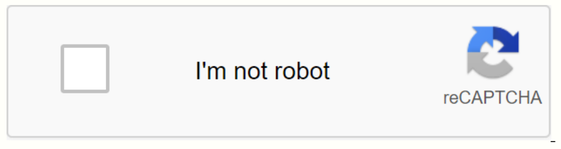
Valores normales de colesterol en niños pdf



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Preventive Services Working Group in the US (2016). Screening for lipid disorders in children and adolescents. 6. 6. Doi: 10.1001/Jama.2016.9852. Accessed August 9, 2016. Expert Group on Integrated Guidelines for the Cardiovascular System and Risk Reduction in Children and Adolescents (2011); Expert Group on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents: Summary Report. Pediatrics, 128(Top 5): S213-S256. Committee on Practice and Outpatient Medicine, Working Party on the Timing of Bright Future Periodicity (2016). recommendations for the prevention of paediatric health care in 2016. Pediatrics, 137(1). DOI: 10.1542/PEDS.2015-3908. Accessed December 7, 2015. Grundy SM, et al. (2018). 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guidelines for Blood Cholesterol Management: Report of the American College of Cardiology/American Heart Association of Clinical Practice Guidelines. Journal of the American Cardiologist, published online November 8, 2018: S0735. Doi: 10.1016/d.jacques.2018.11.003. Accessed January 28, 2019. You may be trying to access this site from a secure browser on the server. Enable scripts and reload the page. IntroductionNumerous studies show that the process of atherosclerosis begins in childhood1,2, although its clinical manifestations do not appear until adulthood. The importance of blood concentrations of total cholesterol (CT) and cholesterol associated with low density lipoproteins (c-LDL) led to the acceptance of lipid hypotheses in the atherosclerosis genesis, although this does not exclude the presence of other endogenous and exogenous risk factors3. Several epidemiological studies have shown that thrombogenic factors play an important role in atherosgenesis and the frequency of thromboembolic complications in atherosclerotic diseases, given that thrombogenic factors are factors of coronary heart disease. There is now growing evidence that high cholesterol concentrations attached to high-density lipoproteins (c-HDL) may play a protective role against the formation of atherosclerotic plaque. Several studies have shown the role of C-HDL in the reverse transport of cholesterol, consisting of the interaction of apolipoprotein A1 (apo A1) and c-HDL with peripheral cells, to remove excess cholesterol from fatty deposits in cell membranes and to transport it to the liver, where it is degraded and excreted as bile acid. Increasing the amount of Apo A1 increases the reverse transport of cholesterol. In addition, other studies have attributed the C-HDL antioxidant and modulating properties to the inflammatory response4. On the other hand, there are authors who establish a link between concentrations and the creation of an antithrombotic state5-7. The purpose of our work is to concentrations of C-HDL and those of lipid and thrombogenic parameters in the paediatric population. Patients and methodsInterested 110 children, 6 and 7 years, from an epidemiological study of the prevalence of hypercholesterolemia in children in Bisqui, all of them supposedly healthy. In any case, parents were asked to include the children in the survey. Each of them received blood after 12 hours of fasting. The blood samples obtained are centrifuged and serum and plasma subfractive processes are obtained, in which the following parameters are determined: CT, triglycerides, c-HDL, c-LDL, apo A1, apo B100, lipoprotein (Lp[a]), D-dimmer, fibrinogen and plasminogen activator type 1 (PAI-1). Apo A1 and B100 were analysed using immunoturbidimetric methods (Tina-quantum), with a measuring range of 20-400 mg/dL, the coefficient of variation (CV) interservation for apo A1 2,4 % (x x x 40 mg/dl) and 1,6 % (x x x 176 mg/dl) and for apo B100 of 2,5 % (x x x 29 mg/dl) and 1,1 % (x x 112 mg/dl). Lp(a) was determined by immunoenzyme analysis (ELISA) (TintElize Lp [a], Biopool), the measurement interval was 0-60 mg/ dL and CV interseries, 7.7.7% (x x x 10 mg/ dL) and 2.7% (x x x 40 mg/ dL). To determine D-dimmer concentrations, the elfa method (enzyme-related fluorescent test) was used to test an immunoenzyme with a range of 45-10,000 ng/ ml, the CV interseries was 5.7% (x x x x 264 ng/ ml) and 7.1% (x x x 7,283 5/ml). Fibrinogen is measured by coagulometry (IL Instrument Laboratories) by the Klaus method. The measurement interval is 70- 700 mg/1l, cv-a tenteries is 1.31 % (x x x 334 mg/dL) and 2.83 % (x 96 mg/dL). A quantitative bioimmunological method (Biopool International) has been used to determine the active PIP-1, the measuring interval is 2-50 U/ml and cv interserie, 16,9 % (x x x x 2 U/ml) and 3,6 % (x 36 U/ ml). CT, triglycerides and c-HDL are determined by routine enzymatic methods (Roche C-LDL is calculated by Friedewald.Statistical analysis The parameters are expressed in standard mean value and deviations (DE). In order to estimate differences in lipid and thrombogenic levels based on low (first fourth quarter) and high (second and third quartile) c-HDL values, we use a T-test of the Man-Whitney parametric variables and U test for non-parametric variables. c-HDL and the various parameters studied, we used spearman coefficient correlation. In all cases, p-value is considered significant < 0.05. For statistical analysis of the data, an SSS statistical package of FSB version 11 was used. 5. Results from the 110 children studied, 60 were children (54.5 %) Table 1 lists lipid profile values (CT, c-HDL, c-LDL, triglycerides, apo A1, apo B100 and Lp[a]) and thrombogenic (fibrinogen, D-dimmer and PAI-1) in the aggregate sample tested; en todos ellos se incluye el intervalo de confianza (IC) para una p < 0,05. Por sexos, las niñas presentaron valores más elevados y estadísticamente significativos de c-LDL (114,84 ± 24,18 frente a 104,98 ± 21,73 mg/dl), CT/c-HDL (2,90 ± 0,65 frente a 2,65 ± 0,58), apo B (97,20 ± 13,58 frente a 87,90 ± 14,76 mg/dl) y fibrinógeno (282,27 ± 41,05 frente a 257,44 ± 51,69 mg/dl) que los niños, con una p de 0,026; 0,040; 0,001, y 0,01, respectivamente. Niveles de los parámetros estudiados por valores de colesterol HDLAl dividir la muestra en dos grupos, basándonos en las concentraciones de c-HDL ≤ 62 mg/dl (primer cuartil) y > 62 mg/dl (segundo y tercer cuartil), los niños con valores más bajos de c-HDL presentaron concentraciones significativamente disminuidas de CT (0,002), de apo A1 (0,000) y de apo B100 (0,034); y más altos y estadísticamente significativos de CT/c-HDL (0,006), fibrinógeno (0,01) y PAI-1 (0,018) (tabla 2). Correlation between C-HDL concentrations and lipid and thrombogenic factors, concentrations of C-HDL correlate positively and significantly with CT and A1 apo, and negatively and significantly with the CT/ c-HDL ratio, fibrinogen and PAI-1 (Table 3). DiscussionIn our study we observed, like other authors, that girls had a greater prevalence of lipid profile changes than boys, which contrasted with a lower cardiovascular risk for adulthood, although it is known that this behavior appears to change in puberty, possibly due to hormonal changes occurring at this stage8.9. We also see higher concentrations of fibrinogen in girls than in boys. Sánchez-Bayle et al10, in a study of 2,224 children aged 2 to 18 years, they describe a similar situation except in the 10-12 year group, and these differences are statistically significant in the group of 6-9 and 16-18 years, with p < 0.001.C-HDL being an important predictive factor for cardiovascular risk, so high values are associated with low cardiovascular risk, and vice versa11-13. In our study, C-HDL concentrations were positively and significantly intertwined with CT and A1 apo concentrations and negatively and significantly with CT/ c-HDL, fibrinogen and PAI-1 concentrations. Given the close link between c-HDL and ratio [r] x 0.919), the antiatherogenous effect attributed to high concentrations of c-HDL can be assumed to be partly due to the contribution of A1 apo. The direct and significant relationship between C-HDL and CT concentrations is due to children presenting high C-HDL values, and in many cases the increase in total cholesterol is due to the C-HDL fraction, a fact described by various authors14,15. Kannel16, based mainly on the Framingham study, suggests using the CT/C-HDL ratio as a better cardiovascular risk marker than CT and c-HDL separately. Several epidemiological studies have shown that hemoreological factors play an important role in atherosgenesis and the frequency of thromboembolic complications of arteriosclerotic diseases, taking into account predictive factors of coronary heart disease. Within these hemoreological factors, plasma viscosity is a factor of great importance, which depends largely on the concentration of fibrinogen, a factor that in turn significantly affects erythretic aggregation; therefore, an increase in the concentration of fibrinogen leads to a delay in blood flow, thereby favoring endothelial damage and, therefore, the development of atherosclerosis. However, there are few hemoreological data in the pediatric population, and some of them are contradictory. Dalmau Serra et al17, in the study of 36 children affected by familial hypercholesterolemia, found hemoreological changes consisting of increased platelet aggregation and an increase in plasma viscosity, compared to the control group, but did not find a significant increase in fibrinogen. This suggests that children with hypercholesterolemia have hemogreological changes associated with dyslipemia. Jay et al18 evaluated the same hemorrological parameters in 16 children with family hypercholesterolemia and found no significant differences in any of them, so they concluded that the hemogreological changes present in adults with hypercholesterolemia were not a direct consequence of hyperlipidemia. Albisetti et al19 examined 36 children with hypercholesterolemia and found a significant increase in concentrations of fibrinogen, plasminogen and a2-macroglobulin compared to a control group. They concluded that there is a decrease in fibrinolytic activity in asymptomatic children with dyslipemia. Bao et al20 determined concentrations of fibrinogen at 3,047 suggested healthy children between the ages of 5 and 17 years and found an independent link between c-HDL and fibrinogen concentrations. PAI-1 is the main inhibitor of plasminogen activators, so it plays a key role in regulating fibrinolytic activity in the systemic circulation. Various evidence and experimentally show that an increase in MYP-1, both in circulation and locally, can contribute to the development of thrombosis21,22. In our study, C-HDL concentrations were reversed associated with fibrinogen and PAI-1 concentrations, suggesting that children with low concentrations of c-HDL had hemoreological and hemostiotic changes that may contribute to the development of atheroma injury. In conclusion, our results suggest that in the studied population in babies, high CT concentrations may be due to high C-HDL concentrations. On the other hand, we find a feedback and statistically significant relationship between C-HDL concentrations and fibrinogen and PAI-1 concentrations, suggesting that children with lower concentrations of c-HDL have an increase in coagulative activity and a decrease in fibrinolytic activity. This, in the future, can lead to an increased risk of cardiovascular disease. Thank you for this work being done thanks to the funding of the University of the Basque Country/Euskal Herriko Unibertsitatea. UPV Project Report 078.352-EA237/96. Correspondence: Dr. G. T. Saiz Mebe. Foundation for the Study and Training of Cardiovascular Disease (FIDEC). 48013 Bilbao. Spain. Email: nfpirezj@lg.ehu.es nfpirezj@lg.ehu.es

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