Meet the New Cardio Diplomates!

What to do with Insomnia?

CPR video released

What is the Obesity Paradox?
Calorie counting your merienda
Do waivers from patients protect the MD?

PHA makes history, draws 22K Nationwidest CPR Day
Get that edge in ACLS. Be certified now!

Learn CPR and Save Lives!

REFERENCES:

* Insulin Degludec is the generic name of Tresiba® FlexTouch®
Editor's Note

It's a CPR Day Special Issue!

I can’t help it. CPR as promoted by the Philippine Heart Association is really going some good place.

Well, for those who have just arrived from Mars or the Moon, the PHA has recently staged the most ambitious nationwide mass CPR campaign last April 25, 2016. Call it ambitious, but it did gather at least 22,000 participants from over a hundred sites all over the country. It will remain unprecedented, unless the PHA through the CPR Council stages another event of a bigger magnitude next year!

But come to think of it, just within two months of preparation, that huge participation dwarfed the crowd gathered by nearby Malaysia, Singapore and Hong Kong in the past couple of years. It didn’t happen by nearby Malaysia, Singapore and Hong Kong, participation dwarfed the crowd gathered by nearby Malaysia, Singapore and Hong Kong.

So for the fifth issue of The Heart News and Views, we dedicate this to the devotion, passion and hard work of all who made April 25, 2016 practically a National CPR Day. But of course, we couldn’t let you miss the other favorite parts of this magazine. The opinion pages still carry that variety of flavors from your regular columnists. Dr. Saturnino Javier talks about his Obama experience. Dr. Celina Aquino vents on anger while Dr. Alex Junia and yours truly cannot get over with CPR issues. On Board, Helen Ong-Garcia reveals her travails putting up with the 47th Annual PHA Convention Scientific Program.

We didn’t forget the Walk and Talk. We will count calories from your fave snacks. TRIVIV writer Jason Santos reveals what are stories behind this year’s annual convention? Tell how the PHA wrote history on that fateful day April 25, 2016 practically a National CPR Day.

PHA officers demonstrate how to save a drowning victim. PHA prexy Alex Junia bares this issue with her thought-provoking reflections. Read on the offerings of our fifth issue. Just enjoy and savor this. You can’t help it. ♥

The Heart News & Views is open to advertisements. For rates and reservations, please call PHA Secretariat at 470-5525, 470-5528.

For comments, suggestions or contributions send to: heartnews@apha.org.ph Suite 1108 East Tower, Philippine Stock Exchange Centre, Ortigas, Pasig City
The April 25, 2016 Nationwide Mass (Cardiopulmonary Resuscitation) CPR Campaign is a significant event etched in Philippine history by the Philippine Heart Association.

Going towards that vision of a CPR-ready Philippines, the PHA CPR Council flexed all muscles and moved all mountains in a short span of time to stage the first ever nationwide awareness campaign on CPR for the lay.

A half-day event, the humble PHA gathered three other big organizations, that for some may be quite impossible to bring together. But the Department of Health, the Philippine Red Cross and the American Heart Association heeded the invitation to propagate the message on the need to learn CPR. All four groups rolled up their sleeves and put their feet down on the ground to push for that common goal of inculcating in the mind of the Pinoy: “Save a Life. Learn CPR.”

For this particular activity, advocates for the propagation of knowledge and skills on lifesaving techniques took precious time out from their personal and busy schedules to be one with PHA even just for a day.

PHA members, cardiologists and other physicians, professors in Universities, public officials, lay people from Luzon, Visayas and Mindanao gathered more than 22,000 participants from more than 100 sites. Selflessly, these PHA allies offered themselves to be instruments of realizing the PHA mission and vision of a CPR-skill-equipped Pinoy.

This big event may not have clinched a Guinness world record (for lack of a technical procedure to monitor such simultaneous nationwide event), the event was successful enough to catch the attention of a nation on the importance of CPR. With the help of media (from TV, radio, print and of course social media), the issue on CPR became almost akin to the prevailing and current political and election issues.

In Southeast Asia, Malaysia recorded some 6,000 participants in its mass CPR training in 2015. Singapore gathered some 1,000 participants in 2012 and Hong Kong trained around 200 last year. Being a first timer, the PHA is mighty proud of at least 22,000 participants!

On one hand, it is just a hope that this “noise” the PHA together with all its partners made was convincingly enough to push for the last time the passage of Senate House Bill 3016, also known as the “Samboy Lim Bill” into law. The Bill seeks to include a course on CPR in the high school curriculum. The third and final reading of such bill is set this May 23, 2016.

With such awareness created in the general population, the PHA now faces a stiffer challenge of sustaining such. Awareness may start or may be revved up by one single big event, but it does not end there. Such advocacy entails a lifetime commitment.

To this end, perhaps it is high time for the PHA to clamor for a National CPR Day from the government. One day in the calendar may be enough to keep the fire ablaze not just for the PHA, but for all stakeholders as well. With or without the passage of the CPR bill, a National CPR Day will be a constant reminder of the significance of learning CPR for all.

But putting aside all these aspirations, we bow our heads to the PHA Board led by its indefatigable trio President Alex Junia, Advocacy Chair Orlando Bugarin and CPR Council Chair Francis Lavapie for steering the whole PHA and our allies to this historic success. The PHA together with all its allies are proud of at least 22,000 participants!

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Despite time and financial constraints as well as limitations in logistics, this April 25, 2016 simultaneous Nationwide Mass CPR Campaign was an enormous success. The huge success can now be recorded in Philippine history as the first ever CPR campaign conducted simultaneously in huge number nationwide.

Initally, the target number of sites was 60. Midway in the preparations, the number of sites swelled. But on d-day itself, there were 109 sites yielding 22,000 participants. As of press time, at least 51 satellite sites have not submitted their reports. The sites in Luzon gathered 6,594 participants, with the biggest volume at NCR. Mindanao drew 5,043 participants while Mindanao assembled 1,076 participants.

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A clearer Vision 2020: CPR-ready Philippines

Such an ambitious but accomplished goal, the event revved up Vision 2020: CPR-ready Philippines. The impressive turnout is expected to buoy Senate Bill 3016, an act that requires K-12 High School students to undergo CPR training. The 3rd reading at the Senate is slated for May 23, 2016.

The dynamic members of the PBA Board and Council on CPR chaired by Dr. Francis Lavapie, the Chapters, training institutions, Department of Health, American Heart Association, AXA Phils., Atty. Darlene Marie Berberabe, Pag-Ibig president and ex-wife of Samboy Lim, Alvin Patrimonio, Sen. Sonny Angara and Rep. Josefiter "Yeng" Guiao (1st Dist., Pampanga) and mass media played foremost roles in the staging of the CPR-Ready Philippines Campaign through the Nationwide Mass CPR training.

Lim who gained the moniker "the Skywalker" was at the peak of his career as a PBA player from the mid '80s to the late '90s. He suffered cardiac arrest during an exhibition game at the Ynares Gym in Pasig City in November 2014, but did not get CPR because not one among his PBA colleagues at the Ynares gym knew how to perform it. ER doctors said he was admitted without a pulse because it was estimated that his brain was deprived of oxygen for at least 23 minutes. He fell into coma. Now, Lim is bedridden and is attended to by three nurses on three shifts. Samboy

PEOPLE OF ALL WALKS OF LIFE with one singular goal: Learn CPR to Save a Life, troop to the Quezon Memorial Circle.

The youngest participants were Joseph Exequiel and Joshua Lorenzo Bugarin and Bonn Nathaniel Gagelonia-N. Miranda. What do they have in common? They are all10 years old and in grade 4. The Bugarin twins who go to Montessori Balanga, Bataan, tell "we have been encouraging our classmates that doing CPR training is cool, something that we learned from Dad and Mom." Miranda who is from Ateneo de Manila University, says "I am here because of my grandmother and neighbors who are not getting any younger. This is one of my best summer lessons."
Lim’s story prompted his family, represented by Berberabe, to support the PhA Advocacy to teach CPR on a mass basis so that heart attack patients may receive the life-saving hands-only CPR, to prevent irreparable brain damage.

At the forefront of the simultaneous Nationwide Mass CPR were Drs. Francis Lavapie, PhA Council on CPR chair; Alex Jumia, PhA president; Orlando Bugarin, PhA director/Advocacy Committee chair; who were stationed at the CPR Central Site at the Quezon Memorial Circle (QMC), with PhA Vice President Dr. Raul Lapitan and CPR council member Dr. Luigi Segundo, the attending physician of Lim.

CPR video for the Masses
For the nationwide CPR campaign, a video on administering CPR was produced intended for the general population. The making of the video was made possible through the PhA network of CPR allies. Berberabe negotiated the PhA-AxA partnership that spearheaded the production of the said video, with AxA as the financial arm.

PBA legend Alvin Patrimonio, a close friend of Lim and Berberabe, served as narrator in the video and gave his services pro bono. The other info-mercial actors, Lavapie and Segundo, just like all the PHA members, devoted their time and talent free of charge all for the love of PHA.

Most Active PHA Council
Over the years, the PhA CPR Council has consistently kept its ranking as the most prolific council among the 16 PHA Councils. In their respective dominions, these probinsyano MDs (Junia is Cebu-based, Bugarin comes from Balanga, Bataan, while Lavapie hails from San Jose City, Nueva Ecija), are reputed for being indefatigable and unrelenting in bringing CPR to the grassroots. As PHA national level officers, they have been diligently working hard on their vow to put the Philippines on the list of CPR-Ready counties.

The idea of coming up with a high-impact nationwide CPR campaign was proposed by Dr. Raul Ramboyong, a past chair of the CPR Council. Every batch of 100 CPR training participants was required to watch the CPR instructional video that was played on giants screens before undergoing the actual CPR training.

Other Passionate Allies
Ladies at the helm of top government, private and an NGO – Maria Belinda Evangelista, DOH health Emergency Management Bureau; Gwendolyn Pang, Philippine Red Cross secretary general; Bernadeth Padua, chief inspector, Bureau of Fire Protection Quezon City Central Site; and Amor Balagtas, chief Marketing Officer, AXA Philippines graced the Central site hop at the Quezon Memorial Circle (QMC), reiterated their support for the CPR-Ready Philippines Advocacy.

Padua said, “it is important that at least one family members knows how to do CPR.” According to Balagtas, “we all have our respective activities but let us find time to learn CPR and support this kind of advocacy.”

Pang told PHA that their agency is happy to know that a group like PhA which is focused on nationwide CPR training for health professionals and the lay exists. PRC concentrates on a wider array of humanitarian services; the provision of blood and short-term palliatives; as well as participation in disaster-related activities.

Among the oldest participants are Myrna Basa, 61, a former employee of DZRV (Radio Veritas) and her husband Danko Basa, 60, who used to work for TV5. Both of them are compliant patients, they see their heart doctors regularly and take their meds religiously. Myrna says “we have never felt so good knowing that learning CPR is easy. Definitely, we will do our part in making the CPR instructional video and actual CPR demo viral.”

People of all ages, professions & socio-economic status
Cebu’s “adopted” cities -- Ormoc (497), Tagbilaran (203) and Dumaguete (215) had an aggregate of 915 participants, with Drs. Rhodette Arevalo, Leah Polidario, Leila Diaz, Jane and Ronald Ramiro, and Kenneth Coo overseeing.

The Medical City and its 22 satellite clinics, with Dr. Raul Ramboyong as the contact person, gathered 1,376 patients.

Bacolod had a combined number of 1,360 people trained with Dr. Cristine Marie Puey handling Bacolod City and Emmanuel Villanueva conducting Negros Occidental.

Among training institutions and universities in one single site, UST gathered 378. Of this figure, 203 were at the UST Grounds which was manned by Dr. Don Reyes, while 175 were organized by AHA under the UST Faculty of Medicine and Surgery.

The Department of Health NCR and Regional sites had 7,074 participants, while the DOH Central Office got 237.

In NCR, the sheer volume of 4,408 was divided between Manila (856), Quezon City (713), Pasig (1617), Valenzuela (50), Malabon (130), Muntinlupa (110), and Makati (180).

These sites were handled by Drs. Girard Abragan, Eli Sunga, Don Robespierre Reyes, Roger Velasco, Francis Lavapie, Gina Inciong, Bridget Fernandez, Lourdes Buniy, Clara Tolentino, Raul Ramboyong, Nerrisa Sabarre, Elizabeth Gayle Ramos, Regidor Encabo, Oscar Payawal, Allan Romero, Ma. Rita Santos, Ma. Teresa Torres, PN Batile Evangelista, Jon Hernandez of San Miguel, and Jericho Adolfo of the Paranaque DRM/MMO.

The complete turnout for all participating sites across the country was an ample size of 22,000 people. GPG
THE MEDICAL CITY
IN PASIG,
21 SATELLITE CLINICS

BACOLOD CITY
InFocus

CALOOCAN CITY

PARAÑAQUE CITY

CITY OF MANILA

PASAY CITY

LAS PIÑAS CITY
In solidarity with PHA’s initiative for the Nationwide Mass Training on Cardiopulmonary Resuscitation (CPR), Thomasian cardiologists conducted CPR training with a twist.

Organized by the UST Hospital Section of Cardiology and Thomasian Heart Specialist Alumni Association (THESAA), the España-based heart doctors taught and instructed some 203 University of Sto. Tomas students, teachers, non-academic personnel and passersby via a “tour-de-CPR.”

Participants were grouped in batches and were toured through different stations by a cardiologist. Each station was dedicated to some important facts and steps in administering CPR that were printed on posters.

Registration was held at the historical Arch of the Centuries fronting España Boulevard. Participants were ushered through the walkway at the center of the park where the different stations were strategically positioned.

Highlight of the “tour” culminated by the iconic Plaza Benavidez fronting the equally iconic UNESCO world heritage site Main Building where participants were taught and asked to do chest compressions on mannequins to the tune of Beegees’ Staying Alive that was playing loudly around the area the whole time.

Certificates were handed at the Benavidez monument where batches had their obligatory picture taken thereafter.

By Jason Santos, MD, FPCP
Forty-two media people covered the Central Site at the QMC. ABS-CBN’s Umagang Kay Ganda’s Tina Marasigan did a live broadcast and took CPR lessons on air with fellow media members, PHA staff, family and friends.

Beyond QMC, the UNTV crew was deployed at the Fatima university hospital in Bulacan. GMA 7 was dispatched in TMC. Outside of Metro Manila, ABS-CBN Cebu gave the event pre-and post publicity.

The CPR media output at a glance:

### PRE-PUBLICITY

- **March 2, 2016**
  - DWIZ 882Khz
  - Radyo Klinika, 7-8pm
  - Host: Marou Sarne
  - Dr. Orlando Bugarin
  - CPR with plugging...

- **March 9, 2016**
  - DWIZ 998Khz
  - Radyo Klinika
  - Host: Marou Sarne
  - Dr. Raul Lapitan
  - RHD in adults with CPR event plugging

- **March 10, 2016**
  - DzMM 630KHz
  - Todo2 Walang Preno
  - Host: Winnie Velasquez/Ariel Ureta
  - Dr. Ryan Buendia
  - Heart attack

- **March 10, 2016**
  - DzBB 594KHz
  - Magandang Gabi, Dok
  - Host: Nina Corpuz
  - Dr. Paul Baello
  - CPR demo with plugging

- **March 11, 2016**
  - DzBB 594KHz
  - Easy. Easy Lang
  - Host: Susan Enrquez & Lala Roque
  - Dr. Paul Baello
  - CPR demo with plugging

- **March 16, 2016**
  - DWIZ 998Khz
  - Radyo Klinika
  - Host: Marco Same
  - Dr. Francis Lavapie
  - CPR with plugging

- **March 18, 2016**
  - TV 5-92.3 Action TV
  - Metro Sabado
  - Host: Alex Tinsay & Issa Reniva-Cruz
  - Dr. Christopher Nazal
  - CPR for the near-drowning victim

- **March 19, 2016**
  - DzBB 594KHz
  - Magandang Gabi, Dok
  - Host: Nina Corpuz
  - Dr. Paul Baello
  - CPR event plugging

- **March 22, 2016**
  - DZBB 594KHz - radio
  - Easy-Easy Lang
  - Host: Susan Enrquez & Lala Roque
  - Dr. Edward Gacrama
  - CPR with plugging

### NATIONWIDE MASS CPR

**Central Site, Quezon Memorial Circle**

**April 25, 2016**

### POST PUBLICITY

- **May 2, 2016**
  - DZBB 594KHz
  - Magandang Gabi, Dok
  - Host: Nina Corpuz
  - Dr. Bernadette Halasan
  - Vascular Medicine

- **May 4, 2016**
  - ABS-CBN
  - Salamat Dok 6am
  - Host: Bernadette Halasan
  - Dr. Alex Junia

- **May 8, 2016**
  - ABS-CBN
  - Salamat Dok 6am
  - Host: Bernadette Halasan
  - Dr. Alex Junia

**Media:** Radio/ live streaming

- **March 1, 2016**
  - DzMM 630KHZ
  - Magandang Gabi, Dok
  - Host: Nina Corpuz
  - Dr. John David Tan
  - Depression & the heart
  - Case of Wenn Deramas
  - with CPR plugging

**April 26, 2016**

- **Philippine Star**
  - Metro News
  - Color Photo Release

- **April 26, 2016**
  - Business Mirror
  - Editorial
  - Learn how to do CPR and become a lifesaver

**May 6, 2016**

- **DZMM**
  - Magandang Gabi Dok
  - Dr. Paul Baello
  - Hypertension

- **April 26, 2016**
  - Philippine Star
  - Metro News
  - Color Photo Release

- **April 26, 2016**
  - The Manila Times
  - Photo release

- **April 26, 2016**
  - The Standard
  - Manny Palmero
  - Photo release

- **April 26, 2016**
  - Business Mirror
  - CPR Campaign

**May 8, 2016**

- **ABS-CBN**
  - Salamat Dok 6am
  - Host: Bernadette Halasan
  - Dr. Alex Junia

**ABS-CBN** leads the pack, UKG does live broadcast

ABS-CBN leads the pack, UKG does live broadcast
Summer is here. Everyone looks forward to the great joys of summer which conjures up extensive escape to the beach and or extended stay in the pool.

Before planning your holiday escapades and the diverse ways of beating the blistering summer heat, ask yourself – am I equipped and ready to respond quickly to emergency situations—like near-drowning and sudden cardiac death?

Make sure you are geared to go…. with must-tools and must-haves.

Do you know what to do when a family member, a friend or a colleague, figures in a near-drowning incident or heart attack?

Working on the Cardiopulmonary Resuscitation (CPR)-Ready Philippines Status, the Philippine Heart Association (PhA) regularly conducts basic life support or CPR and advanced cardiac life support trainings.

Buoyed by the success of the Hands-Only CPR for the Lay Lecture/Training it conducted at Annabelle’s on T. Morato Avenue, Quezon City on Feb. 16, 2016, PhA Vice President Dr. Raul Lapitan, Treasurer Dr. Helen Ong Garcia and Francis Lavapie, chair of the PhA Council on CPR went back to the same strategic venue on March 15, 2016, to do a CPR Lecture/Demo for the Near-Drowning Victim.

The CPR Advocacy program is a major thrust of PhA President Dr. Alex Junia.

In attendance are members of media, predominantly the habitues of the every Tuesday Philippine College of Physicians Health Forum @ Annabelle’s and long-time media friends of the associations.

The trainers were Lavapie, who was assisted by Roland Diola, an emergency medical technician, and a volunteer member of the PhA CPR Expanded Council.

Two years ago, Lavapie, did a heroic act. He came to the aid of a drowning colleague, Dr. Nonato Jowin Sison who suffered from muscle cramps. Adding to the challenge was Sison is much taller and heavier than Lavapie and the resuscitation was done on a boat that was sailing on rough waters. Lavapie saved Sison’s life. Sison, 56 is a practising cardiologist in Tarlac.

According to the PhA, you don’t have to be a doctor or a health professional to do CPR on a drowning or a sudden cardiac arrest victim.

Lavapie stressed that “basic CPR with mouth-to-mouth resuscitation should be done —30:2 on a near drowning victim who is not breathing with no pulse.”

He added “always maximize all efforts in drowning especially in young patients. All resuscitated post drowning patients should be brought to the hospital for further observation and workup. There is not much difference in resuscitating arrest and near-drowning victim in terms of basic steps and procedure. The main difference is hands-only CPR should not be done on the drowning victim.”

Lapitan said “basic knowledge of life-saving techniques gives a lay person the confidence to rescue or resuscitate a near-drowning or a heart attack patient who lost consciousness but time is of the essence. Prompt and proper action are crucial in emergency situations like accident scenes and traumatic injuries to save lives.

“A family member who knows how to administer CPR on a near-drowning and heart attack victim will give his/her is a big. When you leave Annabelle’s you are CPR-ready but make sure you are CPR-Ready all-year round,” said Ong Garcia.

Cardios, celebrity broadcasters hype National CPR Day

Must-tools this summer and beyond CPR for the near-drowning
Now, PHA has a CPR Instructional Video

The CPR Instructional Video is only a few clicks away. Simply go to youtube.com and type PHA AXA then you can watch: PHA AXA CPR IV 1080P HD.

PHA President Dr. Alex Junia says that the video is designed more as a reminder or a stimulant so that people will prod themselves to learn hands-on CPR training to be able to respond to a cardiac arrest emergency and do the proper way of administering CPR.

The conception and production of this invaluable life-saving tool were made possible through a grant by AXA Philippines, which prefers to be referred to as a partner of PHA.

"Through this effort, we aim at helping bring more awareness among Filipinos that CPR is easy to learn. At the core of our business is to provide our customers protection, prevention and preparation. By equipping them with the basic knowledge and skills needed to perform CPR, we hope to save not just the lives of our loved ones but that of our countrymen, as well," said Amor Balagtas, chief marketing and Customer Experience Officer.

The PHA-AXA deal was brokered by Pag-ibig President Atty. Darlene Berberabe, ex-wife of retired PBA cager Samboy Lim. Berberabe and the Lims have pledged to embrace CPR as their Advocacy.

Alvin Patrimonio, one of Lim’s PBA friends, Dr. Luigi Segundo, Lim’s attending physician and Dr. Francis Lavapie, PHA Council on CPR chair are the major players in the infomercial video. To further support the PHA advocacy, AXA Philippines with a good number of its key personnel and employees dashed to the Quezon City Memorial Site, to re-affirm and prove their public service calling.

A PBA icon...

The dynamic creative team
Drs. Maribeth Delos Santos and Maria Teresa Abola presented their local experiences in the management of peripheral vascular diseases during the sessions on Vascular Pathology: International Perspectives from the Philippine Heart Association and American College of Cardiology.

Delos Santos, the Chief of the Training Division of the Philippine Heart Center Department of Education, Training and Research, delivered her talk titled “Surgical Outcomes of Aortic Dissection: Philippine Heart Center experience 2006-2015.”

Abola, a past President of the Philippine Heart Association, gave her talk on “Takayasu Arteritis: Patient Profile and Outcomes.”

The two were joined by two other speakers from Indonesia, Iwan Dakota and Doni Firman who shared his experience on “TEVAR Procedures for Aortic Dissection: Indonesia Perspective,” and Doni Firman who talked on “Microvascular Obstruction in Primary Percutaneous Coronary Intervention: Indonesian Data.”

The forum was moderated by Dr. Aaron Kugelmass of the ACC, Dr. Alex Junia, president of the PHA, and Dr. Sunarya Soerianata of Indonesia.

ACC16: Philippine Chapter shares experience on Vascular diseases

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April 2, 2016 CHICAGO, USA- In yet another landmark meeting where thousands of the world’s cardiovascular and medical professionals and allied specialists came together to get the cutting-edge science and practice-changing updates in cardiovascular care, two renowned Filipino cardiologists were among the distinguished faculty during the 65th Annual Scientific Session and Expo of the American College of Cardiology.

ACC2016 Sessions

The Philippine Heart Association and the Indonesian Heart Association held a joint symposium on “Vascular Pathology: Understanding Interventions: International Perspectives.”

In photo. Drs. Maria Teresa Abola (5th from L) and Maribeth delos Santos (extreme R), lecturers in the said symposium; Dr. Joel Abanilla (extreme L), ACC Philippine Chapter Governor, PHA President Dr. Alex Junia, ACC Session Chair Dr. Michael Mack; IHA President Dr. Anwar Santoso and speakers Drs. Ian Dakota and Doni Firman.
SLMC’s gradis first Pinoy to secure EHRA-APHRS grant

By Gynna P. Sepulvado

Dr. Ian Lusoc, a graduate of St. Luke’s Medical Center Heart Institute and a native of Bacolod City is the first is the recipient of the joint European Heart Rhythm Association (EHRA) – Asia Pacific Heart Rhythm Society (APHRS) scholarship program.

This was announced by Philippine Heart Association (PHA) President Dr. Alex Junia who said “this is another feather on the cap of PHA and Lusoc, the first and only Filipino to clinch such grant, to date.”

The grant is a one-year full scholarship fellowship training in arrhythmia and cardiac pacing with emphasis on catheter ablation at the Heart Rhythm Management Center, Universiteit Ziekenhuis Brussel in Brussels, Belgium facilitated by EHRA and APHRS. The training is headed by Prof. Dr. Pedro Brugada, a prominent name in the international cardiac arrhythmia circuit. Financial support is from the US-based device company St. Jude Medical. Lusoc is excited to train under the tutelage of Brugada. “All cardiologists know him. I will train under him,” he said. He told THNV he will leave for Brussels immediately after the release of his Belgian physician visa.

Brugada had been invited by the PHA thru then PHA Director Dr. Ma. Belen Carisma, as a speaker on Brugada Syndrome in one of the past conventions in the early 2000s. Carisma herself is an electrophysiologist. Junia strove for the affiliation of PHA with the European Society of Cardiology (ESC) during the early onset of his term. According to Lusoc, “Dr. Junia opened the window of opportunity for me. He broke the good news when he came to Bacolod City last August 2015 to induct the new members of the PHA Western Visayas-Negros Occidental Chapter. That strengthened my resolve to work anew on my application for a scholarship on electrophysiology in Europe.”

Lusoc went through tough times during the application period. He said “because the Philippines is a non-EU country (outside of the European Union), a diploma equivalent for my medical education credentials is a pre-requisite. I took it for several months and after earning my diploma equivalent in May 2015 everything fell into place.”

In addition, he said that since English is the official language in the training center, he had to learn Dutch by getting into an online course. “Belgium’s official languages are Dutch (57%), French (42%) and German (1%).” In his essay which he submitted to the EHRA and APHRS, Lusoc underscored four good reasons why he wanted to pursue electrophysiology. “It is my first love. I want to teach in this field. There is no available electrophysiologist in my region. I want to serve Negros Occidental, my home province as a cardiologist-electrophysiologist,” Lusoc wrote from the heart.

Lusoc also believes that such development will further spur advancement, particularly the establishment of the first local catheterization laboratory in Bacolod City where complex and difficult arrhythmia cases need not be sent to Manila or Cebu anymore. A native of Bacolod City, Negros Occidental, Lusoc became a full-fledged PHA Fellow in May 2015. He is required to attend this year’s 9th Asia-Pacific Heart Rhythm Scientific Session in Seoul, South Korea where he will meet representatives of his training center in Brussels.

The EHRA and APHRS are sister societies. EHRA is a registered branch of the ESC. The EHRA Education Committee is committed to offer cardiologists subspecializing in pacing and arrhythmias continuous medical education. APHRS is the first and only society organized in the Asia-Pacific Region to promote excellence and advancement in the diagnosis and treatment of the patients with heart rhythm disorders.

PHN Board passer clinches APHRS scholarship

Twin triumphs for De Guzman

By Gynna P. Sepulvado

Dr. Maria Blanca de Guzman from UST Hospital emerged as the only Filipino who made it to the batch of 2016 Asia Pacific Heart Rhythm Society (APHRS) scholars, said an upbeat PHA President Dr. Alex Junia.

It’s a double victory for De Guzman, who is one of the 64 newly-minted 2016 PHA adult cardiology fellows who will take their oath during the Convocation rites of the 47th PHA Annual Convention & Scientific Meeting on May 25, 2016. An exultant De Guzman told THNV this is a boon. “I have never felt so blessed. I worked and prayed hard for it because I don’t want to burden my parents further. I also consider this a humbling experience because there were too many applicants. I can’t thank my parents, Benigno and Ofelia and my mentors enough – Drs. Marcellus Francis Ramirez and Milagros Yamamoto for the guidance and motivation.” It was Ramirez who urged her on to apply for the scholarship. Yamamoto and Ramirez partly wrote in their letter of endorsement to the APHRS that “Dr. Maria Blanca De Guzman is highly recommended by our institution.” De Guzman filed her application in August 2105 and got the APHRS letter of acceptance in November last year.

She vowed to come back right after her Subspecialty in Electrophysiology with Emphasis on Cardiac Pacing-ICD - TRC at the National Heart Singapore, to establish her practice in Bocasia where she lives and in nearby Bulacan towns and of course, at the UST Hospital, her beloved alma mater.

One of the Pontifical University’s cream of the crop, she graduated from medical school cum laude and was a Benemeritus award winner in 2008; BS Med Tech magna cum laude, Rector’s Awardee, Faculty of Pharmacy and BST Med Tech batch valedictorian in 2004. The other two recipients of the scholarship given by the Tokyo-based APHRS are from Papua New Guinea and New Zealand. APHRS is the first and only society organized in the Asia-Pacific Region to promote excellence and advancement in the diagnosis and treatment of the patients with heart rhythm disorders.

Benefits for ESC members

Individual members of Affiliated Cardiac Societies enjoy benefits similar to the individual members of ESC National Cardiac Societies, if they provide the ESC with written confirmation of their membership from their Affiliated Cardiac Society.

Benefits for members of Affiliated Cardiac Society:

• Discount prices on ESC educational products
• Aristocrat subscription prices to ESC journals
• Free access to ESC online educational resources
• Information about ESC congresses
• Information about ESC Educational Programmes
• Receive electronic version of the fortnightly MyESC News
• Access to customer services through ESC International Affairs Department

Members of the Affiliated Cardiac Societies can apply for membership of ESC Working Groups and Associations. They may also apply to become Fellows or Nurse Fellows of the ESC...
BP ng Teacher Ko, Alaga Ko caravan continues
Isabela, Puerto Princesa & Butuan post 792 attendees

By Genesis F. Gagelonia

BP ng Teacher Ko, Alaga Ko aka the Philippine Heart Association (PHA) Hypertension caravan traveled to Angadanan in Isabela province, Puerto Princesa in Palawan and Butuan City in Agusan del Norte in March and April 2016.

Consistent with the PHA’s thrust, the caravan aims at assessing the incidence of hypertension or high blood pressure (BP) and other risk factors (diabetes, dyslipidemia, and obesity) among 792 teachers and non-teaching personnel. ECG was done on those who needed the procedure.

Dr. Irma Yape, past chair of PHA Council on Hypertension; Ronnie Manliclic, LRI-Therapharma Manila Marketing & Operations Support Services Manager; and Myrna Dela Cruz, PHA Council supervisor were the indispensable trio in these three destinations.

Lower Cagayan Valley adventures
Being invertebrate multi-tasking travelers, every BP ng Teacher Ko... hop and hub is feverishly anticipated by the team as another opportunity to bring their Advocacy service to new heights and another learning experience to new depths. Everyone is a wayfarer off to do another Advocacy task. These intrinsically generous and adventurous souls are transported to a culture they will explore and savor. Negligible travel snags didn’t obscure their intense Advocacy spirit.

On March 31, 2016, the adventure party (Belinda Beltran DepEd Manila, Myrna Dela Cruz, Cristeta Reyes, and yours truly) boarded the 12nn Manila-Tuguegarao Cebu Pacific flight which was almost one hour delayed.

Land transfer from the Tuguegarao Airport to Angadanan, with two brief stop-overs (to grab snacks which included binallay kangkanen (a Ilocano generic term for rice cakes from a stall in Ilagan City) took almost three hours.

We arrived at the Angadanan Central School for the biggest number of turnout with 356 teachers and non-teaching personnel from different public schools.

In her welcome remarks, Angadanan Mayor Lourdes Panganiban hailed PHA “for travelling far -- by air and land to our humble town, to conduct this noble undertaking.” She also called on her constituents to “take to heart their health.”

Yape, PHA Cagayan Valley Chapter President Dr. Enrico Amado Constantino (from Bayombong, Nueva Vizcaya), Drs. Emmanuel Salamanca (from Santiago City), Michele Reyes-Maniano (from Roxas, Isabela), Edda Mallin (Cauayan City), Charito Dayos (Roxas, Isabela) took part in the risk factor screenings by interpreting the patients results, prescribing medications, giving home instructions and healthy lifestyle tips.

LRI-Therapharma’s lower Cagayan Valley came in full force. Making up the group were Rex Daguro, PhA Council supervisor; Samuel Itchon and Isabela Division Nurse Legarda Go, RN, who brokered the holding of the BP ng Teacher Ko... in Angadanan.

Angadanan scores the most participants

Of these sites, Angadanan Central School, venue of the April 1, 2016 BP ng Teacher Ko... gathered the biggest number of turnout with 356 teachers and non-teaching personnel from different public schools.

BP ng Teacher Ko... is a joint undertaking of the PHA, Department of Education (DepEd), Philippine Society of Hypertension, through a grant by LRI-Therapharma’s sponsorship commenced four years ago.

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An hour later, the second batch -- Dr. Irma Yape and Ronnie Manliclic were Tuguegarao-bound via PAL. The only hitch – Dr. Yape was told that her check-in luggage was inadvertently bumped off. Our good natured side got the better of us. A delayed flight is still a blessing. We were spared of engine trouble while in mid-air. Tuguegarao, Cagayan is three hours away from Angadanan, Isabela. PAL made sure that Dr. Yape had her baggage flown to the Cauayan (Isabela) Airport in the early morning of April 1. Cauayan is 30 minutes away from Angadanan.

Knowledge is beautiful especially when shared. The binallay which melts in your mouth has a story to tell. “Back in the ’60s, it was a revered delicacy because it symbolizes Jesus Christ’s body and blood. That is why in the sixties, we would get to satisfy our craving for binallay only once a year, during the Holy Week.” according to Lulette Villanuev, my bakbayan college classmate I accidentally bumped into at the kakanin kiosk.

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Caravan travels to Palawan

The March 11, 2016 BP ng Teacher Ko... at the Sta. Monica Elementary School, Puerto Princesa, Palawan, posted an attendance of 253.

Aside from Yape, the consultation desks were manned by PHA Southern Tagalog Chapter President Dr. Regente Lapicik and members – Drs. Josephine Go-Cruz, Gilbert Paa, Leo Acharon and Marcelyn Yap; and Palawan Medical Society members – Drs. Adelito Poas, Arnaldo Favia Jr., Nicole Reyes, Ruel Agui, Aressa Hermiliza, Marissa Legaspi-Marcial, Joanna Flores, Ruth Mihalieres and Reynaldo Samson. DepEd Manila was represented by Dr. Maricon Dumlao and Loida Ramos who were joined by colleagues in the DepEd Division. Elise Barrios, PhD OIC-Office of the Schools Division Superintendent, Puerto Princesa City; and Shirley Cudina, OIC – Principal, Sta. Monica Elementary School as well as Dep Ed Health and Nutrition Section personnel.

Manliclic joined forces with his colleagues from LRI-Therapharma Southern Luzon.

Butuan teachers get BP checked

Some 183 teachers participated in the BP ng Teacher Ko... at the Dep Ed Regional Office in Butuan City on March 18, 2016.

With Yape, Manliclic and dela Cruz in the Butuan sortie were Girlie Azurin (Dep ed Manila), Irene Alejo (PHA staff) who were joined by Dr. Sylvia Hargos, president of PHA Northwestern Mindanao Chapter, Drs. Achimedes Brodith, Delfin Dayos, Ma. Theresa Layese and Annaliza Gonzales; IM consultants: Drs. Jayel Rabisanto and Joem Jay Oliva; Dr. Ramir Uytico Dep Ed Division Office CESO IV OIC assistant regional director; and LRI Therapharma group deployed in Butuan City.

The Patient with Heart Disease in the Pediatrician’s Clinic

By Eden D. Latosa, MD, FPPS, FPCC

Advances in the understanding and diagnosing neonates and fetuses with cardiovascular problems have been remarkable, shifting the focus from the young child to the neonate and more recently to the fetus.

The changing health care environment and evolving managed care era have placed greater demands on the primary care physician or pediatrician to manage pediatric patients with significantly more diversified and challenging medical conditions. The goal of care for patients with heart disease (congenital or acquired) who are in their adolescence is to best prepare them to deal with issues that may arise now or in the future. Critical to this process is a successful transition from a pediatric to an adult health care.

A young heart’s issues

A patient with heart disease in the pediatrician’s clinic may be faced with various health issues namely, issues related to the heart disease that a patient has, issues involving other organ-system as a result of the heart disease, medical and surgical issues which are non-cardiac as well as other health issues that may be encountered as the patient grows.

Among the issues related to the presence of heart disease, the pediatrician has to be familiar with the different congenital, acquired and other lifestyle
diseases that can be present in the pediatric age group in order to deliver the best health care.

This familiarization needs a close coordination between the pediatrician and pediatric cardiologist, the latter providing important informations in order to deliver the best care. One of the more important informations is the type of repair or procedure that a patient with congenital heart disease has undergone.

Questions of the heart

Definitively, there would be questions that need to be answered.

Was the procedure done a complete true repair that resulted in the restoration of normal cardiac anatomy and function? This is expected in simple lesions like VSD, ASD, PDA, Coarctation of Aorta and cyanotic lesion like TGA who has undergone Arterial Switch Operation.

Did the repair result into residual lesions wherein remaining defects like valve insufficiency or arrhythmias may be present and require future intervention? This type of repair is common following surgical procedures for TOF, AVSD, PS or AS (following balloon valvuloplasty).

Another form of repair may require prosthetic materials such as those using prosthetic valves or conduit that may require re-operation to replace prosthetic valve because of somatic growth and/or degeneration of prosthetic material. Examples of lesions are Pulmonary Aresia with VSD as well as truncus arteriosus.

Lastly, some CHDs are recommended for physiologic repair only. In this type of repair, the abnormal cardiovascular physiology is corrected but without the benefit of correcting the abnormal anatomy. Senning and Mustard operations for TGA with VSD and Fontan operation for Single Ventricle fall under this category. These patients may encounter late complications requiring surgical or medical intervention or both.

Post-operative Issues

There are post-operative issues that a pediatrician should also be aware of. These include the risk for infective endocarditis, non-cardiac problems that may be pre-existing like abnormality in growth and development (failure to thrive), social and neurologic development, genetics and pregnancy particularly the risk of recurrence of CHD in subsequent pregnancies, effect of pregnancy to a woman with pulmonary hypertension or important residual obstructive heart disease and the teratogenic effects of some drugs to the fetus.

Extra-cardiac Issues

One non-cardiac health issue that must be known to the pediatrician is the presence of immunodeficiency syndrome and the importance of providing immunization to them. Other issues include recurrent URTI in some patients with unrepaird heart defects which can lead to cardiac decompensation; dehydration and electrolyte disturbances as well as; and travel issues for some patients with elevated pulmonary vascular resistance, significant desaturation and heart failure.

In teenagers with CHD or RHD, the choice of contraception should be individualized based on their primary cardiac defect, type of surgical repair done, residual defects and functional status. There are instances wherein a patient with heart disease may have to undergo non-cardiac surgeries.

The role of the pediatrician is to assess the risks of the procedure, provide measures to minimize the occurrence of complications and/or coordinate with pediatric cardiologist/cardiovascular surgeon for a safe and successful operation.

Since children with heart disease who have undergone successful cardiac operation or device intervention grow up and become eligible for employment, appropriate career choice through a consultation with experts should be provided. They should also be given choices to engage in sports activities, exercise and get insurance coverage. A pre-participation sports screening is needed for these group of people.

The roles of the pediatrician that are applicable to patients with heart disease can be summarized as follows:

1. to take charge of their patient’s care,
2. to prevent fractioned care, and
3. to involve family members and patient in the medical decision making with ongoing education.
American expert talks on fetal echocardiography

Pediatric cardiologist Dr. Stephen Miller from the Duke Children’s Pediatric and Congenital Heart Center, Durham, NC, USA, shared his expertise on fetal echocardiography with local experts.

Miller in a huddle with colleagues from Manila

The lecture was held last April 21, 2016 at the Mandarin Sky, Banawe, Quezon City. In attendance were consultants and fellows from the Philippine Heart Center (PHC) and Philippine General Hospital (PGH).

Miller reviewed the basics of fetal echocardiography and showed echocardiographic clips. He further emphasized the importance of a referral system from different subspecialties that include perinatology, neonatology, pediatric interventional cardiologist and thoracocardiovascular surgery. The pediatric cardiologist underscored the need for risk assessment and gave pointers on determining the most appropriate time for fetal delivery.

Dr. Eden Latosa is the president of the Philippine Society of Pediatric Cardiology. She is affiliated with the Philippine Heart Center and Dr. Jose Reyes Memorial Hospital.

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- Pooja Gupta, MD Caring for a Teen with Congenital Heart Disease-Pediatric Clinics of North America 61 (2014) 207-228
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Ten Filipino children with various congenital heart defects underwent successful surgical corrections for free.

Through a global grant sponsored by Rotarians in the United States and in the Philippines, the teams of Duke University Medical Center and Philippine Children’s Medical Center (PCMC) collaborated once more in the 5th Open Heart Surgery Mission last April 18 to 23, 2016. Backing up the joint venture, the Gift of Life International provides hope to children with heart disease who live in emerging countries.

This endeavor has the objective to empower local health care professionals and develop a sustainable pediatric cardiac surgery program that will benefit more children in their country of birth.

Since its inception in 2013 at PCMC, a total of 51 kids have benefited from this program in the Philippines. The team is led by heart surgeons Andrew Lodge and Karl Reyes and pediatric cardiologists Steve Miller and Jonas Del Rosario. The other local members of the team include Ms. Ina dela Paz Bunyi, Leah Arceo-Pucana, Rache Ninfalga, Glenda Tubianosa and Paul Tan.
Such is the springboard for the thrust of the 46th Philippine Heart Association Annual Convention and Scientific Meetings, according to Dr. Jorge Sison, this year’s PhA secretary and convention over-all chair.

“The challenge posed on us cardiologists is how to tailor our strategies to specific sub-populations where ‘run-of-the-mill’ approach in managing cardiac patients may not be applicable. Hence, the theme “Optimizing Cardiovascular Care in Diverse Population,” Sison further said.

Set for May 25-27, 2016, the annual convention will be held at the luxurious Edsa Shangri-La Hotel. The first convention-hotel in Mandaluyong City, Edsa Shang has been official convention facility, office and home-away-from-home of the organizing committee, the PhA Secretariat and the delegates for the past 23 years.

2016, a year of significant changes

The convention will focus on different populations, which is highly relevant in this era of frequent travel and patients with multiple co-morbidities.

PHA President Dr. Alex Junia observes “each day, we encounter patients with a constellation of problems, a number of which are remote from the field of cardiology but still affect the heart’s processes and functions. The topics included in this year’s meetings will address our questions regarding diagnosis and treatment.”

Dr. Helen Ong-Garcia, PhA treasurer and 47th PhA Convention Scientific Committee chair stressed that “2016 is truly becoming a year of significant change, with awareness that a single choice in time could make a significant torrential change for the future whether it pertains to political or economic genre.”

This year, the Scientific Committee focuses on the elderly, pregnant, diabetic, pediatric (hypertension, arrhythmia, vascular), students, working class (includes call center personnel), renal patients, teachers, women, and other noteworthy topics for discussion. The mode of delivery would be intra-disciplinary (among different sub-specialties) interdisciplinary (among different specialties) and interactive (panel discussions, etc).

Highlights of the 46th Annual Convention

This year’s Mariano M. Alimurung Lecturer is Dr. Norbert Lingling D. Uy, a past PhA president who served in 2004-2005.

An American foreign speaker will deliver the Dr. Ramiro De Guia Lecture. Dr. Juan Viles Gonzalez will talk on non-pharmacologic therapy for atrial fibrillation.

Furthermore, the Dr. Homobono B. Calleja Lecture will feature another American cardiologist. Prof. Manni Vannan will talk on progress in the diagnosis and management of valvular heart diseases.

Novel this year is the President’s Lecture. The lecture will have incumbent PHA President Dr. Alex Junia as the first ever to deliver such lecture. His talk will focus on exercise and the heart.

Like in the previous year, this year’s convention will offer a long list of foreign speakers who will be sharing their respective expertise in cardiology. Regular activities that include research presentations and colloquia, awarding of PhA College Awards, inter-hospital quiz competition and luncheon symposia will be expected. The annual business meeting will be held on May 26.

PHA hosts ASEAN Echo meet

For its pre-convention activity on May 24, the PHA will play host to the ASEAN Society of Echocardiography Scientific Meeting. This regional meet will be in collaboration with the Philippine Society of Echocardiography.

One of the highlights of the ASEAN echo meet in Manila will be the establishment of a regional echo society. Election of officers will seal the creation of such ASEAN society.

Be ready for the Fellowship Night of the annual PhA convention on May 27, 2016 promises to be an evening of rock music and madness.

“Bandamonium,” a coinage by Dr. Orlando Bugarin, chair of the Socials Committee, is derived from two words – banda (the Filipino word for band which could mean a rock band) and pandemonium.

Expect to see the other side of cardiologists letting their hair down. The emcees – Drs. Francis Lavapie, Don Robespierre Reyes and Bernadette Santiago-Hassan promise the Fellowship Night is going to be a hilarious gig.

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The management of cardiovascular disease (CVD) remains a continuing hurdle despite abundance of evidence and guidelines born out of landmark studies, research and development, advance technology and availability of precise and targeted pharmacologic treatment.
The Candidates for the PHA Board of Directors 2016-2017

**BUGARIN, Orlando R., MD**

- Member of the PHA Board of Directors and Director III
- Chair of the Advocacy Committee
- Past Chair, PHA Council on Cardiopulmonary Resuscitation and Member of the PHA Council on CPR since 2008
- Implemented the Guidelines in Conducting BLS-ACLS Workshops among PHA accredited trainers during his term as council chair
- One of the proponents for the ongoing “CPR Outcome Among Adult Cardiac Arrest Patients in Tertiary Hospitals in the Philippines: A Prospective Study”
- Served as Faculty during the PHA annual conventions

**CINCO, Jude Erric L., MD**

- Training Officer, The Medical City Critical Care Medicine Fellowship Training Program
- Assistant Professor, Ateneo School of Medicine and Public Health
- Assistant Chair for Research, The Medical City Department of Medicine
- Member, The Medical City Institutional Review Board
- Most Outstanding Mentor for the Department of Medicine of The Medical City
- Chosen by Ateneo School of Medicine and Public Health interns Batch 2012-2015

**GARCIA, Helen Ong, MD**

- Member, PHA Board of Directors and Director I
- Treasurer and Director in-Charge of Research
- Chair, PHA 47th Annual Convention Scientific Committee
- Past Chair of Continuing Education Program Committee
- Past Chair of the PHA Council on Cardiac Rehabilitation
- Served as faculty during the PHA annual conventions

**GLORIA, Frederick Philip B., MD**

- Steering Committee/Core Group Member, PHA Specialty Board of Adult Cardiology
- Task Force for Core Curriculum Guidelines
- Lecturer, PHA SBAC Review Course
- Voting Panel Member, 2015 Clinical Practice Guidelines on Dyslipidemia
- Assistant Training Officer, Section of Cardiology, Dept. of Medicine, UPI-PGH
- Scientific Committee Chair, 1st Philippine Cardiovascular Summit, UP - PGH CVS
- Clinical Associate Professor, College of Medicine, University of the Philippines
- OS 250 (Cardiovascular System Module on Human Pathophysiology and Therapeutics) and OS 250.1 (Cardiovascular Elective Rotation on Cardiovascular Diagnostics and Diagnosis) Module Coordinator, College of Medicine, University of the Philippines

**CO, Marlon T., MD**

- Fellow, Philippine Specialty Board of Internal Medicine
- Fellow, Philippine Specialty Board of Adult Cardiology
- Member, Council on Hypertension, Philippine Heart Association
- Member, American College of Clinical Endocrinologists-Philippine Chapter
- Member, European Association for Cardiovascular Prevention and Rehabilitation
- Past-President, Philippine Heart Association, Cebu Chapter
- President, Cebu Medical Society (2014-2015)
- Outstanding Leadership Award from Philippine Medical Association 2014-2015 (Gaining 3rd Most Active Component Society Award for Cebu Medical Society 2014-2019)
- CME/Scientific Chair, 10th Philippine Medical Association Annual Convention 2019
- Served as Faculty, PHA Annual Conventions (2011 and 2015)
- Served as Faculty, Philippine College of Physicians Annual Convention 2014
- Congress Faculty, Asia Pacific Congress on Hypertension 2014, Cebu
- Congress Faculty Asia Pacific Cardiovascular Symposium 2014 in Guangro, China
- Active Staff Consultant of Cebu Doctors University Hospital and University of Cebu Medical Center
- Past President, Cardiac Rehabilitation Society of the Philippines
- Head, Resuscitative Services SLMC Global City
- Head, Cardiac Rehabilitation Unit SLMC QC and Chinese General Hospital
- Former Training Officer, St. Luke’s Medical Center Heart Institute in Oton City
- Department Chair, St. Luke’s Medical Center Stress Laboratory, Global City, Taguig
- Former Chair, Outpatient Services Division of the St. Luke’s Medical Center, Oton City
- President, Cebu Medical Society (2014-2015)
- 3rd Most Active Component Society Award for Cebu Medical Society 2014-2019
- CME/Scientific Chair, 10th Philippine Medical Association Annual Convention 2019
- Served as Faculty, PHA Annual Conventions (2011 and 2015)
- Served as Faculty, Philippine College of Physicians Annual Convention 2014
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- Head, Cardiac Rehabilitation Unit SLMC QC and Chinese General Hospital
- Former Training Officer, St. Luke’s Medical Center Heart Institute in Oton City
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- Congress Faculty, Asia Pacific Congress on Hypertension 2014, Cebu
- Congress Faculty Asia Pacific Cardiovascular Symposium 2014 in Guangro, China
- Active Staff Consultant of Cebu Doctors University Hospital and University of Cebu Medical Center
LAPITAN, Raul L., MD

- Member, PHA Board of Directors and Vice President
- Chair, Committee on Councils and Chapters
- Chair, Heart Month 2016 Celebration
- Past Chair, Publications Committee
- Past Chair: PHA Continuing Education Program Committee (initiated CORE-five series; Sub-Committee on CEP, Socials Committee, PHA Committees on Advocacy, World Heart Day 2013, Heart Month 2012
- Former Member: PHA Awards Committee and PHA Council on Hypertension
- Former Over-all Training Officer, Makati Medical Center Section of Cardiology (2009-2010)
- Chief, Section of Cardiology, Director of the Adult Intensive and Critical Care Unit, and Head of the Heart Station of the San Juan Medical Center
- Member, Philippine Society of Echocardiography
- Member, Makati Medical Society
- Affiliated with the Makati Medical Center and Asian Hospital and Medical Center

LEUS, Aurelia G., MD

- Philippine Heart Association CME Awardee 2005
- Outstanding Leadership Award in Medicine from UEDM-MMC College of Medicine Alumni Association, Inc. 2013
- Former Training Officer, Pediatric Cardiology, Philippine Heart Center 2000-2003 and Chief Fellow PHC 1992-1993
- Member, Philippine Society of Echocardiography
- Life Member, Philippine Medical Association and Philippine Medical Women’s Association
- Member, Makati Medical Society, Philippine Pediatric Society
- Affiliated with the Makati Medical Center and Philippine Heart Center

RIBU, Ramon O., MD

- Past Chair, PHA Council on Cardiovascular Surgery
- Member, PHA Council on Cardiovascular Surgery
- Fellow, Philippine College of Surgeons, Fellow International College of Surgeons, Philippine Association of Thoracic and Cardiovascular Surgeons Inc, Philippine Heart Association
- Member, Wound Care Society of the Philippines, Philippine Medical Association, Quezon City Medical Society and Philippine Heart Center Medical Alumni Association
- Assistant Professor, Fatima College of Medicine
- Clinical Professor, Far Eastern University- NRMF
- Head, Wound Care Section, Department of Cardiovascular Surgery and Anesthesia, Philippine Heart Center
- Section Chief, Adult Congenital, Thoracic, Arrhythmia and Miscellaneous Section (TAMOS), Department of Cardiovascular Surgery and Anesthesia

REY, Nannette R., MD

- Member, PHA Board of Directors and Director I
- Chair, Committee on Continuing Medical Education Committee
- Chair, PHA Sub-Committee on Continuing Education Program
- President, PHA Southern Tagalog Chapter for six (6) consecutive years 2006-2011
- Member, PHA Council on Electrophysiology
- Member, Philippine Society of Hypertension & Philippine Lipid & Atherosclerosis Society
- Member, Cavite Medical Society
- Assistant Professor 5, De La Salle University Health Sciences Institute
- Member, Residents’ Training Committee
- Department of Medicine, De La Salle University Medical Center (2011 until present)
- Chair, Department of Medicine, Tagaytay Medical Center
- Served as faculty during the PHA annual conventions
- Organized BLS and ACLS courses and Heart Month, World Heart Day events for the PHA Southern Tagalog Chapter
- Affiliated with De La Salle University Medical Center and Tagaytay Medical Center
- Principal Investigator for several ongoing international clinical trials: (AVeRROeS, AVerEEs-XTOLe, eLIXA, COMPASS, TIPS)

SISON, Jorge A., MD

- PHA Young Investigators Award 1984
- Head, Cardiology Section, Medical Center Manila
- Immediate Past Chair, Department of Medicine, Medical Center Manila
- Main author: Hypertension Prevalence (Presyon 1, 2, 3) and Target Organ Surveys in Hypertension in the Philippines (Phyton 1-4)
- Composer of PHA Hymn

VILELA, Gilbert C., MD

- Founding President, Philippine Heart Association in Central Luzon
- Member, Expert Panels of the two Philippine Heart Association Guidelines on Coronary Artery Disease
- Member, Committee on Core Curriculum, Philippine Heart Association
- Faculty, PHA Annual Conventions
- Member, Philippine Society of Hypertension
- Member, Philippine Lipid Society
- International Associate, American College of Cardiology
- Past President, Philippine Heart Center Medical Alumni Society
- Department Manager for Education, Training and Research, Philippine Heart Center
- Editor-in-Chief, Philippine Heart Center Journal
- Chair: Personnel Selection Board for House Staff, Philippine Heart Center
- Member, Office for Strategic Management, Philippine Heart Center
- Former Chair, Coronary Artery Disease Section, Division of Clinical Cardiology, Department of Adult Cardiology, Philippine Heart Center
- Former Chair, Training Faculty, Department of Adult Cardiology, Philippine Heart Center
- Former Training Officer, Division of Clinical Cardiology, Philippine Heart Center
The country has 68 newly certified heart experts. Sixty-four out of 96 or 67% hurdled the written and practical examinations for Diplomate in Adult Cardiology given on April 23, 2016 at the Henry Sy Auditorium of St. Luke’s Medical Center Global.

The announcement was made by Dr. Efren Vicaldo, chairman of the Specialty Board of Adult Cardiology (SBAC).

Four made it to the written and practical examinations for Diplomate in Pediatric Cardiology given on March 17 and 18, 2016 at the PhA heart house, according to Dr. Teofilo Cantre, chair of the Specialty Board of Pediatric Cardiology (SBPC).

The SBAC members are: Drs. Ma. Belen Carisma, Maria Teresa Abola, Eleanor Lopez and Isabelo Ongtengco Jr. The SBPC members are Drs. Olympia Malanyaon, Aurora Gamponia, Magdalena Lagamayo and Ninfa Villanueva.

Earlier in March, the PhA led by board member Dr. Nanette Rey conducted a five-day review course for all interested board takers in adult cardiology. The intensive review focused on practical approaches to taking both the written and practical examinations. The review lectures were given by members of the PhA.

The conferment ceremonies will be held on May 25, 2016, 7:30 am at the Isla 2 Ballroom of EDSA Shangri-La Hotel during the Opening Ceremonies of the 47th PhA Annual Convention.
Implications of the PHA’s CPR Bill and Awareness Campaign

The PHA, the CPR Council at least, is all agog with the third and final reading of Senate Bill 3016 otherwise known as the “Samboy Lim Bill” on May 23, 2016. The suspense is there whether or not such bill will be passed as a law, and enacted thereafter.

It seems it was a spate of good fate that all stars are aligning for a CPR-ready Philippines. I was still quite new then in the PHA and in the CPR Council when the idea of a CPR-ready country was being floated around. Step by step, bit by bit, we are seeing rays of the rising sun.

Not counting chicks before the eggs hatch, the implementation of such law, if ever the bill becomes a law (I am crossing my fingers at the moment), will take another bumpy and rough road. Of course new problems arise with every solution that comes, but such kind of problem is practically good. Implementing rules and regulation will have to be done. Teachers nationwide must be trained on BLS and how to teach it. Who will train teachers may be another issue for laborious discussions. A new course requires new instrumentation for teaching. An additional job means additional budget. With all of these to accomplish, one year of drafting how to align for a CPR-ready Philippines. I was still quite new then in the PHA and in the CPR Council when the idea of a CPR-ready country was being floated around. Step by step, bit by bit, we are seeing rays of the rising sun.

First, the DOH now understands that there is a need for universal knowledge in ACLS trainings. The whole idea that it’s the AHA that is the umbrella organization in the country that covers all and holds mandate over similar organizations that offer BLS-ACLS trainings, including the PHA.

It is a good thing that there were meetings and consultations between and among different stakeholders that included the PHA, AHA and PRC. Now, authorities in the DOH understand that both PHA and AHA are on equal footing under the ILCOR, the global authority in BLS-ACLS.

Third, through several meetings, the DOH have come to learn about the capacity of each of the three organizations mentioned.

The PRC can only offer trainings on BLS and other emergency and life saving skills. The AHA through its regional head Dr. Delima himself apparently admitted that the AHA modules on BLS and ACLS are designed to help non-US trained nurses and other paramedical professionals comply with their BLS-ACLS requirements should they apply for work in the US.

From what I understand and my own experience, such AHA modules are not exactly designed for physicians and other health care providers (HCPs) who are required to master intensive ACLS in the hospital or ambulance setting.

The PHA of course has dedicated its members to such advocacy on training both lay and health care oriented or advocacy driven is another issue to tackle.) With these recognition, training may be streamlined to duly accredited institutions of authority. Fly-by-night business enterprises may be avoided.

Second, some minds in the DOH have the whole thing to think that it’s the AHA that is the umbrella organization in the country that covers all and holds mandate over similar organizations that offer BLS-ACLS trainings, including the PHA.

The PHA’s CPR Bill and Awareness Campaign

The Obama Assignment: The opportunity for Service, Call of Duty or Useless Protocol?

Four or five months ago, the medical director of Makati Medical Center (MMC), Dr. Benjamin N. Almuron, called to ask if I was willing to accept an assignment as physician for the forthcoming Asia Pacific Economic Cooperation (APEC) Summit in November 2015. My instant reply was “Opo, Doctor. Of course, I will take it.”

MMO was one of the few private tertiary facilities tapped by the Department of Health (DOH) to provide close-in medical assistance for the 21 leaders who would arrive for the meeting.

My assignment? I was designated to be the close-in physician for the President of the United States, Barack Hussein Obama II. It dawned on me that if, heaven forbid, President Obama had a stroke or a heart attack, I would be at the forefront of his medical response team in the Philippines.

Really, now? Certainly, I had my fair share of medical emergencies in the past – including heart attacks and strokes. The ONLY difference? (Call it the only extremely vital difference.) This assignment now involves the world’s most powerful leader, the leader of the world’s largest democracy and the prime target for assassination by some of the world’s most vicious terrorist networks.

What is the chance that I will even be able to hold Obama’s arm for blood pressure determination? Or insert an intravenous line on his arm? Or even the thought of subjecting him to a coronary angiogram? What is the likelihood that a physician of a developing Third World country will be able to render direct medical care to a world leader whose security force must have been through decades of enhanced and improved security precautions, advanced medical preparations and surveillance systems brought about undoubtedly by a John F. Kennedy assassination in 1963 and a Ronald Reagan assassination attempt in 1981?

I would dare say that the probability was infinitesimally low, if not absolutely, zero. I already accepted that Obama would surely have his own contingent to provide him the most advanced medical and surgical care possible. He reportedly flew in with six doctors from the White House during his state visit to the UK in 2011. I was certain he had a fully equipped medical facility in his ship docked nearby in Manila Bay. I was surprised that the U.S. Navy’s Arleigh Burke-class USS Fitzgerald which arrived in Manila before his arrival would likewise have the medical capability to attend to the US president.

The medical arrangements and provisions for a US President must be mind-boggling. It is well known that his medical team always travels ahead of the contingent to determine the accessibility and adequacy of the nearest medical facility. It has been reported that the US President’s plane (Air Force One) has a fully functional operating room and a full stock pharmacy. It has been touted that the presidential limousine or “The Beast” has a refrigerator that is fully stocked with the president’s blood type.

For five days, I was holed up in Hotel Sofitel to stand by for the US President. With a nurse and an ambulance driver, we patiently waited for any task on hand as deemed by the Presidential Security Group.

One wonders – was this APEC assignment a useless endeavor, a waste of time, a squander of resources? Clearly, MMC embraced the invitation as a patriotic duty when DOH asked for medical and paramedical personnel for the summit. Consider me a protocol-mandated counterpart of the visiting dignary’s medical team, a necessary accesorial medical professional from the host government or a perfuratory medical provision for a visiting head of state.

Without any hint of sadness, insult or insecurity, I consider myself the back-up of a back-up, a back-up.

Whether or not, by any figment of imagination, I would be “blessed” with the singular opportunity to render medical service to Obama, my team remained ready to do the job – as we hoped for the best and prepared for the worst.

My assignment? I was designated to be the close-in physician for the President of the United States, Barack Hussein Obama II.
#CPReadyPH: It Can Be Done

During my inaugural address, I mentioned that the members of PHA council on CPR have conducted numerous BLS/ACLS training sessions all over the country in their quest for the elusive dream of a BLS-ready Philippines.

Widespread training in Japan and statewide training in North Carolina were instrumental in increasing bystander CPR rates. This was translated to a significant improvement in neurologically intact survival in post-cardiac arrest patients.

If most Filipinos know how to perform BLS, we can increase the rates of bystander CPR before the arrival of emergency medical services. During the past months, the Council on CPR chaired by Dr. Francis Lavapie worked harder than their usual towards the attainment of this goal.

In the July-August 2015 issue of the The Heart News and Views (THNV), I mentioned the “Samboy Lim Bill” or House Bill 3016 that intends to include teaching of CPR in the basic education curriculum. Perhaps, everybody now knows what happened to the PBA legend. He collapsed during a basketball rehearsal but received no resuscitative measures because nobody knew how to administer CPR. Defying all odds, he was revived but was initially comatose. Months later, he was able to now open his eyes, but nevertheless immobile on bed.

Perhaps, this is what triggered the PHA officers and board of directors together with Dr. Lavapie to conduct numerous BLS/ACLS training sessions all over the country in their quest for the elusive dream of a BLS-ready Philippines.

In line with this, DOH held consultative meetings for the creation of a unified training module for BLS (maybe eventually also ACLS) incorporating suggestions from the PHA, Philippine Red Cross (PRC) and American Heart Association (AHA). These modules will be used for BLS training of healthcare providers, non-medical persons and high school students. In turn, each training group will provide DOH with a list of trainees with their addresses for the DOH database. This list will be used to tap possible first responders in cases of out-of-hospital cardiac arrest.

Together with PRC and AHA, we are set to sign a memorandum of agreement with DOH for this partnership. Once this MOA is approved, DOH will issue a memorandum that BLS training from any of the DOH-recognized providers, PRC, PRC and AHA, should be accepted in any institution.

The CPR council members met during the Training-The-Trainers activity last February 2016 to assess the status of the council projects. Past chairs, Drs. Ramonotto Halayague, Oscar Payawal, Raul Rambuyong, Marcellus Francis Ramirez and Bugarin, provided insights into the history of the council, the current state and future directions.

It was during that meeting that the plan for a mass CPR campaign was laid. It was to be conducted prior to the third reading of the Samboym Lim bill. The date April 25, 2016 was chosen since May would be full of election-related social, broadcast and print media.

Dr. Bugarin and Lavapie were also able to touch base with the Health Emergency Management Bureau (HEMB) chaired by Dr. Gloria Balboa of the Department of Health (DOH). During their talks, it was emphasized that DOH will be the lead agency in creating and maintaining standards in CPR especially since the agency has the capacity to implement BLS training on a nationwide scale.

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Some four years ago in my rather flamboyant and free spirit type life (am sure many will agree), I would say being a director in the Philippine Heart Association Board is never in my lifeline. Impressions of being corporately serious and academically proper in image never seem to be me so I deemed it will never be me. So lo and behold, fate stepped in and here I am, facing a rather intriguing yet satisfying journey for which I have been demythicized in the past three years.

Every director has a vital role to play upon entry to this team. Every role meant to serve a purpose for both the growth of the person and to harness for the growth of the Association. In my present state and responsibility, I now faced the task of taking charge of one of the most daunting tasks of them all: the Chairmanship of the Scientific Committee of the Annual Convention.

Now, let me be honest with you. I am but your average regular cardiologist on the block. I read, I listen, I update, I research. But, hey, I am no Braunwald nor Calleja or Abarquez. It daunts me that now I have to come up with a program that will benefit all and make the PHA proud. Duh! What should a common lady do then. I did not just call a friend. I called FRIENDS!

The PHA Board of Directors (my family team) and my Scientific Team (Ricky Tiongco, Rodney Jimenez, Gigi Brillantes, Ronald Cuyco) brilliantly brainstormed with me the theme on Diversity. As we wanted to cater to as many interests and need so the Filipino Cardiologists, this is the IT theme. Since we are on the roll regarding diversification, then why don’t we do so for the type of patients we normally see in our regular practice? From womb to wheelchair, from house, community to hospital.

On top of that, to repetitively say the catchy phrase of the year, as we diversify, we would like to do so the whole kilometer. Let’s also modify the mode of communication. Alas! Change is coming.

Now let’s talk about titles. Never in my mundane life have I ever thought naming an activity is an art form. Wanting to avoid the conundrum of terms like excellence, world class, advances, etc, it was challenging to come up with a theme name. Finally, the very Filipino trait of simplicity prevailed. Why don’t we just name it the way it is. We aim to maximize the knowledge to delivery of cardiac care to different type of patients. So the title is beautified: “Optimizing Cardiovascular Healthcare to Diverse Populations.”

Thus, the wheels have started turning. The concept promulgated to all the dynamic council chairs and the Scientific Program. “Optimizing Cardiovascular Healthcare in Diverse Populations” is born. Again, friends are the key here. Friends and dynamic council chairs of the PHA who followed suit and with passion and fervor worked to bring to life the very seed where the theme of the annual convention should uproot from.

Now, proudly, it is there. There have been challenges along the way but overall, I have been blessed with minimal glitches as there are mentors, pals, colleagues, dedicated people who made the road less bumpy. Unity in Diversity isn’t it a beautiful thing? My many thanks to all who made this Scientific Meet 2016. My insignificant life is totally enriched. It’s good to be in and of service to the PHA.
Can one be fat and still be fit and healthy? Conventional concept holds that to be physically lean is to be fit and fab. Conversely, the overwhelming presumption that being obese is being unhealthy. People who are plump or those who tip towards the overweight side of the scale are most often than not considered as walking time bombs waiting to explode. This is due to robust data that greater weights pose greater risks for cardiovascular complications.

According to the United Nations Food and Agriculture Organization (FAO), the Philippines and India are among the developing countries with high prevalence of nutritional problems of obesity and under-nutrition. Three out of 10 Filipino adults 20 years old and above are either overweight or obese. The occurrence of obesity is most prevalent in the 40-49 age group and least in people 70 years old and up, the report said. The report also noted that there are more females who are obese than males. Specifically, and among obesity or apple-shaped obesity is more common among women than men. Research have strongly shown that obesity is a major risk factor for heart disease, stroke, certain types of cancer and sudden cardiac death. But in recent years, questions sparking debates have been raised by researchers on obesity. Recent studies have been challenging conventional wisdom showing that not only is it possible to be both fat and fit, but fitness is actually a more significant measure of health rather than body weight alone.

The Obesity Paradox: Being overweight is now believed to help protect patients with an increasingly long list of medical problems, including pneumonia, burns, stroke, cancer, hypertension, and heart disease.

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Recent research published in the Lancet Diabetes and Endocrinology, being overweight was shown to decrease the chances of developing dementia. According to Dr. Nawab Qaddash, the researcher of the study, this finding might be associated with cardiovascular conditions.

Since its first publication, a number of studies came out confirming the existence of “obesity paradox.” Being overweight is now believed to help protect patients with an increasingly long list of medical problems, including pneumonia, burns, stroke, cancer, hypertension, and heart disease. Researchers who have tried to disprove the existence of such paradox failed trying. Most investigators accept the evidence behind such paradox, though there still much to contest on what the paradox means for health. According to Gregg Fonarow, a cardiology researcher at University of California, Los Angeles, “It’s been shown consistently enough in different disease states.”

Carl Lavie, a cardiologist in Jefferson, Louisiana, was one of the first clinicians to describe the paradox. It took him over a year to find a publication that would print his findings. On the other hand, Katherine Flegal, an epidemiologist at the US Centers for Disease Control and Prevention, together her colleagues, looked at hundreds of mortality studies that included data on body mass index (BMI). People with BMIs of more than 25 are classed as overweight, and those with a BMI over 30 as obese. Flegal’s research group found out that the lowest mortality rates are among people in the overweight to mildly obese categories. While it’s true that these groups were slightly more likely to suffer from heart diseases and some other life-threatening conditions in the first place, many other factors, not just obesity, influence the likelihood of a person getting heart diseases. A strong link between weight and disease only emerges among people with severe obesity. With these findings, extrapolations may lead to believe that a little extra weight may actually be protective and thus beneficial.

The Healthy Perks of Being Fat

In an article written by Jonathan Wells, five benefits of being overweight and mildly obese were identified in men:

1. Reduced risk of Rheumatoid Arthritis

Latest researches showed that men with higher BMI have a lower chance of developing chronic arthritis. Unfortunately, this finding is only limited to men. Women are not spared from the dreaded disease. Fat is not protective in women against rheumatoid arthritis.

This is supported by a study done by Carl turesson, a professor of Medicine at Lund University in Sweden. turesson conducted a case-control study in 350 overweight and obese men. The study showed that up to 65% of the study population are least likely to develop this autoimmune disease. He attributed this finding to the presence of visceral fat in the abdomen which combats the condition. That the added weight can actually help prevent arthritis.

2. Overweight people are least likely to develop Dementia

In a recent research published in The Lancet Diabetes and Endocrinology, being overweight was shown to decrease the chances of developing dementia. According to Dr. Nawab Qaddash, the researcher of the study, this finding might be associated with cardiovascular conditions.
used “to provide insight to looking for a mechanism and developing new treatments for dementia. In addition, doctors, public health scientists and policy makers may need to rethink how to identify who is at high risk for dementia.”

3. Being overweight can mean a stronger immune system.

The deep layers of fat or the omentum around an obese individual’s organs seem to interact with the omentum in the cellular level, aiding in the regulation of the immune system’s response. In a study entitled Cellular Basis of Tissue Regeneration by Omentum, authors propose that mesenchymal stem cells which are specialized cells found in abdominal fat helps in the repair of tissues.

4. Overweight people might have increased longevity and recovery time.

Fat tissue, as well as the hormones it releases, improves bodily defense mechanisms by providing vital energy reserves and anti-inflammatory agents. Thus, even though overweight or obese individuals may be more susceptible to serious health issues to begin with, they are less likely to die from them

than those with underweight or even healthy BMIs. According to Dr. Brian Kit, in an interview, “When you’re sick, your body may require more energy to heal properly, to some extent, extra fat can provide a crucial boost so you can bounce back faster.”

5. Overweight individuals may perform better in sex.

Estradiol, a female hormone which can be found in the abdominal fat of obese men is known to retard male orgasm. Orgasm may actually be prolonged for an average 7.3 minutes compared to those men who are underweight or of normal BMI.

Fitness over Weight

Further studies and debate should still be made to prove and verify the existence of the “obesity paradox.” Many would still advocate achieving a normal BMI as a gauge of health. But bottom line is, your fitness level seems to be more important than your weight.

According to Steven Blair, PED, of the Cooper Institute in Dallas, “people who are obese but fit, according to cardiovascular measurement such as stress tests, have death rates half that of normal-weight people who are unfit.”

The benefits of exercise go far beyond burning calories. Being physically active helps prevent heart disease, Type 2 Diabetes Mellitus, depression, some forms of cancer, and osteoporosis. It can also improve mood, enhance self-esteem, reduce anxiety, and help manage stress.

Improving fitness level usually results in increased muscle mass, which means the body burns more calories at all the time. Recent studies found no increased risk of death for overweight people, suggesting that people with a few extra pounds but otherwise healthy lifestyles can be relatively healthy.

As of present, new findings from scientific investigations continue to reshape our paradigms on health. Being fit or fat either by choice or circumstance has now become an issue for debate. But what remains to be far from being debatable is the benefit of leading a healthy lifestyle that includes adequate exercise and proper nutrition on everyone, either fit or fat.

Dr. Jason Santos is in his first year of fellowship training in adult cardiology at the University of Sto. Tomas Hospital.

7 Reasons to run the Mayon 360º Ultramarathon

The Mayon 80km Ultramarathon was first organized in 2009 by the father of Philippine Ultramarathons, Retired Major General Jovie Narcisse in cooperation with the local government of Albay. The race route circumnavigates the majestic Mayon Volcano. It is basically a “double marathon” and is actually 6 kilometers longer than advertised.

One can join the solo category or form a 2-man or 4-man relay team. The route starts at 4am with a 10 kilometer uphill stretch to Cagsawa and that’s just for starters. As the sun begins to rise, runners are treated to more hill ascents from kilometer 20 in Camalig and Ligao city.

Kilometer 25 onwards is no different as more hills greet the runners as you reach Guinobatan all the way to Tabaco at kilometer 40. Temperatures rise to a treacherous 40ºC even as runners try to negotiate the tough and cruel inclines when they reach the town of Malikpot in kilometer 50 and Bacacay and Sto. Domingo in kilometer 60 all the way to the finish line.

Basically, the race pushes your body to its physical and mental limits. So why even bother signing up for the Mayon 360 Ultramarathon?

This writer has been blessed to have finished this race three times since 2014 (twice alongside my wife) and it sure does hurt like hell each time!

I had summoned all the happy thoughts and memories, prayed to God countless times; and during the 2014 and 2015 editions, Rona and I have talked about practically everything there is that a couple can talk about. Our tempers even clashed which caused us to throw tantrums like kids during the actual race.

One would have all the reasons not to sign up for the Mayon 360 Ultramarathon? But what remains to be far from being debatable is the benefit of leading a healthy lifestyle that includes adequate exercise and proper nutrition on everyone, either fit or fat.
Walk | Talk

1. It’s RACE-cation! It falls around early April so the sun is up, the weather is fine and the kids are on summer vacation. Legazpi is such a lovely town with all the tourist destinations only within a few minutes from each other. Some of these include Lignon Hill which gives you a bird’s eye view of the city and a picture perfect view of Mayon Volcano, the famous Cagsawa ruins, Embarcaderos de Legazpi and, if you’re on the adventurous side, ride an ATV all the way to the green and black lava trails of previous Mayon Volcano eruptions.

2. Beaches! After running 85 kilometers, why not reward yourself by taking a dip into the waters of Misibis Bay or go island hopping and visit the point where Legazpi bay meets the Pacific ocean?

3. More places to visit! Sorsogon is just 100 kilometers away from Legazpi and it is home to the “pink” beach. The sands of Subic Beach in Malabon give a pink hue owing to the countless corals in its shores. Along the way, you can get to visit the Fish Sanctuary to feed the fish or take a boat ride around Bulusan lake and bathe in its hot springs.

4. Reconnect with friends. In Legazpi lies the “Heart Centre” of Albay and is home to a number of fellow cardiologists. Drs. Arbel Perete, Thad Ciocson and Josephine Recierdo never fail to welcome us with open arms whenever race season comes around.

5. The mayon 360 is one the few races wherein local runners and hometown heroes consistently beat Kenyan and other international runners. In the ultramarathon community, the names of Mario Maglinao, Janette Agura, Melanie Malihan, Seannah Swift and Lao Ogerio would never go unnoticed.

6. A time for meditation. Running such a tough race is a good way to know more about one's self. An ultrarunner has, in this case, 16 hours to pray, meditate and reexamine his/her character. It gives an unforgettable experience when one can develop focus and perseverance that can be useful in everyday life.

7. Dr. Hermie Saludes is an interventional cardiologist and an ultramarathon runner. He usually joins marathons with his wife. He has finished the Bataan Death March 160km in 2014 and 102km races three times. He has also finished the Mayon 360 Ultramarathon, which is one of the wonderful local races we have in the Philippines. Any aspiring ultramarathoner worth his salt should include this in the bucket list. Once one has tried running the roads of Albay, one would know why this runner keeps coming back for more.
Physical inactivity causes maladaptive changes in all organ components of oxygen transport. Most cancer patients do not adhere to exercise recommendations and can experience significant declines in physical activity levels from pre-to-post diagnosis.

Exercise for Cancer Patients: a Novel Concept of Cardiac Rehabilitation

Aside from the disease itself, cancer is a disease that has quite a significant impact on physical stamina on those afflicted by it, and such effects on patients themselves and on relatives and friends are far-reaching.

Traditional treatment which consists of some combination of surgery, chemotherapy, radiation and/or immunotherapy may eradicate the tumor but often leaves individuals struggling to regain the quality of life they once had before cancer diagnosis.

Both the malignancy and the treatment may cause multiple physiological and psychological impairment, leading to considerable functional morbidity and an increased risk of mortality from non-cancer-related causes.

Benefits of Exercise

Structured exercise training is established as the cornerstone of primary and secondary disease prevention in multiple clinical settings. In cardiovascular disease, there is irrefutable evidence that people who exercise intensively have a lower risk of heart disease.

According to a recent research presented at the 2015 ESC Congress, exercise helps increase telomerase activity—the enzyme that helps repair DNA to slow down the inevitable aging process. Just adding 25 minutes of brisk walking per day can add an additional three to seven years of life.

Exercise in Cancer Patients

In stark contrast, the role of exercise following a diagnosis of cancer has, until recently, received comparably less attention. The precise reasons for this are unknown but likely stem from the prevailing dogma that a cancer diagnosis is associated with poor prognosis, immune deficiency, and other severe debilitating side effects that preclude participation in, and benefit from, exercise training.

Exercise training is a pleiotropic therapeutic strategy with the capacity to act across multiple organ systems to facilitate attenuation and prevention of cancer therapy-associated morbidity as well as improve clinical outcomes in patients with cancer.

Evidence of Impaired Fitness

Persuasive evidence is emerging showing that cancer patients have significant impairments in cardiorespiratory fitness. There is also evidence of significant impairment in cancer patient populations that are considered, in general, to have good functional status.

In a cohort of 130 patients with operable breast cancer with ‘good’ performance status (Karnofsky Score ≥70) and normal cardiac function (that is, resting left ventricular ejection fraction ≥50%), 27 months following the completion of primary adjuvant therapy the mean VO2peak was 22% below that of age-matched sedentary healthy women.

Physical inactivity causes maladaptive changes in all organ components of oxygen transport. Most cancer patients do not adhere to exercise recommendations and can experience significant declines in physical activity levels from pre-to-post diagnosis.

Physical activity combined with the adverse effects of anti-cancer therapy on all components of the oxygen cascade involving an integration of cardiac, pulmonary, skeletal muscle as well as hematologic system abnormalities will markedly reduce cardiorespiratory fitness.

Evidence of Exercise as Therapy

There are many ongoing trials regarding the benefits of exercise in cancer patients. A study by Chico et al showed that low intensity exercise training during doxorubicin treatment protects against cardiotoxicity by enhancing antioxidant defenses and inhibiting apoptosis.

Adams et al noted that a structured exercise program along with supportive care in patients with cancer led to increases in muscular strength, physical performance, reduced fatigue and pain as well as improvements in physical functioning and SF-36 scores.

A structured exercise program, similar to our comprehensive cardiac rehabilitation programs, when tailored and individualized to the cancer patient will have numerous benefits that involve multiple organ systems.

Exercise Recommendations in Cancer Patients

According to the exercise recommendation guidelines for cancer patients by Schmitz et al, after undergoing examination for eligibility and if without contraindications (such as fever, anemia of <8 gm/L, low platelet count, severe nausea, and low absolute neutrophil count), exercise training is done best before or early into treatment.

Exercise should be in the low to moderate intensity range (around 40-70% of maximum predicted heart rate). The interventions are progressive, the dosage is varied and individualized depending on the status of the patient, with a mean frequency of twice weekly with a duration of about 40 minutes, and should balance both aerobic and anaerobic activities.

Starting an Exercise Program

Similar to cardiac rehabilitation, a cancer rehabilitation program requires a multidisciplinary approach involving
all those in cancer care, including the oncologist, the surgeon, the cardiologist, the exercise therapist and the rehab nurse. This can be done with approval from both the primary physician as well as the patient and the family members. It must be emphasized that every cancer patient is unique and one size does not fit all. The program components can consist of lectures, psychosocial interventions and group sharing tailored to the patient which adds to the exercise program to improve fitness as well as strength, flexibility and relaxation.

Where do we begin and where can we go from here? The Oncology Rehabilitation Program at the Ottawa Regional Cancer Centre was the first in the world to describe a safe and effective exercise intervention program showing that patients with a variety of cancers at various stages of illness can safely participate in a program of structured physical activity with no adverse events. Such findings became the basis for most of the exercise recommendations in the ACSM guidelines for cancer patients. Its applicability however in the local setting remains to be seen. Evidence for its efficacy as well as funding for research if this approach can be realized are needed. Other major hurdles include the requirement to establish programs with personnel possessing the specialized knowledge of exercise-oncology principles, limited access to specialized services in rural communities, and possibly lack of oncologist referral and support. But the evidence is already mounting and more are underway and if a physician is given the opportunity to make a difference and improve the quality of life of a cancer patient, then by all means a physical rehabilitation program for the cancer patient is a worthwhile endeavor. It is a novel concept, which provides an opportunity especially for cardiovascular health care practitioners to be involved holistically in cancer related patient care. ♥

Dr. Lucky Cuenza has just finished his training in cardiac rehabilitation at the Philippine Heart Center. He is set to train further in sports rehabilitation in the US soon.

It’s snack time! DECONSTRUCTING THE PINOY MERIENDA

In all those various taste buds that densely populate the Pinoy tongue, it is not surprising the typical Filipino eats at least five times a day. Three square meals and at least two meriendas in between, with an occasional midnight snack. Such gustatory delight is something intrinsic to the Filipino culture of celebrating life and its abundance. This same gastronomic culture more often than not borders on prodigality and imprudence. A more-than-occasional momentary delight may be paid by a one-time big-time catastrophic disease or a chronically punishing cardiometabolic illness in the future. Again, we have looked into the Pinoy’s 10 favorite kinds of merienda. We counted the calories and, again, we recommend ways to burn them, if one cannot just simply resist such gastronomic temptations. After reading this, imagine how much calories we are gobbling up on a day-to-day basis from snacks alone! ♥

Calorie Counter

By Don Robespierre C. Reyes, MD, FPCP, FPCC

Calorie Counter

Calorie Counter
Accounts from history books may explain how Asian noodles got their way onto Philippine dining tables. But how these noodles became a Pinoy staple? From dried to fried, to sautéed to soupy renditions, noodles are just in every corner in the country.

This is it, Pancit!

Spaghetting Pababa o Pataas?

Italian staple spaghetti has also found its way to the Pinoy Hapagkainan. No occasion is complete without spaghetti! A favorite merienda, Pinoys have owned this dish rendering it basically sweet!

Oh My Siopao!

Chinese influence cannot be denied. From traditions to clothing to cuisine, oriental touch is everywhere! A meal by itself, siopao is usually enjoyed with beef or chicken mani, a combination of calorie-rich carb!

Philippine Heroes: Banana Saba or Camote?

Two staples that saved Pinoys from starvation during the Japanese War were saging na saba and sweet potato or camote. Well, half a century later, these two saviors are still very much around from side streets to fancy restaurants.

Oh Those Fried Flour-based Patties!

Enjoy the crunch of okoy and the fluffiness of sweet maruya, but beware the oil that seeped deeply into each patty!

Stuffing it up with Empanada

Perhaps, introduced to Pinoys by Spanish (or Portuguese?) conquistadores more than four centuries ago, different versions have been made of empanada. Basically it is dough wrapping any stuffing - from meat to veggies and fruits, and deep fried. Yes, it is deep fried!

Calorie Counter

How to burn 160 calories:
- 41 minutes brisk walking
- 13 minutes jogging
- 21 minutes cycling

How to burn 286 calories:
- 73 minutes brisk walking
- 32 minutes jogging
- 38 minutes cycling

How to burn 393 calories:
- 73 minutes brisk walking
- 32 minutes jogging
- 38 minutes cycling

How to burn 290 calories:
- 93 minutes brisk walking
- 39 minutes jogging
- 47 minutes cycling

How to burn 350 calories:
- 144 minutes brisk walking
- 44 minutes swimming
- 75 minutes cycling

How to burn 390 calories:
- 144 minutes brisk walking
- 44 minutes swimming
- 75 minutes cycling

How to burn 263 calories:
- 67 minutes brisk walking
- 20 minutes swimming
- 36 minutes cycling

How to burn 256 calories:
- 67 minutes brisk walking
- 20 minutes swimming
- 36 minutes cycling

How to burn 200 calories:
- 67 minutes brisk walking
- 20 minutes swimming
- 36 minutes cycling
Why does the Filipino palate easily adapt to outside influence? Most of our main dishes bear Spanish, American, Chinese and Japanese marks. Perhaps because Filipinos are a product of mixed races and just like our modern Asian neighbors, we have become Westernized and developed an acquired taste for international and fusion cuisines.

We always get exhilarated to see a new foreign restaurant especially if it’s a neighborhood food outlet. We may be aware that nothing beats homecooking or lutong bahay, quality and quantity wise, but with our cosmopolitan and fast-paced lifestyle, we are tempted and compelled to try the new kid on the block.

On Malingap St. cor. Matahimik St. in teachers’ Village, Quezon City, restaurants and eateries are dime a dozen. Rivalry has never been as stiff. One of the newbies is the barely eight-month-old Gyoza and Ramen house (GRh) which serenely stands near the fringes of Malingap Street towards Kalayaan Ave. Actually, the whole stretch of Anonas extension, Maginhawa and Malingap streets that interlace the three villages - Sikatuna, uP and teachers’- is an emerging food destination that has become a magnet for foodies from Metro Manila.

You can’t escape GRh, a small and quaint Japanese resto. Located at a crossroads, its frontage is ensconced with Japanese string lights, paper lanterns and tree lights.

There is something beguiling about GRH. After my first visit, GBH disabused my belief that a Japanese restaurant that churns out authentic and healthy Japanese fare is expensive and can be intimidating. It prides itself in its homespun charm (that reminds me of the roadside Japanese restaurants in the outskirts of Japan) and amiable, hands-on owners, sisters-in-law Dani and Agnes Dayao.

Kakanin and company

Rice is a major agricultural crop in the country. It’s no wonder why region to region, there would be different versions of rice products. Carbs and sugar plus coconut meat or milk are the usual combo, so what else do we expect of calories?

How to burn 130 calories: 
- 33 minutes brisk walking
- 15 minutes jogging
- 10 minutes swimming
- 18 minutes cycling

Lumpiang Togue (1 small serving)
130 cal
Goldilocks Lumpiang Ubod (1 serving, no sauce)
32 cal

It’s Bloody Meaty Delicious

All-time favorite regular meal or merienda, dinuguan is undeniably a sinful pleasure. But dinuguan doesn’t do crimes alone. It comes along with puto or a steaming cup of white rice, and yes, that can be taken for snacks!

How to burn 150 calories: 
- 39 minutes brisk walking
- 17 minutes jogging
- 12 minutes swimming
- 20 minutes cycling

Goldilocks DINUGUAN (220 GRAMS)
150 cal
Goldilocks PUTO (1 PIECE)
121 cal

Streetfood Faves!

If you’re within the university area, expect a throng of hungry students (and professionals, too) flocking a street vendor in cart on the side walks. Yes, it’s the odd balls and other dumplings on a bamboo stick that you immerse into those jars of either sweet, sour or spicy sauce concoctions where other customers also dip their dumplings into.

How to burn 400 calories: 
- 103 minutes brisk walking
- 46 minutes jogging
- 31 minutes swimming
- 54 minutes cycling

Pork Siomai Fried (1 piece)
84 cal
Kikiam (100g)
400 cal

Sources:
1. www.calorieking.com
2. www.myfitnesspal.com
3. www.caloriecount.com
4. www.calorielab.com
5. www.fatsecret.com

Walk & Talk

HealthyFinds

March - April 2016 • THE HEART NEWS&VIEWS 106

March - April 2016 • THE HEART NEWS&VIEWS 107
Japanese comfort foods in town. It is the only impeccable gyoza, ramen, chahan and other authentic Japanese food.

Sun. If not, quality and quantity can be compromised. Ingredients are sourced from the Land of the Rising THNV that 80 percent of their ingredients are unique and distinct. You just can’t use Chinese-Japanese fusion dishes. Gyoza and are up by the Japanese, while tempura is an exception.

Incidentally, are used in moderation by the Japanese. A major introduction of meat-based dishes such as tonkatsu. Significantly, meat, oils, fats and dairy products are used in moderation by the Japanese. Historically, the chicken and pork are Chinese-Japanese fusion dishes.

Japanese food preparation is a big challenge. Its ingredients are unique and distinct. You just can’t use substitutes because by doing so, the food loses its local tang. Agnes tells THNV that 80 percent of their ingredients are sourced from the Land of the Rising Sun. If not, quality and quantity can be compromised or jeopardized, and so with the eating authentic Japanese food.

The 33-seater GBh is home to the best, impeccable gyoza, ramen, chahan and other Japanese comfort foods in town. It is the only Japanese restaurant, so far, in the metropolis, that whip-ups gyoza in seven flavours and a wide selection of ramen.

I settled for the miso soup, chicken teppanyaki, shrimp and Kushiage gyoza which was so “oishi” (very delicious) as well as the agedashi dōfu, which was exceptionally good. The gyoza or dumpling is tender and generous in its filling. The very smooth tofu or agedashi dōfu, which was delicious) as well as the shrimp and kutchay gyoza, which was so “oishi” (very good).

GBH has had to different locations and had assumed different names as a re-branding tack, yet its regular customers managed to put a tracker on the new outlet.

Dani shares the common food review of their loyal customers, verbatim: “It’s because of the uniqueness and Authenticity of the gyoza and ramen concoctions which we can’t find anywhere else!”

Dr. Edward Gacrama, chief Fellow, Philippine Heart Center (PHC) training officer, tells THNV “yeah, we love the place. It’s cozy, and has fair pricing for its food quality. The chicken and beef teppanyaki are our top choices.”

On my first visit, I saw Dr. Gacrama and how. My GBh food trip was overwhelming. GBH is a cut above the rest. Chef Agnes shares two recipes which on the GBH’s list of most popular orders with a group of adult and pediatric cardiologists from PHC. One of them was Dr. Rhodora de Leon. “Our hearts are bursting with joy every time we hear these generous compliments from them!” Dani admits.

GBH is a gastronomic discovery. It has the best gyoza, ebi tempura, agedashi dōfu and yasai itame in town. For someone with an adventurous tongue that craves for a balanced diet, I punctuated my meal with the vanilla ice cream with mochi balls and the banana tempura.

For someone with an adventurous tongue that craves for a balanced diet, I punctuated my meal with the vanilla ice cream with mochi balls and the banana tempura.

Dani declares that “our group of regular customers range from families with children, couples, doctors and other health professionals, employees from the public and private sectors, students, teachers, artists and people from ABS-CBN and GMA.

The adults love the agedashi dōfu, shrimp gyosya, seafood ramen, chahan and the vegetable side dish yasai itame. Grown-up children on the other hand go for the kani salad, original and mixed gyosya, kimchi chahan, beef teppanyaki, sesame & miso ramen and spicy tama, too.

On my second and third visit, with family members and journalist friends, we had the same order. Dani adds “the kids who are so adorable and who we love having around, usually choose the shoyu ramen, original chahan, ebi tempura, tori karaage, vanilla ice cream with mochi balls and the banana tempura.”

GBH values its customers needs and wants. She says “sometimes we also act on the suggestions when warranted. We try to maintain an open line of communication with our customers as much as possible as they are the reason we are in business. We usually introduce new items in our menu once or twice a year.”
The Case
A woman who was on her second pregnancy and in early stage of labor went to the emergency room of a private institution. She was irregularly seen at the charity clinic for pre-natal check-up. After having been appraised of the hospital cost and the patient fully assessed by the OB-Gyne resident to be in early labor with the baby in good condition, the patient was advised and decided to transfer to a government hospital as the family could not pay the deposit. A waiver for the transfer was signed. The patient was transferred to a government hospital but was denied admission due to a lack of NICU or nursery bed and was advised to transfer to another government hospital where the baby was assessed to be already dead. Understandably, the family was so angry that the event was posted on social media calling the doctors involved as killer doctors and other derogatory remarks that definitely tarnished their reputation and causing them so much anxiety and sleepless nights.

AGEDASHI DOFU
Ingredients:
1 pack Japanese firm tofu
1 cup cornstarch
Soya oil for frying
1 tbsp. grated radish
For dashi sauce:
2 tbsp. mirin
2 tbsp. Kikkoman soy sauce
1 cup water
1/2 tsp. dashi no moto
Instructions:
1. Boil all ingredients of dashi sauce in a pot. Set aside.
2. Cut tofu into 6 equal blocks.
3. Coat tofu with starch and deep fry in soya oil.
4. Serve with grated radish and dashi sauce.

YASAI ITAME
Ingredients:
200g bean sprouts
1 small carrots thinly sliced
1-4 cup canned sliced mushroom
4 stalks kutchay (nira), thinly sliced
100g thinly sliced pork
1/8 tsp. minced garlic
1/8 tsp. minced ginger
1/4 tsp. salt
1 tsp. soy sauce
1 tsp. sesame oil
1/8 tsp. dashi no moto
Instructions:
1. Sauté garlic and ginger in oil.
2. Add pork. Cook for 5 minutes.
3. Add all the vegetables and stir fry for 2-3 minutes in high heat.
4. Season with salt, dashi no moto, soy sauce and sesame oil.
5. Serve while hot.

CARDIO & THE LAW
Waivers and Transfers
Doctors’ Emergency Issues at the ER

I am citing this theoretical case as a take-off point to give light to issues that often confront our colleagues at the emergency room.

The Case
A woman who was on her second pregnancy and in early stage of labor went to the emergency room of a private institution. She was irregularly seen at the charity clinic for pre-natal check-up. After having been appraised of the hospital cost and the patient fully assessed by the OB-Gyne resident to be in early labor with the baby in good condition, the patient was advised and decided to transfer to a government hospital as the family could not pay the deposit. A waiver for the transfer was signed. The patient was transferred to a government hospital but was denied admission due to a lack of NICU or nursery bed and was advised to transfer to another government hospital where the baby was assessed to be already dead. Understandably, the family was so angry that the event was posted on social media calling the doctors involved as killer doctors and other derogatory remarks that definitely tarnished their reputation and causing them so much anxiety and sleepless nights.

The issues:
1. Was the non-acceptance for admission and the subsequent transfer legal? Was the waiver valid?
2. What are the duties and responsibilities of residents in training?
3. Who takes responsibility for the liabilities that they may legally incur if proven negligent?
4. The issue of social media and cyber-bullying.

The Law
The issue on refusal to admit is fully covered by Republic Act No. 8344 which was approved last August 25, 1997. It is an act penalizing the refusal of hospitals and medical clinics to administer appropriate initial medical treatment and support in emergency.
or serious cases, even without a deposit. By inference, refusal to admit non-emergency and non-serious cases for whatever reason and their subsequent transfer is not punishable under the law. The only question here is what consists “emergency” and “serious” cases.

Emergency vs. Serious Case
The law defines “emergency” as a condition or state of a patient wherein based on the objective findings of a prudent medical officer on duty for the day, there is immediate danger and where delay in initial support and treatment may cause loss of life or cause permanent disability to the patient. On the other hand, “serious” case is defined as a condition of a patient characterized by gravity or danger wherein based on the objective findings of a prudent medical officer on duty for the day when left unattended to, may cause loss of life or cause permanent disability to the patient.

I am giving emphasis on the words above as these are the defenses available to the physician should a litigation ensue, and as in any civil or criminal case, the burden of proof lies on the complainant.

The Rule on Transfer
The institution may transfer the patient, preferably to a government hospital especially in the case of poor or indigent patients, only after appropriate initial medical treatment and stabilization is made, with consent of the patient or his next of kin and after the receiving hospital or medical clinic agrees to the transfer.

If the patient is unconscious, incapable of giving consent and/or unaccompanied, the physician can transfer the patient even without his consent but after it has been established that such transfer entails less risks than the patient’s continued confinement. Once the above basic requirements are met, other rules shall be taken into consideration. The transferring and receiving hospital shall be as much as practicable, be within 10 kilometer radius of each other and the transfer shall at all times be properly documented.

Hospitals may require a deposit or advance payment when the patient is no longer under the state of emergency and he/she refuses to be transferred. Admitting forms and transfer forms issued by the transferring hospital should accompany the patient with information of the vital signs, name of the attending physician, treatment given, name of receiving hospital, name of contact person and approving official at receiving hospital, consent of the patient or companion (not applicable to minor/unconscious and accompanied) and such other information the referring physician deems necessary. In case of refusal of transfer, the name of the hospital, the name(s) of persons who refused and the reason(s) for the refusal should be written in the ER Admission Form.

Penal Provisions
The medical officer who violates the above provision is punishable by imprisonment of not less than six (6) months and one (1) day but not more than two (2) years and four (4) months, or a fine of not less than Twenty Thousand Pesos (P20,000.00) but not more than One Hundred Thousand Pesos (P100,000.00) or both at the discretion of the court.

However, if such violation was committed pursuant to an established policy of the hospital or clinic or upon instruction of its management, the director or officer of such hospital or clinic responsible for the formulation and implementation of four (4) to six (6) years, or a fine of not less than One Hundred Thousand Pesos (P100,000.00), but not more than Five Hundred Thousand Pesos (P500,000.00) or both, at the discretion of the court.

Other Provisions
To demonstrate compliance, copy of the law and this implementing rules and regulations should be displayed prominently at hospital emergency rooms, hospital admission, counters and medical clinic premises. There should be an established hospital and billing procedure stating that billing should not commence until the essential appropriate treatment of emergency and serious cases has been completed; and definite instructions to personnel to provide prompt and immediate medical attention to emergency and serious cases without any prior requirements for payment or deposit.

It is clarified that the law and this administrative order covers only the provision of medical and surgical goods and services, and do not cover the provision of non-medical amenities which have nothing to do with the treatment of the emergency or serious case. The provisions of and payment for these non-medical amenities is subject to appropriate institutional business practice.

On Waivers
The law did not mention “waiver” in all its provisions but consent, and the two, though may release the parties from liability, have different prerequisites to be valid. In this particular case, what was signed was a waiver to transfer.

By definition, a waiver is the voluntary relinquishment or surrender of some known right or privilege. For a waiver to be valid, it must be made voluntarily and with the full knowledge (or the ability to know) of the right being waived, should be unambiguous and clear to a reasonable person, the parties to the waiver have equal bargaining power or on the same equal footing without undue pressure or duress to the one giving the waiver, and the terms in the waiver should not be against public policy or for an illegal purpose.

In some jurisdictions, it is limited and not enforceable for future rights. A consent on the other hand, has no established right or privilege for the party giving such. To be valid, there must be a disclosure of all the information and adequate comprehension needed to come up with a wise decision and this must be given voluntarily without external pressure such as coercion, manipulation,
Hypertension, is it time to SPRINT for change?

Tracking what we call hypertension nowadays may be viewed as a hot topic for discussion. As much as we could say to our patients that hypertension can be defined as having two blood pressure determinations of ≥140/90mmHg on two separate occasions under appropriate conditions, it may not actually be as simple as that.

We know that hypertension may be considered as a vasculopathy, and inflammation may also be present in the pathophysiological background. We therefore realize that patients whom we call as hypertensive likely also have other medical conditions such as diabetes, possess other risk factors, and even have at times target organ damage. That is why hypertension may not be the pure disease itself, but part of the bigger, nastier picture of the patient's general condition, with clustering of risk factors.

Different Folks, Different Strokes

The optimal blood pressure target for hypertension management is another matter. Most recent guidelines until 2013 had discussed that getting the blood pressure to less than 140/90mmHg for the general population is recommended. However, for patients 60 years old and above a target BP of <160/90mmHg should be considered. This higher threshold for this age group consider the possibility of higher incidences of orthostatic hypotension, syncope and other complications that may be encountered with an equally aggressive BP lowering strategy compared to younger patients.

And of course when these guidelines came out stating these differences in the approach to hypertensive patients based on age groups, it could not be helped that reactions and opinions would emerge. After all, patients had been treated without such dichotomy for many years until recently. The Prospective Studies Collaboration (Lancet 2002) had demonstrated that stroke and ischemic heart disease mortality are directly correlated with increases in systolic and diastolic blood pressure and advances in age.

Such puts emphasis particularly that the older the patients with hypertension, the higher the cardiovascular risk. A meta-analysis of outcome trials involving 15,693 elderly patients with isolated systolic hypertension (Staessen JA et al. Lancet 2000) showed that treating ISH when the systolic BP was greater than 160mmHg reduced total mortality by 13%, stroke by 30%, cardiovascular mortality by 16%, and coronary events by 23%. The results were more apparent in men, ages 70 above, and in higher risk patients. Stroke prevention had the highest impact with a number needed to treat of 48.

Hence the question is, are we doing the correct balancing act when considering the benefits and risks of blood pressure management in hypertension considering age?

Running the SPRINT results

A randomized control trial on intensive versus standard blood pressure control called SPRINT (NEJM Nov. 2015) enrolled 9071 high cardiovascular risk patients without diabetes or prior stroke. Patients were randomized to two treatment strategies targeting an SBP of <120mmHg for the intensive group and <140mmHg for the standard treatment group. Office BPs were determined using the OMRON automated blood pressure device.

After a median follow-up of 3.5 years, the primary outcome (composite of MI, ACS, stroke, CHF, or death from cardiovascular causes) was significantly lower in the intensive management group (HR 0.75 95% CI, 0.64-0.9). The reported number needed to treat was 61.

The treatment effects were driven primarily by significant reductions in heart failure, cardiovascular death, death from any cause, primary outcome or death. The improvement in the primary outcome was observed to begin about 12 months from the onset of the trial.

The treatment effect appeared to be similar across age groups, gender, race, presence of previous chronic kidney disease, previous cardiovascular disease, or ranges of systolic blood pressure (no heterogeneity).

Patients deemed to have resistant type of hypertension were also apparently excluded from the study. The researchers excluded diabetics for the SPRINT trial since such patients were not studied in the ACCORD trial.

SPRINT vs ACCORD

Some interesting differences between the SPRINT and the ACCORD trial: SPRINT trial had older patients averaging 67 years old (28% of which were ages ≥75). It is also noteworthy to mention that the SPRINT Trial is twice the size practically of the ACCORD study, and enrolled patients with observed 10-year CV Framingham risk score of 20. The ACCORD study likewise enrolled diabetic patients without CKD (target organ damage/established Cardiovascular disease subset), and hence cardiovascular risk stratification is arguably relatively lower risk. So perhaps both studies have complementary information for the clinician without necessarily having clashing conclusions.

The SPRINT trial did not demonstrate significant overall differences in serious adverse events. The investigators did report however, more cases of electrolyte abnormalities, hypotension, and acute kidney injury when targeting a systolic BP <120mmHg. Peculiar also was that orthostatic hypotension was less frequent in the intensive strategy arm, perhaps the doctors watched their patients like a hawk. This may also be the reason why falls reported were also less in the intensive strategy group.

However if you look at the absolute risk for the adverse event such as syncope (intensive arm= 3.5%, vs. standard arm= 2.4%, P = 0.03), the risk is small in occurrence for each subset of patients of 4600 plus.

Although adverse events are not a welcome occurrence for any of us, if we weigh the benefits and risks of attaining a systolic BP <120mmHg to hypertensive patients at high cardiovascular risk such as those patients in the SPRINT trial, there seems to be pretty impressive data for the clinician to consider adopting this management strategy.

We should also bear in mind that we have to get these high cardiovascular risk patients to their goal BP is likewise an important matter with the appropriate antihypertensive strategies, and be partners with our patients to the best of our ability. The ACCORD study was a long term study designed to target SBP <120mmHg. The SPRINT trial was a shorter term study designed to target SBP <140mmHg.

Heartlines Updates

By Richard Henry P. Tiongco II, MD, FPCP, FPCC

March - April 2016

...we have to get these high cardiovascular risk patients to their goal BP is likewise an important matter with the appropriate antihypertensive strategies, and be partners with our patients...
Yes, Insomnia is common in clinical practice

**CardioLinks**

By: Alejandro Bimbo F. Diaz, MD

**Finding reasons behind insomnia**

In spite clear definitions of sleep disorders, the diagnostic criteria mainly focus on associating the subjective complaint with contributing factors such as mental disorders or medical problems rather than identifying the underlying pathological mechanism (Bonnet, Burton, & Arand, 2014). Persistent sleep disturbances including insomnia and excessive sleepiness are considered risk factors for the development of mental illnesses and substance use disorders. A multidimensional approach is significant in providing a differential diagnosis with due consideration to coexisting medical and neurological conditions.

**As a practicing neurologist-psychiatrist, I have frequently encountered patients with problems in sleeping or insomnia as one of their primary concerns either as part of their main medical condition under treatment or as their main reason for clinic consult.**

One case for example is a stroke patient who I thought was having a post-stroke depression causing his insomnia. A more detailed history taking led me to conclude there was more than one reason causing his condition. To make the long story short, the patient had difficulty initiating sleep because of the recurring uncomfortable feeling in his legs every time he lies down to prepare to sleep. Indeed, my patient was suffering from a condition called Restless Leg Syndrome. The depression was more likely a consequence of his insomnia.

Many prescription drugs can interfere or disrupt the patient’s sleep. These include some anti-hypertensive and cardiac medications, certain antidepressants, stimulants for patients diagnosed with ADHD. Some over-the-counter drugs, which contain stimulants such as decongestants, weight loss supplements, anti-migraine pain medications, and caffeine, can cause insomnia. Taking coffee late in the day as well excessive alcohol intake may disrupt normal sleep. As one ages, the quality of sleep gets poorer. Also, the internal clock advances so that an older individual gets tired easier, thus he sleeps earlier and consequently, wakes up earlier.

**How much sleep is good?**

But how much sleep do we need? Young or old, generally we all need the same amount of sleep. I personally recommend seven to eight hours of sleep. A number of objective tests are utilized to determine primary insomnia patients in comparison to controls. The polysomnogram (PSG) is the most common test used, however, differences in PSG are less evident in patients with subjective complaints alone. Altered PSG results, primarily decreased total sleep time, is associated with significant clinical pathology. Medical risk in insomnia increases directly as total sleep time is decreased, as revealed by early-onset, REM sleep latency, and sleep architecture,

**Far from the more frequently thought of causes such as depression and anxiety, there are many causes of insomnia, both medical and non-medical. A good and thorough clinical history can usually reveal the possible etiology or predisposing factor of the patient’s sleep problem.**
In studies that used PSG measures to quantify insomnia pathology (Fernandez-Mendoza, et al., 2012; Vgontzas, Liao, et al., 2009), patients with insomnia have been shown to have disrupted circadian rhythms in adults. Benzodiazepine hypnotics have long been used as first-line treatment of insomnia. BZs are appropriate for short-term treatment, approximately less than four weeks, due to tolerance and dependence that may occur with long-term use. BZ withdrawal may cause several undesirable symptoms including anxiety, depression, insomnia, and irritability. Therefore, gradual tapering of the dose is recommended. According to some studies, non-benzodiazepine hypnotics are most efficacious as sleep-onset medications. There are fewer reports of next day impairment with non-benzodiazepines than with benzodiazepines.

In addition, there are few drug interactions with these agents. Zolpidem is most commonly prescribed for insomnia. Studies have shown that zolpidem is most beneficial as a sleep onset agent rather than for sleep maintenance. Rebound insomnia may occur with abrupt discontinuation. Antidepressants have not been approved for the treatment of insomnia. However, the use of selective agents may be effective in patients with co-existing depression. The delay in seeking medical care is one of the biggest disadvantages of using OTC products in the treatment of insomnia. Furthermore, opportunities are lost for more efficacious management of insomnia as well as diagnosis of underlying medical conditions.

Insomnia is considered as a common problem necessitating appropriate treatment approaches depending on underlying pathologies. Treatment generally involves a short period of time while insomnia left untreated and which is associated with an undiagnosed medical or psychiatric disorders.

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The prevalence of insomnia in adults has infiltrated in the past years. The common occurrence of insomnia is due to the morbidity and mortality (Reeve & Bates, 2010). The major causes of insomnia are sleep disorders, stress, anxiety, depression, and aging. In addition, the use of medications for insomnia has increased over the past years. However, the use of these medications is not recommended due to its potential side effects. Older patients are more vulnerable to anticholinergic properties of anti-histamines including urinary retention, dry mouth, constipation, blurred vision, memory impairment, orthostatic hypotension, palpitations, dizziness, grogginess and mental confusion. Of the herbs promoted for sleep enhancement, only melatonin and valerian have shown to have beneficial properties. The FDA has approved the use melatonin for the treatment of disrupted circadian rhythms in adults. Benzodiazepine hypnotics have long been used as first-line treatment of insomnia. BZs are appropriate for short-term treatment, approximately less than four weeks, due to tolerance and dependence that may occur with long-term use. BZ withdrawal may cause several undesirable symptoms including anxiety, depression, insomnia, and irritability. Therefore, gradual tapering of the dose is recommended. According to some studies, non-benzodiazepine hypnotics are most efficacious as sleep-onset medications. There are fewer reports of next day impairment with non-benzodiazepines than with benzodiazepines.

In addition, there are few drug interactions with these agents. Zolpidem is most commonly prescribed for insomnia. Studies have shown that zolpidem is most beneficial as a sleep onset agent rather than for sleep maintenance. Rebound insomnia may occur with abrupt discontinuation. Antidepressants have not been approved for the treatment of insomnia. However, the use of selective agents may be effective in patients with co-existing depression. The delay in seeking medical care is one of the biggest disadvantages of using OTC products in the treatment of insomnia. Furthermore, opportunities are lost for more efficacious management of insomnia as well as diagnosis of underlying medical conditions.

Insomnia is considered as a common problem necessitating appropriate treatment approaches depending on underlying pathologies. Treatment generally involves a short period of time while insomnia left untreated and which is associated with an undiagnosed medical or psychiatric disorders.
Unitive and procreative aspect of the conjugal act or marital act is inescapable. Second, each couple is called to responsible parenthood.

In artificial contraception, there is the unitive aspect but the procreative dimension is deliberately cut whereas in IVF, there is procreation without the unitive purpose because the meeting of the sperm and the egg happens in the petri dish. The technology replaces the conjugal act which makes it unethical.

In both cases, a radical separation has been introduced between the two essential elements of human reproduction. Like the two sides of a coin these two dimensions must remain together for the act of intercourse to be fully and truly human.

In other words, what makes the sexual act fully human (contrary to mere instinctive act of self-pleasure) is the radical generality that occurs precisely in desiring children and simultaneously desiring to give the total gift of self to the other.

That is why even if the gametes came from the husband and wife, IVF is unethical because fertilization happens in the laboratory. We do not have the freedom to change natural vital human acts. Thus, for human procreation to be ethical, the sperm must fertilize the egg in the proper place where nature intends, ie in the distal end of the fallopian tube of the wife (in vivo).

The fact that it can be done in a petri dish does not make it moral.

Currently, there is a method and achieved great success in case of multiple pregnancies, what happens if the couple only wants one? Embryo reduction is done by choosing the "best one." This is a form of "adultery in the petri dish".

Other Ethical Issues
In case of multiple pregnancies, what happens if the couple only wants one? Embryo reduction is done by choosing the "best one." This is a form of abortion.

What about the issue of sperm or ovum donor in case of same-sex relationships? Or in heterosexual couples, with either the husband or the wife having infertility problems?

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The ultimate purpose of marriage is procreation. A child, for that matter, is not a commodity, a possession, a thing or an object that we may or may not decide to have, similar to buying a car or a house. A child is a gift from God. All life, especially human life, is a gift from God. With such, to have a child is not a right, but a gift from the Supreme Maker.

Couples, however, do have the right to desire to have children. In fact, for marriage to be valid, in the Christian context, the couple has a responsibility to desire children. But whether offspring will come or not in spite efforts to conceive remains the prerogative of God. A couple's acceptance of their

On Artificial Conception
“... and you will be like gods” Genesis 3:5

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References:
Reflections

Calming Reflections from the Sea of Galilee

4.26.16

Nababagabag!

A Tagalog word meaning troubled, it happens when we experience a sense of anxiety over things or situations that we face, have no control of or that is not according to our liking. This word came to mind as I thought of the disciples’ boat ride on the Sea of Galilee where they encountered a storm and became afraid.

Matthew 14:24-27

“But the ship was now in the midst of the sea, tossed with waves: for the wind was contrary. And in the fourth watch of the night Jesus went unto them, walking on the sea. And when the disciples saw him walking on the sea, they were troubled, saying, It is a spirit; and they cried out for fear. But straightway Jesus speak unto them, saying, Be of good cheer; it is I; be not afraid.”

Nababagabag!

That is what we become when our focus deviates from Christ to our present circumstances. This can often result in a sense of drowning from our trials much like what Peter felt when he literally took his eyes off Christ as he walked over water and he began to sink.

Matthew 14:28-33

“And Peter answered him and said, Lord, if it be thou, bid me come unto thee on the water. And he said, Come. And when Peter was come down out of the ship, he walked on the water, to go to Jesus. But when he saw the wind boisterous, he was afraid; and beginning to sink, he cried, saying, Lord, save me. And immediately Jesus stretched forth his hand, and caught him, and said unto him, O thou of little faith.

wherefore didst thou doubt? And when they were come into the ship, the wind ceased. Then they that were in the ship came and worshipped.”

Nababagabag!

It reflects my feelings of uncertainty when I perceive things or situations to be contrary to my plans, much like the disciples did when they encountered yet another storm.

Luke 8:23-24

“Now it happened, on a certain day, that He got into a boat with His disciples. And He said to them, “Let us cross over to the other side of the lake.” And they launched out. But as they sailed He fell asleep. And

The Tranquil Freshwater Lake (Not Salt Sea) of Galilee

The Ancient Boat at the Boat Museum

A trip is not complete without St. Peter’s fish or fried tilapia and fries ;-)
Reflections

A windstorm came down on the lake, and they were filling with water, and were in jeopardy. And they came to Him and awoke Him, saying, “Master, Master, we are perishing!”

Nababagabag!
It is what I become when I forget that though things are out of my control, our God always is!

Luke 8:24,25

“Then He arose and rebuked the wind and the raging of the water. And they ceased, and there was a calm. But He said to them, “Where is your faith?”

Christ perceptively asked “Where is your faith?” Is our faith in other people? Is our faith placed on “boats” filled with man made “lifesavers” when what we need to do is to remember our life giving, life saving GOD who created and controls man, his inventions, circumstances and even nature itself.

The Psalmist wisely advised in Psalm 46:10 “Be still, and know that I am God.”

Quit struggling and “Be still!” The root word is raphe or to “slacken one’s pace and cease from struggles.”

Be quiet enough to ‘Know’ ‘Yada’ or consider that He IS GOD.

Why? Let us recount just a few of the thousands of reasons why we should be still in Psalm 46.

1 God is our refuge and strength, A very present help in trouble.

2 Therefore we will not fear, Even though the earth be removed, And though the mountains be carried into the midst of the sea;

3 Though its waters roar and be troubled, Though the mountains shake with its swelling. Selah

11 The Lord of hosts is with us; The God of Jacob is our refuge.

It is when I quit struggling that he can step in to quiet my restless soul. It is when I am quiet that I hear his still small voice saying “It is I,” I am with you, you are not alone - be not afraid! It is when I thoroughly and thoughtfully consider who He is that I come to fully know that God is who He says He is!

Yes Lord, when something that is happening is not according to my liking, help my uneasy soul to cease from its strivings and allow you instead to work out your best thought out plan in my life. Fret and fight no longer. Be still, and know that he is God!

♥
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