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DIABETES WATCH

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September - December 2008

YEAR XXV, NO.3

PDA TURNS GOLD

Alcohol and diabetes:
when too much and too
little hurts

Diabetic emergencies
in children

Illicit drugs and
diabetes:
A deadly mix

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2009





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FROM THE
EDITOR'S DESK

It's amazing how quickly time flies! This is the third and final issue of DiabetesWatch and we have dedicated this issue to complete our triumvirate of topics, this time focusing on children and adolescents with Type 1 diabetes. Perspectives from a Type 1 diabetic, is kindly shared by Paula, who was first diagnosed during the summer before high school. A matching article from her mom Anne, provides an insight into a mother's fears, concerns and successes. I personally thank you both for sharing this important and

private part of your lives, so that others may learn from your experiences, both challenges and triumphs. May we, their health care providers, learn from these valuable insights to understand our patients and their families better.

Endocrinologists provide us with the lead articles: "The Growing Problem of Diabetes in children" by Past President Dr. Rosa Allyn Sy and "Diabetic Emergencies in Kids" by Dr. Lorna Abad. A variety of interesting topics such as "Cool Gadgets for Kids" by Dr. Mia Fojas, "Christmas Treats for Diabetic Kids" by nutritionist Emy Cardino and "Resources of Parents and Kids with Diabetes" by the Informatics team are presented here.

Let me take this opportunity, at the end of the year, to thank the hardworking and competent staff, led by Managing Editor Tish Gatbonton, whose help is extremely valuable in bringing us these issues. Thank you to the support of the PDA Board with special mention to Dr. Tippy Plata-Que for her inspiration. I do hope we were able to live up to her high expectations for the magazine. Thanks to Dondi and to the Secretariat for all their valuable work. Finally, special thanks to our readers, the diabetics and their families and all health care providers. You are the reason for this magazine! We do hope we have addressed your questions and concerns. We hope you continue to ask questions, as we try to provide answers to the best of what is currently known.

Cheers for the New Year!

Elizabeth Paz-Pacheco
—Elizabeth Paz-Pacheco, MD—
Editor-in-Chief



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An affiliate society of the Philippine College of Physicians (PCP)
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Be the prime mover of excellent diabetes care and prevention in the Philippines

OUR VISION

A diabetes-free Philippines.

OUR VALUES

INTEGRITY *Above all, the nobility of our purpose. We serve patients, pursue education and conduct research with passion and without regard for personal gain. Honesty and transparency rule our behavior in relating with fellow members, partners, supporters and other stakeholders of our association.*

EXCELLENCE *Perfectionists, we expect from ourselves only the best effort. We continuously upgrade our knowledge and skills, adopt ever-improving technologies, and expand the reach of our services to attain a diabetes-free Philippines. Our mentors, generous with their knowledge and time, model excellent leadership.*

COOPERATION *We work as one for the common good. Enjoying the camaraderie, observing politeness and maintaining loyalty even in dissent. We partner with companies and other specialties that reach for the same goal. Caring for everyone's well being, we make work pleasant for members and staff.*

COMMITMENT *Persistent in our search for solutions to diabetes. We have selflessly devoted over four decades to the improvement of diabetes care, education and research to prevent the onset of the disease in high risk individuals and the complications in those already afflicted by it. We take on responsibilities with diligence until their successful conclusion. We shall not rest until we achieve a diabetes-free Philippines.*

YOUR PRESIDENT SPEAKS



Last year marked the 50th year of PDA and it is worthy to note that through all these years our the association has become a proactive and dedicated initiator of measures aimed at preventing diabetes and helping those who are already afflicted live better lives.

A lot of activities happened in the past months. The PDA together with PSEM, ISDFI and PCDEF initiated the Clinical Practice Guidelines on Diabetes. On September 21-27, last year, the association joined in the Medicine Week Celebration spearheaded by the PMA.

During the 25th PDA Annual Convention on November 11 - 12, 2008 the association bestowed on Dr. Ricardo E. Fernando the 2nd PDA Award of Excellence in Diabetes and held the 2nd Ricardo E. Fernando and 2nd Augusto D. Litonjua Endowed Lectureships. During the President's Reception on November 11, to celebrate the society's 50th anniversary, medals of recognition were awarded to our presidents and past and present board members. Our new corporate name, Diabetes Philippines, and new logo were launched. Meanwhile the association held a fellowship dinner on November 12, 2008.

During the World Diabetes Day celebration, several activities were implemented. The "Bring Diabetes to Light" poster illustration contest among 10 to 18 year-old students was conducted. On November 14, several buildings nationwide were lighted in blue. An animation display was set-up at SM Megamall. Press conferences and radio television interviews took place. A public lecture "Gimik Diabetes" Year 2 materialized on November 15.

Finally on December 2-3, the 4th Course on Diabetes and Vascular Disease was held, and on December 3, the PDA held its annual Christmas and appreciation party.

Truly, PDA's 50th year was also a very fruitful year.

Tommy S. Ty Willing
Tommy S. Ty Willing, MD
PDA President



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 -- Another emergency state which could be seen in diabetic children treated with insulin is hypoglycemia.

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 -- Fantastic Voyage was the title of a sci-fi movie I watched wayback in the late 1960s.

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Aurora G. Macaballug, MD
 -- A New Year's Resolution is a commitment that an individual makes to a project or the reforming of a habit.

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Navigating the Net: Helpful websites for parents and kids with diabetes
Cecille R. dela Paz, MD and Cecilia A. Jimeno, MD
 -- There are many websites in the internet with all sorts of useful tips, tools, advice and resources to help parents and kids with diabetes cope with this disease that typically affects adults.

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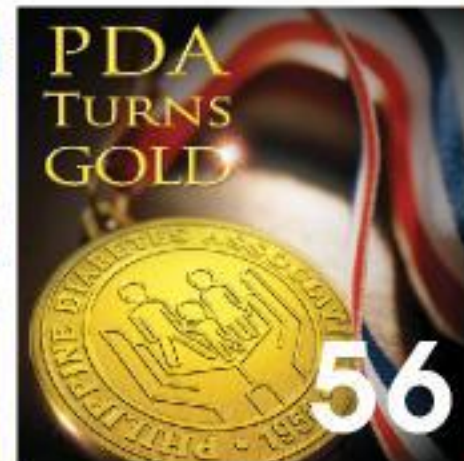
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Camp Cape the 13th - Tricks and Treats
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MEANDERINGS



The Ideal Anti-Diabetic Pill?

Augusto D. Litonjua, MD
Editor Emeritus



The consensus statement of the American Diabetes Association and the European Association for the Study of Diabetes on the medical management of hyperglycemia in type 2 diabetes appears simultaneously in the December 2008 issues of *Diabetes Care* and *Diabetologia*. This is the updated consensus algorithm

for the initiation and adjustment of therapy in type 2 diabetic patients.

The present algorithm is more simple in its diagrammatic presentation than the older one. It will not be produced here as it is not the intention to repeat what the two journals are representing.

As in the older consensus, there may not be universal acceptance of the way we should treat our diabetic patients. But the panel which wrote the statement consists of a formidable array of recognized specialists from many quarters of the globe - the United States, the United Kingdom, Italy, and Canada. One point of difference of opinion may be in the selection of medications for use in the algorithm, and the exclusion of some drugs which many of us employ presently in the therapy of diabetes.

The choice of the specific antihyperglycemic agents is 'predicated on their effectiveness in lowering glucose, extraglycemic effects that may reduce long term complications, safety profiles, tolerability, ease of use and expense.'

Prominent in the recommendations is of course the interventions to correct overnutrition and a sedentary lifestyle.

The recommended drugs are:

1. **Metformin** - the major effect of metformin is to reduce the overproduction of glucose by the liver, thus lowering the fasting plasma glucose. Its major asset is in not producing hypoglycemia with its major nonglycemic effect of weight stability or modest weight loss.
2. **Sulfonylureas** - these agents lower the blood sugar by stimulating insulin release from pancreas. The preferred

sulfonylureas in the consensus statement are: gliclazide, glimepiride and glipizide.

3. **Pioglitazone** - this is an 'insulin sensitizer.' It increases the sensitivity of muscles, liver and fat to the effects of insulin. The other drug available in the Philippines of the same class as pioglitazone - rosiglitazone - is not advised to be used because of 'the potential cardiovascular risk associated' with it. A new study called the APPROACH trial may enhance or negate this statement of the consensus group.

4. **Exenatide** - this relatively new drug on the Philippine market stimulates insulin secretion and suppresses glucagon when the blood sugar is high. It has the added benefit of weight loss by suppressing appetite and slowing gastric emptying.

5. **Insulin** - it is the oldest medicine that lowers the blood sugar, and has undergone major changes in the past, ostensibly to improve its clinical benefits. It is the most effective agent to lower high blood sugars.

In the algorithm, each step is driven by the level of the glycosylated hemoglobin, or HbA1c. One proceeds to the next step if the desired HbA1c of equal to or less than 7% is not achieved within the reasonable time.

At the moment of diagnosis of type 2 diabetes mellitus, the following abnormalities are seen in the patient:

1. *insulin resistance,*
2. *insulin deficiency, and*
3. *deficiency of the incretin factors* (the intestinal substances which stimulate insulin secretion and suppress glucagon production after a meal, plus modifying food intake). Dr. Ralph de Fronzo calls attention to these pathophysiologic defects in type 2 diabetes mellitus, and many more defects (he cites 8 major defects) which need to be addressed at once, if we are to achieve the goal of a controlled HbA1c in a sooner possible time, to avert further complications. This was the gist of his Banting Lecture of 2008 - the lectureship being awarded in recognition of his scientific achievements.

Thus, a better initiating therapy for type 2 diabetes mellitus - if finally supported by the study of de Fronzo to compare his triple therapy with the consensus algorithm's step by step addition of single drug - would be to have a concoction of drugs: insulin sensitizers (metformin and pioglitazone), insulin stimulators (?sulfonylureas, although de Fronzo is against this), and incretin replacement.

The above just shows the complexity of what type 2 diabetes mellitus is - thus, the search for the ideal antidiabetic pill must continue. 

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT DIABETES (BUT WAS AFRAID TO ASK!)

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



Diabetes occurs in all age groups. Adult diabetics have a lot of problems different from children and teens. In this issue of *Diabetes Watch* we tackle a very interesting group: the teen with diabetes. The teenage years bring many changes and challenges. Having to deal with these changes plus having to deal with your diabetes is indeed daunting to many. So read on and learn from your questions.

I am embarrassed to talk about birth control, pregnancy, alcohol or drugs with my doctor. How can I be open up to my doctor?

It is important to be at ease with your doctor. He will be your "physician-for-life" and it is necessary to have an open and honest relationship. These are "heavy questions" and your doctor will be more than happy to clear up these issues with you. You need to be clear and specific about your questions. Come prepared with a list and be ready to take notes when necessary. Remember your health depends a lot on this relationship.

Should I tell my friends about my diabetes? I hide my testing supplies and syringes. I don't want them to feel sorry about my diabetes.

This is one secret you need to tell your friends. If they know, then they will understand why you are not eating that birthday cake or not drinking regular drinks or going slow on that pizza. If you get a hypoglycemic reaction, they will know what to do to help you. Some friends will understand and accept you and become curious about your disease. Some might see you differently. Most of your friends, I'm sure, will respect you as a person with diabetes.

Do I tell everyone about my diabetes?

You may choose to do that. There is a downside to doing this. You may get strange looks and comments from some people who just don't understand anything about diabetes. You will have to explain your disease and tell them that

they can't "catch" diabetes. Another option is telling only some select friends. If they are really your friends they will treat you with respect. In school, make sure that your teachers know about your illness especially your P.E. teacher. Make sure that your school physician knows about your diabetes.

What do I do if my friends pressure me to do things which are bad for my diabetes?

Be assertive and learn to say "NO." Repeat it if you must. Do not be swayed by peer pressure. You know it is not good therefore say NO! You may explain briefly why you are saying NO. Keep it brief and simple. Do not apologize.

You need to work things out to control your diabetes. Keep to your meal plan. Exercise a lot. Don't forget to monitor your blood sugars and inject insulin. There are a lot of things which you will experience as you grow up. Taking control of your diabetes is your priority. This is a lifelong process. If your sugars are in good control, hopefully you do not get the complications associated with this disease.

We welcome your comments and suggestions. Please fax your questions to 532-7126 or email me at mbmirasol@yahoo.com. We would like to hear from you. 

DIABETIC DYSLIPIDEMIA

Open your eyes to microvascular risks

Diabetic retinopathy

At least 50 million people are likely to have diabetic retinopathy and this number is projected to double by the year 2025 if no major control activity is developed.¹

Diabetic nephropathy

Diabetic neuropathy

SAME ADS

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New
Lancet
2007

- Reduces the need for laser treatment in patients with and without known diabetic retinopathy²
- Decreases development and progression of existing diabetic eye disease³

Rapid benefits from eight months onward and increased throughout the study period⁴

Additive to tight blood pressure and glycemic control⁵

- New data to follow up the results of the 2005 FIELD study⁶

Sub-analysis⁷

Out of 8735 patients, 482 underwent one or more laser treatments during the study. In total, 802 courses of laser treatment for diabetic retinopathy were performed.

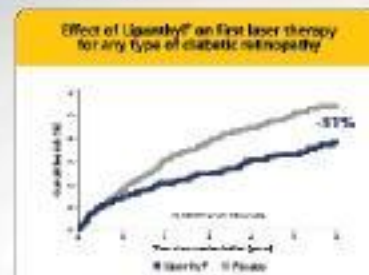
Endpoints

Criteria for laser treatment for:
- Proliferative disease
- proliferative to nonproliferative retinopathy

Lipanthyl[®] reduces the leading cause of blindness and vision deterioration for T2D¹

- Lipanthyl reduces the need for laser treatment for any type of diabetic eye disease

First laser therapy



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Reduction in the need for cumulative laser treatment:
-37% for overall population
-40% for patients with no retinopathy at baseline



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THERE'S MORE TO IT THAN WHAT YOU THINK

Illicit drugs and diabetes: A deadly mix

Juan Maria Ibarra O. Co, MD
Cardinal Santos Medical Center

As if having to deal with a chronic illness isn't difficult enough, some diabetics have complicated their lives further by experimenting, and later habitually using, illicit drugs. *Methamphetamine* (shabu) and marijuana are the most widely used in the Philippines, although *methylenedioxymethamphetamine* (ecstasy), cocaine and morphine have found their way into some circles.

In many communities, these drugs aren't that hard to come by, especially when you have the money to pay for it. One user admits to buying shabu from a dealer who hangs out all day at the nearby sari-sari store. Transactions are done in the open, indiscreetly in broad daylight. One college student gets his weekly supply of marijuana from the *labandera* (laundry lady) who visits his dorm to pick-up and deliver his clothes. Prices are lower for new users in an attempt to lure them, but subsequently increase as addiction develops.

Younger individuals are more susceptible to the temptations of drug use. Driven by a desperate desire to be accepted, they imitate the behavior of their friends and peers, ignorant of the potential dangers of its use. Some people with low self-esteem have resorted to drug use to alleviate shyness and relieve nervousness.

Many users utilize these drugs to "escape" - they self-medicate themselves in an attempt to distract them from their problems, or to avoid unpleasant mood states, including depression, anxiety, anger and even boredom. Others use drugs simply for

its gratifying effects, particularly the profound pleasure that develops, often referred to as a "high" or "rush." Lastly, curiosity drives some to experiment and try these agents.

Diabetics should undoubtedly veer away from illicit drugs. The behavioral and cognitive effects associated with its use often lead to an irresponsible neglect of one's health - certainly unacceptable in diabetics, whose management relies on an overall healthy lifestyle of proper nutrition and physical activity. Dietary plans are abandoned and users are often too exhausted from the resulting "high" to exercise. Even worse, most patients discontinue their medications, leading to potentially dangerous, and even fatal acute hyperglycemic episodes.

Beyond the behavioral effects are physiologic effects that are particularly detrimental to diabetics. Shabu use has been linked with hypertension, blood vessel inflammation, kidney damage, heart valve infections, irregular heart rhythms, stroke and erectile dysfunction. Marijuana use is associated with increased appetite, binge eating and weight gain. It may trigger the onset of a heart attack in patients at high risk for development of heart disease, and has been associated with an increased risk for stroke.

Ecstasy may cause abnormally elevated body temperatures, memory impairment, decreased blood flow to the brain and permanent brain damage. Cocaine is one of the most dangerous drugs and causes hypertension, fast and irregular heart rhythms, hyperactivity, restlessness, seizures,

strokes, respiratory failure, heart failure, heart attacks and kidney failure.

Each of these agents, in sufficiently high doses, can inadvertently lead to death.

Experimenting with drugs to satisfy a curiosity should never be considered or undertaken. The heightened sense of pleasure associated with its use can be so compelling that the brain would want that feeling back, again and again. Because tolerance develops, higher doses of the agent are required more frequently to achieve the desired sensation. Once psychological and physical dependence develops, attempts to quit are difficult due to the development of withdrawal symptoms upon drug discontinuation. Common symptoms include fatigue, disturbed sleeping patterns, irritability, intense hunger, depression, anxiety, and various psychotic reactions.

All things considered, the dangers of illicit drug use clearly outweigh the temporary "escape" brought about these agents. Avoid them at all costs and resist the temptation, lest you be drawn into the addiction and dependence that so many have fallen into. Learn to say "NO" and stay in control of your life, living it to the fullest of health. 

For more information on illicit drugs, including a list of national drug rehabilitation centers, download "Vision 2010: A Drug-Free Philippines" at www.gov.ph/publications/drugfree.pdf.



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ALCOHOL AND DIABETES: WHEN TOO MUCH AND TOO LITTLE HURTS

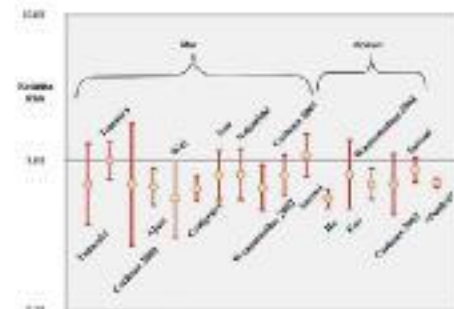
Nemencio A. Nicodemus, Jr., MD
Manila Doctors Hospital

Alcoholism carries with it a negative connotation whenever the topic is discussed in the clinics. People who are dependent on this substance would prefer to be anonymous. However, abuse of this substance is very common and is almost synonymous to celebration or parties. The two scenarios seem contradictory, and the same is true for the effect of alcohol intake on the risk of developing diabetes: too much of it is bad and, as research shows, too little of it may be not favourable, too (... at least as far as developing diabetes is concerned). Here are the evidences.

Twins of the Finnish Twin Cohort, born before 1958 and totalling 22,778 were surveyed from 1975 with the following

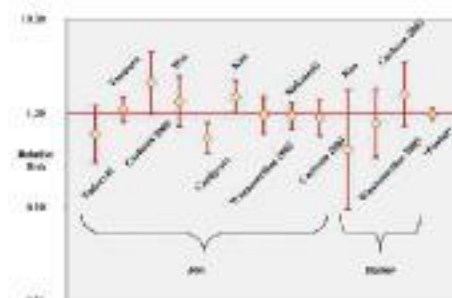
information being recorded: alcohol, smoking, diet, physical activity, medical and social conditions. By record linkage to national registers of hospital discharge and prescribed medication, 580 incident cases of type 2 diabetes were identified during 20 years of follow-up. Further analysis of the alcohol intake data showed that moderate alcohol consumption (5-29.9 g/day in men and 5-19.9 g/day in women) was associated with a trend toward reduced incidence of type 2 diabetes compared with low consumption (<5 g/day). Lean women with high alcohol consumption (>20 g/day) were 190 times more likely to develop type 2 diabetes. Interestingly, binge drinkers were 110 times more likely to develop type 2 diabetes. In this study, women were more affected

by the association than men.¹



Two years later, another cohort study, this time involving only older women (n=16,330), aged 49 to 70 years observed for a mean of 6 years, showed a linear inverse association (P= 0.007) between alcohol consumption and type 2 diabetes risk. Compared with women who abstained from alcohol drinking, women consuming moderate amounts

of alcohol per week (5-30 g) had 14% lower risk for type 2 diabetes. The risk progressively lowered with higher intake of alcohol reaching the greatest reduction (36%) with alcohol intake of 70 - 140 g per week. However, when alcohol intake exceeded this amount, the risk went the opposite direction, going up. From these data, it can be seen that lifetime alcohol consumption was associated with type 2 diabetes in a U-shaped fashion.²



Thereafter, two meta-analyses came out in the same year talking about alcohol consumption and type 2 diabetes. The first one included 15 original prospective cohort studies that included 11,959 incident cases of type 2 diabetes in 369,862 individuals followed for 12 years. After pooling the data, a U-shaped relationship was found. Compared with nonconsumers, the risk for type 2 diabetes in those who consumed 76 g/day alcohol was significantly reduced by 13%. This was further reduced by almost 30% among people with moderate consumption (6-48 g/day). But among heavy drinkers (≥48 g/day), the risk was equal to that in non-consumers. In general, the trends for larger risk reduction were observed for women compared with men.³

The same findings were reported by Carlsson, et al in their meta-analysis of epidemiologic studies. 4 Moderate alcohol consumption had a protective effect on diabetes in the order of 30%. Moderate alcohol intake was defined as approximately 5-30 g of alcohol per day. This corresponds to about 0.5-2.5 drinks per day. The first figure illustrates the effect of moderate alcohol consumption on diabetes risk.

However, high alcohol consumption had no protective effect and one cannot rule out that large intakes of alcohol may increase the risk of type 2 diabetes. High alcohol intake was defined as 730 g per day (corresponding to about three drinks per day or more). This effect is illustrated in the second figure.

The finding of a U-shaped relationship between alcohol consumption and type 2 diabetes risk is analogous with the relationship with cardiovascular diseases and may partly share underlying mechanisms. Moderate alcohol consumption is known to increase HDL cholesterol concentration, whereas, at higher consumption levels, body weight, triglyceride concentration, and blood pressure increase. Another plausible mechanism is through the anti-inflammatory effect of alcohol. Enhanced insulin sensitivity with lower plasma insulin concentrations is another (and more type 2 diabetes-specific) plausible mechanism because inverse and U-shaped relationships between alcohol consumption and insulin levels have been shown.^{3, 5}

Since the effect of alcohol intake is hard to study in an experimental setting, these epidemiologic data are the best evidences available to support the effect of alcoholic intake on the risk of diabetes, although they may have certain limitations.

Based on the evidences, moderation in everything, including alcohol intake, is still the key to healthy living. The threshold for safe drinking recommended are as follows:

- no more than two units of alcohol per day for women
- no more than three units per day for men
- you should have at least two drink-free days a week

One unit of alcohol is defined by the



following:

- Half a pint (250ml) of average strength beer
- 125ml glass of wine 8% ABV
- One standard pub measure of spirits (25ml)
- 25ml of fortified wine, such as sherry or port

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METFORMIN AT 50: *The duel with diabetes continues*

Florence Amorado-Santos, MD
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Simple Drug with simple beginnings

Metformin was first described in scientific literature in 1957 and belongs to the biguanide class of anti-diabetic agents. The history of biguanides can be traced from the use of *Galega officinalis* (goat's-rue or French lilac) as a treatment for diabetes in medieval Europe. Guanidine, the active component of galega, was used to synthesize several antidiabetic compounds in the 1920s, and metformin (*dimethylbiguanide*) and phenformin (*phenethylbiguanide*), the two main biguanides were introduced in the late 1950s. Lactic acidosis was strongly associated with phenformin and it was withdrawn from clinical use from many countries in the 1970s. It was not a major problem with metformin and it was continuously used in many countries either as monotherapy or in combination with a sulfonylurea (either glibenclamide or gliclazide in our local setting). At present, metformin has an important role in the alcove of diabetes management.

Metformin as it was and as it is now

After the metformin tablet is ingested, 50-60 percent is readily available for absorption in the entire intestinal tract passing through a very narrow absorption window. It is excreted in the kidneys within 12 hours and this process is very dependent on the filtering capacity of the kidneys. There is minimal binding with proteins and metformin, hence, it is widely distributed in the tissues, higher concentration found in the liver and kidneys and highest in the salivary glands and intestinal wall. The most

prominent adverse effect of metformin is gastrointestinal discomfort. Some patients experience bloatedness, flatulence, nausea, vomiting and diarrhea which will always be the reasons for discontinuing the drug. These are common when metformin is first administered and if the dose is increased. However, these can be avoided by starting with a low dose and increasing the dose gradually. In 2004, a newer generation of the extended-release metformin became available, whose innovation technology causes lesser gastrointestinal side effects resulting to better compliance from the patient by reducing pill burden with the same glucose lowering effect as the original immediate-release tablets.

Metformin and diabetes duel through the years

Despite the discovery of insulin in the 1920s and the existence of sulfonylureas (glyburide, glibenclamide) in the 1940s to treat diabetes, there was a compelling need for additional drugs to improve glycemic control.

The glucose-lowering effect of metformin is mainly attributed to the decrease in hepatic glucose output and enhanced glucose peripheral uptake, i.e. in the muscles and adipose tissue.



Other minor actions may contribute such as increased intestinal use of insulin and decreased fatty-acid oxidation (breakdown of fatty acid). Metformin decreases basal hepatic glucose output in patients with T2DM, providing an important mechanism through which the drug lowers fasting plasma glucose concentrations. In isolated hepatocytes (liver cells), therapeutic concentrations of metformin enhance the suppression of gluconeogenesis (production of glucose) by insulin and reduce glucagon-stimulated gluconeogenesis. Glucagon is the counterregulatory hormone that raises blood sugar when it is below the threshold.

Metformin improves oral glucose tolerance, whereas the plasma insulin response to glucose is unchanged or may be decreased in patients with hyperinsulinemia. The reduction in the incremental increase in plasma glucose concentrations after oral glucose administration is similar to the reduction in fasting plasma glucose concentrations. However, during daytime glucose profiles, postprandial plasma glucose concentrations are lowered by metformin therapy, especially after the midday meal. These changes may be due to delayed glucose absorption, although overall absorption of a glucose load is not reduced by metformin, or they may reflect the time required for the absorption of metformin and accumulation of the drug in tissue.

Metformin decreases fatty-acid oxidation by 10 to 20 percent, which in turn reduces plasma glucose concentrations by means of the glucose-fatty-acid cycle. Experiments have shown that metformin has little overall effect on oxidative metabolism (it causes a small decrease in fatty-

Metformin is at the forefront of the diabetes algorithm as its mechanism of action broadens and goes beyond blood glucose control.



acid oxidation and a small increase in glucose oxidation), implicating glycogen formation as an important part of the increased glucose disposal. Metformin appears to be ineffective in tissues that are acutely insensitive to insulin (e.g., brain, renal medulla, and skin). Metformin does not increase insulin secretion, it only increases insulin sensitivity. Therefore, metformin is not associated with causing hypoglycemia.

Metformin therapy causes a small increase in basal and postprandial blood lactate concentrations, within the normal range. The interpretation of these increases, however, needs to take into account the fact that obesity and diabetes slightly raise blood lactate concentrations. The increased blood lactate concentrations are probably caused by metformin-induced conversion of glucose to lactate by the intestinal mucosa. The lactate then enters the portal circulation and is largely cleared by the liver, in which it serves as a gluconeogenic substrate. When the liver is inundated with fuels after a meal, more lactate gains entry into the systemic circulation. Enhanced splanchnic glucose-lactate-glucose

cycling contributes to the overall increase in glucose turnover noted after metformin administration in animals.

Diabetes and beyond

An ideal anti-diabetic drug would enhance cellular insulin sensitivity, inhibit excess intestinal absorption of sugar, reduce excess liver production of glucose, promote weight loss and reduce cardiovascular risk factors.

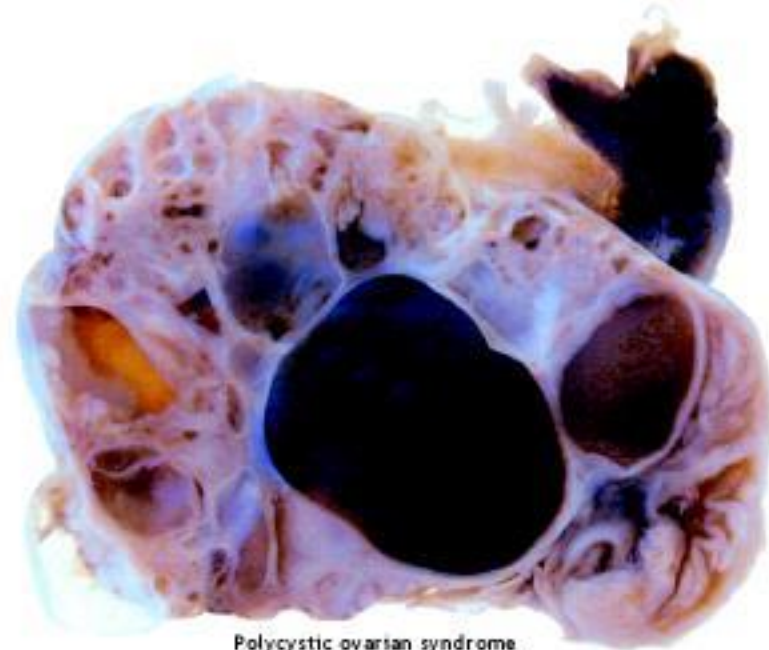
According to Dr. Ward Dean, aging causes insulin resistance. Metformin increases hypothalamo-pituitary sensitivity that declines with age. As we get older, there is a loss of sensitivity of the hypothalamus and the peripheral tissues to the effects of insulin, which causes elevated blood insulin levels leading to harmful and age-accelerating related effects. These effects include: increased infections, microvascular complications like retinopathy (eye problems), nephropathy (kidney problems), neuropathies (nerve problems), hypercholesterolemia, hypertension, premature atherosclerosis and obesity,

which eventually evolve into cardiovascular problems.

Type 2 diabetes often present with a cluster of cardiovascular risk factors like visceral obesity, hypertension, high triglyceride and low high density lipoprotein (HDL) cholesterol levels, and hypofibrinolysis, all of which form insulin resistance and potentially contribute to increased cardiovascular risk. In the United Kingdom Prospective Diabetes Study (UKPDS), a large landmark trial on diabetes, compared with conventional therapy of diet and exercise, sulfonylureas and insulin, metformin was the only medication that reduced diabetes related deaths, heart attacks and strokes. The potentially preventive effects of metformin on type 2 diabetes and evolving cardiovascular complications include a decrease in total cholesterol and low density cholesterol (LDL), free fatty acids, tissue plasminogen activator antigen and insulin levels.

For women in the reproductive age range, polycystic ovarian syndrome (PCOS) is a serious common cause of infertility because of the endocrine abnormalities (increased male

hormones such as androstenedione and testosterone) that accompany elevated insulin levels. These patients present with abnormal bleeding, infertility, obesity, excess hair growth, hair loss and acne. Polycystic ovarian syndrome seems to have a genetic component in which those who are affected often have both male and female relatives with type 2 diabetes, obesity, elevated blood triglycerides or high blood pressure. Metformin, at doses of 500 mg to 850 mg three times per day, has been shown to reverse these endocrine abnormalities. In women with polycystic ovarian syndrome, metformin reduced systolic blood pressure, hyperinsulinemia and insulin resistance, and facilitated menstrual regulation and pregnancy.



Polycystic ovarian syndrome

Metformin has been found to suppress the growth of some tumors and enhance the activity of anti-cancer drugs. By giving the immune system a boost, metformin can improve cellular immunity. It has also been found to reduce the incidence of chemically induced cancer in rats.

The way metformin improves cellular immunity is linked to its blood sugar lowering effect by improving receptor sensitivity and number. Bacteria, fungi and some viruses tend to feed on sugar. By diminishing their fuel supply, we diminish them. That is why diabetics and other individuals with endocrine abnormalities tend to be more prone to infections and poor healing of wounds if blood glucose is uncontrolled.

Precautions

Metformin is not recommended for people who have a history of kidney or liver disease, or a history of congestive heart failure. People with a history of alcohol abuse should also avoid taking the drug, as serious lactic acidosis can develop in these individuals. In most patients it occurs because one or more contraindications were overlooked, predominantly

renal insufficiency, leading to high plasma metformin concentrations. Additional factors that increase blood lactate concentrations are often present - for example, a major illness causing hypotension with low tissue perfusion, other causes of hypoxia, liver disease, or alcohol abuse. Lactic acidosis is suspected if any of these symptoms are present: weakness, increasing sleepiness, slow heart rate, cold feeling, muscle pain, shortness of breath, stomach pain, feeling light-headed, and fainting.

A patient undergoing any contrast study (X-ray, CT scan which will use dye for contrast) should inform the physician and metformin must be withdrawn temporarily.

Metformin is also contraindicated if patient has allergy to metformin or if with liver disease and heart disease. These issues must be tackled with the physician before using metformin for dose adjustment or to request for any additional test prior to intake.

Long term use of metformin may cause malabsorption of vitamin B12. Low plasma vitamin B12 or folate concentrations are rarely clinically important and are reversed by the

discontinuation of metformin or by appropriate supplementation.

This medication is not expected to be harmful to an unborn baby. The doctor must know if the patient is pregnant or plans to become pregnant during treatment. It is not known whether metformin passes into breast milk or if it could harm a nursing baby. Do not take metformin without first talking to the doctor if breast-feeding a baby. Metformin should not be given to a child younger than 10 years old. Extended-release metformin should not be given to a child younger than 17 years old.

The early years that metformin was used for the treatment of diabetes, it's clear cut role was still to be further elucidated. However, through the years, it had remained at the blurb. Metformin is at the forefront of the diabetes algorithm as its mechanism of action broadens and goes beyond blood glucose control.

Metformin for 50 years had continuously battled with the wrath of diabetes mellitus. 

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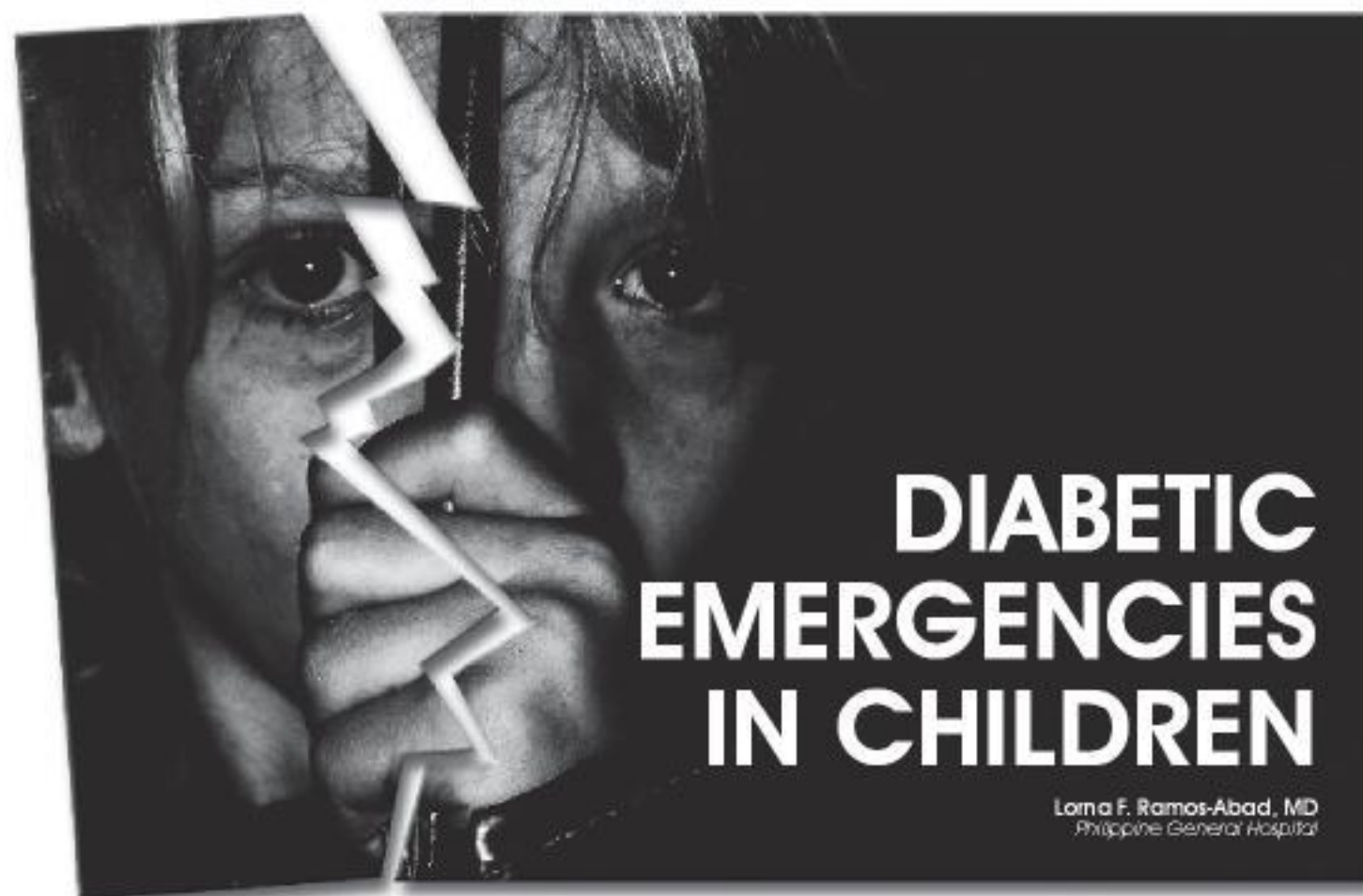


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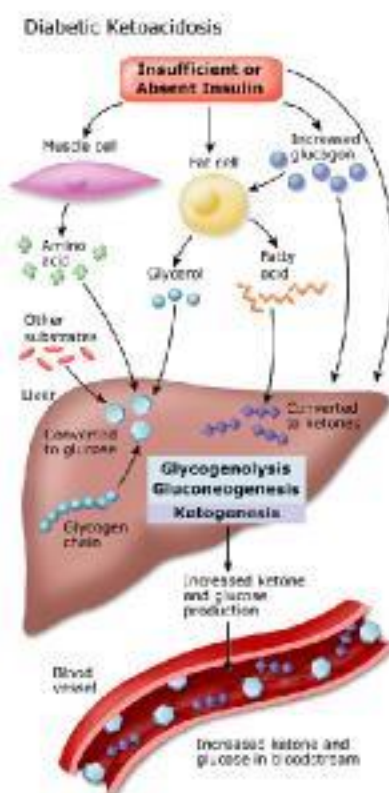


Type 1 diabetes, which is due to relative or absolute insulin deficiency, is the most common form in children. A catastrophic condition that may develop is "diabetic ketoacidosis" (DKA) which could be the initial manifestation in 25-30 % of new patients. For known diabetics, DKA could be triggered by an infection, emotional stress or omission of insulin. With an average mortality rate of 10%, early recognition and appropriate management is the key to a successful outcome. Another emergency state which could be seen in diabetic children treated with insulin is hypoglycemia (low blood sugar).

How does DKA present in children?

A child in DKA would have exaggeration of the classic presentation of diabetes

which are polyuria (increased frequency of urination, nocturia), polydipsia (excessive thirst). Enuresis (bedwetting) in a previously toilet-trained or dry child at night is another helpful clue. Non-specific manifestations include nausea, vomiting, abdominal pain, irritability and headache. The abdominal pain and tenderness could be severe mimicking acute appendicitis. Sensorial changes like drowsiness, disorientation, hallucination increases the likelihood that the diabetic child is in DKA. Difficulty of breathing as well as rapid breathing is another common presentation. On examination, the child in DKA would be dehydrated (dry oral mucosa, mottled skin, weak pulses) but a very important point that differentiates DKA from other causes of dehydration is the presence of good urine output despite dehydration.



It might be difficult to prevent DKA for new cases since the initial manifestations of a diabetes could be nonspecific and history is not thoroughly taken. For known diabetics, prevention can be attained by regular self blood glucose monitoring and religious administration of insulin.

What to do when DKA is suspected?

Since DKA could be the presenting problem in 25% of new cases, the burden of recognition lies on the first contact physician. History taking should entail a good review of system especially if the complaint is nonspecific including weight loss. It might be a good practice for all clinicians to keep a glucometer in their office to check the blood glucose of patients seeking consult when a history of polyuria, polydipsia, polyphagia and nocturia are elicited. If blood glucose is high, the child should be referred to a hospital preferably with ICU facility.

For those who are diagnosed with Type 1 DM, blood glucose monitoring to include ketone monitoring should be done during sick days and when the mentioned symptoms are noted. The child/parents should notify his/her endocrinologist or the child should be brought to the hospital immediately.

How to prevent DKA?

It might be difficult to prevent DKA for new cases since the initial manifestations of a diabetes could be nonspecific and history is not thoroughly taken. For known diabetics, prevention can be attained by regular self blood glucose monitoring and religious administration of insulin. In the event of illness, consult with the primary physician is mandatory. Crucial to prevention of DKA is EDUCATION of the patient and family - to make them understand why the need for injections and monitoring, proper dietary manipulation. During the adolescent years, the role of the psychologist and psychiatrist are important to ensure emotional stability.



NOTE ON HYPOGLYCEMIA

Hypoglycemia or low blood glucose is complication that can be seen in children on insulin injection and even those on oral hypoglycemic drugs. The child feels dizzy, would express extreme hunger, be weak and shaky. Cold sweats and pallor are readily noticeable. In extreme cases, the child/adolescent may go into frank seizures or loss of consciousness. It is thus important that the school physician/nurse and teachers be aware of the clinical condition of the child so that emergency measures could be instituted while awaiting conduction to the hospital.

Immediate intervention includes giving soda or fruit juices or rubbing sugar under the tongue of the child. Again, education to prevent such occurrence is important. Regular checking of blood glucose for insulin adjustments, regularity of meals, activity-related insulin dose should be entrenched in the psyche of all diabetic children. Hypoglycemia is worse than hyperglycemia since the brain cells are dependent on glucose for effective functioning. Recurrent hypoglycemia can lead to permanent brain impairment so LET's keep our blood glucose to as close the normal levels as possible. 



Fantastic Voyage was the title of a scifi movie I watched wayback in the late 1960's. The movie was later on made a novel by no less than Isaac Asimov. The story goes this way. At the height of the cold war, the United States and the Soviet Union both developed technology that allowed matter to be miniaturized using a process that shrinks individual atoms. A Soviet scientist who figured out how to make the shrinking process work indefinitely defects to the West with the help of the CIA. However, an attempted assassination leaves him comatose, with a blood clot in his brain (presumably inaccessible to the best neurosurgeons at the time, and recall that CT scans were first deployed in 1974). To save his life, the Americans (of course) assemble a team of surgeons and a nurse (sexy Racquel

system their submarine maneuvers through the veins and into heart, the alveoli of the lungs, and into the cerebral circulation where they successfully remove the blood clot. It was like Scientific American meets Hollywood as the Proteus trekked inside the circulation traveling among red blood cells, maneuvering across flapping heart valves and hurdling their craft into the ventricle, maneuvering as if white water rafting the narrowing rivers of the pulmonary circulation, into the pulmonary alveoli where a gush of wind replenishes their oxygen, and then onwards into the turbulent ebb and flow of the left ventricle until they reach aorta, where for the first time they view the internal architecture of the arterial circulation.

Whereas miniturization of people and submarines remains scifi, gadgets in

Welch) who then board a submarine called Proteus. The ship with the team on board is miniaturized to micrometer dimensions, and injected into the body of the scientist. Their mission was to remove the blood clot using lasers, and the team had only an hour to accomplish this before the immune system could detect and attack them. What makes the movie memorable is the trek through the circulatory

the interventional world have long been miniaturized, not yet quite the micrometer size of the Proteus submarine, but small enough to enter literally anywhere along the coronary and cerebral circulation to view arterial architecture and topography with an angioscope, the image is not quite as microscopic as what the scifi writers imagined in 1966. But the Hollywood scifi writers failed to arm the miniturized voyagers with sonar technology in their trek into the human circulation, an irony as they were onboard a naval submarine in their journey. (The US Navy perfected sonar technology long before it was applied to medicine.)

Our knowledge of atherosclerotic disease has grown in leaps in bounds because of the decades of work by vascular biologists and cardiovascular pathologists who have compiled a compendium on the natural history of the atherosclerotic disease. Their studies go beyond the cellular level, even describing the process of how white blood cells infiltrate the inner lining of vessels, in the process attracting low density particles like bad cholesterol and glycosylated proteins, and inviting a legion of migratory vascular smooth muscles to secrete collagen and other matrix to form what they now term the vulnerable plaque. The white blood cells coalesce, and when they die, they leave behind a lake of cholesterol, the so called lipid pool separated by thin layer of matrix from the vessel lumen. As time passes, these white blood cells secrete microsubstances (cytokines) that create more space for more plaque growth, but sometimes in the process of growth, these substances dissolve the outer lining of plaques, in effect rupturing the plaque and exposing the lipid pool underneath to the circulating blood. This initiates a catastrophic cascade of blood clot formation which could end up in a heart attack or stroke.

In the 1960's coronary angiography was

perfected in Cleveland Clinic with Dr. Mason Sones and later on Dr. Melvin Judkins who designed catheters that would literally seek out coronaries at the flick of the wrist, injection of dye allowed radiographic visualization of the coronary vessels. Coronary angiography was gold standard for decades, and probably still is, in defining the extent and severity of coronary disease. Decades later, Cleveland Clinic becomes an organ transplant center, and they routinely do coronary angiography on transplant donors, usually young adult victims of vehicular accidents. And there was this new technology, called intravascular ultrasound (IVUS), the



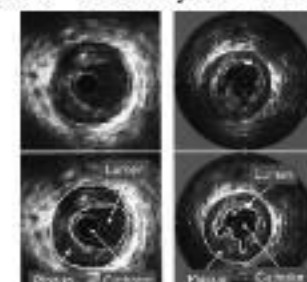
IVUS demonstrates that normal looking vessels on angiography may actually have atherosclerotic plaques.

same technology for vascular ultrasound of carotids done outside the body, but the probe is miniaturized so it can enter small vessels and probe from within. Like the crew on board the miniaturized submarine, IVUS can map out the architecture of the vessel wall, and give a clue as to its histology. In that same hospital, Dr. Steve Nissen took his IVUS probes into the coronaries of heart transplant donors, expecting to see pristine coronaries as the angiographers had described. Instead his IVUS images revealed the early vestiges of atherosclerosis in these young adults.

So indeed atherosclerosis starts early, and everything that the vascular biologists and pathologists have described all these years is now viewable in vivo! Now IVUS is still in its infancy, software and hardware for virtual histology, infrared spectroscopy, optical coherence tomography is still in evolution but IVUS technology will certainly revolutionize the what we know about coronary and

cerebrovascular disease in the years to come. I eagerly await what the Japanese are developing in their bioengineering labs, they still have the edge in angioscopy and routinely use IVUS to complement angiography and angioplasty.

Dr. Nissen has done at least 3 landmark studies using IVUS; with surrogate end points I concede, but landmark nonetheless for the cutting edge technology and its implications to atherosclerosis progression and to vascular biology. He studied statins, which are cholesterol lowering medications, and recently, pioglitazone, a medicine for lowering blood sugar. Statins and glitazones are known to impact on the atherosclerotic disease process, and Dr. Nissen wanted to document their effect using IVUS. In the REVERSAL trial, he studied 500 patients with coronary disease using IVUS to demonstrate plaque size and volume. He showed that 18 months high dose atorvastatin (as compared to standard dose pravastatin) therapy can retard the growth of the atherosclerotic plaque, and in a few cases he showed actual regression of plaques. A few years later, he



Reversal of atherosclerosis after 18 months lipid lowering is demonstrable on IVUS.

recruited another 500 patients with coronary disease in ASTEROID, this time he showed that 18 months high dose of rosuvastatin can actually reduce the size and volume of atherosclerotic plaques. And this year with the PERISCOPE trial, he demonstrated using the same IVUS technology that pioglitazone arrests the progression of atherosclerosis in coronary vessels similarly after 18 months of therapy in 500 diabetic patients. The data are consistent with the findings of another study which demonstrated pioglitazone

reduced carotid intima-media thickness.

Now maybe the nonbelievers will argue that Dr. Nissen is making a mountain of a molehill, the regression was in square millimeters or cube millimeters (plaque volume), does that really dent what took decades of unhealthy lifestyle to accumulate and miles of endothelial surface that atherosclerosis affects. The answer is there, 18 months of aggressive therapy to lower cholesterol and glucose and the progression of disease is at least arrested. What if therapy with the glitazone and/or the statin were continued for another 5 years or even a decade, is there reason to think that the disease progression will retard or even reverse? Are not the studies the closest approximation of a virtual biopsy that indeed aggressive lowering cholesterol and blood sugar arrests disease progression?

For those too young to know what *Fantastic Voyage* the movie was all about, Amazon.com still has it available in DVD format, and the pocketbook by Asimov is likewise on sale. I doubt know if there is a pirated version in Metrowalk or Quiapo. Google it up, and you will come across a book, a completely different book, also titled *Fantastic Voyage*, by high-tech visionary Ray Kurzweil and life-extension expert Dr. Terry Grossman. An excerpt from the book mentions a program designed to slow aging and disease processes. I have only read that tiny online excerpt but I will be disappointed if they did not include the voluminous work of vascular biologists and the vascular ultrasonographers in their opus. It seems as if some fantastic voyage goes on in the minds of other visionary scientists. In the meantime, I continue to learn the intricacies of diabetes and cardiovascular disease and the interventions used to halt its relentless progression. Join me, a simple reader of vascular biology and diabetes, and enjoy the ride. *D*

KITCHEN CORNER

Christmas Treats for Diabetic Kids

Ma. Imelda Q. Cardino, MSFN
Makati Medical Center (Diabetes Clinic)

Birthdays, anniversaries, graduation....any memorable occasion and definitely the HOLIDAYS... are always celebrated with a SPECIAL MEAL. If you have diabetes, can you have a festive dinner and yet keep your blood sugar within target? Certainly! With some imagination sprinkled with creativity it definitely is possible to have a HAPPY HOLIDAY!

The supermarkets and a number of bakeshops have an array of goodies which are sugar-free. An important reminder though: these items are sugar-free BUT NOT CALORIE-FREE! So-called "calorie-free" foods do not contribute significant calories whereas sugar-free foods add varying amounts of energy, depending on what they are made of. Foods with "no added sugar" or "no sugar added" are also different. No added sugar means that no ADDITIONAL sugar has been added except these present in the ingredients used. No sugar added means that there is no table sugar added but the product may contain other forms of sugar such as glucose, corn syrup, maltodextrin and others.

Whenever you intend to buy these "specially-formulated" foods, always look for the nutrition facts on the label. If the label does not give you the information you need to make a wise choice (calories, serving size, amount and type of fat, type of sweeteners added, ingredients, etc), think twice before buying the product.

If artificial sweeteners are to be used, a number are available. These artificial sweeteners will NOT BE DISCUSSED here in detail since there is another

article on the various artificial sweeteners. Mentioned here are those you usually find in supermarkets or drugstores to familiarize you when you do shop. Sugar alcohols or polyols you will see listed in the ingredients are: erythritol, isomalt, lactitol, maltitol, mannitol, polyglycitol, sorbitol, and xylitol. However, please use them PRUDENTLY specially for the very young. ASK YOUR PEDIATRIC ENDOCRINOLOGIST FOR GUIDANCE.

ASPARTAME brands; not stable to heat so do not add during ACTUAL COOKING but may be added even to very hot foods



ACESULFAME - K (ACE - K) brands; stable to heat; usually added as sweetening agent WITH aspartame in products such as in light/ diet

carbonated beverages

SUCRALOSE brands; stable to heat; usually added as sweetening agent WITH Ace-K such as in sugar-free flavored sparkling water and light iced tea

SORBITOL brand; usually added to SUGAR-FREE chewing gum, ice cream, candies, etc; MAY HAVE A LAXATIVE EFFECT WHEN TAKEN IN SIGNIFICANT AMOUNTS

Pasta dishes, main courses, even desserts may be festive yet "diabetes-" and "heart-" friendly. Some recipes are included here but certainly you can use your imagination to create something even much better. For instance, your taco salad filling has lots of possibilities: seafood, gindara fish, different types of cheese, a variety of vegetables such as alfalfa and arugula. Instead of chicken in the Miracle Chicken Skillet recipe you may use lean beef or pork instead. Instead of shrimp in the Quick and Easy Shrimp Primavera, substitute smoked salmon for a different flavor...or even turkey ham! A change of sauce already gives the dish a completely different flavor. Some basic sauces are also provided.

Children are definitely attracted to lots of vibrant colors and different shapes hence there are some suggestions as to presentation as well. Let your creativity come to the fore!

So kids....and kids at heart...have a happy, festive, "diabetes-" and "heart-"friendly treat this Christmas! Ho ho ho!

Miracle Chicken Skillet

Prep: 10 min. | Total: 45 min

1/4 cup Miracle Whip Dressing
1 1/2 cups minute white rice, uncooked
1 1/2 cups chicken broth
1 tbsp. chili powder
4 small boneless skinless chicken breast halves (1 lb)
1 tomato, chopped
1/2 cup Kraft Shredded Cheddar Cheese

Mix Dressing, rice, broth and chili powder in large skillet. Top with chicken

Bring to boil; cover. Reduce heat to low; simmer 25 min.

Top with remaining ingredients. Cook an additional 10 min.

Makes 4 servings

Grilled Vegetable- Stuffed Beef Roulades

Ingredients:

2 tablespoon of low sodium soy sauce
2 tablespoon of packed light brown sugar
1 pound of beef tenderloin, well-trimmed
Salt and freshly ground black pepper to taste (optional)
4 green onions, green tops cut into 3 inch lengths and sliced lengthwise
2 ribs of celery, julienned into 1/4 x 4 inch pieces
1 each red and yellow bell peppers, trimmed, seeded, and cut into 1/4 inch pieces
2 teaspoons of olive oil

Procedures:

1. Light the grill or preheat the broiler. In a small bowl, whisk together the soy sauce and the brown sugar until dissolved. Set aside.

2. Cut the tenderloin crosswise into 8 portions, approximately 1/2 inch thick slices. Trim off any fat or connective



tissue. Place each slice between 2 pieces of plastic wrap. Use the flat side of a meat pounder to pound out each slice, keeping it in a rectangular shape, until it is about 1/8 inch thick. Remove the plastic wrap and transfer the thin slice to a larger plate. Continue until all the beef is pounded. Brush one side of the beef pieces with the soy sauce mixture and place it on a clean surface. Sprinkle with salt and pepper.

3. Distribute the green onions, celery and pepper slices equally on each piece of beef. Roll up lengthwise and skewer each roulade with two toothpicks so the rolls are taut and will not unroll.

4. Grill or broil the beef rolls, brushing with a little olive oil so they will not stick to the cooking surface. Grill each roll until well browned, and the vegetables inside are hot but not mushy (about 5 minutes turning once). Serve immediately. May be served with potatoes for dinner or with 4 cups of mixed green as a luncheon dish.

Makes 4 servings.

ASSORTED SAUCES

Cheese Sauce

1 cup ricotta cheese
3/4 cup skim milk
1 tablespoon grated Geska cheese
Freshly ground black pepper

Bring water to the boil and add leeks. Reduce heat, cover and simmer for 8 minutes. Remove from pan, drain and chill.

To make the sauce, blend all the ingredients and chill. Just before serving, pour over leeks and garnish with parsley.
Serves 4

Garlic and Parsley Sauce

Only true garlic lovers will appreciate this addictive sauce

10 cloves garlic, finely chopped
1 cup finely chopped fresh parsley
1 cup unsweetened orange juice
Squeeze lemon juice
Freshly ground black pepper

Blend all ingredients and mix through freshly cooked pasta

Serves 4

Tomato and Lemon Sauce

1 cup fresh lemon juice
500 g (1lb) very ripe tomatoes
1 tablespoon tomato paste
1 clove garlic
Freshly ground black pepper

Place all ingredients in a saucepan and simmer covered for 10 minutes. Puree, simmer for further 5 minutes and serve with freshly cooked pasta.

Serves 4

Mushroom and Ricotta Sauce

300g (9 1/2 oz) fresh ricotta cheese
1 cup skim milk
2 cloves garlic, finely chopped
Freshly ground black pepper
300g (9 1/2 oz) fresh button mushrooms, cleaned and slice
Finely chopped fresh parsley, for garnish

Puree ricotta cheese with skim milk, garlic and black pepper. Stir in sliced mushrooms. Garnish with parsley.

Serves 4

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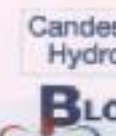
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A row of seven black silhouettes of people standing side-by-side. From left to right: a man in a t-shirt and pants, a man in a t-shirt and pants, a woman in a long-sleeved top and pants, a man in a t-shirt and pants, a woman in a t-shirt and pants, a man in a t-shirt and pants, and a woman in a long-sleeved top and pants. The silhouettes are solid black and set against a white background.

"I ask you to believe - not just in my ability to bring about change... I'm asking you to believe in yours."

- Pres. Elect, Barack Obama, during his election campaign

From the start of his campaign for the Republican nomination, I have been glued to the personality of Pres. Obama. His fresh political views backed up by the sincerity and confidence that he exudes is truly a quality one can emulate. His call for change is not self-centered: he encouraged everyone to change. He believed in the ability of the people to exact change particularly that which a person can do himself.

Let me clarify this early that this is not an expose of my political stripe. What I would like to point out here is that it's never too late to resolve for a change - a change that will definitely improve us as a person. And the earlier we begin changing for our

improvement, the better it is for us.
So when shall we commence?

I'm sure that a lot of people would agree that a new year always signifies a brand new start. I questioned the importance of coming out with a new year's resolution each year during my elementary days until I realized that it gave kids a blueprint of what they want to achieve for themselves for the following year. Bless our teachers!

We're nearing the end of 2008. So why not plan now for the better YOU in 2009?

A New Year's Resolution is a commitment that an individual makes to a project or the reforming of a habit, often a lifestyle change that is

generally interpreted as advantageous. I emphasize the words commitment, and change, and advantageous as these are the core principles in guiding us in planning out our New Year's Resolutions.

I have only included in my list a few goals. I deemed these to be very useful and attainable. However, these are centered in one specific adjective: **HEALTHY.**

1. **Lose weight.** And I would also like to include here: **Eat Right.**

I wouldn't be surprised if you'd raise an eyebrow and frown on this one. After all, this may be a yearly resolution for many and this may sound too trite already.

Losing weight does not mean going on a crash diet. If you are obese or overweight, be realistic in dealing with weight issues. Do not expect to lose weight significantly and miraculously find yourself sexy, or at least in your ideal body weight, when you look in the mirror after going on a diet for a week or two.

No diet regimen, popular or otherwise, has been designed up to this time to be perfect for everyone. Begin losing weight by eating right. The food pyramid will guide you in making a choice in preparing food for you and your family. Use fats, oils and sweets sparingly. Instead of table sugar, choose among a wide variety of artificial sweeteners like aspartame, sucralose, acesulfame-K. Have 2-3 servings of milk, yogurt, cheese, meats, poultry, fish, dry beans, eggs, and nuts per day. Eat enough fruits, about 2-4 servings in a day. Eat more vegetables and sources of complex carbohydrates such as bread, cereal, rice and pasta. For the diabetics, remember that you have a malfunctioning sugar metabolism. So be very particular with the serving size of the different food groups. Consult your dietician for proper understanding of the serving size. A piece of a certain food does not necessarily equal its serving size. For example, 1 serving size of meat approximates the size of your palm or that of a matchbox. If you are overweight or obese, try reducing your caloric intake by 500 calories/day. Approximately, try cutting down what you eat by half. You may not be able to do this successfully overnight. But make sure that you achieve this goal in two weeks at least.

Try calorie counting. Be astute in checking out the nutritional facts of the food you eat. These are seen on the packaging of several drinks and food that you take. Check out a bag of potato chips and you'll see the nutritional data at the back. Of all the diets, the one that may be

the most practical is to remember to stop eating when your stomach tells you that you had a sufficient fill. Our body is equipped with several hormones that act as sensors of caloric intake. Satiety signals such as cholecystokinin, ghrelin and incretins (GLP-1), to name a few, regulate food intake. However, hedonic and mood related eating may lead to consumption of calories above what our body needs. Recognize these factors (hedonic and mood related need) that may affect food intake. Know when you had enough and heed to the signals that your body, particularly your stomach, tells you when you had your fill. Within six months after starting your eat-right-lose-weight resolution, you should be 5 to 10% less of your baseline weight. This amount of weight loss is proven to be beneficial for metabolic control of diabetics. But this does not mean that achieving 5 - 10% weight loss is enough. Aim for more pound cuts until you achieve your ideal body weight.

2. Get Fit. The American Diabetes Association recommends that people with diabetes should have at least 150 min/week of moderate-intensity aerobic physical activity. Moderate intensity physical activity means that



you should be able to attain 50 to 70% of your maximal heart rate during exercise (calculate for predicted maximal heart rate by using $220 - \text{age}$). Exercise 3 - 4 times per week. If there is no contraindication, people with diabetes are encouraged to do resistance training. This amount of exercise has a beneficial effect on sugar control as evidenced in the reduction in A1c (your 3-month average blood sugar).

However, before embarking on an exercise program, it would be prudent to consult with your doctor first. Ask for his go-signal and recommendation as to how far can you go with your exercise. The presence of retinopathy as well as neuropathy will have to be considered in tailoring your exercise regimen.

There are so many forms of exercise and sports that you can get into. The number of calories burned per hour in low-impact aerobics is around 295, leisure bicycling - 230, social badminton around 250, aerobic dancing around 350, slow ballroom dancing - 175, golf - 230, jogging - 400, and swimming - 350. If schedule is a problem, or you have limited resources, go ahead and have fun exercising at home. General house cleaning will burn around 200 calories per hour. Moving furniture around the house may burn around 350 calories per hour.¹ Getting into exercise will help you maintain the weight you lost upon following the 'Lose Weight' resolution so these two should go hand in hand.

Burn your calories and enjoy its benefits!

3. Stop Smoking. This is a no-brainer. Smoking is proven to increase the risk for developing cardiovascular disease even in people without diabetes. Smoking further causes constriction of the blood vessels. Coupled with diabetes, smoking causes premature development of microvascular complications (retinopathy, neuropathy,



nephropathy).

Ask your doctor for available medicines that can help you. But before doing so, strengthen your determination to cease smoking. Set a quit date, quick!

4. Drink Less Alcohol. Alcohol intake increases the risk of developing hypoglycemia in diabetics.

The metabolism of alcohol relies largely to the liver. Thirty to 90 minutes after having a drink, the alcohol in the bloodstream is at its highest. The body reacts to this like a toxin. The liver would try to clear out the system from alcohol as fast as it can. Upon doing so, the liver will not put out glucose until it is able to metabolize the alcohol. This is the reason why alcohol should not be taken on an empty stomach; you will develop hypoglycemia.

Limit your drink to 1 per day, if you're a woman, and 2 if you're a man. One alcohol containing beverage is defined as 12 oz beer or 5 oz wine, or 1.5oz distilled spirits. Each contains around 15g alcohol.²

There are better choices for diabetics as far as alcohol containing beverages is concerned. Choose drinks that contain less alcohol and sugar. Light

beer and dry wines are good choices. Although an occasional drink may not hurt your blood sugar control, it can affect your eating plan and make losing weight more difficult. Alcohol is considered empty calories because it does not supply you with any nutrients. Two light beers equal about 200 extra calories.³ Now that is indeed something to think about.

5. Reduce Overall Stress. During stress, counter-regulatory hormones such as epinephrine and cortisol kick in and this could increase your blood sugar. Moreover, it is during stressful times that a person looks for a quick fix, the comfort food. One would tend to eat more than is required and the choice of food is usually unwisely done.

Remember to sit back, view things objectively, go through the events in proper perspective. Take a deep breath and focus yourself. Challenges given to us are commensurate of the capabilities that we are blessed with. Say a little prayer. Then try to relax.

Recent research showed that while 52% of participants in a Resolution study were confident of success with their goals, only 12% actually achieved their goals.⁴ Goal setting increased success rate in males. On the other hand, women succeeded 10% more when they got peer support. Carrying on with your New Year's resolution will never be easy. Expect some roller coaster ride. This may be a cliché but it is true that it doesn't matter if we fall down. What matters is that we manage to get up and try again. Now, start making a list of your New Year's Resolution. Do not wait for New Year's Eve to think about the healthy person that you want to be in 2009. Always keep in mind the basic principles: commitment, change, and advantageous.

Have a healthy New Year, everyone!

¹ <http://shapefit.com>
² Diabetes Care 2008
³ American Diabetes Association.
<http://www.diabetes.org>
⁴ Experiment Findings by Richard Wiseman 2008

2009 Diabetes Philippines Calendar of Activities



37th DiabetesWorkshop
 Vigan, Ilocos
 February 20 - 21, 2009
 (Friday - Saturday)

38th DiabetesWorkshop
 Hotel Palmeras, Zamboanga
 March 12 - 13, 2009
 (Thursday - Friday)

Unite for Diabetes
 Century Park Hotel, Manila
 July 16 - 17, 2009
 (Thursday - Friday)

Special Lay
 Venue: TBA
 July 18, 2009 (Saturday)

39th DiabetesWorkshop
 Davao/Cebu (tentative)
 August/September 2009
 (Friday - Saturday)

Gimik Diabetes Year 3
 November 14, 2009 (Saturday)

26th Annual Convention (Diabetes Philippines, formerly PDA)
 Venue: TBA
 November 17 - 18, 2009 (Tuesday - Wednesday)

5th Course on Diabetes and Vascular Disease (Diabetes Philippines, formerly PDA)
 December 1-2, 2009
 (Tuesday - Wednesday)

INFORMATICS

Navigating the Net: "Helpful websites for parents and kids with diabetes"



Cecille R. dela Paz, MD
East Avenue Medical Center

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UP-Philippines General Hospital

Are you an anxious parent who has a young child recently diagnosed with diabetes? Or do you have a school age son or daughter who is already diagnosed to have Type 1 diabetes and you don't know how to prepare his food for school or who wonders how he or she is coping in school; or whether the school nurse knows how to help your child in case of a hypoglycemic episode? Your child's doctor is of course the best source of information, along with the diabetes nurse or educator, but at the end of your sessions with these professionals there are always questions left unasked or unanswered due to limitations of a busy office or clinic practice. Take heart! There are many websites in the internet with all sorts of useful tips, tools, advice, resources and even humorous anecdotes to help parents and kids with diabetes cope with this disease that typically afflicts adults. Adults who are first told about a chronic disease like diabetes usually feel sad and depressed, even helpless that the condition will invariably lead to complications, disability and death. Imagine then to be told that one of your children has diabetes. These websites help parents and kids cope by providing information that may not always be available even to doctors, such as the experiences of parents and families with a child who has diabetes. Going through all the available online resources can be overwhelming and time-consuming so here are some websites that are easy to navigate yet filled with everything you need to know about diabetes in children. More importantly, the information you get is up to date and reliable.

1. Children with Diabetes (CWD) site

If you go to google, (www.google.com) and type diabetes in children, then you will find that the top website for parents and kids with diabetes is called "children with diabetes" (<http://www.childrenwithdiabetes.com>). If you access the site you will learn why it is the favorite of kids and parents alike. Some of the reasons are that the site: (1) is user friendly and really easy to navigate; (2) has many useful sections for kids with diabetes and their parents; (3) has important sections for adults with Type 1 diabetes; (4) encourages socialization



American Diabetes Association.
Cure • Care • Commitment

and interaction between kids with diabetes, or between parents; and (5) contains humorous anecdotes that is bound to get any reader laughing. The CWD site is an online community for kids, families and adults with diabetes.

The site offers families and caregivers guidance, with original high-quality, science-based content and practical suggestions from sources such as pediatric endocrinologists, certified

diabetes educators, nurses, nutritionists, researchers, advocates, and fellow parents. They also offer an extensive family support network with access to chat rooms where you can talk with fellow parents and even grandparents. There is even an "Ask the Diabetes Team" section where you can post questions to health professionals or you can also review the answers to recent questions posted.

To access the site, go to www.childrenwithdiabetes.com. The different search topics are all on the leftmost side. The site complies with the HONcode standard for trustworthy health information.

2. Another good website is the URL of the National (USA) Diabetes Education Program (NDEP).

The NDEP is a federally funded program sponsored by the U.S. Department of Health and Human Services' National Institutes of Health and the Centers for Disease Control and Prevention. The segment dedicated to children and adolescents with diabetes have tip sheets with easy-to-digest modules that have colorful pictures and drawings. Once they've completed the different modules, your child can test his knowledge on diabetes by taking the interactive quiz.

But what the really noteworthy segment of the site is the section "When Your Child is Diagnosed with Diabetes: Parents' Questions for the Health Care Team" which contains questions that can help families talk to the doctor and other members of the diabetes team. It provides links to other



websites that will help you answer your questions about the diabetes that your child may have. It answers such basic questions as: What are the different types of diabetes? Which type of diabetes does our child have? Will it ever go away? Does it mean our other children will get diabetes too? What about other family members? Questions that are asked and answered by the site links include the emotional issues that your child and the whole family will face (or are facing) [www.diabetes.org/for-parents-and-kids/living-with-diabetes/age-related-issues.jsp] and ongoing researches that provide hope to these kids with Type 1 diabetes [www.TODAYstudy.org; Juvenile Diabetes Research Foundation International (JDRF) www.jdrf.org and the www.childrenwithdiabetes.com].

To access the site, go to www.ndep.nih.gov. For kids with diabetes, click on "About Diabetes and Pre-diabetes" then scroll down and go to "Resources for Children and



Adolescents".

3. The American Diabetes Association Website

The ADA website is a useful site for learning about diabetes in general but it also a very good resource for parents and kids as it caters to their specific needs. The site more than adequately

covers the basic information on diabetes and its management. But what is unique to the site are the discussions on the different issues you will face as your child grows up with diabetes. The segment on "Living with Diabetes" gives you a rundown on the various age-related concerns of diabetic children and how to deal with them. It also gives advice on how to deal with family and friends as well as school issues that could come up in the course of bringing up a diabetic child. For older children who can begin to start learning about their disease, they can start their journey of discovery in a special section, "Planet D", that is especially for them. The site does not neglect the challenges teenagers face when dealing with diabetes, and there are lengthy discussion on the issues of driving, dating, alcohol and smoking and peer pressure.

To access the site, go to www.diabetes.org. On the leftmost side of the home page, there is a menu listing all the available topics for review. Click on "For Parents and Kids" and a drop down menu of the different section appears. Worthwhile segments to read through include the following: What is Diabetes?, Diabetes Care, Living with Diabetes, Planet D, For Teens.

4. An e-book for Parents (and families) of children with Diabetes

As parents, the questions about your kid's diabetes are endless. Being knowledgeable about the disease is one way of equipping yourself in order to in turn answer the questions that your kids may ask. There is nothing like reading a book, and there is just that resource that is available for free on the internet. This book entitled, "So Your Child has Diabetes" was

previously available only on-line by purchasing it for a few dollars, but is now available for free at this website: <http://www.mychildhasdiabetes.com/diabetes-e-book.htm>.

This is the tag-line of the book: "This e-book was written for parents whose child has been newly diagnosed with Type 1 Juvenile Diabetes. We understand exactly what you are going through right now. We know all of the fears, frustrations, feelings of helplessness, remorse, guilt and anger that you may be experiencing. We have been where you are, gazing upon our child and wondering what do I do now? These pages will help you answer that question. They will also give you an idea of what's to come. We will help you to anticipate and prepare for the changes that you, your child, and the rest of you family are about to face. Remember that you are not alone."

Caring for children with diabetes is not easy but parents who are better informed also become less anxious and thus, help their children to enjoy their childhood more despite diabetes. But the information on the internet can also be sometimes overwhelming and confusing. One good trick to systematize learning about diabetes is to write down your questions about your child's diabetes and specific issues about its management, then ask the doctor these questions on the next visit. Or write down your questions, research on the internet for preliminary information, but still verify these facts or advice from your child's doctor. Just a precaution, do not follow any advice on the internet of which you are either unsure, or which runs counter to the doctor's advice, or which is experimental or untested. ALWAYS ask your doctor first before trying out anything from the net, especially those magical cures from supplements that are frequently advertised on-line. Surfing the net with your kids can also be a time for bonding, and can be both educational and fun. After all, diabetes is really a family affair. 

IDF 2009

20TH WORLD DIABETES CONGRESS
MONTREAL
18 - 22 OCTOBER 2009

DATES & CONGRESS VENUE

The 20th World Diabetes Congress will be held from Sunday 18 to Thursday 22 October 2009 at:

Palais des Congrès de Montréal
(Montreal Convention Centre)
Montréal (Quebec)
Canada
www.congresmtd.com

ORGANIZATION

All enquiries and correspondence in relation to the congress should be directed to:

20th World Diabetes Congress
International Diabetes Federation
Avenue Emile de Mot 19
B-1000 Brussels • Belgium
Telephone: +32-2-5431632
Telefax: +32-2-2-4030830
E-mail: wdc@idf.org

THE INTERNATIONAL DIABETES FEDERATION (IDF)

The International Diabetes Federation is the only global advocate for people with diabetes.

IDF is a non-governmental organization in official relations with the World Health Organization and the Pan American Health Organization. Its mission is to work with its member associations to enhance the lives of people with diabetes.

Since it first took up the diabetes cause in 1950, IDF has evolved into an umbrella organization of 200 member associations in 160 countries.

The IDF World Diabetes Congress is now held every two years. It combines top-level science with programme sessions aimed at helping IDF member associations to work more effectively.

The 20th World Diabetes Congress will be organized in partnership with the Canadian Diabetes Association (CDA) and Diabète Québec, the Quebec Diabetes Association.

The chosen setting for this event is Montréal, boasting a unique combination of European flair and North American savoir-faire. The world's second-largest French-speaking city is equally cosmopolitan; conversations here are threaded with French, English and very often dozens of other world languages.

Discover one of the world's most dazzling cities at the 20th World Diabetes Congress.

www.worlddiabetescongress.org



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- Enriched with vitamins and minerals essential to people with diabetes
- Nutrient-dense and low-calorie for better weight management
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GLUCERNA SR - a complete and balanced formula for diabetics who want to be in control.



... "A diabetic's journey: As told by Mom and Paula"

Paula Guevara and Anna Guevara

JUVENILE DIABETES seems such a dreaded disease. Never did it cross my mind that I may have to deal with it.

My daughter was about 11 then. She was such a skinny kid. In fact I always gave her chocolates and cakes hoping she would gain weight. Eventually I resigned myself to the fact that she is really the "skinny type." In fact I should be happy about it as she would not have a weight problem in the future. She would always look good whatever dress she wears.

I remember it was during summer. When she goes out with her friends, she would pass by the office and we would go home together. She got to my office early. She complained it was so hot outside which made her so thirsty. She kept drinking coke and I noticed she kept going to the bathroom. Of course, I figured she kept going to the bathroom cause she kept drinking coke...its summer!!!

The traffic on the expressway was so heavy that night. My daughter suddenly said, "Mama, I need to go to the bathroom!" It was so dark outside and there was nowhere to stop, so I told her to just do it in the car. I scolded her that she should have gone to the bathroom before we left

for home. But she said, "I did, but I just need to go again."

I found it strange. So I called my doctor friend. She suggested I immediately have a urinalysis. The laboratory result showed high sugar in her urine...which pointed to diabetes.

I immediately brought her to an endocrinologist, who after some tests, confirmed it as Type 2. So there were bimonthly visits to her doctor reworking the dosage of her medicines everytime. Diabetes didn't affect my daughter too much then. All she had to do was take her medicines which were in tablet form and see the doctor every other week. There are times her sugar was ok and so no medicines and times so high and so more medicines. The doctor said sometimes the diabetes goes on a honeymoon and her sugar becomes normal. All this time, I was praying she would always have a "honeymoon." My

daughter hated seeing the doctor which was every other week. We had to wait hours for our turn only to be told "increase or decrease the dosage." This went on for almost a year, then the doctor said, "I am giving her maximum dosage on the medicine and it's not working. We need to put her on insulin. We need to admit her in the hospital for a week to monitor the insulin intake and to train her to do it on herself."

That really scared me, but did I have a choice? At this time, a friend of mine called and asked how my daughter was doing with her diabetes. I relayed how bimonthly appointments with the doctor and the long wait was so terrible and it seems it was getting worse as she now needs to take insulin shots. Immediately my friend mentioned a juvenile endocrinologist who just came back from the States.

The juvenile endocrinologist, being trained to handle kids, had a very good rapport with my daughter. There were tests she had done, which immediately confirmed my daughter was Type 1. So that one year with the other doctor was a waste.

Oh no, so it's JUVENILE DIABETES!!! So what now.

I got hold of all the books I could read on it, but of



course they say the same thing, you need injections and blood tests everyday and controlled food intake.

She was admitted to the hospital where she was taught how to do her glucose tests and insulin injections twice a day. That seemed to be easy. My daughter said it was easy to inject as the needle was so fine. Then, the controlled diet. The dietician instructed us all food intake must be measured and taken only 5 times a day at specific times. This was the hard part especially for a kid. Imagine, no more french fries, hamburgers and potato chips !!!

It was such an ordeal. And it hurt me seeing my daughter hate her sickness. How I wish I was the one with diabetes. She was just a kid, what would she know about this! How can she enjoy her childhood and more so her later years?

I would often cry myself to sleep with all the "whys" I could not answer. But as a mother I had to be strong. I resolved I had no choice but to make do with the situation.

And so I faced the issues head on:

The doctor was very encouraging. She explained to me "JUVENILE DIABETES" is just like asthma, no big thing really. You just have to monitor. The good thing with insulin injections, it will control the sugar."

And so I made my daughter feel it was no big deal. I made her think it made her "cool." It made her "different." She initially mentioned the needle in the hospital was better than that I get in the drugstore. It had less pain. Of course, immediately I checked with their Central Supplies and got them to sell to me. I made sure she had the neatest supplies. Instead of having to bring alcohol, I would get the alcohol swabs from Hong Kong which was not available here then. It simplifies the things she brings. I got her a small insulated bag to put her things in.

As recommended by her doctor, we went to Ms. Sanirose Orbeta to understand the issues on how to feel she is eating "normal." After one afternoon with her, we threw away the strict diet plan of the hospital. Alas, she would still take junk foods sometimes.



Singapore and the United States. She is presently preparing to take her masters abroad. There are more stories but for the moment this is what I want to share with you. How your child copes with this disease is highly dependent on how the parents handle the situation.

Paula Guevara
(27 years old)

I studied European Languages in UP Diliman and graduated Magna cum Laude in 2003. After university, I spent six months teaching English in Lithuania as part of AIESEC's International Traineeship Exchange Program. I currently organize cultural events at the Goethe-Institut Manila (German Cultural Center).

Anna Guevara

I am an Architect, Senior Partner of R. R. Payumo and Partners and a Director of the Homeowners Association of the residential condominium where we live which is Renaissance 3000 (Ortigas Center, Pasig City).



When she has to go out with friends on weekends, a few days before, we try the restaurant and go through the menu so she knows what to order.

In school, at the start of every school year, I had to meet with her teachers to discuss the schedule of her meals and possible attacks that she may have and what is to be done. The teachers were very sympathetic. My daughter liked this as she gets exempted on "strenuous" works like cleaning the blackboard.

What I have relayed to you is how we got started on JUVENILE DIABETES when my daughter was only 11 years old. She is now 27 years old, and graduated Magna Cum Laude. She has been travelling all over the world for work and site seeing as far as Russia, Lithuania, Finland, Germany, Laos, Cambodia, Malaysia, Hong Kong,



Paula says: Getting diagnosed with diabetes is the last thing one expects during the summer before high school, but that's exactly what happened to me. After a few days of unquenchable thirst and frequent trips to the bathroom, my mother figured something was wrong with me. Her doctor friend told me to go to the hospital for a blood test. Hours later, it was confirmed: I had diabetes.

Awareness about the illness was still low at that time. I was lucky, one of my favorite book series in elementary had a main character who was diabetic. So when I was first diagnosed, I had some idea of what was wrong with me and what my life was going to be like from then on. The thought of regular insulin shots, swearing off sweets and keeping a close watch on what I ate made me cry, but after that I was calm. It took a while for the news to sink in. It wasn't just new medicine and a new diet that had been thrust upon me; it was also an awareness of the need to live a healthy lifestyle. I remember reading a long list of complications associated with diabetes and being really scared. I wondered if I'd still be able to have a life while making sure my diabetes is under control. That first year in high school was one

for the books. Aside from having to deal with the academic and social side of things, I also spent a good amount of time on my health. I was at the hospital every week, then every month and then every two months. My teachers at school knew practically nothing about diabetes, so I gave many a description of what was needed of me and what to do in cases of emergency. There were times when my friends and I used the obscurity of my disease to our advantage: I actually invoked my diabetes once to avoid playing a softball game, and my friends would often tell their moms that I (and they) would have to be fed regularly or else "I would die". I can't believe we got away with that, but it's a good illustration of how little people knew about diabetes back then!

Being diabetic was actually easier than I thought it would be. The blood glucose tests, pills and insulin shots are burdensome at first, but you learn to live with them. I didn't even find the meals every three hours too much of a hassle since Filipinos eat that often anyway. My mid-morning snack coincided with recess and my afternoon snack served as merienda. The only new meal was my midnight snack, which I didn't mind since I never slept

earlier than midnight anyway. I was actually misdiagnosed: I lived as a Type II diabetic for a little under a year before switching to a pediatric endocrinologist who declared me a Type I diabetic. The week I started insulin shots was the week before final exams. As a result, my last week in school that year was pretty stressful. That I managed to earn multiple honors that year is something I consider one of my greatest achievements. I think it also shows how non-radical a change my diabetes was.

At the start, I was very self-conscious about giving myself insulin injections. In time, my family and friends got used to seeing me do it, and the looks from strangers when I ate at restaurants stopped bothering me. I still try to inject discreetly. Sometimes I take my shot without people noticing! The past years have seen an amazing rise in diabetes awareness, though, so I don't get asked questions anymore. I never have problems when I travel or when I'm abroad. Once, at a train leaving Russia, the border guard took one look at my insulin vials and asked, "diabetic?". "Yes," I answered. And that was that. 

PDA ON THE MOVE

2nd PASOO Wellness Summit

SM Megamall Bldg. B. Megatrade Hall 1.
August 23, 2008

The committee of the Philippine Association for the Study of Overweight and Obesity (PASOO) concocted an array of topics for the 2nd PASOO Annual Convention and Wellness Summit Program.

The 2nd wellness summit, "Wastong Bigat, Kalusugan ang Katapat, Lose Weight, Stay fit, Feel Great" was held last August 23, 2008 at the SM Megatrade Hall 1. The summit highlighted exercise demonstration across all ages and participants were familiarized with the cardio metabolic risk profiles. Ably guided by doctor specialist and fitness and nutrition experts, a total of 980 participants indubitably enjoyed the program. It was entirely lots of fun as participants not only listened to the lectures but also engaged in the different exercise regimens and cooking lessons presented to them.



PDA supports National Medicine Week

Manila Pavillion
September 21, 2008

The PDA shows its support for PMA's 51st National Medicine Week celebration by participating on its opening ceremonies held last September 21, 2008 at the Manila Pavillion as well as conducting free blood sugar screening, blood pressure determination and fat analysis at Watsons SM Megamall and Watsons SM North Edsa last September 23, 2008 in cooperation with Watsons, Abbott and Omron.



World Heart Day

The Arena, San Juan City
September 28, 2008

The PDA participated this years World Heart Day celebration last September 28, 2008 at The Arena in San Juan City. Advocacy materials have been given to the attendees of this event.

Induction of Diabetes Philippines Pangasinan Chapter Officers

Star Plaza Hotel, Dagupan Pangasinan
November 22, 2008

From dormant to being active in preventing diabetes thru different activities that will promote awareness, this is the what the Diabetes Philippines Pangasinan chapter want to inform the Pangasinense after inducing their new sets of officers headed by their President, Dr. Isabelita Siapno held last November 22, 2008 at Star Plaza Hotel, Dagupan, Pangasinan. Dr. Susan Yu-Gan (treasurer, Diabetes Philippines National) conducted the oath taking of the new sets of officers of the Diabetes Philippines Pangasinan chapter.



4th Course on Diabetes and Vascular Disease

Century Park Hotel, Manila
December 2 - 3, 2008

Held at the Century Park Hotel, Manila was the 4th course on Diabetes and Vascular Disease. Around 500 participants convened to witness Professor John Chapman, President Elect of the European Atherosclerosis Society. Professor Chapman discussed the "New and Emerging CVD Risk Factors; The role of HDL Related Proteins". He also tackled "The Need for Comprehensive Lipid Management". The course directors were Dr. Tommy Ty Willing and Dr. Rody Sy. Also around to support the event were Dr. Rima Tan and Dr. Susan Yu-Gan.

Induction of Diabetes Philippines Batangas Chapter Officers

Hotel Pontefino, Batangas
December 6, 2008

Being said to be one of the most active chapters by conducting activities to prevent diabetes throughout the province of Batangas. The Diabetes Philippines Batangas chapter new sets of officers are oath to perform more than what they have shown for the previous years headed by their newly elect President, Dr. Oliver Bautista after their induction held last December 6, 2008 at Hotel Pontefino, Batangas City



GIMIK DIABETES 2008

Ma. Imelda Q. Cardino, MSFN
Makati Medical Center (Diabetes Clinic)



The year 2008 was most special to the Philippine Diabetes Association (PDA) and its members for a number of reasons:

- The association celebrated its 50th (golden) anniversary.
- This was the first time the lay program, entitled "GIMIK DIABETES", was held in a movie house.
- Since the session was held in the cinema, there were no booths for giveaways and food sampling.
- The association is now called DIABETES PHILIPPINES.

The affair was, as expected, well-attended. Experts were invited to discuss topics of relevance to the participants.

One of the highlights of the program was the awarding of plaques and tokens to the winners of the Poster Making Contest. It was invigorating to note that the winners were very young (elementary and high school students) and a number even came from one family.

Dr. Richard Elwynn Fernando reviewed the target values for blood sugar as well as some important reminders on how to maintain a healthy and complication-free life.

Mrs. Sanirose Orbeta corrected common misconceptions about food. She clarified that calamansi does not effect weight loss nor does water cause weight gain. She explained that bitter or sour foods do not lower blood sugar since these foods were believed to "neutralize" sweetness. She also touched on the common belief that tomato, eggplant, and other seeded

vegetables cause an elevated uric acid. Prudence on the use of table sugar was advised.

Mrs. Ma. Imelda Cardino gave some practical tips on how to have a festive meal for the holidays that will be "diabetes-friendly." Common fast food items and their calorie content were shown to illustrate the importance of managing one's energy intake. It was mentioned that the this issue of Diabetes Watch will include holiday treats.

Dr. Ma. Teresa Plata-Que reiterated the importance of foot care to prevent amputation. Simple guidelines were discussed. Pictures were shown for better understanding.

Dr. Cecile Jimeno's topic on food supplements elicited a number of questions from the audience. She explained why these products do not have approved therapeutic claims. As expected, issues on ampalaya and coconut oil were asked. One participant even gave a label of a certain product for comments. Dr. Jimeno deferred her response since she would need to review the components of the said product.

The issue on the safety of aspartame was raised as well as the use of food

supplements. Mrs. Cardino reminded the audience to renew their membership so they could get a copy of the Diabetes Watch. A topic on artificial sweeteners is included in the last quarter issue of the magazine.

The participants were requested to suggest topics they want to be included in the next lay convention.

Because of the enthusiastic participation of everyone, the activity was indeed a success.

The Lighter side of Diabetes by Dr. Allan Hernandez



Kiddie Gizmos and Gadgets

Mia C. Fojas, MD
Medical Center Manila

Cool gadgets for kids for treatment and monitoring

How does one convince a child to check his own glucose?

Some children have gotten used to the idea and the frequent pricking feeling. For the teens who have recently been diagnosed with diabetes, the idea of frequent puncturing may freak them out. Parents should be armed with the correct incentives to persuade glucose testing in their children. Gadgets should also be innovative enough to help the parents out.

With the computer games era, one attempt to facilitate glucose testing is through "Glucoboy". This is a glucose meter designed as a cartridge that can be attached into Game Boy Advance. The more a child tests his glucose, points are earned ("Glucose Rewards Points" or GRP's) unlocking games. GRP's can also be converted to game currency for purchasing tokens or other game items.

A game also features the diabetic teen named "Kyle" with his sister "Kate" who could answer frequently-asked-questions regarding diabetes.

Novel? maybe. Effective? for as long as this would be the only cartridge they own.

For more information, access: www.glucoboy.com



Glucoboy, a game compatible with the Game Boy Advance or DS Lite, that makes monitoring and achieving blood sugar goals fun.



Kate & Kyle

Why I haven't bought an iPhone ... not yet, anyway!

Iris Thiele Isip Tan, MD
UP-Philippine General Hospital

I suffer from severe iPhone envy! Its sleek gleaming surface and cool screen icons make me itch to hand over my credit card. What has kept me from getting one? Well, for one thing, I'm a Smart subscriber and iPhone works with Globe. That's not a real barrier! But before you go and buy an iPhone, here are some things you CANNOT do with a n i P h o n e (<http://infotech.indiatimes.com> accessed 5 Dec 2008):

No video recording option.

The iPhone has a 2 megapixel camera which can take decent still pictures but not videos. That's disappointing for a mom like me as I often take videos of my children on the fly. Although I haven't tried it, it would be nice to be able to record a scientific lecture with your phone for example, if it were allowed.

Cannot send MMS. As a physician, I have sometimes taken pictures of interesting skin lesions or even diabetic feet and sent them to colleagues via MMS for opinion. This will not be possible with an iPhone unless you send the snapshot via email.

Cannot forward SMS. iPhone users can only forward text through email. That can be a bit cumbersome, but it could also be a plus if you remember all those occasions you forwarded a text message to the wrong person!

Cannot send SMS to multiple contacts.

Why not?! I often have to send text reminders of meetings to a group of people, so the lack of this feature simply will not do.

No cut, copy and paste.

Wow! Even my old Nokia phone had this feature. I can imagine how difficult this can get since it happens often that you need to transfer data i.e. phone numbers, URLs etc from one phone application to another.

Cannot replace battery on your own.

Hmm, that means you cannot put in a spare battery if you run out of juice. Not that I've ever had to do that. I got a car charger instead of a spare cellphone battery.

No support for wireless modem.

Darn, you cannot connect wirelessly to your laptop and browse the web with an iPhone. Most 3G phones support this feature.

Cannot share files via bluetooth.

One wonders then what the bluetooth is for? The iPhone cannot share mp3, images and video files via bluetooth.

Cannot view Flash.

When users browse through webpages with Adobe Flash, it will display empty spaces with missing icons. This limits the web browsing experience with the device.

No r i n g t o n e

customization. There are only two options: ring or silent. That means

I am still hoping that the iPhone will evolve enough to replace my PDA if not my phone. I've been a Palm OS PDA user since 1998 and so it pains me to say that this operating system is probably dying or dead as there have been no releases since the Palm T/X several years back.

you cannot tell if it's your husband calling or your boss or your secretary!

Cannot send contact information via SMS,

bluetooth or wifi. Antisocial indeed! The iPhone also cannot receive business cards from other phones via

SMS, bluetooth or wifi.

This is sad really, how else can I send my clinic schedule when someone asks for it thru text?

Now despite these, I am still hoping that the iPhone will evolve enough to replace my PDA if not my phone. I've been a Palm OS PDA user since 1998

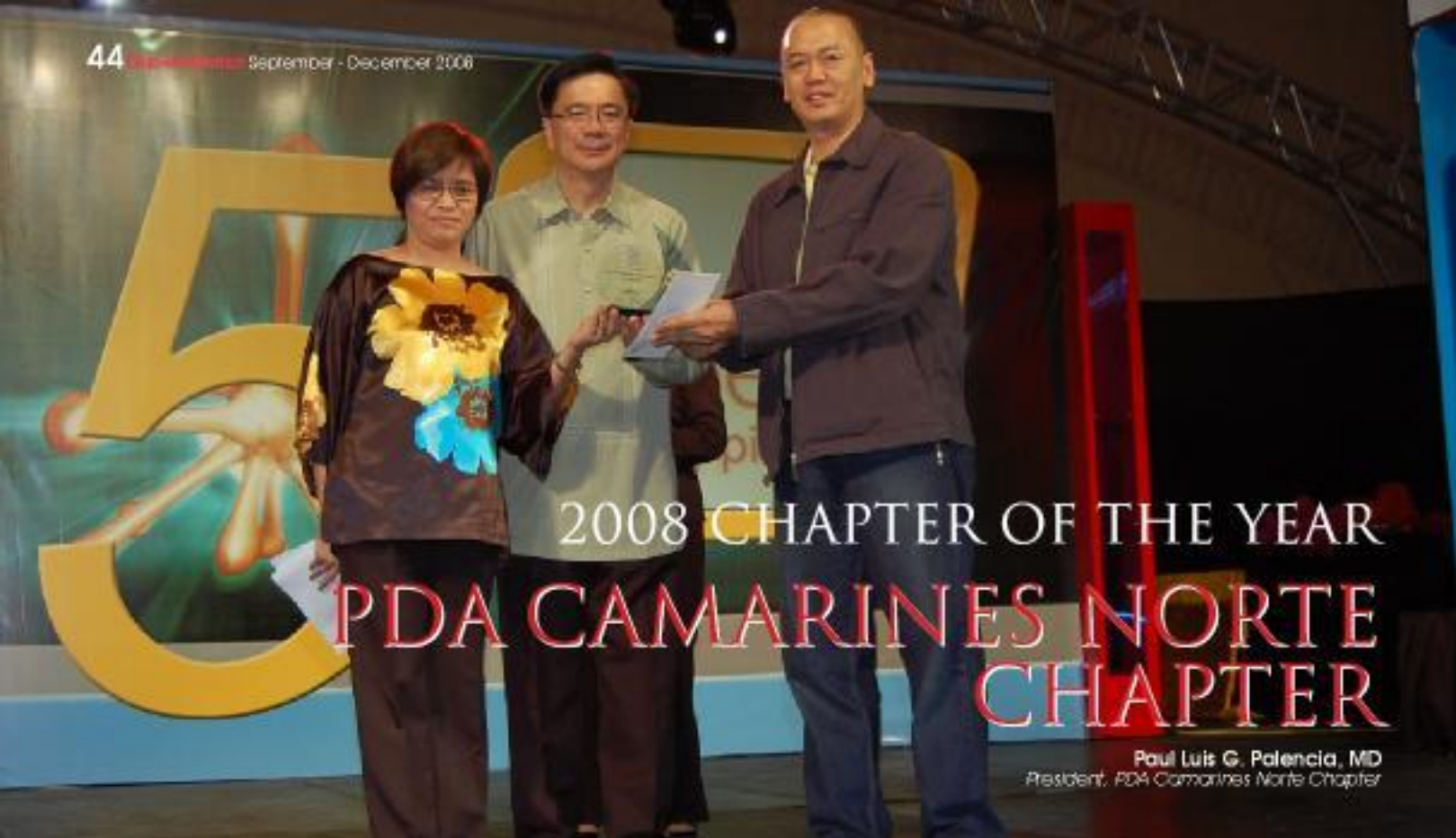
and so it pains me to say that this operating system is probably dying or dead as there have been no releases since the Palm T/X several years back.

I looked at iTunes and found several promising medical applications available. There are several medical calculators (i.e. MediMath Medical Calculator, iDocTool, Fluid and Electrolyte Calculator, ABG). I am itching to try Patient Tracker, an electronic medical record application. There's MedsLog, an application I can recommend to my patients, as it reminds the user when to take medicines and keeps a log as well. I can use Perfect OB Wheel to determine the due dates of my patients with gestational diabetes. With EyePhone, I can check for visual acuity and gauge pupil size. It even has an Amsler grid and Ishihara test for color blindness. The very popular 5-minute Clinical Consult also has an iPhone version now, for a whopping \$74.99. For practicing evidence-based medicine, there's iNNT which takes baseline estimates of risks and treatment effectiveness to construct graphical displays of risk and treatment effectiveness. This makes it easier to communicate these concepts to patients. You can also search PubMed with PubSearchPlus, although only abstracts are available.

But the most tempting by far is the availability of good ol' Epocrates Rx, which I have on my Palm T/X. The iPhone version has photos of pills allowing identification, which I think is really cool!

I don't think I will get an iPhone, yet ... but I might get a second-generation iPod Touch this Christmas. I just found out that the medical applications that run on the iPhone also run on the iPod Touch, it might be worth a try!





2008 CHAPTER OF THE YEAR

PDA CAMARINES NORTE CHAPTER

Paul Luis G. Palencia, MD
President, PDA Camarines Norte Chapter

The PDA - Camarines Norte Chapter is proud and thankful to be the 2008 national winner for Best Diabetes Chapter during the Annual Golden PDA Celebration held last November 11-12, 2008. Congratulations to all the other diabetes chapters who in their own ways worked hard to educate, treat and support diabetic patients. It is obvious that diabetes is on the rise and many patients are not being taken care of properly. We need more doctors doing charitable / free consultations especially during this time of economic instability and financial crisis.

The majority of diabetic patients often go without meds, especially the type 1 diabetics. Most of them are on the down trend medically; others stop going to school or unable to work thereby becoming a burden to their families. The unfortunate young ones die in charitable institutions without insulin or any other interventions.

I am personally happy with the fifty thousand peso cash gift to offset the Optium machines given to our 12 towns

plus the boxes of Optium strips being used during every visit. I then realized, and asked myself ... "What if we did not win? Who will shoulder the expenses, most especially for our future plans and projects..." We all know it is very hard to seek support nowadays from the pharmaceutical companies and NGO's alike not only because of the country's but largely due to the world's economic situation today.

PDA - CN Chapter has served the province from its three bases, namely:

1) CN Provincial Hospital which became the umbrella to the twelve towns and big barangays wherein municipal/barangay diabetes clubs were established, lectures and free consultations were conducted, and Optium meters given.

2) Our Lady of Lourdes Hospital - the first tertiary private hospital in the province wherein the same services were done and Optium meters given to CN Provincial Hospital, Labo District Hospital, CN Diabetes Association, CANORECO, CN Water District, Provincial Capitol, Bureau of Jail

Management and Penology, CN State College, Urban Poor Resettlement, Camp Dogongan, Holy Trinity Cathedral, DepEd, indigent patients and all type 1 DM. Seminars, symposiums and workshops were also held in the province, both with PDA (33rd Workshop) and UERMMMC- ISDFI.

3) DepEd - for the Teachers Health and Welfare Enhancement Program done in batches wherein laboratory examinations like FBS, T. Cholesterol, CBC, Blood typing, Urinalysis, foot examination, Doppler Foot UTZ, ECG and Bone Densitometry were given free.

A lot is still to be done. Future plans include looking for Type 1 DMs from DepEd and comparing the province' profile of diabetics with that of the national and international profile.

A famous author once said ...in every community there is work to be done...and in every heart there is a power to do it!

MABALOS!

DIABETES, A STORY OF HOPE

Ma. Antonette Lourdes Lopez-Aportadera, MD
Nolo City

The first World Diabetes Day was held through the initiative of the World Health Organization (WHO) and the International Diabetes Federation (IDF) on November 14, 1991. IDF also spearheaded the efforts to declare the day an official United Nations day. United Nations General Assembly unanimously passed UN Resolution 61/225 on December 20, 2006. The resolution designates the November 14 as World Diabetes Day to be observed every year beginning in 2007. Diabetes is now considered as an important global public health problem that requires urgent attention from policy-makers and health planners around the world. The day was chosen because it was the birthday of Frederick Banting who was credited for the discovery of insulin.

The theme of World Diabetes Day for 2007 and 2008 is *Diabetes in Children and Adolescents*. For 2009-13, it is Education and Prevention. The previous themes were *Diabetes and Obesity* (2004), *Diabetes and Foot Care* (2005) and *Diabetes in the Disadvantaged and the Vulnerable* (2006).

The choice of the present theme will

draw attention to the fact that diabetes is one of the most common chronic diseases of childhood. About 70,000 children under the age of 15 are diagnosed with type 1 diabetes every year, according to International Diabetes Federation estimates. Every day more than 200 children are diagnosed with type 1 diabetes, requiring them to take multiple daily insulin shots and monitor the glucose levels in their blood. It is increasing at a rate of 3% each year among children and rising even faster in pre-school children at a rate of 5% per year. Currently, over 500,000 children under the age of 15 live with diabetes. Type 2 diabetes has been reported in children as young as eight years old. In Japan, the prevalence of type 2 diabetes amongst junior high school children has doubled from 7.3 per 100,000 in 1976-80 to 13.9 per 100,000 in 1991-95 with type 2 diabetes now outnumbering type 1 diabetes in that country.

Close to 75,000 children with type 1 diabetes in the developing world need life-saving insulin to survive. Life-saving diabetes medication and monitoring equipment are also often unavailable or unaffordable. As a result, many

children with diabetes die soon after diagnosis, or have poor control and quality of life, and develop the devastating complications of the disease early.

As of 2000, World Health Organization data showed at least 171 million people worldwide suffer from diabetes, or 2.8% of the population. Today, an estimated 246 million people worldwide are affected. Its incidence is increasing rapidly, and it is estimated that this number will almost double by the year 2030. Data that takes into account deaths in which diabetes was a contributory condition, suggests that approximately 2.9 million deaths per year are attributable to diabetes. Most countries report that incidence rates have at least doubled or more in the last 20 years. Incidence appears to increase with distance from the equator. It is at present more common (especially type 2) in the more developed countries but by 2030 most patients will likely be found in Asia and Africa. The increase in incidence of diabetes in developing countries will be attributed to urbanization, lifestyle changes, like "Western-style" fast food diet and awareness that leads to early detection and diagnosis in

these areas. In 2007, an estimated 22 million children under the age of 5 years were overweight throughout the world. More than 75% of overweight and obese children live in low- and middle-income countries.

The figures are staggering for an ailment that perplexed healers in the past for its being uncommon and incurable. The Centre for Disease Control has now termed it "a worldwide epidemic."

Diabetes has been mentioned since antiquity with earliest reference attributed to the ancient Egyptians who first mentioned a rare disease characterized by frequent urination and weight loss as early as 1550 BC. The oldest historical documents to mention remedies for the treatment of excessive urination (polyuria) are attributed to the Ebers Papyrus, which was discovered in 1872 by, of course, Georg Ebers (1837-98).

Sushruta of Kashi, India (6th century BC) made detailed references to diabetes as "sweet urine disease" or Madhumeha by observing that flies and ants were attracted to a person's urine. He also identified it with obesity in his medical treatise, *The Sushruta Samhita*. The Korean, Chinese, and Japanese also mentioned it as "sugar urine disease".

It was Aretaeus the Cappadocian (30-90) who gave it the name. Diabetes, from the Greek verb *diabainein*, meant "to stride, walk, or stand with legs

asunder" and was itself a conjunction of the prefix *dia-*, "across, apart," and the verb *bainein*, "to walk, stand," meaning "a flowing through." Diabetes, or "one that straddles," or specifically "a siphon, sweet flow" was used to name the disease that was marked by the discharge of excessive amounts of urine. Aretaeus tried to treat it but did not come up with good results leading him to comment that "life (with diabetes) is short, disgusting and painful," and to call the disease as "a wonderful affection, not very frequent among men, being a melting down of the flesh and limbs into urine." In fact, it was widely believed that Hippocrates (460-370 BC) did not mention it because the Father of Medicine thought it was incurable.

Diabetes was also referred to by Claudius Galenus or Galen (129-200) of Pergamum as "diarrhea of the urine" and "the thirsty disease." Galen, whom Emperor Marcus Aurelius described as *Primum sane medicorum esse, philosophorum autem solumm* (first among doctors and unique among philosophers) discussed diabetes in a number of his works. Magnus of Nisibis, who taught medicine at Alexandria in Fourth century, would cite Galen in his own work on the urine.

Ibn Seena of Afshana, Persia or in Latin, Avicenna (980-1037) described diabetes mellitus as the abnormal appetite and the collapse of sexual functions and he documented the sweet taste of diabetic urine in *Qanon fi-l-Tibb* or *The Canon of Medicine*. He would also elaborate on diabetic gangrene and diabetes insipidus, almost a millennium ahead of the Jesuit educated Johann Peter Frank (1745-1821) to whom the clinical differentiation between diabetes mellitus and diabetes insipidus was attributed.

Moshe ben Maimon or Moses Maimonides (1138 to 1204) claimed to have seen more than 20 cases in his practice at Fostat, Egypt where he was the personal physician of Sultan Saladin



of Egypt. He thought that diabetes was caused by the sweet waters of the Nile and that the hot and humid condition had some effects on the kidneys.

By 1674, Thomas Willis (1621-75) observed that urine was sweet (glycosuria) in patients with this condition which was then known as Willis' Disease. He claimed that diabetes was primarily a disease of the blood and not the kidneys. Willis proposed that the sweetness first appeared in the blood and was later found in the urine. His observations were published in *Pharmaceutice rationalis* in 1674. The following year, Willis (yes, of *Cerebri anatomie* and Circle of Willis fame) added the word mellitus or Latin for "honey" to the old disorder and the condition has since then been known as diabetes mellitus.

In an experiment, Matthew Dobson (1732-82) proved that people with diabetes eliminate sugar in their urine by heating urine of diabetic patients. He described the resultant whitish residue, which, as "granulated and broke easily between the fingers; it smelled sweet like brown sugar, neither could it be distinguished from sugar, except that the sweetness left a slight sense of coolness on the palate." Dobson confirmed that the sweet taste

was because of an excess of a kind of sugar in the urine and blood of people with diabetes. Dobson's *Experiment and observations on the urine in diabetes* was published in the Medical Observations and Inquiries and was presented to the medical society of London in 1776. The relationship between the pancreas and diabetes was first suggested by Thomas Cawley after he noted in an autopsy the damaged pancreas of a patient who had died of diabetes whose pancreas showed stones, and signs of tissue damage. His observation, *A singular case of diabetes*, was published in the London Medical Journal in 1788. The significance of this vital clue was not to be appreciated by the medical community until the early 20th century.

The new field of endocrinology was ushered in by an ironic twist of fate. Before he became a physician, Claude Bernard (1813-78) had literary aspirations. When he, however, presented his five-act play *Arthur de Bretagne* to literary critic and University of Sorbonne professor Saint-Marc Gerard (1801-73) for his opinion, he was bluntly advised to take up medicine instead. He did. He would discover that the liver produced a substance that affects blood sugar levels in 1857. He isolated the substance which he called *le milieu interieur* or "the internal secretion" of the liver. It would be known as "glycogen," which was the precursor of glucose in the body. His discovery and investigations on the functions of the pancreas would lead to the development of a new field for learning in medicine which would be known as endocrinology.

Paul Langerhan (1847-88) presented most famous histological finding, the pancreatic islets, in his doctoral dissertation, "Contributions to the microscopic anatomy of the pancreas," to Berlin Pathological Institute in February of 1869. Langerhans acknowledged that he did not know the function of these ductless cells,

which he described as "islands of clear cells throughout the gland, staining differently than the surrounding tissue," and which "were more richly innervated." He even ventured an incorrect hypothesis that they might be lymph nodes. They were later shown to secrete insulin and were named "islets of Langerhans," in his honour in 1893 by the French histologist Gustave-Edouard Laguesse (1861-1927). Laguesse is remembered for his research on the secretions of this cells which he believed had a role in digestion. He is acknowledged as a pioneering endocrinologist.



The French pharmacist, Apollinaire Bouchardat (1809-66) recognized that fasting was a method to reduce glycosuria, and stressed the importance of exercise and diet in the treatment of diabetes prior to the advent of insulin therapy. He also developed a procedure for self-testing to determine the presence of glucose in the urine. Bouchardat is often credited as the founder of diabetology.

William Frederick Pavy (1829-1911), who discovered Pavy's disease, a cyclic or recurrent physiologic albuminuria, published in 1862 his conclusions on the quantitative relationship between the degree of hyperglycaemia and glycosuria in *Researches on the nature*

and treatment of diabetes. A leading expert in diabetes of his time, and one-time (in 1900), the president of the Medical and Chirurgical Society of London, he spent almost 20 years trying to disprove Claude Bernard's theory of the glycogen-glucose metabolic cycle.

Oscar Minkowski (1858-1931) and Josef Von Mering (1849-1908) building on the experiment of Johann Brunner (1653-1727) induced diabetes in dogs by removing their pancreas in their landmark study at the University of Strasbourg in 1889. Brunner performed the first experiments on the internal secretion of the pancreas by removing the pancreas from dogs which then displayed extreme thirst and polyuria. He published his observations in *Experimenta nova circa pancreas* in 1709. The annual Minkowski Prize for outstanding research of a younger investigator in diabetes is given in recognition of that discovery by the European Association of the Study of Diabetes. In his 1916 work, *The endocrine organs*, University of Edinburgh professor Edward Albert Sharpey-Schafer (1850-1935) suggested that the chemical that was normally produced by the pancreas had a role in carbohydrate metabolism. He proposed the name, *insulin*, from the Latin *insula*, or island, in reference to the islets of lumps of cells in the pancreas that befuddled Langerhans. The distinction of being the first person to have injected a pancreatic extract with partial success would go to a German physician. Georg Ludwig Zuelzer (1870-1949) was able to extract animal pancreas with alcohol and saline in his experiments on rabbits. He injected the extracts called Acomatrol to a comatose diabetic patient in 1906. There was initial improvement but the patient relapsed and died when the extract was used up in a few days. His further experiments in 1908 included injecting five more diabetic patients with pancreatic extracts. They resulted in limited success because impurities caused fever.





Like Cawley, Moses Barron (1884-1975) noted in *The Relation of the Islets of Langerhans to Diabetes with Special Reference to Cases of Pancreatic Lithiasis* published in the November 1920 issue of *Surgery, Gynaecology and Obstetrics*, that the blockage of the main pancreatic duct resulted in degeneration of the acinar glandular cells but not the islet cells. He also suggested the possibility of isolating the substances from the pancreas which could be used to treat diabetes by working on the experiments of Minkowski and Von Mering.

Frederick Banting (1891-1941) who had read Barron's article worked on the suggestion with a twenty-two year old medical student, Charles Herbert Best (1899-1978) and a biochemist, James Bertram Collip (1892-1965) in the facilities provided by John James Richard Macleod (1876-1935) at the University of Toronto in 1921. They were able to demonstrate that the pancreatic extract which they initially called *isletin*, from healthy dogs could reverse induced diabetes in depancreatized dogs. They eventually went on to purify insulin from bovine pancreas that made insulin injections a widely available treatment as early as 1922. Banting and Macleod were awarded the Nobel Prize in Physiology

or Medicine in 1923. Both went on to publicly recognized Best and Collips contribution in the discovery. The team also made the patent on the process available without charge and did not attempt to control commercial production. Insulin became available for clinical care throughout the world within 2 years.

An earlier study was started a decade ago by Nicola Paulescu (1869-1931) in Bucharest, Romania. By 1916 he was able to develop an aqueous pancreatic extract that caused hypoglycaemia in dogs. He called extract, *pancreine* and even had it patented (patent number 6254) on April 10, 1922 in his country. Paulescu detailed his experiments in four papers published in the Romanian Section of the Society of Biology in Paris between April 24 and June 23, 1921. He would submit the same as *Research on the Role of the Pancreas in Food Assimilation* to the *Archives Internationales de Physiologie* in Liège, Belgium, and was published in its August 1921.

Controversies hounded the selection of the 1923 Nobel Prize. It was extremely unusual for a medical discovery to be honoured in this way so soon after it had been made. This reflected the significance of the

discovery of insulin. It should be noted that the nomination was followed by protests from both Georg Zuelzer and Nicholas Paulescu, who claimed priority. Paulescu's publication preceded the work of the Toronto by eight months. His representations to the French Academy of Medicine went naught, as the Nobel Award Committee ruled that once an award made, no review was allowed. Banting would also later regret misquoting Paulescu attributing such to errors in the translation of the French language. Having missed out on the Nobel Prize, acclaim and recognition as the true discoverer of pancreine or now known as insulin would come only after Paulescu's death.

Another milestone in the history of diabetes was the discovery of sulfonylureas in 1942. Marcel Janbon, a French pharmacologist was trying to find a cure for typhoid. He discovered that the compound sulfonylurea in sulfonamide induced hypoglycemia in animals. At around the same time, French doctor, Jean Sterne, expounded on the side effect --- the lowering of blood sugar --- of the biguanides which would include metformin. The 1960s saw the pioneering works in biochemistry of the Belgian Nobel laureate, Christian de Duve. He discovered, with use of the electron microscope, small circular sack like structures that prevented the enzymes from interacting with other compounds. He would call them, peroxisomes, because of their knack for generating hydrogen peroxide. Peroxisomes would contribute in the breakdown of carbohydrates. By the 1990s, toxicologists Isabelle Issemann and Stephen Green would decipher, and would produce in large quantities, the protein that could trigger the biochemical reactions for the proliferation of the peroxisomes. They aptly called this protein PPAR, or peroxisome proliferator activated receptor. These discoveries laid down the introduction of a new class of anti-diabetic drugs, the glitazones which

became available in 1999.

Rosalyn Sussman Yalow would collaborate with Solomon Berson to develop radioimmunoassay, the radioisotope tracing technique that allows the measurement of tiny quantities of various biological substances in the blood. It was originally geared for use in the study insulin levels in diabetes mellitus. They would publish their work, *Immunoassay of endogenous plasma insulin in man* in the *Journal of Clinical Investigation* in 1960. Yalow would be awarded the 1977 Nobel Prize in Medicine for "the development of radioimmunoassays of peptide hormones." (Berson died in 1972.) By the early 1980s, breakthroughs in recombinant DNA technology and genetic engineering coupled with better understanding of the basic amino acid structure of insulin and species differences, resulted in the development of 'human insulin' and, more recently, insulin analogues and continuous subcutaneous insulin infusion therapies that allow therapy to be as close as possible to the actual

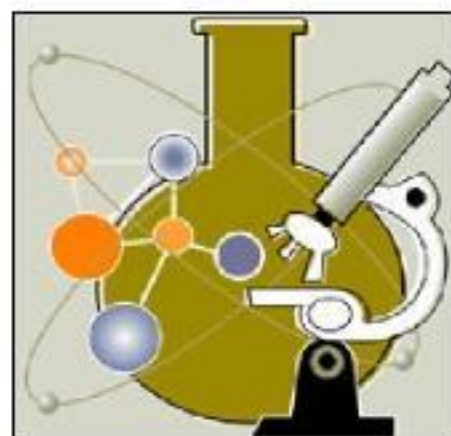


physiological insulin secretion. It was, however, insulin that immediately offered hope to those afflicted by such a debilitating and so frequently fatal disease. The discovery

by Banting et al was epoch making because it laid the foundation for large-scale insulin production. Life expectancy of diabetic patients dramatically increased. Between 1914 and 1922 the life expectancy of a diabetic had been 6.1 years from diagnosis. By 1950 to 1957, it had increased to 18.2 years. In young diabetics (< 30 years old at onset), a life expectancy before the first world war of only 1.3 years from diagnosis, by 1957 - 35 years after the introduction of insulin - to 26.4 years.

Derrick Dunlop, of the *yellow card* fame for the drug safety monitoring in the United Kingdom, would describe in his opening remarks during a 1965 Diabetes Mellitus Symposium at the University of Edinburgh that he (had) "never seen anything in medicine more heart-warming or rewarding than to watch those diabetic patients raise them themselves step by step out of the valley of the shadow". He also emphasized that insulin therapy provided diabetics maximum relief with minimum toxicity.

Insulin, though, has not provided the cure for diabetes mellitus. Retinopathy, nephropathy, neuropathy, gastropathy, coronary and peripheral angiopathy remain sequelae of the disease. Are these complications "to be regarded fatalistically as something inherent in the diabetic process?" Dunlop queried. Another area of concern is the availability and affordability of insulin to diabetics who live in poor countries. "It's been 87 years since the discovery of insulin, yet many of the world's most vulnerable citizens, including many children, die needlessly because of lack of access to this essential drug. This is a global shame. We owe it to future generations to address this issue now," Dr Jean-Claude Mbanya, President-Elect of the International Diabetes Federation said. During the IDF forum, No child should die of diabetes, at Belgium on October 13, 2008, IDF outlined the global efforts to address issues facing the patients,



their families, their health providers, their caregivers and more importantly world policy makers. They will come in the form of effective treatment with insulin which should include making it available and affordable to all in need, prevention of both diabetes and its complications. Measures are to be done within the context of every child's or adolescent's normal physical and emotional growth, and every adult's normal life style. Only then can we reply in the negative to Dr. Dunlop's query.

This time hope comes not through the dedication of one team but from the concerted effort of one global community. Louise Pasteur said these words in 1888 during the inauguration of *Institute Pasteur*: "Of this we may be sure, that science, in obeying the law of humanity, will always labour to enlarge the frontiers of life." Yes, we see Hope. 

Dr. Lopez-Aportadera finished her fellowship training in Endocrinology and Metabolism at the Beth Israel Medical Center in New York City. She is the chief of the Section of Endocrinology and Metabolism of the Iloilo Mission Hospital.

This time I'll be *artificially* sweeter and lighter

Elaine Cunanan, MD
University of Santo Tomas Hospital

We, Filipinos, are renowned for our fondness for sweets. The "kakanin" and good old "halo-halo" are a common fare during fiestas and family gatherings. "Puto bumbong" and "bibingka" never fail to tantalize the taste buds after the midnight mass. However, it is this same "sweets" affection that is currently tagged as one of the reasons for the rising incidence of diabetes and obesity in our country. Are artificial sweeteners the necessary ingredients that will allow us to savor our sweet treats without gaining the extra calories?

What are artificial sweeteners?

Artificial or non-nutritive sweeteners are substances that provide the sweetness of ordinary table sugar (sucrose) minus the calories. Since they are much sweeter than sucrose, an extremely small amount is needed to create the same sweetness. Thus, products made with artificial sweeteners have much lower calories than those made with sucrose.

Five artificial sweeteners are currently approved by the US Food and Drug Administration (FDA). An "acceptable daily intake" (ADI) has been set for each sweetener. This is the maximum amount that can be safely consumed each day over a lifetime. ADIs are set at about 100 times less than the smallest amount that might cause harm. Let us look at each of these sweeteners.

Saccharin



Saccharin was the first artificial sweetener discovered in 1879. It is 300-

500 times sweeter than sucrose. Although it has a bitter aftertaste, this can be minimized by blending it with other sweeteners.

In 1977, saccharin was almost pulled out from the market due to findings that it can cause bladder cancer in laboratory rats. Subsequent studies have found that it is unlikely to occur in humans, since the mechanism believed to cause cancer in mice does not exist in humans. The original study has also been criticized due to the very high dosages used which were hundreds of times higher than that for humans.

In 2000, the National Toxicology Program (NTP) of the National Institutes of Health concluded that saccharin should be removed from the list of potential carcinogens. The warning has now been removed from saccharin-containing products.

Aspartame

Aspartame was accidentally discovered in 1965 by James Schlatter while working on an anti-ulcer drug. He noted its sweet taste when he licked his aspartame-contaminated finger. It is derived from two amino acids aspartic acid and phenylalanine. It is 200 times as sweet as sucrose with a similar caloric value (4 kilocalories/gram), but the amount used is small enough to consider aspartame essentially free of calories. It is partly converted in the body to methanol but the quantity is much lower than those produced by natural foods.



It loses its sweetness when heated though, so it can not be used for cooking or baking.

Some studies have initially linked aspartame with brain tumors as well as leukemias and lymphomas in laboratory animals. Subsequent studies conducted and reviewed by the FDA, NTP and the European Food Safety Authority have concluded that there is no scientific evidence supporting a link between aspartame and any type of cancer. There is also no proof that aspartame causes or worsens Parkinson's, Alzheimer's, multiple sclerosis or systemic lupus erythematosus. Just recently, a panel of leading experts convened and came up with a comprehensive reappraisal which conclusively determined that aspartame is safe.

Because of the phenylalanine component, people with the rare disorder, phenylketonuria should restrict aspartame use because their body cannot metabolize phenylalanine.

Acesulfame-K (potassium)

Acesulfame-K is 200 times sweeter than sugar with zero calories. It is not metabolized or stored in the body. In 1988, the FDA and Food and Agriculture Organization Joint Expert Committee on Food Additives have evaluated the sweetener's safety and have declared it safe for human consumption.

Neotame

Neotame is chemically similar to aspartame but is much sweeter. It is 7,000 to 13,000 times sweeter than sucrose. It does not accumulate in the body and is rapidly excreted unchanged. It is stable when heated so it can be used in cooking or baking. It is considered safe for those suffering from phenylketonuria since it is not metabolized into phenylalanine. Neotame was approved by the FDA in 2002, but is not yet widely used in food products.

Sucralose

Sucralose is produced from sucrose when three chlorine atoms replace three hydroxyl groups. It was accidentally discovered during the process of developing an insecticide. It is 600 times as sweet as sucrose. It is stable in heat and can be used in baked and fried goods. Although sucralose is made from table sugar, it adds no calories because it is minimally absorbed by the body and passes out unchanged.

After reviewing more than 110 animal and human studies, the FDA approved sucralose in 1999 for use as a general-purpose sweetener.



The product Splenda which contains sucralose is not calorie-free though. It is also composed of calorie-containing glucose and maltodextrin (nutritive sugars which are breakdown products of carbohydrates) to increase bulk.

Are artificial sweeteners beneficial for diabetics?

The American Diabetes Association states that they are a safe alternative for diabetics since they do not significantly affect glycemic control, insulin levels, blood lipid levels or blood pressure. However, keep in mind that if you do have diabetes, some foods containing artificial sweeteners may contain other carbohydrates which can affect your blood glucose level.

Are artificial sweeteners safe for pregnant women and children?

Aspartame, acesulfame-K and sucralose have been deemed safe for use in moderation during pregnancy and lactation.

Studies show that saccharin crosses the placenta and may remain in fetal tissue, so its use by pregnant women still remains in question.

If you are pregnant, consult your obstetrician prior to using artificial sweeteners.

Several studies have documented that the FDA-approved artificial sweeteners are safe for children above 2 years of age. However, children still need calories from nutritious foods to achieve proper growth and development.

The American Diebetic Association discourages the use of artificial sweeteners in children less than 2 years old since their safety has not been sufficiently assessed in this age group.

What are the advantages and disadvantages of using artificial sweeteners?

Artificial sweeteners supply sweetness to your food with little added calories than foods containing sucrose. It can be useful for losing weight or preventing weight gain. However, some sugar-free foods may contain more calories and more fat than the sugar sweetened versions.

You can check the "Nutrition Facts" on the label to see whether you are really getting fewer calories. You can also check the fat content. Consider price as well. Sugar-free varieties usually cost more.

Whether you are munching on a sucrose-sweetened snack or an artificially-sweetened one, it pays to remember that too much of a good thing can be a bad thing. Drink and eat in moderation. *Bon appetit!*

Approved Artificial sweeteners	Brand Names	Sweetness compared to sugar	ADI* milligrams (mg) per kilogram (kg)	Estimated ADI equivalent**	Can be used for cooking or baking
Saccharin	Sweet'N Low, SugarTwin	300-500x	5 mg per kg	9 to 12 packets of sweetener	Yes
Aspartame	NutraSweet, Equal, PAL sweet	200x	50 mg per kg	18 to 19 cans of diet cola	No
Acesulfame K	Sunett, Sweet One	200x	15 mg per kg	30 to 32 cans of diet cola	Yes
Sucralose	Splenda	600x	5 mg per kg	6 cans of diet cola	Yes
Neotame	-----	7,000-13,000	18 mg a day	not available in our country	Yes

*Acceptable daily intake (ADI) limit per kilogram (2.2 pounds) of body weight.
**Product-consumption equivalent for a 150-pound person

Footprints in time

Tommy S. Ty Willing, MD
Metropolitan Medical Center

The Philippine Diabetes Association Story



Genesis

In July 1958, a group of internists and devoted physicians, seeing the need to unify all interests and entities that were concerned with diabetes mellitus in the Philippines, banded together to form the nucleus of a single organization. The group's efforts bore fruit when on September 27, 1958 the Philippine Diabetes Association, or PDA, was born. The memorable event, held

at the historic Club Filipino in San Juan, was timed to coincide with the visit of Dr. Howard Root, from the Joslin Clinic in Boston, Massachusetts. Dr. Wenceslao Vitug was elected as the first president.

In the organization's *infancy to early-adulthood* years, Dr. Vitug was succeeded by a total of 13 well-known internists. Those first 24 years may be considered as a learning period for the

organizers, a time to familiarize with the workings of the service organization they had put up. It was also a time to look for, and identify potential allies and supporters in the corporate world. Then too, it was a time, both for the member-doctors and the diabetics themselves, to really start getting to know diabetes better. Thus, seminars became a regular treat, for the physicians and their patients too.



Litonjua gets things done

In 1983, Dr. Augusto D. Litonjua became president and for next 11 years he brought vigor and dynamism to the society.

The PDA passed through several milestones during Dr. Litonjua's stewardship. In 1984, the association was listed with Securities and Exchange Commission and incorporated as a juridical entity. The PDA Lay Organization was set up in the same year, and *DiabetesWatch*-which would eventually become the official publication of the society-first saw print. Even the seed for the PDA convention-an activity that was to become a regular and uninterrupted yearly pursuit-was planted in 1984. Small wonder therefore that in the same year, the association won recognition as member of the International Diabetes Federation (IDF).

In 1987, the PDA started organizing chapters nationwide. The first chapter was established in Davao City and from then on other chapters were organized, eventually bringing the number to a total of thirty one.

In 1987 too, the PDA and the PSEM co-hosted the 4th Congress of the ASEAN Federation of Endocrine Societies (AFES).

PDA workshops, which were intended to provide intensive 3-day courses to physicians-with members of the PDA Board serving as faculty-were conducted in various places of the country beginning 1990. The first workshop was held in Legaspi City, and to date, 36 such workshops have already been conducted.

In 1991, the PDA joined the annual global celebration of **World Diabetes Day**, which is now held every 14th of November.

On **June 15, 1992**, the PDA office was inaugurated, and the occasion was graced by the presence of past PDA presidents and the heads of pharmaceutical corporate members. Indeed, the PDA now beams with pride as it calls Unit 25, Facilities Center, 548 Shaw Boulevard, Mandaluyong City, its home.

In **July 1994**, the society participated in the annual observance of **Diabetes**

Awareness Week, an activity that was spearheaded by the Philippine Center for Diabetes Education Foundation, Inc. (PCDEF/Diabetes Center). From then on, it became an annual event for the PDA as well.

The guru's legacy is continued

In 1995, under Dr. Mary Anne Lim-Abraham's leadership, the PDA co-hosted with PSEM the 8th AFES Congress at the Philippine International Convention Center.

In 1996, the PDA started to participate in the annual convention of the Philippine Lipid Society (PLS) and the Philippine Society of Hypertension (PSH).

In 1997, Dr. Lina Lantion-Ang succeeded Dr. Lim-Abraham as president, and during her term the PDA participated for the first time in booth exhibits at the International Diabetes Federation (IDF) and International Diabetes Federation Western Pacific Regions (IDFWPR) congresses. From that time on, the PDA has participated and showcased its activities, without fail, in every congress of the two big groups.

In 1998, the PDA joined forces with the PSH and PLS in putting up seed money to conduct the Hypertension, Diabetes and Lipid (HDL) Survey, in cooperation with the Food and Nutrition Research Institute - Department of Health (FNRI-DOH).

New millennium ushers in a strong PDA

In 2001, during the term of Dr. Ruby T. Go, the Mission and Vision of PDA were formulated. The PDA website, www.diabetesphil.org, was launched. To encourage local research, PDA research grants were offered to qualified applicants.

On **February 17-21, 2002**, the Third

Congress of the Asia Pacific Society of Atherosclerosis and Vascular Diseases (APSVD) was held at the Waterfront Hotel in Cebu City. The PDA actively participated in it.

Also worth-mentioning was PDA's coordination with PCDEF (Diabetes Center Philippines) in the International Diabetes Federation's (IDF's) **Adopt a Child with Diabetes** project.

Busy Rosa Allyn Sy

2003 was a particularly hectic year for the PDA. Under the guidance of its new president, Dr. Rosa Allyn G. Sy, the PDA Mission and Vision were incorporated into the association's by-laws.

A diabetes advocacy campaign, highlighted by the signing of a memorandum of agreement by the PCDEF, PDA, and Johnson and Johnson Medical Philippines on "D" **Fight Diabetes**, was held on May 7, 2003 at the Richmond Hotel, Pasig City.

Other activities of the association in 2003 were (1) participation in the International Committee of the Diabetes Magazine (ICDM) Congress in Versailles, France on August 21 - 23; (2) participation in the IDF Association Village during the 18th World Diabetes Congress in Paris France on August 24-29; (3) participation in, and active contribution to, the Research on National Nutrition and Health Survey (NNHES).

Still in 2003, four big organizations, the PDA, PSEM, PCDEF and the ISDFI, after several meetings with the

Secretary of Health and BFAD released a **consensus statement** on the use of AMPALAYA in the management of diabetes mellitus.

On October 15 - 16, 2004 the PDA scored another "first" when it held the 1st Course on Diabetes and Vascular Disease at Century Park Hotel, Manila. The activity was organized by the PDA Council on Complications and jointly sponsored by the Giovanni Lorenzini Medical Foundation, Milan Italy, and Texas, USA, the International Atherosclerosis Society (IAS) and the Asia Pacific Society of Atherosclerosis and Vascular Disease (APSVD).

On November 23, 2004, the 1st PDA Award of Excellence in Diabetes was bestowed on Dr. Augusto D. Litonjua during the annual convention of the association.

PDA key goes to Plata-Que

Dr. Ma. Teresa Plata-Que, began her term in 2005. Bringing PDA out to public awareness was a significant

accomplishment as PDA engaged tri-media to meet this goal. A short TV commercial "Deadly ang Diabetes Campaign" was aired during the 2005 Diabetes Awareness Week.

In early 2006, in support of the Department of Health's Healthy Lifestyle Campaign, PDA developed 5 healthy lifestyle messages: Eat Right, Exercise, Relax, Watch your Waist and Don't Smoke. On November 4-5, 2006, in a bid to reach a greater number of people, PDA held the "Diabetes Expo" at the SM Megatrade Hall.

Another activity was the 2nd Course on Diabetes and Vascular Disease, pet project of the Council on Complications, and made possible by the same organizations that sponsored the first course.

On October 25, The PDA joined the Philippine Lipid and Atherosclerosis Society (PLAS) in the Coconut Summit.

Dr. Plata Que's last act as president was the society's participation in the exhibition at the Global Village of the

International Diabetes Federation, on December 2-7, 2006 at the International Convention Center in Cape Town, South Africa.

Tough job at my doorstep

In 2007, I succeeded Dr. Plata Que as president. On May 26 that year the society was recognized and awarded as the **Most Outstanding Affiliate Society** of the Philippine Medical Association.

On July 12 - 13, the 1st **Unite for Diabetes** meeting was held at the Crowne Plaza Galleria Manila. It was initiated by the PDA with the support of PSEM, ISDF, and the PCDEF. Among those present during the successful 2-day scientific event was the current IDF president, Professor Martin Silink, and the presidents and officers of the 4 major societies.

In 2007 too, the PDA was the major sponsor of the Philippine Cardiovascular Disease Outcome Study (PhilCOS) - Diabetes Mellitus Arm, an 8-year research on the incidence of diabetes mellitus, taken from the 1998 Food and Nutrition Research Institute - National Nutrition Surveys (FNRI-NNS) and covering 6 regions. The study was headed by Dr. Rody G. Sy.

On November 11, the PDA, together with PSEM, ISDFI, PCDEF, Philippine Association of Diabetes Educators (PADE), Philippine Society of Pediatric Metabolism and Endocrinology (PSPME), and the Consortium of Government Diabetes Clinics, in cooperation with Therapharma and broadcast media ABS-CBN, hosted the GIMIK DIABETES, a day of lectures and entertainment, at SMX Convention Center. More than 1000 attendees participated.

On November 13 - 14, I as chairman and president of the PDA, and Dr. Editha Arceo-Dalisay, as vice chairman and vice president, represented the society in the 1st United Nations-led observance of World Diabetes Day at the UN Headquarters, New York, USA.

On November 20 - 21, the PDA annual convention for the first time bestowed on two well-known scientific researchers two **endowed lectureship awards** in honor of the two great pillars of Philippine Diabetology. Professor Hannele Yki-Jarvinen, Professor of Medicine, University of Helsinki, Finland was the recipient of the 1st Dr. Augusto D. Litonjua Endowed Lectureship



Award. On the other hand, Dr. Rody G. Sy was the recipient of the 1st Dr. Ricardo E. Fernando Endowed Lectureship Award.

2008, the 50th year of the PDA's foundation turned out to be another busy and memorable year for the organization. On January 23 the board made three important decisions. One, it repackaged the corporate profile of the association to make it more attuned to the current situation. The new corporate name of the society is now **Diabetes Philippines**. Two, it revised the PDA the Mission and Vision. Three, it adopted a new corporate logo, composed of a stylized human form and an extended arm. These changes were submitted to the members, for ratification, and then to the Securities

and Exchange Commission (SEC), for approval. SEC's imprimatur was given on September 9, 2008.

On August 25, a workshop tasked to formulate the *Clinical Practices Guidelines on Diabetes* was conducted. This was a joint venture of the PDA, PSEM, ISDF and Diabetes Center.

More activities took place in November and December. During the 25th PDA annual convention last November 11, Dr. Ricardo E. Fernando received the **PDA Award of Excellence in Diabetes**. The 2nd Dr. Ricardo E. Fernando Endowed Lectureship and the 2nd Dr. Augusto D. Litonjua Endowed Lectureship were delivered. On the first night of the two-day convention, the *President's Reception* was held to celebrate the society's 50th anniversary, while on the following night, November 12, the society hosted a fellowship dinner.

On December 2 and 3, the 4th Course on Diabetes and Vascular Disease were held. On December 3, the annual Christmas and Appreciation party of the association took place.

Even as the Philippine Diabetes Association celebrated its 50th birthday last year we are proud of the fact that it has zealously guarded and maintained its dynamism. It has become proactive, dedicated, and a selfless protector of the people's health. More importantly, it remains a staunch guardian of people with diabetes and their families. Amid the fast changing lifestyles of Filipinos, the organization expects bigger challenges as it continues battling the disease, but with the able guidance of its officers, and the wholehearted cooperation of all its members, it will succeed in its altruistic mission. 



PDA TURNS GOLD



2008: THE YEAR PDA TURNED GOLD

Jorge Ty, MD
Metropolitan Medical Center

The 50th founding anniversary of an organization like the 50th birthday of a person is celebrated, if not with pomp and pageantry, in a very special manner at least. That is understandable, for not every person or organization is given the chance to reach that milestone. In the case of the Philippine Diabetes Association, or what is now Diabetes Philippines, that important point in its development came last year, and as expected, the organization did not let it pass unnoticed. On the contrary the PDA board of directors, led by President Tommy S. Ty Willing, lined up several activities to fittingly commemorate the occasion.

The first of such activities was an

appreciation dinner, held last October 18, 2008 at Yurakuen Restaurant, Diamond Hotel, Manila. That night, the PDA acknowledged the officers and members of pharmaceutical companies who served as board members of the association at one time or another during the past 50 years. In recognition of their individual services, the PDA not just treated them to a hearty meal but awarded appropriate medals to each of them.

Then on November 11, Dr. Tommy Ty Willing, hosted the President's Reception, at the Crowne Plaza Ballroom, in Mandaluyong City. The very formal affair started with cocktails, and an animated exchange of pleasantries and photo ops with and

among the arriving guests.

At 7 pm on the dot, thanks to the protocol-conscious and stickler-for-punctuality president, guests were ushered into the ballroom, and, with everybody was seated, Dr. Ty Willing delivered his welcome remarks.

In his short speech, Dr. Ty Willing attributed the remarkable staying power and longevity of PDA to the men and women who led it in succession during the half century that it has been operating. As Dr. Ty Willing aptly put it, "The trends they (the PDA leaders) set designed and marked the footprints of achievement, with each footprint creating inroads towards progressive paths in education, research, networking and advocacy."

Right after the president's speech, an elegantly-prepared video presentation appeared on two big screens, and the long history of the PDA was chronologically presented, its milestones aptly highlighted.

After the video presentation, PDA Vice Chair and Vice President, Dr. Editha Dalisay, formally recognized PDA's leaders, from Dr. Wenceslao Vitug to Dr. Ty Willing, the incumbent president. Many (Dr. Vitug, Dr. Basilio Valdez, Dr. Agustin Liboro, Dr. Paolo Campos, Dr. Carmen Salgado-Ora, Dr. Gonzalo Austria, Dr. Sergio Rustia, Dr. Lim Uy Ching, Dr. Virgilio Gonzales, Dr. Leland Villadolid and Dr. Flora Pascasio, Dr. Nestor Santiago, Dr. Lina Lantion-Ang and Dr. Mary Anne Lim-Abraham), did not make it to the affair, for different reasons. Some have long reported to the Great Beyond. Others (Drs. Rustia and Gonzales) are based abroad. Two relatively recent past presidents, Dr. Lina Lantion-Ang and Dr. Lim-Abraham, were fulfilling equally-important commitments. Dr. Santiago was in his sick bed. Yet, those who were not around shared the limelight just the same with the other past presidents who were physically present, even if just in the minds and hearts of the PDA members.

But Dr. Aurora Villegas Cinco was there.

So were Dr. Herminio Germar, Dr. Augusto Litonjua, Dr. Ruby Go, Dr. Rosa Allyn Sy, Dr. Ma. Teresa Plata-Que, and the incumbent of course. All those present received a medallion from Dr. Ty Willing, while Dr. Ty Willing himself received his medallion from his mentor, Dr. Augusto D. Litonjua.

Next to receive a plaque of appreciation was Dr. Jorge Ty, a medical colleague who edited the commemorative magazine PDA at 50.

Then, the members of the board of directors, both past and present, received their respective medallions from the incumbent PDA president "in acknowledgment of the support they gave in charting the dreams, goals and objectives of PDA." Immediately thereafter, Dr. Ty Willing proposed a toast to the honorees "That they may serve as examples of leadership to those who will follow them, and...so that their commitments and ideals may serve as beacons of courage, hope and wisdom to their co-workers in the organization."

Another video presentation followed to formally introduce the new name of PDA and to unveil its new logo, and when the two videos were through, members of the Manila Dance Center appeared on stage and performed a dance number to the tune of Reach Out and Touch. Then they moved downstage and distributed flaglets to the audience.

After dinner, Ballet Manila and Manila Dance Center Company (composed of gifted and specially-trained children, from financially-challenged families, and mentored by master dancers and choreographers Luther Perez and Tony Fabella) entertained the audience with six dance numbers, namely, ALLEGRO (Lisa Macuja and six boys, plus MDC Dancers), DALAGANG PILIPINA, BEAUTIFUL LIFE with MDC, MAGANDANG GABI, SANAY WALA NANG WAKAS (Lisa Macuja) and TAMBOL AT PADYAK (BM and MDC Dancers).

Finally, at the fellowship party that was held the following night, PDA corporate members and PDA chapters were awarded plaques of recognition. In addition, each PDA chapter was given the new Diabetes Philippines banner, and the PDA Camarines Norte Chapter bagged the 2008 PDA Chapter of the Year Award. On hand to receive

the plaque was Dr. Luis Palencia, president of the winning chapter.

The entertainment portion had Club Mwah as performers.

All things considered, the celebration of the PDA's 50th anniversary was a resounding success. 



Photo taken at the appreciation dinner for, and awarding of medals to the past PDA board members from pharmaceutical companies, held last October 18, 2008 at Yurakuen Restaurant, Diamond Hotel, Manila. First row from left: Mr. Gilbert Donato, Mr. Jong Abad, Mr. Tony Ancheta, Mr. Erick Adarve, Dr. Ruby T. Go, Ms. Mariposa Genato, Dr. Tommy S. Ty Willing, Dr. Augusto D. Litonjua, Mr. Edgar Zaragoza, Dr. Siaksoan Chan-Cua, Mrs. Ma. Imelda Q. Cardina, Mrs. Sanirase S. Orbeta and Mr. Ammieto Bacus. Second row from left: Ms. Barbie Syypap, Ms. Pauline Espiritu, Ms. Nemila Jason, Ms. Evangelina Reyes, representative from Corbridge Ms. Sheryl Balilo, Ms. Vangie de Jesus, Ms. Mariowee Ngo, Ms. Marian Andaluz, Dr. Cynthia Halli-Manabat, Dr. Editha Arceo-Dalisay, Ms. Josephine Padua, Ms. Lou Galang, Ms. Odette Magno.



Pictures taken at the Cocktail Party preceding the President's Reception last November 11, 2008.



Other pictures taken at the Cocktail Party preceding the President's Reception last November 11, 2008.



At the awarding of medals to PDA Presidents, November 11, 2008. From Left: Dr. Editha-Arceo Dalisay, Dr. Aurora Villegas-Cinco, Dr. Hermilio Germar, Dr. Augusto D. Litonjua, Dr. Ruby T. Go, Dr. Rosa Allyn G. Sy, Dr. Ma. Teresa Plata-Que and Dr. Tommy S. Ty-Willing. Not present: Dr. Frances Lina Lantion-Ang and Dr. Mary Anne Lim-Abraham.



At the medal awarding ceremony, past and current PDA board members pose with President Tommy Ty-Willing and Dr. Editha Arceo-Dalisay. Not present during the awarding were Dr. Cynthia Halili-Manabat & Dr. Elizabeth Paz-Pacheco.

PRESIDENT'S RECEPTION, November 11, 2008, featuring Ms. Lisa Macuja, with Ballet Manila and the Manila Dance Company.





PDA AT 50 MAGAZINE - released during the President's Reception held last November 11, 2008 at Crowne Plaza Galleria Manila



Drug representatives from Philippine Blue Cross Biotech Corp., Therapharma, Scigen, Servier Philippines, Solvay Pharma, Sanofi-Aventis, Novo Nordisk, Natropharm, Merck, GlaxoSmithKline, Bole Takeda, Becton Dickinsons, Bayer Philippines, Tenunio, LRI and Abbott. oblige a photo op with Dr. Tommy S. Ty Willing and Dr. Editha Arceo-Dallsay, after receiving plaque of recognition for their respective companies last Nov. 12, 2008. The representatives of Eli Lilly, Johnson & Johnson, Boehringer Ingelheim, Merckant, Pfizer and Roche were absent.



AT THE AWARING OF PLAQUES OF RECOGNITION TO PDA CHAPTERS, November 12, 2008. Photo shows, from left: Dr. Concepcion Pizarro-Noche (Capiz Roxas Chapter), Dr. Evelyn Gamallo (Cebu), Dr. Theresa Marie V. Folter (Batangas), Dr. Jubilla Balderas (Pangasinan), Dr. Jose Cape (Albay), Dr. Editha Arceo-Dallsay (Diabetes Philippines, Vice-President), Dr. Tommy S. Ty Willing (Diabetes Philippines, President), Dr. Josefa Yanga (Bulacan), Dr. Francis Pasaporte (Iloilo), Dr. Cosme (Laguna), Dr. Paul Luis Palencia (Camarines Norte), Dr. Maria Lourdes Reyes-Gonzales (Lucena), Dr. Nick Vilatuya (Pasig), and Dr. Liduvina Dorion (Sorsogon).

Dr. Paul Luis Palencia (right), president, PDA Camarines Norte Chapter, receives Drs. Tommy Ty Willing and Editha Arceo-Dallsay the CHAPTER OF THE YEAR AWARD plaque, on behalf of his chapter. The awarding took place on November 12, 2008.



Club Mwah performers give their all at the Fellowship Night of Diabetes Philippines' 25th Annual Convention, Nov. 12, 2008.



THE 25TH PDA ANNUAL CONVENTION: A RESOUNDING SUCCESS

Jorge Ty, MD
Metropolitan Medical Center

The 25th annual convention of the Philippine Diabetes Association was held last November 11-12, 2008 at the Crowne Plaza Hotel, Galleria Manila. The two-day scientific event had for its theme **PDA Turns Gold** to emphasize the fact that the organization was simultaneously celebrating the fiftieth anniversary of its founding.

On the first day of the convention, the 2nd Award of Excellence in Diabetes was bestowed on Dr. Ricardo E. Fernando. The award was first launched on November 23, 2004, during the PDA convention that year, "to honor any member of the association who had contributed in its success and advancement." The first awardee was Dr. Augusto D. Litonjua, himself a prime mover of PDA.

The scientific part of the 2008 convention had a total of 29 topics, including *Oxidative Stress in Diabetes Mellitus*, the subject matter of Australian Professor Richard O'Brien's lecture. Professor O'Brien, the lone international speaker, is clinical dean of the Austin Northern Schools, University of Melbourne. He is an endocrinologist, an associate professor of Medicine at the University of Melbourne, and a visiting scientist at the Baker Heart Research Institute.

At the same convention, the delegates had the good fortune of being able to listen to two Endowed Lectureships that were delivered by no less than the two acknowledged pillars of Philippine Diabetology—Dr. Ricardo E. Fernando and Dr. Augusto D. Litonjua. Dr. Fernando gave the 2nd Dr. Augusto D. Litonjua Endowed Lectureship on

November 11, the first day of the 2-day scientific event, entitled "Upstream Recognition of Diabetes." The next day, November 12, Dr. Litonjua "returned the favor" by giving the 2nd Dr. Ricardo E. Fernando Endowed Lectureship. He discussed "The Changing Landscape of Type 2 Diabetes Etiology: Time to Modify Management Paradigms." Both Dr. Fernando and Dr. Litonjua are well-known in the Philippine medical community and abroad. Both have impeccable credentials as teachers, lecturers, and researchers, and both are devoted family men. Both have held many positions in the academe and have been responsible for founding many organizations. It goes without saying that both are recipients of multiple awards, and they in fact continue to reap some more.

The PDA Endowed Lectureships are supported by unrestricted educational grants from Servier Philippines, LRI, Therapharma and Merck Inc.

Some research grant awardee research papers were also presented, including, *The Predictive Value of HbA1C Measurement in Detecting Type 2 Diabetes Among Individuals with Non-Diagnostic Fasting Glucose*, by Dr. Rebecca Lim-Alba, *Prevalence of Biochemical Hypogonadism Among Type 2 Diabetic Male Filipinos: An Age-matched Case Control Study*, by Dr. Alpeniano Fuertes, *Effects of the Use of Locally-Available Cane Vinegar on the Glucose Response on Healthy Subjects*, by Dr. Ma. Cecilia Gonzales, and, *Association of Waist-Height Ratio and Insulin Resistance Among Adolescents*, by Dr. Eve Fernandez.

Other topics, including those discussed during the two company-sponsored lunch symposia, tackled updates in the prevention and treatment of diabetes and its complications, and other topics related to the chronic illness.

NEW PDA BOARD ELECTED

By: Dr. Jorge Ty

The 25th PDA annual convention last November 11-12 saw the election or re-election for many of the members of the association's board of directors for the year 2009-2010. The lucky 9 who got the members' endorsement and nod include: Dr. Tommy S. Ty Willing, Dr. Editha Arceo-Dalisay, Dr. Elizabeth Paz-Pacheco, Dr. Susan Yung-Gan, Dr. Gabriel Jasul, Jr., Dr. Richard Elwynn Fernando, Dr. Rima Tan, Mrs. Ma. Imelda Q. Cardino and Mrs. Sanirose Orbeta.



After delivering the 2nd Augusto D. Litonjua Endowed Lectureship on November 11, 2008, Dr. Ricardo E. Fernando, left, receives a medal from Dr. Litonjua himself.



At the 2nd PDA AWARD OF EXCELLENCE IN DIABETES awarding ceremony on November 11, 2008, "Tatay" Ric (Dr. Ricardo E. Fernando) poses with Drs. Tommy S. Ty Willing and Editha Arceo-Dalisay, top officers of Diabetes Philippines.



Dr. Augusto D. Litonjua bends a little as he receives a medallion right after delivering the 2nd Dr. Ricardo E. Fernando Endowed Lectureship on Nov. 12, 2008. "Doing the honors" is Dr. Fernando himself.

Finally, a new name and logo for PDA

Jorge Ty, MD
Metropolitan Medical Center

It's official: What formerly was Philippine Diabetes Association in now Diabetes Philippines, and, as expected, she now carries a new logo. The change in name formally took place last November 11, during the first day of the 25th PDA annual convention, or more specifically, during the president's evening reception for a select group of guests. In that gathering, a well-crafted video presentation detailed the rationale for the change in name, in line with an earlier decision of the organization's board to repackage her corporate profile "to keep her attuned to the current situation". Of course, with her new baptism came a revised mission and vision, a new logo, and even a new e-mail address: diabetesphilippines@pltdsl.net.

The new logo was repeatedly featured and shown during the evening reception, especially its metamorphosis from a composite of a "snake entwined around the rod as a symbol of the medical profession, a cup that represented knowledge of diabetes, and a beehive that depicted honey, or diabetes itself, to the family-focused figure of the Litonjua-modified logo, and finally, to the family figure being transformed into just one figure and stretching its extended arms as though reaching out to all stakeholders.

With the changes now in place, the dream of the leadership of PDA to have the association's corporate profile repackaged is now realized. 



NEW NAME AND LOGO OF PDA. Introduced and unveiled last November 11, 2008.

Diabetes Philippines
Unit 25 Facilities Centre, 548 Shaw Boulevard
Mandaluyong City, 1550 Philippines
Telefax : (632) 531-1278; Tel.No.: 534-9559
Email Address: diabetesphilippines@pltdsl.net
Website: www.diabetesphil.org

World Diabetes Day: How Diabetes Philippines celebrated it

Jorge Ty, MD
Metropolitan Medical Center

World Diabetes Day, a red, or rather, blue-letter day for diabetes-focused organizations worldwide was celebrated by Diabetes Philippines (formerly Philippine Diabetes Association) through a series of activities that began as early as September 2008. That month, multi-colored World Diabetes Day posters, prominently displaying the words "No child should die of diabetes-the theme of this year's celebration-were released and posted at different hospitals and clinics around the country. Also on the same month, the PDA started distributing, both to drivers of public utility vehicles and to private vehicle owners as well, the World Diabetes Day car stickers TYPE MO? KAYA MO! The following month, World Diabetes Day tarpaulins were distributed to the different PDA chapters and posted in different diabetes clinics, barangay health centers and hospitals.

On November 7, the Bring Diabetes to Light Poster Illustration Contest, a project of Diabetes Philippines in cooperation with the Philippine Center for Diabetes Education Foundation, Inc (Diabetes Center Philippines) and Servier Philippines, which was launched on October 6, 2008 for 10 to 18 year-old students, and had a total of 63 entries, was concluded, with the winning entries selected at the Servier Philippines main office in Makati City. The winners were however officially known only last November 15, at SM Megamall, Cinema 4, during Diabetes Philippines' lay convention's GIMIK DIABETES. There, they received their awards.

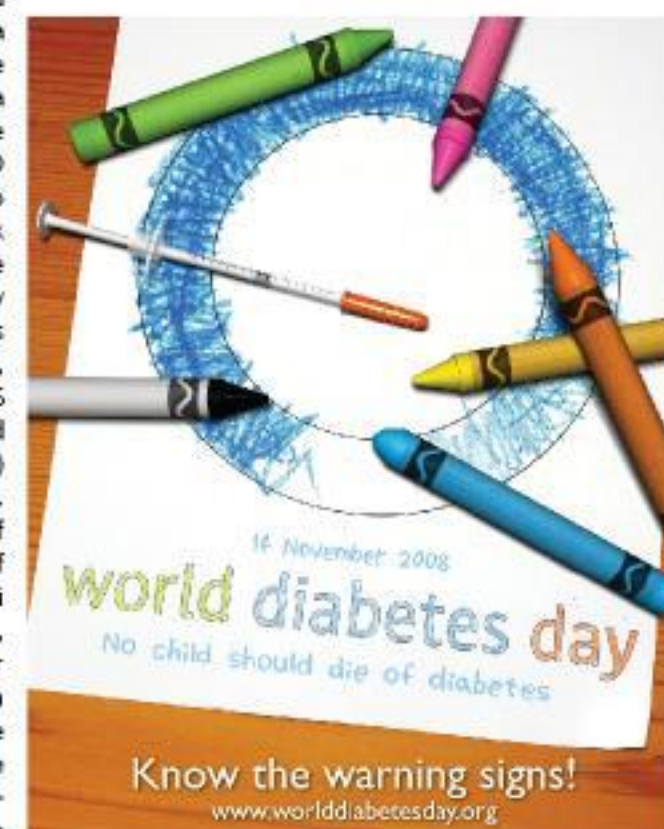
Also in connection with the celebration of World Diabetes Day, Pres. Tommy S. Ty Willing, as well as Diabetes Philippines board members, Dr. Susan

Yu-Gan and Mrs. Ma. Imelda Q. Cardino, were interviewed on separate occasions, on DZMM Teleradyo, DZMM Radio Patrol, and in the TV Program *Salamat Doc*, and they tackled various topics related to the dreaded disease.

On November 11, a World Diabetes Day advertisement appeared in the Philippine Daily Inquirer. Through it, Diabetes Philippines and some of its corporate partners invited the public to join them in the Bring Diabetes to Light illumination of several buildings and monuments in Metro Manila and other cities. On that same day, Diabetes Philippines and the Department of Health, in cooperation with Merck Sharp and Dohme conducted a press conference at the Crowne Plaza Galleria Manila regarding the November 14 WDD celebration. Those who spoke during that talk with mediamen were Dr. Tommy S. Ty Willing, Diabetes Philippines president, Dr. Rody Sy, PLAS (Philippine Lipid and Atherosclerosis Society) past president, Dr. Yolanda Oliveros of DOH (Department of Health), and Ms. Angeli Valenciano, trustee, Diabetes Center Philippines. Also in that same event, blue candles were lit by the attendees. Similarly-colored candles were distributed to the delegates of the 25th PDA Annual Convention on November 11 and 12-as well as the guests

of 50th Anniversary Celebration of the PDA-with the instruction that they be lighted on November 14. World Diabetes Day button pins were also distributed during the convention, and World Diabetes Day stickers were pasted on the plastic wrappers of Gardenia and Walter bread and Eng Bee Tin *hopia* that were sold during the week-long celebration of World Diabetes Day.

On November 13 to 19, a *Mall Animation Display* was held at the SM Megamall Bldg A activity area. There, free blood pressure check and fat analysis were offered by Omron, free blood sugar testing, by Abbott,



Thousands of World Diabetes Day posters like this one were released and posted at different hospitals and doctors' clinics nationwide in celebration of World Diabetes Day

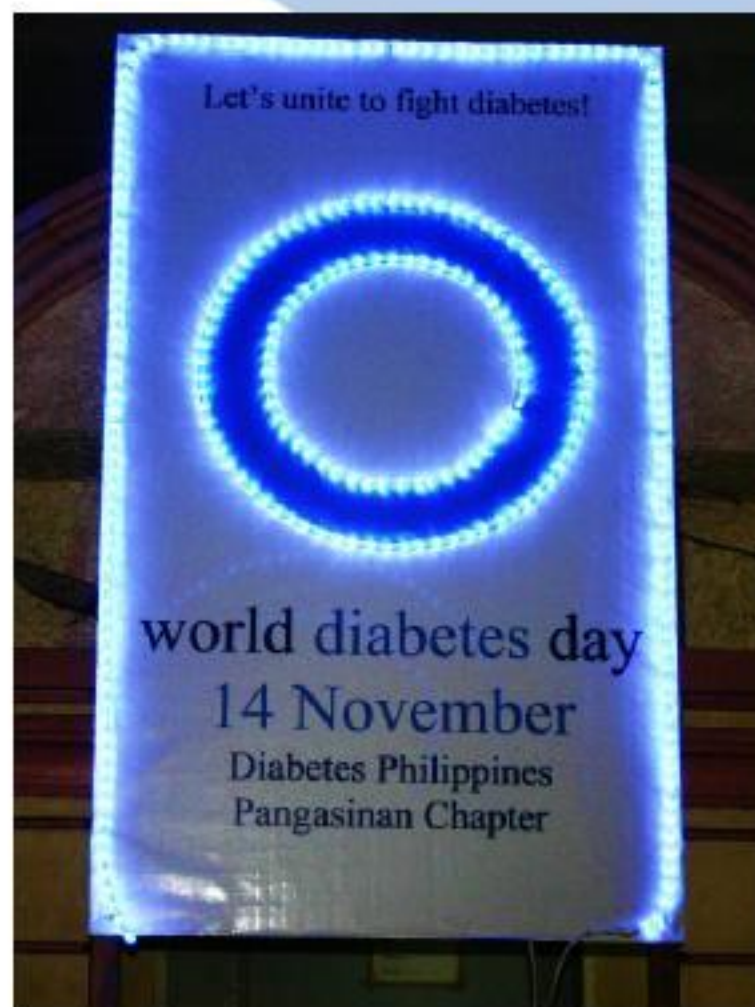
Philippine Blue Cross, Fernando Medical Enterprises, Inc and Johnson and Johnson. Similarly, bread and artificial sweeteners were distributed for sampling by Gardenia Bakeries, Creative Bakers (Walter bread) and Merisant Sweeteners.

Then on November 14, or on World Diabetes Day itself, several activities also took place. In Las Pinas City, the Diabetes Educational Center of the University of Perpetual Help Delta System Medical Center, participated in an activity that is actually done worldwide called "Global Diabetes Walk." In Mandaluyong City, 120 students from the Rizal Technological University formed a human blue circle to mark the occasion. Students in Kidapawan, North Cotabato did the same. Then in the evening of the same day, many buildings, landmarks and monuments, specifically, the ABS-CBN Building, Cultural Center of the Philippines, GMA 7 Network Tower, Mandaluyong City Hall, the Manila City Hall Clock Tower, Pasay City Hall, the Imperial Palace Suites in Quezon City, the Main Entrance of Tiendesitas in Pasig City, the University of San Jose-Recoletos in Cebu City, and the Tabaco City Hall and the Battle of Legaspi Monument, both in Albay, were lighted in blue to show the support of their respective managements, and those of some local executives, for the *Bring Diabetes to Light* campaign. At One Esplanade in Pasay City, Servier Philippines, on the occasion of the launching of "ADVANCE" study had its guests light blue candles. At the Araneta Coliseum in Quezon City, during Gary Valenciano's Gary V Live at 25 concert, the WDD blue circle was launched and WDD stickers were given to those who attended.

Finally, on November 15, at the annual lay convention of Diabetes Philippines, "GIMIK Diabetes Year 2" was held at the SM Megamall Bldg A, Cinema 4. On that occasion, lectures on diabetes were conducted, and the attendees were made aware of the WDD's blue circle.



World Diabetes Day car stickers (TYPE MO? KAYA MO!) were distributed last September 2008 to PUV drivers and private car owners, including healthcare professionals.



A sample of the World Diabetes Day tarpaulins that were released in October 2008 and displayed at PDA chapters, diabetes clinics, barangay health centers and hospitals.



This World Diabetes Day advertisement appeared in the Philippine Inquirer last November 11, 2008.



Dr. Tommy S. Ty (extreme right), Dr. Rody Sy, DOH's Dr. Yolanda Oliveros (2nd from right), Ms. Angel Valenciano (2nd from left), and Ms. Precy Cuevas of DOH, light their WDD blue candles during the press conference held at the Crowne Plaza Galleria Manila on November 11, 2008. The affair was a joint undertaking of Diabetes Philippines and the Department of Health, in cooperation with Merck Sharp and Dohme.



Other attendees of the November 11 press conference light their respective blue candles too.



WORLD DIABETES DAY BLUE CANDLES and BUTTON PINS - given during the 25th PDA Annual Convention and PDA 50th Anniversary Celebration on November 11, 2008.



World Diabetes Day stickers adorn the plastic wrappers of Gardenia and Walter Bread during the week-long celebration of World Diabetes Day.



At the MALL ANIMATION DISPLAY, SM Megamall Bldg. Activity Area, Dr. Ruby Lim-Ty Wiling and Dr. Tommy Ty-Walling (2nd from right and extreme right), pose with the staff of Diabetes Philippines. Mall Animation Display was held last November 13 to 19, 2008.



Personnel of the University of Perpetual Help Dalta System Medical Center (Diabetes Educational Center) in Las Pinas City participate in the Global Diabetes Walk in celebration of World Diabetes Day. The event took place last November 14.



Participants of the GLOBAL DIABETES WALK in Las Pinas City, all in WDD celebration-relevant blue uniforms, gamely pose, with the facade of one of their university's edifices as backdrop.

120 students from the Rizal Technological University in Mandaluyong City form a human blue circle during the celebration of World Diabetes Day on November 14, 2008...



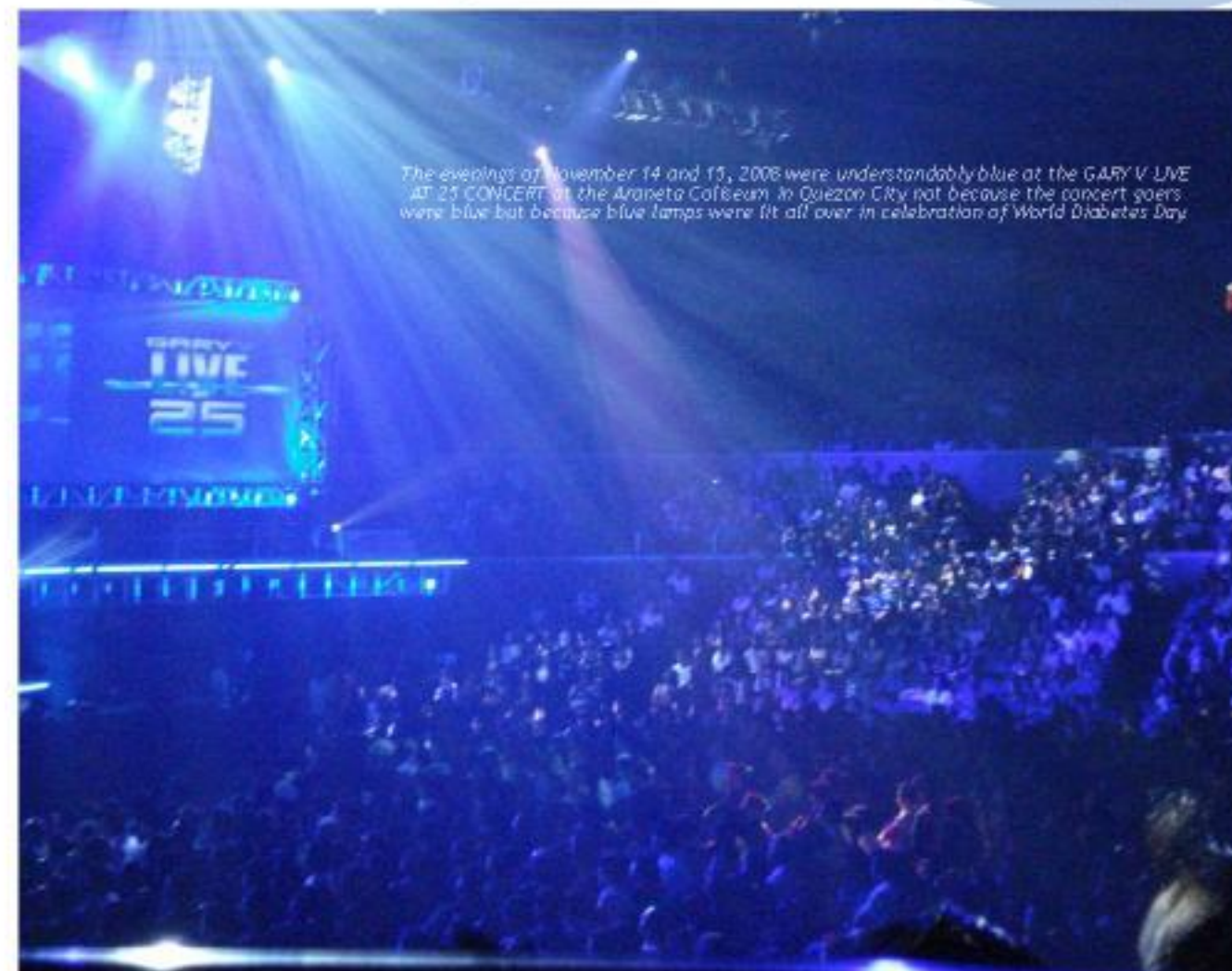
...So do students of Kidapawan, North Cotabato



At the GARY V LIVE AT 25 CONCERT (Araneta Coliseum, Quezon City, November 14-15, 2008), popular singer-actor, UNICEF ambassador and Type 1 diabetic Gary Valenciano, (5th from right), wife Angeli to his right, and son Paolo, (extreme right), take time out to pose with PDA officers and staff.



The evenings of November 14 and 15, 2008 were understandably blue at the GARY V LIVE AT 25 CONCERT at the Araneta Coliseum in Quezon City not because the concert goers were blue but because blue lamps were lit all over in celebration of World Diabetes Day.

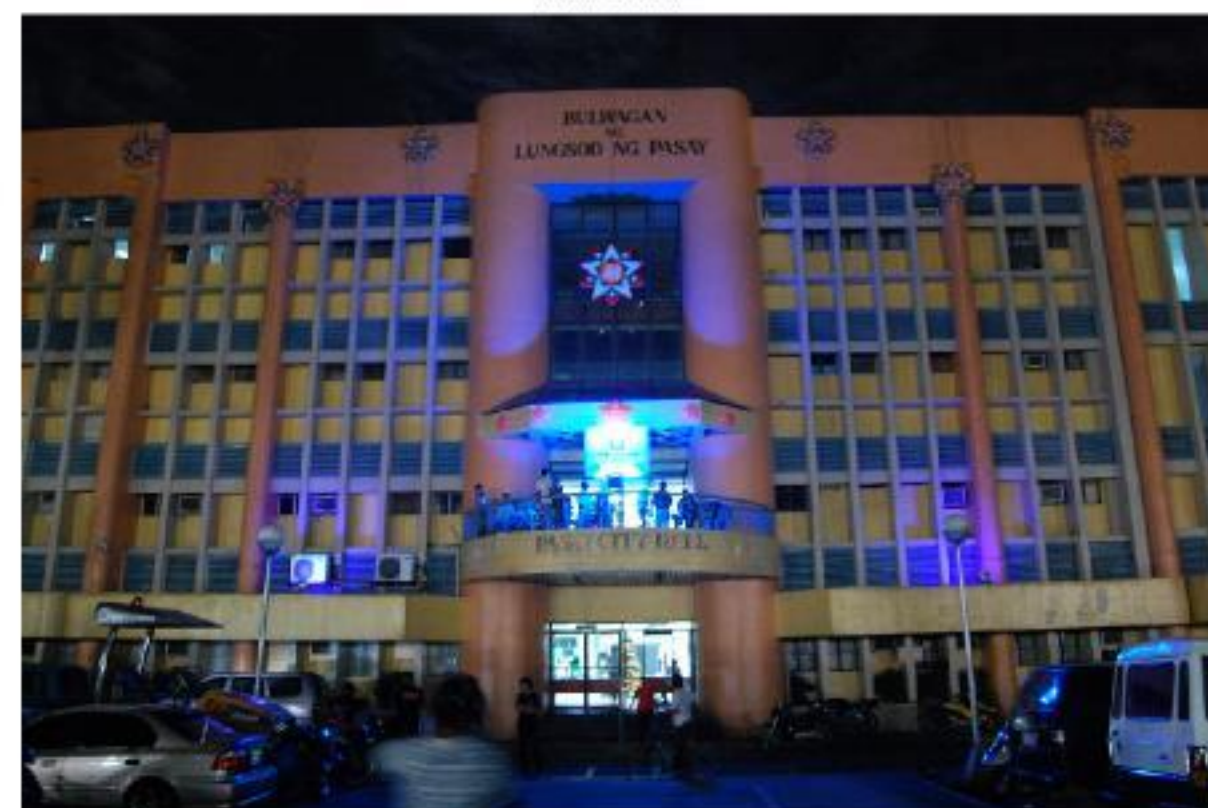


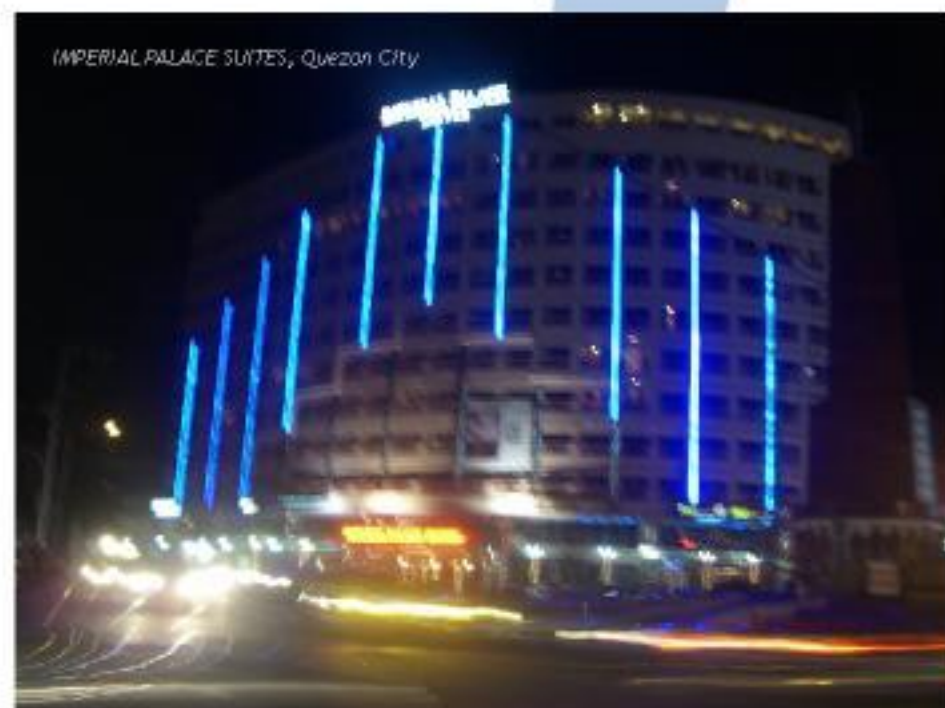


Landmarks and edifices that were lighted blue on the night of November 14, 2008 to let everyone know that it was World Diabetes Day.



PASAY CITY HALL





IMPERIAL PALACE SUITES, Quezon City



TIEN DESITAS MAIN ENTRANCE LANDMARK, Pasig City



UNIVERSITY OF SAN JOSE - RECOLETOS, CEBU CITY

Landmarks and edifices that were lighted blue on the night of November 14, 2008 to let everyone know that it was World Diabetes Day.

People of Tabaco City light a candle and witness the lighting up in blue of the Tabaco City Hall.



TABACO CITY HALL, ALBAY



Dr. Jose Cape, extreme right, president, Diabetes Philippines, Albay Chapter, pose with some of his members, with World Diabetes Day and Diabetes Philippines banners in front of them and a lighted-in-blue Legaspi Monument as backdrop.



ONE ESPLANADE, Pasay City

GIMIK DIABETES YEAR 2, held on November 15 during the lay convention of Diabetes Philippines in connection with WORLD DIABETES DAY, conducted lectures regarding the chronic disease, and made the participants aware of the blue circle symbol of WDD. Shown here are the prime movers of the activity, posing with Pres. Tommy S. Ty Wilting.



The Philippine Diabetes Association, Inc. in cooperation with the Philippine Center for Diabetes Education Foundation, Inc. (Diabetes Center Philippines) and Servier Philippines launched the Bring Diabetes to Light Poster Illustration Contest in October 2008 in line with the November 14 celebration of World Diabetes Day. Ms. Maxine Lorraine T. Ty, finalist from St Stephen High School, shows her work.



Young participants and finalists of the BRING DIABETES TO LIGHT POSTER ILLUSTRATION CONTEST pose with Diabetes Philippines president, Dr. Tommy S. Ty Wilting, (2nd from left), Mrs. Ma. Imelda Q. Cardino (extreme left), and Dr. Marilyn Villanuel of Servier Philippines, (extreme right).



The growing problem of diabetes in children

Rosa Allyn G. Sy, MD
Cardinal Santos Medical Center



Diabetes mellitus is a chronic disease that affects all ages. We have become accustomed to thinking of type 1 diabetes as a disease that commonly occurs in childhood and of type 2 diabetes as a disease that usually arises in the middle age. However in the last 2 decades the prevalence of type 2 diabetes in children is growing significantly around the world and is challenging the medical field not only because of the economic burden but more importantly, because of the public health implications of the disease which puts them at a greater risk to develop diabetes complications.

Type 1 diabetes is estimated to affect 110,000 thousand children in the Southeast Asia region and 25,000 in the Western Pacific region with the highest incidence rate in European countries like Finland and Sweden as reported by the IDF in 2007. In the small survey done by the Philippine Diabetes Association and Diabetes Philippines, an estimated incidence of type 1 diabetes mellitus in childhood and adolescent in Metro Manila is 0.6 / 100,000 in 1998 and 0.55 per 100,000 in 1999, while the prevalence rate is reported at 2.8 / 1000,000 among children 0-14 years of age.

Type 2 diabetes is appearing in younger and younger patients. This phenomenon is particularly well studied in the USA where the prevalence of childhood type 2 diabetes among 12-19 year olds is 4.1 / 100,000. In Japan they reported an incidence of 2.76 per 100,000 from

1981 - 2002. In the Philippines to date we don't have a registry as to the prevalence and incidence of type 2 diabetes in the country but anecdotal reports of clinical practitioners tell us that the number of children showing signs and symptoms of this condition confirmed by laboratory levels of greater than 126 mgs / dl is increasing. Although genetics and cultural factors play an important role and members of certain ethnic groups appear to be particularly prone to developing type 2 diabetes, the driving force behind this increased prevalence of type 2 diabetes are the lack of exercise, energy-rich diets and obesity that are characteristics of developed countries as well as the developing countries. Undoubtedly, the presence of excess fat in children that renders their insulin ineffective and deficient is the main culprit in the rapid rise of type 2 among children and adolescents.

Children with type 2 diabetes unlike type 1 diabetes do not present acutely. In fact some do not have any manifestations until they develop complications like headache, blurring of vision because of rising blood pressure or complains of difficulty in ambulation because of arthritis. Some may have frequent urinary infections or even skin infection. Most of obese children will show darkening of nape and armpits called acanthosis nigricans, which is an important indicator of insulin resistance and requires attention.

With the increasing rise of obesity

leading to type 2 diabetes and other metabolic problems like hypertension and dyslipidemia in children, there is no doubt that the management of obesity is becoming an urgent clinical priority globally.

The principal goal in the management of type 2 diabetes in children is to normalize blood glucose in order to reduce the risk of diabetic complications. Children with diabetes should be encouraged to adapt a healthy lifestyle - daily exercise or increasing physical activity of 45 to 60 minutes a day 4-5 x a week combined with healthy eating habits avoiding junk and processed foods is the cornerstone in the management of children with diabetes. However; since children are not small adults, strategies for the management of type 2 diabetes must be adapted for their particular needs.

For type 1 diabetes mellitus, children should be given insulin injections for survival and for growth and normal development. For type 2 diabetes oral medications may be enough to maintain normal glucose levels. Managing type 2 diabetes in children is a big challenge to both the physician and the family. A great balancing act of behavioral modification and medication use is the key to a successful management of diabetes mellitus in children. **D**

Partying with diabetes

Ma. Imelda Q. Cardino, MSN
Makati Medical Center (Diabetes Clinic)

When birthdays, anniversaries, graduation, awards.... the HOLIDAYS...are mentioned.... what comes to mind? PARTIES definitely!... an opportunity for families and friends to come together and have a marvelous time. If you happen to have diabetes, can you really, really look forward to PARTYING? A very, very big YES! This is simply a big challenge so all it takes is PLANNING AHEAD WITH CARE! In other words, BE PREPARED!

Here are a few practical tips:

Eat a healthy snack prior to leaving for the party. A fresh garden salad with some balsamic vinegar dressing sprinkled with low fat cheese and tuna flakes is nice.... or a whole wheat bread chicken sandwich with a light dressing and lettuce, cucumber, and tomatoes. Eating something before you attend a party will prevent you from overeating.

Anticipate the foods you will find in the party. This allows you to plan and thus avoid "unconscious eating".... that is, when the serving platter is passed or when you get to the buffet table, you get "automatically" and thus "obstruct" your conscious thinking to make a "healthy choice." Hence you end up with a little of everything that ends up a substantial something.

Wear clothes that fit well. Belts and well-fitting pants do not leave much room for "expansion".... hence you won't be tempted to overeat. Loose clothes would comfortably allow so much MORE room

for the anticipated added girth after a meal.

Know your own limits. Be aware of the choices and portions you put on your plate. After all, if your blood glucose shoots up to heaven then it is also you who will bear the consequences.... and the expenses as well!

Remember to check your blood sugar. Knowing your glucose level is important in order for you to plan appropriately your next course of action. If in case your glucose levels had gone way off target, simply pick yourself up and get on course again. Guilt-feelings or feeling depressed won't help put you back on track.

About an hour or so AFTER your holiday meal, do your regular exercise. This will help burn the calories you have taken. Follow the recommended guidelines on safe exercise.

Dessert, anyone? You know yourself better than anyone else. You know which desserts are more "agreeable" with you. Hence, select wisely and prudently. Be aware of the type and amount you are getting. Remember, you always have a choice.

This is a social event so SOCIALIZE! Move around, renew friendship, make new friends, get to know everyone better... "bond".... fully enjoy the company....and be less focused on the menu.

Cheers to the Holidays! If you do decide to take some alcohol, keep it to a maximum of one standard

drink if you are a female or two standard drinks if you are a male. Make sure it is taken WITH your meal. Keep in mind that since this is alcohol, it will interact with your medications hence the reason for keeping the amount within "safe" limits.

Water, water, and more water! This does not mean you cannot enjoy your favorite light/diet beverages but simply to remind you to take water. Water does not only aid digestion but it also makes you feel the meal is indeed satisfying.

Choose a "nutritious" meal. It is indeed a party....so why not enjoy yourself and at the same time promote your health, too. Choose a good mixture of vegetables and legumes, lean meat (seafoods, chicken, beef, pork, etc), and some complex carbohydrates (pasta, brown rice, or whole wheat bread). Try to shy away from too oily or greasy foods... or at least skim-off the fat and grease.

Be positive. Instead of dwelling on what you are better off avoiding, focus on all the other items you can take some of and enjoy. Think of all the advantages of wise choices. Remember what good effects appropriate choices will have on your overall well-being.

So.... even though keeping yourself focused on "healthy targets" through the holidays is definitely tough, it is still the BEST WAY to assure that the season is indeed going to be a FESTIVE ONE! HAVE A MARVELOUSLY HAPPY HOLIDAY! **D**



Again, Camp Cope, came in with a bang! May 1 to 4, 2008 were the dates and where was it held? Of course, in Forest Club, Bgy. Masaya, Puyupuy, Laguna. It was the 13th camp and oh, boy, we really had a lot of tricks and treats.

What were the highlights of the camp? Trick 1: to go up 3.5 kilometers reaching the Art Center of the Philippines in Los Banos and go down 3.5 kilometers to the bus. A trekking feat indeed. Most of the campers and counselors made it. The staff? Well, lets just say some degenerative knees couldn't stand it.

Trick 2: Getting really dirty and wet. Would you hold a slimy frog, run with it and then pass to your teammate? Would you crawl in mud with most of your body getting really dirty? Would you play a game of "Catch the dragon's tail ala Takeshi's castle" while being doused by a water gun? Answer of the campers and counselors: YES!!!

Trick 3: Injecting insulin for the first time. Some of our younger campers about the age of 8 had their first chance of injecting themselves with insulin. Of course, with the prodding and cheers of the counselors, fellow campers, and staff. Way to go kids! Your parents will be proud of



you. Starting them young \to cope with the diabetes life.

Trick 4: Iron Chef. All four groups had their chance of showing their skill of making a mouth watering, delicious, presentable, yet nutritious and diabetes friendly dessert.

Treat 1: Cooling off after a wet and dirty activity via enjoying the pool.

Treat 2: Learning the basic tools of coping with diabetes through rap sessions of insulin injection, glucose monitoring, and psychosocial issues.

Treat 3: Hearing from the "idols" talking about living with diabetes. Our inspirational speakers were Joby Belmonte and Trisha Maranon.

Treat 4: Halloween-in-Summer party. Last night of the camp was the most awaited. The theme of the party was patterned after the number 13. . Everybody had dressed up according to their group names: Frankies, Zombies, Vampies,



Camp Cope the 13th Tricks and Treats

Jose Carlos Miranda, MD
Our Lady of Pilar Medical Center

and Goblins.

Treat 5: Awards. Those deserving got free glucose meters, insulins, syringes. Congratulations!!!

Treat 6: Memories of fun, heartaches, laughter. New friends.

These are just a few of what happened for the past four days. We can't wait for next year for our 14th CAMP COPE. See you soon!!!!



4 million Filipinos have diabetes mellitus.*



A powerful commitment to their future

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