yearly trend in the percentage of the population with body mass index (BMI) in normal-weight (BMI<25), over-weight (BMI 25–29.9), and obese (BMI≥30) ranges, is modelled using multinomial logistic regression, stratifying by gender and age group (20–39, 40–59,≥60 years). The fitted models are used to compare trends between states and to forecast levels of obesity in the future. A previously developed micro-simulation model is used to assess the burden of 13 diseases caused by obesity and estimate the economic impact implied by the forecasted trends. Data of the US–National Health and Nutrition Examination Survey collected over the same period are used to investigate the extent of self-reporting bias in BRFSS.

Results In 2010, the proportion of obese (BMI≥30) men and women in the US was 33% and 35%, respectively, whilst the proportions of over-weight (BMI 25–30) were 42% and 34%. The fitted models forecast an increase in the proportion of obese individuals to up to 70% by 2030. The results revealed increasing levels of obesity in all states, although the rate of increase varies among states. Comparing BRFSS data with data from NHANES, showed that at all ages both men and women slightly over-report their height, whilst women under-report their weight by 5kg on average. Under-reporting of weight is reduced after age 65.

Conclusion Obesity rates are rapidly and steadily increasing in the US posing a threat to population health and a substantial economic burden. As self-reporting bias may significantly underestimate BMI in women, the estimated burden of obesity may be conservative.

Conclusion Results suggest that fibre from certain food sources and not others may be more beneficial for prevention of stroke. This may occur because different foods contain fibre fractions in varying quantities. Non-significant results for the continuous exposures suggest associations may be non-linear. The results may also reflect benefits simply from ‘fruit’ or ‘nut and seed’ consumption rather than specifically fibre from these sources.

Results In the UK in 2008, stroke was responsible for over 43,000 deaths. Dietary fibre intake may reduce stroke risk through modifying one or more risk factor such as body weight, blood cholesterol, or blood pressure. Food sources of fibre can be examined in relation to risk as different foods contain different types of fibre which have differing proposed actions within the body.

Methods 31,036 women recruited in 1995 provided dietary information relating to the previous 12 months using a 217-item food frequency questionnaire. Total dietary fibre intakes were estimated as both non-starch polysaccharide (NSP) and Association of Official Analytical Chemist (AOAC) values. Insoluble fibre, soluble fibre and fibre (NSP) from a variety of food sources were also examined. Stroke mortality was registered from baseline through the Office of National Statistics. Cox proportional hazard ratios were generated to explore risk using both categorical (fifths of intake) and continuous exposure variables. Model adjustments: age, body mass index, energy intake, ethanol, physical activity, smoking and socio-economic status.

Results After 14 years, 130 fatal stroke cases were observed. Fatal stroke risk was similar for total fibre assessed either as NSP or AOAC and both were protectively associated with risk. Overall, risk was roughly halved in each intake category compared to the lowest although this was only significant in the 3rd (NSP/AOAC) and 4th (AOAC) category. Those consuming 24 vs. 14g/d of NSP or 37 vs. 22g/d AOAC had their risk of stroke halved [Englyst: hazard ratio 0.47 (95% confidence interval 0.24, 0.92)] [AOAC: 0.47 (0.25, 0.89) p=0.021]. For fibre from nuts and seeds, the highest intake category (0.55g/d) saw a 56% risk reduction [0.44 (0.23, 0.85), p=0.012] compared to the lowest (0g/d). Fibre from fruit was also protectively associated with risk of stroke in the 4th (5.8g/d) vs. 1st category (1.4g/d) [0.50 (0.25, 0.97), p=0.041]. These significant associations were not seen in every category comparison and results for continuous exposures were not statistically significant for any of the exposures explored. No association was observed with fibre from cereals, vegetables or legumes.
Abstracts

Background Compared to UK white European adults, UK black African-Caribbean adults have higher mean systolic (SBP) and diastolic (DBP) blood pressure; UK South Asian adults have higher mean DBP but lower SBP. However, information on blood pressure in UK children from different ethnic groups is limited. The aim of this study was to compare blood pressure levels in UK children of black African-Caribbean, South Asian and white European origin.

Methods A cross sectional study of 5,666 UK primary school children of South Asian, black African Caribbean, and white European origin aged 9 to 10 years was undertaken. Ethnic and socioeconomic differences in SDF and DBP (as means and differences with their 95% confidence intervals) were obtained from multilevel linear regression models fitting school as a random effect in order to take account of the natural clustering of children within school. All analyses were adjusted for sex, age, month of assessment, blood pressure observer, room temperature and time of day of measurement fitted as fixed effects. The effects of adjustment for height, adiposity (fat mass index, sum of skinfolds) fitted as continuous variables, and socioeconomic circumstances on ethnic differences in blood pressure were then explored.

Results After adjustment for height and adiposity, black African-Caribbean children had a lower mean SBP than white Europeans (mean difference 1.62 mmHg, 95% CI 0.86, 2.38 mmHg), while mean DBP was similar (mean difference 0.38 mmHg, 95%CI –0.12, 1.28 mmHg). The mean SBP difference was particularly marked in black African children. In similar analyses, South Asian children had a lower mean SBP (mean difference 1.10 mmHg, 95%CI 0.34, 1.86 mmHg) than white Europeans and a higher mean DBP (mean difference 1.07 mmHg, 95%CI 0.57, 1.76 mmHg). The mean DBP difference was particularly marked among Indian and Bangladeshi, rather than Pakistani, children. Blood pressure was largely unrelated to socioeconomic circumstances; the ethnic differences in blood pressure were not affected by socioeconomic adjustment.

Conclusion A blood pressure pattern similar to that in adults is present in UK South Asian but not in UK black African-Caribbean children at 9–10 years. This suggests that key determinants of ethnic differences in blood pressure operate at different stages of the life course in these different ethnic groups. Understanding the reasons for the early emergence of ethnic differences in blood pressure (particularly among South Asians) is an important research priority.

Methods This was a cross-sectional school-based study of 4633 nine and ten-year-old children (response rate 68%), predominantly of South Asian, black African-Caribbean and white European origin. Participants had detailed assessments of adiposity (including body mass index, skinfold thicknesses and fat mass index from bioimpedance) and provided fasting blood samples for assessment of HbA1c and insulin resistance (Homeostatic model assessment-insulin resistance; HOMA-IR). Associations between HOMA-IR (log transformed), HbA1c and adiposity markers were estimated using multilevel linear regression.

Results All adiposity measures were positively associated with insulin resistance in all ethnic groups. However there were clear ethnic differences in the strength of association (p ethnic difference <0.001). The percentage increase in HOMA-IR for a one SD increase in fat mass index was 36.3% (95% CI 32.1%, 40.5%) for South Asians and 25.1% (95% CI 21.1%, 29.3%) for white Europeans; black African-Caribbeans were similar to white Europeans (26.4%, 95% CI 22.5%, 30.4%). All adiposity markers were positively associated with HbA1c in both South Asians and black African-Caribbeans: the percentage increase in HbA1c for a one SD increase in fat mass index in was 0.04% (95% CI 0.02%, 0.06%) in both ethnic groups. However there was no association among white Europeans (0.01%, 95% CI 0.00%, 0.03%).

Conclusion Even in childhood, both insulin resistance and HbA1c levels appear more sensitive to adiposity in South Asians. Among children of black African-Caribbean origin, HbA1c levels but not insulin resistance appear more sensitive to adiposity. The reasons for these differences in sensitivity to adiposity need to be understood. The results imply that early prevention of childhood obesity among South Asians and black African-Caribbeans is a particular priority for future control of type 2 diabetes in these high risk ethnic groups.