کارگاه‌های آموزشی مرکز اطلاعات علمی

مقاله نویسی علوم انسانی

اصول تنظیم قراردادها

آموزش مهارت های کاربردی در تدوین و چاپ مقاله
Introduction. High serum levels of lipoprotein(a) and homocysteine are risk factors of cardiovascular disease which are prevalent in patients on hemodialysis. Controversy exists about the effects of hydroxymethylglutaryl-CoA reductase inhibitors on serum lipoprotein(a) levels in patients on hemodialysis. Also, deficiency of some water soluble vitamins and administration of statins may raise serum levels of homocysteine in these patients. This study was designed to investigate serum levels of lipoprotein(a) and homocysteine in patients on hemodialysis who were taking a statin, vitamin B6, and folic acid.

Materials and Methods. We investigated on 152 patients with maintenance hemodialysis who were taking atorvastatin or lovastatin, vitamin B6, and folic acid for at least 6 months. Their serum levels were obtained to measure lipoprotein(a) and homocysteine levels, as well as triglyceride, total cholesterol, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol.

Results. The mean serum values of total cholesterol, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol and triglyceride were significantly less than the maximum reference values \( (P < .001) \). The mean serum level of lipoprotein(a) was also less than the reference value \( (P = .009) \), but homocysteine level was 33% higher on average than the reference value \( (P < .001) \).

Conclusions. Our study demonstrated that in our patients on hemodialysis, the mean serum level of homocysteine was about 30% higher than the reference value although they were receiving vitamin B6 and folic acid. Hence, they were still exposed to the risk of cardiovascular disease.
enhancement of inflammation, and thrombophilic profile. Serum level of homocysteine is increased in patients on hemodialysis and predisposes them to CVD. Homocysteine also induces glomerular injury and sclerosis. Deficiency of some water soluble vitamins, especially vitamin B6, vitamin B12, and folic acid may result in hyperhomocysteinemia. Thus, treatment with these vitamins can reduce serum homocysteine levels, and may lower the risk of CVD in patients on hemodialysis.

On the other hand, some lipid-modifying and antihypertensive drugs have been shown to increase homocysteine serum levels. Thus, a combination of vitamins and lipid-lowering drugs can have contradictory effects on homocysteine and lipoprotein(a) levels. The purpose of this study was to determine serum levels of lipoprotein(a) and homocysteine in patients on maintenance hemodialysis who were taking a hydroxymethylglutaryl-CoA (HMG-CoA) reductase inhibitor, vitamin B6, and folic acid.

MATERIALS AND METHODS

In this cross-sectional study, we investigated patients on maintenance hemodialysis in 2 large referral hospitals. We selected 152 patients who were on antilipid therapy with either atorvastatin or lovastatin, both 20 mg/d; vitamin B6, 40 mg/d; and folic acid, 1 mg/d; for at least 6 months. They were undergoing dialysis 3 times a week for at least 1 year.

Their fasting blood samples which were being collected monthly for routine laboratory examinations were also analyzed for serum lipoprotein(a) and homocysteine levels. Serum level of lipoprotein(a) was assessed by enzyme-linked immunosorbent assay (Biopool US Inc, Ventura, California, USA) and homocysteine, by enzymatic cycling method (Diazyme, Dresden, Germany). The blood samples were also assessed for serum levels of triglyceride (enzymatic Gop-PAP method), total cholesterol (enzymatic-calorimetric CHOP-PAP method), high-density lipoprotein cholesterol (HDLC; direct enzymatic method), and low-density lipoprotein cholesterol (LDLC; calculated with Friedwald equation). All these biochemical assays were done using diagnostic kits made by Bioactiva Diagnostica (Homburg, Germany). Since the LDLC measurement with Friedwald equation is falsified when triglyceride is over 400 mg/dL, we excluded results of LDLC from the analyses in patient with this condition.

The 24-hour dietary recall was recorded 2 times after a 45-day interval in patients on hemodialysis to investigate variations in their food intake and to control diet-related confounding factors. The Food Processor II software (ESHA Research, Salem, Oregon, USA) was used to process macronutrients and micronutrients intakes based on the dietary reference intakes. The independent t test and the paired t test were applied to analyze differences in variables between groups using the SPSS software (Statistical Package for the Social Sciences, version 13.0, SPSS Inc, Chicago, Ill, USA). Results of continuous variables were expressed as mean ± standard deviation. P values less than .05 were considered significant.

RESULTS

A total of 152 patients on hemodialysis, 91 men (59.9%) and 61 women (40.1%) were studied. The mean age of patients was 53.5 ± 14.0 years, ranged from 21 to 81 years (men, 53.6 ± 14.4 years and women, 53.2 ± 13.4 years). The mean serum values of lipoprotein(a), homocysteine, total cholesterol, HDLC, and triglyceride in the patients and the reference values are shown in Table 1. All these values of serum lipid markers were

<table>
<thead>
<tr>
<th>Serum levels</th>
<th>Men</th>
<th>Women</th>
<th>All Patients</th>
<th>Maximum RV</th>
<th>Mean Levels/RV, %</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipoprotein(a), mg/dL</td>
<td>22.04 ± 2.15</td>
<td>29.72 ± 3.19</td>
<td>25.13 ± 1.83</td>
<td>30</td>
<td>83</td>
<td>.009</td>
</tr>
<tr>
<td>Homocysteine, mg/dL</td>
<td>19.75 ± 0.56</td>
<td>20.41 ± 0.75</td>
<td>20.01 ± 0.45</td>
<td>15</td>
<td>133</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Total cholesterol, mg/dL</td>
<td>154.68 ± 3.93</td>
<td>152.83 ± 4.66</td>
<td>153.94 ± 3.00</td>
<td>200</td>
<td>77</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>LDLC, mg/dL†</td>
<td>86.02 ± 3.25</td>
<td>86.22 ± 3.54</td>
<td>86.10 ± 2.40</td>
<td>130</td>
<td>66</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>HDLC, mg/dL</td>
<td>41.54 ± 0.68</td>
<td>40.14 ± 0.85</td>
<td>40.98 ± 0.53</td>
<td>45</td>
<td>91</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Triglyceride, mg/dL</td>
<td>148.01 ± 9.05</td>
<td>162.50 ± 10.78</td>
<td>153.82 ± 6.94</td>
<td>200</td>
<td>77</td>
<td>&lt; .001</td>
</tr>
</tbody>
</table>

*aValues are expressed as mean standard deviation. RV indicates reference values; LDLC, low-density lipoprotein cholesterol; HDLC, and high-density lipoprotein cholesterol.

†Three patients were excluded from analysis due to their high serum triglyceride levels (> 400 mg/dL).
significantly less than the maximum reference values ($P < .001$). The mean serum level of lipoprotein(a) was also less than the reference value ($P = .009$), but homocysteine level was 33% higher on average than the reference value ($P < .001$). The 24-hour dietary recall results are shown in Table 2. There were no significant variations between the two times in terms of energy and nutrients intakes.

**DISCUSSION**

Cardiovascular disease is the main cause of mortality in patients on hemodialysis. Lipoprotein(a) and homocysteine are two independent risk factors of cardiovascular disease. Our findings showed that serum lipoprotein(a) levels were 17% lower than the maximum normal level, on the average, in patients on hemodialysis who were taking a statin, folic acid, and vitamin B6. Serum homocysteine concentration, however, was 33% higher than normal in the studied patients.

Longenecker and colleagues showed contradictory results to our findings; serum lipoprotein(a) levels had increased in their patients on hemodialysis which could predispose them to CVD. There are limited data on how diet and drugs affect serum lipoprotein(a) levels. Serum lipoprotein(a) levels are unaffected by lipid-lowering dietary treatment, and they increase even by dietary trans fatty acids. Monte and Mezdour demonstrated that neither treatment with HMG-CoA reductase inhibitors, nor fibrate drugs resulted in significant lowering of lipoprotein(a) levels, while Joy and colleagues and also Navarro and coworkers showed that atorvastatin could decrease serum lipoprotein(a) levels in patients on hemodialysis. In our study, the mean serum level of total cholesterol, LDLC, HDLC, triglyceride, and lipoprotein(a) were significantly lower than reference values (Table 1), which confirms findings of the two latter studies.

This may be, at least proportionally, because not only all our patients were taking atorvastatin or lovastatin for at least 6 month, but also their mean total energy intake were significantly less than the dietary reference intakes (Table 2). Our study showed that the mean food intakes of vitamins B6 and folic acid were less than the dietary reference intakes (Table 2). Basically, these patients have poor appetite and are especially reluctant to take high-potassium vitamin-rich vegetables and fruits. The other problem is that water soluble vitamins can be excreted through dialysis membranes. Our study showed even though these patients were taking vitamin B6 and folic acid supplements, their serum homocysteine levels were still high. This suggests that probably these therapeutic dosages had not been adequate to meet the need for these vitamins, or there are other unknown underlying metabolic reasons for high homocysteine levels that need further investigations.

Overall, our main limitation of the study, which was the lack of a control group of patients on hemodialysis without statins and vitamins administration, precludes making a strong conclusion based on our findings. Therefore, it is appropriate to design a case-control study of patients on hemodialysis who are taking and not taking HMG-CoA reductase inhibitors and vitamins.

**CONCLUSIONS**

Our findings indicate that although patients

**Table 2.** Daily Energy and Nutrient Intake of Patients on Hemodialysis

<table>
<thead>
<tr>
<th>Energy and Nutrients</th>
<th>1st Evaluation</th>
<th>2nd Evaluation*</th>
<th>$P$</th>
<th>Dietary Reference Intakes$^{14}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy, kcal/d</td>
<td>1220.0 ± 190.5</td>
<td>1212.4 ± 252.3</td>
<td>.86</td>
<td>2700 to 3000</td>
</tr>
<tr>
<td>Protein, g/d</td>
<td>64.4 ± 8.9</td>
<td>64.8 ± 12.5</td>
<td>.84</td>
<td>56 to 46</td>
</tr>
<tr>
<td>Carbohydrate, g/d</td>
<td>137.0 ± 21.9</td>
<td>144.8 ± 26.0</td>
<td>.07</td>
<td>130 to 130</td>
</tr>
<tr>
<td>Fat, g/d</td>
<td>47.7 ± 13.7</td>
<td>46.2 ± 15.0</td>
<td>.62</td>
<td>...</td>
</tr>
<tr>
<td>Vitamin B6, mg/d</td>
<td>1.0 ± 0.2</td>
<td>1.0 ± 0.1</td>
<td>.68</td>
<td>1.3 to 1.7</td>
</tr>
<tr>
<td>Vitamin B12, μg/d</td>
<td>3.1 ± 1.2</td>
<td>3.1 ± 1.5</td>
<td>.95</td>
<td>2.4</td>
</tr>
<tr>
<td>Folic acid, μg/d</td>
<td>157.3 ± 33.0</td>
<td>152.2 ± 36.1</td>
<td>.41</td>
<td>400</td>
</tr>
</tbody>
</table>

*The 2nd evaluation was done after a 45 days interval. Ellipses indicate not determined.
on hemodialysis, even if being on routine administration of HMG-CoA reductase inhibitors, vitamin B6, and folic acid supplements, may have serum homocysteine levels up to 30% more than normal, hence, exposing them to the risk of CVD. We need further investigations to determine whether this increase is due to administration of lipid-lowering drugs or other factors.

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CONFLICT OF INTEREST
None declared.

REFERENCES

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