



RESEARCH ARTICLE

EVALUATION OF METABOLIC SYNDROME IN HEALTHY YEMENI POPULATIONS

Gamil Alrubaiee¹ , Ali Alyahawi^{2*}

¹Department of Applied Medical Sciences, Al-Razi University, Yemen.

²Department of Pharmacy, Al-Razi University, Yemen.

Article Info:



Article History:

Received: 10 October 2019
 Reviewed: 6 November 2019
 Accepted: 30 December 2019
 Published: 15 January 2020

Cite this article:

Alrubaiee G, Alyahawi A. Evaluation of metabolic syndrome in healthy Yemeni populations. Universal Journal of Pharmaceutical Research 2019; 4(6):49-53.
<https://doi.org/10.22270/ujpr.v4i6.336>

*Address for Correspondence:

Dr. Ali Alyahawi, Department of Pharmacy, Al-Razi University, Yemen. Tel: 00967-775957401.
 E-mail: alyahawipharm@yahoo.com

Abstract

Objective: The metabolic syndrome is characterized by several cardiovascular risk factors and is associated with an increased incidence of diabetes, cardiovascular events and mortality. The prevalence of metabolic syndrome is increasing in epidemic proportions worldwide. The present study aimed to investigate the prevalence of metabolic syndrome and its components in healthy populations in Sana'a, Yemen.

Methods: This study was a cross-sectional study conducted from February 2019 to April 2019. A total of 120 healthy populations (40 years ≤ old) were selected. The study protocol was approved by the institutional ethical committee and informed consent was obtained from all the enrolled study patients for their inclusion in the screening and participation in the research.

Results: In the current study, the presence of more than or equal to any three of the above mentioned factors is required for the diagnosis of metabolic syndrome. The total prevalence of metabolic syndrome among the study subjects was 40.0% ($p < 0.001$) and 62.5% of them were within 40-49 years old. In the present study, there was not statically significant difference between the khat chewing and the metabolic syndrome.

Conclusion: The prevalence of metabolic syndrome among healthy Yemeni populations was very high and it is associated with increased morbidity and mortality. This emphasizes the need for more attention to investigate this condition to decreasing the prevalence of cardiovascular morbidity and mortality in these subjects.

Keywords: Criteria, metabolic syndrome, prevalence, Yemen.

INTRODUCTION

Metabolic syndrome was first identified during the late 1980 and was characterized by the clustering of abdominal obesity, elevated blood pressure, hyperglycemia, and dyslipidemia¹. Subjects with metabolic syndrome are at increased risk for coronary artery disease (CAD), and the present of metabolic syndrome can increase the risk of all new-onset cardiovascular disease (CVD) by 25 %². In addition, metabolic syndrome is associated with an increased risk of death from coronary heart diseases, cardiovascular diseases, and all other causes³. Metabolic syndrome increases the risk of type 2 diabetes mellitus and cardiovascular disease (CVD) by a 5-fold and 2-fold, respectively during the next 5 to 10 years⁴. Recently, the prevalence of metabolic syndrome has been reported to be between 10% and 84% globally according to the age, sex, and races of the population⁵. About twenty-five percent of adults in the U.S. have

the metabolic syndrome⁶. The prevalence of metabolic syndrome in the Middle East and North African (MENA) region is known for its high, where it has been reported to be 45.5% and 24.3% in Tunisia, using the International Diabetes Federation (IDF) criteria and Adult Treatment Panel (ATP III) definition, respectively⁷. The prevalence of metabolic syndrome in Gulf countries, as part of the Middle East, has shown ranges from 17% in Oman⁸ to 40.5% in the United Arab Emirates (UAE)⁹, according to the ATP III and IDF criteria, respectively. According to Al-Rubeaan *et al.*, the prevalence of metabolic syndrome in Saudi Arabia was 39.8% and 31.6% in 2018, depending on the ATP III and IDF criteria¹⁰. The metabolic syndrome is recognized as a significant public-health problem. Due to changes in the social environment, the numbers of people with metabolic syndrome have been increased during the past years. Therefore, the main aim of the current study was to estimate the prevalence of metabolic syndrome and its risk factors among the

adult Yemeni population in comparison to other countries.

METHODS

This study was a cross-sectional study conducted from February 2019 to May 2019. A total of 120 of healthy populations (40 years ≤ old) were selected. Full ethical clearance was obtained from the qualified authorities who approved the study design and the informed consent was obtained from all the study subjects for their inclusion in the screening and participation in the research.

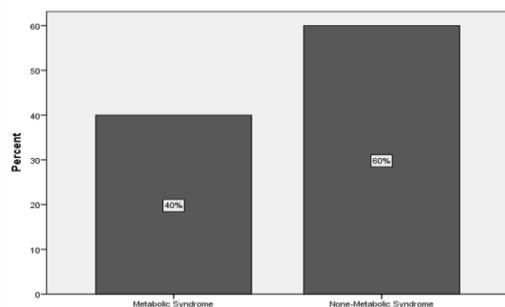


Figure 1: Prevalence of metabolic syndrome among the study sample among gender and waist circumference.

To institute the metabolic syndrome into clinical practice, several scientific organizations have attempted to introduce definition of the syndrome. In the present study, the diagnosis of metabolic syndrome based on the American Heart Association/National Heart, Lung, and Blood Institute (AHA/NHLBI) and to a joint statement from several large organizations¹¹.

Table 1: Prevalence of metabolic syndrome among the study populations.

Variable	Level of variable	N	%	p-value
Metabolic Syndrome	Yes	48	40.0	0.001
	No	72	60.0	
	Total	120	100.0	

The patients must meet at least three of the following criteria for diagnosis of metabolic syndrome:

- Increased waist circumference (40 inches [102 cm] or greater in men and 35 inches [89 cm] or greater in women).
- Triglycerides of 150 mg/dl (1.70 mmol/l) or greater.
- Low high-density lipoprotein (HDL) cholesterol (less than 40 mg/dl [1.03 mmol/l] in men and less than 50 mg/dl [1.29 mmol/l] in women).
- Systolic blood pressure (BP) of 130 mm Hg or greater, diastolic BP of 85 mm Hg or greater.
- Fasting blood glucose of 100 mg/dl (5.6 mmol/l) or greater.

In the current study, the presence of more than or equal to any three of the above mentioned factors is required for the diagnosis of metabolic syndrome. Populations with established chronic diseases were excluded to homogenize the study subjects.

Table 2: The prevalence of metabolic syndrome among gender.

Variable		Metabolic Syndrome		Total	p-value
		Yes	No		
Gender	Male	21 (30.4%)	48	69	0.013
	Female	27 (52.9%)	24	51	
	Total	48	72	120	
Waist circumference (WC)	No	22	60	82	0.001
	Yes	26	12	38	
	Total	48	72	168	

All the study subjects were personally interviewed by the trained interviewers. The following variables were evaluated: age, sex, waist circumference, HDL cholesterol, triglycerides, fasting glucose, and blood pressure. Statistical analysis was done by SPSS software version 21.0 by using Pearson's Chi-square test. Categorical variables were expressed as percentages. *p*-value of less than 0.05 was considered significant.

Table 3: The prevalence of different variables among subjects with metabolic syndrome.

Variable		Metabolic Syndrome		Total	p-value
		No	Yes		
Triglyceride	No	52	17	69	0.001
	Yes	20	31	51	
	Total	72	48	120	
HDL-Cholesterol	Yes	37	32	69	0.001
	No	11	40	51	
	Total	48	72	120	
Blood Pressure (BP)	No	58	23	81	0.001
	Yes	14	25	39	
	Total	72	48	120	
Fasting Blood Glucose (FBG)	No	39	7	46	0.001
	Yes	33	41	74	
	Total	72	48	120	

RESULTS

The overall prevalence of metabolic syndrome was 40% (*p*-value < 0.001), and was significantly higher in women than in men (52.9% vs 30.4%, respectively; *p*-value = 0.01). Out of 69 males, 21 (30.4%) had Metabolic Syndrome and 27 (52.9%) of females had metabolic syndrome (Table 2). There was significantly relationship between the prevalence of waist circumference and metabolic syndrome (*p*-value < 0.001). Twenty six of patients with increased waist circumference had metabolic syndrome, in comparison, 22 of patients with metabolic syndrome did not have increased waist circumference. Table 3 showed the distribution of metabolic syndrome by Triglyceride. Results in this table indicated that the relationship between metabolic syndrome and prevalence of triglyceride was high significant (*p*-value < 0.001). The relationship between metabolic syndrome and HDL cholesterol level was statistically significant (*p*-value < 0.001). According to the study findings, 37 (77.1%) of subjects with metabolic syndrome had low HDL (<40 mg/dl in male or <50 in

female). However, 11 of subjects with metabolic syndrome had normal HDL cholesterol level.

Table 4: The distribution of age group, smoking, and khat chewing among patients with metabolic syndrome.

Variable		Metabolic Syndrome		Total	p-value
		Yes	No		
Age group	40-49	30	47	77	0.113
	50-59	10	21	31	
	60 or greater	8	4	12	
Smoking	Yes	18	22	40	0.429
	No	30	50	80	
Khat chewing	Yes	34	14	48	0.124
	No	41	31	72	

The association between metabolic syndrome and blood pressure was analyzed in the Table 7. Results in this table showed high significantly relationship (p -value<0.001). Based on the study results, 25 (52.1%) of subjects with metabolic syndrome had high blood pressure. In the current study, the relationship between metabolic syndrome and fasting blood glucose (FBG) was statistically significant (p -value< 0.001). In addition, 41 (85.4%) of subjects with metabolic syndrome had high FBG. Similarly, there was not any relationship between metabolic syndrome and Khat chewing or smoking (p -value=0.124; 0.420, respectively).

Table 5: Distribution of metabolic syndrome criteria among subjects with metabolic syndrome.

Variable		Metabolic Syndrome		%
		Yes	No	
Waist Circumference	No	22	60	54.2
	Yes	26	12	
Triglyceride	No	17	52	67.6
	Yes	31	20	
HDL-C	Yes	37	32	77.1
	No	11	40	
Blood Pressure	No	23	58	52.1
	Yes	25	14	
Fasting Blood Glucose	No	7	39	85

The study results reported a high prevalence of metabolic syndrome criteria among subjects with metabolic syndrome. The most frequently observed component of metabolic syndrome was found to be Fasting Blood Glucose (FBG), followed by HDL-C (Table 5). According to the study findings, HDL-C had significant relationship between men and women (p -value<0.001). There were not statistically significant between the khat chewing and metabolic criteria. In addition, there were not statistically significant between the metabolic syndrome and khat chewing.

DISCUSSION

Metabolic syndrome is a serious health problem and its prevalence increasing globally. To our knowledge, this

is the first Yemeni study that focuses on the estimation of the prevalence of metabolic syndrome in the general population by using the American Heart Association/National Heart, Lung, and Blood Institute (AHA/NHLBI) and to a joint statement from several large organizations. According to the study results, the prevalence of metabolic syndrome was seen in 40 % of the study subjects. This result is consistent with results from other studies, where the prevalence of metabolic syndrome was 38.5% among Americans¹² and of 33.5% in the population of India¹³. However; it is high compared to prevalence in the South African population (25.5%)¹⁴ and lower than that of the population of Nepal (61.7%)¹⁵. These differences in the prevalence can be explained by the interaction of genetic and environmental factors, which have long been known to play a key role in the pathophysiology of metabolic syndrome¹⁶. Furthermore, the study of the metabolic syndrome prevalence according to sex showed a significantly higher prevalence in females (52.9%) compared to males (30.4%). This result is similar to many studies^{17,18}. However, it was in consistent with others where the prevalence is similar between both sexes¹⁹. Factors such as weight gain after pregnancy, diabetes mellitus during pregnancy, polycystic ovary syndrome, preeclampsia, use of hormonal contraceptives, and menopause may increase the risk of metabolic syndrome in women²⁰. In addition, we observed a variation in the prevalence of metabolic syndrome according to age with a maximum at the fourth decade among the study sample (62.5%). This may be related to the most study subjects within this age group (64.2%). A decline was observed in the prevalence of metabolic syndrome in patients aged over 60 years. This may be related to the increase of the mortality in people with metabolic syndrome of ≥ 60 years old. Moreover, the association between premature mortality and the presence of metabolic syndrome has been described in many studies^{17,21}. Also the lack of consensus on metabolic syndromes definitions and the cutoff points used for its components, especially regarding waist circumference, has resulted in these differences. The comparisons between Yemen and other countries must be made with caution. Because in Yemen and most of other studies were conducted in a small area or a city, they cannot be representative of the whole country. Therefore, generalizing the study results to all population is a point of concern²². Also the differences between people might to genetic variations that could effect on metabolic syndrome criteria²³. In terms of individual criteria, the major factors contributing to metabolic syndrome were fasting blood glucose (85%), followed by HDL-C and triglyceride (77.1% and 67.6%; respectively). These findings could be associated with the high prevalence of insulin resistance and the propensity for elevated triglyceride levels in patients with metabolic syndrome. Furthermore, about 34.2% of participants in the sample survey were unaware of pre-existing diabetes. After evaluation, 85% in this group were eventually diagnosed with metabolic syndrome. In a study conducted by Delavari *et al.*,²⁴ greater waist circumference values and lower HDL

cholesterol have also been reported in Iranian communities than in Western populations. This might be due to other classical cardiovascular risk factors, such as smoking, dietary salt intake, physical inactivity, and other habits along with Khat may modify the extent of association between Khat chewing and metabolic criteria.

In contrast to previous studies, Khat chewing had a significant effect on carbohydrate metabolism by a reduced insulin secretion, insulin resistance^{25,26} and cathinone-induced catecholamines secretion; which would raise blood glucose levels²⁷.

Table 6: Distribution of metabolic syndrome criteria according to gender.

Variable		Gender		Total	p-value
		Male	Female		
TG	<150 mg/dl	41	28	69	0.621
	150 mg/dL or greater	28	23	51	
HDL-C	<40 mg/dl in men or <50 in women	30	39	69	0.001
	40 mg/dL or greater in men or = 50 or greater in women	39	12	51	
Waist circumference	<89 cm in women or <102 cm in men	51	31	82	0.13
	89 cm in women or greater or 102 cm or greater in men	18 (26.1%)	20 (39.2%)	38	
Fasting Blood Glucose	<100 mg/dL	28	18	46	0.56
	100 mg/dL or greater	41	33	74	
Blood pressure	<130/85 mm	43	38	81	0.16
	130/85 mm Hg or greater	26	13	39	

Table 7: Distribution of metabolic syndrome criteria among subjects with khat chewing.

Variable		Khat chewing		p-value
		Yes	No	
Waist Circumference	No	51	31	0.92
	Yes	24	14	
Triglyceride	No	39	30	0.12
	Yes	36	15	
HDL-C	Yes	41	28	0.42
	No	34	17	
Blood Pressure	No	46	35	0.062
	Yes	29	39	
Fasting Blood Glucose	Yes	48	26	0.50
	No	27	19	

A study conducted to investigate the effect of khat chewing on the blood glucose level of normal chewers in comparison to the effects of two antidiabetic drugs in diabetic patients showed that the percentage of sugar decrease in khat chewers²⁸. Recently, a study done by Murray *et al.*, reported that khat chewing significantly decreased the sensation of hunger and increase the feelings of fullness²⁹. This hormone may attribute to the decreased of appetite and body weight that observed in khat chewers³⁰.

CONCLUSIONS

In conclusion, this study places Yemen as one of the countries with the highest prevalence of metabolic syndrome. The risk factors for metabolic syndrome in Yemeni populations were similar to those reported internationally. In addition, women were at a greater risk of having metabolic syndrome. The major causes of metabolic syndrome are unhealthy life styles and eating habits. This emphasizes the need for more attention to evaluate this condition to decreasing the prevalence of cardiovascular morbidity and mortality in these subjects. Furthermore, in order to prevent metabolic syndrome, policy makers should consider the promotion of a healthy diet and physical activity in the future strategies of health care of Yemeni population.

ACKNOWLEDGEMENTS

The authors extend their thanks and appreciation to the Al-Razi University, Yemen to provide necessary facilities for this work.

AUTHOR'S CONTRIBUTION

Alrubaiie G: writing original draft, methodology, investigation. **Alyahawi A:** formal analysis, data curation, conceptualization.

DATA AVAILABILITY

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

CONFLICT OF INTEREST

No conflict of interest associated with this work.

REFERENCES

1. Reaven GM. Role of insulin resistance in human disease. *Diabetes*. 1988; 37: 1595–607.
<https://doi.org/10.2337/diab.37.12.1595>

2. Grundy SM, Brewer HB Jr, Cleeman JI, Smith SC Jr, Lenfant C. National Heart, Lung, and Blood Institute; American Heart Association. Definition of metabolic syndrome: report of the National Heart, Lung, and Blood Institute/American Heart Association conference on scientific issues related to definition. *Arterioscler Thromb Vasc Biol* 2004; 24:e13-8.
<https://doi.org/10.1161/01.ATV.0000111245.75752.C6>
3. Malik S, Wong ND, Franklin SS, Kamath TV, L'Italien GJ, Pio JR, *et al.* Impact of the metabolic syndrome on mortality from coronary heart disease, cardiovascular disease, and all causes in United States adults. *Circulation* 2004; 110:1245-50.
<https://doi.org/10.1161/01.CIR.0000140677.20606.0E>
4. Alberti KG, Eckel RH, Grundy SM, *et al.* Harmonizing the metabolic syndrome: a joint interim statement of the international diabetes federation task force on epidemiology and prevention; National heart, lung, and blood institute; American heart association; World heart federation; International atherosclerosis society; and International association for the study of obesity, *Circulation*. 2009; 120(16):1640-1645.
<https://doi.org/10.1161/CIRCULATIONAHA.109.192644>
5. Kaur J. A comprehensive review on metabolic syndrome. *Cardiol Res Pract*. 2014;
<https://doi.org/10.1155/2014/943162>
6. Ford ES, Giles WH, Dietz WH: Prevalence of the metabolic syndrome among U.S. adults: findings from the third National Health and Nutrition Examination Survey. *J America Med Assoc* 2002; 287:356-359.
<https://doi.org/10.1001/jama.287.3.356>
7. Bouguerra R, Alberti H, Smida H, Salem LB, Rayana CB, El Atti J, *et al.* Waist circumference cut-off points for identification of abdominal obesity among the Tunisian adult population. *Diabetes Obes Metab* 2007; 9:859-68.
<https://doi.org/10.1111/j.1463-1326.2006.00667.x>
8. Al-Lawati JA, Mohammed AJ, Al-Hinai HQ, Jousilahti P. Prevalence of the metabolic syndrome among Omani adults. *Diabetes Care* 2003; 26:1781-5.
<https://doi.org/10.1016/j.pmedr.2017.07.004>
9. Malik M, Razig SA. The prevalence of the metabolic syndrome among the multiethnic population of the United Arab Emirates: a report of a national survey. *Metab Syndr Relat Disord* 2008; 6:177-86.
<https://doi.org/10.1186/s12889-018-6215-x>
10. Al-Rubeaan, *et al.* Prevalence of metabolic syndrome in Saudi Arabia-a cross sectional study. *BMC Endocrine Disor* 2018; 18:16
<https://doi.org/10.1186/s12902-018-0244-4>
11. Alberti KG, Eckel RH, Grundy SM, *et al.* Harmonizing the metabolic syndrome: a joint interim statement of the International Diabetes Federation Task Force on Epidemiology and Prevention; National Heart, Lung, and Blood Institute; American Heart Association; World Heart Federation; International Atherosclerosis Society; and International Association for the Study of Obesity. *Circulation* 2009; 120(16):1640-1645.
<https://doi.org/10.1161/CIRCULATIONAHA.109.192644>
12. Ford ES, Li C, Zhao G. Prevalence and correlates of metabolic syndrome based on a harmonious definition among adults in the US. *J Diabetes* 2010; 2:180-193.
<https://doi.org/10.2147/DMSO.S61245>
13. Prasad DS, Kabir Z, Dash AK, Das BC. Prevalence and risk factors for metabolic syndrome in Asian Indians: A community study from urban Eastern India. *J Cardiovasc Dis Res* 2012; 3:204-211.
<https://doi.org/10.4103/0975-3583.98895>
14. Motala AA, Esterhuizen T, Pirie FJ, Omar MA. Prevalence of metabolic syndrome and determination of the optimal waist circumference cutoff points in a rural South African community. *Diabetes Care* 2011; 34: 1032-1037.
<https://doi.org/10.2337/dc10-1921>
15. Maharjan BR, Bhandary S, Shrestha I, Sunuwar L, Shrestha S. Prevalence of metabolic syndrome in local population of Patan. *Med J Shre Birendra Hosp* 2012; 11:27-31.
<https://doi.org/10.2147/DMSO.S61245>
16. El Brini, *et al.* Prevalence of metabolic syndrome and its components based on a harmonious definition among adults in Morocco. *Diabetes Metabolic Syndrome Obesity: Targ Therap* 2014;7: 341-346.
<https://doi.org/10.2147/DMSO.S61245>
17. Jesmin S, Islam MR, Islam AM, *et al.* Comprehensive assessment of metabolic syndrome among Rural Bangladeshi Women. *BMC Public Health* 2012; 12:49;
<https://doi.org/10.1186/1471-2458-12-49>
18. Ali A, Ali A, Samar A. Prevalence of *Helicobacter pylori* among asymptomatic populations in Sana'a, Yemen. *Universal J Pharm Res*. 2018; 3(3): 31-35.
<https://doi.org/10.22270/ujpr.v3i3.163>
19. Santos AC, Severo M, Barros H. Incidence and risk factors for the metabolic syndrome in an urban South European population. *Prev Med* 2010; 50:99-105.
<https://doi.org/10.1016/j.ypmed.2009.11.011>
20. Bentley-Lewis R, Koruda K, Seely EW. The metabolic syndrome in women. *Nat Clin Pract Endocrinol Metab* 2007; 3(10):696-704.
<https://doi.org/10.1038/ncpendmet0616>
21. Isomaa B, Almgren P, Tuomi T, *et al.* Cardiovascular morbidity and mortality associated with the metabolic syndrome. *Diabetes Care* 2001; 24:683-689.
<https://doi.org/10.2337/diacare.24.4.683>
22. Park YW, Zhu S, Palaniappan L, Heshka S, Carnethon MR, Heymsfield SB. The metabolic syndrome: Prevalence and associated risk factor findings in the US population from the Third National Health and Nutrition Examination Survey, 1988-1994. *Arch Intern Med* 2003; 163(4): 36-42.
PMID: 12588201
23. Lear SA, James PT, Ko GT, *et al.* Appropriateness of waist circumference and waist-to-hip ratio cutoffs for different ethnic groups. *Eur J Clin Nutr* 2010; 64:42-61.
<https://doi.org/10.1038/ejcn.2009.70>
24. Delavari A, Forouzanfar MH, Alikhani S, Sharifian A, Kelishadi R. First nationwide study of the prevalence of the metabolic syndrome and optimal cutoff points of waist circumference in the Middle East: the national survey of risk factors for noncommunicable diseases of Iran. *Diabetes Care* 2009; 32(6): 1092-7.
<https://doi.org/10.2337/dc08-1800>
25. Shojima N, Sakoda H, Ogihara T, Fujishiro M, Katagiri H *et al.* Humoral regulation of resistin expression in 3T3-L1 and mouse adipose cells. *Diabetes* 2002; 51: 1737-1744.
<https://doi.org/10.2337/diabetes.51.6.1737>
26. Misra M, Bredella MA, Tsai P, Mendes N, Miller KK, *et al.* Lower growth hormone and higher cortisol are associated with greater visceral adiposity, intramyocellular lipids and insulin resistance in overweight girls. *Am J Physiol Endocrinol Metab* 2008; 295: E385-E392.
<https://doi.org/10.1152/ajpendo.00052.2008>
27. Al-Motarreb A, Al-Habori M, Bradley KJ. Khat chewing, cardiovascular diseases and other internal medical problems: The current situation and directions for future research. *J Ethnopharmacol* 2010; 132: 540-548.
<https://doi.org/10.1016/j.jep.2010.07.001>
28. Taleb M, Bechyn M. Effect of *Catha edulis* leaves on plasma glucose. *Agricultura Tropicaet Subtropica* 2009; 42 (1):6.
<https://doi.org/10.1538/expanim.18-0057>
29. Murray CD, Le Roux, *et al.* The effect of khat (*Catha edulis*) as an appetite suppressant is independent of ghrelin and PYY secretion. *Appetite* 2008; 51, 747-750.
<https://doi.org/10.1016/j.appet.2008.06.012>
30. Al-Dubai W, Al-Habori M, Al-Geiry. Human khat (*Catha edulis*) chewers have elevated plasma leptin and non esterified fatty acids. *Nutri Res* 2006; 26, 632-636.
<https://doi.org/10.1186/s13104-015-1601-2>