyday. Look for cuts, blisters, cry-

thema and blackish areas. Report these findings to your doctor immediately.

- You should have a foot-screen once a year.

- Apply lotion to dry skin daily.

- Avoid footbaths. Always ask someone to test the temperature of anything hot that you will take.

When buying shoes:

- Select shoes with a wide toebox and buy the pair in the afternoon. Wear the 2 shoes for only 1-2 hours so as to allow your feet to become accustomed to your shoes.

- Avoid wearing high-heeled shoes.

When cutting toenails:

- Cut them straight across and do not cut down the sides of nails to avoid ingrown toenails.

Calluses:

- Calluses should be trimmed only by a trained health care professional.

- The use of Dr. Scholl's solutions for corns and calluses should be avoided.

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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.

Warnings:

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:

Recommended daily dose is 900 to 1200 mg in single or two divided doses. The 900 mg dose is given as a single dose one-half hour before the evening meal. The 1200 mg dose is given in two divided doses one-half hour before the morning and evening meals.

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Diabetes is associated with a lot of chronic complications. Among these are hypertension, retinopathy (eye involvement) and nephropathy (kidney failure).

Chronic Complications of Diabetes

Susan T. Yu-Gan, MD
Metropolitan Hospital

HYPERTENSION

Up to 20% of type 1 diabetics with diabetes more than 15 years have diastolic blood pressure levels above 100 mmHg. With type 2 diabetes, the incidence shows about 40% of males and 53% of females recorded high blood pressure levels.

The combination of raised blood pressure and diabetes is a serious situation. The presence of hypertension in diabetes is associated with reduced survival, the predominant cause of death being myocardial infarction (heart attack) in 40% of cases. When hypertension and diabetes co-exist, the risk

does not simply double but the risk is increased exponentially with greatest risk for young adults, especially women. Hypertension does not only increase the risk for heart attack, it also accelerates the decline of kidney function in established nephropathy, contributing to end stage kidney function, as well as eye disorders such as exudative retinopathy and retinal vein thrombosis (occlusion).

Why does hypertension occur more frequently among diabetics? The cause includes an essential genetic component, altered blood vessel reactivity, salt retention and possibly a re-

sult of hyperinsulinism.

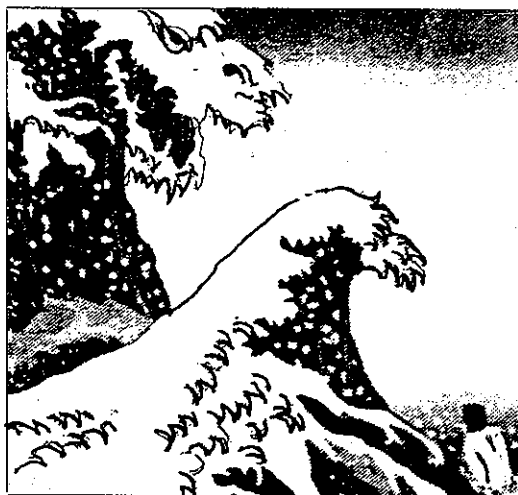
Treatment of hypertension is important because lowering of elevated BP is associated with reduction of stroke, heart attacks, heart failure and improvement in peripheral arterial blood flow. Initial management of hypertensive diabetics should include advice on lifestyle, reduction of excessive weight, diet modification by reducing sodium and saturated fat intake and by limiting alcohol consumption. In choosing an anti-hypertensive drug for diabetics, one should consider that some drugs carry particular problems for the diabetic patients while

some have particular benefits for the patient.

RETINOPATHY

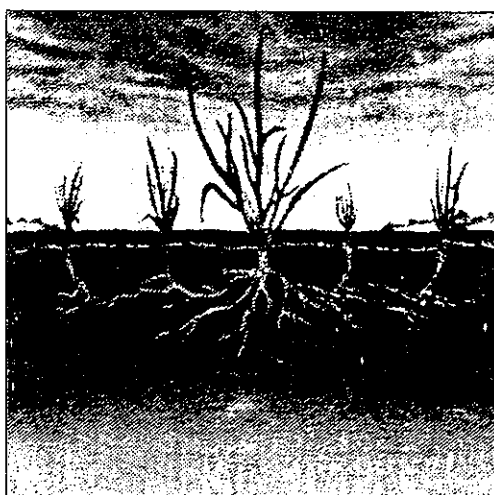
The eyes are said to be the mirror to the soul. In screening for complications in diabetics, this also holds true. The eyes are one of the most accessible organs to look for damage due to diabetes. However, despite the advent of retinal laser photocoagulation, and more recently vitreoretinal surgery, diabetic retinopathy remains a blinding disorder. It is now the leading cause of legal blindness in the U.S. and in the U.K. The main causes of visual loss from diabetic retinopathy are: 1. Disturbance to the macula, affecting central vision (diabetic maculopathy) and 2. Profound retinal ischemia leading to proliferative retinopathy.

The risk of developing dia-
(Continued on page 14)



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The eye is like a camera, which has a part that focuses the objects we see, called the retina. Clear vision depends on the blood vessels, nerves, eye fluid with its protein and fats, and the macula (center of vision). If the blood sugar is uncontrolled (>200 mg/dl) for 5 years or more, these important structures are affected, and diabetic retinopathy develops. The earliest sign is the leakage of eye fluid and its substances into the neighboring structure (vitreous humor). This is due to increased eye fluid flow (permeability) or damaged (burst microaneurysms) small blood vessels (capillaries). This leakage can now be detected by injection of a dye (fluorescein) and results in closure of the affected blood vessels as healing proceeds. The eventual scarring is what we call background retinopathy. If the resulting

SAVE THOSE PRECIOUS EYES! *Know About Diabetes Retinopathy*

Leilani B. Mercado-Asis, MD, PhD
University of Santo Tomas

edema affects the macula, a diabetic patient may experience blurring of vision. See your eye specialist right away to differentiate this problem from blur-

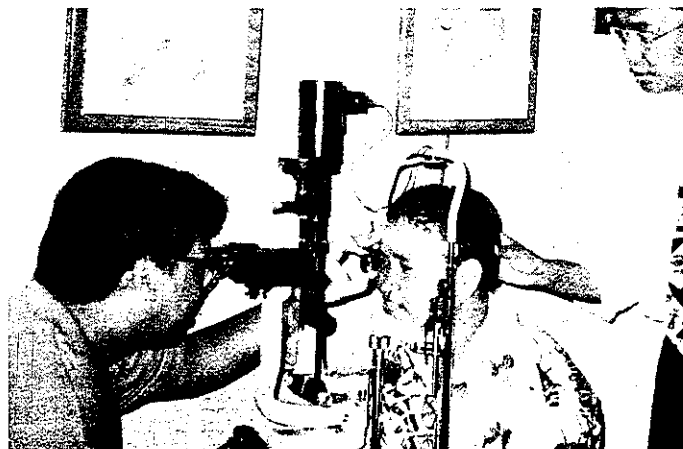
ring of vision due only to extremely high blood sugar. Retinopathy is suspected if glasses do not correct vision.

The formation of new

blood vessels (neovascularization) is the second stage of this eye complication, called proliferative retinopathy. The structure of the new blood vessels is abnormal and they easily break. The leakage of blood into the retina makes the patient sees spider webs in their field of vision. The most serious complications of proliferative retinopathy are the vitreal and retinal breakage, which leads to total and complete blindness.

Laser or photocoagulation is the treatment for diabetic retinopathy. Even if you have already this eye complication, it is your eye specialist who will know if you need to be treated. A yearly eye check-up is a must even if you do not feel anything.

Remember that all these serious complications can be avoided if your blood sugar control is good. That's the only way you'll save those precious eyes.



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UKPDS...

(from page 8)

randomized study, current guidelines suggest that intensive glucose control maintained with HgbA1c of <7.0% can reduce diabetes complications significantly. Lastly, all therapy used for control of blood glucose (insulin, chlorpropamide, glibenclamide & metformin) are effective in reducing HgbA1c, and that all anti-hypertensive agents, as long as they can bring down the BP of Type 2 patients, can likewise cause risk reduction. The study also suggests that sulfonylureas have no evidence of deleterious effects on MI, sudden death and diabetes-related death and that insulin therapy has no evidence that it causes more atheromatous related deaths.

Hypoglycemia...

(from page 8)

blood sugar such as frequent thirst and urination. The patient is also advised to have more frequent glucose monitoring at home in order to detect any hypoglycemia. He is often taught how to adjust his medications especially during times of stress. In addition, his family members are taught how to administer glucagon intramuscularly when hypoglycemia with loss of consciousness occurs.

Hypoglycemia unawareness is a complication of diabetes. When present, it should alert the physician and patient to the danger of unrecognized hypoglycemia. Frequent blood sugar monitoring is required especially in the elderly patient. Education of patient and family members is important.

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Chronic...

(from page 12)

betic retinopathy increases with the duration of the diabetes. At diagnosis < 5% of patients will have retinopathy. After 10 years, the prevalence rises to 40-50% and after 20 years > 90% of patients will have some form of retinal abnormality. When these changes threaten vision, early treatment can prevent sight loss in many cases. In order to prevent sight loss, screening for diabetic retinopathy should be emphasized. Firstly, which diabetic patients should be screened and how often? All type 2 diabetics should have a baseline funduscopy done and this should be repeated yearly if there are no abnormalities noted. For type 1 diabetics, screening can be started 5 years after the onset of the disease and yearly there-

after. The reason for this is that most type 1 diabetics develop more symptoms so that they are usually diagnosed early. Unlike type 2 diabetics who are usually asymptomatic or have milder symptoms, so that by the time they are diagnosed, they may already have had the disease for 5 to 7 years, by which time chronic complications may have already set in. Secondly, who should do the screening and with what tools? GPs are in an ideal position to recruit and screen patients under their care. The main tools are the Snellen chart (for checking visual acuity), the direct ophthalmoscope and the pinhole. First, get the best visual acuity and repeat with the pinhole. If the visual acuity fell by 2 lines since the last exam, diabetic maculopathy should be suspected. Performance of the

(Continued on page 15)

Chronic...

(from page 14)

screening physician can be greatly improved by practice and training. Ideally, a full inspection of the ocular fundus should be made thru a dilated pupil. If the health care physician feels uncomfortable in screening patients, these patients should be referred to an ophthalmologist for proper examination. The gold standard for detection of diabetic retinopathy is binocular stereoscopic slit lamp biomicroscopy conducted by an ophthalmologist thru a dilated pupil.

NEPHROPATHY

One of the most feared complication of diabetes is nephropathy or kidney damage. Once the kidneys fail, the patient may require dialysis or kidney transplant. As always, an ounce of prevention is worth a pound of cure. We should therefore, emphasize prevention of kidney damage in diabetics.

The initial abnormalities involved are an increase in kidney size and function. The mechanism for increase in renal size is unknown but may be due to the effects of glucose or growth promoting factors such as insulin and growth hormone. Therefore, elevated glucose levels present as a risk factor for kidney damage. Other risk factors for diabetic nephropathy also include cigarette smoking and abnormal lipid levels. The initial abnormalities mentioned here may be reversible by improved glycemic control and elimination of the other risk factors.

The increase in size and function can be detected by determining the glomerular filtration rate. However, this is quite an expensive procedure. The more practical screening procedure

would be testing for microalbuminuria. Microalbuminuria is urine albumin excretion of 10 to 300 micrograms per minute and is an excellent prediction of the development of clinical nephropathy and proliferative retinopathy in type 1 DM. This can be detected just by a simple dipstick method. As in screening for retinopathy, it is recommended that all type 2 diabetics be screened at the time of diagnosis while type 1 diabetics should be screened 5 years after the onset of the disease. Ideally, microalbuminuria should be checked quarterly.

Treatment should focus on patients with persistent microalbuminuria (present on 3 successive occasions) particularly when the urine albumin (determined using radioimmunoassay) and urine creatinine ratio is rising rapidly. The principal modes of therapy are improvement in glycemic control, lowering of BP and low protein diets. Protein intake of between 12 - 15% of total calories per day or an approximate intake of 1 gram of protein per kilogram body weight per day is reasonable. However, we must ensure that the patient is receiving an adequate supply of proteins with high biological value and the diet is not deficient in other essential nutrients. Glycemic control is also extremely important. Insulin therapy may be necessary to achieve this. Early anti-hypertensive therapy is also recommended for patients with microalbuminuria. Aim for BP of 130/80 with avoidance of hypotension. Treatment should initially be dietary, with restriction of salt and alcohol and weight loss wherever appropriate. If drugs are required, the various options are low dose diuretics, beta-blockers, calcium antagonists and ACE inhibitors.

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"The Other Words of Diabetes" PDA ANNUAL CONVENTION

The Philippine Diabetes Association is pleased to invite you to its Annual Convention with the theme "The Other Worlds of Diabetes" on December 1 and 2 1998 at the Century Park Hotel, Manila. The speakers are well known experts locally in their respective specialties. Some of the topics to be discussed in the meeting include:

Day 1: December 1, 1998

Plenary Lecture: UKPDS - How Does It Affect Diabetes Care?
Dr. Augusto D. Litonjua

Symposium I: Special Problems in Diabetes

- New Therapeutic Approaches to Diabetic Retinopathy

Dr. Cesar Ramon G. Espiritu

- Recurrent UTI in the Diabetic Patient

Dr. Jennifer A. Chua

- Rheumatologic Manifestations of Diabetes

Dr. Clemente M. Amante

Meet the Expert Sessions: (Concurrent Sessions)

- Management of Hypertension in the Diabetic: Evidence Based Medicine

Dr. Antonio Miguel L. Dans

- Diabetes and Pregnancy

Dr. Mary Anne Lim-Abraham

Symposium II: Autonomic Dysfunction in Diabetes

- Neurogenic Bladder

Dr. Eduardo Rivera

- Cardiovascular Autonomic Dysfunction

Dr. William T. Chua

Symposium III: Diabetes in the Philippines

- DCDGP Survey Results

Dr. Mary Anne Lim-Abraham

Day 2: December 2, 1998

Plenary Lecture: The Vascular Endothelium in Diabetes and Atherosclerosis

Dr. Ricardo E. Fernando

Symposium I: The Foot in Diabetes

- Assessment and Manage-

ment of Foot Ulcers

Dr. Ma. Teresa Plata-Que

- Orthoses/Prostheses for the Diabetic Foot

Ms. Mileanor Reyes, CPO, CPED

- Rehabilitation of the Diabetic Amputee

Dr. Bee Giok K. Tan-Sales

Meet the Expert Session: (Concurrent Sessions)

- Insulin Treatment in the Hospitalized Patient

Dr. Lina C. Lantion-Ang

- Diagnosing Cardiovascular Disease in the Diabetic Patient

Dr. Rody G. Sy

Symposium II: Diabetes and Other Diseases

- Drug Induced Diabetes

Dr. Elizabeth Paz-Pacheco

- Onychomycosis: Recognition and Management

Dr. Amelia Lazaro-Medina

- Diabetes in Endocrine Disease

Dr. Joselynna S. Anel-Quimpo



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Augusto D. Litonjua, M.D.

Editors

Rosa Allyn G. Sy, M.D.

Patricia Gatbonton, M.D.

Members

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DIABETES CENTER HOLDS 3rd NATIONAL ASSEMBLY FOR DIABETES EDUCATORS

The Philippine Center for Diabetes Education Foundation, Inc., will hold its 3rd National Assembly for Diabetes Educators on November 30, 1998 from 8:00 a.m. to 5:00 p.m. at Century Park Hotel, Manila.

An Update on Type 1 will highlight the affair. This is in line with the interests of the International Diabetes Federation Section on Childhood and Adolescent Diabetes.

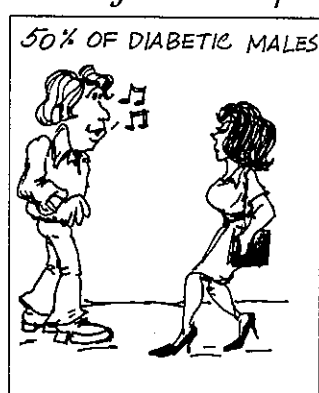
The guest speaker, Dr. Martin Silink, is a famous Pediatric Endocrinologist from Sydney, Australia. His major research interests have been the pancreatic beta cell, diabetes in the young and diabetes compli-

cations. He has written over 90 research articles and contributed numerous chapters in pediatric endocrine and diabetes textbooks.

The audience will have a chance to participate during the interactive session with renowned international and local speakers around.

They will earn units from the CPE Council for Medicine, Nursing and Nutrition & Dietetics.

The Lighter Side of Diabetes



by Dr. Allan Hernandez

