Estimation of Serum Homeostasis Model Assessment-Insulin Resistance and Lipid Profile in Beta-thalassemia Major Patients and their Correlation with Iron Overload in Koya City

Kochar K. Saleh*, Saman R. Abdullah, Rukhosh E. Mekha

Department of Community Health, Koya Technical Institute, Erbil Polytechnic University, Erbil, Kurdistan Region – Iraq

INTRODUCTION

Major β-thalassemia is a very serious blood condition since individuals with it are unable to make enough healthy red blood cells and depend on blood transfusions all their life (Khattak and Khan, 2004). It is the most prevalent type of thalassemia as it is common in certain populations and causes severe anemia in its homozygous state (Thein, 2005). Thalassemia represents the most common single gene disorder causing a major public health problem. β-thalassemia major characterized by progressive anemia manifested during the 2nd 6 months of life, associated with splenomegaly and chronic hemolytic anemia that sustain life (Danjou et al., 2011; Driscoll et al., 2003). B-thalassemia major is caused by the complete absence of β-globin chain production resulting from reduced synthesis of one or more globin chains, which can be caused by different globin gene mutation resulting in ineffective hematopoiesis, increased hemolysis, and early onset anemia. Most types of β-thalassemias are due to point mutations, and deletion mutations found in rare cases, many mutations associated with β-thalassemia either reduce β-globin gene expression (β- type) or completely suppress beta-globin gene (β0-type) (Haghi et al., 2009).

Major β-thalassemia is the most prevalent type of thalassemia, because of anemia caused in thalassemia major, patients are pale, fatigue, and have a slower rate of growth (Ambekar et al., 2001). Lipid abnormalities have been detected in different types of beta-thalassemia, and in various hematological disorders including sickle cell disease, glucose-6-phosphate dehydrogenase deficiency, spherocytosis, aplastic anemia, and myelodysplastic syndrome (Sutay, 2016; Ricchi et al., 2009). The pathogenesis of these abnormalities is not exactly clear, but there are many suggested mechanisms including plasma dilution due to anemia, accelerated erythropoiesis resulting in increased cholesterol uptake by macrophages of the reticuloendothelial system, defective liver functioning due to iron overload, and macrophage system activation with cytokine release and hormonal disturbances (Al-Quobaili...
and Asali, 2004). Our aim and objectives in the present study to show what are the main physiological changes occur in patients that suffer with major β-thalassaemia and what are the main significant correlations between each parameter.

**MATERIALS AND METHODS**

The design of the present investigations is composed of 86 subjects divided equally between two groups; the first group is the patient group, which included 43 major β-thalassemia children, who were managed for the clinical symptoms and treatments at the hospital of shaheed Dr. Khaled in the Koya city. The second group is a control group, which included 43 apparently healthy children randomly, selected, who served as a control group of the study. The control groups were age- and sex-matched to the patients, the mean age of the patients (9.1 ± 2.2 and controls 8.8 ± 1.9 years). Six milliliters sample of venous blood taken from each patient before the scheduled blood transfusion using a disposable syringe. Then, it used for the estimation of serum homeostasis model assessment-insulin resistance and lipid profile in major B-thalassemia patients and their correlation with iron overload by used full-automated (cobas e 411 and cobas c 111) instruments used for assessment each parameter, which include lipid profiles, serum insulin, and glucose. Statistical analysis: SPSS (Statistical Package for the Social Sciences) (Version 20) statistical software was used to analyze the data. Differences in mean values between two groups were analyzed by two samples t-test (independent Student’s t-test between healthy and thalassemia patients and paired sample t-test between male thalassemia and female thalassemia) and correlation coefficient. Probably level of $P < 0.05$ level of significant was considered to be statistically significant.

**RESULTS**

The result of the current study showed significant changes in the iron overload, serum glucose concentration, and in the insulin resistance index (IRI) of the major β-thalassemia patients as compared with healthy control groups in the same ages and sex, while there are no significant changes in the serum insulin concentration of the 43 β-thalassemia. Major patients were managing at the hospital of shaheed Dr. Khaled in Koya city, as shown in Table 1 and Figure 1.

The insulin resistance index was significantly higher in β-thalassemia major patients compared to control groups (3.90 ± 5.7) versus (2.90 ± 1.2), ($P = 0.048$). There was not any correlation between insulin resistance and other biochemical factors such as iron overload except glucose and insulin, as shown in Table 2 and Figure 2.

There is no significant difference between the ages of patients and controls, in the 43 β-thalassemia. Major patients, which include 23 male and 21 female patients that mean age of β-thalassemia major patients was 8.03 ± 4.0 years and healthy control groups was 7.81 ± 3.11 years, which include 86 healthy control groups which sex and ages were matched with patients, as shown in Figures 3 and 4.

In patients, the fasting serum glucose correlated with the iron overload indicators like serum iron overload, there is no correlation seen with serum glucose ($r = 0.002$), as shown in Table 3 and Figure 5. About 6.9% ($n = 3$) of patients had a serum glucose level equal to or higher than 5.5 mmol/L. A fasting glucose level of 53.4% ($n = 23$) of patients was more than 6.5 mmol/L among whom 20.9% ($n = 9$) were determined as diabetes mellitus and 18.6% ($n = 8$) as a prediabetic state with repeated tests, and all controls had a normal fasting serum glucose except one participant with a serum glucose of 6.2 mmol/L.

There was no significant difference between the serum insulin level of β-thalassemia major patients and control groups ($P = 0.215$), but slightly decrease of the serum insulin level of β-thalassemia major patients as compared with healthy control groups. About 5% of the patients ($n = 2$) and 11.6% of the controls ($n = 5$) had a serum insulin higher than 24 μIU/mL. There is no

**Table 1: Demographic and general characterization of the study population**

<table>
<thead>
<tr>
<th>Mean ages</th>
<th>Mean ages of patients/ male (Mean±SE)</th>
<th>Mean ages of controls/ male (Mean±SE)</th>
<th>Mean ages of patients/ female (Mean±SE)</th>
<th>Mean ages of controls/ female (Mean±SE)</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta-thalassemia</td>
<td>8.22±0.6</td>
<td>8.1±0.4</td>
<td>7.84±0.4</td>
<td>7.52±0.9</td>
<td>*NS</td>
</tr>
<tr>
<td>Gender (M/F)</td>
<td>22/21</td>
<td>43/43</td>
<td>22/21</td>
<td>43/43</td>
<td>*NS</td>
</tr>
<tr>
<td>Beta-thalassemia majors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Random serum glucose (mmol/L)</td>
<td>6.6±0.1</td>
<td></td>
<td>4.2±0.1</td>
<td></td>
<td>0.001**</td>
</tr>
<tr>
<td>Serum insulin (μIU/mL)</td>
<td>14.7±1</td>
<td></td>
<td>15.1±1.2</td>
<td></td>
<td>*NS</td>
</tr>
<tr>
<td>Insulin resistance index</td>
<td>3.90±0.8</td>
<td></td>
<td>2.90±0.1</td>
<td></td>
<td>0.048*</td>
</tr>
<tr>
<td>Iron (ng/ml)</td>
<td>167.1±0.06</td>
<td></td>
<td>112.3±0.1</td>
<td></td>
<td>0.01*</td>
</tr>
</tbody>
</table>

* NS: Non-significant differences between controls and patients (male and female)
significant correlation seen between serum insulin levels and serum iron overload \((r = -0.159)\), as shown in Table 4.

A significant changes confirmed in the lipid profile of 43 βeta-thalassemia. Major patients as showed in the previous result that serum glucose concentration was significantly higher in the βeta-thalassemia major patients than in the controls \((P = 0.01)\), as shown in Table 5.

Lipid abnormality occurs in βeta-thalassemia major patients, which includes serum total cholesterol (TC) \((121.9 \pm 36.7 \text{ mg/dl})\), serum triglycerides (TG) \((182.09 \pm 43.1 \text{ mg/dl})\), low-density lipoprotein-cholesterol (LDL-C) \((65.2 \pm 1.9 \text{ mg/dl})\), high-density lipoprotein-cholesterol (HDL-C) \((29.5 \pm 7.8 \text{ mg/dl})\), and very-low-density lipoprotein (VLDL) \((23.47 \pm 12.13 \text{ mg/dl})\) levels compared with normal healthy controls, as shown in the following Figures 6-9.

There are no significant changes confirmed in the lipid profile of the healthy control groups, as shown in

![Figure 1: Standard error of the mean changes in homeostasis model assessment-insulin resistance in the study population](image1)

![Figure 2: Correlation between iron overload and insulin resistance index](image2)

![Figure 3: Standard error of the mean ages distribution of the studied populations](image3)

![Figure 4: Gender distribution among the study population](image4)
Table 5: Analysis of lipid profile in patients

<table>
<thead>
<tr>
<th>Parameters</th>
<th>TC (mg/dl)</th>
<th>TG (mg/dl)</th>
<th>LDL-C (mg/dl)</th>
<th>HDL-C (mg/dl)</th>
<th>VLDL-C (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>183</td>
<td>357</td>
<td>116</td>
<td>54</td>
<td>189</td>
</tr>
<tr>
<td>Minimum</td>
<td>95</td>
<td>60</td>
<td>18</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Median</td>
<td>114.30</td>
<td>97.30</td>
<td>66.30</td>
<td>25.10</td>
<td>22.20</td>
</tr>
<tr>
<td>Mean</td>
<td>121.9±36.7</td>
<td>182.09±43.1</td>
<td>65.2±1.9</td>
<td>29.5±7.8</td>
<td>23.47±12.13</td>
</tr>
</tbody>
</table>

TC: Total cholesterol, TG: Triglycerides, LDL-C: Low-density lipoprotein-cholesterol, HDL-C: High-density lipoprotein-cholesterol, VLDL: Very-low-density lipoprotein

Table 6: Analysis of lipid profile in controls

<table>
<thead>
<tr>
<th>Parameters</th>
<th>TC (mg/dl)</th>
<th>TG (mg/dl)</th>
<th>LDL-C (mg/dl)</th>
<th>HDL-C (mg/dl)</th>
<th>VLDL-C (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>145</td>
<td>105</td>
<td>100</td>
<td>54</td>
<td>36</td>
</tr>
<tr>
<td>Minimum</td>
<td>95</td>
<td>55</td>
<td>50</td>
<td>40</td>
<td>13</td>
</tr>
<tr>
<td>Std. deviation</td>
<td>14.981</td>
<td>16.735</td>
<td>15.816</td>
<td>4.138</td>
<td>7.103</td>
</tr>
<tr>
<td>Median</td>
<td>126.10</td>
<td>77.00</td>
<td>78.40</td>
<td>46.10</td>
<td>22.00</td>
</tr>
<tr>
<td>Mean</td>
<td>178.7±14.6</td>
<td>124.14±12.1</td>
<td>79.7±14.5</td>
<td>48.6±4.2</td>
<td>26.52±5.47</td>
</tr>
</tbody>
</table>

TC: Total cholesterol, TG: Triglycerides, LDL-C: Low-density lipoprotein-cholesterol, HDL-C: High-density lipoprotein-cholesterol, VLDL: Very-low-density lipoprotein

Figure 5: Correlation between iron overload and serum glucose

There is no significant correlation seen between iron overload and serum TG, as shown in Table 9. Serum TG were significantly higher in βeta-thalassemia major patients compared with healthy control groups (121.9 ± 36.7 mg/dl) versus (178.7 ± 14.6 mg/dl), respectively, (P = 0.000). Close to 25% of patients had a serum TG more than (231.09 mg/dl), while in the controls, this percentage was 4.6%. The serum TG in female patients and male patients was no significantly higher than each other were. There is no significant correlation seen between iron overload and serum TG.

Figure 6: Standard error of the mean serum triglycerides in the study population

Table 6. While the present study showed, lipid profile was significantly higher in the βeta-thalassemia major patients than in the healthy control groups (P = 0.01).

Lipid profile occurs in healthy control groups, which includes serum TC (178.7 ± 14.6 mg/dl), serum TG (124.14 ± 12.11 mg/dl), LDL-C (79.7 ± 14.5 mg/dl), HDL-C (48.6 ± 4.2 mg/dl), and VLDL (26.52 ± 5.47 mg/dl) levels compared patients. The serum cholesterol (TC) it had no significant correlation with iron overload about (r = 0.139, P = 0.374), as shown in Table 7 and Figure 10, while serum cholesterol (TC) was significantly lower in βeta-thalassemia major patients compared with healthy control groups (121.9 ± 36.7 mg/dl) versus (178.7 ± 14.6 mg/dl), respectively, (P = 0.000). Only three of the controls had a cholesterol level more than 190 ± 1.6 mg/dl.

There is no significant correlation seen between iron overload and serum TG, as shown in Table 9 and Figure 11. Serum LDL-C was significantly lower in βeta-thalassemia. Major patients compared with healthy control groups (65.2 ± 1.9 mg/dl) versus (79.7 ± 14.5 mg/dl), respectively, (P = 0.001), as shown in Table 8. Close to 13.9% (n = 6) of patients had a serum LDL-C levels more than 70 ± 2.7 mg/dl and 86% (n = 37) of patients less than 65 ± 2.7 mg/dl. Seven percent of the controls had a serum LDL-C level less than 55 ± 2.4 mg/dl.

There is no significant correlation seen between iron overload and serum TG, as shown in Table 11 and
HDL-C was significantly lower in β-thalassemia. Major patients compared with healthy control groups (29.5 ± 7.8 mg/dl) versus (48.6 ± 4.2 mg/dl), respectively, \((P = 0.000)\), as shown in Table 8. Around 23.25\% (\(n = 10\)) of patients had a serum HDL-C levels less than 25 ± 2.6 mg/dl and 76.74\% (\(n = 33\)) of patients less than 35 ± 5.7 mg/dl. Eight percent of the controls had a serum HDL-C level less than 45 ± 2.4 mg/dl.

There is no significant correlation seen between iron overload and serum TG, as shown in Table 7 and Figure 10. VLDL was lower in β-thalassemia. Major patients as compared with healthy control groups (23.47 ± 12.13 mg/dl) versus (26.52 ± 5.47 mg/dl), respectively, \((P = 0.167)\), as shown in Table 8. Approximately 18.6\% (\(n = 8\)) of patients had a VLDL levels more than 25 ± 2.6 mg/dl and 79\% (\(n = 34\)) of patients less than 24 ± 4.7 mg/dl, while only one patients had a VLDL level less than 20 ± 1.2 mg/dl.
Many studies explain the mechanism of changes in serum insulin, glucose, and lipid profile of thalassemia particularly in Beta-thalassemia major such as the previous of (Shams et al., 2010), this alteration due to abnormality in hepatic biosynthesis that include anemia and iron overload (Ambekar et al., 2001; Calandra et al., 2004). In current study showed that there are significant differences have been detected between the values of Beta-thalassemia major patients and healthy control groups. It was appear that in Beta-thalassemia major patient’s serum levels of iron overload ($P = 0.01$) significantly higher than healthy control groups, this result supported by numerous reports that published on iron overload and endocrine problems in Beta-thalassemia major such as Ariffin et al., 2017, its related with frequent blood transfusions for increased life expectancy and improved the quality of health and life for the patients with B-thalassemia major, but this frequent blood transfusions cause progressive iron overload, which is a major clinical complication of patients and lead to damages to the liver and other organs of the body (Khaleel et al., 2013).

On the other hand, serum glucose and IRI significantly higher in B-thalassemia major patients rather than healthy control groups; it is related with pancreatic failure because normally the islet cells must produce more insulin to overcome hyperglycemia (Agarwal et al., 2003). It is likely that an increased levels of iron overload cause iron toxicity in the liver and pancreas and insulin dysregulation, due to hepatic and pancreatic dysfunction, which is most likely the cause of impaired glucose metabolism in Beta-thalassemia major patient this result agreement with the finding of Ambekar et al., 2001, while serum insulin there is no significant differences ($P = 0.048$) between B-thalassemia patients and control groups. In the lipid profile of B-thalassemia major patient’s serum levels which included TC, HDL-C, and LDL-C was low as compared to healthy control groups.

In addition, total TG levels in B-thalassemia major patient were higher than healthy control groups, it is because of many factors that related with complication of iron overload in the body of thalassemia patients, while the VLDL-C ($P = 0.167$) does not show any significant changes and differences in the values that mean neither low nor high as compared with healthy control groups, frequently reported on lipid abnormality in Beta-thalassemia but its pathophysiology is not totally clear (Al-Quobaili and Asali, 2004; Weatherall, 2001), however results of present study correlate well with previous study (Seddon et al., 1994) and Maioli et al. in their results published from 1984 to 1997 suggested that liver damage, accelerated erythropoiesis, and an increased uptake of LDL by macrophages and histiocytes of the reticuloendothelial system are the main causes of low plasma cholesterol in thalassemia (Hashemieh et al., 2011). In 1991, Goldfarb et al. found low plasma cholesterol and abnormality in the structure and composition of lipoproteins in Beta-thalassemia major. In our study, hypertriglyceridemia and hypocholesterolemia were observed. It seems that the main mechanism of hypocholesterolemia in beta-thalassemia
major is severe iron overload these abnormalities can be caused by many mechanisms including plasma dilution because of anemia, accelerated erythropoiesis resulting in increased cholesterol uptake by macrophages and histiocytes of the reticuloendothelial system, defective liver functioning because of iron overload, macrophage system activation with cytokine release and hormonal disturbances (Amendola et al., 2007) while some researchers observed that the lipid profile in thalassemia major patients is not influenced by age, sex, liver injury, and hemoglobin or ferritin levels (Haghi et al., 2009). The higher erythroid bone marrow activity with enhanced cholesterol consumption could be the dominant mechanism implicated in the lipid abnormalities of thalassemia major patients (Tuzmen and Schechter, 2001). Our findings of hypocholesterolemia and hypertriglyceridemia in patients of beta-thalassemia major were supported by other studies (Sutay, 2016; Patne et al., 2012).

**CONCLUSION**

Results in our study revealed that Beta-thalassemia patients had hypertriglyceridemia, hypocholesterolemia, and low LDL-cholesterol and HDL-cholesterol levels, while VLDL-cholesterol was not significantly changed, so it must be a screening for concern of better evaluation of the cardiovascular risk factors in these patients. Therefore, the prevalence’s of lipid abnormality are useful to avoid unnecessary evaluation in patients with Beta-thalassemia major. The mean in serum glucose concentrations increased in Beta-thalassemia major patients and developments of diabetes mellitus appeared. In addition, hypertriglyceridemia and hypocholesterolemia revealed among children suffering from Beta-thalassemia major, while away serum insulin level was not significant changes.

**REFERENCES**


