



DiabetesWatch

JANUARY-JUNE 2004

YEAR XXI, NO.1

Popular Diets: *sorting fads from facts*

Fasting blood sugar: *is it 100 or 110 mg/dl?*

Fast facts about insulin

A close look at alternative medicine



from the editor's desk



DiabetesWatch

It was in the year 1994 when the evidence for a concept which was intuitively known became available. The Diabetes Complications and Control trial which was a study involving more than 1000 Type 1 diabetics for a period of 9 years proved that intensive blood sugar control reduced the risk of diabetic complications in Type 1 diabetic patients. This observation was subsequently confirmed in Type 2 diabetics with the UKPDS (United Kingdom Prospective Diabetes Study), a trial which ran from 10-20 years.

The past 10 years is witness to the many new concepts and drugs which have been developed to help the person with diabetes achieve stricter treatment targets. New criteria for classifying and diagnosing diabetes has been released and new products have come out to help in the intensification of diabetes treatment. Some of the new trends include carbohydrate counting, combination therapy for oral antidiabetics agents and antihypertensives, and early insulin therapy to preserve beta cell function and prevent glucotoxicity.

In this issue you will be reading about the implications of a lower range of normal for the fasting blood sugar as well as developments in the insulin market which has resulted in faster and more physiologic insulin preparations. One of our nutrition experts will be dwelling on popular diets - Atkins, South Beach? and another article takes a closer look at the alternative medicine market which is definitely booming all over the world.

So, we still have a good read for all of you. We hope that if you enjoyed this magazine, you will conclude that there is hope in the horizon, despite the warning about the menace of diabetes in our last issue. Share this magazine with a relative or friend and better still join the Philippine Diabetes Association and stay on top of your health.

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"an affiliate society of the Philippine Medical Association" (PMA)
"an affiliate society of the Philippine College of Physicians" (PCP)
"a member of the International Diabetes Federations" (IDF)

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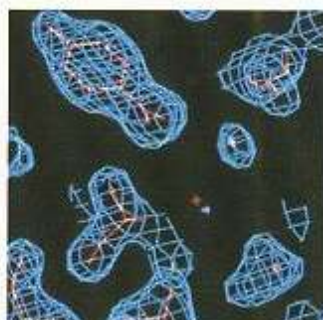
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DiabetesWatch

Diabetes is not only devastating-causing damage to different organs-it is also indeed very costly. Urgent action is needed to avert this global public health crisis! International as well as regional and local diabetes organizations continue to strive to lessen the impact of diabetes upon the quality of life of those currently living with diabetes. Just recently the International Diabetes Federation redefined its mission statement in line with their vision of Living in a world without diabetes. As of May 31, 2004, the mission of IDF will be To promote diabetes care, prevention and cure worldwide-a goal very much similar to OUR mission and vision. This change will certainly strengthen the process of collaboration with and between IDF member associations and will create opportunities to work toward the prevention of the decline in the quality of care of our diabetic patients.

In the last six months, the Philippine Diabetes Association has collaborated closely with the different

medical associations and organizations in promoting awareness and education through a healthy lifestyle. It strongly supports the Diabetes Awareness Week of The Diabetes Center this July and the International Diabetes Federation (IDF) World Diabetes Day on November 14, which will focus this year on "Diabetes and Obesity." Last April, after several months of hard work and meetings of the Interim Steering Committee and the Technical Working group on diet and Nutrition-where PDA is a member-and ably represented by a member of the board of directors, Ms Susan Trinidad, we formally signed the Memorandum of Agreement on The Coalition on the Prevention of Non-communicable Diseases of the Department of Health and the World Health Organization.

As we emphasized the need for patient empowerment, we have now organized the Philippine Diabetes Association Lay Affiliate under the auspices of PDA Council on Education chaired by Susan Trinidad. My congratulations to the newly elected officers headed by the Mr. Dan Daez. I truly believe that through our lay affiliate we will hear the voices of our patients better and will bridge the gap that may have existed between the

health care provider and our patients in the past. This new endeavor together with the concerted hard work of the different PDA chapters will truly bring our association to the forefront in excellent diabetes care and education in our region.

This year as we work around our strategies of Education, Advocacy, Networking and Research, the Philippine Diabetes Association promises to continue to promote the best possible care and to strive for the prevention of diabetes complications and of diabetes itself through our different councils. For those with diabetes, we believe that there is life after diabetes and certainly hope that one day we can help find a cure. Together we are stronger... together we will fight Diabetes and its complications!

Rosa Allyn G. Sy, M.D.
Chairman & President

Meanderings

Augusto D. Litonjua, M.D.
Editor Emeritus



Diabetes Care Without Boundaries:

The ASEAN Diabetes Educators

In 1993, I had a dream.

Following the 7th ASEAN Federation of Endocrine Societies (AFES) Congress held in Kuala Lumpur, Malaysia, I sounded out some members of AFES about forming a group within AFES that would spearhead the training of diabetes educators in the region, using a uniform regional guideline on diabetes education. The response was very favorable. Forwith, each of the member country of AFES sent representatives to the first organizational meeting in Singapore at the Goodwood Park Hotel. Together with Dr. Roberto Mirasol and Dr. Araceli Panelo, we formed the Philippine Delegation.

The most laudable achievement of the first meeting was the approval of the proposal that a common core curriculum be adopted among diabetes educators in the region. Thus, if the plan pushed through, a Filipino patient with diabetes traveling to any of the ASEAN member countries would receive the same instruction on diabetes care as he would in Manila, and so forth.

A first symposium was held in Manila in December of 1994 to which more than 200 diabetes educators were present. Following this heartening response, a third meeting was held in Singapore at Beaufort Hotel where an educator's manual was fashioned and formally launched in Manila in December of 1995.

However, in the ensuing four

years, while two more meetings were held in Singapore and then in Bangkok, the original purpose of the group was forgotten - that of training diabetes educators in the region using a common core curriculum.

There, the dream lay dormant for several years. There was one more feeble attempt to revive the ASEAN Diabetes Educators Group three years ago when Prof. Mustaffa (Malaysia), Prof. Soegondo (Indonesia) and I met at the Hotel Intercontinental, Manila.

"We almost wanted to give up hope on the ASEAN Diabetes Educators concept. After several meetings held in association with other international and regional conferences, the ASEAN Diabetes Educators began to take reality."

Our first target was Malaysia where we tried to form a nurse educator group at their first National Diabetes Congress, in 2002. The proposal met with disapproval by the Malaysian doctors. In 2004, I saw the realization of the dream.

We almost wanted to give up hope on the ASEAN Diabetes Educators concept. Then, comes along Dr. John Flores of Johnson and Johnson. He broached the idea to me of having an organization of diabetes educators in ASEAN with a Harvard group as the trainers. I told him about the revival of the ASEAN Diabetes Group instead. I thought there was a group of physicians in the region competent of

organizing this without outside help - using ASEAN methods of educating ASEAN diabetic patients. After several meetings held in association with other international and regional conferences, the ASEAN Diabetes Educators began to take reality. Johnson and Johnson's top honchos, Mr. Ben Avancena and Mr. Mike del Prado were very supportive of the project - because without them, the logistics of the project would be impossible to hurdle.

Last March, core educators met in Manila - educators from Vietnam, Thailand, Malaysia, Indonesia and Philippines. Not only was a core curriculum common to the member countries adopted, but basic lectures on the curriculum were delivered, criticized, modified, and finally adopted for use and an educators manual was the culminating result.

The core group then agreed to train 30 or more educators in their respective countries. We meet again in July in Hanoi, Vietnam to look at the obstacles and other problems of this training program.

Thus, hopefully, diabetes education, and with it, better diabetes care will march on in the ASEAN region. We are very hopeful this time, of having an active and continuing group of dedicated diabetes educators. A textbook which is evidence based has been published. A manual for patients is forthcoming. We have gone further than anytime in the past this time. The expectations are at their peak. 

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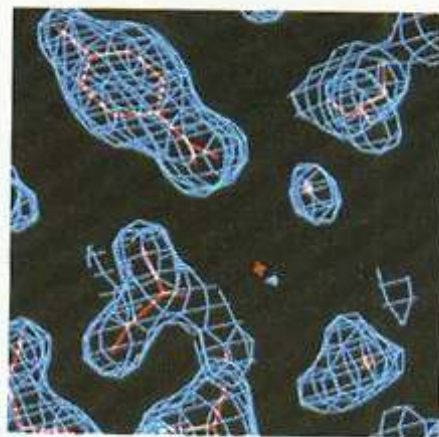
FAST FACTS ABOUT INSULIN

Insulin is one of the most important discoveries in the field of diabetes. In type 1 diabetes mellitus, the body does not produce its own insulin so insulin treatment is needed for survival. In diabetes type 2, the body may produce insulin, but not in sufficient quantity or is less effective than expected. Eventually, most people with type 2 diabetes will require insulin treatment to achieve good glucose control because of the progressive decline in its production.

What is insulin? Insulin is a hormone that specialized beta cells in the pancreas produce. It maintains blood glucose levels in the normal physiologic range to prevent damage resulting from excessive glucose to organs such as the eyes, kidneys and heart. Insulin is a messenger that allows glucose from the bloodstream to enter cells and release the energy from glucose to allow normal cellular functions.

Insulin is the oldest and the only naturally occurring antidiabetic agent in the human body. It also has the most potent glucose-lowering ability, with no upper dose limit as compared to the oral antidiabetic agents. The older forms of insulin came from animal sources (pigs and cows) and were more allergenic. Today, human insulin has replaced animal insulin. Human insulin is genetically engineered and produced in laboratories using *E. coli* or yeast cells as vehicles.

Insulins are classified according to



Insulin-crystallized

how fast they act (onset), how long they stay in the blood (duration of action) and when they are most active (peak of action). The fast acting insulins include the regular human insulins Humulin R and Actrapid. They are used mainly to lower the blood glucose after a meal. However, their action starts 30-60 minutes after injection so they have to be given 30 minutes before eating. Their action peaks at 2-4 hours and lasts for 6-8 hours.

Faster acting insulins which closely mimic natural insulin secretion with meals have been developed. These are the analogs Lispro (Humalog) and

“Most people with type 2 diabetes will require insulin treatment to achieve good glucose control because of the progressive decline in its production.”

Aspart (Novorapid). (Glulisine is being developed). The amino acid sequence in the insulin structure has

Insulin is the oldest and the only naturally occurring antidiabetic agent in the human body.

been modified to achieve a more rapid onset of action of 5-15 minutes. They can thus be injected right before eating. The peak of action is 1 hour so it can coincide with the expected time when blood glucose is highest after a meal. They also lose their effect in 4-5 hours, this avoids the blood sugar from dropping too much in between meals.

Fast acting insulins have to be combined with intermediate acting, long acting or basal insulins to achieve a smoother glucose control 24 hours a day. The intermediate acting insulins (Humulin N and Insulatard/Monotard) begin to act in 2-4 hours, peak at 4-8 hours and last for 12-16 hours. They are combined with fast acting insulins in a twice a day program (split-mixed regimen) before breakfast and dinner.

Long acting insulins (Ultratard and Humulin U) start to act at 4-6 hours, peak minimally and last about 16-20 hours. They are generally given at bedtime to suppress glucose production at night with 3 premeal injections of fast acting insulin. This

is the basal-bolus regimen which is the most physiologic way of giving insulin but has the disadvantage of multiple daily injections. In place of a long acting insulin, the basal

insulin analog glargine (lantus) can be given. It is a long-acting insulin, acts in 1-2 hours, does not peak so it

FAST FACTS ABOUT INSULIN

“The most common reasons among my patients are the fear of injection and very low blood glucose (hypoglycemia) and developing dependence on insulin.”

mimics basal insulin secretion, and lasts for 24 hours. Since it has no peak, early morning drops in blood glucose are avoided. Detemir is another basal analog but may be more intermediate acting than long acting.

Premixed insulins consist of regular insulins and intermediate insulins in a fixed dose combination. Though they are more convenient to administer, they have less flexibility in dose adjustments.

Insulin is delivered by needle injection underneath the skin with a syringe, a prefilled disposable pen (Novolet) or a refillable pen (Humapen, Novopen). A no-needle jet injector can deliver insulin by high pressure. Insulin pumps which are worn outside the body and connected to a flexible catheter underneath the skin can deliver continuous rapid acting insulin and avoids multiple injections.

The inhalational insulins which deliver fast acting insulins are now in late stage clinical development. They can come in dry powder form (Exubera) inhaled through the mouth and absorbed through the lungs. It can also be sprayed in the inner cheeks (Oralen). Being a protein, insulin is not given orally because it is digested in the stomach.

In type 1 diabetes, insulin is not an option but a must. In type 2 diabetes short term early insulin treatment has

been shown to cause remission or better long term diabetes control an indication that insulin can preserve beta cell function. Insulin can thus be given at the start of diabetes type

2. It is given also in the presence of complications, weight loss and when maximal doses of a combination of 3 oral diabetic drugs fail to achieve glucose targets. An intermediate insulin or a basal insulin is taken at bedtime with oral diabetes drugs. The simplicity of this regimen makes it easier to implement and more acceptable to patients. Alternatively, tablets may be discontinued and replaced with insulin. With insulin alone or in addition to tablets, there is greater chance of

achieving target levels of blood glucose. Consequently, the toxic effect of high glucose on the pancreatic beta cell (glucotoxicity) and long term complications of diabetes are reduced.

Why do people with diabetes type 2 hesitate to use insulin? The most common reasons among my patients are the fear of injection and very low blood glucose (hypoglycemia) and

developing dependence on insulin. With the very fine coated needles of insulin syringes or pens, patients find out that insulin injections are not that painful. A finger prick with blood testing is even more painful. Hypoglycemia can be avoided with proper precautions such as regular meals and snacks, taking extra snack before an exercise and correct insulin doses. I tell my patients that starting insulin does not make you dependent on it. Like oral antidiabetic drugs, addition of insulin may become necessary in the course of diabetes to achieve and sustain better glucose control. **D**



EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT DIABETES (but were afraid to ask...)

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

Blood glucose meters have been around for quite sometime. People with diabetes know that they are supposed to check their blood sugars. It's use however, despite its many advantages is limited for a number of reasons. In this issue of Diabetes Watch we answer some of your perplexing questions regarding meters.

Q "What is the best reason for checking my blood sugar?"

A The best reason and probably the most important reason is that it helps you make the right decision about how you will manage your diabetes. When you feel low then you get immediate results and know what to do. When you are high then you can do a great deal about this value. You may either do some adjustment in your meal plan or adjust your insulin or medications to help you maintain better control. Recent studies have confirmed that people who tested more often had better blood glucose control.

Q "How often should I check my blood sugars?"

A It all depends on your treatment plan. You can get a good picture of your blood glucose control if you check before meals and two hours after meals, but this will require you to test at least 8 times a day! You may stagger testing times and get a picture of blood sugars with twice daily determination. Those on basal bolus regimen usually will test four times daily. Pregnant diabetics often test more to attain optimal blood glucose control. You can work this out with your doctor or nurse educator.

Q "Should I test when I'm sick?"

A You should test more often when you are sick. The stress of an illness can provide immediate feedback regarding your sugars. Similarly when you are confined your doctor usually takes your blood sugars more often. Some medicines may worsen blood glucose control and testing will give you an idea how your sugars are behaving.

Q "What are other uses of blood glucose meters?"

A If you are exercising, then determining sugars before and after an activity will help you assess what exercise does to your blood glucose levels. It could also detect low blood sugars when you are not able to detect them (hypoglycemia unawareness). Testing will alert you that the blood sugar is dropping. Another use of determining blood sugars is when trying out new dishes. It would help you gauge the amount and type of food and its effect on your blood sugar.

Q "What kind of meters should I buy?"

A There are many varied reason why one should choose a particular meter. It will depend on user. Some want it simple. Some would want a bigger memory. Some would want it smaller; still others would want larger ones for ease in handling. Some would opt for swiftness in giving out the reading; others want a downloadable meter. No matter what brand of meter you eventually buy, take into consideration - your lifestyle, abilities and personal preference. Most important reasons for choosing one are accurate results and affordability.

*We welcome your comments, suggestions, questions.
We would like to hear from you.
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NEW ADA CRITERIA

Lina C. Lantlon-Ang, MD

“People with Pre-Diabetes can prevent or delay the development of Type 2 diabetes mellitus by as much as 58% through early and intensive lifestyle treatment such as diet and regular exercise.”

FASTING BLOOD SUGAR... IS IT 100 OR 110 mg/dl?

The fasting blood sugar (FBS) is a convenient and useful indicator of good and bad health. It requires an eight hour fast and only one blood extraction. In relation to diabetes mellitus, the critical FBS level has undergone gradual revisions to even lower levels, as the threshold of FBS at which Diabetes Mellitus can be prevented has remained elusive up to the present time.

In October 2003, an International Expert Committee lowered the cut point for normal fasting blood sugar from 110 mg/dl to below 100 mg/dl. The optimal sensitivity and specificity for the prediction of diabetes mellitus by the fasting plasma glucose was studied using the receiver operator curve method. Based on observations of the receiver operator curve closest to 100% sensitivity

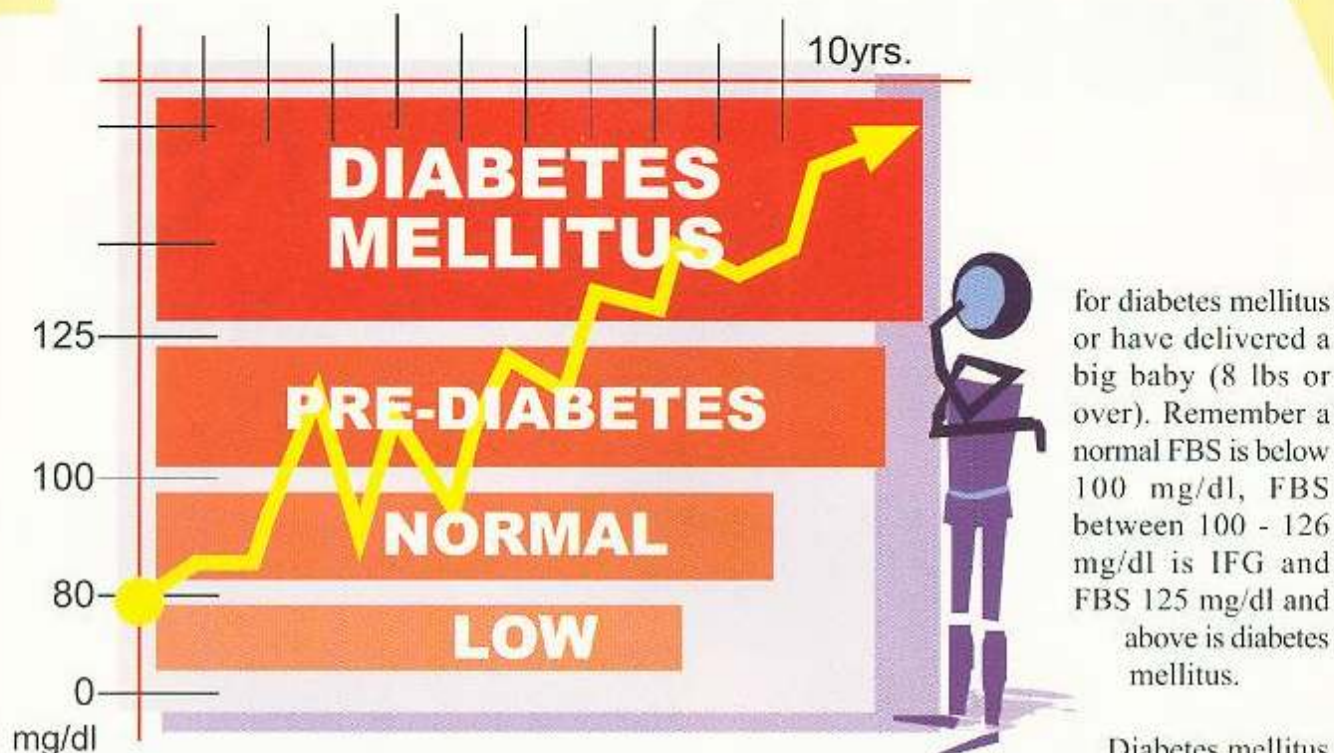
and specificity the blood sugar range of 81-126 mg/dl was 103 mg/dl in a Dutch population, 97 mg/dl in a Pima Indian population, 94 mg/dl in a Mauritius population, and 94 mg/dl in a San Antonio population, all below the 110 mg/dl cut point for normal FBS. A fasting blood sugar value 100 mg/dl to 125 mg/dl would lead to a diagnosis of

impaired fasting glucose (IFG). Using the OGTT, a 2 hour blood glucose value of between 140 mg/dl and 199 mg/dl is diagnosed as impaired glucose tolerance (IGT). Both IFG and IGT are now termed PRE-DIABETES.

Pre-diabetes is the state that occurs



“Studies show that many people who fall in the Pre-diabetic range will go on to develop diabetes mellitus within 10 years.”



when a person's blood sugar levels are higher than normal but not yet high enough for a diagnosis of diabetes mellitus. Studies show that many people who fall in the pre-diabetes range will go on to develop diabetes mellitus within 10 years. People with pre-diabetes also have an increased risk of cardiovascular disease such as stroke and myocardial infarction or heart attack compared to people with blood sugar in the normal range. Lowering the threshold for normal FBS should help pick up more people who are at increased risk for developing diabetes mellitus and cardiovascular diseases.

Well designed and long term

Diabetes Prevention Programs such as the Diabetes Prevention Program (DPP) in the United States and the Finnish Diabetes Prevention Study have shown that people with pre-diabetes can prevent or delay the development of Type 2 diabetes mellitus by as much as 58% through early and intensive lifestyle treatment such as diet and regular exercise. We hope, but we do not know yet, that by intervening earlier we might also reduce the risk of diabetes complications including cardiovascular complications.

Have a fasting blood sugar screen if you are 45 years old or older, overweight, hypertensive, with a strong family history

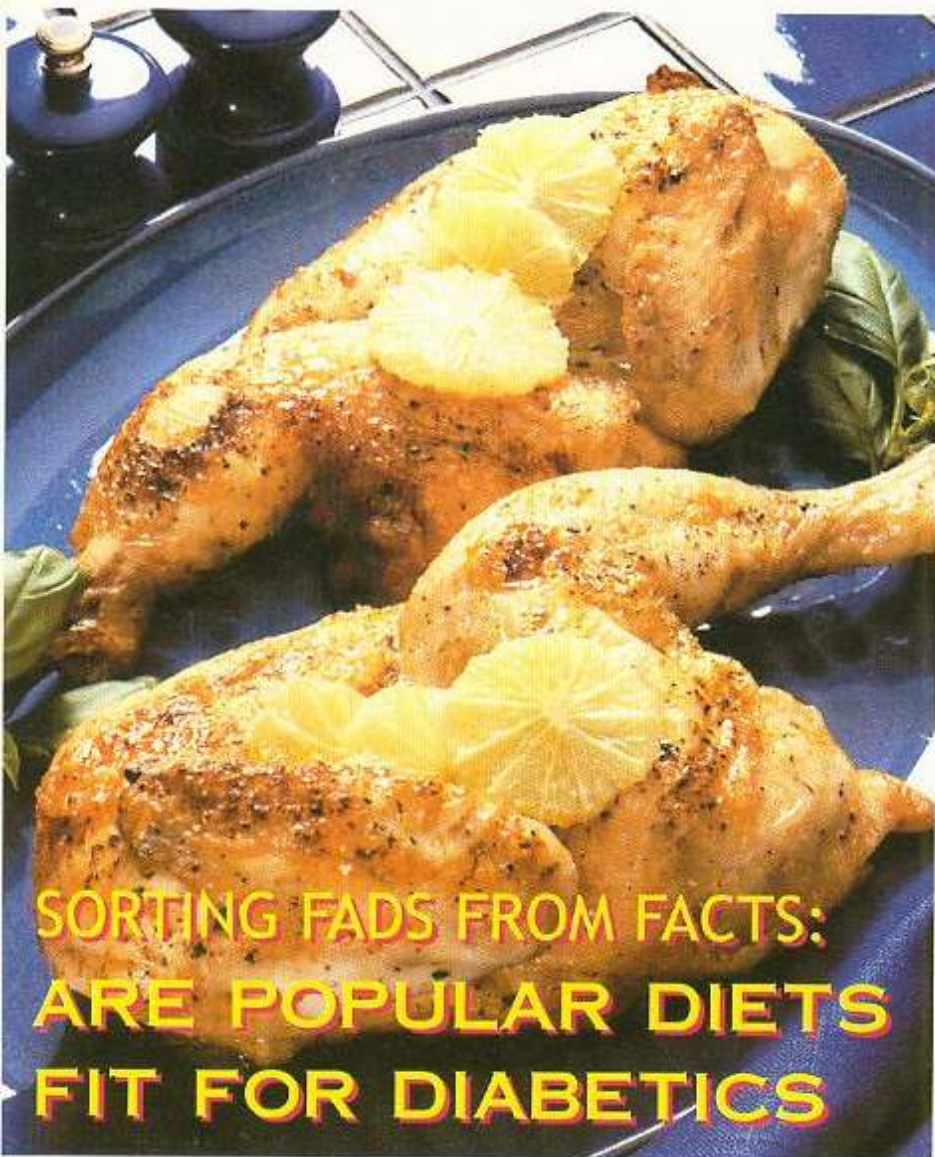
Diabetes mellitus can be prevented with early, intensive and consistent lifestyle treatment. 



POPULAR DIETS

by: Gabriel V. Jasul, Jr., MD
St. Luke's Medical Center

"The lack of or too little fruit, vegetables, nonfat dairy products and whole grains in these diets may raise blood pressure because of associated reductions in essential electrolytes like potassium, calcium and magnesium and increased sodium intake."



SORTING FADS FROM FACTS: ARE POPULAR DIETS FIT FOR DIABETICS

Losing weight is a difficult task. This is evident in the constant battle of the bulge that many overweight people with and without diabetes face throughout life. And what's more, maintaining any weight lost for a long period or permanently is even more daunting. Many factors—both genetic and environmental—influence the regulation of food intake

and energy expenditure and its relationship to body weight. The complexity of the weight problem and the benefits of even modest weight loss provide a fertile ground for popular or fad diets promising quick and painless weight loss.

The modern-day glut of information appears to be double-edged particularly with regards to a sensible

diet. While the abundance of accessible information raises our awareness to many useful tips for health, it also peddles possibly misleading and confusing data. Popular or fad diets are one such hot topic. Fortunately, more and more publications are coming out objectively addressing the safety and long-term efficacy of these so-called fad diets, particularly in people with diabetes. Is it fair then to say that advertisements for these fad diets lack solid evidence? Most likely YES because much of their "evidence" tend to be based on anecdotal reports, theories and patient testimonials. Any promise of a "quick fix" from any form of diet, or any treatment for that matter, must be taken with a grain of salt. You should seek professional advice before even considering following such diets.

Why the concern for these fad diets? These fad diets are really based on the premise that a major alteration in the distribution of the food components (i.e., carbohydrates, protein and fats) will lead to significant weight loss, and, consequently better health status. The most popular among them is the high-protein, low-carbohydrate diet, promoted by Dr. Robert Atkins. Many other variations increase the protein and/or the fat content in the diet, while substantially decreasing carbohydrate content in varying proportions and methods. Among them are Zone, Sugar Busters and Protein Power. A more recent addition, South Beach diet is also a modified version of the same dietary approach.

POPULAR DIETS

"Fad diets do cause weight loss because these diets ultimately contain lower calories BUT in a disproportionate and unnatural distribution."

What are the effects of these diets?

Short-term, they do cause significant weight loss, greater than that seen in the so-called "heart-healthy," low fat, balanced diet that is accepted and recommended not only for diabetics but for most people, in general. The quick weight loss seen with these fad diets is most likely due to the diuretic (water loss through the urine) effect from low carbohydrate intake and its effect on salt and water loss, glycogen (a storage form of sugar in the liver) depletion and ketosis (the formation of ketone bodies as a byproduct of fat metabolism). Metabolic ketosis further appears to cause loss of appetite, leading to lower caloric intake. The studies on these fad diets are short-term, often 6 months, sometimes, up to 12 months. The longer studies tend to show no significant difference in terms of weight loss over time, implying lack of sustainability of such diets for longer period of time.

What are possible adverse effects of these fad diets? These diets generally advocate animal protein and therefore, these diets also contain more saturated fat and cholesterol, potentially raising levels of bad cholesterol (LDL). The lack of or too little fruit, vegetables, nonfat dairy products and whole grains in these diets may raise blood pressure because of associated reductions in essential electrolytes like potassium, calcium and magnesium and increased sodium intake. High-protein foods are high in purines and increase uric acid levels, causing gout in patients at risk. Excess protein in the body promotes calcium loss in the urine, facilitating

osteoporosis (thinning of the bones).

Excess protein may also exert additional load for the kidney, predisposing the diabetic patients in particular to worsening of diabetic kidney disease. Likewise, restriction of food choices will limit intake of known healthful foods (fruits, vegetables, cereals, low-fat milk, etc) that will in turn, lead to deficiencies in essential vitamins, minerals and fiber, therefore losing their known beneficial effects on health maintenance and disease prevention (heart disease, cancer, etc).

Successful weight loss and long-term weight loss maintenance depend on the basic law of thermodynamics. Energy in equals energy out. If food taken in is more than what your body uses up, weight gain will result. Weight loss will then occur when food taken in is less than what the body used up. Fad diets do cause weight loss because these diets ultimately contain lower calories BUT

restricted, balanced meals abundant in grains, vegetables and fruits, together with regular physical activity. Clearly, this is a more sensible approach promoting healthy lifestyle for diabetics and non-diabetics alike. Many studies in the last few decades demonstrate the beneficial effects of heart-healthy reduced fat diets and their findings are too significant to ignore.

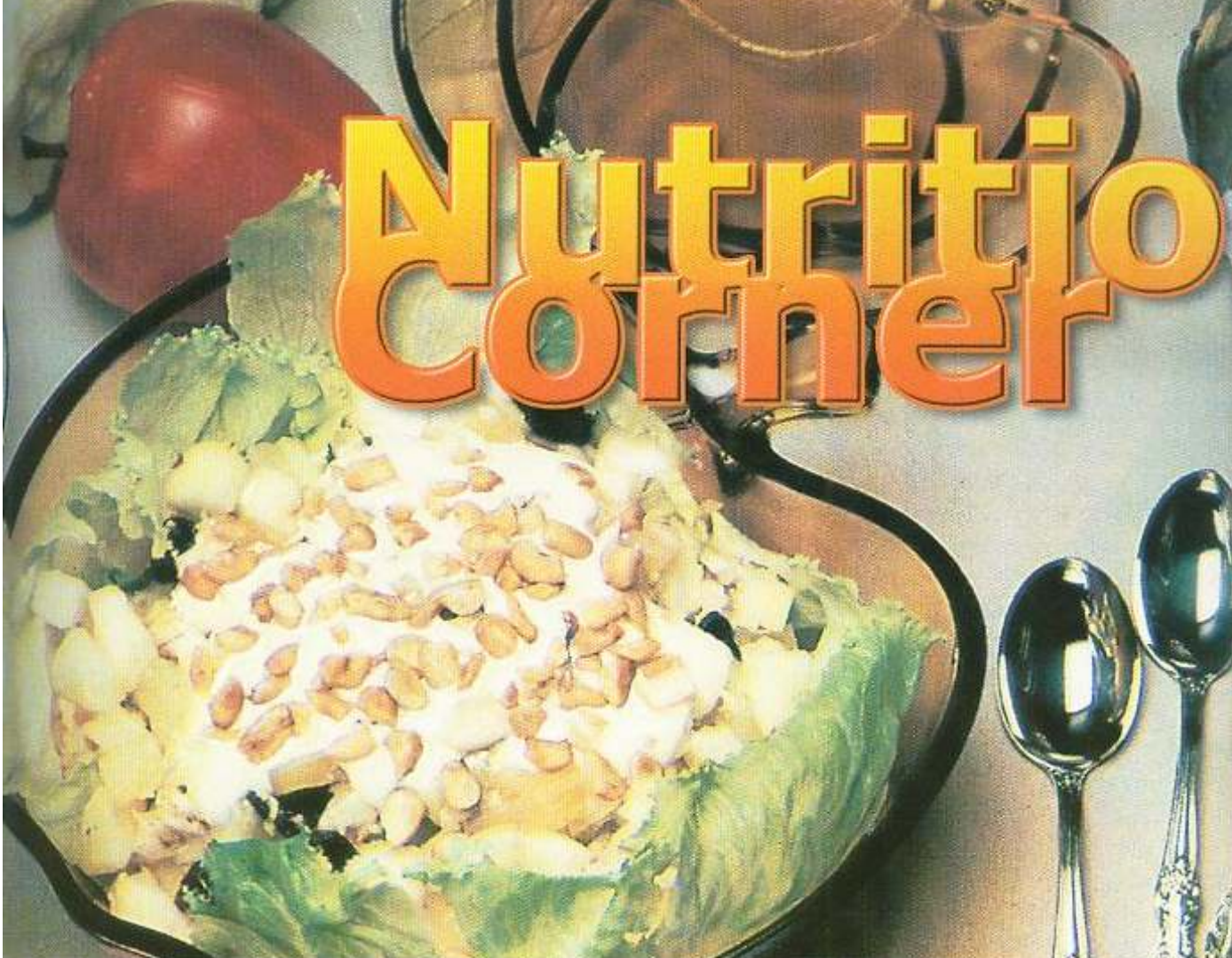
In the face of so-called dietary propaganda and nutritional non-sense, leading health organizations have come up with their dietary recommendations and guidelines for persons with multiple risk factors for cardiovascular disease, clearly including diabetics. To summarize these points, the balanced diet should be reasonably proportional with carbohydrates, 50-60 percent, fat, less than 30 percent, and protein 15 percent, maximum 20 percent, of the total calories per day. The diet should not omit or restrict carbohydrates.



in a disproportionate and unnatural distribution. Fad diets, with its known potential harms, are not compatible with long-term human health. To answer the question: are fad diets fit for diabetics, and most people? OBVIOUSLY, NO!

The ideal approach is dietary modification consisting of fat-

Selected protein foods should not contribute excess total fat, saturated fat or cholesterol. Lastly, the diet must be safely implemented over the long term, providing adequate nutrients, supporting dietary compliance with a healthful eating plan and promoting healthy weight maintenance and disease risk reduction. **D**



Nutrition Corner

Source: Healthy Heart Cookbook, Philippine Copyright 1991

Chicken Fruit Salad

Ingredients:

2 pcs.	apples, medium, diced
1 tsp.	calamansi juice
200 gms.	boiled chicken meat, diced
1 cup	pineapple chunks
4 tbsp.	mayonaise
$\frac{1}{4}$ tsp.	curry powder
$\frac{1}{4}$ cup	cashew nuts
1 tbsp.	raisins

Procedure:

1. Peel and dice apples.
2. Sprinkle with calamansi juice.
3. Toss all ingredients together. Chill.
4. Spoon individual portions onto salad greens and serve cold.
5. Garnish with raisins.

Per serving:

fats	:	11 gm.
cholesterol	:	28 mg.
sodium	:	74 mg.
calories	:	183 cal.
carbohydrates	:	10 gm.
protein	:	8 gm.

A CLOSE LOOK AT

by: Ma. Teresa Plata-Que, M.D.

ALTERNATIVE MEDICINE

Nowadays there is a trend to use some alternative therapies along side with conventional medicine merging in what is called "integrative" or "holistic" medicine.

Extra virgin coconut oil... charantia...intra...ginseng... squalene...mahogany seeds...these are but part of a never ending list of health products which have hit the health scene and captured the interest of people. Popularized by media and endorsed by local personalities, they are but a few of so many dietary supplements which stake a claim to the cure of diseases like cancer, diabetes, heart disease, rheumatism, asthma and the like. Since way back there has been an ongoing romance between the Filipino public and alternative medicine of which these products are but a small part. Complementary and alternative medicine, or CAM, is not a single unified tradition. The term covers practices ranging from acupuncture to iridology, colonics, chelation therapy, homeopathy and the like. Because few of these therapies have been thoroughly evaluated in controlled studies, their effectiveness is still widely debated.

Conventional medicine, on the other hand, refers to healthcare that includes doctors and hospitals. Some people are afraid of doctors and hospitals for a variety of reasons. The high cost of medical care is one reality which drives people to try out the local herb doctors such as the *herbolarios* and *hilots* especially in far flung areas. Others are convinced by stories of

cures or healing benefits experienced by people they trust and by popular movie and media personalities. Some media personalities highlight mistakes that doctors make painting the medical profession in a bad light neglecting the many heroic and unselfish deeds which dot the landscape of medical care. Conventional medicine may seem cold, uncaring, business like and lacking the warmth of true and genuine compassion. Truth be told alternative treatments can also be expensive. A one hour consult with an alternative medicine practitioner can cost a patient a minimum of P2000.00 pesos and treatments can range from 3,000. to 60,000 pesos. Many people though will spend on these treatments because they believe that they will get well especially if administered in a warm and caring

environment. About \$30 billion is spent every year on alternative treatment in the U.S. alone.

Why is it that medical practitioners tend to view alternative treatments with distrust?

In the medical world, before treatments or drugs can be used for certain illnesses, tests or trials have to be done to see if the treatment really works and is safe to use. In this type of trial, a new treatment is used in a number of patients and responses to treatment are observed and recorded in a systematic manner. When comparing people's responses to treatment, everyone tested should be in a similar environment. To ensure that there will be no bias in the results, factors influencing the treatment are controlled by the people doing the research. One method of control is by having some people receive the true drug while others receive what looks like the drug but really has no effect or what is known as a "placebo". The "placebo effect" is a phenomenon in medicine whereby a patient will get well even if a treatment truly has no effect. Many times it is the faith of the patient in the person administering the treatment that helps him to get well. These "controlled clinical trials" are performed in a strict and ethical environment and governed by international rules. A lot of time and



A CLOSE LOOK AT ALTERNATIVE MEDICINE

money goes into the study of a single drug or treatment before it can be released into the market and used by many people.

Most alternative therapies have little or no compelling clinical evidence to support their effectiveness or safety. For many therapies, the only evidence offered is a group of anecdotal reports—the testimony of users of the therapy. Perhaps even worse is the way popular media introduce alternative medicine concepts. As soon as a new therapy begins to show some positive results in some people, reports in the popular media promote it as though it has been proven.

Many herbal remedies are approved as food supplements without therapeutic claims but are marketed in such a way that patients believe it to be effective in curing illness. Some stop their regular medicines with disastrous results. *Cynthia H. started to lose weight and began to feel fatigued easily last April. She went to see a thyroid specialist who diagnosed her to have an active thyroid and prescribed medicine to control it. However she took it only for a month and then went to an alternative practitioner who gave her shots and pills which cost her an average of P600.00 every two weeks. After two months repeat tests showed that the treatment had no effect so she went back to her first doctor.* Many preparations are not regulated and may not have the true amount of ingredients indicated in their labels. There are reports of renal failure among users of a Chinese herb in some beauty salons in Belgium.

Of course, there are a lot of horror stories even with conventional drugs.

Nowadays there is a trend to use some alternative therapies along side with conventional medicine merging in what is called "integrative" or "holistic" medicine. Locally and abroad established medical institutions are including research in alternative therapies with the aim of proving that treatments which have been used for centuries may in fact really have scientific evidence of their efficacy.

Health is wealth. A wise person does well to carefully examine the

treatments which he will be subjected to. It is good to go to a caring physician who will give good advice on treatments that will benefit and not harm. People should indeed pursue therapies that are the most effective and affordable. They need not assume that conventional medicine is always the safest and the most effective answer to human ills. But they must also be discerning in the treatments that they are willing to try. **D**

Why is it that medical practitioners tend to view alternative treatments with distrust?



CAMP COPE: THE SAGA CONTINUES...

by: Susan B. Trinidad, R.N.
Makati Medical Center

Our camps have an immediate, positive impact on the lives of many children each year.

Camp Cope has grown tremendously over the years. For the last 6 years, we have been holding it at the Los Baños Forest Club in Los Baños, Laguna. It has complete camping facilities like basketball court, swimming pool, field for ball games, conference rooms and even a man-made lake for fishing and other water activities.

The camp sessions follow a very rigorous schedule with maximum flexibility in the different programs. The routines are: blood sugar testing 4-6 times a day, insulin injection 3-4 times a day, exercise programs, then breakfast of mostly cereals, fruits, skim milk and oats. This includes counting of their calories to meet their daily requirements. Active and less active programs are conducted to burn their calories. Most of the teachings, however, are gained through informal gatherings with medical staff and counselors. The campers enjoy the panel discussion and open forum with the experts.

A variety show featuring the various talents of each group was one of the highlights for this year's camp. But of course, the post election fever was still in the air during the 4-day camp. So we

had our own version of GMA, FPJ, PING and ROCO to the delight of the whole group. They were really applauded with their excellent programs for the people with diabetes.

Our camps have an immediate, positive impact on the lives of many children each year. Likewise, their families were touched too. They realized how important this camp is for their children. Erika, a nine year old, attended the camp for the first time. She has a fear of needles and the mere thought of inserting it on her body scares her to death. After spending just 4 days with the medical staff and the counselors, as well as the other campers, Erika went home with brand new courage. On top of the knowledge she has gained about insulin, she can now do it herself. And guess what her mom says about the achievement: a very motivating, "I'm proud of you Erika!" This is just one story which for us, the staff, is very encouraging. CAMP COPE continues to provide learning and skills enhancement in a festive environment. This is our way of



teaching children and young adults the intricacies of the disease in a safe environment and letting them discover themselves without too much pressure from people around them.

Dr. Augusto D. Litonjua's vision is on its ninth year and still growing strong. More and more young people with diabetes have experienced their desire to join us. In fact, the number of participants grows higher each year, from a humble beginning of 15 campers to over 40 campers.

The saga will continue for as long as dedicated people are around to support us in this worthwhile endeavor. Knowing these people are with us drives us further to continue with our programs with the goal of increasing the positive impact of camping in the lives of young people with diabetes. 



PDA

On The Move



2004 LAKAD PUSO
Quezon City Circle
February 08, 2004

PDA board members and patients, led by PDA president Dr. Rosa Allyn Sy joins the yearly Lakad Puso organized by the Philippine Heart Association.



Dr. Ronaldo De Ramos, PDA Chapter President for Nueva Ecija, coordinated the 27th Diabetes Workshop at the Acropolis North Water Camp, Nueva Ecija.



Dr. Rosa Allyn Sy, PDA president is elected treasurer and financial committee leader of the IDF-WPR last March 2004.

**PDA 27th
DIABETES WORKSHOP**
March 12-13, 2004



The **PDA Lay Affiliate** is a group of concerned people with diabetes whose main task is to coordinate the activities of the lay in accordance to the by laws set forth by the PDA.

PDA LAY OFFICERS 2004

Mr. Adriano D. Daez
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Mr. Robinson Manguerra
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Mr. Roberto C. Rantael
PRO
Ms. Patricia C. Montaos
PRO



NOVO NORDISK MEDIA PRIZE

Dr. Patricia Gatbonton, (right) editor in chief of Health News, and assistant editor of Diabetes Watch, receives the Novo Nordisk Media Prize 2004 for excellence in diabetes writing from Mr. Bengt G. Avodin, Novo Nordisk General Manager.

The paper of Dr. Florence Amorado-Santos which won the PDA/Pfizer Research Grant last November 2003 also won 2nd place at the oral paper presentation contest of the American Association of Clinical Endocrinologists held last April of this year. The paper is on "Comparison of Cord Blood Insulin in Large for Gestational Age (LGA) Infants and Appropriate for Age (AGE) Infants of Non-Diabetic Pregnancies (A Pilot Study)."

Upcoming events:

Diabetes Awareness Week :
July 25-August 1, 2004

28th Diabetes Workshop :
Cagayan De Oro : September 24-25, 2004

A Course on Diabetes and Vascular Disease:
October 15-16, 2004 : Century Park Hotel, Manila

World Diabetes Day : November 14, 2004

PDA Lay Annual Convention :
November 20, 2004 : Century Park Hotel, Manila

PDA Annual Convention : November 23-24, 2004
Edsa Shangri-la Hotel, Mandaluyong

CLASS ACTION

BY MARIE MCCARREN

There are now five classes of diabetes pills and several combination oral meds as well. Each has a different way of helping you control your diabetes.

TYPE 1 DIABETES is a clearcut problem with a clearcut solution. Problem: The pancreas no longer makes any insulin. Solution: Inject insulin.

Type 2 diabetes is not so basic. If you're a typical person with type 2, your blood glucose levels are high because you have:

- A pancreas that doesn't make enough insulin
- A liver that releases too much glucose
- Muscle cells that don't easily take in glucose

Here's how things worked *before* you developed diabetes:

You ate. Your blood glucose level started to go up. When your pancreas sensed the glucose, it sent out insulin. When your muscle and fat cells sensed the insulin, they let in glucose.

Your liver helped control your blood glucose levels, too. It tracked insulin levels in your blood. Under normal conditions, when there was insulin in your blood, glucose levels were high, too. Your liver would say, "Oh, good, the body just ate. No need for me to send out glucose."

But when you didn't eat for hours (like when you were sleeping), your liver sensed the lack of insulin in your blood. It then decided to put out glucose to keep your level from dropping too low. But today you have type 2 diabetes. If your diabetes is typical, it began like this:

You'd eat. Your blood glucose levels would go up. Your pancreas would put out the right amount of insulin. But your muscle cells couldn't sense the insulin. So they didn't take in much glucose.

Your liver may have failed to sense the

insulin, too. It would think, "Hmm, no insulin means the body hasn't eaten recently. I'd better put out glucose."

Your pancreas would sense that there was still a lot of glucose in your blood, so it would produce extra insulin. This may have gone on for years. When your pancreas could no longer keep up with the extra demand, your blood glucose levels went up and stayed up. And you were told you had diabetes.

So type 2 diabetes involves several problems with several possible solutions. One is insulin injections. These can overcome insulin resistance. There are also five classes of diabetes pills. Each class acts in a different way to control blood glucose levels. (See the illustration on page 29 for more on how each class works.)

Many people benefit from taking two or more diabetes drugs, each of which addresses a different problem. Such combination therapy is so common that some drug companies now market combination pills.

No matter which diabetes pill you use, you still need enough insulin in your body—either natural or injected—to move glucose into cells.

Marie McCarren is the author of Insulin For Type 2 Diabetes: Fears, Myths, And Truths and Carb Counting Made Easy. She lives in Arnold, Md.

Class
Biguanides

Main Site of Action
Liver

How They Control
Blood Glucose
*Keep the liver from
releasing too much
glucose, and also
make muscle cells
more sensitive to
insulin.*

Class
Sulfonylureas

Main Site of Action
Pancreas

How They
Control
Blood Glucose
*Stimulate
pancreas
to secrete
more insulin.*

Class
Meglitinides

Main Site of Action
Pancreas

How They
Control
Blood Glucose
*Stimulate pancreas
to secrete more
insulin, much like
sulfonylureas,
but are shorter
in action.*

Class
*Thiazolidinediones
(TZDs)*

Main Site of Action
Muscle cells

How They Control
Blood Glucose
*Make muscle
cells more
sensitive to
insulin.*

Class
*alpha-Glucosidase
Inhibitors*

Main Site of Action
Intestine

How They Control Blood
Glucose
*Slow the digestion of
some carbohydrates.
After-meal blood glucose
peaks aren't as high.*

WHERE The Action Is

This diagram illustrates
where and how different
classes of type 2 drugs
help control diabetes.

HUMAN BODY SILHOUETTE BY SCOTT CAMAZINE/PHOTO RESEARCHERS; ILLUSTRATORS OF INTERNAL ORGANS BY BRIAN EVANS/PHOTO RESEARCHERS;
ILLUSTRATION OF FOREARM MUSCLES BY BO VIESLAND, MIM/SCIENCE PHOTO LIBRARY/PHOTO RESEARCHERS.

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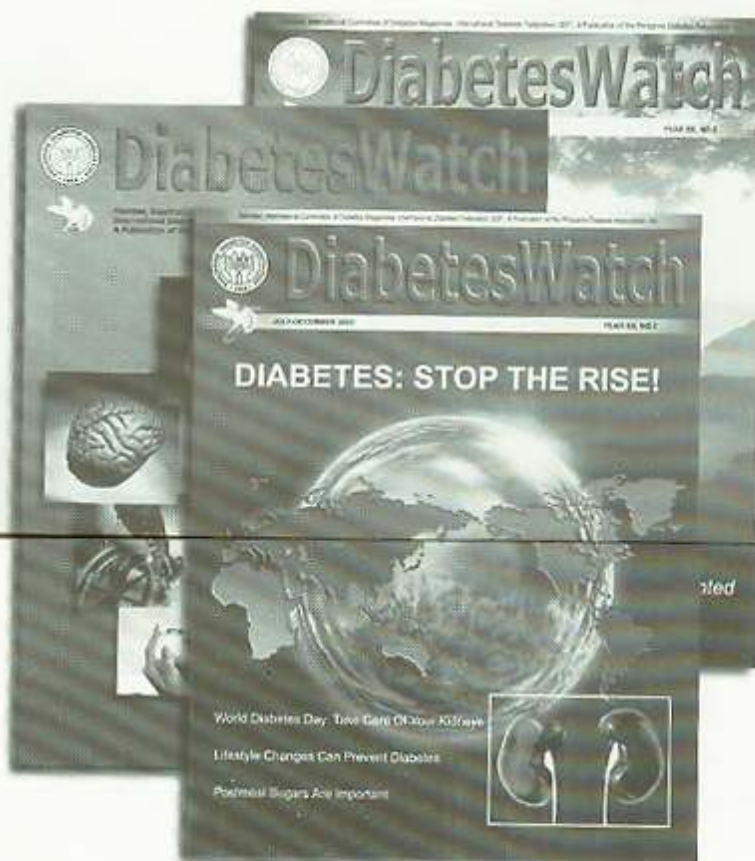


DiabetesWatch

and receive:

- *free subscription to the Diabetes Watch*
- *free attendance to the PDA Annual Lay Convention*
- *free registration to scientific seminars (for medical personnel)*

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PDA
now!!!**





PHILIPPINES 2005

ASEAN FEDERATION OF ENDOCRINE SOCIETIES Congress

Theme:

Interactions between Clinical and Molecular Endocrinology

December 7-10, 2005

Philippine International Convention Center
Manila, Philippines

Organized by:

The Philippine Society of Endocrinology and Metabolism, Inc. (PSEM)
and

The Philippine Diabetes Association, Inc. (PDA)

