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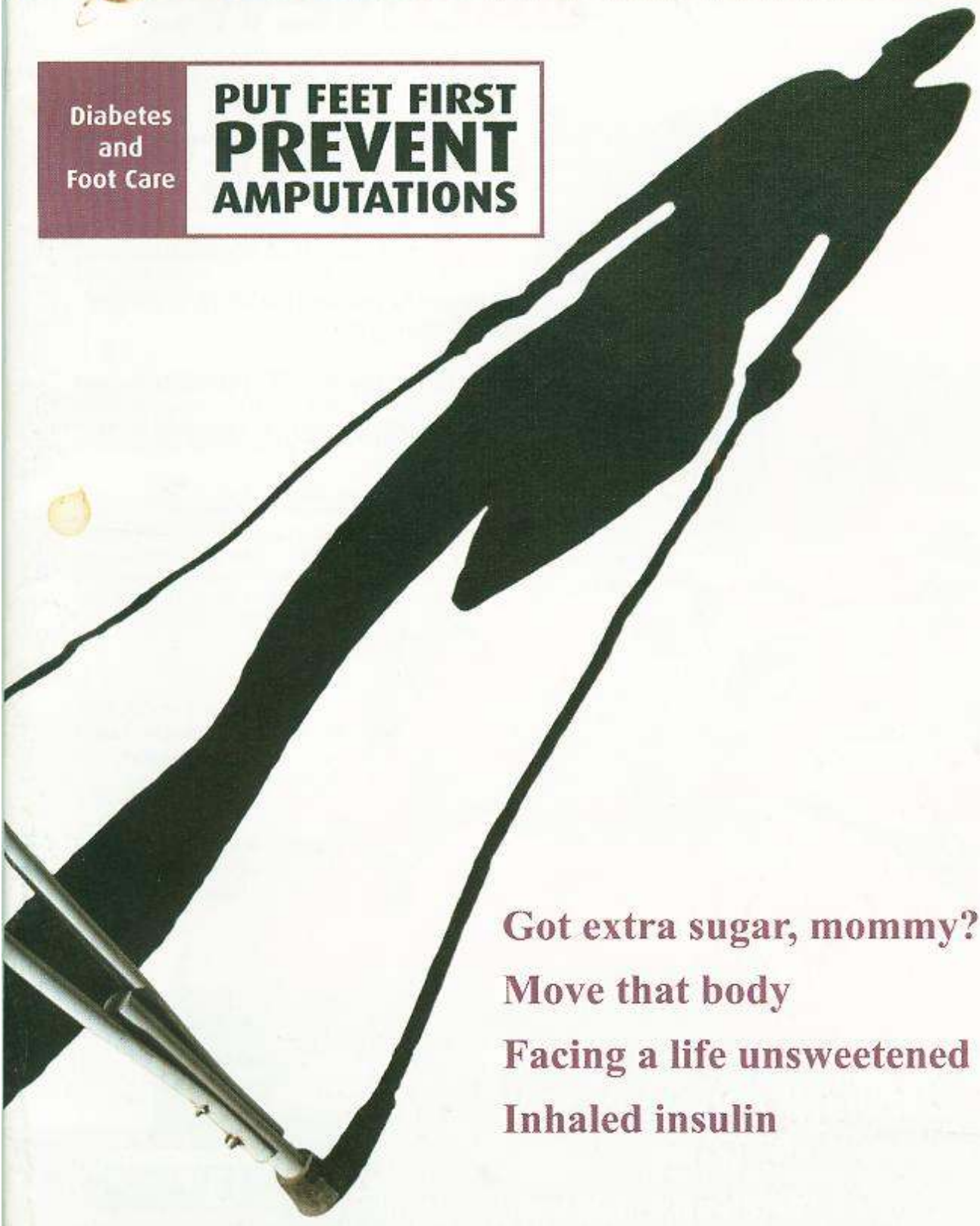
DiabetesWatch

JANUARY-JUNE 2005 YEAR XXII, NO.1

Diabetes and Foot Care

PUT FEET FIRST PREVENT AMPUTATIONS



Got extra sugar, mommy?

Move that body

Facing a life unsweetened

Inhaled insulin

WORLD DIABETES DAY 2005

14 NOV

An initiative of the International Diabetes Federation and the World Health Organization

www.worlddiabetesday.org

contents

January-June 2005 Issue
DiabetesWatch

Feature Articles

Regular Articles

Your President speaks

PHILIPPINE DIABETES ASSOCIATION, INC.

Every 30 seconds a lower limb is lost to diabetes.

Here in the Philippines one out of two diabetic patients with foot problems may end up with a lower limb amputation.

85% of diabetes related amputations start out with a foot ulcer.

Since diabetes is a chronic, lifelong condition treatment goals have to be constantly monitored and achieved so as to avoid the devastating consequences of complications like limb amputation, stroke, heart attack, blindness, and kidney failure.

Chronic hyperglycemia damages nerves leading to loss of sensation and poor blood circulation in the feet and legs. Trauma, tight shoes or insect bites can lead to wounds which can become infected and then set in motion the chain of events ending with a limb amputation. What is it like to lose a limb? Compared to a normal person an amputee walks more slowly and the higher the level of amputation the greater the stress on the heart and lungs. Because of the loss of mobility, he will have to depend on the care given to him by his relatives. Artificial legs can cost anywhere from 10,000 to 45,000 pesos. No wonder many diabetic amputees become depressed. Statistics show that more than 50% of diabetics with lower limb amputations die within 5 years!

The best way to avoid a limb amputation is to make sure that blood sugars are always as close to normal as possible. Conquer your appetite and sloth. Invest in a good home glucose monitoring device. Exercise regularly. De-stress and relax. Meet with God daily. Visit your doctor and diabetes healthcare team regularly. Ask your diabetes doctor to check your feet at least once a year.

Amputations can be avoided.

MA. TERESA PLATA QUE, M.D.

"an affiliate society of the Philippine Medical Association" (PMA)
"an affiliate society of the Philippine College of Physicians" (PCP)
"a member of the International Diabetes Federation" (IDF)

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Meanderings

Augusto D. Litonjua, MD
Editor Emeritus

Not all lean men are created equal!

The body mass index, or BMI, classifies a person's weight into underweight, normal weight, overweight and obese. It is obtained by dividing one's weight in kilos by the square of one's height in centimeters. If the resulting quotient is between 19.9 and 22.9 kg/m², then one is considered as having a normal weight. We then presume this person to be in the pink of health, especially if he is young. But this conclusion cannot be applied to all young people with normal BMIs, for there is a subgroup of individuals who are metabolically obese, but of normal weight (MONW).

The MONW individuals are subgroup who have normal BMIs, but have abnormalities of an obese person. Characteristically, these persons are young - usually below 40 years of age, with high levels of insulin in their bodies (this is so, because the tissues of the body are not responding to insulin in the normal manner, thus the pancreas has to increase its output of insulin to overcome this 'resistance' of tissues to insulin) and various degrees of fat abnormalities, e.g., high serum triglycerides and low HDL. These abnormalities - the hyperinsulinemia and the fat abnormalities - predispose the individuals to diabetes mellitus and heart disease in later years. Unfortunately, the abnormalities are not detected because of the presumption of health on the basis of a normal BMI!

What makes an MONW person different from a metabolically normal person? The MONW has a higher amount of intra-abdominal fat (as reflected in a high waist circumference) with a normal BMI, high fat deposits in the liver and in the muscles, low muscle mass, insulin resistance and high triglycerides in his blood. The blood pressure may also be elevated in various degrees. The estimate is that there are 13% to 18% of these individuals in the population.

One of the reasons why MONW individuals are metabolically abnormal, is because they spend less energy for every unit of exercise or physical activity as compared to a metabolically normal person. Thus, there is more excess fat to be deposited in abnormal sites.

The diagnosis of MONW can be suspected in a young individual with a bigger waist circumference than normal (more than 90 cm in men, more than 80 cm in women), who may have high blood pressure, high triglycerides in their blood and low good cholesterol (HDL). The diagnosis must be made early to avert the appearance of diabetes mellitus and heart disease. There are now good drugs to lower the blood pressure, lower the blood triglycerides and increase the HDL. In addition, drugs to lower the resistance of the tissues of the body to the effects of insulin are now available. Thus, the need for early diagnosis of MONW.

The presence of MONW in our population also suggests that it may not be the BMI that is best to measure, but rather the waist circumference. As an aid to diagnosing the presence of MONW, the accompanying table may be of great help.

Proposed Scoring Method for Identifying an MONW Individual (MONW = Metabolically Obese, Normal Weight)

From perspective in Diabetes: The metabolically obese, normal-weight individual revisited Neil Ruderman, Donald Chishlom, Xavier Pi-Sunyer, and Stephen Schneider
Diabetes, Vol 47, May 1998

Presence of associated disease or biochemical abnormalities	Points
Hyperglycemia	
Type 2 diabetes	4
Impaired glucose tolerance (IGT)	4
Gestational Diabetes	3
Impaired fasting glucose (110-125)	2

Hypertriglyceridemia (fasting)	
Triglycerides > 150 mg/dl/HDL cholesterol <35	3
Triglycerides > 150 mg/dl	2
Triglycerides > 100 - 150 mg/dl	1
Essential hypertension	
Blood pressure >140/90 mmHg	2
Blood pressure 125-140/85-90	1
Polycystic ovaries	4
Premature coronary heart disease (under age 60 years)	3
Uric acid (>8 mg/dl)	2
Family History (first-degree relatives)	
Type 2 diabetes or impaired glucose tolerance	3
Essential Hypertension (under age 60 years)	2
Hypertriglyceridemia	3
Premature coronary heart disease (under age 60)	2
Presence of predisposing factors	
Low birth weight (<2.5 kg)	2
Inactivity (<90min aerobic exercise/week)	2
Evidence of mild obesity or central adiposity (maximum 4 points)	
Weight gain: <4, 8, or 12 kg after age 18 years (W), 21 years (M)	1-3
BMI: 23-25, 25-27 kgm²	1, 2
(Waist (inches)	
28-30, > 30 (W)	1, 2
34-36, > 36 (M)	1, 2
Ethnic group at high risk	1-3

MONW individual equals a score of 7 points or greater. Scheme applies to men and women aged 20-55 years with BMI < 27kg/m²

From the Plenary Lecture: Fit-Fat Individual: At increased risk for diabetes and macrovascular disease by Dr. Augusto D. Litonjua. PDA annual convention, 23 November 2004.

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT DIABETES

(but were afraid to ask...)

Roberto C. Mirasol, MD
St. Luke's Medical Center

Sexual dysfunction, specifically erectile dysfunction (ED) affects men with diabetes. It is truly worrisome especially for young, sexually active men who have been diagnosed with diabetes. In this issue of Diabetes Watch we will answer your often asked questions on impotence or erectile dysfunction (the more politically correct terminology).

Q "Is ED a huge problem among male diabetics?"

A very big problem indeed, the recent estimates show that half of men with diabetes will have ED. It tends to develop 10- 15 years earlier in male diabetics than in non diabetics. Above the age of 55, the likelihood of having difficulties with an erection occurs in approximately 70% of men with diabetes. Above age 70, there is about a 95% likelihood of having some difficulty with erectile function.

Q I know my ED is from my diabetes, what actually caused my ED?

A There are many reasons why men with diabetes develop ED. It involves impairment in the nerves called diabetic neuropathy as well as impairment in the blood vessels. To achieve an erection, men need good blood vessels and nerves and a desire to have sex. Diabetes can affect all of these.

Q How do I know I have an ED problem?

A If you cannot totally achieve an erection, definitely you have a problem. If you have erections but could not sustain it for actual penetration in 50% of attempts then you have a problem. If you have brief erections most of the time then you also have a problem. Worry not, the problem can be solved!

Q Can I prevent ED?

A It is preventable. All you have to do is adopt a simple and healthy lifestyle. These are quitting smoking, exercising regularly, and reducing stress. These may be all that is needed to find relief. You need to maintain a healthy weight. Take your prescribed diabetes medications. Avoid excessive use of alcohol. If you have hypertension, find out if your hypertension medications causes ED. Talk to your doctor about your problem and I'm sure he would be able to help you. Very important: Diabetes should be controlled. The best advise is to keep your sugars down to keep your sex life soaring.

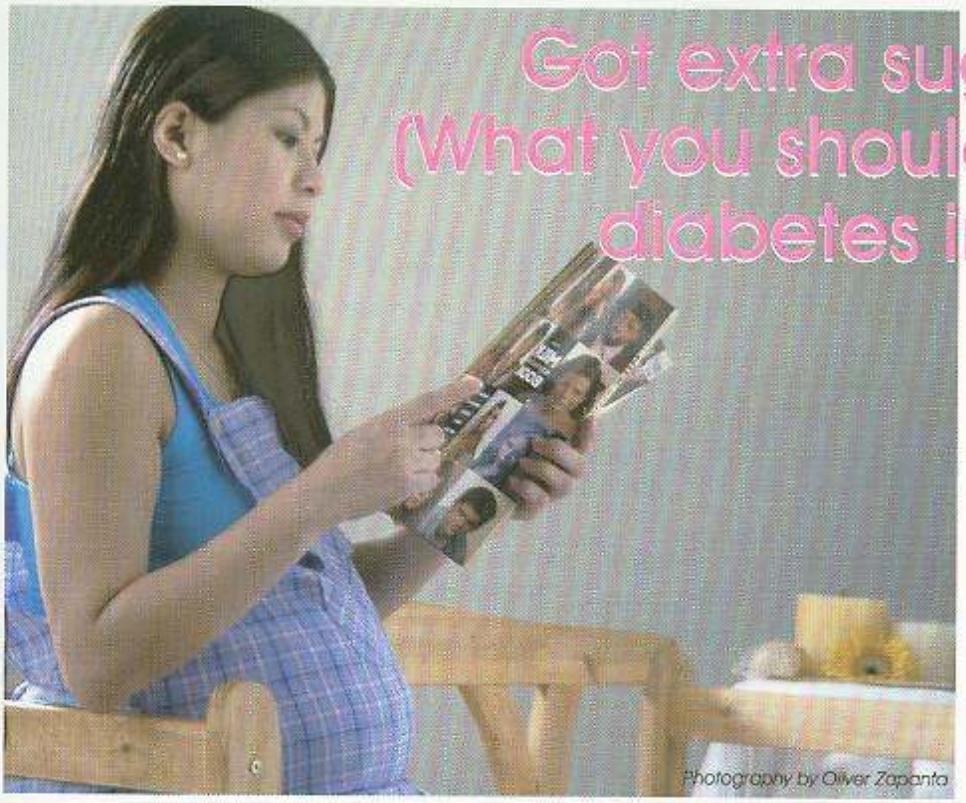
Q **I have heard a lot about drugs being used for ED. Are they all the same? Are they safe to use?**

A Drugs effective for ED are Viagra, Cialis or Levitra. The differences between these drugs are their onset of action, duration of action and interaction with food. Viagra should be taken an hour before sexual intercourse and lasts for around four hours. It is affected with food intake. Levitra should be taken 20 - 30 minutes before sexual intercourse and duration is around the same as Viagra. Cialis has the longest duration of action and may last up to 36 hours. Both Levitra and Cialis are not affected by food intake. They are generally safe to use. However, because people with diabetes also tend to have problems with their heart, these medications may not be appropriate especially if you are taking nitrates. Talk to your doctor to determine what treatment is best.

Q **If oral drugs do not work, is there any other remedy? Help!**

A Additional treatments you may want to consider include intracavernous injection therapy (Caverject), vacuum constriction devices, intraurethral therapy (MUSE) and sex therapy.

I'm sure you have more questions. We welcome your queries, comments or suggestions. Call or fax us at 5311278 or e-mail me at *mbmirasol@yahoo.com.*



Got extra sugar, mommy? (What you should know about diabetes in pregnancy)

Florence Amorado-Santos, MD
University of Sto. Tomas Hospital

The increasing number of individuals who have hypertension, diabetes mellitus, dyslipidemia and obesity is a growing concern. Many studies have looked into how to decrease the different risk factors leading to these conditions. Unfortunately, the pregnant woman who traditionally plays the most passive but renowned role in the household during the nine months of pregnancy is not spared.

Gestational diabetes mellitus (GDM) or diabetes in pregnancy is defined as any degree of glucose intolerance with onset or first recognition during the index pregnancy. When diabetes (either Type 1 or Type 2) had been diagnosed prior to conception, it is called pregestational diabetes mellitus. Between 2 to 7 percent of expectant mothers develop GDM, making it one of the most common health problems that can affect pregnancy. In Asia, it occurs in 4 percent of pregnancies.

In the non-pregnant state, diabetes develops when there is either beta cell (cells that produce insulin in your pancreas) dysfunction where your body cannot produce enough insulin or your body cannot effectively use the insulin it produces (insulin resistance) and your pancreas tries very hard to produce extra insulin but just can't. Both of these defects can lead to hyperglycemia.

What happens during pregnancy? During pregnancy, hormones are in chaos and it is harder for one's body to utilize insulin and the pancreas has work double time. For many women, this isn't a problem since their pancreas can compensate so their blood glucose levels remain normal especially during the latter end of pregnancy when the tolerance to glucose decreases. But in some mothers, this coping mechanism is not adequate leading to gestational diabetes.

Other hormones are known to affect maternal glucose metabolism: Progesterone reduces the ability of insulin to suppress endogenous glucose production. In late pregnancy, maternal concentrations of cortisol are approximately 2.5-fold higher than in the pregnant state leading to decreased phosphorylation of the insulin receptor and decreased insulin receptor substrate-1. Human placental lactogen is thought to be one of the hormones primarily responsible for the 50 percent decrease in insulin sensitivity with advancing gestation.

To compensate for this significant insulin resistance, there is up to a threefold increase in pancreatic B-cell insulin secretion over that of the non-pregnant woman in response to the same amount of exogenous glucose. This balance between lower insulin sensitivity and higher insulin production maintains glucose homeostasis in pregnancy and ensures appropriate nourishment for growth and development in the fetus. Gestational diabetes occurs when this balance can no longer be maintained.

Probably the next question is: How would I know if I have diabetes during my pregnancy?

The American Diabetes Association (ADA) has recommended that risk assessment for GDM should be done during the first prenatal visit. High-risk patients include those with marked obesity, personal history of GDM, glucose spillage in the urine or a strong family history of diabetes. These women should undergo glucose screening as soon as possible.

If negative for the initial screening, they are retested between the 24th-28th week of gestation when glucose intolerance starts to increase. Women of average risk can be tested during the 24-28 weeks of gestation. Low risk patients need no glucose testing. They are

Good nutrition is the cornerstone of a healthy pregnancy. Do not think that "you are eating for two." Instead, you would only need an additional 200-300 calories from the non-pregnant caloric requirement in order to meet the needs of the growing baby.

considered low risk if patient is < 25 years old, normal weight during pregnancy, belongs to an ethnic group with low GDM prevalence, no known diabetes in first-degree relatives, no history of abnormal glucose tolerance and no history of poor obstetric outcome.

Screening for GDM can be either a one-step or two-step approach. The one-step approach goes directly to the diagnostic 100 grams oral glucose tolerance test (OGTT) without prior plasma or serum glucose screening. This is considered cost-effective and less cumbersome to high risk patients. The two-step approach first entails an initial oral glucose challenge test (OGCT) with 50 grams glucose and doing a diagnostic OGTT if the result is greater than 140 mg/dl, the glucose threshold value.

Diagnostic criteria for the 100 grams OGTT (modified by Carpenter & Coustan) where two or more of the venous plasma concentrations must be met or exceeded for positive diagnosis are as follows:

Fasting= 95 mg/dl (5.3 mmol/l)
1 hour = 180 mg/dl (10.0 mmol/l)
2 hour = 155 mg/dl (8.6 mmol/l)
3 hour = 140 mg/dl (7.8 mmol/l)

Diagnosis of GDM may bring apprehension if not fear to the mother. This is why patients must have regular follow-ups in order to have proper management either with diet and exercise alone or with insulin injections to maintain good glucose control for the duration of pregnancy. (Mind you, mothers with GDM are among those patients who are easiest to convince to have daily insulin injections!)

Failure to maintain acceptable blood glucose values during fasting (< 105 mg/dl) or postprandial (< 130 mg/dl after 2 hours) with medical nutrition therapy will require the use of insulin injections. It is essential that patients will be able to do self-monitoring of blood glucose 3-4 times a day during the first few days from diagnosis to determine one's profile. Oral hypoglycemic tablets do not have sufficient data regarding their safety in pregnant women. Checking for ketones (result of breakdown of fat stores) in the urine may be done once or twice a week. This could determine if the mother is not eating enough and might need some adjustments in her diet.

Maternal and fetal risks accompanying poorly controlled blood glucose during pregnancy include increased chance of delivery by cesarean section, increased episodes of urinary tract infections, development of pregnancy induced hypertension, delivery of a macrosomic (large, fat) baby, birth trauma (shoulder dystocia), respiratory distress syndrome, prolonged newborn jaundice and neonatal hypoglycemia.

Good nutrition is the cornerstone of a healthy pregnancy. Do not think that "you are eating for two." Instead, you would only need an additional 200-300 calories from the non-pregnant caloric requirement in order to meet the needs of the growing baby. The ADA recommends that all GDM mothers receive nutritional counseling from a licensed dietitian. The medical nutrition therapy should be individualized and tailored according to the maternal weight and height.

Exercise is an excellent way to help improve glucose control even in pregnant mothers. It also offers flexibility and can prepare the mother for childbirth. In addition, regular exercise can help relieve back pains, muscle cramps, swelling, constipation and difficulty in sleeping that accompany pregnancy. However, any strenuous exercise must be discussed with the obstetrician.

Reclassification of maternal glycemic status should be performed 6 weeks postpartum. Women who have had gestational diabetes have a 30-50 percent increased risk of developing Type 2 diabetes mellitus later in life. Further, these mothers have a 40-50 percent chance of developing diabetes in the next pregnancy. It is important at this point that patient's glucose control be checked at regular intervals and start adapting lifestyle changes.

All mothers want to deliver a healthy if not a perfect baby. It's not easy to live with a condition which one knows can affect the health of the unborn child. Although it can be stressful to regularly prick fingers to monitor blood sugar and follow a specific diet and exercise plan or daily insulin injections, it could all be worth it to prevent all the complications of gestational diabetes. Stop worrying because you will end up eating all of the wrong foods or neglect exercise, it could also make your sugar levels to go up.

Instead, learn about your condition. Ask questions to your doctor or diabetes educator. Education is still your most powerful tool to overcome all the worrying. There's no better way to nourish that baby inside but with a healthy body and a healthy mind.

Move that body!

Jovie C. Galan, DpSc, BPE

"Hypokinetic Disease" is the term for diseases that are related to or caused by, lack of physical activity. Coronary heart disease, obesity, diabetes, high blood pressure, lower back problems, joint disorders are some of the so-called hypokinetic diseases.

The primary reason for these is that most of us have never been taught how to be responsible for our own physical fitness. The ordinary tasks of daily living no longer provide us with enough vigorous exercise to develop and maintain ideal body weight good muscle tone, or cardiovascular fitness. Our body is designed for physical activity; we have the same body as our ancestors who needed to be strong just to stay alive. They engaged in hours and hours of hard labor to ensure their survival. Physical activity was their way of life. The industrial age changed all these. Our modern day tools and machines have eliminated our need for walking, running, lifting & climbing. We have a great need for a personalized fitness program to make our body function the way it was designed for. By achieving physical fitness we can engage in a life style that produces health and happiness.

What is Physical Fitness?

According to the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD) Physical Fitness is a state of physical being with attributes that contributes to: 1.) Performing daily activities with vigor, 2.) Having minimal risk of health problems that are related to lack of exercise, 3.) Providing a fitness base for participation in a variety of physical activities.

Simply put, it is the ability of a person to do work with vigor and pleasure without undue fatigue with energy left for enjoying hobbies, recreational activities and for meeting unforeseen emergencies.

Physical fitness relates to how you feel mentally as well as physically. Basic to it are proper nutrition, adequate rest and relaxation, good health practices, medical and dental care and most important of all: Exercise. It is built upon two major factors namely:

HEALTH RELATED FITNESS ASPECT

- Cardiovascular Endurance - The ability of the circulatory and respiratory system to supply fuel, most importantly oxygen during sustained physical activity.
- Muscular Endurance - The ability of certain muscle groups to exert external force for many repetitions or successive exertions.
- Flexibility - The range of motion available in joint.
- Strength - The amount of external force which a muscle can exert.
- Relaxation - A neuromuscular accomplishment that results in a reduction of tension in the skeletal musculature.

MOTOR OR SKILL RELATED FITNESS

- Balance - The maintenance of equilibrium while stationary or moving.
- Coordination - The ability to use our sense together with the body parts in performing motor task smoothly and accurately.

A healthy lifestyle which includes a proper physical fitness program can help us enjoy a longer, happier healthier and a more productive life.

- Agility - The ability to rapidly change position of the entire body in space with speed and accuracy.
- Power - The ability to transfer energy into force at fast rate of speed.
- Speed - The ability to perform a movement in a short period of time.
- Reaction time - The time elapsing between the stimulation and the beginning of the reaction to it.

The health related fitness aspect can contribute to a state of positive health by reducing chances of degenerative diseases; increase work efficiency and eliminate muscle soreness.

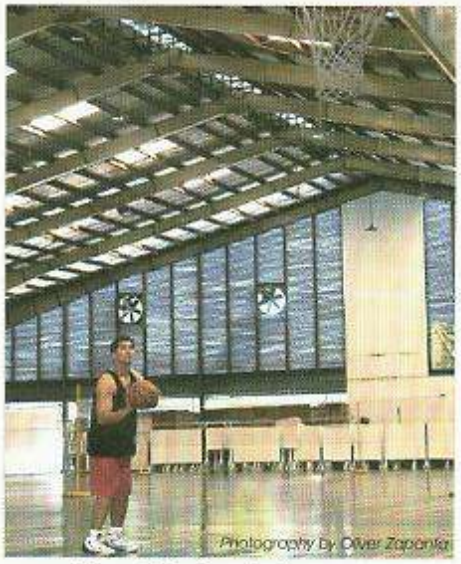
The motor or skill related fitness aspect contributes to the individuals' ability to perform skills and to participate in enjoyable leisure time activities. These two aspects are essential in an exercise program so as to achieve "Total Fitness."

The ancient Greeks taught us that intelligence and skill can only function at the peak of their capacity when the body is healthy and strong. Hardy spirits and tough minds usually inhabit sound bodies. Bearing these in mind, physical fitness is the basis of all activities in our society. If our bodies grow soft and inactive, if we fail to encourage physical development and prowess we will undermine our capacity for thought, for work and for the use of those skills vital to an individual's life.

EXERCISE GUIDELINES

In order to attain maximal benefits from exercise it is essential that a regular progressive program be planned to meet the specific needs of the individual. Prior to planning an exercise program the following factors should be considered:

- The program should be based on the evaluation of the individual's present fitness status. These would also include a complete medical examination so as to get a clearance from the personal or family physician.
- Fitness cannot be developed overnight. The exercise program should progress from moderate to more vigorous exercises until the desired fitness level is attained. When achieved, it becomes a life plan to maintain our fitness level.
- The program should be regular which means at least 3-4 times a week. 30 minutes to 1 hour per session.
- Every aspect of the fitness should be considered in developing an exercise program. It should involve all the muscles in the body, because they are responsible for the movement of the joints, maintenance of posture, support of body weight, circulation of blood, and for respiration elimination.



MYTHS AND FALLACIES - THE TRUTH ABOUT EXERCISE

The individual who has made the decision to undergo a fitness program should be able to separate truth from fallacy about exercise. One should remember that this decision is a lifetime plan so he/she must start it right.

We are often confused by the "commercialism of exercise." We see advertisements on TV and newspapers selling machines and programs that most often do not work. Some ads would make us believe that when certain muscles are exercised the fatty tissues in the immediate area are "burned up." Studies show that groups of muscles can be developed but fat loss is not localized to certain specific sites. Exercise causes fat to be burned from all over the body and not from a specific area. "Spot reducing" does not work. Perspiration or sweat does not promote fitness. A lot of people think that the more you perspire the more fat you burn. The body is designed to keep itself from overheating. The sweat glands begin to secrete water when our body temperature increases. It is further cooled down when perspiration evaporates. Therefore, sweating does not do anything other than lower the body temperature. It does not burn fat. Fitness is developed by exercising the muscles of the body, not the sweat glands.

A HEALTHY LIFESTYLE:

People who live longer exercise regularly. The human body was created to be exercised. When we become sedentary, the joints stiffen, the muscles weaken, the circulatory system is

affected by increased fat, the heart loses strength and thus we become prone to injury and disease. Being overweight is more than a matter of individual discomfort. It is related to several chronic diseases, shortened life expectancy and emotional problems. Exercise helps a person feel good, look good and work better. Various organs and systems of the body are stimulated and as a result function more properly. It also improves a person's posture and decreases the frequency of lower back pain and disability. Exercise can ward off the effects of aging and improve both physical and mental being.

A healthy lifestyle which includes a proper physical fitness program can help us enjoy a longer, happier healthier and a more productive life. So - **"LETS EXERCISE!"**

Source:
Fitness for Life
Applied Kinesiology
The West Point Fitness and Diet Book

Jovie C. Galan, DpSc, BPE
Bachelor of Physical Education
Diploma in Sports Coaching

Ang kabutihang dulot ng ehersisyo

Mrs. Lolita Trazo

Ang ehersisyo ay di na bago sa akin dahil bata pa ako ay mahilig na ako sa gawaing ito dahil ayaw kong tumaba. Calisthenics lang naman at walking ang ginagawa ko noon .
Mula ng sumali ako sa weekly exercise ng mga diabetiko na alaga ni Mam Jovy* nakaramdam ako ng maraming pagbabago. Enjoy ako sa gawaing ito dahil scientific
at tunay na naiinat ang kaliit liitang bahagi ng aking katawan.

Dati rati napakadali kong mapagod kahit na sa kaunting gawaing bahay lamang. Ngayon, nakakaya ko nang gawin ang gawaing bahay nang walang katulong. Nakakapamalengke at nakakapunta ako sa grocery nang walang taga dala nang aking mga pinamili. Pakiramdam ko mas malakas ako ngayon kaysa nung 70 years old ako. Nung tumuntong ako ng 70 years di ko na kayang itulak ang wheelchair ng asawa ko tuwing check up niya sa Phil Heart Center. Ngayon na mag se seventy three na ako, nakakaya ko nang itulak mag-isa ang wheelchair niya (of course, nakasakay siya). Isa pa, napakasarap ng tulog ko, magabi man o tanghali kahit napakainit ng panahon. Siempre dahil bumaba ang timbang ko, lumiit ako ng kaunti sa dati kahit na overweight pa ako ng 1 kilo.

Isa pang magandang resulta ng ehersisyo ay ang pagkawala ng hilo ko sa tuwing mahihiga ako at tatagilid sa kaliwa. Parang pakiramdam ko ay lumulubog ako. Ang sabi ng "oncologist" ko ito raw ay "vertigo".

Ang mga braso ko ay mabigat pagdating ng gabi dahil sa pagod. Pero, simula ng mag-ehersisyo ako medyo nawawala na ang pamimigat nito. Sa kabuuan gumaang ang pakiramdam ko. Dati rati nung di pa ako sumasali sa group exercise parang di kaya ng paa kong dalhin ang katawan ko. Ok na ok na ako. Siguro ganun din ang mga kasama ko. .
Ako ay nagpapasalamat sa staff ng diabetes clinic na ginawang instrumento ng Panginoon upang matupad ang pag-eehersisyong ito. Higit sa lahat nagpapasalamat ako sa Panginoon dahil sa tulong niya sa aming mga diabetiko na mabuhay ng normal at maligaya sa aming kalagayan.

**exercise physiologist*

Si Mrs. Trazo ay isang type 2 diabetic na dumadalo linggo linggo sa ehersisyo ng Diabetes Clinic sa East Avenue Medical Center. Siya ay naging biktima ng breast cancer at heart attack nung 1992.

PDA Award of Excellence

Rosa Allyn G. Sy, MD
Immediate Past President

Through the years the Philippine Diabetes Association has witnessed not only the dedication of its officers and board but of its many members as well. And after more than 4 ½ decades we felt that it was about time to give recognition to those individuals who have shown their unwavering commitment in ensuring that the objectives of the PDA are carried on for the benefits of the many Filipinos with diabetes and their family.

For this reason, the association gave the very first PDA Award of Excellence in Diabetes to its deserving member after considering the criteria set forth by the committee. Beyond the recognition, we wish to draw inspiration from the PDA Award for Excellence in Diabetes, an inspiration to move our association further on.

Our first awardee is Prof. Augusto D. Litonjua, MD, a prolific researcher, and exceptional educator and mentor, a dedicated physician and advocate of diabetes care. He helped organize various local and international organizations related to diabetes such as AFES, ASGODIP, and founded the Asean Diabetes Educators, among any others. He is the 15th president of the PDA whose term lasted for 11 fruitful years. Under his leadership, Philippine Diabetes Association became a staunch promoter of education as a right of diabetic patients. In this regard, he personally conducted lectures on diabetes to trainors and patients alike.

He started the Diabetes Watch, a PDA publication which brings information and education to our patients and their families. PDA chapters were organized under his term. Likewise he established the Philippine Center for Diabetes Education Foundation Awareness Week every 4th Sunday of July. Its was also during his term that PDA became a member of the prestigious International Diabetes Federation(IDF); IDF-Western Pacific Region. Together with the other board members he decided to change the PDA seal to dramatize present concern for the family, not only diabetic patients. PDA, with his perseverance found its permanent home at Facilities Centre in Mandaluyong City.

Upcoming events...

FITNESS WALK 2005
"Let's Walk Together"
CCP Complex, Roxas Blvd., Pasay City
September 4, 2005 (5:00am to 10:00am)

PHILIPPINE ASSOCIATION FOR THE STUDY OF OVERWEIGHT AND OBESITY
11th ANNUAL CONVENTION
2nd POSTGRADUATE COURSE
New Horizons in the Treatment of Obesity
The Westin Philippine Plaza Hotel, Roxas Blvd., Pasay City September 5-6, 2005

30th Diabetes Workshop
Gerry Roxas Foundation Resource Center & Convention Hall
Dayao, Roxas City 5800
October 28 - 29, 2005 (Friday & Saturday)

A one-day lecture on Diabetes Strategies for the Primary Care Physicians
Venue: Natrapharm Office
Patriot Bldg., Km. 18
West Service Rd.,
Sucat Parañaque
November 14, 2005 (Monday)

World Diabetes Day
Theme: Put Feet First Prevent Amputations
Date: November 14, 2005 (Monday)

PDA LAY ANNUAL CONVENTION
Century Park Hotel, Manila
November 19, 2005

ASEAN FEDERATION OF ENDOCRINE SOCIETIES (AFES)
Philippine International Convention Center
December 7-10, 2005

PDA ALBAY CHAPTER

Lina Delos Reyes-Asido, MD
BRTTH

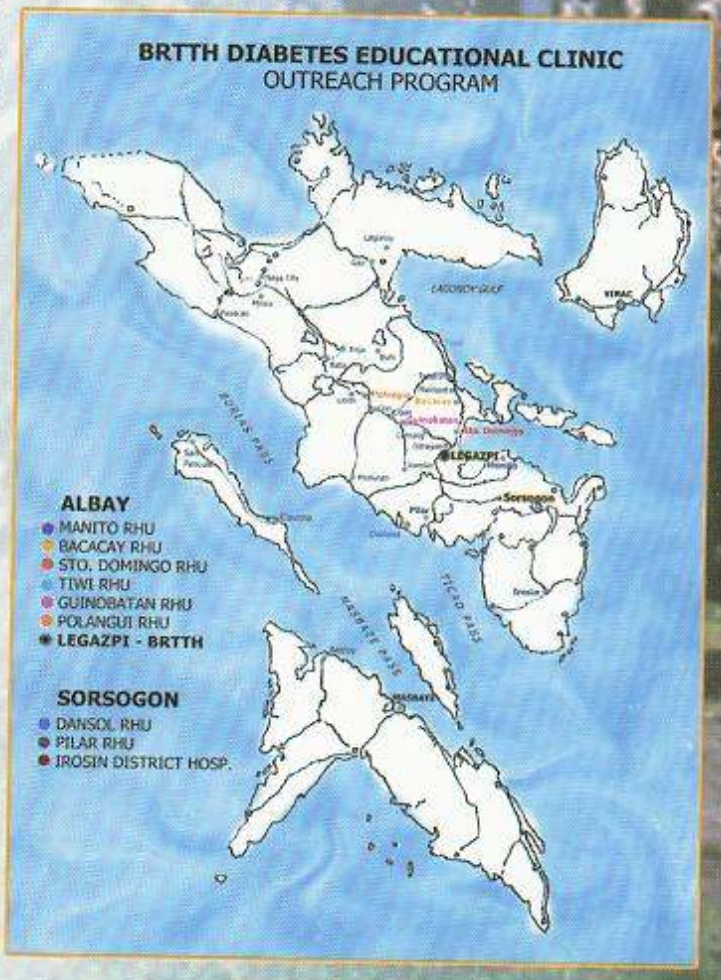
The chapter hibernated for 10 years when nobody had the courage to get the cudgels to steer after 3 past presidents.

Nevertheless, the Bicol Regional Training & Teaching Hospital's (Formerly Albay Provincial Hospital) Diabetes Team; headed by it's physician, nurse & dietitian after their training at the Diabetes Center spearheaded all the annual activities of the diabetic patients in their week-long celebration of the National Diabetes Week Activity: Alay-Lakad, Exercises, Holy Mass, glucose and cholesterol screening, Peripheral Artery Disease and Micral screening. Lectures on the nature of diabetes, complications, various forms of medications, diet and exercises were undertaken for family members of diabetics, other lay audience, teachers, midwives, medical students, nursing students, dietitians and government employees, every year for the past ten years.

For the past 5 years, outreach programs for Diabetes Clinics in various rural health units and district hospitals were organized and their own local sets of officers were elected up to the present. We conduct monthly diabetic clinics for the province of Albay: Tiwi RHU, Bacacay RHU, Sto. Domingo RHU, Guinobatan RHU, Polangui RHU and Manito RHU. Sorsogon had been included making our chapter a regional one. We organized diabetic clinics in Irosin District Hospital and Pilar RHU.

Last year's celebration of Diabetes Awareness Week was different from previous activities, we sponsored a musical concert for the benefit of the Albay Diabetics Association with the full support of the Hon. Governor of Albay. "The Night of Stars Concert," with 4 singers - all champions in various national TV contests generously asked for meager talent fees. It was a resounding success.

All patients in the BRTTH and Rural Health Units Diabetic Club and their families bought tickets, pharmaceutical companies showed their support by donating cash or kind. Our doctors danced with guests in an intermission number. Proceeds from the concert went toward the procurement of glucometers, strips, lancets, and were given to target RHU Diabetes Clinics. Medicines were procured at low cost making them very affordable to patients.



Last year, Dr. Rosa Allyn G. Sy, PDA President (2004), tapped me again to resurrect the chapter, hence we had an election of new sets of officers for PDA Albay.

We hosted the 29th DiabetesWorkshop on April 29-30, 2005 at Casablanca Hotel, Legazpi City. We had an overwhelming attendance from MD's, nurses, dietitians and lay.

In essence, therefore in spite of the 10 years hibernation, we barely had to call a full-blown code to our chapter. This was evidenced by the active participation and eager cooperation of all those who were present in our activities and the increased number of satellite diabetic units in the rural areas.

President	:	**Dr. Jose Cope**
Vice President 1st	:	**Dr. Jude Rivera**
Vice President 2nd	:	**Dr. Joana M. Limos**
Secretary	:	**Dr. Mayen Isip**
Treasurer	:	**Dr. Cathy Barrameda**
PRO	:	**Dr. Joey Solano**
Advisers	:	**Dr. Lina Delos Reyes-Asido**
		Dr. Merle Camba-Farrokhiz

Reported by:

Dr. Lina Delos Reyes-Asido

- *Diabetes Team Physician Assoc. Educator*
- *PDA 29th Diabetes Workshop Coordinator*
- *Past President, Albay Chapter 1995*

Facing a life unsweetened

Conrado Flores Viriña

Diabetes caught me while I wasn't looking. Like probably hundreds of thousands of people before me, I discovered that I am diabetic purely by accident.

It happened late last year. Around November.

One morning, I felt pain in the groin area after a pee. It lasted a few seconds but the pain was excruciating. The following day, there was no sequel to the painful urination but the incident left me puzzled and slightly worried. I decided to see an urologist.

The urologist made me undergo several tests. He wanted to know the state of my 4-decade old kidneys, bladder, and prostrate. And I must confess the real possibility of having prostrate problems entered my fearful head. But then again, I reassured myself, it could simply be urinary infection, easily cured by antibiotics or some other form of medicine.

When the test results came in, the urologist told me that my kidneys, bladder and prostrate all appeared A-okay. Nothing in the tests could indicate the cause of my painful urination. He opined that it could have been mere muscle strain due to extraneous physical activity. Anyway, I tested negative for urologic problems so I was just glad about that and thanked him.

As I was about to get up and leave, the doctor asked me to sit down again. The tests also showed a higher than normal blood sugar count. He asked if I have a diabetic relative. I said, yes, my late father.

The urologist sighed -- not a good sign, really -- and recommended I see an endocrinologist soon as possible. Just to be sure, he said. Yeah, right.

Period of Ignorance & Denial.
I went on with my usual life for a few days as if nothing happened. After all, I wasn't feeling any pain, wasn't feeling any discomfort in my body. I plunged right back into my hectic stressful enjoyable work and shoved the whole disturbing incident in the farthest, darkest corner of my brain.

I told my wife about the suspicion of the urologist, of course. I also shared the same with my mother. Both of them strongly advised I go see an endocrinologist.

I eventually did, but not before going off to a business convention abroad where Singaporean food flowed, drinks brimmed for days, and the shop talk went on and on till the wee hours of the morning. By the time I returned home and actually consulted my endocrinologist face to face, my blood sugar count had risen from a high 245 to an alarming 300!

Facing the Bloody Truth.
My endocrinologist, immediately went to work on me. She didn't mince words. If I don't follow a very strict program of diet and exercise, I may lose my sight, lose my limbs, have a heart attack, have a stroke, become impotent (a horrible prospect by itself), or die early! Her chilling words, delivered in a mild, gentle tone, shook me awake to a totally new reality I never even imagined could happen to me.

You see, I haven't had a sweet tooth since I was a scrawny kid in Caloocan. I have never been fond of sweet deserts like cakes and pastries. It has never been my habit of putting lots of sugar in my coffee. Half a teaspoon of sugar in a cup suffices for me. So getting diabetes was, to my misinformed mind, a possibility as remote as acquiring pecs and abs like those of Brad Pitt's.

Little did I know that my love for SMB (San Miguel Beer) and deep affection for rice are as bad as having a strong liking for sweets. And the fact that I was in my forties, that my dad was diabetic, and that my only real exercise is my 1 hour weekend runs - well, all these things led me to where I was: Right in front of an endocrinologist.

My Journey in a Journal.
I was declared overweight by a mere 8 pounds but still had to go down to 140. That's supposed to be the ideal weight for my 5'7" frame. Actually, I even ballooned to 155 lbs last year. And we are talking about a man who was less than a hundred pounds during his college years!

The other target, which was fine with me, was to lose my growing jelly-belly.

I was referred to a nutritionist. The dietician gave me a strict low-carb, low-cal diet. Just 1 cup of rice for breakfast! 1 ½ cup of rice for lunch! Viands in matchbox sizes! ¾ cup veggies! No softdrinks! No beer! Avoid wine! I felt like she was putting me on starvation mode. For someone not used to measuring his intake of rice, it proved to be pure agony the first few days. And I was instructed to keep track of every single morsel I take from dawn to night.

On top of this, I was supposed to prick my finger each day to check my blood sugar. It is bad enough when some doctor or nurse pricks your finger for blood. It is far more unnerving to deliberately prick yourself, to make a self-inflicted wound. Not a very nice thing to do at all. But I did it anyway. Had to.

The hardest was the very first. It took me so long to begin. There I was, numbly staring at my finger while holding the glucometer for about 20 minutes. And to think, I was asked to do a blood-sugar read twice a day -- one before breakfast (FBS) and another one 2 hours after dinner - for at least 30 days!

I started recording my meals and my blood sugar count every single day for almost 2 months. The objective, is for me to 'know' my body, to learn the kind of food and drink that is good (or bad) for my sugary blood.

Of course, the first few weeks were quite difficult. I was changing my lifestyle, my outlook, my behavior, my eating habits. But I said to myself, if I want to live longer, live a longer quality life, I had to discipline myself.

It was hard.

Excerpt from my Diet Journal below:

Date	Meals	TestTime	BloodCount	Comments
Jan10	5:30am-cup of coffee 7-7:30am Brkfast- 1 cup rice, 1 ½ MBS(match box size) corned beef 9:30am -1 mug hot Charantia. 12:30-1pm Lunch- 1 cup rice, 1 inihaw na tilapia, 1 MBS adobo pork, 2 thin slices of green mango w bagoong. 3pm- 1 cup black coffee 9-9:30pm Dinner 1 ½ cup rice, 1 ½ MBS salmon belly grilled, ¾ cup green salad w bacon bits & Marivic's dressing.	**5:10am** **12mdnight**	**6.3** **10.0**	**[Note: This is way too much lunch.** Masyado ginanahan eating during my boss' bday celebration. **Social pressure to enjoy food is a factor to be overcome.]** **[Note:** This is what my doctor warned me about. **Skipping merienda makes me way too hungry by the next meal,** tempting me to eat beyond my diet. Remember advice of doctor: **DRINK WATER BEFORE EATING!**
Jan11	5:20AM cup of coffee 6:45-7am Brkfst 1 cup rice, 1 pc fried biya, 2 tbsp kamatis 12:25-1:15pm Lunch 1 small plate green salad at Kitchen rest. Includs pomelo grapes white cheese nuts balsamic vinegar. No meat. 3:30-4:30pm 2 glasses of sugar free lemonade 8-8:30pm Dinner 1 ½ cup rice, 1 MBS roast chicken, ¾ cup veg chicharo & green pepper, some mixed nuts.	**5:15am** **10:45pm**	**7.1** **7.8**	**Exercise: 5:30-5:50- 150 ABSwings.** **Note:** *Around 4:pm, my eyes became blurry for a few long seconds. Got me worried a bit.* (Ed comment: Conrad ate a very low caloric lunch) **Exercise: 9:30-9:45pm Thighs & lower legs stretching.**

Date	Meals	TestTime	BloodCount	Comments
Jan13	5:45- cup of coffee 7:30am brkfst 1cup rice, 1 pc fried biya, 1tbsp kamatis	5:40am	6.5	**Note: FBS taken 8 hrs after last meal. 2day** I try anew to make **a 7-point test thru out the workday.**
	10am cup o' tea 11am 1 pc graham cracker	10:20am	6.2	**Almost 3hrs aftr breakfast**
	12:30-12:45pm lunch 1 ½ cup rice, 1 MBS fried fish, 1 MBS beef apritada, 1 pc lumpiang shanghai.	12:15pm	6.1	**Before lunch**
	3:30pm 5pcs sunflower biscuits	2:35pm	8.5	**Almost 2 hrs after lunch**
	7-7:30pm meriendacena: 2 pcs bbq, 2 small pcs okoy, 2 small pcs fried spring roll, ½ glass red wine [GMA party]			
	9:35-9:45pm dinner½ rice, 1MBS giniling with eggs	12midnight	6.3	

Moving On.

It has been half a year since I found out I have this malady.

I now have accepted the cold reality that I will never be cured of diabetes and eventually will be taking expensive medicines; hopefully, still a few years from today. I now know that it is critical for me to habitually check the state of my blood sugar and to closely monitor my intake of carbs and fats, my level of antioxidants, the calories I consume, and the amount of exercises I do, among other things.

In short, I am gradually learning how to live with diabetes.

Now - and I am sure you would agree -- it isn't the sweetest thing to be diabetic and it can be a struggle many times. But it doesn't mean my life has turned sour or bland or pitiful.

It just means my body is no longer what it used to be.

And that I should embrace life in a far healthier way.

Every. Single. Day.

Mr. Conrado Viriña has been in the advertising business for >20 years.

Playing the diabetes numbers game

Patricia B. Gatbonton, MD
Our Lady of Lourdes Hospital

Controlling your diabetes is like winning at Bingo-get the right numbers in the right combination on your card and you win.

By now, persons with diabetes already know that diabetes is a chronic disease with no cure, and that keeping your blood sugar and other parameters under control is the best way to keep complications at bay.

Different players in the diabetes world have differing recommendations for certain values and that adds to the public's confusion. We will refer to the American Diabetes Association goals of therapy unless otherwise specified.

These are the numbers that count:

<7 percent HbA1c---glycated hemoglobin is a measure of average blood sugar of the last three months, it factors contributions from both fasting blood sugar and post meal sugars into the equation.

The ADA recommends < 7 percent, the American College of Clinical Endocrinology and the International Diabetes Federation cut off is lower, at 6.5 percent.

<100 mg/dl is normal blood glucose.

In November 2003, the American Diabetes Association lowered the threshold for normal blood sugars to 80 to 99 mg/dl. Any reading between 100-125 mg/dL is impaired fasting glucose or IFG. Diabetes is diagnosed with a FBS of > 126 mg/dl on two separate occasions.

The ADA goal for fasting blood sugar is between

90-130 mg/dL (5.0-7.2 mmol/dL). The two-hour post meal goal is

<180 mg/dL (10 mmol/L).

<130/80 mm Hg is blood pressure goal for persons with diabetes. Those patients with blood pressure under 140/90 mm Hg can try lifestyle modification with weight loss and exercise, patients with BP above 140/90 mm Hg will need medication. Drugs with particular renal protective benefit include ACE inhibitors or an angiotensin receptor blocker (ARB).

<100 mg/dl LDL-C-bad cholesterol. This small, dense, bad cholesterol is a crucial player in the formation of atherosclerotic plaques that block crucial arteries that bring blood to the heart and brain. As of July 2004, the Adult Treatment Panel (ATP) II of the National Cholesterol Education Program recommends bringing this number even lower, to <70 mg/dl, in those at high risk, including patients with diabetes. Those patients with high levels of LDL cholesterol will need treatment with a statin-a class of drug which interferes with key enzymes in cholesterol formation-in addition to lifestyle management.

>45 in men and **>55** in women HDL-C-good cholesterol. The cardioprotective cholesterol, good cholesterol helps clear the system of the bad cholesterol and prevents the formation of plaques. HDL-C levels can go up with exercise, drug

The key is that you and your physician sit down and set goals that are realistic, reasonable and achievable together. That way, you will be a winning team.

therapy with statins and nicotinic acid derivatives can also help.

<150 mg/dl Triglycerides-the fat globules floating around in circulation. High triglycerides are part of the usual profile of a patient with diabetes. Too high levels can also come from alcohol intake and high blood sugar levels. Best addressed with a low fat diet, medicating with a fibrate may be necessary to prevent pancreatitis, fatty liver and other complications.

<31 inches (80 cm) in women and **<35** inches (90 cm) in men-Waist circumference. The inches around our waistline are indicators of fat within the abdomen as well as the subcutaneous fat (bilbil). This bad fat is a marker for insulin resistance, leads to fatty acid and excess sugar production besides making our side-view profile less attractive.

18.5-22.9 -normal body mass index (BMI). BMI is a measure of how overweight or obese a person is. Overweight and obese persons have a bigger risk of developing lifestyle disease like hypertension, diabetes and abnormal cholesterol profile. Keeping your BMI within normal and losing weight-even 5 to 10 percent-leads to tremendous metabolic benefits in a patient with diabetes.

30-60 minutes a day of exercise. Moderate physical exercise-between 30-60 minutes a day-optimizes maximum oxygen uptake, increases basal energy expenditure and improves cardiovascular fitness and helps lose weight.

These are the most important numbers for a person with diabetes. However, each individual may have specific situations that may lead their physician to recommend higher, or lower goals. The elderly, patients with liver or kidney disease, patients who have had a stroke, heart attack or are disabled are examples.

The key is that you and your physician sit down and set goals that are realistic, reasonable and achievable together. That way, you will be a winning team.

Bingo.

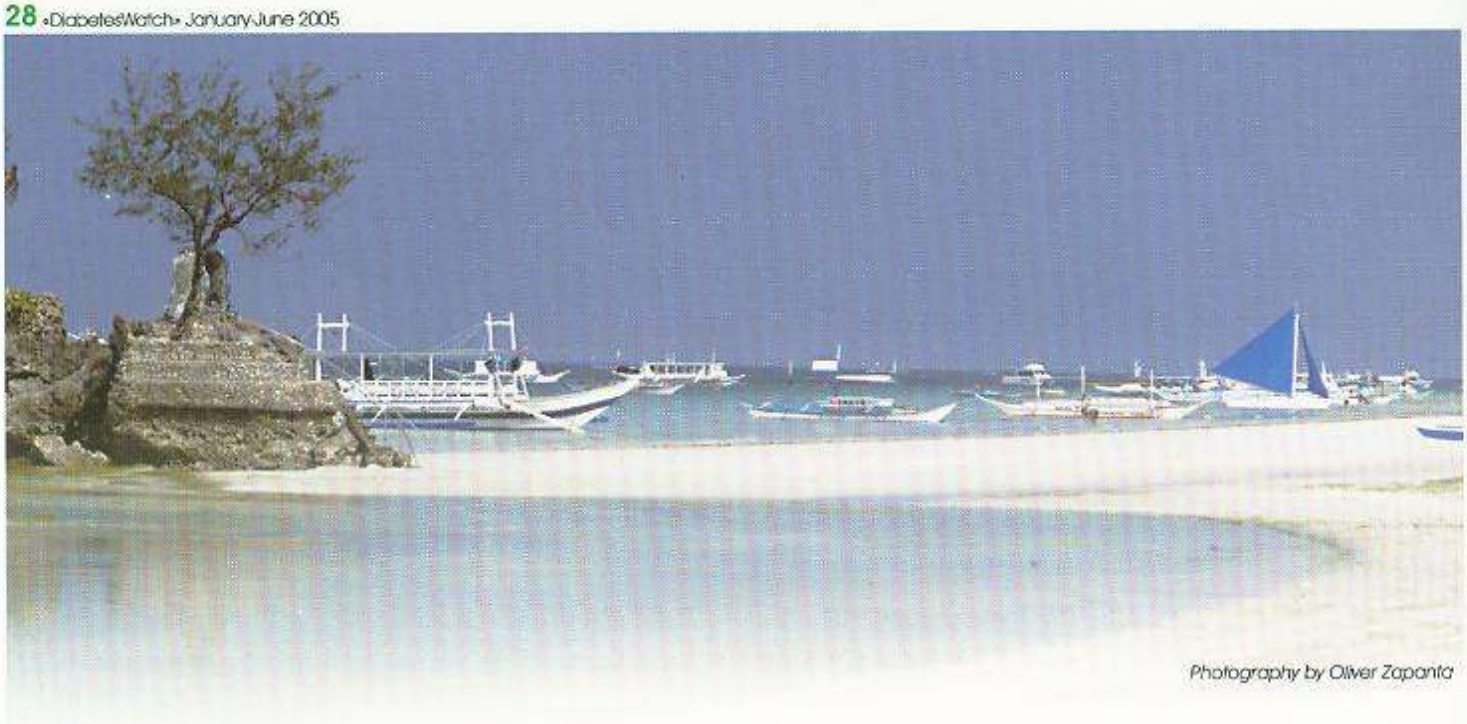
Sidebar:

Are you obese or overweight? Take the DW quiz

Step 1:
Measure your BMI with this formula:
BMI = body weight (in kg) ÷ square of stature (height, in meters)

Step 2:
Look up your BMI in this table (for nationals of the Asian Pacific region only)

Classification	BMI	Cardiovascular risk
Underweight	<18.5	Low (but increased risk of other clinical problems)
Normal	18.5-22.9	Average
Overweight	>23	
At risk	23-24.9	Increased
Obese I	25-29.9	Moderate
Obese II	>30	Severe



Photography by Oliver Zapanta

TRIPS & THE CITY

BORACAY : UNTAINTED ISLAND CHARM

Ma. Vanessa Zapanta

"Boracay" - Features an unadulterated island living in the Philippines, all in a seven kilometer, palm fringed, white powdery sand beach .

Its main allure, one that sets it apart from the best beaches in the world, is its fine sand as soft as talc. It is cool to the feet, even under the scorching midday sun.

The west side beach offers the best sunset view in the country with the splashes of the colors orange, magenta, peach and gold giving you a sense of melancholy and serenity found nowhere else.

The waters' depth level has along, even gradation where you can clearly see minute school of fishes darting between your legs. The very rare, luminous white "puca" shells, said to be the most premium in the world, can be found here.

Boracay is at its finest during the rainy season and a good "sight-seeing" ground during cold December. It's a place where people from all generations and cultures converge and party. Perhaps it's the diversity of nature that made me fall in love with the place.

Getting There

There are four ways to get to Boracay:
1. Direct flight from Manila to Caticlan in Panay (1 hour) via Asian Spirit and SeaAir then by a 30-minute motorized ferry ride
2. Direct flight from Manila to Aklan (1 hour) then a two-hour overland trip to Caticlan and a 30-minute ferry ride
3. Via Our Lady of Lipa from North Pier to Dumaguit (18 hours), then a two-hour land trip to Caticlan and a 30-minute ferry ride
4. Via Ro-Ro from Batangas Pier to Boracay

Where to Stay

There are two ways of getting accommodations. First by booking in advance via travel agencies or the internet but you have to pay more for this convenience .Club Panoly, Fridays, Seawind, Regency, Willy's Rock, Boracay Terraces, Sand Castle and Pearl of the Pacific is more on the upscale living. Food is often served by the beach with the complete ambience of Island Paradise. Candles, light torches and acoustic music fills the romantic air.

The second one if you are on a budget, there are options available to you on the White Beach. Get off at Station 2

There are lots of things to do in Boracay - relax, shop, man/babe-hunt, island hop, snorkel, dive, banana boat ride, parasail, wall climb and Party!

(center of the island) or Station 3. Walk along the beach and ask around.

Places to Visit

Jonah's has the tastiest banana peanut shake on Boracay. Great Sunset view and a celebrity hang-out.

Cocomangas is home of the Moondogs Shooters Club, people who drink 15 kinds of alcoholic beverages under time pressure. You'll get an engraved dog tag displayed on the restaurant wall. An evidence of great valor and spirited bravery.

Mandalay Spa is a high-end relaxation for the upper echelon of the society. An alternative is lying on the beach and calling "manang" to do the Php 200 massage using coconut oil.

D-Mall is a shop-a-holics haven. The New Talipapa is also available for the bargain hunters.

Aria is a party place for the celebs and celeb-hunters.

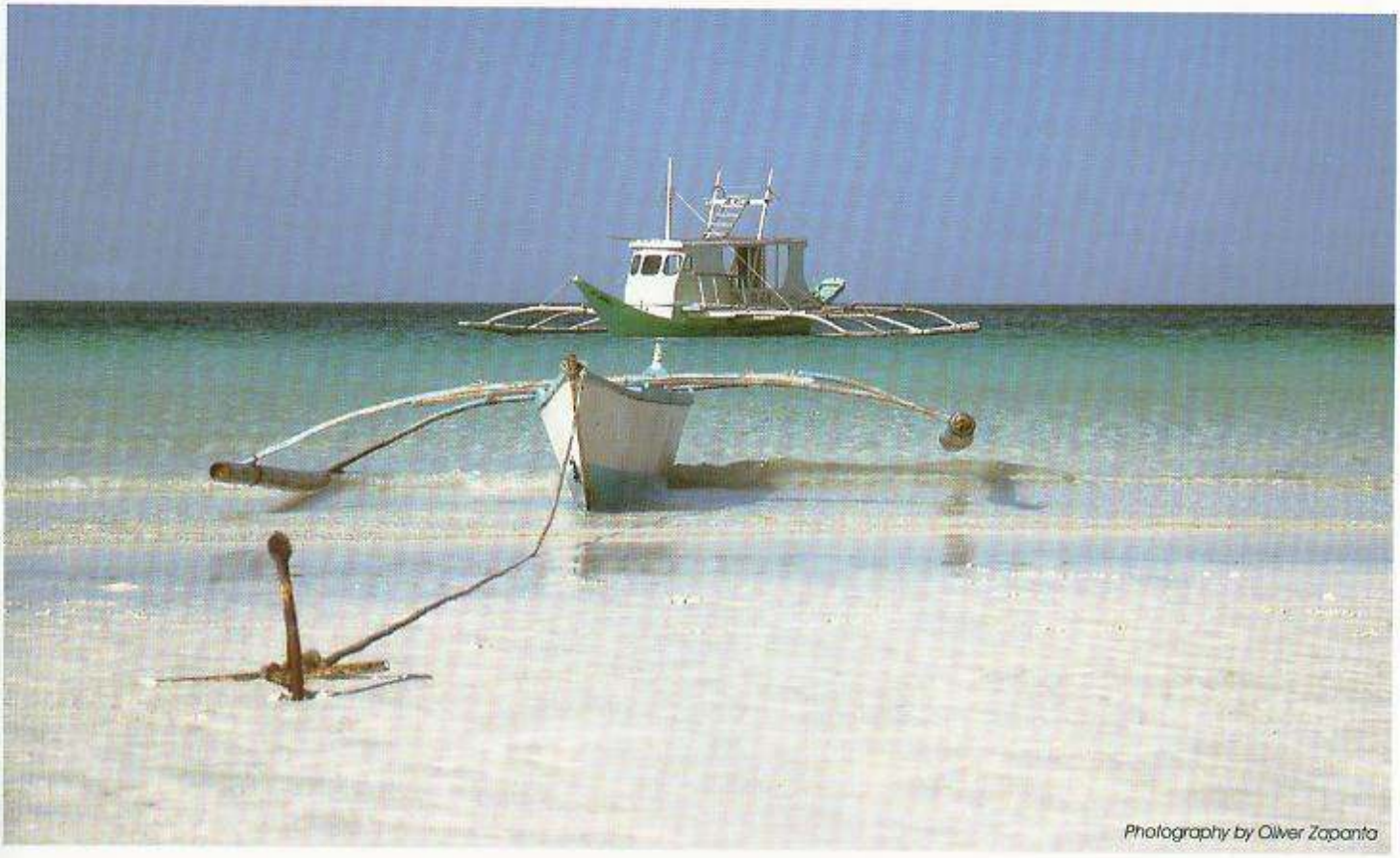
Hey Jude - great pizza hang-out. Try Pizza Margherita

True Food - Indian restaurant

Zorba - Greek Restaurant

There are lots of things to do in Boracay - relax, shop, man/babe-hunt, island hop, snorkel, dive, banana boat ride, parasail, wall climb and Party! It's a kind of place that you will come back to even if you've been there a lot of times. It offers variety of activities both for the adventurous and the laid-back.

A great romantic companion is a one essential part of this whole package. The sunset is more colorful, dinners are more delightful, and activities are more fun. It makes the getaway more meaningful and worth remembering. It has been said that love is the capacity to feel deeply, to enjoy simply, to think freely, to risk life and to be needed. It needs your significant other to feel this. Happiness is a way of travel - not a destination.



Photography by Oliver Zapanta

Kitchen corner

A healthy vacation food map for safe eating

Sanirose S. Orbeta, RD

Photography by Oliver Zaporta

Every summer when most kids are out of school it is usually family travel time to beaches, to one's province, or even to foreign lands. Just being together to bond, to enjoy one another, to meet new friends and even relatives is truly a joyful experience for busy families. However, the best laid and well planned family outings can take a sudden detour or even be postponed when a member gets suddenly sick along the trip with a bad case of diarrhea happen or food poisoning.

Travel Trends

According to a travel survey, of the 60 percent who plan to take vacations this summer 90 percent will be traveling by car and 97 percent will bring their own food. 22 percent will be traveling by bus and will either pack food or eat on route, 52 percent will be traveling by plane carrying some meals or snack. Travelers who pack food to eat on the way to their destination typically bring sandwiches (67 percent), chips, cookies, soft drinks and hopia (66 percent) sometimes prepackaged lunches with meat and hard boiled eggs (28 percent). Any or all of these food can spoil if not kept at proper temperatures.

The survey also reveals 30 percent leave the food they bring unrefrigerated for three to four hours, and 15 percent leave it out for more than four hours. "This can create a food safety hazard for travelers and their companions." "Perishable foods should never be left out and unrefrigerated for more than two hours, the point at which harmful bacteria begin to multiply rapidly." In hot weather (above 90°F), time is reduced to one hour.

Preparing Foods "To Go" the Distance

For some reason we have the inborn habit of bringing food wherever we go. We need "baon" just in case there is no food to buy when we get hungry. The following are few easy pre-travel food preparation tips:

- ✓ Wash hands with soap and water before preparing sandwiches and packing them in cellophane. When switching tasks, such as handling raw and then cutting vegetables or peeling fruits wash hands thoroughly. Also, make sure food preparation surfaces are clean and all containers are clean and odorless after long storage.
- ✓ Be sure to pack moist towelettes to clean up before digging in your food bag.
- ✓ In hot weather, transport perishable

food in a cooler (packed with ice or ice packs) or in the back seat of an air-conditioned car instead of the trunk. It's great if you have a refrigerator thermometer to ensure the temperature remains below 40°F.

✓If traveling by plane or bus where space is tight, freeze a juice box or yogurt for a chilly treat that will also help keep other foods cool. Pack foods in a small, soft-cover travel cooler that will conveniently slip under the seat. Or, give each family member his or her own insulated lunch bag full of favorites.

✓If stopping in a scenic roadside for a mid-trip picnic and cook-out, remember to grill foods to proper and safe temperatures: hamburgers (at least 160°F), hot dogs (reheat to 160°F), and chicken (170°F). Pack raw meats for the trip in a cooler, placing them in a well-sealed container or wrapping tightly in saran foil. Be sure to keep them separate from other packed foods as raw juices from the meat can easily contaminate ready-to-eat foods.

✓Don't forget that carry-out and fast food are also susceptible to food poisoning if not properly handled. If not eaten or refrigerated within two hours, toss it out.

✓Carry chilled fruits with skin on like bananas, apples and oranges as they are refreshing to munch on the way.

Your Kitchen on The Move

Another common eating style during summer is eating Al Fresco or outdoor eating. Remember to apply the same home food safety techniques when preparing meals inside or outside the safety of your kitchen.

As summer temperatures rises, so do risks of food borne illness. Keep outdoor dining safe by following a few easy steps:

- ❑ Bust Bacteria. With many families planning to use their grill at least twice a week this summer, halt harmful bacteria in its tracks. Scrub the grill with hot soapy water before cooking up your outdoor favorites. Store them clean.
- ❑ Soap Up Frequently. Wash hands before, during and after food preparation. Pack moist towelettes or hand sanitizers in your cooker for those moments when soap and water are not readily available.
- ❑ Prep that Party Food. Thaw frozen food in the refrigerator or microwave, not on the countertop or outside at the party. Remember to marinate foods in the refrigerator, and never reuse marinade used on raw meat or poultry unless it's boiled first.
- ❑ Keep Coolers Cool. All foods should be refrigerated promptly below 40°F, so be sure to keep coolers stocked with plenty of ice or ice packs. Freeze bottles of water or juice boxes for a refreshing treat that will also help keep foods packed around them cool.
- ❑ In-between Use. Make it a habit to clean out coolers with soap and water between uses.
- ❑ Different Plates for Grilling. Keep raw meats and ready-to-eat foods separate; ditto for the utensils used to handle each. Pack extra color-coded plates and utensils to help prevent cross-contamination. Use different spoons and forks to taste, stir and serve.
- ❑ Stay in Tune with Temps. Favorite summer foods can be harmful if not fully cooked. Never partially grill meat or half cooked poultry then finish cooking later. Cook thoroughly before packing and then reheat later.
- ❑ Expiration Dates are Important. Pay particular attention to expiration dates on packaging, especially for processed meats like luncheon meat, corned beef, ham and dairy products like milk, cheese and yogurt.

World Diabetes Day 2005

Diabetes and Foot Care

PUT FEET FIRST PREVENT AMPUTATIONS

FOOT FACTS

- Every 30 seconds a leg is lost to diabetes somewhere in the world.
- Up to 70% of all leg amputations happen to people with diabetes.
- In developed countries, up to five per cent of people with diabetes have a foot problem.
- Foot problems are the most common cause of admission to hospital for people with diabetes.
- In developing countries, it is estimated that foot problems may account for as much as 40% of available healthcare resources.
- The direct cost of an amputation associated with the diabetic foot is estimated to be between US$30,000 and US$60,000.
- Most amputations begin with a foot ulcer.
- One in every six people with diabetes will have a foot ulcer during their lifetime. Each year 4 million people worldwide get a foot ulcer.
- In most cases diabetic foot ulcers and amputations can be prevented. It is estimated that up to 85% of amputations could be avoided.
- Significant reductions in amputations can be achieved by well-organised diabetic foot care teams, good diabetes control and well-informed self care.