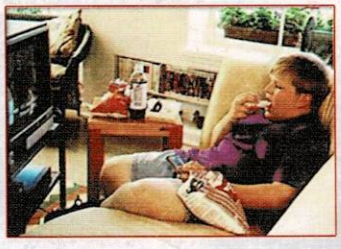
Member, International Committee of Diabetes Magazines, International Diabetes Federation (IDF), A Publication of the Philippine Diabetes Association, Inc.

DiabetesWatch

JULY - DECEMBER 2004 YEAR XXI, NO. 2

OBESITY in Children





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Control those sugar rises with carb counting

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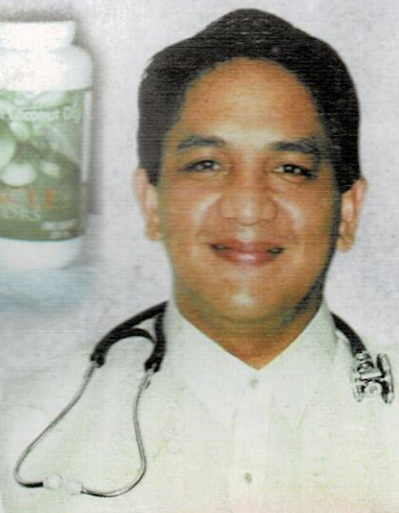
Time for an oil change?

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3. UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). Lancet 1998; 352: 854-865.

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From the editor's desk

PHILIPPINE DIABETES ASSOCIATION, INC.

DiabetesWatch

Hi! Have you ever thought about the phrase "you are what you eat"? Many people go through life without a thoughtful approach to food and eating and allow themselves to be guided mostly by their appetites and senses. The number of overweight and obese people today and the alarm signals about the diabetes pandemic attests to this observation. We are constantly bombarded with advertisements about food most of which may not be healthy. In the rush of life however these convenience foods become daily fair. Add lack of exercise and the daily stress of life to this state of affairs and the result is what is known today as diseases of lifestyle – diabetes, cancer and heart disease.

I once asked a young executive who was hypertensive, diabetic and hyperlipidemic if she could change her way of life in the next two to three years and she sadly said no.

What then? Will the majority be doomed to these diseases of the modern century which is sure to worsen during this information age which is now upon us where everything is faster and perhaps imposes more stress to our beings?

In keeping with the theme of this year's World Diabetes Day, this issue of Diabetes Watch looks at the problems of overweight and obesity. There's a lot of talk about food, strategies for weight loss, and for good measure we've thrown in an inspiring story about a busy professional who decided to lose weight and gain health.

Finally, in our challenge to maintain good health let us not forget to seek the help of God Almighty for strength to overcome our appetites and weaknesses in the daily hurdle of life.

MA. TERESA PLATA QUE, M.D.
Editor-in Chief
tpque@diabetesphil.org

"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 Federation" (IDF)

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Tel. Nos. (632) 531-1278, (632) 534-9559
Fax No. (632) 531-1278
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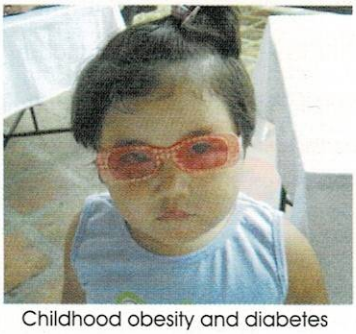

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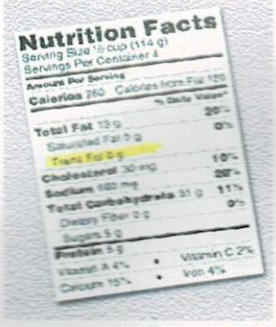

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Taking a second look at virgin coconut oil

Regular Articles

Your president speaks

DiabetesWatch

Now on its 3rd year, the national headquarters once again hosted the PDA chapter Presidents Meeting last July 31, 2004. A total of 10 presidents from the different chapters attended and signified their commitment to help strengthen our mission in order to achieve our vision of a Diabetes-free Philippines.

Past President, Dr. Lina Lantion-Ang, opened the Presidents' Meeting with her words of wisdom that was truly inspiring for everyone to steadfastly pursue our mission in accordance to the values that we strongly uphold. Other distinct leaders of the Philippine Diabetes Association such as Drs. Augusto D. Litonjua, Mary Anne Lim-Abrahan and Ruby T. Go were also present to show their unselfish support and commitment to our beloved association. Significantly, this meeting became more meaningful to everybody because of the team-building activities that were organized.

Furthermore, I am honored this year to announce the launching of two important and special projects of our association; namely: The Healthy Lifestyle VCD duo – video on exercise and nutrition, and the PDA Award of Excellence in Diabetes.

The Healthy Lifestyle VCD duo – video on exercise and nutrition was launched during the World Diabetes Day celebration in connection with the main thrust of the International Diabetes Federation, World Health Organization and the Philippine Coalition for the Prevention of Non-communicable diseases of the Department of Health to prevent the diabetes epidemic by encouraging the public to adopt a healthier lifestyle.

The second project for this year is the launch of the PDA Award of Excellence in Diabetes during the 2004 PDA Annual Convention. This award was envisioned to honor any member of the association who had contributed in the success and advancement of our association. Undeniably, our first Awardee is Prof. Augusto D. Litonjua, MD. He is a man for all seasons who more than deserves this honor for his unselfish dream to help diabetic patients. He is one of the prime movers who made the PDA what it is today. With his dynamism, dedication and intelligence, he laid all the groundwork for a better association.

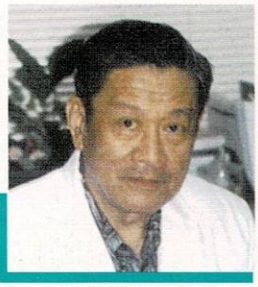
Our work has just started...with the enormous challenge ahead of us we need each other to reach our common goal. I know together, our voice will be louder...together we are stronger in our fight against Diabetes and its complications. I cannot thank everybody enough for your undying passion, dedication and support, which will certainly keep all our dreams moving.

Warm yuletide greetings to everyone!

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

Meanderings

Augusto D. Litonjua, MD
Editor Emeritus



Not all obese people are created equal!

Obesity has become an epidemic all around the world. It is now considered a disease plaguing mankind. This has been attributed to the intake of energy rich dense foods coupled with a more sedentary life style. In the Philippines, obesity is becoming a huge problem.

Why is obesity of concern? By itself, obesity can lead to heart disease. Add to thisthe direct deleterious effect of obesity on the heart to the fact that obesity also engenders other metabolic diseases that makes one more prone to a heart disease. Thus, obesity causes the insensitivity of the tissues to the effect of insulin. As a consequence, the pancreas tries to overcome this defect by producing more insulin to cause a state of hyperinsulinism. Obesity also has been shown to be a cause of high blood pressure or hypertension. Obesity can lead to the elevation of cholesterol and triglycerides in the blood, or dyslipidemia. And obesity is known as one of the strongest environmental factors that can induce diabetes mellitus. Thus, obesity can carry with it a dangerous metabolic cluster – hyperinsulinism, hypertension, dyslipidemia, diabetes and heart disease! The impact of obesity on one's health is therefore tremendous.

How does one know that he is obese? By the Asia-Pacific Guidelines, obesity is present if one has a body mass index of 25kg/m² or greater. The BMI is obtained by dividing one's weight in kilograms by one's height in meter squared. By universal acclamation, obesity carries with it a cluster of metabolic risks that predisposes him to a variety of heart conditions, and even to the risk of heart attack or death.

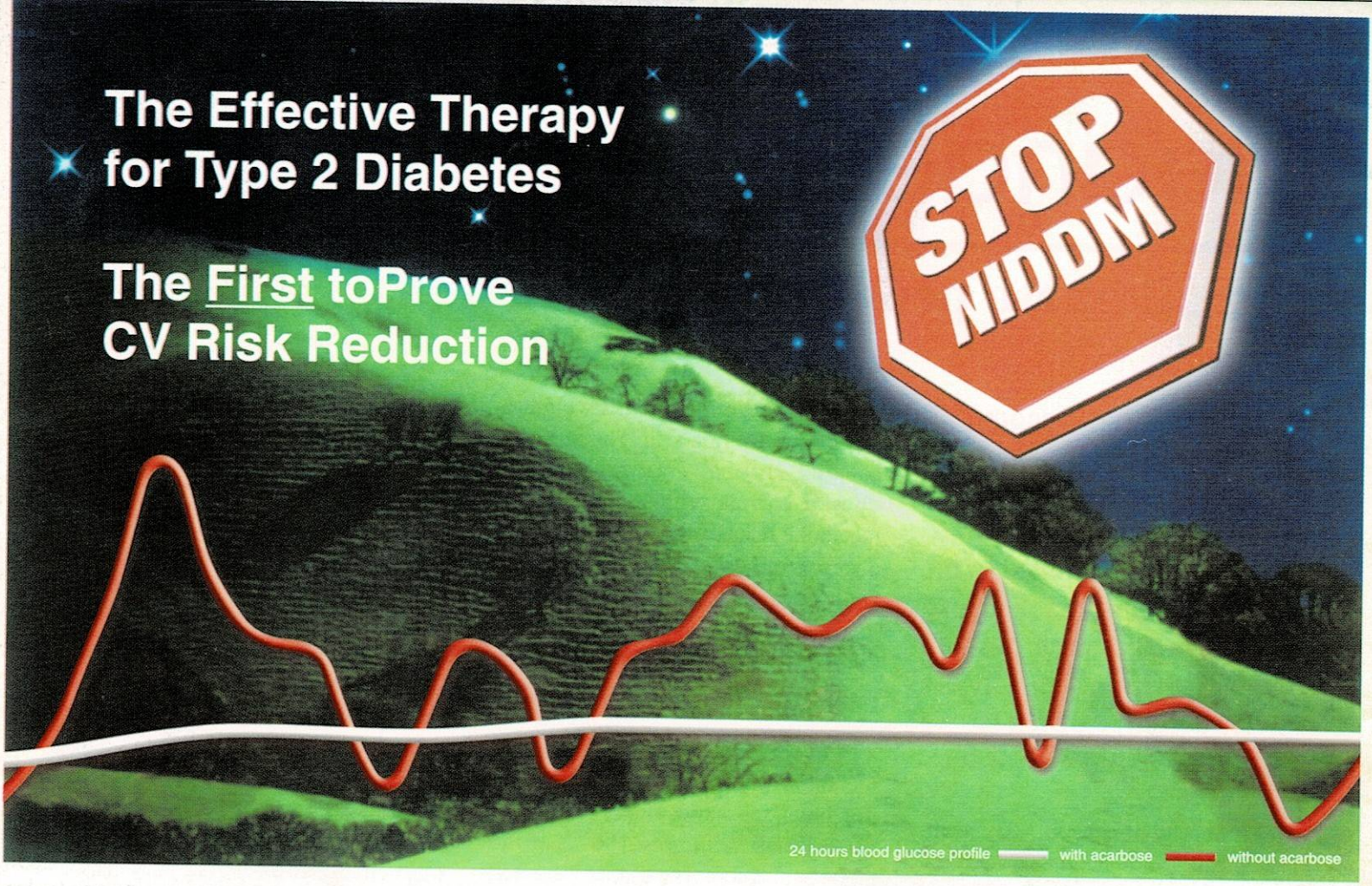
Of one is obese, does this necessarily doom him to an ominous cardiovascular end? Recent studies show that about 20% of obese individuals are considered metabolically healthy, that is, they do not have the same degree of heart disease risk as the rest (80%) of the obese population. The former is labeled "Metabolically Healthy, but Obese" or MHO type of obesity. The greater majority is classified as At Risk, Obese.

What distinguishes these two subtypes of obesity? Ask your physician to determine whether you are 'insulin sensitive', (normal responsiveness of the tissues to the normal amount of insulin produced by the pancreas), or whether you are 'insulin resistant'. This can readily be done by assaying your triglycerides and your good cholesterol (HDL) in the blood. Having obtained these, then divide your triglycerides in mg% by your HDL in mg%. If the quotient is below 3.5, then you are insulin sensitive. If on the other hand, your triglyceride: HDL ratio is greater than 3.5, then you are insulin resistant! If the latter exists in an obese person, then he becomes one of the 80% of the obese population who is at risk for diabetes, hypertension, hypernisulinism, dyslipidemia and eventually cardiovascular mortality.

What in obesity seems to be the cause of insulin resistance? Studies have shown that it is not merely the BMI that determines the health of an individual, but more so the amount of visceral fat. This fat which is located inside the abdominal cavity can be accurately determined by the computerized tomography scan or more popularly known as CT scan. In Japan, the cut-off point for a healthy visceral fat is less than 100 square centimeters, while in Canada, the healthy abdomen should contain no more than 130 square centimeters fat. In the clinics, the surrogate marker for the CT scan is the waist circumference. Ask your doctor what is the normal for your sex. Thus, an MHO individual has a high BMI like the At Risk Obese, but he has less intraabdominal fat—which is what makes him insulin sensitive.

If one belongs to the MHO subtype of obesity, one should not be lulled into a false sense of security that all is okay health-wise. A more recent study which needs more large scale subjects, has shown that there is still a risk for earlier atherosclerosis (hardening of the walls of the arteries) among the MHO individuals.

Thus, as compared to the At Risk Obese, the MHO is less prone for a cluster of diseases, such as, hyperinsulinism, hypertension, diabetes, dyslipidemia, and heart disease. But in comparison to those with a normal BMI, normal waist circumference with normal insulin sensitivity, there is still a modicum of heart disease risk for the MHO individual. So equally take care!



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[1]Mertes G Diabetes Research and Clinical Practice 52 (2001) 193-204; [2]Chiasson J-L et al. JAMA 290 (2003) 486-494; [3]Hanefeld M et al. Eur Heart Journal 25 (2004) 10-16; [4]Chiasson J-L et al. Lancet 359 (2002) 2072-77; [5]Menelly GS et al. Diabetes Care 23 (2000) 1162; [6]Yang WY et al. Chin J Endocrinol Metabol 17 (2001) 131-136

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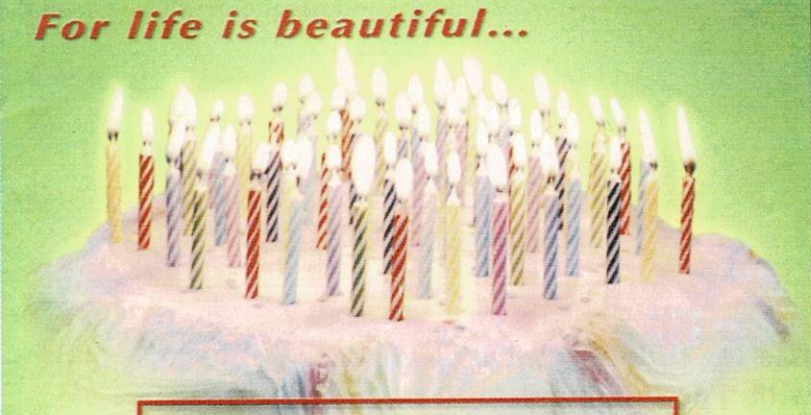

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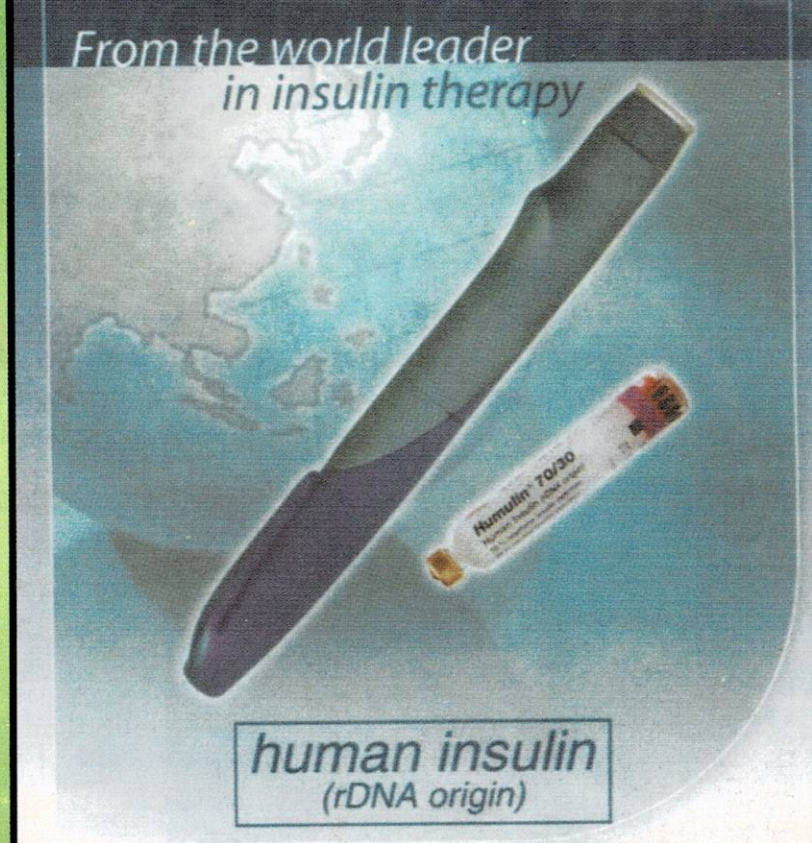

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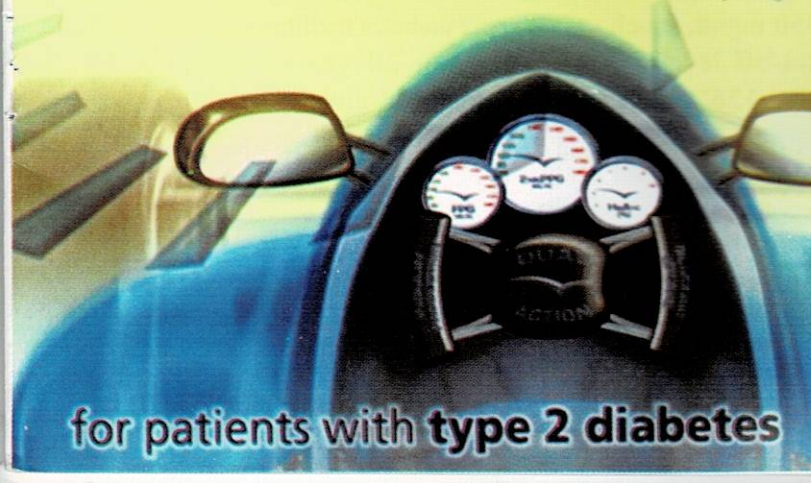

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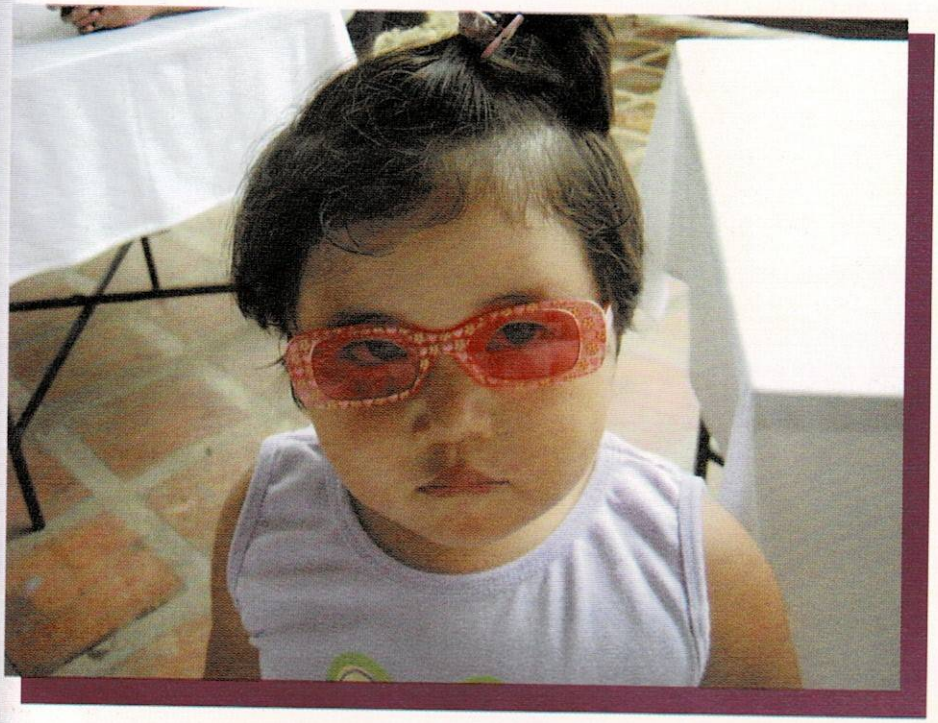
Childhood obesity and diabetes

Sioksoan Chan-Cua, MD
Pediatric Endocrinologist
Cardinal Santos Memorial Hospital

"Overweight and obesity are increasingly affecting children and adolescents, resulting in more and more children being diagnosed with type 2 diabetes, until recently a disease more frequently associated with adults and elderly."



Juan is a 12 year-old adolescent boy. He is tall and heavy. His grandparents are very proud of him. Indeed, they are quite happy to have such a BIG grandson. They often give him money to buy fried chicken and soft drinks in the fast food restaurant in the neighborhood. His uncles and aunts usually give him bags of chocolates as "pasalubong" He also likes Chippy and pizzas which are delivered soon after dialing for home delivery. He has plenty of snacks which he can eat while watching television. He plays computer games – well, he is an expert and a typical e-generation kid!

About a month ago, Juan's parents noted that their son started to lose weight. Juan probably ate less; he might be too stressed during the examination period. He woke up at least once during midnight to go to the toilet. They thought he drank too much during the day. They did not pay too much attention to that. They became alarmed one morning when they saw ants crawling near the spilled urine on the floor.

"Mabuti pa ang langgam, alam!" Indeed, Juan's fasting blood glucose (FBG) level was 350 mg/dl, much higher than the cut-off level for diabetes, which is, 126 mg/dl.

Juan's parents could not believe the laboratory result. However, the repeat FBG level was still elevated at 290 mg/dl. Juan's doctor confirmed he had diabetes mellitus.

Juan has type 2 diabetes mellitus, formerly known as "adult-onset diabetes mellitus" because it used to occur in adults after 40-50 years of age. Nowadays, many children with newly diagnosed diabetes are found to be type 2, and not type 1. Type 1 diabetes was previously called "juvenile-onset diabetes;" it's an autoimmune disease and requires insulin as therapy. Type 2 diabetes in children and adolescents is related to obesity. It requires lifestyle changes such as eating a healthy diet and being physically active. The medication is an oral hypoglycemic drug.

Type 2 diabetes now has emerged as a major complication of childhood obesity. Studies have shown that in USA:

- 1/3 of new diabetics between 10 - 19 years of age had type 2 diabetes
- > 90% of new patients with type 2 diabetes mellitus were obese - they had a body mass index (BMI)> 90th percentile for age
- ~ 40% had a BMI > 40 kg/m2 (severe obesity)
- Type 2 diabetes mellitus in persons less than 20 years of age is increasing dramatically due to increasing obesity and inactivity.

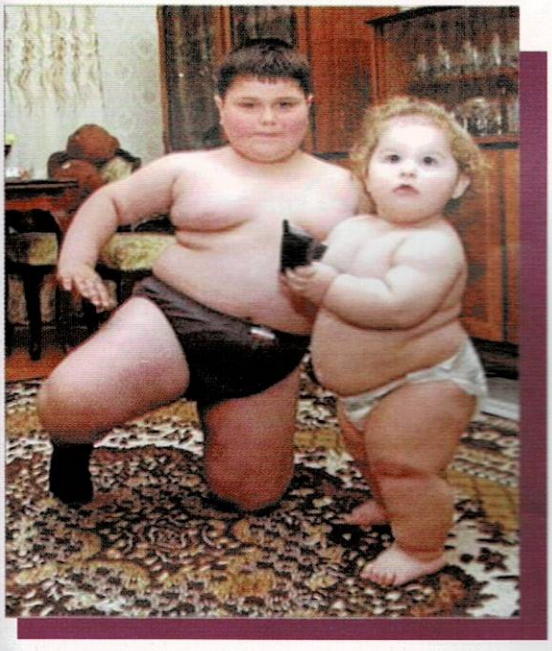
In a recent study (International Diabetes Federation – Western Pacific Region CHILDHOOD AND ADOLESCENCE DIABCARE 2003 Study), 321 adolescents with type 2

Childhood obesity and diabetes

"The most cost-effective way to treat obesity-related complications (including diabetic nephropathy or kidney disease) is primary prevention/intervention, which is, prevention of obesity. "

diabetes were included. The mean age of was 14 years (14.4 ± 2.4 yr) and the mean BMI was high, 26.5 ± 6.6. Among the Filipino adolescents, 84.2% were either overweight or obese (36.8% overweight, 47.4% obese).

According to the International Obesity Task Force (IOTF), up to 1.7 billion of the world's population is already at risk of weight-related non-communicable diseases such as diabetes and heart disease. Overweight and obesity are increasingly affecting children and adolescents, resulting in more and more children being diagnosed with type 2 diabetes, until recently a disease more frequently associated with adults and elderly.



November 14 is World Diabetes Day, the primary global diabetes awareness campaign. This year, the slogan is "Fight Obesity, Prevent Diabetes." Overweight and obesity are the main modifiable risk factors for type 2 diabetes. Lifestyle changes such as eating a healthy diet and being physically active are effective in delaying and, in many cases, preventing the onset of type 2 diabetes, and reducing the risk of developing complications in people with diabetes.

The most cost-effective way to treat obesity-related complications (including diabetic nephropathy or kidney disease) is **primary prevention/intervention**, which is, **prevention of obesity**. Based on all available epidemiological data, prevention should begin in preschool and early infancy. Keep the weight of the children within the normal range (not too thin, not too fat).

Secondary prevention/intervention is the treatment of individuals who have developed a disease **to prevent or delay the development of complications**. Juan has just been diagnosed to have diabetes mellitus. He needs to be treated with oral hypoglycemic drugs in order to bring down his blood glucose levels to normal range. Most importantly, he needs to change and have a healthy lifestyle by being LESS sedentary and NOT taking excessive calories.

To prevent pediatric overweight and obesity, the Recommendations on Health Supervision by the American Academy of Pediatrics (AAP) include the following:

- Encourage, support, and protect breastfeeding
- Encourage parents and caregivers to promote healthy eating patterns by offering nutritious snacks, such as vegetables and fruits, low-fat dairy foods, and whole grains;
- Encourage children's autonomy in self-regulation of food intake and setting appropriate limits on choices, and modeling healthy food choices.
- Routinely promote physical activity, including unstructured play at home, in school, in child care settings, and throughout the community.
- Recommend limitation of television and video time to a maximum of 2 hours per day.

Childhood obesity is like a time bomb. So, don't keep it in the body. If it is already present, it is better to remove it before it explodes. FIGHT OBESITY, PREVENT DIABETES!

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3. Data on file. Laboratoires Fournier S.A. France

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EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT DIABETES

(but were afraid to ask...)

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

Fats, fats, fats! Today we answer your questions on fat. We realize the importance of cutting back on fats. We dispel some of the myths associated with fats. Read on and learn.

Q "Does a higher fat intake contribute to a higher caloric intake?"

A It does. A gram of fat contributes 9 calorie vs. a gram of carbohydrate or protein, which contributes 4 calories. Research supports the idea that reduced fat meal plans maintained over a long-term contribute to weight loss and improvement in dyslipidemia (abnormal cholesterol levels).

Q "What can I do to cut down on my fat intake?"

A There are several ways you can do that. Eat smaller and fewer meat servings. Meat has marbled fat (fat incorporated into the meat itself). Choose leaner cuts of meats. If eating meat, remove visible fats, even before cooking. Avoid chicken skin. Cook using low fat cooking methods—baking, broiling, roasting. When frying or sautéing foods, use nonfat cooking spray or a small amount of vegetable oil. Use vegetable oil such as corn oil, safflower or olive oil rather than butter, margarine or shortening. Refrain from eating too much of hotdogs, hams sausages, longganiza, tocino and bacon. Stay away from organ meats (bopis, brain, sisig, dinuguan, batchoy, liver, etc.). Eat eggs sparingly. Chill gravies, soups or stews until the fat hardens. Remove the fat layer, reheat and serve. Use nonfat or low fat alternatives such as low fat mayonnaise or salad dressing, low fat cheese, light margarine. Use nonfat milk. Say no to junk food. Cakes, pastries, doughnuts, croissant, ice cream are not only high in sugar they are also high in fats. The most important thing is that you must pay attention to the total amount of saturated fat and calories you eat.

Q "It is safe for me to use lower-fat or fat-free foods?"

A Using these foods may help you achieve your lipid goals especially if you have a lipid problem. These may also reduce total energy intake. Manufacturers of lower-fat or fat free foods use a group of ingredients known as fat replacers. These mimic certain properties of fat. Most of the fat replacers are carbohydrate-based ingredients such as modified food starch, polydextrose, guar gum, xanthin and maltodextrins. The disadvantage is that most of these foods will be lower in fat but higher in carbohydrate content with minimal caloric savings. Most of the fat replacers are approved as GRAS substances- Generally Recognized as Safe.

Q "What are monounsaturated and polyunsaturated fats? What are the effects of these fats on lipid levels?"

A Monosaturated fats (MUFA) and polyunsaturated Fats (PUFA) are plant derived oils. They are considered less atherogenic than the saturated facts. Some examples are corn oil, olive oil, avocado, safflower oil and rapeseed oil. MUFA and PUFA reduced blood cholesterol concentrations when they replace saturated fatty acids in the foods we eat. It is believed that in the absence of weight loss, a diet high in total carbohydrate (>55% of energy) can lead to elevated triglycerides and decreased high-density lipoprotein cholesterol (good cholesterol). This does not occur with substitution of MUFA or PUFA for saturated fats. The National Cholesterol Education Program suggests that MUFA can be up to 20% of total energy and PUFA up to 10% of total energy intake. Take into consideration portion sizes. You can easily increase energy intake if you are not aware.

I'm sure you have more questions. We welcome your queries, comments or suggestions. Call or fax us at 5311278 or e-mail me at *mbmirasol@yahoo.com.*

Lower your postmeal sugars: try carbohydrate counting!

Edel Navarrette, RND

By keeping the amount of carbohydrates constant in a meal or snack, the rise in postmeal sugar can be controlled.

The nutritionist is a very important member of the diabetes team and plays a big role in guiding patients through the proper diet to achieve good blood sugar control. Two large scale trials involving thousands of patients, the Diabetes Control and Complications Trial and the United Kingdom Prospective Diabetes Study, were able to demonstrate that the achievement of excellent diabetes control can prevent or delay diabetes complications.

In the DCCT, carbohydrate counting was used as one of four meal planning approaches and was found to be effective in helping people achieve glycemic control while allowing flexibility in their food choices.

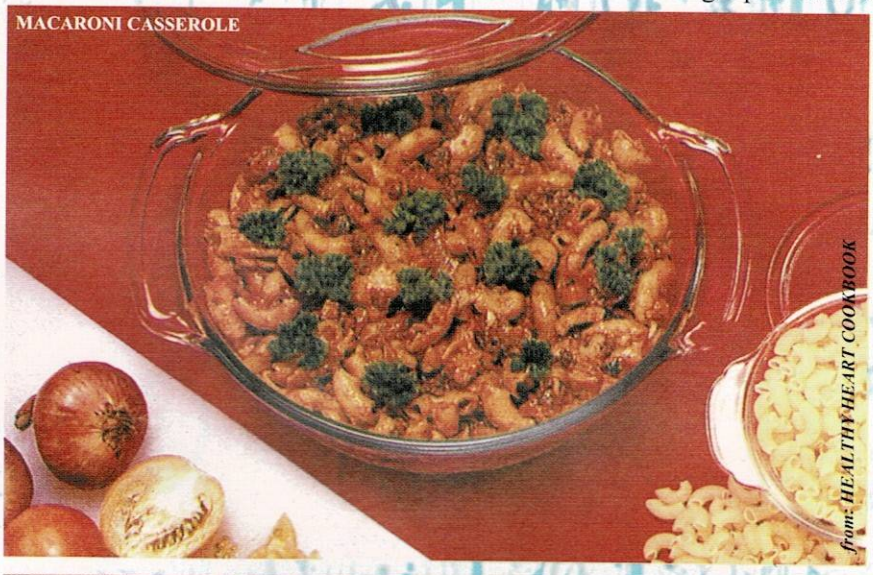
What nutrient makes my blood sugar go up?

Carbohydrate in the food we eat is the primary nutrient that raises blood sugars after meals. Carbohydrate begins to raise blood sugars within 15 minutes of initial food intake and is converted to nearly 100% glucose within 2 hours. This is not true for the calorie containing nutrients such as protein, fat and alcohol.

Diets high in complex carbs like vegetables, root crops, whole grains and fruit provide healthy nutrition for a long and healthy life. This contrasts with a high fat diet which has been linked to obesity, diabetes, cancer and heart disease. In the diabetic patient, carbs must be balanced with insulin(naturally produced in the body or injected) and exercise to keep the blood sugars normal. Therefore, eating a balanced meal at regular times and eating the same amount of carbohydrates consistenly with every meal are ways to be able to control blood sugar levels.

What is carb counting?

Carb counting is based on 2 ideas. The first is that eating equal amounts



Lower your postmeal sugars:
try carbohydrate counting!

"In the diabetic patient, carbs must be balanced with insulin(naturally produced in the body or injected) and exercise to keep the blood sugars normal. Therefore, eating a balanced meal at regular times and eating the same amount of carbohydrates consistenly with every meal are ways to be able to control blood sugar levels."

of sugar, such as in fruit, or starch, such as bread or pasta, will raise blood sugar about the same amount. Carbohydrate is the main nutrient that affects blood sugar while protein and fat have much less effect. Therefore, by keeping the amount of carbohydrates constant in a meal or snack, the rise in postmeal sugar can be controlled.

How does carb counting work?

***See your nutritionist.**

It is best to start by meeting with your nutritionist to discuss your desire to start carbohydrate counting. She can help individualize the recommendations and give you more information than can be provided here. She will also tell you how many choices of carbohydrates you can have for a meal or a snack which will keep your blood sugars within good control.

***Learn the carb counts of food.**

Let us have an example. John needs 45 gms of carbohydrate for breakfast everyday.
He can get this from rice or bread ,fruit and milk or yogurt on days when he is not rushing out to work. On more hectic days, John gets his requirement of 45gms of carbohydrate by eating pandesal, low sugar jelly and a glass of milk. Knowing portions is important. Memorize the gms or caloric content of food that you eat everyday. 3 small pandesal is equivalent to ½ cup of rice and both have 100 calories or 23 gm of carbohydrate.

***Start your plan and monitor results**

Use your blood glucose meter to test 2 hours after eating. Keep a food diary, record your meal selections and glucose levels, and look for patterns of highs and lows that could be associated with specific foods. Bring your records to your doctor and nutritionist.

Carbohydrate counting offers more variety in choices and provides a more accurate guess of how blood sugars will rise after a meal or snack. It may even allow you to swap an occasional high sugar food (even though it may contain fewer nutrients) for other carbohydrate containing foods.

Edel Navarrette is currently a nutrition fellow at the St. Luke's Medical Center where she has her private office and is actively involved with the Rainbow Camp Philippines,Inc.

FNRI Food Exchange Lists for Meal Planning

Group/Lists	Amount/1-choice	CHO (gm)
Carbohydrate group Rice and substitute		
	½ cup rice 2 slices bread 1 cup bihon 1 cup corn flakes ½ cup binatog	23
Fruit	1 slice mango 1 small banana 10 pcs grapes ¾ cup papaya ½ cup pineapple 1/3 cup juice	10
Milk	1 glass(non-fat, low fat or whole milk)	12
Vegetable	½ cup, cooked 1 cup, raw	3

Diabetes management is not a walk in the park.

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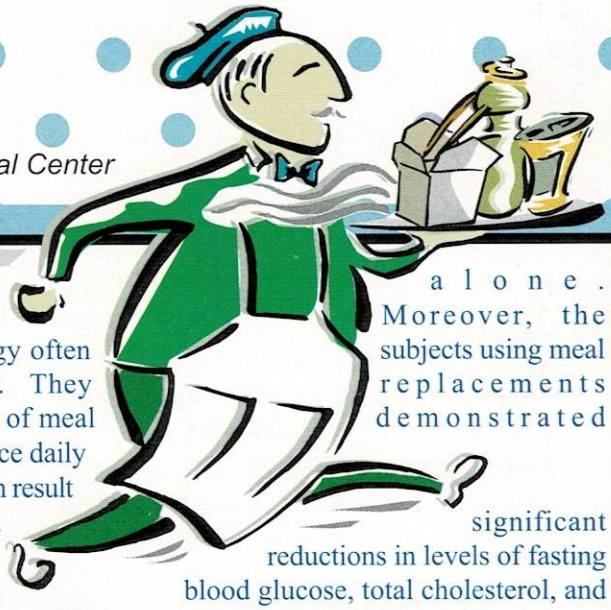
Meal replacements anyone?

Editha I. Arceo-Dalisay, MD, *St. Lukes Medical Center*



An important part of diabetes care and management is medical nutrition therapy. Its goals include :

1. Attain and maintain optimal metabolic outcomes including :
   a. blood glucose levels
   b. lipoprotein profile
   c. blood pressure levels
2. Prevent and treat the chronic complications of diabetes
3. Improve health through healthy food choices and physical activity
4. Address individual nutritional needs.

In clinical practice, we realize that the adoption of medical nutrition therapy (MNT) could be difficult and challenging. This is because we live in an environment where fastfood is becoming the norm rather than the exception.. Fastfoods often lack the nutritional balance that our patients require. Thus, our patients are finding it very difficult to maintain their MNT while eating away from home.

In the past couple of years, specially designed nutritional drinks and meal replacements have been introduced in the market such as Glucerna SR, Choice-DM and Nutren Diabetes. This can be a practical solution as it is convenient and it enhances the dietary adherence of our patients with diabetes.

The use of these meal replacements have been endorsed by the ADA and the European Nutritional Guidelines to promote weight loss among our patients on a daily basis. The ADA states that " meal replacements provide a defined amount of energy often as a formula product". They further state that the use of meal replacements once or twice daily to replace a usual meal can result in significant weight loss. The benefits of the use of meal replacements include convenience, portion size and calorie control, and their compatibility with calorie-controlled diets.

"Because we live in an environment where fastfood is becoming the norm rather than the exception, our patients are finding it very difficult to maintain their MNT while eating away from home."

In a study involving 75 obese subjects with type 2 diabetes the use of meal replacement was assessed. The patients were given 1200-1500kcal/day for 12 weeks and were randomized into three categories : diet with no meal replacements, diet using 2 meal replacements per day sweetened with oligosaccharides, and diet using 2 meal replacements per day fortified with sucrose, fructose, or lactose. Weight loss was comparable between the two meal replacement cohorts and was greater than the loss achieved through diet alone. Moreover, the subjects using meal replacements demonstrated significant reductions in levels of fasting blood glucose, total cholesterol, and LDL-cholesterol as compared to those who received no meal replacement.

In a meta analysis done by Heymsfield and colleagues they have found that meal replacement plans safely and effectively produce significant sustainable weight loss and improve weight related risk factors of diabetes. The intake of 2 meal replacements per day and a sensible third meal was shown to produce weight loss and 1 meal replacement a day combined with sensible eating enabled weight maintenance.

In clinical practice another group of patients who could benefit from meal replacement plan will be the elderly diabetic patients. As we know, our elderly patients with diabetes have problems meeting their nutritional requirements for various reasons. With the advantages of convenience, more accurate assessments of portion size and calorie intake they will surely be helped in meeting their nutritional goals. So in the future, I think studies should be directed towards the benefits of meal replacement plans among elderly patients with diabetes.

Dr. Michael Jaro's personal journey to health and fitness

Ma. Teresa P. Que, MD, *National Kidney Institute*

Losing weight is a challenge and not very many pass the hurdle. It is easy to shed pounds especially with sufficient motivation. The real challenge however, lies in keeping the weight off. The secret is that weight loss will only be sustained if a person is able to permanently change his ways of thinking, eating and exercising.

One not so busy morning I had the chance to talk to a young, busy cardiologist from the National Kidney Institute. Dr. Michael Jaro had trained with us in Internal Medicine some years back after which he pursued a Cardiology fellowship at the UP-PGH. I had seen him as a trim, energetic resident and as a young consultant starting his practice. To my consternation as his patients grew in number so did his waistline. I would sometimes kid him that because of his genes he might become diabetic one day. Two years ago he went on a lifestyle changing course and lost a significant amount of weight. This is his story.

What made you decide to lose weight?

I come from a very high risk family. My mom has diabetes and hypertension and my dad had a major myocardial infarction. I noiced that my blood pressure response to stress went as high as 160/110 even after moderate exercise. I was 240 lbs with a waistline of 40 cm in my 5'11" frame. The obvious thing to do was to lose weight for health and aesthetic reasons.

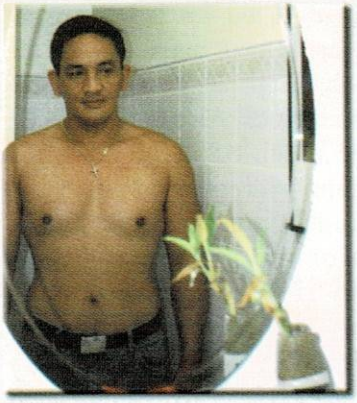
How did you do it?

In a previous attempt to lose weight I went on a low calorie diet and lost 12-15 lbs in a period of 2 months. The problem is that whenever I stopped dieting the pounds easily came back in a matter of 2 weeks. This time I enrolled in a gym along with a friend. Initially it was difficult because of my schedule but I managed to go 3x a week and kept it up for 1 year and 2 months. We would do stretching for 30 minutes and the actual exercise lasted for 2-3 hours. I also changed my diet. I avoided sweets. I used to consume 1 liter a day of regular Coke. I shifted to 6 cans of Coke lite a day and removed sweet juices like Tang and Eight o'clock. I made it a point to eat fruits and drink plenty of water. I did not fast but I made a conscious selection of foods. I ate salads with vinaigrette. I used to like Century Tuna flakes in oil and I shifted

Before

After

Before



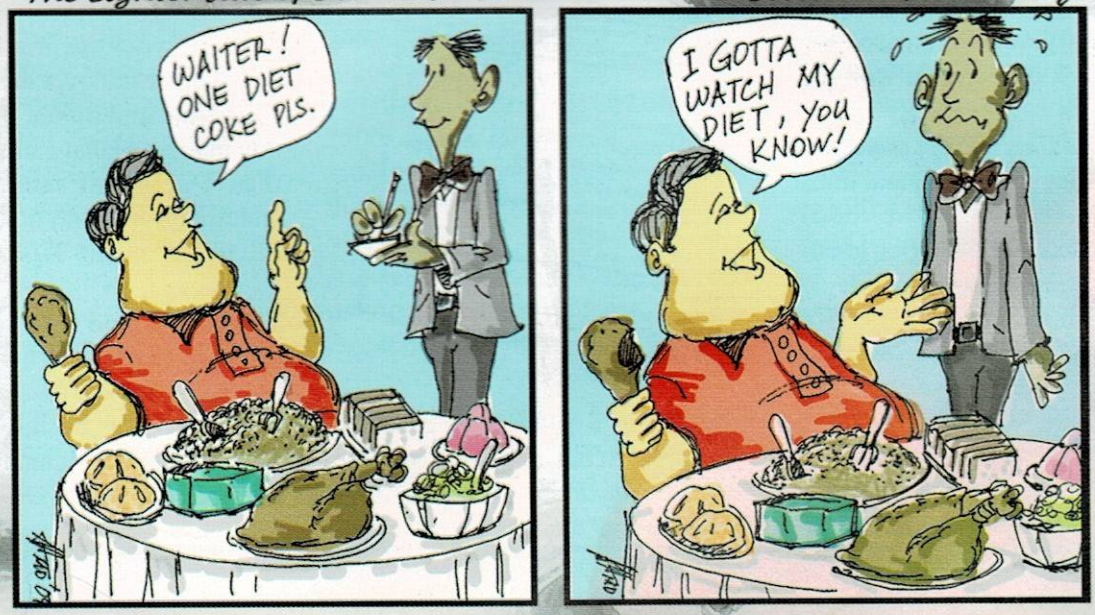
After

to Century Tuna flakes in brine. Avoid oil in the first place because even if you shift to healthy oils like olive oil or corn oil gm per gm its still 9 calories. If you want to lose weight avoid the oil in the first place. I ate chicken but avoided the skin. I started with less than 1600 calories. Sundays, I allowed myself to eat with gusto but still avoided fat. After 6 months I was down to 30 lbs. I had lost 1-11/2 lbs per week which was just right.

Have you been able to maintain your weight loss?

After I stopped going to Fitness First, I created my own gym at home (with weights, bench press, flat bars) and I am into more activities now. I stopped regular exercise for a while due to several meetings abroad, but I gained only 41/2 lbs in a span of 5 months even if I was eating regularly, taking snacks and going out with my family. This is remarkable because in the past when I was just dieting I would lose 15 lbs and gain it back in a matter of 2-3 weeks. My waistline will go down to 38 inches then it would go back to 39 inches. My metabolism has increased because of my regular exercise. I still run in the village, I swim and I do weights. What I do is cross training to avoid injury and work out different parts of my body. The quadriceps and the hamstrings are big muscles which consume a lot of energy. I exercise 3x a week for about an hour. I also encourage my daughter to exercise because she is on the heavy side. We play badminton. Exercise is very, very crucial. My blood pressure now is 110-115/60-70. In the past after holding clinic for about 5-6 hours, my blood pressure would shoot up to 150/110. If you don't give time to exercise then you will easily get back what you have lost. We eat and we we even indulge at times especially when there are parties. It's a hard life and that is the reality. The secret of success is really the discipline and the time that you give to exercise.

The Lighter side of Diabetes — *Dr. Allan Hernandez*



Trans fat alert!

FELICIDAD V. VELANDRIA, RND
Food and Nutrition Research Institute

Trans fats or trans fatty acids (TFAs) are basically formed through hydrogenation (a manufacturing process that turns healthy vegetable oils into solid or hard fats like margarine and shortenings).

Are you watching what kind of fat you're eating? One of the leading risk factors for type 2 diabetes is obesity or excess body fat resulting from an imbalance between energy intake and physical activity. Dietary fats probably also influence the onset of type 2 diabetes but the long term effects of specific types of dietary fatty acids on insulin resistance remain unclear.

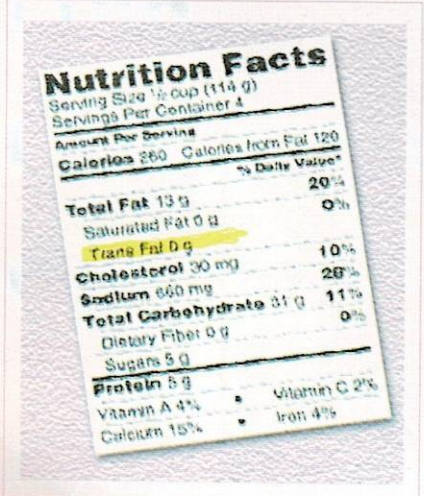
However, recent scientific evidence suggests that trans fats significantly increase the risk of type 2 diabetes. A team of researchers from the Harvard School of Health examined the relationship between different types of dietary fat and the risk of type 2 diabetes. The study involved 84,000 women aged 34 to 59 years old. All were free of diabetes, cardiovascular diseases and cancer at the start of the study. After 14 years, about 2,500 cases of type 2 diabetes were recorded. A close examination at the detailed dietary information gathered periodically from the subjects, the researchers concluded that trans fatty acids increased the risk of type 2 diabetes in women.

Saturated fats (fats that are generally solid at room temperature) and trans fats increase LDL (the bad) cholesterol, decrease HDL (the good) cholesterol and also raise triglyceride levels and may increase insulin resistance. These fats also cause major clogging of arteries and increase risk of heart disease.

Trans fats or trans fatty acids (TFAs) are type of saturated fat that occurs naturally in small amounts both in animal foods like beef fat, milk and dairy products and in few plant foods. TFAs are basically formed through hydrogenation (a manufacturing process that turns healthy vegetable oils into solid or hard fats like margarine and shortenings). Processed foods also contained these TFAs such as french fries, fried chicken, doughnuts, cookies, pastries, crackers, cereal bars and waffles, among others.

Food manufacturers hydrogenate liquid vegetable oils to make them firmer and extend their storage life. Hydrogenated fats are more stable (can be re-used many times in deep-frying) and make piecrusts flakier and french fries crispier. But above all, hydrogenated fats or trans fats are popular because they increase flavor stability hence, making food taste good.

One tip to determine the amount of



trans fat in a food is to read the ingredient label and look for the *shortening, hydrogenated or partially hydrogenated oil*. The higher up on the list these ingredients appear, the more trans fat. One can also add up the amount of fat in a food product (saturated, monounsaturated and polyunsaturated), provided the amounts are listed and compare the total with the total fat printed on the label. If they much up, the difference is likely trans fat, especially if partially hydrogenated oil is one of the first ingredients listed. Look for trans fat listing just below saturated fat on the Nutrition Fact panel, already on some processed foods. Also, pay attention to how much of the food eaten containing hydrogenated oils. Even if a product contained negligible amount of trans fat, these will likely add up if one eats twice the recommended or usual serving size. Knowledge on how to identify *trans* fat on the food label gives information on how to make food choices that help reduce the risk of diabetes and other serious health problems.

To avoid or limit trans fatty acids in the diet, look for processed foods made with unhydrogenated oils rather than hydrogenated or saturated fats. The American Heart Association (AHA) advises use of soft margarines (tub margarine) over the harder stick margarine and butter. Furthermore, buy margarine that contains no more than 2 grams of saturated fat per tablespoon and with liquid vegetable oil listed as the first ingredient.

The bottom line is to keep total fat intake to low level. The less total fat you ingest, the less trans and saturated fats you'll get. So now there's no excuse for not watching the amount and type of fat you are eating!

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The lipid laden diabetic

Tommy Ty-Willing, MD, *Metropolitan Hospital*

Clinical trial evidence suggests that more aggressive management of even modest lipid abnormalities in type 2 diabetes leads to reduction of the incidence of myocardial infarction, stroke, and vascular death.

Type 2 Diabetes increases the risk of cardiovascular disease (CVD) between two and six-fold, and shortens life expectancy by 5 to 10 years. Cardiovascular disease is the leading cause of morbidity and mortality in patients with type 2 diabetes. The risk of myocardial infarction (heart attack) in diabetic individuals who have not had a previous heart attack can be as high as in non-diabetic individuals with a history of heart attack. Such is the recognition of the increased risk that diabetes has been established as a CVD risk factor equivalent.

The increased risk for heart attack is related in part to lipid (blood fats) abnormalities.

Diabetic dyslipidemia is characterized by three lipoprotein abnormalities: Elevated very low-density lipoprotein (VLDL), small lowdensity lipoprotein (LDL) particles and low high density lipoprotein (HDL). This type of dyslipidemia occurs frequently in patients with premature CHD and appears to be an atherogenic lipoprotein phenotype independent of elevated LDL cholesterol.

Patterns of dyslipidemia in Type 2 diabetes

In type 2 diabetes, moderate hypertriglyceridemia associated with reduced levels of HDL cholesterol is common. When glycemia is well controlled, serum triglycerides in type 2 diabetes patients can be normal. Since glycemia control is often insufficient, serum triglycerides in type 2 diabetic patients typically are elevated. A correlation of hypertriglyceridemia can be found with both glycemic control and obesity. Diabetic hypertriglyceridemia is based on enhanced liver VLDL secretion and diminished VLDL and chylomicron clearance. Because of their cholesterol content, increase in triglyceride-rich lipoproteins leads to mild elevation in total serum cholesterol. When glycemic control is poor, total serum cholesterol in type 2 diabetes can be significantly enhanced due to the additional accumulation of LDL. Distinct quantitative and qualitative alterations of lipoproteins are present in type 2 diabetic patients.

The impact of triglycerides on LDL composition

Type 2 diabetic patients with good or reasonable glycemic control have normal LDL cholesterol concentration. Nevertheless, LDL catabolism is impaired in patients with moderately severe diabetes, resulting in an increased proportion of triglycerides. The increase in the concentration of small, dense LDL in serum, their glycation and oxidative modification contribute to the increase of total serum LDL in poorly controlled diabetic subjects. Under conditions of poor glycemic control, LDL of type 2 diabetic patients contain an elevated proportion of triglycerides, mostly at the expense of cholesterol. Triglyceride enrichment in LDL is even more pronounced in obese type 2 diabetic patients with elevated total serum triglycerides. Since triglyceride enrichment in LDL modulates particle size and density, small dense and triglyceride-rich LDL subfractions are found to be elevated in type 2 diabetes. Diabetic hyperinsulinemia based on insulin resistance might further promote the formation of small, dense LDL. Finally, small dense LDL subfractions exhibit enhanced susceptibility for oxidation which again enhances modification. Alterations in the lipid composition or size of LDL-particles have consequences for their binding to lipoprotein receptors; triglyceride-rich and small, dense LDL show reduced cellular uptake via the LDL-receptor, leading to accumulation of LDL in the vascular system.

HDL (Good Cholesterol)

A decrease in HDL cholesterol up to 20% in type 2 diabetic patients has often been reported in combination with altered composition of HDL. Similar to VLDL and LDL, HDL particles contain an increased proportion of triglycerides. Triglyceride-rich HDL show a faster catabolic rate than normal HDL, followed by a decreased number of circulating HDL particles. The decrease of HDL in type 2 diabetes is mostly accounted for by the decrease in the HDL_2 subfraction.

Management of Lipid disorders in type 2 diabetes

Since the risk of CHD is excessive in diabetic patients, recommendations of an aggressive lowering of LDL cholesterol levels, given for patients with established CHD, can also be extended to diabetic patients. The US Adult Treatment Panel III of the National Cholesterol Education Program recommended that the target level of LDL cholesterol should be less than 2.6 mmol/1 (100 mg/dl).

With regard to the potential benefits of lowering serum triglycerides in diabetic patients, pharmacological

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT DIABETES

(but were afraid to ask...)

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

Fats, fats, fats! Today we answer your questions on fat. We realize the importance of cutting back on fats. We dispel some of the myths associated with fats. Read on and learn.

Q "Does a higher fat intake contribute to a higher caloric intake?"

A It does. A gram of fat contributes 9 calorie vs. a gram of carbohydrate or protein, which contributes 4 calories. Research supports the idea that reduced fat meal plans maintained over a long-term contribute to weight loss and improvement in dyslipidemia (abnormal cholesterol levels).

Q "What can I do to cut down on my fat intake?"

A There are several ways you can do that. Eat smaller and fewer meat servings. Meat has marbled fat (fat incorporated into the meat itself). Choose leaner cuts of meats. If eating meat, remove visible fats, even before cooking. Avoid chicken skin. Cook using low fat cooking methods—baking, broiling, roasting. When frying or sautéing foods, use nonfat cooking spray or a small amount of vegetable oil. Use vegetable oil such as corn oil, safflower or olive oil rather than butter, margarine or shortening. Refrain from eating too much of hotdogs, hams sausages, longganiza, tocino and bacon. Stay away from organ meats (bopis, brain, sisig, dinuguan, batchoy, liver, etc.). Eat eggs sparingly. Chill gravies, soups or stews until the fat hardens. Remove the fat layer, reheat and serve. Use nonfat or low fat alternatives such as low fat mayonnaise or salad dressing, low fat cheese, light margarine. Use nonfat milk. Say no to junk food. Cakes, pastries, doughnuts, croissant, ice cream are not only high in sugar they are also high in fats. The most important thing is that you must pay attention to the total amount of saturated fat and calories you eat.

Q "It is safe for me to use lower-fat or fat-free foods?"

A Using these foods may help you achieve your lipid goals especially if you have a lipid problem. These may also reduce total energy intake. Manufacturers of lower-fat or fat free foods use a group of ingredients known as fat replacers. These mimic certain properties of fat. Most of the fat replacers are carbohydrate-based ingredients such as modified food starch, polydextrose, guar gum, xanthin and maltodextrins. The disadvantage is that most of these foods will be lower in fat but higher in carbohydrate content with minimal caloric savings. Most of the fat replacers are approved as GRAS substances- Generally Recognized as Safe.

Q "What are monounsaturated and polyunsaturated fats? What are the effects of these fats on lipid levels?"

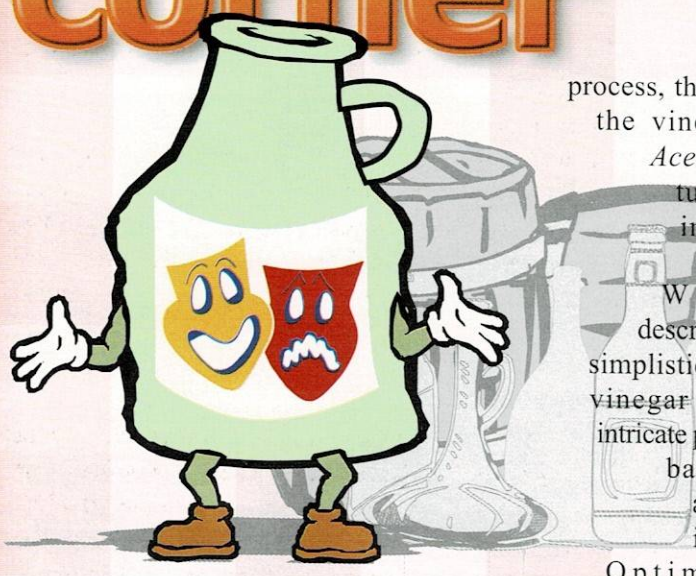
A Monosaturated fats (MUFA) and polyunsaturated Fats (PUFA) are plant derived oils. They are considered less atherogenic than the saturated facts. Some examples are corn oil, olive oil, avocado, safflower oil and rapeseed oil. MUFA and PUFA reduced blood cholesterol concentrations when they replace saturated fatty acids in the foods we eat. It is believed that in the absence of weight loss, a diet high in total carbohydrate (>55% of energy) can lead to elevated triglycerides and decreased high-density lipoprotein cholesterol (good cholesterol). This does not occur with substitution of MUFA or PUFA for saturated fats. The National Cholesterol Education Program suggests that MUFA can be up to 20% of total energy and PUFA up to 10% of total energy intake. Take into consideration portion sizes. You can easily increase energy intake if you are not aware.

I'm sure you have more questions. We welcome your queries, comments or suggestions. Call or fax us at 5311278 or e-mail me at *mbmirasol@yahoo.com.*

Kitchen corner

The many faces of vinegar

Maricris B. Encarnacion



At a native dinner I once hosted at home, *a balikbayan* guest picked up one of three *Ugu Bigyan* pottery jars that I had on the buffet table. "These are so beautiful but why do they have S, P, and T embossed on them?" she asked. "That's for *suka, patis* and *toyo*." I replied. She was fascinated at the ingenuity of the artist and I was quietly gleeful that once again, a foreigner was able to appreciate *Pinoy* talent. Vinegar, fish sauce and soy sauce are staple condiments of Filipino cuisine. They are in constant use in cooking and dipping and are ubiquitous regulars in our dining tables. Of the three, however, it is vinegar that transcends regional tastes.

Ten thousand years ago, a cask of wine that had accidentally gone bad led to the serendipitous discovery of vinegar. Instead of dreadful wine, they found sour wine or *vinaigre*, in French. Vinegar is a product of two separate biochemical processes, both the result of the action of microorganisms. The first process is alcoholic fermentation when the action of yeasts changes natural sugars into alcohol. In the second process, the introduction of the vinegar bacteria—*Acetobacter aceti*—turns the alcohol into acetic acid.

While this description may sound simplistic, the making of vinegar is actually an intricate procedure. Proper bacterial cultures and timing are important. Optimal natural fermentation happens only after 45 to 60 days, under well-controlled conditions. Vinegar makers then pasteurize the end product to prevent "mother" or vinegar cloud from forming.

"Mother" of vinegar naturally occurs in vinegar products as the result of *Acetobacter aceti* itself. "Mother" is actually cellulose, a natural carbohydrate which is the fiber in foods like celery and lettuce. It is harmless and not a sign of spoilage. Shaking or filtering before use can remove it.

All vinegars contain acetic acid. The debate on whether or not a particular brand of vinegar is "natural" or not should focus, therefore on the process of fermentation.

Natural fermentation occurs slowly since the *Acetobacter aceti* bacteria need oxygen to thrive. Because only the surface area of the alcoholic liquid is exposed to the oxygen in air, it takes a while for the vinegar bacteria to "consume" a whole container and transform it into the final product. The result is mellow vinegar that captures the characteristics of its parent wine from grapes, from coconuts, from malt, from other fruits.

In commercial vinegar making, compressed air is blown into stainless steel tanks containing cheap wine. The *Acetobacter aceti,* plumped up by an abundant supply of oxygen, gobbles up the alcohol in record time and converts a whole tank into vinegar anywhere from 3 hours to 3 days instead of 45 to 60 days. The result is vinegar that is simply sour, harsh, one dimensional and devoid of character.

Vinegar can be made from almost anything that contains sugar or starch – fruits, grains and roots. A wide range of vinegars is produced worldwide; with each type dependent on what is abundant in each country. Wine countries like Italy and France manufacture red and white wine vinegar from grapes. In England and Germany, beer and hops are common alcoholic beverages, and malt vinegar is the perfect companion to Fish and Chips. Germans also use it almost exclusively for pickling cabbage and meat. Date vinegar is popular in the Middle East where date trees flourish in the dry desert air. The rice-growing countries of Japan and China turn out excellent rice vinegars. North America makes apple cider vinegar while coconut and cane vinegars are widely available throughout Southeast Asia and India.

The most popular premium vinegar though, is Balsamic vinegar, from the sugar-laden *Trebbiano* or *Spergola* grapes that grow around the hills of Modena and Reggio, Italy. Traditional Balsamic vinegar is pure

"Vinegar can be made from almost anything that contains sugar or starch – fruits, grains and roots. A wide range of vinegars is produced worldwide; with each type dependent on what is abundant in each country."

and has nothing else added to it. It is aged for a minimum of 10 years and transferred every year to different wood barrels. This is done so that the vinegar can capture the different flavors of the approved woods—oak, cherry, chestnut, mulberry, acacia, juniper, and ash.

Vinegar's many uses hark back to ancient times. The Babylonians used it as a preservative. To the Romans, it was a beverage. Hippocrates extolled its medicinal properties and Biblical references show that it was used for soothing and healing. Cleopatra won her wager that she could consume a fortune in a single meal by dissolving precious pearls in vinegar and drinking it. In the Middle Ages, vinegar was an antiseptic and an antidote against the plague.

Today, we still use vinegar for cooking, for cleaning, for disinfecting and for health. It is a popular condiment often flavored with herbs and fruits. White vinegar is a cheap and effective household cleaner and sanitizer. Natural apple cider vinegar is touted in non-mainstream medicine as a wonder drug that promotes longevity. Vinegar is also useful for the treatment of rashes, bites and other minor ailments when camping.

We have many types of vinegar in the Philippines, each with its distinctive taste. Coconut vinegar made from *tuba* or the sap of the coconut tree is expectedly the most common due to the large population of coconut trees throughout our archipelago. It is also the most neutral in flavor.

Sukang Iloko from *basi*--naturally fermented sugarcane juice infused with the leaves, fruits and bark of the medicinal *samak* tree—is an indispensable companion to crisp Vigan *longganiza*. *Sukang Paombong* or *sukang sasa,* dark and fragrant, is made from nipa sap and is one in Bulacan's long list of home-grown products.

Currently making waves is *sukang irok* or *sukang kaong,* from the sap of the sugar palm tree or *Arenga pinnata* grown in Indang, Cavite. Arengga vinegar, a brand name struggling for instant recall, is the world's only bottled sugar palm vinegar. The manufacturing of this certified organic vinegar, from the propagation of the sugar palm tree to the harvest of the sweet sap to the natural fermentation in *burnay* jars is a story in itself. Its long journey from seed to frosted bottled has merited attention from CBI (Center for Promotion of Imports), the Netherlands as an organic food ingredient with export potential to EU. It will be presented during CBI's export marketing seminar in the Netherlands in November 2004. Arengga vinegar as a product has won several awards and plaudits: Among others, one of Top Nine Products at the Australian Fine Food Fair in September 2004; one of only four products selected for sponsoring by the ASEAN-Japan Center at Ginza, Tokyo. It has earned its bragging rights and can be claimed by every bashing-weary Filipino as Proudly *Pinoy.*

The next time you shop for condiments, remember your choices of naturally fermented vinegar. You should end up with more than one bottle marked "S" at your table.

The author was a contributor to Food Magazine, an ABS-CBN publication; the food editor of Zee Quarterly, a Cebu lifestyle magazine; and a food columnist of The Freeman, Cebu, a regional broadsheet. She is currently the Cebu correspondent for Metro Society, ABS-CBN's newest lifestyle publication.

Comments and reactions can be sent to the author at:
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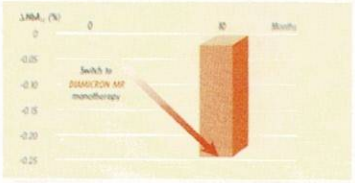

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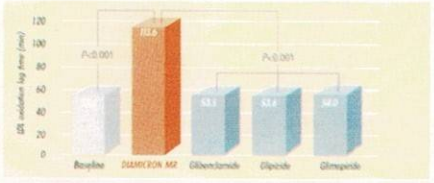

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1. Sattig GK, Ashcroft HM, Br J Pharmacol. 2001;133:193-199. 2. Gribble FM, Tucker SJ, Seino S, Ashcroft FM. Diabetes. 1998;47:1412-1418. 3. Sridon FM, Ashcroft FM. Diabetologia. 1999;42:640-646. 4. Drouin P and the Diamicron MR study group. J Diabetes Complications. 2000;14:165-171. 5. O'Brien PC, Lee M, Bonaiti N, Mertuin J. J Diabetes Complications. 2000;14:201-206.

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1. Rendell,et.al. Skin Blood Flow and Current Perception in Pentoxifylline Treated Diabetic Neuropathy. Angiology Volume 43(10):843-851,pp. 1992.
2. Belcaro G. et. al. Intermittent claudication in diabetes; treatment with pentoxifylline - a 10 month, controlled, randomized trial. Angiology. 2002 Jan-Feb.
3. Ramani, et. al. Hemorheologic approach in the treatment of diabetic foot ulcer. Angiology 1993 Aug; 44(8):623-6

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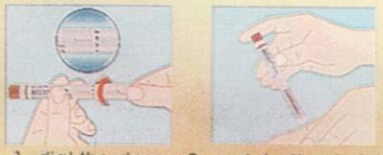

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TIME FOR AN OIL CHANGE?

Taking a second look at virgin coconut oil

Eliza Mei Perez-Francisco, MD

Lately, there has been a lot of interest on the uses and benefits of "virgin" coconut oil. Several newspaper and magazine have devoted column space, the product showcased in trade shows, and there was a blitz of radio and television on-air publicity. Some doctors have gone on the record to attest its effectiveness and even the Department of Health and World Health Organization are looking into its vast potential as a functional food. However, lingering doubts as to its efficacy and safety remain, mainly because of the fear that it is cholesterol-laden and causes heart disease. The question unanswered is, "Is virgin coconut oil really beneficial to health"?

The United States in the 1960`s gave coconut oil a bad name. It had the dubious honor of being the most saturated oil and condemned by media as "unhealthy." With the help of the soybean oil industry's lobby, the U.S. government adopted dietary guidelines, claiming that the consumption of saturated fat caused heart disease and raised serum cholesterol levels.

This claim is now debunked as a MYTH, the conclusions based on flawed and biased scientific studies using coconut oil on animals. Researchers fed animals with non-physiologically high doses of hydrogenated coconut oil. Take note that *all hydrogenated oils produce higher serum cholesterol levels,* whether they are saturated oil or not. Recently, the United States took a second look at the benefits of coconut oil. Modern research has shown that not all saturated fats are the same and that the fats in coconut oil, called Medium Chain Triglycerides (**MCTs**), have unique metabolic properties and functions. DR. Bruce Fife, a naturopathic doctor and author of the book "The Healing Miracles Of Coconut Oil", recently visited Manila exclaimed, *"Coconut oil is the healthiest oil on earth!"*

Virgin Coconut Oil vs RBD Oil

The Philippine Coconut Authority defines virgin coconut oil as: "oil obtained from the fresh, mature kernel of coconut by mechanical or natural means, with or without the uses of heat, without undergoing chemical refining, bleaching or deodorizing, and which does not lead to alteration of the oil." It is pure and raw, and does not use additives in the process. It retains the fresh scent and taste of coconuts.

Other commercial grade coconut oils are made from *copra* instead of fresh coconuts. The extract, which is impure and unsuitable for consumption, requires additional processes such as **RBD**--- Refining, Bleaching, and Deodorizing, requiring additional high heat and chemical solvents. **RBD** oils are often hydrogenated or partially hydrogenated to improve stability and texture. **RBD** oils have no taste and smell.

Saturated fats vs Unsaturated Fats

Fats and oils may be classified according to the length of the carbon chain and the degree of saturation. (See diagram). Simply put, saturated fats turn solid under cold conditions and unsaturated fats remain in the liquid state. Saturated fats are more stable and are not vulnerable to oxidation (rancidity) and formation of 'harmful' free radicals. Unsaturated vegetable oils often undergo the process of hydrogenation to make them more stable to prolong shelf life. When heated, unsaturated hydrogenated oils may produce trans-fatty acids, and these have been linked to heart disease.

Virgin Coconut Oil and Disease

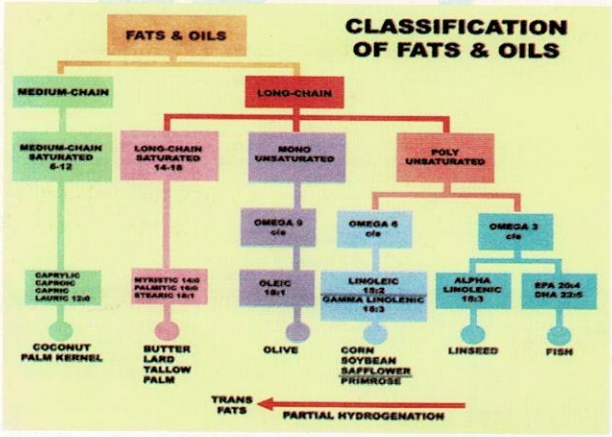
Contrary to popular belief, coconut oil does not contain high amounts of cholesterol nor does it cause heart disease. Among the oils of plant-origin, coconut oil contains the least amount of cholesterol, around 0-14 parts per million. Epidemiological data collected by Dr. Conrado Dayrit, an eminent, pharmacologist and cardiologist, shows that populations who consume coconut products, have a low prevalence of heart disease (e.g.

TIME FOR AN OIL CHANGE?

Taking a second look at virgin coconut oil

The fatty acids in coconut oil do not require bile and pancreatic enzymes for digestion and absorption. Instead, they are absorbed directly from the intestines and sent straight to the liver and converted to energy.

Sri Lanka, Polynesian Islands). Furthermore, it is noteworthy that the Bicolanos who consume the most coconut oil among Filipinos, have the lowest prevalence of heart and cerebrovascular disease. This finding was presented at a symposium at Phil. Coconut Authority in 1987 by Dr. Rodolfo Florentino, a distinguished nutritionist and physician.



Source: "Health Effects of All-Natural Coconut Oil" - United Coconut Associations of the Philippines.

Medical research has shown that coconut oil does not cause adverse effects on the lipid profile of patients. Blackburn et al in 1998 reviewed the literature on coconut oil and made the conclusion that "when [coconut oil is] fed physiologically with other fats or adequately supplemented with linoleic acid, [it] is a neutral fat in terms of atherogenicity."

A study of the **PCRDF** conducted at the New England Deaconess Hospital, a Harvard Medical School affiliate, showed that a diet rich in coconut oil increased the so called "good cholesterol" **HDL** in subjects.

Virgin Coconut Oil and Diabetes

The current dietary recommendation for diabetics, aside from counting carbohydrates, is limiting fat intake. Dr. Fife claims, " There is one fat that diabetics can eat without fear. That fat is coconut oil." It may help stabilize glucose levels, thus reducing the effects of the disease. Garfinkel et al in Journal of Surgical Research in 1992 reported that lauric acid and capric acid, both present in coconut oil, have potent effects on insulin secretion. Also, coconut oil in the diet enhances insulin action and improves binding affinity compared to other oils.

The fatty acids in coconut oil do not require bile and pancreatic enzymes for digestion and absorption. Instead, they are absorbed directly from the intestines and sent straight to the liver and converted to energy. Thus, coconut oil puts less strain on the pancreas during mealtimes when insulin is much needed, and allows the organ to rest and function more efficiently. The unique pathway of digestion of **MCTs** in coconut oil makes it also helpful in diabetic patients with gallbladder disease or in those who have trouble digesting fats. There are reports that coconut oil has a thermogenic (fat-burning) effect and raises the metabolic rate. It may be useful in promoting weight loss in diabetics patients who are overweight or obese. A boost in metabolism may also be beneficial in increasing insulin production and glucose absorption into the cells.

When we ingest coconut oil, lauric acid is converted to monolaurin in the body. Dr. Mary Enig, a renowned nutritionist and biochemist, presented several researches on the antimicrobial (anti-viral, anti-bacterial, anti-fungal) properties of coconut oil. Among the lipid-coated microbes inactivated by monolauriun are opportunistic viruses, herpes virus, H. influenzae, Staphylococcus, Streptococcus, Candida albicans, all of which may cause infections in the diabetic patient.

I've heard of a lot of diabetic patients reporting better sugar levels, less hunger pangs and sugar cravings, weight loss, and better cholesterol levels with virgin coconut oil. Because these remain to be anecdotal reports and testimonies, more research in the field is expected.

In the mean time, the list of uses and users of virgin coconut oil grows exponentially. Now that you have taken a second look at coconut virgin oil,

DON'T YOU THINK IT'S TIME FOR AN OIL CHANGE?

**The author is a certified family physician currently practicing preventive and holistic nutrition. She had completed a combined masters/doctorate in holistic nutrition from Clayton College of Natural Health and currently taking her Fellowship in Nutrition Support at St. Luke's Medical Center.*

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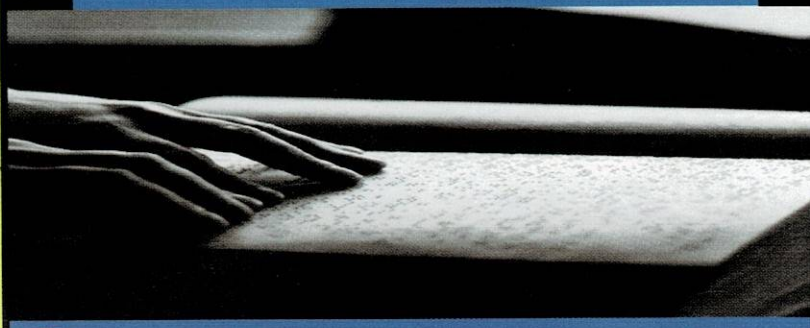

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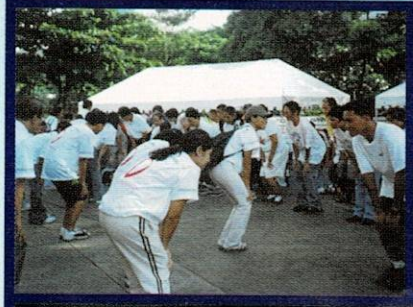
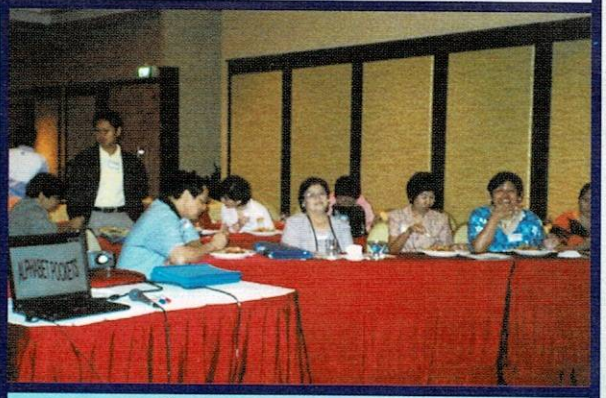
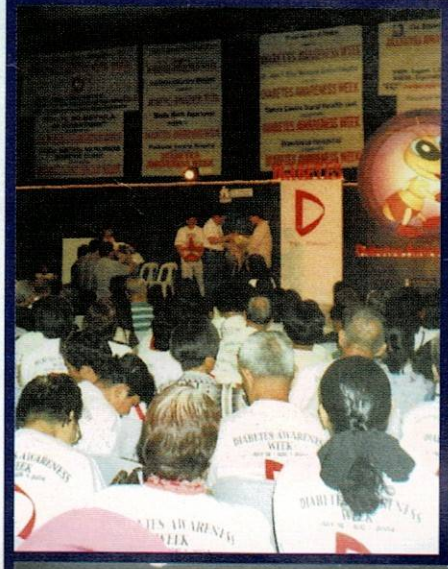
PDA On The Move

The second half of the year was action packed as usual for the Philippine Diabetes Association. After a short summer hiatus, the officers plunged right into preparations for the **Annual Diabetes Awareness Week** celebrations kicking off in two separate places, on **July 18 at the Barcie International Center in Bulacan and at the Ayala Center in Cebu on July 25, 2004.** *(photos below)*

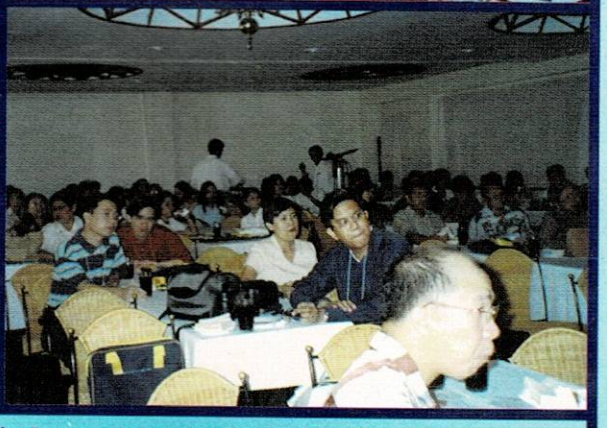




The **July 31st** weekend found the PDA board, PDA past presidents and 11 PDA chapter presidents from all over the country at the Belleveu Hotel in Alabang for the third chapter presidents' meeting and team building activity. *(top & bottom photos)*



The activity focused on how to strengthen individual chapters and plan activities for the next year. The overnight activity was planned so that they would be in place for the **Diabetes Awareness Week Celebration at Ayala Alabang Town Center** the next day. *(right photo & below)*



After this, the board went to Cagayan de Oro, Mindanao for the **28th Diabetes Workshop** at the Xavier Sports and Country Club from September 24-25, 2004. The coordinator was Dr. Teresa Plata Que.*(right photo)* The meeting attracted 129 physicians from all over the region. The Lay workshop held at the Grand Caprice Restaurant and Convention Center on September 25, *(left photo)* was also successful with 80 participants. The officers also enjoyed the hospitality of Dr. Nonen Sison, who graciously opened her home and table to the visiting Manilenos.

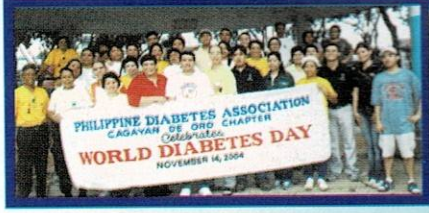
Back home in Manila, the next big event was the Course on Diabetes and Vascular Disease spearheaded by the Council on Diabetes Complications with Drs. Tommy Ty Willing and Rody Sy co-chairing the meeting. The two day affair at the Century Park Sheraton from October 15-16 had 424 participants. *(left photos)*

The **PDA Healthy Lifestyle Video**, a project of the **Council on Exercise and Nutrition** chaired by Dr. Rosa Allyn Sy and Dr. Edith Dalisay, was launched at a press conference at the Discovery Suites *(above photos)* on November 10, 2004. Drs. Ruby T. Go spoke on the epidemiology of diabetes around the world and focused on the Philippine problem while Dr.Rosa Sy introduced the objectives of the video to members of the press. A short preview followed and each attendee was given a copy of the CD-rom.

Our pharmaceutical partner, Natrapharm, was instrumental in making the symposium on **Strategies in Diabetes Management for the Primary Care Physicians** held on November 12 a success. They hosted the venue at the Natrapharm offices in the South Super Highway. *(left side photos)*

The **PDA Lay Annual Convention** at the Century Park Hotel was a fun filled activity with 354 participants. *(left photo & below)*

The World Diabetes Day celebration on November 14, 2004 was a concerted nationwide effort with all the PDA chapters organizing local activities to commemorate the day. Among the activities included were a screening for diabetes mellitus, healthy lifestyle lectures and exercise sessions. *(Daet, Camarines Norte-top photo, Cagayan de Oro-lower photos)*



The culminating activity for the year was the Annual Convention on November 23-24, 2004 at the Edsa Shangri-la Hotel. For the first time, we had more than 1,006 attendees who enjoyed the scientific program with the theme, "Looking the Big Picture of Diabetes," with Dr. Tommy Ty Willing *(lower right photo)* as the overall convention chair. Also given to Dr. Augusto D. Litonjua the PDA Award of Excellence in Diabetes. *(lower left photo)*

It was, as always, a busy, but fulfilling year for the board, who worked all year round toward the mission and vision of a diabetes free Philippines.

What will 2005 have in store for the PDA? We will keep you posted!

PDA Cebu Chapter

MARIAN K. DENOPOL, MD
President, PDA Cebu Chapter

Another year is about to culminate and its time to look at this year's past activities. A moment or two of soul-searching would help us look forward so that we can make focused and workable goals for next year's targets. The mission and vision towards a diabetes free country and adequate control of complications will serve as the beacon of each PDA Chapter.

Education is one of our objectives that has truly been served this past year. January's calendar noted members of PDA Cebu giving lectures about glucose monitoring and the new insulin s and proper use and methods of injection. Succeeding educational activities focused on diabetes direction and essentials of diabetes care. Various lectures done by different diabetologists and endocrinologists from Cebu City and PDA – Manila to the members of the Cebu Medical Society focused on the use of different sulfonylureas, drugs for erectile dysfunction and diabetic nephropathy. Medicine week participation was done with a week long blood sugar and cholesterol screening. Lectures on diabetes mellitus and low cholesterol diet were also done.

The big event this year was the kick – off ceremonies for the Diabetes Awareness Week done at Ayala Center last July 25, 2004. Dr. Augusto D. Litonjua and members of the PDA board and secretarial staff honored us with their presence. All the diabetes clinics and DOH regional staff worked hard to produce a big attendance.

We had one outreach from Cebu to Siquijor. Mayor Villa of Larena, Siquijor and the PESO requested Cebu PDA for diabetes screening and lecturers to help prevent and control diabetes in the area.

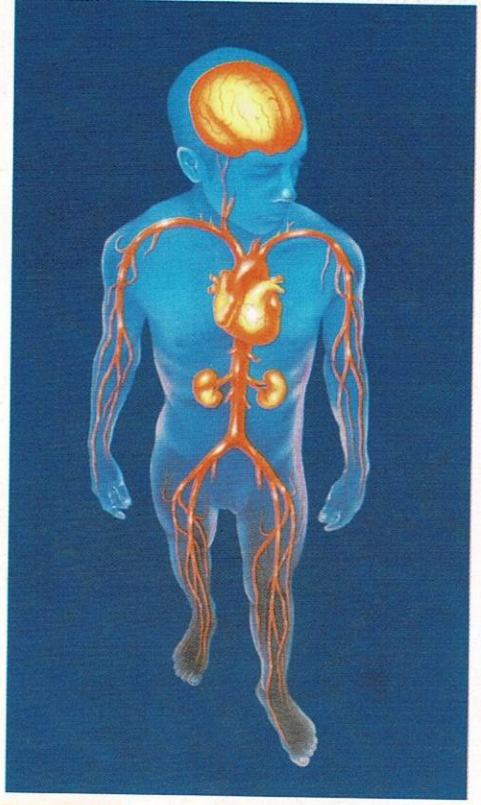
PDA Cebu Chapter

For all these, we are most grateful to the Lord. For granting us the grace to carry on our struggle in the fight against diabetes. There is still so much to be done. We also appreciate the guidance of the mother chapter and our various pharmaceutical partners for their unselfish support.

Dr. Evelyn Gamallo spearheaded the revival of the Sweet Generation Club of the Sacred Heart Hospital this year.

However we need more hands to help in the huge work ahead. There is a need for more committed drive and reinforcement of a strong diabetes control direction.

We thank the mother chapter for recognizing our efforts in the PDA Cebu Chapter endeavors.



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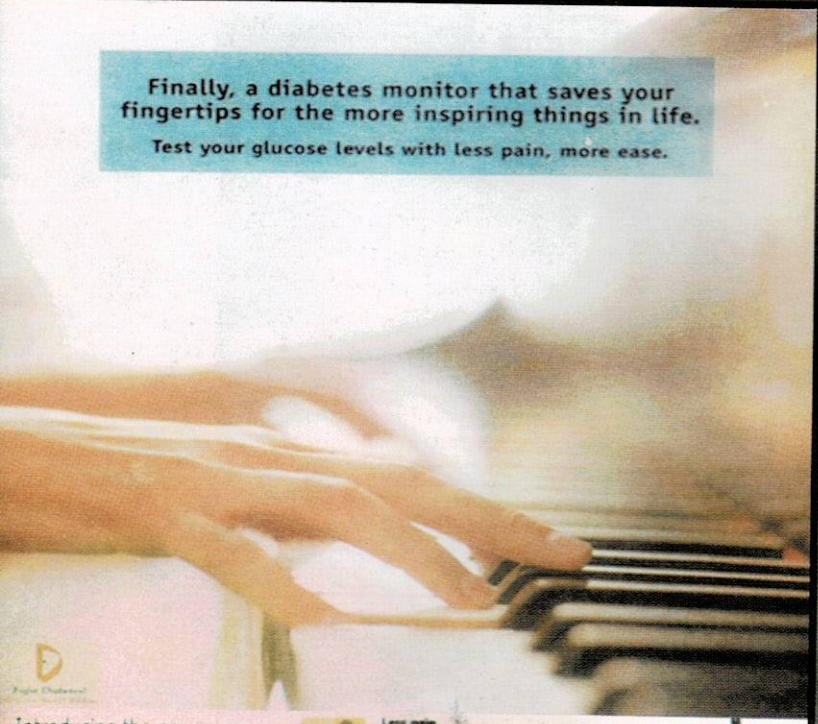

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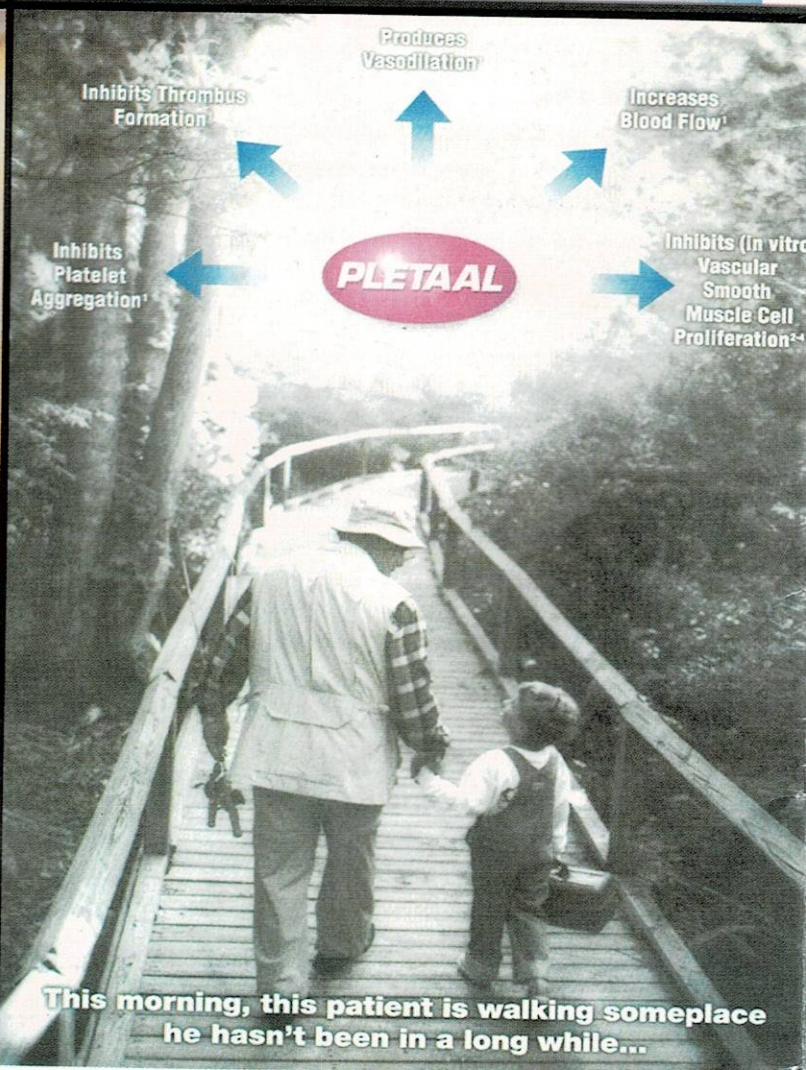

Diabetes and obesity: time to act

Rosa Allyn G. Sy, MD, FPCP, FPSEM

"Using the standard classification of obesity, more than 1.1 billion people are estimated to be overweight of whom 320 million are now calculated to be obese."

With globalization, there have been dramatic changes in the human environment, behavior and way of life. The rapid cultural and social changes, ageing population, increasing urbanization and shifting dietary practices with respect to fat, caloric sweeteners, refined carbohydrate and reduced physical activity levels brought about by low-energy demand occupational activities, unhealthy lifestyle and behavioral patterns have resulted in escalating rates of obesity.

Using the standard classification of obesity, more than 1.1 billion people are estimated to be overweight of whom 320 million are now calculated to be obese. The International Obesity Task-Force (IOTF) estimates that 1.7 billion people may be exposed to weight-related health risks particularly type 2 diabetes mellitus. A recent phenomenon is the rising prevalence of overweight and obesity among school-age children 5-17 years old, which undoubtedly poses a critical threat to health. IOTF analysis has shown that overweight and obesity affect one in 10 children worldwide but the rate is double in Europe and 3x as great across the entire Americas.

The rising global epidemic of obesity has led to the alarming increase of diabetes mellitus. World Health Organization (WHO) and IOTF reports indicate that approximately 88 percent of diabetes mellitus globally can be attributed to BMI greater than 21 which leads to insulin resistance, a core defect seen in type 2 diabetes mellitus. The twin epidemics of diabetes mellitus and obesity indeed represent the biggest public health challenge of the 21st century. Experts now believe that it is no longer possible to rely only on management and prevention strategies that focus on the individual. Responses are required at the population level as well. Hence, this year **World Diabetes Day**, held every 14th day of November, focuses on Diabetes and Obesity with the theme ***FIGHT OBESITY PREVENT DIABETES.***

The Philippine Diabetes Association once again joined the International Diabetes Federation and the World Health Organization in observing the World Diabetes Day by holding a week long activity that focuses on healthy lifestyle programs since major changes in both physical inactivity and food explain the development of the obesity and diabetes crisis. This is in concert with the main objective of the Philippine Coalition for the Prevention of Non-Communicable Diseases of the Department of Health of which the Philippine Diabetes Association is an active member of its steering committee.

To address both issues of physical inactivity and unhealthy eating habits, the Council on Exercise and the Council on Nutrition of the Philippine Diabetes Association launched the 1st VCD on Exercise and Nutrition on November 10, 2004 during a press conference held in Sta. Maria function room of Discovery Suites, Ortigas Center, Pasig City. This video is the first Filipino ever-produced instructional video on exercise and nutrition, which we hope will help and guide our Filipino diabetic patients, and their families live a healthier lifestyle. The video presents the benefits of exercise and healthy eating habits as well as the step by step instructions of a safe and sound exercise program; different nutrition issues and misconceptions are tackled; and the importance of reading food label was emphasized.

A half-day scientific symposium on Diabetes Strategies for the Primary Care Physicians was organized for the government health care professionals. It was a well-attended symposium held at the Natrapharm auditorium in Km. 18, West Service Road, Sucat, Paraòaque on November 12, 2004.

Last November 14, 2004, the different PDA chapters in the different regions of the country together with the national headquarter did a simultaneous diabetes screening followed by a lecture on Healthy Lifestyle for the patients and their families. The 'Healthy Lifestyle VCD DUO' launched in the different regions of the country during this World Diabetes Day celebration was highlighted by the actual exercise participation of the different patients and their families.

As stated by the International Diabetes Federation it may already be late, but a global effort can be made to transform diets, encourage less dependence on motorized transport and promote efforts to restore physical activity into our daily lives.

The Time to Act is now!

Philippine Diabetes Association

Member of International Diabetes Federation
Affiliate member of Philippine College of Physicians

FIGHT obesity

Prevent diabetes

WORLD DIABETES DAY
2004
14 NOV

PDA Activities for World Diabetes Day

November 10, 2004
- Launch of Healthy Lifestye VCDs and Press Conference

November 12, 2004
- Strategies in Diabetes Management for the Primary Care Physicians
  - Scientific Symposium for Government Physicians and Health Officers

November 14, 2004
- Simultaneous National Screening for Diabetes Mellitus, Healthy Lifestyle Lectures and Exercise

World Diabetes Day is co-sponsored by the International Diabetes Federation and the World Health Organization.