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Tables should be given a brief informative title and a Roman number separately from the figures. Each table should be typed on a separate sheet of paper. Footnotes should be designated within the table and explained below it in order. The number of tables should be kept to a minimum. Tables whose content can be fully incorporated in the text should be eliminated.

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<thead>
<tr>
<th>DATE</th>
<th>HOST CHAPTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>August, 1992</td>
<td>- Central Luzon Chapter</td>
</tr>
<tr>
<td>September, 1992</td>
<td>- Northern Luzon Chapter</td>
</tr>
<tr>
<td>November, 1992</td>
<td>- Eastern Visayas Chapter</td>
</tr>
<tr>
<td>January, 1993</td>
<td>- Southern Mindanao Chapter</td>
</tr>
<tr>
<td>February, 1993</td>
<td>- Western Visayas Chapter</td>
</tr>
<tr>
<td>March, 1993</td>
<td>- Southern Luzon Chapter</td>
</tr>
</tbody>
</table>

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WESTMONT PHARMACEUTICALS, IN
COCONUT OIL CONSUMPTION AND CORONARY HEART DISEASE

Hanz Kaunitz, M.D.* and Conrado S. Dayrit, M.D., FPCP**

The desirability of coconut oil as dietary fat, particularly as regards coronary heart disease, is still questioned by some investigators. Some twenty years ago, the use of coconut oil in human nutrition was already advocated (Kaunitz 1970). Those opposed to the dietary use of coconut oil point to its high content of saturated fatty acids which are blamed for increasing serum cholesterol levels and promoting atherogenesis in various animal feeding experiments. In contrast the polyunsaturated fatty acids, linoleic acid (18:2ω6) in particular, are classified as essential fatty acids (EFA) and credited with cholesterol-lowering and atherosclerosis-preventive effects. It is important to note that these animal studies that showed hypercholesterolemia from coconut oil were not supplied the required small amount of essential fatty acid which coconut oil happens to lack.2,3

Hashim et al (1959)4 demonstrated that coconut oil was not a “bad oil” when they compared EFA-rich safflower oil (SFO) with an equal mixture of safflower oil and coconut oil (SFO-CNO) on 10 hypercholesterolemic males, 8 of whom were survivors of myocardial infarction; they showed that both SFO and SFO-CNO caused marked decreased in the serum cholesterol and that the SFO-CNO effect was obtained regardless of whether it was fed before or after the safflower oil.

While the fatty acids of coconut oil are indeed saturated, coconut oil having an iodine value of 10 (Hashim et al 1959)4, they are predominantly (67%) C8 to C12 in length, classified as MCT or medium chain triglycerides (Kaunitz et al 1960)5. Senior (1967)6, Bach and Babayan (1982)7 - although C12 appears to partially partake of the transport and metabolism characteristics of long chain triglycerides (LCTs). The MCTs stand in direct contrast to the C16-C18 LCTs of animal and dairy origin; Bach and Babayan (1982)7 stressed their marked differences in absorption, transport and metabolism: LCTs reach the liver through the lymphatics and are mostly (70%) carried to the peripheral tissues by the lipoproteins; MCTs are carried directly to the liver by the portal circulation where they undergo rapid oxidation into energy with little being carried to the peripheral tissues or fat depots by lipoproteins. MCTs do not promote obesity.

Epidemiologic data

If coconut oil were truly hypercholesterogenic, then, following the Diet-Heart theory and the Seven-Country
Table I. Coconut Oil Consumption and Average Age at Death In Various Asiatic Countries.

<table>
<thead>
<tr>
<th>Country</th>
<th>Annual Intake Metric Tons x1000</th>
<th>Population (millions)</th>
<th>Annual Per Capital Intake of Coconut Oil (Kg)</th>
<th>Average Age at Death (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>16.3</td>
<td>98.66</td>
<td>.165</td>
<td>55.3</td>
</tr>
<tr>
<td>Burma</td>
<td>2.3</td>
<td>37.15</td>
<td>.062</td>
<td>55.8</td>
</tr>
<tr>
<td>China</td>
<td>22.7</td>
<td>1059.52</td>
<td>.022</td>
<td>68.7</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>1.1</td>
<td>5.46</td>
<td>.202</td>
<td>73.8</td>
</tr>
<tr>
<td>India</td>
<td>238.1</td>
<td>759.86</td>
<td>.313</td>
<td>55.6</td>
</tr>
<tr>
<td>Indonesia</td>
<td>562.7</td>
<td>163.30</td>
<td>3.444</td>
<td>55.2</td>
</tr>
<tr>
<td>Japan</td>
<td>69.9</td>
<td>120.75</td>
<td>.581</td>
<td>74.8</td>
</tr>
<tr>
<td>Korea (South)</td>
<td>21.6</td>
<td>41.06</td>
<td>.052</td>
<td>62.7</td>
</tr>
<tr>
<td>West Malaysia</td>
<td>.7</td>
<td>15.68</td>
<td>.005</td>
<td>67.6</td>
</tr>
<tr>
<td>Pakistan</td>
<td>10.0</td>
<td>96.18</td>
<td>.104</td>
<td>59.0</td>
</tr>
<tr>
<td>Philippines</td>
<td>287.7</td>
<td>54.38</td>
<td>5.291</td>
<td>60.2</td>
</tr>
<tr>
<td>Singapore</td>
<td>5.2</td>
<td>2.56</td>
<td>2.035</td>
<td>59.2</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>56.7</td>
<td>15.84</td>
<td>3.580</td>
<td>67.8</td>
</tr>
</tbody>
</table>

Average Age at Death

(males)

Figure 1. Coconut Oil Consumption and Average Age at Death In Various Asiatic Countries

type of evidence, populations whose diets are rich in coconut oil should show elevated serum cholesterol levels and high morbidity and mortality rates of coronary heart disease. But this has not been shown to be the case in these populations.

There are only a few countries taking coconut oil in high amounts where population studies can be done. The U.S. consumption of this oil is only 1-2% of daily calories. In Asia, only three countries (Philippines, Sri Lanka and Indonesia) are listed in the 1985 UN Demographic Yearbook as having high annual per capita intake of coconut oil (Table I, Fig. 1). The average age-at-death in these three countries are 60.2 and 63.3 years for male and female Filipinos, 67.8 and 71.6 years for male and female Sri Lankans and 55.2 and 54.9 years for Indonesians. However, confounding variables, such as high prevalence of respiratory infections, measles, diarrheas and other infectious diseases in these countries make the exercise of relating coconut oil consumption with age-at-death largely misleading.

Table II. Coconut Diet - Polynesian Atolls

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PUKAPUKA</td>
<td>TOKELAU</td>
<td>PUKAPUKA</td>
<td>TOKELAU</td>
<td></td>
</tr>
<tr>
<td>Kcal</td>
<td>2120</td>
<td>2520</td>
<td>1810</td>
<td>2100</td>
<td></td>
</tr>
<tr>
<td>Protein (g)</td>
<td>31</td>
<td>34</td>
<td>53</td>
<td>63</td>
<td>Mostly fish</td>
</tr>
<tr>
<td>Fat (total g)</td>
<td>83</td>
<td>155</td>
<td>60</td>
<td>131</td>
<td>Mostly coconut</td>
</tr>
<tr>
<td>% of total calories</td>
<td>35.2%</td>
<td>55.7%</td>
<td>39.8%</td>
<td>56.1%</td>
<td></td>
</tr>
<tr>
<td>Fat, saturated (g)</td>
<td>63</td>
<td>137</td>
<td>64</td>
<td>120</td>
<td>Mostly coconut</td>
</tr>
<tr>
<td>Fat, unsaturated (g)</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Cholesterol (mg)</td>
<td>73</td>
<td>51</td>
<td>70</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Carbohydrate (g)</td>
<td>283</td>
<td>229</td>
<td>230</td>
<td>189</td>
<td></td>
</tr>
<tr>
<td>Serum cholesterol (mg)</td>
<td>170</td>
<td>208</td>
<td>176</td>
<td>216</td>
<td></td>
</tr>
</tbody>
</table>


Polynesians

Unlisted in the above-cited reports, the peoples of the Polynesian Puka-Puka and Tokelau islands are high coconut consumers. Prior et al's (1981) studies of these people (Table II) showed low levels of serum cholesterol (170-176 mg/dl) among the Puka Pukans despite a high intake of 35-40% fat mostly from coconut. Somewhat higher serum cholesterol levels (208-216 mg/dl) were observed among the Tokelauans whose intake of fat, also mostly from coconut, was even higher (55% of daily calories). The coronary heart disease prevalence among these Polynesians was low and has remained low (Prior, personal communication 1990).

Philippines

Heart disease is reported to be the number 2 cause of death in the Philippines with 67.7/100,000 mortality rate. (Philippine Health Statistics 1987). The reliability of this mortality rate is questionable because of the lack of physicians in the rural areas where medical attendance...
of the sick is estimated to be only 60%. The morbidity figures on heart disease ranks it as number 9; it is outranked by infectious diseases of the respiratory and gastrointestinal systems, tuberculosis, malaria and measles. Viewed globally, the Philippines is at the bottom of the ladder in CHD mortality (Fig. 2).

The average daily Filipino diet is low in total energy (about 1800 Kcal) as well as in fat which is only about 15% of total calories, excepting Manila with 22.8% (Table III). Of the 12 regions of the Philippines, Bicol has the highest intake of fat from coconut because they cook most food in coconut milk; 62.5% of the dietary fat of Bicolanos is from coconut. Despite this, the Bicolano mortality rate from coronary and cerebrovascular diseases is the lowest among the five important regions of Luzon island, Philippines. It is notable that a daily coconut fat intake twice that of other regions is associated with only about half as much coronary heart disease mortality.

Figure 2. Dietary Fat and Coronary Heart Disease in Various Countries
Coconut Oil Consumption and Coronary Heart Disease

Table III. “Diet:Heart” Data from 5 Regions of the Philippines (1984)

<table>
<thead>
<tr>
<th></th>
<th>Metro Manila</th>
<th>Ilocos</th>
<th>Central Luzon</th>
<th>Southern Tagalog</th>
<th>Bicol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy (kcal)</td>
<td>1,797</td>
<td>1,872</td>
<td>1,922</td>
<td>1,746</td>
<td>1,734</td>
</tr>
<tr>
<td>% of Total Calories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protein</td>
<td>11.7</td>
<td>11.3</td>
<td>11.0</td>
<td>11.5</td>
<td>10.8</td>
</tr>
<tr>
<td>Carbohydrates</td>
<td>65.5</td>
<td>75.0</td>
<td>73.8</td>
<td>73.3</td>
<td>72.9</td>
</tr>
<tr>
<td>Fats</td>
<td>22.8</td>
<td>13.6</td>
<td>15.0</td>
<td>15.1</td>
<td>16.3</td>
</tr>
<tr>
<td>% of Fat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coconut oil &amp; milk</td>
<td>36.7</td>
<td>32.1</td>
<td>35.2</td>
<td>38.3</td>
<td>62.4</td>
</tr>
</tbody>
</table>

Mortality

|                     |               |        |               |                  |      |
| Coronary Heart Disease | 2,582       | 991    | 1,691         | 2,076            | 937  |
| Cerebrovascular      | 1,781        | 1,715  | 2,029         | 2,002            | 905  |


Sri Lanka

Mendis et al (1989)’’ replaced the customary dietary coconut oil with corn oil in the diets of 16 free-living healthy young adult Sri Lankan males. Like Filipinos, typical Sri Lankan meals is low in fat. The observation periods for the two diets was 6 weeks - phase I with coconut oil, coconut milk and coconut kernel; phase II with cow’s milk powder and corn oil substituted for the coconut oil. The blood lipid values taken at the end of each phase are shown in Table IV. Two very notable findings are: (1) that while corn oil lowers the total serum cholesterol to 146 ± 13.4mg%, it also lowers the HDL-cholesterol from 43.43 to 25.43 mg% thereby raising the LDL:HDL ratio to rise from 3.0:1 to the less desirable higher ratio of 3.9:1. (2) that the low serum cholesterol mean level of 179.6 when the subjects were

Table IV. Blood Lipids Before and After Replacement of Coconut Oil in Sri Lankan Diet

<table>
<thead>
<tr>
<th></th>
<th>Total Cholesterol</th>
<th>LDL-Cholesterol</th>
<th>HDL-Cholesterol</th>
<th>LDL:HDL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mg/dl Mean ± SE</td>
<td>mg/dl Mean ± SE</td>
<td>mg/dl Mean ± SE</td>
<td></td>
</tr>
<tr>
<td>Phase 1</td>
<td>179.6 ± 9.1</td>
<td>131.6 ± 8.9</td>
<td>43.43 ± 5.01</td>
<td>3.0:1</td>
</tr>
<tr>
<td>Phase 2</td>
<td>146.0 ± 13.4</td>
<td>100.3 ± 8.8</td>
<td>25.43 ± 3.95</td>
<td>3.9:1</td>
</tr>
<tr>
<td>t-test</td>
<td>p &lt; 0.05</td>
<td>p &lt; 0.05</td>
<td>p &lt; 0.025</td>
<td></td>
</tr>
</tbody>
</table>

taking their regular Sri Lankan diet with coconut oil is low enough to carry a very low coronary risk, being at the lower flat position of the serum cholesterol-mortality curve published by the NCEP-NHLBI (Fig 3).

**SUMMARY**

All available population studies show that dietary coconut oil does not lead to high serum cholesterol nor to high coronary heart disease mortality or morbidity rate.

The Cholesterol lowering effect of EFA-rich corn oil may really not be so beneficial inasmuch as the HDL-cholesterol is simultaneously decreased and the ratio of cholesterol or LDL to HDL is thereby increased.
References


ANNOUNCEMENT

As of May 18, 1992 Dr. Alan Chang has requested us to include the name of Dr. Mary Anne Lim-Abrahan, FPCP in the list of authors of the paper "Usefulness of Cardiovascular Reflex Test in Determining Autonomic Dysfunction Among NIDDM Patients", published in Vol. 29, No. 4, (July-August) 1991 issue.

This notice serves as our compliance with his request.
THE PHILIPPINE COLLEGE OF PHYSICIANS
in cooperation with
PARKE DAVIS - WARNER LAMBERT CO.
announces the
1993 PCP-PARKE DAVIS ANNUAL AWARD OF EXCELLENCE IN RESIDENCY IN INTERNAL MEDICINE (OUTSTANDING RESIDENT IN INTERNAL MEDICINE)

QUALIFICATIONS:
1. Contest is open only to residents currently at the third year level of training in any of the accredited PCP training centers in the country;
2. Candidate must be an Associate Fellow of the PCP;
3. Candidate must have presented or published scientific papers in a research forum or PCP convention;
4. Nomination must be endorsed/certified by the Chairman or Training Officer of the Department of Medicine.

THE AWARD SHALL CONSIST OF:
1. A grant of P20,000 (Twenty Thousand Pesos) to the winning candidate;
2. A grant of P10,000 (Ten Thousand Pesos) to the Department of Medicine where the awardee is training;
3. A plaque of recognition;
4. A one-year subscription to any specialty journal of choice of the awardee.


ALL NOMINATIONS AND SUPPORTING DOCUMENTS MUST BE RECEIVED AT THE PCP SECRETARIAT NOT LATER THAN 28 FEBRUARY 1993

THE PHILIPPINE COLLEGE OF PHYSICIANS
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4. Abstracts and full manuscripts in 6 copies must be submitted;
5. Candidate must be certified/endorsed by the Chief of the subspecialty section and the Chairman/Training Officer of the Department of Medicine.

THE AWARD SHALL CONSIST OF:
1. A grant of P20,000 (Twenty Thousand Pesos) to the winning candidate;
2. A grant of P10,000 (Ten Thousand Pesos) to the specialty section or department of medicine where the awardee is training;
3. A plaque of recognition;
4. A one-year subscription to any specialty journal of choice of the awardee.


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FOR PARTICULARS, CONTACT:
THE PCP SECRETARIAT
Unit 33, Facilities Centre
548 Shaw Boulevard, Mandaluyong, M.M.
Tel Nos. 531-12-04 and 531-12-81