INTRODUCTION
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Ischaemic heart disease consists of major cause of mortality in present stress age and is a global problem involving both developing as well as developed countries (W.H.O., 1982; Hiroyasu et al, 1989; Gordon, 1977). Main risk factors of ischaemic heart disease are atherosclerosis and hyperlipidemia leading to deposition of lipids on the intima of arteries causing narrowing of vessels. Due to narrowing of vessels, specially coronary arteries, blood supply to heart becomes deficient resulting into myocardial ischaemia (Edwin, 1990; Lewis, 1988).

Relation of serum level of total cholesterol to coronary heart disease (or atherosclerotic heart disease) is well established (WHO, 1982; Atherosclerosis study group, 1984; Stamler, 1986; Conference on health effects of blood lipids, 1979).

An increased risk of coronary heart disease (CHD) is associated with a high serum total cholesterol concentration (Gordon, 1977; Heaton, 1984; Goldbourt, 1985; Grundy, 1986; 1987; Thomas, 1990) and low density lipoprotein (LDL) cholesterol (Kannel et al, 1971; Keys et al, 1972; Brown et al, 1986; Steinberg et al, 1989), a low high density lipoprotein (HDL) (Kannel et al, 1979; Goldbourt, 1985; Castelli, 1986a) and in some circumstances high triglycerides (Castelli, 1986b).
Increased lipids: triglycerides, total cholesterol, LDL and very low density lipoprotein (VLDL) cholesterol and decreased HDL cholesterol are the major factors in causing atherosclerosis and ischaemic heart disease (IHD) (Bhatia, 1980).

The analysis of results of serum cholesterol levels and six year mortality from stroke in 350,977 men screened for the multiple risk factors intervention trial (MRFIT) showed that the rate of mortality due to coronary heart disease was 124.4 and 160.3 per 10,000 among the men aged 35–57 years with S. cholesterol levels more than 200 and 300 mg/dl respectively. This rate was highest in the study. It was also observed that within every cholesterol category age adjusted death rates from coronary heart disease were higher than for all strokes. Death rate from CHD and that from all cardiovascular diseases were positively associated with serum cholesterol levels (Kiyosus et al., 1989).

Of particular clinical significance is the evidence that certain plasma lipoprotein abnormalities are causally related to atherosclerosis and atherosclerotic heart disease and others are predictive of a high risk of this disorder (Lewis, 1988). Elevation of serum cholesterol level or more specifically a low density lipoprotein (LDL) cholesterol level is widely accepted as a major risk factor for development of ischaemic heart disease (Key, 1972; Kannel et al., 1971).
Recent clinical and experimental studies of various kinds have firmly established that elevated plasma concentrations of LDL are associated with accelerated atherogenesis (Tyroler, 1987; Goldstein et al., 1977; Steinberg; 1983; 1989).

There is now good evidence from clinical trials and other observations that reduction of serum cholesterol in men with high concentrations can reduce the incidence of coronary heart disease (Consensus conference, 1985; Committee on medical aspects, 1984; Lipid Research Clinic, 1984a, 1984b). Clinical trials in selected patients seem to indicate that effective modification of risk factors (e.g. plasma lipid level) can slow the growth of coronary atherosclerosis (Edwin, 1990). Clinical intervention studies have demonstrated the therapeutic value of correcting hypercholesterolemia (Tyroler, 1987; Lowering blood cholesterol, 1985).

Medical scientists are of the opinion that antilipidemic, antidiabetic and antihypertensive drugs and other measures that can decrease catecholamine levels are considered to be remedy for myocardial infarction (Raab, 1971). It is now a well established fact that reduction in blood cholesterol levels reduces the risk of myocardial ischaemia. 25% reduction of blood cholesterol levels reduces the risk of myocardial ischaemia by 50% (Lowering blood cholesterol 1985; Tyroler, 1987).
Vigorous global research is going on to search the agents to control hyperlipidemia. Indian scientists have directed their research towards herbs having hypolipidemic and cardioprotective potential based on few references in age old Ayurvedic texts.

The present formulation is based upon the thorough research data accumulated so far (Satyavati et al., 1966; 1969a; 1969b; 1987; Sastry, 1967; Saxena, 1980; Tripathi et al., 1968; 1975; 1976; 1979; 1984; Dwivedi et al., 1987; 1988; 1989). Hence it was felt desirable to conduct clinical trials on this new combination of age old hypolipidemic/cardioprotective herbal drugs, Terminalia arjuna W & A bark, Inula racemosa hook root and Commiphora mukul ex stocks resin with the primary aim of analyzing the effect of the drug on different components of serum lipids i.e. on total serum cholesterol, triglycerides, VLDL, LDL and HDL in hypertension, diabetes mellitus and coronary artery disease.