



“EVALUATION OF SERUM HIGH-DENSITY LIPOPROTEIN AND LOW-DENSITY LIPOPROTEIN IN PATIENTS WITH RHEUMATOID ARTHRITIS”

Bhupesh Medatwal¹, Bhavana Shrivastava², Jai Prakash Yogi^{3*}, Bushra Fiza⁴, Maheep Sinha⁵

Abstract

Introduction: Rheumatoid arthritis is a chronic systemic disease characterized by systemic features and joint involvement and it can lead to significant morbidity and mortality. The etiology of the disease could be attributable to genetic and nongenetic factors as hormonal, environmental, and infectious factors. Altered lipid levels have been reported in various inflammatory diseases including RA. There is an increased risk of atherosclerosis and cardiovascular disease in RA subjects than in the general population. **Aim:** The present study was planned to evaluate and compare the levels of serum HDL and LDL between RA patients and healthy controls.

Methodology: Total of 80 subjects, 40 were patients with RA while 40 were age and sex matched healthy controls.

Results and Discussion: The majority of patients were female. Decreased levels of HDL and Increased levels of LDL were observed in RA patients than controls.

¹PhD Scholar, Department of Biochemistry, Mahatma Gandhi Medical College & Hospital, Jaipur, Rajasthan, India

²Tutor, Department of Anatomy, Pacific Institute of Medical Sciences, Umarda, Udaipur, Rajasthan, India

^{3*}Assistant Professor, Department of Biochemistry, ESIC Medical College & Hospital, Alwar, Rajasthan, India

⁴Professor, Department of Biochemistry, Mahatma Gandhi Medical College & Hospital, Jaipur, Rajasthan, India

⁵Ph. D Supervisor, Department of Biochemistry, Mahatma Gandhi Medical College & Hospital, Jaipur, Rajasthan, India

***Correspondence Author:** Jai Prakash Yogi

*Assistant Professor, Department of Biochemistry, ESIC Medical College & Hospital, Alwar, Rajasthan, India, Email: jpyogi20@gmail.com

DOI: - 10.48047/ecb/2023.12.si10.00402

INTRODUCTION

Rheumatoid arthritis is a persistent systemic disease affecting often the synovium, main to joint damage and bone destruction¹. RA causes huge morbidity due to synovial inflammation, joint destruction, and related disability².

RA is characterized by systemic capabilities and joint involvement and it can lead to substantial morbidity and mortality³. studies have shown accelerated untimely mortality in sufferers with RA in comparison with the overall population⁴⁻⁷. The etiology of the disorder can be a consequence of genetic and nongenetic factors as hormonal, environmental, and infectious factors³.

numerous investigators mentioned an extra of cardiovascular morbidity and mortality amongst RA sufferers. In lively RA, the majority of cardiovascular deaths result from accelerated atherosclerosis⁸⁻⁹.

Altered lipid levels have been suggested in diverse inflammatory disorders including RA¹⁰. There is an improved hazard of atherosclerosis and cardiovascular disease (CVD) in RA subjects than in the overall population¹¹. Danger elements for atherosclerotic events and CVD include males, increased age, elevated plasma total cholesterol (TC) and low-density lipoprotein (LDL), reduced high-density lipoprotein (HDL), high blood pressure, smoking, and diabetes mellitus¹²⁻¹⁵. approximately 50% of atherosclerotic coronary artery disease (CAD) in the network occurs in the absence of traditional risk factors¹⁶. In widespread, and with some versions among several studies, the lipid profile of RA patients with untreated RA is generally characterized by lower serum HDL while contrasting outcomes were posted on the serum TC and LDL¹⁷⁻²¹.

The present study was planned to evaluate serum HDL levels and serum LDL levels in RA patients and compare them with the healthy control group.

METHODOLOGY

The study design was a case-control study and conducted in the Department of Biochemistry

OBSERVATIONS

with the collaboration of the Department of Medicine, Mahatma Gandhi Medical College and Hospital, Sitapura, Jaipur, Rajasthan.

Patients (n=40) diagnosed with Rheumatoid arthritis by Rheumatologist, and age and sex matched healthy subjects (n=40) fulfilling inclusion and exclusion criteria were enrolled for the study.

An informed consent was taken before the collection of the sample from cases. The study was conducted after approval from the Institutional Ethics Committee.

Blood samples after overnight fasting were collected by standard aseptic techniques. The samples collected were subjected to the following investigations:

- High-density lipoprotein (HDL) – (Phosphotungstic acid method)
 - Direct low-density lipoprotein (LDL) – (Colorimetric endpoint method)
- Investigations were estimated on Vitros 5600 Chemistry analyzer.

Inclusion criteria:

- Age between 30 to 70 years, either gender.
- Patients who were willing to participate in the study.

Exclusion Criteria:

- Diagnosed cases of cardiovascular diseases and chronic kidney disease.
- Pregnant and lactating Women.
- Patients with malignancy.
- Subjects with Age < 30 years and > 70 years

Statistical analysis:

The results obtained were presented as mean \pm SD. Data analysis was performed using SPSS version 26. The data was carefully evaluated to obtain the mean values and SD and compared as student's 't' test between subjects and controls. $p \leq 0.05$ was considered as statistically significant.

Table 1: Gender-wise distribution of Cases

Gender	Case	%
Male	10	25%
Female	30	75%

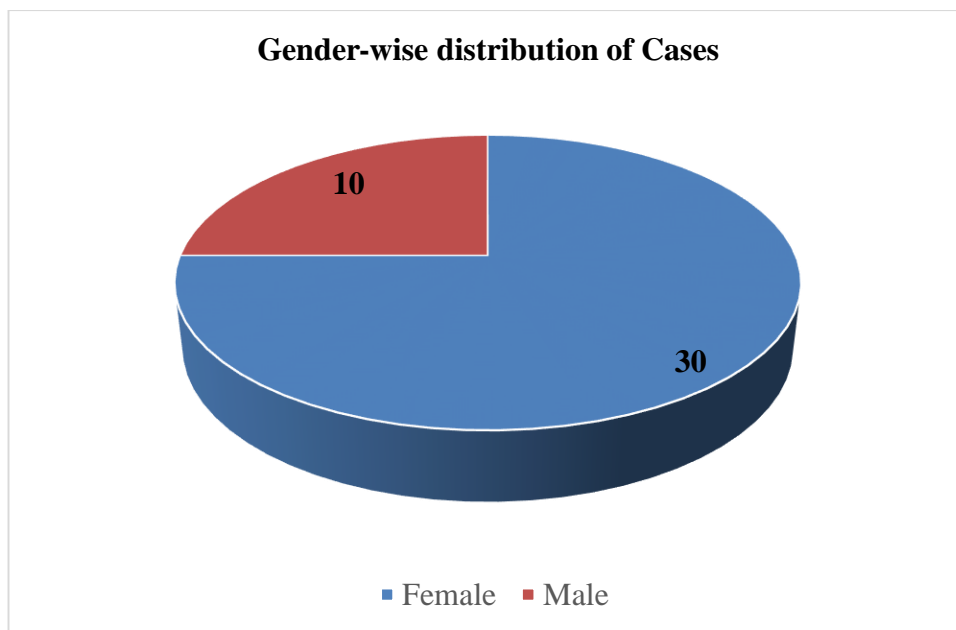


Figure 1: Gender-wise distribution of Cases

Table 2: Comparison of mean values of HDL and LDL in cases with control groups.

	Cases (n=40)	Controls (n=40)	t value	p value
HDL (mg/dl)	31.55±6.501	48.66±9.028	-9.73	<0.001
LDL (mg/dl)	104.39±17.835	79.31±25.98	5.03	<0.001

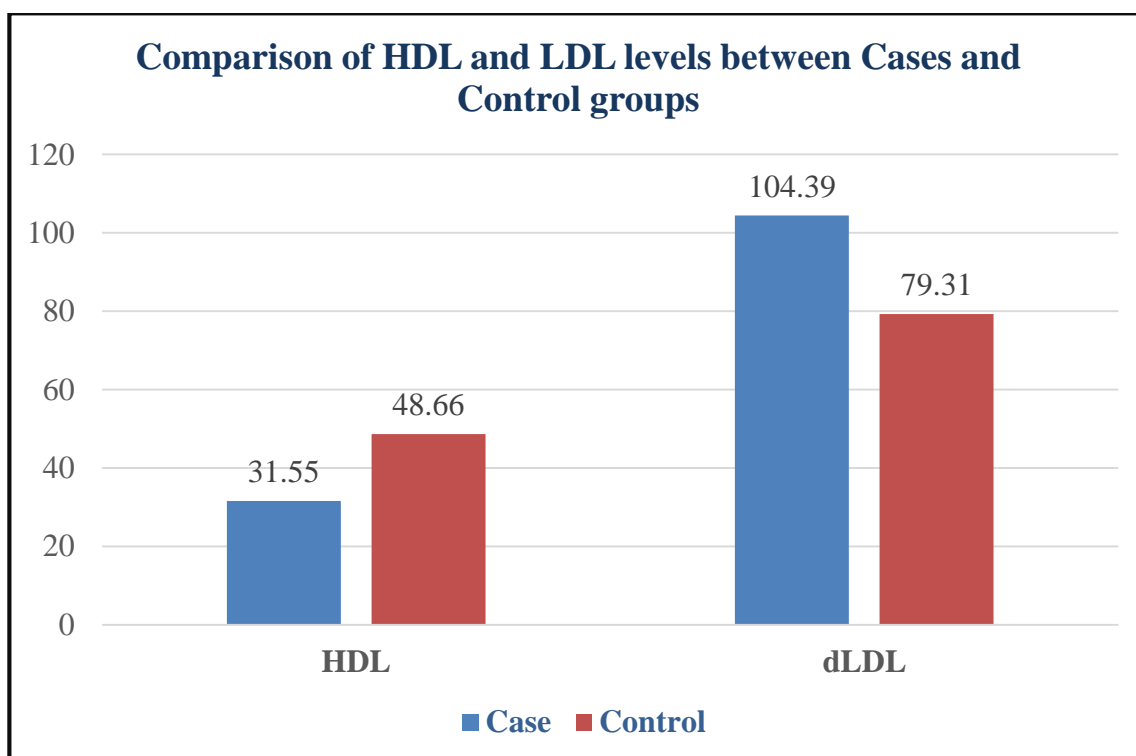


Figure 2: Comparison of mean values of HDL and LDL in cases with control groups.

RESULTS AND DISCUSSION: -

In the present study when cases (RA patients) were distributed on the basis of their gender, the majority of patients were female 75% (about 3 times higher) than male 25% as shown in Table 1 and Figure 1. According to WHO, about 70% of people living with rheumatoid arthritis are women *Eur. Chem. Bull. 2023, 12(Special Issue 10), 3517–3521*

⁽²²⁾. Similar findings were suggested by A study by **Rossini M et al.,2010⁽²³⁾ and Chavan VU et al., 2015⁽²⁴⁾**. The male-female ratio was comparable with that of the control group. In the present study, it was observed that the level of HDL was lower among RA patients when compared with the control group. P value is 3519

<0.001 hence it was highly significant as shown in Table 2 & Figure 2.

The present study shows that the level of LDL was significantly higher among RA patients when compared with the control group with a P value is <0.001 as shown in Table 2 & Figure 2. Similar observations were found by **Chavan VU et al., 2015⁽²⁴⁾** and **Yadav S et al., 2018⁽²⁵⁾**.

Rheumatoid arthritis (RA) is a chronic inflammatory disease that, if untreated, can cause severe damage to the joints and their surrounding tissue. It can lead to heart, lung or nervous system problems. It affects 0.8% of the total population of the world with an annual incidence of 0.5 - 1% in both developed and developing countries. Altered lipid levels have been reported in various inflammatory diseases including RA. There is an increased risk of atherosclerosis and CVDs in RA subjects than in the general population.

The total study population (n=80) was divided into two major groups; case group: comprising of RA patients (n=40) and control group: comprising of age and sex matched healthy individuals (n=40).

The major observations drawn from the study were:

- Of the total cases (n=40), the majority of cases 75% were female as compared to 25% male. The male-female ratio was comparable with that of the control group.
- Mean levels of serum HDL were significantly lower in RA patients when compared with the control group.
- Mean levels of LDL were significantly higher in RA patients when compared with the control group.

Conclusion: -

The present study concluded that Females are more affected by RA. Low HDL and high LDL levels were found in RA patients than healthy controls. However, the present study recommends thorough research with a large sample size.

BIBLIOGRAPHY AND REFERENCES

1. Gravallesse EM. Bone destruction in arthritis. *Annals of the rheumatic diseases*. 2002 Nov 1;61(suppl 2): ii84-6.
2. Gabriel SE, Crowson CS, Kremers HM, Doran MF, Turesson C, O'Fallon WM, Matteson EL. Survival in rheumatoid arthritis: a population-based analysis of trends over 40 years. *Arthritis & Rheumatism*. 2003 Jan;48(1):54-8.
3. Azzeh FS. Relationship between vitamin D and rheumatoid arthritis disease. *Pakistan Journal of Nutrition*. 2012 Mar 1;11(3):293.
4. Isomäki HA, Mutru O, Koota K. Death rate and causes of death in patients with rheumatoid arthritis. *Scandinavian journal of rheumatology*. 1975 Jan 1;4(4):205-8.
5. Mutru O, Laakso M, Isomäki H, Koota K. Ten-year mortality and causes of death in patients with rheumatoid arthritis. *Br Med J (Clin Res Ed)*. 1985 Jun 15;290(6484):1797-9.
6. Watson DJ, Rhodes T, Guess HA. All-cause mortality and vascular events among patients with rheumatoid arthritis, osteoarthritis, or no arthritis in the UK General Practice Research Database. *The Journal of rheumatology*. 2003 Jun 1;30(6):1196-1202.
7. Georgiadis AN, Papavasiliou EC, Lourida ES, Alamanos Y, Kostara C, Tselepis AD, Drosos AA. Atherogenic lipid profile is a feature characteristic of patients with early rheumatoid arthritis: effect of early treatment—a prospective, controlled study. *Arthritis research & therapy*. 2006 Jun;8(3):1-7.
8. Goodson N: Coronary artery disease and rheumatoid arthritis. 2002, 14:115-120.
9. Van Doornum S, McColl G, Wicks IP. Accelerated atherosclerosis: an extraarticular feature of rheumatoid arthritis? *Arthritis & Rheumatism: Official Journal of the American College of Rheumatology*. 2002 Apr;46(4):862-73.
10. Popa CD, Dessein P. Atherosclerosis in Rheumatoid Arthritis.
11. Mirjafari H, Al-Husain A, Bruce IN. Cardiovascular risk factors in inflammatory arthritis. *Current opinion in lipidology*. 2011 Aug 1;22(4):296-301.
12. Castelli WP, Garrison RJ, Wilson PW, Abbott RD, Kalousdian S, Kannel WB. Incidence of coronary heart disease and lipoprotein cholesterol levels: the Framingham Study. *Jama*. 1986 Nov 28;256(20):2835-8.
13. Kannel WB, Neaton JD, Wentworth D, Thomas HE, Stamler J, Hulley, SB, Kjelsberg MO: Overall and coronary heart disease mortality rates in relation to major risk factors in 325,348 men screened for the MRFIT. *Multiple Risk Factor Intervention Trial*. *Am Heart J* 1986, 112:825-836.
14. Manninen V, Elo MO, Frick MH, Haapa K, Heinonen OP, Heinsalmi P, Helo P, Huttunen JK, Kaitaniemi P, Koskinen P, Mäenpää H. Lipid alterations and decline in

- the incidence of coronary heart disease in the Helsinki Heart Study. *Jama*. 1988 Aug 5;260(5):641-51.
15. Cui Y, Blumenthal RS, Flaws JA, Whiteman MK, Langenberg P, Bachorik PS, Bush TL. Non-high-density lipoprotein cholesterol level as a predictor of cardiovascular disease mortality. *Archives of internal medicine*. 2001 Jun 11;161(11):1413-9.
 16. Ross R. The pathogenesis of atherosclerosis: a perspective for the 1990s. *Nature*. 1993 Apr 29;362(6423):801-9.
 17. Boers M, Nurmohamed MT, Doelman CJ, Lard LR, Verhoeven AC, Voskuyl AE, Huizinga TW, Van de Stadt RJ, Dijkmans BA, van der Linden S. Influence of glucocorticoids and disease activity on total and high-density lipoprotein cholesterol in patients with rheumatoid arthritis. *Annals of the rheumatic diseases*. 2003 Sep 1;62(9):842-5.
 18. Situnayake RD, Kitas G. Dyslipidaemia and rheumatoid arthritis. *Annals of the rheumatic diseases*. 1997 Jun 1;56(6):341-2.
 19. Lorber M, Aviram M, Linn S, Scharf Y, Brook JG. Hypocholesterolaemia and abnormal high-density lipoprotein in rheumatoid arthritis. *Rheumatology*. 1985 Aug 1;24(3):250-5.
 20. Frati E, Castagna ML, Bacarelli MR, Fioravanti A, Giordano N, Taddeo A, Marcolongo R. Plasma levels of apolipoprotein and HDL-cholesterol in patients with rheumatoid arthritis. *Bollettino Della Societa Italiana di Biologia Sperimentale*. 1984 Sep 1;60(9):1791-6.
 21. Lazarevic MB, Vitic J, Mladenovic V, Myones BL, Skosey JL, Swedler WI. Dyslipoproteinemia in the course of active rheumatoid arthritis. In *Seminars in arthritis and rheumatism* 1992 Dec 1 (Vol. 22, No. 3, pp. 172-180). WB Saunders.
 22. GBD 2019: Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019.
 23. Rossini M, Maddali Bongi S, La Montagna G, Minisola G, Malavolta N, Bernini L, Cacace E, Sinigaglia L, Di Munno O, Adami S. Vitamin D deficiency in rheumatoid arthritis: prevalence, determinants and associations with disease activity and disability. *Arthritis research & therapy*. 2010 Dec;12:1-7.
 24. Chavan VU, Ramavataram DV, Patel PA, Rupani MP. Evaluation of serum magnesium, lipid profile and various biochemical parameters as risk factors of cardiovascular diseases in patients with rheumatoid arthritis. *Journal of clinical and diagnostic research: JCDR*. 2015 Apr;9(4):BC01.
 25. Yadav S, Goswami RK, Bora GK. Correlative study between lipid profile and disease activity in patients with Rheumatoid arthritis – a hospital-based study. *Int. J. Adv. Res.* 6(4), 625-632.