

Letter to the Editor



Letter by In-Kyung Jeong Regarding Article, Trends in Prevalence of Hypertriglyceridemia and Related Factors in Korean Adults: A Serial Cross-Sectional Study

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Conflict of Interest

The author has no conflicts of interest to declare.

Dyslipidemia is one of the major risk factors of atherosclerotic cardiovascular disease (ASCVD).¹ Among the components of dyslipidemia, hypertriglyceridemia (HTG) is associated with residual risk factors of ASCVD after optimization of low-density lipoprotein-cholesterol (LDL-C) with statins.² Many guidelines suggested that the target goal for managing HTG is less than 150 mg/dL.³⁻⁵ Therefore, it is crucial for the management HTG to estimate the overall prevalence of HTG and analyze it in people with contributing factors, including alcohol consumption, obesity, hypertension, and type 2 diabetes.

Even though the dyslipidemia fact sheet (DFS) 2022 reported the prevalence of HTG as one of dyslipidemia components, there was no detailed report that focused solely on HTG before Park et al.⁶ published the HTG prevalence. According to the DFS 2022 in Korea, the age-standardized prevalence of HTG (≥ 200 mg/dL) gradually increased from 15.3% in 2007 to 16.8% in 2016, decreased to 13.6% in 2019, and then increased again to 15% in 2020 during coronavirus disease 2019 pandemic, using data from the 2007–2020 Korea National Health and Nutrition Examination Survey (KNHANES).⁷ Park et al.⁶ showed that the prevalence of HTG in Korean adults aged 20 years or older was 28.9% at ≥ 150 mg/dL and 15.4% at ≥ 200 mg/dL based on the same data (2007–2020 KNHANES). The prevalence and pattern of HTG were different between men and women. The prevalence of HTG in men was higher than that of women, peaking in middle age. Smoking and alcohol consumption are exacerbating factors. The prevalence of HTG in women increased in the post-menopausal state. Due to the increasing numbers of people with obesity, insulin resistance and type 2 diabetes, the prevalence of HTG has continued to rise. The prevalences of HTG in people with obesity, hypertension, and diabetes were higher than those in people without comorbidities, especially a significant big difference in young people. The lowest levels of education and income were associated with HTG. USA data from 2007–2014 US NHANES showed that the overall prevalence of statin-treated patients with triglyceride levels ≥ 150 mg/dL was 25.9%.⁸ Among statin-treated adults, the proportion with triglyceride (TG) levels ≥ 150 mg/dL was 31.6% and ranged from 27.6% to 39.5% for those who also had LDL-C levels < 100 mg/dL and type 2 diabetes or ASCVD. Park et al.⁶ did not showed the prevalence of HTG in patients with

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

ASCVD or statin-treated patients. If it were analyzed, it could provide the important meaning to HTG as a residual cardiovascular (CV) risk factor.

The most important principle for treating people with HTG is to manage lifestyle factors associated with elevated TG, including alcohol consumption, smoking, physical inactivity, and high carbohydrate and high-fat diet. Recent clinical trials that lowered triglyceride levels by fenofibrate, pemafibrate, and omega 3 fatty acids did not show a significant reduction in ASCVD events. These results suggested that apo B or remnant cholesterol of triglyceride-rich lipoproteins (TRLs), rather than HTG per se, are more important pathophysiologic factors in ASCVD.⁹ Therefore, the epidemiologic data about apo B or remnant TRLs also need to be explored to manage the residual CV risk factors.

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