

Editöryal Yorum / Editorial

A different approach to cardiovascular risk factors

Kardiyovasküler risk faktörlerine farklı bir bakış

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It seems that we are at the beginning of a new era regarding the evaluation of cardiovascular (CV) risk factors.

Hypercholesterolemia, one of the major CV risk factors, can be successfully treated and the associated risk can be decreased significantly by statin therapy.^[1-5] There are also various pharmacologic agents that can maintain normal levels of blood pressure and blood glucose. However, we are now realizing that the risk associated with dyslipidemia does not disappear only by reducing low-density lipoprotein cholesterol. The vascular effects of very-low-density lipoproteins and remnant lipoproteins, and the significance of reducing these in terms of cardioprotection need to be determined. The fact that the agents used to effectively raise high-density lipoprotein cholesterol, whose lower level is a risk factor for CV diseases, do not decrease CV events, has shown that the issue is far more complicated than thought.^[6]

Decreasing blood pressure reduces the CV event risk in hypertensive patients.^[7] Unfortunately, blood pressure control rates are not high enough in the world and in our country. Currently, in most of the countries, more than three out of four hypertensive patients cannot be taken under control. In many countries including Turkey, hypertension control rates do not even reach 10%. It is wrong to consider the hypertensive patient as only having high blood pressure. Essential hypertension should be regarded as a parameter of metabolic syndrome. Besides blood pressure-lowering effects, other vascular and metabolic effects of antihypertensive treatment

should also be considered.^[8-14] Agents with long-term proven effectiveness and reliability should not be disfavored all of a sudden with speculative comments on some of their drawbacks, and new agents which have not been tested adequately should not be presented as miraculous remedies. The agents used in hypertensive treatment should not be regarded as only blood pressure-lowering agents, they should be re-evaluated as to their efficiencies in CV protection. Especially, the benefits and risks of inhibition of renin-angiotensin-aldosterone system, which has a critical role in vascular physiology, should be properly established. We need thorough and correct interpretations of the studies investigating the contributions and adverse effects of adding one more agent to the therapy in patients receiving multiagent therapy for a high CV risk.

Diabetes mellitus remains as the disease that requires a new approach above all. Many questions that need to be answered have arisen: How correct is it to regard type 2 diabetes mellitus, whose prevalence increases rapidly, as an endocrine disease of the pancreas? The most important factor in the increase in the incidence of type 2 diabetes mellitus is abdominal obesity which is a result of unhealthy lifestyle. How successful would the algorithms that offer individual pharmacologic treatment plans for abdominal obesity, insulin resistance, diabetes mellitus, and CV disease be in maintaining the health of people of the 21st century? Would it not be more convenient to think of both abdominal obesity and insulin resistance as a biological adaptation to, even a protection mechanism against a pathological life-

style, rather than pathologies to be treated? Is it a realistic approach to change the diagnosis to diabetes mellitus when fasting plasma glucose rises to 126 mg/dl in a patient with metabolic syndrome? At a time when large-scale studies^[15,16] appear one by one showing the failure of treatments that target hyperglycemia and aim to achieve normoglycemia at all costs, isn't it time to establish new guidelines for the treatment of type 2 diabetes, which would strongly limit the use of insulins, insulin secretagogues, and antihyperglycemic agents which have contributing effects on hypoglycemia and/or obesity? Will the diagnosis still be called as type 2 diabetes in the future?

Abdominal obesity, which is the most significant sign of a poor lifestyle of modern times, caused by an imbalanced and excessive diet and inadequate exercise, has been defined with different limit values for individual societies.^[17] Is it right to actually determine an exact waist circumference limit for abdominal obesity that represents cardiometabolic risk?

This supplemental issue of the Archives of the Turkish Society of Cardiology was allocated to our attempts to find answers to these questions.

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