Increased rates of overweight and obesity have been reported in recent years in developed countries. Current International Obesity Task Force estimates suggest that worldwide at least 1.1 billion adults are overweight, including 312 million who are obese. In the USA, 35% of adults are overweight and an additional 30% are obese. Mean body mass index (BMI) as well as the prevalence of overweight and obesity (measured using the indirect measurement of fatness\textsuperscript{11,12}) increased progressively since 1960 to reach 25%; and in women in the same age group, the prevalence increased to reach 10.5% in 1990\textsuperscript{4}. The overweight/obesity prevalence increased between 1993 and 2003 in a Swiss city, and was associated with a higher fat mass. This observation remained statistically significant after adjustment for age, sex and leisure-time activity.

Conclusion: Overweight prevalence increased between 1993 and 2003 in a Swiss city, and was associated with a higher fat mass. This observation remained statistically significant after adjustment for age, sex and leisure-time activity.
with 1993, and further to determine the association of age, sex and leisure-time activity with BMI, FFMI and FMI.

There are no previously published studies that report body composition trends over a 10-year period. Although other studies\textsuperscript{15–17} have reported body composition changes over time, these studies are limited in length of follow-up or number of subjects.

**Methods**

**Subjects**

The study population comprised two samples of healthy volunteers (1993, \(n = 802\); 2003, \(n = 1631\)) between the ages of 20 and 74 years in Geneva, Switzerland who were non-randomly recruited through advertisement in local newspapers, at trade fairs and fun runs, among public administration staff, and by invitations sent to leisure clubs for the elderly in 1993 and 2003. Identical procedures and measurements were used for both data collection points. Subjects with known acute pathologies or physical handicap were excluded. Volunteers were invited to participate in the study if they had not visited a physicians in the last 6 months for acute or chronic conditions. Subjects with conditions that might interfere with bioelectrical impedance analysis (BIA) measurements were excluded, including water or electrolyte abnormalities (e.g. pachydermia secondary to hypothyroidism) and abnormal body geometry (such as amputation, limb atrophy). Study participants were exclusively Caucasians.

The protocol to perform BIA measurements and obtain physical activity, health status and medication data was approved by the Geneva University Hospital Ethics Committee, and study subjects gave written informed consent.

**Body composition measurements**

Body height was measured to the nearest 0.5 cm and body weight to the nearest 0.1 kg on a balance beam scale. Subjects were dressed in indoor clothing without shoes and heavy sweaters or jackets. Whole-body resistance was measured with four surface electrodes placed on the right wrist and ankle, as previously described\textsuperscript{18}. Briefly, an electrical current of 50 kHz and 0.8 mA was produced by a generator (Bio-Z2\textsuperscript{8}; Spengler) and applied to the skin using adhesive electrodes (3M Red Dot T; 3M Health Care) with the subject lying supine\textsuperscript{19}. The skin was cleaned with 70% alcohol.

The FFM was calculated by the following previously validated multiple regression equation\textsuperscript{20}: \[ FFMI = -4.104 + (0.518 \times \text{height}^2 \times \text{resistance}) + (0.231 \times \text{weight}) + (0.130 \times \text{reactance}) + (4.229 \times \text{sex} \ (\text{men} = 1, \text{women} = 0)) \]

BF was calculated as weight − FFM. The BMI, FFMI and FMI were derived as FFM and BF (kg), respectively, divided by height (m) squared (kg m\(^{-2}\)).

FFMI and FMI (kg m\(^{-2}\)) were used to classify patients as normal or high FFMI, and normal, high or very high FMI.

Ranges of FFMI and FMI were derived from polynomial regression equations for each of the BMI cut-offs (18.5, 25 and 30 kg m\(^{-2}\)) from our healthy subjects (\(n = 5635\))\textsuperscript{21}. These cut-offs correspond to World Health Organization categories for normal weight (18.5–25 kg m\(^{-2}\)), overweight (25–29.9 kg m\(^{-2}\)) and obese (≥ 30 kg m\(^{-2}\)). We did not consider the categories below 18.5 kg m\(^{-2}\) because of the small number of subjects falling into this category.

The FMI (kg m\(^{-2}\)) was considered\textsuperscript{21} ‘normal’ if \(< 19.7\) (men) and \(< 16.7\) (women); and ‘high’ if ≥ 19.8 (men) and ≥ 16.8 (women).

The BMI (kg m\(^{-2}\)) was considered ‘normal’ if \(< 25\) (men) and \(< 19.8\) (women); ‘high’ if \(≥ 26\) (men) and \(≥ 22\) (women).

**Leisure-time activity**

Subjects completed a questionnaire to specify the hours and minutes of physical activity per week performed on a regular basis throughout the year, including seasonal variations. Leisure-time activity in this study was predominantly walking, with seasonal activities including skiing, swimming and bicycling. The subjects who performed > 3 h of physical activity per week for longer than 2 months were classified as ‘physically active’. Only physical activity at moderate or high intensity (4.0 metabolic equivalents (METs) or more, as defined by the activity intensity codes by the Minnesota Leisure Time Activities Questionnaire\textsuperscript{22}), was counted. Subjects who reported less than 3 h of leisure-time activity per week were classified as ‘sedentary’, as previously reported by our group\textsuperscript{23,24}.

**Statistical methods**

The results are expressed as the mean ± standard deviation. The differences between age, leisure-time activity groups and between 1993 and 2003 were analysed by unpaired \(t\)-tests using Statview 5.0. Chi-square was used to determine differences between body composition classifications. Statistical significance was set at \(P \leq 0.05\) for all tests.

Multivariable linear regression was used to model the evolution of body composition between the 1993 and the 2003 subjects. In addition to the time of measurement (1993 or 2003), age, sex and leisure-time activity were introduced in the model. This procedure was performed because we wanted to take into account any age, sex or physical activity differences between the two cohorts. It was reasonable to postulate that changes in demographic composition and leisure habits could have occurred in a 10-year time frame. Therefore, in order to capture the true ‘time’ effect, this modelling was performed in order to control for potential confounding variables. Coefficients associated with the time of measurement therefore captured the evolution of body composition adjusted for sex, age and leisure-time activity between two samples of convenience, recruited in similar conditions.
Results

Comparison of 1993 and 2003 cohort
There was no significant difference in the number of active compared with sedentary study participants between 1993 and 2003 (Table 1). On the other hand, the 2003 cohort included significantly more women than the 1993 cohort. Mean age was significantly higher in 2003 (41.4 ± 11.8 years) than in 1993 (38.1 ± 12.5 years).

The mean BMI was significantly higher in 2003 (P < 0.001) (Fig. 1). A greater number of subjects were overweight/obese in 2003 (27.5%) compared with 1993 (17.2%, chi-square P < 0.001). The FFMI was not significantly higher in 2003 compared with 1993. However, significantly more subjects had a high FFMI in 2003 (30.2%) than in 1993 (21.8%, chi-square P < 0.001). The FMI was significantly higher in 2003 than in 1993 and a greater number of subjects had a high FMI in 2003 (28.0%) compared with 1993 (20.3%, chi-square P < 0.001) (Table 1).

After adjustment for the relevant covariates (age, sex and level of activity), the body composition indices were only slightly different from the unadjusted results (BMI 22.6 ± 0.1 kg m$^{-2}$ for the 1993 subjects and 23.5 ± 0.07 kg m$^{-2}$ for the 2003 subjects, P < 0.001; FMI 5.1 ± 0.07 kg m$^{-2}$ for the 1993 subjects and 5.6 ± 0.05 kg m$^{-2}$ for the 2003 subjects, P < 0.001; FFMI 17.5 ± 0.05 kg m$^{-2}$ for the 1993 subjects and 17.8 ± 0.03 kg m$^{-2}$ for the 2003 subjects, P < 0.001). However, the difference between the 1993 and the 2003 cohort concerning the FFMI became statistically significant when adjusted values were used.

Sedentary and active cohorts
The mean BMI, FMI and FFMI were significantly higher in 2003 than in 1993 in sedentary and active men and women (except for non-significant differences in sedentary women).

The mean BMI was significantly higher in sedentary subjects in both 2003 and 1993 (men, 25.0 ± 3.0 and 23.7 ± 2.6 kg m$^{-2}$; women, 23.0 ± 3.3 and 22.6 ± 3.3 kg m$^{-2}$) than in the active cohort (men, 24.1 ± 2.6 and 22.9 ± 2.6 kg m$^{-2}$; women, 22.0 ± 2.8 and 20.6 ± 1.9 kg m$^{-2}$, respectively, P < 0.05). Similarly, the mean FMI was significantly higher in the sedentary subjects (men, 5.5 ± 2.0 and 4.8 ± 1.8 kg m$^{-2}$; women, 6.9 ± 2.2 and 6.7 ± 2.3 kg m$^{-2}$) than in the active cohort (men, 4.6 ± 1.7 and 4.7 ± 1.4 kg m$^{-2}$; women, 5.7 ± 1.6 and 6.0 ± 2.0 kg m$^{-2}$, P < 0.001) in 2003 and 1993, respectively. FFMI was not significantly higher in 1993 in active than in sedentary subjects (men, 18.9 ± 1.2 and 18.9 ± 1.4 kg m$^{-2}$; women, 15.6 ± 1.0 and 16.1 ± 1.4 kg m$^{-2}$, P > 0.05) and in 2003 in men (19.3 ± 1.4 and 19.5 ± 1.6 kg m$^{-2}$, P > 0.05), but was significantly higher in sedentary than active women in 1993 (16.0 ± 1.4 and 15.6 ± 1.0 kg m$^{-2}$, P = 0.02).

In order to take into account the observed differences in sex and age distributions and to isolate the ‘pure’ time effect represented by the study period, a multivariable analysis that adjusts for these differences was used. The multivariate regression model (Table 2) shows that leisure-time activity was negatively associated with all body composition indices. Age and year of inclusion were associated with an increase in all three body composition indices. Men had a significantly higher BMI and FFMI, and a significantly lower FMI than women.

<table>
<thead>
<tr>
<th>Table 1 Characteristics of the two cohorts of subjects</th>
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<td>1993 (n = 802)</td>
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<td>Active subjects</td>
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<td>Mean FMI (kg m$^{-2}$)</td>
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FFMI – fat-free mass index; FMI – fat mass index; BMI – body mass index. Results are expressed as n (%) or mean ± standard deviation.
Discussion

Prevalence of overweight and obesity
Overall the prevalence of overweight/obesity was 10% higher and the prevalence of high FMI was 8.0% higher in 2003 than in 1993. This suggested that overall rates of overweight and obesity are on the rise in Switzerland. The study showed that 27.6 and 5.4% of sedentary subjects, respectively, were considered overweight and obese in 2003, which is similar to overweight and obesity rates of 29 and 8%, respectively, reported in a random survey in Switzerland25. This compared with overweight and obesity rates of 65% (35 and 30%, respectively) in the USA2, 60% in Germany26 and obesity rates of 19% in Spain27, reported in the late 1990s/early 2000s. Thus the rate of overweight in Switzerland is gradually approaching that seen in the USA and Western Europe, but obesity rates remain slightly lower than in other developed countries. Only six (<0.01%) sedentary and active subjects had BMI >35 kg m\(^{-2}\). Rates of overweight and obesity in this study were lower because of exclusion of subjects with health-related problems (recent hospitalisation, chronic disease). However, the BMI change from 1993 to 2003 could result in considerable increases in overweight and obesity in the future.

Our study showed that the higher prevalence of overweight/obesity in 2003 than 1993 resulted partly in a higher prevalence of high FFMI in active subjects. This effect can be considered beneficial, because higher lean tissue reserves are thought to protect from detrimental effects of malnutrition, such as sarcopenia and frailty in older subjects15,28.

The prevalence of low and high/very high FMI was similar to the prevalence of low and overweight/obese BMI. Overall the prevalence of high and very high FMI was underestimated by 1–2% by BMI. This suggests that in healthy, physically active subjects, BMI provides a good estimation of fatness. However, our previous studies have shown significant underestimations of fatness by BMI in patients at hospital admission29,30 and patients with respiratory insufficiencies31. This finding suggests that excess body fat is poorly estimated by BMI in sedentary subjects or those with chronic diseases. Our study did not determine fat distribution, i.e. did not distinguish between central and subcutaneous adiposity, and no data are available on the possible shift of fat from limbs to trunk.

Association of leisure-time activity, sex, age and year of inclusion with BMI, FFMI and FMI
As expected, sex was positively associated with FFMI and negatively associated with FMI. Numerous studies have documented higher muscle mass and lower body fat in men than in women15,32. BMI was also positively associated with sex, men having a higher BMI than women.

Our results show that leisure-time activity was negatively associated with BMI, FFMI and FMI. Leisure-time activity may, through the effects of increased energy expenditure, preserve both functional status and lean body mass, and contribute to reduce fat accumulation53. In previous studies14, low recreational activity reported at follow-up survey was strongly associated with major weight gain (>13 kg over the preceding 10 years).

Even though the age and gender composition of the two cohorts were different, the year of inclusion remained statistically significant in a multivariable analysis and was positively associated with BMI, FFMI and FMI. We are thus confident that we captured a real evolution of body composition in the Geneva population across a 10-year period. The association of age and year of inclusion (2003 versus 1993) with BMI increase was higher than the beneficial effects of leisure-time activity and thus resulted in higher BMI and FMI in both the sedentary and active cohort in 2003 than 1993 and also resulted in higher FFMI in 2003. This suggests that the higher weights and BMI, at least within the limits of change reported in this study, did not necessarily have a negative effect on body composition in active subjects in view of the higher prevalence of high FFMI and low FMI (data not shown). The lower rates of obesity in the active subjects also suggest that leisure-time activity had a positive effect on BMI and weight, and support a relationship between physical inactivity and the development of overweight and obesity54.

Haapanen et al.54 found that increased physical activity was associated with small body mass gain and low physical activity, and, in particular, decreasing levels of activity during a 10-year follow-up period was strongly associated with large body mass gain.

| Table 2 | Associations of physical activity, sex and age on body mass index and body composition indices |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| | | BMi | | | FFMI | | | FMI | |
| | | Coefficient | 95% CI | P | | | Coefficient | 95% CI | P | | | Coefficient | 95% CI | P |
| Leisure-time activity (active versus sedentary) | | | | | | | | | | | | | | |
| Sex (men versus women) | | | | | | | | | | | | | | |
| Age (each additional decade) | | | | | | | | | | | | | | |
| Cohort (2003 versus 1993) | | | | | | | | | | | | | | |

BMI – body mass index; FFMI – fat-free mass index; FMI – fat mass index; CI – confidence interval.
Our active subjects expended at least 720 kcal week\(^{-1}\) (180 min week\(^{-1}\) at 4 METS) on leisure-time activity. Physical activity expending 1000 kcal week\(^{-1}\) has been associated with a 30\% reduction in all-cause mortality rates, and a slightly favourable effect on all-cause mortality has been noted with physical activity as low as a 500 kcal week\(^{-1}\) (Kesaniemi et al.\(^{35}\)). Lee et al.\(^{26}\) found that fit but overweight men (BMI \(\geq 27.8 \text{ kg m}^{-2}\)) had a similar rate of all-cause mortality to physically fit men of above normal weight and had a lower risk of all-cause mortality than unfit, normal weight men. Unfit men had substantially higher cardiovascular disease mortality than fit men in each BMI group\(^{36}\).

Numerous studies have shown a J- or U-shaped relationship between BMI and mortality\(^{6,37,38}\) and a U-shaped relationship between BMI and expenditure on health care\(^{39}\). Heitman et al.\(^{7}\) suggested that the apparent U-shaped association between BMI and total mortality may be the result of compound risk functions from BF and FFM, e.g. total mortality was a linear function of high BF and low FFM. Allison et al.\(^{6}\) evaluated a hypothetical model in which death increased linearly with BF and decreased linearly with FFM. In spite of higher weights in our active subjects in 2003 than in 1993, the active subjects showed a desirable profile of body composition with preserved FFMI and smaller increases in FMI than our active subjects in 2003 than in 1993 in a sample of convenience recruited in a Swiss city, and was mainly associated with an increase in fat mass. This observation remained statistically significant after adjustment for age, sex and leisure-time activity.

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**Authorship responsibilities:** U.G.K. was involved in data design, collection of data, analysis of data and writing of the manuscript. L.G. and M.P.K. carried out analysis of data and writing of the manuscript. C.P. was involved in data design, data analysis, writing of the manuscript, and obtaining Institutional Review Board approval and funding.

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10-year overweight trends in a Swiss city


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