Affluence putting health of Malaysians at risk

By LAME it on metabolic disorders. Health Ministry statistics show that diabetes is today a common Malaysian malaise while coronary artery disease and obesity rates are rising alarmingly, even among the young.

These diseases are all most likely a result of metabolic disorders caused by abnormal chemical reactions in the body that disrupt the metabolic process, resulting in too much of some substances or too little of others that one needs to stay healthy.

These diseases have been blamed on the increasing affluence of Malaysians, where they consume more rich food, indulge in sinful snacks and exercise less due to time spent at work.

Chronic metabolic disease, which includes coronary heart disease, hypertension, dyslipidaemia and impaired glucose metabolism, is already the dominant topic in healthcare in many parts of the world.

Medical experts are predicting that over the next 50 years the problems caused by this cluster of disorders are expected to increase.

University of Sydney’s School of Molecular and Microbial Medicine head, Professor Dr Ian Caterson, said this was particularly true in Asia, where these problems were increasing exponentially.

“While it is often forgotten, the prevention and treatment of one of the major underlying causes of these chronic metabolic diseases — obesity, and particularly abdominal obesity,” said Dr Caterson, who has over 170 publications in scientific journals and books.

Dr Caterson, who is also Robert Professor of Human Nutrition at Sydney University, said visceral fat releases hormones and inflammatory factors which cause or exacerbate these problems.

Reducing abdominal fat needs to be one of the priorities of prevention and management, Dr Caterson said.

He said the problem of increasing resistance and abdominal adiposity in Asia was worse than in other parts of the world.

He said the best way to reduce abdominal adiposity was by lifestyle change and where necessary, the use of weight loss pharmacotherapies or other adjunctive treatment.

There are several drugs available, those centrally acting (trizanoham and sibutramine) and peripherally acting (loritralisal).

“We are living in an era where we can produce a drug by lifestyle change and where necessary, the use of weight loss pharmacotherapies or other adjunctive treatment. There are several drugs available, those centrally acting (trizanoham and sibutramine) and peripherally acting (loritralisal).”

“Unfortunately, the use of weight loss drugs is not well understood, there is general apprehension, adverse reactions and even environmental and social change resulting in food intake and in activity, but there is not a single pattern that can explain all cases.”

Rather, there are multiple lifestyle changes that makes early intervention and prevention difficult but not impossible.

In Australia, Dr Caterson said, doctors needed to recognise these at risk.

It is not difficult to assess adiposity clinically but we don’t.

If we do, we find it difficult to be the subject with patients.

He pointed out that metabolic disease had started and was slowly making its presence felt among children and adolescents.

“We are getting better at monitoring the crises produced by metabolic disease but individuals still suffer in their quality of life. Even those who are ‘just’ obese have significantly reduced quality of life.”

Dr Caterson said metabolic disease is slowly making its presence felt among children and adolescents.

Malaysia is on track to becoming a developed nation — that is the good news. But the bad news is that Malaysians suffer from many diseases predominantly seen in fully developed countries, writes ANNIE FREDA CRUZ.
THE GOOD & THE BAD

CHOLESTEROL can’t dissolve in the blood. It has to be transported to and from the cells by carriers called lipoproteins.

Low-density lipoprotein, or LDL, is known as “bad” cholesterol. High-density lipoprotein, or HDL, is known as “good” cholesterol.

These two, together with triglycerides and Lp(a) cholesterol, make up the total body cholesterol count, which can be determined through a blood test.

LDL cholesterol: When too much LDL (bad) cholesterol circulates in the blood, it can slowly build up in the inner walls of the arteries that feed the heart and brain. Together with other substances, it can form plaque, a thick, hard deposit that can narrow the arteries and make them less flexible. This condition is known as atherosclerosis. If a clot forms and blocks a narrowed artery, heart attack or stroke can result.

HDL cholesterol: About one-fourth to one-third of blood cholesterol is carried by high-density lipoproteins (HDL). It is known as “good” cholesterol because high levels of HDL seem to protect against heart attack. Low levels of HDL (less than 40 mg/dL) also increase the risk of heart disease.

Medical experts think that HDL tends to carry cholesterol away from the arteries and back to the liver, where it’s passed from the body. Some experts believe that HDL removes excess cholesterol from arterial plaque, thus slowing its buildup.

Triglycerides: Triglycerides are a form of fat made in the body. Elevated level of triglycerides can be due to overweight, obesity, physical inactivity, cigarette smoking, excess alcohol consumption and a diet very high in carbohydrates (60 per cent of total calories or more).

People with high triglycerides often have a high total cholesterol level, including a high LDL level and a low HDL level.

Many people with heart disease and/or diabetes also have high triglyceride levels.

Lp(a) cholesterol: Lp(a) is a genetic variation of LDL cholesterol. A high level of Lp(a) is a significant risk factor for the premature development of fatty deposits in arteries. Lp(a) isn’t fully understood, but it may interact with substances found in artery walls and contribute to the buildup of fatty deposits.

Source: MedlinePlus