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Asian Americans: Diabetes Prevalence Across U.S. and World Health Organization Weight Classifications

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RESEARCH DESIGN AND METHODS — Data on Asian American adults (n = 7,414) from the National Health Interview Survey for 1997–2005 were analyzed. Diabetes prevalence was estimated across weight and ethnic group strata.

RESULTS — Regardless of BMI classification, Asian Indians and Filipinos had the highest prevalence of overweight (34–47 and 35–47%, respectively, compared with 20–38% in Chinese; P < 0.05). Asian Indians also had the highest ethnic-specific diabetes prevalence (ranging from 6–7% among the normal weight to 19–33% among the obese) compared with non-Hispanic whites: odds ratio (95% CI) for Asian Indians 2.0 (1.5–2.6), adjusted for age and sex, and 3.1 (2.4–4.0) with additional adjustment for BMI.

CONCLUSIONS — Asian Indian ethnicity, but not other Asian ethnicities, was strongly associated with diabetes. Weight classification as a marker of diabetes risk may need to accommodate differences across Asian subgroups.

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CONCLUSIONS — Although the prevalence of overweight and obesity are a function of the BMI standard used, a consistent pattern of higher overweight prevalence was demonstrated in Asian Indians and Filipinos compared with Chinese. Regardless of the BMI standard used, higher proportions of Asian Indians reported diabetes compared with other Asian subgroups and whites. In addition, compared with non-Hispanic whites, Asian Indian ethnicity alone was associated with diabetes, and other Asian ethnicities were not. After adjusting for BMI, all Asian subgroups were more likely to have diabetes than non-Hispanic whites.

Associations between BMI and diabetes have been previously shown to be modified by ethnicity (5). Studies have shown that Filipinos have higher diabetes prevalence than Chinese (6). Asian Indians have higher prevalence of diabetes than several other subgroups, and the risk increases at lower BMI thresholds (5). Although we do not know why there are differences in diabetes prevalence across Asian subgroups, a possible explanation is the differential associations between quantity and distribution of adiposity and metabolic risk. For example, increased susceptibility to diabetes in Asian Indians compared with Europeans (7) despite lower BMIs (8) is attributed to central adiposity, which may be due to lifestyle and/or genetic/intrauterine predisposition.

The use of BMI as a measure of body proportion is a limitation because of its inability to provide information on body fat distribution and central adiposity. Continued routine use of BMI in research and clinical practice is related to logistical ease in collecting height and weight (measured or self-reported) data. The WHO Asian weight standard is viewed as acceptable when more precise measures of adiposity are not available; however, this study indicates that for Asian Indians, ethnicity alone may be as informative as BMI with regard to diabetes risk.

A limitation of this study is the use of self-reported data, including self-reported height, weight, and diabetes. Although undiagnosed diabetes cannot be assessed using NHIS, a study in New York found that Asians had a rate of undiagnosed diabetes similar to that of non-Hispanic whites (9). As a result, the current study most likely underestimates the total diabetes prevalence in these populations. Furthermore, NHIS is a cross-sectional survey and does not include body weight at the time of diabetes diagnosis. The main strength of this study is the use of nationally representative data with a relatively large Asian sample.

In conclusion, this study demonstrates that Asian Indian ethnicity alone is associated with diabetes risk. We also find that the utility of the WHO Asian weight standard as a marker of diabetes risk may not be equivalent across different Asian subgroups. Prospective studies assessing the complex relationships between body shape, size, fat distribution, and development of cardiometabolic diseases across heterogeneous Asian groups are needed.

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