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1. Drouin P. and the Diamicron MR Study Group. *J Diabetes Complications*. 2000; 14 : 185-191
2. Gribble FM, Ashcroft. *Diabetologia* 1999; 42 : 845-848.
3. O'Brien R.J. *Diabetes Complications*. 2000; 14 : 201-206
4. Kimoto K, Susuki K, Kizaki T, et al. *Biochem Biophys Res Com*, 2003; 33 : 112-119

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diabetesWATCH

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July - December 2009 YEAR XXIX, NO.2

philippines

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What's Too Little can be
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- Cusi K, Corsoli A, DeFronzo RA. Metabolic effects of metformin on glucose and lactate metabolism in non-insulin dependent diabetes mellitus. *J Clin Endocrinol Metab* 1996; 81 (11): 4059-67.
- Landin K, Tengborn L, Smith UJ. Treating Insulin Resistance in hypertension with metformin reduces both blood pressure and metabolic risk factors. *J Intern Med* 1991; Feb; 229:181-7
- UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). *Lancet* 1998; 352: 854-665.



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From the EDITOR'S DESK



Morbidity from diabetes involves both macrovascular (atherosclerosis) and microvascular diseases (retinopathy, nephropathy, and neuropathy).

This issue focuses on microvascular complications. These are blindness, kidney failure and loss of limb...quite devastating, yet preventable. So the earlier a diabetic recognizes, accepts and understands the disease process, the greater the likelihood of not having these complications and its accompanying burdens.

Early screening of high risk individuals to detect diabetes and proper management in known diabetics are important steps to preventing these complications. Interventions such as excellent blood sugar and blood pressure control and smoking cessation can limit end-organ damage. Proper and timely monitoring with foot examination, dilated eye exam, measurements of hemoglobin A1C, microalbumin and serum creatinine, to name a few, are essential in providing good care for the diabetic patient.

Go check yourself and assess your status. Consult with your doctor. Remember, we can prevent these complications. Hope you learn a lot from this issue with varied topics focusing on microvascular diseases in diabetes.

Let's all welcome the new decade with renewed hope and steadfast faith!

Elizabeth Paz-Pacheco
Elizabeth Paz-Pacheco, MD
Editor-in-chief



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OUR VISION

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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



Diabetes Day celebration.

Meanwhile the staffs for DiabetesWatch have chosen to tackle, in the July-December issue, the microvascular complications of diabetes.

As the night gets longer and temperature gets cooler, and Christmas carols fill the air, I would like to greet everyone a Merry Christmas and a Happy New Year.

Tommy S. Ty Willing

Tommy S. Ty Willing, MD
President



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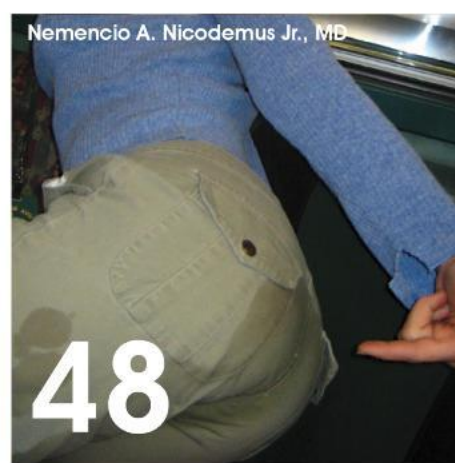
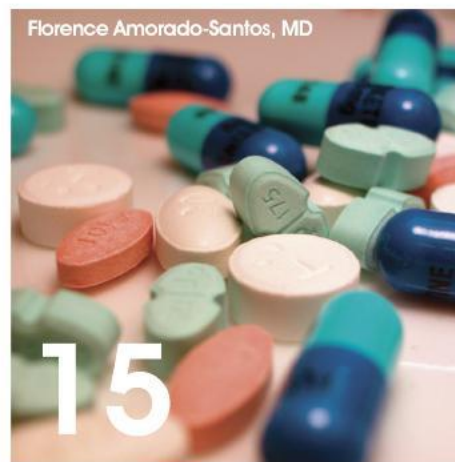
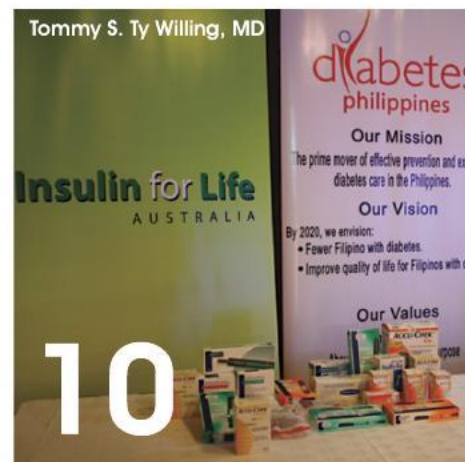
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July - December 2009



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MEANDERINGS



Eye complication in Type 1 diabetes predicted by high hemoglobin

Augusto D. Lifonjua, MD
Editor Emeritus

"We became interested in this possibility after recognizing that some animal studies had suggested erythropoietin (a kidney hormone that matures the red blood cells) and related growth factors promoted retinopathy and our own observation that patients with type 1 diabetes have - at least in young adulthood - higher hemoglobin levels."

- Trevor J. Orchard, M.B.B.Ch., M.Med.Sci., F.A.H.A.

High hemoglobin levels may be associated with an advanced type of eye complication in type 1 diabetes mellitus. This is called proliferative diabetic retinopathy (PDR). The findings were reported by the Pittsburgh Epidemiology of Diabetes Complications Study and published in a recent issue of the *Archives of Ophthalmology*.

Dr. Trevor J. Orchard of the Study Group says, "We became interested in this possibility after recognizing that some animal studies had suggested erythropoietin (a kidney hormone that matures the red blood cells) and related growth factors promoted retinopathy and our own observation that patients with type 1 diabetes have - at least in young adulthood - higher hemoglobin levels."

The mechanism between hemoglobin and the eye complication is likely to be a complex one. The physical properties of blood flow are altered in diabetes and these disturbances might be associated with retinopathy. Some studies indicate that anemia may be related to PDR, whereas other



evidence links the condition to increased red cell volume and viscosity.

The study enrolled patients between 1986 and 1988. The mean age of the subjects was 28 years and the mean duration of their diabetes was 19 years. At the start of the study, all subjects were free of PDR. Hemoglobin levels at start ranged from 9.2 to 20.0 g/dL in men and 14.1 g/dL in women.

Four hundred twenty six participants underwent an 18 year follow-up examination with visual field testing and photographs of their fundi between

the years 2004 and 2007. The incidence of PDR was 48 percent. The findings in men showed a 'linear positive association' between hemoglobin and PDR incidence. In women, hemoglobin levels were significantly predictive of PDR. While the authors caution the interpretation of the sex differences, but believe that their findings may influence clinical treatment. Initially, it is conceivable that hemoglobin levels could help identify those most at risk. These patients should allow initiation of general intensive prevention, e.g, A1c and blood pressure control. Later on, it may be possible that specific interventions could be mounted when the pathogenetic pathways are more fully understood.

Dr. Orchard strongly urges physicians to 'be on the lookout for retinopathy progression in these type 1 diabetic patients with a hemoglobin greater than 16.0 g/dL. (This item quotes a lot from Karla Gale's report from Reuters Health Information). ○

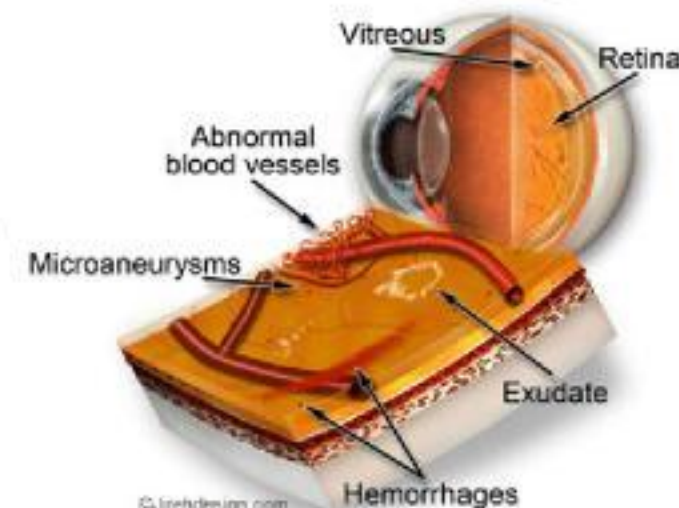
EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT DIABETES (BUT WAS AFRAID TO ASK!)

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



Complications from diabetes can be prevented. Knowledge of such is the first step in prevention. In this issue of Diabetes Watch we will answer your questions on one of the most dreaded complication of diabetes - diabetic retinopathy.

Diabetic Retinopathy



I have some blurring of vision. I noticed this whenever my sugars are high. Will I go blind?

High blood sugar is associated with some blurring of vision. The blurring resolves as your sugar is in good control. More important however is that diabetes can affect the back of the eye called retina. When blood vessels in the retina are damaged, they may leak, bleed, swell, or develop branches. This damage can lead to diabetic retinopathy. In advanced eye disease from diabetes, you can go blind.

Are there symptoms which I should watch out for?

Watch out for blurring of vision, blank areas, or glare when in bright light. As the disease progresses you may experience some cloudy vision, blind spots, and floaters. Floaters are small spots that float across the field of vision. If you experience any of the above, you should go to your eye doctor as soon as possible.

What do I do to prevent blindness from diabetes?

DM retinopathy is now the leading cause of blindness here in the Philippines. This complication from diabetes is absolutely preventable. The first step is to control your blood sugars. Several studies - the Diabetes Control and Complications Trial and the United Kingdom Prospective Diabetes Study have shown that if we control our blood sugar, the risk of getting DM retinopathy will be reduced. The other strategy is to see your eye doctor once a year or even every 6 months if you have eye problems.

My eye doctor said that I have some bleeding and swelling

at the back of my eye and I need laser. Is the procedure safe?

The leaking vessels are usually treated directly with laser photocoagulation. Your eye doctor can also do laser burns in a grid pattern covering the affected area. Laser photocoagulation burns and destroys part of the retina and often results in some permanent vision loss. Treatment may cause mild loss of central vision, reduced night vision, and decreased ability to focus. Some people may lose some of their side (peripheral) vision. But the vision loss caused by laser treatment is mild compared with the vision loss that may be caused by untreated retinopathy.

Is my cataract due to my diabetes?

Cataracts occur as people get older. Diabetes increases risk of cataract formation. The longer your diabetes the more prone you have for cataract.

Do I need surgery?

If you cannot do a lot of things you used to do, then consider surgery. The procedure is easy and is an out patient procedure. Your blood sugars should be very well controlled to prevent complications.

I hope we were able to address your eye problem associated with diabetes. The key is prevention. Remember to visit your eye doctor regularly. ○

We welcome questions, comments or suggestions
Fax these at 5311278

Insulin for Life DONATION

Tommy S. Ty Willing, MD
Metropolitan Medical Center

Insulin for Life has donated emergency supply of insulin to Diabetes Philippines, for distribution to the flood victims. Insulin for Life (IFL) Inc. is an Australian-based charitable organization, a major objective of which is to supply insulin, and other diabetes care and treatment products, to diabetics abroad who cannot otherwise obtain such supplies, or who would have great difficulty doing so either because of the supplies' prohibitive costs, or for other reasons. The supplies were donated by individuals, clinics, hospitals and other organisations in Australia and overseas. The individual donors included persons with diabetes who no longer require them.

The goods donated to Diabetes Philippines included insulin, syringes, needles, lancets, strips and meters. The organization gathered the flood victims to a little celebration during the World Diabetes Day (WDD) and used the occasion to distribute the supplies.

Diabetes Philippines thanks Insulin for Life (IFL) Inc. and International Diabetes Foundation (IDF) for their kind assistance.



DIABETES PHILIPPINES HOLDS ANNUAL CONVENTION

Susan Yu-Gan, MD
Metropolitan Medical Center



The 26th Annual Convention of Diabetes Philippines was held last November 11 to 12, 2009 with the theme "Unraveling the Multiple Facets of Diabetes" back to back with the 5th Course on Diabetes and Vascular Disease which followed on November 13, 2009. The venue was the Century Park Hotel. The sessions which covered the different aspects of diabetes from pathogenesis to treatment to complications, from pregnancy to childhood to adulthood, were well attended by the 998 registered participants.

The Grand ballroom was jam-packed with spill over in the Kachina Ballroom. The convention's highlights included the 2 endowed lectureships of Prof Augusto Litonjua which was delivered by Prof. Giancarlo Viberti and that of Dr. Ricardo Fernando delivered by Dr. Juliana CN Chan. Prof. Viberti discussed the harmful effects of Angiotensin II and how angiotensin receptor blockers deliver organ protective effects beyond BP lowering by decreasing proteinuria, limiting inflammation, affecting metabolism thru blocking the effects of RAS on Insulin resistance and beta cell

dysfunction. Dr. Juliana Chan's talk entitled "Redefining Diabetes and Creating Alternative Solution" showcased the treatment of diabetes doing it their way. She expounded on how Asians differ from Westerners in the development of the disease. Their multidisciplinary team uses a nurse and a trained clerk per clinic to establish a registry seeing 6 to 12 patients every morning depending on the complexity of the protocols. Their ultimate goal is "to improve the quality of life of people with diabetes thru creation of knowledge and development of human resources."

This year's convention also featured the Asian Association for the Study of Diabetes represented by Dr. Daisuke Yabe who introduced the Association and expounded on the origins and conceptualization of the organization of which the Philippines is a member.

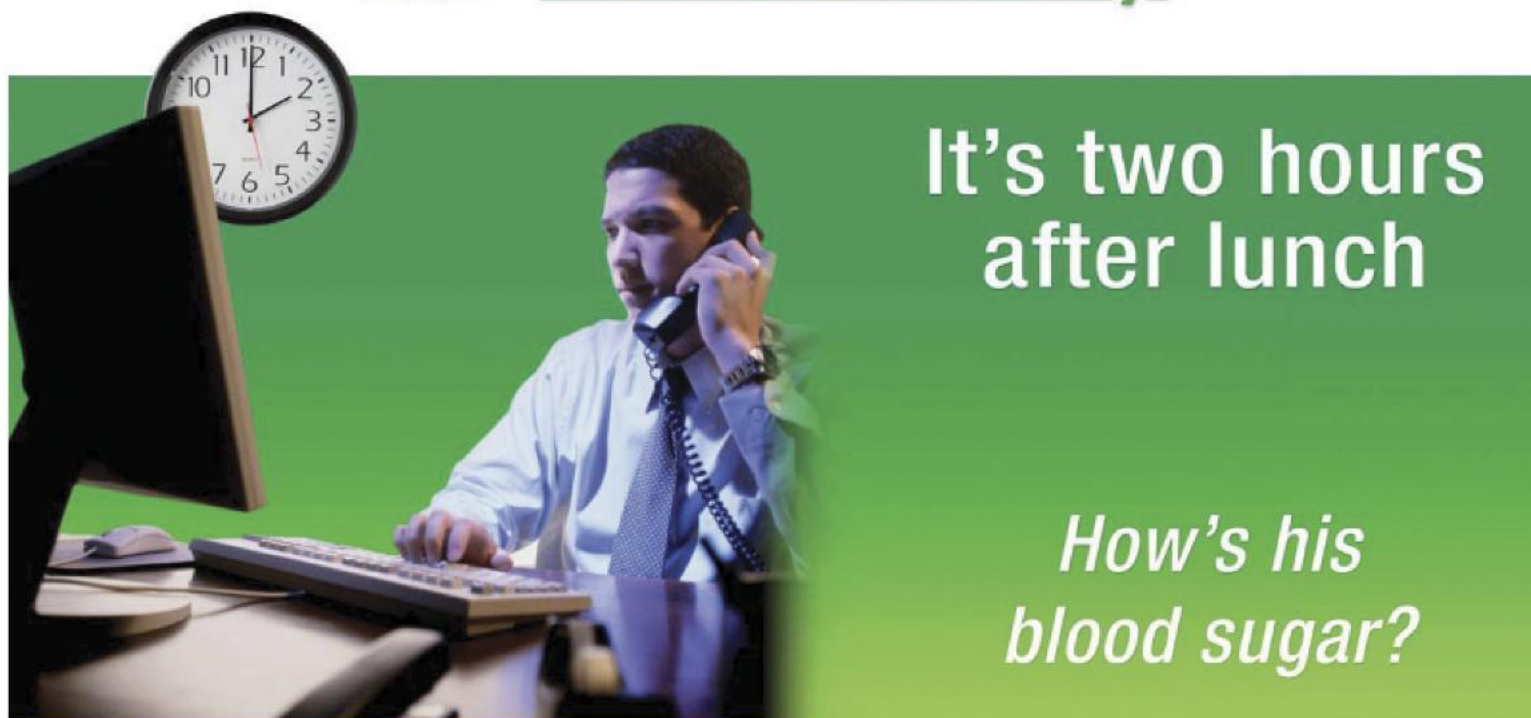
To sum it all up, we had a very fruitful annual convention. It was a time to learn, a time to get reacquainted with old friends, and of course, to make new ones.

Diabetes Philippines would like to thank all the people who have made this convention a success: to all the speakers who unselfishly shared their wealth of knowledge with us, the chairpersons who facilitated all the sessions, our friends from the pharmaceutical companies for their untiring support and to all the attendees who spent their precious time with us throughout the three days of the convention. Special thanks go to the secretariat who made all this possible. ○



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What's too little can be too much for diabetic kidneys

Florence Amorado-Santos, MD
Batangas Regional Hospital



Polypharmacy (having several drugs in the regimen) is becoming the trend in diabetes management. Targeting good glucose control to avoid complications is the goal of every physician. However, one drug will not conquer it all and more often than not, doctors resort to multiple drug therapy. Whether this will be a boon or bane, the diabetic kidney would have the first and last thing to say.

There are specific drug classes used in everyday practice for individual patients that warrant attention in terms of their nephrotoxic (potential

damage to the kidneys) effects. Twenty percent of community and hospital acquired episodes of acute renal failure is due to drugs. The diabetic patient is tremendously exposed and is not spared from this reality. The older patients are exposed to as much as 66 percent to nephrotoxicity mainly because they have higher incidence of diabetes, cardiovascular disease, take multiple medications and are exposed to more diagnostic and therapeutic procedures with the potential harm to kidney function. Although the impairment to the kidneys may be reversible, it entails cost and may need different interventions including

hospitalization.

ANTIBIOTICS

These class of drug can induce kidney malfunctions through several mechanisms: direct toxicity to the renal tubules, allergic interstitial nephritis and crystallization of the antibiotic within the renal tubules.

AMINOGLYCOSIDES are well known antibiotics known as amikacin, gentamicin, kanamycin, neomycin, netilmicin, paromomycin, streptomycin, and tobramycin. These agents are used to treat various



bacterial infections but are known for their direct toxic effects to the kidneys since they are excreted solely in the urine. It is imperative that dosage of these drugs be adjusted according to kidney function but this wouldn't be a guarantee of its safety since their effects in the kidney's are well established. Aminoglycosides are excreted solely in the urine and can be directly toxic to the tubules of the kidneys. In patients with normal kidney functions, once daily dosing can be convenient and safer but there is still no evidence that the same approach applies to the impaired kidneys. In general, these drugs should be avoided if patients have renal insufficiency.

The occurrence of fever, rash, progressive malfunctioning of the kidneys and blood findings of eosinophilia (blood sign of allergic reactions) should raise the suspicion of allergic interstitial nephritis. This is considered to be an eccentric reaction of many drugs and it is quite

difficult to predict and prevent this side effect. Antibiotics such as penicillin, cephalosporins, fluoroquinolones ciprofloxacin are the usual offending agents and occurs after prolonged use of these drugs.

Patients with chronic renal insufficiency can be affected by drugs such as sulfas, acyclovir and indinavir (for treatment of HIV) producing acute shutdown of the kidneys brought by crystallization of antibiotics in the tubules. Despite adequate hydration which could help prevent this side effect, this may not be too helpful in the already damaged kidneys and can lead to permanent dialysis.

NSAIDS/COX - 2 inhibitors

Non-steroidal anti-inflammatory drugs (NSAIDs) examples of which are mefenamic acid, ibuprofen, diclofenac sodium, naproxen sodium are drugs used to alleviate joint and muscle pains. In patients with renal problems,

these agents can cause edema, hypertension, congestive heart failure, acute kidney failure which may need dialytic support. These adverse effects are usually dose dependent and reversible although patients with advanced renal failure can lead to lifelong dialysis. Acetaminophen is considered safest for patients and can be a suitable and practical alternative, though if used in combination with other analgesics can also result to kidney malfunction. When acetaminophen is used as monotherapy and with the recommended dosage it would rarely be nephrotoxic. For very severe joint pains in gouty arthritis, adjusted dosage of colchicine, joint injection or short course of systemic corticosteroids would be preferable than NSAIDs. If a diabetic patient with renal impairment would really require an anti-inflammatory agent, it should be given the shortest time possible, the lowest dose necessary with monitoring of the occurrence of edema.

ACE (ANGIOTENSIN CONVERTING ENZYME) INHIBITOR/ARBs (ANGIOTENSIN RECEPTOR BLOCKER)

These drugs are widely used for cardiovascular disease, hypertension and chronic nephropathy (act as protection to the kidneys), which are well tolerated by a large number of stable patients. However, for patients with advanced renal failure, these drugs may do more harm than good since they can trigger uremia (retention of blood waste products normally excreted in the urine), hyperkalemia (increased potassium in the blood) and dialysis dependence. Patients who are dehydrated should also be cautioned if they are receiving ACE inhibitors or ARBs since they can trigger acute kidney malfunction. Temporary withdrawal of these agents is mandated and can be resumed once normal volume status of the patient had been restored. In high risk patients (elderly with many co-morbid conditions), there should be monitoring of blood pressure, creatinine and potassium if these drugs

are initiated or doses are to be increased.

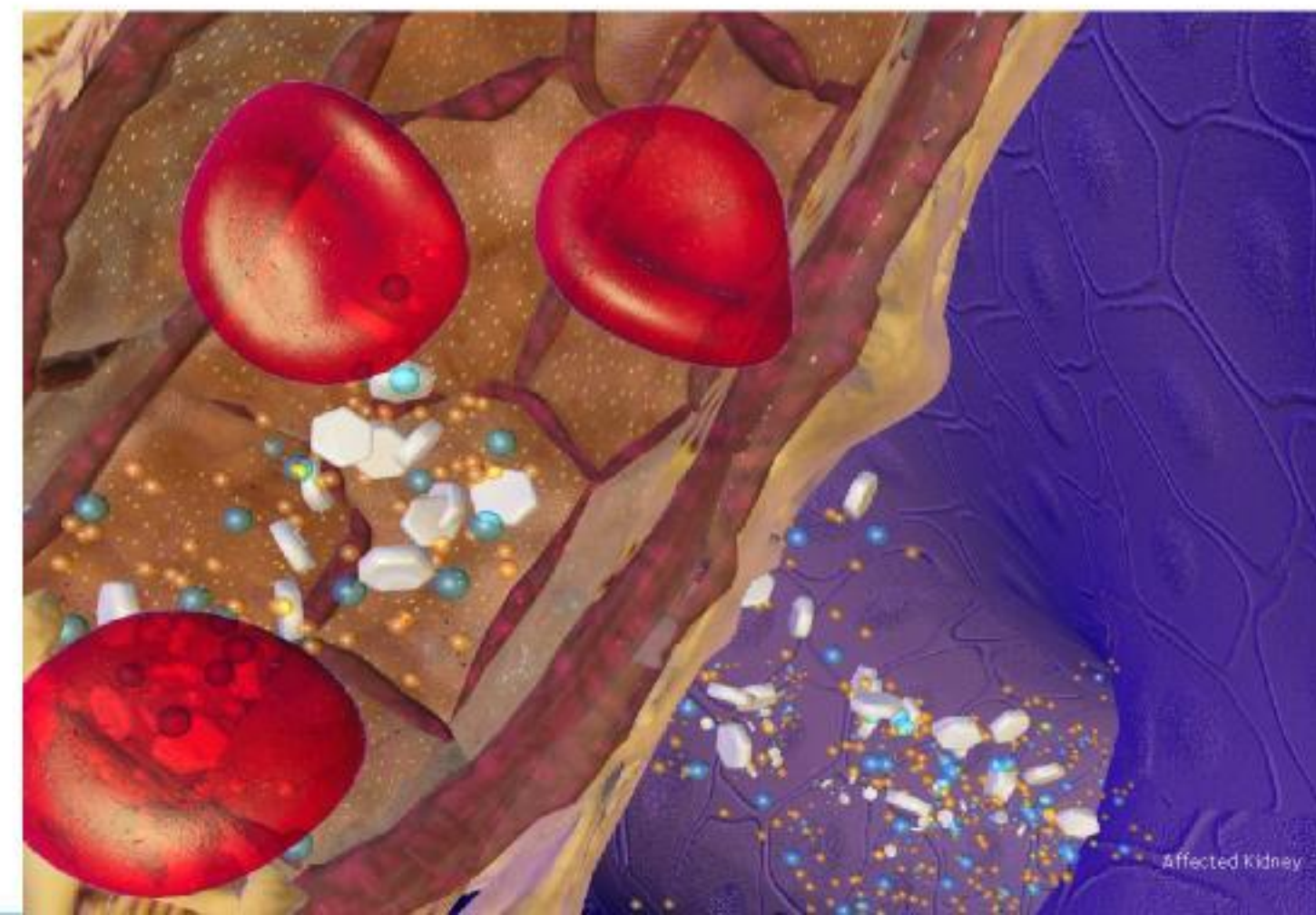
INTRAVENOUS CONTRAST DYE

Exposure to high molecular weight/ionic contrast dye can cause vasospasm (constriction of the blood vessels) of the kidney arteries and lead to acute failure in susceptible patients. Risk factors include diabetes, myeloma, chronic renal failure, dehydration, diuretic therapy and congestive heart failure. Adequate hydration prior to the administration of this dye may lessen the episodes of nephrotoxicity. Other literature says that the use of prophylactic mucomyst (mucolytic inhalation) can eliminate the renal effects of the dye in high risk patients. The alternative at present is to use a low molecular/non ionic dye as contrast but this is still not certain and would need further studies. Overall, it would be safe if intravenous contrast dye in general be avoided in extremely high risk patients with advanced kidney disease.

TAKE HOME MESSAGE

Almost all drugs are eliminated by the kidneys. General preventive measures for the physician would be to choose less nephrotoxic but equally effective drugs whenever possible, correct the risk factors for nephrotoxicity (dehydration, electrolyte abnormalities), assess baseline kidney function, adjust dosages of medication according to kidney function and avoid drug combinations that are not friendly to the patient's kidneys.

Most episodes of renal impairment due to drugs are reversible. Renal function generally returns to baseline provided the side effect was recognized early and the offending medication is discontinued immediately. Failure to have a good clinical eye and to recognize abnormal laboratory results may lead to detrimental effects whether the medication dose may be too little or too much for the diabetic kidneys. ○



Affected kidney

GIMIK DIABETES YEAR 3 WORLD DIABETES DAY CELEBRATION

Lay Annual Convention
Century Park Hotel, Manila
November 14, 2009

DIYABETES KO: KONTROLADO KO!

Tommy S. Ty Willing, MD
Metropolitan Medical Center

Gimik Diabetes" was conceptualized 3 years ago as an activity where diabetes-related topics are discussed using terminologies that are simple and understandable. The activity is usually held on a Saturday close to November 14 (World Diabetes Day).

This year's "Gimik Diabetes" was held on November 14. It began with a motorcade from 6:30 in the morning, starting from 3 points, namely, Unilab Mandaluyong, Quezon City Circle and Bonifacio Hi Street, Taguig City. Around 100 vehicles participated.

Cars were adorned with banners, streamers and white balloons printed with the blue circle, the logo of World Diabetes Day. World Diabetes Day stickers were attached to the rear windshield of all vehicles. The motorcade passed through areas frequented by people doing morning exercise and other physical activities. The participants eventually converged at the Cultural Center Complex and

then drove through the SM Mall of Asia and the Harrison Plaza complex. They then headed to the nearby Century Park Hotel.

The program proper started with an exercise demo led by LRI Fenoflex Dancers wherein the participants enjoyed the morning physical activity.

Dr. Tommy Ty Willing, chairman and president of Diabetes Philippines then welcomed all the participants. Dr. Richard Elwyn Fernando followed suit, with a talk on "Mga No Approved Therapeutic Claims: May Tulong Ba Sa Kontrol?" Mrs. Ma. Imelda Q. Cardino was next, and she discussed "Mga Pagkain at Glycemic Index: Ano na nga ba?" Mrs. Sanirose S. Orbeta then tackled "Pausong Diet: Uso lang ba?" Finally, Dr. Tommy Ty Willing explained the use of insulin.

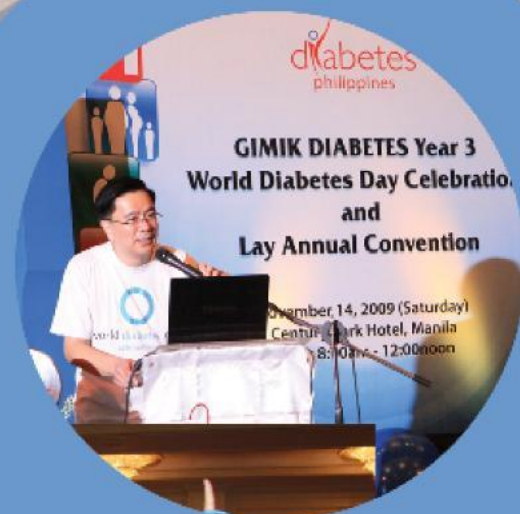
On the lighter side, "Finger Hoop" game was introduced. The finger hoop is a small blue circle twirled around the fingertip of the player, as long as he

or she can. With a little self-control and practice, the player can become a top finger hoop athlete, who can perform stupendous tricks "without lifting a finger"! Diabetes management is a bit like Finger Hoop: with some practice and experience, one can perfect it.

Lastly, an exciting "Diabetes Bingo" was held, hosted by Dr. Joey Miranda and Dr. Carol Montano. Diabetes Bingo was a novel form of education and fun. Each number called out had an accompanying diabetes-related question, with the host explaining to the participants the meaning of-and the answer to-the question. The process was repeated as each number was called until somebody shouted BINGO!

At the end of the program the participants went home, each of them with World Diabetes Day T-shirt and keychain.

All things considered, the activity was a success. 





" Presidential Proclamation No. 1942, declares Nov 14 as World Diabetes Day in the Philippines"

MALACAÑANG
Manila

BY THE PRESIDENT OF THE PHILIPPINES

PROCLAMATION NO. 1942

DECLARING NOVEMBER 14 OF EACH YEAR AS "WORLD DIABETES DAY"

WHEREAS, the Diabetes Philippines, Inc. is composed of multidisciplinary medical and allied professionals organized in 1958 to help address the prevention, treatment and control of diabetes mellitus in the Philippines;

WHEREAS, nearly 4.7 million Filipinos suffer from diabetes mellitus and its cardiovascular complications and tens of thousands are unnecessarily, disabled and/or die prematurely from it;

WHEREAS, the impact of premature death and disability is counted not only in the loss that families bear but also on the negative effects on our national productivity and socio-economic development;

WHEREAS, it is urgent that the different strategies in the prevention, treatment and control of diabetes mellitus be actively pursued to reduce diabetes mellitus related deaths and disability.

NOW, THEREFORE, I, GLORIA MACAPAGAL-ARROYO, President of the Republic of the Philippines, by virtue of the powers vested in me by law, do hereby declare November 14 of every year as World Diabetes Day in the Philippines.

All government and non-governmental agencies, such as the Department of Health and the Department of Social Welfare and Development are enjoined to collaborate and cooperate with the Diabetes Philippines, Inc. in advocating and implementing activities to prevent and control diabetes mellitus and its cardiovascular complications.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the Republic of the Philippines to be affixed.

Done in the City of Manila, this 16th day of November, in the year of Our Lord, Two Thousand and Nine.

Gloria M. Arroyo



By the President:

Eduardo R. Ermita
EDUARDO R. ERMITA
Executive Secretary



CERTIFIED COPY:

MARIANITO M. DIMAANDAL
DIRECTOR IV
MALACAÑANG RECORDS OFFICE

"Southern Mindanao Chapter Diabetes Philippines' outstanding event"

DAVAO city



In the fight against one of the country's top causes of morbidity and mortality, the 2009 Diabetes week was conducted in Davao City. The activity was a huge success and coined as a well endowed event of the year. This was spearheaded by the area President, Dr. Roy B. Ferrer of the Diabetes Philippines Southern Mindanao Chapter. The initial preparations for the activity was arduously done early on and was executed smoothly and effortlessly in coordination with the National President, Dr. Tommy S. Ty Willing, together with the local Chapter Officers and Members of Diabetes Philippines.

The opening activity was conducted in Davao Medical Center (DMC) on July 19, 2009. The activity was geared towards Diabetes prevention and early detection. Screening for Diabetes, Cholesterol and Foot screening was conducted with a lay forum in the lush garden of DMC. Diabetic and non-diabetic lay audience members were given a full length health education focusing on the cause, prevention of diabetes as well as its management by

Davao City's top Diabetologists and Endocrinologists namely the President himself, Dr. Roy Ferrer, Dr. Veronica Racho, the Vice-President, Dr. Lowell Amoguis, the Secretary, Dr. Suzette Alegarbes and Dr. Eleonor Du gave their insights and provided supplemental lectures as well.

The main event was held on August 7-8 2009 at the Ballroom of Grand Men Seng Hotel in Davao City. As the number of newly diagnosed cases of diabetes is continuously on the rise and at such an alarming rate, it has become a

dreaded disease in the country and the chapter has given much emphasis to this fact. In this regard, they have hosted a two-day diabetes workshop for healthcare professionals and a half day lecture for the lay.

New innovations in the prevention and management were the core foci of the workshop that was conducted by Diabetes Philippines, Manila. They have invited Medical Doctors, Nurses and Dieticians all over South Mindanao and nearby provinces to attend this workshop to impart such updates. They



Roy B Ferrer, MD
Diabetes Philippines Davao Chapter President



have anticipated a minimum number of 300-400 delegates to take part of the said workshop. The chapter was foreseeing the big event and created a Committee assigned to plan, prepare, oversee and execute this monumental event. The members of the committee includes: Physical - Dr. Leo and Mae Gallardo together with Dr. Jeannie

Awards - Dr. Ma. Evangeline Durban and Dr. Marie Anne Villegas; and AV / Technical / Slides - Dr. Suzette Alegarbes. With such unity and camaraderie of the chapter officers, members and the pharmaceutical companies in delivering the best outcome in this epic bout per bout fight and prevention of Diabetes, the



Himagan; Programme & Invitation - Dr. Lowell Amoguis with communication thru Pharma Assistance and distribution of fliers; Documentation & Publishing - Dr. Jeff Ho; Registration - Dr. Veronica Racho and Dr. Mila Alquiza together with LRI; Ways and Means - Dr. Roy Ferrer; Accommodation and Food - Dr. Yvette Tan and Dr. Ma. Teresa Isaguirre; Welcome Committee & Guest Relations - Dr. Judy Anne Gatmin & Dr. Bisnar; Transportation - Dr. Hansel Magno;

turnout was an overwhelming success with attendance reaching to as much as 700 + + in total.

The attendees were comprised of 300 MDs, 300 nurses/Allied Professional and 100++ lay persons. The all-out effort, enthusiasm and support was truly commendable as the event triumphantly attained what Diabetes Philippines aims to do. 

diabetes
philippines



2010 SCHEDULE OF ACTIVITIES

39th DiabetesWorkshop

- February 23, 2010(Tuesday) Golden Palace Restaurant, Daet, CamarinesNorte
- February 24, 2010 (Wednesday) Villa Caceres, Naga City, CamarinesSur-Our Lady of Fatima Church, Tabuco, Naga City, CamarinesSur
- February 25-26, 2010 (Thursday-Friday) Legazpi City, Albay

40th DiabetesWorkshop

Cebu
Date: TBA

UNITE for Diabetes

Crowne Plaza Galleria,
Manila July 15-16, 2010

27th Annual Convention of
Diabetes Philippines
Asian Association for the Study
on Diabetes (AASD)
6th Course on Diabetes and
Vascular Disease
Century Park Hotel
November 10 -12, 2010
(Wednesday-Friday)

Gimik Diabetes Year 4
World Diabetes Day Celebration
November 13, 2010
(Saturday) Venue: TBA

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

KITCHEN CORNER

HEALTHY DINING WHEN KIDNEYS FAIL

Ma. Imelda Q. Cardino, RND
Makati Medical Center

Managing diabetes is like caring for a child: you need lots of patience, oodles of discipline as well all the support he/she can get..... support that may be psychological, emotional, financial.

Just like a vehicle, however, there is "depreciation of vital parts" over time.... and so complications develop specially when diabetes control is not consistent. Considered the most expensive is kidney complications. A significant component of management is appropriate nutrition. Individualization of the diet is important since calories, protein allowance, sodium and potassium levels vary. A general guideline based on the University of Virginia Health System (Charlottesville, Virginia) recommendations are provided here.

1. Protein

- ① For growth, building muscles and tissue repair
- ① Too much protein turns into a waste product called urea that your kidneys cannot get rid of.
- ① Goal: adequate protein for nourishment, but not too much to avoid making too much urea.
- ① Suggested sources of protein: lean meat, poultry, , fish, seafood, eggs.
- ① Usually you will need about one matchbox size serving each breakfast, lunch, and dinner. Snacks may contain some protein but this will depend on the total daily amount allowed. Ask your nutritionist-dietitian how much protein is prescribed for you.

2. Sodium

- ① High sodium intake can increase blood pressure and fluid retention (edema).
- ① High sodium foods: canned soups, canned/processed meat/fish / poultry, "fast foods", olives, pickles and relishes, soda crackers, bread and other bakery products. Other sources of sodium are table salt, "patis", soy sauce, "bagoong", vetsin, baking soda, and others.
- ① Learn to read food labels to note salt sources like sodium nitrate/nitrite, monosodium glutamate, etc.
- ① Ask your nutritionist-dietitian how much sodium you are allowed so that appropriate meal combination is prepared for you.

3. Fluids

- ① If you are retaining fluids, you may need to limit liquid intake to 4-5 cups of fluid a day. Your kidney specialist will tell you how much fluids you may take daily. Measure any liquid or any food that melts in your mouth like sugar-free ice cream, ice, sugar-free Jell-O, broth, coffee, tea, etc.
- ① Excess fluid in the body causes difficulty breathing, chest pain, edema, high blood pressure. Your nutritionist-dietitian can share tips on how to control thirst and dry mouth.

4. Phosphorus

- ① Your kidneys may not be able to remove phosphorus from your blood.
- ① High levels of phosphorus weaken your bones and can cause them to break easily.
- ① Control phosphorus by avoiding high phosphorus foods: dried beans

and peas, nuts, liver and other organ meats (such as: liver, kidney), cola drinks, beer, canned salmon, milk and cheese.

① Your nutritionist-dietitian will guide you as to appropriate choices and amount of the specific foods you may take.

5. Potassium

- ① Restriction of potassium varies depending on the stage of your kidney disease and your lab results. Ask your doctor about your potassium level.
- ① High levels of potassium can cause rapid heartbeat. In serious cases, a heart attack may occur.
- ① Control potassium by avoiding high potassium foods: bananas, orange, kiwi, greens, broccoli, dried beans, "salt substitutes", nuts.
- ① Limit tomatoes to 2 thin slices daily.
- ① Generally, juicy fruits and dark green leafy vegetables are high in potassium. Legumes and lentils are also good potassium sources.
- ① Since potassium content of fruits, vegetables and other foods vary, consult your nutritionist-dietitian for guidance.

6. Carbohydrates

- ① Keep track of your carbohydrate intake in order to attain your energy target.
- ① Carbohydrate sources may be rice, bread, bijon, spaghetti noodles, pan de sal, loaf bread, pan de leche, dinner roll.
- ① Camote, ube, gabi and other root crops are not recommended since they contribute as much as 500 mgs of potassium per exchange.
- ① Your nutritionist-dietitian will tell you how much carbohydrate

you may take each meal.

7. Fats

- ① Fats are important in order for you to attain the target calorie you need to maintain daily. Recommended sources are olive oil, peanut oil, canola oil, corn oil, soya oil, etc. The amount of salted fats such as soya oil-based margarine need to be considered in the

computation of your sodium in addition to the calorie contributed. Make sure that the fat allowed in your meal plan is used or added to your meals. Your fat allowances are needed to help you meet your energy requirement without affecting the over-all protein content of your diet.

Other considerations:

8. Vitamins and Minerals

① Vitamins made for patients with kidney disease may be prescribed by the physician. Take only whatever has been prescribed and in the amount specified. Do not take over-the-counter vitamins. Likewise, take mineral supplements only if they have been prescribed by your doctor. ○

A sample meal plan is provided here. Again, since individual dietary prescriptions for calorie, protein, etc vary, it is best that you consult your nutritionist-dietitian as to amount.

BREAKFAST

Sugar-Free Molded Ripe Jackfruit
Stir-fried Beef Tips
Garlic Fried Rice
Sugar-Free Ginger Ale ("Salabat")

**AM SNACK**

Pancit Puti with Eggwhite

**LUNCH**

Consommé
Salmon Fillet in Lemon-Butter Sauce
Singkamas, Chicharo, Togue Guisado
Rice
Fresh Lychees

**PM SNACK**

Melba Toast with Sugar-Free Pineapple Jelly

**SUPPER**

Sopa de Ajos
Fried Herbed Chicken
Labong Salad (balsamic vinegar dressing)
Fresh Grapes



Diabetes Center Philippines launches the Prof. Augusto D. Litonjua Award Lecture in Diabetes



Cynthia Halili-Manabat, MD
Asian Hospital and Medical Center

Last November 10, 2009, the Diabetes Center Philippines held its 2009 National Assembly for Diabetes Educators at the Century Park Hotel, with the theme: At the Forefront of Diabetes Education: New Ideas, New Techniques.

On this occasion, the Center launched the Prof. Augusto D. Litonjua Award Lecture in Diabetes. The first awardee was Prof. Naoko Tajima, Chairperson and Professor at the Division of Diabetes, Metabolism and Endocrinology, Jikei University School of Medicine, Tokyo, Japan. She discussed the rapid increase in the incidence of Type 2 Diabetes throughout Asia, with attention to the role expected of diabetes educators.

Topics for the morning session focused on the Changing Face of Diabetes Education, where innovative teaching techniques such as "Diabetes Conversations", the patient as educator and using the internet to educate, were discussed. The afternoon session tackled Healthy Outcomes and Influencing Positive Change. Topics discussed included Weight Maintenance, Exercise, Behavior Modification and the Lowdown on Coffee.

In addition, twenty nine new associate diabetes educators were also certified and inducted. These included doctors, nurses and dietitians who had completed the Intensive Training Course of the Center, had gone back to their respective localities, set up satellite clinics there, and educated at least 500 patients over a two year period. ○

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1. Rosell et al. Skin Blood Flow and Current Perfusion in Pentoxifylline Treated Diabetic Neuropathy. Angiology Volume 43(14): 843-851 pp. 1992
2. Belcaro G. et al. Intermittent claudication in diabetes: treatment with pentoxifylline - a 10 months controlled, randomized trial. Angiology 2002 Jan-Feb
3. Harwood, et al. Hemorheologic approach in the treatment of diabetic foot ulcer. Angiology 1993 Aug; 44(8):823-6

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Navigating the Net: Online Resources for Eye Complications in Diabetes

Cecile R. dela Paz, MD
East Avenue Medical Center



Living with diabetes also means learning to live with the specter of diabetic complications. While diabetes can affect all of the body's major organs, nothing is more frightening than the prospect of losing one's vision. Diabetes is a leading cause of preventable blindness worldwide and all diabetic patients, whether newly diagnosed or those who have been living with the disease for years should be aware of the different eye complications that can arise. You can access these different websites to find out more.

The ADA Website: www.diabetes.org.

The website of the American Diabetes Association (ADA) is always a good jump-off point for starting your journey into the world of diabetes. When the home page appears, click on the topic "Living with Diabetes" and scroll down the database containing the different diabetic complications. Click on eye complications and a list of the different eye diseases associated with diabetes is listed: Glaucoma, Cataracts and Retinopathy. The different risk factors and treatments are also discussed. The site also offers a comprehensive review of the other possible complications of diabetes and it would also be worth your while to go through each one too.

The National Eye Institute & the National Institutes of Health Website: www.nei.nih.gov

The National Eye Institute (NEI) website is another reliable source of information on eye disease in general and it also has an extensive section devoted to diabetic eye disease. To access this topic, click on "A - Z Eye



Health Topics" and scroll down. To make the learning more interesting, you can also click on "Diabetic Eye Disease photos" to see images of the different diseases discussed. Once you have completed all the modules, you can take and "Eye-Q" quiz and test yourself on your newly acquired eye knowledge.

This site is also helpful for doctors and other health professionals. There is a section devoted to research highlights from the Diabetic Retinopathy Study (DRS) and Early Treatment Diabetic Retinopathy Study (ETDRS).

This website is a public awareness campaign sponsored by the American Academy of Ophthalmology. The site provides a very comprehensive but easily understandable modules on diabetic retinopathy. On the home page, click on "Diseases" then on "Diabetic Retinopathy" on the right side of the web page. The first module

"How does diabetes affect the eyes?" appears. The second module discusses the different kinds of diabetic retinopathy. Photos and videos that you can click on and watch enhance the learning experience. The module on diagnosing diabetic retinopathy is particularly useful because it details the different procedures that an ophthalmologist does when he sees a patient. Another module also discusses how diabetic retinopathy is treated. It will explain the roles that laser surgery and vitrectomy plays in the management of this disease.

Hopefully, these websites will encourage our diabetic patients to learn more about their disease. The internet can provide both patients and doctors valuable information and resources to help us understand what the eye complications are, how to diagnose it and eventually how to treat and even prevent them from happening.



Navigating the Net: Websites on Diabetic Kidney Disease

Simple Internet Tools for Diabetes Complications

Cecilia A. Jimeno, M.D.
UP Philippine General Hospital

Fast facts about diabetes and its complications from the world wide web ...

4,320 every 20 seconds. That's how often someone is diagnosed with diabetes worldwide.

In the Philippines, diabetes is the #1 cause of end stage renal disease leading to dialysis. 41% of all patients on dialysis have diabetes mellitus as of 2003.

The Philippine Renal Disease Registry of the Department of Health reports that renal disease, now the tenth in the list of the country's fatal diseases kills about 7,000 Filipinos annually (www.pia.gov.ph).

Diabetic patients certainly do not want to be part of these statistics and prevention is the key to avoiding the development of complications. The internet is a rich resource for references for diabetes education in general, and for prevention of diabetic nephropathy in particular. For doctors treating these patients, there are also many websites which contain simple clinical tools and teaching aids.

The website of the American Diabetes Association (see facing page) has several sections for physicians, as well as for patients and their family (www.diabetes.org/). The section on diabetic nephropathy or kidney damage caused by diabetes talks about what the kidneys do, how diabetes causes kidney disease, prevention and treatment, including diet and control of other co-morbid diseases like hypertension. There are also materials for diabetics who already have kidney failure, explaining what dialysis is and

the types of dialysis, and other options for patients who have kidney failure.

More detailed and specific information about diabetic nephropathy can also be found in the website of the U.S. National Institutes of Health National Kidney Disease Education Program (www.nkdep.nih.gov/resources). This site has a section for doctors and professionals with teaching aids for patients and a simple GFR (glomerular filtration rate) calculators. This also has links to the website of the American Diabetes Association.



Locally, we also have the website of the Philippine Society of Nephrology (<http://www.psn.ph/faq>) which answers very simply and clearly some common questions about kidney disease in general, with some information as well about diabetic nephropathy, the most common form of kidney disease leading to dialysis in the Philippines. The FAQ section may be a little difficult to find but it is at the right upper menu of the site.

Living with diabetes and coping with its complications is not easy and many feel helpless when diagnosed with diabetic kidney disease. But truly, knowledge is power! Surfing the net will make you become better informed, and help you win the daily battle against diabetes and its complications

in a simple and enjoyable way.

Sometimes this filtering system breaks down. Diabetes can damage the kidneys and cause them to fail. Failing kidneys lose their ability to filter out waste products, resulting in kidney disease.

How does diabetes cause kidney disease?

When our bodies digest the protein we eat, the process creates waste products. In the kidneys, millions of tiny blood vessels (capillaries) with even tinier holes in them act as filters. As blood flows through the blood vessels, small molecules such as waste products squeeze through the holes. These waste products become part of the urine. Useful substances, such as protein and red blood cells, are too big to pass through the holes in the filter and stay in the blood.

Diabetes can damage this system. High levels of blood sugar make the kidneys filter too much blood. All this extra work is hard on the filters. After many years, they start to leak and useful protein is lost in the urine. Having small amounts of protein in the urine is called microalbuminuria.

When kidney disease is diagnosed early, (during microalbuminuria), several treatments may keep kidney disease from getting worse. Having larger amounts of protein in the urine is called macroalbuminuria. When kidney disease is caught later (during macroalbuminuria), end-stage renal disease, or ESRD, usually follows. In time, the stress of overwork causes the kidneys to lose their filtering ability. Waste products then start to build up in the blood. Finally, the kidneys fail. This failure, ESRD, is very serious. A

Diabetic kidney disease can be prevented by keeping blood sugar in your target range. Research has shown that tight blood sugar control reduces the risk of microalbuminuria by one third. In people who already had microalbuminuria, the risk of progressing to macroalbuminuria was cut in half.

person with ESRD needs to have a kidney transplant or to have the blood filtered by machine (dialysis).

Who gets kidney disease?

Not everyone with diabetes develops kidney disease. Factors that can influence kidney disease development include genetics, blood sugar control, and blood pressure.

The better a person keeps diabetes and blood pressure under control, the lower the chance of getting kidney disease.

What are the symptoms?

The kidneys work hard to make up for the failing capillaries so kidney disease produces no symptoms until almost all function is gone. Also, the symptoms of kidney disease are not specific. The first symptom of kidney disease is often fluid buildup. Other symptoms of

kidney disease include loss of sleep, poor appetite, upset stomach, weakness, and difficulty concentrating.

It is vital to see a doctor regularly. The doctor can check blood pressure, urine (for protein), blood (for waste products), and organs for other complications of diabetes.

How can I prevent it?

Diabetic kidney disease can be prevented by keeping blood sugar in your target range. Research has shown that tight blood sugar control reduces the risk of microalbuminuria by one third. In people who already had microalbuminuria, the risk of progressing to macroalbuminuria was cut in half. Other studies have suggested that tight control can reverse microalbuminuria.

Treatments for kidney disease Self-care



Important treatments for kidney disease are tight control of blood glucose and blood pressure. Blood pressure has a dramatic effect on the rate at which the disease progresses. Even a mild rise in blood pressure can quickly make kidney disease worsen. Four ways to lower your blood pressure are losing weight, eating less salt, avoiding alcohol and tobacco, and getting regular exercise.

Drugs

When these methods fail, certain medicines may be able to lower blood pressure. There are several kinds of blood pressure drugs, however, not all are equally good for people with diabetes. Some raise blood sugar levels or mask some of the symptoms of low blood sugar. Doctors usually prefer people with diabetes to take blood pressure drugs called ACE inhibitors.

ACE inhibitors are recommended for most people with diabetes, high blood pressure, and kidney disease. Recent studies suggest that ACE inhibitors, which include captopril and enalapril, slow kidney disease in addition to lowering blood pressure. In fact, these drugs are helpful even in people who do not have high blood pressure.

Diet

Another treatment some doctors use with macroalbuminuria is a low-protein diet. Protein seems to increase how hard the kidneys must work. A low-protein diet can decrease protein loss in the urine and increase protein levels in the blood. Never start a low-protein diet without talking to your health care team.

Kidney Failure

Once kidneys fail, dialysis is necessary. The person must choose whether to continue with dialysis or to get a kidney transplant. This choice should be made as a team effort. The team should include the doctor and diabetes educator, a nephrologist. ○

diabetes ON THE MOVE philippines

17th Diabetes Awareness Week

July 19 - 26, 2009

Theme: "Stop Diabetes? Pwede!!!"

Nueva Ecija - July 11, 2009

- Held at the N.E. Pacific Mall, Cabanatuan City Nueva Ecija as prelude for the 2009 Diabetes Awareness Week on July 19-26, with the theme "Stop Diabetes? Pwede!!!".



SM Mall of Asia - July 19, 2009

Following the success of Prelude in Nueva Ecija different diabetic group from Manila and nearby provinces participated this year's Diabetes Awareness Week Opening Ceremonies held at SM Mall of Asia last July 19, 2009 (Sunday). A day of activity that started by the cheerdancing moves of UST *Salinggawi* Dance Troupe followed by the *Bulilit* Health Workers from Batangas, recognition ceremonies for the Diabetes Achievers as well as ballroom dancing competition among diabetes satellite clinic are some of the segments that is highly-anticipated. Appearances from Kapuso artists Dingdong Dantes, Victor Aliwalas, Belli and Flori, Marissa Sanchez, Ram Chavez, together with Chad Borja, Bobby Yan, Abby Cruz and Aiza Seguerra capped the long day celebration full of fun and learning.



SM City Batangas - (July 26, 2009)

Activities similar to SM Mall of Asia serve as the highlights of the Closing Ceremonies of DAW held at the Event Center of SM City Batangas.



East Avenue Medical Center (July 27 - 31, 2009)

The East Avenue Medical Center Diabetes Clinic headed by Dr. Ma. Teresa Plata-Que organized a week long activity in line with the celebration of Diabetes Awareness Week. Free blood glucose monitoring, video presentation, educational materials, exercise workshop and cooking demonstration highlighted this event.



3rd Wellness Summit

September 12, 2009 (MegaTrade Hall 2, SM Megamall Bldg. B Mandaluyong City)

The success of previous Wellness Summit making it annual event of the Philippine Association for the Study of Overweight and Obesity (PASOO), which is now on its 3rd year with the theme entitled "Wastong Bigat Kalusugan ang



15th PASOO Annual Convention

September 5, 2009 (Crowne Plaza Galleria Manila)

Last September 5, 2009, the Philippine Association for the Study of Overweight and Obesity held its 15th Annual Convention with the theme "From Theory to Public Policy: Addressing Challengers and Trends in Obesity Now". The programme was organized by the overall chair and PASOO President, Dr. Elizabeth Paz-Pacheco and the scientific chair Dr. Gabriel V. Jasul were almost 500 delegates attended this year's convention.



Diabetes Philippines supports National Medicine Week

September 22, 2009 (Watsons SM Megamall Bldg. A, Mandaluyong City)

The Diabetes Philippines shows its support during the National Medicine Week celebration by conducting free blood pressure determination and blood sugar testing at Watsons SM Megamall last September 22, 2009 in cooperation with Watsons, Fernando Medical Enterprises Inc. (FMEI) and Omron.



Katapat Part 2, Fit and Fab without the Flab" headed by their President Dr. Elizabeth Paz-Pacheco and Chair of 3rd Wellness Summit Dr. Mia Fojas. The summit features exercise demonstration across all ages, free glucose and cholesterol monitoring and participants were familiarized with the cardio metabolic risk profiles. Diabetes Philippines also showcased its advocacy materials giving flyers to the participants to understand diabetes and how to take control. The affair was, as expected, well-attended.



PHA Heart Fair 2009

December 13, 2009 (Central Plaza Eastwood City, Libis Quezon City)

The Philippine Heart Association (PHA) celebrates Heart Fair 2009 last December 13, 2009 at the Central Plaza of Eastwood City in Libis, Quezon City with the theme "Kakaibang Pasko sa Kakaibang Panahon". Advocacy materials have been given to the participants of this event.



Diabetes Philippines Pangasinan Chapter 2nd Diabetes Symposium

November 20, 2009 (City De Luxe Restaurant, Pangasinan)

Diabetes Philippines Pangasinan Chapter headed by their President Dr. Isabelita Siapno in cooperation with Pangasinan Medical Society organized the 2nd Diabetes Symposium entitled "Sweet Talk - From Basic to Updates" held last November 20, 2009 at the City De Luxe Restaurant, Pangasinan. Dr. Susan Yu-Gan, Dr. Rima Tan and Mrs. Sanirose S. Orbeta (Diabetes Philippines Officers) are among the invited speakers. World Diabetes Day Posters and advocacy flyer were given to the participants.



PSEM at AFES Thailand

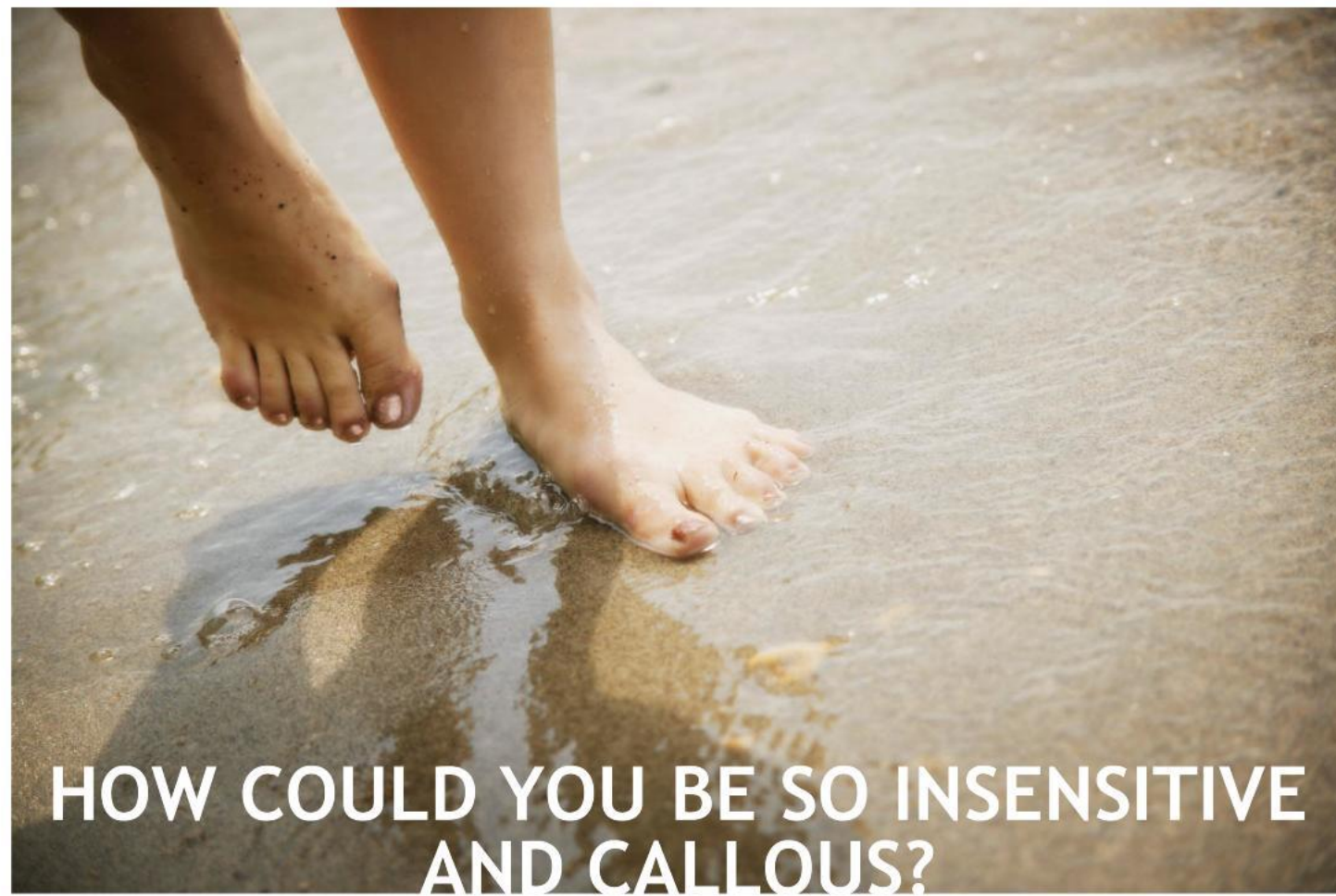
Pepito Dela Peña, MD
East Avenue Medical Center



Thailand, the Land of the Free, located at the heart of southeast Asia is where the 15th congress of Asean Federation of Endocrine Societies (AFES 2009) was held. Our gracious host, associate professor Ampha Suthijumroon, the chairman of organizing committee of AFES Thailand spearheaded the occasion last November 28 to Dec 1, 2009 at the Queen Sirikit National Convention. The Philippine Society of Endocrinology and Metabolism headed by our amiable president Dr. Patricia Gatbonton, who with our other revered consultants (Dr. Mary Anne Lim-Abrahan, Dr. Gabriel Jasul, Dr. Joselyna Anel-Quimpo and Dr. Rosa Sy) rendered a helping hand to make the event a success.

The affair was well attended. A total of 1600 delegates represented 33 different countries worldwide. The highlight of the Congress is the much awaited Fellowship Night. All of our neighbours in the ASEAN Federation were all astounded when the Philippine delegation performed on stage. Almost all fancied that the ones singing and dancing were all professionals rather than doctors! Indeed, practice doesn't make perfect --- it makes permanent! Permanent it was, for it created a lasting impression that the Philippine delegation were not "mere" endocrinologists but an accomplished thespians as well. HO CHI MINH CITY here we come! ○





HOW COULD YOU BE SO INSENSITIVE AND CALLOUS?

Nemencio A. Nicodemus Jr., MD
Manila Doctors Hospital

Diabetic foot ulcers are a very costly and common public health challenge. Although health care providers always emphasize awareness of this problem, the incidence of foot ulcers and amputation still remains staggeringly high. The rate of amputation in individuals with diabetes is 10 times higher than in persons without diabetes. In fact, diabetes is associated with 60 percent of non-traumatic lower-limb amputations. These dreaded complications related to diabetes have severe impact on the individual patient and the society in general because they severely limit function, work capacity, and quality of life.

The feet of patients with diabetes are at increased risk for ulceration because of the damaging effects of diabetic

peripheral neuropathy. Ulcers are usually the end result of the interplay between several component factors, including poor sensation, structural foot abnormalities, and local trauma. Poor sensation is the manifestation of diabetic neuropathy.

Diabetic peripheral neuropathy is a mixed sensorimotor process affecting multiple nerve fibers. The most well-known and common of these is sensory neuropathy, which leads to loss of protective sensation. Motor neuropathy, on the other hand, leads to foot muscle atrophy and subsequent anatomic foot deformity, such as clawfoot, hammertoes, or Charcot foot.

The result of these foot deformities is abnormal weight-bearing distribution in the foot, which places high-pressure areas at risk for skin breakdown.

Autonomic neuropathy also decreases normal temperature and secretion regulation, which impairs the effectiveness of the skin as a protective barrier.

Diabetic neuropathy is one of the leading causes of foot ulceration. It is estimated that 80 percent of patients with diabetes who have foot lesions have known peripheral neuropathy. Currently, the gold standard for clinic evaluation of sensory neuropathy in patients with diabetes is the use of the 10-g Semmes-Weinstein monofilament. Other useful clinical evaluation techniques include testing vibratory perception threshold, ankle reflex and using a subjective neuropathy scoring system, such as the University of Texas Subjective Peripheral Neuropathy verbal questionnaire. All of these screening

techniques are sensitive for the determination of neuropathy and prediction of ulceration risk and the use of multiple screening techniques increase the specificity.

Even if diabetic neuropathy may be extensive, ulcerations generally do not occur spontaneously in the foot of a patient with diabetes unless there is local trauma. This may be caused by poor footwear or other external insult, such as trauma from nail clipping, falls, or repetitive trauma.

A study looked at the clinical indicators of diabetic neuropathy and found that sensory neuropathy, foot deformities or established vascular disease (by history of prior ulceration or amputation) are significant predictors of ulceration. Specific foot deformities that have been found to be predictive of lower extremity ulceration include hammer/claw foot deformities and structural deformities, such as Charcot foot and drop foot. Other possible risk factors that predict ulceration include ankle-brachial index, glycemic control (measured by HbA1C), visual acuity, smoking and duration of diabetes mellitus. Glycemic control has also been shown in studies to be associated with lower extremity amputations.

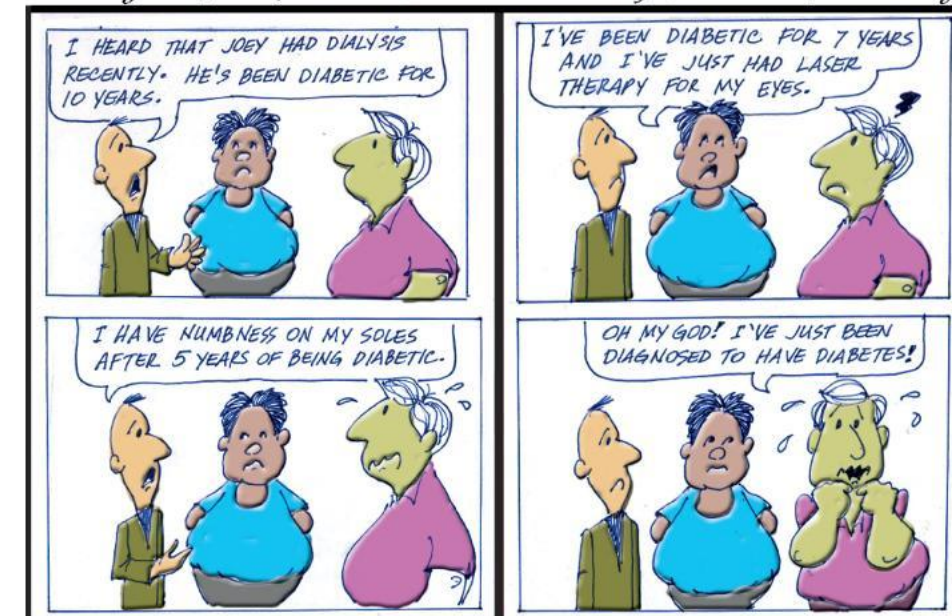
Once an ulcer is present, healing may be impaired by the same factors that contributed to the initial ulceration, including elevated blood glucose and

abnormal pressure distribution. Poor circulation and infection may further impede healing in patients with foot ulcerations.

One of the main challenges in reducing the incidence of diabetic foot ulcerations is in determining what interventions are most effective. Several medical therapies are under evaluation for treatment of diabetic neuropathy, although their impact on diabetic complications such as diabetic foot ulcers is unclear. Aggressive glycemic control has been associated with significant decreases in the incidence of peripheral neuropathy but has not been found to reverse the effects of neuropathy.

The Lighter side of Diabetes

by Dr. Allan Hernandez



The current standard of care for patients with diabetes includes an annual foot examination, during which the physician may evaluate for peripheral neuropathy, callus formation, onychomycosis, structural foot deformities, circulatory disturbances, wounds, and appropriateness of footwear. Regular foot examination may help identify patients at risk for ulceration, which allows the physician to stratify patients according to risk of ulceration to guide interventions and may reveal modifiable risk factors that can decrease the likelihood of ulceration.

Something as mild as loss of sensation should not be taken for granted by patients with diabetes because its effects are very damaging. The bottom line is: patients should not be insensitive and callous to these changes in their feet. ○

WARNING: THE METER SAYS HI! CHECK KETONES!

Nemencio A. Nicodemus Jr., MD
Manila Doctors Hospital

Nothing is more disturbing to a patient, and more so to the doctor, than to see that the glucometer reads HI (meaning blood glucose greater than 500 mg/dl) with a warning to check ketones. In severe cases, this heralds the development of hyperglycemic crises, more commonly known to us as DKA and HHS.

Diabetic ketoacidosis (DKA) and the hyperosmolar hyperglycemic state (HHS) are the two most serious acute metabolic complications of diabetes. In the US, mortality from DKA has been estimated at <1% in general, but tends to be higher among the elderly and those with concomitant illness. On the other hand, mortality among patients with HHS ranges from 5 to 20%.

The triad of uncontrolled hyperglycemia, metabolic acidosis, and increased ketone concentration characterizes DKA. HHS is characterized by severe hyperglycemia, hyperosmolality, and dehydration in the absence of significant ketoacidosis. Most patients with DKA have autoimmune type 1 diabetes. However, patients with type 2 diabetes are also at risk during the catabolic stress of acute illness such as trauma, surgery, or infections.

In DKA, the reduced effective insulin concentrations and increased concentrations of counter-regulatory hormones (catecholamines, cortisol, glucagon, and growth hormone) lead to hyperglycemia and ketosis. These hormone imbalance, in turn, leads to the release of free fatty acids into the circulation from adipose tissue (lipolysis) and subsequent its subsequent oxidation in the liver to form ketone bodies (β -hydroxybutyrate and acetoacetate). Thus, the patient

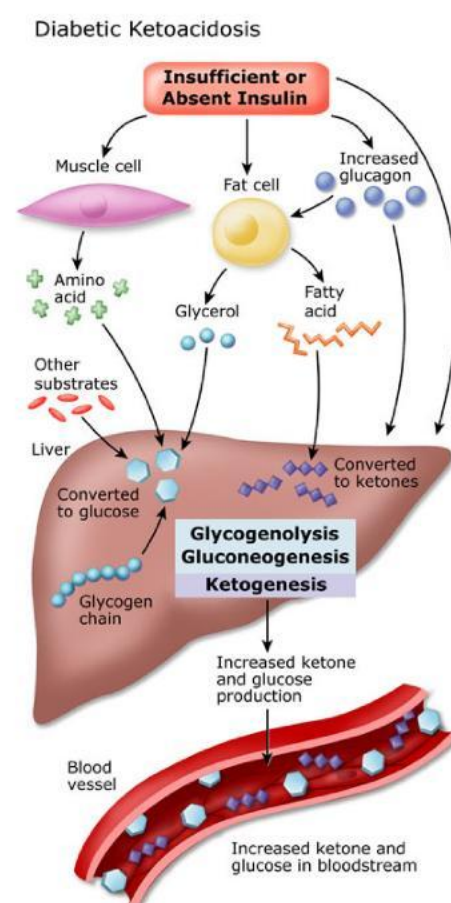
develops ketonemia and metabolic acidosis.

More recent studies point that the hyperglycemia in patients with hyperglycemic crises is associated with a severe inflammatory state characterized by an elevation of pro-inflammatory cytokines, C-reactive protein, reactive oxygen species, and lipid peroxidation. There is also an increase in the cardiovascular risk factors, plasminogen activator inhibitor-1 and free fatty acids in the absence of obvious infection or cardiovascular pathology. All of these parameters return to near-normal values with insulin therapy and hydration within 24 h.

HHS is distinguished from DKA by its greater degree of dehydration (due to osmotic diuresis) and differences in insulin availability. Insulin levels in HHS are inadequate to facilitate glucose utilization by insulin-sensitive tissues but adequate to prevent lipolysis and subsequent ketogenesis.

The most common precipitating factor in the development of DKA and HHS is still infection. Other precipitating factors include discontinuation of or inadequate insulin therapy, pancreatitis, myocardial infarction, cerebrovascular accident, and drugs. Drugs that affect carbohydrate metabolism, such as corticosteroids, thiazides and sympathomimetic agents may precipitate the development of hyperglycemic crises, as well.

In recent years, an increasing number of DKA cases without precipitating cause have been reported. The clinical presentation in such cases is acute, as in classical type 1 diabetes. However, after a short period of insulin therapy, remission is seen even without insulin



treatment. These patients tend to present with obesity, strong family history of diabetes, measurable pancreatic insulin reserve and low levels of autoimmune markers of β -cell destruction. This variant of diabetes has been referred to as "ketosis-prone type 2 diabetes".

Successful treatment of DKA and HHS requires correction of dehydration, hyperglycemia, and electrolyte imbalances; identification of comorbid precipitating events; and above all, frequent patient monitoring.

Initial fluid therapy is directed toward expansion of the intravascular, interstitial, and intracellular volume

Patients with known diabetes may be given insulin at the dosage they were receiving before the onset of hyperglycemic crises so long as it was controlling glucose properly. In insulin-naïve patients, a multidose insulin regimen should be started at a dose of 0.5-0.8 units/ kg/day.

and restoration of renal perfusion. In the absence of cardiac compromise, 1 to 1.5 liters of isotonic saline (0.9% NaCl) is infused during the first hour. Subsequent choice for fluid replacement depends on hemodynamics, the state of hydration, serum electrolyte levels, and urinary output. In general, 0.45% NaCl infused at 250-500 ml/h is appropriate if the corrected serum sodium is normal or elevated while 0.9% NaCl is infused at a similar rate if corrected serum sodium is low. Fluid replacement should correct estimated deficits within the first 24 h. Aggressive rehydration with subsequent correction of the hyperosmolar state has been shown to result in better response to low-dose insulin therapy. Once the plasma glucose is ≥ 200 mg/dl, 5% dextrose should be added to replacement fluids to allow continued insulin administration until ketonemia is controlled while at the same time avoiding hypoglycemia.

The mainstay in the treatment of DKA involves the administration of regular insulin via continuous intravenous infusion or by frequent subcutaneous or intramuscular injections. Randomized controlled studies have shown that insulin therapy is effective regardless of the route of administration. The administration of continuous intravenous infusion of regular insulin is the preferred route because of its short half-life and easy titration.

Treatment algorithms recommended the administration of an initial intravenous dose of regular insulin (0.1 units/kg) followed by the infusion of 0.1 units/ kg/h insulin. Low-dose insulin infusion protocols decrease plasma glucose concentration at a rate of 50-75 mg/dl/ h. If plasma glucose does not decrease by this much from the

initial value in the first hour, the insulin infusion should be increased every hour until a steady glucose decline is achieved. Thereafter, the rate of insulin administration or the concentration of dextrose should be adjusted to maintain glucose values between 150 and 200 mg/dl in DKA or 250 and 300 mg/dl in HHS until they are resolved.

Treatment with subcutaneous rapid-acting insulin analogs (lispro and aspart) has been shown to be an effective alternative to the use of intravenous regular insulin in the treatment of DKA. Treatment of patients with mild and moderate DKA with subcutaneous rapid-acting insulin analogs every 1 or 2 h in



non-intensive care unit (ICU) settings has been shown to be as safe and effective as the treatment with intravenous regular insulin in the ICU.

Patients with DKA and HHS should be treated with continuous intravenous insulin until the hyperglycemic crisis is resolved. Criteria for resolution of ketoacidosis include a blood glucose <200 mg/dl and two of the following criteria: a serum bicarbonate level ≥ 15 mEq/L, a venous pH >7.3 , and a calculated anion gap ≥ 12 mEq/L. Resolution of HHS is associated with normal osmolality and regain of normal mental status. When this occurs, subcutaneous insulin therapy can be started. To prevent recurrence of hyperglycemia or ketoacidosis during the transition period to subcutaneous

insulin, it is important to allow an overlap of 1-2 h between discontinuation of intravenous insulin and the administration of subcutaneous insulin.

Patients with known diabetes may be given insulin at the dosage they were receiving before the onset of hyperglycemic crises so long as it was controlling glucose properly. In insulin-naïve patients, a multidose insulin regimen should be started at a dose of 0.5-0.8 units/ kg/day. Human insulin (NPH and regular) are usually given in two or three doses per day. More recently, basal-bolus regimens with basal (glargine and detemir) and rapid-acting insulin analogs (lispro, aspart, or glulisine) have been proposed as a more physiologic insulin regimen. Hypoglycemia is a common complication with overzealous treatment of hyperglycemic crises with insulin but has occurred less often with the low-dose insulin therapy. Frequent blood glucose monitoring (every 1-2 h) is mandatory to recognize hypoglycemia because many patients who develop hypoglycemia during treatment do not experience adrenergic manifestations of sweating, nervousness, fatigue, hunger, and tachycardia.

Many cases of DKA and HHS can be prevented by better access to medical care, proper patient education, and effective communication with a health care provider during an intercurrent illness. The use of home glucose meters allows early recognition of impending ketoacidosis, which may help to guide insulin therapy at home and, possibly prevent hospitalization. It is important for healthcare providers to educate patients on the importance of this small device that can save their lives in times of emergency. ○

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1. Kahn S, Haffner S, Heise M, et al. Glycemic durability of rosiglitazone, metformin, or glyburide monotherapy. N Engl J Med 2002;345:861-69.
Erratum in N Engl J Med 2007;355:1357-1358.

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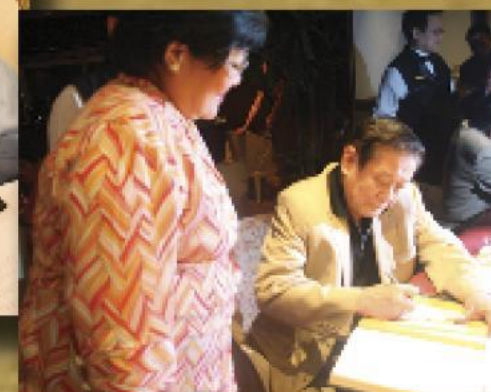
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BOOK LAUNCHING

November 11, 2009
Top of the Century,
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How Sweet It Is To Have an iPhone

Iris Thiele Isip Tan, MD
UP-Philippine General Hospital

Nope, I don't have an iPhone yet (and that's another story) but if you're a diabetic and you do have an iPhone, then that's sweet! Here's why.

Keeping track of blood sugar levels is an integral part of diabetes care. The doctor will ask you to log your glucometer readings in a notebook that indicates the date and time, whether the reading was before or after a meal and perhaps the food you ate. At every clinic visit, your doctor checks this diabetes log. An understanding of the dips and peaks of your blood sugar record helps the doctor tailor fit the medications to your lifestyle.

A casual search at the iTunes App Store reveals many applications that can be used on an iPhone or iPod touch to keep such a diabetes record. These applications allow recording glucose levels, insulin injections and

medications, carbohydrate intake, weight and even exercise workouts. Input is customizable that you can track blood glucose in both mg/dL and mmol/L. Some even graph these values so you can show them to the doctor at your clinic visit. These applications can display weekly and monthly averages of blood glucose levels as well as plot minimum and maximum values. Advanced options include filtering which allow graphing only glucose readings above 200 mg/dL for example or readings after ten pm. One app can even estimate A1c. More innovative applications allow export to csv file for saving/editing, printing, the capability to email data to your care provider, or synchronization to an online data repository or personal computer for easier viewing. Most applications offer password protection for the data.

Beyond just being a glucose log, one app provides useful facts about

diabetes treatment, set as wallpaper which will be readable every time you use your iPhone. One app provides an injection site diagram while another has an integrated food database with reference information on thousands of foods. A carbohydrate counter is incorporated in one application that allows the user to enter nutrition details for packaged foods, and which also generates a food journal for sharing with doctors.

Some applications were authored by diabetics such as Diabetes Diary by Chris Bowley and Diabetes Log by Chris Ross, a type 1 diabetic. I only found three free applications but most of these applications seem reasonably priced. I have provided a list below but do check the iTunes App Store as more applications are added often. Check out which one works for you and impress your doctor at the next clinic visit! 



Diabetes Pilot \$11.99
Diamedic \$5.99
Track 3: Diabetes Planner & Carb Counter \$5.99

GlutcoRecord \$2.99
Islet - Diabetes Assistant \$2.99
Diabetes Diary \$2.99
Diabetic Tracker Unlimited \$1.99
Glucose Tracker \$0.99
Blood Glucose Tracker (iDiabetes) \$0.99
Screenshot for Diabetes Diary

DiabetesGrapher Free free
Glucose Buddy - Diabetes Helper free
Diabetes Log free

COUNCIL MEETING OF THE WESTERN PACIFIC REGION OCTOBER 17, 2009 PALAIS des CONGRES de MONTREAL (PdC)

Tommy S. Ty Willing, MD
Metropolitan Medical Center

The Council Meeting of the Western Pacific Region was held last October 17, 2009 at Rm. 522bc, 5th floor, Palais Des Congres De Montreal (PdC). The meeting was presided by the chair of the IDF-WPR, Mr. Gordon Bunyan. Diabetes Philippines was represented by Dr. Tommy S. Ty Willing, president and Dr. Edith Arceo-Dalisay, vice president.

Mr. Gordon Bunyan made a brief presentation entitled Governance Review-Changing the IDF Constitution. Prof. Juliana Chan presented the 2006-2010 Western Pacific Declaration on Diabetes (WPDD) plan of action through a "jigsaw of prevention and control of diabetes".

All candidates for the 2009 - 2012 position for IDF office were given the chance to express their campaign and plans for the next triennium.

Prof. Lee Mon-Kyu invited all the delegates to attend the 8th IDF-WPR Congress 2010 in Busan, Korea.

All member countries reported on their individual projects and activities. The meeting was very tiring but encouraging as all member countries of the IDF-WPR showed their support to continue their individual efforts to promote diabetes education and prevention. 



BEDWETTING IN ADULT PEOPLE WITH DIABETES

Nemencio A. Nicodemus Jr., MD
Manila Doctors Hospital

Frequent urination is one of the classic symptoms of type 2 diabetes mellitus, along with excessive thirst and weight loss. Most of the time, frequent urination occurs at night so that the patient complains of insomnia because of the need to rise up and go the toilet. But is it possible for the adult diabetic patient to also manifest with bedwetting?

In medical terms, bedwetting is referred to as enuresis. Studies show that at least 2 percent of adults have a lack of control of urination during the night. This is called nocturnal enuresis. Nocturnal enuresis is not to be confused with nocturia or waking two or more times per night to void. The latter is one of the classical manifestations of diabetes.

Different types of enuresis exist, which need to be differentiated. Persistent primary nocturnal enuresis is a condition that begins during childhood, where nighttime dryness has not been achieved for longer than six months. About 2-3 percent of male and female adults that are older than 18 years of age have this type of nocturnal enuresis.

Adult-onset secondary enuresis is defined as nocturnal enuresis in which nighttime dryness is achieved at some point in life and, for some, dryness may have occurred for years, but nighttime wetting begins at an older age. It must be understood that bedwetting, in this case, is unintentional and is not something that can be voluntarily controlled at any age.

A variety of medical and psychological disorders are associated with secondary enuresis. Nocturnal enuresis occurs in type 2 diabetes as a result of the production of ineffective amounts of Antidiuretic Hormone or ADH. ADH is

Studies show that at least 2 percent of adults have a lack of control of urination during the night. This is called nocturnal enuresis. Nocturnal enuresis is not to be confused with nocturia or waking two or more times per night to void.

a signaling hormone that tells the kidneys to decrease the amount of urine produced. Normally the body produces more ADH at night causing the kidneys to produce less urine. Decreased urine production at night allows people to sleep through the night without having to urinate. However, people with diabetes do not produce the appropriate amount of this hormone at night, which leads to high production of urine. This abnormality is defined as nocturnal polyuria, the excessive production of urine during sleep, which can cause nocturnal enuresis in adults.

Additional causes of secondary enuresis include urinary tract infection, urinary tract stones, neurological disorders, anatomical abnormalities, urinary tract calculi, prostate cancer, prostate enlargement, bladder cancer, and obstructive sleep apnea. In very rare cases, acute anxiety or emotional disorder may cause adult bedwetting.

When evaluating an adult patient with enuresis, the history should include the onset, duration, and severity of enuresis; presence of daytime wetting, constipation, genitourinary symptoms, and neurologic symptoms. It is also

Bedwetting or nocturnal enuresis is a problem that should be recognized among patients with diabetes because, aside from being a sign of uncontrolled diabetes, it may point to diabetic complications and other medical conditions that need further evaluation and more focused treatment.

very important to elicit the patient's medical and psychosocial history. The following details can assist the physician to determine the cause and severity of enuresis:

- When voiding occurs during the day and night
- When the accidents occur (time of day or night)
- Amount of urine voided
- Drinking patterns (does the patient drink a lot of fluids in the later afternoon/evening?)
- What the patient drinks (sugary, caffeinated, artificially sweetened, carbonated, alcoholic drinks, etc.)
- Nature of the urinary stream (is the urinary stream strong and constant or is there difficulty initiating a void or continuous dribbling?)
- Any existing recurrent urinary tract infections
- The number of wet versus dry nights
- Other symptoms associated with nocturnal enuresis such as night sweats

A complete physical examination, together with a focused neurologic examination, greatly aids in further assessing the possible causes of enuresis. Among the laboratory tests, urinalysis and serum glucose are helpful because they can detect not just infection but also the presence of glucosuria (glucose in the urine) and elevated serum glucose levels among patients with diabetes. Imaging and urodynamic studies are also helpful to screen for the presence of neurogenic bladder, a subtype of diabetic neuropathy which affects the muscles of the urinary bladder causing the inability of the detrusor muscles to completely empty the bladder of the urine.

Once diagnosed, it is important to start treatment at once because of the



embarrassment that is caused by the "accidents" at night. Treatments consist of several behavioural and pharmacologic interventions. It should be noted, however, that good glycemic control is a pre-requisite before any other form of therapy is instituted because uncontrolled diabetes in itself may manifest with nocturia and nocturnal enuresis.

These are some of the behavioural therapies for diabetics with nocturnal enuresis:

- **Monitoring Fluid Intake:** Limiting intake of fluids in the late afternoon and evening before bedtime causes a decreased amount of urine produced at night. This could be a helpful first step to reduce wet nights. Also, decreasing the amount of caffeinated and alcoholic beverages may help. However, this does not mean that one should reduce his overall fluid intake. Only change the time of fluid intake, as drinking adequate fluids is important for general health.
- **Bedwetting Alarm System:** A bedwetting alarm is a device that awakens an individual from sleep as soon as the accident begins. Multiple variations of the alarm exist, ranging from vibrating to sounding alarms and wet-detection devices that can be

attached to the underwear or a pad on which the individual sleeps. Once awakened, the individual is able to stop the flow of urine, finish voiding in the bathroom, and return to bed. Eventually the body is conditioned to wake up with the urge to urinate before wetting the bed.

- **Waking:** While this option does not treat the problem, it may be helpful in preventing a wet bed. It involves setting an alarm during the night at a random time in order to urinate. It is important to set the alarm at a random time so that the bladder does not grow accustomed to emptying at a scheduled time during the night regardless of whether or not one is awake.

The pharmacologic options for the treatment of nocturnal enuresis may be used alone or combined with some of the behavioral treatments listed above, which have generally been proven to be more effective. Many studies have shown, however, that while pharmacological treatment may be initially effective in lowering the number of wet nights, the medicine is often effective only as long as it is taken. In other words, relapse rates are high once treatment has stopped. This is because only the symptoms are addressed by the medication rather than the underlying condition or causal factors. These medications include Desmopressin, Imipramine (a tricyclic antidepressant) and Anticholinergic Medications (e.g. Oxybutynin).

Bedwetting or nocturnal enuresis is a problem that should be recognized among patients with diabetes because, aside from being a sign of uncontrolled diabetes, it may point to diabetic complications and other medical conditions that need further evaluation and more focused treatment. ○



IDF 20th World Diabetes Congress

Diabetes Philippines participates in Global Village at Palais des Congrès de Montréal, Canada last October 18 - 22, 2009

Tommy S. Ty Willing, MD
Metropolitan Medical Center

The Global Village is an area within the exhibition hall dedicated to the IDF Member Associations. It gives IDF Member Associations the opportunity to interact with the diabetes community at large. Its main objective is to serve as an avenue of exchange among associations and for them to showcase their activities. 200 diabetes member associations from more than 160 countries and territories joined the Global Village by presenting their work in a colorful and creative way. This lively and innovative social space attracted a large number of delegates throughout the congress.

The Diabetes Philippines booth was designed to showcase the strategies and activities of the association. There were 6 different customized posters posted on the panels of the booth showing networking, education, research, advocacy, a Philippine map containing the 24 Diabetes Philippines chapters, and the World Diabetes Day poster featuring the World Diabetes Day celebration in the Philippines. We also showcased our IEC materials and

DiabetesWatch.

As part of this year's World Diabetes Day campaign, a 3-minute video put the IDF World Diabetes Day poster icons in motion, thus making them more visually appealing to audiences of all ages. The video was also shown in our booth.

As a token to our visitors, 2010 calendars, Diabetes Philippines key chains and World Diabetes Day A4 size posters containing all the 3 messages of understanding diabetes were given. The Diabetes Philippines booth was indeed well visited by both foreign and well-known local personalities in the field of diabetes.

Diabetes Philippines booth was visited by delegates attending the congress including VIPs, like IDF President Jean Claude Mbanya, IDF President Elect Michael Hirst, IDF Past Presidents Prof. Martin Silink and Prof. George Alberti,

IDF staff Dominique Roberts, Lorenzo Piemonte, Corrine Seedie, Katie Dain, Prof. Philip Home, and IDF-WPR President Prof. Yutaka Seino. Ms. Esther Ng, IDF Western Pacific Regional Manager, Prof. Juliana Chan, Executive Committee member (WPDD) and IDF-WPR Past President Gordon Bunyan. ○



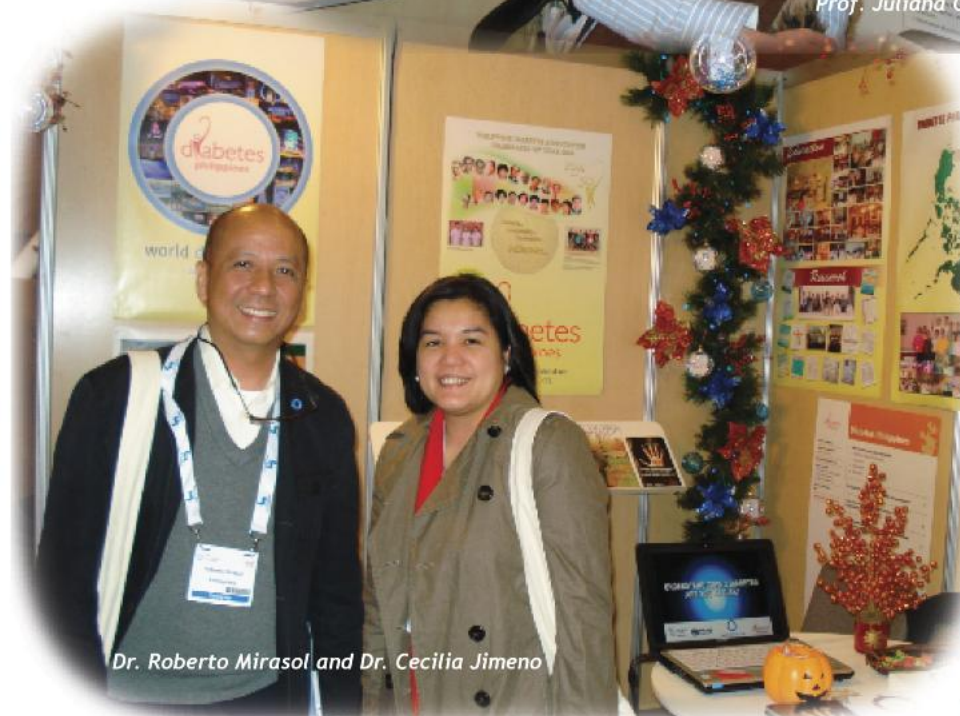
Dr. Tommy S. Ty Willing and IDF President Elect Michael Hirst



Dr. Tommy Ty Willing and Ms. Esther Ng



Prof. Juliana Chan



Dr. Roberto Mirasol and Dr. Cecilia Jimeno



Dr. Tommy Ty Willing and Prof. George Alberti



From left: Dr. Tommy Ty Willing, Dr. Richard Elwyn Fernando, Dr. Ma. Teresa Plata-Que and Ms. Ruth Gelito



Dr. Tommy Ty Willing and Dominique Roberts



Prof. Yutaka Seino and Dr. Tommy Ty Willing



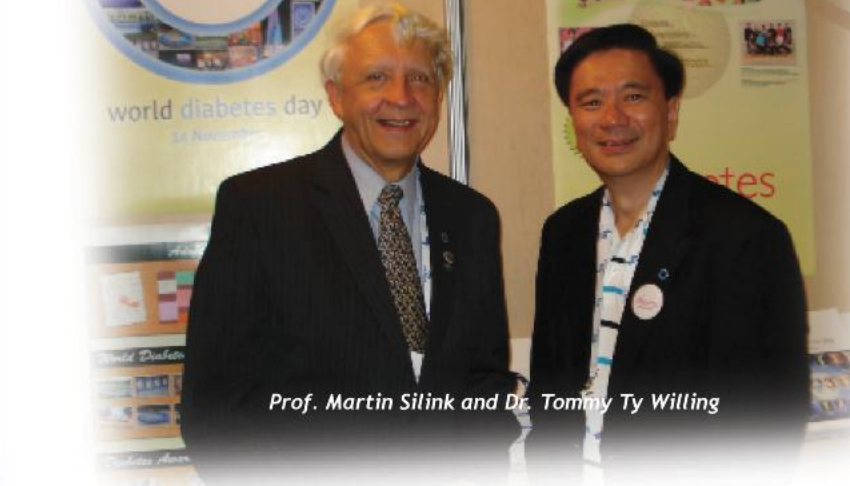
Dr. Tommy Ty Willing and IDF President Jean Claude Mbanya



Lorenzo Piemonte, Corrie Seedie and Katie Dain (IDF Staff)



From left: Dr. Carolyn Narvacan-Montano, Dr. Thelma Crisostomo, Dr. Tommy Ty Willing, Dory Blobner, Prof. Philip Home, Ms. Erlinda Inocencio and Dr. Ruby Lim



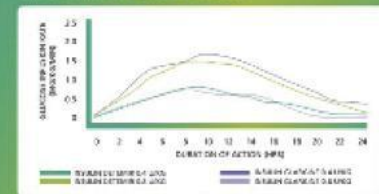
Prof. Martin Silink and Dr. Tommy Ty Willing



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