Review of Literature
Hyperlipoproteinaemias are disturbances of lipid transport that result from accelerated synthesis or retarded degradation of lipoproteins that transport cholesterol and triglycerides through plasma. Elevated plasma lipoprotein levels are important clinically because they can cause two life threatening diseases: atherosclerosis and pancreatitis. A reduction in plasma lipoprotein - cholesterol levels, achieved by diet and drugs, reduces the risk of myocardial infarction in subjects of hyperlipoproteinaemia (Peto et al. 1985).

Considerable epidemiological data is now available which establishes a direct link between increased total plasma cholesterol concentrations and the development of STC, CHD & LDL atherosclerosis. A similar link has shown for raised concentrations of individual atherogenic lipoprotein in particular the LDL fraction (Hulley and Rhoads, 1982.; Kannel et al. 1984). In contrast, a strong inverse relation has been fond between HDL cholesterol concentration and the risk of coronary artery disease (Gordon et al. 1981; Golboult et al., 1980). Though it’s not certain whether increased triglycerides are an independent risk factor (pockoet et al. 1980), high concentrations are usually accompanied by low concentrations of HDL and this may be their link with coronary risk. Dietary and drug induced in cholesterol concentrations are not only associated with a decrease in the rate of progression of atherosclerosis in patients with established disease especially of coronary arteries but also of regression when steps are taken to reduce plasma cholesterol concentrations (Duffield et al. 1983 and Brensike et al. 1984).

Atherosclerosis is disease of large and medium sized muscular arteries and has basic lesion: Atheroma or fibrofatty plaque consisting of raised focal plaque within the intima having a core of lipid mainly cholesterol usually complexed to proteins and cholesterol esters and a covering fibrous cap (Robbins and Cotran, 1984). of the various risk factors 4 are considered to be of prime importance - hyperlipidaemia, hypertension, cigarette smoking, diabetes. Others are physical inactivity, obesity, stress and behavioural patterns etc.
The Framingham's study (1976) showed that in men and women 35-44 years of age, serum cholesterol levels 265 mg/dl or more have five times higher risk of IHD than are levels 220 mg/dl or less. The most striking association with atherosclerosis (A.S.) and I.H.D. is with elevated levels of I.DL (Weiss et al. 1972), but hyper lipidaemia with increased concentrations of VLDL also appears to increase the risk. In contrast serum levels of HDL are inversely related to risk (Heirs et al. 1980).

**CHANGES IN LIPID LIPOPROTEIN LEVELS**

**AFTER HIGH CHOLESTEROL DIET**

Effect of long term and short term feeding of diet rich in cholesterol evokes variable responses and is subject to individual variation. Dietary fat and cholesterol causes changes in specific lipoprotein in a variety of species (Mahley et al, Arora RC et al). Quantitatively a change in specific lipoprotein may be dramatic in one species than in another. These changes have been associated with the development of atherosclerosis in experimental models (Mahley et al). Considering effect of diet on individual lipoprotein fractions.

**TOTAL SERUM CHOLESTEROL (STC)**

In 1956 Ancelkeys, JT Anderson et al concluded that serum cholesterol level is essentially independent of the cholesterol intake over the whole range of natural human diets. But latter on it was proved beyond doubt that feeding cholesterol rich diet for 2-8 weeks raises total serum cholesterol in blood (Arora RC et al, Messinger et al, Conner et al, Deborah Applebaum et al).

In an earlier report, Bruhn (1940) observed a 20% rise in mean cholesterol level after a fat load. Effect of high cholesterol fat load on post prandial cholesterol levels has also been studied in the past by several workers, but insignificant difference has been found between post prandial and 10 to 14 hours tasting value (Albrink and mán 1956; Pomeranze et al. 1954; Shilling et al. 1964). All these workers observed plasma cholesterol values upto 24 hours after a test meal. On the other hand Nikkila
and Konttinen (1962) demonstrated a significant decrease in cholesterol level six hours after a fat diet in healthy soldiers.

Hanno Krauss, Pieter Groot in Oct., 1987 reported insignificant changes in STC after feeding 0.5 gm/m² of cholesterol and taking readings at 2 hrs interval for 14 hrs.

In adolescents with initial cholesterol levels greater than 200 mg/dl, a 50 percent decrease in cholesterol intake led to an appreciable drop (15.6%) in cholesterol levels, but the effect was much more modest (8.3%) in those with lower initial levels (Gandey et al. 1972).

In another large survey of school children, there was no positive correlation between the low (80-130 mg/dl), the intermediate (157-180 mg/dl) and the high (194-426 mg/dl) cholesterol levels, with the mean daily intake of energy, sugar, fat, saturated fat and cholesterol (Weidann et al 1978.). However, in 7 different studies summarised recently, significantly weak correlation were noted between serum lipids and dietary P/S ratio (Mellies and Glueck, 1983).

In a survey of school age children examining the influence of nutrients on LDL cholesterol, it was concluded that the higher intake of cholesterol and lower ratio of P/S was associated with higher value of LDL cholesterol. Strict vegetarians have been reported having lower serum cholesterol than lactovegetarians and non vegetarians (Sacks et al, 1975; Knuiman et al, 1982).

Textured vegetable proteins lowered STC in hypercholesterolemic subjects with no change or a slight elevation of HDL cholesterol, no effect or only minor change have been observed in normolipidemic subjects (Sirtori et al, 1985).

The replacement of animal protein with vegetable protein in the diet has been suggested to reduce the diet linked atherogenic risk (Carroll, 1982).

However, Sacks et al (1983) found no appreciable correlation between total intake of protein, when consumed above minimum requirement and serum cholesterol level.

Early fat intake does not influence subsequent serum lipids level. Serum cholesterol was higher during the first 9-12 months of life in breast feed babies, but
there was little difference subsequently (Friedman and Goldberg, 1976; Huttunen et al. 1983). In addition to its high cholesterol content (20 mg/dl), breast milk has decreased P/S ratio of fatty acids when compared to formulas. In a report dealing with feeding habits and serum lipids in infants and children, there was a direct correlation between serum lipids and the amount of saturated fat as well its P/S ratio in infants aged 6 to 10 months, but no such correlation was found in 3-4 years old children. The type and duration of early feeding practices had little influence on subsequent serum lipid levels (Anderson et al. 1979). Results of human studies, therefore do not agree with animals work, which suggest that a low post natal dietary cholesterol homeostasis. In fact it was shown that children aged 7-12 years who were fed low cholesterol formulas has lower mean serum cholesterol than those fed cow's milk or breast milk (Hodgson et al. 1976). Another study could not document an effect of a low versus a moderate cholesterol intake during first six month of life in response to large cholesterol intake during second 6 months of life (Glueck, 1972).

**HIGH DENSITY LIPOPROTEINS (HDL)**

High density lipoproteins are lipid protein complexes defined by flotation in the ultra centrifuge between density 1.063 and 1.21 gm per ml, by the presence of major protein constituents, apolipoprotein A-I, and A-II, and by alpha migration on electrophoresis. Three classes of HDL are separated on the basis of flotation rates on ultracentrifugation. HDL₁ have flotation rates between 0-3.5 HDL₂ have rates in excess of 3.5. The third and minor HDL₃ is sometimes found at d <1.063 and overlaps with the low density lipoprotein distribution. Recently Mahley and colleagues have identified a distinct sub type of HDL designated HDLₑ or apo E-HDLₑ. This is found in the plasma of cholesterol fed animals, and to a much smaller extent in humans fed high cholesterol, high saturated fat diets. HDLₑ differs from other sub type of presence of apolipoprotein E. This property confers an affinity for the low density lipoprotein receptor (Mahley and Wet agraber, 1978).

The lipid constituents of HDL exhibit variations. Cholesterol ester content may range from 10-20 percent, triglycerides are normally less than 4 percent. The
ratio of cholesterol to triglyceride in HDL may show wide fluctuations with increase being observed after dietary cholesterol supplementation (Mistry et al. 1977) and decrease being found in patients with hypertriglyceridemia (Weisweiler et al. 1977), uremia (Brunzell et al. 1977) and Ischemic heart disease (Carlson et al. 1975).

The bulk of HDL mass appears to arise from the interaction of precursor particle nascent HDL secreted by the liver and intestines, with lipids and protein released during the catabolism of triglyceride rich lipoprotein. A portion of HDL also arises from transfer and uptake of lipids, particularly free cholesterol, from cell membrane.

**FACTORS MODULATING HDL LEVELS IN HUMANS**

(a) • **Constitutional Factors**

In most population it has been demonstrated that women have higher levels of HDL than men at all ages following puberty. Exogenous androgen administration lowers HDL levels in men (Furmen et al. 1967). A drop in HDL level seen in males at around the time of puberty (Beagtehole et al. 1980) has been related to the degree of sexual maturation (Frerich et al. 1978 and Morrison et al. 1979).

Transient increase in HDL₂ have been reported at or near the time of ovulation (Barelay et al. 1965). No changes in HDL cholesterol have been found during pregnancy (Kinnunen et al. 1980).

There also exist a strong genetic influence in disease states. Reduced levels of HDL cholesterol is found in adult first degree relatives and prepubertal and pubertal children of patients with a history of acute myocardial infarction (Micheli et al. 1979; Pometta et al. 1979; Robertson et al. 1980). Recently, evidence for autosomal dominant inheritance of low HDL levels has been reported in large kindred with a high prevalence of coronary disease (Verganie et al. 1981). High level of HDL has also been reported in black American population (Tyroler et al. 1975).

HDL level also change with age. In males the levels are stable until puberty and adolescence, during which there is a decline followed by relatively stable levels in adulthood until ages 55-60, where there is an increase, and then a plateau in older
age group. In females there is a small linear increase in HDLC from childhood to about 60 years, after which no age effect is apparent (Heiss et al, 1980).

(b) **Obesity and HDL**

HDL levels are lower in obese individual than in non obese controls (Wilson et al, 1972; Carlson et al, 1975 and Glueck et al). During the course of weight loss, an increase in HDL cholesterol concentration has been reported to occur in association with reduction in VLDL and total triglycerides concentration (Wilson et al, 1972). But in other studies HDL cholesterol showed either no change or a reduction (Widholm et al, 1978; Thompson, 1979, Howard, 1979).

(c) **Physical Activity and HDL**

High levels of HDLC are reported to be related with high level of endurance type exercise, including long distance runners, cross country skiers, lumber jacks, tennis player, and soccer player (Wood et al, 1977; Lehtonen et al, 1978; Lehtonen and Viikari et al, 1978, and Vodak et al, 1980).

Reduction in adiposity, in combination with mild exercise program, resulted in no increase in HDL cholesterol whereas a drop in HDL cholesterol was found with caloric restriction in the absence of exercise (Weltman et al, 1980).

(d) **Alcohol and HDL**

Alcohol ingestion has been reported to raise levels of HDL (Johansson et al, 1974; Belfrage et al, 1977). But the results of Glueck et al (1980) were contradictory to the above statement.

In a large epidemiological study levels of HDL cholesterol and amount of habitual alcohol intake in moderate range have been independently correlated (Castelli et al, 1977).

(e) **Relationship of diet and HDL**

Diet is an important modulator of the synthesis, secretion, and concentration of serum lipoprotein. Conflicting reports have appeared on effect of dietary cholesterol on HDL levels.

Borden et al (1964) reported enhanced levels of HDL in rats fed cholesterol while Haft et al (1962) and Kritchevsky (1965) reported no change in HDL levels in
cholesterol fed rats.

Reiser et al. (1966) and Howard et al. (1968) reported decreased level of HDL cholesterol in rats fed with high cholesterol diet.

Narayan (1971) demonstrated that HDL₂ decreased drastically about 50% in rats fed with high cholesterol diet. These results confirmed the earlier observation of Reiser et al. (1966) that rat serum HDL level was decreased irrespective of whether a saturated or unsaturated fat was used in the diet supplemented with cholesterol. In short term feeding studies, marked reduced in dietary fat and isocaloric increase in carbohydrate resulted in decrease in HDL cholesterol in conjunction with elevation of serum triglyceride and VLDL. Studies of HDL composition have shown a decrease in ratio of apolipoprotein A-I to A-II and a decrease in HDL cholesterol-to-protein ratio (Schonfeld et al., 1976) consistent with a selective decrease in HDL₂ species (Blum et al., 1977).

There is evidence that substitution of large quantities of poly-unsaturated fat for saturated fat in diet can result in lower levels of HDL lipids and proteins (Nichaman et al., 1967). An increase in the P:S fat ratio from 0.25 : 1 to 4:1 in food diet fed to four normal subjects for five weeks resulted in reduction of HDL cholesterol and apolipoproteins A-I concentration of 33 and 21 percent respectively, with an associated reduction in HDL₂ : HDL₃ ratio (Shepherd et al., 1978). Other studies have however reported either no change (Lewis, 1978, shore et al., 1981) or increase (Jackson and Glueck, 1980) in levels of HDL cholesterol with feeding of diets enriched in polyunsaturated fats. High dietary intake of cholesterol, in the form of three to six egg yolk per day, has been reported to produce increase in apolipoprotein E-containing HDL-sub species in human (Mahley et al., 1978). This effect was seen whether or not there was an increase in total plasma cholesterol. Despite the fact that HDL containing apolipoprotein E represented only a minor fraction to the total HDL, its presence was shown to account for an increase of 2.6 to 4 times the binding of HDL to LDL receptors of fibroblasts as compared to pretreatment HDL (Mahley et al., 1981). But this was not observed in another study (Applebaum et al., 1979). Recently it has been reported that level of HDL cholesterol and serum apolipoprotein A-I, but not
apolipoprotein E increased with the feeding of diets high in both cholesterol and saturated fat (Tan et al., 1974).

A final consideration in evaluating the effects of dietary variables on HDL is that, while levels of HDL cholesterol and plasma apolipoprotein A-I are similar after overnight fast and the nonfasting state (Henderson et al., 1980), changes in levels and composition of HDL have been shown to occur actually after meals containing fat. Cholesterol, phospholipid, and C-apolipoprotein levels in HDL$_2$ increase and cholesterol in HDL decreases (Havel, 1973; Baggio et al., 1980) in conjunction with transfer of chylomicron lipids to HDL during the course of their catabolism. Recently it has been shown that HDL apolipoprotein A-I levels increased when fat was consumed in divided doses over a 10 hours period, but not when the same amount of fat was ingested as a single load (Key et al., 1980).

**LOW DENSITY LIPOPROTEIN - CHOLESTEROL (LDLC)**

LDLC is generated by the degradation and removal of triglyceride from very low density lipoprotein (VLDL) in the plasma, their density is in the range of 1.019-1.063 and they contain apoprotein B100. More than 75 percent of the total cholesterol present in the plasma is in the form of LDLC.

One function of LDL is to supply cholesterol to a variety of extrahepatic parenchymal cells, such as adrenal cortical cells, lymphocytes, muscle cell and renal cells. In 1977 Goldstein hypothesized the concept of LDL receptor. The presence of these receptors have been confirmed by many laboratories. LDL receptors are present on the cell surface of liver, adrenal cortical cell, lymphocyte muscle cell and renal cells. LDL that binds to this receptor is taken up by receptor mediated endocytosis and digested by lysosome within the cells. The Cholesterol esters of LDL are hydrolyzed by lysosomal cholesterol esterase, and the liberated cholesterol is used both form membrane synthesis and as a precursor for steroid hormone synthesis. Liver uses the LDLc for synthesis of bile acids and for generation of free cholesterol which is secreted into the bile.
In humans around 80 percent of LDL is removed from the plasma each day by the LDL receptor pathway the remainder is degraded by scavenger cell system in phagocytic cells in reticulo endothelial system.

**DIET INDUCED CHANGES IN LDL**

Diet high in fat and cholesterol cause an elevation in LDL in most animals (Mahley, 1978). The response in man varies, but in those subjects who have an elevation in plasma cholesterol, there is an elevation in plasma LDL levels. Deborah applebaum et al (1979) demonstrated significant rise of LDL levels. Deborah applebaum et al (1979) demonstrated significant rise of LDL level in human volunteers after feeding 500 mg of egg yolk cholesterol per day for 30 days.

Age related difference in rise of LDL was demonstrated by Arora and Gupta (1987). They found out that rise of total serum cholesterol after feeding high fat high cholesterol breakfast for one week was much more pronounced in young (20-30 gm) volunteers with major portion of rise being contributed by increased LDL. Contrary in older age person the rise of STC was less marked with LDL contributing mainly in the increased levels.

Baudet et al demonstrated that there was significant fall in level of LDL in five volunteers 3 hours and 5 hours after taking butter diet. They attributed this fall due to defect in VLDL hydrolysis by serum lipases and due to metabolic blocking in liver or adipose tissue.

In addition to this the diet induced LDL are larger than LDL from the same species on low fat, low cholesterol diet. In a study performed by Rudel and co-workers in 1979 on rhesus monkey showed that, high cholesterol diet induced LDL have molecular weight which are 1.5 fold larger than those of control LDL. Further more St. Clair and Leight in 1978 have reported that the diet induced large LDL are capable of stimulating cholesteryl esterification and accumulation in smooth muscle cells to a greater extent than are normal LDL.

An additional alteration in the LDL, induced by the high cholesterol diets involve the apoprotein constituents. In normal LDL, the B-apoprotein is the major
detectable apoprotein moiety, however, in several species the LDK contain a variable 
amount of the E apoprotein following cholesterol feeding (Mahley et al. 1977; Rudel 
et al. 1979).

**CONTROL OF PLASMA CHOLESTEROL LEVEL BY LDL RECEPTORS**

A decade of intense investigation has established a central role for 
lipoprotein receptors in regulating plasma cholesterol traffic. Operationally, the IDL/ 
LDL receptor system can be considered the primary transport mechanism for 
endogenous cholesterol. LDL are generated in the plasma by the degradation of 
intermediate density lipoprotein (IDL). Generated LDL is removed relatively slowly 
from plasma by binding to LDL receptors in the liver and extra hepatic tissues (kita 
et al. 1982). In rabbits, rats and hamsters, more than half of the total LDL receptors 
are located in the liver. However the precise distribution of these receptors in man in 
unknown.

**REGULATION OF HEPATIC LDL RECEPTORS**

Hepatic LDL receptors are suppressed whenever the livers content of 
cholesterol increases or its demand for cholesterol is reduced. This receptor 
suppression occurs when a high cholesterol diet is consumed (Hui et al. 1981) or 
when bile acids are infused (Angelin et al. 1983). Conversely, LDL receptors increases 
when hepatic cholesterol synthesis is blocked by drugs compactin or mevinolin 
(Goldstein et al. 1982 and Bilheimer et al. 1983), when bile acid binding resins are 
given (Shepherd et al. 1980), or when an ileal by pass is created (Spengel et al. 
1982). Fasting has also been shown to suppress LDL receptor in rabbits (Golstein, 
1982). LDL receptors can be stimulated by thyroxine (Thompson, 1981) and by 
pharmacologic doses of estrogen (Winder, 1980). Hepatic LDL receptors decline 
when rabbits are fed a diet composed only of sucrose and casein (Chao et al. 1982). 
In dogs, hepatic receptors fall with ageing (mahley et al. 1981).

All of the changes in receptor activity alter the rate of uptake of LDL by 
the liver and cause reciprocal changes in plasma LDL levels. Whenever hepatic LDL,
receptors are suppressed, the plasma LDL level rises, conversely whenever these
receptors are induced, the plasma LDL level falls.

FAMILIAL HYPERCHOLESTEROLEMIA AND LDL RECEPTOR

Familial hypercholesterolemia is best defined clinically, genetically and
biochemically a disorder characterized by (a) selective elevation in the plasma level
of LDL (b) deposition of LDL derived cholesterol in abnormal sites in the body (c)
Inheritance as an autosomal dominant trait with a gene dosage effect. It occurs at a
frequency of about 1 in 500 person.

The basic defect is reduced number of LDL receptors. In normal person
about 45 percent of the plasma LDL pool is removed from the plasma daily by the
receptors, where in familial hypercholesterolemia heterozygotes this value is 25-30
percent and in homozygotes it is about 15 percent. This receptor deficiency results in
accumulation of LDL into the plasma, leading to raised level and premature
atherosclerosis.

TRIGLYCERIDES AND VERY LOW DENSITY LIPOPROTEINS (VLDL)

The level of serum triglycerides (STG) rises considerably after fat ingestion.
Rise in the triglycerides level after fat ingestion has been reported after giving different
amounts of the fat load and measuring the blood levels at different time interval

Angerval (1963) has reported a significant correlation between fasting,
3½ hours value and 7½ hours value of serum triglyceride postprandially.

Clafsky et al (1976) noted a biphasic plasma triglyceride curve with an
initial peak occurring 1 to 3 hours after feeding and secondary peak after 4 to 7
hours. The primary peak was accounted by increase in chylomicron levels in more
than 98% cases, whereas secondary peak represented rise in very low density
lipoprotein (VLDL) level in 82%.

In 1957, Havel concluded that increment in the concentration of
triglycerides in the serum following ingestion of fat is entirely the result of an increase
in their concentration in VLDL.

Excess production of VLDL and triglyceride is more often due to secondary abnormalities than to primary factors, perhaps the most common cause is high caloric intake associated with obesity, excess alcohol and excess carbohydrate. Increased levels are also found in diabetes mellitus, nephrotic syndrome and hypothyroidism with obesity. Delayed clearance of triglyceride from the serum is noted in cases of ischemic heart disease after high fat diet (Arora et al. 1987, Brown et al. 1961).

**VLDL - REMANANTS**

Also known as beta VLDL, these particles are smaller than normal VLDL and contain more cholesterol. Both of these characteristics impart atherogenic potential to VLDL remnants.

**BETA VLDL AND CHOLESTEROL FED MAN**

In addition to a report by Mistry et al (1976) beta VLDL can be induced by cholesterol feeding in man, preliminary studies from the Gladstone foundation laboratories for cardiovascular disease indicate that certain individual respond to high fat, high cholesterol diet by producing lipoproteins which are capable of delivering cholesterol to macrophages. The beta VLDL may occur transiently as minor components of the human plasma fractions after diets high in fat and cholesterol are consumed, and may cause repeated cholesterol deposition in cells in the arterial wall over the years. The beta VLDL, either chylomicron remnants or hepatic lipoprotein may represent the atherogenic particle postulated several years ago by Zilversmit. This alteration in the lipoprotien fraction may represent the most significant diet induced changes in lipoprotien predisposing to accelerated atherosclerosis.

**SERUM TRIGLYCERIDE AND EXERCISE**

Reduced level of triglycerides are found after exercise (Cohen and Goldberg, 1960). On the other hand, Billimoria et al (1959) found that the alimentary lipemia occurred early in exercising than in resting subjects. The explanation put
forward for decreased levels of triglycerides for energy production.

**CHYLOMICRONS**

Chylomicrons are large lipoprotein particles containing dietary triglyceride and cholesterol. They are vehicle of lipid transport in exogenous pathway. There chylomicrons are secreted into the intestinal lymph and pass into the general circulation for transport to the capillaries of adipose tissue and skeletal muscle where they are acted upon by lipoprotein lipase liberating free fatty acids and monoglyceride. The remaining particle deprived of triglyceride is termed as chylomicron remnant which is rich in cholesterly ester. This remnant travels to the liver, where it is taken up by chylomicron remnant receptor and metabolised.

Different fats give rise to specific type of chylomicrons. Triolein gives large distinctive spherical chylomicrons while those seen after tristearin are creamy and very in shape and are comparatively small.

Chylomicrons are rapidly cleared from the plasma and normally are not present after an overnight fast. The detection of these particles in fasting plasma is always abnormal and may indicate presence of other hyperlipidemias.

The simplest method to detect chylomicron in post prandial state is "Creaming in the Cold". Increased level of chylomicron in the plasma may be found in cases of genetic defect involving the enzyme, Lipoprotein lipase and in familial form of hypertriglyceridemia.

**ATHEROSCLEROSIS: A POST PRANDIAL PHENOMENON**

The possibility of atherosclerosis being a post prandial phenomenon was first proposed by Zilversmit (1973). He hypothesised that chylomicron remnant or beta VLDL may occur transiently as minor components of the human plasma fractions after diet high in fat and cholesterol is consumed and this may cause repeated cholesterol deposition in cells in the arterial wall over the years, while the fasting cholesterol level may remain normal during the life time.

If atherogenesis is a post prandial phenomenon then premature CAD must be common in hyperchylomicronemic states. However, in familial lipoprotein lipase
deficiency enormous quantities of chylomicrons accumulate in plasma, but accelerated atherosclerosis has not been reported (Fredrikson et al. 1970).

**ATHEROSCLEROSIS AND LIPID, LIPOPROTEIN LEVELS**

Serum Cholesterol - Observational research indicated a linear relationship with a 2% increase in risk for CHD for a 1% increase in S. Cholesterol. This dose response effect occurs at any level of cholesterol and is apparent in both men and women and African-American and white. A 10% increase in S. Cholesterol was found to increase mortality from Ischemic H.D. by 54% at age 40, 39% at age 50, 27% at age 60, 20% at age 70, and 19% at age 80. High density Lipoprotein HDL Cholesterol has emerged as an important independent predictor of CHD for every 1 mg% decrease in HDL cholesterol, there is a 3% to 4% increase in CAD. An emerging body of evidence now indicates that the ratio of total or LDL cholesterol to HDL cholesterol may be an important predictor of the risk of VHD. One Unit decrease in this ratio decreases that risk of myocardial Infarction by 53% Accumulating evidence indicates that triglyceride rich lipoproteins [Chylomicron remnant VLDL, IDL] may also play a role in atherogenesis.

Elevated triglycerides are clearly associated with CHD, particularly in the setting of low HDL cholesterol levels and among women, but whether or not they represent an independent factor after control for other lipids remains unclear. Primary and secondary prevention trials in which cholesterol reduction was the only intervention shows that a 10% reduction is serum cholesterol results in highly significant reductions of 9% to 10% for CHD death rate and 18% for CHD events, the effects was greater with increasing duration of treatment. A 10% reduction in cholesterol was associated with a 7% reduction in CHD events among those treated for less than 2 years, 22% among those treated from 2.1 to 5 years, and 25% among those treated for more than 5 years.

Thus, the totality of evidence clearly indicates that higher cholesterol levels, increase and cholesterol lowering decreases risk of CHD.
Saturated fat and cholesterol intake increases cholesterol levels, when monounsaturated and polyunsaturated fats replace carbohydrate in the diet, they do not appear to have a major impact on serum cholesterol however, when they replace saturated fats they appear to lower cholesterol. Dietary changes often affect several aspects of the lipid profile, a single cholesterol measure is not the best way to characterize the atherogenic potential of the lipid profile. Saturated fats appear to raise both HDL and LDL cholesterol, whereas mono unsaturated fat increases HDL while lowering LDL cholesterol. The effect of poly unsaturated fats on LDL and HDL cholesterol remains unclear, the n-6 poly unsaturated fatty acid such as linoleic acid, tends to lower LDL cholesterol and may lower HDL at higher intake level, the n-3 polyunsaturated fats [Fish oils] do not seem to have a dramatic effect on serum cholesterol. Dietary fat may affect clotting factors, prostacycline levels, and other parameters. But one must remember that a very low fat diet has been associated with low rates of CAD in asian populations but has been associated with increased risk of hemorrhagic stroke.

Subclasses of HDL, can be fractioned by zonal ultracentrifugation and include HDL, and HDL. Among these subgroups HDL appears to have the strongest inverse relationship with CAD and accounts for different levels of HDLc between men and women (Gofman et al. 1954). The possible mechanism by which HDL cholesterol decreases atherosclerosis includes :

1. Reversal of cholesterol transport from the peripheral cells to the liver for removal from the body (Miller, 1975).
2. Inhibition of LDL cholesterol uptake by cells at the LDL receptor sites.

Trans fatty acids - Trans fatty acids are the results of hydrogenation of vegetable oils, processed by heating in the presence of a metal catalyst to turn liquid vegetable oils into solids at room temperature and enhancing shelf life. Foods high in these trans fatty acids include margarine, vegetable shortening and processed foods such as cookies, crackers and candies. Transfatty acids appear to increase LDL and decrease HDL.
Fish Oils - The idea that fish oil n-3 polyunsaturated fatty acid, reduce the risk of CHD was based on the low rates of heart disease among the Japanese and greenland Eskimos. Fish oils appear to have an effect on lowering triglyceride and the triglyceride - rich VLDL however, their effect on total, LDL and HDL cholesterol is less clear. Based on current data whether increased intake of marine oils from fish or as supplements will reduce the risk of CHD is unclear.

DIETARY THERAPY

In the NCEP guidelines, the primary therapy for dyslipidemia is dietary. Reduction of saturated fat and cholesterol consumption is part of trait of life stlye modifications that should include weight loss if necessary and increased physical activity as approprite.

**DIETARY THERAPY LEVELS IN ADULTS**

<table>
<thead>
<tr>
<th>Risk</th>
<th>LDL Cholesterol level mg/dl</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without CHD, fewer than two other risk factors</td>
<td>&gt; 160</td>
<td>&lt; 160</td>
</tr>
<tr>
<td>Without CHD, two more other risk factor</td>
<td>&gt; 130</td>
<td>&lt; 130</td>
</tr>
<tr>
<td>With CHD or other atherosclerotic disease</td>
<td>&gt; 100</td>
<td>&lt; 100</td>
</tr>
</tbody>
</table>

**DIETARY THERAPY OF HIGH BLOOD CHOLESTEROL**

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Step I Diet</th>
<th>Step II Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Total Fat</td>
<td>&lt; 30% of total calories</td>
<td>&lt; 30% of total calories</td>
</tr>
<tr>
<td>* Saturated fat</td>
<td>8-10 % of total calories</td>
<td>&lt; 7% of total calories</td>
</tr>
<tr>
<td>* Polyunsaturated fat</td>
<td>&lt; 15 % of total calories</td>
<td>&lt; 10% of total calories</td>
</tr>
<tr>
<td>* Mono unsaturated fat</td>
<td>&lt; 55% of total calories</td>
<td>&lt; 15% of total calories</td>
</tr>
<tr>
<td>* Cholesterol</td>
<td>&lt; 300 mg/day</td>
<td>&lt; 200 mg/day</td>
</tr>
<tr>
<td>* Protein</td>
<td>15 % of total calories</td>
<td>15 % of total calories</td>
</tr>
</tbody>
</table>

* Total calories should be sufficient to maintain ideal weight.

**Stept I diet** - In primary prevention in patients following a typical western diet, the initial diet is step I diet which is recommended for the general population aged at least 2 years.

**Stept II diet** - In patients whose LDL cholesterol remains elevated despite adherence to the step I Diet for 3 months the step II diet should be initiated.

In patients previously consuming a typical western diet institution of the step I diet generally decreases total cholesterol 5 to 7 percent and instituition of step
II diet decreases total cholesterol an additional 5 to 13 percent.

**FAT TOLERANCE TEST AND ITS IMPLICATIONS**

The concept of fat/cholesterol tolerance test is not entirely new. In 1907 Neuman, after giving a fat load studied the quantitative lipid changes in form of chylomicron count after a fat load.

Introduction of isotopes, revolutionised the study of lipid metabolism. Berekovits (1963) pointed out that radioactive fat tolerance is a better index for determining the functional state of lipid metabolism.

Zilversmit et al (1979) brought forward the view that atherosclerosis may be a post prandial phenomenon with chylomicron and VLDL remnants of post prandial phase contributing to the development of atherosclerosis. This concept again aroused interest in determination of post prandial changes in lipid fraction often a meal rich in fat and cholesterol.

Subsequent work by Hanno Krauss et al (1987) did not reveal any significant changes in serum total cholesterol after a heavy fat cholesterol load but found significant difference in triglyceride levels.

Arora et al (1987) put forward the concept of triglyceride tolerance test which showed significant difference in peak levels of STG in normal healthy, patient of IHD and that of diabetes.

Diet prior to the loading test meal, may be decisive under metabolic ward conditions, significant difference in fat tolerance has been reported in healthy subjects on an isocaloric diet, when the dialy fat intake per kg of body weight was varied from 0.1 to 2 gm (Havel, 1957). The lowest intake gives the highest fat tolerance. In contrast to the above, no change in the fat tolerance has been noted when the fat content of the diet was raised from 40 to 54% for three weeks (Horlick, 1957).

In an interpopulation study, no difference has been reported in the fat tolerance of three different communities who consume 17.45 and 60% respectively of their total calories as fat (Bouchier and Bronte Steward, 1961).

Composition of the test meal also plays an important role. In human beings, glucose one hour and half an hour before as well as one and a half hour after a fat
meal reduced or even eliminated the serum triglyceride rise (Albrink and Man, 1956). Glucose addition to 131 I-labelled triolein caused a flatter triglyceride curve as compared to ingestion of the latter only (Berkowits et al. 1959). The depression of free fatty acid' (FFA) and serum triglyceride levels following increased glucose utilisation is thought to result from a decrease in the mobilisation of fatty acids from the fat depot of the body (Gordon, 1957). There is also evidence that an increase in hepatic fat synthesis may be important in the reduction of the serum FFA levels (Shoemaker et al. 1960).

Long term studies of the effect of dietary protein on lipid level indicate that low protein intake is accompanied by a depression of serum lipids (Olson et al. 1957).

In 1962, Jams F sullivan demonstrated that increasing the relative content of protein in a meal results in higher levels of serum triglycerides in the post prandial period.

In 1957, Havel demonstrated fall in cholesterol level 4 hours after taking high fat diet in two male subjects.

**FACTORS MODIFYING FAT TOLERANCE**

(a) Age

Fat tolerance and age have shown different responses. Chylomicron count has been shown to rise more after a fat load in subjects more than 50 years as compared to the younger group (Becker et al., 1949; 50) similar results were found in turbidity measurements (Marder et al. 1952; Schwartz et al. 1952). Using the same chylomicron counting principles, exactly opposite finding have been observed, and significantly lower chylomicron count in response to fat loading in older subjects, over 50 years as compared to younger subjects has been seen (Grunner and Hilden, 1953).

In a more illustrative work by Herzstein et al (1953), it was observed that the total fats persisted longer in serum after fat loading subjects.

(b) Body weight

No significant correlation between body weight and the duration of lipemia
in response to fat meal has been seen (Barritt, 1956). The fat tolerance rose appreciably after weight reduction was enforced.

(c) Exercise

It has been observed that at rest the lipid level of normal subjects increased by 42% after 3 hours of fat meal and the maximum was attained after 4 hours, while at work these figures were 34% at 3 hours (Nissen, 1931). Higher chylomicron counts after fat loading in person at rest than in persons at work have been seen (Marder et al., 1952).

**REPRODUCIBILITY OF FAT TOLERANCE**

By large, fat tolerance curve is reproducible over a period of six months with very little variation (Norten, 1950; Osmon et al., 1957). However, Bronte Stewart and Blankburn (1958) found considerable variability in response to the same fat load. Although those who exhibited a "high curve" continued to do so and vice versa.

**LIPOPROTEINS : PATHOGENIC ROLE**

Low density lipoproteins (LDL) and intermediate density lipoproteins (IDL) enter the arterial intima from plasma in man at rates directly related to their plasma concentration (Neithaus et al, 1977; Nicoll et al., 1981) and accumulate particularly in region already atheromatous. Endothelial injury greatly enhances this process. The cholesterol of atheromatus lesions is principally derived from plasma (Zilversmit, 1968). The interactions of LDL with cells of atheromatous plaques have been studied in some detail. Smooth muscle cells and fibroblast have receptors that mediate uptake of LDL (Goldstein and Brown, 1974 and Bierman & Albers, 1975) its cholesterol is released by lysosomal degradation. Macrophages lack those receptors but acquire lipoprotein cholesterol by other processes, including receptor mediated uptake of altered LDL. In contact with cultured endothelial cell, LDL is modified, permitting macrophages to degrade it (Henriksen et al, 1981). Normally equilibrium is maintained in influx and efflux of cholesterol from the cell. Transport of cholesterol from peripheral cells to the liver may be mediated by HDL, soon after Miller and Miller (1975) advanced the concept that this function of HDL my favouring mobilisation of
cholesterol from arterial wall, might explain the inverse relationship between HDL and risk of coronary heart disease.

**THE LIPOPROTEINS: PREDICTORS OF CHD**

The association of lipoprotein with coronary heart disease has been studied in depth in epidemiological studies. These associations are strong, predictive and independent of other risk factors.

Concentration of LDL cholesterol are directly related to and are predictive of the risk of coronary heart disease over a wide age range (Gordon et al., 1981). Mortality rates from coronary heart disease in different communities are directly and linearly related with serum concentrations of cholesterol and LDL cholesterol (Lewis et al., 1978). HDL cholesterol concentrations are even more strongly predictive of the risk of coronary heart disease in most (Gordon et al., 1981; Goldbourn and Modalie, 1979) but not in all studies (Wilkund et al., 1980). The relation being inverse, but unlike LDL, HDL cholesterol concentration do not correlate inversely with mortality rates from coronary heart disease in different countries.

Hyperlipidemia usually runs in family. screening for hypercholesterolemia at age of 12 years is fairly predictive of adult hypercholesterolemia close to 50% of the top quintile (88%) for cholesterol. were similarly placed at follow up, nine years later, of interest was the observation that those who dropped out of the top quintile at follow up had a lower incidence of obesity, smoked less and were more active (Orchard et al., 1983).

In childhood HDL contributes proportionately more to the total cholesterol concentration, in a survey of 6775 school children a substantial proportion of those with hypercholesterolemia were attributable to high HDL cholesterol levels (Morrison et al., 1979). The ratio of total cholesterol to HDL cholesterol is about as efficient as any other lipid profile (Kannel et al., 1979). A ratio of 5 indicates the average high risk in affluent western populations, and ratio exceeding this are definite cause of concern within the range of serum cholesterol value that are common encountered. A more optimal ratio is in the vicinity of 3.5 corresponding to half the standard risk and resembling that found in low CHD incidence countreis (Gordon et al., 1982).