WORLD HEART DAY 2014

September is SUDDEN CARDIAC ARREST Awareness Month
The PHA CPR Council has been very dynamic and untiring for the past many years in promoting awareness on SCA and in providing training seminars and workshops on Basic Life Support and Advanced Cardiac Life Support not just for healthcare providers but for the lay as well. It has even tied up with certain government and non-government organizations in pushing its vision to materialize.

But the PHA is humble enough to admit that being a non-government entity and a professional society, its initiatives and efforts to propel its advocacy on CPR to a national scale are limited and not adequate. The PHA cannot do this alone. It needs the government, other organizations and agencies and even media to speed its efforts to fruition.

National awareness of SCA and the good chances of reviving a victim is a very important first step in realizing the PHA's dream. But for the national government though Congress to take notice and interest and eventually draft laws on AEDs and pertinent matters may be next to impossible. More so that our lawmakers are presently preoccupied with self-preservation in politics, not to mention the forthcoming 2016 elections.

But the PHA CPR Council will not tire in beating the drum until the sound is heard and will be acted upon appropriately.

In the meantime that lobbying at Congress seems to be a long shot, the CPR Council is now at the drawing boards drafting plans to partner with some local government units.
Training the Trainors' bid:
CPR savvy should be a beyond-frontiers thing. Even nurses in far-flung areas should be able to recognize arrhythmia.

10 World Heart Day 2014
PHA minds St. John Bosco residents and parishioners. Multi-disciplinary docs dance with Health czar and ABS-CBN Big Losers survivors.

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Editor’s Note

Significant ‘ber months

The start of September of every year reminds us how closer we are to the Christmas season. Indeed, there are 91 days separating September and December, and interestingly, September begins on the same day of the week as December every year. And before you know it, we will already be preparing for the coming new year.

In this September–October issue, the *PHA NewsBriefs* highlights three events: World Heart Day 2014, Sudden Cardiac Arrest (SCA) Awareness Month, and the 7th National Basic and Advanced Cardiac Life Support (BLS and ACLS) Training the Trainors course. How providential it is that these three events are interrelated.

Every year, the association actively joins hands with the World Heart Federation, taking a proactive role in the campaign against heart diseases, promoting a healthy lifestyle (HL) and undertaking activities to increase public awareness on early detection and control of risk factors. Taking off from our last issue’s focus on Atrial Fibrillation Awareness, this edition puts the spotlight on September as Sudden Cardiac Arrest Awareness Month. SCA remains a major public health concern, despite advances in medicine and interventions. When someone has a cardiac arrest, his or her survival depends greatly on immediately getting cardiopulmonary resuscitation (CPR) from a bystander. Public awareness about SCA, the value of early CPR and the use of the automatic external defibrillator (AED) is vital. The PHA, as always, continues in its campaign of promoting HL, educating the lay and the healthcare providers about CPR, and increasing the community’s knowledge about SCA, through these three events.

The activities of the Councils and the Chapters with their corresponding newly appointed chairs and chapter presidents, and the happenings in the different training institutions, are documented in this issue. An article describing the first year anniversary of the great Bohol earthquake, from the perspective of a PHA cardiologist is featured. The Legal and Bioethics sections focus on different issues important to the medical and cardiovascular profession. A landmark trial and a new drug are discussed in the scientific section. As expected, the Lay Forum and Dysrhythmic Tales sections provide entertaining, educational and exciting reads. Finally, the inevitable Mexico principle is tackled by one of our very own opinionated columnists.

To all our readers and to all PHA members, have a good read! On behalf of the PHAN team, let me be the first to greet you an advanced Merry Christmas! ♥

Mighty

About the Cover

PHA goes out of the box by veering away from the tradition of taking a Metro Manila city or town as partner for World Heart Day (WHD). This time, it is an alliance with the St. John Bosco Parish Church in Makati City, with its “residents, adopted children and teens” as priority patients.

On its 7th year, Training the Trainors 2014 relentlessly harps on the value of cardiopulmonary resuscitation and automated external defibrillator to save lives. The swelling list of attendees fuels the PHA Council on CPR’s passion to evolve.

Bottom photo shows the labyrinth of the esoteric CV system. September is Sudden Cardiac Arrest Month. September 28, 2014 is WHD 2014. ♥
Equating visibility with all-out support, public prominence and increasing the PHA’s ante, a dynamic Dr. Joel M. Abanilla (JMA) started off and continues his term with a long line up of engagements.

Aside from the usual Chapter rounds, Council events and major traditional activities were major exploratory meetings with the PHA Councils, Sub-specialty societies and pharmaceutical industry partners as well as potential Advocacy allies. The Inauguration of the Dr. Mariano M. Alimurung Center at the Makati Medical Center was the last but a must leg of his September calendar. Dr. Alimurung was the founding president of PHA (related story on page 27).

### On the fast lane

**QUEZON CITY, Aug. 26, 2014** -- The PHA Board led by JMA meets up with heads of sub-specialty societies (Philippine Society of Echocardiography, Philippine Society of Cardiac Catheterization and Intervention, Philippine Society of Pediatric Cardiology, Philippine Association of Clinical Electrocardiography, Philippine Heart Rhythm Society, Heart Failure Society of the Philippines, Philippine Society of Critical Care Medicine, Cardiac Rehab Society of the Philippines, Philippine Society of Cardiotoracic Anesthesiologists, Philippine Society of Hypertension, Philippine Lipid Society and Foundation for Lay Education on Heart Diseases, Inc.) and the PHA Council chairs to mull over the merits of data sharing and identify possible drawbacks. The Council chairs presented their projects. JMA also announced that the Chapters expressed interest in participating in Research endeavors.

**EDSA SHANGRI-LA HOTEL, Mandaluyong City, August 27, 2014** -- JMA joins colleagues from the St. Luke’s Heart Institute in witnessing the unveiling of the H.B. Calleja Heart and Vascular Institute icon, marking its transition from SLHI.

**MANDALUYONG CITY, Oct. 3, 2014** -- Luminaries from the cardiology, showbiz and pharmaceutical worlds (l-r): Dr. Danilo Chiong, Watsons director of training health, Drs. Dante Morales and JMA, Edu Manzano, Lorna Tolentino and Dr. Tony Leachon at the launch of the Watsons Go Generics promo. JMA bails Watsons’ giving free BP check to its clients. He says “this gives our PHA Lay Advocacy Awareness Campaign a major push. We advise the public to know their blood pressure for early intervention and proper management. High BP is one of the risk factors of cardiovascular diseases.”
This year, our goal is to widely spread the PHA CPR Council’s training not only to the expanded councils but also to more lay personnel and EMTs.

Council chair Dr. Francis Lavapie made the statement before the 106 participants of the 7th National Basic Life Support and Advanced Cardiac Life Support Training the Trainors’, October 3-5, 2014 at the Legend Villas, Mandaluyong City.

Also on hand were members of the PHA Board.

The Council’s thrust is to elevate the level of awareness and training among lay members to decrease the time from the onset of cardiac arrest to the onset of CPR, which frequently occurs more often outside the hospital setting, either at home or in public places. Hence, survival outcomes among cardiac arrest patients will tend to improve.

The CPR Council is the most active and multi-awarded among the 17 PHA councils. Another pioneering venture of the council this year is hosting its first ever Trainors’ Course in Cebu City to accommodate and train more doctors outside of Metro Manila.

Aside from the new Trainors’ training, a one-day refresher was conducted among the 30 previous trainors to review them of theory and the techniques on how to conduct a training.

The training still followed the 2010 CPR guidelines which emphasized on the following salient points: CAB (Compressions, Airway, Breathing) instead of ABC, no more “Look, Listen, and Feel” so as not to take so much time initiating the CPR, pushing harder (at least two inches deep of chest compressions)

By Bernadette Santiago-Halasan, MD
and faster (at least 100/min, deemphasizing pulse checks to not more than 10 secs and checking for normal breathing together with unresponsiveness and the practice of hands only CPR for the untrained lay rescuer. This shall be the PHA’s current standard of practice until new guidelines and possible changes will be out next year.

The three-day activity ended with much learning and enthusiasm from the new trainors. Lavapie closed the activity with this take-home message to the new trainors: “The meaning of life is to find your gift, but the purpose
of life is to give it away”. He urged the new trainors to share all their talents and skills in the aim of improving life and better survival outcomes in the future.

The activity would not have been a success without our sponsor LRI-Therapharma. ♥

**PHA COUNCIL ON CPR**

**SPEAKERS AND FACILITATORS:**

Francis Lavapie, MD
Orlando Bugarin, MD
Marcellus Francis Ramirez, MD
Raul Ramboyong, MD
Alex Junia, MD
Don Robespierre Reyes, MD
Jose Paolo Prado, MD
Elmer Llanes, MD
Connie Sison, MD
Albert Hans Bautista, MD
Eduardo Tin-Hay, MD
Jannice Lorrie Cruz, MD
Jude Erric Cinco, MD
Bernadette Halasan, MD
Ma. Luz Soria, MD
Aileen Cynthia DL Llarena, MD
Gina Alemany, MD
Crismelita Banes, MD
Jerelyn Adviento, MD
At least 120 countries around the world all together celebrated World Heart Day (WHD) 2014 on Sept. 28, 2014, the last Sunday of September.

In the Philippines, cardiovascular doctors, collectively known as the Philippine Heart Association (PHA) in Manila and in 11 PHA chapters, assembled to hype the global movement “To create heart-healthy environments”, the WHD theme this year.

As early as 7a.m., parishioners from nearby barangays and young residents of St. John Bosco Church, Makati City dashed to the registration area of the WHD Fair and Medical Mission in the church's premises.

At least 600 adults and children (2 to 19 years old) availed of the screenings for cardiovascular risks (blood pressure taking, sugar and cholesterol tests, body mass index, ECG and lung Xray, etc.) of adults and children.

Health Asec. Enrique Tayag urged the public to adopt a healthy lifestyle, adding adults and children alike should be empowered to be heart-health
advocates. He also advised Filipinos “to go easy on salty, sugary and fatty foods. Dancing is a good form of exercise,” before leading the group dance exercise.

The other simultaneous activities were lectures on healthy lifestyle for adults and children, basic life support (BLS) or cardio pulmonary resuscitation workshop for the lay, and the group fitness program led by celebrity coach Jim and Tony Saret who were with the Biggest Loser Team.

PHA President Dr. Joel Abanilla said “Jumpstart your day with the 52-100 code.

Dr. Raul Lapitan, PHA Secretary and concurrent WHD 2014 chair, said “encourage your employer to provide help to colleagues who want to quit smoking; raise a howl when you see smoking zones located near playgrounds, schools or close to entrances; bike or walk to school/work if you can; take the stairs and go for a walk during your lunch break you can do it for 4 minutes; push for healthy food in your office’s and children’s school cafeteria.”

He added “the key to a healthy heart and community is healthy living. Everything boils down to prevention. Start your day right. Jumpstart your heart with 52-100 daily – as in 5 servings of fruits and/or vegetables, 2 hours maximum screen time for children, 1 hour of physical activity, 0 soda or sugary drinks and 0 smoking and second-hand smoke” to avoid the onset of CVDs (heart disease and stroke).

PHA President Dr. Joel Abanilla said “Make sure your home is a healthy haven, same with your neighbourhood, before going out to promote the creation and cultivation of a heart-friendly environ.”

Heart disease and stroke are the world’s leading cause of death, claiming 17.3 million lives each year and the numbers are on the rise.
World Health Organization Philippine Representative Dr. Julie Hall said: “We are here not to celebrate these premature deaths, but to mark fun things and release endorphin, the happy hormone and to urge everyone to practice a healthy living.”

Eighty percent of premature deaths from CVDs could be avoided if the main risk factors -- unhealthy diet, physical inactivity and smoking are controlled, according to heart experts.

In most cases, the individual who eats and drinks too much, smokes and doesn’t exercise, gets all the blame for having CVD. Actually, the environment (where we live, work, hang around or play) may be beneficial or detrimental to our health. Urbanized environments and our fast-paced life have changed our lifestyle, eating patterns and preferences, the PHA said.

Many individuals are “trapped” in their habit-forming routine and different settings -- lack of access to green spaces (cramped condo-living has been the norm among small families and young professionals); going for affordable but unhealthy school/office meals and fast foods (that are oil-, salt- and extender-laden); addiction to cigarette; and exposure to second-hand smoke.

Smokers are getting younger. Children should be taught that even second-hand smoke is bad for the heart and other vital organs. Train them to be sporty. Even playing in the garden does wonders to the body. Be firm in your policy on less than two hours of watching TV or tinkering with their gadgets, said PHA Director and Advocacy Committee Chair Dr. Helen Ong-Garcia.

The PHA hails and supports the Department of Health’s (DOH) directive to schools to ban the selling of junk food and sugared drinks and soda in the cafeteria.

The Philippines, through the PHA is one of the 120 WHF member-countries that observes WHD every last Sunday of September.

Through the years, the DOH, WHO, Heart Foundation of the Philippines, tertiary hospitals and pharmaceutical companies have been the staunch supporters of the PHA in this yearly endeavour.

The PHA national office and its 11 Chapters (Northern Luzon, Cagayan Valley, Central Luzon, Southern Tagalog, Bicol, Cebu, Western Visayas-Negros Occidental, Western Visayas Panay, NorthWestern Mindanao, Southern Mindanao-Davao, Zamboanga Peninsula) are solid in pitching their Advocacy programs – the 52-100 tagline, Creating heart-healthy environment, bringing CPR to every Filipino home, workplace and public place; and in lobbying for the passage of an ordinance or a law requiring the installation of automated electronic defibrillators (AEDs) in all establishments, government offices and public places.
HeartNews

WHD 2014 in a nutshell
Getting to know the silent killer

By Marcellus Francis Ramirez, MD

Unlike cardiovascular conditions such as hypertension and ischemic heart disease, not much is known by the public regarding Sudden Cardiac Death (SCD), and little information is disseminated through lay fora and lectures. And yet, it is one condition that contributes to significant mortality in the adult population, with major and catastrophic psychological and emotional effects on the family.

In contrast to the usual chronic diseases that contribute to mortality and morbidity such as heart disease and cancer, SCD is an unpredictable condition. Like a thief in the night, it strikes without warning, leaving relatives of victims with tremendous psychological and emotional burden. Stories which run as “Why did he die? He was so well yesterday, then he suddenly died this morning! He didn’t even say goodbye!” are common among relatives of victims of this condition.

What is SCD?

SCD is a condition where there is an abrupt loss of heart function which is caused by a sudden chaotic cardiac rhythm. The most widely accepted definition given by the World Health Organization is “a sudden collapse occurring within one hour of symptoms” and characterized by a sudden cardiac arrest with cessation of cardiac functions. Today, SCD remains the single largest categoric cause of natural death in the United States, and probably also in the Philippines, accounting for an incidence of approximately 0.1 to 0.2% per year in the adult population. It probably accounts for approximately 50% of deaths from cardiovascular disease.

What causes SCD?

SCD is most commonly due to a fatal electrical rhythm dysfunction in the heart or arrhythmia, specifically termed a “ventricular fibrillation”. In this condition, the heart beats 400 to 500 beats per minute, causing the normal rhythmic contractions to stop, and causing inability of the heart to pump blood and oxygen to the rest of the body. Within seconds, the brain becomes depleted of oxygen and the person loses consciousness. If not treated immediately, this condition deteriorates to “asystole”, wherein the heart ultimately stops beating, and the person dies.

SCD most commonly occurs in a setting of heart disease. The most common underlying cause is coronary artery disease, characterized by cholesterol deposition causing narrowing within the vessels supplying the heart.
heart muscle, leading to decrease in coronary blood flow or ischemia. SCD is the most common, and often the first manifestation of coronary artery disease. Other causes include the cardiomyopathies, wherein the heart dilates and becomes larger than normal and is not able to pump blood effectively. In rare instances, SCD may occur even in persons without any apparent heart disease.

**Why is SCD the Silent Killer?**
What makes SCD a silent killer is that unlike a heart attack, which has the typical symptoms of chest pain and breathlessness, SCD has no warning signs and symptoms.

**Is SCD the same as a heart attack?**
No. A heart attack, or myocardial infarction, is caused by a sudden decrease in blood flow of a blood vessel supplying the heart muscle (coronary artery). SCD is caused by a sudden abnormal heart rhythm (ventricular fibrillation). However, some heart attacks may present as SCD, and SCD may occasionally be the first presentation of a patient with coronary artery disease.

**How can SCD be treated?**
The only way to treat a SCD attack is to set the rapid heartbeat to its normal rhythm by delivering an electrical shock to the heart using defibrillators. This can only be done when the patient is brought to the hospital emergency room immediately. For those individuals who are identified as patients at high risk of suffering from a SCD attack, and those who survived a SCD attack, an implantable cardioverter-defibrillator (ICD), a pocket-sized device which sends an electric current to the heart when the heartbeat goes rapid, could be implanted in the body.

**Can SCD be prevented?**
Yes. It has been found out that about ¾ of all SCD patients show signs of a previous heart attack, and around 80% have previous coronary artery disease. As such, awareness of risk for SCD is important, so that proper preventative and therapeutic measures may be instituted.

**Ways to prevent SCD:**
Although SCD is an unpredictable event, there are certain groups of people who have a high risk for this event and who are more prone to develop SCD. These include those with a family history of SCD, those with heart failure caused by either coronary heart disease or cardiomyopathy, those with severe cardiac hypertrophy (severe heart muscle dilatation and thickening), who have electrical disorders of the heart, such as Brugada syndrome, and those who have survived a previous cardiac arrest.

Furthermore, people who have high blood pressure, high cholesterol, diabetes, with family history of heart disease, who are obese and are smokers, are at risk of developing coronary artery disease, which in turn could lead to SCD. Therefore, prevention of these risk factors may prevent SCD. Treatment of these risk factors may also prevent development of SCD.

**Awareness of SCD risk**

**Who is at risk for SCD**
- Those with heart failure caused by either coronary heart disease or cardiomyopathy
- Those with severe cardiac hypertrophy (severe heart muscle dilatation and thickening).
- Those with a familial history of SCD.
- Those who have electrical disorders of the heart, such as Brugada syndrome (in local terms “bangungot”), Long QT syndrome, and selected patients with Wolff-Parkinson White syndrome.
- Those with previous SCD or Cardiac Arrest Survivors

**Prevention for Coronary Artery Disease**
- Eat a healthy diet
- Regular exercise
- Stop smoking
- Maintain a healthy body weight
- Manage stress
- Have regular heart check ups

**Conditions that Predispose to Arrhythmia and Sudden Cardiac Death**

**ABNORMAL HEART STRUCTURE**
- Coronary artery disease
- Heart failure – Cardiomyopathy - dilated cardiomyopathy - hypertrophic cardiomyopathy
- Heart valve diseases

**NORMAL HEART STRUCTURE**
- Electrical disorders of the heart
  - Brugada syndrome (“Bangungot”)
  - Long QT syndrome
  - Wolff Parkinson White syndrome
- Idiopathic ventricular fibrillation
- Myocarditis

**Image courtesy of the PHA Council on CPR**
CEBU
New heights, new depths
Buoyed by its remarkable exploits, Cebu aims to surpass its past feats. It is working on the following goals: 100-percent attendance in CME (Lay education/awareness, Lifestyle and Anti-Obesity Campaign) and community outreach programs; improved member cooperation/attendance in all the activities; a big majority of participating GPs, residents and doctors from other disciplines in the post-graduate course and Hypertension/Acute Coronary Syndrome Summit.

The Chapter is also gearing up for the forging of a sustainable Smoking Cessation Campaign in schools/universities that is endorsed by the local government unit; and the Christmas Party at the Home for the Aged with 250 attendees (doctors and lay). The entertainment program will include a brief lay lecture on cardiovascular disease prevention.

The Medical Mission will have 50 to 100 indigenous/tribal groups as beneficiaries.

The World Heart Day 2014 Celebration is hedged on the theme: Creating heart-healthy environment and the 52-100 Campaign.

Cebu should be able to influence the residents that it is never too late to take good care of their hearts. The Chapter will utilize social media, the most effective tool in advocating the PHA campaign.

BICOL
Conventional approach
The Chapter will engage in traditional activities:

World Heart Day 2014 targets 100 percent attendance and committed members who are enjoined to recruit non-members as participants.

Lecture/Lay Forum for Clinical Practitioners – these postgraduate lectures should be able to draw 50 doctor-attendees and Cardiovascular Risk Factor Identification – prior the risk factor screening will be a lecture and 52-100 CD showing.

CENTRAL LUZON
Come one, come all
Quarterly CME activities, particularly BLS/ACLS in different hospitals/agencies is numero uno and the best way to encourage participation of the members and spawn a tie-up with local medical societies. Every activity will train 60 lay or health professionals. The team is composed of Chapter members, IM and non-IM physicians, ancillary/ and medical staff and government civil servants.

The rest are: Lay lecturers and updates targeting 20 non-medical members of the community will be spearheaded by Chapter members and have pharmaceutical groups as sponsor; a Medical Mission with 50 to 100 indigenous citizens as patients in coordination with LGUS.

SOUTHERN TAGALOG REGION
The more, the merrier
The PHA STC is working double time to get the full support of all its members and allied professionals in the lay fora in communities and hospitals in the region. The Healthy Lifestyle (51-100) messages will be disseminated through media (radio guestings); seminars in industrial companies; lectures in schools and in the communities with the help of barangay health workers. The Chapter officers are gunning for a 100-percent attendance in all these activities.

The rest are: Lay lecturers and updates targeting 20 non-medical members of the community will be spearheaded by Chapter members and have pharmaceutical groups as sponsor; a Medical Mission with 50 to 100 indigenous citizens as patients in coordination with LGUS.

All the current management guidelines will be tackled in the BLS/
ACLs postgrad conference, CME seminars and specialty seminars, with a 50-percent audience.

WESTERN VISAYAS -- NEGROS OCCIDENTAL
Conservative stance

The Chapter is concentrating on three big projects:

The creation of Lay Healthy Lifestyle Slides (on the hazards of smoking, obesity and hypertension) for radio programs. It is a concerted effort among all local PHA members who will take part in the making of the slides and tap sponsors.

The Arrhythmia Postgrad Course that will draw 80 participants – GPs, resident and interns. Research Protocol – Making Workshop that will involve 10 residents and their respective hospitals and they have to publish three research papers per year.

WESTERN VISAYAS-PANAY
Status quo but on a bigger scale

Post-grad symposium and ACLS/ BLS accreditation of allied-medical professionals fundraisers will hopefully post revenues higher by at least 50 percent than last year's turnout. More heads are better than one. An active collaboration with local medical societies is underway. A yearly post-grad activity that caters to GP-IM practitioners is also on the drawing board.

World Heart Day in September 2014 and Heart Month in February 2015 should have at least 85 percent attendees -- Fellows, including past Chapter presidents. Massive information dissemination will be done thru email and SMS brigade.

To draw a huge crowd, health-related activities like free clinics (consultation, lab works, ECG, etc.) and Lay Forum (BP screening and awareness) and Disease Prevention seminars will be conducted quarterly or bi-monthly; conducting lay fora with BP Awareness and Screenings as well as Cardiovascular Disease Prevention Seminars that will require local media coverage.

COMMITTEE ON CEPC
Knowledge knows no frontiers

PHA-initiated Continuing Medical Education modules on different CV diseases will be cascaded through the website and seminars in major training institutions/chapters. The goal is to update/disseminate advances/guidelines in the treatment of algorithm.

The benchmarks are: the number of CME grant per institution/chapter. Website-based CME for which CME will be granted upon completion of course (e.g. lipid 2014 Hypertension Updates). Eighty-five percent participation in website CME courses and regular dissemination are the measure of success.

PHA NEWSBRIEFS
A valuable tool for information dissemination among the members, the PHA NewsBriefs is bent on targeting prompt publication and accomplish at least 80 percent circulation. Its perennial problems are the lack of advertisers and news contributions from different councils and chapters as well as delayed submission of articles.

PHA WEBSITE
A mouse click away

Instant heart news is only a click away. Unfortunately, only a small percentage of PHA members are actively logging onto the site. The editorial team is aiming for a 50 percent increase in readership, 30 percent increase in Council/Chapter news, more CME materials and CME credits to increase members' participation. A significant number of members do not use email.

The suggestions were: Website should have a dedicated writing staff; facilitation of updating of Philippine Journal of Cardiology issues for upload and access and improved coordination between the Website Committee, the NewsBriefs and PJC staff.
Media play up diverse angles

Abanilla: CVD more likely to claim Pinoy lives than Ebola

By Gynna P. Gagelonia

What we lacked in numbers, we made up for it in value. World Heart Day (WHD) 2014 and the Philippine College of Physicians (PCP) Health Forum @ Annabel’s notched up hits.

During WHD and the media forum, PHA had to compete with earth-shaking stories (the Ebola virus plague hounding the international community, the shocking Binay properties exposé and disturbing alleged irregularities in the Department of Health).

PHA President Dr. Joel Abanilla said: “while we, Filipinos are in panic mode over the possibility of Ebola Virus reaching the Philippines, heart disease and stroke or cardiovascular diseases (CVD), the top killer diseases are right on Philippine soil and are more likely to take more lives.”

ABS-CBN’s Salamat Dok, GMA 7’s Pinoy MD, GMA News, Philippine Daily Inquirer, Manila Bulletin and the Philippine News Agency; as well as industry players like PTV 4, TV 5, Global News Network, Net 25 Sonshine TV 39, DWAD, DZRH, DZXL, Radyo Agila, Business Mirror, People’s Monitor and Dyaryo Pinoy covered both events and generated thought-provoking news angles.

These news stories were pegged on “Creating Heart-Healthy Environment”, PHA’s relentless effort in earning the Cardiopulmonary Resuscitation (CPR) Ready status and in getting the national and local governments’ endorsement of the automated external defibrillator (AED) as a must life-saving tool.

The WHD 2014 Heart Fair at the St. John Bosco Parish in Makati City on Sept. 28, 2014, a Sunday, was covered by 22 tri media people. The PCP Health Forum on “Dealing with Sudden Cardiac Arrest & Creating Heart-Friendly Environment on Oct. 14, 2014 at Annabelle’s T. Morato Ave., Quezon City was attended by 28 members of the press. Both events were the perfect vehicle that gave the 52-100 battlecry new mileage.

Aside from affording the PHA Advocacy program continuous exposure, ABS-CBN/DzMM’s Magandang Gabi, Dok and DzMM’s Radyo Klinika provided pre-publicity to the WHD celebration.

Partial media hype list:
<table>
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<tr>
<th>Entity/Program</th>
<th>Exposure Date</th>
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<td>Dyaryo Pilipino</td>
<td>Oct. 24/14</td>
<td>PHA: Atake sa Puso maisasalba ng CPR, AED</td>
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<tr>
<td>PDI</td>
<td>Oct. 21/14</td>
<td>Knowing CPR will save more lives, say docs</td>
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<td>Manila Bulletin</td>
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<td>Afraid of Ebola? Hearts are a bigger killer</td>
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<td>Oct. 20/14</td>
<td>Thousands die of cardiac arrest</td>
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<td>Abs-CBN Salamat Dok</td>
<td>Oct. 19, 2014</td>
<td>Priceless value of CPR and portable AED because witnesses don’t know CPR</td>
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<td>Oct. 11/14</td>
<td>Heart disease, stroke continue to threaten health</td>
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<td>PTV4 WeekendNews</td>
<td>Oct. 5/14, 6pm</td>
<td>Teledyardo peg: Heart Fair and 52-100</td>
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<td>GMA7 Pinoy MD</td>
<td>Oct. 4/14</td>
<td>PHA Medical Mission</td>
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<td>Philippine News Agency</td>
<td>Sept. 28/14</td>
<td>Heart experts celebrate WHD; Pitches 52-100 lifestyle</td>
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<td>Tayag says eating a lot of salt, sugar is bad for our health (with video clip)</td>
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<td>Sunstar.online</td>
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<td>Radyo Cinco/92.3 khz TV and radio Metro Sabado</td>
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<td>plugging with background of WHD Host: Izza Reniva-Cruz</td>
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<td>DzMM Salamat Dok</td>
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<td>DzMM Salamat Dok</td>
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<td>Dr. Ina Bunyi</td>
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Related story:
Remate
August 2014
Leonor Abanilla & the Magic of Punta Villa
Eighty percent of out-of-hospital arrest happens in the home. And records show that roughly 50 percent of deaths from cardiovascular disease (CVD) happen as sudden cardiac arrest with at least one family member present.

Philippine Heart Association (PHA) Council on Cardiac Pulmonary Resuscitation (CPR) chair Dr. Francis Lavapie added that “only four to six percent of sudden cardiac arrest patients survive because the person with them don’t know how to do CPR.”

CPR must be started within four to six minutes after cardiac arrest to prevent brain death. Study shows that CPR can save lives even if it only buys time and has limitations. And the use of a very handy automated external defibrillator (AED) brings the survival rate higher.

These very precious information came from a team of heart doctors from the Philippine College of Physicians and PHA. PHA, led by its key officers --Drs. Joel Abanilla, Alex Junia, vice president; Raul Lapitan, secretary; Lavapie, Orlando Bugarin, Don Reyes, an avid CPR Council member, and PCP President Dr. Tony Leachon who called on the public and private sectors to support the PHA’s bid to be a CPR-equipped country and Advocacy for the Lay Programs during the PCP Health Forum at Annabelle’s on Oct. 14, 2014. In attendance were 28 media members.

In the Philippines, manual defibrillator machines are commonly found in the hospitals. Only a few government agencies are equipped with AEDs. Even in big establishments and offices, we rarely see an AED. The PHA would love to see the day when these life-saving AEDs are found everywhere, said Bugarin, immediate past chair of the CPR council.

“We really need to address this. We have to find ways to increase the survival rate. Every Filipino, even grade school or high school students, must know how to do proper CPR” added Lavapie.

The AED automatically diagnoses fatal cardiac arrhythmia, stops the arrhythmia and lets the heart re-establish a regular beat.

L-r: Drs. Bugarin, Lavapie, Abanilla, Leachon, Lapitan and Junia

PHA to media:

CPR, AED can save more lives
PHA Vice President Alex Junia told the 100 Asia Health Summit delegates, mostly high-ranking officers of top multi-national and local corporations to “inject 52-100 in your daily routine” to keep a healthy heart. Jumpstart your Heart with 52-100 is the new name of the Healthy Lifestyle advocacy of PHA.

His lecture was titled “52-100 Campaign of the PHA: Fight Heart Disease, the No. 1 Killer in the Philippines.”

The Cebu-based Junia joined an elite panel of multi-disciplinary speakers at the Summit on October 14, 2014 at the Raffles Manila in Makati City, who all shared their expertise in keeping a healthy mind and body as well as a stimulating healthy workplace and environment.

Junia also stressed that “adults and children alike should not just be taught to be health conscious but should be empowered to be ambassadors of 52-100. From your own homes, spread the 52-100 code through interactive sessions, social media, posters and stickers in school.”

“52-100 stands for 5 servings of fruits and/or vegetables, 2 hours maximum screen time for children and not more than 2 grams of salt consumption; 1 hour of physical activity, 0 soda or sugary drinks and 0 smoking and second-hand smoke, to stay heart-healthy”, he said.

The re-branding of “Mag-Healthy lifestyle Tayo” to 52-100 was inspired by US First Lady Michelle Obama’s 52-10 campaign. PHA added another “0” to dramatize the perils of smoking and the harsh reality that smoking among children from 10 years old and up is on the rise in the Philippines.

The 52-100 video was played before and after Junia’s lecture which was aided by a powerpoint presentation. An impressed Richard Mills, from the Chalre Associates Management Company repeatedly played the 52-100 video during the lunch break.

The two speakers after Junia also echoed the PHA’s 52-100 campaign.

PHA is a member of the Resuscitation Council of Asia, the regional component society of the International Liaison Committee on Resuscitation (ILCOR).

Every year, the PHA conducts the Training the Trainors which is participated in by PHA members, physicians with different specialties and nurses; hospital-based and emergency medical providers.

PHA conducts CPR trainings around the country and encourages law enforcers and other field personnel to be able to respond to emergency or do first-aid.

During the celebration of World Heart Day on September 26, 2013, 300 Metro Manila Development Authority field personnel attended the CPR lecture and workshop at the MMDA Compound in Makati City.

At least 150 parking and traffic aides of the Cebu City Traffic Operations Management (CITOM) attended a crash course on basic life support or CPR at the Plaza del Independencia in Cebu City. It was the culminating activity of Heart Month in February 2014.

Of the 11 PHA Chapters, Davao and Cebu Chapters have been taking the lead in conducting Basic Life Support and Advanced Cardiac Life Support trainings.
BP ng Teacher Ko...

Expands horizons, boosts members’ bond

The four-year-old “BP ng Teacher Ko, Alaga Ko” caravan has traveled far and wide. “More than the mileage, the BP ng Teacher Ko...continues to reunite Manila- and Chapter-based cardiologists for an Advocacy program that is dedicated to public school teachers. In hindsight, these out-of-town sorties have been benefiting the reaching-out to the Chapters and members’ activation bid of the present Board,” said PHA Vice President Dr. Alex Junia.

In the inclusive months of September and October, the PHA Council on Hypertension travelled to the country’s major islands -- Luzon (Taguig City, Metro Manila on Sept. 5); Visayas (Tagbilaran City, Bohol on Oct. 17) and Mindanao (Cagayan de Oro City on Sept. 19, 2014).

The indefatigable Dr. Irma Marie Yape, PHA Council on Hypertension immediate past chair, led her colleagues in all the three hops.

BP ng Teacher Ko... is a national BP and Risk Factor Screening Clinic for the country’s public school teachers and personnel. A joint project among the PHA, Department of Education head office and the Hypertension Society of the Philippines, through a grant from LRI-Therapharma, it aims to establish the prevalence of the hypertension plague among teachers and eventually a registry.

At the Upper Bicutan Elementary School in Taguig, 180 teachers-patients availed of the free clinic and blood works.

The consultation desks were manned by Fellows from the Manila Doctors Hospital (Drs. April Pines and Mitch Uy); UP-PGH (Drs. Eileen Cunanan and Ariel Valones); and SLMC Global (Drs. Loudon Antonio and Kristoffer Tanseco).

The Dep Education personnel who
assisted in the activity were: 20 nurses, Dr. Lorna Publico, the doctor in-charge and coordinator.

Venue of the Tagbilaran hop was the Dep Ed Division Office in Tagbilaran City which logged 200 teachers. Yape was assisted by Bohol-based PHA members and non-cardiologist. They were Drs. Jane Ramiro, Ronald Ramiro, Lalaine delos Santos and Imelda Jumangit (all from Ramiro Hospital) and Violo Llorente Jr. (MMG Coop Hospital).

The DepEd group consisted of 25 nurses and teachers, coordinated by Nicasio Degamo, the nurse in-charge, through a directive from Evangel Luminarias, PhD, the division superintendent.

In Cag de Oro, 262 teachers flocked to the Cagayan de Oro City National High School. PHA Northwestern Mindanao Chapter officers and members – Drs. Kenneth Oporto (vice president); Anne Christine Co-Kho, Ma. Rowena Rocha, Geraldin Pon, Ma. Teresita Palamine and Marife Mejias, joined Yape at the consultation area. With them were 25 nurses and teacher-coordinator Dr. Baldomero Mark Meso, the DepEd Regional office medical officer.
**Doodz: I would like to initiate a Cardiac Cath registry**

Dr. Eduardo “Doodz” Tin Hay, chair of the PHA Council on Cardiac Catheterization and Interventions enthusiastically expounds on the Registry project the Council is venturing into. He believes that PHA needs to take a conservative stance while testing the waters.

**PHAN: Briefly describe your plans for the Council**

**ETH:** In keeping with the PHA Mission/Vision to advance the standards of cardiac care in the Philippines, I would like to initiate the Cardiac cath registry even at its pilot stage. I understand the travails of polishing the edges of its data collection form, together with its protocol for the registry to make it more practical and feasible for collection, but someone’s gotta do it, and maybe it is me at this point in time. Most, if not all of our neighboring countries have their own Cardiac cath registry from where they would formulate their local studies, improve their national standards of care and compare data with neighboring countries. Just imagine if we could initiate and sustain such registry, the huge implications it would have on the researches being conducted by our Fellows in training as well as our health care system.

Since I am also a Board of Director of the affiliate Philippine Society of Cardiac Cath and Interventions, it would also be nice to hook up with our affiliate society, and organize some laymen fora concerning CAD and cath procedures to help improve health care delivery in the country.

I do hope that other things would continue to pop up along the way where the council could contribute to the over-all mission of the organization in its own special way.

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

I would not say that there should be a specific time frame to accomplish a feat like a registry program but I believe that once it’s initiated, it would be worthwhile and could be a defining moment for the council and the whole organization. Besides, I don’t like to plan things that really wouldn’t work and play out at the end, I am the type that tries to keep things practical and realistic.

**What makes your Council different from the other Councils?**

In my opinion, the Council doesn’t have a clear and well-substantiated objective compared to the other Councils as of this date, mainly due to overlap with other affiliate societies. The council needs more dedicated members that could help jumpstart some of the objectives of the Council and encourage other interventional cardiologists to join the fray.

Technologies have always been at the forefront of the interventional field and another thing that makes this particular Council different from the others is that particular need to keep abreast with the latest thing in intervention especially for CME for us to keep up with our neighboring countries.

**How would your Council contribute to the over-all PHA goal/vision?**

With our busy schedules frequently creeping up to drain all our energies and remaining time, hopefully we can extend help thru education, research and healthcare delivery, done intermittently or by piecemeal.

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

Members who are able and willing to work are extremely needed as well as the machinery to gather data and sustain data collection per institution.

**Is the Council open to new members? How can someone obtain membership in your Council? What are the membership criteria/qualifications?**

Of course! Our Doors are always open to a helping hand. All PCC fellows in good standing with PHA are welcome.

The field of Interventional Cardiology continues to be a growing subspecialty. What are your thoughts regarding this?

At the time of this writing, significant strides have been made in the field of mitral valve apparatus intervention with clips, application of TaVi/TAVR have been wider than before plus coronary stent polymer evolution and platform development have taken another huge leap for the last five years. I guess there’s no limit
to men’s innovation and passion for health and longevity. Hence, it is our duty as physicians to stay well-informed and keep up with these developments for the welfare of our Filipino patients.

As Physicians, we all know that there’s no limit to learning in the medical field and interaction with neighboring countries and various societies are much needed in order for us to achieve such.

**How many local institutions are currently offering subspecialty fellowships in this field?**

Around 4.

**How does the Philippines compare with its neighboring Asian countries as well as the US and the rest of the world, in terms of knowledge, skill and competence in the field of invasive cardiology?**

It’s quite hard to compare especially since we don’t have a national registry and also data/census sharing between institutions and PHA/PSCCI have been inadequate early on. In my own opinion, I would say we have well-trained, fully competent interventional Cardiologists in our ranks that could fare well if not better than interventional cardiologists from neighboring countries especially if given the chance to handle novel devices and the right amount of resources. I am always hoping that personal and territorial differences would not come in the way of progress of healthcare advancement especially here in our setting.

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

Hard work, cooperation, commitment and last but maybe the most important thing if you ask me will be clear and constant communication between PHA and its members.

**Name:** Eduardo “Doodz” Tin Hay

**Age:** Always a guessing game!

**Institutions:** Philippine Heart Center, Chinese General Hospital, St. Luke’s Medical Center, Quezon City

**Medical school:** UST College of Medicine *Cam Laude*

**Training institution in Cardiology:** Philippine Heart Center

**Subspecialty:** Interventional Cardiology

**Training institution in Cardiac subspecialty:** National University Hospital in Singapore

**Present positions/Academic titles:**
Fellow -- Philippine College of Physicians, Philippine College of Cardiology and Philippine Society of Cardiac Catheterization & Interventions
Council chair, PHA Council on Cardiac Cath & Interventions,
Active council member, PHA Council on CPR and PHA Council on Coronary Artery Disease
Board of Director, Philippine Society of Cardiac Cath and interventions; CAD section faculty, Philippine Heart Center;
Faculty Professor, SLMC College of Medicine

**EDITORIAL... from Page 2**

thoroughfare is not open, perhaps taking the service road is a wiser move.

Emergency health care cannot wait for our busy lawmakers. City or municipal ordinances may be easier and faster to make and may facilitate the implementation of projects. Health units including the barangay health workers, the local police and firemen may be instrumental in implementing a program that provides appropriate care for SCA victims.

The road towards a CPR-ready and AED-equipped Philippines is going to be long, rough and tough. The United States also took time before laws on AED were fully implemented. Japan, the country in Asia whose passion in CPR science is unparalleled, has had its share of raised eyebrows whether deploying AEDs using public funds is practical and beneficial. To date, the US and Japan are the two leading providers of AEDs in public areas in the world, with Europe coming in third.

But hopes are high. The completion of the research on SCA being initiated by the PHA CPR Council this year may oil and rev things up. Data to support and justify a nationwide and institutionalized program in the provision of emergency medical care to SCA victims may just be the fuel to jumpstart the legislative engine in Congress.

But until a law on SCA emergency medical care and AED is passed in Congress, the PHA will remain perpetually steadfast and ever energetic in its mission in educating and training health care providers and the ordinary lay in delivering BLS and ACLS to save more lives.

And hopefully one day, that heart and lightning or right arrow graphic will be a common sight and popular as the most popular gadget symbol in the Philippines. ♥
How can SCD be treated?

An implantable cardioverter-defibrillator (ICD), a pocket-sized device which sends an electric current to the heart when the heartbeat goes rapid, could be implanted in a person suffering from a SCD attack, and those who survived a SCD attack, an immediate. For those individuals who are identified as patients at high risk of developing ventricular fibrillation, it is preferred treatment for patients who have survived a SCD and those at high risk for SCD.

The only way to treat a SCD attack is to set the rapid heartbeat to its normal rhythm by delivering an electrical shock to the heart using defibrillators. This can only be done when the patient is brought to the hospital emergency room immediately. For those individuals who are identified as patients at high risk of developing ventricular fibrillation, it is preferred treatment for patients who have survived a SCD attack and those at high risk for SCD.

Rhythm by delivering an electrical shock to the heart using defibrillators. This can only be done when the patient is brought to the hospital emergency room immediately. For those individuals who are identified as patients at high risk of developing ventricular fibrillation, it is preferred treatment for patients who have survived a SCD and those at high risk for SCD.

Ways to prevent SCD:

1. Primary prevention of Coronary Artery Disease
   - Regular health screening and heart check ups are life-saving and sometimes timely for some SCD patients. Early identification and treatment of coronary artery disease remains crucial in the prevention of SCD. Identification of other asymptomatic but potentially fatal electrical disorders of the heart and other heart diseases may pave way to prevention and treatment of SCD attacks in high-risk patients.

2. Secondary prevention of SCD
   - In the event that a person collapses from SCD, the key to survival is early defibrillation. Every second and every minute delay from SCD onset to defibrillation reduces the chance for survival. Hence, knowledge of what to do in case a person collapses from SCD, is key. This includes immediate call for an ambulance or medical assistance. Knowledge of proper Cardiopulmonary Resuscitation (CPR) and Basic Life Support techniques are worthwhile and have proven to be life-saving. This may be learned through short courses on Basic CPR which are given by the Philippine Heart Association, as well as by different hospitals and training institutions.

   For patients who are at high risk for SCD, implantation of an ICD have been proven to be useful for survival. This is a small device which is implanted on the left chest by an electrophysiologist. It works by delivering an electric current to the heart to stabilize the heart rhythm every time the heart goes into ventricular fibrillation. It is the preferred treatment for patients who have survived a SCD and those at high risk for SCD.

Summary:

SCD is an important cause of death and morbidity. In the Philippines, however, considerable work still needs to be done in identifying the population at high risk. Awareness of the different risk factors and primary prevention of heart disease are important aspects in this approach. Finally, there are therapeutic options and preventative measures that are available and applicable for this condition.
Dr. Mariano M. Alimurung Center unveiled

MAKATI CITY, Sept. 29, 2014 -- Makati Medical Center (MMC) unveiled its state-of-the-science Dr. Mariano M. Alimurung Center. The late Dr. M. Alimurung was one of the best cardiologists in the country and one of the founders of MMC.

The ceremony coincided with the World Heart Day celebration.

Located on the 4th floor of MakatiMed’s Tower 1, the Mariano M. Alimurung Center is composed of the Medical Surgical Intensive Care Unit (Medical Intensive Care Unit and Surgical Intensive Care Unit), Neuro–Cardiovascular Intensive Care Unit (Acute Stroke Unit, Neurology Intensive Care Unit, Neurosurgery Intensive Care Unit, and Cardiovascular Intensive Care Unit), Advanced Cardio–thoracic & Vascular Care Services (Cardiac Catheterization, Hemodynamics and Intervention, Cardiothoracic & Vascular Operating Rooms, and Cardiothoracic & Vascular Recovery Room), Cardiovascular Telemetry & Medical Step Down Unit, and the Mariano M. Alimurung Satellite Library.

Alimurung, who passed away in 1989, formalized cardiology as a specialty in the country in 1952 when he founded and organized the PHA.

The event was attended by Health Secretary Enrique Ona, PHA President Dr. Joel Abanilla, Dr. Benjamin Alimurung, son of Dr. Alimurung and MakatiMed Medical Director; Ernesto Escalante, VP for Supply Chain Management, representing President & CEO Rosalie Montenegro; Manuel Fernandez, Jr., MD, Executive VP; and heads of the Intensive Care Units, Department Chairpersons, section chiefs, members of the Board of Directors of PHA, colleagues and students of Dr. Mariano Alimurung from University of Sto. Tomas.

Alimurung’s relatives, MakatiMed consultants, and hospital staff were also in attendance.

Ona said: “for the past several decades, cardiovascular disease has been ranked as the number one cause of mortality and morbidity, not just in the Philippines but worldwide, and this reality underscores the need for comprehensive cardiovascular care services,” adding, “it is for this reason that the Department of Health is truly grateful for its partners in the private sector and the Makati Medical Center, which embarks on an aggressive approach in the field of cardiovascular diseases to deliver total quality healthcare to its patients and their families.”

“With the naming of the Mariano M. Alimurung Center, Makati Medical Center joins the short list of tertiary hospitals in Metro Manila that offers state-of-the-science cardiothoracic and cardiovascular care services,” he said.

The young Alimurung expressed his gratitude to MakatiMed on behalf of the Alimurung family. He said “my father’s memory lives on” as the work continues for the current cardiology practitioners in the country and their successors. He mentioned that his children – “the next generation” – were also studying medicine to continue their legacy.

The unveiling of the Center also became a celebration of Dr. Mariano Alimurung’s life and contributions to the field of medicine. At MakatiMed, he served as chairman of the Department of Medicine, director of the Coronary Care Unit, and head of the Cardiology Section. He was also the first director of the Office of Medical Education, a position he held until his passing in 1989.

Doctors reminisced and shared stories about their mentor. Dr. Noel Rosas said “he elevated the practice of cardiology in the country”, while Dr. Fernandez called him “a source of inspiration in our practice”. Dr. Nambayan-Abad honored “the man’s magnanimity”.

In his toast at the close of the ceremony, Dr. Abanilla hoped the Center would serve as “an inspiration for the rest of the archipelago.”

L-R: Drs. B. Alimurung, son of the late Dr. M. Alimurung and MMC medical director; Joel Abanilla, PHA president; Health Secretary Enrique Ona; Manuel Fernandez, Jr., and Ernesto Escalante Makati Med executive VP and VP for Supply Chain Management, respectively.
Armamentarium for the current cardiology practice

By Anna Adora, MD

In its constant pursuit to uphold the Philippine Heart Center’s (PHC) mission to provide comprehensive cardiovascular care enhanced by education and research that is accessible to all, the PHC Department of Adult Cardiology produced four successful postgraduate courses for the year 2014. These courses were open and free of charge to all medical practitioners.

“Updates in Clinical Cardiology” which was held on October 9 – 10, 2014 served as a refresher course and dealt with dynamic updates and issues in the field of cardiology. As a new year is approaching, the PHC Department of Adult Cardiology is excited to be at the forefront of another batch of postgraduate courses.

Dealing on “All About Aneurysms” and held from August 6 – 7, the course was composed of lectures on the etiology, diagnosis, medical and surgical management from an accomplished team of invasive and vascular cardiologists as well as thoracic and cardiovascular surgeons.

In collaboration with the Pintig Puso Foundation, the “Approach to Common Cardiac Emergencies” tackled cardiac emergencies such as ACS, cardiogenic shock, aortic dissection, acute limb ischemia, tachy and bradyarrhythmias were discussed. The attendees, who were mostly internal medicine residents, postgraduate interns and general practitioners, certainly went home with added confidence on dealing with these cardiac emergencies.

“Everyday Cardiology” expounded on the ECG and X-ray workshops where the participants practiced these skills with the experts – Dr. Erdie Fadreguilan from the Division of Electrophysiology and Dr. Sara Zampaga of the PHC Department of Radiology. Updates on the latest guidelines on diabetes, hypertension, and dyslipidemia were also tackled, arming the participants with new knowledge for their daily practice.

Arrhythmia cases in real world practice

By Lauren Valera, MD, UST Hospital

The Second Arrhythmia Club Meeting is a venue for the cardiology fellows of each training institution to share different arrhythmia cases that they have encountered.

A panel of experts shared their expertise in electrophysiology (EPS). The Philippine Heart Center Medical Alumni Society (PHC-MAS), in cooperation with Pharmalink and Sanofi hosted the Sept. 12, 2014 at the Sulo Riviera Hotel in Quezon City.

Dr. Marcellus Francis Ramirez moderated the session. Fellows from the different training institutions participated during the interactive question and answered the different questions posed during the presentation.

Dr. Jennifer Jeanne Viceria, a senior cardiology fellow from University of Santo Tomas Hospital, presented “Idiopathic Left Ventricular Tachycardia: Three Electrophysiologic Phenomenon in a Single Patient”.

She explained different interesting electrophysiologic concept the presence of retrograde ventriculoatrial conduction in ventricular tachycardia, the induction of ventriculoatrial dissociation by adenosine injection, and the memory T waves after conversion of tachycardia which mimic ischemia.

Important algorithms in the diagnosis of wide complex tachycardias such as the Brugada criteria and the Vereckei algorithm were discussed. She also emphasized that idiopathic left ventricular tachycardia may be mistaken as supraventricular tachycardia because of the slightly “narrow” QRS complexes compared to the usual ventricular tachycardia.

Dr. Anna Cristine Adora, cardiology fellow from the PHC discussed “Ventricular Arrhythmias in the Absence of Structural Heart Disease”. The panel of experts – Drs. Joel Abanilla, Ronald Cuyco, Michael Agbayani and Lyn Lagamayo provided additional insights during the session.
Eight patients with indications for biventricular pacing received free cardiac resynchronization devices care during a mission headed by US-based electrophysiologist Dr. Rodrigo Chan from September 1 to 4, 2014.

It was held at the Philippine General Hospital and Manila Doctors Hospital. The patients had severe systolic dysfunction with wide QRS complexes or systolic by Sonny Abrahan, MD

Breaking the Code

By Sonny Abrahan, MD

The Section of Cardiology of the UP-Philippine General Hospital successfully conducted its 38th Annual Postgraduate Course on Electrocardiography, entitled Breaking the Code last September 19-20, 2014 at the Diamond Hotel.

More than 100 participants from various institutions and provinces braved typhoon Mario's battery to learn the basics of ECG interpretation. The UP-PGH Cardiology Faculty of the UP-PGH imparted their knowledge through brief and simplified lectures. These were then reinforced by several workshops wherein the participants applied what they learned by interpreting tracings from actual patients, with the guidance of the PGH Cardiology fellows. Lucky attendees who were able to interpret difficult tracings correctly got to bring home power banks and gift certificates for overnight stay at One Tagaytay Place. Proceeds of the two-day event will go to the Pusong Pinoy Foundation, which assists in the needs of indigent cardiac patients of PGH.

Chest X-ray of a patient with a biventricular pacemaker - defibrillator. The quadripolar left ventricular lead (yellow arrow) is positioned in a tributary of the coronary sinus. The dual-coil right ventricular lead (green arrow) is positioned in the right ventricular apex and the atrial lead (red arrow) is anchored to the right atrial appendage. (Image courtesy of Dr. Michael Agbayani)
TAGBILARAN, CITY October 15, 2014 -- Church bells in the city and the entire Bohol province rang in unison for 33 seconds at 8:12 Wednesday morning. Along with the pealing of bells, there were blowing of horns, patrol cars and ambulance sirens for 33 seconds province-wide, followed by prayer services and Eucharistic celebrations in all the localities. The ringing reminded everyone of how the natural disaster has affected us, why and how the people should move on and even do better. This was followed by the groundbreaking of a proposed earthquake memorial shrine in Banat-I Hill in the Bool District of Tagbilaran City.

It is the first year anniversary of the Bohol 7.2 magnitude earthquake which struck the province on Oct. 15, 2013, causing loss of lives, destruction of properties and economic decline. Despite the disaster, the national and local governments, civil society and the private sector remained focus on recovery and rehabilitation efforts.

President Benigno ‘Noynoy’ Aquino III officially declared Oct. 15 as a special non-working day in the Province of Bohol through Presidential Proclamation No. 887. The proclamation also supports the wish of the Province of Bohol, represented by Gov. Edgar Chatto, to commemorate the earthquake

A year after the Great West Bohol earthquake

By Jane Regner-Ramiro, MD

Photos lifted from the Internet
anniversary as a Day of Prayer and Thanksgiving.

One of the focal points of the anniversary was the Bohol provincial government’s Ceremonial turn-over of Core Shelters to 5,426 beneficiaries in 17 towns of Bohol. Certificate of Entitlements were already distributed in 16 towns. In the municipality of Cortes, 458 quake-affected families in 14 barangays were given 25-square meter bungalow houses. Cortes was one of the areas in Bohol struck by the earthquake and is just adjacent to Tagbilaran City.

Another highlight of the commemoration was the inauguration of the Art Gallery in Santa Monica Parish Convent of Albur town with photos, video, painting exhibits and documentary reports on the results and impact of the earthquake. Of the three churches totally destroyed, only the statue of Christ the King stands in front of the rubble of the Holy Cross Parish of Maribojoc town.

The day after, there was a MOA Signing Ceremony between the Japanese International Cooperation Agency, Nagoya Institute of Technology, Municipality of Tubigon and the Bohol Island State University on the Japanese Technical Cooperation for Grassroots Project for the Enhancement of Capacity for Participatory Disaster Management on Prevention, Preparedness, Response and Recovery.

Since the 7.2 magnitude earthquake, all local government units have equipped themselves for disaster preparedness and response.

**Busting Bisperas**

By virtue of an executive order by Chatto, the Oktubre Kinse: The Bohol Earthquake Memorial Executive Committee was formed.

The ExeCom made sure there was intense drumbeating four days prior to the memorial event. A fundraising concert was staged at the Bohol Cultural Center by the Singing Priests of Bohol for the renovation of a seminary college building in Tagbilaran City; back-to-back free concerts by the Loboc Children’s Choir and the Paring Bol-anon with the Holy Name University Chorale drew droves of spectators; and a four-hour prayer evening vigil on October 14.

**Reconstruction Boom**

Chatto further said: “We are back to business. We can expect Bohol to be still a food basket of Region 7. Bohol has recovered 70 percent, and declared “Bohol has moved on already. Bumangon na ang Bohol”.

Restoration of the concrete bridges and churches -- Baclayon Church, the oldest stone church in the country built in 1595; Immaculate Concepcion Dauis Church in Panglao and a new diversion road 20 meters further fronting the Baclayon Church beside the coastline has been built to protect the fragile belfry. ♥
STA. ROSA, Sept. 27, 2014 – PHA STC lined up a series of activities in celebration of World Heart Day 2014. The chapter met up at the Seda Hotel, Nuvali, Sta. Rosa wherein more than 60 participants signed up for the Hypertension Peak Symposium sponsored by Menarini Philippines.

The symo kicked off with a lecture on “Hypertension and Co-morbidities” given by Dra. Lalaine Cañete-Kesiel followed by a lecture on “Hypertension and Heart Rate” by Dr. Michael Tiuseco and a review on “Hypertension and Cognition” as shared by Dr. Romulo Rosita. Dr. Helen Ong-Garcia graced the event as a representative of PHA National.

The group had a lively exchange of questions on topics regarding Hypertension that are not usually tackled.

Prior, STC with friends from Getz Pharma Phils. had a tree-planting activity in Nuvali, Sta. Rosa, Laguna. Ardith Dominguez-Tan, MD
PHA STC members with sponsor Getz Pharma Phils. at the tree-planting site in Nuvali, Sta. Rosa

With their families
Multi-disciplinary docs mark WHD

By Stela Mabanag, MD

SAN FERNANDO, La Union, Sept. 27, 2014 – Adult and pediatric cardiologists from PHA-Northern Luzon, La Union Medical Society (LUMS), Philippine Pediatric Society North Luzon (PPS-NL) and San Fernando City Health Office in La Union, bonded together to engage in multi-activities that will boost up their Advocacy programs and increase general and heart-health knowledge.

Dr. Gerry Acosta, delivered a lecture on cardiovascular risk assessment in children at Max’s Restaurant. Dr. Brenda Espinosa tackled World Heart Day’s history and expounded on this year’s theme: Creating Heart-Healthy environment.

The PHA-NL Chapter officers, members, employees of the San Fernando City Health Office led the early morning Zumba and Aerobic exercises at the City Square which gathered about 100 participants. A motorcade around the city ushered in the program proper.

The week-long event was initiated by chapter president Dr. Stella Mabanag who was assisted by Drs. Espinosa (past president), Nathaniel Cortez and Leah Sanglay.

Lectures, workshops and examinations were delivered and administered by chapter members from La Union together with PHA CPR Council member Dr. Don Robespierre Reyes. With reports from Leah Sanglay, MD
**5 hospitals in Iloilo:**

*Frontliners all*

*By Rhodelyn Besanes-Almenana, MD & Felibert Dianco, MD*

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**Western Visayas Negros Occ.**

Everyday is World Heart Day

**ACOLOD CITY, Sept. 28, 2014 --** The chapter was joined by their young and active at heart senior citizens “The Senior Citizen Hataw Group” at the Bacolod City Lagoon park for an early morning exercise. They danced their hearts to salsa, samba, cha-cha, hip hop in celebration of World Heart Day.

A parade led by the Medtrek group (Medical professional bikers and Riverside Medical center delegates) walked up the streets from Lopez east and ended up to join the dancing group. The celebration was ended with a short lecture on PHA code 52-100 by Dr. Francisco Maleza. The event may have long passed, but in the hearts of the young and the old, every day is World Heart Day.

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**ILOILO CITY, Sept. 27, 2014 – WV Visayas Panay conducted a flurry of World Heart Day 2014 (WHD) and CME activities.**

Led by chapter President Dr. Felibert Dianco, WHD was a two-day affair that involved the different training institutions in Iloilo -- the Iloilo Mission Hospital (IMH), Iloilo Doctors Hospital (IDH), St. Paul’s Hospital (SPH), Western Visayas Medical Center (WVMC) and West Visayas State University Medical Center WVSUMC). Newbie The Medical City-Iloilo, a tertiary cardiovascular center also actively joined in the celebration.

IMH hosted the 1st ACLS Inter-hospital Quiz Bowl that was participated in by the five training hospitals. Questions were sourced from the ACLS 2010 guidelines, contributions from the PHA and prepared by Dr. Jun Degayo, quiz contest head Dr. Dexter Dale Briones was the quiz master.

Well attended by interns, PGIs, residents and cardiologists from Iloilo, emerging as grand winner was the Iloilo Mission Hospital with its quizzers Drs. Kenneth Griengo, Josie Jaranilla, Kahlil Triumfante and JG Padojinog. Their coach was Dr. Matias Apistar. The team received a trophy and P7,000.00.

The second place went to SPH followed by WVSU-MC. The 2nd and 3rd placer also received a trophy and cash prize of P5,000.00 and P3,000.00 respectively.

Simultaneously conducted were the quiz and poster-making competition that showcased the artistic side of the doctors and hospital employees. Nine individuals from all the participating hospitals joined the contest with the theme of “World Heart Day”. Kent Pareja from TMC-Iloilo got the first place.

On day 2 the activity started at 5:30 am with a fun run followed by Zumba dances led by the representatives from different institutions. More than 200 participants enjoyed the activity. The event commences with the awarding of winners from the ACLS quiz bowl and poster-making contest.

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**VIS-MIN Sub-Editor: Bernadette S. Halasan, MD**
Thereafter, the FBS and cholesterol screenings followed. In line with this year’s theme, PHA Cebu Chapter launched Sports Cardiology in the city which according to the current Chapter president Dr. Carolyn Fermin, is a discipline dedicated to the cardiovascular care of athletes and individuals of all ages who are into an exercise regimen.

And asked why Sports Cardiology? It’s simply because you put your HEART into it! Lay fora were then conducted which tackled on Strategies to Prevent Exercise Related Injuries, Return to Exercise After Surgical Repair of an Injury, and Sports Cardiology which were expertly discussed by the gurus of sports, orthopedic and cardiovascular medicine namely Drs. Rhoel Dejaño, Antonio San Juan and Ma. Rosan Trani, respectively. The event was then capped by an hour Zumba Fest as well as the awarding ceremonies for the winners of the Fun Run.

Cebu City, Sept. 28, 2014—Cebu PHA Chapter successfully celebrated this year’s World Heart Day simultaneously with the rest of the PHA chapters in the country with the theme “Create Heart-Healthy Environments.” The Chapter started off the early morning activities with a 3K and 6K fun run that gathered people from all walks of life.

By: Bernadette Santiago-Halasan, MD
**ACLS Trainers’ Training: A first in Cebu**

By: Cecile Cabias-Jaca, MD

CEBU CITY, Sept. 13, 2014 – Due to the increasing number of demands for BLS/ACLS in Cebu City and the Visayas, the PHA-Cebu Chapter requested PHA National chapter to grant the former’s request to train trainers in Cebu. Cebu Chapter’s request was granted.

Last September 12 & 13, PHA Cebu Chapter held its first BLS/ACLS Trainors training at Quest Hotel wherein about 9 PHA members renewed their certification as trainors (including one from Tacloban) and about 21 first-time participants (including one from Bohol) joined. The course was conducted by trainers Dr. Louella Quijano, the chapter’s Resuscitation Committee Chair and Dr. Jobert Mejia, the course director and was spearheaded by the chapter president, Dr. Carolyn Fermin and graced by PHA Manila CPR council members Dr. Orlando Bugarin and Dr. Don Robespierre Reyes with PHA National Vice-President Dr. Alex Junia.

DIPOLLOG CITY, Sept. 28, 2014 – A Cardiovascular Disease Risk Screening and Consultation started the Chapter’s World Heart Day (WHD) celebration. Spearheaded by the chapter President Dr. Richard Myles Montesclaros, it was conducted in cooperation with the DepED division of Zamboanga del Norte with more than 200 participants.

“We opted for a BP ng Teacher Ko, Alaga Ko set-up. Despite snags like logistics, we conducted a successful Cardiovascular Disease Risk Screening and Consultation last Sept. 28, 2014, in celebration of WHD 2014,” an optimistic Montesclaros, told *PHAN.*

The screening (for blood pressure determination, FBS, total cholesterol, uric acid levels, with ECG) was held at the Zamboanga del Norte Teachers’ Gymnasium. A short lecture hinged on the WHD theme: Creating heart-healthy environments was given by Montesclaros.

An AVP showing of the PHA’s banner program: the 52-100 campaign, preceded the screening. A joint undertaking among the PHA NW Mindanao Chapter, DepEd Division of Zamboanga and LRI-Therharma, Montesclaros spearheaded the activity.

“I am so thankful that my colleagues did not mind travelling far to get to Dipolog City. We could have posted a bigger attendance if not for the long distance travel. The teachers had to commute from one hour to four hours to get to the site. I can’t thank Unilab LRI-Therharma and Westmont enough for being a staunch supporter of our undertakings,” Montesclaros added.
In a free market society, the merchant sells and the consumer buys, both seeking an advantage from his side. There is expense and risk on either side: every buyer considers his need but remembers the exhortation of “caveat emptor” and the seller puts up capital for promotion in addition to the cost of the product itself. Business models always include an allowance for such promotions, as the consumer is entirely within his rights to weigh one product against another. In an ideal world, the quality of the product would speak for itself. But considering the frailties of human nature, the gift-wrapping sometimes becomes as important (or even more?) as the gift itself.

The complex relationships that exist between the health care provider and the pharmaceutical-medical device industry cannot be easily defined. While considering the frailties of human nature, the gift-wrapping sometimes becomes as important (or even more?) as the gift itself.

The Mexico guidelines:

Caught in tangled wed

Deconstructing the Doctor–Pharma Industry ties

By Celine T. Aquino, MD

“Oh what a tangled web we weave, when first we practice to deceive”

– Sir Walter Scott (Marmion, 1808)

It so happens that nature abhors a vacuum and therefore everything we do comes back to us in some way or form. There are so many possible intricate relationships between two entities, such that it is safe to say that for every beneficent effect, there is one bound to become less beneficent. In this context, a neutral relationship would be nigh impossible, especially between provider and consumer.

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provider and pharmaceutical industry does not fall into this category but does it fall under the heading of “profiting from the provision of health care”?

In May of this year, an administrative order was drafted by government agencies on “Ethical Standards for Health Product Promotion,” the objective of which was to promote the right of all Filipinos to health and health information by ensuring an honest and ethical promotion of health care products. It highlights the importance of professional ethical conduct among all involved in the industries that produce drugs and medical devices. The draft was based on two principles being implemented abroad namely, “The Kuala Lumpur principles: Medical Device Sector Code of Ethics,” and “The Mexico City Principles for Voluntary Codes of Business Ethics in the Biopharmaceutical Sector.” The Philippines signed both documents and adopted both codes in the FDA’s Circulars Nos. 2013-024 and 2014-007 with the gist being:

1 no financial or material gifts or benefits (e.g., sponsorships or foreign travels) or members of their families for the purpose of promoting products of a company;

2 Refreshments and/or meals incidental to the main purpose of the events can only be provided exclusively to legitimate participants of the event, and must be moderate. Companies are prohibited from paying expenses of accompanying guests of HCPs;

3 Companies may provide promotional aids to HCPs provided these (a) are of modest value; (b) are relevant to the practice of medicine or education of the patients; and (c) do not subsidize normal routine operations. Promotional aids should contain only the brand and generic name of the product and/or the Company name, and shall not include taglines or promotional claims.

The Mexico City Principles for Voluntary Codes of Business Ethics in the Biopharmaceutical Sector

It is not that the charter describes anything new – or unexpected. The code of professional conduct can be said to imply, if not name, everything that is embodied in the charter. Disbursements in the form of foreign travels, evening entertainment, presents and money fall under the heading of inducement, a means of persuasion to benefit the company. Such “perks” are part and parcel of any business relationship but is there reason to consider that such a practice could be detrimental to the third party, the patient?

There will always be allotment in every company’s budget for research and development, and this includes sponsoring avenues for medical updates. In any organization of health care providers, there are annual meetings and for many reasons they are usually set in the capital city. For many health care providers, the expense of the travel and time away from work is not practical and the only way to attend is via corporate sponsorship. The new charter seeks to limit this to the very bones of board and lodging. This is as it should be.

But in this aspect, the charter does not consider cultural factors. Take the Philippines, for instance. We are a naturally hospitable people and while urban sophistication may have done away with the save-all-year-blow-it-all-during-the-barrio-fiesta mentality, vestiges remain. In addition to the convention curriculum, the host society of an event goes all out to provide entertainment and frills. So how can a pharmaceutical partner do less? The culture demands an open and generous hand in the sponsorship and a board-and-lodging-that’s-all approach is tantamount to leaving a guest to his own devices, something unheard of in Filipino culture.

For quite a few of us, the annual event offers a reprieve from the day-to-day stress of work, a chance to meet up with old friends and mentors. Like policemen, medical personnel have no off-days. Physicians especially are on-call 24/7/365. We may take days off but always with the provision that some colleague is able to handle problems of patients for whom we have responsibility. Annual conventions are therefore an important part of maintaining personal and professional equilibrium.

Should the proposed administrative order put a stop to wholesale sponsorships for convention attendance as many pharmaceutical companies have started to do, then we must rethink our idea of conventions. With social media and the world wide web providing everything from medical updates to how-I-do-it blogs, these may very well go the way of the dinosaur.

As a recurring event that serves as a forum for showcasing up-and-coming speakers, innovative teaching methods and a review of the way we practice and train young physicians, the convention is also a social event during which physicians separated by geography can reestablish human contact. If it should all end, that would be a pity.

"To successfully provide effective, safe and good quality drugs, as well as to protect the people’s rights to health, it is essential to maintain professionalism and high ethical standards in the interactions among the stakeholders in the pharmaceutical industry, including manufacturers, distributors, traders, healthcare practitioners, healthcare-based institutions and patients organizations."

Final Draft of the DOH Administrative Order on Ethical Standards for Health Product Promotion. May 2014
A case of medical negligence

When a patient engages the services of a physician and the physician accepts the patient, a physician-patient relationship is generated and the DUTY of the physician begins to exist. Such duty continues until he is dismissed by the patient or he withdraws from the relationship after a reasonable notice or severance of the relationship upon the mutual consent of the parties; and the cessation of the necessity that gave rise to the relationship.

“In accepting a case, the physician, for all intents and purposes, represents that he has the needed training and skill possessed by physicians and surgeons practicing in the same field; and that he will employ such training, care, and skill in the treatment of the patient. Thus, in treating his patient, a physician is under a duty to the former to exercise that degree of care, skill and diligence which physicians in the same general neighborhood and in the same general line of practice ordinarily possess and exercise in like cases.” (Snyder v. Panteleo (1956) 143. This is what we call standard of care. Failure to employ such standard of care constitutes BREACH OF DUTY. The patient in a medical negligence case must usually demonstrate that the defendant physician departed from an accepted medical standard of care. This is the most difficult requirement to prove as the plaintiff must establish the standard of care in the place at that particular time which necessarily is variable and convince the court there is significant deviation from that standard. These most often needs the testimony of an expert witness, who is most often a colleague of the defendant unless the questioned act is really gross (i.e. leaving a gauze or a surgical instrument inside a patient’s abdomen) that the principle of res ipsa loquitur applies. In the case of a physician, the anesthesiologist committed breach of duty when he saw the patient only an hour before the supposed procedure and failed to take notes of all the vital events during the critical moments of anesthetic induction as shown by the anesthesia record. These clearly demonstrated failure to observe the standard of care demanded from all anesthesiologists. As for the surgeon, making the fastest, anxious patient wait for more than three hours inside the operating room was clearly a breach of duty and a lack of courtesy. To successfully pursue a claim, the plaintiff must prove by preponderance of evidence that, one, the physician failed to do something which a reasonably prudent health care provider would have done, or that he did something that a reasonably prudent health care provider would not have done; and two, the failure or action caused injury to the patient.

Another element in medical negligence cases is CAUSATION which is divided into two inquiries: whether the doctor’s actions in fact caused the harm to the patient and whether these were the proximate cause of the patient’s injury. The proximate cause of an injury is that cause, which, in the natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury, and without which the result would not have occurred. Just as with the elements of duty and breach of the same, in order to establish the proximate cause of the injury by a preponderance of the evidence in a medical malpractice/negligence action, the patient must similarly use expert testimony, because the question of whether the alleged professional negligence caused the patient’s injury is generally one for expert medical knowledge beyond the realm of the average layperson; using the specialized training and knowledge of his field, the expert’s role is to present to the court a realistic assessment of the likelihood that the physician’s alleged negligence caused the patient’s injury. Courts frequently call upon expert testimony to interpret and advise, after examining medical records concerning the nature of injuries,

WHILE SUBSTERNAL chest heaviness is the classic manifestation of angina (cardiac chest pain), it is not the only manifestation. Aligned with the nerve distribution (dermatomes) of the heart, the discomfort can range from jaw pain to pain in the shoulders and to the left arm and all the way to the epigastrium. There are also so-called "anginal equivalents" that are not pain but can be any of the following: fainting/syncope, nausea, cold sweats and a "feeling of impending doom". So if you are 70 (risk factor: advanced age), you should consult the cardiologist before the dentist. Remember that a toothache is unlikely to kill you.

8. Tagal nito'ng mga gamot ko. Mga 10 years na mula ang bypass ko. OK naman bawat check-up ni doc. Tigilan ko nga ….

PEOPLE, THERE IS no such thing as cure for a disorder like CAD. At best, lifestyle modification and drug therapy for hypertension, diabetes, lipid problems can stem the progression of the disease. There are some reports of regression of the disease with pharmacologic agents. When BP, glucose, cholesterol, stress test, 2D echo, etc. are reported to be normal during follow-up, it means the drugs are effective and therefore should be continued.

9. Mga brod, hindi na ako makasali sa morning hike natin... Na-angioplasty na ako.

NOW REALLY. The objective of all interventions in the patient with CAD is to ensure a better quality of life. After a successful revascularization, cardiac rehabilitation consisting of a supervised gradually increasing regimen of exercise is considered the essential next step: the objective, of course, being to return the patient to his normal routine. If you could go hiking before the angioplasty, you certainly can again after a successful angioplasty.


TIME IS MUSCLE. This is the motto of the cardiovascular interventionist and it means that the likelihood of survival and best outcome is inversely proportional to the time duration between first symptom and definitive treatment. The PHA is campaigning for early and aggressive intervention and this will only be possible with early recognition. Your doctor will not be angry if you disturb him in the night for an angina… well, maybe a little grouchy, but never truly angry. Please consult ASAP. Your life may depend on it.

Ischemic heart disease  Last of a 2-part series
When the heart stops to beat

A normal heart can stop in an instant. No other organ in the body can cease to function in a split second. The electricity that drives the heart can stop precipitously or electrical activity can become so chaotic that there is no effective heart action. The heart can go into purposeless contraction – its beats becoming ineffective to maintain circulation and life of the organism.

It was Galen, a noted physician of the 2nd century who wrote, “motus cordis a natura perficitur,” the movement of the heart is ruled by its own nature. This is probably the earliest description of the heart as an automatic organ. And in 1681, Borell noted that the heart even when removed from the body can contract for some time – “ac automa movetur,” it moves like an automation.

Generator of the heart

The generator of the heart is called sinus node pacemaker. It is called a pacemaker because it paces the normal rhythm of the heart. The sinus node pacemaker assumes the responsibility of generating the electrical current and through a system of transmission lines electrifies the whole heart to initiate a powerful contraction. The normal pacemaker of the heart suppresses subsidiary pacemakers or latent pacemakers so that only one rhythm dominates from beat to beat. When more than one pacemaker becomes active, the rhythm becomes disorderly and if not treated, electrical chaos may take over and the heart either stops or goes into purposeless and ineffective contractions called fibrillation.

Artificial pacemakers

When any type of heart disease is complicated by pacemaker disorder or the electrical current produced by the pacemaker cannot be transmitted to the muscles of the heart, an artificial pacemaker can provide the stimulus when the diseased pacemaker of the heart cannot generate current or when subsidiary pacemakers cannot initiate an impulse below the defective transmission lines and electrify the rest of the heart. Having reconstructed the transmission lines and/or provided the necessary stimulus to beef up a failing generator, the heart muscle can now contract. It is, therefore, obvious that the heart muscle must be in good condition. The decision to implant an artificial pacemaker is dependent on the health of the muscle of the heart. A badly damaged heart muscle deserves no further lease of life from artificial pacemakers. Artificial pacemakers are electrically safe. The current they provide are too weak to start chaotic heart action even when falling during a critical period of the heart cycle.

Heart attacks

Many heart attacks are complicated in the first few hours after the onset of chest pain with irregular heart beat. Statistics have it that about 60-70 per cent of patients who sustain a heart attack never reach the hospital and die because of electrical aberration. The uneven oxygenation of the muscles of the heart may spark high voltage or the attack may knock off the pacemaker or transmission lines. An alert bystander may deliver a blow on the chest and initiate a regular rhythm to supplant a disorderly electrical activity or a regular compression of the anterior chest at 50-60 per minute may sustain the circulation while waiting for definite treatment in the hospital or arrival of the doctor. The first few hours after any chest pain are therefore quite critical. In case of doubt, always check with your doctor. Not all chest pains are from the heart. Find out quickly the difference by going to the doctor now. Do not delay and cause yourself unnecessary anxiety. It could be more costly and worse, it could be fatal.
New Anti-DM drug reduces blood pressure

By Don Robespierre C. Reyes, MD

A new drug intended to control hyperglycemia independent of insulin has been shown to modestly decrease blood pressure. Dapagliflozin, marketed as Forxiga (Astra Zeneca) in the Philippines, is the newest oral tablet for Type 2 Diabetes Mellitus established to significantly bring down Hba1C levels. It is a highly potent selective and reversible inhibitor of sodium glucose cotransporter 2 (SGLT2) that results in reduced renal glucose reabsorption consequently causing glucuresis and glycosuria.

In several trials using dapagliflozin, a 3-6 mmHg and 2-3 mmHg drop in seated systolic and diastolic blood pressures, respectively was observed at week 24 of using dapagliflozin 10mg daily. No increased incidence of hypotension was seen in these trials.

In the trial conducted by Bailey et al, hypertensive patients who were not at goal BP levels at baseline were able to achieve BP targets with dapagliflozin at 24 weeks without adjusting anti-hypertensive drugs.

Investigators attribute modest dips in blood pressure to osmotic diuresis particularly, and to sodium loss to a certain degree. However, no meaningful changes in electrolytes have been observed from trials in general. Pharmacologic studies find no significant interaction between dapagliflozin and hydrochlorothiazide or valsartan.

Experts do not recommend down titration of anti-hypertensive medications upon initiation of dapagliflozin but rather a watchful observation of BP levels especially in those taking diuretics, volume depleted individuals and in the elderly who may be more prone to orthostatic hypotension. Dose adjustments in BP lowering agents may be warranted after weeks of therapy with the new anti-diabetic drug.

Weight Loss

Moreover, weight loss of about 2-4 kilograms has been observed in patients taking dapagliflozin from 24-52 weeks of treatment compared to placebo and other oral hypoglycemic agents. The weight loss is thought to be due to increased glycosuria decreasing substrates for fat deposition in the body.

Lipid Leves

Small changes in lipid profile have also been noted in patients taking dapagliflozin compared to placebo. Mean percent changes by 50 weeks of therapy compared to placebo were as follows: total cholesterol: 1.5% vs -0.7%, HDL cholesterol: 6.5% vs 2.5%, LDL cholesterol: 3.5% vs -0.7% and triglycerides: -3.9% vs 0.5%

Macrovascular Outcomes

Clinical studies have yet to establish conclusive evidence of macrovascular risk reduction with dapagliflozin. However, a meta-analysis of 14 clinical trials did not show an increased risk for adverse cardiovascular events with dapagliflozin use.

About the Drug

Dapagliflozin propanediol is a film-coated tablet that comes in 5mg and 10mg preparations. It is indicated as an adjunct to diet and exercise to improve glycemic control in Type 2 Diabetics.

It may be used as a mono therapy or as an add-on combination with metformin, a thiazolidinedione, a sulfonylurea and insulin. It could also be given an an initial combination with metformin. It is not intended for Type 1 Diabetes Mellitus patients and should not be used in patients with ketoacidosis. The drug has not been studied in patients with severe renal impairment (eGFR <30ml/min/1.73m2) and should not be used in these cases.

The recommended dose is 10mg given once a day regardless of meal intake. It is metabolized extensively and gets eliminated in the urine.

Common undesirable events include urinary tract infections (occurring in <5% of trial patients) that responded to standard care of treatment. Hypoglycemic episodes depended on the type of background therapy, with more episodes occurring in patients taking add-on sulfonylurea and insulin.

Patients taking dapagliflozin may experience polyuria. Volume depletion is not common occurring in <1%. Volume depletion may be seen in patients concomitantly taking loop diuretics.

References:

The Prospective Comparison of ARNI with ACEI to Determine Impact on Global Mortality and Morbidity in Heart Failure trial (PARADIGM-HF), presented during the recent ESC Congress held in Barcelona, Spain, excited heart failure specialists as the trial was terminated earlier than planned because of its very promising results.

What is ARNI?
ARNI is a combination of sacubitril (AHU377) and valsartan. This combination, codenamed as LCZ696, acts both on the natriuretic peptide system and renin angiotensin aldosterone system. While the ARB valsartan blocks the effects of the renin angiotensin system, sacubitril upregulates the effects of the neuropeptides by inhibiting neprilysin. This dual mechanism harnesses the heart’s natural protection against heart failure.

PARADIGM HF in a nutshell
The trial investigated the long term effects of LCZ696 (ARNI 200mg, valsartan 160mg) given twice a day on morbidity and mortality in patients with heart failure with reduced ejection fraction (HFREF) compared to the well-respected heart failure drug enalapril given 10mg twice a day.

The primary outcome was the composite of death from cardiovascular causes and first hospitalization for heart failure. Secondary outcome measures consisted of time to death from any cause, change from baseline to eight months in the clinical summary score on the Kansas City Cardiomyopathy Questionnaire, time to new onset atrial fibrillation and time to occurrence of decline in renal function.

This randomized controlled trial enrolled more than 8000 participants from 47 countries. Patients had a mean age of 63 years and mean ejection fraction of 29% presenting with NYHA Class II-IV symptoms. BNP and nT pro-BNP were on the high side and participants were on optimal medical management that included a stable dose of beta blockers and ACEi or ARB equivalent to at least 10mg of enalapril per day.

The trial ran from December 2009 to November 2012 and was terminated earlier than planned because benefits of LCZ696 on cardiovascular mortality were evident early into the trial, with the good results consistent among all specified subgroups.

In terms of primary endpoint, a 20% reduction in cardiovascular death or first hospitalization for heart failure in the LCZ696 group compared to the enalapril group (p<0.001) was seen. LCZ696 significantly reduced death
from all causes and from cardiovascular reasons by 16% and 20%, respectively (both at p<0.001). Hospitalization due to heart failure was likewise lower in the LCZ696 compared to enalapril by 21% (p<0.001). Symptoms were also more meaningfully reduced in the experimental group. New-onset atrial fibrillation was similar in both. The number-needed-to-treat to prevent one primary event was 21, and to prevent one cardiovascular death was 32.

In terms of safety, more symptomatic hypotension cases were seen in the LCZ696 arm, but these events did not necessitate discontinuation of the experimental drug. The time-to- demise in renal function was similar on both new and old drugs. The LCZ696 group demonstrated less cough and hyperkalemia compared to the ACEi group.

Better than enalapril?

Enalapril has been historically shown via the CONSENSUS and SOLVD trials to reduce mortality and hospitalization. At present, ACEIs remain to be the gold standard in heart failure management as trials on ARBs have had conflicting results.

While it is tempting to think that this new combination has the clear advantage over enalapril in patients with heart failure, care must be observed when comparing a damp towel to a soaked one.

Patients enrolled in the CONSENSUS trial involved no more than 300 participants, but were older with a mean age of 70 years, and sicker with all patients in NYHA stage IV when compared to subjects enrolled to the PARADIGM HF trial. The 20-year age gap between the two trials definitely means a difference in the definition of optimal management and therapeutic approaches.

The PARADIGM HF has more resemblance with the SOLVD trial in terms of patient profile, though the latter included not more than 3000 patients. In both trials, patients were relatively young and were relatively drier. However, ejection fraction was worse in the SOLVD trial at 25%. With the SOLVD done in the late 80s, differences in treatment standards have unquestionably affected trial outcomes likewise.

Moreover, enalapril doses in the PARADIGM HF trial are higher compared to both SOLVD and CONSENSUS trials. Logically, patients whose heart failure are more stable would have tolerated higher doses of antihypertensive agents like enalapril, and could perhaps affected the results at the end.

A company sponsored investigation, it is no wonder why valsartan was chosen to be combined with sacubutril instead of omaprilat, whose very promising antihypertensive potential was short-lived because of its life-threatening adverse effect, angioedema. Valsartan nevertheless, has undoubtedly proven its worth in heart failure with the Val-HeFt trial.

Moreover, while valsartan was titrated to a maximum dose as what was achieved in the Val-HeFt trial, enalapril was titrated to only half the dose of what was achieved in previous heart failure trials. Whether or not it was the higher dose of valsartan compared to a lower dose of enalapril that gave the edge for LCZ696 needs further investigation. To this note furthermore, whether sacubutril as an add on to valsartan spelled the difference or was just a “sugar pill” remains a mystery. Another investigation comparing LCZ696 and valsartan alone can unlock this mystery.

Applicable in the Real World?

Participants in the PARADIGM HF trial and other heart failure trials are relatively young. In our real world practice, we tend to see more elderly heart patients who prove to be more difficult to handle. Whether or not the results of the PARADIGM HF can be generalizable to the older population rests on the confidence and clinical judgement of the physician on the new drug if and when LCZ696 becomes available in the market.

Issues on its adverse effects need to be addressed. While run in periods may filter “unwanted participants” from joining the trial rendering the investigation a carefully designed methodology, it actually deviates from the real world practice where there are no actual run in periods.

The PARADIGM HF trial may have enrolled a huge number of participants, but a good number of patients were sieved out during the run in periods and after randomization. A big 10% in the run in period and another 10% after randomization were excluded because of adverse events, mostly hypotension. Practically, there was roughly 20% of the population who were intolerant to the experimental drug, and the 80% who went through the investigation represented the almost perfect candidate for the new drug.

The world awaits the final approval for this drug to be made available. In spite the perceived flaws of the trial and certain issues that surround the validity of its results, the PARADIGM HF trial has definitely given hope for heart failure patients that something that seems to be better than the present gold standard of treatment is now within reach. After quite sometime, a new promising drug will definitely shift present paradigms in heart failure management for better outcomes.

References:


Advance directive part 2

By Angelita Miguel-Aguirre, MD

Dr. Angelita M. Aguirre is a professor of Medicine and Bioethics at the University of Santo Tomas Faculty of Medicine and Surgery, an Honorary Fellow of the Thomasian Heart Specialists Alumni Association, and a consultant staff of the Makati Medical Center.

This is a continuation of last issue’s Bioethics section dealing on common important bioethical issues related to Cardiology. Our correspondent. In this issue, we feature common case scenarios and questions that are encountered.

I. Case Scenario

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

Multiple Choice

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

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

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

4. Regarding the antibiotics in this case—
A. It is still part of ordinary care and preserves life
B. It cannot be withheld because the patient’s family can afford it
C. The family should have asked the patient to decide on this when he was still mentally fit.
D. It is already inordinate at this point and will just prolong the dying process

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

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

7. In withholding CPR – the letter “A” which stands for “attempt” is now added to DNR to make it DNAr. Which is true?
A. It doesn’t really matter which terminology is used.
B. We should just continue the term DNR because it connotes success if undertaken
C. It more clearly indicates that success at resuscitation often is not achieved
D. It is up to the Bioethics Committee/Institution which term to use

8. The terminal care of an affluent patient with an important social status should be
A. different from a poor patient
B. determined by his relatives regardless of what the attending physician advise
C. dependent on what the Bioethics Committee decides
D. the same with an ordinary or poor patient based on ethical grounds

II. Case Scenario 2

M.R.A. is a 27-year-old messenger who suffered severe brain injury from a motorcycle accident. He was eventually connected to the respirator because of respiratory distress. He progressively deteriorated and by the 6rd hospital day, the Glasgow Coma scale is 3. The attending physician who is an Internist advised the family to remove the respirator so that “he can go peacefully.” The parents are distraught and want to do everything to sustain the life of M.R.A.

See Page 48
Leap of faith

A previous healthy 26-year old male was brought to the ER by his cardiologist-father when he complained of unrelenting palpitations. His 12-lead EKG (Tracing A) revealed wide QRS (0.120 sec) tachycardia at 160 bpm. The typical RBBB QRS morphology with a taller right than left “rabbit ear” favors SVT over VT on the basis of aberrant conduction of rapid supraventricular impulses. The upright QRS complexes in all six precordial leads without a transition zone favors VT over SVT. Such positive precordial concordance implies that the impulses originate from a posterior LV focus without having to traverse the interventricular septum to activate the opposite ventricle. An abnormal QRS axis of (−) 80° in this case favors VT over SVT which is consistent with a left posterior fascicular origin.

There is a type of monomorphic VT commonly observed in relatively young patients without structural heart disease in which the QRS complexes have RBBB morphology typically but not necessarily narrow QRS widths, and superiorly oriented QRS axis. This idiopathic VT is known to be re-entrant in mechanism and verapamil sensitive.

In spite of lingering doubts on the diagnosis of VT, anxiety regarding the possibility of catastrophic hypotension, and the intimidating presence of the father; intravenous verapamil was given. Within a minute, there was progressive slowing of the VT rate (Tracing B) and intermittent appearance of p waves (*) indicating the presence of AV dissociation. The latter confirmed the diagnosis of VT. Subsequently, there was an abrupt conversion to sinus rhythm with type I second degree AV block, narrow QRS complexes, and normal QRS axis (Tracing C).

The first step has to be taken in order to find out what lies ahead… even if the first step maybe a leap of faith.

“HOW WOULD YOU KNOW IF YOU’RE A FLYING SQUIRREL IF YOU DON’T TRY?”

By Edgardo S. Timbol, MD

DYSRHYTHMIC TALES

• Director, HB Calleja Heart Institute, Angeles University Foundation Medical Center
Four cardiac resynchronization therapy pacemakers (CRT-Ps) and four cardiac resynchronization therapy defibrillators (CRT-Ds) were implanted by a team of cardiac electrophysiologists consisting of Drs. Chan, Giselle Gervacio, Erdie Padreguilan, and Michael Aghayani. The cardiac implantable electronic devices were donated by Dr. Chan and Andrew Nash, with the assistance of local distributor Edge Medical Devices.

Chan, a graduate of the University of the Philippines College of Medicine, has a thriving practice in Arizona but plans to keep coming back to Manila to aid local cardiologists in various projects.

### BIOETHICS...from Page 46

**Multiple Choice:**

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

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

3. Ethical Issues in Brain Death –
   A. A Bioethics Committee is required to decide on it
   B. Any two physicians can declare it
   C. Must be determined by 2 doctors, one of them an expert on cognitive function
   D. One physician is enough to declare it

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

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

### III. Case Scenario 3

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

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

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

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

Send your replies to phil.heart@yahoo.com. Answers and discussion will be featured in our next issue.

### CARDIO & THE LAW...from Page 40

future medical, disability and other issues before the court. Clearly enough, the comatose state of the patient can be directly attributed to the failure of the anesthesiologist to intubate on time and the subsequent hypoxic encephalopathy, the DAMAGE component of the negligence. Though the surgeon’s negligence of coming very late did not directly cause the injury, he was convicted all the same being the “captain of the ship”.

This case is one of the few cases decided by the Supreme Court in favor of the plaintiff. As you can see from this case, the litigation process is very long. It took 17 years for the case to reach its conclusion. One can just imagine the sufferings endured by the doctors involved. The threat for medical negligence suits has increased in the past years and has created a lot of anxiety among medical practitioners. But unless the act is overtly below the standard of care and grossly negligent, the case rarely reaches the court and does not progress if ever. The best repellant of physicians against medical negligence suits are still the good relationship and constant communication with the patient and his family, updating one’s self regularly of his specialty to be able to conform to that standard of care, avoid treating patients outside one’s specialty unless absolutely necessary under the circumstances and document everything in the chart.

Send your replies to phil.heart@yahoo.com. Answers and discussion will be featured in our next issue.

### PHA NewsBriefs

- D. One physician is enough to declare it

- C. any family member who is present
Bohol is slowly but surely picking up the pieces caused by the 7.2-magnitude earthquake that struck the province and the rest of Central Visayas on October 15, 2013.

The tremor drastically changed Bohol exactly a year ago. Antique churches that were remnants of Spanish civilization crumbled. The shaking of the earth wrinkled and partly chopped the Chocolate Hills. Some business establishments and houses collapsed.

Three months after, inbound traffic began to swell.

Thanks to the Bohol folk for doing their best to find a sense of normalcy; the tourism moguls from the public and private sectors who have been working hand in hand to recoup the industry’s and related industries’ losses; as well as the all-out support of people and governments across the nation and globe.

Tourism’s major and beat players (who have had capitalized on God’s mind-blowing designs—the lush Chocolate Hills, verdant rainforest, bucolic beaches, magnificent underwater scene, spectacular panorama, fascinating Tarsier, etc. and man-made creations—vintage churches, charming resorts, etc., to put Bohol on the local and international tourism map) were bent on moving mountains, so to speak, to bring the tourists back.

Everyone looked at the golden opportunity under the rubble.

Actually, the intrepid Europeans and Russians were among the few repeat visitors who insisted on flying to Bohol after the disaster, according to travel agents.

Bohol Governor Edgar Chatto said “Bohol is now a good learning destination for ecology, culture, heritage, coastal environment protection, and geological tours.”

“Geo-science Tour” packages are doing well. They were conceptualized after number of local and foreign tourists expressed eagerness to see the quake’s remnants.

The ruins of the churches are now added attractions—three-kilometer long crack that traverses several farms in the village of Anonang in Inabanga town, the land mass rise in Sagbayan and the Loon and Maribojoc coastline.

Its most popular destinations—The Chocolate Hills, beaches, Loboc River, etc. are brimming with tourists again.

Bohol is internationally known as a tourist’s haven and is among the country’s Top 10 destinations.

The warm Boholanos can speak Filipino and English. Its medical community is healthy and the peace and order situation is good. GPGagelonia ♥
Feature //

“Personally, I emulate the fashion statements of Audrey Hepburn, Princess Diana, Catherine Zeta-Jones and Jennifer Lopez.”

Marienella’s well-balanced life

Whether you bump into her in the hospital, in the Convention hall or beyond the confines of the medical circle, you’ll notice people are giving this lady a second glance.

Gorgeous, she is a head turner. And her curves are in the right places. On a few occasions this writer was with this lady, she was asked if she was with an “artista”.

Dr. Maria Ronella “Marienella”, chair of the PHA Council on Congenital Heart Disease is among the PHA’s mainstay performers. Yes she is a star in her own right.

Endowed with multi-talents like the gift of healing, knack for the Arts, people skills and blessed with physical attributes, Marienella takes great pains to harness her skills and maintain her assets.

“There’s a notion that if someone tells you, you have good genes, they mean you can eat a whale and not gain a pound and you don’t do anything because you’re naturally beautiful. I believe in the motto, “No Pain, No Gain”.

Gaining weight is inevitable as one ages. So the pediatric-cardiologist adheres to her health regimen – regular exercise, and low-fat and low-calorie diet. She is enrolled in an exercise program that she is interested in to be truly motivated to go on.

“Finally, I am into ballet, a childhood dream. Ballet is great for toning and flexibility and it also trains me to have a great posture and good core stability. It is fun and invigorating. I attend Adult Ballet classes at Halili-Cruz School of Ballet three times a week.”

What makes up her diet plate? She follows the “Eat Breakfast like a King, Lunch like a Prince and Dinner like a Pauper” rule.

Among her staple Breakfast foods are: low-fat yogurt with berries, oat meal with fresh fruits (apples, oranges, kiwi, bananas, strawberries) and strictly a handful of nuts, cheddar omelet, whole-wheat bread, hard-boiled eggs and freshly squeezed orange juice.

“Lunch fuels the second half of my day just as breakfast gives me a much-needed boost in the morning. I prefer lunch that is rich in fiber,” she says. Her choices are: veggies and fruits, whole grains, beans, nuts, lean meats of grilled chicken and beef with mixed vegetables, tuna sandwich, tuna salad, chicken salad, steamed vegetables, pesto pasta, pan-fried fish and stir-fried shrimps.

She takes dinner at least 3-4 hours before bedtime. “I avoid greasy food late at night cuz it does not only disrupt sleep but also absorbs more unwanted calories and fats. I prefer light foods, like grilled fish with stir-fried veggies, chicken and pasta, fresh fruits, steamed fish in soy sauce, mozzarella cheese with tomatoes, vegetable salad with tuna flakes and parmesan cheese,” she avers.

No-no foods are soda, cookies/cakes and other sugary baked pastries, white bread, pizza, hamburgers, steaks, ice cream and processed meats/foods and junk food.

She believes that everyone who is on a diet deserves a cheat day once a week. She looks forward to rewarding herself with no-no foods like pizza, hamburgers, chocolates, steak, etc. BUT in moderation AND with control.

“My cheat day treat stops my craving, keeps my sanity in check and increases my motivation. However, I cut down on my food intake for the next few days of the week as a form of compensation,” she says.

In the past years, Marienella has been in the medical horizon limelight being a mainstay in PHA and other medical societies’ (Philippine Pediatric Society, Philippine Society of Pediatric Cardiology, Philippine Medical Association, Catholic Physicians Guild of the Philippines, Makati Medical Center, fund-raising concerts, benefit shows and weddings of colleagues) gigs.
She says, “whenever I sing to the audience, I get a certain high as though my body, heart and mind are in a harmonic convergence, a wonderful euphoric feeling of fulfillment.”

Music is a universal language and medium and has a curative effect.

“Music is the food for the soul as an old adage goes. It has the power to shift my mood, manage my stress-induced agitation and stimulate positive reaction in me. In that regard, singing and dancing truly is a form of therapy for me,” adds Marienella.

She also stands out because of her fashion sense. The fashion icons she looks up to are all Hollywood big shots. “Personally, I emulate the fashion statements of Audrey Hepburn, Princess Diana, Catherine Zeta-Jones and Jennifer Lopez. My mother is the prominent figure that has the greatest influence in my life and my fashion style. She dressed me up during my growing up years in a very well color-coordinated way from head to toe, and that explains why I carry that matching color trait till these days. I guess being a ‘fashionista’ is somehow within a personal level.”

“I may not be a professional singer per se, but somehow I am, as others say, a kind of celebrity in my own right, therefore, I have a responsibility to my audience to be presentable. I have to look my best whenever I perform and that includes being able to fit into my attire.

I don’t have any particular beauty secret. For me, a very important factor for the over-all physical beauty starts with hygiene, getting lots of sleep, drinking lots of water, no smoking, no drinking, no drugs, no late nights hanging in bars, a good balanced diet, and most, of all exercise.

On the other hand, inner beauty comes from within—having peace of mind, positive outlook in life, contentment and most of all, having love in your heart for yourself and others. These are the essential ingredients that bring out the true beauty and calm aura of a person.

Pursuing her passion keeps her going. As she puts it “my world will not be complete without singing, one my greatest passions. It is a gift from God and every time I’m invited to sing, I know somehow, I am able to touch the hearts of those I serenade.”

Most recently, in February this year, she gave in to her long-compelling enthusiasm to paint under the superb guidance of Maestro Fernando Sena. Painting is an expression of her love for the Arts. With pride in her tone, she says, “it was truly a very fulfilling experience to have been able to exhibit my paintings during the 45th Foundation Anniversary Celebration of Makati Medical Center last May 30, 2014.”

Dr. Maria Ronella Francisco’s Philosophy in life is “Always Aim to be the Best I can Be”. GPGagelonia ♥
simply means:

5. Eating 5 servings of fruits and vegetables per day

2. Limiting to just two hours of TV or computer per day

1. Having one hour of exercise per day

0. Zero to sugared beverages

0. Zero to smoking

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