The Incident of Heart Diseases in Hypertension in Bangladesh

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Abstract
Introduction: For cardiovascular disease (CVD), hypertension is the strongest risk factor.
Objective: In this study our main aim is to discover the incident of heart diseases in hypertension of hypertension in Bangladesh.
Method: This cross-sectional study was conducted at different private hospital in Khulna from January 2015 to January 2016 where 530 rural and urban individuals (age ≥21 years) were evaluated and all data was recorded methodically in a preformed data sheet and was analyzed by relevant statistical procedures.
Results: in the study 99 male and 64 female belongs to hypertension group. Also, age and heart diseases strongly correlated with hypertension.
Conclusion: we can conclude that in Bangladesh patients with hypertension is prone to have heart diseases. More studies are suggestive to estimate the incidence of hypertension in heart diseases.
Keywords: Cardiovascular disease (CVD), Hypertension, High blood pressure.

Introduction
Hypertension (HTN or HT), also recognized as high blood pressure (HBP), which is a long-term medical disorder in which the blood pressure in the arteries is persistently elevated. High blood pressure typically does not cause symptoms. High blood pressure is classified as either primary (essential) high blood pressure or secondary high blood pressure. Around 90–95% of cases are primary, defined as high blood pressure due to nonspecific lifestyle and genetic factors. Lifestyle factors that intensification the risk include excess salt in the diet, excess body weight, smoking, and alcohol use. The remaining 5–10% of cases are categorized as secondary high blood pressure, defined as high blood pressure due to an
Hypertension is the top risk factor for death and disability internationally and disproportionately impacts low-and middle-income countries (LMICs), where more than two-thirds of people with hypertension live. In 2010, an assessed 9.4 million deaths and 162 million years of life were lost due to hypertension. Hypertension is the main cause for more than half of the cardiovascular diseases (CVD), stroke and heart failure and is a foremost risk factor for fetal and maternal deaths in pregnancy, dementia and renal failure. The occurrence of hypertension is growing worldwide and is predicted to affect more than 500 million people by 2025.\[^3\]

**Figure-1:** The progression from lifestyle changes to the incidence of hypertension and cardiovascular disease (CVD). CHD indicates coronary heart disease by scheme presentation \[^4\]
Hypertension is a substantial community health challenge and has a main impact on healthcare costs, contributing to around 10% of total healthcare spending internationally. Hypertension imposes a thoughtful economic burden on individuals, households, healthcare systems and the entire state. In current years, hypertension and CVDs have increased in South-East Asia including Bangladesh as a result of rapid urbanization, increased life expectancy, unhealthy diet, and lifestyle fluctuations. In this study our main objective is to discover the incidence of heart diseases in hypertension of hypertension in Bangladesh.

Objective

General Objective
➢ To evaluate the incidence of heart diseases in hypertension of hypertension in Bangladesh.

Specific Objective
➢ To detect frequency of hypertension and non-hypertension in the patients.
➢ To estimate incidence of systolic and diastolic hypertension of all study patients.

Methodology

Study type
➢ This was a cross sectional study.

Study place and period
➢ This study was conducted from January 2015 to January 2016 at different private hospital in Khulna district.

Method
➢ A random sample of 530 rural and urban individual (age ≥21 years) were included in a cross-sectional study. All male and female ≥20 years of age were considered eligible except pregnant women and subjects on medication. The eligible participants were informed about the objectives of the study. After providing the informed consent, each interested individual was requested to attend the nearby health care center. Each participant's was interviewed for the status of physical activities, family history of hypertension, diabetes, smoking, annual income etc were collected using modified WHO-STEPS protocol. Diagnosis of hypertension (WHO criteria): Grade 1 (mild) = 140-159/ 90-99 mm of Hg, Grade 2 (moderate) = 160-179 / 100-109 mm of Hg, Grade 3 (severe) = ≥ 180/ ≥110 mm of Hg.

Statistical Analysis
➢ All data was recorded methodically in a preformed data sheet and was analyzed by relevant statistical procedures with the windows software version 12.0. The prevalence rates of hypertension were determined by simple percentage. Unpaired t-test, chi-square tests were done to see the level of significance. All associations were tested by co-relation coefficient (r). Binary logistic regression was used to quantify the individual risk prediction of hypertension with different independent risk factors. All statistical test were considered significant at the level of 95% (p<0.05)

Result
In table-1 shows age distribution of the patients where for both male and female, most of the patients belongs to (41-50) age group. The following figure is given below in detail:

| Age group | Male, % | Female, % |
|-----------|--------|-----------|
| 21-30     | 5%     | 4.9%      |
| 31-40     | 8%     | 8.1%      |
| 41-50     | 56%    | 53%       |
| 51-60     | 21     | 22        |
| 61-70     | 10%    | 12%       |

In figure-2 shows gender distribution of the patients were among 530 patents male patients were 18.1% higher than female. The following figure is given below in detail:
In figure-3 shows the frequency of hypertension and non-hypertension in the patients were out of 530 patients 99 male and 64 female belongs to hypertension group. The following figure is given below in detail:

**Figure-2:** Gender distribution of the patients

In table-2 shows the incidence of systolic and diastolic hypertension of all study patients, where among total 530 patients, systolic hypertension were 25.81% whereas diastolic hypertension 30.61%. The following table is given below in detail:

**Table-2:** The incidence of systolic and diastolic hypertension of all study patients.

| Group                  | %   |
|------------------------|-----|
| Systolic hypertension  | 25.81% |
| Non systolic hypertension | 74.1% |
| Total                  | 100% |
| Diastolic hypertension | 30.61% |
| Non diastolic hypertension | 69.3% |
| Total                  | 100% |

In table-3 shows Correlation of hypertension with family history, smoking, occupation, physical activity, annual income, obesity, BMI, Gender, heart diseases and age in patients where we found that mostly age and heart diseases strongly correlated with hypertension than other variable. The following table is given below in detail:

**Table-3:** Correlation of hypertension with family history, smoking, occupation, physical activity, annual income, obesity, BMI, Gender, heart diseases and age in patients

| Correlation of hypertension with | r-value | p-value |
|---------------------------------|---------|---------|
| Family history                  | -.228   | <0.01   |
| Smoking                         | -.126   | <0.01   |
| Income                          | -.131   | <0.01   |
| Occupation                      | .009    | >0.05   |
| Physical activity               | -.141   | <0.01   |
| Obesity                         | -.284   | <0.01   |
| BMI                             | .276    | <0.01   |
| Gender                          | -.023   | >0.05   |
| Age                             | -.286   | <0.01   |
| Heart diseases                  | -.287   | <0.01   |

In figure-4 shows relation of diastolic blood pressure stratified by total cholesterol level to 6-year incidence of coronary heart disease events in the Framingham Heart Study where a more dramatic rise in CHD event risk with DBP among those with higher cholesterol levels. The following figure is given below in detail:

**Figure-4:** Distribution of patients according their living place

In figure-4 shows distribution of patients according their living place where 51% people lived in rural area where as 49% people in urban area. The following figure is given below in detail:
Discussion

In this cross-sectional study, our goal was to discover the incident of heart diseases in hypertension of hypertension in Bangladesh. Hypertension, is the strongest risk factor for cardiovascular disease (CVD) or heart diseases.

In our study, the blood pressure was measured in all study patients where we found that the blood pressure was statistically significantly higher in hypertension as compared with non-hypertension. during the study we noted that the prevalence of hypertension observed in this study was higher than the previous study.\[6\]

Hypertension is a major public health issue in Bangladesh, India and in other developing countries Countries with an ageing population will be expected to have a higher prevalence of hypertension than developing countries with a younger population's such as Bangladesh, India, but there are studies, which have documented in developing countries, a high prevalence rate of hypertension \[7\][8]. Our study also showed that with the increasing age gradually more subject with hypertension and that was similar with other finding. \[9\]

In this study we detected that the frequency of hypertension in male was 99 and in female was 64 respectively. Though the prevalence rate was higher in male but there was no statistically significant difference between male and female. Our study showed that the hypertension prevalence was high among people with high obesity. The similar finding also observed in different studies done in different rural area of India. In this study we also observed that high prevalence of hypertension of patients with positive heart diseases and heart diseases. Also hypertension strongly correlated with each other, where different study supported our observation.

In this study we also observed that high prevalence of hypertension of patients with positive heart diseases and heart diseases and hypertension strongly correlated with each other, where different study supported our observation. During the study where among total 530 patients, we found that systolic hypertension was 25.81% whereas diastolic hypertension 30.61%. But one study reported that MI patients were more affected by high systolic blood pressure than diastolic blood pressure. It might be due to injury of endothelium by systolic blood pressure and thereby enhanced atherosclerosis. Elevated serum triglycerides, total cholesterol, and LDL had been well-established risk factors of cardiovascular disease.

Another study reported that extra salt intake along with age, BMI, physical inactivity, tobacco use and family history of stroke/CVD was found to have significant relationship with hypertension and pre-hypertension.\[5\] Also, more than 35 million people in coastal Bangladesh are vulnerable to increasing freshwater salinization; elevated salinity in drinking water has been found to be associated with higher BP in young coastal populations. During the study we also found positive correlation with this report because in the study that most the patients from rural area, so they might unaware threatful effect of salinity in drinking water. The overall risk perception regarding excessive salt consumption is low and
there is widespread belief that the cooking process can render the salt harmless. High salt intake presumably contributes to hypertension, which is an established risk factor for CAD.[10][11]

Conclusion
After several outcome, we can conclude that in Bangladesh patients with hypertension is prone to have heart diseases. More studies are suggestive to estimate the incidence of hypertension in heart diseases.

References
1. Naish J, Court DS (2014). Medical sciences (2 ed.). p. 562. ISBN 9780702052491
2. Lackland DT, Weber MA (May 2015). "Global burden of cardiovascular disease and stroke: hypertension at the core". The Canadian Journal of Cardiology. 31 (5): 569–71. doi:10.1016/j.cjca.2015.01.009. PMID 25795106
3. Islam, Shiekh Mohammed Shariful, A. K. M. Mainuddin, Md Serajul Islam, Mohammad Azizul Karim, Sabrina Zaman Mou, Shamsul Arefin, and Kamrun Nahar Chowdhury. "Prevalence of risk factors for hypertension: A cross-sectional study in an urban area of Bangladesh." Global Cardiology Science and Practice (2015): 43.
4. Anand, Sonia S., Shofiqul Islam, Annika Rosengren, Maria Grazia Franzosi, Krisela Steyn, Afzal Hussein Yusufali, Matyas Keltai, Rafael Diaz, Sumathy Rangarajan, and Salim Yusuf. "Risk factors for myocardial infarction in women and men: insights from the INTERHEART study." European heart journal 29, no. 7 (2008): 932-940.
5. Islam AM, Mohibullah AK, Paul T. Cardiovascular disease in Bangladesh: a review. Bangladesh Heart Journal. 2016;31(2):80-99.
6. Sayeed MA, Khan AR, Banu A, Hussain MZ. Prevalence of diabetes and hypertension in a rural population of Bangladesh. Diabetes Care1995; 18: 555–558.
7. Nissien A, Bothig S, Grenroth H, Lopez AD. Hypertension in developing countries. World Health Stat Q 1988; 41: 141–154.
8. Reddy KS. Hypertension control in developing countries: generic issues. J Hum Hypertension 1996; 10: 33–38.
9. Chobanion AV, Bakris GL, Black HR. The seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure. JAMA 2003; 289: 2560–2572.
10. U.S. Department of Health and Human Services and U.S. Department of Agriculture. 2015–2020 Dietary Guidelines for Americans. 8th Edition. December 2015. Available at http://health.gov/dietaryguidelines/2015/guidelines/ .Accessed September 17, 2016.
11. Rasheed S, Siddique AK, Sharmin T, Hasan AM, Hanifi SM, Iqbal M, et al. Salt intake and health risk in climate change vulnerable coastal Bangladesh: What role do beliefs and practices play? PLoS One. 2016 Apr 4;11(4):e0152783.