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ECTOPIC MURMURS

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Opinions and articles published herein are those of the authors and do not necessarily reflect that of the FEUDNSM Alumni Foundation

Chicago Hall of Fame Inducts Alumni

CESAR V REYES MD[68]

Honorio T Benzon MD[71], professor of anesthesiology at Northwestern University Feinberg School of Medicine, and Nunilo G Rubio MD[67],

HONORIO BENZON MD

clinical associate professor of medicine at Loyola University of Chicago Stricth School of Medicine, are inducted into the

continue to page 15

Message from the PRESIDENT

Our 32nd annual reunion in Las Vegas NV slated for June

OSCAR C TUAZON MD

15-18, 2011, is getting closer. I encourage our alumni to look on their busy schedule and make time to attend this once-a-year event.

continue to page 15

Message from the BOARD CHAIRMAN

School day memories are our shining moment dedicated to the graduating Class.

PEPITO C RIVERA MD

My first year in medical school was very exciting. In the mornings, I would dress in my crisp, white uniform, check myself in the mirror, adjust my hair, and declare myself attractive and

continue to page 14

CHICAGO 2011 Model Family *of , from left, Dr Noel Rubio, Dr Elenita Rubio, Mrs and Mr Nate Rubio, Dr Nunilo Rubio[67], and Mrs and Dr Nunilo Rubio Jr.*

FAITH CORNER

REV MELVIN ANTONIO MD[65]

Forty years ago, on July 20, 1969, two men made history by walking on the surface of the moon. That feat was amazing, in and of itself. But what happened before Buzz Aldrin and Neil Armstrong exited the lunar module is perhaps even more amazing, if only because very few people know about it and those who knew have long forgotten.

REV MELVIN ANTONIO MD

The fact is, Aldrin took communion on the surface of the moon on that memorable day.

Eric Metaxas, author of the book, ***Everything You Always Wanted to Know About God (But Were Afraid To Ask)*** talks about meeting Aldrin a few years ago and got confirmation of the story from the astronaut himself.

The author gives this account of the meeting: As a bit of background, it so happened that Aldrin was an elder at the Presbyterian Church that he attended in Texas, and knowing that he would soon be doing something that is unprecedented in human history, he felt that he should mark the occasion in a very special way.

Aldrin asked his minister to consecrate communion elements that he would take with him to the moon. Aldrin and Armstrong had only been

continue to page 13

WHEN YOU DREAM IT, DO IT.
OUR CHILDREN MUST KNOW HOW WE CAME TO AMERICA

CESAR D CANDARI MD[61]

FCAP Emeritus

How I came to America from Antique is a story similar to the other 22,000 Filipino American doctors practicing in this country. By the same token, Filipino professionals - lawyers, engineers, nurses, dentists and others - came the same way. I believe it is important to inform the younger generations of Filipino descent about their history.

CESAR CANDARI MD

In the 1970s and 1980s, Filipinos were invisible to mainstream society. How often in those days did you find Filipinos in books, magazines, television, or radio? Now we see changes. Yes, indeed, there are changes.

As Filipino Americans, we need to tell our story and when it all began.

In reviewing this particular subject, I believe it will be of significant interest to relate this history to everyone, in particular to our American-born children.

Since the early 1900's successive waves of Filipinos have migrated to other countries in search of employment. Mass migration, however, began in

continue to page 12

TENDERLY YOURS

NOLI C GUINIGUNDO MD[62]

1. Most of us who attended the last Winter meeting in Long Beach, California, took Southwest Airlines. It was the cheapest available plane fare as compared to other airlines.

NOLI C GUINIGUNDO MD

The first 3 luggage are free; and it was mentioned that there is no cancellation fee. Then recently, it was reported that its 737 fleet had a hole overhead near the wings. It is still under investigation, but we are glad we are all safe and sound after our flight to and from Los Angeles International Airport.

2. Solicitation for advertising for our 32nd annual alumni reunion is on the way. We strongly suggest that Silver and Golden Jubilarians advertise in the souvenir program. This is one in a lifetime opportunity to have your name, practice, family pictures printed in the program as well as your fellow classmates.

3. Class[62] is observing our 50th jubilee in 2012. We have been busy trying to organize our own souvenir program and to what extent we will perform during the Saturday night grand ball. We were hoping to show our faces after 50 years post medical school. During the *Balik*-FEU which Ding and I missed on account of the cancellation of flights due to the weather, I have to touch bases with Dr Linda Tamesis if the celebrants will still perform

continue to page 12

BACKYARD BIRDS

ROLANDO
SOLIS MD

ROLANDO M SOLIS MD[63]

Red-bellied woodpecker

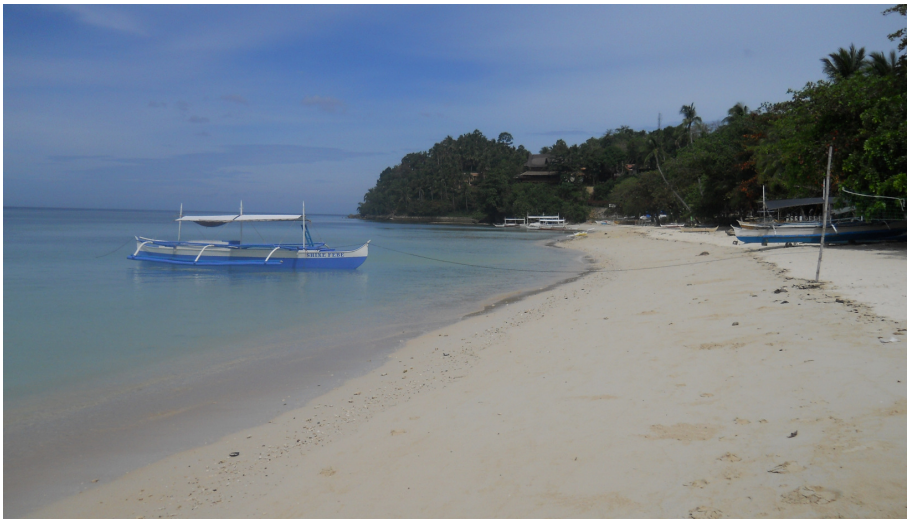
Female Cardinal

Male Cardinal

MAY IMAGES

PIO SIAN MD[65]

PIO SIAN MD



Sipalay Beach, Negros Occidental, *where there is a resort built by the Swiss and Austrians with all the old world conveniences on a tropical paradise, without the crowds and noise of a highly commercialized vacation destination. They have a dive school and weekly trips to Palawan. They speak the Austrian language which sounds like autocratic German. The place is a little pricey but it is well worth it. English is widely spoken too. They cater to Europeans mostly. There are other places to see but when operated by Pinoys they are usually* **tinipid**, **kinapos**, *and therefore substandard.*

Bacolod Home for Abused Girls *visited by Drs Hirfa and Pio Sian (at the back row). There is a church that supports the Home which normally gets funding from Spain. The last two years, however, the funding had been almost zero as the Spanish representative taking care of the finances allegedly embezzled the money. Spanish Justice is swift as the embezzler is now in jail. The Home is like a regular orphanage. Girls as young as four are taken in. Room and board are provided for. They are treated well. A visiting psychologist checks on their progress. The girls can leave anytime if the family can provide the same care. They are sent to school up to college. But scholarship is very hard to get as these girls are not gifted, plus the trauma of their history. They have to get an education until their release at age 18. The Sisters in charge are worried if they do not get job outside before release, they might end up in the streets selling themselves. We got to know the Sisters about 5 years ago and started to help. First, Hirfa would collect used children's clothing and send them thru* **Balik-Bayan** *boxes. Later we would get those items at thrift shops. A few bags of M&M chocolates and some candy bars would light-up their languid faces. A couple of dozen eggs and some flowers from our vacation home every Friday are appreciated more than their worth. Later we help the Sisters financially and sometimes take care of the girls. We are also able to ask friends for help and most give selflessly. At present there are 37 girls of different ages and backgrounds. Some are from well to do but most are below the poverty line. The youngest is 4 years old, some are already past 18 but prefer to stay even as* **alilang kanin**. *Most girls have families but all feel safer at the House. On holidays some families pick them up. In Christmas 2009, two girls were left, nobody picked them up. They cried and cried hard. Charlotte, 6, and Angelica, 8, were picked up by Hirfa. We took them to Jollibee for a hamburger then to SM to get some footwear. I have misplaced the Smart card chip pictures but still remember the expressions in their faces. To help/ donate to the Home, please contact Sister Alma R Alovera (middle, back row) at* holyfamilyhome@yahoo.com

ON PROSTATE CANCER, SCREENING, AND OTHER TOPICS

Here is an interesting article: PROSTATE CANCER SCREENING FAILS TO REDUCE RISK.


ANTONIO ONG MD

The longest study yet on prostate cancer testing provides more evidence that getting screening does not cut the chances of dying from the disease. In a 20-year study of more than 9000 Swedish men, researchers found no difference in the rate of prostate cancers deaths between the men who were periodically screened and those who were not.

Routine screening for prostate cancer is controversial, and the new results are unlikely to end the debate about the value of testing. Critics say screening leads to unnecessary biopsies and treatment, with little proof that it saves lives. Testing is done with a physical exam (DRE---Digital Rectal Examination) and a PSA blood test.

There is no escaping the fact that we need a better tool...to help detect prostate cancers that actually need treating, as opposed to innocent ones that do not, Macolm Matson, a prostate cancer expert at Cancer Research UK said in a statement. *In the meantime, men should be fully informed about the pros and cons of having their PSA measured.*

The standard PSA blood test is so named because it looks for high levels of prostate-specific antigen. The test is controversial because the PSA level can be high for many reasons. A positive result must be confirmed by a biopsy.

If prostate cancer is found, there is no agreement on the best way to treat it: *watchful waiting*, surgery, hormone therapy, radiation, or some combination of those. Most tumors grow so slowly they are never life threatening, and the treatments can have serious side effects.

The Swedish study was done in the eastern Sweden city of Norrkoping. From 9,026 men, about 1,500 were randomly selected to be screened every three years from 1987 to 1996. They received digital exams only on the first two visits, the PSA test was added for the next two. For the fourth and final screening, only age 69 or under were included. The remaining 7532 men were not screened.

During the 20 years of follow-up, 85 men (about 6 %) in the screened group and 292 men (about 4%) in the no-screening group were diagnosed with prostate cancer. The death rate from prostate cancer was similar in both groups, the researchers reported.

The American Cancer Society does not recommend routine screening for most men, and there is no government screening program in Britain because officials say the PSA test is too unreliable. Two other big papers published in recent years have also failed to show much benefit for screening.

Any comment from the urologists or pathologists?

ANTONIO ONG MD
Retired Neurosurgeon, Hawaii

One has to interpret the Swedish data with great deal of skepticism. Sweden like most European states has socialized medicine where:


ANTONIO Q CHAN MD

Health care is rationed; hence preventive care is talked about but hardly implemented due to budgetary constraint. Thus, PSA is hardly ordered nor performed. Much less with CT scans, MRIs.

Since Swedish's physicians are paid much less, there is no incentive to spend much time with each patient visit. This is when potential lethal illnesses are often time missed.
85 men (about 6%) in the screened group and 292 men (about 4%) in the no-screening group were diagnosed with prostate cancer. The death rate from prostate cancer was similar in both groups, the researchers reported."

The statement above belies the main problems with this study from statistical relevance standpoint: *85 men (treated) were matched against the non-treated group (292 men).* There is no valid statistical power here to make a coherent analysis; >>

hence the conclusion is invalid. More often these subjects died of mostly cardiovascular (CV) illnesses other than cancer of the prostate. So how can one extrapolate that PSA and closer cancer screening is meaningless as a contributor to mortality?

Since CV morbidity and mortality played a major role in one's life expectancy; how can CV illnesses as a cause of mortality be ignored in statistical analysis of death rates from prostate cancer?

It is not because PSA was discovered at Stanford (Dr Thomas Stamey); but I am a believer in PSA screening. Most of Chanwell Clinic patient populations are > 65 years of age; in some instances by the time suspicion of prostate cancer comes to one mind, there is already bone metastasis (aggressive tumor).

As for me, I get PSA 1-2 times a year although it has been normal.

I am interested to hear comments from our urology experts Frank Chan and Emilio Chu.

Here is the CANCER Survival Rates between USA and Europe & Canada. Sweden fared a little better than some European cohort but less than that of USA: http://www.firstthings.com/blogs/secondhandsmoke/2009/07/21/most-cancer-survival-rates-in-usa-better-than-europe-and-canada/

Implications. Once Obamacare is implemented, USA death rates from cancer and heart disease will approach and even surpassed that of Europe and Canada. Sweden population is 1/31 that of the USA; hence a vast country like the USA with massive budget deficits tends to have more inefficiencies in a monopolistic, bureaucratic, government-managed (or shall I say often "mismanaged") healthcare system. It will be a nightmare.

ANTONIO Q CHAN MD MBA FAHA FACC RPSGT
Chairman, Chanwell Clinic, Institute for Heart & Sleep Disorders AND Adjunct Clinical Professor of Medicine, Stanford University School of Medicine

In response to this current article and prostate cancer screening in general, I have a few comments to make.

FRANK CHAN MD

This article's argument in favor of no-screening is not well supported.

The article states that better tools are needed to determine which patients require treatment. Such tools are already available (staging and Gleason score).

That an increase in the PSA level does not always indicate carcinoma of the prostate (false positive). PSA was never intended to be disease specific but rather organ specific. The diagnosis of carcinoma of the prostate is not based solely on PSA.

That there is no agreement in treatment plan. Yes, treatment plans are well established and are based on the following: the stage of the disease, patient's medical condition and longevity and patient's choice. Side effects of the treatments are worse than the disease itself. This was true in the 1970s and 1980s but hardly is the case now. Robotic surgery, radiotherapy and hormonal treatment have significantly improved survival as well as the quality of life.

That prostate cancer screening provides no benefit. In the 1970s when prostate cancer screening was an unknown entity, most patients were being diagnosed in their late stages. With the introduction of the screening, we now are diagnosing patients with early stage disease resulting in higher cure rate. One must not be misled to think that carcinoma of the prostate does not kill. This is ultimately a systemic disease and its journey to death is not a pleasant one as I have observed in so many of my patients.

Dr. A. Chan's comments about this article are very appropriate. Until we have a single reliable diagnostic test this controversy will continue. Countries with a single payer system will shy away from screening because of the added expense. Organizations that just look at numbers without patient contact will be in that camp. While urologists radiotherapists and medical oncologists having direct contact with patients and having observed the positive effect of treatment will favor screening. Some might, however, question their intentions because of conflict of interest.

Here is my opinion regarding prostate cancer screening. Yes, I favor screening. The process is simple, inexpensive, patient-friendly, and can save >>

lives. Screening starts at age 40 years, or younger when there is a family history of cancer, and in all individuals who still have 10 years and more life expectancy.

The treatment for carcinoma of the prostate is well established. The side effects of the different treatment modalities are not as significant as some medical publications have stated. Early prostate cancer when treated appropriately can be cured. Death from carcinoma of the prostate is slow and agonizing.

Please check out the the Sloan Kettering website which has a short video conference on prostate cancer screening. It is very informative.

FRANK CHAN MD
American Board Certified Urologist
Mesa, Arizona

It is nice to hear your thoughts on this, Frank. My God, I missed your medical insights. This is your area of expertise. I did not mean to invade your territory. All my comments related to statistics and economics of healthcare. Regarding the Swedish study, there are telling data wherein my estimate of USA death rates from cancer compared to Europe and Canada could be way off. I believe once Obamacare is implemented, the death rates from cancer and heart disease would exceed that of Canada, Europe and the former Soviet Unions.


ANTONIO Q CHAN MD

Here are the reasons:

Sweden has a population of 9.3 million and the USA is 311 million or more than 31 times that of Sweden. Inefficiencies tend to be magnified when one is dealing with larger numbers.

USA is more political with entrenched bureaucracy of HMOs, Managed Care, etc.; and 30+ million illegal aliens; record budget deficits; and bankruptcy of cities and states. People are already dependent on massive entitlements and other people paying for their healthcare --- the taxpayers, rather than being self-sufficient. Hence, there will be far more rationing than ever existed. Cancer diagnosis and timely treatment will be much delayed and death rate would soar! The same is true with death rates from heart disease.

We do PSA in all new male patients > 40 years; and yearly thereafter. I am cognizant of non-neoplastic elevation of PSA. I believe that we have saved lives with reduce morbidity and mortality by addressing early on risk factors. In 1970s to early 1990s, I used to see two to three acute myocardial infarctions per week in our patient population. The last acute myocardial infarction that I saw was about seven years ago. What is the reason for our virtual "elimination" of this deadly disease? We treat all their risk factors: hypertension, diabetes mellitus, high cholesterol, sleep apnea, etc. Heart attacks and strokes at least among Chanwell Clinic population are now a rarity.

By doing all of these regimens early on in an inexpensive way, We save the healthcare system a lot of money down the road through reduce emergency room visits, hospitalization and expensive invasive and surgical interventions, e.g., pacemaker, dialysis, coronary artery bypass graft, kidney transplants, cancer treatment, and the like.

ANTONIO Q CHAN MD MBA FAHA FACC RPSGT
Chairman, Chanwell Clinic, Institute for Heart & Sleep Disorders AND Adjunct Clinical Professor of Medicine, Stanford University School of Medicine

This report is nothing new but further confirmed my position on this issue over the past 15 years.


EMILIO CHU MD

1) Low volume, low grade, low stage prostatic cancer (PC) can be safely followed up with active surveillance regardless of age.

2) PC screening should only be done in patient with at least a 10 years life expectancy where he can benefit with some form of curative treatment plan

3) Curative treatment modalities should be offer to moderate volume, e.g., palpable lesion, positive core biopsy on at least 50% microscopic field, moderate grade of Gleason >6, stage B (ocalized disease) because this type of PC will progress and metastasize, and ultimately kill with a very painful terminal course.

4) Curative treatment option of total radical prostatectomy >

on this type of localized disease has a cure rate of 90% for 10 years or more, while IMRT, brachytherapy, or cryotherapy will provide 5 years cure rate of 80%-85%. So appropriate treatment decision should be based on life expectancy, side effects of each form of treatment acceptable to the patient, availability and affordability.

5) Stage C disease will be best treated with IMRT plus androgen suppression.

6) Stage D disease is best treated with total androgen suppression.

7) Hormone-resistant Stage D is be best treated with Provenge immunotherapy or chemotherapy.

As you can see, the proper therapeutic choice is totally based on accurate staging, Gleason grading, and age at the time of diagnosis and co-morbidity. That means a second opinion on the biopsy diagnosis and grading is highly desirable to make a decision on each patient.

That is my opinion as of today 2011

EMILIO CHU MD
Urologist,Yorba Linda CA

Addendum: Booster *Shots* blog reported that *prostate-cancer screening is at the center of a medical divide, with some medical experts saying men should be screened frequently and others saying too many are screened and that the false alarms aren't worth the trouble*. And a study earlier this month, which found that men in their *early 70's are getting screened at almost double the rate of men in their early 50's*, got cheers from neither side of the debate.

The study, published online in the Journal of Clinical Oncology found that *24% of men age 50-54 had been screened with a PSA blood test in the previous year, while 46% of men age 70 to 74 had been screened*.

Additionally, active surveillance for low-risk prostate cancer offers a safe alternative to immediate curative intervention and may reduce overtreatment and adverse events, investigators in a large clinical study concluded.

A third of 769 patients eventually had surgery or radiation therapy, but delaying intervention for as long as 10 years caused no apparent harm.

The cohort had a median survival free of intervention of 6.5 years, and the 10-year intervention-free survival was 41% in study participants, who had a median age of 66 at diagnosis, according to an article published online in the Journal of Clinical Oncology.

This study offers the most conclusive evidence to date that active surveillance may be the preferred option for the vast majority of older men diagnosed with a very low-grade or small-volume form of prostate cancer, senior author H. Ballentine Carter, MD, of Johns Hopkins, said in a statement.

These are men with a favorable-risk disease profile to begin with. Since widespread use of PSA screening for prostate cancer began in the 1990s, disease stage at diagnosis has declined dramatically, such that the majority of newly diagnosed prostate cancers are low risk. Although highly successful, PSA screening has sparked controversy about the potential for overdiagnosis and overtreatment of clinically trivial disease that would not become life-threatening in a man's lifetime (J Natl Cancer Inst 2003; 95: 868-878).

Further evidence of overdiagnosis and overtreatment has come from recent studies suggesting that prevention of one prostate cancer death would require active treatment of 48 men for nine years or 12 men for 14 years (N Engl J Med 2009; 360-1320-1328, Lancet Oncol 2010; 11: 725-732).

Moreover, results of two large prostate cancer screening studies showed no evidence of a survival benefit with PSA testing.

Several studies of active surveillance with curative intent has shown a low prostate cancer-specific mortality during relatively short-term follow-up, Carter and co-authors noted in the introduction of their paper.

But those positive findings have failed to quell concern that delaying definitive treatment for prostate cancer might sacrifice the window of opportunity to achieve a cure.

Since 1995 Carter and colleagues at Johns Hopkins have offered active surveillance with curative intent as an alternative to immediate intervention for older men with clinically low-risk prostate cancer (T1c or lower). Preliminary data supported the conservative strategy for selected older men with low-risk prostate cancer (J Urol 2002; 167: 1231-1234). >>

In the current paper, the authors reported updated results of the Johns Hopkins active surveillance experience with a larger patient population. The program's entry criteria, which have since been adopted by the National Comprehensive Cancer Network, consist of:
Disease stage T1c or lower at diagnosis
PSA density <0.15 ng/mL
Gleason score ≤6
Two or fewer biopsy cores containing cancer
No core with more than 50% cancer

Selected patients with a Gleason score of ≤6 but who otherwise did not meet the criteria could enter active surveillance if they had comorbidities that precluded immediate intervention or if they preferred active surveillance for personal reasons.

The surveillance protocol included semiannual PSA testing and digital rectal examination and annual 12- or 14-core biopsy. Clinicians recommended curative intervention to men who no longer met entry criteria at follow-up.

The total cohort has a median follow-up of 2.7 years (range 0.01 to 15). Several baseline characteristics differed significantly between men who opted for definitive therapy during follow-up and those who remained in surveillance:
Median PSA 5.0 versus 4.7 ng/mL, P=0.003
Percent free PSA, 16.2% versus 18.0%, P=0.024
PSA density, 0.11 versus 0.10 ng/mL, P<0.001
Year of diagnosis, 2003 versus 2006, P<0.001

Men who did not meet all entry criteria were more likely to have definitive treatment (P=0.026) and biopsy reclassification (P<0.001) as compared with those who met the criteria.
Intervention-free survival was 81% after two years of follow-up, 59% at five years, and 41% at 10 years.

Of the 255 men who had curative treatment, 188 (73.7%) had interventions as a result of disease reclassification on biopsy, and the remaining patients opted for intervention on the basis of personal preference or other considerations.

Median follow-up after intervention was two years in men who had surgery and 2.8 years for those who had radiation therapy. Biochemical (PSA) recurrence occurred in 9.4% of men who had definitive treatment.

None of cohort developed distant metastases or died of prostate cancer.

Limitations of the study included relatively short follow-up time (which leaves open the possibility of later adverse outcomes and which necessitated the use of biochemical recurrence as a *proxy* for long-term outcomes) and a highly motivated population for active surveillance which might not generalize to all low-risk prostate cancer patients.

AN OPEN LETTER

To: Reverend Thomas Stoeckel,
Executive Director
Medical Ministries International
1004 San Jose #101
Clovis, CA 93612

My name is Dr. Cesar D. Candari, and I am a retired pathologist who practiced in San Diego for thirty years. I am originally from Pandan, Antique, Philippines, and, at this juncture, I am chairman emeritus of the Pandan Antique Foundation (PAF), a nonprofit, public benefit corporation registered in California. Our mission is to undertake various support programs, projects, and activities geared toward helping our beloved hometown of Pandan and its impoverished people from the ravages of poverty. We provide healthcare that meet the needs of our community.


CESAR CANDARI MD

I am writing in hopes that you can help provide medical supplies and hospital equipment for the Justice Calixto O. Zaldivar Memorial Hospital in Pandan. The hospital needs medical supplies and equipment - hospital beds, bed sheets, operating room tables, surgical room lights, and anesthesia equipment among other necessities - which we would like to list and send to you.

I have seen firsthand the deplorable condition of my hometown's dilapidated 25-bed community hospital. In 2000, I went home on a medical >>

mission, saw the sad condition of the hospital, and last January 2011, eleven years later the situation has not improved much, with rusted spring beds without mattresses, two vastly under-equipped surgical rooms, and other signs of bad conditions.

In response to what I had seen in 2000, I helped establish the Pandan Antique Foundation. Presently, we have three major goals. First, we have a program for helping the poor people of Pandan with medical emergencies. Second, we are initiating a program to treat people with tuberculosis, which has devastated the Philippine's region. Finally, we aim to initiate a vaccination program for children in collaboration with the government

To achieve our goals, we need ongoing funding. What we are asking is for you to participate in our adopt-a-hospital program, in which you would help support ongoing free medical clinics and our mission to provide healthcare for those sickly and poor in Pandan.

Thank you in advance for your most generous gift of compassion and giving.

CESAR D CANDARI MD[61]

Everyone is invited to the

FEUMAANI

20.5th Biennial Anniversary

Speakers Seminar

at Drury Lane Oakbrook

Recognition of Medical Missionaries Dinner Dance

at the Lexington House

Hickory Hills IL

Saturday, July 30, 2011

LETTER TO THE EDITOR

I thoroughly enjoyed Dr. Cesar Candari's exposé on

REV MELVIN ANTONIO MD

charlatans in the Philippines. The practice is rampant enough and presents a challenge for legitimate healthcare providers to counter a culture that is still deeply embedded in Filipino psyche. I congratulate Dr. Candari in bringing this issue to the readership of Ectopic Murmurs. It certainly should raise the awareness of health care providers on what they are likely to encounter in their practice of medicine, not just in the Philippines, but even here in the U.S. which is a melting pot of cultures. Filipinos have their *herbolarios*, Latinos have their *curanderos*, Native Americans have their medicine men/women, Haitians have their voodoo, refugees from Southeast Asia have their copper coins, the list goes on. The way this *folk medicine* is practiced varies from culture to culture. I was medical director of the Mescalero Indian Hospital in New Mexico and had contact with Apache medicine men/women during that time. I chose to integrate their *expertise* into the medical practice of our providers, rather than antagonizing them and the patients who were under their influence. The medicine men/women among the Apaches are treated with respect. They are highly spiritual people and are called upon to *create a peaceful relationship between the people and nature.* They use incantations and prayers. They do not practice *quackery* as described by Dr Candari. They do not interfere with the treatment of patients. In fact, they contribute to the mental and spiritual well being of patients. They do not expect to be paid for their services as they believe that they would lose their gifts if used for personal gain. I fully support Dr Candari's promotion of holistic medicine. I would even support its inclusion in the curriculum of medical schools and offering as a specialty. Mexico has such a specialty being offered in Guadalajara. As an ordained minister, I truly believe in the power of prayer in the overall well-being of patients, whether it be physical, mental or spiritual. However, it becomes quackery when it is the only modality that is used in patient care and presents a barrier that keeps the patient from seeking timely and appropriate medical care.

REVEREND
MELVIN ANTONIO MD[65]

LETTER TO THE EDITOR

I am glad to read my copy of the ECTOPIC MURMURS and get to know the activities of my friends and colleagues, a lot easier than my notebook which I carried to Philippines until our return Saturday.

I am also mighty proud of your missions to Palawan and other places where the populace appreciate your efforts---and who desperately need your help. I wish I can say the same to medical and political leaders that makes *missioning* harder than it is. They should know >

HIRFA SIAN MD and PIO SIAN MD

that we spend great deal when we go on a mission, not supported by any big company nor a big magazine publisher.

Gawad Kalinga must have bigger recognition.

To President Oscar Tuazon and Chairman Pepito Rivera, you have my support.

Melvin, although I do not belong to your sect, keep the spirit going.

To those colleagues who enjoy travel, keep going while you can, you are young only once and life is too short.

Rolly, your breathtaking photographs are an inspiration to us forever amateurs. Patience in wildlife photography is an understatement. I hope you have a copyrighted album soon.

Personally, we are enjoying retirement quietly, but sometimes we go out West, mostly at the reservations 2-3 months at a time. I wish I could take Rolly to take the pictures for me of the spectacular views out there.

We spent February and March in the Visayas, I find it hard to swallow local delicacies, like *sugpo*, *alimango* and the world's best seafoods, while millions are starving.

It is appalling that people reject RH (reproductive health).

It is sad to see blatant corruption at ALL levels; even sadder is the decline of education.

Masses are misinformed, less educated, or just plain taken advantaged of.

Productivity is naught.

Everything manufactured (from China) are too expensive.

Production for export is always praised and aimed for, but quality control is unheard of. Those who can afford quality are usually foreigners. *Pinoys* are only for cheap labor. Serfdom is still rampant, especially on sugar *haciendas*. The saddest part is the locals accept the lifestyle as if it was God-given. Cane cutter with 8-10 children, is Hirfa's (Mrs Sian) pet peeve.

I tried to learn how to make Coco-diesel succesfully, brought in a 4-5 ton coconut oil expeller and a 200 liter diesel processor. Coconuts almost disappeared because of demands for coco-lumber! Talk about a fabled goose! We kept on lecturing all around to plant replacement coconuts and cut old ones only when the replacements are bearing. I guess we are geared to instant gratification.

That is all for now before you run out of room.

PIO M SIAN MD[65]

LETTER TO THE EDITOR

Thank you very much for sending us the **ECTOPIC MURMURS**. We really appreciate it very much. Is it not too late to join the Greek Isle Turkey tour?

We just send Tricia your e-mail.

Thank you also for promoting the *Gawad Kalinga* Hope Ball. Here in Texas we are supporting the work for the poor by *Gawad Kainga*. We are building the Port Arthur/ Beaumont Texas Village in the same place that the Hope Ball beneficiaries would be.

We would do anything for *Gawad Kalinga*.

Our trip to Israel and Egypt was wonderful and well organized. Our family enjoyed

TRICIA PUNSALAN MD and LINDA PUNSALAN MD

it very much.

Thank you to all the leaders and members of the FEUMAANI.

God bless and warm regards to your family. God bless,

PHILIP PUNSALAN
LINDA PUNSALAN MD

MAY QUOTE

Work with anxious concern to achieve your salvation. It is God who, in His good will toward you, begets in you any measure of desire or achievement. In everything, act without grumbling or arguing: prove yourselves innocent and straightforward, children of God, without reproach. **Philippians 2:12b-15a**

TENDERLY YOURS

continued from page 3

during the Saturday night grand ball slated at the Crowne Plaza near the Manila Galleria. It was mentioned that some quarters wanted the venue to be at the Shangri-La EDSA. We will probably know this year what the situation is.

4. Through this column, I would like to encourage those who will join us in Las Vegas in June to please send in your registration early enough to avoid the last minute rush and longer waiting at the registration desk. Do not forget also to make your reservation at the Monte Carlo Hotel (deadline May 15, 011). Again please do these things early. Good luck and God bless.

5. As of April 11, 2011 there were only 9 registrants for the June 15-18 alumni reunion . Please do not wait until May to register. Let us help each other avoid the rush to register.

OUR CHILDREN

continued from page 3

the early 20th century when the demand for labor in the plantations of Hawaii and farmlands of California attracted thousands of mostly male laborers.

The movement of agricultural workers later expanded from California to Washington and in Alaska, to work in fish canneries. This migration was reduced to fifty persons a year following the Tydings-McDuffie Act of 1934. Its main purpose was to exclude Filipinos because they were perceived as a social problem, disease carriers, and an economical threat. The American attitude toward Filipinos changed with the onset of World War II. The United States Navy's recruitment of Filipinos, who were exempt from the aforementioned quota, offset this prejudice. Successive waves of Filipino migrants, mostly professional workers, followed in the 1960s. They were Filipino nurses, doctors, and medical technicians, who filled in the skill gaps in the United States.

To trace back before the 1900s, there were earlier Spanish-speaking Filipinos who were not truly immigrants but instead were transplanted to America by accident. They were appropriately called *accident immigrants*, for they served as Spanish labor rather than American. It was not until 1898, when the US acquired the Philippine territory at the end of the Spanish-American regime, when true immigration to the United States began.

Briefly, I will try to categorize and organize the different types of Filipinos who came to America. With the passage of time, these categories may change among the Filipinos coming to North America. We see that different classes of Filipinos arrived in the US, each having their own sets of goals and objectives. The one common denominator which has drawn these people here is the demand for Filipino labor supply.

We Filipinos came to America in four waves:

1. The First Wave were the *Manilamen*, 1763;

2. The Second Wave were the *Pensionados* and the *Manongs*, 1900-1940;

3. The Third Wave were the Navy men, 1945-65; and

4. The fourth Wave the Professionals, late 1950s up to the present.

Filipinos had settled in North America before the American Revolution. The earliest recorded presence of Filipinos in what is today the United States occurred in October 1587, when mariners under Spanish command landed in Morro Bay, California. In 1565 the Spanish galleons from the Philippines were bound for Acapulco, Mexico, thereby creating the Manila-Acapulco trade route. Among the crew members of the Philippine-made Spanish galleons were Spanish-speaking Filipinos, the *Manilamen*. The earliest permanent Filipino Americans to arrive in the New World landed in 1763 in Louisiana. As sailors and navigators on board the Spanish galleons, Filipinos--also known as *Manilamen*, or Spanish-speaking Filipinos--jumped ship to escape the brutality of their Spanish masters. Many of the sailors were subjected to hard labor for the galleon service. They made their first permanent settlement in the bayous and marshes of Louisiana. They built houses on stilts along the gulf ports of New Orleans and were the first in the United States to introduce the sun-drying process of shrimp. They created settlements such as Saint Malo LA and Manila Village in Barataria Bay. The oldest place was St. Malo, a small fishing >

village that existed in St. Bernard Paris LA on the shore of Lake Borgne from the mid 18th century until the destructive New Orleans Hurricane of 1915. St Malo was a free republic inside French-Louisiana; at one time, three to four hundred people lived there.

Other settlements like St Malo sprouted in other areas. In the early 1900s a Filipino community leader revealed there were over two thousand *Manilamen* in the New Orleans community alone, and the Louisiana area outside of New Orleans housed several hundred Filipinos. During the War of 1812, Filipinos from Manila Village, near New Orleans, were among the *Batarians* who fought against the British with Jean Lafitte in the Battle of New Orleans.

From 1900-1940 the second wave of immigrants, the laborers who worked in the plantations of Hawaii, showed up on American shores.

Later the demand expanded from California to Washington and in Alaska to work in fish canneries.

On the other hand, the *pensionados* were sons and daughters of rich, influential families, who came to the U.S. specifically to obtain a college education. They were given Philippine government grants and fellowships, known as government pensions, hence the term *pensionados*. They were to return to the Philippines after completing their academic work. Because of their small number on American campuses and temporary status in the US, they did not pose a threat to the majority of white Americans.

Beginning in the early 1900's, *pensionados* portrayed that identification with the image of being well-mannered, well groomed, and knowledgeable of white American etiquette. Since the early *pensionados* experienced little prejudice and discrimination, they came back to the Philippines with glowing reports and unrealistic views of mainstream American culture. These impressions gave false hopes and expectations to the immigrant laborers known as the *manongs*, or old timers.

To be continued.

(Dr. Candari has written a book, *Success is a Journey, his memoir from Antique to America*, of which these are excerpts.

The book can be ordered at http://www.Amazon.com . Book prize- $12.50 plus shipping of $2.77; or by email , contact drcdcmd@cox.net; Tel. 702.269.6490)

FAITH CORNER

continued from page 3

on the surface of the moon a few minutes when Aldrin made the following announcement: *This is the lunar module pilot. I would like to take this opportunity to ask every person listening in, whoever and wherever they may be, to pause for a moment and contemplate the events of the past few hours and to give thanks in his or her own way.* He then ended radio communication and there, on the surface of the moon, 250,000 miles above the earth, he read a verse from the Gospel of John, and he took communion.

Here is Aldrin's account of what happened:

In the radio blackout, I opened the little plastic packages which contained the bread and the wine. I poured the wine into the chalice our church had given me. In the one-sixth gravity of the moon, the wine slowly curled and gracefully came up the side of the cup. Then I read the Scripture: **I am the vine, you are the branches. Those who abide in me and I in them bear much fruit because apart from me you can do nothing**. (**John 15:5**)

I had intended to read my communion passage back to earth, but at the last minute (they) had requested me that I not do this. NASA was already embroiled in a legal battle with Madelyn Murray O'Hare, the celebrated opponent of religion, over the Apollo 8 crew reading from Genesis while orbiting the moon at Christmas. I agreed reluctantly. I ate the tiny Host and swallowed the wine. I gave thanks for the intelligence and spirit that had brought two young pilots to the Sea of Tranquility. It was interesting for me to think: the very first liquid ever poured on the moon, and the very first food eaten were communion elements. And of course, it is interesting that some of the first words on the moon were the words of Jesus Christ, who made the earth and the moon and who, in the immortal words of Dante, is >

Himself the **Love that moves the sun and other stars**.

This is the kind of story that we hardly hear about these days. At a time when all we hear about in the news media are stories of terror, war, economic and environmental disasters, the account of the first communion on the moon is one that we might pay attention to. It is a story of faith in action. The scriptural passage read by Aldrin appropriately reminds us of the fact that apart from the divine hand of God, we can do nothing.

From the CHAIRMAN

continued from page 1

handsome. That feeling would follow me to school; and I sometimes felt I had the admiration of other students. Our professors told us the course was challenging and only a few students would be chosen to graduate. Most of the students were very intelligent, resourceful, and dedicated, so this announcement caused some concern for us. Soon they gave us lists of textbooks and references, and introduced us to such lofty subjects: gross anatomy, physiology, histology and biochemistry.

It did not take long for my feelings of superiority to change to anxiety and panic. My beautific smile with two dimples became a mellower smile. My eyes became sunken with dark rings from lack of sleep and late night studies. I lost some weight and began to have that older worldlier look, a few grey hairs and wrinkles on the forehead. I began to realize why I had felt so young and good looking when I started, compared to those already into their studies.

In gross anatomy, we were assigned cadaver with four students to a body. We studied the human organ systems, identifying the structures and organ functions. More than once, I found live maggots crawling on my hands. Studying was a constant every night, on Saturday and Sunday. Most of my time was spent in the medical library. Even with all the challenges, I survived the first year. However, I had heard from students ahead of me that the second was harder.

The first day of the second year, I did not even have time to comb my hair. I always found a few minutes to go to chapel to pray because I was going to need all the help I could get. The teachers for the second year were even more strict, unfriendly and unapproachable. Many classmates did not survive year two; and in fact year two was referred to as the cut-off year because this was where the less focused students were cut-out of the group. Once final exams were completed, the promotion board would meet, review test scores and student reports, and decide which ones advanced to third year.

When I arrived for third year, I immediately noticed that the size of classes was smaller; and the number in our class had shrunk dramatically. I no longer had an appetite and had a slim figure. I spent my time studying, attending classes and praying. The classes were more specific, but I finally began to *connect the dots* and make more sense of my studies. This was the year we began to interact with patients in the hospital setting. Finally, I was able to practice on live patients. I was introduced to stethoscopes, sphygmomanometers and neurological hammers. I got in the habit of wearing my stethoscope around my neck even when I was not at the hospital, sometimes even when I was out riding in the public jeepney, and enjoyed having people call me *doctor*. It elated me to hear doctor. I felt puffed up and began to think more about the future instead of only about class. I had fourteen subjects during third year and my prayers were answered when I passed all fourteen. My fourth year was spent mostly in various hospitals completing my senior clerkship rotation. I studied infectious diseases at San Lazaro Hospital, pulmonary tuberculosis at Quezon Institute, OB/GYN at Rizal Provincial Hospital and finished my surgical rotation at North General Jose Reyes Memorial Hospital. Looking back, I think the third and fourth years were more intense, but less stressful. I even completed my make-up classes for absences and deficiencies. Finally, the end of the tunnel was in reach.

From this point, I studied for my Philippine medical boards and ECFMG so I could go the USA to complete a surgical residency. Even as I studied, I partied and prepared for the graduation ceremonies. The graduation was a visual, finite, moment we all aspired to; the >

moment when we could legally be referred as doctors. I no longer needed the stethoscope to prove my worth. There have been some changes to the system over the years, but the stress, worry, and nervousness remain for each class that begins. I have always cherished my memories of those years and have enjoyed a busy and prosperous lifestyle because of the outstanding education I received from my alma mater. Some of my classmates have already passed away and I remember them in my prayers.

My other classmates may see a little of themselves in these remembrances.

PEPITO C RIVERA MD

From the PRESIDENT

continued from page 1

All attending alumni will be able to listen and update their practice with the current changes in the field of medicine.

Our tireless CME chairman,. Cesar Reyes MD, has prepared very interesting topics for us.

Most of all, you will be able to meet your classmates and re-establish your comradeship.

The city of Las Vegas can also offer a lot of things for you to relax, e.g., the casinos and innumerable shows, as well as the cheapest buffets in the world.

Early registration is recommended because the Monte Carlo Resort and Casino has offered us the best rate in town, unless you are a high roller.

The deadline for registration is on May 15, 2011 and there will no extension. Our reservation code is **XFEUM11**.

Please register now.

The FEUDNRSM Alumni Foundation Southern California Chapter is getting ready and preparing for our 33rd annual reunion and scientific convention for July 2012!

OSCAR C TUAZON MD[74]

CHICAGO HALL

continued from page 1

Chicago Filipino American Hall of Fame.

Dr Benson is recognized for his excellence in medical education; while Dr Rubio with Dr Elenita Rubio and children are honored as Chicago's 2011 model family.

As a senior associate chair for academic affairs and chief of pain medicine at Northwestern University medical school, Dr Benson's research interest is in neurophysiology. He has written 50 original articles, review articles, editorials, and 80 book chapters in the field of pain medicine and regional anesthesia. He is the editor of *Essentials of pain medicine and regional anesthesia*", *Raj's Practical management of pain*, *Spinal injections and peripheral nerve blocks*, Anesthesia and Analgesia, Regional Anesthesia and Pain Medicine, and Pain Practice, and Clinical Journal of Pain.

Dr Benson lectures at international meetings in the United States, Asia, Europe, and Middle East. He is included in the *Best Doctors in America*, *America's Top Doctors*, and *Top Doctors in Chicago*.

Likewise, the Rubio family is quite extraordinary and honored as such.

Dr Rubio is internist and endocrinologist, and directs t diabetes mellitus center at St Elizabeth Hospital/ St Mary Hospital Medical Centers of Chicago.

Dr Elenita Rubio is a practicing internist in Chicago.

Their sons: Nunilo Rubio Jr MD, is an academic pediatrician and endocrinologist in Houston TX.;

Noel Rubio MD practices internal medicine and family medicine in the Chicago westside; and

Dr Nate Rubio is a Houston TX rehabilitation therapist.

Our congratulations to Drs Benzon and Rubio!

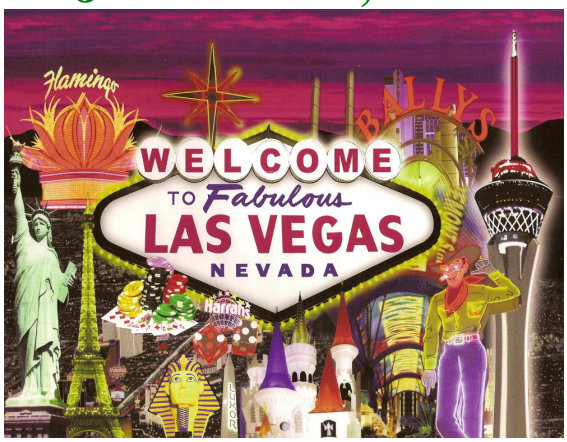
JOINT GET TOGETHER PARTY
Class[63]
Class[64]
and Class[65]
Thursday, June 16, 2011
6:00 pm
Venue: Café
Spring Mountain & Jones
Dinner, Karaoke and dancing

Hosts: Dr Art Basa
440-525-0909 216-244-4348
Drs Daniel Fabito & Reggie Tobias
702-622-2974
Dr Linda Fabito
702 -622-2976

If you have prior dinner commitment, you are welcome to join us during dancing, karaoke and singing

32nd Annual Reunion & Scientific Convention

June 15 – 18, 2011



Monte Carlo Resort & Casino, Las Vegas NV
Hotel room rate for June 15th-16th $50/night
June 17th–18th, $115/night, plus taxes
Telephone (888) 529-4828
(702) 730-7000
Hotel Reservation deadline May 15, 2011

Celebrants
Class61 (Golden Jubilee)
Class86 (Silver Jubilee)
Class66 (Sapphire Jubilee)
Class71 (Ruby Jubilee)
Class76 (Coral Jubilee)
Class81 (Pearl Jubilee)
Class91 (20th Anniversary)
Class96 (15th Anniversary)
Class01 (10th Anniversary)

Editorials

commentary, news releases, letters to the editor, column proposal and manuscripts are invited. Email submission, including figures or pictures, is preferred.

ECTOPIC MURMURS

Deadline for the June 2011 issue: May 15, 2011
Email to acvrear@aol.com

Balik-FEU 2012

January 26-28, 2012

Venue Crowne Plaza Galleria at Ortigas & EDSA

CELEBRANTS
Class62 (Golden Jubilee)
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STUDENT ACHIEVEMENT AWARD

Do you want to know a little bit more about the Student Achievement Awards? The cost for each Student Achievement Award is $50. If you want your award in perpetuity, it is $1050. You can label your award in your name, or in the name of the person you wish to honor. So let me challenge you to channel the extra dollars of your donation/ charity budget to recognize an honor-roll needy student or two at the medical school. Your donation(s) are tax-deductible. Please make your check payable to FEUDNRSM Alumni Foundation. Your donation this year will be awarded during the Student Recognition of the 2012 Balik-FEU in mid-January 2012 at the FEU-NRMF Institute of Medicine, in West Fairview, Quezon City. If you want you can also distribute your award(s) in person during the ceremonies! Let me hear from you about your award(s).

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