

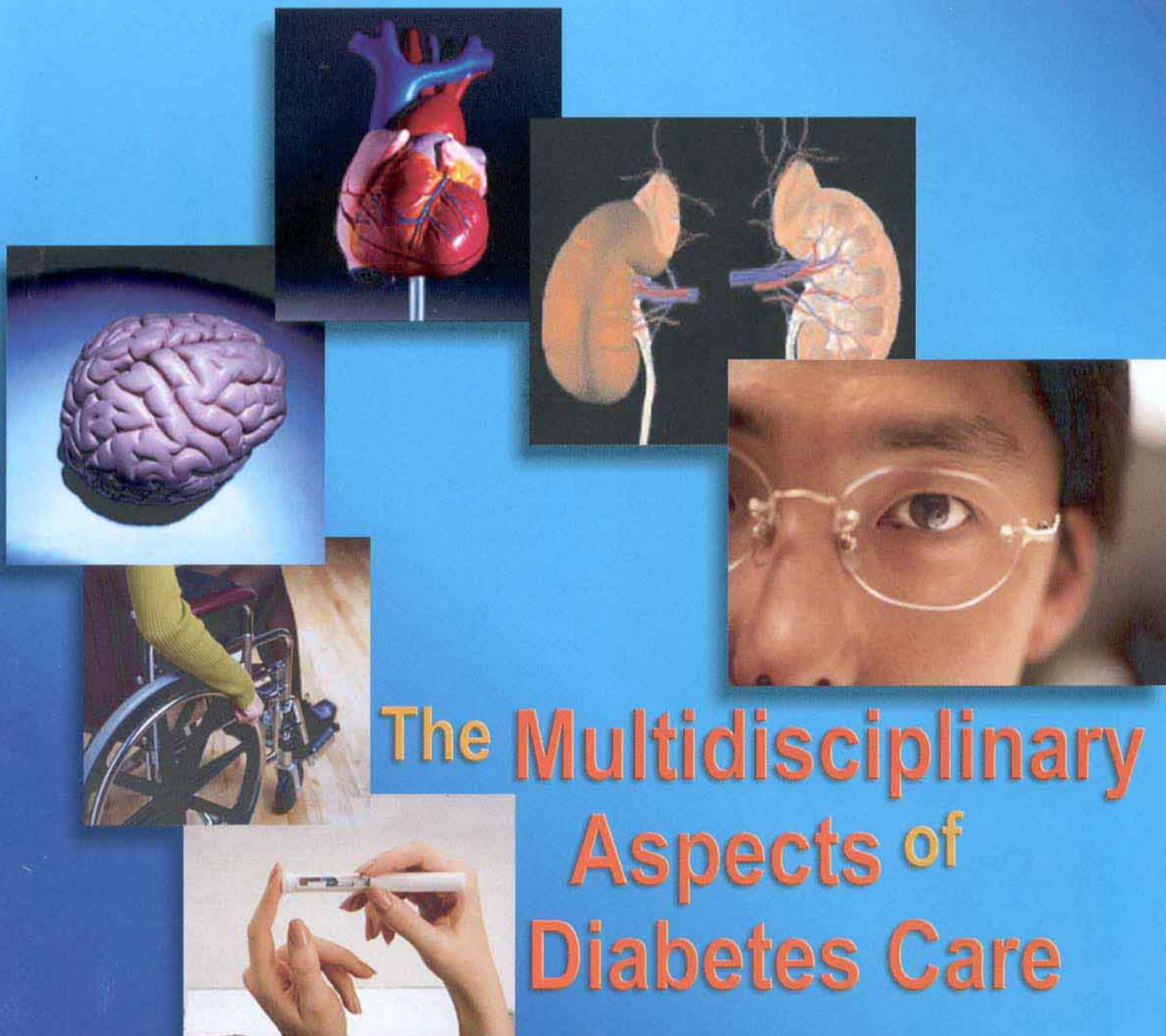


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The Multidisciplinary
Aspects of
Diabetes Care



REFLECTIONS OF AN ELDERLY DIABETIC

RICARDO E. FERNANDO, MD
St. Luke's Medical Center



I turned seventy three in May this year. In 1995 while on a diabetes workshop in Mindanao, at the height of "Red Tide" in Luzon, we stumbled into a unique seafood restaurant in the middle of fish ponds – oysters, crabs, shrimps, fish and what have you – ad libitum together with three cans of Cali (eat all you can, drink all you can!!). The restaurant ran out of boiled rice with the twelve of us filling up ourselves "in compensation" for the inhibition we had to go through in Luzon.

The following morning I registered an FBS of 385 mgs. thrice done. I was caught not practicing what I was preaching! For a while I had forgotten that I had an uncle who was a diabetic. Fortunately, the hyperglycemia was not too difficult to control. Initially I kept on reminding myself that I had no business counseling diabetics if I cannot control my own blood sugars properly. The next tragedy happened in New York City on September 11, where I was caught without medicines for one week, thanks to Bin Laden. It was not too difficult to correct that upon arrival in the Philippines. Like I always tell my patients – (Disiplina ang Kailangan) – especially when my drugs were not available in the USA.

I still cannot understand why so many diabetics want to hide their disease when there are 300 million of us all over the world. I have always been an optimist even in the midst of the worst that life has doled out to us. When we suffered a very severe financial crisis in the earlier days – with the threat of imprisonment – we turned our faces up to heaven and said "The worst has come,



we are down under. There is no other way but up." And we found out that God really does listen to our prayers.

I started to put up the Institute for Studies on Diabetes in 1989 and over the years we have encountered all the worst that the devil could devise to put us down. We all looked up and today the sun is still shining. In spite of all the miseries and evil in this world, this still is my Father's world! All depressed diabetics should rank themselves "with the lilies of the fields and the birds of the air" – heaven has not forgotten you!

Like the man called Job in the Good Book, there is no challenge to man's existence that one cannot face successfully when the connections are right. I have a picture on my desk which

has a quotation that continues to inspire me – "The task ahead of us can never be greater than the power behind us." I would like to paraphrase it thus – "the problems of the diabetic cannot be greater than the One who really cares for us."

I often tease my patients when I ask if they know how to pray. The answer often is "I pray everyday." I would then suggest that they pray more and harder. "Kulitin nyo ang langit!" Nothing better could consistently help those who are despondent.

Food? I love vegetables, thanks to my mother's prodding. *Upo, Chayote, kalabasa, ampalaya, carrots, pipino*. Seafoods? Yes! Avoiding oil as much as possible. Chicken breast without skin. Changing lifestyle is no easy work among a population that has grown up over a hundred years with softdrinks and hamburgers and ham and butter. But where one's future depends on it – eat to live, not live to eat.

Many people at this age become so obsessed with "the nearness of death" especially when plagued by various complications. With a little help from above, this can easily be converted to

"the nearness of life." We always talk about the beauty of heaven but seem to be hesitant to go up there. And many people pass on without being able to say "O grave where is thy victory, O death where is thy sting!"

Living life to the fullest is not the sole property of the physically healthy alone. It is a distinction of all people who persistently look up... not down.



Expert Recommendations

The American Diabetes Association (ADA) recommends immunization *for all patients with diabetes, from age 6 months and older, beginning each September.* The influenza vaccine should be systematically given to diabetic patients who live in nursing homes, for those who need regular check-ups or are frequently hospitalized, or those who also have heart or lung disease. The best time to receive influenza vaccine from October-November, just before the start of the season.

Go get your vaccine before the flu season begins

The dose and type of vaccine administered depends on the patient's age. Because the flu strains change from year to year, vaccines are made from strains of influenza A and B most likely to circulate in the U.S. during the winter. The Philippines, although equatorial, has flu patterns similar to the northern hemisphere, and the vaccines distributed in the country are appropriate for our part of the world.

Immunity to influenza fades over time, so yearly vaccination is necessary. There is no need to get more than one shot within the same flu season.

Ramon Caray, product manager for adult vaccines of Aventis Pasteur, points out that the WHO recommended current vaccine for 2002-2003 includes Influenza A/Moscow virus which is the most isolated strain in the country based on the January-July flu surveillance at the RITM.

Vaxigrip, a trivalent split-virus flu vaccine available from Aventis Pasteur, has been proven effective and safe in preventing flu. It is preferred because it is better able to provoke an immune response and because it will not cause any flu-like symptoms.

The most common side effect is a mild soreness at the vaccination site—a small price to pay for a potentially life-saving treatment.

Don't end up like Leonard: ask your doctor about the flu vaccination today.

SIDE BAR:

WHAT CAN I EXPECT FROM A FLU VACCINATION?

From Aventis Pasteur

By getting vaccinated you will:

- Avoid illness, and therefore absenteeism from work, or spoiling your holidays
- You will reduce the risk of transmitting flu to family members, friends or co-workers
- You will improve your quality of life and leisure time, reduce the risk of job stress by avoiding long absences, or just simply avoid an annoying illness
- Remember it will be life saving for people at risk

Camp Cope

Lucky "7"

JOSE S. MIRANDA, MD

Program Director, Camp Cope

Camp was held in our "home" – Forest Club at Bgy. Masaya, Puypuy, Laguna. It was held last May 23 to 26, 2002.

Day 1. We all went to the plant of Mead Johnson where we had a tour, had yoga exercise, learned how to make cartoons, and made some dessert. We arrived at the camp, had orientation... then the fellowship night. That was some night. We had some guests of entertainment. Some sang songs, the other one sang and danced (who says we're shy!).

Day 2. Exercise in the morning, followed by rap sessions, and indoor games. That afternoon, it was fiesta time. We had native games such as pukpok palayaok, kadang-kadang, and hulihang baboy. It was a great exercise for the campers and the pigs... Trees were planted that afternoon. At night, we had swimming and games by the pool.

Day 3. Were we tired? Nope. Exercise in the morning, followed by rap sessions, camp feud, and arts and crafts. That afternoon, activities were ceramic painting, palm print – we all had our hands imprinted on a big banner, fishing and outdoor games. This year being our seventh year, the theme was "Uncle Bob's Lucky Seven Party." These kids were really talented. The puppet show was very entertaining.

Day 4. A bazaar was set up showcasing all the arts, crafts, and writings of all the campers and counselors. Of course, if last year we had "Reynas" in our Santacruzán, this year we had "Hari" for a change. We had "Hari" ng diyeta, ehersisyo, and metro. A mass was followed then the awarding and closing ceremonies.

Bonding and sharing. The rap sessions were very "touching". Letting it out, sharing experiences as a diabetic made our campers and counselors feel at home with each other. Everyone has his/her own experience to tell. Some may have been very vocal, some expressed through art, and some expressed by just being there all the time, joining in all of the activities. All had a great time, there was never a dull moment.

Just like in a family, as the years go by, the feeling of fulfillment come to your senses when you see your kids (campers) become more mature and responsible. This is how I see it in this year's camp. It had been seven years and we are still growing and learning new things. This holds true for the campers, counselors, and staff.

We are all looking forward for more years of camp. Seven is just a milestone. A lucky number, so to speak. It was really lucky and fulfilling for all of us. We may have new campers, but they seemed to have been with us for a long time. This 4 days of camp, we made new friends, learned a lot of things about diabetes, and had great fun.

Diabetes and the Flu: Nothing to Sneeze At

PATRICIA B. GATBONTON, MD
Endocrinologist, Our Lady of Lourdes Hospital

It is a little known piece of health trivia, but Leonard Thompson, the first person ever to receive insulin, died in 1935, not of his diabetes, but of complications from pneumonia that followed the flu. Even today, some 80 years later, the poor success rate in preventing death or serious illness from influenza in patients with diabetes is mostly due to lack of preventive immunization.

Around since ancient civilizations, (Hippocrates recorded an outbreak of the flu in 412 BC), this old disease has managed to stay around because of its unique ability to reinvent itself time and again.

Each year, some 10 percent of the world's population, an astounding 500 million people in all, come down with the flu.

Influenza, commonly known as the flu, is a contagious viral infection – a constant health threat that requires prevention as well as early diagnosis and treatment. A subset of the population, the very young (between 6 months and two years old) and persons 50 years old and above have a high risk of being hospitalized from serious complications of the flu like pneumonia.

To date, three worldwide outbreaks (pandemics) have cost millions of lives. Reducing the toll of future epidemics is now possible with vaccines that have been proven to reduce complications in adults with underlying medical conditions like diabetics.

A deadly duo

Diabetes and the flu are a deadly duo. Diabetics are more prone to catch the flu, and when infected, become sicker than the non-diabetic patients. Our immune system, which helps us fight infection, does not function normally when blood sugars are high; though the vaccine itself does not raise insulin levels or worsen glucose control. Complications like pneumonia and blood borne-infections occur more frequently because diabetics usually have other problems, such as chronic heart and kidney disease.

Diabetic patients should be counseled to have a yearly flu shot, just as they should have yearly foot and eye exams by professionals.

Flu season lasts all year long

The Philippines, a tropical country, has flu all year round. Two peaks are identified: at the start of the rainy season and at the beginning of the cold “-ber” months. This is in contrast

to the northern and the southern hemispheres whose flu season is seasonal, and begins at the onset of winter.

The Department of Health in 2000 ranked the flu and influenza like illnesses (ILIs) as the 4th leading cause of morbidity in the country.

The latest flu surveillance data from January-July 2002 shows that the Influenza A/Moscow strain was the predominant isolate (39 percent of samples).

One smart virus

The influenza virus is able to re-infect humans year after year by reinventing itself. This it does by continuously making small changes in the way it replicates its genetic material. Through this process, the virus can keep reinvading a person's immune system, because the system is in effect faced by a new strain of flu virus every time.

The virus is airborne, and is passed on through droplets from the coughs and sneezes of the infected person that a healthy person nearby may inhale. The virus can live for several hours outside the human body; replicates within 4-6 hours; and the contaminated person begins to feel ill between 18 and 72 hours after being exposed.

The common cold does not equal the flu

The symptoms of flu: fever-cough, headache, muscle pain and prostration-are familiar to everyone. A hallmark of the flu is that the symptoms develop rapidly. One minute you're fine, the next minute you're flat in bed. Sore throat, while common, is generally not severe. Redness, tearing and light sensitivity of the eyes is yet another common symptom.

For all frail, elderly patient the only symptoms may be tiredness, confusion, and a stuffy nose. Physical findings are generally not helpful. Although most people use the terms “colds and flu” to mean the same thing, we need to differentiate influenza from the common cold, which is caused mostly by rhinoviruses.

With the flu, fever is usually high, lasts 3-4 days; cough is a frequent and early symptom; headache is prominent and often disabling. Your body feels beat up, and even after you are “well”, you may feel physically exhausted for many weeks.

Prevention is key: Vaccination the answer

The main way to prevent influenza is vaccination. In the United States, more than 65 percent of adults over age 65 are routinely immunized, as are the majority of nursing home residents. The biggest problem: immunization rates are very low among the population that will most benefit from vaccination. Only 30 percent of high-risk patients, including those with diabetes under age 65 years, receive the flu vaccine. This number is probably even lower in the Philippines. Clearly, immunization rates need to be improved in patients with diabetes.

Focus on Fiber... From page 18

oranges and other fruits may be added to dishes such as biscuits, muffins, puddings and sauces.

8. Proceed cooked vegetables such as beans, carrots, peas, spinach, squash, singkamas may be used to thicken sauces and soup.

Yet, take this word of caution, a sudden change from a low fiber diet to a high fiber diet may result in digestive problems such as bowel pains, excessive gas (flatulence) and diarrhea.

There should be liberal amounts of water, about 10-12 glasses per day should be ingested.

All in all, exercise moderation and better still consult your doctor/dietitian for more specific nutrition related questions on the intake of fiber. A variety of whole grain products, fruit and vegetables will ensure a good mixture of fiber constituents, and make a positive contribution to the over all nutritional value of the diet.

Happy Fiber Eating Day!

SOME FOOD SOURCES OF INSOLUBLE AND SOLUBLE DIETARY FIBER

INSOLUBLE FIBER

Brown rice
Fruits and vegetables skins,
and peels
Green beans
Green peas
Nuts
Rice bran
Wheat bran
Whole grain products

SOLUBLE FIBER

Apples Oats
Barley Oranges
Broccoli Potatoes
Carrots
Corn
Dried beans
Grapefruit
Oat bean

AMONG LOCALLY AVAILABLE FOODS, THE FOLLOWING ARE GOOD SOURCES OF DIETARY FIBER

Corn on a cob	Apple with skin
Whole wheat bread	Avocado
Espasol	Chico
Puto, puti	Tiesa
Suman sa ibos	Guava
Suman sa lihiya	Watermelon
Sotanghon, cooked	Bataw
Bihon, cooked	Kadyos
Peanuts, boiled	green langka, cooked
Soybeans	sigarilyas
Tokwa	

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REFERENCES: 1. Benfante RA, et al. Great Therapeutic Role. Diabetes 1994; 43: 217-221. 2. NIH Consensus Doc. Full Prescribing Information is Available Upon Request. Bristol-Myers Squibb (Phil.) Inc. Extending & Enhancing Human Life. Source: 1. Lonn M, Hansson L, et al. Effect of angiotensin-converting-enzyme inhibition compared with conventional therapy on cardiovascular morbidity and mortality in hypertension: The Capoten Prevention Project (CAPT), randomized trial. The Lancet 1992; 352: 811-816.

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Being there

What has no calories, prevents constipation, may lower the risk of colon cancer and diabetes, and is generally underconsumed by people selecting a western-type diet?

- A. WATER
- B. DIETARY FIBER
- C. GELATIN

The answer is B. DIETARY FIBER.

Over the years, fiber has been discussed in terms of "crude fiber" which is simply the residue after a food sample is treated in the laboratory with a solvent, hot acid, and hot alkali.

Dietary fiber on the other hand, is defined as including all the components of a food that are not broken down by enzymes in the human digestive tract to produce small molecular compounds which are absorbed into the blood stream. They come in both fibrous (insoluble) and nonfibrous (soluble) forms, and many foods contain both types of fiber.

Thus it is incorrect to use "crude fiber" in dietary descriptions which becomes of limited value, since it may represent about as little as one-seventh of the total dietary fiber of the food. Let's take fruit as an example, its value is particularly understated by this method. Even the word "fiber" might be misleading, since not all the components of "dietary fiber" are fibrous in the usual physical sense, while foods that do not contain recognizable fibers, such as muscle meats, do not yield undigestible residue.

What are the benefits of Dietary Fiber?

1. It relieves constipation problems by increasing the water content of stool thus decreasing pressure within the colon.
2. It may protect against the development of colorectal cancer by decreasing colonic transit time.
3. It has a positive impact on weight

control because it delays gastric emptying time and enhances a feeling of fullness.

4. It improves glucose tolerance by delaying the movement of carbohydrates into the small intestine.
5. It removes cholesterol by binding with bile in the intestine and causing it to be excreted.

DIETARY GUIDELINES ON FIBER

Different countries have their own dietary guidelines. These are fundamental guidelines that will help contribute good health through proper nutrition.

bring beneficial effects to our body.

To summarize, the health benefits of Insoluble (fibrous) and soluble (non-fibrous) dietary fiber is that:

INSOLUBLE

FIBER - Prevents Constipation
Avoid Hemorrhoids

SOLUBLE

FIBER - Lowers blood cholesterol
Delays glucose absorption

For those who do not wish to bother calculating fiber and calorie contents, here are some suggestions:

1. All plant foods are likely to contain more fiber than animal foods unless they are properly cooked.

KITCHEN CORNER

FOCUS ON FIBER

MA. ELOISA E. VILLARAZA, RND
Dietitian, St. Luke's Medical Center

The Nutritional Guidelines for Filipinos 2000 which was developed by the Technical Working Group on the Nutritional Guidelines for Filipinos led by the Food and Nutrition Research Institute of the Department of Science and Technology (FNRI-DOST) has emphasized in guideline No. 5 – EAT MORE VEGETABLES, FRUITS AND ROOTCROPS. And these are the very foods where we can get our dietary fiber onto our dining tables.

As to how much fiber is recommended, there still has to have some scientific evidence of how much is enough. Based on observation and reported few studies, the dietary fiber intake of Filipino ranges from 9 to 10 grams per day. Dietitians recommend at least an intake of 10-20 grams which will

2. Fresh, unrefined foods usually contain more fiber than processed food.
3. Green leafy vegetables and stems of plants are higher in fiber than starchy roots and tubers. An exception to this rule is the inulin containing roots and fibers.
4. Seed coats of grains and legumes are high in fiber, as are the skins and peels of fruits and vegetables.
5. The sprouting of seeds results in more fiber and less food energy.
6. Whole fruits and vegetables usually contain more non nutritional carbohydrates than the juices extracted from them, since juice extraction generally involves removal of the fiber by straining or other means.
7. The pulpy residue from the juicing of

Continued on page 19



Yes Virginia, Santa Claus is ^{Probably} Diabetic

PATRICIA B. GATBONTON, MD

Endocrinologist, Our Lady of Lourdes Hospital

Letter received by e-mail:

Dear Madam,

I am writing because Santa Claus has a really big tummy like my daddy. Daddy went to a doctor. His doctor does not allow him to eat a lot anymore because he has diabetes. Could Santa be sick, too, like daddy?

Love,
Virginia, 11

From out of the mouth of babes indeed. It took a child to bring to our attention a very logical, possible association. Could Santa Claus be sick? Could he be diabetic like Virginia's father?

Jolly old St. Nicholas, Santa Claus, Father Christmas, whatever name he goes by, exudes holiday cheer, his hearty chuckles and "ho, ho, hos" are synonymous with Christmas. A universal figure, Santa is familiar to everyone—even in places where it does not even snow.

Virginia certainly got me thinking, so I researched that classic, *A Visit from St. Nicholas* by Clement Moore, which narrates Santa's journey from home to home on Christmas Eve. Perhaps it could give me some clues.

It was the night before Christmas

Father in the story has the first—and it turns out, the only sighting of St. Nick. Woken by a clatter on the roof he says:

*"...to my wondering eyes should appear,
but a miniature sleigh and eight tiny reindeer.
With a little old driver, so lively and quick,
I knew in a moment it must be St. Nick."*

We can tell from Father's description, that St. Nicholas is old, but physically fit, he comes down the chimney with "a bound." He is pretty strong too, for he could carry:

*"A bundle of toys he had flung on his back,
He looked like a peddler just opening his pack."*

Father's superficial (and subjective) description continues as follows:

*"His eyes—how they twinkled! His dimples, how merry!
His cheeks were like roses, his nose like a cherry!
His droll little mouth was drawn up like a bow;
And the beard of his chin was as white as the snow.
The stump of a pipe he held tight in his teeth,
And the smoke, it encircled his head like a wreath.
He had a broad face and a little round belly,
That shook when he laughed, like a bowl full of jelly.
He was chubby and plump, a right jolly old elf
And I laughed when I saw him in spite of myself."*

Santa Claus had a broad face, and a round belly, chubby and plump, with a stomach that was jiggly.

The tale of the tape

What interests me, a physician, is why Santa's cheeks and nose were so red, with a facial plethora. Were

his cheeks red and rosy (flushed) purely from the cold weather? (I would expect him to be blue with frostbite.) Other possibilities to consider perhaps: arterial hypertension, or maybe a little (or a lot) of alcohol on the sleigh ride over to warm up on the long journey from the Arctic Circle?

Santa obviously has a large abdomen, with the fat centrally located around his paunch (nowadays referred to as a beer belly). Of the several ways to measure degree of obesity available to us, the simplest would be a body mass index (BMI), the waist circumference and the waist/hip ratio.

All we need to do is get a tape measure around Santa's waist and hips. If his waistline is greater than 35 inches, Santa satisfies the criteria for 'android obesity.'

Or if Santa's waist-hip ratio were greater than 0.9, he would also fulfill the criteria.

To calculate BMI, we need to know both his height and weight. Unfortunately we have no idea from the story how tall Santa is — Father refers to him as a jolly old elf.

Can we infer from 'elf' that Santa is short? In the fairy lore of Tolkien's Middle Earth, imps, gnomes and dwarfs are traditionally short (as are hobbits). But Elves-like Legolas and Elrond - stand as tall as men. I digress.

In this case, given Father's scant information, we would not be able to calculate Santa's body mass index (BMI), or waist circumference accurately.

Short of conducting a proper physical examination myself, (or getting information from a more reliable eyewitness than Father), by eyeballing Santa from every angle, in every picture ever taken of him, you will conclude that he is pretty hefty. By World Health Organization classification at least obese class 1 (BMI >30). I am sure no self respecting physician will argue with me.

Maybe Rudolph, or one of the other reindeer pulling his sleigh, might give us an idea of how much extra weight they are pulling.

Apples or pears

Android (or apple shape, or male pattern) obesity is highly associated with the insulin resistance syndrome. Also known as Syndrome X, it is a clustering of cardiovascular and metabolic problems that includes: elevated insulin levels, high blood pressure, abnormal blood sugars (may not yet reach diabetic levels), high total and bad cholesterol levels, and high uric acid levels among others.

This is in contrast to gynecoid (or pear shape, or female pattern) obesity where fat deposits at the buttocks and hips and has no association to the aforementioned problems.

Santa better watch out

Because Santa has been around town a long time (his longevity is amazing), he is at the age where chronic lifestyle diseases develop.

It is no surprise that Santa is obese. Even if he appears fit and strong, remember Father's description will be 180 years old in 2003. Santa has aged since the

story was first told, and by all accounts, now lives a sedentary lifestyle. He rides a sleigh instead of walking (one reindeer, Vixen, mighty vexed, wants extra pay for excess baggage, and she doesn't mean toys). Santa now merely supervises all his elves at the toy factory, and does no manual labor of his own. (He spends all his time answering fan-mail.) Just think of all those gallons of milk (full-cream no less) and cookies (Oreo's or chocolate chip are favorites) he consumes at every single household he visits, every season.

Worse of all, Santa cannot seem to kick the habit, he is still puffing away (even if he insists he does not inhale) at his pipe.

When Santa Claus next comes to town

Santa needs to get a proper medical examination, get some blood tests and whatever else his doctor thinks necessary, including medication. The most important: Santa needs to overhaul his lifestyle.

What can you, boys and girls (young and old), do to help old Santa out?

For starters, don't stress him out with too long a wish list. He needs to spend less time answering fan mail and seeing to each of your wish list toys. That will free him up for plenty of exercise time.

Don't leave Santa cookies; serve fruit and yogurt, or if you insist, lower calorie snacks like skyflakes or ginger cookies. Leave skim milk, or a diet decaffeinated softdrink. Or a short, decaf, non-fat cafe latte from Starbucks, but hold the almond biscotti. Water is best: all natural, no calories.

Put a NO SMOKING sign at the door (or chimney entrance), and don't leave an ashtray lying around.

Have a sign at the bottom of your drive: PARK REINDEER HERE, so Santa will have to walk up to the house. Install rungs in your chimney stack so Santa will have to climb down, then up again.

If we all cooperate, next Christmas season when Santa comes to town, we may not recognize him. He will be a shadow of his former self, leaner, but definitely healthier.

Editor's last word to Virginia

Yes, Virginia, Santa Claus is probably diabetic for all the reasons I already gave. If not now, he may be by 2025 — when there will be 300 million other people all over the world with diabetes.

But don't worry, both your daddy and Santa can reduce their risk for diabetes (and for being stuck in the chimney) by doing all the things doctors suggest.

Most of all, Virginia: Pray that Santa (and daddy), be good, for goodness sake!

Love, Patricia

P.S. I almost forgot, to quote Santa Claus himself: "Merry Christmas to all, and to all a goodnight!"



How I Survived Diabetes

Mrs. Nenita U. Socrates

Retired UP Professor

Diabetes has never been a stranger to me. Even before I was in Grade 1, I already had an intimate knowledge with this killer disease. I remember my obese, very pretty grandmother with a gargantuan appetite who did not walk but waddled like a duck.

They had a big house and underneath was a spacious camarin (storehouse) exclusively for food jars of pickled salted meat (pork, beef, venison and even monkey meat), hanging from big hooks fixed on racks. There were big baskets of different kinds of fruits, *chicos*, *mangoes*, harvested from their many farms scattered all over the province and brought by bancas cruising along the Cagayan River. Abundant were *panocha* (brown sugar molded into halved coconut shell; eaten like hard candy), jars of *muscavado* (highly unprocessed, crystal-coarse granules of brown sugar), and sacks of regular and glutinous rice. Grandmother could finish four huge mangoes in one sitting and she loved to mold her cooked rice into balls and roll it in muscavado. In her pocket she would always have bits of *panocha* for her candy. I never saw my grandmother without a bowl of native rice cake (*suman*) near her. To her good food meant meat, preferably pork with thick fat. Vegetables, especially leafy ones were not served at the table, relegated eating only for goats. My grandmother, died before her 50th birthday of a stroke when we were no longer in Ilocos. She knew she had diabetes but she did not take this seriously.

Grandma's whole family was diabetic, most of its offspring also became diabetics. An aunt's daughter, my first cousin, lost both legs and became blind. A first cousin was incapacitated as both legs were amputated due to diabetes. She died a few years after. Her daughter and a son both became blind.

It was in early 1974 that I became a confirmed adult diabetic. Joe, my husband, whose parents were both diabetics, likewise became an adult diabetic ten years or so after.

It is easier to follow more faithfully the rigorous, restrictive regimen of diabetics if there are two of you living with those demands. My husband and I cooperate with each other, trying to enjoy life under such strict requirements. It was relatively easier for me,

since I'm a psychologist I have succeeded beautifully to actively detest 'harmful' food and to love 'healthy food'. I became a vegetable/fish/fowl lover. It helps that except for ice cream, I have never enjoyed pastries, sweets and candy, not even American chocolate bars. My husband was more often tempted to eat forbidden dishes.

Aside from our regularly testing our blood sugar with the One Touch Glucose Monitor, we have been submitting ourselves twice a year to glycohemoglobin test.

My father had always instilled in me to respect diabetes as it is a deadly, treacherous disease. It is incurable but it can be controlled by diet, exercise and medication. Personally, I would add another factor, self-discipline. From the onset of my malady, my husband and I walked briskly around the UP campus where we were both teaching, or wherever we were, for an hour, every morning. We bought a treadmill to exercise on when it rained, or for some reason we could not exercise outdoors. Even when we were traveling on a cruise or visiting our children abroad, we never missed our one-hour walk.

We continued our daily one-hour walk until November 1998 when I was felled by a diabetic stroke that affected my left side and rendered me incapable of walking without the aid of a walker. I did not suffer from elevated blood pressure or cholesterol or from any heart problem. The doctor told me that had I not exercised and walked daily and monitored my food intake, the effect of the stroke would have been more devastating. I placed myself under the care of a rehabilitation doctor and a physical therapist. Religiously and consistently, I followed an almost one-and-a-half hour of daily exercise and walking

between two sets of parallel bars- one set outdoors, the other indoors. Likewise, my husband also suffered from a diabetic stroke towards the end of 2001. (Incidentally, my husband died of prostate cancer that had metastasized to his bones 06 June 2002.)

From the time I had the stroke, and way beyond even after Joe's death, I never miss my ½ hour daily exercise which consists of sets of exercises taught to me by my doctor in rehabilitation medicine. Part of the exercise is done while I am lying down, half an hour is for walking briskly with a walker without wheels that has to be lifted. I have therma bands with the strongest resistance and I also use weights. I religiously do this because I fear the onslaught of osteoporosis which aged people like me are prone to, and is painful and disabling.

Last 17 August 2002, I went to Dr. Manuel Agulto, my ophthalmologist for years, for one of my bi-yearly required eye examination. He gave me a clean bill of health. I reminded him that I had been a diabetic for 28 years, and except for my diabetic stroke, I had been spared from other major complications. The kind doctor replied, "This is because you have kept your diabetes well controlled."

It is difficult to live with your diabetes, but only at the start. It takes a tremendous amount of will-power to live the way you are advised to live if you want to shield yourself from the vicious onslaught of your disease. But this is only at the beginning, after a while, you do not need will power for you will find yourself wanting to live harmoniously with your diabetes, coming to terms with the reality of the disease. It is no longer a sacrifice, but a matter of choice, a happy acceptance of your life, an armour from destruction.

In my old age of 78 years, my life has been a life of moderation, I just want to live a healthy life. This has always meant no nicotine, no coffee or chocolate or alcoholic drinks, soft drinks, not even diet drinks, no red meat, no fat, no pastries or anything sweet. I keep my weight down, sleep well, avoid stress and traveling in smog-filled avenues. Sure I eat "forbidden" food sometimes—a few teaspoons of ice cream, sizzling lechon, chicharon and other sinful delicacies, but always in moderation and very seldom. Besides, I have stopped really hankering for these, realizing that to me, they are no longer as desirable as they used to be. And this is not sour grapes... I embrace this life with acceptance, and more with passion and love.



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caution if liver disease is present.

Metformin can be used in the elderly but not in the presence of renal insufficiency, congestive heart failure, hypoxic states, acute illnesses, severe infections, liver disease, and hemodynamic instability because of the increased risk of developing lactic acidosis. Alpha-glucosidase inhibitors, which inhibit conversion of starches to monosaccharides thereby slowing glu-

cose absorption and tempering the rise in postprandial glucose, have not been widely tested in the elderly but are generally safe and effective. They are limited though by side effects of flatulence and diarrhea. Thiazolidinediones reverse insulin resistance and increase insulin secretion and may be used in patients with impaired renal function, however hepatotoxicity is a concern, and their use in the elderly is still limited. Insulin is often underutilized in the elderly because of the perception that it is difficult to use or dangerous. However it can control hyperglycemia very well and improve quality of life. If the patient cannot check his blood glucose or administer insulin himself, proper education and instructions can be given

to a capable caregiver.

Retinopathy

Studies looking at diabetic retinopathy in those over 70 years of age showed that it occurs in only 15 to 20 percent of patients. However, annual eye examinations are still recommended because cataracts and glaucoma are twice to thrice as common in the elderly diabetic. Also increasing poor vision with age can lead to accidents, decreased mobility, social isolation, inability to read medicine labels, and measure blood glucose or insulin doses.

Nephropathy

Routine screening for microalbuminuria is generally not recommended for those over 70 years of age, unless dealing with a "physiologically young" elderly diabetic, because the interval to the development of end stage renal failure is over 10 years. In addition, albuminuria in the elderly may be due to other causes and not necessarily due to diabetic nephropathy.

Foot Problems

The prevalence of diabetic neuropathy is more than 50 percent in those above 60 years. With increasing age, vascular and neurologic disease becomes more prevalent. Foot problems pose an important concern for the elderly diabetic and may cause morbidity. It is therefore recommended that a foot examination be performed at every doctor visit, and detailed neurological and peripheral vascular assessments be done every year or as warranted.

Cardiovascular Disease

Coronary heart disease (CHD) is the leading cause of death in elderly diabetics. The following interventions may help in reducing their risk of

CHD: treating hypertension and dyslipidemia, exercising, stopping smoking and taking aspirin.

For elderly hypertensive diabetics, the goal is to lower systolic BP to < 160 mm Hg and to lower diastolic BP to 85-90 mmHg. Angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) can be used in the elderly because these drugs have minimal metabolic complications and they have been shown to provide significant cardiovascular benefits in the higher risk older diabetic.

For dyslipidemia, clinical trials have shown that benefits may be seen with cholesterol lowering in patients with CHD in as early six months of therapy. Several years was previously believed to be the time interval to see any effects or expected benefits from cholesterol lowering on atherosclerosis. Current recommendations are to start treatment if LDL cholesterol is > 100 mg/dl with a goal of 70-80 mg/dl, especially if they already have cardiovascular disease. The benefit of lowering cholesterol in elderly patients is similar to the young adult. Statins may be used for hypercholesterolemia and mild hypertriglyceridemia, whereas fibric acid derivatives may be used for marked hypertriglyceridemia.

Exercise will improve insulin sensitivity in diabetics, reduce cardiovascular risk, as well as help them maintain physical function. Weight training added to aerobic exercise has been shown to be beneficial in the frail elderly.

Unless they have a contraindication to taking aspirin, it is generally recommended to take 325 mg of enteric coated aspirin daily as primary prevention, as well as secondary prevention for those already with evidence of large-vessel vascular disease.

How do we treat elderly diabetics? Should we observe strict glycemic control? Can we be liberal with their diet and nutrition? Given their advanced age, should we be as concerned with the development of microvascular (retinopathy, nephropathy) and macrovascular complications (cardiovascular disease)? How about control of blood pressure and cholesterol levels? Are any of the medications used to treat diabetes in the young contraindicated in the elderly?

The geriatric population, defined as persons aged 65 years and older, is increasing in number as health care improves. With aging, there are changes that occur in the physiology and function of the body. The elderly are of special concern to us because of their increased functional disability, multiple medical problems and multisystem diseases, as well as accompanying polypharmacy.

The prevalence of diabetes increases with age, and is estimated to be between 10-20 percent in the geriatric age group. There is increased glucose intolerance caused by a decrease in peripheral glucose utilization and metabolism, and a decrease in insulin secretion. Changes in their body composition (more fat and less muscle), physical inactivity and poor diet are also contributory factors.

Certain medications they may be on, such as thiazide diuretics, glucocorticoids, estrogen, lithium, phenothiazines, nicotinic acid, and sugar containing medications may contribute to or exacerbate hyperglycemia.

Diagnosis

The same criteria used to diagnose diabetes in younger persons is used to diagnose diabetes in the elderly: fasting blood sugar <110mg/dl – normal, 110-125mg/dl – impaired fasting glucose, and >125 mg/dl – diabetes.



HEALTH CONCERN ELDERLY DIA

Jocelyn Jayme Wohld
Endocrinologist, St. Luke's Med

Complications secondary to hyperglycemia develop in the elderly too.

Uncontrolled hyperglycemia in the elderly may lead to dehydration which can result in a functional decline in mentation and alteration in cognition. The elderly have an impaired thirst perception and do not develop polydipsia as younger individuals may do. This is one reason why they develop hyperosmolar states more frequently. Polyuria may manifest as urinary incontinence rather than as complaints of frequent urination. Elderly men may dismiss their symptoms as secondary to prostatic hypertrophy. Hyperglycemia may impair vision leading to an increased risk of falls and accidents.

Hypoglycemia on the other hand, may manifest mainly with neuroglycopenic symptoms such as confusion, rather than adrenergic symptoms such as sweating, nervousness and tremor because of autonomic nerve dysfunction. If the elderly person is disabled, they may not have ready access to food and may not respond appropriately to reverse their hypoglycemia.

Glycemic control

Target HbA1c levels need to be decided on an individual basis. A "physiologically young" elderly diabetic who is expected to have 5 to 15 more years of life expectancy should aim for an HbA1c of 7 to 8% to decrease their risk of developing microvascular complications. Whereas in an elderly individual who is expected to have less

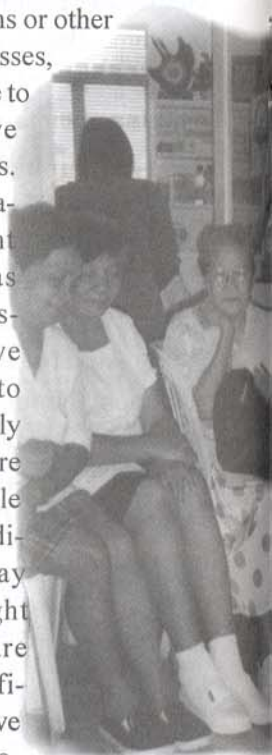
than 5 years of life expectancy and has chronic complications or other life-threatening illnesses, it may be appropriate to allow them to have higher HbA1c levels. Dementia is a contraindication for tight control, whereas severe physical disability is a relative contraindication to tight control especially if food and drink are not readily accessible to them. Other conditions which may contraindicate tight glucose control are chronic renal insufficiency, cirrhosis, active alcoholism, and autonomic nerve dysfunction.

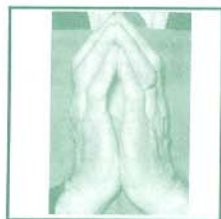
Nutrition

Diet remains an important cornerstone of therapy for the elderly. They are equally at risk for developing malnutrition as they are for developing obesity. Quality of life may be improved with less restrictive diets without sacrificing glycemic control.

Medications

Oral hypoglycemic agents as well as insulin are safe in the elderly, albeit with limitations for particular drugs. Sulfonylureas, especially the second generation glipizide and glyburide, may be used in the elderly with renal dysfunction, but should be used with





Oh, My Aching Joints!

ADORA GATLABAYAN-DEL ROSARIO, MD
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When you ask patients coming to the clinic for snapping fingers or shoulder pain if they have diabetes, oftentimes the answer is affirmative. For some patients who don't know they are diabetics, their fasting blood sugars turn out to be elevated when tested in a number of cases.

Stenosing tenosynovitis or "trigger fingers", a catching and snapping of the fingers results from inflammation of the flexor digitorum tendon. In this condition, the finger locks in a painful bent position and then suddenly snaps open. In some cases you may need to straighten your finger out with your other hand. There is tenderness, swelling or small bumps in the palm of your hand. It is frequent in diabetics probably due to excessive glycosylation of collagen in the skin and periarticular structures and to decreased collagen degeneration and removal resulting in thick, inelastic tissues. This pathogenesis has also been implicated in other joint complications of diabetes mellitus like diabetic stiff hand syndrome, Dupuytren's contractures and other soft tissue rheumatisms, such as those commonly affecting the shoulders.

Adhesive capsulitis of the shoulder, with or without calcific tendonitis is well established as a complication of diabetes. It can be associated with frozen shoulder syndrome and with reflex sympathetic dystrophy. Although sometimes associated with recurrent painful tendonitis and bursitis, the

loss of motion can be painless and insidious.

The treatment for stenosing tenosynovitis and adhesive capsulitis consists of non-steroidal anti-inflammatory drugs preferably topical or applied rather than in oral form. Physical therapy is also advocated but if the response is unsatisfactory, we give injections of intralesional steroid combined with anaesthetic agents.

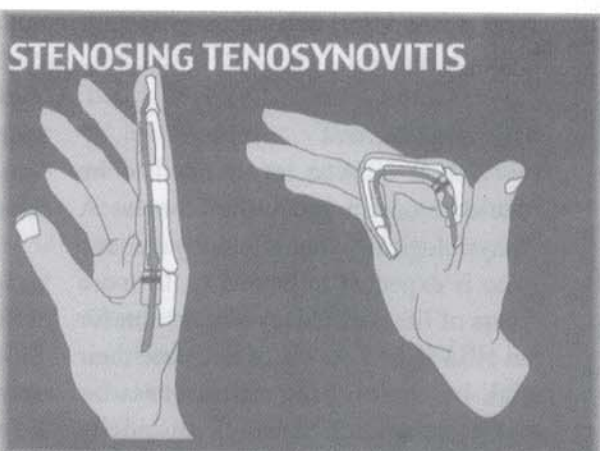
The **diabetic stiff hand syndrome**, also known as diabetic cheirarthropathy and the limited joint mobility syndrome, is a common complication of both type I and type II diabetes mellitus. In its advanced stages the finger remains permanently contracted at the metacarpophalangeal and proximal interphalangeal joints, and the thick shiny skin may resemble that of scleroderma. The "prayer sign" result from progressive thickening of tendons, joint capsules and subcutaneous tissues. It occurs in 30 percent or more of patients with long standing diabetes and is predictive of renal, retinal and other

diabetic complications. Therapy with aldose reductase inhibitor has been reported to be beneficial although further studies are needed.

Dupuytren's contractures may be seen in patient with the diabetic stiff hand syndrome, or they may occur alone. It may be seen relatively early in the course of the disease and the prevalence is about 30 percent in adult diabetics.

Carpal tunnel syndrome occurs in about 25 percent of individuals with diabetes mellitus. This is due to compression of the median nerve as it passes between the wrist bones and strong ligament. This nerve supplies sensation to the first three fingers and part of the ring finger and provides strength to thumb muscle. Symptoms include numbness, sensation of swelling, weakness of the thumb and unexplained hand pain. Surgical release at the proper time is necessary to prevent thenar muscle atrophy.

Diffuse idiopathic skeletal hyperostosis (DISH) has a very strong association with obese type II diabetes. It is manifested by proliferative new bone formation at joint margins, particularly in the axial skeleton, appearing clinically as diminished mobility similar to that seen in ankylosing spondylitis. The pathophysiologic mechanism has not yet been elucidated, although it may be related more to hyperlipidemia and other metabolic factors than to diabetes alone.



treatment options include:

Prokinetic Drugs: Metoclopramide and domperidone stimulates stomach muscle contractions and aid in esophageal and stomach elimination of food. They help control nausea and vomiting. Uncommon side effects include drowsiness, weakness, and problems in bodily movements.

Erythromycin: an antibiotic found to be beneficial by increasing GIT muscle contractions. It improves the stomach's emptying time and helps move food from the esophagus to the small intestine. Occasional complications include nausea and abdominal cramps.

Clonidine: an anti-hypertensive drug useful in diabetic diarrhea. It stimulates the alpha-adrenergic receptors - nerve receptors important in sending information throughout the GIT tract.

Octreotide: helps control the absorptive and secretory functions of the GIT. It regulates GIT functions and lessens GIT secretion that may cause diabetic diarrhea.

Miscellaneous Drugs: In severe diarrhea, antidiarrheals such as diphenoxylate with atropine or loperamide may be of help. The use of psyllium (fiber supplement from a certain kind of plant) may provide added bulk in stools

Special Measures: In severe gastroparesis, nutrition is facilitated either by insertion of a temporary feeding tube directly to the small intestine (*jejunostomy tube*) or by giving nutrition through intravenous route (*parenteral feeding*). Surgery may be indicated in cases of megacolon with probable colonic perforation.

What Can You Do To Avoid These Problems?

1. Better Blood Sugar Control

- Be more meticulous with your follow-up with your doctor
- Be more religious in taking your medicine
- Be more conscientious in monitoring your blood sugar level.

2. Change your eating habits

- Eat six smaller meals rather than three large meals a day.
With less food in your stomach at one time, you may not feel overly full after meals.
- Avoid fatty foods
They naturally slow down digestion.
- Avoid foodstuffs rich in fiber if with gastroparesis

Fiber is more difficult to digest. The indigestible component of fiber rich foods may remain too long in the stomach and possibly form bezoars. On the other hand, patients with constipation may desire more fiber in their diet to provide more bulk in their stools.

Rosiglitazone
Avandia
Sensitivity and harmony in diabetes care

The majority of patients on monotherapy would benefit from improved glycemic control

Inadequate glycemic control



On metformin (maximal tolerated dose)
Obese
HbA_{1c} is rising



On rosiglitazone (maximal tolerated dose)
Can't tolerate metformin
HbA_{1c} is rising

Add Avandia 4mg OD

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WHEN YOUR STOMACH HURTS

Tummy problems in Diabetes

Felix L. Domingo, Jr., MD

Gastroenterologist, East Avenue Medical Center

Complications of diabetes involving the heart, brain and kidneys are widely known. However, few are aware that it also affects the gastrointestinal tract, from the esophagus to the colon. Many diabetics have suffered symptoms such as difficulty in swallowing, constipation, diarrhea, nausea and vomiting. These problems are more commonly seen in older diabetic patients with very poor blood sugar control despite long-term insulin treatment. Many will already have cardiac complications or neuropathies.

Diabetes can damage the nerve supply of the GIT responsible for the control of its movement, digestion, and absorptive functions. Persistently high sugar levels cause chemical damages in nerves and the blood vessels supplying oxygen and nutrients to the nerves. Once damage occurs, the muscles of the GIT tract will not work making the movement of food slower or. Nutrient absorption will also be affected and can present as either diarrhea or constipation.

What Are Common GIT Problems in Elderly Diabetics?

Esophageal and Gastric Dysfunction

Affected patients usually complain of swallowing difficulties and heartburn. In severe cases of gastric paralysis (*gastroparesis diabetorum*), patients may complain of epigastric distress, nausea, bloating, and vomiting. This is seen in as much as 58% of diabetics with poor blood sugar control. With slowed movement, food particles may accumulate, harden, and cause mechanical intestinal obstruction (called *bezoars*).

Diabetic Diarrhea

In 10-20% of poorly controlled diabetes, abnormalities in the small intestinal absorption would present as chronic diarrhea. This is more seen among patients with esophageal/gastric dysfunctions. Some may complain of fecal incontinence.

Constipation and Megacolon

Involvement of the large intestine usually causes constipation. In fact, this may be the most common GIT complaint among diabetics. Ulcers along the anal region may develop due to frequent passage of hard stools (*stercoral ulcers*). In severe cases, the colon may markedly dilate (termed as *megacolon*). As a complication, the colon may rupture (colonic perforation).

How Do We Work-up Patients With These Problems?

Usually, patients will come in with fairly identifiable GIT problems secondary to diabetes. Further diagnostic work-ups to either verify this or to rule out other diseases presenting the same way may be necessary.

X-ray Studies

With severe abdominal pain and vomiting, abdominal x-rays may show a greatly distended stomach if with gastroparesis or markedly dilated large intestinal loops as seen in megacolon. A barium study may be requested for further evaluation. For upper GIT problems, the patient will be asked to drink a thick liquid (barium) after fasting for 12 hours. Normally, there should be no more food left in the stomach by this time and retained food may indicate gastroparesis. The patient may also be asked to take in a meal that contains barium (*barium beefsteak meal*) and

will be observed while his stomach digests the meal. For chronic diarrhea or constipation, a barium enema may be done to rule out other problems.

Endoscopy

In endoscopy, a long and flexible endoscope is inserted either through the mouth or rectum. A built-in camera allows the GIT to be viewed on a television screen. An esophagogastroduodenoscopy (EGD) is done to assess the upper GIT while a colonoscopy assesses the large intestine. The advantage of endoscopy over barium studies is that your doctor could proceed with biopsies if necessary. Subtle mucosal changes may be better seen during endoscopy. Endoscopic maneuvers may address the problems with bezoars.

Manometry

This test measures the electro-mechanical impulses within the stomach. A thin tube is passed down the throat up to the stomach. The stomach's electrical and mechanical activity will be measured and problems in the stomach's movement will be detected.

Radiolabelled Scintigraphy

The patient will be asked to eat food containing a low-dose non-hazardous radioactive substance. A machine will detect the radioisotope in the stomach and its movement in the GIT. If more than half of the food will remain in the stomach after 2 hours, then the patient is very likely suffering from gastric motility problems.

How Do We Treat These Problems?

The best treatment is still achieving good blood sugar control either with oral medicines or insulin therapy. Other



Skin Changes With Aging

ANGELA LAVADIA, M.D.

Dermatologist, St. Luke's Medical Center

In the golden years of our life, our skin exhibits many characteristic changes. In diabetics, these skin changes are even more prominent.

Itching or pruritus is the most common skin complaint among the elderly. This is usually characterized by dry, rough and scaly skin often without any specific skin lesions.

Sometimes, the sensation of itchiness can be so severe and the scratching so intense that excoriations may result. These can lead to eczematous conditions and even infection, if left unrelieved.

The use of liberal amounts of moisturizing lotions especially after bathing can help in minimizing itching.

The skin of an aged person is easily disrupted. Friction and shearing forces can greatly affect the skin resulting in tears and blister formation. The blood vessels are easily injured leading to easy bruising even with light pressure. This is because the collagen fibers, which give support to our skin and blood vessels, become coarser and more randomly organized as we age. The delicate vertical elastic fibers which hold our skin together at the junction of the epidermis (outer layer of the skin) are decreased in amount resulting in less resiliency and elasticity. Wound healing occurs more slowly in the elderly. There is less skin re-growth after an injury than at younger ages. Prevention of external injuries and care is very important.

Changes Associated with Diabetes

Some skin changes have been associated with the more mature diabetic. Among these are "skin spots," "diabetic bullae," and pigmented purpuric dermatoses.

Skin spots of diabetic dermopathy are darkly colored oval or round areas on the lower legs of the mature diabetic. These are found in roughly 30-60 percent of the diabetic population. These lesions are related to pigment changes resulting from injury to skin that is poorly vascularized,

not only from the diabetes itself, but also due to the aging of the skin. Skin spots are often thought of as a sign of blood vessel injury in other organs of the body.

Diabetic Bullae

Diabetic bullae or the appearance of spontaneous blisters on the hands and feet is sometimes seen among diabetics. The blisters are clear, fluid-containing and may heal within 2-5 weeks. Some blisters may be blood-tinged and heal with scarring, while others may be tender and non-scarring. The elderly diabetic is even more prone to developing these blisters.

Pigmented Purpuric Dermatoses (PPD)

Dark, brownish-orange, bruise-like patches on the lower legs known as Pigmented Purpuric Dermatoses (PPD) is another manifestation of diabetes mellitus limited to older patients. These result from actual leakage of red blood cells from the small blood vessels in the skin. Pigmented Purpuric Dermatoses is often considered a marker for small blood vessel injury due to diabetes.

Skin Infections

Skin infections in the elderly diabetic are quite common.

The superficial fungal infections, are often encountered. The feet are very commonly affected by this life-long disease, especially in men and maybe misdiagnosed as "dry skin." The soles of the feet, the areas between the toes and even the nails can be involved.

Areas of redundant or flabby skin folds often get affected by Candidiasis, a type of superficial fungal infection common among elderly diabetics. The areas beneath the breasts and the groins, for example, which are kept moist by perspiration are usual sites of this condition. The angles of the mouth is another commonly affected site in the elderly because of the redundant folds of the skin which are kept warm and moist by oral secretions.

Successful treatment of these candidal infections include blood sugar control and the use of anti-fungal creams. Oral anti-fungals may sometimes be required. Some bacterial infections, such as boils or pyodermas may often go undetected in the elderly. Swelling and slight tenderness may be the only sign of a bacterial skin infection that would have been warm, red and associated with fever in a younger patient. Frequent self-examination is the key to early detection of these common fungal and bacterial infections.

Diabetic Foot

Diabetes mellitus often affects the small nerves of the feet resulting in areas of numbness and loss of pain and temperature sensation. Care must be taken to keep these numb areas protected and free from wounds and sores. Injury prevention, well-fitting and comfortable footwear and regular self-examination are important in preventing the development of ulcers.

In summary, it is good to remember that in the elderly, the signs of skin problems may not be as pronounced as in the younger age group. Prevention is the key to good skin care in the elderly diabetic.



Diabetic dermopathy "shin spots"



ROBERT C. MIRASOL, MD
St. Luke's Medical Center

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

(BUT WERE AFRAID TO ASK)

Herbal Medicines have been used since ancient times. In fact many of our current drugs have been derived from plant sources. Studies have shown that around 25–40 percent of our current medicines is derived from herb sources. In a recent survey it was found that there was a 400 percent increase in use of herbal medicines. More and more people with diabetes are turning to herbal medicines. Here are some answers to your most frequently asked questions.

Why do people use herbal medicines?

The primary reason is dissatisfaction with the current medical practice. The medications being prescribed are costly and have known side effects. People tend to think that using herbal medicines will minimize side effects and will be better since it is natural. Another reason is that people need self-empowerment. Since these herbal medicines are mostly supplements, are over the counter and need no prescription or a visit to a doctor, they can be used freely.

What should we look at when buying herbal medicines? There are plant variables and manufacturing variables. Plant variables include non-contamination with other species. They should be organically grown, free from insecticides and pesticides. They should be grown away from polluted areas where toxic fumes accumulate. The soil must also be monitored and must be free from any contaminants. The portion of the plant must also be considered—whether the leaf, root or bark possesses the active ingredient. There are manufacturing variables as well—material extraction, packaging, storage,

shelf life and shipping stability.

Why should we be careful? If you are using an herbal supplement for diabetes, then you consume the drug in large quantities and the toxic substances might accumulate producing unwanted side effects.

Are these approved by the BFAD?

Some have approval as supplements. Most have no therapeutic claims. Most have not undergone randomized controlled trials to prove their efficacy and claim. Most are really worthless and useless. So be careful about using these products.

What are some herbal medicines used for diabetes?

There are studies using *Gymnema silvestre*, whose active ingredient is unknown. This herbal medicine has been shown to produce loss of ability to detect sweets. More clinical studies are needed to prove its claim. The liquid extract of *Aloe vera* has also been shown to reduce glucose. Duhat seeds have been shown to lower sugars but produce cancers in experimental animals. *Banaba* leaves and mahogany seeds have no glucose lowering effects.

What about ampalaya? *Momordica charantia* commonly known as ampalaya, has been shown to produce blood glucose lowering effects. The leaves possess the active ingredient. There are only two known varieties of ampalaya that have blood glucose lowering potential. These are found in Makiling and in Cavite according to Dr. Maramba of the Institute of



Pharmacology at UP- PGH. The first five trellises should be boiled in a clay pot without cover to release the active ingredient. These plants should be organically grown.

Are there clinical trials being done to prove its claim?

The Institute of Pharmacology is on its Phase III clinical trials. They have done studies in tablet form and found out that it was comparable to glibenclamide in lowering glycosylated Hgb and blood sugars. The ones currently in the market have not been tested and should be studied in a clinical trial.

Are there other uses of Ampalaya? The fruit juice is used for chronic colitis. If the fruit is macerated it could be used as a medicine for wounds. The sap has been useful as a parasiticide. The vine is a powerful anti-helminthic and purgative. The leaves have also been found to possess antibacterial qualities.

Is it mutagenic or cancer producing?

The tests using AMES test, Micromander, REC assay and Host mediated assay have been found to be negative. Therefore it does not produce cancers.

Will I use ampalaya? Until further studies are published or released, I will not recommend it as medicine as of now. We welcome your comments and suggestions. You may fax me at 531-1278 or email me at mbmiraso@yahoo.com.

Your President Speaks



As the holiday season approaches, we will again have the PDA annual convention scheduled on the first week of December. Dr. Edith Dalisay, the scientific chairperson, has prepared a comprehensive program to be presented by the different councils. We invite the public, especially diabetic patients themselves, to participate and share their experiences as well, in the activities and lectures of the lay convention, with Ms. Susan Trinidad as chairperson.

Diabetes occurs most frequently in the 5th to 6th decade of life although there has been a gradual rise in the prevalence of diabetes among adolescents and young adults. This issue of Diabetes Watch focuses on the health concerns of the elderly diabetic. It includes the different special problems that may be unique in this subgroup of diabetics where the mortality is highest because of the presence of many other concomitant illnesses. Physicians caring for these diabetics will find the discussion relevant and useful in their clinical practice.

And as a reminder to all, visit the PDA website (www.diabetesphil.org) to get an update of the different events of the association and post questions to the memo board for any concerns related to diabetes.

RUBY T. GO, MD



VISIT THE PDA WEBSITE
www.diabetesphil.org

CONTENTS

July to December 2002

Cover

8 When Your Stomach Hurts

Why do diabetics complain of stomach trouble
Felix Domingo, MD

12 Health Concerns of the Elderly Diabetic

Age brings a unique set of challenges
Jocelyn Jayme Wohldorf, MD

17 Is Santa Claus Diabetic?

With his big round belly Santa is surely a diabetic candidate
Patricia Gatbonton, MD

Features

6 Skin Changes with Aging

Angela Lavadia, MD

11 Oh, My Aching Joints!

Adora Gatlabayan - Del Rosario, MD

14 How I Survived Diabetes

Nenita Socrates

20 Diabetes and the Flu

Patricia Gatbonton, MD

21 Lucky Seven

Joey Miranda, MD

22 Reflections of an Elderly Diabetic

Ricardo Fernando, MD

Regular Columns

2 Meanderings

Augusto Litonjua, MD

3 Your President Speaks

Ruby T. Go, MD

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

Roberto C. Mirasol, MD

18 Kitchen Corner

Focus on Fiber
Eloisa Villaraza, RND

23 News

The Lighter Side of Diabetes
Allan S. Hernandez, MD

Meanderings



There are many risks of Type 2 Diabetes Mellitus (T2DM) in the elderly. In one survey, it was found that there were 184 deaths/1000 from heart disease in those with T2DM; as compared to 118/1000 in those without diabetes. When deaths from all causes were considered, there were 364 deaths/1000 in those with T2DM whereas there were only 209/1000 in those without diabetes.

Why does the elderly become susceptible to T2DM? Many causes have been surmised. Insulin secretion becomes inadequate as the years advance. Then, too, because of the changed metabolic milieu, there is increased production of 'free radicals' which are harmful to many tissues of the body, and this can contribute to what is known as 'insulin resistance' – a condition where the tissues do not respond to insulin as they should. The elderly individual loses his muscles and increases his body fat which can also lead to insulin resistance. As one grows older, physical activity is lessened, another contributory factor to insulin resistance.

How should one treat the elderly diabetic? There are no clear cut goals to aim for. Many studies have not shown that intensive glucose control will improve vascular endpoints for the geriatric population. Goals for blood sugar control may be harder to achieve in the elderly because of the greater dangers of hypoglycemia, or low blood sugar levels.

Drs. Diana Chau and Steven V. Edelman in the fall issue of *Clinical Diabetes* say: "Goals of therapy for the elderly diabetic patients should include an evaluation of their functional status, life expectancy, social and financial support, and their own desires for treatment. A full geriatric assessment performed before establishing any long-term diabetes therapy may aid in identifying potential problems that could significantly impair the success of a given therapy. Often, elderly patients have cognitive impairments, limitations in their activities of daily living, undiagnosed depression, and difficult social issues that need to be addressed."

The population of the elderly is increasing. More attention should be paid to the complex needs of this segment of our population, especially those with Type 2 Diabetes Mellitus.

AUGUSTO D. LITONJUA, MD



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NEWS YOU CAN USE

Type 2 Diabetes Can Be Prevented!

CYNTHIA HALILI-MANABAT

Several well designed clinical studies have shown that type 2 diabetes can be prevented.

A Finnish study that looked at 522 middle aged obese subjects with impaired glucose tolerance (IGT), a stage that occurs between normal glucose metabolism and Type 2 diabetes, showed that after an average follow-up of 3 years, there was a 58% reduction in the incidence of diabetes in the lifestyle intervention group versus those who had only received routine diet and exercise counseling. "Life-style intervention" in this instance included: 5% weight loss, reduction of fat intake, especially saturated fats (animal fat), increase in fiber intake and exercise of 150 min/week.

SHOULD I BE TESTED FOR PRE-DIABETES?

You should have a glucose test (fasting plasma glucose or oral glucose tolerance test) if you are...

- greater than 45 years of age
- younger than 45 years but with any one of the following:
 - overweight
 - parent of sibling with Type 2 Diabetes
 - previous Gestational Diabetes (Diabetes in Pregnancy)
 - hypertensive
 - dyslipidemic (abnormal cholesterol or triglyceride levels)

Your Eyes and Diabetes

Don't lose sight of the risks

World Diabetes Day

14 November

Reaching millions of people around the world

The Lighter side of Diabetes

by Dr. Allan Hernandez

