13th World Heart Day
Take the road to a healthy heart

Life work balance of busy cardios

Do heart docs care about their own hearts?

National heart chapters drum up healthy lifestyle

What you should know about Obstructive Sleep Apnea (OSA)
MINIMAL CASH OUTLAY
Will serve as commitment fee which will be utilized on the first period of the contract (only for hospitals with existing pipeline system)

UP TO 20% LESS ON THE PREVAILING PRICE OF OXYGEN

FREE FIFTY (50) UNITS OF SELF-SEALING WALL OUTLET BASE ON THE PRICE OF OXYGEN

HOSPITALS WITHOUT PIPELINE, INSTALLATION EXPENSE WILL BE CHARGED TO MONTHLY BILL

FREE 24 HOURS MAINTENANCE AND MANNING OF THE SYSTEMS
FREE MAINTENANCE ON SECONDARY EQUIPMENTS
(FLOW METERS, HUMIDIFIERS, SUCTION REGULATORS, SUCTION BOTTLES)
FREE CHECK UP ON GAS PIPELINES TO ENSURE A LEAK-FREE SYSTEM
ESTIMATED PHP 30,000.00 MONTHLY LABOR COST

FREE OXYGEN SELF-SEALING WALL OUTLET
QUANTITY WILL BE DETERMINED BASED ON THE OXYGEN CONSUMPTION OF THE HOSPITAL

FREE SHARP AND INFECTIOUS SHREDDING MACHINE

FREE OXYGEN GENERATOR HOUSE

SAVE APPROXIMATELY 350 LITERS OF OXYGEN FROM ELIMINATING RESIDUAL WASTAGE FROM THE CYLINDER

EQUIPMENT CAN PRODUCE 50% PERCENT MORE FROM THE CURRENT VOLUME OF OXYGEN SHOULD THE DEMAND OF OXYGEN GOES HIGHER IN VOLUME

WITHDRAWAL OF OXYGEN CYLINDER DEPOSITS FROM SUPPLIERS

VERY SAFE AND NON-HAZARDOUS
OXYGEN PRESSURE BEING OPERATED IS AT 120 PSI ONLY

BMC HOSPITAL SYSTEMS EXCEEDED FROM THE INTERNATIONAL STANDARD IN TERMS OF MEDICAL OXYGEN PURITY
INTERNATIONAL STANDARD IS 92.55%
BMC OXYGEN GENERATOR CAN PRODUCE OXYGEN OF UP TO 97%

BMC HOSPITAL SYSTEMS IS OPEN WILLING TO ENGAGE IN PUBLIC-PRIVATE PARTNERSHIP (PPP) FOR GOVERNMENT HOSPITALS

BMC IS THE 2ND BIGGEST TRAINING CENTER FOR WELDING IN THE WORLD
THE ONLY TRAINING CENTER THAT CAN OFFER OXY-ACETYLENE GAS WELDING WITH SILVER BRAZING SPECIFICALLY REQUIRED FOR MEDICAL GAS PIPELINE SYSTEM
ENSURES LEAK-FREE SYSTEM
Editorial

The need for public access defibrillation

One of the key thrusts of the Philippine Heart Association this year, building up on last year’s initiatives to increase awareness of the importance of learning cardiopulmonary resuscitation (CPR), is the greater availability and accessibility of automated external defibrillators or AEDs. Such portable electronic devices that recognize life-threatening arrhythmias and deliver electrical shock to terminate the arrhythmia and reestablish the effective cardiac rhythm may be the key to saving one’s life when they are within easy reach for use by the lay people, bystander and healthcare professionals responding to a cardiac arrest situation.

Modern AEDs are now suitable for easy use by both lay and medical professionals alike. The newer models analyse the victim’s ECG rhythm and determine the need for a shock — whether by the unit itself (for fully automated defibrillators) or by the operator when prompted (for semi-automatic units).

In the United Kingdom, approximately 30,000 people suffer cardiac arrests outside the hospital and are treated by responding emergency medical personnel each year. Electrical defibrillation is recognized as the only effective therapy for cardiac arrest caused by ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT).

There is wealth of evidence to support the value of early defibrillation in ensuring a favourable outcome for cardiopulmonary arrest. Some studies even cite it as the single most important determinant of survival. Reports indicate that if defibrillation is delivered promptly and appropriately, the survival rates can be as high as 75%. Notably, the success of defibrillation diminishes at a rate of about 10% with each minute of delay.

Thus, many resuscitation councils and groups worldwide have strongly recommended a policy of early defibrillation with the minimum of delay in victims of VF/VT cardiac arrest. The International Liaison Committee on Resuscitation (ILCOR), the principal forum which was established in 1992 for resuscitation organizations worldwide, maintained in its Consensus on Science and Treatment Recommendations that an AED can be used safely and effectively without previous training. This indicates that the use of an AED should not be restricted to trained rescuers. Nonetheless, training is encouraged to improve the timing and manner of shock delivery. Short videos and self-instruction courses combined with hands-on practice are considered effective alternative to instructor-led courses for both basic and advanced life support.

The importance of tapping the public in performing bystander resuscitation is a definitive strategy that can translate to improving outcomes after cardiac arrests. Just very recently, the large Danish Cardiac Arrest Registry involving nearly 20,000 out-of-hospital cardiac arrests between 2001 and 2010 (JAMA, October 2013) highlighted the contribution of bystander efforts in improving survival after cardiac arrest. Over a nearly 10-year period, the Danish registry indicated that more patients survived upon hospital arrival, and that the 30-day and one-year survival likewise improved. Importantly, bystander resuscitation was a factor that was associated with higher survival rates.

The PHA is moving towards fully engaging the public, the policy makers and the legislative sector in ensuring the greater availability of public access defibrillation. This will mandate installation of such units in public places and crowded areas like schools, malls, buildings, sports complexes, concert venues, convention halls, among others.

In this strategy, the vital need for collaboration with public officials and private entities cannot be overemphasized – as it will require concerted efforts and considerable resources. For a start, the preliminary discussions with the Metro Manila Development Authority (MMDA) during the World Heart Day Celebration in September 2013 has resulted in favourable endorsement (though unofficially) of the AED initiative from the leadership of MMDA. More focused discussions that will bring forth specific details, expectations, requirements and time frames are now in order.
MMDA chair Francis Tolentino backs PHA AED bid

World Heart Day 2013 is inimitable
The radical changes -- switching to a new partner and giving every Board member a WHD posting -- is a windfall.

National heart Chapters drum up healthy lifestyle

Dr. Alisa Bernan is named Research Committee chair

Fiercest quake in RP history
215 die in Bohol, 13 in Cebu; damage placed at billions

Life Work Balance
Know their diverse and similar styles as they shift roles from doctors to parents or daughters or sons. Find out what matters most at the end of the day.

Cardiolinks
Dangerous Snoring: Obstructive Sleep Apnea Syndrome
By Ruth M. Divinagracia, MD

Cardio and the Law
Proposed Physicians’ Act of 2012
By Atty. Angie A. Yap, MD

Dysrhythmic Tales
Shock-resistant SVT
By Edgardo S. Timbol, MD

Escape Beat
Shall it now be – life begins at 100?
By Saturnino P. Javier, MD

How do cardiologists take care of their hearts?
Editor’s note

As a Member of the World Heart Federation (WHF), the Philippine Heart Association (PHA) joins the world in celebrating the 13th World Heart Day (WhD). WHD began in 2000 to raise public awareness and action that heart disease and stroke are the world’s leading cause of death, claiming 17.3 million lives each year. This year’s WHD Theme is, “Taking the Road to a Healthy Heart”—a simple yet profound message, which drives home the point that leading a healthy lifestyle is, indeed, achievable.

Many strategies, campaigns and guidelines have been implemented toward reducing the burden of heart disease; yet the numbers are still rising. By 2030, it is projected that deaths from heart, vascular diseases and stroke will reach 23 million annually. This information empowers one towards being proactive and purposively avoid the risks of heart disease. Everyone should be responsible for his or her own health.

Taking a preventive viewpoint, PHA has embarked on a public advocacy campaign to affirm that at least 80 percent of premature deaths from heart disease and stroke are actually preventable. As medical professionals, it is our moral obligation to share the knowledge that individual risks can be reduced by avoiding what can be modified (e.g., smoking, unhealthy diet and physical inactivity), and by managing what can be controlled (e.g., hypertension, diabetes, high cholesterol).

This year, PHA has chosen the Metropolitan Manila Development Authority (MMDA) as WhD partner. Why this partnership? Consider these parallels: For a more organized metropolis, MMDA is tasked to plan, monitor and coordinate functions of government services, especially in traffic monitoring, and exercises regulatory and supervisory powers. On the other hand, cardiologists have overall plan of care of their patients’ heart and the entire network of arteries and veins to avoid unwanted clogging in these so-called ‘highway systems’ through a comprehensive and managed care approach. Sharing the same passion for order and prevention of chaos and disaster, the PHA-MMDA partnership would strengthen the battlecry for a responsible and healthier citizenry.

In a national statement, DOH Secretary Dr. Enrique Ona joined PHA President Dr. Eugene Reyes in commending Dr. Alex Junia, PHA Secretary and WHD Committee Chairman, and MMDA Chair Francis Tolentino for this merger. It is further hoped that this will be a sustainable life-changing project toward a health-conscious and truly healthier Philippines.

“Make healthy choices”. “Take responsibility over your health.” These are but two themes of PHA programs through the years. As you go through the features of this issue, it will be evident that the PHA Newsbriefs seeks to remind our readers of the importance of taking the road to a healthy heart and maintain overall health and wellbeing.

Cardiologists themselves share their personal statements on how they take care of their own hearts, maintain balance of life and career, as well as deal with their health challenges.

Through the PHAN, PHA hopes to be a knowledge leader, as it guides and encourages doctors and lay readers alike to push forward a choice of having a healthy lifestyle, consistent with WHF goals and programs.

Go PHA! Go Philippines! Take the road to a healthy heart! ♥

The occasion was a perfect forum for the American College of Cardiology (ACC) Leadership Meeting on Sept. 1, 2013. With PHA President EBR were Drs. Joel Abanilla (vice president); Raul Lapitan (treasurer) and Helen Ong-Garcia (director). Other foreign attendees were Drs. William Zoghbi, Christopher Bode, Huon Gray and Neal Kovach.

EBR gave updates about the ACC Philippine Chapter’s future plans. Tackled, too were: partnerships, nurse programs, access to the Journal of American College of Cardiology and MOA-signing on rebates. The ACC international chapters stand to earn monetary rewards for bringing in members to the ACC Annual Meeting, Mar. 29-31, 2014 in Washington, D.C.

QUEZON CITY, Sept. 10, 2013 – At the Philippine College of Physicians (PCP) Health Forum at Annabel’s, EBR called on the government and media to be an aggressive supporter of the World Heart Federation goal: 25% reduction in premature cardiovascular disease death by 2025. The PHA vowed to play a major part in this colossal task.

MANILA, Sept. 16, 2013 – The shoot for the joint GMA Kapuso Foundation Bisig Bayan-PHA ECG Clinic plug, with EBR as endorser, took 20 minutes but the upshot is beyond price. The Sept. 28 ECG Clinic created/increased awareness on the availability of these services, value of the ECG machine and knowledge about healthy lifestyle and cardiovascular disease prevention/management and about the existence of doctors and media moguls with a heart.

QUEZON CITY, Sept. 29, 2013 – EBR’s conversations about the heart with Salamat Dok hosts Alvin Elchico and Bernadeth Sembrano was enlightening. His guesting stint on Salamat Dok was made possible through Manila Doctor’s Hospital initiatives.
MANILA, Oct. 8, 2013 – EBR granted GMA 7’s request for a stat interview on the value of automated electric defibrillator (AED). His video clips were used by Jessica Soho’s State of the Nation show that aired at 10pm on the same day. PHA employee Ronaldo “Ning” Grande gave an on-air lecture on how to use the AED.

**EBR’s September to October 2013 Calendar:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>Aug 31 – Sept. 5</td>
<td>ESC Congress</td>
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<td>Aug. 31</td>
<td>ACC Presidents’ Dinner</td>
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<td>Sept. 01</td>
<td>ACC Leadership Meeting</td>
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<td>Sept. 10</td>
<td>PCP Health Forum at Annabel’s Theme: PHA-led World Heart Day 2013</td>
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<td>Sept. 12</td>
<td>Meeting with Therapharma</td>
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<td>Sept. 16</td>
<td>GMA shoot for ECG Clinic</td>
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<td>Sept. 21</td>
<td>Negros Occidental Induction</td>
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<td>Sept. 23</td>
<td>Meeting with Central Luzon Chapter</td>
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<td>Sept. 24</td>
<td>Pampanga – Central Luzon WHD celebration</td>
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<td>Sept. 26</td>
<td>World Heart Day 2013 at MMDA</td>
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<td>Sept. 27</td>
<td>CPR Training the Trainors</td>
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<td>Sept. 29</td>
<td>Salamat Dok, courtesy of Manila Doctor’s Hospital</td>
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<tr>
<td>Sept. 30</td>
<td>Philippine Society of Echocardiography</td>
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<td>Oct. 03</td>
<td>Meeting with MSD</td>
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<td>Oct. 05</td>
<td>CME Initiatives with PHA Chapters</td>
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<td>Oct. 08</td>
<td>Shoot Channel 7 plugging for AED awareness for State of the Nation</td>
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<td>Oct. 15</td>
<td>Meeting with Archbishop Villegas “Stewards of Health”</td>
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<td>Oct. 18</td>
<td>PCP Meeting, Membership, Disaster Management, Stem Cell</td>
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<td>Oct. 19</td>
<td>Workshop with Councils Guidelines, Registries</td>
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<td>Philippine Star Heart Line: Pass the Code 52100</td>
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**Know your Organization**

**PHA Board of Directors**

For specific concerns, you may write the designated Director thru phil.heart@yahoo.com
MMDA backs PHA bid:
Lifesaver defib in every building

By Gynna P. Gagelonia

PASIG CITY, Sept. 26, 2013 – “Sudden death can happen to anyone, any time and anywhere.” This is bad news. And the good news. Study shows that cardiopulmonary resuscitation (CPR) can save lives even if it only buys time and has limitations.

That is why CPR should be followed by defibrillation with the use of a very handy automated external defibrillator (AED), that are now available in the local market; and the Philippine Heart Association (PHA) has found an ally in Metropolitan Manila Development Authority chairman Francis Tolentino and media, in lobbying for the passage of a law/an ordinance requiring all business establishments and public places to install these emergency heart-reviving tools called AEDs. It is a must to do cardiogenic shock with an AED which should be operated by a CPR expert during the most critical time of beating the five-minute limit to prevent brain damage. Failure to revive the heart will block the supply of oxygen to the brain.

“Thirty percent of the adult population die of cardiovascular disease (CVD). In the US, Japan and Singapore, AEDs are ubiquitous tools you find on every corner of the road. These countries have cut their CV deaths because of AEDs,” said PHA President Dr. Eugene Reyes.

“However, in the Philippines, defibrillator machines are commonly found in the hospitals. Sad to say, only a few government agencies are equipped with AEDs. Even in big establishments and offices, we rarely see an AED. The PHA would love to see the day these life-saving AEDs are found everywhere,” he added.

“Like fire extinguishers, defibrillators should be available everywhere because they help in saving lives,” said Tolentino.

For decades, on the PHA Advocacy’s top agenda is the relentless provision of CPR trainings to both health professionals and the lay.

What is 52-100?

This is not a secret pass code. Pass it on to seniors, adults and children.

Your daily guide to a hearty meal:

- 5 servings of fruits and vegetables
- 2 hours of screen time or less per day
- 1 hour of daily moderate physical activity
- 0 sugar-sweetened beverages, junk food
- 0 zero exposure to tobacco smoke

Obesity is a global problem. It is on the rise in the Philippines, even among children. Obesity in childhood may cause heart disease, said PHA Director and Advocacy chair Dr. Jonas del Rosario. Obese kids and overweight kids are prone to hypertension, high cholesterol, diabetes mellitus and they have very low self esteem.

According to Dr. Jorge Sison, PHA director, 10 percent of the adolescent population are hypertensive.

Extreme cases exist among the students -- obesity in private schools and malnutrition in government schools.

“One does not contract heart disease overnight, Del Rosario added. “It is the end-result of accumulated bad habits.” He told media “our arteries are like the water pipelines. When you keep on filling it with high-fat solids and fluids, in due time, you have blocked arteries or a clogged water duct.”

In the United States, there is an all-out war against childhood obesity and at the frontline is US First Lady Michelle Obama, he added. ♥
MAKATI CITY, September 30, 2013 – World Heart Day (WHD) 2013 was exceptional exceeding all its past performances in the last 12 years.

The huge success can be attributed to multi factors. PHA Secretary concurrent WHD chair Dr. Alex Junia’s resolve to digress from tradition –changing its partner from a city to the Manila Metropolitan Authority (MMDA). Zeroing in on the MMDA and its field workers was a media magnet.

MMDA Chair Francis Tolentino, a lawyer and former mayor of Tagaytay City, a sought-after interviewee committed to endorse the PHA’s automated electronic defibrillator (AED) and anti-smoking campaigns.

On Sept. 10, 2013, PHA grabbed the opportunity to be at the every-Tuesday morning Philippine College of Physicians Health Forum to announce the WHD activities. Letters about the diverse pegs of WHD 2103 were also sent in advanced to media news desks. Working hand in hand with the MMDA Press Office was an added advantage. Post WHD media exposure followed.

WHD 2013: Unprecedented

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### Others

- **Mia Standard/Today** Cardiac aid pushed to save lives 09/27/13
- **Philippines Today** WHD 2013 checks up Teachers heart health 09/16/13
- **Vital Signs** PHA, MMDA partners For World Heart Day 09/17/13
- **Journal Online** MMDA backs Defib installation 09/28/13
- **Zambo Times** Advocacy against Obesity in children strengthens 09/11/13
- **DZEC 1026 khz** Peg: WHD theme Materials: voice clips of Drs. A. Junia/ J. del Rosario 09/14/13
- **DZXL 558 khz** Dr. Helen Ong-Garcia Topic: HL from womb…, family biz, CVD incidence, Pinoy culture/foreign influence; 52-100 9/21/13
- **UNTV Ch. Good Morning, Kuya** Drs. J. Del Rosario RF/RHD 9/24/13
- **J. Abanilla** Stroke/PVD 9/25/13
- **V. Mappala** Congenital Heart Disease 9/26/13
- **A. Junia** WHD activities, PHA-MMDA Partnership/52-100 9/27/13
- **Men’s Health magazine** Dr. R. Lapitan How to stay healthy in your 20s, 30s, 40s 10/17/13
- **Unang Hirit** Dr. R. Lapitan Is karaoke singing good for the heart?
- **GMA Bisig Bayan** PHA Free BP/ECG plugging/documentation Dr. J. Abanilla Dr. Reynaldo Neri St. Luke’s Heart Institute/ Philippine Heart Center Fellows
MAKATI CITY, Sept. 26, 2013 – The Department of Health (DOH) extolled the Philippine Heart Association (PHA) and other stakeholders in health, for being a catalyst in the advancements in the country’s healthcare service delivery, especially to the two lowest quintile of our populace, which it refers to as “poor” and “near poor.”

The message of Health Secretary Enrique Ona was delivered by Floramel Joy Songsong, Department of Health Communications consultant. She also quoted Ona as saying: “Health is a right but being healthy is a choice. We at DOH, have actually started and road-tested the “Belly for Gud Health: The Executive Edition Challenge,” a waist measurement reduction drive through Healthy Lifestyle intervention among executives and officials of the DOH. And we’ve awarded the biggest losers, accordingly”.

“Most of the 300 MMDA field employees were diagnosed to be hypertensive and obese after undergoing Risk Factor Screenings (blood pressure or BP and waist circumference check, cholesterol and sugar determination, ECG and ankle-brachial index and carotid artery index) for early diagnosis and intervention, said PHA Secretary Dr. Alex Junia, concurrent WHD 2013 chair said.

In the past decades, diseases of the heart and blood vessels were prevalent among the rich. But in recent years, a high incidence of the same diseases was noted among the low-income group. Fatty and salty foods, smoking, unhealthy environment and stress lead to cardiovascular diseases which are lifestyle related.

Junia added that the collated data will be included in the PHA Heart Fair Risk Factor Screening Registry and patients with risk factors are advised to attend the succeeding PHA Heart Fairs for follow-up consultation/screenings.

A recent study divulged that awareness on cardiovascular disease (CVD) prevention and management is very low among the low-income group,
Ona

Dr. Junia, Tolentino, Dr. Reyes

Tolentino (in white barong) is one of the Risk Factor screening desks’ first patient

The association’s incumbent officers had their adopted chapters during the WHD 2013 celebration.

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<thead>
<tr>
<th>Name</th>
<th>Chapter</th>
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<tr>
<td>Eugene Reyes, MD</td>
<td>Central Luzon</td>
<td>9/24/13</td>
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<tr>
<td>Joel Abanilla, MD</td>
<td>Mandaluyong/Pasay</td>
<td>9/26-28/13</td>
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<tr>
<td>Jonas del Rosario, MD</td>
<td>Bicol Legazpi</td>
<td>9/28/13</td>
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<tr>
<td>Alex Junia, MD</td>
<td>Northern Luzon</td>
<td>9/29/13</td>
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<tr>
<td>Saturnino Javier, MD</td>
<td>Southern Tagalog</td>
<td>9/29/13</td>
</tr>
<tr>
<td>Raul Lapitan, MD</td>
<td>Visayas - Bacolod City</td>
<td>9/29/13</td>
</tr>
<tr>
<td>Helen Ong-Gracia, MD</td>
<td>Cebu City</td>
<td>9/29/13</td>
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among the urban poor and in the rural areas where smoking and hypertension are prevalent,” said PHA President Dr. Eugene Reyes.

Songsong further quoted the Health czar as saying: “I dream of the day when our hospitals and health facilities would only be servicing the need of the populace to stay healthy, as we’ve already addressed and controlled the non-communicable diseases with Healthy Lifestyle among Filipinos. And I hope that you here in MMDA and all other Filipinos will be able to catch the same Vision. “

The DOH also stressed that

By Gynna P. Gagelonia

Dr. Junia, Tolentino, Dr. Reyes
“through the Aquino Health Agenda or Kalusugan Pangkalahatan program, it has prioritized the health needs of its poorest countrymen and it is doing this by expanding Philhealth coverage and benefits, improving government health facilities, and scaling up public interventions to prevent complicated diseases.”

**QUOTES**

**Francis Tolentino:** “This is the first time MMDA is having this type of outreach program – with free clinic, healthy lifestyle lecture and CPR demo – which we all need. Thank you, PHA.”

**Eugene Reyes, MD:** “Don’t saddle your heart with unhealthy practices like heavy eating, smoking, staying up late and physical inactivity.”

**Joel Abanilla, MD:** “The PHA-led BP ng Teacher Ko, Alaga Ko caravan is a BP and risk factors diagnostic activity. Collated data will form the hypertension registry of public school teachers in the country.”

**Alex Junia, MD:** “Exercise, even running at the pace your body can take and a balanced diet, do wonders to the heart.”

**Raul Lapitan, MD:** “We need an agency like MMDA as an ally in promoting our anti-smoking campaign and in lobbying for AEDs (automated electronic defibrillators) so that they can help save lives.”

**Jorge Sison, MD:** Hypertensive patients are getting younger. Stay healthy to put high blood pressure at bay. Once a hypertensive, always a hypertensive.

**Jonas del Rosario, MD:** “Obesity is the end-product of casualness about our health. Childhood obesity is an epidemic in the US, we can’t be far behind, if we don’t shape up. Obesity is a coronary risk factor.”

**Helen Ong-Garcia, MD:** “Every woman is the central figure of the home. When children lose their mother, the entire family’s lifestyle changes. Moms, mind your health. In this country, women seek professional help when it’s kinda late.”
Annually, the Philippines, through the PHA, and 200 World Heart Federation-member societies from 194 countries, mark the synchronized global event on the last Sunday of September.

This year’s theme: “Take the Road to a Healthy Heart” promotes healthy lifestyle, longevity and quality living among the general public with special focus on the man on the street.

For the first time, World Heart Day (WHD) 2013 was a two-fold celebration—on Sept. 26, 2013 the PHA Heart Fair partnered with a government MMDA and on Sept. 28 and 29, 2013, PHA Board members travelled to their adopted chapters (PHA Northern Luzon, Central Luzon, Southern Tagalog, Bicol, Cebu, Bacolod Western Visayas, Northwestern Mindanao and Davao-Southern Mindanao), to join the Chapters officers, LGU executives and their allies from the pharmaceutical fold and different fronts, in marking a high-impact, unprecedented celebration.

The PHA was specially cited by the World Heart Federation for its “impressive and large-scale WHD celebrations” in September 2003 and September 2007. It is a feat the association aimed to replicate and we did, actually, we even surpassed it, said Junia.

The following pharmaceutical companies that supported the risk factor screenings at the WHD Fair at MMDA were: MSD, Westmont, Pascual Pharma, Cathay YSS, Sanofi-Aventis, Patrop Pharma, Takeda, LRI-Therapharma, Novartis and Boehringer/Eli Lilly.

In past WHD celebrations, the PHA had the following local government units as partners: Marikina, Pasig, Quezon City, Pasay, Manila, Taguig, Mandaluyong, Makati, San Juan and Cainta. This year, PHA reached out to MMDA’s field personnel.
The announcement was made by the PHA Board of Directors who was in full force at the Philippine College of Physicians Health Forum @ Annabel’s on T. Morato Ave., Quezon City. The theme was: “Take the Road to a Healthy Heart”.

Latest statistics show that death rate from non-communicable diseases (NCDs): like CVD (which includes heart disease and stroke), diabetes, cancer and chronic respiratory diseases, is on the rise.

“There is an ominous trend of NCDs because of unhealthy practices. Only 7 out of 100 adult Filipinos exercise; obese children and adult is a growing breed. Physical inactivity and obesity are risk factors for CVD”, said PHA Secretary Dr. Alex Junia and concurrent WHD 2013 Committee chair.

Premature deaths from CVD can be curbed that is why the PHA has been strongly endorsing Healthy Lifestyle to prevent the onset of lifestyle-induced diseases like heart ailments and stroke.

The WHF 2025 goal is a colossal task but the PHA is honoured to be part of such an endeavour. “Realistically, the PHA, or the medical community cannot do this alone. An intensified strategy needs enormous and continuous support from a cohesive group and our own government,” said PHA President Dr. Eugene Reyes.

He hailed the passage of the Sin Tax Reform which can result in a significant reduction in smoking prevalence. Reyes said, the influence of the World Heart Federation to the United Nations and subsequently to the Philippines, has resulted in a P10-billion contribution from the President’s Funds to Philhealth for national health reforms. However, we need to urge policy makers to craft and ratify more laws so that every Filipino will receive quality, if not excellent healthcare.

The government has to address more problems like: poverty, healthy food production, pollution and lack of infrastructure. Due to poverty, the poor cannot afford even simple, balanced and nutritious foods. Seventy percent of the population belongs to class D & E.

Pollution is now an emerging risk factor for CVD. Lack of infrastructure to protect the population from pollution adds up to burden.

in developed countries, very affordable fresh fruits, vegetables and freshly prepared foods in packs are available in convenience stores. Singaporeans are shielded from fumes because they have underground passageway for pedestrians. Amsterdam has bikers’ lane and pocket parks, added Reyes.

CVD prevention is a lot cheaper than management. “Definitely it is both inexpensive and effective. Children, adults and seniors should engage in at least 30-minute exercise daily in the form of dancing, running, See Page 37
A walk in the clouds
By Helenne Joie M. Brown, MD/ Photos by Rochie Hojilla, MD

BAGUIO CITY, Sept. 28, 2013 -- Steadfast in its role to promote a healthy heart, the Philippine Heart Association-Northern Luzon Chapter members braved the biting cold and light rain, then walked through Baguio City's bustling business district, to celebrate World Heart Day 2013.

PHA's two dynamic secretaries, Drs. Alex Junia (PHA national), who represented the entire PHA Board and Alina Fatima Hojilla (PHA NL), with Drs. Justina Calibuso, Dave Padilla and this writer, as well as members of the Baguio-Benguet Medical Society (led by Dr. Rochie Hojilla and Drs. Robert and Therese Tolentino); allied medical personnel, pharmaceutical company officers and representatives as well as lay community members, led the crowd.

With the Notre Dame de Chartres Hospital grounds as starting point, the WHD walkathon participants wound their way through historic, scenic Session Road and Harrison Road, amidst thick fog and sporadic drizzles, as if everyone was walking in the clouds.

The parade was followed by a program at the Notre Dame that was highlighted by a lecture on risk reduction via a healthy lifestyle and modification for those who had abused their health by Dr. Dave Anthony Padilla, the youngest cardiologist in the City of Pines, to date.

An enthralling lecture on the importance of smoking cessation was given by Dr. Cosme Galasgas Jr., a local pulmonologist.

Both lectures generated stimulating questions from the audience, composed of lay community members and allied medical people. Free screenings ensued in the form of 12-led ECG taking, fasting blood sugar and lipid profile determination and interpertation.

All in all, the WHD celebration was a success in Baguio. The theme “Taking the Road to a Healthy Heart” was transformed into reality as the people of Baguio City – some who walked with us, some who witnessed our walk in the clouds, are aware that we did anew a proactive move toward a healthy heart.
A day with Bahay Pag-ibig residents

SAN FERNANDO, PAMPANGA, Sept. 24, 2013 – Under the baton of Dr. Francis Pelagio, PHA Central Luzon, in cooperation with the Pampanga Medical Society, marked World Heart Day 2013 with the 70 residents of Bahay Pag-Ibig at the Holy Angel Village in this city. They were joined by PHA President Dr. Eugene Reyes.

These 70 elderly Filipinos and foreigners who were abandoned by their families and relatives were subjected to risk factor screenings. They were diagnosed to be suffering from hypertension, diabetes, heart disease and stroke, among others.

Bahay Pag-Ibig is a non-profit and non-political institution that takes care and provides for the needs of its occupants through charitable donations.

Fun Run and Zumba in Southern Tagalog

STA. ROSA, Laguna, Sept. 29, 2013 – Buoyed by the World Heart Day 2013 theme: Take the Road to a Healthy Heart, Philippine Heart Association (PHA) Southern Tagalog marked the day with a big Fun Run and Zumba Fest at Greenfield City.

Seven-hundred runners who hail from the Southern Tagalog Region arrived at the 3k, 5k and 10K fun run starting line as early as 5am.

PHA President Dr. David Salvador said: running is good for the heart. It tones the muscles and strengthens the bones.

The event was graced by immediate past PHA president Dr. Saturnino Javier, who comes from Batangas. All the PHA ST Chapter officers – Drs. Rex Palma, PHA ST vice president; Regente Lapak (PHA ST director for Laguna), Armand Gurango and Lilibeth Maravilla and the rest of the members made sure everyone had a great time.

The 10k Fun Run winner: Michael Villamor. The 5k fun Run winners: Michael Bakong, 1st place; Reymar Delacion, 2nd place; Richard Sigue, 3rd place.
Fun Run with master and pet
By Virgette Gay Mollaneda, MD

CEBU CITY, Sept 29, 2013 – The PHA Cebu Chapter did a successful World Heart Day activity which was flooded with more than 880 delegates across all walks of life. It was spearheaded by Philippine Heart Association (PHA) Cebu chapter president Dr. Wilfredo Ypil and the rest of the PHA officers in cooperation with our friends from Westmont.

The over-all organizing chair was Dr. Michael Tabaloc. It was also graced by the presence of a prominent cardiologist and a board member of the National PHA, Dr. Helen Ong Garcia. It was a well-attended affair with most of Cebu’s renowned cardiologists engaging actively in the said event that started with an energetic aero dance, with our participants warming up for the main event, the Fun Run.

This time, the run had an interesting scheme for pets were invited to join a 1km walk with their owners. It was such an amusing sight to behold. The 3K, 6K and 15K run were well participated by a number of delegates, from the pharmaceutical and medical group. The run was also open to the public.

All the 15K finishers were given medals. After the sweat-drenching, energy-burning yet fun-marathon, a brief lay forum on second-hand smoking was given by Dr. Aileen Lomarda, a new bred cardiologist from Chong Hua Hospital–Heart Institute.

Following the short lecture was another caloric burning exercise from the aero dance performers with the rest of the runners. Awarding of winners of the run culminated the momentous event. Truly it was a fun-filled, purposeful lingering occasion celebrated with the concerted effort of our cardiology and pharmaceutical team in Cebu.

OZAMIZ CITY, Sept. 29, 2013 – PHA Northwestern Mindanao partnered with Misamis Occidental Medical Society-Ozamiz (MOMS) to be able to hit its targets: to do cardiovascular disease screenings on women and children at the Ozamiz City National High School. The group was able to attend to 100 DepEd teachers, non-teaching employees and their relatives.

Dr. Josephine Saligan, chapter president said, “we took their BP, ECG, Total Cholesterol and FBS and we did free consultations. Those with hypertension, diabetes and dyslipidemia were given free starter doses, courtesy of LRI Therapharma, and were advised to follow-up at the OPD Cardio Clinic of Mayor Hilarion A. Ramiro Sr. Regional Hospital (MHARS RTTH)”. MHARS RTTH is a DOH hospital where Saligan holds a weekly clinic free consultation.

The WHD flyers were distributed and read aloud to the teachers, instructing them to include healthy diet and regular exercise and most of all healthy living in their lesson plan or instruction manual.

According to Saligan, such experience opened her eyes to the sad fact that even among teachers and government employees, health expenses which include seeking consultation on how to access healthcare is the least of their concerns. “These are indicators that we have to do the same activity in the same place next year,” said Saligan.
Interactive Cardio-Metabolic Summit

By Cecille Cabias-Jaca, MD

CEBU CITY, August 31, 2013 -- PHA Cebu Chapter President Dr. Wilfredo Ypil, along with Continuing Medical Education chair Drs. Celine Aquino and Joebert Meja, summit coordinator, ushered in an eventful 2013-2014 with the recently successful “Cardio-Metabolic Summit: Obesity, Diabetes and Coronary Artery Disease.”

Interactive Cardio-Metabolic Summit

By Cecille Cabias-Jaca, MD

CEBU CITY, August 31, 2013 -- PHA Cebu Chapter President Dr. Wilfredo Ypil, along with Continuing Medical Education chair Drs. Celine Aquino and Joebert Meja, summit coordinator, ushered in an eventful 2013-2014 with the recently successful “Cardio-Metabolic Summit: Obesity, Diabetes and Coronary Artery Disease.”

Held at the Sinulog Ballroom of the Cebu City Sports Complex, the half-day lecture was sponsored by Merck Sharp and Dohme. Dr. Consolacion Cutiliar, an endocrinologist, tackled obesity; AACE immediate past president Dr. Marsha Tolentino talked about diabetes, while Dr. Abe Montejo did CAD.

The lunch symposium had Drs. Marivic Vestal, Mayleen Laico (nephrologist) and Marsha Tolentino as lecturers. With resident physicians, fellows and consultants as attendees, it ended with a very interactive and informative open forum with Dr. Carolyn Fermin as moderator.

PHA WV Negros Occidental officers’ oathtaking

BACOLOD CITY, Sept. 21, 2013 -- PHA President Dr. Eugene Reyes (extreme L) inducts into office the officers of PHA Western Visayas-Negros Occidental (L-R): Drs. Luciene Villacin (president); Francisco Maleza (vice president); Susan Logronio (board member); Sheila Mae Villar (secretary); Stephanie Valera (treasurer); Christine Puey (board member) and Edwin Tomas (board member) at the L’Fischer Hotel.
RP delegates present work at 10th ICCAD

By Bianca De Guzman, MD (UST)

FLORENCE, Italy, Oct. 16, 2013 -- Three Philippine delegates (right to left) -- Drs. Anina Theresa Domalanta (UST Hospital), (The Medical City), and Lauren Valera (UST Hospital), presented the oral/poster presentation of their respective studies as entries at the 10th International Congress on Coronary Artery Disease at the 10th International Congress on Coronary Artery Disease (ICCAD) 20130th from October 13-16, 2013.

The Congress, which was attended to by researchers, clinicians, interventionalists and cardiovascular surgeons, tackled comprehensive updates on all aspects of coronary disease - from adequate prevention to appropriate interventions. Likewise, it provided various discussions and open forums on the new challenges regarding structural heart disease and valve disease, and offered the latest data that has emerged from basic research laboratories and clinical centers around the world. Domalanta presented a study on endothelial dysfunction in patients with exaggerated blood pressure response during treadmill stress test and a meta-analysis on oral efficacy of statin in the reduction of cardiovascular endpoints among patients with chronic kidney disease and those on hemodialysis. Valera presented how heart rate recovery determination improved the diagnostic accuracy of treadmill exercise stress test, while Villena showed comparison of transradial versus femoral approach for patients with acute ST Elevation myocardial infarction who underwent primary percutaneous coronary intervention. Dr. Raul Ramboyong, a consultant from the Medical City, was also one of the delegates in the meeting.

VIPs in EPS shine at arrhythmia in the Asia Pacific

HONGKONG, Oct. 6, 2013 -- PHA's noted electrophysiologists were part of the 3,000 attendees in the biggest joint arrhythmia conference in the Asia Pacific Region Oct. 3 to 6, 2013 in HongKong. Co-endorsed by the Heart Rhythm Society, the European Heart Rhythm Association and European Society of Cardiology meeting featured ground-breaking scientific updates in arrhythmia management, with focus and highlights on atrial fibrillation, sudden cardiac death, new drugs and ablation therapies, device therapy and cardiac resynchronization techniques.

Dr. Edmund Ang, an electrophysiologist and current head of the St. Luke's Global City Cardiac Arrhythmia Center, delivered the lecture, “Anticoagulation in Patients with Renal Dysfunction” during the session on Practical Application of Antithrombotic Therapy in Atrial Fibrillation. Dr. Giselle Gervacio, also from the St. Luke’s Medical Center, talked on “Active and Passive Pacemaker Lead Fixation” during the Pacing Workshop on the Cardiac Pacemaker Lead.

Among the list of Faculty who chaired sessions during the convention were electrophysiologists Drs. Belen Carisma, Marcellus Francis Ramirez, and Dr. Anthony King, who also served as part of the Scientific Advisory Board. Other delegates from the Philippines included Dr. Erdie Fadreguilan, Carlos Delas Llagas, Josekito Atabug, Vincent Valencia, and Delta Canela.

Meanwhile, Dr. Michael Joseph Agbayani, presented his paper entitled “Permanent Pacemaker and Implantable Cardioverter-Defibrillator Implantation Worsens Tricuspid Regurgitation and May Be Associated with More Heart Failure Admissions.” Agbayani, currently a fellow in Electrophysiology at the National University Hospital in Singapore, is a graduate of the Philippine General Hospital Cardiology training program and will be ending his fellowship late this year.
MANDALUYONG CITY, SEPT. 28, 2013 The 6th National Basic Life Support & Advanced Cardiac Life Support Training the Trainors Course reinforced anew the PHA Council on CPR’s activities and refreshed the recollection of 79 participants about the 2010 CPR Guidelines.

The same set of guidelines remains as the standard CPR principles being practiced by the trainers and every training provider.

Every year, the dynamic PHA Council on CPR, the most active of all the 17 PHA councils, conducts training the trainers exercise which has LRI-Therapharma as sponsor.

The PHA CPR training module is patterned from the American Heart Association.

Guidelines that introduced major changes:

Do C-A-B (compressions, airway, breathing) stat. The C-A-B steps in CPR save more lives than A-B-C (airway, breathing, circulation) which is passé. Mouth to mouth is passé. Using C-A-B puts emphasis on high quality chest compressions with minimal interruptions. This applies to adults, children and infants but excludes newborns.

According to experts starting with the C (chest compressions), will help oxygen-rich blood circulate through the blood faster. This is important for victims of sudden cardiac arrest. AHA says that the old approach caused delays in doing compressions, which are considered the most urgent aspect of CPR.

Forget the “look, listen and feel“ approach. The Basic Life Support algorithm has been simplified to doing the immediate activation of the emergency response system and starting chest compressions for any unresponsive adult victim with no breathing or no normal breathing.

At least 2 inches deep at a rate of at least 100/min. Increasing the depth of compression for adult victims from 1-1/2 to 2 inches (5cm), ensures high quality CPR, with continued emphasis on minimizing interruption in compressions and avoiding excessive ventilation.

The launching of the Hands-only CPR Campaign for lay people in the PHA website has reduced the barriers to bystanders who had the fear of doing mouth to mouth resuscitation due to lack of confidence.
### THE ATTENDEES

**PHA Central Luzon Chapter**  
Marietta Ablang, MD  
Gabriel Jocson, MD  
Cheryl Peralta, MD  
Manuel Montenegro, MD

**PHA Northern Luzon Chapter**  
Angelita Go, MD  
Annie Olarte, MD  
Michael Martin C. Baccay, MD  
Ellen Palomares, MD

**PHA Southern Tagalog Chapter**  
Ma Rhodora Valenzona, MD  
Ma Vilinda Villanueva, MD

**PHA Bicol Chapter**  
Osler Galen Carino, MD  
Fiorello De Leon, MD  
Tony Dy, MD

**PHA Cebu Chapter**  
Carolyn Fermin, MD  
Jose Albert Mejia, MD  
Ma. Louella Quijano, MD

**PHA Western Visayas Chapter – Bacolod Chapter**  
Conelio Borreros II, MD  
Vim Samonte, MD

**PHA Northwestern Mindanao**  
Kathleen Go-Echavez, MD  
Richard Myles Montesclaros, MD

**AUF**  
Gil Francis S. Pelagio, MD  
Harold C. Sunga, MD

**CGH**  
Michael Calasabatan, MD  
Cherie Clemente, MD

**CSMC**  
Maria Angela S. Cruz-Anacleto, MD  
J Antonio Bautista, MD (BLS Only)

**MMC**  
Shaula M. Cabreros, MD  
Michael P Rome, MD

**PGH**  
Rodel Buftizon, MD  
Maribel Barcelon-Cruz, MD  
Marcelyn A. Fusiero, MD  
Alexander Manguba Jr., MD  
Felimon Morales Jr., MD  
Marc Denver A. Tiongson, MD

**PHC**  
Eleazar Daet, MD

**SLMC**  
Anna Mae Domingo, MD  
Erwin Jannino Ybanez, MD

**TMC**  
Erwin Dolores, MD  
Claire garduque-Sebastian, MD

**UPHDMC**  
Jo Cris Gutierrez, MD  
Russel Reyes, MD

**UST**  
Leovino S. Acharon, MD  
Franco Rubrica, MD

**Other Hospitals**  
Amang Rodriguez  
Jonathan U. Pacquing, MD  
James Paul Garcia, MD

**Medical Center Manila**  
Arvin Yamul, MD  
Abdullah Marohomsalic, MD

**Mt Carmel Diocesan Hospital Lucena**  
Gay Rosalyn P. Guinto, MD  
Elleen Rose Bunag-So, MD

**Phil Society of Anesthesiologists**  
Jo-An Trilde F. Ocubillo, MD  
Karen Ann A. Espejo, MD  
Marina Vanessa A. Cristi, MD  
Abelardo Alan T. Prodigalidad, MD

**University of Perpetual Help, Binalan**  
Katherine Benitez, MD

**Dr Pablo Torres Hospital, Bacolod**  
Mr. Carlo Jun Examen  
Ms. Glenda Omana

**Medical Center Muntinlupa**  
Mark Corleto Untalan Jr., MD

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**3-days Training the Trainers Attendees: - (56)**

<table>
<thead>
<tr>
<th>Chapter/Region</th>
<th>Attendees</th>
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</table>
| PHA Central Luzon Chapter | Domicias Albacite, MD  
Arnel G. Gabriel, MD |
| PHA Northern Luzon Chapter | Max Geronimo T. Butardo, MD  
Abegil Vinluan, MD |
| PHA Southern Tagalog Chapter | Francis Martin Armada, MD  
Emma Angela Jacob, MD  
Apollo Modelo, MD |
| PHA Bicol Chapter | Jerusa Barce, MD |
| PHA Cebu Chapter | Bernadette Halasan, MD  
Abe Montejo, MD |
| Dumaguete | Silahis Rosario, MD  
Elery Vaughn T. Libo-on, MD |
| PHA Western Visayas Chapter | Francis Cyth S. Ganzon, MD  
Claire Perez, MD  
Ma. Luisa Sarbues, MD |
| PHA Western Visayas – Bacolod Chapter | Francisco Maleza, MD  
Edwin Tomas, MD |
| PHA Northwestern Mindanao | Kathleen Go-Echavez, MD  
Richard Myles Montesclaros, MD |
| AUF | Gil Francis S. Pelagio, MD  
Harold C. Sunga, MD |
| CGH | Michael Calasabatan, MD  
Cherie Clemente, MD |
| CSMC | Maria Angela S. Cruz-Anacleto, MD  
J Antonio Bautista, MD (BLS Only) |
| MMC | Shaula M. Cabreros, MD  
Michael P Rome, MD |
| PGH | Rodel Buftizon, MD  
Maribel Barcelon-Cruz, MD  
Marcelyn A. Fusiero, MD  
Alexander Manguba Jr., MD  
Felimon Morales Jr., MD  
Marc Denver A. Tiongson, MD |
| PHC | Eleazar Daet, MD |
| SLMC | Anna Mae Domingo, MD  
Erwin Jannino Ybanez, MD |
| TMC | Erwin Dolores, MD  
Claire garduque-Sebastian, MD |
| UPHDMC | Jo Cris Gutierrez, MD  
Russel Reyes, MD |
| UST | Leovino S. Acharon, MD  
Franco Rubrica, MD |
| Other Hospitals | Amang Rodriguez  
Jonathan U. Pacquing, MD  
James Paul Garcia, MD |
| Medical Center Manila | Arvin Yamul, MD  
Abdullah Marohomsalic, MD |
| Mt Carmel Diocesan Hospital Lucena | Gay Rosalyn P. Guinto, MD  
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| Dr Pablo Torres Hospital, Bacolod | Mr. Carlo Jun Examen  
Ms. Glenda Omana |
| Medical Center Muntinlupa | Mark Corleto Untalan Jr., MD |

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**THE ATTENDEES**

**PHA Vice President** Dr. Joel Abanilla  
(seated, 5th fr. L)  
Secretary Dr. Alex Junia  
(seated, 4th fr. L)  
and PHA Council on CPR chair Dr. Orlando Bugarin  
(seated, 6th fr. L)  
with the Council/Chapter members and attendees—predominantly doctors. The rest were hospital staff.
BP ng Teacher Ko... makes waves in Cebu

By Gynna P. Gagelonia, MD

CEBU CITY, October 12, 2013 -- The PHA Council on Hypertension-PHA Cebu Chapter alliance, with full support from LRI-Therapharma, gave the “BP ng Titser Ko, Alaga Ko” a major push. The team of doctors was composed of cardiologists, IM residents, post graduate interns and medical clerks. While the BP check, ECG and cholesterol tests were done, an informative lecture on “Matters of the Heart” was being given by Dr. Aileen Lomarda, one of Cebu’s youngest cardiologists.

“BP ng Teacher Ko...” steered by PHA Council on Hypertension chair Dr. Irma Yape, left an ineffaceable mark in cosmopolitan Cebu.

PHA Cebu Chapter, led by Dr. Wilfredo Ypil was in full force. According to one of the teachers and a media person, the 17 Cebu-based cardiologists who manned the consultation desks are among the best in the Queen City of the South.

“Nothing beats the feeling of serving the people who have helped shape our minds. It’s payback time to our mentors”, said Ypil.

The 265 participants composed of teachers and non-teaching personnel are elementary and high school teachers from public schools, including science day/night schools in the city and neighboring towns of Cebu province.

PHA Secretary Alex Junia’s giving the thumbs-up to call on media to dash to the “BP ng Teacher Ko” site...
was a wise decision. The event gained enormous media visibility/support. ABS-CBN, GMA7, TV5, Radyo Bombo and PDI-Cebu Daily News covered the event. Thanks to Cebu Daily News managing editor Ares Gutierrez who introduced this writer to Cebu media’s cream of the crop. Cebu Daily is owned by the Philippine Daily Inquirer. Gutierrez had worked as a reporter and as an editor for Philippine national dailies and Dubai Gulf News before joining Cebu Daily News.

Drs. Junia, Yape, Ypil and Carolyn Ferrin, were interviewed by media. They talked about “BP ng Teacher Ko...’s” history, the risk factors of cardiovascular diseases, which include hypertension; diet, healthy lifestyle, CVD prevention and management.

At any given day, there is human traffic in the venue, Mabolo Elementary School which has a huge auditorium/function hall and sprawling grounds, the convergence point of senior citizens and a giant stage for socio-political events in the city.

The teachers were all ears to the very interesting lay-friendly lecture on Healthy Lifestyle tackled by Dealia Sirion, a nutritionist-nurse.

According to Dr. Josephine Valencia, DepEd Cebu medical officer, the pre-registration record showed that 400 DepEd teachers and non-teaching personnel will avail of the screenings.

She said, “when we hit 400, we even turned down at least 100 late registrants who were hoping they would beat the deadline and given consideration, given their big number.”

Unfortunately, over a hundred backed out last minute. Some were in denial, while the rest, don’t have extra money for fare. What a waste because that’s exactly the number we declined.

She added “teachers are generally hard up because their pay is not enough to tide them over till the next payday due to escalating cost of living.”

It turned out, that all of the Cebu DepEd employees are suffering from hypertension. Valencia said “they are hypertensive because we had a pre-selection process.” She had looked forward for “BP ng Teacher Ko...” because that was their chance to avail of free follow-up tests and consultations. She also told PHAN that DepEd personnel don’t have health benefits.

Dumaguete is BP caravan’s 23rd hop

DUMAGUETE CITY, Sept. 22, 2013 -- This pastoral city had its share of the limelight. The Negros Chronicle covered and highlighted BP ng Teacher Ko, Alaga Ko in Dumaguete.

It was the top story of page 20 of the 40-year-old daily. Its lead reads: “The Philippine Heart Association, the organization of cardiologists in the country, extended their 23rd stop in Dumaguete, to conduct free Risk Factor screening, particularly hypertension, for all city public school teachers here.”

Dumaguete gathered 241 teachers at the West City Elementary School, through the efforts of Dr. Berna Ysulan, DepEd medical officer.

Yape got big support from her Dumagueteno colleagues – Drs. Erlyn Demerre, Susan Denura and Kenneth Coo who are among Dumaguete’s outstanding children. Manila-based Demerre is an eminent heart doctor. Yape’s practice is also picking up. Denura is a fast-rising cardiologist in Dumaguete, while Coo is a noted Nephrologist. They were aided by eight residents from the Siliman Medical Center. Yape is a native of Ozamis City while Demerre, Denura and Coo were born and raised in Dumaguete.

During the consultations, Yape and Demerre both confirmed that 25 percent of 90 million Filipinos are hypertensive. The risk factors of this disease are heart attack and stroke. Demerre further said that the key to prevention of any heart disease is proper diet, regular exercise and check up with your doctor.

Dr. Marizoon Dumiao from the DepEd head office lectured about Healthy Lifestyle.
Most teachers diagnosed as hypertensive

SAN RAFAEL, Bulacan, Sept. 6, 2013 -- Dr. Irma Yape joined forces with a team from the PHA Central Luzon chapter, headed by president Dr. Gil Francis Pelagio, Drs. Solita Abesamis-Bayan, Rene Fernandez and Michelle Ferrer-Serrano (who tackled Healthy Lifestyle in her lecture), attended to some 270 teachers from the Maginal Elementary School who were predominantly hypertensive.

The patients were subjected to hypertension risk factor screenings. Also on hand were Drs. Therma Aljibe and Kristin Sevilla from the DepEd Manila and Bulacan, respectively.

Apparently, the trend – 25 percent of the 90 million Filipinos has been established and the succeeding results in the BP Caravan sites serve as confirmatory tests. The “BP ng Teacher Ko” hopes betrayed the plight of dedicated public school teachers.

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### MEDIA EXPOSURE

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### TARGET STUDY SITES AND DATES OF SCREENING

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Bernan is Research Committee chair

QUEZON CITY, October 5, 2013 -- PHA President Dr. Eugene Reyes named Dr. Alisa Bernan, chair of the PHA Committee on Research at the Crowne Plaza Manila Galleria Hotel. Her appointment officially starts today.

The announcement of Bernan’s appointment was followed by an oathtaking administered by Reyes. Witnessing the oathtaking rites were members of the PHA Board -- Dr. Joel Abanilla, vice president; Romeo Cruz, VP for Finance; Drs. Alex Junia, secretary; Raul Lapitan (treasurer); Helen Ong-Garcia (director) and Saturnino Javier (immediate past president).

The posting of Bernan at the helm of the Committee on Research will beef up the PHA’s ambitious Research undertakings. Research is the flagship project of the Reyes administration. Bernan is currently a candidate for the degree of Master of Science in Clinical Epidemiology at the Department of Clinical Epidemiology at the University of the Philippines College of Medicine. She is working on data collection for her thesis entitled “Validation of the MacNew Heart Disease Health-Related Quality of Life among Filipinos with Acute Coronary Syndrome”.

A past president of PHA Southern Mindanao-Davao, it was during her two-year presidency from 2008 to 2010 that the Chapter achieved remarkable feats.

‘We don’t have data’

The Philippine Heart Association held a research forum for members of the different councils regarding creation of clinical practice guidelines (CPGs) and patient registries on October 19, 2013 at the Crowne Plaza. Many agreed that creating CPGs may not be feasible at this time but the council on CAD will update its registry and the councils on Congenital Heart Disease, Electrophysiology, Cardiopulmonary Resuscitation and Heart Failure will embark on creation of patient registries. Many councils have, in fact, started their own respective registries but confused as to how to go about it. We asked why they want to do it, the answer is “because we don’t have data”.

Clinical information is key to assessment, monitoring, management and policy development of patients with cardiovascular disease. We gather information on a daily basis in our face-to-face encounters with our patients. in the clinics, in the lab, in the hospital – data is gathered daily. What we lack is a comprehensive and integrated information system to address the growing burden of cardiovascular disease in the Philippines including reliable and updated data that can be used by healthcare providers, policy-makers, researchers and the public.

The research committee is working with the different PHA councils for the creation of a systematic, methodical and integrated patient information system for our patients from which registries can be made.

Local guidelines for better heart care out in 2 years

QUEZON CITY, Oct. 19, 2013 – Local treatment guidelines designed for enhanced better and affordable heart health care that will greatly benefit the underprivileged sector of society, will be off the press in two years’ time.

There should be a set of PHA local guidelines tailored for a certain location. Poverty should no longer be a barrier. In the US, in a matter of hours, angioplasty or bypass surgery is done. In the Philippines, it takes months because money is a big problem. With the expansion of Philhealth coverage, which includes even the overseas foreign workers (OFWs), this is a windfall for the common people with heart disease.

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ECG is crucial

MANILA, Sept. 19, 2013 -- The ECG is important in the diagnosis and prognosis of cardiovascular disease. It is useful in identifying and confirming the presence of myocardial infarction (MI) or heart attack or an abnormal heart beat or arrhythmia.

Some 140 health professionals -- mostly medical residents, almost half were nurses and a few were cardiology fellows -- attended the University of the Philippine-Philippine General Hospital annual 2013 ECG Course, conducted by the institution's cardiology section.

Held on Sept. 18-19, 2013 at the Diamond Hotel, Roxas Boulevard, Manila, the participants hail from as far up north of the Philippines as Ilocos Norte and from as far down south as Davao.

Fourteen lectures were presented by leading cardiology faculty of the UP College of Medicine -- from the basics such as normal ECG reading to advanced topics like arrhythmia management.

Meticulously tackled were the various causes of abnormal cardiac conduction, as well as its accurate identification using the ECG; pattern recognition, meaning, finding the equivalent of a particular ECG; technical aspects of ECG reading and troubleshooting, arrhythmia identification, complimented by a difficult ECG workshop and panel discussion.

The lecture was titled “The Heart and the Kidney” and was ably given by Dr. Agnes Mejia, professor and dean of the UP College of Medicine.

Mejia discussed the complex dynamics and importance of the cardiovascular and renal systems in disease presentation and management.

As the 2nd RFA Lecturer, the Board of Directors of the UP-PGH Alumni Association led by Dr. Raul Jara, unanimously voted and presented a resolution naming Mejia an honorary member of the association. Physicians, alumni, fellows, residents, students, and guests were in attendance during the presentation.

The proceeds from the course will be donated to the Pusong Pinoy Foundation, Inc. of the UP-PGH Section of Cardiology which provides financial assistance to indigent patients.

Paul M. Reganit, MD
Jodette Lavente, MD

Añonuevo is new cardiology chief

Dr. John Añonuevo, a US-trained interventional cardiologist and former training officer of the UP-Philippine General Hospital cardiology fellowship program is the new chief of the Section of Cardiology. He will assume his post on December 1, 2013.

He was appointed by UP-PGH Director Dr. Jose Gonzales and Department of Medicine Chair Dr. Rody Sy.

Dr. Añonuevo succeeds Dr. Raul Jara in an eminent line of cardiologists -- from Drs. Gregorio Patacsil, Ramon Abarquez, Jr, Rody Sy, to Nelson Abelardo.

He is a man of great integrity; a paradigm of a multi-faceted person, with good people and administrative management skills.

The UP-PGH community welcomes his appointment and looks forward to his service as a leader, mentor, and researcher.

Paul M. Reganit, MD
The maiden issue (July to September 2013) of “Heart Tunes” is out. The launching of the four-page Heart Tunes, the official quarterly lay publication of the St. Luke’s Heart Institute (SLHI), coincided with the 27th founding anniversary of St. Luke’s Heart Institute every first week of August.

It reaches out to the valued patients of St. Luke’s Medical Center-Quezon City, and residents within the vicinity, to foster a better understanding of the general concepts and trends in the care of the heart patient, especially on CVD prevention.

Catering to non-medical practitioners, “Heart Tunes” was conceived as a small publication with invaluable heart health information and issues, said Dr. Antonio Sibulo, St. Luke’s Heart Institute Department of Preventive Cardiology and Cardiac Rehabilitation head.

He added “we recognized the vital role that each individual plays in the prevention and management of cardiovascular disease, as well as the promotion and maintenance of one’s overall health and well-being,” added Sibulo.

Dr. Homobono B. Calleja is the founder and Director Emeritus of St. Luke’s Heart Institute.

Editorial staff of Heart Tunes are Drs. Erlyn Demerre (editor-in-chief), Irma Yape and Maita Senandrin (managing editors), Helen Ong-Garcia (circulation). The contributors are various cardiology fellows of the SLHI.

Local guidelines...from Page 25

“The American Heart Association (AHA), Canadian or European guidelines are not applicable to us, especially to the marginalized sector. Having our own treatment guidelines tailored for the local setting, will redound to patient empowerment. Potent and reasonable medicines and treatment options should be presented to the patient. Together, the physician and the patient will decide on risk strategies,” said PHA President Dr. Eugene Reyes.

He added that “we will produce guidelines in a systematic way. A writer will be hired to do the technical report but the Research Committee has to know how it is being done”.

Reyes suggested to the group that there has to be a separate set of guideline for the less-privileged sector, for men and women.

In the process of working on the guidelines, it better to start with symptoms. If it is acute coronary syndrome (ACS), there has to be recommendations on how to work it up.

PHA Vice President Dr. Joel Abanilla told the 16 PHA Councils that it is high time that we do another registry because the Dyslipidemia and Coronary Artery Disease guidelines are obsolete. Of these guidelines, only 67 percent were applicable, 28 percent were not applicable. The mandate of the Councils is to do registries.

Dr. Alisa Bernan, a past president of PHA Davao Chapter, is Research Committee chair.

Reyes said that under Bernan, we will create a Guideline Development Group (GDG). The Task Force on Clinical Guidelines is composed of an expert panel and stakeholder representatives who have to come up with an implementation and dissemination plan.

The Research Committee is working with the different PHA councils for the creation of a systematic, methodical and integrated patient information system for our patients from which registries can be made.

The goals of the practice guidelines are to improve health care, decrease variations in practice, save money and to protect patients and practitioners.

Bernan said even though research is a thankless job, she has put her heart into research. Part of her task is to do the overview and treatment guidelines.

This development in PHA’s Research area is a paradigm shift. Abanilla said “our main thrust is research. We will be creating a research foundation. The ranking of each pharmaceutical company will be based on the grants they have extended to PHA. The highest level is platinum.”

There’s an allocation for research. The Councils just need to give their registry design then we will help you raise the budget.

Drs. Raul Lapitan and Helen Ong-Garcia were the master of ceremonies. Lapitan announced for news updates, visit the PHA website: http://www.phil.heart.org, while Ong-Garcia said that we can look forward to a duly replenished research program.

GPGagelonia ♥
TAGBILARAN CITY, October 28, 2013 – Two weeks after the destructive quake, when aftershocks were coming a little less frequent, aboard Air Asia which was two-thirds empty, we touched down Tagbilaran Airport. The St. Luke’s Heart Institute group composed of Drs. Sue Ann Locnen, our coordinator, Marilou De Jesus, Jerome Laceda, Lea Dimaano, and myself, met up with Land Rover Club Philippines led by Paul Hinlo, the lead organization for this mission, Malaysia Elite Disaster Rescue Foundation, and other friend doctors from Asian Hospital and UERM. Target areas for this four-day mission were Barangays Libertad Norte, Libertad Sur and Canmano in Sagbayan and Cambansag and Abehan in San Isidro. Soup kitchen, safety information, relief goods distribution, debriefing and medical services comprise the relief mission. We expected to witness despair and disarray in a destitute land shattered and shaken and repeatedly shaken. Instead, in amazed disbelief, we saw much more than the remarkable resilience Filipinos are known for. We found Bohol oozing with quiet sanguineness. We also found genuine spirit of altruism in the people we have worked with.

The Bohol Earthquake: Making a fight of it

By Malou Bunyi, MD

We met Dave Collins, an Australian who has been living in Bohol for 15 years and whose love for this province clearly surfaces. With the map of Bohol, he oriented us as to the extent of damage the quake caused, identifying which roads were passable and which were not. The rescue team later on would be led to explode a huge boulder that hung by the roadside to prevent it from causing danger to people. We then met John Maguinot of Youthlead who initiated Bangon Bohol Relief Drive. John gave us insights regarding the need to converge all organizations wanting to help Bohol for an orderly way of relief distribution, avoiding surpluses in some and ensuring that no communities are left out. With him is Patrick Eleazar, a medical student who came all the way from Cebu together with some nurses just to help Bohol in its dire circumstance. As they pose for picture, we noticed that they raise their right hand as if in a pledge and do the four-finger sign and say: “For the Philippines.” They have staged their actions to immediate relief, early recovery, and rehabilitation and rebuilding. The leadership skills, the solidarity, the clarity of purpose, the drive, the idealism of these youth will leave one bewildered that such kind of people exist, upholding what Rizal premised of the youth, and that this country indeed has hope. John, espousing transformational leadership, says politics is not in his mind. Hooray!

A tour around the devastated city sank our hearts. The Chocolate Hills that moved us to love this amiable place were split. Roads were cracked. We held the pieces of church ruins in our hands and felt how this fragile limestone was no match to this killer quake. At the backdrop of the fallen Baclayon church, the symbol of Bohol devastation, was a rainbow—an affirmation that God has not forgotten what He has promised.

The story of Bohol earthquake came alive as we interacted with the people during our medical mission. The 7.2 magnitude quake was literally a violent shake, based on their accounts. They were shaken up and down, forward and backward, side to side, all of the longest 35 seconds of their lives. They got out of their houses crawling, because they were unable to stand up with that violent shaking. Those who were in the field would see huge boulders running down the mountains from which they couldn’t run away or they would fall down. Instead, lying prone, they would duck for cover holding on to bushes face down, praying that they wouldn’t get run over by the boulders. Our hearts cried with those who have just buried their dead. As they tell their stories, it was very difficult not to get affected or not to be thankful that we have been spared from this blow. To be listened to heal their spirits much more than the medicines healed their bodies. And listening to them enriched our hearts.

See Page 31
Fiercest quake in RP history

215 die in Bohol, 13 in Cebu; damage placed at billions

By Gynna Gagelonia

A huge percentage of humanity opted to cocoon in the comforts of their homes and be laidback on Oct. 15, 2013, Tuesday, a public holiday. In observance of the Muslim Holiday of Eid-al-Adha, Malacanang declared Oct. 15 a national holiday.

In a matter of seconds, the still and lazy mood that Tuesday morning was replaced by commotion by an earthquake that rocked Bohol (intensity 8), Cebu (intensity 7), and some towns of Visayas and Mindanao.

One of the fiercest quakes in Philippine history triggered 2,078 aftershocks, 39 of which were felt all over the Visayas Region and as far as Mindanao; as well as landslides.

Call it blessing in disguise. Schools, offices and some business were closed, this helped reduce the number of casualties.

Holiday spared lives

Bohol endured the tremor’s brunt. Cebu was not as badly rattled.

Video footages of falling debris, hysterical people running for their lives at the height of the tremor and news updates on TV/broadcast networks, on social media, kept netizens and non-netizens posted.

Outpouring of words of comfort and avalanches of aid that came in many forms was overwhelming.

FORTUNATELY, all members of the PHA family based in the Visayas and Mindanao escaped the impact of the tremor. Our very own cardiologists were quick in taking part in the rescue and relief operations.

Earthquakes in the Philippines are quite common because the Philippines is on top of the Pacific Ring of Fire. The various earth tremors in the crust of the earth cause the earthquakes.

Magnitude is the measurement of the energy released at the source of the earthquake while intensity describes the strength of shaking based on its visible effects on objects and the environment.

Damage to property in Bohol was placed at P2.2 billion. About 215 people were confirmed dead, 877 were injured and 8 were missing.

In Cebu, 13 people were confirmed dead, 96 people were hurt and 404,107 families or more than 1.9 million people were affected by the quake.

Nearly 71,900 residential houses were damaged, out of which 14,480 were totally wrecked. Worst affected were the towns closest to the epicenter like Loon, Tubigon, Carmen, Calape, Sagbayan, San Isidro, Clarin and Catigbian, Bohol.

Period structures crumble

Vintage churches and tourist spots that were partially or totally damaged were the Baclayon Church, Sta. Cruz Parish Church, the Chocolate Hills Bell Tower and Observation Deck in Carmen town. The Tagbilaran Port Terminal, the municipal halls of 12 schools and the Cong. Natalino P. Castillo Sr. Memorial Hospital in Loon town gave way, where an unknown number of patients were trapped and killed. Thirty-two bridges, including many along the National Road, and 13 road sections were damaged and impassable, getting in the way of aid efforts. There was power outage in the province.

Furthermore the prolonged period of aftershocks that forced the population to resettle outside in makeshift shelters, for fear of staying in weakened buildings, caused psychological trauma.

Community health centers and hospitals were rendered uninhabitable, resulting in makeshift wards outside. The food supply was disrupted with many markets not operating for a week after the quake.

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**Sto. Nino Basilica collapse**

The Basilica Minore del Santo Nino, a must-see historic site; and a building in Pasil Fish Pork in Cebu City collapsed, killing five people and injuring seven people. Some hospitals such as the Cebu Doctors’ University Hospital and St. Vincent Hospital sustained minor damages. A part of Mandue Market was knocked down.

**An awakening**

By Jane Ramiro, MD

TAGBILARAN CITY, October 30, 2013 -- The earthquake has big lessons to impart. It is an eye opener to all. We have to be serious with disaster drills, not only on institutions, but likewise on educating the entire populace. And most importantly, life is God’s sovereign grace and we all have to be ready anytime.

I was home -- in Tagbilaran City, Bohol during the earthquake.

In the first few seconds that the quake began, I thought it was just nothing for I’m a native of La Carlota City, Negros Occidental, wherein we would experience small intensity quakes when I was young. However, when I felt the jolts did not stop, and I noticed that the walls were cracking and things in the house were falling, I cried aloud to our Lord Jesus Christ to please stop the earthquake! Indeed it did after a 30-second shake, although I thought that magnitude 7.2 lasted much longer.

**24/7 on call**

Despite the horrible sight on the streets, call-of-duty comes first. The most common cases I attended to that day and the entire week, were only a few anxious patients, some went into hypertensive urgencies and the rest were the usual patients on my service in the private hospital to which I’m affiliated. Several earthquake-related injuries were admitted under the surgery department. A lot of these patients though were admitted in the government hospital.

**Charity begins at home**

I took part in the medical missions jointly conducted by the Philippine College of Physicians Bohol Chapter and Bohol Medical Society, and the rest of the specialty groups in Bohol which immediately activated and mobilized the trauma and disaster teams. Our pharmaceutical friends sent their support stat. Coordinated medical missions were done all throughout Bohol especially on those heavily stricken areas.

Infrastructures in Tagbilaran were not heavily affected and fortunately, no cardiologist was hurt. There were no reports of damaged properties owned by cardiologists, either.

The national government’s disaster management was pretty well. The emergency disaster team was immediately alerted. However, there were towns which could not bring casualties to the city due to roads and bridges that broke down. If ever they could travel, it would take them about two hours instead of the usual 15-30 minutes travel time. No electricity. No communication. There was news blackout on what was going on outside Tagbilaran City for a couple of days. Loon and Maribojoc towns were isolated due to ripped bridges. The provincial government coordinated with different sectors including the medical associations of Bohol which facilitated medical supplies and future medical missions on the island.

**Just on time**

Relief operations and aid from the national government was good enough. President Simeon Benigno Aquino III came on the third day. Interior and Local Government Secretary Mar Roxas came a day before the president and he stayed for almost a week. Likewise, Philippine National Red Cross Chair Richard Gordon came to oversee their operations.

Bohol is undergoing rehabilitation and Tagbilaran is taking the smooth road to recovery. The bridges linking Tagbilaran to the outlying towns are now passable.

However, some people in the affected areas, where a lot of school buildings collapsed, are still sleeping in their tents since they claim they’d still feel the tremors. Classes are being held under the tents Mondays to Saturdays.

Aside from the centuries-old churches, the Loon District Hospital and some health centers in the towns near the epicenter were a total wreck. Restoration process is ongoing. Tourism and other industries are gradually bouncing back.
I was jarred from my seat as I felt the ground move violently underneath me. The cracking sound of smashed vases and other ornaments accompanied my mother's cry of terror. I struggled to keep my balance as I led her out to the driveway and shouted for the rest of our household to run to the open space before us. For what felt like an eternity, in reality it took less than a minute of torture. I immediately assessed the condition of my mother and our household who, although greatly shaken, were thankfully safe and healthy.

A doctor first and foremost, after several strong aftershocks, I walked to the Borja Family Hospital to check the damage and how my patients fared. To my utter relief, the hospital's sound foundation and emergency preparedness saved the medical staff, personnel, patients, including mine and visitors from harm. On my way home, I saw so many people on the streets. They were shocked at the sight of devastated buildings. On my way home, I saw so many people on the streets. They were shocked at the sight of devastated buildings.

Nevertheless, I witnessed bayanihan. Everyone, including members of my family, comforting and helping one another.

I’ve always known and this belief was just confirmed anew today, that Bohol will reclaim and rebuild its beauty through the strength and faith of its people. Boholanons in the Philippines and all over the world will make it happen.

and blessed our souls. Most were not sick of anything organic. They complained of inability to sleep, loss of appetite, headache, palpitations, epigastric discomfort. They would tell you that symptoms started when the quake happened, and they come back whenever there were aftershocks. The aftershocks were punishing, making it difficult for their spirits to quiet down as if they were repeatedly tortured without letting up. As we started the day’s activity in prayer, we felt a thud that made our hearts jump a little.

While there were symptoms of anxiety, there were also evidences of a quiet resolve to come back. They were content that they have a daily ration of food from relief goods. But what if relief flow stops? "Oh, there are a lot of plants around." How long will they stay in the tents? They will go back to their houses when the aftershocks stop. What about those who do not have houses to go back to? They have plans to slowly rebuild their houses. "There are a lot of woods to use." Such uncomplaining people. We were more insecure about their future than they were.

We moved around and tried to feel the life in this small tent city. They were not actually tents but drapes put together to simulate a house but not one without spaces in between the drapes. We peeked inside one of the tents which houses 9 families, and we were surprised at how orderly and clean it was inside. The mattresses and planks of wood covered the ground. Their clothes and things were neatly stacked at the sides.

In one area, the kids gathered playing with balloons. Kelvin, part of the Malaysian team is a street magician and a balloon artist. He says the joy he gets in doing these things in disaster areas is priceless.

Making a fight... See Page 30

The balloons put a smile in the faces of the kids. Another Malaysian bought all the icedrops of 2 vendors and made the kids line up for it. What a feast!

During our last night, a short thunderous sound came from down under as the earth moved. Henceforth, that made our bathroom times quick and short. That farewell shake sealed our mission and yoked our hearts with the Boholanons.

It was a delight to see how people gather up and how the God-designed ingredient of goodness in men comes out naturally during times like this. Meeting extraordinarily gifted and sincere people was an added bonus. Most of us have never believed in the true value of a medical mission but this has been an enriching experience for us. We came to heal but instead we went home with healthier souls. Quakes do move the ground to shatter the earth but they move the spirit to gather the soul. It felt good to somehow be in the fight.
Freman Cerezo, MD
St. Luke’s Medical Center

"IN SICKNESS and in health," and yes, even unto death... These must be the words that ran through Dr. Freman Cerezo’s mind as Marge, his wife of 17 years, came face to face with the rare Neuromyelitis Optica Spectrum Disorder.

September of 2012 saw Marge attending to her ill father in the ICU of a hospital in Dagupan, Pangasinan. Little did she know that the monstrous stress of the moment would put a dent on her and her family’s life. By the third day of her daughterly duties, she was vomiting, which they thought was a severe case of gastritis. Cerezo then opted to fetch his wife and bring her back home. Vomiting continued, then Marge was already complaining of dizziness. He decided to bring her to St. Luke’s Medical Center when he saw that she was having severe nystagmus and diplopia and couldn’t watch television nor read anything anymore. At this time, she already lost bladder and bowel function and Cerezo assumed his dual role of husband and doctor as he did straight urinary catheterization and manual extraction of stools for a dear wife. Marge was awkward and uncomfortable with the situation but the dutiful husband that is Cerezo assured her that he is the right person who should do these things.

Aside from playing the role of husband and doctor, he was father to their children, putting up a brave and strong front and explaining their mother’s condition as he prepared for the worst for their family. Worst was the fact that he may lose a wife and that his children may lose a mother, but he never discussed this with Marge and the kids. He braced himself for the inevitable future and played his different roles on a daily basis, taking even the role Marge is unable to play at the moment, being a mother and a household manager.

Signs and symptoms for Marge were getting uncontrollably strange and fearsome. She started to grow weaker and needed assistance to walk. The following day, she was completely and helplessly unambulatory. The stranger the scenario for them, the firmer the resolve of this multitasking doctor to be one sturdy anchor for the family. He was well aware that he needed to stand firm and steady himself as these gale-force winds pass unfairly unmindful of the many new responsibilities just recently assigned to him. He was president of the St. Luke’s Heart Institute Alumni Association, and was only recently promoted assistant director of St. Luke’s Extension Clinic when life tested his mettle.

Throughout all these, Cerezo rolled with everything coming their family’s way. He tried to play his roles well, but never attempted to control things. Surrender may be his other term for not taking control. He leaned on some other people for much needed support like his mother-in-law, friends, and co-doctors. He cried unashamedly when the brave front he has set became heavy. He continued to discharge his duties as a doctor and tipped the balance from time to time to accommodate the demands of his other roles—like missing a clinic in favor of keeping Marge company in procedures like plasmapheresis, or just holding her hands to assure her of his love and support.

More than a year is over since those long stormy days. The calm has set in and life has been kind. Marge is back in her usual role but changed some things in life to lessen the impact of stress and prevent recurrence. Cerezo gets a birthday card from kids with this message: “We are leaning on a sturdy wall.”
Loewe Go, MD  
St. Luke’s Medical Center, Cardinal Santos Medical Center, The Medical City

I make it a point to attend special events and activities at school, even if I have to shuttle half way around the globe twice. Most recently, I did this for a conference and a planned family vacation just so I can accommodate my daughter’s performance that sits in between travel dates. And I do this for all my three kids: Maddie 16, Leo 14, Mira 11, to be fair in making equal opportunities and experiences for each of them.

Thanks to technology (especially FaceTime and Skype), I can do my tasks and travel and still be connected with my kids. By letting them know that you think about them even if you are away and that you are still part of their daily lives, they can feel more secure. I am very fortunate to have achieved a good life, work and family balance because of my very supportive and loving wife, Margie.

Giselle Gervacio, MD  
St. Luke’s  
Medical Center  
The Medical City

I get this balance by trying to think like a kid, and as my friend Dr. Jean Alcover says, working less but working more passionately.

Ramon Reyes, MD  
St. Luke’s Medical Center

Everything needs proper budgeting of one’s time. Even my workout which I do 4x a week is budgeted time. It is important to set priorities, less extracurricular. I always prioritize my activities making some sort of a timetable. For this I want to thank Dr. HB Calleja because he is the one who taught us that time is very important. That’s the reason why he subjected us to this kind of training so that we could be good doctors in our field.

Saligan with 60-year-old mom

Stella Marie Mabanag, MD  
La Union

I maintain my life work balance by scheduling each activity and planning ahead while allowing some flexibility in time frames. That way, I can choose to work or not. Then I plan my off time when I absolutely do not think of work at all.

Josephine Saligan, MD  
President, PHA Northwestern Mindanao Chapter

Now that I practice in my hometown, I have more emotional and financial balance, contentment in my life and work. My family support is here in Ozamiz City. In my practice, I aspire to deliver, treat patients effectively and promptly. I am able to achieve this by training my secretary and staff. I am also blessed with a clinic housed in our family-owned building that is right in the heart of Ozamiz. Church, shops, restaurants, market, salon and banks are walking distance. Right now, construction of my Heart, Vascular, Arrhythmia and medical facility is underway. Target date of completion is this first quarter of 2014. I am hands-on in its planning and execution, as well as financing with the help of my siblings. PHA Northwestern Mindanao chapter is currently organizing a postgraduate course. I start my day early with a cup of coffee while browsing Facebook, then I do exercise, take a long shower and a quick breakfast.

Then I do my hospital rounds then clinic at midday. Our ancestral house where I live with my 84-year-old mother is on the same block as my clinic that is why I can dash home for lunch. From my home, I proceed to the government hospital where I am a part time consultant, to do my rounds and 2D Echo reading. Usually, I go home at 8 or 9 pm on weekdays. Before going to bed, I watch TV or browse the Net. With smartphone, iPad and laptop, I am able to squeeze in browsing the Net for the latest Cardiology news at Medscape and Cardiosource. Gone is the proverbial obsolete provincial doctor.
In between our monthly staff meeting, I had a candid and revealing discussion with some of our pediatric cardiology staff regarding personal primary and secondary cardiac preventive measures and how each one of us maintain “Life/Work” balance.

Their answers straight from their hearts:

**Jhuliet Balderas, MD**

gets caught up with family and friends over a good meal. Believing in the value of preventive care, she makes sure she and her family members have their regular health checks. To unwind, she watches a movie or goes to the gym. Having regular pockets of time for self and family enables Juliet to keep up her dynamic leadership at the Philippine Heart Center Department of Pedia Cardio and as head of the PHC’s Office of Strategic Management.

**Juan Reganion, MD**, a pediatric cardiac interventionalist, makes sure he “strikes exclusive quality time” in his calendar for his wife Ciel and six daughters, and makes room for personal pleasurable time of indulgence by gardening, farming and playing golf. These -- plus eating the right food and having the right attitude has kept him and his family in noticeably good shape.

**Martha Martinez-Santiago, MD** goes on weekly (as much as possible, without fail) date nights, reserved just for her and her hubby Ramon. An active advocate for healthy lifestyle -- Martha sends her kids (Tatiana and Diego) off to school with “homemade baon” daily. As much as possible she refrains from having pork at home. Occasionally, she does give in to pleas for Krispy Kreme.

**Pacita Lopez-Ballelos, MD**

Jing as we fondly call her, at the outset, limited her work time to three hospitals; scheduled her clinic hours round her kids’ (Patricia and Luis) school hours, to make sure she will be home when they knock off from school. The “cool and collected” Jing enjoys a relaxing meal with family and friends and actively serves as Sunday School Teacher in her church where her children at times ministers in music.

**Aurora Gamponia, MD**

assessment is the key to a good balance… Assessing which activity and event (where she is invited or needed) is more important helps her plan “work hours” vs. “rest and recreation time. Re preventive cardiac care, as much as possible she practices a healthy lifestyle and educate her family about harmful vs. beneficial food/activities. Not so difficult to instill when you have a surgeon husband Dr. Rey (equally kept in shape) and budding adult cardio-to-be daughter Katrina (I am sure Christine also). Dr. Au makes sure that she creates anti-stress activities for herself and her family members. It is thus not a wonder that she has remained her graceful self all these years.

**Maria Theresa (Mayette) Claudio-Rosqueta, MD**

takes pleasure in going out on weekends with her husband, Robert and two daughters, Mia and Maia. After a hectic days’ work, Mayette still looks forward to tutoring and playing with her kids. She claims that’s how she has kept herself young through the years.

So finally, how does the author, **Ina Bunyi, MD**, try to balance her life and practice wellness?

Having family and extended family responsibilities add up to the pressures of work in two government hospitals (PHC & PCMC) and Society obligations. Through the course of time “I finally learned the wisdom of establishing a set of priorities that help me settle on parameters -- on activities/work... On these occasions, I do critical decisions with my level-headed husband, Dan, with whom I have always shared regular quality date or recreation time with.

Having personal devotion time of reading God’s word and prayer helps set the tone for each day. I know that I am helpless without God but that I can do all things through the strength He supplies (John 15:5, Philippians 4:13). I usually end up with a song or two that keeps my mind and heart right. So do not be surprised when you hear someone whistling along the Stairwells of Philippine Heart Center – it might just be me. ;-) That by the way, walking regularly (eating right) is how I practice personal preventive cardiology. Wellness of heart and soul truly go together. ♥
How do cardiologists take care of their hearts

Gregorio Rogelio, MD  
St. Luke’s Medical Center  
Cardinal Santos Medical Center

My quest for maintaining good health started when I hit 48. Nearing my golden age, I embarked on a program that will make me achieve my goal of staying “Healthy at 50”. This is how I take care of my heart: 1) I maintain my ideal body weight; I stick to a “nibbling” diet - I trained my brain and my stomach to get used to small, frequent feedings - six tiny servings a day - low in fat, low in carbs (2 small pan de sal or 3 tablespoonfuls of rice). I start my breakfast and dinner with a glass of fresh fruit and carrot shake with a little honey, followed by the main course of veggies plus fish or lean meat and end it with dessert of fresh fruits. I hardly eat lunch; only half a meal - the other half I share with my clinic nurse. Snacks are even lighter, usually liquid food like juice, soybean milk or nata de coco drink occasionally with cookies or hopia. Now my stomach easily gets satiated with just a little, increase in content. It seems that with proper conditioning, my stomach expands less, decreasing my gastric capacity, as if I had functional gastrectomy. 2) I do a little exercise - one hour of dancing (modern and zumba) plus half an hour of strength training 2x a week in the gym. I lift weights (30 lbs) 160 reps, and do at least 200 push-ups at home every morning. This diet-exercise regimen made me lose 13 lbs. Now, my BMI is 22kg/m2 (IBW) with 17% total body fat. 3) I’m an advocate of preventive medicine. I believe that prevention is better than cure. I take statin even if my lipids are normal. And my BP when I’m relaxed and rested is normal, I still take losartan 100 mg daily because the stress at work makes my BP high 10-12 hours everyday. 4) Stress is everybody’s problem I handle mine by doing things that have nothing to do with cardiology and medicine. Dancing in the gym with friends who are not doctors (there are very few doctors in the gym anyway) and talking to them about things other than hospital stuff relieves my tension. The usual topics are shopping, gimmicks, parties, travel and, of course, the favorite topic - VANITY. 5) Socializing with friends who are not doctors is another way of taking my mind away from the stress of work. Dining out, attending parties and ballroom dancing with fun-loving and good-looking people make me happy, to say the least. 6) I do stress testing, echo, chest X-ray and chemistry once a year usually on my birthday. I hope I can keep this kind of lifestyle and maintain good health for a long, long time.

Iris Maravillas-Garcia, MD  
Philippine Heart Center  
The Medical City

“My wonderful husband takes care of my heart! Ha ha ha! Eto serious answer: Physically, nothing beats healthy, high fiber, low salt and low fat diet together with regular exercise; Mentally, finding time to enjoy the things you love doing; Spiritually, daily prayer and meditation on God’s word.”

Marilou De Jesus, MD  
St. Luke’s Heart Medical Center

“I guess being on the positive side, and trying to be more organized coz it lessens my stress.”

Maria Lourdes C. Malilay, MD  
Philippine Heart Center

Avoiding all those fatty foods and staying fit aren’t the only way to keep your heart in a good shape. Smiling, enjoying life and being with the people you love ( e.g. With my 4 kids ) makes the heart go “lub dub lub dub”. “lub life, lub life”. Live, laugh, love. It goes along way ♥

Norberto Tuñ, MD  
Philippine Heart Center

“Simple. By not using the elevator and using the stairs instead.”
My personal journey through cancer and chemotherapy

By Ardith Dominguez-Tan, MD, FPCC

How is one supposed to receive the news of a cancer diagnosis? Is there a dignified way to do it or does one just break down and cry? I was 46 when I was diagnosed to have a large mediastinal mass after almost more than a month of a dry cough.

It came as an itching sensation that needed to be coughed out. Initially, I thought it was the usual post-nasal drip from years of chronic sinusitis but when it kept me up nights I knew there was more to it. Chest x-rays then a chest CT scan showed a large mediastinal mass. At the top of my mind I knew there was the possibility that this was a malignant tumor. A CT guided biopsy was the next step. I was sweating nervously as the biopsy was scheduled because I knew a needle would have to go through my chest and I didn’t relish the idea. I would be rendered just like any other patient when for so many years I had played the role of doctor reassuring patients that things would turn out alright. Thirteen years of practicing as a cardiologist had schooled me into keeping my cool in front of patients even when I could feel my insides churning. I would have to call on that again for a seemingly simple procedure as a CT guided chest biopsy. It would show me whether I had the same fortitude as my own patients who had undergone the same. I informed my friends, both lay and medical colleagues, of my situation so they could pray for me. One particular friend who had just finished chemotherapy the year before even offered to just hold my hand during the procedure. The kindness and empathy in that offer touched me beyond anything she could have imagined.

My husband stayed close during the biopsy but I could feel the tension in him when he held my hand before the procedure. During the biopsy I willed myself to stay still. The local anesthesia went through my skin as a sharp sensation followed by a numbness. In my mind I prayed “Lord, bahala ka na.” I kept my eyes closed as I went through the CT scanner and told myself not to panic as a recorded male voice repeatedly told me “Pigil po ang hininga” then “Hinga na po.” After the procedure we solemnly left the CT scan unit, my husband, my son and myself.

Life would simply have to go on as we waited for the official biopsy results.

It has been my habit to enjoy early mornings where I can sit at the side of our king-sized bed while my husband and my four year-old little girl sleep on the bed beside me. These dawn moments allow me time to reflect on what has been going on in my life. It allows me time to communicate with my God and just look forward to the day ahead. It is “my time.” Early in the morning after the biopsy I sat quietly thinking to myself “Why me, Lord? If you were going to allow cancer in someone’s life, why did it have to be me? Why not a murderer, or a rapist or a common criminal who...
is useless to society? Why give it to a doctor like me who has a 4 year old daughter? Haven’t I lived a relatively healthy lifestyle? Are you a God who gives and then takes away? I asked that if it be your will I get married then you provide the right person and you did. I asked for a child even when I was 40 years old at the time and had polycystic ovary syndrome and you gave me the little girl I wanted so much so, why cancer at this time? ” There was no clear answer for me. But the words of Jeremiah 29:11 came to me “I know the plans that I have for you, plans for welfare and not for calamity to give you a future and a hope.”

The biopsy showed that the mass was most likely a thymoma with a differential diagnosis of broncho-alveolar carcinoma. I welcomed the diagnosis, although as a doctor, I knew the treatment would entail opening up my chest to get the mass out. I didn’t relish the thought. We had no family history of cancer and I had never smoked or liked exposure to smoking so I was confident that this could not be lung cancer. Who wanted to get cancer anyway?

I approached a cardiovascular surgeon whom I trusted and we planned the mediastinotomy third week of May 2010. Friends who knew my condition advised me to seek a second opinion and so I took my Chest CT with me and consulted another surgeon who personally accompanied me to the chief of Radiology at Lung Center. Upon reviewing my studies he told me in no uncertain terms that lung cancer could not be ruled out and due to the presence of lymph nodes in my chest, if this was lung cancer, I would be stage 3. I felt numb inside but went through the motions of thanking him. He kindly offered me any help he could give and requested that I update him whatever came of my surgery. As I left the parking lot I acted normal but deep inside the uncertainty mounted. Would I survive the surgery? Could I handle the chemotherapy if it was needed? I could only hope and pray. Meanwhile I still coughed incessantly.

I sat down with my husband and kids and explained the situation to them. We discussed our finances and set the date for the surgery. On the night prior to the operation my anesthesiologist sat down and we decided that although I would be under general anesthesia she would still give me an epidural since I might still cough post-op. This would reduce the post-op pain. It also became a reality to me that I would expect to wake up hooked to a ventilator. Having been practicing for 13 years at the time I had seen plenty of my patients hooked to a ventilator and I did not welcome the thought. What stuck in my mind was seeing

Intra-op pictures taken by a pulmonologist friend who monitored me during the surgery and the mediastinal mass being lifted up

Lifesaver... from Page 8

To bring awareness on healthy lifestyle, cardiovascular disease and CPR skills to every home and to every Filipino, is an ambitious goal the PHA has been working on. It is one of the Advocacy projects of the PHA through its Council on CPR which is chaired by Dr. Orlando Bugarin.

Bugarin said “the price range of an AED is from P70,000.00 to P270,000. But price should not be an issue in its procurement because we don’t put a price tag on a person’s life because a loved one’s worth is priceless.”

Meanwhile, recently the PHA did free CPR trainings to MMDA traffic enforcers and other field personnel to be able to respond to emergency or do first-aid. They were also subjected to free consultation and risk factor screenings (BP/body mass index check; sugar/cholesterol levels test; ECG) to determine their chance of contracting diseases of the heart and the blood vessels including hypertension and diabetes.

Work on 25%... from Page 14

brisk walking with household chores. To make it a lot easier, it is best to settle for a form of exercise that you love best and make sure to consult your doctor about the exercise that is good for you,” Junia added.

What is the message of “take the road to a healthy heart”? you plant the seed of healthy lifestyle in the womb. Parents, especially, the mother takes full charge of the family’s well-being. but she has to take good care of herself while nurturing her loved ones. A healthy family results in a healthy society and a healthy country.

Dr. Helen Ong-Garcia, PHA director said, “mother is the central figure in the family because she does multi-roles – mother, wife, cook, disciplinarian, and many more, while keeping a job or building a career. However, she has to prioritize her own health issues.”

The Sept. 11 Health Forum was the jump-off point of the month-long celebration of World Heart Day 2013 to a string of activities that will have the simultaneous culminating events (Heart Fairs with Risk Factor Screenings and Cardiopulmonary Resuscitation Lecture/Demos) in the nine PHA Chapters– NCR, Northern Luzon, Central Luzon, Southern Tagalog, Bicol, Cebu, Bacolod Western Visayas, Northwestern Mindanao and Davao-Southern Mindanao on Sept. 29, 2013.
Sleep apnea is a common sleep disorder that affects approximately 1 out of 5 people, similar to the prevalence of diabetes and asthma. The most common form is obstructive sleep apnea (OSA) wherein there is stoppage of breathing (“apnea”) or shallow breathing (“hypopnea”) due to the collapsibility of the relaxed upper airway during sleep. Up to 6% of middle aged to the older age group would have signs and symptoms that would warrant treatment.

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The physiology is fairly simple – sleep induces a state of relaxation which leads to the deep tissues of the throat to relax against the back thus blocking the upper airway - leading to partial or complete airway obstruction. After a few seconds, the sleeper suffocates. The control center at the medulla would sense these events (with the concomitant hypoxemia and hypercapnia) and would “wake” the sleeper enough to gasp and resume breathing. Most of these awakenings are subclinical and could not be remembered by the sleeper. This cycle of sleep-apnea- wake-gasp-breathe-sleep may happen hundreds of times at night. Heart rate and blood pressure in patients with sleep apnea do not “dip” during sleep (which normally do) and may at times even increase. These continuous non-dipping lead to significant heart strain. Eventually the body’s automatic “wake-up” system is weakened due to this toxic environment and the apneas and hypopneas get more severe in number and duration. Regardless of the duration of time in bed, the quality of sleep is poor due to fragmentation.

Why treat sleep apnea? OSA has been linked to htn, increased risk heart disease (ischemic heart disease, arrhythmia, heart failure, dilated cardiomyopathy, pulmonary hypertension/cor pulmonale), diabetes mellitus and stroke. Sudden death during sleep has been found to be higher among untreated patients with sleep apnea than the general population. There is a 6X increase risks in accidents among drivers with OSA compared to nonapneics.

Prevalence studies have shown the following: 48% of patients with DM have sleep apnea (SA). One of the poorly recognized causes of poor DM control is undiagnosed OSA. 37% of all hypertensives have SA. Amongst people requiring 4 or more medications for BP control, the number increases to 87%. OSA by itself has been shown to cause HTN and using CPAP (Continuous Positive Airway Pressure) the preferred treatment for SA, has been shown to improve BP control. 70% of those who have had a stroke have SA. This association was seen in both infarct and hemorrhagic stroke. Non-treatment of OSA in patients with stroke will significantly increase the risk for another stroke.

The gold standard for diagnosing SA is an overnight polysomnography (sleep study) done in a sleep laboratory. Screening tests like overnight oximetry, apnealink devices have likewise been used. The advantage of an overnight polysomnography is that a therapeutic trial for positive pressure ventilation (CPAP or Bilevel Positive Airway Pressure) can be done in the same study. A sleep technician will be with the patient at all times who can give real time feedback to the sleep physician, who can then help the patient acclimatize to the CPAP machine and mask systems. Which patient will require a sleep study will depend on the patient’s symptoms, comorbidities and physical examination. A questionnaire to assess the patient’s degree of sleepiness—the Epworth Sleepiness scale—is often used during the initial assessment.

Treatment of OSA include the use of CPAP, which is considered the most effective treatment (or Bilevel PAP in cases when there is concomitant hypoventilation as seen in patients with both COPD and OSA), oral dental appliance/mandibular advancement device ( worn to mechanically open the upper airways) and surgery (with uvulopalatopharyngoplasty being the most popular). The choice and suitability of treatment will depend on the results of the sleep study, the patient’s preference and the assessment of the sleep specialist. Adjuncts to therapy will include weight management, avoidance of alcohol and medications that decrease muscle tone, and sleep hygiene.

Sleep Apnea is a “silent epidemic” – often unrecognized and undiagnosed, and thus untreated. Its impact on health cannot be overemphasized and cardiologists, who often are the gatekeepers to the well-being of most patients, will best serve their patients if they realize that dangerous snoring can in fact, be deadly.
Cardio & the Law

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

“I am a cardiologist first and foremost. Law is my second love,” says Yap, the lone female cardiologist-lawyer in the PHA family. Through this column, Yap give valuable and practical legal advice to PHA doctors 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 and gives free legal consultations pro bono.

First of a two-part series

Proposed Physicians’ Act of 2012

The year 2014 most probably will be the year for dramatic changes, at least, as far as the medical profession is concerned. The proposed amendment to the very old Physicians’ Act of 1959 (RA 2382) has been passed by the house, deliberated by the Senate and most likely will be passed into law this year. Whatever technicalities might have caused the delay of its passage is beyond our concern. The fact is, it will be a law, effectively repealing Republic Act 2382 and we will be subject to its substantial changes. I deemed it therefore necessary for us to take an early look at the provisions that may impact on us as medical practitioners.

The present article will present the substantial changes made in the proposed law, bearing in mind that there might still be some changes until it has been approved by the president, that it is mostly generalities and that the specifics will be provided by the implementing rules and regulations to be laid down by a Committee to be established within 90 days after the law’s approval.

The amendments are related to medical education, licensure examinations, regulation of the practice of medicine, integration of the profession into one Accredited Professional Organization (APO) for Physicians, the mandatory continuing medical education and its penal provisions. Personally, I feel most of the major changes including the qualifications of the members of the Professional Regulatory Board of Medicine, the integration into one APO and the mandatory continuing medical education are modeled after that of the legal profession.

The bill is entitled “An Act Regulating the Education and Licensure of Physicians and the Practice of Medicine in the Philippines, Repealing for the Purpose Republic Act No. 2382, as Amended, and for Other Purposes.”

The prerequisites to the practice of medicine include a valid certificate of registration and a valid professional identification card issued by the Commission, a valid special/temporary permit issued by the Professional Regulatory Board of Medicine (Board) or unless he/she is exempted by this Act from holding any of the foregoing certificates of registration are a member of the integrated APO of Physicians and its component society in good standing. All successful examinees, after complying with all the legal requirements and payment of dues will be registered and issued certificates of registration and professional identification cards. They will likewise be deemed members of the duly recognized integrated APO for Physicians upon compliance with all requirements and payment of compulsory dues. The professional identification card and the membership identification card issued by the integrated APO of Physicians, will be sufficient evidence that the physician can lawfully practice his/her profession. All physicians whose names appear at the Registry/Roll/Roster of Physicians at the time the law takes effect will be automatically be registered by the Board and the Commission as physicians and, thereafter, by the integrated APO as its bona member. It will be a mandatory requirement that a registered physician must indicate his/her certificate of registration number, the number and the expiry date of the professional identification card and his/her APO membership card, and the professional tax receipt number on the prescription and other documents he/she signs, uses or issues in connection with the practice of his/her profession.

The act also sets the regulation of the practice of the medical profession. It defines acts constituting the practice of medicine which include physically examining any person for any disease, injury or deformity, or diagnosing, treating, operating, prescribing or dispensing any remedy therefor; examining a person’s mental condition for any ailment, real or imaginary, regardless of the nature of the remedy or treatment administered, prescribed or recommended; offering or undertaking to diagnose, treat, operate or prescribe and administer any remedy for any human disease, injury, deformity, physical or mental condition either personally or by means of signs, cards or advertisements by way of mass media or any other means of communication; using or affixing “MD” with his/her name in the practice of the medical profession or in his/her written or oral communications; or conducting formal medical classes in medical schools, seminars, lectures, symposia and the like.

Medical students enrolled in an accredited medical college or school, or any graduate of medicine undergoing training, serving without any professional fee in any government or private hospital are not considered as engaging in the practice of medicine as long as he/she is under the supervision and control of a duly registered/licensed physician.

A special/temporary permit may be issued by Board to physicians licensed from foreign countries/states whose services are either for a fee or free if they are internationally well-known specialists or publicly acknowledged as experts in any area of medical specialization; and if their services are urgently necessary, owing to the lack of available local specialists/experts, or for the promotion or advancement of the practice of medicine including, but not limited to, the conduct of formal classes, acting as resource persons in medical seminars, fora, symposia and the like; ♥

To be continued
A 65-year old female with recurrent palpitations presented at the ER feeling weak and lightheaded. With an unappreciable bP, it was decided to electrically cardiovert the narrow QRS tachycardia appearing on the cardiac monitor at 190 bpm. Incremental energy settings of 100 to 200 joules failed to suppress the SVT (tracings A, B and C). The best response to cardioversion was observed after the fourth shock of 200 joules (tracing B) after which there was a slowing of the heart rate to 170 bpm and a brief appearance of P-like waves (marked by ‘#’). Likewise, the T waves became taller and the prominent S waves seen in tracing A which probably represented rate related bundle branch block disappeared. Even if the BP was barely palpable at 80 mmHg systolic with a heart rate of 170 bpm, verapamil 5 mg was nonetheless given i.v.in an apparent “leap of faith”. Within a few minutes, there was a gradual slowing of the heart rate to 110 bpm. Then, P waves emerged out of the T waves with prolonged P-R intervals at 0.24 secs (tracing D). Subsequently as the P-R intervals became longer (at 0.28 secs), the P waves encroached upon and merged with the preceding T-waves. Thereafter, the heart rates somewhat accelerated to 120 bpm (tracing E). The observed response to i.v. verapamil as a “cooling-down then warming-up” of the heart rate and not as an abrupt cessation of the SVT suggests that enhanced automaticity rather than re-entry could be the underlying mechanism of the tachycardia. The upright P waves in the lead II monitoring leads point to an ectopic origin in the vicinity of the SAN. 

Verapamil is known to block the slow Ca++ channels responsible for the late component of phase 4 spontaneous depolarization in subsidiary atrial pacemakers having the effect of decreasing their rate of ectopic impulse formation. There was a real concern of a possible vasodilator-mediated aggravation of hypotension after i.v. verapamil. The apprehension, however, was short-lived. As the patient’s heart rate progressively decreased, her BP gradually increased. What’s wrong with a patient’s heart that is beating too fast for comfort may not be corrected by electric shocks.
Shall it now be – life begins at 100?

Longevity seems to be a ‘gift’ that many individuals in the next generation will be bequeathed with. An article from The Lancet (January 2010) estimated that many of the children born today will live until the age of 100. (The “gift” is meant to impart a cautionary take on how living to a hundred years may be viewed or taken. After all, one cannot assume that living for a century is a welcome proposition for everyone if given a choice.)

Go figure. How many would want to live till a hundred if such would mean being wheelchair-bound, half-paralyzed, breathing through a hole on the windpipe, aided by an indwelling urinary catheter and a stomach tube, totally nurse-assisted during feeding, and can only respond to familiar faces and figures with minimal hand gestures and facial grimaces? Such is a ‘life’ many may not want at all.

Yet, it is projected that many of the children born today will live for a century. One may consider that this is a result of various factors - scientific breakthroughs, medical innovations and improved healthcare delivery, social support systems, among others.

I distinctly remember how this 85-year-old patient of mine gets very embarrassed whenever I ask her how ‘young’ she is. She instantaneously recoils and hesitates to divulge her age, clearly indicating that any discussion about age makes her uncomfortable. I have relentlessly prodded her to declare with pride and impunity that she has reached 85 years with strong bones, intact speech, able gait and sharp memory – which many others her age cannot claim as much.

I initially thought that her hesitation was just feigned shyness. Then, she admitted one day that she was really mortified to state her age because she was convinced that she had overstayed already - “… because all my contemporaries and friends had long passed away.”

I paused, sighed and remained quiet for a while. Here is someone so strong and alive, yet very much uncomfortable that she has remained so while her peers have joined the Creator. Here is someone so ill at ease that she has gone beyond what others have failed to tread. Then I realize that her tentativeness and reluctance are defense mechanisms that really conceal a well-defined and singular appreciation of the extra time she has been blessed with and how she savours it in her own way by not flaunting and gloating about it since her other friends have not been as ‘blessed’.

Anecdotally, many physicians may share the observation that indeed, even today’s patients are getting older. Truth to tell, one parameter that can indicate that patients are living longer is the number of invites one gets for celebrations of birth anniversaries at 80 and above. It is always an invigorating and empowering feeling for a healthcare provider (ok, call it ego-tripping too) to see octogenarian and nonagenarian patients visiting the clinic every so often. A sudoku-solving 87, a ballroom-dancing 91, a pack-a-day smoking 86 (How I can make her quit “in her twilight years” – as she would always point out) and a glamorous pearl-decked and diamond-bedazzling 84 in heels – quite fascinating sights to behold. Genuinely blessed.

A few years back, in the e-group forum for my batch mates in UST Medicine, the frequent postings of kind words of condolences and messages of sympathies for deceased parents had become so bothersome that this prompted a colleague to remark that indeed, the parents of many of those belonging to my batch are somehow lounging around in the pre-departure area of their lives.

With longevity improving, as science and technology keep growing, the pre-departure times may have to be delayed and the boarding times may just take a while for those belonging to the younger generations – as they are poised to become centenarians. For many of those who will be gifted with such projected longevity, this calls for adjustment of life’s itinerary. Shall it now be “life begins at 100”?♥
Tourist photography with a zing!

c. Selective blurring is used by film artists to emphasize an order of importance (your main subject) and blur the background to signify far distance. This makes the main subject of your picture stand out and dominate the scene. Typically used for portraits, macrophotography etc.

Figure 8: Again taken with aperture priority F16 to sustain a sharp image from front to back. The shades of colors from front to back turns from sharp silhouette to blurs creating distance.

Figure 9: Using a big aperture of about F4 created a very sharp image of the Venus statues and blurring the distant village to make the monument stand out.

Figure 10: I chose to position the parrot in a little diagonal across the picture to create a more dynamic picture plus a shallow depth of field (ISO 100 aperture priority of 2.8mm at a 70mm focal length). A lot of travelers get into museums and zoos and compact camera settings should be dialed into a “portrait or macro” mode to take these shots.

d. Planes and lines create perceptions of depth. Converging lines like bridges, railroad tracks help to lead the eye of the viewer to the main subject of the photograph.

Figure 11: SETTINGS: DSLR (ISO 200, Aperture priority of F16 taken on a 17-40mm wide lens at 17mm focal length). For compact camera – use “landscape mode”. The boat was taken on a diagonal angle and pointing to the cloud formation to catch the eye. Other visual clues: the boat is positioned at the lower 1/3rd of the picture (RULE OF THIRDS) framed by the sand (FRAMING), I also used a circular polarizing filter to make the sky and clouds saturated with deeper blues and whites respectively.

Figure 12: SETTINGS: DSLR (ISO 200, Aperture priority of F9 taken on a 17-40mm wide lens at 17 mm focal length). Use “landscape mode” for compact cameras. I used the cloud formation as leading lines to guide the eyes of the viewer into the red boat which is off center to make a more dynamic composition.

In summary, a perception of DEPTH is created by using an Aperture priority as the main setting. A deep depth of field will allow details to be distinct from foreground to background by using small apertures: F11-F16 for DSLR and “landscape” icon in compact cameras. Whereas, a shallow depth of field is used to emphasize a subject by blurring the background making the subject pop out of the scene. Here, big apertures are used F5 and bigger (F4-1.8) for DSLR and “Portrait, Macro or even Night Mode” for compact cameras.

All these create a perception of depth and allows you to share to your viewer a more realistic experience you have enjoyed in your travel.
In the beginning the universe was unisex. Only man inhabited the planet Earth. The Creator in his infinite wisdom knew man was terribly lonely hence he fashioned woman to keep him company. In time, this companionship led to sex problems big and small. The scripture has it that man was taken from the rib of man, anatomically quite close enough to the heart. No wonder sex has spawned not a few heart problems literally and medically.

Myths and pseudosciences have surrounded the true meaning of sex since man was told to “go and multiply.” However, sex has definite biological commitments with the heart in health and in disease. It sounds almost apocalyptical to mention that the heart among other things has its own sex problems.

**Anatomical differences**

Heart weights and measurements in health are generally smaller in females. The electrocardiograms of males and females are not significantly different although deviations from the normal in the stress electrocardiogram (record of electrical events of the heart during exercise) of females are more difficult to interpret. Invariably the response of the heart in love making becomes a frequent query be it for curiosity or fact. Like exercise, the sex act or if you wish “sexercise” has been equated to represent a fixed number of calories burned or metabolic unit equivalents. The final test, however, is not the amount of external work completed by the subject but the internal work done by the heart. Chest discomfort and/or pain arising from a compromised heart muscle occurs at a relatively fixed level of product of the heart rate (beats per minute) multiplied by the peak systolic pressure (the numerator in the blood pressure recording) for any given subject. For the same type of external work done, the heart rate and blood pressure may vary widely depending on several factors like temperature, mental and emotional conditions. Hence, the work done by the heart is not necessarily related to the external work completed by the subject.

**Heart ailments – in males and in females**

In disease, sex may be a minor or major determining factor. Certain heart lesions or types of heart diseases are influenced or modified by the sex of the patient. Specific instances will be cited in the following discussion.

For a starter, we can begin with congenital heart disease. Congenital heart disease arises from anomalies of growth and development of the young heart. A baby girl who has one of the more common anomalies at birth is likely to have a patent ductus arteriosus or an atrial septal defect. Patent ductus arteriosus refers to the artery before birth that remains open even when its use after birth is no longer necessary and atrial septal defect is a hole in the wall separating the two smaller chambers (atria) of the heart. The dominance of girls over boys in these two defects is around 2:1. On the other hand, abnormalities of the great vessels (the pulmonary artery and the aorta take off from the wrong chamber) and anomalies of the semilunar valves (valves in the heart guarding the entrance to the main arterial trunks from the heart) are definitely in the boys’ column by as much as 3 to 5:1. Boys and girls are about even when the hole in the heart involves the ventricular septum (the wall separating the two ventricles).

If one were to get rheumatic heart disease, the valve most often involved is the mitral. There are 2 to 3 female patients to 1 male with mitral valve disease. For aortic valve disease the reverse is true, that is, 3 to 4 males to 1 female. Tricuspid valve disease singly or when combined with mitral disease occurs predominantly in women.

Infection or inflammation also affects the 3 layers of the heart (see diagram). From inside out, these layers are: endocardium, myocardium and pericardium. The endocardium is the thin sheet of tissue lining the cavities of the heart; the myocardium is the working muscle responsible for contraction and the pericardium is the double-layered sac containing some lubricant fluid that covers the surface of the heart. Endocarditis (inflammation of the endocardium) affects both sexes equally but may be modified by the invading bacteria. These appears to be no sex dominance in inflammations affecting the myocardium, although, in acute pericarditis men are affected slightly more than women.

**YOUR HEART AND HOW IT WORKS**
Our food preference can control and change many risk factors for heart disease and atherosclerosis, as well as hypertension, diabetes, high cholesterol levels and obesity. With the proper diet, we can greatly lower our risks of developing artery blockages that result in strokes and heart attacks. Consumption of healthy foods is just as important as limiting certain kinds.

Being aware and conscious of which food types to avoid and which ones to eat more is the first step towards a heart-healthy diet.

1. Reduce cholesterol and unhealthy fats
   This is the most important measure to bring down blood cholesterol levels. Hereunder are the guidelines for the daily limit of fats and cholesterol by the American Heart Association:

<table>
<thead>
<tr>
<th>Type of Fat</th>
<th>Examples</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturated Fat</td>
<td>Animal products (meat, chicken, seafood, eggs, dairy products, lard and butter), tropical oils like coconut and palm oil</td>
<td>Less than 7% of total daily calories</td>
</tr>
<tr>
<td>Trans Fat</td>
<td>Partially hydrogenated vegetable oils, fried foods, margarine, commercially baked foods (cakes, cookies and crackers)</td>
<td>Less than 1% of total daily calories</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Animal products (meat, chicken, seafood, eggs, dairy products, lard and butter)</td>
<td>Less than 300 mg/day for healthy adults, less than 200 mg/day for those with high LDL (bad cholesterol)</td>
</tr>
</tbody>
</table>

Always check the food labels, especially of snacks, for fat content. Even those labeled “reduced fat” may be made with oils containing trans fats. A hint is the words “partially hydrogenated” or “hydrogenated.” Keep to a minimum intake of butter, certain salad dressings, fried foods, snacks, cookies and cakes.

When cooking, use monounsaturated fats such as olive oil or canola oil, rather than saturated fats. Another alternative is polyunsaturated fats such as corn oil and safflower oil. However, all fats have a lot of calories, thus moderation is very important.

2. Go for low-fat protein sources
   Skinless chicken, fish, lean meat, egg whites, legumes and low-fat dairy products (yogurt or low-fat cheese) are good protein sources low in fat.
   Steamed chicken breasts and non-fat milk contain even much less fat than deep-fried chicken legs. It is best to use lean ground meats or ground chicken rather than the usual ground meat when making spaghetti. Fish such as salmon and mackerel, and soybean and walnuts contains a lot of omega-3 fatty acids, which may help lower the risk of heart disease. Soy protein is a delectable substitute for animal protein.

   Avoid full cream milk and other dairy products such as ice cream, lamang loob such as liver, fatty meats such as liempo, sausages and hot dogs, bacon, egg yolks, and fried or canned meats.

3. Have more vegetables, fruits, whole grains and legumes
   These are rich in vitamins, minerals, and fiber. They also contain flavonoids and other substances that help combat cardiovascular disease. Make it a habit to wash and dice carrots, turnips, broccoli and other vegetables and store them in the fridge for a healthy merienda alternative, same with a platter of fresh fruits.

   Whole grains are loaded with fiber and nutrients. Have whole grain bread or pasta instead of those made from refined flour, and brown rice instead of white rice. Oatmeal or bran cereals are better choices than doughnuts or pancakes.

4. Go easy on the salt
   Limit your sodium intake to about a teaspoon a day of 2300 milligrams. This includes salt added at the table and at cooking, from...
canned and processed foods such as corned beef and luncheon meats, and condiments such as patis, baguio and soy sauce.

People with high blood pressure, CVD and older adults need less than 1,500 milligrams of sodium daily.

There are versions of soy sauce and salt substitutes that contain less salt. Other herbs and spices can also be used to season food instead of salt.

5. Eat in moderation

Quantity and quality go together. The amount of food we eat is as important as the kinds we consume. Servings are particular amounts of food that can help us monitor how much we take in. For example, a serving of meat is 2-3 ounces, similar to the size of a deck of cards. A rice serving is about the size of a tennis ball. This will provide more space on your plate for vegetables and fruit.

6. Plan daily menus

Variety is key to making the healthy diet appetizing, and ensures that we get a merry mix of nutrients. With a plenty food sources to choose from, the planning of daily menus can be an enjoyable family activity.

7. Have regular meals

Skipping meals results in pigging out in the next meals -- leading to snacking (usually junk foods) and overeating. Eat balanced meals with an adequate amount of nutrients and calories. Too much calories will make one gain weight, but too little will cause the body to break down itself or digest itself to provide enough energy.

8. Drink plenty of water

Water is vital to many processes in the body, so be sure to keep hydrated.

9. Enjoy your heart-healthy diet

A cook with some creativity can whip up mouth-watering low-salt dishes flavored with ginger, garlic, cilantro and other spices. Low-cholesterol and nutritious foods can also be luscious. Healthy dining is a matter of attitude -- it is not deprivation, but eating an improved diet that will help prolong life.

My personal journey... See Page 37

them flail their arms while they were being suctioned. My anesthesiologist was thoughtful enough to offer me intravenous sedation to make the experience less traumatic.

On the morning of surgery, all I remembered was talking to my 15 year old son when the nurse came in to give me an IV sedative. I was out after that. The next thing I remember was waking up really sleepy in the ICU hooked to a respirator. I opened my eyes to see my husband hovering over me then stroking my forehead. Everything was a blur to me but I could distinctly recall feeling a coughing episode coming on and then the nurse suctioning my secretions until I felt this thin irritating sensation in my throat which caused me to flail around like a fish out of water. This happened again and again whenever I had fits of coughing. “So that’s why patients go wild whenever they’re suctioned!” I later thought in my head. It was probably one of the worst experiences I had ever gone through. Although I remained groggy during my stay in the ICU I remained conscious enough to realize when the nurse assigned to me allowed me to slip down the bed without caring that my bed sheet had slipped off while she and a fellow nurse rattled off to each other. It wasn’t that they didn’t care but they were probably so used to doing the routine and thinking that an intubated patient was a non-conscious patient that they didn’t realize how callous their indifference was from a patient’s point of view. I also remember writing down on a piece of paper requesting that the private nurse I had arranged to have be allowed in my room. I vaguely remember my Pulmonologist friend showing me pictures of my opened chest and the mass they had gotten out from me during my surgery. I was extubated on the afternoon a day after my operation. As soon as my Pulmonologist had pulled the tube I requested that I be transferred out to a regular room. Again, I could now empathize with my patients requesting to be moved out of the ICU as soon as possible.

TO BE CONTINUED
How have we come so far:

The journey of Echocardiography Guidelines Implementation (Part 2)

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

A letter announcing that successful candidates will be conferred the title of “Fellow of the PSE”, defining what it means to be a PSE Fellow and its voluntary nature, and specifying the above criteria for Level 3 recognition, were sent out to institutions two weeks before the 19th Annual Convention of the PSE. In response, there was a deluge of applications for Level 3 recognition which were deliberated upon by the JCA up to the last day of the convention. In view of the above requirements, the current batch of echocardiography clinical research fellows who finished their training in 2013, and applied for Level 3 recognition, took the first ever certifying exams in echocardiography; all seven candidates passed with flying colors.

Of note, a special PSE Board Meeting was held on Sept. 17, 2013 to formally state and approve that Dr. Homobono Calleja be conferred the title of Fellow Emeritus of the PSE. Then on Sept. 24, 2013, past presidents and officers of the PSE and JCA members were invited to become Fellows of the PSE, in recognition of their invaluable services to the Society.

The Founding Father and Fellow Emeritus Dr. Calleja formally inducted the past presidents and officers of the PSE and JCA members into Fellowship during the opening ceremonies on Sept. 30, 2013. During the closing ceremonies on Oct. 1, 2013, the successful candidates were inducted into Fellowship by Dr. Norbert Uy as JCA Chair and yours truly as PSE President. All in all, there were 130 candidates who were inducted as Fellows of the Society during the convention – quite an auspicious beginning…

And to remind us what it means to be a Fellow of the PSE:

Fellowship with the PSE recognizes the dedicated member with a comprehensive knowledge of all aspects of echocardiography and the required skills to perform and interpret echocardiography. It also recognizes the adherence of the member to the ideals, Code of Ethics and the aspirations of the Society. It recognizes the commitment of the member to improving the practice of ultrasound and imaging of the heart and cardiovascular system for better patient outcomes through continuing education and training and peer review.

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- Keep updated on PHA News and Events.
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- Various CME activities of the PHA- echo and vascular symposia, interactive case presentations, are also uploaded regularly.
- Access free electronic copies of journal articles through our E-Library.
- Download copies of PHA journals and guidelines in the publications section.
- You may also get online CME credits through our monthly Dr. Kamara Online CME Program.
- Invite patients and friends to browse our lay education resources.

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A doctor who walks the talk, he adheres to the tenets of a healthy lifestyle. Weekly, he plays golf.
He says that as a clinician, he has to be an epitome of a fit doctor and as a healer, he devotes enough time to all his patients. “I make it worth their time,” he says. The 2003 PHA Golden Heart Awardee steered the PHA in 1998.

VASCULAR DISEASES
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.

ACS & INTERVENTION
Ariel Miranda, MD – “Enterpriseing” 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.

LIPIDOLOGY
Lourdes Ella Gonzales, 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.

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Clara Sy Tolentino, MD – She is a seasoned clinician, academician, lecturer and researcher, who magnanimously shares her talent and time to the PHA’s continuing medical education and Advocacy undertakings.
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The University of the East Ramon Magsaysay Medical Center stimulated his interest in medicine and its specialties. St. Luke’s Medical Center-Quezon City, honed his knack for internal medicine and clinical cardiology.
Enraptured by the wonders and convolution of the field of echocardiography, he took his Fellowship in Advanced Echocardiography at the Princess Alexandra Hospital University of Queensland in Brisbane, Australia.

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Edward-Bengjie Magsombol, MD – He specialized in Adult Cardiology and earned his Fellowship in Nuclear Cardiology at the St. Luke’s Medical Center, Quezon City from 1997-2000. One year after, he pursued his Visiting Fellowship in Nuclear Cardiology at the Rush Presbyterian St. Luke’s Medical Center, Chicago, Illinois, USA. In 2003, he passed the American Society of Nuclear Cardiology Board Exam.
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This section is a venue for continuing medical education in the various subspecialties. Section editors and contributors share valuable knowledge that would be relevant to everyday practice. Contributions, comments and reactions are welcome. Please email to eic_phan@yahoo.com
Review of the state of the art paper on inferior vena cava filters

( Ido Weinberg, MD., John Kaufman, MD., Michael Jaff, DO published in 2013 JACC )

By Jenny Beltran, MD, FSVM

SINCE its inception, for the past 2 decades, inferior vena cava filter (IVCF) insertion has increased. Several medical societies like the ACCP, and the AHA gave a level 1 or 2A recommendation to IVCF use in acute VTE in patients with contraindications to anticoagulation or with active bleeding complication and recurrent acute PE despite therapeutic anticoagulation. Relative indications with level 2B recommendation to IVCF use in patients with large free-floating proximal DVT, patients receiving pharmacologic or pharmacomechanical thrombolysis, difficulty achieving anticoagulation and poor cardiopulmonary reserve.

However, there is an increased trend towards the use IVCF either as a prophylactic measure or as an alternative to anticoagulation. Often, this practice is advocated in certain high risk patients without VTE. Fear of bleeding is often encountered by physicians administering anticoagulation to at risk patients.

In a report of 371 chronically immobilized patients with stroke who received IVCF, most commonly had contraindication to anticoagulation (68%) and as prophylaxis (22%). In a median of 3 weeks, PE occurred in 54 (15%), DVT in about 60 (16%) and symptomatic IVCF thrombosis in 5 (1.3%).

Cancer patients anticoagulated for VTE are at particular risk for recurrent VTE and bleeding. IVCF is usually indicated in this type of population in the setting of VTE. A major concern is caval thrombosis. Retrospective analysis of outcomes in 308 patients who had IVCF for varying indications reported IVCF thrombosis in 14 (4.5%), PE in 4 (1.3%), and retroperitoneal hemorrhage in 2 (0.7%). An 8 year follow up of a multivariate analysis of the PREPIC (Prevention du Risqué d’Embolie Pulmonaire par Interruption Cave) trial showed cancer is at increased risk for recurrent DVT (hazard ratio: 2.46, 95% confidence interval [CI]: 1.27 to 4.73, p = 0.007).

Are IVCF filters effective in preventing pulmonary emboli? Let us look into these data. The PREPIC trial was a prospective, randomized, controlled study of 400 patients with DVT and who are at high risk for PE received anticoagulation with or without permanent IVCF. At 12 days, there was a significant reduction in PE in the IVCF group (4.8% vs. 1.1%, p=0.03). Many died of causes unrelated to VTE, and IVCF did not show a mortality benefit. At 2 years, 20.8% in the IVCF group developed symptomatic DVT as against 11.6% in the non-filter group. The mortality was similar between groups (21.6% vs. 20.1%, p=0.66). There was a no significant decrease in PE in the IVCF group (3.4% vs. 6.3%, p=0.16). At 8 years, there was a persistent significant reduction in PE, and increased rate of DVT in the IVCF group. However, there was still no mortality benefit. It was only in unstable patients with PE in the IVCF group that showed a significant mortality benefit.

Most reports on IVCF related thrombus complications lack information on whether patients were on anticoagulation and the quality and intensity of anticoagulation. The increased IVCF use still lack high quality evidence. Future directions on the use of IVCF will be guided by the ongoing PREPIC 2, comparing outcomes of patients with VTE on anticoagulation, with or without retrievable IVCF, a national IVCF registry collecting data of patients with IVCF for 48 months. ♥

Cardiovascular disease in women

By Antonio S. Sibulo, Jr., MD

IT is a known fact that the prevalence of cardiovascular disease (CVD) is higher in men than in women. It is believed that the female hormone, estrogen, protects the young premenopausal woman from heart disease and this accounts for its low prevalence in women. About ten years after a woman goes into menopause, the prevalence of CVD in both genders tend to approximate each other. Women worry so much about the risk of breast cancer but more women die from CVD than breast cancer every year. In the Philippines, for every female who die from cancer, 8 die from CVD. For every woman who dies from pregnancy and childbirth, 33 die from CVD.

The female patient with CVD differ in their clinical presentation compared to men. Almost 50% of women do not have symptoms versus 38% in men. Women have other presenting symptoms aside from chest pains which may include back, abdominal, shoulder and jaw pains, difficulty of breathing, nausea, indigestion, and fatigue compared to men. Women may present with more co-morbid conditions such as hypertension, diabetes and generally, older than men. Likewise, clinical outcomes are worse in women than men during heart attack. The 30 day risk of death is 11.3% vs 5.5% in males. The one year mortality after a heart attack is 44% in women compared to 27% in males. The disparity in clinical outcomes are due to differences in baseline demographic characteristics among genders. The other factor is gender bias. There are differences in the diagnosis and treatment of heart disease. The diagnosis of heart attack are more often missed in women than in men and major therapeutic interventions are more often delayed or not given at all.

Cardiovascular disease prevention in women is equally important and should commence long before menopause. Female patients may be stratified into risk categories to either a) high risk as those patients with coronary heart disease b) intermediate risk and c) low risk. Management is individualized according to level of risk. The appropriate and extent of diagnostic tests to be undertaken also depends on the level of disease burden present in a particular patient. The multitude of diagnostic modalities available at the disposal of clinicians make it convenient for the physician and the patient to confirm the presence or absence of the disease process. A timely check–up is of prime importance and we cannot underscore the importance of heart disease prevention. To simplify approach, we may adopt the ABC’s of management goals. A) Antiplaitelet agents such as aspirin/clopidogrel may be used for high risk patients. Ace-inhibitors may be used to prevent cardiac events and for control of blood pressure. Use Antianginal agents to relieve chest pains. B) Blood pressure control. Target a blood pressure of < 135/80 and <130/80 for those with type 2 diabetes. Use Beta blockers for those with heart failure and/ or after a heart attack. C) Cholesterol management goal levels include LDL chol < 100 mg/dl for those with CHD, HDL chol >50 mg/dl and triglyceride <150 mg/dl.
Catheter ablation

By Clara S. Tolentino, MD

SINCE 5000 BC, the ancient man had been interested in the study of the heart rhythm. But the clinical significance of abnormal rhythm was appreciated even more in the 1800s, and the term “arrhythmia” was introduced. Around the same period, the effectiveness of drugs to control arrhythmias was first acknowledged. However, the pro-arrhythmic effects, multiple adverse events, and low efficacy rates of antiarrhythmics led to the development of other interventions.

The late 1960s saw the birth of electrophysiologic studies through the use of intracardiac catheters. Concurrently, surgical techniques for managing refractory tachyarrhythmias gained popularity. Combining the two technologies, catheter-based termination of arrhythmia was developed.

Initially, an external defibrillator was employed to deliver high voltage direct current energy to a catheter tip placed at the targeted endocardial site. This generated a burn resulting in local tissue damage. The technique was utilized to create AV block in refractory supraventricular tachyarrhythmias such as atrial fibrillation, disrupt accessory pathways, and terminate atrial and ventricular tachycardias. However, the high incidence of complications, including cardiac perforation, left ventricular dysfunction, and death, restricted its application.

In 1985, radiofrequency catheter ablation was introduced. It uses low voltage high frequency electrical energy, similar to electrocautery, that creates small focal lesions about 5-7 mm in diameter and 3-5 mm in depth by resistive heating of cardiac tissue. Complications of catheter ablation include risks associated with radiation exposure (e.g. burn), vascular access (e.g. bleeding, hematoma, deep venous thrombosis, arteriovenous fistula), catheter manipulation (e.g. valvular damage, myocardial puncture), and delivery of RF energy (e.g. AV block, stroke, cardiac perforation, tamponade).

Saline irrigated catheters, developed in 1995, improved the outcome of ablation by allowing the use of higher temperatures producing larger lesions and by preventing tissue coagulum formation minimizing the possibility of thromboembolism.

Factors that affect the need for RF ablation include the frequency and duration of tachycardia, patient’s tolerance of symptoms, efficacy and adverse effects of antiarrhythmic drugs, the requirement for lifelong drug therapy, presence of concomitant structural heart disease, and individual’s lifestyle and treatment preference. In certain cases, RFA may be recommended as first line therapy.

In atrioventricular nodal reentry, the most common SVT, the slow AV node pathway is ablated. Success rate is 95% to 99% and average complication rate is 0.5%. In atrioventricular reentry, the accessory pathway, a collection of fibrous tissue connecting the atrial and ventricular muscles, is localized and burned. Efficacy rate is 66% to 100%, recurrence rate is 2% to 16%, and complication rate is 0% to 8%, depending on the position of the pathway. Patients with preexcitation and tachycardia (WPW syndrome), especially those with hemodynamic compromise during arrhythmia or those with atrial fibrillation and rapid conduction over the accessory pathway, are recommended to undergo RFA as initial management. In focal atrial tachycardia, which may be automatic, triggered, or microreentrant, and in macroreentrant AT or flutter, the arrhythmia site, which may be located in either of the atria, is identified and ablated. Success rate of RFA is 70% to 100%. On the other hand, typical atrial flutter is cavotricuspid isthmus dependent, and burning across this area effectively interrupts the circuit in 85% to 95% of cases.

RFA can be used to maintain sinus rhythm in selected patients with symptomatic paroxysmal or persistent AF who have failed pharmacologic treatment or are intolerant of antiarrhythmics. While the mechanism of AF remains controversial, some trigger or substrate regions which can be ablated have been identified, particularly the pulmonary veins, the left atrial posterior wall, vagal innervations, superior and inferior vena cava, and others. Efficacy rate is 60% to 80%. Procedural success is affected by the duration of AF, left atrial size and volume, left ventricular dysfunction, presence of structural heart disease, and the technique used. In chronic AF with uncontrolled rate despite pharmacological therapy or if tachycardia induced cardiomyopathy is suspected, catheter ablation of the AV node may be considered.

Likewise, RFA is indicated in sustained monomorphic ventricular tachycardia (such as idiopathic right or left ventricular outflow tract tachycardia, bundle branch reentrant VT), symptomatic nonsustained monomorphic VT, recurrent symptomatic monomorphic PVCs, very frequent asymptomatic monomorphic PVCs to prevent or treat tachycardia-induced cardiomyopathy, as adjunct in patients with ICD receiving multiple shocks due to sustained or recurrent VT, and VT storms initiated by PVCs of similar morphology, particularly in drug refractory VT and in patients who cannot tolerate medications or prefer not to take drugs. In ischemic and non-ischemic cardiomyopathy VT, inducible VTs and the border zones between infarcted and normal tissues are ablated. Efficacy rate of RFA is 52% to 79% depending on the type and location of VT.

Advances in catheter ablation have greatly influenced the outcome of the procedure. Newer vascular sheaths and diagnostic and ablation catheters have improved maneuverability, both endocardially and epicardially. Cryoablation, utilizing liquid nitrogen, allows creation of reversible lesions to reduce unnecessary damage to tissues around the target site. Other energy sources being explored include laser, microwave, ultrasound, infrared and beta radiation, pressure necrosis, and direct heating. Three dimensional mapping and navigation systems generate heart models allowing demarcation of structures that must be avoided during ablation, create maps of the tachycardia especially for complex anatomy and to locate non-sustained arrhythmias or tachycardias causing hemodynamic compromise, and permit positioning of catheters with minimal use of fluoroscopy.

With its high success rates and low complication rates, catheter ablation has become the mainstay of nonpharmacologic management of tachycardias. From 5000 BC to present, man’s perception of heart rhythm has indeed evolved significantly.
Would medical management be enough?

By Edward-Bengie L. Magsombol, MD • Abigail Louise D. Te, MD

CASE

This is a case of a 52-year old male, who works as an airport policeman. His risk factors are hypertension, diabetes, and dyslipidemia with a good outpatient follow up. He consulted because of effort-related retrosternal chest pain with no accompanying symptoms.

The patient underwent treadmill exercise test with equivocal result and achieved a workload of 10.4 METS. He was then advised by his cardiologist to undergo myocardial perfusion imaging (MPI).

Figure 1 below shows the colored polar map and gated study of this patient.

Results showed a moderate sized, moderately severe inducible ischemia in the apex, mid-apical anterior wall and apical inferior segment with corresponding stress-induced hypokinesia on gated study. Ejection Fraction was within the lower normal limits post stress (53%) and at rest (51%). He was advised to undergo coronary angiogram but refused. He opted for optimal medical treatment with aggressive lifestyle modification and agreed to do follow-up MPI later to determine further direction of management. 3 months after, a repeat MPI was done showing no perfusion abnormality with significant increase in post stress EF (67%) and resting EF (58%) as shown in Figure 2 below.

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**Figure 1.** Colored polar map and gated study

**Figure 2.** Colored polar map and gated study after 3 months on optimal medical treatment
DISCUSSION AND CONCLUSION

Treadmill Exercise Test (TET) is adequate for most patients who can exercise well and has an interpretable baseline ECG. However, inpatients with intermediate pretest probability such as our patient, it has a much lower sensitivity and specificity in detecting significant coronary artery disease (CAD). Stress imaging, especially pharmacologic stress, either by myocardial perfusion imaging (MPI), echocardiography or cardiac magnetic resonance (CMR) imaging are all rational options for patients who cannot exercise or whose baseline ECG’s are either abnormal or uninterpretable. Imaging modalities that estimate the severity of physiologic rather than anatomic coronary abnormalities more accurately predict risk for a cardiovascular (CV) event. In this patient, a TET was initially performed which was equivocal though he achieved a workload of 10.4 METs. Hence, MPI was done. The patient was advised coronary angiography on the basis of the initial MPI findings. However, patient refused due to financial reasons and opted for medical treatment.

The decision to give medical therapy or do invasive management on a patient suspected of having CAD depends upon the risk for a subsequent cardiovascular event. Medical therapy is the foundation upon which all treatment for patients with stable CAD is based, regardless of whether revascularization is performed. This was shown in the COURAGE (Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation) trial where they tested multiple simultaneous lifestyle and pharmacologic interventions (referred to as “optimal medical therapy” [oMt] with or without percutaneous coronary intervention (PCI) in patients with stable CAD. The study showed that initial strategy of PCI (plus OMT) did not reduce death, myocardial infarction, or other major cardiovascular events compared with OMT alone. The study has also shown that adherence to lifestyle and medication prescription was very high and resulted in significant improvement in risk factor targets. 

Currently, there are no available guidelines on follow-up imaging of patients diagnosed with coronary artery disease on optimum medical management and lifestyle modification. However, it is recommended to do follow-up imaging 3-6 months from initial study. In this case, repeat stress MPI showed significant improvement of both perfusion and LV function after 3 months of intensive lifestyle modification and optimal medical therapy. Hence, in accordance with the COURAGE trial, optimal medical management was a viable alternative to invasive intervention in this patient, who, despite having significant inducible myocardial ischemia, was still clinically stable. In addition to risk stratification, stress MPI is a very good imaging modality to follow-up efficacy of intervention, whether by optimal medical treatment or revascularization.

Preventive PCI Redux

By Ariel A. Miranda, MD, FPCC

MANY of you are aware of the provocative results of the PRAMI Trial (Preventive Angioplasty in Myocardial Infarction) published by Wald et all in the September 2013 issue of the NEJM. The study tests the strategy of preventive PCI of non-culprit lesions in the setting of STEMI. I would like to comment on the implication of this study.

After successful PCI of the infarct-related artery, patients were randomly assigned to additional PCI of clinically significant stenosis (preventive PCI). The control group received aggressive medical management and additional PCI was only performed for refractory angina with objective evidence of ischemia. The investigators found that after a mean of 23 months follow-up, the primary outcome event (cardiac death, myocardial infarction, and refractory angina) had occurred in 8.9% in the preventive PCI group versus 22.9% in the optimal medical therapy arm, a 65% relative reduction in risk. All components of the primary endpoint were favorably affected. Importantly, non-fatal MI was reduced by 68% and cardiac mortality was likewise reduced by 66%.

I find the results provocative because it is the widely held belief that only PCI of thrombosed lesions reduces infarction and mortality. No randomized study has demonstrated that PCI of non-infarct lesions prevents death and MI compared to optimal medical management. The COURAGE trial has shown that PCI does not outperform optimal medical therapy in reducing death and MI. The PRAMI trial therefore implies that non-culprit lesions are not as seemingly innocent as we widely believe. In ACS the entire coronary tree is affected by multiple inflammatory lesions. Coronary angiography,IVUS (intravascular ultrasound), and CT coronary angiography have demonstrated that vulnerable plaques and plaque rupture can occur in multiple sites in the coronary tree of patients with ACS. The PROSPECT Trial, a natural history study of non-culprit lesions in ACS, reported that the risk of recurrent ACS increases 3 fold to 18% in the next 2 years innon-culprit lesions that have a large atheroma burden, small lumen area, and plaques with large lipid pools with very thin-caps.

This study is proof of concept that PCI may have the potential to stabilize these plaques. However, this study will not change existing guidelines. I don’t see a mad-rush to perform multi-lesion PCI in the setting of STEMI. The study of Wald spanned 3 years and yet he only enrolled 405 patients. Therefore, this is a highly select group. Many questions need to be answered. Will the results be the same if PCI of non-culprit lesions were staged? In which patients is it safe to undergo multi-lesion PCI? Will lesion selection by IVUS, NIRS (near infra-red spectroscopy), OCT(optical coherence tomography), or FFR be better than conventional angiography?

The study has definitely led to a paradigm shift that has the potential to alter the management of ACS.

Legacy of periodic monitoring of liver function tests in patients on Chronic Statin Therapy

By Lourdes Ella G. Santos, MD and James A. Underberg, MD

LEGACY is defined as that which is by or received from a predecessor. Physicians' practice style and technique are often modeled on predecessors. These are habits that begin during medical school and residency, trickle down into fellowship and are often carried over into clinical practice. One such ritual is the periodic monitoring of liver function tests in patients receiving chronic statin therapy and the knee-jerk discontinuation of treatment based on mild elevations. What evidence supports this?

The post-hoc analysis of patients enrolled in the Greek Atorvastatin and Coronary Heart Disease Evaluation (GREACE) study assessed the safety and efficacy of long-term statin treatment in patients with coronary heart disease (CHD) and abnormal liver tests.1 The primary outcome was risk reduction for the first recurrent cardiovascular event in patients on statins with moderately abnormal liver tests compared to patients with abnormal liver function tests not treated with statin therapy. Secondary endpoints included the effects of statins on liver tests.

Briefly, the GREACE study evaluated 1,600 patients with CHD who were followed for three years.2 Patients were randomized to either treatment with atorvastatin (10-80 mg/day) to achieve the National Cholesterol Education Program expert panel (Adult Treatment Panel III) (NCEP ATP III) low-density lipoprotein cholesterol (LDL-C) target (2.6 mmol/l; 100 mg/dl) or “usual” care. Usual care included lifestyle changes such as adoption of a low-fat diet, weight loss and exercise, and all necessary drug treatments, including lipid-lowering agents.

During the study, 437 patients with baseline moderately abnormal liver tests—defined as less than three times the upper limit of normal—were followed for three years. Elevations in liver function tests (LFT) were attributed to non-alcoholic fatty liver disease (NAFLD) based on ultrasound findings and after ruling out other causes of LFT elevations, such as alcohol misuse, hepatitis B and C, Wilson's disease and autoimmune hepatitis. Of these patients, 227 were treated with a statin and 210 were not. Patients who started the trial with abnormal liver function tests and received a statin showed the greatest benefit with a 68% relative risk reduction (3.2 events per 100 patient years) compared with patients who did not receive a statin (10 events per 100 patient years). This benefit was even greater than that reported for patients on statin therapy with baseline normal liver tests.

In the 227 patients with raised concentrations of ALT, AST or GGT at baseline who received statins, a reduction in liver tests was noted during the three-year follow-up. Conversely, in the group not taking statins, statistically significant worsening of liver tests was noted (Figure 1). Withdrawal rates did not differ between patients who received statins and those who did not. Overall, the frequency of liver-related adverse effects during chronic statin treatment was low (1.1%).

The GREACE study addresses the dilemma of potential hepatotoxicity. Physicians historically have developed a low threshold for stopping treatment with even minimal elevations from baseline. The fear of inducing liver injury with prescribed medications may lead to regimen change and even early discontinuation of a therapy with proven cardiovascular benefit in patients across various risk levels. We may be causing a greater disservice to patients by changing treatment based on a laboratory test that has not been shown to predict an adverse outcome.

In their combined clinical advisory on the use and safety of statins, the American College of Cardiology (ACC), American Heart Association (AHA) and National Heart, Lung and Blood Institute (NHLBI), do not endorse routine monitoring of creatine kinase (CK) levels in patients taking statin medications. Modest transaminase elevations less than three times the upper limit for stopping treatment with even minimal elevations from baseline are not thought to be a contraindication to initiating, continuing or advancing statin therapy as long as patients are carefully monitored.2 Even asymptomatic patients with moderate (between 3 and 10 times the ULN) elevations at baseline, during treatment or after a drug holiday are advised to continue treatment with a statin without harm.

In 2006, the National Lipid Association Statin Safety Task Force was assembled to thoroughly address the safety of statins based on a comprehensive review of available evidence
and to summarize the findings on record. The report of the task force states clearly that, for isolated, asymptomatic elevations in transaminase levels less than three times the upper limits of normal (ULN), statins should not be discontinued. For levels more than three times ULN during routine evaluation, closer monitoring of liver function tests is recommended with the intention of identifying other causes of liver function elevations prior to withdrawing statin therapy. The published report also counsels on the safety of administering statin therapy in patients with chronic liver disease, compensated cirrhosis, nonalcoholic fatty liver disease, or nonalcoholic steatohepatitis.\(^5,6\) Final conclusions and recommendations regarding the liver and statin safety are shown in Table 1.

Of late, the U.S. Food and Drug Administration (FDA) package inserts for statins have seen some changes in their recommendations for ALT monitoring for patients on statins (Table 2). Of the generic statins, liver-function monitoring with lovastatin is no longer suggested for asymptomatic patients without a history of liver disease.

Several reports have shown that people with baseline liver enzymes are not at higher risk for hepatotoxicity from statins.\(^7,8\) Specifically, studies in NASH patients have shown histological and liver test improvements while on therapy.\(^9,10\) Statin use has also been demonstrated to have a low frequency of abnormalities of liver function tests and hepatitides when compared with placebo.\(^11,15\)

In light of compelling new data, monitoring liver function tests should be customized to individual patients instead of using habitual over-testing of ALT and AST levels on all patients on statins. Greater tolerance should be prompted with a goal to sustain statin treatment, especially in high-risk people. In keeping with the emphasis of personalized medicine tailored to each distinctive patient, we should not be too quick to order liver function tests routinely nor to discontinue statins with escalating levels. Maintenance of statin therapy, especially in indicated people, should be the greatest service we offer patients.

### Summary of changes in liver-test recommendations on U.S. Food and Drug Administration package inserts.

<table>
<thead>
<tr>
<th>Older statin package insert</th>
<th>Current package insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lovastatin</td>
<td>(2001) LET's before and at 6 and 12 weeks after start or elevation of dose and semiannually</td>
</tr>
<tr>
<td>Simvastatin</td>
<td>(2000) LET's before treatment and semiannually for first year or until 1 year after last elevation</td>
</tr>
<tr>
<td>Pravastatin</td>
<td>(2001) LET's before initiation of therapy, before elevation of dose, and when otherwise clinically indicated</td>
</tr>
<tr>
<td>Fluvastatin</td>
<td>(2001) LET's before and at 12 weeks after the initiation of therapy and when otherwise clinically indicated</td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>(2001) LET's before initiation of therapy, after elevation of dose, and semiannually</td>
</tr>
<tr>
<td>Rosuvastatin</td>
<td>(2003) LET's before and at 12 weeks after the initiation of therapy and any elevation of dose and periodically (e.g., semi-annually thereafter)</td>
</tr>
</tbody>
</table>

References:

Imaging the heart in 3 dimensions

By Donald Cristobal, MD

Through the years, 2DE has become a vital tool in Cardiac research and clinical practice and an integral part of Cardiology as a whole. However, this fundamental role is not without recognized limitations. Images derived using 2DE heavily relies on geometric assumptions which are potential sources of errors. Evaluation of a complex cardiac pathology in 2DE perspective would require “3D mental reconstructions” based on the series of 2D images obtained from different levels of planes. Such method may result to overestimation or underestimation in measuring the region of interest. Furthermore, 2D images lack the “full volume” of the structure being interrogated and fall short in showing the region of interest in en-face views. 2D imaging does not have the capability of cropping, angulating, and tilting/rotating images in order to visualize a particular region from different perspectives. With these limitations, cardiac imaging further flourished as the continuing evolution of technology paved the way for the development of three dimensional (3D) imaging. 3D echocardiography (3DE) offers the ability to improve and expand the diagnostic capabilities of cardiac ultrasound (2). Its value has already been demonstrated and recognized in several areas.

Use of 3DE in Left Ventricular (LV) Volumes, Ejection Fraction and LV Mass

Measuring LV ejection fraction through Simpson’s, although more accurate than M-mode because of less geometric assumptions, is still prone to errors such as foreshortening and inaccuracies in defining endocardial borders. These limitations have been surmounted by the use of 3DE resulting to improvement in the accuracy of obtained measurements (Fig. 1).

Evidences from several studies have shown better agreement of measurements using 3D than 2D echocardiography with MRI (3-5). More recent studies comparing MRI with live 3DE show very good correlation and agreement (6-7).

The most commonly used formula for estimating LV mass is that proposed by American Society of Echocardiography (ASE) based on M-mode and 2DE. However, this formula has geometrical assumptions and may not perform adequately in distorted ventricle (8). Several comparative studies have proven that 3DE is more accurate than M-mode or 2DE methods to calculate LV mass compared to CMR as the reference standard (9) (Fig 2).

Moreover, it is important to note that 3D full volume data set can be reverted back to 2 to 3 simultaneous orthogonal 2D imaging planes (i.e. biplane or triplane imaging) through multiplanar reconstruction (MPR). Through this matrix-array transducers, converting 3D datasets into 2D images and vice versa can be done and simultaneous display of 3D and 2D images is likewise possible, allowing greater flexibility, accuracy, reproducibility and efficiency among echocardiographers (Fig. 3).
Use of 3D in Valvular and Congenital Defect Evaluation and Intervention

3DE has been proven to be very useful and successful in evaluation of valvular heart disease and structural relationships in congenital heart conditions. The online and off-line capability of the 3D images obtained from acquired real time 3D (RT3D), 3D zoom and 3D full volumescan be readily manipulated with the use of a dedicated workstation resulting to easier images analysis and quantification. The overall increased in the accuracy and reproducibility in reporting 3DE studies compared to several 2D planes are now realized in different centers. It has added the ability to view the entire valve in one image with the bonus of depth leading to several studies showing that 3DE is the best noninvasive method for determination of mitral valve pathology (10). Figure 4 show its use in valvular pathology.

Similarly, details in congenital heart diseases are readily evaluated with 3DE, providing very relevant clinical information. Visualizing structures in its en face view and in different perspectives allows easier communication with patients for better understanding of their cardiac conditions and aids surgeons/operators in the pre-procedural planning and during the intervention itself. This became a reality because the images can be visualized using three display modalities: volume rendering, surface rendering and tomographic slices (9) (Fig. 5).
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