Au revoir, tough but rewarding 2013

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Editorial

Are we ready when the next disaster strikes?

The country just experienced a natural disaster of such unimaginable magnitude that inflicted overwhelming damage to life and property, and left us all absolutely stunned. The rest of the world responded quickly, and actually seemed better oriented on what had happened and what needed to be done than what our government mustered to show. Earlier, our government leaders had claimed that they were ready; indeed, they had prepared, but they were not ready for what would happen and what had to be done after that.

Far from it!

It took a while after the Yolanda super typhoon struck before the victims felt the existence of government. In Leyte, everything was in shambles and everyone was a victim, including the people who were supposed to minimize damage, offer protection, or at least respond to emergencies. No doubt that the desire to help was readily felt from everyone everywhere, but what mattered out there was not the desire or the ability to help but the actual help itself that came on time.

The Philippines is, indeed, just a part of the global community. The warnings of imminent disaster of very massive proportions came from CNN and alerted the entire world of what was to come. Storm chasers from foreign land were already in Tacloban 2 days before Yolanda smashed through. Days later, the rest of the world flew in to provide food, water and medical aid. They came by air and by sea, equipped not just with relief resources but with expertise in dealing with crises. We were very impressed with what we saw in terms of organization and efficiency. They were ready and they were there while our government agencies were still getting their act together. The rest of us responded quickly, too, perhaps not in the most organized and effective way but certainly in the manner that we do best – with our hearts! Our resilience may impress the rest of the world as in fact it has been immediately noticed, but what matters most is that we learn from our misfortunes and avoid being in the same state of stunned immobility the next time around.

If, indeed, climate change has a lot to do with what is happening, let us be forewarned that more catastrophes are going to happen. And because the medical profession invariably plays a central role in their aftermath, it behooves us to organize – not by field of specialization but by the capacity to deal with all sorts of health conditions at any given time anywhere. Since our best resource is medical expertise, we need to enlist beforehand who among us are to be mobilized first, what they are prepared to deliver under a crisis situation, where their locations are, and how they can be contacted.

We can leave the relief drive for food, water and clothes to the lay community; we are going to deliver medical care because that’s what we do best – with adequate and appropriate medical equipment and supplies available and ready for mobilization at any moment notice.

God forbid that it would happen, but what if, for example, a major earthquake demolished most of Metro-Manila where the central government sits and most of the medical associations and the NGOs hold office? Are there Philippine Medical Association, Philippine College of Physicians, or Philippine Heart Association chapters somewhere else in the country pre-assigned to quickly and decisively take over and mobilize their respective members nationwide to provide medical support? Are these chapters equipped with the information and the means to mobilize members outside Metro-Manila? Is there a plan that each of the chapters of these associations keep somewhere, to be activated when pre-defined crises happen?

If the answer is No then the work ahead is massive! ☺
PHA Board Confessions: Do they walk their talk?
With a hectic pace, how do they practice what they preach.

LRI-Therapharma renews sponsorship
BP ng Teacher Ko, Alaga Ko will make greater strides around the nation as it gets fresh funds from LRI-Therapharma.

News Feature: Sin Tax: What’s Up?
After one year, Dr. Tony Leachon gives an assessment of the impact of the Sin Tax Law. Leachon was one of the most avid advocates of the Sin Tax Bill. He was a fixture in fora that called for its passage. With fellow health professionals, (among them was then PHA President Dr. Saturnino Javier), they joined Pro-Sin Tax Law lobby groups that made a strong representation at the Senate hearings.

Life Work Balance: PHA Dads & Moms
Does a balance between life and work really exist for the busy cardiologist?

Perspectives
In-denial and playing politics
By Ernesto E. Chan, MD

Dysrhythmic Tales
The longest pause
By Edgardo S. Timbol, MD

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

Cardiolinks
Relax... It’s O-K!
By Brian Cabral, MD

Year 2013 took PHA and the country to a roller-coaster ride. A look into PHA’s 61st year.

Glorious year that was!
Editor’s note

This issue is a tribute to all the dedicated and committed members of the Philippine Heart Association (PHA) who survived Super Typhoon “Yolanda”—the PHA Board of Directors and Members, cardiology training institutions, pharmaceutical allies and partners who were either at the frontlines or silent supporters of the relief operations.

The PHA Board unanimously decided to send cash and in-kind donations to the disaster-stricken PHA members in Tacloban andOrmoc cities.

The PHA assistance amounted to P7 million. Of this amount, P5 million was allotted for the displaced cardiologists, while about P2 million was used to secure blankets and bed sheets to worst-hit communities. The blankets were sent through the Manila Doctors’ Hospital-Metro Bank Foundation group, which managed to personally deliver these goods on the same week that Yolanda hit central Philippines.

The bayanihan spirit reigned, and spread across the globe. Everyone the most busy heart doctors, the heavy-weights and emerging names in cardiology pushed aside some schedules to ensure that their colleagues were all accounted for. Some even went out of their way to conduct medical missions.

Our very own cardiologists coordinated medical teams, the Philippine Heart Institute, University of Santo Tomas Hospital, The Medical City, Perpetual Succour Hospital and Chonghua Hospital, which flew to the Yolanda-ravaged areas in central Visayas. There were also several fund-raising events organized for the benefit of Yolanda victims.

This special edition of the PHA Newsbriefs documents similar and diverse scenarios—heart-warming and heart-rending—during the emergency and even in its aftermath.

PHA-Philippine College of Cardiology is at the helm of the Cardiology training institutions across the Philippines to ensure quality cardiovascular education and care for everyone. Incumbent President Dr. Eugene Reyes, through the Specialty Board of Adult Cardiology and the Specialty Board of Pediatric Cardiology, imposes on the integration of core values into the curriculum. Beyond these mandates is the commitment to look after the well-being of its members. ♥
EBR commends SBAC projects

In his President’s Report, EBR announced that the training officers (TOs) are amenable to having a standard Core Curriculum which will include the different measures and indicators that will be incorporated with the existing Core Values of the PHA.

Matters tackled were: Intellectual honesty with the reported cases of plagiarism; some become TOs without really undergoing training in becoming one; the PHA Specialty Board on Adult Cardiology program will include teaching.

Continuity is crucial. Thus, EBR is keen on endorsing the projects of the SBAC Sub Committees on Core Curriculum, Accreditation, Quality Assurance and Sub Specialty to the next PHA president.

Doctors are expected to know how to teach because this profession deals with patient care. The SBAC program will also include a unit on medical education particularly for those interested in becoming TOs and Institutions that don’t have a teaching arm. Not a problem for institutions attached to universities.

EBR added that SBAC will also push for the registry since it would be a better indicator of the institution rather than just having the training fellows present their logbook of the cases supposedly handled.

‘Project Bigay Tulong’ assists Leyte cardios

At the November 2013 Board Meeting, Project Bigay Tulong was formed to do fund-raising activities like the sale of goods and a mini concert. Its first beneficiaries were its Yolanda-displaced members who can’t practice for a period of one year.

The Board approved financial aid of P50,000 each for the following Tacloban-based doctors: Drs. Felicisimo Abuyabor, Belen Balagapo, Ernesto Chan, Leila Díaz, Carlo del Pilar, Belen Diannante, Leah Polidario, and Jonalie Redona. (related story on page 8)

The list of Yolanda victims in Ormoc and other parts of Leyte include: Drs. Chunito Yu, William Co, Rhodette Arevalo and Honey Alcantara. Each of them received P25,000.00 in financial support.

Aside from these disbursements, the Board approved a P200,000-allocation for blankets, T-shirts and underwear to the victims of Typhoon Yolanda and additional financial support for the Tacloban-based doctors.
EBR’s November to December 2013 Calendar:

Nov. 06  ACC Chapter – Philippines Meeting
Nov. 07  MOA Signing with Menarini
          CME Initiatives Program – Hypertension Peak
Nov. 23  Real World Practice Workshop and Fellows in Training Christmas Party
Nov. 12  Heartline column: Diabetes is as Serious as Heart Disease
Nov. 26  Heartline column: Forever Young and Slim

DECEMBER
Meetings
Dec. 05  MOA Signing with Bayer
          CME Initiatives Program – Clotting Institute
Dec. 09  SBAC Meeting with Cardiology Section Chairs and Training Officers (TOs) of the Accredited Training Institutions

Know your Organization

PHA Board of Directors

For specific concerns, you may write the designated Director thru phil.heart@yahoo.com

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Diabetes is as serious as Heart Disease

Heartline column: Diabetes is as Serious as Heart Disease

FOREVER YOUNG AND SLIM

Heartline column: Forever Young and Slim

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Helen Ong-Garcia, MD
Director
Task Force on Community Service & Special Projects

Elections and Nominations
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PHA in the heart of Yolanda crisis

What have you taught us?

By Gynna P. Gagelonia

Twelve members of the PHA family (from Tacloban—Drs. Felicisimo Abuyabor III, Belen Balagapo, Ernesto Chan, Leila Diaz, Carlo del Pilar, Belen Diamante, Leah Polidario, and Jonalie Redona; fromOrmoc—Drs. Chunito Yu, William Co, Rhodette Arevalo and Honey Alcantara) in Leyte had a brush-with-death experience in the hands of an irate Mother Nature, embodied by super typhoon Yolanda, internationally codenamed Haiyan.

Five of them -- Drs. Abuyabor III, Balagapo, Chan, Diaz and Polidario -- related their petrifying ordeal to PHAN.

Coastal Tacloban, the capital city of Leyte, was the eye of the most destructive storm that smashed into Philippine soil on Nov 8, 2013.

To date, almost 7,000 lives were lost, countless are still missing, damage to properties was placed at billions.

Being given a new lease on life by our Creator is the only thing that matters to these doctors. All members of their families and all the families in the neighborhood cheated death.

Three days before the storm, they made sure their loved ones, especially their folks and kids started to hibernate in their comfort zones. Either at the foot or on top of a rocky mountain; or near the fringes of the sea, their charming homes are made of heavy-duty materials and are nestled on solid ground. They are their permanent citadel and refuge, they all thought so.

All of them were in their respective havens when Yolanda made its menacing landfall.

Having been “used” to relatively strong typhoons, they were equipped and prepared for the worst calamity.

One week before the storm, they had more than enough survival tools and food supplies.

Heeding PAGASA’s storm warning, they made sure they called it a night as early as 6pm of Nov. 7.

Although they weathered the storm in their own abode, dodging Yolanda was tough. Strong winds, heavy rain and 16-feet waves pummeled through the coastal areas and beyond.

In a few hours, their homes had ripped roofs and fragmented windows. Mud cascading from the mountains, blackish water streaming from the streets, had rapidly seeped into their houses.

During these times, the five doctors had to put priority on their role as a parent, spouse, daughter/son, or siblings to their families. It was only one day and two days after, that they managed to see their patients.

While struggling against Yolanda’s battery, they also prayed for the safety of their relatives who live nearby and their patients.

Even though they were victims, themselves, they shared rice, canned goods, bottled water, etc. from their pantries to the families of the househelp and to their neighbors.

The Bethany hospital (oldest private hospital in Tacloban) was the most badly hit hospital in Tacloban. Since it is located around 100-200 meters from the Magallanes coastal area, its entire first floor was inundated. The
PHA NewsBriefs

November - December 2013

laboratory, diagnostic machines, dialysis center, records section, and offices were all on the 1st floor. Equipment like MRI, CT scan, 2D Echo machine and even laboratory machines were damaged beyond repair. The hospital was totally crippled. It will be temporarily closed for six months while undergoing rehabilitation and reconstruction.

Only half of the 1st floor of the Divine Word Hospital was flooded. The rest of the hospitals only suffered mild to moderate structural damage.

The calm after the storm strengthened their doggedness to check out their patients.

A grisly sight seemingly lifted from the movie “Apocalypse” stunned them. On the roads were corpses and all sorts of debris -- fallen trees, cars, wood planks, posts, electric wires, galvanized irons, etc. Throngs of people, with baffled expression, were aimlessly walking about, many of them were limping and bleeding.

During Yolanda and post-Yolanda scenes exposed human strengths and flaws. It divulged corruption in the public and private sectors; and inefficiency and incompetence in government.

Tsunami, the man on the street would have understood and many lives would have been spared because they would have run to higher grounds. The local government units would not have put up evacuation centers near the sea.

After seeing their patients, three doctors – Abuyabor, Chan and Diaz left Tacloban amid reports about more criminal elements pillaging, raping and murdering.

Abuyabor and his family decided to leave the city, primarily for their children’s welfare. When he surveyed the streets, he saw the destruction and news about people looting groceries, and no policemen were around, because they were also affected.

The scary situation was dire enough to make Diaz’ mouth perpetually dry and send her into bouts of nausea. For her, peace of mind especially that all of them are all females (my mother, five year-old daughters and a maid) in the house, they flew to Cebu and stayed for three weeks in an apartment owned by Dr. Dang Ebo in Consolacion town.

Chan rode on a Cebu-bound jampacked C-130 with his wife. They stayed in his in-laws’ house in Talisay City for two weeks. He said “understandably, the city government was paralyzed. Many people perished, including policemen… He believes many people relied on looting foodstuffs. That can be tolerated to an extent because there were no sources of food. Some kind-hearted grocery owners even opened their groceries to give food freely. What was not justifiable was when people started robbing appliances, jewelry, and forcing to open ATMs and banks…” These were not acceptable.”

As of press time, Chan and Diaz have gone back in their old houses, except Abuyabor who have resettled in Davao City, with his family.

Here are their stories:

We’re back to basics
By Ma. Belen Balagapo, MD

So far, life has been made so simple. Household chores are done mano-mano (manually). Rain water is used for washing the dishes /clothes and bathing. We have gotten used to fetching water to the kitchen and restroom; taking a bath with rain water as it rains everyday, at times; sleeping with a mosquito net, without an airconditioner or an electric fan.

Our drinking water is sourced from relief centers and some temporary water refilling areas in the city which were placed by national and international rescue teams.

I live in my parents’ house which was slightly damaged. Our roof has been temporarily repaired but not the glass windows and the flooring in the sala since construction materials are still not available or scarce, making them very expensive. Some windows are now covered with tarpaulin.

Looking back, my parents, sister-in-law and nephew were with me in the house during the typhoon. ‘The whole time the typhoon pounded, I was so scared. There was zero visibility on the streets because of the gusty winds. It seemed like we were floating on white clouds.'
At the height of the typhoon, we stayed in our kitchen because the roofing there is concrete. People in the neighbourhood panicked because of a “Tsunami alert”, hence we transferred to a higher place, a four-storey commercial building which is two houses away from our place. We stayed there the whole night and went back to our place in the morning.

There were flying galvanized irons that included ours. At the moment, a tarpaulin serves as our roof because materials are still limited and only a few hardware have opened. Prices are sky-high.

I am affiliated with the Bethany Hospital as an active consultant and training officer in IM; RTR Hospital (active consultant and lecturer RTR Med. School); Divine Word Hospital (visiting consultant); Mother of Mercy Hospital (visiting consultant); and Tacloban Doctors’ Medical Center (visiting consultant).

On Nov. 8, I had in-patients at Bethany Hospital, Divine Word Hospital and RTR Hospital. After three days, the patients were asked by the management to leave the hospital because they were running out of hospital food, medicines and supplies. One day after the storm, I did my rounds. I had to see my patients because they were still under my care and my responsibility.

On Dec. 2, I resumed my clinic at RTR hospital, but we started admitting both charity and private patients last Nov. 27. I also started my clinic at Divine Word hospital, also this December.

After the typhoon, I helped the residents at the ER of RTR hospital. I get to attend to some of the casualties. There were medical missions composed of foreign medical teams but there were also medical missions composed of Filipino doctors and health workers (DOH, PSN, MMC, MDs from Davao, local MDs, etc.). We were not able to join some medical missions composed of foreign medical teams because there were groups who won’t allow local MDs to join them.

The most important lesson I learned from Yolanda is -- always be ready, especially spiritually because you’ll never know when your time comes.

Accept your weakness, do not point your fingers to others and do not be greedy. Share whatever you have.

The typhoon taught me that in life, only the essential things matter -- family and faith in the Almighty. I learned that the comfort I used to enjoy was good, but I can still live as a good child of the universe even without those vanities.

Taclobanons and the people of Leyte and Samar have so much to thank for the Almighty for still giving us a chance to live, they call it “second life”, as well as to all those who helped and are still helping us get up and move on, all “kababayans” and even our international friends. Our common motto here is:

- TINDOG Tacloban, Tindog Leyte and Samar.

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**‘Material things are ephemeral’**

By Lea Polidario, MD

We lost some properties but what’s more precious is your family and to hold on to God for His provision. Maybe, this is a way for God to remind me that all these material goods are just temporary. Everything that I should do has to be according to God’s plan.

I’m still staying in the same house. My house is in Palo, Leyte, a town next to Tacloban, one of the heavily devastated areas. We are at the center of Palo, 5 to 6 km away from the coastal area.

During the typhoon, my 93-year-old mother, sister and two nephews were with me.

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**‘Our kids’ welfare, education prompted us to migrate’**

By Felícisimo Abuyabor III, MD

On Nov. 5, we were fully-equipped with survival gear. On Nov. 7, the weather was still fine. You can still watch a movie.

At about 3am of Nov. 8, the winds started to be felt. Then at 5am, I still managed to savor my coffee. Shortly, the wind blew harder. It was howling. Trees were falling. The rain was not heavy compared to the winds.

We moved to the first floor at the back of the stairs. The glass windows on the 2nd floor shattered.

At 7am, blackish water flowed underneath the doors. When the door was opened, all our furniture were already floating! Our house is elevated (from the level of the road by two feet). In less than a
The United Arab Emirates Cardiology Society donated $2,957.50 to the Yolanda victims upon the initiative of the American College of Cardiology Philippine Chapter, through the ACC Assembly of International Governors.

Past PHA President Dr. Saturnino Javier is the governor of ACC Philippine Chapter.

The cash donation was sent to the Philippine Heart Association account by Dr. Wael Abdulrahman Almahmeed of the UAE Cardiology Society.

The request of Javier and incumbent PHA President Dr. Eugene Reyes, was acted upon ASAP by Connie Liu, associate specialist, International Affairs, ACC, by sending a letter of solicitation to the ACC Assembly of International Governors.

The letter partly read: “we ask that you join us in supporting our friends, colleagues, their families and the entire Philippine nation as they attempt to recover from the impact of Haiyan.

Javier said “the Filipino people are eternally grateful. In the light of this unimaginable and unprecedented tragedy, the messages of support and pledges of aid have truly assuaged the pain and trauma that this catastrophe has caused our countrymen.”

The storm, one of the largest ever recorded, has left hundreds of thousands of people displaced and without basic necessities.

Christmas 2014 with my family and relatives

The Philippine Heart Association gave us financial help which was substantial. The Philippine College of Physician extended financial support, too.

Our eldest son, John Felix, a 3rd year high school student is now enrolled at the Philippine Science High School in Davao. Angela Marie, who is in Grade 8 is now at the University of Immaculate Conception. Our youngest is Mark Vincent who is 10 years old, has autism. The kids remarkably, are able to handle the situation well, except that they missed their classmates. They have new friends. Fortunately, we have not observed any unusual behaviour linked to the incident.

Geraldine and I are now with the Brokenshire Hospital, Davao City. We will start our practice in January 2014. We are back to step one in our career -- no patient.

It is sad that we had to leave Tacloban and our patients. I have guilt feelings.

They have being calling to ask when will we resume our clinic. But the children’s welfare and education were the foremost considerations in our decision to emigrate.

There were many foreign doctors who were well-equipped and prepared. They erected tent hospitals in a matter of hours, complete with electric generators and accessories. They were there!

A medical Team from Davao, headed by Mayor Rodrigo Duterte came. And we thank them all.

All the medical facilities of Tacloban City were damaged if not completely destroyed. Since the doctors, nurses, and all hospital personnel and their families were also affected, they had to take care of their families first. The medical system was paralyzed.

Two top-ranking national government employees were there before the typhoon. They were not able to mobilize the military and police within two days to maintain order. There were no communication facilities after the typhoon!

Let us stop the blame game. What are we going to do? Are we going to prepare for such kind of event in the future? Or are we just going to leave it to our government to prepare?
We thank God for saving us— for letting us live another life. After the storm you realize that actually, you received many blessings but have not noticed them. God gave us everything and He can take away anything, everything in a split second.

‘An Apocalypse setting’
By Leila Diaz, MD

On the night of Nov. 7, I started following the tweets of storm-chasers and international weather centers. Late that night, I learned that it was going to be a deadly typhoon and the strongest storm to hit the planet in decades, with winds up to 300kph. That was the time when I thought that I may not have prepared enough.

In a way, I was prepared. PAG-ASA gave adequate warnings days ahead that a super typhoon was coming, although they focused more on the strength of the typhoon; however, they failed to explain what a storm surge was.

On hindsight, I should have put up storm shutters. Six hours before Yolanda made its landfall, I saw this map on Twitter showing the extent of the “tidal surge,” and I told myself that the area seemed very large.

I thought then that a tidal surge will come in the form of a rise in sea level or flooding; I had no idea that it will come in the form of deadly, 16-feet waves battering the coastal areas and beyond, taking thousands of lives and causing widespread devastation of apocalyptic proportions.

I no longer suffer from the anxiety attacks that I had during the first week after Yolanda. I have started to move on and resumed my practice on Dec. 16, 2013. Overall, there is a lot of improvement in Tacloban since a month ago.

We live about two to three kms. from the nearest coastal area, which is San Jose. We’re staying in the same house. Luckily, compared to most, my house sustained only minimal damage involving the gutters, exterior ceiling, garage, and a few broken glass panes. I have already contacted a builder for the repair. We’re still waiting for the materials to arrive.

I have one daughter, Victoria. She turned 5 on Nov. 22. Victoria is in pre-school. Her school will open on Jan. 24, 2014. At the moment, she thinks she’s on a big holiday, and she seems to be enjoying it.

Two days before Yolanda, I was already planning on a Marvel Superhero cake for her (she’s a Spiderman fanatic). Unfortunately, Yolanda threw a wrench at her birthday celebration. She’s fine, and was not traumatized by the storm. I tried very hard to put up a brave front during the storm and after, so that may have helped.

I was with my daughter and mother, and one female helper during the storm. Our areas has had no history of flooding, but the strong winds blew rain water inside our house. The first thing that I did was to secure my daughter and my mother in the upper bedroom at the western side of the house, which was dry and safe from the winds and rain. Then, my helper and I tried to stem the flow of rainwater coming through the master bedroom. When that turned out to be a hopeless case, I got all my valuables and fled to the bedroom of my daughter. I then started reciting all the prayers that I knew. The phrase “…now and in the hour of our death…” kept on flashing through my mind, so I was thinking, will we come out of this alive?

It was only on Nov. 9 that I got to see the extent of the devastation. A scene out of an apocalyptic movie met me. There was so much chaos on the street. And then, the looting. It was so heart-breaking and depressing. I did not see a single police or military personnel during the first two days after Yolanda. I did not see rescuers looking under the debris for survivors.

During an expected devastating calamity such as Yolanda, relief and rescue teams prepositioned outside the affected area must be ready for dispatch within 24 hours. Communication is very important; a disaster-proof communication system must be in place. Tacloban must be reconstructed in such a way that it will be climate-change resilient.

I’m affiliated with the Divine Word Hospital, Bethany Hospital, Mother of Mercy Hospital, and Tacloban Doctors’ Medical Center. My out-patient clinics are in Bethany Hospital and Divine Word Hospital.

I had 2 in-patients at the Bethany Hospital and one at the...
Divine Word Hospital. All of them were discharged by the residents-on-duty by the afternoon of November 8, 2013. All three contacted me a week later by SMS or email informing me that they were alright.

Among my admitted patients, only one was a bit problematic because she was congested when she came in on Nov. 7. So I was worried that she might not be able to cope with the stress of the typhoon. The other two were ambulatory patients who were admitted because of stress-induced hypertension and anxiety attack, hence they could evacuate easily if worse comes to worst. I went to the Bethany Hospital on Nov. 9; the entire first floor of the hospital, as well as the hospital grounds were covered with mud: it was dark and practically deserted except for a few volunteer medics doing emergency wound care. Almost all of the patients had been sent home except for the morbid ones, and they have already been prepared for transfer to hospitals outside Tacloban. I also thought about my other regular patients who were living near the coastal areas. Sadly, two of them (husband and wife) died in the storm surge in San Jose.

During the immediate aftermath of Yolanda, I was not able to attend to some casualties or participate in medical missions. Being the sole head of the family and the decision-maker, I had to attend to my family first.

I was able to join a medical mission when I came back; I also participated in an 18K unity run to raise funds and donations for Yolanda survivors.

I think there was not much disparity in the number of foreign medical teams and local ones. The foreign medical teams arrived earlier though, tended to be bigger, and stayed longer in the devastated areas compared to the local ones.

The important lessons learned from Yolanda are: Everything you have can be gone in the wink of an eye. This tragedy made me realize more that the most important things in life are not things but people and relationships.

Yolanda has also made me more appreciative of even the smallest blessings like the water we drink, shelter, food on the table and dignity of work. Setting aside an emergency fund is important.

To my fellow Leytenos, we are stronger than Yolanda. No calamity can break the faith and spirit of the Warays. We will rise from this.

To the local national governments, stop the politicking; please work hand in hand to help the survivors get up and move forward...

The outpouring of help and support is overwhelming. My heartfelt thanks goes to the Filipinos both here and abroad who have extended invaluable help; the volunteers from all corners of the Philippines and the world, making this gargantuan relief effort possible; the street kid who donated his P2.00, or Shoichi, a six-year-old Japanese boy who donated his entire piggy-bank savings, all the way up to the billions donated by countries large and small—thank you from the bottom of our hearts; my colleagues in the PHA and Philippine Heart Center-MAS, thank you very much for extending assistance to my family and I, during our difficult times; my friends and relatives who offered prayers, as well as words of inspiration and encouragement. You made the yoke so much lighter.

I thought my house was disaster-proof
By Ernesto E. Chan, MD

I am presently staying in my house on an elevated ground near the foot of a mountain, which is five kilometers away from downtown Tacloban and about one kilometer from the nearest coastal area.

My wife managed to institute repairs to the damages a few weeks after the typhoon. However, we still do not have electricity and water is being pumped from a deep well with an electric generator we purchased recently. The prices of basic commodities are very high and many are not yet available.

On Dec. 6, I reopened my clinic at the Divine Word Hospital downtown. There are fewer patients than before despite the closure of Bethany Hospital. The supply of medicines are not stable, patients need to go to nearby cities to buy.

I was at home during the typhoon. After Yolanda, there was so much uncertainty. My two sons were in Cebu City during the typhoon. They are PT students of Velez College and they have not gone home yet.

During the typhoon, the waterfall from the mountain forced the gate at the back of the house to open and flood the house. I could hear different sounds -- purring of the strong winds, banging and clanging of metals and flying corrugated steel sheets. The tremendous volume of water flowing in and out of the house was alarming. I thought of its terrible impact on the low-lying areas.

We continually swept the water down so the level did not rise significantly to cause severe damage to the appliances and the cars like what happened in the city proper.

After the storm, there were more challenges: Source of water for washing and flushing. We had to pump water from a neighbor and transport to the house. For drinking, I had 10 jugs of processed water ready and security of the premises.

Sad to say, I was so complacent on the preparations for the coming of the storm. I felt my house was protected. There are firewalls on both sides which rise above the roof, mountain at the back, a house in front across the street and we on higher ground. I knew category 4 typhoon was coming but I was not curious about what PAGASA or CNN had to say about the weather forecast. I forgot to pile sandbags at the back of the house as I used to do. The heavy downpour of water surprised me. It was never like that before.

I am a member of the Divine Word Hospital Disaster Committee. In our discussions, we anticipated that if the power station soaked in water, it would paralyze hospital operations. The stand-by power was...
Physicians bond to help Visayans

"Guiuan, Eastern Samar, Philippines was badly hit by Typhoon Yolanda. They need medicines… Bring food, water, clothes… Bring cadaver bags…. No help is coming…” Another message came, “Can you assemble a team to join me in a plane bound for Guiuan tomorrow?"

The next day, we flew with boxes of antibiotics and analgesics to Samar.

To cure and comfort
By Michael Tee, MD; Jose Bayani Baylon, MD; Paul Ferdinand Reganit, MD

GUIUAN, Samar – From afar, we cannot help but admire the crystal clear blue waters and coral formation of the island. Up close, the coastline was desolate with piled debris from destroyed houses, bent and cut trees, etc. We landed safely and later saw a Philippine Army C-130 plane transporting sacks of rice and fetching wounded victims.

The mayor met us. What ensued were coordination/giving orders to the staff; consultations and assessment of medical needs. Most of the patients received treatment. There was lack of supplies. At the only operational hospital, a young man asked the group to see his mother, fearing that she might have suffered a hip fracture. Upon examination, it was normal, and with a sigh of relief, mother and child were so thankful.

Four patients were transported to Cebu – two skull fractures and one tibial fracture, a ruptured achilles tendon, and an American tourist who collapsed due to lack of food and water for three days.

On our way out, the young man and his mother waved to us and we realized, one of us failed to give her adequate supply of analgesics. All have been dispensed.

For doctors, the feeling of being able to cure and can comfort is very gratifying.

We are back in Manila and we have donated nearly USD 50,000 worth of supplies to Guiuan.

Egalitarians all
By Paul Ferdinand Reganit, MD

ROXAS CITY -- We came here, expecting to treat the sick and the downtrodden, but we ended up like everyone else -- as anonymous volunteers re-packing relief goods at the ground floor of the Capiz Provincial Capitol. For a relief operation so close to one of the hardest hit areas in the Visayas by typhoon Haiyan, the urgency was palpable.

Assembly lines emerged anywhere and everywhere in the capitol. Every hand was a helping hand, be it an army sergeant's, a boy scout's, or a medical student's. "Noodles, noodles… pass… sardines… rice… knot, pass" — the pace was akin to military cadence, as if every second wasted and fumbled meant another rumble in a survivor's stomach. There was no time to consider nutritional value; this was a remedy for hunger numbering in the thousands.

The two-hour drive from Roxas to Dumarao town, the governor's hometown, seemed like an endless road of destruction -- trees stripped off their leaves; toppled electric posts that reminded us of the recent past, when electricity was hardly even considered a luxury; nipa huts and houses of galvanized iron reduced into heaps of bamboo and metal sheets. Not to far were concrete houses that stood still.

In the midst of all these, we were at the back of a rusty truck with sacks of relief goods. On what we had perceived as a beautiful day, our feelings couldn't have been more in conflict.

With reports from Michael Jose Arcilla, MD; Jose Paolo Albano, MD; Karen Joy Adiao, MD; Ana Ligaya Agoncillo, MD
‘We rise to the occasion’
By Sherrywinn Simon, MD

ORMOC CITY, Nov. 23, 2014 -- Scenes of our beleaguered kababaysan in this city became international headlines. There was a loud call for urgent help to the affected region. The compassionate heart of the Thomasian doctors quickly and silently rose to the occasion.

The UST Section of Cardiology, together with the Bataan Medical Society (BMS) and Couples For Christ (CFC) Ministry, brought together a disaster response 17-man medical team to typhoon-devastated Ormoc. The team of doctors, dentists and nurses was spearheaded by UST Cardiology’s Dr. Milagros Yamamoto, CFC’s Dr. Jose Yamamoto, and BMS’ Dr. Orlando Bugarin with his pediatrician wife Dr. Maricar Bugarin. They brought with them boxes of relief goods and medicines for the two-day mission. Two UST Cardiology fellows -- Dr. Kirstin Yap, including this writer, were part of the team. The group tirelessly kept on with the mission and without them noticing they were able to reach a total of 4,000 patients from different ages. The team left the area exhausted but fulfilled, bringing along with them the gratitude expressed by the people. Together, they shared a gleaming ray of hope as the city struggles to thrive and start anew.

Despite news of overflowing help received by the area, support and provisions still evaded those in far-flung places. Thus, the campaign for assistance to deliver basic necessities continues.

MEANWHILE, separate Medical Missions were conducted in Capiz and Aklan. Dr. Marcelius Francis Ramirez and Luisa Sarbues reached out to the people of Roxas City, Capiz, and in Maayon, Tapaz and Dumalag by distributing relief goods and extending medical care. Dr. Rodelio De Sagun went on to give aid in the province of Aklan, particularly in Batan and Altavas towns. This was in collaboration with the UST Faculty of Medicine and Surgery.

The Luzon-based team stayed for three days in the city and they were hosted by CFC members in Ormoc. Despite their ordeal, they showed the warm hospitality known among Leytenos which was deeply appreciated by the team. In coordination with the local officials, the barangays of Can-Adying, Camp Downes, Bagong Buhay and Margen were visited amidst alternating rainshowers and scourging heat. Medical services consisted of pediatric, surgical, dermatologic, ob-gyne, adult medicine and dental treatment teams.

De Sagun with other members of the team to Batan and Altava

Ramirez (standing, 7th fr. R) with members of the UST Department of Medicine medical mission team

The Bugarins (front row, center) with cardiology fellow Kristin Yap and other members of the medical mission team to Ormoc

UST Cardio fellows help out in packing relief goods for the Visayas

The Bugarins (front row, center) with cardiology fellow Kristin Yap and other members of the medical mission team to Ormoc
Calm after the storm
By Adriel Guerrero, MD

TACLOBAN CITY, Nov. 29, 2013 -- I was a medical and psychosocial team volunteer under the Operation Compassion and Department of Social Welfare and Development from Nov. 26-29, 2013. We served four barangays in Mayorga town and two barangays in Tanauan town, Leyte.

At the Tacloban Airport, we were met by scenes of devastation and despair left by Yolanda. Our hearts melted with compassion as our van negotiated through recently opened roads, which were made passable after the fallen coconut trees were chopped and the mounds of sand were washed out by the water surge.

The mission site was not a “site” at all. Before setting up, we had to sweep out mud and fix overhanging, loose GI sheets of tattered roofs. The registration and waiting areas for patients were located at the “unroofed” court while the medical and dental teams were assigned inside the Barangay Hall where we walked through shattered window glass.

In Manila, you need at least a week to coordinate with local officials to ensure 100 percent attendance but here, in less than an hour, 250 patients registered for consultation. Despite the sweltering heat, the queue was orderly and calm. Everyone waited for his/her turn to be examined, and was ready to tell his/her stories of braving the storm and watching some relatives drown; fathers feeding their families with snails, fallen coconut, uprooted camote and kamoteng kahoy. Three to five days after the storm, food was scarce, there was no electricity, and talks of looting were everywhere.

These all changed as we ended the mission. We saw transformation everywhere. Faces lit up with gratitude as the storm-stricken people waved goodbye. While seeing glimmers of hope we thanked the Lord for allowing us to be His hands and feet in extending a helping hand to our beloved kababayans. We will come back soon.
Multi-specialty teams fly to Leyte, Iloilo

By Irwin Bundalian, MD

The Medical City (TMC) had conducted several fund-raising activities for our brothers in Visayas who were devastated by typhoon Yolanda. Aside from the monetary help, food and clothing that were given from the hearts of TMC staff, the hospital also shared what we do best: medical aid, with our brand of patient partnership.

The hospital assembled their best specialists from Medicine, Surgery, Pediatrics, Obstetrics, Psychiatry and all other specialties and services. TMC sent two teams to Leyte and Iloilo composed mostly of consultants who voluntarily sacrificed their time and brought all the hope and inspiration from the entire community.

The first medical mission was sent toOrmoc and Isabel, Leyte from November 18 to 21, 2013. The group was headed by Dr. Jose Antonio Salud (Chairman, TMC Department of Surgery) who was able to serve 700 plus patients during the entire weekend.

While the second team was sent to Estancia, Iloilo on November 29, 2013, in coordination with The Medical City Iloilo (TMCI). The team was headed by Dr. Roberto Alfabeto, Director of Medical Services Group of TMCI. The team was joined by consultants from TMC Pasig, headed by no less than our very own Dr. Eugene Ramos (SVP, Medical Services Group of TMC).

It is also worthy to mention that aside from these two medical missions, TMC is also setting up a mobile clinic in the Visayas that will continuously provide medical care to the localities. This will help in the rehabilitation of the Visayas particularly in the field of Medicine. The community is hoping for the full recovery of the region, with all the help that each one of us could provide.
KALIBO, AKLAN, Nov. 29, 2013 – Our hearts had been unsettled. We would find no rest unless we do our small part in pulling our fellowmen out of ravages of furious Yolanda, out of the stench of modern-day necropolis that is closer to fiction or figment than real. After several calls, text messages, and meetings – we were ready to share in the burden of the victims of Yolanda. We wanted to tell them “It will be alright. You have company.” Sama-sama tayo!

The road was rough and steep alongside cliffs. Our minibus would roll back from time to time. We would beg the driver to let us walk through the steep portion of the road. Each one had a prayer deep inside.

Drs. Kelly Reyes, Mel Balajadia, Albert Bunyi, Paris Go, Mano Turalba, Jerome Laceda, Leah Dimaano and Clara Tolentino patiently sat with people to give medical care. Twenty days past Yolanda, the soul rather than the body was sicker. The challenging job of dispensing meds was done by Drs. Malu Afable, Joana Manalo, nurse Joseph Padilla, and med rep-cum-pharmacist Eric Hallares. They had late lunch to keep the line short.

Mighty winds rocked the house as if forcing its way to get in. The winds didn’t stop until a portion of the house gave way. Then they ran to a safer place but not before waiting for the winds to quiet down first or they would be carried away. As the winds released its might again, they stopped for cover, then ran again. Each time they looked up to see where the coconuts fly to keep them safe. As you let them tell their stories, their thoughts,
CEBU CITY, Dec. 8, 2013 -- For PHA-Cebu, the true essence of Christmas is spreading your blessings, according to our Savior’s will. After all, Christmas stands for Christ and the masses or his people.

Barely a month after super typhoon Yolanda, members of the Cebu Chapter opted to celebrate their traditional Christmas party with the children of Daanbantayan, a northern municipality of Cebu, one of the badly devastated areas of the province. Christmas is well spent when we give the light of love and share to those who need it most.

As early as 5:30 am, we left for the three 3-hour land trip. Another batch, headed by the PHA Cebu Chapter President Dr. Wilfredo Ypil, dropped by Bogo, a small city, to donate medical goods to the typhoon victims, before proceeding to Daanbantayan.

Everyone enjoyed the hot lugaw and ice cream sharing with almost 400 plus kids. After the distribution of gifts, the kids gathered for a little party -- complete with clowns, games and raffles. Every Chapter member brought a bag of toys for all the kids.
PASIG CITY, Dec. 13, 2013 – The VOICE: Songs of Hope, Faith and Inspiration featured the different homegrown talents of TMC -- consultants and trainees from different departments. World-class performers John Lesaca and Eric Santos graced the event and rendered songs for free! This benefit concert for Yolanda victims was able to raise a hefty sum. The goal is to put up an ambulatory hospital in the Visayas region.

The TMC Department of Medicine Christmas Party was a musical variety entitled VINTAGE: Internist at Center Stage. Every section of the Department composed of consultants, fellows and trainees, did a 15-minute performance. The competition fever among the participants was very high.

For the fifth consecutive year, the TMC Section of Cardiology bagged the first prize, this time, with its number “One Heart, One Love, One World, One Christmas”. According to Dr. Raul Ramboyong, the group’s indefatigable concept director, “our message to all our brethren in the Visayas is in spite of all the tragedies ang pag-ibig sana’y maghari, sapat nang si Jesus ang kasama mo, tuloy na tuloy pa rin ang Pasko (Jesus’ love and presence reign amid the turmoil. We will commemorate the birth of our Saviour, Jesus Christ).”

Voyage, an art exhibit was aimed at showcasing different cultures and displaying our deep gratitude to all the countries that extended to help the typhoon victims. Memorabilia, trinkets, reprinted photos and famous paintings from all over the world (from the collections of TMC consultants) were displayed for one week along the bridgeways of the hospital. Ramboyong said that thru a visit to this make-shift museum, one can explore the world in 20 minutes.

Aside from the ambulatory clinic that is being set-up by TMC, the hospital assembled their best specialists from Medicine, Surgery, Pediatrics, Obstetrics and all other specialties and services. TMC sent two teams to Tacloban and Iloilo composed mostly of consultants who brought all the hope and inspiration from the entire TMC community.

These activities came into fruition through the concerted efforts of TMC’s Professional Services Development Office, the Medical Training Office (MTO), Dr. Maffy Tayson (chairman of the Medicine Department) and Ramboyong (consultant, IM/Cardiology Section of Cardiology), together with the IM residents and Cardiology fellows.

Medicine Week (Dec. 9-13, 2013) was celebrated with a bang by The Medical City (TMC). All the events were fundraisers that were dedicated to the displaced typhoon victims.
Quezon City, Dec. 6, 2013 -- The customary PHA Christmas bash for its constant industry allies was a celebration of life.

Central Visayas is still reeling from typhoon Yolanda’s rage. Feeling for the Yolanda victims, particularly the affected PHA members, the PHA Board opted for a humble party that was held at the sparsely but discerningly embellished Fab Room of Crowne Plaza Manila Galleria.

The jovial hosts (Drs. Eugene Reyes, Joel Abanilla, Alex Junia, Raul Lapitan, Jorge Sison, Jonas del Rosario and Helen Ong-Garcia, and the PHA Secretariat, led by its executive director Gina Inciong, met the guests at the registration.

From the registration counter, some guests gravitated towards the solicitation table that sold bottles of choc-nut butter. Sales from the sandwich spread will be donated to the PHA members-typhoon Yolanda victims.

The entertainment segment was hosted by PHA Secretary Dr. Alex Junia and PHA Director Dr. Helen Ong-Garcia.
Super Typhoon Yolanda exposed corruption in government and private entities. It showed the poor quality of infrastructure and buildings. It also bared the survival instincts of every human being.

The calamity made us realize that with one act of God, so many people rich or poor, young or old, man or woman can perish.

A 300-million worth of Convention Center in Palo Leyte collapsed killing several evacuees. Was it over-priced or substandard? Not for me to determine.

New set of posts and wires were constructed, another expense and possible source of corruption.

Apparently, the national government was not ready to handle a disaster of such magnitude. They were in denial stage and playing politics when many survivors were on the verge of dying of hunger and diseases. They did not want to hear the death toll rising beyond 10,000. But a lawyer from Tanauan, Leyte estimated that in his town alone the death toll could reach 7,000.

PAGASA failed to communicate to the man on the street what storm surge is. Even a newscaster, Mr. Ted Faillon was not well informed because he and his crew stayed in a house near the sea and almost drowned. It is suggested that PAGASA should speak in the simplest terms, most easily understood by the public and give stern warnings and strict recommendations.

Was that man made or wrath of nature? When foul smelling, black septic tank like water from the sea was sucked up and poured back to Tacloban and coastal towns, it was like nature returning the dirt that man made. I was told that after the surge, the beaches that were formerly very dirty became blue and clean. This is nature telling us to stop polluting the sea, the beaches and environment.

Each one of us will be facing our Creator and we will be on our own, no companions. It can come at a time we do not expect. It calls to mind “death is like a thief that comes in the night”. When you are called to face God, are you ready? Do you have a relationship with Him?

No matter how wealthy you are, you will never bring it in your death. Matthew 6:19-21. These verses remind us that treasures on earth will be destroyed by moth and rust and will be stolen by thieves. We are advised to store treasures in heaven because it will not get lost.

When people you do not know come to help and show love and care, it tells us that we do not need a Yolanda or wait for a Yolanda to show love for our neighbor. Remember, it is the second greatest commandment. Let us help people in need, share what we can share. Let us not wait for God to remind us to help others. And let us not do this only on Christmas.

Poor infrastructure, poor planning and preparation and poor information campaign and non-adherence to laws, policies and guidelines can lead to higher casualties during calamities. Corruption is evil. Let us help fight this malady.

Here are my messages –

To the local Government:
Yes, Tindog (rise) Tacloban, Tindog Leyte and Samar and other provinces affected by Yolanda. We all need help but we also need to help ourselves by standing on our own. No amount of help can make us stand but ourselves. Let us not lose hope. This is just temporary, a big trial, act of God with a purpose. Let us examine ourselves and see what is lacking in us, what and where we failed and let us learn from the lessons taught us. Let us also be prepared for the worst calamities that may come by disaster preparedness, improving infrastructure, housing architecture and by following guidelines. Let us strengthen sister city/LGU relationships with Luzon and Mindanao and even abroad so that in times of calamities our sister LGUs can immediately come to the rescue. When a disaster hits so many provinces every LGU becomes a priority and only those not affected are capable of assisting.

To the national government:
Come up with a comprehensive disaster management and preparation for calamities big or small; put competent staff in PAGASA and the Disaster Council; Stop politicking and preparing for the next election. Do not remove trained officers especially in PAGASA and the Disaster Council simply because they are not your allies; Do not put barriers and limitation to foreign donations when there is a disaster; Do not repack relief goods and change to inferior quality products; Give relief goods that will last for weeks, not just for a day or two; Prosecute mishandling and stealing of relief goods; Continue to help other countries in times of calamities no matter how meager the resources are; Thank you for helping Eastern Visayas and other affected regions.

To Filipinos in the Philippines:
Thank you for your donations, support and prayers. Thank you for sympathizing with the victims. Let us learn from the lessons of Yolanda particularly on the care of our environment and the love for our fellowmen.

To Filipinos abroad:
Thank you for your financial and material assistance to the victims of Yolanda. I know that you are physically separated from majority of Filipinos but your hearts are still 100 percent Filipinos. God bless you and may you be given ample provisions and protection.
Rising from the ruins

Still shots that encapsulate devastation and getting to your feet; bayanihan and courage, hope and faith.
Dysrhythmic Tales

By Edgardo S. Timbol, MD, Director, HB Calleja Heart Institute, Angeles University Foundation Medical Center

The longest pause

It is not only the sinus node (SN) that could be sick in sick sinus syndrome but the subsidiary pacemakers as well. Protracted asystole develops when the back-up pacemakers from the atria to the ventricles fail to generate rescue beats in the absence of impulses emerging out of the SN.

Asystole manifests on the ECG as a prolonged absence of P waves due to the failure of impulse generation by the SN and/or the failure of impulse conduction out of the sino-atrial (SA) junction. The former mechanism produces sinus pause or sinus arrest; the latter results in SA block in which the asystolic intervals are multiples of the shortest P-P intervals. No such mathematical relationship is demonstrable in sinus pause or sinus arrest. In sinus pause, there is simply a delay in the appearance of the next P wave. In sinus arrest, there is a complete absence of P waves with escape beats.

The foregoing ECG in leads V₁, V₂ and V₆ from a 76-year old male from Guagua, Pampanga with increasing frequency of syncopal episodes reveals an underlying sinus rhythm with sinus arrhythmia (SA) and asystole of varying duration from 2 to 9 seconds. Measurements of the P-P intervals show no exact mathematical relationship between the long and short P-P cycles attributable in part to the presence of SA. Hence, exclusion of SA block from diagnostic consideration even if the long pauses are not multiples of the basic sinus rate, is not without doubt. The asystolic intervals are consistently terminated by P waves (marked with J) with normal PR intervals and QRS complexes. In all likelihood, sinus pause, not sinus arrest, is responsible for the prolonged atrial inactivity in this case.

It does not matter whether a symptomatic patient has sinus arrest or sinus pause. In either case, he could certainly benefit from anti-bradycardia pacing. Precise distinction of sinus pause from sinus arrest is simply an academic exercise with trivial significance therapeutically. The duration of asystole in this case, however, may be significant as a trivia. Unless there is a counterclaim to the contrary, asystole of 9.4 sec. duration could be longest pause recorded using a simple manually operated ECG machine in the outpatient setting.

Also in Pampanga is the “longest bridge in the world” that connects the Tagalog-speaking town of Calumpit with the Kapampangan-speaking town of Apalit. An egg in Calumpit becomes a bird already upon reaching Apalit.

Egg is “itlog”

Calumpit

Egg is “ebon”

Apalit

♥
Last of a two-part series

Proposed Physicians’ Act of 2012

Same special/temporary permit may also be issued to physicians licensed in foreign countries/states who intend to render services for free and limited only to indigent patients in a particular hospital, center or clinic and that they render such services under the direct supervision and control of a duly registered/licensed physician; and to physicians licensed in foreign countries/states employed as exchange professors in any area of medical specialization. The permit issued will be for a period of only one (1) year subject to renewal or extension, for a specific area of medical specialization and specific place of practice, such as clinic, hospital, center or College of Medicine.

Grounds for suspension from the practice of profession or revocation of the certificate of registration of a physician, or issuance of a reprimand or cancellation of the special/temporary permit issued to a foreign physician include final conviction by a court of competent jurisdiction of any criminal offense involving moral turpitude; immoral or dishonorable conduct; insanity; fraud in the acquisition of the certificate of registration and the professional identification card or special/temporary permit; gross negligence; ignorance or incompetence in the practice of his/her profession, resulting in an injury to or death of the patient; addiction to alcoholic beverages, to any habit forming drug or to any form of illegal gambling, rendering him incompetent to practice his/her profession; making or causing to be made false, misleading, extravagant or unethical advertisements wherein things other than his name, profession, limitation of practice, clinic hours, office and home address are mentioned; issuance of any false statement or spreading any false news or rumor which is derogatory to the character and reputation of another physician without justifiable motive; knowingly issuing any false medical certificates and/or findings, or making any fraudulent claims with government or private health insurance; performance of, or aiding in, any criminal abortion; performing any act constituting the practice of an area of medical specialization without fulfilling the specialization requirements prescribed by the Board; knowingly aiding or subjecting one’s self to be a patient of any person who is unqualified or unregistered to practice medicine or an area of medical specialization, except in aid of training of a medical student, or performing any act constituting the practice of medicine or an area of medical specialization in behalf of any such unlicensed or unregistered person. However, this provision does not apply when an act constituting the practice of medicine or an area of medical specialization is performed in a hospital, clinic or medical center as an accredited practitioner of such hospital, clinic or medical center. Thus, all hospitals, clinics and medical centers will be required to furnish the appropriate regional office of the DOH a list of all medical practitioners duly accredited to practice within their respective institutions every three (3) months. Other grounds include violation of any provision of the Code of Ethics for Physicians; practice of profession during the period of his suspension and willful failure or refusal to be a member of the integrated Accredited Professional Organization (APO) for Physicians or expulsion or termination of membership therefrom. Revoked certificate of registration and professional identification cards maybe re-issued after two (2) years if the respondent has acted in an exemplary manner in the community.

The more important section and I think will be the source of many violent reactions is the proposed integration of the profession into one national Accredited Professional Organization (APO) of Physicians much like that of the Integrated Bar of the Philippines.

A mandatory continuing medical education also much like that of the mandatory continuing legal education will also be implemented.

Finally, a penalty of imprisonment of not less than one year but not exceeding five years or a fine of not less than P200,000.00 but not exceeding P500,000.00, or both, will be meted to any person who practices or offers to practice medicine in the Philippines without a valid certificate of registration and a valid professional identification card, or a valid temporary/special permit, any person who shall use or advertise any title or description tending to convey the impression to the public that he/she is a registered and licensed physician or medical specialist who shall abet or assist in the illegal practice by a person who is not lawfully qualified to practice medicine or any area of medical specialization, any person who actually engages in the practice of medicine as defined without any certificate of registration, any person who shall attempt to use a revoked or suspended certificate of registration or a cancelled temporary/special permit, any person who shall use or advertise any title or description tending to convey the impression to the general public that he/she is a registered and licensed physician when in fact he/she is not, any registered and licensed physician or medical specialist who shall use or advertise any title or description tending to convey the impression to the public that he/she is a specialist in an area of medical limitation of practice, clinic hours, office and home address are mentioned; issuance of any false statement or spreading any false news or rumor which is derogatory to the character and reputation of another physician without justifiable motive; knowingly issuing any false medical certificates and/or findings, or making any fraudulent claims with government or private health insurance; performance of, or aiding in, any criminal abortion; performing any act constituting the practice of an area of medical specialization without fulfilling the specialization requirements prescribed by the Board; knowingly aiding or subjecting one’s self to be a patient of any person who is unqualified or unregistered to practice medicine or an area of medical specialization, except in aid of training of a medical student, or performing any act constituting the practice of medicine or an area of medical specialization in behalf of any such unlicensed or unregistered person. However, this provision does not apply when an act constituting the practice of medicine or an area of medical specialization is performed in a hospital, clinic or medical center as an accredited practitioner of such hospital, clinic or medical center. Thus, all hospitals, clinics and medical centers will be required to furnish the appropriate regional office of the DOH a list of all medical practitioners duly accredited to practice within their respective institutions every three (3) months. Other grounds include violation of any provision of the Code of Ethics for Physicians; practice of profession during the period of his suspension and willful failure or refusal to be a member of the integrated Accredited Professional Organization (APO) for Physicians or expulsion or termination of membership therefrom. Revoked certificate of registration and professional identification cards maybe re-issued after two (2) years if the respondent has acted in an exemplary manner in the community.

The more important section and I think will be the source of many violent reactions is the proposed integration of the profession into one national Accredited Professional Organization (APO) of Physicians much like that of the Integrated Bar of the Philippines.

A mandatory continuing medical education also much like that of the mandatory continuing legal education will also be implemented.

Finally, a penalty of imprisonment of not less than one year but not exceeding five years or a fine of not less than P200,000.00 but not exceeding P500,000.00, or both, will be meted to any person who practices or offers to practice medicine in the Philippines without a valid certificate of registration and a valid professional identification card, or a valid temporary/special permit, any person who shall use or advertise any title or description tending to convey the impression to the public that he/she is a registered and licensed physician or medical specialist who shall abet or assist in the illegal practice by a person who is not lawfully qualified to practice medicine or any area of medical specialization, any person who actually engages in the practice of medicine as defined without any certificate of registration, any person who shall attempt to use a revoked or suspended certificate of registration or a cancelled temporary/special permit, any person who shall use or advertise any title or description tending to convey the impression to the general public that he/she is a registered and licensed physician when in fact he/she is not, any registered and licensed physician or medical specialist who shall use or advertise any title or description tending to convey the impression to the general public that he/she is a specialist in an area of medical
specialization when in fact he/she is not and any registered physician who shall commit any of the prohibited acts as enumerated.

When a registered and licensed physician or medical specialist abets or assists in the illegal practice by a person who is not lawfully qualified to practice medicine or any area of medical specialization or any person who actually engages in the practice of medicine by physically examining any person for any disease, injury or deformity, or diagnosing, treating, operating, prescribing or dispensing any remedy therefor or 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 is committed by a person against three (3) or more persons, or when any of such acts is committed by at least three (3) persons who cooperated and confederated with one another, or when death occurs performing any act constituting the practice of an area of medical specialization without fulfilling the specialization requirements prescribed by the Board the offense shall be considered as a qualified violation and will be punishable by life imprisonment and a fine of not less than P500,000.00 but not more than P2,000,000.00.

In summary, the proposed amendments to the Physicians’ Act of 1959 provide for more regulating bodies, stricter regulations to the entry into medical practice and the medical practice itself and imposing stiffer penalties for the violations of its provisions.

Relax... It’s O–K+

It’s not uncommon in my practice to get a call from the cardiology team asking to assist with the management of a patient with hyperkalemia and acute kidney injury. On a few occasions, I’ve found the hyperkalemia to be disproportionate to the level of renal function and, upon further investigation, found this to be as a result of zealous correction of the potassium level to >4 mEq/L in patients in the cardiac unit. I have often wondered about this practice and whether or not there was firm evidence for keeping the potassium in the 4-5 mEq/L range (or even 4.5-5.5 as suggested by some authors). A quick literature search brought up a paper published in JAMA last January 2012 entitled Serum potassium levels and mortality in acute myocardial infarction by Goyal et al.

As mentioned in their paper, the data suggesting that low potassium levels are associated with increased mortality are relatively old and date from an era when ventricular arrhythmias were more common following an MI. Quoting from the article: “Most prior studies were conducted before the routine use of β-blockers, reperfusion therapy, and early invasive management in eligible patients with AMI. In addition, these studies were small (usually <1,000 patients), which precluded a robust assessment of the relationship between potassium levels and mortality. Furthermore, most of these studies focused on the outcome of post-infarction ventricular arrhythmias, which occur much less frequently in the current AMI treatment era.”

The authors of this study used a database of patients presenting to 67 US hospitals with a confirmed code for MI and increased cardiac biomarkers. In total >39,000 patients were included. They looked primarily at post-admission potassium levels and their relationship with in-hospital mortality and the occurrence of arrhythmias. As one would expect, there was a U-shaped curve for the relationship between in-hospital mortality and the potassium level. What was unexpected, however, was that the lowest mortality was seen in patients with a potassium between 3.5 and 4.5 mEq/L and that the mortality doubled in patients with a potassium between 4.5 and 5 mEq/L. This was born out in the fully adjusted model. The odds ratio for in-hospital mortality was 1.96 (CI 1.64-2.34) for patients with a potassium between 4.5 and 5 mEq/L. Interestingly, the risk of a ventricular arrhythmia was the same in patients in the midrange of potassium values and only increased in patients with a potassium of below 3 or above 5 mEq/L. This contrasted with the mortality data and the authors suggest this might be in part a result of incorrect coding of ventricular arrhythmias, and is a potential limitation of the study. Also, this study certainly does not prove that replacing potassium to a level above 4.5 mEq/L is dangerous. This can only be answered by a randomized controlled trial. There may be some residual confounders that were unaccounted for in the model. Still, as the authors point out, this study challenges current guidelines and suggest that a better target for potassium in patients following an acute MI would be 3.5-4.5 mEq/L.
Congenital heart defect and your child

DURING the first three months of pregnancy, the heart of the young fetus is undergoing rapid changes in its development. As with anything being created, formed or fashioned some aberrations may happen. The normal pattern can be arrested at any stage so that growth and development of the young heart takes an abnormal course. If the fetus has to survive, nature undertakes compensatory mechanisms to correct the first abnormality with the object of letting life continue. Thus, it happens that two or more defects co-exist in a manner to correct an original abnormality. Luckily in some instances, a defect may be minor — not life threatening, hence, mother nature does nothing to correct the fault. However, distortion of physical laws relevant to fluids (blood) and conduits (blood vessels) may produce a secondary effect without substantially altering the original design.

Somefactor responsible for these abnormalities are known. For example, German measles contracted by the mother during pregnancy, drugs like thalidomide, high altitudes and late pregnancies (mother in the late thirties or forties) are definitely linked to higher incidence of congenital heart defects. The same type of defect may keep recurring from generation to generation in one family. It is, therefore, of advantage to know the specific type or defect if only to give a potential clue for diagnosis to a future member of the family who may develop a congenital heart defect.

In general, as a preventive measure, mothers should be quite careful during their pregnancy. Avoid physical trauma (car accidents, falls, etc.), chemical injuries (tranquilizers), infections (viral – chicken pox, German measles) and possibly mental and emotional tensions especially during the formative period of the heart (first 8 weeks of pregnancy).

It is customary and helpful to divide congenital heart diseases into those that make the baby blue (cyanotic group) and those that are not (acyanotic). The latter retains the normal healthy looking color all the time but a small group may have blue color during periods of crying and straining.

It is important that once your suspicion of a heart trouble in your child is aroused, you remain calm and composed and let the heart specialist settle the problem for you. See your heart doctor for advice. Herein we shall discuss the most common congenital heart defects, their salient features and their treatment.

1. Patent ductus arteriosus – This is a defect brought about by non-closure of an artery (blood vessel) connecting the pulmonary artery and the aorta used during fetal life in the womb to carry blood from the pulmonary artery to the aorta. After birth, this connection is not necessary. In fact, if it continues to carry blood, an abnormal situation sets in producing an overload on the left ventricle. The left ventricle, therefore, has to work harder and in the long run it enlarges and fails.

Before the heart fails, the symptoms may be nil or minimal. A loud murmur (an abnormal heart sound) may be first detected on a casual preschool examination. Treatment of this condition by surgery is not urgent if there are no symptoms. Ligation of the artery is done when the child is in the best of health. When symptoms directly related to the strain imposed by this abnormality on the heart appears, surgical intervention becomes urgent. With proper reconditioning of the heart, ligation of the patent ductus can be done without unnecessary surgical risk.

Fortunately, a new mode of treatment is now being evaluated with favorable results. This will avoid surgical ligation of the artery. The new method uses a plug brought to the site of the abnormal artery by means of catheter. The catheter is introduced into the artery in the same manner as in cardiac catheterization.

Further reports in medical journals on the successes with this methods are eagerly anticipated. We hope this will become an established form of treatment for many if not all the cases of this congenital abnormality.

2. Atrial septal defect – This is an abnormal connection between the 2 small chambers of the heart called atria (atrium, singular). They are called right atrium and left atrium. The right atrium collects blue blood from the veins draining the head, neck, arms, chest, abdomen and legs. The left atrium collects blood exclusively from the lungs after blood is turned red by the addition of oxygen. A normal connection between the right atrium and the left atrium is obtainable during life in the womb. This normal connection may persist after birth. In other instances, the formation of the wall separating the chambers may be defective. This was called interatrial septum may be perforated in several places or the normal perforation may be bigger than normal. In yet another type of defect, the primary wall may be quite deficient giving rise to a more serious anomaly that is harder to correct.

Depending on the pressures obtainable in the two atria and the size of flow in the connection (size of shunt), the symptoms will vary. Many cases do not have cyanosis (blue color of the fingers, toes, lips or ear lobes). During periods of crying, a temporary blueness may be perceptible. Growth is generally not stunted.

Correct diagnosis of this condition may not be so easy. Hence, it is imperative that cardiac catheterization be done as soon as the situation is discovered. The surgeon would want precise diagnosis of the type and size of the defect. These are important for definitive surgical correction of the defect and in avoiding possible surgical risks.

TO BE CONTINUED ✔

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

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Doing the Eu-Genio and other games

By Gynna P. Gagelonia

PASIG CITY, December 10, 2013 -- Christmas 2013 is twice as significant in the book of the Philippine Heart Association Secretariat.

According to old-timers in the PHA Secretariat -- Catherine Morado and Ronaldo Grande, so far, this is the first and only PHA Board-PHA Secretariat Christmas bash that the entire Board stayed on from start to finish.

PHA Board of Directors 2013-2014 -- (Drs. Eugene Reyes, president; Joel Abanilla, vice president; Alex Junia, secretary; Raul Lapitan, treasurer; Jorge Sison, Jonas del Rosario and Helen Ong-Garcia, directors, as well as Frederick Alegre, VP for External Affairs, revelled with the staff -- played with them in all the games like revere-charade, banana-eating contest, “Meron-Wala” and “Pinoy Henyo”, which was given a new coinage Eu-Genio that night because the President found it so exciting and challenging. Jenny Ymasa, a Council coordinator, prepared the questions but it turned out some members of the Board had a hand in it, too.

The ever-ebullient Dr. Hogar (Garcia) was the emcee.

Meanwhile, during the time-honoured Christmas wish-giving, the Board acknowledged the staff for their contributions to the society and reiterated that they are appreciated and are members of the PHA family. However, they were challenged to make the PHA Secretariat a more fertile ground and healthy work area in 2014, to be able to deliver excellent accomplishments, quantity and quality wise.

Three members of the Secretariat also conveyed their gratefulness to the Board and at the same time, one of them expressed her sentiments. ♥
Christmas wish for the Staff from the PHA Board of Directors

Dr. Eugene Reyes: Next year, we hope to get more outputs.

Dr. Joel Abanilla: Be passionate with your job. Keep the passion.

Dr. Alex Junia: I pray for world peace and peace among the secretariat in 2014.

Dr. Raul Lapitan: We expect much better accomplishments, far better than this year.

Dr. Jorge Sison: My wish -- that you will be a more cohesive group and more quality and quantity-oriented group.

Dr. Jonas del Rosario: Be more focused workers.

Dr. Helen Ong-Garcia: I hope I was able to infect you with my fashion sense and passion for my vocation; thank you for accepting my idiosyncrasies.

Frederick Alegre: I wish all the best for my PHA family.

Dr. Saturnino Javier: It’s a good time to remember you’re part of the family that we treasure. The Board is your family that cares about your well-being.

From the Staff to the Board:

Jennilyn Faye Ymasa: For always considering our interests, thank you. Merry Christmas, guys!

Irene Alejo: We are aware and will always be grateful for any form of benefits from the Board. Merry Christmas and a Happy New Year, to all!

Catherine Morado: Twenty years or two decades of service to the association. I have learned to love my job and PHA. I hope the PHA appreciates me and my service, and will focus on my length of service and my sacrifices, as well as the staff who have been here for almost 20 years. ♥
PHA Board confessions: Do they walk their talk?

I believe these practices lower my risk of coronary heart disease and other cardiovascular diseases:

2. We use olive oil or canola oil for cooking. The best way to avoid saturated fats is to reduce the use of margarine and butter. Limiting saturated fats or trans fats are early effective ways to prevent abnormal cholesterol level.
3. I avoid canned goods, instant, salted or ready-to-eat foods.
4. Fruits and vegetables are always part of my diet. They are low in --- but are rich in fibers.
5. I do brisk- and slow- or leisure walk for at least 30-45 minutes everyday.
6. NO to smoking.
7. Being a Director of PHA for the past 3 years, I have learned how to manage time. I never treat “stress” as a problem but as a challenge. Stop chasing the past but learn from it and move forward.
8. Proper outlook in life creates a healthy mind and healthy heart. I always spend priceless time with my family, wife and children. I cook for them or watch a movie during weekends.
9. Once in awhile, I allow a “cheat” day but I never let it turn into an excuse in giving up the eating healthy strategies. I have 2 - 4 bottles of beer or 2 - 3 glasses of wine on a separate occasion per week with a few slices of blue cheese. Chocolate is not an issue.
10. Stay in constant communication with the BEST CARDIOLOGIST ABOVE.

Raul L. Lapitan, MD

I walk instead of taking the escalator/elevator.
I make time to run.
I eat more veggies, making sure I minimize my fat intake. But the most difficult of all, is how to saw NO to sweets.

Alex T. Junia, MD

I walk instead of taking the escalator/elevator.
I make time to run.
I eat plenty of leafy vegetables
I take fish oil
I also take vitamin D
And drink red wine --

Eugene B. Reyes, MD

I keep my LDL down by taking statins
I prevent DM and HPN
I eat plenty of leafy vegetables
I take fish oil
I also take vitamin D

Jorge A. Sison, MD

Being active in sports most days of the week, eating more fruits and vegetables, never smoke and try to laugh as much as i can

Jose Jonas D. Del Rosario, MD

I always think of balance diet whenever I have a meal.
I avoid or minimize snacking.
I have shied away from sugary beverages like juices and sodas.
I do more walking up and downstairs than using elevators.
Moderate alcohol consumption, especially red wine in social events.
I stay away from others’ cigarette smokes.
I make sure stress doesn’t get over me. I manage it.
I make sure my favorite leisure activities are part of my daily grind, like listening to music and playing my guitar.
I take multivitamins daily.
I do calisthenics every morning.

Jorge A. Sison, MD

I am a vegetarian. Most of the time, I cook my own food. I exercise three times a week at the gym doing circuit training or TRx.
I watch my weight making sure am in the right BMI.
I have an annual blood chemistries and stress test to check my cardiac status and cholesterol and sugar.
I do not smoke neither does my husband. We make sure we have a day off a week to de-stress.

Helen Ong-Garcia, MD

Raul L. Lapitan, MD
This Christmas may have been different and challenging for some, what with the different calamities that came our way. Yet, each of us found it in our hearts to share, and find it’s true meaning. We asked some of our PHA Cebu Chapter officers on what their wishes are this holiday season as well as their favourite Christmas nook.

Wilfredo Ypil, MD (PHA Cebu President)

The living room where we get to place our Christmas tree remains my favourite Christmas nook. The evergreen leaves decorated with Christmas ornaments brings out the kid in me.

My Yuletide wish this year is happiness and peace for all especially for the survivors of this year’s calamities.

Carolyn Fermin, MD (Vice President)

We celebrate this season thanking family and friends for touching our lives by sharing with us their time and friendship. As we continue to help our less fortunate brothers, we pray that our land will continue to heal, that those who are sick will be healed, those who are hurt be comforted and those who have lost everything will somehow find meaning.

Francisco Chio, Jr., MD (Treasurer)

My favourite nook at Christmas time is the “family living room” where my five children are provided with and decorate their very own Christmas tree with trimmings of personal choice.

Leah Villamor, MD (Director)

The dining room on dinner time is my favourite nook at Christmas and everyday. This is a place where we talk endlessly about anything mindless of the time that passes by.

May the spirit of sharing and love prosper all throughout the world so that there’ll be less misery.

By Nadith Pe, MD

Christmas nook & Christmas wishes

Christmas is for most of us one of the best holidays of the year. It’s a time to be with family and friends… a season of joy and giving. Truly Christmas is for the young ones and the young at heart.

By Nadith Pe, MD

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**Heart News**

**Councils’ Track**

**BP ng Teacher Ko, Alaga Ko!…**

**LRI-Therapharma renews sponsorship**

LRI-Therapharma signified its interest in sponsoring anew “BP ng Teacher Ko, Alaga Ko” for another three years. The verbal agreement was made during a meeting of the “BP ng Teacher Ko…” group composed of Dr. Irma Yape (chair, PHA Council on Hypertension); Dr. Ella Naliponguit (head, DepEd, Division of Health and Nutrition); Loida Ramos (Dep Ed) and Jerome Estregan (CME specialist, LRI-Therapharma).

The meeting was held at Starbucks located at the ground floor of the Philippine Stock Exchange Center. Naliponguit told the group “the Dep Ed Division on Health is currently undergoing a reorganization program so we might not handle BP ng Teacher Ko, Alaga Ko. However, I assure you will be properly endorsed.” In the meantime, it is status quo. The nitty-gritty of the MOA will be reviewed by the PHA Board of Directors, Dep Ed and LRI-Therapharma officers. The identified sites are subject for approval. Yape announced that the council is coming up with a protocol on the project. Data from the screenings will be used for research study. Naliponguit requested that DeEd will be provided with a copy of the protocol together with the MOA; and the conduct of research study should be included in the MOA.

**Goes up North…**

**LAOAG CITY, Nov. 16, 2013** – Some 432 public school teachers in this idyllic capital city of Ilocos Norte availed of the blood pressure taking and other risk factor screenings (cholesterol, fasting blood sugar tests and ECG as needed). A big majority of them were diagnosed to be hypertensive and have a clustering of risk factors. According to Yape, they had to extend the clinic till 2pm because of the long line of patients that needed to undergo ECG. Basis for ECG were: abnormal BP, sugar level and total cholesterol; more than 50 years old and above.

The free clinic was jointly conducted by the Philippine Heart Association Council on Hypertension chair Dr. Irma Yape; PHA Northern Luzon members – Drs. Ellen Palomares, Maureen Valentin and three residents from the Don Mariano Memorial Medical Center.

They were assisted by 28 nurses and medical personnel coordinated by Dr. Loida Natividad, medical officer. Dr. Marizon Dumlao from the Department of Education head office in Pasig City, Manila, lectured on about “Healthy Lifestyle”.

Project in collaboration with PHA, Dep Ed, PSH and LRI-Therapharma.

**… and down South**

**LUCENA CITY, Dec. 6, 2013** – One out of three of the 320 teachers and personnel of West 1 Elementary School in this pastoral city of Quezon Province are hypertensive, according to Dr. Yape.

The Lucena team was composed Yape and six PHA Southern Tagalog Chapter members – Drs. Delta Canela, Edwin Pureza, Samantha Mortos, Cesar Quinto, Mabel Nosce, and Charon Constantino all from Mt. Carmel Diocesan Hospital. Assisting them were 20 nurses and medical personnel. Dr. Beth Cada from DepEd Lucena City coordinated the BP Clinic in Lucena.
When Two Hearts meet…
Trends in ACS Syndrome

By Ritche Go, MD

MANDALUYONG CITY, Dec. 11, 2013 -- The 1st University of Santo Tomas and Chinese General Hospital Coronary (UCC) Summit, the first of its kind where two Cardiology sections from two hospitals would collaborate, provided an in-depth look at Acute Coronary Syndrome (ACS) and the newest approach in diagnosis and management.

Venue was the Edsa Shangri-La Hotel. This timely event was also made possible by Astra Zeneca Philippines, whose efforts in the continuing pursuit knowledge in ACS has always been very evident through the years in the local cardiology scene. Cardiologists, internists, general practitioners, trainees, and other healthcare professionals composed the equally interested audience who filled the whole ballroom.

The lectures were both aimed at information dissemination and stimulating interaction. Keypads were given to each participant for some questions included in the lecture. Questions and comments were entertained throughout the lectures, creating a relaxed but enthusiastic mood.

The moderators were the chief fellows of the two sections of Cardiology -- Drs. Cherie Clemente and Anina Domalanta.

The opening remarks were delivered by Dr. Wilson Tan de Guzman, head of both the Cardiac Catheterization and Intervention Unit of UST and Chinese General Hospital’s Department of Internal Medicine.

Tan de Guzman lectured on Management of ST Segment Elevation Myocardial Infarction which he incorporated with the newest guideline in the management of STEMI. It was a highly informative but easy to understand 40-minute lecture, simplified with the aid of slides.

CGH’S equally reputable cardiologist, Dr. Eduardo Tin Hay, followed it up with his lecture on the management of Non-ST segment elevation Myocardial Infarction and Unstable Angina.
Tin Hay tackled the equally interesting topic with his wit and enthusiasm. UST Hospital Medical Director, Dr. Eduardo Caguioa talked about Optimal Medical Management for Intractable Angina. Delivering an expert opinion, he spoke using just four slides that were information-loaded even on the new and upcoming trends in the management of Angina.

UST’s Dr. Marcellus Ramirez’s lecture focused on Arrhythmias in Acute Coronary Syndrome. He fascinated the audience with his straight to the point lecture and amused us with his slides. His presentation of ECG strips was a reviewer to some and additional learning to others.

A lunch symposium entitled “New P2Y12 Inhibitors: Crossroads in the Management of Acute Coronary Syndrome” ensued with both Tan de Guzman and Caguioa as speakers, with the ever-intriguing Dr. Don Robespierre Reyes as host. It was a debate type of lecture with the two experts giving their take on each topic provided. It was a meeting of two great minds from the two participating institutions.

CGH’s Dr. Henry Chan opened the afternoon session with his lecture on “Cardiogenic Shock in ACS.” He presented a very good lecture that kept the audience awake during these unholy hours post lunch. He captivated the audience with his tips on what to do with one of the most feared sequelae of myocardial infarction.

Dr. Pio Purino, a thoracic cardiovascular surgeon from UST and the Philippine Heart Center, presented his lecture on the role of Coronary Bypass Surgery in ACS. Purino, with his vast experience in cardiac surgery clarified some points on CABG with regards to its indications, guidelines and evidence based merits of the procedure in the management of ACS. The lecture provided another point of view in management of ACS.

The whole day affair was concluded with an interactive Educational Game show entitled “The ACS Challenge.” With Drs. Jade Javier and Erva Magbanua as hosts. This UST Cardiology “patented” educational game show followed the format of the famous game “The Jeopardy”. Questions were taken from the lectures given and some additional trivia questions were also included to both review and entertain the audience which kept the whole ballroom rocking. Major prizes were given and all participants went home with prizes.

The successful ACS summit was closed by Caguioa, who hailed the participants, organizers and the sponsor. “This was truly a day that marked a successful cooperation of two equally reputable Cardiology institutions in the country. Not only did this summit educate and entertain but it also exemplified what two institutions with the same cause and goal can do. Two heads are better than one as what they say, but far more great things will come when two hearts meet. The proponents from the two centers parted ways saying “Perhaps, we can do this more often.”

WHAT HAVE... From Page 13

slightly elevated and majority of the diagnostic machines were located on the first floor. We never expected that water would rise and flood the ground floor and damage all the equipment. I only learned about storm surge after the storm while it was being discussed on TV when I was already in Cebu.

There was enough food in the house when we left for Cebu. The caretakers were the family of my secretary, two working students and a drug representative. In my absence, they were very resourceful in getting relief goods and fetching water from neighbors with a water pump. The relief goods were being distributed by the barangay chairman and people had to fall in line. However, this was not done frequently. Some Christian churches also gave relief goods to church members.

When we boarded the C-130 we brought along necessities -- a few clothes, I-pads and ATM cards.

My children are: Don Jason Chan, 20 years old and Paul Jonas Chan 18 years old. They were in Cebu City during the typhoon. They do not need to see a psychologist.

The day after the storm, I walked for approximately two kilometers but I did not proceed because of the flooded streets. The next day (Nov. 10), I again tried to walk to the hospital as the waters had subsided. I negotiated a five- or more kilometer walk and reached the hospital. The sight was shocking. The hospital was disorganized, dirty and smelly. The ground was slippery and muddy. There was no electricity, no water, IV fluids and medicines. The first floor was crowded with people, like a war zone. Wounded patients occupied the second floor, even the lobby was overcrowded. It was like a marketplace. Many were sitting on the stairways. The patients at the ICU were bagged manually. I made my rounds and discharged all my patients. No one was in serious condition. All patients were discharged without being asked to pay the bills.

Almost everyone was a victim. I believe no house was spared. Many people perished including policemen. Many vehicles were damaged and many establishments were destroyed. The City Government was paralyzed temporarily. There were no relief goods available.

Several weeks later, there were more police forces from the other provinces visible in strategic locations and maintaining peace and order. There were also many MMDA and DPWH dump trucks coming from other regions. Noticeably, there were more trucks provided by the Tsuchi Foundation.
their feelings, most break down with teary eyes and a struggling to fight the fear that comes back. Some stories have no ending-like lost relatives from nearby towns of Leyte and Tacloban, Debriefing session was handled by psychologists Zillah Herrera and Yoly Alba, Dr. Malou Bunyi, and some trained locals. Ushering them in to reenter the life before Yolanda came was an experience.

We prepared 1,220 pieces of blankets, hygiene kits, 40 cavans of rice, several packs of noodles, breads, water. We exhausted all means to bring the goods to its destination-catch the loading schedule of cargo ship, beg for assistance from the Philippine Air Force, line-up for the C-130 chopper, scout for commercial sea vessel, etc. Dr. Rene Reyes took charge of relief goods distribution. A most important relief item were packets of seeds of short gestation that brought excitement to a lot of people. A sense of beginning. These people will get going sooner than we think.

At almost midnight before we left Manila, some young people knocked at the house with 3 big boxes of brand new toys and balloons. Early on, we packed coloring books. These completed our mission. The balloons, they never failed to brighten up a day. The coloring books were a hit! Dr. Irma Yape led the play therapy. Eric Hallarces learned balloon art before embarking on this mission. Mannix, Global City vascular lab manager was an expert inflator. Children smiled and laughed and held each other’s hands. It was like living life all over again.

All throughout, president Dr. Malou De Jesus ran here and there to oversee things, also making sure the team did not starve.

It started when Drs. William Chua, Antonio Sibulo and Romeo Saavedra chose SLHIAAI as trustee for their donation to the victims of Yolanda. Then there were others who parted with their hard-earned money just to help. And then those who helped called on others to help, too. Friends, relatives and patients of alumni, med reps, gave their share. It spread like wildfire, this virus of generosity. Aside from the alumni, we received donations from PCP Rizal Chapter, Rotary Club of Manila, PMP Diagnostics, Ace Diagnostics, Department of Medicine of Clínica Antipolo Hospital, Aqua DJ, Mille Luce Homeowners’ Association, , St. John of Beverley School, Vascular lab techs and research fellows and a lot of ordinary folks and private citizens.

LRI-Therapharma, Pharex and several drug companies gave medicines. Our relatives, secretaries and drivers, fellows, and St. Luke’s security personnel helped in repacking goods. Care Caravan helped us transport some of the goods to its destination. LRI-Therapharma provided the cargo van on our way to the airport. Dr. Au Tanzo gave us pork jerky as baon. Melvin of LRI-Therapharma sent protein bars for quick source of energy. Some members of the team paid their own airfare to share in the burden.

Now that’s what we call amazing! Our hearts were overwhelmed by such outpour of goodness. Together it can be done. Two people are better than one because they get more done by working together.

On our return flight to Manila
Thus, the PHA Continuing Education Program Committee and the Subcommittee on Cardio Fellows in Training chaired by Drs. Jorge Sison and Jonas del Rosario, respectively, conducted the “How to Prepare for Real World Practice 2013: Empowering the Young Cardiologist” to provide them with an intuitive understanding of the different career paths and to enlighten them on the other aspects of clinical practice.

Solely sponsored by Natrpharm-Patriot, it was held in the Natrpharm-Patriot Bldg. in Sucat, Paranaque City.

Committed to their vow in working toward cardiovascular excellence and health, 10 Cardiology consultants and two lay speakers introduced the novice heart doctors to their respective disciplines and advised them to be guided by moral principles and strength of character, the benchmark that excellence is a way of life; taught them investments, about taxes, fees and licenses; the seamless benefits of a paperless clinic; how to avoid medico legal and tax problems; most of all, even the cardiologist, the most highly-educated doctor, is a student for life; a resolute researcher, teacher/mentor and is good at shifting from one role to another.

In his opening remarks, PHA President Eugene Reyes said: “you hurdled all the difficult tests to get where you are now. Always remember that attending to a patient is a chance to serve and getting involved in PHA activities is a privilege.”

In his closing remarks, PHA Vice President Joel Abanilla said that cardiologists are multi-faceted. They can do well as a clinician, academician and as a medical director, at the same time, they should nurture their other talents.

The long but fruitful day, was capped by the Fellowship Night-cum-Christmas Treat for the Fellows by Natrpharm, It showed another best side of cardiology.

All the training institutions were represented -- Philippine Heart Center, St. Luke’s Medical Center, UP-PGH, Cardinal Santos Medical Center, UST-Hospital, Makati Medical Center, Chinese General Hospital, The Medical City, Chong Hua Hospital, Perpetual Succor Hospital, University of Perpetual Help Delta Medical Center and Angeles University Foundation.

Breaking from the traditional Training-in-Fellow Christmas Party in November, attendees of the Real World lectures, played “Minute to Win It”. Similar to the Philippine version of “Minute to Win It” that airs on ABS-CBN, the contestants joined in a sequence of challenges that make the most of readily available items at the ballroom of Natrpharm, in less than one minute each. As they level up, the challenge becomes more difficult. The contests are given the option to decide whether to go on and get to earn more cash prize; or to stop playing and take the money they’ve earned. ♥
The speakers and their topics:

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<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>SPEAKERS</th>
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<tr>
<td>8:30 AM</td>
<td>REGISTRATION</td>
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<td></td>
<td>Invocation</td>
<td>Helen Ong-Garcia, MD</td>
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<td>Opening Remarks</td>
<td>Eugenio B. Reyes, MD</td>
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<td>Message from the Sponsor</td>
<td>Ms. Maria Rosal Rosales</td>
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<td>Overview of the workshop</td>
<td>Jose Jonas D. Del Rosario, MD</td>
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<td>9:00 - 9:30</td>
<td>The Paperless Clinic</td>
<td>Pedro P. San Diego Jr., MD</td>
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<td>9:30 - 9:50</td>
<td>Keys to a successful practice</td>
<td>Ma. Belen O. Carisma, MD</td>
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<td>9:50 - 10:10</td>
<td>Lessons learned thru the years</td>
<td>Ramon F. Abarquez, Jr., MD</td>
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<td>10:10 - 10:30</td>
<td>Pitfalls that you should avoid</td>
<td>Romeo A. Divinagracia, MD</td>
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<td>10:30 - 11:00</td>
<td>OPEN FORUM (Break)</td>
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<td>11:00 - 11:30</td>
<td>Gadgets/Applications to enhance your practice</td>
<td>Ivan Noel G. Olegario, MD</td>
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<td>11:30 - 12:30</td>
<td>LUNCH</td>
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<td>12:30 - 1:00</td>
<td>Investments 101</td>
<td>Ms. Rubi Garcia</td>
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<td>1:00 - 1:45</td>
<td>Taxes, Fees and Licenses</td>
<td>Mr. Romeo B. Cruz</td>
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<td>1:45 - 2:00</td>
<td>OPEN FORUM</td>
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<td>2:00 - 2:20</td>
<td>Researcher</td>
<td>Rody G. Sy, MD</td>
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<td>2:20 - 2:40</td>
<td>Trainer/Teacher</td>
<td>Raul D. Jara, MD</td>
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<td>2:40 - 3:00</td>
<td>Medical Director</td>
<td>Beaver R. Tamesis, MD</td>
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<td>3:00 - 3:30</td>
<td>OPEN FORUM / BREAK</td>
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<td>3:30 - 4:00</td>
<td>Ethics of practice</td>
<td>Victoria Edna G. Monzon, MD</td>
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<td>4:00 - 4:30</td>
<td>Protection yourself from malpractice</td>
<td>Teresita Sanchez, MD</td>
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<td>4:30 - 5:00</td>
<td>Keeping up with the scientific literature</td>
<td>Maria Kuz Joanna B. Soria, MD</td>
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<tr>
<td>5:00 PM</td>
<td>Closing Remarks</td>
<td>Joel M. Abanilla, MD</td>
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The Medical City started its training for level 3 echocardiographers last year. On its second year, much transformations, enhancements and innovations are continuously being made, making the section as one of the most dynamic and demanding sections in The Medical City. Mylene Navarro-Genuino, a graduate of TMC cardiology training and is now one of the two research fellows-in-training in Echocardiography.

**Difficult, but doable**

By Ana Beatriz R. Medrano, MD

Mylene Navarro-Genuino is one of the clinical research Fellows for this year. She was also the past chief fellow of Cardiology Department. Married to a surgeon and mother to Alessandra Beatrice, how does she balance family life and work? A mother, a wife and a trainee – these are demanding roles she has to perform and must perform well. She cannot compromise one from another for all of these are vital.

For Mylene: 24 hours a day is not enough.

Early to rise, late to sleep.

Always on multi-tasking skill mode.

Married to Dr. Banny Bay Eugenio who is also a trainee in the Surgery Department, both were very busy. Early in marriage, they were granted a very precious gift. Mylene’s pregnancy was very difficult. She had to bear standing and walking all day even if she has sore legs from daily and nightly cramps and edema. She has to go on her daily duties while panting and catching her breath with hemoglobin of 80mg/dl. The frequent epistaxis brought about by the summer heat made it even worse. To avoid make-up duties due to additional leaves, she has to bear the pain of early labor contractions. It is a good thing that she has an obstetrician friend whom she can call when something about the pregnancy is amiss since she has also skipped some of her prenatal check-ups. After all of these, she just prayed that everything will be alright.

Finally, the delivery day arrived however, it was complicated by prolonged leaking bag of water. Delivery, christening and training the new nanny almost occurred simultaneously because she has to return to training. Since she missed her invasive cardiology rotation, she took it in a row while pumping, packing and freezing breast milk in between breaks. Alessandra Beatrice cannot tolerate pure formula feeding because of Hirschsprung’s disease.

At 1 year old, Alessandra Beatrice’s medical conditioned worsened. She has been on chronic laxatives and colonic lavage from fecal impaction. On top of that, she started having bouts of moderate infections. What is very painful is not being there beside her daughter at times when she needs to be confined since all the allowable leaves and absences were already consumed. There were occasions that her daughter needs her, but she is taking care of other patients. Her daughter was on frequent admissions and work-ups due to recurrent sepsis. Her daughter’s almost 24/7 ice baths, seizures and apnea episodes, repeated urine and blood collections, difficult IV insertions, intubation and resuscitation, ultrasounds, renal scan and other diagnostic procedures were too much to bear. On top of that, the hospital costs was too much for a young couple who are both in training.

With all the emotional, physical and psychological stresses, not to mention the financial responsibilities she has to handle, there were times that she was tempted to resign from her training. But it is during her darkest moments that God shone His light the brightest. She wouldn’t have survived all of this if not for her loving and equally responsible husband, family and friends who never left her side and supported her.

Mylene has this message to all cardiology moms especially those who are still in training: It’s difficult and for some, may even be extremely difficult but don’t lose hope because it’s doable. At times you feel like quitting, go tell yourself “I will not be a trainee forever. This, too, shall pass.” You might find yourself crying at times, missing a lot of firsts with your kid, feeling guilty that the mom she knows is the one in the picture and not you in person and can’t help but think “hey, she won’t remember anyway” just to placate yourself but still hurt thinking further “but i won’t forget I missed this and that.” Yes, indeed you won’t forget but better to cherish those little moments you spend together rather than wasting additional time brooding on the might-have-been.

Look forward and the brighter side of things and like I always say, look for the silver lining. There will be lots rewards on the way…a little smiling face to come home to, with never ending eager hugs and kisses for you, someone who practically begs to hear your voice no matter how bad you sing…someone who will look at you as if you’re a hero...and be proud because a hero you are indeed in your own right. ♥
Past the trying times

In every stage of our life, there are choices to make. While our Maker holds our life’s blueprint, the choices we make with the free spirit, will be awarded to us—a customized design of each of our lives.

Edda Mae Omambing-Mallilin, a 3rd year Adult Cardiology Fellow of St. Luke’s Heart Institute, is never too young to be presented with life’s challenges and options. The fellowship designed to mould her into a cardiologist, coincided with life’s training to form her persona.

When she started with her training in Cardiology, she already had an 8-month old baby. Only a month into training, she got married to the father of her baby. There were a lot of adjustments but her life was beginning to rearrange for the better.

Most would think that the training should be easier without a baby to take care of. On the contrary, this mother-cardiologist-in-training was so discomforted and distracted when her baby was staying with her in-laws in the province. Things were easier for her after she got her baby to stay with her, of course, with a nanny. She was more efficient and more focused in training, aware of the fact that on a daily basis, she has to slip out of her cardiology fellow costume to assume the role of a mother and a wife.

Just as she was perfecting her balancing act between her cardiology training and her family life, this news jolted her—a preauricular mass together with multiple palpable lymph nodes diagnosis. It came while she was barely done with her first year in training. While there was nothing inauspicious in the biopsy, the tumor markers had strong indications that she had a very aggressive form of lymphoma.

Her feeble heart manifested with the questions in her mind—“Why did I still have to go into training if this illness would get me? Why was I allowed to bear a child if I cannot see her grow up?” While seated quietly in her room, she looked at all the material things around her and saw their meaninglessness. A series of conversations with her God ensued. After some time, the mass that her oncologist strongly suggested to be removed because of its aggressiveness has disappeared.

Towards the end of her 2ndyear, she had a second pregnancy, a kind of blessing which doubles as a burden in training. She continued with firm steps on her life’s balance beam. In a few months, this mother of two, will graduate from cardiology training, and most likely from a phase of her life.

As she graduates, she chooses a simple life, and a practice that would not compromise her family. The quiet eloquence of that day when earthly possessions lost its meaning, will surely surface as she puts a signature on her life’s design. Her most recent FB post reads: “Ask yourself what is really important and then have the courage to build your life around that answer.” ♥

To Foreign Nationals:
Words will not be enough to express our gratitude and thanks for the services you have rendered and continuously doing for the Filipinos affected by Yolanda typhoon. You have become among the inspirations for the people of Tacloban and other areas to rise again because with your help, with your presence, you have eased the suffering and burden of the victims, you have made life easier and recovery faster. I pray that your countries will be blessed a thousand fold and that God will protect your people from calamities similar to this.

To the PHA Board:
Thank you for the financial assistance that you have extended my family. It came at a time that it was least expected. What you freely gave I will pass on to others as I continue to help and care for people in need. More power to you and God bless you and your families. ♥
Four months after "open heart" concert, Jeramie Jordan, 22 years old, daughter of a domestic helper from Singapore, was operated on.

There was no trace of hopelessness in Jeramie. Every ounce of her lifeblood speaks of a quiet and positive attitude. When ordered by parents not to tire herself with play, young Jeramie would simply obey though she was asymptomatic. She has accepted the frequent visits to hospitals due to respiratory infections as a way of life.

The thought of not being able to finish her studies or to have a normal family life did not cross her mind.

Before the surgery, Jeramie began to feel the symptoms of her heart ailment. She started to entertain the idea of a heart surgery. She and her family went to a doctor and an open heart surgery was set. Before minding financial matters, Jeramie, now a graduate of Computer Science, searched about her heart condition.

After much study, she found out that she has an option not to be opened up. She wanted what she would later learn as an Amplatz septal occluder be used on her. In search for a solution to her condition, the family was led to St. Luke’s Heart Institute alumnus Dr. Gery Pura, a townmate, who then took her to the hospital’s social services. St. Luke’s Medical Center, St. Luke’s Heart Institute Alumni Association, and the parents of Jeramie joined forces for an Atrial Septal Defect Repair. “Open Heart!” has started a momentum.

SLHIAA is bent on touching more hearts in whatever way.

In an unprecedented and collective move, the St. Luke’s Heart Institute Alumni literally sweated it out at the concert “Open Heart!” which featured Gary Valenciano, just to be able to raise funds for indigent cardiac patients.

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‘Open Heart’ gains momentum

By Malou Bunyi, MD

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Jeramie Jordan, 22

At around 5 years old, she already knew she has a hole in her heart. This did not stop her from living life as she should. She finished Computer Science but would always back out from job applications whenever she would reach the medical examination part because she knew she wouldn’t pass.

SLHIAA president Dr. Malou De Jesus (2nd fr l) with Dr. Manolito Turalba, auditor and coordinator for surgery of Ame (middle) with parents

Fit to work. Precious words for a daughter of a domestic helper in Singapore. Now there is no backing out. Her Atrial Septal Defect has been repaired last December 11, 2013. Ame is the first beneficiary of “Open Heart!” held last August 10, 2013. She vows to pay the goodness she received to other people who would need her help.

St. Lukes Heart Institute Alumni Association, Inc.
LET US SAVE MORE HEARTS.
Sin Tax Law: What’s up?

By Anthony Leachon, MD
Vice President, Philippine College of Physicians
Director, UP Manila Public Affairs

Approved in December 2012 after three decades of an impasse in Congress, the Sin Tax is expected to generate more than P36 billion at the end of this year—seven percent higher than earlier projected. What are the new issues facing the implementation of the new law and what are the new directions we need to undertake to make it a success?

1. Watering down and discrediting the Sin Tax law

On December 20, 2013, we celebrated the first year anniversary of the signing of the Sin Tax Law by President Benigno Aquino III. The government raised the excise tax on cigarettes to increase tax collection and, allegedly, to force smokers to quit or at least smoke less. With the price of cigarettes sky-high because of the higher taxes, the government reasoned out, smokers would either smoke less or quit smoking completely, thus saving themselves from the ravages of strokes, heart attacks, lung cancer, emphysema and COPD (chronic obstructive pulmonary disease), all of which can be fatal. The economic burden of smoking related illnesses is a whopping P188 billion, according to the study done by Dr. Antonio Dans of the University of the Philippines College of Medicine. Medical cost, loss of productivity and premature deaths.

The high tax law has been in force since January. Has it forced smokers to quit? Though a longitudinal study has to be done to see the correlation of smoking with sin tax or prices of cigarettes - I say, of course. It’s yes.

According to the Department of Finance, a 10%- increase in price of cigarettes correspond to 5% reduction in consumption rate.

2. Smuggling

When the “Sin Tax” was being crafted, that cigarette smuggling would flourish, as had happened here before and in other countries when taxes were raised drastically. It is happening now. But that was the red herring warning of tobacco industry. If we have a good and effective Bureau of Customs (BOC) then smuggling will not be a problem. We have seen the change in leadership at BoC recently.

Smuggled cigarettes sell for P1 per stick, less if you buy by the pack. They are sold out in the streets, in sari-sari and convenience stores everywhere with posters that scream “low prices!” at every passing man, woman, and child.

Unfortunately, smokers who can buy cheap cigarettes tend to smoke more and are not financially motivated to quit. It’s addicting. Already, 25% of Filipino smokers of higher-priced premium and subpremium brands have shifted to the smuggled P1 brands. – it’s bad since the poor and young are the ones most vulnerable to smoking-related illnesses. 50% of the population is below 25 years old. We have a very young population.

3. Dirtiest tactic is to Attack the poor and young - why? The poor has no access to prevention! They are stressed out and perhaps with less education

In the Philippines’ 100-billion-stick market, that translates to 25 billion sticks or 1.25 billion packs that should have been taxed at a higher rate of P25 per pack, instead of just P12. The government is losing about P16.3 billion in taxes per year.

The tobacco industry has been issuing false news to deceive the public and legislators. Unverified Statistics show that contrary to expectations, the smoking rate among Filipinos has not subsided since Republic Act No. 10351 was implemented. This is not true. In my clinic a lot of urban poor has quit smoking. To entice the poor and young, tobacco industry is pushing for smuggled drugs.

The increment may be slight but it is certainly puzzling. The reason is the raging popularity of cheap smuggled cigarettes.

4. Misleading and deceptive cigarette prices

Under a high excise tax regime, how can cigarettes be made at such ridiculously low prices?

RA 10351 collapsed the previous four-tier tax rate to only two—high-priced and low-priced—with the high-priced brands paying a tax of P25 and the low-tier paying half, P12, for each pack of cigarettes.

Makers of cheap cigarettes pay not only the P12 in excise tax but also P1.91 as value-added tax, P5 for wholesaler margins, and discounts for downstream retailers. After everything is settled, manufacturers of cheap cigarettes are left with almost nothing with which to manufacture a pack that sells for less than P20.

5. Use substandard raw materials or outright tax evasion

There are only two ways that a cigarette manufacturer can turn a profit from the P1-per-stick brands. By using substandard raw materials or outright tax evasion.

Worse, what Filipinos are smoking now is much more harmful to their health than what they used to smoke. What happened?

Cheap cigarettes are made of poor-quality tobacco called “sweepings.” Also known as refuse or scraps, sweepings are discards raked up from warehouse floors after high-grade tobacco for premium cigarette makers are sold. It is the equivalent of “pagpag,” a sorry mix of leftovers from fast-food restaurants gathered by the poor for re-cooking and resale to hungry neighbors.

Cheap cigarettes from China flooding PH

Sweepings constitute the cigarettes produced in China’s Yunxiao county, where the cheapest cigarettes in the world are made. With a measy population of 392,000, Yunxiao hosts 200 cigarette factories producing 400 billion counterfeit cigarettes a year, four times the volume of the Philippine tobacco industry.
Year 2013 was a heyday for PHA. Major events made an indelible impression on the public, media and the entire PHA membership.

Heart Month at the Quezon Memorial Circle was a big hit. In terms of attendance, impact, uniqueness and diversity, World Heart Day this year is unsurpassed; the celebrations in Manila and in the chapters were a cheerful combination of traditional and radical. Kudos should go to PHA Secretary Alex Junia, concurrent WHD committee chair. This year also marked year one of the Acute Coronary Syndrome Registry; the establishment of the ACC-Philippine Chapter; birth of the PHA Lay Arm. The organization utilized media to make its stance on stem cell therapy known.

Camp Brave Heart on Year 7 continued to inspire and challenge the young; as well as draw anchorage from people. The 44th PHA Annual Convention was graced by internationally-renowned cardiologists and was the launching pad of the ACC Philippine Chapter and the 1st Ramon Abarquez Jr. Professorial Lecture.

PHA President Eugene Reyes’ flagship project RICH (Research, Institutions, Collaboration and Harmonization) is fast gaining headway. He is also part of the Philhealth Z benefits expansion lobby group. The PHA Councils on Hypertension and Cardio-pulmonary Resuscitation retained their foothold as top performers, while the PHA Council on CAD which is doing it slowly but surely, ranked third.

On October 13, Bohol and Cebu were rocked by an earthquake. Barely a month after, on Nov. 8, Tacloban,Ormoc in Leyte, Samar and Roxas City, were battered by Yolanda, the fiercest Typhoon ever to lash the Visayas. Some PHA family members in these Visayan cities/towns all of them survived and the good news — they got an outpouring of massive support from PHA and from various fronts.

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**January to February 2013**

**PHAN cover: Amorsolo painting that depicts how Filipinos value healthy lifestyle as a family business**

PHA post-Valentine treat heats up QC circle regulars
The Quezon City Parks and Wildlife Promenaders were treated to free risk factor screenings, CPR lecture and demo, healthy lifestyle, eating lectures by 20 cardiologists led by the PHA Board. PHA partnered with elementary schools. Park regulars attended the Heart Month Fair themed: “Heart Wellness is a Family Business.” It was a feat that was complemented by the presence, message and performance of Usec Eric Tayag.

ACS Registry makes a stride at 1
PHC yields 151 patient-enrolees
On year one, the Acute Coronary Syndrome (ACS) Registry marked a milestone despite some obstacles. Buoyed by such feat, the promise of an expanded network and fresh funds to extend its lifetime, the group vowed to transform the Registry into an evolving endeavour and ultimately, a Philippine Heart Association landmark.

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Glorious year that was!
The Philippine Heart Center (151), UP-Philippine General Hospital (130) and Manila Doctors Hospital (66) had the biggest number of patients enrolled in the ACS Registry with 12 participating hospitals. The ACS registry commenced in Nov. 2011.

ON STEM CELL THERAPY
PHA: ‘No’ to SCT for heart disease
Has yet to undergo extensive research
The PHA statement was issued by PHA President Dr. Saturnino Javier before mass media covering the every Tuesday Philippine College of Physicians (PCP) Health Forum on Feb. 5, 2013 at Annabel’s on T. Morato Ave., Quezon City.

PHA’s stand: “The Philippine Heart Association does not recommend SCT of any kind (from bone marrow, adipose tissues and non-human sources) as a standard of care to reduce cardiovascular risk in patients with heart disease (coronary heart disease and heart failure).”

“The PHA supports ethically conducted research studies that will help shed light on some of the uncertainties regarding this modality before it can be recommended as a standard of care in heart disease. This basically acknowledges that more studies with robust designs are needed to further elucidate on the role of SCDD as a strategy for heart disease.”

The Medical City does it as an innovative practice
St. Luke’s Medical Center: ‘Yes’ for bone marrow diseases
Experts address hypertension burden, its complications
Four vital organs, -- the heart, brain, kidneys and endocrine glands are involved in the pathogenesis (or development) of hypertension. Once one of these organs is injured, the other organs are also damaged.

A team of sub-specialists who looked into the connection of these major body parts afforded some 326 multi-disciplinary physicians, predominantly cardiologists, a better understanding of hypertension and its co-morbidities. We expect to address the hypertension burden better and manage the potential complications as well, said Philippine Heart Association President Dr. Saturnino Javier.

Camp Brave Heart 7
At the Fun Ranch was another day of worthwhile outdoor escapade. This year’s theme was Valiant Hearts: Little Warriors of Hope. Every kid was enthusiastic to venture into another kind of fun and challenge. Every parent was as eager to witness how his/her post-op child would show his/her survival instinct, confidence and social skills.

HEART MONTH 2013 IN THE CHAPTERS
Northwestern Mindanao: Awesome
Northern Luzon: Unmatched, action filled
Davao Southern Mindanao: Tough but thrilling
Southern Tagalog: Vivacious & educational
Cebu: Dealing with multi emergencies
Cebu: On the airwaves

TMC Heart Week 2013
Exploring the human body’s hub

UST Cardiology Save-a-Heart Program: Thomasian legacy lives on

St. Luke’s alumni mark Heart Month at Clinica Antipolo
Javier-Uy named CSMC medical director
Cardios with mended hearts: Drs. Homobono Calleja, Marie Simonette Ganzon, Romeo Arniego, Jose Villaroman, Jr., Joseelito Atabug, Andrew Carreon, Victor Gonzales and Ramon Roces

Dekada 60
Dr. Rodolfo Soto, Dr. Rody Sy, Dr. Antonio Sibulo, Dr. Edgardo Ortiz, Dr. Annette Borromeo

March-April 2013

PHAN cover: Display of candidates for the PHA board 2013-2014

PHA establishes an ACC Chapter
The Washington DC-based American College of Cardiology (ACC) formally instituted the Philippine Heart Association (PHA) as ACC-Philippine Chapter on Nov. 8, 2012.

The Philippines now joins ASEAN members – Malaysia, Thailand, and Singapore, and HongKong which have organized an International chapter.

PhilHealth expands Z benefits
Having the best interest of the Filipino at heart, and in the spirit of social solidarity, equity and access to quality healthcare, PhilHealth has designed an expanded catastrophic benefit package for expensive and life-threatening cardiac conditions. These were chosen based on current evidence that effective survival rates and quality of life of patients.

PHA Lay Arm starts on the right track
44 hospital staff, majority of whom are non-medical professionals, a few are nurses and a midwife, signed up as members of the PHA Lay Arm during an organizational meeting at the Makati Medical Center.

4 DepEd offices: A breeding ground of CVD bug?

PHA DSM Community Outreach Program
200 px undergo free cholesterol, FBS tests

Bukidnon lawyers get CV screening

67% pass adult cardio diplomate exams

PHA has pediatric cardiologists

PHA 44th Annual Convention & Scientific Meeting
PHA @60 Pegged on Strategies, Realities & Networks

Media given access to some sessions, lectures

2013 UP-PGH Heart Week zeroes in on VTE

UP-PGH Cardiogenomics Study Group
**May - June 2013**

**Philippine Heart Center’s Cream of the Crop**

Drs. Jun Maximo Lasco, Maria Johanna Matheu Jaluague and Jun Maximo Lasco scoop top awards

**Presidency Handover**

From Saturnino Javier, MD to Eugene Reyes, MD

Reyes takes on PHA rudder; vows to resume research, registry projects

**Recipient of Presidential Citations:**

Drs. Orlando Bugarin (Council on CPR), Irma Yape (Council on Hypertension), Liberty Yaneza (Council on Coronary Artery Disease), Erlyn Demerre (PHA NewsBriefs) and Peter San Diego (Website Committee)

**CPR 2K13 Challenge:** Southern Tagalog group wins

**PHA Servier Award for Most Outstanding Research**

Fabio Enrique Posas bags 1st, 3rd prizes

**American College of Cardiology Philippine Chapter launching**

44th PHA Confab draws 1,744 attendees

**Know the YIA winners** -- Philippine Heart Center’s Drs. Jose Donato Magno, Maria Johanna Matheu Jaluague and Jun Maximo Lasco

**Nobel Prize winner Dr. Luis Ignarro** says “nitrix oxide is a boon”

**Dr. Helen Ong- Garcia is the latest addition to the PHA Board of Directors**

**1st Dr. Ramon Abarquez Jr. Professorial Lecture**

Why is coronary microcirculation ignored? -- Romeo Divinagracia

**ACC Philippine Chapter launched**

ACC president William Zoghbi: We owe ourselves “me” time

**College Awardees**

Loyalty Awardees: Victor Lim Gonzalez, MD
Camilo I. Porciuncula, MD, PhD
Aida Baltazar, MD
Gerardo Manzo, MD
Romeo Ariniego, MD
Anthony King Jr.

**Etiology of Sudden Cardiac Death**

**July - August 2013**

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Reyes takes on PHA rudder; vows to resume research, registry projects

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Magno, Jaluague and Lasco scoop top awards

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**Etiology of Sudden Cardiac Death**

**PHAN cover: PHA’s first couple Eugene, Amalia & son Euan**

PHA president Eugene B. Reyes: “Collectively, my flagship project is nicknamed RICH as in Research, Institutions, Collaboration and Harmonization pivoted on the RICH (Respect, integrity, commitment and honesty) key values.”

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

**Chapter proxies to issue good standing certificates to members**

**Phil. Star Heartline, PHA web resume** following the renewal of Merck Sharp & Dohme (MSD) commitment to sponsor.

**Reyes to Councils: Chart your priorities: Registries, Research, CME & Advocacy**

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

**Gearing up for a CPR-ready status**

The PHA Board will support the Council’s endeavors to get close to hitting its goals.

**BP ng Teacher Ko! Alaga ko goes around Luz-Vi-Minda**

**PHA takes MMDA as WHD partner**

**PCP-PHA Heart Health Forum: Start them young**

**Heart-to-heart with Dr. Eugene Reyes**

**New Section**

Life—Work Balance
PHA Moms
PHA Dads
PHA Sons and Daughters
Fiercest quake in RP history
215 die in Bohol, 13 in Cebu; damage placed at billions

The Bohol earthquake: Making a fight of it

BP ng Teacher Ko... Makes waves in Cebu

Dumaguete is BP Caravan’s 23rd hop
most teachers are hypertensive

Dr. Alisa Bernan is Research Committee chair

Local guidelines for better heart care out in 2 years
‘We don’t have data’ --BERNAN

ECG is crucial

VIPs in EPS shine at foreign arrhythmia summit

November-December 2013

PHAN cover: Yolanda’s hardest punch lands on Tacloban, PHA donates P200,000 worth of blankets

Ten PHA members are typhoon victims

Xmas party for pharmas dedicated to Yolanda victims

Chapters, Councils, training institutions, alumni in all-fore-one and one-for-all cause --Tacloban’s, Ormoc’s, Samar’s, Roxas’ rise

BP ng Teacher Ko...on the super fast lane

After Real World Fellows ready for a vast, challenging horizon

Trends in ACS ♥

SIN TAX... From Page 41

Cheaper cigarettes

Tobacco giant Philip Morris Fortune Tobacco Corp. has sought permission to manufacture four variants of its Marlboro products as low-priced cigarettes. A pack of Marlboro costs P55 but is sold at P4 to P5 per stick at retail stores. On the other hand, Mighty sells for only P36 a pack and currently dominates the tobacco market. But lab tests reveal that their products are nothing but “poop sticks,” which emit higher levels of dangerous chemicals—80 percent more nicotine, 130 percent more carbon monoxide—and contain impurities like insect eggs and human feces.

After the successful Sin Tax Law, I believe we need to reflect on the most significant program to reduce smoking related illnesses.

New York Mayor Michael Bloomberg signed landmark legislation Tuesday banning the sale of tobacco products to anyone under the age of 21, making New York the first large city or state in the country to prohibit sales to young adults.

City health officials hope that raising the legal purchase age from 18 to 21 will lead to a big decline in smoking rates in a critical age group. A majority of smokers get addicted to cigarettes before age 21, and then have trouble quitting, even if they want to do so.

Smoke-free environment - I dream of a Davao, Singapore or New York type of environment where laws are truly laws. Non-communicable diseases (NCDs) are not diseases of individuals but diseases of society, since we are affected by our environment -- people will smoke if cigarettes are cheap and available.

Strategically, the government needs a good radar screen to monitor not only NCDs -- strokes, coronary artery disease, cancers, chronic obstructive pulmonary disease and diabetes mellitus. The government can’t do it alone and the private sector has to step up and partner with the Department of Health and other relevant stakeholders to solve this looming health crisis; the country is also under siege by communicable diseases like measles, pneumonia, tuberculosis and HIV illness.

Here then is our situation at the start of the 21st century. We have accumulated stupendous know-how. We have assigned the most highly trained, highly skilled, and hardworking people in our society. And with it, they have indeed achieved extraordinary things. Preventable failures are common and quite persistent, not to mention demoralizing, demotivating and disappointing, across many fields -- from health to business, finance to government.

And the reason is increasingly evident: the volume and complexity of what we know has exceeded our individual abilities to deliver the results effectively, safely, or reliably.

Thus we need a different game plan for overcoming preventable failures, one that builds on partnerships, collective efforts, long experience and takes advantage of the expertise of people who are willing to help to solve the health inequities of our country.

And so can we. Indeed, against the complexity of the world, we must. There’s no other choice. Lives are at stake. When we look closely, we recognize the same balls being dropped over and over, even by those of great ability and determination. We know the patterns and yet we fail. We see the costs of losing lives.

It’s time to try something else. Now or never. ♥
Life Work Balance section is a PHAN regular featuring various cardiologists as they reveal their secret formula in performing their multiple tasks and maintaining good health.

Balancing life and work can be quite a challenge. I set a time threshold for every patient, I play badminton regularly every TTH evenings. For the family to feel my presence no matter how busy I get, I always find time for special occasions.

Melco T. Perez, MD
Chinese General Hospital and Medical Center

A cardiologist mom is like navigating a narrow strait of water with a very delicate boat. It requires thorough knowledge of the route. The ability to deviate and maneuver as the circumstances demand and to resolve to reach the destination. That is the welfare of the family and patients. Never get into a situation where you have to choose either.

Alicia Gicale Adarna, MD
Philippine Heart Center

I am my kids’ only dad and my role is irreplaceable. I make it a point to make time for family. We regularly have planned vacations and I am around for special events that is why I regulate my clinic hours. There are other competent doctors who can take charge and care for my patients when I am not around!

Manuel Ignatius Edmilao, MD
Cagayan de Oro Medical Center
I am a clinician three times a week because nothing takes precedence over my two growing girls, aged 10 and 8. I see to it that I am the one who tutors them especially my youngest girl who needs therapy. I have the advantage of having a cardiologist for a husband (Dr. Ricky Choa) since he can take my place to attend to toxic admissions so I can best fulfill my role as a mother.

Vivian D. Choa, MD
Cardinal Santos Medical Center

With my very busy schedule, it’s a blessing from the Lord that I have such a wonderful husband who is my extra hand. It’s not that easy to start a career while fulfilling my goals of becoming the best wife and mother I could be. Priorities have to be set. My family is my treasure and my topmost priority. I make sure I spend quality time with my husband Jhun and my daughter Therese. I try my best to be at home when Therese wakes up and before she goes to bed. Sunday is family day for us so I bring my family with me when I make rounds.:)

Christy Mendoza-Reyes, MD
Philippine Heart Center

I’m not just an ordinary PHA mom;) I have a special child, with special needs who has never failed to make me happy everyday;) I wake up early, read ECGs while she’s still asleep. I answer calls while she’s about to be awake, and when she’s up, I give her milk, bathe her, put her to sleep again and endorse her to my aunt (her yaya). I do rounds then come back home for a very late lunch, just to see how she’s doing, but I never touch her “coz I just came from the hospitals... Then I go back to clinic, attend to new referrals for the day. If there’s none, that’s the time I buy her needs like diapers, milk and stuff. I come home late like 8 or 9 pm, take a shower and play with her. She usually waits for me and she seldom goes to sleep without me. Then she wakes up at dawn like 4am, plays a little with me then goes back to sleep again at around 5am. That’s the time I either read ECGs or sleep if there’s none. Hehehe.

Sheila Abadonio-Villar, MD
Philippine Heart Center

Being a mom is as tough as being a cardiologist. My day begins early, as I have to drop my daughter and nieces to school. I start my clinic early and finish all my work by 4pm, just in time to pick them up in school. After an early dinner, I tutor them and when we’re done, it’s time to mind the take-home paper works and news updates. Thank you so much, PHC Fellows for keeping my patients stable at night. Someday, you will have kids of your own and I am sure you will be good at balancing your time for the love of your life -- your family and your profession.

Jennifer Dimayuga-Mendoza, MD
Philippine Heart Center

Time management so I can juggle between being a mom to growing teens and a doctor.

Corbelita Sengson, MD
Philippine Heart Center

PHANewsBriefs • November – December 2013
Just like any human being, healers dread the 2 debilitating big Cs as in cancer and coronary artery disease, and they can be the most difficult patients…rarely, submissive patients…Find out how they confronted their condition, how they carried on… These cardiologists share their voyage of courage and hope as the pillar of the family, as doctors and patients.

My personal journey thru CA and chemo 2nd of three part series

By Ardith Dominguez-Tan, MD, FPCC

When I was fully awake and transferred to my room it was then I was able to physically assess myself. I had a midline sternotomy wound and chest tubes were coming out from both sides of my chest attached to closed drain bottles. At that point it didn’t really bother me for as long as I was no longer intubated and hooked to a ventilator. The only private nurse I could get was a male nurse whom I had previously worked with in the ICU. This didn’t bother me. He looked after me for twelve hours during the night shift so my husband could be free to look after the kids and so my mother could be free to rest at home.

I had always hated not being able to shower or take a bath daily so I asked him if he could shampoo my shoulder length hair daily. He said this would not be a problem so he shampooed me daily on the bed and the first time I had a bowel movement he assisted me by clamping my tubes while I pulled my IV stand in one hand and carried my urine bag in the other as we painstakingly made our way to the bathroom. I refused to have my bowel movement in bed and I refused to have a diaper. Not only was I not comfortable doing it in bed I wanted to save myself the indignity of having to be wiped and cleaned by somebody else. Isn’t that typically like a doctor?

Soon, my fellow doctors and hospital personnel came to visit even though there was a “NO VISITORS ALLOWED” sign on my door. As typical of the hospital community—only 2 entitles really know what goes on—You and the whole hospital. It was from them I learned that when my chest was opened up the mediastinal mass was seen to be closely adherent to my pericardium and partly to my lungs. I also learned that the surgery extended up to six hours from the expected 4 hours because of this. My close doctor friends came inside the operating room just to see how I was doing and monitored the progress of my surgery. I also learned that my fellow cardiologists thought I would not make it since I was inside for so long and the surgeon couldn’t take the mass out. It looked more like a malignancy than a benign mass. I was touched to learn that my senior consultant took the time to leave his clinic and wait in the corridor as I was wheeled out of the operating room. He accompanied my stretcher until I was settled inside the ICU. I learned that another colleague made sure I kept my privacy inside the ICU and did not allow people who were just curious to see me access into my room. All these small acts to help maintain my privacy I wasn’t aware of at the time but I am fully appreciative of.

I was so excited to see my four year old little girl visit me for the first time on my second post-op day. She came in wearing a full regalia of plastic jewelry from earrings to bracelets to darkglasses and bag. The first thing she said when she saw me in bed was “Mom, what are you doing in bed and why are you using my dad’s blanket?” I had requested that I be allowed to use my husbands flannel blanket as it brought me comfort. Seeing my little girl was an affirmation for me that God was indeed alive and that there was hope for my future. As I went through the process of healing I made up my mind that I would remain open, cancer or not, and that I would do what it takes to heal completely because that little girl of mine deserved to grow up with a mother who could take care of her.

Surprisingly, during my week of recovery in the hospital I felt very little pain. I did everything I was told to do. I did my breathing exercises, I walked around the room. As the surgical resident pulled out one of my chest tubes I didn’t’ even realize that the tube had already been pulled out because I felt no pain. I realized
the tube was out when I saw him holding this blood stained tube beside me. I was surprised when my Anesthesiologist informed me during her rounds that evidently my epidural anesthesia doses had been discontinued one day early.

On the day my remaining chest tube was to be removed I had to have a chest ultrasound. I didn’t really care that patients and hospital personnel would see me being wheeled around. I was used to being the “doctor” and not the “patient.” “For today,” I thought to myself, “I am a patient.” My daughter got the chance to sit on my lap while I was wheeled to Radiology Ultrasound which was housed in a separate building. Once the Radiologist pronounced that there was hardly any fluid left I knew I would be free of my remaining tube and I would probably be sent home the following day.

Once home, the one thing I missed most was being able to lift up my 4 year old when she wanted to be carried. It was my habit to hold her up and let her wash her hands at the kitchen sink before we ate meals. I had to delegate that to my house help after the first month from surgery and since she was always curious she kept asking why I couldn’t carry her. Time and again I, along with her yaya, had to explain why. At least I could hug her and hold her close when we watched TV in bed together.

During my first official visit with my medical oncologist, I learned that my official histologic diagnosis was primary mediastinal (thymic) large B cell lymphoma (WHO classification). This was after larger samples were sent out for additional tests. I would undergo my first chemotherapy session a month from surgery. That meant sometime June of 2010. I was told I would expect to spend exactly P101,361.24 every three weeks. Every three weeks? I wouldn’t even have a month to wait to get that amount of money and I wouldn’t be able to practice in that time! As doctors, we never really bother about how much we need to spend until something happens that suddenly prevents us from earning by seeing patients. I joked around about it but deep down I worried as both my kids were schooling. Still, the Lord assured me that He remained Jehovah Jireh—“God will provide.” I had no choice but to hold Him at His word.

During my long months of chemotherapy I had to sit down and explain to my daughter that ‘mama has cancer’ as the main reason why I could not attend her school activities. She seemed to take it matter of factly and one day asked me point blank “Mom, are you gonna die?” I was so taken aback by the question I didn’t know whether to laugh or to cry.

I had one month to prepare for my chemo after surgery. The time was too long to not be doing anything so I came in to work at our heart station and being able to read echocardiography and treadmill exercise studies afforded me with some income which I knew I would need during the time I couldn’t see patients. I was overwhelmed when Dra. Elinor Lopez, then PHA president, took the effort to meet with me in Tagaytay and handed me a check to cover part of my first chemo session as the PHAs financial support of its members. It brought me elation when my fellow cardiologists at De La Salle University Medical Center reached into their pockets and handed me checks and what cash they could as they realized the financial difficulties that lay ahead for me. These small acts of generosity uplifted my spirit and reaffirmed to me that the God who allowed this condition in my life was holding true to His promise that He would provide.

I was to be admitted during my first chemotherapy as my response to it had not been determined as of yet. I called up a breast cancer survivor friend who wisely advised me to cut my hair ahead of time as a way to condition myself when I eventually started losing my hair. She also advised me where I could buy a wig made from real hair. I went to David’s Salon and explained the situation to them. I watched as my shoulder-length hair fell in large clumps to the floor. I kept reminding myself that it would grow back in. My sister, a trauma surgeon, was unable to be with me during my surgery as she worked abroad with an international non-governmental organization. She made it a point to come home and stay with me during my first chemotherapy session. She accompanied me as I bought my first wig.

I settled for a short one as it was what I could afford at the time. I was also told that wigs tended to be hot especially during the summer months. The small steps I was taking to prepare me for chemotherapy I felt armed me. My first chemotherapy session in the hospital was uneventful. I was given cyclophosphamide, epirubicin, prednisone, vancomycin and rituximab. It was the latter that made my regimen so expensive but it was also the one that was specifically meant for my lymphoma.

I drove myself and my sister to the hospital as she was still jetlagged from her trip home. While admitted my close friends came to visit me and one particular friend handed me a thick white envelope and told me it was meant for my lymphoma. I watched as my friend who wisely advised me to cut my hair ahead of time as a way to condition myself when I eventually started losing my hair.

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Contributors

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

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.

ECHOCARDIOGRAPHY

Donald Cristobal, MD – He is an active cardiology consultant at the St. Luke’s Medical Center Global City and concurrent level III Echocardiographer. 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.

CV SURGERY

Christopher C. Cheng, MD – A dedicated member of the PHA Council on Cardiovascular Surgery and a perennial lecturer in PHA continuing medical education courses, he is affiliated with the Philippine Heart Center where he holds key posts -- division chief of the Department of Surgery and Anesthesia and Cardiovascular Research; Surgery training coordinator of the Department of Education, Training and Research; and a member of the Cardiovascular Surgery Training Committee.

SPORTS CARDIOLOGY

Eden D. Latosa, MD – A pediatric cardiologist and an electrophysiologist, Dr. Eden Latosa is the chair of the Department of Pediatrics of the Jose Reyes Memorial Medical Center. At the Far Eastern University-NRMFPHC, she takes on multi roles -- as a pediatric cardiology consultant and Faculty, and as an IRB member and consultant. She was also a past chair of the Department of Pediatrics of Fabella Hospital.
BIMA and multiple arterial grafts for CABG

By Christopher C. Cheng, MD

THREE decades ago, the Cleveland Clinic Group first reported that the use of Left internal mammary artery (LIMA) on the left anterior descending artery (LAD) significantly improved the long-term survival of patients undergoing CABG. Likewise, it also reduced incidence of subsequent myocardial infarction, recurrent angina and repeat revascularization. This improvement in survival persists up to the second and third decade of follow-up. (1)

The anatomical and physiological characteristic of the internal mammary artery (IMA) makes it a superior conduit over its saphenous vein counterpart. IMA has a higher ratio of discontinuous internal elastic membrane, to its thin media in its wall, rendering it less prone for spasm and for development of atherosclerosis. Likewise, IMA has an increased rate of nitric oxide and prostacyclin production, both, which are potent vasodilators.

These structural and physiologic properties of IMA lower the atherosclerotic tendency of the conduit. At 10 to 15 years, patency rate of this graft is around 90-95%.

In contrast, the saphenous vein has a thinner more permeable intima, and a thinner elastic media with more muscular layer. These factors predispose more for development of intimal hyperplasia and thrombosis. About half of these grafts can occlude in ten years after CABG.

If one IMA can confer a significant survival benefit, then it would not be surprising that an additional IMA would result to an incremental favorable outcome. Despite strong clinical evidences favoring Bilateral internal mammary artery (BIMA) use as grafts, its use in the current practice in the US is around 5%, and fewer than 10% in Europe. In our center, use of BIMA accounted to less than 2% of the total CABG for the past year.

The Arterial Revascularization Trial (ART), a randomized trial attempted to add more scientific data on the debate between single internal mammary arteries (SIMA) vs. BIMA grafting. They compared 3,102 patients in 28 centers in seven countries. (2). The one year outcomes showed that 30 days mortalities was above 1% in both groups, and just over 2% at one year. The incidence of stroke, myocardial infarction and repeat revascularization were not significantly different between the two subsets, which were all around 2%.

Noted though was the higher rate of deep sternal wound infection requiring reconstruction from -0.6% (SIMA) to 1.3% (BIMA) group. It must be taken into account though that fifty percent of the latter group had diabetes, compared to one fourth of the total surgical population in the ART study.

With more judicious choice of patients for BIMA, and modified harvesting technique (skeletonizing, rather than using a pedicled LIMA), the incidence deep sternal wound infection requiring reconstruction can be lowered.

MULTIPLE ARTERIAL CABG

In anticipation of an additional improvement in clinical outcomes for CABG, several centers have started using non-IMA arteries –e.g. radial, gastroepiploic arteries as graft conduits. Some retrospective studies have documented incremental survival benefits by increasing the number of arterial grafts. (2,3)

The MultArt study by Locker et al, a recent observational and retrospective study reviewed 8,266 Mayo Clinic patients who had isolated CABG from 1993 to 2009. Patients were stratified into LIMA with SVG (LIMA-SV, n=7,435) or MultArt group (n=1,187). Propensity score analysis matched 1,153 patients. Operative mortality was not significantly different for the two groups –MultArt: 0.8% vs 2.1% in LIMA-SV.

Late survival was greater for MultArt vs LIMA-SV with a10-15 year survival of 84% and 71% vs. 61% and 36% (p<0.001) in unmatched groups and 83% and 70% vs 80% and 60%, respectively (p<0.0025) in matched groups.

Likewise, MultArt group with bilateral BIMA (BIMA-SV) also had an improved long-term survival of 86% and 76% vs. BIMA alone- 82% and 75%, at 10 and 15 years (p<0.001).

BIMA with radial artery (BIMA-RA), and LIMA with radial artery (LIMA-RA) also conferred a better 10-year survival (84% and 74%, p<0.001) than LIMA-SV.

Although these findings suggest that LIMA to LAD, with an additional arterial grafting to the non-LAD conferred a survival advantage, it’s still unproven that these results apply to higher risk subgroups of patients. (4)

Methods to extend saphenous vein patency

Despite evidences demonstrating the additional survival advantage of BIMA over SIMA, the saphenous vein still, is the most used second graft conduit. This is most likely because of its abundance and “user friendliness”.

In addition to the well-recognized ways of improving saphenous vein graft patentcy such as early administration of ASA after surgery, maintaining a low cholesterol level, cessation of smoking, etc; surgical technique modification like: “No-touch technique”, and reduction of the distending pressure has demonstrated improved Saphenous vein graft patency comparable to IMA in some study. (5) Neither of the above methods though, had demonstrate conclusively, elimination of intimal thickening in either experimental models, or human vein grafts.

With the low use of BIMA and multiple arterial in current practice, CABG has not yet reached its fullest possible therapeutic advantage in coronary revascularization.

The latest recommendations by the European Society of
Guidance on the reversal of the new oral thrombin and factor Xa inhibitors

By Jenny L. Beltran, MD, FPCP, FPCC, FSVM

The FDA approved release of the new oral anticoagulants, dabigatran, rivaroxaban have created excitement over its use. It has transformed into a wave of enthusiasm on the forefront as VTE prophylaxis in orthopedic surgery, for stroke prevention in nonvalvular atrial fibrillation and as treatment for deep vein thrombosis. Recently, apixaban has been launched as a new oral anticoagulant for VTE prophylaxis in orthopedic surgery patients. These new oral anticoagulants (NOACs) either inhibit thrombin (factor IIa) or factor Xa and have advantages over warfarin which include less food-drug interactions, less drug-drug interactions and no need for laboratory monitoring. There are no proven antidotes for bleeding complications of NOACs, but there is a need for a practical guide regarding the clinical approach to patients who have a clinically important bleeding or who require emergent reversal of the anticoagulant effect due to surgery or an invasive procedure. Representatives from ten organizations that focus on thrombosis and anticoagulation convened a meeting in December 2011 and collaborated to develop a practical guidance to help clinicians manage the reversal of NOACs. The members of the meeting belong to the Thrombosis and Hemostasis Summit of North America, Hemostasis and Thrombosis Research Society, Anticoagulation Forum, the American Thrombosis and Hemostasis Network, American Heart Association, North American Specialized Coagulation Laboratory Association, National Hemophilia Foundation, Association of Hemophilia Clinic Directors of Canada, National Blood Clot Alliance, Foundation for Women and Girls with Blood Disorders and the Thrombosis Interest Group of Canada.

The American College of Chest Physicians recently changed the guidelines on the reversal of anticoagulation in patients receiving warfarin with major bleeding. In conjunction with vitamin K, it has been suggested to use four factor prothrombin complex concentrates (PCCs) containing nonactivated factors II, VII, IX and X (Beriplex, Octaplex) rather than fresh frozen plasma. However, these are Grade 2C recommendations.

The advantage of NOACs is that in general, they have a shorter half-life than warfarin (7-17 hrs vs 38 - 42 hrs). Dabigatran has a half-life of 12 -17 hrs, rivaroxaban has a half-life of 7 - 11 hrs, and apixaban has a half-life of 9 - 14 hrs. The anticoagulant effect of the NOACs dissipate much faster than with warfarin. It will take 4 - 5 days for the anticoagulant effect of warfarin to be eliminated after warfarin has been stopped.

Given the relatively short half-lives of NOACs, withholding further doses and supportive care is likely to be sufficient for most patients. In patients with normal renal function, most of the anticoagulant effect of the NOACs will dissipate within a day or two. General measures to reverse the anticoagulant effect of patients who present with significant bleeding will include fluid resuscitation, red blood transfusion, maintenance of renal function, diagnostic and therapeutic measures to identify the source of bleeding and to apply hemostatic measures like surgical intervention if needed. For those patients who have an anticoagulant overdose, they may become candidates for gastric lavage, and administration of activated charcoal if these interventions can be done within a few hours of drug ingestion so as to effectively prevent drug absorption. Hemodialysis can be used for drugs that are not highly protein-bound. Practical issues like obtaining vascular access in anticoagulated patients, how quickly hemodialysis can be started, and how long hemodialysis should continue are barriers to this type of reversal. However in patients with impaired renal function who will require more time to clear the drug, hemodialysis should be considered.

Dabigatran is only 38% protein bound. Oral activated charcoal has been found to effectively absorb dabigatran after recent ingestion. It offers a low side effect treatment option. There was no data regarding the use of activated charcoal in animal or human studies with rivaroxaban. Hemodialysis will remove 2/3 of dabigatran, around 62% at 2 hours and 68% at 4 hours of hemodialysis. Rivaroxaban is highly protein-bound and found to be unlikely removed during hemodialysis. Data suggest fresh frozen plasma maybe effective in limiting dabigatran associated hemorrhage in mice, still, data on how these results correlate with use in humans, or what dose of fresh frozen plasma would be used requires further study. There was no data regarding rivaroxaban and the use of fresh frozen plasma in animal and human studies. The reversal of the new anticoagulants with fresh frozen plasma would require overwhelming the direct effect of either factor IIa or Xa, and not merely replacing the depleted factor concentration in the reversal of vitamin K antagonists. The use of factor VIIa is associated with increased in arterial thrombosis. Factor VIIa decreases the bleeding time in rats that have been given dabigatran or rivaroxaban and does not reverse the anticoagulant effect of these drugs. There has been no human studies to date and still unclear if factor VIIa will be useful for emergent reversal of the NOACs. There have been no studies evaluating the effect of PCCs on bleeding in humans receiving the new anticoagulants. There was no data regarding the use of activated charcoal, hemodialysis, factor VIIa, PCCs for the reversal of the anticoagulant effect of apixaban. Based on the current level of information, all authors from this meeting agreed that an equally justifiable approach is to continue with supportive care and local measures to arrest bleeding.

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Adding Anticoagulants to DAPT in ACS: Treading a fine line

By Ariel A. Miranda, MD, FPCC

Despite advances in anti-platelet therapy, >10% of ACS patients remain at substantial risk for recurrent events. This is in part due to continued thrombin activity which persists for 6-9 months after the index event. Thrombin is both a pro-coagulant and a potent platelet agonist. Trials combining warfarin with aspirin, although favorable, are relatively outdated. The current practice is to use dual anti-platelet therapy (DAPT) even in non-stented patients. The new oral anti-coagulants (NOACS) are ideal because they overcome many of the shortcomings of warfarin (food and drug interactions, narrow therapeutic window, variable dose–response relationship, and need for frequent monitoring), thus offering a new treatment strategy. However, dabigatran (REDEEM Trial), apixaban (APPRaise 2) and vorapaxar (TRACER) have not had much success, largely due to failure to reduce ischemic endpoints coupled with an increase in bleeding complications. Only rivaroxaban (ATLAS ACS-2 TIMI 51) has reported favorable outcomes with the low dose formulation.

The role of rivaroxaban, an oral direct Xa inhibitor, in the secondary prevention of events in ACS patients was evaluated in the ATLAS ACS-2 TIMI 51 Trial which reported its main results in September 2011 (NEJM) and its STEMI sub-study in September 2013 (JACC). ATLAS ACS-2 enrolled over 15,000 patients into three arms: low dose rivaroxaban (2.5 mg BID), intermediate dose rivaroxaban (5 mg BID) versus placebo. Patients with a previous history of stroke or TIA were excluded, as this group has been shown to have a high risk of intracranial bleed in previous trials of other antithrombotic agents. Over 80% of patients in the active treatment group were on ASA and clopidogrel and over half of patients were classified as high risk STEMI. The study period ran for a mean of 30 months. Loss to follow-up rate was reported to be only ~0.2%. The main findings were a 15% relative reduction in the composite endpoints of CV death, MI, and stroke, largely driven by CV death and MI. This reduction was seen early as the first 30 days. The most important observation was a 36% relative reduction in mortality in patients low dose rivaroxaban. This translates to one death prevented for every 56 patients treated for two years. Surprisingly, there was no reduction in death with the 5 mg dose. However, there was a reduction in MI that was seen in the 5 mg arm only. They also reported a 35% and 25% relative reduction in stent thrombosis and large spontaneous MI, respectively. With regards to adverse events, there was a significant increase in major bleeding and GI bleeds with both doses of rivaroxaban (1.8% and 2.4% for the 2.5 mg and 5 mg arms respectively versus 0.6% for placebo). Importantly, there was no statistically significant increase in fatal bleeds.

On the basis of these results the European Medicines Agency (EMA) Committee for Medicinal Products for Human Use adopted a positive opinion on the use of low dose rivaroxaban in combination with low dose ASA with or without ticlopidine/clopidogrel in patients with ACS and elevated biomarkers. A positive opinion by the Agency brings rivaroxaban one step closer to approval if the opinion is adopted. However, despite the favorable outcome of the ATLAS ACS-2 trial the US FDA advisory panel took a different stand and twice (May 2012 and January 2014) it voted against the use of rivaroxaban in the secondary prevention of ACS.

What led the US FDA advisory panel to come up with a different opinion? The panel cited several issues that challenged the validity of the ATLAS ACS-2 results: the larger than usual missing data, particularly vital status and the absence of a clear dose response curve, i.e., the 5 mg dose did not lead to lower ischemic event rates. There were interesting divergent outcomes in the trial: CV death drove the benefit with the 2.5 mg dose, whereas a reduction in MI drove the benefit in the 5-mg arm. The lack of mortality benefit in the 5 mg arm could not be completely accounted for by the increased fatal bleeds in this group. The sponsor could not offer a plausible biological explanation why the 5 mg dose but not the 2.5 mg dose reduced MI. But more than these unexpected biologic differences, the more important issue that dominated the meeting was the missing data on 1117 patients (7% of the population) who withdrew their consent and whose vital status could not be ascertained. This was much greater than the 0.2% lost to follow-up rate reported in the publication. The advisory panel points out that the 7% of patients whose ultimate vital status remains unknown is much greater than the 1.5% absolute difference in mortality in favor of low dose rivaroxaban. Therefore, the missing data results in statistical uncertainty regarding the outcome of the trial. The advisory panel issued a complete response letter to the sponsoring company and between the first and second US FDA advisory panel meeting, the sponsor went on a huge global effort to complete the data which reduced the rate of unknown vital status to 3.2%. However, this was still considered by the advisory panel much higher than the rates reported in contemporary trials like TRITON TIMI-38 (0.12%) and PLATO(0.01%). Approval was again denied in the January 2014 meeting.

While the NOACS have all shown good results as an alternative to warfarin in patients with atrial fibrillation and DVT, their use in patients with ACS is fraught with difficulty because the risk of bleeding increases in patients already on DAPT. How do we then go forward regarding adding anticoagulants, specifically rivaroxaban, in ACS? The panel members suggested further reducing the missing vital status data. In
Cardiovascular screening prior to physical activity and sports

By Eden D. Latosa, MD

The cardiovascular benefits of regular physical exercise are well established. However, a small proportion of young athletes less than 35 years old with unsuspecting heart disease are at increased risk of exercise-related sudden cardiac death (SCD). Majority of such deaths are attributable to cardiac anomalies, which can be identified during life. The sudden death of a young individual is the most tragic event in sports. It is a significant athletic, political, medical and social problem with great impact on public opinion and the media since this catastrophic event involves individuals who are considered apparently healthy and are often treated as heroes.

The risk of SCD in athletes increases with age and is greater in male subjects. Its incidence among US high school and college athletes (11-24 years old) has been estimated to be less than 1 in 100,000 participants per year, whereas a prospective study in Italy reported a yearly incidence of approximately 3 in 100,000 athletes (12-35 years old). Adolescents and young adults involved in a sports activity have an estimated risk of SCD 2.8 times greater than their non-athletic counterparts. The combination of physical exercise and underlying cardiovascular disorders rather than exercise alone, triggers athletic field arrhythmic cardiac arrest. Physicians and athletic trainers should ensure that athletes are systematically screened to identify those with potentially lethal heart disease and to protect them against the increased risk of SCD.

Referred for screening are athletes with clinical signs of cardiovascular disease (CVD); those who have incidental findings of heart disease such as a murmur during a routine clinical practice through history and physical examination; those young athletes who are suspected as having CVD during a large population screening and those with either a congenital or acquired heart disease who wanted to join physical activities.

Causes of Sudden Death

A variety of CV abnormalities represent the most common causes of sudden death in competitive athletes. The precise lesions responsible for athletic field catastrophe differ considerably with regard to age. In athletes younger than 35 years, the vast majority of SD is due to several congenital cardiac malformations: hypertrophic cardiomyopathy is the most predominant abnormality occurring in about 1/3 of cases. The next most frequent cause is congenital coronary anomalies particularly anomalous origin of the left main coronary from the right sinus of Valsalva. These deaths occur most commonly in team sports such as basketball and football. Other less common causes of SCD are CHD, myocarditis, DCM, Marfan Syndrome and ARVC. Rare causes are MVP, AS, arrhythmias, conduction system disorders and channelopathies.

Pathophysiological mechanism for SCD in young individuals

It is said that in the above causes, interaction between anatomical and functional disorders result in electrical irritability. Exercise triggers arrhythmias in individuals with cardiovascular disorders. Several factors such as transient decreases of left coronary flow, acidosis, hypoxia, hemodynamic disturbances, neurophysiological disorders, or the effect of toxic substances such as drugs, may act on such a substrate and trigger either ventricular extrasystoles, VT, VF or SD. It seems that the exercise characteristics play an important role; the risk is higher for those who participate in prolonged high-intensity effort (above anaerobic threshold) in the presence of electrolyte disturbances, high temperature (atmospheric temperature of more than 32°C and relative humidity more than 50-75%) or when exercise takes place in a high altitude.

The risk of SD is quadrupled in individuals with sympathetic over activity. Strenuous exercise stimulates sympathetic nervous system, increasing catecholamine levels, which enhance the risk of VT, platelet accumulation formation of thrombi and rupture of atheromatous plaque. Catecholamine often shorten the effective refractory period of a healthy or slightly diseased myocardium leading to potentially malignant or fatal arrhythmia either through increased automaticity or triggered activity or sometimes as a result of re-entry.

SD during sports can also be due to non-cardiac causes such as bronchial asthma, rupture of cerebral aneurysm, heatstroke, etc. Deaths have also been reported among athletes from neck and chest injuries, or following a sudden onset of blunt blow to the precordium (commotion cordis). Long-term use of anabolic steroids causes acute or chronic complications during exercise such as arterial hypertension, arrhythmias, coronary artery disease, and a number of cases such as SCD in young athletes.

Pre-participation C.V. Screening

Proper and complete regular pre-participation CV screening contributes to the identification of athletes affected by the CVD, so that appropriate intervention may lead to prevention of SD. The American Heart Association (AHA) has presented consensus panel recommendation of the 36th Bethesda Conference for eligibility and disqualification of competitive athletes which are predicted on the prior diagnosis of CV abnormalities (Table 1).
Table 1. AHA Consensus Panel Recommendation for Pre-participation Athletic Screening

**Family History**
1. Premature SCD
2. Heart Disease in surviving relatives < 5yrs old

**Personal History**
3. Heart murmur
4. Systemic Hypertension
5. Fatigue
6. Syncope/Near-syncope
7. Excessive/Unexplained exertional dyspnea
8. Exertional chest pain

**Physical Examination**
9. Heart murmur (supine/standing)
10. Femoral arterial pulses (to exclude CA)
11. Stigmata of Marfan’s Syndrome
12. Brachial BP Measurement

Ideally an efficient PPS test should miss very few individuals with at-risk CV diseases, although a proportion of false (+) results can be accepted. Most CV conditions responsible for SCD in YCAs are clinically silent and unlikely to be suspected or diagnosed on the basis of spontaneous symptoms. The Italian screening program has included ECG in its screening; this has shown substantial incremental value for identifying asymptomatic athletes who has potentially lethal heart disorders and might be as sensitive as echocardiographic examination.

Flow chart for Italian Protocol of CV Pre-participation screening

The final objective of screening athletes for CV diseases is to prevent SCD during sports. A time-trend analysis of the incidence of SCD in young competitive athletes in the Veneto region of Italy over 26 years (1979-2004) demonstrated a sharp decline of mortality rates after the introduction of the nationwide screening program. The annual incidence of SCD in athletes decreased by 89%, from 3.6/100,000 athletes/years in the pre-screening period (1979-1981) to 0.4/100,000 athletes/years in the late screening period (1993-2004). Most of the reduced death rate was due to fewer cases of SCD from cardiomyopathy.

**Alternative Preventive Strategies**
The presence of a free-standing, automated external defibrillator at sporting events might be a valuable back-up for conditions unrecognized by ECG screening such as CAD, but should be considered neither a substitute for APE nor a justification for participation in competitive sports of athletes who are at risk for heart disease. Chances for on-filed successful resuscitation are remote, even if CPR is started immediately and defibrillator equipment is readily available. Drezner and Rogers reported that only 11% of athletes with underlying cardiomyopathy survived from athletic field cardiac arrest despite a witnessed collapse, timely CPR, and prompt defibrillation.

**Conclusion**
Pre-participation cardiovascular evaluation of competitive athletes essentially based on ECG screening to be a lifesaving strategy that adequately meets the criteria for a good screening preparation according to the long term Italian experiences.

1. The risk of SCD during sports represents a serious health problem.
2. ECG screening allows identification of still asymptomatic athletes at risk of CVD.
4. Early detection and management of athletes favorably modifies the outcome of the underlying disease and leads to reductions of SCD.

Classification of ECG Abnormalities in the athlete

<table>
<thead>
<tr>
<th>Group 1 Common up to 80%</th>
<th>Group 2 Uncommon (&lt;5%)</th>
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<tbody>
<tr>
<td>Sinus bradycardia</td>
<td>T wave inversion</td>
</tr>
<tr>
<td>First degree AV block</td>
<td>ST segment depression</td>
</tr>
<tr>
<td>Notched QRS in V1 or</td>
<td>Pathological Q waves</td>
</tr>
<tr>
<td>IRBBB</td>
<td>LAE</td>
</tr>
<tr>
<td>Early repolarization</td>
<td>LAD/LAH</td>
</tr>
<tr>
<td>Isolated QRS voltage</td>
<td>RAD/LPH</td>
</tr>
<tr>
<td>criteria for LVH</td>
<td>Complete LBBB or RBBB</td>
</tr>
</tbody>
</table>

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Imaging the heart in 3 dimensions (part 2)

By Donald Cristobal, MD

A study recently evaluated the relevance of 3DE for the characterization and measurement of the atrial septal defect area during percutaneous closure (11). Locally, 3DE has also been utilized (Figs. 6 and 7).

Fig. 6 Characterization and quantification of the size atrial septal defect during 3D zoom acquisition is feasible prior to catheter-based atrial septal closure. It is accurate to identify the widest measurement of the size and area of the defect including measurements of its tissue margins as seen from the (A) LA side and (B) RA side.

Fig. 7. Real time 3D Zoom of the deployment of the ASD closure device as viewed from the LA perspective. The LA plate of the device is seen expanding and sitting on the margin of the defect. A balloon was also identified on the superior margin of the device. It was used to assist in the optimal positioning of the device to prevent from pulling back into the right atrium.

Fortunately, there is already increasing awareness of the capabilities of 3DE leading to increase in its utilization in the local setting, particularly in St. Luke’s Medical Center. Biplane (Xplane) and real time 3D (RT3D) have been extensively employed to guide electrophysiologist for safe atrial puncture during 3D AF ablation (Fig 8).

Fig. 8. (A) The use of 3D probe can assist the optimal placement of catheters prior to septal puncture during the AF ablation. Our center uses 2D images in two orthogonal planes that are simultaneously displayed (Xplane mode) to aide in visualizing the tenting of the catheters. This has proven as an alternative to an expensive intracardiac echocardiography (ICE). (B) Post puncture as shown in 3D live for quick assessment of the spatial association of the catheter to the adjacent structures.

The application of real time 3D (RT3D) increases accuracy in ruling out LA appendage thrombus prior to cardioversion (Fig. 9).

Fig. 9. The 3D full volume of the left atrial appendage. Prior to acquiring 3D full volume data set, 2D image optimization was performed by adjusting the depth, focus, gain and sector width of the region of interest. This technique enhances image resolution and hence producing excellent 3D images when cropped to expose the coronal, sagittal, transverse or oblique cut of the appendage.
Displayed 3D images and 3D colors have accurately identified potential intra and post-operational complications during valvular surgeries (Fig 10). Saline bubble study presented in 3D has likewise been shown to be feasible and reproducible (Fig 11).

**Future Direction**

With the rapid development of the software and hardwares (echo machine and the probe) and technology in general, expanding the capabilities of 3DE and overcoming the current limitations of 3DE can be foreseen. With the improving temporal and spatial resolution of 3D echo, it is envisioned to be comparable to CT scan and cardiac MRI with the advantage of avoiding exposure to radiation. A protocol that utilizes one full volume acquisition with superior resolution compared to dedicated 2D echo probe will drastically shorten image acquisition and improve overall accuracy in quantification and reporting compared to conventional 2D acquisition, with elimination of stitching artifacts. Rapid, accurate, and reproducible EF can be obtained by real time 3D using an automated trabecular edge contouring algorithm. Furthermore, automated contour correction to detect the compacted myocardium yields accurate and reproducible 3D LV volumes.

Limitations

Advancement in technology do not occur without recognizing limitations that need to be further assessed. Despite the advantages demonstrated by 3DE, image quality depends heavily on good image windows. Hence, techniques to optimize 3D acquisition need to be further evaluated and validated. Temporal resolution is dependent on the sampling rates of commercially available software, another aspect which also needs to be considered. Stitching artifacts from gated acquisition, translational movement of the heart and breathing needs to be minimized or should be totally eliminated in the future development of the machine and its software. With the current 3DE protocol, performance of hemodynamic studies through pulsed and continuous wave Doppler study is not possible when engaged in the 3D mode.

A common misconception is that performing 3D is more expensive, another factor that limits its utility. Because it is more time-efficient in image acquisitions, more studies can be done within a certain period, allowing more patients to be evaluated, equally beneficial for patients, sonographers, physicians, and economically, for the echocardiography laboratories/centers as well.

**Fig. 11.** Saline bubble study is now not only shown in 2D but in 3D images as well. It has been already utilized in our center to see bubble in a different perspective. Negative contrast effect and its association with the defect can be better appreciated through 3D volume rendering.

**Fig. 10.** The utilization of the 3D color during the valvular surgery cannot be underestimated. Assessment of the post-aortic valve replacement for the paravalvar leak and its exact location can be accurately identified by displaying the leak in surgeon’s view. The severity of the paravalvar leak can be viewed from the ventricular side (A) or from the aortic perspective (B).
Much ado about guidelines

By Lourdes Ella G. Santos, MD

The 2013 American College of Cardiology/American Heart Association (ACC/AHA) Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults was released in the fourth quarter of last year. Since then there has been an onslaught of controversies surrounding the guidelines. Why this reaction? To best appreciate the disputes, let us walk through the history of lipidology.

Back in 1970, normal cholesterol was considered to be 280-300 mg/dL. Few people then had heard of low-density lipoprotein (LDL-C) or high-density lipoprotein (HDL-C). After about a decade, acceptable cholesterol became 240 mg/dL and HDL-C and LDL-C became recognized as risk factors for cardiovascular disease (CVD). By 1990, statins became the focus of clinical practice giving way to the race to define plaque regression and safety. LDL-C had established its role as a measurable risk for the development of CVD.

In a turn of events, the NHLBI ATP IV Panel members transitioned to the 2013 ACC/AHA guideline Expert Panel. Instead of offering a comprehensive approach to lipid management as the previous ATP guidelines did, the 2013 ACC/AHA cholesterol guidelines focused on treatments proven to reduce atherosclerotic cardiovascular disease (ASCVD) specifically statin therapy. Four statin benefit groups were identified: 1. Individuals with clinical ASCVD, 2. Individuals with LDL-C > 190 mg/dL without secondary cause (Primary Hyperlipidemia), 3. Diabetics (Type I or Type II DM) age 40 – 75 years with LDL-C 70-189 mg/dL and 4. Non-diabetics age 40-75 years with LDL-C 70-189 mg/dL with a 10 year ASCVD risk > 7.5% based on the ASCVD risk calculator provided (Fig 2).

Fig 1. More Intensive LDL-C Goals for High Risk Individuals Over Time

Fig 2. Major recommendations for statin therapy for ASCVD prevention

According to the recommendations, once the four statin benefit groups are identified, initiation of therapy becomes a critical factor in reducing ASCVD events. Patients with clinical ASCVD should be started on high intensity statin therapy if the age is < 75 years while those older than 75 years are downgraded to moderate intensity statin therapy. Primary
hyperlipidemia or persons with LDL-C > 190 mg/dL should also be given high intensity statin therapy. Individuals with diabetes are risk stratified based on their 10 year ASCVD risk. If the calculated risk is >7.5% then high intensity statin therapy is indicated, if the calculated risk is <7.5 % then they are relegated to moderate intensity statin therapy. For primary prevention, computed 10 year ASCVD risk will determine if the patient should be started on high or moderate intensity statin therapy.

High intensity statin therapy is defined as a statin that can lower LDL-C by approximately > 50% whereas moderate intensity statin therapy drops LDL-C by approximately 30-50%. Table 1 lists statin options.

Table 1. High-Moderate and Low-Intensity Statin Therapy (Used in the RCTs reviewed by the Expert Panel)

<table>
<thead>
<tr>
<th>High-Intensity Statin Therapy</th>
<th>Moderate-Intensity Statin Therapy</th>
<th>Low-Intensity Statin Therapy</th>
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<tbody>
<tr>
<td>Daily dose lowers LDL-C on average, by approximately ≥50%</td>
<td>Daily dose lowers LDL-C on average, by approximately 30% to &lt;50%</td>
<td>Daily dose lowers LDL-C on average, by &lt;30%</td>
</tr>
<tr>
<td>Atorvastatin (40)-80 mg Rosuvastatin 20 (40) mg</td>
<td>Atorvastatin 10 (20) mg Rosuvastatin (5) 10 mg Simvastatin 20-40 mg Pravastatin 40 (80) mg Lovastatin 40 mg Fluvastatin XL 80 mg Fluvastatin 40 mg bid Pitavastatin 2-4 mg</td>
<td>Simvastatin 10 mg Pravastatin 10-20 mg Lovastatin 20 mg Fluvastatin 20-40 mg Pitavastatin 1 mg</td>
</tr>
</tbody>
</table>

For primary prevention, in patients who fail to fall into a statin benefit group, additional factors may inform treatment decision-making. These include family history of premature ASCVD, elevated lifetime risk of ASCVD, LDL-C > 160 mg/dL, hs-CRP > 2.0 mg/dL, or subclinical atherosclerosis determined by a CAC score > 300 or ABI < 0.9. In these patients discussion of the potential for ASCVD risk reduction benefit has to be weighed against the potential for adverse effects of starting statin therapy.

The rationale behind not continuing to treat to target LDL-C is that the panel felt that current randomized control trial data do not indicate what specific LDL-C level goals should be. There have been no head-to-head comparison trials of dose titration to achievement of different LDL-C intensities. They believe, however, that there is compelling evidence that appropriate intensity of statin therapy should be used to reduce ASCVD risk in those most likely to benefit.

This is a new perspective on LDL-C goals. No longer are we encouraged to aggressively bring down LDL-C goals to pre-set targets but to identify those who will benefit and start them on recommended intensity statin therapy.

That these guidelines will eventually be accepted by physicians and incorporated into clinical practice remains to be seen. ♥

TREADING...from Page 53

addition, they suggested that a new trial concentrating on the low dose formulation will provide a more robust data set.

While awaiting the outcome of these suggestions, it is probably reasonable to suggest low dose rivaroxaban, low dose aspirin and clopidogrel only for the very high-risk ACS patient (positive biomarkers, multiple stents, overlapping stents, history of stent thrombosis, left main disease, long lesions, large thrombus burden, and diabetics) who are not at high bleeding risk. High risk for bleed would be patients age >75 years, history of TIA/stroke and gastrointestinal bleeding, hepatic or renal disease, malignancy, or excessive fall risk. You must have a detailed discussion with the patient about the relative benefits and risks of adding rivaroxaban to DAPT.

For patients who cannot take clopidogrel and the risk of bleeding are acceptable, the addition of an oral anticoagulant has been shown to be beneficial. This is based on several favorable meta-analyses in patients whose INR on warfarin therapy can be consistently maintained between 2.0 and 3.0. It seems reasonable to substitute low dose rivaroxaban for warfarin in these patients.

For the patient who cannot take aspirin, reasonable options include clopidogrel in combination with either warfarin or low dose rivaroxaban, however these two strategies have not been compared.

Adding NOACs to DAPT in ACS has great potential to further reduce recurrent ischemic events. We will need more robust data coming from well-designed and properly executed studies before we find the right balance of benefit to risk. At present, only patients in the highest risk category should receive aggressive anticoagulant therapy - Primum non nocere. ♥

BIMA...from Page 51

Cardiology (ESC)/ European Association for Cardio-Thoracic Surgery (EACTS) and American College of Cardiology Foundation (ACCF)/ American Heart Association (ACCF/ AHA) guidelines actually support use of more arterial grafts in CABG.

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