

Sally Squires

One Size Does Not Fit All

The 36-year-old South Asian immigrant didn't seem like a typical candidate for a heart attack. He was lean, a nonsmoker and had healthy blood pressure, although his cholesterol levels hovered just above normal. But when his chest pain lasted for an hour, he headed for the emergency room.

Good thing. Not only was he having a major heart attack, which doctors treated with clot-busting drugs, but he also had three badly blocked arteries that required bypass surgery and was diagnosed with Type 2 diabetes.

So how does a young guy seemingly in good health suddenly become such a medical train wreck?

Add ethnicity to the list of risk factors for heart disease, Type 2 diabetes and the metabolic syndrome, which is a cluster of problems including high blood pressure, elevated blood sugar and too many blood fats. This case was reported in 2006 in the journal *Circulation* by an international team of doctors who hoped to alert colleagues to watch for similar patients who might be slipping under the medical radar.

An estimated 3 million transplanted South Asians live in the United States and Canada. Studies suggest that this diverse group — with family roots in India, Pakistan, Nepal, Sri Lanka and Bangladesh — is three to five times more likely to have a heart attack or to die from heart disease than the overall U.S. population. This is true even though many of them are at a healthy weight, by Western standards.

Research hints at other ethnic differences. African Americans

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An Ethnicity Risk Factor

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seem to be at much greater risk of high blood pressure compared with other groups. Pima Indians and other indigenous peoples have soaring rates of Type 2 diabetes, a condition that is also two to five times more common in Hispanics than in non-Hispanic whites here.

The explanation appears to be the way fat accumulates. At the same weight, people of some minority groups, including South Asians, pile on more fat around the middle. Those differences are prompting some international health groups to adjust their screening tools by race.

Take the well-known body mass index, or BMI. It uses height and weight to gauge risk of weight-related complications. (BMI is calculated by dividing a person's weight in kilograms by height in meters squared.)

The National Heart, Lung, and Blood Institute sets a BMI of 18.5 to 24.9 as healthy; 25 to 29.9 as overweight and 30 and higher as obese.

But studies suggest that these cutoffs may give a false sense of security to people of Asian ancestry and cause unnecessary concern to those with African roots.

So the World Health Organization has lowered the BMI cutoff for obesity for Asians from 30 to 25.

The International Diabetes Federation (IDF) has also set varying cutoffs for waist circumference. In Americans, the IDF says, waistlines of 40 inches or larger are cause for concern in men, 35 inches or larger in women. For residents of Europe and the Middle East, the IDF set cutoffs of 37 inches for men, 32 for women. Men from China, Central America and South America are advised by

the IDF to keep their waists at less than 35 inches; for women in these areas, the limit is 32 inches.

"I definitely pay attention to the race of my patients," notes Dipanjan Banerjee, a cardiovascular fellow at Stanford University and co-author of a recent report in the *International Journal of Obesity* on using ethnic-specific criteria to improve the diagnosis of the metabolic syndrome. "If I see a South Asian man who is young with chest pain, I know that the probability of his having heart disease is higher than a Caucasian man the same age. So I do tend to be more aggressive with those patients."

But Banerjee also notes that taking into account the ethnicity of patients gets into some thorny questions.

Race is generally self-reported and may reflect a person's identity more than his genetic makeup. "How do you determine who is actually African or Indian?" he asks. "What we are trying to capture with these crude racial classifications is a greater understanding of risk factors."

He envisions a day when doctors will instead sample genetic profiles that will be far more accurate than skin color or country of origin in assessing risk. "We are moving towards genetic therapy for cardiovascular disease and other medical conditions," he says. "That is what we are all trying to do."

 Join Sally Squires from 1 to 2 p.m. today online at www.leanplateclub.com, where you can subscribe to the free weekly Lean Plate Club e-mail newsletter. E-mail her at leanplateclub@washpost.com.

Around the Waist, Around the Globe

MAXIMUM WAIST CIRCUMFERENCE GUIDELINES (in inches)

	Men	Women
Americans	40	35
Europeans	37	32
South Asians	35	32
Chinese	35	32
Japanese	34	35
Ethnic South and Central Americans	35	32
Sub-Saharan Africans	37	32

SOURCES: International Diabetes Federation, 2005; Milan Gupta, MD, McMaster University; Narendra Singh, MD, Emory University; Subodh Verma, MD, PhD, University of Toronto; *Circulation*.

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