



Giornata formativa in collaborazione con ISDE FVG

**“ALIMENTAZIONE, AMBIENTE E CORRETTI STILI DI VITA: LA PREVENZIONE
INDIFFERIBILE”**

Sabato 30 settembre 2023 (dalle 9.00 alle 13.00)

Palazzo Belgrado – Salone del Parlamento - Piazza Patriarcato 3 Udine

**Mangiare bene, la salute inizia
a tavola.**

Cosa devono sapere il Medico e l'Odontoiatra?

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Esperta dell'Autorità Europea per la
Sicurezza Alimentare 2020-2024

Responsabile del Gruppo di
ricerca Nutrizione Molecolare

- Effetti farmacologici di polifenoli alimentari, in particolare i pigmenti del vino rosso.
- Bilirubina: chimica, farmacologia, fisio-patologia, biomarcatori di stili di vita

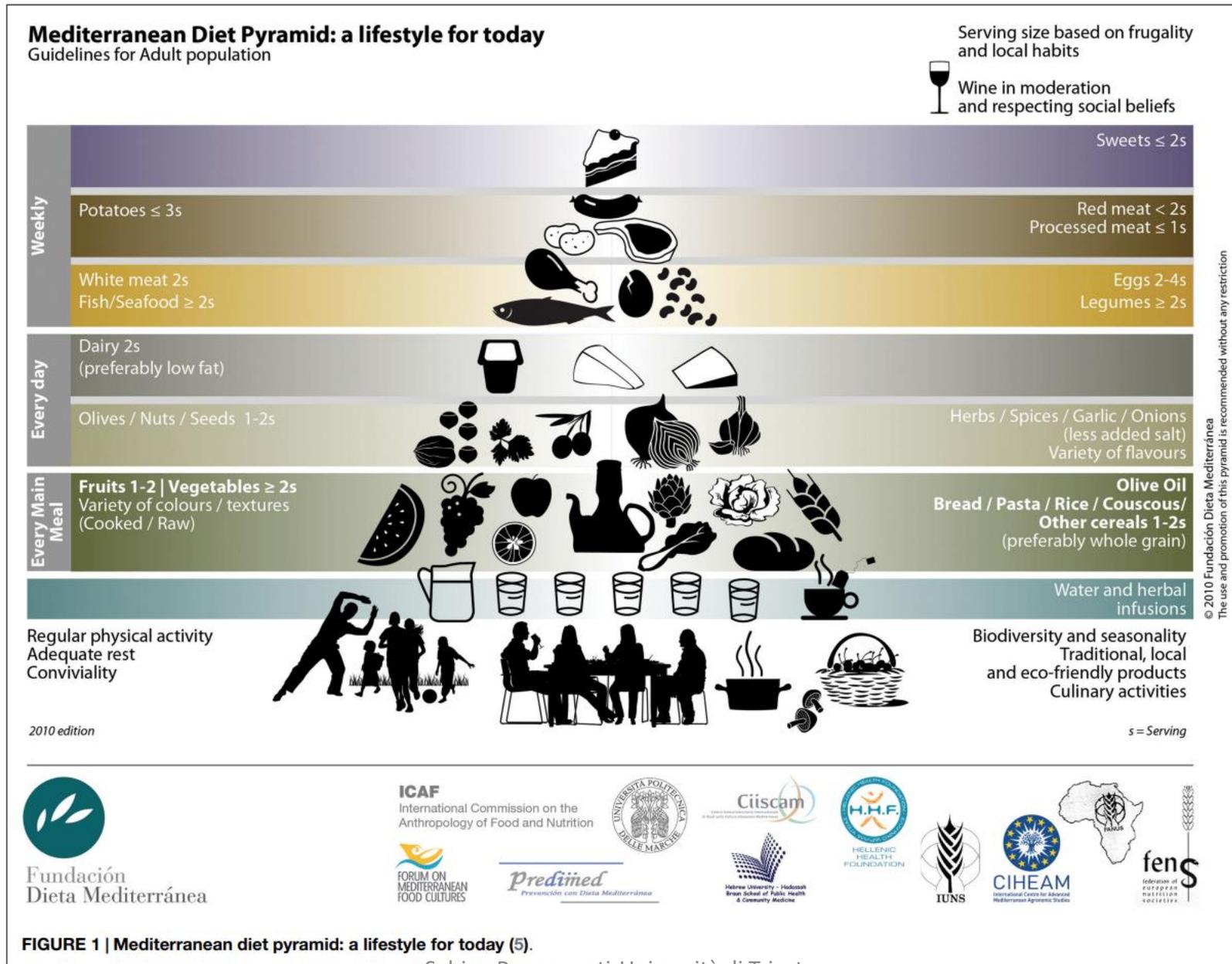


FIGURE 1 | Mediterranean diet pyramid: a lifestyle for today (5).

La dieta mediterranea – patrimonio immateriale dell’Umanità UNESCO



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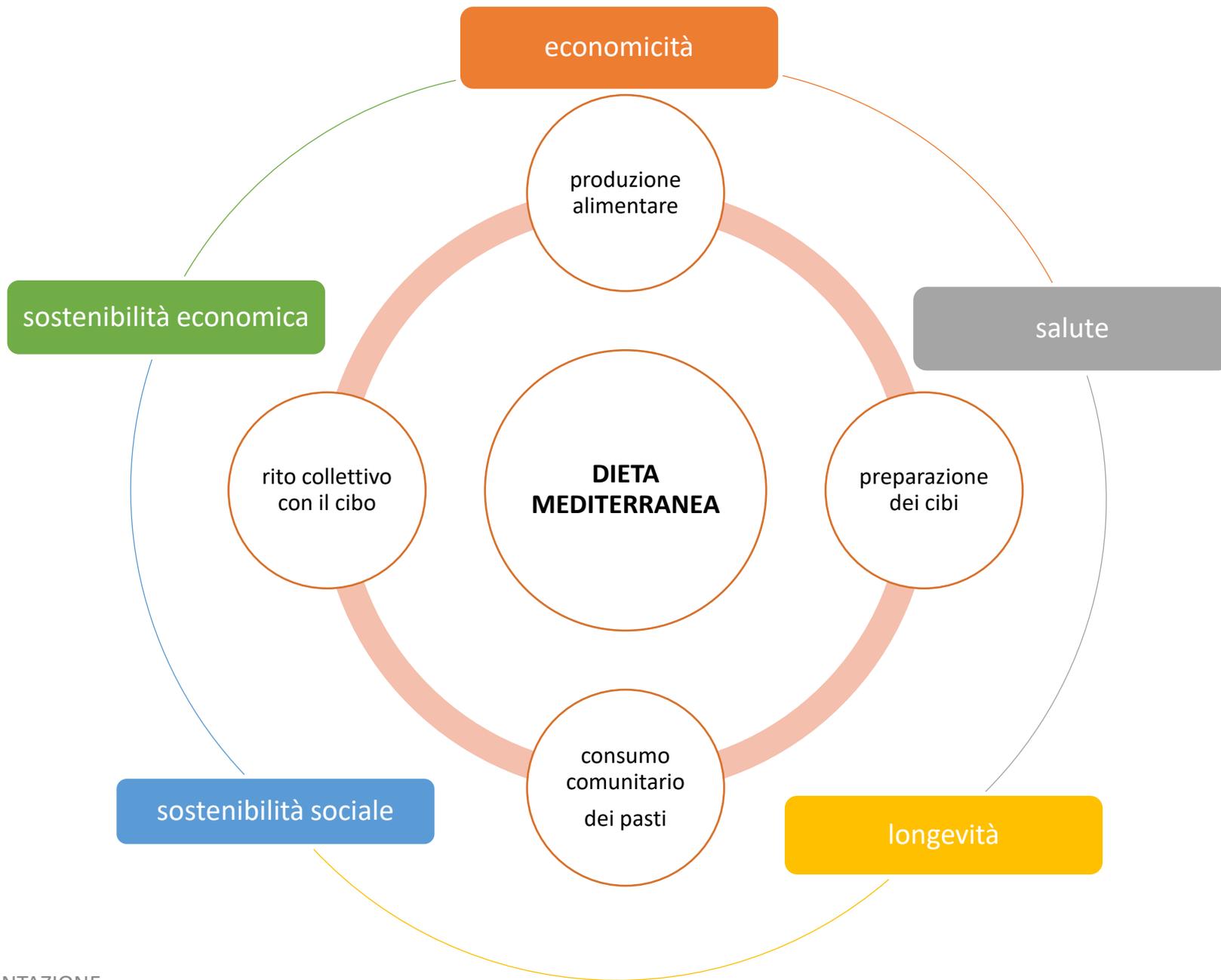
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[CONTATTI](#)





Temi

1. Quali sono i limiti della dieta mediterranea?
 - può portare all'aumento della massa corporea
2. Perché fa bene mangiare frutta e verdura in abbondanza?
 - si sa ancora poco, ma i numeri confermano che quest'abitudine ci protegge
3. Il consumo di vino nella dieta mediterranea
 - buone notizie

La dieta mediterranea non garantisce salute se si mangia troppo

La percentuale di donne obese è maggiore nell'area mediterranea che nella media mondiale

e cresce più che in altre aree

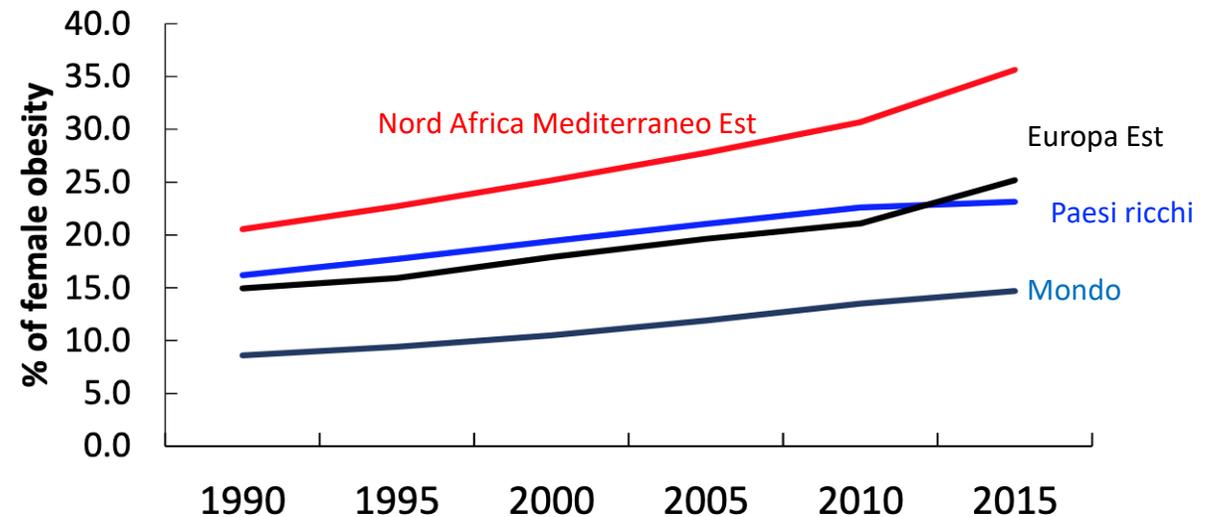


Figure 2. Percent of female obesity (BMI >30 kg/m²) in Mediterranean country groups, 1990–2015, compared to world trends. Key (from top to bottom): Red line North African and Eastern Mediterranean countries; Blue line High Income countries; Black line Eastern Europe LMIC; Grey line World. (Source reference 16 from WHO data).

The ranges for GNI in 2015 according to the county groups were as follows: high-income countries from 0.724 (Italy) to 0.576 (Croatia); for the European LMIC, from 0.613 (Bosnia and Herzegovina) to (Turkey) (0.466). For North Africa and East Mediterranean LMIC, the indices ranged from 0.531 (Tunisia) to 0.377 (Egypt). The purpose of GNI is not to “name and shame”, but, rather, to learn from other similar countries how to improve the situation. In summary, since 1995 the triple burden of malnutrition has shown a shrinking hungry, and expanding fat world. In the Mediterranean Countries, the GNI has in fact decreased, except for European LMIC. The plea is to return to traditional Mediterranean lifestyle choices of frugality and moderation at meal times.

La massa corporea è un indicatore predittivo molto affidabile di mortalità da varie cause

Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies



Prospective Studies Collaboration*

Summary

Background The main associations of body-mass index (BMI) with overall and cause-specific mortality can best be assessed by long-term prospective follow-up of large numbers of people. The Prospective Studies Collaboration aimed to investigate these associations by sharing data from many studies.

Methods Collaborative analyses were undertaken of baseline BMI versus mortality in 57 prospective studies with 894 576 participants, mostly in western Europe and North America (61% [n=541 452] male, mean recruitment age 46 [SD 11] years, median recruitment year 1979 [IQR 1975–85], mean BMI 25 [SD 4] kg/m²). The analyses were adjusted for age, sex, smoking status, and study. To limit reverse causality, the first 5 years of follow-up were excluded, leaving 66 552 deaths of known cause during a mean of 8 (SD 6) further years of follow-up (mean age at death 67 [SD 10] years): 30 416 vascular; 2070 diabetic, renal or hepatic; 22 592 neoplastic; 3770 respiratory; 7704 other.

Findings In both sexes, mortality was lowest at about 22·5–25 kg/m². Above this range, positive associations were recorded for several specific causes and inverse associations for none, the absolute excess risks for higher BMI and smoking were roughly additive, and each 5 kg/m² higher BMI was on average associated with about 30% higher overall mortality (hazard ratio per 5 kg/m² [HR] 1·29 [95% CI 1·27–1·32]): 40% for vascular mortality (HR 1·41 [1·37–1·45]); 60–120% for diabetic, renal, and hepatic mortality (HRs 2·16 [1·89–2·46], 1·59 [1·27–1·99], and 1·82 [1·59–2·09], respectively); 10% for neoplastic mortality (HR 1·10 [1·06–1·15]); and 20% for respiratory and for all other mortality (HRs 1·20 [1·07–1·34] and 1·20 [1·16–1·25], respectively). Below the range 22·5–25 kg/m², BMI was associated inversely with overall mortality, mainly because of strong inverse associations with respiratory disease and lung cancer. These inverse associations were much stronger for smokers than for non-smokers, despite cigarette consumption per smoker varying little with BMI.

Interpretation Although other anthropometric measures (eg, waist circumference, waist-to-hip ratio) could well add extra information to BMI, and BMI to them, BMI is in itself a strong predictor of overall mortality both above and below the apparent optimum of about 22·5–25 kg/m². The progressive excess mortality above this range is due mainly to vascular disease and is probably largely causal. At 30–35 kg/m², median survival is reduced by 2–4 years; at 40–45 kg/m², it is reduced by 8–10 years (which is comparable with the effects of smoking). The definite excess mortality below 22·5 kg/m² is due mainly to smoking-related diseases, and is not fully explained.

Funding UK Medical Research Council, British Heart Foundation, Cancer Research UK, EU BIOMED programme, US National Institute on Aging, and Clinical Trial Service Unit (Oxford, UK).

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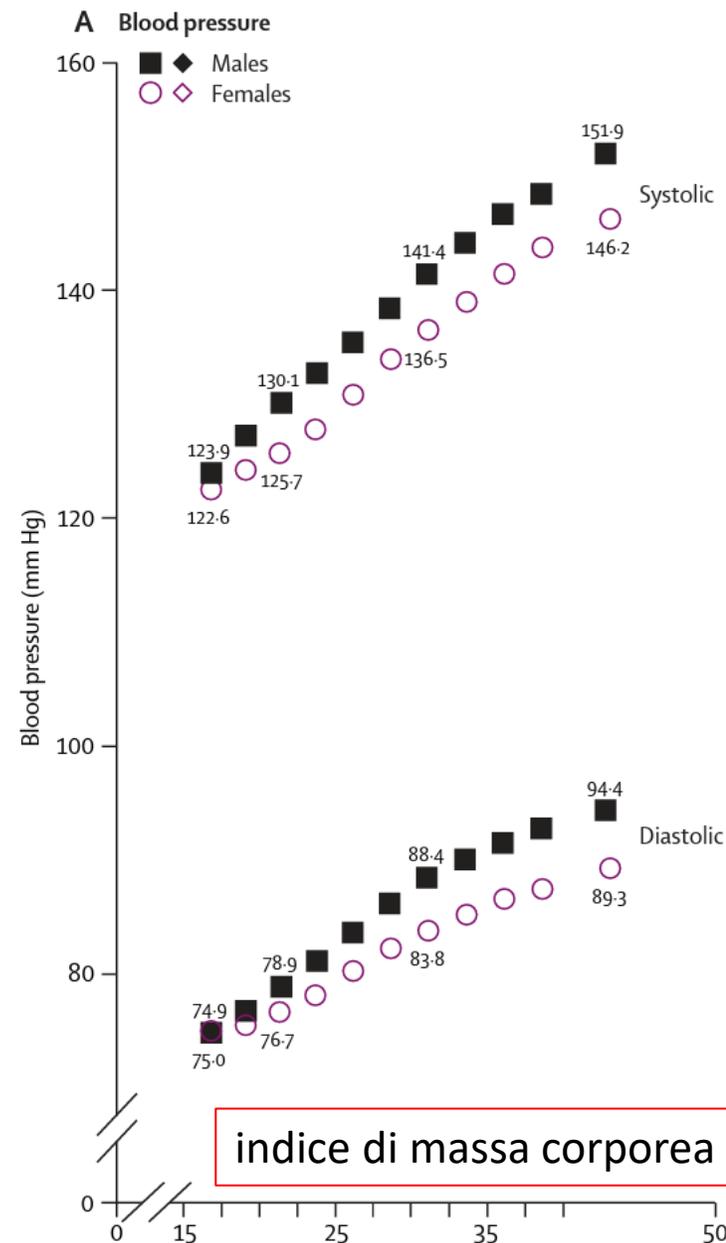
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La pressione arteriosa cresce linearmente con l'aumento della massa corporea

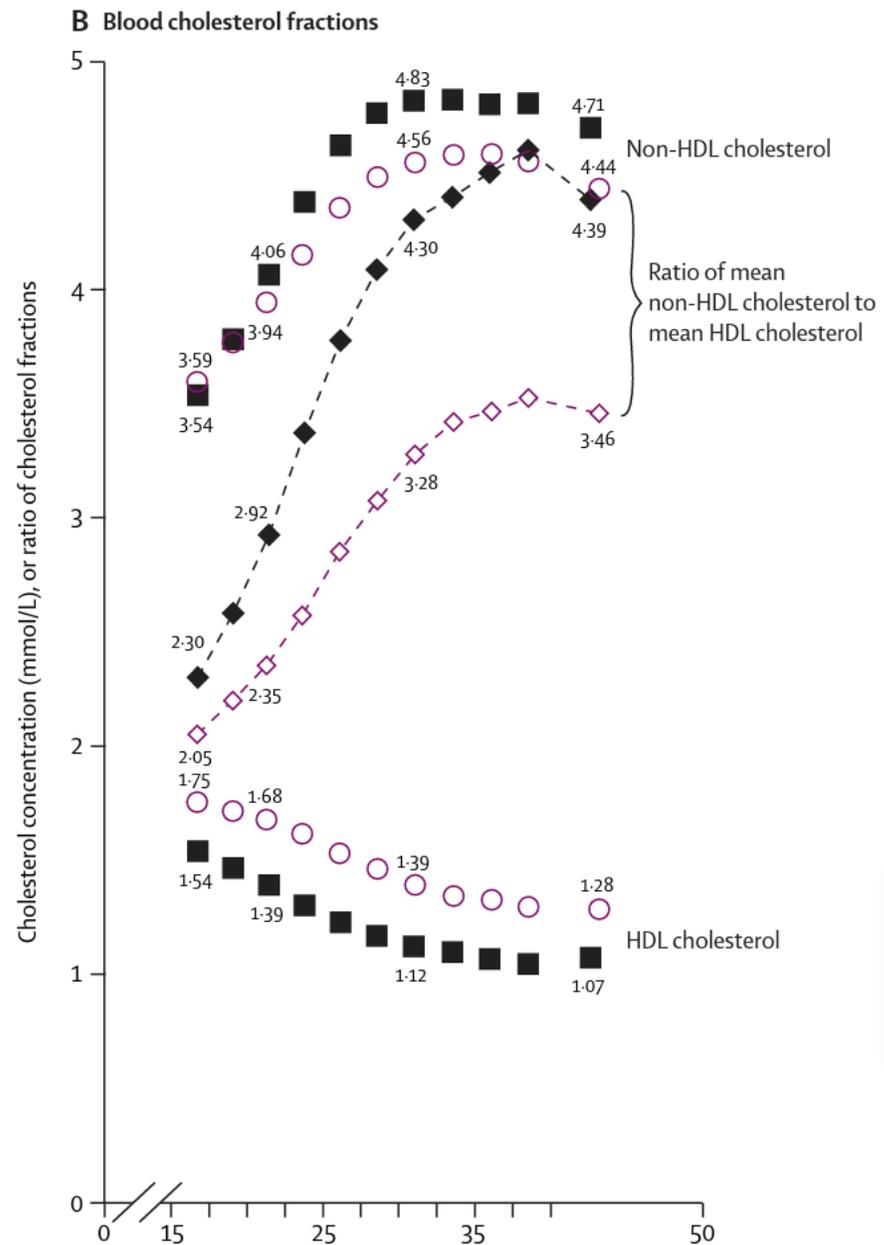
Ideal BMI = 22.5 – 25 kg/m²

«each 5 kg/m² higher BMI was on average associated with about 30% higher overall mortality»



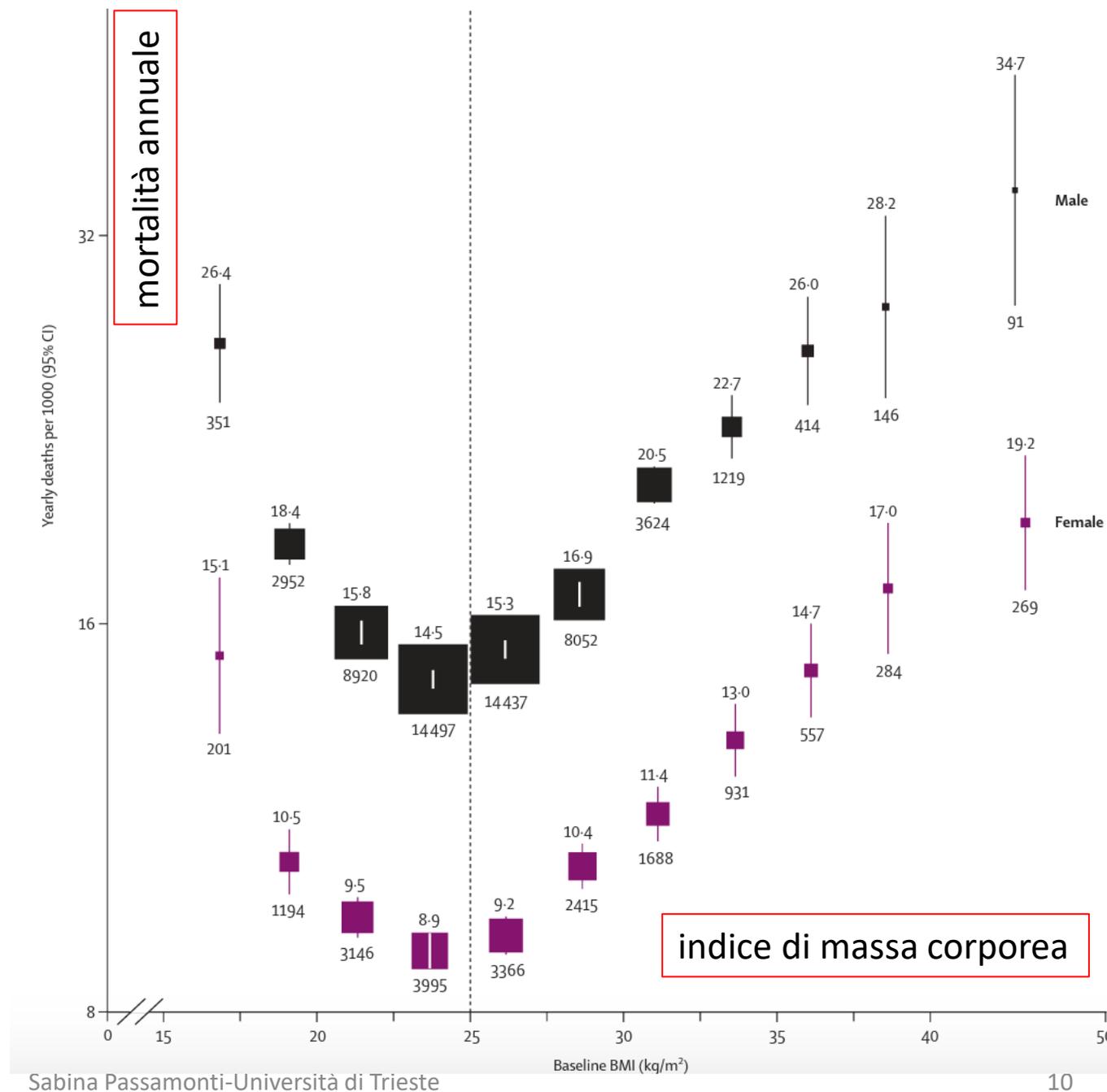
Il colesterolo non-HDL cresce moderatamente con l'aumento della massa corporea, ma il colesterolo HDL cala con l'aumento della massa corporea

Il rapporto non-HDL/HDL dipende fortemente da piccoli incrementi di massa corporea, soprattutto nei maschi



Il tasso di mortalità cresce linearmente con l'aumento della massa corporea

al sopra del valore ottimale (25 kg/m²)



Un indice di massa corporea più elevato è associato a un rischio maggiore di sviluppare il diabete di tipo 2.

- 216 cohort studies
- 2.3 million individuals with type 2 diabetes
- 26 million participants



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Anthropometric and adiposity indicators and risk of type 2 diabetes: systematic review and dose-response meta-analysis of cohort studies

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ABSTRACT

OBJECTIVE

To present a comprehensive review of the association between measures of body weight, waist, and fat, and different ratios of these measures, and the risk of type 2 diabetes.

DESIGN

Systematic review and dose-response meta-analysis of cohort studies.

DATA SOURCES

PubMed, Scopus, and Web of Science up to 1 May 2021.

REVIEW METHODS

Cohort studies looking at the association between general or central adiposity and body fat content and the risk of type 2 diabetes in the general adult population were included. Two of the authors extracted the data in duplicate. Random effects dose-response meta-analyses were performed to estimate the degree of the associations. Curvilinear associations were modelled with a one stage weighted mixed effects meta-analysis.

RESULTS

for a 10% higher percentage body fat, 1.09 (1.05 to 1.13, n=5) for an increase in body shape index of 0.005 units, 2.55 (1.59 to 4.10, n=4) for a 10% higher body adiposity index, and 1.11 (0.98 to 1.27; n=14) for a 10 cm larger hip circumference. A strong positive linear association was found between body mass index and the risk of type 2 diabetes. Positive linear or monotonic associations were also found in all regions and ethnicities, without marked deviation from linearity at a specific cut-off value. Indices of central fatness, independent of overall adiposity, also had positive linear or monotonic associations with the risk of type 2 diabetes. Positive linear or monotonic associations were also found for total and visceral fat mass, although the number of studies was small.

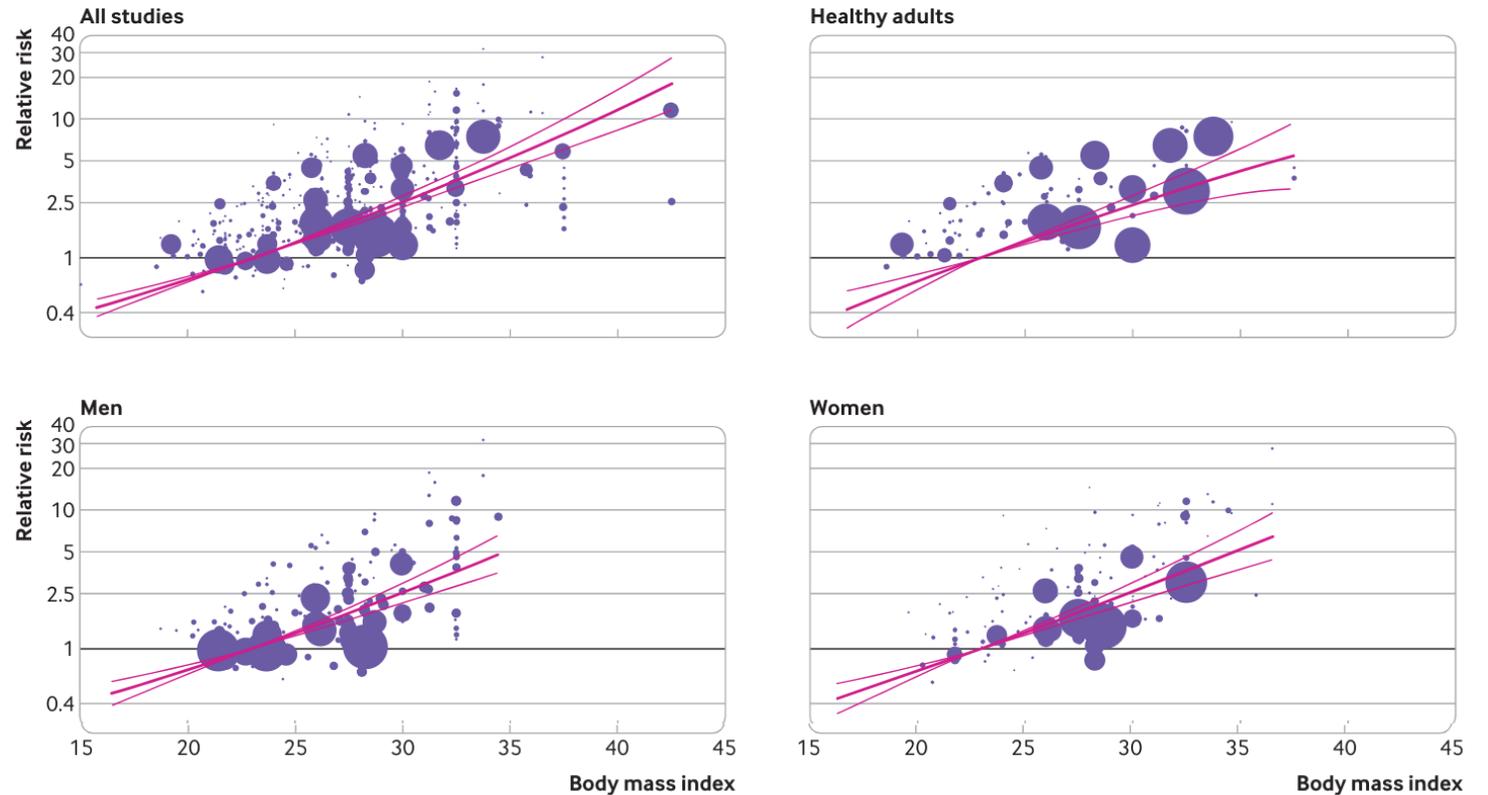
CONCLUSIONS

A higher body mass index was associated with a greater risk of developing type 2 diabetes. A larger waist circumference, independent of overall adiposity, was strongly and linearly associated with the risk of type 2 diabetes.

SYSTEMATIC REVIEW REGISTRATION
PROSPERO CRD42021255338.

Il rischio di diabete di tipo 2 cresce linearmente con la massa corporea

RESEARCH



Controllare la massa corporea

Usare l'indice di massa corporea per controllare il peso ideale

$$\text{IMC} = \text{peso (kg)} / \text{altezza (m)}^2$$

$$\text{IMC} = \text{kg} / \text{m} \times \text{m}$$

esempio: IMC = 60 / 1,60 x 1,60 = 23,43



CENTRO DI RICERCA ALIMENTI E NUTRIZIONE

Linee guida per una sana alimentazione



BILANCIA I NUTRIENTI E MANTIENI IL PESO

1. Controlla il peso e mantieniti sempre attivo pag. 21

PIÙ È MEGLIO

2. Più frutta e verdura pag. 39

3. Più cereali integrali e legumi pag. 51

4. Bevi ogni giorno acqua in abbondanza pag. 61

MENO È MEGLIO

5. Grassi: scegli quali e limita la quantità pag. 75

6. Zuccheri, dolci e bevande zuccherate: meno è meglio pag. 91

7. Il sale? Meno è meglio pag. 101

8. Bevande alcoliche: il meno possibile pag. 111

SCEGLI LA VARIETÀ, LA SICUREZZA E LA SOSTENIBILITÀ

9. Varia la tua alimentazione: come e perché pag. 125

10. Consigli speciali per... pag. 145

11. Attenti alle diete e all'uso degli integratori senza basi scientifiche pag. 183

12. La sicurezza degli alimenti dipende anche da te pag. 203

13. Sostenibilità delle diete: tutti possiamo contribuire pag. 223

Figura 1.1 – Schema per la valutazione dell'IMC negli adulti

		PESO Kg																												
		45	47,5	50	52,5	55	57,5	60	62,5	65	67,5	70	72,5	75	77,5	80	82,5	85	87,5	90	92,5	95	97,5	100	102,5	105	107,5	110	112,5	115
A L T E Z Z A m	1,98	11,5	12,1	12,8	13,4	14,0	14,7	15,3	15,9	16,6	17,2	17,9	18,5	19,1	19,8	20,4	21,0	21,7	22,3	23,0	23,6	24,2	24,9	25,5	26,1	26,8	27,4	28,1	28,7	29,3
	1,96	11,7	12,4	13,0	13,7	14,3	15,0	15,6	16,3	16,9	17,6	18,2	18,9	19,5	20,2	20,8	21,5	22,1	22,8	23,4	24,1	24,7	25,4	26,0	26,7	27,3	28,0	28,6	29,3	29,9
	1,94	12,0	12,6	13,3	13,9	14,6	15,3	15,9	16,6	17,3	17,9	18,6	19,3	19,9	20,6	21,3	21,9	22,6	23,2	23,9	24,6	25,2	25,9	26,6	27,2	27,9	28,6	29,2	29,9	30,6
	1,92	12,2	12,9	13,6	14,2	14,9	15,6	16,3	17,0	17,6	18,3	19,0	19,7	20,3	21,0	21,7	22,4	23,1	23,7	24,4	25,1	25,8	26,4	27,1	27,8	28,5	29,2	29,8	30,5	31,2
	1,90	12,5	13,2	13,9	14,5	15,2	15,9	16,6	17,3	18,0	18,7	19,4	20,1	20,8	21,5	22,2	22,9	23,5	24,2	24,9	25,6	26,3	27,0	27,7	28,4	29,1	29,8	30,5	31,2	31,9
	1,88	12,7	13,4	14,1	14,9	15,6	16,3	17,0	17,7	18,4	19,1	19,8	20,5	21,2	21,9	22,6	23,3	24,0	24,8	25,5	26,2	26,9	27,6	28,3	29,0	29,7	30,4	31,1	31,8	32,5
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	1,84	13,3	14,0	14,8	15,5	16,2	17,0	17,7	18,5	19,2	19,9	20,7	21,4	22,2	22,9	23,6	24,4	25,1	25,8	26,6	27,3	28,1	28,8	29,5	30,3	31,0	31,8	32,5	33,2	34,0
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	1,78	14,2	15,0	15,8	16,6	17,4	18,1	18,9	19,7	20,5	21,3	22,1	22,9	23,7	24,5	25,2	26,0	26,8	27,6	28,4	29,2	30,0	30,8	31,6	32,4	33,1	33,9	34,7	35,5	36,3
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	1,74	14,9	15,7	16,5	17,3	18,2	19,0	19,8	20,6	21,5	22,3	23,1	23,9	24,8	25,6	26,4	27,2	28,1	28,9	29,7	30,6	31,4	32,2	33,0	33,9	34,7	35,5	36,3	37,2	38,0
	1,72	15,2	16,1	16,9	17,7	18,6	19,4	20,3	21,1	22,0	22,8	23,7	24,5	25,4	26,2	27,0	27,9	28,7	29,6	30,4	31,3	32,1	33,0	33,8	34,6	35,5	36,3	37,2	38,0	38,9
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	1,68	15,9	16,8	17,7	18,6	19,5	20,4	21,3	22,1	23,0	23,9	24,8	25,7	26,6	27,5	28,3	29,2	30,1	31,0	31,9	32,8	33,7	34,5	35,4	36,3	37,2	38,1	39,0	39,9	40,7
	1,66	16,3	17,2	18,1	19,1	20,0	20,9	21,8	22,7	23,6	24,5	25,4	26,3	27,2	28,1	29,0	29,9	30,8	31,8	32,7	33,6	34,5	35,4	36,3	37,2	38,1	39,0	39,9	40,8	41,7
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	1,60	17,6	18,6	19,5	20,5	21,5	22,5	23,4	24,4	25,4	26,4	27,3	28,3	29,3	30,3	31,3	32,2	33,2	34,2	35,2	36,1	37,1	38,1	39,1	40,0	41,0	42,0	43,0	43,9	44,9
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1,48	20,5	21,7	22,8	24,0	25,1	26,3	27,4	28,5	29,7	30,8	32,0	33,1	34,2	35,4	36,5	37,7	38,8	39,9	41,1	42,2	43,4	44,5	45,7	46,8	47,9	49,1	50,2	51,4	52,5	

Magrezza severa < 16	Magrezza moderata 16 - 16,9	Sottopeso 17-18,4	Normopeso 18,5-24,9	Sovrappeso 25 - 29,9	Obesità moderata 30-39,9	Obesità grave ≥ 40
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Quale impatto sulla salute ha *non*
seguire la dieta mediterranea?



Health effects of dietary risks in 195 countries, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017



GBD 2017 Diet Collaborators*

Summary

Lancet 2019; 393: 1958–72

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See [Comment](#) page 1916

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Background Suboptimal diet is an important preventable risk factor for non-communicable diseases (NCDs); however, its impact on the burden of NCDs has not been systematically evaluated. This study aimed to evaluate the consumption of major foods and nutrients across 195 countries and to quantify the impact of their suboptimal intake on NCD mortality and morbidity.

Methods By use of a comparative risk assessment approach, we estimated the proportion of disease-specific burden attributable to each dietary risk factor (also referred to as population attributable fraction) among adults aged 25 years or older. The main inputs to this analysis included the intake of each dietary factor, the effect size of the dietary factor on disease endpoint, and the level of intake associated with the lowest risk of mortality. Then, by use of disease-specific population attributable fractions, mortality, and disability-adjusted life-years (DALYs), we calculated the number of deaths and DALYs attributable to diet for each disease outcome.

Findings In 2017, 11 million (95% uncertainty interval [UI] 10–12) deaths and 255 million (234–274) DALYs were attributable to dietary risk factors. High intake of sodium (3 million [1–5] deaths and 70 million [34–118] DALYs), low intake of whole grains (3 million [2–4] deaths and 82 million [59–109] DALYs), and low intake of fruits (2 million [1–4] deaths and 65 million [41–92] DALYs) were the leading dietary risk factors for deaths and DALYs globally and in many countries. Dietary data were from mixed sources and were not available for all countries, increasing the statistical uncertainty of our estimates.

Interpretation This study provides a comprehensive picture of the potential impact of suboptimal diet on NCD mortality and morbidity, highlighting the need for improving diet across nations. Our findings will inform implementation of evidence-based dietary interventions and provide a platform for evaluation of their impact on human health annually.

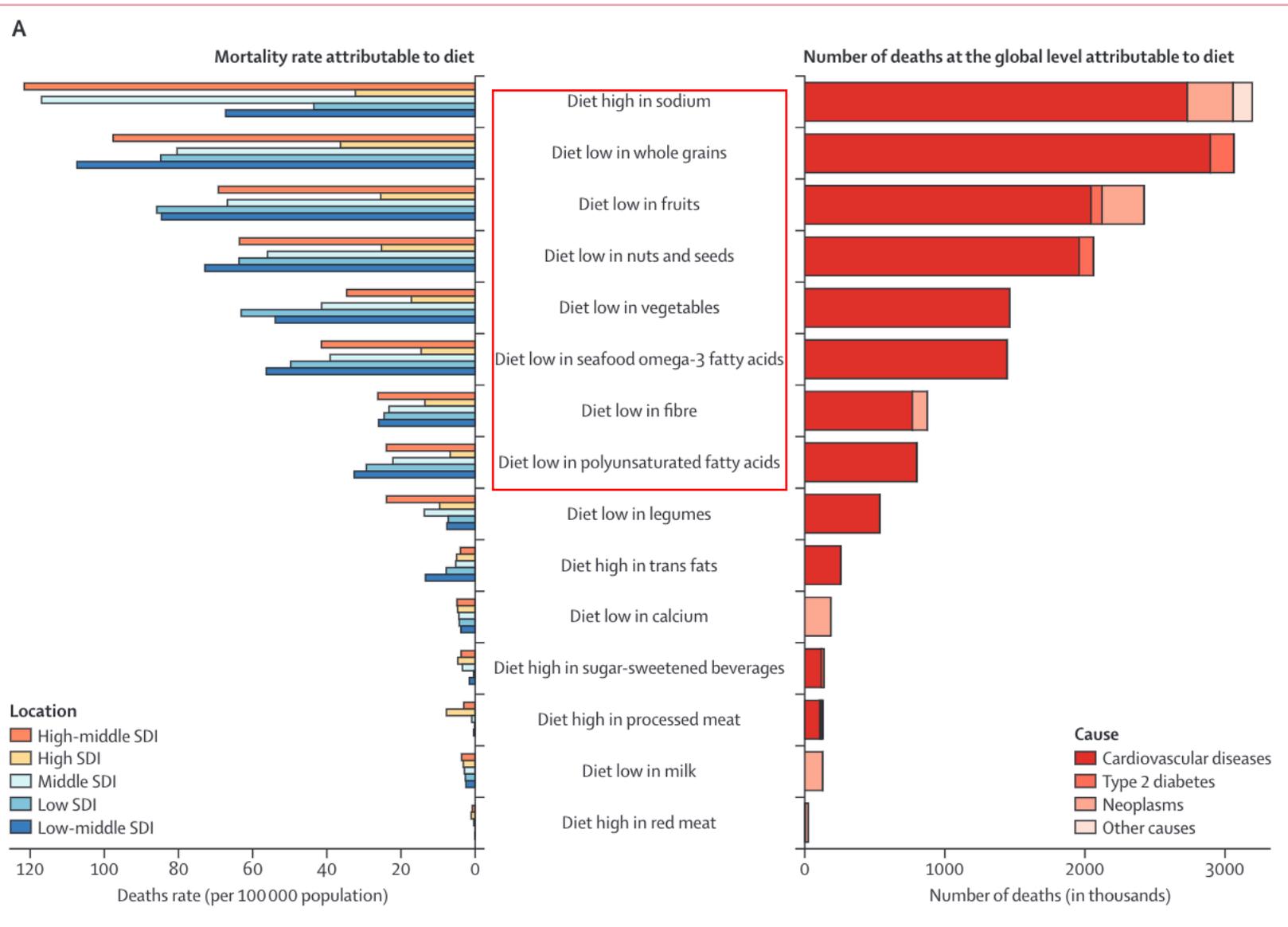
Funding Bill & Melinda Gates Foundation.

FATTORI DI RISCHIO

	Exposure definition	Optimal level of intake (optimal range of intake)	Data representativeness index (%)
Poca frutta	Diet low in fruits Mean daily consumption of fruits (fresh, frozen, cooked, canned, or dried fruits, excluding fruit juices and salted or pickled fruits)	250 g (200–300) per day	94.9
Poca verdura	Diet low in vegetables Mean daily consumption of vegetables (fresh, frozen, cooked, canned, or dried vegetables, excluding legumes and salted or pickled vegetables, juices, nuts, seeds, and starchy vegetables such as potatoes or corn)	360 g (290–430) per day	94.9
Pochi legumi	Diet low in legumes Mean daily consumption of legumes (fresh, frozen, cooked, canned, or dried legumes)	60 g (50–70) per day	94.9
Pochi cereali integrali	Diet low in whole grains Mean daily consumption of whole grains (bran, germ, and endosperm in their natural proportion) from breakfast cereals, bread, rice, pasta, biscuits, muffins, tortillas, pancakes, and other sources	125 g (100–150) per day	94.9
Poca frutta secca	Diet low in nuts and seeds Mean daily consumption of nut and seed foods	21 g (16–25) per day	94.9
Poco latte	Diet low in milk Mean daily consumption of milk including non-fat, low-fat, and full-fat milk, excluding soy milk and other plant derivatives	435 g (350–520) per day	94.9
Troppo carne	Diet high in red meat Mean daily consumption of red meat (beef, pork, lamb, and goat, but excluding poultry, fish, eggs, and all processed meats)	23 g (18–27) per day	94.9
Troppi insaccati	Diet high in processed meat Mean daily consumption of meat preserved by smoking, curing, salting, or addition of chemical preservatives	2 g (0–4) per day	36.9
Troppe bibite dolci	Diet high in sugar-sweetened beverages Mean daily consumption of beverages with ≥50 kcal per 226.8 serving, including carbonated beverages, sodas, energy drinks, fruit drinks, but excluding 100% fruit and vegetable juices	3 g (0–5) per day	36.9
Poca fibra	Diet low in fibre Mean daily intake of fibre from all sources including fruits, vegetables, grains, legumes, and pulses	24 g (19–28) per day	94.9
Poco calcio	Diet low in calcium Mean daily intake of calcium from all sources, including milk, yogurt, and cheese	1.25 g (1.00–1.50) per day	94.9
Poco pesce	Diet low in seafood omega-3 fatty acids Mean daily intake of eicosapentaenoic acid and docosahexaenoic acid	250 mg (200–300) per day	94.9
Poco olio	Diet low in polyunsaturated fatty acids Mean daily intake of omega-6 fatty acids from all sources, mainly liquid vegetable oils, including soybean oil, corn oil, and safflower oil	11% (9–13) of total daily energy	94.9
Troppo margarina	Diet high in trans fatty acids Mean daily intake of trans fat from all sources, mainly partially hydrogenated vegetable oils and ruminant products	0.5% (0.0–1.0) of total daily energy	36.9
Troppo sale	Diet high in sodium 24 h urinary sodium measured in g per day	3 g (1–5) per day*	26.2

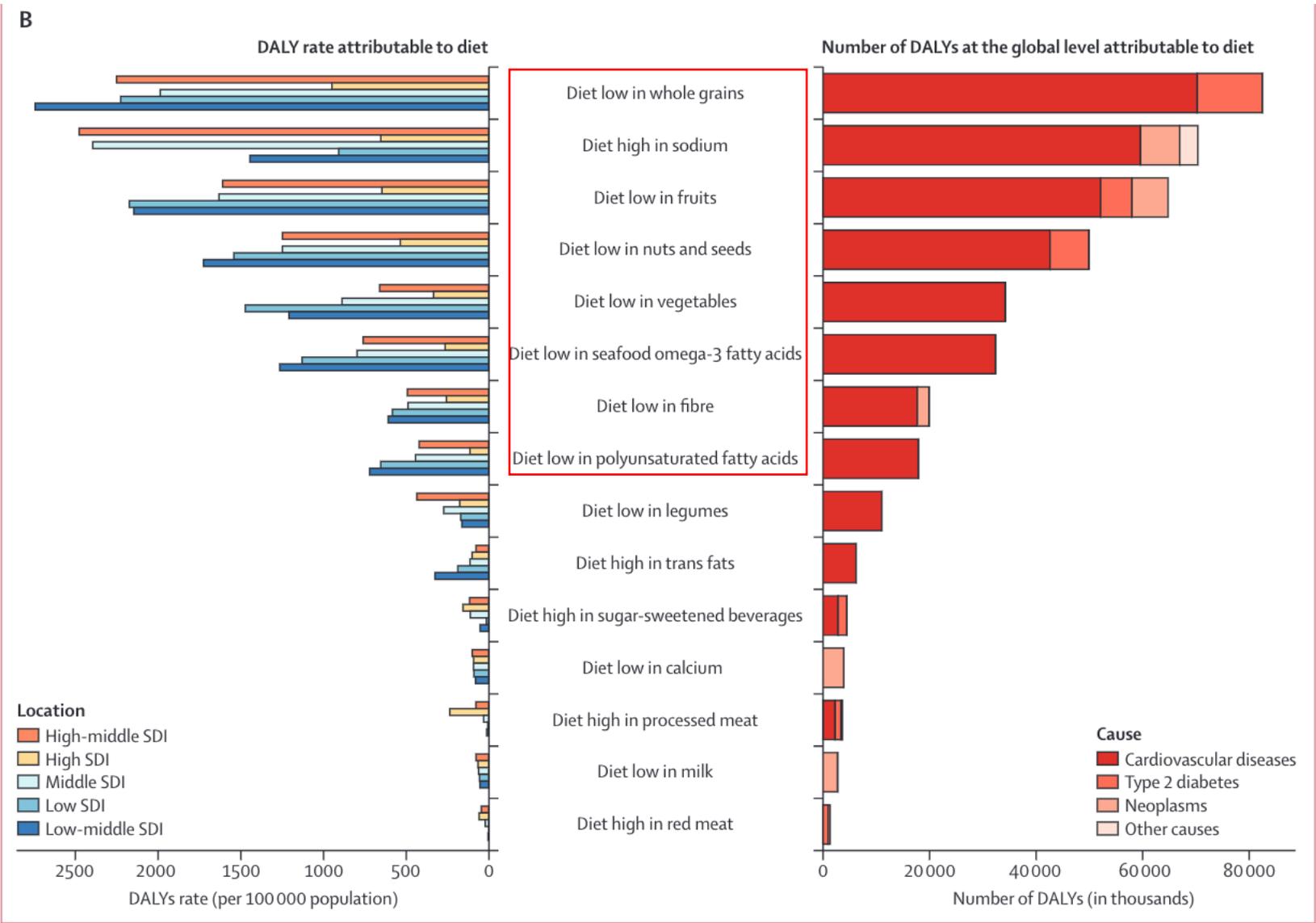
*To reflect the uncertainty in existing evidence on optimal level of intake for sodium, 1–5 g per day was considered as the uncertainty range for the optimal level of sodium where less than 2.3 g per day is the intake level of sodium associated with the lowest level of blood pressure in randomised controlled trials and 4–5 g per day is the level of sodium intake associated with the lowest risk of cardiovascular disease in observational studies.

Table: Dietary risk factor exposure definitions, optimal level, and data representativeness index, 1990–2017



MORTALITÀ E ALIMENTAZIONE RISCHIOSA

Figure 3: Number of deaths and DALYs and age-standardised mortality rate and DALY rate (per 100 000 population) attributable to individual dietary risks at the global and SDI level in 2017
 DALY=disability-adjusted life-year. SDI=Socio-demographic Index.

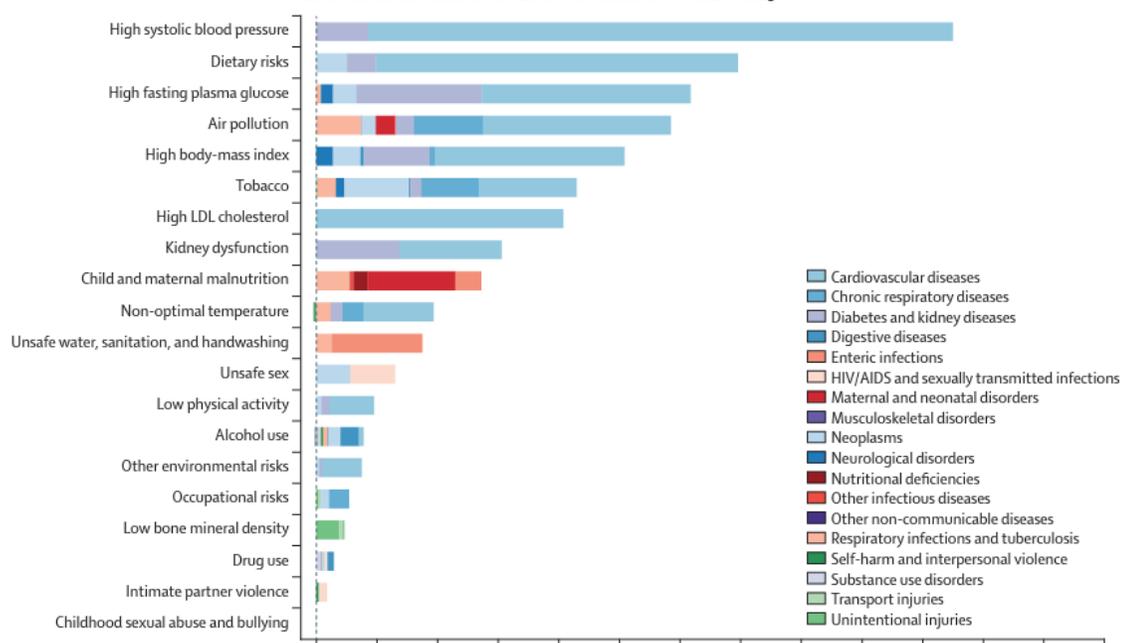


DALY (mortalità prematura & malattia) e ALIMENTAZIONE RISCHIOSA

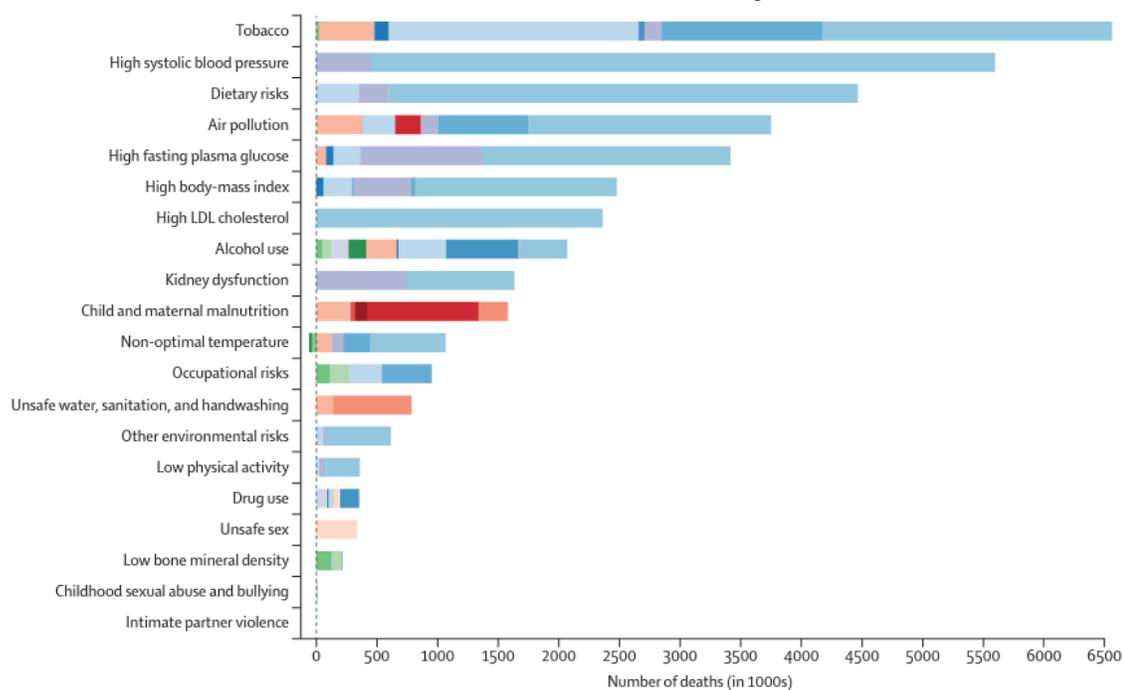
alimentari non ha costi economici

Figure 3: Number of deaths and DALYs and age-standardised mortality rate and DALY rate (per 100 000 population) attributable to individual dietary risks at the global and SDI level in 2017. DALY=disability-adjusted life-year. SDI=Socio-demographic Index.

A Global attributable deaths from Level 2 risk factors for females in 2019



B Global attributable deaths from Level 2 risk factors for males in 2019



Cause principali di morte nelle donne e negli uomini nel mondo

- 1 - ipertensione
- 2 - dieta rischiosa
- 3 - diabete

Correggere gli stili alimentari non costa nulla

- ❖ RIDURRE IL SALE
- ❖ AUMENTARE I CEREALI INTEGRALI
- ❖ AUMENTARE FRUTTA E VERDURE (fresche)
- ❖ AUMENTARE I LEGUMI (tutti i tipi, tutti i prodotti)
- ❖ CONSUMARE 2 PORZIONI DI PESCE / SETTIMANA (pesce azzurro)
- ❖ NON ELIMINARE LA CARNE

Alcol e mortalità

Il moderato consumo di alcol riduce il rischio di malattie cardiovascolari

STUDIO

Soglie di rischio per il consumo di alcol: analisi combinata dei dati di 599.912 bevitori in 83 studi prospettici

Lancet 2018; 391: 1513–23

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)30134-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30134-X/fulltext)

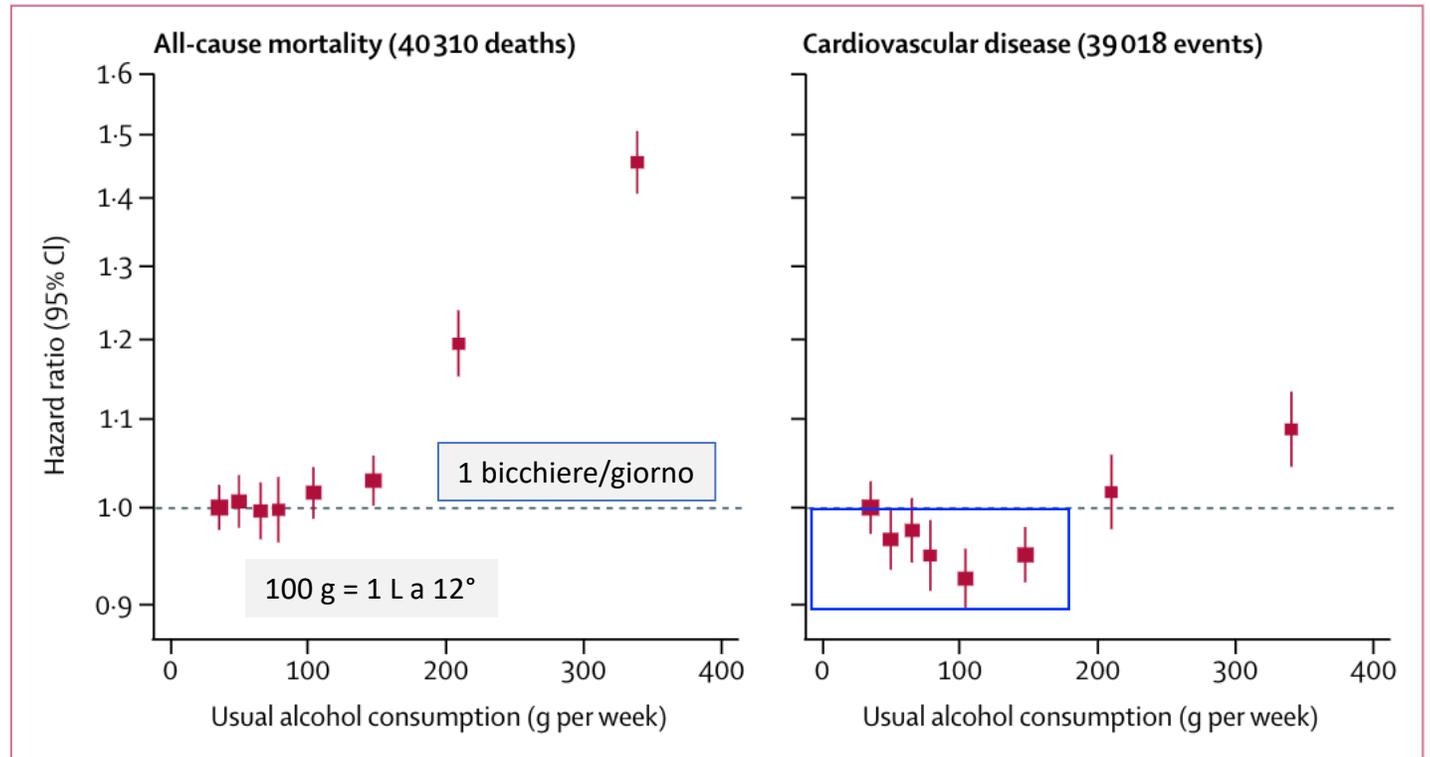
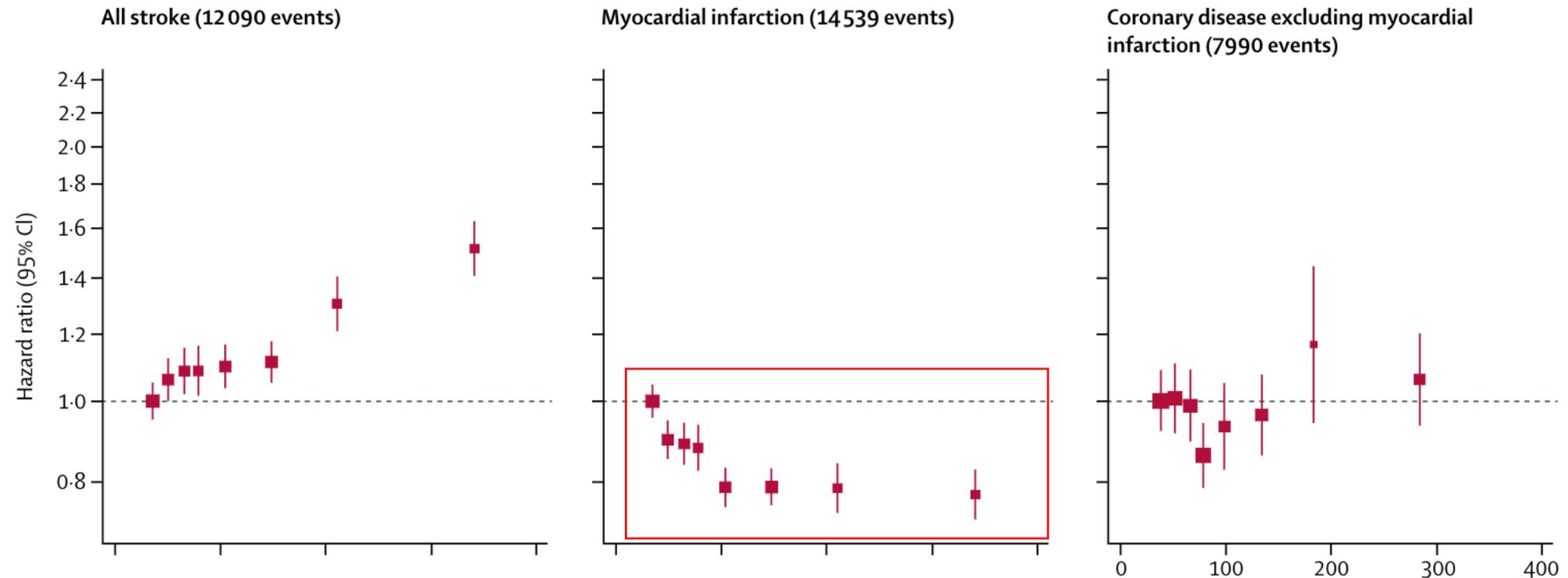
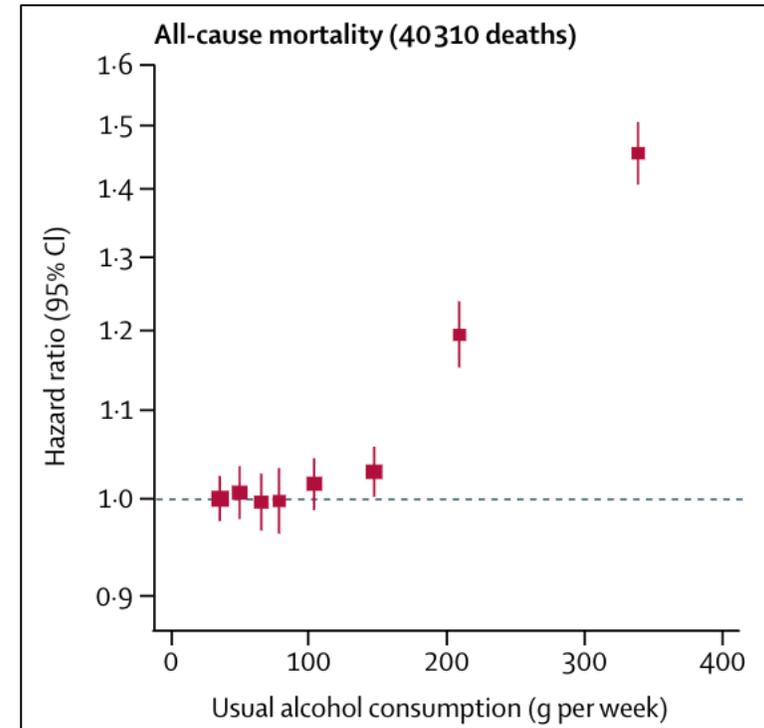
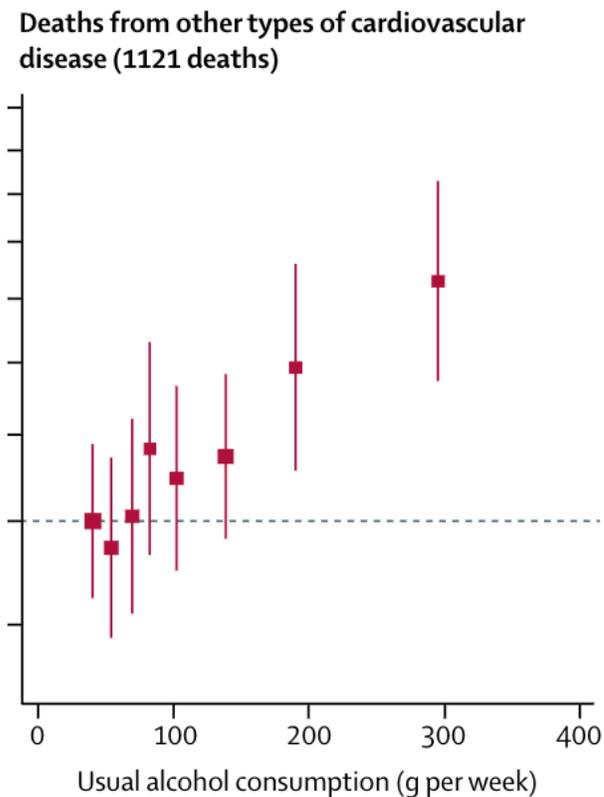
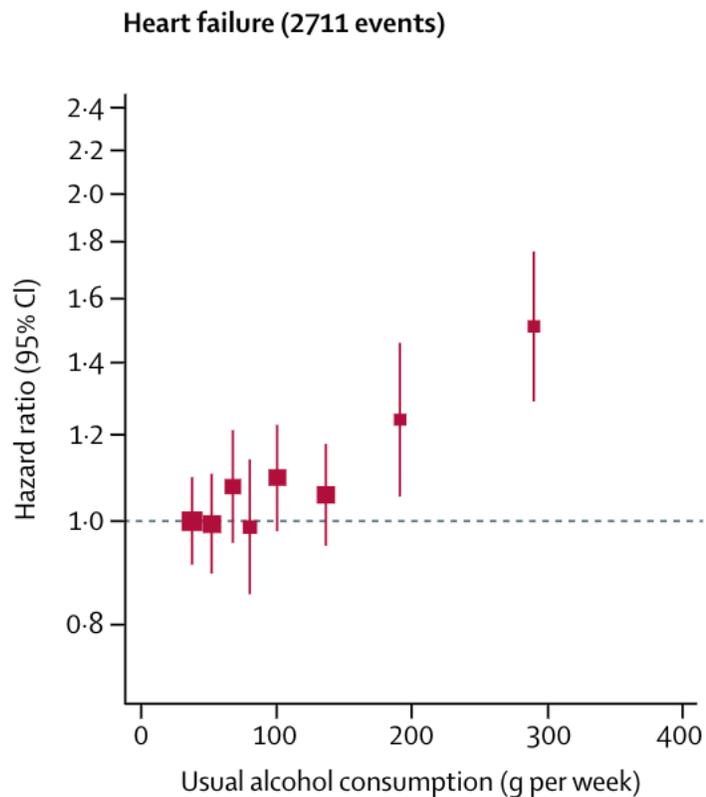


Figure 1: Associations of usual alcohol consumption with all-cause mortality and the aggregate of cardiovascular disease in current drinkers

Il moderato consumo di alcol riduce il rischio di infarto cardiaco ma non ictus cerebrale



Il moderato consumo di alcol non protegge dall'insufficienza cardiaca o da cause non cardiache di morte, ma nemmeno le favorisce



Tuttavia, gli astemi hanno un rischio maggiore di circa il 20 % (1.2 invece di 1.0)

Commento:

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)32192-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32192-5/fulltext)

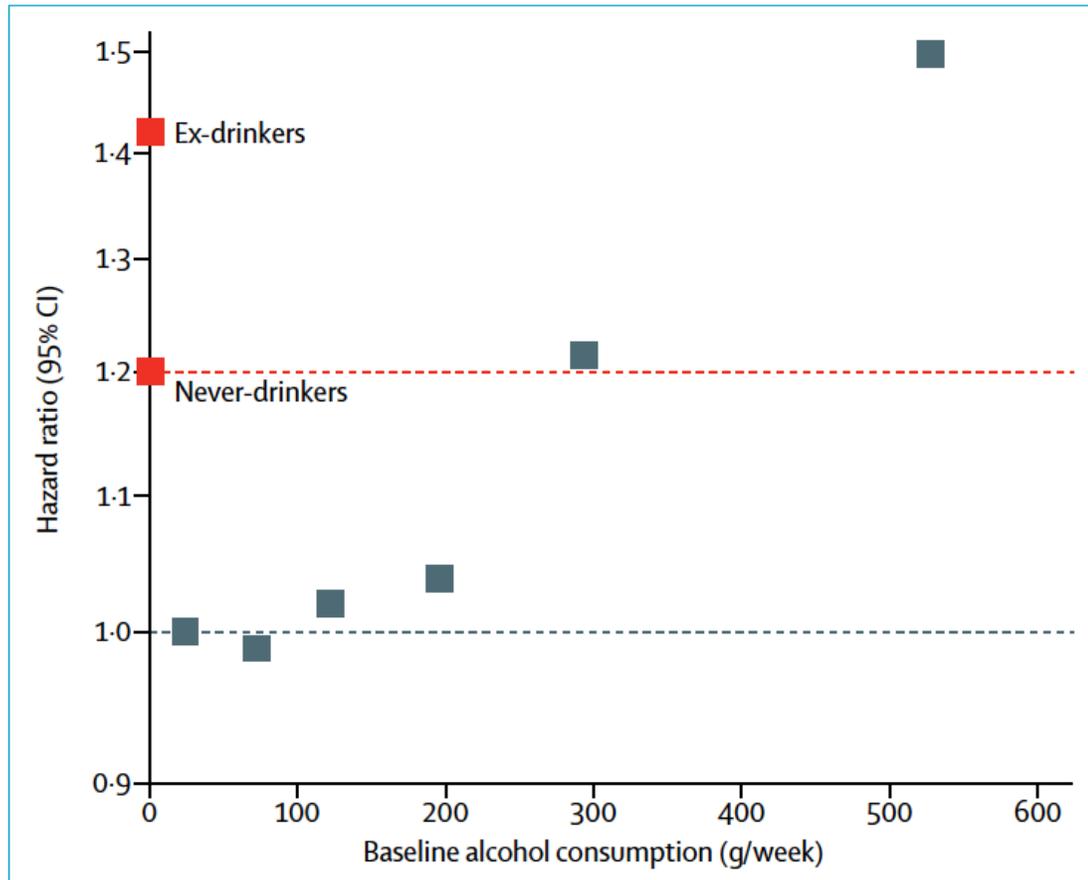
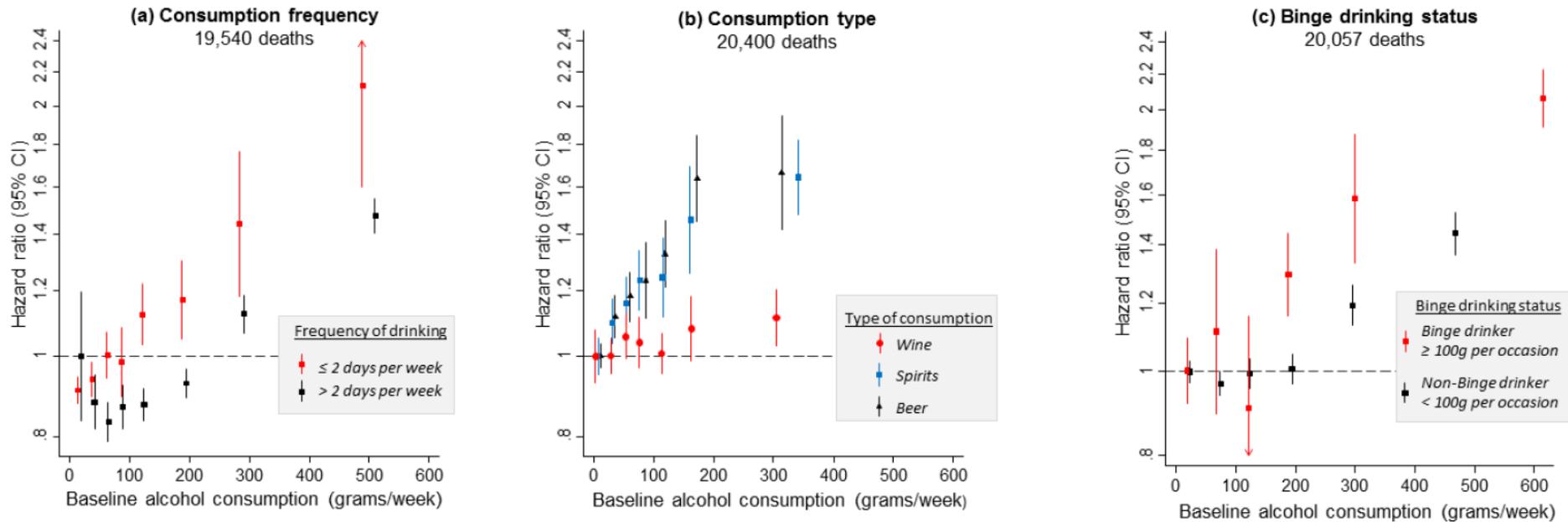


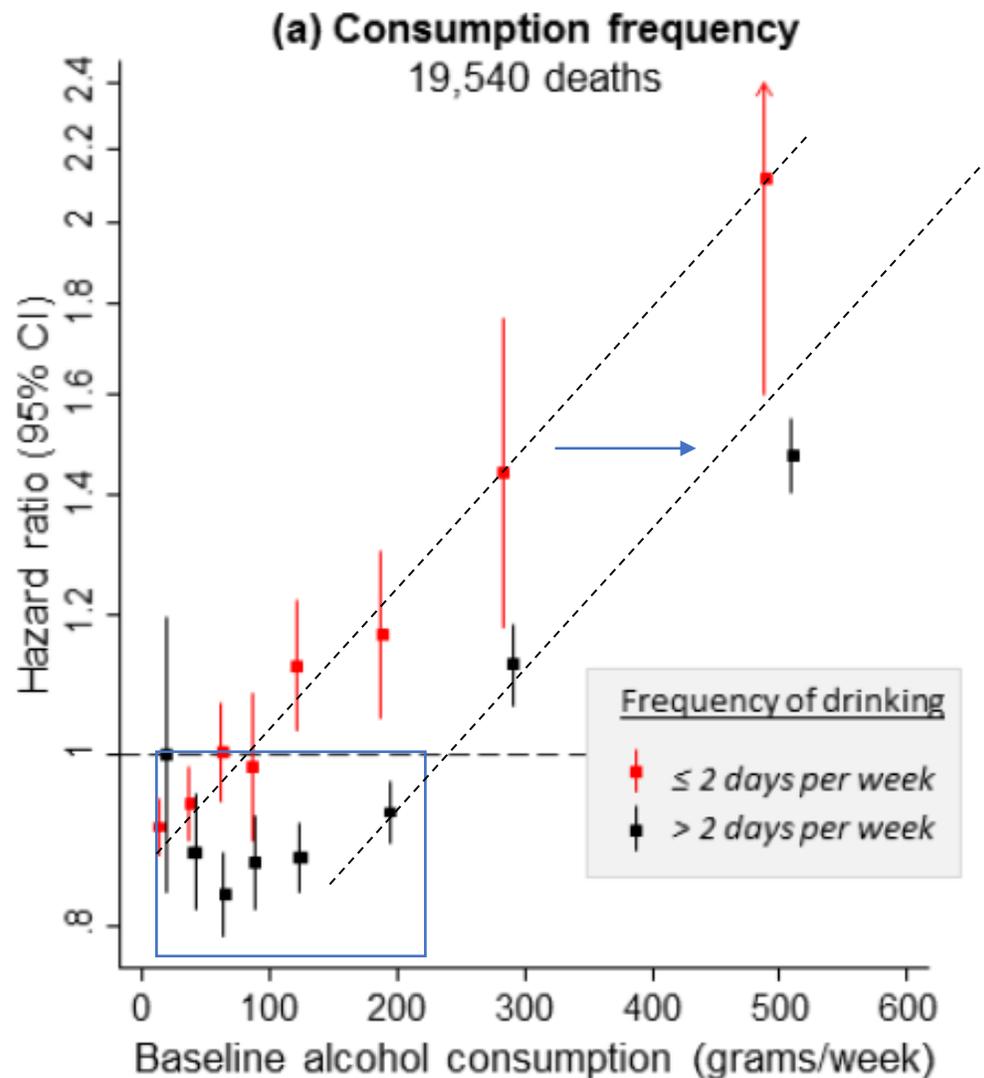
Figure: Shape of association of usual alcohol consumption with various risks

The J-shaped curve of association between alcohol consumption and various risks usually includes never-drinkers as the reference group; ex-drinkers must be omitted. Excluding the non-drinkers means the lowest risk is no longer found in those consuming 250–350 g of alcohol per week, but instead is found in those consuming up to 50 g of alcohol per week.

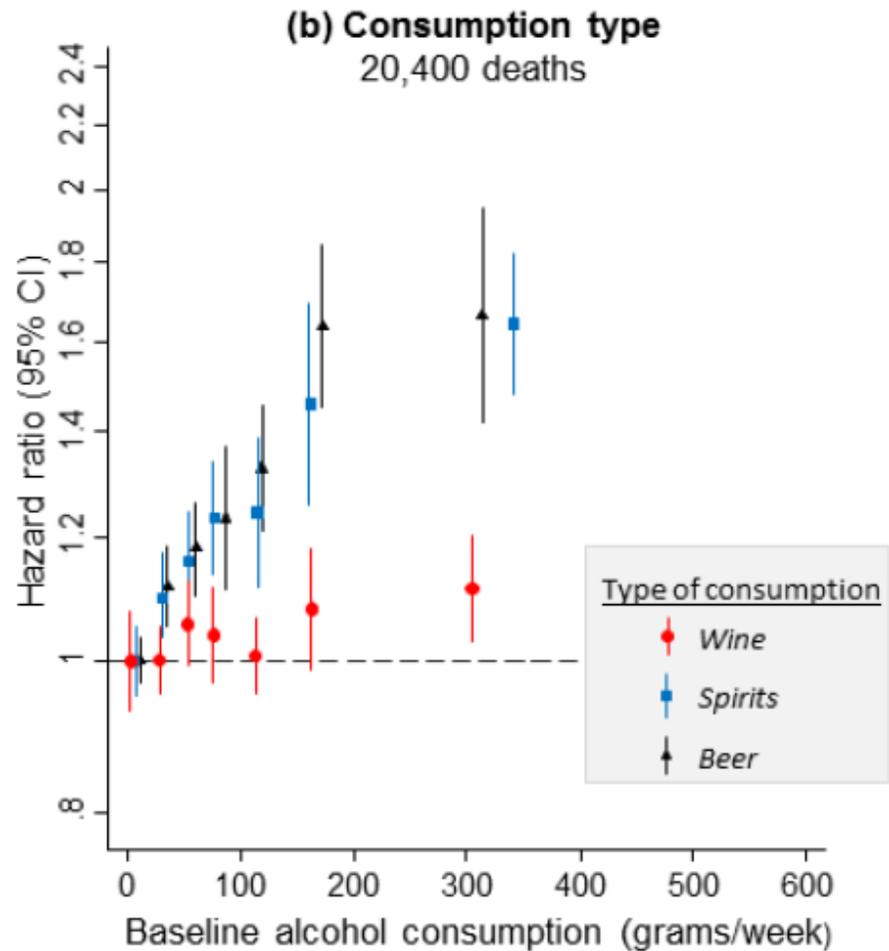
Alcuni aspetti molto particolari

Figure 17: Shapes of associations of baseline alcohol consumption with all-cause mortality by (a) consumption frequency, (b) consumption type* and (c) binge drinking status.





Il consumo moderato e periodico abbassa il rischio di morte, rispetto al consumo moderato e saltuario



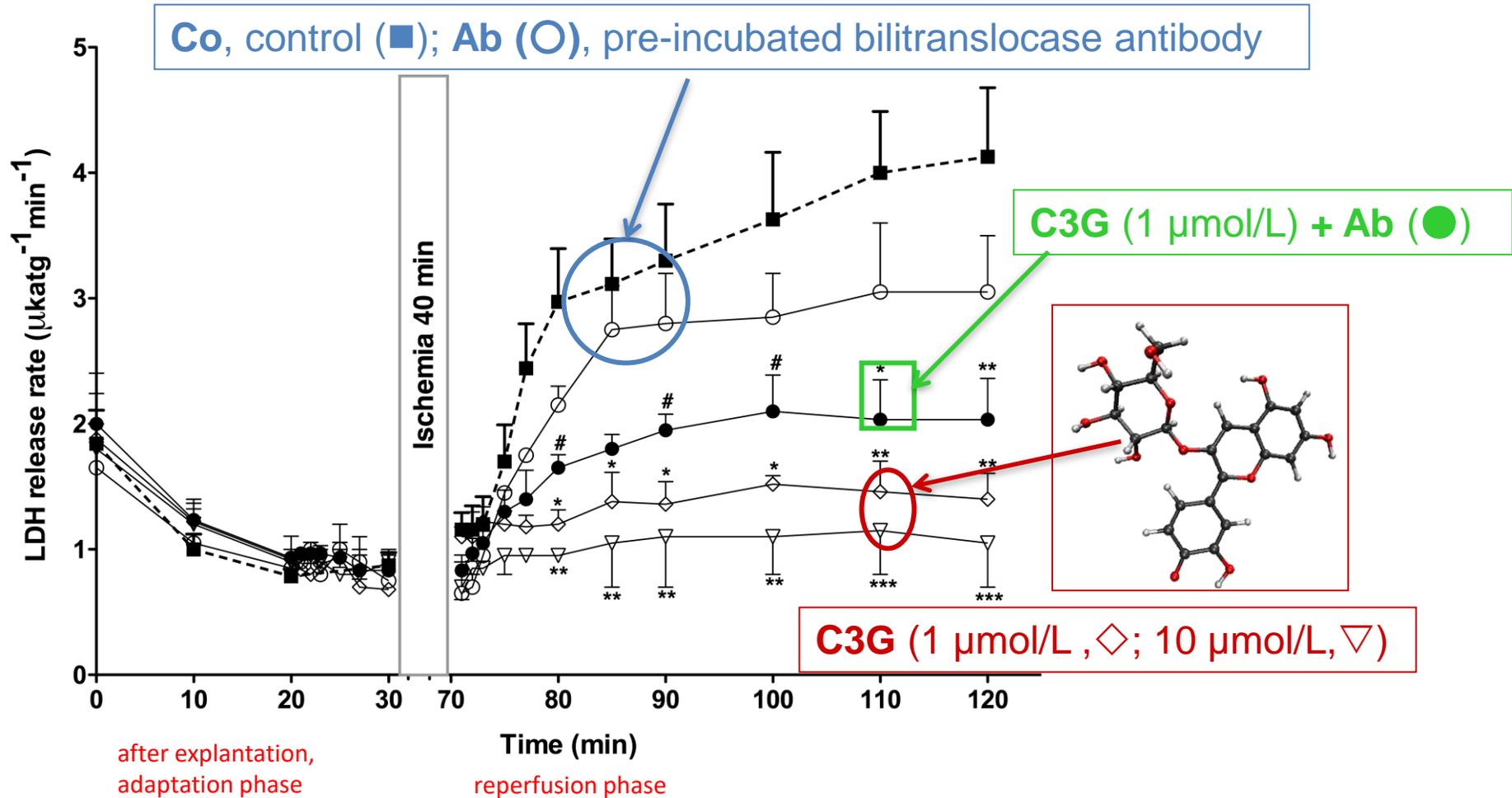
Liquori e birra
sono molto più
rischiosi del vino

I polifenoli del vino sono cardioprotettivi

Il caso della cianidina 3-glucoside

Uno dei pigmenti rossi del vino

LDH is a marker of myocardial cell death.
 It is released by the ischemic heart.
 However, cyanidin 3-glucoside prevents cell death.



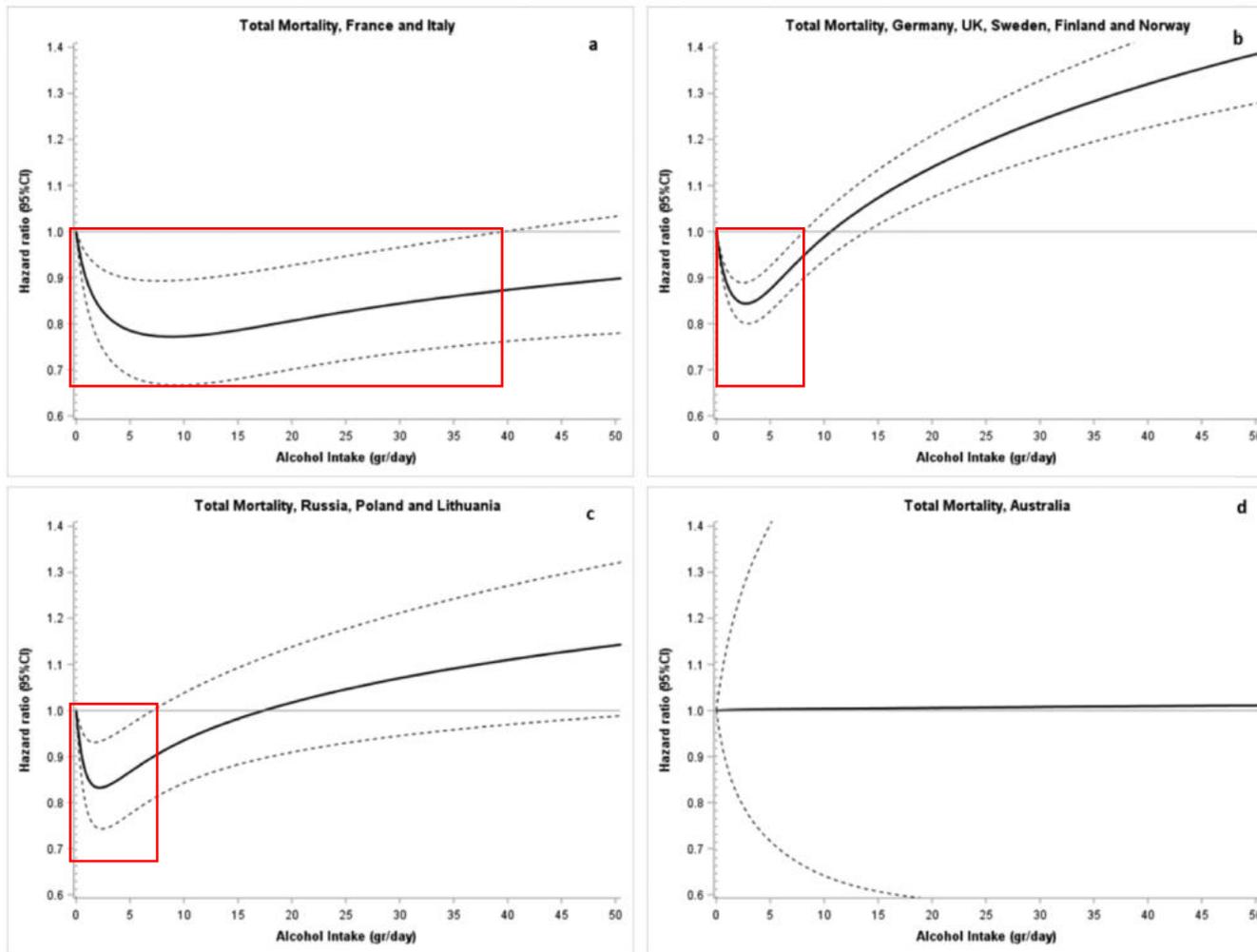


Figure 2 Dose–response relationship between alcohol dosing and total mortality in different cohorts grouped by geographical location. See Fig. 1 for the remainder

Il moderato consumo di alcol influenza il rischio di mortalità in modo molto diverso in vari Paesi

Alcohol intake and total mortality in 1 42 960 individuals from the MORGAM Project: a population-based study

Augusto Di Castelnuovo¹ , Simona Costanzo² , Marialaura Bonaccio², Patrick McElduff³, Allan Linneberg⁴, Veikko Salomaa⁵, Satu Männistö⁵, Marie Moitry⁶, Jean Ferrières⁷, Jean Dallongeville⁸, Barbara Thorand⁹, Hermann Brenner¹⁰, Marco Ferrario¹¹, Giovanni Veronesi¹¹, Emanuela Pettenuzzo¹¹, Abdonas Tamosiunas¹², Inger Njølstad¹³, Wojciech Drygas¹⁴, Yuri Nikitin¹⁵, Stefan Söderberg¹⁶, Frank Kee¹⁷, Guido Grassi¹⁸, Dirk Westermann¹⁹, Benedikt Schrage¹⁹, Salim Dabboura¹⁹, Tanja Zeller¹⁹, Kari Kuulasmaa⁵, Stefan Blankenberg¹⁹, Maria Benedetta Donati², Giovanni de Gaetano² & Licia Iacoviello^{2,11} 

Raccomandazioni del Ministero della salute

Le nuove indicazioni italiane definiscono a **basso rischio** un consumo di:

- 2 unità alcoliche al giorno per gli uomini
- 1 unità alcolica al giorno per le donne
- 1 unità alcolica al giorno per le persone con più di 65 anni
- zero unità di alcol sotto i 18 anni

1 unità alcolica corrisponde a **12 grammi di alcol puro** ed equivale a:

- un bicchiere di vino (125 ml a 12°)
- una lattina di birra (330 ml a 4,5°)
- un aperitivo (80 ml a 38°)
- un bicchierino di superalcolico (40 ml a 40°).



Vino nella dieta mediterranea

Il Vino non è acqua

LE CALORIE NEL VINO



bianco leggero 125 ml 115 kcal
rosso strutturato 125 ml 140 kcal
vino passito 125 ml 250-290 kcal



Quattroclici - Conoscere il Vino

Il tuo Corso online sul Vino



Una **porzione standard** di pasta al pomodoro **da 80 g** apporta **358 Kcal**. Per ottenere questo calcolo abbiamo preso in considerazione le 288 Kcal degli 80 grammi di pasta, le 30 Kcal della salsa di pomodoro e le 40 Kcal dell'olio d'oliva usato per condirla. Totale = 358 Kcal per un piatto di pasta al pomodoro da 80 grammi.

Se si consuma del vino, si deve
ridurre il consumo di altri cibi

Obiettivo

massa corporea controllata

Grazie della vostra attenzione

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