ISSN 1908-1227

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

diabetes philippines WATCH

A Publication of the Diabetes Philippines

September - December 2010

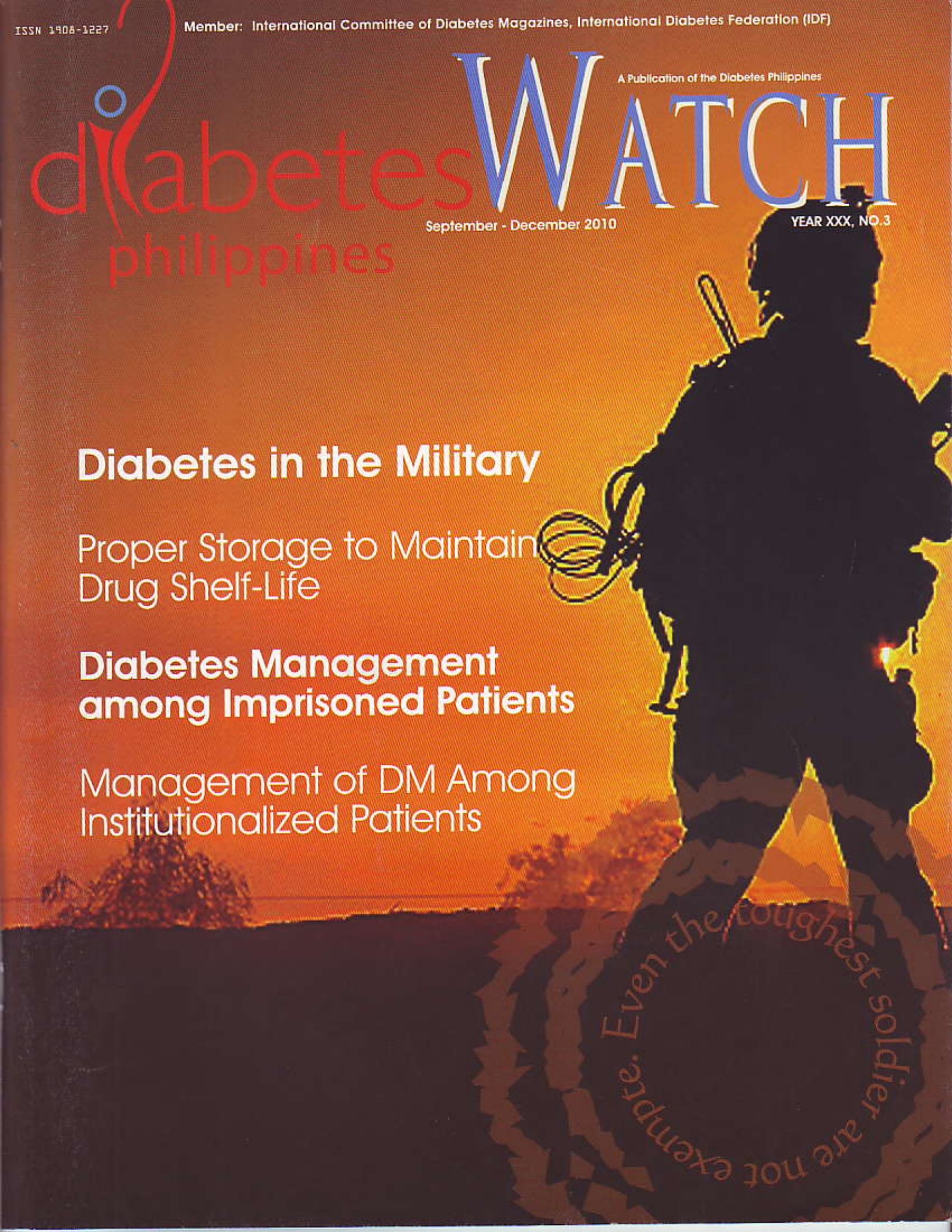
YEAR XXX, NO.3

Diabetes in the Military

Proper Storage to Maintain Drug Shelf-Life

Diabetes Management among Imprisoned Patients

Management of DM Among Institutionalized Patients



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From the EDITOR'S DESK

Sharing some pearls on diabetes care (the journey that was...)

It was in 2008 when this magazine, DiabetesWatch, was turned over to this team. In these three years, we covered themes that we hope provided comprehensive, timely and relevant discussions for diabetics and health care providers throughout the country. Thanks to all who have made these three years a success: to Drs. Rosa Allyn Sy and Teresa Plata-Que, for their leadership and inspiration, to our mentors and Past Presidents, for paving the way in transforming these exciting ideas to printed materials and to the Editorial staff with their regular contributions and inputs to making each issue an enjoyable and educational experience for its readers.

I wish to give special mention to Dr. Patricia Gatbonton for her significant contribution, as Managing Editor for the past several years, for being instrumental in making this magazine achieve its goals.

Finally, thanks to our members and readers (both medical professionals and diabetics) for sharing this journey with us. It was indeed a pleasure and we hope you enjoyed and learned from the articles. We do hope that with these efforts we have helped improve the lives of our Filipino diabetics.

Stay healthy and put more meaning to life!

Elizabeth Paz-Pacheco

Elizabeth Paz-Pacheco, MD
Editor-in-chief

Your President Speaks

Philippine Diabetes Association (now "Diabetes Philippines") board in 1989. I have seen her pass through different milestones, starting from the stewardship of Dr. Augusto D. Lintonjua to the present. In 1991, the first Diabetes Workshop was held and since then it has been conducted on a fairly regular basis. To date, 40 Diabetes Workshops have been held. In 1992, the association finally had her permanent headquarters. In 1995, she co-hosted the AFES (ASEAN Federation of Endocrine Society) Congress for the second time, which was repeated for the 3rd time in 2005, when she co-hosted another AFES congress.

Of course, through the years, changes were effected and more activities were held. DiabetesWatch was transformed from a 4-page black-and-white newsletter to a full color magazine. The association joined PCDEF (Philippine Center for Diabetes Foundation) in advocating for the observance of Diabetes Awareness Week, which became an annual celebration. Her by-laws underwent revisions.

In 2004, PDA "networked" with another society by becoming member of the IAS (International Atherosclerosis Society). Moreover, she became more involved with the IDF (International Diabetes Foundation) by participating in Council Meetings and the IDF Global Village during Diabetes Congresses.

I assumed the presidency in 2007. During my term, the association's advocacy campaign also focused on diabetes awareness and education. That year, I spearheaded a scientific convention called Unite for Diabetes, wherein the PDA, PSEM, ISDF and PCDEF participated. The lay convention was re-named "Gimik Diabetes" to make it more appealing to our participants. The association celebrated her 50th anniversary in 2008, with a change of her corporate image through a new name and a new logo. PDA at 50 and Ginto, a coffee table book, saw print. The association lobbied with Pres. Gloria Macapagal-Arroyo to issue a presidential proclamation declaring November 14 as World Diabetes Day. In 2010, the first Consensus Panel Meeting of the Unite for Diabetes, entitled First Steps to Developing a Unified Guideline for the Management of Diabetes in the Philippines, was held. I continuously represented the association in the IDF-WPR Council meeting. I witnessed the growth of Diabetes Philippines, not just in terms of the number of activities held but even in finances. There was a time when our treasurer had to advance her personal money to pay for the associations' obligations. Now, I am happy to report that the association is financially stable.

This will be the last issue where I will be addressing you as the President of our association. I would therefore like to take this opportunity to thank everybody for your support and understanding.

Tommy S. Ty Willing, MD
President

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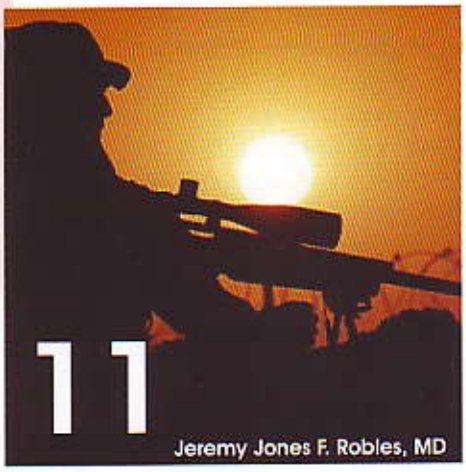
Printed by Lizamen Commercial Printing

September - December 2010



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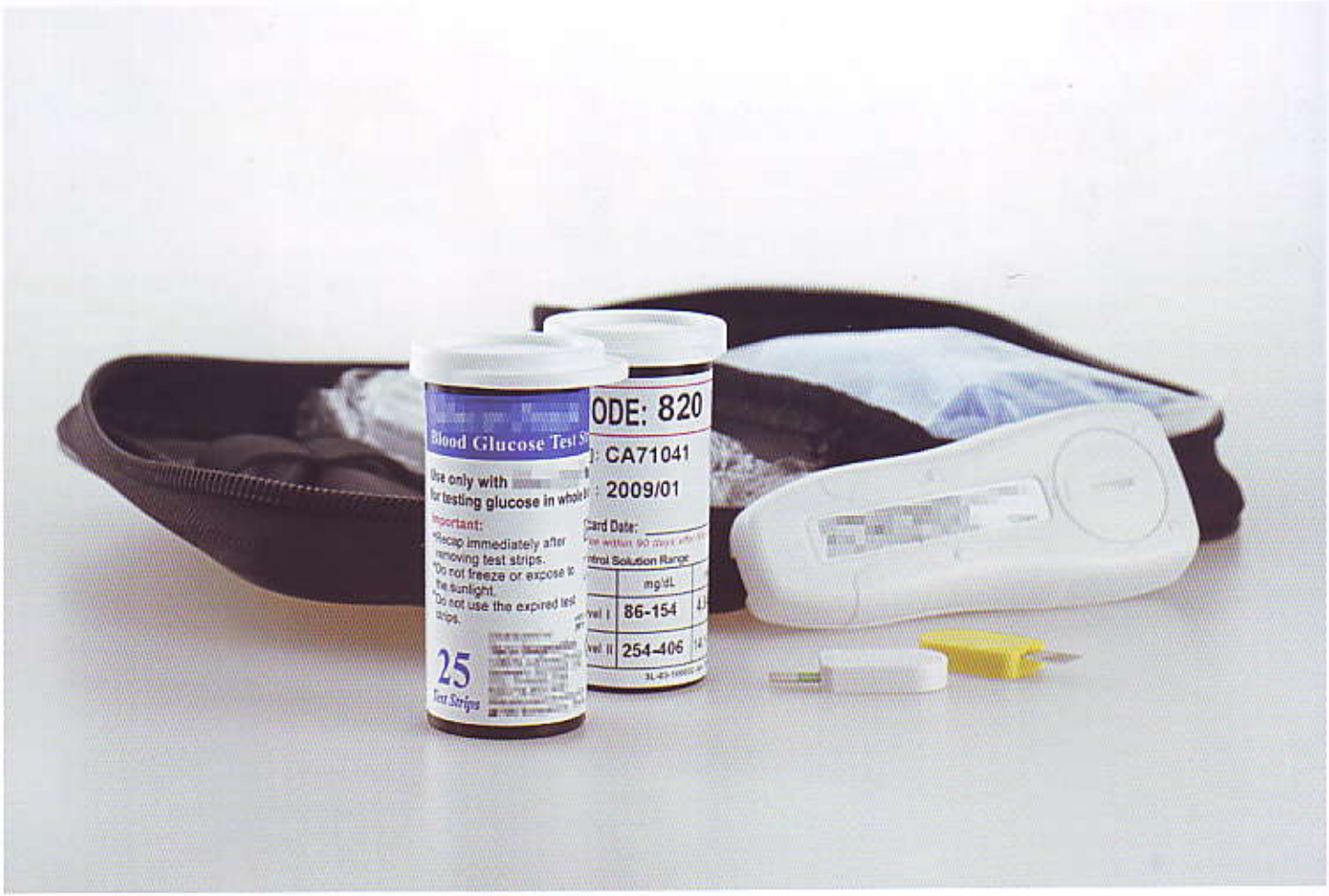
MEANDERINGS

The Year that Was - - - Diabetes 2010

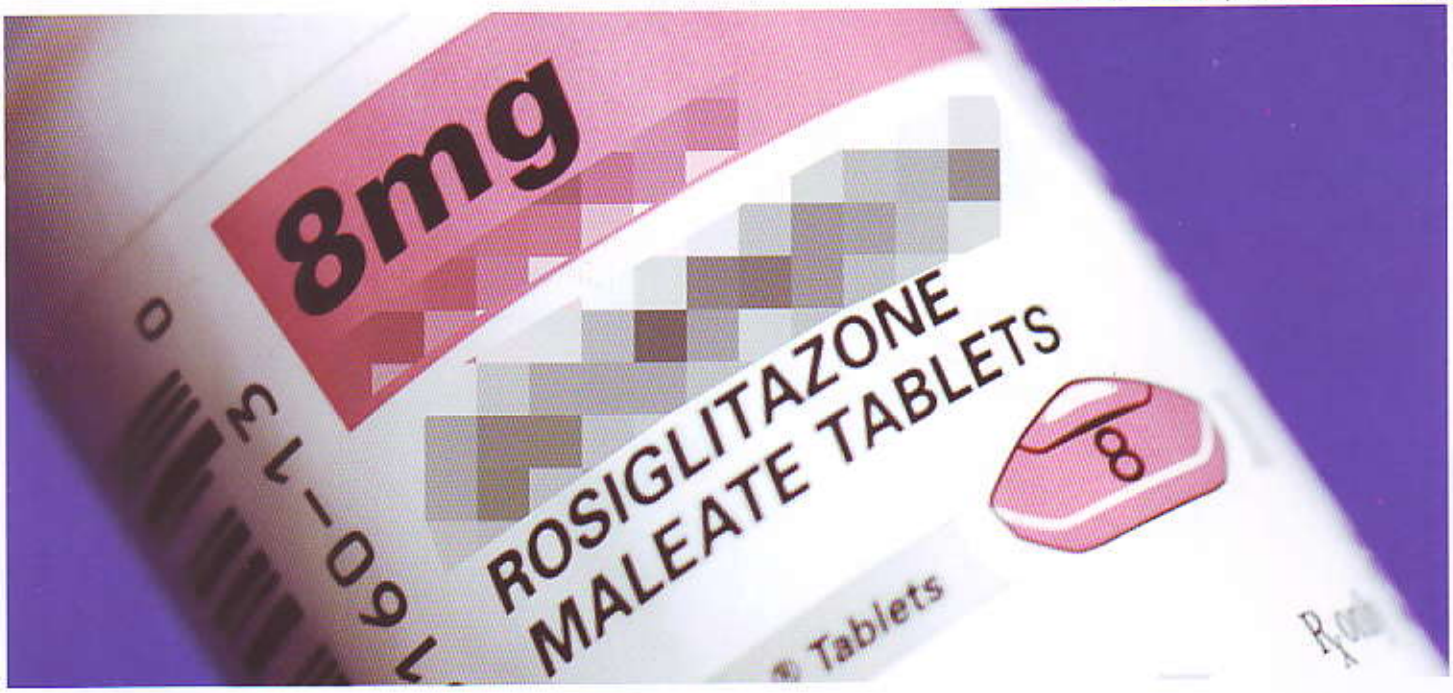
Augusto D. Litonjua, MD
Editor Emeritus

I got the idea for this column from 2 articles in Medscape Diabetes & Endocrinology. One was posted on 17 December 2010, by G.A. Nichols and the other was posted 29 December by Dr. A.L. Peters



The ACCORD Study and our goals for the target A1c:

As everyone knows, the universal target for the control of diabetes is the A1c, which measures the average glycemias or blood sugars for the past 3 months. The American Diabetes Association recommends a target of less than 7%,



while the American College of Endocrinology recommends a lower A1c of less than 6.5%. The aims of these A1c levels are to avert the complications of diabetes related to high blood sugars. There were 3 large studies published in 2010, correlating blood sugar control to the incidence of complications.

One of these, the ACCORD Study created quite a stir in the diabetes world. ACCORD was conducted in 10,000 patients with type 2 diabetes mellitus, at high risk for the complications of diabetes. Patients were either assigned to the intensive glycemic control which aimed for an A1c of less than 6%, and the standard group in which the target A1c was between &%-&.9%. To everyone's surprise, the study was stopped early (February 2008) because of the increased number of deaths in the intensive glycemic group. The findings went against the general belief that the lower the patient's A1c was, the better.

There were many discussions and further analyses that were made of the results of ACCORD. The latest conclusions are, "The risk of death with the intensive strategy group increased approximately linearly from an A1c of 6% to 9%. And mortality was greater in the intensive group, compared with the standard group, only when the average A1c was greater than 7%. Those who easily achieved target A1c levels had the lowest risk of death, while those who struggled to achieve low A1c levels had the highest risk of death."

In clinical practice, what these new findings suggest is that if you are a healthy patient with diabetes, then achieving an A1c of less than 6%, will hold a lot of benefits. However, if you are an older patient with more than 10 years of the disease, then a higher A1c level would be more appropriate. It thus says, that no one rule will apply to all patients, but treatment should be individualized. For the general population, an A1c of less than 7% can be a safe goal.

The lost battle of Rosiglitazone

The European Council banned the use of rosiglitazone because of its cardiovascular side effects. The US FDA placed a lot of restrictions on the use of the drug, making it most impossible to prescribe rosiglitazone the usual way. The Philippine FDA followed the example of European Council - such that the drug, sold under the trade name Avandia, is no longer available for use in the Philippines. There has been a lot of concern in the safety of drugs, even after its prolonged use by patients.

Diabetes and Cancer

A topic that generated a lot of interest among physicians treating patients with type 2 diabetes, is the risk of cancer associated with having diabetes. Among the known findings from a group of analyses showed that having type 2 diabetes imparts a 2-fold or higher risk for cancers of the liver, pancreas, and endometrium. There is a lesser risk for the cancers of the colon and rectum, breast and the bladder. The studies found that certain cancers, such as lung cancer, do not appear to be associated with diabetes, with the evidence inconclusive to cancers of the kidney and lymphoma. The study also notes that diabetes associated with a lower risk of prostatic cancer. One good news on the relation between diabetes and cancer, is that metformin not only lowers the blood sugar and protects the heart, but recent data show that it also helps reduce rates of cancer in type 2 diabetes patients and may also reduce mortality. Thus, metformin does earn the title of 'wonder drug of diabetes.'

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

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

In this issue of Diabetes Watch we deal with your questions on diabetes in the work place. The general principles of management of diabetes are fairly standard. There is however differences in the management in different settings like the workplace. Read on and learn more.

I am applying for a job. Should I disclose that I have diabetes?

This is a matter of personal choice. You have to consider the job you are applying for, the side effects of drugs that you are taking, the impact of your disease amongst your co- workers. You should not, however, be discriminated against in case you choose to disclose as long as you are qualified for the job.

Are there particular jobs or careers which are not appropriate for people with diabetes?

Yes. You cannot be in the armed forces, jobs which require you to transport passengers such as pilots, bus, jeep or taxi drivers, pilots and flight airline crew or jobs which require use of heavy machinery. This is particularly true if you are on insulin and hypoglycemia is a concern.

Can I be discriminated against just because I have diabetes?

Your diabetes should not prevent you from pursuing your dreams. Every step in the recruitment should not be discriminatory from the application to acceptance, from the medical interview to the physical exam. It should not even affect job promotion, career changes or whether this is your first or last job.

I was diagnosed with Type 1 diabetes recently but I have been a taxi driver since 5 years ago. Should I switch jobs?

You may have to do so especially if your blood sugars are hard to control. There are other options available for you e.g. vehicle maintenance, driving instructor or a desk job.

Will I be able to retain my job even if I have diabetes?

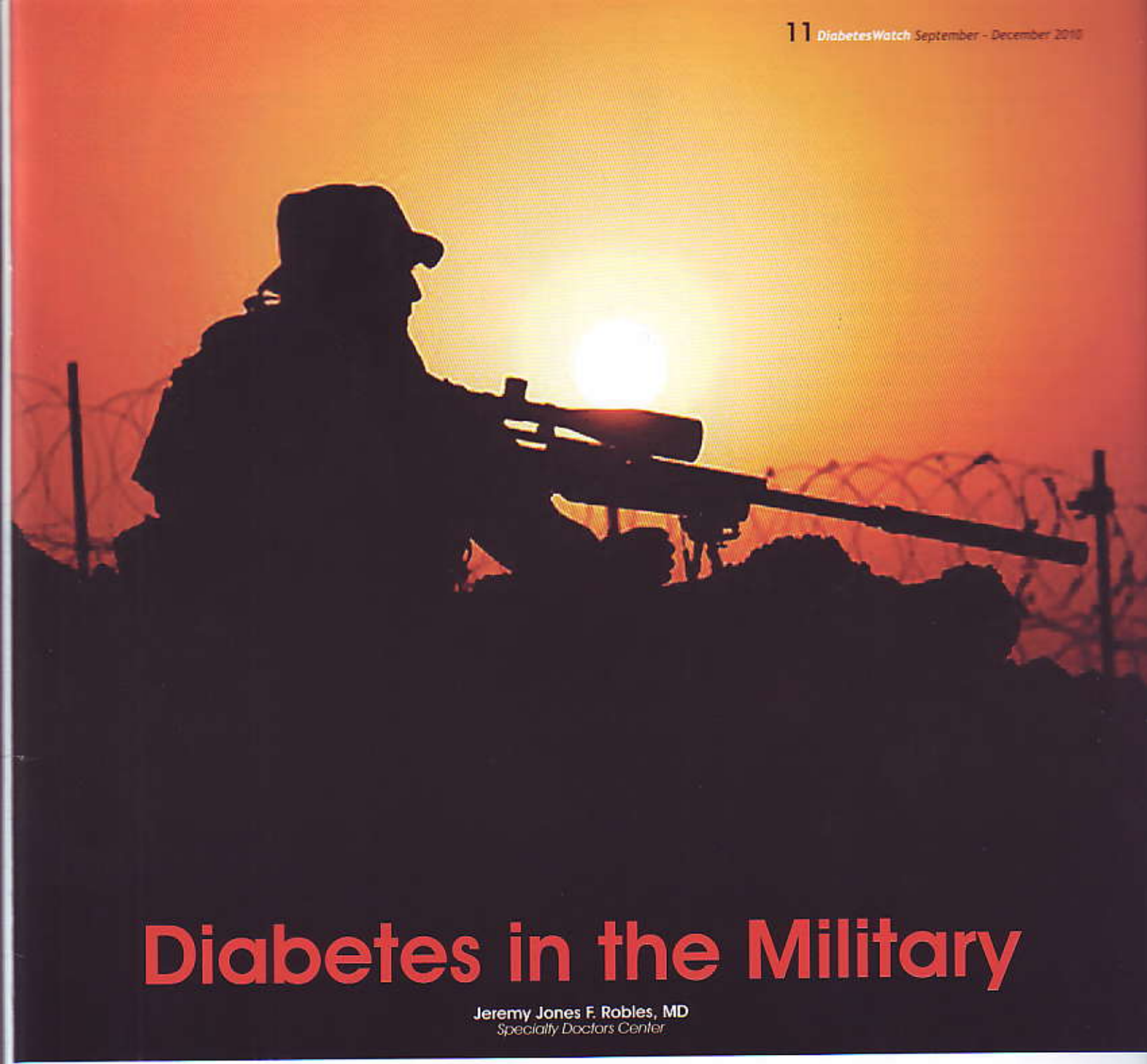
Sure. All you need to do is to properly manage your diabetes. You should be in close contact with your endocrinologist for proper control of your blood sugars and the complications associated with diabetes. Your meal plan should be checked and suited to the type of job you are in. Advice on proper intake of medications is very important. Talk to your co workers about your diabetes.

Are there laws which protect us from discrimination?

Yes, it is unlawful if an employer refuses to employ you after a medical identifies you as having diabetes. If an employer also limits your job responsibilities, refuses promotions or training just because of your diabetes. It is discriminatory if you are fired just because you have diabetes. You must however prove that your diabetes is not affecting your performance at work.

I would like to thank all of you who have been closely following my column for several years now. Your comments and suggestions were truly inspiring. Till we meet again. Fight Diabetes!

We hope we were able to answer your questions. If you have more questions, suggestions or reactions, call or fax us at 5311278 or e mail me at mbmirasol@yahoo.com



Diabetes in the Military

Jeremy Jones F. Robles, MD
Specialty Doctors Center

Every so often I get a bunch of military men come and visit me at the clinic to consult because of an abnormal blood sugar level taken on screening done in the nearby camp. Unlike the rest of us in the city, they are not at liberty to leave the camp as often as they would want. Although the army doctors and medical staff of the camp usually take care of the basic needs, the more complicated problems get referred to the other doctors or hospital.

The truth about diabetes is that it can affect even the toughest soldier in the army, so no one is exempted. Pertinent risk factors include physical inactivity, high blood pressure, abnormal cholesterol levels, history of stroke or prediabetes and having relatives with diabetes.

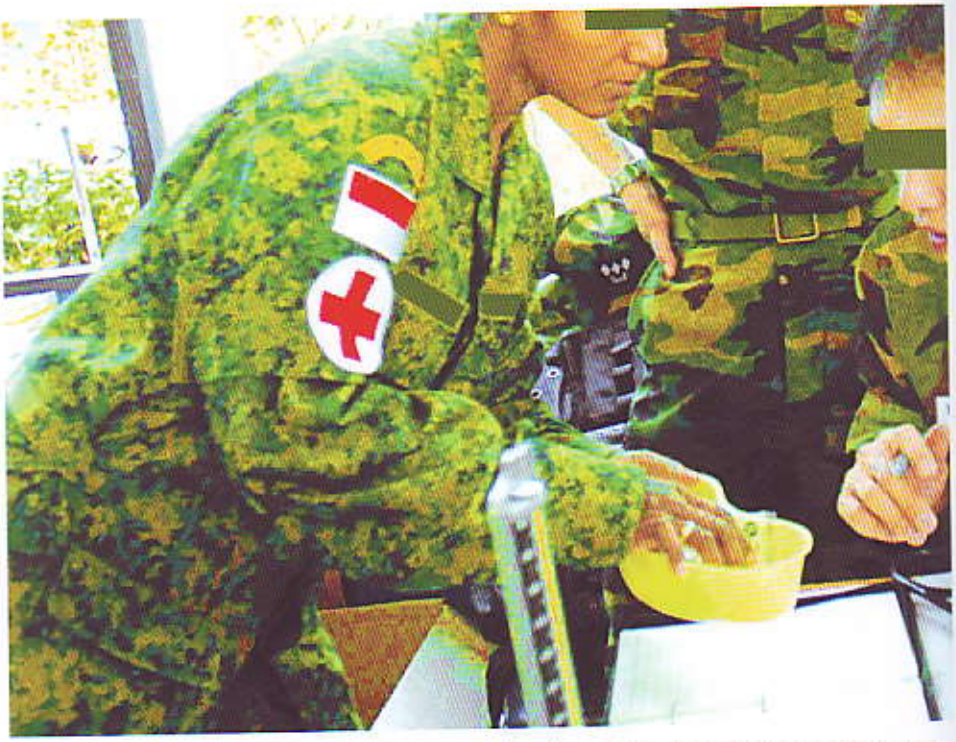
Diagnosis

There are four tests you can use to diagnose diabetes mellitus. These are fasting blood sugar, glycosylated hemoglobin, random blood sugar and oral glucose challenge. The simplest, cheapest and most available would be the fasting blood sugar. After an 8 hour fast, blood is drawn from the arm and tested. A value less than 100 mg/dl is normal while a result between 100-125 mg/dl put you at risk for diabetes. If you have a sugar value of 126 or more then you are likely to be diabetic and would need further medical check-up. Most of the time the signs and symptoms of diabetes trigger the evaluation. Weight loss, frequent urination, thirst and lack of energy are

common complaints. The usual age of onset is 40 years old.

Treatment

The treatment of diabetes can be intimidating but the basic elements of successful control of blood sugar depend on adequate education on diabetes. Lifestyle change is very important. There is no cure for diabetes only control. There are several oral medications available in the market that can be taken. You will need to see your doctor regularly so you can be given the best medication for you. In certain cases severely uncontrolled diabetes may need insulin therapy. Innovations in delivery using portable pens have made the use of insulin easier than ever.



Special Situations

During field assignments access to healthcare may be limited so make sure you have adequate diabetes medication with you for the duration of the tour. A handy diabetes kit should include a glucose meter with enough strips, alcohol and cotton. Materials for wound care should be prepared just in case you get wounded along the way. Antibiotics that can be taken for several days should also be ready.

As difficult as it may be, eat as regularly as you can, especially if you are taking medications. Episodes of low blood sugar may happen so candies or cookies on your bag may come in handy. Being diabetic puts you at risk for several complications that may need to be evaluated prior to sending you off for a long assignment. These long-term complications can manifest as blurring of vision, numbness on hands and feet and kidney problems.

Overall, consider the general condition. The army doctors can assess appropriately if it would be a good idea to send you off with the rest of the troops. You will have your own battles to cope with.

Strategies for Diabetes Management

Eat regularly. In a typical day we Filipinos end up eating more than what we need. Change you habits, eat 3 major meals at a regular time and have a balanced meal. Avoid fatty food and limit your rice. Fruits are good for you but eat just enough. Snacks can be taken in between meals but keep in mind that the amount of food you eat should be less than your regular meal.

Stay fit and lose weight. Diet and exercise alone can prevent the progression to diabetes in patients considered at risk for the disease. Exercise daily to burn the excess calories that you have acquired. This will also help you lose weight and improve your metabolic profile.

Treat hypertension and high cholesterol. There is good chance that

Blood sugar monitoring is essential for you to know how you are doing. Check your blood sugar regularly so you will know how you are doing. The best times to check your sugar will be early morning before you have taken your breakfast and 2 hours after your lunch.

diabetic patients are also hypertensive and have abnormal cholesterol levels. Your risk for cardiovascular disease will increase if these other diseases are present. They should be treated aggressively and appropriately.

Stop alcohol and smoking. These vices compound you problem. Regardless of whatever reason you have in favor of smoking and alcohol, there is really no justification for you to continue especially if you are diabetic. Save your money for your medication and tests.

Monitor your progress. Blood sugar monitoring is essential for you to know how you are doing. Check your blood sugar regularly so you will know how you are doing. The best times to check your sugar will be early morning before you have taken your breakfast and 2 hours after your lunch.

Drink your medications. Diabetes is a lifelong disease. Keep this in mind. You will have to take your medications regularly and follow-up with your doctor. Medications should be adjusted according to your progress.

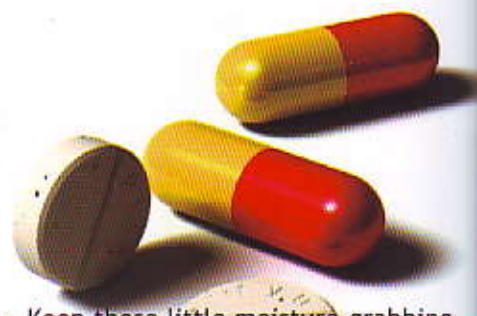
Treat your wounds. If you get a cut or get wounded make sure you take care of it. Wounds take time to heal especially if you have uncontrolled sugar levels. Proper dressing should be done and appropriate antibiotic therapy should be initiated.

Final words

Even the younger men may experience an early onset of symptoms if you have a strong family history. Screening for diabetes can help identify patients with abnormal blood sugar levels. Have yourself tested if you are at risk. Pursue the evaluation if needed. It is always better to prevent the complications by controlling your sugar aggressively at the early stage of the disease.

Don't lose hope! We know more about diabetes today. Read about your disease and understand its nature. Do not be afraid to ask questions and learn as much as you can. You are not alone, more and more diabetics are diagnosed each day so don't be afraid to speak up. Let your family know since you will need all the support you can get.

Proper Storage to Maintain Drug Shelf-Life



Florence Amorado-Santos, MD
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Shelf life is the duration of time given to any perishable item such as food, drinks, medicine or chemicals before they are considered unsuitable for sale, use or consumption. It is the recommended time that products can be stored, during which the defined quality of a specified proportion of the goods remains acceptable under expected (or specified) conditions of distribution, storage and display. In some places, a best before, use by or freshness date is required on packaged perishable foods.

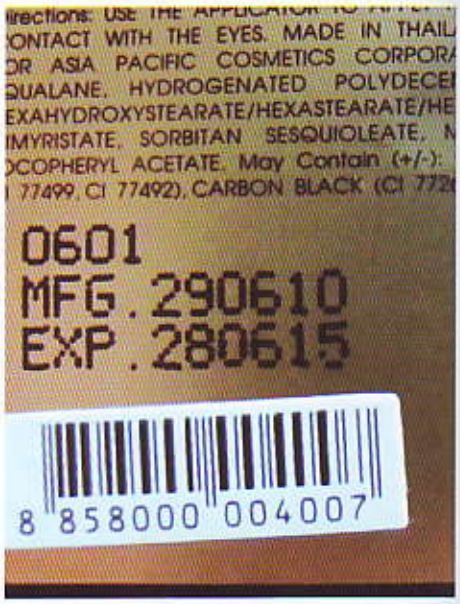
The term shelf life needs to be differentiated from the more commonly known expiration date which pertains to product safety while shelf life relates to product quality. Some, but not all medications retain potency and are usually safe briefly following the expiration date, but must be checked with specific medications. If your medications have been stored under good conditions, they should retain all or much of their potency for at least one to two years following their expiration date, even after the container is opened. But you should discard any pills that have become discolored, turned powdery, or smell strong; any liquids that appear cloudy or filmy; or any tubes of cream that are hardened or cracked. Expired medications are not always dangerous, but they can be ineffective after the "use by" date. However,some drugs, such as tetracycline antibiotics, can be dangerous if used after their expiration date causing damage to kidney tubules.

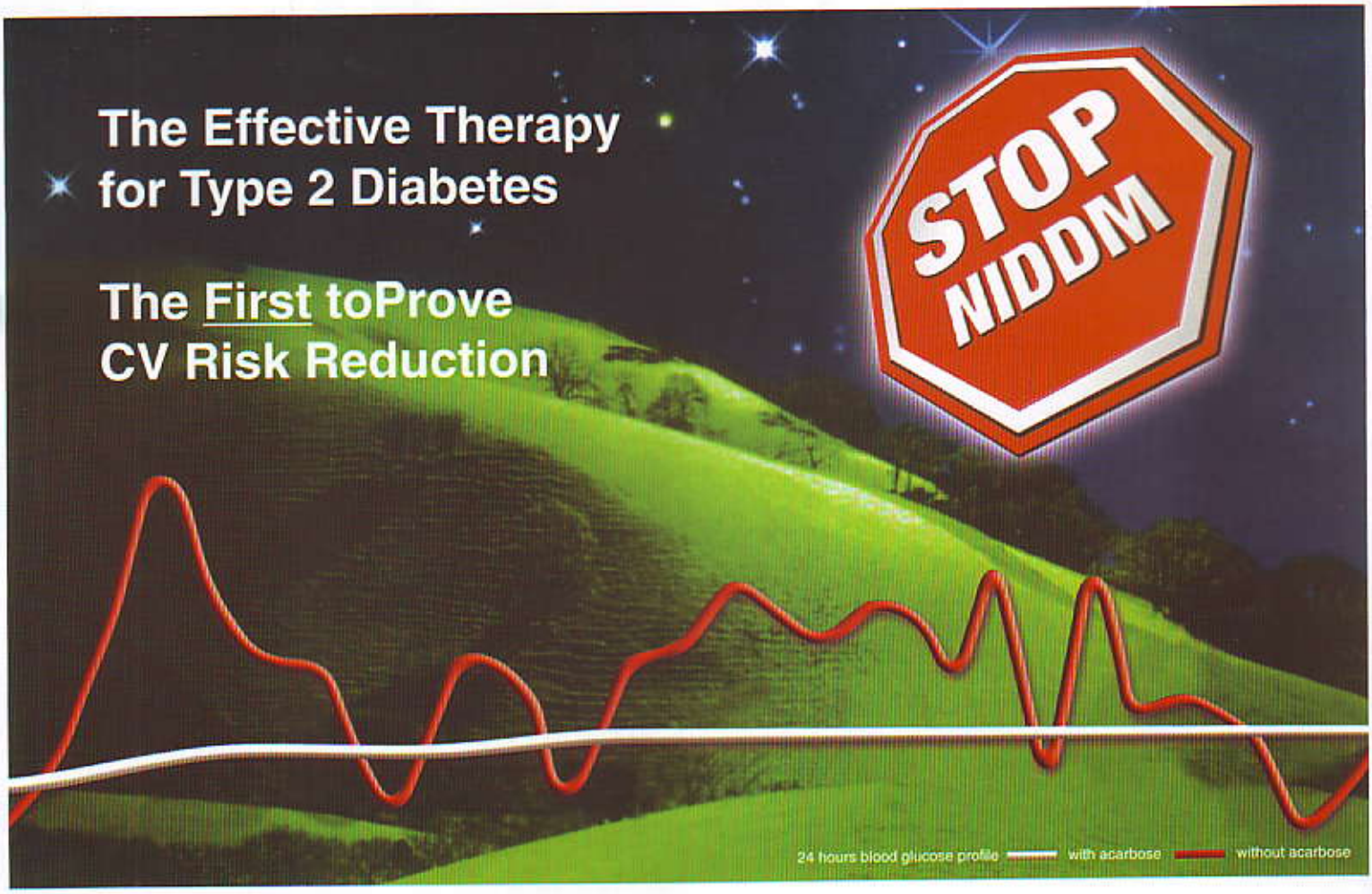
Once passed its shelf life, a product might still be safe, but the quality is no longer guaranteed. Determining the exact shelf life of prescription drugs is difficult, the process is called stability analysis. While labels are used and do indicate an expiration date, the actual effectiveness and true shelf life of prescription drugs which is literally the length of time a drug can stay on the shelf without degrading to unacceptable levels may indeed be much longer.

Several factors that variably influence drug shelf life includes: exposure to light and heat, transmission of gases (including humidity), mechanical stresses, and contamination by things such as microorganisms. The integrity of a product lies in the concentration of a chemical compound, microbiological index and moisture content. Some degradation factors can be controlled by use of appropriate packaging. For example, the amber bottle used for medications blocks damaging wavelengths of light. Transparent bottles do not. Packaging with barrier materials (e.g. low moisture vapor transmission rate, etc.) extends the shelf life of some foods and pharmaceuticals. Preservatives and antioxidants may be incorporated into some food and drug products to extend their shelf life. Some companies use measures such as induction sealing and vacuum pouches to assist in the extension of the shelf life of their products.

Here are some general tips on how to keep medications at their utmost effectiveness:

- Avoid using medicine cabinets. Bathrooms can have too much moisture which can degrade tablets and capsules.
- Keep medications in a dry place and out of direct sunlight and places with large temperature fluctuations like the kitchen or cabinets right above the oven. Ideal room temperatures are 59 to 86°F, 15 to 30°C.
- Keep cabinets and pill boxes out of reach for children.
- Keep those little moisture-grabbing dessication packets in medicine bottles when storing for longer periods. Remove packing cotton as it can hold moisture.
- Keep containers tightly closed after each use.
- Keep medications in their original containers to retain all the important dosage information. Original labels provide important information on drug identity and expiration.
- Refrigerate only those medications that call for refrigeration. Never freeze medications unless directed to do so by the pharmacist or doctor.
- Never place different medications together in a container. Storing drugs together can cause unwanted interactions.
- During travel, don't store your medications in the glove compartment, which can become damaged by outside temperatures, the heater, or air conditioner.
- Do not freeze insulin preparations.
- Medications like insulin and some liquid antibiotics, do degrade quickly and should be used by the expiration date.





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

Glucobay®. Acarbose: tablets 50, 100mg. **Packs:** Country specific. **Indications:** Diabetes mellitus in combination with diet. **Dosage:** According to individual response. Start with 50 mg od increased to 100 mg tid. Dosage increase interval 1-2 or more weeks. If afternoon blood glucose levels are low, skip midday dose. Swallow tablets immediately before meals or chew at meal beginning. **Contraindications:** hypersensitivity to acarbose, pregnancy, lactation. Children and adolescents, who are less than 18 years of age. **Precautions:** Caution to patients with chronic digestion, absorption disorders and conditions aggravated by increased intestinal gas formation e.g. large hernias, constrictions and ulcers of large intestines. Foodstuffs containing sugar mat lead to intestinal discomfort and diarrhoea. In case of hypoglycemia use dextrose (not sucrose). **Interactions:** Dose of antidiabetic therapy may be reduced on addition to Glucobay®. Antacids, cholestyramine, intestinal absorbents and digestive enzymes may reduce its effect (avoid simultaneous intake). **Side effects:** They are dose and substrate-related and generally subside with continued treatment. They can be minimized by adherence to diabetic diet and avoidance of sucrose-containing foodstuffs. Feeling of fullness, abdominal distension, flatulence, soft stools and diarrhoea. Individual cases of asymptomatic transaminase increase disappearing completely after discontinuation of therapy. **Full prescribing information available by:** Bayer HealthCare AG, PH-GSM Regional Marketing Asia-Pacific, D051368 Leverkusen, Germany.

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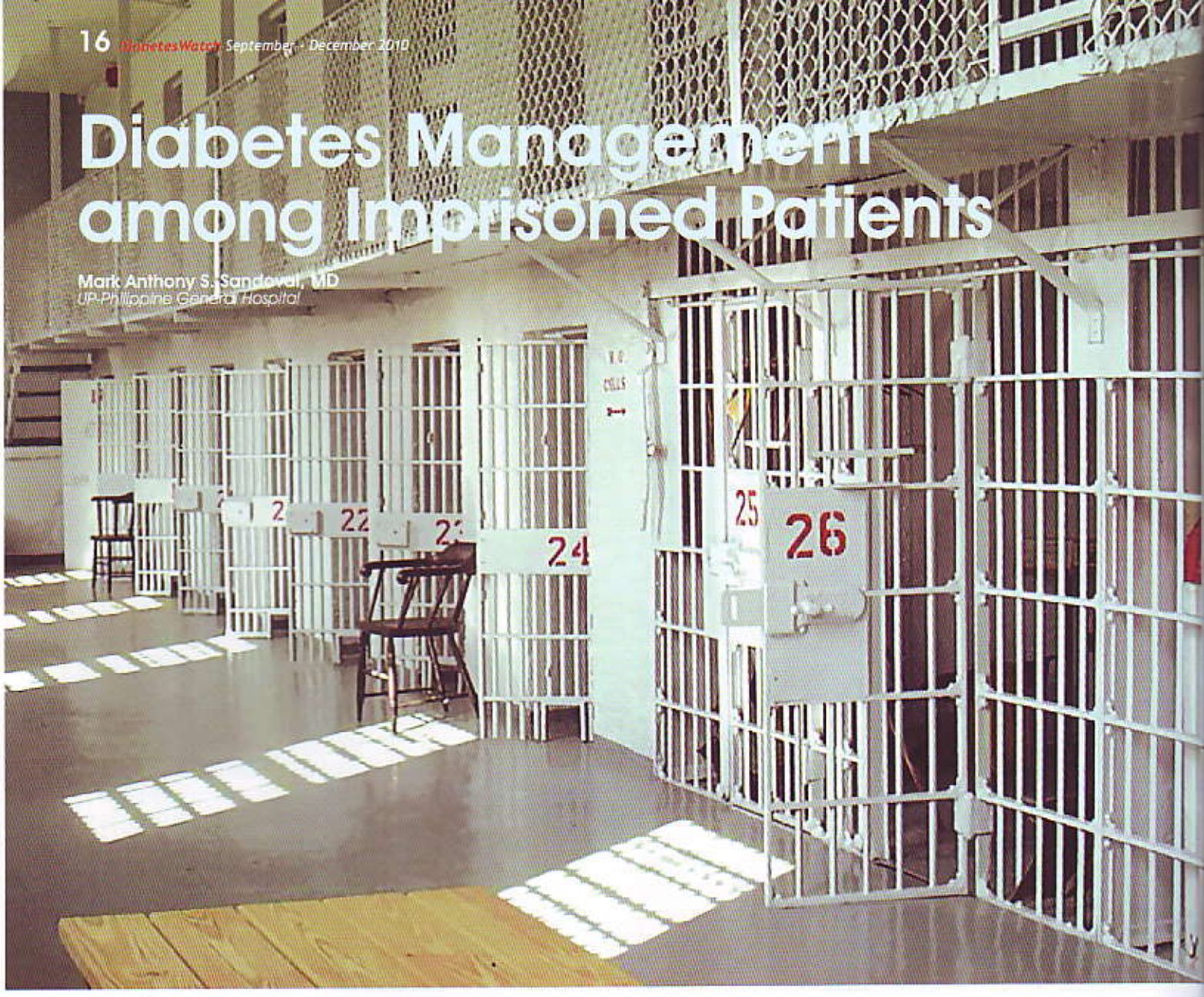
Diabetes Management among Imprisoned Patients

Mark Anthony S. Sandoval, MD
UP-Philippine General Hospital



Patients who get arrested and need to be imprisoned often have so many issues to take care of - dealing with law enforcement personnel, consulting with lawyers, having their daily routines disrupted and having to face the fact that they need to be separated from their families and friends. Having diabetes or any chronic illness for that matter adds another thing for them to consider while they are under the jurisdiction of the penal system.

Being imprisoned does not mean that the standard of care that a diabetic should receive should be suboptimal. They deserve to be treated for their diabetes just like anyone in the general population. There are several peculiar factors that need to be considered in the care of an imprisoned diabetic.

Upon reception before a correctional facility, inmates must be asked whether they know that they have diabetes. Inmates with diabetes on insulin treatment must be identified immediately since they are the ones at high risk for developing hypoglycemia or hyperglycemia and diabetic ketoacidosis. It is recommended that the capillary blood glucose levels of these patients be measured within 1-2 hours of arrival to the correctional facility. More importantly, inmates who manifest with altered mental status, agitation, combativeness, and diaphoresis should have their capillary blood glucose checked immediately. Hypoglycemia and even hyperglycemia must be immediately ruled out in these instances. Since alcohol and substance abuse are also prevalent among persons who have brushes with the law, alcohol and substance intoxication and withdrawal syndromes are among the other considerations for those who have these symptoms. These manifestations might also be just a part of the normal emotional response of any person if he or she has to face being arrested and incarcerated.

Upon intake or admission into prison, a comprehensive medical history must be taken. They are asked about the type and duration of their diabetes, medications they are taking (dosing and schedule), presence of complications, family history, alcohol and substance use, behavioral health issues (depression, distress, suicidal tendencies), pregnancy (for females of childbearing age) and whether they have received prior diabetes education.

A comprehensive physical examination must also be done by a licensed health care provider. Just as in any diabetic, the complete exam should include the height, weight, blood pressure, eye or retinal exam, cardiac exam, peripheral

Ideally, prison facilities should have drug formularies that carry all types of insulin (rapid-, short-, intermediate- and long-acting) and oral antidiabetic agents (sulfonylureas, biguanides, thiazolidinediones, and alpha glucosidase inhibitors), and that patients have access to these provisions.

pulses, foot and neurologic exam. Laboratory testing is also recommended to determine the current level of blood sugar control and presence of complications. Among the tests that are to be taken are HbA1c, blood glucose, lipid profile, urine microalbumin, and urine ketones, AST/ALT and creatinine as clinically indicated. Females who are pregnant at the time of incarceration should be screened for gestational diabetes as well.

During the reception and intake into the correctional facility, meal and medication intake should continue as scheduled.

If security regulations will allow, it is said that it is good to have insulin-receiving patients be placed in a common unit within the facility. This will facilitate meal provisions and medication administrations. Also, interacting with other diabetics allows one to share experiences with the others and to learn from others as well. Moreover, housing these patients together would make it easier for prison personnel to respond to emergency situations in the event that one would develop hypo- or hyperglycemia.

Having prison staff trained in diabetes management should also be available in any correctional facility. If there is no doctor available, the prison staff should be knowledgeable on what symptoms and blood sugar levels they need watch out for which require referral to a physician.

Ideally, prison facilities should have drug formularies that carry all types of insulin (rapid-, short-, intermediate- and long-acting) and oral antidiabetic agents (sulfonylureas, biguanides, thiazolidinediones, and alpha glucosidase inhibitors), and that patients have access to these provisions. In the Philippine setting, however, out-of-pocket financing is the usual scheme and the patients' families might need to buy and bring these medications to their imprisoned relative.

Having medications in the individual's possession is one factor that needs to be considered. On one hand, security issues would mandate that these are better off in the hands of prison personnel rather than kept on the inmates' bodies since insulin needles and vials may be used to harm others while insulin and oral hypoglycemic agents may be taken in excess to consummate suicide. On the other hand, having these medications in the possession of the inmates will allow autonomy, foster diabetes self-management and would assure prompt and timely intake.

The need for inmates to be transferred from one place to another also has to be considered in their diabetes management. Inmates may often be escorted and transported out of the prison facility to attend court proceedings or to have outside medical consultations, for example. During transport, meal and medication intake schedules should also be followed so as to avoid hypoglycemia and hyperglycemia. Packed meals, medications and glucose tablets, solutions or candies should be brought with the inmate during these times.

Inmates are also transferred from one prison facility to another. It is important that the transferring facility be able to endorse to the receiving facility the inmate's medical status. A medical transfer summary should be brought along with the inmate and include at least the following data: current medication schedule and dosage, date and time of last medication administration, recent laboratory results, presence of acute and chronic diabetes complications, information on scheduled appointments with a health facility, and contact information of personnel whom the receiving facility can coordinate with should additional information be needed.

In conclusion, imprisonment does not mean that the standards of diabetes care need to be compromised. Diabetics should still receive optimal treatment while in the custody of the penal system. However, there are several factors that need to be considered in their care that are peculiar to diabetics in prison. ○

Reference:
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"How Is Diabetes Handled In Schools: What Administrators, Parents and Students Need To Know"

Jay S. Fonte, MD
UST Hospital

During the early part of the 21st century, a survey was conducted in 222 randomly selected schools and 141 parents in the United States. About 30% (65 of 222) of schools responded with 80% of them having confirmed to having students or pupils with diabetes mellitus enrolled while 33% of parents surveyed affirmed to having diabetic child in elementary or high school. Of the schools who responded, nearly 10% did not have a policy pertaining to diabetes management and almost 17% of schools did not have staff trained to respond to diabetes emergency. Furthermore, about 50% of the schools indicated that parents of children with diabetes did not provide the school with the necessary medical information to care for the child while at school and many cited lack of parental involvement as an obstacle to the optimal care of students with diabetes. On the other hand, 21.2% of parents were dissatisfied with the care of their child at school, 20% reported that their child was not allowed to participate in all school activities without restriction and was not allowed to go on school field trips unless accompanied by a parent or school nurse and was not allowed participate in sports.

Why should diabetes mellitus be addressed at the school level? Diabetes mellitus is a chronic disorder characterized by inability of the body to use glucose as source of energy due to absolute or relative insulin deficiency. Type 1 diabetes mellitus is due to autoimmune destruction of the insulin-producing cells of the pancreas with onset mostly in childhood or adolescence. Type 2 diabetes mellitus, on the other hand, is brought about by insulin resistance with relative insulin deficiency that occurs mostly in middle-aged or older adults. However, it has been observed in the past decades that more and more youth are being diagnosed with type 2 diabetes. Children with diabetes mellitus are special group of diabetic patients that, when compared to their adult counterparts, are at higher chances of developing acute complications of diabetes such as hyperglycemia or high blood glucose and hypoglycemia or low blood glucose which are both life threatening. In children and young adults, insulin is the only approved treatment for both types 1 and 2 diabetes. The latter group may be given with metformin as well to make the body more sensitive

to insulin. School activities such as sports and failure to take snacks may put the student at risk of hypoglycemia while missing the dose of insulin will make the student hyperglycemic. The school should be able to address the psychosocial issues of diabetes as well. Adolescents want to fit with their peers and don't want to be different and the school should be sensitive to the child who is struggling with issues related to their disease. Diabetes should not prevent participation in sports, going to parties or having social relationships.

How then should diabetes be handled in schools? The school administrators and parents/guardians should work hand in hand to assure that students with diabetes have the support needed to manage the disease in the school setting. This can be done in the presence of a trained school staff that is able to respond appropriately to diabetes emergencies. The school and the parents should be able to provide individual care plan and, to support the student in becoming independent with their self care management that is consistent with their age and interest and to enhance opportunities for children with diabetes to participate fully in all school functions.

To guide the schools in their understanding of diabetes and its management, several schools in the United States have come up with guidelines and recommendations on how to manage diabetes at school. To cite a few, a comprehensive guide for managing students with diabetes at school was initiated by the Pediatric Education for Diabetes in Schools (PEDS) and the Vermont Department of Health Diabetes Control Program in Burlington, VT. In order to assist the delivery of health care, resource materials were provided for parents and healthcare providers managing diabetes at school that contains general information about the disease and recommendations for care which can be easily understood by the lay readers. Posters on how to administer insulin and treatment for low and high blood glucose levels were also provided. They also provided a manual to assist school staff in assuring that children who have diabetes, and their families, have the support needed to manage the disease in the school setting. The manual contains general information about diabetes, care planning including parent conference, individual care plan and training, daily management such as glucose monitoring, and emergency treatment for low and high blood glucose levels, meal planning, exercise

and sports, insulin, and the roles and responsibilities of the parent/guardian, student, health care team, and all other school administrators from the principal, school nurse to the bus driver. The National Institutes of Health in 2001 established the Diabetes Education in Tribal Schools (DETS) in order to increase understanding of health, diabetes, and maintaining life in balance specifically among American Indian and Alaska Native students.

Realizing that diabetes will reach epidemic proportions in the coming years, health care programs of schools extended beyond care for those with diabetes already but for the prevention of the disease as well. Soft drinks, sugary snacks, and other junk foods are banned from schools and healthier alternatives are encouraged such as fruits, vegetables, and low-fat dairy products. The Sandy Lake First Nation School Diabetes Prevention curriculum is a 2-year curriculum which begins in grade 3 and continues in grade 4 in Ontario Canada. Two lessons are taught once a week for approximately 30 minutes each which address three main components: making healthy food choices, daily physical activity, and learning about diabetes.

In the Philippines, the National Nutrition and Health Survey in 2008 have estimated the prevalence of diabetes mellitus type 2 based on fasting blood glucose (>/= 7 mmol/L) to be at 7.2% in the general population. Among these, 0.4% was aged 20-29 years while data for younger patients are not available. Nevertheless, the prevalence of diabetes mellitus among school-aged children can be estimated from data of other countries and observations of endocrinologists in their clinics that while the prevalence of type 1 diabetes remains the same, there is increasing prevalence of type 2 diabetes in the adolescence which parallels the increasing prevalence of obesity among this age group. Several programs about health in general are being practiced among schools in the Philippines. These include physical exercises after a flag ceremony, physical education, celebration of the nutrition month, and promotion of sport activities. However, a formal diabetes management program is not part of the regular curriculum but definitely worth looking at as much as we talk about the controversial sex education to be included in the curriculum.

In schools were diabetes management is not available, recommendations similar to what is being practiced in other countries can be adapted. A summary of recommendations on how to manage diabetes at school is shown in table 1. Health clinics in schools should have glucose meters and strips that can be used in cases of suspected hypo- or hyperglycemia and the supplies to address both conditions. School nurses may undergo training or attend short diabetes education courses such as that conducted by the Philippine Center for Diabetes Education Foundation or attend annual conventions of the Diabetes Philippines and the Philippine Society of Endocrinology and Metabolism. Diabetes education should not be restricted to patients afflicted with the disease but should be a concern of the general population in order to prevent it from happening. After all, it is only when we know about diabetes that we become more sensitive to someone with the disease. That someone may be our child, our student, or our classmate.

Table1. Responsibilities Of The School Administrators And Parents To Ensure Safety Of A Diabetic Student

The school and parents/guardian should work hand in hand to assure that the following are available at the school at all times:

Glucose meter and blood glucose strips
Supplies needed to treat hypoglycemia and hyperglycemia including

Snacks
Insulin and syringes and appropriate storage
Emergency contact phone numbers
Ketone test kit
Complete medical history information on the diabetes care plan form including
Normal blood glucose ranges
Meal schedule
Symptoms of hypoglycemia and/or hyperglycemia

An adult and back-up adult (school nurse) who is trained to assist the student with the following tasks in accordance with the established diabetes care plan:
Blood glucose testing
Record keeping
Respond to out-of-range test results (low and high blood glucose)
Ketone testing
Insulin administration

An adult and back-up adult (usually the classroom teacher) who is able to:
Know the meal and snack schedule of the student
Work with the parents to coordinate the student's meal schedule with the schedule of the school day
Notify the parents, in advance, of any change in the school that could affect the student's meal schedule
Remind younger students of their snack time (if needed)

A private location in the school for the students to do blood glucose level testing and administer insulin

Permission for the student to:
- *See school medical personnel upon request*
- *Eat a snack when necessary to prevent hypoglycemia*
- *Miss school without consequences for medical appointments with a doctor's note*
- *Use the restroom and access fluids whenever necessary*

PHYSICIANS' CORNER

DRUGS ON TOP OF DIET VS. DIET ON TOP OF DRUGS

Nemencio A. Nicodemus Jr., MD
Manila Doctors Hospital

The practice on diabetes pharmacologic management has drastically changed over the past two years because of the results of several clinical trials which showed "surprising" revelation regarding targets, specifically those of glucose or blood pressure.

However, the recommendations as far as dietary intervention is concerned seemed to have changed very little. We acknowledge the essential role of medical nutrition therapy as an initial intervention to control blood glucose. Then we add pharmacologic agents to achieve better glucose control. Lately, more aggressive management has been recommended that prescribes Metformin together with lifestyle intervention as the initial step in achieving target glycemic levels. Thereafter, the focus is on more intensive control of glucose with the use of additional pharmacologic agents

Overweight participants were recommended to achieve at least 5% weight loss. The emphasis was on appropriate food quantities, vegetables, fruit, legumes, wholegrain cereals, fish, nuts, low fat dairy products and appropriate fats and oils.

advising early combination therapy. It is assumed, based on this model, that lifestyle interventions are still being carried out as eagerly as they were at the start of therapy.

But the reality is as the years pass by that a diabetic patient is on pharmacologic agents, the more he relies on these drugs for glucose control and less on the lifestyle intervention, specifically the diet modification part. The physician, on the other hand, focuses on intensifying pharmacologic agents and adjusting their doses to achieve optimum doses, if not maximum tolerated doses.

The question is: When glycemic targets are still not achieved despite optimal pharmacologic interventions, is still there a role for additional intensive dietary modification?

The LOADD study (Lifestyle Over and above Drugs in Diabetes Study) provides the answer. Perhaps without discussing the results, you have already guessed the answer correctly: Yes, intensive dietary modification can still significantly improve glycemic control among patients who are already on optimum pharmacotherapy. The study enrolled type 2 diabetic patients less than 70 years old with HbA1c > 7.0 % despite optimized drug treatments and were randomized to intensive individualized dietary advice for six months vs. usual medical surveillance. It must be emphasized that the participants in the study were already receiving maximally tolerated classes and doses of drug treatments for blood

glucose, blood pressure and lipid control based on guidelines.

The other important question is: What nutritional interventions have been shown based on the study to improve glycemic control over and above optimum drug therapy?

In the LOADD study, the participants were already given standard dietary advice by their dietitian, doctor or nurse prior to enrolment. But as part of the study, they were given:

- Additional two individual sessions with the dietitian
- Monthly sessions for five months
- One group education session within the first two months
- Telephone calls by the dietitian between visits to reinforce the dietary advice

The family members were also encouraged to attend the dietary education sessions.

The intensive dietary advice was similar to those advocated by international guidelines, as follows:

- Protein - 10-20% of total energy
- Total fat <30% of total energy
- Saturated fat < 10% of total energy
- PUFA < 10% of total energy
- Carbohydrate - 45-60% of total energy
- Dietary fiber 40 g/day (half as soluble fiber)

Overweight participants were recommended to achieve at least 5% weight loss. The emphasis was on appropriate food quantities, vegetables, fruit, legumes, wholegrain cereals, fish, nuts, low fat dairy products and appropriate fats and oils.

These dietary interventions on top of optimized drug therapy led to a significant 0.4% lower Hba1c at the end of six months ($p<0.007$) compared to controls after adjustments for important factors, such as baseline A1c, age and sex. Furthermore, more patients had reduction in the dose of their prescribed hypoglycaemic drugs in the intervention group compared to controls.

Aside from glucose lowering, the intervention also led to significant improvements in body weight, BMI, waist circumference, BP and lipid profile.

This study only reinforces the need for us physicians to consistently push for intensive dietary modification throughout the entire time that we are treating our patients with diabetes. There are certain dietary advices that consistently produce good results. However, aside from the actual advice, frequent reinforcement of this dietary advice is equally important and this is where we need to work hand-in-hand and closely with the dietitians and/or nurse educators.

The sequence therefore in the management of diabetes may need to be modified from (a) diet + drug to (b) drug optimization to (c) optimized drug regimen + intensive diet intervention.

Management of DM Among Institutionalized Patients

Cindy V. Josol, MD
UP-Philippine General Hospital

Type 2 Diabetes Mellitus (DM) has reached epidemic proportions. Its prevalence which currently stands at 190 million is projected to double by the year 2025(1). In 2007, 12.2 million people and about 25% nursing home residents fulfilled the diagnostic criteria for diabetes. Adults age 60 and older most of whom are residing in nursing homes is predicted to comprise two-thirds of the diabetic population by the year 2025(2). Local data on the prevalence of DM in long term care facilities is lacking.

Management of diabetes in institutionalized elderly patients is extremely difficult because of several factors such as decreased thirst perception, reduced exercise tolerance, deteriorating vision, arthritis, depression, and social problems complicating management. They comprise a vulnerable group who often take multiple medications and who experience frequent infections, high rates of acute DM complications such as hyperosmolar states from dehydration which can be reduced by good glycemic control.

Very little has been published regarding glucose control for the institutionalized person with diabetes. Principles of diabetes management are basically the same as in non-institutionalized diabetic adults however clinical goals must be individualized and balanced against life expectancy and patient preferences to maintain the highest quality of life for the residents. While the American Diabetes Association (ADA) recommends a glycosylated haemoglobin or HbAlc (which shows blood glucose control during the past 2-3 months) target of <7%, a less stringent target of 8% is said to be more likely to be realistic and appropriate for residents in nursing homes(3,4). Patients in nursing homes can have variable life expectancies, many live for only 3 to 4 years or less after admission and HbAlc reduction is maybe more valuable for monitoring than actual reduction of microvascular and macrovascular complications.

Nonpharmacologic Management

A. Medical Nutrition Therapy

Older diabetic subjects, especially those in nursing homes tend to be underweight than overweight. Low body weight has been associated with greater morbidity and mortality in the elderly hence caution should be exercised when prescribing weight loss diets. Meal plans such as, no concentrated sweets, no sugar added, low sugar, and liberal diabetic diet also are no longer appropriate(5). It has been shown that residents eat better when they are given less restrictive diet. They should be served a regular menu with consistency in the amount and timing of carbohydrate. Dietary plan includes small portions of regular desserts, and carbohydrate provided at meals and snacks, as long as they are consistent from one day to the next. This plan focuses on providing diabetic residents of long term care facilities with food that is appealing and similar to that provided to other residents but that does not have adverse effects on glycemic control.

Hydration is also very important.

Decreased thirst perception, dementia, and difficulty accessing liquids may lead many nursing home residents to be dehydrated. When residents are at risk for inadequate fluid intake, diet orders should include instructions to ensure that an adequate volume of fluid is consumed.

B. Physical Activity

Exercise is one of the cornerstones of diabetes management. However, it may not be feasible and may even be dangerous for some nursing home residents with physical and cognitive disabilities due to deconditioning, arthritis, visual problems, autonomic and peripheral neuropathy, balance problems, and dementia. Exercise should be undertaken in moderation and not in excess. It must be tailored to the individual's preferences, abilities, and overall medical condition. Staff supervising the activity should be educated about blood glucose testing before, during, and after physical activity, recognition of symptoms of hypoglycaemia and its treatment, and proper timing of exercise periods with food and medication intake(5). It must also be kept in mind that some individuals with longstanding diabetes such as those residing in nursing homes may develop hypoglycaemic unawareness.

Pharmacologic Management

Type 2 DM is a progressive disease, ultimately requiring pharmacologic therapy to maintain normoglycemia in 50% to 75% of all patients. However, selection of antidiabetic medications for patients in nursing homes is extremely difficult. Several factors such as drug side effects, regimen complexity, risk of hypoglycaemia, presence of comorbid health conditions, and cost of drug should be taken into consideration in choosing the appropriate medications for these patients.

1) Metformin

Hypoglycemia is uncommon with metformin. It is also associated with anorexia and one of its benefits is weight loss or weight maintenance, whereas other antidiabetic agents are usually accompanied by weight gain. However in frail elderly nursing home residents, the possibility of anorexia and weight loss may limit its use. It should also be avoided in patients with impaired renal or hepatic function, and dehydration.

2) Insulin Sensitizers (Thiazolidinediones)

Like metformin, hypoglycaemia is exceedingly rare with these agents, particularly when given as monotherapy. However they should be used with caution in patients with liver or renal dysfunction as these agents can cause edema and fluid retention. They are also contraindicated in patients with congestive heart failure New York Heart Classification III or IV.

3) Alpha-Glucosidase Inhibitors (i.e. Acarbose, Miglitol)

These drugs are most effective in those with elevated postprandial blood glucose levels and high carbohydrate meal plan. Major adverse effects such flatulence and diarrhea may limit use of these agents in elderly diabetics in nursing homes. They should also be used with caution in those with renal insufficiency.

4) Dipeptidyl-Peptidase IV Inhibitors

These are newer class of medications which include sitagliptin, vildagliptin, and saxagliptin that have also shown promise in the elderly. Hypoglycemia with monotherapy is rare with these agents. They are generally well-tolerated and guidelines exist for dosing in those with renal insufficiency.

5) Insulin Secretagogues

Weight gain often occurs in patients taking any of the insulin secretagogues. Hence, they are most effective in leaner residents with impaired insulin secretion.

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Cooperating Agencies

The Philippine Society of Endocrinology and Metabolism (PSEM)

International Association for the Study of Obesity (IASO)

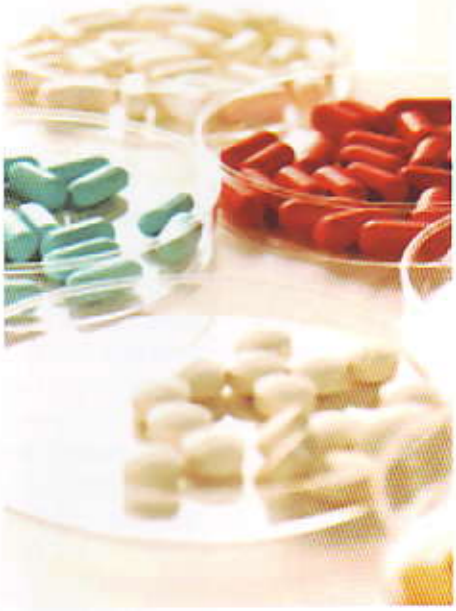
The management of institutionalized subjects with diabetes is extremely challenging. When prescribing antidiabetic medications for this population, providers should take into consideration possible drug side effects and drug interactions.

A. Sulfonylureas (i.e. glibenclamide, glipizide, gliclazide, glimepiride)
Safety is a major consideration in its use in the elderly nursing home resident as profound hypoglycaemia can occur. Since hypoglycaemia is difficult to ascertain in those with dementia and cognitive impairment, these agents should be used with caution in this group of patients. Closer monitoring is needed in elderly diabetics given these drugs particularly in the setting of decreasing oral intake.

B. Non-Sulfonylureas (i.e. nateglinide, repaglinide)
These drugs are more beneficial in elderly residents who have erratic eating habits or poor appetites. They are usually taken before meals and if a resident decides not to eat, they can be withheld.

6) Combination Oral Agent Therapy
(i.e. glibenclamide + metformin, glipizide + metformin, glimepiride + metformin, pioglitazone + metformin, sitagliptin + metformin)
Single pill combinations may help in improving compliance and reduce cost in the elderly nursing home resident who usually takes multiple medications for other co-morbid conditions.

7) Insulin
Since a large proportion of elderly diabetic patients in nursing homes have been diagnosed with diabetes for a number of years, it is likely that a good proportion would require insulin replacement as a result of diminished beta cell function. Older human insulins (NPH and regular) are less expensive but are limited by variability in serum stability, absorption, and potential risk of hypoglycaemia. Newer analog insulins (lispro, aspart, glulisine, glargine, and detemir) are more



expensive compared to older human insulin formulations but are associated with lesser risk of hypoglycaemia. These insulins are also available in pen injector devices which can increase the accuracy of dosing. Initiation of insulin in institutionalized diabetics should be done with the involvement of a multidisciplinary team which includes the doctor/endocrinologist, dietician, diabetes educator as well as the nursing home staff who will be monitoring glucose levels and insulin dose of the patients.

Apart from glycemic control, ***blood pressure control, lipid management, aspirin therapy, and influenza and pneumococcal immunization*** should also be paid particular attention to in any institutionalized diabetic patient.

Conclusion
The management of institutionalized subjects with diabetes is extremely challenging. When prescribing antidiabetic medications for this population, providers should take into consideration possible drug side effects and drug interactions. Ideal management requires a multidisciplinary approach which involves the endocrinologist, diabetes educator, dietician, and nursing home staff handling the patient. Goals of management should also be tailored to the patient's preferences, abilities, and overall medical condition with the ultimate aim of improving the patient's quality of life.

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KITCHEN CORNER

SNACKING AT WORK

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

"Individuals with diabetes need to eat at regular intervals. Regularity of meal intake is important to achieve good glucose control...which is important to prevent complications or delay progression of complications. Thus, following the prescribed snack (part of the dietary recommendation) when one is at work could pose a problem. Snacks must be taken within the allowable break time in the office, must be varied to avoid monotony, must be easy to prepare and pack to office and should not spoil easily. Buying just any snack item available may not fit the prescribed food portions in one's dietary meal plan. Hence the challenge is to provide suitable snacks or at least find some convenience foods that could fit the prescribed food portions. One very basic thing to do is to spend time READING NUTRITION LABELS.

Random Thoughts on Snacks:

Look at the calorie per serving (encircled in purple)... meaning.... READ NUTRITION LABELS on products. It may be possible that the whole packet is not just one serving but may be equivalent to more than one (in this example the whole pack yields 5 servings).

Take note of the carbohydrate content specially if you need to count your carbohydrate portions. The example above will be equivalent to approximately ONE RICE EXCHANGE (carbohydrate grams encircled in yellow) based on the Philippine Exchange List. However, the CALORIE content of 3 pieces of the oatmeal cookies above is approximately equivalent to ONE RICE EXCHANGE AND ONE FAT EXCHANGE based on the Philippine Food Exchange List (140 calories) . If the allowed calorie for snack is only ONE RICE EXCHANGE OR EQUIVALENT TO 100 CALORIES then only TWO PIECES OF THE SAID COOKIE MAY BE EATEN.

Sugar alcohols such as sorbitol, maltitol, etc (encircled in red) may cause diarrhea when taken is substantial amounts, hence the warning on the labels. These forms of artificial sweeteners are NOT RECOMMENDED FOR THE VERY YOUNG OR FOR PREGNANT WOMEN.

Look at the sugar content. One teaspoon of sugar is approximately 5 grams. Therefore, amounts higher than 5 grams of sugar PER SERVING OR PER PORTION means the amount of sugar you will be taking in is more than one teaspoon for each serving or portion.

If one is prescribed a low salt diet, a rough estimation of the sodium content for each snack will be around 200 mgs per serving MAXIMUM. The LESS sodium content the better. Since the oatmeal cookies shown above has 130 mgs of sodium per serving (encircled in blue) then the snack may be acceptable for those on a low salt diet as well. Please understand that PRESCRIBED DIETARY SODIUM (such as 2,000 mgs DAILY or less) will require consultation with a registered nutritionist-dietitian for a individual calculation/pattern. Fo instance, if the prescription is onl 2,000 mgs Sodium daily, the exampl Yakisoba noodle below is definitel NOT ALLOWED (see red circle) becaus the product contains 930 mgs sodiu per serving. Almost 50% of the DAIL sodium allowance has been consume by a single serving of the said instan noodle below.

Home-made sandwiches are easier t

prepare to conform with the allowe food portions. For example, 2 slices o the small loaf bread is equivalent t one rice exchange; ¼ cup of boile lean meat (flaked chicken, NO FAT bee or pork) is one meat exchange; 1 ts of mayonnaise is one fat exchange Put some fresh lettuce, cucumber an tomato slices as fillers. Pimientos ma be added for flavour or jalapeno peppe for "zing".

Fresh garden salad may be a more filling snack: FREE fresh lettuce cucumber and tomatoes. Vinegar ma be used as dressing (balsamic or cide vinegar certainly lends a differen flavour). Artificial sweeteners an spices/herbs may be added for flavor

FOR RICE EXCHANGE (choose ONE):

- slices regular size loaf bread, toasted, cut into cubes and added as croutons just before eating
- ½ cup canned whole kernel corn added to the salad
- 1 packet of soda crackers as accompaniment

IF THERE IS FAT EXCHANGE (choose ONE):

- ½ avocado, cut into cubes
- 2 level teaspoons of chopped greaseless nuts
- 1 strip of bacon, chopped

IF THERE IS MEAT EXCHANGE (choose ONE):

- 2 pieces of boiled eggwhite, chopped
- ¼ cup loosely-packed tuna canned in vegetable broth or brine
- 1/3 cup of plain yogurt or cottage cheese
- 1/8 slice of a regular bar of cheese, cut into cubes.

Greaseless or roasted nuts are also good snacks. Nuts are one of nature's perfect foods, since they offer a highly nutritious package of fiber and therefore low in glycemic index. They contain protein and heart-healthy unsaturated fats plus antioxidants. They are filling as well. The following portions are about 100 calories each (approximately 15 grams per portion):

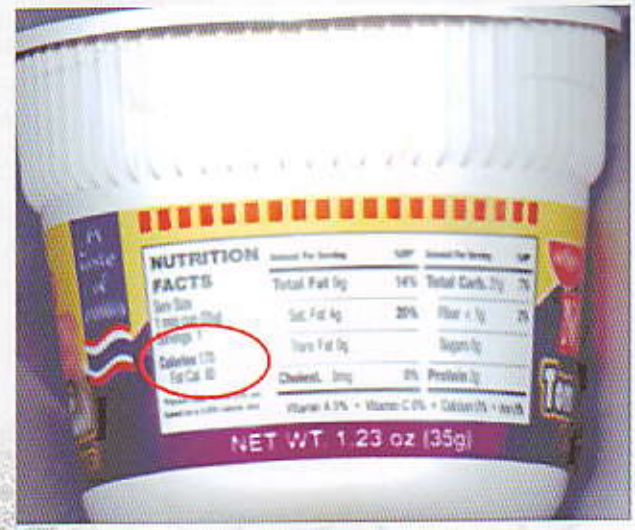
ALMONDS ---- 13 pieces BRAZIL ---- 4 pieces
PEANUTS ----- 16 pieces CASHEW ---- 10 pieces
PISTACHIO ---- 25 pieces WALNUT ---- 4 pieces
MACADAMIA --- 5 pieces PINE NUTS ---- 100 pieces

Soups as snacks would require a little more effort but they are good choices. This is because researches showed that soups tend to be more filling and therefore helpful for those who need to lose weight. Ideally soup should be prepared from home in order to include ingredients in one's dietary pattern. It may brought to the office in a thermo jug to keep it hot.

Others might find instant soups (the kind which just require the addition of hot water) the more practical alternative specially since hot water is readily available in offices. These products are generally high in salt making them "poor choices". However, if instant soups are selected as snack, then, as mentioned earlier, READ NUTRITION LABELS. Some examples are shown below.

SAMPLE 1

SAMPLE 2



SAMPLE 1 SAMPLE 2

If the allowed snack is **ONE RICE EXCHANGE**, the equivalent of which is 100 calories, then the whole cup of SAMPLE 1 may be consumed but

ONLY ½ OF SAMPLE 2. Vegetables (like cabbage, pechay baguio, etc) may be pre-cut and blanched at home then added to the cup soup just before eating.

A suggestion from Ms. Joy Bauer------Watery or leafy vegetables are considered as FREE foods. They can be paired with LOW FAT cottage cheese as dips for a filling and nutritious snack. So go ahead....slice some cucumber, celery, bell pepper, romaine, lettuce....and munch away! (approximately 110 calories)

Another snack from Ms. Joy Bauer-----Guacamole (a heart-healthy pick, thanks to the monounsaturated fats in avocado) and hummus (made from nutrient-rich, high-fiber chickpeas) both make great snacking dips. Try a quarter cup of either with sliced vegetables leafy or watery vegetables for your next mid-afternoon snack. (approximately 120 to 150 calories)

FREE FOOD ITEMS such as black tea or coffee (with your artificial sweetener of choice), DIET or SUGAR-FREE COLAS, sugar-free gelatine may be taken as tolerated. You may even make your own sugar-free ices using artificial flavours/colors plus your artificial sweetener of choice. A word of caution though: not all sugar-free or artificially-sweetened drinks are essentially calorie-free... or just ONE SERVING per bottle! Again, CHECK THE NUTRITION LABEL.

With a little patience, a little effort, a sprinkling of creativity....snacking at work will be enjoyable, varied, healthy and delicious ...and certainly zesty!

Navigating the Net: Diabetes in the Workplace

Cecille R. dela Paz, MD
East Avenue Medical Center

The health and welfare of employees are very important to any company's bottom line. Making sure that they stay healthy decreases work absenteeism and increases worker productivity. Because diabetes prevalence is increasing, it is not unlikely that it will have a big impact on the workplace in the near future. Diabetes is a leading cause of morbidity and mortality in our country. The direct cost of caring for a diabetic patient is staggering and the potential impact it could have on indirect costs like disability, work loss, and premature death can be substantial. Setting up a diabetes prevention or management plan appropriate to your company is an important first step to addressing the problem and the internet is an excellent source of information on the issue.

The Diabetes At Work Website (www.diabetesatwork.org) promises to help companies reduce health care costs and improve productivity by keeping employees healthy. The website is a collaborative effort of the National Diabetes Education Program, under the auspices of the National Institutes of Health and the Centers for Disease Control, and various public and private organizations in the US.

The website provides tools and resources for all the stakeholders. The site is easy to navigate and accessing the different articles is as simple as clicking on the topics that are or interest to you. Some of the topics are even available as Powerpoint slides that can be used for lectures and PDF documents that can be used for handouts.

For employers and decision makers, the site can help you how to estimate the number of employees in your company with diabetes and estimate the total cost the disease is costing your company. Furthermore, the site can also help you develop a diabetes prevention and management program that could be tailor-made to your institution. You could also browse through success stories - examples of companies who have implemented these programs in their organizations and have had stellar return on investments (ROI) in the form of healthier employees and reduced health care costs, improved productivity, or reduced absenteeism.

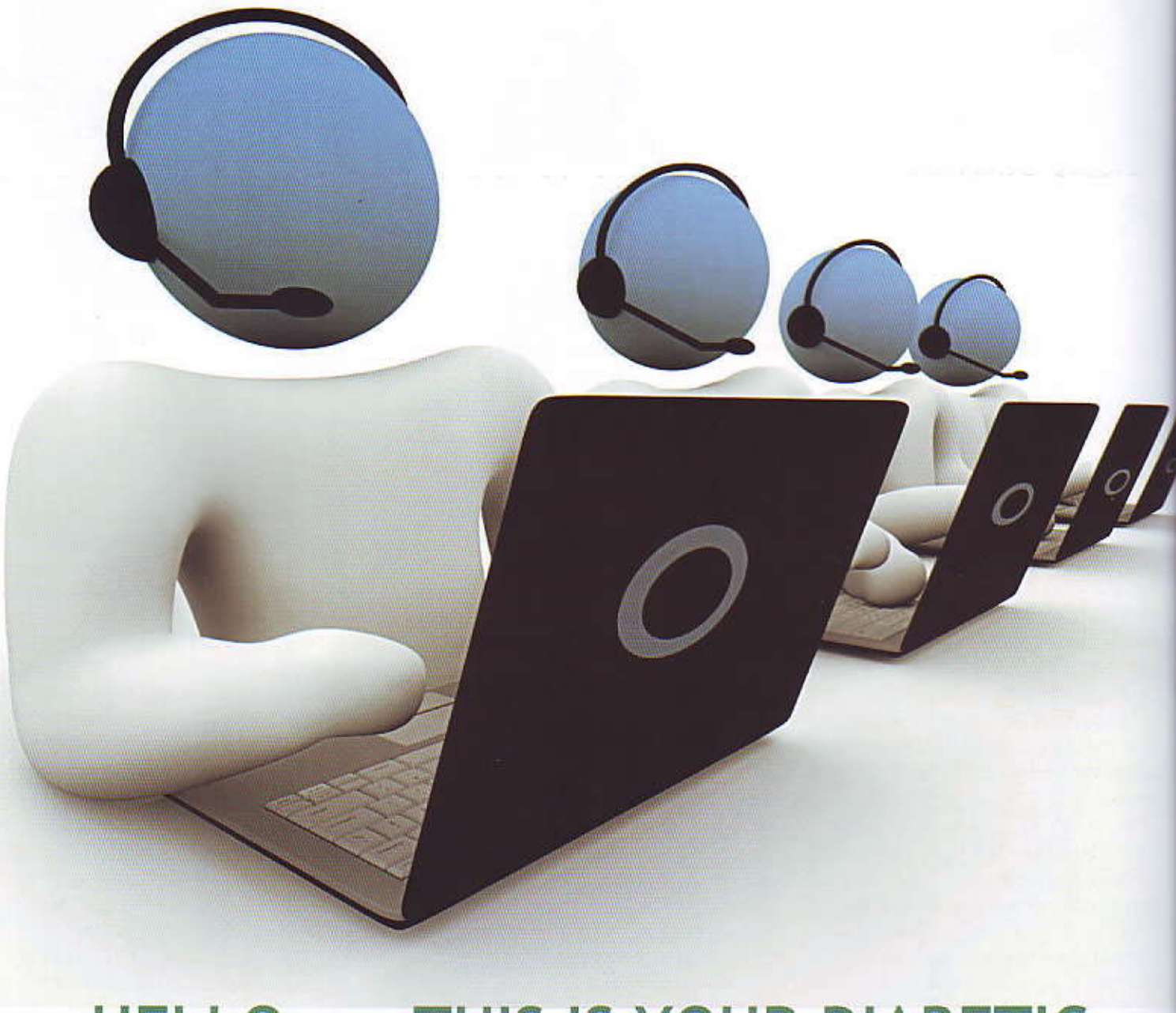
The website also has resources for people with or at risk for diabetes, their families and their caregivers. Lesson plans available in the site include understanding diabetes, tips on how to get and stay healthy with diabetes, topics on getting moving and eating well, and special focus on your emotional well-being and cardiovascular disease.

For occupational health providers and diabetes educators, there are also separate sections that could help you development worksite wellness programs in your institutions. There are also evaluation tools and links to help you evaluate the success and utility of your programs.

The American Diabetes Association website (www.diabetes.org) is also another helpful website for employers who are thinking of setting up a diabetes prevention and management program in their companies. In order to access the relevant information, click on "In My Community" at the top of the webpage, go to "Community Programs" found on the left hand side and select "Winning at Work".

Diabetes Facts gives you an overview on what diabetes can cost your workplace. Work Resources gives awareness materials about detecting, preventing and managing diabetes. Guide Resources has downloadable resources to support your implemention activities. The site also has information on diabetes and employee rights in the workplace. While the latter topic may be more relevant for people in the US, this might serve as a blueprint for formulating our own laws against discrimination for people with diabetes.

It is clear that addressing the problem of diabetes in the workplace is the responsibility of both employers and employees alike. Investing in your employees' well-being may be the best business move you'll ever make.



HELLO. . . THIS IS YOUR DIABETIC CALL CENTER AGENT SPEAKING. HOW MAY I HELP YOU?

Aurora Macaballug, MD
UST Hospital

Obviously, working in a call center, wherein there is a reversal of the day and night shifts, creates more challenge in the proper management of diabetes. The natural circadian rhythm or the body's internal clock is disrupted and this may result in mental and physical stress that may affect blood glucose control.

Stress causes the release of hormones that increase the blood glucose. In addition to this, altered eating habits and activities while working in a call center can result in fluctuations in blood glucose control.

The following are key points that diabetics may try to remember when working in a call center.

1. Monitor your blood glucose. Self-monitoring of blood glucose (SMBG) may have to be done more frequently

As in any working condition, the proper management of diabetes entails a lot of understanding and discipline. Be knowledgeable about your condition and take control.

particularly when you've just started working in a different shift. This will allow you to observe any fluctuations in your blood glucose and will help you and your doctor to adjust your insulin or diabetes pills as necessary.

2. Plan your meals.

Regardless of the type of diabetes, medication used, or shift worked, proper nutrition, thus, meal planning, is the foundation of diabetes management. Good meal planning includes evenly spaced meals and snacks. For those working on afternoon shifts, a larger evening meal may be taken to compensate for the increased physical activity ahead. For those working in midnight shifts, the meal taken at around 10 pm may be increased as this will be the person's start of the day. These changes will correspond to the breakfast taken during the 'normal' morning that people working in an 8 to 5 shift have.

Coffee is a staple in call centers; this keeps the employees awake during the wee hours of the morning when people are normally sleeping. It is not uncommon to see call center denizens drink coffee very frequently. Beware of this practice as you may not be able to keep track of your sugar intake. Some may argue that they make use of artificial sweeteners for their coffee. As this may curb the amount of sugar that one takes, one has to remember that coffee may make a person feel full even with little or no food intake at all. This is quite dangerous because inappropriate caloric intake will put a diabetic at a higher risk for developing hypoglycemia.
Remember to eat the right food at the right time.

3. Continue with exercising.

Your new shift work shouldn't be a deterrent for you to exercise. Aside from the fitness that you get from a regular physical activity, exercise stimulates the secretion of hormones that will make you alert but in a relaxed way. Adjust your exercise to the time that best suits you.

4. Keep in mind the timing of your medication.

It is most prudent to consult your doctor and discuss with him/her about your plans of seeking employment in a call center. Most oral antidiabetic agents are best taken before meals at regular equal times of the day. Typically, these are given before breakfast and/or before dinner. In the same manner, insulins have expected onset, peak, and duration of action that makes the timing of administration most crucial. With the help of your physician, these medications have to be adjusted in dosing to suit new schedule.

As in any working condition, the proper management of diabetes entails a lot of understanding and discipline. Be knowledgeable about your condition and take control.

diabetes philippines ON THE MOVE

3rd Unite for Diabetes

(September 3, 2010 – Crowne Plaza Galleria, Manila)

- Updates on the development of the Philippine Clinical Practice Guideline in Diabetes, a project organized by Diabetes Philippines, Philippine Society of Endocrinology and Metabolism, Institute for Studies on Diabetes Foundation Inc. and the Philippine Center for Diabetes Education Foundation Inc. was the highlight of the 3rd Unite for Diabetes with the theme "Working Together in the Fight Against Diabetes" held last September 3, 2010 at Crowne Plaza Galleria, Manila. Other topics includes NNHeS and Recent Data and their Implications, discussion on Glycoslated Hemoglobin (HbA1c) Testing in the Philippines and Defining Glycemic Targets and Choosing Therapeutic Agents for Diabetes. Almost 300 participants graced this year's Unite for Diabetes convention.

16th PASOO Annual Convention

(September 4, 2010; Crowne Plaza Galleria Manila)

- Last September 4, 2010, the Philippine Association for the Study of Overweight and Obesity held its 16th Annual Convention with the theme " Pre-Examining Obesity Recommendations : Successful Outcomes & Lifelong Uses of Treatment In Obesity Now". The programme was organized by the overall chair and PASOO President, Dr. Elizabeth Paz-Pacheco. More than 500 delegates attended this year's convention. The Diabetes Philipines distributed flyers and showcased its advocacy materials as well as membership campaign.

5th Public Health Convention on the Prevention and Control of Non-Communicable Diseases
(September 23-24, 2010; Century Park Hotel, Manila)

- As a member of the DOH Coalition, the Diabetes Philippines took part on the 5th Public Health Convention on the Prevention and Control of Non-Communicable Diseases held last September 23-24, 2010 at Century Park Hotel, Manila. Dr. Susan Yu-Gan talks on the current initiatives on diabetes treatment and management. We distributed poster and flyers for diabetes awareness and membership campaign during the said convention which was, as expected, well-attended.

GMA Kapuso Foundation Medical Mission
(November 23, 2010, Brgy. Ithan Binangonan, Rizal)

- The GMA Kapuso foundation together with Diabetes Philippines conducted a health awareness on diabetes to our underprivileged fellowmen at Barangay Ithan in Binganonan Rizal last November 23, 2010. Free random blood sugar tests were administered to over 200 indigent individuals in the said barangay to communicate the importance of having this test for early detection and also help create awareness in the society. After the screening, Dr. Richard Elwyn Fernando discussed important information about diabetes and other related health concerns about the disease which includes prevention and management. Flyers for diabetes awareness were also given during the said activity.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Filipinos Working Overseas: To clear or not to clear?

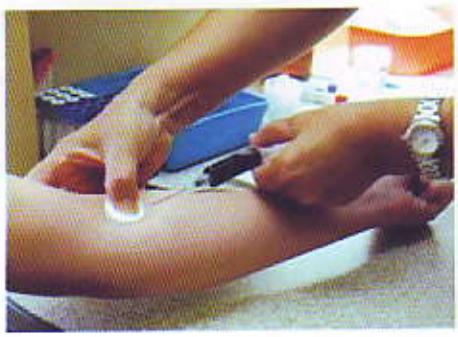
Sheila Lim, MD
UP - Philippine General Hospital

Talk about luck. You recently attended a job fair and were instantly hired on the spot as a construction engineer in the Middle East. It's a good paying job with lots of benefits. You fixed all your required documents complete with an impressive resume. You put on your best attire (You can easily be mistaken as a celebrity, no less!) and just as you were expecting to see the oil-riched country of Dubai, you were asked to see a physician first for a physical examination. Confident that you are perfectly fit with no symptoms, you marched into the doctor's clinic only to be dismayed that you apparently have diabetes mellitus! How did that happen? Is your dream of becoming a full-fledged overseas worker slowly going out the window?

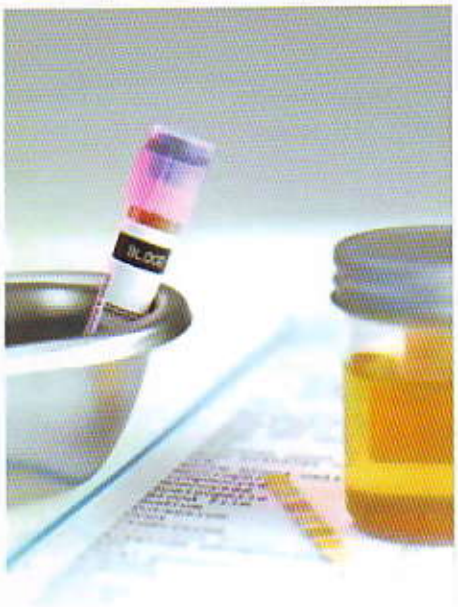
This is a common scenario. Since a lot of newly diagnosed diabetics seem physically healthy without any subjective complaints, they often do not seek consult. It is often an incidental finding in a routine examination. But all is not lost! How can you be cleared for work given that you have diabetes mellitus?

Aside from certain companies that prohibit jobs such as commercial aircraft pilots, air-traffic controllers, train drivers, the armed forces, and off-shore oil-rig work, patients with diabetes and good sugar control can still be cleared for employment abroad. On diagnosis, the doctor would usually require the following tests:

• HbA1c - which is a measure of your blood sugar control for the past 2 - 3 months. This would reflect your fasting blood sugar and postprandial sugar levels (the blood sugar that you would have after eating).



• Creatinine - the marker of how your kidneys are working since diabetics are



prone to have kidney problems in the presence of poor blood sugar control. This may also help in the choice of medications that will be prescribed to you.

• Lipid profile - which tests the good, the bad (and the ugly?) cholesterol in

our body (We don't want to clog our blood vessels right?)

• Urinalysis or urine micral test - to check if you are already excreting

albumin (which is a protein) in our urine. This will help our friendly neighborhood kidney doctor to prevent problems in the future.

During the initial visit, the patients' weight, height, waist circumference, and blood pressure are also obtained. (Oops! The chocolate cake that you sneaked out of the ref will definitely bring extra bulge to the measuring tape!) In addition, it is a usual practice for the patient and doctor to talk about goals for physical activity, nutritional advice, smoking cessation, and reducing body weight.

Although diabetes is a disease that you will live with for the rest of your lives (How comforting!), it is a disorder that can be controlled with appropriate medications and preventive measures. We have patients as old as 96 years old that are happily living with diabetes because of early aggressive management. The physician will tailor the best therapeutic option for the patient prior to leaving the country and discuss the importance of regular follow-up and blood sugar monitoring. We would like to address, if not to prevent, the possible complications that may lead to significant morbidity and mortality. That is why aside from medications that lower blood sugar, drugs that decrease cholesterol levels and prevent kidney problems may also be given by the doctor.

It is predicted that the Philippines will rank 9th among the countries with the most number of diabetics in the year 2030. That is why it is the thrust of the medical societies to help avoid this from happening. With the right TLC (which can mean Tender Loving Care or Therapeutic Lifestyle Change), we can still battle this much dreaded epidemic. Let us all work together for a better and happier diabetes-controlled life! Happy HEALTHY eating!

diabetes philippines

2011 SCHEDULE OF ACTIVITIES

41st DiabetesWorkshop and 6th Diabetes Forum
Baguio Country Club, Baguio City
April 1-2, 2011 (Friday- Saturday)

42nd DiabetesWorkshop and 7th Diabetes Forum
Iloilo
July 15-16, 2011 (Friday-Saturday)

43rd DiabetesWorkshop and 8th Diabetes Forum
Venue: Laguna
October 7-8, 2011 (Friday-Saturday)

28th Annual Convention of Diabetes Philippines
7th Course on Diabetes and Vascular Disease
Century Park Hotel
November 9 - 11, 2011 (Wednesday-Friday)

Gimik Diabetes Year 5
World Diabetes Day Celebration/Lay Annual Convention
November 12, 2011 (Saturday)

FOR INQUIRIES PLEASE CALL:Diabetes Philippine Secretariat
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Reference:
1. Kahn S, Haffner S, Heise MA, et al. Glycemic durability of rosiglitazone, metformin, or glyburide monotherapy. N Engl J Med 2006;355:2427-443. Erratum in N Engl J Med 2007;356:1387-388.

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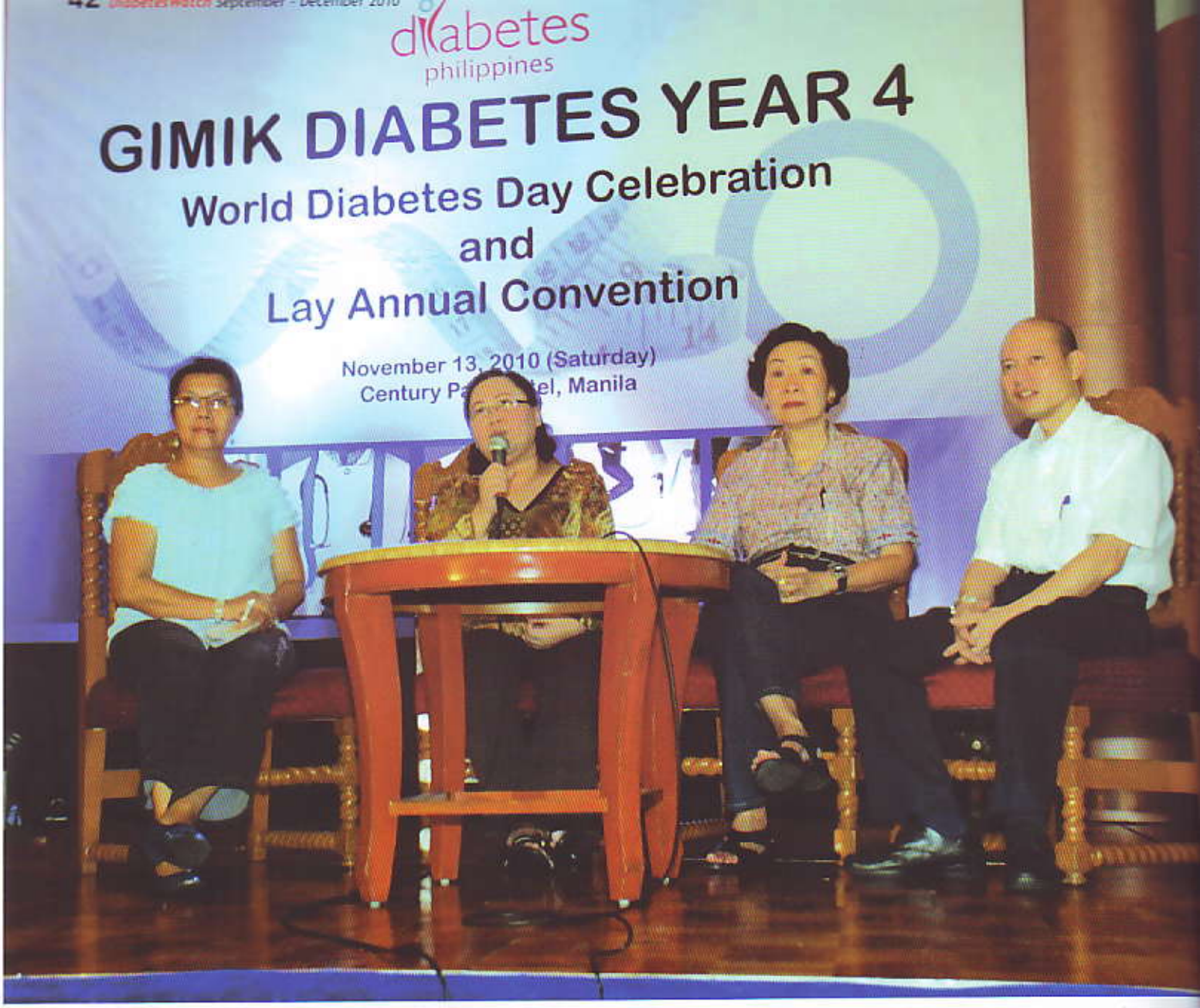


GIMIK DIABETES 2010

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

Diabetes Philippines held the 4th GIMIK DIABETES at the Century Park Hotel last November 13, 2010 (Saturday). One hundred thirty-seven attendees from all over Metro Manila enjoyed free blood-glucose screening, blood pressure determination and food sampling (Glucerna, Non-fat Ice Cream and bread products). Experts gave very interesting lectures on varied topics free of charge to the lay with updated Diabetes Philippines membership.

Dr. Susan Yu-Gan, explained the stages of liver damage, starting from the fatty liver and ending up in cirrhosis (death of the liver tissue). She emphasized treatment of the fatty liver: good nutrition and weight loss, regular exercise, stop smoking, avoidance of alcohol, and of course good glucose control along with maintenance of normal blood pressure as well as control of triglycerides.

Dr. Richard Elwyn Fernando explained common myths and misconceptions about diabetes. He elaborated on why "SPECIAL" foods for persons with diabetes are not necessary. Wise selection of foods and prudent intake are important. Insulin is not addictive;

it is an essential medication in the control of diabetes and prevention of complications. There are medical conditions which would require its lifetime use (such as in Type 1) or long-term use (such as in Type 2 with uncontrolled diabetes or with complications). Fat cells decrease in size with weight loss, not in number.

Mrs. Sanirose Orbeta emphasized that food should be taken in appropriate amounts. In other words, recommended foods should not be taken in excess.

Mrs. Ma. Imelda Cardino explained that artificial sweeteners are "safe" as long as the amount taken is within acceptable limits and used as recommended.

Mr. Erlando James Abilo gave very practical tips on exercise. He led the audience in doing a "fun" exercise that obviously everyone enjoyed. Dr. Leilani Mercado-Asis explained bone fracture and osteoporosis in diabetes and how this can be prevented.

The audience participated actively in the Open Forum, asking interesting questions which benefited everyone in attendance. The Panel gave very comprehensive and practical responses.

Dr. Susan Yu-Gan closed the program at 5:00 pm. ○

Lifestyle Change with the HealthSeeker App on facebook

Iris Thiele Isip Tan, MD
Philippine General Hospital

Are you on Facebook? You just might want to sign up if you're not of the 16 million (plus) Filipinos on this social network. You can then check out HealthSeeker. It's an application that encourages taking small steps toward a healthier lifestyle. It's tagline is "Simple steps, healthier together!"

HealthSeeker was developed jointly by the Joslin Diabetes Center and the Diabetes Hands Foundation, with support by Boehringer Ingelheim Pharmaceuticals, Inc. Take note of the disclaimer before going any further -

"Any content created for or included in the HealthSeeker Game is for the purpose of providing information only. It is not intended as the practice of medicine or the provision of medical care or services, nor is it intended to provide individualized medical or nutritional services. This game does not provide medical advice."

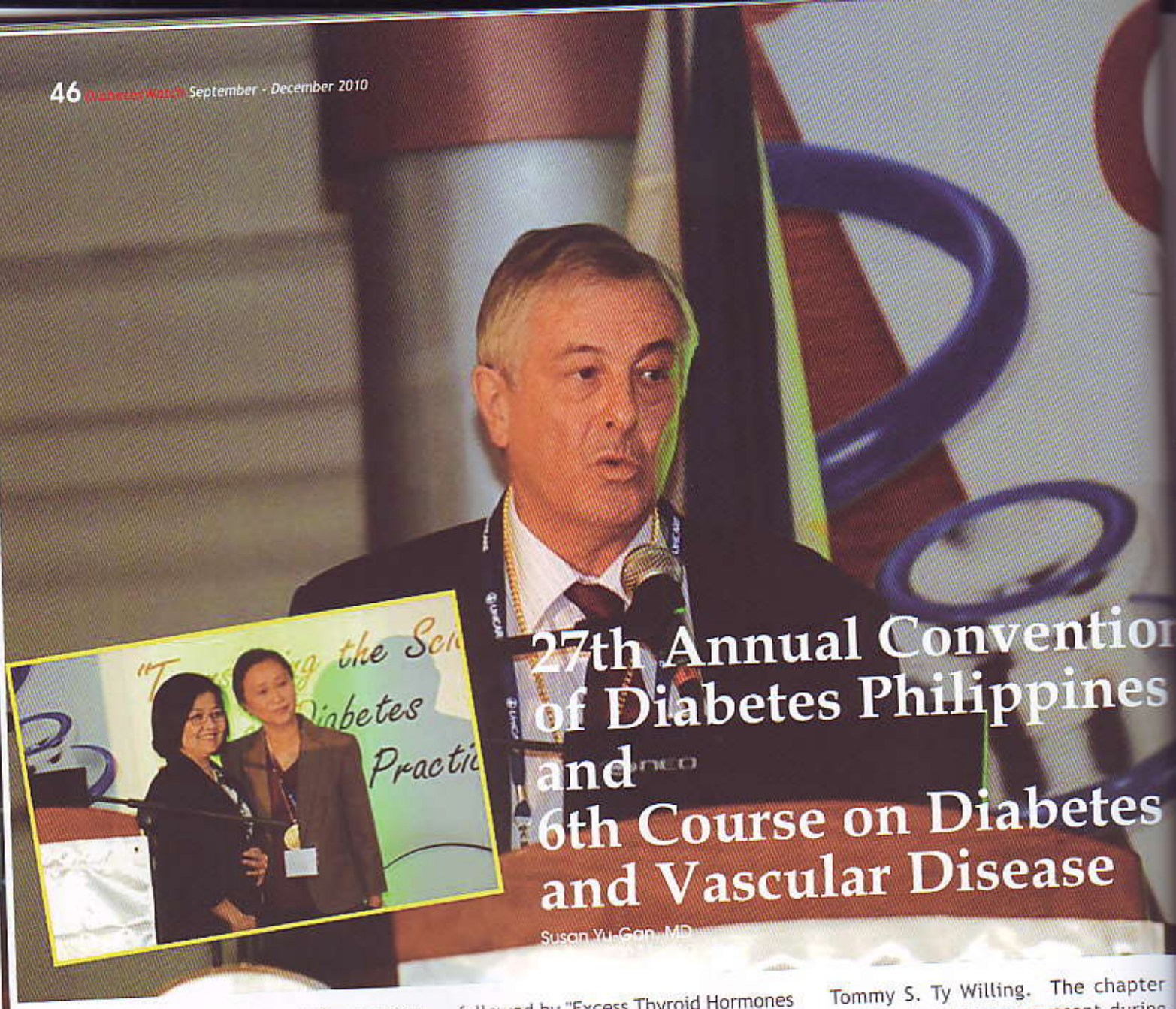
After signing up, you can pick any of 15 missions that serve to reinforce health living such as:

1. Over the Rainbow: The Fruits and Veggies Mission
2. Size Matters!
3. Snack Attack!
4. The Phat Mission!
5. A New Beginning!
6. Chill out! The Anti-Stress Mission
7. Jack Sprat Could Eat No Fat
8. I WILL Move it! Move it!
9. A Dash'll Do Ya: The Sodium Mission
10. Groovy Grains! The Whole Grain Mission
11. What the Fiber?
12. It's a Numbers Game! The Monitoring Mission
13. Carbs Count
14. Move it! Move it!
15. Roughin' It: The Fiber Mission

The missions are also coded for the lifestyle goals they try to achieve. E to promote healthy eating and good nutrition. D to assist in improving or maintaining diabetes (glycemic) control. W to promote achievement and maintenance of a healthy weight. H to promote heart health and reduce the risk of heart disease.

When you click on a mission, you're given an action plan for the week. For example, "Weigh yourself at the same time of the day." This must be done at least once this week. When you complete a mission, you gain experience points. And since it's a Facebook app, of course it's a social game as well so you also gain points if you invite friends to join you in the quest for a healthier lifestyle! Interestingly, instead of a Facebook wall, you get a "Fridge Door" where you and your friends can share your thoughts. There's even a motivational daily tip or quote to keep you going.

Give it a try, see you on FB!



27th Annual Convention of Diabetes Philippines and 6th Course on Diabetes and Vascular Disease

Susan Yu-Gan, MD

The 27th Annual Convention of Diabetes Philippines was held last November 10 to 11, 2010 with the theme "Translating the Science of Diabetes Into Clinical Practice" back to back with the 6th Course on Diabetes and Vascular Disease which followed on November 12, 2010 at Century Park Hotel, Manila. A total of 35 topics were presented to 915 registered participants.

On this occasion, the ISDFI Chorale graced the invocation and national anthem followed by a welcome remark from our dear president Dr. Tommy S. Ty Willing. The plenary lecturers were Dr. Ruby T. Go talked on "The Key to Unlocking T2DM: The Role of Lipotoxicity in Islet Dysfunction" followed by "Excess Thyroid Hormones and Carbohydrates Metabolism delivered by Dr. Augusto D. Litonjua. The 4th Augusto D. Litonjua Endowed lectureship was awarded to Prof. Clive Cockram. He discussed "Diabetes in Hong Kong and Asia: A quarter century of learning how to manage risk." The 2010 Diabetes Philippines - Servier Research Grant was also awarded to Dr. Monica Therese B. Cating-Cabral entitled "The Prevalence of Insulin Resistance and Metabolic Syndrome in Young Adult Patient Newly Diagnosed with Pre-diabetes and T2 Diabetes Mellitus at the Philippine General Hospital."

The annual chapter president's meeting was also held after the scientific lectures on the first day headed by Dr. Tommy S. Ty Willing. The chapter presidents who were present during the meeting were: Dr. Dwight C. Black, Baguio-Benguet Chapter, Dr. Oliver P. Bautista, Batangas Chapter, Dr. Magnolia B. Reyes, Cagayan Chapter, Dr. Paul Luis G. Palencia, Camarines Chapter, Dr. Evelyn G. Gamallo, Cebu Chapter, Dr. Francis I. Pasaporte, Iloilo Chapter, Dr. Antonio S. Chua and Dr. Delia Becina, Laguna Chapter, Dr. Jubilia B. De Guzman, Pangasinan Chapter and Dr. Liduvina F. Dorion, Sorsogon Chapter. The main objective of the meeting is to strengthen the ties between Diabetes Philippines national to its chapter members and to discuss future plans for the year 2011.

On the second day, plenary lecturer

were Dr. Ricardo E. Fernando who talked on "Benefits of Early Intensive Multifactoral Therapy in T2DM", "Herbal Remedies for Diabetes - Show me the Evidence" by Dr. Mia C. Fojas, "Using Behavioral Change Tools in Clinical Practice" by Dr. Ma. Teresa Plata-Que and "Glycemic Abnormalities in Post Kidney Transplant delivered by Dr. Brian Michael I. Cabral. The 4th Dr. Ricardo E. Fernando Endowed lectureship was awarded to Dr. Mary Anne Lim-Abrahan and her topic "Is the Risk for Diabetes Determined at Mid-Childhood?"

The 2011 - 2012 officers and board of directors of Diabetes Philippines were also elected, namely (alphabetical order) Dr. Agnes T. Cruz, Dr. Richard Elwyn V. Fernando, Dr. Joy Arabelle C. Fontanilla, Dr. Susan Yu-Gan, Dr. Francis I. Pasaporte, Dr. Rima T. Tan, Dr. Tommy S. Ty Willing, Mrs. Ma. Imelda Q. Cardino and Mrs. Sanirose S. Orbeta.

The 6th Course on Diabetes and Vascular Disease was held on the third day. The following topics were discussed and presented by our top caliber speakers: Cellular Mechanisms of Cardiovascular Complications of Type 2 Diabetes: Translating Science to Clinical Practice, Dr. Elizabeth Paz-Pacheco, The Metabolic Interface between Diabetes and the Failing Heart by Dr. Mary Anne Lim-Abrahan, Dietary Fat and CVD Risk by Dr. Richard Elwyn V. Fernando, Evidence for the Effectiveness of Nutrition Therapy Interventions for CVD and Diabetes by Dr. Rosa Allyn G. Sy, Beneficial and Harmful Cardiovascular Effects of OADs by Dr. Araceli Panelo, Revascularization vs. Medical Treatment for Coronary Disease in Diabetes by Dr. Iris Thiele isip-Tan, Emerging Therapies for Diabetic Nephropathy by Dr. Albert Chua and Should the Presence of CVD Affect Glycemic Targets in T2DM by Dr. Roberto C. Mirasol.

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. We should, of course, not forget our very dedicated staff who made all these possible. See you all in the next annual convention of Diabetes Philippines!

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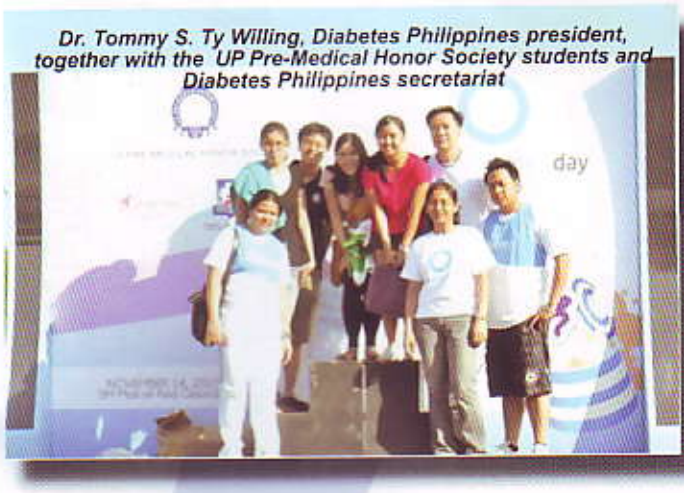


Dr. Tommy S. Ty Willing, Diabetes Philippines president, together with the UP Pre-Medical Honor Society students and Diabetes Philippines secretariat

The UP Pre-Medical Honor Society students together with Dr. Tommy S. Ty Willing

Regardless of age, everyone is enjoying the fun run.

A diabetic lay member who participated during the fun run

Warm up exercise before the start of the race.

SUGAR RUSH

Tommy S. Ty Willing, MD
Metropolitan Medical Center

To celebrate last year's World Diabetes Day, Diabetes Philippines, together with the UP Pre-Medical Honor Society students, conducted on November 14, 2010 "Sugar Rush"-1-kilometer fun walk, and 3, 5, and 10-kilometer fun run-at the SM Mall of Asia grounds. A total of 936 people registered and participated, including 187 from Diabetes Philippines.

A 30-minute warm-up started at 5:00, then the 10-k run commenced at exactly 5:30 am. At 15-minute intervals, the 5k, 3k and 1k fun walk followed.

The top 3 10k winners were Willie Kotich, Gerald Sabal and Tadashi Shina. On the other hand, the top 3 5k winners were Wendell Garcia, Ramil Ramos and Arjay Balita. Antony Garcia, Jojo Costimiano and Jepard Chua emerged first, second and third, respectively, in the 3k category.

The activity was a success despite the fact that it was the first time for Diabetes Philippines to spearhead such undertaking.

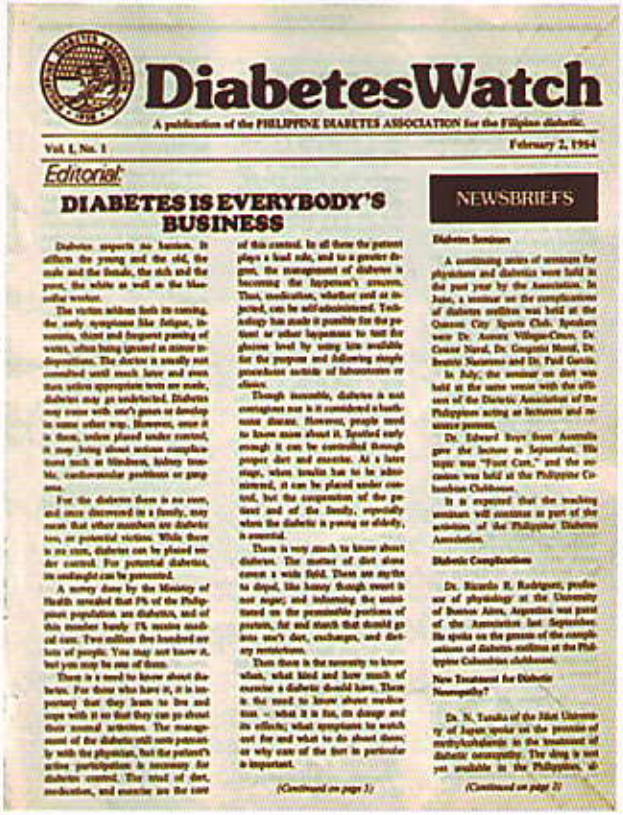
The evolution of DiabetesWatch

Rosa Allyn G. Sy, MD
Cardinal Santos Medical Center

The first issue of DiabetesWatch came out on February 1984. Conceived by the Philippine Diabetes Association (PDA) as a newsletter, the editorial staff was composed of Dr. Augusto Litonjua, President and Chairman of the PDA and his members, Professor Irene Cortes and Drs. Flora Pascasio and Celia Talusan. The maiden offering was 6 pages in black and white, with the lead article, "Diabetes is Everybody's Business."

Subsequent issues in the first year were limited to 4 pages and the number of contributors expanded to include Drs. Ricardo Fernando, Lina Lantion Dr. Aurora Cinco.

Over the next few years, the newsletter came out two to three times a year. The content consisted of two to three articles on diabetes, nutrition and PDA news. For instance, DiabetesWatch chronicles that the PDA chapters were first organized in 1987 and that the UERM-ISDF Diabetes

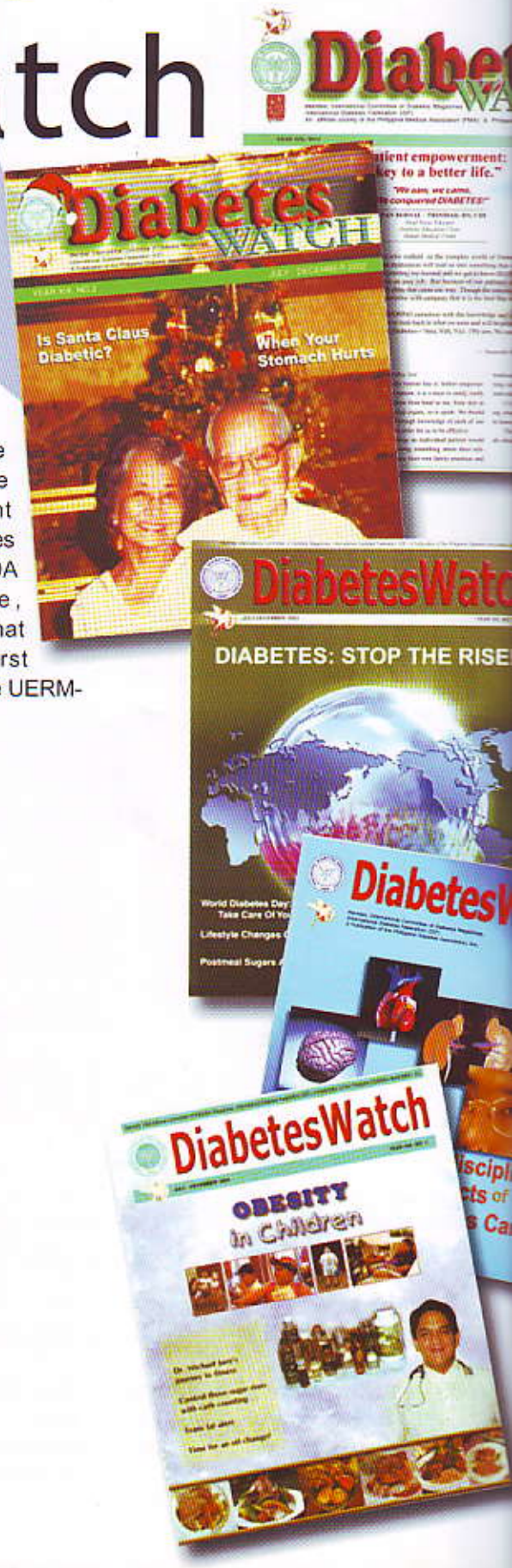


DiabetesWatch
A publication of the PHILIPPINE DIABETES ASSOCIATION for the Filipino diabetic
Vol. I, No. 1 February 2, 1984

Editorial:

DIABETES IS EVERYBODY'S BUSINESS

NEWSBRIEFS



Institute opened in 1989. By 1989, the newsletter was beefed up to 8 pages. Contributions from international writers were also included, courtesy of the tie up with the International Diabetes Federation which allows member countries to cull articles from official sources to use in their own publications.

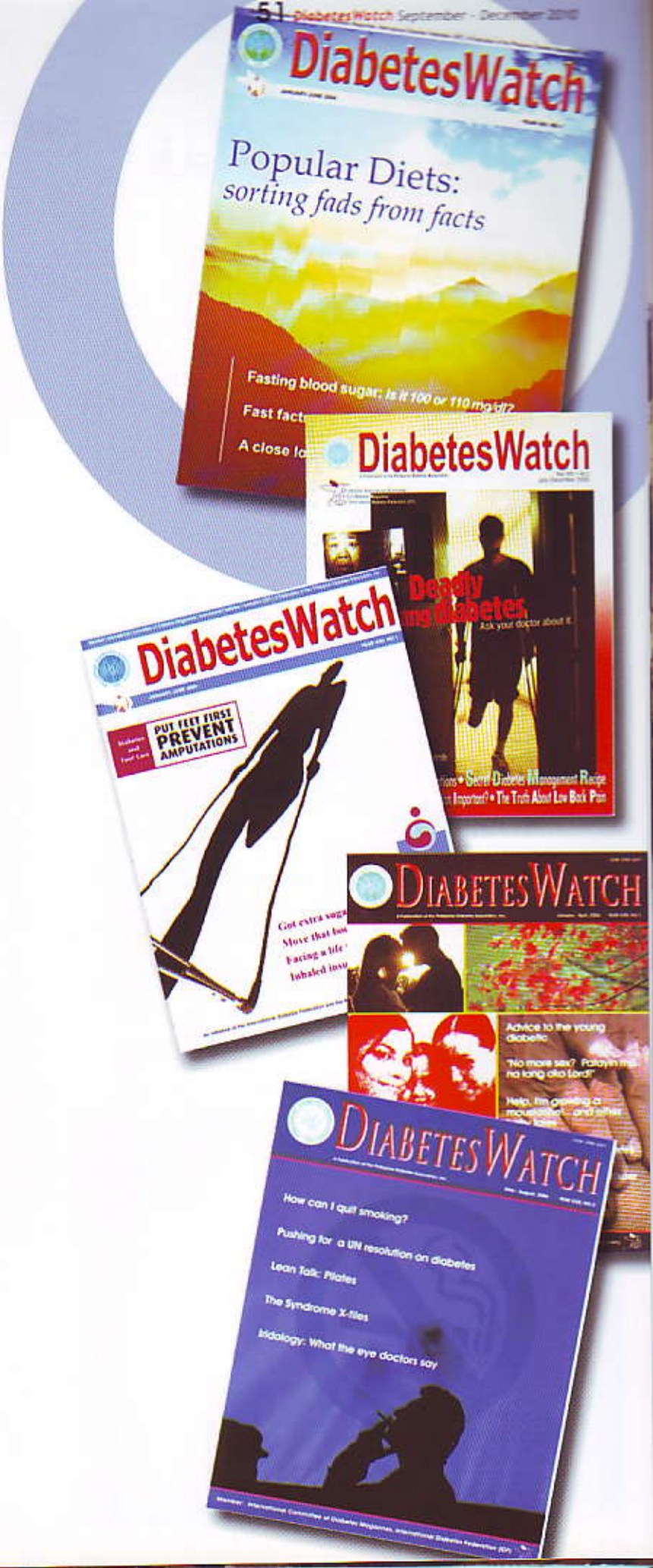
In 1992, DiabetesWatch reports a new logo and a new home for PDA. In 1993, the newsletter joyously announced the creation of Diabetes Awareness Week.

In 1994, the editorial staff was formally organized to include Dr. Litonjua as chair. New staff members included Dr. Honolina Gomez, and Drs. Roberto Mirasol and Allan Hernandez. The first column of the popular, "Everything you wanted to know about Diabetes," was conceived and the newsletter became 12 pages.

In 1995, the first "The Lighter Side of Diabetes," the cartoon by Dr. Allan Hernandez came out and has been a regular feature of the magazine since.

Also in 1995 , the newsletter was turned into a biannual production divided from January-June and July to December.

By July 1997, a new editorial team was put together. Dr. Augusto D. Litonjua, Jr. was editor emeritus, and editors were Drs. Rosa Allyn G. Sy and Patricia B. Gatbonton. Drs. Mirasol and Hernandez were maintained as members of the editorial team. Two new sections were also formalized, "Meanderings," for Dr. Litonjua to editorialize any issue on diabetes that he wanted to comment on, and "Your President Speaks," to give the current PDA president a forum to address any society concerns to PDA members. Dr. Sy also implemented a theme per issue, in order to bring focus, coherence and relevance to the content. Because of the increased number of columns and articles, the pages was also increased to 16.



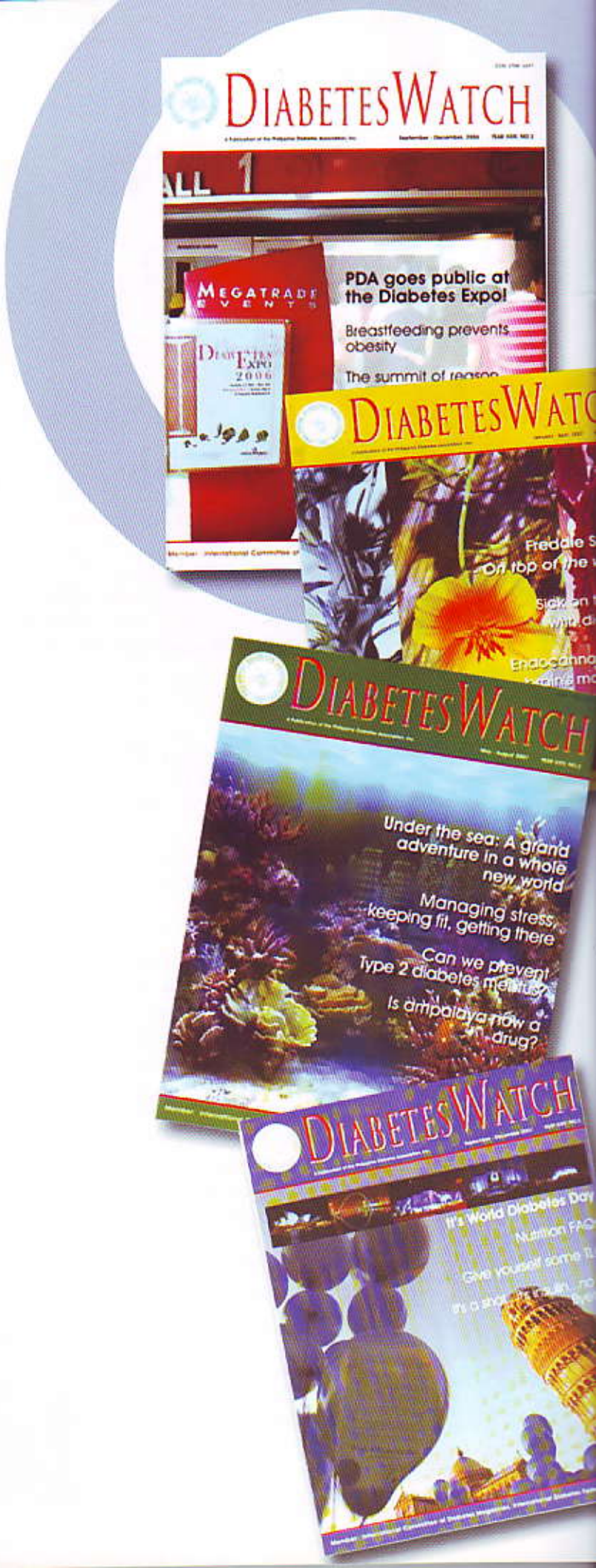
By 2001, DiabetesWatch was morphing into a 20 page colored newsletter cum magazine with specific sections features, news and medical sciences in order to balance information for doctors as well as lay readers. Dr. Sy attended a IDF magazine meeting and was inspired to transform the newsletter into a magazine. However, because of limited funds at the time, she compromised for a modified newsletter, an almost magazine. The first theme for this new look, "Diabetes in Children." New sections, Kitchen Corner and PDA on the Move were also added.

In 2002, Dr. Teresa Plata-Que took over from Dr. Rosa Sy as editor in chief. Dr. Que continued all the previous sections and took the next step forward: turning DiabetesWatch into a 24 page full color magazine. In 2003, because of the great reviews, the magazine became 36 pages. Other changes included adding additional staff in the person of Dr. Florence A. Santos and hiring a design and layout artist, Dondi Gerardino to produce covers specific to each issue's theme.

In 2006, DiabetesWatch became a thrice yearly magazine, with issues from January to April, May to August, and September to December.

In 2008, current editor-in-chief, Dr. Elizabeth Paz-Pacheco took over DiabetesWatch from Dr. Plata-Que. She put together a whole new staff, with editors and subeditors to improve the flow of work. The Features editor is Dr. Nemencio Nicodemus, and the following editors and subeditors: Dr. Gabriel Jasul, Jr., Nutrition Editor, Nutrition Sub editors, Ms. Sanirose Orbeta and Ms. Ma. Imelda Q. Cardino. News editors are Dr. Pepito Dela Pena and Dr. Mia C. Fojas. A new section on medical informatics was created with the following team: Drs. Iris Thiele isip-Tan, Cecilia A. Jimeno and Cecille Dela Paz.

Dr. Pacheco also put together a team of contributors,

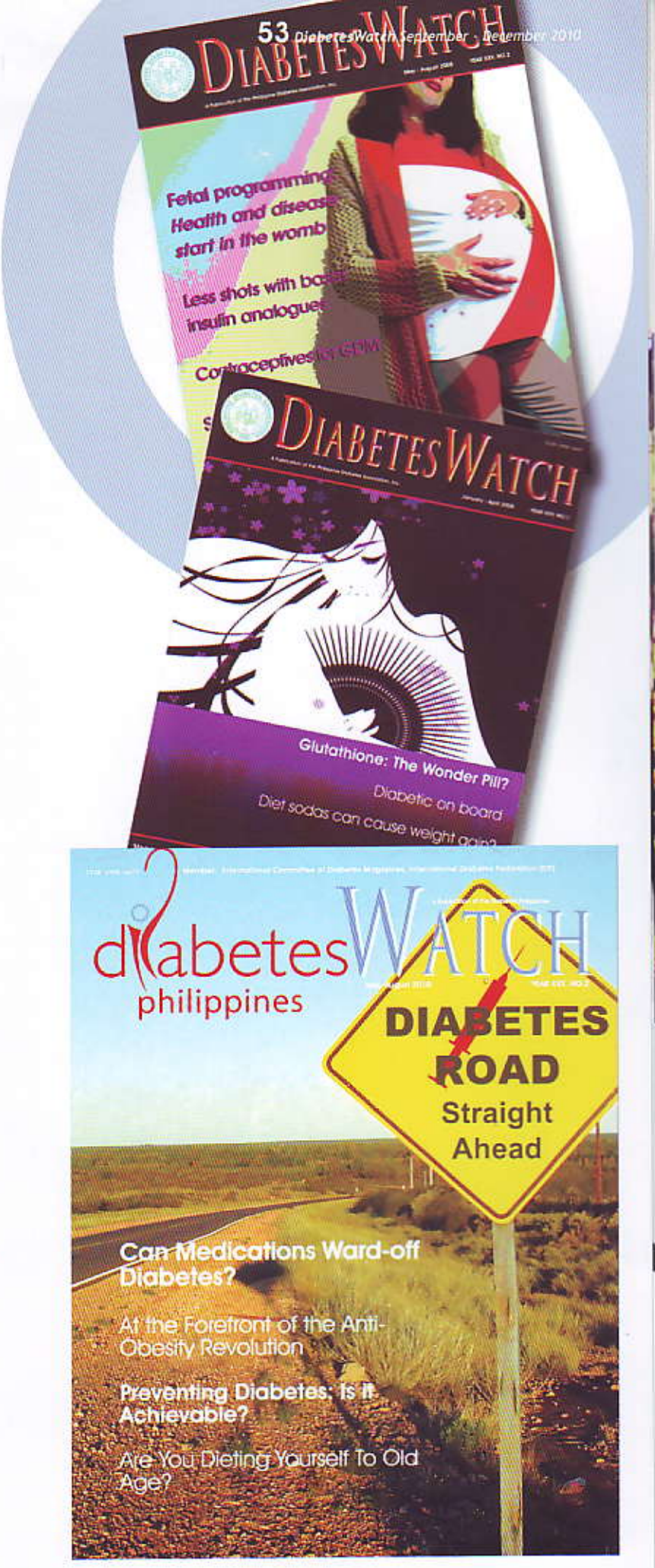


some outside the endocrine-diabetic community to give an outside perspective on diabetes. In 2009, mandated by the PDA board, DiabetesWatch was again a biannual production maintaining the different themes as laid out by the editorial team. In this last issue of 2010, DiabetesWatch prepares again to undergo another metamorphosis with a different team. In its 26 year journey, it has changed from a black and white newsletter to the good looking magazine it has become today.

In its journey, and during the infancy of desktop publishing, the articles would be typewritten, copyedited and typeset manually. The editorial staff would literally cut and paste (using actual scissors and glue) the dummy copy pages for the printers. A tedious and messy process!

Admittedly, the newsletter started out with physicians with none or very little knowledge of writing, editing and publication. The subsequent editors and teams literally learned on the job, putting in time and effort with no thought of renumeration. Drs. Tippy Que and Tish Gatbonton were fortunate in 2004 to attend an IDF sponsored diabetes magazine workshop in Versailles, France with international editors from the UK, ADA and journalists whose sessions helped the editorial team improve the concept, content and look of DiabetesWatch.

What all the teams had in common was the dedication and responsibility to do the best they could. And they have. Kudos and thanks to all those who have been contributed to DiabetesWatch through all these years. ○



THE diabetes WATCH philippines

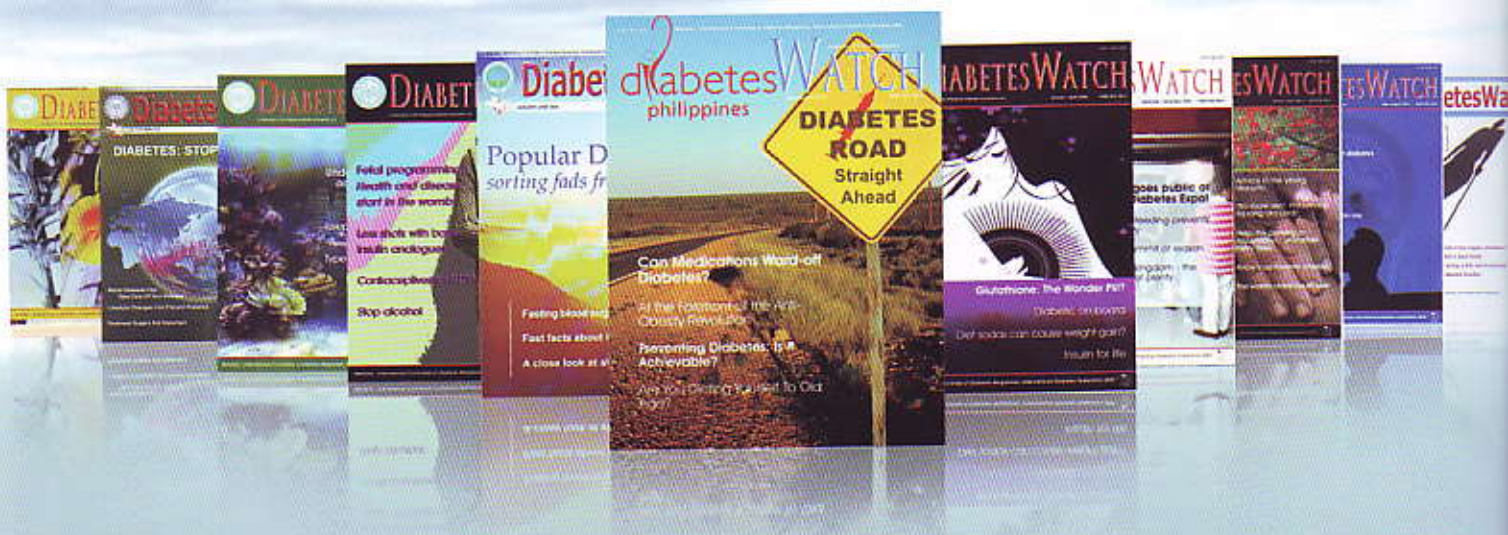
Ma. Teresa Plata-Que, MD
National Kidney and Transplant Institute

The DiabetesWatch magazine, official publication of the Philippine Diabetes Association. Now Diabetes Philippines, was founded by Dr. Augusto D. Litonjua and was first published in 1983. Dr. Litonjua gave the name 'DiabetesWatch' emphasizing the one word to it but capitalizing D and W. It began as a newsletter, which chronicled the activities of the PDA. The first 3 issues was sponsored wholly by Boehringer Mannheim, and then subsidized by ads from the corporate pharmaceuticals later on. The issues were distributed to the chapters of the PDA when they were formed and it was well received.

It was in an EASD meeting in Finland that the formal organization of diabetes magazines was conceived giving rise to the International Committee of Diabetes Magazines (ICDM). In Tampere, Finland there was a 2-3 day meeting of all editors of diabetes magazines. In this meeting Dr. Litonjua was asked to talk on the role of pharmaceutical agencies in the publication of newsletters. In 2003, another meeting was held in Paris which was attended by Dr. Ma. Teresa P. Que, then editor in chief and Dr. Patricia Gatbonton, managing editor. During this meeting pointers were given on how we can improve the diabetes magazine. In attendance were other editors-in-chief and staff members from diabetes publications all over the world. Each had brought along copies of their magazine to share with everyone. A British journalist gave tips and pointers about magazine etiquette. Another editor suggested that we sell the magazine for a small fee so that it will have value for the person who buys it. It was strongly recommended that professional help be sought to improve magazine look and format. After this meeting the magazine was transformed from a partial color newsletter to a full color 36 page magazine. Dondi Gerardino, art director, joined the staff in 2003 and is responsible for the colorful graphics and attractive layout.

What makes the DiabetesWatch unique compared to other diabetes magazines locally is that the articles are written mostly by physicians and members of the diabetes healthcare team such as endocrinologists, gastroenterologists, nutritionists. The articles are quite lay friendly and updates the reader on the latest news and trends in the diabetes world)

Dr. Rosa Sy served as editor in chief for several years after Dr. Litonjua followed by Dr. Ma. Teresa P. Que. The current editor in chief is Dr. Elizabeth Paz Pacheco.



COUNCIL MEETING OF THE WESTERN PACIFIC REGION

Tommy S. Ty Willing, MD
Metropolitan Medical Center

The council meeting of the Western Pacific Regon was held last October 16, 2010 at Narimaru APEC House, Busan, Korea.

The meeting was presided over by Prof. Yutaka Seino, IDFWPR chairman. Diabetes Philippines was represented by Dr. Tommy Ty Willing.

The most important topic discussed during the meeting was the Global Diabetes Care Plan by Ms. Ann Keeling, chair of the NCD Alliance Steering Group and CEO of the International Diabetes Federation. Ms. Keeling recalled that on 13 May 2010, the United Nations General Assembly unanimously passed Resolution 64/265, to hold a high-level summit on non-communicable diseases (NCDs) in September 2011. The resolution was the result of a campaign led by the NCD alliance, composed of the International Diabetes Federation (IDF), the International Union against Tuberculosis

and Lung Disease (The Union), the Union for International Cancer Control (UICC) and the World Heart Federation (WHF).

UN resolution 64/265 states that the September 2011 summit will focus on the four most prominent non-communicable diseases, namely, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, and the common risk factors of tobacco use, alcohol abuse, unhealthy diet, physical inactivity and environmental carcinogens.

The UN Summit on NCDs (UNS) will be organized under the direction of the UN General Assembly, with the support of the UN Department of Economic and Social Affairs (UNDESA) and the World Health Organization (WHO). The logistics will be taken care of by the UN Department for General Assembly and Conference Management (DGACM). The meeting will take place at the UN Headquarters in New York. When and how long it will be held will still have to be finalized, although it is expected to take place within the period of 16-19th September 2011 before the opening of the main UN General Assembly session on 20th September 2011.

The summit will be the biggest and the best opportunity to put NCDs on the global agenda. It has the potential to secure commitments from heads of governments for a coordinated global response to NCDs, like substantially increasing financial resources for them, and, in effect, saving millions from premature death and debilitating health complications. It can also lead not just to commitments but to measurable targets, which can be monitored, and through regular reporting, can hold accountable those who made the commitments.

The IDF Global Diabetes Plan (2011-2021) will provide a strategic action framework to rally new key partners, push forward research and development, and have a rapid impact on diabetes in the regions bearing the brunt of the global diabetes epidemic. The plan will be presented to UN agencies, politicians, bureaucrats, international aid agencies, philanthropic organizations and business leaders. The IDF Global Diabetes Care Model will guide governments on the implementation of essential approaches to addressing diabetes, providing a model that can be adapted to different cultural and economic contexts. As IDF President Jean Claude Mbanya said, "The world must move from talk to action now."

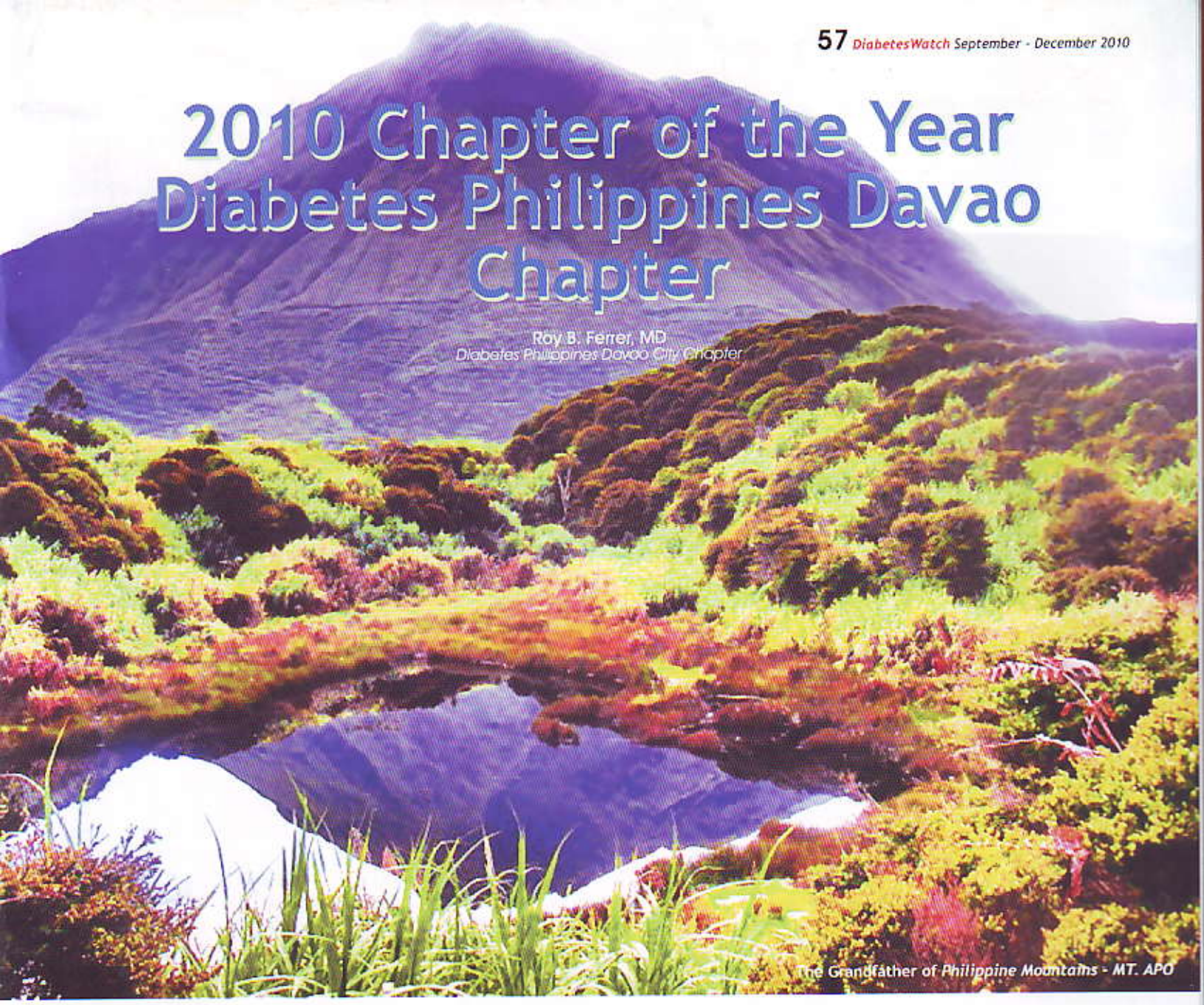
Diabetes Philippines presented a 3-minute video that was played during a break of the meeting. Through it, the IDF WDD posters were put into motion, making them more visually appealing to audiences of all ages.

All member countries likewise reported on their individual projects.

It was also announced that the next APDEC will be held in August 2011 in Seoul, South Korea. On the other hand, the 9th IDF-WPR Congress will be in Japan, while the 10th IDF-QPR Congress will take place in Singapore in 2014. ○

2010 Chapter of the Year Diabetes Philippines Davao Chapter

Roy B. Ferrer, MD
Diabetes Philippines Davao City Chapter



The Grandfather of *Philippine Mountains* - MT. APO

Battling the debilitating disease that is diabetes is not a one-man ordeal for the patient, it is rather a concerted effort of many individuals. Physicians play a crucial role in the whole treatment since they are the most reliable source of information and help that the patient can get.

Diabetic patients are then very lucky that Diabetes Philippines is at the forefront in batting this serious and widespread disease among Filipinos today. Moreover, Davao City chapter, headed by Dr. Roy Ferrer, is a force to reckon with in their great passion to reach out to as many diabetic patients as possible. The Davao Chapter has initiated many activities to spread awareness and rally the fight against diabetes. Breaking from the confines of their own clinics, these physicians go out further to help the lay through these succeeding events.

The opening of Diabetes Awareness

Week was celebrated last July 19-29, 2009 at Davao Medical Center, Healing Garden. In partnership with Davao Medical Center and Mindanao Diabetes Center, the members and officers of Philippine Diabetes spearheaded the celebration for Davao's diabetic patients. In support for active and healthy lifestyle the participants enjoyed an early morning workout alongside with their very game physicians. They were all smiles as they grooved and moved to the beat. Dra. Suzette Quiaoit-Alegarbes, Dr. Lowel Amoguis and Dra. Veronica Racho presented lectures on diabetes. Other physicians such as Dr. Leo Gallardo, Dra. Ma. Theresa Isaguirre and Dra. Louisa Bisnar were also there to give

their medical advice on the screening results (FBS, Cholesterol and BP).

On a much bigger scale, Davao Chapter of Diabetes Philippines organized the 38th Diabetes Workshop held at Grand Men Seng Hotel last August 7-8, 2009. This time around, the effort to educate and spread awareness was directed not only to the patients but also to physicians and allied health professionals. It was a one big event that targeted three different groups,

a program was set for physicians, another for the patients and lastly a set for the allied health professionals (nurses and dieticians).

Barely just two months later, the unstoppable team was rounded up again for the celebration of the World Diabetes Day on November 14, 2009. Davao Chapter President Dr Roy B. Ferrer coined the headline *"Labanan ang Diabetes, Kaya Natin 'to!"* and organized a free clinic at People's Park Davao with the aim that the Dabawenyos be given the chance to fight diabetes (*Labanan ang Diabetes...*). This is to strengthen the advocacy against diabetes by making them aware that the debilitating effects of this dreaded disease can be minimized, if not totally eradicated through proper management. Moreover, a lay forum was also prepared with Dr. Suzette Quiaoit-Alagarbes as the speaker. Pharmaceutical companies pledged their support to provide BP apparatuses, FBS (Fasting Blood Sugar) and cholesterol screening, obesity screening and the manpower to perform the tests. Radio broadcasts and banner tarpaulin were in place to invite the people and make them aware of the event.

On November 14, 2009 at around 5:30AM the park was already in a festive mood with a buzz of people in queue to avail of the BP taking, FBS screening, cholesterol screening, obesity screening, and finally consultation from PDA Davao member consultants. World Diabetes Day banners were a visible mark of the celebration as they surround the tents where the screenings and consultations took place. Dr. Mila Alquiza was among those first to arrive and instructed the pharmaceutical companies to follow the screening flow prepared by Dr. Veronica Racho. The first step was to undergo BP taking, followed by FBS screening, then cholesterol and obesity tests. Finally, the attendees' last stop would be the consultation table where Dr. Yvette Tan, Dr. Francis Ho, Dr. Leo Gallardo, Dr Ma. Clara Isaguirre and

Dr. Mila Alquiza gave their diagnostic explanations regarding the different results. They also provided their management for those diagnosed diabetics while preventive measures were given to those at risk. At around 7:00AM, people were gathered at the park's conference room for the lay forum given by Dr. Suzette Quiaoit-Alegarbes, who was assisted by Dr Francis Ho.

People from all over Davao who attended were grateful for the free clinic. Not only were they able to save because of the free tests and consultation, more importantly they were made aware that Diabetes Philippines member consultants from the city are sincere in helping them have power over diabetes and its complications.

The activity ended at around 9:00AM, the people having gone off to go on with their day, the staff and consultants stayed behind for a small gathering over light breakfast, coffee and warm smiles. After the early morning goings-on, there is a feeling of fulfilment because it was a success, having screened almost 200 people.

While most are still getting the hang of having just ushered the new year 2010, the dynamic members of Diabetes Philippines Davao are already getting their hands full with preparations for the 2nd Lipid Weekend Course in partnership with the Philippine Society of Endocrinology and Metabolism. This year's theme: Challenges in Dyslipidemia Management is brought to life by high calibre speakers lecturing on the pertinent topic. The physicians all over Davao and its neighbouring cities showed their support and interest as the attendees reached over 200 doctors converging at Marco Polo Hotel Davao for the event. Lay patients are also enlightened by the lay lecture forum conducted on the first day of the 2-day event.

Finally, this July 19-25 saw the celebration of National Disability Week. Diabetes Philippines Davao Chapter President Dr. Roy Ferrer spearheaded the coordination to partner in this year's celebration, bringing the banner *"Labanan ang Diabetes, now na"*. He pooled pharmaceutical companies to the event to do blood sugar screening (FBS), BP screening, foot screening, cholesterol screening, and BMI screening. Dr. Ferrer shared his expertise on the field of diabetes management and complications as he lectured at SM Davao's entertainment

area during the lay forum.

Truly, a lot of activities has been done to go out and spread the advocacy against diabetes, spreading the campaign for healthy lifestyle and following treatment of appropriate medical intervention. However, the work does not stop, the series of events organized by the Diabetes Philippines Davao Chapter will reach its fullness when most diagnosed diabetic patients in the city would have earned their life back because they have championed over this disease by keeping their blood glucose levels at goal, maintaining healthy lifestyle, proper diet and faithful in keeping their maintenance medication as prescribed by their physicians. The partnership among patient and physicians continues as Diabetes Philippines Davao City Chapter looks forward to continually being at the forefront in the rally against diabetes. We are grateful and proud to be the recipient of the 2010 Chapter of the Year and we would also like to congratulate all the other chapters who in their own ways worked hard to educate, treat and support diabetic patients. ○

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

THE EFFICACY OF FRUGAL DINING FOR DIABETICS IN THE MIDST OF PLENTY

Sanirose S. Orbeta, MS, RD, FA
Consulting Clinical and Sports N

Mrs. Sanirose S. Orbeta talks on the "The Efficacy of Frug Dining for Diabetics in the Midst of Plenty"

8th International Diabetes Federation - Western Pacifi Region Congress

Susan Yu-Gan, MD
Metropolitan Medical Center

The 8th IDF - WPR Congress was held last October 17 - 20, 2010 at Bexco, Busan, Korea. It provides a great opportunity to share ideas and visions for advances in diabetes among scientific professionals, specialist physicians, healthcare related professionals and people with diabetes from western pacific region as well as all over the world.

The WPR Village is an area within the exhibit hall dedicated to the IDF - WPR Member Associations. The purpose is to play an important role as a way of sharing between associations and for them to showcase their activities. For this year, the WPR Village is composed of 21 booth spaces from 13 countries namely; Cambodia, China, Thailand, Australia, Hongkong, New Zealand, Singapore, Indonesia, Japan, Malaysia, Taiwan, Korea, and Philippines.

The Diabetes Philippines booth was designed to showcase the strategies

and activities of the association. There were 7 different customized posters which were posted on the panels of the booth showing networking, education, research, advocacy, a Philippine map containing the 24 Diabetes Philippines chapters, World Diabetes Day Poster and the Sugar Rush activity which is part of our WDD celebration. We also showcased our IEC materials, DiabetesWatch magazine and the 2011 WDD posters. Our booth was visited by well known local and foreign delegates in the field of diabetes. As a token to our visitors, 2011 calendars, and Diabetes Philippines key chains were given.

We did not only participate in the WPR Village but we were also represented during the scientific sessions. Invited speakers from the Philippines were Dr. Elizabeth Paz-Pacheco who talked on "T45G Adiponectin Gene Polymorphisms and Its Association with Hyperglycemia in Adult Filipinos Seen at the Philippine General Hospital - A Pilot Study"; Dr. Cecilia A Jimeno who presented on "Adapting International Guidelines to Local Realities in Diabetes Care in the Philippines"; and Mrs. Sanirose Orbeta who discussed "The Efficacy of Frugal Dining for Diabetics in the Midst of Plenty". Indeed, Diabetes Philippines has made an indelible mark in the IDF-WPR. ○

From left: Dr. Sriwanna Poolsappasidh (Thailand), Ms. Ruth Gelito and Dr. Wannee Nitiyanant (Thailand)

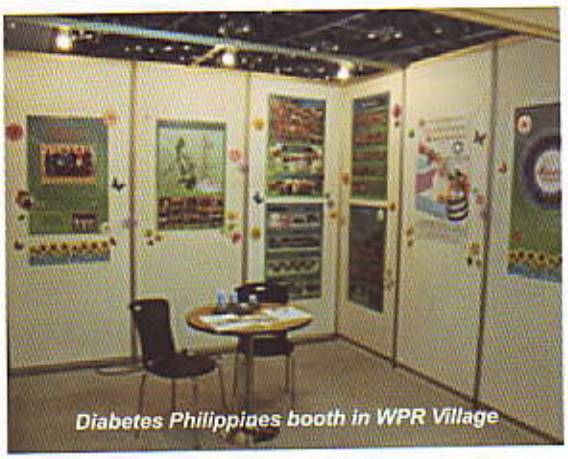

Dr. Antonio Chua

Dr. Susan Yu-Gan and Dr. Elaine Cunanan


Ms. Ann Keeling (Belgium)

Ms. Christine Pei Ti Hsu (Taiwan)


Dr. Tommy S. Ty Willing and Dr. Ruby Lim


Diabetes Philippines booth in WPR Village

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- The first scored modified-release formulation allowing progressive titration[6]
- Protective on the β-cell[8,9] and the cardiovascular system[1,3,5,10]

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1 to 2 tablets* at breakfast

*In most patients

Full prescribing information available upon request.

SERVIER

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