News

Heart disease is more common in late sleepers, and it is largely avoidable.



Cardiovascular risk may be increased in those who stay up late. Better sleep, smoking cessation, and metabolic control, however, may counteract much of that risk, according to this extensive UK study.

Cardiovascular health may be determined by circadian rhythms.
Globally, cardiovascular disease (CVD) continues to be the major cause of death. Even while there are ways to lower the risk of CVD by changing lifestyle factors including diet, exercise, and nicotine use, the American Heart Association (AHA) has released guidelines that stress how important sleep duration is for preserving good cardiovascular health.

The timing of a person's sleep and wakefulness can determine their chronotype; certain circadian rhythms are linked to an increased risk of cardiometabolic disease. Adults with an evening chronotype, for instance, are more likely than those with an intermediate chronotype to suffer from circadian disruption.

The development of unhealthy lifestyle choices including smoking, drinking alcohol, and eating poorly have all been linked to circadian misalignment, which can have a detrimental effect on behavior and reward-related brain functions. Numerous physiological impacts, such as increased nervous system activation, dysregulation of blood pressure, glucose, and lipid profiles, and altered hypothalamic-pituitary-adrenal (HPA) axis activity, are also brought on by chronic disruption of normal circadian cycles.

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Chronology of the UK Biobank data connection, LE8, and CVD

The data utilized in this investigation came from participants in the UK Biobank who were between the ages of 39 and 74 and had no past history of myocardial infarction or stroke. A single question was used to self-report chronotype, while the Life's Essential 8 (LE8) score was used to evaluate cardiovascular health.

The relationship between chronotype and CVD risk over time was assessed using Cox proportional hazards models. Numerous occupational, familial, and sociodemographic risk factors were taken into account when adjusting these estimates.

Evening chronotypes exhibit increased lifestyle risk for CVD.

Participants in the study were tracked for a median of 13.8 years, during which time 17,584 new CVD events—defined as myocardial infarction or stroke with first onset—were recorded, including 11,091 heart attacks and 7,214 strokes. The median LE8 scores for men and women were 65 and 70, respectively, while the mean score was 67. Seven percent of the survey participants reported having unfavorable scores of less than fifty.

Eight percent of study participants had a "definitely evening" chronotype, while roughly 67% indicated an intermediate chronotype. Those with a "definitely evening" chronotype were more likely to be younger, less affluent, educated, and shift workers than those with an intermediate chronotype.

Participants with a "definitely evening" chronotype had a mean LE8 score of 65, while those

with an intermediate chronotype had a mean score of 68. Participants with the "definitely evening" chronotype were about 79% more likely than those with the "intermediate" chronotype to have poor LE8 scores, and those with the "definitely morning" chronotype were about 5% less likely to have low LE8 scores.

With the "definitely evening" chronotype, poor LE8 scores were more prevalent in six of the eight LE8 components. Blood pressure and blood lipids were the outliers to these findings, while nicotine use and sleep deprivation were most strongly associated with low LE8 scores.

bad sleep was almost 30% more common among research participants with the "definitely morning" chronotype, but bad eating was less prevalent. While the prevalence of low LE8 scores among men was almost 67% higher, women with the "definitely evening" chronotype were nearly twice as likely (96%) to have low LE8 scores.

Participants with the evening chronotype had a 16% higher risk of CVD, with relationships that were suggestively stronger but not statistically significant being shown among men, older people, non-shift workers, and those with low LE8 scores. There was no indication that cardiovascular hereditary risk altered the effect.

Approximately 75% of the correlation between chronotype and CVD was explained by the LE8 score's inherent indirect influence. At 34% of the association, nicotine use mediated the highest risk, while blood glucose, body weight, sleep, and food each contributed 11%–14% to the risk of CVD.

Extended follow-up enhances results but restricts claims of causation.
This study is the first to explore the role of LE8 in mediating chronotype-incident CVD associations. Its long follow-up time, inclusion of several health behaviors, and prospective design—which supports temporal ordering but does not prove causation—are further strengths.

Multiple sensitivity analyses were conducted to guarantee the robustness of any observations, and the high sample size increased statistical power while lowering random error.

The use of a single chronotype inquiry, which may lead to misclassification, is one of the notable shortcomings. However, there was a high correlation between the answers to this question and validated scores.

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The single-point chronotype and LE8 score evaluations reduce confidence in the temporal sequence of mediators and result by limiting the degree to which chronotype precedes cardiovascular health behaviors. Furthermore, the U.K. Biobank cohort's largely healthy and White demographic restricts how broadly these results may be applied.

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