Member, International Committee of Diabetes Magazines, International Diabetes Federation

DiabetesWatch

an affiliate society of the Philippine Medical Association (PMA) • Philippine College of Physicians (PCP) • member of the International Diabetes Federation (IDF)

YEAR XVI, NO. 1 **JANUARY - JUNE 1999**

DIABETES in the ELDERLY

Ricardo E. Fernando, MD
Institute for the Study of Diabetes
Foundation, Inc.

The prevalence of diabetes rises with age. In the 1982-1983 National Diabetes Survey, prevalence from 0.6% at ages 20-29 rose to 12.96% at age beyond 65.

Several factors predispose the elderly to the onset of diabetes. Prominent among these is genetics. One is born into a family of diabetics and inherits genes associated with glucose intolerance. These genes haunt the offspring even up to ages beyond 90.

Then as individuals get older, there is a tendency towards a decrease in physical activity, sedentary living and increase in weight - all of which are deterious to the welfare especially of those born susceptible.

The above conditions may or may not accompany age-related insulin resistance: a decrease in insulin secretion, altered insulin sensitivity, and a decline in insulin effectiveness.

Diabetes is a prominent member of a big family of diseases of lifestyle which includes obesity, hypertension, glucose intolerance, coronary artery diseases, strokes and others. Essential hypertensives are generally considered insulin resistant.

On top of the above misfortunes, one often finds co-existing illnesses. Among the elderly who require various medications, illness brings stress that can upset the glucose balance and lead to diabetes. There are a few common medicines which can cause impairment of glucose tolerance even in the younger age groups, i.e. steroids, diuretics, etc.

It is wise to encourage the older members of our society to maintain a healthy lifestyle — balanced diet, normal weight, nicotine and alcohol free — especially when they come from families affected by diseases of lifestyle. Persons aged 70 and 80 without diabetes are no reason for exemption from this principle for I have seen diabetes diagnosed at the age of 94!!!

Hew PDA Officers and Board of Directors

The Editorial Staff congratulates and welcomes the new set of officers and hoard of directors of the Philippine Diabetes Association for the year 1999-2000.

Officers:
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I ice-President:
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Diabetes Workshop

The two day 17th Diabetes Workshop coordinated by Drs. Tommy Ty-Willing. Erdulfo Tandoc & Marlisa N. Calma held last April 9-11, 1999 at the Island Cove Resort. C'avite City was both fruitful and successful. This workshop jointly sponsored by the PDA Cavite Chapter. PAFP and Cavite Medical Society, drew 169 registrants (113 physicians and 56 Para-Medical). The newest feature of workshop was the Advanced Module on Diabetic Foot headed by Dr. Teresa Plata-Que. The course was designed to demonstrate basic skills needed by doctors and diabetes nurse educators in caring for the high risk loot. It included 5 practical modules namely: Foot Assessment. Nail and Callus Care. Wound Care and Modern Dressing, Footwear and Footcare. and Therapeutic Shoes. This module was opened to participants who had completed previous workshops.

The 18th Diabetes Workshop

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IDF - WPR Congress

On August 25-28. 1999, experts in the field of diabetes from Western Pacific Region and other nearby countries will meet in Sydney, Australia for the 4th International Diabetes Federation-Western Pacific Region (IDF-WPR) Congress. The Congress will focus on important topics impacting on the Asia Pacific Region as we enter the new millenium. More than 80 invited speakers will present their expertise and experiences during this meeting. In one of the symposia. Dr. Una Lantion-Ang, PDA President, will report the DIABCARE-ASIA Project (Phase 2) results while Dr. Rosa Allyn G. Sy. in a separate syposium, will present the Critical Issues in Childhood Diabetes in Developing Countries.

A day before the official start of the Congress, a pre-congress Diabetes Education Study has been arranged and will focus on Nutrition Assessment, Women's Health,

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Lina C Lantion-Ang, MD
PDA, President

THE DIABETIC WHO AGES WELL

As the PDA joins the other medical societies in the Philippines pay tribute to our senior citizens, we single out the elderly Filipino diabetic who has learned to take good care of himself and his disease through the years.

The elderly diabetic who ages well is compliant with his diet. He goes for rice or bread or cereals, or noodles as sources of his carbohydrates. He goes for fish, vegetables and fruits and takes meat in moderation. He drinks a tat of water and shuns away from sweets and alcohol.

Even if beset by some limitations from arthritis, he knows that he can perform low to moderate intensity exercises to maintain, if not improve, his heart and lung function. He takes his medications at the proper dose and the right time unless incapacitated by poor eyesight or marked memory loss. He knows he has to avoid swings of too low or too high blood sugars by monitoring his blood sugars regularly when able.

He inspects his feet everyday and keeps them clean, soft and free from skin cracks. He has his nails trimmed properly to prevent ingrown toenails. The nailbeds are kept shiny and free from fungal infections that render them brittle and lustreless. He feels for the pulses of his feet and wears shoes that provide ample space for his toes and feet.

He knows that blood pressure should be kept normal and if high, should not be allowed to go untreated. This is to prevent strokes and heart attacks.

He keeps his weight down and completely avoids smoking. He listens and follows his doctor's advice and submits himself to periodic blood sugar, lipids, urinary protein and eye tests.

And when all of these are done he can look back and say, "As a diabetic, I have lived an active life that was meaningful and productive."

Indeed, he is the diabetic who has aged well!

An Update on Foot Management Set

Susan B. Trinidad, RN
Head Nurse Educator
Diabetes Clinic, MMC

Saving the limb of a diabetic patient is an important objective that any health professional would aim for.

It is for this reason that the Diabetes Center has invited a Podiatrist and a Wound Management Consultant from Melbourne, Australia to provide further training on foot management.

Both specialists play a vital role in the care of patients who are at risk to develop chronic complications such as neuropathy and vascular problems.

Dr. Augusto D. Litonjua gave a lecture on Neuropathy and Diabetes while Dr. Vic Gisbert, a vascular surgeon, talked on vascular problems among diabetics.

The update was held last June 30-July 2. 1999 at Makati Medical Center.

Augusto D. Litonjua, MD
Editor Emeritus

ERECTILE DYSFUNCTION

It is used to be called 'impotence'. Now. the term has been changed to 'erectile dysfunction' to mean the consistent inability to attain and maintain an erection adequate for sexual intercourse. In a macho society as ours. no man would readily admit to such an incapacity.

In the United States. it is estimated that 10-15 million men have erectile dysfunction. or ED. This means greater than 10% of the male population. A meeting last year on the subject of ED says that the actual number of affected men may he greater than estimated as many men with minimal or moderate ED may not seek treatment. or cultural barriers may prevent some men from seeking treatment.

What relationship does ED have to DM (diabetes mellitus)? Of the men afflicted with ED in the United States. 30% have diabetes as the cause.

What else are the relationships of KD and DM? The incidence of HI) in DM rises with age - 9% of diabetic men between the ages of 20 and 29 years have KD: the number rises to 95% by age 70 years! More than half of male diabetics will experience ED in the first 10 years of their disease. Thus. there is a strong relationship of diabetes mellitus with sexual dysfunction.

Vinik and Richardson also write that KI) is a predictor for the development of generalized disease of the blood vessels and may well herald the premature demise from a heart attack. The penis is a divining rod. capable of identifying individuals at risk for a vascular catastrophe long before it occurs.'

Sometimes. the occurence of KD may precede the rise of the blood glucose. KD co-exists with abnormalities of the lipids in the blood. - raised cholesterol and EDE (bad cholesterol) levels. and low HDI, (good cholesterol).

Because of the foregoing associations. the man with diabetes who now experiences penile failure must report this to his physician. Much is known now about KD - its causes and its treatment.

The diagnosis of KD has also become easier and may not involve any laboratory procedures. The International Index of Erectile Function is a five-question standardi/.ed test that can be filled out in a few minutes in privacy. It provides objective standards by which to measure sexual function. It is scored on a scale of 0 to 5 where lower scores indicate greater dysfuntion and therefore a greater need for therapy. Ask you physician for it.

It is not advisable for men with KD to self-medicate with male hormone preparations. While low testosterone is associated with ED. there is a low frequency of hormonal defects associated with the greater number of causes for ED. There is also the danger of provoking the spread of an occult malignancy of the prostate gland with the use of male hormone preparations.

Treatment of ED may sometimes involve the simple expediency of changing one's lifestyle (Stop smoking or drinking heavily) or modifying some medications. especially those which lower the blood pressure. Psychosexual counselling may suffice for others.

The use of drugs is a second option for the medical treatment of ED. There are a variety in use these days. The most common of them would be the penile injection of agents which relax the smooth muscles of the penis or those which can cause the dilation of the penile vessels. - for verily. erection is nothing more than the inflow of blood into the penile organs and the retention of such blood for an appropriate period of time. These days too. one can opt for the oral intake of sildenafil. which works for greater than 65% of diabetic men.

The last resort for the impotent man would be the surgical procedures of implanting prosthetic

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Diabetes GenterHolds 11th Training Course

Diabetes.

The Philippine Center for Diabetes Education Foundation. Inc.. held its 11th Intensive Training Course for Diabetes Education on June 28 till July 3. 1999.

Placing special emphasis on the prevention of foot problems. a three-day basic foot management course was part of the curriculum. Anne Vinicombe. Podiatrist and Sandra Dean. Wound Management Consultant from Australia shared their expertise in the care of patients who are at risk to develop foot complications.

Participants came all the way from Davao. Bukidnon. Batangas. Quirino Province. Pampanga. Eaguna and Metro Manila.

is set on August 6-8. 1999 at the SEARCA Auditorium. UP Eos Baños Campus. College. Eaguna. For more information call the PDA office at 531-1278.

IDF ...

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Foot Care. and Exercise.

Dr. Eina Lantion-Ang. President of PDA. and Dr. Mary Anne Lim-Abrahan. Past President of PDA. will represent the country during the IDF-WPR Regional Council Meeting. An updated country member association report will be presented by Dr. Ang.

PDA Cebu Chapter:

Marian Denopol, MD
Chapter President, PDA Cebu

The Philippine Diabetes Association Cebu Chapter was organized back in 1990 during a doctors' meeting at Sacred Heart Hospital through the initiation of Dr. Fay Dano who was our founder and first president. Dr. Augusto Litonjua. then national President. was our inspiration and guide as we took up the challenge of diabetes awareness. prevention and control.

One of our first activities uas the induction of our officers. 1 he chapter uas honored hy the presence of Dr. Augusto Litonjua who was our induction officer.

Among the initial activities during the first two years were the formation and strengthening of live PDA diabetes clinics in the city namely: Sacred Heart Hospital. Dr. Fay Dano: Metro Cebu Community Hospital. Dr. Elma Baculao: Cebu City Medical Center. Dr. Esperanza Fernandez: Mandaue City PMWA Diabetes Clinic. Dr. Bernardita Amigo: and Vicente Sotto Memorial Medical Center. Dr. Marian Denopol.

Inter-hospital meetings were done from time to lime to promote better diabetes care as well as discuss common problems and possible solutions.

Annual lav lectures were held till 1996 10 promote diabetes education. lopics included signs and symptoms of DM. meal planning. exercise and loot care. and carl) awareness of complications.

1991 was a very busv vear because the 1st PDA Midvear Convention was held in Cebu Citv Midtown Hotel. I he PDA workshop lor diabetes teams was also held here for 3 days at Kan-Iraq Hotel. Banilad.

Several outreach programs were initiated hv PDA in the surrounding towns of Carmen. Argao. Ginatilan. and Dalaguete. Cebu. Lectures were given to patients and paramedical personnel. Free blood sugar screening and consultations plus starter doses of medicines were also given.

On December 1994. a one-day seminar jointly sponsored by PDA-Cebu and Cebu Medical Society was held with local. national and foreign speakers.

Another diabetes workshop was held in July 1995 with joint efforts from speakers from Ihe Institute for Studies in Diabetes Foundation at the Cebu Grand Hotel. Many doctors from the Visayas and Mindanao areas attended.

The first month of 1996 saw the PDA-Footcare Workshop with no less than podiatrists from the International Diabetes Institute as faculty. During this year. a weekly Saturday morning of one hour period of diabetes awareness discussions were done over a radio station with different doctors. nurses and dietitians as discussants. This activity was co-sponsored by Merck Pharmaceuticals. The radio program had an open telephone question and answer portion with the listening public. This activilv continued for six months. Diabetes awareness week was celebrated with a motorcade and free diabetes clinic and lectures during the last week of Julv. I he quarterly Diabetes Forum was started with ease discussions from different hopsitals. A 3-dav diabetes education course uas also started with Baver and the Phil. Academv of Family Physicians.

I he vear 1997 started with a lecture on "Diet in the Diabetic Patient" with Dr. Ricardo I . Fernando as speaker at (ebu Plaza. An outreach activitv at Ginatilan. Cebu upon invitation of the town council was held on the lasl weekend of January 1 he first Diabetes Fair was held on December 7. 1997 at Cebu Centerpoint Hotel and was attended bv 60 participants. Dr. Gerrv Tan served as lecturer during the Diabetes Awareness Week celebration on Julv 1997.

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CAMP COPE IV AT

Jose Carlos S. Miranda, MD

How can we describe Camp Cope IV? Putting it into writing may not be possible. Just ask the campers and vou'll know.

Camp (ope (V was held lor the 2nd time (1) at Forest Club. Brgy. Puypuy. Nasa\a. I os Baños (Home Sweet Home) last Mav 6-9, 1999. I vervone was there. the campers. the counselors. counselors-in-training. medical staff. nursing staff. dietitians. exercise physiologist. and our friends from the pharmaceutical and diagnostic companies.

Activities planned by the statT and the counselors were fun. exciting. and had a lot of "teachable

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I)iabetic children aged 5-7 years old. who joined the camp. illustrated the three important things in their lives

Good News for Smokers

Elwyn V. Fernando, MD
St. Luke's Medical Center

Good News for Bad News

Nicotine is the ingredient of tobacco that causes dependence. It has been designated as an addictive drug. The more tobacco a person smokes. the more he is likely to develop one or more of the complications of smoking: blockade of blood vessels to the brain (carotid artery atherosclerosis). heart attack (myocardial infarction). impotence (erectile dysfunction). high blood sugar (insulin resistance). elevated fats in the blood (dyslipidemia). abnormal babies (low birth weight infants). and cancer (bronchogenic carcinoma). Who would want to develop these diseases by continuing to smoke? Researches have shown that after two years of stopping the habit. one has reduced his risk of acquiring these diseases by half. Giving up the habit permanently brings the risk down to levels of non-smokers.

Smoking and Your Loved Ones

Passive smoking is the inhalation of smoke without directly sniffing it from cigarettes. like breathing in the smoke from a smoker beside you. The risk for having the complications is the same for both active and passive smokers. Who are the passive smokers? They are usually our loved ones. A sign in Hongkong reads: Smoking will kill your loved ones. While this is true. quitting will also reduce the risk and this is the good news. Kicking the habit not only saves you but also the persons you care about.

New **Tools for Our Generation**

During the last ten years. a lot of devices and gadgets have been developed to help smokers quit. We now know how the enemy nicotine behaves. There are a hundred ways to stop smoking but no single one will work for everybody. In any war. you need an effective strategy to win.

The smoker should be able to realize the reason for lighting that cigarette. He should have motivation to tackle his inner feelings for wanting to smoke. He should have the commitment not to give up. He should have an organized plan of attack. The smoker who quits with motivation. commitment and organization has a much higher chance of successfully dropping the habit for good.

Some smokers will need the help of group programs. A visit to your lung doctor (pulmonologist) will enlighten you to the quit smoking programs available in our country. This gives us a wide array of tools we can use.

The Road is Long and Winding

Be prepared. Smokers who quit know it is a long and winding road. It may be easy for some but difficult for many. One must have a plan. The desire to quit must be strong and supported by commitment to reach that goal.

The initial period is usually very difficult and alcohol consumption should be avoided. Will power is of prime importance and this faculty is adversely affected by alcohol.

Timing is another important aspect. Since quitting smoking initially puts one's life in disarray. quitting at a time of personal crisis is usually bound for failure.

Nicotine and Diabetes

If you have diabetes and you smoke at the same time. the decision should be clear. Decide to quit now and commit to it. Design a plan that will work for you. See a specialist if necessary. We are nagging you because we care. We know there are persons who love you. And we know that you love them. too.

Camp Cope IV...

moments." The first day came and we went swimming. fishing (WOW! The place never ran out of fish!). had rap sessions and camp fire. That day made everyone secure. at ease. and familiar with the place and with each other.

The second day was a little different since we went to nearby Caliraya where all got to trek. watched an entertaining. educational and inspiring "top spinning show." and had a memorable boat ride. Since it was an active day tor everyone. we reserved the night for watching a movie (complete with popcorn). We were all singing "George. George. George. George of the Jungle" after that.

On the third day. we had water Olympics. arts and crafts. rap sessions. and a GREEN party. The party was really something. especially for the staff. The reason? We were the participants in most of the games.

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PDA Cebu ...

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The year 1998 was also full of activities: February 1998. Workshop on Footcare with podiatrists from Caldwell University Hospital. Australia: April 1998. joint PDA-PCS Scientific Lecture on Nutrition of Diabetic Surgical Patient with a foreign speaker sponsored by Mead-Johnson: May 15. 1998. Scientific Lecture by Dr. Roberto Mirasol on the Role of Post Prandial Hyperglycemia on Atherosclerosis: July 1998. a celebration of the tenth year anniversary of PDA-Cebu during the Diabetes Awareness Week: July 17-19. 1998. was also the date for the second PAFP-PDA sponsored diabetes education course for family physicians.

PDA Cebu is hopeful that 1999 will be as fruitful as the previous years. Our on-going activities are directed towards helping the family practitioners and doctors from the city and province in the

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ASPARTAME, IS IT HARMFUL?

Mary Anne Lim-Abrahan, MD
Philippine General Hospital

The latest electronic (e-mail) health scare campaign by "Nancy Markle" attacks the artificial sweetener aspartame. It links aspartame to Alzheimer's, systemic lupus, diabetic complications, headaches and seizures, multiple sclerosis, cancer, brain defects, and the Gulf War syndrome.

Locally, there were publications and clarifications (Marietta Velasco Giron's column, "The Consumer", *Philippine Daily Inquirer*, January 27, 1999; *Manila Bulletin*, June 2, 1999; *Food Facts Asia*. First Quarter, 1999). Dr. Kenneth Hartigan-Go, Deputy Director of the Bureau of Food and Drugs Administration (BFAD) forwarded inquiries to the US Food and Drugs Administration (FDA). The websites for science-based information on aspartame contains the reply of Dr. David Hattan, Acting Director of the Division of Human Effects Evaluation in the FDA center for Food Safety and Applied Nutrition and is available at www.fda.gov: the lack of evidence for the association of aspartame and multiple sclerosis can be obtained at www.msfacts.org/aspartame.htm; and more information can be obtained from the International Food Information Council Foundation at http://illcinfo.heaith.org.

Aspartame is a low-calorie sweetener used in foods (such as tabletop sweetener and beverages, powdered fruit and lea drinks, low calorie soft drinks and desserts) in more than 90 countries around the world. Two hundred limes sweeter than sugar, aspartame can be used in place of sugar and therefore reduces the calorie content of a number of foods. It enhances citrus and other fruit flavors, and does not contribute to tooth decay.

Aspartame is made by joining two amino acids, aspartic acid and phenylalanine and a small amount of methanol. Aspartic acid and phenylalanine are naturally found in all protein-containing foods like meat, grains and dairy products. Methanol is found in many foods such as fruit and vegetables dishes. It is responsible for the "pop" that you hear when opening a bottle of juice that was previously opened and left unrefrigerated.

In the body, aspartame is digested like any other protein. It is broken down into its basic components and absorbed in the blood with no accumulation in the body. Aspartame is broken down by heat and therefore cannot be used in recipes requiring lengthy heating or baking. If one insisted and added aspartame during baking, aspartame's components will separate and it would not provide the desired sweetness.

Aspartame was approved by the US FDA in 1981 Tor use in powdered mixes and as a tabletop sweetener. In 1996, it was approved for use in all foods and beverages, including products such as syrups, salad dressings and certain snack foods where prior approval had not yet been obtained. There were well over 100 separate toxicological and clinical studies conducted to establish the safety of aspartame before it was approved for use. In a recent study done at the Massachusetts Institute of Technology (MI'1) Clinical Research Center and published in the American Journal of Nutrition 199X: (68:531-7), 48 healthy volunteers consumed large daily doses of aspartame with no effect on neuropsychologic, neurophysiologic or behavioral functioning.

Aspartame is safe for the general public, including diabetics, pregnant and nursing women, and children. Persons with the rare hereditary condition known as phenylketonuria (PKU) cannot metabolize phenylalaninc, one of the amino acids of aspartame, and must control their intake levels of phenylalanine. Phenylketonurics must refrain from using aspartame. The US FDA requires that products sweetened with aspartame carry the statement on the label that they contain phenylalanine. Earlier studies done to evaluate the possibilty that aspartame causes seizures or enhances the susceptibility to seizures showed that there was no evidence of contributing to the frequency of occurence or severity of seizures in seizure-prone children and adults.

The FDA further qualifies the issue on methanol, that results from the hydrolysis (breaking up) of aspartame, and is taken up by the cells of the body then metabolized first to formaldehyde and then to formate. The key information is that the levels of ingestion are very modest. In reality, there are other foodstuffs that we (you and I) ingest that supplies as much and sometimes even more methanol like citrus fruits and juices, tomatoes or tomato juice. Therefore, the methanol from aspartame is the same as from other sources, and in the quantities consumed, is very modest and readily metabolized.

The FDA also reported that aspartame use was not associated with birth defects, both in animal and human studies. Likewise, there was no proven association with brain tumors.

The FDA uses the concept of an Acceptable Daily Intake (AD1) for food additives. The ADI represents an intake level that if maintained each day throughout a person's lifetime would be considered safe. The ADI for aspartame has been set at 50 milligrams per kilogram (mg/kg) of body weight. The

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50-lb Child	150-lb	# of servings of typical foods sweetened by aspartame
7	20	12-oz. containers of carbonated softdrinks
II	34	8-oz. servings of powdered fruit drink
14	42	4-oz. servings of gelatin dessert
32	97	packets of tabletop sweetener

Danger in the Medicine Cabinet — *Drugs that can Worsen your Diabetes*

Patricia B. Gatbonton, MD
Our Lady of Lourdes Hospital

Many of our patients with diabetes - particularly elderly people — have concomitant medical problems such as hypertension, chronic obstructive pulmonary diseases (COPD) such as emphysema and bronchitis; asthma and arthritis problems that may require medication other than their oral hypoglycemic drugs or insulin.

Wolfgang Rathmann, MD, in his article, "Costs and Effectiveness of Medications in Diabetic *Patients*" *(Drug Benefit Trends,* 1998) highlights this problem and suggests that drug-prescribing patterns for these concomitant problems in diabetics must be different from those usually prescribed for non-diabetic patients.

Some of Dr. Rathmann's findings:

❖ A longitudinal study of elderly community residents indicates that the presence of diabetes is a much stronger predictor of increased drug prescriptions than age, sex, number of health care visits, or prior hospitalizations.

* Diabetic subjects receive more drug prescriptions in almost all drug categories than patients in the non-diabetic population.

These include antibiotics (penicillin, cephalosporin, aminoglycosides); central nervous system drugs (antipsychotics, barbiturates); cardiovascular drugs (antihypertensives, diuretics); gastrointestinal agents (anti-diarrheal, anticmetics); analgesics and anti-inflammatory agents (NSAIDs, systemic steroids). He found that most of these drugs were used 2 or 3 limes more often among diabetic subjects than among non-diabetics.

Some of these common medications may induce glucose intolerance. **Judging from these findings, polypharmacy seems to be the norm among diabetic patients. What these patients and their physicians may not know is that some of the common medications prescribed for these conditions may induce or "unmask" glucose intolerance in a previously normal patient, or worsen an existing diabetes.**

These drugs may be diabetogenic by one or more mechanisms:

1) By a direct or indirect effect on insulin secretion. These direct effects may be mediated by the drug itself or through changes in counterregulatory hormones or cations (K+) involved in insulin secretion.

2) By impairing insulin action at hepatic or extrahepatic sites.

3) Or a combination of the above.

Table 1 shows a *partial list* of some of these drugs; the more commonly prescribed drugs will be discussed briefly.

Diuretics and Beta-blockers

Diuretics and beta-blockers are among some of most commonly prescribed anti-hypertensives. Recent studies have found a three-to-four-fold increase in glucose intolerance in patients taking thiazides. (The incidence varies between 10-40%. depending on the duration of administration of the drug). Patients given non-selective beta-blockers had a 5-6 time increase in risk. Patients taking a combination of the two drugs had a 11-time increased risk of developing glucose intolerance.

Although thiazides may have a direct effect on insulin secretion. their hypoglycemic effect is also seen to a lesser degree with loop diuretics such as furosemide. They

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Brandy *and Your* Body

Elwyn V. Fernando, MD
St. Luke's Medical Center

Brandy contains an alcohol that doctors call ethanol. Different alcoholic beverages contain alcohol at different concentrations. Hard alcoholic drinks like brandy and vodka contain more ethanol that light alcoholic drinks like beer. Nevertheless, they all contain ethanol.

Liver Effects:

Normally, the liver makes sugar from stored glycogen in its cells whenever the blood sugar goes too low. When alcohol is in the blood stream, the liver preferentially works on removing it from the circulation while sugar production is stopped. This is also the reason why people who drink alcohol experience lowering of blood sugar. In a way, ethanol lowers the blood sugar level by damaging healthy liver tissue.

Weight Effects:

Alcoholic beverages contain lots of calories with no essential nutrient. Some vitamins are even depleted by alcohol. The extra calories from alcohol account for the excess weight of alcohol drinkers. In fact, alcohol is listed as a fat exchange. Incorporating it in your meal plan may mean reducing nutrient rich calories from healthier food sources.

Nerve Effects:

Nerves are pathways for feeling. Ethanol is directly toxic to nerves so that drinking may increase pain and numbness in patients with diabetic **nerve problems** (neuropathy). Limiting the **intake** of alcoholic beverages may even improve erectile function.

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Danger in ...

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Table 1. Diabetogenic Pharmacologic Agents

Drugs that affect insulin secretion:
- *Anticonvulsant*
  - Phenytoin (Dilantin)
- *Diuretics*
  - Thiazides
  - Furosemide (Lasix)
- *Pesticides*
  - DDT
  - Pyriminil (Vacor)
- *Antihelminthics*
  - Pentamidine
- *Antineoplastics*
  - L-Asparaginase
  - Mithramycin
  - Cyclosporine

Drugs that affect insulin action:
- *Hormones*
  - Calcium
  - Glucagon
  - Glucocorticoids (prednisone, dexamethasone)
  - Growth hormone
  - Estrogen (including OCP)

Drugs that affect both insulin secretion and insulin action:
- *Adrenergic compounds*
  - Epinephrine
  - Norepinephrine
- *Antihypertensives*
  - Clonidine (Catapres)
  - Diazoxide
  - Prazosin (Minipres)
- *Blocking Agents*
  - β-Adrenergic blockers (propranolol)
  - Ca channel blockers
  - Histaminergic blockers
- *Psychopharmacologic agents*
  - Benzodiazepines
    - Diazepam (Valium)
  - Ethanol
  - Opiates (morphine)
  - Phenothiazines

impair insulin secretion indirectly through hypokalemia; and discontinuation of the diuretic or K+ replacement corrects glucose intolerance.

Non-selective beta-blockers have an inhibitory effect on insulin secretion. It is not unusual for glucose tolerance to worsen in patients on these medications. Selective beta-blockade (like atenolol) would have a smaller effect on insulin secretion.

Phenytoin (Dilantin)

A commonly prescribed anticonvulsant, phenytoin has a direct effect on both the first and second phases of insulin secretion by blocking Na^+ or Ca^+ transport across the beta-cell membrane. Its effect is dose-related.

Pentamidine

Used extensively for treatment of *Pneumocystis carinii* pneumonia in AIDS patients, it has been related with an increased incidence of insulin dependent diabetes mellitus. Its effect on glucose homeostasis comes from its pancreatic beta-cell cytotoxic effects, which lead to beta-cell exhaustion and insulin deficiency.

Glucocorticoids

Prescribed widely and indiscriminately for a variety of conditions ranging from COPD to arthritis, glucocorticoids can increase glucose production as well as cause insulin resistance, hyperinsulinemia and increased glucagon levels.

Estrogen and Oral Contraceptives

These also promote the development of insulin resistance but to a lesser degree than glucocorticoids. The practitioner must take this into consideration when prescribing contraceptives or hormone replacements in diabetic women.

Nicotinic Acid

Prescribed for cholesterol elevation, nicotinic acid is relatively contraindicated in diabetics. It induces peripheral insulin insensitivity particularly in patients with limited beta-cell reserve or preexisting diabetes.

Cyclosporine

Usually used in conjunction with steroids for renal transplant patients, its effect on glucose metabolism is thought to be independent of that of glucocorticoids. It may have a direct inhibitory effect on beta-cells.

Opiates

The hyperglycemic effect of morphine has been well described and patients addicted to morphine have impaired beta cell responsive to glucose.

USE WITH CAUTION

Despite valid concerns regarding their adverse metabolic effects and the loss of hypoglycemic awareness, beta-blockers and diuretics do have a role in the management of diabetic patients. That is also true of the other drugs on the list.

Before these drugs are prescribed, however, the physician should weigh the risks and benefits of the therapy and advise the patient on how to compensate for the expected elevation in his or her blood sugar. The patient may need to monitor his blood sugar more frequently than usual, and have his oral hypoglycemic agents and/or insulin adjusted as necessary.

When such a patient is seen by another physician, he must be sure to let the new doctor know he is a diabetic; and if the doctor prescribes new medications, the diabetic patient must first clear them with his old doctor. The patient must also be sure to have a complete list of the medication he is taking during his scheduled visit to his diabetes doctor, so that he and the doctor can review his therapy every so often.

In conclusion, the thing to remember is that elevated blood sugars may not be the patient's fault. And the solution to poor sugar control may lie simply in reviewing the medications the patient is taking -- and removing the offending agent from his or her medicine cabinet.

Everything you always wanted to know about DIA

Roberto C. Mirasol, MD
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Infection in diabetes is commonplace. In fact, there are some infections which occur exclusively among diabetic patients. It is also true that infections among diabetic patients are generally worse. This issue of Diabetes Watch will discuss why you are prone to develop infections and how to deal with them.

Why are diabetics prone to infections?

There are a number of reasons why you are prone to infections. There arc a number of defenses used by our body to combat infection. These defenses include the skin, blood supply, lymphocytes and immunity. All of these have been found to have some form of defect among patients with diabetes.

If I am prone, how can 1 increase my resistance against infections?

First, you need to control your blood sugars. Eat a well balanced diet. Exercise regularly. Take plenty of tluids or water. Sleep at least eight hours per day. Stay away from people who are ill.

Are skin infections more common among diabetic patients?

Yes, and the more common are the staphylococcal skin infections, which can be treated with antibiotics. Fungal infections also occur more frequently among diabetic patients. Likewise, they need to be treated depending on the extent of the lesion.

My dentist tells me that diabetics are affected more with periodontal disease, is this true?

Your dentist is correct. This disorder is more common and more severe among patients with diabetes. Associated factors include your age (the older the more severe). blood sugar (worse in those with high blood sugars), duration of diabetes (longer the diabetes the greater chance of severe disease). and occurrence of complications. Dental care and hygiene is important to prevent you from getting this disease.

/ have vaginal itchiness, what should I do?

Aside from controlling your sugars, you need a gynecologist to check on you. If the blood sugars go down the itchiness usually subsides.

/ have urinary tract infections every now and then, is it bad?

Frequent urinary tract infections are bad. One of the reasons for this is that the bladder is affected with diabetes and you might have a neurogenic bladder (you do not empty your bladder fully) thereby making you prone to infections. You need to be treated with the proper antibiotics. Your doctor will check your urine regularly and will sometimes do cultures on them. Drink a lot of water.

Is TB a problem among diabetics?

It is indeed a major problem. The major host defense mechanism against TB is the cell-mediated immunity, which is defective in people with diabetes. We often see patients who are newly diagnosed with diabetes who have tuberculosis as well. You need to be screened for this disease. Treatment for uncomplicated cases includes multiple drugs especially for the first two months of therapy. The key here is compliance so you do not develop resistance.

How about pneumonia?

1 he more usual route of infection is by inhalation of pathogenic organisms, which colonize the throat. In diabetics, there is increase nasal carriage or throat carriage of particular organisms which make them prone to infections. Chronic illness like diabetes may change the normal organisms found to organisms which are more difficult to treat. If you get pneumonia they are usually more severe.

There are more infectious diseases which we have not tackled. We have barely scratched the surface. The best advice is really to lead a healthy lifestyle and keep those sugars down!

We welcome your comments, queries and suggestion. Please fax at 531-1278.

Erectile ... (From Page 3)

devices into the penis or the more formidable corrective surgery for a severely abnormal blood flow.

ED has been the cause of broken homes and broken relationships. Largely, it has been the fault of the man because of his reluctance to admit to his illness. Sex should be discussed openly with the physician, because sexual problems can he helped.

Aspartame ...

table shows the number of servings of typical foods sweetened completely with aspartame that individuals would have to consume everyday to reach the ADI.

In summary, after the numerous clinical studies on aspartame, the US FDA continues to consider aspartame to be among the most thoroughly tested of the food additives.

Camp Cope IV ...

(From Page 5)

The fourth day was the culmination. A mass was celebrated, followed by the presentation from the campers, counselors, and the staff. Awards were also given.

After all that, different reactions were overheard such as "Ahhh, Camp Cope is over," or "I have survived Camp Cope," or "Camp Cope is over?!!! Bitin!"

Well, Camp Cope IV is over but we'll have it year after year after year. So expect to hear from us again and again and again!

Brandy ...

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Eye Effects:

, The sensitive portion of the eye is called the retina. Alcohol may cause blood vessels to the retina to leak or bleed leading to blindness. Heavy intake of alcohol (more than 3 drinks a day) is associated with progression of diabetic eye disease.

Blood Pressure Effects:

Researches have proven that patients with hypertension or high blood pressure can lower their blood pressure if they stop taking alcohol. Although, it is not known how alcohol affects blood pressure, the association has been proven.

Blood Composition Effects:

Ethanol stimulates the liver to produce more fat called triglycerides. Too much of this fat in the bloodstream may cause hardening of the blood vessels (atherosclerosis).

Drug Interaction Effects:

Alcohol can interact with drugs making it stronger or weaker. Ethanol, for example, make some diabetes drugs more potent and lead to very low blood sugars.

That Brandy In Your Body:

Brandy is just like any other alcoholic beverage. Others may contain more or less ethanol. If you are holding a glass of brandy, think again before you sip.

... Herbal Supplements

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of the insulin causes the increase of serum glucose level. Based on the study by Neil Solomon, MD, PhD of the University of Maryland School of Medicine, the noni fruit contains proxeronine, a lysozyme which assists in the repair of the damaged beta-cells, thus relieving the ailment by regaining its original insulin producing capability. However, no clinical trials have been published that would support the test results of noni on laboratory mice.

Despite the claimed findings on this new product, the fact still remains that diseases are products of deterioration. Diseases are manifestation of the failure of a certain organ or system to work according to its regular function either due to its own physical or physiological defect or caused by an external factor.

There is further need to study the external causes since these are more subject to control than the physical defect. The research done on ampalaya and noni are basically to answer this need of arresting the disorder through regular diet. However, this is where the need for caution comes in.

As a food product or a supplement, its main function is to assist in the proper nourishment of the human body. This is merely to assure its proper nourishment and nothing more. However, there is no guarantee to using a product based on some laboratory results to prevent or even cure a disease.

The best advice we can give is still the use of proper nourishment based on a holistic approach. The risk is reduced with proper assistance from a professional nutritionist or physician. An assessment of a need should be determined first and foremost, prior to the alteration of the regular diet. An effect may not always be consistent lor all cases. Proper professional advice on the sale use of a health supplement is therefore highly recommended. Health supplements should not have any misleading claims toward therapy.

Diabetes and Dermatology

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Diabetes affects almost every organ in the body. It is hardly surprising that this disease has numerous manifestations in the largest organ of all. the skin. Skin disorders may preeede. signal or appear late in the eourse of the diabetes. The changes ean he secondary to the abnormal carbohydrate metabolism. small and large blood vessel disease. impaired ability to handle infections or to some unknown factors. Some of these skin changes can provide clues to diabetes.

DIABETIC DERMOPATHY - This is the most common skin sign of diabetes. It is also referred to as the "spotted leg syndrome" and "skin spots." It manifests as small. slightly depressed round or oval brown painless patches over the front and the sides of the lower portions of the legs. The condition has been seen in nondiabetics but the majority of patients are adult diabetics with severe long-standing disease. Diabetic dermopathy. being asymptomatic. requires no treatment except for protection from trauma.

PRURITUS - Generalized itching or pruritus in diabetics is not unusual. It is a commonly held belief that pruritus is a symptom of diabetes. However. it has been shown that excessively dry skin (xerolic eczema) is the cause rather than some endocrine disorder.

VITILIGO - Vitiligo is a disorder of skin pigmentation in which focal degeneration of pigment-producing cells called melanocytes results in sharply defined depigmented white patches surrounded by normal or hyperpigmented borders. The most commonly affected sites are the extremities and face. Autoimmune and genetic factors have been advanced to explain the higher than expected coexistence of vitiligo and diabetes.

DIABETIC BULLAE - Although not really common. the sudden appearance of one or more noninflammatory tense blisters. generally involving the back and sides of the hand and feet. forearms and lower legs. is a distinct diabetic marker. Adult males with severe long-standing diabetes are atl'eeted more often than females. Diabetic bullae range from one to several centimeters in diameter. often bilateral. and contain generally clear sterile fluid. Unlike burn blisters. diabetic bullae are not surrounded by red borders and are not painful. The lesions heal by themselves in a few weeks. Outside of preventing secondary infection no treatment is necessary.

ERUPTIVE XANTHOMAS - Eruptive xanthomas may appear when serum triglyceride (a fraction of blood lipid or fat) levels are elevated. The majority of patients with this condition are diabetics in poor control. The eruption is of multiple. firm. pink-yellow small (2-3 mm in diameter) elevations in the skin (papules) appearing in crops. The favored sites are the extremities and the trunk. With the correction of hypertriglyceridemia and control of diabetes. the lesions spontaneously disappear.

SKIN INFECTION - For many years. it has been believed that diabetics are more prone to bacterial and fungal skin infections than people without diabetes. With the exceptions of infections due to *Candida albicans* (a yeast) and *Corynebacterium minitissimum* (a bacteria). this assumption is probably incorrect in well-controlled diabetics without major complications of their disease. In such patients. the host defense is comparable to normal individuals. By contrast. in patients who are poorly controlled. the host defenses change. This results in more infections, a tendency for the infection

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Much research has been done on Diabetes Mellitus which in the US alone wreaks as much as US$25 billion worth of expenses from direct and indirect costs related to this dreaded disease. This figure is estimated to be doubled annually due to its complications (Medical Sciences Bulletin. Pharmaceutical Information Associates. Ltd.) In 1998. it is estimated that the world market for self-help diabetes products would. within the year. reach $ 7.6 billion (Telemed Virtual Reality Publication. 1998 Nov. 3(11):123).

Diabetes Mellitus is a disorder resulting from insufficient or absence of insulin production by the pancreas. Insulin is the hormone responsible for the absorption of blood sugar (glucose) into the body's cells and its storage in the liver and fat cells for future use. Glucose provides the day to day energy needed by the cells to perform normal body functions. People with reduced or no insulin have high amounts of glucose in the blood and since their cells could not use this. they feel fatigue and hunger. and are prone to weight loss.

There are two types of diabetes mellilus: Type I diabetes mellitus requires that patients be given regular injections of insulin since the pancreas has totally stopped producing insulin and Type 2 diabetes mellitus. insulin production does not meet the body's needs. In 1997. 5% of the world population was affected by the latter type of diabetes which is also noted to be the more common of the two.

Serious attention is given to Type 2 since more deaths and cardiac arrests are related to this including other complications like amputation. kidney failure. and blindness or other vision disorders. Moreover. most Type 2 do not manifest symptoms on the onset of the disease. thus the delayed detection leads to high risk complications.

Advances in research have already been achieved with regards to detection and diagnosis. Studies on the genetic progression of the disease are ongoing for both IDDM and N1DDM. One major development includes the determination of susceptibility up to the chromosome level indicating the specific chromosome region in a subject that would establish an individual's predisposition to this disorder.

New drugs have also been developed which have a mode of action intended to affect the organs responsible for the development of the disorder. Most of these drugs mimic the insulin-secreting beta-cells of the pancreas. The net effect would be to imitate the action of insulin on serum glucose.

Other than drugs. there are new products that somehow approximate the action these new drugs have against diabetes mellitus and its accompanying complications. Glucose homeostasis is the basic principle of these health products mode of action. This has been observed in herbal preparations specifically bitter gourd locally known as ampalaya (Momordica charantia) and/or noni fruit (Morinda citrifolia).

Ampalaya

Ampalaya extract was investigated by several research institutions for its hypoglycemic effect and they found that the mode of action occurs in several ways. One is by suppressing the glucose transfer from the stomach to the small intestine and altering the glucose

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The Filipino Pyramid ...

(From Page 16)

cer and even weight loss if taken in correct proportion.

❒ It is nutritionally sound because it can he followed for the rest of our lives regardless of age, gender. activity. and occupation.

❒ It is an excellent tool for menu planning and preparation because it outlines the food on which to revolve our meal planning.

❒ It is globally oriented as it can he followed anywhere in the world either in the north or south. from carribean to mediterranean. The pyramid food choices can he ordered according to one's needs.

1 You can customize the Filipino Pyramid Food (iuide to suit every taste and region in the country.

❒ It is an excellent food guide for the wellness crowd such as the elite and recreational athletes or any sportsman who needs to eat for endurance and energy.

❒ It is cost-effective because the foods recommended are the basic Filipino staple. cheap. available. and affordable as it emphasizes a cheaper base source such as rice. corn. rootcrops. and vegetables compared to meats and seafoods.

❒ The pyramid food graphics has been extensively tested to a wide segment of the population. consumers. health professionals. and athletes and they all understood what they are supposed to eat.

❒ It is visually powerful. user-friendly. attractive, and radically different from all educational tool graphic such as the pie graphs. the food wheel. and the rainbow.

As a clinical and sports nutritionist practitioner. this deceptively simple and easy to recognize and to memorize figure (The Filipino Pyramid Food Guide) is here to stay because it is a perfect food match to the way we Filipinos generally eat: plenty of rice. little *ulam.* and some vegetables and fruits. It is one of the most effective educational tools I have come across since it is easy to explain the concept of eating sequentially from the base and less at the top. I can safely say it is a convenient. simple. visual. memorable teaching aid. Try it! The Food (iuide Pyramid really makes a difference. It is an easy food outline that will simplify food counseling to your patients.

... Dermatology

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to spread and be more protracted and severe. Response to therapy is often suboptimal until diabetes is controlled.

FURUNCLE - Furuncle or boil is a round. painful swelling that begins in a hair follicle and generally ends in abscess formation with central accumulation of pus. The lesion is caused by *Staphylococcus aureus* bacteria. Diabetes should always be exeluded in individuals with recurring boils or with boils seemingly resistant to antibiotic therapy.

CANDIDAL INFECTIONS - *Candida albicans* may cause different types of lesions of the skin. nails and mucous membranes. Diabetics with poor glycemic control are more likely to manifest symptoms of this infection with improvement related to control.

VULVOVAGINITIS *Candidaalbicans* is a common inhabitant of the vaginal tract but in uncontrolled diabetes. it mav cause severe itchiness. irritation, swelling. redness and extreme burning of the vaginal mucosa. There may be associated vaginal discharge and pimple-like lesions (satellite lesions) on the bordering skin and the groin. This conditions occur in about half of all diabetic women and is a frequent cause of pruritus or itchiness affecting the sex organ.

PARONYCHIA - Candidal paronychia is a long-standing inflammation of the nail fold caused by *Candida albicans.* It particularly occurs in patients who are frequently exposed to water (housewives. cooks. laundry workers). Nail infection manifests as slow erosion of the lateral borders of the nails. gradual thickening and brownish discoloration of the nail plates and the development of pronounced horizontal ridges.

ORAL CANDIDIASIS - This is seen in elderly. debilitated. malnourished patients and diabetics. The mucous membrane of the mouth and the tongue may be covered by grayish-white membranous

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plaques. The lesion may spread to involve the angle of the mouth. Successful treatment of oral candidiasis may be achieved with specific antifungal agents.

CANDIDAL INTERTRIGO - Pruritic eruptions caused by *Candida albicans* arise between folds of skin of the groin, under large pendulous breasts, or under overhanging abdominal folds (intertrigenous areas). The lesions appear as pinkish moist patches surrounded by thin scales of skin with great tendency to develop fissures (cracks). Often tiny superficial elevations of the skin with pus (pustules) may be observed adjacent to the patches.

ERYTHRASMA - This is a skin disease caused by *Corynebacterium minitissimum* bacteria. The disease is manifested by tan-red, fine scaly patches in intertrigenous areas (groin, axillae, submammary (breast) folds, and abdominal skin folds. *Corynebacterium minitissimum* can ferment glucose and this may explain the higher than normal incidence of this disease among diabetics.

When dealing with skin disorders in diabetics, factors that tend to aggravate the disease should be considered. Such factors include uncontrolled diabetes giving rise to abnormalities in white blood cell function, small and large blood vessel disease especially of the lower extremities and neuropathy. Antimicrobial drugs may be needed in some skin disorders but reversal or alleviation of aggravating factors may greatly enhance the healing process.

PDA Cebu ...

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screening and management of diabetic patients. This requires strong coordination among PDA, City Health. Provincial Health, and the Dept. of Health to promote case finding and early detection of complications.

... Herbal Supplements

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transport at the brush border of the small intestine. This was shown by the suppressing action in the gastric emptying of laboratory rats including inhibition of glucose uptake in the rat's small intestine in vitro (Matsuda 11. et al. Chemical Pharmacology Bulletin. Kyoto Pharmaceutical University. 1998 Sep: 46(9): 1399-1403).

Another way is by exhibiting an insulin-like characteristic. A study done in Kyushu University in Japan, revealed that the seed contains a ribosome-inactivating protein and the specific amino acid sequence exhibiting this action was identified. The compound responsible for this catalytic activity is momordin-a found in ampalaya seeds (Minami Y.. Funatsu G.. Bioscience Biotechnology Biochemistry 1993 July; 57(7):1 Hi-1144). The insulin-like characteristic may be attributed to the insulin-like molecules found in ampalaya seeds as reported by Ng TB et al. These molecules exhibited antilipolytic and lipogenic activities in the isolated adipocytes (Journal of Ethnopharmacology. 1986 January: 15(1):107-117).

The third mode of action was observed in a study conducted in the University of Dhaka. Bangladesh. It was observed that ampalaya extract together with *Coccinia Indica* lowers blood glucose in two ways: a) by depressing the enzymes that catalyze glucose synthesis. and b) by activitating the enzyme G6PDH that enhances its anti-cancer activity. (Proc West Pharmacol Soc 1996: 39:7-9, Department of Pharmacology, John A. Burns School of Medicine, University of Hawaii. Honolulu 96822, USA.)

Noni Juice

The immunomodulating effect of noni is the basis for its function on diabetes mellitus particularly if the disease is an autoimmune disorder like Type 1 (IDDM). In 1DDM. the destruction of the beta-cells responsible for the production

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The Filipino Pyramid Food Guide
for Today's Lifestyle

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Consulting Clinical and
Sports Nutritionist

An important educational tool for nutrition and health made its public debut in 1992 when the US Department of Agriculture promulgated the Food Guide Pyramid. It has become the official food guide for the US and the only one recognized by the various US Federal Agencies and Health Institutions because it has been tested extensively and scientifically to a wide variety of population groups. The Pyramid Food Guide has been accepted by nutrition educators, food scientists, dietetic practitioners, and health professionals because of its simplicity. All focus groups have been encouraged to create their own pyramid food guide adopted to their country's needs, the people's cultural habits, regional eating patterns and differences in eating practices, ethnic beliefs and other culturally sensitive issues. Hence, I came out with our own version of the Pyramid Food Guide.

To make the Pyramid Food Guide relevant to Filipinos, I started to refine the old pyramid food concept used in my nutrition clinic for years. To validate the use of the Pyramid Food Guide for its normal dissemination as the new recommended dietary educational tool for today's eating lifestyle, I asked the assistance of Filipino Food Anthropologists and Food Communicators to clarify and regroup our foods the Filipino way. I also consulted Dr. Rodolfo Florentino, then the Director of Food and Nutrition Research Institute (FNRI) and the FNRI Staff led by Ms. Felicidad Velandria. We came out with our very own Filipino Pyramid Food Guide with 2 major differences from all the pyramid food guides of the world. Our milk, cheese and dairy products were not given a separate slot but were incorporated with the major protein groupings. The majority of Filipinos are not milk-drinkers and dairy product consumers. We get our calcium from sources like seafoods such as *dilis, tahong,* oyster, sardines, and leafy vegetables like *saluyot, malunggay,* and *alugbati*. We have also included fats as a formal food group while the rest of the world's pyramids do not emphasize fat. Some Filipinos need those calories from fat and for the absorption of the fat soluble vitamins.

We are adapting the Filipino Pyramid Food Guide for Today's Lifestyle due to the following reasons:

❒ At a glance, one can see the totality and completeness of a good basic diet.

❒ It illustrates clearly the 3 major principles needed for good nutrition: variety, moderation, and proportionality.

a It is a clear distinct figure, easy to remember and understand and interpret for any audience, young and old.

❒ Due to its simplicity, it is less confusing because one can immediately see the foods to emphasize and the foods to eat less of. We use action words such as eat most, eat more, eat some, and eat a little.

❒ There is focus and it is easy to identify the food groups to choose from.

G It concurs with our current clinical recommendations of eating higher complex carbohydrates, low protein, low saturated fat and high fiber. Hence, it is good to follow for those with chronic diseases such as diabetes, chronic heart diseases, hypertension, dyslipidemia, gout, arthritis, certain types of can-

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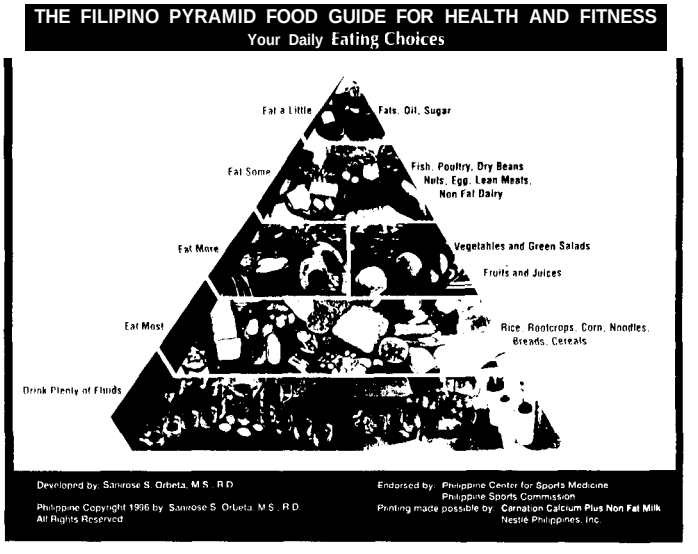

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DiabetesWatch
A publication of the
Philippine Diabetes Association. Inc.

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