Pinoy Heart Month thru the years, QUO VADIS?
MINIMAL CASH OUTLAY
WILL SERVE AS COMMITMENT FEE WHICH WILL BE UTILIZED ON THE FIRST PERIOD OF THE CONTRACT (ONLY FOR HOSPITALS WITH EXISTING PIPELINE SYSTEM)

UP TO 20% LESS ON THE PREVAILING PRICE OF OXYGEN

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

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

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

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

FREE SHARP AND INFECTIOUS SHREDDING MACHINE

FREE OXYGEN GENERATOR HOUSE

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

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

WITHDRAWAL OF OXYGEN CYLINDER DEPOSITS FROM SUPPLIERS

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OXYGEN PRESSURE BEING OPERATED IS AT 120 PSI ONLY

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Editorial

Heart Month 2014: Quo vadis?

Ever since Dr. Mariano Alimurung, first President of the Philippine Heart Association (PHA), initiated the celebration of “Heart Day” on 14 February in 1953, Heart Month has always been marked every year. Extensive media campaigns proved vital in sustaining public interest in PHA’s advocacy—turning supporters into advocates for heart health even to this day.

During the term of Dr. Paulo Campos, 15th PHA President, the first lay activity, entitled “Heart and Husbands for Women Only” was conducted, creating public awareness on heart disease in both men and women. When the U.S. Congress urged then President John F. Kennedy to proclaim February as the “American Heart Month” in 1963, the PHA leaders led initial efforts to develop the “Philippine Heart Month”. It was during the term of then PHA President Dr. Ramon Abarquez (1970-71) when the late Philippine President Ferdinand Marcos formally declared February as Philippine Heart Month.

In 2002, the “Mag-Healthy Lifestyle (HL) tayo” campaign was implemented by 50th PHA president Dr. Edgardo Ortiz. Now, 12 years later, the campaign shifted its slogan to “Take 52-100 daily,” which was launched in February this year in Cebu City—the first-ever out of Manila national PHA celebration.

In 2003, during the term of Dr. Annette Borromeo, the NNHES (National Nutrition and Health Survey) was launched, with the PHA as major stakeholder. Dr. Borromeo also carried the “Mag-HL Tayo” flag toward attaining a Guinness world record for the biggest mass aerobic session participated in by Filipinos at the Rizal Park. Dr. Romeo Santos pursued this campaign during his term, and forged linkages with the Department of Health and related non-governmental organizations.

In 2005, statistics on heart disease in the U.S. showed that coronary heart disease claimed more lives than other leading causes among women at 213,572 females. Breast cancer had 41,116, while lung cancer had 8,946, with cancer having 41,116, while lung cancer had 8,946, with cancer having 8,946. Noting this development, PHA, through Dr. Norbert Lingling Uy’s term, 53rd PHA President Dr. Esperanza Cabral, worked for the “Women’s Health Advocacy”. This initiative was sustained throughout the terms of women presidents of PHA—Dr. Ma. Belen Carisma, Dr. Maria Teresa Abola and Dr. Eleanor Lopez. The two PHA presidents who succeeded them—Dr. Isabelo Ongtengco and Dr. Saturnino Javier—continued the advocacy of the three predecessors. Dr. Ongtengco started on the vital link between doctor and heart patient through registries, while Dr. Javier opened PHA to the lay, now the PHA lay arm.

Today, under the leadership of Dr. Eugene Reyes, PHA takes bolder strides to maintain more robust and solid Registries of various heart conditions through viable research and development strategies toward attaining better prevention and management of heart disease.

Despite the risk of heart disease and stroke increasing with age, many people are still unaware of their blood pressure, sugar and total cholesterol levels. More so, many do not want to take personal responsibility over their own health care. PHA emphasizes that the management of risk factors is cost effective because first time diagnosis of cardiovascular disease can be debilitating and can be fatal even in women and so emphasis should be placed heavily on management of risk factors before irreversible damage occurs. Hence, PHA supports more aggressive management of identifiable risk factors such as smoking, obesity, high blood pressure, cholesterol and sugar, and even home and work-related stress.

Smoking increases the risk of a heart attack up to six times in heavy smokers. However, non-smoking can significantly reduce the risk of heart attack by 50 per cent within the first year. After the fifth year of non-smoking the risk for coronary heart disease can level off to that of a non-smoker but passive smoking also increases the risk.

Obesity is on the rise especially among the youth. An attainable goal to shed off 5 to 10 per cent of obese body weight can lower cholesterol, blood pressure and sugar levels. Cutting on daily caloric intake of 500 per day coupled with 30 minutes of moderate activity, or a pedometer goal of 10,000 steps per day can potentially bring one’s weight down to one to two pounds per week. Physical activity does not need to be structured exercise and can involve creative ways to move, like brisk walking, taking the stairs, and the like. It goes without saying that stress management at home or in the office is important—it can increase cardiovascular disease risk by an alarming 75%.

As PHA enters another year, may our collective mission to reduce the ravages of heart disease in the Philippines spread across the country toward creating a truly healthy nation. Without the concerted efforts of the PHA membership, as well as the proactive community response, heart disease, including stroke, will remain the country’s top killer.

Where does PHA go from here? Quo vadis, PHA let’s fight heart disease together and better every day!
1st out-of-town Heart Month in Cebu

The “men on the street”, – the park promenaders, bike buffs, street vendors, CITOM employees, barangay workers, roving media men, students who prefer going to school by foot, the vibrant members of the medical and pharmaceutical communities, link up to achieve a high-impact Heart Fair.

Watch out for A-WATCH

Collation of data for Asean Women Registry fast-tracked

Camp Brave Heart 8

Is a celebration of life. Post-op kids get the hang of the yearly CBH treat.

Acute Coronary Syndrome Registry Updates

Lack of funds put off stat PCI, CABG

Escape Beat

The Dynamics of PHA Board (part1)
By Saturnino P. Javier, MD

Dysrhythmic Tales

Bidirectional Wide QRS Tachycardia of the Third Kind
By Edgardo S. Timbol, MD

Perspectives

Finding the Middle Ground
By Sue Ann R. Locnen, MD

Cardio and the Law

The Responsible Parenthood & Reproductive Health Act of 2012
By Atty. Angeles A. Yap, MD
Editor’s note

Treasure time and health

Though the mission towards cardiovascular disease (CVD) prevention and management is an all-year-round voyage for the Philippine Heart Association (PHA), the Heart Month issue of the PHA NewsBriefs (PHAN) is dedicated to portray the concerted activities of the PHA for health awareness all over country. This is designed to affirm that the PHA is not only an icon of national heart health but a tireless warrior against CVD.

January-February is the time of year that the PHA leads the nation in taking time out to listen to our hearts, to pamper and to care, to stop and segregate time for our individual heart health which is hoped to last the whole year. Year in and year out. Hence, our cover for this issue shows the different faces that the PHA NewsBriefs donned over the years during Heart Month celebrations.

For Heart Month 2014, the 52-100 is launched for the young and old, which hopefully can be a quick, but lasting guiding principle for each of us. It simply means, 5 servings of fruits and vegetables per day, 2 hours only per day of sitting behind the computer or TV, 1 hour exercise everyday, 0 for zero to sugared beverages and 0 zero smoking.

As we look forward to what is in store for us in 2014, let’s set time for our health and remember PHA’s battle cries over the years: “I Work with Heart”, “The Heart of the Youth is the Heart of the Nation,” “Heart Wellness is a Family Business” and many more.

Whatever the battle cry, we will achieve nothing if we do not acknowledge that time and health are gifts from God. Once we see that we are but players in the big game and all-inclusive plan of God, we begin to develop a deep discernment and profound sense of accountability to the Giver of our time and health and hence our purpose. Promoting and maintaining heart health and general well-being is thus a social responsibility, a personal stewardship and a divine privilege.

We cannot extend the 24 hours we have in a day, but we can choose to use it wisely. And setting aside time for health is mandated upon us. Time is the most mysterious and expensive commodity. The famous adage “health is wealth” adds to the enigma of time, and how we spend it and preserve or maintain our health.

Time and health makes all things equal, transcending all spheres of society and breaking all hierarchies and domains.

Cardiovascular health is a global concern, yet the war against it is a personal war, for everyone is at risk, cardiologists included. No one is exempt. As we heartily work at purposefully using our time and prioritizing our health, let’s live life with a thankful and positive spirit in all circumstances. The result is a better person with an inner strength that can withstand life’s challenges, including the battle for good heart health at home, and in the workplace.

This year’s January-February issue of PHAN archives the events that capped the annual Heart Month 2014 celebration which was for the first time brought outside Manila, particularly Cebu. As you browse through the pages of this PHAN issue may you see reason for being the heart and muscle of PHA as members. To value time is to give time and to value health is to prioritize and live a healthy lifestyle. This is what this whole talk of Heart Month and Wear Red Day is. It’s about knowing and doing and being.

Go forth soldiers of the Philippine Heart Association. Give yourself and your family the GIFT of TIME and HEALTH. Remember always that God cares about our work, our time and our health regardless of our station. Rise up to the challenge of a healthier 2014 and beyond. ♥
CEBU CITY, Feb. 13, 2014 – Photo op right after a working dinner. PHA National and Cebu officers with their respective skeletal forces give the Feb. 16 Heart Fair plan a once-over. In photo (1st row) Gynna Gagelonia, PHA MRO; Drs. Jonas del Rosario, Raul Lapitan, Helen Ong-Garcia and Alex Junia as well as Karen Andrino, PHA Cebu secretary; 2nd row, Drs. Joel Abanilla, Jorge Sison, EBR, Wilfredo Ypil (partly covered) PHA Advocacy Coordinator Irene Alejo, Bernadette Halasan and Dr. Brett Batocoy. Not in photo is PHA executive director Gina Inciong. Everyone enjoyed the heart-friendly fare at the Asian Fusion restaurant.
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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Membership

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ACC Chapter-Philippines

The Feb. 4, 14 and 25 columns of EBR “Ensuring a Healthy Life is not the Doc’s job alone”, “Hypertension is deadly but controllable” and “Time to Attack Heart Attack” are part of the Lay Awareness Dissemination advocacy of PHA through MSD.
CEBU CITY, February 16, 2014 -- At 5 am, as the sun was gradually making its majestic presence over the horizon, human traffic was building up around Plaza Independencia. At least 400 people from all walks of life, at their own pace, dashed to this public park, the site of the free 2014 Heart Month Fair, organized by the Philippine Heart Association (PHA) National and Cebu Chapter.

Some came by foot, a good number by bike and a few by car.

Adults aged 30 and up were queued up at the consultation and Risk Factor Screening desks, while young adults, with kids in tow, were milled around the pretty ladies donning sports gear. The rest, who opted to momentarily remain at a standstill, roved their eyes on the booths that ringed the fair.

From 6am to 8am, the fit dancers gyrated to the bouncy beat that provided a festive feel to the action-filled event.

Seeing the aero and zumba buffs, fit cyclers and lean high school students lugging their jump ropes made many spectators mull over their lifestyles.

The Queen City was unanimously chosen as the hub of Heart Month celebration the day after the culmination of the Feb. 12-15, 2014 10th Asia Pacific Congress of Hypertension at the Radisson Blue Hotel in this city.

PHA believes it is a propitious time to seize while the Queen City of the South was at the limelight, and in keeping with the reaching out to the Chapters program of PHA.

PHA Vice President Dr. Joel Abanilla, concurrent Heart Month 2014 chair, stressed “Heart Month or Valentine’s Day is not all about making a renewal of a vow to keep a healthy heart or strong ties with your loved one. Heart Month is a celebration of life, and what makes this particular occasion more meaningful and historic for us is, we chose Cebu as the center stage of the 41st commemoration of Heart Month, three months after the October 2013 earthquake and at a time Cebu plays host to a much-awaited international event.”

By Gynna P. Gagelonia

First out-of-town CEBU HEART MONTH makes waves
FREE CLINIC
At 7am, the Booth rounds ensued. The consultation desks (where patients with their filled out forms, had a BP check, were assessed), screening counters (where the cholesterol /sugar tests, body mass index, and waist circumference taking were done) and ECG nooks (on an as-needed basis) attended to the patients who were also given free medicines, courtesy of the PHA’s pharmaceutical allies.

They were: LRI-Therapharma, Westmont, Boehringer Ingelheim, Getz Pharma, Pascual Pharmaceutical, Takeda, ADP Pharma, Servier Philippines, Astra Zeneca, Aspen, MSD, Sanofi, Patriot Pharma and Littman.

After getting all their test results, the patients went back to their attending cardiologists at the fair, who explained their blood chem results, diagnosis, why one needs to be a compliant patient and what being under maintenance meds means.

The results of the Risk Factors screenings from this particular samplings will be added to the ongoing PHA Heart Fair registry. Of the 281 Heart Fair questionnaires that were distributed, 195 were filled out and returned, of this figure, 105 (53.85%) are males while 90 (46.15%) are females; 149 (76.41%) are aged 20-59 while 46 (23.59%) are 60 years old and above, said PHA Secretary Alex Junia.

JUMPSTART YOUR HEART WITH 52-100
The unveiling of the Jumpstart your Heart with 52-100 logo before the crowd that included Cebu media was one of the highlights of the Fair. PHA Director Dr. Jonas del Rosario, concurrent Advocacy Committee chair, announced that the “Jumpstart your Heart with 52-100” is the new PHA tagline.

He said “52-100 is your daily dosage to a healthy heart. Do 52-100: as in consume FIVE servings of vegetables and fruits; have a maximum TWO hours of screen time (TV/ computer); do ONE hour of moderate physical activity; have O soda and sweetened juices (give your children fresh milk and water); and do O smoking. This prescription is for seniors, adults and children.”

“Prevention is better than a pound of cure. 52-100 is the best preventive measure. After seeing and feeling the results, pass it on. Do your testimonial. Be 52-100’s walking ad. You don’t contract heart disease overnight. The healthy heart seed begins in the womb and nurturing is an endless process”, said PHA President Dr. Eugene Reyes.

PHA Director Dr. Helen Ong-Garcia said “we, as cardiologists, always stress that daily physical activity, like running at least one hour, helps regulate your heart rate. Running or any form of exercise should be a family activity. Jumpstart your heart with a simple sport like skipping rope.”

The emcees Junia Ong-Garcia introduced the Jump Rope participants. And here’s the judges’ (Drs.

CITOM GETS CPR TRAINING
A few steps away, heart doctors led by Dr. Louella Quijano, chair of the PHA Cebu Chapter CPR Committee were conducting a cardiopulmonary resuscitation lecture, followed by the hands-only demonstration before Cebu City Traffic Operation Management (CITOM) personnel -- traffic enforcers and parking aides. One of the goals of the PHA Cebu is to teach life-saving skills to CITOM’s 150 traffic personnel.

The media people who were around expressed interest in learning the ABCs of CPR.
At the media briefing, Abanilla said one of PHA’s top agenda is to bring hands-only CPR to every home and to every man on the street, so to speak. “We are teaching CITOM the proper skills to be able to respond to emergency situations on the road while buying time and awaiting the para-medics’ arrival,” said PHA Cebu Chapter President Dr. Wilfredo Ypil.

At the next tent, Healthy Lifestyle Lay lectures were also simultaneously conducted. Also on hand were Drs. Brett Batoctoy, Bernadette Santiago-Halasan, Cecile Jaca.

MEDIA COVERAGE

ABS-CBN, GMA7, Sun Star and Cebu Daily News pegged their stories on the free CPR crash course for CITOM, to equip them with life-saving skills while GMA 7’s story lead was “Jumpstart your heart with 52-100.” Their interviewee-news sources were Reyes, Abanilla, Ypil, del Rosario and Quijano.

Impressed by the simultaneous activities, the media people were there as journalists and spectators.

PHA OFFICERS IN FULL FORCE

The PHA National Board of Directors (Drs. Reyes, Abanilla, Junia, Lapitan, Jorge Sison, del Rosario, and Ong-Garcia) and the PHA Cebu Chapter Officers -- Drs. Ypil, Carolyn Femin, Brett Batoctoy, Leah Villamor, Delia Caracut and Pilberito Chin were in full force at the first out-of-town Heart Month Celebration.

Participating Cebu hospitals -- Chong Hua Hospital, Cebu Velez General Hospital, Perpetual Succour, Cebu Doctors Hospital, Vicente Sotto Memorial Medical Center and Sacred Heart Hospital, posted their Fellows-in-Training at the consultation desks.

Over the years, the PHA, with the support of the Department of Health, Heart Foundation of the Philippines and pharmaceutical companies, have been at the forefront of Heart Month. PHA is composed of 1,500 cardiologists from the National Capital Region and eight chapters around the country -- the PHA Central Luzon, Northern Luzon, Bicol, Cebu, Iloilo-Western Visayas, Bacolod Negros Occidental, Northwestern Mindanao and Davao-Southern Mindanao which simultaneously conduct Heart Month with similar activities.

In retrospect, under Presidential Decree 1093, in 1972, February every year was declared Heart Month, and the PHA was named as the lead organizer of the annual event.

M.J. CUENCO RESIDENTS TROOP TO PLAZA INDEPENDENCIA

Some 50 residents of M.J. Cuenco, Cebu City with Joel Garganera, Tinago Barangay captain, joined fellow Cebuans at Plaza Independencia as patients and spectators. Early on, they danced Zumba with the crowd that grew every minute, availed of the risk factor screenings, grabbed some bite of the packed breakfast, witnessed the CPR lecture/demo on the CITOM personnel, then watched the Jump Rope competition which is actually a combination of an interpretative dance and skip rope number, said one of the middle-aged ladies.

The Garganera brood pledged support for the Heart Fair as early as one week before the Feb. 16 Heart Fair. And how, they delivered.
FREE MOBILE AD VIA TINDAK-BISDAK

Instead of dining out on Feb. 14, a big group of bikers, collectively known as the Tindak-Bisdak Folding Bike Society (TBFBS), adhered to their every-Friday 6pm cycling sked and even volunteered to be a mobile advertiser of the Feb. 16 free PHA Heart Fair 2014 at Plaza Independencia.

At exactly 6pm, 50 members of TBFBS assembled at the bike store and Air/Sea ticketing office on MJ Cuenco St., Cebu City, of businessman and bike collector Jay Garganera, founder and president of TBFBS.

MJ Cuenco is one of the busy major arteries of Cebu.

Using a megaphone, Garganera promoted the Feb. 16 Heart Fair activities, particularly the free consultations, with risk factor screenings, CPR lecture and demo and 52-100 launching at the Plaza Independencia.

The group scooted around the city with the PHA Heart Fair banner. Their guest-bikers included Gina Inciong and Irene Alejo, PHA executive editor and coordinator, respectively.

Shortly before 8pm, the bikers were back, in time for the on-the-house dinner.

On the buffet table were hot pospas, lean pork barbecue, buko juice and ripe mango. Over dinner, the group talked about current events, future biking safaris and other wellness activities. Before they called it a night, Garganera, announced the Heart Fair anew. He also told PHAN “dinner is always on me but I don’t mind. This is a small price to pay for the gains I have been enjoying from our exciting biking adventure.”

In 2008, he had a mild stroke and abnormally high cholesterol levels. He said “my cardiologist, Dr. Alex Junia stressed that taking maintenance meds is not enough. I was told to watch my diet and engage in a sport that I enjoy doing.” Garganera loathes basketball and running.

He added “I was never a biker because I considered it as a lonely sport. One day, my feet just led me on to a surplus bike store.”

Fast forward to 2014. Jay’s Bike Store is a showcase of his bike collection and units that are for sale and is the assembly point and last stop of Tindak-Bisday members.

Garganera’s blood chem results have been normal in the past years. “Biking burns your calories. It tones your muscles and strengthens your bones. It’s fun to go biking as a group because it strengthen your ties with your neighbours and biking buddies,” he added.

Garganera’s immediate family – his wife, two daughters, and all his four siblings are regular bikers.

There were cyclists, who came with their entire brood. A man who is in his late 30s, came with one of his two sons, Raphael “Raprap” Jimenez, 10. Rap’s 13-year-old big brother is also biker. He missed the Feb. 14 biking spree because he was sick. The boys had been into biking since they were 5 years old. Father and son confessed this particular sport is one of their bonding moments.

Raprap has the build of a sports buff. He said exercise in the form of biking keeps him going. The only time he skips this thrice-a-week routine is when he is sick or when he has a long test.

A husband and wife, who are both nurses, with their 16-year-old daughter are among the regulars of Tindak Bisdak. ♥

Tindak-Bisdak bikers
<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>ACTIVITY</th>
<th>HOST/GUEST-RESOURCE PERSON</th>
</tr>
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<tbody>
<tr>
<td>Jan. 16/14 Thu Clinic/Taping</td>
<td>• GMA PINOY, MD Topic: Pano nakakatulong ang potassium content ng sayote sa dugo/puso?</td>
<td>Guest: Dr. Helen Ong-Garcia Hosts: Drs. Jean Marquez &amp; Rolando Balburias, Connie Sison</td>
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<tr>
<td>Feb. 1/14</td>
<td>• ABS CBN Salamat Dok Topic: Congenital Heart Diseases 52-100</td>
<td>Hosts: Bernadette Sembrano &amp; Alvin Elchico Guest: Dr. Jonas del Rosario</td>
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<tr>
<td>Feb. 5/14, Wed</td>
<td>TV4 THE DOCTOR IS IN Topic: Kalendar yong Pangkalusugan: CV diseases/heart month</td>
<td>Host: Health Asec Eric Tayag Guest: Dr. Helen Ong-Garcia</td>
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<tr>
<td>Feb. 1/14</td>
<td>• ABS CBN Magandang Gabi, Dok Topic: Bakit madaming na-i-stroke pag malamig ang panahon</td>
<td>Host: Nina Corpuz Guest: Dr. Irma Yape</td>
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<tr>
<td>Feb. 8/14 Sat 11am Shoot doc's clinic Broadcast date: Feb. 15</td>
<td>• GMA PINOY MD Topic: Healthy, Unhealthy Heart</td>
<td>Hosts: Drs. Jean Marquez, Rolando Balburias &amp; Guest: Dr. Timothy Dy</td>
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<tr>
<td>LBC 30 min. heart health lecture</td>
<td>Good Morning Kuya Usapang Pangkalusugan Topic: How to cut heart attack risk</td>
<td>Hosts: Lyn Perez &amp; Daniel Razon Guest: Dr. Noel Rosas</td>
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<td>Feb. 11/14 Tue 7pm</td>
<td>SOLAR NEWS Med Talk Topic: Heart diseases: congenital heart disease</td>
<td>Host: Angel Jacob Guests: Dr. Jonas del Rosario Dr. Helen Ong-Garcia</td>
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<tr>
<td>Feb. 21/14 Fri 5pm</td>
<td>LBC 30 min. heart health lecture</td>
<td>Guest: Dr. Helen Ong-Garcia Thru PCP LBC Corporate Office, 5th Flr., Star Cruise Ctr., Newport, Pasay City</td>
</tr>
<tr>
<td>Feb. 11/14 Tue 6pm</td>
<td>• Men's Health magazine Topic: Myths about heart disease</td>
<td>Interviewee: Dr. H.Ong-Garcia</td>
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<td>CEBU HEART MONTH FAIR 2014 EVENT PROPER Plaza Independencia, M.J. Cuenco, Cebu City</td>
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<td></td>
<td>• Sun Star • Cebu Daily News</td>
<td>Interviewees: Drs. Wilfredo Ypil and Louella Quijano</td>
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<td>Feb. 18</td>
<td>• Gma 7 Cebu Topic: 52-100 CPR</td>
<td>Interviewees: Drs. Eugene Reyes, Joel Abanilla, Wilfredo Ypil, Jonas Del Rosario and L. Quijano</td>
</tr>
<tr>
<td>Feb. 20 8:30pm</td>
<td>• ABS-CBN Magandang Gabi Dok Topic: Congenital Heart Disease</td>
<td>Host: Dra. Luisa Ticzon-Puyat Guest: Dr. Jonas del Rosario</td>
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A-WATCH collaborative project on track

By Gynna P. Gagelonia

CEBU CITY, Feb. 13, 2014 – The ASEAN Congress of Cardiology in Malaysia in June 2014 will be the launching pad of a collaborative A-WATCH research project that will reveal the prevalence of cardiovascular disease (CVD) among ASEAN women and the culture malady that puts their well-being at the back seat.

A brainchild of Philippine Heart Association Council on Women’s Health (PHA-CWH) chair Dr. Milagros Yamamoto, A-WATCH stands for ASEAN Women Advocacy Toward CV Health. It was launched during the 18th ASEAN Congress of Cardiology (AsCC) at the Waterfront Hotel Lahug, Cebu City in December 2010.

After four years, Yamamoto met up with members of the A-WATCH Core Group on Feb. 13, 2014 to chart its plans for the ambitious A-WATCH registry project at the Secretariat Room of the Radisson Blue Hotel, venue of the Feb. 13-15, 2014 Asia Pacific Hypertension Congress hosted by the Queen City.

In attendance were PHA-CWH members Drs. Ma. Adelaida Iboleon-Dy and Maita Senadrin and Dr. Putra Antara from the Indonesian Heart Society (IHS).

Yamamoto said that the A-WATCH endeavour should be a consolidated data on ASEAN women with acute coronary syndrome; the patients’ behaviour in terms of symptoms, the time they sought consultation, the doctors’ response and treatment time (door to needle, door to balloon time) how many availed of PCI; and reperfusion for medical management from the member-countries’ registries.

For the benefit of Antara who represented IHS. Yamamoto gave the history of the PHA-CWH, its Mission/Vision, evolution, as well as its past and ongoing major projects.

The highlights of the group’s meeting include the charting of the A-WATCH goals and plans:

- To beef up media links/generate massive multi-media mileage; Educate more women to view heart disease also as an important female issue, not just a male issue; to regularly see the doctor;
- Encourage ASEAN members to share their data so we can come up with the ASEAN Perspective: Women with CVD study; and
- Come up/out with a research material to be used as reference in training workers on women’s heart health education/promotion.

Yamamoto endeavoured to establish a registry on the prevalence of coronary artery disease (CAD) among ASEAN women “because currently, there are no pooled statistics on ASEAN women with CAD. What we have are US/European statistics,” she said.

Demographics is also important. Adverse events and death among women with ACS is on the rise because they get help quite late. Their situation is aggravated by the Asian culture that ranks men as top priority while women are relegated as second priority.

“But did you know that even a lot of American women ignore the symptoms of heart disease and the fact that it is the number one cause of death because they have always believed that cancer is tops in terms of morbidity and mortality?”, added Yamamoto.

Philippine scenario

“Data sourced from the Department of Health (DOH) showed that CVD is the top killer disease among men and women. There was no further information on attitude/perceptions, etc.,” said Senadrin.

Aside from the DOH, the sources of data are the PHA-led Presyon 3, BP ng Teacher Ko, Alaga Ko and the ACS registry. Presyon 3 was completed this month. The four-year-old BP ng Teacher Ko, Alaga Ko (a nationwide hypertension

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PASIG CITY, February 10, 2014 -- To give way to persistent demand, Camp Brave Heart (CBH) 8 settled for the same venue, Fun Ranch, a huge one-stop shop playground.

The CBH sequel was another exciting adventure. It’s a place every kid on the block is raring to explore. For the repeat visitor, it is worth going back to.

Broadcast journalist Bernadette Sembrano, model-TV host and actress Angel Jacob and actress LJ Reyes did not just play and mingle with the kids. They told the children that there’s a bright future for them. They just have to take good care of their health, especially their heart, focus on their studies and to be God-fearing individuals.

The PHA Board -- cheered them up and encouraged them to go back to school, engage in physical activities and stimulating pursuits.

The traditional indoor (poster making and entertainment) and outdoor activities (brick assembly, obstacle course with rope unravelling, rides, crossing the hanging bridge) put across very important survival tips and facts of life: There will always be a smooth and rough ride. There is no bridge one cannot cross.

Entanglements will pass. You have to learn to deal with nice and harsh people. With a supportive family, strong faith and fortitude, you become a survivor and you will be a somebody.

Riding on the 52-100 crest, the new PHA tagline, the CBH year 8 theme is “Jumpstart Your Heart: Go 52-100”.

CBH was another forum for
the PHA to introduce 52-100 to a set of kids most of whom are post-op pediatrics cases. The rest are being worked up while awaiting their schedule for surgery.

The digital age with all the symbols of IT revolution has made internet access almost trouble-free. IT tools and toys are the daily norm for every techie kid. The disadvantage is virtual games have become handy. Thus, encouraging your kids to go out and play is not as easy as it was before the advent of the IT age more than a decade ago.

So 52-100 came at the right time

PHA Director and Advocacy Committee chair Dr. Jonas del Rosario said: “Both exercise and physical activity keep children healthy. A study bares that students who are more active excel in academics. Go 52-100 for a healthy body and a healthy heart.”

Sembrano (center) is flanked by PHA doctors

Dr. Sison

Jacob

Phi Kappa MU Fraternity of the University of the Philippines with Dr. del Rosario & Sembrano (center)
Media has never been as ingenious with story leads

ENTERPRISING media pegs at a glance.

GMA7 Pinoy MD on Feb. 1, 2014 tackled “Paano nakakatulong ang potassium content ng sayote sa dugo/puso?”. Guest: Dr. Helen Ong-Garcia is a PHA director and concurrent co-chair of the PHA Advocacy Committee.

Hosts: Drs. Jean Marquez, a dermatologist and Rolando Balburias, an internist and concurrent director of the Philippine College of Physicians.

Pinoy MD is a weekly magazine health program that airs every Saturday from 7 to 8am. Its goal is to bring useful and life-saving health information to the viewers.

ABS-CBN 2 Salamat, Dok, a weekend current affairs program that focuses on medicine and health issues, it airs every Saturday (6-7am) and Sunday (8-9am).

ABS-CBN 2 DzMM (630khz/Ch 26) Magandang Gabi, Dok on Feb. 3, 2014 was pegged on “Bakit dumadami ang na-stroke lalo na pag malamig ang panahon?” Guest: Irma Yape, chairperson of the PHA Council on Hypertension

Host: Nina Corpuz is a reporter for newscasts TV Patrol and Bandila, The ABS-CBN News Channel (ANC), Studio 23 and www.abs-cbnnews.com. She also anchors a news program, Balitang Europe, which airs on The Filipino Channel (TFC) and ANC. Magandang Gabi, Dok airs from Monday to Friday, 8:30 to 9pm.

ABS CBN2 Magandang Gabi, Dok on Feb. 20, 2014 “Congenital Diseases…part II”

Dr. Helen Ong-Garcia: “A healthy heart makes itself unnoticed. You shouldn’t hear your heart pounding unless you intentionally monitor it or take your pulse rate. There’s a link between heart to stomach and back pains. When you feel these symptoms, go to the ER. Potassium is good for the heart and reduces your cancer risk. Vegetables and fruits are excellent sources of potassium.”

Dr. Jonas del Rosario: “The key to a healthy and strong heart is 52-100. Fat deposits develop even in childhood that is why parents have to teach even their toddlers the value of 52-100.”
Guest: Dr. Helen Ong-Garcia
Host: Health Asec. Eric Tayag

The Doctor is in is a co-production of the Department of Health and TV4, the state-owned television channel.

UNTV (Channel 37) Good Morning Kuya: Usapang Pangkalusugan on Feb. 10, 2014, 6:30 to 7:30am was hewed on “How to cut heart attack and stroke risk? How do you pamper the heart?” Guest: Dr. Noel Rosas is the chair of the PHA Council on Preventive Cardiology and an active member of the PHA Advocacy Committee. He is affiliated with the Makati Medical Center.

Through Good Morning Kuya, he started many public service projects such as free medical/dental check-ups and medicines for the indigent. Razon’s regular free medical missions are achieved through his Mobile Clinic Bus which can reach even far-flung towns in the Philippines.

Lyn Perez is one of the pioneers of UNTV. Aside from hosting UNTV’s “Good Morning Kuya’s” medical segment, she is also a radio anchor for UNTV Radio’s free consultation broadcast, “Ikonsulta Mo.”

Good Morning Kuya is a magazine show that airs daily from 6:30 to 7:30am.

Solar News MEDTALK on Feb. 13, 2014 focused on “Let’s talk congenital and adult heart diseases. Tips that are good for the heart, literally and figuratively, on the eve of Valentine’s Day.” Guests: Drs. Jonas del Rosario and Helen Ong-Garcia.

Host: Angel Jacob, commercial model, TV host and actress.

MEDTALK is a weekly, late-night on-air medical-consultation program that covers a variety of medical and health topics, providing action tools to help people take control of their health. On-air consultation from viewers via the program’s social media portals, email, SMS and phone lines. A case study is also part of the show.

GMA 7 Pinoy MD on Feb. 15, 2014 showed a “Healthy, Unhealthy Heart”. Guest: Dr. Timothy Dy, chair of the PHA Website committee and past chair of the Council on Cardiac Catheterization.

With the aid of a case study video, he ably explained the difference of a healthy heart from an unhealthy one and how transcatheter aortic valve replacement it.

Drs. Del Rosario & Ong-Garcia with MEDTalk host Angel Jacob

Dr. Ong-Garcia with Asec. Tayag

Dr. Rosas

Dr. Irma Yape: “Hypertension is called a silent epidemic or killer because one out of four adult Filipinos have high blood pressure and most of them don’t feel the symptoms. The ideal blood pressure is 120/80. During the cool months, most people delay and conveniently forget their regular check-up. They tend to be less-physically active; crave for fatty, sodium- and sugar-rich foods. Worse.”

Dr. Noel Rosas: “The key to a healthy body and a healthy heart is a healthy lifestyle. Always remember and practice the tenets of a healthy lifestyle – keep your body mass index, weight, blood pressure, sugar and cholesterol at normal levels.”

Dr. Luisa Ticzon-Puyat: “We give you loads of healthy tips through consultation on air. That is not enough, you have to see your doctor.”

Nina Corpuz: “What do doctors call hypertension a silent epidemic and silent killer? Is it true that the cases are higher in during the raisy or cool season?”
Cebu, the first out-of-Manila venue of Heart Month had “52-100” as the centrepiece of the celebration on Feb. 16, 2014.

An adaptation from the “52-10” tagline of pediatric cardiologists groups in the US, the PHA added one more “0” for smoking in the wake of a growing number of Filipino smokers among the young population.

PHA strongly prescribes 52-100 as in: 5 servings of vegetables and fruits; not more than 2 hours of video and TV time; 1 hour of exercise or physical activity; 0 sweetened drinks and soda; 0 smoking; to stay healthy and to avoid cardiovascular diseases.

Over the years, the Healthy Lifestyle Campaign integrated the Department of Health’s and PHA’s regular physical activity, weight control, healthy diet, anti-smoking, nutrition, stress management and regular check up programs.

All the way through, the PHA vibrant presidents from 2002 to 2014 – Drs. Edgardo Ortiz, Annette Borromeo, Romeo Santos, Norbert Lingling Uy, Mariano Lopez, Cesar Recto III, Efren Vicaldo, Ma. Belen Carisma, Maria Teresa Abola, Eleanor Lopez, Isabelo Ongtengco, Saturnino Javier and Eugene Reyes, have kept the HL Advocacy a priority.

HISTORY
At the onset of 2002, PHA imagined a Lifestyle Advocacy project for the lay, then found a perfect match in the Department of Health (DoH) in February of the same year. The partners conceived a robust and promising baby called Mag-Healthy Lifestyle Tayo* after the sealing of the DOH-PHA Mag-Healthy Lifestyle Tayo project, and even pursued Malacanang’s support, and offshoot were two declarations: “Year 2002 is National Year of the Heart” and “2002 to 2012 is Decade of Cardiology”.

A good provider, the DoH spent a substantial sum on the grand launching of “Mag- HL Tayo which coincided with Heart Month 2013 at the Luneta Park in Manila on February 16, 2013.

An events organizer was tapped to take charge of the entire event. Multi-media was fully utilized. It was a star-and glitterati-studded launching, ushered in by the traditional PHA-led Heart Month Lakad Puso and the well-publicized Mass Aerobics which gathered 100,000 people. Several months after, the Mass Aerobics at Luneta made it to the Guinness Book of World Records.

HL FEVER
The PHA, DoH, World Health Organization-Manila and Heart Foundation of the Philippines and tertiary hospitals (which are PHA-accredited training institutions) and pharmaceutical companies have always joined hands in holding Heart Month (every February), World Heart Day (every last Sunday of September), PHA Annual Convention & Scientific Meeting (every May) and special projects that are hinged on the tenets of a HL in many forms, for long-term relevance.

Inherently infused with the advocacy spirit and ingenuity, the PHA family with its allies outside of the medical and pharmaceutical realms have relentlessly nurtured the Advocacy projects.

Media has stood by the PHA, it has remained as one of PHA’s constant partners.

EVOLUTION/MILESTONES
The years 2006 to 2014 are considered as the HL Advocacy’s heyday.

PHA President 2002-2003 Dr. Annette Borromeo (left) with Health Secretary Manuel Dayrit at the Feb. 16, 2003 launching of Mag-Healthy Lifestyle Tayo.
THE Medical City was one of the right places for Philippine Heart Association Director Dr. Helen Ong-Garcia, concurrent Advocacy Committee co-chair, to hype “52-100”.

Ong-Garcia graced TMC’s Heart Month 2014 celebration themed “New Heart Resolutions”.

In the audience were TMC officers and personnel as well as patients.

“Today, we earmark new goals, new targets, renew commitments to live and promote living the “52-100” way. Initially conceptualized by the World Health Organization as “52-10” to spearhead the fight Obesity among children, the PHA has adopted this and further extended this concept to “52-100”, to emphasize healthy lifestyle strategies to combat heart diseases,” she said.

Ong-Garcia added “the hardest battle we always face in this advocacy has always been the promulgation of the prevention of disease rather than the cure. It has always been known that for most doctors, frustration arises when we find that prescriptions are more often than not more welcome with our patients than moderation in food, smoking, and participating in exercise.”

The PHA advocates and lives the 52-100 way.

She went on sharing simply enumerates:

- 5: eating 5 servings of fruits and vegetables per day
- 2: Limiting to just two hours of TV or computer per day
- 0: Having one hour of exercise per day
- Zero to sugared beverages
- Zero to smoking

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Dr. Helen Ong Garcia with Dr. Eugene Ramos (4th fr. R) and other cardiology biggies
Financial crunch delays PCI, CABG

**Hypertension is the most common risk factor**

**MANILA, Jan. 24, 2014** – Non-STEMI (956 or 49.4%) is the most common condition among the 1,940 patients enrolled in the PHA Acute Coronary Syndrome Registry Program. There are 690 STEMI cases, 216 UA and 11 non-ACS cases.

Majority of 53% are more than 61 years old; 556 or 29% are aged 51-60 while 513 or 26% are aged 61-70.

Prolonged door to ER, door to ECG time and door to balloon time, and adequate door to needle time were noted.

Of this batch of patients, 184 went against the doctors’ advise to go under invasive strategy due to financial constraints (134), no consent from the patient (35) and no consent from the closest relative (15). The same record shows that 144 patients had delay in the performance of door to balloon time. The reason cited for the delay in the recommended 90 minutes door to balloon time were: awaiting informed consent, awaiting funds for deposit, delay in the referral and other reasons.

There was delay in the performance of ECG on 1,683 or 88.5% patients. The recommended time in the guidelines of ER to ECG is 10 minutes.

Three-hundred twenty patients underwent PCI while 38 underwent CABG.

Some 79% patients were managed medically, 21.1% were managed with PCI or CABG while 9% were advised to undergo coronary angiogram but the procedure was not done.

Culled from the Nov. 2011-November 2013 registry, the average number of patients per month is 80.

While there was good adherence rate with regards to Class I Drugs, there was poor counselling on Lifestyle Modification and referral to cardiac rehab.

These data were highlighted by Dr. Liberty Yaneza, chair of the PHA Coronary Artery Disease and of the ACS Registry Steering Committee during the “3rd ACS Summit: Barriers to Optimizing Medical Therapy” on Jan. 25, 2014 at the UST Hospital Benavidez Cancer Institute Auditorium. Her report was titled, “PHA ACS Registry Updates”.

She recommended that other strategies should be sought.

The patients’ risk factor profile pie shows: 76.10% hypertension, 38.80% diabetes, smoking history 33.50%, menopause 30.60% and prior angina 27.40%.

The most common symptoms presented were: chest pain or heavy pressure on the chest 1,400 or 74.5%.

The atypical/angina equivalents are: choking sensation 302, nausea/vomiting 76, epigastric pain 83 and cardiac arrest/aborted sudden death 11.

The PHA ACSR is is a multicenter, prospective, observational registry of clinical management practices and patient outcomes of ACS.

The data were gathered from 13 PHA accredited hospitals with cardiology training programs – Philippine Heart Center, UP-Philippine General Hospital, etc.
The Medical City, Makati Medical Center, Chinese General Hospital, St. Luke’s Medical Center, Cardinal Santos Medical Center, Angeles University Hospital and Medical Center, Manila Doctors’ Hospital, UST Hospital, University of Perpetual DALTA, Perpetual Succour Hospital and Chong Hua Hospital.

The top 3 hospitals in terms of number of ACS patients are the Philippine Heart Center, UP-PGH and The Medical City, necessarily in this order; 956 or 49.28 are NSTEMI cases; 757 or 39.02 are STEMI; 216 or 11.13% are UA and 11 or 0.57% are non-ACS.

The Steering Committee is made up of Drs. Eleanor Lopez, Maria Teresa Abola, Eugene Reyes, Joel Abanilla, Felix Eduardo Punzalan, Liberty Yaneza and Imelda Caole Ang who oversee the Technical Committee, consultant/Coordinators/PI, Chief/Senior Fellows and research assistants.

What’s new: export catheter – manual thrombectomy performed in selected cases with heavy thrombus burden and multiple passes effect more aspiration.

**APPLES AND ORANGES**

The topics/issues tackled were recent updates in the use of anti-thrombotics; challenges met in the management of ACS, treat the ACS. Don’t forget to get the patient’s and relatives’ informed written consent. Dialyze the patient andperfuse the coronaries as soon as possible or at the same time. This case is a question of chicken and the egg.”

Dr. John Anonuevo: “With increased efficacy of anti-thrombotics, there is a corresponding increase in risk of bleeding. Ultimately, the brand of antiplatelets and anticoagulant to be used depends on the cardiologists.”

Dr. Eduardo Caguioa: “With regards to renal failure in the setting of ACS, renal failure that develops ACS, treat the ACS. Don’t forget to get the patient’s and relatives” informed written consent. Dialyze the patient and perfuse the coronaries as soon as possible or at the same time. This case is a question of chicken and the egg.”

Dr. Rowena Casas-Rebolido: “What is the end result of early or immediate revascularization in NSTEMI? The good thing about early revascularization of unstable coronary lesions is it will prevent ischemic events that would otherwise occur during medical therapy and the bad thing is thrombus burden and unstable plaques may compromise safety or percutaneous revascularization which may increase the risk of periprocedural ischemic complications. One of the stumbling blocks is patient delay. One of the solutions is patient education.”

Dr. Gilbert Villela: “It is the obligation of PHA to find the people with risks. The Philippines does not have its own guidelines on stable angina. What are the determinants of invasive? At the PHC, the timing of revascularization is dictated by the patient himself. The 30-hour delay in door to hospital time has been noted. After the episodes of chest pains stop, they procrastinate their trip to the hospital.”

Dr. John Anonuevo: “With increased efficacy of anti-thrombotics, there is a corresponding increase in risk of bleeding. Ultimately, the brand of antiplatelets and anticoagulant to be used depends on the cardiologists.”

Dr. Cynthia de Lara: “I check the parameters of the hemodynamics of the patient. I will go more invasive rather than medical therapy.”

Dr. Bengie Magsombol: “It depends on the severity of the symptoms.”

Dr. Marcellus Ramirez: “We stick to the guidelines. Patients come from different sectors, regardless of their status, we offer the best treatment to every patient. He/she has to be aggressively managed well.”

Dr. Donato Maranon: “How far I can stretch? Always bear in mind what the guideline says about the endpoints for medical therapy.”

Dr. Timothy Dy: “What’s New in the Invasive Management of ACS? ACS is a spectrum of clinical presentations: STEMI, NSTEMI and UA. It is almost always associated with a ruptured plaque with partial or complete thrombosis.

Primary PCI is the recommended treatment for STEMI. Though controversial in patients with NSTEMI and UA, if there are high-risk features (shock, prior CABG or MI, CHF, arrhythmia) urgent revascularization is likewise recommended over conservative treatment.

Summarizing the RIVAL Trial, he said: “radial access prevents major vascular complications; radial access may be particularly beneficial in high volume center and in STEMI”.

He added : “What’s new? Access: Femoral to radial “miniaturization of equipment without sacrificing catheter lumen, torque-ability and support; “radial access gives rise to less access site complication: easier hemostasis, less hermatoma and earlier mobility; no need for bed rest.

In the (previous) standard PCI technique: load patients with ASA and Clopidogrell +/- GPIIbilla; femoral access; coronary angiogram with diagnostic catheters; administer heparin; shift to a guide catheter; wire vessel; perform balloon angioplasty and finish with stenting.”

**ACSM UPDATE**

The topics/issues tackled were recent updates in the use of anti-thrombotics; challenges met in the management of ACS; optimal timing of coronary intervention and what’s new in the invasive management of ACS.
BP ng Teacher Ko... revs down

The BP ng Teacher Ko... Caravan was temporarily stalled until the memorandum of agreement among the Philippine Heart Association, Department of Education, Philippines Society of Hypertension and LRI-Therapharma is signed.

Thus, the PHA Council on Hypertension under the leadership of its chairperson Dr. Irma Yape conducted just one BP ng Teacher Ko... clinic on Jan. 30, 2014 at the Pilar Elementry School in Pilar, Bataan. Giving their all-out support were PHA Central Luzon President Dr. Gil Francis Pelagio and his members – Drs. Orlando Bugarin, Domicias Albacite and Honesto del Rosario; DepEd personnel and Bataan-based health professionals – Drs. Noel Reyes and 32 nurses.

In a related development, Pharex committed anew to sustain http://www.pinoyhighblood.com/ this year, while the complete PRESYON 3 data saw print in the Philippine Journal of Cardiology January 2013-June 2013 issue.

PHA is RCA Meet 2015 host

The Resuscitation Council of Asia (RCA) will have its official website while the Philippines will host the RCA Meeting in May 2015 were among the highlights of the 10th RCA meeting in Seoul last month. The RCA Meeting in Manila will be conducted as a Pre-Convention activity of the 46th PHA Annual Convention and Scientific Meeting.

Two of the most high-profile CPR gurus, current PHA Council on CPR chair Dr. Orlando Bugarin and his predecessor Dr. Francis Marcellus Ramirez attended the meeting.

Ramirez and Bugarin joined members from Singapore, Japan, Korea, Taiwan and Thailand.

The group unanimously agreed on the establishment of the website which will serve as a link for speedy communication among the members and as a source of news updates for all the members. Other matters tackled were: RCA’s financial status and funding/management of the website.

The next RCA Meeting which is slated for February 2014 will be held in HongKong while the June meeting will have Taiwan as venue.

The International Liaison Committee on Resuscitation (ILCOR) meeting will be held in Canada. The Council has conducted seven trainings in the following: New Sinai Hospital, Cavite (Trainors: Drs. Valenzona and his group); Dagupan Doctors Hospital (Trainors: PHA Northern Luzon); PHA Heart House (Trainor: Dr. Eric Cinco and Ning Grande); Capitol Medical Center ( Speakers: Drs. Allan Romero, Gynna Cabrera, Melco Perez, Irma Yape, Ryan Padilla; Megacode: Dr. Floyd decilles Jasmin); Cagayan Valley Sanitarium, Trainor: Dr. Elmer Linao & Ning Grande) and Cardinal Santos Medical Center.

CPR Guidelines for Chapters OK’d

The PHA Board has approved the CPR Guidelines for the Chapter which will soon be circulated among the Chapter presidents and CPR trainors.

Dr. Orlando Bugarin, chair of the PHA Council on CPR presented the guidelines to the PHA Board and the Chapter presidents on Jan. 24, 2014 at the Bayleaf Hotel in Intramuros, Manila.

The body approved the following guidelines in conducting BLS-ACLS Workshops:

1. Standardized lectures and modules of the PHA-CPR Council should be used for seminars/trainings.
2. Trainors/organizers should be certified trainors of the PHA-CPR Council.
3. Doctors, specialists or trainors of the particular seminar who are not certified by PHA-CPR Council as trainors may give lectures using our standard modules, but they cannot facilitate the megacode.
4. Organizers of seminars should coordinate with the PHA Secretariat regarding the rentals of BLS ACLS equipment, training manuals, speakers and expenses or honorarium.
5. PHA-CPR Council rates on rentals of equipment, manuals and speaker’s honorarium will apply to all BLS-ACLS training seminars.
6. The Organizers or Course director of the training seminar should inform the concerned PHA chapter about the details of the event (schedule, trainors, participants and venues); the Organizers may give at least 5 % of the net revenue of the training seminar to the PHA chapter concerned.

Meanwhile, during the January-February inclusive period, the Council has conducted seven trainings in the following: New Sinai Hospital, Cavite (Trainors: Drs. Valenzona and his group); Dagupan Doctors Hospital (Trainors: PHA Northern Luzon); PHA Heart House (Trainor: Dr. Eric Cinco and Ning Grande); Capitol Medical Center (Speakers: Drs. Allan Romero, Gynna Cabrera, Melco Perez, Irma Yape, Ryan Padilla; Megacode: Dr. Floyd decilles Jasmin); Cagayan Valley Sanitarium, Trainor: Dr. Elmer Linao & Ning Grande).
ACS Registry gets fresh funds

PHA President Dr. Eugene Reyes announced that of the P1 million proceeds of the Acute Coronary Syndrome Summit, P540,000 were incurred as expenditures. The P460,000 net revenues will be used for the ACS Registry. The good news is Astra Zeneca vowed to infuse an additional P500,000 for the ACS Registry funds.

Dr. Liberty Yaneza, chair of the PHA Council on Coronary Artery Disease (CAD) said that the February 2014 ACS Registry Patient/Hospital Activity Report showed the following: Philippine Heart Center (665), UP-Philippine General Hospital (315); The Medical City (255); Makati Medical Center (119); St. Luke's Medical Center (121); Chinese General Hospital (117); Cardinal Santos Medical Center (112); Manila Doctors Hospital (107); Angeles University Hospital (98); University of Santo Tomas Hospital (98); University of Perpetual Help-Delta Medical Hospital (43); Perpetual Succour Hospital (21); Chong Hua Hospital (9). These translate to a total number of 2,080 patients. Vis-a-vis the same report for January 2014, the total was 1,940 with the same hospitals – PhC, uP-Pgh and tmC as top three leading institutions in terms of number of ACS Registry Patients. The December 2013 ACS Registry had 1,702 patient-enrolees.

New CAD Guidelines underway

Three groups – the ST Elevation Myocardia Infarction (STEMI), Non-STEMI and Stable Ischemic Heart Disease (SIHD) under the CAD Council, headed respectively by Drs. Victor Lazaro, Sue Ann Locnen and Myra Dolor-Torres, with their Task Force members, are in the middle of crafting the clinical practice guidelines for the management of patients with these cases. The discussions, highlights and changes of the statements, as well as presentation of the grade system are being fast-tracked.

FROM MAG HL... from Page 20

good media materials like Deadma?, Dead Ka!, PHA Healthy Heart Cookfest I and II; Mag-HL Tayo sa Resto I and II; Tugtog ng Puso (Keeping Filipino Hearts Healthy); PHA-DzMM Magandang Gabi, Dok tie-up; PHA Assembly for Advocacy or PHA AAA; PHA-Vice Mayors League of the Philippines collaboration; P1.9M support from Novartis for the Hypertension Awareness Campaign; P800,00.00 PHA-Abbott deal that nurtured the First PHA Diet Guide; Mag-HL Tayo sa Resto II; Mabuhay Ka, Pusong Pinay (Long live, Filipino Women) AVP; Healthy Lifestyle Passport and BP ng Teacher Ko, Alaga Ko!

The HL tagline has gone beyond its Advocacy fibre. PHA pillars have recognized and zeroed in on the value and marketability of the HL peg. Even entrepreneurs have capitalized on the Healthy Lifestyle tagline’s viability.

REWARDS

PHA bagged the Special Trailblazer Visionary Leadership Award from the Department of Health and the Philippine Coalition for the Prevention and Control of Non-Communicable Diseases, “for being the foremost and staunchest ally of the coalition in the promotion of a Healthy Lifestyle.”

The PHA citation which was the culminating part of the 2009 Most Outstanding Healthy Lifestyle Advocates Awards Nights on Nov. 27, 2009, came with a P100,000 prize.

PHA acknowledged the commendation with this statement: “This award validates the efforts of the PHA and all its leaders who embraced HL advocacy as a flagship project. It likewise inspires all future leaderships to invigorate and sustain the thrust on a campaign that needs more to be done.”

The major programs were relatively good exploits. But admittedly, despite the popularity of the HL tagline, PHA cannot lay claim on the fact that HL is synonymous to PHA. It has not hit its ultimate target due to financial constraints. It can never beat or at least be at par with the marketing blitz of business establishments with deep pockets. The gratis air time and editorial space from media is appreciated but realistically, it is not enough to warrant name recall or a lasting impact.

PHA continues to explore new frontiers in Advocacy. This includes broadening the network of HL allies and widening of door of opportunities for the PHA.

Mag-Healthy Lifestyle is timeless but the digital and new media age times dictate that a re-branding is the best option. Let’s “Take 52-100 daily”. ♥
Postgrad course draws healthcare pros; a big success

CAGAYAN DE ORO CITY, Feb. 28, 2014 -- In celebration of Heart Month 2014, PHA Northwestern Mindanao Chapter held a Cardiovascular Postgraduate Course on the “Current Trends in Heart and Vascular Diseases Management” for all health professionals at the Cagayan de Oro Mallberry Suites Hotel which turned out to be a big success and was graced by PHA President Dr. Eugene Reyes.

PHA NW Mindanao Chapter President Dr. Josephine Saligan said “it was a well-attended CME activity that was designed for all healthcare professionals, knowing that nurses and technologists directly assist us in the monitoring and care of our patients especially those in the ICU and heart station.”

She added “we harnessed our very own Chapter members as speakers to give recognition to the driving force of the region’s Cardiovascular Care. It was a venue to showcase what is currently available, what is new and accessible to the patients like the Cathlab and Open Heart Surgery in CDO.

Finally, the postgrad was a convergence point of the NW Mindanaoan members who are geographically far apart from each other. These cities are Tandag, Surigao, Butuan, Bukidnon, Zamboanga, Dipolog, Oroquieta, Ozamiz and Iligan. The event was punctuated by the business meeting and fellowship dinner with the PHA president.

JSALIGAN, MD ♦
THE PHA Cebu Chapter recently held its 15th post graduate course last January 27, 2014 at the City Sports Club Cebu with its theme: “MATCHPOINT: When A Critical Decision Decide the Outcome.”

The day started with a trivia game, “UTOKAY PHA-edition”. The Perpetual Succour Hospital fellows bagged the first place, followed by the representatives of the Philippine Pediatric Society and the Philippine College of Physicians garnering second and third place respectively. The symposium then formally opened with a little history and a parade of the chapter members in their Chapter jackets.

There was a diverse array of topics of relevance to clinical practice. The top-notch speakers included Dr. Edgar Tan who discussed the topic: “When a patient on oral anticoagulant develop ACS: is it safe to kick serve the antiplatelet?”. Drs. Rudy Amatong, Francisco Chio, Jr and Florenz Eubil Bilocura revisited the Patent Foramen Ovale and its closure.

ACS: is it safe to kick serve the antiplatelet? Drs. Rudy Amatong, Francisco Chio, Jr and Florenz Eubil Bilocura revisited the Patent Foramen Ovale and its closure.

The afternoon session started with a lunch symposium with Dr. Mohammad Ali Adbul Kadir as guest speaker. The J syndrome and early repolarization pattern was tackled by Dr. Marivic Vestal. Pulmonary hypertension was extensively discussed by Drs. John Clifford Aranas and Jose Albert Mejia. Dr. Carolyn Fermin likewise discussed the latest in the management of nocturnal blood pressure surges. The day concluded with Drs. Ana Marie Cabaero, Bernadette Halasan and Robert Paul Cantoy who talked about “Emerging Dilemmas in Statin Use: A Grandslam Bid to Conquer Dyslipidemia”.

It was indeed a meeting of the minds. A total of 359 registrants attended the day long didactic sessions.
PORAC, Pampanga, February 9, 2014 – It was a Sunday of sharing for the St. Luke’s Heart Institute Alumni who travelled through rough roads to reach the village of the indigenous Aetas. “Project Red” was a Heart Month activity spearheaded by SLHIAA President Dr. Malou De Jesus and Project Coordinator Dr. Manolito Turalba.

Over 50 families benefited from the medical mission. Several relief packs were distributed consisting of blankets, canned goods, and noodles. This happy interaction was also a rare occasion to serve our underprivileged brothers. Games were played and the smile and laughter of these kids just blended so well with their thick and frizzy hair enough to warm the hearts of alumni. The balloons were a hit with the kids, leading them to chant “lobol, lobo!” They broke into riotous joy as they got their balloons. The families feasted on “adobo” and “lechon paksiw” prepared by the alumni themselves. In appreciation, the elders of the Aetas performed their tribal dance and some kids did a song number, expressing their pride in being aetas and in what they can do. “Project Red” was a cool way to gain healthier hearts for these cardiologists.
After over two decades in the cocoon, Electrophysiology (EP) in the Philippines is ready to move to the next level. Starting out with a core of dedicated, hardworking physicians from the Philippine Heart Center, Makati Medical Center, St. Luke’s Medical Center and the Philippine General Hospital, the group can now boast of spearheading and founding a now 30-strong society called the Philippine Heart Rhythm Society (PHRS), headed by Dr. Belen Carisma and Dr. Anthony King, which was formally inaugurated in May 2013.

The society’s goals are: to educate by simplifying the study and practice of arrhythmia, something which many have unreasonably grown to dread; to make its treatment more accessible to Filipinos.

As its maiden project, and hand in hand with the Philippine Heart Association, the society will be holding its first annual meeting on May 27, 2014, also serving as the Pre-convention activity of the Philippine Heart Association.

Budding cardiologists from different hospitals in the country will present their analyses of their very own arrhythmia cases, with the top three cases being recognized with awards after the activity.

The afternoon will be devoted to presentations by Dr. Rodrigo Chan, a graduate of the University of the Philippines and the Mayo Clinic, and currently practicing at the Banner Heart Hospital in Arizona, on The Atrial Defibrillator: State of the Art Treatment of Atrial Fibrillation. This will be followed by Dr. Giselle Gervacio’s presentation on Early Experience on 3D mapping: Bridging the gap during RF ablation.

Now available at the St. Luke’s Medical Center, 3D mapping has allowed the performance of more complex ablations including ablation of atrial fibrillation, ischemic ventricular tachycardia, complicated accessory pathways and atrial tachycardia, procedures which previously could not be successfully performed in the Philippines.

After the meeting, continued camaraderie and a lively exchange of ideas is expected during the society’s fellowship night to be held at the CHOPS, Edsa Shangri-La on the evening of May 27.

For the rest of the year, spearheading research on arrhythmia as well as More Advanced Discussion (MAD) about Arrhythmias meetings in key cities around the country are also on the drawing board. The former is expected to serve as the basis for future policy making, including possibly Medicare coverage for the treatment of arrhythmias, while the latter is our attempt to bring the discussion of arrhythmias to our colleagues in the provinces.

All in all, with its sights set on simplifying the study and treatment of electrical problems of the heart and making it more accessible to all, the PHRS butterfly is ready to emerge.
Two months after “Yolanda”, avalanches of aid and support for Leyte still keep cascading. The generosity contagion is in the air. So the Philippine Heart Association (PHA) staged “After the Storm” fundraising-concert on January 25, 2014 to be able to give further assistance to Tacloban.

‘AFTER THE STORM’
SONGS FROM THE HEART

By Gynna P. Gagelonia

The Philippine Heart Center DAPA Hall’s stage assembled musically-inclined people from Philippine theatre and the music industry, the medical/cardiology circuit, and the pharmaceutical community with the singular goal to chip in the funding for the Tacloban cardiologists.

PHA’s Luciano Pavarotti Dr. Joel Abanilla is the man behind “After the Storm” and several past gigs of the association.

The group was composed of singers of different generations with their genre of music -- veteran performers like Noel Cabangon, Cocoy Laurel, the UP Concert Chorus, the Fortenors, Jai Aracama, PHA talents (Drs. Abanilla, Nannette Rey, Marienella Francisco, Mark Brillantes and Rodney Jimenez as well as PHA Southern Tagalog heart doctors) and fast-rising talents like Miguel Aguila, Hadasa Von Camporaso, Valerie Fortuna, Keith Sison and Monaliza Darao.

Spotted among the audience were top names from the cardiology (some came with their spouses, family friends and patients) pharmaceutical and music/entertainment scenes.

Fides Cuyugan-Asencio, grand dame of Philippine stage and voice mentor to generations of Filipino performers. She was Abanilla’s vocal coach during the latter’s high school days. Cuyugan-Asencio has been a fixture in Fellowship Nights of the PHA. The Morato and Cuenca families were in full force. One of ABS-CBN’s most bankable stars, matinee idol Jake Cuenca came with his father Juanito.
Cuenca, grandmother Elvira Morato-Cuenca and grand uncle Manoling Morato, former Movie and TV Review and Classification Board chair and former Philippine Charity Sweepstakes Office chair and director. And former actress Imelda Ilanan who is an epitome of a woman who is aging gracefully. Ilanan, the mother of actress Maricel Laxa-Pangilinan is married to Ben Avancena, a cousin of Abanilla.

The cardiology group was led by PHA pillars -- Dr. Rafael Castillo (with his wife Dr. Rebecca); Drs. Marcelito Durante, Raul Jara, Dr. Mariano Lopez (with his wife Joy) Dr. Maria Teresa Abola (with hubby Mel), and Dr. Ma. Belen Carisma.

PHA members -- Dr. Ma. Adelaida Iboleon-Dy, chair of the PHA Council on Congestive Heart Failure and an active

Jake Cuenca & Dr. Francisco
member of the PHA Council on Women's Heart Health. She is the assistant medical director for medical education and training of St. Luke's Heart Center Global; and Dr. Leandro Bongosia who is also a singer.

While Dr. Francisco was belting out “Maria Mercedes”, Cuenca went up the stage to dance with the singing doctor. Cuenca is one of the lead actors of the network’s soap “Maria Mercedes”, an adaptation from the Mexican telenovela.

After his number, Laurel sat with the audience and watched his colleagues. A stage and movie talent, he’s part of the original cast of Filipino theater artists who joined Miss Saigon in London and later on in Australia. He is a son of the late Philippine Vice President Salvador Laurel and stage luminary Celia Díaz-Laurel.

Abanilla got full support from his fellow Board of Directors –Drs. Eugene Reyes (president); Alex Junia (secretary) Raul Lapitan (treasurer), Jorge Sison (director) Jonas del Rosario (director) and Helen Ong-Garcia (director) as well as Saturnino Javier (immediate past president), who ably emceed the show.

“We produced this benefit concert specially for our PHA brothers and sisters who were displaced by Yolanda. To all the performers, our pharmaceutical sponsors and PHA members who bought tickets and to our members who had to travel far to support this project, we can’t thank you enough,” said Reyes.

Despite their hectic skeds, these wonderful people said ‘count me in’. Most of them have been part of past PHA Fellowship Nights.

One of PHA’s perennial emcees, Ong-Garcia, who is also known as Hogar to friends said “we are so pleased that all the talents in this show are well respected and have made waves here and abroad.”

Abanilla said “some of you might be wondering that this concert for a cause is kinda late in the day. We have the purest intentions to extend help to the same people anew. Holding it in November or December was difficult as most venues had already been blocked.”

PHA Secretary Dr. Alex Junia, one of the heavyweight cardiologists in Cebu, said: “exactly two months after the Yolanda surge, our colleagues from Tacloban, Palo and Ormoc are getting back on their feet because of their resilience and ingenuity. But any amount or form of help from us will pep them up. They will rise from their ruins.”
TAGUIG CITY, Feb. 7, 2014 -- Doctors of St. Luke’s Medical Center-Global City (SLMC-GC) and members of the Fashion Designers Association of the Philippines (FDAP) teamed up to stage a unique fashion show dubbed “The Wear Red Fashion Show” at the William H. Quasha Pavilion (main lobby) of the hospital, to support Wear Red Day. Wear Red Day is a global campaign initiated by the American Heart Association (AHA) to promote heart health awareness among women. This is the fourth year that SLMC-GC’s Heart Institute, together with the Manuel and Grace Palaganas Women’s Heart Health Unit (WHHU) is hosting Wear Red Day.

The Fashion show showcased some of the best red creations of FDAP members, modeled by female doctors from St. Luke’s cardiology, obstetrics & gynecology, pulmonology, pediatrics, geriatric medicine, internal medicine and dentistry units. The program opened with an acoustic rendition of “Firework” by Lee Grane of the Voice of the Philippines, followed by St. Luke’s doctors who gamely strutted the catwalk for the advocacy. Some of the country’s beauty titlists and professional models also joined in to lend their support.

WHHU, the only facility in the country dedicated to women and their unique cardiovascular concerns, likewise offered free ECGs to the first 150 women aged 18 years old and above who came to SLMC-GC wearing red.

According to AHA statistics, coronary heart disease is the no. 1 killer of women aged over 25, but only 13% see it as a serious threat. The association thus decided to mark every 1st Friday of February as a day not only to wear something red, but also for men and women to join forces and commit to combating the disease.

Locally, statistics of the Department of Health lists diseases of the heart and diseases of the vascular system as the number 1 and 2 causes of female mortality in the country. Unfortunately, majority of women in the country think that they would most likely die of cancer than of a heart attack, according to a study conducted under the Philippine Heart Association Council on Women’s Women’s Heart Health.
The University of Santo Tomas Hospital Section of Cardiology and the Thomasian Heart Specialists Alumni Association (THESAA), will conduct its annual summer postgraduate symposium - a one-day comprehensive course entitled “Fantastic F.O.U.R.: Unravelling the Challenges of Important Cardiac Diseases” at the Subic Bay Travellers Hotel, Olongapo on April 4, 2014.

The course aims to provide the basic must-knows in the recognition and management of four important cardiac emergencies: hypertensive crisis, acute coronary syndromes, arrhythmias and heart failure. Fantastic FOUR, also stands for the titles of the lectures that will serve as main content of the course: “Fighting Hypertension the JNC8 Way” by Dr. Joselito Atabug; “Overcoming the challenges of acute coronary syndromes - by Dr Wilson Tan De Guzman, Uncomplexing complex Arrhythmias” by Dr. Marcellus Francis Ramirez; “Rescuing the Failing Heart” - by Dr. Alvin Lim. The afternoon session will feature an interactive ECG workshop and gameshow.

In the same tradition as the first three postgraduate courses “FIRST BLOOD: Simplifying Cardiac Emergencies” in Balanga, Bataan in 2011, then “CLIFFHANGER!: The Tools and Tactics in Dealing with Cardiovascular Emergencies”, in Legazpi City, Bicol in 2012, followed by “TOTAL RECALL of Basic Tips and Tricks in Emergency ECGs” in Laoag, Ilocos Norte in 2013, the UST Section of Cardiology and THESAA have kept the custom of naming their vents after titles of blockbuster Hollywood movies. The title “Fantastic Four” was chosen to also commemorate its 4th out-of-town summer postgraduate course.

The organizing committee, led by Dr. Cindy De Lara, THESAA president and overall-chair, and Dr. Clarissa Mendoza, this year’s Scientific Committee head, promises a day of learning new tips and tricks in the management of cardiac emergency cases. For details on the course, you may contact the Secretariat Luz Calapre at 09162172565; 7499738; or e-mail: USTTHESAA@yahoo.com, Facebook: Thesaa Usth.

MANILA, January 25, 2014 -- To date, the annual Save-a-Heart program of the UST Hospital Section of Cardiology has done free coronary angiogram, angioplasty and pacemaker insertion on hundreds of patients. The most recent program was held from January 20 – 25, 2014 at the USTH Cardiac Catheterization and Intervention unit.

The UST Medical Alumni Association of America, through its executive director, Dr. Primo Andres, an interventionist based in Indiana, USA, has kept its partnership with the USTH Section of Cardiology headed by Dr. Milagros Yamamoto. Dr. Wilson Tan De Guzman, head of the Cardiac Catheterization and Intervention laboratory and Dr. Eduardo Caguioa, USTH Medical director and all the consultants have been active supporters of Save-a-Heart for the last 10 years.

It is a first-come, first-serve basis. Patients were screened thoroughly as to their indications for the said procedures. Nineteen patients underwent Diagnostic Coronary Angiography, four had PTCA, and three patients subsequently had CABG. Moreover, four patients had permanent pacemaker insertion. All of the procedures went well and all the patients said they can’t thank UST Hospital and the doctors enough for the new lease on life.

Since it started in 2004, the Save-A-Heart which is held every January or February as a project of the USTMAA and the Section of Cardiology, has benefited a total of 160 patients. This included 110 who availed of free coronary angiograms, 38 who underwent free angioplasty with stenting, 15 permanent pacemaker insertion, 2 implantable cardioverter defibrillator insertion, and 5 open heart surgeries.

Overall, this year’s Save-a-Heart was a big success. The patients have grown in numbers every year. This event has again exemplified the Thomasian’s kind and compassionate heart - one that is always willing to help others in their own special way; a heart that gives back to the community a service that needs nothing in return; a heart that will provide the utmost care and long-term benefit for the patients. This annual event has always introduced the Thomasian Heart to the whole cardiology community.
Outstanding UP-PGH Cardiology Awardee

By Paul M. Reganit, MD

ALABANG, MUNTINLUPA, Jan. 11, 2014 -- The University of the Philippines-Philippine General Hospital Cardiology Alumni Association unveiled its advocacy program at the Ayala Alabang Country Club, honoring Dr. Romeo Ariniego with the 2014 Outstanding Alumni Award.

Witnessing the citation rites were PHA president Dr. Eugene Reyes along with the CVS consultant staff led by section chief Dr. John Anonuevo and Drs. Ramon Abarquez Jr, Rody Sy, Nelson Abelardo, Raul Jara, Yobs Punzalan, Ricky Tiongco, Paul Reganit, Eric Gloria, Elmer Llanes, and Donny Magno.

The outstanding alumni award is given to a person who has had significant contributions in teaching, training, and research. Ariniego has made a lasting impact as a teacher, mentor, and academician while at the helm of Dela Salle College of Medicine and Dela Salle University Medical Center in Cavite. He was presented the Oblation statue for his services in the field of medicine. Dr. David Salvador, PHA Southern Tagalog Chapter president, was duly represented.

In his message, Reyes focused on the theme “Registries, Research, CME, and Advocacy” and the need for mission, core values, leadership, and outcome measures. For his part, Ariniego emphasized the importance of having a mentor, and identified and thanked Abarquez as his own role model.

On the lighter side, the CVS fellows prepared an audio-visual presentation chronicling the history of the UP-PGH Section of Cardiology through the years, capturing endearing and iconic moments which elicited laughter from the audience. Songs followed and wine flowed against the genteel backdrop of the expansive green of the golf course. It was indeed a soothing night among friends!

Heart Week Celebration centers on Mag HL Tayo

By Joey Duya, MD and Paul Reganit, MD

IN LINE with the celebration of the National Heart Month, the UP PGH Section of Cardiology launched the UP-PGH Heart Week 2014 themed “Stop Heart Attack! Mag-Healthy Lifestyle Tayo!” on Feb. 10, 2014. In response to the increasing number of patients having coronary artery disease, it advocates lifestyle modification as primary and secondary prevention for heart attack.

The opening program was attended by cardiologists of the section, headed by Dr. John Anonuevo, with former section chiefs -- Drs. Raul Jara, Nelson Abelardo, Rody Sy, and Ramon Abarquez, Jr., Dr. Eugene Reyes, PHA President, gave a very light, yet informative talk on ways to promote healthy behavior. He promoted the “52-100 – Jumpstart your Heart Slogan” of the PHA -- Consume 5 servings of fruits and vegetables daily; limit salt intake to less than 2g/day; limit video time to less than 2 hours a day; 1 hour of aerobic exercise most days of the week; zero intake of sugary drinks and alcoholic beverages; zero smoking.

Members of the newly organized PATCHED support group, an organization of patients with adult congenital heart diseases were also in attendance.

To aid in the section’s advocacy to disseminate quality health information to the public, an informative instructional video was launched discussing the presentation, management, and prevention of acute coronary syndrome to lay people. The video will be flashed daily on newly donated television screens in the medical wards (Ward 1 and 3). The program culminated with an energetic dance number by members of the PATCHED group.
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

I HAVE been married for almost 29 years and have four children and one grandson.
I’ve been a doctor for 31 years, an internist for 22 years and a cardiologist for 17 years. (It depresses me sometimes to think that I have been reading ECGs far longer than my residents (average age 26).

In my off times, I like to read and I dabble in writing and illustrating stuff. Most of what I do is trash, but it entertains my friends and kept my kids amused when they were young. There’s nothing like telling a story and having your mother illustrate the princess being carried off by a dragon. Now that the kids are grown-up, I discovered that my craft fascinates my residents too – there’s nothing like a teacher/consultant who can illustrate the cardiac cycle complete with the valves and papillary muscles.

I also like to travel and eat. Fortunately, I choose my friends with care and associate only with those who appreciate my bumper sticker: “EAT RIGHT,

EXERCISE EVERYDAY, DIE ANYWAY.”
Long ago, I made the decision that if ever there would be a conflict between the career and the family, the family takes precedence. I realized that that principle may have kept me from advancing as quickly as I would have liked. And to be honest, there may have been some “what-ifs” but honestly, now, I have no regrets and I would make all the same mistakes, live it all the same if I had to.

Celine Aquino, MD
Cebu Doctor University Hospital

IN my work, I try to put God first. Right now the kids are all grown-ups so sometimes, I spend more time working. But I see to it that I keep Doris happy (wink, wink...). I make sure that I am in the right relationship with God and other people. That is my stress buster.

Efren Jovellanos, MD
PHA Past President, Northern Luzon Chapter
Dagupan Doctors Memorial Hospital and Nazareth General Hospital
FOR me, the key to balance is BELIEVING and OBEYING Matthew 6:33: that when you seek FIRST God’s kingdom and righteousness, ALL these other things that we care about: family, work, personal matters, will be added to us. Only when priorities are in the right order can balance be achieved.

Edward-Bengie Magsombol, MD
St. Luke’s Medical Center

RETURNING to Tarlac 17 years after my pursuit for my life-long dream of becoming a doctor stirred in me ambivalent emotions. Like most junior cardiologists in practice, I braced myself for the day-to-day struggle of building my career. I recall being updated with current events as clinic hours were spent reading newspapers back and forth. I remember being absolutely flustered at the horrors of becoming a “tax-paying” citizen.

However, the generosity and trust of my colleagues in Tarlac that helped shape my professional path into a better form. The many years of medical school education and training proved to be my greatest ally against the colossal task of preparing for my upcoming wedding. In between clinic hours and hospital rounds, I managed to correspond with various suppliers and coordinators with the speed and expertise of a seasoned events planner. For the first time, in many years, I appreciated being accustomed to perpetual stress.

Edward-Bengie Magsombol, MD
St. Luke’s Medical Center

I WAS brought up by my parents with the attitude of always finding time for the family, no matter how busy one is. And now, having my own core family, I make it a point to share quality time, and always communicate with my husband on a daily basis, sharing with each other the events of the day in our work. We always look for common interest as our bonding moments -- like walking and playing with our dogs, watching movies at home, eating out, travelling and most importantly going to church together.

Mary Lou Cera-Garcia, MD
St. Luke’s Medical Center

Edward-Bengie Magsombol, MD
St. Luke’s Medical Center

Charo Cachero-Bustos, MD
Jecsons Medical Center
Central Luzon Hospital
Ramos General Hospital, Tarlac

Edward-Bengie Magsombol, MD
St. Luke’s Medical Center
My infectious disease doctor-colleagues had forewarned me that during my chemotherapy I should stay away from my 4-year-old daughter who was then in Kindergarten as she would be full of ‘bugs’ from school. So I had to stay at my mother’s house for the first five days after chemo for two reasons -- I wouldn’t have too much exposure to my daughter and to avoid exposing her to my chemo agents which I would pass out through my urine. After that first chemo, one my most painful emotional experiences was to hear her come home to my mother’s house after school, excitedly shouting “Mom! Mom!” through a closed door which I couldn’t open for fear of how my immuno-compromised body would react. I cannot put into words how my arms ached at wanting to hold my child. I just sat and shed silent tears. Only another mother going through the same hurt can understand what that means.

As my chemo sessions progressed I learned how to deal with chemotherapy. I learned that I could hold my daughter and hug her for as long as she had taken her shower after coming home from school. It felt good to kiss her cool chubby cheeks and hear her ready chuckle when she was happy at something. I learned to keep a ready box of disposable masks. She thought it was fun to wear a mask when she came to my room to see me. Those little moments we had together just sitting and holding hands as I waited for my body to heal is probably one of the most rewarding reasons why getting sick gave me more time to just sit still and enjoy the moment.

I made it a point to list down things I could do as I had more time on my hands. I planned to learn to cook new recipes at home, go back to writing poems and maybe write my experience on being a cancer patient, learn a new language and finally learn how to play the guitar.

During the first few days after chemo, I felt weak and nauseous. I kept remembering that cancer patients were in a hypercoagulable state so I kept drinking and drinking water even when I didn’t feel like it. I could taste the chemo drugs on my tongue and it actually helped to have food in my mouth so that I wouldn’t feel the chemo aftertaste. The intra-venous anti-emetic agent I was given was so effective that I never vomited throughout my chemotherapy. The weakness was also partly because I would have to get up every 2 to 3 hours to urinate since I was taking in so much water. Despite the weakness I made it a point to force myself not to break my routine of exercising every morning before having breakfast.

On the third week after my first chemo I had a hair stylist trim my hair even further as I prepared for my hair to fall out. She styled it crew-cut. The glory of a woman is in her hair, hence, I felt like I was losing a big part of my femininity. I told myself I would wear bigger earrings so I wouldn’t be mistaken for a guy. Even with my crew cut, hair started falling on the third week. So, in exasperation, I asked my husband to shave off my hair completely. It felt strange running my fingers through my pale bald head for the first time. It was only at this time that I really appreciated how ‘oval’ my head was. While my hair was falling out, my eyebrows started thinning. I learned a lot of things -- how to pencil in my eyebrows to make them look thicker; the meticulous process of putting on a scalp cap before putting on my wig to make the wig fit better; how to shampoo and condition my wig regularly; and the proper way to comb it to make it last longer; to take more care with my appearance so that I could at least, have some semblance of normalcy. It wasn’t really an attempt to hide the fact that I had cancer but it was a personal attempt to affirm that I was still alive, that I was fighting cancer and that I was still attractive even if it was through my Eryn, now 7, and myself with my hair back to its former length.
that the salesgirls who saw me regularly doing grocery never even figured that I was undergoing chemotherapy or that I had cancer. They thought I had an allergy which was why I always had a mask under my chin!

I would drive myself going to the hospital and I appreciated how the drivers of other drivers gave me preferential treatment by pulling out to give me a parking space while they double parked. When I passed by the hallway or bought medicine at the Pharmacy, people would call out to me and ask me how I was doing. Some would just give me a small smile. I didn’t bother to find out if they were doing it out of concern or pity. All knew is that somebody cared enough to give me a smile and I showed my appreciation by smiling back. I didn’t know if by knowing I had cancer and was fighting it I might inadvertently be giving hope to someone going through the same trial.

As I went through chemo I continued to claim before the Lord that if He had a specific purpose for allowing me to have cancer then He should enable the mass to be reduced by 50% after the third cycle. A repeat Chest CT scan done after my third cycle showed that the mediastinal mass had reduced by more than 50%. My family was overjoyed at the outcome. I baked a special dinner for my family as we thanked the Lord and we were overjoyed at the outcome. I continued to claim before God that if he had a specific purpose for allowing me to have cancer then He should enable the mass to be reduced by more than 50% after the third cycle.

It was very humbling to compare notes with lay patients and I felt it helped them realize that doctors are just as human as they are and go through the same pain and suffering as they do.

Growing back my hair

eyes alone. The motions I was going through to improve my appearance helped me maintain my self-esteem when at the back of my mind I wasn’t sure if, at the end, I would make it.

My oncologist had warned me that my skin would get darker and that my nails would assume a grayish discoloration. It was a godsend that the fashion trend for nail color was dark shades. I had been conservative in the past with my color choices preferring creams and peach shades. Using darker shades of nail color made me appreciate how well they hid my discolored nails and how much fairer they made my skin look. My tongue eventually developed a bluish discoloration and often, I felt better having something in my mouth as the taste of food blocked out the taste of chemo that was perpetually in my mouth.

Growing back my hair

I had always been one to have mouth sores whenever my resistance was down prior to cancer. On the third week after every chemo cycle my mouth would have 5-6 mouth sores at a time. It was after the fifth cycle that I was so expectantly because it gave me something to look forward to. I opted to do all my chemo at my institution so that other doctors and other patients could see that it is possible to get it done there. I would carry my chemo paraphernalia with me from my office to the Onco Unit. I must have carried my wig so well because a husband of a patient complained to the nurse one day “Si doktora pala binibigyan din ng pulang gamot na ‘yan tulad ng misis ko eh hindi sya nakakalbo. Ang misis ko nakalbo natin!” The Onco nurse laughingly informed him, “Tay, naka-wig na rin po si doktora.” When people complimented me on how well I looked, I would joke around that I looked even better when I didn’t have cancer. It wasn’t so much that I was callous about having cancer rather I didn’t want to lose my sense of humor despite the cancer. I learned to take better care of how I looked. I always kept it a personal policy that when one is a patient, one doesn’t need to smell or look like a patient!

Sometimes, while doing outpatient chemo, I would be seated close to or near one of my own patients whom I had previously given cardiac clearance to. It was very humbling to compare notes with lay patients and I felt it helped them realize that doctors are just as human as they are and go through the same pain and suffering as they do.

As to my clinical practice, when I tried to get back to practice in between chemo sessions I found out that I would tire easily. Since I still had an income as an echocardiographer, my secretary distributed my outpatients to different cardiology colleagues. At the first sign of a respiratory infection, I was immediately put on antibiotics so that my next chemo session would be on schedule. There was just one instance where my white blood cell count went low enough to require Granulocyte Stimulating Factor (GCSF) injections.

I had always been one to have mouth sores whenever my resistance was down prior to cancer. On the third week after every chemo cycle my mouth would have 5-6 mouth sores at a time. It was after the fifth cycle that I was so...
That I would have just one more chemo oncologist and I came to an agreement the lymphoma! I wanted to shout and informed me that there was no sign of friend radiologist who read the scan out clear. Imagine my joy when the Lord would allow the PET CT to come I prayed together claiming that the before the scan, my husband and ordered a PET CT scan. On the night week.

After my sixth cycle, my oncologist my husband and depressed over my mouth sores which inhibited me from eating. I broke down in front of my husband and cried. He encouraged me, telling me that I was nearly done with chemotherapy and that this was not the time to give up. There was a large sore on my tongue and about 3-4 more on my cheeks and one on my lower gum. I had to eat “lugaw” for almost a week as it was the only soft food I could tolerate. Whenever something particularly ‘hard’ touched the sore on my tongue my ears would literally ring from the pain. Somehow I made it through that week.

After my sixth cycle, my oncologist ordered a PET CT scan. On the night before the scan, my husband and I prayed together claiming that the Lord would allow the PET CT to come out clear. Imagine my joy when the friend radiologist who read the scan informed me that there was no sign of the lymphoma! I wanted to shout and share the news with everyone I met! My oncologist and I came to an agreement that I would have just one more chemo.

Immediately after my last chemo in December of 2010, I went back to seeing in-patients. It was at this time that I learned that the 6-year-old son of a diabetic female patient of mine had been diagnosed with rhabdomyosarcoma and had to undergo ray amputation of the fourth digit of his left hand followed by chemo. As I visited the boy and talked with his mother during his third chemo cycle I found him in his room staring at a cartoon feature, refusing to look at anyone in white coming in through the door. I came in wearing my white gown as I had just finished doing morning rounds. He was probably wary of anyone coming in sticking him with needles. As I left the room it dawned on me that I had no right to complain that I had been diagnosed with cancer at the age of 46 and had to have chemo when here was this 6-year-old boy his life barely starting and already he was going through what I had been through.

I continued to wear my wig as my hair grew back in. For someone who had naturally straight hair, the curly waves of my new hair was a welcome change. Some people told me that the short “do” suited me better than the shoulder-length hair I had sported prior to chemotherapy. My daughter personally requested that I grow out my hair as she prefers me with long hair.

They say that having gone through sickness makes you a better doctor. I certainly hope so. As I resumed practice I began to realize that patients being referred to me for cardio-pulmonary clearance prior to surgery for some form of malignancy seemed to be encouraged and left my clinic with a lighter heart once they learned that I had also had cancer and chemotherapy and survived.

Everyone who has ever had cancer and gone through chemotherapy has their own story to tell. Some, like myself, made it through while others, despite their brave fight, did not. No one chooses to get cancer. And I have never met anyone who is happy with the diagnosis. Some have a family history but many others, like myself, do not. Why God allows it I do not know. Why some are taken, despite the best of what Medicine can offer, and why some survive I will never understand nor will I be able to fathom. We may never know until we come face to face with our Supreme Maker and then the clay can ask the Potter finally - “Why, Lord?”

All I know is that the God who is God of all has a purpose for everything that happens in our lives and it is in faith that we trust Him.

After my diagnosis, there were those close to me who were also diagnosed. Most of them with breast cancer. Many of them doctors, like myself. As we went through chemotherapy at the same time, there was a feeling that we were in this together, a sisterhood of sorts. Some of those same friends have passed away and some are survivors. As a survivor, I can honor their memory in small ways- by passing on the wig/s and scarves that helped me through it all, by giving another cancer patient tips on how to weather the trip, by helping out financially no matter how small the amount. Many have left behind husbands and children--some adult, some as young as my own. If God should grant that I can be a mother-of-sorts to some of those kids in some small way, then I will have honored their memory.

I cannot judge those who choose to keep their journey private as the memory opens fresh wounds of times better forgotten. I write my story not to tout the fact that I survived but rather, in the hope, that my journey will find an echo in the lives of others who’ve been through it. That by sharing, they too, can encourage those travelling the same road and somehow make a difference.

My life will never be the same. It never can once you’ve had cancer. I have learned to choose what is important to me and what is not. I have learned to discern what I can and cannot change, I have learned not to ‘sweat the small stuff’ and accept the ‘it will do.’ I have learned that my life as a doctor is important but not as important as coming home and hearing a small voice calling out “Mom, you’re home!”

My son and daughter
The dynamics of PHA Board

By Saturnino P. Javier, MD, FPCP, FPCC, FACC, PHA Immediate Past President

LET me start with a conclusion first.

I have been “privileged and blessed” (some would argue that there are better terms to describe it - like punished, cursed, “masochized”) to sit in seven Boards of Directors of the Philippine Heart Association (PHA) from 2006 to 2013.

With six presidents, and six or seven new board members for the last seven years, one can consider the PHA board experience a classic example of the fine art and science of how to integrate survival instincts with Medicine, Sociology, Psychology, Labor, Accounting, Banking, Investment, Management and Legal Jurisprudence.

Every year, the PHA membership elects seven cardiologists to the Board as directors. In general, one new board member is elected every year to join the six incumbents. Occasionally, by chance or by fluke, two names may be elected and which effectively dislodges an incumbent from the Board. The directors themselves elect the officers. Traditionally, the most senior director in the Board is elected as President, and each director inches up the ladder every year to the presidency.

How are the nominees chosen? After being nominated by five PHA members in good standing and approved by the Committee on Nominations, the directors are elected by secret ballot or by electronic voting.

The votes are cast while taking into account any or all of the following – credentials (I want to believe so), personality (really?), hospital affiliation (I must concede), popularity (this is very much a democratic process), campaigning efforts (some really go on a vicious campaign).

Fortunately, this is not an election where guns, goons and gold thrive. No money here, no guns fired here, no bullies and no cheating here (to this day I believe). But this is where unseen forces work – charisma, institutional support, personality perception, name recall, pedigree and visibility. Throw in some measure of luck, destiny and divine intercession.

Seven years in seven PHA boards required me to sit through an average of five hours per meeting usually from 7 P.M. to 12 M.N., in roughly 72 monthly board meetings. Some presidents had inordinately longer meetings with fewer matters resolved, while others had shorter ones with far more issues addressed.

Fortunately again, the internet era ushered in mechanisms that facilitated discussions and agreements – particularly the e-group which allowed smaller, less critical issues to be addressed and resolved outside the meeting proper.

I must have missed one board meeting during the Cesar Recto presidency (due to a PHA-initiated healthy lifestyle advocacy campaign commitment in Boracay where I had to speak before the Vice Mayors League of the Philippines) and maybe another one during Isabelo Ongtengco’s term due to an acute viral infection. In my faithful recollection, I have not missed any other meeting hence up to my term as President in 2012-2013.

So, what happens inside the boardroom-cum-courtroom-cum-classroom-cum-gladiatorial arena?

Call these board meetings a small assembly of opinionated and decisive parliamentarians dressed in white. These gatherings gave me a ringside perspective of an active participant in an assembly of cardiologists who momentarily function as the Ultimate Multitasker – as legislator, arbiter, judge, implementer, executor, pacifier, litigator or mediator.

Here in this arena, one sees how ideas and thoughts are expounded - amidst personality differences, institutional origins, temper thresholds, parliamentary protocols, collegial sensibilities, time considerations and occasional near-inebriation when a little wine is served after dinner or before adjournment - depending on whose term one is serving under.

Through the years, one could launch a personality assessment course of each board member – when the objective, issue-driven and professional boardroom performance is juxtaposed with the subjective, personality-centered out-of-the-boardroom commentaries.

If only for the singular opportunity to see through each Board member after being up close and personal with each one for the duration of one’s stay in the PHA Board, one just could not help but feel blessed. With the opportunity came the lesson. With the lessons came the change. With the change ushered in the growth.

There were three women presidents during those years - an unprecedented phenomenon for a board that used to be dominated by male cardiologists despite the occasional emergence to power of an Esperanza Cabral or an Asuncion Reloza.

I had three women presidents – the charmingly persuasive and soft spoken Belen Carisma, the straightforward and tenaciously hardworking Eleanor Lopez and the extremely focused, nearly obsessive compulsive Teresa Abola. The terms of four male PHA presidents sandwiched the women’s. They were the ever-smiling, doggedly determined Cesar Recto, the quiet, team-playing Isabelo Ongtengco and the cool and persistent Efren Vicaldo.

Without them meaning to, and without me asking for it, each PHA president gave me a tutorial-seminar-workshop of how things should be run as the top officer of the now 60-year-old organization of Filipino cardiologists.

TO BE CONTINUED

Escape Beat

February 2014

PHA NewsBriefs
The following ECG tracings were recorded from a 66-year old female with dilated cardiomyopathy. The top 3 tracings in leads III, V1 and V6 reveal an underlying sinus rhythm with intermittent appearance of P waves which are followed by normal PR intervals and normal QRS complexes. There is no particular pattern in the occurrence of such sino-atrial driven beats (marked S). Two sets of wide QRS complexes are distinctly identifiable. The first set of wide QRS complexes having RBBB morphology are most likely re-entrant PVC’s (marked P) based on their constant coupling intervals (0.48 secs) with preceding QRS complexes. The RBBB morphology and inferiorly oriented axis of these QRS complexes point to a focus in the LV outflow tract. The second set of QRS complexes with LBBB morphology has delayed and variable coupling intervals (0.84 to 1.04 sec). They are probably ventricular escape beats (marked E) which are activated when the heart rate falls below 50 bpm. A fusion beat (marked SE with an asterisk) appearing in lead V6 is generated by the simultaneous occurrence of a normally conducted ventricular beat and a ventricular escape beat. These LBBB type QRS complexes are, in all likelihood, automatic rather than re-entrant ectopic beats based on the highly variable coupling intervals and the observed occurrence of a fusion beat. Their LBBB morphology and the superiorly oriented QRS axis indicate an RV apical origin. The protracted post-PVC pause probably enabled RV Purkinje fibers to spontaneously depolarize to their threshold for automatic discharge.

It is to be noted that the PVC’s (marked P) are coupled with either normally conducted QRS complexes (marked S) or ventricular escape beats (marked E). A succession of ventricular couplets composed of ventricular escape beats (E) and re-entrant PVC’s (P) gives rise to a run of wide QRS complexes with alternating opposite BBB morphology, bidirectional QRS axes, and divergent arrhythmogenic mechanisms. The apparent group beating is produced by the intervening post-extrasystolic pauses separating the pairs of automatic and re-entrant ventricular ectopic beats.

Seldomly encountered bidirectional wide QRS tachycardia of the third kind is actually biventricular tachycardia. The latter terminology may be exotic, but the arrhythmia being alluded to is not out of this world.
Finding the Middle Ground

TO SAY I was surprised with this invitation is an understatement. After that initial emotion, I in fact went through some sort of a denial. Am I that old to stand as a principal sponsor at a wedding ceremony for the first time? You know, those milestones in your life after hitting 40 or as present-day vocabulary goes -- life events. It seemed only yesterday when I was in your place, having graduated from residency at the turn of the century (in 2000). Wide-eyed and green-horned, I set out to make a name for myself then, filled with a mixture of hope, trepidation and excitement, leaving the comfort zone of UERMM for the first time.

But in the blink of an eye, 14 years had passed. I am equally honored and terrified to speak before you today. For what can I say that will inspire young specialists as they embark on their careers or as they pursue subspecialty training? I have been in private practice for seven years (going eight), such a short time compared to what the medical luminaries in this room have gone through. So please be mindful that whatever advice I dish out today has a seven-year warranty period. We meet again in seven years and resume this talk about life. By that time, I will be the one listening to you.

For the past weeks, I have been contemplating on what to say. Is there any prescription or algorithm for success particularly in medical practice? After the rigorous training and personal sacrifice you all have gone through, is life going to get better? This, I believe, will depend on how you define success. We should have our own idea of what success is for us and not what others think of it, for in the end, we write our own destinies. We should shape our times rather than be shaped by it. As I continue to go through my own journey, I try to uphold some ideals. I cannot claim that I am successful every time. Far from it. But I try hard to be. To seek to be better by itself is commendable. I believe. There are at least four things which I hope to always remember and try to practice. I share them with you today.

This is not in any order of importance.

Always strive for excellence. Pursue perfection in everything and anything that you do, both in your professional and private lives. In caring for patients, leave no stone untorned in finding answers to their clinical problems. When something doesn’t seem to fit, do not try to squeeze it in. It means you need to rethink your clinical impression. Read on it, go back to the books or shall I say go on line? Passing specialty examinations doesn’t mean the learning stops. But it means the responsibility increases, for your word begins to hold more weight as you accumulate more letters after your name. I have always said that wisdom is knowing what you don’t know, accepting it and doing something about it. Early on in my practice, I used to and still do in fact call doctor-friends for opinion on difficult cases. And I myself receive a number of phone calls from former trainees practicing out of town, asking for my input and occasionally I feel, just for my moral support and validation that what they are doing is correct. In the pursuit of excellence, we should not be alone. We need help and it is not wrong to ask for it. There should be no room for misplaced pride in the betterment of patient care.

Secondly, it takes a certain strength of character to be trusted with someone else’s well-being and in many instances, with someone else’s life. Doctors take a front seat in the face of human suffering and human joy. The joy, we can handle remarkably. The satisfaction of seeing patients get better is immeasurable. Occasionally, we even get heady with success and approach disease with arrogance, forgetting that we too, are just human. The suffering can also get to you, quite unexpectedly sometimes. Recently, I personally conducted the resuscitation of a long-time patient. After realizing all our efforts were futile, I proceeded to talk to the elderly husband. To my astonishment, my tears started to fall while telling him I cannot save his lovely wife. And to my utter embarrassment, he ended up comforting me, thanking me for all my care throughout the years. In my young career, there seemed to be moments when I had more difficulty than the family in accepting my patient’s mortality, mistakenly equating it with my own failure. On the other extreme, we run the risk of developing indifference after prolonged and constant exposure to the ill. Indeed, it takes a lot of character to find the middle ground in all these. But find it, we must. You will soon realize that only a few are given the privilege to witness birth, death, the joys and sorrows of other people the way we do. Take that privilege to heart and safeguard it with humility.

Thirdly, excellence and a strong character are for naught if they are not tempered with kindness. Throughout your careers, you will come across all types of people including difficult ones and very difficult ones. Patients and their relatives may become critical of you in spite of your best efforts. Equally exhausted, we are sometimes tempted to engage them in a debate. But do remember that they are distraught and may not be in the best frame of mind. Keep your composure and find the most opportune time to explain things in a language that they will understand. I personally find it helpful to end a consult with the phrase “may tanong pa po ba kayo?” for the reserved, quiet patient and for the cantankerous relative. Additionally, our patients should not be the sole recipients of our kindness. I am not asking you to be pushovers or to be the next Mother Theresa, but let us also try to think and speak kindly of others in general, especially of our colleagues and those who help us in patient care. Though we should continuously demand excellence from others, we should also do so politely because higher education doesn’t entitle anyone to talk down on people. Some say kindness opens you to abuse. I do not ascribe to that thinking. Kindness should never be equated with weakness because we can still be just yet kind.

See Page 45
The Responsible Parenthood & Reproductive Health Act of 2012

No law had undergone so much scrutiny, opposition and deliberation not only by the people and the Congress but also by the Executive Department and finally, by the Supreme Court, the final arbiter of constitutionality issues, than Republic Act No. 10354, otherwise known as the Responsible Parenthood and Reproductive Health Act of 2012.

The Act was conceived a long time ago, but was approved by the Congress only last December 19, 2012 and signed into law by President Benigno Aquino two days after, December 21, 2012 amid a number of protests. But even after its implementing rules and regulations has been approved last March 15, 2013, the Supreme Court promptly issued a status quo order last March 18, 2013, stopping its implementation indefinitely after about 14 petitions against its constitutionality were filed. On April 8, 2014, the Supreme Court finally declared the law “not unconstitutional” except for its eight provisions I will enumerate later.

The opposition boils down to several issues - the mandate of the State to promote the welfare of its people in all aspects including reproductive health, the right of a couple to decide for its own family, the family as the basic unit of society, the right of the unborn child to life and the freedom of religion and belief.

I may sound so simplistic, but the conflict lies in the different interpretation of the issues, as everyone seemed to have his own interpretation.

Since the law is on matters of health, doctors are included as “health care providers”. In fact, almost, if not all of the provisions being struck down as unconstitutional affects medical practitioners. For us cardiologists, we may find ourselves face to face with the law when a “gravidocardiac” patient and her doctor asks us or makes us decide if she will be allowed pregnancy, what contraceptive to use or even the use of cardiac medications which may affect conception and pregnancy.

I have read the entirety of the law even before its 8 provisions have been stricken down. I found its Declaration of Policy and Guiding Principles well-meaning and apt for our times. But I was appalled by some of the provisions I have considered almost dictatorial forcing one to do something against his will on the pains of being penalized. But the same provisions have been stricken down, thanks to the Supreme Court.

The law mandates the government to promote, without bias, all effective natural and modern methods of family planning that are medically safe and legal, making it available to everyone “ethical and medically safe, legal, accessible, affordable, non-abortifacient, effective and quality reproductive health care services and supplies”. Implementation of the law necessarily is a multi-agency involvement including the DOH, the FDA, the DepEd and Ched, the PMA, the LGU, the DOLE, NGOs, etc.

The eight provisions declared unconstitutional by the Supreme Court are as follows:

- Section 7 and the corresponding provisions in the Implementing Rules and Regulations, insofar as (a) they require private health facilities and non-maternity hospitals owned and operated by a religious group to refer patients, not in an emergency of life-threatening cases, as defined under RA 8544, to another health facility which is conveniently accessible, and (b) allow minor patients or minors who have suffered miscarriage access to modern methods of family planning without written consent from their parents or guardian;
- Section 23 (a)(1) and the corresponding provision in the IRR, particularly Section 5.24 insofar as it punishes a health provider who fails or refuses to disseminate information regarding programs and services on reproductive health, regardless of his or her religious beliefs;
- Section 23(a)(2)(1) insofar as they allow a married individual in an emergency or life-threatening situation, as defined under RA 8544, to undergo reproductive health procedures without the consent of the spouse;
- Section 23(a)(3) and the corresponding provisions in the IRR, particularly Section 5.24 insofar as they punish any health care provider who fails and or refuses to refer a patient not in an emergency or life-threatening case as defined under RA 8544 to another health care service provider within the same facility or one which is conveniently accessible, regardless of his or her belief;
- Section 23 (b) and the corresponding provision in the IRR, particularly Section 5.24 insofar as they punish any public officer who refuses to support reproductive health programs or shall do any act that hinders the full implementation of a reproductive health program, regardless of his or her religious beliefs;
- Section 17 and the corresponding provision in the IRR regarding the rendering pro bono reproductive health service insofar as they affect the conscientious objector in securing Philhealth accreditation;
FINDING... from Page 43

Fourthly, of all the human traits, the one which may very well carry us through some rough times is a good sense of humor. It is indeed true that laughter is the best medicine. Remember how it feels to laugh with all your heart? We all have to learn how to laugh at ourselves. And we all have to learn how to laugh with our patients. Of course, needless to say, it should be done in the most appropriate time and manner. No green jokes please. Green jokes with patients are absolute contraindications. Most patients are naturally anxious to see a doctor so in such instances, you might need to exert some charm offensive. Hold their hands, put your hand on their shoulders or simply spend extra time with them. In healing bodies, the mind and spirit are as important, more so in some occasions. By this time in your lives, I am also certain that you are concerned about the more practical side of matters, providing for your young family or simply becoming independent financially. I remember what Dr. Joven Cuanang once said when we were trainees. Always put the welfare of your patients first, do what is proper and the rewards will follow naturally. I have found that to be true in training and eventually in private practice. I can assure you that you will have everything that you will need materially to lead decent lives. You will be able to send your children to good schools, too. Sometimes, at the end of a clinic day, I am overwhelmed with the amount of gifts and food that I receive from my patients. I am sure that many other practitioners in this room feel the same way. From appetizers to desserts, I am given full meals enough to last me a week. I have always told my parents that I will never go hungry because of these. You see, what patients are forbidden to eat, they will give to their doctors. Maybe, as a form of bribe, too. On the other hand, having everything that you would want is another matter. Because wanting, may be limitless and frustrating. Between need and want is something you have to discern on your own. With the proper compass, you may continue to touch lives and your life may continue to be touched by others because the essence of medicine is truly service. Most people pay a price to feel the gratification of being useful to others but it is our privilege to be soon a daily basis.

Before I close, I wish to thank the graduates for a couple of things, one is for the care that you have tendered toward our own private patients. I know you occasionally got your own share of criticisms from us but I also know you understand why (well hopefully, you did). For all my imperfections and self doubt, I also must have done something correctly for you have invited me here today. For that, you have my undying gratitude.

Finally, I warmly congratulate you, your parents, spouses, guardians, everyone and anyone who made it possible for you to be here in this momentous occasion. I pray that we have equipped you with more than enough knowledge, skills and professionalism as you begin your life’s adventures outside the walls of this proud institution. Know that wherever your fortunes may take you, you will always have a home here. Go follow your bliss and Godspeed.

Thank you and good day to all.

♥

A-WATCH... from Page 15

and risk factor screening on public school teachers) and the two-year-old ACS Registry (a survey on patients from the 12 PHA-accredited training institutions in Metro Manila, Central Luzon and Cebu) are both work in progress. Data gathered from women will be included in the A-WATCH Registry.

Indonesian setting

“At the moment, only one government hospital which is in Bali can share data. The Indonesian Heart Society hopes that soon enough, more institutions will be able to join the A-WATCH survey,” said Antara.

Iboleon-Dy said, “at this stage, A-WATCH will make do with the data it has. We cannot generalize so we will emphasize that it was sourced from one hospital. I spoke to an Indonesian cardiologist from Malaysia. We can look at their methodology.”

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quotes from three famous people.

From Thomas Edison: “The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease.”

From Herophilus of the Ancient Grecian times, “When health is absent, wisdom cannot reveal itself, art cannot become manifest, strength cannot be exerted, wealth is useless, and reason is powerless.”

And according to Samuel Johnson: “To preserve health is a moral and religious duty, for health is the basis of all social virtues. We can no longer be useful when we are not well.”

Again, we congratulate The Medical City for this continuous enlightened program to promote a healthy heart.

THE RESPONSIBLE... from Page 44

• Section 3.01(a) and (11) insofar as it penalizes a health service provider who will require parental consent from the minor in not emergency or serious situations.

Personally, I feel some of the provisions that have been stricken down must have been upheld and some of the provisions considered constitutional must have been declared otherwise. My personal opinion of course is now moot as the Supreme Court had already spoken. I just fervently hope that whatever opposition there still is from both parties (as the pro-RH group is still considering to file a motion for reconsideration and the anti-RH group considering a civil disobedience) will now end. The Philippines has already too many problems to handle and adding one more certainly will not make things any better for the Philippines and its people.
Congenital heart defect & your child

3. **Ventricular Septal Defect** – this anomaly is a break in the wall dividing the two ventricles. The ventricles are the pumping and bigger chambers of the heart. Normally, the left and right ventricles even in fetal life are completely separated from each other by the dividing wall called interventricular septum. This assures complete separation of the blue blood coming from the right atrium and the size of the communication varies as well as the location. Sometimes there are more than one communication.

The symptoms also vary from practically none to transient cyanosis on crying or straining. A loud heart murmur with thrill (a purring sensation when the hand is placed over the chest) is heard over the heart area to the left of the breast bone.

Diagnosis is usually made by auscultation and electrocardiogram but for definite diagnosis cardiac catheterization is necessary.

Although some of these holes may close the treatment is closure by patch during surgery. If a hole does not close at age around 14 years, then no further closure is expected.

4. **Pulmonic Stenosis** – This defect produces obstruction to the normal blood flow. It is located either at the pulmonary valve or in an area called the infundibulum or outflow tract of the right ventricle.

In yet another version of this obstruction to flow of blood from the right ventricle, the pulmonary artery itself is underdeveloped. This is a difficult situation and the child is usually very sick and blue. The severity of the obstruction at the pulmonary valve or at the infundibulum again can vary from case to case. A rough murmur of obstruction is heard at the upper part of the heart area close to the breast bone.

Diagnosis is usually easy by auscultation, electrocardiogram and chest x-ray. Again from correct location of the obstruction and for pressure data necessary for definite evaluation for surgery, cardiac catheterization is necessary. Mild cases can go through life with no problem but those showing signs of increased pressure behind the obstruction, surgery is mandatory.

5. **Coarctation of the aorta** – is a constriction or narrowing in the upper part of this artery usually at the site of insertion of the ductus arteriosus. This is manifested by higher blood pressure in the arms compared to the legs. The pulse in the groin may be absent or barely perceptible. A murmur is heard at the back between the shoulder blades along the left side of the spine.

Usually this is an isolated defect but some may show other cardiac defects. It is, therefore, necessary that a complete evaluation of the cardiac status is made to rule out accompanying cardiac anomalies. The increased blood pressure in the arms carries the same risks as other high blood pressure states. The heart becomes enlarged and the possibility of breaking a blood vessel in the brain (stroke) is increased. As soon as the diagnosis is made, surgical correction becomes imperative to avoid the above complications.

6. **Tetralogy of Fallot** – This is a classic example of what is described as a complex of anomalies. It is the commonest type in this group. The primary defect is a ventricular septal communication (see #3). Nature, in trying to correct this fault, creates an obstruction in the outflow tract of the right ventricle producing pulmonic stenosis (see #4). This is the second part of the complex. For the third, the aorta instead of originating solely from the left ventricle (as in normal hearts) sits astride over the right ventricle. The fourth and last part of the complex (tetra, means four) is the right ventricular enlargement, a result directly attributable to the first two defects.

The child may remain pink or become blue depending on the interplay of the factors involved and the alteration of physical laws of fluid. Cardiac catheterization is absolutely necessary to determine precise alterations in the dynamics of the heart. Complete surgical repair is now possible in one stage operations.

This is just a capsule presentation of a few congenital heart defects. There are many more that many books and scientific papers have been written about them.

The future looks brighter as more and more of these defects become correctible with the surgeon’s knife and with better techniques. Not too long ago within our present generation, many of them die but those who will be born tomorrow will definitely have a better day. Not that we pray and wish they have a congenital heart defect but just in case they do, we can now feel happy for them. ♥
This section is a venue for continuing medical education in the various subspecialties. Section editors and contributors share valuable knowledge that would be relevant to everyday practice. Contributions, comments and reactions are welcome. Please email to eic_phan@yahoo.com

**Contributors**

**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.

**ACD & 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.

**ECHOCARDIOGRAPHY**

Edwin S. Tucay, MD – Educated and trained both in private and government institutions (University of Sto. Tomas, Ospital ng Maynila Medical Center and Philippine Heart Center), he is the best exemplar of a passionate and a compassionate physician and lecturer; and a student for life. Recently, he also earned his diploma in Master in Business Administration in Health from the Ateneo Graduate School of Business. Currently, he is secretary of the Philippine Society of Echocardiography; assistant director, Medical Services of World Citi Medical Center; an active staff, of the PHC Noninvasive Cardiovascular Laboratory. He is also very much involved with the Foundation for Lay Education on Heart Diseases (as a faculty member) and as a member of the American Society of Echocardiography and the Asean Cardiac Imaging Society. He was past chair of the PHA Council on Echocardiography.

**VASCULAR DISEASES**

Jonathan James G. Bernardo, MD – After becoming a full-fledged adult cardiologist, Dr. Bernado was trained to poke into the complexities of vascular medicine. His hospital affiliations are -- St. Luke’s Medical Center, QC; Ospital ng Makati; Commonwealth Hospital & Medical Center. A researcher at heart, he is at the helm of the SLMC Heart Institute Cardiovascular Research Committee. Committed to serve the institutions that nurtured him as a Cardiology fellow and a resident, he an active member of the Department of Education and Training, SLMC HI and Residents Training Committee of the Department of Internal Medicine, Ospital ng Makati
MODERN pharmacotherapy simultaneously attacks multiple pathways in the platelet activation and coagulation cascade. ASA inhibits thromboxane formation while Clopidogrel, Prasugrel, and Ticagrelor neutralize the ADP receptors. Cilostazol increases cAMP production and Tirofiban blocks the final common pathway of platelet aggregation. Unfractionated heparin, low molecular weight heparins (LMWH), and the direct anti-thrombin Bivalrudin block various coagulation factors in the cascade. Oral anticoagulants include the tried and tested Coumadin and the new agents Dabigatran, Rivaroxaban, and Apixaban.

Although we often take these developments for granted, it may surprise you to learn that the exponential explosion of progress and innovation in ACS pharmacotherapy only occurred 30 years ago. But it’s probably best to start from the very beginning by tracing the history of salicylates. The use of salicylates, the active component of the willow bark, dates back 3000 B.C. to the time of the Egyptians. The Ebbers Papyrus, a compendium of Egyptian medicine written around 1500 B.C., describes the use of the willow bark in the treatment of aches, pains, and fever. This practice continued and spread extensively. In pre-industrial Europe, there is abundant record of the use of the willow bark in folk medicine. The active compound would finally be extracted from the willow bark by Italian chemists in 1823 and was named salicin.

The Discovery of ASA, Heparin, and Coumadin

Many ascribe the commercialization of aspirin to Felix Hoffman, a chemist working for Bayer, who rediscovered the earlier work of the French chemist Gerhardt. Gerhardt modified salicylic acid, an effective but highly unpleasant treatment for rheumatism, to a less gastric irritating compound. Despite his discovery Gerhardt seemed uninterested in exploiting the product. Hoffman refined the procedure further and convinced Bayer to patent and market acetylsalicylic acid. It was renamed Aspirin (“A” in acetyl chloride, the “spir” in Spiraea ulmaria, the plant they derived the salicylic acid from, and “in” was then a familiar name ending for medicines. It may interest the reader to know that the patents for Aspirin and Heroin were owned by Bayer. When World War I broke out the Allies would lose their source of Aspirin. Thus, after Germany lost the war, the Allies forced Bayer to give up both patents as stipulated in the Treaty of Versailles.

There is still an existing controversy to whom the discovery of Heparin should be credited. It was initially
The thromboplastic action of cephalin

Jay McLean
From the Physiological Laboratory of the Johns Hopkins University
Received for publication, June 15, 1918

attributed to the Dr. William H. Howell of Johns Hopkins Medical School, but later authors would recognize Dr. Jay McLean, then a second-year medicine student who was doing research work under the direction of Dr. Howell. McLean isolated a phosphatide from canine liver which possessed anticoagulant properties. He named it Cephalin in his paper published in 1916. However, McLean had to leave college in 1917 because of financial difficulties. One year later, in 1918, Dr. Howell and his research assistant, L. Emmett Holt Jr., isolated another anticoagulant apparently distinct from that isolated by McLean. Dr. Howell called it “heparin” (from the Greek word for liver, hepar). McLean claimed to have discovered heparin before Dr. Howell did, although he only did it so openly after Dr. Howell passed away. The latest inquiry into this debate was from Marcum who wrote that scientific discovery “is seldom made by an individual in isolation but often occurs in a community of scholars and their intellectual history or traditions”. It was Marcum’s conclusion that “the work of McLean changed the focus of Howell’s research, pointing him to the right direction where to investigate”.

The heparin isolated in those days was impure and induced significant adverse reactions; hence its use was limited to laboratory research. Dr. C. Best, who would later collaborate with Dr. Banting and become famous for insulin, took an interest in purifying heparin. In 1937, 20 years after the discovery of heparin, Dr. Best finally obtained sufficient quantities of medical grade heparin to allow human use. At present heparin is obtained from pig or bovine intestines. The manufacturing process for heparin remains much the same today as in the early 1900’s, utilizing a sequence of extraction and filtration processes. Dr. Brinkhous would eventually elucidate that Heparin needed a plasma factor, initially named heparin co-factor but later changed to antithrombin, to exert its anticoagulant effect.

The third to be discovered was Warfarin. Around the 1920’s, cattle in the mid-West USA became afflicted with a bleeding disorder which occurred 15-30 days after they ate sweet clover hay. It was discovered by chemist Dr. Karl Link that spoiled moldy sweet clover hay caused the problem. Apparently, fungal action on coumarin, the chemical which produced the sweet smell of clover, oxidized it to dicoumarol. It was demonstrated to be a weak anticoagulant that interfered with Vitamin K dependent carboxylation of several clotting factors. Link had the idea to use it as a rodenticide, but it first needed to be altered to make it more potent and rapidly acting. This improved compound was synthesized in 1946 and was named Warfarin after the agency (Wisconsin Alumni Research Foundation) which funded their work. It was later to be known as Coumadin.

Its use as an anticoagulant in humans first came to notice in 1951 when a sailor overdosed with Warfarin in a suicide attempt. A few years after it started to be used in man, U.S. President D. Eisenhowe was treated with heparin and coumadin in 1955 during his first heart attack. He would later have more MI’s, 14 cardiac arrests and was one of the early recipients of Bretylium and the procedure called aortic balloon counterpulsion, IABP for short.

Another historical figure who received coumadin was the infamous Russian leader Josef Stalin. But this time it was used not to make him well, but rather to assassinate him. Stalin’s uncontrolled hypertension could explain the massive cerebral hemorrhage found on autopsy. However, the additional finding of massive gastro-intestinal hemorrhage raised suspicion of foul play. Lavrentiy Beria, head of the NKVD (forerunner of the KGB) later confessed he administered coumadin to Stalin in a plot that was hatched with Yugoslavian President Tito in retaliation for the numerous assassination attempts on him by Stalin. After Stalin’s death in 1953, Beria made a bid for power but was outfoxed by Nikita Khrushchev, who despaired him. Khrushchev had him arrested, charged with spying for Britain and shot.

It would take close to 50 years before ASA was used in coronary artery disease. In the 1950’s, the effect of ASA on bleeding was recognized by American
physician Dr. L. Craven as a potential treatment for coronary thrombosis. However, his scientific methods were so flawed he was only able to publish his findings in an obscure medical journal.

**The Period of Wandering in the Desert**

Despite the favorable media attention given to coumadin and heparin, their role in the treatment of acute coronary syndromes between the years 1940-1980’s was constantly debated. The same would also be true for ASA. As late as the mid 1970’s, the role of antplatelet and anticoagulant medications in the treatment of acute coronary syndromes was not yet conclusively established.

A succession of scientific articles cast serious doubt, going as far as calling their use a “therapeutic enigma”. A survey of physician practices from 1970-79 published in Circulationshowed an actual decline in the use of anticoagulants from 70% to 40%. Even the use of ASA was, at best, only 40%.

A large part of the confusion came from improperly designed trials and the influential ideas by the distinguished cardiovascular pathologist Dr. William Roberts who doubted the thrombosis theory of MI. For him, thrombosis was not the antecedent cause of MI. Rather, it was an epiphenomenon and the infarction could have led to coronary thrombosis. He wrote in an editorial published in Circulation (1974) “in conclusion, there is substantial evidence that acute thrombus formation does not precipitate acute fatal ischemic heart disease”. He goes on to quote the 1925 paper of Nathanson that “it is most reasonable to regard thrombus not as an entity, but merely as one of the end results of coronary disease.”

(To be continued)
The advancement of technology and human technical skill have made cardiac intervention expanded over the past few years. With these various cardiac interventions the role of echocardiography has also rapidly evolved to provide better appreciation of the cardiac anatomy. Current cardiac interventions that ranged from the closure of atrial septal defect to percutaneous mitral valve repair procedures, closure of prosthetic dehiscence, occlusion of the left atrial appendage, and certain catheter ablation procedures require transseptal puncture to have access to the left heart. Hence, a successful transseptal access is a significant requirement for these procedures. Unfortunately, the anatomic variability in the position and orientation of the fossa ovalis and its surrounding structures may present specific challenges even those interventional cardiologists with significant transseptal experience.

Two-dimensional (2D) transesophageal echocardiography (TEE) has been used as the imaging modality to guide transseptal crossing. Although 2DTEE can display the interatrial septum (IAS) in several planes, the planes always intersect the septum perpendicularly. Consequently, this structure is imaged as a linear echo, which may be thicker around the fossa ovalis (muscular rim) and thinner at the level of the floor. Moreover, the spatial relationship with the surrounding cardiac structures is difficult to appreciate, because this technique lacks the third dimension. In the past few years, advances in computer and crystal technology have led to the introduction of matrix-array transducers that have several thousand electrically active elements that can be used in microbeam forming to generate real-time (RT) three-dimensional (3D) images. More recently, the reduction in size of the transducer footprint has led to the development of RT3DTEE (real time 3D transesophageal echocardiography). Because of lack of interference from bone and lung, and the closer proximity of the transducer to the posterior structures of the heart (which permits imaging at higher frequencies), this technique provides real time three dimensional images of acceptable quality. A unique peculiarity of 3D echocardiographic representation is the ability to visualize septa from an “en face” perspective providing a better appreciation of the fossa ovalis in particular, interatrial septum in general and its relation to the surrounding structures.

In this review, the approach for acquiring and processing RT 3D transesophageal echocardiographic images of the IAS will be presented, septal anatomy as it is visualized by RT 3D TEE during septal puncture will be illustrated, and atrial septal defect with the surrounding structures before and during device closure will be shown.

Image acquisition of the interatrial septum

The “en face perspective” of the interatrial septum can be obtained from any transesophageal 3D angle but what is preferred is the 90 degree bicaval plane. Once the 2D transesophageal echocardiographic bicaval view has been obtained, the “zoom acquisition” modality is used. The dimension of the sectors should be as large as possible in the x (lateral) and z (elevation) directions, to include the entire IAS and surrounding structures, while the y (depth) direction should be set to include only the left and the right-sides of the septum (Figures 1A and 1B). These specific settings allow the IAS to be acquired in high resolution, excluding right-sided surrounding structures that may cover the right aspect of the IAS. The extensive area scanned causes a frame rate as low as 5 Hz which does not have a significant impact on the image since the interatrial septum is relatively immobile. Once the pyramidal data set has been acquired, a 90 degree up-down angulation shows the entire left side aspect of the IAS in an en face perspective (Figures 1C and 1D). To obtain an anatomically correct orientation, the image should be rotated in such way that the mitral valve is toward the left lower corner of the image (Figure 2A). A 180 degree counter clockwise rotation shows the right side of the septum with the fossa ovalis and the entrance of superior vena cava (Figures 2B –2D). The optimal control for imaging the interatrial septum using the Philips IE33 is shown in table 1.

Figure 1 (A,B) Multiplanar reconstruction modality (QLAB; Philips, Medical Systems) showing the extent of pyramidal truncated data set to include the entire IAS. The y direction of the sector is set to include both sides of the IAS and exclude right surrounding structures that may cover the right aspect of the IAS. (C) The acquired volumetric data set, (D) A 90 degree up-down angulation (curved arrow) shows the entire left side aspect of the IAS in “en face perspective.” AO, Aorta; CS, coronary sinus; MV, mitral valve.
Figure 2 (A) The left side of the IAS from the left perspective in “anatomically correct orientation.” Note as the truncated pyramidal data set is the largest possible in the x and z directions, this specific set allows not only the IAS to be included but also the orifice of right upper pulmonary vein (RUPV). (B–D) By rotating the volume data set in the direction of the arrow, the right side of the AS is displayed progressively, showing the crater shaped fossa ovalis (FO) and the entrance of superior vena cava (SVC). MV, Mitral valve.

Table 1 Optimal controls for imaging the IAS

<table>
<thead>
<tr>
<th>Settings</th>
<th>Scale/Control</th>
<th>Suggested setting for right atrial structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain</td>
<td>10–40 (1–100)</td>
<td>Fine tuning of gain setting, increasing the gain until noise appears and then decreasing to the lowest level possible to remove noise while maintaining anatomic structures (particularly the fossa ovalis) visible</td>
</tr>
<tr>
<td>Compression</td>
<td>1–3 (1–10)</td>
<td>Use low values that, enhancing edges, make the margins of the fossa ovalis distinguishable</td>
</tr>
<tr>
<td>Smoothing</td>
<td>6–7 (1–10)</td>
<td>Medium values maintain precise definition of the IAS while reducing the roughness of its surface</td>
</tr>
<tr>
<td>Vision control</td>
<td>(A–H)</td>
<td>Vision control F, G, and H have the highest resolution</td>
</tr>
<tr>
<td>Color map vision</td>
<td>Vision</td>
<td>The blue/bronze modality enhances depth perception</td>
</tr>
<tr>
<td>XRES button</td>
<td>Off/low/medium level</td>
<td>The medium level enhances resolution</td>
</tr>
</tbody>
</table>

Real-time three-dimensional transesophageal echocardiography of the transseptal crossing

Transseptal puncture has been performed safely by experienced operators with less than 1% complications associated with the procedure. A better perspective of IAS provided by 3D TEE is expected to reduce further the complications. The acquisition of 3D transesophageal echocardiographic images (in addition to standard 2D transesophageal images) may be useful for planning before and during the transseptal puncture (TSP). Before the procedure, 3D TEE may facilitate understanding of the morphology of the IAS for interventionists; in addition, 3D TEE may be also valuable in patients at high risk for TSP (i.e., extreme rotation of the cardiac axis, repeated TSP, small size of fossa ovalis, oraneurysmal IAS). During the procedure, 3D TEE may provide better guidance for TSP compared with 2D TEE. The most appropriate site for the puncture is indeed usually identified through recognition of 2D transesophageal echocardiographic “tenting” of the fossa ovalis. However, following the intracardiac catheter and establishing its position relative to the fossa ovalis may be difficult with 2D TEE; multiple views and continuous imaging adjustments are required. Occasionally, on the basis of fluoroscopy or tactile feedback, interventionists may be aware of striking the fossa ovalis, where as the simultaneous 2D TEE does not visualize any tenting (Figure 3A). Switching from 2D to 3D TEE in live modality may show the tenting located deeper in relation to the 2D plane (Figure 3B). Even when the “tenting” is visualized with 2D TEE, only a short segment (if any) of the catheter can be in the same scan plane and therefore visualized. The Real Time 3D TEE image can be rotated from the right to left atrial perspective, and the catheter is easily detected because part of its length is always included in the pyramidal ultrasound sector. The low frame rate does not significantly impair the imaging of the transseptal crossing, because the engaged catheter on the superior margin of the fossa ovalis remains relatively fixed (Figure 4A and 4B).
3D TEE of atrial septal defect and its intervention

Among the cardiac interventions that require cardiac imaging is the device closure of atrial septal defect. 2D TEE has been the initial imaging guide for the interventionalist but 3D TEE has evolved to offer its advantage. 3D TEE has been used preoperatively to identify the number, type, size, shape, location, rim tissue, and septal length in one view (Figure 5), whereas on 2D TEE, these require multiple views. Likewise, following the courses of catheters and wires as well as analyzing device conformation in 3D space (Figure 6) is often greatly facilitated and much faster with 3D TEE compared with 2D TEE. For these particular tasks, 3D TEE is preferred. Furthermore, determination of the exact shape and orientation by 2D TEE is quite challenging, if not impossible. The overall roles of 2D and 3D TEE remain complementary. 3D TEE is able to show clearly the presence of multiple atrial septal defect, deficient or inadequate rim and non-secundum defects which are not suitable for device closure.

Figure 5: Secundum atrial septal defect in right atrial and left atrial end face views. These views show the ASD with the rim distance from the superior vena cava (1), aorta (2), atrioventricular valve (3), inferior vena cava (4), and right pulmonary vein (5).

Figure 6: Multiple views of Amplatzer ASD closure device

REFERENCES


Review, comments on the 2011 ACCF/AHA PAD guideline updates

By Jonathan James G. Bernardo, MD

The most comprehensive guideline recommendations from the American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) for the management of patients with peripheral arterial disease (PAD) was released in 2005. A focused updated was published in 2011, and a compilation of the 2005 comprehensive guidelines and the 2011 focused update was released in 2013.

The writing group assigned to the 2011 focused update, after reviewing the data, decided that the recommendations for lower extremity, and abdominal aortic disease had to be revised, but the recommendations for renal and mesenteric artery disease remained valid.

However, there were clarifications for that matter: 1) There were no new pivotal trials (at that time) for medical therapy for renal disease. 2) As regards revascularization for renal disease, new studies support a limited role for it. The ASTRAL (Angioplasty and Stent for Renal Artery Lesions) trial for instance, concluded that there was no clinical benefit from revascularization in patients with atherosclerotic renovascular disease. Ongoing trials at that time, such as the CORAL (Cardiovascular Outcomes in Renal Atherosclerotic Lesions) trial are expected to shed more light in this area. Lastly, the methods of revascularization in the 2005 recommendation remains.

Here are some important points in the 2011 update:

1) An ankle-brachial index (ABI) should be obtained in all diabetic patients with suspected lower extremity PAD with age > 65 (Class I), as opposed to the previous recommendation of > 70. This is because PAD is often underdiagnosed and untreated before limb ischemic symptoms become severe and early detection of peripheral atherosclerotic disease is emphasized. Smoking has always been among the top risk factors for atherosclerosis. The writers of 2011 update decided to be more aggressive in this regard and expanded the recommendations for smoking cessation interventions. This was after reviewing that observational studies showed that 5% of smoking cessation attempts with the help of physicians are successful compared only 0.1% success rate in patients who try to quit on their own. Varenicline, which demonstrated superior smoking cessation rates over nicotine replacement and bupropion, is an additional recommendation (Class I) under the 2011 update.

2) Antiplatelet therapy has always been a mainstay...
Beyond LDL-Cholesterol: Exploring Non-HDL and ApoB

By Lourdes Ella G. Santos, MD

TREATMENT of low-density lipoprotein cholesterol (LDL-C) has been the standard of care in managing patients with cardiovascular disease and those at risk. Data from multiple trials and studies have demonstrated the link between between LDL-C levels and cardiovascular events, and this relationship is consistent with a large body of epidemiological data. As such, the impact of reducing LDL-C to reduce CV risk has been established.

This is reflected in current international guidelines where LDL-C remains the primary target of therapy in treating dyslipidemia. But is treating LDL-C enough? Is focusing only on low-density lipoprotein still the most optimal strategy? Should we go beyond LDL-C?

A limitation in using an approach that focuses only on LDL-C lies in a substantial number of patients who receive treatment and achieve recommended goals, or even lower, and still develop the complications of atherosclerotic cardiovascular disease. This problem continues to pose as a treatment gap and has been referred to as residual risk.

One explanation for this discrepancy is the mismatch that has been described in many patients between the measured LDL-C reported on the basic lipid panel not reflecting the actual number of atherogenic particles. And the reason for this is that when we measure LDL-C, we are only measuring one out of the four lipoprotein classes.

VLDL, IDL, and LDL all contain apolipoprotein B (ApoB) on their surface. Retention of ApoB-containing particles in the subendothelium is the key initiating process in atherogenesis. Early responses to apoB retention include monocyte entry, differentiation into macrophages ingesting retained lipoproteins to become foam cells and smooth muscle cell migration. This eventually leads to lesion development and maladaptive changes such as macrophage death and plaque necrosis.

So when LDL-C is measured, it may not account for the entire amount of proatherogenic lipoprotein particles. On the other hand, when we compute for non-HDL, which is easily calculated by subtracting high-density lipoprotein (HDL-C) from total cholesterol (TC), it accounts for all atherogenic lipoprotein classes. VLDL, IDL, and LDL all contain apolipoprotein B, and together are considered non-HDL cholesterol.

Non-HDL = TC – HDL-C

The benefit of using non-HDL in lipid assessment is simplified by measurement of total and HDL cholesterol levels without the need to fast and without regard to triglycerides. Simple calculation allows numerical computation of the total number of potential atherogenic particles. There is mounting evidence that LDL cholesterol calculated from fasting samples used to measure triglycerides, total cholesterol, and HDL cholesterol pulled off, the VLDL particle shrinks, becoming IDL, and then triglyceride removal from IDL converts it into LDL.

HDL is the smallest lipoprotein. Instead of taking cholesterol from the liver to other tissues, it picks up cholesterol from these tissues and brings it to steriodogenic tissues, the liver, or the kidneys. That is why it is considered the good cholesterol playing a role in the reverse cholesterol transport.

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### Major Classifications of Lipoproteins

| Very-low-density lipoprotein (VLDL) |
| Intermediate-density lipoprotein (IDL) |
| Low-density lipoprotein (LDL) |
| High-density lipoprotein (HDL) |

**Table 1. Classifications of Lipoproteins**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
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| Very-low-density lipoprotein (VLDL) |Released from the liver into the plasma.| IDL and LDL are products of lipolysis - removal of triglycerides - from VLDL. That is, as VLDL moves through the bloodstream, tissues selectively pull off the triglycerides to provide energy for tissues in the form of fatty acids. As triglycerides are...
is no more effective than using the non-HDL cholesterol level to predict the risk of vascular disease2,3.

In the same manner, measuring Apo B can give a better measure of the number of atherogenic particles. We know that for each atherogenic particle of VLDL, VLDL remnants and LDL there is one molecule of apoB on its surface regardless of their sizes and their composition so that with a 1:1 ratio, Apo B measures the actual number of potentially atherogenic lipoprotein particles.

LDL particles usually account for about 90% of the total Apo B particles and the remaining 10% come from VLDL. The exception is in certain conditions such as familial dyslipoproteinemia. The benefit of Apo B determination over LDL-C then is that it includes the cholesterol in VLDL and may be a better surrogate for the number of LDL particles.

A meta-analysis evaluating LDL-C, non-HDL and apoB as markers of cardiovascular risk looked at published epidemiological studies with estimates of the relative risks of fatal or non-fatal ischemic CV events. 233,455 subjects and 22,950 events were identified. Over a 10-year period, non-HDL prevents 300,000 more events than an LDL-C strategy and apoB prevents 500,000 more events than a non-HDL-C strategy4.

So in the type of medicine we are currently practicing that is so entrenched on evidence, if increasing clinical data will show LDL-C falling behind non-HDL and apoB, is the shift away from LDL-C as standard of care inevitable? Let’s wait and see.

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in the management of obstructive atherosclerotic disease, most especially since acute cardiovascular events is still the leading cause of morbidity and mortality among PAD patients. Clopidogrel still remains an alternative to ASA therapy (Class II), but the combination of ASA and clopidogrel in patients with lower extremity PAD is now included(Class IIb recommendation).

• The use of oral anticoagulation (vitamin k antagonists) on top of antiplatelet therapy for PAD was never recommended, and in the recent guideline, additional evidence supported the Class III recommendation against the use of such combinations.2 However, with the advent of the new generation of oral anticoagulants (NOAC), research for their use has expanded from the treatment and prophylaxis of venous thromboembolism and stroke prevention in atrial fibrillation (for which in such indications, their use has already been approved), to acute coronary syndrome and peripheral arterial disease (on-going studies). In light of this, we may see the emergence of NOACs in the treatment of PAD in the future.

• As regards open surgery versus balloon angioplasty in critical limb ischemia, long term follow-up studies show no significant difference in outcome (amputation-free, or overall survival). The same was true in aneurysm-related morbidity and mortality with abdominal aortic aneurysms. There were findings of lower procedural mortality with endovascular aneurysm repair, however, these findings were not sustained. The recommendation on the method of aneurysm repair is what the attending physicians deem the most appropriate to each individual case.

The diagnosis and management of peripheral arterial disease has always been progressive and there are a lot of on-going studies and researches in this area of cardiovascular medicine. The 2011 update (and compilation of 2005 an 2011 updates released in 2013) for PAD has kept physicians abreast in the current recommendations in peripheral arterial disease while results in significant landmark trials steadily poured in. This effectively bridged the gap between the development of these trials and how the results can be effectively used in actual clinical settings. Today, three years after the last update, we may still find the recommendations applicable to our present clinical practice, but we may expect more radical changes in the years to come especially with results from recent studies in NOACs.

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