

Singapore Government

PRESS RELEASE

Information Division, Ministry of Culture, City Hall, Singapore 0617 - tel: 328191 ext. 352, 353, 354 / 362207 / 362271

10-1/80/09/22

National Archives and
Records Centre, Singapore.

27 SEP 1980

Acc. No. NARC

80	0024	10
----	------	----

SPEECH BY MINISTER FOR HEALTH, DR TOH CHIN CHYE
AT THE 3RD ASEAN CONGRESS OF CARDIOLOGY OFFICIAL OPENING
AT THE MANDARIN BALLROOM, MANDARIN HOTEL
ON MONDAY, 22 SEPTEMBER '80 AT 6.00 PM

In industrial societies life expectancy has been increased by reducing mortality from infectious diseases. If life expectancy were 50 years we would not be conscious of cancer or CHD mortality rates. When the span of life is now 70 years degenerative diseases or chronic diseases come more and more to the attention of physicians.

In 1979 deaths from all forms of heart diseases accounted for 16 per cent of total mortality in Singapore. From 1969-1979 the mortality ratio for ischaemic heart disease standardised to the age structure of the population increased from 100 to 151 showing a 51 per cent increase in the number of persons who died from CHD. This trend is opposite to the decline in the death rate from ischaemic heart disease in the USA, Canada, Australia, Finland, and Switzerland.

The decline was not world wide. So then what are the reasons for the decline in these countries? Is it due to better patient care and ingenious coronary by-pass operations being performed? Using data obtained from coronary care units and from coronary artery surgery it has been calculated that intensive care in coronary care units can only reduce CHD mortality rates by no more than four to five per cent and coronary surgery by four per cent. This does not explain a decline of 21 per cent in the USA between 1968 and 1976 and 14 per cent in Australia between 1968 and 1975.

Obviously the improvement in CHD mortality rates in these countries is due to more than medical and surgical interventions. Can the reasons for decline in CHD mortality rates be identified?

Epidemiologists are concluding that lifestyles, hypertension, stress, diet and obesity are contributory to the incidence in CHD. If these factors can be regulated then the risk of CHD can be reduced. Cigarette smoking is a lifestyle and there is general consensus that ischaemic heart disease is correlated with cigarette smoking. In the USA 54 per cent adult males smoked in 1964 but only 37 per cent in 1980. It is difficult to lay off the habit until an attack of angina occurs followed by a stern warning from the doctor. Discouraging cigarette smoking as a concerted international public health effort has not been as successfully co-ordinated by WHO as for smallpox since too many vested interests are involved. And of course cigarette smoking has had a very long history since the middle of the 16th century when tobacco was introduced into Europe from the New World by Portuguese and Spanish sailors and subsequently spread to Asia as part of commerce and trade.

In hypertension the danger of a high blood pressure is rupture of the blood vessels that may occur in a vital organ. If it is in the brain it leads to a stroke, if it is in the heart it leads to cardiac failure. The lower the blood pressure the lower is the risk of CHD. Until the complex enzymatic process that leads to hypertension is understood a lowered salt intake and medical treatment are recommended for lowering blood pressure.

Volumes have been written on the effects of stress including Hans Selge's monumental work. Stress induces nervous and hormonal responses which affect the circulation but epidemiologists have been cautious not to venture into an area where stress is not only difficult to measure but means different things to different people and cultures. Inflation and unemployment generate stresses and strains on a whole

society but there is no report of increased heart attacks. Perhaps it reflects the capability of people to adapt to a lower standard of living. It may be that social welfare measures like unemployment benefits have cushioned the effects of stress. On the other hand there are case stories of persons collapsing when faced with severe and sudden emotional stress.

So we come to nutrition and diet. Studies from Framingham in the USA, Oslo and London on population groups whose histories were followed for periods of 16, 10 and seven years respectively suggest a positive correlation between high plasma cholesterol concentrations and deaths from CHD. The hypothesis is that cholesterol favours the formation of plaques in blood vessels and arising out of this hypothesis food lovers are warned to lay off saturated fats and cholesterol. How do you like this as the chef's recommended menu for the day:

Saturated fatty acids	10 per cent
Mono-unsaturated fatty acids	10 per cent
Polyunsaturated fatty acids	10 per cent
Cholesterol	300 mg/day
Total calories	30 per cent

It is a diet for those who wish to live in space but as earthlings most of us prefer our plate of fried rice or char kway teow with an egg thrown in.

Renior and Reubens might have not earned their fame if the women they painted were polyunsaturated. Neither birds nor fish would have hatched out of their eggs if they worried about the cholesterol in the yolk.

Whales and seals float in their own fat but no one knows whether CHD is prevalent among these mammals. Female seals can take cheer in the report that among female human beings there is no significant association between serum cholesterol concentration and mortality from IHD.

The diet-heart theory received a blow when the Food and Nutrition Board of the US National Academy of Sciences reported recently that there was inadequate data to suggest that the risk of heart disease can be reduced by a recommended diet.

The diet hypothesis is controversial but confusion is now added by other studies which suggest that mortality rate from CHD is related to high plasma cholesterol and the risk of dying from cancer to low plasma cholesterol. If this is true can a change in diet be advocated if it reduces the risk of one fatal condition but increases the risk of another.

I would like to borrow an anecdote from the Medical Tribune. This is a story about two friends of Dr Rene Dubos an emeritus professor at Rockefeller University both of them physicians.

"Dr William Henry Welch had a gargantuan appetite with a preference for rich, well-seasoned foods. He loved sweets, wine and liquor. He early became obese but remained intellectually active to the end of his life. He died of cancer in his 85th year.

Dr Oswald T. Avery ate sparingly. Two slices of toast, a few leaves of lettuce and several cups of coffee seemed to be his ideal meal. We used to say that he could be in nutritional balance only by fixing atmospheric nitrogen. He never weighed more than 90 pounds. He died of cancer in his 79th year."

So we have our choices.

#####