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Diagnosis and treatment of obese children with insulin resistance

Aa, M.P. van der

Citation

Aa, M. P. van der. (2016, December 13). *Diagnosis and treatment of obese children with insulin resistance*. Retrieved from <https://hdl.handle.net/1887/44921>

Version: Not Applicable (or Unknown)

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Author: Aa, Marloes van der

Title: Diagnosis and treatment of obese children with insulin resistance

Issue Date: 2016-12-13



Chapter 6b

Long-term treatment with metformin in obese, insulin resistant adolescents

Results of a randomized double blinded placebo-controlled trial

Marloes P. van der Aa

Marieke A.J. Elst

Ewoudt M.W. van de Garde

Edgar G.A.H. van Mil

Catherijne A.J. Knibbe

M.M.J. van der Vorst

Nutrition & Diabetes 2016 Aug 29;6(8):e228

Abstract

Background

As adolescents with obesity and insulin resistance may be refractory to lifestyle intervention therapy alone, additional off-label metformin therapy is often used. In this study, the long-term efficacy and safety of metformin *versus* placebo in adolescents with obesity and insulin resistance is studied.

Methods

In a randomized placebo controlled double blinded trial, 62 adolescents with obesity aged 10-16 years old with insulin resistance received 2000mg of metformin or placebo daily and physical training twice weekly over 18 months. Primary endpoints were change in BMI and insulin resistance measured by the Homeostasis Model Assessment for Insulin Resistance (HOMA-IR). Secondary endpoints were safety and tolerability of metformin. Other endpoints were body fat percentage and HbA1c.

Results

Forty-two participants completed the 18 month-study (66% girls, median age 13 (12-15) years, BMI 30.0 (28.3-35.0) kg/m² and HOMA-IR 4.08 (2.40-5.88)). Median Δ BMI was +0.2 (-2.9-1.3) kg/m² (metformin) versus +1.2 (-0.3-2.4) kg/m² (placebo) ($p=0.015$). No significant difference was observed for HOMA-IR. No serious adverse events were reported. Median change in fat percentage was -3.1 (-4.8-0.3) vs -0.8 (-3.2-1.6)% ($p=0.150$), in fat mass -0.2 (-5.2-2.1) vs +2.0 (1.2-6.4) kg ($p=0.007$), in fat free mass +2.0 (-0.1-4.0) vs +4.5 (1.3-11.6) kg ($p=0.047$), and in Δ HbA1c +1.0 (-1.0-2.3) vs +3.0 (0.0-5.0) mmol/mol ($p=0.020$) (metformin vs placebo).

Conclusions

Long-term treatment with metformin in adolescents with obesity and insulin resistance results in stabilisation of BMI and improved body composition compared to placebo. Therefore, metformin may be useful as additional therapy in combination with lifestyle intervention in adolescents with obesity and insulin resistance.

Introduction

Childhood obesity is an important pediatric health issue, with rising prevalence rates in almost all European countries, the United States and Canada [1]. While it was recently reported that the prevalence of overweight and obesity may be stabilizing, percentages are still high, i.e. 37.8 and 36.6% for 11-15 years old boys and girls respectively [2].

Obesity increases the risk of insulin resistance (IR). Children with obesity with IR have a higher risk of developing type 2 diabetes mellitus (T2DM) [3], metabolic syndrome [3,4] and cardiovascular diseases [5,6]. Reduction of body mass index (BMI) is known to reduce the risk of developing these diseases [7-9]. However, IR might be a limiting factor in losing weight in children and adolescents with obesity. In a study by Chiavaroli et al. the efficacy of a one-year weight loss intervention programme in children with and without IR, was evaluated. Children without IR achieved a reduction in BMI-standard deviation score (BMI-SDS) following a weight loss intervention programme, whereas children with IR did not [10]. Therefore, for children with obesity and IR additional (pharmacotherapeutic) therapies to lose weight are often considered.

Metformin is an antidiabetic drug, which reduces peripheral insulin resistance, increases the peripheral glucose uptake and decreases gluconeogenesis of the liver [11]. Although metformin is approved for the treatment of T2DM from the age of 10 years onwards, there is an increasing number of prescriptions for off-label indications such as obesity, polycystic ovarian syndrome (PCOS) and type 1 diabetes mellitus, with percentages reported between 8-20% [12-14].

The evidence for the efficacy of metformin in the treatment of obesity and IR in children is however scarce. A systematic review and meta-analysis of five randomized trials with a trial duration of 6 months (n=320) showed a moderate reduction in BMI (-1.42 kg/m² (95%CI 0.83-2.02)) and in IR measured by the Homeostasis Model Assessment for Insulin Resistance (HOMA-IR) (-2.01 (95%CI 0.75-3.26)) [15]. Long-term data on the efficacy of metformin is limited to one trial, which studied the efficacy of metformin over 48 weeks, and reported a small reduction in BMI [16]. No other studies with treatment duration more than 6 months were identified.

Therefore, the aim of this randomized, double blinded, placebo controlled trial (RCT) in adolescents with obesity with IR is to study the effect of metformin versus placebo on the change in BMI and in IR (measured by HOMA-IR) after 18 months. Secondary objectives included safety and tolerability, as well as change in body fat percentage, HbA1c, quality of life, and physical fitness after 18 months.

Methods

A brief description of the methods is provided here, since the study protocol has been published elsewhere [17].

Study design and participants

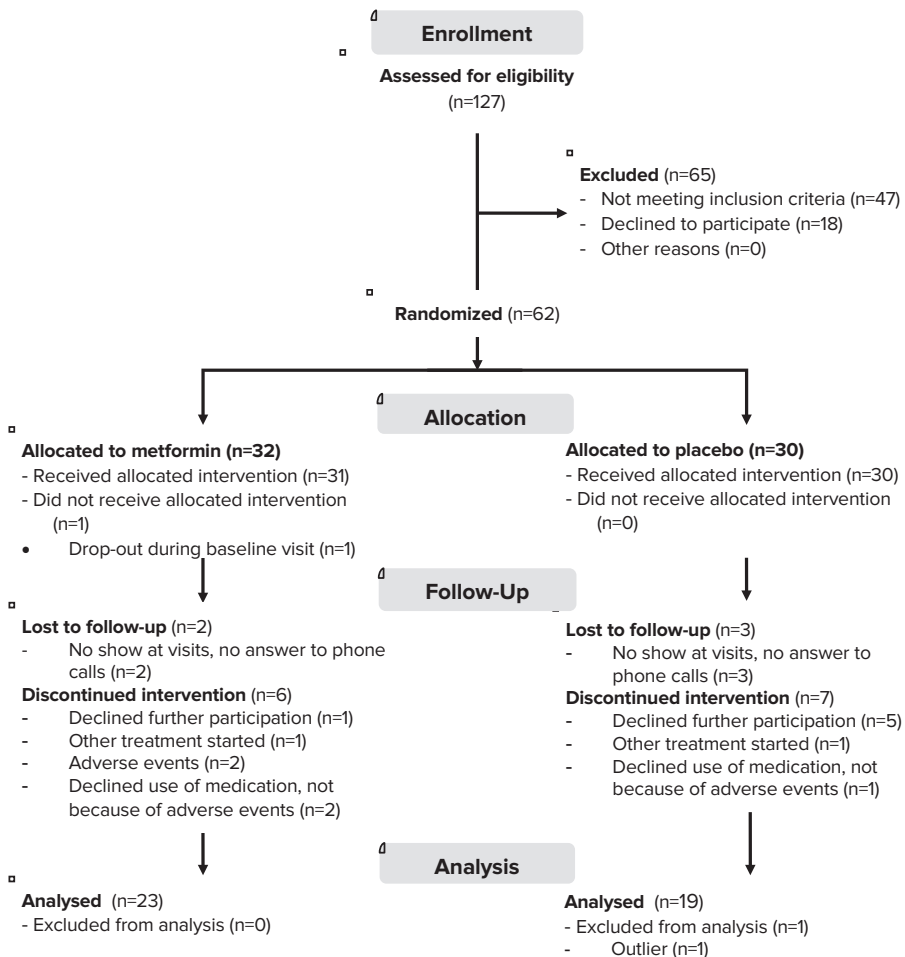
In this 18 months multicentre RCT (ClinicalTrials.gov number NCT01487993), participants were recruited at the pediatric outpatient clinics of the participating study centres (St. Antonius Hospital in Nieuwegein/Utrecht (July 2011-March 2014) and Jeroen Bosch Hospital, 's Hertogenbosch (November 2012-March 2014), The Netherlands). For inclusion and exclusion criteria see Figure 1. All clinical measurements were performed in the pediatric outpatient clinics or day-care wards of these hospitals; the fitness tests were performed at the physical therapy outpatient clinic of the St. Antonius Hospital and the Sports Medical Centre of the Jeroen Bosch Hospital. The study protocol was approved by the Medical Ethical Committee of the St. Antonius Hospital, Nieuwegein/Utrecht, the Netherlands and written informed consent was obtained from the parents and if applicable from the children (aged ≥ 12 years). From the younger children, oral consent was obtained. All procedures were in accordance with the Declaration of Helsinki and the Medical Research Involving Human Subjects Act (WMO) of the Netherlands.

Randomisation and blinding

Consecutive study numbers for eligible participants corresponding with the randomisation code and medication number (e.g. Study number 1, corresponds with randomisation number 1 and medication number 1) were allocated. The randomisation schedule (in blocks of 20 per study centre) was generated by the department of Clinical Pharmacy of the St. Antonius Hospital, using PASW Statistics 18.0. Both subjects and study staff were blinded during the 18-month treatment period. The randomisation code was kept secured in the department of Clinical Pharmacy. The blind was not broken for any of the participants.

Sample size

For Δ BMI, a group sample size of 47 per group was calculated to have 90% power with a significance level of 5% to detect a difference of 2.94% in BMI (Δ BMI ± 1 kg/m²). For Δ HOMA-IR, a group sample size of 60 participants per group was found to detect a difference of 1.6 in HOMA-IR with a significance level of 5% and 90% power. Taking a drop-out of 20% into account, the sample size was set at 144 participants.



Inclusion criteria: Age 10-16 years; BMI-SDS > 2.3; HOMA-IR ≥ 3.4; Caucasian descent; Written informed consent

Exclusion criteria: T2DM; PCOS; Endocrine disorders treated with corticosteroids; Height < 1.3 SD from target height; Syndromal disorders; Pregnancy; (History of) alcohol abuse; Impaired renal function (GFR < 80ml/min); Impaired hepatic function (ALT > 150% of normal value for age); Insufficient knowledge of Dutch language

Figure 1. Consort Flow Diagram

Interventions

Medication

All participants received either immediate-release metformin 500 mg tablets (Centrapharm, Etten-Leur, The Netherlands or identical placebo tablets (Apotheek Haagse Ziekenhuizen, Den Haag, The Netherlands) in an increasing dosing regimen, with a maximum dose of two tablets twice daily in the fourth study week. Subjects were

advised to take the medication during or after breakfast and dinner. In case of gastrointestinal complaints, the dosage was reduced to the last well-tolerated dose. After symptoms had disappeared, the dosage was again increased to the maximum of two tablets twice daily, if tolerated. To estimate medication compliance, pill counts were performed on returned medication packages during each hospital visit (every 3 months).

Physical training

Physical training by a physical therapist was offered twice weekly to all participants. During the monthly phone calls and three monthly visits participants were encouraged to attend these trainings.

Outcomes

Primary outcome measures

Primary endpoint was the change in BMI after 18 months (Δ BMI). BMI was calculated as $\text{weight (kg)} / (\text{height (m)})^2$, and was assessed every 3 months. The corresponding age and sex adjusted BMI, the BMI-SDS, was calculated by the “TNO Groeicalculator voor professionals” (<https://groeisweb.pgdata.nl/calculator.asp>). As second primary outcome, Δ HOMA-IR over 18 months ($\text{HOMA-IR} = \text{fasting plasma glucose (FPG)}(\text{mmol/L}) \times \text{fasting plasma insulin (FPI)}(\text{mU/L}) / 22.5$) was evaluated [18]. FPG and FPI were measured and HOMA-IR was calculated every 3 months.

Secondary outcome measures

Secondary endpoints were safety and tolerability of metformin. Safety outcome measures were renal and hepatic function tests, measured at baseline and every 3 months during treatment. Vitamin B12 levels were measured, and levels <140 pmol/l were defined as abnormal. Tolerability was assessed by the amount of observed adverse events, and the achieved maximum dosage levels. The reasons for drop out of participants were registered.

Other outcome measures

Other endpoints were change in body fat percentage measured by bio-impedance analysis (BIA) using a leg-to-leg BIA measurement, and HbA1c after 18 months. Furthermore, change in quality of life assessed using a validated Dutch translation of the Impact of Weight on Quality of Life-Kids (IWQOL-kids) questionnaire [19,20] and change in physical fitness assessed during validated fitness tests after 18 months were

analysed. Participants were asked to fulfil a dietary diary at baseline, 9 months and 18 months to calculate caloric intake.

Statistical analysis

All participants who started treatment (i.e. they used at least 1 tablet of metformin or placebo) and finished follow up of 18 months were analysed. Since most parameters were not normally distributed, data are reported as medians with interquartile ranges. To assess the effect of metformin versus placebo after 18 months of treatment on the continuous scales, the Mann Whitney U test was applied. To compare the frequencies of categorical, dichotomous data, a chi-squared test was used. All analyses have been conducted with SPSS for Windows version 22.0.

Results

Participants

One hundred twenty-seven (127) participants were assessed for eligibility (Figure 1). Sixty-two (62) participants were allocated to metformin (n=32) or placebo (n=30), of which 42 could be included in the final analysis (Figure 1). One patient in the placebo group was excluded from the analysis, because this patient was an outlier with a change in BMI-SDS of -4.47. There was no difference in baseline age, sex, BMI, HbA1c and HOMA-IR between the participants lost to follow up and participants who completed the 18-month treatment period (supplemental table 1 and 2).

Baseline characteristics

Baseline characteristics of the analysed participants are presented in table 1. Overall more girls than boys were included. In both groups, most participants were early pubertal and family history positive for obesity and diabetes mellitus was frequently reported. Median BMI at baseline was 29.8 (28.1-34.5) kg/m² for the metformin and 30.5 (28.7-38.6) kg/m² for the placebo group, corresponding with an age and sex specific BMI-SDS of 3.10 (2.72-3.52) and 3.38 (3.10-4.20) respectively (Table 1).

Table 1. Baseline characteristics of the analysed participants

		Metformin (n= 23)	Placebo (n=19)
<i>Clinical measurements</i>			
Age (yr)		13.6 (12.6-15.3)	12.0 (11.3-14.0)
Gender, n (%)			
- Boys		6 (26.1)	8 (42.1)
- Girls		17 (73.9)	11 (57.9)
Height (cm)		162.9 (159.0-168.0)	162.0 (160.0-166.0)
Height-SDS		-0.08 (-0.65-0.71)	0.51 (-0.15-1.34)
Weight (kg)		82.2 (75.4-92.7)	86.1 (74.0-103.0)
BMI (kg/m ²)		29.8 (28.1-34.5)	30.5 (28.7-38.6)
BMI-SDS		3.10 (2.72-3.52)	3.38 (3.10-4.20)
Hip circumference (cm)		101.0 (93.0-107.8)	100.8 (96.9-112.3) [#]
Waist circumference (cm)		97.0 (94.0-106.0)	103.8 (100.0-119.4) [#]
Waist-to hip ratio		1.00 (0.95-1.04)	1.05 (0.96-1.10) [#]
Systolic blood pressure (mmHg)		118 (115-124)	119 (113-126)
Diastolic blood pressure (mmHg)		69 (61-72)	67 (57-77)
Tanner stage, n (%)			
- Prepubertal (Tanner stage 1)		3 (13.0)	3 (16.7)
- Pubertal (Tanner stage 2-4)		17 (74.0)	12 (66.6)
- Postpubertal (Tanner stage 5)		3 (13.0)	3 (16.7)
<i>Family-history, first and/or second degree, n (%)</i>			
Obesity		20 (86.9)	16 (84.2)
Diabetes Mellitus		15 (65.2)	9 (47.4)
Hypercholesterolemia		14 (60.9)	9 (47.4)
Hypertension		16 (69.5)	13 (68.4)
Cardiovascular disease		14 (60.9)	14 (73.7)
<i>Highest level of education, n (%)</i>			
Participant	<i>Lowest</i>	4 (17.4)	8 (42.1)
	<i>Low</i>	16 (69.6)	7 (36.8)
	<i>Middle</i>	3 (13.0)	4 (21.1)
	<i>High</i>	0 (0)	0 (0)
Father	<i>Lowest</i>	2 (8.7)	1 (5.3)
	<i>Low</i>	9 (39.1)	5 (26.3)
	<i>Middle</i>	7 (30.4)	9 (47.4)
	<i>High</i>	3 (13.0)	2 (10.5)
	<i>Unknown</i>	2 (8.7)	2 (10.5)
Mother	<i>Lowest</i>	0 (0)	3 (15.8)
	<i>Low</i>	10 (43.5)	10 (52.6)
	<i>Middle</i>	8 (34.8)	4 (21.1)
	<i>High</i>	4 (17.4)	0 (0)
	<i>Unknown</i>	1 (4.3)	2 (10.5)

Table 1. Baseline characteristics of the analysed participants (continued)

	Metformin (n= 23)	Placebo (n=19)
<i>Biochemical measurements</i>		
Glucose 0' (mmol/l)	4.8 (4.7-5.0)	4.8 (4.5-5.0)
Glucose 120' (mmol/l)	6.0 (5.6-6.6)	5.9 (4.8-7.2)
Insulin 0' (mU/l)	18.0 (11.0-27.0)	23.0 (12.0-26.0)
Insulin 120' (mU/l)	94.0 (63.0-138.0)	90.0 (54.0-128.0)
HOMA-IR	4.00 (2.30-6.36)	4.85 (2.40-5.78)
HbA1c (mmol/mol)	33 (31-34)	32 (31-34)
Cholesterol (mmol/l)	4.8 (3.9-5.3)	4.4 (4.1-5.0)
HDL (mmol/l)	1.10 (1.02-1.22)	1.16 (1.03-1.36)
LDL (mmol/l)	2.9 (2.3-3.3)	2.4 (2.1-3.2)
TG (mmol/l)	1.4 (0.9-1.6)	1.4 (1.0-1.8)
Total cholesterol/HDL-ratio	4.3 (3.4-4.7)	3.8 (2.7-5.0)
ALT (U/l)	19 (15-26)	21.5 (14.5-28.5)
Creatinine (μmol/l)	51 (48-55)	50 (47-56)
Vitamin B12 (pmol/l)	365 (267-420)	336 (280-492)
<i>Bio-impedance</i>		
Body fat (%)	38.6 (36.5-43.2)	41.2 (36.9-44.1) [#]
Fat mass (kg)	31.8 (25.0-39.4)	33.6 (27.6-48.5) [#]
Fat free mass (kg)	48.9 (45.4-53.0)	50.4 (42.6-54.5) [#]
<i>Quality of Life by IWQOL-Kids</i>		
	<i>n=22</i>	<i>n=15</i>
Section 1, Physical comfort	83.3 (72.5-94.2)	73.3 (63.3-86.7)
Section 2, Body esteem	75.6 (63.3-88.3)	68.9 (55.6-84.4)
Section 3, Social life	86.7 (76.7-93.3)	86.7 (80.0-90.0)
Section 4, Family relations	100 (95.8-100)	100 (90.0-100)
<i>Physical fitness</i>		
	<i>n=18</i>	<i>n=13</i>
Shuttle walk test, distance in m	1500 (1138-1500)	1500 (955-1500)
9 meter sprint test (sec)	2.47 (2.35-2.60)	2.70 (2.05-3.00)
10x5 m sprint test (sec)	20.63 (19.21-23.45)	20.28 (19.15-22.10)
Situps in 30 seconds (n)	21 (17-30)	17 (14-19)
Time to stand up from supine position	2.10 (1.80-2.84)	2.40 (1.90-2.96)

Reported values are median (Interquartile range) or numbers (%). [#] n=18

Abbreviations: SDS – standard deviation score; BMI – body mass index; HOMA-IR - homeostasis model assessment for insulin resistance; HDL – high density lipoprotein; LDL – low density lipoprotein; ALT – alanine aminotransferase; IWQOL – impact of weight on quality of life.

Medication compliance

Two participants did not return any medication packages during the study. In the metformin group 74% (17/22 participants) returned their medication boxes at least 4 times, versus 69% in the placebo group (13/18 participants). The returned boxes contained on average 28% and 24% of its content for the metformin and placebo groups,

respectively. In case of full compliance, the remaining content should be 7% because all medication boxes had a surplus when dispensed.

Effect on BMI and HOMA-IR

Table 2 presents the 18 months treatment results of metformin versus placebo; the absolute values for BMI and other parameters, as well as changes over 0-18 months are displayed. After 18 months, median Δ BMI was +0.2 (-2.9-1.3) kg/m² in the metformin group versus +1.2 (-0.3-2.4) kg/m² in the placebo group (p=0.015). Figure 2 shows that this difference between the two groups can be explained by a decrease in Δ BMI in the metformin group during the first 6-9 months of treatment and subsequent return to baseline values, which was not observed in the placebo group.

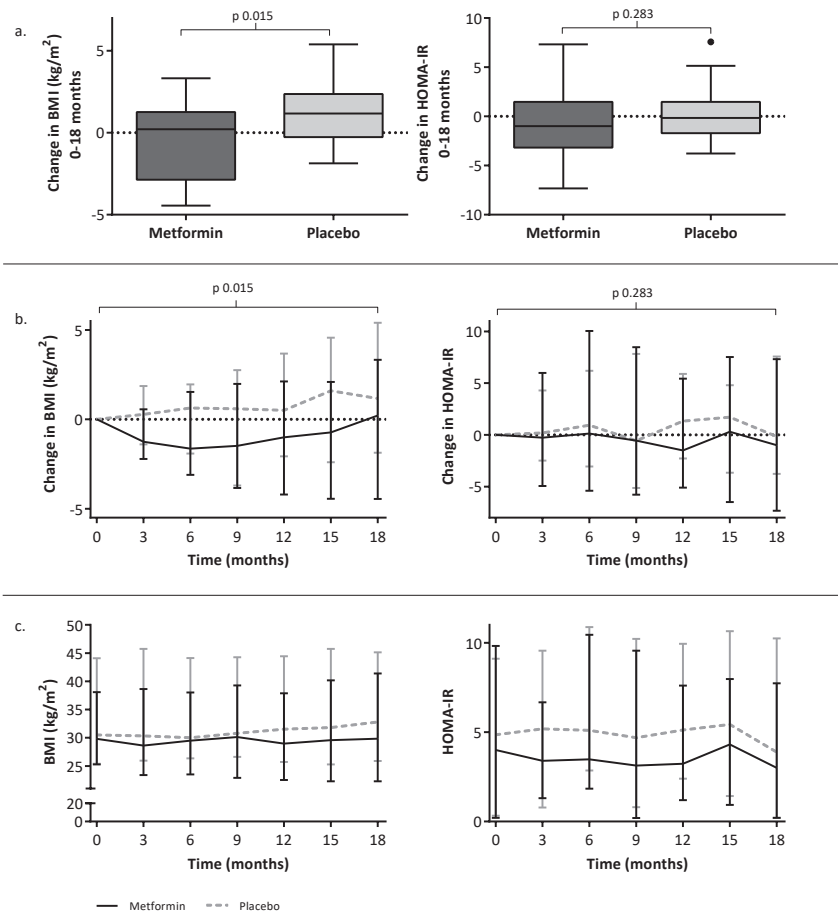


Figure 2. Effect of metformin on primary endpoints BMI and HOMA-IR after 18 months
a. Change in BMI and HOMA-IR between t=0 and t=18 months; *b.* Median Δ BMI and Δ HOMA-IR over time; *c.* Median BMI and HOMA-IR over time.

Table 2. Treatment effects of metformin versus placebo after 18 months

	Metformin (n= 23)			Placebo (n=19)			Metformin vs placebo, p-value
	T=0	T=18	Δ T=18 – T=0	T=0	T=18	Δ T=18 – T=0	
Primary outcomes							
BMI	29.8 (28.1-34.5)	29.9 (26.3-33.6)	0.2 (-2.9-1.3)	30.5 (28.7-38.6)	32.8 (29.3-40.4)	1.2 (-0.3-2.4)	0.02
BMI-SDS	3.10 (2.72-3.52)	2.90 (2.34-3.39)	-0.12 (-.50-0.08)	3.38 (3.10-4.20)	3.29 (3.02-4.18)	0.04 (-.24-0.10)	
HOMA-IR	4.00 (2.30-6.36)	3.00 (2.00-4.29)	-1.00 (-3.17-2.25)	4.85 (2.40-5.78)	3.88 (2.86-5.56)	-0.16 (-1.71-1.48)	0.28
Other outcomes							
HbA1c	33.0 (31.0-34.0)	33.5 (30.8-34.3)	1.0 (-1.0-2.3)	32.0 (31.0-34.0)	36.0 (33.0-37.0)	3.0 (0.0-5.0)	0.02
Height (cm)	162.9 (159.0-168.0)	166.5 (160.3-171.0)	2.1 (0.5-6.6)	162.0 (160.0-166.0)	168.3 (163.7-171.3)	6.2 (2.5-8.7)	
Weight (kg)	82.2 (75.4-92.7)	83.4 (76.6-94.2)	1.6 (-4.2-5.9)	86.1 (74.0-103)	96.7 (79.0-111.0)	12.0 (2.7-17.0)	
Bio-impedance							
Body fat %	38.6 (36.5-43.2)	37.6 (30.9-40.9)	-3.1 (-4.8-0.3)	41.2 (36.9-44.1)	41.2 (37.7-46.9)	-0.8 (-3.2-1.6)	0.15
Fat mass (kg)	31.8 (25.0-39.4)	31.1 (22.6-37.6)	-0.2 (-5.2-2.1)	33.6 (27.6-48.5)	34.9 (29.5-53.1)	2.0 (1.2-6.4)	0.007
Fat free mass (kg)	48.9 (45.4-53.0)	49.4 (46.7-55.4)	2.0 (-0.1-4.0)	50.4 (42.6-54.5)	52.0 (48.9-65.1)	4.5 (1.3-11.6)	
IWQOL-kids							
Total score	83.0 (76.7-91.9)	90.0 (81.5-98.1)	2.6 (0.2-5.7)	80.0 (72.6-85.2)	84.8 (77.8-90.0)	5.2 (-2.2-9.6)	0.94
Section 1	83.3 (72.5-94.2)	91.7 (79.2-100)	6.7 (0-13.3)	73.3 (63.3-86.7)	90.0 (76.7-93.3)	6.7 (3.3-21.7)	0.41
Section 2	75.6 (63.3-88.3)	82.2 (66.1-94.4)	2.2 (-2.2-5.6)	68.9 (55.6-84.4)	73.3 (67.8-87.8)	5.6 (-3.9-10.6)	0.66
Section 3	86.7 (76.7-93.3)	95.0 (86.7-99.2)	3.3 (0-6.7)	86.7 (80.0-90.0)	90.0 (86.7-95.0)	0 (-6.7-6.7)	0.25
Section 4	100 (95.8-100)	100 (95.8-100)	0 (0-3.3)	100 (90.0-100)	100 (95.0-100)	0 (0-5.8)	0.86

Table 2. Treatment effects of metformin versus placebo after 18 months (continued)

	Metformin (n= 23)				Placebo (n=19)				Metformin vs placebo, p-value
	T=0	T=18	Δ T=18 – T=0	T=0	T=18	Δ T=18 – T=0	T=0	Δ T=18 – T=0	
<i>Fitness test</i>		<i>n=15</i>					<i>n=7</i>		
Shuttle walk test (m)	1500 (1163-1500)	1500 (1415-1500)	0 (0-120)	1180 (850-1500)	1360 (1170-1500)	270 (-100-320)			0.52
9 meter sprint (sec)	2.48 (2.40-2.65)	2.53 (2.38-2.71)	0.01 (-0.14-0.12)	2.70 (2.00-3.09)	2.60 (2.47-3.04)	0.08 (-0.37-0.58)			0.46
10x5 m sprint (sec)	20.63 (19.21-23.44)	20.58 (19.14-21.46)	-0.40 (-2.30-0.60)	21.00 (20.00-25.53)	21.10 (20.53-24.03)	-0.10 (-0.60-0.53)			0.46
Situps in 30 seconds (n)	21 (17-30)	24 (19-30)	0 (-11-8)	17 (14-19)	23 (19-25)	5 (4-11)			0.33
Time to stand up from supine position (sec)	2.10 (1.80-2.84)	2.31 (2.13-2.58)	-0.05 (-0.33-0.61)	2.40 (1.90-2.96)	2.88 (2.26-2.93)	-0.03 (-0.32-1.24)			0.49

All values are median (IQR). Abbreviations: BMI – body mass index; SDS – standard deviation score; HOMA-IR - homeostasis model assessment for insulin resistance; 1WQOL – impact of weight on quality of life

No significant difference was observed for Δ HOMA-IR after 18 months between both groups (Table 2). Figure 2 shows that in accordance with this lack of difference between the groups at 18 months, there is also no evidence for a difference in profile of Δ HOMA-IR over time during the study.

Secondary endpoints safety and tolerability

Safety

No severe adverse events occurred in either group. There were no derangements of renal or hepatic function (Table 3). In three participants of the metformin group, vitamin B12 levels below the threshold of 140 pmol/l were measured at 18 months (136, 117 and 108 pmol/l respectively).

Table 3. Safety and tolerability of metformin versus placebo

	Metformin (n= 23)	Placebo (n=19)	p-value
<i>Safety, n(%)</i>			
ALT > 69 U/l (girls) or >78 U/l (boys)	0	0	NA
GFR < 60 ml/min	0	0	NA
Vitamin B12 <140 pmol/l	3 (13.0)	0	NA
<i>Tolerability</i>			
<i>Adverse events, n(%)</i>			
Nausea	17 (73.9)	8 (42.1)	0.04
Diarrhoea	14 (60.9)	9 (47.4)	0.38

Abbreviations: ALT – alanine aminotransferase; GFR – glomerular filtration rate; NA – not applicable

Tolerability

Two out of nine participants lost to follow up in the metformin group discontinued treatment because of adverse events. One patient had severe nausea despite dosage reductions. The other patient suffering from abdominal pain and discomfort, was not willing to try dosage reductions and terminated study participation. Four participants in the metformin group did not tolerate the maximum dose of 2000mg daily because of adverse events; these participants used 1000 mg daily (n=3) or 1500 mg daily (n=1). In the placebo group, no participants dropped out because of adverse events.

Well-known side effects of metformin, nausea and diarrhoea, were reported in both groups during the study, but participants using metformin suffered significantly more from nausea (73.9%, n=17) than the participants receiving placebo (42.1%, n=8) (p=0.037). Diarrhoea occurred in 60.9 % (n=14) of the metformin users and 47.4% (n=9) of the placebo users (p=0.38) (Table 3).

Effect of metformin on HbA1c and body composition

Table 2 and Figure 3 show that HbA1c increased in both groups, with a significantly larger increase in the placebo group ($p=0.02$). None of the participants had HbA1c values above the normal threshold after 18 months.

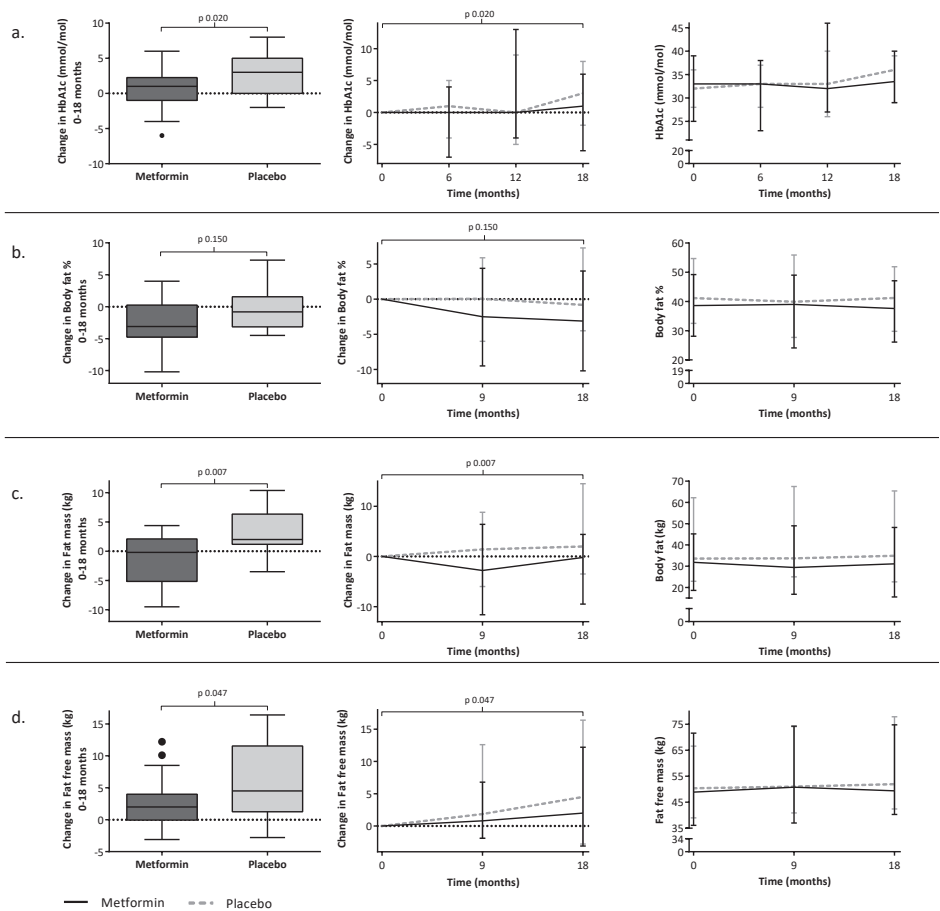


Figure 3. Effect of metformin on HbA1c and body composition after 18 months
Boxplots represent the Δ -values between $t=0$ and $t=18$ months. Graphs represent median values.

In the metformin group, fat mass decreased versus an increase in the placebo group ($p=0.007$) (Table 2, figure 3). Concerning fat free mass, in the metformin group the increase was + 2.0 (-0.1-4.0) kg versus + 4.5 (1.3-11.6) kg in the placebo group ($p=0.047$). There was no significant change in body fat percentage (Figure 3).

Effect of metformin on quality of life and physical fitness

Table 2 shows results for quality of life measured by IWQOL-kids. For all sections and the total score, there was no difference in quality of life. Due to a poor attendance at the physical tests after 18 months, physical fitness tests could only be analysed in a small subgroup (metformin $n=15$, placebo $n=7$) (Table 2). At baseline, more than 50% of the participants completed the shuttle walk test, therefore the median score of the shuttle walk test was similar to the maximum score and no significant differences were observed in this small subgroup. Dietary diaries were not completed and returned adequately, and therefore the caloric intake could not be calculated and analysed.

Discussion

In this RCT in adolescents with obesity and insulin resistance, we found that assignment to the metformin group was associated with an initial decrease in BMI over the first 6-9 months of treatment after which BMI returned to baseline level, whereas BMI increased in placebo users. Changes in body composition and HbA1c over 18 months were also in favour of metformin. In contrast, in the placebo group, a steady increase in BMI was observed over 18 months. No serious adverse events were reported and most participants tolerated metformin up to 1000mg twice daily, only two participants discontinued treatment because of adverse events.

Our study is the first study in an obese non-diabetic pediatric population reporting on the long term effect (> 1 year of treatment) of metformin on BMI. Beneficial effects on BMI upon short term treatment with metformin have been reported before by Burgert et al, who reported upon 4-month treatment a reduction in BMI of -0.9 kg/m^2 (95%CI -2.0 - 0.3 kg/m^2) versus an increase in BMI of $+1.2 \text{ kg/m}^2$ (-0.1 - 2.4 kg/m^2) in placebo [21]. Upon 48 weeks of treatment, Wilson et al. reported a significant reduction in BMI of $-0.9 \pm 0.5 \text{ kg/m}^2$ for the metformin group versus $+0.2 \pm 0.5 \text{ kg/m}^2$ in the placebo group ($p=0.03$) [16]. Comparing our results with these previous short term results, it seems that our results after 12 months closely resemble them (i.e. median ΔBMI -1.0 (-3.4 - 0.6) kg/m^2 for metformin versus $+0.6$ (-0.2 - 2.1) kg/m^2 for placebo, Figure 2). In our study, where we report on treatment effects after 18 months, the difference between metformin and placebo remained significant even though it seems that BMI values return to baseline in the metformin group. However, in the placebo group there was no evidence of a decrease in BMI (Figure 2). An intriguing question is therefore how BMI will change over time after these 18 months. Lavine et al. treated children with obesity and non-alcoholic fatty liver disease for 96 weeks with metformin [22]. However, the treatment in this study was not primarily focused on weight loss, and participants did not receive lifestyle intervention. They reported changes in BMI after 96 weeks of $+1.3$

(0.6-2.0) kg/m² for metformin versus +1.9 (1.1-2.7) kg/m² for placebo (p=0.25) [22]. This finding illustrates that metformin without lifestyle intervention may not be effective in changing BMI. As a consequence, follow up results of our study (open label results) upon 36 months treatment with metformin with lifestyle intervention will need to be awaited [17]. Until then, in our opinion, lifestyle intervention remains an important part of obesity treatment to which metformin therapy over 18 months seems to be of added value to reduce BMI.

In our study, two participants discontinued treatment and four participants received a reduced dosage because of adverse events, even though there were no serious adverse events or derangements in hepatic and renal function tests. These findings are comparable to the study of Wilson et al. of 48 weeks, where 1 patient dropped out because of nausea [16]. In studies where metformin was administered over 2-6 months, no severe adverse events, elevated hepatic or renal function tests, or decreased vitamin B12 were reported. Concerning vitamin B12, in our study, 3 participants in the metformin group had decreased vitamin B12 levels and therefore monitoring of vitamin B12 levels upon long-term use of metformin should be considered. In all studies nausea and diarrhoea were the most frequently reported side-effects [21,23-29]. Even though these side effects of metformin are mostly mild and self-limiting, a small number of participants (6%) did not tolerate metformin because of these side-effects [28]. It is known that the incidence of gastro-intestinal side-effects is higher in patients using immediate release metformin compared to extended release metformin [30-32]. Therefore, the use of extended release metformin could be considered in the small number of patients with serious gastro-intestinal side-effects. From this study, it seems that safety and tolerability of long term metformin treatment is comparable to short-term treatment (6 months to 48 weeks), with no serious adverse events and only a small percentage of participants who do not tolerate metformin.

In the current study, participants treated with metformin were found to have an improved body composition measured by BIA after 18 months, with a decrease in fat mass and increase in fat free mass compared to placebo. In the placebo group, the change in fat free mass was larger than the change in fat mass. The placebo group has a larger increase in height (table 2) during the 18 months; the increase in fat free mass might be related to this increase in height. We assume that this increase in height, and therewith in fat free mass, is caused by a difference in pubertal stage during the study. At t=18months, in the metformin group 38.1% was pubertal (Tanner Stage 2-4) and 57.1% postpubertal (Tanner stage 5), compared to 64.7% pubertal and 35.3% postpubertal in the placebo group. In the metformin group an increase in fat free mass in accordance with their increase in height over 18 months was found, without an increase in fat mass, resulting in a stable BMI. Also in other studies, a favourable effect of metformin on body composition (measured by DEXA or BIA) after 2-11 months of

treatment, compared to placebo was reported [16,21,24,29]. In adults, a decrease in body fat percentage was related to a decrease in systolic and diastolic blood pressure and cholesterol levels [33]. Therefore, a change in body composition during metformin treatment might have a positive influence on cardiovascular risk factors.

A limitation of our study is the number of included participants. For the primary endpoint (Δ BMI), 66% of the targeted number of participants was included, while for the change in HOMA-IR this percentage was only 43%, despite a prolongation of the inclusion period by 1.5 years. Furthermore, the dropout rate was 32%, whereas a dropout rate of 20% was anticipated. This high dropout rate illustrates the difficulties in motivating adolescents with obesity for long-term treatment and follow up. This difficulty is underlined by the poor attendance at physical fitness tests and by the dietary diaries, which had limited completeness and reliability. Frequent phone calls and written reminders by the study staff did not improve the compliance. The low number of included participants and high dropout rate could have resulted in insufficient power to statistically test our hypotheses. However, although our study has less power than anticipated, we were able to detect a significant effect of metformin on the primary outcome measure (Δ BMI). For comparison, with respect to the IR outcome, other studies with sufficient power did not find an effect on IR after 6 months and 48 weeks either [16,25,28]. Another limitation is the measurement of IR. All participants had HOMA-IR ≥ 3.4 during the screening for eligibility. At baseline, which was planned within a few weeks from screening, some participants had HOMA-IR values <3.4 , while still being obese (BMI-SDS > 2.3). As a possible explanation for this finding, participants may not tell the truth about their fasting state during the screening. Another reason may be the large coefficient of variation that has been reported for fasting insulin [34,35]. Since HOMA-IR is based on fasting insulin, HOMA-IR will vary as well resulting in HOMA-IR < 3.4 , thereby explaining the lack of difference in this parameter.

Conclusion

In conclusion, long-term treatment with metformin in adolescents with obesity and insulin resistance results in a stabilisation of BMI and improved body composition compared to placebo. Therefore, metformin may be considered a safe additional therapy in combination with lifestyle intervention.

Acknowledgement

The authors would like to acknowledge ZonMw for funding our study and all members of the project group responsible for submitting the project idea to the ZonMw Program for Priority Medicines for Children. Rifka Peeters of the department of Clinical Pharmacy of the St Antonius Hospital is acknowledged for supporting the logistics of trial medication, and research nurses Bianca Broere and Kitty Blauwendraat for their assistance in the data collection.

Contributors statement

MP van der Aa collected the data, carried out the data analyses, drafted the initial manuscript, and approved the final manuscript as submitted. MAJ Elst collected the data, critically reviewed the manuscript, and approved the final manuscript as submitted. EMW van de Garde supervised the data analysis, critically reviewed the manuscript, and approved the final manuscript as submitted. EGAH van Mil conceptualized and designed the study, critically reviewed the manuscript, and approved the final manuscript as submitted. MMJ van der Vorst and CAJ Knibbe conceptualized and designed the study, drafted the initial manuscript, and approved the final manuscript as submitted.

Conflict of interest

The authors declare no conflict of interest.

References

1. Ahluwalia N, Dalmasso P, Rasmussen M, Lipsky L, Currie C, Haug E, et al. Trends in overweight prevalence among 11-, 13- and 15-year-olds in 25 countries in Europe, Canada and USA from 2002 to 2010. *Eur J Public Health* 2015 Apr;25 Suppl 2:28-32.
2. van Jaarsveld CH, Gulliford MC. Childhood obesity trends from primary care electronic health records in England between 1994 and 2013: population-based cohort study. *Arch Dis Child* 2015 Mar;100(3):214-219.
3. Levy-Marchal C, Arslanian S, Cutfield W, Sinaiko A, Druet C, Marcovecchio ML, et al. Insulin resistance in children: Consensus, perspective, and future directions. *J Clin Endocrinol Metab* 2010 ;95(12):5189-5198.
4. Burrows RA, Leiva LB, Weisstaub G, Lera LM, Albala CB, Blanco E, et al. High HOMA-IR, adjusted for puberty, relates to the metabolic syndrome in overweight and obese Chilean youths. *Pediatr Diabetes* 2011 May;12(3 Pt 2):212-218.
5. Pankow JS, Jacobs DR, Jr., Steinberger J, Moran A, Sinaiko AR. Insulin resistance and cardiovascular disease risk factors in children of parents with the insulin resistance (metabolic) syndrome. *Diabetes Care* 2004 03;27(3):775-780.
6. Cruz ML, Shaibi GQ, Weigensberg MJ, Spruijt-Metz D, Ball GD, Goran MI. Pediatric obesity and insulin resistance: chronic disease risk and implications for treatment and prevention beyond body weight modification. *Annu Rev Nutr* 2005;25:435-468.
7. Oberbach A, Neuhaus J, Inge T, Kirsch K, Schlichting N, Bluher S, et al. Bariatric surgery in severely obese adolescents improves major comorbidities including hyperuricemia. *Metabolism* 2014 Feb;63(2):242-249.
8. Arrigo T, Gitto E, Ferrau V, Munafo C, Alibrandi A, Marseglia GL, et al. Effect of weight reduction on leptin, total ghrelin and obestatin concentrations in prepubertal children. *J Biol Regul Homeost Agents* 2012 Jan-Mar;26(1 Suppl):S95-103.
9. Gronbaek H, Lange A, Birkebaek NH, Holland-Fischer P, Solvig J, Horlyck A, et al. Effect of a 10-week weight loss camp on fatty liver disease and insulin sensitivity in obese Danish children. *J Pediatr Gastroenterol Nutr* 2012 Feb;54(2):223-228.
10. Chiavaroli V, Giannini C, D'Adamo E, de Giorgis T, Torello M, D'Orazio N, et al. Weight loss in obese prepubertal children: the influence of insulin resistance. *Endocr Res* 2013;38(1):48-57.
11. Cusi K, Consoli A, DeFronzo RA. Metabolic effects of metformin on glucose and lactate metabolism in noninsulin-dependent diabetes mellitus. *J Clin Endocrinol Metab* 1996 Nov;81(11):4059-4067.
12. Fazeli Farsani S, Souverein PC, Overbeek JA, van der Vorst MM, Knibbe CA, Herings RM, et al. Long term trends in oral antidiabetic drug use among children and adolescents in the Netherlands. *Br J Clin Pharmacol* 2015 Aug;80(2):294-303.
13. Hsia Y, Dawoud D, Sutcliffe AG, Viner RM, Kinra S, Wong IC. Unlicensed use of metformin in children and adolescents in the UK. *Br J Clin Pharmacol* 2012 01;73(1):135-139.
14. Kostev K, Richter H. Unlicensed use of metformin in children and adolescents in Germany and France. *Br J Clin Pharmacol* 2012 Feb;73(2):307-308.
15. Park MH, Kinra S, Ward KJ, White B, Viner RM. Metformin for obesity in children and adolescents: a systematic review. *Diabetes Care* 2009 09;32(9):1743-1745.
16. Wilson DM, Abrams SH, Aye T, Lee PD, Lenders C, Lustig RH, et al. Metformin extended release treatment of adolescent obesity: a 48-week randomized, double-blind, placebo-controlled trial with 48-week follow up. *Arch Pediatr Adolesc Med* 2010 02;164(2):116-123.

17. van der Aa MP, Elst MA, van Mil EG, Knibbe CA, van der Vorst MM. METFORMIN: an efficacy, safety and pharmacokinetic study on the short-term and long-term use in obese children and adolescents - study protocol of a randomized controlled study. *Trials* 2014 Jun 5;15:207-6215-15-207.
18. Matthews DR, Hosker JP, Rudenski AS, Naylor BA, Treacher DF, Turner RC. Homeostasis model assessment: insulin resistance and beta-cell function from fasting plasma glucose and insulin concentrations in man. *Diabetologia* 1985 Jul;28(7):412-419.
19. Kolotkin RL, Zeller M, Modi AC, Samsa GP, Quinlan NP, Yanovski JA, et al. Assessing weight-related quality of life in adolescents. *Obesity (Silver Spring)* 2006 03;14(3):448-457.
20. Wouters EJM, Geenen R, Kolotkin RL, Vingerhoets AJJM. Met lichaamsgewicht samenhangende kwaliteit van leven bij adolescenten. *Psychometrische kwaliteit van de Nederlandse vertaling van de IWQOL-Kids. Tijdschrift voor Kindergeneeskunde* 2010;78(3):119-125.
21. Burgert TS, Duran EJ, Goldberg-Gell R, Dziura J, Yeckel CW, Katz S, et al. Short-term metabolic and cardiovascular effects of metformin in markedly obese adolescents with normal glucose tolerance. *Pediatr Diabetes* 2008 12;9(6):567-576.
22. Lavine JE, Schwimmer JB, Van Natta ML, Molleston JP, Murray KF, Rosenthal P, et al. Effect of vitamin E or metformin for treatment of nonalcoholic fatty liver disease in children and adolescents: the TONIC randomized controlled trial. *JAMA* 2011 Apr 27;305(16):1659-1668.
23. Freemark M, Bursey D. The effects of metformin on body mass index and glucose tolerance in obese adolescents with fasting hyperinsulinemia and a family history of type 2 diabetes. *Pediatrics* 2001 Apr;107(4):E55.
24. Kay JP, Alemzadeh R, Langley G, D'Angelo L, Smith P, Holshouser S. Beneficial effects of metformin in normoglycemic morbidly obese adolescents. *Metabolism* 2001 12;50(12):1457-1461.
25. Kendall D, Vail A, Amin R, Barrett T, Dimitri P, Ivison F, et al. Metformin in obese children and adolescents: the MOCA trial. *J Clin Endocrinol Metab* 2013 Jan;98(1):322-329.
26. Love-Osborne K, Sheeder J, Zeitler P. Addition of metformin to a lifestyle modification program in adolescents with insulin resistance. *J Pediatr* 2008 06;152(6):817-822.
27. Srinivasan S, Ambler GR, Baur LA, Garnett SP, Tepsa M, Yap F, et al. Randomized, controlled trial of metformin for obesity and insulin resistance in children and adolescents: improvement in body composition and fasting insulin. *J Clin Endocrinol Metab* 2006 06;91(6):2074-2080.
28. Wiegand S, l'Allemand D, Hubel H, Krude H, Burmann M, Martus P, et al. Metformin and placebo therapy both improve weight management and fasting insulin in obese insulin-resistant adolescents: a prospective, placebo-controlled, randomized study. *Eur J Endocrinol* 2010 Oct;163(4):585-592.
29. Yanovski JA, Krakoff J, Salaita CG, McDuffie JR, Kozlosky M, Sebring NG, et al. Effects of metformin on body weight and body composition in obese insulin-resistant children: a randomized clinical trial. *Diabetes* 2011 02;60(2):477-485.
30. Ali S, Fonseca V. Overview of metformin: special focus on metformin extended release. *Expert Opin Pharmacother* 2012 Aug;13(12):1797-1805.
31. Blonde L, Dailey GE, Jabbour SA, Reasner CA, Mills DJ. Gastrointestinal tolerability of extended-release metformin tablets compared to immediate-release metformin tablets: results of a retrospective cohort study. *Curr Med Res Opin* 2004 Apr;20(4):565-572.
32. Schwartz S, Fonseca V, Berner B, Cramer M, Chiang YK, Lewin A. Efficacy, tolerability, and safety of a novel once-daily extended-release metformin in patients with type 2 diabetes. *Diabetes Care* 2006 Apr;29(4):759-764.

33. Diaz Cisneros FJ, Rivera Cisneros AE, Lopez Martinez MG, Garcia Gonzalez MR, Lopez Ortega H. Effects of an aerobic exercise program and diet on body composition and cardiovascular function in obese persons. *Arch Inst Cardiol Mex* 1986 Nov-Dec;56(6):527-533.
34. Antuna-Puente B, Faraj M, Karelis AD, Garrel D, Prud'homme D, Rabasa-Lhoret R, et al. HOMA or QUICKI: Is it useful to test the reproducibility of formulas? *Diabetes Metab* 2008 /;34(3):294-296.
35. Henriquez S, Jara N, Bunout D, Hirsch S, de la Maza MP, Leiva L, et al. Variability of formulas to assess insulin sensitivity and their association with the Matsuda index. *Nutr Hosp* 2013 Sep-Oct;28(5):1594-1598.

SUPPLEMENTARY MATERIALS TO CHAPTER 6B

Supplemental table 1. Comparison of baseline data of participants lost to follow up and participants who completed the first part of the study.

	Follow up complete (n=43)	Lost to follow up (n=18)	P-value
Age	13.4 (11.7-15.2)	12.38 (11.4-15.3)	0.61
Gender			n (%)
- Boys	14 (82.4)	3 (17.6)	0.21
- Girls	29 (65.9)	15 (34.1)	
BMI	30.0 (28.3-35.0)	32.4 (28.9-35.2)	0.45
BMI-SDS	3.25 (2.86-3.65)	3.44 (2.99-3.63)	0.49
HbA1c	33 (31-34)	31 (30-35)	0.17
HOMA-IR	4.08 (2.40-5.88)	4.10 (3.23-5.77)	0.55

Supplemental table 2. Baseline characteristics of all randomized participants Reported values are median (Interquartile range) or numbers (%).

	Metformin (n= 31)	Placebo (n=30)
<i>Clinical measurements</i>		
Age (yr)	13.6 (11.8-15.2)	12.9 (11.4-15.2)
Gender, n (%)		
- Boys	7 (22.6)	10 (33.3)
- Girls	24 (77.4)	20 (66.7)
Height (cm)	162.0 (156.0-168.0)	162.6 (159.4-166.3)
Height-SDS	-0.01 (-0.56-0.64)	0.34 (-0.27-1.17)
Weight (kg)	80.2 (72.4-92.7)	87.5 (74.2-98.7)
BMI (kg/m ²)	30.3 (28.2-34.5)	32.0 (28.9-36.3)
BMI-SDS	3.20 (2.72-3.55)	3.44 (3.10-4.02)
Hip circumference (cm)	102.5 (94.5-108.0)	103.4 (96.0-113.3)
Waist circumference (cm)	99.0 (94.0-107.8)	103.0 (99.5-114.0)
Waist-to hip ratio	1.00 (0.95-1.06)	1.04 (0.93-1.10)
Systolic blood pressure (mmHg)	118 (115-124)	121 (116-127)
Diastolic blood pressure (mmHg)	68 (61-72)	67 (59-76)
Tanner stage, n (%)		
- Prepubertal (TS 1)	5 (16.1)	5 (16.7)
- Pubertal (TS 2-4)	23 (74.2)	19 (65.5)
- Postpubertal (TS 5)	3 (9.7)	5 (16.7)
<i>Family-history, first and/or second degree, n (%)</i>		
Obesity	28 (90.3)	24 (80.0)
Diabetes mellitus	21 (67.7)	15 (50.0)
Hypercholesterolemia	20 (64.5)	14 (46.7)
Hypertension	22 (71.0)	20 (66.7)
Cardiovascular disease	19 (61.3)	19 (63.3)
<i>Highest level of education, n (%)</i>		
Participant		
- Lowest	7 (22.6)	11 (36.7)
- Low	20 (64.5)	10 (33.3)
- Middle	4 (12.9)	9 (30.0)
- High	0 (0)	0 (0)
Father		
- Lowest	3 (9.7)	4 (13.3)
- Low	11 (35.5)	9 (30.0)
- Middle	10 (32.3)	11 (36.7)
- High	4 (12.9)	4 (13.3)
- Unknown	3 (9.7)	2 (6.7)
Mother		
- Lowest	1 (3.2)	5 (16.7)
- Low	14 (45.2)	12 (40.0)
- Middle	9 (29.0)	10 (33.3)
- High	6 (19.4)	1 (3.3)
- Unknown	1 (3.2)	2 (6.7)

Supplemental table 2. Baseline characteristics of all randomized participants Reported values are median (Interquartile range) or numbers (%). (continued)

	Metformin (n= 31)	Placebo (n=30)
<i>Biochemical measurements</i>		
Glucose 0' (mmol/l)	4.8 (4.6-5.0)	4.8 (4.5-4.9)
Glucose 120' (mmol/l)	5.8 (6.1-7.0)	5.9 (5.1-6.9)
Insulin 0' (mU/l)	20.0 (13.0-27.0)	18.0 (12.0-26.0)
Insulin 120' (mU/l)	103.0 (67.0-146.0)	75.5 (52.5-131.0)
HOMA-IR	4.09 (2.60-6.27)	4.04 (2.52-5.59)
HbA1c (mmol/mol)	33 (30-34)	32 (30-34)
Cholesterol (mmol/l)	4.7 (3.9-5.2)	4.5 (4.1-5.0)
HDL (mmol/l)	1.14 (1.02-1.27)	1.14 (1.01-1.42)
LDL (mmol/l)	2.9 (2.3-3.1)	2.4 (2.1-3.2)
TG (mmol/l)	1.4 (1.0-1.7)	1.5 (1.0-1.8)
Total cholesterol/HDL-ratio		
ALT (U/l)	20 (16-28)	21 (15-27)
Kreatinin (μmol/l)	50 (48-55)	52 (47-59)
Vitamin B12 (pmol/l)	365 (267-429)	337 (253-427)
<i>Bio-impedance</i>		<i>n=29</i>
Body fat (%)	39.3 (36.9-44.0)	41.5 (36.8-46.1)
Fat mass (kg)	32.1 (27.1-39.4)	36.1 (28.1-46.8)
Fat free mass (kg)	47.7 (43.5-52.5)	51.0 (44.3-54.7)
<i>Quality of Life by IWQOL-Kids</i>		<i>n=24</i>
Section 1, Physical comfort	25.5 (21.8-28.3)	24.5 (19.0-27.0)
Section 2, Body esteem	32.5 (26.0-38.3)	30.0 (25.3-36.8)
Section 3, Social life	26.5 (23.0-29.0)	26.0 (24.3-27.8)
Section 4, Family relations	30.0 (29.0-30.0)	30.0 (28.0-30.0)
<i>Physical fitness</i>		<i>n=16</i>
Shuttle walk test, distance in m	1500 (1118-1500)	1500 (1065-1500)
9 meter sprinttest (sec)	2.50 (2.40-2.69)	2.69 (2.03-2.91)
10x5 m sprinttest (sec)	21.52 (19.30-23.94)	20.28 (19.20-23.00)
Situps in 30 seconds (n)	21 (18-30)	20 (17-24)
Time to stand up from supine position	2.25 (1.85-2.86)	2.40 (1.80-2.72)

Reported values are median (Interquartile range) or numbers (%).

Abbreviations: SDS – standard deviation score; BMI – body mass index; HOMA-IR - homeostasis model assessment for insulin resistance; HDL – high density lipoprotein; LDL – low density lipoprotein; ALT – alanine aminotransferase; IWQOL – impact of weight on quality of life.

