PHA’s First Family

Dr. Eugene B. Reyes:
‘Registries, Research, CME and Advocacy’
BRILLIANT METAL CRAFT AND MACHINE DESIGN

BMC HOSPITAL SYSTEMS

OXYGEN GENERATOR

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Editorial

The PHA Presidency

The PHA has a new president!

Every year, a turnover occurs and the transition from one president to the next also sees the entry of a newly-elected director to the PHA Board. A new surge of energy makes way for new plans, a sharper focus, and hopefully, a determination to get things done. Admittedly, one year is too short for a president to accomplish much, to imbue his presidency with that one special thing that would define his tenure. The challenges can be daunting, and the tasks depend on so many factors that may not be easy to control.

While it is actually the Board that ensures the smooth transition and continuity of the endeavors and engagements of the PHA as an institution, the president has the prerogative to dictate the agenda and define the way forward. At 60 years, the association, through its board, has both the experience, the influence, and the wherewithal to navigate the traditional demands on the organization by its constituents. The Board takes over the helm when the president defaults or fails to make the grade. But a good president clearly makes the difference.

It takes 6 years from the time a new Board member assumes office up to the time that he earns the opportunity to assume the Presidency by election. There were instances in the past when a member of the Board got derailed from the journey to the presidency – by accident, design, or frustration. As a rule, however, a new Board member has more than enough time to capture the full meaning of where the PHA is, where it is headed, and what needs to be done. He also has about the same amount of time to figure out whether he has it in himself to lead the association. By the time the 7th year comes, he should be ready; if he isn’t, then the PHA has a president just the same – and fortunately only for one year.

In its 60 years of existence, the PHA has had a lot more wins than losses. Through the challenges and opportunities for growth, the association has produced leaders whom we remember with pride. In the last couple of years, as the association started becoming more externally engaged and made inroads in influencing cardiovascular health policies, we have also begun seeing a new brand of leadership style that augurs well for the rapidly changing terrain of healthcare.

Our new president, Dr. Eugenio Reyes, had 6 full years to internalize everything about the PHA, and to know his capabilities and liabilities in running it. He comes prepared with open eyes. He puts us at ease with his capture of the issues that the PHA must engage in, and the clarity with which he sees his role as president within the limited period he has in his hands. We wish him the best in the coming months! ♥
Over a healthy mix of pica-pica and a few sips of red wine, the two Eugenes, among God’s greatest gifts to local cardiology, talk about the PHA’s top agenda for Dr. Eugene Reyes’ term.

Reyes meets PHA Councils to chart priorities
Registries, Research, CME & Advocacy

Check which major projects are tops on the Councils’ list vis-à-vis the President’s RICH list.

Gearing up for a CPR-Ready status
To get close to a CPR-Ready Country status, the Council on CPR harnesses the “opportunities” and its “strengths”. So far, it is the first and only council that did its own CPR Strategic Planning Workshop.
BP ng Teacher Ko! Alaga Ko... spans Luz-Vi-Minda
The Council on Hypertension’s BP ng Teacher Ko, Alaga Ko has travelled far and wide. Check its trail.

Of PHA Dads, Moms, Sons & Daughters
28 Dr. Jane Galang will let you in a secret – to a successful home front and medical practice.
30 In a nutshell, 6 cardiologists talk about wearing many hats every single day.
31 Dr. Marlon Co reveals that VIPS and IT tools make things easy for him and find out the positive attitude Drs. Delta Canela and Marian Manalo share.

Cardiolsinks
This column is meant to link cardiology with various subspecialties in Internal Medicine and serves as a resource for the cardiologist on issues in clinical practice. This column is open to specialists under the Philippine College of Physicians who are willing to impart pearls from their respective field of expertise.

Cardio and the Law
This gives the PHA Newsbriefs a venue to deal with legalities of medical practice as expounded by Atty. Angeles Yap, MD (past president of PHA Northwesrern Mindanao Chapter).

Dysrhythmic Tales
This column is exclusively authored by Dr. Edgardo S. Timbol, (Director, Angeles University Foundation Medical Center HB Calleja Heart Institute) to help the clinical cardiologist unravel the intricacies of electrophysiology.

Perspectives
This column is open to all as a venue for expression.
Contributors

Cecille Jaca, MD
Several verses and poems which she would pen while passing time at the campus, saw print in her high school paper at St. Theresa’s College, Cebu. Even in medical school at the Cebu Doctors’ College of Medicine, she took on reportorial and editorial tasks as associate editor of their school yearbook. Her frenzied pace as a Cardiology Fellow-in-training at Chong Hua Heart Institute did not stop her from doing legwork and writing for PHAN.

Bernadette Santiago-Halasan, MD
Her exposure to mixed cultures in a co-ed campus at the University of the Philippines-Diliman, University of Sto. Tomas and at the Chong Hua Hospital, her cradle of medical and cardiovascular know-how, stimulated her journalistic skills.

Even in her senior year as a Cardiology Fellow-in-training in 2013, she managed to do researches which she presented in local and international meetings and write articles for the PHA NewsBeats.

Her typical day is hectic. She sees patients at Chong Hua Hospital, Cebu Velez General Hospital, St. Vincent General Hospital and Sacred Heart Hospital, where she is also a clinical professor; and is on-call as a PHA Cebu chapter member and PHAN contributor.

Jose Donato Magno, MD
Magno is a new ASCI member and the only Filipino presenter at the 7th Congress of the Asian Society of Cardiovascular Imaging. He specializes in non-invasive cardiology and is part of the consultant staff at the Philippine General Hospital, Philippine Heart Center and the Angeles University Foundation Medical Center. Serving as clinical associate professor of the UP-College of Medicine and PGH, he puts premium on the training of young cardiologists in the country.

Paul Reganit, MD
Dr. Reganit is a clinical associate professor of medicine at the UP College of Medicine. He completed his medicine residency at New York University School of Medicine and his chief cardiology fellowship at the UP-Philippine General Hospital. He holds a master’s degree in public health from Harvard University. He was Philippine Heart Association’s 2010 Most Outstanding Cardiology Fellow.

Ardith Dominguez-Tan, MD
One of Silang, Cavite’s most talented daughters is a noted cardiologist, a dedicated teacher and a good writer. Nonetheless, she is at her best in playing her roles as mother and wife.

Currently, she is at the helm of the non-invasive laboratory of the Dela Salle University Medical Center known as the Dr. Romeo P. Arniego Cardiovascular Laboratory. She is also an assistant professor at the Dela Salle College of Medicine.

Regular exercise and walking are part of her regular routine.

Columns

Dysrhythmic Tales
Edgardo Timbol, MD
“Writing is invigorating”, that is why Dr. Edgardo Timbol’s Dysrhythmic Tales reserve is bottomless. He came out with his Dysrhythmic Tales book in 2010.

His hospital affiliations are the Angeles University Foundation Medical Center (where he is the director of the HB Calleja Heart Institute) and Philippine Heart Center.

Cardio and the Law
Atty. Angeles Yap, MD
“I am a cardiologist first and foremost. Law is my second love,” says Yap, the lone female cardiologist-lawyer in the PHA family. Through her this column, she gives free legal advice to PHA doctor and lay readers.

She is affiliated with the Valencia Sanitarium and Hospital and the Lavina Hospital in Valencia City, Bukidnon.

“I have no time for litigations” she says, but she accepts medical, notarial job and gives free legal consultations pro bono.

Perspectives
Atty. Danilo Bunyi
For the last two decades, Bunyi has been with the Development Bank of the Philippines as corporate secretary. He is part time faculty at the Ateneo de Manila University John Gokongwei School of Management.

He is married to Dr. Ma. Ina Dela Paz Bunyi. The Bunyis believe that a couple that shares the same love for writing, stays together. Years back, they met at the Ateneo de Manila University campus where Bunyi took legal management while Dela Paz was a BS Psychology student.

Cardio Links
Monica Therese Cating-Cabral, MD
While keeping her academic excellence as a college senior, she was editor in chief of “Metamorphosis”, the publication of St. Louis University College of Natural Sciences in 1996. She graduated cum laude and was among the Top Ten Outstanding Students of the Cordillera Autonomous Region.

A clinician, researcher and writer, she has authored a long list of publications and researches.

Her hospital affiliations are: Asian Hospital and Medical Center, Makati Medical Center and St. Luke’s Medical Center.
Editor’s note

The entire Philippine Heart Association (PHA) and its allies will be led to perform as one toward the creation and growth of Registries, Research, Continuing Medical Education and Advocacy, in that order, under the charismatic leadership of Dr. Eugene Reyes, 62nd PHA President.

The PHA Newsbriefs (PHAN), likewise, dons a new face to match the platform and direction of President Reyes’ flagship projects.

The PHAN will categorize its contents into sections for easing reading and referencing. And each section will have its specified editor: News and Advocacy (Francis Marcellus Ramirez, MD); Features and Lifestyle (Ma. Lourdes Bunyi, MD), Councils’ Track and Registries (Myla Supe, MD); Chapters’ Track and Hospital Observer (Bea Medrano, MD); Alumni Page, and A day in the life of a Fellow (Irwin Bundalian, MD); Pediatric Cardiology (Ina Bunyi, MD).

PHAN features the Academic and Research Section, which will be headed by Don Robespierre Reyes, MD. Under this section are assigned editors for the different subspecialty sections that are tasked to create a Continuing Medical Education Plan for the year (July 2013-June 2014).

The editors will, thus, tap key members who may write out their CME plan (e.g., back to basics or what’s new in the field, etc.) and they can be contributors themselves. Members can write directly to them for inquiries, suggestions and contributions:

- Acute Coronary Syndrome and Interventions: Ariel Miranda, MD
- Cardiac Rehabilitation: Antonio Sibulo, MD
- Cardiovascular Surgery: Christopher Cheng, MD
- Cardiovascular Imaging: Edward Benjie Magsombol, MD
- Echocardiography: Mary Ong Go, MD
- Electrophysiology: Clara Tolentino, MD
- Lipidology: Lourdes Ella Gonzales-Santos, MD
- Sports Cardiology: Frederick Cheng, MD
- Vascular Diseases: Jenny Beltran, MD

PHAN shall continue to bring its readers the standard columns: Cardiology and the Law by Atty. Angeles Yap, MD; Dysrhythmic Tales by Eduardo Timbol, MD; and Cardiolinks to connect Cardiology with all the other subspecialties of Internal Medicine. Soon, the PHAN favorite sections: “Excess Baggage” and “Escape Beat” by Editorial Consultants Dr. Eugene Ramos and Dr Saturnino Javier, respectively, will grace PHAN anew.

PHAN staff and contributors would appreciate contributions from all Members to make PHAN a relevant venue for a healthy exchange of career, social and family life balance, while being the mouthpiece of the PHA for its programs and projects.

We assure the members and readers that PHAN will always have a place for you and your thoughts. Discover yourself through your involvement with the PHA and the PHA Newsbriefs!

Together for a more progressive and dynamic PHA! ♥
I am honored to be the 62nd president of our beloved Philippine Heart Association. I have never felt so privileged and proud, because as I accept the PHA leadership baton, very important people in my life are with me on this very special occasion – a good number of past PHA presidents, some are my mentors; my beautiful wife, Amalia and my soon-to-be-born, son; and my ever-supportive sister, Ditas Reyes-Gonzales, the representative of my siblings; who have inspired and motivated me to excel in all my pursuits and achieve my dreams…

Collectively, my flagship project is nicknamed RICH as in Research, Institutions, Collaboration and Harmonization, pivoted on the RICH (respect, integrity, commitment and honesty) key values.

Please allow me to be more specific. You will see and be part of these major activities: Series of Research, Regional Collaboration Reinforcement; Chapters/Councils Empowerment; Membership Activation; Advocacy Fortification and Committee on Legislation Activation.

Driven by my commitment to advance cardiovascular education and care, the PHA will step up its pace and widen its horizon.

These are huge tasks but they are practical and doable. The Board of Directors can’t do them alone. With your active support and involvement, this voyage will be smooth-sailing and the PHA will soar to greater heights. Thank you and good night. ♥
From the President’s desk

**SBAC has 2 new sub-committees**

**CEBU CITY, July 12, 2013**

-- The Specialty Board of Adult Cardiology’s (SBAC) requisites will be integrated with Philhealth and HMO requirements. Prior to the approval of re-accreditation of the various training program, SBAC must assess the performance of the training institutions, through the regular submission of performance measures.

The Board created the SBAC Committee on Core Curriculum to standardize the training program of all accredited institutions and the Committee on Accreditation; and to formulate policies and guidelines for the accreditation and certification of institutions for Adult Cardiology Training.

SBAC has to be provided with information about the areas of practice of members to help develop training programs in the different localities with the long-term objective of even distribution of cardiologists practicing in the country.

PHA President Dr. Eugene Reyes made this announcement during his Chapter rounds in Davao, Southern Tagalog Region and Cebu.

Reyes flew to Cebu to visit the training institutions and administer the oath of the 2013-2014 officers under the leadership of Dr. Wilfredo Ypil Jr.

Chapter prexies to issue good standing certificates

**CEBU CITY, July 12, 2013** – A PHA Certificate of Good Standing signed by the Chapter president is a prerequisite to the PHA national society-issued certificate of good standing.

The certificates of participation/endorsement should be signed by a Chapter president, Council chair or Committee chair.

In his working trips to Cebu, Davao and Southern Tagalog, Reyes ordered the Chapters to draft guidelines that are applicable to their areas. These guidelines will be submitted to the Board and will be merged with the output of the other Chapters.

Reyes also called on the cardio diplomates to be active in the projects and programs of the PHA prior to their induction as PCC fellows.

**HeartLine, PHA web resume**

**MAKATI CITY, July 10, 2013**

-- Readers of the Philippine Star “HeartLine” will be happy to read more heart columns following the renewal of Merck Sharp & Dohme (MSD) commitment to sponsor “HeartLine.”

Authored by incumbent PHA President Dr. Eugene Reyes, “HeartLine” will see print every other Tuesday from July 2013 to June 2014.

The MSD sponsorship also covers the PHA website E-library, 45th PHA Annual Convention Website and the registries.

The announcement was made by Dr. Beaver Tamesis, MSD Cardiovascular Medicine business unit director.
Reyes meets PHA Councils to chart priorities: Registries, Research, CME & Advocacy

By Gynna P. Gagelonia

PASIG CITY, July 6, 2013 – Registries, Research, Continuing Medical Education and Advocacy (Knowledge, Attitude and Practices) make up the flagship project of Philippine Heart Association (PHA) from July 2013 to June 2014, under the stewardship of Dr. Eugene Reyes, PHA president.

Reyes facilitated the half-day, compact 2013 Councils and Committees Strategic Planning Workshop held at the PHA Heart House at the Philippine Stock Exchange Center Building, Ortigas, Pasig City.

He stressed “we have to ensure that the functions of the Councils, Committees and Chapters are up to date. We ought to identify problems and needs.”

Fifteen of the 16 PHA Councils presented their project scheme with timelines and particulars.

The PHA Councils on Coronary Artery Disease, Hypertension, Cardiac Catheterization, Cardiac Rehabilitation, Congenital Heart Disease, Electrophysiology, Heart Failure, and Surgery will engage in registries.

Research delving into knowledge, attitude and Practices (KAP), will be tackled by the Councils on Cardiopulmonary Resuscitation and Rheumatic Fever and Rheumatic Heart Disease.

The Councils on CPR, EPS, Echocardiography, Cardiovascular Anaesthesia and Cardiovascular Imaging will also contribute to CME.

Four councils (Hypertension, RF-RHD, Preventive Cardiology and Stroke and Peripheral
Vascular Disease) will do lay awareness Advocacy.

**Extensive Documentation**

The Council on CAD's ongoing "Acute Coronary Syndrome Registry" which started in November 2011, renewed its pledge to nurture this endeavor. It aims to get fresh enrollees and a higher follow-up rate with the great support and backing of the Specialty Board of Adult Cardiology. The quarterly internal validation of charts will be done in September this year and in January 2014. Its annual report will be one of the highlights of the 45th PHA Annual Convention in May 2014. Some P1.5 to 2M is earmarked for the ACS Registry. Dr. Liberty Yaneza is at the helm of the council.

Under the baton of Dr. Richard Henry Tiongco III, the Council on Cardiac Catheterization's "Catheterization Registry" data are currently being finalized. The protocol/consent forms and the electronic data form should be completed in August and September, respectively, this year. The Pilot test is slated for October while the assessment of the pilot test takes place in November, and the launching will be by yearend 2013. This project will need more or less P1.5 million.

It will take eight months (from August 2013 to February 2104) to work on the "National Registry of Congenital Heart Diseases" protocol; three months (March to May) to establish the registry, according to Dr. Maria Ronella Francisco. The period from June to December 2014 will be meetings of the pediatric cardiologists. The acquisition of software will be done within January or February 2015, while the following month will be dedicated to data collection.

Dubbed "Cardiac Rehab Research Paper Archiving and National Cardiac Rehab Registry", Council on Cardiac Rehabilitation chair Dr. Carlos Ponciano Esguerra said, right now, they are identifying the institutions, collating/archiving the research papers.

November 2013 to February 2014 will be project selection and identification of variables/parameters. The launch is set for March 2014. The Council earmarked P50,000 for this project.

A P1.150-million venture, the "Pacemaker, ICD, CRT and Ablation Registry" of the Council on EPS, led by Dr. Gladys Ruth David, is currently in the protocol-making stage that should be finalized by October; approved by the Research Committee in November; and presented to the PHA Board in January 2014. Protocol Presentation to Physicians/Hospitals and Implementation will take place in February and March 2014.

With a whopping P3-million budget, the "National Heart Failure Registry" of the Council on Cardiovascular Surgery chaired by Dr. Aquileo Rico is now in the process of formulating the registry and MOA with participating cardiac surgery centers till September. Training of registry personnel will be done during the last quarter of the year. The Council will usher in 2014 with a fresh harvest of quarterly data with data analysis. Collection of new batch of data ensues from February to May 2014. Two pharmaceutical companies expressed interest in sponsorship of this project.

The "National Heart Failure Registry" of the Congestive Heart Failure council manned by Dr. Ma. Adelaida Ibboleondy is in the groundwork stage. September and October are set for meetings with hospital trainers and the group. A workshop follows in November. Data collection begins in January 2014.

Dr. Irma Yape, Council on Hypertension chair reported that the P3-million "Presyon 3" is ongoing, however, no timelines on results or completion were provided.

**Seamless schooling**

On the EPS council’s drawing board are the “EPS Summit: Bradyarrhythmia gathered data and come out with a comprehensive report on “RF/RHD Knowledge, Attitudes and Practices”, with a minimal budget of P15,000 to P20,000.

With the PHA goal to bring CPR knowledge to every home and community, the Council on CPR chair Dr. Orlando Bugarin said that this is the right time to tackle the “Research Study on the KAP on CPR in the Philippines”. So far, on the first two months of this fiscal year, it accomplished strategic planning and the formulation of protocol. The dissemination of data sheet and questionnaire will be in September. Collection of data will take six months – from October 2013 to March 2014. Presentation will be in May 2014. Budget was not provided.

**In-depth Research**

Council on RF/RHD head Dr. Ma. Bernadette Azcueta vowed to explore/analyze
right now, selection of areas and coordination are taking place. Implementation begins in September. This is a P300,000 venture.

The “Echocardiography Bimonthly Scientific Symposium 2014” of the Echo council chaired by Dr. Joyce Jumangit is in the planning phase. Collection of cases and collaboration with the training institutions; finalization of topics and venue will happen from September to November. Implementation will be in January 2014. Budget per meeting is P9,000.00

The Council on Cardiovascular Anesthesia and Critical care under the leadership of Dr. Elmer Linao, will conduct the “Critical Care Management Protocol Bi-Monthly Meeting 2014”. Planning/meeting and presentation of topics are ongoing. By September, a meeting with all the Cardio Fellows/Consultants and Section chiefs will be called. Preparation of interesting cases and approval of cases for discussion should take place in October, followed by the finalization in November and dry run in December. Implementation will be in January 2014.

Dr. Edward Benjie Magsombol, chair of the Council on Cardiovascular Imaging opted to pursue “Continuing Education on the Appropriate use of CV Imaging”. The 1st CVI and 2nd CVI forum are slated in September and November while the 3rd CVI and 4th CVI will be in February and April 2014.
Far reaching Advocacy

The Council on Hypertension which has been heading in the right direction (in terms of schedule and impact) with the Department of Education and LRI-Therapharma, is bent on pursuing BP ng Teacher Ko… said Dr. Irma Yape, Council chair. The BP ng Teacher Ko… memorandum of agreement signing will be in September or October this year. BP ng Teacher Ko requires a P1 million annual budget.

The screenings of school children and lectures about hypertension prevention/management will initially be conducted in two Quezon City public schools. Other identified areas are Cagayan Valley, Vigan, Ilocos and Marinduque, said Azcueta. Budget was not indicated.

The PHA-Metropolitan Manila Development Authority Smoking Cessation Partnership Program will be sealed on September 26, 2013. It is an undertaking of the PHA Council on Preventive Cardiology chaired by Dr. Noel Rosas. Concretization and completion of the project’s modules will be done in September, while the series of lectures will be whole-year round. No budget was provided.

Aptly nicknamed “PAA” as in “Peripheral Artery disease Awareness” will have the Council of Stroke and Peripheral Vascular Disease as lead implementer and the DepEd and Commission on Higher Education as partners; with the support of the Philippine Society of Vascular Medicine and Otsuka. Council on Stroke/PVD chair Dr. Maribeth delos Santos said that a PAD module in the works. They are looking at a media partner, preferably a radio program for a PAD consultation on air program. For this year, two lectures are in their pipeline. Their working budget is P201,300.00.

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Vision: The PHA Council on CPR shall be a leading organization in the Philippines in providing CPR training and be recognized and respected globally.

Mission: To teach, educate, train and certify adult and pediatric CPR providers -- who are healthcare practitioners (medical, allied medical practitioners or emergency medical technicians) and the Lay.

Gearing up for a CPR-Ready status

PASIG City, July 27, 2013 – In its bid to clinch the “Philippines: A CPR-Ready Country” tag and the declaration of “National CPR Days”, the Philippine Heart Association (PHA) Council on Cardiopulmonary Resuscitation (CPR) set aside this day for the CPR strategic planning workshop, held at Richmonde Hotel on San Miguel Avenue in this eastern city.

PHA President Dr. Eugene Reyes called on the Council to sustain the momentum. The Board will support the Councils’ endeavors, to get close to hitting its goals. It will seize the “Opportunities” of doing lay Advocacy utilizing multi-media; research; comprehensive BLS/ACLS training programs for medical professionals/allied member, including Training the Trainors with a bigger class size; formulation of guidelines; working out the integration of CPR in grade school to college curriculum thru DepEd; and automated external defibrillator, according to Dr. Orlando Bugarin, chair of the PHA Council on CPR.

All health professionals and workers, even cardiologists are required to undergo BLS and ACLS trainings every two years to learn new techniques/guidelines. This will redound in improve survival of patients in cardiac arrest.

The PHA became International Liaison Commission on Resuscitation (ILCOR)-accredited in 2010 during the tenure of Dr. Marcellus Francis Ramirez as Council chair. Buoyed by its feats, the Council has lived up to its reputation as the most active and revered council that has been conducting BLS/ACLS trainings around the country. It takes pride in its “Strengths” -- an established and standardized training program; highly competent members/trainor; growing number of members; enough equipment; international recognition; network/partnerships with hospital training institutions; non-government agencies and media; very affordable/accessible quality CPR training and a supportive PHA Board and members.

The “weaknesses” (research deficiency; financial snag; dwindling commitment among the trainors/members; technical/management support/manpower; participation in international conventions and literature/reference materials (library); lacking in data recording/filing/documentation/database/registry) will be reversed by the “opportunities”.

The mushrooming of American Heart Association-accredited, Department of Health-initiated CPR trainings, failure to meet the hike in demand for trainings and CPR Certificate piracy are the “threats” the Council has to confront.

GPGagelonia
There is a 30 percent hypertension prevalence among at least 6,000 public school teachers in the country. This development in the BP ng Teacher Ko, Alaga Ko was given by Dr. Irma Yape, chair of Philippine Heart Association (PHA) Council on Hypertension, which is in charge of the three-year-old BP ng Teacher Ko project.

BP ng Teacher Ko has been to 21 schools in Luzon, Visayas, and Mindanao. These schools were picked at random by the Department of Education, a partner of the and LRI-Therapharma in the national BP ng Teacher Ko... project.

In July and August 2013, The Council was in Iloilo City, Ragay and General Santos City.

The BP check includes sugar and cholesterol level tests. Of the 21 destinations of the BP ng Teacher Ko... caravan, 19 were done in public schools while two were conducted in the Department of Education offices in Pasig and Quezon City.

BP ng Teacher Ko... aims to establish the prevalence of hypertension among the public teachers and educate them about hypertension prevention and management.
Ragay, Camarines Sur

Virac, Catanduanes

Gen. Santos, South Cotabato
World Heart Day 2013 trail

PHA takes MMDA as partner

Metropolitan Manila Development Authority (MMDA) is the Philippine Heart Association’s (PHA) World Heart Day 2013 partner.

This is breaking the 11-year tradition of taking a city/town as WHD partner.

“Buoyed by the digression and man-on-the-street concept, we are casting our sights on the MMDA field workers,” said PHA Secretary Dr. Alex Junia, concurrent WHD 2013 chair.

The Geneva-based World Heart Federation chose “Take the Road to a Healthy Heart” as WHD 2013 theme.

MMDA Chair Francis Tolentino warmly welcomed the alliance proposal of PHA. The PHA-NCR World Heart Day Fair will be held on Sept, 26, 2013, 7:30 am to 12nn at the MMDA Compound in Guadalupe, Makati City. Some 300 hundred MMDA field workers and employees will be subjected to risk factor screenings (BP, body mass index check-up, blood sugar and cholesterol level tests, ECG) and will participate in the Healthy Lifestyle lay lecture and Basic Life Support (CPR) lecture/demo. The event’s highlight is the signing of PHA-MMDA Anti-Smoking Campaign manifesto.

PHA is a staunch anti-smoking advocate because smoking is one of the risk factors of cardiovascular diseases.

Junia added that the results of their tests will be collated and incorporated with the heart fair risk factor registry.

The PHA represents the Philippines in the WHF roster of and takes the lead in the WHD celebration in the Philippines. WHD urged its 200 member-nations to include public talks and screenings, walks and runs, sporting events and many more in their WHD activities.

Junia Tolentino

Pre-publicity stunt

The peg: “Profile the men on the street” proved to be effective.

GMA 7 Kapuso Foundation Bisig Project will support the PHA-led WHD 2013 through a Free ECG Work-Up with six PHA cardiologists manning the consultation desks, on Sept. 28, 2013, 7am to 12 noon at GMA 7 Compound, 11th Jamboree St., Quezon City.

PHA Vice President Dr. Joel Abanilla will lead the team of heart doctors from the Philippine Heart Center and St. Luke’s Quezon City. Dr. Reynaldo Neri, former chair of the PHA Council on Hypertension will deliver a lecture on hypertension prevention and management in the vernacular.

Patients will come from relocation sites in neighboring towns of Metro Manila.

ABS-CBN Salamat, Dok on Sept. 29, 2013, 7:30 am will have PHA President Eugene Reyes as resource person on a gamut of heart health concerns and issues and about the history and significance of the yearly international WHD celebrations.

UNTV Good Morning Kuya’s heart segment (7:15am) will usher in the September 29, 2013 simultaneous international celebration thru a daily interview with a PHA guest from Sept. 23 to 27, 2013. UNTV is located at UNTV Building on Edsa-Philam Homes, Quezon City.

The Sept. 10, 2013 PCP Health forum will be an avenue to endorse the series of PHA activities in Manila and in the PHA chapters.
Aimed at advancing the art and science of the sub-specialty in the Asian region, the Asian Society of Cardiovascular Imaging held the 7th installment of its annual congress at the China National Convention Centre from Aug. 16-18, 2013.

Attracting a high-level group of 525 of delegates composed of radiologists, cardiologists and imaging specialists from various countries, the ASCI 2013 became a fertile ground for the latest and most advanced developments in the dynamic field of cardiac imaging.

The scientific program put certain imaging modalities under the radar, particularly computed tomography and magnetic resonance of the CV system. Dr. Daniel Berman (USA) made a succinct presentation on the future role of cardiac imaging in the management of patients with heart disease. Banking on his expertise as chief of Cardiac Imaging and Nuclear Cardiology at the Cedars-Sinai Heart Institute, Berman highlighted the use of positron emission tomography (PET) for the quantification of absolute myocardial blood flow, the value of molecular imaging in the differentiation of stable from active atherosclerosis, as well as the emergence of novel risk factors for CV risk assessment in intermediate-risk patients.

He also emphasized the concept of “value-based medicine” wherein technological assessments are utilized on the basis of their impact on management and clinical outcomes.

One classic example of enhanced technology

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Rosy atmosphere ahead

BEIJING, Aug. 18, 2013 -- As experts from Asian nations work together to come up with the best possible imaging results for our patients, the horizon for the science of cardiovascular (CV) imaging is not as blurry as it once seemed.

The author with ASCI President-elect Dr. John Hoe of Singapore
**PCP-PHA Heart Health Forum**

**Start them young**

By Gynna P. Gagelonia

On a regular basis, the Philippine College of Physician (PCP) Health Forum at Annabel’s will be an avenue for the Philippine Heart Association (PHA) and media to exchange information and dissect the news.

Every first Tuesday of the month, starting in July 2, 2013, PHA will host the PCP breakfast forum; and as long as a slot is available, the PHA can use the forum for special announcements.

“Being an institution, the health forum is the perfect vehicle for the much-needed mileage of the PHA’s Advocacy undertakings that have been work in progress,” said Dr. Jonas del Rosario, PHA Director and concurrent Advocacy Committee chair.

In a formal letter sent to PHA in June, PCP chair of Media Communications Committee chair Dr. Rolando Balburias said that part of the reformatting tack of PCP is to open the every-Tuesday Health Forum to medical societies.

The PHA Board of Directors welcomed the invitation and agreed to take six slots for one year.

**A GOOD START**

Thirty media people (from ABS-CBN News and Magandang Gabi, Dok, TV5, PTV4, Net 25, UNTV, PNA, H&L, Radyo Inquirer, Business Mirror, DZME, etc.), all Health Forum regulars and PHA’s media friends -- covered the July 2, 2013 PCP-PHA Health Forum at Annabel’s on T. Morato Ave., Quezon City.

The messages of the panel of speakers -- PHA officers – Drs. Eugene Reyes, Jonas del Rosario, Helen Ong Garcia, president and directors, respectively; DepEd’s Dr. Ella Napolonguit and celebrity chef Nino Logarta, stimulated media well. The gimmick -- distribution of free samples of “Chicken and mushroom patty with chimuchurri sauce”, a concoction of Logarta was a hit and became a photo opportunity.

“Heart Health Habits: Start Them Young” was the focal point of the discussion.

♥

**Drs. del Rosario, Reyes & Chef Logarta, Drs. Napolonguit and Ong-Garcia**

Mediamen

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**Health Forum generated Media mileage**

- **ANC News**
  How to prevent kids from getting sick; Healthy foods in the campus
  07/2/13

- **ABS-CBN**
  Salamat Dok
  Host: Atom Araullo
  Hypertension among kids
  07/14/13

- **Radyo Inquirer**
  12nn news
  Start the Kids Young
  07/02/13

- **Phil. News Agency**
  Celebrity chef shares tips to healthy cooking
  07/3/13

- **DZEC News**
  Raising Healthy Kids
  07/3/13

- **DZEC Health Watch**
  Cheap, healthy and easy to cook dishes
  07/08/13

- **PTV4 News**
  Start the kids young...
  7/4/13

- **Project Food FB Acct.**
  Heart Health Habits: Start them young (with pix)
  Vital Signs
**44th PHA Annual Convention Media Mileage**

**Phil. Star**
Menarini brings Nobel Prize Awardee to Mla 05/30/13

**IBC**
PHA@60: Strategies, Realities ... 05/29/13

**Net 25**
Nitric Oxide 05/30/13

**UNTV**
Nitric Oxide 05/30/13

**Abante Tonite**
HPN among public school teachers 06/01/13

**PTV4 News**
Hypertension 06/01/13

**PDI**
Menarini brings Laureate scientist to Manila 06/07/13

**ANC Pipol**
Dr. Fabio Enrique Posas 06/07/13

**TV5 Aksyon Weekend**
New Medical Treatment story 06/29/13

**Men's Health**
Endothelial Dysfunction June/13

**DZMM**
Hypertension 07/18/13

**BusinessWorld**
Blurb quote Dr. Irma Yape Easing the Tension (Hypertension) 7/18/13

**Phil. News Agency**
1,400 medical practitioners join PHA confab

**Phil. News Agency**
Younger stroke, heart web attack sufferers due smoking

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**Dr. Saturnino Javier on DZMM Salamat Dok with Nina Corpuz**
By Eugenio Jose F. Ramos, MD

HAN Editorial Consultant Dr. Eugenio Jose F. Ramos takes time out of his busy schedule to pick on the brain of an equally busy cardiologist, PHA President Dr. Eugene B. Reyes to dissect his one year agenda for PHA.

**EJFR:** Congratulations for the opportunity and the privilege to be the leader of a such a well-respected association, the PHA. It's been 61 years that the PHA has been around and during those 61 years up to now, it has achieved a lot and a lot of presidents and leaders have come and gone. Some of them in a major way, some in a minor way. I would like now to start our conversation with the question, where do you place yourself in the 61 years and how do you project the PHA is going to be at least in the next 5 years?

**EBR:** I place myself on the 62nd because I am the 62nd president. I am ahead of everyone because I am the leader of the current year. The PHA is striving to reduce cardiovascular (CV) burden in its own influence. People expect so much from PHA. The PHA is the Advocacy arm of the Department of Health when it comes to CV disease information campaign.

A lot of developments will be generated by the two-prong things that I will do: Heart disease prevention to the highest standard; and better quality of treatment.

For years, the PHA has focused on prevention. As clinicians, we see a lot of marginalized people. I think 75 percent of the population belong to the C&D economic status. They can go to an organization that promotes awareness. We should continue to pursue lay awareness education. We may not be effective in the population level but in the individual level, we can be effective. Another role of the PHA is to put quality on the training standards to the highest level. With my instruction, the Specialty Board of Cardiology created a sub-committee on core curriculum to standardize the training of Cardio Fellows, side by side with the sub-committee on accreditation. Part of its task is to see to it that a particular institution is implementing the core curriculum. When the SBAC gives an exam its basis is the core curriculum that is adapted to local practice, not Braunwald. Subspecialty trainings will also be standardized through the Specialty Board of Cardiology.

*What are the measures of the core curriculum at the end of five years?*

We need a map to draw our direction. We don't know where we are so we want to measure from a pattern, designed from the guidelines we have created.

*I'd like to pursue what you said that we don't know where we are. That is an indictment. In other words, in the past, we were basing our decision on perception?*

Because we don't have the numbers. In the past, leaders based on the reality. How people perceive us is a good metric. Right now, we have the numbers, we can measure just like GPS we know where we are. Our only problem is how to translate it into numbers. For example, we are always

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**Heart disease prevention to the highest standard; and better quality of treatment.**
As a PHA president, I want to be remembered as a focused leader; somebody who utilized research for policy changes to improve healthcare.

Heart-to-heart with **DR. EUGENE REYES**
present in conventions held in Asean countries, after that we have established our relations with the American College of Cardiology.

Maybe we have to change our perspective. All people are going to die. We can’t prevent death but we can prevent premature death. There must be another way of measuring the effectiveness.

I think the cardiologists over the years have been effective because the epidemic has made the cardiologist an important fixture. Up to what extent are we focusing on the other aspects? Are we just on the receiving end?

Our past presidents have focused on prevention. Most of us are focused on treatment. Everybody is coming up with treatment guidelines. So why not put treatment to the highest standard?

You mentioned that it is an advocacy in a sense... governance the media, the lifestyle the global trends. Up to what extent can the PHA gain some anchor on partnerships and policy making?

We are a member of the World Heart Federation (WHF). Every year, we give a report. The World Health Organization assigned the WHF to represent all associations during the association meetings. This is our problem. The WHF is convinced that the United Nations should direct the WHF members from Third World countries to focus on health.

What is the impact of this?

We will try to influence public health. We have major influence on Philhealth. It is merely utilizing research into policy-making. I think we have somehow influenced Philhealth to increase the MI (myocardial infarction) benefits for Philhealth contributors.

President Benigno Aquino III has allocated P10 billion every year to Philhealth. It’s like a cycle. We urged the government to increase the budget for public health. Why not draw the P10 million from PDAF rather than get from the gross national product. It’s very hard because of politics.

The President will definitely increase PhilHealth benefits from P12,000 to P18,000 but we are not yet satisfied. We are proposing for an expanded coverage for all the patients. We are lobbying for a P25,000.00 coverage for any MI acute coronary syndrome. This is the right price for a specific disease.

In the next months that you are president. What are the things that you can achieve?

Philhealth’s standardization of the quality of care... lobbying for more legislation like the AEDs (automated electronic defibrillators) which is a life-saving tool that every establishment should have. We will pursue that. Here at the Philippine Stock Exchange Center, a 30-floor building that houses big companies, we are the only one equipped with an AED. In a matter of months, we are convinced that the Philhealth coverage will be higher.

That is a good one, all buildings have AEDs some Congressmen are just waiting. Do we have allies in Congress?

Yes, but if we don’t see concrete results in Congress, we will go directly to the mayors, Metropolitan Manila Development Authority is one. I will be able to convince the mayors of towns and cities who will see the wisdom of having an AED. Eventually, more and more will follow.

What are the changes in your mindset? Perception and attitude.... When you were elected you have certain perception.. Every year until seven years later, you saw the past presidents doing their own thing.
Nothing, it is just a continuity of plans. I changed a lot, in terms of competence, I learned how to manage. I can be a good manager now. I know how to handle people, do strategic planning, how to make budget, how to deal with difficult situations especially politics. I know how to say ‘no’ and ‘yes’. I have a direction, I need a mover.

May is going to be the end of your turn. How would you like to see yourself in terms of how you will deliver your valedictory.

When you enter the Board, you already have a plan. My plan was how to translate Research into policies and better patient care, eventually. One year as president is never enough but the six years that I was with the Board, prepared me well for this post. When you become president you execute what you have done in the past six years, and that is what I am doing now.

What really is the vision of the PHA?

Kinda abstract for me. Realistically, we are the leading, not a leading heart society. There is no other organization here if you are referring to a big group of cardiovascular specialists. It is only the PHA.

What do you think is the kind of leadership that would be necessary? What kind of strength? There is no way you can affect change... without governance...

I totally agree with you and that is what we have been doing. There are doctors who got into politics. They lost their focus. They have conflict of interest. They lost the health and the care. We need a good doctor who can represent us in Congress and in the Senate.

What kind of research will the PHA benefit from?

I have initiated it already --the Acute Coronary Syndrome Registry. Based on survey, in most cases, the onset of symptom is about 48 hours before a patient goes to the hospital because of the high expense fear factor. With Philhealth’s inclusion of heart diseases, patients will go the ER right way. Now, we need to lobby for thrombolytics. I am inviting PhilHealth to be part of this project.

I am very impressed with the focus -- that you started with the Acute Coronary Syndrome Registry and you were able to get data. That is why you have all those things that you can work on. And the other thing that requires legislation, that already by itself is a focused program that is already achievable in the next months. I was looking at you that you have a grasp of what you are looking at that is achievable. I am really impressed with the AEDs, Philhealth, ACS registry.
How is your assessment of the typical cardiologist and how would you like or dream to change him?

From the very beginning, I want them to understand that seeing a patient is an opportunity to serve.

Is that in the curriculum?

In every way, the manner of teaching should include the core values. I have specifically inserted in my core curriculum.

Improve the value of cardiologists. Walk the talk. I should be an example to my young fellows. I don't want to change the old ones, madami sila.

It may not be necessarily the old ones. The ones charging much are not necessarily the old ones, they are young ones who are in a hurry to become rich.

Don't be in a hurry to earn to get a house, car, investment, etc. Then each time they look at their checkbooks, they want more. One day they will realize they don't need it anymore. We need to change their perspective.

What do you think are your personal strengths that will become handy as PHA president?

I am a mover who is capable of identifying and classifying people -- the critic who just pass judgment on anything but does nothing; the manager, who is good at dealing with the situation; and the mover who stimulates you to be productive and excel. I am a mover, sometimes they call me a dictator. A lot of times the critic sees the important things which we don't see. I listen to them, di ako nagagalit. They don't do anything but I don't tell them that. My weakness is sometimes I am too kind. Authoritative leadership is most effective. I need continuity of programs of power. I involve all the directors in decision-making. I make them feel very important that is why I ask them. But there are a few things that I decide on unilaterally.
That is a strength. What are your weaknesses?

My weakness is my mom. I was so emotionally attached to her so I was so devastated when I lost her. Mainipin ako. Religion is also a weakness. It binds you. It stops you every now and then.

Are you giving salaries to the PHA staff?

Yes, we are in the grading process.

Are there structure you want to change?

Not the structure, execute what needs to be carried out. The chart looks great but the only problem is the staff don’t have a complete grasp of their work load.

You never mentioned about your communication plan. The way you can execute your Advocacy. What is your communication strategy? Can you assess it?

I’ve started my Chapter rounds. I will announce to all the chapters my concrete plans/measures and the relevance of group text blast, email blast. Re communication strategy, utilize media particularly TV and radio which are the most effective channel in this fast-paced times. The website is for the young and the corporate people.

Assess the current state of the PHA membership. Any changes you’d like to do in the general membership?

There are more young people who are aggressive and too assertive. Well, that depends on where they are trained. The training in institution dictates their practice. The core curriculum will standardize this.

I also instructed SBAC to assess the quality performance of all the members. They said it is very difficult so they will do it last. There are some who are no longer keen on attending the convention after passing the Board because they feel they are done. We will put a stop to this. Their presence in the conventions and in CME activities is a must. The institutions will be empowered to do updates on CME, PRC and PhilHealth accreditation for their graduates in past years for a fee.

Let’s talk about the heart patient. Up to what extent is he aware of the fact that the PHA is around? Do you ever measure that? It is not how much we are publicly known or famous. I am a patient who knows no doctor. I am not economically capable, I kind of depend on agencies or a government hospital for my welfare. As far as the heart patient is concerned, do you think that the existence of PHA matters at all?

That is a very good question, very relevant. As far as I know there is awareness and appreciation.

Among the marginalized population, we are not popular but we are working on this. Among individual patients, it is their doctors who introduce and talk about PHA and its relevance.

Describe the PHA brand of patient care.

In general, “caring”, there is no brand yet. That is something that the next presidents can work on.

Ethics is always an issue among docs and fathers … up to what extent should the cardiologist put premium on the family?

I value family a lot. You are a mirror image of the kind of family you have. If not for my family, I would not have attained my dreams -- my profession and my stature. Family and career are my priorities.

Have you ever considered not having any religion?

When you die you need that. Dami ko na binasa tungkol sa Atheism. Lahat ng mason kilala ko ultimately they converted into Catholicism.

A lot of things happened to you during your time in the Board. All the milestones in seven years. You got devastated. Your mom died, you got married, you lost your son, now you are a father. That should mean something.

Yes, I lost my mom and my son, I became PHA president and a father, in seven years, that is why I will never forget PHA. I consider PHA as my family. Now the question is will PHA remember me and love me the way I did and will always do.
Do you think that it makes a
difference that you have gained a
lot of wisdom when you became a
father?

The training for a doctor, a
cardiologist, father and as an ordinary
citizen is never-ending.

Is the birth of your son a
distraction from doing a lot of
things that have been brewing in the
next 10 years?

He is not a distraction but an
inspiration and hopefully, I will be an
inspiration to him, too.

How do you want to be
remembered as PHA president?

As PHA president, I want to be
remembered as somebody who
utilized research for policy changes
that will improve healthcare. A
focused leader. Focus on the realities
to decrease premature death. I am
continuing the Collaboration program
of Dr. Bong Javier.

EUGENE B. REYES, MD
By Gynna P. Gagelonia

By virtue of his birth order, the second to the
youngest and the youngest boy in a brood of
six, Dr. Eugene Reyes was and continues
to be everybody’s favorite. Despite the
admiration and attention he was getting as
the intellectual and iskolar ng bayan, he has
remained level-headed.

Looking back, he said, his simple folks his
father Mauro, while his mother Lourdes, opted
for a career shift from a pianist/musician to a
full-time housewife and mother. His parents
imbued all their offspring with golden values, with
emphasis on strong Faith, integrity, humility and
close family times. The Reyes kids heeded their
parents’ advice that education is a top priority.

A dutiful son and sibling, who was an
achiever early on, Gene’s family supported all
his endeavors. Their hands-on “Nanay” and
all his elder siblings stimulated him enough to
aim high, to pursue cardiology.

The Reyes couple reared six children
who are all successful in their respective
professions. Dr. Eugene is the only
medical doctor. Gerry, is a deputy director
at the Bangko Sentral ng Pilipinas. Al and
Butch are both businessmen. Ditas is a
dentist. Marilou is an optometrist and a
businesswoman.

His arduous pace as a full-fledged heart
doctor who has carved a niche as a clinician,
lector, researcher and an academician, never
got in the way of his role as a devoted son and
sibling. He lived with and took good care of his
father who passed away in 1994 and his mother
who joined her Creator in 2009.

Now a family man himself, his approach
has a very close resemblance to that of his
parents’. In terms of priority, nothing can
take precedence over family – Euan his son and
Amalia “Mia”, his wife.

He considers himself very lucky to have
Mia for a wife. She was a US-based nurse
who completed postgraduate courses and
certification exams in New Jersey and
did community service from mentoring
nurses and interns to being a volunteer
at the American Heart Association yearly
Heart Walk. In 2010, right after getting her
acceptance letter as a masteral degree
scholar at the University of Los Angeles, she
got Dr. Eugene’s wedding proposal. The
rest is history. Dr. Eugene and Mia have
so many things in common – family oriented
and zest for Advocacy work. Mia is a full-
time wife and mom to Euan. Of course, his
siblings who have their own growing families,
will always be family to him.

As a person, Dr. Eugene Reyes is
passionate and compassionate. He is the
type who wants to get things done
promptly but perfectly. He is a sucker for
relishless learning. Perhaps, it is because
of his orthodox background and humble
beginnings that he feels for the financially-
challenged people.

Aside from amassing cardiology books,
does he have an assembly of a particular
stuff that he is fascinated with? He says,
“You, I love collecting candle holders
which I started to acquire in 1996. I have
about 40 pairs. The most precious and my
favorite pieces are kept in the curio cabinet,
while the rest serve as decorative and
functional fixtures.

He recalls “when I was a kid, I was
amazed by the tall candles in the church.
Later on, I realized that it is actually not
about the candle but about the candle
holder”. A pair of candleholders is a must-
when he goes out of town or out of
the country. Not being able to get one is
a big deal. “Yes, I really feel bad when I
fail to get one.” He says, adding “I go for
candelabras that is classic and has local
touch, something that is reflective of the
place where I bought it.”

7TH CONGRESS... From Page 17

positively influencing patient outcomes is the use of multi-
detector computed tomography (MDCT) for the accurate
assessment of aortic root dimensions for patients undergoing
transcatheter aortic valve replacement (TAVR). According to Dr.
Jonathon Leipsic (Canada), director of the Advanced Cardiac
Imaging Fellowship at St. Paul’s Hospital in Vancouver, subtle
findings on CT can spell the difference between a successful
TAVR and one laden with post-op complications. Knowledge
that the aortic valve annulus is actually a 3-pronged coronet
rather than a simple circular structure is key to a better
appreciation of 3-dimensional information derived from MDCT
and its relevance in the occurrence of post-operative valvular
leaks due to valve undersizing.

Recognizing the need for fresh perspectives on cardiac
imaging, the ASCI organizing committee also provided
young investigators an excellent stage to share their exciting
findings on CV research. Chosen papers included the incremental
value of Cine MRI over echocardiography in the assessment
of tricuspid annulus and right ventricular function in isolated tricuspid
regurgitation, the prognostic role of CMR-myocardial fibrosis in
hypertrophic cardiomyopathy, and the implications of Asian norms
for aortic root dimensions on aortic valve prosthesis sizing.

Amid an array of topics was the pervading theme – emphasis
on quality improvement not only in terms of image production
but also its analysis and reporting. The Advanced Reporting
session by Dr. Jens Bremerich (Switzerland) focused on the
undeniable impact of quality assurance initiatives by imaging
laboratories for the purpose of implementing standardization,
gaining accreditation and improving workflow.

Apart from solidifying its role as a premiere society for CV
imaging in Asia, the ASCI was able to transcend boundaries
and barriers in cardiology and radiology, highlighting the value of
collaborative efforts within and across specialty societies
Dabigatran etexilate

Pradaxa®

Simply superior stroke prevention

Twin Stars for Power and Protection

Telmisartan Amlodipine besilate
A mother is beauty and hope to her children, her smile gives them that feeling of security despite all their troubles. A mother is selfless, she never thinks of herself over her kids. A mother's courage makes her children confident and undaunted, no matter how stormy a path may be. A mother has wisdom, she's always there for a piece of advice in any situation. A mother is her children's strength, the light in her children's lives.

On the part of a career woman, a cardiologist at that, motherhood is such a great endeavour, that it amounts to or even weighs more than our careers, beyond making it more than just a mere balancing act. I am privileged to get a personal perspective from Dr. Jane Chua-Galang, one of our multi-talented and multi-awarded cardiologists, who is admired by her colleagues and protégées for being one of the most eloquent versatile leaders both in the field of medicine and in cardiology.

When I asked how she does the balancing act between motherhood and career, she simply answers: “I believe there can never be a balance...only a CHOICE of one over the other. For me, at any time or at any place, my being a MOTHER will always take precedence over my being a cardiologist. This is not to mean that I do not care for my patients or that I will not be the best cardiologist for them.

BLESSINGS on the hand of women!
Angels guard its strength and grace.
In the palace, cottage, hovel,
Oh, no matter where the place;
Would that never storms assailed it,
Rainbows ever gently curled,
For the hand that rocks the cradle
Is the hand that rules the world.

– William Ross Wallace (1819-1881)

To the contrary, my patients know that, because I have performed my family duties and given my best for my home, then they can expect my wholehearted attention when I see them.”

When asked of any guiding principles in life both as a daughter and as a mother and how her mother has influenced her into what she has achieved right now, she shared the fact that she grew up with very family-centered/family-oriented parents. To quote Dra. Galang, “All through my life I have always known this and I appreciate it, although there are times when I may not have agreed with the manner of “implementation” especially when I was younger. My mother has always been the more vocal partner, as I am, often giving voice to what was in my father’s mind. She is a feisty and headstrong woman, presenting the perfect foil to my father’s quiet personality. Yet, we always knew that despite this apparent lop-sided “power status”, he wielded a strong yet gentle hand. And this is how I and my husband deal with our family too. I am noisy, gregarious, genuinely loquacious - always with the hope that this attitude will enable and allow my children to be open, honest, real in their dealings with us.”

Learning from her mother, she is guided by the principle that
“there is always a right time and a right place for everything”. “We may not hit the “right” mark all the time, but I know that if we follow this mantra, we learn to persevere and wait, to act properly under pressure, to respect and be respected, to be ethical, decent, to appreciate what we have and to respect the other person,” says Dra. Galang. She further expressed on the side of raising her kids, “My children are taught to admire but shun jealousy, to always be presentable but not overdone (although I give room for personal tastes and expressions), and TO ALWAYS LIVE WITHIN OUR MEANS.”

Mother-daughter bondings are very important and it may be a simple Sunday stroll with mom or a gregarious event like celebrating mom’s 75th birthday. Asked if there have been any special moments shared with her mom, she states, “I do not look for rare special events. A special moment may be simple - times when my mother, despite her present unsteady gait and physical frailty, still worries when she sees that I may not be feeling well or when she becomes distraught when she sees that I may be having problems of any kind. Funny for one who is weaker to worry about the stronger one.”

As for her special bonding moments with her daughters, she expressed that their special bonding moments are when they go out shopping and succeed in finding the PERFEKT BUY - inexpensive, and is just what they were looking for. “We marvel together at our great talent in finding the right choice,” she stated.

In life, there are the most important things our mothers have done that we eventually do with our kids, too. This does not make Dra. Galang an exception to the rule as she has followed some values passed on from mother to daughter and making it her guide to raising her kids as well. “I specially remember and appreciate my mother’s giving up a career to be a fulltime homemaker. And care for us she did, down to our daily needs! Although there were no extravagant feasts, just simple old-fashioned genuine care. This is what I want to show my kids - genuine care, sincere, persistent, consistent. They should never forget that TRUST must be gained, not merely expected,” says Dra. Jane. Some things, though ought to be modified as it is passed on from generation to generation. “My mother is a rather formal person - not keen on physical displays of affection. I, on the other hand, love hugging the kids, holding their hands despite their frequent objections. I want more expressions of affection.”

Going to the more serious side of the business, being a daughter as well as being a mother has truly helped her as a cardiologist and being part of the PHA. “I’d like to think that, being a hands-on mom and daughter (my mother lives with us) definitely helps me as a cardiologist and member of the PHA - why because this defines me. This defines my character - motherly, nurturing, always working the best way I know how, always wanting the best for my patients and the organization. I do my work with passion. Any project, big or small, gets my 100% and more. I do not aim to always please, but to get the most with whatever I am assigned to do or what I set out to do. Others may even sometimes be acutely unkind, saying my involvement may be simplistic, old-fashioned, inconsequential -- but my involvement will always be wholehearted and passionate,” Dra. Galang states.

At the end of our conversation, she leaves words of wisdom to young, working cardiologists moms and thus, she closed our short talk with this statement: “To the young working cardio mothers, be reminded that no amount of success outside the home can replace failure within. So always seek to make THE CHOICE - because in the home there can be no replacement, no substitutes. JUST YOU! As to your patients, treat them as individuals, not room numbers or cases. Give empathy, understanding for they, too, have families who need them.”

– Jane Galang, MD

Bernadette J. Santiago-Halasan, MD
Fatherhood

Any man can father a child, but it takes a real man to be a father. Fatherhood is beyond being a good provider. A father is every family’s pillar. He is a child’s source of strength, best supporter, number one disciplinarian and top mentor. He leads by example. He teaches them life’s ABCs, golden values, challenges, coping mechanism, etc. Open-minded, he allows his children to be denizens of their day and age, and accepts the fact that even his own kids aren’t exactly like him. He respects his kids’ individuality. He spends quality time with his children.

A good father also shows the impact of affection by processing his love and respect for the mother in front of their children.

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A good father also shows the impact of affection by processing his love and respect for the mother in front of their children.
Of PHA Sons & Daughters

MARLON CO, MD

I maintain life-work balance by consciously dividing my time among career, family, colleagues and friends. My supportive, wife Arlene, help me achieve such balance. Living in this age of ultra-modern gadgets that allow me to do FB, viber, Skype, etc., to check out my loved ones and patients, is a big advantage.

Most of all, I thank God for giving me the gift of time to see a movie and dine out with my Mom every weekend; party with family, friends, siblings and relatives; and do organizational meetings, conventions, outreach programs, etc., and help organized social events.

They are simple and great pleasures I enjoy. I thank God for all these blessings.

“A daughter may outgrow your lap, but she will never outgrow your heart.”

--Anonymous

DELTA CANELA, MD

Southern Tagalog Chapter

“If you can still laugh then you have kept the balance between life and work.”

MARIAN MANALO, MD

Southern Tagalog Chapter

“It is really difficult to balance … I am strict with my schedule. There’s time allotted for family, clinic and myself. I need to rest… I go to the gym from 6am to 6:30am two to three times a week. (RTDs) round table discussions are a regular thing for me.

I am a dutiful daughter to my parents and I am cognizant that they are getting old. When I get home there’s a faucet to close… I spend time with both of them and tuck my Tatay to bed.

With foreign trips, I have learned the art of saying no. It pains me to decline but I need to spend more time with my parents.

DODEE RIGOR:

“I work hard but I make sure that I have time for my children and wife especially during weekends. Whenever, I go out of town, I bring my family with me. If the kids have school, I bring my wife with me.”

ARIEL MIRANDA: The nature of my subspecialty requires me to be on call 24/7 which is tough because I’m both a Dad to my family and to my 94-year mom as I am the only remaining kin to her. I make sure that I stay with her for at least 3 hours every day, and provide her with simple pleasures like a constant supply of her favorite ice cream (smiley). I’m also the house handyman -- I tend to her garden, clean the house, do simple restoration, paint jobs and electrical repairs.

I go home to Laguna on weekends. Saturday nights and Sundays are reserved for family day and bonding. We watch movies, eat out, or go on short scenic trips around Laguna and Batangas. My kids are into sports and I drive them to the wake boarding site in Nuvvali. They’re into music also and I try to teach them some guitar riff of yesteryear. But they don’t seem impressed with my prowess (or lack of it smiley). I don’t get to attend international conventions and I rarely go on out of town conferences. It doesn’t matter much to me. To borrow a catchy advertising xxxx, pigging out on pizza with the family are priceless. For everything else, there’s the internet.

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QUEZON CITY, August 5, 2013 – The intense flavor of St. Luke’s Heart Institute 27th year anniversary celebration is a testament to its strength, clarity of purpose, and certainty of direction.

August 5 saw the formal opening ceremony highlighted by the optimistic message of an auspicious future for St. Luke’s Medical Center Quezon City, delivered by this year’s HB Calleja Awardee Dr. Edgardo Cortez. Cortez is the current president and CEO of SLMC. He reported that St. Luke’s Global City is showing signs of robust performance and efforts in hospital improvement is expected to be directed towards QC in light of this development.

Cited too were the pioneers of the Heart Institute. Dr. Homobono Calleja, its founder and Director Emeritus, and the six fellows whom he invited 27 years ago to head the different departments of what is now the SLHI. They are Drs. Romeo Saavedra, William Chua, Antonio Sibulo, Jr., Jose Yulde (represented by Dr. Greg Rogelio), Fatima Collado, and Danilo Kuizon were each awarded a “Seedling” sculpture by the Heart Institute handed by Calleja. The sculpture, crafted by famous sculptor Ferdinand Cacnio, recognized how each of these pioneers were as seeds of the now strong and grown up Heart Institute. On the same occasion, Calleja was honored by the SLHI as the hands that planted these seeds. A “Trees” sculpture by the same artist was handed to him by the two chief fellows Drs. Bob Magbanua and Roger Suyom representing the youngest members of the SLHI family. The sculpture shows Calleja looking up the tall grown up trees around him. After Calleja’s inspiring keynote address, Kuizon, the incumbent SLHI head, delivered the Director’s Report.

The traditional Sunday Family Day preceded the opening ceremony. The well-attended hyped blast of competing departments dubbed “HI goes Broadway!” and the run for the title “The Voice of HI” spelled a joyous camaraderie that hinted on an exciting anniversary celebration for the rest of the week. Director Ruel Bayani led the panel of judges for the event which was capped by the dance number of the Family Day team led by Dr. Manolito Turalba.

Meanwhile, the annual Aug. 7 Lay Fora, under the leadership of Dr. Joana Manalo rode on the popular TV show “Please be Careful with my Heart” and used the same title unmindful of how many have used the same title in several other occasions. About 100 patients enjoyed the discussion about Diabetes, and Hypertension and fellowship over bowls of arrozcaldo.

The 7th Annual Cardiovascular Symposium was held in the Season’s Ballroom in Luxent Hotel from Aug. 8-9. Chaired by Dr. Freman Cerezo it drew 120 participants from different hospitals in a scholarly discussion of novel management options.

This year’s anniversary billowed on the night of Fellowship on August 10 as SLHI Alumni Association (SLHIAA) took over to stage “Open Heart!.” Dr. Marilou De Jesus acted as Socials Committee chair and overall project coordinator for Open Heart!, a fellowship night and fundraising for the benefit of indigent cardiac patients requiring cardiac surgery. De Jesus is also current president of SLHIAA. The night of fellowship amused and amazed.
some 1,000 people that gathered inside Crossroad Center at Mother Ignacia. The performances of SLHI doctors leveled up to that given by veteran artists Rachel Alejandro and Gary Valenciano to the delight of the uninhibited audience.

The SLHI Anniversary is never complete without the annual HB Golf Cup. Held at the unspoiled and rustic terrains of Canlubang Golf Club last August 14, the event was led by golfer Dr. Richard Torres.

A look at its beginnings—this marks the year’s celebration. SLHI looks back and honors its pioneers. Its alumni look back to give what they have received.

The Pintig Puso Foundation of the Philippine Heart Center’s 12th Post-Graduate Course on “Answers to Common Cardiology Problems in Daily Clinical Practice” confronted a gamut of issues. Dr. Maria Teresa Abola, MD was the moderator.

Very fruitful and informative, the two-day course bared and addressed the common findings and dilemma that cardiologists, internists and general practitioners come across in their everyday practice; practical approaches to common cardiac symptoms and findings like abnormal ECG; diagnostic approach to patients with dyspnea, palpitation and leg edema or claudication; contentious pre-employment clearances are encountered. More issues on cardiomegaly, chest pain and cardiac murmurs; challenging conditions of difficult to treat hypertension, patients with end-stage/refractory congestive heart failure and angina and cardiac conditions complicated by renal failure; facts about controversial and new innovations in cardiology such as stem-cell therapy in heart diseases and chelation therapy were tackled.

By Ana Beatriz R. Medrano, MD
UP-PGH teambuilding target: Mission Possible

By Christine Train / Paul Reganit, MD

MANILA, Aug. 24, 2013 – Obstacles, achievements, goals, and future plans were the focus of the annual teambuilding dubbed “A Call for the Mission Possible” of the University of the Philippines-Philippine General Hospital Section of Cardiology at the One Hotel, Tagaytay, Cavite.

Held in collaboration with Natrapharm and Convergent Consulting, it started with the business meeting presided by “agent” Dr. Mark Vicente, chief fellow of the section, attended by CVS fellows and consultants led by section chief Dr. Raul Jara, along with Drs. Ramon Abarquez, Nelson Abelardo, John Anonuevo, Maria Teresa Abola, Wilfred Dee, Eugene Reyes, Giselle Gervacio, Eric Sion, Richard Tiongco, Frederick Philip Gloria, Paul Reganit, and Elmer Jasper Llanes.

The three major activities for the teambuilding proper: “The Ball of Fire”, tested the group’s strategic skills, oneness in direction, innovativeness; the “Blivet”, a test of good communication skills and “The Art of Listening and Going Beyond Barriers”; and the “Hula Wave”, a test for unified, quick, purposeful act, in achieving a certain goal.

After surpassing the challenges, the group had a lot of take-home insights: Jara, during the synthesis, said “sometimes, when you see someone leading, learn to take the backseat to be a follower.” The fellowship night paved the way for all the consultants, without exemption, to sing their favorite songs and for the fellows, to showcase their talents.

Just as Henry Ford once said, “coming together is a beginning, keeping together is progress, working together is success”, the 2013 teambuilding dared the entire UP-PGH cardiologists to be prime movers in the preservation of life, and as agents of change, healing, and compassion.

The same occasion was the pre-launching pad of the echo book “The Second Research Compendium” authored by Jara, with Punzalan as editor; and breeding ground of association’s constitution and by-laws, with the newly-elected Board of Directors led by Jara (president), Abelardo (vice-president), Reganit (secretary), Anonuevo (treasurer), Tiongco, Tiongco, and Jean Alcover (directors), and Abarquez (honorary director).

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UP-PGH’s pride
Open Heart!
It had to happen

By Ma. Lourdes Bunyi, MD
Overall Organizing Chair
SLHI 27th Anniversary

QUEZON CITY, August 10, 2013
-- It all started with something that tugged the heart to do a task much bigger than one’s self. That thing tugged so deep in the soul to be ignored. While its magnitude was understandably coupled with unease, it was definite that only disobedience to the call would dissolve and scatter it into thin air. “Open Heart!” had to happen.

The task was too big for one person. The bargain was if somebody else would believe and agree to take the call, it would happen. Dr. Malou De Jesus, then VP of SLHIAAI took on the challenge to spearhead the project. Then Alumni president Dr. Freman Cerezo and the group agreed to take an active part. Then Dr. Rodney Jimenez agreed to share his creative prowess. And then there were more.

Open Heart! if it had to happen, needed an artist. But not Gary V. He was too big to consider. But Gary V was on the list of artists being considered. And then it was Gary V indeed. Communications felt like it would take forever. It was tedious and energy-draining. The process was long. “I am challenged by this. It has to happen.” These words were overheard from the telephone line on the end of Gary V’s camp.

Open Heart! had to happen because the alumni had to be brought to a different level of attaining a purpose.

Budgeting, organization, strategic planning, negotiations, marketing, and communications were done. Some took the ride well, some got dazed with the pace and the altitude.

Despite pain and sweat, Open Heart happened with a lot of miracles and unexpected support. The pre-production meeting was well attended complete with a well-arranged decorated room with flowers courtesy of the surgical conference that did not push through on that day. The dress rehearsal at the venue opened with a word of prayer that brought the house together. The patience, cooperation, and all-out performance of everyone involved were mesmerizing. Practice performances were amazing and well applauded. It foreshadowed a spectacle.

The show on the night of August 10 was a sight to behold and an experience to cherish. Crossroad Center on Mother Ignacia, the venue was transformed into a fellowship hall with tables draped with linens of black, gold, and red, that gathered close to 1,000 spectators. The show started with Doxology, a moving rendition of “I look to You” by Boyce Avenue participated in by 30 people doing hand mime in black light. An exhilarating mob dance followed which set the jovial mood of the night setting the crowd’s spirits in high gear. They danced on stage and they danced on the floor, they danced on the left side, and on the right side, and everywhere. The excitement was tempered a little by the melodious voice of Dr. Helga Sta. Maria singing “On My Own” from Les Misérables. A ballet-hiphop mash up to the tune of “Heart’s Cry” by Drehz performed by Dr. Rocky Willis, Nikki Roxas, and nurse Joanne Iniego left the audience impressed with the classy undulating body movements amid chequered dice roll. Dr. Leandro Bongosia and family wowed the crowd with a heartwarming rendition of “Mr. Sandman” and “When I Fall in Love.” The pace and altitude charmed every single soul in the audience. The energy, and gallantry on stage charmed performers and audience alike, beaming from ear to ear.

As if there was no end to this avalanche of performances, Rachel Alejandro came out with her signature song “Nakapatatak.” The treat continued as Drs. Rene Reyes and Johnny Shia joined Alejandro with “The Way You Look Tonight.” Alejandro did not disappoint the crowd as she continued on with a high-powered performance of 80’s Medley to everyone’s delight proving that her star has not dimmed. There was no sign of flaring the eyes nor the spirit of the crowd with the string of performances. Consultants, pharmaceutical industry partners, and hospital staff enchanted the night as they sashayed along the catwalk garbed in interesting apparels provided by Fashion Designers Alliance.

The big part of Open Heart! was completed by the man whose camp first hinted that Open Heart! would happen. Gary V, in his unique blend of warmth, energy, and gallantry on stage charmed every single soul in the audience. The doctors among the crowd were totally stripped of their usual timidity and blushing reaction, joining the rest in inching their way for a rare photo-op with the night’s ultimate performer. The house was scandalously euphoric as Gary V himself announced Gilas Pilipinas team winning scandalously euphoric as Gary V himself announced Gilas Pilipinas team winning over South Korea! The Gary V segment was power-packed and there was no trace that the long stretch of the night consumed the crowd’s enthusiasm. The night closed in high energy, each one, performers and audience alike, beaming with satisfaction and declaring that Open Heart! was worth their money, their time, and their effort.

The event opened the hearts of a lot of people. The fellowship it created lingered. More than a month hence and the aftertaste of Open Heart! still permeates the air. It was a sovereign direction that left a message in each one.
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GENERAL ASSEMBLY

STA. ROSA, Laguna, Aug. 14, 2013 – The PHA STC held its first general assembly under the new PHA national leadership of Dr. Eugene Reyes at Uncle Cheffy’s Restaurant, Nuvali, Sta. Rosa, Laguna. Reyes shared his plans and projects for the coming year. The chapter was also awarded a plaque of appreciation from PHA national office for its invaluable support for the chapter projects during the 60th Anniversary celebration of the PHA-STC. The assembly was supported by Menarini Philippines.

REVISITING VISION, MISSION AND VALUES

SAN JUAN, Batangas, Aug. 31, 2013 – Core members of the PHA Southern Tagalog Chapter held their Mission-Vision workshop at the Estrellas de Mendoza Playa Resort at Laiya Ibabao.

Nineteen members of the chapter consisting of past and present officers as well as liaison officers revisited the mission and vision 2004 of the group. Ammieto Bacus of Therapharma-LRI facilitated the whole workshop. The Vision decided on by the chapter is: “The Beacon of Cardiovascular Care in the Southern Tagalog Region” with the Mission: “We advocate to provide holistic and quality cardiovascular care to the people of Southern Tagalog through the collective, proactive and collegial efforts of our members and allied health partners.”
EBU City, July 12, 2013 – Imagine seeing Angelina Jolie (after mastectomy) and Brad Pitt, Marilyn Monroe, Christopher De Leon, Ferdinand Marcos mingling with Kate Middleton and Audrey Hepburn in the same room? Well, that was the scenario during the PHA Cebu Chapter Induction at the Quest Hotel Conference Room as PHA members came with the looks they thought they most resemble with the theme “KalokAlikes”. It was of course made more special with the presence of the PHA national President, Dr. Eugene Reyes, who inducted into office the PHA Cebu Chapter Officers for 2013-2014.

Another highlight was the awarding of the Lifetime Achievement Award to Dr. Victor Gonzalez, who is also this year’s National PHA Fellow Loyalty Awardee. It was indeed a night of transformations and facsimiles as the PHA members and their families arrayed with different personas. Of course it would not be complete without the display of singing and dancing prowess by the Cardiology Fellows and our friends from Astra Zeneca and University of Cebu dance troupe.
Cooking for Heart Health!
By Cecile Cabias-Jaca, MD

CEBU CITY, PHA - The American Heart Association has defined what it means to have ideal cardiovascular health and one of which is by promoting a healthy diet and lifestyle. Healthy eating is not about strict nutrition philosophies, staying unrealistically thin, or depriving yourself of the foods you love. Rather, it's about feeling great, having more energy, stabilizing your mood, and keeping yourself as healthy as possible—all of which can be achieved by learning some nutrition basics. To promote this advocacy, PHA Cebu Chapter held a 3-hour cook fest themed: “Cooking for Heart Health” last May 25, 2013 held at the Philippine School of Culinary Arts, Maxwell Hotel where several guest chefs demonstrated different healthy and delicious menus from appetizers down to desserts plus a short lecture on healthy food substitutes. Earlier that day, some PHA members also joined in the actual preparation and cooking of the healthy food to be served for the food tasting later after the cooking demonstrations. After the event, everyone went home with both a satisfied palate and full stomach as well as equipped with new information too. So who said that you cannot mix scrumptious food with good health?

PHA CEBU ACLS Trainers go to Bohol!

TAGBILARAN CITY, Bohol, June 22, 2013 – Armed with the aim to impart both cognitive knowledge and psychomotor skills of CPR and to provide a standardised care to cardiac arrest victims in accordance with the specific guidelines, ACLS trainers from PHA Cebu Chapter, Drs. Louella Quijano, Cecile Jaca, Giovanni Pinili, and Alex Junia spent their weekend (June 22 - 23) to conduct BLS and ACLS training to 32 nurses, resident physicians and consultants of the Governor Celestino Gallares Memorial Hospital in Tagbilaran City, Bohol held at the La Roca Hotel. The first day was spent on different lectures on BLS and ACLS, followed by a written examination and megacode on the second day. It was indeed a gruelling yet informative and interactive two-day course for saving lives!

Distance comes between NL members

BAGUIO City, July 2013 – Distance does not always make the heart fonder. Topography and the dwindling sponsorship of industry allies further dampened the interest of members of PHA Northern Luzon in supporting and attending meetings and activities.

PHA Northern Luzon spans 13 provinces --Mountain Province, Benguet, La Union, Ilocos Norte, Ilocos Sur, Pangasinan, Zambales, Nueva Vizcaya, Isabela, Cagayan, Kalinga, Apayao and Ifugao. Members from the Ilocos Region, Isabela and Cagayan rarely made it to the activities for years.

Actually, this has been a perennial problem, said PHA Northern Luzon president Dr. Annie Urmaza-Olarte during a meeting with the PHA Board of Directors.

On the same occasion, PHA President Dr. Eugene Reyes said “let’s be positive. There is always a solution to the problem.” Among the suggestions were: to bring CME activities that are similar to the Landmark Trials to these provinces where members have been inactive.

Urmaza-Olarte said that she requires the members from other areas like Nueva Vizcaya, Isabela and Cagayan to conduct a parallel activity that should be documented.

Reyes said that PHA NCR will only issue a Certificate of Good Standing to PHA members that are endorsed by their chapter. The Chapter will formally recommend members of good standing. Meanwhile, all the Chapters should set the criteria on how to be a member of good standing.
Sugar, spice and everything nice

Eating right is fundamental to our health. We are encouraged to consume a balanced diet of carbohydrates, protein and fats. Studies have shown though that some foods may provide additional health benefits for certain disease states, such as cardiovascular disease and diabetes.

Fruit consumption and diabetes

Fruits and vegetables are essential for adequate nutrition and it has been reported that sufficient daily intake could help prevent major diseases, including heart disease, certain cancers and diabetes.

Some fruits in particular may be linked to a lower risk of type 2 diabetes mellitus (T2DM). This was concluded from a recent report that combined data from 3 studies: the Nurses’ Health Study (n = 66,105), Nurses’ Health Study II (n = 85,104), and Health Professionals Follow-up Study (n = 36,173). All participants completed questionnaires assessing health and lifestyle factors, including diet, every two years.

The study suggests that eating more blueberries, apples and grapes may be linked to a reduced risk of T2DM. Researchers found that each additional three servings per week of whole fruit was associated with a significant 2% lower odds of T2DM incidence after adjustment for other dietary, lifestyle, and personal risk factors. The advantage was greatest with blueberries, at 26% lower odds per three servings a week. The differences in the associations between individual fruits were not accounted for by variation in the glycemic index (which represents the quality of carbohydrate) or glycemic load (which represents the quality and quantity of carbohydrate and their interaction) of individual fruits.

On the other hand, an increased consumption of fruit juice was linked to a higher risk of developing T2DM. For the same amount of fruit juice there was an increased risk of 8%. If whole fruits were substituted for fruit juice there was an associated lower risk for the development of T2DM, except for strawberries (3% higher risk) and cantaloupe (10% higher risk.).

The limitations of this study however include inevitable errors in the estimates of fruit consumption and the possibility of recall bias. The study population also primarily consisted of health professionals with European ancestry. Thus the findings may not be generalized to other populations.

Despite these limitations, this study reiterates how fruit is an important part of a healthy diet. The World Health Organization and Food and Agriculture Organization of the United Nations (WHO/FAO) recommend a minimum of 400 grams of fruit and vegetables per day (excluding potatoes and other starchy tubers) for the prevention of chronic diseases such as heart disease, cancer, diabetes and obesity, as well as for the prevention and alleviation of several micronutrient deficiencies, especially in less developed countries.

Cinnamon and diabetes

Cinnamon has been hypothesized to provide health benefits, such as the ability to lower cholesterol and blood glucose. The lowering of blood glucose levels is attributed to its active component cinnamaldehyde, which is thought to provide insulin release, enhance insulin sensitivity and increase insulin disposal.

An updated systematic review and meta-analysis of 10 randomized controlled trials (RCTs) evaluating cinnamon’s effect on glucose and lipid levels suggests that cinnamon appears to have a short-term benefit for diabetics. Researchers found that ingestion of 120 mg/day to 6 grams/day (approximately 1½ teaspoons) of cinnamon for 4 to 18 weeks significantly reduced levels of fasting plasma glucose by a mean of 24.59 mg/dL. Levels of total cholesterol, LDL and triglycerides were also reduced. There was no significant effect however on decreasing hemoglobin A1c (HbA1c) levels, possibly because the short duration of the studies did not allow for a significant change to be observed. Cinnamon also increased levels of HDL.

There were high degrees however of heterogeneity present for all analyses except HDL. This may limit the ability to apply these results to patient care, because the preferred dose of cinnamon and duration of therapy are unclear.

Due to its pungent taste and odor, cinnamon is typically not taken alone but is used as a condiment and flavoring for both sweet and savory dishes. The trials specified administration in relation to food, with most taking cinnamon with meals. Despite being used as a common spice, there are however potential side effects of cinnamon. Although poorly documented in humans, these include allergies and hypersensitivity to cinnamon, hepatotoxicity that results from coumarin isolates found in Cinnamomum cassia bark, decreased platelet counts and increased risk of bleeding.

These studies suggest that certain foods may be better than others when it comes to diabetes and heart disease. Given their limitations however, we should not encourage our patients to overindulge in either fruit or cinnamon. But until further research can be done, we can at least inform our patients that it won’t hurt to sprinkle a little cinnamon over their next serving fruit.

References:
Expounding on the Hospital Detention Bill

On April 27, 2007, then President Gloria Macapagal Arroyo signed Republic Act no. 9439, more popularly known as the “Hospital Detention Bill” which addresses the problem involving some hospitals and medical clinics that refuse to discharge patients due to the latter’s inability to pay their hospital bills or medical expenses. The law had caused intense reaction especially among private hospital owners, to the degree that the Private Hospitals Association of the Philippines (PHAP) had threatened to hold a regular boycott or a hospital holiday every month during which, for a day or two, only emergency cases will be entertained and the hospitals will retain the right not to treat “non-emergency” cases, until 2008, if the government fails to repeal or come up with reasonable implementing rules and regulations. Of course for good reasons. Subsequently, the implementing rules and regulations (IRR) were issued by the Department of Health, at least resolving most of the important issues.

The law makes it unlawful for any hospital or medical clinic in the country to detain or to otherwise cause, directly or indirectly, the detention of patients who have fully or partially recovered or have been adequately attended to for reasons of non-payment in part or in full of hospital bills or medical expenses. Further, said patients have the right to demand the issuance of the corresponding medical certificate and other pertinent papers required for their release. In the case of a deceased patient, the corresponding death certificate and other documents required for interment and other purposes shall be released to any of his surviving relatives requesting for the same. But this specifically excludes patients who stayed in private rooms.

But the law also protects the interest of the hospital by giving them recourse. The patient or the responsible person, must execute a promissory note covering the unpaid obligation before he is released. The promissory note shall be secured by either a mortgage or by a guarantee of a co-maker, who will be jointly and severally liable with the patient for the unpaid obligation. In case of the deceased patient, the cadaver shall be released together with the death certificate and other documents necessary for interment, even if the responsible person refused to execute a promissory note. Other documents however, will be released only after the execution of the same. In the event the documents will be needed for purposes of getting the benefits from the Social Security System, Government Service Insurance System, Philippine Health Insurance Corporation, insurance policies or pre-need plans, the hospital may require the execution of an assignment of proceeds up to the extent of the hospital bills or medical expenses/hospitalization expenses.

Violation of this law subjects the responsible officer or employee of the hospital or medical clinic to a fine of not less than P20,000.00, but not more than P50,000.00, or imprisonment of not less than one month, but not more than six months, or both such fine and imprisonment, at the discretion of the proper court.

To date, six years after the law’s enactment, no case has reached the Supreme Court for its violation.

CARDO & THE LAW

By Atty. Angie A. Yap, MD, Past President, PHA NW Mindanao, Bachelor of Laws (LLB)

Health experts now have proof that laughter is good medicine.

A good belly laugh can send 20% more blood flowing through your entire body. One study found that when people watched a funny movie, their blood flow increased. That’s why laughter might just be the perfect antidote to stress. When you laugh, the lining of your blood vessel walls relaxes and expands, Krasuski says. So have a good giggle. Your heart will thank you.

White meats generally contain less fat than dark meats. Turkey is one of the lowest fat meats and makes a great low-fat sandwich.
Smiley’s lost charm

The contour of elevated ST Segments used to be regarded as expression of the expected emotional response to their prognostic implications in patients with chest pains. Elevated ST segments with upward concavities that follow the contour of a smile are “Smiley” ST segments (Fig. A). On the other hand, ST segment elevations with upward convexities that inscribe a frown are “Frowney” ST segments, (Fig. B). The early repolarization pattern of normal variantstypically presents with “Smiley” ST segments. The acute injury pattern of incipient myocardial infarction typically manifests “Frowney” ST segments.

Tracings IA & IB were recorded from an asymptomatic 16-year old male student who wanted to engage in physically demanding sports. His 2-D echocardiogram was normal but his ECG showed 1 to 4 mm. “Smiley” ST segments in the anterior leads (tracing IA). Thus, he was subjected to a Bruce protocol treadmill stress test. There was normalization of the “Smiley” ST segments which remained at the isoelectric line throughout the test to a maximum workload of 17.2 METS. The result was really something to smile about.

Tracing IIA which was obtained from a 45-year old male showed 2 to 3 mm. ST segment elevations with upward concavities in leads V1 to V3. The “Smiley” ST segments could engender complacency in anticipation of a benign outcome. However, the optimistic outlook was short-lived. During a particularly intense anginal episode, the ST segments became markedly elevated measuring up to 15 mm. in amplitude in lead V4. The ST segments appeared to drag the R’ of the RBBB configuration of the QRS complex. In leads V1 to V3, the downstrokes of the ST segments were convex; in leads V4 to V6, their upstrokes were concave. The unmistakable diagnosis was STEMI involving the anterior wall with a new onset RBBB. Whether coronary vasospasms or coronary plaque rupture was the predominant mechanism responsible for the sudden appearance of subepicardial injury pattern could not be ascertained. Nonetheless, the patient was thrombolized. Subsequently, symptomatic and electrocardiographic improvement was observed within an hour after IV streptokinase.

Tracings IIIA & IIIB recorded in lead II belonged to a 33-year old male diagnosed with inferior wall STEMI revealing transformation of “Smiley” into “Frowney” ST segments in less than an hour. Angioplasty was successful in opening up a 90% proximal right coronary stenosis. Elevated ST segments with upward concavities are not necessarily normal variants with benign implications. As a harbinger of glad tidings, “Smiley” has lost his charm.

“Smiley” can morph into “Frowney” and into other personalities. ♥
What it is like to be doctor’s hubby

It’s 2:00 a.m. and I am awakened by “beep-beep-beep” emanating from a phone placed next to our bed. The phone has been a permanent fixture in our bedroom nightstand, lying beside journals and exam questions half made and tucked in Moss and Adam’s Heart Diseases in Infants, Children and Adolescents.

With eyes half-open, I see my wife reading the message sent and she utters the word “stat”. Thinking, “Why does someone want to discuss statistics at two o’clock in the morning? I strain to open my eyes a bit more as I see my wife getting dressed in five minutes flat (and I wonder why she can’t do the same on a regular day) while talking on the phone to the fellow on duty about someone called “Jatene” who needed an emergency echo.

Still half dazed, my wife gives me a kiss and an “I’ll be back soon” (“soon” generally means one or two hours.) As I hear our car pull out of the driveway, I try to go back to sleep still wondering “who in the world would name his child Jatene” and what on earth is a “TPI”?

Is it the new fuel injection system for Honda Civic SIR or a new form of accident insurance coverage?

What mesmerized me so much about doctors is how they can talk to each other using only three or four letter acronyms like “did you see the patient in 329A who has PDA with IE in CHF who was given DOPA? 329 A needs a PDA ligation.”

I once listened to a morning endorsement that sounded something like “Si post-AVR ay for PTPA at yung TGA post-BAS ay for re-cath”. You find it kind of strange when an affiliate says “yung PDA patient for BT shunting” and everybody starts laughing. Bakiiit? My wife would eventually (thankfully) walk me through the cases and procedures. For someone whose medical vocabulary is limited to ER, OR, and ICU, it can be very difficult to follow the discussions and I begin to regret having left my latest issue of Golf Digest in the back seat of our car underneath the scattered volumes

After a regular working day, we do a little shopping and as I open the trunk of our car I have to make room for the grocery bags by setting aside the medicine samples and give-aways accumulated during the last two medical conventions.

One difficulty though of being married to a doctor is when you have the flu, it’s unacceptable that you have flu with all the fuss that is made and a battery of tests you unwillingly undergo, you are thought to have either dengue fever, typhoid, or meningitis- to find out in the end that it was indeed only just the flu. I mean, who else can enjoy an intravenous fluid insertion in the comfort of your own living room?

At the end of the day though, I really don’t mind the myriad of three letter acronyms, the scattered books and journals and the medicine samples sufficient enough to start a small pharmacy - with my wife resting quietly in my arms I know she had done her best to help her patients and give them the medical attention they needed.

As I begin to fall asleep and I feel my wife now breathing evenly against my chest, my eyes start to close and just before I doze off into REM sleep (another one of those pesky three letter acronyms)- I suddenly hear a familiar “beep-beep-beep…”

Written during my wife’s fellowship days. It seems like nothing is extraordinary, just a run of the mill, in fact a “natural” part of a doctor’s daily life… at least to a fellow doctor. But to a non-medical spouse, everything is foreign, patients have become “rooms and procedures” and worst, the family the doctor-spouse is working for is oftentimes neglected, albeit unintentionally. Most, if not all, are guilty of this, at one time or another. We hope this serve as a reminder to all of us.
Why I fired my Secretary.

Last week was my birthday and I didn’t feel very well waking up on that morning.

I went downstairs for breakfast hoping my wife would be pleasant and say, ‘Happy Birthday!’ and possibly have a small present for me.

As it turned out, she barely said good morning, let alone ‘Happy Birthday.’

I thought... Well, that’s marriage for you, but the kids.... They will remember.

As it turned out, she barely said good morning, let alone ‘Happy Birthday.’

I thought... Well, that’s marriage for you, but the kids.... They will remember.

My kids came bouncing down stairs to breakfast

and didn’t say a word. So when I left for the office, I felt pretty low and somewhat despondent.

As I walked into my office, my secretary Jane said, ‘Good Morning Boss, and by the way Happy Birthday!’ It felt a little better that at least someone had remembered.

I worked until one o’clock, when Jane knocked on my door and said, ‘You know, It’s such a beautiful day outside, and it is your Birthday, what do you say we go out to lunch, just you and me.’ I said, ‘Thanks, Jane, that’s the greatest thing I’ve heard all day. Let’s go!’

We went to lunch. But we didn’t go where we normally would go. She chose instead a quiet bistro with a private table. We had two martinis each and I enjoyed the meal tremendously.

On the way back to the office, Jane said, ‘You know, It’s such a beautiful day... We don’t need to go straight back to the office, Do We?’

I responded, ‘I guess not. What do you have in mind?’ She said, ‘Let’s drop by my apartment, it’s just around the corner.’

After arriving at her apartment, Jane turned to me and said, ‘Boss, if you don’t mind, I’m going to step into the bedroom for just a moment. I’ll be right back.’

‘Ok.’ I nervously replied.

She went into the bedroom and, after a couple of minutes, she came out carrying a huge birthday cake ...... Followed by my wife, my kids, and dozens of my friends and co-workers, all singing ‘Happy Birthday’.

And I just sat there...

On the couch... Naked....

A man and his wife, now in their 60’s, were celebrating their 40th wedding anniversary.

On their special day, a good fairy came to them and said that because they had been so good that each one of them could have one wish.

The wife wished for a trip around the world with her husband.

Whoosh! Immediately she had airline/cruise tickets in her hands.

The man wished for a female companion 30 years younger...

Whoosh...immediately he turned ninety!!!

Gotta love that fairy! ♥

** stories/jokes compiled from the internet

Pls share your baby snapshots and see if your friends and colleagues can recognize you. Submit to eic_phan@yahoo.com

Guess who?

text 0917 5771299

1. Marlon Co, MD
2. Adriel E. Guerrero, MD

By Rei Salangsang, MD

PHAn Fun • ** stories/jokes compiled from the internet

July - August 2013 • PHA NewsBriefs
Tourist photography with a zing!

Cardiologists travel far and wide to attend international conventions. A by-product of our trip, we take home snapshots of places, people and culture. I call this “Tourist Photography”.

A photograph is a two dimensional image of a scene captured by your camera. Our travel photos would be more life-like if we apply visual cues commonly used by the pros.

Perception of DEPTH (3 dimensionality)

a. Light falling on a subject, maybe a landscape, building, monument, or even people, would determine the shape of an object while shadows reveal position, relative distance, depth and even texture of a surface.

Figure 1 amply describes this. We don’t need to take a direct picture of the sun setting as most photographers do. Using sunset light hitting the rocks on the foreground conveys an image of a warm, soothing sunset. In addition, due to the small aperture (F9) in twilight, the shutter speed automatically became slower causing the waves to blur and creating a “misty” effect which conveys “calmness or serenity”.

Figure 5: SETTINGS: For DSLR (ISO 100mm, Aperture priority F16 shot with a ultrawide lens). For compact cameras, use “landscape mode”. This was taken almost noon so objects appear shadowless from the sun directly above. A body of water would then create reflections.

b. Aerial perspective is used to illustrate distance. Due to light dispersion, distant or background objects will appear as having lower contrast (cooler or lighter tones) compared to foreground objects having greater contrast (heavy or warmer tones).

In Figure 2, I woke up early to catch the mist at Taal Lake. Using the edge of the cliff as foreground to create a sense of depth, you can use an aperture of F16 or smaller to capture clear details from front to back of the picture.

The landscape mode in a compact camera is represented by the icon depicting two mountains in a range.

Figure 6: This was taken around 8am thus the sunlight hit the objects at around 45 degree angle creating shapes of the boats and bridge. Other visual cues to enhance this picture are a) symmetry (two boats at both ends of the picture divided by a central bridge). b) converging lines created by both rails of the bridge, c) repetition created by reflections of the boats on the water.

In Figure 7, Objects at the foreground of a picture should be sharp and well identified. The background, mountain range has created different shades of gray and silhouette thus suggesting that they are at a distance from each other and not on the same plane thus making a three dimensional picture.
How have we come so far: The journey of Echocardiography Guidelines Implementation

By Loewe O. Go, MD – President Philippine Society of Echocardiography

After the creation of the Philippine Society of Echocardiography (PSE) in 1990 by our founding father, Dr. Homobono Calleja, and its subsequent incorporation in 1992, the PSE signed a memorandum of understanding with the Philippine Heart Association (PHA) on May 17, 1996 in which the PHA agreed to, among other things, “respect the autonomy” of the PSE and “give preference to the PSE in spearheading projects related to formulation of policies, activities and opinion regarding” the knowledge and application of quality echocardiography.

From 2002-2004, the PHA Council on Echocardiography and PSE formulated the Guidelines for Echocardiography thru different task forces composed of 46 members (physicians and echo technologists). The results of this collaborative work between the PHA Council on Echocardiography (chaired at the time by Dr. Mary Ong Go under the presidency of Dr. Romeo Santos) and the PSE (under the leadership of Dr. Joel Abanilla) were published in 2004 in the Philippine Journal of Internal Medicine and Philippine Journal of Cardiology (Vol. 32, No. 4, Oct-Dec 2004). Among other matters, the Guidelines provided the criteria to distinguish Level 1, 2, and 3 echocardiographers, and these were subsequently presented in the conventions of the PHA (2005) and PSE (2006 & 2007) by past PSE presidents Drs. Norbert Lingling Uy and Abanilla.

In 2007, a committee on competency guidelines chaired by Santos (PSE) and co-chaired by Dr. Edwin Tucay (PHA Council on Echo) was established to draft the policies on implementation of the Guidelines. The implementing rules and regulations (IRR) were presented to the Specialty Board of Adult Cardiology and endorsed on March 17, 2008 by then SBAC chair Dr. Raul D. Jara. Further refinement of the IRR was done and submitted on December 8, 2009 to the PHA thru the SBAC.

The IRR for competency guidelines called for the formation of a Joint Committee for Accreditation whose term of office is three years and members include: past PSE president and level 3 echocardiographer as JCA chairman (Uy), an incumbent level 3 PSE member (Tucay), a representative from echo technologists (Aileen Senga), chair of the PHA Council on Echocardiography as JCA co-chair (Dr. Joyce Jumangit), and another representative of the PHA Council on Echocardiography who is pediatric echocardiographer (Dr. Aurora Gamponia). The JCA was tasked to nominate to the PSE Board - with the imprimatur of the SBAC – physicians as recognized Echocardiographers (Level 1, 2, or 3), and laboratories as Echocardiography Training Programs (for Level 3 and echo technologists).

In implementing the competency guidelines for echocardiography, a period of leniency was established from January 1 to December 31, 2010 (and eventually extended to December 31, 2012 as cutoff for candidates to be exempted from certifying examination or “grandfather’s clause”) during which time the Guidelines were interpreted broadly and liberally. The process of recognition as Level 3 echocardiographers was either by invitation, wherein the JCA recommended recognition of a cardiologist as Level 3 echocardiographer to PSE Board, or by application, wherein the JCA received and evaluated applications for Level 3 recognition.

Consistent with the competency guidelines, the following credentials were required of candidates by the JCA for Level 3 recognition:

1. Specialty certification from the Specialty Board of Adult Cardiology or Pediatric Cardiology Special Board of the Philippine College of Cardiology/Philippine Heart Association or its equivalent certification obtained in foreign countries.

2. Certificate of completion of at least one year training in cardiovascular ultrasound.

3. For those who finished training program in echocardiography after December 31, 2012, a certification of passing the qualifying examination given by the Joint Committee for Accreditation.
In the absence of a certificate of training, particularly those who have been practicing echocardiography on or before December 31, 2012, the following will be considered:
1. Specialty Certification
2. A sworn statement of experience in cardiovascular ultrasonography satisfying the required guidelines of the PSE for level three (LEVEL 3) competency in echocardiography.
3. Any of the following:
   a. Scientific publications in topics related to echocardiography.
   b. Commitment to education in echocardiography as demonstrated on a regular basis by teaching.
   c. Active participation in PSE sponsored activities or other local/regional echocardiography societies.

In March 19, 2013, JCA chairman Uy convened with representatives from hospitals with formal echocardiography training programs to form the committee responsible for designing and conducting the qualifying examination (or echo board exam). The members of the committee (and the institutions represented) were: Ong Go (Cardinal Santos Medical Center), Dr. Gregorio Rogelio (St. Luke's Medical Center), Santos (Philippine Heart Center), and Tucay (The Medical City). Topics to be covered in the examination were distributed to the committee members, with instructions that the questions will be vetted and selected in subsequent meetings so that the echo board exam will be conducted during the PSE annual convention in September. Hence the stage was set for the implementation of the competency guidelines for echocardiography.

Echocardiography updates 2013
(Philippine Heart Center)

By Ana Beatriz R. Medrano, MD

Echocardiography is an advancing science. New innovations are created and new data are made available and analyzed. The attraction of echocardiography is its convenience and availability. It is a non-invasive diagnostic modality that can study hemodynamics, cardiac structures and functions of an individual. Since its discovery, the system was modified through the years.

From the simplest wall motion analysis and ejection fraction determination, strain and strain rate were developed as more objective measurements of myocardial contractility and function. Cardiac structures were visualized through the two-dimensional image. Difficulties encountered were answered by transesophageal echocardiography. However, a more detailed and enhanced technology emerged, which is the 3-dimensional echocardiography.

Through the evolution of echocardiography, it became a fundamental part of Cardiology. Formally established as a division of cardiology, specialists were trained. Though, several institutions are offering training in echocardiography, most parts of the country does not have a specialist. Thus level II echocardiographers read and interpret echocardiographic studies. It is for this reason why this post-graduate course was made. It was a collaboration of the Philippine Heart Center Non-Invasive Cardiology Division headed by Dr. Romeo Santos and the Philippine Heart Center Medical Alumni Society, Inc chaired by Dr. Theresa Menor.

The event was held May 9 and 10 at the Dr. Avenilo P. Aventura Hall. Specialists in pediatric and adult echocardiography including the father of Philippine Echocardiography, Dr. Homobono B. Calleja, delivered in-depth lectures regarding the most up-to-date techniques and must-know knowledge in echocardiography.

It was well attended mostly by level 2 echocardiographers who practices in provinces and cardiology fellows-in-training from different institutions. Topics varied from diastolic and systolic function with the inclusion of strain and strain rate. Hemodynamic assessment through echo and 3D-echocardiography were also included. Issues encountered in valvular lesions were presented. Pediatric echocardiographers focused on complex congenital heart diseases and interventional procedures. Clinical cases related to the lectures were highlighted.

This two-day course was an effective means to educate cardiologists especially the non-specialists in echocardiography. It was a short but a very productive program. Right after it finished, attendees were already looking forward to the Echocardiography Updates 2014.
Your heart & how it works

The cardiac output – enough or too little?

The ultimate measure of efficiency of the heart as a pump is expressed in the cardiac output. This refers to the effective amount of blood that the heart can pump in a unit of time, say in a minute. It is usually measured in cubic centimeters (cc) or liters per minute. The output of blood from the ventricles per beat is called the stroke volume. If the heart beats at 72 per minute, it has a stroke volume of about 75 cc. In other words, the output of the heart (cardiac output) can be computed by multiplying the stroke volume with the heart rate. An increasing in cardiac output can be achieved simply by increasing the rate of the heart or by increasing the stroke volume or both. Under normal resting or basal conditions, the heart pumps 5 quarts of blood in a minute, 75 gallons in an hour, 70 barrels in a day and 18 million barrels in 70 years.

The heart has reserve power

The sole function of the heart is to pump blood to maintain adequate and effective cardiac output must be maintained at all times. During a 24-hour period, the needs of the body may vary widely. In addition, the needs of one organ may be entirely different from another. For example, during meals and shortly thereafter, while digestion of the food goes on, the stomach and intestines demand more blood than in between meals. Similarly, an organ may be inflamed or infected. Adequate circulation must be maintained not only for the normal needs of that organ but extra blood carrying nutrient materials, vitamins, and antibiotics must be delivered to combat the infection. The heart therefore has to react according to the demands of the tissues for blood. It can call on its reserve power to perform greater amounts of work by increasing the heart rate, the stroke volume or both. The chambers of the heart may even dilate or the muscular wall may thicken to achieve a more effective and forceful ejection of blood from its chambers. One or more of these reserve mechanisms may operate in any given situation. Beyond the limits of this reserve power and in the face of a sustained overload (diastole). For more complete survey of the blood pressure, it is important to determine the pressure in both arms and in the legs. Normally, the blood pressure in the legs is higher than in the arms. Variations in the pressure readings in both arms also occur.

The diastolic pressure is the more important of the two pressure readings. This is what the doctor wants to find out: to determine whether the patient has high blood pressure or not. Fluctuations in the systolic pressure are common during 24-hour period and should not cause unnecessary worry. Sustained elevation of the diastolic pressure above 90 mm of mercury and the systolic above 150 mm of mercury at any age is called hypertension (high blood pressure). Prolonged elevation of this pressure deteriorates the reserve power of the heart. It is imperative that the pressure should be brought to normal levels with proper treatment. Abnormally low blood vessels pressure may occur and may lead to a condition called shock. Shock is nothing else but a collapse of the circulation. Blood flowing through the blood vessels becomes very sluggish. This is an emergency situation. Prompt, proper, and adequate treatment should be instituted without delay.

Here and there, a few abnormal conditions have been cited just for clarity. Truly, the heart has discharged its function well if the circulation is maintained effectively and adequately at all times. It is obvious, that one cannot abuse and misuse the great potential reserve of the heart to accommodate additional work imposed on it, if such a demand is not properly called for. We should learn to take care and preserve this cardiac reserve for it may mean actually a new lease of life to us when the time comes that we need extra work from our heart. For example, on can easily avoid excessive exercise or fatigue. Likewise, excessive smoking or inordinate addiction to coffee may precipitate unnecessary palpitations and faster heart rates.

A life with moderation, without of course depriving ourselves of the good things in life, may pay handsome dividends in the form of a vigorous and healthy heart even when ripe old age eventually overtakes us.
PHAN opens this academic and research section to create a venue for Pres. Eugene Reyes’ thrust on continuing medical education and research. The section is subdivided into subspecialties with corresponding experts in the field. These section editors have committed to overseeing the topics to be published, as contributors or editors so as to ensure healthy and relevant discussions. All members are encouraged to make a relevant contribution, send a comment or reaction through eic_phan@yahoo.com

**SECTION EDITORS**

Acute Coronary Syndrome and Interventions: Ariel Miranda, MD  
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Sports Cardiology: Federick Cheng, MD  
Vascular Diseases: Jenny Beltran, MD

**Contributors**

**ACS & INTERVENTION**

Ariel Miranda, MD

“Enterprising” is a single word that paints a big picture of this very talented man. Ever curious about the complexities of life, this topnotch plumber in the cardiology sphere, finds time to write, do photography and restoration job at home. Presently, he is a consultant and section head of invasive cardiology and director of the Cardinal Santos Medical Center Heart Institute Cardiovascular Catheterization Laboratory.

**VASCULAR MEDICINE**

Jenny Beltran, MD

Two decades in practice as a clinician, lecturer, researcher and author, rolled into one, polished her writing skills. One of the local cardiology community’s very few peripheral vascular disease specialists, Beltran holds clinic at St. Luke’s Quezon City, Metropolitan Manila Medical Center.

**ELECTROPHYSIOLOGY**

Carlo Nierras, MD

The author had his fellowship training in cardiac electrophysiology and pacing at Linkou-Chang Gung Memorial Hospital, Taiwan and is a Certified Cardiac Device Specialist (CCDS) by the International Board of Heart Rhythm Examiners (IBHRE). He is the first to be certified by IBHRE in the country.

**LIPIDOLOGY**

Lourdes Ella Gonzales-Santos, MD

She strikes anyone as someone who is endowed with beauty and brains. From a university to college scholar of the University of the Philippines, she continued to bag citations till her clerkship days at the UP-PGH to Cardiology Fellowship at the Cardinal Santos Medical Center. Even at the New York University in Manhattan where she had her Lipidology training, she was given academic appointments. She is an author of research papers that were circulated in the Philippines and in the United States.
Are ICDs cost effective?

By Carlo Nierras, MD

Patients with heart failure due to previous myocardial infarction (heart attack) or cardiomyopathy (weakening in the muscle of the heart) are at risk of dying due to sudden cardiac death (SCD); and that is regardless of whether they have or don’t have any history of malignant cardiac arrhythmias (abnormal heart rhythm). These types of patients are being managed primarily with medical therapies (anti-arrhythmics and/or a combination of other cardiovascular medications). Only a few are being offered an implantable cardioverter defibrillator (ICD) relative to the number of patients being treated medically. In the United States, approximately 325,000 deaths each year are attributed to SCD; that is more deaths than the annual deaths attributed to lung cancer, breast cancer, and AIDS combined. The trend of increasing SCD events is now becoming a global problem. It is estimated that more than 95% of SCD victims die before even reaching the hospital and it usually happens without any warning or symptoms.

The prevailing thinking among Filipinos is that ICDs are too expensive, thus, their usage is very minimal in spite of strong and compelling evidence in several landmark trials, showing their superior life-saving benefits over conventional medical therapies. In order for ICDs to be considered cost-effective, they must improve quality of life and/or lengthen life compared to other conventional therapies, and prevent other adverse events and the cost of treating these events. Let’s explore the proven evidence of ICD’s life-saving benefits and then look at the evidence highlighting the cost-effectiveness of various often-used therapies, and conclude by looking at the cost of not getting an ICD.

For life-saving benefits, ICD therapy has been proven to be superior to amiodarone, the most commonly used anti-arrhythmic drug among patients with heart failure, based on 3 landmark studies, namely, the AVID, the SCD-HeFT, and the MADIT trials. The AVID trial was a secondary prevention trial involving patients who had survived near-fatal ventricular fibrillation (VF) or sustained ventricular tachycardia (VT), randomized to receive an ICD versus anti-arrhythmic drugs, primarily amiodarone. VF and VT are life-threatening arrhythmias that cause SCD. The trial showed that among survivors of VF or VT, the ICD is superior to anti-arrhythmic drugs for increasing overall survival (31% reduction in all-cause mortality).

The second trial, SCD-HeFT, was a primary prevention study involving patients with chronic heart failure due to an ischemic (evidence of coronary artery disease or CAD) or to a non-ischemic cause. The patients were randomized to receive either an ICD, amiodarone or a placebo. This trial showed that ICD therapy reduced overall deaths by 23%, which proved its superiority against conventional medical therapies.

The MADIT trial was also a primary prevention study involving post-myocardial infarction patients with heart failure, and with spontaneous non-sustained VT and inducible VT on electrophysiologic study. The patients were randomized to be given an ICD or an anti-arrhythmic drug (80% of the subjects were given amiodarone). This trial showed that in patients with a prior myocardial infarction who are at high risk for VF or VT, prophylactic therapy with an ICD leads to improved survival as compared with conventional medical therapy.

Now, we asked the question in the title, “Are ICDs Cost Effective?” The book entitled “Evidence-Based Cardiology,” 3rd edition, Chapter 4, by Mark A. Hlatky from Stanford University, examined the concepts related to health economics. The question will be answered after a quick review of the methodologies and concepts used to determine cost effectiveness and/or the cost benefit of a particular therapy. The author first looked at several key factors in answering this question and provided perspectives on how healthcare providers and patients should view the cost of any therapy.

Here are some of the highlights:

“The cost of medical care has been rising steadily for the past 40 years in all developed countries. As a consequence, physicians must now consider cost as they design programs to prevent, diagnose, and treat disease. In the United States, cardiovascular diseases consume a large share of healthcare resources, so cardiovascular specialists must be particular knowledgeable about health economics.”

“Provision of cardiovascular services requires resources in all societies, irrespective of the method of financing or delivering healthcare. Coronary bypass surgery, for example, is very resource intensive, requiring cardiac surgeons, a cardiac anesthesiologist or anesthetist, a perfusionist, several nurses, and considerable quantities of specialized supplies and equipment. The resources used in the care of patients and the increasing sophistication of that care drive healthcare costs up in each of these countries, irrespective of the way in which such care is paid for.”

“Cost-effectiveness analysis is a method of weighing the cost of a service in light of the health effects it confers in an attempt to facilitate the ultimate value judgment about whether the service is “worth” the cost. If two alternative therapies are either known to yield identical results or can be shown to be clinically equivalent, they can be compared on the basis of cost alone. In such situations, the relative costs of the alternatives become the predominant consideration.”

The author then stated, “The increased knowledge and compulsion in applying cost-effectiveness analysis has led to the increasing sophistication of the concepts and methodologies used to determine cost effectiveness.”

The author added, “The increased knowledge and compulsion in applying cost-effectiveness analysis has led to the increasing sophistication of the concepts and methodologies used to determine cost effectiveness.”

The author then concluded, “The increased knowledge and compulsion in applying cost-effectiveness analysis has led to the increasing sophistication of the concepts and methodologies used to determine cost effectiveness.”
“Many alternative therapies are known to differ both in clinical outcomes and in cost. In this situation, both the difference in cost and the difference in effectiveness of the therapeutic alternatives must be measured and weighted against each other. When the effectiveness on intervention is measured in clinical terms (for example, lives saved, years of life added), the analysis is termed “cost effectiveness”.

“A basic principle of cost-effectiveness analysis is that the analysis should compare alternative programs and not look at any single program in isolation. Thus, a drug to treat life-threatening arrhythmias might be compared with placebo, or an ICD might be compared with a drug. In essence, cost-effectiveness analysis must always answer the question “cost effective compared with what?”

“Another principle is that the costs included in cost-effectiveness analysis should be comprehensive. The cost of a specific therapy should include the cost of the intervention itself (for example, thrombolytic therapy for acute myocardial infarction) and the costs of any complications the therapy induced, (for example, bleeding), less any cost savings due to reduction of complications (such as heart failure). The need for other concomitant therapy should also be included, which is particularly important when assessing the cost effectiveness of screening programs or diagnostic testing strategies. The length of follow-up should be sufficient to include all relevant costs and benefits—such as readmissions to the hospital due to treatment failures.”

“Non-monetary costs directly related to the medical intervention should also be included, such as the cost of home care by the patient’s family, since omission of these costs would bias assessments toward programs that rely on unpaid work by family members or volunteers. Other costs not directly related to the intervention, however, such as the patient’s lost wages or pension costs, are omitted by convention from the measured costs in a cost-effectiveness analysis.”

“In summary, a cost-effectiveness analysis should include all medical costs, including those of complications of therapy and adverse effects prevented. The study should be of sufficient duration to measure all relevant costs and benefits of the treatment. All costs and benefits should be included, regardless of who bears or receives them. For example, renal dialysis is a form of therapy that most people would consider expensive, and yet dialysis is an intervention that the United States and most other industrialized countries provide as a life-saving therapy. The end-stage renal disease program in the United States costs about $50,000 (PHP 2,200,000) a year per patient and if this therapy were withdrawn, the patient would die. Thus, renal dialysis has a cost-effectiveness ratio of $50,000 per year of life saved (or if one considers the reduced quality of life for a dialysis patient, perhaps $75,000 (PHP 3,200,000) per quality-adjusted year of life saved). Therapies with cost-effectiveness ratios considerably more favorable than renal dialysis would be considered very cost effective, whereas therapies with cost effective ratios much higher would be considered too expensive.”

As shown in the table below, the author compared the cost-effectiveness of selected cardiovascular therapies, and it shows that ICDs cost-effectiveness ratio is more favorable than renal dialysis. ICDs are also more cost effective than statin therapy for primary prevention, coronary artery bypass graft surgery (CABG) for one or two-vessel CAD, and percutaneous coronary intervention (PCI) for patients with mild angina.

Now, back to our question to start, “Are ICDs Cost Effective”? If you apply the methodology of the cost-

### Table 1: Cost Effectiveness of Selected Cardiovascular Therapies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Patient group</th>
<th>Cost effectiveness*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statin</td>
<td>Post-MI</td>
<td>Saves dollars and lives</td>
</tr>
<tr>
<td>ACE inhibitor</td>
<td>Chol &gt;250 CHF</td>
<td>Saves dollars and lives</td>
</tr>
<tr>
<td>Radio frequency ablation</td>
<td>EF&lt;35% WPW, post cardiac arrest</td>
<td>Saves dollars and lives</td>
</tr>
<tr>
<td>Physical counseling</td>
<td>Smoking</td>
<td>$1300</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>Post-MI</td>
<td>$3600</td>
</tr>
<tr>
<td>CABG</td>
<td>Left main CAD</td>
<td>$9200</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>Low-risk Post MI</td>
<td>$20200</td>
</tr>
<tr>
<td>Statin</td>
<td>Primary prevention Men 55-64 Chol &gt;300</td>
<td>$20200</td>
</tr>
<tr>
<td>ICA vs SK</td>
<td>Acute MI Sustained VT</td>
<td>$32800</td>
</tr>
<tr>
<td>ICD</td>
<td>Two-vessel CAD Angina</td>
<td>$35000</td>
</tr>
<tr>
<td>CABG</td>
<td>Three risk factors</td>
<td>$42500</td>
</tr>
<tr>
<td>Statin</td>
<td>Primary prevention Men 55-64 Chol &gt;300 No other risk factors</td>
<td>$79300</td>
</tr>
<tr>
<td>PCI</td>
<td>Mild angina (COURAGE)</td>
<td>$168000</td>
</tr>
<tr>
<td>CABG</td>
<td>Single-vessel CAD Mild angina</td>
<td>$1142000</td>
</tr>
<tr>
<td>Statin</td>
<td>Primary prevention 35-44 year old women Chol &gt;300 No other risk factors</td>
<td>$2024800</td>
</tr>
</tbody>
</table>

* $ values, dollars per year of life added.
ACE, angiotensin-converting enzyme, inhibitor; CABG, coronary artery bypass graft; CAD, coronary artery disease; CHF, congestive heart failure; Chol, Cholesterol; EF, ejection fraction; ICD, implantable cardioverter defibrillator; MI, myocardial infarction; ICA, tissue plasminogen activator; SK, streptokinase; VT, ventricular tachycardia; WPW, Wolf-Parkinson-White syndrome
Source: adapted from Kupersmith et al 10-12

See Page 55
Searching for needles in the hay stack

By Lourdes Ella Gonzales-Santos, MD

In August 2013, the European Atherosclerosis Society (EAS) published a consensus statement for screening and treatment of heterozygous familial hypercholesterolemia (FH). One month later, the National Lipid Association launched its online FH patient registry. With this growing interest in FH individuals, are we doing our part in identifying this at-risk population?

Familial hypercholesterolemia is a disorder that causes severe elevations in low-density lipoprotein cholesterol (LDLc). It is characterized by a defective allele (or alleles) in the gene coding for LDL receptors (LDLR) resulting in dysfunctional LDLR which reduce the catabolism of LDL particles. As a result there is a marked increase in LDL plasma concentration (> 95th percentile). These excess LDL are deposited in scavenger cells and form the physical stigmata of tendon xanthomas, xanthelasmas and arcus cornealis.

More importantly, LDLc deposits in blood vessels leading to premature cardiovascular disease. Homozygous FH manifests in infancy with children at risk for early coronary events, sudden death or acute myocardial infarction occurring as young as 1-2 years. Heterozygous FH presents with premature coronary artery disease by the fourth decade in untreated men while the onset of symptoms in women lags behind men by approximately 10-15 years. The overwhelming majority of affected persons are heterozygotes.

But how common is FH in our part of the world? In the Asia-Pacific Region, it is estimated that more than 5.2 million persons are suffering from this condition - the majority still remain undiagnosed and vastly undertreated. At present no data is available regarding FH in Filipinos. The only study documenting LDL-R gene mutations in Filipinos in 2005 was a participation in a global initiative to identify genetic profiles of patients with FH. 60 unrelated heterozygous FH Filipinos with mean LDLc of 227 mg/dl were included with at least 6 novel gene mutations.

Worldwide, there are three diagnostic tools for FH:

<table>
<thead>
<tr>
<th>Simon Broome Register Group (SBRG) in the UK</th>
<th>Make Early Diagnosis Prevent Early Death (MEDPED) in the U.S.</th>
<th>Dutch Lipid Clinic Network (DLCN)</th>
</tr>
</thead>
</table>
| Results are classified as **definite or possible**:  
i. if TC (LDL) >290 (>190) in the index patient or 1st/2nd degree relative + presence of TX patient is considered **definite FH**  
ii. Above criteria + family history myocardial infarction or TC>290 is considered **possible FH** | Utilizes age-related cutoffs for TC (LDL) which are further delineated by whether results pertain to general population or to patient with 1st, 2nd or 3rd relative with FH  
i. <20 yrs age TC(LDL) 270 (200)mg/dL; 20-29 yrs 290(220); 30-39 yrs 340(240); >40 yrs 360 (260)  
ii. Lowered strata in the setting of positive family history | **Definite, probable, or possible** categories:  
i. Score is derived from total points obtained from family history of LDL > 95th percentile; family history of premature vascular disease; 1st degree relative with TX or AC; LDL >95th percentile in child <18 yrs age; TX or AC present at <45 yrs; elevated LDL-C; positive DNA testing for LDLR  
ii. >8 points is **definite**: 6-8 points **probable**: 3-5 points **possible** |

* TC Total cholesterol, LDL Low-density lipoprotein, TX Tendon xanthoma, AC Arcus cornealis

With these guidelines outlined, the key to finding FH individuals lies in thorough history taking of premature family or personal medical history as well as complete physical examination looking specifically for cholesterol deposits. These red flags should prompt evaluation with fasting lipid profiles. Likewise, patients referred with baseline elevated LDLc beyond the 95th percentile should be evaluated with these findings in mind. Our role as physicians for early detection rests in being alert to these signs to improve case-finding and to facilitate cascade screening for other family members at risk. This way...
Since FH is associated with premature coronary heart disease, early detection and treatment of FH may save many lives by preventing that initial myocardial infarction.

The role of early detection and aggressive management to lower LDL level helps prevent or slows down the progression of coronary atherosclerosis. Therefore, screening for and management of HeFH is crucial in primary and secondary prevention of cardiovascular disease. Prevention of premature coronary heart disease is important with early detection through cholesterol testing in young adults. Screening of family members is vital to identify similarly affected relatives. All these factors cannot overly emphasize the importance of proper identification of patients with HeFH.

Since HeFH is associated with a high risk for premature CAD, health professionals should be alert to the signs found during a physical examination and to the laboratory values suggestive of HeFH. In line with this, we would like to call for aggressive screening for individuals suspected with HeFH. The following lists the Dutch Lipid Network (DLN) for standard diagnostic criteria for HeFH with a point-scoring system for possible (3-5 points), probable (6-8 points) and definite (>8 points) HeFH.

In patients with LDL cholesterol >195 mg/dL with a personal or family history of premature coronary or vascular disease (male <55 years, female <60 years), please contact the cardiology fellow for a full referral to the Lipid Clinic for evaluation of HeFH and patient education.

Clinical practice guidelines on the management of vascular diseases have evolved from the year of its inception till the present. Evidence based guidelines on venous thromboembolism, date as far back to the year 1986 until the year 2011, and almost 10 years of continued updates and revisions on peripheral arterial diseases. The influx of new evidence has sparked reviews of late-breaking clinical trials that could have a significant impact on the important patient outcomes and quality of care.

The ACCF/AHA (American College of Cardiology Foundation/ American Heart Association) in collaboration with different society working groups came up with the set of clinical practice guidelines on peripheral arterial diseases and a focused update that was released on year 2011. The advancement of medical therapy stimulated the Taskforce to designate the term, guideline-directed medical therapy. This term represents optimal medical therapy as defined by the ACCF/AHA guideline recommended therapies (i.e. Class 1) and will be in use in future guidelines.

The latest ACCP (American College of Chest Physicians), year 2012 guidelines included recommendations on the use of the new oral anticoagulants in venous thromboembolism prophylaxis in major orthopaedic surgery. There are now current recommendations on the use of new oral anticoagulants in the treatment of deep venous thrombosis and pulmonary embolism. Rivaroxaban (Xarelto) is the first new oral anticoagulant to receive regulatory approval for the acute and continued treatment of deep venous thrombosis and pulmonary embolism. Rivaroxaban can be given as a single drug in the treatment of pulmonary embolism while dabigatran (Pradaxa) needs 5-7 days of heparin treatment. Use of Rivaroxaban in pulmonary embolism was given Grade 2B recommendation. The rest of the guidelines remain current on the treatment of deep venous thrombosis and pulmonary embolism.

Are we ready to use personalized vascular medicine care, individualized patient treatment in this era? Maybe not yet, we still have to wait for further data on the ‘omics’ sciences of genomics, proteomics, and metabolomics. It will be worth waiting for and its implementation will be challenging.
In the September 2013 issue of the New England Journal of Medicine, Menees et al report on the outcome of this initiative. He evaluated reduction in D2B times and its effect on 30-day mortality in patients undergoing primary PCI. Their source was the large U.S. national Cardiovascular Data Registry database (2005 to 2009) which included over 96,000 patients.

Menees found that D2B times significantly improved from a median of 83 minutes at the start of the study to 67 minutes 5 years later. Likewise, the proportion of patients achieving a D2B time of <90 minutes increased from 59.7% to 83%. However, despite a successful implementation of the ACC and AHA D2B time initiatives, the authors failed to find a significant reduction in 30-day mortality (4.8% vs. 4.7%, p=nS). Analysis of pre-specified high-risk groups of interest yielded the same outcome: elderly (12.5% vs. 11.1%, p=NS), anterior wall MI (7.2% vs. 6.9%, p=NS), and cardiogenic shock (27.4% vs. 27.2%, p=NS).

They offered the following to explain lack of reduction in 30-day mortality despite improving D2B times:

1. This was an observational study, thus many factors could not be controlled. However, they also point out correctly that it is not possible to do a randomized controlled trial on D2B times hence Registry data will be our best source.

2. The 30-day study period may have been too short to see mortality differences.

3. The 16 minutes improvement in D2B time was not sufficiently large to affect mortality. An earlier study by Gibson showed that reduction in D2B time from 115 to 75 minutes (40 minute difference) was associated with a decline in mortality from 8.6% to 3.1%. However, as mortality becomes smaller and smaller, demonstrating further reduction will require a larger incremental reduction in D2B time or a bigger population to provide adequate statistical power.

In my opinion, the 3rd explanation is most plausible but only when it is related to total ischemic time (TIT). Door to treatment time (D2N and D2B time) actually accounts for only a third of the entire delay known as TIT. TIT represents the total duration of ischemia and begins from symptom onset. TIT correlates better with mortality than D2N and D2B times.

Beyond 90-120 min. from onset of ischemia there is very little salvageable myocardium left. It has been shown that the longest delay is from symptom onset to presentation to ER. Worldwide, less than 10% of patients are treated within 2 hours of pain onset. Since most patients present to the hospital on the 3rd to 4th hour of pain onset they are beyond this "golden period". Intervention gains little salvage of myocardium and survival probably relates more to the "open artery hypothesis". On the other hand, restoration of flow within the first 30 min. after coronary occlusion can actually abort an infarction. Data from large trials have shown that fibrinolytic therapy performed within 2 hours after symptom onset can result in as much as 8 lives saved per hundred compared to only 1-2 lives saved for patients treated beyond 2 hours.

**Insights from our local ACS Registry Data**

The preliminary results of the PHA ACS Registry provide sobering data. The mean time from symptom onset to presentation was 31 +/- 58 hours. Although the mean D2N time was 90.8 min., the values ranged widely (5-1375 min). Mean D2B time was 6 hours (0-23.45 hours). The data is still preliminary and areas of improvement, including reporting data as median times, have been identified.

Often, the greatest cause of delay in treatment is patient related. Patient related delays are influenced by level of awareness and knowledge, misconceptions, age, sex, character of pain, prior history myocardial infarction, and financial concerns. Patients often do not know what vital steps must be taken immediately during an attack. The practical solution is increased public awareness similar to successful national campaigns against smoking ("Yosi Kadin").

The PHA ACS Registry Data also identify a need to accelerate door to treatment times once the patient arrives at the ER. However, far greater number of lives will be saved if we can mount an awareness and education campaign that alters patient’s behavior and encourages them to seek care earlier.

The answer therefore does not require new technology. Rather, the solution is simply getting more patients to the ER much earlier. ♥
ARE ICDs ... From Page 51

effectiveness models used by the
author from Stanford, the answer is
ABSOLUTELY YES. ICDs are not
only better in SCD prevention, but
they are also more cost-effective
than anti-arrhythmic medications like
amiodarone. When counselling our
patients on getting ICDs, we should
look more at the cost of not getting the
ICD to determine its cost-effectiveness
and affordability for these patients.

What we know from the evidence
is that more than 50% of qualified
ICD patients will die from sudden
cardiac arrest if they don’t receive the
device, and within the first 2 years,
the Heart Rhythm Society states that
approximately 30% of them will die.

The cost of treatment at the cardiac
care unit (CCU) on big private hospitals
could easily range around 50,000-
100,000 PHP per day. A patient was
recently admitted at a private hospital
in Metro Manila due to an aborted SCD
and he was awaiting an ICD device.
Patient was on 4 life-saving medications
and was on dialysis, and ultimately died
from the complications of the sudden
cardiac arrest. The cost of his care and
the financial burden on his friends and
family was significantly greater than the
cost of getting the ICD.

In conclusion, ICDs are
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enthusiastically offer to patients
to save their lives, improve
their quality of life, and potentially save
them lots of money on lost wages,
additional medical expenses,
or costly CCU admissions. The
evidence is compelling about
ICDs life-saving benefits and
cost-effectiveness. As medical
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SEARCHING FOR NEEDLES ... From Page 53

of 10 million FH patients are living in
this part of the world, of which the
vast majority is not aware of their
dangerous condition, let alone being
adequately treated. Obviously, an
intensive case-finding program to
identify patients and subsequent clinical
management are required to prevent
premature cardiovascular disease and
death caused by the consequences
of inherited hypercholesterolemia. This
article describes the current situation
concerning FH and the initiatives and
actions undertaken in Australia to
contribute to actively identifying patients
with FH in that country.

Five classes of mutations have been
identified, ranging from null alleles
which fail to produce the protein, to
defects which uniquely block multiple
steps in the process of transport,
binding and recycling. Removal rate of
LDL-C declines, and the plasma level
increases.2,3 There are more than
1,600 mutations of LDLR known to
cause FH.4
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