Being big or growing fast: systematic review of size and growth in infancy and later obesity

Janis Baird, David Fisher, Patricia Lucas, Jos Kleijnen, Helen Roberts and Catherine Law

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Abstract

Objectives To assess the association between infant size or growth and subsequent obesity and to determine if any association has been stable over time.

Design Systematic review.

Data sources Medline, Embase, bibliographies of included studies, contact with first authors of included studies and other experts.

Inclusion criteria Studies that assessed the relation between infant size or growth during the first two years of life and subsequent obesity.

Main outcome measure Obesity at any age after infancy.

Results 24 studies met the inclusion criteria (22 cohort and two case-control studies). Of these, 18 assessed the relation between infant size and subsequent obesity, most showing that infants who were defined as “obese” or who were at the highest end of the distribution for weight or body mass index were at increased risk of obesity. Compared with non-obese infants, in those who had been obese odds ratios or relative risks for subsequent obesity ranged from 1.35 to 9.38. Ten studies assessed the relation of infant growth with subsequent obesity and most showed that infants who grew more rapidly were at increased risk of obesity. Compared with other infants, in infants with rapid growth odds ratios and relative risks of later obesity ranged from 1.17 to 5.70. Associations were consistent for obesity at different ages and for people born over a period from 1927 to 1994.

Conclusions Infants who are at the highest end of the distribution for weight or body mass index or who grow rapidly during infancy are at increased risk of subsequent obesity.

Introduction

Levels of overweight and obesity have increased markedly during the past decade in all age groups. The UK government has set a target to halt the year on year rise in obesity in children aged ≤11 by 2010 as part of an overall strategy to tackle the rising prevalence of obesity in the population. Given the lack of evidence of effective treatments, action to achieve this target must focus mainly on prevention. It is not clear, however, how early in life prevention could begin.

Observational evidence suggests that faster growth during childhood is associated with an increased risk of obesity in later life, suggesting that interventions aimed at modifying childhood growth could prevent adult obesity. Recent studies in the US and Finland have shown that patterns of growth during infancy may be associated with both childhood and adult obesity, suggesting the potential for intervention during infancy. The precise patterns of growth leading to obesity are unclear and both infant size and infant growth have been implicated.

We carried out a systematic review to assess the association between infant growth and subsequent obesity and to establish whether groups of infants with particular patterns of growth are at greater risk. We considered both size and growth because each is important in understanding the growth status of an infant—for example, an infant may be small but be growing rapidly. Given secular trends in children’s growth, we also assessed whether any associations identified in the past are likely to apply to infants now.

Methods

This research was part of a wider review of scientific evidence on infant growth and health and wellbeing throughout the life course, which was carried out alongside a review of lay perspectives on infant size and growth, supplemented by individual and focus group interviews (J Baird et al, Defining optimal infant growth for lifetime health: a systematic review of lay and scientific literature (unpublished report)). We sought studies that described the relation between any aspect of infant growth or size and the development of overweight or obesity at any later age. Studies of infant size were eligible for inclusion if they reported at least one measurement of infant size between 3 months and 2 years. We included studies of infant growth if they reported at least two measurements of size up to 2 years, of which at least one was between 3 months and 2 years.

The outcomes we considered were overweight or obesity. We did not specify a definition of obesity as studies may have been published before currently accepted definitions were introduced. We did not impose any limits in relation to language, study timing, or setting.

We searched Medline and Embase from their start dates to June 2005 and hand searched the bibliographies of all included studies. We also contacted first authors of included studies and other experts to identify further published or unpublished analyses.

We followed the methods recommended by the Centre for Reviews and Dissemination. Study quality was assessed by using a checklist and summarised as to whether there was a low, medium, or high risk of bias for study results. The confounding factors we considered important in the relation between infant size or growth and obesity were socioeconomic status, parental size, and method of infant feeding.
Papers

Our approach to synthesis was mainly narrative but we explored the potential for meta-analysis according to standard procedures.10

Results

We identified 27949 references. Screening of abstracts and reference lists identified 24 studies that met our inclusion criteria. All 24 studies were observational (22 cohort studies and two case-control). All but two studies were based in developed countries.

We considered that 15 studies were at medium risk of bias, six at high risk, and three at low risk. Common sources of bias were insufficient description of participants, high rates of attrition, and inadequate consideration of confounding factors.

Studies of infant size

Eighteen studies assessed the relationship between infant size and obesity at ages ranging from 3 to 35 years (table 1). Most focused on “infant obesity” defined in various ways or on infants at the highest end of the distribution of weight or body mass index. Year of birth of infants was 1927 to 1992. Sixteen were cohort studies, two were case-control studies, and all but one were set in developed countries.

Eleven studies described infant obesity with varying definitions based on body mass index,11-15 weight, weight for height,16-21 or skinfold thickness21 (table 1). When reporting the findings of these studies we have used the term infant obesity to describe exposure status, though we recognise that the definition of infant obesity is controversial. The seven other studies assessed infant size in terms of weight,22–24 weight for height,25,26 or body mass index without using a definition of infant obesity.

All studies used centile points in body mass index, skinfolds, weight for height, or a clinical definition to define obesity as an outcome. Six studies focused on obesity in childhood up to the age of 10; four of these defined obesity according to weight for height17,18,20,23 and two according to body mass index.24,25 Five studies focused on obesity in adolescence (9-18 years), three defining obesity by body mass index,14,15,16 and two using weight.24,25 Seven studies described adult obesity, four using body mass index to define obesity11-13 and three using weight or skinfold thickness measurements.16,21,26 Most of the studies in adults were of those aged 20-35 years.

Table 1 Summary data extracted from studies of infant size, ordered by year of birth

<table>
<thead>
<tr>
<th>Study</th>
<th>No of subjects, year of birth</th>
<th>Measure of infant size</th>
<th>Definition of obesity</th>
<th>Analysis</th>
<th>Size of effect</th>
<th>Risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moseberg (1989)</td>
<td>27 (sex not reported), 1927-47</td>
<td>BMI at 75th centile</td>
<td>Weight for height</td>
<td>Weight for height SD scores with obesity reported in infancy and at follow-up in adulthood</td>
<td>SD scores (5E of mean): 2.3 (0.31) on admission; 1.8 (0.46) in late childhood; 0.2 (0.28) in adulthood (40-50 years)</td>
<td>High</td>
</tr>
<tr>
<td>Guo (1984) USA</td>
<td>555 (50% male), 1929-60</td>
<td>BMI at 70th centile or &gt;26 kg/m²</td>
<td>Logistic regression giving odds ratio for overweight in adulthood (higher BMI centile in infancy v lower one (50th, 75th centiles used)</td>
<td>Odds ratios (95% CI) at 1 year: 1.48 (0.99 to 2.21) for males; 1.54 (1.01 to 2.35) for females; at 2 years: 1.63 (1.04 to 2.54) for males; 1.51 (0.96 to 2.36) for females</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Eriksson (2003) Helsinki, Finland</td>
<td>2135 male, 2380 female, 1933-44</td>
<td>BMI at 6 months</td>
<td>Maximum lifetime risk of obesity defined as BMI &gt;30 kg/m² at 60-70 years</td>
<td>Incidence (%) of adult obesity in each of four BMI categories at 6 months</td>
<td>Cumulative incidence (95% CI): males: 28.6 (24.1 to 33.1) in lowest 6 month group (&lt;16.3 kg/m²), 44.1 (40.0 to 48.5) in highest 6 month group (&gt;18.0 kg/m²); P&lt;0.0001 for trend; females: 27.5 (23.8 to 31.3) in lowest 6 month group (&lt;16.3 kg/m²), 36.8 (32.0 to 41.7) in highest 6 month group (&gt;18.0 kg/m²); P&lt;0.001 for trend</td>
<td>Medium</td>
</tr>
<tr>
<td>Head (1965) Washington DC; Massachusetts, USA</td>
<td>158 cases, 94 controls (all female), 1945-50</td>
<td>1 year weight (lb)</td>
<td>Cases (clinically obese) and controls (not obese) at mean age 15 years</td>
<td>Mean values for infant size reported for cases and controls, with SDs and t tests for differences</td>
<td>Mean difference in 1 year weight (lb): cases-controls 1.446 (P=0.009)</td>
<td>High</td>
</tr>
<tr>
<td>Chorney (1979) Rochester, USA</td>
<td>366 (sex not reported), 1945-55</td>
<td>Infant obesity: weight centile &gt;90th at 3 and 6 months</td>
<td>Contingency tables of heavy, average, and light infants and underweight, normal, overweight, and obese adults, from which relative risks of adult obesity in “obese” v non-obese infants were derived</td>
<td>Relative risks: 1.63 (1.14 to 2.33) for unadjusted (n=366), 1.81 (0.96 to 3.44) for neither parent overweight (n=225), 3.37 (1.69 to 6.70) for at least one parent overweight (n=110), and 2.51 (2.25 to 2.80) for combined (n=335)</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Asher (1966) Birmingham, UK</td>
<td>137 (sex not reported); 21 cases, 24 controls, 1950</td>
<td>Infant obesity: weight &gt;90th centile at 6 months; &gt;97th centile at 1 year</td>
<td>Childhood obesity: weight &gt;90th centile at 3-5 years; weight &gt;97th centile at 5 years</td>
<td>Relative risk for child obesity in “obese” v non-obese infants</td>
<td>Relative risks: 9.33 (5.02 to 16.7) for weight &gt;90th centile at 3-5 years; 6.56 (2.90 to 14.8) for weight for height &gt;97th centile at 5 years</td>
<td>High</td>
</tr>
<tr>
<td>Rolland-Cachera (1987) France</td>
<td>164 (52% male), 1950</td>
<td>Infant obesity: BMI &gt;75th centile</td>
<td>BMI &gt;23.4 kg/m² (men) or &gt;22.3 kg/m² (women) at 21 years</td>
<td>Relative risk of obesity at 21 years in “obese” v non-obese infants</td>
<td>Relative risk (95% CI): 2.76 (1.32 to 5.77)</td>
<td>Medium</td>
</tr>
<tr>
<td>Gunn (1985) Tecumseh, USA</td>
<td>125 (29% male), 1957-60</td>
<td>Infant obesity at 2 years: triceps skinfold &gt;85th centile for age/sex. Same definition for subscapular skinfold.</td>
<td>Same definitions as for infancy at 21-22 years</td>
<td>Percentage of “obese” infants who remained obese 20 years later, with P value for deviation from chance figure of 15% (with binomial test)</td>
<td>Percentage of obese infant (triceps): 33.3% (P&lt;0.01) at 2-7 years; 32.8% (P&lt;0.01) at 2-22 years; percentage of obese infant (subscapular) 33.3% (P&lt;0.01) at 2-1 years; 20.0% (P&lt;0.06) at 2-22 years</td>
<td>Medium</td>
</tr>
<tr>
<td>Johnston (1978) Philadelphia, USA</td>
<td>798 (51% male), 1958-65</td>
<td>Relative weight, weight for height &gt;1 SD at 1 year (high) v ≤1 SD at 1 year (low)</td>
<td>At 8-15 years: relative weight (predicted weight/actual weight) ≥100%, triceps skinfold &gt;90th centile for age, sex/race</td>
<td>Relative risk of obesity at ages 9-15 years, according to whether subjects had high or low relative weight or skinfold thickness at 1 year, stratified for sex</td>
<td>Relative risk (95% CI) for relative weight 3.15 (2.15 to 6.54) for males, 4.06 (2.52 to 6.53) for females; for triceps skinfold 2.97 (2.03 to 4.35) for males, 2.70 (1.74 to 4.37) for females</td>
<td>High</td>
</tr>
</tbody>
</table>
There was considerable consistency in study findings. Eleven studies found that infants who were heavier during infancy or were defined as obese were more likely to develop obesity in childhood, though not significant, was consistent with the findings of the other studies.13 Of the seven studies in adulthood, three reported significant associations between infant size and later obesity. Two studies showed that obese infants were more likely to be obese as young adults at ages 20-30 years than non-obese infants,15,16 and the third found that larger size at 6 months of age was associated with increased lifetime risk of obesity.7 The findings of three other studies of adults suggested a positive relation between infant size and later obesity but were not significant.11,12,13 The final study, which was based on only 27 participants, failed to show an association.14 Year of birth in the studies of adults ranged between 1929 and 1970, suggesting that associations have been consistent over time.

### Studies of infant growth

<table>
<thead>
<tr>
<th>Study</th>
<th>No of subjects, year of birth</th>
<th>Measure of infant size</th>
<th>Definition of obesity</th>
<th>Analysis</th>
<th>Size of effect</th>
<th>Risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilkinson (1977)†24 Newcastle upon Tyne, UK</td>
<td>48 cases, 48 controls (42% male), 1960-2</td>
<td>Weight at 6 and 12 months (obese &gt;95th centile)</td>
<td>Obesity at 10 years, defined as weight for height &gt;97th centile. Controls defined as weight for height &lt; 85th centile</td>
<td>Odds ratio of obesity at 10 years according to weight at 6 and 12 months</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Whitaker (1997)25 Washington State, USA</td>
<td>854 (36% male), 1965-70</td>
<td>Infant obesity: BMI &gt; 35th centile (obese) or &gt; 95th (very obese) at 2 years</td>
<td>BMI &gt; 23.8 kg/m² (men) or &gt; 27.3 kg/m² (women) at 25 years</td>
<td>Logistic regression giving odds ratios for BMI in adulthood by whether “obese” or “very obese” in infancy v “not obese”</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Poskitt (1977)26 Dudley, UK</td>
<td>203 (49% male), 1968-70</td>
<td>Percentage weight at age when height is at 50th centile, measured at around 5 months (obese &gt;120%)</td>
<td>Same, at around 5 years</td>
<td>Relative risk of childhood obesity at 5 years of age for “obese” infants v non-obese infants</td>
<td>Relative risk (95% CI) 3.0 (1.6 to 5.5)</td>
<td>Medium</td>
</tr>
<tr>
<td>Timboon (2002)20 New South Wales, Australia</td>
<td>83 (44% male), 1972</td>
<td>BMI &gt; 1 SD from group mean for age at 1 year</td>
<td>BMI &gt; 1 SD from group mean at 15 years</td>
<td>Relative risk of obesity at 15 years for “obese” v non-obese infants</td>
<td>Relative risk (95% CI) 2.03 (0.47 to 8.82)</td>
<td>Medium</td>
</tr>
<tr>
<td>He (1999)27 Göteborg, Sweden</td>
<td>3650 (51% male), 1972-5</td>
<td>Infant obesity: BMI &gt; 18 kg/m² (both sexes) at 1-2 years</td>
<td>BMI &gt; 25 kg/m² (both sexes) at 18 years</td>
<td>Odds ratio of obesity at 18 years according to whether “obese” at 1 or 2 years</td>
<td>Odds ratio 99.5% (95% CI) 1.30 (0.90 to 1.88) for males, 1.06 (0.72 to 1.57) for females</td>
<td>Medium</td>
</tr>
<tr>
<td>Monterio (2003)28 Pelotas, Brazil</td>
<td>1041 (52% male), 1982</td>
<td>Weight for height SD score at 2 years</td>
<td>BMI &gt; 85th centile at 14-16 years</td>
<td>Odds ratio of overweight and obesity in adolescence associated with 1 unit change in infancy Z scores for size</td>
<td>Unadjusted odds ratio (cut off +1 SD at 2 years) 3.54 (2.53 to 4.90); odds ratio for 1 unit z score increase in weight for height SD 1.35 (1.53 to 1.73) adjusted for socioeconomic status, maternal size, and infant feeding</td>
<td>Low</td>
</tr>
<tr>
<td>Satter (2002)29 USA</td>
<td>19 397 (50% male), 1985-90</td>
<td>Infant size: weight at 1 year (g)</td>
<td>BMI &gt; 95th centile for age and sex at 7 years</td>
<td>Logistic regression giving odds ratio for risk of overweight at 7 years according to each unit (100g) increase in weight at 1 year</td>
<td>Odds ratios (95% CI) 1.05 (1.04 to 1.05) unadjusted; 1.50 (1.38 to 1.63) adjusted for sex, birth weight, maternal BMI, and education</td>
<td>Medium</td>
</tr>
<tr>
<td>Mei (2003)30 USA</td>
<td>380 518 (51% male), 1966-90</td>
<td>Weight for height &gt; 95th centile at 0-11 months (1); weight for height &gt; 95th centile at 12-23 months (2)</td>
<td>Weight for height &gt;95th centile at 24-35 months (3); weight for height &gt;95th centile at 36-47 months (4)</td>
<td>Relative risk of childhood obesity according to infant obesity category. No confidence intervals reported</td>
<td>Relative risk 3.3 for (1) and (3); 2.9 for (1) and (4); 6.4 for (2) and (3), 5.3 for (2) and (4)</td>
<td>Medium</td>
</tr>
<tr>
<td>Reilly (2005)31 Avon, UK</td>
<td>857 (sex not stated for infant growth analysis; 51% in entire cohort), 1991-2</td>
<td>Weight SD scores at 8 and 18 months</td>
<td>Obesity at age 7 years, defined as BMI &gt; 95th centile relative to UK 1990 reference population</td>
<td>Logistic regression giving odds ratio of obesity at 7 years of age for children in highest quartile for weight SD score at 18 months v children in other quartiles</td>
<td>Odds ratio (95% CI) for weight at 8 months: 3.03 (1.89 to 4.85) unadjusted; 3.13 (1.43 to 6.85) adjusted; weight at 18 months: 3.71 (2.29 to 6.00) unadjusted; 2.65 (1.25 to 5.59) adjusted (adjusted for birth weight, maternal smoking, parental obesity, hours of sleep at age 30 months, time spent watching television at 30 months, diet, maternal education, sex)</td>
<td>Low</td>
</tr>
</tbody>
</table>

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1. Definitions of infant growth. 2. Effect sizes ranged between relative risk of 1.35 and odds ratio of 3.0 for adolescent obesity in infants at the highest end of the weight distribution. 3. If in obese compared with non-obese infants. 4. The years of birth ranged from 1945 to 1982, suggesting that these relations have been consistent over time. 5. In the remaining study the direction of the association, though not significant, was consistent with the findings of the other studies. 6. Of the seven studies in adulthood, three reported significant associations between infant size and later obesity. Two studies showed that obese infants were more likely to be obese as young adults at ages 20-30 years than non-obese infants, and the third found that larger size at 6 months of age was associated with increased lifetime risk of obesity. The findings of three other studies of adults suggested a positive relation between infant size and later obesity but were not significant. The final study, which was based on only 27 participants, failed to show an association. Year of birth in the studies of adults ranged between 1929 and 1970, suggesting that associations have been consistent over time.
life. Two studies used increase in weight for age or weight for height scores.

Six studies examined obesity in children, four with body mass index and two with weight. Of two studies of adolescents, one defined obesity according to body mass index and the other used a clinical definition. Both the studies of young adults defined obesity by body mass index.

Seven of the ten studies examining infant growth found that more rapid growth in infancy was associated with greater risk of obesity at ages ranging from 4.5 to 20 years. In four studies of childhood, odds ratios of obesity in children who grew more rapidly in infancy compared with those who grew less rapidly ranged between 1.06 and 5.70. The studies of adolescents and young adults reported odds ratios of later obesity ranging from 1.41 to 5.29. The analyses in six of the seven studies were adjusted for important confounding factors and we considered three studies to have a low risk of bias. Associations between infant growth and later obesity were consistent over time: year of birth ranged from 1945 to 1994. Three studies, two in children and one in adolescents, failed to show an association between infant growth and later obesity.

We could not carry out a meta-analysis of the relation between infant size or growth and later obesity because the definitions of both the exposures (infant size or growth) and outcomes (childhood or adult obesity) varied widely between studies.

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Table 2 Summary data extracted from studies of infant growth, ordered by year of birth

<table>
<thead>
<tr>
<th>Study</th>
<th>No of subjects, year of birth</th>
<th>Measure of infant growth</th>
<th>Definition of obesity</th>
<th>Analysis</th>
<th>Size of effect</th>
<th>Risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heidel (1965)</td>
<td>158 cases 94 controls (all female), 1945-50</td>
<td>Weight (lb) or height (in) gain from 0-6, 6-12, and 0-12 months</td>
<td>Cases and controls defined for outcome (obesity) at mean cases and controls</td>
<td>Difference in mean values for weight or height gain at various intervals in infancy for cases and controls</td>
<td>For cases-controls: -0.540 (P=0.174) for weight gain (lb) 0-6 months, 0.565 (P=0.208) for height gain (in) 0-6 months, 1.586 (P=0.003) for weight gain (lb) 6-12 year, 0.508 (P=0.282) for height gain (in) 0 to 1 year, 0.482 (P=0.144) for weight gain (lb) 6-12 months, 0.035 (P=0.804) for height gain (in) 6-12 months</td>
<td>High</td>
</tr>
<tr>
<td>Stettler (2002)</td>
<td>USA</td>
<td>19 397 (50% male), 1959-65</td>
<td>Growth from birth to 4 months</td>
<td>Logistic regression giving odds ratio for obesity at 7 years by rate of weight gain from birth to 4 months in units of 100 g/month</td>
<td>Odds ratio (95% CI): 1.29 (1.25 to 1.33) unadjusted, 1.17 (1.11 to 1.24) adjusted (adjusted for sex, birth weight, maternal BMI, and education and other size-growth variables)</td>
<td>Medium</td>
</tr>
<tr>
<td>Stettler (2003)</td>
<td>Philadelphia, USA</td>
<td>300 (54% male), 1959-66</td>
<td>Increase in weight for age &gt;1 SD above mean from birth to 4 months (rapid weight gain)</td>
<td>Logistic regression giving odds ratios for risk of obesity or overweight at 20 years by presence of rapid weight gain from birth to 4 months</td>
<td>Odds ratios (95% CI): 2.73 (1.20 to 6.23) adjusted, 5.29 (1.55 to 17.64) adjusted for maternal size and education, birth weight and sex</td>
<td>Medium</td>
</tr>
<tr>
<td>Est (1970)</td>
<td>Sheffield, UK</td>
<td>224 (54% male), 1961</td>
<td>Weight gain &gt;80th centile over first 6 months of life (rapid weight gain)</td>
<td>Logistic regression giving odds ratio for obesity at 8 years associated with rapid weight gain up to 6 months of age</td>
<td>Relative risk (95% CI) 4.05 (0.94 to 17.5)</td>
<td>Medium</td>
</tr>
<tr>
<td>Mollin (1973)</td>
<td>Uppsala, Sweden (Medicine)</td>
<td>465 males 507 females, 1965</td>
<td>Rapid growth: weight gain over 1 year &gt;7.5 kg, or weight gain over months 1-4 and 9-12 &gt;97th centile for age</td>
<td>Logistic regression giving odds ratio for childhood obesity by infant weight gain (&quot;rapid&quot; or &quot;normal&quot;)</td>
<td>Relative risk (95% CI) for weight gain over 1 year &gt;7.5 kg: 2.32 (1.03 to 7.07) for males, 1.72 (0.80 to 4.94) for females; for weight gain over months 1-4 and 9-12 &gt;97th centile for age: 16.9 (4.70 to 61.0) for males, 3.33 (0.64 to 2.36) for females</td>
<td>Medium</td>
</tr>
<tr>
<td>Stettler (2005)</td>
<td>Iowa, USA</td>
<td>655 (52.4% male), 1965-78</td>
<td>Weight gain from birth to 112 days of age (lb)</td>
<td>Logistic regression giving odds ratio (95% CI) for adult overweight according to both absolute weight gain (g) and changes in weight for age SD score between birth and 132 days</td>
<td>Odds ratio (95% CI) for weight gain (expressed in 100 g units): 1.04 (1.01 to 1.08) for change in weight for age SD score; 1.41 (1.09 to 1.82) (adjusted for birth weight, sex, type of formula feed, parental overweight status, subject’s income)</td>
<td>Medium</td>
</tr>
<tr>
<td>Monteiro (2003)</td>
<td>Pelotas, Brazil</td>
<td>1047 (52% male), 1982</td>
<td>Weight-for-height SD score at 2 years (&quot;rapid growth&quot;): &gt;0.67 z score change 0-2 years</td>
<td>Odds ratio of overweight and obesity in adolescence associated with rapid growth</td>
<td>Odds ratio (95% CI) of overweight and obesity at 14-16 years 1.66 (1.20 to 2.31) adjusted for socioeconomic status, maternal size, and infant feeding</td>
<td>Low</td>
</tr>
<tr>
<td>Stettler (2005)</td>
<td>Seychelles</td>
<td>5514 (49% male), 1985-90</td>
<td>Weight gain during 1st year of life (kg)</td>
<td>Obesity, using international obesity task force charts at ages 4.5-17.4 years</td>
<td>Logistic regression giving odds ratio (95% CI) for childhood obesity according to rate of weight gain in first year (rapid v normal)</td>
<td>Low</td>
</tr>
<tr>
<td>Reilly (2005)</td>
<td>Avon, UK</td>
<td>857 (% male not stated for infant growth analysis, 51% in entire cohort), 1991-2</td>
<td>Weight gain from birth to 1 year of age (g)</td>
<td>Obesity at age 7 years, defined as BMI &gt;95th centile relative to UK 1990 reference population</td>
<td>Logistic regression giving odds ratio (95% CI) for obesity at 7 years by rate of weight gain from birth to 12 months of age in units of 100 g per month</td>
<td>Low</td>
</tr>
<tr>
<td>Tawchide (2004)</td>
<td>South Germany</td>
<td>435 (5% male not stated) 1992-4</td>
<td>Overweight status at school entry (age 5 to 6.9 years) according to IOTF definitions (BMI &gt;85th centile for age and sex)</td>
<td>Odds ratio for overweight at school entry in children with weight gain greater &gt;768 g at age 2 years v those with weight gain at or below this level</td>
<td>Odds ratio (95% CI) 5.7 (4.5 to 7.1)</td>
<td>High</td>
</tr>
</tbody>
</table>
Discussion

This review suggests that both size and growth during infancy are related to risk of obesity in children and adults. Most studies of infant size found that infants who were defined as "obese" or who were at the highest end of the distribution for weight or body mass index were more likely to develop obesity in childhood, adolescence, or early adulthood than other infants. The evidence relating to infant growth was also consistent across most studies reviewed. Infants who grew more rapidly (usually measured as weight gain) were more likely to be obese in childhood, adolescence, and early adulthood than other infants. There was no evidence to suggest that exposure at a particular time during infancy was critical: larger size or a rapid phase of growth at a range of intervals during the first and second year of life predisposed to later obesity. Associations were also consistent across a range of settings in developed countries; for obesity measured in childhood, adolescence, and early adulthood; and over time for people born from 1927 to 1994.

Strengths and limitations of this review

Our findings amplify those of earlier systematic reviews. These studies were of variable quality. We therefore relied on published data from studies that were of variable quality.

Comparison with other research

Our findings amplify those of earlier systematic reviews. These found that rapid growth at different ages in childhood was associated with greater risk of later obesity.1 One review also found that birth weight was positively associated with adult body mass index.4 In our review odds ratios and relative risks of subsequent obesity in infants who had been obese compared with non-obese infants ranged between 1.35 and 9.38. Though not directly comparable, odds ratios tended to be lower in the studies of birth weight. For example, in a study of young Swedish men odds ratio of overweight increased from 1.07 to 1.67 going from the lowest (≤5th centile) to the highest (>95th centile) birthweight group.12 In our review both large infant size and rapid infant growth were associated with later obesity. Babies who are small at birth experience rapid growth, at least in early infancy. Taken with other evidence, our review suggests that both prenatal and infant growth trajectories may be important in predicting adult obesity.

Conclusions

Infants in the highest end of the distribution for weight or body mass index and those who grow rapidly are at increased risk of obesity in childhood and adulthood. This suggests that factors during infancy or before that are related to infant growth influence the risk of later obesity. To inform public health policy aimed at reducing levels of childhood obesity, future research needs to investigate the determinants of these patterns of growth. The relation of infant growth with other health outcomes should be explored to assess whether interventions to alter infant growth to prevent obesity are likely to be associated with other benefits or harms. It will also be important to assess whether factors influencing infant growth are amenable to change, to establish which strategies might alter infant growth, and to find out whether these are acceptable to parents.

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