The Gallop

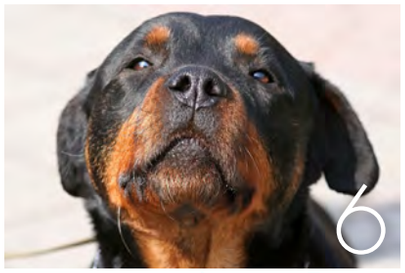
PHC MEDICAL ALUMNI SOCIETY INC. 1982

SEPTEMBER - OCTOBER ISSUE 2010 PHILIPPINE HEART CENTER MEDICAL ALUMNI SOCIETY NEWSLETTER

Abanilla Sworn in as

29th President of the PHC-MAS

WHAT'S INSIDE



The Gallop

Official Newsletter of the Philippine Heart Center Medical Alumni Society, Inc.

VISION

The Philippine Heart Center Medical Alumni Society is the Family of world-class physicians committed towards a common goal of leadership in healthcare provisions and education.

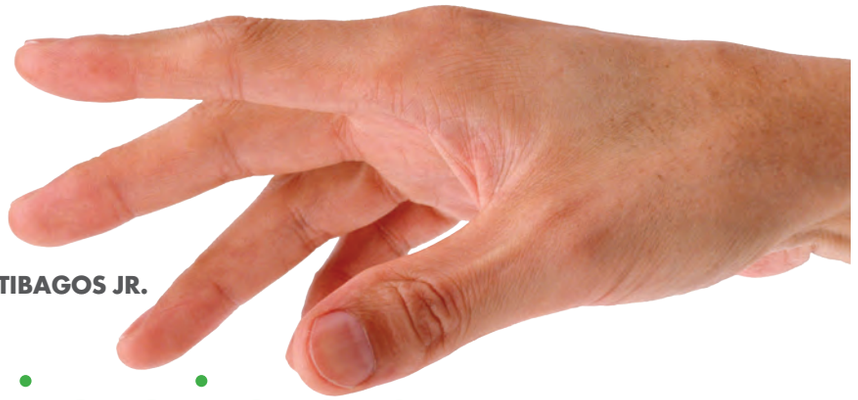
MISSION

To promote the pursuit of professional excellence and awaken a sustained dedication to service to the PHC-MAS, PHC and Country by providing the highest quality of healthcare services to the Filipino people.

For comments, suggestions and contributions, you can reach us at:

PHC-MAS, INC.
2nd floor, Medical Arts Bldg.
Philippine Heart Center
East Avenue, Quezon City
1100 Philippines

Telephone No.: (632) 925 2401
Extensions 3227 & 3228
Telefax No.: (632) 926 8792
Cellphone No.: 0920 9109685
E-mail: phcmas@phc.gov.ph



By Dr. **FLORIDO A. ATIBAGOS JR.**

New Beginnings, New Hope

The word "new" evokes a feeling of excitement, hope and at times apprehension. These are exactly the thoughts that were running in my mind as I witnessed the oath-taking ceremonies of Dr. Joel Abanilla as the 29th President of the PHC-MAS. Serendipitously, he was inducted two days earlier from the inaugural of the 15th President of the Philippines, Benigno Simeon Aquino III.

Two days after Dr. Abanilla's inaugural, the entire nation, together with a crowd mostly clad in yellow, witnessed the historic passing of the torch from outgoing President Gloria Arroyo to the President-elect, Benigno Simeon Aquino III. As I watch history unfold in front of me, the same thoughts that I had two days ago were again running in my mind.

As I have said, the thought of having a new leader can spark a feeling of excitement. Perhaps, any newly elected leader is always welcomed with renewed hope. An air of excitement is always expected after a new leader is installed. Excitement comes from the notion that the new leader might just spring up a surprise. The new leader could start new innovations that could set things in motion towards the achievement of whatever progress they could bring.

Hope in the sense that, this newly elected person could help improve everything we see around us. Hope that could bring changes in our lives. Hope that could bring fulfilment to almost anything possible.

Apprehension in the sense that all of these are gargantuan tasks and that our newly elected leaders could fail and not achieve any of these. Our leaders are just as human as we all are. Just like us they are also filled with human frailties and imperfections. But these are just mere thoughts. In our own little way, we could help banish all of these apprehensions. We can start by not becoming indifferent; we can start by not merely becoming fence-sitters. We have to actively participate. Our voices must be heard. Then and only then and no matter who gets elected will surely succeed if we start by changing our mindsets.

President's Message

By Dr. JOEL M. ABANILLA

The PHC MAS was organized to serve as the vital link between the mother institution-Philippine Heart Center and its graduates. As such, our Society serves as the liaison that constantly remind all PHC graduates the high standard of learning that has been developed and the duty to maintain such standards. Moreover, the Society is also trying to keep the wonderful bonding that has been established since the training days and maintaining that sense of belonging or the spirit of family among PHC graduates.

To translate these lofty goals into reality, the PHC MAS has laid down an array of activities for incoming fiscal year. The Friday Club that will be held every 3rd or 4th Friday of the month will be revived. This will be chaired by Dr. Cecil Bondoc and will provide a good opportunity for the house staff to renew ties and make up for lost time. A theme of interest to the members will be chosen each meeting and a department will be designated as caretaker or host. Birthday celebrants of the month will also be honored with a candle-blowing ceremony. Spontaneous display of talents will definitely be expected.

Revival of our newsletter "The Gallop" has already been decided. It will be a quarterly issue and several columnists have already agreed to make up its editorial staff. It will be designed as an easy-to-read medium featuring our fellow alumni from various corners of the country, newsbits, humor columns, trivia, synopsis of late breaking trials, etc to name a few. Dr. Atibagos accepted to be the editor-in-chief and MSD Phils. agreed to take care of the printing and distribution of the four issues.

Brainstorming for the out-of-town CME activities has been done and it has been decided that we will conduct half-day lecture-workshops on diagnostic cardiopulmonology in three cities namely Iloilo, Cebu and Baguio. This will be in cooperation with our local chapters and the Philippine Academy of Family Physicians.

The lecture-workshop will be followed by a half-day Medical Mission/Outreach activity. Dr. Cuyco will be chairman of the out-of-town CME programme while Dr. Juvenal Quitiquit will chair the Medical Mission/Outreach activity. Therapharma, Natrapharm, and Pfizer Phils. will be tapped as sponsors.

The Annual Convention will be chaired by Dr. Maria Paz Mateo and, as in the previous years, will be held in April 2011. A new twist in the form of an interactive case management format will be adopted. The Interhospital Quiz Contest among our young residents will be retained. If sponsorship will not be a problem, return to Crowne Plaza as venue is being considered.

A Summer Camp in a beautiful resort is being planned for the 2011 summer vacation time. This is intended to be a rare exciting family day where both our very busy alumni members and their children can enjoy each other's company.

The Annual Homecoming which is held during the second day of the PHA Convention will definitely be again something to look forward to. Photo exhibits by each batch, the participation by our local chapters in the talent portion of the program and many other new activities are being planned.

With the increasing number of Heart Center graduates in key cities of the country, creation of new chapters are being encouraged. The cities of Baguio and Davao have been identified to have the number of members needed to form a new chapter.

The other smaller but important projects that have been started in the previous years, such as support for the fellows research competition, renovation of the alumni office, upgrade of office facilities, etc will also be given attention.

The present set of officers and members of the board will have their hands full but nothing can be more rewarding than seeing the participation of our fellow alumni in these various undertakings.

Abanilla Sworn in as 29th President of the PHC-MAS

Barely two days before the historic inaugural of Benigno Simeon Aquino III, the PHC-MAS has sworn in its 29th President. No less than one of the PHC's distinguished alumnus, Dr Joel Abanilla, took his oath of office before the presence of former PHC-MAS presidents such as Drs. Tes Abola and Noe Babilonia as the inducting officer at the Figaro coffee shop at the Philippine Heart Center. Also inducted were, Dr. Corazon Estevanez as the Vice President, Dr. Teresa Menor as the Secretary, Dr. Ma. Paz Mateo as the Treasurer, Dr. Myla Gloria Supe as the Auditor. Drs. Florido Atibagos, Ma. Lourdes Badion, Cecile Bondoc, Ronald Cuyco , Jose Melanio Grayda, Elenor Gagalang, Emmanuel Jarcia , Ronaldo Manuel, Juvenal Quitiquit and Juan Reganion took their oath of office as the new PHC-MAS Board of Directors .

Barely warming their feet, the newly inducted officers and board of directors held the first board meeting with the newly installed president at the helm. A major part of the agenda was to revitalize, reformat and to increase the number of its activities particularly those of giving assistance to the less fortunate as well as the needs of some of its members. Dr Abanilla's guiding principle in all of these could be summed up with his thoughts of "keeping the alumni spirit on fire". Perhaps it is his way of reaching out to those who are in need as well as to reconnect with some "inactive" PHC-MAS alumni.

The first few weeks of his administration saw a more energized Friday Club. The Friday club was reformatted from the usual concept of merrymaking and eating. The new Friday Club introduced a lecture on a particular topic that is of common interest to some of its alumni, of course with the exception of medicine. Also included in the reformatted Friday Club was the celebration in honor of the PHC alumni celebrating their birthdays in that particular month.

Aside from these, Dr Abanilla was likewise holding regular meetings with our industry partners. This was done to get the assurance of their continued support in all of the activities and programs of the PHC-MAS such as the medical missions, assistance to alumni members, PHC-MAS Christmas Party and the much anticipated Annual Homecoming and Symposium held every month of April. This activity is widely participated in by those from the regional chapters as well as those from the nearby hospitals in Metro Manila. With Dr Abanilla at the helm, we could hope for a much revitalized PHC-MAS.

PHC MEDICAL ALUMNI SOCIETY INC. 1982

Max

By Dr. INA BUNYI

We called him Max, short for a famous coffee brand, Maxwell, because Dan and I loved coffee, and Max was as black as freshly-made brew.

We called him Max, short for a famous coffee brand, Maxwell, because Dan and I loved coffee, and Max was as black as freshly-made brew. He was a Rottweiller, just a month old when we got him from a friend. As he grew older and bigger, it was evident that although people feared him, he truly was just a 'puppy at heart' that got a little older every year. He could be tough and ferocious when he wanted to, his booming bark scaring the wits out of the garbage collector when he escaped one time, and causing the bill collector to miss a step or two when given a Max surprise attack. With us however, a long "Maaaxiii" call would send him scurrying to our feet, hurriedly sitting, lying down and rolling over so he could get a pat and a tummy rub. It wasn't hard to give.

It was Holy Week and no business establishments were open, when we noticed Max looking kind of sick, I was hoping that he would shake it off like any other illness he got. It was the morning after Easter when I noticed his heavy and fast breathing that was usually a sign of acid building up from a generalized infection. He tried to get up when I patted and called him and when he finally did, it turned out that he used up his last ounce of energy. I tried to give a little bit of first aid, a little oral hydration and some medication, but it was too late. He succumbed too fast. I watched him helplessly as he took his last breath. We eventually had to wrap him up, and as we did, I couldn't help but cry over poor Max. I grieved at how he suffered, and I cried over my neglect, but my cries were too late. I should have done what I could have while he was still alive. I had lost my chance.

"How many are the lost that I have lifted?
How many are the chained I've helped to free?
I wonder have I done my best for Jesus,
When he has done so much for me."

It was then at that moment the thought came: How many of my loved ones, my family and friends, have I known to be aching and needing comfort and care? How many of them are in need of God's Word, yet I haven't shared it with them enough and as often as I could? The Lord spoke to my heart– if I could cry like that over my poor dog, how about my loved ones - my family and friends that I care so much more about and love so deeply? Man is plagued by a spiritual illness to which I have found a cure, a cure that has brought me joy untold, but have I done my best to impart it? Have I really tried? How long do I wait before I tell them? I pray I won't wait until it's too late.•

Acts 4:29 "And now, Lord … grant unto thy servant, that with all boldness (I) may speak thy word."

Philippians 1:20 "According to my earnest expectation and my hope, that in nothing I shall be ashamed, but that with all boldness, as always, so now also Christ shall be magnified in my body, whether it be by life, or by death."

Merchants in Medicine

By Dr. LEAHDETTE PADUA

Majority of us physicians believes that our profession is, first and foremost, a vocation. Secondly, it is a source of livelihood. To most, it is the sole source of income. However, there are a few who may have some business acumen and try their luck in different business ventures.

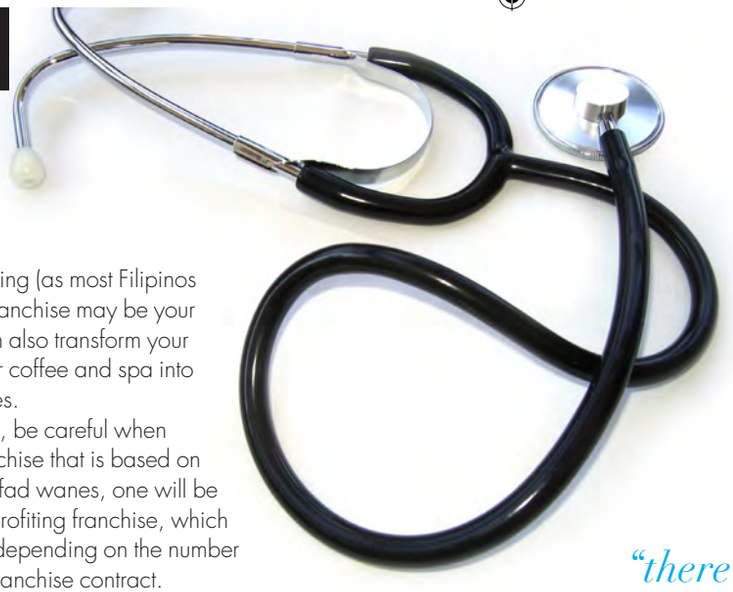
Entrepreneurship in medicine comes in various forms. Some doctors provide capital or put up stocks in some business establishment. These are the investors. Others will just provide their expertise and act as consultants. On the other hand, there are a number of medical professionals who are really hands-on in their businesses. These are the merchants in medicine.

The selection of the type of business ventures these 'merchants in medicine' go into depends on several factors. The budget is one of the most important things to consider. Setting up a business requires capital and it can range from a five-digit to nine-digit figure. Some require bank loans to finance their business enterprise. Besides the budget, the interest of the doctor-businessman comes into play. Some turn their hobbies, such as farming, into a secondary source of income. These provide an outlet for relaxation as well as earnings. Some consider health-related trades, like setting up diagnostic centers and pharmacies. Some will consider the trend of the times. Currently, there is a trend for franchising, particularly in the food arena.

Here are some examples of the business ventures that one may consider going into (if one had the spare time, energy and resources).

1. **Franchising.** Wikipedia defines this as "the practice of using another firm's successful model." In this business model, one relies on the success of a trademark to further one's economic growth. With a lot of different franchise opportunities to select from, either locally or globally (from the food business to service-oriented ones), the doctor-businessman can choose one that is within his liking.

There are several things to consider before committing to this type of business. First is the budget: kiosks and water refilling stations cost a minimum investment of several thousands of pesos; while service type and education and training franchises need at least a million bucks to set up. Likewise, the doctor-merchant should take into account his interest. If you're



interested in eating (as most Filipinos are), the food franchise may be your calling. You can also transform your appreciation for coffee and spa into business ventures.

One more thing, be careful when selecting a franchise that is based on fads. Once the fad wanes, one will be left with a non-profiting franchise, which you are tied to depending on the number of years in the franchise contract.

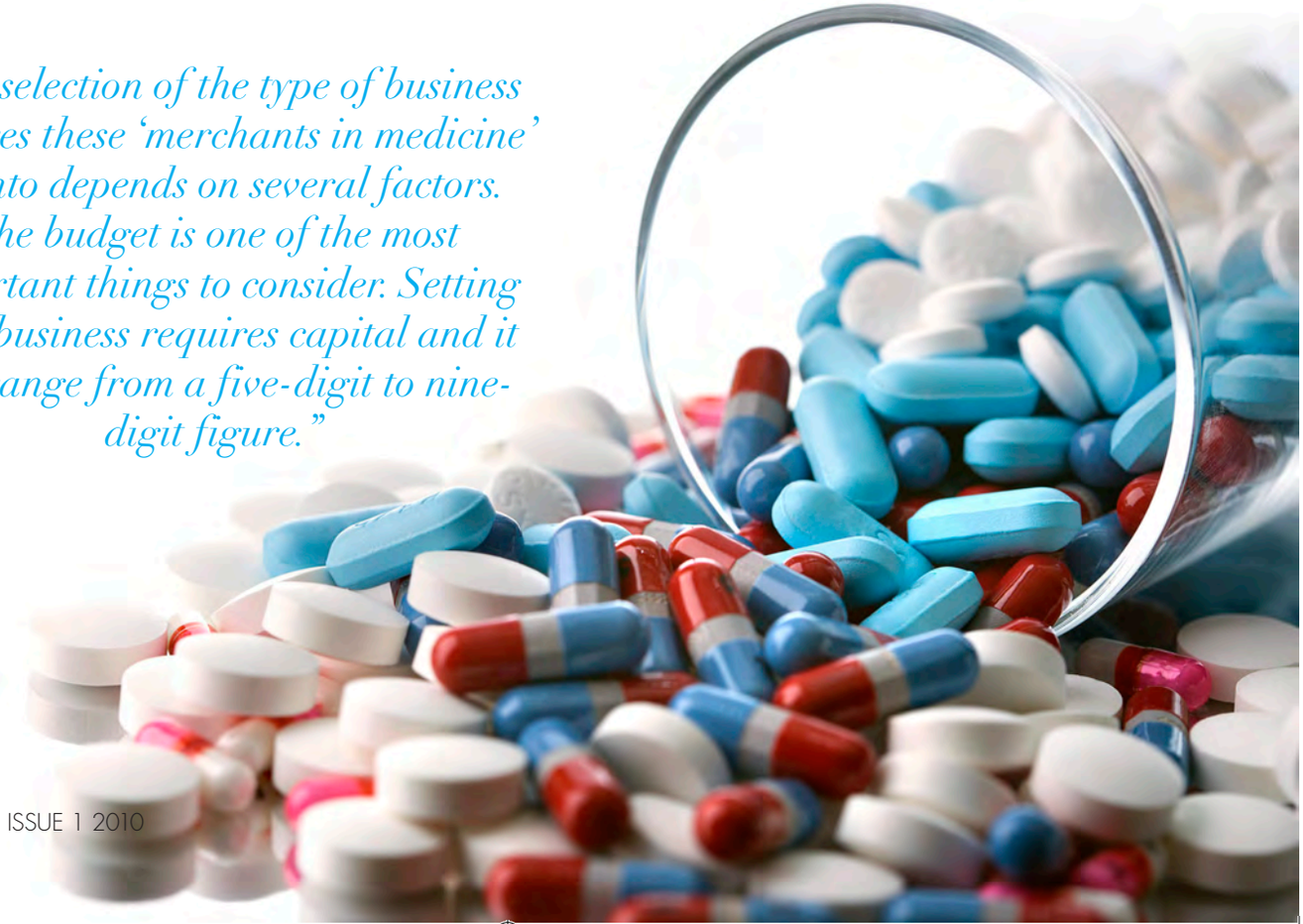
2. **Family Business.** If one is fortunate enough to belong to an enterprising family, he can participate in the family business actively as a manager or a senior officer or passively, as a silent investor. In some families, the doctor-merchant is trained at a young age in the family business, but is given the opportunity of pursuing his medical interest on the side. The advantage of being in the family business is that it strengthens the familial bond of loyalty, dedication and service. Also, the family's coffers are protected. On the other hand, familial disputes may arise, especially if there are conflicting interests among the involved parties.
3. **Sole Trader.** This is for the 'risk takers' who want to be original. They are the ones who want to set-up their own brands. They are the ones who do not want to be limited by the restrictions set by the franchisors or by their own families. The advantage of this type of business is that you set up your own definitions, goals and limitations. In other words, you are your own boss. However, there are disadvantages for this type of venture. First, your products or services may not 'click' since the public may be afraid to try on a new label or brand. But remember, some franchises start with an original label, which with a good product plus good advertising and marketing, many consumers started to select and became a household name. Secondly, you are on your own. You do not have the training, which most franchisors give, or the experience and expertise the family can offer. For every mistake you commit, which may either be trivial or major, you do not have a back-up.

"there are a number of medical professionals who are really hands-on in their businesses. These are the merchants in medicine."

There are a lot of business opportunities for the enterprising doctor besides the ones listed above. If you have the extra time and resources, you may try to 'sail' in the entrepreneurship, but remember the tips to keep you afloat. Happy cruising!

Resources: *Wikipedia, http://franchisephilippines.org*

"The selection of the type of business ventures these 'merchants in medicine' go into depends on several factors. The budget is one of the most important things to consider. Setting up a business requires capital and it can range from a five-digit to nine-digit figure."



LANDMARK CLINICAL TRIALS

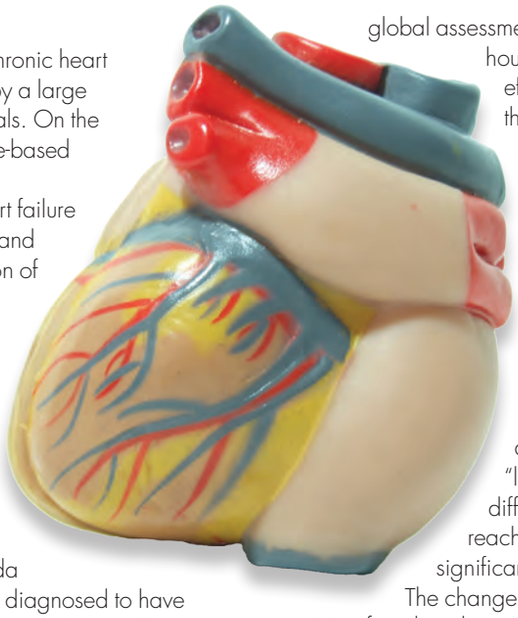
(SEPTEMBER 2010 ISSUE)

By Dr. ERDIE C. FADREGUILAN

In the era of evidenced-based practice, it is critical that clinicians are abreast with the latest clinical trials concerning patient care. In this article, an overview of three recent clinical trials in the field of cardiovascular medicine is presented.

DOSE

The treatment of chronic heart failure is supported by a large number of clinical trials. On the other hand, evidence-based therapy for acutely decompensated heart failure is lacking. The dose and route of administration of loop diuretics, for instance, remain to be empiric. The DOSE trial (Diuretic Optimization Strategies Evaluation) enrolled 308 acute heart failure patients in the US and Canada who were previously diagnosed to have chronic congestive heart failure and being maintained on oral loop diuretic specifically furosemide at 80-240 mg/day for at least 1 month. They were randomized to receive intravenous furosemide at "low" versus "high" doses and in continuous infusion versus a bolus every 12 hours in a double-blind, double-dummy design. "Low" dose corresponded to the patients' usual oral dose while "high" dose is 2.5 times the usual patients' dose. Patients with systolic blood pressure below 90 mm Hg and anticipation for coronary angiogram were excluded.



Patients were reassessed at 48 hours and either switched to oral diuretic, maintained on the assigned regimen or had their doses increased. Symptoms as gauged by patient global assessment score at 72 hours, the primary efficacy endpoint of the trial, were not statistically different from the continuous versus the bolus strategy. Though there was note of a trend towards greater and more rapid symptomatic relief with the "high" dose than the "low" dose, the difference did not reach statistical significance (p = 0.06).

The change in serum creatinine from baseline to 72 hours, the primary safety end point, was +0.05 mg/dL for intermittent dosing and +0-07 mg/dL for continuous infusion (p = 0.45). It was +0.04 mg in the low-dose group and +0.08 mg/dL in the high-dose group (p = 0.21).

Though the trial was not powered adequately to measure clinical outcomes of death and re-hospitalization or emergency room visits, there were no statistically significant differences in the rates favoring any group. Despite the absence of statistical difference in the study endpoints, the authors concluded that bolus administration in higher doses may be convenient, safe as well as efficient in patients with acutely decompensated heart failure.

Reviewer's comment:

Bolus at lower doses was shown to be as effective in the study and may be preferred in patients deemed to be at greater risk of complications from diuretic use like patients with relatively low systolic blood pressure and in centers where monitoring may be limited.

RACE II

Rate control has been shown to be non-inferior to rhythm control (conversion to sinus rhythm) in previous trials in the treatment of patients with permanent atrial fibrillation of less than 12 months duration (AFFIRM, RACE, HOT-CAFE). Furthermore, rhythm control was associated with a greater number of hospitalizations mostly from need of electrical cardioversion and adverse drug events in the AFFIRM Trial, thus rate control is often the therapy of choice in patients with permanent atrial fibrillation. Present guidelines recommend strict rate control in the belief that this strategy is associated with less symptoms and complications like development of heart failure despite absence of solid evidence to support such.

RACE II (Rate Control Efficacy in Permanent Atrial Fibrillation: A Comparison Between Lenient Versus Strict Rate Control II), published in the April 2010 issue of The New England Journal of Medicine, was a prospective, multicenter, randomized, open-label, non-inferiority trial designed to compare two rate-control strategies. Six hundred fourteen patients in The Netherlands with permanent atrial fibrillation up to 12 months and age

less than or equal to 80 years were randomly assigned to "lenient" heart rate control defined as resting heart rate less than 110 beats per minute or "strict" rate control strategy defined as target heart rate of less than 80 beats per minute at rest and less than 110 beats per minute during moderate exercise.

Patients were given beta-blockers, non-dihydropyridine calcium channel blockers and/or digoxin to achieve desired cardiac rates and followed up for a maximum of three years. The cumulative incidence of the primary composite outcome of death from cardiovascular causes, hospitalization for heart failure, and stroke, embolism, life-threatening arrhythmia events was 12.9% in the lenient rate control group and 14.9% in the strict rate control group (p value <0.001 for the pre specified non-inferiority margin). Likewise, the secondary endpoints of symptoms referable to atrial fibrillation (dyspnea, fatigue and palpitations) were similar in both groups (p = 0.92).

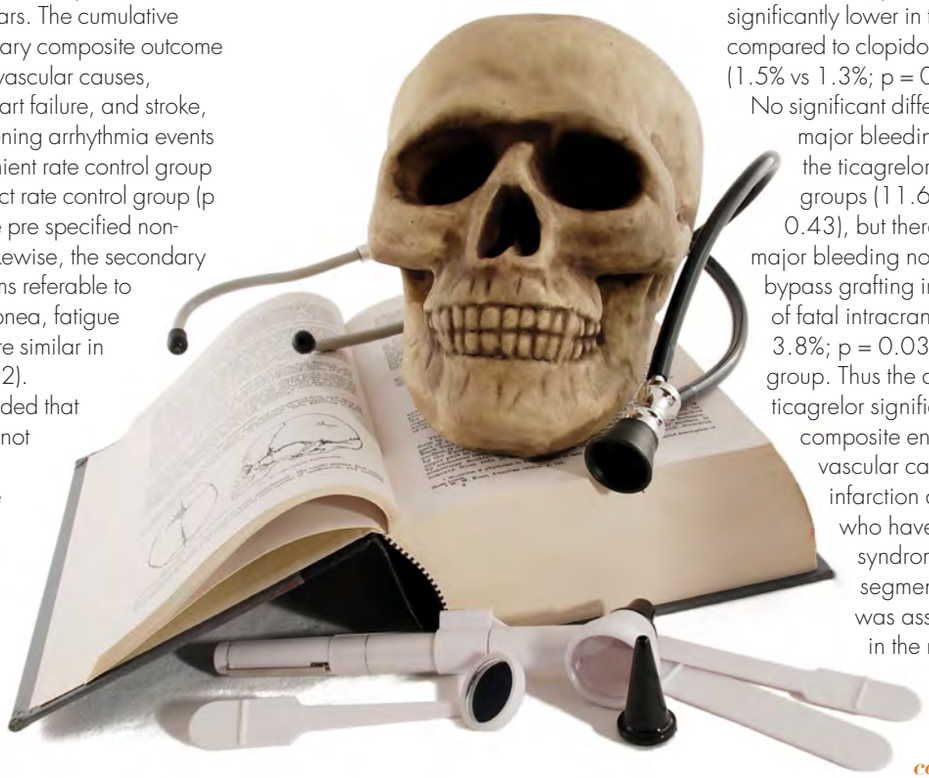
The authors concluded that lenient rate control is not inferior to strict rate control strategy in the treatment of patients with permanent atrial fibrillation and may prove to be more convenient since fewer clinic visits are required with potential benefit of lower adverse events resulting from less medication use as opposed to that needed for strict rate control.

Reviewer's comment:

Of interest is the finding that more patients in the lenient rate control group met the cardiac rate criteria compared to the patients assigned to the strict rate control group (97.7% and 67.0%, respectively; p< 0.001) which may explain the lack of difference in the outcomes between the two rate control strategies. A trial with more stringent and effective rate control regimens would ideally ensure that the relevant target rates are achieved in all patients and thus would be more conclusive.

PLATO

The efficacy of clopidogrel is hampered by the slow and variable metabolism of the pro-drug to the active metabolite and an increased risk of stent thrombosis and myocardial infarction in patients with poor response. Ticagrelor, a reversible and direct-acting inhibitor of the adenosine diphosphate receptor P2Y12, provides greater and more consistent inhibition than clopidogrel. The Study of Platelet Inhibition and Patient Outcomes (PLATO) – a multicenter, randomized, double-blind trial - was conducted to determine whether ticagrelor is superior to clopidogrel for the prevention of composite endpoints of cardiovascular death, myocardial infarction and stroke. Included in the trial were 18,624 patients hospitalized for acute coronary syndrome, with or without ST segment elevation, with an onset of symptoms within 24 hours.



Patients were either randomized to ticagrelor (180-mg loading dose, 90 mg twice daily thereafter) or clopidogrel (300 to 600-mg loading dose, 75 mg once daily thereafter). At 12 months, the primary efficacy endpoint had occurred in 9.8% of patients receiving ticagrelor as compared with 11.7% of those patients receiving clopidogrel (HR 0.84; 95% CI 0.77 to 0.92; p < 0.001). The benefit was already apparent within 30 days of therapy. Individually, cardiovascular death (4.0% vs 5.1%; p = 0.001) and myocardial infarction (5.8% vs 6.9%; p = 0.005) were significantly lower in the ticagrelor group compared to clopidogrel group but not stroke (1.5% vs 1.3%; p = 0.22).

No significant difference in the rate of major bleeding was found between the ticagrelor and clopidogrel groups (11.6% vs 11.2%; p = 0.43), but there was an excess in major bleeding not related to coronary bypass grafting including more instances of fatal intracranial bleeding (4.5% vs 3.8%; p = 0.03) in the ticagrelor group. Thus the authors concluded that ticagrelor significantly reduced the composite endpoints of death from vascular causes, myocardial infarction and stroke in patients who have acute coronary syndrome with or without ST segment elevation. This benefit was associated with increase in the rate of non-procedure-related bleeding.

Reviewer's comment:

The additional benefit in the primary efficacy endpoint with ticagrelor was associated with some safety concerns. In the ticagrelor group, dyspnea was more commonly observed (13.8% vs 7.8%) although most episodes resolved within one week of treatment. Ventricular pauses exceeding three seconds were also more common with ticagrelor than clopidogrel. However symptomatic bradycardia was not different between the groups. Serum uric acid and creatinine also increased more in the ticagrelor group which spontaneously resolved within the first 30 days of treatment.

TRIBYA ATBP...

By Dr. Ramon O. Ribu

1. **St. Patrick, the patron saint of Ireland is**
   a. Roman
   b. an Irish
   c. Spaniard
   d. French

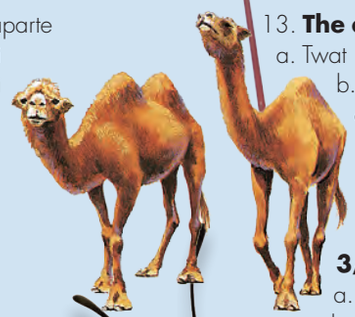
2. **All the Apostles of Jesus were martyred except one who died of natural causes**
   a. Matthew
   b. John
   c. Peter
   d. Mark

3. **Coffee is the second largest traded item in international commerce. The first is**
   a. Tea
   b. Petrol
   c. Chocolate
   d. Perfume

4. **Eau de Cologne was originally marketed as a way of protecting oneself from**
   a. Bubonic plague
   b. Cholera
   c. Flu pandemic
   d. Body odor

5. **The national flag of Italy was designed by**
   a. Napoleon Bonaparte
   b. Benito Mussolini
   c. Roberto Rosellini
   d. Galileo

6. **The Camel has ___ eyelids**
   a. 2
   b. 3
   c. 4
   d. 5



7. **A bee has ___ eyes**
   a. 5
   b. 3
   c. 4
   d. 6

8. **Mosquitoes are attracted to people who just ate this fruit**
   a. Mango
   b. Apple
   c. Banana
   d. Melon

9. **This animal cannot walk backwards**
   a. Kangaroo
   b. Horse
   c. Elephant
   d. Giraffe

10. **Before mercury, this was used to fill thermometers**
    a. Brandy
    b. Saline solution
    c. Honey
    d. Milk

11. **The first man-made object to break the sound barrier was a**
    a. Car
    b. Whip
    c. Airplane
    d. Arrow

12. **The plastic things at the end of shoelaces are called**
    a. Aglets
    b. Endings
    c. Twinning
    d. Twits

13. **The dot over letter 'i' is called**
    a. Twat
    b. Tittle
    c. Doodle
    d. Google

14. **The slanted line that divides fractions e.g. ½, 3/6 is called**
    a. Virgule
    b. Sylant
    c. Ampersand
    d. Twaddle

15. **The driest desert on earth is**
    a. Death Valley - North America
    b. Atacama Desert - South America
    c. Gobi Desert - Asia
    d. Sahara - Africa

16. **The nursery rhyme "ring-a-ring-o-roses" actually refers to**
    a. Bubonic Plague
    b. War of the Roses
    c. World War 1
    d. French Revolution

CLUE TO ANSWERS:

- Most successful Swedish singing group

  __ __ __ __
  1 2 3 4

- Strong rope

  __ __ __ __ __
  5 6 7 8 9

- "Humble" in Tagalog

  __ __ __
  10 11 12

- "Go down" in Tagalog

  __ __ __ __
  13 14 15 16

Based on the presentation of
Dr. Karam Kostner at the
Philippine Heart Association
Lunch Symposium

Niacin and Laropiprant:
A novel combination to fight cholesterol

Cholesterol and atherogenicity

Cardiovascular diseases, which manifest as heart attacks or strokes are major killers worldwide. Vascular diseases are characterized by altered endothelial integrity, combined with inflammation and buildup of lipids, cholesterol, calcium, and other cellular debris. According to Dr. Karam Kostner, consultant cardiologist with Mater Hospital and the University of Queensland in Australia, the increased levels of low-density lipoprotein cholesterol (LDL-C), triglycerides (TG), lipoprotein(a) (Lp(a)) accelerate atherosclerosis and increase the risk of cardiovascular disease. Aside from these known factors, Dr. Kostner added decreased levels of high-density lipoprotein cholesterol (HDL-C), citing that with increased cases of atherosclerosis is an increasing frequency of low HDL-C worldwide, including the Philippines.

Residual risk despite statin use

Statins, which are cholesterol lowering drugs, have been the gold standard in the treatment of atherosclerosis and lipid disorders. However, in this lecture last May 27 during the Philippine Heart Association Symposium, held at the Shangri-La Plaza in Mandaluyong City, Dr. Kostner cited a collection of clinical trials, such as the Scandinavian Simvastatin Survival Study and West of Scotland Coronary Prevention Study, which prove that despite the benefits of statins as cholesterol-lowering drugs, 60 to 70 percent of residual risk remains.

The return of nicotinic acid (niacin) as a lipid lowering agent

Extended-release niacin (N-ER) is considered the most effective agent for increasing HDL-C, which is appropriate for comprehensive management of lipids, says Dr. Kostner. HDL has antioxidant, anti-inflammatory, antithrombotic, and profibrinolytic properties that along with its role in reverse cholesterol transport appear to lead to an overall antiatherothrombotic effect. A study by Goldberg[1] showed that N-ER decreases LDL by 21 percent, Lp(a) by 26 percent, and TG by 44 percent, while increasing HDL by 29.5 percent.

The HDL-Atherosclerosis Treatment Study, a small study of 160 patient with coronary disease and low HDL-C, showed that when niacin was combined with simvastatin, it was able to significantly reduce the risk of coronary death, myocardial infarction, stroke or revascularization for worsening ischemia by about 60% compared to placebo. Large trials assessing the incremental effect of niacin beyond statin monotherapy are ongoing.

Niacin induced flushing

Niacin, in lipid-modifying doses (1000-2000mg), frequently causes cutaneous flushing by stimulating the DP1 receptor of prostaglandin D_2 (PGD_2). Acetyl salicylic acid, or aspirin, is an established inhibitor of prostaglandin synthesis and has been recommended to control this side effect of niacin therapy. But since aspirin is a nonselective inhibitor, one study showed that low doses fail to control flushing[3], and side effects such as bleeding may still occur.

Laropiprant and niacin

Laropiprant (LRPT) is an effective therapy to reduce flushing in patients receiving niacin. Since it's a selective inhibitor that acts as a DP1 antagonist, LRPT reduces vasodilation without the use of aspirin. TREDAPTIVE by MSD combines nicotinic acid and laropiprant. It is now approved for treatment of dyslipidemia, in patients with combined mixed dyslipidemia and patients with primary hypercholesterolemia.

Studies[4-6] have shown that the ERN/LRPT combination significantly decreased moderate to severe flushing compared to N-ER alone. The Asia Flushing Study[6] ERN/LRPT III trial had the same conclusion: ERN/LRPT can effectively reduce LDL-C, increase HDL-C while controlling facial flushing , making it less frequent and less severe. This makes it possible for physicians to achieve the higher doses of niacin that may achieve comprehensive lipid control. Debra Kush and coauthors conclude: "ERN/LRPT, used as monotherapy or added to ongoing statin therapy, resulted in significant improvements in multiple lipid/lipoprotient parameters and was generally well tolerated."

Specific Indications

TREDAPTIVE is indicated to be used alone or in combination with HMG-CoA reductase inhibitors (statins) as an adjunct to diet to reduce LDL-C, triglycerides, LDLC: HDL-C ratio, non-HDL-C, apo B, and increase HDL-C and apo A-I in patients with primary hypercholesterolemia (heterozygous familial and non familial) or mixed dyslipidemia.

In patients with a history of MI or coronary heart disease, niacin is indicated to reduce the risk of a recurrent nonfatal MI.

In patients with dyslipidemia, niacin with statin or bile acid sequestrant is indicated to slow progression or promote regression of atherosclerosis.

Niacin, alone or in combination with a bile acid sequestrant, is indicated as an adjunct to diet for the reduction of elevated total and LDL cholesterol levels in patients with hypercholesterolemia when the response to a diet restricted in saturated fat and cholesterol and other non-pharmacologic measures alone has been inadequate.

Niacin is also indicated as adjunctive therapy for the treatment of adult patients with very high serum triglyceride levels who present a risk of pancreatitis and who do not respond adequately to a determined dietary effort to control them.

Selected Safety Information

TREDAPTIVE is a contraindicated in patients with hypersensitivity to the active substances or to any of the excipients, significant or unexplained hepatic dysfunction, active peptic ulcer disease or arterial bleeding.

The most common side effect of TREDAPTIVE is flushing (skin redness , warmth, and itching). Other side effects seen in controlled clinical trials in>1 percent of patients included dizziness, headache, paresthesia, diarrhea , dyspepsia, nausea, vomiting, erythema, pruritus, rash, urticaria, and feeling hot. Elevations in ALT or AST (consecutive, ≥ 3x ULN) fasting glucose, and uric acid were also reported.

Liver function tests are recommended before initiation, every 6 to 12 weeks for the first year, and periodically (eg, semi-annually) thereafter. Periodic serum creatine kinase (CK) should be considered with any signs and symptoms of muscle pain, tenderness, or weakness during the initial months of therapy with TREDAPTIVE and a statin and when dosage of either drug is increased.

Caution should be used when treating Chinese patients with TREDAPTIVE coadministered with simvastatin or ezetimibe/simvastatin (particularly simvastatin doses of 40 mg or higher) because of a higher than expected incidence of myopathy in those patients. Because the risk of myopathy with statins is dose-related, the use of TREDAPTIVE with simvastatin 80 mg or ezetimibe/simvastatin 10/80 mg is not recommended in chinese patients. It is unknown whether there is an increased risk of myopathy in other Asian patients treated with TREDAPTIVE coadministered with simvastatin or ezetimibe/simvastatin.

Diabetic or potentially diabetic patients should be observed closely. Adjustment of diet and/or hypoglycemic therapy may be necessary.

References from Dr. Kostner's presentation:
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Merck Sharp and Dohme (I.A.) Corporation
a Philippine subsidiary of Merck & Co., Inc., Whitehouse Station, N.J., U.S.A.
26/F Philamlife Tower, 8767 Paseo de Roxas, Makati City 1226
Tel.: (632) 7849500 • Fax.: (632) 8850773 to 75 • www.msd.com.ph

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