



Roles of triglyceride and phosphate in atherosclerosis of diabetic hemodialysis patients

Mohammad Rezapour¹, Elnaz Payani², Masoumeh Taran³, Ali Rajabzadeh Ghatari⁴, Morteza Khavanin Zadeh^{5*}

Received: 04 Mar 2016

Published: 15 Dec 2017

Abstract

Background: A growing number of patients with End-Stage Renal Disease (ESRD) are undergoing long-term hemodialysis (HD). HD needs a vascular access (VA) and complications of VA account for a sizable proportion of its costs. One of the important cardiovascular diseases (CVD) is atherosclerosis, which is a major cause of premature deaths in the world. So, it is essential to find the risk factors to treat them before they cause an obvious CVD.

Methods: We analyzed data from 174 ESRD patients who were candidate for Arterio Venous Fistula (AVF) creation from April 2008 to March 2009 in Hasheminejad Kidney Center by convenient sampling. X-ray images were used and C 4.5 algorithm of data mining techniques revealed the roles of two risk factors for atherosclerosis of diabetic ESRD patients. Pearson coefficient was also used to measure the correlation between the parameters.

Results: Diabetic patients had significantly more calcified arteries in their forearm X-ray than other patients ($p < 0.001$). Occurrence of atherosclerotic CVD in diabetic HD patients has an adverse relation compared with the controlled levels of their plasma levels of Triglyceride (TG) and Phosphorus. We found an inverse effect of TG and phosphorus plasma levels on the atherosclerotic involvement of radial and ulnar arteries in diabetic HD patients. We observed that the prevalence of radial and ulnar arteries calcification in these patients is lower when they have higher plasma levels of TG and phosphorus.

Conclusion: This study investigates the role of high plasma levels of TG and phosphorus in the development of atherosclerosis in diabetic HD patients. Although many studies showed that hypertriglyceridemia plays a promoting role in the development of CVD, our study also found an inverse effect of plasma levels of TG on the atherosclerotic involvement of radial and ulnar arteries in diabetic patients, and therefore our results support this suspicion that hypertriglyceridemia plays a significant role in developing atherosclerosis.

Keywords: Image Mining, X-ray, Arterial Calcification, Atherosclerosis, Diabetes Mellitus, Triglyceride, Phosphorus, inverse effect

Copyright © Iran University of Medical Sciences

Cite this article as: Rezapour M, Payani E, Taran M, Rajabzadeh Ghatari A, Khavanin Zadeh M. Roles of triglyceride and phosphate in atherosclerosis of diabetic hemodialysis patients. *Med J Islam Repub Iran.* 2017 (15 Dec);31:80. <https://doi.org/10.18869/mjiri.31.80>

Introduction

A growing number of patients with End-Stage Renal Disease (ESRD) are undergoing long-term hemodialysis (HD). In the US, more than 871,000 persons were treated for ESRD in 2009, which represented an increase of nearly 600% between 1980 and 2009, and accounted for 6% of the 2009 Medicare budget (\$29 billion) (1).

Complications of HD access account for a sizable proportion of these costs (1, 2).

Reducing morbidity and costs of vascular access (VA) maintenance is a challenge in HD patients. Arterio Venous Fistula (AVF) has least complications and AVF is preferred VA method. In Iran, AVF remains the first choice

Corresponding author: Dr Morteza Khavanin Zadeh, khavaninzadeh.m@iums.ac.ir

¹ Department of Information Technology Management, Science and Research Branch, Islamic Azad University, Tehran, Iran.

² Bamberg Clinic, Germany.

³ Applied Mathematics Institute for Advanced Studies in Basic Sciences (IASBS), Zanjan, Iran.

⁴ Tarbiat Modares University, Tehran, Iran.

⁵ Iran University of Medical Sciences, Hasheminejad Kidney Center (HKC), Tehran, Iran.

↑What is "already known" in this topic:

Atherosclerosis is an important cardiovascular disease (CVD) and is a major cause of premature deaths in the world. Specially, vascular calcification - as a representative of atherosclerosis - is a risk factor for mortality due to CVD in End-Stage Renal Disease (ESRD) patients.

→What this article adds:

There is an adverse relation in atherosclerosis formation in diabetic ESRD patients such that the prevalence of radial and ulnar arteries calcification is lower when they have higher plasma levels of Triglyceride (TG) and Phosphorus.

for VA and rate of AVF has increased remarkably, reaching up to 93.4% and comparable to other VA methods (3).

The total number of ESRD patients undergoing renal replacement therapy (RRT) in 2007 was 32,686, which denotes a prevalence of 435.8 per million population (PMP). This number is very high compared with 1997, 2000 and 2006, when the prevalence of ESRD was 137 pmp, 238 pmp and 357 pmp, respectively. The incidence of ESRD patients also seems to be increased, from 13.82 pmp in 1997 to 49.9 pmp in 2000 and 63.8 pmp in 2006. It is possible that the increase is due to the increased recognition of the disease due to the increase in the number of HD centers (150 in 1997, 227 in 2000 and 316 in 2006), kidney transplantation centers, transplantations (22.8 pmp in 1997 to 26.5 pmp in 2006) and nephrologists in our country. Also, the number of patients on HD increased from 587 (106.7 pmp) in 1991 in Tehran to 12500 (179 pmp) in 2006 (4-7). Moreover, the statistics of ESRD incidence and prevalence in years 2008-2012 has been published by USRDS (8).

We summarized these rates in Table 1 and illustrated their trends in Fig. 1.

Moreover, atherosclerosis is a chronic inflammatory disease of large- to medium-sized arteries and is the main underlying cause of death worldwide (9). Cardiovascular diseases (CVD) due to atherosclerosis are one of the major reasons for disease burden in developed countries (10).

Atherosclerosis causes obvious CVD, and CVD is one of the causes of premature deaths. Since atherosclerotic plaque grows slowly, it does not lead to symptoms, and affected individuals usually remain asymptomatic. For instance, patients mostly have no cardiac symptoms until the lesion causes 70-80% narrowing of the coronary vessels (11). However, several myocardial infarctions are the consequences of an atherosclerotic plaque, which does not cause a high-grade stenosis and therefore does not yet restrict the coronary arteries blood flow (12, 13). Also, elevated LDL cholesterol, high triglyceride (TG), low high-density lipoprotein (HDL) cholesterol, smoking, hypertension and diabetes mellitus, are known risk factors for vascular diseases, including atherosclerosis (14-16).

Furthermore, vascular calcification is a representative of atherosclerosis, and it is also known as a risk factor for mortality due to CVD in ESRD patients. Vascular calcification is detectable by radiography and X-ray computed tomography (CT) (17, 18).

Some studies revealed that classic risk factors for atherosclerosis such as age, sex, hypertension, high blood glucose level and dyslipidemia are the most common causes of atherosclerosis, which are responsible for even more than 50% cases of atherosclerosis (19-23).

Imaging plays a critical role in early diagnosis and treatment of VA failure (24). However, catheter fistulography cannot evaluate extravascular structures,

Table 1. The incidence and prevalence of patients with ESRD in Iran (1997-2012)

Year (s)	ESRD Incidence (PMP)	ESRD Prevalence (PMP)
1997	13.82	137
2000	49.9	238
2006	63.8	357
2007	-	435.8
2008	99	491
2009	101	529
2010	106	556
2011	108	586
2012	105	621

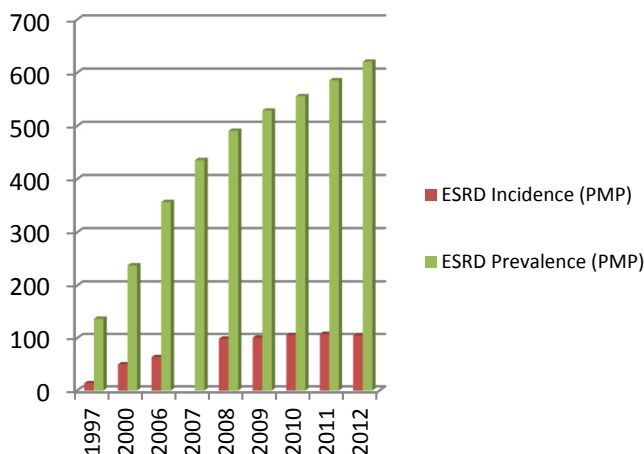


Fig. 1. The trends of incidence and prevalence rates of ESRD in Iran (1997-2012)

Table 2. The parameters of calcification detection by radiologist and surgeons

Parameters in Figures 3, 4	Comment	Range1	Range2
Calcification	Dose patient have calcification in X-ray?	'1'= Seen	'2'= Not Seen
Radiologist	Detecting calcification by radiologist	'1'= Seen	'2'= Not Seen
Expert	Detecting calcification by surgeons	'1'= Seen	'2'= Not Seen
Length	The length of Arterial Calcification	It is measured by centimeters & is denoted with the colors (Figures 3, 4).	

**Fig. 2.** Arterial calcification in their forearm Radiographies

such as in cases of stenosis or obstruction secondary to external compression. Delineation of the central vascular anatomy, including the aorta, subclavian artery, and superior vena cava, may require multiple injection runs and/or multiple punctures, which can create patient discomfort and add to the cost of the procedure (25).

These facts demonstrate that further consideration should be given to atherosclerosis and its risk factors.

Data mining is a process, which is used to extract potentially useful information from large amounts of data (26). Usual methods of statistical analysis cannot analyze and process some information because they are too abundant and complicated, but data mining is the technique, which can change these complex data into helpful information (27). Since medical data mining is an effective analytical technique for exploring previously unknown and potentially useful data, it is now becoming popular in healthcare system (28). In the field of medicine, data mining is a useful technique to extract information, which is helpful in decision making (29). Specially, the extracted information from data mining can help surgeons to detect and predict surgical complications (30, 31).

The goal of our study is to assess and report the correlation between different risk factors for atherosclerosis, using data mining technique. Thus the risk factors of atherosclerosis can be interpreted based on these possible correlations in future. Also, the maximum level of different risk factors might be adjusted based on these findings.

Methods

In the present study, we analyzed data from 174 patients with ESRD who were candidates for AVF creation. Patients were included from April 2008 to March 2009 in Hasheminejad Kidney Center by convenient sampling. Forearm X-ray (anteroposterior and lateral projection) was done for all individuals and reported by a radiologist before surgery. Clinical and laboratory data (including atherosclerosis risk factors) were obtained through checklists. Our approach was based on a standard process model, namely CRISP-DM (Cross-Industry Standard Process for Data mining) (32). We used Rapidminer software for analyzing data.

We used data mining techniques, as its applications have become increasingly essential for healthcare organizations to make decisions based on the analysis of huge amounts of clinical data generated by healthcare transactions (28). Nevertheless, running these techniques on low volume datasets is also useful (29). According to data mining approaches, Rezapour et al. (2017) have presented a system which controls outcomes of AVF surgery in ESRD patients (33).

Before running decision tree based on C 4.5 algorithm, we reviewed and compared the status of calcification detected by radiologists and surgeons. In this comparison we used some parameters as mentioned in Table 2.

From all patients with the mean age of 56 ± 16.1 years (58.6% male and 41.4% female), 18% ($n=34$) had arterial calcification in their forearm radiographs (Fig. 2).

Results

As illustrated in Fig. 3, the scatter plot shows the diagnosis errors of radiologists in the northwest corner of the plot. In the northeast of this plot, when calcification was not apparent in X-Ray (no points at the southeast area), the radiologists did not reported its existence; but in the northwest corner of it, some errors have occurred: there are cases of existing calcifications in X-Ray (the red points in southwest area) which radiologists could not diagnosed them (there is no red point in northwest area).

On the other hand, Figure 4 shows that surgeons had more diagnosis errors if the decision was made without radiography; In addition to radiologist's diagnostic errors (Northwest corner of Fig. 3), surgeon had made two mistakes of another kind (Southeast corner of Fig. 4): two patients were diagnosed with atherosclerosis whereas they have not any evidence of calcification in X-Ray.

So we saw that using X-rays helps surgeons to make more accurate diagnosis.

Furthermore, Pearson correlation test showed that diabetic patients had significantly more calcified arteries in forearm X-ray than other patients ($p < 0.001$). Noticing this fact, after running decision tree on our gathered data, we

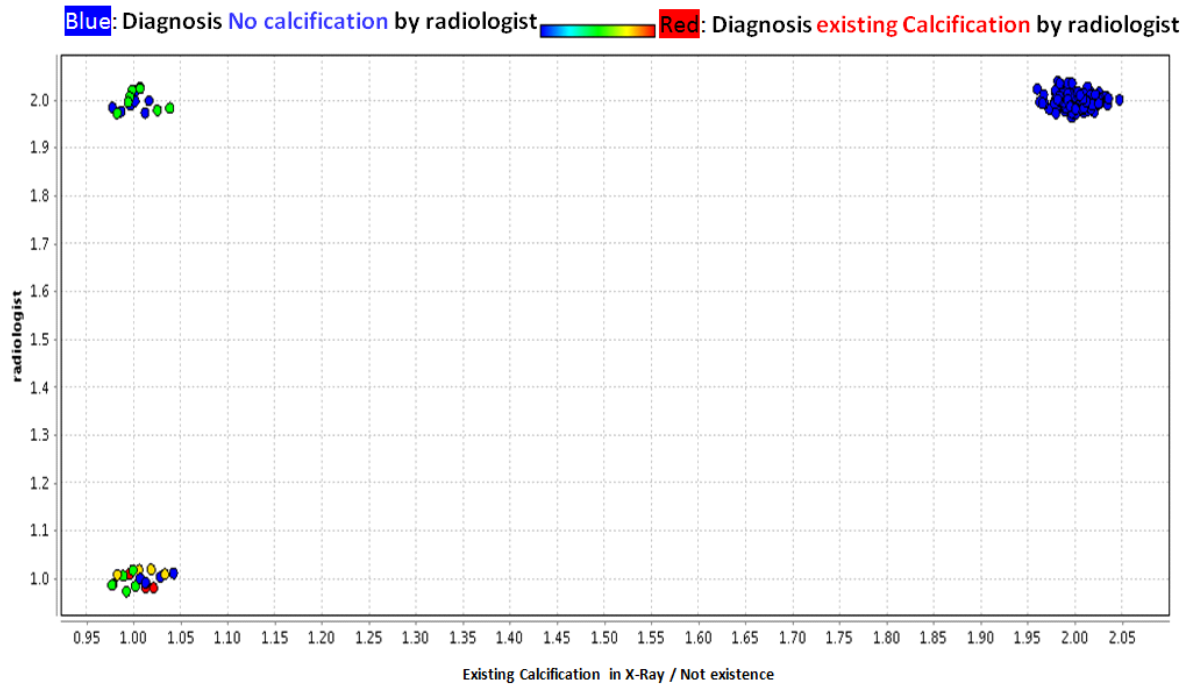


Fig. 3. Forearm arterial calcification in radiography and calcification cases reported by radiologists: the diagnosis errors in the northwest corner

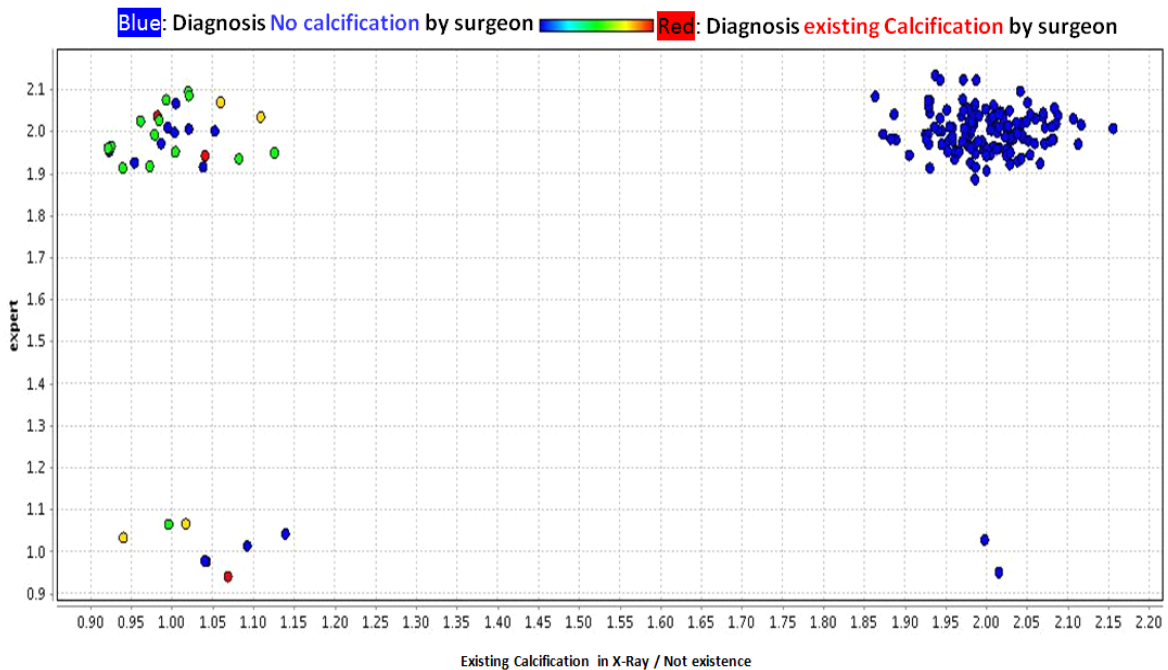


Fig. 4. Forearm arterial calcification in radiography and calcification cases reported by surgeons: the diagnosis errors in the northwest and southeast corners

focused on the extracted laws which explain more properties of this group of patients. As shown in Fig. 5, occurrence of atherosclerosis disease in diabetic patients has an adverse relation with controlled levels of their plasma levels of TG and Phosphorus. The extracted rules from Fig. 5 are summarized in Table 3.

Discussion

Our analysis on the role of hyperphosphatemia in atherosclerosis shows different results from some previous studies, which reported hyperphosphatemia as a risk factor for

atherosclerosis. In the present study we found an inverse effect of plasma levels of TG on atherosclerotic involvement of radial and ulnar arteries in diabetic patients, and therefore our results support this suspicion that hypertriglyceridemia plays a significant role in developing atherosclerosis. Also, the present study shows that the prevalence of radial and ulnar arteries calcification in patients with 9.5-21 years' history of diabetes mellitus who have ESRD and normal level of Triglyceride (TG) is lower when plasma level of phosphorus is higher than 6 mg/dL.

Since atherosclerosis is the major underlying cause of

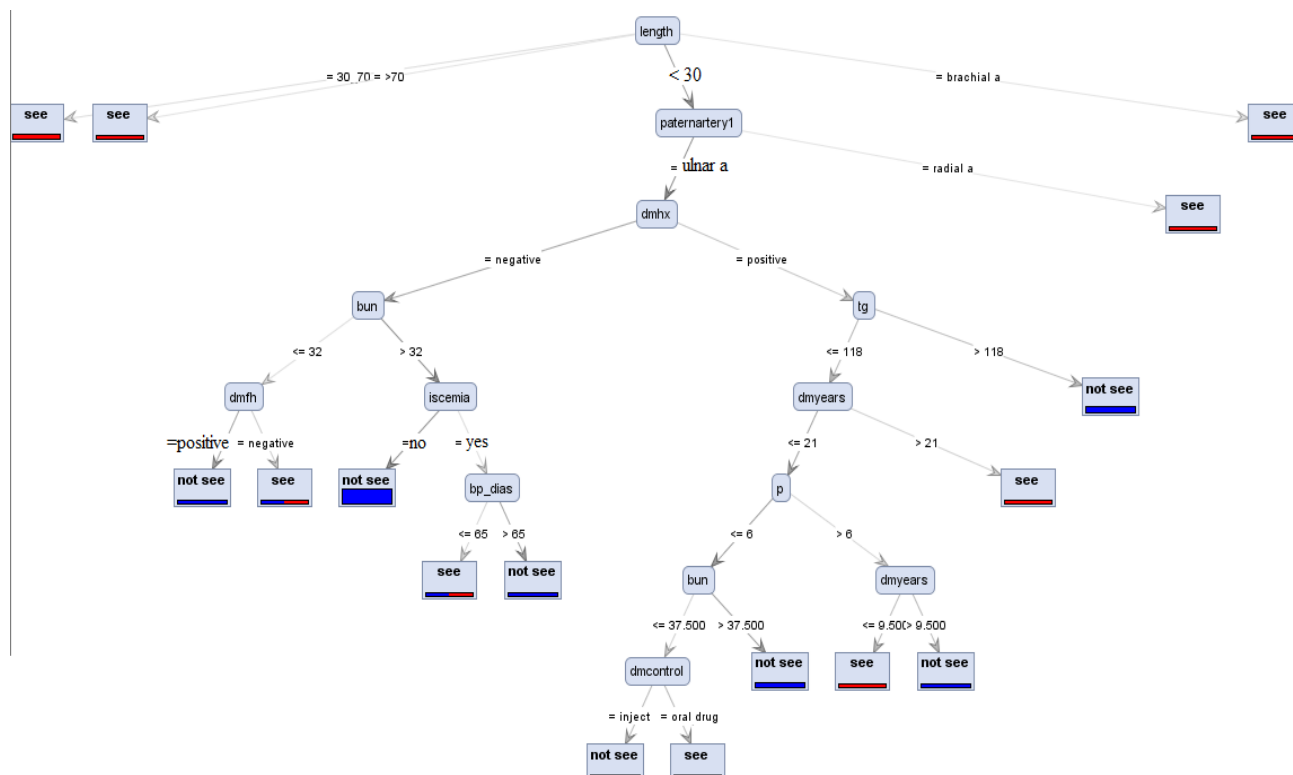


Fig. 5. In diabetic patients, atherosclerosis is not seen when their Triglyceride or Phosphorus is high

Table 3. The extracted rules on patients with diabetes history (dmhx=positive) from Figure 5

Rule I: When these patients have Triglyceride more than 118 (in figure 5: Triglyceride (TG) >118), then they do not have Arterial Calcification.

Rule II: If Triglyceride was equal or less than 118 (TG ≤118), then diabetic patients with 21 years or more (dmyears>21) have Atherosclerosis Disease.

Rule III: If (TG ≤ 118) and (9.5 < dmyears ≤ 21) then for (Phosphorus>6) diabetic patients do not have Arterial Calcification.

mortality in the world (1), reduction and treatment of risk factors for atherosclerosis are the most effective ways to prevent cardiovascular diseases (CVD) (34) and it is essential to find the risk factors and to treat them effectively before they cause an obvious CVD. In this study, we try to find and interpret the correlations between these different risk factors.

Our analysis on diabetic patients with ESRD who were candidates for AVF creation, shows an inverse effect of the role of high plasma levels of TG and phosphorous in the development of atherosclerosis. Although many studies showed that hypertriglyceridemia plays a promoting role in the development of atherosclerotic plaques (9-11), the outcome of our study differs from some of these studies.

Talayero et al. reported that hypertriglyceridemia is a risk factor for CVD and TG level is considered to be a biomarker of CVD risk given its association with atherogenic lipoproteins (35). Hotta et al. investigated the relation between hypertriglyceridemia and serum adipocyte-derived proteins and showed that hypertriglyceridemia plays an important role in the development of atherosclerosis and it causes abnormalities in plasma level of some adipocyte-derived proteins (36).

On the other hand, the role of TG in triggering the atherosclerotic lesions is still controversial (37). Some studies

obtained contradictory evidence for the role of hypertriglyceridemia in promoting atherosclerotic lesions and its related vascular calcification.

For instance, Freitas et al. studied on healthy individuals who were 80 or over 80 years of age and have shown that there is no relation between TG and coronary calcium score (CCS) (38). Also, Kannel et al. in a study on lipid-induced coronary heart disease (CHD) reported that hypertriglyceridemia is not an independent risk factor for CHD (39). Moreover, despite Talayero et al. reported hypertriglyceridemia as an important risk factor for CVD, they found no evidence of any correlation between lowering TG level and reduced CVD risk (8).

Since TG is not water-soluble, it bounds to a lipoprotein to be transported in the blood in its lipoprotein-bound form. In many cases, hypertriglyceridemia is accompanied by high plasma levels of chylomicron and very low-density lipoprotein (VLDL). Chylomicron is metabolized and the remaining products of this metabolism play a role in developing of atherosclerosis (37, 40). Due to the small size of these remaining products they can simply infiltrate into sub-endothelial space and cause atherosclerotic lesions (41, 42).

Apart from this contradictory evidence, Qin et al. reported a significant correlation of traditional risk factors for carotid atherosclerosis with gender and age. According to

this study, the cut points and risk factors must be described based on specific sex and age categories. They also found that optimal range of fasting blood glucose as well as total cholesterol should be adjusted not only based on known optimal levels but also based on gender, age (34). As we found that the plasma level of TG is higher in diabetic patients with ESRD with less radial and ulnar arteries calcification, the result of our study supports the above-mentioned study.

Moreover, another risk factor for coronary artery atherosclerosis is serum phosphorous level. (43). A study by Foley et al. shows that higher level of blood phosphorus, even in the normal range, might be a risk factor for coronary artery atherosclerosis not only in patients with advanced chronic kidney disease (CKD), but also in healthy individuals (43).

Since the outcome of our study differs from some of the previous studies, further research should be performed to observe the effect of hypertriglyceridemia and hyperphosphatemia on the incidence of atherosclerosis and vascular calcification in patients with other risk factors for vascular diseases.

Conclusion

As we have found an inverse effect on ESRD patients who were smoking (44) and an adverse effect in hypertensive patients on AVF failure (45), in the present study we found an inverse effect in diabetic patients with ESRD. The detected inverse effect is about triglyceride and phosphorus plasma levels on the atherosclerotic involvement of radial and ulnar arteries. We observed that the prevalence of radial and ulnar arteries calcification in diabetic patients who simultaneously suffer from renal failure is lower when they have higher plasma levels of TG and phosphorous. Finally, we recommend using data mining approaches to reveal unknown, useful and novel relations between medical variables.

Conflict of Interests

The authors declare that they have no competing interests.

References

1. US Renal Data System. USRDS 2011 annual data report: Atlas of chronic kidney disease and end-stage renal disease in the United States. USRDS, Bethesda, 2011.
2. Rose DA, Sonaike E, Hughes K. Hemodialysis access. *Surg Clin North Am.* 2013 Aug 31;93(4):997-1012.
3. Khavanin Zadeh M., Rezapour M., Khavanin Zadeh M, Balin Parast M, Rezapour H, The Relationship between Risk Factors of Hemodialysis Patients and Arterio Venus Fistula Maturation at Hasheminezhad Hospital. *Iran J Surg.* 2015; 22(4):11. Available at: http://www.ijss.ir/library/upload/article/af_44473325%20Hemodialysis-Dr.Khavaninzadeh%201830.pdf
4. Aghighi M, Heidary Rouchi A, Zamyadi M, Mahdavi-Mazdeh M, Rajolani H, et al. Dialysis in Iran. *Iran J Kidney Dis.* 2008 Jan;2(1):11-5.
5. Najafi I, Hakemi M, Safari S, Atabak S, Sanadgol H, Nouri-Majalan N, et al. The story of continuous ambulatory peritoneal dialysis in Iran. *Perit Dial Int.* 2010 Jul 1;30(4):430-433.
6. Haghghi AN, Broumand B, D'Amico M, Locatelli F, Ritz E. The epidemiology of end-stage renal disease in Iran in an international perspective. *Nephrol Dial Transplant.* 2002 Jan 1;17(1):28-32.
7. Mahdavi-Mazdeh M, Zamyadi M, Nafar M. Assessment of management and treatment responses in haemodialysis patients from Tehran province, Iran. *Nephrol Dial Transplant.* 2008 Jan 1;23(1):288-293.

8. USRDS, (2014). "Chapter 10: International Comparisons". USRDS Annual Data Report, Volume 2 – ESRD. Available from: http://www.usrds.org/2014/download/V2_Ch_10_International_14.pdf.
9. Kutkut I, Meens MJ, McKee TA, Bochaton-Piallat ML, Kwak BR. Lymphatic vessels: an emerging actor in atherosclerotic plaque development. *Eur J Clin Invest.* 2015 Jan 1;45(1):100-108.
10. Miller DT, Ridker PM, Libby P, Kwiatkowski DJ. Atherosclerosis: the path from genomics to therapeutics. *J Am Coll Cardiol.* 2007 Apr 17;49(15):1589-1599.
11. Kucharska E. [Arteriosclerosis--selected aspects]. *Przegląd lekarski.* 2013 Dec;71(7):400-402.
12. Naghavi M, Libby P, Falk E, Casscells SW, Litovsky S, Rumberger J, et al. From vulnerable plaque to vulnerable patient a call for new definitions and risk assessment strategies: part I. *Circulation.* 2003 Oct 7;108(14):1664-1672.
13. Naghavi M, Libby P, Falk E, Casscells SW, Litovsky S, Rumberger J, et al. From vulnerable plaque to vulnerable patient a call for new definitions and risk assessment strategies: Part II. *Circulation.* 2003 Oct 14;108(15):1772-1778.
14. Grundy SM, Cleeman JI, Merz CN, Brewer HB, Clark LT, Hunninghake DB, et al. Implications of recent clinical trials for the national cholesterol education program adult treatment panel III guidelines. *J. Am. Coll. Cardiol.* 2004 Aug 4;44(3):720-732.
15. Grundy S, Becker D, Clark LT, Cooper RS, Denke MA, Howard J, et al. Detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III). *Circulation-Hagerstown.* 2002 Sep;106(25):3143.
16. Lloyd-Jones D, Adams R, Carnethon M, De Simone G, Ferguson TB, Flegal K, et al. Heart disease and stroke statistics—2009 update a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation.* 2009 Jan 27;119(3):e21-181.
17. Tamiya E, Hada Y, Ando T, Murota Y, Ito N, Sugishita K, Shimizu T, Asano KI. Thoracic aortic calcification measured by X-ray computed tomography vs age and risk factors of arteriosclerosis. *Int J Angiol.* 1997 Dec 1;6(1):1-4.
18. Schlieper G, Krüger T, Djuric Z, Damjanovic T, Markovic N, Schurgers LJ, et al. Vascular access calcification predicts mortality in hemodialysis patients. *Kidney Int.* 2008 Dec 2;74(12):1582-1587.
19. Croke M. New Zealand cardiovascular guidelines: best practice evidence-based guideline: the assessment and management of cardiovascular risk December 2003. *Clin Biochem Rev.* 2007 Feb;28(1):19.
20. Rundek T, Blanton SH, Bartels S, Dong C, Raval A, Demmer RT, et al. Traditional risk factors are not major contributors to the variance in carotid intima-media thickness. *Stroke.* 2013 Aug 1;44(8):2101-2108.
21. Takahashi R, Taguchi N, Suzuki M, Cheng XW, Numaguchi Y, Tsukamoto H, et al. Cholesterol and triglyceride concentrations in lipoproteins as related to carotid intima-media thickness. *Int Heart J.* 2012;53(1):29-34.
22. Khalil A, Huffman MD, Prabhakaran D, Osmond C, Fall CH, Tandon N, et al. Predictors of carotid intima-media thickness and carotid plaque in young Indian adults: The New Delhi Birth Cohort. *Int J Cardiol.* 2013 Aug 20;167(4):1322-1328.
23. Amer MS, Khater MS, Omar OH, Mabrouk RA, Mostafa SA. Association between Framingham risk score and subclinical atherosclerosis among elderly with both type 2 diabetes mellitus and healthy subjects. *Am J Cardiovasc Dis.* 2014 Jan 1;4(1):14-19.
24. Back MR, Bandyk DF. Current status of surveillance of hemodialysis access grafts. *Ann Vasc Surg.* 2001 Jul 31;15(4):491-502.
25. Ahmed S, Raman SP, Fishman EK. Three-dimensional MDCT angiography for the assessment of arteriovenous grafts and fistulas in hemodialysis access. *Diagn Interv Radiol.* 2016 Jan 19.
26. Ramos-Miguel A, Perez-Zaballos T, Perez D, Falconb JC, Ramosb A. Use of data mining to predict significant factors and benefits of bilateral cochlear implantation. *Eur Arch Otorhinolaryngol.* 2015 Nov 1;272(11):3157-3162.
27. Bala S, Kumar K. A Literature Review on Kidney Disease Prediction using Data Mining Classification Technique. *Int J Comput Sci Mob Comp (IJCSMC).* 2014 Jul;3(7):960-967.
28. Koh HC, Tan G. Data mining applications in healthcare. *J Healthc Inf Manag.* 2011 Jan;19(2):65.
29. Rezapour M, Khavaninzadeh M. Association between non-matured arterio-venus fistula and blood pressure in hemodialysis patients. *Med J Islam Repub Iran.* 2014; 28:144. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25695002>

30. Rezapour M, Khavanin Zadeh M, Sepehri MM. Implementation of predictive data mining techniques for identifying risk factors of early AVF failure in hemodialysis patients. *Comput Math Methods Med.* 2013 Jun 4;2013. Available at: <http://dx.doi.org/10.1155/2013/830745>
31. Rezapour M, Taran S, Balin Parast M, Khavanin Zadeh M. The impact of vascular diameter ratio on hemodialysis maturation time: Evidence from data mining approaches and thermo-dynamics law. *Med J Islam Repub Iran* 2016 (19 April). Vol. 30:359.
32. Sepehri MM, Khavaninzadeh M, Rezapour M, Teimourpour B. A data mining approach to fistula surgery failure analysis in hemodialysis patients. In 2011 18th Iranian Conference of Biomedical Engineering (IC-BME) 2011 Dec.
33. Rezapour M, et al. "Forecasting Surgical Outcomes Using a Fuzzy-Based Decision System". *Int. J. Hosp. Res. (IJHR)*. 2017; Accepted, Under Publishing.
34. Qin G, Luo L, Lv L, Xiao Y, Tu J, Tao L, et al. Decision tree analysis of traditional risk factors of carotid atherosclerosis and a cutpoint-based prevention strategy. *PLoS one.* 2014 Nov 14;9(11): e111769.
35. Talayero BG, Sacks FM. The role of triglycerides in atherosclerosis. *Current cardiology reports.* 2011 Dec 1;13(6):544-552.
36. Hotta K, Funahashi T, Arita Y, Takahashi M, Matsuda M, Okamoto Y, et al. Plasma concentrations of a novel, adipose-specific protein, adiponectin, in type 2 diabetic patients. *Arterioscler Thromb Vasc Biol.* 2000 Jun 1;20(6):1595-1599.
37. Matsumoto S, Gotoh N, Hishinuma S, Abe Y, Shimizu Y, Katano Y, et al. The role of hypertriglyceridemia in the development of atherosclerosis and endothelial dysfunction. *Nutrients.* 2014 Mar 24;6(3):1236-1250.
38. Freitas WM, Quaglia LA, Santos SN, de Paula RC, Santos RD, Blaha M, et al. Low HDL cholesterol but not high LDL cholesterol is independently associated with subclinical coronary atherosclerosis in healthy octogenarians. *Aging Clin Exp Res.* 2015 Feb 1;27(1):61-7.
39. Kannel WB. Lipids, diabetes, and coronary heart disease: insights from the Framingham Study. *Am Heart J.* 1985 Nov 30;110(5):1100-1107.
40. Zilversmit DB. A proposal linking atherogenesis to the interaction of endothelial lipoprotein lipase with triglyceride-rich lipoproteins. *Circ Res.* 1973 Dec 1;33(6):633-638.
41. Alipour A, Elte JW, van Zaanen HC, Rietveld AP, Cabezas MC. Postprandial inflammation and endothelial dysfunction. *Biochem Soc Trans.* 2007 Jun 1;35(3):466-469.
42. Tomkin GH, Owens D. The chylomicron: relationship to atherosclerosis. *Int J Vasc Med.* 2011 Oct 5; 2012.
43. Foley RN, Collins AJ, Herzog CA, Ishani A, Kalra PA. Serum Phosphorus Levels Associate with Coronary Atherosclerosis in Young Adults. *J Am Soc Nephrol (JASN).* 2009;20(2):397-404.
44. Khavanin Zadeh M, Rezapour M, Sepehri MM. Data mining performance in identifying the Risk Factors of early arteriovenous fistula failure in Hemodialysis Patients. *Int. J. Hosp. Res.* 2013 Mar 1;2(1):49-54. Is available at: <http://ijhr.iums.ac.ir/index.php/ijhr/article/view/52/116>
45. Rezapour M, Sepehri M.M, Khavanin Zadeh M and Alborzi M. Data Mining Application for Detect Impacts of Infection and Hypertension on Vascular Surgery Complications. 2th Int Conf on Knowledge-Based Research in Computer Engine. 2017; 2(1):9.