Mrs. Rita Lopez Ongtengco believes that the family that prays together, stays together. All her children are treated equal. She is very protective of their only girl but can’t help being protective either, of her five good-looking boys.

One of the rules which they should comply with is giving their mom their whereabouts.

While dating Bel, the fresh nutritionist/dietitian was waiting the green light from a prospective employer. At that time, the young GP worked at Lourdes Hospital as a clerk while looking forward to his IM training in the US right after passing the medical board exams.

Rita’s career plan was aborted by Bel’s marriage proposal. The newly-weds flew to the United States where Bel had his IM training and started a family. Jayson and Richard, their two elder sons, were born in the US. She assumed multi roles -- wife and mom sans household helps and still managed to teach catechism the entire five-and-a-half years they were there. When they came back to the Philippines, the Ongtengco brood continued to grow while the doctor’s profession continued to flourish.

Dr. Bel through the eyes of wife Rita.

How do you describe Dr. Bel as a husband?
A very good provider and a dedicated husband. He is a wise spender. He is half-Chinese, half-Filipino.

As a father?
Very caring. The moment he gets home he focuses his full attention on them. No homework for him.

As a lolo?
The best lolo ever. He is proud of his three grandchildren. He even finds time to play “Angry Bird” with them. If he didn’t become a cardiologist, he is one of the best and most dedicated pediatricians.

As a father in law
Very nice and he treats them like his own kids.

Thank you Madame Rita for sharing Dr. Bel with the PHA!
What’s up? Dabigatran, Dronedarone and others

For this issue, we will provide our dear readers and subscribers updates of what were featured in the previous What’s Taking Flight issues.

Dabigatran: extreme care in the frail and elderly

While Filipino physicians are slowly gaining their confidence on the use of dabigatran (Pradaxa, Boehringer-Ingelheim), new cases of major bleeding with the use of this new anticoagulant have been reported in the Archives of Internal Medicine.

We quote from the July 2011 edition of the Archives of Internal Medicine:

“The first case was a woman aged 84, with a body weight of 40kg and poor renal function (CrCl 32ml/min / 1.73m2), who was being treated with dabigatran 75mg twice daily for AF; she was also receiving amiodarone. She was admitted with abdominal pain and rectal bleeding, and during the course of her admission developed massive rectal bleeding that was fatal. Haemostasis was impaired with an activated partial thromboplastin time (APTT) of 6.43 seconds (reference range <1.16 seconds) and prothrombin time of >60 seconds (reference range, 6-13 seconds). Trough plasma concentration of dabigatran was very high (5600 microgram/l; expected range, 31-225 microgram/l).”

“The second case was also a woman, aged 89, with a body weight of 45kg and CrCl 29 mL/min / 1.73 m2. She was admitted for removal of a cochlear implant, but reported a 1-week his.

The surgery concentration was 2670 microgram/l. The surgery prothrombin time 32 seconds; dabigatran plasma concentration of dabigatran was very high (5600 microgram/l; expected range, 31-225 microgram/l).”

While dabigatran labels include warning or precaution on its use in elderly patients and in those with renal impairment, more doctors are into prescribing this novel drug even to the elderly and the frail. Note must be taken that the RELY trial included only a few elderly and lean patients (mean age is 72 yrs, mean weight is 82kg).

The RELY trial have provided convincing data that dabigatran is beneficial among the relatively young patients with AF, but the medical community worldwide awaits the publication of the detailed analysis of the RELY data by age. More issues on dabigatran that need settlement include its interaction with amiodarone that increases the former’s bioavailability, tests to determine its overdose and the inavailability of an antidote to overdose.

These new developments entail the clinician to practice utmost care and vigilance in prescribing dabigatran to the elderly, the frail and the renally impaired until we see convincing evidence to support its use in these select populations.

Recently launched in June in the Philippines, dabigatran is indicated for the prevention of stroke in patients with atrial fibrillation on the basis of the favorable RELY trial results. From that trial, the 150mg BID dose was found superior over warfarin but carried more risks in bleeding and the 110mg BID dose was found equivalent to warfarin even in terms of safety. Of course, the advantage of this novel anticoagulant over traditional warfarin deemed bigger and more significant is doing away with regular INR monitoring.

In European countries (the UK has yet to approve dabigatran for stroke/AF indication), Canada and most countries, the 150mg and 110mg BID dose have been approved for such stroke/AF indication. The US has been more careful with its recommendations, approving only the 150mg dose and 75mg dose for patients with severe renal impairment. US FDA stated that the data in favor of a 110-mg dose “were suggestive but not entirely convincing.”

War of the Statins: IT’S A TIE!

A randomized clinical trial comparing the effects of rosuvastatin (Crestor) and atorvastatin (Lipitor) on coronary artery atheroma volume reduction determined by intravascular ultrasound showed similar results.

In a company press release by trial sponsor Astra Zeneca, the percent atheroma volume results “demonstrated a numerically greater reduction in favor of rosuvastatin vs atorvastatin but did not reach statistical significance.”

However, there was a statistically significant reduction in total atheroma volume (secondary endpoint) with rosuvastatin use compared with atorvastatin.

Involving over 1,385 patients over two years, the Study of Coronary Atheroma by Intravascular Ultrasound: Effect of Rosuvastatin Versus Atorvastatin (SATURN) “targeted a prespecified ≥40mm coronary segment. The trial started enrolling subjects in 2008 and ended last year, however the number of patients included was not not able to empower the trial for clinical end points.

More data and analyses on the SATURN results will be presented by its investigators at the American Heart Association Scientific Sessions this coming November 2011.

Ticagrelor finally hurdles FDA approval, but...

The FDA has finally approved ticagrelor (Brillinta, Astra Zeneca) this July six months after the drug was approved in Europe. The drug was approved to reduce cardiovascular death and MI in patients with acute coronary syndromes.

The new approval requires then inclusion of a box warning about bleeding risks stating that use of this drug is not recommended in patients taking more than 100 mg/day of aspirin.

FDA’s Dr. Norman Stockbridge, in an interview with Medscape, noted that “in both the United States and the rest of the world, patients on low-dose aspirin have better outcomes using ticagrelor. The FDA spokesperson added that findings in both regions, patients on high-dose aspirin do better with clopidogrel, a finding that was seen for the overall composite endpoint and the major components of CV death and MI.

This was the analysis that got the backing
of the FDA after the PLATO trial was hounded by the North American Anomaly. Patients form the US and Canada (North America) who were put on ticagrelor did not fare as good as other subjects around the globe did.

In Canada, ticagrelor was likewise recently approved specifying that the drug be coadministered with a low (though higher than the US recommendation) maintenance dose of aspirin of 75-150 mg.

In the PLATO trial, ticagrelor (together with aspirin) significantly reduced the combined endpoints of CV deaths, stroke, and MI in patients by 16% as compared with clopidogrel plus aspirin. This new antplatelet agent will be made available in the Philippines by next year.

Alas! Dronedarone drowns in PALLAS

The PALLAS trial (Permanent Atrial fibrillation outcome Study) using dronedarone (Multaq, Sanofi Aventis) on top of standard therapy was prematurely stopped this July because of a significant increase in cardiovascular events in the dronedarone arm. Fortunately on one hand, the early discontinuation of the trial was not related to any adverse hepatic event (It must be recalled that dronedarone have been beleaguered with serious and fatal hepatic events following its use.)

The PALLAS trial was a double-blind, placebo controlled phase IIIb comparing dronedarone to placebo in patients with permanent AF. It had two composite primary endpoints, major CV events and CV hospitalization or death from any cause. The study was started in July 2010 and was set to be completed by August in 2013, targeting more than 10,000 enrolled subjects.

Dronedarone is currently approved for use only in patients with non-permanent AF.

Confessions of a Fellow-In-Training:

What’s In a Name?

One of my non-medical friends who used to join me and my doctor-friends in our travels once remarked that our life in this profession is extraordinary—deserving of a sitcom in primetime television. Not only do we live horrible schedules and gravely inhuman work hours, we also subsist on a totally absurd and unjust paycheck, inversely proportional to the extent of our labor and psychosocial and emotional burden. What he found most amusing, however, was the fact that we never run out of intellectual conversations. According to him, ordinary dialogues in the outside world where he came from usually revolve on the mundane, the casual, and the superficial. Doctors, on the other hand, talk about life - what they try to save, and what they miss in the process.

This good friend, one of the most amazing and profound people I’ve ever had the good fortune of running into, had the habit of listening to us while we rant and whine about our work and our patients, once in a while giving his trademark lach ronic comments or a wordless mocking grin. After being exposed to us for several instances, however, he concluded that doctors all over the world, no matter how diverse and strange, will always find something to talk about - their patients.

But while doctors occasionally consider their patients’ cases fodder for casual conversations, I realized patients also talk about their doctors a lot more than I expected them to. During yesterday’s out-patient clinic, I overheard a bunch of patients talking about their own doctors, reminiscent of those Tito, Vic, and Joey sessions in Eat Bulaga’s Bulagan.


Patient B: Mas mabait yung doktor ko! Lagi ako nginibigyan ng napagpang gamot! Eto may mga abstract at referral letter pa. Kaya nakakalapit ako agad sa mga senador.

Patient C: Pinakamagaling yata yung doktor ko! Mukha pa syang artista! Mabait na, maganda pa.

Patient A: Talaga? Anong pangalan ng doktor mo?

Patient C: (blurt out a gravely mispronounced name of someone familiar) Basta yung maputi na parang model. Tawag ko nga dun si Dra. KC. (probably referring to KC Concepcion)

Patient B: Yung akin, di ko matandanan ang pangalan e. Ang hafa kasi. Basta yung mataba na mataba akong ang tyan. Pero kahit ganun yun, mabait yun!

I was wishing Patient C was talking about me, though that would be highly unlikely. I’m probably more of Patient A’s doctor. Ehem, ehem. I was laughing to myself at this thought while busy scribbling on my patients’ charts when I overheard another OPD conversation, this time at the nurses’ table.

Nurse: Nanay, sino po ang doktor nyo?

Patient: Hmmm, basta yung mabait po.

Nurse: Nanay naman, mabait naman lahat dito. Kelangan ko yung pangalan ng doktor nyo.

Patient: (To her companion) Sino nga ba yung duktoran yun? Ah, naadla ko na si Dra. Alcobar! Yung mabait! Malaking babae na mabait. Oo nga, si Dra. Alcobar - yung matangkad na mataba! Ahhh, waaatattt?! The grossly mispronounced surname, I can forgive. But mataba?? That’s an abomination! I’ve been on a diet for months, yo-yoing between fat and fatter, getting depressed and sulky over it and my patient who doesn’t even pay me anything just called me fat??!

I stared at my poor patient, like I was going to pounce on her and give her a defibrillatory dose of shock waves - all 360 joules of it. But then catching my glance, suddenly, her face lit up. “Duktora Alcobar!! Duktora Alcobar!!”

I couldn’t help but smile at her. And the old woman, obviously pleased at seeing me, hobbled and teetered toward me using all her post-stroke effort, and gave me a hug. Surprised and touched by this display of affection, all my impulsive irritation evaporated. Sigh... Ok, I don’t really mind being called fat. She’s right anyway.

Come to think of it, I wouldn’t really mind if my patients could not pronounce my name properly. And I wouldn’t really mind if they only remember me as “matangkad”or “malaki” or even as “mataba”. For as long as once in a while an old woman will smile at me the way that-patient-who-called-me-fat did, or if a blind old man will claim with unblinking certainty, “Alam mo duktora, ang ganda ganda mo”, I guess I’ll be all right.

Perhaps I’m doing fine, after all.
Gap Phenomenon

1. An office worker leaves in his car early to avoid the rush hour traffic. Recognizing the green traffic light from afar, he drives down the empty street at 70 kph.

2. Seeing the traffic light turn from green to yellow, he slows down his car to 40 kph to avoid coming to an abrupt stop at the anticipated red light.

3. Approaching the red light that has just been turned on, he decelerates further to 20 kph to allow more time to elapse before the next shift in the traffic light.

4. Driving at 20 kph, he gets to the intersection at the shift to the green light. He then accelerates his car to 70 kph again.

The foregoing account is a simple analogy to a complex electrophysiological event exemplified in the following tracing. Two to one (2:1) AV block is clearly depicted in the second half of the tracing. Two PAC’s (marked by *) which are successfully but unexpectedly conducted to the ventricles are shown in the first half. The paradoxical conduction of PAC’s in the presence of second degree AV block could be explained on the basis of the gap phenomenon.

In the analogy, the car represents the impulses traveling from the atria to the ventricles. Some of the impulses coming from the SA node that rapidly traverse the AV node encounter the effective refractory period (red light) of the His-Purkinje (HP) system. As a result, their passage through this distal pathway is blocked and ventricular activation fails. Intermittent failure of conduction at the HP level is responsible for second degree AV block with 2:1 AV conduction observed in the tracing.

With shorter coupling intervals, impulses driven by PAC’s slowly negotiate the AV node which is still in its relative refractory period (yellow light). By the time these impulses pass through the AV node, the HP system has completed its effective refractory period (green light). Then, distal conduction to the ventricles is allowed to proceed unhampered. A gap in impulse transmission from the AV node to the HP system enables the recovery of excitability in the latter.

This tracing was presented in the Dec 2009 – Jan 2011 issue of the PHAN. Supranormal conduction of PAC’s and retrograde conduction of PJCS were considered as possible mechanisms. In electrophysiology (EP), everything is possible. But what is most plausible is most probable.

By Edgardo S. Timbol, MD
The Law and the Practice of Medicine

Doctrines applied in medical malpractice cases

The factual venue and attending circumstances surrounding a possible case of malpractice is as varied as the kinds of diseases, the individual differences, the so many possible management options, the training of the physician, his assistants and staff and even the financial capacity of the patient involved. To hold a physician liable, several doctrines have been applied. These doctrines are kept sufficiently flexible so as to cope with different situations and maybe applied now but later may become obsolete because of the demands of justice and the changing times. I am discussing some of the most common doctrines that are still in use today.

The first doctrine and one which we are familiar more with is the Doctrine of vicarious liability or Doctrine of Respondent Superior. Generally, the law provides that every person is liable for the consequences of his or her own negligence when another person is injured as a result. In some instances however, the physician is made liable for the mistakes of those who are working for him and is therefore made to pay for damages. Vicarious liability simple means the responsibility of a person on the negligence of another. In the medical setting, this occurs in various forms: a) the Doctrine of Ostensible Agent holds that the principal (the physician) is bound by the acts of his agent with the apparent authority which he knowingly permits the agent (his staff) to assume, or which he holds the agent out to the public as possessing. The question in every case is whether the physician has, by his voluntary act, placed the agent in such a situation that a person of ordinary prudence, conversant with business usages and the nature of the particular business is justified in presuming that such agent has authority to perform the particular act in question; b) in the Borrowed Servant Doctrine, a physician is held liable for the acts of the hospital staff who he temporarily supervises in the course of his patient management. Residents and nurses are employees (or servants) of the hospital and the latter is generally held liable for their negligence. There are times however, when the former are under the direct control and supervision of the physician while performing their duties. By fiction of law, they are deemed borrowed from the hospital by the physician and being the new employer or master, the latter must be held liable for their negligence; c) Captain of the Ship Doctrine usually applies to surgeons who are likened to a ship captain who must be responsible for the safety of his crew and the passengers of the vessel. This doctrine holds the head surgeon responsible not only for the wrongful acts of those who are under his physical control but also those wherein he has extension of control.

To make the superior responsible for the faults of his employee’s negligence, it must be proven that the employee was chosen by the superior (not applicable in the Borrowed Servant Doctrine), that the act in question was performed according to the orders of the superior and that the wrongful act was on the occasion of the function entrusted to him. Once the above requisites are present, the only defense of the superior to extricate himself from such liability is to prove that he has exercised due care and diligence in the selection and supervision of his employees. In the Doctrine of Vicarious Liability, the superior is made so liable because the negligent employee usually have not enough money, the superior has the power to select his employees, that he has benefited from his employee’s work and he is in a better position to approximate future damage.

The Doctrine of res ipsa loquitur or the Doctrine of Common Knowledge literally means the thing speaks for itself. Generally, when one is sued for a wrongdoing, the burden of proving the same lies on the defendant. In this doctrine, when an injury occurs in circumstances where it is shown that the act complained of is under the management of the defendant and that such injury does not happen in the ordinary course of things if such management or control use proper care, the burden of proof shifts to the defendant. He is prima facie held negligent in the absence of sufficient explanation. For this doctrine to be applicable, three requisites must be present, namely, the accident is of a kind which ordinarily does not occur in the absence of someone’s negligence, the injury is caused by an instrumentality within the exclusive control of the defendant or defendants and there was no contributing conduct by the plaintiff. Common cases applying this doctrine includes leaving objects in the patient’s body at the time of surgery, injury to a healthy part of the body in the treatment area or to a part remote from the treatment area, removal of a wrong part of the body when another part was intended, teeth dropping down the windpipe during intubation, burns in the course of an admission, infection resulting from unsterilized instruments, failure to take x-rays to diagnose possible fractures, fracture set so badly that the deficiency of the workmanship is apparent to anybody, disability directly resulting from injection of drugs into the body and explosion of anesthetic gases.

The Doctrine of contributory negligence refers to the conduct in the part of the plaintiff contributing as a legal cause to the harm he has suffered which falls below the standard to which he is required to conform for his own protection. If the proximate cause of the injury is the plaintiff’s own negligence, he cannot recover damages. But if his negligence only contributed to the injury, the proximate cause of which is the physician’s negligence, the latter’s liability will be mitigated or lessened by the court.

The Doctrine of continuing negligence is applicable where a physician fails to further investigate a case after a prolonged treatment produces no improvement when in fact normally it would.

The Doctrine of Assumption of risk is based on the maxim see Page 30
The cardiologist, OFW and Survival 101

Ours is a country where overseas Filipino workers (OFW) drive the economy to stability and resiliency. Their remittances from years of hard work in foreign lands prop the local economy to withstand global events that could otherwise impact on the market much more negatively.

The Filipino doctors’ clinics abound of OFW tales – stories of motivated, ambitious, sometimes desperate Filipinos trying to change the course of their lives by working elsewhere where pastures are greener, dreams are bigger and life is easier. The four corners of a Filipino physician’s clinic are mute witnesses to genuine pitiable pleadings, pathetic bargaining, occasional deceptive strategies, even fatalistic posturing.

Cardiologists are usually called upon to assess a prospective worker’s condition if he or she has any cardiac impediment or impairment that may pose a threat to his well-being while working abroad. In many cases, the cardiologist provides the final medical go-signal allowing or prohibiting the overseas worker from pursuing a dream or realizing an aspiration. And that effectively puts the cardiologist at the receiving end of pleas, tears, sobs, even subtle bribery.

This can prove to be a tough call many times. For in the eyes of the OFW, only the physician stands in the way of a life in the dreamy state of California or the dizzyingly fast-paced life of New York. How can this heart doctor have the heart to be the last obstacle to a happier and more progressive life elsewhere? For the OFW, the doctor is the hindrance to a life away from galung-gong and kangkong, thus being viewed as the uncaring, uncooperative and unyielding force that recklessly crushes and trashes a dream.

In reality, the cardiologist happens to be just doing his job of ensuring that a worker is medically fit to travel and work abroad. How can a well-meaning clinician let someone with severe symptomatic CAD work in foreign lands prop the local economy to withstand global events that could otherwise impact on the market much more negatively.

Ours is a country where overseas Filipino workers (OFW) drive the economy to stability and resiliency. Their remittances from years of hard work in foreign lands prop the local economy to withstand global events that could otherwise impact on the market much more negatively.
St. Luke’s Heart Institute marks 25 years of Cardiology

By Jeffrey M. de Jesus, MD

A quarter of a century has passed since the establishment of the St. Luke’s Heart Institute under the leadership of its Director Emeritus Dr. Homobono Calleja. The St. Luke’s Heart Institute was formally inaugurated on August 5, 1986 and became the country’s first private heart center of excellence, dedicated to the management of cardiac disease and committed to providing excellent patient care. Formed way ahead of its time, the Heart Institute has been the leading edge in cardiology.

The Heart Institute Family has grown through the years. Its noble ideals have been passed to each member who has walked through its hallways and have spread throughout the archipelago and the globe. In celebration of 25 glorious years of achievement in the field of Cardiology, the organizing committee headed by Dr. Frederick Cheng prepared a week-long activity highlighted by the “5th Annual Cardiovascular Symposium” which brought to light updates on clinical practices and review of the present as well as future therapies in cardiology.

A ribbon-cutting ceremony held last August 10, 2011 jumpstarted the anniversary celebration. Dr. Isabelo Ongtengco, the current PHA president introduced former health secretary Dr. Esparanza Cabral as the Guest of Honor. Dr. Cabral spoke of her fondest memories while she was working with Dr. Calleja, the visionary who founded the institute. Business meetings were held in the afternoon. As part of its commitment of giving quality service and education to patients, a Lay Forum was also held.

The following day, the Edsa Shangri-La Hotel in Ortigas provided the backdrop for the 5th Annual Cardiovascular Symposium entitled “Celebrating 25 years of Cardiology: Innovation, Influence, Inspiration.” This marked the culmination of the week-long celebration. The two-day symposium provided updates on groundbreaking researches and technologies as well as practical and simple techniques to aid not just the cardiovascular specialist but also internists, residents, family physicians and other allied medical professionals. The event included topics on new medical therapies, venous thromboembolism, critical limb ischemia, coronary artery disease, heart failure and sudden cardiac death.

For the first time, all of the five directors of the Heart Institute were brought together on one stage. Founding director, Dr. Homobono B. Calleja started out to discuss a topic closest to his heart, Infective Endocarditis. Then the other past directors spoke on their expertise in succession, Dr. William T. Chua on the Evolution of Electrophysiology; Dr. Romeo D. Saavedra on CAD in the 22nd Century; Dr. Antonio S. Sibulo on Cardiac Rehabilitation in the Philippines and the region. Then, current HI director Dr. Danilo Kuizon gave a brief history of the HI, its progress over the 25 years and its impact on Philippine Cardiology.

The Scientific committee headed by Dr. Erlyn Demerre tediously selected key topics in Cardiology and successfully provided each attendee with a valuable educational experience. The event was such a success that empty seats were hard to find.

The 25th annual celebration ended with the HI Fellowship and Awards night which was well attended by HI consultants and alumni. Dr. Maita Senadrin was the lady behind the success of the night.

The St. Luke’s Heart Institute is at the forefront of Philippine cardiology; now and always. Mabuhay!

In a Different Light unveiled

By Dennis C. Fernandez, MD, SLMC Cardiology Fellow

The St. Luke’s Heart Institute 25th Anniversary was marked with the launching of a coffee table book entitled “In a Different Light”, a 100-page compilation of portrait photographs of the St. Luke’s Heart Institute Family, Fellows and Mentors in Cardiology, that includes Drs. Homobono Calleja, Isabelo Ongtengco and Fatima Collado, among others. At the helm of this publication is Dr. Rodney Jimenez, head of the 25th Anniversary Documentation Committee and the photographer himself.

This book highlights the many facets of SLHI’s indefatigable cardiologists behind their white coats and stethoscopes, with glimpses of their personal passion, hobbies and interests in a different perspective -- outside clinical cardiology practice, hence it is aptly called “In a Different Light.”

Through the words of Dr. Danilo Kuizon, the Heart Institute Director puts in, this coffee table book is an enduring testament to the St. Luke’s Heart Institute’s 25 marvelous years. ♥
FOR THE FIRST TIME IN OVER 50 YEARS
A BETTER OPTION THAN WARFARIN IS AVAILABLE

STROKE PREVENTION

Introducing
Pradaxa® 150 mg bid
Dabigatran etexilate
Simply superior stroke prevention

Twin Stars for Power and Protection

Telmisartan Amlodipine besilate

Twyndata
Organ-specific Protection Beyond 24-hour BP Control

- Proven End-Organ Protection
- More Effective 24-hour BP Reductions
- Distinct Pharmacologic Profile

ABRIDGED PRESCRIBING INFORMATION:
INDICATIONS: Treatment of essential hypertension. Prevention of cardiovascular morbidity and mortality in patients 55 years or older at high risk of cardiovascular disease. CONTRAINDICATIONS: Hypersensitivity to the active substance or to any of the excipients; pregnancy, lactation, history of or high risk of angioedema, urticaria, anaphylactic reactions. GENERAL WARNINGS and PRECAUTIONS: Angiotensin II receptor antagonists should not be administered during pregnancy. Unless contraindicated, angiotensin II receptor antagonist therapy is considered essential, patients planning pregnancy should be counselled to avoid angiotensin II receptor antagonist therapy. A small number of women have used angiotensin II receptor antagonists should be stopped immediately if angiotensin II receptor antagonists were stopped; if angiotensin II receptor antagonist therapy was initiated, there is an increased risk of adverse reactions and renal insufficiency. When patients with bilateral renal artery stenosis or stenosis of the artery to a single functioning kidney are treated with medications that affect RAAS, increases in serum creatinine and urea may occur. The risk of increased serum creatinine and urea may be less with angiotensin II receptor antagonists than with ACE inhibitors or ARBs. The risk of increased serum creatinine and changes in GFR with angiotensin II receptor antagonists may be less than with ACE inhibitors or ARBs. The risk of increased serum creatinine and changes in GFR with angiotensin II receptor antagonists may be less than with ACE inhibitors or ARBs. The risk of increased serum creatinine and changes in GFR with angiotensin II receptor antagonists may be less than with ACE inhibitors or ARBs. The risk of increased serum creatinine and changes in GFR with angiotensin II receptor antagonists may be less than with ACE inhibitors or ARBs. 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REFERENCES:

Boehringer Ingelheim (Phl) Inc.
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News Flash... from Page 16

dothelium of blood vessels responds favorably among patients who are able to laugh. His data — dating back a decade — indicated that when people laugh, their brachial arteries dilate as measured by the brachial artery reactivity test (BART). When faced with mental stress, those arteries constrict. For example, the participants’ blood vessels opened wider when volunteers watched scenes from the farce There’s Something About Mary. But blood vessels tended to constrict when participants watched the graphic violence of the drama Saving Private Ryan. The difference ranged from 30% to 50% in diameter, Miller said.

“The magnitude of change we saw in the endothelium after laughing was consistent and similar to the benefit we might see with aerobic exercise or statin use,” Miller said. “When a person exhibits anger, and turns beet red, I can almost predict how they are going to do as they recover from myocardial infarction,” commented John Harold, MD, vice president of the American College of Cardiology and a clinical professor of medicine at the University of California, Los Angeles.

“These studies reflect my own clinical experience,” Harold told MedPage Today. “We can see that anger and stress have an impact on outcomes. It’s completely intuitive.”

Harold suggested the studies indicate that emotions play a significant role in how people recover from coronary events. “When we talk with patients post-myocardial infarction, we talk about relaxation and doing exercise; not to work from dawn to dusk,” he said.

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purest and perfect form, is an embodiment of our Christian values, as lived and taught by our Lord Jesus Christ. He said: “You know that those who are regarded as rulers of the Gentiles lord it over them, and their high officials exercise authority over them. Not so with you. Instead, whoever wants to become great among you must be your servant, and whoever wants to be first must be slave of all. For even the Son of Man did not come to be served, but to serve, and to give his life as a ransom for many.” (Mark 10:42-45)

So who is a so-called servant leader? Larry Spears, with the help of Greenleaf, identifies 10 characteristics that describe the essence of a servant leader. These are essential components to effective leadership—listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of others, and building community. Servant leadership encourages collaboration, trust, empathy, and the ethical use of power.

Some leaders, however, consciously or unknowingly adopt a top-down hierarchical approach, which runs counter to the principles of servant leadership. They end up stressed and frustrated in carrying out their roles, often with under-motivated or uncooperative constituents.

Throughout PHA history, we can see that its 60 presidents are first and foremost, servants at heart. No one can survive PHA leadership without making a conscious decision to serve in order to better lead others, and not increase one’s power or influence. A PHA leader, therefore, is a servant leader. This has been the PHA leadership model, with the view to enhance the growth of individual members, inspiring them to boost teamwork and personal involvement. It is servant leadership—from the bottom to the top post—that has given the PHA its distinction in the medical community. In the end, what is important is not what we have done for ourselves, but for our fellow members, and our countrymen.

The PHA is not only about its presidents. It is also about each and every member in various capacities and roles who seek not to find what the organization can do for them, but render service instead without compulsion or prejudice. Whatever position we hold, let us strive to be servant leaders. Let’s endeavor to meet the needs of those we lead to help bring out the best in them. We should be ready to listen and be life coaches to promote self expression, not suppression. Prioritizing the other person’s interest, we can build a sense of community—the PHA Community.

As we discover servant leaders in our midst, we learn to be more appreciative of others and even of ourselves as we seek, and ultimately find the servant heart within us. A life-emulating servant leadership can yet be our lasting contribution to the PHA, and society at large.

May we all be servant leaders—maturing in wisdom, knowledge and experience for an even greater and nobler PHA, toward a healthier Philippines!
Portrait Photography

A portrait is a classic photograph capturing the character and personality of the subject. It is much more than an I.D. or a passport photo as a portrait also portrays the photographer’s impression of the subject. A portrait essentially gives the viewer a clue to both the subject’s and the photographer’s character. As in any good photograph, a good portrait also follows the basic rules of photo composition, lighting, and artistic design.

Here is a review of basic photography techniques discussed in previews issues:
1. Frame within a frame
2. Rule of thirds
3. Fill the frame
4. Create a story
5. Use sidelighting to add drama
6. Emphasize catchlight on the eyes
7. Play around with eye contact

Presented in this issue are a few samples of Dr. Rodney Jimenez’s portrait photographs featured in St. Luke’s Heart Institute 25th Anniversary coffee table book aptly titled “In a Different Light”. Notice how he has applied these basic photography techniques to come up with such stunning portraits.

The 25th Anniversary of the St. Luke’s Medical Center Heart Institute was made special with the launching of the coffee table book, a portrait of the men and women of the Heart Institute portrayed “In a Different Light”. The book is a testament of the work of photographer extraordinaire, Dr. Rodney Jimenez... a man whose talents knows no boundaries. Indeed, Dr. Rodney’s selfless efforts paid off as he proficiently captured the pictures of HI and with profound creativity turned into an inspiring work of art... Vivid, whimsical, and imaginative. Truly each picture is worth a thousand words.
An ounce of prevention is worth more than a pound of cure. The dictum which fosters the very principle of cardiac rehabilitation as the main strategy for secondary prevention is easier said than done. The discipline that is cardiac rehabilitation is no newbie to the field of cardiology.

Even as early as the 1970's it has been an accepted fact that cardiac patients of every level of affection will benefit in being enrolled in a comprehensive preventive and fostering program to ensure return to functionality and quality of life. Yet even in the era of Apples and Facebook, the statistics remain dismal. This must then be a call for revitalization, for a new kind of Council drive to take a step back and review the panorama of CARE here in our country so as to forge a dynamic path forward.

As of the present, there are 7 active cardiac rehabilitation units in the Philippines. Most stand independent as a single discipline focused on a specific mission and vision. Some are collaborated still within the walls of the Physical Rehabilitation Discipline. Different phases of evolution yet if we are to re-evaluate the commonality among all CARE providers, the same angst are felt. Appropriately enthused and battle ready, horribly under-

**TMC CRP Program- A Decade of Growth**

By Dr. Carlos R. Esguerra, MD

**COMMENCING early this year 2011, we have adapted the Individualized Cardiac Treatment Plan (ITP) as a way of initially assessing, reassessing each patient periodically until discharge with forms provided by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). Aside from the progress notes, this allows ease on determining the assessment, appropriate intervention, education and target goals on the four following foundations: 1) Exercise, 2) Nutrition (includes diet, weight, BMI, lipid, diabetes and blood pressure control), 3) Education (on tobacco, and preventive medications), 4) Psychosocial. This is standard of care in the United States and Canada in documenting the short and long term goals we discuss with our partners, our patients in The Medical City. The AACVPR has emphasized the value of the ITP in each Cardiac Rehab program (but may be customized with the locale setting) in reimburse-

**Complete Cardiac Rehab services now available in Las Pinas**

By Mary Dawn Aquino-Nablo MD

THE Cardiac Rehabilitation and Wellness Center of the UPHDMC Heart and Vascular Institute (HVI) is ideally located within the campus of the University of Perpetual Help Dalta Medical Center (UPHDMC) in Las Pinas City, right next to the Cardiovascular Diagnostic Center and a few steps away from the Cardiovascular Intensive Care and Telemetry units. The Cardiac Rehabilitation and Wellness Center has a spacious fully air-conditioned gym with a mounted television for the comfort and entertainment of the patients. Like commercial gyms, patients have access to fully automated treadmill, stationary bike, stepper, cross trainer, rower, various gradations of dumb bells and ankle weights. Consultation rooms with examining beds are integrated into the complex, allowing additional consultations and examinations, as needed. Additionally, an arm and leg ergometer is available for use at the bedside, if needed by the admitted patients. A cardiac defibrillator, along with

**Moving Forward: CSMC Cardiac Rehab Unit**

By Michael Anthony A. Dela Cruz, MD

“As progress, of the best kind, is comparatively slow. Great results cannot be achieved at once; and we must be satisfied to advance in life as we walk, step by step” – Samuel Smiles

As the first sight of blinding light struck Danny’s eyes, he felt a diversified sensation of warmth, untouched and a retuned human being after a long dark slumber surrounded by metallic humming sounds and electronic beeps echoing the four cornered room. The past few days he had spent on his hospital bed made him ruminate gradually the reason why he’s been there for quite some time. Alas, he remembered, it was surgery - a Coronary Artery Bypass Graft Surgery, though still difficult to fathom, all he could recollect was he needed the procedure to open the arteries of his heart to ease up the chest pain he had been suffering for days. “And now, it’s time for you to make your first step out of that bed” said the man in a fresh long white blazer, as he was instructing and assisting Danny that

**SLMC - Cardiac Rehab: A Truly Worldclass CARE For You.**

By Irma Yape, MD

DISEASES of the heart and the vascular system are the two most common causes of mortality and morbidity in the Philippines. In response to this alarming data, cardiac rehabilitation program was initiated in the Philippines with one of the first centers established here at St. Luke’s Medical Center (SLMC), Quezon City.

Founded 15 years ago by one of the Philippines most recognized cardiologist, Dr Antonio Sibulo, the SLMC Cardiac Rehabilitation (CARE) Center since then has become an integral component in the health care for the various patients of the Heart Institute. It is very instrumental to the recovery path of patients after myocardial infarction, those patients who underwent revascularization procedures like coronary artery bypass graft (CABG) surgery or percutaneous coronary interventions (PCI’s); stable chronic heart failure; and patients following cardiac surgical procedures for heart valve repair and/or replacement.

The SLMC CARE program
Cardiac Rehab in the Philippines – Are we there yet?

PSH, Chong Hua Cardiac Rehab comprehensive program

By Ma. Rosan Trani, MD

CARDIAC rehabilitation is an integral component of the continuum of care for patients with cardiovascular diseases. This is characterized by the provision of a comprehensive long term services including medical evaluation, prescriptive exercises, cardiac risk factor modification, education, counseling and behavioral intervention. All with the purpose of reducing cardiovascular risk and promoting an active lifestyle for patients with cardiovascular disease.

Currently in Cebu City, there are two centers which provide a supervised, structured cardiac rehabilitation program. These are the Cebu Heart Institute-Perpetual Succour Hospital (PSH) and Chong Hua Hospital Heart Institute (CHH). PSH started its program in August 1998 while CHH opened its program in July 2003. In both program, 80%-90% of referrals are post open heart surgery patients particularly post CABG patients. At CHH, there has been a noticeable increase in referrals post PCI. However, overall utilization rates of cardiac rehabilitation as a secondary

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MMC Cardiac Rehab has gone a long way

By Paul Quetua, MD

THE year 1996 marked the start of the realization of a great dream. As claimed by Dr. Adolfo Bellosillo, “no management of any cardiovascular case is considered complete without cardiac rehabilitation incorporated in the total care of patients”, brilliant and passionate cardiologists: Florina Kaluag, MD, then the head of the Section of Cardiology, Benjamin Alimurung, MD, head of the Cardiovascular Diagnostic Laboratory, Adolfo Bellosillo, MD, president of Cardiac Rehabilitation Society of the Philippines, Leticia Andres, MD and Angelita Aguirre, MD, distinguished members of the Section of Cardiology, drafted the plans for a Cardiac Rehabilitation Unit in Makati Medical Center.

The Cardiovascular Rehabilitation and Preventive Cardiology Unit (CVRPCU) was formally inaugurated in 15 September 1998 with Leticia Andres, MD, as its founding director, in response to the need for a physician-supervised rehabilitation program which helps and guides patients during their recovery from a coronary event or cardiovascular procedures

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PHC: Pioneer in Cardiac Rehab

By Myla Gloria Salazar-Supe, MD

THE pioneer in the field of cardiac rehabilitation in the country, the Philippine Heart Center- Cardiac Rehabilitation Section has been a major proponent of primary and secondary prevention of cardiac diseases since its inception in 1975.

Housed at the 8th floor of the Medical Arts Building, it long held the distinction of having the longest 3-lane indoor oval track. It is also one of the few centers offering a sub-specialty fellowship in Cardiac Rehabilitation and has since produced five graduates (Dr. Marissa Joson, Dr. Rene Librojo, Dr. Sylvia Hangos, missing one and Dr. Edgar Ebba).

The following services are available to patients: The Comprehensive Cardiac Rehabilitation Program (CCReP) designed to help patients with heart disease recover faster from surgery and return to full and productive lives. The program is composed of 3 phases: Phase 1 or In-patient Phase, Phase II or Early Recovery Phase and Phase III or Maintenance Phase. Each phase is
there are five stages of behavior change: 1. Precontemplation (patient do not intend to change), 2) Contemplation (intend to change), 3) Preparation (have made some changes), 4) Action (actively engaging in a new behavior), 5) Maintenance (sustaining change over time). The coach approach will always be remembered in enhancing these changes.

The "Coach Approach"
“People are generally better persuaded by the reasons which they have themselves discovered, than by those which have come to the mind of others.”- Blaise Pascal- French Philosopher (17th century). This was reported by Kate Larsen in the recent AACVPR 2011 Annual Meeting as Opening Keynote. We deal with cardiac patients everyday and we have an impact in their lives, and this may apply to our loved ones and ourselves as well. We are adapting this practice of “coach approach” to our patients at the Medical City. Instead of adding burden to others, we change our hats from being experts to being “coaches”. This entails collaboration with the patient and solution-focused. Being the greatest listener is the best—and that’s what patients need. RELATIONSHIP IS THE HEART OF COACHING. Facts, fears and force don’t work for our patients. They need to be listened to and understood. We try to be mindful, calm, and warm, at the same time affirming, playful and courageous. “Listen until you do not exist. Affirm the patient’s strengths. Show empathy, be nonjudgmental and show acceptance. You and your patient will be fully more alive, and awake!“- Larsen. We tried this to our patients and it really does wonders. The relationship is enhanced, and we get to understand and appreciate each other better. This applies to helping patients change their behavior. Because in Cardiac Rehab there are five stages of behavior change: 1.

The Medical City
Typical scenes at the cardiac rehab unit at
Precontemplation (patient do not intend to change), 2) Contemplation (intend to change), 3) Preparation (have made some changes), 4) Action (actively engaging in a new behavior), 5) Maintenance (sustaining change over time).

Fellowship Training
• The Cardiology Fellows undergo two to three activities per month. One didactic, one journal club and if there’s time: an online proceeding of an interesting topic form the Annual Meeting of the AACVPR. The Staff likewise attends annually the Cardiac Rehabilitation Society of the Philippines.
• Clinical Research Fellowship in Cardiac Rehabilitation is undergoing process and hope to start June of 2012. The Program Director is Dr. Marisa Joson and the Training Officer, will be Dr. Achilles Esguerra. The Council of Cardiac Rehabilitation of the Philippine heart Association will be consulted regarding this matter for policy-making.

Plans Now and Beyond
• There is still a lot of work to do. The goal is to sustain the increase the referrals and utilization to Cardiac Rehabilitation. This will entail Marketing plans in organizing lectures to health organizations, medical schools; articles to journals and magazines; research papers to medical journals. We plan to have an “Open House” June 2012.
  • To improve our policies in conjunction with the “Core of the Matter” of Cardiac Rehabilitation Programs which include the triad of
    - Core Competencies
    - Core Components of Cardiac Rehabilitation
    - Performance Measures
  • Include Cardiac Rehab in other clinical pathways as in heart failure, post PCI procedures, etc.
  • Marketing through the Social Network?? (Facebook, Twitter, Yelp)
  • Continue Cardiac Rehab Staff monthly meetings and evaluation
  • More Involvement with the Philippine Heart Center Council on Cardiac Rehabilitation

I would like to mention, lest I forget, that the success of the Cardiac Rehabilitation Program of the Medical City for the past decade is due largely to the support of its Cardiology Staff, the Hospital Administration, and its constant infusion of management training and skills (hands on) to give better care and quality and the trust of the Medical City patients. And most especially to Founder Dr. Marcelo Esguerra Last to mention, but not the least, is the Cardiac Rehab Staff, in its dedication, passion in the delivery of the best cardiac rehabilitation care to their partners, the patients.

Staff:
Nurses: Wilma Basillo, Xyza Herrera
Nurse Assistant Manager: Beth Faylogna
Physiatrists: Dr. Celso Bate, Dr. Jun Rafanan, Dr. Mavic Tango
Cardiac Rehab Cardiologists: Dr. Marisa Joson, Dr. Achilles Esguerra
Consultant Dir: Dr. Carlos R. Esguerra
Dietician: Carol Hernandez
Psychiatrist: Dr. Dulce Sahagun
All Rotating Physical Therapists
Moving Forward... from Page 32

morning to stride his right foot forward and maneuver his body around his bed. It was his first small step, followed by a slow steady gait and gradually progressed to a momentous pace the following days. Now that Danny is more rejuvenated and confident, he had left all his uncertainties behind. After complying with the initial phase of his cardiac rehabilitation, he is now ready to go home, ready to face a new chapter, a new beginning in his life, a more assertive outlook as he recuperates and incessantly completes the entire program.

It is a fact that cardiac rehabilitation has a good over-all impact on patients with coronary artery disease and chronic heart failure. It has been widely recognized by different international guidelines as a Class I recommendation and should be an integral part on the treatment and management plans.

The year 2007 was prolific for the Cardiovascular Institute of Cardinal Santos Medical Center when the Open Heart Surgery Program was given a lift by the hospital and its organizing partners. This led to the idea of setting up and reorganizing the cardiac rehabilitation program for post-op patients. The development was initiated by Dr. Loewe Go (CVI executive director) and Dr. Jose Albert Mejia, who was still a 1st year fellow in adult cardiology at that time. Dr. Go tapped the services of 2 home-grown cardiologists namely Dr. Zenaida Javier-Uy and Dr. Perfecto Palafox to build the program. Dr. Helen Ong-Garcia, who had helped other institutions in developing programs for cardiac rehabilitation, was also consulted for the improvement and expansion. Dr. Irma Yape’s application was also approved and was added to the list of Cardiac Rehab Consultants. And, the rest was all history.

In January of 2008, the official cardiac rehabilitation program of the hospital was formally introduced. A total of 68 patients were enrolled in its preliminary year, majority were post bypass and valve surgery patients. The ensuing years showed an increase in the number of patients being enrolled, covering wider scope of referrals, from post AMI to heart failure to chronic CAD patients who underwent angioplasty. With these, the institute expanded the program and acquired new exercise machines like treadmill and bicycle ergonometers, exercise accessories and the latest was a centralized wireless telemetry. Likewise, a bigger venue was allotted for the unit to accommodate both the new materials and the growing number of patients.

“At first, I was not really convinced in doing cardiac rehab until I was recommended to enroll at Cardinal Santos Medical Center. It has really changed my personal outlook in life after my angioplasty and bypass surgery because the doctors and the staff assigned to me took time to provide one-on-one session” says Jun Uy, one of the program’s “suki” since 2008 and has been continuously enrolling phase III because he enjoys the program. “Cardiac Rehabilitation for me has been a confidence builder and everytime I would exercise, I just fill happy, my mood becomes jolly. Exercise became something that I look forward to” added Uy. As a matter of fact, he highly recommends CSMC and encourages people even without heart disease, to enroll in the program.

Indeed, the program is still young, as compared with other centers. But, just as any child learning to walk, or a post-op patient regaining confidence to face the world, the CSMC’s cardiac rehabilitation program is guided by experienced doctors and staff directing every step as it moves along the right path towards success. Presently, the institute’s cardiac rehabilitation program provides 3 intensive phases with individualized set of training suited for a particular patient. The program anticipates constant progress and development as every doctor and patients recognize the significance of cardiac rehabilitation.

Cardiac Rehabilitation Unit
Head: Dr. Zenaida Javier-Uy
Consultants: Dr. Perfecto Palafox
Dr. Irma Yape
Dr. Helen Ong-Garcia
Staff: Princess Anne Arga, R.N.
Ana Liza Derla, P.T.R.P.
Dandino Alvarez, R.N.
Frederick Gavril Leysen, R.N.
Timothy Joshua Clavel, R.N.

Complete... from Page 32

a crash cart fully equipped with emergency medications and intubation set, is always on standby, for the exclusive use of the CARE patients.

The UPHDMC-HVI’s Cardiac Rehabilitation (CARE) Package boasts of an individualized and medically supervised program which incorporates progressive therapeutic exercises, counselling, and lectures on improving cardiac patient’s health. Cardiac rehabilitation always starts with an initial interview and evaluation by a cardiac rehabilitation specialist. This is to orient the patient to the program, identify areas of risk inherent to the patient’s medical condition, formulate a cardiac rehabilitation plan tailored fit to the patient’s specific needs, and to ensure that safety is maintained when initiating and continuing the exercise program.

Admitted patients generally start with Phase I as soon as they are deemed stable, usually within a few days after a heart attack, revascularization or open heart procedure. Phase I program consists of 7 sessions of daily, gradual but progressive therapeutic exercises and culminates in a treadmill exercise test to determine the patient’s functional capacity, in preparation for Phase II.

Out-patients usually start with the Phase II program, which may consist of a 12- or 24- session schedule of therapeutic exercises, conducted 2 to 3x a week. Patients are encouraged to attend a monthly lecture/open forum with cardiology specialists on various topics related to improving the patient’s lifestyle and intended to answer common patient queries and health related worries. The program ends with a treadmill exercise test to evaluate the improvement in the patient’s status and to aid in the formulation of further CARE program for the maintenance phases III and IV.

In all phases of CARE, patients are hooked to a cardiac monitor prior to and until the end of exercise to ascertain safety with increasing physical activity. Oxygen saturation and random sugar levels are checked, depending on the patient’s pre-determined co-morbidities. There is a 1:1 ratio between the patient and the physical therapist with special training in cardiac rehabilitation.

At the UPHDMC-HVI’s Cardiac Rehabilitation and Wellness Center aims to provide cardiac patients, of Las Pinas City and its environs, with an effective and safe program that will restore the maximum level of activity, compatible with the functional capability of their heart, and ultimately, to lessen hospitalization and death secondary to cardiovascular disease.
**PHC... from Page 33**
designed to address the different needs of the patient and maximize their gain in the various stages of their recovery

Project H.O.P.E. (Health Optimization through Prevention and Exercise) is a rehabilitation program that includes exercise and health education lectures designed specifically for patients with Heart Failure and is being done twice in a week.

The Lifestyle Clinic is a primary or secondary prevention program that focuses on risk factor identification and modification, physical fitness assessment, as well as physical activity and exercise counselling.

The Starter’s Class is a beginners program that includes a complete physical fitness assessment program and exercise prescription for home-based or out-of-center exercise.

Dr. Leandro Bongosia, heads the team of five consultants, a couple of nurses, a physical therapist, dietician, social worker, priest, as well as a bevy of rotating cardiology fellows and interns for physical therapy.

The PHC also has its own separate Pediatric Cardiac Rehabilitation unit headed by Dra. Ina Bunyi. Like many of its contemporaries, the PHC Cardiac Rehabilitation Section has not been spared from the challenges brought by an unstable economy. In the past 2 years, referrals to the section dropped by 15-20%.

Faced with rising prices for surgical intervention, cardiac rehabilitation was among those removed from surgical-package-deals (SPD) several years ago in an attempt to curb down costs. It has just been recently re-instated among SPD patients undergoing CABG surgery but is yet unavailable to other patients as SPD.

**MMC... from Page 33**
like Coronary Artery Bypass Graft Surgery (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA). It offered a multidisciplinary approach to cardiac care involving the—primaryattending physician, rehabilitation cardiologist, physical therapist, nurse-educator, psychologist, and nutritionist-dietician—all in partnership in the care of the patient.

Its scope has widened to include two more programs: Preventive Pediatric Cardiology Program (PPCP), which was launched in 2001, and the Smoking Cessation Program. Currently, it offers three phases—

- Phase I: In-patient early ambulation program
- Phase II: Out-patient cardiac rehabilitation, and
- Phase III: Physical fitness program.

Currently, there are 63 patients enrolled.

Since its inception, hundreds of patients have enrolled in the program with remarkable results and impressive recoveries. With its continuing achievements, the unit was given a bigger space and is now situated beside the Heart Station/Cardiovascular Diagnostic Laboratory (CVDL), on the 3rd floor of the new building. It is now headed by Adolfo Bellosillo, MD, with Angelita Aguirre, MD as his assistant. Leticia Andres, MD, Milagros Uy, MD, and Enrique Del Fuerte, MD, completes the consultant staff.

**PHCenter: Pediatric Cardiac Rehabilitation (PediaCaRe)**

*A multi-disciplinary team working together to promote the well-being of children with heart disease*

By Maria Ina de la Paz-Bunyi, MD

Unbeknownst probably to a majority of adult cardiologists is the existence of our Pediatric Cardiac Rehabilitation (PediaCaRe) section at the Philippine Heart Center. It was in early 2001 when the then PHC Director, Dr. Ludgerio Torres and Pediatric Cardiology Department Chairman Dr. Lourdes SR. Casas, assigned to me the task of setting up PediaCaRe. Through the referral of Dr. Marcelo Esquerra, we were able to attend a seminar on the proper establishment of a cardiac Rehab Program in Melbourne Australia which was coupled with an in-depth observation at the children’s cardiac unit of the Royal Children’s Hospital.

With this as a start and by reviewing pediatric related cardiac rehabilitation research, we joined forces with the Physical Rehab Department under the leadership of Dr. Ricardo Agyayan and the much needed, highly skilled and efficient team of physical therapists and pediatric nurses. We formally opened PediaCaRe on May 2002, largely through the help of the PHC and from a grant from Sanofi Aventis Corporation. Needless to say, this involves a multi-disciplinary approach and depending on the cases referred, we would also utilize our allied services units such as the Pulmonary, Dietary and Psychiatry section.

Pediatric Cardiac Rehabilitation is a supervised, progressive training program to improve aerobic fitness in children and adolescents with impaired cardiovascular responses through exercise. The training program would be usually done two to three times a week for a period of twelve weeks and is comprised of various forms of aerobic and strengthening exercises. These exercises are performed starting at 15-minute durations and progress into an hour, targeting an initial 60% of the maximum heart rate. By the fourth to six week, 70 - 80% of the maximum heart rate is obtained. The Rate of Perceived Exertion (Borg Scale) is also assessed especially for patients on rate controllers. A six minute walk-test is done prior to and at the end of the training sessions.

The GOALS of PediaCaRe are as follows:

1. To restore patients to baseline function who had normal exercise tolerance prior to surgery
2. To rehabilitate patients who had exercise limitations prior to surgery after successful surgery so that they may realize their normal potential;
3. To Educate patients and their families on specific heart diseases, to provide nutritional counseling, as well as guidelines on activities of daily living.

Those WHO MAY BENEFIT are patients who have undergone heart surgery to correct an existing cardiovascular defect; those who have undergone palliative surgery who are left with residual hemodynamic impairment; and those with chronic acquired cardiovascular disease and obesity.

A Pilot study on the “Effects of Post-operative Exercise Training on the Functional Capacity of Patients with CHD” by the Nursing Division on Pediatric Care in collaboration with Division of Pediatric Cardiology done in February 2001 showed a “significant improvement in heart rate response, performance of daily living, and shortened patient hospital stay.”

About three years ago, another study on “The effect of exercise training on the six minute walk distance of children enrolled in pediatric cardiac rehabilitation program” was done by Dr. Emely G. Anupol showing that the 6 MWD (minute walk distance) improved and approximated reference values for age and sex of comparable normal children with patients experiencing less fatigue, and exhibiting more energy and therefore endurance.

Our rehab section continues to operate under the support of our present Director Dr. Manuel Chuia Chiaco and Department Chairman Dr. Jhiuilet Balderas. Our dedicated nursing team composed of Ms. Diane Gurne, Maricel Punzal or Katrina Anne Limos will be happy to entertain inquiries, fee free to call 925-2401 local 3818 on M-F from 8AM-5PM or call and leave a message with Ms. Lorna Mangaliman at local 2363. Our office is located on the 8th floor of the Philippine Heart Center Medical Arts Building.
is the most comprehensive locally, which involves personalized exercises executed by a specialized team inclusive of cardiologists subspecialist in cardiac rehabilitation, cardiac nurses and physical therapists; patient education; nutritional guidance; and psychosocial support. The technical improvements (machineries) in the unit are at par with foreign renowned CARE institutions abroad. To ensure safety and for intensive monitoring, wireless telemetry are available for patients classified under moderate to high risk.

The CARE program likewise contributes to the Heart Institutes goal of producing specialists that exemplify excellence in their respective area of influence. It has been witness to the molding of four of its graduates into strong advocates and practitioners of cardiac rehabilitation (Dr Helen Ong-Garcia (President, Cardiac Rehabilitation Society of the Philippines CARES-P), Dr. Ma. Paz Mildred Luque (Vice-President, CARES-P), Dr Irma Marie Yape (Board Member, CARES-P) and Dr. Dawn Nablo (Auditor, CARES-P). Presently, it caters to two clinical research fellows that will continue its purpose and aid in its growth.

With the continued demand for holistic approach to patient’s health care, SLMC is proud to present another addition to its Cardiac Rehabilitation Program through establishment of the Cardiac Rehabilitation Center at the SLMC Global City Taguig—equal and parallel in its objective towards total cardiac care.

The 15 years of SLMC Heart Institute...
It is known among Filipino travelers that anyone who visits Palawan can never resist its charm. This phenomenon is called Kambak-Kambak Syndrome, where visitors to Palawan inevitably fall in love with the place and invariably desire to come back. Some would even choose to stay there for good. This is not surprising since Palawan is definitely one of the most beautiful places in the country, perhaps even the world. Touted by the National Geographic as one of the Top 20 Best Trips for 2011, Palawan boasts of pristine beaches, secluded lagoons, magnificent limestone karst cliffs, lush rainforests, and coral reefs with the highest biodiversity.

My addiction to Palawan began in 2010, after witnessing a number of my friends have acquired the legendary Kambak-Kambak Syndrome. At that time, I had already roamed around perhaps half of all the provinces of the Philippines, but I’ve never set foot in Palawan. Being a low-budget traveler, I had this notion that traveling to Palawan was expensive. My friends convinced me otherwise. While there are some luxurious, extravagant, and ridiculously expensive resorts in Palawan, there are more budget-friendly, rustic accommodations that cater to backpackers like me. So in 2010, I brought my backpack and my camera and decided to experience Palawan.

My first trip was to Puerto Princesa, to explore the famous St. Paul’s Subterranean River (also called the Puerto Princesa Underground River), chosen by UNESCO as a World Heritage Site, and the Philippines’ only bet for the selection of the New Seven Wonders of Nature that will conclude at the end of 2011. True enough, I went back to Palawan after barely three months, and then came back again, and again.

Palawan is the largest province of the Philippines, with a total land area of almost 15,000 square kilometers. It comprises almost 2,000 kilometers of coastline stretching across 1,768 islands. Because of this huge land area, Palawan is the 2nd province in the Philippines with the lowest population density (the number one being Batanes). Notable destinations in the province include the Calamianes Islands, the biggest of which are Busuanga and Coron. Also famous, especially among foreign travelers, is the Bacuit Archipelago located in the town of El Nido in the northern part of Palawan. The town of San Vicente, midway between Puerto Princesa and El Nido, has picturesque white-sand beaches that stretch for miles, perfect for the world-wearied soul who needs to rest from the stresses of the city. South of Puerto Princesa are the towns of Narra and Aborlan, with verdant rainforests and unspoiled waterfalls. Other interesting destinations include the southern towns of Brooke’s Point and Bataraza and the quaint, mysterious island-towns of Cuyo and Cagayancillo over the eastern side of Palawan Island.

The city of Puerto Princesa, despite being a bustling metropolis, is an ecotourism destination by itself. It is the 2nd biggest city in the Philippines in terms of land area (next to Davao), and is consistently among the cleanest and most peaceful cities in the country every year. Dubbed as a “city within a forest”, it has a charming mix of the energy of urban life in a laid-back, leisurely pace. There are a variety of activities that would suit any kind of traveler – Ugong Rock climbing for the adventurous types, dolphin-watching, island hopping and beach-bumming at Honda Bay for those who just want to relax, hiking across the Monkey Trail toward the underground river in Sabang for those who want to rough it.
one of the islets in El Nido town. Tour packages are standardized, and these include a guide, boat trip to a specified set of islands, and a sumptuous lunch of seafood by the beach.

Breathtaking Bacuit Archipelago in El Nido

Tour packages are standardized. They include: a guide, boat trip to a specific set of islands, and a sumptuous lunch of seafood by the beach.

Nature-stretched seaside of Shake Island, a leg of the standard Honda Bay tour. Offshore, visitors can feed the fishes with bread. Great snorkeling sites abound.

With Palawan’s beauty and diverse possibilities of adventure and exploration in an ecosystem that remains relatively undisturbed, Palawan is indeed the Philippines’ Last Frontier. Sadly, this may also be true in terms of health care. Hence, the challenge lies not only in preserving Palawan’s ecology, it is also in sending brave frontiersmen and women who will change the health landscape of the province.

Jean is a senior cardiology fellow at UP-PGH who loves to wander around the Philippines during her free time. Her favorite travel buddy is her DSLR camera, but human company, if available, is also much appreciated.)
Cardio Metabolic

CLOPIDOGREL
CLOPIVAZ
75mg Film-Coated Tablet
ANTITHROMBOTIC

ORLISTAT
LESOFAT
120 mg and 60 mg Capsules
ANTI-OBESITY

ROSUVASTATIN
Calcium
RUSTOR
10 mg & 20 mg Film Coated Tablet
ANTIHYPERTENSIIVE

AMLODIPINE Besylate
AMLODINE
5 mg and 10 mg Tablet
ANTIHYPERLIPIDAEMIC