2014 PHA CAD Guidelines out

In Focus: CAD

A windfall: Product of Research-savvy heart docs
Editorial

What the guidelines tell us

In this day and age when a deluge of information and conflicting expert opinions exist in the field of medicine, recommendations to guide physicians in the care of patients are necessary to carry out the responsibility of promoting health for the general population. These guidelines are based, culled and born from best evidence defined by limitations imposed by time and space on financially expensive and logistically challenging scientific investigations.

Thus the general and practical attitude of a lot of countries, mostly Third World, outside North America and Europe to adopt, follow and be dependent on foreign clinical practice guidelines in the care of their patients in their respective local settings.

While the principles of management may be sacred and may not be challenged in general, the rules of delivery of care may be specifically challenging. Availability and cost of drugs and sophisticated facilities, the lack of technical skills and race and culture among several other factors may all pose as limitations to the full implementation of guidelines. These impediments deprive the patient of benefitting from ideal recommendations.

This is the reason why we congratulate the PHA Council on Coronary Artery Disease for the recent release of the first ever Philippine Clinical Practice Guidelines for the Management of Coronary Artery Disease. The Council has realized that in our local setting, we have different and special needs that foreign guidelines cannot answer. To realize such need is a very crucial initial step in the formulation of our own local recommendations that are deemed to be more appropriate for the care of our patients.

But beyond what the new local guidelines literally contain, we have to take on the challenges imposed by coming up with one.

The release of this set of recommendations necessitate the constant revisit and updating as needed. The political will and the undying commitment of the PHA leadership with the CAD Council is key to the perpetuity and applicability of these guidelines.

It is beyond debate that we need local guidelines to suit our needs in the local setting. Thus, it is logical that we need local data to fuel local guidelines. The great challenge, therefore, is to produce local data through the conduct of clinical trials, researches and other scientific investigations specifically directed towards answering what Philippine health care in the field of cardiology needs.

But the greater challenge is how to involve and obtain the support of the national government, or at least NGOs and interested parties perhaps, in conducting these investigations and researches that will provide data needed to formulate recommendations of national health interests. We must constantly remind ourselves and the Government that cardiovascular diseases remain to be the leading causes of mortality and morbidity in the country.

Moreover, the PHA in general, and the CAD Council in particular are now

See Page 39
12  Latest CAD Guidelines: A Boon
Peruse the 2014 PHA CAD Guidelines. How soon can we wean ourselves from foreign guidelines? Find out what the experts say.

25  PHA CME Program’s coffers gets P2.1-M grant from Pfizer Phils.
MOA signing sealed on Pfizer’s 60th anniversary.

15  On CAD Guidelines...
Well-written and easy to read
By Timothy C. Dy, MD

columns

32  Lay Forum
You heart and exercise
By Homobono B. Calleja, MD

33  Escape Beat
Saving lives while dying
By Saturnino P. Javier, MD

35  Opinionated MD
Facts & myths about exercise
By Celine T. Aquino, MD

special report

The Warays move on...
The author, Dr. Leila Diaz, witnessed Yolanda’s wrath. She recounts how her beloved birthplace and strong-willed kababayans carried on... coped and rose above the heartbreaking tragedy.

PHA NewsBriefs • November – December 2014 3
As we end another year in the history of the Philippine Heart Association and usher in a new one, let me share to you the Top 10 stories of the PHA Newsbriefs for the year 2014:

1. PHA holds First Out of Town Heart Month in Cebu, Launches 52100. The new tagline of the PHA’s healthy lifestyle advocacy was launched during various activities in celebration of Heart Month. Cebu became the first out of town venue of Heart Month as it was commemorated on February 15, 2014. The tagline, “52100” stands for “5 servings of vegetables and fruits, not more than 2 hours of video and TV time, 1 hour of exercise or physical activity, 0 sweetened drinks and soda, and 0 smoking”, in order to stay healthy and avoid cardiovascular diseases.

2. 3rd Acute Coronary Syndrome (ACS) Summit Focuses on Barriers to Optimizing Medical Treatment in ACS. The 3rd ACS Summit was held in University of Santo Tomas Hospital on Jan. 25, 2014. Part of the highlights of the meeting was the data presented by the Council on Coronary Artery Disease (CAD), focusing on the findings from the PHA ACS Registry. Non ST Elevation Myocardial Infarct was the most common ACS condition, while hypertension was the most common risk factor. Majority of the patients were managed medically, with financial reasons cited as the main factor for the delay or refusal of pharmacological or interventional reperfusion strategies.

3. Heart Healers lend a Helping Hand After the Storm. The PHA staged “After the Storm”, a fundraising concert to provide assistance to those affected by the Yolanda Supertyphoon in Tacloban. The concert was held last January 25, 2014 at the Philippine Heart Center DAPA Hall. The musical event featured performances from several PHA personalities and veteran performers from the entertainment industry such as Noel Cabangon, Cocoy Laurel, the UP Concert Chorus, and Fortenors.

4. The PHA Invades the American College of Cardiology (ACC), Makes History. See Page 24
Eventful November & December

In November and December, a dynamic JMA attended a series of meetings, formal occasions and social bashes—from induction, Council consultations, MOA signings, launchings, workshops to Christmas parties.

Nov. 04, Philippine Society of Echocardiography Induction of Officers; Nov. 07, Heart Failure Registry; Nov. 10, Core Give Pfizer MOA Signing; Nov. 12, Council on Women’s Health Meeting; Nov. 17, Dinner Meeting with Otsuka; Nov. 18, Cardiac Cath Meeting on Registry; Nov. 22, Real World Practice Workshop; Nov. 27, CAD Guidelines Launch; Dec. 02, Meeting on AF Registry with Pfizer; Dec. 04, PHA-Pharma friends Christmas Party; Dec. 09, Council on Congenital Heart Disease Presentation of protocol of CHD Registry for submission to the Research Committee and Dec. 20, PHA Staff Christmas Party.

“The PHA CAD Guidelines launch got strong representation from the cardiology circuit and generated impressive media exposure from the Philippine Daily Inquirer, Philippine Star, GMA 7 Online, Medical Observer, Net 25, DwIZ, People’s Journal and Pinoy Lifestyle”, JMA told his colleagues during the Dec. 2014 Board meeting.

In photo: JMA with PHA CAD Council chair Dr. Victor Lazaro (L) and Vice President Alex Junia (R) during the PHA CAD Guidelines Media Launch at the Joy Nostalg Oakwood Hotel on Nov. 28, 2014.


El Presidente dropped by the Heart House to personally hand his personal gifts and the Board’s Christmas tokens for the 12-member PHA Staff, led by Gina Capili-Inciong (L) despite a hectic sked and the bumper-to-bumper traffic.

PHA President Dr. Joel Abanilla and Pfizer Phils. Medical Director Dr. Cristobal Duno formalize the PHA-Pfizer deal.
For 17 years, they had a cloistered life through pre-med, medical school and trainings. These senior PHA Fellows-in-Training are required to attend the one-day 10th Real World Practice, a forum for the young heart doctors to concretize their decisions on which career path to take; learn about legalities, investments and BIR matters; and to be reminded about golden values.

For 10 consecutive years, the Natrapharm Patriot Pharmaceutical Corp. has been a staunch supporter of this Continuing Medical Education activity of the PHA. Held on Nov. 22, 2014, it was held at the Patriot Pharmaceutical Corp. building in Parañaque City.

Dr. Nannette Rey, PHA director and concurrent CEPC co-chair, the moderator, deftly gave insights on a gamut of situations. She said “your mentors want to see you go equipped with the essentials as you venture into the vast world.”

The speakers and their words of wisdom:

**The Paperless Clinic**
*Dr. Pedro P. San Diego Jr.*

“Initially, your basic tools are an electronic stethoscope, laptop, desktop and your cell phone. You can never go wrong with having your electronic medical records in soft copy, backed up by a hard copy. This makes it easier for your secretary to do a demographics of your patients. Bank your file photos on Icloud”.

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*HeartNews*
Establishing a practice
Dr. Francis Lavapie

“At the outset, finalize your road map in life. If you decide to practice in the province, be ready to be a well-rounded and service-oriented clinician especially to the less-fortunate. Be an active community member. As early as my training days, I knew I will join my pediatrician wife who had set up a clinic in San Jose (in Nueva Ecija) where we would settle. I was bent on establishing a family and career with her. Living in the province is not as stressful as city living and traffic is smooth.”

Setting Professional Fees
Dr. Leah Mabilangan de las Llagas

“Practice is not all about making money. It is about earning respect, experience and excellence. When you start, remember the 4As -- ability, amiability, accessibility and affordability. Your dictum should be to give your patients proper care. Don’t just cancel clinic because you have an obligation to your patients. Your satisfied parents will be the ones who will give you referrals. Don’t forget to adhere to what is moral and ethical. Adapt to the locality. Stay within the range of the going rate. If your fee is way above the standard rate, you will not get referrals.”

The Researcher
Dr. Tony Dans

“A clinician and researcher has the cutting-edge. It helps when clinicians are advocates because they have an extensive network and people listen. You don’t have to be the trunk of the tree. You need to train. There are low-budget, high-impact studies. The prize of research is not a contest. During your Fellowship, decide if you will stay in the country or abroad. If you’re leaving, don’t waste your time here. You should respect your fellow doctors. Establish camaraderie, don’t be dominating. Be ready to be an internist. Build rapport with your patients. Add spice and humor to life. Be considerate to the less-privileged and get involved in community service. Put spirituality in your practice.”

The Academe
Dr. Ardith Dominguez-Tan

“I love mentoring and nurturing. There is nothing more enjoyable than to impart knowledge. If you survived a very serious illness you have more appreciation for life. You will handle lives, not livestock. Let me quote these lines from Confucius: “walking with two other men, each of them will serve as my teacher. I will pick out the good points of the one and imitate them, the bad points of the other and correct them in myself.”

Complying with PhilHealth, Accreditation & IC 10 for Cardiac Diseases
Dr. Marc Antony Cepeda

“You get compensated for your services. Renew before your birthday. How to Save for the Future & Early Retirement “My job is to study my clients’ money patterns. Have a wealthy mentality. Wealth begins in your mind. Some people are poor because of their mindset. Money has an attached emotion. Find ways to put spirituality in your practice.”
to generate income. Spend only 50 percent of your money. You have to have a strong EQ (emotional quotient), the ability to deal with people to survive. Let me share the SM (Shoe Mart or Senen Mendiola) formula: The wealthy mindset saves 30 percent of his income, buys stocks and invests in real state.” Senen Mendiola is Henry Sy’s long-time business associate partner, adviser and accountant.

Rey calls him the Money doctor.

**Taxes, Fees & Licenses**
*Atty. Kerwin Tan*

“"You have to be brain smart and street mart. My job is to tell you how to preserve your millions; teach you withholding tax compliance; and the steps in negotiating with the Bureau of Internal Revenue and application for registration forms 1903 and 1901. The three great illnesses in our society are: Hedonism, materialism and lack of sense of God.”

**Medical Ethics**
*Dr. Edna Monzon*

“Avoid fee splitting. No commission. No kickbacks. We should not ask the pharma company to subsidize our personal needs. Half the world are in the wrong sense in their pursuit for happiness. They think it consists of giving and receiving. On the contrary, it consist of giving and sharing.”

**Power Dressing**
*Dr. Juliana Tamayo*

“Style is different from fashion. The Golden rules on how to dress for success:

Look current: make sure your investment buys have a timeless look and feel so you can jazz them up for the occasion. Never worry about wearing the same outfit style all the time as long as it looks great on you.

It is nice to know that while fashion come and go you can go on looking your best year after year.

Let me share a quote from Tom Ford, Gucci: ‘Once you find something that works, keep it’.

Doctors have to be appropriately dressed. The men and ladies have to go for the corporate or smart casual look. The ladies’ dress or skirt should be below-the-knee length. Take note of the business etiquette: Have a pleasant attitude. Always smile and say please. Never run out of business cards. Make sure they are never wrinkled or scribbled upon. They are a personal reflection of you.”

**The Corporate MD Medical Director**
*Dr. Ma. Rosario Sevilla*

“Why would a cardiologist take up the challenge of being a medical director? To some it is an advocacy. It is a way of bringing evidence-based medicine into pharmacy; influencing change in industry practice and modifying MD behaviour. It is an avenue to see how your skills measure up to a company requirement. It is a new environment for someone who is bored with practice and teaching.

Here are the positions to cast your sights on.

In the Corporations: NGO or non-profit companies (WHO, Unicef, Doctors without borders -- medical consultants, program manager and adviser.

Health/hospital management: institutional positions, chief of clinics, medical director, hospital administrator and institute director.”

*From l: PHA Board of Directors -- Drs. Jorge Sison, Joel Abanilla, Helen Ong-Garcia and Nannette Rey*
Focus: Coronary Artery Disease
Dissecting CAD

By Marcellus Francis L. Ramirez, MD

What is CAD?
It is a condition characterized by narrowing of the blood vessels supplying the heart muscle which are called “coronary arteries”. The narrowing may be brought about by cholesterol deposition (termed atherosclerosis), a blood clot, or spasm of the blood vessel itself leading to decrease in blood flow or ischemia.

What are the signs and symptoms of CAD?
CAD usually presents with a characteristic chest pain called “angina”. This is described as heaviness or oppressive or throbbing type of discomfort in the center of the chest. It may radiate to the neck, the jaw, the shoulders, the left arm, and the upper abdominal area. Usually the pain or discomfort is precipitated by effort or stress, whether physical or emotional stress, and relieved by rest or intake of medications. This condition is generally called Chronic Stable Angina.

Other accompanying symptoms of the pain include shortness of breath, cold sweats, and nausea.

Sometimes, CAD may present initially as a heart attack, which is due to sudden complete blockage of the coronary vessel brought about by rupture of the cholesterol plaque which leads to a blood clot that occludes the artery. The obstruction causes the specific heart muscle supplied by the artery to die. These patients present with a more severe type of chest pain that occurs even at rest, and is not relieved by medications. This condition is termed Acute Coronary Syndrome.

In rare occasions, a CAD may present fatally as sudden death or cardiac arrest.

Sometimes though, CAD may present with no symptoms at all.

What are the risk factors that predispose one to develop CAD?

<table>
<thead>
<tr>
<th>Risk Factors for Atherosclerosis/CAD</th>
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<tr>
<td><strong>Uncontrollable</strong></td>
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<td>• Sex</td>
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<td>• Hereditary</td>
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<td><strong>Controllable</strong></td>
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<td>• High blood pressure</td>
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<td>• High blood cholesterol</td>
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<tr>
<td>• Physical activity</td>
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<td>• Diabetes</td>
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How is CAD diagnosed?

Patients with clinical manifestations of CAD or those with risk factors to develop CAD must consult a physician so that they can be properly worked up and assessed. A detailed history and clinical examination is usually the first step. Diagnostic tests which are usually done include an electrocardiogram (ECG), a chest X-ray, and several blood chemistry tests to evaluate for risk factors for CAD (glucose, cholesterol, triglycerides, HDL, LDL). A 2-dimensional echocardiogram may be requested to evaluate heart structure and function.

Patients may then be screened for CAD using a variety of cardiac imaging tests. The exercise treadmill stress test is the most common initial screening test. Other examinations may include a stress echocardiogram or myocardial perfusion scan.

How is CAD managed or treated?

Many people are able to manage coronary artery disease with lifestyle changes and medications. Lifestyle modification should include a low-cholesterol diet, regular exercise, weight reduction, smoking cessation, and stress management. Control of risk factors such as hypertension and diabetes is very important. Medications for CAD include antiplatelets such as aspirin or clopidogrel, beta blockers such as metoprolol, bisoprolol or atenolol; nitrates; calcium channel blockers like diltiazem, verapamil or amlodipine; statins such as simvastatin, atorvastatin and rosuvastatin; and ACE inhibitors or angiotensin receptor blockers. Regular follow up with the physician is vital.

Other people with severe CAD may need intervention in the form of angioplasty or surgery.

Coronary angiogram and angioplasty

Coronary angiography is the definitive diagnostic procedure for CAD. Angioplasty is a therapeutic procedure for CAD. These are performed in a specialized unit inside the hospital called the Cardiac Catheterization Laboratory, or Cathlab.
Fig. 6. Coronary angiography consists of insertion of a catheter into the arteries of either the upper or lower extremities, and advancing this into the heart in order to visualize the coronary arteries.

Fig. 7. Angioplasty: a balloon catheter is passed through the guiding catheter to the area of the coronary artery that is narrowed. The angioplasty catheter is moved over a guide wire until the balloon is within the narrowed segment. The balloon is inflated, compressing the plaque against the artery wall, until the artery has been sufficiently opened.

Fig. 8. Coronary Stenting: a stent is introduced into a blood vessel on a balloon catheter and advanced into the blocked area of the artery. The balloon is then inflated and causes the stent to expand until it fits the inner wall of the vessel, conforming to contours as needed. The balloon is then deflated and drawn back, while the stent stays in place permanently, holding the vessel open and improving the flow of blood.

Fig. 9. Coronary artery bypass surgery (CABG) consists of harvesting a healthy blood vessel from the leg, arm or chest. This blood vessel is used to create a new blood flow path in the heart and is used to connect two blood vessel in order to "bypass" the blocked portion of the diseased artery. This enables blood to reach the heart muscle that is originally supplied by the blocked artery.
2014 CAD Guidelines out

In a span of five years, there are a lot of new, more suitable means in fighting coronary artery diseases (CADs). This is why the Philippine Heart Association (PHA), the professional organization of cardiovascular specialists in the country, published the revised “2014 Philippine Clinical Practice Guidelines for the Management of Coronary Artery Disease.” The booklet is an updated edition of the 2009 guidelines that the PHA published, containing advances in medical knowledge on CADs and local clinical practice, as reflected in the ongoing PHA Acute Coronary Syndrome Registry.

Speaking during a media briefing last Nov. 27, PHA president Dr. Joel M. Abanilla said the guidelines will enable Filipino medical practitioners, especially the frontliners—those who firstly and primarily deal with CAD patients—to detect and manage CADs better.

“It aims to assist Filipino physicians in making clinical decisions in the management of CADs and ultimately to improve the quality of care of Filipino patients with this life-threatening disease.”

The guidelines incorporate the latest international and local studies on the pathophysiology, diagnosis, treatment and prevention of CAD; and fine-tune their findings to make them relevant and applicable in the local setting, Abanilla said.

Dr. Victor L. Lazaro, chair of PHA Council on Coronary Artery Disease, added that the 2014 guidelines contain new recommendations on the use of new medications, such as anti-platelets and heart-rate-controlling medicines, and new machines.

The guidelines are for general practitioners, family physicians, ER (emergency room) doctors, nurses, internists, cardiologists and other medical personnel, with the latest proven recommendations classified as “strongly recommended,” “recommended,” and “may be recommended” for specific treatments and modalities.

Burden of CADs

CADs occur when the coronary arteries—the major blood vessels that supply the heart with blood, oxygen and nutrients—become damaged or diseased, usually through the accumulation of cholesterol-containing deposits or plaque in the arteries and the inflammation this causes, said Dr. Myra Dolor-Torres, chair of PHA task force on stable ischemic heart disease. The resulting decreased blood flow may cause chest pain or angina, shortness of breath, etc., and a complete blockage can cause a heart attack, said Dr. Sue Ann R. Locnen, chair of PHA task force on non-ST...
elevation myocardial Infarction.
The burden of CADs in the country is significant, since cardiovascular diseases not only rank among the country’s top 10 causes of sickness, but also among the top killers of Filipinos. According to the Department of Health, 170,000 Filipinos die yearly because of cardiovascular diseases.

The main risk factors of CADs include smoking, diabetes, high blood pressure, high cholesterol, sedentary lifestyle, obesity and family history of the diseases, said Dr. Imelda Caole-Ang, chair PHA CAD Registry.

Dr. Liberty Yaneza, immediate past chair of the Council on CAD said, “the revised guidelines can be a tool to help combat CAD. The guidelines can help lessen incidents and deaths caused by CADs by helping the physicians make clinical decisions. The effort is just one of PHA commitments ‘to elevate the standards of local cardiology education and care for everyone.”

Sponsored by AstraZeneca Philippines, the guidelines will be distributed starting next year through the 11 PHA chapters nationwide. Distribution of the booklet will continue for the next two years. The booklet will also be available in an e-book form, downloadable from the PHA website.
BACKGROUND

The Philippine Heart Association (PHA) Council on Coronary Artery Disease (CAD) published in 2009 the first edition of the Philippine Clinical Practice Guidelines on CAD. Since then, there have been a lot of advancements in the field of Cardiology (particularly on CAD). And together with the two year results of the Acute Coronary Syndrome (ACS) registry, the Council on CAD was able to incorporate local data in writing these new set of Clinical Practice Guidelines.

OBJECTIVE

It has been the objective of the PHA through its Council on CAD to formulate local guidelines that will improve the quality of health care among Filipinos with CAD. Specifically, guidelines were written to assist all Filipino health care providers (especially the frontliners; physicians – whether Emergency Medicine, Family Medicine, Internal Medicine, Cardiologists; as well as nurses and paramedical services) in diagnosis and management of CAD. It aims to define the standard of care for CAD and to make it relevant to existing international guidelines and suitable to local practice.

HOW WAS THE CPG FORMED

The CPG writing group was made of three task forces, one for each clinical presentation of CAD: 1) stable ischemic heart disease (previously chronic table angina pectoris); 2) non-ST elevation ACS or NSTEMI-ACS (previously Unstable Angina/NSTEMI) and 3) ST elevation myocardial infarction or STEMI. Each task force has its own set of members and recognized experts.

Members and experts of each task force specialized in different fields of Cardiology – general cardiology, echocardiography and non-invasive imaging, invasive cardiology, critical care and thoracic cardiovascular surgery. Each task force conducted countless meetings and consultations to come up with its own set of guidelines. Presentations to the other task forces as well as to the current board of directors of PHA and to all stakeholders (including Philhealth, Department of Health/DOH, Philippine Medical Association/PMA, Philippine Nurses Association/PNA, Emergency and Family Medicine and Philippine College of Physician) were also made.

DIFFERENCE FROM WESTERN GUIDELINES

The grading of recommendations was patterned after the recommendation used by the American College of Cardiology/American Heart Association. However, statements were more simple and more direct than its Western counterpart. Class I, IIa, IIb and III recommendations were revised to “strongly recommended”, “recommended”, “may be recommended” or “not recommended”.

DIFFICULTIES IN IMPLEMENTATION

What is new from these guidelines was the emphasis on Pre-Test Probability (PTP) of disease that will influence the physician in their approach to the diagnosis; importance of non-invasive imaging; responsibility of the health professionals to give guideline-directed medical treatment; and consider invasive management with an expected benefit to the patient’s prognosis and symptoms.

SIHD

Formerly known as the Chronic Stable Angina Pectoris, the Stable Ischemic Heart Disease (SIHD) is the stable presentation of the entire spectrum of IHD. A total of 25 statements were written and proposed by the task force. Statements 1 to 22 consider patients who have first manifestation of angina with suspected IHD and assessed to be in a chronic stable situation. Statement 23 deals with patients with angina with normal coronary arteries (microvascular angina). While statement 24 deals with patients who have refractory angina and the last statement considers asymptomatic patient at risk for CAD.

What is new with the present guidelines were the emphasis on Pre-Test Probability (PTP) of disease that will influence the physician in their approach to the diagnosis; importance of non-invasive imaging; responsibility of the health professionals to give guideline-directed medical treatment; and consider invasive management with an expected benefit to the patient’s prognosis and symptoms.

NSTEMI

The other two presentations of CAD, comprise acute coronary syndrome, with (STEMI) or without ST elevation on ECG (NSTEMI/UA). In the recent report of PHA ACS registry, the mortality rate for ACS was 7.8%. The local event rate for mortality for NSTEMI was 8.9% and higher than...
The 2009 PHA CAD Guidelines was a culmination of efforts from multiple cardiology specialties, spearheaded first by Dr. Myra Dolor-Torres and later brought to completion by Dr. Liberty Yaneza. It was a coup de grace for local cardiology to have its own guidelines. And it was an extremely well-thought-out piece that took into consideration the large body of evidence in CAD treatment internationally, and then translating it into practical terms for local physicians to use.

Well-written and easy to read

By Timothy Dy, MD

Fast forward six years to 2015, the PHA has now published its new CAD guidelines. Leafing through its 120 pages, one will find once again an extremely well-written and easy-to-read document that is both concise and comprehensive. The current guidelines were deemed necessary as there are treatment changes in the last six years that have made it to mainstream cardiology that were obviously not part of the 2009 publication. In addition, the PHA ACS (Acute Coronary Syndrome) Registry that was started in 2011 has gathered important and interesting information on how CAD is being treated in the Philippines along with data on adherence to guidelines and what the outcomes have been. Information from the ACS registry have now been included in the new guidelines to provide a snapshot, or an evaluation if you will, on how local cardiologists treat patients with CAD and how we compare with what is recommended, indirectly pointing to us where we can potentially improve as a group.

As in the initial publication, the current guidelines are divided into three parts: 1. Stable ischemic heart disease (SIHD), 2. Unstable angina and non-ST elevation myocardial infarction and 3. ST-elevation MI. Each of the three topics are once more thoroughly reviewed. Many of the sections are largely similar or identical to the previous guidelines with the addition of several new statements.

I. Stable Ischemic Heart Disease

For SIHD, there is new emphasis on the long-taught use of Pre-test Probability (PTP) in ordering diagnostic examinations. Drawing from the Bayesian theory, the guidelines for stable CAD now emphasize assessment of the likelihood of CAD and take this into consideration when ordering further diagnostic tests. The goal would be to decrease the likelihood of false positives and false negatives that come with ordering these examinations.

The current guidelines for SIHD likewise take into consideration advances in interventional cardiology, emphasizing the new-found ability to assess the functional significance of any anatomic lesion noted on coronary angiography. The advent of Intravascular Ultrasound (IVUS) and Fractional Flow Reserve (FFr) as additional tools in the cardiac catheterization laboratory may help identify lesions that would require further treatment with revascularization.

II. Non-ST elevation ACS

For the section of Non-ST segment elevation ACS, the new statements concentrate on the advent of newer anti-platelet agents like ticagrelor and prasugrel. It also emphasizes the importance of identifying, as well as considering transfer of a high-risk patient to a facility with more comprehensive faculties. This takes into consideration the fact that many patients in our country still present first to a facility closest to their home or work, and that this facility may not be a tertiary care center.

Data gleaned from the PHA ACS Registry is likewise used in this section to come up with ‘number needed to treat’ (NNT) data for certain agents, giving clinicians a clearer idea of the impact of these regimens in the patient population.

Cardiac rehabilitation is now also emphasized in this section, highlighting its importance in decreasing long-term morbidity and mortality in CAD patients.

III. Acute ST-Elevation ACS

In the last section that deals with ST-elevation MI (STEMI), there are eight new statements, representing the biggest increase in the 3 subsections. These highlight the

See Page 29

Dr. Timothy Dy is the chair of the PHA Website Committee and the former chair of the Council on Cardiac Catheterization and Intervention. A former PHA Director, he was a member of the Writing Committee of the 2009 CAD Guidelines.
In 2009, the PHA Council on CAD published the Philippine Practice Guidelines (CPG) on CAD, which included guidelines on chronic stable angina pectoris (CSAP), unstable angina or non-ST elevation myocardial infarction (UA/NSTEMI), and ST-elevation myocardial infarction (STEMI). The complete objectives of the CPGs were as follows:

**General Objective:**
To improve the quality of health care among Filipinos with CAD.

**Specific objectives:**
- To assist Filipino physicians in making clinical decisions in the management of CAD.
- To define the standard of care for CAD in the local setting.
- To make existing international guidelines more clinically relevant and applicable to local practice.

Since then, there have been several studies that contribute to a new knowledge base about the pathophysiology, diagnosis, treatment, and prevention of CAD. Further, the two-year year data results of the ongoing PHA-Acute Coronary Syndrome Registry (PHA-ACSR) have also been useful in the formulation of these updated guidelines as the former reflects real world practice in our local setting. These present guidelines aim to update the 2009 Guidelines with this new knowledge base.

The CPG Writing Group was composed of three Task Forces, one for each clinical presentation of CAD (i.e. stable ischemic heart disease [SIHD]; non-ST elevation acute coronary syndrome [NSTE-ACS], and ST elevation myocardial infarction [STEMI]). Each task force reviewed the 2009 statements and updated international guidelines; and graded major published literature for CAD from 2009 until the present.

Each task force with their own set of members and panel of recognized experts had several meetings not only among themselves but also consultative meetings with other Task forces to discuss each one’s recommendations and for consideration of any additional inputs from the other task forces. Eventually, statements were presented to the current board of directors of PHA and subsequently to all stakeholders that included Philhealth, the Department of Health, Philippine College of Physicians, among others.

After review, the Task Forces proposed new/revised statement of recommendation, where applicable. The grading of recommendation proposed by the American College of Cardiology/American Heart
Association (ACC/AHA) was followed but stated in a simplified manner. The statements “strongly recommended”; ‘recommended’; ‘may be recommended’; or ‘not recommended or contraindicated’ were used similar to class I, IIa, IIb and III recommendations proposed by the ACC/AHA respectively.

The statement “strongly recommended” means that the procedure or treatment should be performed or administered based on sufficient evidence from multiple randomized trials or meta analyses.

The statement “is recommended” means that the procedure or treatment is beneficial or effective based on sufficient evidence from single randomized trials, meta analyses, or expert opinion.

The statement “may be recommended” means that the procedure or treatment is useful or effective although with some conflicting evidence from one trial to another.

The statement “not recommended or contraindicated” means that the procedure is not useful or effective and may be harmful based on sufficient evidence from multiple/single, randomized/non-randomized trials or meta analyses.

Majority rule applied in adopting statements that would be most suitable to the local community where disagreements existed.

These CPGs are divided into three parts: One for each clinical presentation of CAD.

It must be emphasized that these guidelines should not be regarded as absolute rules, but merely as frameworks to assist clinical practitioners in the management of patients with CAD. The approach to each patient must be individualized to take into account the overall clinical picture. The healthcare provider should apply his sound clinical judgment particularly when confronted with inadequate medical facilities, limited financial resources, or when faced with unique clinical scenarios for which no set recommendations may apply.

These guidelines relied heavily on published foreign guidelines due to scarcity of large-scale local studies on CAD. Expectedly, some recommendations may not be applicable in certain communities due to limited health resources. To address this challenge, some recommendations were modified to render them suitable to local practice. Nonetheless, local data including information form PHA ACS Registry were integrated whenever possible.

The Council on CAD will also create a task force to ensure the dissemination and monitor the implementation of these CPGs. The latter will hopefully provide meaningful research questions for future studies in the Philippines and answer some questions related to health outcomes and practices.

**PHAN: Can you describe what are the major feature or features of this guideline?**

**VL:** The major feature of the 2014 PHA CAD guidelines is the addition of some statements based on local data (CAD registry), the guidelines were tailored to fit the need of our local society and the addition of new medications and approach to the management of CAD.

**Is there a previous version of the PHA CAD Guidelines? How different is this new one from that and what are the important changes?**

The first Philippine guideline was released in the year 2009. The differences from the previous are listed above.

**PHAN: Why was there a need for the CAD Council to come up with this new guideline?**

The previous guideline was mostly based on international guidelines, thus the new guidelines incorporated some local data. The new guideline was also tailored fit to suit the Filipino patient and hospitals. In addition, newer approaches to CAD as well as new medications are now included in international guidelines, which can be adopted to the present Philippine guidelines.

**Are the recommendations in this guideline based on local data, local trials, or local consensus? Or are these still based on international data?**

Majority of the statements come from international guidelines and data, but local data has been included.

**Can you describe how different is this guideline from the ACC/AHA Guidelines? How different is it also from the ESC Guidelines?**

Consideration was given to the local setting, such as transport, cost, etc. This makes our guideline tailor fit to the Filipino society.

**Is there a plan to update this in the future? If so, when?**

There are plans to update the guideline in the future. Updates can come if there are any new approaches, modalities, medications in the treatment of CAD. The previous guideline came up with an update after 5 years. Maybe an update can be done within 5 years depending on both local and international data.

**Among the ASEAN Countries, are there any countries that also have local guidelines on CAD.**

I'm not sure about ASEAN countries who have CAD guidelines. According to Dr. Abanilla, he mentioned during the launch that only a few have guidelines (approximately 3).
The Council on Cardiac Rehabilitation was one of the original Councils of the Philippine Heart Association, formed in 1982. It aims to improve the application of cardiac rehabilitation in the care of post-cardiac surgery and post-myocardial infarct patients, as well as promote awareness on the benefits of cardiac rehabilitation. Today, it implements its programs in joint agreement with the Cardiac Rehabilitation Society of the Philippines. The newly inducted chair is Dr. Carlos Esguerra.

Can you briefly relate the circumstances that led you to become the Chairman of the Council on CARDIAC REHAB?

I have been a council member for many years and suddenly Helen Ong-Garcia on her second year as council chair for the PHA Council on Cardiac Rehab, was elected board member of the PHA. That left the position vacant. She made a shortlist of three names to Dr. Eugene Reyes and the latter chose me. So I’m not exactly new, this is my second year and hopefully to finish by 2016 May.

Briefly describe the objectives of the Council.

To promote and increase awareness of cardiac rehabilitation in the country
To collaborate with specialty society (CARESP or PACVPR) and be aligned with cardiac rehab activities, registry and formulation and implementation of guidelines

What objectives have already been met?
Guidelines in setting up a Cardiac Rehab Program was published in 2009 although may need an update
Collaboration with CARESP on ongoing data extraction on the utilization of Cardiac Rehab in ACS registry of the PHA

What objectives still need to be fulfilled?
There is still a lot to be done regarding cardiac rehab in the country. What is happening is that more and more patients require cardiac rehab and evidence-based guidelines have given Class IA level of recommendation for acute MI, IIA for CHF. And these services are concentrated in the tertiary hospitals. There still needs to have more cardiologists involve and become advocates of cardiac rehab in this country. The ideal situation is to set up cardiac rehab societies in each region in the country and have their promotional/educational campaigns in alignment with the PHA council and with guidance of component societies such as the CARESP or PACVPR.

What are the current programs that you are undertaking/working on in your Council?
We want to know how Cardiologists behave as far as referring patients to cardiac rehab in the institutions at least that are involved in the Acute Coronary Syndrome Registry of the PHA Council of CAD. We will do data extraction on the utilization rate of Cardiac rehab in this registry at least. It may not represent national practice but at least may give us an idea of what the utilization rate is in these tertiary hospitals with Cardiac rehab units. A lot of information may be garnered from this project.

Do you think the length of time of your term as Chair is enough to accomplish the programs that you have planned for your Council?
Any term may not be enough or can be enough depending on the goals one has for the council.

How would your Council contribute to the overall PHA goal/vision?
In small ways, to promote cardiac rehab and increase its awareness and that it is an essential component of cardiovascular care.

Name: Carlos Ponciano R. Esguerra, MD
Age: 56
Institution: The Medical City
Medical school: UERMMMC
Training institution in Cardiology: St. Luke’s Heart Institute
Present positions: Section Head in Cardiology, The Medical City; Consultant Director-Cardiac Rehabilitation Unit of The Medical City
Clinic affiliations: The Medical City; San Juan de Dios Hospital

See Page 34
The Council on Electrophysiology and Cardiac Pacing is now chaired by Dr. Erdie Fadreguilan. The Council holds teaching conferences and nationwide lectures on arrhythmia recognition and management. The Council continues to update its registries on arrhythmia device implantations (pacemakers and cardioverter-defibrillators) and radiofrequency catheter ablations. Aimed with the ultimate goal of improving the care of patients with arrhythmia, it collaborates with the newly formed Philippine Heart Rhythm Society in its advocacies and activities.

**How long have you been in the Council?**
Since June 2014

**Can you briefly relate the circumstances that led you to become the chairman of the Council on EPS?**
Dr. Nannette Rey was supposedly the new chair of the Council on EP. However, since she was elected to the PHA Board, the position was left vacant and I guess, I’m the one next in line.

**Briefly describe the objectives of the Council.**
The Council aims to continue to be an instrument of the PHA when it comes to its advocacy of improving cardiac health care in the country, specifically on patients with arrhythmia when it regards to the Council on EP.

**What objectives have already been met? What objectives still need to be fulfilled?**
I believe that achieving the objective is a continuing process.

**What are the current programs that you are undertaking/working on in your Council?**
The Council plans to continue with the current programs of increasing the awareness of physicians in general when it comes to the subspecialty of EP and Pacing. That includes conducting conferences with educational grants from Pharmaceutical and Device company partners. The Council plans to embark on doing an Atrial Fibrillation Registry. It is ironic that we don't have local data on the most common clinical arrhythmia found on clinical practice.

**How long is your term as Chair?**
3 years

**Do you think the length of time of your term as chair is enough to accomplish the programs that you have planned for your Council? How long do you think should be the ideal duration of time of Chairmanship?**
Yes, 3 years should be enough.

**What makes your Council different from the other Councils? How would your Council contribute to the overall PHA goal/vision? Are there any particular research interests/projects that your Council is involved in or has interest in pursuing?**
Atrial fibrillation registry

**What needs do you think should be provided to help your Council serve better? Any requests or wishes?**
Doing a registry entails expenses and the Council hopes that the PHA provides the necessary financial grant.

**Is the Council open to new members? How can someone obtain membership in your Council? What are the membership criteria/qualifications?**
Definitely. Anyone interested in the practice of arrhythmia is welcome to join the Council. They should also satisfy the general qualifications as prescribed by the PHA.

See Page 34

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**Name:** Erdie Cruz Fadreguilan  
**Age:** 43  
**Institution:** Philippine Heart Center  
**Medical school:** University of Santo Tomas  
**Training institution in Cardiology:** UP-Philippine General Hospital  
**Subspecialty:** Cardiac Electrophysiology and Pacing  
**Training institution in Cardiac subspecialty:** Philippine Heart Center  
**Present positions:** Medical Specialist II, Philippine Heart Center  
**Clinic affiliations:** Philippine Heart Center
Both held in November, the venues were the San Jose National High School in Antipolo City which had a turnout of 211 on Nov. 7 and the Commonwealth High School, Quezon City with 180 participants on Nov. 28. In Antipolo, Drs. Federick Cheng and Irma Marie Yape, current and immediate past chairs of the PHA Council on Hypertension were assisted by their members Drs. Jerome Laceda, Imelda Balajadia, Philip Chua; and Fellows in training from The Medical City (Drs. Felipe Navarro III and Aina Macasaet) and the Cardinal Santos Medical Center (Drs. Ryan Astudillo).

Albeno del Monte Jr. was the coordinator of the team of 40 nurses and teachers who assisted in the Antipolo mission.

In Quezon City, Federick Cheng led the Medical team which consisted of Fellows from the Philippine Heart Center – Drs. Irene Celedonio, Thessie Valdez, Rowena Amador and Paolo Nocom; and Chinese General Hospital – Drs. John Steven Tiu, Ivan Paul Valdez and Shiela Anghad.

On hand were 25 Dep Ed nurses and teachers under the leadership of Ms. Lacson, Dep Ed Division health coordinator.

### Summary of Screenings in 2014

<table>
<thead>
<tr>
<th>Date</th>
<th>Venue</th>
<th>No. of teachers/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 30</td>
<td>Pilar Elem. School, Bataan</td>
<td>287</td>
</tr>
<tr>
<td>June 20</td>
<td>Ormoc Central Elementary School, Leyte</td>
<td>212</td>
</tr>
<tr>
<td>June 27</td>
<td>Paranaque National High Paranaque City</td>
<td>168</td>
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<tr>
<td>July 18</td>
<td>San Juan National High San Juan City</td>
<td>108</td>
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<tr>
<td>August 1</td>
<td>Tuguegarao North Central School, Tuguegarao City</td>
<td>343</td>
</tr>
<tr>
<td>August 22</td>
<td>Mandaluyong Elementary School, Mandaluyong City</td>
<td>125</td>
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<tr>
<td>Sept 5</td>
<td>Upper Bicutan Elem School, Taguig City</td>
<td>180</td>
</tr>
<tr>
<td>Sept 19</td>
<td>CDO City High School, Cagayan De Oro</td>
<td>262</td>
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<tr>
<td>Oct 17</td>
<td>Tagbilaran City Division Office, Bohol</td>
<td>161</td>
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<tr>
<td>Nov 7</td>
<td>San Jose High School, Antipolo City, Rizal</td>
<td>211</td>
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<tr>
<td>Nov 28</td>
<td>Commonwealth High School Quezon City</td>
<td>180</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,237</td>
</tr>
</tbody>
</table>
For the first time “Educational cases from South East Asian countries” were featured at the recently concluded Singapore Live convention.

The organizers invited the Philippine community through the PHA Council of Cardiac Catheterization and Philippine Society of Cardiac Catheterization and Intervention (to participate and present interesting and educational cases.

Drs. Raymond Liberato, Cherie Clemente and Ariel Miranda presented interesting cases for discussion and interaction to the panel and crowd.

Photo shows Manila’s eminent interventionalists hobnobbing with their colleagues from SEA.

CVNS Workshop ‘15
slated for Mar 27-28

The Cardiovascular, Neurovascular and Stroke Workshop 2015 will be held at the Aloft Kuala Lumpur Sentral Hotel, Kuala Lumpur, Malaysia on March 27-28, 2015.

Open to national and ASEAN participants, it is a two- full-day workshop for general radiologists, radiologists with interest in cardiovascular and neurovascular imaging, radiologists or interventionists involved in neurovascular and peripheral vascular work, neurologists and cardiologists.

For more details, visit www.mdcmeasia.com or call the Secretariat CVNS Workshop 2015 c/o MD CME ASIA SDN BHD thru tel: +603 2242 0902 / +6016 206 9610.
Are you safe in the place?

By Don Robespierre C. Reyes, MD

In my curiosity of knowing the availability of Automated External Defibrillators (AED) in public places or in areas where there are lots of people, I tried snooping around the corners of Fitness First MOA where I (occasionally) go to for a quick run.

To my delighted surprise, I glanced upon that electrical symbol within a heart. It was an AED! I was tempted to reach for that red bag, open it and check whether it contained that gadget complete with the pads and everything. But before people suspected me of taking illegally what wasn’t mine, I called for one of the fitness trainers and started investigating in a conversational and casual manner.

Of course I introduced myself to him (forgot his name) and asked him if he knew what the bag contained and what it was for. He replied it was an AED and can be used in patients who might be suffering from a cardiac arrest. He further said he and all other trainers were trained on basic life support and how to use the AED.

With a bit of jolly intimidation, I challenged him to demonstrate how to do CPR to which he obliged. And the guy knew what he was doing! I couldn’t help but be delighted, assured that this establishment offers some form of safety and emergency response for customers!

After a pint of security for my heart with what I found with the AED and a gallon of perspiration on the treadmill, I washed up and went to one big grocery nearby. My curiosity heightened as I saw a security guard roving the grocery lanes. I approached him and started some small talk. I did not actually introduce myself properly because if I did, that would create some personal panic within him. I asked him if the grocery has an AED, and his reply was “ano po?” I repeated my question and explained what it was, and he replied that he doesn’t know it, haven’t seen one and he was not sure if there was one within the area.

I followed it up with another question “Marunong kang mag CPR?” to which he replied “ano po?”

So I explained what it was, thinking he was not just able to hear it clearly from me since we were in a not-so-silent public place. The guard said he has some idea about it but that was just about it. He further said that he was not trained to do such and he is not aware of any protocol in any case somebody collapses in the grocery. All that he personally knows is to call up the nurse whose office was located not so near the grocery.

Not quite losing hope with the grocery, I went to ask the cashier and the “dizers” the same questions I asked the guard. Just like any teleserye on Philippine TV, my ending is predictable: I lost hope and gave up. ✿
Association Welcomes 56 New Diplomates. 48 out of 86 passed the written and oral examinations for Adult Cardiology given by the PHA SBAC, while 8 successfully hurdled the examinations for Pediatric Cardiology administered by the PHA SBPC.

Annual Convention Attended by 1,688 Delegates. The 45th Annual Convention and Scientific Meeting was held last May 28-30 at the EDSA Shangri-La Hotel, Mandaluyong, with the theme “Targets and Beyond: Cross-talks and Strategies”. The Mariano Alimurung Lecturer, Dra Annette Borromeo tackled the relationship between the physician and pharmaceutical industry. At the culmination of the meeting, Dr. Joel Abanilla was inducted as the 63rd PHA President. Meanwhile, the newly formed Philippine Heart Rhythm Society also held its first pre-convention Scientific Session last May 27, 2014.

PHA Councils On The Go. In time with the celebration of Sudden Cardiac Arrest Awareness month in September, the PHA CPR Council conducted the 7th National BLS and ACLS Training the Trainors on October 3-5, 2014 at the Legend Villas, Mandaluyong City. A first ever BLS and ACLS Training the Trainors Course was conducted in Cebu City on September 13, 2014, catering to trainers from Cebu and Western Visayas. The PHA together with the CPR Council also campaigned for CPR-readiness in the community and for the increased availability of AEDs in public places during the PCP Health Forum held in Annabelle’s last October 14, 2014. Meanwhile, the PHA Council on Hypertension continued with their advocacy “BP ng Teacher ko, Alaga ko” by conducting numerous activities on risk factor screening in quite a number of public schools in Metro Manila and in different provinces.

World Heart Day 2014 Emphasizes Heart Healthy Choices. Once again, the PHA joined the World Heart Federation, along with 120 countries in the world, in celebrating World Heart Day last September 28, 2014. The event this year was held in St John Bosco Church, Makati, with the theme, “To create heart-healthy environments”. Talks on healthy lifestyle, the PHA’s 52100 campaign, sessions on cardiopulmonary resuscitation and a group fitness program led by celebrity fitness coaches from the Biggest Loser reality show, highlighted the affair.

PHA launches CAD Guidelines. The PHA launched the 2014 PHA Clinical Practice Guidelines for the Diagnosis and Management of Coronary Artery Disease last Nov. 24, 2014 at the Oakwood Hotel, Mandaluyong City. The 2014 edition includes new statements based on local data taken from the PHA ACS registry and tailor-fit to the needs of the Filipino patient. This guideline is a product of hard work from the CAD Council and definitely an achievement for the PHA.

March 29, 2014 marked an important milestone in the history of the PHA as the first ever joint symposium of the PHA, the ACC and the Mexican Society of Cardiology was held during the 63rd ACC Scientific Sessions in Washington. Two fellows of the PHA – Dra Helga Sta Maria and Dr. Benjie Magsombol, spoke on the advances of multimodality cardiac imaging during the joint session. PHA was the only chapter in Asia represented in the international meeting and this marked the first time in PHA history that the Association took part in an official joint session conducted during the conference.

Five Independent PHA Chapters Created. In a move to improve membership activation in the provinces, the PHA created 5 independent chapters from the existing major chapters. In Luzon, 4 chapters were created - Baguio-Benguet, Dagupan, Cagayan-Tuguegarao-Isabela, La Union, to add to the main Ilocos Region Chapter, while Zamboanga Chapter was created in the Mindanao region.

In cooperation with the Ilocos Region Chapter, the PHA independently conducted the 1st Ilocos Region Cardiology Seminar and Networking last Nov. 23, 2014 at the Oakwood Hotel, Mandaluyong.

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CME gets P2.1-M grant from Pfizer

Core-Give and the Heart Failure Academy Continuing Medical Education Programs of the Philippine Heart Association (PHA) got P2.1 million in contribution from Pfizer, Inc., Philippines’ (Pfizer). The fresh funds will keep these CME projects going and extend their reach in one NCR city and nine provincial/local chapters.

The PHA-Pfizer memorandum of agreement signing took place on Nov. 10, 2014 at the New World Hotel, Makati City. Signatories to the contract are PHA President Dr. Joel Abanilla and Pfizer medical Director Dr. Cristobal Dumo Jr., while PHA Director Dr. Helen Ong-Garcia and Atty. Monina Vierneza, Pfizer director, Legal Affairs signed as witnesses. Also on hand were PHA officers -- Drs. Raul Lapitan, secretary; Nannette Rey, director and Eugene Reyes, immediate past president and Pfizer executives.

The Core-Give project is a brainchild of Lapitan. On its 60th founding anniversary, Pfizer contributes to promotion of cardiovascular health through scientific meetings addressing issues on cardio-metabolic disease through the Cardiology syndrome series; PHA and Pfizer have agreed to cooperate with each other toward the mutual objective of providing a venue for scientific exchange of practical knowledge and continuing medical education.

The event seeks to gather experts and practitioners in the Philippines by presenting the most relevant, basic and clinical scientific information on cardio-metabolic disease.

For its part, PHA undertakes to: involve the PHA officers and Board of Directors and the PHA Secretariat in the planning and organization of the “Event”. Both parties agreed to support, collaborate and cooperate with each other for the Cardiology Syndrome series of events. ♥
Big names in print media gave the 2014 PHA Coronary Artery Disease Guidelines Launching ample publicity. PHA regular media allies -- ABS-CBN/ DzMM Magandang Gabi, Dok was more interested in pediatric cardiac cases and in Holiday-induced diseases; and DwIZ Radyo Klinika capitalized on heart sub-specialties and the PHA’s 52-100 Advocacy Campaign.

### 2014 PHA CAD Guidelines Launching

<table>
<thead>
<tr>
<th>Title</th>
<th>Media Entity</th>
<th>Date</th>
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<tbody>
<tr>
<td>New treatment guidelines for CAD</td>
<td>People’s Journal</td>
<td>Nov. 29, 2014</td>
</tr>
<tr>
<td>PHA releases latest treatment guidelines for CAD</td>
<td>Medical Observer</td>
<td>Nov. 29, 2014</td>
</tr>
<tr>
<td>PHA releases updated guidelines for CAD</td>
<td>GMA News Online</td>
<td>Dec. 1, 2014</td>
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<tr>
<td>CVD is still the country’s top killer each year, 170,000 Filipinos die from CVD</td>
<td>Philippine Daily Inquirer</td>
<td>Dec. 2, 2014</td>
</tr>
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<td>New booklet on managing CAD for distribution nationwide</td>
<td>Philippine Daily Inquirer</td>
<td>Dec. 6, 2014</td>
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<tr>
<td>Latest treatment for CAD disease released</td>
<td>Philippine Star</td>
<td>Dec. 18, 2014</td>
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<td>Heart to Heart</td>
<td>Philippine Daily Inquirer</td>
<td>Dec. 9, 2014</td>
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Teleradyo
ABS-CBN/DzMM
(Ch. 26; 630khz)
Magandang Gabi, Dok,
8:30 to 9pm
Hosts: Nina Corpuz/
Dr. Luisa Puyat Ticzon

Dr. Ma. Ina Bunyi
CV risk reduction in patient
Oct. 13, 2014

Dr. Jhuliet Balderas
CGH and VSD
Pediatric cardiac rehab/wellness
Oct. 6, 2014

Congenital Heart Disease
(Dilated CM)
Case of Jugo Arroyo Bernas
Nov. 3, 2014

Dr. Christopher Oliver Nazal
Holiday heart syndrome
Dec. 12, 2014

Dr. Nannete Rey
COPD & the Heart
Nov. 5, 2014

Dr. Helen Ong-Garcia
52-100
Nov. 12, 2014

52-100 & Media
Noche Recipes
Dec. 31, 2014

Dr. Adriel Guerrero
Preventive Cardiology
Nov. 26, 2014

Preventive Cardiology/
Guilt-free holiday foods
Dec. 24, 2014

Dr. Alex Junia
Diseases of the Heart/
Blood vessels
Nov. 19, 2014

Dr. Maximo Lasco
Common heart Diseases
Dec. 17, 2014

DwIZ 882Khz
Live streaming
Radyo Klinika
7am to 8pm; Host:
Avee Devierre

Dr. David Raymund
Salvador
Electrophysiology
Dec. 3, 2014

Dr. Bernadette
Santigo Halasan
CVD-free Christmas
Dec. 10, 2014

TV5 Newscast
Aksyon Tonite,
8:30pm

Dr. Joel Abanilla
Relevance
of CAD Guidelines
Dec. 21, 2014

Dr. Nangste Rey
COPD & the Heart
Nov. 5, 2014

Dr. Helen Ong-Garcia
52-100
Nov. 12, 2014

52-100 & Media
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Aksyon Tonite,
8:30pm

Dr. Joel Abanilla
Relevance
of CAD Guidelines
Dec. 21, 2014
Echo stars at Advanced 12-lead EKG course

By Jose Donato A. Magno, MD

No other cardiac diagnostic tool will probably be as pervasive and timeless as the electrocardiogram (ECG).

More than a century after the publication of the very first human EKG tracing by Waller and the standard wave nomenclature proposed by Einthoven, the ECG diagram still continues to be an invaluable component in any clinician’s diagnostic repertoire. It is therefore no wonder that efforts directed towards continuing education in the field of electrocardiography still find relevance in today’s practice of medicine.

In the tradition of excellence and progressiveness which the culinary capital of the country is known for, the Section of Cardiology of the Angeles University Foundation Medical Center staged the 3rd edition of its biennial postgraduate course on Advanced 12-lead EKG recently in Clarkfield, Pampanga. This course electrified its participants with its exotic scientific menu delivered by a star-studded faculty line-up which featured some of the finest cardiologists and EKG experts in the country today.

The high-octane level of scientific discourse that transpired in this one-day event was not for the faint of heart, as luminaries in the world of medicine and cardiology shared their personal secrets in demystifying the seemingly esoteric field of electrocardiography, with the main intent of providing key insights for the Filipino heart-care provider. Dr. Homobono Calleja (director Emeritus, St. Luke’s Medical Center) jumpstarted the sessions with his colorful recollection of the historical landmarks that punctuated the EKG timeline, highlighting key discoveries and personalities that paved the way for the ECG to flourish in the field of human medicine.

He was followed by another icon in Philippine Cardiology, Dr. Ramon Abarquez, Jr. (Professor Emeritus, St. Luke’s Medical Center) jumpstarted the sessions with his colorful recollection of the historical landmarks that punctuated the EKG timeline, highlighting key discoveries and personalities that paved the way for the ECG to flourish in the field of human medicine. He was followed by another icon in Philippine Cardiology, Dr. Ramon Abarquez, Jr. (Professor Emeritus, UP College of Medicine), who dazzled the audience with his razor-sharp assertions and thought-provoking observations regarding non-specific ST-T wave abnormalities. Dr. William Chua (Professor, St. Luke’s College of Medicine) succinctly described how wide QRS tachycardias due to supraventricular tachycardia differ from those due to those with ventricular origin, stating that “In ventricular tachycardia, every beat counts.” Dr. Mario Joselito Garcia (chair, Angeles University Foundation Medical Center Department of Medicine) sized up the EKG situation by tackling the finer points regarding the electrocardiographic diagnosis of chamber hypertrophy. Dr. Nelson Abalardo (chief, Manila Doctors Hospital Section of Cardiology) was brilliant as always, lighting up the atmosphere with his animated discussion of power failure and its classic EKG features.

To prevent the audience from falling into a deep noontime slumber or “bangungot.” Dr. Giselle Gervacio (Training Officer, UP PGH Section of Cardiology) eloquently dissected the EKG markers of sudden death, emphasizing that “Nothing is more ominous than ventricular tachycardia occurring in the setting of acute coronary syndrome.” Dr. Marcellus Ramirez (Chair, UST Hospital Department of Medical Education and Research) then fired up the sessions with his emphatic arguments regarding...
STI-elevation and EKG markers of reperfusion. Recognizing that myocardial infarction may be obscured by certain conditions, Dr. Maria Belen Carisma (President, Philippine Heart Rhythm Society) gave practical tips to unmask the diagnosis in the presence of bundle branch blocks and artificially-paced beats. Meanwhile, Dr. Manuel Zacarias (Professor, UST Faculty of Medicine and Surgery) injected a dash of humor to differentiate the various causes of pauses, using practical analogies to explain disorders of automaticity and conduction. Dr. Clara Tolentino (Instructor, UERM Department of Pharmacology) picked up the tempo with a discussion of supraventricular arrhythmias. The scientific sessions were wrapped up with a presentation of miscellaneous EKG revelations by Dr. Raul Jara (Past President, Philippine Heart Association), who seasoned the discussion with personal clinical anecdotes that kept the audience intrigued until the very end.

The sessions were punctuated by challenging ECG cases which were moderated by Drs. Gabriel Jocson III, Elaine Payumo and Jose Donato Magno. The event was likewise graced by Dr. Orlando Bugarin (former chair, PHA Council on Cardiopulmonary Resuscitation) who handled the luncheon symposium, Dr. Gil Francis Pelagio (President, PHA Central Luzon Chapter), and Dr. Jan Denton Chua (CEO, HB Calleja Heart Institutes) who gave the audience an encapsulated story of the HB Calleja Heart Institute at the AUFMC and how it has grown through the years in terms of training programs, cardiovascular technologies, and patients served.

**STORY BEHIND... from Page 14**

the mortality rate for UA which was 3.2% The task force on NTSEMI updated the 23 statements from the previous to 26 statements. New statements focus on the introduction of new anti-platelet agents and importance of transfer strategy. New score models for stratification have been emphasized as well (Thrombolysis in Myocardial Infarction/TIMI, Global Registry of Acute Coronary Events/GRACE and the Heart Score Model).

**STEMI**

The task force on STEMI was able to come up with 33 statements, in contrast to the previous guidelines that had 25 statements. Major changes include those regarding pre-hospital recognition, transfer strategies; new medication and anti-platelets; arrhythmia and therapeutic hypothermia. Emphasis is also placed on risk stratification and cardiac rehabilitation.

**WELL-WRITTEN... from Page 15**

current deficiencies in our local system and serves as a challenge to us as practicing cardiologists.

Early recognition of STEMI is recommended in the guidelines and is comprised mostly of lay education on recognizing signs and symptoms of STEMI so that patients can be brought to the emergency room as early as possible.

Early out-of-hospital recognition of STEMI has been proven in multiple studies in multiple countries to improve survival of patients. This usually entails a robust public emergency service (think 911 in the United States) and the ability to not only identify STEMI in the field, but also initiate treatment (thrombolytic therapy in the ambulance). This is usually followed by identifying a percutaneous coronary intervention (PCI) capable facility and contacting this facility while en route to facilitate any PCI upon arrival if necessary. These steps are currently still lacking in local practice. But with the advent of smartphones and mobile internet, these seem more possible in the local setting if a network can be organized amongst our ambulance companies.

As in the non-ST elevation ACS section, early transfer of a patient to a PCI-capable facility is emphasized. This will help address the issue of non-reperfusion or re-occlusion in some patients after thrombolytic therapy.

Additional statements are likewise made for new anti-platelet agents and ivrabdine, including the basis for its inclusion in the guidelines.

Treatment for survivors of cardiac arrest are likewise included. These include measures such as therapeutic hypothermia, management of patients with ventricular tachyarrhythmias and even guidelines on Implantable Cardiac Defibrillators (ICD).

Lastly, cardiac rehabilitation is once more emphasized for patients who survive STEMI. The morbidity and mortality advantage of undergoing cardiac rehabilitation is once more highlighted.

**Summary**

Going through the guidelines, one can’t help but feel proud to be part of the PHA. The document is comprehensive, and despite being 120 pages is neither longer nor shorter than it should be. It is written out in easily digested statements and covers the whole gamut of possible CAD presentations. For even the most up-to-date cardiologist, the guidelines can and will continue to serve as an easily obtained reference. If this were a book review, the guidelines deserves two thumbs up!
Special Report

So how is Tacloban City and the nearby towns one year after Yolanda wrecked havoc? The scenario now is vastly different from the apocalyptic scene that the world saw last year. The stench of death no longer permeates the air. Roads have been cleared of debris. Electricity is back. The residents no longer walk around like zombies. All these changes were deemed impossible a year ago. But the Warays have bounced back and moved on. Life has resumed.

As of August 2014, 80% of businesses have resumed and around 600 new businesses have opened. Transport services and the hotel industry have resumed briskly compared to last year.

But is life really back to normal in Tacloban?

On the surface, it might seem that it is. The streets are full of vehicles; the traffic jam is even worse than the pre-Yolanda period. Malls and fastfood joints have re-opened, with people flocking to them. With the proliferation of new restobars, the nightlife is very much alive. The cost of basic commodities has gone back

Back on its feet

By Leila Diaz, MD

It has been a year since Typhoon Yolanda devastated Eastern Visayas and nearby areas, killing thousands (the exact number we will never know), changing the lives of millions of people whose homes were destroyed and livelihoods imperiled.

Ed’s note: The author hails from Tacloban City where she took her MD, internship and residency. The Philippine Heart Center was the cradle of her adult cardiology training. She sub-specialized in echocardiography at St. Luke’s Heart Institute.

She is affiliated with the Bethany Hospital, Mother of Mercy Hospital, Divine Word Hospital and Tacloban Doctors’ Medical Center both in Tacloban City.
to normal. What remains expensive though are the prices of construction materials as well as manpower cost.

Even the tourism industry has been resurrected. Everybody thought that Yolanda killed tourism in Eastern Visayas. But one week after Yolanda, 27 hotels were operating. The whole world was in Tacloban and everybody was looking for rooms. According to the Department of Tourism, there are currently 50 hotels operating in the area. Tourist arrival and demand for hotel rooms is expected to rise steeply in January 2015 with the visit of Pope Francis. The present tactic of the DOT is to focus on “Voluntourism” – with tours outside Tacloban, mixing activities for a worthy cause with leisure and adventure pursuits.

The health sector is as busy as ever, thanks to local non government organizations (NGOs) and international non government organizations (INGOs). The Eastern Visayas Regional Medical Center and the Tacloban City Hospital both underwent a major facelift and has upgraded their facilities and equipment. By January 2014, all of the five private hospitals in Tacloban have resumed normal operations, except for one. Bethany Hospital, owned by the UCCP and one of the top two hospitals in the region, has remained closed until now for reasons that remain unclear. Most of the private hospitals have received donations from NGOs and INGOs in terms of armamentarium and tools, which are better than before. Despite the improvement in facilities and services, the rates are still comparable to that of the pre-Yolanda period.

As for the doctors in the private sector, only around three have chosen to relocate outside Eastern Visayas. Medical practice started to pick up around February of this year when most of the residents came back from their exodus. All of the cardiologists have resumed their busy practice. Proof is the daily SRO crowd in the outside patient department lobby of one of the big hospitals in the city.

It took a longer time for the pharmacies and drugstores to revert back to normal. There was shortage in the supply of medicine during the first few months of 2014, what with the major drugstores closed and many pharmaceutical companies leaving the area. It was not until the month of June, when the Mercury Drugstore branches reopened that things started to look up for the pharmaceutical industry. One year after Yolanda, all the drugstores in Tacloban have reopened and around 98% of the pharmaceutical companies are back.

It has been said that Yolanda was a great equalizer. It did not choose its victims; during the surge and the immediate aftermath, people belonging to different social strata were almost equally affected. It’s a different story during the recovery and reconstruction phase. Those who had more recovered faster, while the poor are recovering at a snail’s pace, if at all.

Even before Yolanda hit, the Samar-Leyte area was already one of the poorest regions in the country. Yolanda only put in starker terms the poverty of many of the residents. According to a very recent Oxfam report, “close to a million people continue to live in inadequate shelters and are still struggling to find the resources to resume their livelihoods. In Tacloban alone, there are still 4,114 families living in bunkhouses. Only 142 (0.06%) of 14,500 promised permanent homes had been built and thousands are still living in danger zones.

According to Tacloban City Mayor Alfred Romualdez, Tacloban city is only back by about 50%. The reconstruction phase is expected to take four to five years as opined by the
"Philosophically," wrote Dr. Louis Katz of Chicago in an analysis of physical fitness, “all individuals should be in the ‘pink of condition’ since life is full of unexpected periods of extraordinary exertion resulting from physical and emotional stresses. Man, like other animals, has to prepare for “fight or flight.” Unfortunately, progress in automation and the comforts of modern living have removed many of these “conditioning” stresses. Avoidance of smoking, correction of an overly-rich diet, and regulated, moderate exercise, at present seem to be the best way of putting modern Man back in the “pink of condition.”

Benefits of physical training

Physical training for the ordinary individual, most especially for a cardiac, is not aimed at developing a superior skill in any given sport or physical activity. Doctors advise their patients who play golf, for example, not to “play to win” or engage in a competitive game. The purpose is to relieve nervous tension and accustom the body to react to physical stress without any undue strain.

The findings of leading researchers in this field, as summarized by Dr. Katz show that many benefits may be derived from a physical fitness program. The individual relaxes more readily and recovers from exertion more rapidly. The functions of his respiratory system, his liver, and his kidneys are improved. Muscular performance becomes more efficient and the musculature increases in size and vascularity.

In a physically trained person, as compared to the untrained, the heart beat is slower both at rest and during a given level of exercises. There is an increase in the amount of blood ejected with each stroke or contraction of the heart, thereby also increasing the amount of oxygen (carried by the blood) available to the body. Physical training also increases the size and strength of the heart muscles. This, within limits, helps supply the energy when a greater effort is required of the heart, instead of if having to dilate and increase its rate of contraction as in the case of an untrained person. All this increased efficiency of the heart’s action during rest and bodily exertion means that less oxygen is required by the heart through its coronary blood supply.

Theoretically, the growth of additional branches or collaterals of the coronary blood vessels is enhanced by an exercise program, especially when the blood flow in the heart muscles has become insufficient to disease. The training program should exercise the large muscle groups, especially the lower extremities. The exercise should be the moving type as in calisthenics, bicyling (stationary and otherwise), swimming and jogging. The program should at least call for exercise sessions at least three times a week, from one-half to one hour each, on a year-round basis.

What are the hazzards of a physical training program to the heart patient? What precautions should be taken? The potential dangers require constant evaluation and supervision by the physician. Regular check-ups consisting of a clinical history, physical examination, and a electrocardiogram (especially during and after exercise) are necessary to evaluate the patient’s response to increased physical exertion. The patient should be taught how to identify the signs...
While the patient was awaiting schedule for the pacemaker implantation, the partner did his preliminary rounds. Alas, while doing his rounds, the patient went into seizures after developing torsade de pointes which manifested right while her physician was in front of her.

Acting with dispatch, he brought the patient to the appropriate hospital unit for temporary pacemaker implantation. A few days later, the patient eventually received the permanent pacemaker, transferred out of ICU and discharged in stable condition. She had later followed up after a week or two and was doing extremely well.

Quite ironically and tragically, the doctor, who saved her life, had died – less than two months after saving hers – from far-advanced cancer.

All of 40 years, this colleague of mine, unknown to me and many others, had been harbouring a self-diagnosed malignancy. He knew he had very limited time to live. He was aware he would succumb soon. And he planned for his exit in the clearest manner possible – his own terms.

From the condominium he occupied for years, he moved to his parents’ abode and decided to stay with them and his siblings for the rest of his remaining days. He imposed a no-visitor’s policy except for two dear mentors who must have begged endlessly to allow them to see him, touch him and reassure him. He did not seek further treatment. He did not want to be hospitalized. No respirators. No nasogastric tubes. No chemotherapy. No life-support systems.

Just his family and himself – and his faith.

Quite a religious devotee, who regularly received the Holy Eucharist everyday in the hospital during the regular noon mass, he devoted his remaining time to his family. Yet, he would not pass on the chance to save another life – that of a patient of mine.

Three days after he saved my patient’s life, he disappeared from the hospital. He made a sudden leave of absence from hospital commitments and medical responsibilities, embraced the solitude of home and the warmth of family togetherness. His sudden absence triggered an avalanche of why’s, what’s and how come’s.

I can only smile in amusement at the genuine concern that filled the air. I can only mumble quietly to myself – let us respect his wishes, let us give him his space.

He must have become too weak to do the final closing sutures on this patient of mine that when his partner mentor offered to do the last few stitches, he readily obliged. I would imagine that in his days of vigor and strength, he would not let such a menial task be done by his mentor.

In the end, he must have wanted to leave everyone with the indelible images of a laughing, joking and heckling friend and colleague. He must have wanted to spare everyone the agony of watching him suffer. He must have wished to disallow any opportunity for pity.

What can be nobler than continuing on to embrace the calling of a profession that mandates one to heal and save lives, when one is fully aware that the life he wishes to sustain for someone else, is the same dear life that he slowly loses grip on? What can be more selfless than making someone else breathe when you yourself are running short of it? Can anything be more genuinely Christian?

Dr. Von Meldrick Gonda, one of the country’s top electrophysiologists, succumbed to cancer on August 22. To my knowledge, the last life-saving procedure he performed was on this patient of mine.

I could only surmise that this was a divinely
and symptoms that will tell him he is exerting too much effort and is going beyond the limits of safety. Especially significant would be the appearance of these signs even after the cessation of effort.

To exercise or not to exercise

Some investigations have questioned the value of a physical training program for cardiacs, especially coronary patients. Doubts arise as to the benefits of exercise to a coronary patient when one considers that other factors are involved in a training program. Weight reduction, avoidance of smoking, and an altered diet are other elements in a physical fitness program that may produce the benefits ascribed to exercise. Does a physical fitness program lessen the possibility of a heart attack? Does it reduce the mortality resulting from attacks? Does it increase the efficiency of bodily response to the stress associated with the production of a heart attack? The answers, as summarized by Dr. Katz in his analysis, are at either suggestive or not clear.

What is agreed upon by most cardiologist is that a physical fitness program for cardiac patients has a profound psychological effect. It improves a “psychological cripple” filled with all sorts of incapacitating “phobias.” To quote Dr. Kayz – “the patient is kept aware of his potential danger but in an agreeable rather than a fearful way. He is therefore, more amenable to the advice given him by his physician who is (in a physical training program) an interested, constantly available advisor.”

COUNCIL ON CARDIAC... from Page 18

What needs do you think should be provided to help your Council serve better? Any requests or wishes?

My wish is for the council to have more members, younger blood, who will keep the fire burning for the love of cardiac rehab and be more proactive in the activities and implementation of the goals. Right now, the challenge is, we are so few in the council and it is difficult to set meetings because of time schedules and areas of demographic practice. One of our council members just have to fly from Cebu just to attend meetings which hopefully will be more regular.

I think the chairman should be full time in council activities because in my case, I also am Section Chief of the Section of Cardiology in Medical City, my time is quite limited.

What are the future thrusts of the Council?

The future thrust of the council is to push Cardiologists to refer to cardiac rehab. To believe in it. And to make the public more aware of it and its substantial benefits. For example, in exercise alleviation in heart failure, exercise training acts even better than an ACE inhibitor as studies show.

In your opinion, how can each PHA member serve in order to help the Association achieve its goal?

Each PHA member can help serve the association by supporting its activities and be more proactive and innovative as far as collaborating with PHA in their respective communities. Duties of voting, attending annual conventions are basic.

Final words:

There is still a lot of work to be done. Cardiac rehab will flourish in this country if members of the council, supported by the Board and the whole association are burning with faith in the practice of cardiac rehab in the country, with hope that in the future, we will have acculturated cardiologists, doctors in the practice of cardiac rehabilitation and its components (exercise training, nutrition, psychosocial counseling, and secondary prevention by lifestyle change and modification of risk factors) for the love of country and fellowmen. In this way, there will be less re-hospitalizations, deaths, more survival time and quality of life in every patient with cardiac disease.

COUNCIL ON EPS... from Page 19

What are the future thrusts of the Council? What is the current status of the country as far as access to treatment options for arrhythmia is concerned?

The Centers that offer invasive electrophysiology remain to be limited to 5 Medical Centers in Metro Manila and Cebu. Centers that can perform device implants, including permanent pacemakers, implantable cardioverter-defibrillator (ICD) and cardiac resynchronization therapy devices (CRT) are increasing in numbers.

The international community commemorates Sudden Cardiac Arrest Awareness month every September. What is the current burden of this condition in our country today?

Unfortunately, I believe, there is no local data on SCD.

Briefly, how do we fare in terms of skill and expertise in the therapeutic interventions for sudden cardiac arrest and other arrhythmias?

I can confidently say that we are at par with the rest of the world when it comes to interventions both invasive and noninvasive. We can now perform complex ablations for atrial fibrillation and ventricular arrhythmias. Device implants for ICD and CRT are steadily increasing.
**Facts and myths about exercise**

1. **Masama bang maligo pagkatapos mag-exercise.**

   Exercise properly begins with warm-up and cool-down. Bathing gets rid of sweat, relaxes the muscles and refreshes for the next activity. If you want to retain your friends, ignore this old wives’ tale.

2. **Lumalaki ang mga masel ninyo’ng mga babae kung panay ang exercise!**

   Isometric exercise bulks up muscle, exemplified by high resistance weight training. Low resistance repetitive exercise results in improved muscle tone with minimal or no increase in bulk. If it were true that repetitive motion (exercise) resulted in bulky muscle, kids nowadays would have thumbs the size of dishes.

3. **Basta exercise, “no-pain no-gain”**

   Regular progressive aerobic exercise allows the muscles to become efficient and maintain aerobic metabolism longer. When pushed to the limits of endurution, muscle metabolism shifts to the more energy-thrifty anaerobic metabolism; unfortunately the by-product of such is lactic acid which is the cause of the pain during exercise. If your objective is Arnold Schwarzenegger, then yes “no-pain-no-gain”. If not, not.


   Then explain whales.

5. **Pasmado ka, kung umiinom ka ng tubig habang nag-e-exercise.**

   “Pasmo” is translated as fatigue. Water, that essential element for life, is constantly lost in the body excretions and secretions, in addition to the “insensible” loss during breathing. These losses are accelerated during exercise and must be replaced, otherwise dehydration commences starting a domino effect of renal shutdown, cardiovascular and neurologic collapse. So on the contrary, drinking water during exercise reduces the chances of malaise.

6. **Wala’ng kwenta ang pag-e-exercise, lumalakas lang ang ganang kumain**

   Ridiculous. If true, then those of us whose exercise consists of TV surfing should never be hungry. What is perceived as hunger after exercise is usually just thirst and will respond to adequate water intake.

7. **Natural lang na sumakit ang katawan pagkatapos mag-exercise.**

   The muscle ache during exercise is related to lactic acid that accumulates in the muscle during prolonged exercise when aerobic shifts to anaerobic metabolism; when occurring after exercise, it could mean some degree of musculoskeletal injury. (see number 3)
In this issue, we highlight the answers to last issue’s Bioethics Section which featured questions on ethical principles and issues related to medical and cardiovascular practice, along with a short discussion on the practical application of principles in the daily management of our patients.

First Case Scenario
GMN is an 85-year-old male, retired neurosurgeon who suffered from Alzheimer’s disease and kept in a health care facility for nursing care. He became progressively disabled after he developed a stroke and has suffered from repeated bouts of pneumonia but this time his relatives have decided to forgo another round of antibiotics. The attending physician also explained to the family that the patient will not benefit from cardiopulmonary resuscitation in case he goes into cardiac arrest.

Ethical questions:
1. Caring for the serious and terminally-ill patient requires –
   A. going beyond ordinary care to ensure that mercy killing is not resorted to
   B. the same skills from physicians attending to the basic needs of patients
   C. doing everything possible to prolong the life of the patient
   D. relief of pain by terminal sedation
   Answer: B

2. In a chronically-ill and dying patient which of the following should NOT be discontinued?
   A. Special high protein parenteral food
   B. Respirator
   C. Hydration, nutrition, comfort and nursing care
   D. Antibiotics
   Answer: C

3. Hospice Care has gained support since it was reactivated by a Filipino American Physician in the U.S. and in the Philippines, Dr. Josefina Magno. Which is true regarding hospice care?
   A. It makes the sure that a peaceful death is hastened
   B. The nursing staff are trained to give terminal sedation to relieve pain
   C. It neither hastens nor prolongs the dying process by team effort
   D. The attending physician shares the responsibility of caring for the patient with the relatives
   Answer: C

4. Regarding the antibiotics in this case –
   A. They are still part of ordinary care and preserve life
   B. They cannot be withheld because the patients family can afford it
   C. The family should have asked the patient to decide on this when he was still mentally fit.
   D. They are already inordinate at this point and just prolonging the dying process
   Answer: D

5. True regarding passive euthanasia:
   A. It is the same as direct euthanasia
   B. It is morally acceptable
   C. It is equivalent to “allowing to die”
   D. It is death-induced by withholding an effective treatment or procedure
   Answer: D

6. Once a DO NOT ATTEMPT RESUSCITATION (DNAR) is ordered in the chart –
   A. it can no longer be revoked so the doctors must be sure about it before writing it in the chart
   B. the order must be reviewed periodically
   C. the nurses may no longer take vital signs regularly
   D. the attending physician may just advise the staff to inform him when the patient dies
   Answer: B

7. In withholding CPR - the letter “A” which stands for “attempt” is now added to DNR to make it DNAR. Which is true?
   A. It doesn't really matter which terminology is used.
   B. We should just continue the term DNR because it connotes success if undertaken
   C. It more clearly indicates that success at resuscitation often is not achieved
   D. It is up to the Bioethics Committee/ Institution which term to use
   Answer: C
8. The terminal care of an affluent patient with an important social status should be:
A. different from a poor patient
B. determined by his relatives regardless of what the attending physician advise
C. dependent on what the Bioethics Committee decides
D. the same with an ordinary or poor patient based on ethical grounds
Answer: D

II. Case Scenario 2
M.R.A. is a 27-year-old messenger who suffered severe brain injury from a motorcycle accident. He was eventually connected to the respirator because of respiratory distress. He progressively deteriorated and by the 6th hospital day the Glasgow Coma scale is 3. The attending physician who is an Internist advised the family that there is no hope for recovery so it would be ethical to remove the respirator so that “he can go peacefully.”

The parents are distraught and want to do everything to sustain the life of M.R.A. The decision of the doctor is-
A. morally acceptable
B. unethical because the gastrostomy/nasogastric tube are just an ordinary or proportionate means, and will simply prolong the dying process
C. ethical because it is justified by the principle of double effect
D. any relative who is interested should remove the respirator?

Answer: D

1. Removing the respirator from a patient with severe brain injury with Glasgow coma scale of 3 is:
A. a form of active euthanasia
B. a form of passive euthanasia
C. withdrawal of optional or non-obligatory treatment
D. direct euthanasia
Answer: C

2. In patients with fatal pathology or with no hope for recovery:
A. the physician has the right to decide for the family what is best for the patient
B. the physician should discuss the status of the patient and enlighten and convince them about the right option
C. the physician must refer to the Bioethics Committee and let them decide what to do
D. the patients family should be left to decide what they feel is right
Answer: B

3. Ethical Issues in Brain death –
A. a Bioethics Committee is required to decide on it
B. any two physicians can declare it
C. must be determined by 2 doctors, one of them an expert on cognitive function
D. one physician is enough to declare it
Answer: C

4. If the attending doctor’s assessment is that the respirator is a futile and disproportionate means of sustaining the patient and the family accepts it, who should remove the respirator?
A. any family member who is present
B. the Nurse in charge
C. the Resident on duty
D. the Attending physician
Answer: D

5. The decision to withhold or withdraw life support –
A. can be difficult because of fear of litigation
B. the sole prerogative of the attending physician
C. is easy because the family generally understands
D. spiritual guidance is not important because this is a purely medical event
Answer: A

III. Case Scenario 3
A 78-year-old patient is suffering from Stage IV colon cancer. She has been unable to eat but refused gastrostomy and nasogastric tube for feeding so she was kept on parenteral feeding which cost P 8,000/day. She has received the anointing of the sick. She eventually became comatose from multi-system organ failure so the family decided to just keep her on IV fluids as the attending doctor recommended until her eventual demise.

1. The decision of the doctor is –
A. unethical because it is a form of passive euthanasia
B. unethical because the gastrostomy/nasogastric tube are just an ordinary procedures so the Doctors should have insisted to insert either one of it.
C. ethical because it simply allowed the patient to die naturally
D. ethical because it is justified by the principle of double effect
Answer: C

2. In the terminally-ill patient, truth telling requires that the condition must be told by the physician to:
A. the relatives to avoid distressing the patient
B. the competent patient or the patient’s proxy if he is incompetent
C. the competent patient
D. Any relative who is interested
Answer: B

3. Passive euthanasia –
A. is the same as direct euthanasia
B. morally acceptable
C. is equivalent to “allowing to die”
D. is death induced by withholding an effective treatment or procedure
Answer: D

If you got all the correct answers, that means you were able to apply the Bioethical principles discussed in the first part of this series based on Christian and Catholic Ethics.

To further elucidate some key points -- take note that caring for the terminally-ill does not require special skills. What we need is to apply the same compassionate care and concern to provide the basic needs of patients which is to maintain hydration and nutrition, provide comfort care and relief of pain.

In patients with a fatal pathology, procedures that are burdensome and will simply prolong the dying process are inordinate or considered extraordinary and therefore non-obligatory, Pope Pius XII on his address to doctors reminded us that “Humans are obliged to take care of and prolong their lives through ordinary or proportionate means, and...”
Patients have the right to refuse invasive treatment procedures which they feel are burdensome. Even some patients who can afford refuse dialysis, coronary bypass surgery, or organ transplants. They prefer to just be treated medically until the end. That should come after a careful and thorough discussion of the physician with the patient and family to ensure informed decision and respect for autonomy.

In case of dilemma, the role of the Bioethics Committee is consultative and advisory. The attending physician remains to be the decision maker.

An Innovation of the DNAR or withholding of cardiopulmonary resuscitation (CPR) is the POLST- meaning Physician Orders for Life-Sustaining Treatment— to address the medical needs of the patients with terminal illness, chronic and critical illness, or advanced illness, to decide whether there is reasonable hope or benefit if CPR is done. The difficulty in deciding on this in many situations is because of the fear of litigation. But as experience shows us, what is important is a good patient-doctor relationship and continued communication with the patient and the family so that they fully understand the status of the patient and what is going on.

Since Cicely Saunders pioneered the modern hospice movement in the mid 20th century, it initially focused on care given at home. The main focus of her foundation was to understand the patients' total pain which includes physical symptoms, mental distress, social and emotional problems…the syndromes of pain rather than the syndromes of disease, which was her major concern.

Saunders’ vision for hospice care aimed to address the total pain of the patient. She was a lifelong opponent of euthanasia. Take note that relief of pain is not the same as terminal sedation which deliberately delivers high doses of pain relievers to hasten the death of the patient and is therefore an active form of euthanasia. Hospice neither hastens nor postpones death. It addresses properly the problem of pain and loneliness and spiritual care. A team of care givers accompanies the terminally ill patient in their final journey and give genuine compassion.

In the Philippines, Dr. Josefina Magno introduced hospice care (She was also the one who developed the Georgetown University pilot project on Hospice Care). It will be ideal if all our hospitals will develop their own. Now, several national bodies have recognized the important and concurrent role of providing hospice and palliative care in hospital settings.

On a final note let us remember that – “GOOD medicine cures sometimes, palliates often, and comforts always.”

Asian Development Bank.

From Day 1 after Yolanda, the international community came in with financial and operational support. Up to the present, international NGOs are still very visible and very active during the recovery and reconstruction phase. Similarly, the private sector has not been delinquent in its effort to help in rebuilding efforts. National government agencies and local governments are doing the best that they could under the circumstances; bureaucracy and politicking has hampered their efforts, however. A lot of credit should go the much-vaulted resilience of the residents. Indeed, “the strongest typhoon could not bend the will of the strongest people in the world.”

Clearly, a lot still needs to be done.

The international community and private sector are doing their jobs. It is the national government who must focus on scaling up recovery efforts. Politics should be set aside.

The President must bear in mind that not all of those who live in Tacloban are Romualdez. The priority needs of those most affected by the typhoon must be addressed.
faced with the challenge to evaluate whether or not this set of guidelines will create a significant and positive impact on the healthcare it was designed for. This evaluation will be necessary in the review and updating of the recommendations in the future.

Lastly, the need for more local clinical practice guidelines for cardiovascular healthcare has become more pressing. While advances in cardiovascular healthcare happen in leaps and bounds around the globe, the sad fact remains that real world practice is far from ideal for most heart patients in the Philippines. Thus the need for more appropriate or suitable local guidelines.

In conclusion, the beauty of coming up with local guidelines is not to boast that we now have our own. It is not even in the fact that our practice of cardiology has reached a higher level of maturity, seasoned enough to cater to the needs of our patients. But it is in the reason why we came up with these guidelines: because now we know and understand our patients better, and we will act to make them better, too. Now, that is the heart of Philippine Cardiology.

♥

ESCAPE BEAT... from Page 33

designed opportunity before he was granted eternal peace. Or that this was a final call of duty that he sought to respond to before signing off with his Hippocratic calling. Or that this was really second nature to the kind of committed and involved clinician that he was. And that this was his ultimate passport to heaven. (Yet to many who knew him, he was already guaranteed indefinite stay in His Kingdom)

So long, Von. Sleep in Thy Holy embrace. ♥

OPINIONATED... from Page 35


Aerobic exercise is defined as “the continuous rhythmic contraction of large muscle groups”; this is in order that the maximum effects of efficient aerobic glucose-based metabolism will be achieved. Unless you are in-charge of mopping the floors of Palace Versailles, you will hardly employ the large leg muscles continuously for housework. Housework is tedious and wearing but hardly the exercise prescribed by health experts.

9. Ma-apendik ka diyan! Kakakain mo lang, nag-exercise ka na.

It is incredible that this idea is widespread even among physicians. Vigorous exercise immediately after a meal will shunt blood flow away from the splanchnic (gastrointestinal tract) where it is needed and can cause a cramp and GI distress. Appendicitis begins with obstruction and inflammation of the appendix; in this country where intestinal parasites abound, the role of exercise in appendicitis is probably that of helminthic exercise and migration.

10. Sapat na ang exercise, hindi na kailangang mag-diet para pumayat.

Exercise alone is only moderately effective for weight loss and the role of exercise is mainly for the maintenance of weight loss. The consumption of the 300 or so calories derived from a cheeseburger would require exercising for an hour! The best strategy for weight loss is a combination of exercise and dietary restriction and the first exercise to practice is shaking your head to the question of “Would you like a second helping?” ♥

EDITORIAL... from Page 2

The PHA Website E-Library

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♥
The Year that Was...

In a nutshell, PHA's indelible marks and tracks in 2014.

January - February 2014
• First out-of-town Heart Month in Cebu makes waves. At least 400 people from all walks of life by foot, car and bike, dashed to Plaza Independencia to take part in the free Heart Month Fair. Organized by PHA National and Cebu, the Queen City of the South is the launching pad of 52-100 outside of Manila.
• A-WATCH collaborative project on track – PHA Council on Women's Health Dr. Milagros Yamamoto with two (Drs. Ma. Adelaida Iboleon-Dy and Mita Senadrin) of her active members met up with members of the A-Watch (Asean Women Advocacy toward CV Health) Core Group in Cebu on Feb. 13, 2014 to chart their plans for the A-Watch Registry.
• Enterprising media pursue story leads
• 52-100 takes moderate strides
• financial Crunch delays PCI, CABg
• Hypertension is the most common risk factor

March - April 2014
• Know your Candidates! Vote wisely
• PHA Booth occupies a strategic spot at 63rd ACC.14 Meet in Washington
• 56 hurdle Diplomate exams
• Asian heart docs par excellence are this year’s Professorial Lecturers
Drs. Annette Pizarro-Borromeo, Saturnino Javier, Carolyn Lam Su Ping, Rodrigo Chan and Wilberto Lopez
• April media exposure: A continuum of issues
• Northern Luzon split into 4 Chapters
Geographically challenged Northern Luzon Chapter is now composed of the Baguio-Benguet, Dagupan, Pangasinan, La Union-Ilocos (Norte and Sur) and Cagayan Valley (Nueva Viscaya, Isabela and Tuguegarao) clusters.
• 45th PHA Annual Convention & Scientific Meeting Works on “Targets & Beyond: Cross-talks and Strategies”
• Manila and Cebu cardios make it to prestigious Lifetime Achievement and College Awards

May - June 2014
• Dr. Joel Abanilla, 63rd PHA president, has research as numero uno agenda
• 1,688 attend 45th PHA confab
• Dr. Fatima Collado: First lady to lead SLHI
• Dr. A. Borromeo, the Dr. Mariano Alimurung Lecturer, tackles Complex Physician-pharmaceutical industry links
• Dr. Carolyn Lam Su Ping, the Dr. HB Calleja Professorial Lecturer expounded on Echo’s role in diastology to Heart Failure.”
• Dr. Saturnino Javier, the Dr. Rodolfo Soto Professorial Lecturer talked about the “Evolution of Cardiac Cath and Interventions”
• Dr. Rodrigo Chan, the Dr. Ramiro de Guia Memorial Lecturer stressed that “Cardiac Resynchronization Therapy is knowing the leads, location.”
• Dr. Wilberto Lopez, the first Dr. Santiago V. Guzman Memorial Lecturer said that the Philippine Foundation for the Prevention and Control of RF/RHD has made a big leap at 20 years old.
• UP-PGH fellows scoop major awards
Dr. Lowe Chiong is Most Outstanding Fellow
Dr. Jaime Alfonso Aherrera is YIA
• PHC rules PHA – SERVIER Most Outstanding Research in Cardiology – Dr. Maria Teresa Abola named first prize in PHA Servier MORC; Drs. Patricia Agunod-Cheng and Raul Jara
• Dr. Edgardo Timbol tops Arrhythmia case contest
• Madocs lords it over at the Cardio Fellows Debate
• UP-PGH pays fitting homage to one of its greatest scholars—Dr. Esperanza Cabral
• PHA urges public to live the 52-100 way
• NL scores double victory at Fellowship Night
• Presidential Citations: Drs. Orlando Bugarin (Council on CPR), Irma Marie Yape (Council on Hypertension), Timothy Dy (Website), Mariano Lopez (Specialty Board on Adult Cardiology), Norbert Lingling Uy (Sub-Committee on Accreditation) and Nelson Abelardo (Sub-Committee on Core Curriculum).
• Northern Luzon scores double victory
It clinched the top prize in the Group Dance Contest and Ramp Modelling Contest during the Fellowship Night of the 45th PHA Annual Convention & Scientific Meeting

July-August 2014
• One-on-one with the President
• Strategic Planning Workshop 2014, Focus: Registry & Research – An assessment of the PHA’s performance/role in the advancement of local cardiology, cardiovascular education and mileage of Lay awareness Advocacy Campaign.
• In focus: It’s Atrial Fibrillation Awareness Month
• AF: Updates & Controversies
• Atrial Fibrillation: Catheter Ablation
• Deja Vu – From 2006 to 2012, there were three lady board of directors. In the May 2014 polls, Drs. Nannette Rey and Aurelia Leus made it to the election derby.
• DZMM, DWIZ, DZRH broadcast PHA battlecry
3 radio stations DWIZ, ABS-CBN DZMM and DZRH served as mouthpieces of the association’s lay advocacy programs.
• PHA, DwIZ in 1-year partnership
• RP Healthcare Workforce to Pnoy: Solve health crisis
A big group of health professionals declared a national workforce crisis and exhorted President Benigno Aquino III and Congress to “take immediate sustained and dramatic steps to solve this urgent situation because it puts the lives of millions of Filipinos at risk.”
• RP to host 1st Asian CPR Summit in 2015
• BP ng Teacher Ko, Alaga Ko on track
• Seamless CME programs are coming up
• Changing of the Guard in the Chapter
• SLHImarks 28th year
Dr. IV Ongtengco: HB Awardee
• Enchanting Iloilo
• Tribute to Dr. Erlyn Demerara: 8 Precious Years with PHAN

September - October 2014
• It’s Sudden Cardiac Arrest Month
• Training de traitors should be a beyond-frontiers thing. Doctors in far-flung areas should be able to recognize arrhythmia.
• World Heart Day 2014: PHA partners with Don Bosco Parish
• Abs-Cbn Big Loser survivors grace WHD celebration at Don Bosco Parish in Makati
• What’s Up Bohol? Tagbilaran and its neighboring towns pick-up the pieces
• Abanilla: Pinoy’s more likely to lose lives than Ebola. What we lacked in numbers, we made up for it in value.
• At PCP Health Forum: CPR and AED can save more lives
• 80% of out-of-hospital arrest happens in the home, with at least one family member present
• Asia Health Summit gives 52-100 ample mileage – PHA Vice President Alex Junia tells the 100 Asia Health Summit delegates, mostly ranking officers of top multi national and local corporations to integrate 52-100 into their daily routine.
• BP ng Teacher Ko... expands horizon
• One year after the Great West Bohol earthquake.
After an entire day of orientation on the complexities and realities of actual cardiology practice, the Fellows with good grace, hastily put on their Cosplay costumes. The event’s highlight was the very stiff Cosplay contest which showcased the institutions’ very own talents who impersonated their favourite anime characters. The event started and ended with a bang with much glamour and pomp as the Fellows from different institutions and PHA Board members partied. Adding to the excitement were the strong presence of the PHA Board and institutions’ training officers who, just like their Fellows, donned their favourite characters’ signature outfit.

Nov. 22, 2014 was a historic day in the PHA calendar. It was blocked for the staging of the back-to-back “How to Prepare for Real World Practice” workshop and Fellows Christmas Party themed “A Very-Cosplay Christmas. Natrapharm-Patriot has been an all-out sponsor of this PHA-Continuing Medical Education activity. Venue was at the Natrapharm-Building in Sucat, Parañaque City.
The Philippine General Hospital clinched its fifth straight 1st place status while The Medical City and Chinese General Hospital won the 2nd and 3rd places, respectively. Special awards were also given to the institutions and individual fellows.

Finally, despite the competition, the event fostered a great night of camaraderie and fellowship among the future cardiologists of the country.

The event was hosted by the ever energetic Drs. Helen Ong-Garcia and Nanette Rey, Continuing Education Program Committee chair and Sub-Committee on Cardio Fellows-in Training chair, respectively.
The Philippines stands out for holding the longest Yule celebration. Unique and unparalleled. That’s how Christmas Pinoy style is. The Filipinos’ preference for fusion fare and decors has some bearing on their having mixed bloodlines. Having strong family ties and adherence to their cultural heritage are inimitably very-Pinoy. These customs are very evident during Christmas and New Year. Christmas and New Year give every family member a good reason to dash home.

PHAN peeks into a few cardiologists’ homes to discover their Christmas traditions. GPGagelonia

The more, the merrier. Our collection of Christmas ornaments and cutlery is growing. We just make sure they are cohesive and coordinated as they occupy a new nook and cranny in our home.

Our huge Christmas tree at the sala and three parol (lanterns) by the main door are the focal points in the house. For our Christmas Eve recipes we have ham, beef caldereta, menudo, lechong manok, igado (an Ilocano pork dish), fish fillet with sweet sour sauce, traditional Christmas colors. Red rules the house. It is timeless. It is hot, especially when complemented by shades of green, white and gold, in this order.

Red is hot & timeless
By Annette P. Borromeo, MD
Past PHA president

We are conventional lot that is why we stick to the striking and festive traditional Christmas colors. Red rules the house. It is timeless. It is hot, especially when complemented by shades of green, white and gold, in this order.

Let me show you our collection of Christmas ornaments and cutlery. We just make sure they are cohesive and coordinated as they occupy a new nook and cranny in our home.

Our huge Christmas tree at the sala and three parol (lanterns) by the main door are the focal points in the house. For our Christmas Eve recipes we have ham, beef caldereta, menudo, lechong manok, igado (an Ilocano pork dish), fish fillet with sweet sour sauce, lettuce-avocado salad, queso de bola, a variety of fruits, and the cheese plate appetizer (consisting of brie cheese, Ritz biscuits or triscuits with grapes and nuts), yema balls and other dessert churned out by my daughters. We always make sure that the pantry has a refill of the cheese appetizer and other delicacies for guests.

Cheese Plate Appetizer & Avocado Salad
**Panara & Parol thru the years**  
_By Franz Pelagio, MD_  
President, PHA Central Luzon

Our signature Christmas and New Year menu is called _panara_. A traditional _Simbang Gabi_ (Midnight Mass) delicacy here in Pampanga, it resembles the fried lumpia. It is often paired with _puto lason_ (it may not sound too palatable but that’s how our white puto is called here in Pampanga) which gives a balance of mild sweetness to the tangy and spicy taste of _panara_. _Panara_ is stuffed with shredded unripe papaya and seafood -- either shrimp or crab or both and dashed with East-West fare  
_By David Salvador, MD_  
President, Southern Tagalog Chapter

Our family goes for the traditional family recipes during the holiday season. Our staple Noche Buena includes chicken potroast, kare-kare, pancit molo, ham and _queso de bola_. The family bakes a special cheesecake based on a secret family recipe two days before Christmas and this is served on the Christmas table as well as given to friends as gifts.

New Year Media noche consists of grilled steaks, sausages and pork barbeque done outside the house while watching the fireworks display.

**Magical Christmas tree, lights**  
_By Estela Mabanag, MD_  
PHA Northern Luzon, president

Christmas calls for special recipes prepared with the participation of each member of the family, thus making it a seasonal tradition. _Paella_ pleases everyone with all the ingredients thrown in for that tasty flavorful fare.

With regards to decors, there may not be a yearly theme but there will always be Christmas lights. Lights that symbolize peace and joy and characterize the spirit of the season.

One particular piece of decor we’ve always had over the years is the mini silver Christmas tree with tiny trimmings. Perched on a big antique table, this tiny tree is a conversation piece that gets swarmed with gifts.

**Something old, something new**  
We don’t really have a theme every year. We use our traditional decors and add up some more pieces through the years. My wife, Bing usually decides on the Christmas decorations every year. She skillfully blends the old and new ones, spicing them up with new ribbons and details. She has a knack for making old ornaments look new!

Our Christmas angel has been with the family since we were kids. One particular piece of decor we’ve always had over the years is the mini silver Christmas tree with tiny trimmings. Perched on a big antique table, this tiny tree is a conversation piece that gets swarmed with gifts.

See Page 46
my wife's family for decades as their Christmas tree topper. When we got married, it was handed to my wife when we celebrated our first Christmas as a new family. It has been a part of our own family Christmas tree since then. We also have this large Nativity Scene that is displayed every Christmas, the background of which changes every year. All other Christmas frills are built around this scene. ♥

salt and black pepper. The vegetable and seafood mixture is cooked first then it is enveloped in rice wrappers. It is later fried until golden crisp. The result is a crunchy and fairly-spiced fried papaya empanada.

We don't have themes. Our color scheme yearly usually plays around the hues of gold, green and red.

The Christmas arrangement in our home is a collective effort by the whole family.

Our all-time favourite Christmas decor is the flickering San Fernando lantern, locally called “Pernandung Parul” which is hung by the main door. It is made of beautifully-arranged stained windowpane oyster (Capiz) patterned to that of a star that glows wonderfully when lit. Right after Midnight Mass, we turn on the parol, which has never failed to mesmerize passers-by. ♥

simply means:

- Eating 5 servings of fruits and vegetables per day
- Limiting to just two hours of TV or computer per day
- Having one hour of exercise per day
- Zero to sugared beverages
- Zero to smoking

♥
A novice Philippine Heart Rhythm Society (PHRS) made sure it celebrated its small but significant strides, on the breezy and starry night of December 11, 2014. Venue of the PHRS Thanksgiving-Christmas Party was the picturesque Ayala Hillside Clubhouse in Matandang Balara, Quezon City.

Two prominent electrophysiologists -- Drs. William Chua and Ma. Belen Carisma, PHRS president and members -- emerging names in EPS like Drs. Gladys David and Eden Gabriel attended to the guests – PHA President Dr. Joel Abanilla, PHA Council on EPS chair Dr. Erdie Fadreguilan and pharmaceutical allies.

What made the night twice as joyful and revealing was the Videoke singing. It was a night for a good number of singing cardiologists and pharma people around at that time. One of PHRS’s mission is the promotion of research. PHRS is the youngest affiliate society of the PHA.
In attendance were 31 CME officers from Astra Zeneca, LRI-Therapharma, Natrapharm, Menarini, MSD, Boehringer Ingelheim, Merck, Takeda, Pascual Pharma, Servier, ADP Pharma, Pfizer and Getz Pharma.

The Board’s revered predecessors (Drs. Ramon Abarquez, Avenilo Aventura, Francisco Dizon, Jose Yulde, Marcelito Durante, Maria Teresa Abola who came with hubby Mel and Saturnino Javier); the Council Chairs (Drs. Eduardo Tin Hay, Jude Erric Cinco, Gary Lopez), also came and gladly joined in the parlor games and crooned with the superb guest performers Misses Hadasa Von Camporaso and Mona Liza Darao.

The emcees, Drs. Junia, Ong-Garcia and Rey effortlessly kept the night young and amusing. The success of the party can be partly attributed to the PHA Staff who have mastered the ropes of running events. ♥
Health Hazards:

Holiday food and drinks and their Caloric content

**Savory Foods**
- Ham, Regular – 34 calories for every slice (75oz)
- Baked Ham – 207 calories for every 3 oz serving
- Queso de Bola – 90 calories per 1 serving
- Spaghetti – 220 calories for every 1 cup serving
- Lechon – 113 calories for a 50 grams serving
- Fresh Lumpia with sauce – 273 calories for each piece
- Macaroni Salad – 440 calories for every ¾ cup
- Potato Salad – 357 calories for 1 cup
- Paella Valenciana – 392 calories for 1 cup

**Sweet Foods**
- Bibingka – 100 calories per slice
- Puto Bumbong – 200 calories for 4 pieces
- Buko Salad - 500 calories in a small bowl
- Fruit Cake – 324 calories for 100 grams

**Beverages**
- Beer – 43 calories per 100 grams
- Red Wine – 73 calories a glass
- White Wine – 85 calories a glass
- Champagne – 85 calories a glass
- Cognac – 163 calories

Photo credit: Internet
Another traditional December activity on the PHA calendar is the PHA Staff Christmas party. This year, it took place on Dec. 18, 2014 at the Heart House, Suite 1108, East Tower, PSEC Centre, Pasig City.

It was graced by no less than the PHA President, Dr. Joel Abanilla. After a quick lunch with the staff, he handed his personal presents and the Board’s token to each of the 12 employees. The Staff admire him for his all-year-round thoughtfulness and for bringing them home-treats from trips that are tailored to the former’s individual tastes.

As in the past years, Jenny Ymasa, the perennial emcee, took charge of the parlor games. Irene Alejo, did not mind lugging her DVD player all the way from Bulacan just to please her Videoke-addict officemates. Everyone, did his/her part in soliciting prizes for the raffle so that no one goes home empty handed.

The yummy concoctions – baked turkey with diced potato, apples, celery and raisins stuffing, braised beef, spaghetti, vegetable salad and chocolate cake —were gifts from Mrs. Teresita Yao, the official caterer of PHA.
Whether we celebrate Christmas and New Year in old-fashioned or modern style, let’s wish each other a Merry December and a Prosperous and Peaceful 2015!

From the PHA Board of Directors 2015