PHA ties up with huge human resources group
Cardiac Rehab in RP—Are we there yet?
An ounce of prevention is worth more than a pound of cure, says Dr. Helen Ong Garcia, president of CARESP…

TV, broadcast media sustain PHA Advocacy
ABS-CBN, DZMM, GMA, DZIQ, etc. among regular supporters

Despedida, bienvenida for Council custodians

SLHI marks silver year

Doc nurses Palawan Kambak-Kambak syndrome
Bitten by the Puerto Princesa bug, Dr. Jean Alcover flies anew to RP’s last frontier

SEPTEMBER TO OCTOBER

World Heart Day 2011 sets high-record performance
PHA-Cainta a budding partnership that drew 1,500 people

Joint manifesto signing with PHA boosts Cainta’s health agenda

Characterized by firsts:
In full force Cainta Barangay Health Workers packed pediatric-Cardio desks, interactive lectures

UN leads global vision vs lifestyle diseases

WHD 2011 in the Chapters
Cebu style: Running and dancing on the street kick off event
Bicol’s spirits are high even in wet weather
STC meets WHD targets
Davao Fun Run draws 1,700 participants
Pasumbal lectures on HPN in kids, adults
P’gasinan ACLS surpasses set goal

TV primetime shows spawn P40M media value for WHD 2011

Acute Coronary Syndrome Summit:
Chapter presidents report the lack of CV facilities, quality care in the province

BP ng Teacher Ko, Alaga Ko caravan goes to P’panga, QC DepEd

Reyes, Larronda, Lazo rule the successful PHC Supercats

Memoirs of Cardio Fellows …
Living beyond the title
Int’l Academic Exchange focuses on EPS px
TMC Fellows shines in 9th ICCA in Venice

Mediaman Ricky Alegre is new PHA VP for external affairs

Kahn: PHA is one of the best things that ever happened to me

Dr. Cabuling conquers Greece shooting range

Zesty Zambo
Discover how this tiny Spanish village keeps its charms ♥
AUFMC: 1st PHA-accredited institution in CL

The Angeles University Foundation Medical Center (AUFMC) in Angeles, Pampanga is the first Philippine Heart Association-accredited training institution in Central Luzon.

The PHA Specialty Board for Adult Cardiology under the leadership of PHA past president Dr. Romeo Cruz, granted the hospital a three-year provisional accreditation for its adult cardiology training program from March 1, 2012 to February 28, 2015.

SBAC made the following recommendations to the AUFMC: strengthen outpatient (OP) cardiovascular care inclusive of exposure to valvular and congenital heart disease cases by increasing the number of hours scheduled in the OPD. This should include outside rotation in the government hospital near your area; increase the exposure of your fellows in training in Coronary/Intensive patient care by including outside rotation in the government hospital around the area; increase the exposure of your training fellows in cardiovascular radiology by including rotation in the Radiology department; Memorandum of understanding/agreement should be formally made with the corresponding institutions where outside rotations are done; within the next three years preparations should be made to establish a one-year level 3 training program in echocardiography based on the requirements set by the Philippine Society of Echo and the PHA Council on Echo. SBAC may re-evaluate the AUFMC training program and revisit the institution on a yearly basis or as needed to assess the program of its training program.

Outpour of generosity pervades SLHI family

Instead of a traditional Christmas party, the St. Luke’s Heart Institute alumni, together with the cardiology fellows and some friends opted to celebrate Christmas in a different style.

As early as September, the group planned a gift-giving activity for the residents of Tahanang Walang Hagdanan, a house for persons with disability (PWD). The event was also a Christmas get-together for St. Luke’s Heart Institute alumni and friends, a way to bind the group in a common spirit of giving.

It started with a call for people who “want to add quiet meaning in a season of merriment...” so the invitation goes. In an overwhelming display of generosity, an outpour of donation in cash and in kind came. Project leader and SLHIAA treasurer Dr. Malou De Jesus, with the help of technicians at the vascular laboratory spent hours putting into gift bags the donations which filled up a cubicle.

In the morning of November 30, a convoy trooped to Cainta, Rizal where TWH residents were eagerly waiting. SLHI Alumni and friends clad in bright green shirts printed with the words ‘Stronger Together’ walked into the hall where some 250 PWDs, all in wheelchairs, were gathered. The program commenced with a prayer, followed by the singing of the National Anthem. SLHIAA president Dr. Malou Bunyi gave the opening message. “What the group can give are material things that can be consumed but the real gift of Christmas is the Savior who was born for us,” she uttered in Filipino.

A song by one of the resident PWDs started the joyful event. Not to be outdone, Dr. Rey Neri, representing the doctors, rendered his own version of “Walk Through The Storm” and imparted some words of hope. The excitement heightened as...
SAN JUAN CITY, November 11, 2011 – Most people are getting busier preparing for the yuletide season. But for most cardiology fellows, this is the time when everyone is collating the results and data of their researches. Despite all the difficulties, everyone is deliberately focused on beating the deadline since the best scientific paper is at stake in the 5th Cardinal Santos Medical Center – Cardiovascular Institute Annual Cardiology Fellows Research Paper Presentation.

After a stringent analysis, the winning researchers entitled “Association of Non-dipping Status and Cardiovascular Risk Factors in Filipino Patients at the Cardinal Santos Medical Center”, was awarded to Dr. Jonah Amora named as 2nd place was Dr. Michael Anthony Dela Cruz whose research is on the “Comparison of the Framingham Risk Score and Reynolds Risk Score in the Prediction of Cardiovascular Events Among Executive Check-up Patients at Cardinal Santos Medical Center”. The 3rd place went to Dr. Harim Santos, for his entry “Procedural Outcomes of Patients with Chronic Total Occlusion undergoing Percutaneous Coronary Intervention at Cardinal Santos Medical Center”. The panel of judges composed of Dr. Myra Dolor-Torres, chair of the PHA Sub committee on Continuing Education Program Committee; Dr. Maria Lourdes Santos, a former chief fellow and graduate of the CVI and had just recently finished her specialty training in Lipidology at the New York University; and Dr. Guinevere Dy-Agra, a pulmonologist at CSMC, whose dedication and passion for research made her a regular invitee for the Annual event.

Research writing is certainly a part of cardiology training and the exercise has stimulated the fellows’ minds as they complete their output, not merely as part of their requirement, but for the satisfaction of individual intellectual curiosity.

Status and Cardiovascular Risk Factors in Filipino Patients at the Cardinal Santos Medical Center

♥

UPHDMC re-accredited by PHA SBAC

The Philippine Heart Association Specialty Board of Adult Cardiology (SBAC) re-accredited the University of Perpetual Help Delta Medical Center’s (UPHDMC) Adult Cardiology Training Program from January 2012 to December 31, 2014.

In a letter to Dr. Juliana Tamayo, chair of the UPHDMC Department of Cardiology from SBAC signed by its chair Dr. Romeo Santos, “the board cites your institution for fully complying with all the basic requirements necessary for an Adult Cardiology training program. However, here are some recommendations: spread and share the specialty practice of cardiology to our less-privileged countrymen and at the same time, increase exposure of your training to cardiovascular cases, the SBAC encourages your institution to include in your rotation government hospitals around your area which lack cardiological expertise in the management of their cases. We likewise encourage you to develop your non-invasive laboratory so that a level three training in echocardiography based on the Philippine Society of Echocardiography and PHA guidelines will be established soon. The other members of SBAC are Drs. Norbert Lingling Uy, Mariano Lopez, Cesar Recto, and Efren Vicaldo. Drs. Elmer Linao and Helga Sta. Maria are members of the UPHDMC Department of Cardiology.

♥

CLIFFHANGER sympo in Bicol set

The University of Santo Tomas Hospital Section of Cardiology, and the Thomsonian Heart Specialists Alumni Association, Inc. (THESAA), will hold its annual out of town postgraduate symposium entitled “CLIFFHANGER!: The Tools and Tactics in Dealing with Cardiovascular Emergencies” at the Hotel Piazza in Legaspi City, Bicol on March 30, 2012. This course aims to deliver high quality comprehensive insight into cardiovascular medicine for both physicians and allied health professionals. The scope of this one day educational forum focuses on cardiac emergencies, with emphasis on common cardiovascular diseases seen in the community. Highlights include sessions on the must-knows about cardiology and cardiac emergency in the community level for both specialists and non-specialists. For details, contact Luz Calapre 09162172565 or Chief Fellow Gertie Plameras 7499738.
Navigating the seas of Hypertension

(Last of a two-part series)

In the 1993 the fifth JNC report introduced a new classification of SBP and DBP relating to high blood pressure risk for cardiovascular disease. The term life-style modification was used in lieu of nonpharmacologic therapy and introduced an algorithm describing manifestations of target-organ disease (TOD). The report also suggested indications for the use of ambulatory pressure monitoring.

The sixth JNC report was published in November 1997. The classification of 4 stages of hypertension from mild to severe (>210 mmHg SBP and >120 mmHg DBP) of JNC V was reduced to 3 stages by eliminating the 4th state of very severe and deleting the modifiers mild, moderate and severe. The report placed strong emphasis on absolute risk and benefit and used risk stratification as an important determinant of treatment strategy. Further the report reaffirmed the initial pharmacologic therapy with diuretics and beta-blockers for uncomplicated hypertension and introduced an algorithm describing manifestations of target-organ disease (TOD).

The current consensus of pharmacologic treatment of hypertension is based on combination of 2 drugs with complimentary action targeting different mechanisms of hypertension. Table 3 shows the basic rationale for drug combinations. Advantages of low dose combinations are easily understood in the context of increased efficacy, increased tolerability and safety and better compliance with once a day dose preparation. The benefits that accrue from low dose fixed combinations to the hypertensive patient are: 1. maximum efficacy, 2. minimum adverse effects. Profiling hypertensives according to risk factor, target organ disease and comorbid factors by the clinician provides further advantage to both patient and physician.  

Summary

The cut-off level of blood pressure separating the seas of hypertension from the shores of normotension remains obstinately arbitrary. The risk of cardiovascular events rises as one sails away from the sands of time. The aging process imposes a heavy toll in morbidity and mortality on those who sail into the penumbra of the lengthening shadows of life. We cannot change the direction of the wind but certainly we can adjust our sail.

Table 1. What is normal blood pressure?

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<th>Blood Pressure</th>
<th>120/80</th>
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<th>140/80</th>
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Table 2. WHO/ISH guidelines on hypertension

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Table 3. Rational combinations for the treatment of hypertensive patients

<table>
<thead>
<tr>
<th>Combination</th>
<th>1. Diuretic and B-blocker</th>
<th>2. Diuretic and ACE inhibitor/ARB</th>
<th>3. Calcium antagonist and B-blocker</th>
<th>4. Calcium antagonist and ACE inhibitor/ARB</th>
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<tr>
<td>Blood Pressure</td>
<td>Not controlled in S4</td>
<td>Controlled in S4</td>
<td>SBP&gt;145 mmHg or</td>
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The Wind

Who has seen the wind
Neither I nor you
But when the wind blows

You know the wind is passing through.
Who can change its course
Neither I nor you
Brave soul adjust your sails
To reach the shores of destiny.

Columbus and Magellan saw land
Neither saw the wind
Both knew when the wind blows
Only God can see the wind or change its course.

– HBC 2004

By Homobono B. Calleja, MD
Director Emeritus
St. Luke’s Heart Institute

‘We cannot change the direction of the wind but we can adjust our sail’ – HBC 2001

CARDIO VIEWPOINTS

November - December 2011 • PHA NewsBriefs
The SHARP Trial:

Sharp Shooting CKD patients with Simvastatin+Ezetimibe

The suspense is over. After some bouts with controversies that clouded the simvastatin+ezetimibe combination (Vytorin, Merck), the final results of the Study for Heart and Renal Protection (SHARP) was released in mid 2011 and further analyses followed suit before the year ended.

The SHARP trial beams with seemingly gigantic positive findings on the use of Vytorin in patients with chronic kidney disease (who have no history of previous myocardial infarction or coronary revascularization) for risk reduction in major atherosclerotic and vascular events.

Involving more than 9,000 participants randomized to the study drug and placebo, a 17% reduction in major atherosclerotic events (coronary death, MI, non-hemorrhagic stroke or revascularization) was noted in participants taking Vytorin compared to the placebo arm.

In terms of its secondary outcomes, a 15% reduction in the risk of major vascular events was seen with the treatment group compared to placebo.

Surprisingly sharp or not so sharp after all?

The relatively good numbers shown in the SHARP trial make the simvastatin+ezetimibe combination appear to be the better anti-cholesterol drug compared to atorvastatin and rosuvastatin when it comes to CKD patients. Previous trials involving these two drugs (4D and AURORA, respectively) failed to establish positive results for CKD patients who were on dialysis.

A head-to-head comparison among these three trials is difficult, if not impossible. Several reasons explain this. One is that coronary revascularization was not included as a primary endpoint in the 4D and AURORA trials, making statistical comparisons unlikely.

Moreover, it must be noted that these three trials have stark differences in terms of patient population (even though all trials recruited CKD patients). The two earlier trials involved only patients on hemodialysis (who were considered to be sicker) in contrast to the two-thirds of SHARP trial participants who were pre-dialytic patients. The other third of patients who were on dialysis either were maintained on hemodialysis or peritoneal dialysis.

From the SHARP trial, major atherosclerotic and vascular events were reduced by 22% in the non-dialytic patients (6,247 patients) while a non-significant 10% reduction in atherosclerotic events and 6% decrease in vascular events were seen in the dialytic group. The appalling number noted in the latter group is similar to what were shown in the 4D and AURORA.

Further, patients on dialysis demonstrated a smaller advantage in terms of LDL-C reduction compared to the non-dialytic group (26% vs 34%).

From these we can glean that patients on dialysis may have a different pathophysiology of cardiovascular diseases compared to non-dialytic CKD patients, and should therefore be considered a different and special group of patients at risk for cardiovascular diseases.

But analyses offer convincing data that the LDL-C weighted proportional effects in 4D, AURORA and SHARP were statistically compatible for non-fatal MI, non-fatal hemorrhagic stroke, and non-fatal non-hemorrhagic stroke. These make the SHARP results likewise compatible and consistent with the data from the Cholesterol Treatment Trialist’s Collaboration (CTT) metaanalysis. Findings from the CTT demonstrated a 20% risk reduction in myocardial infarction or coronary death, stroke, or coronary revascularization per 1mmol/reduction in LDL-C with statin treatment.

Looking closer into the data from SHARP, the trial failed to reach statistical significance for cardiac death or non-fatal MI, inspire risk ratios for individual type of events favoring the combination drug. However, this appears to be consistent with findings in other trials on interventions in patients with heart disease.

It can be inferred that the major advantage of the combination drug lies in the prevention of certain strokes and coronary revascularizations, but not fatal heart attacks and death.

Who and what to target then?

The SHARP has offered good results and evidence that primary prevention via lipid lowering therapy among CKD patients is an excellent target that can translate to lowering the risk of cardiovascular events. The pre-dialysis patient is a clear target, but it gets a little blurry with a patient on maintenance dialysis.

It is undeniable that SHARP is a landmark trial that can change the present practice guidelines. Numbers appear overwhelming and quite easily persuasive to believe. However, careful judgment as in all situations is necessary.

(For this edition, we got a well-respected nephrologist and a key opinion leader and speaker in the country to give her commentary on the SHARP.)

FAST FACTS: SHARP TRIAL

- RCT involving 9,270 patients with CKD (3,023 were dialysis dependent)
- Participants ≥40 yrs without history of MI or coronary revascularization, with LDL lowering treatment not clearly indicated or contraindicated
- Key outcome: major atherosclerotic events (coronary death, MI, non-hemorrhagic stroke or any revascularization)
- Subsidiary outcomes: major vascular events (cardiac death, MI, any stroke, or any revascularization)
- Main renal outcome: ESRD (dialysis or transplant)
- Simvastatin 20 + Ezetimibe 10mg daily vs placebo
- Follow up of a median 4.9 years
- 17% reduction in major atherosclerotic events with Vytorin (RR 0.83, 95% CI, p 0.0021)
- 15% reduction in major vascular events (p 0.0012)
- No substantial effect on kidney disease progression
- No statistical significant difference in outcome between dialytic and non-dialytic population
- Lipid lowering generally safe, not associated with cancer or rhabdomyolysis
- NNT 30-40/1000 for 5 years
- Merck sponsored research.
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

Twynsta®
TELMISARTAN

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, bilateral, single, severe hepatic impairment. WARNINGS and PRECAUTIONS: Angioedema, if necessary, should not be given during pregnancy. Unless contraindicated, angiotensin II receptor antagonist therapy is considered essential, patients planning pregnancy should be changed to alternative antihypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is confirmed, treatment with angiotensin II receptor antagonists should be stopped immediately and if appropriate, alternative therapy should be started. There is an increased risk of adverse reactions and fetal malformations when patients with bilateral renal artery stenosis or stenosis of the artery to a single functioning kidney are treated with medicines that affect RAAS. Symptomatic hypotension, especially after the first dose, may occur in patients who are volume- and/or sodium-depleted. As a consequence of inhibiting the RAAS changes in renal function have been reported in susceptible individuals, especially if combining medical products that affect this system. Patients with primary renin deficiency will generally not respond. Special caution for patients with heart or renal transplant, or obstructive hypertrophic, cardiomyopathy. Hypokalemia may occur especially in the presence of renal impairment and heart failure. Patients with hepatic impairment can have reduced clearance. Tablets contain sodium, therefore not suitable for patients with renal/renal conditions of fructose intolerance. As with any antihypertensive agent, excessive blood pressure in patients with ischemic/cholesterolemia cardiovascular disease could result in myocardial infarction or stroke. Before driving or operating machinery, alcohol or awareness impact can occur when taking antihypertensive treatment INTERACTIONS: May increase the hypotensive effect of other antihypertensive agents; increases plasma digoxin concentration; reversible increases in serum lithium concentrations, PREGNANCY AND LACTATION: Concomitant use during pregnancy and lactation SIDE EFFECTS: Dizziness, headache, sinus tract infections, upper respiratory tract infections, anemia, eosinophilia, thrombocytopenia, anaphylactic reaction, hyperkalemia. hyperkalaemia, anxiety, insomnia, depression, syncope, visual disturbance, vertigo, bleeding, cough, hyperglycemia, hyperglycemia, electrolyte abnormalities, dehydration, edema, dry mouth, headache. Infection, nausea, vomiting, hypotension, anemia, and/or nausea. side effects are rare. Before initiating treatment, carefully consider the potential benefits and risks of angiotensin II receptor antagonists. The recommended dose is 40 mg once daily. Prevention of cardiovascular death and mortality. The recommended dose is being once daily. Not recommended for use in children below 18 years due to limited data on safety and efficacy.

REFERENCES
Boehringer Ingelheim (Phils) Inc.
8741 Paseo de Roxas, Makati City

Boehringer Ingelheim (Phils) Inc.
8741 Paseo de Roxas, Makati City
Laugh Cure

FILIPINOS are known to be a resilient breed because they laugh even at the simplest jokes and even find time to laugh at the worst or most trying circumstances. While other cultures might not understand why Filipinos can laugh in the midst of a tight situation, this inherent ability of ours can yet be a remedy for our ills.

The potential effects involved in laughing are not generally understood and for years doctors have wondered about the physiological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh. Now researchers are suggesting that a hearty guffaw may well be the best medicine on mechanical and psychological benefits of a good laugh.

Contributed by Joselito Atabug, MD
Capitol Medical Center

Medical mission bloopers
A medical undergrad fratman volunteered to take care of the medicines for distribution. When the time came for the mission in a depressed area, he arrived 30 minutes late. The senior fratmen decided to reschedule the event. Why? The undergrad brought only 1 big box full of appetite stimulants! The people had nothing to eat if the medicines work! Hahaha

Clerkship bloopers
As a neophyte medical senior or clerk as we in our institution, we recall funny and unforgettable rib tickling experiences. A colleague on his first 24-hour duty ran frantically to the rest of his group mates very worried asking what the antidote for mercury was. The score: frantic clerk was checking the oral temperature with a thermometer when hell broke loose and the patient suddenly convulsed.

Hihhi

A groupmate who was always absent was on deck at the pediatrics ER section. He examined the baby and ordered a chest x-ray telling the mother to bring back to him the “wait” reading. We called him aside and told him that it was called “wet” reading. He retorted by telling us that he taught it was “wait” because we “wait” for the result. hehehe ♥

PHAN FUN

Cardio Crossword

By Rei Salangsang, MD

ACROSS
1. P2Y12, inhibit ADP induced platelet aggregation
2. Most common cardiac manifestation of SLE
3. Major structural component of the pericardium
4. Used for security surveillance
5. Irregularly irregular rhythm
6. Abbreviation of company; also a prefix to denote companion
7. Used to treat anemia; also denotes metal
8. Idiopathic large vessel vasculitis of young adults affecting the aorta and its major branches
9. To ___ is human, to forgive is divine
10. Name of the car in “knight rider”
11. Four legged animal mostly used in the middle east and deserted areas
12. Symptoms used to connote tenderness
13. Third note of the musical syllabus
14. Word used to greet someone to be polite
15. Drug of choice for hypertension in pregnancy
16. Latest antiarrhythmic agent for the treatment of AF
17. Arrhythmia with atrial rates between 100-130 associated with marked variation of P wave morphology and irregular P-P interval
18. Headed by Jose Manuel Barroso
19. A room in the hospital equipped to perform surgical procedures
20. an opening

DOWN
1. Most common organism for IE in adults
2. Shortness of breath that occurs 2-4 hours after lying down
3. ECG pattern with short PR interval and presence of delta wave in the QRS complex
4. Titer used to diagnose SLE
5. Most widely used anti platelet agent irresively acetylating and inhibiting platelet COX-1
6. Synonymous of fast
7. Most rigorously evaluated preoperative scoring system used in cardiac surgery
8. Most common etiologic agent of pericarditis
9. Opposite of in
10. ECG pattern with short PR interval and normal or narrow QRS complex
11. To go in
12. In the old testament, an Egyptian made of Sarah who bore Ishmael to Abraham
13. Type of arteritis presenting as new onset atypical and severe headache, scalp and temporal artery tenderness, acute visual loss, polymyalgia rheumatic, and pain in muscles of mastication
14. Most common postoperative ECG anomaly and is transient
15. An acute coronary syndrome associated with chest pain, ecg changes, and elevations of biomarkers
16. Echocardiographic finding of abrupt displacement of IVS during diastole in constrictive pericarditis

CARDIO CROSSWORD ANSWER

We encourage original contributions of jokes or cartoons or quotes inspired by work in the clinics or hospital arena or the humdrum of our daily routines. Please send to eic_phan@yahoo.com
...A day in the life of a cardiologist in progress...

ICDs save lives, says foreign speaker

“ICDs save lives” emphasized Dr. Irene Chung, a prominent cardiac electrophysiologist from Tan Tock Seng Hospital in Singapore during her talk on “Current Trends in Implantable Cardioverter-Defibrillator (ICD) Therapies” held at the BCI Coffee Shop, University of Santo Tomas Hospital on November 25, 2011.

The activity was organized by the UST Section of Cardiology, Cardiac Catheterization Unit in coordination with St. Jude Medical. Defibrillator therapy has been proven to be very effective and saves lives as shown in several primary prevention trials such as MUST, MADIT II, and SCD-HeFT, to name a few. Life-saving shocks are the raisons d'être of an ICD. Ironically, shocks also cause much of the morbidity associated with an ICD. Despite their undoubted evidenced-based credentials, ICDs, even the newer generation ones, are plagued by their inherent shortcoming—inappropriate therapies. The incidence of inappropriate shocks remain high occurring in as much as 50% of patients with ICDs and the related impact on patients’ quality of life and mental well-being is paramount.

Dr. Chung’s short but concise and informative talk enlightened the audience with the available tools and strategies to overcome this steadfast challenge. She briefly tackled on various ways to improve sensing and discrimination, minimizing T wave oversensing, decision T x programming, antitachycardia pacing as first therapy, as well as the role of higher energy devices. Indeed we can get MORE out of the ICD with LESS risks.

Vascular Presentations: Rare Cases

The Philippine Heart Association Council on Stroke and Peripheral Vascular Diseases (PVD) and Philippine Society of Vascular Medicine in cooperation with Pharex hosted a Vascular Case Presentation Contest held on November 21, 2011 at UP-Ayala Technohub, Quezon City.

This event was spearheaded by Dr. Maribeth T. Delos Santos, chair of the Council on Stroke and PVD and was well-attended by consultants and cardiology fellows from different hospitals.

Ten training institutions from various parts of the country joined the occasion wherein 12 interesting vascular cases were presented. Participating hospitals included Cardinal Santos Medical Center, Chinese General Hospital, Makati Medical Center, Perpetual Succour Hospital-Cebu, Philippine General Hospital, Philippine Heart Center, St. Luke’s Medical Center, The Medical City, University of Perpetual Help Delta Medical Center and University of Santo Tomas Hospital. Dr. Patricia Agunod-Cheng, Dr. Jenny Beltran, Dr. Leadette Padua and Dr. Jennifer Nailes served as judges.

This event ended with a huge success and three cases were adjudged as winners. Dr. Noel Lapus from St. Luke’s Medical Center bagged the third prize for his paper entitled “First Encounter with Transplant Renal Artery Stenosis.” Declared second place was Dr. Angelo Dave C. Javier from Philippine General Hospital who presented a case entitled “Bilateral Lower Limb Amputation due to TB Arteritis: A Catastrophic Consequence of Extrapulmonary TB.” Proclaimed as best paper/presenter was Dr. Rowena L. Ona from the University of Santo Tomas Hospital who presented a rare case of upper extremity thrombophlebitis exhibiting after a peritonsillar infection entitled “A Different Facet of Lemierre’s Syndrome.” Each participant received a monetary prize accordingly.

By Regina Yao, MD

By Samantha Mortos-Obispo, MD
The Shocked Heart

A previously healthy 37-year-old male electrical engineer was heard snoring loudly and observed to be breathing laboriously with profuse sweating around midnight. That he was not merely having a bad dream was suspected by the wife who rushed him to the nearest hospital. At the emergency room, he was found to be having ventricular fibrillation (VF) as shown in the following ECG strip (tracing A).

After two defibrillation “shocks” of 200 joules, VF was converted initially to idioventricular rhythm and subsequently to sinus tachycardia (tracing B).

The patient had a normal treadmill stress test and a normal 2-D echocardiogram from an annual medical examination three years earlier. Blood extracted during cardio-pulmonary resuscitation (CPR) showed normal K+ and Mg+2 levels. Troponin T was slightly elevated. Prior intake of drugs and alcohol was denied by the informants.

Obviously, the patient had sudden unexplained nocturnal death. Could it be “bangungot,” the local version of Brugada syndrome? The ECG in leads V1 to V6 recorded within an hour post-CPR is shown below (tracing C).

In lead V1, the high take-off of the J points gives rise to greater than 2 mm. ST segment elevations that descend without discernible isoelectric intervals to inverted T waves. The pattern inscribed by the elevated ST segments is compatible with the so-called “coved” type. In lead V2, the elevated ST segments dip downwards shortly after the J points producing apparent notching. From their peaks, the ST segments then descend merging with most likely prominent TU complexes. The pattern of the ST segments in lead V2 is not typical for either the “coved” or the “saddle back” type. In leads V3 and V4, there are also ST elevations from the J points producing no particular patterns.

The high take-off of the J points produces an apparent rSr’ or right bundle branch block QRS pattern of 0.10 sec duration. The prominent S waves in leads V5 and V6 substantiate the presence of incomplete right bundle branch block (IRBB).

The diagnostic features of Brugada syndrome; i.e., ST segment elevation and IRBB in leads V1 and V2, are evident on the patient’s ECG.

The elevated ST segments could also be attributed to an acute anterior wall MI or sustained vasospasm (Prinzmetal angina) involving the left anterior descending coronary artery. Electrical instability from the compromised myocardium could also generate VT/VF.

A “shocked” heart may also manifest elevated ST segments resulting from the intense electrical energy delivered during defibrillation. Some degree of non-ischemic injury to the subepicardium is believed to be responsible for the STT wave changes in the leads facing the myocardial segments closest to the defibrillator paddles.

Reversibility of the repolarization abnormalities is highlighted by the ECG (tracing D) taken after 24 hours in which the elevated ST segments are no longer evident. This finding does little in terms of establishing the etiology of the elevated ST segments. The ECG charges associated with the Brugada syndrome, Prinzmetal angina, and the “shocked” heart could be evanescent.

The ECG cannot precisely diagnose a “shocked” heart.

But, a chest X-ray can definitely detect a “shocking” heart.
Celebrity, tragedy and infamy

Prior to his death, Michael Jackson would understandably or expectedly be a dream patient for any top-calibre cardiologist in California (or for any physician in any part of the world for that matter). Who would not have wanted to be the personal physician of a global superstar like Jackson and be by his side in all his concerts and travels? Who would not have envied (or even hated) Dr. Conrad Murray?

Murray, a cardiologist, was Jackson’s personal physician when the superstar died of drug overdose in his Los Angeles home in June 2009. Murray stood trial for involuntary manslaughter and was convicted and meted a punishment of four years in jail. Furthermore, in restitution for the death of Jackson, he must pay the family and heirs of the actor a hundred million dollars.

Sadly for Murray, his fortune as Jackson’s chosen, turned to be his greatest misfortune as the pop icon’s convicted felon. He would now go down in history as the man responsible for his death. How one’s sworn oath as healer and caregiver can lead to prison and global notoriety is undeniably ironic and tragic. Whoever thought that handling a celebrity can be an invitation for tragedy? Or infamy?

Taking care of VIPs surely must have its perks. That one has been singled out to be the cardiologist of a prominent politician, entertainer or celebrity is certainly one delectable ego trip. The fringe benefits include being cited on media write-ups and television/radio programs as the physician of the rich and famous. It can usher in the all too important status symbol, instant recognition and the indirect name promotion and advertisement. When one’s face and name are broadcast on nationwide television and emblazoned on daily broadsheets, it becomes one giant calling card flashed for all viewers to see. There will always be one gullible soul who will think that if Mr. Celebrity, with all his clout, money and power, is willing to entrust his heart or his health to this physician, then the latter must be good.

The price of such prominence and recognition will be the added stress and strain of such association. I remember a colleague being lambasted on some radio programs many years ago by all-knowing radio commentators for his apparent incapability and incompetence in controlling the blood pressure of a governor patient who was being tried for murder.

The association can also bring about harassment by media entities prodding the physician to issue a statement regarding the patient’s status or condition. Worse, one can be misquoted for any remark one may have regarding the involved official. A few years back, I remember getting a call from a worried congressman patient who called my attention for divulging my findings concerning the blood vessels of his heart to media people. Aside from stressing to him that all patient information were confidential, all I could say was – “I never spoke with any media person.”

Fortunately or not, I have my fair share of celebrities, dignitaries or politicians as patients. Having such is both a blessing and a bane. In general, I am humbled by the mix of names that have become patients of mine. Many are unassuming, undemanding, low-profile individuals whose demeanor and behaviour in the clinic or the hospital, whether in-patient or out-patient, are in stark contrast with their media persona. This convicted rapist is a very soft-spoken, yielding, obedient patient who regularly submits himself to general check-ups without qualms or excessive demands. This other congressman accused of murder is one who is as meek as a lamb, who always pays consultation and hospitalization fees in cold cash. This brilliant legal luminary of a solon is an amiable, remarkably pleasant gentleman who, at 86 years of age, still addresses me with a humbling po and opo. And this relatively young solon from a nearby province is an extremely devoted family man and loving husband who always remains profusely apologetic for every call he makes to inquire on his chemistry results.

Personal beliefs, political biases and ideological persuasions take the backseat when one attends to controversial personalities. One tries to master the art of learning to suppress one’s own convictions to render objective and impartial care to everyone.

In all clinical care situations involving big-time personalities, one must constantly remember and convince himself that the right strategy is to treat everyone with the same degree of scientific decision-making and clinical disposition regardless of name, position, pocket depth, ego size and star power. It is when one gets blinded with celebrity luster or political lineage that one loses sight of this mandate to render objective and equitable degree of care. One can only wonder if this could have been the lot of Dr. Conrad Murray.

By Saturnino P. Javier, MD
Why do we fail in curbing and preventing NCDs?

The modern world has given us tremendous know-how, yet avoidable failures continue to plague us everywhere, in healthcare and government, in law, and in finance. And the reason is quite simple and obvious. The volume and complexity of things that we are doing, far exceeds our capacity to properly deliver and achieve it—consistently, correctly and safely.

In 1970’s, the philosophers Samuel Gorovitz and Alasdair MacIntyre published a short essay on the nature of human fallibility that I read two weeks ago and haven’t stopped pondering since. The query they sought to answer was why we fail at what we set out to do in the world. One reason, they said, is “necessary fallibility” – some things we want to do are simply beyond our ability and capacity. We are not perfect and all knowing. Even enhanced by iPhones, iPads, technology, our physical and mental powers are limited. Much of the world and universe is-and will forever remain – outside our understanding and control.

IGNORANCE and INEPTITUDE

There are clear realities, however, in which control is within our reach. We can do coronary artery bypass grafts, lap surgeries, laser eye therapies and many more. In such realms, Gorovitz and MacIntyre pointed out, there are two reasons that we may nonetheless fail.

The first is IGNORANCE, we may err because science has given us only partial understanding of the world and how it works. There are skyscrapers we do not yet know how to build, typhoons we cannot predict, heart attacks we still haven’t how to stop. The second type of failure the philosophers call INEPTITUDE – because in these cases, the knowledge and awareness exist, yet we fail to apply it correctly; like smoking – we know it’s bad for our health and yet smokers allow themselves to suffer and die prematurely. This is really absurd.

According to Prof. Antonio Dans, et al, in the Lancet article, Feb 19, 2011, chronic non-communicable diseases or NCDs (stroke, heart disease, cancer and COPD) is a major public health problem in the Philippines and in the South East Asia. Southeast Asia faces an epidemic of chronic non-communicable diseases, now responsible for 60% of deaths in the region. The problem stems from environmental factors that promote tobacco use, unhealthy diet, and inadequate physical activity. Disadvantaged populations are the hardest hit, with death rates inversely proportional to a country’s gross national income. Families shoulder the financial burden, but entire economies suffer as well. Death and disability from NCDs can exert an economic burden in 2 ways: indirectly, through loss of productivity and income, and directly, through household spending on chronic medical care, often of catastrophic proportions. These preventable conditions can cause major drain on the economy because of avoidable morbidity and mortality.

Developing countries have not only the double burden of communicable and chronic disease, but many also experience the simultaneous challenge of health-system reform. Without universal access to care, well-integrated health services, and strong leadership in public health, response to the above challenges will be inefficient. In such circumstances, the greatest health gains could come from structured preventive strategies.

The success of any healthcare system despite the low financing for health from public funds, is related to a unique and innovative unique healthcare spending related to a unique and innovative system despite the low financing, providing cost-effective care that promotes health but we reward sickness? We have a present system as one that pays for procedures not cures; interventions not outcomes; transactions not transformations. We “penalize” doctors for providing cost-effective care that promotes health but we reward them for interventions regardless of outcome, redundancy, and waste.

Multi-sectoral approach needed

Although attempts to control non-communicable diseases are increasing, more needs to be done. Health-care systems need to be redesigned to deliver chronic care that is founded on existing primary health-care facilities, but supported by good referral systems. Surveillance of key modifiable risk factors is needed to monitor the magnitude of the problem and to study the effects of interventions. All branches of government and all sectors of society have to get involved in establishing environments that are conducive to healthy living. Inaction will affect millions of lives—often, the lives of those who have the least in life.

Philippine Health Care – quo vadis? The Health for the Filipinos is not about extending insurance coverage and deciding who to pay for health care, and how much – important as those things are, it makes no sense just to figure out a better way to pay the bills for a system that is dysfunctional, ineffect, and broken. We also have to change the health care system itself, beginning with a sharp new emphasis on prevention and public health.

Perhaps we can convene a meeting with the medical societies, for a start. DOH Secretary Enrique Ona agrees with the suggestion to shift the focus of DOH from sick care to health care; The DOH will take the lead in addressing ignorance and ineptitude in healthcare and will communicate with all government agencies to contribute their share on health.

Health is not only the accountability of DOH it is our accountability as citizens. But, our government leaders should step up and think of creative ways to improve our condition.

We can ask DepEd, DOST, and CHED to insert preventive health education modules into the academic curriculum; we can ask DPWH, DILG, MMDA and LGU heads to clean up the