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DIABETESWATCH

A Publication of the Philippine Diabetes Association, Inc. January - April, 2006 YEAR XXIII, NO.1

Advice to the young diabetic

"No more sex? Patayin mo na lang ako Lord!"

Help, I'm growing a moustache!...and other hairy tales

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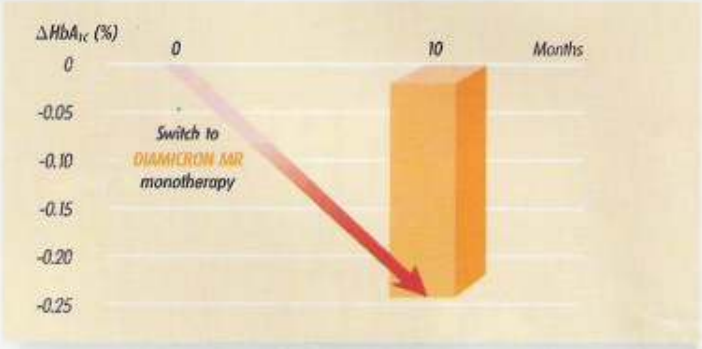

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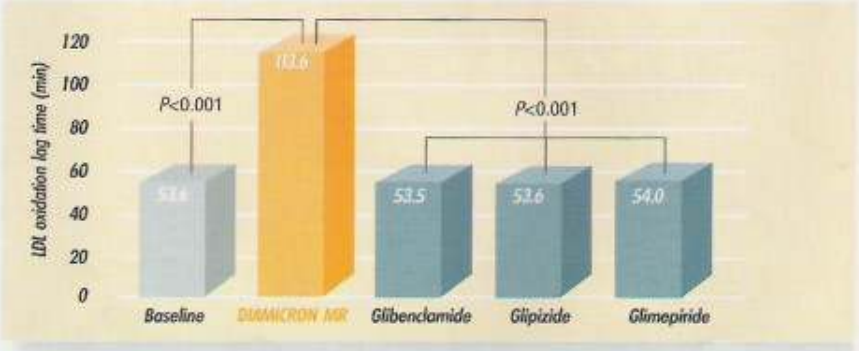

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1. Song DK, Ashcroft FM. *Br J Pharmacol.* 2001;133:193-199. 2. Gribble FM, Tucker SJ, Seino S, Ashcroft FM. *Diabetes.* 1998;47:1412-1418. 3. Gribble FM, Ashcroft FM. *Diabetologia.* 1999;42:845-848. 4. Drouin P and the Diamicron MR study group. *J Diabetes Complications.* 2000;14:185-191. 5. O'Brien RC, Luo M, Balazs N, Mercuri J. *J Diabetes Complications.* 2000;14:201-206.

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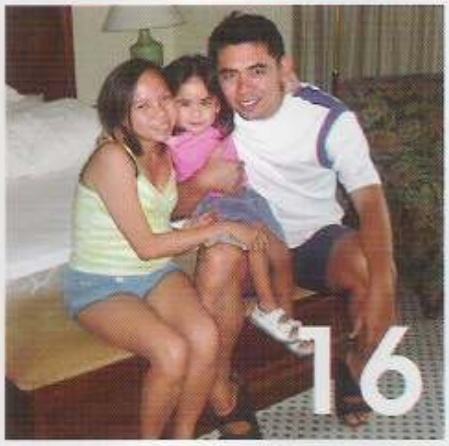

Regular Articles

Your President speaks

Welcome to this year's first issue of Diabetes Watch, your association's magazine on diabetes and healthy lifestyle. The goal this year is to come out with three issues filled with helpful information to ease the daily discipline of living with diabetes. Our association also continues to join hands with the Department of Health's Coalition on Healthy Lifestyle. This coalition is a group composed of different medical societies cooperating with the DOH Department of Non-Communicable Diseases in projects aimed at averting the onslaught of degenerative diseases.

This year promises to be as busy as ever not only for the mother society but for the different PDA chapters nationwide. As you may have noticed from our last issue, the contact information of the most active chapters is now included in the magazine. This should facilitate the flow of information both to healthcare workers and our patients. We are also trying to continually update our website for information that you may need and don't forget that you can use this to link to international websites as well. I hope that you can drop us a line or two for your comments and observations. We'd love to hear from you!

Do browse over the activities planned for this year and don't forget to attend the Diabetes Expo on November 4 and 5 which promises to be a grand event!

As you very well know achieving a healthy lifestyle is not always easy and there are so many roadblocks that can hinder one's resolve and best efforts. Your healthcare providers always remind you(nag sometimes) to eat a healthy diet, (yes fruits and vegetables and fish), to exercise at least 3x a week, to laugh at life (and de-stress everyday) and to drink your medicines faithfully. Remember that you are not alone and it's always good to seek out medical groups and organizations where you can get tips and information not only from the experts but from flesh and blood people who struggle with the same hurdles as you. Be careful with health information coming from TV commercials, especially from food supplements which are being touted as cure alls or super protectors from disease. Some of these commercials have inaccurate health claims and can be dangerous when followed.

Always read Diabetes Watch - it 's full of information that you can trust!

MA. TERESA PLATA QUE, M.D.

DiabetesWatch

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PHILIPPINE DIABETES ASSOCIATION, INC.

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"An affiliate society of the Philippine College of Physicians" (PCP)
"A member of the International Diabetes Federation" (IDF)

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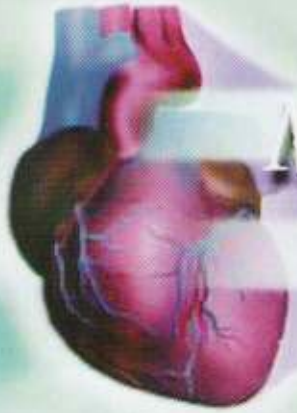

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MEANDERINGS

Augusto D. Litonjua, MD
Editor Emeritus

The 'Latest' on Exercise

Brisk walking was the most common form of leisure time physical activity that was practiced by the subjects in the study.

Our society no longer demands physical activity for our daily living. But, where there is a rising prevalence of obesity and diabetes, the benefits of regular physical activity have been emphasized many times, in different publications. However, the relationship between amounts of physical activity and long term beneficial effects in type 2 diabetes is not known.

In a recent issue of DiabetesCare, Libreto and co-workers from Perugia, Italy discuss these aspects in their article entitled, "Make your diabetic patients walk." The sub-title is, 'Long term impact of different amounts of physical activity on type 2 diabetes.'

In short, the recommendation is a target of 3 mile daily walk of 1 hour/day at a pace of 3 mph, or 45 minutes/day at a pace of 4 mph. Over a 2 year period, this activity is expected to produce the following results:

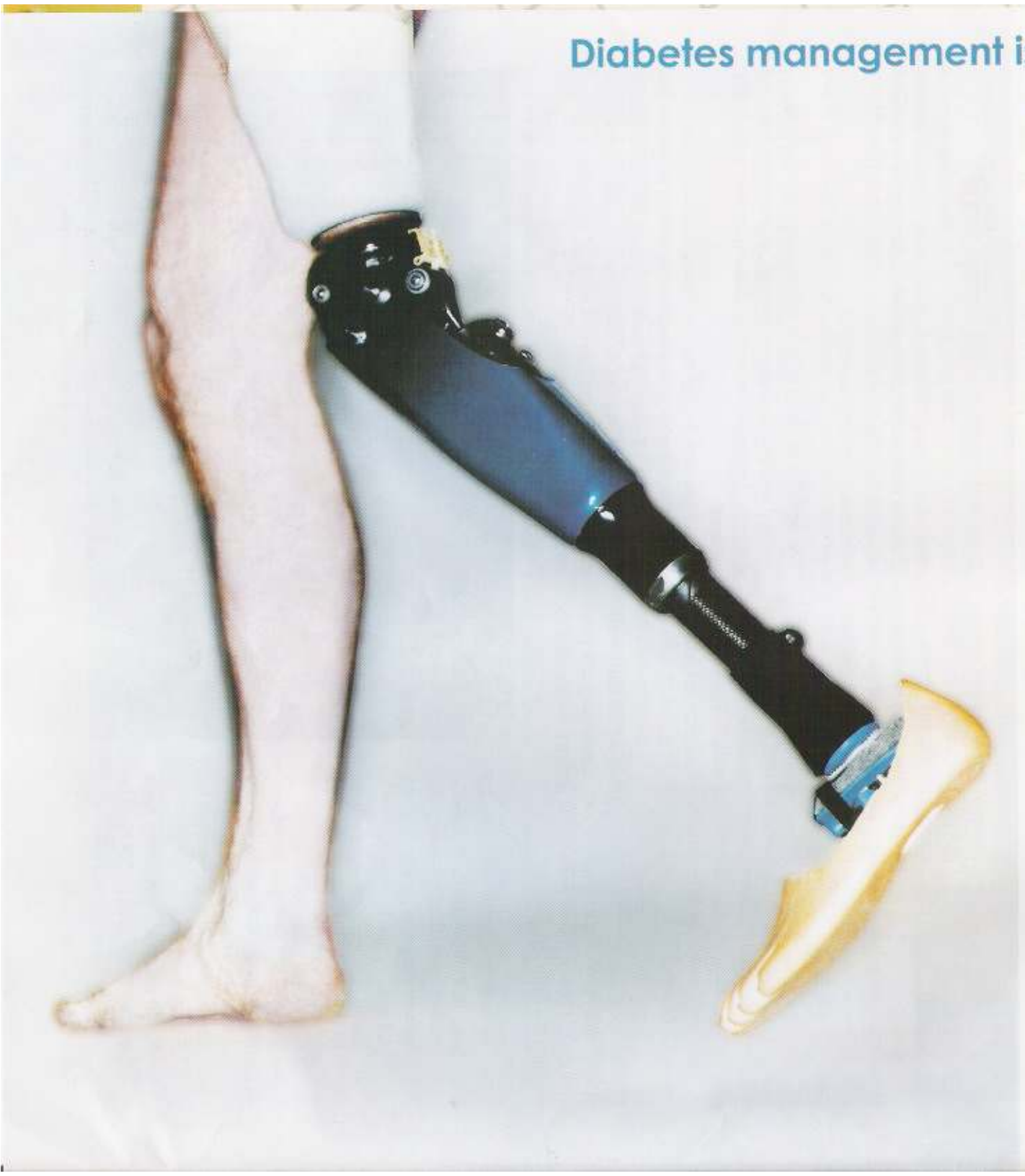
a. Reduction of body weight by 2.4 kg. In terms of BMI, this is a reduction of 0.9 kg/m2 and a waist circumference reduction by 4.8 cm.
b. Fasting plasma glucose is reduced by 0.9 mmol/L and HbA1c by 1.5%
c. Systolic and diastolic blood pressures are reduced by 10 and 7 mm Hg, respectively.
d. Resting heart rate is improved by 5 beats/minutes.
e. the 10 year risk for coronary heart disease is lessened by 2.4 %. The good cholesterol, or HDL cholesterol, is increased by 0.12 mmol/L.

Greater amounts of energy expenditure resulted in added improvements in clinical pictures of patients.

Brisk walking was the most common form of leisure time physical activity that was practiced by the subjects in the study. For those unable to do this form of physical activity (patients with peripheral neuropathy), exercises with reduced physical impact like stationary cycling, water gym or swimming were recommended.

The benefits in terms of cost of treatment in these patients showed remarkable financial savings. Prescription costs for diabetes, hypertension and lipid disorders were markedly reduced.

Thus, it is not enough that patients be told to exercise, but the amount of physical activity must be individually prescribed. For just the reduced costs of medications in an economy of escalating price of medical care, this is reason enough to exercise properly.



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EVERYTHING YOU'VE ALWAYS WANTED TO KNOW ABOUT DIABETES (BUT WERE AFRAID TO ASK...)

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

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

Q A

Why do people use herbal medicines?

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

Q A

What should we look at when buying herbal medicines?

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

Q A

Why should we be careful?

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

Q A

Are these approved by the BFAD?

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

Q A

What are some herbal medicines used for diabetes?

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

Q A

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Q A

What about ampalaya?

Momordica charantia commonly known as ampalaya, has been shown to produce blood glucose lowering effects. The leaves possess the active ingredient. There are only two know varieties of ampalaya that have blood glucose lowering potential. There are found in Makiling and in Cavite according to Dr. Maramba of the Institute of Pharmacology at UP-PGH. The first five trellises should be boiled in a clay pot without cover to release the active ingredient. These plants should be organically grown.

Q A

Are there clinical trials being done to prove its claim?

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

Q A

Are there other uses of Amplaya?

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

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.*

Advice to the young diabetic

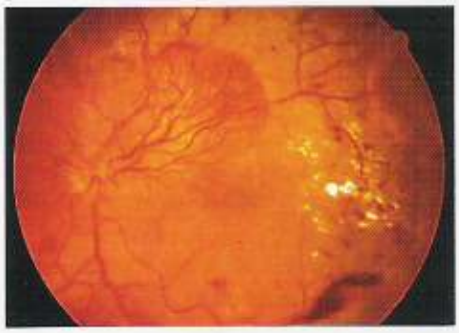
Sylvia Capistrano-Estrada, MD
Asian Hospital

You've been diagnosed with diabetes... What now? Your endocrinologist has prescribed insulin and a set of rules to keep your blood sugar within certain levels. You are advised to check your blood sugar at least twice a day, exercise regularly and eat a balanced diet that you must strictly follow. Why should you? Why make the effort to keep your blood sugar "under control"? What's in it for you?

The reason: Diabetes affects your whole body...and studies have shown that if you keep your blood sugar within the acceptable range, complications will be delayed.

DIABETIC COMPLICATIONS. What are they?

When a person has had diabetes mellitus (DM) for a few years, some organs of his body are damaged because of the prolonged exposure to high blood sugar. These effects are called complications. The eyes, kidneys, nerves, blood vessels and feet are particularly sensitive to high blood sugar and with time, show the ill effects. These complications are described below.



Eye problems. RETINOPATHY refers to damage to the retina, the area at the back of the eye that has blood vessels and nerves. When DM is uncontrolled, the retina is slowly damaged and as this occurs, the eye tries to repair itself by growing more blood vessels...a condition called proliferative retinopathy (PF). This blocks eyesight. The occurrence of PF is related to poor diabetic control, long duration of DM, high blood pressure and increased blood lipids. Treatment is by laser or eye surgery.

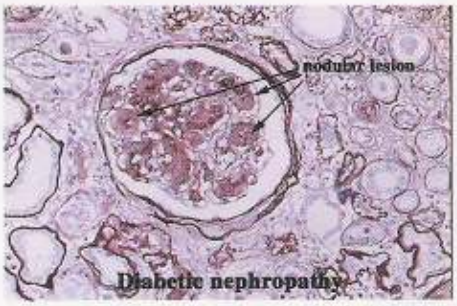
Although PF usually occurs 10-15 years after the diagnosis of DM, it has been reported in younger children too. Therefore, it is recommended that all adolescents be examined for PF every year after having had DM for at least 2 years; and after 5 years in pre-pubertal children with DM. Good blood sugar control delays the onset and progression of early retinopathy.

CATARACTS or clouding of the lens of the eyes is another complication. In children, they are called stellate cataracts and have occurred even after short duration DM of less than 5 years. Needless to say, this causes poor eyesight and can be treated only by eye surgery.

Young diabetics occasionally experience ERROR OF REFRACTION or blurred vision and difficulty of focusing one's eyes at the time of diagnosis. This is a temporary event due to the "imbalance" that results from insulin injection into the body. Insulin helps blood sugar enter the cells where sugar is used as energy.

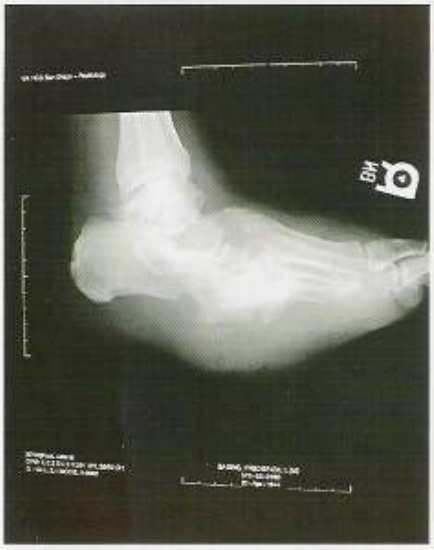
In a few weeks, the body adjusts and the refractive errors vanish. Therefore, the prescription of eyeglasses should be delayed. The diabetic must be re-evaluated after 3 months to see if indeed he needs the corrective lenses.

Kidney problems. The kidneys are progressively damaged when DM remains poorly controlled over a long time. This condition is called DIABETIC NEPHROPATHY (DN). It affects 30% of insulin dependent diabetics (IDDM). In its full blown phase (overt DN), diabetics have high blood pressure, protein spillage in the urine and failing kidneys. Overt DN is corrected only by dialysis or kidney transplantation. By history, this usually happens after 15-20 years of diabetes. Evidence supports that good DM control delays the progression to overt DN.



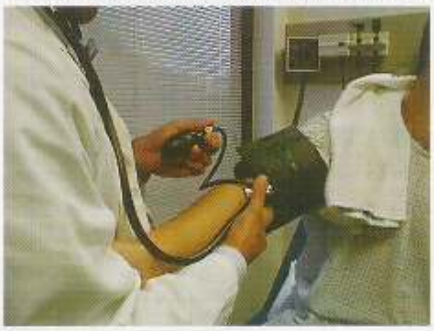
One of the earliest signs of malfunctioning kidneys is the finding of minute amounts of protein (microalbuminuria, MA) in the urine. When this happens, efforts to control DM must be maximized. Medications are given to slow down or even stop further kidney damage. MA can occur after 2-5

years of diabetes. Therefore, the current recommendation is to screen the urine at least every 6 months for MA after 2 years of DM in adolescents and after 5 years in pre-pubertal diabetics.



Nerve problems. DIABETIC NEUROPATHY is nerve damage that results from poorly controlled DM. These include numbness, "pins & needles" sensation in the legs and feet, loss of vibratory sense and decreased reflexes. Fortunately for children with DM, neuropathy is not very common. However, screening for early nerve dysfunction is recommended because if picked up early, neuropathy can be reversed by improved DM control.

Vascular problems. High blood pressure, high cholesterol and a sedentary lifestyle in older diabetics put them at a higher risk of heart attack and stroke. The primary problem is narrowing of blood vessels because of deposits of cholesterol and lipids in their inner walls. Our young diabetics will grow old too. They can prevent the onset of these problems by stricter blood sugar control, regular exercise and proper diabetic dietary management.



Foot problems. Children with DM must be extra careful with their feet. Flat feet and other foot problems must be corrected early because these may increase the risk of DM foot problems later. Among the adult diabetics, it is not uncommon to hear about leg amputation. The usual story starts with a wound that does not heal and becomes infected. Because of the persistently high blood sugar and poor blood supply to the foot, the infection spreads further causing some areas of the foot to decay. When the infection becomes widespread and poses a threat to the patient's life, amputation becomes the only option.

I have outlined the more common long - term complications of diabetes. There are other complications associated with DM that one must be aware of: impaired growth and development, lipohypertrophy, limited joint mobility, osteopenia, and necrobiosis lipoidica diabeticorum.

As a young diabetic, it is important for you to visit your endocrinologist regularly in order for him to assess how well you are. Your height and weight are good measures of DM control. Poor gains in height and weight and delayed pubertal development are often seen in children with persistently poor blood sugar control. Consider insulin insufficiency. On the other hand, if you are gaining too much weight, you may be injecting too much insulin.

When you prefer to inject insulin in a particular site (e.g. abdomen), after some time, you will notice a bulge in the area. This is called lipohypertrophy. Stop using this site right away and start rotating you injection sites. Your doctor can give you guidelines on this.

Limited joint mobility means your being unable to flex or bend certain joints because of skin thickening in the area. This is seen with poorly controlled DM. The joints in the fingers, wrists, elbows, neck and spine may be affected. This development of early joint limitation may lead to early development of kidney, vascular and foot problems.

Low bone mineral density (osteopenia) has been reported in children with DM. Although the long- term clinical significance has not been established, we can guess that this may have effects on the calcium balance, bone strength and possibly, growth.

Necrobiosis lipoidica diabeticorum are round red spots (sometime ulcers) seen on the skin of the lower legs in patients with poorly controlled DM. The exact cause is unknown and treatment is still controversial. Some have used aspirin. If you should see any of these, please see your doctor right away.

Having diabetes should not spoil your life. Know your diabetes: its ins and outs and learn how to live with it. By achieving near normal blood sugar levels you can prevent the onset and progression of complications. The choice is yours.

Sylvia Capistrano-Estrada, MD is a Pediatric Endocrinologist and a Metabolic Specialist.

"NO MORE SEX? PATAYIN MO NA LANG AKO, LORD!"

Cynthia de Castro

A friend of mine in his thirties was told that having sex is a "no-no" for diabetics. "What? I'd rather die", he exclaimed. Yes, for many people -especially those who are still sexually active - or would like to remain so -feel like they've been handed the death sentence if their sex life is curtailed. "Diyos ko, patayin mo na lang ako, Lord", was how one relative expressed his sentiment upon hearing this discussion.

I remember a conversation between two male friends who both had diabetes and were griping about their disease. The older one said, "I'm so glad this happened now that we're in our sixties. And it's a good thing my wife loves reading pocketbooks. Kaya, binibili ko na lang siya ng sandamakmak na pocketbooks para malibang siya sa gabi." His kumpare chuckled as he shared his own way of dealing with his impotency. He whispered, "Kami nga para na lang magkapatid kung mag-halikan. I kiss her on the cheeks or on the forehead. Mahirap na ma-umpisahan ang hindi ko naman kaya tapusin eh."

This is one of the most common myths about diabetes - that all diabetics can no longer have sex. Well, the great news is that this is pure nonsense! Most diabetic men are normally potent and women do not lose their sex drive once they get diabetes. Many people with diabetes can have happy, healthy sex lives like average people. Being diabetic should not prevent patients from enjoying sex. However, like most healthy decisions, there are important factors to bear in mind to make sure "you can still have your cake and eat it too", in a manner of speaking.

First of all, know that people with diabetes can gain as much pleasure from the sexual aspects of a marriage relationship as anyone else. Some single diabetics are afraid of starting a close relationship with a member of the opposite sex. Many are shy about telling possible partners in life that they are diabetics for fear that he or she will break off the relationship. But hiding your diabetes may lead to more and more lies and evasions.

BJ, who has had diabetes since he was a child, shares his experience. "When I met Alice, I knew she was the one for me. But I was embarrassed and afraid to tell her about my diabetes. Naisip ko sasagutin na lang niya yung mga healthy na nanliligaw sa kanya. I had to have daily insulin shots. My diet was too restricted. I may die young and make her a widow at an early age. Or worse, what if I develop complications and she ends up taking care of me? Baka sabihin eh, hindi asawa ang kailangan ko, nurse or caregiver. But, sobrang love ko siya at ayokong mawala siya sa akin so I had to take the chance. Thank God I was able to conquer all my fears! Nag-pray ako ng husto -at sinabi ko I love her and I can't live without her -but I hope she can live with my diabetes. Well, mabuti na lang may irresistible charm ako (joke lang!) kasi she

said "yes". We've been married for ten years now and we have a lovely daughter who makes each day worth living."

Like BJ and Alice, people do enjoy sex, inspite of diabetes. But a little precaution is needed. So here are some practical tips from Dr. Rowan Hillson, senior Registrar in Diabetes and Endocrinology at the Radcliffe Infirmary, Oxford and author of Diabetes, A Beyond Basics Guide.

• The act of intercourse is a form of exercise and most often happens at a time when you would usually be resting. If you are having sex regularly at night, you need to increase your bedtime snack or reduce your evening insulin, especially if you tend to have low glucose levels during the night.

• If you are an insulin-treated diabetic you should keep some glucose tablets under the pillow or beside the bed so that you can eat them quickly should you feel hypoglycaemic, for whatever reason.

• If you have intercourse at other times, perhaps unexpectedly, and you know that it will bring your glucose down, eat some food or a couple of glucose tablets immediately afterwards. An unexpected hypoglycaemic attack can spoil a beautiful evening.

• Sometimes, before your diabetes is controlled or at times of poor glucose control, you may not feel much like sex because you are just not very fit. Indeed, you may feel below par generally and need as much sleep as you can get. You may be snappy or irritable with the people you love the most. But as your glucose levels return towards normal, your energy levels should improve and this includes your sexual energy and desire for sexual intimacy.

• If your glucose level is high, you may not be a very relaxing person to share a bed with because the increased urine output makes you get up to pass urine during the night and you have to keep drinking because you are thirsty.

• The important thing is that you are eating right, exercising regularly, you are trim and at your ideal weight and taking your medicines. Be sure you are relaxed and not stressed out from work or pressure before engaging in sexual intimacy.

• Although it is a myth that all diabetic men are impotent, there certainly occurs some impotence in some men, especially during the later years. This is thought to be due to autonomic neuropathy because the autonomic nervous system is responsible for the increase in blood flow to the penis which causes it to become firm and erect. If you think you are losing your sex drive, don't bottle up your worries inside you but discuss them with your doctor. Your doctor will not be embarrassed or think it odd that you want to discuss your sex life. A diabetes specialist will be used to discussing such problems. After a full medical check-up, it may be that there is a non-diabetic hormonal reason for your impotence that can be put right by hormone injections.

• Many illnesses, not just diabetes, if not controlled, may result in temporary impotence and loss of sexual drive. But once the illness is treated, full potency and sex drive returns.

So, persons with diabetes need not live celibate lives. All they need to do is remember that sex uses up a lot of energy so they just need to prepare for it well. With lots of love and care, sex and the diabetic can live happily together, everafter.

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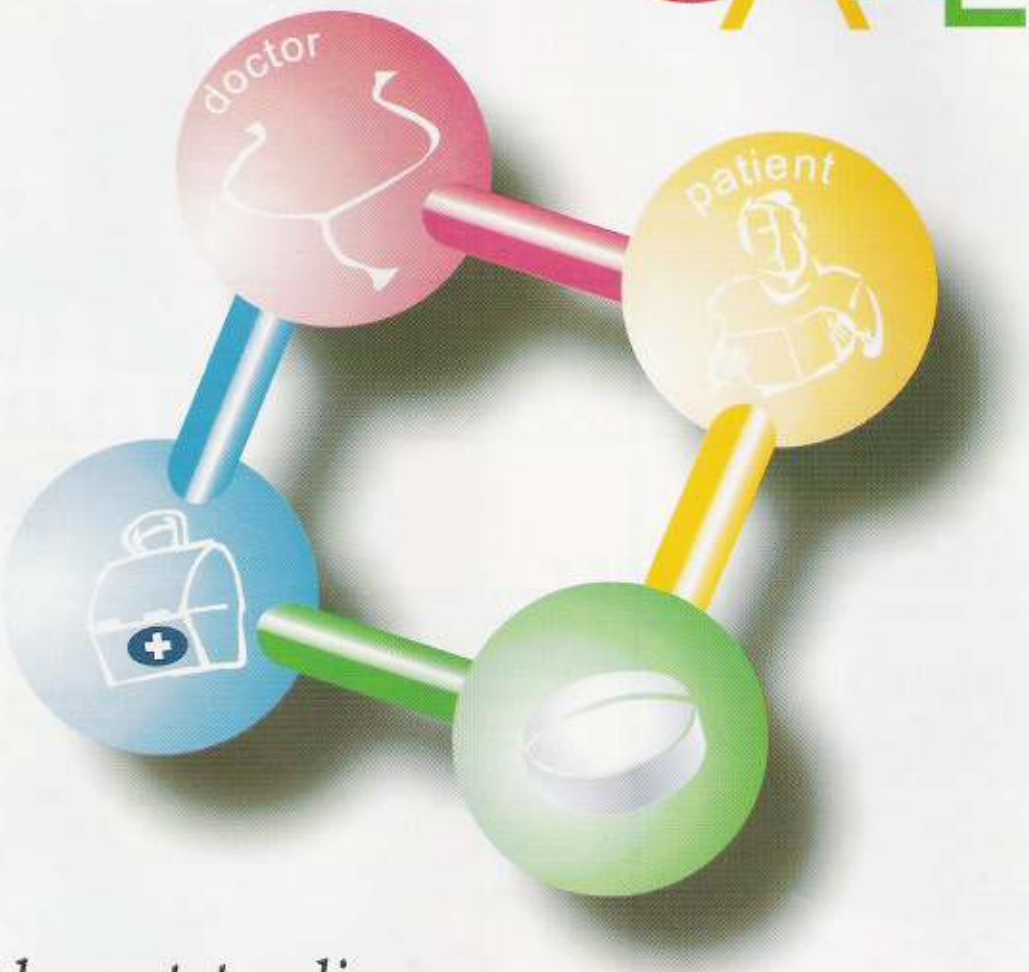

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DIABETES & EXERCISE
THE TAI CHI CONNECTION

Amado D. Samia Jr.

I will attempt in this article to explain how tai chi, an ancient of Chinese exercise, can serve as catalyst in managing diabetes.

Firstly, why is diabetes a serious ailment?
Simply stated, diabetes is a metabolic disorder where a person has a high level of sugar in his blood. High blood sugar can actually damage the tiny capillaries that carry the oxygen and nutrient-rich blood from the arteries to different parts of the body. And when neither oxygen nor nutrients cannot get into the cells, the resulting injuries set the person to a variety of problems such as heart disease, strokes and circulatory problems in the arms and legs. POOR CIRCULATION is one major reason that someone with diabetes has twice the risk of arterial disease in the limbs as someone without the disease. The impaired circulation will lead to more damages that may ultimately cause him to lose one or both legs. Other complications may be blindness or kidney failure.

A diabetic treatment regimen has 3 cornerstones: Nutrition, Weight Control and Exercise. Among the 3 modalities, exercise has the most direct influence on blood circulation. Diabetics need to get their arms and legs moving and the heart pumping. The right exercise strengthens the heartbeat, helps control blood sugar levels and increases blood circulation to the extremities. There is ample evidence that exercise increases the number of insulin receptors on the cells. In fact to a person with diabetes, the appropriate form of exercise is like a dose of insulin to his blood. Repetition, rhythmic movements involving the large muscles, arms and legs are the best for diabetics.

Why is Tai Chi then a good form of exercise for diabetics?
Historically, Tai Chi is a gentle form of exercise which originated from China. Not only has it been proven consistently by scientific studies to improve flexibility, strength and fitness, it also delivers many other health benefits making it suitable for diabetics.

Modern Maturity magazine says, "According to Tai Chi enthusiasts, the discipline can prevent many ailments, including high blood pressure, tuberculosis and diabetes and US scientists agree that Tai Chi can offer some important fitness benefits particularly for older adults."

One factor that aggravates the diabetic condition is stress. Blood glucose tends to rise immediately if the person is stressed. In fact, diabetes and emotions are so interrelated that disease is easily aggravated by trivial problems. Tai Chi is unique in that while it enhances physical fitness, it does it in a very gentle and relaxed manner.

Working Woman magazine goes on to explain, "Mind/body workouts are kinder to the joints and muscles..reduce the tension that often contribute to the development of disease which make them especially appropriate for high powered stressed out baby boomers. Unlike most conventional exercises, these forms are intended to stretch, tone and relax the whole body instead of isolated parts based on a series of progressive choreographed movements coordinated with deep breathing."

Medical studies also have found that Tai Chi improves facets of the mind. We know that people who have diabetes are stressed because of the lifestyle changes that the disease imposes on them. Tai Chi has features that can offset this problem. The mind has tremendous effects upon the body. Tai Chi integrates both. The conscious mind of the practitioner controls the chi (an internal energy) which then influences the body to move as directed. After a while the body's movements become coordinated and well balanced. Tai Chi enhances the mind so that it's often referred to as meditation in motion. The gentle and slow movements open up energy channels that are blocked. The rhythmic movements of the muscle, spine and joints pump energy all over the entire body. It brings about healing by improving circulation of the blood and other body fluids.

Lastly, Tai Chi is a progressive exercise that one can start learning regardless of age. It's very affordable because it does not require expensive equipment, special clothing or structured environment like that of a swimming pool. It's very interesting to learn and a pleasure to perform. There's no end to appreciating its beauty as an art form. It can hold one's motivation as one progresses from one level of mastery to the next.

There are various ways of learning Tai Chi. One can learn it from books or videos, but nothing compares learning it from a flesh and blood instructor because of the energetic component of the exercise. Tai Chi an ancient form of Chinese healing has come of age in the treatment and management of diabetes.

Amado D. Samia Jr. is a certified Bionergy Psychologist and an accredited TCA Tai Chi Instructor.

A FUNNY LOOK AT DIABETES

Nel Mondoy

If Mylene Mercado were taller, she would have joined the Miss Universe contest. After all, this 30-year-old government employee has the slender body of a model, the spontaneous wit of a stand-up comedian and the charm of a popular movie actress. But she has another ace up her sleeve, one that no other contestant can match: the talent of injecting insulin.

"Sasali ako ng Miss Universe dahil magaling ako mag-inject," Mylene says in her playfully exaggerated tone that people close to her surely know. "Wala akong kalaban na gagawa nun. Mananalo ako. Tignan ko lang kung sino ang gagaya sa akin." She punctuates her last word with a snobbish swing of the head and a slight upward tilt of the chin, which makes one remember Edu Manzano during his days of hosting The Weakest Link, only with more oomph.

Indeed, Mylene never seems to run out of humor and poise even when narrating those gloomy days when she found out she had diabetes. It was only a few days after her graduation when she noticed that she was not gaining back the weight she lost for her debut. She went on a strict diet prior to her 18th birthday so she could fit into her sexy gown. But despite eating all the food she wanted after that occasion, Mylene remained reed-thin.

Her gaunt appearance soon became the buzz in her school. Enrolled in an exclusive, all-girl college, her classmates began to speculate about her drastic weight loss. Some said she was taking drugs; others rumored she had an abortion. For Mercado, however, there was only one logical cause of her problem: "Bulate ito."

"How could I have an abortion when I didn't even have a boyfriend at that time? Of course, I didn't take drugs. But when I looked at myself in the mirror, ang pangit ko. I've been eating a lot pero hindi ako tumataba. I could only reach one conclusion at that time: Bulate nga ito," she shares. In an effort to seek an answer to her weight problem, Mylene sought the help of the only doctor she knew: her family's pediatrician. The doctor then referred her to a gastroenterologist. After a battery of tests, her godmother at the National Kidney Institute (NKI) immediately called up her residence. Her mother spoke with her ninang over the phone and though she was told to rest in her room, she could still hear them talking. She heard phrases like "pag matanda meron nyan", "basta may pera mabubuhay", and "magastos". She tried to figure out what was happening, but what she had already heard led her to formulate another shocking conclusion: she had cancer.

Due to her father's insistence that she be admitted despite the lack of rooms at the NKI at that time, Mylene got a simple room without a TV and a telephone. She had hardly warmed her bed when "all the manananggals in the world" came to suck her blood dry. "Lahat yata ng nurse doon gustong kumuha ng dugo ko. Kinuhaan na ako nung morning, tapos kukuhanan ka nanaman after a few hours," Mylene says with a laugh. "Kaya ang sabi ko, 'My God may leukemia ako. Because it had something to do with the blood. They kept on getting my blood."

The next day, she was introduced to her life-long endocrinologist, Dr. Teresa Plata-Que. To underscore the seriousness of her illness, Dr. Plata-Que asked to be left alone with her patient. "I think her first words were 'Life doesn't end here.' At ang next ko na narinig sa kanya ay, 'You have to inject insulin for the rest of your life,'" Mylene reminisces. "Actually, wala akong naintindihan sa mga sinabi nya kasi she said it in a very calm way. I thought, 'Ano kaya ang pinagsasabi nito?' And then the images of Dolzura Cortez and Vilma Santos came to my mind because I thought I have been diagnosed with AIDS."

Dr. Plata-Que, however, assured Mylene that her disease, though serious, could be kept at bay unlike AIDS. Mylene can still lead a normal life provided that she sticks close to her doctor-prescribed diet and be strict about her insulin injections. But the young diabetic patient was becoming increasingly worried: "A syringe is not a very ordinary thing in life. Nobody can say that it's an ordinary thing or it's an ordinary part of anybody's life."

The syringe did become her valuable partner in battling diabetes and it also symbolized the stigma she suffered as a diabetic in school. Everybody was talking about her and her strange disease. There was a time when some classmates of hers mistook a pen-type syringe for a ballpen and swiped

"There was a time when I got hospitalized dahil nag-away lang kami ng boyfriend ko. Imagine that. Ma-stress lang ako, ma-inis lang ako, nage-end up na ako sa hospital. I hate it,"

it off her necktie. When it produced no ink, that's when they realized that they had a syringe in their hands. "Ay, injection!," Mylene screams, echoing the over-the-top shriek of her classmates.

"Do you know how it feels na parang may nagsasabi sa iyo na you're so weird? Para bang kakaiba ang ginagawa mo. Nagi-isa lang ako sa iskwelahan na may ganito. Wala bang pwedeng mahawa para maintindihan nila?" Mylene adds. She began feeling like an outsider in school and, to make matters worse, diabetes was threatening to limit her social life. She could not stay up late with friends like she used to because it would surely cause a ketoacidosis attack, a condition wherein the blood becomes acidic due to the breakdown of body fat instead of glucose for energy. A diabetic ketoacidosis attack would always make her vomit and cause nausea and stomach pain. In the worst case, it could leave her comatose.

Of course, her condition hindered her studies as well. Though she performs well in academics, the stress she encountered while doing projects and other schoolwork led to ketoacidosis episodes many times. Finishing her thesis proved to be a hassle, too, as it required her to spend long nights to research and write her topic. She considered herself cursed: she could not stay up late, she should avoid stress (which is almost impossible), she can only eat certain types of food, and she has to adhere to the schedule of her insulin shots.

"There was a time when I got hospitalized dahil nag-away lang kami ng boyfriend ko. Imagine that. Ma-stress lang ako, ma-inis lang ako, nage-end up na ako sa hospital. I hate it," Mylene says.

Nevertheless, her friends stayed by her side most of the time. One of them even learned how to administer insulin properly in case she needed to be injected in areas she could not reach. "I had many classmates who were very supportive of me. For instance, they won't eat unless finished na yung injection ko. Parang pinaramdam nila sa akin na OK lang yan," she adds. With the help and care of her friends and family, Mylene graduated from St. Paul College-Quezon City with a business management degree in 1996. Her troubles with diabetes did not end, however. It even became a significant factor when she was applying for a job. There was one company that seemed interested to hire her, but when the interview session came, they asked her just one question: how long have you had diabetes? "That was that," she says. "Walang ibang questions. They said, 'We'll just call you.'"

Mylene bagged her current job by putting a positive spin on her disease. When the interviewers seemed fearful about her condition, she reasoned that diabetes has helped her a lot professionally. How? "If not for diabetes, I will never manage and discipline myself well," she answers. "I am able to eat the right food and exercise well. I think too much of the problem but I think of it positively. I take my illness as a challenge."

Now a mother and a wife, Mylene considers herself blessed after all. She married a supportive husband who does not only know more about diabetes, but also makes a living out of it as a medical representative for a large pharmaceutical company. Because of him, she learned to look at her illness with a humorous point of view.

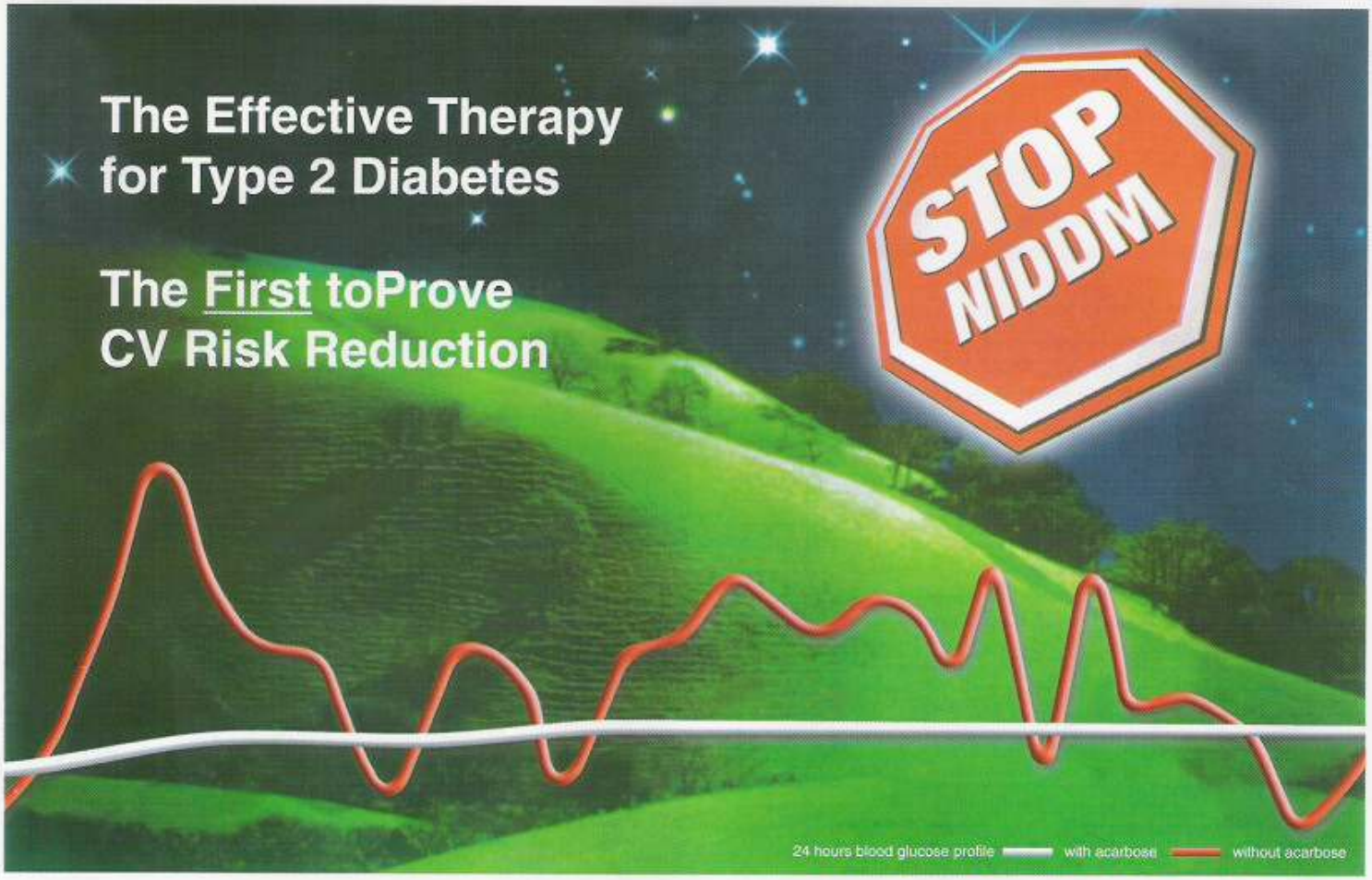
"Minsan tatawag yan, 'O, ano ang blood sugar natin ngayon? Itaya natin yan sa lotto. O baka pang-jueteng yan," she says with a laugh.

She also credits her doctor for encouraging her to be disciplined about her food intake as well as her insulin schedule. "Si Dr. Que, nagse-set sya ng goals. Kapag hindi ka nagkaroon ng major attack for months, may prize ka sa kanya. For example, she'll waive

her professional fee on your next visit. That's how she motivated me." To date, she has not suffered any major attacks that required hospitalization.

But how does she deal with stress, which has caused many ketoacidosis episodes before? That's when her daughter, Alexandra, comes in. "I just play with her," she says while gazing outside the café we were in. "We take her out, we go to the mall, we go out of town. That's when I feel I have no disease at all."

Indeed, if Mylene Mercado joined the Miss Universe contest, she would have won easily. Not that she has the slender body of a model, the spontaneous wit of a stand-up comedian, the charm of a popular movie actress or her unmatched talent of injecting herself with insulin. It's her uncanny ability to view the darkest moments of her life in a humorous light. Comedy, after all, is the sum of tragedy plus time.



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Help, I'm growing a moustache

...AND OTHER HAIRY TALES

Patricia B. Gatbonton, MD
Our Lady of Lourdes Hospital

You've probably seen the phenomenon on Ripley's *Believe it or not*...the wolf man or bearded lady, who has more than just a nice crop of hair on his or her head, they are a veritable walking carpet. Families like the Ramos Gomez's of Mexico are extreme, 19 members of the family have severe hirsutism but excess male pattern hair growth runs along a spectrum: from light facial and body hair to something like Chewbacca of the Star Wars trilogy. For years these excessively hairy individuals, trapeze artist brothers Larry and Danny-certified by the Guinness Book of World Records-draw in the crowds at the Mexican State Circus. People have a fascination for the bizarre, the brothers even have their own website devoted to the "Wolf People." Recall the popular movies, *An American Werewolf in London*, and *Wolf* (with Jack Nicholson), and how masks and makeup transformed these men into dark, curly haired beasts.

The hair covering our bodies (and a rudimentary tail bone) is a legacy of our simian cousins, providing us both warmth and protection. As *Homo erectus* we straightened our backbones, walked upright and shed our covering. After learning to produce heat artificially, we no longer had any need for our hairy pelt.

Homo sapiens, to his shame, has so soon forgotten his ancestry. How many times have you heard someone say of another, "You're as hairy as an ape."

When is too much hair just too much and becomes a medical concern?

By the hair on your chinny-chin-chin

Hirsutism is excess terminal body hair growth in places where this type of hair does not normally appear. Though hirsuitism affects both sexes, it is usually only a problem for women. There are two types of body hair. Vellus hair is the fine, non-pigmented or lightly colored hair on our face and body, the type that covers newborn babies (lanugo). Excess levels of androgens (male steroid hormones) do not affect its growth. Terminal hair is the dark, coarse, pigmented, androgen-responsive hair usually found in the underarms, scalp, eyebrows and pubic area. With abnormal hormone stimulation and growth, they appear on a woman's face as side burns, beard, mustache, or goatee. This hair may also appear in between the breasts, chest, abdomen and in the male upright triangle genital hair pattern, a reverse of the traditional female inverted triangle.

Although different race and ethnic backgrounds contribute to the amount of body hair-Asians and Native Americans have little body hair, Mediterranean women have moderately heavy body hair-what is abnormal depends mainly on how much the woman's normal hair growth pattern has changed.

Cultural norms dictate what is beautiful but for most of the world, fair is good. White, smooth and hairless skin is ideal. Imagine Mona Lisa with a mustache-she would have nothing to smile about. The world's obsession with this beauty model explains the proliferation of lightening and skin whitening products in the market, including the numerous treatments for hair removal available: bleaching, shaving, plucking, waxing, depilatories and electrolysis.

Eyebrows maybe waxed, plucked or threaded, mustache hair bleached, waxed or chemically disintegrated with a depilatory, armpit or leg hair shaved, waxed, plucked or melted.

Unattractive and unsightly, excess hair growth-especially if rapid and accompanied by other signs of virilization (increasing maleness like male pattern balding, acne, pimples, deepening voice and enlarging clitoris)-should be brought to medical attention.

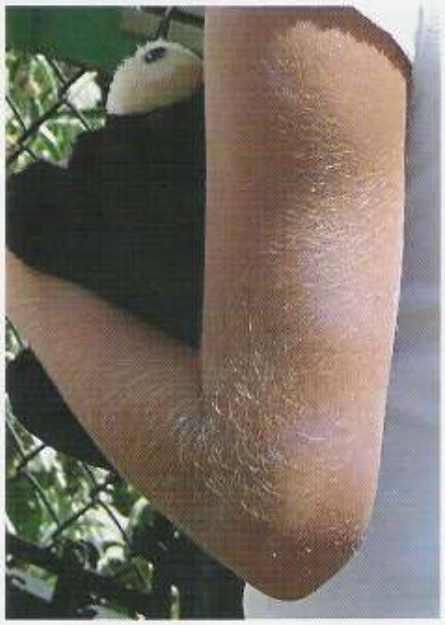
Initially, a woman may visit a general medicine specialist or dermatologist, but may need to see a specialist in hormones (endocrinologist) or a gynecologist to deal with the problem. The physician should be sensitive, thorough, yet not split any hairs (no pun intended) in finding out what might be wrong with you.

Hair-raising diseases

Idiopathic hirsutism and ***polycystic ovary syndrome*** are the two most common causes of excess hair growth.

A woman has idiopathic hirsutism when they are hirsute but have no other abnormal clinical symptoms. According to Dr. Ricardo Azziz, an eminent specialist in the field from the University of Alabama at Birmingham, idiopathic hirsuitism occurs in 5 to 15 percent of the normal population. Upon investigation, these women usually have normal serum androgen concentrations and ovulate regularly.

Polycystic Ovarian Disease (PCOS) affects 5 to 10 percent of women in their reproductive years and is the most common abnormal endocrine problem affecting women. The disorder is characterized by the association between abnormal (anovulatory) menstrual periods and ovaries with multiple, large cysts. The physiologic basis of PCOS is now much clearer with its direct relationship to high levels of insulin (insulin resistance). PCOS is a chronic state of high androgen production with many significant short-term and long-term implications for patients such as infrequent



(oligomenorrhea) or absent menstruation (amenorrhea), infertility, abnormal glucose levels or frank Type 2 diabetes mellitus, cardiovascular disease, increased risk of endometrial cancer, and excessive body hair. Other male hormone excess symptoms of PCOS include acne and male pattern hair loss or balding. Fifty to 60 percent of women with PCOS are obese.

How hairy is hairy?

As mentioned earlier, what amounts to excess facial and body hair is culture subjective. To avoid bias and stick to a universally understood definition, physicians use the Ferriman Gallway scoring system (since 1961) to define hirsutism. Doctors do a visual inspection over 9 body areas for the presence of excess hair growth. Hair growth ranges from a scale of 0 (no terminal hair) to 4 (maximal growth) for a total score of 36. A score of 8 or more indicates the presence of excess androgens. Visual inspection may not be enough to indicate a hirsutism problem because many women remove the hair before the consultation. As uncomfortable as it may be for the afflicted woman, letting the hair grow out to its maximum length before seeing a physician will help determine both the severity and approach to the problem.

Getting to the root of the matter

The physician will also ask about a person's medical history, any menstrual irregularity, drug intake and do a thorough physical examination, alert for signs of virilization already mentioned. These clues are usually enough to provide a diagnosis.

Hair today, gone tomorrow

Dr. Azziz recommends treatment begin as soon as the diagnosis is certain and not to wait for full-blown symptoms or significant hirsutism, especially when dealing with young girls. When excess androgens transform vellus to terminal hair, it is generally irreversible. Any terminal hair that remains after hormonal therapy will require electrolysis for permanent removal.

Treatment options for excess hair include hormonal therapy and mechanical removal.

Hormonal therapy

Dr. Azziz stresses that the purpose of hormone therapy is to correct the underlying problem, stop new hair growth and potentially slow the growth of terminal hair already present.

Oral contraceptives (OCPs) suppress excess ovarian androgen production and are able to slow hair growth in 60 to100 percent of hyperandrogenic women. Physicians generally consider OCPs in a formulation that contains a low dose of estrogen and a nonandrogenic progestin to be first-line therapy for women with idiopathic, familial hirsutism and PCOS. Women with hypertension, bleeding or clotting disorders, migraines, smoker or a family history of breast and/or uterine cancer, should not use OCPs to treat hirsutism.

Anti-male pills

Antiandrogens are an effective treatment for hirsutism. Women on these drugs who are sexually active should also be on an OCP because these drugs hamper intrauterine sexual development, especially in a male fetus. Antiandrogens include *spironolactone* and *flutamide* that block androgen receptors. *Finasteride* (Propecia), a common medicine for male pattern

baldness, inhibits an enzyme that converts testosterone into a more potent form. By using these drugs, hair will become finer and less apparent, though it may take up to six months to see the effect. In the United States, only spironolactone is in use for hirsutism and is effective in 60 to 70 percent of women.

Vanishing cream

Vaniqa, (13. 9 percent *eflornithine hydrochloride*) is a new FDA approved prescription medication to reduce unwanted facial hair around the lips and under the chin. Vaniqa actively inhibits an enzyme in the root of the hair follicle responsible for hair growth. Use the fragrance-free medication, similar to a moisturizing cream, twice a day. The patient will notice a difference in four to eight weeks.

Crop removal

Mechanical hair removal is the most popular treatment option for the treatment of hirsutism. This involves bleaching or physically removing unwanted hair: Shaving, plucking, waxing, electrolysis, laser hair removal, depilatories, etc. Some methods involve less of an ouch, work better and last longer, but most are not really permanent. A women with PCOS may have to go back several times in order to get the problem under control.

Although plucking and waxing are common fixes, Dr. Azziz does not recommend them. Plucking is a quick and easy way to hide excess hair in the early stages but can distort the follicle and can cause the hair to thicken and become darker.

Waxing involves applying cold wax strips or warm wax with a cloth strip covering over the affected area. The strip is peeled off against the direction of hair growth. Waxing can cause several problems. Like plucking, waxing distorts the hair follicle since it essentially yanks the hair out. Improperly done, it can cause skin damage, breaks (bruise-like marks) and ingrown hair.

Shaving is quick but removes not only problem hair but also the fine hair, unaffected hair as well. Women may need to shave daily or in extreme cases, more than once a day to avoid stubble or a five o'clock shadow.

Depilatories remove hair by using chemicals that dissolve the hair and then allow you to wipe or wash it away. Though it works quickly, the harsh chemicals can cause skin irritation, breakout and allergy.

Electrolysis is an expensive, painstaking and painful method for controlling excess hair. After applying local anesthesia, a technician inserts a fine needle along the hair shaft and sends an electrical pulse into the root. The hair releases from the follicle and comes out easily with tweezers. It costs between US $50-75 an hour and may involve several weeks to several months' worth of treatment.

The final and most expensive option is laser hair removal. The laser's light beam generates energy that the hair's pigment absorbs, eventually destroying the hair. Lasers work best on people with dark hair and light skin because with darker skin pigments, the skin and the hair "compete" for the laser's heat. This unhealthy competition can result in skin damage. Laser treatments can cost US $200-700 dollars for small to moderate areas and a few thousand dollars for larger areas.

Don't tear your hair out

Although the most common causes of excessive hair growth are not life threatening, they are certainly life changing. The condition, either idiopathic hirsutism or PCOS is chronic, not usually reversible, and if left untreated, causes a gradual increase in hair growth as the woman ages.

Therapy is indefinite because increased androgen production or sensitivity is life-long. Dr. Azziz counsels women that it may take six to eight months for a noticeable effect, if it occurs at all. With menopause, the condition may actually worsen because the ovary still produces physiologically significant androgens, without the hampering effect of estrogen. Also as they age, many women find that the balance between treatment and cosmetic concerns changes and chose to stop treatment.

So whatever you decide to do for treatment, it is up to you, your doctor and to some extent, your budget. Consider also your concept of beauty, self-image and extent of emotional distress. Taking care of the hairy issues of hirsutism, getting to the root of the matter, will make you feel better about yourself.

You go girl-a woman of substance-mustachioed or not.

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

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References:
1. Lipanthyl® SUPRA Product Monograph. Laboratoires Fournier S.A. France
2. Guichard JP et al. A new formulation of fenofibrate: suprabioavailable tablets. Cur Med Res Opin 2000; 16(2): 134-8
3. Data on file. Laboratoires Fournier S.A. France

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"There's a diabetic in my chair!"

Mike A. Tan, DDM

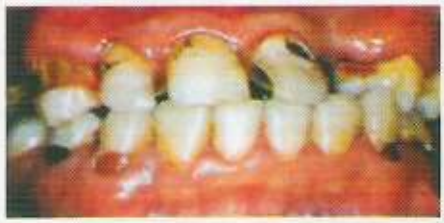
Not that kind of chair, not your sofa. My dental chair. Yes, I am a dentist-a periodontist, to be more precise. If you are diabetic, an endocrinologist, a family physician with diabetic patients, or even another dentist attending to a patient who happens to be diabetic, this may be a good time to settle down and give this page a good read.

There are about 80 million people in our country today, give or take a few thousand un-recorded or un-registered births (!!!). Out of this, roughly 14% are susceptible to some form of periodontal disease. (It's a group of conditions brought about by the presence of the right strain of bacteria in the right amounts colonizing the spaces between the gums and the teeth, and the teeth surfaces as well, in a genetically pre-determined susceptible individual. The poor fellow then develops a kind of host reaction where the destructive response overpowers the protective one. This leads to the teeth losing their attachments to the surrounding gums as well as to the anchoring bone, which in turn usually leads to the loss of the all important bone itself).

That's gum disease, the type which, if left untreated, can easily lead to premature tooth loss. That's a staggering figure when you translate that to smaller figures - 8 or so million patients in danger of having their teeth fall out when they sneeze hard. No wonder them cold tablets are selling like hotcakes. Combine this with the ever increasing trend of your friendly neighborhood doctor telling you that you're diabetic , or that you're on the cusp of crossing the threshold , then you start to wonder if you should switch to anti-ulcer pills instead.

Over the past 20 or so years, much research has been directed towards establishing the relationship, if any, between periodontal disease and diabetes. Currently, it's pretty much accepted that there indeed is a strong association between the two entities, perhaps not to the degree that diabetics will develop gum disease or vice versa, but enough for me to make some inquiries regarding the endocrinologic (if there is such a word) balance of patients referred to my clinic for a periodontal evaluation. Truth to tell, it isn't surprising that these poor patients don't even realize they're suffering from gum disease, much less diabetes. Herein lies the imminent difficulty in treating this subgroup of patients. Patients who are diabetic and have gum disease.

From my point of view, an uncontrolled diabetic susceptible to gum disease is a time bomb waiting to explode. These are the patients who often present with symptoms such as multiple gum abscess, mobile teeth, bleeding gums, and bad breath. Perhaps the biggest hurdle is to get them to seek proper medical care for their condition. Not the knee jerk type where medical advice and treatment is quickly obtained but is not continued long term, but serious, life long metabolic control by a qualified endocrinologist.



Uncontrolled or under managed diabetics do not respond well , even to the best periodontal treatment procedures. It's got something to do with their PMN's (for you non-doctors, that's a group of defense cells against infections) not working 100% as well as their blood vessels not perfectly doing their thing (angiopathy). This means there is a high risk of failure during and after treatment of their gum disease. As such, it is generally agreed that the uncontrolled or poorly controlled diabetic patient should not receive elective dental treatment until metabolic control is established. Hyperglycemia associated with poor diabetic control may predispose the patient to infection and poor wound healing.

Fortunately, once this is explained adequately and patients have digested it well, they do accede in seeking the proper care. These hopeful and cooperative patients may now be deemed ready to move on to greener pastures - periodontal therapy. I say therapy as treatment sometimes connotes a one time procedure which eliminates gum disease forever. Alas this is not so simple. Real therapy should include proper diagnosis and classification, treatment planning, active treatment and supportive periodontal care . Like diabetes, it's life long.

Fortunately, evidence has shown that properly maintained diabetic patients with periodontal disease respond very well to properly dispensed gum therapy. In fact, there is all the reason to expect them to do as well as non-diabetics. So when I walk in to my surgery to face that "diabetic in my chair," I can tell them the good news : "You don't have to worry about catching a cold!"

Mike A. Tan, DDM
UP College of Dentistry, 1988; Univ. of Queensland School of Dentistry, 1997
PRO-Phil. Society of Periodontology, Member, Asia Pacific Soc. Periodontology

PDA BATANGAS CHAPTER: ON THE GO!

Theresa Marie Valdez-Faller, MD

So the good news is out - the Batangas Chapter of the PDA was awarded the best chapter for the year 2005! And who do you think was the happiest? Well, the energetic president Dr. Glenn Dimatatac nonetheless. The officers and members were also ecstatic. We worked hard throughout the year for this.

After the new set of Officers' induction in September 2004 at the Mt. Malarayat Country Club by Dr Rosa Sy, everybody started working right away. As a result, the general membership increased by 32, and this was through invitation and active participation of our Chapter in the activities of other societies. The current membership was likewise strengthened by the quarterly lectures conducted during membership meetings dubbed as "Meeting with the Experts." To ensure province-wide participation, the venue for these meetings was rotated in the different areas of Batangas like Taal and Lipa City.

For our regular " Adopt a Barangay" community service project for the year 2005, the chapter chose the Alay Kapwa Foundation of the San Sebastian Parish of Lipa City. Around 100 patients came monthly to join our activity every 3rd Saturday of the month. They were given free consultation, blood glucose and cholesterol determination, ECG and ABI. More so, they learned a lot from the lectures concerning the nature and complications of DM, diet and physical fitness activities. For 2006, our adopted Barangay will be in the municipality of Calaca, Batangas.

The chapter's Diabetes Awareness Week activities held in July 2005 included a week long free blood glucose and cholesterol screening. This was highlighted by concurrent lectures on DM and its complications in the 2 tertiary hospitals of Lipa City - the Lipa Medix Medical Center and Mary Mediatrix Medical Center. The chapter also sent a 300 person delegation who actively participated in the closing ceremonies of the Diabetes Awareness Week at the Market Market Mall, Taguig City.

To celebrate the World Diabetes Day last November 14, 2005, with the theme "Put Feet First, PREVENT Amputations", the chapter conducted a simultaneous free clinic and foot screening at the Fernando Airbase Hospital, Lipa Medix Medical Center and Mary Mediatrix Medical Center. A total of 200 persons participated in the activity including patients, hospital personnel, soldiers and their dependents.

Presently, we are preparing for the 32nd PDA Postgraduate Course in Diabetes, to be held in Batangas in August 2006. We will be inviting all the medical practitioners, paramedical personnel of the different hospitals, clinics and health units within the province of Batangas and nearby provinces who are interested in Diabetes Mellitus. That's what's keeping us up and excited.

Busy, busy, busy. That's how we can describe the Batangas Chapter of the Philippine Diabetes Association.

Nutrition facts on food labels: maximize their use!

MA. IMELDA Q. CARDINO, RND

Have you done your grocery shopping? Did you take time to check out those food labels? Reading nutrition facts on food labels is a habit one MUST develop…if you haven't been doing it yet. Anyone who is health conscious must find time to go through the nutrition facts before purchasing the item. Though not all will have the nutrition facts on their labels, most items would at least enumerate the ingredients. Comparing ingredients of similar products will help one decide which is the better choice….other than the price! People who have to be cautious about sugar should also watch out for:

- High fructose syrup
- Fruit juice concentrate
- Maltose
- Dextrose
- Sucrose
- Honey
- Maple syrup
- Molasses.

Generally, if you are looking at percentages of nutrients, the American Food and Drug Administration (USFDA) gave the general recommendation as far as nutrients are concerned that 5% or less is LOW and 20% or more is HIGH. For example, cow's milk with 2% milkfat is LOW FAT MILK. Cow's milk with reduced fat will definitely have less cholesterol/saturated fat.

Food labels are useful, especially if one has to count calories for various reasons: weight control, glucose control, prevention of metabolic problems, etc. When reading them, note that food labels have two parts:

✓ The MAIN or TOP - specific information like serving size, number of servings per pack, etc

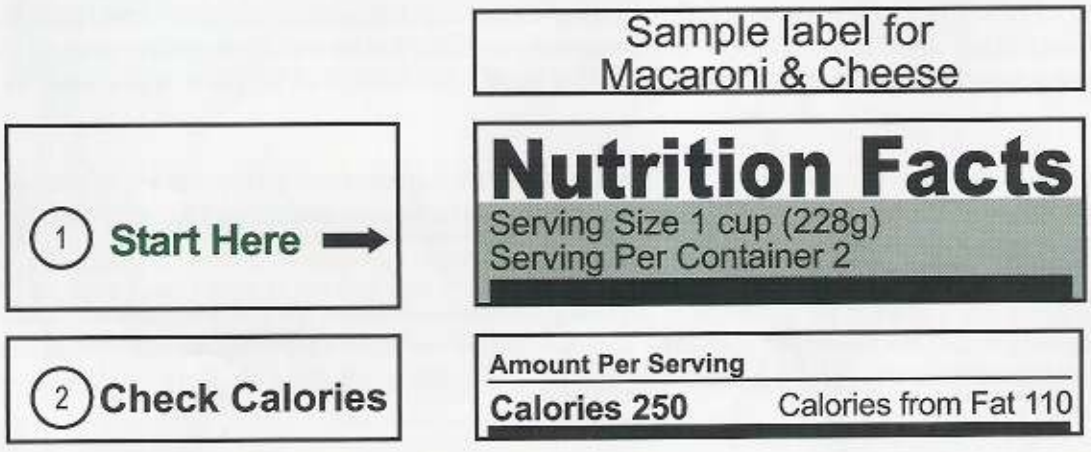
✓ The BOTTOM - footnotes with daily values usually compared to 2,000 calorie - or 2,500-calorie diet.

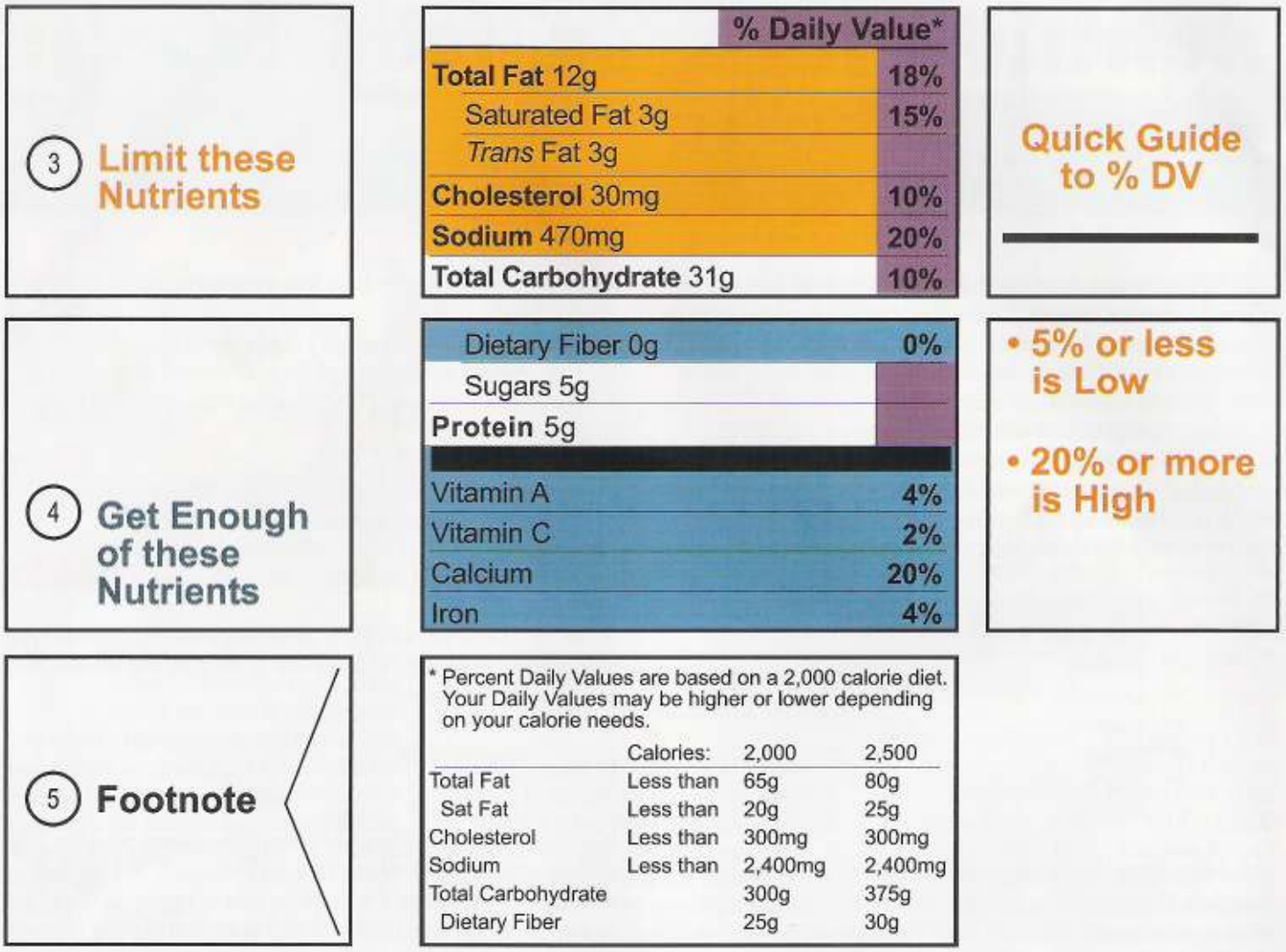
While the calorie per serving is important, other nutrients are just as important, especially with regards to the type and amount of fat the product contains:

- Total fat
- Saturated fat
- Trans fat
- Cholesterol

If one has to stabilize blood pressure or has a heart condition, the sodium content per serving is valuable. Minerals like calcium and phosphorus are also worth taking note of especially if one has kidney problems. Iron content as well as amount of other vitamins like Vitamin A and Vitamin C are important to prevent nutritional deficiencies.

Below is an illustration of the food label and how to understand the entries on it:



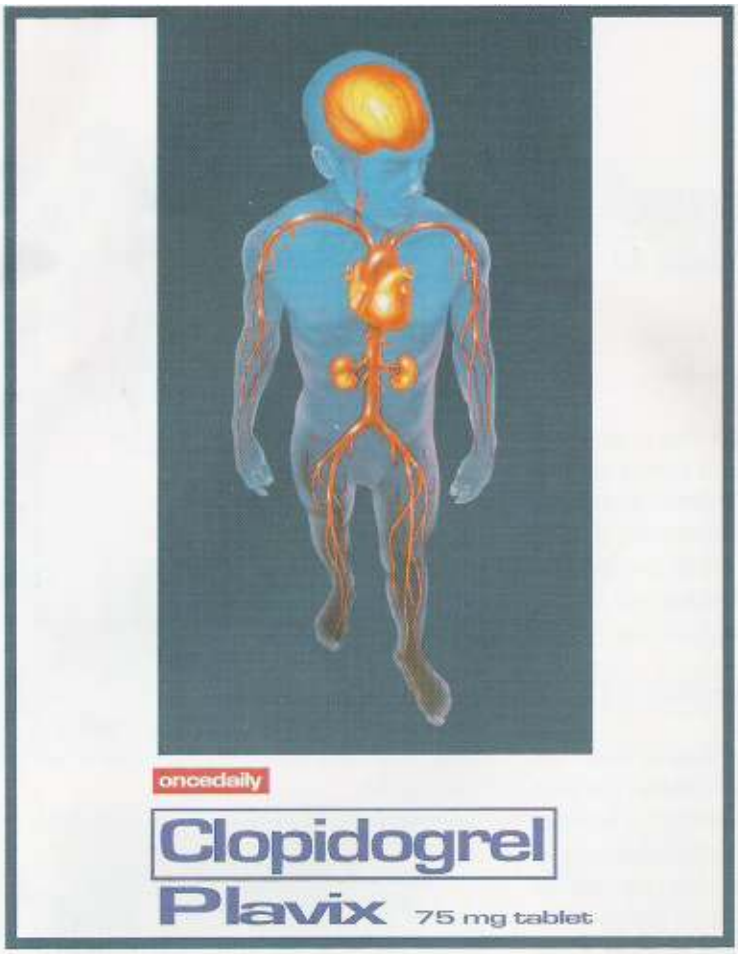


If one is counting calories, the labels will guide the consumer as to how a specific product may be taken "in exchange" for items in the calculated diet that has to be observed. Because it is difficult to find a product that will be exactly the equivalent in the Food Exchange List, 20 calories more or less may be allowed for deviation. If the excess is more that 20, it is necessary to "trade off" some items in the meal plan.

Some entries on labels tend to confuse. For example, the label will boldly say "10 calories" followed by very small print "for every 250 ml". The pack is 355 ml but will be "silent" as to the number of servings per pack. You just have to figure that out yourself. Some labels will give the serving size in grams but unless you have a dietetic scale at home it will be difficult for you to approximate the serving size.

A word of caution: it does not mean that because a product is sugar-free it is calorie-free. A processed meat product with reduced fat content does not necessarily contain less salt. A product reduced in salt content may not be reduced in sugar content. A fat-free dressing will most likely contain a significant amount of carbohydrate.

There are hundreds of dietetic foods one will see in the supermarket. It is not possible to name them all or to give guidelines that will cover them all. The best thing to do is have the patience to read labels and try to understand them. One writer has commented some food labels appear to give inaccurate information… and they cause confusion! Nevertheless, try to read and understand them…and use the information to your advantage!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Kitchen Corner

Know your favorite cheese

Sanirose S. Orbeta, RD

Cheese has become a universal, all-time favorite food. Because of its high demand a delicious array of cheese flavors and textures are now being sold in most supermarkets, especially in Duty Free Shops in International Markets and Airports.

Likewise, restaurants everywhere are adding cheese dishes to their menus. Cheeses are no longer just appetizers but also desserts. They have become main courses for example a cheese soufflé, cheddar cheese soup, cheese lasagna, cheese fondue, quesadillas to name a few.

Don't Feel Guilty Enjoying Cheese

There are low-fat and high-fat varieties to choose from and an occasional indulgence is okay.

a. An ounce of cheese roughly 30gm is considered low fat when the label states it has anywhere from 2-5 gms of fat per serving, a medium fat content carries 6-7 gms per serving, and a high fat variety has 8-10 grams of fat per serving.

b. It's a good source of calcium. The harder the cheese the more calcium it contains. An ounce of cheddar or Swiss cheese has 219 mg of calcium. An adult needs 1,000 mg calcium daily.

c. Adds protein. One slice of semi-hard cheese like Monterey Jack or Gruyere has 6 to 8 gm protein about the same amount as one ounce of beef, chicken or pork. That's why vegetarians can complete protein requirements plus added phosphorus, riboflavin and vitamin A from the cheese.

d. Good for lactose intolerant stomachs. These people can enjoy the cheese from processed milk as the processing turn lactose into more digestible lactic acid.

e. Prevent cavities. According to the Dairy Council Association aged cheese such as cheddar and mozzarella when consumed as snacks, alters the mouth's acidity, creating an environment that slows cavity formation. Cheese is a better snack than chocolate or ice cream.

The Five Common Categories of Cheese

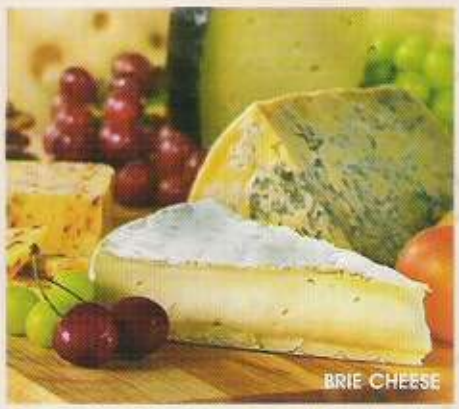
People around the world love to smell and taste the cheeses of other nations. But how many of us could tell the difference between Brie and Gorgonzola? Is Feta the same as goat's cheese? When is cheese ripened? Is stinky cheese better? There are so many categories of cheese, goat's cheese alone have 80 varieties. Here are some classifications of what we eat.

I. Soft and Semi-soft.
Aged one week to three months. These are good melting cheeses. Soft cheeses in this group have thin, velvety rind and open from the outside in.

Livarot
- this is a "smelly" cheese, with an aroma much more potent than its nutty, salty, beer flavor. It yields to the touch, but if is sunken in the center it is overripe and too strong. Look for Livarot made by Graindorge or Levasseuer.
Similar cheeses: French Pont-l'Eveque or Reblochon, Italian Taleggio.

Brie
- Brie de Meaux is the king of cheeses-benign, creamy and slightly sour. *Similar cheeses: Italian Toma or Paglia-style cheeses, French Camembert.*

II. Hard and Semi-hard
Aged one month to four years. Good for cooking and melting. These cheeses usually have natural rinds and are typically aged longer and have denser textures than semi-soft cheeses.


BRIE CHEESE

Parmigiano-Reggiano
- an Italian cheese with an inedible oiled rind. Amazingly piquant; slightly salty. *Similar cheeses: Italian Pecorino, Dutch aged Gouda, American dry Jack, American Parmesan, Wisconsin Roth Kase aged Gruyere.*

Morbier
- this French cheese has a creamy brown rind, a fresh aroma and a nutty, fruity flavor. The interior has two layers separated by a thin stripe of ash. Look for the Brunnerois brand.
Similar cheeses: Swiss Raclette, Italian Fontina, French Saint-Nectaire

Emmental
- commonly known as Swiss cheese, true

Emmental is much firmer than what is sliced in the deli. It has a fruity, woody, nutty flavor with a savory bit. Make sure the rind is stamped, " Switzerland."
Similar cheeses: French Comte, Norwegian Jarlsberg, Greek Kefalograviera.

Manchego
- sheep's milk cheese from Spain with a sweet, mild flavor. Buy wedges cut from a piece labeled "La Mancha" (there are many inferior imitators).
Similar cheeses: Vermont Shepherd Putney Tomme, Swiss Tete de Moine.

III. Cheddars
Aged two months to four years. Most cheddar is technically in the hard-cheese category.

Clothed-Wrapped Cheddar
- the traditional cheddar, made from cow's milk, has firm, buttery, earthy flavor.
Similar cheeses: English Cheshire, French Cantal and other smoked cheddars.

Extra-Sharp Cheddar
- a rich, moist buttery yellow or orange cheese with an explosive but pleasant bite.
Similar cheeses: Vermont Grafton Four Star Cheddar, Shelburne Farms Farmhouse Cheddar, Cabot Vintage Choice, Black Diamond Canadian Cheddar.

Sharp Cheddar
- a white or orange cheese with a smooth flavor.
Similar cheeses: Oregon Tillamook Vintage White Cheddar, Wisconsin Carr Valley Cheese Sharp Cheddar, California Vela Cheese Company raw-milk Sharp Cheddar, Monterey Jack.

IV. Blue Cheese
The curds that will become a blue-veined cheese are often inoculated with the mold Penicillium roqueforti. Once shaped, the cheese is skewered to create veins where air can penetrate, which allows the blue mold to grow.

Gorgonzola
- an Italian blue cheese with a slightly thicky crust, moist and buttery. The Dolce latte brand is a slightly toned-down Gorgonzola.
Similar cheeses: Danish Classic Saga, French Roquefort or Bleu de Bresse, German Cambozola.

Semi-Soft Blue
- a taste that is both salty and sweet and slightly peppery. Avoid buying pieces with dry or crumbly edges.
Similar cheeses: Massachusetts Great Hill Blue, Vermont Boucher Blue, French Bleu d'Auvergne.


GORGONZOLA CHEESE

Stilton
- a firm yet crumbly English cheese with profuse blue-green streaks, strong and tangy. Buy wedges not scoop.
Similar cheeses: Colorado Bingham Hill Rustic Blue, California Point Reyes Original Blue, Whole Foods Organic Blue Gouda.

V. Goat Cheese
Chevre, the French word for "goat", can be used to refer to any goat cheese, and there are as many varieties of goat's-milk cheese are there are of cow's milk.

Fresh Goat Cheese
-a moist, flaky, tart and spicy cheese; may be coated with herbs, ash or peppercorns.
Similar cheeses: French Selles sur Cher, New York Coach Farm Pyramid, Colorado haystack Mountain.

Banon
- a fresh goat cheese that's wrapped in wine-soaked grape or chestnut leaves. The cheese is white with a bit of blue mold in the rind; it has a pleasant sourness.
Similar cheeses: Washington State Sally Jackson Banon, French Banon.

Aged Chevre
-aged goat cheese tastes rounder and less tart.
Similar cheeses: Vermont Butter and Cheese Company Goat Fontina, Holland Goat Gouda, California Laura Chenel Tome, California Cypress Grove Humboldt Fog.

Treat Cheese Right

Store -Keep cheese in the vegetable drawer with an unwrapped head of lettuce which will provide the right level of humidity. Wrap cheese in wax paper, foil or plastic, so it can "breathe." For funny cheeses, like Brie, plastic wrap directly on the cut surface to prevent oozing, take cheese out of the refrigerator one to two hours before serving (cold mutes flavor).

Cut - when serving several cheeses, use different knife for each one, so flavors don't mingle.

Taste - to keep palate fresh, eat cheese in order of mildest to most pungent

Toss - the harder the cheese, the longer it lasts. Fresh and soft cheese, like Ricotta and Brie will keep about two weeks; hard cheeses like Parmesan and Manchego will be good for up to several months.

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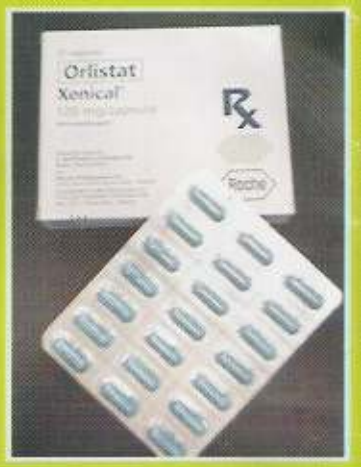

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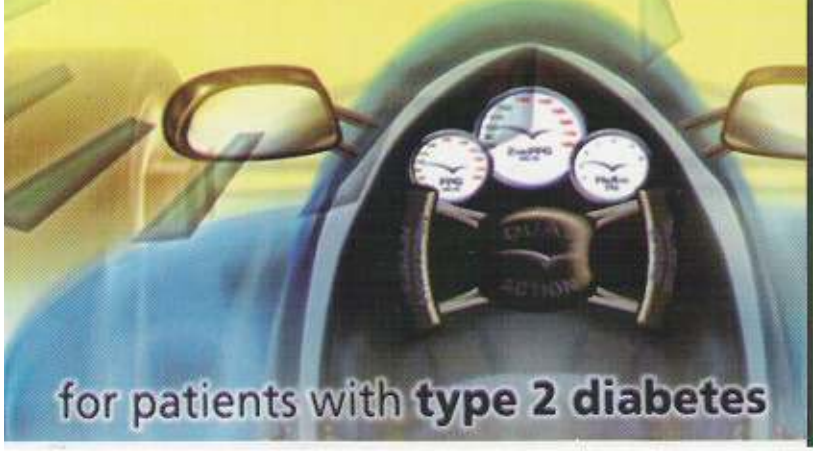

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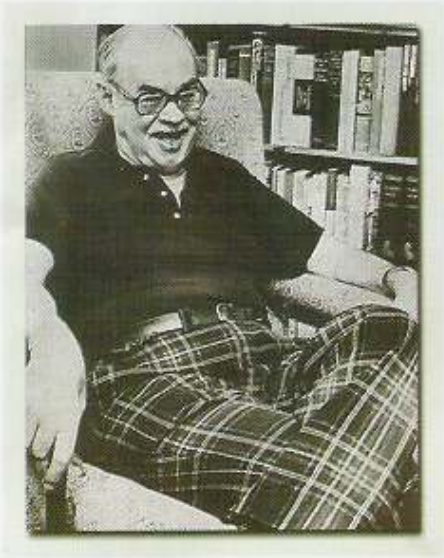

Ted Ryder - the world's longest insulin user (71 years!)

Cynthia de Castro

More than 80 years ago, the diagnosis of diabetes was like a death sentence. At that time, the only treatment given by doctors for persons with diabetes was to force the patients to eat sparingly. Their bodies had lost the ability to metabolize food properly, so they were advised to only eat the small quantities they could metabolize. At best, these "undernutrition" diets allowed diabetics to prolong their life for a year or two while they slowly starved to death.

Then, in 1922, a team of researchers led by Dr. Frederick Banting and Professor JJR Macleod in the University of Toronto discovered insulin. Banting and his co-workers announced the successful trials of the great medical breakthrough, suddenly giving hope to countless persons afflicted with diabetes around the world.

One of these diabetics was Theodore "Ted" Ryder, a five year old, 27 pound human skeleton who, a year before, at age four, had begun to show the symptoms of severe juvenile diabetes- excessive urination, insatiable thirst and hunger and rapid weight loss. Ted's physician uncle went to Toronto and pleaded with Dr.Banting to accept the child for treatment. But insulin was in desperately short supply that Banting told him to wait three months. "Doctor, he won't be alive by then," Ryder's uncle said. Banting relented.

Within a few months, Ted Ryder had come back to life and apparent good health, a beautiful example of what even medical personnel were calling the "miracles" wrought by insulin. He was one of the first dozen humans to receive insulin in that magical season of 1922. The team of Banting, Macleod, Charles Best and JB Collip witnessed near- resurrections of diabetic patients after treatment with insulin.

Ted Ryder had a long and satisfying life, faithfully using insulin and a healthy diet to control his diabetes. He had been a librarian and a world traveler and had suffered none of the serious side-effects of diabetes that still plague many insulin-takers.

In 1978, fifty-six years after the discovery of insulin, the last of its discoverers, Charles Best died. A few years later, Michael Bliss, a University of Toronto historian and special correspondent to The Star (Toronto, Canada) discovered that one of the first ones to receive insulin, Ted Ryder, was still alive, after more than 60 years. For the next decade, Ted enjoyed a kind of celebrity status as the world's longest insulin user. The American Diabetes Association gave him a special medal and made a coloring book about him, Teddy Ryder Rides Again. It was a memorable day at the US National Institutes of Health when Ted met the new generation of diabetes researchers, reminisced about his life and gave autographs. And it was truly memorable when Ryder came to the University of Toronto in October 1990 for the unveiling of an historical display about the discovery of insulin. It featured his own "before" and "after" pictures, and there he was in the flesh.

Ted suffered congestive heart failure in the summer of 1992 and gradually wound down. On March 8,1993, Ted Ryder died in his sleep from heart failure at age 76. Having taken insulin for 71 years, Ted outlived all the initial insulin-takers and his physicians. With his death, the world has lost our last living link with the great events of 1922 in Toronto. But the discovery itself lives on daily, in millions of diabetics around the world.

Before

After

REFERENCE MATERIALS: Practical Diabetes International July-Aug 1995 issue. Photos of Ted Ryder as a boy from FG Banting Papers, Thomas Fisher Book Library, University of Toronto.

PDA ON THE MOVE

PDA Chapter Presidents Meeting Jan.28, 2006 Richmonde Hotel

PDA Chapter President Meeting Jan.28, 2006 Richmonde Hotel

Lakad Puso, QuezonCity Circle February 12, 2006

PLS PSH LAY FORUM Feb.05,2006 EDSA Shangri-la

Upcoming events...

31st Diabetes Workshop
Villa Isabel, Sorsogon City
May 12-13, 2006

Diabetes Awareness Week
July 16, 2006 - Legaspi City
July 23, 2006 - Glorietta, Makati City
July 30, 2006 - Market Market, Taguig

Diabetes Strategies for the Primary Care Physicians
Century Park Hotel, Manila
July 27-28, 2006

32nd Diabetes Workshop
Batangas
August or September 2006 *(TBA)*

Global Risk/2nd Course on Diabetes and Vascular Diseases
Century Park Hotel, Manila
October 12-13, 2006

Diabetes Expo
Mega Mall (Megatrade Hall 1)
November 4-5, 2006

World Diabetes Day Celebration
November 14, 2006

Wound Workshop
Century Park Hotel, Manila
November 18, 2006

PDA Annual Convention
Century Park Hotel, Manila
November 21-22, 2006

Molecular Diabetology Meeting
(venue TBA)
November 24-25, 2006

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1. Cuzi K, Consoli A, DeFronzo RA. Metabolic effects of metformin on glucose and lactate metabolism in non-insulin dependent diabetes mellitus. J Clin Endocrinol Metab 1996; 81 (11): 4059-67.
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