

Separate and combined associations of obesity and metabolic health with coronary heart disease: a pan-European case-cohort analysis

Camille Lassale^{1,2,*†}, Ioanna Tzoulaki^{1,3†}, Karel G.M. Moons⁴, Michael Sweeting⁵, Jolanda Boer⁶, Laura Johnson⁷, José María Huerta^{8,9}, Claudia Agnoli¹⁰, Heinz Freisling¹¹, Elisabete Weiderpass^{12,13,14,15}, Patrik Wennberg¹⁶, Daphne L. van der A⁶, Larraitz Arriola¹⁷, Vassiliki Benetou^{18,19}, Heiner Boeing²⁰, Fabrice Bonnet^{21,22}, Sandra M. Colorado-Yohar^{8,23}, Gunnar Engström²⁴, Anne K. Eriksen²⁵, Pietro Ferrari¹¹, Sara Grioni¹⁰, Matthias Johansson¹¹, Rudolf Kaaks²⁶, Michail Katsoulis¹⁹, Verena Katzke²⁶, Timothy J. Key²⁷, Giuseppe Matullo^{28,29}, Olle Melander²⁴, Elena Molina-Portillo^{9,30}, Concepción Moreno-Iribas³¹, Margareta Norberg³², Kim Overvad^{33,34}, Salvatore Panico³⁵, J. Ramón Quirós³⁶, Calogero Saieva³⁷, Guri Skeie³⁸, Annika Steffen²⁰, Magdalena Stepien¹¹, Anne Tjønneland²⁵, Antonia Trichopoulou^{18,19}, Rosario Tumino³⁹, Yvonne T. van der Schouw⁴, W.M. Monique Verschuren^{4,6}, Claudia Langenberg⁴⁰, Emanuele Di Angelantonio^{5,41}, Elio Riboli¹, Nicholas J. Wareham⁴⁰, John Danesh^{5,41,42}, and Adam S. Butterworth^{5,41}

¹Department of Epidemiology and Biostatistics, Imperial College London, London W2 1PG, UK; ²Department of Epidemiology and Public Health, University College London, 1-19 Torrington Place, London WC1E 7HB, UK; ³Department of Hygiene and Epidemiology, University of Ioannina, 45110, Ioannina, Greece; ⁴Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht, Heidelberglaan 100, 3584 Utrecht, The Netherlands; ⁵Department of Public Health and Primary Care, MRC/BHF Cardiovascular Epidemiology Unit, University of Cambridge, 2 Worts' Causeway, Cambridge CB1 8RN, UK; ⁶National Institute for Public Health and the Environment (RIVM), Antonie van Leeuwenhoeklaan 9, 3721 MA Bilthoven, The Netherlands; ⁷Centre for Exercise, Nutrition and Health Sciences, School for Policy Studies, University of Bristol, Senate House, Tyndall Ave, Bristol BS8 1TH, UK; ⁸Department of Epidemiology, Murcia Regional Health Council, IMIB-Arrixaca, Ronda de Levante, 11, 30008, Murcia, Spain; ⁹CIBER Epidemiología y Salud Pública (CIBERESP), Instituto de Salud Carlos III, C/ Monforte de Lemos 3-5, 28029 Madrid, Spain; ¹⁰Epidemiology and Prevention Unit, Fondazione IRCCS Istituto Nazionale dei Tumori, Via Giacomo Venezian, 1, 20133 Milan, Italy; ¹¹Section of Nutrition and Metabolism, International Agency for Research on Cancer (IARC-WHO), 150 Cours Albert Thomas, 69008 Lyon, France; ¹²Department of Community Medicine, Faculty of Health Sciences, University of Tromsø, The Arctic University of Norway, Hansine Hansens veg 18, 9019 Tromsø, Norway; ¹³Department of Research, Cancer Registry of Norway, Institute of Population-Based Cancer Research, Ullernchausseen 64, 0379 Oslo, Norway; ¹⁴Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Solnavägen 1, 171 77 Solna Stockholm, Sweden; ¹⁵Genetic Epidemiology Group, Folkhälsan Research Center, Topeliuksenkatu 20, 00250 Helsinki, Finland; ¹⁶Department of Public Health and Clinical Medicine, Family medicine, Umeå University, 901 87 Umeå, Sweden; ¹⁷Public Health Division of Gipuzkoa, Instituto Bio-Donostia, Basque Government, Calle Doctor Begiristain, 20014 Donostia/Gipuzkoa, Spain; ¹⁸Department of Hygiene, Epidemiology and Medical Statistics, WHO Collaborating Center for Nutrition and Health, Unit of Nutritional Epidemiology and Nutrition in Public Health, School of Medicine, National and Kapodistrian University of Athens, Athens 157 72, Greece; ¹⁹Hellenic Health Foundation, Kaisareias 13 & Alexandroupoleos, 115 27, Athens, Greece; ²⁰Department of Epidemiology, German Institute of Human Nutrition (DIfE), Potsdam-Rehbrücke, Arthur-Scheunert-Allee 114, 14558 Nuthetal, Germany; ²¹Université de Rennes 1, CHU de Rennes, Hôpital Sud 16 bd Bulgarie, 35203 Rennes, France; ²²Inserm (Institut National De La Santé Et De La Recherche Médical), Centre for Research in Epidemiology and Population Health (CESP), U1018, 16 Avenue Paul Vaillant Couturier, 94800 Villejuif, France; ²³National School of Public Health, Research Group on Demography and Health, University of Antioquia, Cl. 67 #53 – 108 Medellín, Colombia; ²⁴Department of Clinical Sciences Malmö, Lund University, Bergsgatan 31 B, 214 45 Malmö, Sweden; ²⁵Diet, Genes and Environment, Danish Cancer Society Research Center, Strandboulevarden 49, 2100 Copenhagen, Denmark; ²⁶Division of Cancer Epidemiology, German Cancer Research Center (DKFZ), Im Neuenheimer Feld 580, 69120 Heidelberg, Germany; ²⁷Cancer Epidemiology Unit, Nuffield Department of Population Health University of Oxford, Old Road Campus, Oxford OX3 7LF, UK; ²⁸Human Genetics Foundation, Via Nizza 52 10126 Turin, Italy; ²⁹Department of Medical Sciences, University of Turin, Via Giuseppe Verdi, 8, 10124 Turin, Italy; ³⁰Escuela Andaluza de Salud Pública, Instituto de Investigación Biosanitaria ibs.GRANADA, Hospitales Universitarios de Granada/Universidad de Granada, Av. del Hospicio, s/n, 18010 Granada, Spain; ³¹Public Health Institute of Navarra, IdiSNA, Calle de Irunlarrea, 3, 31008 Pamplona, Spain; ³²Department of Public Health and Clinical Medicine, Epidemiology and Global Health, Umeå University, 901 87 Umeå, Sweden; ³³Department of Public Health, Section for Epidemiology, Aarhus University, Nordre Ringgade 1, 8000 Aarhus, Denmark; ³⁴Department of Cardiology, Aalborg University Hospital, Reberbansgade 15, 9000 Aalborg, Denmark; ³⁵Dipartimento di Medicina Clinica e Chirurgia, Federico II University, Corso Umberto I, 40, 80138 Naples, Italy; ³⁶Public Health Directorate, Asturias,

* Corresponding author. Tel: + 44 20 7679 8265, Fax: + 44 20 7813 0242, Email: c.lassale@ucl.ac.uk

† The first two authors contributed equally to this manuscript.

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General Elorza 32, 33001 Oviedo, Spain; ³⁷Cancer Risk Factors and Lifestyle Epidemiology Unit, Cancer Research and Prevention Institute (ISPO), Via Cosimo Il Vecchio, 2, 50139 Florence, Italy; ³⁸Department of Community Medicine, University of Tromsø—the Arctic University of Norway, Hansine Hansens veg 18, 9019 Tromsø, Norway; ³⁹Cancer Registry and Histopathology Unit, Civic—M.P. Arezzo Hospital, ASP Contrada Rito, 97100 Ragusa, Italy; ⁴⁰Medical Research Council Epidemiology Unit, University of Cambridge, 2 Worts' Causeway, Cambridge CB1 8RN, UK; ⁴¹National Institute for Health Research Blood and Transplant Research Unit in Donor Health and Genomics, University of Cambridge, Trinity Ln, Cambridge CB2 1TN, UK; and ⁴²Department of Human Genetics, Wellcome Trust Sanger Institute, Hinxton CB10 1SA, UK

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Aims

The hypothesis of 'metabolically healthy obesity' implies that, in the absence of metabolic dysfunction, individuals with excess adiposity are not at greater cardiovascular risk. We tested this hypothesis in a large pan-European prospective study.

Methods and results

We conducted a case-cohort analysis in the 520 000-person European Prospective Investigation into Cancer and Nutrition study ('EPIC-CVD'). During a median follow-up of 12.2 years, we recorded 7637 incident coronary heart disease (CHD) cases. Using cut-offs recommended by guidelines, we defined obesity and overweight using body mass index (BMI), and metabolic dysfunction ('unhealthy') as ≥ 3 of elevated blood pressure, hypertriglyceridaemia, low HDL-cholesterol, hyperglycaemia, and elevated waist circumference. We calculated hazard ratios (HRs) and 95% confidence intervals (95% CI) within each country using Prentice-weighted Cox proportional hazard regressions, accounting for age, sex, centre, education, smoking, diet, and physical activity. Compared with metabolically healthy normal weight people (reference), HRs were 2.15 (95% CI: 1.79; 2.57) for unhealthy normal weight, 2.33 (1.97; 2.76) for unhealthy overweight, and 2.54 (2.21; 2.92) for unhealthy obese people. Compared with the reference group, HRs were 1.26 (1.14; 1.40) and 1.28 (1.03; 1.58) for metabolically healthy overweight and obese people, respectively. These results were robust to various sensitivity analyses.

Conclusion

Irrespective of BMI, metabolically unhealthy individuals had higher CHD risk than their healthy counterparts. Conversely, irrespective of metabolic health, overweight and obese people had higher CHD risk than lean people. These findings challenge the concept of 'metabolically healthy obesity', encouraging population-wide strategies to tackle obesity.

Keywords

Coronary heart disease • Adiposity • Obesity • Metabolic syndrome • Epidemiology

Introduction

Overall and abdominal obesity, commonly measured by body mass index (BMI) and waist circumference (WC), are important risk factors for coronary heart disease (CHD).^{1–3} The effects of obesity on CHD are thought to be largely mediated by other cardiometabolic risk factors such as insulin resistance, atherogenic dyslipidaemia, and type 2 diabetes.⁴ However, many obese people have few or no elevated metabolic risk factors included in the definition of the Metabolic Syndrome (MetS),⁵ suggesting that there may be a group of obese people—the 'metabolically healthy obese'—who are not at higher cardiovascular risk.⁶ There is no consensus on the criteria to define this subtype, and an estimated 3–57% of obese individuals are considered 'metabolically healthy obese' depending on the population under study and the definition used.⁷ There has been conflicting evidence on whether 'metabolically healthy obese' people are at higher risk of cardiovascular disease (CVD) or type 2 diabetes,^{8–17} with recent meta-analyses challenging the concept of the 'metabolically healthy obesity' by showing higher cardiovascular risk among obese individuals with no MetS.^{14,15,17,18} The existence of 'metabolically healthy obesity' has also been questioned by the latest European Society of Cardiology (ESC) guidelines for CVD prevention.¹⁹ However, previous studies have been limited by incomplete adjustment for potentially important confounders (such as physical activity and smoking), short duration of follow-up (and hence small numbers of incident CHD events) and use of composite outcomes, such as all-cause mortality. More powerful

and detailed studies with precisely defined outcomes are therefore needed to clarify the association with CHD risk, since heterogeneous effects of obesity according to metabolic health could have important implications for risk prevention strategies.

To address this, we analysed 7637 incident CHD cases recorded during 12.2 years of follow-up from the European Prospective Investigation into Cancer and Nutrition cardiovascular disease (EPIC-CVD) case-cohort study. Our primary aim was to examine the separate and combined associations of obesity and metabolic health with CHD.

Methods

Study population

EPIC-CVD is a prospective case-cohort study nested within the European Prospective Investigation into Cancer and Nutrition (EPIC) study. Briefly, EPIC includes 366 521 women and 153 457 men, mostly aged 35 to 70 years old at baseline, recruited between 1991 and 1999 at 23 centres across 10 European countries: Denmark, France, Germany, Greece, Italy, the Netherlands, Norway, Spain, Sweden, and the UK. Adults were invited from the local general population except in the French centre (women in a national health insurance plan), some Italian and Spanish centres (recruited through local blood donor associations), Utrecht (The Netherlands), and Florence (Italy) (women invited for population-based breast cancer screening programmes), and Oxford (UK) (specifically recruited a substantial proportion of vegetarians). At baseline, participants gave a blood sample and completed questionnaires

on diet, lifestyle, and medical history. Detailed baseline characteristics of the EPIC cohort have been previously described.²⁰

A case-cohort study nested in a large prospective cohort is similar to a nested case-control study with the difference that a random subcohort is selected for use as a reference group, rather than matched controls. This design is efficient as it does not require all study participants to have exposure measurement and has the advantages of a longitudinal cohort study with prospective assessment of key exposures that are not subject to recall bias. Unlike the nested case-control design, it allows risk to be measured at any time until the end of follow-up and permits time-to-event analysis.²¹ A representative random subcohort of 18 249 participants (62% women), stratified by centre, was selected for the EPIC-CVD project, constituting a case-cohort design. After exclusion of 609 participants with a prior history of myocardial infarction or stroke at baseline, 17 640 subcohort members remained. In total in the EPIC study, 13 964 incident CHD cases developed during follow-up, of whom 631 belong to the subcohort. Ethical review boards of the International Agency for Research on Cancer and all local institutions where participants had been recruited gave approval for the original EPIC study, and all participants gave written informed consent.

Blood pressure measurements were not available for the centres in Norway, Asturias, or Navarra, and WC was not recorded in Norway and Umea.²² These centres were excluded from the analyses, as well as the French centre due to the limited number of incident CHD events ($n = 41$). Further exclusions were performed based on missing exposure and covariate data, described below. All analyses were performed in a sample restricted to participants with no missing data (complete-case analysis). Because exclusions due to missing data may result in a selected sample, we also used a multiple imputation approach as a sensitivity analysis to compare the results with the complete-case approach. A schematic representation of the EPIC-CVD case-cohort design and sample selection is given in Supplementary material online, *Figure S1*.

Definitions of obesity and metabolic disorders

Trained health professionals measured blood pressure (BP),²³ weight, height, and waist circumference (WC),²⁴ except in the France and Oxford centres where body size measurements were self-reported.²⁵ BMI was calculated as weight (kg) divided by the square of height (m^2). Obesity was defined according to the World Health Organization²⁶ as $BMI \geq 30 \text{ kg/m}^2$, overweight as $25 \leq BMI < 30 \text{ kg/m}^2$, and normal weight as $18.5 \leq BMI < 25 \text{ kg/m}^2$. Underweight ($BMI < 18.5$) participants were excluded due to the limited number ($n = 264$, less than 1% of the subcohort).

Total cholesterol, HDL-cholesterol, triglycerides, and glucose were measured in baseline serum samples on a Roche auto-analyser (Roche diagnostics, USA) and HbA1c was measured in the erythrocyte fraction using the Tosoh-G8 HPLC analyser (Tosoh Bioscience, Japan) at Stichting Huisartsen Laboratorium (Etten-Leur, Netherlands). Fasting status was available for 87% of participants. Metabolic Syndrome (MetS) was defined according to the 2009 Joint Interim Statement of the International Diabetes Federation Task Force on Epidemiology and Prevention; National Heart, Lung, and Blood Institute; American Heart Association; World Heart Federation; International Atherosclerosis Society; and International Association for the Study of Obesity⁵ as having three or more of the following metabolic abnormalities: (i) elevated BP, defined as systolic BP ≥ 130 and/or diastolic BP ≥ 85 mmHg and/or use of antihypertensive medication at baseline and/or self-reported history of hypertension; (ii) hypertriglyceridaemia, defined as triglycerides ≥ 1.7 mmol/L (150 mg/dL) or current use of lipid-lowering medication at baseline; (iii)

low HDL-cholesterol, defined as < 1.0 mmol/L (40 mg/dL) for men and < 1.3 mmol/L (50 mg/dL) for women; (iv) hyperglycaemia, defined as fasting blood glucose ≥ 5.6 mmol/L (100 mg/dL) or non-fasting blood glucose ≥ 7.8 mmol/L (140 mg/dL, with fasting defined as ≥ 3 h between last meal and blood draw²⁷) and/or current use of antidiabetic medication at baseline and/or self-reported history of diabetes; or (v) elevated waist circumference, defined as WC ≥ 94 cm for men and WC ≥ 80 cm for women. Where information on fasting status was not available (23% of participants), the non-fasting cut-off was used for glucose. Diabetes was defined as a self-reported history and/or HbA1c $\geq 6.5\%$.

Covariate definition

Validated questionnaires were used to obtain information on education, smoking habits, dietary intake (including alcohol intake), and physical activity at study baseline. The Cambridge Index of physical activity was derived by combining occupational with recreational activity level to produce four groups: active, moderately active, moderately inactive and inactive.²⁸ Usual diet over the previous 12 months was assessed using validated country/centre-specific dietary questionnaires,²⁴ allowing the calculation of food group, individual energy and nutrient intakes (derived from the EPIC nutrient database²⁹). To summarize diet quality for adjustment purposes, we computed a Mediterranean diet score, ranging from 0 to 18, with greater scores given to higher intakes of fruit, vegetables, legumes, nuts, grains, and fish, lower intakes of red meat and dairy, and moderate intake of alcohol.³⁰

Outcome ascertainment

Incident CHD cases were defined as first CHD events, whether non-fatal or fatal, consisting of ICD-10 codes I20–I25, which include myocardial infarction, other acute ischaemic heart diseases, chronic ischaemic heart disease and angina pectoris.³¹ EPIC centres used methods including self-report, linkage to primary and secondary care registers, hospital admissions, and mortality data to ascertain events. Non-fatal CHD events were further validated by additional review of individual medical records and/or linkage with registries with validation rates ranging from 82 to 100%,³² while fatal CHD events were generally ascertained through mortality registries. End of follow-up for CHD events varied between centres and ranged between 2003 and 2010. Participants known to have left the country were considered lost to follow-up and censored at their date of last follow-up.

Statistical analyses

Characteristics of participants in the subcohort were described across body size phenotypes and compared using ANCOVA, giving adjusted least square means and percentages (and confidence interval) across the six phenotypes. Adjustments were made for centre, sex, age, education, smoking status, and energy intake (for description of dietary intake only).

To assess the association of adiposity markers and metabolically-defined body size phenotypes with incident CHD, we used Prentice-weighted Cox proportional hazards models with robust standard errors to account for the case-cohort design.²¹ Age was the underlying time scale, with entry time defined as the participant's age at recruitment and exit time as age at first fatal or non-fatal CHD event or censoring (whichever came first). For all analyses, we stratified the models by sex and centre. To account for the multi-country design, we followed a two-stage approach where models were fitted separately within country and then country-specific HRs were combined using multivariate random-effects meta-analysis.³³

To assess the shape of associations of BMI and WC with CHD risk, country-specific HRs were calculated by comparing quintiles (defined using all participants) of baseline adiposity values with the lowest

Table 1 Baseline characteristics^a of subcohort participants across metabolically defined body size phenotypes

	Metabolically healthy normal weight	Metabolically unhealthy normal weight	Metabolically healthy overweight	Metabolically unhealthy overweight	Metabolically healthy obese	Metabolically unhealthy obese	P healthy vs. unhealthy obese ^b	P healthy obese vs. normal weight ^b	Unadjusted mean ^c
N	4282	368	2761	1403	751	909			
Women (%)	69 (67, 71)	69 (64, 73)	55 (53, 57)	51 (48, 53)	64 (61, 67)	59 (56, 62)	0.01	0.01	63
Age (years)	50.8 (50.6, 51.1)	55.5 (54.7, 56.3)	52.3 (51.9, 52.6)	54.8 (54.4, 55.3)	52.8 (52.2, 53.4)	54.4 (53.9, 54.9)	<0.0001	<0.0001	53.6 (9.3)
BMI (kg/m ²)	22.7 (22.6, 22.7)	23.5 (23.3, 23.7)	26.9 (26.9, 27.0)	27.5 (27.4, 27.6)	32.6 (32.5, 32.8)	33.3 (33.2, 33.5)	<0.0001	<0.0001	26.1 (4.1)
WC (cm) ^d	79.9 (79.7, 80.1)	85.5 (84.9, 86.2)	88.9 (88.7, 89.2)	93.1 (92.8, 93.5)	101.2 (100.8, 101.7)	105.2 (104.7, 105.6)	NR	NR	86.3 (12.6)
Glucose (mmol/L) ^{d,e}	4.78 (4.73, 4.83)	5.39 (5.24, 5.54)	4.80 (4.75, 4.86)	5.39 (5.31, 5.47)	4.83 (4.72, 4.93)	5.84 (5.74, 5.94)	NR	0.40	5.04 (1.59)
HbA1c (%)	5.45 (5.43, 5.47)	5.62 (5.56, 5.68)	5.47 (5.45, 5.50)	5.69 (5.66, 5.72)	5.57 (5.52, 5.61)	5.96 (5.92, 6.00)	<0.0001	<0.0001	5.5 (0.6)
SBP (mmHg) ^d	127.7 (127.1, 128.3)	137.6 (135.8, 139.3)	131.5 (130.8, 132.2)	139.0 (138.1, 139.9)	135.5 (134.2, 136.7)	143.2 (142.0, 144.3)	NR	<0.0001	132.9 (19.7)
DBP (mm Hg) ^d	78.9 (78.5, 79.2)	84.0 (83.0, 85.0)	81.6 (81.2, 81.9)	85.5 (84.9, 86.0)	84.4 (83.7, 85.1)	87.9 (87.2, 88.6)	NR	<0.0001	82 (10.7)
HDL chol (mmol/L) ^{d,e}	1.60 (1.58, 1.61)	1.17 (1.13, 1.20)	1.48 (1.47, 1.50)	1.15 (1.13, 1.16)	1.46 (1.43, 1.48)	1.10 (1.08, 1.13)	NR	<0.0001	1.48 (0.42)
Total chol (mmol/L) ^e	5.82 (5.78, 5.86)	6.35 (6.24, 6.46)	5.99 (5.95, 6.04)	6.33 (6.27, 6.39)	5.94 (5.87, 6.02)	6.23 (6.15, 6.30)	<0.0001	0.004	6.01 (1.13)
Non HDL chol (mmol/L) ^e	4.22 (4.18, 4.26)	5.18 (5.07, 5.30)	4.51 (4.47, 4.55)	5.19 (5.13, 5.25)	4.49 (4.41, 4.57)	5.12 (5.05, 5.20)	<0.0001	<0.0001	4.53 (1.18)
CRP (mg/L)	1.58 (1.43, 1.73)	2.06 (1.63, 2.49)	2.20 (2.03, 2.37)	2.63 (2.40, 2.86)	3.74 (3.44, 4.05)	4.39 (4.11, 4.67)	0.001	<0.0001	2.34 (4.23)
Triglycerides (mmol/L) ^{d,e}	1.13 (1.10, 1.15)	2.25 (2.17, 2.33)	1.22 (1.19, 1.25)	2.25 (2.20, 2.29)	1.22 (1.16, 1.27)	2.31 (2.25, 2.36)	NR	0.003	1.41 (0.93)
Vegetables (portions/day) ^f	2.67 (2.62, 2.71)	2.65 (2.52, 2.78)	2.68 (2.63, 2.73)	2.73 (2.66, 2.80)	2.60 (2.51, 2.70)	2.71 (2.62, 2.80)	0.08	0.19	2.54 (1.81)
Fruit (portions/day) ^g	2.92 (2.85, 2.99)	2.94 (2.73, 3.15)	3.09 (3.01, 3.17)	3.07 (2.96, 3.18)	3.03 (2.88, 3.18)	3.16 (3.03, 3.30)	0.17	0.19	3.02 (2.29)
Red meat (portions/day) ^h	1.03 (1.01, 1.05)	1.09 (1.03, 1.15)	1.12 (1.10, 1.14)	1.14 (1.11, 1.17)	1.15 (1.11, 1.19)	1.21 (1.17, 1.24)	0.05	<0.0001	1.09 (0.74)
Mediterranean diet score	8.84 (8.77, 8.92)	8.64 (8.42, 8.86)	8.75 (8.66, 8.83)	8.76 (8.65, 8.88)	8.72 (8.57, 8.88)	8.59 (8.45, 8.74)	0.21	0.16	8.55 (3.08)
Energy intake (kcal/day)	2201 (2181, 2220)	2186 (2128, 2243)	2202 (2180, 2224)	2196 (2165, 2226)	2240 (2199, 2280)	2228 (2191, 2265)	0.67	0.08	2149 (623)
Alcohol (drinks/day) ⁱ	1.85 (1.78, 1.91)	1.82 (1.62, 2.01)	1.84 (1.76, 1.92)	1.82 (1.72, 1.93)	1.78 (1.64, 1.92)	1.72 (1.59, 1.85)	0.56	0.36	1.62 (2.13)
Physical activity (%)									
Inactive	22 (21, 24)	25 (21, 29)	23 (22, 25)	27 (25, 29)	31 (28, 34)	32 (29, 34)	0.71	<0.0001	23
Moderately inactive	34 (32, 35)	39 (35, 44)	34 (32, 36)	36 (33, 38)	29 (26, 33)	34 (31, 37)	0.04	0.02	33
Moderately active	24 (23, 25)	19 (14, 23)	22 (21, 24)	19 (17, 22)	20 (17, 23)	18 (16, 21)	0.37	0.02	22
Active	20 (19, 22)	16 (12, 21)	20 (19, 22)	17 (15, 20)	19 (17, 22)	16 (13, 19)	0.07	0.63	21
Education (%)									
No schooling/Primary	35 (33, 36)	43 (39, 48)	43 (41, 44)	46 (44, 48)	52 (49, 55)	51 (48, 54)	0.65	<0.0001	38
Secondary	15 (14, 16)	12 (09, 16)	14 (12, 15)	11 (09, 13)	11 (08, 13)	10 (07, 12)	0.44	0.002	15
Vocational/University	50 (48, 51)	44 (40, 49)	44 (42, 46)	43 (40, 45)	37 (34, 41)	40 (37, 43)	0.31	<0.0001	47
Smoking status (%)									
Never	42 (40, 44)	38 (33, 43)	45 (44, 47)	41 (38, 43)	46 (42, 49)	44 (41, 48)	0.54	0.04	45
Former	29 (27, 30)	24 (20, 29)	31 (29, 33)	33 (30, 35)	34 (31, 38)	32 (29, 35)	0.36	0.002	29
Current	30 (28, 31)	38 (34, 42)	24 (22, 25)	27 (24, 29)	20 (17, 23)	23 (20, 26)	0.10	<0.0001	26

BMI, body mass index; WC, waist circumference; chol, cholesterol; CRP, C-reactive protein; NR, not relevant.

^aValues are adjusted means or percentages (and confidence interval) from ANCOVA, adjusted for centre, sex, age, education, and smoking, as well as energy intake for dietary variables.

^bP-values were calculated using F-test.

^cUnadjusted means (SD) or percentages overall in the subcohort ($n = 10\,474$).

^dValues in bold are components of the metabolic syndrome. The test for difference between metabolically healthy and unhealthy is not presented for these variables as it is not relevant (NR).

^eConversion factors from mmol/L to mg/dL: glucose $\times 18.02$; cholesterol $\times 38.67$; triglycerides $\times 88.57$.

^f1 vegetable portion = 80 g.

^g1 fruit portion = 80 g.

^h1 red meat portion = 110 g of unprocessed meat and 50 g of processed meat.

ⁱ1 alcoholic drink corresponds to 10 g of ethanol.

quintile. The pooled hazard ratios were then plotted against mean values of the adiposity measure within each quintile, accompanied by a group-specific confidence interval derived only from the variance of the log risk in that category (including the reference quintile).³⁴ As associations were approximately log-linear, we calculated HRs associated with 1 standard deviation (SD) higher baseline value (4.10 kg/m² for BMI, 12.7 cm for WC). Heterogeneity between countries was quantified using the I² statistic.³⁵

For analyses of adiposity measures, Model 0 was adjusted for baseline age and smoking status (never, former, current). Model 1 was further adjusted for highest educational level (no schooling/primary, secondary, vocational/university), physical activity, Mediterranean diet score, energy and alcohol intake. Model 2 was further adjusted for the different body size markers, i.e. WC for BMI and BMI for WC. In Model 3, to explore biological pathways potentially underlying the associations, we adjusted for baseline age, smoking status, and intermediate cardiovascular risk factors: blood cholesterol (total and HDL), systolic blood pressure, and diabetes. Interactions on the multiplicative scale between BMI and WC and between BMI and MetS were formally tested.

For analyses of metabolically-defined body size phenotypes, Model A was adjusted for baseline age, smoking status (never, former, current) and highest educational level (no schooling/primary, secondary, vocational/university). To investigate the potential mediating effect of lifestyle habits^{36,37} on the association between metabolically-defined body size phenotypes and CHD risk, we compared Model A to Model B, which further included adjustment for physical activity (Cambridge index: inactive, moderately inactive, moderately active, active), alcohol consumption (g ethanol/day), Mediterranean diet score and energy intake (kcal/day).

The primary complete-case analyses included only participants with non-missing data on anthropometric measurements, blood pressure, blood biomarkers and all covariates, with sensitivity analyses that maximized the number of participants by only excluding those with missing data on the covariates in each analysis model. Additional sensitivity analyses performed were: (i) excluding the first 2 years of follow-up to minimize the potential for reverse causality; (ii) including only 'hard' CHD events, i.e. myocardial infarction and coronary death; (iii) including only events validated with a high level of certainty; (iv) restricting analyses to 'never smokers' only, to apply more rigid control for smoking; (v) separately for men and women to investigate potential differences by sex. For comparability with other studies, we also performed sensitivity analyses with different definitions of obesity or metabolic health: (vi) excluding the WC criterion from the definition of MetS, modifying the definition of metabolically healthy to be <2 abnormalities;^{17,38} (vii) defining metabolically healthy participants as having none of four possible abnormalities (elevated blood pressure, triglyceridaemia, hyperglycaemia, low HDL-cholesterol); (viii) using abdominal obesity index defined as WC ≥ 102 cm for men and WC ≥ 88 cm for women. For the latter, a model (Model C) was fitted including BMI as a continuous covariate. Finally, (ix) we used a multiple imputation approach to impute the missing values for the non-systematically missing variables (i.e. after exclusion of the centres with no data on blood pressure or waist circumference). Five imputed datasets were generated and estimates were combined using Rubin's rules.

All analyses were performed with SAS 9.3 (SAS Institute, Cary, NC, USA) and STATA MP 13.1. We summarize the key aspects of the modelling strategy in Supplementary material online, Figure S2.

Results

After exclusions, there were 10 474 subcohort participants and 7637 incident CHD cases (394 of whom are also in the subcohort)

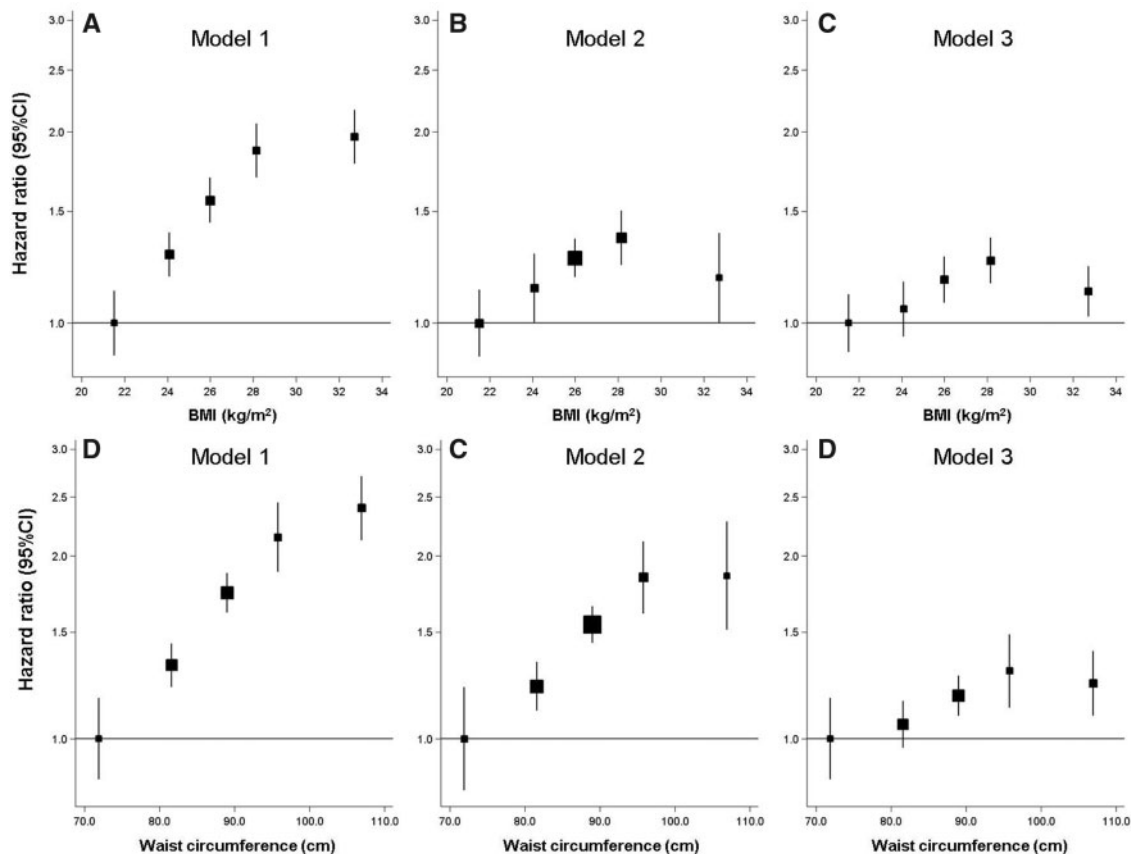


Figure 1 Multivariate hazard ratios for coronary heart disease across quintiles of body mass index (BMI) (A–C) and waist circumference (D–F). Country-specific hazard ratios (HRs) were estimated from Prentice-weighted Cox proportional hazards models, and 95% confidence interval (95% CI) estimated with robust variance, to take into account the case-cohort design. Hazard ratio (HRs) were combined by multivariate random-effects meta-analysis across eight countries and accompanied by a group-specific confidence interval (allowing a confidence interval to be attributed to the reference category). Age was used as the primary time variable, and analyses were stratified by sex and centre. $n = 17\,733$ (7637 cases). Model 1 (A and D): Adjusted for age, smoking, physical activity, Mediterranean diet score, energy, and alcohol intake, educational level. Model 2: Model 1 + adjusted for WC (for BMI, B) or BMI (for WC, E). Model 3 (C and F): Adjusted for age, smoking status, systolic blood pressure, total cholesterol, HDL cholesterol, and history of diabetes. BMI, body mass index; WC, waist circumference, CHD; coronary heart disease.

comprising a total of 17 733 participants who contributed 117 829 person-years at risk in the complete-case analysis. 63% of sub-cohort participants were female and the mean (SD) age and BMI were 53.6 (9.3) years and 26.1 (4.1) kg/m^2 respectively (Table 1). Median follow-up was 12.2 years (interquartile range: 9.7–13.6). 15.8% of subcohort participants were obese, 25.6% had MetS, whilst 45.2% of obese participants were ‘metabolically healthy’. Metabolically healthy obese participants were younger and had lower BMI than obese participants with MetS ($P < 0.0001$). The metabolically healthy obese had worse metabolic parameters (higher lipid levels, blood pressure, HbA1c, C-reactive protein), had higher red meat intake, were less likely to be current smokers, more likely to be inactive and less educated than metabolically healthy normal weight participants (all $P < 0.0001$, Table 1). The proportion of obese participants ranged from 11% in the UK to 30% in Greece and the proportion of obese participants who were metabolically healthy ranged from 31.7% in Germany to 57.9% in Spain (see Supplementary material online, Table S1).

Associations between body size and coronary heart disease

There was a positive approximately log linear association between BMI and CHD risk (Figure 1 and Table 2) after adjusting for potential confounders (Model 1): HR per-standard deviation = 1.25 (95% CI 1.19, 1.32), $P < 0.0001$. While the association was almost perfectly log-linear from quintile 1 to 4, departure from log-linearity was observed at the highest quintile. The risk of CHD almost doubled comparing the highest quintile (mean BMI = 32.7 kg/m^2) to the lowest quintile (mean BMI = 21.5 kg/m^2) (HR = 1.96 [95% CI 1.66, 2.32], $P < 0.0001$). The association was substantially less strong after adjustment for WC (HR = 1.06 [95% CI 0.97, 1.15], $P = 0.20$), likely reflecting the effect of lean mass and peripheral adipose tissue. The association was also substantially attenuated in a model adjusted for intermediate cardiometabolic risk factors (blood pressure, total and HDL-cholesterol, diabetes) (HR = 1.05 [95% CI 1.01, 1.10], $P = 0.03$, Table 2). There was moderate heterogeneity across countries. Results were very similar in sensitivity analyses that use all available individuals with complete data for each

Table 2 Multivariate hazard ratios for coronary heart disease associated with body mass index and waist circumference

	HR ^a	95% CI	P-value	I ² ^b	95% CI
Model 0 ^c					
BMI (kg/m ²)	1.27	(1.21, 1.33)	<.0001	44%	(0%, 75%)
Waist circumference (cm)	1.34	(1.26, 1.42)	<.0001	47%	(0%, 76%)
Model 1 ^d					
BMI (kg/m ²)	1.25	(1.19, 1.32)	<.0001	46%	(0%, 76%)
Waist circumference (cm)	1.32	(1.24, 1.41)	<.0001	51%	(0%, 78%)
Model 2 ^e					
BMI (kg/m ²)	1.06	(0.97, 1.15)	0.20	19%	(0%, 62%)
Waist circumference (cm)	1.24	(1.10, 1.40)	<.0001	43%	(0%, 75%)
Model 3 ^f					
BMI (kg/m ²)	1.05	(1.01, 1.10)	0.03	0%	(0%, 68%)
Waist circumference (cm)	1.06	(1.00, 1.13)	0.06	34%	(0%, 71%)

BMI, body mass index; CHD, coronary heart disease.

^aCountry-specific HRs were estimated from Prentice-weighted Cox proportional hazards models, and 95% CI estimated with robust variance, to take into account the case-cohort design. Hazard ratios were combined by multivariate random-effects meta-analysis across eight countries. Hazard ratios are expressed per 1 SD increase of anthropometric marker (BMI: 4.10 kg/m², WC: 12.7 cm), with age as the primary time variable, stratified by sex and centre. *n* = 17 733 (7637 cases).

^bHeterogeneity across eight European countries.

^cModel 0. HR adjusted for age and smoking.

^dModel 1. HR adjusted for age, smoking, physical activity, Mediterranean diet score, energy and alcohol intake, educational level.

^eModel 2. Model 1 + waist circumference (for BMI) or BMI (for waist circumference).

^fModel 3. HR adjusted for age, smoking, systolic blood pressure, total cholesterol, HDL cholesterol, history of diabetes.

model in turn (Supplementary material online, Table S2). However, results with multiply imputed data showed that, despite being strongly attenuated, the HRs remained significant when adjusted for WC or for intermediate CVD risk factors (Supplementary material online, Table S3). Waist circumference also had positive approximately linear associations with CHD (Figure 1, Table 2), which were robust to adjustment for BMI (HR = 1.24 [95% CI 1.10, 1.40], *P* < 0.0001). Adjustment for cardiometabolic factors substantially attenuated the association (Figure 1, Table 2).

There was a significant interaction between BMI and WC (*P* = 0.005), with a weaker association observed in the upper tertile of each anthropometric factor (Figure 2). For BMI, the HR per-standard deviation increase was 1.27 (95% CI 1.17, 1.38) in the lowest tertile of WC, whereas it was 1.10 (95% CI 1.03, 1.16) in the highest tertile. The association of WC with CHD was stronger at every level of BMI than any of the associations of BMI with CHD across the tertiles of WC: the HR per-standard deviation increase of WC was 1.65 (95% CI 1.43, 1.89) in the lowest tertile of BMI and 1.29 (95% CI 1.21, 1.38) in the highest tertile of BMI.

Associations between metabolically-defined body size phenotypes and coronary heart disease

Compared to the normal weight participants without MetS (reference group), all other metabolically-defined body size phenotypes were at significantly higher risk of CHD (Figure 3) in a fully adjusted model (Model B). Metabolically healthy obese individuals were at higher risk of CHD (HR = 1.28 [95% CI 1.03, 1.58], *P* = 0.02) but this was considerably lower than the risk in metabolically unhealthy groups. MetS was strongly positively associated with CHD risk,

regardless of adiposity, with a HR of 2.15 (95% CI 1.79, 2.57; *P* < 0.0001) for metabolically unhealthy normal weight participants with MetS and a HR of 2.54 (95% CI 2.21, 2.92; *P* < 0.0001) in their obese counterparts. Results were generally consistent across countries (see Supplementary material online, Figure S3; Figure 3). Similar results were obtained from models unadjusted for physical activity and diet (Model A): the HRs were 1.25 (95% CI 1.14, 1.38) and 1.27 (95% CI 1.03–1.57) in the healthy overweight and obese, and 2.17 (95% CI 1.82, 2.59), 2.35 (95% CI 2.02, 2.74) and 2.63 (95% CI 2.30, 3.01) in the unhealthy normal weight, overweight and obese, respectively. There were no significant interactions between BMI and MetS (*P* = 0.19).

Sensitivity analyses show similar results after excluding the first 2 years of follow-up (see Supplementary material online, Table S4), when analyses were restricted to 'harder' CHD events only (see Supplementary material online, Table S5), or when restricting the sample to non-smokers only (see Supplementary material online, Table S6). Analyses restricted to events only validated to the highest level of certainty were qualitatively similar but less precise (see Supplementary material online, Table S7). There was no difference between men and women (*p* for interaction = 0.63, Supplementary material online, Table S8). Estimates from the multiple imputation showed similar trends with the exception of an HR of greater magnitude for the metabolically healthy obese (1.67 [95% CI 1.39; 1.99]) (see Supplementary material online, Table S3).

Sensitivity analyses using a definition of MetS that excludes the WC criterion showed somewhat stronger positive associations for all phenotypes (see Supplementary material online, Table S9). Results were qualitatively similar to the main analysis (but less precise) when a stricter definition of metabolically healthy was used (i.e. having

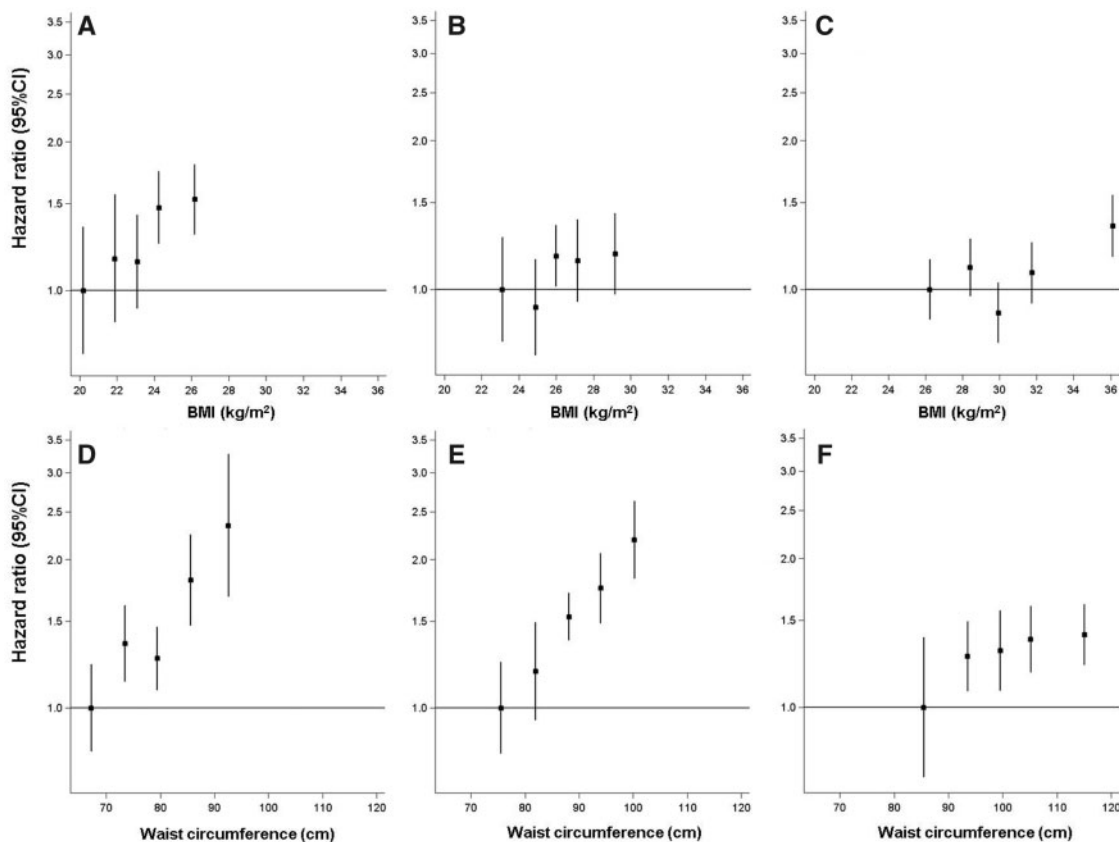


Figure 2 Multivariate hazard ratios (HRs, Model 1^a) for CHD associated with quintiles of BMI per sex-specific tertile of WC (A–C) and quintiles of WC per sex-specific tertile of BMI (D–F). ^aCountry-specific HRs of CHD were estimated from Prentice-weighted Cox proportional hazards models, and 95% confidence interval (95% CI) estimated with robust variance, to take into account the case-cohort design. HRs were combined by multivariate random-effect meta-analysis across eight countries and accompanied by a group-specific confidence interval (allowing a confidence interval to be attributed to the reference category). Age was used as the primary time variable, and analyses were stratified by sex and centre. $n = 17\,733$ (7637 cases). Model 1: Adjusted for age at baseline, smoking, physical activity, educational level, Mediterranean diet score, energy, and alcohol intake. Hazard ratios for quintiles of BMI, in the first (A), second (B), and third (C) sex-specific tertile of WC. Boundaries (cm) by tertiles: Tertile 1, 59–91 (M), 54–76 (F); Tertile 2, 92–99 (M), 77–86 (F); Tertile 3, 100–151 (M), 87–137 (F). Hazard ratios for quintiles of WC, in the first (D), second (E), and third (F) sex-specific tertile of BMI. Boundaries (kg/m^2) by tertiles: Tertile 1, 18.5–25.1 (M), 18.5–23.8 (F); Tertile 2, 25.1–27.9 (M), 23.8–27.4 (F); Tertile 3, 27.9–49.4 (M), 27.4–62.5 (F). P for interaction between BMI and WC = 0.005. BMI, body mass index; WC, waist circumference; CHD, coronary heart disease.

none of the MetS abnormalities) (see Supplementary material online, Table S10). Finally, when obesity was defined by WC (and not by BMI), and MetS did not include the WC criteria, HRs were again qualitatively similar to the main analysis although somewhat stronger (see Supplementary material online, Table S11). When further adjusted for BMI, HRs were attenuated. Agreement between the two definitions of metabolically-defined body size phenotypes where body size is defined by BMI or by WC was only moderate, with a weighted kappa of 0.667 (see Supplementary material online, Table S12).

Discussion

In this prospective case-cohort study with 7637 CHD cases from eight European countries followed-up for a median of 12.2 years, we

assessed the separate and combined effects of body size and metabolic health on CHD. We observed higher CHD risk for general and central adiposity, as defined by BMI and WC, respectively. Whilst the effect of BMI was substantially attenuated on adjustment for WC, the effect of WC appeared to be robust to adjustment for BMI. Metabolically healthy overweight and obese individuals were at higher risk of CHD compared to their normal weight counterparts. However, CHD risk in metabolically unhealthy individuals was markedly higher than in their metabolically healthy counterparts across all BMI categories.

Our study, which is the largest to address this question in terms of the number of incident CHD events, suggests that ‘metabolically healthy’ obesity is not a benign condition. This is of particular importance as overweight people ($\text{BMI} \geq 25$ and < 30) with no traditional cardiometabolic risk factors are not recommended for weight loss

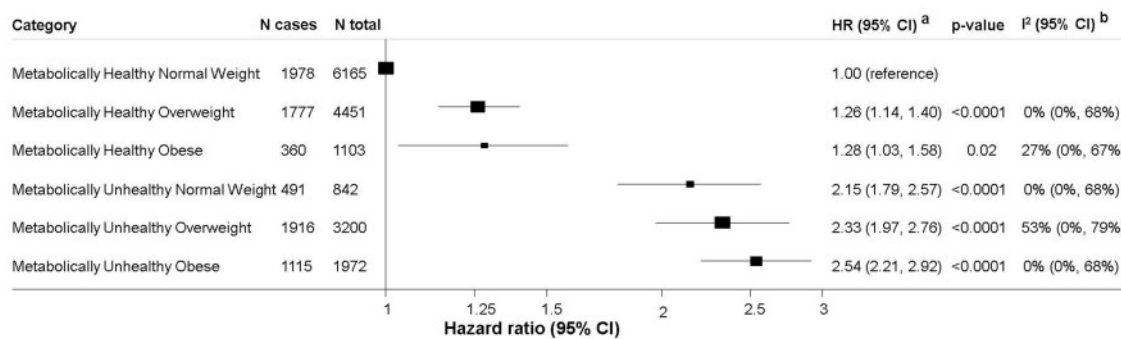


Figure 3 Multivariate hazard ratios of CHD in metabolically-defined body size phenotypes. ^aCountry-specific HRs of CHD were estimated from Prentice-weighted Cox proportional hazards models, and 95% CI estimated with robust variance, to take into account the case-cohort design. Hazard ratios were combined by multivariate random-effects meta-analysis across eight countries. Age was used as the underlying time scale, analyses were stratified by sex and centre, HRs adjusted for age, smoking, educational level, physical activity, Mediterranean diet score, energy, and alcohol intake (Model B). $n = 17\,733$ participants (7637 CHD cases). P for interaction between BMI and MetS = 0.19. ^bHeterogeneity across eight European countries.

treatment by recent UK or USA guidelines.^{39,40} The risk of CHD in metabolically healthy overweight or obese individuals was significantly lower than in the 'metabolically unhealthy' groups, suggesting that obese and overweight individuals without metabolic abnormalities are at intermediate cardiovascular risk between metabolically healthy normal weight individuals and metabolically unhealthy individuals. In support of this hypothesis, we showed that only 6% of the obese had strictly no cardiometabolic abnormality vs. 31% of the normal weight, and that metabolically healthy obese individuals have worse cardiometabolic health than their normal weight counterparts, reflected by higher blood pressure, HbA1c, pro-atherogenic lipids, and C-reactive protein. These data concur with studies that used repeated measurements to evaluate the evolution of metabolically healthy obesity over time, showing that metabolically healthy obese people were more likely to go on to develop metabolic abnormalities (and become metabolically unhealthy obese) than their normal weight counterparts.^{41–47} Despite being acknowledged as a risk factor for CVD, excess weight is not included in the prediction model SCORE.⁴⁸ This algorithm estimates the 10 year risk of fatal CVD and its use is recommended by the ESC Guidelines for CVD risk assessment of patients to assist health professionals in their prevention and treatment strategies.¹⁹ Our results suggest that, even in the absence of multiple traditional CVD risk factors (smoking, type 2 diabetes, high blood pressure, high blood cholesterol), weight-loss strategies through intensive lifestyle advice (diet, exercise, and behaviour modifications) or medical therapy (orlistat or bariatric surgery) should be recommended for obese patients to try to achieve and maintain a healthy body weight to decrease CVD risk. Overall, these results support a population-wide strategy for prevention of obesity and overweight regardless of the initial metabolic status of individuals.

In accordance with previous evidence on CVD, type 2 diabetes, breast and colorectal cancer,^{14,17,49–51} normal weight individuals with metabolic abnormalities had twice the risk of normal weight individuals without metabolic abnormalities. This is consistent with the adverse effects of metabolic factors in cardiovascular health, which are

independent of obesity and accumulation of fat, and could involve inflammation, high-blood pressure, lipotoxicity, and atherosclerosis.^{4,52} We also found that a higher WC was associated with higher risk of CHD at all levels of BMI, including for those in the normal weight category. This is in line with pooled results from 11 prospective studies which found a linear positive association between WC and mortality risk at all levels of BMI ranging from 20 to 50 kg/m²,⁵³ advocating for the importance of an increased waistline at whole spectrum of BMI. Furthermore, a growing body of literature based on novel imaging markers has shown heterogeneity in the cardiovascular phenotype of obesity depending on location of adipose depots, with increased risk observed with visceral adipose tissue compared to subcutaneous fat.^{54–56} This implies that targeted visceral fat loss, rather than overall weight loss, may be a more efficient treatment of obesity to prevent cardiovascular events. Medical therapy with orlistat, which leads to greater reduction in visceral adipose tissue compared to placebo in clinical trials,^{57,58} is a treatment option recommended by the latest ESC guidelines.¹⁹

Positive associations between BMI and WC and CHD are also consistent with previous evidence.^{1–4} Our study confirms both the shape and magnitude of a combined analysis of 39 prospective studies (5259 CHD cases) by the Emerging Risk Factors Collaboration,³ which found a HR of 1.29 (1.22–1.37) for an increase in BMI of 4.56 kg/m² and 1.32 (1.24–1.40) for an increase in WC of 12.6 cm. Our results also align with those of the recent study by the Global BMI Mortality Collaboration, which found a significantly higher risk of CHD death in both the overweight and obesity groups compared with the normal weight group in an analysis including 3 599 426 participants and 54 872 CHD deaths.¹ Although substantially attenuated, an independent effect of BMI and WC remained after adjustment for major potential mediators (SBP, cholesterol, diabetes), indicating that the excess risk for CHD due to high BMI or WC is at least partially mediated by other factors. This is consistent with a pooled analysis of 97 prospective cohort studies from the Prospective Studies Collaboration (57 161 CHD cases), which estimated that these three

factors collectively explained 46% of the excess risk due to adiposity.⁴ The association between adiposity and CHD has been suggested to be causal by Mendelian randomization studies, which have shown that genetic scores indexing BMI or waist-to-hip ratio are associated with risk of CHD.^{59–61} Similar studies have shown causal associations of adiposity with cardiovascular risk factors, supporting the hypothesis of mediation by blood pressure and cholesterol.⁶²

Our study had various strengths, including its prospective design and its large sample size, allowing assessment of risk in various subgroups. Anthropometric factors were mostly measured by trained health professionals, which should reduce measurement error, and concomitant measurement of weight, height, and waist circumference allowed direct comparison of BMI and WC in the same participants. The biomarkers measured and information on medical history permitted exploration of various commonly used definitions of MetS, and the extensive information on covariates (smoking, physical activity, diet quality, alcohol, education) allowed adjustment for a range of potential confounders. However, we cannot rule out the possibility of unmeasured confounding. In particular, as behaviours like physical activity and diet are self-reported at a single time point and were therefore prone to measurement error,^{28,63} it is likely that they were not fully captured.

Study limitations

A potential limitation when comparing our results with previous studies is the lack of consistency in the definition of metabolically healthy obesity.^{38,64} Moreover, by definition, the MetS gives a simplified picture of diverse and complex phenotypes. To overcome this limitation, we chose the most common definition^{14,15,17} (absence of the MetS⁵) and compared several alternative definitions in sensitivity analyses, all of which gave qualitatively similar results. The absence of repeated assessment of metabolic health or adiposity during follow-up meant we were unable to assess within-person variability in adiposity and shed light on the proportion of metabolically healthy obese individuals who became metabolically unhealthy, preventing analyses of 'stable metabolically healthy obesity' and 'transient metabolically healthy obesity'. Finally, we acknowledge that some of the centres included in the EPIC study are not representative of the general population, potentially limiting the generalizability of our findings. For example, the prevalence of metabolically healthy obesity within obese participants (45%) in EPIC-CVD is higher than in some other population-based studies,⁶⁴ suggesting that EPIC participants are likely to be healthier than the general population. However, even if the participants are different from the general population, as long as there is enough variability in the exposure (here, obesity and metabolic health markers), CHD risk estimates and generalizability of the associations are unlikely to be affected.

Conclusions

In this large pan-European study, overweight and obesity were associated with higher risk of CHD, even in the absence of MetS. The presence of metabolic abnormalities was associated with a higher risk of CHD at all levels of adiposity, including in normal weight individuals. Overweight and obese individuals without metabolic dysfunction were at intermediate risk of CHD between healthy normal

weight and metabolically unhealthy individuals. Our results highlight the importance of both obesity and metabolic health in CHD prevention and do not support the concept of 'metabolically healthy obesity'. Population-wide prevention and treatment of obesity is therefore warranted, regardless of metabolic health.

Supplementary material

Supplementary material is available at *European Heart Journal* online.

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Data sharing: For information on how to submit an application for gaining access to EPIC data and/or biospecimens, please follow the instructions at <http://epic.iarc.fr/access/index.php>.

Conflict of interest: none declared.

References

1. The Global BMI Mortality Collaboration. Body-mass index and all-cause mortality: individual-participant-data meta-analysis of 239 prospective studies in four continents. *Lancet* 2016;**388**:776–786.
2. Whitlock G, Lewington S, Sherliker P, Clarke R, Emberson J, Halsey J, Qizilbash N, Collins R, Peto R. Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. *Lancet* 2009;**373**:1083–1096.
3. Wormser D, Kaptoge S, Di Angelantonio E, Wood AM, Pennells L, Thompson A, Sarwar N, Kizer JR, Lawlor DA, Nordestgaard BG, Ridker P, Salomaa V, Stevens J, Woodward M, Sattar N, Collins R, Thompson SG, Whitlock G, Danesh J. Separate and combined associations of body-mass index and abdominal adiposity with cardiovascular disease: collaborative analysis of 58 prospective studies. *Lancet* 2011;**377**:1085–1095.
4. Lu Y, Hajifathalian K, Ezzati M, Woodward M, Rimm EB, Danaei G. Metabolic mediators of the effects of body-mass index, overweight, and obesity on coronary heart disease and stroke: a pooled analysis of 97 prospective cohorts with 1.8 million participants. *Lancet* 2014;**383**:970–983.
5. Alberti KG, Eckel RH, Grundy SM, Zimmet PZ, Cleeman JI, Donato KA, Fruchart JC, James WP, Loria CM, Smith SC Jr. Harmonizing the metabolic syndrome: a joint interim statement of the International Diabetes Federation Task Force on Epidemiology and Prevention; National Heart, Lung, and Blood Institute; American Heart Association; World Heart Federation; International

- Atherosclerosis Society; and International Association for the Study of Obesity. *Circulation* 2009;**120**:1640–1645.
6. Phillips CM. Metabolically healthy obesity: definitions, determinants and clinical implications. *Rev Endocr Metab Disord* 2013;**14**:219–227.
 7. Plourde G, Karelis AD. Current issues in the identification and treatment of metabolically healthy but obese individuals. *Nutr Metab Cardiovasc Dis* 2014;**24**:455–459.
 8. Arnlov J, Ingelsson E, Sundstrom J, Lind L. Impact of body mass index and the metabolic syndrome on the risk of cardiovascular disease and death in middle-aged men. *Circulation* 2010;**121**:230–236.
 9. Aung K, Lorenzo C, Hinojosa MA, Haffner SM. Risk of developing diabetes and cardiovascular disease in metabolically unhealthy normal-weight and metabolically healthy obese individuals. *J Clin Endocrinol Metab* 2014;**99**:462–468.
 10. Flint AJ, Hu FB, Glynn RJ, Caspard H, Manson JE, Willett WC, Rimm EB. Excess weight and the risk of incident coronary heart disease among men and women. *Obesity (Silver Spring)* 2010;**18**:377–383.
 11. Hinnouho GM, Czernichow S, Dugravot A, Nabi H, Brunner EJ, Kivimaki M, Singh-Manoux A. Metabolically healthy obesity and the risk of cardiovascular disease and type 2 diabetes: the Whitehall II cohort study. *Eur Heart J* 2015;**36**:551–559.
 12. Ogorodnikova AD, Kim M, McGinn AP, Muntner P, Khan U, Wildman RP. Incident cardiovascular disease events in metabolically benign obese individuals. *Obesity (Silver Spring)* 2012;**20**:651–659.
 13. Thomsen M, Nordestgaard BG. Myocardial infarction and ischemic heart disease in overweight and obesity with and without metabolic syndrome. *JAMA Intern Med* 2014;**174**:15–22.
 14. Fan J, Song Y, Chen Y, Hui R, Zhang W. Combined effect of obesity and cardio-metabolic abnormality on the risk of cardiovascular disease: a meta-analysis of prospective cohort studies. *Int J Cardiol* 2013;**168**:4761–4768.
 15. Kramer CK, Zinman B, Retnakaran R. Are metabolically healthy overweight and obesity benign conditions? A systematic review and meta-analysis. *Ann Intern Med* 2013;**159**:758–769.
 16. Sung KC, Ryu S, Cheong ES, Kim BS, Kim BJ, Kim YB, Chung PW, Wild SH, Byrnie CD. All-cause and cardiovascular mortality among Koreans: effects of obesity and metabolic health. *Am J Prev Med* 2015;**49**:62–71.
 17. Eckel N, Meidtner K, Kalle-Uhlmann T, Stefan N, Schulze MB. Metabolically healthy obesity and cardiovascular events: a systematic review and meta-analysis. *Eur J Prev Cardiol* 2016;**23**:956–966.
 18. Zheng R, Zhou D, Zhu Y. The long-term prognosis of cardiovascular disease and all-cause mortality for metabolically healthy obesity: a systematic review and meta-analysis. *J Epidemiol Community Health* 2016;**70**:1024–1031.
 19. Piepoli MF, Hoes AW, Agewall S, Albus C, Brotons C, Catapano AL, Cooney MT, Corra U, Cosyns B, Deaton C, Graham I, Hall MS, Hobbs FD, Lochen ML, Lollgen H, Marques-Vidal P, Perk J, Prescott E, Redon J, Richter DJ, Sattar N, Smulders Y, Tiberi M, van der Worp HB, van D I, Verschuren WM. 2016 European Guidelines on cardiovascular disease prevention in clinical practice: The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of 10 societies and by invited experts) Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR). *Eur Heart J* 2016;**37**:2315–2381.
 20. Riboli E, Kaaks R. The EPIC Project: rationale and study design. European Prospective Investigation into Cancer and Nutrition. *Int J Epidemiol* 1997;**26**(Suppl. 1):S6–14.
 21. Prentice RL. A case-cohort design for epidemiologic cohort studies and disease prevention trials. *Biometrika* 1986;**73**:1–11.
 22. Haftenberger M, Lahmann PH, Panico S, Gonzalez CA, Seidell JC, Boeing H, Giurdanella MC, Krogh V, Bueno-de-Mesquita HB, Peeters PH, Skeie G, Hjartaker A, Rodriguez M, Quiros JR, Berglund G, Janlert U, Khaw KT, Spencer EA, Overvad K, Tjonneland A, Clavel-Chapelon F, Tehard B, Miller AB, Klipstein-Grosbusch K, Benetou V, Kiriazi G, Riboli E, Slimani N. Overweight, obesity and fat distribution in 50- to 64-year-old participants in the European Prospective Investigation into Cancer and Nutrition (EPIC). *Public Health Nutr* 2002;**5**:1147–1162.
 23. Schulze MB, Kroke A, Bergmann MM, Boeing H. Differences of blood pressure estimates between consecutive measurements on one occasion: implications for inter-study comparability of epidemiologic studies. *Eur J Epidemiol* 2000;**16**:891–898.
 24. Riboli E, Hunt KJ, Slimani N, Ferrari P, Norat T, Fahey M, Charrondiere UR, Hemon B, Casagrande C, Vignat J, Overvad K, Tjonneland A, Clavel-Chapelon F, Thiebaut A, Wahrendorf J, Boeing H, Trichopoulos D, Trichopoulou A, Vineis P, Palli D, Bueno-de-Mesquita HB, Peeters PH, Lund E, Engeset D, Gonzalez CA, Barricarte A, Berglund G, Hallmans G, Day NE, Key TJ, Kaaks R, Saracci R. European Prospective Investigation into Cancer and Nutrition (EPIC): study populations and data collection. *Public Health Nutr* 2002;**5**:1113–1124.
 25. Spencer EA, Appleby PN, Davey GK, Key TJ. Validity of self-reported height and weight in 4808 EPIC-Oxford participants. *Public Health Nutr* 2002;**5**:561–565.
 26. WHO. Obesity: preventing and managing the global epidemic. Report of a WHO consultation. *World Health Organ Tech Rep Ser* 2000;**894**:i–253.
 27. WHO. *Definition and Diagnosis of Diabetes Mellitus and Intermediate Hyperglycemia—Report of a WHO/IIDF consultation*. Geneva: WHO Press; 2006.
 28. Wareham NJ, Jakes RW, Rennie KL, Schuit J, Mitchell J, Hennings S, Day NE. Validity and repeatability of a simple index derived from the short physical activity questionnaire used in the European Prospective Investigation into Cancer and Nutrition (EPIC) study. *Public Health Nutr* 2003;**6**:407–413.
 29. Slimani N, Deharveng G, Unwin I, Southgate DA, Vignat J, Skeie G, Salvini S, Parpinel M, Moller A, Ireland J, Becker W, Farran A, Westenbrink S, Vasilopoulou E, Unwin J, Borgejodet A, Rohrmann S, Church S, Gnagnarella P, Casagrande C, van Bakel M, Nirdavong M, Boutron-Ruault MC, Stripp C, Tjonneland A, Trichopoulou A, Georga K, Nilsson S, Mattisson I, Ray J, Boeing H, Ocke M, Peeters PH, Jakszyn P, Amiano P, Engeset D, Lund E, de Magistris MS, Sacerdote C, Welch A, Bingham S, Subar AF, Riboli E. The EPIC nutrient database project (ENDB): a first attempt to standardize nutrient databases across the 10 European countries participating in the EPIC study. *Eur J Clin Nutr* 2007;**61**:1037–1056.
 30. Sofi F, Macchi C, Abbate R, Gensini GF, Casini A. Mediterranean diet and health status: an updated meta-analysis and a proposal for a literature-based adherence score. *Public Health Nutr* 2014;**17**:2769–2782.
 31. WHO. *ICD-10: International Statistical Classification of Diseases and Related Health Problems—10th revision*, edition 2010. Geneva, Switzerland: WHO Press; 2011. Report No.: Volume 2—Instruction manual.
 32. Danesh J, Saracci R, Berglund G, Feskens E, Overvad K, Panico S, Thompson S, Fournier A, Clavel-Chapelon F, Canonic M, Kaaks R, Linseisen J, Boeing H, Pischon T, Weikert C, Olsen A, Tjonneland A, Johnsen SP, Jensen MK, Quiros JR, Svatez CA, Perez MJ, Larranaga N, Sanchez CN, Iribas CM, Bingham S, Khaw KT, Wareham N, Key T, Roddam A, Trichopoulou A, Benetou V, Trichopoulos D, Masala G, Sieri S, Tumino R, Sacerdote C, Mattiello A, Verschuren WM, Bueno-de-Mesquita HB, Grobbee DE, van der Schouw YT, Melander O, Hallmans G, Wennberg P, Lund E, Kumle M, Skeie G, Ferrari P, Slimani N, Norat T, Riboli E. EPIC-Heart: the cardiovascular component of a prospective study of nutritional, lifestyle and biological factors in 520,000 middle-aged participants from 10 European countries. *Eur J Epidemiol* 2007;**22**:129–141.
 33. Thompson S, Kaptoge S, White I, Wood A, Perry P, Danesh J. Statistical methods for the time-to-event analysis of individual participant data from multiple epidemiological studies. *Int J Epidemiol* 2010;**39**:1345–1359.
 34. Easton DF, Peto J, Babiker AG. Floating absolute risk: an alternative to relative risk in survival and case-control analysis avoiding an arbitrary reference group. *Stat Med* 1991;**10**:1025–1035.
 35. Ioannidis JP, Patsopoulos NA, Evangelou E. Uncertainty in heterogeneity estimates in meta-analyses. *BMJ* 2007;**335**:914–916.
 36. Bell JA, Hamer M, van Hees VT, Singh-Manoux A, Kivimaki M, Sabia S. Healthy obesity and objective physical activity. *Am J Clin Nutr* 2015;**102**:268–275.
 37. Ortega FB, Lee DC, Katzmarzyk PT, Ruiz JR, Sui X, Church TS, Blair SN. The intriguingly metabolically healthy but obese phenotype: cardiovascular prognosis and role of fitness. *Eur Heart J* 2013;**34**:389–397.
 38. Hinnouho GM, Czernichow S, Dugravot A, Batty GD, Kivimaki M, Singh-Manoux A. Metabolically healthy obesity and risk of mortality: does the definition of metabolically healthy matter? *Diabetes Care* 2013;**36**:2294–2300.
 39. Jensen MD, Ryan DH, Apovian CM, Ard JD, Comuzzie AG, Donato KA, Hu FB, Hubbard VS, Jakicic JM, Kushner RF, Loria CM, Millen BE, Nonas CA, Pi-Sunyer FX, Stevens J, Stevens VJ, Wadden TA, Wolfe BM, Yanovski SZ, Jordan HS, Kendall KA, Lux LJ, Mentor MR, Morgan LC, Trisolini MG, Wnek J, Anderson JL, Halperin JL, Albert NM, Bozkurt B, Brindis RG, Curtis LH, DeMets D, Hochman JS, Kovacs RJ, Ohman EM, Pressler SJ, Sellke FW, Shen WK, Smith SC Jr, Tomaselli GF. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation* 2014;**129**(25 Suppl. 2):S102–S138.
 40. National Institute for Health and Care Excellence. Obesity: Identification, assessment and management of overweight and obesity in children, young people and adults. National Clinical Guideline Centre; 2014. www.nice.org.uk/guidance/cg189 (28 May 2017).
 41. Appleton SL, Seaborn CJ, Visvanathan R, Hill CL, Gill TK, Taylor AW, Adams RJ. Diabetes and cardiovascular disease outcomes in the metabolically healthy obese phenotype: a cohort study. *Diabetes Care* 2013;**36**:2388–2394.
 42. Bobbioni-Harsch E, Pataky Z, Makoundou V, Laville M, Disse E, Anderwald C, Konrad T, Golay A. From metabolic normality to cardiometabolic risk factors in subjects with obesity. *Obesity (Silver Spring)* 2012;**20**:2063–2069.
 43. Soriguer F, Gutierrez-Repiso C, Rubio-Martin E, Garcia-Fuentes E, Almaraz MC, Colomo N, Esteve dA I, de Adana MS, Chaves FJ, Morcillo S, Valdes S,

- Rojo-Martinez G. Metabolically healthy but obese, a matter of time? Findings from the prospective Pizarra study. *J Clin Endocrinol Metab* 2013;**98**:2318–2325.
44. den Engelsen C, Gorter KJ, Salome PL, Rutten GE. Development of metabolic syndrome components in adults with a healthy obese phenotype: a 3-year follow-up. *Obesity (Silver Spring)* 2013;**21**:1025–1030.
45. Bell JA, Hamer M, Sabia S, Singh-Manoux A, Batty GD, Kivimaki M. The natural course of healthy obesity over 20 years. *J Am Coll Cardiol* 2015;**65**:101–102.
46. Bell JA, Hamer M, Batty GD, Singh-Manoux A, Sabia S, Kivimaki M. Incidence of metabolic risk factors among healthy obese adults: 20-year follow-up. *J Am Coll Cardiol* 2015;**66**:871–873.
47. Guo F, Garvey WT. Cardiometabolic disease risk in metabolically healthy and unhealthy obesity: Stability of metabolic health status in adults. *Obesity (Silver Spring)* 2016;**24**:516–525.
48. Conroy RM, Pyorala K, Fitzgerald AP, Sans S, Menotti A, De BG, De BD, Ducimetiere P, Jousilahti P, Keil U, Njolstad I, Oganov RG, Thomsen T, Tunstall-Pedoe H, Tverdal A, Wedel H, Whincup P, Wilhelmsen L, Graham IM. Estimation of ten-year risk of fatal cardiovascular disease in Europe: the SCORE project. *Eur Heart J* 2003;**24**:987–1003.
49. Bell JA, Kivimaki M, Hamer M. Metabolically healthy obesity and risk of incident type 2 diabetes: a meta-analysis of prospective cohort studies. *Obes Rev* 2014;**15**:504–515.
50. Gunter MJ, Xie X, Xue X, Kabat GC, Rohan TE, Wassertheil-Smolter S, Ho GY, Wylie-Rosett J, Greco T, Yu H, Beasley J, Strickler HD. Breast cancer risk in metabolically healthy but overweight postmenopausal women. *Cancer Res* 2015;**75**:270–274.
51. Murphy N, Cross AJ, Abubakar M, Jenab M, Aleksandrova K, Boutron-Ruault MC, Dossus L, Racine A, Kuhn T, Katzke VA, Tjonneland A, Petersen KE, Overvad K, Quiros JR, Jakszyn P, Molina-Montes E, Dorronsoro M, Huerta JM, Barricarte A, Khaw KT, Wareham N, Travis RC, Trichopoulos A, Lagiou P, Trichopoulos D, Masala G, Krogh V, Tumino R, Vineis P, Panico S, Bueno-de-Mesquita HB, Siersema PD, Peeters PH, Ohlsson B, Ericson U, Palmqvist R, Nystrom H, Weiderpass E, Skeie G, Freisling H, Kong SY, Tsilidis K, Muller DC, Riboli E, Gunter MJ. A nested case-control study of metabolically defined body size phenotypes and risk of colorectal cancer in the European Prospective Investigation into Cancer and Nutrition (EPIC). *PLoS Med* 2016;**13**:e1001988.
52. Sarwar N, Gao P, Seshasai SR, Gobin R, Kaptoge S, Di AE, Ingelsson E, Lawlor DA, Selvin E, Stampfer M, Stehouwer CD, Lewington S, Pennells L, Thompson A, Sattar N, White IR, Ray KK, Danesh J. Diabetes mellitus, fasting blood glucose concentration, and risk of vascular disease: a collaborative meta-analysis of 102 prospective studies. *Lancet* 2010;**375**:2215–2222.
53. Cerhan JR, Moore SC, Jacobs EJ, Kitahara CM, Rosenberg PS, Adami HO, Ebbert JO, English DR, Gapstur SM, Giles GG, Horn-Ross PL, Park Y, Patel AV, Robien K, Weiderpass E, Willett WC, Wolk A, Zeleniuch-Jacquotte A, Hartge P, Bernstein L, Berrington de GA. A pooled analysis of waist circumference and mortality in 650,000 adults. *Mayo Clin Proc* 2014;**89**:335–345.
54. Britton KA, Massaro JM, Murabito JM, Kregar BE, Hoffmann U, Fox CS. Body fat distribution, incident cardiovascular disease, cancer, and all-cause mortality. *J Am Coll Cardiol* 2013;**62**:921–925.
55. Neeland IJ, Turer AT, Ayers CR, Berry JD, Rohatgi A, Das SR, Khera A, Vega GL, McGuire DK, Grundy SM, de Lemos JA. Body fat distribution and incident cardiovascular disease in obese adults. *J Am Coll Cardiol* 2015;**65**:2150–2151.
56. Shuster A, Patlas M, Pinthus JH, Mourtzakis M. The clinical importance of visceral adiposity: a critical review of methods for visceral adipose tissue analysis. *Br J Radiol* 2012;**85**:1–10.
57. Smith SR, Stenlof KS, Greenway FL, McHutchison J, Schwartz SM, Dev VB, Berk ES, Kapikian R. Orlistat 60 mg reduces visceral adipose tissue: a 24-week randomized, placebo-controlled, multicenter trial. *Obesity (Silver Spring)* 2011;**19**:1796–1803.
58. Thomas EL, Makwana A, Newbould R, Rao AW, Gambarota G, Frost G, Delafont B, Mishra RG, Matthews PM, Berk ES, Schwartz SM, Bell JD, Beaver JD. Pragmatic study of orlistat 60 mg on abdominal obesity. *Eur J Clin Nutr* 2011;**65**:1256–1262.
59. Emdin CA, Khera AV, Natarajan P, Klarin D, Zekavat SM, Hsiao AJ, Kathiresan S. Genetic association of waist-to-hip ratio with cardiometabolic traits, type 2 diabetes, and coronary heart disease. *JAMA* 2017;**317**:626–634.
60. Hagg S, Fall T, Ploner A, Magi R, Fischer K, Draisma HH, Kals M, de Vries PS, Dehghan A, Willems SM, Sarin AP, Kristiansson K, Nuotio ML, Havulinna AS, de Bruijn RF, Ikram MA, Kuningas M, Stricker BH, Franco OH, Benyamin B, Gieger C, Hall AS, Huikari V, Jula A, Jarvelin MR, Kaakinen M, Kaprio J, Kobl M, Mangino M, Nelson CP, Palotie A, Samani NJ, Spector TD, Strachan DP, Tobin MD, Whitfield JB, Uitterlinden AG, Salomaa V, Syvanen AC, Kuulasmaa K, Magnusson PK, Esko T, Hofman A, de Geus EJ, Lind L, Giedraitis V, Perola M, Evans A, Ferrerres J, Virtamo J, Kee F, Tregouet DA, Arveiler D, Amouyel P, Gianfagna F, Brambilla P, Ripatti S, van Duijn CM, Metspalu A, Prokopenko I, McCarthy MI, Pedersen NL, Ingelsson E. Adiposity as a cause of cardiovascular disease: a Mendelian randomization study. *Int J Epidemiol* 2015;**44**:578–586.
61. Nordestgaard BG, Palmer TM, Benn M, Zacho J, Tybjaerg-Hansen A, Davey SG, Timpson NJ. The effect of elevated body mass index on ischemic heart disease risk: causal estimates from a Mendelian randomisation approach. *PLoS Med* 2012;**9**:e1001212.
62. Holmes MV, Lange LA, Palmer T, Lanktree MB, North KE, Almqogera B, Buxbaum S, Chandrupatla HR, Elbers CC, Guo Y, Hoogeveen RC, Li J, Li YR, Swerdlow DI, Cushman M, Price TS, Curtis SP, Fornage M, Hakonarson H, Patel SR, Redline S, Siscovick DS, Tsai MY, Wilson JG, van der Schouw YT, FitzGerald GA, Hingorani AD, Casas JP, de Bakker PI, Rich SS, Schadt EE, Asselbergs FW, Reiner AP, Keating BJ. Causal effects of body mass index on cardiometabolic traits and events: a Mendelian randomization analysis. *Am J Hum Genet* 2014;**94**:198–208.
63. Kipnis V, Midthune D, Freedman L, Bingham S, Day NE, Riboli E, Ferrari P, Carroll RJ. Bias in dietary-report instruments and its implications for nutritional epidemiology. *Public Health Nutr* 2002;**5**:915–923.
64. Rey-Lopez JP, de Rezende LF, Pastor-Valero M, Tess BH. The prevalence of metabolically healthy obesity: a systematic review and critical evaluation of the definitions used. *Obes Rev* 2014;**15**:781–790.