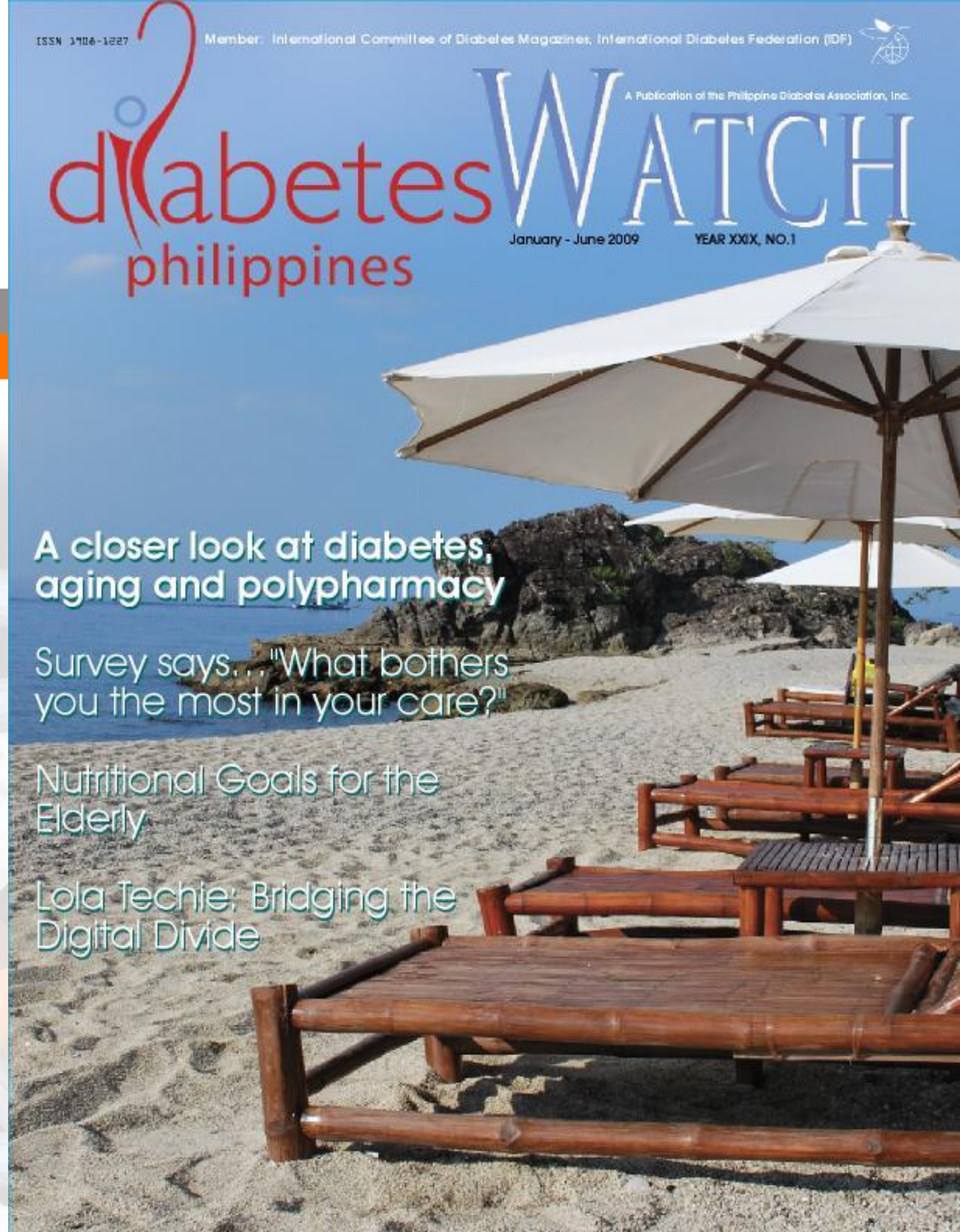
ISSN 1908-1227

Member: International Committee of Diabetes Magazines, International Diabetes Federation (IDF)

diabetes philippines WATCH

A Publication of the Philippine Diabetes Association, Inc.

January - June 2009 YEAR XXIX, NO.1



A closer look at diabetes, aging and polypharmacy

Survey says. . ."What bothers you the most in your care?"

Nutritional Goals for the Elderly

Lola Techie: Bridging the Digital Divide

From the EDITOR'S DESK

Welcome to another year of DMWatch!

This first issue of the year focuses on the elderly diabetic. How do we define elderly? Geriatric medicine has come to the forefront, providing special care to this age group. With medical advances, yes, we do see many diabetics advancing in age. I have several 80 plus and a few 90 plus year-patients, who continue to follow-up regularly and of course, many in their 60s and 70s. I have seen how families vary in their perspectives of caring for the elderly.

What are their concerns? This issue focuses on relevant topics, to name a few: the appropriate evaluation of the elderly diabetic patient; setting up glycemic goals and preventing hypoglycemia. One can learn a lot from the articles on specific diets and physical activity. We put emphasis on special concerns such as management of the visually impaired, diabetes and dementia, and recognizing and managing depression with the deadly combination of advancing age and diabetes.

My patient survey lists sleep problems and food restriction as main concerns. Over and over, these are what bother the elderly diabetic the most.

The Informatics team has interesting "how to do tips" for internet surfing for Lolo and Lola, and are sharing tips for identifying links to diabetes information.

And many more....

As we all realize, it is not easy to grow old. Concerns in these years become even more difficult as a different set of issues come into play. Let's stop and re-think, how do we treat our parents and grandparents? How do we face these twilight years when it's our turn? Hope this issue opens our minds to new insights and new perspectives.

Elizabeth Paz-Pacheco

Elizabeth Paz-Pacheco, MD
Editor-in-chief

diabetes philippines

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The prime mover of effective prevention and excellent diabetes care in the Philippines

OUR VISION

By 2020, we envision:
1. Fewer Filipinos with diabetes
2. Improved quality of life for Filipinos with diabetes

OUR VALUES

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

EXCELLENCE *Passionate workers, 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 our vision. Our mentors, generous with their knowledge and time, model excellent leadership.

COOPERATION *We work as one for the common good,* enjoying the camaraderie, observing respect and maintaining loyalty even in dissent. We partner with institutions and other specialties that aim 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 five 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.

Your PRESIDENT SPEAKS

This is the first issue of DiabetesWatch under our association's new corporate name, Diabetes Philippines.

Due to the increase in life expectancy there's also a corresponding increase in the prevalence of elderly people with diabetes. This issue of DiabetesWatch focuses on the different special problems that may be unique in this group of diabetics. It is also observed that mortality from diabetes and its complications is a higher in this age group. This can be due to the presence of co-morbid illnesses.

Readers are highly encouraged to visit the website www.diabetesphil.org to know more about diabetes and to be updated on our society's activities.

Tommy Ty Willing

Tommy S. Ty Willing, MD
President

The Diabetes Watch is a publication of the Diabetes Philippines with its corporate office located at Unit 25, Facilities Center, 548 Shaw Boulevard, Mandaluyong City, 1501
Tel. Nos. (632) 531-1278, (632) 534-9559
Fax No. (632) 531-1278
e-mail address: diabetesphilippines@platdsl.net
secretariat@diabetesphil.org
www.diabetesphil.org

Printed by Lizamen Printing Services

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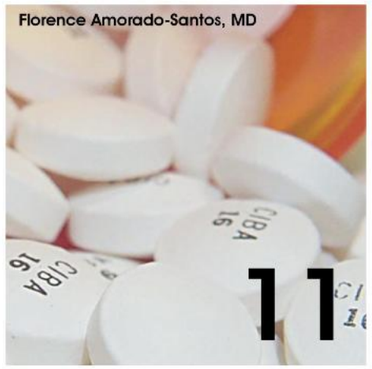
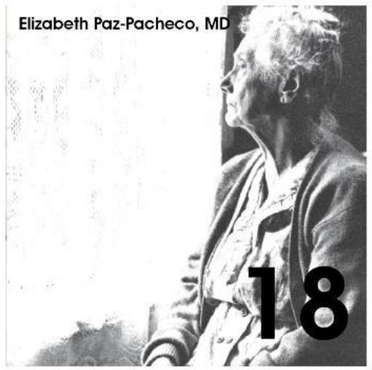




Regular Articles

Diabetes Philippines Chapters

Albay Chapter
President: **CYRIL G. CHUA, MD**
Estevez Memorial Hospital
Guevarra Subdivision, Legazpi City
Tel. (052) 480-2151
Mobile: 0921-9917930

Bagiuo-Benguet Chapter
President: **DWIGHT BLACK, MD**
Rm. 310 AMDC Bldg.
Assumption Medical Diagnostic Clinic
Assumption Rd., Baguio City
Tel. (074) 444-5339
drdsblack@yahoo.com

Batangas Chapter
President: **OLIVER BAUTISTA, MD**
c/o Ghen's Pharmacy
San Antonio, San Pascual
Batangas
Tel. (043) 727-1977/727-2015
Moble: 0917-8866867
opbph@yahoo.com

Bohol Chapter
President: **LOURDES M. GALLEGO, MD**
Dept. of Health Regional Health Office
No. 011 Gov. Celestino Gallares Memorial Hospital *(Formerly Bohol Regional Hospital)*
Tagbilaran City, Bohol 6300
Tel. (038)411-3102 / (038)411-4504
dr.lourdesgallego@yahoo.com.ph

Bulacan Chapter
President: **MA. JOSEFA YANGA, MD**
31 Hulo Meycauayan, Bulacan 3020
Telefax. (02)727-7690
Mobile: 0917-5169375
majosefay@yahoo.com

Cagayan De Oro Chapter
President: **EMILIANA GAKO-PATRIANA, MD**
Polymedic General Hospital
Velez St., Cagayan de Oro City 9000
Tel. (08822)724-892 / (08822)724914 loc. 1217
Mobile: 0917-7149988
patriana_emee@yahoo.com

Cagayan Valley Chapter
President: **MAGNOLIA B. REYES, MD**
III Ugac Extension Luna St., Highway
Tuguegarao City, Cagayan 3500
Tel. (078)844-1571
Mobile: 0917-3269273
mbattungreyes@yahoo.com

Camarines Norte Chapter
President: **PAUL LUIS G. PALENCIA, MD**
OLLH Vinzons Avenue, Daet, Camarines Norte 4603
Tel. (054)721-2664
Mobile: 0917-5312221
infarct2000@yahoo.com

Camarines Sur Chapter
President: **RAMON T. CACERES JR., MD**
G/F Plaza Medica Bldg., Panagniban Drive, Naga City
Tel. (054) 472-1271
G/F Ago General Hospital Rizal St., Legaspi City
Tel. (052) 481-4442
rrncaceres@yahoo.com

Capiz/Roxas Chapter
President: **CONCEPCION PIZARRO-NOCHE**
St. Anthonny Hospital, Roxas City, Capiz 5800
Tel. (036)621-1869
Mobile: 0918- 9207084
pdaroxaschapter@yahoo.com

Cebu Chapter
President: **EVELYN GAMALLO, MD**
Visayas Community Medical Center *(formerly Metro Cebu, Community Hospital)*
Jones Avenue, 6000 Cebu City
Tel. (032)235-1901 to 09 / 2547915

Davao Chapter
President: **ROY B. FERRER, MD**
Limso Hospital Iluster St.
Davao City
Tel. (082) 222-8400
Fax (082) 225-5067
Mobile: 0920- 9205290
diabdoc@yahoo.com

Ilocos Sur Chapter
President: **ESTRELLITA GARCIA-BRINGAS, MD**
Gabriela Silang General Hospital
Vigan, Ilocos Sur 2700
Tel. 077 (722-7347)
Mobile: 0905-2885823
bchaigb@yahoo.com

Iloilo Chapter
President: **FRANCIS PASAPORTE, MD**
Fancom Medical Plaza
Quezon St., Iloilo City 5000
Tel. (033)509-4626
Mobile: 0917-3026543
fipasaporte@hotmail.com

Laguna Chapter
President: **ANTONIO S. CHUA, MD**
Laguna Provincial Hospital
J. de Leon St., Sta. Cruz, Laguna 4009
Tel. (049)808-1560
Mobile: 0917-4574128
doc_tonychua@yahoo.com

Leyte Chapter
President: **AVITO SALINAS, MD**
Divine Word University Hospital
Tacloban City, Leyte 6500
Tel. (053)321-4551
Mobile: 0920-9282435

Lucena Chapter
President: **MA. LOURDES REYES-GONZALES, MD**
Lucena United Doctors Medical Hospital
Bgy. Isabang, Lucena City
Tel. (042)710-5112
Mobile: 0916-4364507

Negros Occidental Chapter
President: **MARIAN JOYCE GARCIA-CO, MD**
Diabetes Clinic & Accu-Check Clinical Laboratory Medical Lane 21st Street,
Bacolod City,
Negros Occidental 6100
Tel. (034)434-1296
Mobile: 0920-9611838

Nueva Ecija Chapter
President: **MANOLO P. HERNAL, MD**
Hernal Medical and Diabetes Care Clinic
#26 National Highway, Del Pilar,
Santa Rosa Nueva Ecija
Mobile: 0917 801 2585
junhernal@yahoo.com

Palawan Chapter
President: **ROSALIE REYES, MD**
Reyes Clinic
Malvar St., Puerto Prinsesa Palawan
Tel. (048)433-4001 / (048)433-4162
Mobile: 0917-5750810

Pangasinan Chapter
President: **ISABELITA SIAPNO, MD**
Siapno Heart and Diabetes Clinic
Perez Blvd. Dagupan City
Mobile: 0917-5081339

Pasig Chapter
President: **NICK VILLATUYA, MD**
8 West Capitol Drive, Kapitolyo, Pasig City 1603
Tel. (02)633-2389 / (02)632-9461
Mobile: 0919-3372002

Sorsogon Chapter
President: **MA. LIDUVINA F. DORION, MD**
Sorsogon Provincial Health Office
4700 Macabog, Sorsogon City
Tel. (056)211-1032
Mobile: 0919-4307003
lidu@globalink.net.ph

Zamboanga Chapter
President: **FATMA IBBA-TIU, MD**
Diabetes Clinic
Ultra Cinema Bldg., San Jose Road,
Zamboanga City 7000
Tel. (062)992-2788
Mobile: 0917-7000625

MEANDERINGS

Seniors and Diabetes Mellitus

Augusto D. Litonjua, MD
Editor Emeritus

This issue of DiabetesWatch devotes itself to diabetes in the elderly. The first question that is proposed is - who is considered elderly? If age is the determining factor, then the government employee who is retired at the age of 65 is elderly. On the other hand, the Supreme Court of the Philippines and the Catholic hierarchy consider 70 and 80 years as the age at which to consider their members as 'spent.'

I feel that in terms of how to manage diabetes according to age, I would go along with the characteristic recommended by the American Diabetes Association (ADA), as my defining parameter for who is to be considered as the healthy senior, and therefore deserves strict control of his diabetes state as the young adult.

In the Clinical Practice Recommendations 2009 of DiabetesCare - journal of Clinical and Applied Research and Education of the ADA - the healthy older adult who should receive diabetes treatment goals as the younger adults is he who is 'functional, cognitively intact, and has significant life expectancy.'

The primary consideration for all patients is the avoidance of too high a blood sugar level leading to symptoms or risk of acute hyperglycemic complications, such as diabetic ketoacidosis, hyperglycemic hyperosmolar state and on the other hand, too low a blood sugar level, such as major hypoglycemic events.

Further, the ADA suggests that cardiovascular risk factors (high blood pressure, lipid abnormalities) should take into consideration the benefits to the older patient with diabetes. Screening for diabetes complications should always pay attention to those which would lead to functional impairment of the patient.

Diet and exercise remain the mainstays of diabetes control in the senior diabetic - with exercise having some 'caveats' in the face of physical defects that senior diabetics may have.

Since hypoglycemia, or very low blood sugar attacks, remain one of the most serious complications of diabetes therapy, I would suggest that the initiating therapy for senior diabetic patients should be those which have no hypoglycemic effects, because they lower the blood sugar other than stimulation of insulin secretion.

METFORMIN - its use is predictable and safe if used correctly. Metformin essentially lowers the blood sugar because of its suppression of hepatic glucose output - in the fasting and postprandial states, thus leading to lowering of the fasting plasma glucose and the postmeal plasma glucose levels. It has also beneficial effects on lipids. The US Food and Drug Administration limits the use of Metformin to patients less that 80 years, unless they have normal renal function, presumably because of the increased risk of lactic acidosis. Patients also may be sensitive to the gastrointestinal side effects of metformin. These can be minimized by the 'gentle introduction' of the drug. There are reports that metformin may cause Vitamin B12 malabsorption - the recommendation is to check the vitamin level every 5 years. If the gastrointestinal side effects are too disturbing, then the new formulation of metformin - metformin XR - may be tried, which should be given once a day during dinner.

GLITAZONES - there are two glitazones on the Philippine market, - pioglitazone and rosiglitazone. These reduce insulin resistance, especially in the muscles and in the adipose tissue, by activating unique receptors in the nuclei of the cells. While they do not cause hypoglycaemia if used alone, one of the glitazones has been associated with an increased risk of heart attacks. Both glitazones cause weight gain, mild edema and anemia (the so-called dilutional anemia). These two drugs are also contraindicated for patients with heart failure. One of the glitazones has been found effective in the hepatic manifestation of the metabolic syndrome, manifested clinically by the rise of the liver enzymes, SGPT and SGOT. One of the glitazones has also beneficial effects on the lipid profile of diabetic patients. Recently glitazone use has been found associated with spontaneous fractures in the wrist and ankle. Consideration must be given this finding.

ACARBOSE - this delays the absorption of carbohydrates in the gut, and therefore, the reduced insulin reserves of diabetic patients can better cope with the blunted rise of the glucose levels in the blood. This is not absorbed systematically, so side effects are rare. Main contraindications are inflammatory bowel disease and sub acute obstruction of the intestines.

INCRETINS - these are the newest drugs in the market. The oral form, which suppress the rapid destruction of the patient's own incretins will restore the physiologic levels of these gut hormones. They stimulate insulin secretion but only when the glucose levels are high. They also suppress a hormone from the pancreas which increases glucose in the blood - glucagon. These are the only known drugs which suppress glucagon production, one of the ways in which they lower the blood glucose levels. These are safe medications except when there is infection and severe renal disease.

The above mentioned drugs can be combined with each other for greater blood sugar lowering effects.

Thus, the senior diabetic patient whose health is compromised by other co-existing conditions, must be dealt with more care. The glycemic and A1c targets which are the norms of control in the younger adult diabetic should not be applied to them. Comfortable and safe levels of glycemia are to be attained, which are less strict than these for the healthy younger adult diabetic patient.

Everything you always wanted to know about diabetes (but was afraid to ask!)

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

This issue of DiabetesWatch tackles the very challenging and unique segment of the population- the elderly diabetic. Diabetes itself is a frightening situation and adding the challenges of being old will bring a whole new dimension in terms of diabetes care. As we treat our patients with the best standard of care, more and more of them grow old. Elderly diabetics have different problems. So read on to learn more.

Is the treatment for elderly diabetics like us different from the others? Yes! As you age, a whole new set of problems emerge. You have to contend with - impaired physical functioning, hence the limitation in your physical activities. There is also memory loss or cognitive dysfunction- medications might be forgotten, simple instructions could be easily forgotten. Elderly individuals are likewise prone to infections. Diabetes complications occur commonly in this age group and harder to treat. Hypoglycemia is a problem and will require close monitoring.

Are there medications which we should refrain from using? Sulfonylurea use is still okay. But you need to use short acting drugs of this class. The longer acting sulfonylureas may produce hypoglycemia among the elderly e.g. glibenclamide. At this age also, you might be using a lot of other drugs which may produce drug- drug interaction. Consult your physician or pharmacist.

My doctor prescribed insulin. Should I worry about hypoglycemia? Insulin is safe to use if used properly. I recommend you take your blood sugars frequently to avoid hypoglycemia. Eat on time and with the correct portions according to your meal plan. Take snacks. Don't miss your meals. If you develop frequent low blood sugars then you should go back to your physician for adjustment of your insulin.

What exercises can I do? Walking is still the best form of exercise. Walk with somebody. Walk in well lit areas. If you find it difficult to walk, there are some armchair exercises which you can do. You may want to do these exercises while watching television. This makes your muscles tight and may improve blood pressure and lipids.

How about my diet? I sometimes miss my meals because of loss of appetite. What should I do? Help! As much as possible, don't miss meals. Eat small frequent feedings. Your dietitian can help you out with your meal plan. Your diet will be no different from other diabetic individuals. Eat more of vegetables to increase fiber in the diet. Avoid too much sources of refined sugars- honey, jams, jellies, preserves, chocolates, cakes, soft drinks, etc. Avoid fats as well.

My doctor says that my creatinine is increasing. What should I do? This increase in creatinine is a sign of kidney disease (nephropathy). This combination of advancing age and falling creatinine clearance with contribution from high blood pressure leads to a high prevalence kidney disease in the elderly diabetics. Your doctor may prescribe an ACE inhibitor at the stage of microalbuminuria (low protein in the urine) to prevent progression to overt kidney disease. You should improve your metabolic control with diet and drugs. This has been demonstrated to reduce urinary protein excretion.

I have problems with urination. I get up several times at night to urinate. What should I do? Your frequent urination maybe a manifestation of uncontrolled diabetes, urinary tract infection, bladder dysfunction as a result of a nerve problem or enlargement of your prostate. These are quite common conditions and will require evaluation from your urologist.

Are my treatment goals different? As with any diabetic your treatment goals should be individualized. Your doctor will prescribe a treatment plan appropriate for your age. Diet and exercise will be tailored according to presence of co morbidities. Drugs will be carefully prescribed to control blood sugars with less hypoglycemia. In the end, you will have better quality of life from better metabolic control despite your age.

We welcome questions, comments or suggestions
Fax these at 5311278

A closer look at diabetes, aging and polypharmacy

Florence Amorado-Santos, MD
Mary Mediatrix Medical Center

"I'm taking a small white pill in the morning before breakfast, a pink pill after breakfast, an oval-shaped pill after lunch, a yellow pill after dinner and a big white tablet before I go to bed..."

Most of the physicians receive this response in the clinic when an elderly diabetic patient is asked what are the medications he is taking for maintenance. Some patients if not most of them, would rarely remember the name and dosage of their pills. But, they would usually remember the color, shape and frequency of the drug they are taking. The physician may mean well when prescribing different medications for various conditions alongside with diabetes, targeting all the other risk factors which may lead to complications. But, could this be a double-edged sword for our diabetic patients?

Polypharmacy is defined as the concurrent use of many different medications by the same person. Several factors predispose patients to the risk of polypharmacy, including having multiple health care providers, an aging population (elderly patients are at greater risk for polypharmacy), complex drug therapies, multiple chronic conditions in a single patient and adverse drug reactions that may be interpreted as new medical conditions. A diabetic patient is a perfect example having all these factors.

THE MORE THE MERRIER?

Taking several drugs for diabetes and its co morbid conditions may bring about several issues to be considered. Drug interactions and side effects are the negative but real-world consequences of multiple drug therapy. Clinically important drug-drug interactions may not be copious but it remains to be a real challenge to the physician since it entails understanding the mechanisms of such interactions. All sorts of drugs, prescription drugs, over-the-counter (OTC) drugs, herbal supplements, complementary therapies or nutritional supplements may all potentially cause side effects.

There are various factors inherent to an aging individual that may promote drug interactions (Table 1). Common disease conditions that accompany diabetes in an elderly are hypertension, dyslipidemia (increased blood fats), heart disease, stroke, blood vessel disease and even depression. Most likely, attending doctors would include an endocrinologist/diabetologist, cardiologist, nephrologist and neurologist. A patient will end up taking 6-8 prescribed pills everyday. Each drug has its own effect both on the body as well as with the other medications. As complications occur or as other disease states are discovered, medications are added leading to complexity of the regimen.

The similarity in the size, color and shape of a pill usually cause confusion for an elderly who has poor vision or any visual impairment with the inability to read prescriptions well. These similarities create confusion in distinguishing one medication from another for both patients and caregivers. The "little white pill" thinking habit is the most common cause why drugs are being taken interchangeably (Table 2).

The level of cognitive function plays an important role to determine the best treatment plan for a diabetic. It affects on how a patient would be able to learn the use of new gadgets or how to regularly take his medications ensuring compliance and adherence. This will avoid medication misuse which can lead to hypoglycemia and treatment failure. Unfortunately, there are specific medications prescribed to an elderly diabetic which can contribute to the decline in cognition. These are drugs having anticholinergic properties associated with reduced memory, reduced ability to perform and cognitive impairment (Table 3). Taking a single drug may not bring side effects but taking it with another agent could give additive effects. This phenomenon is very common for sedatives and antipsychotic agents. The Beer's criteria (Table 4) is a list of medications deemed not appropriate for use in the elderly. This contains a number of agents and can be a reference when evaluating a patient's medication plan. *(For a complete list, please access MEDLINEplus.)*

SELF MEDICATION

Around 60 percent of older patients will always tend to self medicate even after visiting a doctor's clinic. This high rate relates to a number of factors including difficult or inaccurate communication with one or more providers, misunderstanding instructions (related to medications and food consumption), discontinuing or skipping medication (because of adverse effects, fear of dependency,

cost or perception of disease), and mixing OTC and prescription medications. The simple feeling that the prescribed drugs are not working would usually resort to trial and error self medication.

USE OF OVER-THE-COUNTER AND SUPPLEMENTAL DRUGS

It is estimated that in the US, 72 percent of the elderly patients utilize over-the-counter medications and 13 percent use herbal supplements. Commonly used agents are multivitamins, minerals, fish oil, gastrointestinal and central nervous system medications. OTC's have significant interaction with prescribed drugs. Even alternative medicines are not devoid of any drug-related side effects. Gingko, garlic, and fish oils potentiate the effects of blood thinners such as aspirin. Herbal preparations may have diuretic effects just like the effects of synthetic diuretics, furosemide and hydrochlorothiazide which can cause low potassium levels. Patients might be unaware of the different ingredient's effects.

CASCADE-OF-EVENTS PHENOMENON

Adverse reactions may be misinterpreted, leading to inappropriate treatment. A common example is a patient taking metformin as initial treatment for diabetes. Frequent adverse effects of metformin are gastrointestinal side-effects, usually minimized by starting at a low dose and slowly increasing the dosage. However, upon appearance of these effects, the physician may assume the patient is experiencing gastroparesis and start another agent, metoclopramide. For older patients, metoclopramide has a particularly debilitating adverse effect which is dyskinesia. One may recognize dyskinesia as a symptom of Parkinson's disease, thereby initiating treatment for Parkinson's disease rather than discontinuing the metoclopramide. Unfortunately, this is a genuine risk for older adults with diabetes when adverse effects are mistaken for disease states, and treatment is inappropriately initiated, leading to polypharmacy and added potential adverse effects.

Medications may significantly affect the occurrence of hypoglycemia in patients with diabetes. Some medications, such as beta-blockers, mask the adrenergic symptoms (rapid heart rate, shakiness, anxiety) of hypoglycemia, making it difficult for patients to tell they are having an episode. Alcohol impairs the recovery from hypoglycemia. Patients with renal impairment require cautious use of sulfonylureas or insulin. Any circumstance that increases circulating insulin also increases patients' risk of hypoglycemia. Examples include decreased elimination because of impaired kidney function, slower metabolism because of acute or chronic liver dysfunction, and increased duration of drug action because of the

Medications may significantly affect the occurrence of hypoglycemia in patients with diabetes. Some medications, such as beta-blockers, mask the adrenergic symptoms (rapid heart rate, shakiness, anxiety) of hypoglycemia, making it difficult for patients to tell they are having an episode.

use of agents with active metabolites, such as glibenclamide or extended release formulations. The key for providers is to be aware of the medications used by each patient, when they were added, why they are being taken, and what effects they may have when evaluating changes in the patient's conditions or treatment plan.

So, doctors...make sure that before you scribble that prescription, ask for your patient's prescriptions from other healthcare providers to avoid the cutting edge of polypharmacy.

Table 1. Impact of age-specific changes on medications

Age-specific change	Effect	Examples
Pharmacokinetic		
Decreased gastric acid	Decreased absorption of medications requiring an acidic environment	Omeprazole, Vitamin B12
Slowed peristalsis	Longer exposure of medications to gastrointestinal tract	Levodopa
	Increased risk of ulcerations with medications that deteriorate intestinal lining	Aspirin, Non-steroidal anti inflammatory drugs, bispohosphonates
	Administration time between drugs that bind medications and nutrients must be longer to avoid interactions	Levothyroxine, fat soluble vitamins
Active transport of nutrients impaired	Decreased absorption of dietary nutrients	Vitamine B12, Calcium
Decreased hepatic metabolism and blood flow	Slowed elimination of drugs in the liver	Propanolol, Morphine, Verapamil, Diltiazem
Decreased lean body mass		
Decreased total body water	Increased concentration of water soluble drugs	
	Increased risk of dehydration and electrolyte imbalance	Hydrochlorothiazide, furosemide
Decreased albumin concentration	Decreased protein binding,allowing more free drug available, may cause toxicity of medications	Phenytoin, warfarin, verapamil
Phenytoin, warfarin, verapamil	Increased duration of action of fat soluble drugs	Alprazolam
Decreased blood flow	Increased duration of action and potential for toxicity of renally eliminated medications	Sulfonylureas, insulin, metformin, digoxin, lithium, hydrochlorothiazide

Pharmacodynamics		
Downregulation of beta adrenergic receptors	Decreased bronchodilatory response	Albuterol, salmeterol
Decreased baroreceptor response	Postural hypotension with antihypertensive medications	Clonidine, metoprolol, propanolol, atenolol
Decreased synthesis of clotting factors	Increased effect of blood thinners	Warfarin, aspirin

Table 2. Common "little white pills"

Aspirin
Atenolol
Atorvastatin
Captopril
Clonidine
Furosemide
Glibenclamide
Glipizide
Levothyroxine
Lorazepam
Warfarin

Table 3. Medications with significant anticholinergic properties

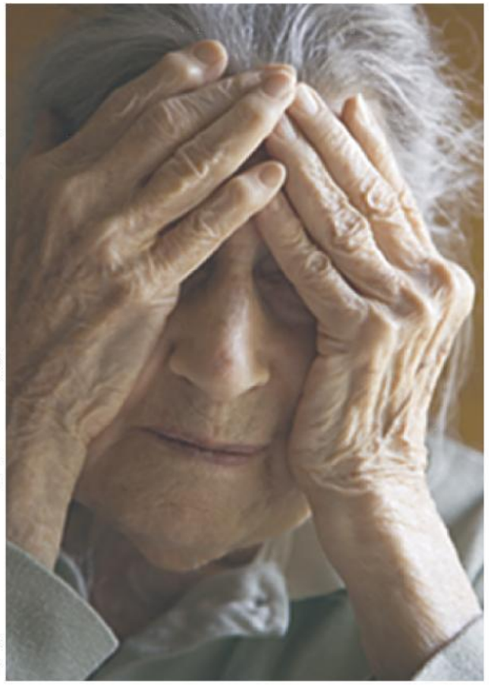
Amitryptiline
Chlorpheniramine (antamin, Nafarin A, Neozep, Mucotuss
Diphenhydramine (Benadryl)
Disopyramide
Donezepil
Hydrcodone
Hydroxyzine
Lithium
Nortryptiline
Olanzepine
Oxybutynin
Paroxetine
Promethazine
Proproxyphene
Tolterodine

Table 4. Selected Medications Listed in Beer's Criteria for Potentially Inappropriate Medication Use in Older Adults

Alprazolam
Indomethzine
Amitryptiline
Ketorolac
Anticholineregic medications
Propoxyphine
Clonidine
Lorazepam
Cyclobenzapine
Diazepam
Fluoxetine
Indomethazine

References:
Segal, et al, "Polypharmacy and its effect on Diabetes in Older Adults"
McKloskey, PharmD, "Polypharmacy: Boon or Bane for the Healthcare Providers?"

Recognizing and managing depression in the elderly diabetic



Pepito De La Peña, MD
East Avenue Medical Center

Before we discuss depression in the elderly diabetic, let me define 2 very important terms.

One of course is the definition of the "elderly", which can be divided into 4 subgroups:

a. 65 to 74 yrs of age : the young old
b. 75 to 84 yrs of age: the middle old
c. 85 to 99 yrs of age : the old old
d. 100 years of age or more : the elite old

Among the subgroups, the fastest growing is the "old old" more commonly known as the advanced older adult population or the "frail elderly". The second term for this topic is depression. Depression may refer to:

a. A mood state which may be normal or part of a psychopathological syndrome.
b. A syndrome which must fulfill 5 of the 9 symptoms. One being a depressed mood or loss of interest/pleasure, present most of the day, nearly every day for a minimum of 2 consecutive weeks.

The 9 symptoms are:

a. Depressed mood
b. Loss of interest/pleasure
c. Change in sleep
d. Change in appetite or weight
e. Change in psychomotor activity
f. Loss of energy
g. Trouble concentrating
h. Thoughts of worthlessness or guilt
i. Thoughts about death and suicide

These can easily be remembered by a mnemonic, "SIG: E - CAPS "(as in prescribe energy capsules). Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicide.

Depression is the most common affective or mood disorder of old age. Depression among the elderly often follows a major precipitating event or loss but may also be 2nd to a medication interaction or an undiagnosed physical condition.

Geriatric depression may also be confused with 'dementia'. However, the cognitive impairment resulting from depression is a result of apathy rather than decline in brain function. It is very difficult to imagine growing old and later accompanied with a chronic disease (diabetes). When depression and medical illness coexist, as they often do, neglect of the depression can retard physical recovery.

Depression is responsive to treatment but is often overlooked and therefore undertreated. Initial management involves evaluation of the patient's medication regimen and eliminating or changing any medications that contribute to depression. In addition to, treatment of the underlying medical conditions (diabetes) that may produce depressive symptoms may alleviate depression. Both anti depressants and short - term psychotherapy, particularly in combination, are effective in late-life depression. It is always recommended that the initial dose of antidepressants be low. The following factors also should be considered in treating depressed diabetic pts: age, other coexisting conditions, adverse effects, and prior response to anti depressants. Caution with the use of anti depressants, as these may give anticholinergic, cardiac and orthostatic adverse effects as well as interactions with antidiabetic medications. And one must not forget the role of the family. Planning for care and understanding the psychosocial issues confronting older people must be accomplished within the context of the family. If dependency needs occur, the spouse often assumes the role of primary caregiver. In the absence of the surviving spouse, an adult child usually assumes caregiver responsibilities and may eventually need help in providing or arranging for care and support.

Always remember if diabetes is a disease that comes from the blood, treatment comes from the (loving) heart!

Survey says..."What bothers you the most in your care?"

Topping the list: food restriction and not being able to sleep well!

Elizabeth Paz-Pacheco, MD
Medical City

I asked several of my diabetic senior citizens the following questions:

What affects you the most in your care for diabetes? What is a major complaint for you now?

These are their answers...

Not being able to eat the foods I like, especially fruits. I need to control my desire for these and other favorite foods.

I have problem sleeping... I get to bed at 8 pm and then awaken at 11pm and that's it... I am awake until morning.

It is obvious how a lifestyle disease can hamper one's desire for delectable foods, but what impressed me is how alteration of sleep patterns can be so dramatic as to affect an individual's routine activities.

What happens to one's sleep cycle as one goes into these years? Does diabetes affect or aggravate this pattern disarray?

What is the most common sleep disorder?

Insomnia is a common complaint. It is defined as difficulty falling asleep, staying asleep, or having sleep that is unrefreshing. In general, people with insomnia sleep less or sleep poorly despite having an adequate chance to sleep. The poor sleep may lead to difficulty functioning during the daytime. Insomnia is not defined by the number of hours slept because "sufficient sleep" can vary from one person to another. Sleep requirements may also decrease with age.

What to do when a patient presents with insomnia?

The clinician should look for coexisting medical conditions, psychiatric disorder, neurologic disease, sleep disorder, medication, or drugs that may alter sleep patterns.

What are these types of medical diseases?

Disorders commonly seen in the elderly include arthritis, ischemic heart disease, urologic disease (enlarged prostate), endocrine disease (menopause, diabetes mellitus, hyperthyroidism), and gastrointestinal disease (gastroesophageal reflux). As has been shown, diabetes is a risk factor for sleep disorders.

What is our answer to this complaint of our patients?

1. Teach good sleeping habits. This is called sleep hygiene education. Advice patients to sleep only as much as necessary to feel rested, maintain a regular sleep schedule, not to force sleep, avoid caffeinated beverages, avoid alcohol near bedtime, do not go to bed hungry, adjust the bedroom environment, resolve concerns or worries before bedtime, and exercise regularly, preferably 4 or more hours before bedtime.

2. Teach patients to relax. Relaxation therapy involves progressively relaxing the muscles from the head down to the feet to promote restfulness and sleep and reduce insomnia. Beginning with the muscles in the face, the muscles are contracted gently for a few seconds and then relaxed. This is repeated several times. The same technique is used for other muscle groups, usually in the following sequence: jaw and neck, shoulders, upper arms, lower arms, fingers, chest, abdomen, buttocks, thighs, calves, and feet. This cycle is repeated for about 45 minutes, if necessary.

3. Teach patients not to spend more than 20 minutes lying in bed trying to fall asleep. If you cannot fall asleep within 20 minutes, you should get up, go to another room and read or find another relaxing activity until you feel sleepy again. Activities such as eating, doing housework, watching TV, which can make you stay awake, should be avoided.

4. Teach them the technique of sleep restriction. Some people with insomnia try to deal with their poor sleep by staying in bed longer in the morning to "make up" some of their lost sleep. This additional sleep later in the morning may make it more difficult to fall asleep that night, resulting in the need to stay in bed even longer the following morning. Sleep restriction breaks this cycle. A rigid bedtime and awakening time are recommended and naps are not permitted. This causes partial sleep deprivation, which increases your need to sleep the next night.

5. Phototherapy, also called light or "sun" therapy, maybe helpful. People may have a problem with their body's "sleep clock" such that they have a difficult time falling asleep until much later in the evening or night than they wish (and therefore wake up later than they wish in the next morning). Patients should be advised to wake up consistently at a given time in the morning, followed by physical activity with exposure to bright light (e.g., a walk outside). Alternately, you may sit in an area with bright sunshine (e.g., near a window or on a porch). The exposure to bright light at specific times helps to reset the body's sleep clock.

6. Sleep disorder specialists may give medications for insomnia. Sedative-hypnotic medications are given by experts, if the sleep disorder interferes with the patient's ability to function during the daytime. The decision to start a medication should be made with a healthcare provider after carefully weighing the potential benefits (e.g., improved daytime symptoms and function) versus the risks (e.g., side effects such as allergic reactions and addiction) as well as cost.

7. Commonly asked is use of Melatonin. Is this useful? Melatonin is a hormone that is normally produced by a gland in the brain. It does not appear to be beneficial in most people who have insomnia, except in people with delayed sleep phase syndrome. It appears to be safe when used for less than three months. However, melatonin is marketed as a food supplement and the ingredients, dose, and purity are not regulated. Listed doses may be higher than that used for the treatment of insomnia.

8. Is alcohol useful as a sleeping aid? When used on a regular basis over the long-term, a person may become dependent on alcohol and develop severe insomnia if alcohol is stopped. Due to numerous health risks, alcohol is not recommended at bedtime for people with insomnia.

DIABETES PHIL VISITS VIGAN.....

Lorenza Evangelina Pipo, MD
St. James Hospital

Last February 20, 2009, the 37th Diabetes Workshop was held at the CAP building in the historic Vigan, Ilocos Sur. The event was a 2-day intensive course of scientific lectures and clinical case discussions on current treatment and management of diabetes attended by physicians coming from the provinces of Ilocos Sur, Ilocos Norte, and even Abra. Simultaneously, a lay forum where almost 50 lay people attended was also held during the second day of the workshop. Free lay screening for diabetes, cholesterol disorders, ECG, and foot screening were conducted during the morning lay fora.

This workshop was made possible through the tireless efforts of the coordinators namely: Dr. Tommy Ty Willing; DP Ilocos Sur chapter President Dr. Estrellita Bringas; PAFP Ilocos Sur chapter President Dr. Rosita Realubin, and...yours truly.

At the end of the 2-day event, we (including Dr. Bringas, Dr. Realubin, and me) were just happy to bring the whole staff and took a local tour at Vigan Heritage, visiting the museums, and old churches, and not to miss Baluarte and had a taste of G.I (Genuine Ilocano) dishes such as empanada, pinakbet, Vigan longganisa, and the world-famous Ilocano bagnet!

Indeed, it was a productive and memorable weekend to our colleagues in the far North and our sincerest gratitude to the speakers and DP Staff who all endured the 9-hour road trip to the North.

"Dios ti agngina kaniayo Apo ken sapay kuma ta agsubli kay to manen"!!

diabetes philippines

2009 SCHEDULE OF ACTIVITIES

26th Annual Convention of Diabetes Philippines
And
5th Course on Diabetes and Vascular Disease
Century Park Hotel, Manila
November 11 - 13, 2009
(Wednesday-Friday)

Gimik Diabetes Year 3 (Lay Lecture)
World Diabetes Day Celebration
November 14, 2009 (Saturday)
Venue: TBA

FOR INQUIRIES PLEASE CALL:
Diabetes Philippine Secretariat
Telefax: (632) 531-1278
Tel.: (632) 534-9559
Email:
diabetesphilippines@pldtdsl.net
Website: www.diabetesphil.org

KITCHEN CORNER

Nutritional Goals for the Elderly

Sanirose S. Orbeta, MSRD
Magallanes Village

Pleasurable Meals in the "Third Age"

It's great that November has been declared the month of the elderly. It makes us aware of that "someday" when we will all eventually age. However, some age faster than others. Still others enjoy getting older and are living life to the hilt, better in fact than when they were young. Why are there differences in the experience of aging process?

The science of gerontology (science for the study of aging) is so advanced so definitive that the aging population should heed what their findings and recommendations are. In fact a new term has emerged to describe the last cycle of life known as the 3rd age. It was after John Glenn's historic 9 days voyage in space at the age of 77 years old that prompted them to coin this new term, "the third age". This terminology is used to describe this time of life as a new beginning of self worth, growth, discovery, taking charge of one's life and enjoying retirement as a new experience. According to John Glenn the icon of the 3rd age and I quote from his inspiring words, "My remarkable physical shape is due to careful eating, light and healthy and the longer they keep active the better off they will be."

Eating Environment

In the Philippines, where we take care of our old people, caregivers, members of the family, yayas or maids, can enhance the eating environment by constantly talking and encouraging the elderly, stressing the importance of finishing meals, drinking fluids throughout the day, or even indulging in personal cravings like ice cream or cake 3 times a day as part of the high calorie meal which they need. Every

effort should be made to make them enjoy meal times. Their eating area should be bright and airy near the garden or porch. Food tray brought to their air-conditioned bedroom should be discouraged. This change of atmosphere will bring them better appetite. Select plates with solid colors and simple patterns that will not obscure the foods placed on the plate. Researchers have seen that appetite increases when they listen to music from their youth and their mood changes with familiar tunes, not noisy rock n' roll or up beat jazz music.

Oral discomfort, dental problems are other problems that limit the frequency, quality and variety of foods eaten. Make sure the foods served are soft and easy to chew, familiar in texture and easy to swallow in size and shape to accommodate their dental problems.

As one ages, the stereotype of physical inactivity, poor health, loss of vision, diminish hearing, bad dentures and general debilitation crops up. These natural effects of aging can be minimized if alert members of the family or friends immediately recognize that older people's eating habits changed drastically. They eat less, they become picky, irritable or simply remote and quiet. A once enjoyed leche flan is all of sudden too sweet, or a well-seasoned pancit has no taste. Many caregivers are at a lost as to what or how to feed them. Some complains that Lola has started to eat "like a bird". She pushes food away every time she eats and hates drinking water or take her medications at the appointed times.

Physiological, psychological, economic and emotional factors contribute to such shifts in behaviors, food preferences and eating habits. These sensory changes occur as a side effect of prolonged medication and chronic illness. Change in vision can cause food color to lose its intensity hence visually less appealing. Auditory impairment makes it difficult to hear the crunchiness of chewy salads. All these sensory loss compromises conversational skill and brings aloofness, frustration and dullness to a once happy social dining experience.

Some Nutrients that Needs Emphasis

You can't stop the clock or reverse the aging process. However, choices you make now can slow the changes and challenges that come with getting older.

Calorie - After age 50, you need fewer calories due to decreased muscle mass and energy expenditure. But that doesn't mean you need fewer nutrients - like calcium, vitamin D, vitamin C and iron, among others. Recommended energy for males 2170 calories and for females 1620 calories based on Recommended Energy and Nutrient Intake - Food and Nutrition Research Institute. Contribution of carbohydrates is 55-70 %, fats 20-30 % and protein 10-15 % to total energy intake.

Calcium - Calcium keeps your bones healthy and helps reduce your risk of osteoporosis. For both men and women over age 50, calcium needs increase 20 percent, to between 1,000 and 1,300 milligrams per day. Example, 1 glass whole cow's milk 329 mg of calcium or 1 slice cheese 233 mg of calcium.

Vitamin D - Your body also needs help from calcium's partner vitamin D to keep your bones strong. Good vitamin D - rich food choices include milk, fortified cereals, eggs, canned salmon or tuna. A 12 - 15 minutes early sunlight exposure is enough vitamin D for the day.

Iron and Vitamin C - To help keep energy levels up, older adults need to make sure iron and vitamin C are part of your daily eating plan, too. Iron-rich foods (12 mg for male and 27 mg for female daily) include meat, poultry, fish, beans, cereal and whole grains. For vitamin C, focus on citrus fruits, mango, papaya, grapes, vitamin C - 70-75 mg per day is minimum requirement.

Managing the 3rd Age Diet

Two major causes of involuntary weight loss in older persons are dental problems and depression so again attentive and solicitous caregivers should know how to make them laugh, smile and be cheerful even in the most trying of circumstances. Dr. Jane White, PhD, RD a noted specialist in gerontology, has developed an easy nutrition checklist (at the end of the article) which is a good screening tool that can help you spot nutrition problems of a loved one before if becomes a case of serious malnutrition.

Minimum Amounts of Various Food Groups to Include Daily

	I. Rice, Bread, Potato & Cereal Group (at least 4-6 servings)	II. Meat Group (at least 2-3 servings)	III. Fruit & vegetables (at least 4-5 servings)	IV. Milk Group (at least 2-3 servings)	V. Water Group 6-8 glasses of any fluids frequently taken throughout the day
	1 serve = ½ cup rice or 2 medium slice bread or ½ cup potato	1 serve = 1 egg or 1 thin slice meat or 1 leg chicken	The more the better	1 serve = 1 glass milk or 1 slice cheese or ½ cup ice cream	
Below are Recommended Food for Easy and Happy Dining					
Mastication	I. Lugaw w/ flaked chicken, soft-cooked oatmeal or farina wheat, noodles, soft French toast, plain consommé w/ croutons, potato soup, angel food cake	II.Chop/grind/ flaked meat, blenderize meat liver, egg, fish, meat loaf, bangus relleno, ground pork w/ potatoes, tofu and shrimps	III. Canned fruits & vegetables, finely chopped fresh fruits w/ cottage cheese, Miswa soup w/ patola and tiny shrimps, Jell-O w/ fruits like peaches, fruit shakes	IV. high-protein drinks, milk shakes, yogurt	V. Water, decaf coffee, herbal tea, flavored water, juices, broths
Taste	Whole grain bread w/ soft spreads like cream cheese, peanut butter, liver spread, pasta, pansit with sauces, potatoes, soft cooked rice w/ pandan leaves to heighten the flavor, rice pudding	Chewing thoroughly & slowly, add herbs and spices, soft cooked meat dishes like Swiss steak, beef picadillo, hamburger steak	Fruit w/o skin, vegetables texture like green beans, eggplant, Jell-O, salads as tolerated, sherbet, strawberry short cake, fruit-filled crepes	Flavored milk, yogurt, spreadable cheese, ice cream w/ barquillos, leche flan, cheese	Water, decaf coffee, herbal tea, flavored water, juices, broths
Dehydration	Whole grains (high fiber), lugaw, rice, cereal of choice w/ non-fat milk, soupy noodles, maiz con hielo (cream style)	Prepare stews, soups, soupy meats, fish sinigang	Vegetable soup, fruit shake and juice, Jell-O, applesauce, mash fruits & vegetables	Milk, yogurt, ice cream, sherbet	Water, decaf coffee, herbal tea, flavored water, juices, broths
Food Intolerance	Cereal as tolerated, plain breads, others as tolerated, soft cooked pasta w/ tomato sauce, pansit	Lean meat as tolerated, chicken, fish, shrimp, crabs as tolerated, bangus en tocho	Any cooked vegetable of choice like kangkong or squash, fruit juice and shakes, fruits	Yogurt, cheese, milk as tolerated, ice cream seem to be enjoyed	Water, decaf coffee, herbal tea, flavored water, juices, broths
Various Daily Food Groups to Include					
Problems Encountered	**Rice, Bread, Potato & Cereal Group (at least 4-6 servings)**	**Meat Group (at least 2-3 servings)**	**Fruit & vegetables (at least 4-5 servings)**	**Milk Group (at least 2-3 servings)**	**Water Group 6-8 glasses (drink frequently throughout the day)**
Mastication	Lugaw w/ flaked chicken, soft-cooked oatmeal or farina wheat, noodles, soft French toast, plain consommé w/ croutons, potato soup, angel food cake	Chop/grind/ flaked meat, blenderize meat liver, Egg, fish, meat loaf, bangus relleno, ground pork w/ potatoes, tofu and shrimps	Canned fruits & vegetables, finely chopped fresh fruits w/ cottage cheese, Miswa soup w/ patola and tiny shrimps, Jell-O w/ fruits like peaches, fruit shakes	high-protein drinks, milk shakes, yogurt	Water, decaf coffee, herbal tea, flavored water, juices, broths
Taste	Whole grain bread w/ soft spreads like cream cheese, peanut butter, liver spread, pasta, pansit with sauces, potatoes, soft cooked rice w/ pandan leaves	Chewing thoroughly & slowly, add herbs and spices, soft cooked meat dishes like Swiss steak, beef picadillo, hamburger steak	Fruit w/o skin, vegetables texture like green beans, eggplant, Jell-O, salads as tolerated, sherbet, strawberry short cake, fruit-filled crepes	Flavored milk, yogurt, spreadable cheese, ice cream w/ barquillos, leche flan, cheese	Water, decaf coffee, herbal tea, flavored water, juices, broths

	to heighten the flavor, rice pudding				
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Also ask them what they feel like eating. When favorite foods are served they tend to eat more.

ASSESS YOUR NUTRITIONAL HEALTH

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Instructions: Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind /or amount of food I eat.	2
I eat fewer than 3 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I eat fewer than 3 starches, potatoes, bread, cereals per day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's -

0-2 ***Good!*** *Recheck your nutritional score in 6 months.*

3-5 ***You are at moderate nutritional risk****. See what can be done to improve your eating habits and lifestyle.*

6 or more ***You are at high nutritional risk****. Bring this checklist the next time you see your doctor, dietitian or other qualified health care professional. Ask for help to improve your nutritional health.*

Instead then of worrying why or how we will eventually die, we should instead focus on reasons why we live as long as we do.

International Diabetes Federation (IDF)
Multidisciplinary Health Professionals Education Program

April 21-23, 2009, Kuala Lumpur Convention Center, Malaysia

Ma. Imelda Q. Cardino, MSFN
Makati Medical Center

The IDF selected a total of 39 delegates for the workshop from the following countries: Cambodia (3), Indonesia (4), Malaysia (8), Mongolia (4), Philippines (4), Singapore (8), Thailand (4), and Vietnam (4).

The faculty consisted of two nurses from Australia, one dietitian from the United Kingdom, and a pediatric endocrinologist from England.

The 3-day workshop was hectic:

Day 1 ... Teaching and Learning Principles
Medical Nutrition Therapy
Role Plays

Day 2 ... Type 2 Management Strategies
Management of Children with Diabetes
Case Studies

Day 3 ... Diabetes Complications
Practical Foot Care
Closing Ceremony

Some Key Learning on Patient Education:

A quote from GEORGE ORWELL drives home the importance of patient education:

"Helping others is good, teaching them to help themselves is better!"

The diabetes educator must:

- have core clinical knowledge and skills
- know teaching and learning principles and have the skills to perform them
- apply behavioral and psychological strategies
- be a good communicator
- have good clinical sense
- possess good presentation skills
- have writing skills

Effective teachers should:

❖ know the topic
❖ elicit participation - patient must be allowed to talk approximately 80% of the time
❖ speak confidently
❖ make clear points
❖ enjoy themselves
❖ admit they do not have all the answers

A Patient needs education:

- so he can make informed decisions
- he may have improved quality of life
- he may be able to use resources more efficiently and effectively
- he may prevent onset of complications of chronic, lifestyle diseases
- he may lead his family to improved health as well

Adults learn best when they are:

- given solutions to their individual problems
- motivated and involved in the whole process
- given written, easy-to-understand materials
- grouped with other people of similar conditions

There is a greater chance of success if adults are:

- allowed to set their own goals and targets
- participants in their health-care process and not just plain listeners/observers
- given opportunities to air their fears and concerns, ask questions, interact not only with the health care team but also with others
- provided with access to support groups

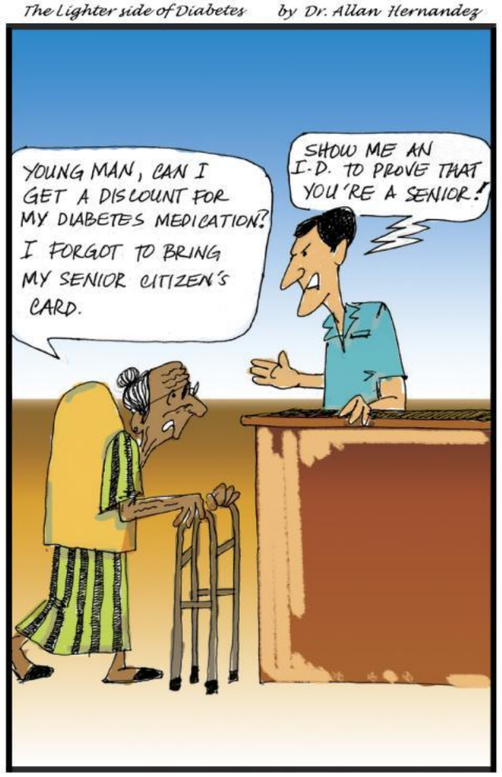
A Few Personal Notes:

The workshop on Foot Care would have been better if there were photos of the club foot, ulcers, and other common foot problems. Enumerating them and simply describing them make it difficult to visualize them, particularly if exposure to these cases are limited. Pictures are be most helpful such as the ones illustrated in the manual of the Foot Council of the International Diabetes Federation.

Some sessions could have been shorter in order to have longer discussion on other topics. For instance, considerable time was spent on asking each participant to comment on the lecturer, listener, and observer in the role playing portion. Part of the time devoted here could have been spent on discussing clinical cases or in foot care treatment. These topics were not discussed longer because of time constraint.

On the whole the program was good. However, the duration should have been at least a week in order to have more in-depth discussion of the various topics and more workshops on complications. Definitely, this kind of training should be repeated and the program could be expanded to allow more workshops. A follow-up training (an update workshop) should also be planned. ○

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



IDF-WPR COUNCIL MEETING IN TAIWAN

Editha Arceo-Dalisay, MD
St. Luke's Medical Center

The IDF-WPR held its Council Meeting in Taipei, Taiwan last March 6-7, 2008. The meeting was presided by the Chair of the IDF-WPR, Mr. Gordon Bunyan. The Diabetes Philippines was represented by its President, Dr. Tommy Ty-Willing and its Vice-President, Dr. Editha Arceo-Dalisay.

The most important topic discussed during the meeting was the changes to the way the IDF is going to be run and governed in the future. Professor Martin Silink, IDF President explained that the IDF has to respond to the changes and demands of the times to be a more effective organization. He said that as the IDF develops it has been increasingly clear that the IDF would need a smaller, more efficient Board that will deal with policy, long term vision and strategy; a skilled, competent and expert executive management structure; and an updated financial management systems. In line with this, the IDF has recently appointed Ms. Ann Keeling as Chief Executive Officer and Mario Fetz as Director of External Relations tasked to oversee the IDF's fund raising activities. Ms. Ann Keeling then gave a brief review of the Governance Review that will restructure the Executive Office of the IDF. The changes proposed in this Governance Review will be ratified during the General Council Meeting in Montreal, Canada during the IDF Meeting.

The other important items discussed during the meeting included : the creation of a Committee to work on the business plan of the IDF-WPR for the next triennium; the diabetes education strategy in the region; the Diabetes Research and Clinical Practice; World Diabetes Day celebration, the IDF Preliminary Strategic Plan and the 8th IDF-WPR Congress in Busan, Korea.

The WPR Education strategies include networking of dedicated diabetes educators in the region, surveying countries' education needs, promoting the IDF multidisciplinary education program, translation of IDF educational materials and enhancing health care professionals' competence. The Diabetes Research and Clinical Practice is now the official journal of the IDF with WPR retaining its primary affiliation with the journal. Its Editor-in-Chief is going to be chosen from the WPR. For World diabetes Day 2009 and the next five years, the theme will be on "Education and Prevention". All member nations were invited to participate actively in the forthcoming IDF-WPR Congress in Busan, Korea to be held on October 17-20, 2010.

The following were elected as Office-Bearers for the Triennium 2009-2012 : Chair - Prof. Yutaka Seino; Chair-Elect - Prof. Cho Nam-Han; Executive Committee Member - Prof. Weng Jianping; Executive Committee Member - Prof. Sidartawan Soegondo; and Executive Committee Member - Dr. Paul Williams.

The Chairman also encouraged countries to work with institutions to make the BRIDGES project of WPR with Eli-Lilly for translational research a reality.

Lastly, all member countries reported on their individual projects. The meeting was very tiring but encouraging as all member countries of the IDF-WPR pledged to continue their individual efforts to promote diabetes education and prevention. Till the next council meeting in Montreal, Canada in time for the IDF World Congress....

Navigating the Net: Surfing the Web for Lolo and Lola

Cecille R. dela Paz, MD
East Avenue Medical Center

We have all been amused by commercials that feature a tech-savvy *lola* having the time of her life on the internet. The web is just that - a collection of interconnected electronic documents from all over the world available at your fingertips. The internet is your gateway to a whole host of new and exciting activities. It could help you get in touch with family and friends here and abroad. You can use it to share your pictures and videos with the rest of the world. You could use the internet as your source of news and information - a valuable research tool on any conceivable topic. And you could do all of these without leaving the house! A lot of Filipino households nowadays have a computer at home and connecting to the internet has never been easier through internet server providers or ISPs which could be your phone or cable TV company. If you don't have a computer with internet access, going online is as easy as going to your neighborhood internet cafe. These days, they are becoming as ubiquitous as sari-sari stores. Senior citizens might be intimidated at first in trying to learn how to navigate the world wide web but it's easy once you know the basics.

If you are a complete newcomer to the world of computers, don't fret. You can ask your children or even your grandchildren to help you identify the different parts and their functions, and of course, how to turn it on. There are a lot of available online tutorial courses and you can access these websites (at first, with some help) to help you take your first steps into computer literacy. This website in particular - *www.bbc.co.uk/computertutor/computertutorone/* is a great starting point. This is the BBC (British Broadcasting Corporation) Computer Tutor. It is an audio-visual interactive guide that makes learning about computers fun . This site will teach you fundamental computer skills while playing games.

It may take some time until you get the hang of it but once you master the basics of using the computer, you are now ready to tackle the web. Again, there are a lot of available online courses and these sites will make life easier:

www.bbc.co.uk/webwise/course/

This links you to the BBC Webwise Online Course. It would be a good idea to start on this tutorial after completing the BBC Computer Tutor Course. The Webwise online course is a good way to learn the how to use the internet. It consists of ten modules and it will offer a comprehensive overview of web surfing - from the how to start an internet connection, to choosing a browser, searching online and emailing. Each module consists of several guides. It may take you some time to complete all of them but the course is flexible enough that you can learn at your own pace. At the end of each guide, you can take a quiz and this will give you a chance to test your knowledge on the topic presented . If you are stumped with terms that you cannot understand, the site also contains a dictionary of sorts - the jargonbuster - so you can look up explanations and definitions of technical terms that will come up during the course. There is even a section on using the healthy way to use the computer and other equipment safely - a particular concern for our seniors.

www.learnthenet.com

This website is another useful tool in learning about the web. It has dubbed itself as "The Internet Owner's Manual" and it is fairly easy to navigate . The left side of the screen contains the different topics that you click on to access. Everything from the basics, to emailing and even online shopping is covered in this website. One article everybody should read is on internet etiquette. The information superhighway is just like any road - all drivers traveling through cyberspace must know the road rules. You can read on this by clicking on "Master the Basics" then "Netiquette".

Hopefully, these guides will encourage our seniors to start using the computers at home and join the online community. So *lolo* and *lola*, welcome to the Information Age and let's go surfing!

Caring for the Aging: Websites and Internet Tools for Physicians Managing Elderly Diabetics

Cecilia A. Jimeno, MD
Manila Adventist Medical Cente

The elderly, and especially the elderly diabetic have special needs and concerns. Much like the other vulnerable group of infants or little children, the elderlt often require special attention, different food, various aids and devices and alterations in their treatment programs compared with other adults. Thus, physicians and health care workers managing elderly diabetics need to be knowledgeable and updated of trends in the management of elderly patients. Nowadays, one of the best sources of information is the world wide web or the internet. There are many websites that provide access to comprehensive content, advice, tips, technology and tools for doctors, nurses and care givers of elderly or aging diabetics.

Many of the general health information websites like the U.S. National Institute of Health's Medline database *(www.ncbi.nlm.nih.gov/Pubmed)* or the its counterpart in the U.K., the National Institute for Clinical Excellence *(www.nice.org.uk)* have searchable content for accessing clinical trials on studies on drugs and interventions, new diagnostic tests, guidelines or technology appraisals for various medical conditions including diabetes and its management in the elderly. The site *www.freemedicaljournals.com* gives complete lists of journals that allow free access to full- text articles.

There are also many journals on geriatric medicine that are available online, which either give free access to abstracts or full-text articles. Below is a table giving some websites of geriatrics, geriatric nursing journals and books on caring for geriatric patients:

Title of Journal	Web address
Geriatrics	
Age and Ageing	http://ageing.oupjournals.org
Journal of American Geriatric Society	www.americangeriatrics.org
Geriatrics	www.geri.com/geriatrics
Clinics in Geriatric Medicine	*www.wbsaunders.com*
Journal of Aging and Health	*www.sagepub.com*
Drugs and Aging	*www.adis.com/journals/drugsaging*
Geriatric Nursing	
Nursing Older People	*www.nursing-standard.co.uk*
Geriatric Nursing	*www.harcourthealth.com*
Geriatrics Textbooks	
The Merck Manual of Geriatrics	*www.merck.com/pubs/mm-geriatrics*
Topics in Geriatrics	*www.mayo.edu/geriatrics-rst*
Geriatric Assessment Methods for Clinical Decision Making	*http://text.nlm.nih.gov/nih/cdc*

Many of the medical professional organizations like the American Diabetes Association *(www.ada.org)* or the British Geriatric Society *(http://www.bgs.org.uk/SpecialInterest/ diabetes.htm)* also have entries regarding the management of diabetes in the elderly. The next table gives a summary of these medical organizations.

Table 2. Websites of Some Geriatrics societies

American Geriatrics Society	www.americangeriatrics.org
Australasian Society for Geriatric Medicine	www.asgm.org.au
British Geriatrics Society	www.bgs.org.uk
National Institute on Aging	www.nih.gov/nia

There are also some websites that are recommended for our elderly patients who are interested to learn more about their disease. The ElderNet site (www.eldernet.com/health.htm) is devoted to promoting health in the elderly and has many useful links. Other useful sites are Elderhope (www.elderhope.com); Eldersearch (www.eldersearch.com) or even the Yahoo seniors site (http://seniors.yahoo.com).

Finally, for elderly diabetics interested in communicating and interacting with other elderly diabetics about their various concerns, there are of course blog sites such as the http://diabeticseniors.blogspot.com/. Of course, nothing beats Facebook (www.facebook.com) or Multiply (www.multiply.com) or even Twitter (www.twitter.com) for networking with other people, whether young or old.

So, what's your "tweet" on dealing with diabetes in the elderly?

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3.http://www.healthinaging.org/public_education/diabetes/medications.php

diabetes philippines ON THE MOVE

14th PSH/PLAS Joint Annual Convention
February 11-13, 2009 (Crowne Plaza Galleria, Manila)

The Diabetes Philippines showcased its Information, Communication and Education materials during the 14th PSH/PLAS Joint Annual Convention held last February 11-13, 2009 at Crowne Plaza Galleria Manila with this year's theme "Bridging Basic Science and Clinical Practice in Atherosclerosis"

37th DiabetesWorkshop
February 20-21, 2009 (CAP Building, Vigan)

After a decade of waiting where it held its 16th DiabetesWorkshop in Laoag, the Diabetes Philippines in cooperation with Diabetes Philippines Ilocos Norte Chapter headed by Drs. Estrellita Garcia-Bringas and Eva Pipo conducted its 37th DiabetesWorkshop in the historic city of Vigan. The 1 ½ day of lectures, discussion and updates in diabetes management for the Ilocanos has been a success. Lay forum was also conducted on the 2nd day.

World Kidney Day
March 12, 2009 (Veterans Memorial Medical Center)

The second PSG/PSDE Philippine Digestive Week with the theme, "Tiyan-Katutak na Istorya: Ikalawang Hirit", was held at the Megatrade Hall 1 of the SM Megamall Building B in Mandaluyong City on 09 March 2008. The PDA participated in the said activity as a promotion of its advocacy campaign. IEC materials were also sold during the activity.

PMA Annual Convention
May 19-22, 2009 (EDSA Shangri-La Paza, Mandaluyong City)

Last May 21, 2009 during the annual convention of the Philippine Medical Association (PMA), the Diabetes Philippines headed by Dr. Susan Yu-Gan together with 6 other societies namely Philippine Society of Endocrinology and Metabolism (PSEM), Philippine Society of Nephrology (PSN), Philippine Society of Pediatric Metabolism and Endocrinology (PSPME), Phil. Academy of Ophthalmology, Phil. Society of Pathology and Philippine Academy of Lactation Consultants conducted a panel discussion about Gestational Diabetes focusing on Insulin Resistance as the root cause of diabetes in line with this years theme of the PMA which is "Womb to Tomb Across the Ages". Seats have been fully occupied during the said session.

3RD LTO ACCREDITED MEDICAL OFFICERS HEALTH AND SAFETY UPDATES
May 23, 2009 (Bulwagan Edu, Land Transportation Office, East Ave., Quezon City)

About 300 Medical Officers of the Land Transportation Office gathered last May 23, 2009 at the Land Transportation Office in Quezon City to learn and be informed on the newest updates on the prevention and management of deadly diseases which include Diabetes. Dr. Richard Elwyn Fernando, director of Diabetes Philippines is one of the speakers and discussed why Diabetes is a Silent Killer.

THE ASIAN ASSOCIATION FOR THE STUDY OF DIABETES

Tommy S. Ty Willing, MD
Metropolitan Medical Center

The Asian Association for the Study of Diabetes (AASD) was launched on March 6, 2009, in Taipei, Taiwan, during the council meeting of the International Diabetes Federation, Western Pacific Region (IDF-WPR). Diabetes associations in Asia were invited to participate.

The AASD was established for the purpose of facilitating discussion on various issues concerning diabetes mellitus and upgrading the level of diabetes research in Asia.

The AASD is comprised of 17 Diabetes Societies, listed in alphabetical order as follows: Cambodia, Diabetes Association, Chinese Diabetes Society, Chinese Taipei Diabetes Association, Diabetes Association of Thailand, Diabetes Hong Kong, Diabetes Philippines, Diabetes Society of Singapore Hong Kong Society of Endocrinology Metabolism and Reproduction, Indonesian Diabetes Association Japan Association for Diabetes Education and Care, Japan Diabetes Society, Korean Diabetes Association, Macau Diabetes Association, Malaysian Diabetes Association, Mongolian Diabetes Association, Taiwanese Association of Diabetes Educators and Vietnam Diabetes Association.

The Executive Board is composed of Prof. Yutaka Seino, Chair; Prof. Hong-Kyu Lee, Vice-Chair and Prof. Wen-Ying Yang, Vice-Chair.

The Board Members, listed in alphabetical order, are Prof. Juliana Chan, Prof. Nam Han Cho, Prof. Lee-Ming Chuang, Prof. Nigishi Hotta, Prof. Takashi Kadowaki, Prof. Moon-Kyu Lee, Prof. Kishio Nanjo, Prof. Naoko Tajima, Prof. Kathryn Tan and Prof. Jianping Weng.

Among the main activities of the AASD are the convening of annual meetings and publishing of an official journal, the "Journal of Diabetes Investigation" referred to as JDI. Prof. Nigishi Hotta is Editor-in-Chief of the journal.

On May 22, 2009, during the 52nd Annual Meeting of the Japan Diabetes Society, the first annual meeting of the AASD was launched with the opening session discussing the "Pathophysiology of Type 2 Diabetes in Asia".

During the AASD Kick-off Symposium the following topics were tackled: Diabetic Complications from Asian Point of View, Prof. Kathryn Tan; Prevention Program from Asian Point of View, Prof. Naoko Tajima; Genetics of Diabetes from Asian Point of View, Prof. Limei Liu; Insulin Resistance from Asian Point of View, Pro. L.T. Ho and Beta Cells from Asian Point of View, Prof. Moon Kyu Lee.

After the symposium, a round table discussion tackled the topic "How to Treat Asian Diabetes". It was chaired by Prof. Atsunori Kashiwagi. The discussants were Khasag Altaisaikhan (Mongolia), Jong Koi Chong (Malaysia), Lim Keuky (Cambodia), Ta Van Binh (Vietnam), Wanee Nitiyanant (Thailand), Sidartawan Soegondo (Indonesia), Tommy S. Ty Willing (Philippines) and Chikako Ito (Japan)

Prof. Jean Claude Mbanya, IDF President-elect and Prof. Edwin Gale, President of the European Association for the Study on Diabetes were the keynote speakers.

IDF CLINICAL GUIDELINE IMPLEMENTATION WORKSHOP

Tommy S. Ty Willing, MD
Metropolitan Medical Center

The International Diabetes Federation (IDF) and the IDF Western Pacific Region invited Diabetes Philippines and other Asian countries to participate in a workshop on the implementation of the IDF Global Guideline for Type 2 diabetes. This is part of the IDF/United Nations Resolution Implementation Plan designed to review each country's progress, to provide and receive advice on the implementation of the global guideline. The meeting was held on April 20, 2009 in Kuala Lumpur, Malaysia.

The objectives of the meeting are: 1) To review the guideline and assess progress within countries in achieving the guideline objectives and targets 2) To identify areas of diabetes prevention and care which could be improved through implementation of the guideline recommendations 3) To assist in developing in-country plans to implement the guideline recommendations in the identified areas of need.

The workshop program was started with an introduction by Prof. Stephen Colagiuri, followed by talks on UN Resolution on Diabetes, IDF Guideline Development and the IDF Global Guideline on Type 2 Diabetes; while Prof. Marg McGill discussed the Outline of IDF Multidisciplinary Health Professionals Education Programme. All the delegates reported on Diabetes in Participating Countries, Diabetes Guidelines in Participating Countries and discussed such topics as The Relevance of IDF Global Guideline in Participating Countries, Setting Guideline Priorities and Identifying Barriers, Addressing Barriers to Guideline Implementation. These sessions were chaired by Pro. Stephen Colagiuri of Sydney Australia and Prof. Ikram Shah b Ismail. Dr. Tommy Ty Willing, chairman and president of Diabetes Philippines and Dr. Cecilia Jimeno, Chair of the Technical Review Committee on Clinical Practice Guidelines represented Diabetes Philippines.

The success of implementing the IDF Global Guideline for Type 2 Diabetes is dependent on the strength and guidance of local and regional key opinion leaders to champion the cause of diabetes prevention and care. Their ability to inform, educate and influence health authorities and fellow healthcare professionals in their respective countries is crucial for effective implementation and ongoing development.

International Diabetes Federation

Lola Techie: Bridging the digital divide

Iris Thiele Isip Tan, MD
San Juan De Dios Hospital

Everyone's talking about *Lola* Techie in the latest internet service provider commercial! After all, isn't it unusual for a Lola to not only be on Facebook but on Twitter and Plurk as well?[1] Market research says that only 11 percent of the Filipino elderly know how to use the internet. Disparities in internet use across social and ethnic strata have long been recognized as the "digital divide". In the US, roughly 70 percent of the population use the Internet but the elderly, nonwhite race/ethnic groups and the poor are less likely to be online - groups more likely to suffer from diabetes.

Perhaps *Lola* Techie can lead the way for the Filipino elderly to embrace the Internet. After all, in a survey [2] conducted in Michigan to document World Wide Web use patterns in middle-aged (ages 40-59), young old (ages 60-74) and old-old adults (ages 75-92), it was found that the two primary predictors for not using the Web were the lack of access to a computer and lack of knowledge about the Web. Hopefully, *Lola* Techie will inspire the Filipino elderly to demand computer time and learn more about the Internet. In the Michigan survey, 60 percent of the old-old respondents, 57 percent of the young-old respondents and 75 percent of the middle-aged respondents specifically wanted to "learn how to access health-related information." *Lola* Techie could surely be googling health information in between Twitter and Facebook!

Emerging Internet technologies have been used to support diabetes care.[4] These include websites that can be used to monitor, educate, provide feedback and facilitate communication with medical staff.

A lot of research is being done in health information technology to develop helpful tools in the management of chronic diseases such as diabetes. But will these tools be useful in the digital divide where the elderly are not connected to the Internet? In an interesting article[3] published in Diabetes Care last March 2008, the authors "hypothesized that diabetic patients not currently online might nonetheless be receptive to adopting future technologies designed to support their diabetes care." In this study, a mail survey was conducted in 4,024 type 2 diabetics in primary care in Massachusetts. Of the 952 respondents,

Internet users were nearly a decade younger, were twice as likely to have a college education and were more likely to be aware of their HbA1c level. Internet users were also more likely than nonusers to use non-health care technology such as cell phones (89 percent vs 38 percent) and digital cameras (56 percent vs 6 percent) And yet despite these significant differences, both users and nonusers were eager to use technology facilitating information-sharing with their doctors i.e. wireless glucometer, BP cuff, activity monitor, scales and smart pillboxes. While the respondents were eager to adopt technology that will allow personalized goals and feedback, the idea of conducting an online visit in place of a clinic visit was unpopular. So perhaps, while we can expect *Lola* Techie to give her doctor a poke in Facebook, she will most likely still want a face-to-face consultation.

Emerging Internet technologies have been used to support diabetes care.[4] These include websites that can be used to monitor, educate, provide feedback and facilitate communication with medical staff. There are websites that focus on all aspects of diabetes self-management. Web portals serve as points of access to information on the Internet from varied sources. Web portals have been used to in diabetes care to allow access to electronic medical records, medication and health history and to provide health care reminders and educational materials. Studies are underway to look at how web-based electronic medical records (EMR) can be integrated with diabetes management. Several interventions used Short Messaging Systems (SMS) as part of an Internet-base blood glucose monitoring system. Patients uploaded blood glucose or blood pressure date to a secure Internet server via cell phone, which were then posted on their EMR. Medical staff reviewed and transmitted recommendations back to the patient via SMS. It has also been suggested that videoconferencing in diabetes care may be more effective than voice-only-contact. Videoconferencing mimicked face-to-face encounters and increased patient satisfaction.

The potential of Internet-based technologies to improve outcomes in patients with diabetes can only be realized if a bridge can be slung over the digital divide that isolates the Filipino elderly. Let us hope that *Lola* Techie will help us get there. ○

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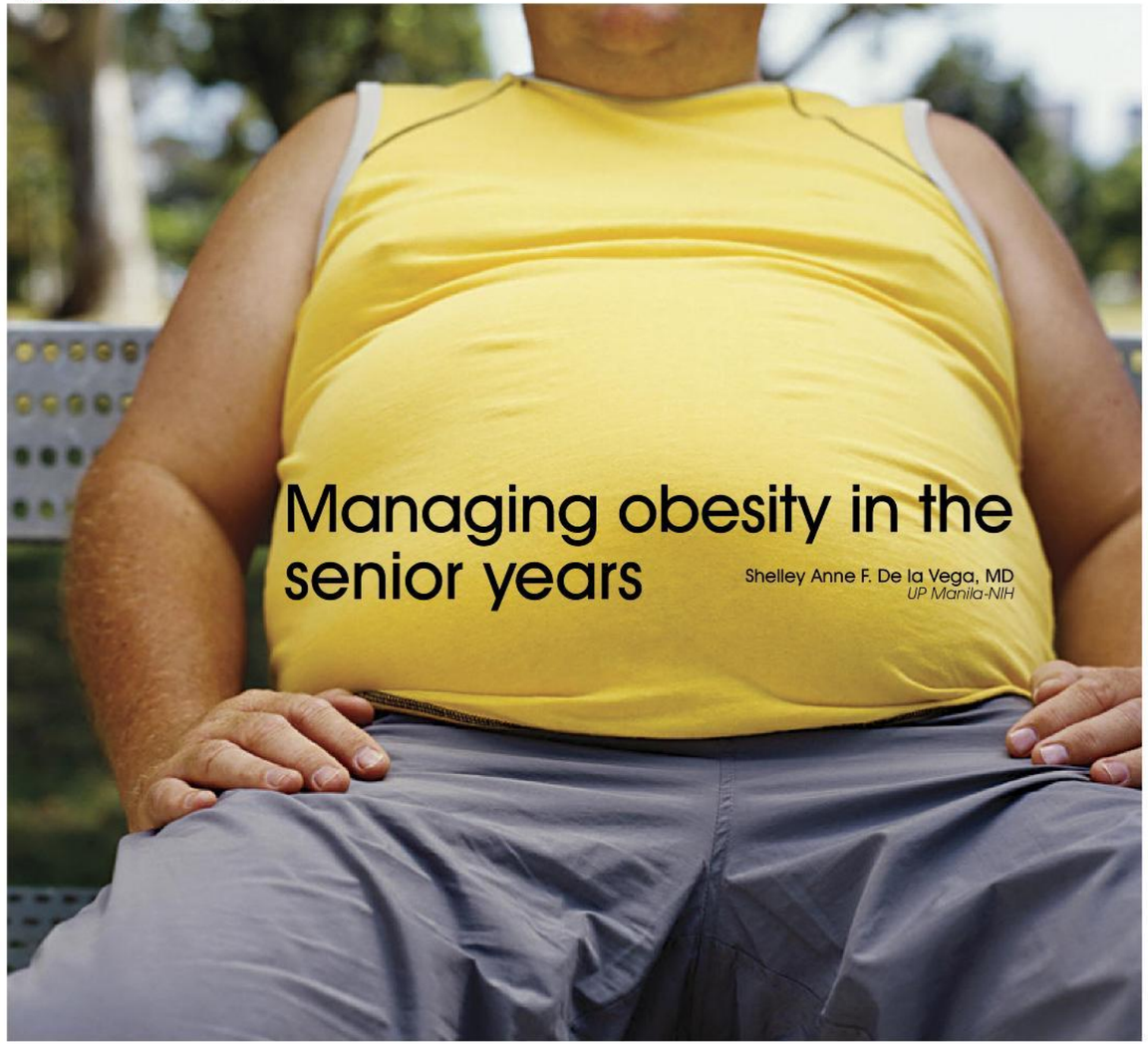


Managing obesity in the senior years

Shelley Anne F. De la Vega, MD
UP Manila-NIH

Is obesity a problem among older Filipinos?

In the 2002 Baseline Survey on the National Objectives of Health (BSNOH OLDER PERSONS, NIH-DOH), 2,690 Filipinos age 60 and older were asked to answer questions regarding nutrition. In this survey, 70 percent described themselves to be medium built (KATAMTAMANG PANGANGATAWAN), 21 percent considered themselves as thin (PAYAT), while only 9.2 percent described themselves as overweight or obese (MATABA). The medium built group described eating a moderate amount of food (66 percent), regularly eating vegetables and exercising (33 percent AND 30 percent respectively) as the main reasons for maintaining their weight. The obese group described eating more than 2 plates of food and lack of exercise as the main reasons for their being obese. Only 1.2 percent of the seniors surveyed received any form of nutritional counseling.

Is obesity bad for older persons?

The association between obesity and mortality declines as age increases. The relationship between obesity and mortality declines with increasing age. Disabled seniors who are obese have a lower mortality rate than underweight frail seniors. Nevertheless, obesity among seniors does continue to increase the risk for heart disease, stroke, some cancers, and arthritis.

What strategies are effecting in managing overweight and obese older persons?

Intensive counseling strategies incorporating behavioral, dietary, and exercise components promote weight loss among older persons. Benefits of such weight loss programs include improved physical functioning, reduced incidence of diabetes and improvement in hypertension. However, it may cause reduced bone density which may lead to osteoporosis. We do not have enough studies on the safe and effective use of surgery (ex. Bariatric) or weight loss pills for older persons. Older persons with heart disease benefit the most with weight reduction. However, treatment should incorporate measures to avoid bone loss such as taking calcium, vitamin D.

Weight loss programs for older persons need to be done on an individualized basis, with special attention to the medical conditions of each individual. This is best performed thru a Comprehensive Geriatric Assessment. Exercise is best started under close supervision of a Rehabilitation specialist.

How can an older person keep fit?

Find activities that they can incorporate into daily behavior. Some useful advice includes:

1. Walk rather than ride a tricycle.
2. Begin hobbies or volunteer in activities requiring physical activity such as gardening, tree planting.
3. Incorporate light physical activity into daily routine. Ex. walk to church, housework.
4. Participate in physical activities with grandchildren. Ex. Brisk walking around the neighborhood or park.
5. Write a food and activity diary and become aware of reasons why you overeat.
6. Encourage your spouse or join a senior citizen club that hosts regular fitness activities like Tai Chi or ballroom dancing.

How can physicians help obese older patients?

Physicians taking care of older patients need to counsel all patients to reduce their consumption of fats and increase their consumption of fruits, vegetables, brown rice and fish. They need to advise older patients about incorporating physical activity into their lives as above. Because counseling alone has not been shown to work, physicians may refer their older obese patients to clinics that are equipped with a multidisciplinary weight management team.

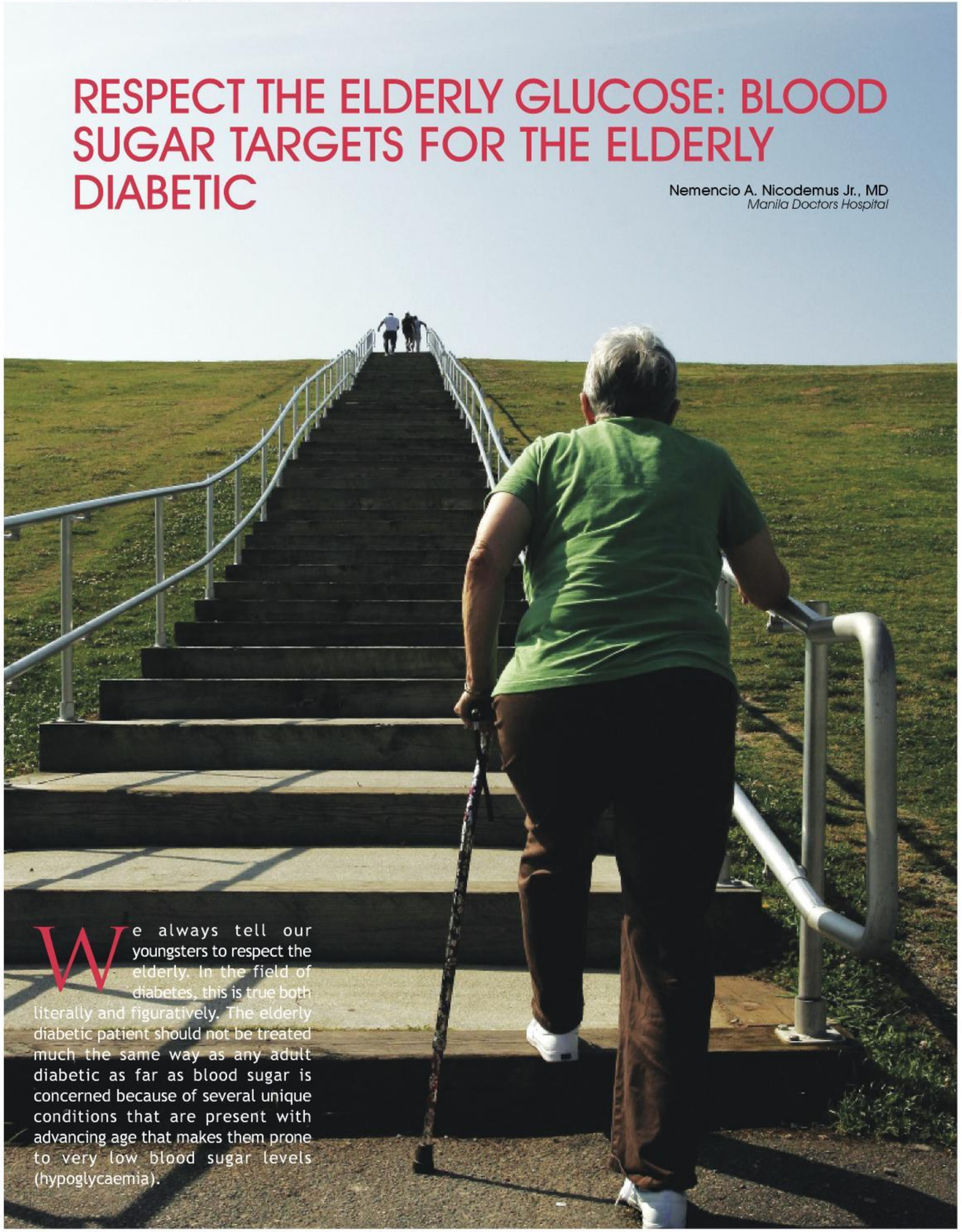
What is the role of the community and the government in promoting health and fitness as people age?

Communities need to provide seniors with safe and accessible areas that can help them remain active and functionally independent. Nutritional education and counseling of Filipinos should include the old. The Active Aging Framework of the WHO encourages optimizing opportunities for health, participation and security in order to enhance quality of life as people age. The NAST Resolutions on Active Aging (Manila Hotel 2009) proposed the following:

1. Create an enabling and conducive work environment while allowing the elderly to work and remain productive (DSWD and DOLE);
2. Develop nutritional standards for the elderly that are affordable and cost effective (DOST);
3. Develop technology for improved access, functional independence, and social connectivity for senior citizens (DOST).
4. Launch information and education campaign to promote lifestyle change through primary and secondary education on aging (DepEd)

RESPECT THE ELDERLY GLUCOSE: BLOOD SUGAR TARGETS FOR THE ELDERLY DIABETIC

Nemencio A. Nicodemus Jr., MD
Manila Doctors Hospital



We always tell our youngsters to respect the elderly. In the field of diabetes, this is true both literally and figuratively. The elderly diabetic patient should not be treated much the same way as any adult diabetic as far as blood sugar is concerned because of several unique conditions that are present with advancing age that makes them prone to very low blood sugar levels (hypoglycaemia).

In the United States, at least 20 percent of patients over the age of 65 years have diabetes. Although we do not have local statistics, it will likely be close to this figure as well. Studies show that older individuals with diabetes have higher rates of premature death, functional disability and coexisting illnesses such as hypertension, CHD and stroke. Because of these, they are also at greater risk for several common geriatric syndromes, such as polypharmacy, depression, cognitive impairment, urinary incontinence, injurious falls, and persistent pain.

Not all elderly diabetics are the same. Some develop diabetes years earlier and may have significant complications. Others who are newly diagnosed may have few complications from the disease. Some older adults with diabetes are frail and have other underlying chronic conditions, or limited physical or cognitive functioning. Other older individuals with diabetes have little co-morbidity and are active. We must, therefore, take this heterogeneity into consideration when setting and prioritizing treatment goals.

Experts recommend that patients who are active, have good cognitive

function, and have significant life expectancy should be encouraged to undertake the responsibility of caring for themselves and be treated using the goals for younger adults with diabetes. Thus, glycosylated hemoglobin (HbA1c) should be brought down to less than or equal to 6.5 percent or fasting blood glucose brought down to less than 110 mg/dl (6.1 mmol/L), as long as this can be achieved as safely as possible. Elderly patients with advanced diabetes complications, severe co-morbid illnesses, or substantial cognitive or functional impairment, should have less intensive glycemic target goals (i.e., HbA1c less than 7 percent or Fasting blood glucose less than 130 mg/dl) because they are less likely to benefit from reducing the risk of microvascular complications and more likely to suffer serious adverse effects from hypoglycemia. For this group of patients, blood sugar targets should be less strict and may be individualized, as long as the hyperglycemia does not

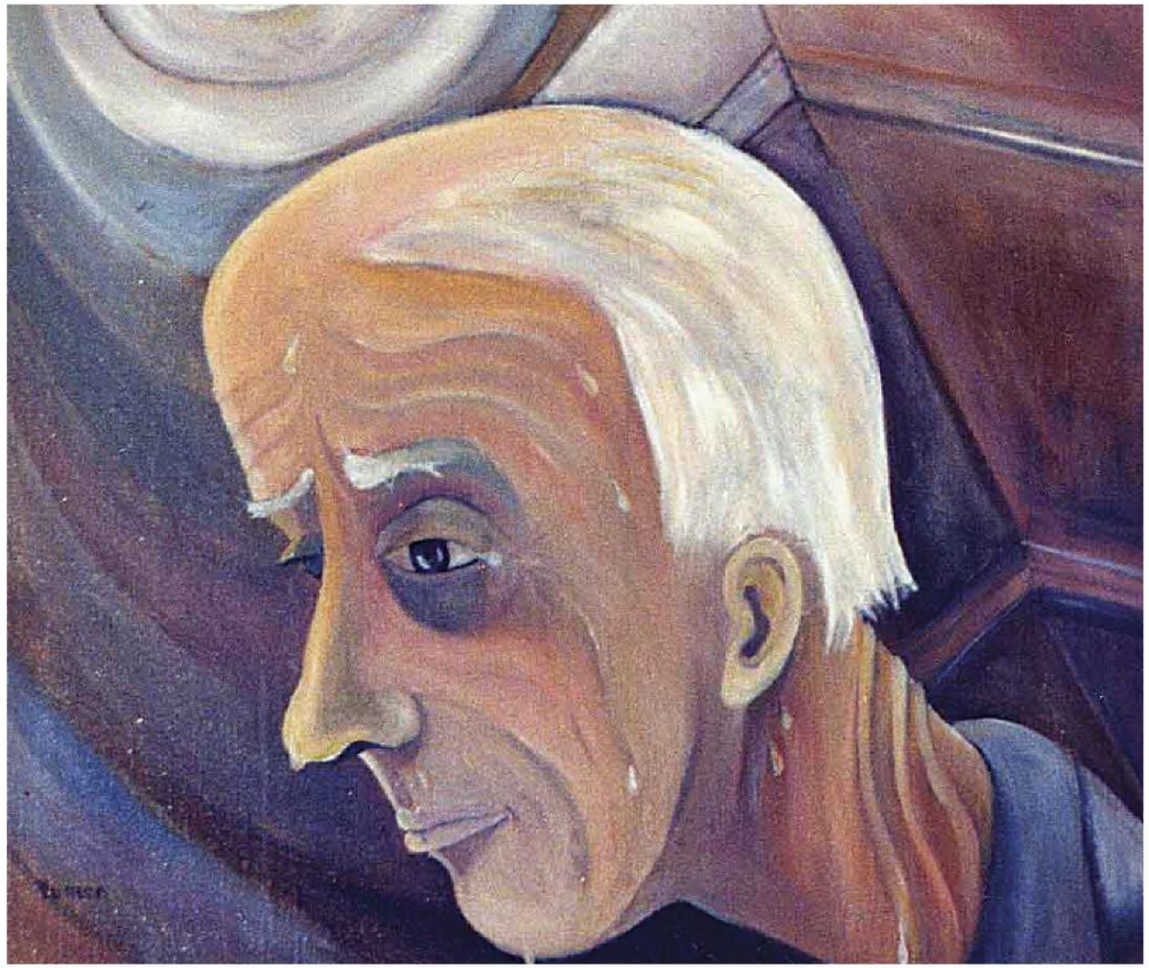
increase the risk of acute complications.

Although control of hyperglycemia may be important in older individuals with diabetes, greater reductions in morbidity and death may result from control of other cardiovascular risk factors rather than from tight glucose control alone. Thus, other cardiovascular risk factors should be treated with the same aggressiveness in older adults. Hypertension and cholesterol control is indicated in all older adults, using several drugs that have already been proven in clinical trials. Aspirin therapy has been shown to benefit older patients with good life expectancy. However, we must remember that the older human body may react differently with medication and therefore, drugs should be started at the lowest dose and titrated up gradually until targets are reached or side effects develop.

Since very few clinical trials involve the elderly diabetic patients, most of the recommendations in the management of this subset of patients come from expert opinions.

Our goal, ultimately, among the elderly diabetics is for them to have good quality of life with minimal, if not free of, complications. Thus, screening for diabetes complications should be individualized in older adults. However, particular attention should be paid to complications that would lead to functional impairment.

In this issue of DiabetesWatch, visual impairment is discussed in another article.



Diabetes and Dementia: The Otherwise but Sweet Connection

Doris M. De la Cuesta-Camagay, MD
Manila Doctor's Hospital

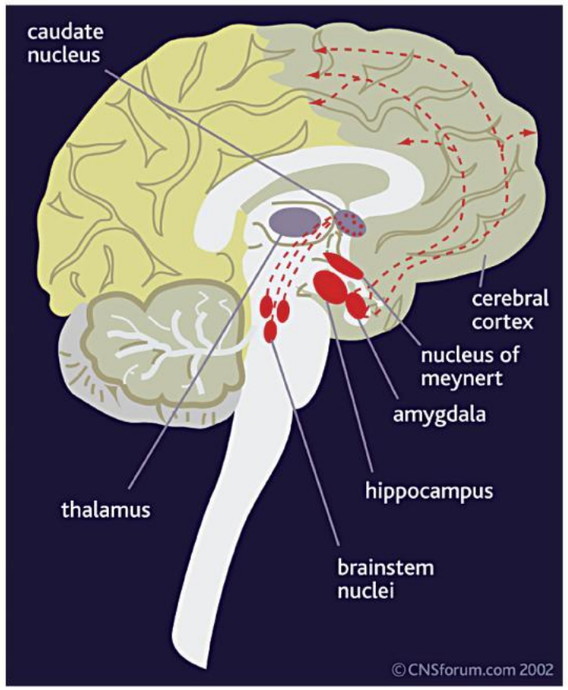
We have all been amusedWe all know that diabetes is a serious disease. It can lead to dangerous health problems, even disability over time, when uncontrolled. We also know that high glucose levels can be managed to prevent or delay future medical concerns. But do we know that diabetes is now also a risk factor for Alzheimer's disease (AD)? Studies are now establishing the otherwise but sweet connection between diabetes and dementia, and showing whether blood glucose control is the focus of prevention of either disease.

The Burden

Dementia is a syndrome characterized primarily by memory impairment, loss of intellectual functions including language and communication, and declining functional ability. Alzheimers disease is one of the irreversible dementias, and the most devastating to the afflicted, and his family. A report prepared by the member countries of Alzheimers Disease International says that in the Asia Pacific region, the number of those afflicted with AD has been increasing from 13 million in 2005 and may reach 64.6 million in 2050. The report of this coalition of nations advocating for the research and care of Alzheimer's Disease further states that the greatest risk factor for dementia is increasing age: after 65, the risk increases exponentially every 5 years. So the older one lives, the greater is the tendency to lose one's mental capacity to a dreaded health concern, and not the kind of slowing of information retrieval due to age. Other factors also related to the development of dementia include hypertension, lack of education, head trauma or any intracerebral vascular insult and family history. Familial factors involved may be genetic, or environmental and lifestyle. As a result of increasing longevity and obesity, diabetes is now considered an epidemic by the World Health Organization because in the Asia-Pacific region alone, there are more than 30 million afflicted with the disease. In Southeast Asia, epidemiologic data is considered scarce, but in the Philippines the prevalence is an estimated 8% in Metromanila and urban centers, similar to Indonesia and Malaysia. With diabetes on epidemic proportions, because of this link, AD and the other dementias will also be on the rise and there is no time to lose.

Although the connection between diabetes and dementia is still not clearly understood, population studies about in western countries are more and more demonstrating the association of the two health concerns.

A popular scientific investigation, The Religious Orders study from the Rush Alzheimer's Disease Center of Chicago, USA followed closely for 5.5 years the cognitive performance of more than 800 nuns, priests and brothers through neuropsychological testing and other evaluation procedures. Over the study period, 151 had a clinical diagnosis of AD, including 31 who had diabetes. The researchers found a 65% increase



in the risk of developing AD among diabetics compared with those who did not have diabetes. But whether the link is due to an AD related process, or because those who developed AD initially had vascular related complications like stroke or high blood pressure was not demonstrated in the Rush research.

Of the two kinds of diabetes, Type 2 diabetes mellitus is the one associated with being overweight, lacking exercise, and having a diet rich in calories. It is also associated with high cholesterol, high blood pressure and smoking in the middle years. Now researches say that these are also the negative risk factors for the health problems of the brain, in the later years. Recent scientific investigations seem to establish more firmly blood pressure, blood sugar and cholesterol levels to the risk of dementia development.

The Diabetes and Alzheimers disease connections

The Alzheimer's Association, a leader in Alzheimer's disease research, care and education proposed several mechanisms to explain the staggering connection between Alzheimer's disease and dementia. First focusing on the biologic mechanism, they carefully expounded on the role of insulin resistance on the development of Type2 Diabetes Mellitus, and then linked insulin resistance to high blood sugar to an increased risk for dementia.

Whilst Type 1 diabetes mellitus is characterized by a lack of production of insulin; in Type 2 there is an adequate production but the body is unable to use it causing a situation of "insulin resistance." This is diagnosed by having abnormally high levels of insulin, and yet the blood sugar levels are within normal or slightly above. Insulin resistance is the underlying feature of "metabolic syndrome," the condition that increases risk for heart disease, diabetes mellitus and stroke.

Metabolic syndrome is identified by the presence of three or more of these signs:

Parameter	Women	Men
Waistline	>35 in	>40 in
HDL	<40 mg/dL	<50mg/dL
Triglycerides	>150mg/dl	>150mg/dL
Blood Pressure	=/> 130/85	=/> 130/85
Fasting Blood Glucose	100-110mg/dl	100-110mg/dl

The sharing of risk factors of either dementia or diabetes were the first observations that led scientists to expand their investigations and have found a biochemical and genetic link between high levels of insulin (greater than 89.4pmol/L) and high levels of APOe-4, the gene that significantly raises Alzheimer's disease risk. The recent advisory from Alzheimer's Association have also pointed out that high insulin levels can also overactivate the enzyme glycogen synthetase kinase 3 (GSK3). GSK3 is the lead enzyme that breaks down the tau protein into neurofibrillary tangles, a hallmark of AD. Another hallmark upon autopsy is the formation of amyloid plaques, of which the first step of its formation is initiated by insulin degrading enzyme (IDE), which are broken down rapidly after a meal.

Even if before these biochemical and genetic links were studied , insulin

Weight loss and physical activity lowers the risk of developing diabetes by improving the body's ability to use insulin and process glucose. The key for dementia-free later years is clear: an active life, low fat diet, and maintaining an ideal body weight.

resistance, Type 2 diabetes mellitus and metabolic syndrome have been well established as risk factors for heart disease and stroke. Though they may not really influence AD development processes, they also increase the risk for Vascular Dementia by affecting the blood vessels in the brain. Vascular Dementia is the second most common cause of the dementias.

Managing Diabetes

Does it mean then that there is no other way to age but have AD or dementia especially among those with strong family histories? So far, no study that shows treatment of diabetes and insulin resistance can prevent or delay the development of AD or the other dementias. Scientists have also tested in small scale, the promise of treatment with anti-diabetic agents of AD patients without diabetes. The results showed some slowing of the cognitive decline with one agent-rosiglitazone-- hence a large Phase III study was recently launched in US and Canada.

Control of midlife heart risk factors, which are also associated with metabolic syndrome, can also reduce the development of dementias in the later years. Scientists from California and Finland who tracked some 10,000 men and women for four decades found out that with a cholesterol level of above 200mg/dL the risk of AD started to go up. Likewise, researchers from the University of Minnesota, the University of North Carolina, John Hopkins and the Mississippi University Center found out that smokers were 70 percent more likely to develop dementia than nonsmokers; those with high blood pressure were 60 percent more likely, and those with diabetes were twice as likely as those without diabetes to develop dementia.
Clearly, what has been known about

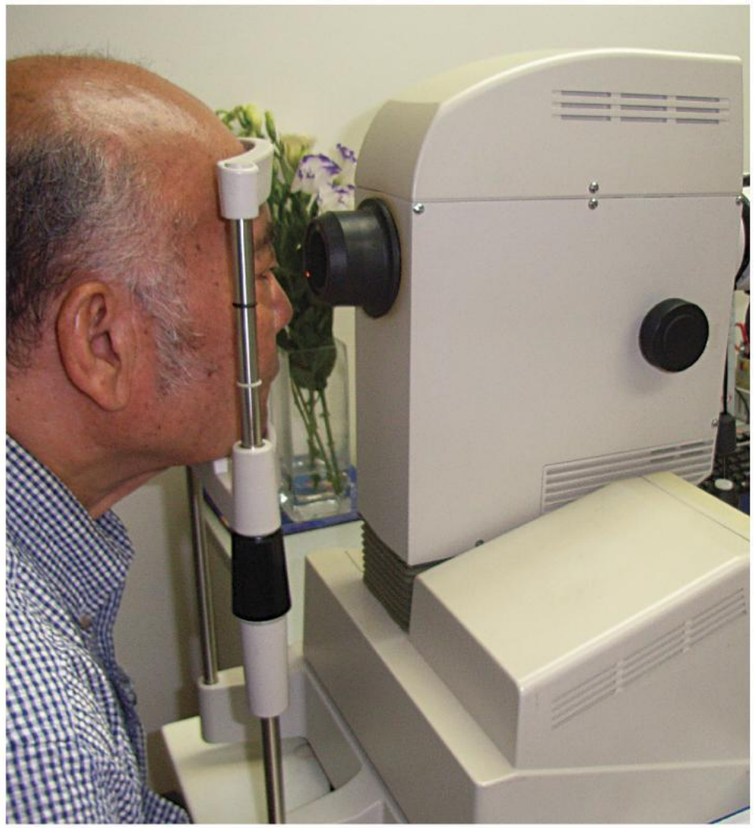
prevention of heart disease and stroke, are also true for the prevention of dementia.

How else to prevent Alzheimer's Disease

Studies on lifestyle modification tell us that there is hope especially for overweight pre-diabetics. In the US, the Diabetes Prevention Program enrolled more than 3,000 elderly pre-diabetics (those who have blood sugar levels higher than normal but not high enough to be called diabetes) and through a program of walking or other moderate exercise 30 minutes five days each week, and eating a low fat diet, demonstrated a loss of 5-7 percent of their body weight and reduced the future risk for diabetes by 58 percent. The program also showed that taking Metformin alone, a drug commonly prescribed to overweight diabetics, without diet and lifestyle modification, was also effective, but in a less dramatic outcome. Weight loss and physical activity lowers the risk of developing diabetes by improving the body's ability to use insulin and process glucose. The key for dementia-free later years is clear: an active life, low fat diet, and maintaining an ideal body weight.

Issues In The Management Of The Visually-Impaired Diabetic Elderly

Estrellita Aurora S. Genuino, M.D.
Manila Doctor's Hospital



Despite developments in the medical management of diabetes and subsequent increase in life span of people with diabetes, it is still inevitable that most diabetics will experience some degree of visual impairment or loss in the decades after onset of the disease.

Major complications of diabetes affecting the eye and causing visual impairment among diabetics include the following: Cataract - the clouding of the eye's lenses which are responsible for the focusing of objects in the person's eyes; Glaucoma - the increase in fluid pressure of the eyes that may lead to damage to the optic nerve which transmits visual pulses to the brain; and most commonly, Diabetic Retinopathy - the damage to the blood vessels in the retina which is a layer of cells inside the eye responsible for light perception.

Diabetics with visual impairment may experience signs and symptoms like blurring or even loss of vision, floating of spots in the eye/s, pain in one or both eyes, inability to identify colors and distortion of objects seen, among others. Some may even have no signs and symptoms despite the presence of complications within the eye. It is therefore essential that diabetic patients have at least annual eye examination -with or without visual complaints- with an ophthalmologist. [Buying a new pair of glasses because of blurred vision may not be enough to clear one's sight because blood sugar levels at any time of the day may affect one's vision]

Tests during the examination include Visual Acuity Test which measures how well one sees at various distances using a vision chart (Snellen and/or Near Vision Chart); Tonometry which uses an instrument that measures the pressures of the eyes; Dilated Eye Exam which allows the ophthalmologist to view the inside of the eye with the use of a lens and light source; and Fundus Photo and Fluorescein Angiography, if indicated by the ophthalmologist, which takes pictures of the inner eye to detect any problems with blood vessels.

Management of diabetics with visual impairment would depend on the results of the eye examination and control of diabetes. Early detection and treatment may save one's vision. Treatment may often include laser therapy or surgery. Low vision rehabilitation can be addressed with certain magnification devices if and when impairment cannot be corrected medically, surgically or with conventional glasses.