

## Chronic diseases of lifestyle in SA

Chronic diseases of lifestyle (CDL) were responsible for some 206 000 deaths in 2000 – more than half of these people younger than age 65 – and this number is expected to rise to more than 243 000 per year by 2010, according to the Medical Research Council's recent report 'Chronic Diseases of Lifestyle in South Africa: 1995-2005'.

The report says that the majority of the South African population has moved towards a Western lifestyle disease profile and that there are about 6 million South Africans with hypertension, 5 million with high blood cholesterol, 1.5 million with diabetes and more than 7 million smokers.

The rates also differ substantially between population groups, with mortality rates per 100 000 from CDLs ranging from 767 in the white and 769 in the African populations to 867 in the coloured and 1 000 in the Indian populations. However,

little difference was found between the provinces, with the poorer provinces having similar mortality rates to the more developed provinces.

The report finds that in addition to the standard risk factors for chronic diseases (i.e. unhealthy diet, lack of exercise, tobacco use), the degree of urbanisation was found to be an independent predictor of patients having hypertension or diabetes. This is of particular concern, given the high degree of urbanisation in South Africans.

Although smoking rates have decreased in South Africa since the tobacco control legislation and policies have been implemented, hypertension, diabetes and other chronic conditions are poorly diagnosed and controlled. Thus there is the need for proper health care for people with CDLs, particularly at primary care level, in order to diagnose these diseases and their risk factors early and to treat them effectively.

The report also notes that, despite the significant policy developments that have taken place at the national level, the implementation of a national strategy for CDLs has not yet been achieved.

Source: [www.mrc.ac.za](http://www.mrc.ac.za)

## 'Unite for diabetes'

The 'Unite for Diabetes' campaign has been launched by the International Diabetes Federation (IDF), with the aim of highlighting the rise of diabetes worldwide and encouraging governments to support a United Nations (UN) Resolution on diabetes.

New data from the Federation show that more than 230 million people – almost 6% of the world's adult population – now live with diabetes. This number is expected to grow to 350 million in less than 20 years if action is not taken. Diabetes is also increasing faster in the world's developing economies than in developed countries, and by 2025 almost 80% of all diabetes



I  my grandchildren

cases are expected to be in low- and middle-income countries.

According to the World Health Organization, the disease could reduce life expectancy globally for the first time in 200 years.

The IDF believes that reversing the current trend of diabetes is not just a health issue, but requires a whole-of-government approach and the attention of the international community. A UN resolution on diabetes would recognise the global burden of diabetes and focus world attention on the need for immediate action, and thereby prompt decision-makers to take preventive actions against its growing health challenge.

The intention is that the resolution would be secured on or around World Diabetes Day (14 November) in 2007.

Source: [www.idf.org/www.unitedfordiabetes.org](http://www.idf.org/www.unitedfordiabetes.org)

## Call for guidelines for prevention, control of cardiovascular disease

Countries should formulate national and regional guidelines for the prevention and control of cardiovascular disease (CVD) using the principles for clinical guidelines developed by the World Heart Federation (WHF), according to the Federation's three officers, chairman of the Scientific Advisory Board Sidney Smith, chief executive officer Janet Voûte, and president Valentin Fuster.

Writing in *Nature Clinical Practice Cardiovascular Medicine* (September 2006), the WHF officers remind that CVD is the world's biggest killer, responsible for 17.5 million deaths in 2005, according to the World Health Organization, and they say that such guidelines should take account of cultural, social, medical and economic circumstances and reflect national or regional priorities and resources.

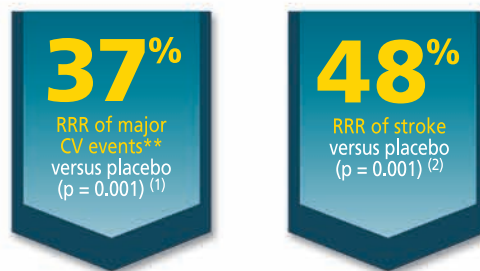
'The health care budget for each nation should reflect a thoughtful determination to assess the specific benefits for primary and secondary prevention programmes based on local epidemiological factors,' the officers say.

The WHF has also been chosen by the World Economic Forum as a key partner on its Workplace Wellness initiative, 'Working Towards Wellness', which is aimed at helping businesses, health experts and policy makers to address and prevent the key risk factors that threaten employee health. The WHF's role is to ensure that chronic diseases, including CVD and stroke, are high on the agenda of the initiative, and the Federation will work closely with international companies to take a hands-on approach on how to establish or expand programmes to improve employee wellness.

Source: [www.worldheart.org](http://www.worldheart.org)

### CARDS\*

Lipitor 10 mg, through its lipid-lowering action, significantly reduced cardiovascular events in type 2 diabetic patients <sup>(1)</sup>



\* 2 838 type 2 diabetic patients randomised to placebo or Lipitor 10 mg daily. Patients had no history of CHD, an LDL-C  $\leq$  4.14 mmol/l and at least one of the following: retinopathy, albuminuria, current smoking or hypertension. Median duration of follow-up was 3.9 years. \*\* Primary endpoint was time to first occurrence of the following: acute CHD events, coronary revascularisation, or stroke

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atorvastatin 10, 20, 40, 80 mg

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References: 1. Colhoun HM, Betteridge DJ, Durrington PN, et al on behalf of the CARDS Investigators. Primary prevention of cardiovascular disease with atorvastatin in type 2 diabetes in the Collaborative Atorvastatin Diabetes Study (CARDS): multicentre randomised placebo-controlled trial. *Lancet* 2004;364:685-696. 2. Lee JD, Morrissey JR, Mikhailidis DP, Patel V. CARDS on the table: should everybody with type 2 diabetes take a statin? *Current Med Res Opin* 2005;21(3):357-361. 54 Lipitor 10, Lipitor 20, Lipitor 40, Lipitor 80 Tablets. Each Lipitor 10, 20, 40 and 80 tablets contains atorvastatin calcium trihydrate, equivalent to 10 mg, 20 mg, 40 mg and 80 mg atorvastatin respectively. Reg. No.: Lipitor 10: 3177.5/0357, Lipitor 20: 3177.5/0358, Lipitor 40: 3177.5/0359, Lipitor 80: 3177.5/0210. **Pharmacological Classification:** A: 7.5 Serum-cholesterol reducers. **Indications:** Lipitor is indicated as an adjunct to diet for reduction of elevated total-cholesterol, LDL-cholesterol, apolipoprotein-B, and triglyceride levels in patients with primary hypercholesterolaemia, mixed dyslipidaemia, and heterozygous familial hypercholesterolaemia. **Contra-indications:** Hypersensitivity to any component of this medication. Active liver disease or unexplained persistent elevations of serum transaminases. Lipitor is contra-indicated in pregnancy, in breast feeding mothers and in women of childbearing potential not using adequate contraceptive measures. An interval of one month should be allowed from stopping Lipitor treatment to conception in the event of planning a pregnancy. Safety and efficacy have not yet been established in children. **Warnings:** **Liver Effects:** Persistent elevations (> 3 times the upper limit of normal (ULN) occurring on 2 or more occasions) in serum transaminases occurred in 0.7% of patients who received atorvastatin in clinical trials. Active liver disease or unexplained persistent transaminase elevations are contra-indications to the use of Lipitor (see **Contra-Indications**). **Skeletal Muscle:** Rhabdomyolysis with or without renal impairment has been reported with the use of HMG-CoA reductase inhibitors. Myalgia has been reported in patients treated with Lipitor (see **Adverse Reactions**). **Dosage:** The patient should be placed on a standard cholesterol-lowering diet before receiving Lipitor and should continue on this diet during treatment with Lipitor. The usual starting dose is 10 mg once a day. Doses should be individualised according to the baseline LDL-C levels, the goal of therapy, and patient response. Adjustment of dosage should only be made after an interval of 4 weeks or more. The maximum recommended dose is 40 mg once a day. The maximum dose for treating patients with homozygous FH is 80 mg. Doses may be given at any time of day with or without food. **Side-Effects and Special Precautions:** The most frequent adverse effects associated with Lipitor therapy, in patients participating in controlled clinical studies were: diarrhoea, constipation, flatulence, dyspepsia, abdominal pain, headache, nausea, myalgia, arthralgia, asthenia, insomnia and rash. The following side-effects have also been reported in clinical trials: muscle cramps, myositis, myopathy, paraesthesia, peripheral neuropathy, pancreatitis, hepatitis, cholestatic jaundice, anorexia, vomiting, alopecia, pruritus, impotence, hyperglycaemia and hypoglycaemia. Allergic reactions have been reported rarely. Lipitor may cause elevation of creatine phosphokinase and dose-related increases in transaminase levels may occur (see **Warnings**). **Licence Holder:** Pfizer Laboratories (Pty) Ltd, Reg No 1954/000781/07, 102 Rivonia Road, Sandton, 2196. Tel (011) 320 6000. Please refer to detailed package insert for full prescribing information. PI REF 06/1997 115/LIP/10/2005/JA