

THE

Official Publication of the Philippine Heart Association

HEART

NEWS

Because your **HEART** matters
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What's COOKING UP with PHA?

In the kitchen with 65th President Raul Lapitan

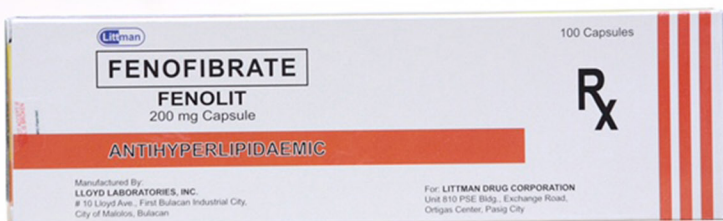
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Editor's Note

Better and Bolder, Healthy Lifestyle, Exercise and More!

The *Heart News and Views* is on its second year under its new name. Revitalized last year, there is no way for us but to become better and bolder in our lay out and more intense, remarkable and practical with content.

As *THNV* has become a voice for the different advocacies of the Philippine Heart Association, my staff will strive harder in bringing you articles that will help heart doctors spread the word on healthy lifestyle and primary preventive strategies to avoid dreaded cardiovascular diseases, among other thrusts.

That is why for this issue, we give emphasis on exercise, a seemingly boon to health but could be a bane to the heart when done in excess. At least two major articles focus on what is enough as an exercise and how to screen competitive athletes for sudden cardiac death (that is no longer uncommon an event nowadays). Read on these articles on the *Walk&Talk* pages where things that we should know about oils and fats can be read, too.

To add on to these hearty lifestyle, new PHA president Raul Lapitan talks about stress as an important risk factor to heart ailments in his column *On the President's Menu* while yours truly offers strategies to rev up the 52100 campaign. Regular columnist Bong Javier offers a humorous but valid solution to curb rising incidence of cardiovascular events with his *Chicharon Tax!* Opinionated Cebuana heart specialist Celine Aquino, on the other hand, busts 10 myths on food for better health.

Of course, be up close and personal with the PHA president (who appears to be a home

daddy-buddy and an aspiring and frustrated chef!) as our cover boy for this issue as *THNV* invades his home and his kitchen and pries into the dynamics of his beautiful family and into his mind as we delve into his plans for the PHA.

To promote the awareness on the different subspecialties in cardiology, we introduce *The Intensivist*. Relatively a new idea in hospital set ups, critical and intensive care cannot be undervalued and must be integral to the provision of health care to the acutely ill patient. We hope to propagate the subspecialty's significance with this issue and the next issues to come.

Our attorney-cardiologist Angie Yap warns us with our hard-earned professional fees as these may just fizzle out into thin air. (No) Thanks to (dubious) hospital policies that complicate and muddle PHIC professional fee collection. Read on this on the *Cardio and the Law* pages.

Further, another angel-writer of *THNV*, Dr. Angelita Aguirre provides the doctor-reader with guidelines how to (morally and ethically) deal with possible pregnancy in rape victims. Read on this on the *Heart and Soul* pages.

On a lighter note, we give you the other side of PHA Golden Heart Awardee Dr. Dante Morales as his children (GMA 7 News anchor Vicky and cardiologist-son Daffy) spill the beans about their daddy-doctor! Be inspired and refreshed with your intentions in life with PHA Baguio Chapter President Karla Posadas' piece in *Northern Exposure* as she shares her dreams, her family, her home and her Baguio. Also, travel with Ina Bunyi as she brings you to Bicol in her *Wandering Paces*, a new section dedicated to travels and travelogues (an MD's fave thing, eh?)

Well, I hope this issue leaves you satisfied but yearning and excited for more. My staff and I also hope that we have given you a near-balanced good read on things that we need as heart health physicians.

Enjoy! Till the next issue! ♥

Robespierre



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About the COVER

Dr. Raul L. Lapitan keeps true to his hardline stance on matters of the heart.

The PHA top gun's mission: To expand CORE-GIVE and advance quality cardiovascular research; put the CPR-Ready Philippines on the fast path via the CPR on Wheels & Wings; keep 52100 going and boost other priority programs of PHA.

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Beyond the passage of the CPR Act

The passage of CPR Bill (aka Samboy Lim Bill) into law this July 17, 2016 is one big step towards realizing a CPR-Ready Philippines. The CPR Act is now known as Republic Act 10871.

Such dream germinated during the time of then CPR Chair Raul Ramboyong, and took some time before it gained momentum in recent years. Big thanks to all, PHA leaders, government and private personalities who took educating and training the nation in saving lives through CPR an advocacy.

But the work is not over. It did not stop with the passage of the law. The bigger job has just actually begun.

The bigger job that the Department of Health together with the PHA, the Philippine Red Cross and the Philippine representation of the American Heart Association is spearheading the creation of a unified module that will be used in teaching CPR to Filipino students.

Representatives from the four entities have already started attending seminars on policy making and module creation in preparation for the implementation of the CPR Act. Among various concerns that need to be raised include the age to start teaching the basics of life support, emergency care and first aid and age-appropriate knowledge and skills to be imparted and trained.

In some Asian countries, awareness and identification of an emergency situation and how to appropriately respond to it like calling for help is taught to early grade schoolers. The act of delivering chest compressions is taught to middle schoolers who are physically able to institute such physical exertion.

Yet a bigger task is the implementation of the module. As to when the CPR Act will be implemented remains to be seen, despite target dates set by the steering committee. The DOH-led committee has yet to meet with the Department of Education regarding implementing rules and regulations among other concerns.

Roles need to be identified. The DOH cannot do this alone. Implementation of modules require regular monitoring, evaluation and reevaluation of competency of trainers and trainees. An agency, department or committee dedicated in updating the module in light of new developments in the science of

“ But the biggest challenge so far is sustaining the momentum of the advocacy that was born from the tragic event that fell on Samboy Lim, a basketball superstar. ”



resuscitation must be established to ensure that the module is taught and implemented well, and that knowledge imparted and skills trained are relevant, practical and updated.

But the biggest challenge so far is sustaining the momentum of the advocacy that was born from the tragic event that fell on Samboy Lim, a basketball superstar. *Ningas cogon*, definitely is a threat to the dynamism that all stakeholders are showing at present towards promoting CPR as a life-saving skill. We cannot wait for another celebrity's tragedy to steer us to move and lobby for another similar law. The PHA must be proactive and not reactive, more so in its advocacies in preserving life.

The PHA efforts, the CPR Council in particular, bore fruits, but more responsibility comes with more achievements. Beyond the passage into law, the CPR Act entails the deployment of AEDs in public areas for public access. Such deployment needs another round of lobbying in Congress for a law to be passed.

Again, our country needs not another tragic event before we can think of saving another life from sudden cardiac death. The PHA must be indefatigable in promoting heart health and unstoppable in pushing its advocacies further.

And that is the most arduous task the PHA has to win over to truly realize a CPR-Ready Philippines. ♥

65TH PHA PRESIDENT DR. RAUL L. LAPITAN:

What's COOKING UP with PHA?

■ By Gynna P. Gagelonia

Location: Dr. Raul & Rona Lapitan's
Tagaytay abode
Photographer: Revoli Cortez
Hair & Make-up artist: Randall Razon
Concept: The HEART Editorial Team

Most people's homes are designed or shaped by either the lifestyle or personality of its dwellers. But when visiting the humble abode of Dr. Raul L. Lapitan, the newest to grace PHA's title of head honcho, it is almost hard to surmise, with all the aesthetic employed that hides all hints, that doctors coupled with five kids inhabit it.

“ I consider cooking not a task but a stress buster and an expression of my artistic inclinations... ”

Nevertheless, this is not surprising for someone like Lapitan, who not only has that acumen in the medical department, but flair in a few other dotting hobbies. The new face on *The Heart News & Views* speaks about his current mission at the forerun of PHA, his interests and life.



Karl and Dana are just happy to aid in occasional kitchen tasks

THE HEARTY COOK

The classy look of the kitchen with an impressive array of equipment shows just how he is as passionate with cooking as he is with his medical duties. “I consider cooking not a task but a stress buster and an expression of my artistic inclinations,” he ponders, describing how the craft becomes even more special when he cooks for his family (wife, Dr. Rona Lapitan, an OB-Gyne and their five children – Lois, Celina, Jed, Karl and Dana) that gives him “most pleasure.”

Apparently, he seems to be just so enthusiastic with the chore that he holds no particular dish he could consider his own signature recipe. “I am into dish exploration. I love learning new recipes, recreating them and creating my own mixtures and



blends,” he claims, haughtily describing himself as a “food artisan” with all his uniqueness in preparing fresh green salads, steaks, grilled dishes, pasta and sauces, and even his own version of *paella*, all rich with garnish.

But, of course, the cookery would be bare without any extra help of the prescription from the doc himself. Lapitan makes it a paramount concern that



In his new role as PHA top gun, the part-time chef flashes his best Duterte look

his masterpieces are prepared in moderation. "I always tell myself that the challenges and changes even in cooking are ceaseless."

However, at the end of it all, medical scholar or not, does it qualify to the general palate? Lapitan contemplates on the time-immemorial argument over who are the better cooks among men and women. And as one would expect, he has interesting

facts prepared with ample research referencing a March 2012 survey of the *Huffington Post* of a couple thousand women, as well as cyber-polling by *Conversion Hub* and *Asia Food Recipe*, which all seem to chauvinistically agree on male cooks. "But on a personal note, anyone can be a good cook as long as you put your heart into it. After all cooking is a passion."



*THE COOKING DOCTOR
always makes sure he dishes
out top-notch creations*

AT THE HELM

Out of the kitchen, and into the heart of the matter. Like all dedicated personnel who has nothing more and nothing less than the task at hand and the goals at point, Dr. Lapitan had had no inkling whatsoever about being lined up as one the leaders steering the boat that is PHA. "From the time I was elected as director, I knew there was no assurance that I'll be PHA president in a few years time. I guess the members appreciate and acknowledge my efforts, and to them, I give my deepest gratitude."

With that in consideration, the pressure entailed in the position comes in immense proportions, accordingly. He goes on to cite the accrued responsibility bearing on him now from his predecessors "who did an excellent and fantastic job keeping the PHA at the frontline of cardiovascular research, healthcare, education and advocacy. From simple decisions to major careful planning, to accountability, no matter how you look at it, your only option is to do better or at least, be at par."

With his leadership comes a fresh look at the PHA's direction and, most importantly, challenges. Lapitan goes on to discuss his own take on turning around any shortcomings found in the organization through "greater commitment among members" and "quality research" in relaying advocacy, which he names as the primary challenges he faces in his turn at the helm.

"I firmly believe that each and every member of the organization has his/her own potentials and talents. Tapping their shoulders with decent recognition will definitely make a lot of difference. We just have to explore all other avenues and think of citations like reasonable incentives and recognition."

In trying to walk this talk within his term that would only last a year, the doctor effaces any hesitation based on the amount of time given to him, and instead takes into consideration "the traditional system of ascendancy in the Board – you have to be a member of the Board for at least six years before reaching the presidency status. One year as PHA top gun is enough."

His agenda is focused primarily on a more dynamic approach to knowledge-based sharing within the chapters, councils, committees and laymen.

Fiscal year 2016-2017 will see bigger CORE-GIVE (CContinuing Medical Education to REinforce and Generate DRIVE for Excellence) milestones in the chapters. PHA has 13 chapters. A brainchild of Lapitan, CORE-GIVE came into existence four years ago during his time as Continuing Education Program Committee (CEPC) head. Aside from the cardiologists who practice in the provinces, GPs, internists and family med specialists will benefit from the activity. Steered by the CEPC, the topics/ issues being tackled/confronted range from the disease itself, landmark studies, controversies and even treatment strategies and updates.

Lapitan also went on to discuss how ongoing protocols (atrial fibrillation, cardiac catheterization, rheumatic fever/rheumatic heart disease and congenital heart disease registries) initiated by the PHA will be fast-tracked and improved. So far, the Councils have completed the protocols on heart failure, cardiomyopathy and acute coronary syndrome. The association is also working on the participation of more training institutions.

Extensive website engagement will also be a priority to further achieve objectives in accessing all available information gateways to the public.

With regards to the PHA Advocacy, Lapitan aims at continuing the efforts already established for a comprehensive educational campaign on staying away from the risk factors (such as obesity, hypertension and smoking) via the 52100 code and knowing your numbers (body mass index and waistline, sugar and cholesterol levels, blood pressure).

Vigilance on the implementation of the CPR Law towards its complete incorporation into the primary education sector is another priority for Lapitan, along with increased partnerships with government and non-government officers for the installation of the automated external defibrillator in communities and the passage of the AED Law.

Considering this, a larger shift towards broader media affiliation would help in sharing PHA Research and Lay Advocacy programs to a wider base of TV/broadcast/ Net viewership/listenership/readership.

“From simple decisions to major careful planning, to accountability, no matter how you look at it, your only option is to do better or at least, be at par.”

“We work as a team and I challenge each member to be proactive, creative and innovative. We move towards a common vision and shared dreams.”

MODIFIED “LAISSEZ-FAIRE” TACK

Sure enough, the length of his assignment could be more than enough for someone like Dr. Lapitan, who is understandably a perfectionist and sees to it that tasks are done in a timely manner. Citing his predecessors, he employs a management approach which he classifies as a modified “Laissez-faire” style of democratic-visionary leadership with, of course, a heart.

“We work as a team and I challenge each member to be proactive, creative and innovative. We move towards a common vision and shared dreams. I believe this can lead to a higher level of satisfaction, enhance efficiency and productive outcomes,” he points out, referring to his equally perfectionist fellow officers ‘who are leaders and team players at the same time.”

He says that PHA “is a well-organized, financially stable, strong, cohesive organization that is composed of highly motivated members, admired for their skills on supervision and integrity, who are steadfast in their mission and vision for the association.” With their help, Lapitan is set to “reinforce the mandates of PHA Councils on up-to-date continuing medical education, creation of guidelines and registries and innovate advocacies” in coordination with various government sectors, NGOs and advertising associates in the road to internationalizing the PHA Annual Convention & Scientific Meeting – which is the ultimate goal he aspires to begin to strive towards under his term for purposes of input exchange with foreign counterparts as well as upping the country’s ante with scientific conferences.

Should circumstances permit, Lapitan aspires to add another fold of contribution to the “Research and Education in CPR and the 52100 Advocacy” once he concludes service.



“One of my goals is to continue the efforts already established for a comprehensive educational campaign on the major risk factors such as obesity, hypertension and smoking; as well as vigilance of the CPR Law.”

**“ Life is beautiful,
full of surprises
and challenges....
Be strong in facing
realities. If you fall,
rise and learn from
your mistakes. Be the
best that you can be.
Make sure to have
Plan B at all times. ”**



MAN ON A MISSION: The secret
ingredient for leadership success



Doctor Dad with daughters Lois and Yna who are both in med school at the UST

LIFE IN OPTIMISM

To the Cardiology Fellows in training, his peers, he is a respected mentor, a stern, soft-spoken, and effective advisor that demands attention whenever he speaks as he is the type to get results as soon as orders are carried out.

But when he is not donning the facade of a doctor, he makes it a point to be a vanguard of the latest not only in his hobby within the culinary realm but the tech industry as well – being the self-professed techie that he is.

Citing his parents and their humble beginnings as his inspiration in raising a family and motivating his children to be God-fearing and students extraordinaire, the 26-year-seasoned cardiologist just exudes with warmth as he took the time to revel about being a spoiling, occasionally strict but cool father to his children who are all fond of his “antics.”

Judging by the look of their house – its slanted front with a geometric touch, coated with a jovial yellow hue, reflects the happy and assured life the family inside has. Attesting to this is the space on the upper



The Lapitan men: The boys Karl and Jed were self-taught on the chess board



BOARD GAMES ARE AMONG THE FAMILY'S FAVORITE PASTIMES Drs. Raul and Rona with their offspring fr. L: Yna, Jed, Dana, Lois and Karl

“ I can be a spoiler to an extent, occasionally strict but a cool father to my children who are all fond of my antics. ”



Lapitan family: A portrait of Health & Harmony



Power hug from “baby” Dana and Mommy Rona

level reserved for family games and leisure, where chess and other board games are strewn and the spacious family/TV room.

He puts faith at the center of his life and tells his children – Lois and Celina who are both taking up medicine in UST, Jed an aspiring architect at the Mapua Institute of Technology, Karl who is in grade 9 at the Ateneo de Manila University and Dana who is in grade 6 at St. Scholastica’s College Manila – the same with their chosen paths. The two youngest, Karl and Dana are just happy to aid in kitchen work every now and then.

He makes it a point to balance being a clinician, PHA President, and family man to his wife and

children, and imparts with them and his subordinates a piece of wisdom: “Life is beautiful, full of surprises and challenges....Be strong in facing realities. If you fall, rise and learn from your mistakes. Be the best that you can be. Make sure to have Plan B at all times.”

In his new mission as PHA President, Lapitan draws strength and inspiration from people he has a lot to thank for in getting the spot, accordingly. “The PHA will accelerate its pace. The road may not be smooth but guided by the mission and vision of the PHA, with your support and active involvement, we can keep ourselves on track, no stones will be left unturned as we move forward.” ♥



CPR ACT LAPSES INTO LAW Angara extols Guiao, PHA

The CPR Act, now known as Republic Act 10871, lapsed into law on July 17, 2016. This came as then Pres. Benigno Simeon Aquino failed to sign it into law before he stepped down from Malacanang this July.

Sen. Juan Edgardo Angara, principal author of the CPR law (Senate Bill 3204), extolled former Pampanga Rep. Yeng Guiao, head coach of the Rain or Shine Elasto Painters in the Philippine Basketball Association, Philippine Heart Association (PHA), and other stakeholders "who helped in the passage of this law which is a very vital measure."

In July 2015, Guiao introduced House Bill 6204 or the CPR Act or "Samboy Lim Bill" to the House Committee on Basic Education and Culture chaired by Rep. Kim Cojuangco.

PHA President Dr. Raul Lapitan lauded Congress and Senate (particularly Reps. Cojuangco and Guiao, Sens. Angara and Pia Cayetano), the family of PBA legend Samboy Lim, represented by the latter's former wife Atty. Darlene Marie Berberabe and their daughter Jamie Lim, for their extreme support.

Lapitan, the new PHA honcho also added that the PHA Board, especially immediate past president Dr. Alex Junia, deserves a pat on the back for this milestone.

PHA is part of the lobby group that successfully pushed for the drafting of House Bill 6204 and Senate Bill 3204, the "CPR Act which requires basic education students to undergo age-appropriate basic life support training."

The PHA Board of Directors 2016-2016 – Drs. Junia, president; Lapitan, vice president; Jorge Sison, secretary; Helen Ong-Garcia, treasurer; Nannette Rey,
See Page 28



Angara



Cojuangco



Cayetano



Guiao

DzMM picks PHA as CPR trainer on Grand Kapamilya Day

MANILA, July 31, 2016 – Giant broadcast network DzMM 630 khz Teleradyo chose the Philippine Heart Association (PHA) as its heart healthcare provider during the latter's Grand Kapamilya Day 30th founding anniversary commemoration.

Held at the huge San Andres Sports Complex from 8am to 5pm, the mammoth event was dedicated to its loyal patrons and aimed to lure new sets of audience. It was open for everyone to explore the numerous services offered by DzMM and its programs.

All the DzMM programs, to name a few – *Magandang Gabi Dok (MGD)*, *Usapang de Campanilla*, *SOCO sa DzMM* and *Aksyon Ngayon* – had their individual booths, and assigned time slots to offer public service. The MGD booth was manned by its hosts Nina Corpuz and Dr. Luisa Puyat.

Dr. Francis Lavapie, PHA Cardiopulmonary Resuscitation (CPR) chair, gave the rudiments of CPR for the bystander before conducting CPR demo with PHA staff Ronaldo Grande, a Basic Life Support (BLS) lay trainer.

Lavapie also said that to avert the onset of heart disease, “let us practice healthy lifestyle and the key to a healthy, happy heart is adhering to 52100 daily. Have your risk factors checked every year to avert heart diseases. On a global and local scale, heart disease is the top killer disease.”

PHA also granted DzMM's request to provide free risk factor screenings (BP, cholesterol/sugar levels and waist circumference check). Getz Pharma, one of the PHA's constant allies, readily accommodated the request. Charity Nagrampa, Getz Pharma product manager, came with her team of medical technicians who did the screenings. GYNNA P. GAGELONIA ♥



Dr. Lavapie (on mike) with DzMM talents

Photo credits "DzMM"

GMA 7's high-profile journalists take CPR lessons

GMA 7's and DzBB's high-profile broadcast journalists and key people from GMA 7 News & Current Affairs, reality, drama and entertainment programs and GMA7 employees made up the 52 number of participants in the two-day (Aug. 8 and 18, 2016) Basic Life Support Training for the Lay at the GMA 7 HR Conference Room, GMA7 Compound on Timog Ave., Quezon City.



Soho, Severino, Alegre, David and Sotto

Concerns:

How do we know if it's cardiac arrest or stroke?

-- Soho

Are CPR respondents protected by the Good Samaritan Act? -- Sotto

Jessica Soho, Howie Severino, Bam Alegre, Kara David and Ali Sotto stood out in the session not just because they are household names but because they asked stirring questions.

They were joined by Marissa Flores, GMA News & Public Affairs senior vice president.

The facilitators were Drs. Erric June Cinco, PHA director and Ariel Valones on day 1 and Drs. Francis Lavapie and Christopher Nazal on day 2, who were assisted by BLS lay trainers Ronaldo Grande, Rolland Diola and Victor Almazan.

On hand too were some members of the PHA Secretariat Gina Inciong, Gynna Gagelonia, Gene Banawa, Irene Alejo and Jeff Morales.

The doctors during their lectures urged media to dramatize the negative impact of

not knowing CPR for the bystander. They cited the cases of basketball stars Samboy Lim and Gilbert Bulawan. It is a basic tool that can save precious lives during the critical two to four-minute time frame. Sudden cardiac death or arrest means sudden loss of consciousness. The CPR golden period is from two to 10 minutes, the stage wherein the rescuer can revive blood circulation to prevent brain damage.

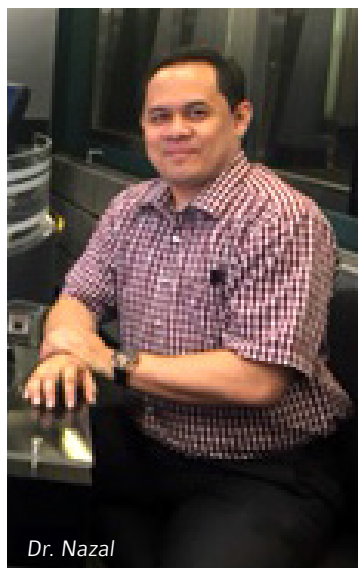
Lavapie said "our country is so laidback when we talk of CPR-readiness. Our dream is to be side by side with our Asian neighbours and Western allies whose citizens, young and old, are CPR trained." In these countries, the life-saving device called automated external defibrillator (AEDs) are also strategically installed in public and private places. **GYNNA P.GAGELONIA ♥**



Dr. Cinco with Kara David, Jessica Soho & Howie Severino



Dr. Lavapie



Dr. Nazal



Proud to be Kapuso and CPR-trained. But they were reminded by the doctors "you need to see us soon for your CPR refresher lessons!"



Dr. Valones

WHEN IS THE HEART READY FOR SPORTS OR INTENSIVE EXERCISE?

■ By Gynna P. Gagelonia

Sudden cardiac death (SCD) or sudden cardiac arrest (SCA) is like an intruder that attacks even the most unlikely victim.

The unexpected, unexplained, sudden death of a professional athlete, a recreational marathoner, especially a teen participating in athletic competitions is a big blow to the family, team, school, and to the sports and medical communities.

A few months ago, basketball aficionados were deeply saddened by the sudden death of a PBA player. In February this year, running enthusiasts were caught flat-footed when two of their colleagues collapsed and died during the Skyway Marathon.

From 2009 to 2011, three high school students (a basketball, baseball and rugby player) died in the campus playing field, two in the middle of the game, one while warming up. A triathlete died in Subic during the Iron Man competition and could not be revived.

Similar unfortunate cases had taken place in the global sports arenas. These stories dramatize the urgent need for the athletic and medical worlds to look into the real underlying cause of death of these athletes.



Guiao



Lapitan



Sison



Bugarin

At the Philippine College of Physicians/ Philippine Heart Association (PHA) Health Forum on July 19, 2016, Filipino heart doctors, collectively known as, the PHA and Rain or Shine Coach Joseller “Yeng” Guiao, told athletes, wanna-be athletes and sporty people that these tragic incidents should serve as a wake-up call.

“Before pursuing a competitive sport, embarking on a regular or an extreme exercise regimen, undergo screening tests (at least an ECG and physical examination). Put your whole heart into it but in the process, always listen to your body. Don’t overwork your heart,” said PHA President Dr. Raul Lapitan.

There is this misconception that athletes and physically active people are physically infallible. Their hearts are enduring and perpetually strong.

“In some athletes, extreme exercise might even promote heart disease. Most likely these people succumbed to heart condition they did not know they had since birth or they had acquired because of lack of screening.”

During diagnostic tests, these particular cases were not detected. Some may be asymptomatic. For a few, there have been red flags that needed medical attention that had been ignored like

unexplained fainting spells (syncope) especially during physical activity, chest pains, palpitations or shortness of breath.

“They were unheeded because they thought people who have always been fit and sporty are the last ones to acquire heart disease,” Lapitan added.

During pre-participation cardiovascular screenings, some heart ailments may not be picked up. In addition, it is sometimes hard to replicate the actual stressful conditions that the heart may be subjected to during intensive sports compared to the clinic setting.

“When someone as young as 20- or 30-something suddenly dies during an athletic or a high-intensive workout, usually the most common cause is hypertrophic obstructive cardiomyopathy (HOCM) or (HCM). It is genetic but can’t be detected at birth. They can be diagnosed in teenagers,” said PHA Vice President Dr. Jorge Sison.

HOCM is a primary disease of the myocardium (the muscle of the heart) in which a portion of the myocardium is hypertrophied (thickened) without any obvious case, creating functional impairments of the cardiac muscle. It is the leading cause of sudden death in people with an underlying cardiac disorder. The training for athletes are rigid and too

long. There have been reported cases of irregular heart beat or arrhythmia that led to SCD,” said Dr. Alex Junia, PHA Cardiopulmonary Resuscitation (CPR)-Ready Philippines adviser.

A marathoner himself, Junia added that “as a regular runner, I have learned to listen to my body. When it tells me to slow down, I slow down. When it tells me to stop, I stop. Running or any sport is also a de-stressor but it can be strenuous and cause you stress when you don’t know when to slow down or halt.”

The PHA also added that a history of premature sudden death in the family (less than 55 years of age) warrants further investigation as well. Additional cardiac evaluation may include an ECG and stress exercise testing. An echocardiogram will rule out majority of the structural and functional heart abnormalities that can cause sudden death. Stress exercise testing on the other hand, measures exercise capacity and overall cardiopulmonary fitness.

PHA Director and Advocacy Committee chair Dr. Orlando Bugarin said that “there are also non-cardiac conditions that may cause athletes to collapse in the field such as asthma, electrolyte imbalance, severe dehydration and heat stroke but since a majority of death in athletes is cardiac in origin, heart screening is a must.”

Though the benefits of exercise are still recognized to enhance our well-being and quality of life, overdoing it is tough for the heart.

Former Pampanga Congressman Guiao believes that “to achieve optimum performance put balance between health and fitness, of course with professional help.”

One of the staunch CPR-Ready Philippines allies of the PHA, Guiao is the main author of House Bill 6204, the CPR Bill or Samboy Lim Bill which requires compulsory hands-only CPR for K-12 students. Approved as Senate Bill 3204 and was enrolled last month, it is expected to lapse into law on July 20, 2016.

PHA conducts advanced cardiac life support trainings for health professionals and basic CPR trainings for the bystander (lay).

Any CPR-equipped person can save the life of a cardiac arrest victim. Effective chest compressions started within 3-5 minutes increases the victim’s chance of survival. ♥



Annual Strategic Planning The PHA Road Map



Mission: Ensuring compassionate and quality cardiovascular care.

Vision: The Philippine Heart Association shall be an Asia-Pacific Leader in Cardiovascular Care by 2021

At the onset of every fiscal year, the new PHA top gun gets down to business with his co-workers in the Board, the Chapter presidents, Council and Committee and Sub-Committee chairpersons, to draft and chart the association's road map in the next five years.

This year's PHA Strategic Planning & Consultative Workshop was held on July 30, 2016 at the Bellevue Hotel in Alabang, Muntinlupa, Metro Manila.

PHA President Dr. Raul Lapitan presented his eight-point agenda platform:

1. Beefing up the Councils & Committees;
2. Beyond Chapter Engagement;
3. Advocacies & Social Responsibilities;
4. Strengthen Beyond-Borders Relationship;
5. Boost Registries, Guideline and Researches;
6. Website Enhancement (Unifying Social Media & Communication)
7. "International" PHA Annual Convention; and
8. Operational Efficiency.



Drs. Gilbert Vilela, Geraldine Pon & Alex Junia

The facilitators employed strategic imperatives, specific strategies, measurable desired outcomes and timelines and principles in engendering inputs. The collective outputs from identified primary concerns which are targeted to have changes and developments by April 2017 were:

Solidarity and Dedication

The aim for a more cohesive group of Councils and Committees. Thirty percent of the entire PHA membership are active council members. The Councils on Rheumatic Fever and Rheumatic Heart Disease and Congenital Heart Disease will post a 10-percent increase in number of active adult cardiologists.

In heart health education (CPR Training Advocacy promotion, Media relations/mileage) in April next year, 30,000 lay people should be aware of the 52100/healthy lifestyle and should have undergone CPR training.

Effective Channel and Conduits

Local clinical practice guidelines can have a wide reach if these will be circulated in the eight PHA chapters and uploaded in the PHA website. The number of hits in the website should be at least 10 per day. One of the cost-effective ways of doing this is by holding symposia and lectures in each region through the eight Chapters as well as conducting CORE-GIVE sessions in all the chapters with 1,000 cardiologist and non-cardiologist attendees.

Social Conscience

In the Advocacy and Social Responsibility department, the Primary Prevention of Cardiovascular Disease using the 52100 platform, harnessing the PHA's constant partners, Department of Health, Department of Education, non-government organizations and media (TV, radio and print), should be ready for implementation in K-12 schools by 2017-2018. The 52100 will have its shining moment with its inclusion in the K-12 curriculum.

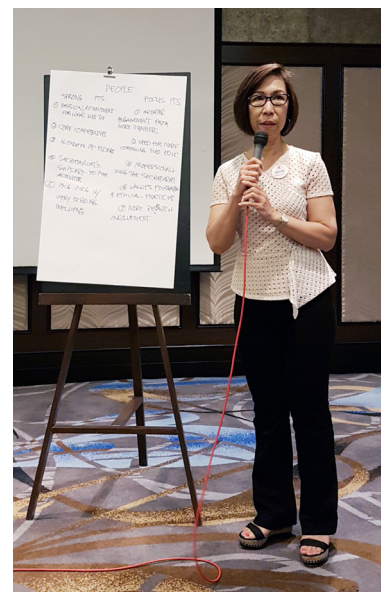
To get CPR-Ready Philippines moving fast and rising high, it is best to capitalize on RA 10871, the CPR Law and the formulated CPR training module; tri-media and a National CPR Day. Provided it has a well-oiled machinery. The performance of the students trained should be evaluated during the school year 2017-2018.

PHA stands out in international confabs

Pillars and emerging names in the local cardiovascular horizon have penetrated the international scene. By all means, this is a stature that the PHA and the Filipino cardiologist should maintain. Better yet, we should exceed our past achievements. PHA should not rest on its laurels. As eternal students, PHA officers should continue to nurture its ties with foreign heart societies in the same

manner that they should be tireless in stimulating young cardiologists.

Looking beyond the Philippine shores, the Philippines will be a conspicuous figure at the ASEAN and European Society of Cardiology exchange trainings and international researches/registries from 2017 to 2019. Although it has proven its worth as an international convention host several times over, it is looking forward to hosting the Asia Pacific Society of Cardiology conference in May 2019 in Manila.



Dr. Ma. Belen Carisma



Drs. Liberty Yaneza, Eleanor Lopez, Robin Flores, Don Reyes, 2nd row, partly hidden, Drs. Francis Lavapie & Orlando Bugarin



Drs. Benjamin Juan Flor Jr., Saturnino Javier, Maricel Regino & Philipp Ines



Dr. O. Bugarin, group leader, confers with his members

Admittedly, the Philippines is laidback with regards to registries, guidelines and researches. During the tenure of Dr. Eugene Reyes as president in 2013-2014, the PHA Councils embarked on registries, guidelines and researches. Lapitan, during his chairmanship of the Continuing Medical Education Committee years ago, designed and implemented CORE-GIVE. From May 2016 to May 2017, the goal is that every Council should conduct one research/guideline/registry with a 10-percent increase in output every year.

Increased efforts on Registries

To make the ongoing registries sustainable, a technical working group for coordinators and research assistants should be created and participating hospitals should be given incentives. An increase by 100 percent in the registered patients every year is envisioned.

Efforts to increase funding and sustain these projects must be exerted. Educational materials and modules must be produced, and collaboration with other societies to help collect, collate and report data must be established.

Flow with the IT wave

The PHA website must invest and venture into social media. The website is envisioned to be a must-visit site by keeping it attractive. Editorial content has to be reinforced. News updates should be uploaded on a regular basis. A social media policy must be created and a dedicated social media administrator must be hired to enhance the website's operations.

Global Standards, issues in local milieu

The PHA annual Convention which has been gathering local and foreign speakers and delegates



Drs. Peter San Diego & Carlos Esguerra

has to keep abreast with global and current topics and issues. Sustaining and strengthening collaborations with ASEAN and Asia Pacific counterparts must be a priority. Target figures include 15 joint sessions with societies in collaboration with approximately 100 participants and having at least 10 renowned foreign speakers during annual conferences. To these ends, these big events need promotion in the website, through media, posters and flyers for international conventions.

Good organization

Operational efficiency is the key to high standardization. To streamline the PHA workforce, officers and staff should attend 10 competency trainings in one year and participate in regular team building activities. Moreover, the need to add to the working staff to improve on the PHA's efficiency is deemed imperative. ♥



Charting of PHA's 2016-2017 agenda

Fellow's Interactive Case Presentation

More than just a heart ache



Reyes



Cunanan



Yamamoto



Victor Michael M. Maderazo

Cebu-based fellows-in-training

Manila-based meet reaches out live to Cebu-based fellows

MANDALUYONG CITY, Aug. 24, 2016 – PHA held its monthly Cardiology fellows-in-training Interactive Case presentation, this time reaching-out to fellows-in-training in Cebu via teleconference at the Unilab Bayanihan Center, Pioneer St., Mandaluyong City.

The case discussion titled “More than just a Heart Ache” tackled the thought-provoking case of a 20-year-old female with palpitations whose other symptoms mimicked myocarditis, food poisoning and acute gastroenteritis,

among others. After a series of tests, it turned out that the palpitations and other discomfort of the patient were triggered by a small but virulent adrenaline mass.

The case was presented by Dr. Alexander Reyes from the UST Hospital while the reactor was Dr. Banisadar Mukaram from Chinese General Hospital. Dr. Elaine Cunanan, an endocrinologist from the UST Hospital was the clincher in this particular case.

The Interactive Case Presentation is a program of the Sub-CEPC committee chaired by PHA Board Director Dr. Gilbert Vilela.

This particular activity gathered well-respected names in local cardiology -- PHA President Dr. Raul Lapitan, former training officer, Makati Medical Center; Dr. Milagro Yamamoto, head, Cardio Section, UST Hospital; Dr. Orlando Bugarin, PHA director/CEPC chair; and Vilela, department manager for Education, Training and Research, Philippine Heart Center.

The topic and presence of clinician-academics

par excellence made the night doubly challenging and stimulating, said Lapitan and Bugarin.

Vilela took the fellows to a virtual tour of the whole-year fellows-in-Training activities (Refresher Course, Real World Practice) and for his parting words, he said “the Board would like to say we are with you in your review.”

In attendance were 120 fellows-in-training from Philippine Heart Center, St. Luke's Medical Center, The Medical City, UP-PGH, UST Hospital, Manila Doctors Hospital, Makati Medical Center, Chinese General Hospital, University of Perpetual Delta, DLSU Medical Center, Mary Mediatrix and Angeles University Foundation.

At the Quest Hotel in Cebu, the participants were fellows from Perpetual Succour and Chong Hua Hospital. This was the first attempt at enjoining other fellows outside Metro Manila via teleconferencing for the PHA's regular conference for cardiology fellows who are still in training.

GYNNA P. GAGELONIA ♥



Drs. Bugarin, Alex Reyes, Ed Gacrama, Jenn Rachelle Santos, Vanessa Yu, Elaine Cunanan, Rhia Dayrit, Gondelyn Cidro, Paul Ablaza, Milagros Yamamoto, Lapitan and Vilela.



CPR on Wheels & Wings from coast to coast

Philippine Heart Association (PHA) President Dr. Raul Lapitan is determined to propel the CPR-Ready Philippines Campaign to a new dimension – to new heights and depths.

“PHA is casting its sights on the tourism sector. We are organizing the CPR-Ready Philippines Campaign’s CPR on Wheels & Wings project, with Boracay as the pilot site and Cebu as the second leg. We are in the process of finalizing the list of destinations,” he said.

PHA is taking the lead in transforming the travel industry players into CPR-equipped establishments.

Boracay is every local and international tourists’ dream destination. The island Paradise is one of the tourism/travel trade’s top cash cows. It generates high volumes of repeat and new inbound international/local traffic.

Lapitan said “we are putting priority on places that burst with visitors. We need to train and teach the municipal and barangay health workers the hotel/resort front liners, staff and support service workers (the boatmen, drivers, tour guides, local police, vendors, et al), how to revive a cardiac arrest and drowning victim. This emergency procedure should be done immediately and properly, while waiting for the ambulance that will take the victim to the hospital.”

There have been news reports about sudden cardiac arrests (SCA) and drowning incidents in bay

resorts and hotels. Deaths from SCA and drowning could have been prevented if these tourists facilities were CPR-equipped and installed

with an external defibrillator. The Philippines has to be in step with its Asian neighbors that are CPR-savvy.

This project is also buoyed by the passage of the CPR Law; huge success of the first simultaneous Nationwide Mass CPR Training in April this year; the notable accomplishments of PHA under the leadership of PHA immediate past president Dr. Alex Junia and the growing number of CPR Advocacy network of allies from all fronts.

“We want to be remembered as the heart society that played a big part in converting these locations into tourism havens to the max,” added Lapitan.

The PHA is set to meet up with Department of Tourism Undersecretary Alma Jimenez on September 19, 2016, to explore the merits of a possible DOT-PHA tie-up.♥





The Manila Times

CPR Law ignites media interest

With mass media by its side in its clamor for the passage of the CPR Bill, the Philippine Heart Association's CPR Advocacy gained impressive media mileage in July and August 2016

A growing number of requests poured in from various media and private organizations

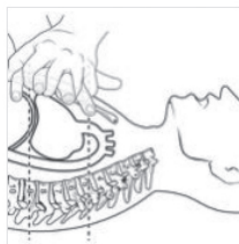
A factor to this boost is the recent passage of the CPR Act (House Bill 6204, Senate bill 3204 now RA 10871), which furthered PHA's advocacy through media partnerships as the vehicle.

Requests for CPR trainings came from the HR Department of GMA 7 network, Health & Lifestyle and the Manila Times, while risk factor screenings were asked by the DzMM Grand Kapamilya Day and GMA Kapuso Foundation with cardiologists in their September barangay medical mission, among others.

See Page 28

BusinessMirror

A broader look at today's business



PHA pushes for House bill promoting CPR training for

RECOGNIZING the school as one of the best training grounds, the Philippine Heart Association (PHA) has reiterated the need for House Bill 6204/Senate Bill

View on

Preview by Yahoo

PHA positive CPR Bill will lapse into law

AS FAR as the Philippine Heart Association (PHA) is concerned, there is no more stopping the CardioPulmonary Resuscitation (CPR) from becoming a

View on www.sunstar.com.ph

Preview by Yahoo



<http://www.mb.com.ph/death-of-pba-player-magnifies-need-for-law-on-cpr-education-doctors>

MGD GUESTINGS



Niña Corpuz with Drs. Adriel Guerrero (above), Cynthia de Lara (center) and Jude Erric Cinco (below)



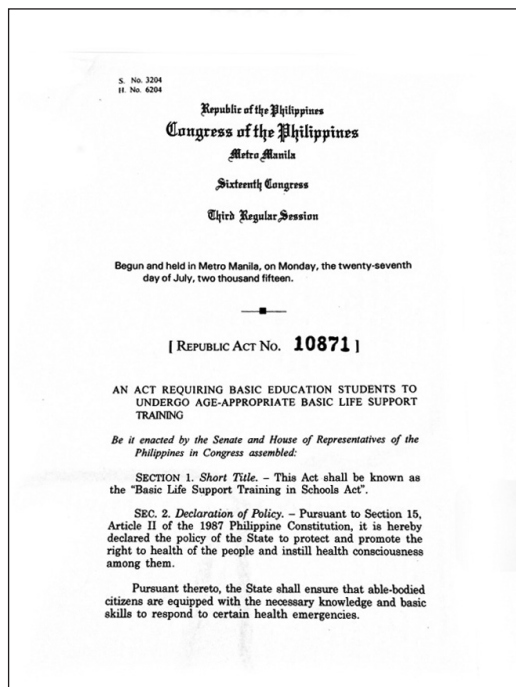
CPR LAW... from Page 27

Media partners have also been punctual in raising awareness to the public about the hazards of cardiovascular implications and how it could affect anyone, as attested by tragedies that befell noted athletes and health icons, former PBA player Samboy Lim – whose ill fate resulted in his current immobile state – and, more recently, PBA athlete, Gilbert Bulawan – whose sudden cardiac arrest led to his unfortunate death.

Other media outlets and publications have also partaken in the effort to hasten the progress of the advocacy, through progress reports on the proposed instigation of CPR into basic and secondary education institutions where CPR is campaigned to be a mandatory learning and education unit for students, as well as follow-up stories for the Bill's status at the Executive Branch of the government for complete integration of the CPR Law in the country.

Medical insights on habits that increase the likelihood of contracting heart complications have also been released as precautionary measures, with efforts being done by cardiologists and the PHA in enlightening everyone about cardiovascular risks and management.

MAUREEN A. GONZALES ♥



CPR ACT... from Page 16

Aurelia Leus and Orlando Bugarin, directors, and Francis Lavapie, chair of the PHA Council on CPR, were in full force in the House and Senate Committee meetings. In all the meetings and hearings, Berberabe was with the PHA doctors.

The PHA Board's initial meeting with Guiao was arranged by PHA Central Luzon Chapter member Dr. Domicias Albacite, a *cabalen* of the good congressman.

Guiao and Angara also call RA10871 the Samboy Lim Law because of the case of the basketball legend which precipitated the filing of the bill. Lim collapsed during an exhibition game with fellow PBA bigshots in November 2014. No one among his colleagues knew how to do basic CPR. The trip from Ynares gym to The Medical City took 26 minutes. He fell into a coma for



Lapitan



Junia



Bugarin



Lavapie

one month. Lim had been out of the hospital but is under the care of nurses 24/7. He undergoes regular therapy and is being visited by doctors in his residence.

Lapitan said that PHA reiterates that "administering 2.5 inches deep, 100-120 chest compressions per minute when someone's heart stopped beating increases the victim's survival rate by 25 percent. The procedure keeps vital blood flow to the heart and brain, therefore preventing brain and organ damage."

He added that "beating the 4-minute window period with CPR

could have minimized the damage to Lim's vital organs."

Angara told reporters that "young Filipinos may become lifesavers now that we have a law requiring cardiopulmonary resuscitation training as part of the country's basic education curriculum. CPR is an essential lifesaving skill that ordinary citizens and even our youth can be trained to do."

The said measure mandates all public and private basic education schools in the country to make CPR training a requisite prior to graduation. ♥

Luz-Vi-Min legs

BP ng Teacher Ko Caravan attends to 903 teacher-patients

■ By Gynna P. Gagelonia

The six-year-old *BP ng Teacher Ko, Alaga Ko* campaign has gone to Luzon (Vigan, Ilocos Sur); Visayas (Kalibo, Aklan) and Mindanao (Surigao) and posted an attendance of 903 in three months from June to August 2016.

The PHA and Department of Education (DepEd), through a grant from LRI-Therapharma, continue the noble mission in spreading cardiovascular disease prevention and management awareness in the education sector.

Every *BP ng Teacher Ko...* event starts with the presentation of the 52100 and *Deadma, Dead Ka* Healthy Lifestyle and Cardiopulmonary Resuscitation (CPR) instructional video and lecture.

The cardiologist that heads the team would explain every tenet of the 52100 and the repercussions of abusing one's health. Not knowing or ignoring your risks like hypertension and obesity can lead to serious cardiovascular diseases which could be avoided with simple, day-to-day compliance with 52100.

The highlight of the activity is the Risk Factors Screenings (Blood Pressure monitoring, sugar and cholesterol examinations, waistline/BMI checks and ECG as needed).

The teacher-patients proceed to the consultation desks once they have the complete results of their tests.

Every patient fills out the form with his personal data and the medical technicians/nurses log the results. The attending physicians interpret their results, give their recommendations – from lifestyle modification side by side with medicine, further tests and follow-up consultation compliance.

Myrna dela Cruz, senior Council coordinator, who is in charge of the *BP ng Teacher Ko...* project, who could operate an ECG machine, would join the nurses in the ECG rooms.



Samonte (on mike) says: "Diet and exercise go together in shedding those extra bulges."



KALIBO, AKLAN

The Kalibo leg on August 6, 2016, was helmed by Dr. Vim Samonte, a dynamic member of PHA Western Visayas Chapter based in Kalibo. He was joined

by 16 members of the Aklan Medical Society (AMS).

As early 6am at the venue, the Kalibo Pilot Elementary School (KPES), some



Perez



Photos By Vim Samonte, MD

253 teachers from across 20 barangays, lined up the consultation desks composed of cardiologists, internists and family doctors.

Other PHA Western Visayas Panay Chapter members present are Drs. Donna Mae Ilio and Claire Perez, and fellows from the AMS, Drs. Eileen May Debuque, Rodney Valencia, Lynn Salido, Arthur Salido, Alan Tolentino, Josephine Ricamonte, Angelita Ureta, Enriquez Wilhelm, Alma dela Cruz, Viz Respiero, Juliet Macahilas, Rhoby Fernandez and Leonardo Tayco.

From DepEd, on hand were Division of Aklan Nurse-in-Charge Dawn Manares Malilay and KPES Principal Allan Relloto.

Samonte said that of the total number of personnel who availed of the risk factor screenings, about 20% or two out of eight examinees were hypertensive and had increased levels of blood sugar and cholesterol.

"If your cholesterol is more than 250, shift to a low-fat diet. If a male's waistline is beyond 34 inches, and a female's beyond 32 inches, shed your extra pounds by embarking on an exercise regimen that is free or cheap," Samonte advised. "Watch your fat and calorie intake. Learn how to cope with stress and know your risks and your numbers," he added.

Samonte also took on the opportunity to announce that "we now have a CPR Law. Students from grade

5 to senior high school are required to undergo CPR training. CPR is for every Filipino, the young and old alike. It is a must that at least one family member is knowledgeable about hands-only CPR. That is why the PHA is taking its CPR training advocacy to a higher level. PHA is keen on bringing CPR to every Filipino home and to every school. We will be a CPR-Ready Philippines with your help."

He told *THNV* that Kalibo, the capital of Aklan is a first-class municipality, but it has yet to have a tertiary hospital. His wish for Kalibo is to have more government and private hospitals with modern equipment and an adequate number of doctors who will attend to the rising cases of non-communicable diseases that include ailments of the heart and the blood vessels.

SURIGAO

The *BP ng Teacher Ko* – Surigao had a turnout of 300 teachers and teaching personnel. It was held at the DepEd Division Office, Penaranda St., Surigao City, Surigao del Norte on August 26, 2016. The activity was met by an equally eager crowd of teaching and non-teaching personnel, this time under the direction of PHA officer-members, Drs. Manolito Go, Howell Hipe and Melvin Cosep.

Giving their support were physicians from the Philippine Medical Association Surigao Chapter.

They were Drs. Richmond Ceniza, Andrea Licuan, Josephine Lagunzad, Victor Dumanggas, Sonny Batac and Rudy Medina; and allies from the education sector - Jembert Namuag, Division nurse in charge, DepEd Division Office of Surigao; and Girlie Azurin, RN, from DepEd Manila.

Ronnie Manliclic from LRI-Therapharma, Manila and the LRI-Therapharma Group in Surigao-Butuan Area were present at the site.

VIGAN

At the Ilocos Sur National High School (ISNHS) in Vigan on June 15, 2016, 350 teachers and other school staff queued up to witness the advocacy unfold and at the same time, to avail of the free screenings.

The medical team was led by PHA Council on Hypertension past Chair Dr. Irma Marie Yape; PHA Northern Luzon Chapter members Drs. Gloria Lahoz and Leslie Asuncion, and Drs. Luz Gregoria Velasco, Melquiades Rosario and Rose Rialubin from the Ilocos Sur Medical Society.

Also in attendance were Anselmo Aludino, superintendent of the Division Office, along with Dr. Maricon Dumlaog, DepEd Manila, and Loida Ramos, RN; ISNHS Office of the SP4 Chief Education Supervisor concurrent OIC, Dr. Giovanni V. Velasco, and Jerome Streegan and Ronnie Manliclic from LRI-Therapharma Northern Luzon Group. MAUREEN A. GONZALES ♥



Yape



Past chair, PHA Council on Hypertension Dr. Yape (2nd row, 4th fr L) and past president, PHA Northern Luzon Chapter Dr. Lahoz (2nd row, extreme L) lead the team of doctors and nurses in the Vigan mission. Also in photo are: Drs. Velasco (3rd row, 1st fr. L); Asuncion (2nd row, 2nd fr R) and Del Rosario (2nd row, extreme R).



PHA Western Visayas-Panay Chapter Media links, social services tops Besanes-Almeñana's agenda

LOILO CITY, August 6, 2016 -- The Philippine Heart Association Western Visayas Panay Chapter is coming in strong with its leader – Dr. Rhodelyn Besanes-Almeñana, at the helm from 2016-2018.

Almeñana took her oath before PHA President Dr. Raul Lapitan who flew from Manila to grace this significant occasion which was witnessed by PHA past President Dr. Joel Abanilla, a native of Iloilo and past chapter presidents and members, some PHA staff and guests from Servier Pharmaceuticals and Abbott Laboratories. The oath-taking rites were held at the Richmonde Hotel, Megaworld Blvd. corner Enterprise Road, Mandurriao, Iloilo.

Likening her new mission to President Rodrigo Duterte's continuance of the accomplishments of past administrations in her inaugural speech, the very articulate Besanes-Almeñana called on her fellow Ilonggos' "very active participation" because "the success and future of our chapter does not solely lie on me" as she added Peter Parker's all too familiar line, "With great power comes great responsibility."

She emphasized the need to network with media in achieving objectives and prolific results. "I think it's time to be more involved in our cardio newspaper, social media and make TV exposures on local channels even just during Sundays of the Heart Month," which will be

her term's primary goal.

Almeñana also described the prospect for broadening the reach of the Chapter's missions outside of the clinic through social services. Looking back, she said the Chapter did it during the Yolanda aftermath. Moreover, she described how past chapter Christmas Parties had the Don Bosco Foundation as beneficiaries. She hopes "to do more of this social services advocacy by being enthusiastic in these real life rewarding activities."

In relation to internal operations, she aspires to "initiate discussion and brainstorm the ideas presented for the benefit of our patients" with regards to administrative and medical updates and guidelines among cardiologists and other colleagues.

"When I joined the PHA strategic planning, the idea that was inculcated in my mind is to be ambitious, in a way of dreaming to be the best chapter once again after several years from the time of Dr. Palmes, but realistic," Almeñana said. "One of my driving forces to be a cardiologist, aside from idolizing my mentors plus the FPCC (and) FPCC, are the happy memories during

my training years,” the Chapter President cited, referring to her residency training years in internal medicine and fellowship training years in cardiology.

With a brief background into her small town beginnings as an achieving medical aspirant and, now, as a mother, Almeñana took pride over the legacy left by past chapter presidents endowed upon her induction which she strives to continue.

A few in particular is the Best Chapter recognition awarded to the PHA-WV Panay Chapter steered by Dr. Patricio Palmes. Prior, Dr. Louie Tirador introduced the memorable *Lakad Puso* event held annually each February, and even the nightly chapter intermissions and dancing competitions which Almeñana herself excelled in.

Quoting once again the words of the Duterte administration, Besanes-Almeñana said of her new



Almeñana & Lapitan

lead in the PHA-WV Panay Chapter that “the ride will be rough. But come and join me just the same. Together, shoulder to shoulder, let



Abanilla

us take the first wobbly steps in this quest,” and reminded the crowd to “dream, learn and achieve the good and hearty things together.” ♥



Past, present and future presidents all

Pepping up the 52100 campaign

While the CPR-Ready Philippines, as one of PHA's advocacies, has taken off in leaps and bounds, the 52100 campaign promoting healthy lifestyle practices as primary preventive strategies against cardiovascular and metabolic diseases is a laggard.



Unlike the advocacy on national CPR-readiness that has the CPR Council to take care of it, the 52100 campaign unfortunately does not have a dedicated council or committee to promote it and to make it eventually successful in terms of its objectives.

Such healthy lifestyle campaign is directly under the PHA board, the Committee on Advocacy in particular, but it cannot be denied that the PHA's hands are full with other official and personal responsibilities. Add the fact that the board is a lean team. Not to underestimate the PHA board's capability, but promoting a campaign on a national scale needs machinery! We cannot expect our society top officers (and it is unfair to do so) to work on this full-time.

If the PHA maintains its passion in pushing the 52100 campaign further, some things have to be done.

Just like in any project where objectives are not met, project leaders must go back to the drawing board and do some re-evaluation. The mission and vision of the campaign (if there are any) should be revisited and assessed whether or not objectives are still timely, practical and realistic.

Strategies (both long and short terms) to implement such a campaign, including manpower, must be drawn clearly. Specific roles must be defined. Timelines and timeline-sensitive objectives must be set. Regular monitoring, evaluation and re-evaluation must be done. Alliances and partnerships on top of sufficient financial fuel must be made and ensured.

In terms of promoting such an awareness campaign, the PHA should forge partnerships with other groups and agencies like the Department of Health, Department of Education, the local government units, some NGOs and perhaps the Senate and Congress. Of course, the role of media cannot be sidelined for obvious reasons.

If the PHA together with other personalities were able to lobby the CPR bill to lawmakers and to elevate the awareness on CPR as a lifesaving technique, then a similar move to include education on healthy lifestyle in

school modules should be aspired for. Or such awareness may be incorporated in regular and yearly school-based celebrations like Nutrition Month held in July.

Such a legislative move (is there any easier and faster route than this?) takes some time before the fruits of labor become manifest. Thus, the need to implement strategies with immediate results.

The PHA may employ the bottom-up approach. Starting with the grassroots or local level before going bigger and wider may be a prudent experimentation. Strategies may include tie ups with some public (and/or private) schools. Programs like poster-making contests, dance competitions or demonstrations and the like help in instilling such awareness in the impressionable minds of the young student. To (re)launch such a campaign may be an easy task, but again, the bigger challenge remains to be the sustainability of such an awareness campaign.

LGUs (together with the City or Rural Health Offices) can be of great help in promoting the 52100 healthy lifestyle campaign. Community-based activities like regular educational sessions on food and nutrition, age-appropriate group exercises or physical activities, smoking cessation programs and similar projects may be implemented.

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“Strategies (both long and short terms) to implement such campaign, including manpower, must be drawn clearly. Specific roles must be defined. Timelines and timeline-sensitive objectives must be set. Regular monitoring, evaluation and re-evaluation must be done. Alliances and partnerships on top of sufficient financial fuel must be made and ensured.”

Chicharon Tax? (Once Again)

(N.B. In June 2012, I wrote this piece for a health magazine. Four years later, under Rody Duterte's administration, the topic assumes more relevant meaning as the current administration mulls the possibility of taxing fatty foods. Portions of this piece have been lifted from the previous article.)

I used to be the over-all chair of the **Healthy Lifestyle Advocacy Committee** of the Philippine Heart Association (PHA) several years ago when I got elected as a member of the Board of Directors of this organization.

As one of the pivotal committees entrusted with the task of promoting cardiovascular wellness as a goal of the Association, the advocacy group would regularly brainstorm with colleagues, media personalities, nutritionists, local government officials and industry heads to craft ways to promote the healthy lifestyle campaign in a wider sector of society. In one meeting that tackled the need for innovative dietary programs and lifestyle interventions, the group jokingly brought up the possibility of lobbying for taxation on fatty foods.

Yes, a 'fat tax.'

Similar to a 'sin tax,' it was viewed as a counterfoil measure in response to the alarming proliferation of fast-food chains that rake in huge profits serving cholesterol-rich burgers, thickly breaded fried chicken and foods rich in harmful trans-fatty acids, among others. Call it whatever you deem best. A *chicharon* tax? Or a *sisig* tax? Or a *bulalo* tax? Maybe even a *lechon* tax? It was a funny joke that really did not seem like it carried any serious intent - at least to those of us who heard it first then.

Well, that joke is now a reality. Denmark beat us (or at least my committee) to the imposition of such taxes on fatty foods with the ultimate goal of imposing healthier eating habits among Danes. The value of the tax was about three USD for every 2.2 pounds of saturated fat. The tax measure was approved by the Danish Parliament in March 2011 to help improve the life expectancy of Danes which had fallen by three years from the international average of 79 years.

Denmark is probably the first country in the world to impose a levy on fatty foods. Expectedly, skeptics have raised doubts on whether or not the tax measure will lead to healthier eating habits among the nationals of Denmark. Time will eventually tell if the taxation policy will impact on the life expectancy and risk profile of Danes.

More than the fat tax itself, what is laudable, is the political will of Denmark and its health leaders to carry out drastic measures to effect a change on people's lifestyles. This political resolve is nonpareil. How many countries and governments can claim to demonstrate such determination to alter societal behaviors and community habits? How many lawmakers are willing to take unpopulist stands to achieve long-term health

ESCAPE BEAT

■ By Saturnino P. Javier, MD, FPCP, FPCC



goals? How many policy-makers are willing to oppose ruling power blocs, billionaire sources of election campaign funds and tobacco industry monopolies for the welfare of the greater majority?

It now appears that the Philippine government has viewed the move to slap a tax on fatty food as a revenue-generating measure as well as a healthy lifestyle campaign strategy. In line with the new administration's policy to generate funds from fatty food taxes, carbon tax, casino and lottery tax, mining taxes, as well as taxes on luxury cars, jewelry and yachts, the proposal includes imposing taxes on high sugar-containing food products, junk foods and soft drinks.

If the bill prospers in Congress, these tax policy reforms that impose taxes on fatty foods, luxury items and casino winnings are expected to bring a net revenue gain of close to 370 billion pesos to the Duterte administration by 2019. The Department of Finance estimates that the fatty food taxes alone will generate 20 billion pesos! That is certainly and literally a lot of grease money!

This fat tax follows on of the heels the previously implemented 'sin tax' on tobacco and alcohol products which were passed during the Aquino administration - a landmark bill that was widely cheered by health proponents, medical associations and anti-smoking campaign propagandists.

Heart disease remains the major cause of death in the Philippines. Major legislative challenges have been hurdled in the campaign for healthy lifestyle. Anti-smoking campaigns - including the sin taxes and graphic health warnings on cigarette packs, have already taken off ground in the last few years. These new taxation reforms, when approved, will add to the latest health-oriented strategies that hopefully will have a forceful impact on the prevalence of heart disease in the country.

For comments, spjavier2958@yahoo.com ♥

MURAG DOKTOR

(OPINIONATED MD)

■ By Celine Teves Aquino, MD, FPCC, FPCC



BUSTING SOME 10 FOOD MYTHS



1 *Kain ka ng kain kasi ng mani. Ayon! Sumasakit na ang arthritis mo!*

Gout is certainly a manifestation of a disorder in urate metabolism; but while uric acid is the byproduct of the breakdown of purine, the bulk of the body's uric acid stores are derived from endogenous breakdown of dying cells. Epithelial cells constantly renew, as do hematologic elements so the uric acid turnover is huge! Diet actually contributes little to the store. It is true that an attack can be precipitated by high purine intake but most authorities point to organ meats, dark-fleshed fish and beer as culprit! Vegetable oils, on the other hand, like peanuts are perfectly safe. How many elephants have you seen with gout anyway?

2 *Hindi naman matamis itong pagkain kaya pwedeng-pwede ito para sa diabetic.*

Now really? Food is food and the body tries very hard to break down everything we eat to glucose, the basic fuel for all body functions. The taste has little to do with what is safe or what is smart in diabetes. We will gain quite as many calories from a yucky tasting plate of liver and onions as we would from a bar of chocolate.



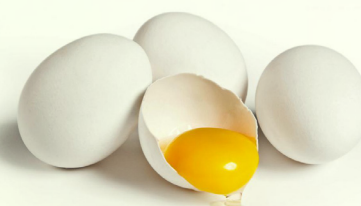
3 *Lechon! Sige na nga, may gamot (statins) naman para sa cholesterol.*

Oh, we'd like that, won't we? But it just does not work that way. Statins are not magic siphons that suck the fat out of our bloodstream.

They are serious drugs that interfere with some important chemical reactions and result in cholesterol lowering, reduced inflammation and plaque stabilization. A statin is not like the "morning-after" pill taken to prevent pregnancy and taking it after gorging on lechon skin will



not prevent the inflammatory effect of red meat and saturated fat. If you believe this strategy works, you might as well feed statins to your pig before extracting bacon from it.



4 *Bawal na bawal ang itlog! Mataas ang cholesterol nito.*

True, the yolk of egg is almost completely fat (cholesterol) in nature but experts agree that eating eggs daily is unlikely to increase heart disease risk in a healthy individual. On the other hand, it has only about 70 calories and provides protein, Vitamin A, calcium and sodium along with around 8% of the daily requirement for fats. It's also cheap and quite filling; and if you eat scrambled eggs made from egg white alone, the taste is absolutely indistinguishable from whole eggs! Believe me. Now if your objection were on religious grounds... an egg is after all, a chicken who is the victim of abortion. But that's another story.



5 *Dahil high blood ka, dapat matabang ang lahat na kinakain mo.*

Have any of you even tried existing on a three gram NaCl diet per day? It is a punishment at par with Chinese water torture. Unless there is co-existing heart failure, there is no need to severely restrict salt in the diet. Yes, even in a hypertensive.



6 *Dahil may sakit ka na sa puso, bawal na bawal na ang baboy; wala nang lechon, adobo, atbp.*

Too simplistic by far. You might as well say eating fish will make you live forever; or becoming vegetarian will prevent coronary artery disease. Such statements imply that one food group is responsible for heart disease; it may be closer to the truth to consider food preparation. For instance, a bowl of pig's feet stew (*nilagang pata ng baboy*) has little fat, is not fried and is way healthier than a dish of deep-fried fish in sweet-sour sauce.

7 *Basta naka-vitamins, ayos lang na hindi na kakain.*

Vitamins are co-factors in metabolism of nutrients. By themselves, they provide no nutrition, so that popping loads of vitamins when one has no time for eating is rather like getting ready for the wedding with all the paraphernalia on hand but missing a bride.



8 *Basta gulay ang kinakain, bababa ang cholesterol.*

Cholesterol is produced by all animal cells as a substitute for the cell wall that contains the elements of the cell. Plants do not produce cholesterol, not even fruits like avocado and *durian*. But the preparation is as important as the content. Vegetables served as tempura are an example of a contradiction where non-cholesterol bearing plants are wrapped in cholesterol-laden batter!



9 *Hindi na tataas ang cholesterol ko, basta hindi na ako kakain ng taba.*

Sounds good in theory. But while cholesterol levels do rise during the first few hours of ingestion of cholesterol-laden foods, the liver will respond by reducing its production; so that there is no good evidence that increased dietary intake is related to the disease known as hypercholesterolemia. It is rather disorders like obesity and diabetes that at once predispose to and aggravate dyslipidemia.

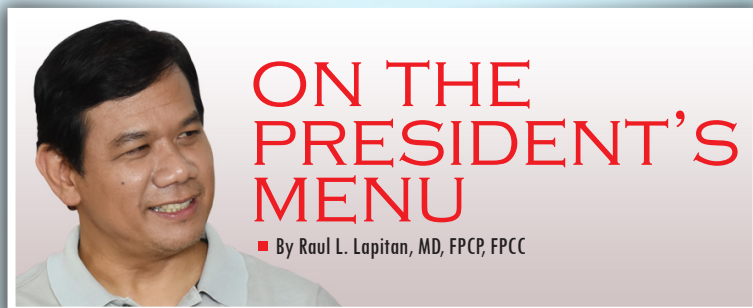


10 *Crackers na lang ang kakainin ko sa pagdadiet ko.*

We really should learn to read the labels. Three crackers gives around 150 kcal but a cup of rice also gives a little more than 150 kcal! Same difference, really (as the kids say). Say I want to lose weight so I have a pack of crackers with jam and a glass of juice – that will come up to a frugal breakfast of around 310 kcal. Trouble is, by 10 AM, I will be hungry enough to eat a drug lord. Now if I ate a half cup of rice with the bottom half of a medium-sized fish (*tinola*) and a banana, I will only be eating 178 kcal and be fuller. Moral of the story: things are not often what they appear. ♥

De-stressing the Stress

A 2009 study of the Department of Health (DOH) found out that 170,000 Filipinos die each year from cardiovascular or heart-related diseases. That's roughly 19 lives lost every hour, accordingly. Naturally, primary causes would point to genetic or lifestyle causes. But one thing comes at a close second – Stress.



THE SILENT KILLER

“Stress, in addition to being itself, was also the cause of itself, and the result of itself.” – Hans Selye

Stress is “the non-specific response of the body to any demand for change,” according to Dr. Hans Selye, who introduced the concept and coined the word “stress” in 1936 (American Institute of Stress or AIS). This signifies how stress is something generated and contracted through external personal experiences. It is brought about by the environment and the circumstances within it.

With its fairly subjective nature, stress is unlike most physical conditions. It does not particularly choose a host to strike – young or old, ill or healthy. Considered the “silent killer,” the main feeding ground of stress is the human emotion, which is why it worsens the state of a sick person and forestalls chances of speedy recovery – or cause someone to be sick even without contracting any foreign bodies – through depression and tension to the person.

Unlike most illnesses, suffering stress could not plainly be treated or completely cured as this banks on feelings and experiences. It cannot entirely be prevented or stopped. But it could be managed.

SIGNS

If you experience a variety of symptoms (i.e., frequent head, neck and back aches, muscle spasms, light headedness and dizziness, heartburn, difficulty breathing or frequent sighing, chest pain and palpitations or rapid pulse, fatigue, weight gain or loss without diet), and/or other symptom descriptions that could just be about anything (because of the free-range nature of stress as defined by the AIS) – then it's likely that you are included in the statistics.

How do we reverse this, then? As wide as its characteristics, stress management has no standard remedy as it could vary from situation to situation and

per person. Nevertheless, there are a couple of surefire ways proven to reduce the effects of stress, if not get rid of it. All follows as instructed by the AIS.

WORKOUT REGIMEN

Aerobic exercises like jogging, cycling and even rhythmic workouts like zumba, ballroom dancing and the like could lighten one's mood and bring about positive energy from within to the surface – highlighting the notion on “a sound mind and a sound body.”

In a featured article of the American Psychological Association, mounting evidence have been found stating the benefits of exercise, especially in treating physically or mentally unhealthy patients. There is a strong link between exercise and mood which could alleviate tension and depression along through sweat and physical exertion. Exercise, it turns out, not only sheds calories but negative energy as well.

Stress causes the heart to beat or function irregularly on a person in a static state, which is improper as this should only happen in situations when a person is active. Therefore, exercise is more than essential in eliminating the effects of stress.

MEDITATION

Yoga turns up at the top of every list when meditation is discussed, but there are other forms of “self-hypnosis” that does not require as much physical effort for some who consider strenuous activities as added stress.

A few would be praying or spiritual medication, as this absorbs all external factors to the peaceful internal recesses of the body; Tai Chi is also an alternative to yoga, and all other body postural routines which require

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“Considered the ‘silent killer,’ the main feeding ground of stress is the human emotion, which is why it worsens the state of a sick person and forestalls chances of speedy recovery.”

11 INANE things you never thought could trigger a Heart Attack

■ By Celine Teves Aquino, MD, FPCP, FPCC
and Marivic Vestal, MD, FPCP, FPCC

Research on cardiovascular diseases

advances has taken off in leaps and bounds and almost every day, a new pop-up will announce a new “risk factor” on your computer screens.

But what is a risk factor and what differentiates it from just another associated condition?

The Framingham guidelines do not accept a new marker as a risk factor unless it has been validated in well-constructed, adequately powered studies to actually predict strong endpoints like death (what could be more definitive than death?).

“Inane” means ridiculous or absurd and this article will explore some factors that at first glance cannot possibly affect the incidence of heart attacks. Let us go through at least 11 “INANE” things that you never thought could cause a heart attack.

(Editor’s Note: This article was derived from a lecture conducted by the two authors during the 2016 PHA Annual Convention and Scientific Meeting.)

1. Skipping Breakfast

From childhood, our parents have incessantly reminded (or scolded) us to eat breakfast, the most important meal of the day. It’s “breakfast”: Break-the-fast. It is called such because the difference between supper and the morning meal averages 10 hours.

For a variety of reasons, one is the morning rush, as a consequence of waking up late. For a thousand and one reasons, this generation skips breakfast. Simple as that.

Were our mothers’ admonitions wrong? In 2013, the Harvard School of Public Health published a study¹ on almost 27,000 middle-aged health professionals followed up for over 16 years.

These subjects were categorized into: those who ate breakfast early (i.e. *before* the regular breakfast time); those who ate at the usual time for breakfast; those who ate lunch as breakfast; and those who ate breakfast between the usual breakfast and lunch hours.

The study showed that people who skipped breakfast had a 27% increased risk for coronary artery disease (CAD) over those who did take it. Surprisingly, while it is commonly thought that people who skip breakfast lose weight, the study found otherwise.

People who skipped breakfast tended to eat higher calorie meals later in the day and to eat more at night! This cycle of feast and famine alters the metabolism and predisposes to metabolic syndrome and subsequently to heart disease.



The study does not claim a cause and effect relationship between skipping breakfast and heart disease, rather, underlines a link between people who skip breakfast and hypertension, obesity and diabetes mellitus. In spite of its limitations, the study validates the health benefits of breakfast.

“...people who skipped breakfast had a 27% increased risk for coronary artery disease (CAD) over those who did take it.”



2. A Heavy Supper

That same Harvard study¹ also showed that late night food bingers put up their CAD risk by 55%. This brings us to our next inane thing: *Tulog-Busog!*

James Gandolfini was a much loved TV actor best known for his role as Tony Soprano in HBO's *The Sopranos* but he made headlines in 2013 when he succumbed to sudden cardiac death.

His cardiac risk profile is not common knowledge but speculation exists that it may have made him a "walking time bomb." Perhaps, an acute heart attack killed the actor. What is common knowledge is that on the night he died, he had an extraordinarily heavy supper consisting of back-to-back orders of fried king prawns plus a large portion of *foie gras* (a well-known delicacy made from the liver of force-fed geese and served as pate), mousse or parfait. But did that do it for poor Tony Soprano? If so, how could a meal like that kill?

A US Veterans' study² reviewed the files of 2,000 MI patients and found that 158 of them had a heavy meal just before their MI. The study went on to conclude that people with an already high-risk profile for heart attacks were four times more likely to have a heart attack after a heavy meal!

A super-sized meal causes blood to be diverted to the splanchnic circulation decreasing blood flow to other important organs and this leads to endothelial dysfunction with resultant impairment of vessel dilatation. The heart rate increases as the splanchnic circulation goes into overdrive. There is release of norepinephrine and subsequent elevation of blood pressure along with the post-prandial increase in triglycerides that results in blood becoming thicker and "fatter." All these events cooking up a perfect menu for a myocardial infarction (MI)!

So can a meal kill you? If you overdo it and you have other risk factors, you bet it can.

3. Christmas

Christmas, as in Christmas?! What?!!!

Christmas may be the most wonderful time of the year as every sappy Christmas song goes. But in reality, Christmas can exact a heavy toll on the heart. The incidence of MI actually rises during Christmas³! Along with the increase in hospitalizations, there is also a rise in the death census during the festive season!

A DZMM *Teleradyo* program hosted by Niña Corpuz actually featured the phenomena of the "Christmas coronary" and the "happy new year heart attack" with guest Dr. Christopher Nazal of the College of Occupational Medicine.

The frequent parties that mark the holiday season are a cue for heavy meals usually featuring roast pig (*lechon*) and the rich desserts that characterize a Filipino celebration.

Another mechanism of the "ho-ho-ho" heart attack is appropriately enough, the so-called "Holiday Heart"—that phenomenon of acute arrhythmia triggered by heavy alcohol use!

For the record, that "holiday heart" does not limit itself to Christmas. It can refer to any holiday when excessive drinking is a feature and in the Philippines (it's more fun to call our country *fiesta islands*), that's practically every day!

The most common of these arrhythmias is atrial fibrillation that can trigger an acute ischemic event, or precipitate heart failure and increase stroke risk.

As this "inane" trigger to an MI features excessive eating and drinking, we are reminded again that in all things, moderation is best.



4. The Fast and the Furious Eating

It cannot be denied that there are cultural variations in a survey of worldwide CVD risk. One of the more often cited is the discrepancy in American and European CAD figures, particularly among the French who are renowned food connoisseurs and gourmards.

When the average American diet was compared with that of an average Frenchman, the French consumes more fat. The French consumes four times as much butter; 60% more cheese; nearly three times as much pork!

Yet strangely, the statistics indicate that the French live longer. Some experts deny such a thing but proponents of “The French Paradox” insist that it has more to do with the more leisurely pace of life and especially the meals in the Continent.

A survey of McDonald’s burger joints indicated that the average American finishes his meal in around 12 minutes. In contrast, the same meal will take 20–22 minutes to consume in Paris. Plus, that same Harvard study looked at restaurant listings

“The French Paradox... has more to do with the more leisurely pace of life and especially the meals...”



in large American cities and found that on average, eat-all-you-can buffets were offered in 80% as opposed to none in the Paris directory.

The prevalence of the Mediterranean diet with less processed food, more of the lean meats and fish, olive oil and nuts and no snacking matters in addition to the “eat slowly, eat portions” dictum. It would seem that the common sense exhortation to take time over meals and to eat healthy is all that is behind the “French paradox.”

5. Alcohol Status? It’s complicated!

The real question is: does alcohol impact the heart? And if it does, is it a positive impact or is it negative?

The data on the effect of alcohol on heart health indicate a complicated relationship.

Absolute alcohol intake in grams equals the number of units of consumed beverage times the amount of alcohol per unit of beverage. To standardize therefore, one drink equals 12 fluid ounces of regular beer, equals 8-9 oz of malt liquor, equals 5 oz table wine equals 1.5 shot of 80-proof spirits.⁴

Moderate⁴ drinking is defined as not more than 1 drink per day for women and not more than 2 drinks per day for men. A “binge”⁴ equals four or more drinks during a single occasion for women and five or more drinks/single session for men.

As in hypertension, researchers⁴ suspect a J-shaped curve to describe CAD risk and alcohol. Three or more drinks/day increases CAD risk and continues to raise it as the number of drinks imbibed increases. But the risk for non-drinkers may be even higher than that for moderate drinkers and the lowest risk is seen in those taking one to two drinks per day. Again, there is the caveat for moderation!



And what about those who quit drinking?

The “ex” in “ex-drinker” does not save these people: ex-drinkers have higher cardiovascular diseases (CVD) and CAD risk than teetotalers! It is believed that the higher risk in ex-drinkers may be related to higher confounding traits that are related to past alcohol use.⁵ And alcohol by itself is already related to higher mortality risk from hypertension, hemorrhagic stroke and cardiomyopathy.

Although moderate alcohol drinkers appear to have 25% less risk of an MI than teetotalers, a report published in the Lancet⁶ indicated that regular alcohol drinkers are 50% more likely to develop cancer and their risk for injury is 29% and the result is a greater overall total mortality from non-cardiovascular death!

To answer the question of the relationship between alcohol consumption, heart disease and total mortality, there are no hard and fast rules. To drink or not to drink? The glass here is both half-full and half-empty reflecting a really complex relationship.

6. (De) Energizing drinks?

In the 1980’s, an Austrian named Dietrich Mateschitz stumbled on a health tonic in Bangkok and began marketing his version in 1987.

His slogan was “Red Bull gives you wings” and the product was of course Red Bull! Riding on the success of his drink, Mr. Mateschitz became a billionaire. Red Bull promised an increase in performance, concentration and reaction speed, an improvement in vigilance, emotional status and stimulated metabolism (whatever that means).

In recent years, media reviled the slogan saying the “Red Bull gives you wings, all right! (But) you gain them because you die!” All this after a rush and rash of media stories about young people dying after consuming Red Bull!

Investigations revealed that the penultimate event before death included acute MI in the setting of an undiagnosed cardiomyopathy in a young basketball player; sudden cardiac standstill after consuming eight cans equivalent to 640 grams of caffeine in five hours; several cans consumed and strenuous activity; and two reports of death after taking Red Bull as a mixer with alcohol. And this is apparently true for all other energy drinks, not just Red Bull.

While reports of deaths may occupy the headlines, energy drinks can have non-fatal but still significant effects, notably emergency hospitalizations and medical illness that simulate some poisonings. An Australian survey noted an increase in Emergency Department admissions for conditions related to the use of energy drinks.

The manufacturers cried “Foul” maintaining that the caffeine content of a can equals a small cup of coffee at most... and that there is no cause for alarm! Or is there?

There have been theories that it is not one ingredient but probably the interaction of several. Investigators look narrowly upon the combination of caffeine and taurine in the setting of almost 13 teaspoons of sugar on average within a can.

An elegant demonstration by an Australian group⁷ demonstrated increased platelet aggregation and vascular dysfunction via the use of platelet aggregometers and brachial artery hyperemia index. Volunteers’ platelet aggregation increased by two to four-fold after ingestion of two cans of energy drinks while their brachial artery hyperemia index reduced. A combination that can certainly lead to an acute ischemic event. Another mechanism is the precipitation of arrhythmia.

Critics argue that the adverse effects did occur uniformly. But careful analysis of the data indicate that the effects were lethal in those who took large amounts of the energy drinks within a shorter period or within a single setting. Excessive physical exertion; mixing with alcohol; pre-existing heart conditions are the more important predictors of “red bull gives you wings... and a harp and halo.”





7. Oral hygiene is Heart Health, too!

The health of the mouth and gums has been generally accepted as a marker for general health. Studies show that oral health can be a marker of many systemic disorders, including CVD.

This concept is not actually new. In the 1920's, doctors already saw the higher incidence of heart disease in those with poor oral health and the response of the doctors at the turn of the century was truly inane. They began to perform wholesale tooth extractions in an effort to prevent or stop heart disease.

Unfortunately, they did not achieve their objective simply because the problem was not in poor teeth - it was in the gums! Gingivitis and periodontitis are both conditions that allow for bacterial build-up in the gums and the toothline that in turn predisposes to bacteremia. The resultant general inflammation begins a ruinous cascade: lipid oxidation that cause macrophages to become foam cells and initiate the fatty streak, the first visible sign of atherosclerosis.

In addition to the inflammatory cytokines, there is a release of enzymes like the metalloproteinases that also contribute to the destabilization of existing plaques and the subsequent cardiovascular event.

The proactive prevention of CVD therefore, could be as simple as brushing your teeth properly and regularly!

8. Traffic

Traffic. Say it again. Traffic.

Oh well. Oh yes. Oh no!

The metropolis traffic situation (that includes Manila and Cebu, let's not talk about world rankings in worst city traffic in the meantime) has steadily declined from bad to worse to horrendous! That is even without the famous floods! All the efforts by the dancing traffic enforcers, the tongue-in-cheek social media posts or even the unfailing Filipino sense of humor have been to no avail.

And the cost of traffic is estimated to be by the billions per day, and these do not come from business losses alone. The Philippine traffic czar(?) in the past administration made a lame excuse for his shortcomings saying that "the traffic may be ruining the lives of thousands daily but at least it's not fatal" – a remark that caused outrage and opened the floodgates of social media attacks.



“ A traffic jam increases MI risk regardless of type of transport. The risk is 2.6 times for people stuck in cars; 3.1 higher for those in buses; and a whopping 3.9 more for those on bicycles! ”

A German study completed in 2001 reported that people stuck in traffic for more than an hour were more likely to suffer a heart attack! In that survey, they looked at 691 survivors of an MI and noted that one out of every 12 MI cases were linked to traffic.

A traffic jam increases MI risk regardless of the type of transport. The risk is 2.6 times for people stuck in cars; 3.1 higher for those in buses; and a whopping 3.9 more for those on bicycles! The link is so immediate, it can be seen within an hour of being stuck in a jam.

And what causes it? Particulates from soot in exhaust, especially diesel engines, were blamed in the study! Stress also probably has a role but it was this factor that was concluded to be most important. This makes air pollution the culprit.

In predisposed individuals, short-term exposure to air pollution will raise risk not only for MI but for arrhythmia as well! The mechanistic effects of air pollution follow the pathway through oxidative stress and inflammation similar to mechanisms behind poor oral hygiene, skipping breakfast and eating heavily.

A whole spectrum of CVD can occur according to the particulate size of the air pollutants, and it is the emission from diesel engines that are particularly harmful. So, in the end, just as all metropolitan roads lead to traffic, so do all roads lead to the heart, and all traffic jams CAN lead to a heart attack! Contrary to what that traffic authority claimed, traffic CAN be fatal!

9. Manny Pacquiao, really now?

The first and only eight-division world boxing champion, in four weight categories, the one and only Manny Pacquiao, also known as the "Pambansang Kamao."



When he fights, everything stops, including crime and the long-running Muslim insurgency in the south. Fans will die for their hero! Literally. It may be stress, the anxiety and excitement because emotions run high when our Manny enters the ring.

The tension of a Pacquiao fight is the cue for norepinehrine to rise that leads to rising blood pressures and risk of a heart attack. In his nationally syndicated column, Dr. Willie Ong wrote some guidelines to be followed before watching a Pacquiao fight that included getting a check-up and avoiding the live telecast if one has a pre-existing heart condition. As our new Senator himself advised: "just watch the replay, you know."

10. Second- or third-hand smoking

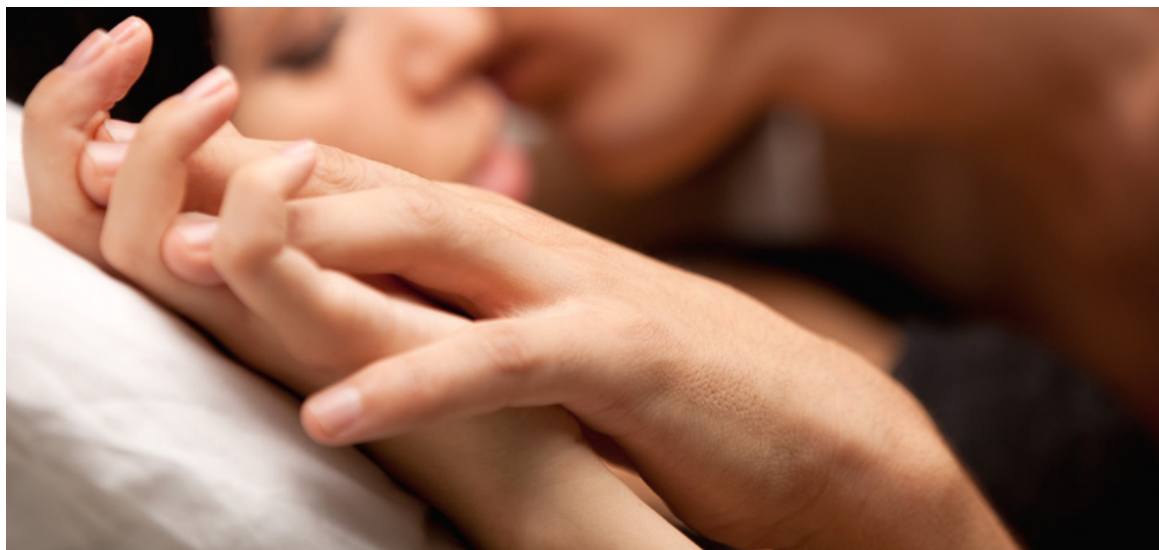


Indirect exposure may be as harmful as the actual thing and a smoking partner may be just as lethal as a smoking gun.

When it comes to smoking, it is not good to give, nor is it any better to receive because second hand smoke kills!

A good number of deaths related to smoking (up to 8%) occur in those who are exposed only indirectly⁸. The risk for heart disease rises by 25-30% from chronic exposure to smoking in the home or workplace. In a nutshell, there is no safe level for second hand smoke and even a little is harmful to health.

Walls cannot protect the non-smoker when there is a smoker in the house; or from a smoker in the family car. The pervasive effect of smoke lingers and spreads through even the most open-windowed, closed-door environments. Furthermore, it is the children whose cardiovascular disease risk rises with chronic exposure to a cigarette smoking parent or guardian⁹. In a word: non-smokers, UNITE! No one should have to die because of someone else's bad habit.



11. Sex

Yes, sex.

Can sex precipitate a heart attack?

This is a famous movie cliché: The lovers meet for a romantic interlude in a secluded hideaway and the guy dies during sex. True story?

A meta-analysis¹⁰ of four studies that showed that men in their 50s and 60s have a 2.7 increased relative risk for MI during periods when they are actively engaging in sex compared to periods when they aren't.

The good news is that actually, less than 1% of MI are induced during sex and the consensus is that the benefits of sex far, far outweigh any potential risk of dying from MI.¹⁰ An American Heart Association-sponsored study¹⁰ did a review of 100 studies with a total of 5,559 autopsied cases of sudden cardiac death (SCD).

Around 0.6% were SCD that occurred during sexual intercourse of which 82-93% were men; and 75% were in an extramarital situation - in most cases, with a younger partner! There are some who would consider this poetic justice and the conclusion is that extramarital sex may be slightly more likely to cause heart attacks!

Public education sites take notice and include the caveat that furtive encounters and extramarital partners

could be fatal for men recovering from a cardiac event!¹¹ The added stress of an illicit sexual encounter can act as a trigger to increase blood pressure, raise the heart rate and trigger a dysrhythmia. So it certainly looks like the formula for "dying in the act" is a middle-aged man + recent MI + illicit sex = SCD. In addition to which, if the unfaithful bastard survives his illicit affair, he still risks death if caught by his legitimate partner!

Upon review of the evidence behind these contenders for a revised coronary risk checklist, it becomes clear that a new description is needed for our top inane things that could break your heart. These situations no longer deserve to be called "inane." From "inane" to "profane," they are very legitimate conditions that can trigger a heart attack! ♥

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“...men in their 50s and 60s have a 2.7 increased relative risk for MI during periods when they are actively engaging in sex...”

PEPPING UP... from Page 34

Going up on the approach and on a bigger, wider and more ambitious level, the PHA may come up with a jingle or an infomercial that can be aired over television and radio. Repetition and easy recall combined drive the message better. A national launch may be a grand way to jumpstart the campaign, but then again sustainability is one big challenge. Of course, funding would be one of the biggest difficulties. It may be difficulties, but not impossible. The political will to realize this is critical in moving a machinery towards PHA's set goals.

Going practical (and frugal), social media is a cheap but efficient way of reaching out

to the targeted population of the campaign. A dedicated Facebook page, or other similar social media applications may be a perfect venue to send out the message about healthy living.

A simple project it may seem, but the 52100 Campaign's significance in promoting healthy lifestyle practices and preventing cardiovascular and metabolic diseases that continue to be the country's number one killer cannot be undervalued.

The PHA is going in the right direction in promoting primary preventive strategies. To be effective in solving healthcare problems, it is but logical to implement solutions even before the onset of the

problem. Or better yet, even before risk factors set in. The strategy can smoothly shift from primary to primordial prevention. The toll on cardiovascular health together with the physical, mental, emotional, social and economic consequences is heavy. That is why the PHA has to be heavy too in pushing for the 52100 Campaign.

Awareness campaigns are generally quite easy to jumpstart, but promoting a lifestyle, more so a healthy one, is a life-long job of reminding. Nothing is actually easy, but big projects need better planning and implementation strategies for lifestyle advocacy projects like the 52100 to take off and fly. ♥

DE-STRESSING... from Page 38

deep breathing exercises to clear the mind and the airways.

Visual imagery is more of something mentalists employ, but it is also proven to relax the mind and body through distracting the imagination. Another most common type of meditation is resorting to music. Resorting to sound and completely surrendering to melody stimulates specific parts of the brain responsible for sleep and dreams – bringing about relaxation in its wake.

PAMPERING

Spas and massage parlors have constantly been a trend ever since rush-hour and traffic began to rise. It is not surprising, though, as trips to pampering stations every now and then are guaranteed ways to rejuvenate worn out cells and muscles which prolong the feeling of stress. Popular picks are aromatherapy and all variants of massage therapy which all aim to stimulate the senses into replenishment, as well as other simple "vanity treatments" such as undergoing hair care in a salon, the usual manicure-pedicure, and a treat to the sauna.

ALTERNATIVE TREATMENT

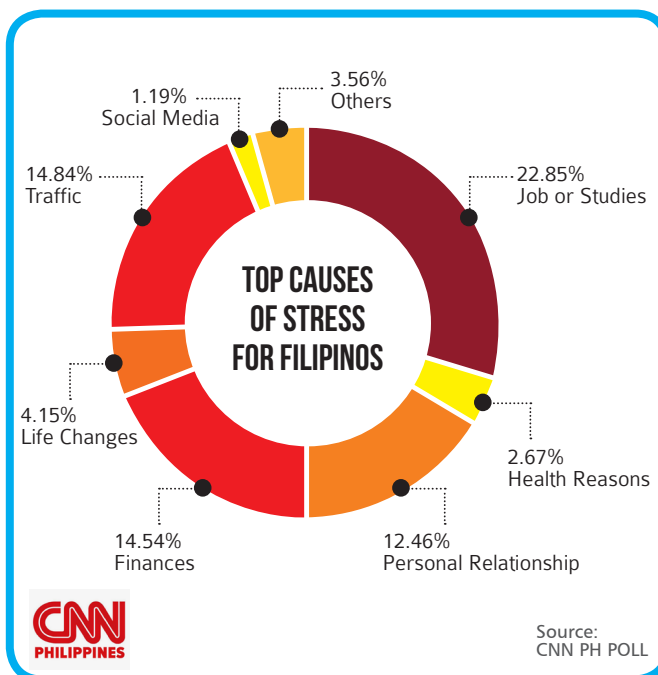
On the other hand, going to these indulgence centers could also be stressing to some because of the costs they have to give up just to relax. It is only reasonable that we get to unwind without hurting our pockets, thereafter. Therefore, a couple of alternative stress-busting, home-remedy ways could also be considered.

People who keep a diary or a daily journal have it easiest to calm down after a long day. You don't have to be adroitly a man of literature to do this correctly – remember, stress reduction is ultimately the point – rather, simply writing about how you feel and pouring them all out on paper will certainly leave you deflated once you put the pen down.

Other means could be laughter – just because laughter is the best medicine for everything down side – and playing with pets as this releases oxytocin or the "cuddle chemical" which instantly puts someone in a good mood. Or doing just about anything you consider as your "happy pill," meaning hobbies. Things you fancy doing could take you away from pressing matters and, should you go back to them later on, face them with a tranquil mind and feeling.

Of course, a lot of people would take the "happy pill" quite literally, by treating stress through drugs and other medication like relaxants, vices such as smoking, gambling and other games, and even shopping and food, to relieve one from stress – which could all lead to more offsets, eventually.

It may already sound overly cliché, but the best way to not experience the full blown effects of stress is to get enough sleep, proper diet, and less caffeine and other stimulants, and proper relaxation. With proper management of oneself, physically and emotionally, the offsets would not be significantly felt. Aiming at having a long life lies on care for the core human mechanism – the mind and the heart. Common illnesses could be avoided, and the road to health could be achieved if we learn to set outlets for our emotions – not to nurse it but to sustain. It is high time for us to be mindful and weary of what clinical surveys are saying. If you don't want to be a statistic, de-stress. ♥





On Death and Dying:

The Intensivist's Role in End-of-Life Care Revisited



THE INTENSIVIST



■ By Jeremiah Butch Tallo Gemarino, MD, FPCP, FPCC

The pen's ink smudged on to the white paper as it mixed with drops of tears that fell from Meera's cheeks (not her real name) as she signed the DNR (Do Not Resuscitate) waiver for her mother who has been in deep coma for the past five days in the coronary care unit (CCU).

Meera's mother was a frail 73-year old hypertensive, diabetic elderly with chronic kidney disease who was admitted due to high risk non-ST segment elevation myocardial infarction. Since admission up to the 5th day at the intensive care unit (ICU), the patient had three episodes of cardiac arrest due to arrhythmia and heart failure. Revascularization was offered but the family declined.

As the light of hope gradually dimmed out on the life of Meera's mother, the intensivist in charge of taking care of the

patient's medical needs shifted his gear from an aggressive and curative strategy to a palliative one.

In the case of Meera's mother, one of the basic reasons for admitting patients to the ICU is to help them survive the impending threat to their lives. On top of that, the ICU is also the place where ill effects of organ dysfunction can be attenuated, if not reversed, and health restored.

But even in the best institutions in the world or in the hands of the most seasoned intensivists (on top of the technological

“ Amidst the chances between living and dying is an intensivist who keenly steers the directions of the therapeutic goals, whether restorative or palliative...”

advances in the dynamic practice of critical care medicine), the fact that people in the ICU still die remains a hard reality.

Though local data is yet to be determined, US data show that as much as 22% or one in every five deaths occur inside the ICU according to the 2008 Consensus Statement of the American College of Critical Care Medicine. Admission to the ICU is therefore a therapeutic gamble. One may come out of it dead or alive.

Amidst the chances between living and dying is an intensivist who keenly steers the directions of the therapeutic goals, whether restorative or palliative, basing on the patient's daily response to treatment. When the patient's illness is unresponsive to treatment and dependence on life support becomes incongruent with the patient's values, ICU clinicians or the intensivists must ensure that patients die with dignity.

According to the 2014 New England Journal of Medicine, the definition of “dying with dignity” acknowledges the intrinsic, unconditional quality of human worth and also the external qualities of physical comfort, autonomy, meaningfulness, preparedness, and interpersonal connection.

With the bothersome alarms of the cardiac monitors and mechanical ventilators along with the enclosed space with no television and no relative always present at the bedside, the ICU complex can be a very inhumane, impersonal, and insensitive place. After the onset of critical illness, most patients and their family members may find it difficult to communicate to unfamiliar ICU clinicians and health care workers in an environment surrounded by machines and monitors. What then can the intensivist do together with the other members of the critical care team to dissipate the impersonal and insensitive ambiance that the dying patient may feel during his stay in the ICU?

The ABCD of Intensive and Critical Care

If cardiopulmonary resuscitation has its CAB mnemonics, intensive and critical care has “ABCD” in taking care of terminally ill patients that the ICU clinician and the critical care team can be guided with. In the 2014 issue of the New England Journal of Medicine entitled “Dying with Dignity in the Intensive Care Unit,” ABCD means: “A” for attitudes, “B” for behaviors, “C” for compassion, and “D” for dialogue.

The intensivists and other clinicians involved should reflect on their own attitudes as these can directly determine their respective approaches to patients. Oftentimes, clinicians need to reflect on their own life experiences to deliver care that is personal and sensitive.

“B” is for Behavior which should enhance patient's dignity. Both verbal and nonverbal communications are key factors that demonstrate the mutual trust and confidence in the doctor-patient relationship. The clinician should not rush but should rather take time to sit down, make eye contact with the patient and the



family, and to communicate in simple terms that the family can understand.

“C” is for Compassion which is the sensitivity towards the suffering of another and the desire to relieve it. The ICU clinician should go beyond medical history and elicit personal stories that accompany the patient’s illness. Despite being confronted with death and illness too many times, compassion is one of the benevolent virtues that brings out the humanity in the ICU clinician.

“D” is for Dialogue which should acknowledge personhood beyond the illness. It is also the clinician’s role to explore the values that are most important to the patient and to seek out the people who can help him through this difficult time. The ICU clinician can also set the mood for the patient and family to reflect and reminisce that could somewhat ease the suffering the family is going through.

In the process of taking care of patients with critical illness who are threatened with imminent death, the intensivist needs to manage a variety of situations that concern the patient, the patient’s family, the ICU staff members, and even himself.

Dealing with the patient

According to the 2015 NICE Guidelines on the Care of the Dying Adult, there are several signs and symptoms that the intensivist or ICU clinician should recognize and address to provide the comfort and care that patients need. These include pain, breathlessness, nausea and vomiting, anxiety, agitation, delirium, and noisy respiratory secretions.

Approximately 40% of hospitalized dying patients have moderate to severe pain in the final three days of life according to the SUPPORT Trial published in the Journal of the American Medical Association (JAMA) published last 1995.

“ It is the intensivist’s role to alleviate pain and suffering which is vital in providing quality end-of-life care.

For the family members of the dying patient, it is inevitable for some to feel a sense of guilt that led to the patient’s terminal illness. ”



It is the intensivist’s role to alleviate pain and suffering which is vital in providing quality end-of-life care. A team of doctors from the Department of Medicine of the University of Toronto drafted a set of consensus guidelines on analgesia and sedation in dying ICU patients published in the BioMed Central Medical Ethics Journal last 2002.

The article reiterates that providing analgesia and sedation for dying patients poses a delicate balance because it creates a very thin line between palliative care and euthanasia. Likewise, the guidelines also mention the Principle of Double Effect which states that “If the amount of narcotics/sedatives required to relieve pain and suffering at the end-of-life may foreseeably cause hastening of death, although the physician’s intent is solely to relieve suffering, this should be considered palliative care.” In effect, the physician involved should clearly document in the chart his intentions in giving sedation and analgesia to avoid any misinterpretation in the management.

To manage the other signs and symptoms like breathlessness, nausea, vomiting, anxiety, delirium, and noisy secretions, the ICU clinician is directed to specific recommendations on end-of-life care. To the dying patient, the medical team involved should not just be a source of physical comfort but psychological and spiritual as well. The doctor should also extract an adequate spiritual history so he can call on pertinent authorities to help alleviate the patient’s suffering.

“...some members of the ICU staff may exhibit indifference or withdrawal when delivering health care.”

The intensivists and other attending physicians must also appropriately deal with the stage of grief the dying patient is going through. According to the book authored by Swiss Psychiatrist Dr. Elisabeth Kubler-Ross, titled *On Death and Dying*, the terminally ill patient goes through five stages of grief: denial and isolation, anger, bargaining, depression, and acceptance. The goal of the ICU clinician and the other attending physicians is to pave the way for the dying patient to reach the acceptance stage to allow him to die with peace and dignity.

Dealing with the patient's family

As the dying patient goes through the five stages of grief as stated in the book of Dr. Kubler-Ross, the patient's family also goes through these stages and must also be appropriately dealt with. With the news of terminal illness or imminent death, most conflicts arise when the patient and the family go through the stages of grief at different paces.

For example, the dying patient has accepted the idea that he is going to die anytime soon yet his family is stuck in the denial or anger stage, thereby creating conflict with the patient, the doctors, and the other members of the critical care team.

For the family members of the dying patient, it is inevitable for some to feel a sense of guilt that led to the patient's terminal illness. Some may feel angry, others may feel lost, and even others may feel indifferent.

To avoid misunderstanding and even projection of the family's disappointment and pent-up aggression to the health care workers, the doctors should spend more time talking with them either to pacify their guilt, redirect their emotions, or even celebrate the patient's life. A good and consoling conversation from the health care workers involved would dissipate the family's sensitivity to the idea that they are being abandoned. The ICU clinician should harmonize this conflict so the patient and the family will be led to the final stage of acceptance and peace.

Dealing with the ICU staff members

With so many deaths occurring in the ICU, doctors, nurses, and attendants are trained to always exercise compassion and sensitivity to the patient and his family. But sometimes the situation may not be so ideal especially

when some members of the ICU staff may exhibit indifference or withdrawal when delivering health care.

The intensivist and the ICU managers should check every so often the psyche of their team members towards palliative care because people taking care of the dying patient at the bedside create a great impact in the quality of end-of-life care.

It is also imperative for the members of the ICU team to avoid a raucous environment inside the ICU complex but rather be mindful to maintain silence and adapt an ambiance conducive to healing. In delivering palliative care, the ICU team should review planned procedures with the other staff members so as not to deviate from the goals of present management.

Dealing with one's own self

From the book "The Intensivist's Challenge: Aging and Career Growth in a High-Stress Medical Specialty," the author wrote that many physicians still fail to open up conversations with dying patients and their families and all too often, intensivists must pick up the pieces of shattered expectations and pay an enormous emotional toll over time.

At the outset, intensivists may feel frustrated and remorseful especially when they are pushed against the wall and left with so little options in the medical management. To save lives is the intensivists' mantra and oftentimes they are depended upon by other physicians to tie over the seemingly inextricable medical condition.

But when one medical problem piles upon another, thereby creating a medical scenario that further elevates the level of care, the intensivist should learn to communicate effectively to the patient and family about the uncensored truths of the situation.

Despite a grueling schedule that attending physicians and the intensivists have, taking time out to sit down and talk to the patient and family members remain to be a valuable way for the medical team to convey care and compassion.

But situations oftentimes are not that considerate. Some doctors may tend to detach themselves from being empathic to avoid emotional labor and psychic suffering because the truth is, doctors are no robots. They are not trained to compartmentalize their emotions. ICU clinicians or intensivists who perceive physical or psychic pain may suffer indirectly yet intensely.

With this scenario, the clinicians are prone to caregiver fatigue which can be translated into emotional withdrawal and eventually compromise the care of dying patients and their families.

On the other end, the clinician can develop a sense of deep emotional attachment to the patient or the family because the persons involved may remind him of a loved one or a familiar situation. In Psychiatry, we call this transference. This scenario can shake the very



“...the intensivist should learn to communicate effectively to the patient and family about the uncensored truths of the situation.”

core of the intensivist's confidence in his capacity to save lives especially when there was failure of medical management that led to the patient's demise.

Though painstakingly hard to follow, ICU clinicians or intensivists should learn to set emotional boundaries so they can efficiently provide appropriate and quality care to patients.

Another setting that can significantly affect the ICU clinician is when the family's views are opposite to his beliefs, thereby creating a form of moral distress. This conflict can greatly affect the way the intensivist, the patient, and his family deal with each other and the situation. That is why, the intensivist should have an infallible perception of the patient's values to maintain mutual trust and confidence in the doctor-patient relationship.

The Inevitable

Death and Dying is a natural process. It is inevitable. Not even the best intensivists in the world or the most advanced ICU set-up could put a stopper to it. Nobody can deny its reality. Just like how Meera's family

accepted the truth of her mother dying, doctors, more so intensivists, should have a clear understanding and acceptance that everybody at some point will go through it. For some, the process of dying may be long and arduous while others may go through it at an instant. But at that moment, whether long or fleeting, the ICU clinician is there to extend help and do measures to save a life.

But more importantly, when death becomes imminent and the patient starts to walk through the mist, the ICU clinician, after adequately explaining to the patient's family the certainty of a losing battle, is called to alleviate pain during the process and allow the patient to die with peace and dignity.

Though the general goal of intensive care medicine is to create an environment that will aid critically-ill patients to survive and return to a functional state that is acceptable to them, the English author and theologian GR Dunstan wrote in one of his books that these sheer truths relate to the quality of delivering intensive care and should strike a chord in the heartstrings of ICU clinicians or any doctor for that matter.

He wrote, "The success of intensive care is not to be measured only by the statistics of survival, as though each death were a medical failure. It is to be measured by the quality of lives preserved or restored; and by the quality of the dying of those in whose interest it is to die; and by the quality of human relationships involved in each death." ♥

Dr. Gemarino is currently a clinical research fellow in Critical and Intensive Care at the Philippine Heart Center



Work Out for the Weak Heart

■ By Lucky R. Cuenza, MD, FPCC, FPCC

Controversies in pre-participation screening in athletes: Where do we stand?

The recent death of 29-year-old PBA player Gilbert Bulawan of Blackwater Elite has sparked calls and debate regarding rigid pre-participation cardiovascular screening of athletes.

According to anecdotal media reports, the cager died because of an “enlarged heart” which was reportedly not detected in prior medical check-ups. In hindsight as medical practitioners, could this tragic event have been prevented? What could have been done? Should we raise the red flag for cardiovascular risk in athletes?

While sudden cardiac death (SCD) in athletes is relatively rare (ranging from 1 in 50,000 to 1 in 100,000 per year), the effects are far reaching with social and liability issues. The event is often dramatic, publicly witnessed and most certainly unexpected in athletes who are considered at the highest paragons of health.

Causes of sudden cardiac death

Physical activity and exercise, while undoubtedly conferring multiple cardiovascular and non-cardiovascular benefits, are associated with a small increase in sudden cardiac death risk and is greatest in sedentary individuals during exercise and the risk increases with age.

It is not that exercise causes sudden death per se, but it may act as a trigger for a possible underlying and previously undetected abnormality. The most common cause is atherosclerotic cardiovascular disease in individuals more than 35 years old. Common causes of SCD in young adults are genetic and congenital cardiovascular abnormalities, including cardiomyopathies and coronary artery anomalies.

In 2-5%, SCD may be caused by a primary electrical heart disease or a channelopathy. Adolescent and young adults involved in competitive sports have an estimated risk of SCD approximately three times greater than that of their non-athletic counterpart.

In about half of autopsy studies on individuals who died from SCD, no apparent cause could be found, and up to half of them were actually asymptomatic for cardiovascular diseases.

Note must be taken that these findings were derived from foreign data. Further, due to its rare albeit dramatic presentation and reliance on media and observational reports, we do not have accurate estimates on the incidence of SCD among athletes locally.

Screening for Sports participation: USA vs Europe and the ECG controversy

The two regions provide models in the conduction of pre-participation screening of athletes. However,

disagreement between the two stems from the use of the simplest technology: the electrocardiogram (ECG).

While different athletic organizations have their own methods of screening, the American Heart Association advocates and recommends the use of the 14-element screening questionnaire. This basically

involves history, physical examination and family history. Any abnormalities in the screening process will require further investigation prior to giving clearance to participate in physically competitive sports.

Europeans on the other hand include the ECG along with history and physical examination (PE). This is based primarily

on an analysis of a nationally mandated Italian screening program by Corrado and colleagues.

The European Society of Cardiology (ESC), the International Olympic Committee (IOC) and most European sports federations have also consequently adapted the European model.

American Heart Association 14-Element Screening (Maron BJ *Circulation* 2014)

Medical History (Parental verification recommended for high school and middle school athletes)

Personal History

1. Exertional chest pain/discomfort
2. Exertional syncope or near-syncope
3. Excessive exertional and unexplained fatigue/fatigue associated with exercise
4. Prior recognition of a heart murmur
5. Elevated systemic blood pressure
6. Prior restriction from participation in sports
7. Prior testing for the heart ordered by a physician

Family history

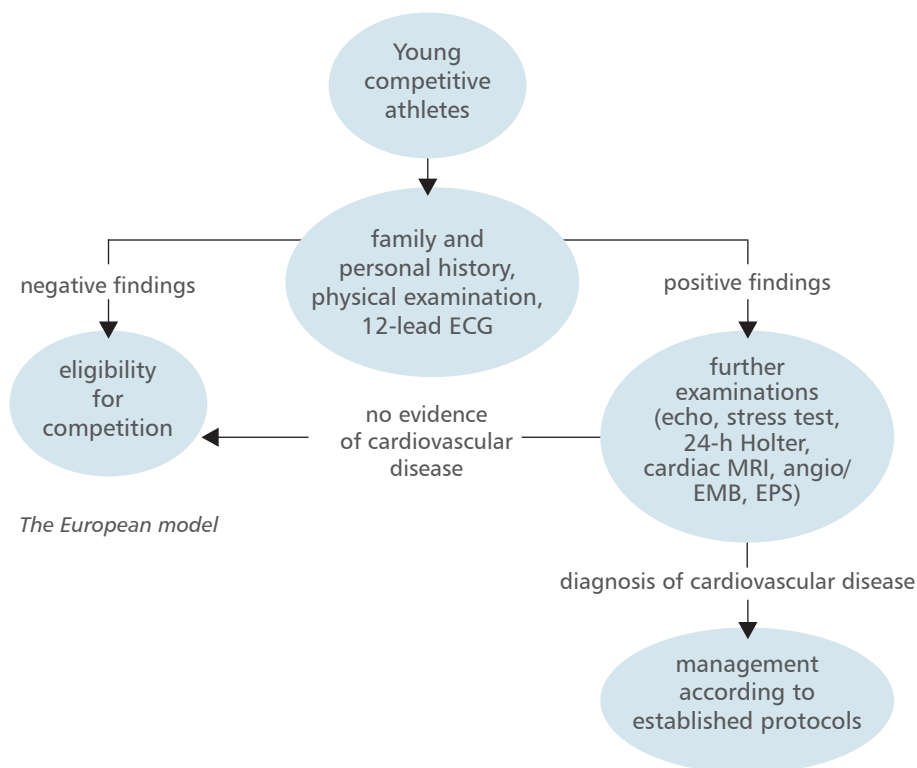
8. Premature death – sudden and unexpected before age 50 yo due to heart disease, in one or more relatives
9. Disability from heart disease in a close relative < 50 yo
10. Specific knowledge of certain cardiac conditions in family members: hypertrophic or dilated cardiomyopathy, long-QT syndrome or other ion channelopathies, Marfan syndrome, or clinically important arrhythmias

Physical exam

11. Heart Murmur-exam supine and standing or with valsalva, specifically to identify murmurs of dynamic L ventricular outflow tract obstruction
12. Femoral pulses to exclude aortic stenosis
13. Physical stigmata of Marfan syndrome
14. Brachial artery blood pressure (sitting, preferably taken in both arms)

Positive/abnormal screen warrants further evaluation and 12-lead EKG
AHA does NOT currently recommend routine 12-lead ECG

The US/AHA recommendations



The European model

What is being done in the Philippines?

For the most part, screening of athletes at the recreational level, as well as the elite level, are inconsistent and arguably not fully standardized. Many professional organizations routinely conduct pre-participation examinations on their athletes, while many other institutions either have pre-participation screening with or without ECG or do not screen them at all.

Usually, a sports medicine specialist does the screening with some access to referrals for cardiovascular assessment. The Philippines is a sports loving nation with an estimated population of 100 million, of which a third is comprised of young millennials who have contributed to an increase in enthusiasm in sports through active participation.

Around 10% of this young population have an interest or may have already been into some form of sports participation. These non-professional athletes participating in many events such as marathons also carry the same risk as the elite population. Should they all be screened the same way as the other professional athletes?

“ The ECG has a high false positive rate at 15%, and the electrical and chamber adaptations of the athletic heart may confound interpretation.”

Pros and cons of screening with or without ECG

Both the European and the American models have undergone a lot of debates and argumentations. Objectively, adding the ECG to the history and physical exam will increase the sensitivity of detection of many underlying cardiovascular disorders.

In the ideal setting, the Philippines may adopt the Italian model. However, this is not as simple as it sounds. The ECG has a high false positive rate at 15%, and the electrical and chamber adaptations of the athletic heart may confound interpretation.

There have been attempts to improve the sensitivity of the ECG. One of such is the Seattle criteria. However, care must be exercised in interpreting the ECG as proficiency in athletic ECG interpretation continues to develop. ECG does not detect some

conditions, such as anomalous coronary arteries. We may miss an abnormality and allow the athlete at risk to play. Conversely, we may subject an athlete to more comprehensive testing and we risk disqualifying an otherwise healthy athlete from participation which can have an impact both psychologically and financially.

To prove the effectiveness of a screening method such as the ECG, we need to be able to prove that doing such improves survival. So far no randomized studies regarding its efficiency in improving outcomes of SCD have been done. Further, in order to properly conduct such a study, we may need to screen lots of athletes with a very high risk of false positives. Following the European model may divert limited health resources from other concerns with possibly a bigger social impact and prevalence.

What can we do?

The following can be implemented to improve cardiovascular care for athletes:

1. Standardization of the pre-participation screening examination

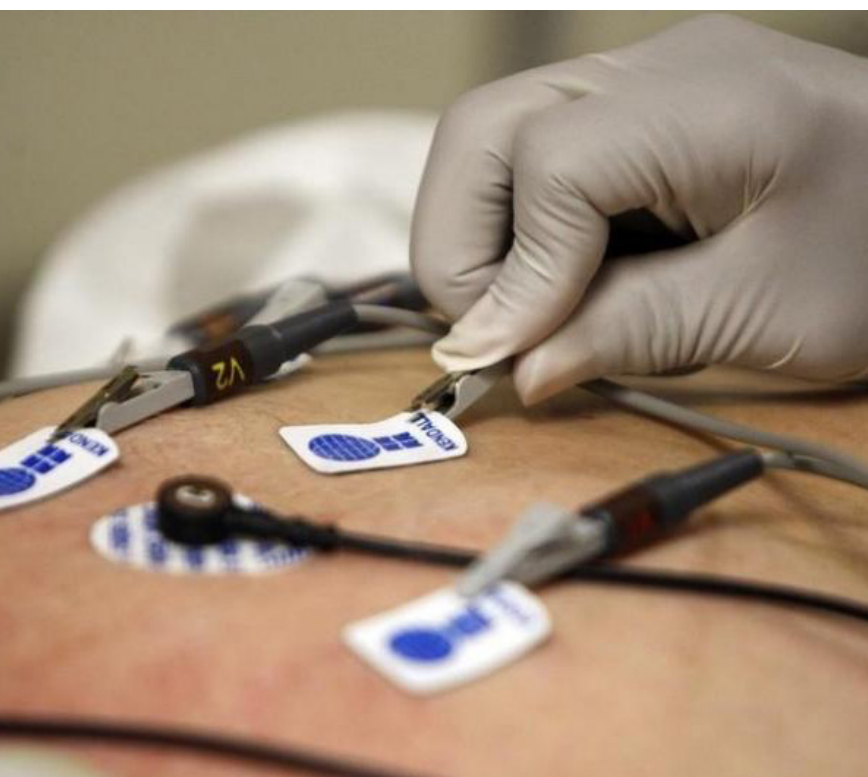
If we adopt the AHA recommendations, we need to be certain of our proficiency. We need to make sure that the conduct of our screenings are done right. We can either use the AHA 14-element screening or the Pre-Participation Physical Evaluation Form (PPE4) as utilized by the American College of Sports Medicine. A comprehensive history, PE and family history, albeit imperfect can increase the chances of uncovering an abnormality.

2. ECG implementation and interpretation

While there is much to debate on the use of ECG in mass screening, it can be suggested to be mandated at least at the elite level. Sports clubs and organizations need to screen their athletes combining the history, PE and the ECG. We do not want them dropping dead on national TV.

The ECG can be included in the pre-participation evaluation with proper allocation of resources. But in order for physicians to properly utilize this tool, medical practitioners need to update themselves and be proficient in interpreting the athlete's ECG changes. The latest revision of the Seattle criteria (2016) will enable cardiologists to better refine the predictive power of the ECG.

“ The ECG can be included in the pre-participation evaluation with proper allocation of resources.”





3. Cardiovascular specialists as part of the athletic team

The cardiologist can and should be an integral part of the sports team, along with orthopaedics, rehabilitation and sports medicine communities. This should involve a team approach in the assessment of the athlete, not just on pre-participation screening but also in eligibility and return-to-play decisions.

4. More research

Our understanding of the physiology and cardiovascular management of athletes has progressed much slower than other heart diseases. Research opportunities are endless. Questions that remain to be answered are good springboards for research: What is the true prevalence of SCD in athletes in our setting? Is hypertrophic cardiomyopathy the most common cause similar to data from abroad? From here, doctors can identify the problem and work on a focused solution.

5. Advocacy

It may be harsh reality that we are still grappling to terms with the effective screening method possible. The PHA Council on Cardiopulmonary Resuscitation have to be commended for their outstanding job in promotion of basic CPR.

This is a low cost intervention that will be sure to save lives and adequate dissemination of knowledge is paramount. And with the

recent successful legislation of the Samboy Lim Bill, we are already a step closer towards the right direction. Other things we can do include determination of availability of defibrillators and formulation of medical action plans in sports arenas, gyms and schools.

Because your heart matters

Cost benefit considerations as well as the problems in implementation may be big stumbling blocks, but the life of an athlete or a non-athlete can never be equated with numbers, money in particular.

There are no easy answers.

Should we mandate screening?

As of the moment, definitely not.

We do not force someone to do something he doesn't want to do, especially if the evidence so far is lacking and we do not have adequate resources to do so. But at the same time we do not want to place these individuals at risk. Individuals feel that they have the right to compete or exercise while organizations and healthcare providers also have a right to protect themselves and the best interests of the patient.

In spite of the rigid screening, it is absolutely impossible to eliminate the risks associated with sport. Exercise and sport related deaths have a wide social impact. We do not want these victims to become just a statistic. The time to be aware, improve our current knowledge and get involved is now. ♥

“ Cost benefit considerations as well as the problems in implementation may be big stumbling blocks...”



By Jason S. Santos, MD, FPCP

THE PARADOX OF EXERCISE: How much is enough and too much?

Half the world is starving while half is trying to lose weight. Most are physically inactive, some are active, while others are inadequately active.

In the first ever President's Lecture in the Philippine Heart Association annual convention history, Dr. Alex Junia reiterated life's universal mantra on moderation. Exercise, just like anything else in this world, has its own paradox, he said.

Speaking before a large crowd during the recent PHA convention last May of this year, the then PHA president defined paradox as a "seemingly absurd or self-contradictory statement or proposition that when investigated or explained may prove to be well-founded or true."

People exercise for different reasons. Most do it for health, wellness, and physical strength. Some are just caught up with the latest craze, like Zumba. While others would claim that exercise is a lifestyle that would provide an overall sense of improved well being.

“...people who are physically active have a significant risk reduction in cardiovascular events including death...”

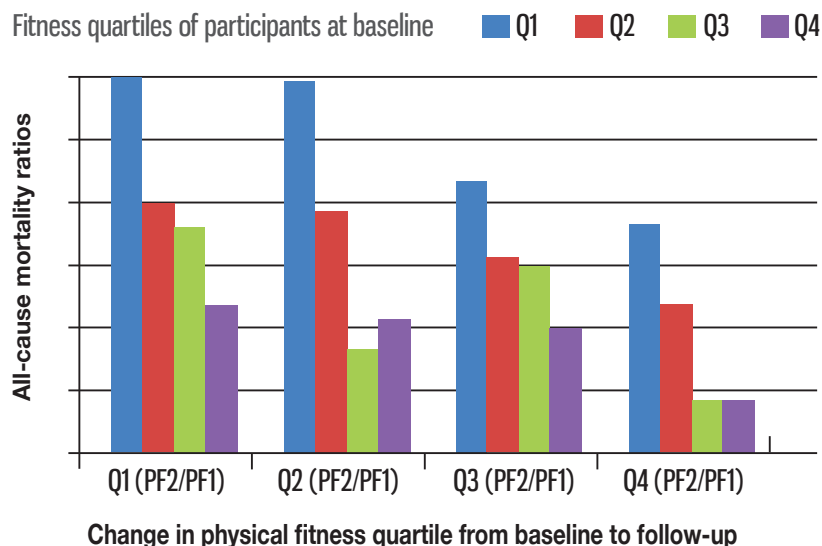
Exercise is beneficial, if you exercise

Citing literature, Junia underscored that “exercise makes people feel better” but the sad truth is that most people are physically inactive or inadequately active.



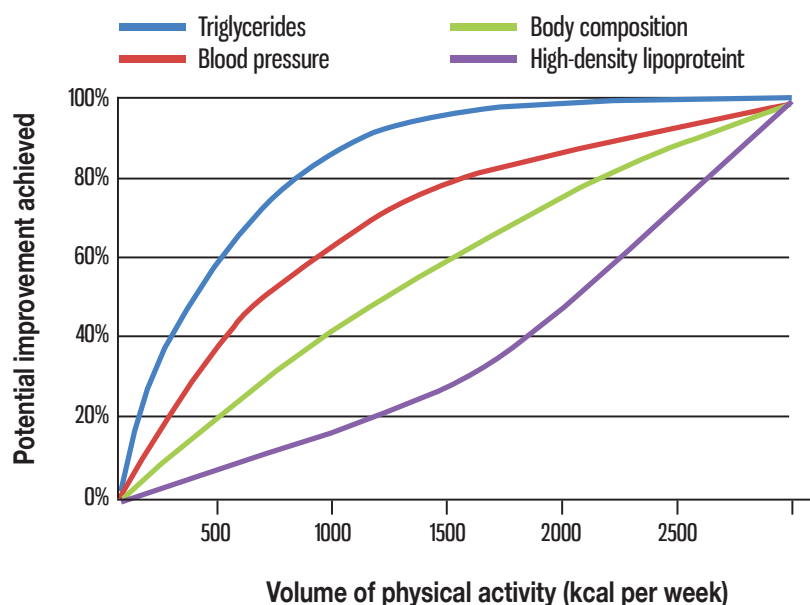
Junia

In a study done by Warburton, people who are physically active have a significant risk reduction in cardiovascular events including death: 31-45% decrease in all-cause mortality, 33-50% in cardiovascular disease



The relationship between changes in aerobic physical fitness and mortality over time.

Warburton et al. BC Medical Journal
May 2016 vol. 58 no. 4.



Theoretical relationship between physical activity and various determinants of health status

Warburton et al. BC Medical Journal
May 2016 vol. 58 no. 4.

(CVD), 32-50% in hypertension and 31-60% in stroke cases. There appeared to be more benefit with aerobic fitness exercises.

Furthermore, exercise has been associated with a drop in the risk of breast and colon cancers, diabetes and osteoporosis compared to those who do not exercise.

While age may cause a progressive decline, physiologic functions and subsequently performance are enhanced during exercise, Junia added.

While chronic exercise training may result in left ventricular dilatation and hypertrophy, the two most common morphological long-term adaptations of the heart, it enhances physiological function during exercise. Early diastolic filling is increased secondary to a combination of increased preload and increased myocardial relaxation. Moreover, advanced imaging techniques show that the heart muscle displays increased contractile strength.

Exercise helps even the failing heart

In a pilot study on exercise training in diastolic heart failure done in Europe, exercise improved functional capacity as measured by metabolic equivalents, physical dimension of quality of life in patients with heart failure with preserved ejection fraction. These were associated with atrial reverse remodeling and improved left ventricular diastolic function.

Elderly individuals who maintain regular exercise training programs benefitted from exercise in terms of cardiac function and aerobic performance that often decline during aging.

In patients with cardiovascular disease, the benefits of exercise are less pronounced, which defines the distinction between the young and healthy individuals who adapt readily, and those who have existing CVD and the elderly.

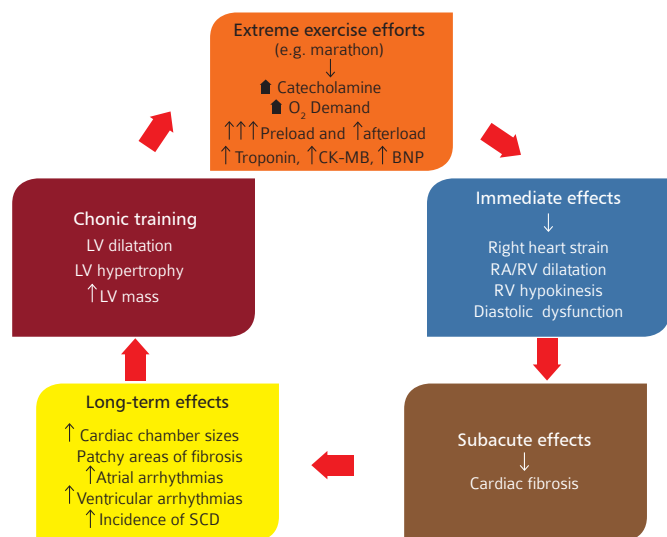
Arteries likewise benefit from exercise as studies show arterial stiffness is significantly lower in individuals with a higher aerobic capacity. Chronic aerobic exercises protect against vascular oxidative stress and inflammation.

Added benefits of exercise include enhanced endothelium-dependent vasodilation through increased production of nitric oxide, including in the coronary circulation.

Further, recent data show that aerobic physical fitness is associated with a fewer deaths from all causes over time, as it is also associated with improvement in blood pressure, triglycerides, HDL and body composition.

Anything excessive is dangerous

Though there may be a rich number of studies that would support the benefits of exercise, evidence also abound that would show the deleterious effect of excessive endurance training, such as the case of triathletes and marathoners.



Proposed pathogenesis of cardiomyopathy in endurance athletes

Lavie, O'Keefe. *Current Sports Medicine Reports* 2015

Acute Effects

Publications by Lavie, O'Keefe et al enumerate the different acute effects of excessive exercise. Investigators noted increased markers of myocardial injury, such as cardiac troponin and B-type natriuretic peptide, dilation of cardiac chambers, especially the atrium and the right ventricle, and reduction in right ventricular function.

Increases in troponin are thought to be caused by increased membrane permeability secondary to an increase in myocardial sarcolemmal permeability. Myocardial cell necrosis is potentially a cause of exercise induced troponin release. Troponin detected in the blood after an exercise connotes myocardial injury with cell death.

Long-term Perils: More is not necessarily better!

Dr. Junia, further noted, in his discourse that the chronic and dangerous effects of excessive endurance exercise (blue shades) (EEE) include cardiac remodeling and fibrosis, non-lethal arrhythmias, particularly increased risk of atrial fibrillation, and potentially more lethal ventricular arrhythmias.

La Gerche and colleagues, in their study, noted acute reduction in right ventricular function that increase with race duration and correlates with increase in biomarkers of myocardial injury. However, all measures of left ventricular function were preserved and there was no relationship between left ventricular function and biomarker levels.

Cases of cardiomyopathy among endurance athletes have been noted to have increased in recent times. Proposed pathogenesis behind this involves a vicious cycle.

Extreme exercise causes the release of catecholamines and subsequently increasing oxygen demand that consequently and immediately strains and dilates the right heart. Right ventricular hypokinesia and diastolic dysfunction may ensue adding to cardiac fibrosis which are classified as subacute effects. With

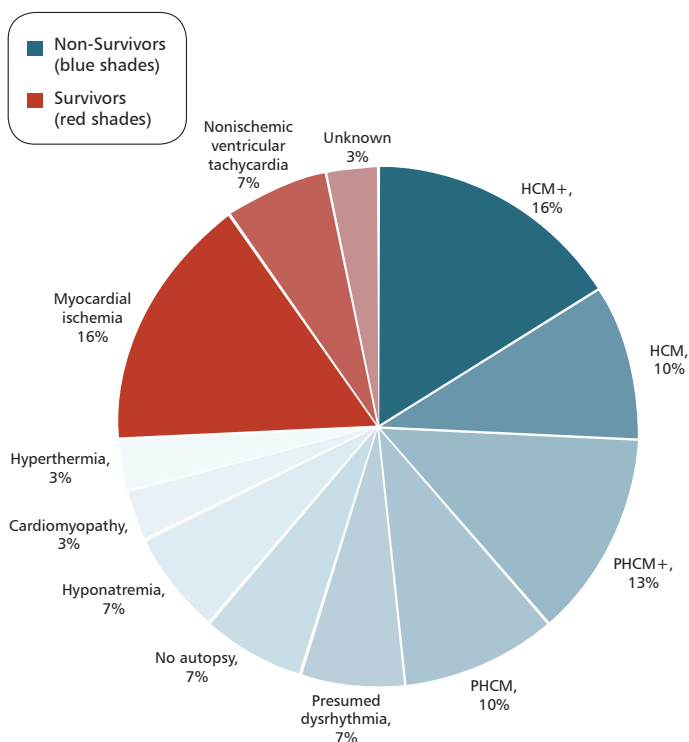
“Evidence also abound that would show the deleterious effect of excessive endurance training, such as the case of triathletes and marathoners.”

fibrosis, long term effects become pronounced that include enlargement of cardiac chambers with more patchy areas of fibrosis, with atrial and ventricular arrhythmias increasing the chances of sudden cardiac death. Eventually, chronic excessive training may result in left ventricular dilation, hypertrophy and an increase in heart mass.

Racing towards the death?

The relative risk of dying among men who exercise more vigorously and frequently is higher than men who do light or no exercise at all.

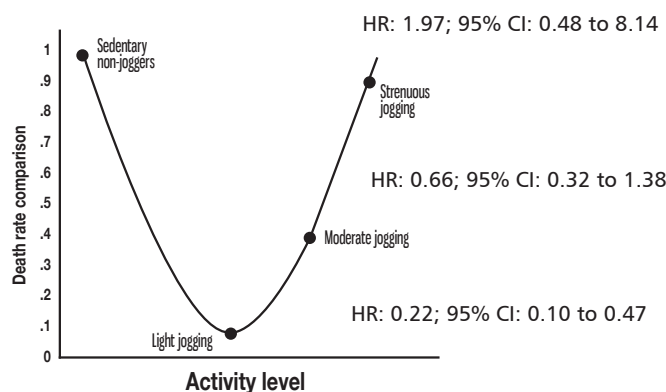
The RACER study revealed that cardiac arrest during long distance races occur with a mean age of 42 ± 13 years with an incidence rate of 0.54/100,000 and occurs more in men than in women. There appears to be a trend towards more deaths as the distance run goes farther.



Causes of Cardiac Arrest among Non-Survivors and Survivors

RACER Study Group. *N Engl J Med* 2012;366:130-40

Association between jogging and death



Schnohr, P. et al. *J Am Coll Cardiol*. 2015; 65(5):411–9

The most common cause of cardiac arrest in survivors is myocardial ischemia and in non-survivors is hypertrophic cardiomyopathy. Most cardiac arrests occurred at the fourth leg of the race and 71% proved fatal.

The study also emphasized the importance of initiating bystander cardiopulmonary resuscitation and an underlying diagnosis other than hypertrophic cardiomyopathy as the strongest predictors of survival.

In the Copenhagen City Heart Study, another startling study that prospectively followed up at least a thousand healthy joggers and almost 4,000 healthy non-joggers for at least a decade, light jogging was associated with a significant and better death risk reduction compared to moderate and strenuous joggers. The best risk reduction was seen in joggers who ran not more than 2.5 hours a week with a frequency of not more than thrice a week.

Results of the prospective study reveal worst outcomes trending towards more strenuous jogging. Strenuous joggers were noted to have similar risks for death with sedentary non-joggers. Strenuous joggers are individuals who run more than three times a week, for a cumulative run of about four hours or more.

In a larger investigation of about 55,000 adults followed up for 15 years, leisure-time running was associated with a reduction in all-cause and cardiovascular mortality risks. About 24% of the study population participated in running.

Persistent runners had a 29% lower all-cause mortality and 50% lower cardiovascular disease-related death compared with those who did not run at all.

“The relative risk of dying among men who exercise more vigorously and frequently is higher than men who do light or no exercise at all.”

Those who benefitted the most were those who ran once or twice a week at a speed of 6mph (9-10kph), six miles per week, less than 51 minutes per week and less than 506 metabolic equivalent minutes per week.

Current guidelines recommend a minimum of 75 min/week of vigorous-intensity aerobic activity for health benefits.

Conclusions

Presented with conflicting information about the benefits and harm of excessive exercise, how can one answer the question “To be fit or not to be fit?” or more appropriately, “How much is sufficiently enough” or “How much is too much?”

Presenting findings from published investigations, Junia stated that running for just five to 10 minutes per day and at slow speeds (<6 miles/h), are associated with markedly reduced risks of death from all causes and cardiovascular disease.

This may motivate healthy but sedentary individuals to begin and continue running for substantial and attainable mortality benefits.

Therefore, on the basis of multiple studies, it would seem most advisable, at least from a population-wide public health standpoint, to limit vigorous exercise training to no more than 60 min/day.

On the other hand, people who participate in vigorous exercise training for non-health reasons should recognize that there may be some increased risk, although relatively small, of such vigorous exercise.

Ideally, however, a weekly cumulative dose of vigorous exercise of not more than five hours may be ideal, including taking one to two days off a week from vigorous and high-intensity exercise.

It is likely that near-maximal health benefits occur at even much lower doses of exercise. Running, even 5 to 10 min/day and at slow speeds (<6 miles/h), is associated with markedly reduced risks of death from all causes and cardiovascular disease.

While recognizing the potential dangers of competitive sports, the numerous benefits of exercise seem to outweigh its negative effects. Long-term endurance exercise practice should not be discouraged in healthy adults as it positively modulates risk factors. Pre-participation screening is recommended, especially in men >40 years with one or more CVD risk factors. Most of the danger associated with exercise is the abrupt initiation of a vigorous exercise program.

The PHA President’s take-home message is not to avoid exercise, but to enter into training or exercise programs in a gradual, prudent manner. On another note, the major threat to health in the 21st century is clearly inadequate levels of physical activity and not the excess of it.

Truth can be found in the words of Hippocrates: “If we could give every individual the right amount of nourishment and exercise, not too little and not too much, we would have found the safest way to health.” And as said by Paracelsus, “the right dose differentiates a poison and a remedy.” ♥

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3. Lavie et al. *Circ Res*. 2015; 117:207-219.
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Prepping up
for a **Triathlon**

39 THINGS WE OUGHT TO KNOW BEFORE WE 'TRI'



The Running Man

■ By Hermogenes R. Saludes, MD, FPCP, FPCC, FPSCCI

We've seen them run looking oh-so-sexy in their body-hugging trisuits. They buzz past us with their high-tech bikes. They also look like lifeguards when they emerge from the water, be it from a pool or in open waters.

Training for a marathon – running, a single sport, can already be taxing and time consuming. But to train and be proficient in three disciplines? Wow! It must be equivalent to subspecialty training in medicine, right?

Well, it's not impossible. Nor will it take up most of your time – if you train smartly and efficiently.

Here are the things this author, a runner, realized as I made the transition/progression from being a pure runner to becoming a triathlete in the past 12 months.

1 You will learn to respect veteran triathletes. Oftentimes, the "young once" make the young blood eat dust!

2 You are not strong enough. Even if you are a sub-4 marathoner, you will struggle in the swim and bike legs.

3 You will hate swimming for about a year of training.

4 You will feel awkward wearing tight and revealing trisuits, but eventually, you will love it.

5 You will have to find a place to swim regularly.

6 You will have to buy new stuff. Gone are the days when all you need are running shoes and shorts!

7 You will have to cough up quite a sum for a decent road or tri bike.

8 You will learn to be friends with your bike mechanic.

9 You will learn to love (and sometimes hate) your swim, bike and running coaches.

10 You will need to learn to dismount from your bike cleats in a split second – or fall face flat on the pavement!

11 You will learn to spend time in Nuvali and Clark.

12 You will likewise attempt to scale the uphill climb to Timberland and Sierra Madre.

13 You will learn to smile, give way and be kind to cyclists on the road.

Editor's note: Why 39 reasons? Hermie just celebrated his 39th birthday, that's why!

HERMIE HAS FINISHED TWO AQUATHLONS AND ONE FULL DISTANCE DUATHLON IN SEPTEMBER AND OCTOBER AND WILL COMPETE IN HIS FIRST TRIATHLON IN NOVEMBER.



Finish Line Bike King SCTEx Duathlon

- 6km run
- 60km bike
- 4km run
- 3hrs 56mins



3rd place Biathlon leg 1, Sept. 2016

Dr. Hermie Saludes is an interventional cardiologist and an ultra marathon runner. He finished the Bataan Death March 160km in 2014 and 102km races three times. He usually joins marathons with his wife. ♥

14 You will have more race-cations! Cebu, Legazpi, Subic and Bohol are only a few of the usual race venues.

15 You will learn to save up for registration fees! (Sometimes, they don't come cheap)

16 You will learn to wake up early to squeeze in a short run or a quick dip.

17 You will have more tan lines.

18 You will be alarmed if your skin returns to its lighter shade

19 You will be humbled by a bunch of 10-year olds who are faster than you in the water.

20 You will pace a slower runner for he will guide you in the grueling bike training.

21 As in running, you will still need to train at least five days a week. Maybe even more.

22 You will finally buy a GPS watch.

23 You will, more than once, wonder what you have been doing all these years.

24 You will finally feel like a varsity player like you've always dreamed of! (Wearing a trisuit with your school colors!)

25 You will learn to watch your diet.

26 But, you will, on many occasions, need to eat more!

27 You will make time for rest and sleep.

28 You will need to call your PT-friend or Rehab Med buddy.

29 You will learn to plan six months to one year in advance.

30 You will need to train for two sports/ disciplines in one day.

31 You will need to practice those transitions (swim to run, run to bike, bike to run).

32 You will learn to run without socks and with squeaking wet shoes on.

33 Did I mention you will hate swimming during the early parts of your training?

34 You will get to feel that exhilarating experience of running 60kph on your bike.

35 You will crash from your bike at least once.

36 You will need cross-training, most often HIIT/circuit training to help reduce injuries and recover faster.

37 You will need to conquer your fear of the open water.

38 You will ALWAYS return to your first love. (In my case, running). It will oftentimes make up for your weak points (in my case, swimming).

39 You will realize that all the time, blood, sweat, tears and effort you spent WILL BE ALL WORTH IT. ♥

Calorie Counter



■ By Don Robespierre C. Reyes, MD, FPCP, FPCC

Understanding **FATS&OILS** in the daily diet

"Doc, di na po ba talaga pwede kumain ng taba?"

Out of the blue, patients may just pose questions like this to doctors, and some doctors may not just be ready to reply confidently with a satisfying answer.

Definitely answers from doctors, even cardiologists, vary. Some are liberal and consenting, while some are stringent and rigid with dietary restrictions. Of course, the health conscious patient may always try to follow, but more often than not, the usual patient fails.

Conflicting evidence on the effects of fat in the body continue to confuse not only

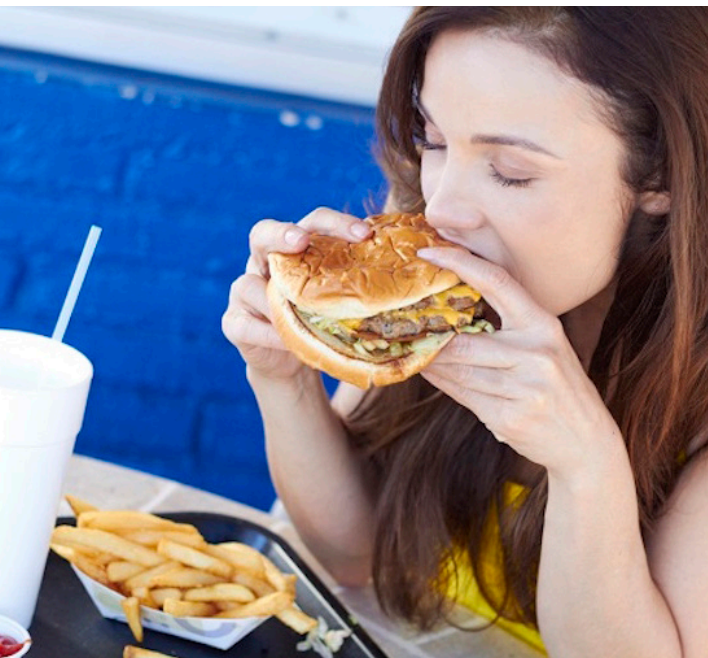
the patient, but the physician as well. But in the light of "better and more reliable" evidence, we stick to well established data on fat and its effects on health.

Here is a guide as to what we can tell our patients regarding the intake of fats.

DO WE REALLY NEED FATS?

Of course, our body needs fats! Physiologically and anatomically, that is. Fats derived from food are important sources of energy and material for cell structure and growth. Without fats, we cannot make up our cell membranes. Fats also protect different organs in the





body aside from keeping it warm. These also aid in the absorption of some nutrients and are vital in the production of some hormones.

Though the common knowledge that fat is bad should be emphasized, patients need to understand that some fats are good and some are not. There are four major types of fats we can derive from foods. These are the saturated fats, trans fats, monounsaturated fats and polyunsaturated fats.

Generally speaking, the bad fats - saturated and trans fats - are solid at room temperature, while the good fats - monounsaturated and polyunsaturated fats - are liquid at ambient temperature. Yes, your butter is bad fat, while your olive oil is good. (When we say room temperature, that's around 20-25°C, with an average 23°C. That's not the usual tropical room temperature we have. So, if your kitchen is air-cooled to 23°C and your cooking oil solidifies, it ain't a healthy oil!)

As such, the bad fats raise the Low Density Lipoprotein (LDL) and promote cholesterol plaque formation and deposition within arterial walls. Plaques may accumulate in the long run and eventually obstruct the artery, thereby limiting blood flow to tissues, say the heart; or plaques may rupture suddenly causing a heart attack. The bad fats also lower high density lipoprotein (HDL), the good cholesterol. Trans fats, in particular, increase the risk of developing heart disease, stroke and Type 2 Diabetes Mellitus.

Consuming high levels of saturated or trans fats can lead to heart diseases and strokes. Nutritionists generally recommend dropping saturated fats and trans fats for monounsaturated fats and polyunsaturated fats. The good fats will maintain a nutritionally adequate diet.

FATS AND WEIGHT LOSS

People who are on a weight loss program are often misled that taking loads of the good fat is alright. Doctors, however, must make them realize that regardless of what type of fat it is, a gram of good or bad fat will still yield nine (9) calories. That's more than double of what a gram of carbohydrate or protein will give at four cal/gram! Yes, excessive intake of fat, even if it's olive or canola oil, will make one gain more weight.

SATURATED FATS

Saturated fats are molecules that have no double bonds between carbon molecules because they are saturated with hydrogen molecules. This makes them solid at room temperature.

Saturated fats abound in the food that we eat. Most of these are derived from animal sources, including meat and dairy products.

Typical examples include the following: fatty beef, lamb, pork, chicken with skin, lard, cream, butter, cheese and other dairy products made from whole or reduced-fat (2 percent) milk.



“ Some cooking oils can be deceiving as their labels would indicate the “no cholesterol” come-on tagline but these plant-based oils, such as palm oil, palm kernel oil and coconut oil, primarily contain saturated fats, though these do not really contain cholesterol. ”

Moreover, a lot of baked goodies and fried food contain high levels of saturated fats. Some cooking oils can be deceiving as their labels would indicate the “no cholesterol” come-on tagline but these plant-based oils, such as palm oil, palm kernel oil and coconut oil, primarily contain saturated fats, though these do not really contain cholesterol.

THE TRANS FATS

Trans fats found in food are broadly categorized into two: the naturally-occurring and the artificial trans fats.

Naturally-occurring trans fats are found in some animal gut and food derived from them, like dairy and meat products, may contain a bit of trans fats. Artificial trans fats (or trans fatty acids) are products of processing by adding hydrogen to liquid vegetable oils. These hydrogenated vegetable oils become solid at room temperature.

In November 2013, the U.S. Food and Drug Administration (FDA) made a preliminary determination that partially hydrogenated oils are no longer Generally Recognized as Safe (GRAS) in human food.

For this reason, doctors must advise their patients to check the label of vegetable cooking oils that they use.

Cooking oil manufacturing businesses prefer trans fats because they are easy to use, inexpensive to produce and last longer compared to its healthier counterparts. Trans fats make food more palatable (though, that would be a deadly delicious taste!). Commercial food establishments, fast food outlets in particular, use trans fat-rich oil in frying because it can be used several times without compromising taste and texture.

Some countries have already restricted the use of trans fats in food establishments.

WHICH FOODS CONTAIN TRANS FATS?

Trans fats can be found in the food we eat daily. By looking at labels, the amount of trans fat contained in a food product can be determined. Labels indicating “partially hydrogenated oils” mean trans fats have been used.

However, some labels may indicate “0 grams trans fat” if the product contains less than 0.5 grams trans fat per serving.

Typical food rich in trans fat are fried foods like doughnuts and baked goods including cakes, pie crusts, biscuits, frozen pizza, cookies, crackers, and stick margarines and other spreads.



NATURALLY OCCURRING TRANS FATS

Some meat and dairy products naturally contain small amounts of trans fats. Sufficient studies have yet to determine whether these naturally occurring trans fats have the same bad effects on cholesterol levels as trans fats that are industrially manufactured.

CAN WE STILL TAKE BEEF STEAK OR PORK ADOBO?

A nutrition expert would always recommend reducing sodium, saturated fat and sugar in the daily diet. AHA recommends a dietary pattern that emphasizes fruits, vegetables, whole grains, low-fat dairy products, poultry, fish and nuts, while limiting red meat and sugary foods and beverages.



If meat has to be taken, choose lean meats and poultry without skin and prepare them without added saturated and trans fat.

The American Heart Association (AHA) recommends a daily allowance of 5% to 6% of calories from saturated and trans fats. For example, if one needs about 1,800 calories a day, no more than 90 mg should come from the bad fat. That's about 200 grams of lean beef or 300 grams of extra lean beef!

Extra lean beef:
eye of round roast and steak
sirloin tip of side steak
top round roast and steak
bottom round roast and steak
top sirloin steak

THE GOOD ALTERNATIVE

Foods high in saturated and trans fats must be replaced with foods rich in monounsaturated and/or polyunsaturated fats. Liquid vegetable oils are preferred over tropical oils. Guidelines also recommend eating fish and nuts and replacing some of the meat with beans or legumes to source out the protein from.

Naturally occurring, unhydrogenated vegetable oils such as canola, safflower, sunflower or olive oil most often are highly recommended.

Thus, check labels and food rich in unhydrogenated oil, and these should be preferred over food with

partially hydrogenated or hydrogenated vegetable oils or saturated fat.

If margarines are inevitable, use of soft margarine as a substitute for butter is recommended. Or use soft margarines (liquid or tub varieties) over harder stick forms. Food with "0 g trans fat" on the Nutrition Facts label and no hydrogenated oils in the ingredients list should be safe and healthy.

Doughnuts, muffins, pies, cakes, cookies and crackers, are examples of foods that contain trans fat. Limiting the intake of these kinds of food would definitely benefit the cardiovascular system!

Commercially fried foods and baked goods made with shortening or partially hydrogenated vegetable oils should be avoided. Not only are these foods very high in fat, but that fat is also likely to be trans fat.

"TRANS FAT-FREE," A HEALTHY FOOD?

Foods labeled "0 trans fat" or cooked with "trans fat-free" oils may contain a lot of saturated fats, which raise your bad cholesterol levels. "Trans fat-free" foods may also be unhealthy in terms of their general nutrient content. For example, baked goods also tend to be high in added sugars and low in nutrients.

In the next issue, we will discuss the good fats, the monounsaturated and polyunsaturated fats, those that can make eating both healthy and enjoyable! ♥

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Anything with PHA is his playground, cardiology is his hobby; retirement is unthinkable

Pressured environments, unpredictable hours and workload schedules that could stretch for hours on end. Aggravated routines have become normal to professionals such as lawyers, business operators, artists, managers and all other collared workers attending to certain ventures.

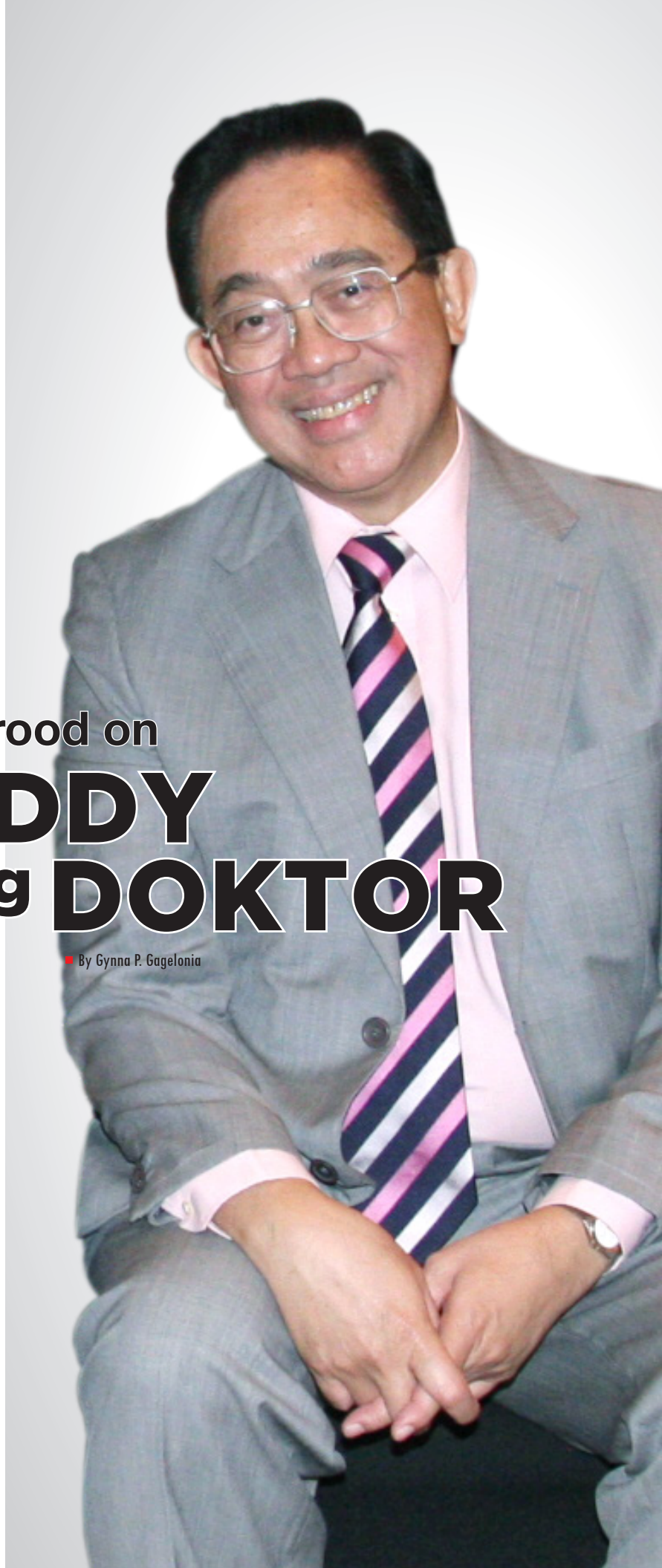
The Morales brood on **Ang DADDY kong DOKTOR**

By Gynna P. Gagelonia

Expecting a balance between life and work in these circumstances could be prolific among them, and none more so than doctors, whose dedication is as unrelenting as the time they are naturally required to allot in their practice.

With the medical profession, the tasks involved almost always result in this vocation becoming one of those likely to drag on for who-knows-how-long, if not a lifetime – and this is exactly something that could be unimaginable to workers as devoted as doctors. In this light, the idea of retirement can be contentious between the doctor and their own family.

Such is the case of Dante D. Morales, MD, who, as a seasoned and renowned cardiologist, hospital administrator, author, researcher and lecturer, is most notable for having popular television newscaster, Vicky Morales, as a daughter – even at the crossroads of his career that has spanned four decades now.



The Heart News and Views (THNV) got to interview three of the four Morales siblings -- Vicky Morales-Reyno (who is married to lawyer Alfonso Victorio Reyno), Dr. Daniel Francisco "Daffy" and Dino Antonio. The eldest Maria Isabel "Mabel" Mañalac, who is US-based with her family, was not around during the interview. Mabel who holds a degree in interior design and Dino, an industrial design graduate, do website design/content and building training videos. Mabel is married to Luis Mañalac. They have two sons -- Eric 17 and Victor 15. The Reynos have three kids -- twins Pipo and Leon, 8 and Daniela, 6.

The interview was done after the elder Morales was bestowed the PHA Golden Heart Award in May this year during the annual PHA convention. The younger Moraleses have more than a few words to say, (un)expectedly, about their father's retirement, as well as his wife Maria Luisa (who is Lou to loved ones and friends), who shares insights as well in raising and growing up in a family helmed by a doctor. "We never really took it against him," says Vicky

of her father, who reveals that certain Christmas and New Year's celebrations would have to be proceeded without him when Dr. Morales takes off to see patients, as they "know that that's the priority."

Most instances would see families of doctors had to risk being together every once in a while due to something as presence-critical as doctors' tasks. Consequently, sacrifices would have to be made as the line between career and family could only get so skewed by their frenzied schedules.

"I gave up my career," states Mom Lou, whom Vicky attests as very sufficient in making up for the doctor's absences for their children. Mom Lou is an interior designer by profession. "In fact, at times that Dr. Morales would have an emergency, sometimes he'd take his time and I'd be the one who would rush him." Daffy, who is the only one among the children to voluntarily inherit the initials of "MD," further proves how their father's profession has helped them understand and be accustomed to the needs and responsibilities that come with it.



Dr. Dante Morales: 2016 PHA Golden Heart Awardee with his family.
Fr. L -- Dr. Daffy, Dino, Mrs. Lou Morales, Vicky and husband Atty. Reyno.
Not in photo is the eldest Mabel, a resident of Palo Alto, California.

“Sasabihin niya tapos na clinic, pero magko-computer pa kami ng 30 mins. Kasi on his way to the elevator, he will chat pa with a patient. Alam na namin so factored in na lahat. In the house DST stands for Dante Saving Time.”

The Morales bunch complete (with Mabel's and Vicky's respective families), in a memorable trip to Vatican

“I guess we just know how to entertain [ourselves], and we're very close *naman*.” He went on to describe how familial roles would be redefined in order to accommodate the hustle and bustle of being a doctor, like how, in some instances, their mom would have to do the driving as she had to be the mom and the dad, with Mom Lou who playfully added, “so he doesn't have to park the car anymore.”

The family also described how they have learned to adapt through the years in dealing with their father's divided attention, with the senior Morales' time with them frequently being shaved because of inevitable last-minute interactions on the way out.

“Minsan nga sa may antayan, kahit sabihin niya na tapos na ako sa clinic, magko-computer pa kami ng 30 minutes kasi on the way down pa sa elevator may makikita siyang patient na mag-uusap pa sila. Alam namin na factored in na lahat yun. Hindi porket tapos na ang clinic, he'll come down and see us right away,” according to Vicky, with Dr. Daffy quipping an eponymous joke within their family about having a DST – Dante Saving Time.

But, of course, with adaptation comes absorption. When asked about their initial career choices, the most obvious one being medicine, the Moraleses were mercurial about

inheriting their father's title.

But as it turns out, the famous journalist originally aspired to be a doctor, but dropped the idea completely during college, accordingly. “He never really lobbied for it, never forced us na, ‘Uy, maganda ‘to’. Hindi, wala siyang ganyan.”

The youngest, Dino, also had his fair share of hesitations, saying how he has “always wanted to be a doctor, but I saw how my brother studied, I saw how my dad still studies, and it was really a lot of time. I was pretty much discouraged to go into medicine. And I thought to myself: Two doctors in the family are enough.”

Save for Dr. Daffy who was formerly objected by Dr. Morales in his decision in becoming a doctor himself. He recalls being handed a wise reminder by his father, about not pursuing a career in the profession if money or riches was the principal goal and concern, bringing him to the realization that “it's really a sincere vocation.”

That doesn't mean, of course, that Dr. Morales did not try, which is almost something automatic about collared workers towards their family. Vicky relays particular recollections wherein their father would ask them to accompany him while he does rounds and they would be left at the nurse's station and chat with them.





An affectionate but authoritarian Lolo to his 5 grandchildren: Eric, Victor, twins Pipo & Leon and Daniela.



A caring husband and partner to wife, Maria Luisa

“He has this OC strain in seeing and checking just about anything in a clinical approach; penchant for adventure and experiencing new things as well as FOMO (fear of missing out).”

“The nurses would feed us all sorts of candies. The patients would give us food while we wait, but that was it, that’s how he exposed us to his environment.”

Even Dr. Daffy would indicate how this subtle introduction to the profession by their Dad would gear him up the most. “It really influenced me, like with meeting with patients and the patients would talk to me saying: if not for your dad, my husband or my dad would no longer be around. It’s very touching. I guess that’s what got me also in the (TV news and public affairs) business.”

The family had plenty more to say when it comes to the man underneath the white coat and stethoscope. The siblings explained how he’s not strict with their grades back in school (rather “reasonable”) but with the grandchildren, instead; how they’re known as the son/daughter of Dr. Morales who was the “doctor *ng tito ko*, doctor *ng lahat, basta*,” and now the father of Vicky Morales; the obsessive/compulsive strain common among doctors in seeing and checking just about anything in a clinical approach; his penchant for adventure and experiencing new things, and “#FOMO” (Fear of Missing Out); the jokes found in his phone revealing his comedic side as well as his peacemaker role in the family; and his sweet loving nature towards his family and especially to his mother.

But could they also quip their stance on the idea of him retiring?

“I hope he won’t retire. He can still share a lot,” was the Morales matriarch’s quick reply.

“Ang joke ng mom ko, si Dr. Daffy will retire first...Kasi that’s how dad is motivated, he loves his work very much. That’s his world. This is his hobby,” Vicky argues.

Dino points out that they tell him to slow down, “para he has more time for his hobbies. *Pero siguro ito na yung hobby.*”

This is somehow seconded by Dr. Daffy who argues that with their father, “anything medical, anything with PHA, that’s his playground *talaga.*”

With health and treatment the only mission he has led throughout life, it is understandable why chances for slowing down could come scarce in a work field such as medicine. Besides, according to Vicky, “He doesn’t want to retire anyway. So, I guess even if you tell him to retire, he won’t retire.” ♥



Continuing his career even at this point of his life, Morales still has his family to support his decisions.

Reverberations



Breathtaking Baguio offers the best of both worlds



Harmony between God's creations and man-made marvels



The famous Lion's head is one of the Pine City's landmarks

Baguio in my mind

NORTHERN EXPOSURE



By Karla Rhea G. Rillera-Posadas, MD, FPCC, FPSE

I know Baguio like the back of my hand. Beyond the personal familiarity, I am also a third generation continuance of a family that chose to take root in this quaint and tranquil city. I grew up listening and absorbing stories of how my elders perceived their lives in Baguio, which I could readily sum up as modest, values-centered and extremely charming. I witnessed and felt their experiences and envisioned myself living out the same life with my own family.

In the past days leading up to my finalization of this article, I had quite a struggle coming into terms on how I see Baguio now vis-à-vis the good old hometown memories that linger in my mind. Think foggy mountains, pine-scented parks, dainty shops, chilly evenings and warm sweaters. The question of what my city means to me has subjected me to a very profound evaluation: I needed to see beyond the rapid transformation that this city has gone through in the past four decades. From my standpoint, this is such a short period to witness it metamorphosed from serene and old-world, to a place overcrowded with structures, vehicles and people.

My daily grind starts and ends with heavy traffic; in between, I witness the urban chaos (back then, each day was laid back and carefree in spite

the demands of school and work). To put substance in this write-up, I had to filter out the disarray of city planning, local politics and metropolitan squalidness. As I reminisced the old times and put it into perspective of how it is now, I kept coming back to one point that truly characterizes Baguio: this is my hometown. It is my home and here is where my definition of family is alive. And it is in this very city that I shall endeavor to love and protect for the next generations to come.

I grew up in a working class family where education and good health were topmost priorities. My parents never pressured me and my siblings to be neurotically competitive in school; instead, Mama and Papa gently reminded us to appreciate what our teachers imparted, have fun with friends, pursue hobbies that interested us and to always practice empathy to the people we come across.

“It is my home and here is where my definition of family is alive. And it is in this very city that I shall endeavor to love and protect for the next generations to come.”

Medical school may have been packed with exhaustive studying but I was comforted by the fact that my professors were competent and encouraging. At that time, the relatively small medical community in Baguio was Godsend as I saw through my mentors that the medical profession is more than just a career; it is a means of ensuring that not one patient gets left behind. Everyone who seeks a doctor must be treated unconditionally. Most of all, the medical community fostered a supportive relationship akin to family.

In our country's capital region, I opted to train in two premier hospitals. I started as a quixotic rookie but I had to toughen up real fast with the daily deluge of patients. The sheer magnitude of patients pushed me and my colleagues beyond what was humanly possible in terms of time and people management. I can only describe my training as nothing short of grueling, competitive, but completely satisfying. My comfort and source of strength was the thought of home and the love of my family.

There were no crossroads at the end of my eight-year training in Metro Manila. I knew in my heart that I needed to go back to my hometown and be one of the building blocks of Baguio's medical field. I wanted to inspire others just as I was inspired by my mentors. Most of all, there is this absolute value to pay it forward to the city that has given me identity.

Fast forward to 2016. Here I am in the City of Pines, practicing my profession and raising my family just as I dreamt of when I was younger. Every day, I walk the streets of downtown Baguio and drive along familiar roads. I am enveloped by the pandemonium of urbanity. I never pondered why I chose to stay; I just knew that it was the right thing to do.

Family and home molded me to be my best and to practice compassion even at the most taxing times. As I see my three children growing up, as I look into my mother's eyes (my father passed away three years ago), as I further relationships with friends and colleagues, as I treat patients with commitment and sincerity, I can say with indubitable pride that Baguio is family. My City. My Home. ♥

Karla Rhea G. Rillera-Posadas, MD is a proud mother of three boys. She is an active consultant and an echocardiographer at Notre Dame de Chartres Hospital in Baguio. She is the current president of the PHA Baguio-Benguet Chapter and loves playing the piano.



Cloud-capped mountains

Bicol Express

■ By Ma. Ina Bunyi, MD, FPCP, FPCC

A 24-hour stay in Bicol was all I could cautiously book a week before an actual trip I made in June. My dad was just then recovering from a heart attack (another story of praise and thanksgiving that awaits serious writing about) and I waited till the last minute to book a flight so I can be part of the sponsors for a "spiritual kid's" wedding.

It is always a joy to see two people divinely led by the Lord to each other and become united in Holy Matrimony. This wedding was no exception. So off I hopped on the airline that initially made it truly possible for "every Juan" to fly - Cebu Pacific.

Every flight is new to me, even though I have flown (and been to Bicol) several times. I love watching the clouds make their "interpretative dance" in the sky. There would always be a mama bear somehow and lots of mushroom clouds.

Just as I have scanned and read the Smile Magazine articles that strike me the most - the flight was almost over even as the attendants breezed through the most awaited game. No longer just a "wave the object" but an easy Q & A about Cebu Pacific's destination. I happily deploined with yet another Cebu Pac pouch in my bag. Another reason to smile.

So what does one do in just a little over 24 hours stay in Bicol?



Up above the world (not) so high ...
Cebu Pacific over Bicol



On arrival Mayon was playing coy



Since I have seen these places I chose to chillax inside the Mall and indulged myself in a rare mani/pedi/color treat! Absolutely relaxing...



Turns out a couple of friends thought of the same thing LOL!! Small world or great minds thinking/craving alike?



The breakwater was already busy with the leisurely fishing guys and aggressive fish sellers. If only Manila was close by, I would be going crazy shopping for a fresh lunch feast...



T'was sweet to see families gathering either to swim or jog along the boulevard and around the famous LEGAZPI sign... Bikers were not to be outdone



I then spent time visiting families of friends and getting some standard pasalubong - pili nuts and baked breads from (another great find) Graceland (across between Goldilocks and McDonald's in food and decor) where we had brunch. We enjoyed its Bicol Specialty inspired Menu.

Majestic Mayon

3



Quick lunch at Ayala - Bicol express no less

4



Selfie with Mayon in the middle of one of the busy streets in the city (please do not do what I did)

5



Although I did not do it this time, a suggested itinerary (which a friend managed to do in such a short time) would be the Cagsawa Ruins and Lignon Hill (I am using old PHA Screening Shots for this).

8



Off to the wedding I went feeling "new" and great to be out of the hospital for a change!

The hectic-turned-fun-and relaxing day ended and I happily snuggled into bed in one of the modest and conveniently located hotels, Hotel Meaco.

I was (unhappily at first), summoned from that wonderful sleep the next day by the hotel clerk announcing the arrival of a friend for my morning tour...

9



A quick shower was followed by a wonderful treat of seeing Mayon almost in its full glory.

13



Time for a little break to shop around... Being the queen of el cheapo I chose to just drop money into one of the massage chairs in another Mall ... Instead of going into one of the spas.

14



Halo-halo was the best choice for lunch to cool me down after the morning's flurry of activities...

I unhurriedly got back to my hotel, luggage all ready and repacked the night before. A van was waiting to take me to the airport, courtesy of a local I had befriended the day before who promised the same P150 airport transport rate.

It seemed I just arrived and now it was time to go. I smiled at the "PUN-ny" thought - I truly and thoroughly relished my spicy BICOL EXPRESS trip. 😊❤

THE NATURE OF PROFESSIONAL FEES

Once the bill is settled, hospital must release docs' PHIC claims in full



CARDIO & THE LAW



■ By Atty. Angeles A. Yap, MD, FPCP, FPCC

I am compelled to write about this topic for the second time as I was alarmed by the grim prospect of abuse regarding doctor professional fees looming on the horizon.

In so doing, I hope to clarify the legal nature of our professional fees, the concept of ownership and possession, the rights that go with ownership and the legal recourse once these rights are violated.

Finally, I wish this knowledge will give us enough strength, confidence and passion to oppose any move from any party that will trample on these rights.

About four years ago, the government in my place withheld the Philippine Health Insurance Corporation (PHIC) claims of a government hospital intended for doctors. Instead, they were given fixed salaries and

their claims were allegedly used to help the hospital and patients in the guise of economic enterprise.

“...doctors in a private hospital were complaining that 4% of their PHIC claims were taken by the hospital...”

The doctors put up a legal battle and early this year, almost four years after their fees were withheld, the court ruled in their favor. Last year, a colleague in Manila called me up and complained that a hospital will be holding their professional fees until they have finished filling up certain hospital forms. I said the hospital cannot do that unless she had signed a waiver to that effect. I don't know what happened to her case.

In the same year, doctors in a private hospital were complaining that 4% of their PHIC claims were taken by the hospital to subsidize the salaries of its staff to prevent them from leaving to look for higher-paying government hospitals. I was told some doctors offered to do that. But the practice had become institutionalized at the expense of the others.

Just a week ago, another hospital is planning to "impose" a 4% cut from the PHIC claims of doctors for the same reason. Different reasons, the same principle – taking away what rightfully belongs to doctors.

Who owns your PF?

Professional fees are prices charged by individuals specially trained in specific fields of arts and sciences, doctors for example, in compensation for their services. It partakes the nature of a personal property. He owns it. It may not initially be in his actual possession as it is held temporarily by the hospital as mandated by a BIR regulation in case of professional fees in excess of PHIC or by the PHIC in case of a PHIC claim. Once the bill has been paid, however, either by the patient or by the PHIC and a paper is given to him stating such payment, the doctor is said to have constructive possession of the same amount - no more, no less.

Possession vs Ownership

Possession is a property interest under which, an individual to the exclusion of all others, is able to exercise power over something. It is a basic property right that entitles the possessor to continue peaceful possession against everyone else except someone with a superior right. It also gives the possessor the right to recover personal property that has been wrongfully taken and the right to recover damages against wrongdoers.

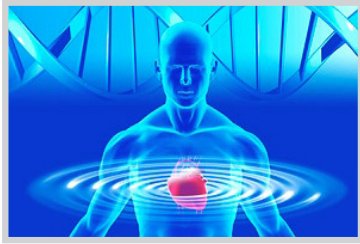
A possessor may not be the owner of a property or he may own it but not possess it. A professional fee is owned by the doctor even if the fee is initially but temporarily possessed by the hospital or PHIC as provided by law (lawful possessor).

The owner has the right to enjoy and dispose of

it, without limitations than those established by law. He has the right of action against the holder and possessor of what he owns to recover it. He has the right to exclude any person from the enjoyment and disposal of it. He can be deprived of his property when and only if ordered by a competent authority, for public use and always upon payment of just compensation. These requirements should be met, otherwise the "taking away" is illegal and the Civil Code is very clear at how one may protect his rights: "and (he) may even use reasonable force necessary to repel or prevent an actual or threatened unlawful physical invasion or usurpation of his property or turn to courts for recourse." ♥

“ Possession is a property interest under which, an individual to the exclusion of all others, is able to exercise power over something. ”





HEART&SOUL

Assisting Female Rape Victims

Dealing with Possible Unwanted Pregnancies at the ER

Doctors occasionally encounter cases of sexual assaults on women at the ER. Unwanted pregnancies have always been seen as a big collateral damage for a female rape victim. Good or bad, the advent of advancing science has allowed us to understand human physiology (fertilization and conception included) and has naggingly tempted scientists to manipulate with it.

With this, can we as doctors prevent conception from taking place in a rape victim?

CASE ANALYSIS:

Alona is a 19-year-old college student who was a victim of sexual assault. She was brought to the Emergency Room by her guardian for evaluation and treatment.

In some cases, we get to encounter cases like that of Alona. Rape is a multifaceted issue coming from such a harrowing experience. Unwanted pregnancy becomes one of the more pressing concerns, aside from the crime itself, the violation against a female, and the trauma that such crime may etch deeply into the psyche of the victim and may adversely affect her life.

First of all what are the examinations or procedures that must be done following the ER rape protocol ?

The basic approach would include the following:

- evidence collection
- checking for sexually transmitted diseases
- determination if the female victim was pregnant at the time of rape
- provision of immediate and long-term sympathetic counseling
- evaluation of the rape victim to determine at what stage of the menstrual cycle she was at the time of rape.

Elements of the Protocol

Take note that no test exists that can determine a pregnancy that could have begun a day or hours, or minutes before. The physical changes in the woman's body relative to pregnancy are not manifested systemically after

conception. Thus, there is no available pregnancy test that could provide the negative result necessary for anti-conceptive treatment (conception could occur after such test was done).

An important consideration as



■ By Angelita Miguel-Aguirre, MD, FPCP

pointed out by the Ethical Religious Directive (ERD) No. 36:

"A female who has been raped should be able to defend herself against a potential conception from the sexual assault."

A rape victim has NOT made the free choice of sexual union, therefore she is free to attempt to neutralize the effects of assault which violated her bodily integrity. This involves attempts to prevent sperm transport or incapacitation; or suppress ovulation.

In the moral sense, this woman's freedom to defend herself from the unwanted consequences of rape, however, DOES NOT include measures which endanger or end the life of the child she may have conceived. Therefore, directly intended abortifacient measures may NOT be used even in cases of rape.

“ A female who has been raped should be able to defend herself against a potential conception from the sexual assault. ”

Some Semantic Manipulation

Physicians must be adept at differentiating contraception and abortion in these situations involving rape. It must be clear to the doctor that abortion is also defined as termination of pregnancy before life conceived becomes viable outside the womb, and such period covers the interval between conception and implantation of the embryo. (ERD 45)

Relevant to this is the semantic manipulation which redefines “contraception” to include the prevention of implantation. It defines the stage between fertilization and implantation to be “pre-embryonic.” This manipulation of language is not born from any new scientific understanding except perhaps from a need to fulfill some political agenda.

Post-coital Agents

Incumbent on this responsibility of dealing with female rape victims is adequate knowledge on conception and the functions of post-coital agents.

Ovral is an estrogen–progesterone combination given at two 100 mcg doses administered 12 hrs. apart. If given after or during ovulation, it acts as an abortifacient by interfering with tubal transport of the zygote or by interfering with implantation. It disturbs the cervical mucus and subsequently prevents sperm penetration, sperm transport and sperm capacitation (Physicians drug reference; www.uptodate.com. 2016).

We have to take note of how the sperm travels. The sperm traverses the cervical mucus at peak phase

(which is the time of ovulation) in a period of 90 seconds. Sperm transport from the cervix to the site of fertilization in the oviduct occurs in about five minutes after intercourse.

Therefore, by the logistics of the usual aftercare of rape in a hospital ER, it is unlikely that Ovral could be administered in time to prevent capacitated sperm from reaching the ovum should there be one present in the tube.

We therefore need an objective laboratory evidence to determine at which phase of ovulation the patient is in. The following are examples:

- pre-ovulatory = (LH (-), progesterone level < 1.5 ng / ml)
- ovulating = (LH (+), progesterone level > 1.5ng/ml & < 6ng/ml
- post ovulatory – *early/ late (LH (-), progesterone >6ng/ml* ; < 6ng/ml for late

This can be determined by the OvukIT urine test to detect the LH surge plus the serum progesterone levels. The Progesterone level in the blood helps categorize the timing of the ovulatory cycle and is combined with the OvukIT urine dip stick test which is a reliable guide in the prediction of ovulation.

If the result turns out positive (+), this indicates that the LH surge is underway, such that the hormonal shift leading to ovulation has already begun and could no longer be blunted or halted by the anti-conceptive formulation such as Ovral.

On the other hand, if the test is negative from the blood test and the urine, and her own account of her cycle corresponds with the results, then the victim may be offered an anti-conceptive intervention of high dose Ovral.

In the event of a negative result, the first of the anti-conceptive dose should be provided in the ER as soon as possible because by delaying its administration, ovulation may have occurred during such delay and the drug subsequently confers an abortifacient effect.

“ Ovral is an estrogen – progesterone combination given at two 100 mcg doses administered 12 hrs. apart. If given after or during ovulation, it acts as an abortifacient by interfering with tubal transport of the zygote or by interfering with implantation. ”



In the moral sense, this woman's freedom to defend herself from the unwanted consequences of rape, however, DOES NOT include measures which endanger or end the life of the child she may have conceived.

On the other hand, if the patient presents positive results, the counsel at the ER will not offer her the formulation and must explain to her the reasons why. A positive (+) result means pregnancy is not an immediate or recent development and not related to the sexual assault.

Anti-ovulant or Abortifacient?

Doctors and anybody else must be wary that while Ovral administration is intended as an anti-ovulant, it may be inadvertently (or intentionally) given as an abortifacient. Therefore, if it is impossible to determine whether or not a rape victim has already ovulated and whether Ovral may prevent ovulation, hospitals or health care institutions, particularly Catholic institutions, should not use it.

However, the Philippine constitution somehow precludes the use of such anti-conceptive. Under Article II Section 12, abortion remains illegal: "Life must be respected from the moment of conception (i.e. fertilization)," which is sustained by the recent decision of the Supreme Court (SC) on the RA 10354 or more commonly known as the Reproductive Health (RH) Law.

One of the eight provisions of the original RH law which was declared by the SC as unconstitutional is Section 3.01(a) and (j) of the Implementing Rules and Regulation insofar as it uses the qualifier "primarily" for contravening sec 4 (a) of the RH Law and violating Art. II Sec. 12 of the Constitution.

There were seven other provisions which were declared as unconstitutional and were eventually removed by the SC before it's nod on the law's constitutionality. Such revisions made the RH Law different from its counterparts in other parts of the world simply because our own version upholds the right to life and religious freedom among other things.

Incidence of Pregnancy after Rape

Studies have shown that pregnancy after a single act of forcible rape is rare under any circumstances (with stress exerting an anti-ovulant effect, perhaps?). In a prospective study of 4,000 rape cases in Minnesota, USA, no pregnancies were reported. In another prospective study of 117 reported cases of rape, there were no pregnancies among the 100 women who did not receive post-rape hormones. Conception was noted to occur rarely at 0 – 4 %. (Everett & Jimerson, 1977; Makhorn, 1979)



Child of a Rape Victim

Julie Makimaa was a child of a rape victim who was given up for adoption. In spite of such situation, she grew up having peace in Jesus Christ. She wanted to be sure her birth mother did have such peace too after such a devastating and traumatic experience. Julie sought and found her, and they both shared the Lord's peace, and were able to fill up the missing pieces in each other's lives. When her birth mother agreed to meet Julie, her husband thanked her immensely for choosing to carry on with such an unwanted pregnancy. Such abortion could have deprived him of meeting her and raising a family!

Comprehensive care for Rape Survivors

A holistic approach to the care of a rape victim should include support systems. In the unlikely event that a woman becomes pregnant as a result of rape, protocols must take into account two victims, the mother and child, and not just one.

There are local support centers namely:

1. Welcome House, Paco Manila - 563-6363; 564 -0728
2. Home for the Angels – 562-8089 ♥

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1. Yancy CW, Jessup M, Bozkurt B, Butler J, Casey DE Jr, Drazner MH, Fonarow GC, Geraci SA, Horwich T, Januzzi JL, Johnson MR, Kasper EK, Levy WC, Masoudi FA, McBride PE, McMurray JJV, Mitchell JE, Peterson PN, Riegel B, Sam F, Stevenson LW, Tang WHW, Tsai EJ, Wilkoff BL. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Circulation. 2013;128:e240-e327.

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