Theme: Diet Therapy:
Nutrition Throughout the field of Healthcare

29 November - 2 December 2012
(29 November open for the public)
Hilton Park Hotel
Nicosia - Cyprus

Organized by:

Under the auspices of:

CyDNA is a member of the:

With the participation of:

The scientific programme offers 27 CPE
Τα προβιοτικά βοηθούν στην ισορροπημένη λειτουργία του εντέρου και εξασφαλίζουν καλύτερη απορρόφηση των βιταμινών και των μεταλλών. Διατηρούν την ισορροπία της εντερικής κλιματικής, προφυτεύοντας από τις ενεργείς διαταραχές (διάρροια, δυσκαλούτα, ασπαστική καλήπωδα), μειώνοντας τις τετελεσίες αυξήσεις που συμβάλλουν στην καρκινογένεση, ενισχύοντας την όμως του οργανισμού εναντίον των λοιμώξεων.

Το ΒΙΟΝ3 είναι ένα αποτελεσματικό από τα καυτά πολυβιταμινούς. Η καθημερινή του λήψη διατηρεί την ισορροπία της ενεργεικής κλιματικής και ενισχύει την όμως του οργανισμού.

**ΜΗΝ ΑΦΗΝΕΤΕ ΤΟΥΣ ΕΝΤΟΝΟΥΣ ΡΥΘΜΟΥΣ ΝΑ ΣΑΣ ΚΑΤΑΒΑΛΛΟΥΝ.**
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Message from the Conference Chair, CyDNA President

Dear friends and colleagues,
It is a privilege for us to welcome colleagues and friends to the 7th International Conference «Diet therapy: Nutrition throughout the field of healthcare».

The conference is held under the auspices and support of the Ministry of Health and the Cyprus Registration Board for Food Scientists, Food Technologists and Dietitians. We are very honoured to welcome for the first time the participation and cooperation of the Atherosclerosis Society of Northern Greece as well as the presence of the European Federation of the Associations of Dietitians and the American Academy of Nutrition and Dietetics. Our goal is to ensure the complete success of our upcoming international conference.

The highlight of our Congress is without doubt the scientific program. The CyDNA Scientific Program Committee has devoted substantial time and effort in developing a program which explores new directions in nutrition and dietetics and debates topics with high profile experts from across the world. With submitted papers accepted into the program, stimulating lead sessions, invited plenary talks, interactive workshops, symposia/satellite and sponsored sessions, our conference reflects the diversity, innovation and commitment of our achievements in the dietetics world. We expect from the Conference to provide a greater understanding of how the profession practices all over the world. It is also the perfect opportunity to meet with international and local colleagues. Complementing the scientific program are the workshops, sponsored seminars, food demonstration and the popular trade exhibition.

The conference’s scientific program is scheduled so as to offer multiplicity of subjects in order to emphasize the role of the dietitian in the whole spectrum of health and community and the necessity to be considered an indispensable member of the health care team and the health care providers. Our theme, Diet therapy: Nutrition throughout the field of healthcare leads to Medical Nutrition Therapy (MNT). MNT is an acknowledged term under nutrition terminology. MNT is an essential component of comprehensive health care. Individuals with a variety of conditions and illnesses can improve their health and quality of life by receiving medical nutrition therapy. During an MNT intervention, dietitians counsel clients/patients on behavioural and lifestyle changes required to impact long-term eating habits and health. Medical Nutrition Therapy includes: performing a comprehensive nutrition assessment; determining the nutrition diagnosis; planning and implementing a nutrition intervention using evidence based nutrition practice guidelines; monitoring and evaluating an individual’s progress over subsequent visits with the dietitian.

Therefore the topics presented in the conference have been selected to give a broad and in depth overview of a number of contemporary and traditional topics in dietetics and nutrition. The conference is addressed mainly to dietetic/nutrition professionals but also to physicians, trainees, nurses, dietetic/nutrition students and other health professionals. The conference is very proud to offer 27 CPEUs by the Commission on Dietetic Registration (EA001). The Continuing Professional Education is very valuable and is encouraged by CyDNA through the Continuing Professional Education Units for professional development and reassurance of high level of dietetic/nutrition practice in Cyprus.

Thank you in particular to our speakers and sponsors for their invaluable contribution and support. We trust that the conference delivers an interactive, highly involved and stimulating program, while providing you with the opportunity to network with your professional and industry colleagues. We are looking forward to seeing you at the conference and we hope that you will find it educational, stimulating, with a great opportunity to network with other health professionals.

A conference of this extent would not be possible without the hard work and dedication of our Planning Committees, members’ support and of course our industry partners, supporters, sponsors and exhibitors.

On behalf of the CyDNA 2012 Planning Committee (Organizing and Scientific), we thank you for your participation in the 7th CyDNA International Conference of Dietetics and CyDNA wishes you memorable experiences from this conference.

The 7th CyDNA conference will give you new dynamism and vision into the future of dietetics.

Dr. Eleni P. Andreou, RD, LD
CyDNA Conference Chair, 2012
President of the Cyprus Dietetic & Nutrition Association
Message from the Cyprus Minister of Health, Dr. Androulla Agrotou

«Νους υγιής εν σώματι υγιεί!»

Η σπουδαία αυτή διαπίστωση των Αρχαίων Ελλήνων, χιλιάδες χρόνια πριν, η οποία επιβεβαιώνεται από επιστημονικές έρευνες μέσα από τις οποίες καταδεικνύεται η απόλυτη συσχέτιση του υγιού σώματος με το υγιές μυαλό, έχει δυστυχώς θυσιαστεί στο βωμό του σύγχρονου τρόπου ζωής και των λανθασμένων συνηθειών διατροφής, που έχουν οδηγήσει στην αύξηση των ασθενειών.

Είναι για αυτόν ακριβώς το λόγο που οφείλουμε επιτέλους να αποδώσουμε την πρέπουσα προσοχή στο θέμα της ορθής διατροφής και της υγείας μέσω της πρόληψης.

Η ορθή διατροφή αποτελεί έναν από τους πιο βασικούς παράγοντες που συμβάλλουν στη διατήρηση της υγείας του ανθρώπου, στην πρόληψη και αντιμετώπιση ασθενειών.

Το Υπουργείο Υγείας αναγνωρίζοντας τη σημασία που έχει η ορθή διατροφή στη ζωή μας, θεωρεί υποχρέωσή του να αγγίζει το θέμα της διατροφής με τέτοιο τρόπο που να ευαισθητοποιεί τον κάθε πολίτη, σύμφωνα με την ηθική και την ευελιξία της εποχής σε ευρύτερο σκοπό καθιστώντας την διατροφή συνηθισμένο σταθερό στο μέλλον.

Αυτή η προσπάθεια ωστόσο, για να είναι επιτυχημένη, πρέπει να έχει άξιος συμπαραστάτη οποιοσδήποτε ονειρεμένοι σκοποί, και να έχει έναν ισχυρό συνδυασμό της επιθυμίας και της πραγματικότητας.

Αυτή η προσπάθεια ωστόσο, για να είναι δυνατό να επιτευχθεί, πρέπει να έχει έναν αξιόπιστο και συνεχίζοντας να έχει έναν αξιόπιστο συνδυασμό της επιθυμίας και της πραγματικότητας.

Χαιρετίζω λοιπόν τις εργασίες του 7ου Συνεδρίου Διαιτολογίας, το οποίο καταπιάνεται με το θέμα της ορθής διατροφής σε όλες τις πτυχές της επικοινωνίας, ισχυρίζομαι για τον προβληματισμό της ανθρώπινης ύπαρξης και της συνειδητοποίησής της του προσωπικού υγειονομικού χώρου.

Σας εύχομαι κάθε επιτυχία.

Dr Antroulla Agrotou
Cyprus Minister of Health
2012
Theme: «Diet Therapy: Nutrition Throughout the field of Healthcare».

Sessions of the Conference

- Cardiovascular disease
- Gastrointestinal and hepatic disorders
- Announcements
- Weight management and metabolic diseases
- Professional development and education
- Cancer
- Evidence Based Practice
- Workshop
Conference Committee

Andreou Eleni  Chair
Philippou Christiana  Treasurer
Chappa Georgia
Constandinidou Nicoletta
Economou Mary
Kakouri Stella
Kalli Procopis
Ntorzi Nikoletta
Pahita Anna
Piki Vasiliki
Tsokkou Panayiota
Vassilopoulou Emilia

Scientific Committee

Andreou Eleni  Efthimiadis Apostolos
Philippou Christiana  Hassapidou Maria
Chappa Georgia
Kalli Procopis

Financial Committee

Andreou Eleni
Philippou Christiana
Chappa Georgia
Kalli Procopis

CyDNA Board

Dr Andreou Eleni  President
Dr Philippou Christiana  Vice President
Michaelidou Polly  Secretary
Kalli Procopis  Treasurer
Dr Philippou Elena  Assistant Secretary
Georgiou Kyriacos  Member
Tsokkou Panayiota  Member

• CyDNA is a member of EFAD and ICDA

Conference Secretariat

TOP KINISIS

Tel.: +357 22713780 - Fax: +357 22869744
E-mail: synedrio@topkinisis.com
2 Leonidou & Acropoleos Ave., 2007 Strovolos
Nicosia - Cyprus

Conference Website
www.cydadiet.org
Cyprus Dietetic and Nutrition Association

Background

History
1991- “Cyprus Association of Food Scientists/ Technologists and Dietitians “Food Scientists, Food Technologists and Dietitians were grouped together due to the small number of the professionals of the different specialisation’s working in Cyprus at that time. “Food” and its relation to the different professions, and the need to be established as professionals in Cyprus brought them together.

1996 - Submission for approval and approval of “the Law for Registration of Dietitians, Food Technologists/Scientists in Cyprus [N31(I)/96]” by Cyprus House of Representatives.

The Ministry of Health appoints the Registration Board for Food Scientists/Technologists and Dietitians in Cyprus every three years where all the dietitians are required to be registered according to the Cyprus law (N31(I)/96).

3 April 1999 - “Cyprus Dietetic Association” became an autonomous association and split from the previous association due to the large number of members of the different disciplines in Cyprus and the realisation of the different educational and professional goals.

2003 CyDA became member of the EFAD/ ICDA

17 January 2007- Change of the name of the association to “Cyprus Dietetic and Nutrition Association”

CyDNA members: 200 active members, 24 students, 5 subscribers, 1 honorary.

Goals
• Promotion, education and protection of the public health and prevention of certain diseases through sound nutritional habits promotion of the profession of dietetics in the hospital/clinical setting, industry, education, media, agriculture, research and private sector.
• Promotion of high educational standards for the science and practice of dietetics in order to protect the profession of dietetics.
• Establishment of the association as the only Professional Body in Cyprus for Dietitians / Clinical Dietitians / Nutritionists.
• Enforcement of and obedience to the Laws/Bylaws and the Code of Ethics.
• Acknowledgement of CyDNA by other International Dietetic Associations and / or Medical Associations.
• International Networking.

MISSION: Guidance, empowerment and reinforcement of the dietetic and nutrition professionals in Cyprus

VISION: The members of CyDNA are the most reliable and valid scientists in the subjects of diet and nutrition

VALUES:
- Members
- Cooperation
- Diversity
- Leadership
- Code of Ethics/ Integrity
- Education
- Social & Cultural Responsibility
Sponsors

Gold

Lanitis

Member of Coca-Cola Hellenic Group

Classic

LifePharma

Supporters

Kypropharm Ltd

ProVital

Pro-activ

Holland & Barrett

Biosearch

Cyta

Nestlé Nutrition

PBORG

Pharmavet Ltd

M.A. PeakPerformance1 Ltd

George Petrou Ltd

FormulaLine L112

Science Technologies

PapaFiliopoulos Ice Cream

Mazi

University of Nicosia

G & P Melas

Squeeze Juice Bars
General Conference Information

Information & Registration Desk
All participants must register. A Registration Desk will be operating throughout the duration of the conference. The Registration Desk will also be operating as an Information Desk for any information or assistance participants may require during the conference. All conference documents will be included in your bags. The badge of each participant gives access to all sessions, exhibition and coffee breaks.

Registration Fees
Registration Fees include attendance to all sessions, entrance to the exhibition area, coffee breaks, conference material and certificate of attendance.

Exhibition Area
An exhibition will be running throughout the duration of the conference in LEDRA B.

Language
The official language of the conference is English.

Cyprus Night: Is igia- “εις υγεία” - To your health!
The Cyprus Night will take place at Ayia Anna Traditional Tavern on Friday, 30th of November 2012 at 21:00. Vouchers for the Cyprus Night can be purchased from the Registration Desk at the price of €42.

Gala Dinner
The Gala Dinner will take place at the Hilton Park Hotel on Saturday, 1st of December 2012, at 20:30. Vouchers for the Gala Dinner can be purchased from the Registration Desk at the price of €50.
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<th>A/A</th>
<th>Speaker</th>
<th>Country</th>
<th>E-mail</th>
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<tbody>
<tr>
<td>1</td>
<td>Agathangelou Petros, MD Cardiology, President of the Cyprus Society of Cardiology</td>
<td>Cyprus</td>
<td><a href="mailto:paga@cytanet.com.cy">paga@cytanet.com.cy</a></td>
</tr>
<tr>
<td>2</td>
<td>Andreou Eleni, RD, LD, DProf (Clinical Dietitian, President of the Cyprus Dietetic &amp; Nutrition Association, Assistant Professor University of Nicosia)</td>
<td>Cyprus</td>
<td><a href="mailto:aeleni@spidernet.com.cy">aeleni@spidernet.com.cy</a></td>
</tr>
<tr>
<td>3</td>
<td>Antoniou Pavlos, MD (Gastroenterologist - Hepatologist)</td>
<td>Cyprus</td>
<td><a href="mailto:p.antoniou@hippocrateon.com">p.antoniou@hippocrateon.com</a></td>
</tr>
<tr>
<td>4</td>
<td>Avraamides Panayiotis, BSc (Hons), MB BS (Lond), FRCP(Lond), FRCP(Edin), MRCP, FESC, (Director, Cardiology Department, Limassol General Hospital)</td>
<td>Cyprus</td>
<td><a href="mailto:panicos@cytanet.com.cy">panicos@cytanet.com.cy</a></td>
</tr>
<tr>
<td>5</td>
<td>De Looy Anne, BSc (Hons) PhD PGDipDiet RD FBDA, (Professor of Dietetics, University of Plymouth)</td>
<td>United Kingdom</td>
<td><a href="mailto:adeloo@plymouth.ac.uk">adeloo@plymouth.ac.uk</a></td>
</tr>
<tr>
<td>6</td>
<td>Efthimiadis Apostolos, (Professor of Cardiology, Aristotle University of Thessaloniki)</td>
<td>Greece</td>
<td><a href="mailto:a_efthimiadis@hotmail.com">a_efthimiadis@hotmail.com</a></td>
</tr>
<tr>
<td>7</td>
<td>Escott – Stump Sylvia, MA, RD, LDN (Director, Dietetic Internship, East Carolina University)</td>
<td>United States of America</td>
<td><a href="mailto:escottstumps@ecu.edu">escottstumps@ecu.edu</a></td>
</tr>
<tr>
<td>8</td>
<td>Hassapidou Maria, Professor of Nutrition and Dietetics, Department of Nutrition and Dietetics, Alexander Technological Educational Institute, Thessaloniki, Greece</td>
<td>Greece</td>
<td><a href="mailto:mnhas@nutr.teithe.gr">mnhas@nutr.teithe.gr</a></td>
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<tr>
<td>9</td>
<td>Heracleides Alexandros, BSc (Hons), MSc, MSc, PhD (Lecturer in Nutrition, Epidemiology and Biostatistics at the University of Nicosia)</td>
<td>Cyprus</td>
<td><a href="mailto:heraclides.a@unic.ac.cy">heraclides.a@unic.ac.cy</a></td>
</tr>
<tr>
<td>10</td>
<td>Ioannou Elina, BSc, MSc, RD Clinical Dietitian, Cyprus Ministry of Health</td>
<td>Cyprus</td>
<td><a href="mailto:ioannou_elina@hotmail.com">ioannou_elina@hotmail.com</a></td>
</tr>
<tr>
<td>11</td>
<td>Kakouri Ioannou Eleni, BSc, Ph.D. Chief Chemist, Head of Quality Assurance and Risk Assessment Units of the State General Laboratory (SGL) of Cyprus</td>
<td>Cyprus</td>
<td><a href="mailto:ekakouri@sgl.moh.gov.cy">ekakouri@sgl.moh.gov.cy</a></td>
</tr>
<tr>
<td>12</td>
<td>Kountouri Stalo, CPD, RD Clinical Dietitian, General Hospital of Famagusta</td>
<td>Cyprus</td>
<td><a href="mailto:kstalord@gmail.com">kstalord@gmail.com</a></td>
</tr>
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<td>13</td>
<td>Kyprianou Theodoros, MD, PhD, EDIC Head, Multidisciplinary Intensive Care Unit, Nicosia General Hospital</td>
<td>Cyprus</td>
<td><a href="mailto:drtheo@cytanet.com.cy">drtheo@cytanet.com.cy</a></td>
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<td>14</td>
<td>Kyriakidou Stella, Psychologist, Member of the Parliament</td>
<td>Cyprus</td>
<td><a href="mailto:skyriakidou@parliament.cy">skyriakidou@parliament.cy</a></td>
</tr>
<tr>
<td>15</td>
<td>Kyriakidou Evi, BSc, MSc, RD Nutrition Support Dietitian, Barts Health NHS Trust</td>
<td>Cyprus/United Kingdom</td>
<td><a href="mailto:evi.kyriakidou@bartshealth.nhs.uk">evi.kyriakidou@bartshealth.nhs.uk</a></td>
</tr>
<tr>
<td>16</td>
<td>Lappa Fotini, BSc (Hons), MSc Dietician – Nutritionist with specialization in Sports Nutrition, Lecturer in Nutrition (Intercollege and the University of Nicosia)</td>
<td>Cyprus</td>
<td><a href="mailto:lappa.f@unic.ac.cy">lappa.f@unic.ac.cy</a></td>
</tr>
<tr>
<td>17</td>
<td>Loizou Despo, BSc (Hons), SRD Clinical Dietitian, Nutritionist, Home Economics Counselor and Teacher</td>
<td>Cyprus</td>
<td><a href="mailto:loizougd@cabelnet.com.cy">loizougd@cabelnet.com.cy</a></td>
</tr>
<tr>
<td>18</td>
<td>Madden Angela, PhD, RD Professional Lead for Dietetics University of Hertfordshire’s</td>
<td>United Kingdom</td>
<td><a href="mailto:a.madden@herts.ac.uk">a.madden@herts.ac.uk</a></td>
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<tr>
<td>19</td>
<td>McClinchy Jane, MSc by Research, Registered Dietitian, Fellow of the Higher Education Academy</td>
<td>United Kingdom</td>
<td><a href="mailto:j.1.mcclinchy@herts.ac.uk">j.1.mcclinchy@herts.ac.uk</a></td>
</tr>
<tr>
<td>20</td>
<td>Papandreou Dimitris, PhD, M.S., M.Ed., R.D Assistant Professor of Nutrition, Department of Life and Health Sciences</td>
<td>Cyprus</td>
<td><a href="mailto:papandreoudimitrios@yahoo.gr">papandreoudimitrios@yahoo.gr</a></td>
</tr>
<tr>
<td>21</td>
<td>Papamichael Demetres, MB BS FRCP (Director, Dept., of Medical Oncology)</td>
<td>Cyprus</td>
<td><a href="mailto:demetris.papamichael@bococ.org.cy">demetris.papamichael@bococ.org.cy</a></td>
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<td>22</td>
<td>Papadopoulou Katerina (President of ACHDAC Adult Congenital Heart Defects Association Cyprus)</td>
<td>Cyprus</td>
<td><a href="mailto:info@achdac.org">info@achdac.org</a></td>
</tr>
<tr>
<td>23</td>
<td>Papadopoulou Nicoleta, MS, RD, CDN (Clinical Dietitian)</td>
<td>Cyprus</td>
<td><a href="mailto:nicoletapapadopoulou@gmail.com">nicoletapapadopoulou@gmail.com</a></td>
</tr>
<tr>
<td>24</td>
<td>Pavlidou Sofia, MD (Scientific Collaborator, Aristotle University of Thessaloniki, Secretary of Atherosclerosis Society of Northern Greece)</td>
<td>Greece</td>
<td><a href="mailto:sofiabmp@yahoo.gr">sofiabmp@yahoo.gr</a></td>
</tr>
<tr>
<td>25</td>
<td>Philippou Charidemou Christiana, RD, DProf (Vice President of CyDNA, Clinical Dietitian and sports nutritionist)</td>
<td>Cyprus</td>
<td><a href="mailto:evelina@cytanet.com.cy">evelina@cytanet.com.cy</a></td>
</tr>
<tr>
<td>26</td>
<td>Philpot Ursula, BSc (hons) , MSc, PGCHE, RD, (Chair of the British Dietetic Association’s Mental Health Group Advanced Practice Dietitian and Senior Lecturer- Eating disorders)</td>
<td>United Kingdom</td>
<td><a href="mailto:u.philpot@leedsmet.ac.uk">u.philpot@leedsmet.ac.uk</a></td>
</tr>
<tr>
<td>27</td>
<td>Risvas Grigoris, PhD (Dietician – Public Health Nutritionist)</td>
<td>Greece</td>
<td><a href="mailto:grisvas@nutrimed.gr">grisvas@nutrimed.gr</a></td>
</tr>
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<td>28</td>
<td>Sanders Tom, BSC, PhD, DSc, RPHNutr, (Professor of Nutrition &amp; Dietetics, King’s College London)</td>
<td>United Kingdom</td>
<td><a href="mailto:tom.sanders@kcl.ac.uk">tom.sanders@kcl.ac.uk</a></td>
</tr>
<tr>
<td>29</td>
<td>Wakil Elie, DIPLOME D’ETAT FRANCAIS DE DOCTEUR EN PHARMACIE / “Human Relations” Specialist</td>
<td>Cyprus</td>
<td><a href="mailto:info@ewhumandev.com">info@ewhumandev.com</a></td>
</tr>
<tr>
<td>30</td>
<td>Yamasaki – Patrikiou Edna, MD, MSc, PhD (Head, Department of Life and Health Sciences, University of Nicosia / Associate Professor, University of Nicosia)</td>
<td>Cyprus</td>
<td><a href="mailto:Yamasaki.e@unic.ac.cy">Yamasaki.e@unic.ac.cy</a></td>
</tr>
<tr>
<td>31</td>
<td>Yiakoumi Ioannis, BSc, MSc Lecture, Intercollege</td>
<td>Cyprus</td>
<td><a href="mailto:ylakoumi.i@unic.ac.cy">ylakoumi.i@unic.ac.cy</a></td>
</tr>
<tr>
<td>32</td>
<td>Zampelas Antonis, BsC, Msc, PhD, (Professor in Human Nutrition, University of Athens)</td>
<td>Greece</td>
<td><a href="mailto:azampelas@aua.gr">azampelas@aua.gr</a></td>
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## Programme at a Glance

<table>
<thead>
<tr>
<th>Time</th>
<th>Thursday, 29 November 2012</th>
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<tbody>
<tr>
<td>18:00 - 18:30</td>
<td>Registrations</td>
</tr>
<tr>
<td>18:30 - 20:30</td>
<td>Panel open for the public (session in Greek)</td>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Friday, 30 November 2012</th>
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<tbody>
<tr>
<td>07:15 - 08:00</td>
<td>Registrations</td>
</tr>
<tr>
<td>08:00 - 09:00</td>
<td>Session 1: Cardiovascular disease</td>
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<tr>
<td>09:00 - 10:00</td>
<td>Panel 1: Mediterranean diet and cardiovascular disease</td>
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<tr>
<td>10:00 - 10:30</td>
<td>Special Event: Nutrigenomics and genetics and nutrition</td>
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<td>10:30 - 11:30</td>
<td>Opening Ceremony / Opening of the exhibition</td>
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<td>11:30 - 12:00</td>
<td>Coffee Break</td>
</tr>
<tr>
<td>12:00 - 13:00</td>
<td>Keynote Speech: Integrated dietary intervention to reduce risk of cardiovascular disease</td>
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<td>Keynote Speech: Impact of the amount &amp; composition of dietary fat and carbohydrate on metabolic syndrome &amp; cardiovascular disease risk</td>
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<tr>
<td>15:15 - 16:15</td>
<td>Session 2: Gastrointestinal and hepatic disorders</td>
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<td>Coffee Break</td>
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<td>Keynote Speech: Medical Nutrition Therapy: Standardized language – making it international</td>
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<tr>
<td>17:30 - 19:00</td>
<td>Panel 3: Gastrointestinal Disorders and Nutrition</td>
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<tr>
<td>21:00</td>
<td>Cyprus Night: Is igia- “εις υγεία” - To your health!</td>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Saturday, 1 December 2012</th>
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<tbody>
<tr>
<td>08:00 - 08:30</td>
<td>Registrations</td>
</tr>
<tr>
<td>08:30 - 09:30</td>
<td>Session 3: Announcements (Oral Presentations-OP, Poster Presentations-PP)</td>
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<tr>
<td>09:30 - 10:00</td>
<td>Coffee Break</td>
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<tr>
<td>10:00 - 12:00</td>
<td>Session 4: Weight management and metabolic diseases</td>
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<tr>
<td>12:00 - 13:00</td>
<td>Satellite Symposium by Lanitis</td>
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<tr>
<td>13:30 - 14:30</td>
<td>Lunch</td>
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<tr>
<td>14:30 - 15:30</td>
<td>Session 5: Professional development and education</td>
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<tr>
<td>15:30 - 16:30</td>
<td>Panel 4: Professional development and education</td>
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<td>16:30 - 17:00</td>
<td>Coffee Break</td>
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<td>20:30</td>
<td>Gala Dinner</td>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Sunday, 2 December 2012</th>
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<tbody>
<tr>
<td>08:00</td>
<td>Registrations</td>
</tr>
<tr>
<td>08:00 - 09:15</td>
<td>Session 7: Evidence Based Practice</td>
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<tr>
<td>09:15 - 10:30</td>
<td>Panel 6: Novelties in Nutrition</td>
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<tr>
<td>10:30 - 11:30</td>
<td>Session 4: (continues) Weight management and metabolic diseases</td>
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<tr>
<td>11:30 - 12:00</td>
<td>Coffee Break &amp; sandwich</td>
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<tr>
<td>12:00 - 13:00</td>
<td>Session 6: (continues) Cancer</td>
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<tr>
<td>13:00 - 15:00</td>
<td>Panel 8: Cancer. Myths and realities</td>
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<tr>
<td>15:00 - 15:15</td>
<td>Closing Ceremony</td>
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</tbody>
</table>
Theme: ‘Diet Therapy: Nutrition Throughout the field of healthcare’

**Sessions:**
- Cardiovascular disease
- Gastrointestinal and hepatic disorders
- Announcements
- Weight management and metabolic diseases
- Professional development and education
- Cancer
- Evidence Based Practice
- Workshop

**Scientific Programme**

Thursday, 29 November 2012 (open for the public)

18:00 - 18:30

Registrations

18:30 - 20:30

**Panel open for the public (session in Greek)**

**Η διατροφή του Κυπρίου και η σχέση της με την πρόληψη των καρδιοπαθειών, Δρ Ελένη Ανδρέου, RD**

(The Cypriot diet and its relation to the prevention of heart disease, Dr. Eleni Andreou)

**Mύθοι και αλήθειες σχετικά με τη διατροφή. Τι πραγματικά ωφελεί την καρδιά μας; Δρ Σοφία Παυλίδου**

(Myths and truths about nutrition. What really is good for our heart? Dr. Sofia Pavlidou)

**Μεσογειακή δίαιτα και καρδιαγγειακά νοσήματα, Δρ Μαρία Χασαπίδου**

(Mediterranean diet and cardiovascular disease, Dr. Maria Hassapidou)

**Καρδιοπάθεια - τρόπος ζωής για το άτομο με καρδιοπάθειες, η φωνή του ασθενή, Κατερίνα Παπαδοπούλου**

(Heart disease - lifestyle for the person with heart disease, the voice of the patient, Katerina Papadopoulou)

**Χαιρετισμός από τον Πρόεδρο της Καρδιολογικής Εταιρείας, Δρ Πέτρο Αγαθάγγελου**

(Address by the President of the Cardiology Society, Dr. Petros Agathangelou)

Moderator: Nikoletta Ntorzi  
Sponsored by: Becel pro.activ.

Friday, 30 November 2012

07:15 - 08:00

Registrations

**SESSION 1: Cardiovascular disease**

8:00 - 9:00

**Panel 1: Mediterranean diet and cardiovascular disease**

Mediterranean diet and effect on cardiovascular disease, Dr Panicos Avraamides, MD

The latest on ω-3 fatty acids: from cardiovascular diseases to mood disorders, Prof Antonis Zampelas

Moderator: Eleni Andreou  
CPE level: I  CPE credit: 1

09:00 - 10:00

**Panel 2: Eat well, love better, move more: treatment of cardiometabolic syndrome**

Role of nutrition and exercise in the treatment of metabolic syndrome, Nicoleta Papadopoulou, RD

Cardiometabolic risk factors, Dr Apostolos Efthimiadis, MD

Moderator: Christiana Philippou  
CPE level: II  CPE credit: 1
10:00 - 10:30  
**Special Event: Nutrigenomics and genetics and nutrition**
Nutrigenetics and nutrigenomics: Scientific breakthrough, but what is the benefit for public health nutrition and everyday dietetic practice? *Dr Alexandros Heraclides*
Moderator: Emilia Vassilopoulou  
CPE level: I  
CPE credit: ½

10:30 - 11:30  
**Opening Ceremony / Opening of the exhibition:**
*Addresses by*
President of Cyprus Dietetic and Nutrition Association, *Dr Eleni P. Andreou*
President of Cyprus Registration Board for Food Scientists, Food Technologists and Dietitians, *Dr Phroso Hadjilouca*
President of Atherosclerosis Society of Northern Greece, *Dr Apostolos Efthimiadis*
President of European Federation of the Associations of Dietitians, *Prof Anne de Looy*
President of Academy of Nutrition and Dietetics, *Sylvia Escott Stump*
Cyprus Minister of Health, *Dr Androulla Agrotou*
Moderator: Nikoletta Ntorzi  
CPE level: III  
CPE credit: 1

11:30-12:00  
Coffee Break

12:00 - 13:00  
**Keynote speaker: Prof Tom Sanders**
Integrated dietary intervention to reduce risk of cardiovascular disease
Moderator: Georgia Chappa  
CPE level: III  
CPE credit: 1

13:00 - 14:15 Lunch

14:15 - 15:15  
**Impact of the amount & composition of dietary fat and carbohydrate on metabolic syndrome & cardiovascular disease risk, Prof Tom Sanders**
Moderator: Georgia Chappa  
CPE level: II  
CPE credit: 1

**SESSION 2: Gastrointestinal and hepatic disorders**

15:15 - 16:15  
**Satellite Symposium by Alkis M. Hadjikyriacos (Frou Frou Biscuits) Public Ltd:**
Culinary demonstration
Fiber: small changes, big difference, *Ioannis Yiakoumis*, chef & *Fotini Lappa*
Moderator: Eleni Andreou  
CPE level: III  
CPE credit: 1

16:15 - 16:30  
Coffee Break

16:30 - 17:30  
**Keynote speaker: Sylvia Escott Stump, RD,LDN**
Medical Nutrition Therapy: Standardized language – making it international
Moderator: Eleni Andreou  
CPE level: II  
CPE credit: 1

17:30 - 19:00  
**Panel 3: Gastrointestinal Disorders and Nutrition**
Celiac disease toolkit: Guiding your patients to a global treatment, *Dr Pavlos Antoniou, MD*
Dysphagia Nutrition Management, *Sylvia Escott Stump, RD,LDN*
New directions in lactose intolerance: moving from science to solutions, *Dr Dimitris Papandreou*
Moderator: Eleni Andreou  
CPE level: II  
CPE credit: 1 ½

21:00  
**Cyprus Night: Is igia- “εις υγεία” - To your health!**
Sessions:

**SESSION 3: Announcements (Oral Presentations-OP, Poster Presentations-PP)**

8:30 - 9:30

**Poster Session / Announcements/ Oral Presentations**

**OP01**

**FTO GENE AND BODY MASS INDEX IN YOUNG EUROPEAN CHILDREN: DO PHYSICAL ACTIVITY LEVELS INFLUENCE THE EFFECT OF THE RISK GENOTYPE?**

*Anna Christina Koni, Guan Wan1, Mark Baile1, Robert Scott, Licia Iacoviello, Alfonso Siani, Paola Russo, Fabio Lauria, Michael Tornaritis, Charalambos Hadjigeorgiou, Toomas Veidebaum, Kenn Konstabel, Staffan Marild, Gabriele Eiben, Luis Moreno, Jose Casajus, Wolfgang Ahrens, Karin Bammann, Eva Kovacs, Denes Molnar, Stefaan De Henauw, Krishna Vyncke, Yannis Pitsiladis, FACSM; on behalf of the IDEFICS Consortium.*

**OP02**

**IMPACT OF BREAKFAST CONSUMPTION ON DIET QUALITY AND HEALTH OUTCOMES IN CYPRIOIT CHILDREN**

*Papoutsou S, Briassoulis G, Chadgigeorgiou Ch, Savva SC, Solea T, Hebestreit A, Pala V, Sieri S, Kourides Y, Kafatos A & Tornaritis M*

**OP03**

**A NATIONAL STUDY OF THE DIETARY INTAKE OF CYPRIOIT CHILDREN AND ADOLESCENTS AGED 6-18 YEARS AND THE EFFECT OF MOTHER’S EDUCATIONAL STATUS AND CHILDREN’S WEIGHT STATUS ON ADHERENCE TO NUTRITIONAL RECOMMENDATIONS**

*E Philippou, MJ Tornaritis, C Hadjigeorgiou, YA Kourides, A Panayi and SC Savva*

**OP04**

**A PIONEER NUTRACEUTICAL FORMULA (PLP10) FOR THE TREATMENT OF RELAPSING REMATING MULTIBLE SCLEROSIS: A RANDOMIZED, DOUBLE BLIND PLACEBO-CONTROLLED PROOF-OF-CONCEPT CLINICAL TRIAL**

*Ioannis S. Patrikios, George N. Loukaides, Evangelia E. Ntzani & Marios C. Pantzaris*

**OP05**

**EFFECTS OF AN INTERVENTION AND MAINTENANCE WEIGHT LOSS DIET WITH AND WITHOUT EXERCISE ON ANTHROPOMETRIC INDICES IN OVERWEIGHT AND OBESE HEALTHY WOMEN.**

*Andreu E, Philippou C, Papandreou D.*

**OP06**

**EXPANSION OF CYPRUS FOOD COMPOSITION TABLES**

*S Yiannopoulos, M. Christodoulidou, K.Kontoghorghe, E. Kakouri and P. Kanari*

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**9:30 - 10:00 Coffee Break**

**SESSION 4: Weight management and metabolic diseases**

10:00-12:00

**Eating disorders workshop: Anorexia & Bulimia, Ursula Philpot, RD**

Moderator: Panayiota Tsokkou

CPE level: II  CPE credit: 2

12:00 - 13:00

**Satellite Symposium by Lanitis: Nutrition Policies for Obesity Prevention, Prof Antonis Zampelas**

Moderator: Nicoletta Constandinidou

CPE level: II  CPE credit: 1

**13:00-14:30 Lunch**
SESSION 5: Professional development and education

14:30 - 15:30  Importance and value of being assertive, *Dr Elie Wakil* (open discussion)
Moderator: Anna Pahita  CPE level: II  CPE credit: 1

15:30 - 16:30  **Panel 4: Professional development and education**
Food - A-Pedia, *Despo Loizou, RD*

The Role of the Multidisciplinary team in giving nutritional advice, *Jane McClinchy, RD*
Moderator: Christiana Philippou  CPE level: I  CPE credit: 1

16:30 - 17:00  **Coffee Break**

17:00 - 18:00  Engaging Current and Future Practitioners to Apply Ethical Actions in Practice
Speakers: *Prof Anne de Looy, RD*
Moderator: Stella Kakouri  CPE level: III  CPE credit: 1

SESSION 6: Cancer

18:00 - 19:00  **Panel 5: The state of the science: evidence to support diet and physical activity recommendations for cancer prevention**
Bowel cancer and treatment, *Dr Demetres Papamichael, MD*

Bowel cancer and nutrition intervention, *Stalo Kountouri, RD, CPD*
Moderator: Nikoleta Ntorzi  CPE level: I  CPE credit: 1

20:30 Gala Dinner

SESSION 7: Evidence Based Practice

08:00 - 09:15  **Panel 6: Novelties in Nutrition**
Labeling of foodstuffs, nutrition and health claims - an EU perspective, *Dr Eleni Ioannou-Kakouri*

Caffeine and Cognitive Function, *Dr Edna Yamasaki, MD*

Non-alcoholic fatty liver disease / NASH, *Dr Angela Madden, RD*
Moderator: Panayiota Tsokkou  CPE level: II  CPE credit: 1 ¼

09:15 - 10:30  **Panel 7: Bridging the Guideline–Practice Gap: The Critical Care Experience**
The critical care experience in ICU, *Dr Theodoros Kyprianou, MD*

Nutrition in critical illness: from theory to daily practice, *Elina Ioannou, RD*

Nutrition and Trauma (presentation of case studies), *Evi Kyriakidou RD*
Moderator: Mary Economou  CPE level: II  CPE credit: 1 ¼

SESSION 4: (continues) Weight management and metabolic diseases

10:30 - 11:30  Nutritional screening using MUST -workshop/interactive presentation
*Dr Angela Madden, RD*
Moderator: Nicoletta Constandinidou  CPE level: II  CPE credit: 1

11:30 - 12:00  **Coffee Break and Sandwich**
SESSION 6: (continues) Cancer

12:00 - 13:00  
**Panel 8: Cancer: Myths and realities**
Myths and realities about cancer –the psychology’s aspect, *Stella Kyriakidou*

Myths and realities about cancer –the nutrition aspect, *Dr Christiana Philippou, RD*
Moderator: Vasiliki Piki  
CPE level: II  
CPE credit: 1

SESSION 8: Workshop

13:00 - 15:00  
Workshop: Nutrition Care Process, *Jane McClinchy, RD*
Moderator: Eleni Andreou  
CPE level: II  
CPE credit: 2

15:00 - 15:15  
**Closing ceremony**
Exhibition CPE credit: 1
Poster CPE credit: 1

**Total CPE: 27**
Perfectly Pure, Purely Perfect!

We proudly make our gourmet ice cream the old fashioned, traditional way, using fresh whole milk, fresh dairy cream and the finest, all natural flavouring ingredients from around the world.

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Now, Get All the Taste but None of the Lactose! 100% Lactose-Free so it’s easier to digest.
Abstracts

- The information presented is according to those given by the authors
- Objectives presented for CPE purposes
Abstract Title

Η διατροφή του Κυπρίου και η σχέση της με την πρόληψη των καρδιοπαθειών
("The Cyprus diet and its relation to the prevention of heart disease")
(Part of panel Open for the Public – session in Greek)

Objectives

1. To evaluate the obesity prevalence and dietary/nutritional practices and habits in adult population in Cyprus.
2. To present the correlation between nutritional habits of Cypriot adults, level of physical activity and biochemical indicators (ie, blood sugar, cholesterol, triglycerides, HDL, LDL levels).
3. To present Nutritional Guidelines for the Cypriot Population.

Learning Outcome Assessment: Participant evaluation of program

Description (Focus Statement)

This presentation for the public is an overview of the epidemiological study of obesity and the determination of the nutritional habits of the Cypriots adults performed by the Cyprus Dietetic and Nutrition Association for the years 2005-2009. The study is showing the epidemic problem of overweight and obesity in Cyprus and the current relation of the nutritional habits of Cypriots with the Mediterranean diet.

Abstract

Many studies have been done for the past and evolution of the Cypriots nutritional habits through the centuries. Dietary habits or changes give evidence for the environment, the status of civilization and the cultural morals of people. Taking into account that “Mediterranean diet” is considered to be the “ideal” diet, it would be very interesting to present the nutritional habits of our ancestors in Cyprus, during the prehistoric times.

In the epidemiological cross-sectional study of Cyprus Dietetic and Nutrition Association, 1001 Cypriot adults of the ages 18-80y participated and were investigated in the study conducted between 2005-2009. The samples were selected randomly with a stratified method and with the range of 51.5% females and 48.5% males. They were interviewed with the use of a self-developed validated questionnaire (physical activity, health condition, medical history, nutritional habits) that included a quantitative food frequency questionnaire and a three-day dietary recall. Specific features of lifestyle patterns and nutritional habits, anthropometric indices (weight, waist circumference, body fat analysis with the use of Bioelectrical Impedance Analysis-BIA, Body Mass Index-BMI) and biochemical indices (FBC, homocysteine, Insulin, Glucose, Fat lipid profile, Uric Acid, Urea, Creatinine, Liver Enzymes, Iron, Phosphorus, Magnesium, CRP, Ferritin) were evaluated.

The study was critically reviewed and given approval by the Cyprus Bioethics Committee. The results presented are the final and they are derived from the representative sample of 1001 subjects for which a full statistical analysis was carried out. The combined percentage of Obese and Overweight people in the Cypriot population is 75.7% for men and 52.9% for women. The percentage of overweight people in Cyprus is 36% and the percentage of obese persons is 27.8%. The correlation between the BMI level and the various percentages of the weight classification for both men and women is shown in Table 1.

<table>
<thead>
<tr>
<th>Class</th>
<th>BMI</th>
<th>% Men</th>
<th>% Women</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;20</td>
<td>2.1</td>
<td>10.5</td>
<td>6.4</td>
</tr>
<tr>
<td>Normal</td>
<td>20-25</td>
<td>22.2</td>
<td>36.6</td>
<td>29.6</td>
</tr>
<tr>
<td>Overweight</td>
<td>25-30</td>
<td>46.9</td>
<td>26.0</td>
<td>36.1</td>
</tr>
<tr>
<td>Obese</td>
<td>&gt; 30</td>
<td>28.8</td>
<td>26.9</td>
<td>27.8</td>
</tr>
<tr>
<td>Mean Value(of BMI)</td>
<td></td>
<td>28.14</td>
<td>26.67</td>
<td>27.38</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td></td>
<td>4.36</td>
<td>6.09</td>
<td>5.37</td>
</tr>
</tbody>
</table>

Prevalence rates of overweight and obese adults.

<table>
<thead>
<tr>
<th></th>
<th>Males (n=485) (%)</th>
<th>Females (n=516) (%)</th>
<th>Total (n=1001) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>117 (24.3)</td>
<td>242 (47)</td>
<td>359 (35.8)</td>
</tr>
<tr>
<td>Overweight</td>
<td>227 (46.9)</td>
<td>134 (26)</td>
<td>361 (36.0)</td>
</tr>
<tr>
<td>Obese</td>
<td>151 (28.8)</td>
<td>140 (27)</td>
<td>291 (28.2)</td>
</tr>
</tbody>
</table>

Chi-square test for differences between gender $x^2$, $P = 0.507$
Assessment of the health risks associated with overweight and obesity in adults should be based on BMI and waist circumference as follows:

<table>
<thead>
<tr>
<th>BMI classification</th>
<th>Low Waist Circumference</th>
<th>High Waist Circumference</th>
<th>Very High Waist Circumference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>no increased risk</td>
<td>increased risk</td>
<td>high risk</td>
</tr>
<tr>
<td>Obesity</td>
<td>increased risk</td>
<td>high risk</td>
<td>very high risk</td>
</tr>
</tbody>
</table>

• for men, waist circumference of less than 94 cm is low, 94-102 cm is high and more than 102 cm is very high
• for women, waist circumference of less than 80 cm is low, 80-88 cm is high and more than 88 cm is very high.

The studied presented showed the following results as far as concern the waist circumference (WC):

**Table 3** indicates the average values arranged by sex for the following clinical lab test indicators: Glucose, Cholesterol, Low Density Lipoprotein (LDL), High Density Lipoprotein (HDL), Triglycerides, Iron, CRP and Insulin.

<table>
<thead>
<tr>
<th>Table 3. Clinical Lab Test Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Glucose (fasting)</td>
</tr>
<tr>
<td>Cholesterol (total)</td>
</tr>
<tr>
<td>LDL</td>
</tr>
<tr>
<td>HDL</td>
</tr>
<tr>
<td>Triglycerides</td>
</tr>
<tr>
<td>Iron</td>
</tr>
<tr>
<td>CRP</td>
</tr>
<tr>
<td>Insulin</td>
</tr>
</tbody>
</table>

Data presented as means ± S.E
Statistically significant (P < 0.05)
*Statistically significant difference between normal and overweight and normal and obese group.
Abbr: BMI=body mass index, WC=waist circumference
Data presented as mean± S.E
Statistically significant (P < 0.05)
*Statistically significant difference between normal and overweight and normal and obese group.
**Adjusted for age and gender
Abbr: TC=total cholesterol, HDL=high density lipoprotein, LDL= low density lipoprotein

A major part of the study investigated the nutritional habits of the Cypriot adult population. In the specific question if breakfast and/or a midmorning snack was consumed, 24.2% of the subjects reported that they take breakfast only, 11.1% mid-morning snack only, 61% had both, and 3.7% had neither breakfast nor a mid-morning snack. The choices for breakfast were as followed: 94.3% of the sample consumed milk with sugar free cereals with fiber, 91.7% milk, 86.8% milk with egg and bread, 83.8% bread with honey/marmalade, 76.0% bread with butter/margarine and honey/jam. The most popular foods for mid-morning snack were: 79.7% for fresh fruit, 74.7% for bakery goods, 79.2% for sandwich, 61.7% for “other” and, 48.8% for coffee. The meals eaten per day were 2.7 ± 0.9 and the number of snacks per day were 1.9 ± 1.1, where the numbers after the ± sign indicate one standard deviation. According to the study 76.8% of the participants eat breakfast regularly, 76.9% eat lunch, 60.8% eat dinner and 39.9% eat intermediate meals. Tables 4 and 5 indicate how often the Cypriot adults prepare meals at home and how often they eat prepared meals, respectively. The study showed that 98.3% of adults in Cyprus use olive oil in salads or with pulses/beans, and 0.5% of them vegetable seed oil. The majority of Cypriots use olive oil in cooking (62.3%), 29% use another type of vegetable oil, 2.6% do not use oil, 2.6% don't know what oil they use, 3.1% don’t cook at home, and 0.4% use butter. The majority of Cypriot adults drink either 1-4 glasses (35.2%) of water, or 5-8 glasses of water (37.3%). Furthermore, 25.3% drink >8 glasses of water and only 2.2% drink 0 glasses per day. The large variety of answers with regard to consumption of water is related to the seasonal nature of water consumption. 57.2% of the subjects consume only the salt used in cooking, 33.9% add salt after cooking, 2.9% use lo-salt, 4% do not use any salt and 1.7%, and don’t use salt but use flavouring cubes instead. Also, 8% were drinking whole fat milk, 55.5% semi skimmed milk and 18.6% skimmed milk.

<table>
<thead>
<tr>
<th>Summary of Dietary and lifestyle characteristics of subjects.</th>
<th>Normal (n=361)</th>
<th>Overweight (n=362)</th>
<th>Obese (n=279)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red meat (servings/d)</td>
<td>0.8 ± 0.7</td>
<td>2.2 ± 0.9</td>
<td>4.4 ± 1.1</td>
<td>0.391</td>
</tr>
<tr>
<td>Fish (servings/d)</td>
<td>0.47 ± 0.1</td>
<td>0.5 ± 0.2</td>
<td>0.4 ± 0.2</td>
<td>0.437</td>
</tr>
<tr>
<td>Vegetables (servings/d)</td>
<td>4.2 ± 1.5</td>
<td>1.1 ± 1.1*</td>
<td>0.7 ± 0.8 *</td>
<td>0.003</td>
</tr>
<tr>
<td>Fruits (servings/d)</td>
<td>3.2 ± 1.6</td>
<td>1.2 ± 1.2*</td>
<td>0.5 ± 0.9 *</td>
<td>0.001</td>
</tr>
<tr>
<td>Alcohol (g/d)</td>
<td>29 ± 5.1</td>
<td>55 ± 4.9*</td>
<td>54 ± 4.8 *</td>
<td>0.001</td>
</tr>
<tr>
<td>Smoking (cig/d)</td>
<td>5 ± 2.7</td>
<td>12 ± 2.6*</td>
<td>15 ± 3 *</td>
<td>0.001</td>
</tr>
<tr>
<td>Exercise (Met x h/d)</td>
<td>6 ± 0.7</td>
<td>3.8 ± 0.7*</td>
<td>3.5 ± 0.6 *</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Data presented as mean± S.E
Statistically significant (P < 0.05)
*Statistically significant difference between normal and overweight and normal and obese group.
**Adjusted for age, gender and energy intake

Obesity and overweight rates are highly prevalent in Cyprus. High-calorie meals and snacks and sedentary lifestyle are among the main reasons for accumulation of body fat in Cypriot adults. Cypriots need to control their snacks and to include more physical activity programs in their daily lifestyle schedules.

1. Cypriots are generally overweight
2. Cypriot men are in worse shape than Cypriot women
3. Cypriot women care more about their weight than men (NOTE for us: In the future we might want to investigate the age dependence of this statement)
4. Cypriots generally avoid physical exercise
5. Cypriots undervalue the importance of regular exercise
6. Cypriots are well-informed about nutritional issues
7. Obesity and overweight contribute to health problems such as dyslipidemia, lower back pain and joint pain

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Speaker’s Details:

**Name:** Eleni P. Andreou  
**Degrees/Credentials:** RD, LD, DProf, FHEA  
**Position Title:** President of Cyprus Dietetic and Nutrition Association, Clinical Dietitian, Assistant Professor, University of Nicosia  
**Employer Address:** 48 Themistokle Dervi 48, Off. 207, Athienitis Centennial Bldg, 1066 Nicosia  
**Contact Address:** 48 Themistokle Dervi 48, Off. 207, Athienitis Centennial Bldg, 1066 Nicosia  
**Phone/Fax/Email:** 00357 22 452288/ 00357 22452292/ aeleni@spidernet.com.cy

Dr Antoniou Pavlos, MD  
Gastroenterologist - Hepatologist

**Abstract Title:**  
Celiac disease toolkit: Guiding your patients to a global treatment  
(Part of Panel: Gastrointestinal Disorders and Nutrition)

**Objectives**

1. To identify the importance of Nutrition Intervention for the treatment of celiac disease  
2. To determine the multifactorial elements of the treatment of celiac disease  
3. To provide medical nutrition therapy (MNT) guidelines for celiac disease to promote optimal health, prevent and treat malabsorption/malnutrition and other comorbidities, and improve quality of life

**Learning Outcome Assessment**

Sensitivity to gluten results in a wide spectrum of manifestations triggered by ingestion of the gluten-containing grains – wheat, barley and rye. As the most common presentation of this disorder in genetically predisposed individuals, coeliac disease (CD) presents with a set of diverse clinical features, which typically includes fatigue, delayed growth, weight loss, diarrhea, anemia, osteoporosis and depression. Improved understanding of pathogenic pathways that underlie coeliac disease has led to development of multiple new therapeutic approaches, some of which have reached clinical studies. It may be especially important to provide optimum aids and eventually alternatives to the gluten-free diet for those with mild or no symptoms for whom the motivation to be gluten-free may be less

**Description (Focus Statement)**

Celiac disease is a genetic disorder affecting children and adults. People with celiac disease are unable to eat foods that contain gluten, which is found in wheat and other grains. In people with celiac disease, gluten sets off an autoimmune reaction that causes the destruction of the villi in the small intestine. People with celiac disease produce antibodies that attack the intestine, causing damage and illness. Untreated celiac disease can be life threatening. Celics are more likely to be afflicted with problems relating to malabsorption, including osteoporosis
tooth enamel defects, central and peripheral nervous system disease, pancreatic disease, internal hemorrhaging, organ disorders (gall bladder, liver, and spleen), and gynecological disorders. Untreated celiac disease has also been linked an increased risk of certain types of cancer, especially intestinal lymphoma.

Abstract:

Sensitivity to gluten results in a wide spectrum of manifestations triggered by ingestion of the gluten-containing grains – wheat, barley and rye. As the most common presentation of this disorder in genetically predisposed individuals, coeliac disease (CD) presents with a set of diverse clinical features, which typically includes fatigue, delayed growth, weight loss, diarrhea, anemia, osteoporosis and depression.[1-4]

When coeliac disease is suspected, serological testing (IgA anti tTg and anti-endomysial antibody) and duodenal biopsies are required to confirm the diagnosis. [5]

A number of routine blood tests should be carried out to identify nutritional deficiencies including haemoglobin, B12, folic acid, iron, serum albumin, and calcium. These should be measured at diagnosis, during symptomatic relapse, and during pregnancy. It is also reasonable to perform these routinely at annual follow-up. [6-7]

Currently, adherence to a gluten-free diet is considered as the first line and indeed only therapy for coeliac disease, which has been proven to relieve the symptoms in most cases and effectively prevent potential complications.

Dietary Treatment
(a) Gluten Exclusion: The cornerstone of therapy is adherence to a gluten free diet (GFD). This means the exclusion of foods containing wheat, rye, barley and oats, although the toxicity of oats is still debated. The avoidance of these cereals is a formidable task as they are found in bread, biscuits, cakes, pastries, breakfast cereals, pasta, beer and most soups, sauces and puddings. Patients may supplement their diet with commercial gluten-free products that are available on prescription by gastroenterologists and dietitians and include gluten-free flour, bread, biscuits, and pasta. Seventy per cent of adults and a greater proportion of children, respond promptly to a GFD, showing improvement of symptoms within weeks or days. Histological improvement usually takes many months to occur.[8-9]

(b) Total vs Partial Gluten Exclusion: The risk of developing small intestinal lymphoma is increased in patients with CD who ingest a diet that contains gluten. Nutritional deficiencies are also more likely to occur. It has been shown that early introduction of a gluten-free diet decreases the subsequent risk of developing autoimmune disorders, particularly diabetes mellitus. Good dietary compliance should reduce the risk of osteoporosis in later life. [10]

(c) Need For Life-Long Treatment: Adolescents may stop their diet in the mistaken belief that they have “grown out of” their CD. Should the diagnosis be in any doubt, a gluten challenge and repeat jejunal biopsy should be undertaken; if the diagnosis is established life-long treatment should be recommended.[11]

(d) Dietary Supplements: Many patients will be found to be suffering from dietary deficiencies at the time of diagnosis, the commonest being iron, folic acid, calcium and vitamin B12. Although these usually resolve spontaneously once on a GFD, it seems reasonable to ensure rapid correction with appropriate supplements.

(e) Bone Abnormalities: Many individuals have osteopenia. It is usual practice to consider bone densitometry scanning on presentation which may be repeated after one to two years of dietary therapy if the initial value is low. Osteoporosis in post-menopausal women may warrant hormone replacement therapy and the use of bisphosphonates in some individuals. Calcium supplementation to achieve an intake of 1500mg a day may be considered.

Follow-Up

In patients with a satisfactory response to diet, specialist outpatient follow-up should ideally be at six to twelve month intervals to assess symptomatic improvement, nutritional state, dietary compliance and to check routine blood tests. A check small intestinal biopsy four to six months after initiating treatment should be performed.[12-13]

It is important to review patients at times of stress, whether this be physical or emotional. Pregnancy is a particularly important time which may lead to deterioration in symptoms or asymptomatic nutritional deficiencies. Low levels of folic acid have been associated with miscarriage and foetal neural tube defects and so should be carefully monitored. Patients who are contemplating conception should supplement their diet with folic acid as they are prone to folic acid deficiency.

Because of the possible long term complications of disease, such as lymphoma and bone disease, it is strongly recommended that life-long follow-up be maintained.[14]

All these concerns along with ineffectiveness in some cases have warranted the development of alternative and complementary approaches to dietary treatment. Improved understanding of pathogenic pathways that underlie coeliac disease has led to development of multiple new therapeutic approaches, some of which have reached clinical studies. It may be especially important to provide optimum aids and eventually alternatives to the gluten-free diet for those with mild or no symptoms for whom the motivation to be gluten-free may be less.[15-16]
References


Speaker's Details:

Name: Dr Antoniou Pavlos
Degree/Credentials: MD
Position Title: Gastroenterologist - Hepatologist
Employer Address: Hippocrateon Private Hospital, Psaron 6-12, T.K. 27509, 2408, Nicosia - Cyprus
Contact Address: Hippocrateon Private Hospital, Psaron 6-12, T.K. 27509, 2408, Nicosia - Cyprus
Phone/Fax/Email Address: +35722356565, +357 22351938, p.antoniou@hippocrateon.com

Dr Avraamides Panayiotis, BSc (Hons), MB BS (Lond), FRCP(Lond), FRCP(Edin), MRCPI, FESC
Director, Cardiology Department, Limassol General Hospital

Abstract Title
Mediterranean diet and effect on cardiovascular disease
(Part of panel: Mediterranean diet and cardiovascular disease)

Objectives:

1. Understand the evidence behind the link between the Mediterranean diet and heart disease
2. Understand which individual components of the diet are incriminated

Abstract:

The Mediterranean diet has been found to be protective from coronary heart disease. Interest in the diet started with the results of the Seven Countries Study which began in 1958. This demonstrated reduced mortality from coronary heart disease in southern Europe compared to northern Europe. Since then there has been
an explosion of research around the subject. The session will attempt to clarify this topic by looking at the evidence and the individual components of the diet.

Speaker’s Details:

Name: Dr Panayiotis Avdramides  
Degree/ Credentials: BSc (Hons), MB BS (Lond), FRCP(Lond), FRCP(Edin), MRCPI, FESC  
Position Title: Director, Cardiology Department, Limassol General Hospital  
Employer Address: Cardiology Department, Limassol General Hospital  
Contact Address: P.O.Box. 25473, 1310, Nicosia, Cyprus  
Email Address: panicos@cytanet.com.cy

Prof De Looy Anne, BSc (Hons) PhD PGDipDiet RD FBDA  
Professor of Dietetics, University of Plymouth

Abstract Title

Engaging Current and Future Practitioners to Apply Ethical Actions in Practice

Objectives

1. Justify the need for standards against which ethical actions in practice can be judged
2. Discuss the requirement for reflective practice and its relationship with ethical behaviour
3. Evaluate the extent and nature of ethical codes of practice
4. Describe and discuss the way competence for the successful engagement of dietitians may be demonstrated.

Learning Outcome Assessment

1. Justify the need for standards against which ethical actions in practice can be judged
The delegate will be able to recount the various standards for practice that have been established through the European Federation of the Associations of dietitians. Further they will be able to show how each standard is required to demonstrate safe and ethical care.

2. Discuss the requirement for reflective practice and its relationship with ethical behaviour
The delegate will be able to describe reflective practice and critically evaluate why this very powerful tool is so important for professionals to use as they self-evaluate their own practice.

3. Evaluate the extent and nature of ethical codes of practice
Using several different ethical codes the delegate will be able to evaluate the individual components and also justify why they are required and how a more balance ethical code can be maintained, monitored and reviewed.

Description (Focus Statement)

Dietitians and all other healthcare practitioners continually interact with vulnerable people for example due to ill-health or their age. It is therefore critical that they undertake their work in a way that does not threaten or in any way cause distress to the individuals in their care. Ethical behaviour is therefore fundamental to all dietitians do. This lecture will investigate the standards against which dietitians can judge their day to day activities and investigate ethical codes as well as how these can be monitored for continuing safe and high quality care.

Abstract

Ethical decisions face dietitians every professional working day of their lives, when deciding about initiating enteral feeding (ADA, 2008; Beyeler et al,1999), treating obese patients (Pace et al, 1991), cancer patients (Hobenshield et al 2012) or genetics related care (Kauwell, 2003) to name but a few. Three key players have a role to play in the ethical actions that dietitians undertake and they are the practitioner themselves, the Professional Association acting together with regulatory procedures in their country and Higher Education Institutes (HEIs). The European Federation of the Associations of Dietitians (EFAD) has adopted three key documents to guide and support all Associations and dietitians practising in Europe. These documents should augment and act as benchmarks for dietitians acting in their own countries. The European Academic and Practitioner Standards for Dietetics (EFAD, 2005) defines the fundamental knowledge set that all dietitians in Europe should obtain before they begin to practice in the field of dietetics. For example regarding professionalism in dietetics it says all students should have:

- A Knowledge of the legal and ethical boundaries together with the professional and personal scope of their practice
- And, Understand the obligation to maintain fitness to practice and the need for career-long and self-directed learning

It is the role of Higher Education to ensure that these standards are being met and in a survey undertaken of those institutions teaching future dietitians about 20% still did not include ethical considerations in their curricular
(de Looy et al, 2010; EFAD, 2005). Yet, practise within a Code of Ethics is essential for all dietitians as a key emphasis is on doing no harm and ensuring safety for the clients.

The European Dietetic Competences and their Performance Indicators (EFAD, 2009) define the ability of the newly qualified dietitian to practice and apply knowledge safely when giving advice on nutrition to clients, healthcare professionals and others. A key competence is at 4.1 and this together with the performance indicators (how the competence is to be demonstrated) is given below:

| 4.1 Identify and manage ethical dilemmas that arise within professional relationships. | • Respects individuals and their rights regardless of race, religious beliefs, colour, gender, physical and/or mental disability, marital status, family status, economic status, education level, age, ancestry or sexual orientation.  
• Respects the dignity and privacy of individuals.  
• Obtains informed consent as required prior to providing services.  
• Serves the best interests of the individual and their needs. |

These competences should provide both the educators in Higher Education an end point for the students wishing to become a dietitian as well as provide the employer of the dietitian with the reassurance that during employment the new dietitian is able to safely advise and implement a diet that will cause no harm to the client.

Finally a National Dietetic Association should have an Ethical code for dietitians which is formally introduced during the education of students and is the code by which all dietitians will practice. EFAD adopted in 2006 the International Code of Ethics and all Associations of Dietitians in Europe will have a code which is implemented in their own country. The code of good practice which accompanies the International code says this;

**Continued competence and professional accountability**
- Ensure accountability to the public
- Accept responsibility for ensuring practice meets legislative requirements
- Maintain continued competence by being responsible for lifelong learning and engaging in self-development.

But in a survey of the members of the International Federation of Dietetic Associations codes of (ethical) conduct were declared in 15 of 20 European member countries.

A professional dietitian does not rely on the knowledge and skills they obtained during their initial education as providing an ethically safe level of service. Knowledge and skills obtained during initial education need to be continually reviewed and revised and this requires constant updating or Lifelong Learning (LLL). To judge whether a practicing dietitian remains competent the employer and the clients will expect that the dietitian continues to demonstrate and improve their competence throughout their working lives. Many European countries require the dietitian to formally remain competent and demonstrate this to retain their credentials or registration so here the responsibility is for the dietitian and the ‘competent authority’ or the professional association working together. EFAD through the Thematic Network for Dietitians (DIETS2) is currently working towards a LLL strategy for EFAD and competences for advanced practice. All of these topics will be considered in the presentation.

References


Abstract Title

Cardiometabolic Risk Factors
(Part of Panel: Eat well, love better, move more: treatment of cardiometabolic syndrome)

Objectives

1. To identify the cardiometabolic risk factors and relate them to nutrition
2. To determine the efficacy of a weight loss and physical activity intervention on the adverse health risks of severe obesity.
3. To determine whether WC predicts diabetes and cardiovascular disease (CVD) beyond that explained by BMI and commonly obtained cardiometabolic risk factors including blood pressure, lipoproteins, and glucose.

Abstract

Despite any therapeutical interventions cardiovascular disease (CVD) remains the leading cause of death in the USA. The revolution of statins caused a significant reduction in cardiovascular events but still a 19.8% of patients under statin therapy experiences one cardiovascular episode in 5 years. This has to do with the global cardiometabolic risk (CMR).

Global cardiometabolic risk represents the overall risk of developing type 2 diabetes and/or cardiovascular disease (including MI and stroke), which is due to a cluster of modifiable risk factors/markers. These include classical risk factors such as smoking, high LDL, hypertension, elevated blood glucose and emerging risk factors closely related to abdominal obesity (especially intra-abdominal adiposity), such as insulin resistance, low HDL, high triglycerides and inflammatory markers.

All the above emerging risk factors are related to central (intra-abdominal) obesity whose prevalence is about to rise even more in the future years. Central obesity is considered even now a world epidemic problem. It is an independent prognostic factor for developing cardiovascular disease and there is evidence to be related to sudden cardiac death and the development of diabetes mellitus.

In 2001 the amount of money expended per capita in Great Britain was >37% for the obese people, that is 1,000 $/person more than a non-obese. The economic burden of obesity is attributed in: type 2 Diabetes, hyperlipidemia, arterial hypertension, cardiovascular disease. Why is that? Because we strongly prefer the sedentary type of lifestyle: no physical exercise and fast food (junk food).

Thus, the management of obesity and other cardiometabolic risk factors seems to be rather important today. The cornerstone to manage a patient with cardiometabolic risk factors is to start with a holistic approach and manage everyone individually. Lifestyle change is the first one to begin to manage the cardiometabolic risk factors. Weight loss based on a balanced diet, regular physical exercise and smoking cessation may help initially. Improvement of lipidemic profile, glycemic profile and blood pressure control by special medication is the next step for the management of cardiometabolic risk. Regular follow up of the patient is essential for his compliance and monitoring any adverse events.

The cardiometabolic risk is attributed to the clustering of risk factors in the obese people. Thus it is the consequence of metabolic syndrome whose prevalence is about to increase due to the global economic crisis which leads to cheap bad quality food. We have to manage individually every patient and looking for other risk factors. Lifestyle change and medication is needed. We also have to give special attention and emphasize in the prevention of obesity to the general population (Physicians, Medical Societies).
A. Abstract Title

Medical Nutrition Therapy: Standardized language – making it international (Keynote Speaker)

Objectives

1. Discuss the importance of using standardized language and the nutrition care process in any environment.
2. Identify at least one behavioral change they will make after the seminar.

Learning Outcome Assessment

Participant evaluation of program
Self-assessment about the appropriate use of IDNT and the nutrition care process

Description (Focus Statement)

Adoption of common nutrition practices and terminology supports more effective outcomes. Health care payers, medical team members, and administrators will be able to identify the true cost-benefit of dietitian services when similar steps and terminology cross international borders of care.

Abstract

Changes in nutritional intake, appetite or weight are essential components of nutrition assessment. Malnutrition is associated with depression of the immune system, impaired wound healing, muscle wasting, longer lengths of hospital stay, higher treatment costs, and increased mortality; screening and implementation of published best-practice guidelines may effectively reduce hospital malnutrition and save costs (Barker et al., 2011.) Yet, nutrition problems can be noted in other settings: excessive or inadequate meal intake, reduced appetite, dysphagia, dependence on non-oral nutrition support, changes in weight, altered fluid intake, exposure to food allergens or unsafe foods, decline in functional capacity, hospitalization, altered mood, reduced social activity or cognitive performance, even inadequate growth. With application of standardized language and terminology, dietitians can assess and intervene in hospitals, home care, child care centers, intensive care, even community health clinics. The four-step nutrition care process (NCP) promotes effective data assessment, followed by the selection of key nutrition diagnoses (problems), interventions, monitoring and evaluation. Writing an accurate P-E-S statement with the Problem (nutrition diagnosis), its Etiology (cause) and Signs and symptoms (measurable indicators) mandates deep critical thinking by the qualified dietitian. Several countries are in the process of validating or adopting the standardized terminology. The Netherlands, United States, Canada, Great Britain, and Australia have made great strides; other countries have begun translating the terminology. Adoption of common terminology supports effective outcomes. Health care payers, medical team members, and administrators will be able to identify the true cost-benefit of dietitian services when similar terminology crosses international borders of care.

References:

Dysphagia Nutrition Management (Part of panel: Gastrointestinal and hepatic disorders)

Objectives

1. Participants will be able to recognize the nutritional risks of dysphagia.
2. Participants will be able to identify aspects of dysphagia that can be managed by dietary changes.
3. Participants will be able to address hydration challenges associated with dysphagia.

Learning Outcome Assessment

Participant evaluation of program
Self-assessment about the nutritional risks of dysphagia; dietary and hydration measures for dysphagia.

Description (Focus Statement)

40-60% of geriatric patients in nursing homes experience dysphagia; 15-30% of patients in acute & rehabilitation may also have difficulty swallowing. Proper assessment and nutritional interventions can prevent choking or aspiration incidents. In addition, progressive use of the 3-stage Dysphagia Diet can alleviate the need for long-term enteral tube feeding in many patients.

Abstract

Difficulty in swallowing results from a neurological, mechanical/structural, or behavioral disorder or condition and requires alterations in food and liquid consistencies. Dietitians must be able to work with the medical team to prevent aspiration and choking in vulnerable patients. It is important to establish Dysphagia Policies, Diet Manual content, and a Task Force including Registered Dietitians, Speech Therapists, Nursing, Physician and Food Service Management. The most severe restriction is Level 3 – Dysphagia Pureed, graduating through mechanically altered foods back to a regular diet when possible.

References:

1) Dining Skills Manual, Academy of Nutrition and Dietetics

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4) National Dysphagia Diet: Standardization for Optimal Care, Academy of Nutrition and Dietetics, 2003

Speaker’s Details:

Name: Escott – Stump Sylvia

Degrees/Credentials: MA, RD, LDN

Position Title: Director, Dietetic Internship, East Carolina University

Employer Address: Mailstop 505, Rivers Building, Greenville, NC 27858

Contact Address: 2405 Royal Drive, Winterville, NC 28590

Phone/Fax/Email: 252-353-5116, Fax 252-328-4276, escottstumps@ecu.edu

Prof Hassapidou Maria

Professor of Nutrition and Dietetics, Department of Nutrition and Dietetics, Alexander Technological Educational Institute, Thessaloniki, Greece

Abstract Title

Μεσογειακή δίαιτα και καρδιαγγειακά νοσήματα (Mediterranean Diet and Cardiovascular Disease)

Part of panel Open for the Public – session in Greek

Objectives

1. Know the basic characteristics of the Mediterranean diet
2. Understand the role of the Med diet in the prevention and treatment of cardiovascular diseases
3. Learn basic dietary practises for a healthier life
Abstract

The Mediterranean diet is well known internationally as a health promoting dietary model, starting from the results of the “seven countries” study by Ancel Keys in the 1960’s, in which the populations of the Mediterranean countries were found to have lower coronary heart disease mortality rate, with Greece having the lowest compared to the other populations of the study.

The Mediterranean diet is traditionally followed by people in the different countries bordering the Mediterranean Sea. It is characterized by a high consumption of fruit, vegetables, legumes, and complex carbohydrates, with a moderate consumption of fish, low consumption of meat and meat products, and moderate consumption of milk and dairy products. The consumption of olive oil is the main source of fats and a low-to-moderate amount of wine is consumed during meals.

The Lyon Heart Study showed that the Mediterranean diet was more effective than a low fat diet in secondary prevention of cardiac events. Since then, several prospective studies in the last 30 years in a large number of subjects from around the world have shown that the Mediterranean diet provides significant and consistent protection from total and cardiovascular mortality.

These results seem to be clinically relevant for public health, in particular for encouraging a Mediterranean-like dietary pattern for primary prevention of cardiovascular diseases. A recent systematic review and meta-analysis by F.Sofi et al (2010) on benefits of adherence to the Mediterranean diet on health showed that a 2-point increase in adherence to the Mediterranean diet was associated with a significant improvement in health status, as seen by a significant reduction in overall mortality (9%), mortality from cardiovascular diseases (9%), incidence of or mortality from cancer (6%), and incidence of Parkinson’s disease and Alzheimer’s disease (13%).

In conclusion individuals who adhere to the principles of the traditional Mediterranean diet end to have a longer life-span due to lower incidence of morbid conditions such as cardiovascular disease, the metabolic syndrome, hypertension, hyperlipidemias. It should be noted though that not only nutrition but a healthy lifestyle including healthy weight and physical activity is needed to prolong the human life-span.

References:


Speaker’s Details:

Name: Hassapidou Maria
Position Title: Professor of Nutrition and Dietetics, Department of Nutrition and Dietetics, Alexander Technological Educational Institute, Thessaloniki, Greece
Employer Address: ATEITH, Thessaloniki, Greece
Contact Address: Riga Fereou 10, 55535, Thessaloniki, Greece
Email: mnhas@nutr.teithe.gr

Dr Heraclides Alexandros, BSc (Hons), MSc, MSc, PhD
Lecturer in Nutrition, Epidemiology and Biostatistics at the Univeristy of Nicosia

Abstract

Nutrigenetics and nutrigenomics: Scientific breakthrough, but what is the benefit for public health nutrition and everyday dietetic practise?

(Part of Special Event: Nutrigenomics and genetics and nutrition)
Objectives

1. Understand the scientific concept of nutrigenetics and nutrigenomics.
2. Appreciate the complex ethical aspect surrounding the application of nutrigenetics and nutrigenomics to human populations.
3. Appreciate how nutrigenetics and nutrigenomics can help improve public health nutrition and everyday dietetics practice and realize the obstacles faced for that.

Description (Focus Statement)

As of 2003, when the human genome was decoded, the face of science in general has dramatically changed and genetic research gained huge attention in all disciplines of health sciences, including nutritional sciences. The field of nutritional genomics studies interactions between diet and the human genome, which may open new horizons for personalized nutrition and identification of high-risk individuals. As science progresses, nutritionists and dietitians must be familiar with these concepts and how they are involved in their everyday practice.

Abstract

Nutritional genomics, which includes the disciplines of nutrigenetics and nutrigenomics, aim at studying the complex interactions between nutrients (as well as specific foods and whole diets) and the genome. Nutrigenomics is the study of genome-wide influences of nutrition, where nutrients are thought of as dietary signals detected by cells, influencing gene expression and metabolite production. In simpler words, nutrigenomics studies how nutrients influence the functioning of our genes at the molecular level. Nutrigenetics on the other hand is the study of the influence of specific genes on physiological responses to nutrients. In simpler words, nutrigenetics studies how our genetic makeup influences diet-disease associations. The contemporary nutritionist/dietitian has a huge task in front of him/her, which is to comprehend the above concepts and try to apply them in his/her everyday practice. In order for this to be achieved, the ethical considerations of nutritional genomics need to be clearly understood. These include ethical/cultural/religious barriers to genetic research in general by certain groups within a society, as well as the practical difficulties in passing health messages involving genetic concepts to individuals. The first point here refers to how certain individuals and groups of individuals within a society may be offended by any type of genetic research (including nutritional genomics) as this may be perceived as ‘playing God’. At the individual level, some patients may strongly oppose the collection of any genetic sample from them and thus application of nutritional genomics is impossible for such individuals. At the population level, organized groups may systematically oppose the conducting of any kind of nutritional genomics research thus spreading the wrong message to the society and influencing negatively the public opinion. The second point mentioned above concerns ethical issues in translating evidence from nutritional genomics research to individuals and groups of individuals who are not, a priori, misconceptioned about this scientific field. These ethical considerations include difficulties from the side of the individual in understanding basic concepts of nutritional genomics such as genetic predisposition or genetic vulnerability or resilience. The main issue here is whether giving health messages involving genetic information to people, will do more harm than good. Research on both the scientific part of the nutritional genomics field and the ethical aspects surrounding it, is in its infancy and lots of work is currently under way on generating new evidence on gene-diet interactions and the best way that such evidence is communicated to populations and individuals.

References:


Speaker’s Details:

Name: Heraklides Alexandros

Degrees/Credentials: BSc (Hons) Biology; MSc Nutrition; MSc Health and Society; PhD Epidemiology and Public Health

Position Title: Lecturer in Nutrition, Epidemiology and Biostatistics at the University of Nicosia / Visiting Scientist at the German Institute of Human Nutrition, Potsdam Rehbrucke

Employer Address: University of Nicosia, 46 Makedonitissis Avenue, 1700 Nicosia, Cyprus

Contact Address: Flat 202, Archiepiskopou Leontiou 17A, 2407, Engomi, Cyprus

Mob Phone/Email: 99091764, heraclides.a@unic.ac.cy, alex_heraclides@yahoo.co.u
Nutrition in critical illness: from theory to daily practice
(Part of panel: Bridging the Guideline-Practice Gap: The Critical Care Experience)

Objectives

1. Have a better and complete understanding of the nutrition guidelines used in the hospitalised setting and the ICU in particular.
2. Learn how to implement knowledge in daily practice.

Description (Focus Statement)

Nutrition in critical illness plays a major role in the final outcome of a hospitalised patient. Aim of this presentation is to analyse the guidelines on nutrition in the hospitalised setting. Special reference on nutrition in the ICU patients will be made. Screening patients and making the correct dietetic intervention is of critical importance. The attendee will learn how to make a judgement based on the daily circumstances and the individual needs of a patient in order to achieve the optimal outcome.

Learning Outcome Assessment

Clinical dietitians and professionals involved in the nutrition therapy of critically ill patients are called to have a thorough knowledge of the nutrition support therapy guidelines. The analytic presentation of the guidelines, the limitations and contraindications and the handouts to be given can be a helpful tool in enabling the attendees to implement knowledge to daily practice.

Abstract

Malnutrition is a common problem affecting a large number of hospitalised patients and is very often not recognized. It also affects recovery from surgery or illness, and increases the incidence and severity of infection. The major significance of nutritional support in the hospitalized setting has been firmly established over the last three decades. Nutrition support has three main objectives: to preserve lean body mass, to maintain immune function and to avert metabolic complications. ASPEN describes Nutrition Support Therapy as “The provision of oral, enteral and parenteral nutrients to treat and to prevent malnutrition, to maintain or restore optimal nutrition status and health”.

Basic objective of this presentation is to offer the professional who works in the demanding environment of a hospital or a health care unit a review of the bibliography and the basic guidelines on both enteral and parenteral nutrition. We are going to go over the guidelines of major societies (ASPEN, ESPEN). Patient selection (screening tools for detecting malnourished patients), formula selection, feeding tube management, feeding protocols, monitoring tolerance and complications, are some of the topics to be analyzed. Moreover, we are going to go over the indications and limitations of all enteral feeding routes: nasogastric, nasojejunal, percutaneous endoscopic gastrostomy and jejunostomy. The indications and the contraindications for parenteral nutrition are also to be discussed. An outline of the nutrition support in special diseases such as diseases of the GI tract, diabetic and renal patients and ICU patients will also be made.

In conclusion, we are going to refer to some of the basic problems occurring in the daily practice nowadays in Cyprus, especially in periods of financial crisis. The judgment of the healthcare professional should be based on the individual circumstances of the patient and should be based on the recommendations of the international guidelines to the maximum extent possible.

References:


Speaker’s Details:

Name: Ioannou Elina
Degrees/Credentials: BSc Dietetics and Nutrition, MSc Public Health Nutrition from Harokopio University Athens
Position Title: Clinical Dietitian, Cyprus Ministry of Health
Employer Address: Limassol General Hospital, P.O.Box: 56060, 3304, Limassol
Contact Address: 33 Ippokratous Street, Flat 201, 2325, Nicosia
Phone/Fax/Email: +357 25801124 / +357 25305783 / ioannou_elina@hotmail.com
Abstract Title

Labeling of Foodstuffs, Nutrition and Health Claims – An EU perspective
Part of panel: Novelties in Nutrition

Objectives

1. To be more informed and more selective in the choices of packaged food.
2. To be well informed about the nutrition and health claims.
3. To learn about the differences between nutrition and health claims.

Description (Focus Statement)

In the Cyprus and others countries market are sometimes advertised food products with misleading nutrition
and health claims. So a better knowledge in this field will help too much in the consumers choices.

Learning Outcome Assessment

All the above will improve the practical but also the scientific knowledge in the field.

Abstract

The requirements and practical aspects and perspectives of the recent European Union (EU) legislation concerning
labeling of foodstuffs and relevant consumer information, nutrition and health claims will be discussed. More
specifically, the requirements of the new Regulation (EU) No 1169/2011 on the provisions of food information
to consumers considerably changes existing EU legislation on food labeling from 13 December 2014 i.e.:
Directive 2000/13/EC concerning labeling, presentation and advertising of foodstuffs and Directive 90/496/
EEC concerning nutrition labeling for foodstuffs. Furthermore the Regulation (EU) No 1924/2006 on nutrition
and health claims made on foods gives a special emphasis to conditions for the use of nutrition and health
claims, scientific substantiation of health claims and the need for their authorization by the European Safety
Authority. A reference will be made to EU list of authorized health claims.

References:

1) REGULATION (EU) No 1169/2011 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the

2) REGULATION (EC) No 1924/2006 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on nutrition
and health claims made on foods.

3) DIRECTIVE 2000/13/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the approximation
of the laws of the Member States relating to the labelling, presentation and advertising of foodstuffs.

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Speaker’s Details:

Name: Dr. Kakouri Eleni
Degrees/Credentials: BSc, Ph.D.
Position Title: Chief Chemist, Head of Quality Assurance and Risk Assessment Units of the State General
Laboratory (SGL) of Cyprus
Employer Address: 44 Kimonos Street, 1451 Nicosia, Cyprus
Contact Address: State General Laboratory, 44 Kimonos Street, 1451 Nicosia, Cyprus
Phone/Fax/Email: +35722809120, +35722316434, ekakouri@sgl.moh.gov.cy
Kountouri Stalo, CPD, R.D  
Clinical Dietitian, General Hospital of Famagusta

Abstract

Bowel cancer and nutrition intervention
(Part of panel: The state of the science: evidence to support diet and physical activity recommendations for cancer prevention)

Objectives

1. Identify the risk factors of bowel cancer
2. Determine the role of a clinical dietitian regarding prevention and treatment of bowel cancer

Description (Focus Statement)

To identify the risk factors of bowel cancer and what we can do as health care professionals to prevent it.

Learning Outcome Assessment

Through the presentation the attendees will be educated on how a clinical dietitian can help to prevent the formation of a bowel tumor and also how to interfere with the bowel cancer treatment.

Abstract

Colorectal cancer is the second leading cause of cancer death among American. The risk of colorectal cancer is increased in those with a family history of colorectal cancer or a history of adenomatous polyps, a precursor lesion for colon cancer. It is estimated that one third of the cancer deaths each year in the US can be attributed to nutrition and other lifestyle factors. The majority of these incidences could be prevented. Overweight and obesity increase the risk of colorectal cancer in men and women, especially when there is high waist to hip circumference. Physical activity has a positive impact on colon cancer. A moderate activity on a regular basis decreases the risk of colon cancer, where a vigorous activity might have an even greater impact. Number of studies agrees that the high consumption of red and processed meat can increase the risk of bowel cancer. This might be happening due to the grilling process which produces carcinogens. Also there is a positive correlation between high fiber intake, especially from whole grains and colorectal cancer. A diet high in fruits, vegetables and whole grains is related with a decrease risk in colorectal cancer. Even though some studies suggest that vitamin D and calcium may lower the risk of the specific type of cancer, the American Cancer Society does not recommend the use of calcium supplement or high consumption of dairy foods. It is recommended to get the RDA of calcium through food sources and not exceed the recommended level. High calcium intake has been associated with an increase risk of prostate cancer. Alcohol consumption can increase the risk of several cancers including colon and rectum especially among men. The treatment of colon cancer might be different for every patient considering the stage and the location of the cancer and also the risks and benefits associated with each one. The treatment can be a surgery, chemotherapy or radiation or a combination and is decided by the physician and the patient. Depending on the treatment, different side effects could appear. These include fatigue, constipation, diarrhea, temporary or permanent colostomy, sores in the mouth, low appetite, difficult in swallowing and tiredness. A clinical dietitian should provide medical nutrition therapy (MNT) guidelines to manage symptoms, preventing weight loss and maintaining optimal nutritional status during cancer treatment. A survivor cancer patient is at risk of other primary cancers. The survivor should be educated on lifestyle changes and dietary recommendations in order to prevent the formation of new tumors.

References

1) www.cancer.org


20) http://www.oncologynutrition.org

21) http://infcr.org

22) http://www.cdc.gov

23) https://www.caring4cancer.com

Speaker’s Details:

Name: Kountouri Stalo
Degrees/Credentials: CPD, R.D
Position Title: Clinical Dietitian
Employer Address: General Hospital of Famagusta
Contact Address: 3 Th. Georgiade Str. 2123, Nicosia, Cyprus
Phone/ Email: 99-541021, kstalord@gmail.com

Dr Kyprianou Theodoros, MD, PhD EDIC
Head, Multidisciplinary Intensive Care Unit, Nicosia General Hospital

Abstract Title

Are guidelines for the critically ill patient nutritional assessment and plan being transferred to practice? (Part of panel: Bridging the Guideline-Practice Gap: The Critical Care Experience)

Objectives

1. Understand the basic elements of guidelines on nutrition of the critically ill adult patients
2. Identify the difficulties and challenges, critical illness poses on optimum nutritional assessment and planning
3. Learn about strategies / practices could be used and attitudes to be adopted

Description (Focus Statement)

Evidence based guidelines addressing the difficulties and challenges critical illness poses on optimum nutritional assessment and planning, do exist. Implementation of these guidelines, however, has been problematic and not uniform due to inherent problems of the ICU environment, personnel attitudes and resistance to change. Understanding the nature of these obstacles would enable the attendees to bridge theory and practice.

Learning Outcome Assessment

5 MCQ (best answer) asked during the presentation and assessed either through voting electronic system or through “hands raising”.

Abstract

Accurate determination of energy needs in hospitalized patients is vital because under-feeding / overfeeding are both associated with complications. Also feeding regimens / route as well as composition and special patients groups needs are all important, especially in critically ill patients where complications and inter-relations are many. REE-predictive equations have been developed based on actual energy expenditure using indirect calorimetry. The accuracy of these equations in groups such as elderly, obese, critically ill, malnourished patients has been questioned. Practice of nutritional support in critically ill patients is consequently suffering from inconsistencies and empiricism. Methods to overcome problems are discussed.

References:


Speaker’s Details:

Name: Dr. Kyprianou Theodoros

Degrees/Credentials: Consultant in Pulmonary Medicine and Intensive Care, Honorary Senior Lecturer/Lead of Clinical Skills, St Georges Univ. of London Medical School

Position Title: Head, Multidisciplinary Intensive Care Unit, Nicosia General Hospital

Employer Address: Ministry of Health

Contact Address: Nicosia General Hospital - Dept. of Intensive Care, 214 Palaios dromos Lemesou, Latsia

Phone/Email: +357 2203809 (08.00 - 16.00), drtheo@cytanet.com.cy

Kyriakidou Stella
Psychologist, Member of Cyprus Parliament

Abstract Title

Myths and realities about cancer – the psychology’s aspect
(Part of panel: Cancer: Myths and realities)

Objectives

1. Identity the rule of psychologist for the treatment of cancer
2. Define the myths and realities for cancer
3. Determine the contribution of the emotional status of the cancer patients to their clinical outcome
Abstract Title

**Nutrition and Trauma (presentation of case studies)**
*(Part of panel: Bridging the Guideline-Practice Gap: The Critical Care Experience)*

**Objectives**

1. Describe the metabolic response to trauma and injury
2. Describe the effects on substrate utilisation
3. Discuss the dietetic implications of these responses

**Description (Focus Statement)**

This session explains the metabolic response to sepsis, trauma and injury and outlines the effects of these responses on substrate utilisation. It aims to enhance the attendees’ knowledge on stress response as well as the dietetic implications of trauma and injury. The relevance to dietetic practice will be explored through a case study presentation.

**Learning Outcome Assessment**

Attendees will be able to discuss the relevance of the metabolic responses to dietetic practice through the presentation of a case study.

**Abstract**

The metabolic responses to injury differ significantly to those of starvation. Severe trauma triggers the release of various neuroendocrine and immunological mediators which induce marked metabolic changes in an attempt to restore the body to its pre-injury condition.

Metabolic changes after trauma are occurring in two different phases, the “ebb” phase and the “flow” phase. The “ebb” phase is initiated within minutes after trauma and persists for several hours after the initial insult. It is characterized by a decline in body temperature and oxygen consumption, aimed at reducing post-traumatic energy depletion (Hasenboehler et al, 2006). The “flow” phase, is described in two parts a) the catabolic and b) the anabolic phase. The initial catabolic phase can last several days or weeks depending on the severity of the insult and is associated with a hypermetabolic state and a significantly increased consumption of energy and oxygen (Trager, DeBacker & Radermacher, 2003; Rixen & Siegel, 2000).

During the stress response there is an increased secretion of pituitary hormones as well as activation of the sympathetic nervous system and immune system as characterized by the release of pro-inflammatory cytokines (Schlag & Redl, 1996; Ertel et al, 1998).

This results in fat mobilisation, hyperglycaemia, sodium and water retention and net protein breakdown. The overall metabolic effect of the hormonal changes is increased catabolism which mobilizes substrates to provide energy sources, and a mechanism to retain salt and water and maintain fluid volume and cardiovascular homeostasis.

Nutrition support in severely injured patients cannot prevent catabolism and negative nitrogen balance and thus the aim of nutrition support is to minimise nitrogen losses. However, it is of key importance not to “overfeed” critically injured patients, since this may contribute to adverse outcomes (Plank & Hill, 2003; Biffl, Moore & Haenel, 2002; Reid, 2006). Early overfeeding of severely injured patients leads to an increase in overall oxygen consumption, carbon dioxide production, hepatic lipogenesis, and hyperglycemia (Reid, 2006).

International clinical guidelines for nutrition support in critically ill patients have been published by various societies including the American Society of Parenteral and Enteral Nutrition (ASPEN), the European Society of Parenteral and Enteral Nutrition (ESPEN), and the Intensive Care Society (ASPEN, 2009; ESPEN, 2006; ICS, 2004).

The ESPEN guidelines suggest providing no more than 20-25kcal/kg per day during the acute and initial phase of critical illness. This can be increased to 25-30kcal/kg per day during the anabolic recovery phase. The ASPEN guidelines suggest the use of predictive equations or providing 25-30kcal/kg per day and the Intensive Care Society recommends the use of 25kcal/kg per day in critically ill patients.
With regards to protein there is no advantage of providing more than 0.2g/kg of nitrogen in severely injured patients as positive nitrogen balance will never be achieved and higher protein intakes are associated with the risks of overfeeding (Elia, 2005).

Once catabolism declines and the patient enters the anabolic phase nutrition support aims to increase protein synthesis and restore muscle mass. Sufficient energy and protein provision is important during this phase in order to replenish losses.

The timing of nutrition support is also critical in the severely injured patient. Although early enteral nutrition has been associated with a decreased posttraumatic infection rate, a shorter duration of hospital stay, and an improved overall outcome (Moore et al, 1994; Spain, 2002), this should be started after the patient is fully resuscitated with a stable cardiovascular system.

References:


Speaker’s Details:

Name: Kyriakidou Evi
Degrees/Credentials: BSc Nutrition, MSc Dietetics
Position Title: Nutrition Support Dietitian, Barts Health NHS Trust
Employer Address: Barts Health NHS Trust, Royal London Hospital, Outpatient Therapies 2nd Floor, Central Tower, London F1 1BB
Contact Address: 81 Oakdale Road, Manor House, London N4 1NU
Phone/Fax/Email: 0044 20 3594 1156 / 0044 20 3594 3215 / evi.kyriakidou@bartshealth.nhs.uk
Abstract Title

Culinary demonstration: Fiber: small changes, big difference

Objectives

1. Provide the most recent information on fiber and its positive effects on human health.
2. Obtain sufficient knowledge on the various nutritional ways of cooking dietary fiber.
3. Obtaining insight into various means of increasing dietary fiber in meals whilst still maintaining the great taste factor and palatable content of such

Description (Focus Statement)

The goal is to impart ideas and knowledge as to the various cooking practices available for increasing dietary fiber content in meals, in order to provide palatable, appealing and nutritionally balanced food. The additional aim is to provide the attendees with further information as to the nutritional and health benefits involved in adopting such practices

Learning Outcome Assessment

• Health and nutritional advantages of using dietary fiber in cooking/meals.
• Ability of increasing dietary fiber content in meals whilst still maintaining quality in taste.

Abstract

Dietary fiber is deemed to be a key component in healthy eating. It contains a unique blend of bioactive components including resistant starches, vitamins, minerals, phytochemicals and antioxidants. So, the health benefits of dietary fiber, as a kind of phytochemical is no longer an issue. Epidemiological and clinical studies demonstrate that a generous intake of dietary fiber reduces risk for developing the following diseases: cardiovascular disease (CVD), hypertension, type two diabetes, obesity, certain gastrointestinal disorders, constipation and hemorrhoids. Furthermore, increased consumption of dietary fiber improves serum lipid concentrations, lowers blood pressure and aids in weight loss and long term weight management.

Defining dietary fiber is a complex process and depends on both nutritional and analytical concepts. Generally speaking dietary fiber is a non-starch polysaccharide in (mostly) plant food that is resistant to digestion and absorption in the small intestine. Simplistically, fibers have been categorized into soluble, such as viscous or fermentable fibers (e.g. pectin) that are fermented in the colon, and insoluble fibers (e.g. wheat bran) that have bulking action but may only be fermented to a limited extent in the colon.

Dietary fiber can be separated into many different fractions. These fractions include arabinoxylan, inulin, pectin, bran, cellulose, β-glucan and resistant starch. The study of these components may give us a better understanding of how and why dietary fiber may decrease the risk of certain diseases as mentioned above. Although the mechanisms behind the reported effects of dietary fiber on human health are not well established, it is believed that the synergistic effect of phytochemicals, increased nutrient content and digestive properties are key elements in the treatment and prevention of obesity and diabetes, reduced CVD and decreased incidence of certain types of cancer.

Fruit, vegetables, whole grains, pulses, cereals and seaweeds are the major sources of dietary components for fiber. Current recommendations for dietary fiber intake (by USDA) are related to age, gender, and energy intake, and the general recommendation for adequate intake is 14 g/1000 kcal. Using the energy guideline of 2000 kcal/day for women and 2600 kcal/day for men, the recommended daily dietary fiber intake is 28 g/day for adult women and 36 g/day for adult men.

Unfortunately, most persons today consume less than half of the recommended levels of dietary fiber daily. The goal of this demonstration is therefore to impart ideas on easy to make recipes for increasing dietary fiber in meals, in order to provide palatable, appealing and nutritionally balanced food with all the health benefits that stem from a higher dietary fiber intake.

References


13) Champagne CM.; Broyles ST.; Moran LD.; Cash KC.; Levy EJ.; Lin PH.; Batch BC.; Lien LF.; Funk KL.; Dalcin A.; Loria C.; Myers VH. “Dietary intakes associated with successful weight loss and maintenance during the Weight Loss Maintenance trial”. J Am Diet Assoc. 2011 Dec;111(12):1826-35.


Speaker’s Details:
Name: Lappa Fotini
Degrees/Credentials: BSc (Hons), MSc
Position Title: Dietitian – Nutritionist with specialization in Sports Nutrition, Lecturer in Nutrition (Intercollege and the University of Nicosia)
Employer Address: Intercollege and The University of Nicosia, Culinary Arts Department, 46 Makedonitissas Ave. P.O.Box 24005, 1700 Nicosia
Contact Address: 53 Stavrou St., 2035 – Strovolos, Nicosia - Cyprus
Phone/ Email: (00357) 22 492148 / lappa.f@unic.ac.cy
Loizou Despo, BSc (Hons), SRD
Clinical Dietitian, Nutritionist, Home Economics Counselor and Teacher

Abstract Title

**Food – A-Pedia (Part of panel: Professional development and education)**

**Objectives**

1. Recognize the importance of promoting health education from the early stages of life
2. Have an overview of how health and nutrition education is applied and promoted in schools
3. Identify the role of the dietitian as a health educator

**Description (Focus Statement)**

Promoting health by fostering healthy eating practices and regular physical activity is believed to have a great impact on health and wellbeing during childhood and later stages in life. Schools are considered as one of the best settings for educating a large segment of the population, including young people, school staff, parents, families and community members. The sub-thematic nutrition education area focuses not only on nutrition education but also on developing skills and behaviours related to good nutritional practices.

**Learning Outcome Assessment**

Participants will be able to incorporate the information and knowledge acquired during the presentation when promoting health and nutrition education goals among children and adolescents (5-14 years).

**Abstract**

Healthy eating practices and regular physical activity have been the focus of many scientific articles, as they are believed to have a great impact on health and wellbeing during childhood and later stages in life.

A number of factors indicate the need to promote health through school-based nutrition education. Such factors include, the on growing epidemic of childhood and adulthood overweight and obesity, as well as the effects this has on the development of other public health problems.

Schools are considered as one of the best settings for educating a large segment of the population, including young people, school staff, parents, families and community members. Thus, when designing and implementing nutrition education activities, a health promoting school approach should take into consideration the needs and interests of the above mentioned groups. Furthermore, such activities should aim in promoting interactions between students, family members, teachers and their social environment.

A number of school-based initiatives have been implemented with the aim of promoting health all around the world. The World Health Organisation has introduced the European Network of Health Promoting Schools project that has led to the development of a school-based nutrition education curriculum, along with a Planning and Evaluation Guide. Furthermore, The Schools for Health in Europe Network (SHE network) is the European platform for school health promotion. The SHE network aims at supporting organisations and professionals to further develop and sustain school health promotion in each member state.

Specifically, at the Netherlands a health promoting school approach was implemented based on eight components, namely; health education, physical activity, food policy, a healthy and safe school environment, participation of parents and community, psychological and social-emotional guidance and counseling, provision of care and workplace health promotion. Additionally, in the United Kingdom, the Food Standard Agency (FSA) launched a set of food competences across the UK, to help young people choose, cook and eat safe healthy food. The competences were set out as a framework of core skills and knowledge for children and young people aged 5-16+ years.

Moreover, in the USA, in 1997 the Centre for Disease Control and Prevention (CDC) issued guidelines for school and community health programmes to promote physical activity and healthy eating among young people, while in 2000, the School Health Index for physical activity and healthy eating was published as a school self-assessment and planning guide to implement health promotion projects in Elementary, Middle and High schools.
Finally, in Cyprus as part of the educational reform of the school curriculum, health education has been introduced mainly through the Home Economics and the Biology subjects, both in primary and secondary school level (5-14 years) taking into consideration the transition from “health education to health promotion”. As such, the new curriculum was designed with emphasis on changing children's attitudes and behaviors towards health, to strengthen their ability to contribute to the creation of a healthy community, by taking into account their physical, social and cultural environment. It is worth noting that the sub-thematic nutrition education area focuses not only on nutrition information but also on developing skills and behaviours related to areas, such as food preparation and cooking, food production, preservation and storage, social and cultural aspects of food and eating as well as on good consumer practices. Furthermore, it enhances self-esteem and promotes a positive body image.

In conclusion, teaching methods should not only be interactive but should also vary depending on the learning objectives of the curriculum. This could include role playing activities and drama, classroom discussions and small projects designed and implemented by the students. Furthermore, the use of specifically designed computer programs for nutrition education and worksheets could be used, together with cooking activities, keeping food records charts, shopping activities, designing meals and menus and taste-testing. In addition, extra-curricular activities could also be endorsed, such as cooking sessions with parents and members of the community, school gardening, organizing exhibitions, organizing and participating in workshop activities, as well as other activities promoting physical wellbeing such as biking or walking to school.

References


Speaker's Details:

Name: Despo Loizou
Degrees/Credentials: BSc (Hons) Nutrition and Dietetics, SRD
Position/Title: Clinical Dietitian, Nutritionist, Home Economics Counselor and Teacher
Employer Address: Ministry of Education and Culture, Kimonos and Thoukididou Corner, 1434, Nicosia, Cyprus
Contact Address: 8 Kikeronos Str. 2028, Dasoupoli, Strovlos, Nicosia, Cyprus
Phone/Fax/Email: +35722446440 / +35722446441 / loizougd@cablenuet.com.cy

Dr. Madden Angela, PhD, RD
Professional Lead for Dietetics, University of Hertfordshire

A. Abstract Title

Nutritional screening using MUST -workshop / Interactive Presentation
(Part of panel: Weight management and metabolic diseases)

Objectives

1. Outline the purpose and value of using nutritional screening.
2. Explain the role of validated tools in nutritional screening and support this with evidence.
3. Describe the challenges and implications associated with nutritional screening and how these can be addressed in practice.

Description (Focus Statement)

This session will review the evidence for screening nutritional status of people in different situations. The process of validating screening tools will be considered with a focus on the Malnutrition Universal Screening Tool (MUST). The challenges and implications associated with using nutritional screening in practice will be considered.

Learning Outcome Assessment

Delegates who wish to assess their learning should write an evidence-based paragraph addressing each of the objectives relating these to their own practice, i.e. clinical, primary care, public health etc.

Abstract

Purpose and value of nutrition screening
Medical screening is defined as the process of identifying apparently healthy people who may be at increased risk of a disease or condition (UK National Screening Committee, 2012). Those identified as being at risk can then be offered further tests and treatment if necessary to improve health. Similarly, nutrition screening aims to identify people who are at increased risk of the consequences of nutritional impairment, including under-nutrition and obesity, and to offer appropriate action to address this. There is considerable evidence to indicate that nutritional impairment is common in people living in the community and in hospitalised patients and, in both these groups, is associated with worse health outcomes. Therefore, using resources to screen for nutritional impairment appears logical. However, nutrition screening will only yield potential benefits if it is undertaken using an appropriate tool and if the findings from the screen are used to determine further nutritional intervention.

The role of validated screening tools
Many different nutrition screening tools are currently in use in different settings and with general and specific populations (Green & Watson, 2005; Phillips et al., 2010). For a tool to be useful, it needs to be systematically developed and evaluated (Jones, 2002). This includes examination in a relevant setting of (1) its reliability
when used by different observers, (2) the contribution made by component variables, e.g. body mass index or weight loss, (3) the appropriateness of the cut-off points used and (4) the ability of the tool to yield results which predict healthcare outcomes. Two commonly used tools which have been widely evaluated include the Malnutrition Universal Screening Tool, MUST, (Elia, 2003) and the Mini Nutritional Assessment, MNA, (Guigoz et al., 1996).

**Challenges associated with nutrition screening**

Whilst establishing the validity of a nutrition screening tool should be an essential pre-requisite for its use, other issues associated with using the tool also need to be considered. These can raise challenges which can be broadly described in two related groups. Firstly, the practicality and logistics of undertaking the measurements, how these are interpreted, the training required, the overall acceptability to those being screened and the costs of implementing the whole process (Elia & Stratton, 2011; Elia & Stratton, 2012). Secondly, as there is little evidence to indicate that nutrition screening alone is associated with beneficial changes in clinical outcome (Weekes et al., 2009; Vincent et al., 2012), the process of screening must fit within a wider nutritional programme that includes suitable intervention for individuals identified as being at nutritional risk. These challenges need to be addressed in clinical and public health practice in order to optimise potential benefits from nutritional screening and intervention.

**References:**


**B. Abstract Title**

**Non-alcoholic fatty liver disease / NASH (Part of panel: Novelties in Nutrition)**

**Objectives**

1. Describe the prevalence, prognosis and putative pathogenesis of non-alcoholic fatty liver disease (NAFLD) and non-alcoholic steatohepatitis (NASH).

2. Evaluate the evidence to support nutritional interventions in the treatment of NAFLD and NASH.

This session will provide an overview of the hepatic complications associated with overweight and obesity. The current evidence to support nutritional intervention in this condition will be presented.

**Learning Outcome Assessment**

Delegates who wish to assess their learning should write an evidence-based paragraph addressing each of the objectives and identify what they consider are the major gaps in the evidence and where future research priorities should lie.
Abstract

Non-alcoholic fatty liver disease (NAFLD) is a term used to describe the early stages of a progressive spectrum of liver conditions that are associated with over-nutrition. In some individuals, this may develop into non-alcoholic steatohepatitis (NASH) and then, sequentially, to fibrosis, cirrhosis and hepatocellular carcinoma although progression is not inevitable. NAFLD is diagnosed when lipid accumulated in the hepatocytes accounts for >5% of the liver weight in people who abstain from alcohol or drink very little (men<21 and women <14 drinks/week) (Basaranoglu et al., 2010). Most people with NAFLD are also at risk from other metabolic disorders including obesity, diabetes and dyslipidaemia.

Prevalence
Prevalence varies with population and diagnostic criteria but an estimated 20% of the general adult population has NAFLD and 3-5% has NASH (Chalasani et al., 2012). Approximately 90% of adults undergoing bariatric surgery for severe obesity have NAFLD with ~5% being diagnosed incidentally with cirrhosis. Age, gender and ethnicity influence prevalence with risk of NAFLD increased in older people, men and Hispanic individuals. Children, especially if obese, may also be affected (Schwimmer et al., 2006).

Prognosis
Individuals with NAFLD have an increased risk of mortality compared to matched healthy populations and cardiovascular disease is the most common cause of death. Those with NASH have an increased risk of liver-related death.

Putative pathogenesis
A ‘two-hit’ mechanism has been proposed to explain the development of NAFLD and progression to NASH based on increased insulin resistance secondary to obesity. This causes (1) peripheral lipolysis and reduced hepatic lipid oxidation leading to accumulation of hepatocyte lipid and then (2) hepatic lipid peroxidation resulting in anti-oxidant stress and cellular damage (Zivkovic et al., 2007). This does not explain NAFLD in non-obese individuals.

Evidence to support dietary management
Lifestyle modification leading to weight loss in adults is most likely to be beneficial with loss of 3-5% of body weight associated with reduction in lipid accumulation in NAFLD whilst a 10% loss is associated with reduced inflammation in NASH. This can be achieved by dietary restriction of energy intake and / or increased energy expenditure through exercise (Chalasani et al., 2012; Thoma et al., 2012). There is some evidence that rapid weight loss (>1.6 kg/week) is not advisable (Andersen et al., 1991) and that a Mediterranean diet and lower intake of fructose / simple sugars may be beneficial (Zivkovic et al., 2007; Yki-Järvinen, 2010). High alcohol intake, defined as men >14 and women >7 drinks/week, is not recommended; the reported potential benefits of consuming <1 drink/day have not been confirmed. The antioxidant effects of vitamin E in pharmacological doses have been examined with varying results and supplements are not currently recommended in NAFLD but 800 IU / day is advised for non-diabetic adults with NASH (Chalasani et al., 2012). No good quality dietary studies have been undertaken in children with NAFLD or NASH but appropriate lifestyle modification in those who are overweight is considered likely to be of benefit.

References

Mc Clinchy Jane, MSc, RD, FHEA
Principal Lecturer and Programme tutor, University of Hertfordshire

A. Abstract Title

The Role of the Multidisciplinary team in giving nutritional advice
(Part of a panel: Professional development and education)

Objectives

1. Discuss the research evidence supporting the need for health care professionals to deliver nutritional advice
2. Discuss the research evidence exploring the potential role for health care professionals in the delivery of nutritional advice
3. Contribute to the discussion regarding how dietitians can support the role of health care professionals in the delivery of nutritional advice

Description (Focus Statement)

Long term health conditions either wholly or partly diet related, continue to increase in the United Kingdom and internationally; however there are insufficient dietitians to provide nutritional advice. This paper pulls together research projects undertaken by the presenter as well as published research to explore the role of the multidisciplinary team in delivering nutritional advice.

Learning Outcome Assessment

The objectives will be assessed through the discussion after the presentation

Abstract

Long term health conditions either wholly or partly diet related, continue to increase in the United Kingdom and internationally. Registered dietitians are the only qualified health professionals that assess diagnose and treat individual nutritional problems at an individual and wider public health level, however there are insufficient dietitians to provide nutritional advice. A wide range of health professionals including GPs, practice nurses, midwives and pharmacists deliver nutritional advice (McClinchy et al. 2011, AfN 2012). In addition the AHPF (2008) identified allied health professionals as being key in supporting the self-management of long term conditions.

In the last twenty years the NHS has shifted from a doctor led organisation to a profession led organisation with a large number of professionals each with their own specialism. This has brought with it concerns about communication between the different professions (Colyer 2004). This paper pulls together research projects undertaken by the presenter as well as published research to explore the role of the multidisciplinary team in delivering nutritional advice.

Across Europe including the UK, dietitians receive referrals from doctors who may need to give first line dietary advice. In the UK the Royal College of Physicians expects doctors to be aware of nutritional problems and how to manage them (Kopelman and Lennard-Jones 2002) and the NHS now gives financial reward to primary care doctors for the improved management of their patients who have long term health conditions including those which are either wholly or partly diet related such as diabetes, hypertension or obesity (NHS Employers 2006). GPs do give nutritional advice (McClinchy et al. 2011) however this may be limited by negative attitudes, lack of knowledge and confidence and time. Nurses are spending more time in managing long term conditions (Truswell et al. 2003) and may have more time to give on-going support to their patients (Laurent et al. 2007), however although they see their role in delivering nutritional advice as important their effectiveness may be limited by lack of training and confidence.

Community pharmacists in the UK now undertake public health work as part of their contract (PSNC 2012) and research has found that their involvement can be effective (Botomino et al. 2008). In France however there is some evidence that their ability to undertake this role may be limited by lack of knowledge (Ragot et al. 2005) and research suggests that their role could be further enhanced by additional training and access to evidence based materials.

There is some evidence that AHPs have a role in delivering nutritional advice for example in referring onto dietitians however they may not feel well equipped to do so (McClinchy et al. 2010). At the same time dietitians may not feel that this is an appropriate role for AHPs because of their lack of training. Both AHPs and dietitians
appear to be uncertain of each other’s role suggesting that the concerns regarding communication between specialist professions raised by Colyer (2004) may limit the effectiveness of nutritional interventions.

With the increase in long term conditions there is a need for dietitians to enlist the support of other healthcare professionals to deliver nutritional interventions at the level of first line advice and to ensure they are aware of who to refer to when specialist advice is required.

References


B. Abstract Title

Workshop: Nutrition Care Process

Objectives

1. Define the NCP and apply this to their own practice
2. Define the IDNT and be able to apply this to their own practice
3. Understand the value of the process and the IDNT to dietetic practice

Description (Focus Statement)

This session aims to support delegates in the application to their own practice, exploring the differences in the processes in use and the use of the IDNT. The session will be an interactive workshop involving group work and the use of case studies.

Learning Outcome Assessment

The objectives will be assessed through the delegates involvement in group work
Abstract

The BDA has recently re-launched the Nutrition and Dietetic Process (N&DP) (BDA, 2012a). The process is considered to be a problem-solving model designed to facilitate communication. The UK process is based on the American Dietetic Association now the Academy of Nutrition and Dietetics (AND). It was included in the dietetic pre-registration education and training guidelines (CPSM, 2000), was first introduced to the association to the UK in 2006, updated in 2009 (BDA, 2009) and included in the BDA curriculum guidelines (BDA, 2008). Following this, universities started to teach the process to their students for them to use whilst on placement; however evidence from student feedback suggests that the use of the process is limited. In addition early results of research suggest that some departments are using the process whilst others in the UK remain uncertain of its effectiveness and concern that it may restrict dietitians’ autonomy. In addition dietitians in the UK use a range of processes for example; SOAP (subjective, objective, assessment, plan); RAT (referral, assessment, treatment); Clinical Reasoning (see Pender 2008). However the use of these may not be standard within any one department.

The International Dietetic and Nutrition Terminology (IDNT) provides a standardised set of terms to describe the results of each step of the model and enables consistency of practice (ADA, 2008)). At the same time as the re-launch of the N&DP the BDA have also produced a record standards briefing (BDA, 2012b) which refers to the use of the IDNT and the need to develop its use. This is already a key part of the USA process and it is the intention of the European dietitians to also use the IDNT.

The evidence from the USA and early UK research suggests that on-going training in the implementation of the process is needed. (Lacey & Pritchett, 2003). The BDA is aware of the need to develop the process and terminology as well as tools to facilitate its use within UK and the importance of learning from international experiences (BDA 2012b).

This session aims to support delegates in the application to their own practice, exploring the differences in the processes in use and the use of the IDNT. The session will be an interactive workshop involving group work and the use of case studies.

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3) BDA (2009) The Nutrition and Dietetic Care Process Birmingham, BDA

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Speaker’s Details:

Name: McClinchy Jane
Degrees/Credentials: MSc by Research, Registered Dietitian, Fellow of the Higher Education Academy
Position Title: Principal Lecturer and Programme Tutor BSc (Hons) Dietetics
Employer Address: University of Hertfordshire College Lane Campus, College Lane, Hatfield, Herts AL109AB
Contact Address: University of Hertfordshire College Lane Campus, College Lane, Hatfield, Herts AL109AB
Phone/Fax/Email: 00441707 285102 / 0044 1707 284977 / j.1.mcclinchy@herts.ac.uk

Dr Papamichael Demetres, MB, BS, FRCP
Director, Dept., of Medical Oncology

Abstract Title

Bowel cancer and treatment
(Part of panel: The state of the science: evidence to support diet and physical activity recommendations for cancer prevention)

Objectives

1. Get a broad overview of current options for systemic chemotherapy for colon cancer
Abstract

More therapeutic options are now available than ever before for patients with metastatic colorectal cancer (mCRC) and as such, treatment decisions have become more complex. A multidisciplinary approach is now more than ever before, required to effectively manage these patients.

In the past few years, many trials have reported on the value of combining biological agents, such as those targeting vascular endothelial growth factor and epidermal growth factor receptors, with chemotherapy. However, despite the plethora of information now available, the optimal treatment strategy for patients with mCRC remains unclear. Indeed, the propensity of investigators to conduct clinical trials utilising a variety of chemotherapy backbones combined with the increased complexity of retrospectively incorporating analyses of genetic mutation status (eg KRAS and BRAF) have led to conflicting results for seemingly similar endpoints, especially overall survival. As a result, guidelines that have been developed, while having some similarities, are quite often different in terms of suggested therapeutic algorithms.

The aim of this presentation is to review and distil the currently available data reported from phase III trials of chemotherapy plus biologics in the mCRC setting.

References:


Speaker's Details:

Name: Papamichael Demetres
Degrees/Credentials: MB BS FRCP
Position Title: Director, Dept., of Medical Oncology
Employer Address: Bank of Cyprus Oncology Centre, 32 Acropoleos Ave., Strovolos 2006, Nicosia
Contact Address: Bank of Cyprus Oncology Centre, 32 Acropoleos Ave., Strovolos 2006, Nicosia
Phone/Fax/Email: +35722 841306 / +357 22511870 / demetris.papamichael@bococ.org.cy

Abstract Title

New directions in lactose intolerance: moving from science to solutions (Part of Satellite Symposium: Gastrointestinal Disorders and Nutrition)

Objectives

1. Identify lactose intolerance and how this differs by age, ethnicity and race.
2. Identify strategies that are effective in managing individuals with lactose intolerance.

Description (Focus Statement)

There are race and age differences in Lactose Intolerance. Evidence regarding the effect of dairy exclusion diets on long-term gastrointestinal and bone health outcomes is relatively sparse in quantity and low in quality. The majority of symptomatic individuals diagnosed with lactose intolerance can likely tolerate up to 12 grams (equivalent of 1 cup of milk) at a given setting with minimal to no symptoms, especially if consumed with other foods.

Learning Outcome Assessment

1. By presenting the definition criteria of lactose intolerance as well as the prevalence in different countries.
2. By describing all possible strategies (lactose reduced milk, hydrolyzed milk, probiotics, e.t.c.) that would benefit individuals with lactose intolerance.

Abstract

Milk and milk products contain high concentrations of the disaccharide lactose (galactose and glucose linked by a beta-galactoside bond). Intestinal absorption of lactose requires that the disaccharide be hydrolyzed to its component monosaccharides, both of which are rapidly transported across the small bowel mucosa. We defined lactose intolerance to be present when ingestion of 50 grams of lactose (or less) as a single dose by a lactose malabsorbing subject induces gastrointestinal symptoms. The problem may become more serious when self-diagnosed lactose intolerant parents place their children on lactose restricted diets (even in the absence of symptoms) or use enzymatic replacement in the belief that the condition is hereditary. Children and adults with lactose Intolerance may avoid dietary milk intake to reduce symptoms of intolerance. Since the avoidance
of milk and milk containing products can result in a dietary calcium intake that is below recommended levels of 1,000 milligrams (mg) per day for men and women and 1,300 mg for adolescents. Osteoporosis and associated fractures secondary to inadequate dietary calcium is the perceived major potential health problem associated with real or assumed lactose intolerance. Current dietary recommendations suggest consuming 3 cups/day of fat-free or low-fat milk or equivalent milk products. This amount is equivalent to about 50 grams of lactose, which we defined to be the threshold of minimum tolerance. Probiotics seem to have promise in the prevention or treatment of several diseases, including lactose intolerance. Data from numerous studies have shown that the appropriate strains of lactic acid bacteria in fermented milk products can relieve symptoms of lactose intolerance by secretion of bacterial lactase into the intestine and stomach. Lactose Intolerance is well recognized by the medical and lay community and is often blamed for being the cause of diarrhea, abdominal pain, bloating, and flatulence. Patients self diagnose the condition and drastically reduce or stop their intake of lactose or use supplements to help digest lactose. This has the variable effect of reducing or alleviating symptoms. However, given the subjective nature of symptoms and the large placebo effect of any dietary manipulation, it is unclear if the response is a placebo effect or due to use of supplements. The literature on efficacy of hydrolyzed milk, probiotics, and supplements to help digest lactose is not so clear with this problem. Rigorous double blinded placebo controlled studies are required to demonstrate efficacy, and larger long-term studies demonstrating effectiveness are needed.

References:


Speaker's Details:

Name: Papandreou Dimitris  
Degrees/Credentials: PhD, M.S., M.Ed., R.D.  
Position Title: Assistant Professor of Nutrition, Department of Life and Health Sciences  
Employer Address: University of Nicosia, 46 Makedonitissas Ave, 1700, Nicosia, Cyprus  
Contact Address: University of Nicosia, 46 Makedonitissas Ave, 1700, Nicosia, Cyprus  
Phones/Email: +306937001606, +35797784892, papandreoudimitrios@yahoo.gr

Papadopoulou Nicoleta, MS, RD, CDN  
Clinical Dietitian

Abstract Title  
Role of nutrition and exercise in the treatment of metabolic syndrome  
(Part of panel: Eat well, love better, move more: treatment of cardiometabolic syndrome)

Objectives

1. Define metabolic syndrome and be able to identify its risk factors
2. Understand the role of dietary interventions/ modifications. Exercise and lifestyle changes in the treatment of metabolic syndrome
3. Identify dietary and lifestyle practices that help with the treatment of metabolic syndrome.

Description (Focus Statement)

It is now known that when certain chronic disease risk factors co-occur (dyslipidemia, hypertension, impaired glucose tolerance, hyperinsulinemia and abdominal obesity), there is an increased risk for cardiovascular disease and diabetes. The metabolic syndrome is a defined collection of three or more these chronic disease risk factors. The treatment of metabolic syndrome aims to treat both the underlying cause of the syndrome, and also to treat the associated cardiovascular risk factors. Since many people with metabolic syndrome are
overweight and lead a sedentary lifestyle, weight reduction, dietary intervention and implementing exercise programmes should be a primary focus on the treatment of metabolic syndrome.

Learning Outcome Assessment

The above objectives are assessed by (1) Defining the metabolic syndrome and its risk factors (2) review the important role of weight reduction, diet, and exercise in improving the metabolic syndrome and its risk factors (3) Review literature on dietary and lifestyle practices that help with the treatment of metabolic syndrome.

Abstract

Metabolic syndrome has received much attention in the last years due to its rising prevalence levels worldwide. There has been much debate regarding the definition of metabolic syndrome, however there is a general agreement that it is mainly characterized by a collection of metabolic disorders, such as dyslipidemia, hypertension, impaired glucose tolerance, hyperinsulinemia and abdominal obesity (1,2). Each of the associated conditions has an independent consequence but collectively, they have a synergistic effect, making the risk of developing both type 2 diabetes and atherosclerotic cardiovascular disease (ASCVD) even greater (1). Metabolic syndrome is a complex illness that is largely influenced by lifestyle factors. Thus, the major emphasis in the management of metabolic syndrome is to lessen the changeable, underlying risk factors such as obesity, physical inactivity, and atherogenic diet (one that is high in saturated fat and cholesterol).

The NCEP ATPIII has recommended therapeutic lifestyle changes (TLC) in order to decrease the incidence of metabolic syndrome (3). Moreover, results from several studies suggest that people with metabolic syndrome may benefit from aggressive lifestyle modifications including dietary alterations and adopting a more physical and active lifestyle (1,2,3,4). Therefore, weight reduction, dietary intervention and implementing exercise programs should be a primary focus and the initial therapies recommended for the treatment of metabolic syndrome. If lifestyle interventions are not enough, then drug treatment for abnormalities in the individual risk factors may be indicated.

Since many people with metabolic syndrome are overweight, weight loss is of primary importance, especially for those individuals with metabolic syndrome who present with abdominal obesity (1,4,5). Weight loss and maintenance of a lower weight are best attained by a combination of reduced caloric intake, exercise, and changes in an individual’s eating and lifestyle behaviors. In certain instances, weight loss drugs, even though of limited use, may be prescribed. In addition, bariatric surgery is another option being used increasingly in the United States for severe obesity. Nevertheless, diet and exercise are the choices of preference.

Beyond weight management and reduction of total calories, substantial evidence indicates that there are protective health benefits from dietary patterns which are high in fruits, vegetables, legumes and whole grains and which include fish, nuts, and low-fat dairy products (2,3,5,6,7,8,9). Moreover, the diet for the treatment of the metabolic syndrome should be limited in the intake of saturated fat. Moderate amounts of monounsaturated fat may be allowed as they do not induce harmful metabolic effects. The traditional Mediterranean diet is one such dietary pattern that has received much attention and has been researched extensively. Indeed, Mediterranean style dietary patterns seem to be effective and particularly promising in reducing the incidence of metabolic syndrome and its associated risk factors.

Lastly, increasing physical activity not only assists in weight loss but also has favorable outcomes on metabolic risk factors (1,3). More importantly, it mitigates overall atherosclerotic cardiovascular disease risk. Current recommended guidelines suggest ≥ 30 minutes of moderate-intensity exercise, such as brisk walking, on most, and preferably all, days of the week. Even greater amounts of physical activity have a greater benefit. Hence, going beyond current recommendations will be particularly beneficial. Nevertheless, for high-risk patients, such as those with recent acute coronary syndromes or recent revascularization, exercise programs should be carried out under medical supervision.

In conclusion, lifestyle interventions should be the first therapies suggested for the treatment of metabolic syndrome. A large body of evidence seems to indicate the significant beneficial effects of diet and exercise in reducing the risks associated with metabolic syndrome and, consequently, any associated co-morbidities.

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Speaker’s Details:

Name: Nicoleta Papadopoulou
Degrees/Credentials: MS, RD, CDN
Position Title: Clinical Dietitian
Employer Address: 6 George Davaris str, suite 101, Strovolos 2024
Contact Address: 6 George Davaris str, suite 101, Strovolos 2024
Phone/Fax/Email: 99458617, 22496577, nicoletapapadopoulou@gmail.com

Dr. Pavlidou Sofia, MD
Scientific Collaborator, Atherosclerosis Outpatient Clinic, Second Department of Cardiology, Medical School, Aristotle University of Thessaloniki, “Hippokration” Hospital, Thessaloniki, Greece
Secretary of Atherosclerosis Society of Northern Greece

Abstract Title

Μύθοι και αλήθειες σχετικά με τη διατροφή. Τι πραγματικά ωφελεί την καρδιά μας; ("Myths and truths about nutrition. What really is good for our heart?")

(Part of panel Open for the Public – session in Greek)

Objectives

1. Improve their health by following a healthy diet

Abstract

Food is essential to the growth of all living organisms as well as their sustenance to life. Besides, the pharmaceutical and by extension healing properties of certain types of food have been known since the era of Hippocrates, who claimed that «food must be our medicine and medicine must be our food».

In Mediterranean cuisine there is a wide range of foods which are supposed to contribute to the good function of the body, more specifically of the cardiovascular system. However, there are controversial opinions and, as a result there is confusion regarding what really benefits and protects us from cardiovascular diseases.

Garlic and onion are two kind of food which are believed to have a positive influence on the reduction of arterial blood pressure and cholesterol. In fact to possibly achieve hypotension and hypolipidemic action, an excessive amount needs to be consumed, that is 15-20 gloves of garlic and 4-5 onions daily.

Red wine contains plenty of substances with beneficial effects on the cardiovascular system. The primary ones are polyphenols e.g resveratrol, glycerol and tanins. These substances act as antioxidants and their action is stronger than that vitamins C and E. They also reduce oxidization of LDL lipoprotein and the agglutination of thrombocytes. Besides, they reduce homocysteine, an aminoacid whose high concentration has a negative effect on the cardiovascular system.

Salt is used not only for making food more savory but also for preserving it. The influence of salt on arterial blood pressure has been indisputable and scientifically established for several decades. Today, it is a given fact excluding salt from our diet is not sufficient but what is also necessary is to maintain ideal bodily weight and reduce consumption of all foods containing large amounts of salt, e.g bread, cheese, sausages, nuts.

Dark chocolate contains polyphenols and flavonoid substances. These substances contribute to the reduction of systolic arterial blood pressure, to the improvement of glucose metabolism and to the increase in tissue sensitivity to insulin. Besides they make endothelium more functional and reduce blood coagulability. Consequently daily consumption of dark chocolate in small quantities has beneficial effects on our cardiovascular system.
Eggs are an extremely popular and nutritious type of food, with its rich in vitamins and minerals, high quality proteins, cholesterol, unsaturated fats and antioxidant compounds. Dyslipidemics often mistakenly exclude this type of food from their diet as consumption of eggs in moderation (up to 3 per week) is allowed as part of a balance diet. Green tea contains polyphenols, which are antioxidant substances that reduce LDL cholesterol, prevent its oxidization while reducing blood coagulability.

Cinnamon is a spice obtained from the inner bark of several trees from genus Cinnamomum and that is used on both sweet and savoury foods. Studies have shown that cinnamon has a lot of benefits to the cardiovascular system. They suggest that just ½ teaspoon of cinnamon per day can reduce the risk of heart and cardiovascular disease, because it can lower LDL cholesterol. Also, several studies have shown that Cinnamon may help treat Type 2 Diabetes by lowering blood sugar levels and increasing the amount of insulin production in the body.

Finally, regarding coffee, today the view that coffee increases arterial blood pressure is widespread and strong it has been proved that the influence of caffeine on arterial blood pressure is temporary after coffee consumption and has no long-term effects. On the other hand, coffee contains antioxidant substances and magnesium, which positively affect endothelium function.

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Speaker’s Details:

Name: Pavlidou Sofia
Degrees/Credentials: Degree of Medicine, Medical School, Aristotle University of Thessaloniki, Student of Dietology, Technological University of Thessaloniki
Position Title: 1. Scientific Collaborator, Atherosclerosis Outpatient Clinic, Second Department of Cardiology, Medical School, Aristotle University of Thessaloniki, “Hippokration” Hospital, Thessaloniki, Greece, 2. Secretary of Atherosclerosis Society of Northern Greece
Contact Address: Str. Kalidopoulou 12, 54642, Thessaloniki, Greece
Phone/Fax/Email: +306948947793, +302310-256839, sofiabmp@yahoo.gr

Dr. Philippou Christiana, RD, DProf
Clinical Dietitian and sports nutritionist
Vice President of CyDNA

Abstract Title

Myths and realities about cancer –the nutrition aspect
(Part of panel: Cancer: Myths and realities)

Objectives

1. Explain the nature of controversy regarding dietary fat, diet fiber, red meat, alcohol, overweight and obesity and the risk of cancer
2. Discuss the role of antioxidant vitamins and minerals in cancer prevention.
3. Discuss current dietary guidelines and rational related to the cancer risk of naturally occurring carcinogens, food additives and contaminants
4. Describe the role of phytochemicals as anticarcinogenic agents.
5. Identify the types of quackery associated with cancer prevention.

Description (Focus Statement)

The relationship between diet and cancer is complex. The current dietary recommendations will be explored and examine the scientific evidence which provide the underlying rationale for those guidelines.

Learning Outcome Assessment

The objectives will be assessed through the discussion after the presentation.

Abstract

The causes of cancer can be genetic, environmental, viral, or related to life style. While strides have been made in the treatment of the disease and survival rates have improved, a cure for cancer remains elusive. Although the relationship between cancer and diet is not as clear as that between smoking and cancer, Wynder and Gori (1977) have estimated that 40 percent of cancer incidence in men and approximately 60 percent in women is associated with diet. The most often quoted figures about diet and cancer come from Doll and Peto (1981) study which estimated that 35 percent of all cancer deaths (range 10 percent to 70 percent) are related to diet. Research suggests that the majority of cancer incidence is due to life-style and environmental factors, supporting the conclusion that most cancers are preventable (NCI, 2009). In fact, experts have indicated that eliminating modifiable risk factors such as smoking and poor nutrition is the most effective way to reduce the burden of cancer (Curry, et al, 2003). About one-third of cancer deaths may be attributable to nutrition and physical activity factors, including excess weight (ACS, 2009).

Some dietary components such as fat and alcohol, as well as obesity seem to promote the cancer process, while others including fiber, vitamin A, and phytochemicals found in fruits and vegetables may be protective or inhibit the cancer process. Dietary substances can be considered carcinogenic or co-carcinogenic and, therefore, associated with increased cancer risk. These include alcohol, salt-cured or smokes meats, foods containing nitrates and nitrates, and a high caloric dietary intake. Food substances may also be proactive or protective, thus reducing cancer risk. Examples of dietary substances from this category include cruciferous vegetables, and possibly vitamin C and D (Kushi, 2006).

Hundreds of studies, both experimental and epidemiological have been done to uncover the importance of dietary fat in the cancer puzzle. In 1982, the National Research Council's (NRC) Committee on Diet, Nutrition and Cancer concluded that of all the dietary components studied up to that time, the scientific evidence was most suggestive of an association between fat intakes and the occurrence of cancer of certain sites, particularly the breast and colon (NRC, 1982). Most experts feel that a low fat diet is still the most prudent course to follow, especially in light of the other diseases in which a high fat diet is implicated.

High fat diets have been weakly associated with an increased risk of colorectal, prostate and postmenopausal breast cancers. Research is ongoing as to whether these associations are due to total amount of fat, specific type of fat, calories contribute by fat, or some other factor related to high fat foods. Although the knowledge is incomplete the advice (AICR 2006, Kushi et al 2006) is to consume fat in moderation emphasizing healthier fats while limiting consumption of unhealthy or saturates fats and in particular to limit consumption of red meats Scientific evidence does not suggest that protein in and of itself modifies the risk of cancer at any site. However, all of the major cancer-relates agencies do caution about the amount of red meat that should be consumed to reduce cancer risk (550-600g/week) (WCRF/AICR 2007).

In regards to overweight and obesity the recommendations are unanimous to achieve and maintain a healthy weight throughout life. Despite the uncertainties associated with fiber research, dietary fiber guidelines are fairly consistent among the major health organizations. They all emphasise the importance of variety when selecting fiber-rich foods. All the major cancer and health agencies offer the same advice to increase the consumption of a variety of fruits and vegetables for vitamins and minerals. The NRC advice is to avoid taking supplements in excess of the RDA in any one day. The WCRF/AICR, 2007 recommends not using supplements to protect against cancer and to aim to meet nutritional needs through diet alone.

The role of nitrates and nitrates in an increased risk of cancer, evidence is also available that salt cures or pickled foods may increase the risk of stomach and oesophageal cancer (WSG, 1991).


Steinmetz and Potter, 1991 suggested that the potential for cancer chemoprevention by non-nutrients components of fruits, vegetables and plant can be overshadowed by the recognition that some of the compounds have shown carcinogenic effects, including certain flavonoids, indoles and phenolic compounds To be sure, other adverse effects of vegetable and fruit consumption must be acknowledged i.e. the presence of nitrates, aflatoxin, and pesticides and herbicides. Furthermore, evidence from many studies now suggests that a diet rich in fruits and vegetables provides protection against cancers of the colon, rectum, stomach, lung, mouth, pharynx and oesophagus and probably reduces the risk of cancers of the breast, bladder, pancreas and larynx. WHO/FAO, 2003, Kushi, 2006, all support the inclusion of generous amount of fruits and vegetables in our diets.

References:


Speaker’s Details:

Name: Christiana Philippou Charidemou
Degrees/Credentials: RD, DProf
Position Title: Clinical Dietitian and Sport nutritionist Vice President of CyDNA
Employer Address: Ministry of Education and European University
Contact Address: Methonis 3 Strovolos 2057 Nicosia / Cyprus
Phone/Fax/Email: 99 497959, evelina@cytanet.com.cy

Philpot Ursula, BSc (hons) , MSc, PGCHE, RD
Chair of the British Dietetic Association’s Mental Health Group
Advanced Practice Dietitian and Senior Lecturer- Eating disorders

Abstract Title

Eating disorders workshop: Anorexia & Bulimia

Objectives

1. Select suitable treatment options for each condition and assess when to signpost to other treatment providers if needed
2. Deliver a range of dietetic interventions to enable behaviour change in clients suffering from Anorexia Nervosa or Bulimia Nervosa

Description (Focus Statement)

The workshop will focus on assessing and guiding clients to appropriate treatment for their eating disorder. The workshop will aim to up- skill dietitians working in this area to deliver a range of dietetic interventions to support behaviour change in clients suffering from either anorexia Nervosa or Bulimia Nervosa. This will be delivered through a series of knowledge updates and practical exercises, and via discussion of case studies. The interventions will be discussed and participants will look at the practical application of dietetic interventions to real life case studies.

Learning Outcome Assessment

To assess knowledge and application of knowledge, the participants will discuss a range of case studies, and will consider which treatment options may be most appropriate, which dietetic interventions they could use, and the rationale for these.
After this presentation, the attendee will be able to:

1. Carry out a dietetic assessment
2. Select suitable dietetic treatment options for each condition
3. Deliver a range of dietetic interventions that enable behaviour change in clients suffering from Anorexia Nervosa or Bulimia Nervosa

Abstract

Working with patients with eating disorders requires a comprehensive level of knowledge and skill mix to meet the complex needs and challenges of this client group. The dietitian should be able to draw on a range of dietetic interventions that can be applied to individual circumstances and that fit with a psychological approach to recovery.

Eating disordered behaviours arise from psychological difficulties and are a way of coping with and communicating distress. A collaborative team of professionals is required to best manage individuals with an eating disorder (Mehler and Anderson 1999), each contributing their own unique skills and expertise. The specialist dietitian is an important member of the multi-disciplinary team (MDT); with the expert skills needed to address these complex disorders involving food, weight and appetite.

As highlighted by the National Institute for Health and Clinical Excellence (NICE) in 2004, dietary counselling should not be provided as the sole treatment for anorexia nervosa. Managing medical risk is not the sole responsibility of the dietitian, although the nutritional assessment is a key aspect of the medical risk assessment, especially during the process of refeeding and in the management of refeeding syndrome (MARSIPAN, 2010; QIS 2006). Nutritional counselling is required to guide an individual back to normalised eating patterns and behaviours, but it is not a substitute for psychotherapy (Beumont, Russell and Touyz 1993).

The specialist eating disorders dietitian (skills and knowledge described below) has a role in assessment, treatment, monitoring, support and education. The role in assessment is to determine nutritional status, eating patterns and behaviour, knowledge, food rules and beliefs, meal planning, shopping and cooking skills, motivation to change, and how underlying psychopathology impacts on eating behaviours and behaviour change. Dietitians are able to accurately assess habitual dietary intakes in people with an eating disorder (Hadigan, Anderson and Miller 2000). The dietitian develops the nutrition section of the treatment plan in consultation with the patient, and then supports the patient and the rest of the MDT throughout implementation. This includes intensive one to one work, but also group work. The development of a good therapeutic relationship is essential (Dresser 1984), as well as enhanced communication skills to support nutritional rehabilitation.

Individuals with an eating disorder are believed to have a good comprehension of nutrition. However, Beaumont et al. (1981) show that individuals with an eating disorder have sound knowledge of the calorie content of foods, but a poor understanding of the basics of healthy eating, and how to meet their nutritional requirements. In addition, there is a tendency for clients with an eating disorder to have faulty ideas and beliefs towards food (Cockfield and Philpot, 2009). It is the responsibility of the dietitian to educate individuals in areas related to nutrition. A broader role in education extends to offering support and education to other health professionals, families, carers, non-specialist dietitians involved with patients with eating disorders, and the general public, through various mediums such as group work, presentations, the media etc. Thus, the specialist dietitian must have excellent communication skills and be a good negotiator, as well as have an up-to-date knowledge of the evidence base to support their advice.

Specialist Dietitians should have a sound knowledge of the development and maintenance of eating disorders in addition to an understanding of the physiological, psychological and medical aspects of a range of eating disorders. This needs to be underpinned by a broad understanding of mental health and psychological interventions and their application e.g. Motivational Enhancement Therapy, Cognitive Behavioural Therapy, Cognitive Analytical Therapy, Dialectical Behaviour Therapy, Interpersonal Therapy, and Psychodynamic/Psychoanalytic Psychotherapy. Enhanced communication, counselling and motivational interviewing skills are vital, especially since not all individuals with an eating disorder are motivated to change their behaviours, and ambivalence is a core condition in Anorexia Nervosa. Where it exists evidenced based nutrition practice should be followed (Wakefield & Williams, 2009; ADA guidelines 2006)

References:


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Speaker’s Details:

Name: Philpot Ursula
Degrees/Credentials: BSc (hons), MSc Nutrition and Dietetics, PGCHE, RD
Chair of the British Dietetic Association’s Mental Health Group www.bda.uk.com
Position Title: Advanced Practice Dietitian and Senior Lecturer- Eating disorders
Employer Address: Leeds Metropolitan University, Faculty of Health and Social Sciences, School of Wellbeing, Calverly Street, Leeds, LS1 3HE
Contact Address: Leeds Metropolitan University, Faculty of Health and Social Sciences, School of Wellbeing, Calverly Street, Leeds, LS1 3HE
Phone/Fax/Email: 01138124996, u.philpot@leedsmet.ac.uk

Dr Risvas Gregoris, PhD
Dietician – Public Health Nutritionist

Abstract Title

Intervention programs for the prevention of childhood obesity at the community level (Part of Satellite Symposium by Lanitis)

Objectives

1. Realize the value of education in the prevention of childhood obesity
2. Comprehend how a successful intervention is planned and implemented according to scientific literature
3. Understand what are the future research needs in the field

Description (Focus Statement)

Childhood obesity is a major public health crisis nationally and internationally. The prevalence of childhood obesity has increased over few years. It is caused by imbalance between calorie intake and calories utilized. One or more factors (genetic, behavioral, and environmental) cause obesity in children. Hence, effective intervention strategies are being used to prevent and control obesity in children. The purpose of this presentation is to address various factors influencing childhood obesity, a variety of interventions and governmental actions addressing obesity and the challenges ahead for managing this epidemic.

Learning Outcome Assessment

Childhood obesity can be tackled at the population level by education, prevention and sustainable interventions related to healthy nutrition practices and physical activity promotion.

Abstract

Childhood obesity is due to the imbalance between caloric intake of the child and the calories utilized. Factors causing childhood obesity are genetic, behavioral, and environmental. Firstly, there are certain genetic factors
which may lead to obesity in children. Genetic factors may influence the metabolism, by changing the body fat content and energy intake and energy expenditure. Heritability of obesity from parents also influences obesity in children. Secondly, there are some behavioral factors which can cause obesity. Children may eat large portions of food, foods high in sugar, and energy-rich foods. Hence, energy intake is higher than energy expenditure. Lack of physical activity also plays an important role in obesity. It is seen that children and teens nowadays lack the required amount of physical activity. Children snack more in front of television and spent most of their time sitting without any physical activity. All these behavioral factors are in a vicious circle with one leading to another. Finally, environmental factors are those that surround the children and influence their food intake and physical activity. Hence, there is need to address this problem at every possible step through effective interventions and motivation strategies. Parents and siblings are the people around the child who can influence child behavior and lifestyle. Hence, effective interventions in a family setting can be beneficial to change child’s behavior of overeating and unhealthy choice of food. Physical activity can be improved by small strategies like parking cars away from stores so that kids can walk and to take stairs instead of elevators or escalators. It is essential that parents are aware of the potential risk the child is facing due to obesity and take actions to control the problem. Children spend most of their time in schools. Hence, school plays an important role in the life of the child.

There are many school-based intervention strategies. Some interventions focus on nutrition-based or physical-based aspect of weight-control independently, while others jointly focus on both aspects of nutrition and physical activity to achieve the aim of weight control in children. Schools can encourage kids to make a healthy food choice and also involve kids in physical activity by strategies like lengthening the time of physical activity; involving them in moderate to vigorous physical activity for short durations, encouraging them to walk or active commuting, and taking stairs instead of elevators. Kids should be encouraged to participate in various physical activities like games and dance groups with more emphasis on non-competitiveness. Classroom-based health education can make older children and teens aware of eating nutritious diet and engaging in regular physical activity.

Community also plays a crucial role in healthy lifestyle of children. The term ‘community’ includes the environment around children along with other factors like geographic location, race, ethnicity, and socioeconomic status. This resource can be effectively used to promote healthy nutrition and healthy behavior. Thus, community can help children to get affordable and accessible healthy food options and encourage healthy nutrition. Community organizations along with parents can promote nutrition and physical activity-based programs for children, eg., walk to school. Community can make the neighborhood safe and accessible to children and motivate them to increase physical activity. Other programs like providing play groups with safe play grounds and bike paths for kids to play outside will reduce their time spent in front of television sets. Community can provide children with easy accessible facilities like gymnasiums and supervised physical education with strategies such as music for physical activities. Community can influence media or local entertainment to promote healthy educational programs for parents and children.

There may be some potential barriers to these interventions, which may make the task of promoting healthy behavior and improving physical activity in children challenging. Financial investment in these interventions is very crucial. All the intervention-based programs need monitoring of progress and sustainability over many years, which may be costly. In today’s world of economic problems funding for such programs is limited. In addition, obese children are mostly discriminated due to their body image. Stigmatization of these children by their peers and by others acts as a mental barrier leading to negative body image and fear of food.

Conclusively, childhood obesity problem can be reduced by educating children and parents about healthy nutrition and encouraging them to be physically active. There are effective interventions and government policies for prevention and control of childhood obesity. Sustainability of these interventions is a key factor, so that children can adopt these healthy behaviors as a lifelong practice and have a healthy life.

References


Speaker’s Details:

Name: Dr. Risvas Gregoris
Degrees/Credentials: PhD, Dietician – Public Health Nutritionist
Position Title: Post- doctoral fellos, Unit of Human Nutrition
Employer Address: Agricultural University of Athens, Iera Odos 75, Athens, Greece
Contact Address: Nutrimed Ltd, Nezer 1, 11743 Athens, Greece
Phone/Fax/Email: +302109239836, grisvas@nutrimed.gr

Prof Sanders Tom, BSC, PhD, DSc, RPHNutr
Professor of Nutrition & Dietetics

A. Abstract Title

Integrated dietary intervention to reduce risk of cardiovascular disease (Keynote speaker)

Objectives

1. Understand the key dietary parameters that modify cardiovascular risk
2. Summarise the find key findings from randomized controlled trials that have used an integrated dietary approach to cardiovascular disease prevention
3. Have a realistic expectation as to what can be achieved by modification of diet in terms of cardiovascular disease prevention

Description (Focus Statement)

Most dietary interventions have focused on modifying single components of diet, whereas in practice individuals have different dietary patterns. This session focuses on the modification of the overall dietary pattern to reduce risk of cardiovascular disease.

Learning Outcome Assessment

To be able to describe the key components of a cardioprotective diet.

Abstract

Most research on the relationship between diet and cardiovascular disease has focused on modifying individual elements of the diet on at a time. In practice people have different dietary patterns and certain dietary patterns are associated with a lower risk of cardiovascular disease notably the Mediterranean diet and western vegetarian diets. For the past few decades, dietary advice for the prevention of cardiovascular disease has focused on avoiding obesity, decreasing the intake of saturated fatty acids and reducing the intake of salt. Many dietary guidelines also focus on reducing the intake of added sugar. Recent meta-analyses have questioned the effectiveness of the current approach which focuses on saturated fat, salt and sugar. This simplistic approach ignores the contribution of certain nutrient dense foods to the diet particularly in the case of oily fish, nuts and dairy foods. Following the observation that people who reported consuming high intakes of fruit and vegetables had a lower risk of cardiovascular disease, it was hypothesised that protection was provided by anti-oxidant vitamins that prevented the oxidation of low density lipoprotein, a step in the atherogenic process. Subsequently, antioxidants vitamins (carotene, tocopherol and vitamin C) and those involved in homocysteine metabolism (folate, vitamin B12, vitamin B6) were suggested to be cardioprotective. However, their efficacy in versus placebo has been put to test in randomized controlled trials and meta-analyses of the results do not support their use in cardiovascular disease prevention. Prospective cohort studies have analysed dietary patterns indicate that the consumption of certain foods such as fruit and vegetables, nuts, oily fish, wholegrain cereals and dairy products are associated with a lower risk of cardiovascular disease whereas intake of red and processed meat and trans fatty acids are associated with a higher risk. The Lyon Heart study first indicated that a Mediterranean style diet compared to the typical modified fat diet was more effective in secondary prevention of cardiovascular disease. Primary prevention trials of diet modification are unlikely to ever be conducted because of the huge number of subjects needed to be studied and the difficulty in determining compliance to treatment. Elevated blood pressure and serum cholesterol (or better still the ratio of total cholesterol:HDL cholesterol) and body weight are the most robust surrogate risk markers for risk of cardiovascular disease according to the Prospective Triallists Collaboration studies. Most dietary intervention trials have focused on modifying one or...
two dietary components on surrogate risk markers. The DASH studies showed that modifying the overall dietary pattern had a more marked effect on lowering blood pressure than that obtained by salt reduction or increased intake of fruit and vegetables. The Portfolio diet demonstrated using rather extreme diets that large reductions in blood cholesterol could be obtained by multiple interventions but the diet is unlikely to be acceptable to many. The CRESSIDA trial was designed to test whether an integrated dietary intervention involving modification of several factors (salt restriction, replacement of saturated fatty acids with monounsaturated fatty acids, increased oily fish, fruit, vegetable and wholegrain intakes and restricted use of added sugar) compared with a balanced traditional British diet in older men and women. The main results of this trial, which will be presented at meeting, and included modest weight loss, reduced LDL cholesterol and lower blood pressure. The intervention diet was found to be very acceptable to the participants and we were able to demonstrate compliance to the diet using a series of biomarkers. The session will conclude with suggestions how this dietary advice can be put into practice.

References:


B. Abstract Title

Impact of the amount & composition of dietary fat and carbohydrate on metabolic syndrome & cardiovascular disease risk

Objectives

1. To be familiar with the current definition of metabolic syndrome and its practical value
2. To have an update on the status of randomized controlled trials of diet that have compared manipulation of macronutrient intake on the physiological parameters of insulin resistance
3. To understand how high carbohydrate diets may exacerbate cardiovascular risk in the overweight

Description (Focus Statement)

There has been much controversy regarding the relative proportions of fat and carbohydrate in the diet in relation to metabolic syndrome and cardiovascular risk. This session will summarise recent trials on indices of risk.

Learning Outcome Assessment

To understand the complexities of the effects of dietary fat and carbohydrate intake on features of metabolic syndrome.

Abstract

The term metabolic syndrome was first coined by Reavan in his Banting lecture. It described a constellation of risk factors: hypertension, dyslipidaemia, microalbuminuria, elevated fasting glucose and gout that were associated with increased risk of cardiovascular disease and type 2 diabetes mellitus. Later definitions are more pragmatic and designed to identify individuals at risk of metabolic syndrome with simple measurements and include measures of central obesity (waist measurement >94 cm for men >80 cm for women) and the presence of 2 out of three other factors (blood pressure >130/85 mm Hg), low HDL (<1.03 for en and <1.29 mmol/L for women) or raised triglycerides (>1.7 mmol/L), or elevated fasting glucose (>5.6 mmol/L). It currently is a moot point whether type 2 diabetes mellitus is a disorder of glucose metabolism or lipid metabolism. It is clear that many of the features develop many years before their is impaired glucose tolerance. What is uncontroversial is that risk of metabolic syndrome increases with central obesity and that regular physical activity reduces the risk of developing it. The role of fat and carbohydrate in modifying the features of metabolic syndrome is less clear. In animal models, fructose or high fat feeding (over 50% energy from fat) is used to produce insulin resistance. However, the relevance of these models to human health is questionable. Human diets consist of a mixture of staches and sugars providing 45-60% of the energy intake whereas fat provides 25-40% energy in economically developed countries. The proportion of energy from fat has fallen close to 35% energy in most European countries. The KANWU study suggested that saturated fatty acid increased insulin resistance whereas monounsaturated fatty acids had a neutral effect. However, this was a finding or borderline statistical significance. Two large randomized controlled trial (RISCK and LIPGENE) have recently tested the hypothesis that replacing saturated fatty acid with monounsaturated fatty acids would improve insulin sensitivity in participants at risk of metabolic syndrome. Neither of the studies was able to demonstrate an adverse effect saturated fatty acid on insulin resistance. The RISCK study also compared low fat/high carbohydrate diets with low or high glycemic
indices and found some evidence to suggest an improvement in insulin sensitivity with the low glycemic index diet. However, both low and high glycemic index high carbohydrate diets lowered HDL cholesterol compared to diets with higher fat intakes and also increased urinary microalbumin excretion. In terms of lipid metabolism, the most favourable effects were noted with a high monounsaturated fat diet with carbohydrates of low glycemic index. The available evidence suggest that the focus on the prevention of metabolic syndromes should be on energy restriction to produce moderate weight loss and the avoidance of physical inactivity. High carbohydrate diets may exacerbate metabolic syndrome particularly if the carbohydrate is derived from high glycemic index foods. Energy restricted diets with a higher proportion of energy from fat (35-40% energy), mainly derived from monounsaturated fatty acids, with a lower proportion of carbohydrate may be preferable to the current dietary advice which recommends diets containing (25-30% energy from fat).

References:


Speaker’s Details:

Name: Prof. Tom Sanders
Degrees/Credentials: BSC, PhD, DSc, RPHNutr
Position Title: Professor of Nutrition & Dietetics
Employer Address: King’s College London, Franklin-Wilkins Building, 150 Stamford Street, London SE1 9NH
Contact Address: Franklin Wikins Building, 150 Stamford Street, London SE1 9NH
Email: tom.sanders@kcl.ac.uk

Dr Wakil Elie
Diplome D'état Francais De Docteur En Pharmacie / “Human Relations” Specialist

Abstract Title
Open discussion: Importance and value of being assertive

Objectives
1. Understand why people are different
2. Evaluate the impact of assertiveness
3. Identify key disclosure skills

Description (Focus Statement)
Being trained in assertive communication actually increases the appropriate use of this sort of behaviour. It enables us to swap old behaviour patterns for a more positive approach to life:
• If we react defensively we are being PASSIVE
• If we attack we are being AGGRESSIVE
• A third, more satisfactory alternative, is to be ASSERTIVE

Learning Outcome Assessment
• Market your self effectively as a professional clinical dietician
• Develop a credible image that inspires confidence
• Reinforce your self-confidence

Abstract
Assertive communication is the ability to express positive and negative ideas and feelings in an open, honest and direct way. It recognises our rights whilst still respecting the rights of others. It allows us to take responsibility for ourselves and our actions without judging or blaming other people. And it allows us to constructively confront and find a mutually satisfying solution where conflict exists.

Passive behaviour is when we:
• Fail to stand up for our rights or do so in such a way that others can easily disregard them
• Express our thoughts, feelings and beliefs in apologetic cautious or self-effacing ways
• Fail to express our views of feelings altogether
Passivity is based on the belief that our own needs and wants will be seen by others to be less important than their own.

Aggressive behaviour is when we:
- Stand up for our own rights in such a way that we violate the rights of another person
- Express thoughts, feelings and beliefs in inappropriate ways, even if we believe those views to be right.
Aggression enhances us at the expense of others and can serve to put another person down. It is based on the belief that our opinions are more important than other people's.

Assertive behaviour is when we:
- Stand up for our own rights in a way that does not violate another person’s rights
It leads to an honest, open and direct expression of our point of view which, at the same time, shows that we understand the other person’s position.

How to be assertive
a) The action → when ...
b) The response → I feel ...
c) The reason/effect → Because ...
d) The preferred outcome → and what I would like ... / What would make it better

Advantages of Assertiveness
- Close working relationships
- Greater confidence in yourself
- Greater confidence in others
- Increased self-responsibility
- Increased self-control
- Savings in time and energy
- An increased chance of everyone winning

Speaker's Details:

Name: Wakil Elie
Degrees/Credentials: Diplome D’etat Francais De Docteur En Pharmacie / “Human Relations” Specialist
Position Title: Director
Employer Address: E.W. Human Development Ltd, 27, A. Araouzos Street, 1076-Nicosia
Contact Address: P. O. Box 27291, 1643-Nicosia
Phone/Fax/Email: 22769048/22769003/info@ewhumanandev.com

Dr Yamasaki – Patrikiou Edna, MD, MSc, PhD
Head, Department of Life and Health Sciences, University of Nicosia
Associate Professor, University of Nicosia

Abstract Title

Caffeine and Cognitive Function
(Part of panel: Novelties in Nutrition)

Objectives

1. Discuss potential benefits, side effects of acute and chronic use of caffeine
2. Characterize caffeine effects on cognition
3. Discuss caffeine and the prevention of cognitive disorders

After this presentation, the attendee will be able to:

1. Cite the general effects of acute and chronic caffeine ingestion in the body and in cognitive function
2. Understand and discuss the potential use of caffeine in the prevention of cognitive disorders
3. Apply to their clinical practice the knowledge of the potential beneficial effects of caffeine in cognitive function

Description (Focus Statement)

This presentation will provide an overall view of acute and chronic caffeine effects in the body and in cognitive function, and the most recent research supporting its use in the prevention of cognitive loss in aging and diseases.

Learning Outcome Assessment

Through discussion of the material presented, and application of its knowledge in clinical practice.
Abstract

Caffeine is probably the most widely consumed and accepted psychoactive substance, producing complex pharmacological actions. A normal person consumes approximately 70-350mg/day or 5 to 8 mg/kg/day (equivalent to 3 cups of coffee), which induces a peak plasma concentration of 0.25 to 2mg/L (or approximately 10uM), and produces overall psychostimulant effects, reducing fatigue and enhancing performance, and also affecting mood and cognitive performance. Higher doses (above 400-500mg/day) may lead to undesired effects (anxiety, increased blood pressure, headache, confusion) among individuals. Repeated exposure to caffeine results in rapid tolerance, and chronic exposure produces effects opposite to that of acute caffeine. The complex actions of caffeine are in part due to its multiple molecular effects, raging from GABAA receptor inhibition, PDE inhibition, and antagonism of adenosine receptors. Differences in the affinity of caffeine for these multiple potential targets may contribute to the biphasic motor and cardiovascular, cognitive responses to increasing doses of caffeine in rodents, and to the anxiety, sleeplessness, and increases in blood pressure and heart rate associated with high doses of caffeine in human. This complexity may also underlie the association of caffeine consumption with a variety of common disorders detected by epidemiological studies, including Dementia, Parkinson’s and Alzheimer’s Diseases.

References:


Speaker’s Details:

Name: Yamasaki – Patrikiou Edna
Degrees/Credentials: MD, MSc, PhD
Position Title: Head, Department of Life and Health Sciences, University of Nicosia / Associate Professor, University of Nicosia
Employer Address: Department of Life and Health Sciences, University of Nicosia, PO Box 24005, 1700 Nicosia
Phone/Email: 22841743, Yamasaki.e@unic.ac.cy

Prof Zampelas Antonis, BSc, MSc, PhD
Professor of Human Nutrition, Agricultural University of Athens

Abstract

Dietary n-3 fatty acids, and especially n-3 fatty acids from fish oils (EPA and DHA), and their effects on health and disease has attracted interest for clinical research and public health since the mid ’50s. The most abundant research on n-3 fatty acids concerns their effects in the prevention of cardiovascular diseases. The use of n-3 fatty acids has been recommended to reduce cardiovascular risk by multiple mechanisms, including a decrease in plasma triglycerides, thrombotic factors, inflammatory markers, and they are effective in preventing cardiovascular events, cardiac death and coronary events, especially in persons with high cardiovascular risk [1]. One of their side effects was considered to be a small increase in plasma glucose levels but overall pooled findings do not support either major harms or benefits of fish/seafood or EPA and DHA on
the development of diabetes [2].

A very recent review, looked at studies which investigated effects of n-3 fatty acid supplementation in pregnant and lactating women and infants during postnatal life, on the visual acuity, psychomotor development, mental performance and growth of infants and children [3]. The results were not consistent. In particular, some studies showed beneficial effects of DHA supplementation during pregnancy and/or lactation especially on visual acuity outcomes and some on long-term neurodevelopment; a few showed positive effects on growth. Some others claimed a beneficial effect of such supplementation on visual, neural, or developmental outcomes and no effects on growth. However, evidence from randomized controlled trials (RCTs) does not seem to demonstrate a clear and consistent benefit of n-3 fatty acids supplementation during pregnancy and/or lactation on term infants growth, neurodevelopment and visual acuity.

Rheumatoid arthritis (RA) is a chronic inflammatory autoimmune disease of the joints and bones and arachidonic acid is the precursor of inflammatory eicosanoids which are involved in RA. Some therapies used in RA target arachidonic acid metabolism. Fish oils have been shown to slow the development of arthritis in animal models and to reduce disease severity [4]. A number of RCTs of fish oils have been performed in patients with RA and there is evidence for a fairly consistent, but modest, benefit of marine n-3 fatty acids on joint swelling and pain, duration of morning stiffness, global assessments of pain and disease activity.

n-3 fatty acids has also been proposed to be protective against dementia and age related cognitive impairment. From a Cochrane review on the benefits of n-3 fatty acids supplementation on cognitive function among cognitively healthy older people, which included also trials conducted with individuals with prevalent poor cognitive function or dementia, there was no evidence to support the routine use of n-3 fatty acid supplements for the prevention, or amelioration, of cognitive decline in later life. [5].

Finally, there is some evidence that n-3 fatty acids may influence neuronal function and mood. It is difficult though to summarize the effects because of considerable heterogeneity in the literature [6]. However, the evidence available provides some support of a benefit of n-3 fatty acids in individuals with but no evidence of any benefit in individuals without a diagnosis of depressive illness.

References:
Measures which have been designed and implemented in the European Union as well as in the United States, in order to promote healthy eating, include advertising controls, public information campaigns, nutrition education, nutritional labeling, nutrition information on menus, fiscal measures: taxes/subsidies on foods, regulation of meals: school and workplace meals [3]. The largest number of measures adopted in the European Union are those intended to promote informed choice, predominantly through public information campaigns and nutrition education in schools. Measures to change the market environment are rare, with the exception of policies aiming to improve the provision of healthy foods in schools. From all these actions taken, and although the assessment of their effectiveness is particularly difficult, it seems that positive results in the behavior change seem to have the nutritional labeling and the monitoring of advertisements which target children. Campaigns which aim the increase in nutritional information seem to improve the willingness towards a change but they do not improve dietary behavior per se. Regarding fiscal measures, there is not enough information of the effectiveness of tax increases in the dietary behavior change and the prevention of obesity in the European Union level. What it seems to be the case is that a small increase in taxes does not lead to beneficial results towards a change in the nutritional behavior but it increases significantly the income of the State. On the other hand, a significant increase in taxes could have some results, but is unknown how these type of increases would influence the whole food chain, from the primary production up to the end product. Therefore, potentially significantly negative impact in the National Economy from for example a decrease in income and/or an increase in unemployment cannot be predicted.

Finally, the role of the Food Industry should not be ignored or underestimated. The re-design of food products aiming at lower energy density, fat, saturated fat, trans fat, sodium and added sugars content could significantly contribute not only in the prevention of obesity but also in the improvement of several risk factors associated with cardiovascular diseases, hypertension, diabetes and cancer.

References:


Speaker’s Details:

Name: Zampelas Antonis
Degrees/Credentials: BSc, MSc, PhD
Position Title: Professor of Human Nutrition
Employer Address: Agricultural University of Athens, Unit of human Nutrition, Department of Food Science and Technology, Agricultural University of Athens, Iera Odos 75, Athens 11855, Greece
Contact Address: Agricultural University of Athens, Unit of human Nutrition, Department of Food Science and Technology, Agricultural University of Athens, Iera Odos 75, Athens 11855, Greece
Phone/Fax/Email: +30 210 5294701, azampelas@aua.gr
**OP01**  FTO GENE AND BODY MASS INDEX IN YOUNG EUROPEAN CHILDREN: DO PHYSICAL ACTIVITY LEVELS INFLUENCE THE EFFECT OF THE RISK GENOTYPE?

Anna Christina Koni¹, Guan Wang¹, Mark Bailey¹, Robert Scott², Licia Iacoviello³, Alfonso Siani⁴, Paola Russo⁴, Fabio Lauria⁴, Michael Tornaritis⁵, Charalampos Hadjigeorgiou⁶, Toomas Veidebaum⁶, Kenn Konstabel⁶, Staffan Marild⁷, Gabriele Eiben⁷, Luis Moreno⁸, Jose Casajus⁸, Wolfgang Ahrens⁹, Karin Bammann⁹, Eva Kovacs¹⁰, Denes Molnar¹⁰, Stefaan De Henauw¹¹, Krishna Vyncke¹¹, Yannis Pitsiladis, FACSM¹¹; on behalf of the IDEFICS Consortium.

1University of Glasgow, Glasgow, United Kingdom. 2University of Cambridge, Cambridge, United Kingdom. 3Catholic University, Campobasso, Italy. 4Institute of Food Sciences-CNR, Avellino, Italy. 5Research and Education Foundation of Child Health, Strovolos, Cyprus. 6National Institute for Health Development, Tallinn, Estonia. 7Göteborg University, Göteborg, Sweden. 8University of Zaragoza, Zaragoza, Spain. 9University of Bremen, Bremen, Germany. 10University of Pecs, Pecs, Hungary. 11University of Ghent, Ghent, Belgium.

Childhood obesity is considered to be one of the most serious public health problems of the 21st century. The worldwide prevalence of obesity has increased dramatically over the past three decades and is continuing to rise rapidly, along with increasing levels of childhood obesity. Although the human genome has not changed over the years, obesity levels and the mortality rates have dramatically increased, thus it becomes more evident that environmental factors such as physical activity or sedentary lifestyle may have a key role in this increase of obesity prevalence. Modifiable lifestyle factors such as levels of physical activity have been shown to be associated with body mass index (BMI). The IDEFICS study with a cohort size of 16,223 young children is one of the largest single studies in the pre-adult life stages to undertake saliva/DNA collection in conjunction with extensive phenotypic assessment and is therefore well-suited for studying the interaction between genes, physical activity and adiposity.

**Purpose:** To investigate environmental and genetic associations on BMI in European children.

**Methods:** Anthropometric measurements (including adiposity) and objectively measured physical activity using accelerometry were assessed in a subgroup of children (n=4,678) aged 2-10 years from the IDEFICS study. DNA from saliva samples was generated for genotyping. Here we report associations between BMI, selected physical activity measures and the FTO gene (rs9939609) as assessed using GLM and regression models.

**Results:** Clear effects on BMI were observed with time spent in sedentary behaviors (P < 0.0001), MVPA (P < 0.0001) and Overall Physical Activity (count.min-1) (P < 0.0001). Gender differences were examined for all these activity measures. FTO (SNP rs9939609) was found to influence age- and gender-adjusted BMI (0.119 unit, p<0.0001), genotype explaining 0.4% of the BMI variance. However, the strength of this association was marginal after further adjustment for main effects of physical activity. No interaction was observed between physical activity patterns and FTO, however the effect size of each copy of the risk allele (A) on obesity-related phenotypes increased with increasing time spent in sedentary behaviors. Although no interactions were found between FTO genotype and time spent in MVPA, the relationship between each copy of the risk allele and increasing MVPA became significant for those who spent less time in MVPA (lower tertile).

**Conclusion:** These preliminary results confirm previous associations between the FTO gene and adiposity in a cohort of European children aged between 2 and 10 years, but they also highlight the need to adjust for levels of physical activity when estimating the genotype effects on obesity risk. Although there was no evidence of a significant PA*FTO interaction, increasing total physical activity or reducing time spent in sedentary behaviour could be beneficial on reducing the genetic effect of FTO on obesity-related traits. This observation has important public health value, as it emphasizes that being physically active may overcome, at least in part, the genetic predisposition to obesity traits induced by variations in the FTO gene.

**OP02**  IMPACT OF BREAKFAST CONSUMPTION ON DIET QUALITY AND HEALTH OUTCOMES IN CYPRIOIT CHILDREN

Papoutsou S¹, Briassoulis G², Chadigiegiorgiou Ch¹, Savva SC¹, Solea T¹, Hebestreit A³, Pala V⁴, Sieri S⁴, Kourides Y¹, Kafatos A⁵ & Tornaritis M¹

¹Research and Education Institute of Child Health, Strovolos, Cyprus  ²Pediatric Intensive Care Unit, University of Crete, Heraklion, Crete, Greece. ³BIPS - Institute for Epidemiology and Prevention Research, Department: Epidemiological Methods and Etiologic Research Head of Unit ‘Lifestyle Related Disorders’ Bremen, Germany ⁴Department of Preventive & Predictive Medicine, Nutritional Epidemiology Unit. Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy ⁵Preventive Medicine and Nutrition Clinic, Department of Social Medicine, Faculty of Medicine, School of Health Sciences, University of Crete, Heraklion, Greece.

**Background:** In Cyprus, where childhood obesity is rising rapidly, breakfast habits of children and their effect on health outcomes, were never thoroughly studied.

**Objective:** To examine diet quality, nutrients intake and health outcomes of children in relation to their breakfast habits.
Design: Cross-sectional subsample data of the IDEFICS study. Breakfast frequency, breakfast quality, Youth Healthy Eating Index (YHEI) and daily nutrients intake were assessed through a parental questionnaire and a 24-h dietary recall. Breakfast frequency was assessed as daily or non daily consumption. Breakfast quality pattern was divided in five breakfast categories: “Ready To Eat cereals consumers”, “milk consumers”, “pastry consumers”, “other breakfast consumers” and “breakfast skippers”. BMI, BMI z-scores, waist circumference, Conicity Index, blood lipid profile and blood pressure were examined in relation to breakfast patterns.

Participants: Cypriot children aged 4 to 8 years from two urban areas in Cyprus: Strovolos and Pafos areas (n=2151). The study was conducted in 2007-2008 in public and private kindergartens and primary schools.

Statistical analyses: Mann–Whitney–U test was used to determine associations between breakfast frequency and health outcomes as well as breakfast quality pattern and nutrient intakes. Logistic regression models were fitted to evaluate associations between breakfast type consumption and insufficient micronutrient intakes (intake lower than the two thirds of RDA/AI) adjusting for sex, area, mother’s age and BMI z-score.

Results: Regarding breakfast frequency consumption, as parents reported, 62.8% of boys and 64.1% of girls eat breakfast daily and around three out of ten children eat breakfast only during weekends. Girls who had breakfast on a daily basis had lower mean BMI, waist circumference, BMI z-score, tendency to lower mean serum total cholesterol and LDL cholesterol, lower mean serum triglycerides, atheromatic index and diastolic blood pressure, than non daily consumers. Both boys and girls that do not eat breakfast daily scored lower in YHEI. The Mean Intake Ratio as calculated for 10 micronutrients (calcium, iron, magnesium, phosphorus, potassium, vitamin A, vitamin C, thiamin, riboflavin and vitamin B6) was higher in Ready To Eat (RTE) cereals consumers than all the other breakfast consumers and breakfast skippers; in addition RTE cereals consumers were more likely to ensure sufficient micronutrients intake, higher carbohydrate intake and lower fat intake when expressed as a percentage of total energy intake. Fiber intake was low for all breakfast type consumers; preference in RTE cereals rich in fibers was extremely low.

Conclusion: Daily breakfast consumption might have a positive effect in controlling children’s diet quality and health indicators including obesity indexes, serum lipid profile and blood pressure. Health professionals in Cyprus must educate parents for the importance of daily breakfast consumption by the whole family, especially when combined with the optimal breakfast choices.

OP03 A NATIONAL STUDY OF THE DIETARY INTAKE OF CYPRIOT CHILDREN AND ADOLESCENTS AGED 6-18 YEARS AMD THE EFFECT OF MOTHER’S EDUCATIONAL STATUS AND CHILDREN’S WEIGHT STATUS ON ADHERENCE TO NUTRITIONAL RECOMMENDATIONS

E Philippou1, MJ Tornaritis1,2, C Hadjigeorgiou1, YA Kourides1, A Panayi1 and SC Savva1
1 Research and Education Institute of Child Health, Nicosia, Cyprus
2 Pedagogical Institute of Cyprus, Nicosia, Cyprus

Aim: To assess the dietary intake of Cypriot children and the influence of their mother’s education and their own weight status on adherence to dietary recommendations.

Methods: The intake of a random sample of 1414 Cypriot children aged 6-18y was assessed using a 3-day food diary. Children were grouped based on their age (6.0-8.9, 9.0-13.8 and 14.0-18.9y) and gender. Adherence to recommendations was estimated and the influence of their mother’s education and their own weight status on adherence were explored.

Results: A large percentage of children exceeded the recommended intakes of total fat (42.4-83.8% in different age groups), saturated fatty acids (90.4-97.1%) and protein (65.2-82.7%), while almost all (94.7-100%) failed to meet the recommended fibre intake. Additionally, a large proportion of children (27.0-59.0%) consumed >300mg/day cholesterol and exceeded the upper limit of sodium (47.5-78.5%). In children aged 9.0-13.9y, there was a high prevalence of inadequacy for magnesium, and in girls aged 14.0-18.9y, of Vitamin B6 (21.0%) and iron (25.3%). Children whose mother was more educated were more likely to consume >15%en from protein (Odds Ratio: 1.81 (95% CI:1.13-2.94) and >300 mg/day cholesterol (2.25 (1.37-3.69) and 1.96 (1.17-3.28) for mothers with secondary and tertiary education respectively). Overweight/obese children were less likely than normal weight children to consume <6% PUFA (0.55 (0.38-0.78) and more likely to consume >15%en protein (1.90 (1.30-2.76) and have a <Adequate Intake of calcium (1.76 (1.12-2.77).

Conclusions: Cypriot children consume a low quality diet. Their mother’s education and their own weight status influence their adherence to dietary recommendations. Public health initiatives need to be developed aiming to improve Cypriot children’s dietary intake.
OP04  A PIONEER NUTRACEUTICAL FORMULA (PLP10) FOR THE TREATMENT OF RELAPSING REMITTING MULTIPLE SCLEROSIS: A RANDOMIZED, DOUBLE BLIND PLACEBO-CONTROLLED PROOF-OF-CONCEPT CLINICAL TRIAL

Ioannis S. Patrikios1,3,4*, George N. Loukaides1,3,4, Evangelia E. Ntzani2 & Marios C. Pantzaris1,3*
1 Neurology Clinic C, The Cyprus Institute of Neurology and Genetics (CING), Nicosia, Cyprus. 2 Clinical and Molecular Epidemiology Unit, Department of Hygiene and Epidemiology, University of Ioannina School of Medicine (UISM), Ioannina, Greece. 3 PALUPA Medical Ltd., CING, Nicosia, Cyprus. 4 European University Department of Health and Science, Nicosia, Cyprus. *Correspondence should be addresses to e-mail: I.Patrikios@euc.ac.cy or pantzar@cing.ac.cy

Background: For many years, the role of polyunsaturated fatty acids (PUFA) in the pathophysiology and development of neurodegenerative diseases and specifically multiple sclerosis has been a subject of considerable discussion and research but without proof of efficacy. We aimed to assess whether our novel intervention, formulated based on systems medicine concept, comprising specific fatty acids and vitamins within a specific ratio, quantity, quality, and structural form reduce disease activity in patients with relapsing remitting multiple sclerosis who were either treated with disease modifying treatment (DMT-interferon or glatiramer acetate) or untreated.

Methods: We contacted a 30-month randomized, double-blind, placebo-controlled, parallel design, phase III proof of concept clinical study at the Cyprus Institute of Neurology and Genetics (CING). An experienced neurologist, a registered clinical dietitian and a medical biochemist with specialties on lipidology and immunology, were the investigators involved in the trial. Of a total of 80 patients, 20 were randomly assigned to receive intervention A (docosahexaenoic acid (DHA)/eicosapentaenoic acid (EPA) (3:1 wt/wt) omega-3, linoleic acid (LA)/gamma (γ)-linolenic acid (GLA) (2:1 wt/wt) omega-6 fatty acids, omega-3/omega-6 (1:1 wt/wt), other specific PUFA, monounsaturated fatty acids (MUFA), minor quantity of specific saturated fatty acids (SFA), vitamin A and vitamin E), 20 to receive γ-tocopherol, intervention C, 20 to receive the combination of interventions A and C, intervention B (PLP10) and 20 to receive placebo, as an oral solution, once daily. The first six months were used as normalization period and considered as pre-entry period. The primary end point was the annualized relapse rate (ARR) and the key secondary end point was the time to disability progression. This study is registered as an International Standard Randomized Controlled Trial, number ISRCTN87818535.

Findings: PLP10 reduced the annual relapse rate (ARR) by 70% (p=0.003), in relation to the baseline ARR and the placebo increased by 46% (p=0.354). During study, for the primary end point, PLP10 reduced the ARR by 58% (95% confidence interval 0.10 to 0.79, p=0.016) and for the secondary end point, significantly reduced the risk of sustained progression of disability by 86% over the two-year period (hazard ratio, 0.11; 95% confidence interval 0·01-0·97, p=0·047) versus placebo. The cumulative probability of progression on basis of survival analysis was 10% in the PLP10 group, and 70% in the placebo group. Proportionately more patients in the PLP10 group (72%) versus placebo group (20%) were free from new or enlarging T2-weighted lesions on brain magnetic resonance image (MRI) scans over the two-year study. No adverse events were reported. Interventions A and C showed no significant efficacy.

Interpretation: PLP10 treatment significantly reduced the ARR, and the risk of sustained disability progression without any adverse or significant side effects. This is the first clinical study of systems medicine approach medical nutrient formula that holds strong promise as an effective treatment for relapsing remitting multiple sclerosis.

OP05  EFFECTS OF AN INTERVENTION AND MAINTENANCE WEIGHT LOSS DIET WITH AND WITHOUT EXERCISE ON ANTHROPOMETRIC INDICES IN OVERWEIGHT AND OBESE HEALTHY WOMEN.

Andreou E, Philippou C, Papandreou D.
Department of Life and Health Science, Intercollege, University of Nicosia, Nicosia, Cyprus.

Background and Aims:
There is growing evidence that excess body weight and body fat levels may lead to various diseases. A low-calorie diet has been found to reduce body weight and fat; however, 95% of patients regain the weight within a short period of time. The aim of this study was to investigate the effects of a reduced-calorie diet with and without exercise on body composition profile as well as to evaluate maintenance of weight loss 18 weeks after the intervention had concluded.

Methods:
Two hundred and six overweight and/or obese women were randomized by a computer to either diet only (DO) or diet and exercise (DE) for an 18-week intervention period and 18 weeks of maintenance. Statistical significance was set at p < 0.05.

Results:
Body mass index (BMI) was reduced by 5.1 in the DE group compared to 3.2 in the DO group 18 weeks after the intervention period had ended; waist circumference (WC) was 14.2 cm lower in the exercise group and 8 cm lower in the diet alone group, and body fat was reduced by 15.5% in the DE group, while no changes were observed in the DO group.

Conclusion:
A combination of a reduced-calorie diet with exercise may successfully reduce weight, BMI, WC and body fat levels.
**Type 2 Diabetes in a Cypriot Population**

Nikoleta Andreou, Dr Alexandros Heraclides, Dr Eleni Andreou

**Background:** Obesity and type 2 diabetes (T2D) have become an epidemic. Obesity is one of the well-recognized risk factors for the development of T2D. Fat estimation through central and overall obesity measurements is associated with diabetes and can be used to detect patients at high risk.

**Aim of the study:** The purpose was to compare central and overall obesity measures in predicting prevalent T2D.

**Methods:** A case-control epidemiological study of 115 participants residing in Cyprus was conducted. The following obesity measures were used: BMI, %body fat, waist circumference (WC), and waist-to-height-ratio (WHtR). Diabetes status was self-reported and confirmed by a physician. Data of demographics, lifestyle factors, dietary habits and medical history were used as potential confounders. Logistic regression was used to determine the association of each obesity measure (categorized into tertiles) and prevalent T2D.

**Results:** There was a positive association between central and overall obesity with T2D. The odds ratio (95% confidence interval) for having diabetes comparing the highest tertile of BMI, %FAT, WC and WHtR ratio with lowest tertile was: 6.22 (95% CI 2.38; 16.25), 3.84 (95% CI 1.45; 10.20), 5.51 (95% CI 2.12; 14.33) and 3.97 (95% CI 1.13; 13.85), respectively, after adjusting for age and gender. The odds ratios were slightly reduced after multivariate adjustment, but the odds of diabetes were still linearly and strongly associated with BMI and waist circumference. A weaker linear association was observed for %FAT, while WHtR did not show a linear association.

**Keywords:** Cyprus traditional foodstuffs, fast-foods, laboratory chemical analyses

**Bibliography**

Introduction: The behaviors contributing to successful long-term weight loss maintenance are not fully understood. Identification and corrections regarding potential barriers arising during the process of weight loss regulation, may arouse a person’s ability to act toward a sustain weight loss goal.

Aim: To identify common barriers during weight loss and maintenance, as experienced by weight loss maintainers, as well as regainers.

Methods: 44 volunteers were recruited (41% males), and formed 4 focus groups of maintainers and 4 of regainers. Participants had intentionally lost at least 10% of their starting weight and kept it off for at least one year (maintainers) or had regained most of the weight initially lost (regainers).

Results: Maintainers compared to regainers were younger (27±7 vs 42±16 yrs, p=0.002) and had a lower current Body Mass Index (24.1±2.8 vs. 31.2±4.3Kg/m2, p<0.001). During weight loss, maintainers reported hunger, external triggers to eat, frustration over slow weight loss rates and emotional eating as the main barriers. Similarly, regainers reported emotional eating, hunger, external triggers to eat and unsatisfactory weight loss rates as barriers during weight loss but they also perceived cravings, time and effort required for cooking and social pressure to lose weight as additional barriers. Furthermore, maintainers reported that common barriers during maintenance were external cues to eat and emotional eating, with few participants stating no barriers. Both maintainers and regainers consider emotional eating to be one of the leading causes of regaining weight, and emotional well-being as an essential factor for long-term weight loss maintenance. However, maintainers reported compensating for emotional eating the following day, by eating less and/or exercising more, whereas regainers did not identify any counterbalancing strategies.

Conclusions: Emotional eating seems to be a commonly-cited barrier for people who have lost weight and maintained it, as well as for those who regained it. Even though both groups are susceptible to emotional eating and neither has a strategy to avoid it, maintainers, but not regainers take corrective action. Further research should reveal potential differences of the perceived barriers and coping strategies.
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* 1 & μοναδικό!

Οι αχατισμένες μας ίδρυσε ΧΑΡΑΛΑΜΠΙΔΗΣ ΚΡΙΣΤΗΣ, ενάθηκαν και μας προσφέρουν ένα & μοναδικό φρέσκο χάλα! Μύλεινο & θρεπτικό. Ο τι καλύτερο για την καθημερινή μας είσπραξη.
Καθώς Εφαρμόζουν πιστοποιήματα συστήματα αξιολόγησης των προϊόντων της, δίνοντας την τελική σάλα τους διεθνών προτύπων ISO 22000 & HACCP.
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