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Editöre Mektup / Letter to the Editor

Everyone has a heart but it may be expressed differently

Herkesin bir kalbi var ama farklı ifade edilebilir

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This article is not about love, as the title may suggest, but about the diseases that attack the heart. Early studies have established beyond doubt that there are socioeconomic differences in disease causation. These differences are especially prominent with respect to cardiac problems and other non-communicable diseases. Current evidence from high-income countries shows that biological, behavioural and psychosocial risk factors present in disadvantaged communities accentuate the link between cardiovascular disease (CVD) and socio-economic Status1. But these issues do not just affect high-income countries. The cultural changes in upper- and lower- middle-income countries due to increasing urbanization and globalization could be generating new risk factors.

Dietary changes, including a new food culture focusing on fast food and home delivery of food, sedentary lifestyles and television culture etc. are some possible factors for future studies. The explanatory paradigms for disease causation are further complicated due to the fact that low socioeconomic status groups in developed countries also share the burden of the Neglected Tropical Diseases. This global view of health is now termed the "blue marble phenomenon" – the idea that "impoverished populations living amidst wealth bear a disproportionate burden of neglected diseases"2. Simplistic explanations based on geographical or economic boundaries may not be appropriate when assessing public health.

Several societies going through positive health transitions are also going through public health crises3. For instance, the state of Kerala, in India, has attracted international attention as a result of several ongoing health crises. The people face the continuing onslaught of multiple epidemic fevers during the monsoon season and, at the same time, they are also struck by a great wave of non-communicable diseases. Without being ambiguous, we can state that this wave has affected the rich and the poor and swept away the economic foundation of many families. Diabetes is one such disease which now cuts across the socio-economic strata and which has to be seen from a multi-dimensional paradigm.

In recent years, the prevalence of cardiovascular diseases and diabetes has become more secular; socio-economic class, which was once thought to be the important differentiating factor for non-communicable diseases in general, and cardiovascular diseases in particular, is disappearing to a large extent4. However, this is not a simple pattern as there are many qualifying factors. Due to bacterial causative agents like Group A Streptococcus, which thrive in poor sanitary and environmental conditions, a low socio-economic status (characterized by poverty, illiteracy and unsanitary living conditions) is a known risk factor for rheumatic heart disease5. This is just one example; although differences do exist with respect to the prevalence of other cardiac problems, the specificities, clinical characteristics and symptoms have not been examined from a class angle. We do not

understand the biological mechanisms yet, but it is our hypothesis that there may be subtle or considerable differences in the way these diseases are expressed, including clinical symptoms and diagnostic indicators, in different socio-economic classes and other social categories. By understanding how cardiac problems vary across different socio-economic groups, we can begin to evolve treatments and management strategies to be more suitable to meet a range of needs.

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