Dr. Joel Abanilla

Research tops his 7-point agenda
Transitions are but inevitable in any organization or government. Along with every change in administration or management come modifications of strategies and schemes, plans and policies, systems and tactics which would set the direction of the particular leadership.

What probably separates an organization like the Philippine Heart Association from other societies is the fact that despite changes in the leadership, the thrust of the institution remains the same. Although each PHA president has his own unique agenda and specific programs that would define his term, and that he would want to leave as a legacy, each and every program under any regime is all geared towards one goal - the improvement of cardiovascular health of the country.

In the past 62 years of existence of the PHA, it has evolved, matured, and strengthened itself with a solid foundation on its values, beliefs and philosophy. Leaders, both great men and women have come and gone, but not without leaving lasting footprints on an organization that they have exceptionally steered into what it is now. The programs and strategies may have differed through the decades, but the mission remains the same.

Each year, new obstacles arise. This cannot be more true this year with the expected rise in cardiovascular disease which goes along with a growing and booming population, the continuing threat to physicians as a whole imposed by the Bureau of Internal Revenue, the rising cost of healthcare, the lack of a comprehensive healthcare system support from the government, the looming Mexico principle. Within the Association, membership activation and engagement, improvement of training and research, enhancement of advocacy programs, and the creation of more registries and guidelines are continuing challenges. These are the difficulties that our 63rd PHA President Dr. Joel Abanilla will have to face as he starts his leadership. These are, however, also opportunities for the Association to shine.

As the PHA enters the third year of its seventh decade, it finds itself in familiar territory as the earlier years of the past era, when the Association faced a fragile period in Philippine history with trials and ordeals like the global terror threat, the economic uncertainties, the threats to the medical profession, the political instability, and the effects of climate change, all of which characterized the 2002-2012 period. But in this same period, the PHA history was defined by several key points-healthy lifestyle, advocacy, mass media exposure, women’s health, international collaborations, relevance and impact to the community. Truly, it was the Decade of the Heart and the Decade of Cardiology.

What will define this present time in the PHAs’ journey? Whatever the challenges are, this Association will rise to the occasion, and live up to the expectations made 62 years ago – “serve a great purpose as a stimulus to cardiovascular research, teaching, and practice in the Far East”- Dr. Paul Dudley White, 1952.

At its 63rd year, the PHAs story remains half told. ♥
Iloilo’s pride
Who is Dr. Joel Abanilla?

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Health crisis looms
There are only 3,000 out of 66,000 physicians in government facilities... this is 10 times less than the 24 healthcare workers per 10,000 population recommended by the World Health Organization

Enchanting Iloilo
is worth going back to
We greet you all on this edition of the *Philippine Heart Association NewsBriefs (PHAN)*. As we start a new term under PHA President Dr. Joel Abanilla, the Newsbriefs also undergoes a transition with a new editor in chief. My job, however, is made easier by the excellent work that our previous editor-in-chief Dr. Erlyn Demerre, has done with the PHA’s official newsletter. Like the PHA, *PHAN* has also evolved through the years. Today, it is something that the Association and any member can be proud of.

As always, the *PHAN* will serve as a medium to inform and disseminate news about the Association. Seeing how the news section has beefed up through the years is a testament to how the PHA has progressed. We convey the news, but it is the PHA and its membership that make the news. We shall maintain all the excellent features- the Councils and Chapters section, the Lifestyle and Features section, Perspectives, the Academics and Research segments, along with the other items and columns that have made *PHAN* an attractive and interesting piece. The section on Lay Education and Advocacy will be strengthened. In this issue, we have made a special focus on Atrial Fibrillation (AF), in commemoration of AF Awareness month in August. We have also added another section on Bioethics in Cardiology. Future issues will include medico-legal and bioethical perspectives about certain issues in cardiovascular medicine, and a special section called INFOcus dealing with controversial topics and subjects relevant to every Cardiologist and to every Filipino citizen.

We in the editorial team are all “students” of Dr. Erlyn and we will carry on her legacy. As *PHAN* continues, she is definitely not leaving us and will stay on as Senior Editorial Consultant. To the editorial staff of *PHAN* and to our new members, welcome back and welcome aboard! To our two leaders- Dr. Joel and Dr. Erlyn – we salute you. *Mabuhay ang PHA!* *Mabuhay ang PHA NewsBriefs!*

**Editor’s Note**

**About the Cover**

Cover photo shows the PHA president by the window of the Avanceña *Balay nga Bato*. This vintage house has made history and continues to weave its one-for-the-books story.

Dr. Joel Melocoton Abanilla shuttles between Manila-Iloilo-Manila twice a month. He stays in the Abanilla residence but drops by the Avanceña ancestral house, to look at the remnants of his family’s glorious past.

See cover story and related stories on pages 6, 46 & 48.

**HOME IS WHERE THE HEART IS**

*Home is where the heart is*
Never breezy, but certainly gratifying. My journey to the PHA presidency was not easy. It was a bit arduous, fraught with bits and pieces of struggles, humbling encounters and moments of doubt of my own capacity to lead a prestigious college as the PHA. Along the way, however, I gathered a few learnings of a lifetime that I will always cherish. My stay at the PHA afforded me the rare opportunity to see its face from different perspectives. I witnessed it evolve, saw where it was heading to and somehow, learned how to chart its course.

Preoccupied with the rigors of work in the PHA, six years seemed to have quietly slipped-by. I am fortunate to immediately follow the presidency of two good friends (Drs. Saturnino Javier and Eugene Reyes) who were imbued with brilliant ideas and clear visions for PHA. Our regular wine sessions were like extensions of Board meetings. We would eat, drink and talk about PHA. When needed to vote on issues, consensus were made over sips of Shiraz or Montepulciano. So, our great guru Dr. Ramon Abarquez need not worry about continuity as an issue. Focus is shared and no flagship projects will be side-tracked.

My top priorities as PHA president are:
1. RESEARCH, 2. IMPROVING THE TRAINING PROGRAMS IN CARDIOLOGY, 3. MEMBERSHIP ACTIVATION, 4. ADVOCACY, 5. INTERNATIONAL COLLABORATION, 6. COMPLIANCE WITH GOVERNMENT and 7. HEART HOUSE.

At this juncture, I’d like to acknowledge and sincerely thank my mentors, colleagues and friends, some of whom have made indelible marks on the pavement along my journey. They are in particular -- Drs. Ramon Abarquez, Homobono “HB” Calleja, Adolfo Bellosillo, Yolando Sulit, Gregorio Patacsil, Dante Morales, Avenilo Aventura, Noe Babilonia, Romeo Saavedra, Jose Yulde, Antonio Sibulo, Annette Borromeo, Maria Teresa Abola and Leni Iboleon-Dy.

See Page 27
One-on-one with the PHA president

One of his favorite nooks in their ancestral home which he calls our old house.
I had knowledge of the flash mob singing. In fact, I requested them (the UP Concert Chorus, some members of the Madrigal Singers, soloists from UP and UST College of Music, Fortenors, cardiologists and pharmaceutical friends-singers, fellows in training, about 50 singers) to do it after my inaugural speech towards the end of the ceremonies. But, I did not expect the tremendous emotional effect on me. I was simply overwhelmed.

What circumstances led you to becoming part of the PHA Board of Directors, and now PHA President?

I was kind of pushed and led on to become a PHA Board of Director by colleagues and mentors after my stint as Philippine Society of Echocardiography President.

Can you describe your family roots and your family, and how you came all the way from Iloilo to becoming a distinguished cardiologist in Manila, and now the PHA President?

With modesty, I am humbled to say that I came from a clan (Avanceña family) of very distinguished personalities with a strong drive for excellence. For most of us in the family, we were brought up with a strong mind set to do good in whatever field we choose. The PHA presidency was never a personal agenda of mine. Hard and a difficult journey as it was, destiny seemed to have brought me here.

What are your current plans/thrusts for the Association?

My priorities, briefly, are the following:
1. Encouragement and augmentation of quality research;
2. Improvement and standardization of training programs in cardiology;
3. Activation of membership;
4. Enhancement of advocacy programs;
5. Maintenance and strengthening of...
mutually beneficial collaborations with other regional and international cardiac societies; 6. Promotion of linkages with other organizations and government to help create policies that will help improve cardiovascular health; 7. Initiate ground work for the creation of a Heart House.

Since your entry into the PHA Board, the Association has been very aggressive and unrelenting in its programs for the lay and for the physicians. What objectives have already been met?

This particular question is hard to answer because it is an ever-moving target. We have barely started with our registries and there is a need to continuously update the guidelines. We are happy with the results of the latest National Health Survey and I like to believe that PHA helped to make this possible but we can never rest on our laurels in this aspect.

What objectives still need to be fulfilled?

We would like to have a robust registry of all major cardiovascular diseases to gauge how good we practice our craft and what areas need improvement. We need to enhance our Advocacy programs for a Healthy Lifestyle and we need a more pro-active legislative agenda.

What are the current programs that you are undertaking/working on?

First is initiating more registries. Secondly, we want to help create an atmosphere of doing more meaningful researches. Third, creating and updating more clinical practice guidelines (CPGs). And lastly, to complete the core curriculum for the cardiology training program and the updated guideline for accreditation of a training institution.

As a leader, what do you think are your strengths and positive traits that you think will help you in steering the association?

I like to believe that through the years I have made so many friends who believe in my capacity and sincerity to serve. My frustrations also taught me to be a better person. Dealing with it with no rancor in my heart made me a happier person as well. I am so elated to note that a lot of my colleagues willingly accepted assignments or requests simply because it was me asking for it.

What do you think are your weaknesses, if there are?

Hard to say no to a friend’s request. I get exhausted at times because of this.

What are the present challenges of the PHA that you foresee?

One is looking and maintaining a healthy funding strategy to support all our research projects.

Secondly, the American College of Cardiogy (ACC) issue: I don’t really believe this is supposed to be a controversy in the real sense. Mutual benefits are derived from the collaboration. The small amount of money lent by PHA was really done in good faith to help create an ACC Chapter where a lot of benefits for PHA and its members can be derived. The money will be eventually reimbursed. We just
have different ways of looking at how things should be done. Thirdly, the Mexico–Kuala Lumpur administrative order 2014, or the “Mexico principle” – there are some apprehensions that this will be restrictive in the participation of pharmaceutical companies in a medical society’s activities. On the other hand, it might also turn out to be more beneficial for the PHA since more finances will now be channeled to CME and research. This will eventually translate to a more affordable quality cardiovascular health care for our countrymen.

**Membership activation seems to still be a problem faced by the PHA. How do you think we can improve on this?**

It has improved in the last few years. We have several more strategies in place to further make it better. Among others,
1. Re-drawing Chapter geographic boundaries to create realistic gatherings
2. Requiring our new Diplomates to participate in council/chapter activities before being certified as full Fellows of PHA.
3. Introducing more CME opportunities in our website
4. Creating more realistic guidelines for active status in the association. After all, Philhealth and other insurance companies now demand that physicians need to be certified as “active” before approving their membership renewal.

**What changes do you plan to undertake in the association in the one-year term that you have?**

So many excellent plans have already been set up by those who came before me. No need to add so much more unless necessary. I just need to spend more effort and time to inspire and produce people (in the Councils, Committees, Chapters, etc) to execute their plans. I like to see things or projects being implemented.

**How can the PHA be relevant to the current health scenario of the Philippines?**

PHA plays a vital role. Unlike in the US where they have distinct roles for the ACC (the college that is tasked to oversee an acceptable high level of education and training program for cardiologists) and the American Heart Association (which focuses more on Healthy Lifestyle advocacies and legislation), we have the PHA doing both important roles in the Philippines.

As a college, the PHA serves to maintain quality education and training of cardiovascular experts in order to maintain good cardiovascular healthcare. As an advocacy arm, PHA collaborates with many other associations and government agencies to teach and educate the ordinary Filipino on ways to improve cardiovascular health.

**In your opinion, in the present day, how is the PHA creating an impact towards public health? Is the association truly effective in its mission?**

Every contribution to help improve public health matters. As I have mentioned, our goals are multifactorial and are moving targets and therefore it is not so much to say or tell whether we are effective or not. We are aware that we need to continue with our advocacies and collaborations with other health agencies. We just have to carefully think which strategy will optimize our efforts and finances.

**Are there any other registries that the PHA is planning on embarking and what would be the significance of these?**

As mentioned, registries will give us a mirror of what we are currently doing and an opportunity to help improve quality of health care. In place now is the ACS Registry. Starting soon are Heart Failure, Atrial Fibrillation, Congenital Heart Diseases, Cardiac Cath Interventions, Coronary Artery Bypass Surgery, and Cardiac Rehab Registries.

**What are the current efforts of the PHA in improving the Philhealth coverage of cardiovascular diseases and procedures? Does the PHA actually have a say in this?**

Philhealth usually deals with Hospital Institutions. But they were present at the stakeholders meeting for our CAD guidelines update. This helps them identify priorities and where to put the money. They will be invited again in other consensus-making activities.

**Can you clarify ‘for the benefit of our membership’, what are the benefits that the PHA and its members have to gain through this PHA-ACC collaboration?**

1. Recognition of the PHA as a very respectable premier cardiac association in the region. ACC will not agree to the creation of an ACC Chapter outside the PHA.
2. The PHA has been invited and will be invited again (2015 in San Diego) in a joint session during the ACC Convention.
3. PHA will get 10% commission of the total registration fees paid by Filipino delegates.
4. Cardiology Fellows in training will be charged with the same registration fee as an associate.
5. Cardiology Fellows in training will have access to soft copies of 2 leading US journals (JACC and Circulation).
6. Special benefit such as a free booth space for the PHA during the ACC convention.
7. PHA representatives will be invited to sit in scientific meetings like creation of guidelines and CPGs.
What about the core curriculum that you mentioned and which the SBAC has been working on? Please describe and clarify.

This will be a detailed guide of all the minimum requirements in each level or year and rotation of a cardiology fellow in training. The core curriculum will define the areas in cardiology training program in which the institution will anchor on activities that will mold competent cardiologists. In short, it will become the reference for teaching materials and courses in cardiology and will include mechanism of self-assessment of the trainees of his training at any point of his/her fellowship.

What Clinical Practice Guidelines (CPGs) is the association embarking on?

Coronary Artery Disease CPGs are almost done. Development of Lipid and Heart Failure CPGs are on-going.

Are there any legislations that the PHA is currently lobbying on in Congress?

We supported the Sin Tax Law, and the printing of graphics on the danger of smoking on cigarette packs. A new legislation committee has been set up and they will be looking at issues like the Mexico Administrative Order 2014, soda restrictions to children, wellness center in call centers, etc.

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

I like to see more motivated and concerned members of the PHA. Each member needs to realize that we all have an important role to play in good healthcare delivery. All efforts put together can result in significant changes for the better. How to harness this energy and cooperation will be the big challenge for us in the Board. I like the membership to know that their officers are paying attention to all these details and we are painstakingly doing what we believe can generate better participation from most motivated members of the association. All our projects that are currently being undertaken are geared towards this end.

Lastly, How do you want to be remembered as a PHA President?

Perhaps as a hard working servant who made things happened in the PHA. ♥
I like to see more motivated PHA members... All efforts put together can result in significant changes for the better.
Registry, Research, Clinical Practice Guidelines and Continuing Medical Education or Lay Advocacy Awareness, program in this order, are the priorities of the PHA Councils, Sub-committees and Chapters.

The yearly Strategic Planning Workshop (2014-2015) which was held on at the Marco Polo Hotel on Meralco Ave., Pasig City on July 12, 2014, assessed the PHA’s performance and role in the advancement of local cardiology, cardiovascular education and mileage of Lay Awareness Advocacy Campaign. Just like a registry, the strategic planning intensive meeting tells the PHA where it is and leads it to the right direction.

PHA President Dr. Joel Abanilla urged the Council chairpersons to “create a plan that’s doable to avoid waste of time and effort. Investigate, do your homework and get the right people. I really appreciate the Chapters’ interest in participating in our Research undertakings.”

The Council chairpersons and co-chair presented their projects, actions plans with timelines, obstacles/potential issues and strategies (actions and resources needed).

CAD Guidelines underway

The Coronary Artery Disease (CAD) Guidelines will be disseminated next month in all the major hospitals, PHA-accredited hospitals and the Chapters. Initially, only 30 to 50 percent of provincial hospitals will receive their copies.

The three-year-old Acute Coronary Syndrome (ACS) Registry remains a priority.

Focus will be on increasing the number of patients in every hospital and on encouraging the old chair members, especially the past chairs, to be active again and to recruit new members. The council’s goals are: to become a big group with service-oriented members; have meetings with 70% attendance and conduct lectures in the PHA chapters.
**CPR in schools, AED in LGUs**

CPR awareness in schools in collaboration with the Department of Education, government agencies and public places; a CPR-Hypertension BP ng Teacher Ko, Alaga Ko caravan are the priority projects of the Council in 2015. It is gearing up for the Resuscitation of Council of Asia Assembly it is hosting on May 26, 2014 (related story on Page 28).

Part of the Chapter’s goals are: inclusion of CPR in the school curriculum, CPR awareness in the Metropolitan Manila Development Authority and local government units and acceptance/endorsement of the AED by at least one city is a good start.

The PHA dreams to see an AED in every establishment and in public places; and the passage of a law making the AED a pre-requisite of the building code; and produce a CPR video infomercial, a powerful tool that will give the project an edge.

The contest is open to PHA-accredited institutions. The presentation/judging will be in May 2014.

**Hypertension data out soon**

The BP ng Teacher Ko, Alaga Ko which is in vigorous progress ends in 2016 and the Council is expected to submit a program review/analysis of data from January to December 2015 and an interim analysis of the project from March to Dec. 2015. Success rate is at least 350 teachers/screening.

A Hypertension awareness program thru mass media tools (newspaper, radio, TV, pamphlets, video. Website) and the Pinoy highblood website will be implemented. PHA will issue statements on detection/treatment of hypertension.

The success will be measured by the increase in the number of queries, questions thru text messages during radio interviews and media value of print exposure.

**75% attendance in CCCI meetings good enough**

By 2015, the Council on Cardiac Catheterization & Interventions hopes to see the active participation among training centers in the quarterly case conferences.

Having a 75%- attendance rate of the training fellows and active
consultants as well as getting at least one research done by every institution, especially the published ones, is stimulating.

The indices will include emergency and elective procedures. Eventually, these research materials can be presented locally and internationally.

To intensify awareness on coronary cases and intervention, the Council has lined up the following projects: PCI Registry standardized protocol, standardized form to be used by all institutions, data collection, public awareness thru education lay-friendly pamphlets for distribution and fora (at least two lectures/fora).

There will be a meeting with all the TOs and CRFs. All materials, log books and questionnaires should be provided.

**Council on Cardiac Rehab**

**Long way to go**

At this point, a registry is not feasible. There are no available data on patients’ profile and utilization rate. Collaboration with the CAD council and cardiac rehab sections in hospitals is crucial because it is where they can source data. The Cardiac Rehab Council has asked the CAD council to give the former an idea on how many should be referred and enrolled to get the utilization rate.

**Cardiomyopathy Cor Pulmonale:**

*We want our own registry*

The Council is targeting the creation/implementation of a national registry for Cardiomyopathy and Cor Pulmonale patients. Six to seven hospitals will be the data collecting centers. Data collection is indeed challenging that is why delay is inevitable. This entails a huge sum so sponsors are needed. Suggestions from the group are welcome.

**CV Anesthesia**

**Wanted: New members**

The Council is keen on reinforcing its membership. Foremost on its agenda is coming up with guidelines for CV anesthesia and CABG surgery.

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**Congenital Heart Disease**

**An epidemiologist is a must**

A data base registry on congenital heart diseases (CHD) is crucial in the Council’s bid to establish the prevalence of CHD. To get started it needs an epidemiologist and funding.

**Echo courses for the IMs, GPs**

The Council will focus on an Echo review of the local and international experience.

PHA will introduce echocardiography to the internists and general practitioners (GPs) in Cebu, Davao, Iloilo and Bicol next year, starting in February 2015; and embark on a three-year research project to derive normal echocardiographic values/parameters for Filipino patients in January 2015.

The first step is to draft a module with definitions of technical terminologies for proper interpretation of echo report. The final presentation for implementation of the research study will start in November 2015 and take 1.5 years.

**CPG on Dyslipidemia dissemination via media**

March 2015 should see the publication and dissemination of the 2014 Clinical Practice Guidelines on Dyslipidemia through different media outlets – dailies and medical journals, website of online publications and medical societies. The local PHA chapters will play an active role in the dissemination of the guidelines.

**Heart Failure Summit set**

It will establish its own registry in the country to be measured by a validated CHF protocol/tools and participated by 90 percent PHA hospitals. A CHF Summit will be conducted in February next year.

**PHA,PPS in RF/RHD tie-up**

The Council on RF/RHD’s first project is the Advocacy on Drafting the Implementing Guidelines in the Control and Prevention of RF/RHD which should be approved by Sept. 2015.

A collaboration among the PHA, Philippine Pediatric Society and Department of Health, by April 2015 the CDs will be distributed in the PHA and PPS chapters.

The second one is the Surveillance of the RF/RHD Registry Review, which is aimed at hitting a 20-percent increase in enrollees.

**Women’s CV Health to get big boost**

In its pipeline are the Advocacy on Women’s Heart Disease Awareness Campaign “Mabuhay ka Pinay”, a Consolidation of data from the Councils on CAD, Hypertension,
In Focus:
It’s Atrial Fibrillation Awareness Month

Dr. Belen Carisma,
president of the newly-formed Philippine Heart Rhythm Society, a former PHA president and editor in chief of the PHA Newsbriefs, talks about AF, its current burden in the country’s healthcare system, and the role that each physician plays in combating this dreaded condition.

Every August, the Heart Rhythm Society, the international organization of heart rhythm experts, commemorate Atrial Fibrillation Awareness Month, highlighting the importance of this arrhythmia and the healthcare burden that it imposes.

Briefly, in the simplest of terms that could be understood by laymen, what is atrial fibrillation?

Normally the heart’s electrical system causes the two upper chambers (atria) to beat in coordination or synchronously with the lower chambers (ventricles).

In atrial fibrillation this coordination is lost with the atria beating chaotically and irregularly losing their coordinated beating with the ventricles.

As a result of this chaotic beating, the atrial contribution to the pumping efficiency of the heart is lost such that if uncorrected, atrial fibrillation will, in the long-term cause the heart to fail, a condition more commonly referred to as heart failure.

What is Atrial Fibrillation?
• NORMALLY, the heart beats regularly at a rate of 60-100 beats per minute.

• IN ATRIAL FIBRILLATION, there is an irregularly irregular heart rhythm, usually with a rate more than 100 beats per minute. Sometimes, the rate may be normal but the rhythm is irregular.

Moreover, inasmuch as there is an irregularly irregular beating of the heart, blood flow within it is not smooth predisposing that heart in atrial fibrillation to form blood clots that may at any time be dislodged and end up in the brain to cause strokes, otherwise known as thromboembolic stroke.

How would you describe the present status or burden of atrial fibrillation in our country?

Atrial fibrillation (AF) presents a major public health burden in our country.

In our setting, AF is brought about not only by non-valvular cause as coronary heart disease but also by valvular cause as rheumatic heart disease.

The most debilitating complication of AF is thromboembolic stroke, the risk of which is 3-5 times with non-valvular AF and 17 times with valvular AF. With both coronary and rheumatic heart diseases being highly prevalent in our country, AF exacts a high economic toll on our very limited health care resources.

AFib Feels Like...
...DRUMS
POUNDING
IN MY CHEST

...THUNDER
RUMBLING
IN MY CHEST

...FISH
FLOPPING
IN MY CHEST

Figure derived with permission from the Heart Rhythm Society website www.hrsonline.org
Add to this is the fact that coronary heart disease remains as the number 1 cause of death in our country killing no less than 109 per 100,000 Filipinos with stroke trailing behind as the number 3 killer and no less than 82 per 100,000 Filipinos succumbing to it. We may not have the direct figures for how many of these deaths have associated AF but we do know that strokes in the presence of AF are more severe and debilitating if not outright fatal.

As such, AF affects the quality of life of affected patients across all realms, from the physical to mental and social aspects.

AF undoubtedly entails a substantial cost burden to the Philippine health care system given the recurrent hospitalizations, treatment interventions not to mention the loss of productivity that patients are faced with.

**What is the prevalence of this condition in our country?**

By the 2003 National Nutrition and Health Survey ECG substudy, the prevalence of atrial fibrillation in the country was at 2%. With the National Statistics Office putting the 15 year old and above at 55 million, this roughly translates to at least a million adult Filipinos affected with this heart rhythm problem.

However, it is established in population-based studies in other parts of the world that the prevalence of atrial fibrillation increases with increasing age and since our elderly population, likewise, has been increasing at a rate faster than the total population rate increase, we can surmise that we would most probably have over a million Filipinos afflicted with AF as of now.

**What are the risk factors for one to develop AF?**

**What conditions are associated with it?**

Many factors predispose one to develop AF. These include age, heart disease, hypertension, alcohol, obesity, family history and other chronic conditions.

**First is age** – the older one gets the higher the risk for AF. As a matter of fact, in the Framingham Heart Study, it was found that the lifetime risk of developing AF was one out of four for those 40 years of age and above for both men and women. As people begin to live longer, each decade of advancing age increases the likelihood of developing AF by 2.1 fold in men and 2.2 fold in women.

**Heart disease** – from congenital to coronary artery disease with or without a heart attack or myocardial infarction, to rheumatic heart disease, to congestive heart failure from any cause and even following a heart surgery, can predispose to AF.

**Hypertension** – high blood pressure that is not well controlled either with medications and or healthy lifestyle commonly predisposes one to AF as well.

**Alcohol** – when consumed in large amounts for many years inevitably causes a heart condition known as alcoholic cardiomyopathy, which may have concomitant AF. But a more common trigger for AF is binge drinking on a weekend or on a holiday in a patient without known heart disease, a condition aptly called holiday heart syndrome. Fortunately, this is reversible upon abstinence from alcohol.

**Obesity** – People who are obese are at high risk of developing atrial fibrillation. For every 1 unit of BMI increase, the risk is increased 1.52 fold for men and 1.46 fold for women.

**Family history** – Parental history of AF is associated with the development of AF in the offspring. Again, it was shown in the Framingham Heart study that if a person had a parent who had AF, then his/her risk for developing AF was 1.85 fold.

Other chronic conditions associated with AF are thyroid disorders, sleep apnea, metabolic syndrome, diabetes mellitus, chronic kidney disease or lung disease.

**Can AF be prevented?**

AF, to a large extent, can be prevented by eliminating if not controlling the preventable and modifiable risk factors such as hypertension, obesity, diabetes and smoking through a sustained healthy lifestyle intervention, albeit there are risk factors that are non-modifiable such as age and heredity.

**How is AF diagnosed?**

AF is diagnosed based on a good medical and family history, a physical examination as well as results from various tests and procedures.

The medical history may or may not elicit a history of irregular palpitations as some AF may be “silent” or “asymptomatic” but it should be able to shed light on the above-mentioned predisposing factors. The physical examination will help corroborate the medical history, e.g. an enlarged thyroid gland for those with thyroid disorders, a heart murmur for those with mitral or aortic valve disease, an overly overweight person for those with metabolic syndrome and/or sleep apnea, to name a few.
The US Heart Rhythm Society commemorates AF awareness month every August, are there any plans that the Philippine Heart Rhythm Society have in line with increasing awareness of this condition?

The Philippine Heart Rhythm Society (PHRS) is a very young organization that has just held its Inaugural Symposium last May 2014. It has had to firstly get itself off the ground, logistics – wise which, in the light of competing forces for resources, has been very challenging.

In line with the US Heart Rhythm Society’s AF awareness this month, PHRS plans to come out with an article in a major broadsheet on AF as part of its advocacy thrust. PHRS realizes this advocacy on AF awareness is not confined to one month in a year but should be a sustained effort in collaboration with the Philippine Heart Association. PHRS would be glad to reverberate this AF awareness campaign in the PHA website in the absence of a PHRS website as of the moment. The aspiration to have an AF registry with the PHA’s Council on Electrophysiology and Cardiac Pacing is one that seeks to break logistical barriers.

Can you briefly describe the objectives of the Philippine Heart Rhythm Society?

The PHRS Vision is to be the leader in heart rhythm management in the Philippines, recognized by the Asia-Pacific region by 2018.

An organization of heart rhythm professionals, its Mission is to give quality care to patients with cardiac rhythm disorders through education, research and advocacy.

These are broad statements that need a block-by-block building up to be reached. Basic towards this end is local data gathering that will be a wellspring of real-world practice from which quality of care can be gleaned via a vis established international clinical practice guidelines.

How would your Society contribute to the overall PHA goal/mission?

Parallel to the PHA vision of providing quality cardiovascular care to all in need of such, PHRS is working towards delivery of heart rhythm care that will redound to patient safety. This implies the performance of specialized procedures by those with adequate special training in cardiac rhythm management. Responding to the Philippine College of Cardiology/Specialty Board of Adult Cardiology’s thrust towards subspecialty accreditation, PHRS is working at guideline formulation in the subspecialty of cardiac electrophysiology especially as regards cardiac electronic implantable device implantation.

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Atrial Fibrillation: Updates and Controversies

By Michael-Joseph F. Agbayani, MD

In the late 1800s, Scottish cardiologist James Mackenzie used an instrument known as a polygraph to record tracings of the jugular and radial pulses of patients with irregular heart rhythms. By documenting the disappearance of the jugular “a” wave in one patient, he committed to paper what is probably the earliest recording of the common tachyarrhythmia now known as atrial fibrillation (AF). After Einthoven’s development of the electrocardiogram in 1903, it was the work of pioneering electrocardiographer Sir Thomas Lewis and Viennese physicians Carl Julius Rothberger and Heinrich Winterberg that formed the foundation of today’s clinical understanding of AF.

So much has happened since then. But despite the growing amount of information regarding AF and rising interest in newer pharmacologic agents and cutting edge technologies, AF-related disability – whether due to severely symptomatic AF, cardioembolic stroke, or heart failure – continues to be a major healthcare burden in Asia. Ten years ago the World Health Organization estimated that 1.8 million individuals in the South East Asian region suffered a first stroke and the number is expected to grow exponentially as the population ages. A significant portion of these ischemic strokes were likely due to AF and were thus preventable causes of disability. In the Philippines, the prevalence of atrial fibrillation in the general population was projected at 0.2%, with elderly males being at the highest risk.

**Stroke Prevention: Is Newer Better?**

Debilitating ischemic strokes are devastating complications of AF, bringing considerable deterioration in quality of life. Stroke prevention thus remains a cornerstone of AF management. While there is a lot of innovation in the field, especially in the last few years, the subject remains fraught with uncertainty.

The 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation now endorses the CHA2DS2-VASc scoring system to assess stroke risk in individuals with non-valvular AF. While Warfarin remains the anticoagulant of choice for valvular AF, novel oral anticoagulants dabigatran, rivaroxaban, and apixaban are now named Class 1B alternatives for non-valvular AF patients with CHA2DS2-VASc scores ≥ 2. This recommendation is based on randomized trials which showed that NOACs compared favorably with Warfarin in decreasing stroke risk: RE-LY (dabigatran), ROCKET-AF (rivaroxaban), and ARISTOTLE (apixaban).

Notwithstanding the development of more nuanced risk assessment tools, underutilization and mis-utilization of anticoagulants remain prevalent in both high and low-risk subgroups, respectively. An analysis of the GARFIELD registry showed that 40.7% of individuals with a CHA2DS2-VASc score ≥2 were not given any anticoagulant therapy and 38.7% of those at low risk (score 0) were subjected to inappropriate anticoagulant therapy. Factors for withholding anticoagulation were physician-related in about half of the high-risk population, underscoring the “real world” difficulties in assessing the risks and benefits of therapy.

The latest controversy in the realm of stroke prevention in AF involves the novel oral anticoagulant dabigatran. A series of articles published in the British Medical Journal (BMJ) have criticized both Boehringer Ingelheim and
regulators: the former for withholding essential information, the latter for allegedly capitulating to industry pressure to fast track drug approval. Concerns about the veracity of RELY data began when the FDA prompted investigators to reanalyze the data for adverse outcomes and they found 81 new events in 80 patients, including 69 bouts of major bleeding. Although the additional adverse events did not affect the trial’s over-all conclusion, the fact that such events were initially overlooked left many to question the integrity of the data, particularly the estimate of the bleeding risk. In fact, the FDA’s Mini-Sentinel database and a meta-analysis of the dabigatran studies show vastly conflicting figures regarding gastrointestinal bleeding. Furthermore, internal documents reviewed by the BMJ allegedly point to a lack of transparency regarding the potential safety benefit of adjusting dosage according to plasma drug levels, a strategy which could potentially reduce bleeding by 30–40%. Although all the NOACs have been marketed as not needing any sort of periodic blood test – a purported advantage over Warfarin – the debacle has led some to have reservations regarding these claims.

For high-risk patients with contraindications to anticoagulation one emerging alternative is left atrial appendage closure through occluders such as the Watchman device. Initial data from two trials are promising but doubts about the strategy’s efficacy and safety remain.

**No Rhythm Like Sinus Rhythm**

AF not only increases risk of stroke but also lowers quality of life and is associated with increased risk of mortality. However, studies investigating the effectiveness of a rhythm control strategy – the largest being the AFFIRM trial – have failed to demonstrate superiority of such an approach over a mere rate control regimen. Remember though that AFFIRM did not compare sinus rhythm with atrial fibrillation but a rhythm control strategy using anti-arrhythmic drugs versus rate control. Anti-arrhythmic drugs confer sinus rhythm 60% of the time at best and though the presence of sinus rhythm does increase survival, the benefit is offset by anti-arrhythmic drug side effects. If an effective method for maintaining sinus rhythm with fewer adverse effects were available, wrote the AFFIRM investigators, “it might improve survival.”

That method could be catheter ablation.

While some clinicians think of catheter ablation for atrial fibrillation as merely pulmonary vein isolation (PVI), the procedure has evolved beyond this. AF is a heterogeneous disease, and patients will have varying structural and electrophysiological substrates that trigger and/or maintain the tachyarrhythmia. In line with this, electrophysiologists have devised various new techniques to improve success, especially for persistent AF. These include the addition of linear ablations, as well as elimination or isolation of non-pulmonary vein triggers and ablation of areas with complex fractionated atrial electrograms, ganglionic plexi, or electrical rotors. Data from studies comparing ablation to anti-arrhythmic drugs as first-line therapy showed lesser atrial tachyarrhythmia burden in patients treated with catheter ablation. While there is a lack of data on stroke risk and mortality (which will hopefully be addressed by ongoing trials), patients who underwent ablation for AF were found to have sustained long-term improvements in quality of life. Catheter ablation for AF was pioneered in the Philippines last year by electrophysiologists in St. Luke’s Medical Center–Global City and acute success rates for the first few cases – which included patients with persistent AF – were very encouraging.

However, all the pharmacologic and technological breakthroughs can blind us to what may actually be crucial to the management of some cases of AF: diet and lifestyle modification. Weight loss and intensive cardiometabolic risk factor management has been shown to reduce AF symptom burden in overweight patients. Adding stringent physician-led risk factor management has also been associated with improved long-term arrhythmia free survival rates in patients who underwent AF ablation.

We have come a long way in the understanding of atrial fibrillation but we are still learning a lot and the way we approach it will likely change in the next few years. Pills and catheters may turn out not be the answers after all.

[Mic Agbayani is a cardiac electrophysiologist currently practicing in Philippine Heart Center, Manila Doctors Hospital and Medical Center Manila.]

**Figures**

Figure: Anatomical shell of the left atrium of a 50-year-old male with symptomatic paroxysmal atrial fibrillation generated by an electroanatomical mapping system (NavX). Electrical isolation of the pulmonary veins was achieved with circumferential ablation lesions (white dots). No recurrence of AF was found after 3 months. (From Gervacio GG. “Early Experience with 3D Mapping: Bridging the Gap During RF Ablation.” Presentation at the Philippine Heart Rhythm Society Inaugural Scientific Symposium on May 27, 2014. Mandaluyong, Metro Manila, Philippines.)

**Sources**

Catheter Ablation of Atrial Fibrillation

By Edmund O. Ang, MD

Atrial fibrillation is the most common form of arrhythmia. Many Filipinos experience atrial fibrillation every year. This common heart disorder occurs when electrical signals in the heart become irregular, causing the heart’s upper chamber to beat out of rhythm. Atrial fibrillation requires medical attention because it could lead to a life-threatening stroke.

Some people with the disorder can have palpitations, chest pain, fatigue, shortness of breath, dizziness or confusion. The condition is diagnosed through an electrocardiogram, which measures the heart's electrical impulses. Medications may be prescribed to prevent blood clots or control heart rate. However, in a significant proportion of people, drugs are either ineffective or lead to unacceptable side effects. In those cases, doctors could recommend catheter ablation for your atrial fibrillation.

Catheter ablation is an atrial fibrillation treatment that is done by a specialized cardiologist known as a cardiac electrophysiologist (EP), who deals with irregular heartbeats (arrhythmias).

It is a minimally-invasive procedure and is a commonly-used treatment for atrial fibrillation as well as other cardiac arrhythmias. Like other atrial fibrillation treatments, it is most successful in treating paroxysmal (episodic) atrial fibrillation, but much progress has been made in treating persistent (continuous) and longstanding persistent (continuous >1 year) atrial fibrillation as well.

It is done on a beating heart in a closed chest procedure. Small punctures are made in the groin and involve threading long, thin, flexible tubes called catheters into the heart. In some cases, a balloon catheter is used instead. Live X-ray images are used to carefully guide the catheter into the heart. The catheter’s tip are then threaded through a tiny incision in the wall (septum) between the left and right atrium (upper heart chambers) and positioned to ablate abnormal tissue causing erratic electrical signals that cause the irregular heartbeat. These are usually located around the pulmonary veins (blood vessels connected to the left atrium) and its surrounding tissues.

Using a cardiac mapping system (specialized computer), a 3-dimensional model is constructed on a computer screen to represent the heart chamber. Sections of the heart are then mapped to locate these abnormal tissues. Subsequently, energy is applied to destroy targeted tissue that has been identified as causing the irregular heartbeats. Two types of energy that can be

<table>
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<th>Atrial Fibrillation Ablation Candidates</th>
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<td>■ Symptomatic Paroxysmal or Persistent AF</td>
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<td>■ Second-line Therapy</td>
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<td>- Failure of Class IC of Class III agent</td>
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<td>- Intolerance to Medical Therapy, Refusal of Medical Therapy</td>
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<td>■ Other Considerations</td>
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<td>- Young patients with paroxysmal AF, in whom decades-long drug therapy is undesirable</td>
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<td>- Congestive Heart Failure due to tachycardia-induced cardiomyopathy, in whom drug choices are limited by presence of CHF</td>
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<tr>
<td>■ Limitations in Efficacy</td>
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<tr>
<td>- Longstanding Persistent AF (&gt;1 year)</td>
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<td>- Enlarged LA (&gt;55 mm)</td>
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<td>- Age &gt; 70 years</td>
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<td>■ Left atrial or Left atrial appendage thrombus - absolute contraindication to AF ablation</td>
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The first AF ablation in the Philippines was documented and published in EP Lab Digest. The article may be viewed through www.eplabdigest.com.

used in the procedure are radiofrequency to generate heat or liquid nitrogen to freeze the targeted areas of the heart and create a lesion of scar tissue. The resulting scar line then acts as a barrier between affected tissue and the rest of the healthy heart, stopping abnormal erratic electrical signals from travelling through the heart resulting in termination of the irregular heartbeats.

An atrial fibrillation ablation procedure can last anywhere from four to six hours and the patient is lightly sedated throughout the entire procedure. Following the procedure, pressure is applied to the site where the catheter was inserted and patients will have to lie still for four to six hours. Their heart rate is closely monitored during this time and patient stays overnight in the hospital. Most people resume normal activities in a few days.

Red dots represent the ablation lesions delivered to isolate the pulmonary veins.

The outcome of your ablation procedure may not be known for approximately 6 – 8 weeks. Episodes of AF may still occur within this period of time and would not necessarily indicate that the procedure was unsuccessful and is part of the evolving process for healing after the ablation. To guard against AF during this period of time, many individuals are prescribed an antiarrhythmic medication, which is later stopped.

A second way radiofrequency ablation can be used to treat AF is with the ablate-and-pace approach. With this procedure, the goal is to control the heart rate (but not to eliminate the AF) by ablating the normal electrical system of the heart called the AV node. The AV node is the only electrical bridge that connects the atria (top chamber) and the ventricles (bottom chamber). Ablation of the AV node electrically disconnects the atria and the ventricle. After ablation of the AV node, the heart rate becomes quite slow and a pacemaker must be inserted. In this manner, the ablation of the AV node prevents any excessive heart rates that may occur during AF; however, the bottom chamber of the heart becomes dependent on the pacemaker to generate the electrical impulses for the heart to beat. It is important to emphasize that this ablation procedure does not eliminate AF. This procedure is to manage the heart rates that are too rapid during episodes of AF, which is often the cause of symptoms.

For more information about atrial fibrillation and different treatment options, talk with your doctor.

Dr. Edmund Ang is the head of the Cardiac Arrhythmia Center at St. Luke's Medical Center in Global City. The SLMC Cardiac Arrhythmia Service successfully performed the first atrial fibrillation ablation in the Philippines in 2012.
Case scenario 1:
A 69-year-old male patient came to the ER with severe chest pain, his ECG disclosed Acute Inferior Myocardial Infarction. He suddenly went into cardiac arrest so cardiopulmonary resuscitation (CPR) was started but it was stopped because a relative says that he does not want resuscitation based on his advance directive.

Is the decision to stop CPR ethical? What is the difference between allowing to die and euthanasia? What are the requirements of an Advance directive?

Let us keep in mind that as health care givers we have to be conscious about two basic principles - e.g. Beneficence and non-maleficence. Our responsibility is always to do what is good for our patients and avoid evil.

In this clinical scenario CPR is a life-saving procedure with a success rate of 30 to 50% in primary cardiac arrest. This acute emergency condition is therefore potentially reversible with appropriate treatment and warrants aggressive intervention. Moreover, the patient is NOT terminally ill, thus to withhold an effective treatment in this condition would be an indirect or passive form of euthanasia.

On the other hand in patients with fatal pathology with no hope of recovery, CPR is NOT indicated and in fact, should not be offered because the procedure will not preserve life but rather just prolong the dying process (dysthanasia) which is also unethical. This should be part of the information that must be discussed with the patient and the family.

Do not attempt resuscitation - DNAR

In the year 2000, the American Heart Association declared that the more appropriate term to use is DNAr rather than Do not resuscitate (DNr). Why? Because “do not attempt resuscitation” more clearly indicates that success at resuscitation often is NOT ACHIEVED. DNr maybe misleading because it suggests that resuscitation would be successful if undertaken. Thus, DNAR is preferred.

Orthothanasia vs. Dysthanasia - What is the difference?

- **ORTHOTHANASIA** - refers to an act of withdrawing or withholding a useless intervention/treatment from a terminally-ill patient who has no hope to reverse the condition. Thus “allowing to die” in the natural course. Etymologically “ortho” & “thanatos” means right death or pleasant death.

- **DYSTHANASIA** - is a process with the intent of prolonging the dying process by all means available. Etymologically – “dys” & “thanatos” mean faulty, imperfect, abnormal or unnatural death.

Let us look at another case scenario --
A 50-year-old female patient with Breast Cancer Stage IV was admitted to the hospital in respiratory distress. The attending physician has not been able to discuss adequately with the patient and the family the severity of the illness. The family wants to do everything to sustain the life of the patient. The patient was eventually intubated and was actively resuscitated when she went to Cardiac arrest.

**What is an Advance Directive?**
It is any expression of a person’s thoughts, wishes or preferences for his/her end of life care and provides instructions or limitations of care, including resuscitation from cardiac arrest. It is based on conversation, written directives, living wills or durable power of attorney for health care, while the patient is still...
competent. Each person may identify in advance a representative to make health care decision/s as his surrogate in the event that he loses the capacity to make health care decisions. The principles to keep in mind in this situation is autonomy and justice.

Is it obligatory to carry out an advance directive?

In general we respect it if it is in conformity with moral law, please note that in Catholic Health Care Institutions and among Christians and Catholics, the decision must be faithful to Catholic moral principles and the patient’s intentions and values or the patient’s best interest.

It must be explained to the surrogate or proxy decision maker that CPR is for the best interest of the patient because the condition of the patient is still reversible. The decision not to resuscitate must be carefully applied to the current condition of the patient.

Advance Directives cannot be used to withhold life - sustaining treatment unless these conditions are met: 1.) A terminal condition is certified by two (2) physicians. 2.) In persistent vegetative state – it must be certified by two (2) physicians including one with special expertise in evaluating cognitive function. 3.) A surrogate has given authorization.

It is interesting to note that based on a U.S. study, fewer than 40% of 9000 seriously ill patients discussed their CPR preferences, whereas only 20% had prepared advance directives. Indeed, a number of patients have qualms that such instruction might be applied prematurely as in case 1 cited above. Some patients therefore, prefer not to give an advance directive but just make sure that the physician they choose will give them utmost care and will neither hasten death nor prolong their dying process.

Déjà vu

History repeats itself, from 2006 to 2012, the PHA Board of Directors, had three lady board of directors – Drs. Ma. Belen Carisma, Maria Teresa Abola and Eleanor Lopez who became PHA presidents. During the May 2014 elections, two well-respected heart specialists Drs. Nannette Rey and Aurelia Leus who have brought honour and verve to their respective turfs, made it to the PHA election derby. The two join Dr. Helen Ong-Garcia who is on her second term as PHA director.

Nannette R. Rey, MD

Her heart-healing and vocal prowess, as well as reputation as an effective and committed leader echo all over and beyond the medical circuit.

To date, she holds the distinction of being the first and only PHA chapter president for six consecutive years.

The past PHA southern Tagalog leader is the current head of the De La Salle University Medical Center Electrophysiology Department where she is also an assistant professor and an active member of its residents’ Training Committee; and chair of the Tagaytay Medical Center Department of Medicine.

Versatile and indefatigable, this singing doctor is an active member of the PHA Council on Electrophysiology, a principal investigator for several ongoing international clinical trials and has served as faculty during the PHA annual conventions and participated in the review of CAD Clinical Practice Guidelines Mission.

This conscientious clinician is also an assiduous academician and advocate of the PHA Mission. Since she became a PHA Fellow, she has munificently offered her voice because she says, singing has a soothing effect on her. Coming from a clan of musicians, she is also good at playing the guitar and banduria.

Aurelia G. Leus, MD

A gem of a doctor, this interventional pediatric cardiologist’s passion for all her multi-roles is well known.

Passionate and dynamic, she displayed her brand of leadership when she held the reins of the PHA Council of RF-RHD, Philippine Society of Cardiovascular Catheterization and Interventions; Philippine Society of Pediatric Cardiology; Makati Medical Center (MMC) Department of Pediatrics and as training officer of the Philippine Heart Center (PHC) Pediatric Cardiology and chief fellow in the same institution.

Currently, she is affiliated with the MMC and PHC.

Babes, as family and friends call her, credits her CPA-father Agapito Leus and doctor-mom Victorina Agapito Leus, for igniting her passion for medicine and the pediatric cardiology discipline.
In these fast-paced times, radio is the most conveniently accessible source of news. This medium generated quite notable media mileage for PHA.

From July to August 2014, the start of the PHA fiscal year, three radio stations -- DwIZ 882 kHZ, ABS-CBN/DZMM 630 kHZ and DzRH 666kHZ served as mouthpieces of the association’s Lay Advocacy programs. DzMM and DZRH are both tele-radyo stations while DwIZ programs can be viewed through live streaming.

On August 15, 2014, veteran broadcaster Angelo Palmones called the PHA to ask for its stand on the much-ballyhoed Ice Bucket Challenge that has been hogging the social network limelight.

PHA President Dr. Joel Abanilla set the ball rolling. On July 5, 2015, Saturday, 5:30 to 6:30 pm, he guested on DZRH’s “Docs on Call” which is hosted by Drs. Willie and Liza Ong.

“I want the public to know that a medical society like the PHA which has a solid Advocacy campaign exists. It has 15 chapters in the provinces and a growing number of cardiologists who deliver quality cardiovascular care. The PHA National office has Councils and Committees that attend to specific Advocacy projects,” was the opening salvo of Abanilla.

He stressed that the PHA is working double time on its Lay Advocacy Awareness Campaign projects: endorsement of the “52-100” code and healthy lifestyle practices; nationwide BP ng Teacher, Alaga Ko screenings and Basic Life Support and Advanced Cardiac Life Support trainings; it will make a stand on heart-health issues and lobby for the passage of a government order that automated electronic defibrillators (AEDs) are must-have devices in business establishments and public places.

In four minutes you have to resuscitate the heart because the brain deteriorates in eight minutes. Failure to do so, the person is brain dead. Using an AED after CPR increases the chance of survival.

Ultimately, the PHA is pining for an enviable very healthy-country status, where one finds international standard health reforms and an adequate number of AEDs in strategic areas; and at least two members who can do CPR in every Filipino home.

Abanilla added that in the US, it is mandated that defibrillators are installed in public places and trained personnel, doctors and paramedic nurses are readily available if you call 911.

The three doctors agreed that all of these undertakings and wish list are doable with the intensive efforts of multi sectors.

Asked on the PHA stand on chelation and fruit juices, the PHA president said: “the PHA does not endorse chelation and within our ranks, no one does chelation. There has been rapid rise in diabetes even among the young that is why we advise parents against giving their children soda and other adulterated drinks. In our Jumpstart your Heart with 52-100... the first zero stands for ‘take 0-sugared drinks.’

“Docs on Call” airs every Saturday, 5:30 to 630pm. DzRH is located at the CCP Complex in Pasay City.

Drs. Willie and Liza are also connected with the Department of Health as consultants and doctor-volunteers for ABS-CBN’s “Salamat, Dok” which airs on Channel 2 every Saturday and Sunday.
The one-year radio board work deal between the PHA and DwIZ Radyo Klinika took effect on June 30, 2014 and PHA will sign off on June 2015. The program is hosted by Avee Devierte.

Hereunder is the list of PHA officers and members with their respective topics, who guested on Radyo from June 30 to August 27, 2014: Drs. Irma Yape (hypertension), Helen Ong-Garcia (the 52-100 code), Jorge Sison (hypertension), Jonas del Rosario (52-100 and pediatric heart problems), Nannette Rey (electrophysiology), Cynthia de Lara (cardiac catheterization); and Raul Lapitan (arrhythmia).

The PHA-DwIZ tie-up was brokered by PHA VP External Affairs Ricky Alegre. DwIZ 882 is located at the Citystate Center, Oranbo, Pasig City.

Radyo Klinika is an on-the-air clinic type of public service program wherein the listeners can call in/text their health concerns. The program has a regular certified medical doctor/specialist who replies to all the questions.

Some of the questions that were either phoned-in or sent thru text, in English, Tag-lish and Filipino, to DzMM, DwIZ and DzRH:

- Can a blockage be diagnosed through ECG?
- What is diastolic dysfunction?
- Is cardiac arrest the same as cardiac relax?
- I had abdominal and chest pain at the same time. Was that a mild heart attack?
- What is rheumatic heart disease?
- Does emotional turmoil affect the heart?
- When does a heart patient merely need angioplasty and when does he need to undergo bypass?
- When a patient undergoes quadruple bypass, the surgeon skips five blocked arteries and will build another skyway, how do you describe the patient’s heart health state and how long he live?

Before taking on the Ice Bucket Challenge
Get your cardio’s clearance

Take on the viral Amyotrophic Lateral Sclerosis (ALS) Ice Bucket Challenge as long as you are not suffering from a pre-existing disease like hypertension or high blood pressure (BP), peripheral arterial disease (PAD) or ischemia, especially coronary artery disease, according to the PHA.

The challenge is a fundraiser that will sustain the ALS Association programs. ALS or Lou Gehrig’s Disease is a debilitating nerve disease with no known cure yet. Therefore people are urged to contribute to the ALS to fund research to find a cure.

But before even trying and passing on the challenge, make sure you and your nominee have been cleared by a heart doctor, PHA Secretary Dr. Jorge Sison warned the public via DZRH’s “Barangay RH” program, anchored by veteran broadcast executive and journalist Angelo Palmones. A tele-radyo, DZRH 555 kHz is the oldest radio station in the country.

He said that pouring ice water with a temperature of near
QUEZON CITY, July 22, 2014 – A big group of health professionals declared a national workforce crisis and exhorted President Benigno Aquino III and Congress to “take immediate, sustained, and dramatic steps to solve this urgent situation because it puts the lives of millions of Filipinos, especially the poor at risk.”

Dr. Esperanza Cabral, a former secretary of the Departments of Heath and Social Welfare and Development, director of the Philippine Heart Center and president of the Philippine Heart Association; former Health Secretary Jaime Galvez Tan, Party-list Representative Leah Paquiz, Philippine College of Physicians President Dr. Tony Leachon, PHA President Dr. Joel Abanilla and Director Dr. Helen Ong-Garcia and heads of medical societies and health groups assembled at the weekly Health Forum at Annabel’s on T. Morato, Quezon City. In attendance were at least 50 media people.

In her State of the Nation Health Address (SONHA) address, Cabral stressed that there are only 0.2 physicians, 0.4 nurses and 1.7 midwives or a total of 2.3 healthcare workers per 10,000 population. In public health facilities, there are only 3,000 out of 66,000 physicians; 5,000 out of 500,000 nurses; and 17,000 out of 74,000 midwives in the country.

The data on health professionals to population ratio are 10 times less than the 24 healthcare workers per 10,000 population recommended by the World Health Organization.

Aside from shortage of doctors, nurses and midwives, the lack of dentists, pharmacists, occupational therapists, physical therapists, speech pathologists, medical technologists, and other allied medical professionals, including partners in healthcare has also been noted.

Infectious and non-communicable diseases have been claiming thousands of Filipino lives; 47.6% of deaths among Filipinos are unattended by a medical doctor or an allied health provider.

There could never be a better time to dramatize the severity of the problem, Cabral added.

**NON-STOP MIGRATION**

Leachon said the so-called brain-drain problem still exists because healthcare workers still seek “greener pastures.” Overseas migration of nurses started when the US opened its doors to migrant doctors and the Vietnam War required nurses.

Another reason is urban migration, wherein students who study medicine remain in Metro Manila instead of going...
back to their hometown to establish their practice. Around 50% of our current workforce is in Manila.

Despite the shortage in the country, Philippine nurses continue to supply 25% of the needs abroad, based on 2010 figures. The Philippines is also the largest exporter of physicians next to India. “The exodus is fuelled about by low salaries relative to other countries, lack of benefits, poor work environment as well as perceived deterioration of the socio-political environment,” the groups said.

Leachon said that with the funds collected from the Sin Tax Law, the government can plan for a universal healthcare. “But in the implementing rules and regulations, for some reason, there is no provision on the workforce program,” he added.

PNOY GETS 80% RATING ON HEALTH

During the media forum, ABS –CBN’s Jing Castañeda ask the health gurus to rate Aquino as far as his administration’s health initiatives are concerned. Cabral, Galvez Tan and Leachon gave Aquino an 80% rating in terms of implementing health care programs.

On the other hand, the PCP gave him 100 each for courage and planning. Under Aquino, three relevant health laws were passed, including the Sin Tax Law. “We gave him 50 for results. Planning is one thing, but we also need the results,” Leachon said.

PRESIDENT’S PAGE... from Page 5

I cannot let this occasion pass without acknowledging Dr. Esperanza Cabral. Her achievements soar above all others. Her exceptional talent and intelligence catapulted her to some of the highest positions in the land, to bring about a huge difference in the lives of millions of Filipinos. She is a woman of steel; and as such, she does not understand the meaning of Fear, grabbing every opportunity to change things for the better.

The past Presidents I have had the privilege of working with: Drs. Belen Carisma, Tes Abola, Eleanor Lopez, Bel Ongtengco, Bong Javier, and Eugene Reyes.

You have paved the way so well. I hope to put to good use all the lessons learned from everyone of you. Last, but not least, I thank my family who may never have understood why I am spending my precious time with PHA, nevertheless, they never ceased to love and support me generously. I heartily appreciate them.

My Mom, the central figure in my family. Mama, you may have your own measures of success in life, but your simple and quiet nod of approval of what I have been doing is more than enough to inspire me to keep on moving forward. I love you, Mama.

My late father, Ricardo. I have always known what you wanted me to do. I will do it Dad, I will always try my best.

In conclusion, I’d like to acknowledge the incoming Board as we set sail once again, to another exciting phase of PHA. I am confident that with your brilliance, dedication and tenacity, the PHA can perpetuate a legacy of excellence, and perhaps discover and explore new grounds.

Our hands will be full the entire coming year. To all, I appeal for support, cooperation, participation and understanding. Thank you, and good night!

GET YOUR CARDIOS ... from Page 25

zero on your head can induce vasovagal response or sudden drop of heart rate that also triggers constriction of the arteries and transient BP rise; obstruction of blood flow which may lead to a heart attack; muscle cramps and sudden occlusion of blood flow in the lower extremities which may result in gangrene.

ALS affects the nerve cells in the brain and the spinal cord. It causes the progressive degeneration of the motor neurons, which control muscle movements. The cause of ALS is not yet completely known. But scientific researches have found that ALS may have some genetic links.

The rules of the ALS Ice Bucket Challenge are: those who have been mentioned or tagged by participants have two options: -- first, record a video of yourself dumping a bucket of ice-cold water onto your head. Second, donate $100 to an ALS charity of your choice.

The ALS challenge for a cause contagion that has gone viral on social media did result in massive support for ALS charities. According to the New York Times, the association has received $41.8 million in donations from July 29 to Aug. 21.

People who turned down the challenge have their own reasons. Among them are “despite its phenomenal popularity and support it has been getting thru social media, it is more about attention-grabbing than philanthropy; and even with its purest intentions of supporting a research program, its rapid popularity ‘cannibalized’ potential donations that other charities would have received.
The brawny five-year-old BP ng Teacher Ko, Alaga Ko has been on track. From June to August 2014, it conducted Risk Factor Screenings in four public schools in the cities of Tuguegarao, Paranaque, Ormoc and Mandaluyong. Close to 1,000 teachers and school personnel availed of the blood pressure taking, cholesterol and sugar test, ECG and check-ups.

Wet readings indicate the presence of a trend -- 33 percent educators are hypertensive.

The Manila-based PHA Council on Hypertension’s out-of-town “BP ng Teacher Ko” has been an instrument in kindling fellowship and activation among the members in Manila and in the Chapters.

On the Council’s calendar are eight more hops which should be done before year end 2014.

At the Mandaluyong Elementary School in Mandaluyong City on Aug. 22, 2014, 125 teachers availed of the risk Factor screenings.

The participating doctors were: PHA Council on Hypertension past chair Dr. Irma Marie Yape; Fellows from the Makati Medical Center (Drs. Michelle Maliwat and Shaula Cabreros) and St. Luke’s Medical Center (Drs. Eduardo Yamboa, Roberta Maria Cawed-Mende, Isniehayah Dumarpa, Glenn Gayos) and UST (Drs. Sherrywin Simon and Ritchie Go).

The 20 nurses and teachers were coordinated by Ma. Belen Unisa, the...
At the Tuguegarao North Central School in Tuguegarao City, making up the group were Dr. Yape, PHA Cagayan Valley Chapter President Dr. Enrico Amadeo Constantino and members: Drs. Valeriano Combate Jr. and Christy Babaran; internal medicine residents from the Cagayan Valley Medical Center Drs. Jose Carlo Valencia and Freedly Sapla and Dr. Ann Quizon from the Department of Education Manila; Dr. Ryan Pacquing from DepEd Tuguegarao who mobilized in 20 nurses and teachers; and LRI-Therapharma executives Joel Manasan, Ronnie Manliclic.

At the Ormoc City Central School in Ormoc City, Leyte, the team was composed of PHA Council of Hypertension chair Dr. Irma Yape; Ormoc-based cardiologists Drs. Rhodette Arevalo and Honey Dayandayan-Alcantara; nephrologist Dr. Mercedita Piamonte; pulmonologist Dr. Nino Jessielito Doydora; and Drs. Rodrigo Capahi, Maidy Ann Arguelles, and Judith Joliano. Also on hand were LRI Therapharma CME Manager Joel Manasan, CSM Manager Ronnie Manliclic, and DM Ryan.
Seamless CME programs are coming up

The Continuing Medical Education’s venturing into a series of Continuing Medical Education Core-Give programs (particularly the Clotting Institute, Hypertension Peak and the postgraduate courses) in the Chapters is a catalyst for change in gears and growth of PHA CME.

Dr. Raul Lapitan, then PHA treasurer and concurrent Continuing Medical Education chair, and Dr. Eugene Reyes, then PHA president, set the right tone for continuing medical education (CME) pursuits in the Chapters during the fiscal year July 2013 to June 2014. Lapitan made sure that the Northern Luzon, Central Luzon, Southern Tagalog Region, and Northwestern Mindanao conducted these CME activities. Stirred up by the impressive success of the Clotting Institute and Hypertension Peak, followed by the postgraduate courses in Central Luzon, Southern Tagalog Region, Northwestern Mindanao and Northern Luzon, several more CME activities that are aimed to empower the communities have been lined up by the Chapters for this year. Drs. Reyes and Lapitan graced these Chapter milestones.

This year, PHA Directors Drs. Helen Ong-Garcia and Nannette Rey are concurrent CME chair and co-chair respectively.

In keeping with the STR Chapter’s vision: To be the “Beacon of Cardiovascular Care in Southern Tagalog Region”, Chapter President Dr. Raymund Salvador announced that a follow-through of the Updates in Basic and Advanced Cardiac Life Support Training Workshop was held in July this year the New Sinai Hospital and Medical Center in Sta. Rosa, Laguna. There will be a Hypertension Peak Symposium in Laguna on Sept. 27, 2014. Plans for more lay education fora, medical missions, BLS/ACLS training program and tree-planting activities are in the works.

Western Visayas Iloilo Chapter President Dr. Felixberto Dianco told PHAN that the Clotting Institute and Hypertension Peak fora has been set for September, too. B. Halasan, MD & J. Adviento, MD
Chapters’ Track

Changing of the Guard

LUZON

Sub-Editor: Jerelyn Adviento, MD

Mabanag steers NL
CV Chapter to get seed money

SAN FERNANDO, LA UNION, August 2, 2014 -- In the midst of an inclement weather, the PHA North Luzon Chapter officers 2014-2016 induction ceremonies took place as scheduled at the Oasis Hotel in this city. PHA National President Dr. Joel Abanilla administered the oath.

“The challenge of leading during the transition period and stressing the importance of dynamic communication as a big factor in meeting the goals of the PHA” was the core of my inaugural address, and I would like to reiterate it now,” said Abanilla.

Prior, the Chapter had a general meeting which was attended by Abanilla. The highlight of the meeting was reaching an accord that the newly-formed Cagayan Valley chapter will receive seed money from the Chapter funds. Cagayan Valley is composed of the provinces of Nueva Vizcaya, Isabela and Cagayan.

The districts of Baguio, Pangasinan, La Union and Ilocos stand to get equal amount of subsidy for their start-up funds. Baguio district has signified its intention to be an autonomous chapter just like Cagayan.

Inducted were Drs. Stella Marie Mabanag, president; Max Geronimo Butardo, vice president; Nathaniel Cortez, secretary; and Leah Sanglay, treasurer.

The Cagayan Valley officers are: Drs. Enrico Constantino, president; Valeriano Combate, vice president; George Ramos, secretary; and Cristy Babaran, treasurer.

Also inducted as new members were: Drs. Desi James Ojascastro from Baguio, Leslie Asuncion, Dennis Fernandez and Ma Eloisa Lazaro-Salvador from Ilocos.

Past presidents of the chapter who were in attendance include Drs. Brenda Espinosa, Efren Jovellanos and immediate past, Annie Olarte.
HeartNews

Chapters’ Track

**Dianco: On my top agenda are CPR, Research, CME**

ILOILO CITY, Aug. 8, 2014 -- Beefing-up the Cardio-Pulmonary Resuscitation (CPR), research and continuing medical education (CME) programs are the major thrusts of the PHA Western Visayas (WV) - Iloilo Chapter under the presidency of Dr. Felibert Dianco. Dianco bared his plans during the 8th PHA WV-Iloilo Chapter Induction of Officers and Fellowship Night 2014 administered by PHA President Dr. Joel Abanilla at the Plazoleta Gay, Hotel del Rio in this city.

Dianco said “with great power comes great responsibility” as he challenged his fellow officers to roll up their sleeves to hit their targets within the set timelines.

“With great power comes great responsibility” as he challenged his fellow officers to roll up their sleeves to hit their targets within the set timelines.

“TWe had to take a lull in our Basic Life Support and Advanced Cardiac Life Support (BLS/ACLS) trainings because of the high costs incurred in bringing in the rented mannequins and a CPR trainor from Manila to Iloilo,” he added.

The Iloilo Chapter has been getting inquiries from interested enrollees so it has to grab the opportunity. Dianco added: “But realistically, we lack the logistics specially manpower and committed members. Our goal is to be self-sustaining. CPR has to get a fresh shot in the arm stat. If there’s a will, there’s a way.”

He told PHAN that revenues generated from the BLS/ACLS programs will be used in the procurement of their own mannequins, megacode paraphernalia and a defibrillator on a staggered basis.

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**Fermin is at the helm of Cebu**

CEBU CITY, JUNE 20, 2014 – The induction of the PHA Cebu Chapter 2014-2015 officers was an occasion to officially install the new set of executives, bestow citation on the Chapter’s outstanding members and to celebrate in style.

Garbed in costumes that instantly reminded us of characters of blockbuster Hollywood movies – The Phantom of the Opera, The Legend of Zorro and Pirates of the Caribbean, PHA President Dr. Joel Abanilla administered the oath of the following: Drs. Carolyn Fermin, president; Brett Batocoyt, vice-president: Francisco Chio Jr., secretary; Leah Villamor, treasurer; Board Members: Drs. Delia Caracut and Edwin Tiempo and immediate past president: Dr. Wilfredo Ypil.

The Lifetime Achievement Award was given to Dr. Rudy Amatong for his exemplary commitments and contributions to the chapter. Ypil, the immediate past president also gave citations to its members for their invaluable support during his term.

Fermin introduced and inducted the new members. The evening was further enlivened by a surprise ballroom dance number by the members and a modern dance by our Astra Zeneca friends.

**Cecile Cabias- Jaca, MD**
SLHI marks 28th year

From SLHI to Dr. HB Calleja Heart & Vascular Institute

The St. Luke’s Heart Institute (SLHI) was renamed Dr. H.B. Calleja Heart and Vascular Institute on Aug 13, 2014 at the Edsa Shangri-La, Mandaluyong City.

It is a gesture of the administration of St. Luke’s Medical Center (SLMC) to honor the man who helped change its course from a humble general hospital to a world class facility.

The occasion coincided with a benefit dinner-show dubbed “HeartBridge”, a collaborative effort of St. Luke’s Medical Center Foundation, Heart Institute Foundation and Alumni Association, spearheaded by Dr. Romeo Saavedra, chair of the Heart Institute.

The highlight of the night was the unveiling of the icon marking the momentous transition of SLHI to Dr. H.B. Calleja Heart and Vascular Institute.

The audio-visual presentation tribute with messages from Calleja’s doctor-son Henry, and past directors of the Heart Institute he built -- Drs. Saavedra, William Chua, Antonio Sibulo, and Danilo Kuizon.

Calleja narrated his life’s journey to an indulging crowd in his appreciation talk.

Chua, the man who crafted the symbolic work of art for the institute, himself a student and follower of Calleja, stood up for a well-deserved recognition.

The special occasion gathered the SLMC top brass and movers, heads of different hospitals, past and present leaders in the medical field, including PMA President Dr. Maria Minerva Calimag and PHA President Dr. Joel Abarilla, pharmaceutical industry partners, and several alumni of the then SLHI who came all the way from the different provinces.

The evening was capped by Jose Mari Chan and Dr. Helga Sta. Maria who regaled the crowd with their music and wit.

Dr. Edgardo Cortez, president and CEO of SLMC said Calleja is the man behind the Heart Institute in his message. Malou Bunyi, MD ♥

IV Ongtengco: HB Calleja Awardee

Dr. Isabelo Ongtengco is this year’s recipient of the HB Calleja Award, a citation given to a person of notable character and significant contribution to the growth of the Heart Institute.

He received his award during the St. Luke’s Medical Center Heart Institute’s (SLHI) 28th year celebration Aug. 14 to 15, 2014 at the Edsa Shangri-La Hotel in Mandaluyong.

The succeeding day showcased the outstanding scholarly works of the Cardiology Fellows through the HB Calleja Young Researcher’s Award as trainees are encouraged to be investigative, inquisitive, analytical and methodical in their studies. Chief Fellow Dr. Douglas Bailon won the coveted top plum. Lay Forum and Free Clinic Services were also conducted for patients.

One of the highlights of the week was the Annual Cardiovascular Symposium in the same venue. Dr. Marilou De Jesus, scientific committee head, presented a well-drafted course themed “Innovative Cardiovascular Medicine at the Forefront of Evolving Clinical Practice Guidelines”.

The 28th year celebration ended with the HB golf cup held in Batangas.

Over-all chair Dr. Freman Cerezo and Socials Committee Chair Dr. Manolito Turalba led the Fellowship Night by ushering the institute family to a yacht party while cruising Manila Bay. Malou Bunyi, MD ♥
Despite high water…

All roads lead to Transformers 4

Despite the heavy traffic and flood brought about by the heavy downpour, supporters and sponsors of the University of the Philippines-Philippine General Hospital Pusong Pinoy Foundation still made their way to SM Mall of Asia to watch the foundation’s movie block screening of the Transformers 4: Age of Extinction last June 26, 2014.

With the help of the consultant staff and fellows of the UP-PGH Section of Cardiology, this year’s screening of Transformers 4 proved to be another success.

Since its inception in 1999, the foundation has been organizing projects such as movie screening, golf tournament, and ECG course others to assist the growing number of indigent patients at UP-PGH. Over the years, the foundation has helped hundreds of patients in need of life-saving cardiovascular interventions and urgent diagnostic procedures.

Last year’s block screening of the The Wolverine has benefited more than 60 patients who had to undergo procedures like permanent pacemaker and ICD, coronary angiography, PCI, and cardiac MRI.

For inquiries and donations, please contact the Pusong Pinoy Foundation, Inc. at telephone # 554-8400 local 3670.

Drs. Sharon Pascua and Paul Reganit ♥

Heart Failure data in women and A-Watch Participation. Mabuhay Ka Pinay should be a catchy multi-media campaign that will gather 50,000 industry leaders as advocates. A separate website on the Women’s Council will be launched in March 2015. The sponsors are non-pharma companies. There will be print and radio ads and a fundraiser dinner gala.

CV Anesthesia and Critical Care

For better CABG patient care

To improve on post-cardiovascular surgery patient care, a survey of hospitals where CABG is performed will be conducted. In January 2015, survey forms will be completed, medical centers doing open heart/CABG surgery will be identified. These hospitals will get the survey, follow up return of the survey and analyze the data form.

Council on CV Imaging

Heartshots to hype CT, MR

The 2-3 CVI Council CME Activities (Heartshots) will continue to promote education on the 3 imaging modalities: nuclear CT and MR, where all cardiology and interested consultants gather. One to two hospitals will be identified to host Heartshots early next year.

The planning and preparation of protocol will take place during Council meetings next year.

The participation of all GPs and IMs of a hospital or chapter where treatment modalities are available is a good gauge.

Council on Cardiovascular Surgery

A CABG Registry

Keen on establishing a national CABG Registry, the Council is venturing into a complete CABG database/patient existing registry. Its measure of success is 100 percent compliance rate of database completion.

It is also initiating a database in other cardiac surgery capable centers, particularly in three government hospitals. These projects should be a work in progress from January to September 2014.

Cardiac Rehabilitation is crucial

Cardiac rehabilitation in ACS patients is vital. Data will be extracted from the PHA ACS Registry to be able to determine whether cardiac rehab is being recommended and complied with. The realistic measure is 50-percent accomplishment of pulling out of ACS data in the past three years, in coordination with the Council on CAD. It is expected that 100 data extraction is done by December 2015.

To be continued ♥
Latosa is PSPC president; New officers inducted

The Philippine Society of Pediatric Cardiology’s (PSPC) 11th set of officers since its inauguration in 1992, was inducted on July 14, 2014 at Mario’s on T. Morato Ave., Quezon City.

Dr. Milagros Bautista, president of the Philippine Pediatric Society, Inc. (PPS) led the PSPC Induction of Board of Directors for July 2014 - June 2016: Drs. Eden Latosa (president), Ma. Corazon Estevanez (vice-president), Ma. Bernadette Azcueta (secretary), and Ma. Ina Dela Paz-Bunyi (treasurer); board of directors- Drs. Ninfa Villanueva and Juliet Balderas, and Dr. Magdalena Lagamayo, immediate past president.

In her inspirational talk, Bautista emphasized the need for commitment, collaboration, competence and cohesiveness among the members of the organizations in order to ensure success in all their endeavours.

PHA President Dr. Joel Abanilla, one of the special guests, acknowledged the invaluable role played by pediatric cardiologists and encouraged the use of one’s gifts/specialties for both the PHA and PSPC.

After the Ceremonial Transfer of Office between the past and incoming presidents, Latosa pointed out the need to re-examine what we have done and where we lack; to use our Mission/Vision as a guide in knowing where we are and what still needs to be accomplished. She also introduced the newly-created Committees and their respective chairs.

The antics and impromptu songs of the society’s favorite emcee Dr. Joni Bote-Nunez and the resounding tenor voice of one of the special guests, Abanilla, had everyone in stitches.

The respective hymns of PHA, PPS, and PSPC of Pediatric Cardiology Hymn, which were penned by cardiologists, were played and sung.

Virgie Mappala, MD

May 2014 saw another transition - the transfer of the presidency from Dr. Eugene Reyes to Dr. Joel Abanilla, both good people with noble intentions and an adequate preparation for the PHA presidency. I don't think a leader with a good capture of what the presidency entails really needs 7 years in the board to prepare.

Being ready for the presidency requires, first and foremost, a clear appreciation of the vision of the PHA, a roadmap how to achieve it from where the association is at the time that he joined the PHA board and as starts his term, a strategy to move forward with the best team he can gather, and a communication plan designed specifically for the various stakeholders of the association. He has to be a leader of men even from outside the boundaries of the PHA, because the effectiveness of the association rests as well on its ability to share common goals with entities that operate from the outside. He knows how to motivate them to support and carry on his plan, driven with fervor that his plan is good – down to the details of its appropriate execution, well-calibrated to minimize ambiguities and uncertainties, and leaving no doubt that it serves a bigger purpose other than his own.

A member of the board who gets used to the ways of the PHA over the years can, when his turn as president comes, simply follow a generic template set in place by tradition (mainly the SOPs adopted by the previous presidents), and just keep everything steady for 12 months, without having to take risks that may only disturb the association’s equilibrium. Twelve months will pass quickly after which he can quietly join the roster of past presidents, contented with simply having been around during the duration of his term, unmindful of the opportunities for leadership missed. He can, of course, opt to pursue at least one cause and be remembered for that one project. A one-issue presidency is perhaps a reasonable goal to work for, given that one year is probably too short to aim for something of wider scope. I don't think the PHA really demands too much from a president; it is the aggressive and determined leader who imposes demands on himself, conscious that there are so many things to address and so little time to attend to all of them.

The presidency is about how the leader moves the association forward to close in on its vision. Admittedly, the vision of the PHA gets muddled through the years as science and technology change by leaps and bounds, and the demands on, and expectations from, the association acquire ambivalence. Here lie the challenges to the PHA as an institution, as misalignments transpire between the traditional mindsets of its members and leaders, on the one hand, and the need for the steadfast pursuit of the institution’s mandates, on the other hand. No doubt, each leader imbues his presidency with the flavor of his personality and the passion that drives his sense of purpose. That is how presidents are commonly remembered – by the way they connect to the members and the outcomes of such connection.

But there’s a rub: the president can lose his center, or slacken his pace, and the directions that the association takes under his watch may be derailed or deviated by a lack of focus or by imbalances in his character. Which is why the board is there to ensure that that doesn’t happen. Which is why PHA members, just like every Filipino citizen, need to be more discerning when they elect their allies to positions of leadership. Woe to the association if every member of the board readily accedes to the president’s wishes in the name of teamwork but to the detriment of the association’s, keeps to himself – ‘until his turn as president comes’ – his novel ideas that can otherwise benefit the association, and looks at his years in the board mainly as a ‘silent’ preparation for his presidency on the 7th year.

The PHA has gone way past its golden anniversary with very significant achievements. Many of the younger members may no longer know the past presidents who served the association through its infancy and adolescence. Most of these past presidents we remember fondly, not necessarily for what they had done as presidents but for who they were and what they stood for. The association has had its wins and losses, hits and misses, but on the whole, it has survived and grown way beyond the personal idiosyncrasies of its leaders. Many of the past presidents are long gone, but the PHA as an institution looms large in the future of cardiology in the country.

During her presidency, Dr. Belen Carisma, an independent single woman of no ordinary means, took on the issue of women’s cardiovascular health as the centerpiece of her term. It was a relevant cause that resonated well during that period; it brought attention to the gender disparities in cardiovascular medicine. That was a good year for womanhood! Dr. Saturnino Javier, a well-respected and passionate writer with a strong sense of right and wrong, imbued his presidency with the same conviction and dignity that defined his writing style, and got the PHA engaged in a wider range of public issues. Dr. Eugene Reyes, the immediate past president, has always been known for his passion with entities that operate from the outside. He knows how to motivate them to support and carry on his plan, driven with fervor that his plan is good – down to the details of its appropriate execution, well-calibrated to minimize ambiguities and uncertainties, and leaving no doubt that it serves a bigger purpose other than his own.

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A Supreme Court-decided case would be a good way to explain some of the legal principles that hopefully would spare us from too much anxiety about a possible litigation, or outcome of a present litigation, or better still, stay away from one.

This is a decided case on April 11, 2002 (G.R. No. 124354), but the unfortunate event happened sometime in 1985. A woman was admitted in a private hospital for elective cholecystectomy. She was scheduled 9:00 am the following day. She was seen by the anesthesiologist, who was chosen for her by the surgeon, one hour before the surgery. The surgeon arrived more than three hours later as he scheduled a proctoscopy 30 minutes before the questioned procedure in another hospital.

During the procedure, a nurse sister-in-law of the patient (a dean of a school of nursing) was allowed to go inside the operating room. During the induction of anesthesia, the anesthesiologist was heard saying “mahirap ata ito i-intubate, mali ata ang napasok” as she attempted another intubation while the patient was noted to be cyanotic and with abdominal distention. Another anesthesiologist was called but the patient developed cardiopulmonary arrest, was successfully resuscitated but became comatose. She stayed at the ICU for 1 month, discharged after 4 months and died after 14 years without ever regaining consciousness.

The family sued the anesthesiologist for medical negligence, the surgeon for solidary liability being the captain of the ship and the hospital also for solidary liability under the principle of employer-employee relationship. The Supreme Court convicted the anesthesiologist for medical negligence and the surgeon under the principle of captain of the ship but acquitted the hospital because there is no employer-employee relationship between the doctors and the hospital.

In other countries, where negligence is committed by a physician, he is liable under the medical malpractice law. In the Philippines, however, since there is no such law, if a physician is found guilty of negligence, he may be held civilly liable for payment of damage based on torts or Article 2176 of the Civil Code or criminally liable for reckless imprudence based on Article 365 of the Revised Penal Code, and not necessarily based on medical malpractice per se. Article 2176 of the Civil Code states that “whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Article 365 of the Revised penal code speaks of imprudence. Reckless imprudence consists in voluntary, but without malice, doing or falling to do an act from which material damage results by reason of inexcusable lack of precaution on the part of the person performing or failing to perform such act, taking into consideration his employment or occupation, degree of intelligence, physical condition and other circumstances regarding persons, time and place. Simple imprudence consists in the lack of precaution displayed in those cases in which the damage impending to be caused is not immediate nor the danger clearly manifest.

To recover in a cause of action for medical negligence (medical malpractice), the patient or his family must prove all of these requirements: that there is the existence of a duty owed by the doctor to the patient to conform to a recognized standard of professional care; that there is breach of that duty; that there is an injury that is causally related to the breach of that duty; and a legally recognizable damage.
Ischemic heart disease

1. Masakit ang dibdib ko. Wala na'ng ibang sanhi: inatake na ako sa puso!

CHEST PAIN is the most commonly recognized symptom of heart disease and in the patient with known risk profile for coronary artery disease (CAD), it should be a primary differential. But there are other causes of chest pain other than the heart and an evaluation of risk profile should be done. Risk factors include family history for premature CAD, advanced age, male gender, diabetes, overweight, hypertension, smoking and cholesterol disorders. The more risk factors present, the greater the chance of CAD. In other words, chest pain in a 50-year-old obese executive who smokes and is taking medication for diabetes and hypertension is more likely to be CAD than chest pain in a 19-year-old man whose girlfriend has found someone new.

2. Dehins ka mag-atake sa puso, pare. Fit and healthy ka at tumakbo ka sa annual marathon ‘di ba?

YOU PROBABLY have not read the reports of marathon runners who end up in the Cardio Unit. Thinking that a good figure and an active lifestyle exempts you from a heart attack is the same as thinking that an elevated cholesterol means you are going to die. The heart attack comes in the wake of a high global risk, i.e. the totality of the risk factors. So a sexy “marathoner” with a father who had a heart attack at 50, who smokes and works in a high stress job by day is more likely to have the heart attack than a vegetarian couch potato whose parents each lived to be a hundred.

3. Sumasakit ang dibdib ko kanina pero sandali lang. hindi na kailangan i-consulta sa doctor.

THAT DEPENDS. Refer to items #1 and #2. If your profile shows significant risk, get to your doctor without delay.

4. Parating kumikirot ang aking puso, lalo na pag idi-in ang dibdib. Pero sabi ng dokor hindi ‘to sakit sa puso. Maki-hanap nga ng iba’ng doktor....

TYPICAL REACTION. Your physician has probably already reviewed your risk profile and must have done a few tests before giving such a reassurance. Consider also that the heart is not a superficial structure and therefore pains that originate from it can not be induced by pressure on the chest. A full discussion including a run-down of the patient’s risk profile can do much towards establishing physician-patient rapport.

5. Noong 21 years old ako, ang ECG ko may “ischemia”; ngayong 50 na ako, ang echocardiogram at stress test ko ay normal! at sabi ni Doc wala akong ischemia. Milagro ba ‘to?

PLEASE. Ischemia refers to the imbalance between perfusion and tissue demand. The majority of cardiac ischemia is attributed to obstruction in the coronary arteries resulting in compromise of the heart function. An untreated ischemic disease of the heart that lasts 29 years is unlikely and an ischemic heart disease in a 21 year old is likely to be a misdiagnosis. ECG patterns for ischemia can be misleading and if the risk profile disagrees with CAD, a more specific test like a stress test should be done.

6. Pagkatapos ng “bypass” ko, sinabihan ako ni Doc na “your arteries are as good as new”. Yehay! Balik sigarilyo na ako!

THIS IS SUCH A TYPICAL male Filipino response. While a bypass does re-establish the arterial conduits to the heart muscle, the new vessels are exposed to the same environment and stressors as the old arteries were and having been handled during surgery, they undergo some degree of deterioration. Some estimates go as high as a 50% attrition rate of vein grafts in the first year after a bypass. Resuming high risk behaviour like smoking is like lighting the fuse on a stick of dynamite.

To be continued ♥
Heartlines & Updates

By Don Robespierre C. Reyes, MD

**Tolvaptan: Wringing out the Best for Heart Failure Patients?**

Heart failure remains to be a leading global menace in cardiovascular health care. Blame it perhaps on the aging population and all risk factors associated with an increased lifespan, but it cannot be denied that the last few decades have not given us a drug or therapy that has been successful in curbing down the rates of events related with heart failure. Save perhaps some evidence-based heart failure therapies and regimens that have brought down the risk of arrhythmias and sudden cardiac deaths, and improved mortality and morbidity benefits in ambulatory chronic heart failure patients, there is relatively little elbow room in the management of acute heart failure syndromes.

I am not just very sure if we should remain happy with the fact that while patients in acute decompensated heart failure experience rapid symptom relief with present and acceptable regimens for this, the harsh reality stings that re-admission and mortality rates due to heart failure still soar high at 30% and 15%, respectively within a 60-90 day post-discharge period. The challenge prevails on how we can address this missing link that will bridge our management to better outcomes. Present management for heart failure includes diuretics to unload patients of volume. Though effective in addressing congestion, the benefits do not come off without some price to pay. Electrolyte imbalances

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**All about Tolvaptan: a product monograph**

**Tolvaptan** comes by the brand name Samsca (Otsuka). It is a vasopressin V2 antagonist and is regarded as the first oral “aquaretic” drug.

**Indication**

Currently, tolvaptan is indicated for the treatment of clinically significant hypervolemic and euvoletic hyponatremia. Hyponatremia is defined as serum sodium <125mEq/L or less marked symptomatic hyponatremia that is resistant to correction with fluid restriction. Patient population that may benefit from this include those in heart failure and those with Syndrome of Inappropriate Antidiuretic Hormone (SIADH).

In volume overloaded heart failure patients, tolvaptan may be added when standard diuretics do not result in adequate diuresis. However, this “aquaretic” agent should be given to patients in combination with the usual diuretics like furosemide, thiazides and aldosterone antagonists

**Contraindication**

From its product monograph, the following are contraindications to the use of tolvaptan: urgent need to raise sodium acutely, inability of patient to sense or appropriately respond to thirst, hypovolemic hyponatremia, concomitant use of strong CYP 3A inhibitors, anuric patients, hypersensitivity to any ingredient of the drug or to benzodiazepine derivatives and patients with hypernatremia.

**Dosage and Administration**

Tolvaptan is available as 15mg tablets. For hyponatremia, patients are required to be admitted to the hospital for initiation and re-initiation of therapy to evaluate responses. Rapid sodium increases and its consequent manifestations must be monitored, prevented and corrected accordingly.

Starting dose is usually 15mg given orally once daily regardless of food intake. After at least 24 hours, the dose is increased to 30mg to a maximum of 60mg a day, as needed depending on the desired serum sodium. Therefore, frequent electrolyte and volume monitoring is required. There is no need to restrict fluid while on tolvaptan and patients are advised to liberally drink fluids in response to thirst.

As an adjunct to other diuretics in the management of volume overload in heart failure patients, the usual starting recommended dose is 15mg daily. However, it seems prudent to start with 7.5mg daily in patients...
oftentimes tip the balance toward harm, a situation that may push back aggressive management.

Thus, the introduction of tolvaptan, a vasopressin V2 receptor antagonist, that practically wrings pure water out of a wet congested cardiovascular system leaving important electrolytes undisturbed, is an exciting addition to our tool box in fixing failing hearts. Hyponatremia (either in the presence of euvoolemia or hypovolemia), its primary indication for use, can be addressed with more confidence without perturbing other electrolytes, blood pressure, heart rate and some hemodynamic parameters.

By theory and evidence, tolvaptan improves symptoms of heart failure, dyspnea in particular. It can induce diuresis of one liter or even more in an instant with just a single dose of 15 mg. This is the reason why patients are not fluid-restricted to avoid volume depletion. Significant weight loss in the initial days of therapy definitely follows.

However, most studies on tolvaptan have not demonstrated long-term benefits, particularly on mortality and morbidity. Administration of this drug entails admission to the hospital with frequent monitoring of serum sodium in a day to watch out for rapid shooting up of such electrolyte and its nasty neurologic sequelae (although this is not quite common in trials on tolvaptan).

The fact that more limitations to whom we can give the drug to (awake, able to sense thirst and able to drink among other criteria) may prove too selective for a smaller set of heart failure patients. (In fact, heart failure is not its primary indication for use. We still await results from studies investigating volume overloaded heart failure patients with specified serum sodium levels.) Moreover, the cost and availability of tolvaptan in the country may also prove to be discriminatory. Launched in Japan in 2010, this is relatively a new drug and the cost is expectedly high. Needless to say, confidence in the drug is still at level one at best for most of practicing physicians in our local setting.

Nevertheless, tolvaptan is a very attractive agent that we can take advantage of for the benefit of our heart failure patients. While benefits of its use may be limited in the acute setting for now, we expect more data on long-term benefits to be churned out in the coming years. And these may further strengthen our confidence in the drug.
We have culled and summarized data from clinical trials on Tolvaptan.

**Active-CHF (Acute and Chronic Therapeutic Impact of a vasopressin Antagonist in Congestive Heart Failure)**

**Effects of Tolvaptan in Patients with Heart Failure**

**Title:** Effects of Tolvaptan, a Vasopressin Antagonist, in Patients Hospitalized with Worsening Heart Failure

**Objective:** This evaluated the short- and intermediate effects of tolvaptan in patients hospitalized with heart failure.

**Methods:** Multicenter RCT, double blind, placebo controlled, parallel group; n=319 with LVEF <40%, persistent HF despite standard therapy.

**Intervention:** Tolvaptan 30, 60 or 90 mg/day for 60 days.

**Results:** Significant decrease in body weight favoring Tolvaptan for all doses with no changes in heart rate and blood pressure, no hypokalemia or worsening renal function. Post-hoc analysis showed lower 60-day mortality in the tolvaptan group with renal dysfunction and severe systemic congestion.

**Salt 1 and 2 (Study of Ascending Levels of Tolvaptan in Hyponatremia 1 and 2)**

**Title:** Tolvaptan, a Selective Oral Vasopressin V2-Receptor Antagonist, for Hyponatremia

**Objective:** This evaluated whether or not tolvaptan might be of benefit in hyponatremia

**Methods:** Multicenter RCT, double blind, placebo controlled; n=448, euvolemic or hypervolemic hyponatremia

**Intervention:** Tolvaptan 15mg daily titrated to 30mg and 60mg daily as necessary for 30 days.

**Results:** Significant increase in serum sodium levels in the tolvaptan group noted on the first four days noted up to 30 days, but hyponatremia recurred a week after discontinuation of drug. Side effects included thirst, dry mouth and increased urination.

**Everest Outcome Trial (Efficacy of Vasopressin Antagonism in Heart Failure Outcome Study with Tolvaptan)**

**Title:** Effects of Oral Tolvaptan in Patients Hospitalized for Worsening Heart Failure

**Objective:** This investigated the effects of tolvaptan initiated in hospitalized patients with heart failure.

**Methods:** Multicenter event-driven RCT, double blind, placebo-controlled; n=4133, age = 65 years, LVEF <30%, NYHA III-IV, 10-month follow up

**Intervention:** Tolvaptan 30mg daily on top of standard therapy for at least 60 days

**Results:** Tolvaptan did not have any significant effect on long-term mortality or heart failure-related morbidity. Tolvaptan significantly improved hyponatremia, patient-assessed dyspnea, day 1 body weight and day 7 edema. Side effects included increased thirst and dry mouth.

**Eclipse (Effect of Tolvaptan on Hemodynamic Parameters in Subjects with Heart Failure)**

**Title:** Acute Hemodynamic Effects of Tolvaptan in Patients with Symptomatic Heart Failure and Systolic Dysfunction

**Objective:** This investigated the acute hemodynamic effect of Tolvaptan

**Methods:** Multicenter RCT, double blind, placebo controlled; n=181 with decompensated heart failure on standard therapy.

**Intervention:** Tolvaptan 15mg, 30mg or 60mg as a single dose

**Results:** Tolvaptan, across all doses, modestly and significantly reduced pulmonary capillary wedge pressure, right atrial pressure and pulmonary artery pressure. Tolvaptan increased urine output by 3 hours in a dose dependent manner without changes in renal function.

**Victor (Vasopressin V2 Receptor Blockade with Tolvaptan versus Fluid Restriction in the Treatment of Hyponatremia)**

**Title:** A Study of Tolvaptan Monotherapy compared to Furosemide and the Combination of Tolvaptan and Furosemide in Patients with Heart Failure and Systolic Dysfunction

**Objective:** This assessed the efficacy and safety of tolvaptan, with or without furosemide, versus placebo or furosemide alone in patients with heart failure.

**Methods:** Multicenter RCT, double blind, placebo-controlled; n=83, age=57-60 years, LVEF <40%, NYHA II-III

**Intervention:** Tolvaptan 30mg and Furosemide 80mg, both either as a single therapy or in combination for seven days.
**Results:** There was significant reduction in weight at end of study for mono therapy with tolvaptan and furosemide and combination of both compared to placebo. Increases in urine output were similar for both tolvaptan alone and tolvaptan+furosemide. When used singly, urine output was more with tolvaptan compared to furosemide. Serum sodium increased within normal range wit tolvaptan use compared to both furosemide and placebo. No changes in serum potassium, blood pressure among others were noted with tolvaptan.

**Quest** (Qualification of Efficacy and Safety in the Study of Tolvaptan in Cardic Edema)

**Title:** Efficacy and Safety of Tolvaptan in Heart Failure Patients with Volume Overload Despite Standard Treatment with Conventional Diuretics

**Objective:** This evaluated the safety and efficacy of Tolvaptan in volume overloaded heart failure patients

**Methods:** Phase III, multicenter, RCT, double blind, placebo controlled; n=110, age = 71 years, LVEF = 48-50%

**Intervention:** Tolvaptan 15mg daily for 7 consecutive days.

**Results:** Tolvaptan significantly reduced body weight and improved symptoms associated with volume overload. Adverse events were not different between the two groups. Serum sodium slightly but significantly increased in the tolvaptan group while serum potassium insignificantly changed. Hypernatremia was similar in both groups.

**Post-marketing Surveillance**

**Title:** Efficacy and Safety of Tolvaptan in Heart Failure Patients with Volume Overload - An Interim Result go Post-Marketing Surveillance in Japan

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For safety, it is prudent to test for hepatic transaminases and bilirubin before starting, during and even after therapy with tolvaptan either for short term (<30days) or long-term use (>30days).

Others. Tolvaptan was associated with gastrointestinal bleeding (10%) in patients with liver cirrhosis.

Drug Interactions. Since tolvaptan is a substrate of CYP 3A, care must be observed in administering the drug concomitantly with CYP 3A inhibitors (ie: ketoconazole, erythromycin, fuconazole, diltiazem, verapamil) and inducers (ie: rifampin, carbamazepine). Grapefruit juice may increase exposure to tolvaptan by 1.8 times. Patients receiving P-gp inhibitors (ie: cyclosporine) may need a reduction in the dose of tolvaptan.

There seems to be no clinically significant interaction of tolvaptan with furosemide, hydrochlorothiazide, digoxin and lovastatin.

**Clinical Pharmacology**

**Mechanism of Action**

Tolvaptan is a highly selective vasopressin V2-receptor antagonist with a more pronounced affinity for the V2-receptor compared to the native arginine vasopressin. When taken orally, tolvaptan 15-60mg antagonize the effect of vasopressin leading to an increase in urine water excretion without significantly changing urine sodium and potassium excretion and serum potassium levels. This so called pure water excretion or “aquaresis” results in decreased urine osmolality and increased serum sodium concentrations.

**Pharmacodynamics/Pharmakokinetics**

The pharmacological activity lags behind the plasma concentration of tolvaptan. It takes two to four hours after taking a 60mg of tolvaptan before the onset of aquaresis and increase in sodium may be noted in a healthy subject. After four to eight hours of ingestion, a peak effect of about 9 mL/min increase in urine output and about 6 mEq increase in serum sodium can be expected.

At 24 hours after a dose, about 60% of the peak effect on serum sodium is still sustained. A single daily dosing is thus appropriate. For aquaresis and increasing serum sodium, recommended doses range from 15-60mg, beyond which no further increases in urine output and sodium is expected.

The area under the curve increases proportionally with dose. However, after doses >60mg, Cmax increases less than proportionally with dose. At least 40% of the dose is absorbed as tolvaptan or metabolites. It is highly protein bound (99%) and food does not interfere with its bioavailability. Tolvaptan is entirely eliminated by non-renal routes and mainly metabolized by CYP 3A.

Moderate or severe hepatic impairment or congestive heart failure decrease the clearance and increase the volume of distribution of tolvaptan, though these are clinically insignificant. Renal handling in patients with creatinine clearance between 79 and 10 ml/min are not different.

**References:**

1. Product Monograph issued by Otsuka
affinity to clinical research and EBM; his tenure brought that to a broader light. Now, it is Dr. Joel Abanilla's turn. We have known him for several years and in a very positive light. Even if he has expressed his plan to also make research the central focus of his term (research should be at the core of an organization like PHA regardless of who the president is), his musicality and love for the arts make us hope that his term will animate cold science with the warmth of culture as the PHA programs are implemented in the coming months.

After him is vice-president Dr. Alex Junia, a breath of change from the perspective of national —and cultural—geography. When his turn comes, he will hopefully infuse the presidency with the nuances of a Cebuano and southern perspective, different and separate from what the long line of past presidents from Metro-Manila have gotten us used to.

Any PHA member may dream of becoming president, but not everyone can be president. The presidency is not about spending 12 months doing standard tasks pre-designed for the position; nor is it about basking in the flavor of one’s personal choices. Personal style and inclinations may nuance the term of a president, but the PHA is an institution that each president should build upon, not with the flavor of his one-year term, but with blocks of innovation, culture, adaptability, and sustainability that the association needs in order to compete for the future.

Indeed, the presidency —as well as being in the board for 7 years— is about building an institution, pursuing its vision, motivating and mobilizing its stakeholders, and making an impact where it matters. It is not akin to erecting a memorial every year, only to be demolished and replaced the following year. The president’s personality may influence his style of leadership, but it has the ability to connect to a bigger audience that is paramount in times when changes have to be made, risks have to be taken, and a cause has to be fought. When he goes through the passage with eyes wide open, the presidency changes him (usually for the better).

As he tries to fill in the shoes of the presidency, he looks at the size of his own feet and discovers that the dimensions of leadership are measured differently. He finds out, sooner than later, that wearing what doesn’t fit well would not be good for him in the next 12 months. To be agile and effective, he has to wear what matches his size! Unless he takes a good look at himself and accepts what he sees, he would not know where to start. For sure, he cannot be what he is not; but he can strive to be the best version of what he really is! Depending on how he fits in, the flavor of his presidency —“when his turn comes”— would define our memory of him, both as president and as a leader. Either the flavor sours, or it becomes enriched with the sweetness of self-discovery and the spices of self-mastery. Regardless of how he finds himself, he has the PHA to thank for. The PHA, too, will thank him for the spices that he will add to the brew that has been 61 years in the making—and counting.
Pre-excited or premature?

By being at the wrong place at the right time, premature ventricular complexes (PVC’s) can masquerade as pre-excited beats. It is possible for such PVC’s to occur in bigeminy with fixed coupling intervals in late diastole shortly after the P waves before the appearance of the expected QRS complexes. This fortuitous EKG presentation can simulate intermittent pre-excitation with 2:1 exit block. Determining whether such wide QRS complexes are truly premature or are pre-excited beats instead has clinical significance.

The foregoing 12-lead EKG with lead II rhythm strips was recorded from a 54-year-old male admitted for unstable angina. Two different types of isorhythmic QRS complexes are easily noticeable, one with normal and the other one with RBBB configuration. The narrow QRS complexes are the beats during normal sinus rhythm. The wide QRS complexes, on the other hand, have tall monophasic r waves with notchings on their downstrokes in lead V1 and small r with deep and wide s waves in lead V6. The atypical RBBB pattern is a characteristic feature of ectopic but not of aberrant ventricular beats. By occurring in bigeminy at the terminal portions of the dissociated P waves, the ectopic beats create illusions of shortened PR intervals and delta waves, thereby mimicking pre-excitation with 2:1 exit block. The RBBB morphology, in conjunction with the anterior, inferior, and rightward orientation of their QRS axes, points to an ectopic origin near the superior portion of the left posterior fascicle. Lateral wall subendocardial ischemia suggested by the repolarization changes in leads I, AVL, V5, and V6 could have generated the electrical heterogeneity responsible for the late diastolic PVC’s in bigeminy observed in this case.

Although certain premature beats appear late, they are still early beats.
Moderately modern and fairly rustic. Visibly Hispanic and ultimately, very Pinoy. Genteel and genial Ilonggos. A gourmet and gourmand's haven. A vacation and convention destination. Iloilo has never ceased to captivate me. These are my impressions of this Western Visayas city.

It was a breezy trip from the Iloilo International Airport to Punta Villa Resort in Arevalo town.

Made up of a cluster of edifices that are bathed in immaculate white paint and snuggled on verdant greens, Punta beckons.

The lobby/reception area doubles as a repository of an assembly of heirloom pieces and collectibles neatly piled in curio cabinets.

The foyer's granite staircase railings are embellished with exquisite glass figures. When the Swarovski crystal chandelier is lit-up, the stairway shimmers and voila, you feel like you are being ushered to the world of fairies.

Our gracious host Dr. Joel Abanilla, said: “occupancy is almost 100 percent. Sorry, you’re having a dorm-type of room.”

We don’t mind at all. We are not here to hibernate in our rooms, we said in unison. I was with the 20-member UP Concert Chorus, led by its choir master and conductor Prof. Janet “Jai” Sabas-Aracama.

After going past the al fresco dining area in the heart of the well-manicured garden, we were motioned to proceed to Café Crispino.

Dining at Café Crispino is a virtual feast for the senses.

The portrait-gallery set-up is Mrs. Leonor Avanceña-Melocoton Abanilla's tribute to her prominent forebears and other famous Ilonggos (Sens. Miriam Defensor-Santiago, Franklin Drilon, Jose Marie Chan, et al.) (Related story on page 48)
The medley of Ilonggo fare dished up by the Abanillas is so luscious—the steaming pansit molo, chicken inasal, chilli crabs, atchuete-flavored fried boneless bangus and very-sweet mangoes.

Punta is a resort that caters to the burgeoning convention, conference and leisure markets.

We got there at a time two regional meetings-cum-exhibit of the Departments of Trade and Industry and Labor and Employment were being conducted.

Punta has 320 guest rooms but 120 rooms are being leased to the C&C Korean Language School.

Meanwhile, there’s a construction boom in the city in preparation for the Asian-Pacific Economic Conference 2015 which Iloilo is hosting.

As a repositioning strategy, Punta has invested in the construction of 155-guestrooms and this development will make Punta the largest convention venue with 500 guestrooms and 10 function rooms. The most magnificent are the Crown and Crystal Ballrooms festooned with intricate trimmings typical of a European banquet hall.

On day 2, we had the pictorial of Dr. Joel (for the PHAN July-Aug. 2014 cover story) in the Avanceña ancestral house (now called the Camiña Balay nga Bato) and the Abanilla family house both on Osmeña Road.

The very eloquent Mrs. Luth Camiña, wife of Gerald Melocoton Camiña, (the latter is Dr. Joel’s first cousin) who gave us the fascinating history of the house and of the Avanceñas.

One of the oldest and most preserved houses in Villa Arevalo, the Balay nga Bato was built in 1865 for Fernando Avanceña. A time-capsule, the house is stuffed with all the stately furniture of the Avanceñas and is the residence of Gerald and his family who had spent a hefty sum for its restoration.

I like the oversized door with a unique Japanese-inspired lock, high ceiling, wide windows, enormous altar, period pieces of furniture and a bust of Chief Justice Ramon Avanceña, one of the center pieces in the huge sala.

On the ground floor you’ll find Lola Rufina’s Heritage Curio Shop (old santos, saints carved in red sandstones, hablon and sinamay, paintings, antique wares, and of course tsokolateras are for sale); the Balay nga Bato offices and the family’s weaving paraphernalia. Lola Rufina is the maternal grandmother of cousins Dr. Joel and Gerald.

The tour is punctuated with the snacks and the most perfect chocolate drink I’ve tasted.

Luth said, “we use excellent quality cacao, but the batirol that was crafted from the guava branch enhances its flavour. Aside from being a sturdy wood, guava contains certain enzymes and when mixed with the tsokolate, produces a heavenly chocolate brew, a great dip for the crispy biscuits from Panaderia de Iloilo and a perfect partner for bland native cakes.”

We also had a quick tour of the colonial-era churches:

The iconic Miag-ao Church which is on the Unesco World Heritage list; Molo Church and Tigbauan Church which are National Historical Landmarks by the National Historical Institute (NHI), Guimbal Church and San Joaquin Church which are also on the NHI National Cultural Treasure directory.

Iloilo pleases every type of tourist. There’s a place for the lavish, mid-range and pragmatic spender. Adventurous by nature, on my last day, I decided to stay at the Zatazza Pension House on Del Carmen St., Jaro Iloilo.

It was my jump-off point to La Paz Market where one can have everything under one roof – breakfast which consisted of a hot bowl of batchoy and coffee; and shopping for home treats (jumbo mangoes and mangosteen, butterscotch bars, pinasugbo, banana chips, ube piaya, barquillos, mamon)
Dr. Joel Avanceña Melocoton Abanilla was born to nobility, belonging to the fourth generation of the legendary Avanceña lineage in Iloilo.

Coming from a clan that is profoundly immersed in history, tradition and culture, Dr. Joel, and his 10 younger siblings grew up believing that you have to live up to the Avanceña way.

His entrepreneur parents Ricardo Abanilla and Leonor Avanceña Melecoton inculcated in the minds and hearts of their children the wisdom of making excellence a way of life. They have to harness their inclinations and shine in all pursuits.

Just like his forebears and mother, Dr. Joel expertly blends his skills as a clinician, researcher and lecturer with his talent as a singer and business adviser in the family-owned enterprises.

From their ancestors and succeeding generations came exemplars of integrity and distinction.

Fernando Avanceña, a tektite weaving mogul, was his great grandfather. Fernando and his wife Eulalia Abaja were the owners of one of the oldest Balay nga Bato in Panay which is bolstered by 24 house posts or baligi that were proudly displayed as status symbol during the 1860s. The architect was Fernando’s brother Fr. Anselmo Avanceña.

Dr. Joel’s famous great granduncle Ramon Avanceña, was the country’s fourth Chief Justice of the Supreme Court. Ramon’s sons Jose, Alberto and Jesus became prominent lawyers.

Another great granduncle who was a brilliant lawyer, Amando Avanceña was an assemblyman of the first district of Iloilo. His great granddaunts Jovita and Ramona Avanceña rose to prominence being educators par excellence who eventually established the Colegio de Sta. Ana, the first exclusive schools for girls in the city.

In the vast sala of the Abanilla home which Dr. Joel refers as our “new” house
One of Fernando’s daughters, Rufina Avanceña married Crispino Melocoton, a college scholar who graduated summa cum laude, served as a first pre-war councilor and Arevalo three-term mayor.

A product of the Colegio de Sta. Ana, Rufina, stimulated all her children, to stand out in their fields of endeavour.

Leonor, the fifth of her seven children grew up in the Avanceña Balay nga Bato. Now, even with a new name -- the Camiña Balay nga Bato (which is still known as the Avanceña ancestral house) majestically sits on bustling Osmena St. The present owners have transformed the lower level into the Lola Rufina Heritage Curio shop. Lola Rufina inherited the house from her parents Fernando and Eulalia.

Dr. Joel says “my mom is a music major graduate and was a piano teacher for 12 years. When she decided to change her career path, eyeing the viable handicrafts and woodcraft importation venture, the first thing she did was take commerce/accounting at the University of San Agustin.”

Eventually, wanting to capitalize on her flair for baking and business management, Leonor with her husband, put up the Panaderia de Iloilo and Punta Villa Resort, a very popular convention and vacation facility.

It is at Punta Villa where Leonor, Dr. Joel and the rest of the family members perfectly fuse their musical and architectural prowess, knack for cooking and business acumen.

All the Abanillas are professionals. Five are Iloilo-based and are involved in the family business. Five live in the United States and Canada, one of them, Dr. Fernando Abanilla, is a noted nephrologist who practices in Florida.

Dr. Joel, the eldest, is a well-revered IM-cardiologist-echocardiographer at the Philippine Heart Center. A devoted son, he flies to Iloilo twice a month to check on his mother who turned 85 on August 9. On August 25, the Most Outstanding Ilonggo Award was bestowed on Leonor Avanceña Melocoton Abanilla during Iloilo City’s Charter Day celebration.

Mother and son take pride in the fact that the Abanilla family share equal passion and entrepreneurial spirit to put the family business in the heart of the Iloilo people.

Like a true Avanceña, who is self-effacing by nature, they lead tranquil and low-profile lives despite their remarkable track record in their respective milieus.

Ever proud of his roots, big brother Joel makes sure that every family member keeps the Avanceña legacy alive. ♥
One of the goals of PHA National is: To introduce the latest CPR techniques to the trainors and to every Filipino home. The Chapters should bring CPR to every health professional and every home in their respective areas. So far, of the 12 PHA Chapters, only Davao, Cebu, Southern Tagalog Region and Central Luzon are self-sustaining when it comes to CPR activities.

The PHA Western Visayas Chapter Committees on Research and CME are under the leadership of Drs. Anastacio and Dianco. They were formed to streamline the operations and to generate more research output. “The Core Give, Clotting Institute and Hypertension Peak activities will be conducted in September or October,” Dianco told PHAN.

Community Outreach Programs and medical missions are also in the pipeline. Dianco said, “it is a sort of BP Ko, Alaga Ko screening. The purpose of the registry is to have patients’ representatives outside Manila. It’s not specifically for teachers and it will include coronary artery disease, hypertension and heart failure.”

Also in attendance were Drs. Matias Apistar, Louie Tirador, Roberto Estepar, Yul Balleza, Patricio Palmes, Lucita Jalbuena and Joel Acosta.

The evening was capped off by dance renditions by residents and interns from Iloilo Mission Hospital and West Visayas State University Medical Center, and song numbers by Dr. Jg Parojinog and the 20-member University of the Philippines Concert Chorus led by Prof. Janet Aracama.

Montesclaros is NW Mindanao proxy

MANDALUYONG CITY, MAY 29, 2014 -- The Northwestern Mindanao Chapter of the Philippine Heart Association elected its new set of officers during the Closing Ceremonies of the 45th PHA Annual Convention and Scientific Meeting at the Edsa Shangri-La Hotel. Inducted by PHA National President Dr. Joel Abanilla, they are: Drs. Richard Myles Montesclaros of Dipolog City, President, Kenneth Oporto of Cagayan de Oro City, Vice-President, Marie Malinis of Oroquieta City, Secretary and Kathleen...
Eight precious years with PHAN

From 2006 to 2014, Dr. Erlyn Piedad Cabanag Demerre served eight Presidents – Drs. Cesar Recto III, Efren Vicaldo, Ma. Belen Carisma, Maria Teresa Abola, Eleanor Lopez, Isabelo Ongtengco, Saturnino Javier and Eugene Reyes, who were extremely pleased with PHAN.

Tucking PHAN to bed for eight years, coming out with 96 PHAN issues is a feat that is hard to beat. Spanking new look. Enhanced pages. Every issue was infused with novelty and is a reflection of every President’s individuality.

The PHA Board led by Dr. Joel Abanilla, tendered an Appreciation Dinner for the dynamic and innovative Demerre, the longest-serving PHAN editor, on August 15, 2014 at the Crowne Plaza Hotel, ADB Road, Quezon City.

In attendance were PHA officers -- Drs. Joel Abanilla, president; Raul Lapitan, secretary and Helen Ong-Garcia; past PHA presidents and PHAN editors in chief Drs. Carisma and Javier; the current and past PHAN Editorial/reportorial team: Dr. Francis Marcellus Ramirez, who is Demerre’s successor; Drs. Don Reyes (the emcee); Marilou Bunyi, Ma. Ina Bunyi, Bernadette Halasan, Jerelyn Adviento and Crismelita Banex; Gyna Gagelonia and Joey dela Cruz; PHA staff -- Gina Inciong, Gene Banawa and Irene Alejo.

For Drs. Abanilla, Carisma and Javier, “Demerre’s performance was extraordinary. More than the gift of writing is her devotion to the job and capability in churning out anything the last minute.”

Demerre rubbed her infectious vigour and enterprising skills on the writers who got used to receiving a litany of assignments from their EIC thru text messages as early as 5a.m.

Even her hubby, Engr. Justice Demerre was PHAN’s “contributing cartoonist and IT guy.” The kids, Gabbie, Kyle and Kurt learned to adapt to the work ethics of their supernom. The final editing stages of PHAN were done in the Demerre residence.

Demerre said: “PHAN has evolved. It is the collective effort of all the staff and a result of the national progression of an evolving dynamic PHA through the years.”

She added “thank you very much for the kind words but I gained more than what I gave because I have forged new ties. I have gained more friends. I brushed shoulders on both sides of the fence. I am the bridge. PHAN is the melting pot of what you want for PHA.”

Dr. Erlyn P. Cabanag Demerre plays all her multi-roles to the hilt. She is a dedicated mom, wife and daughter, a passionate and compassionate heart doctor and founder/chairman of the EPCALM Adult Leukemia Foundation of the Philippines. ❤
Eating 5 servings of fruits and vegetables per day

Limiting to just two hours of TV or computer per day

Having one hour of exercise per day

Zero to sugared beverages

Zero to smoking

simply means: