Gene × dietary pattern interactions in obesity: analysis of up to 68,317 adults of European ancestry

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Gene × dietary pattern interactions in obesity: analysis of up to 68 317 adults of European ancestry

Abstract

Obesity is highly heritable. Genetic variants showing robust associations with obesity traits have been identified through genome-wide association studies. We investigated whether a composite score representing healthy diet modifies associations of these variants with obesity traits. Totally, 32 body mass index (BMI)– and 14 waist–hip ratio (WHR)-associated single nucleotide polymorphisms were genotyped, and genetic risk scores (GRS) were calculated in 18 cohorts of European ancestry (n = 68,317). Diet score was calculated based on self-reported intakes of whole grains, fish, fruits, vegetables, nuts/seeds (favorable) and red/processed meats, sweets, sugar-sweetened beverages and fried potatoes (unfavorable). Multivariable adjusted, linear regression
within each cohort followed by inverse variance-weighted, fixed-effects meta-analysis was used to characterize: (a) associations of each GRS with BMI and BMI-adjusted WHR and (b) diet score modification of genetic associations with BMI and BMI-adjusted WHR. Nominally significant interactions \( (P = 0.006-0.04) \) were observed between the diet score and WHR-GRS (but not BMI-GRS), two WHR loci (GRB14 rs10195252; LYPLAL1 rs4846567) and two BMI loci (LRRN6C rs10968576; MTF3 rs4771122), for the respective BMI-adjusted WHR or BMI outcomes. Although the magnitudes of these select interactions were small, our data indicated that associations between genetic predisposition and obesity traits were stronger with a healthier diet. Our findings generate interesting hypotheses; however, experimental and functional studies are needed to determine their clinical relevance.

### Introduction

The recent obesity epidemic is widely believed to be driven by typical Westernized lifestyles, consisting of diets low in nutrient quality and high in calories, along with physical activity levels insufficient to offset high-caloric consumption. Despite these general relationships, people living within the same obesogenic environment display substantial between-person variability in body weight. Responses to overfeeding or underfeeding have been shown to depend, at least in part, on genetic background (1–3), suggesting that genetic susceptibility to weight change interacts with a person’s environment.

Driven by large-scale meta-analyses of genome-wide association study (GWAS) data, the past decade has witnessed rapid progress in the discovery of genetic variants associated with obesity-related traits (4,5). Although these associations are robust across unique samples, there is little empirical evidence that lifestyle factors modify the effects associated with these variants. Several observational studies show that physical activity may attenuate the genetic predisposition to obesity (6–11). However, it is not known whether it is physical activity alone or other lifestyle factors that correlate with physical activity, such as diet, that underlie these interactions (12–14). Characterizing how diet influences the associations of genetic variants with obesity-related traits in observational studies may help determine the extent that dietary interventions can offset a person’s genetic susceptibility to obesity, and further, may inform the design of clinical trials that are specifically designed to test gene-diet interactions (e.g. genotype-based recall studies). Many published observational studies and clinical trials reporting gene-lifestyle interaction were not designed to test such interactions, and, thus, are underpowered (15).

We previously created a composite diet score, ranking individuals on their intakes of various foods to characterize a generally healthy dietary pattern (16). This approach, compared with one focused on single foods or nutrients, captures the highly complex nature of diet and translates more intuitively to public health. Using this score, we sought to determine whether the associations of established body mass index (BMI)- and waist-hip ratio (WHR)-associated variants, individually or combined, are modified by a composite diet score in adults of European ancestry.

### Results

#### CHARGE diet score

A higher, compared with lower, diet score (reflecting a healthier diet) was associated with lower BMI and BMI-adjusted WHR in models adjusted for potentially confounding physical characteristics and lifestyle factors (Table 1; Supplementary Material, Figs S1 and S2).

### Associations of BMI-GRS and WHR-GRS with BMI and WHR

The BMI-GRS and WHR-GRS were positively associated with BMI and WHR.

### Table 1. Associations of diet score with BMI and WHR in all participants and by sex

<table>
<thead>
<tr>
<th>Outcome: BMI</th>
<th>N</th>
<th>( \beta )</th>
<th>95% CI</th>
<th>( P )-value</th>
<th>( I^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>All(^a)</td>
<td>19</td>
<td>68,317</td>
<td>−0.034</td>
<td>((-0.0419, -0.0266))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>All(^b)</td>
<td>19</td>
<td>66,493</td>
<td>−0.017</td>
<td>((-0.0247, -0.0088))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Women(^a)</td>
<td>17</td>
<td>46,916</td>
<td>−0.043</td>
<td>((-0.0540, -0.0316))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Women(^b)</td>
<td>17</td>
<td>45,796</td>
<td>−0.014</td>
<td>((-0.0257, -0.0025))</td>
<td>0.017</td>
</tr>
<tr>
<td>Men(^a)</td>
<td>18</td>
<td>29,992</td>
<td>−0.022</td>
<td>((-0.0320, -0.012))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Men(^b)</td>
<td>18</td>
<td>29,228</td>
<td>−0.014</td>
<td>((-0.0245, -0.0039))</td>
<td>0.007</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome: BMI-adjusted WHR</th>
<th>N</th>
<th>( \beta )</th>
<th>95% CI</th>
<th>( P )-value</th>
<th>( I^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>All(^a)</td>
<td>17</td>
<td>58,393</td>
<td>−0.0010</td>
<td>((-0.0011, -0.0009))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>All(^b)</td>
<td>17</td>
<td>57,666</td>
<td>−0.0007</td>
<td>((-0.0008, -0.0006))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Women(^a)</td>
<td>15</td>
<td>41,176</td>
<td>−0.0009</td>
<td>((-0.0010, -0.0007))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Women(^b)</td>
<td>15</td>
<td>40,116</td>
<td>−0.0006</td>
<td>((-0.0007, -0.0004))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Men(^a)</td>
<td>16</td>
<td>25,809</td>
<td>−0.0012</td>
<td>((-0.0013, -0.0001))</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Men(^b)</td>
<td>16</td>
<td>25,081</td>
<td>−0.0008</td>
<td>((-0.0010, -0.0007))</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

\(^a\) Associations adjusted for study center and/or family structure (as applicable), age, sex (where relevant) and kcal/day.

\(^b\) Associations adjusted for study center and/or family structure (as applicable), age, sex (where relevant), kcal/day, education, physical activity, smoking and alcohol intake.

\(^c\) Associations adjusted for study center and/or family structure (as applicable), age, sex (where relevant), kcal/day and BMI.

\(^d\) Associations adjusted for study center and/or family structure (as applicable), age, sex (where relevant), kcal/day, BMI, education, physical activity, smoking and alcohol intake.
Table 2. Associations of BMI-GRS and WHR-GRS with BMI and WHR, respectively, in all participants and by sex

<table>
<thead>
<tr>
<th>Group</th>
<th>Marker</th>
<th>Cohorts (N)</th>
<th>N</th>
<th>β</th>
<th>SE</th>
<th>P-value</th>
<th>Direction of association across cohorts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome: BMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>BMI-GRS</td>
<td>18</td>
<td>57 075</td>
<td>0.116</td>
<td>0.005</td>
<td>1.97E–124</td>
<td>++++++++++++++++</td>
</tr>
<tr>
<td>Women</td>
<td>BMI-GRS</td>
<td>16</td>
<td>31 903</td>
<td>0.131</td>
<td>0.007</td>
<td>9.56E–72</td>
<td>++++++++++++</td>
</tr>
<tr>
<td>Men</td>
<td>BMI-GRS</td>
<td>17</td>
<td>25 172</td>
<td>0.102</td>
<td>0.007</td>
<td>1.36E–55</td>
<td>++++++++++++</td>
</tr>
<tr>
<td>Outcome: BMI-adjusted WHR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>WHR-GRS</td>
<td>17</td>
<td>54 294</td>
<td>0.0016</td>
<td>0.0001</td>
<td>2.15E–62</td>
<td>++++++++++++</td>
</tr>
<tr>
<td>Women</td>
<td>WHR-GRS</td>
<td>15</td>
<td>30 196</td>
<td>0.0022</td>
<td>0.0001</td>
<td>1.14E–48</td>
<td>++++++++++++</td>
</tr>
<tr>
<td>Men</td>
<td>WHR-GRS</td>
<td>16</td>
<td>24 098</td>
<td>0.0008</td>
<td>0.0001</td>
<td>1.55E–08</td>
<td>++++++++++++</td>
</tr>
</tbody>
</table>

*Associations adjusted for study center and/or family structure (as applicable), age and sex (where relevant).

Table 3. Interactions of diet score with BMI-GRS, WHR-GRS or select (<0.05) individual SNPs for BMI or WHR (women and men combined)

<table>
<thead>
<tr>
<th>Gene × diet score interactions</th>
<th>Nearest gene</th>
<th>Risk allele</th>
<th>βInteraction</th>
<th>SEInteraction</th>
<th>PInteraction</th>
<th>Direction of association across cohorts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy diet score × BMI-GRS for BMIb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy diet score × rs10968576 for BMIb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy diet score × rs4771122 for BMIb</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Healthy diet score × WHR-GRS for BMI-adjusted WHRc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy diet score × rs10968576 for BMI-adjusted WHRc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy diet score × rs4846567 for BMI-adjusted WHRc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The italicized values represents the P value.

aAssociation adjusted for study center and/or family structure (as applicable), age, sex and kcal/day.
bAssociation adjusted for study center and/or family structure (as applicable), age and sex.
cInteraction adjusted for study center and/or family structure (as applicable), age, sex, kcal/day and BMI.

Discussion

We conducted a broad assessment of the role of a multifactorial diet score on the genetic susceptibility to obesity by examining 32 common variants that have been reliably associated with BMI (5) and an additional 14 common variants that have been associated with BMI-adjusted WHR (4) in populations of European ancestry. Our study is the largest of its kind to date, utilizing a centrally designed and harmonized analysis plan and including cohorts with relatively diverse dietary habits and prevalence of obesity.

Overall, we observed nominal evidence of interaction between the WHR-GRS and the diet score, such that the GRS effect was stronger in those with higher versus lower diet scores. Similarly, we observed suggestive evidence that healthy diet augments the associations of variants in or near four loci with BMI (LRRN6C and MTIF3) and BMI-adjusted WHR (GRB14 and LYPLAL1). While these observations counter the general hypothesis that healthy behaviors can offset risk, it is important to note that although genetic susceptibility was slightly more pronounced in those with healthier diets, at any one level of genetic susceptibility, the BMI or BMI-adjusted WHR was lower in those with healthier diets, at any one level of genetic susceptibility. Nevertheless, the nature of these interactions differs from that observed in studies on the modification of genetic effects by other lifestyle factors, such as those reporting an attenuating influence of physical activity on genetic predisposition to obesity-related traits (6–12,14). Proxy measures of both diet and physical
activity contain an appreciable amount of random measurement error (17), requiring large sample sizes to achieve adequate statistical power. Most of the previous studies on physical activity were larger than the present analysis, and it is also possible that the true sizes of the interactions differ, with larger modifying effects of physical activity than of diet. Sources of systematic error (bias) also exist and are specifically relevant to studies of obesity; in such studies, bias can occur, for example, by over- or underreporting of dietary intake (or physical activity) in people who are overweight or underweight, in part, because participants may be well aware of the links between lifestyle and body composition, and this awareness may impact their response to lifestyle-related questions. While the valid assessment of lifestyle is difficult in large cohorts, so too is differentiating the influence of the observed lifestyle factors and their unmeasured correlates on genetic susceptibility. Thus, further investigation is necessary to elucidate these dynamics, both in terms of study design and physiology, perhaps using more precise tools to assess diet or in more powerful studies of different design (e.g. intervention studies adequately powered to test gene–treatment interactions).

Previous studies involving the genetic regions highlighted in our analyses [LYPLAL1 (18,19), MTIF3 (20,21), GRB14 (22,23) and LRRN6C (24)] delineate their roles in physiology (see also Supplementary Material, Table S7), but few studies have investigated how diet might interact with these loci to influence body composition (25–28). While one longitudinal observation study reported no interactions between various lifestyle factors and LYPLAL1 variation (27), the Diabetes Prevention Program (DPP), an intensive lifestyle intervention study, did observe evidence of interaction on weight change at this locus (25). Specifically, of the 12 loci examined in the DPP study, LYPLAL1 (rs2605100, $r^2 = 0.48$ with rs4846567) was one of three loci for which the test of interaction was statistically significant: the G (versus A) allele conveyed greater short-term weight loss following lifestyle intervention versus control intervention (−0.34 kg per G allele from baseline to 6 months) (25). The Look AHEAD Study (26) examined relationships between 12 obesity-associated gene variants, including MTIF3 (rs7988412, $r^2 = 0.68$ with rs4771122), and caloric intake and eating patterns at baseline. The authors found no association between the variant and baseline caloric intake ($P = 0.99$) or the number of eating occasions ($P = 0.62$). However, in a joint analysis from the DPP and Look AHEAD trials, all loci studied in the present report were examined for interaction with intensive lifestyle modification in relation to weight loss (up to 4 years post-randomizations) (the DPP and Look AHEAD Study groups, personal communication, P.W. Franks). Of the loci studied, the one with the strongest evidence for gene–lifestyle interaction on weight loss was the MTIF3 rs1885988 variant ($r^2 = 0.72$ with the rs4771122 variant studied here). There are no other reports in the published literature on gene–diet interactions for obesity at the LYPLAL1 or MTIF3 loci to our knowledge.

Like most clinically prescribed weight-conscious diets, both the Look AHEAD and DPP lifestyle interventions were designed around general principles of healthy eating, each focusing on caloric and fat goals to guide healthy food selections. In a similar sense, our diet score broadly captures several dietary characteristics; therefore, neither the clinical trials data nor those from our analyses allow us to speculate on the effect modifying roles of individual dietary components. Hence, it is possible that a reductive approach (one focused on individual foods or nutrients) might identify interactions of different magnitudes and directions that could be masked by combining these into a summary score, such as we have done. However, studying each component of the score separately would require many more hypothesis tests, which we concluded that our study is not powered to accommodate. Further, studies that characterize diet more broadly (i.e. as multiple-component dietary patterns) are more easily applied to public health. Similarly, while the GRS allow assessment of overall genetic susceptibility, studying the role of individual variants within the GRS may provide insight into the biology that potentially underlies any observed interactions.

Taking variants that were top ranked in marginal effects GWAS meta-analyses and testing these for interactions with environmental exposures, as we did here, is a pragmatic data reduction strategy; this is so because those variants (or the loci that they tag) are, with high probability, likely to reside on causal pathways for the traits of interest. Although this does not necessarily mean that those variants should interact with environmental exposures, many argue that it is a hypothesis worth testing. In all likelihood, many other variants, which would not be picked up by marginal effects tests, but which modulate the effects of environmental exposures, exist (29).

The present report, alongside others, points to MTIF3 as a region that may interact with dietary factors to influence aspects of adiposity. The remaining results suggest that diet, as represented by our composite score, does not appreciably modify the effects of several loci, singly or collectively, on BMI and BMI-adjusted WHR. This area of research would benefit from future studies that utilize more detailed and precise information on dietary intake, alternative study designs (such as interventions) and other genetic regions that do not reach genome-wide statistical significance in main effects GWAS.

Materials and Methods

This project was coordinated by the Nutrition Working Group of the Cohorts for Heart and Aging Research in Genomic Epidemiology (CHARGE) consortium (30). Each of the 18 contributing cohorts executed analyses locally according to a uniform analysis plan and shared summary statistics with a central data hub for meta-analyses and testing these for interactions with environmental exposures. One of these cohorts, Dietary, Life style and Genetic determinants of Obesity and Metabolic syndrome (DILCOM), provided two independent samples (metabochip and GWAS samples) that were analyzed separately. The 18 cohorts, providing up to 68 317 adults, are described in Table 4. Written informed consent and institutional review board approvals were obtained locally by each participating study. All studies were conducted in accordance with the Helsinki Declaration of 1975 as revised in 1983.

Anthropometry

BMI was calculated as weight in kilograms (kg) divided by height in meters squared (m²). In all except two cohorts, body weight and height were measured by clinical staff at the examination sites; in the Nurses Health Study (NHS) and the Health Professionals Follow-Up Study (HPFS), height and body weight were self-reported by questionnaire (correlation of self-reported with directly measured values: $r = 0.97$) (31). Waist and hip circumferences, used to calculate WHR, were directly measured in 15 cohorts, self-reported in two cohorts (NHS and HPFS), and unavailable in two other cohorts (GLACIER and Health ABC).

Dietary intake and the diet score

Self-reported dietary intake was assessed by food frequency questionnaire (13 cohorts), by a combination of food frequency questionnaire and diet records (one cohort), or by diet records (four cohorts) (Supplementary Material, Table S2). The methods
### Table 4. Clinical characteristic of the study participants by cohort

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Abbreviation</th>
<th>Country</th>
<th>Exam year(^{a})</th>
<th>(N^)</th>
<th>BMI (kg/m(^2))</th>
<th>WHR (cm/cm)</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Smoking</th>
<th>Energy intake (kcal/day)</th>
<th>Diet Score(^{c,d})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atherosclerosis Risk in Communities Study</td>
<td>ARIC</td>
<td>USA</td>
<td>1987–1989</td>
<td>8586</td>
<td>26.7</td>
<td>4.6</td>
<td>0.92</td>
<td>54.2</td>
<td>5.7</td>
<td>53.7</td>
<td>24.4</td>
</tr>
<tr>
<td>Cardiovascular Health Study</td>
<td>CHS</td>
<td>USA</td>
<td>1989–1990</td>
<td>2761</td>
<td>26.0</td>
<td>4.3</td>
<td>0.91</td>
<td>72.3</td>
<td>5.4</td>
<td>62.1</td>
<td>11.5</td>
</tr>
<tr>
<td>Dietary, Life style, and Genetic determinants of Obesity and Metabolic Syndrome</td>
<td>DILGOM (metabochip sample)</td>
<td>Finland</td>
<td>2007</td>
<td>3467</td>
<td>26.6</td>
<td>4.5</td>
<td>0.91</td>
<td>52.4</td>
<td>4.4</td>
<td>52.1</td>
<td>22.4</td>
</tr>
<tr>
<td>Family Heart Study</td>
<td>Family HS</td>
<td>USA</td>
<td>1992</td>
<td>3185</td>
<td>27.4</td>
<td>5.3</td>
<td>0.91</td>
<td>51.4</td>
<td>5.2</td>
<td>51.3</td>
<td>14.7</td>
</tr>
<tr>
<td>Framingham Offspring Study and Framingham Third Generation Study</td>
<td>Framingham</td>
<td>USA</td>
<td>1991–1995</td>
<td>5827</td>
<td>26.7</td>
<td>5.0</td>
<td>0.89</td>
<td>46.1</td>
<td>5.2</td>
<td>54.6</td>
<td>17.2</td>
</tr>
<tr>
<td>Gene–Lifestyle interactions and Complex Traits Involved in Elevated Disease Risk Study</td>
<td>GLACIER</td>
<td>Sweden</td>
<td>1985–2007</td>
<td>5277</td>
<td>25.7</td>
<td>4.0</td>
<td>NA</td>
<td>NA</td>
<td>5.2</td>
<td>51.4</td>
<td>22.3</td>
</tr>
<tr>
<td>Health 2000</td>
<td>Health 2000</td>
<td>Finland</td>
<td>2000–2001</td>
<td>1935</td>
<td>27.3</td>
<td>4.5</td>
<td>0.92</td>
<td>50.5</td>
<td>5.7</td>
<td>51.3</td>
<td>28.8</td>
</tr>
<tr>
<td>Health, Aging and Body Composition</td>
<td>Health ABC</td>
<td>USA</td>
<td>1997–1998</td>
<td>1266</td>
<td>26.2</td>
<td>4.0</td>
<td>NA</td>
<td>NA</td>
<td>5.2</td>
<td>50.6</td>
<td>6.3</td>
</tr>
<tr>
<td>Health Professionals Follow-Up Study</td>
<td>HPFS</td>
<td>USA</td>
<td>1986</td>
<td>896</td>
<td>25.0</td>
<td>2.7</td>
<td>0.94</td>
<td>67.0</td>
<td>5.7</td>
<td>50.6</td>
<td>10.6</td>
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<td>Helsinki Birth Cohort Study</td>
<td>HBCS</td>
<td>Finland</td>
<td>2001–2004</td>
<td>1584</td>
<td>27.4</td>
<td>4.4</td>
<td>0.92</td>
<td>61.5</td>
<td>5.7</td>
<td>58.4</td>
<td>24.4</td>
</tr>
<tr>
<td>Invecchiare in Chianti</td>
<td>InCHIANTI</td>
<td>Italy</td>
<td>1997</td>
<td>991</td>
<td>27.1</td>
<td>4.1</td>
<td>0.90</td>
<td>67.0</td>
<td>5.2</td>
<td>56.2</td>
<td>19.0</td>
</tr>
<tr>
<td>Malmö Diet and Cancer Study</td>
<td>Malmö</td>
<td>Sweden</td>
<td>1991–1996</td>
<td>20319(^{e})</td>
<td>25.4</td>
<td>3.8</td>
<td>0.85</td>
<td>58.5</td>
<td>7.6</td>
<td>59.4</td>
<td>27.6</td>
</tr>
<tr>
<td>Multi-Ethnic Study of Atherosclerosis</td>
<td>MESSA</td>
<td>USA</td>
<td>2000–2002</td>
<td>2146</td>
<td>27.5</td>
<td>4.9</td>
<td>0.92</td>
<td>62.6</td>
<td>10.3</td>
<td>52.4</td>
<td>11.0</td>
</tr>
<tr>
<td>Nurses Health Study</td>
<td>NHS</td>
<td>USA</td>
<td>1986</td>
<td>1187</td>
<td>24.8</td>
<td>4.5</td>
<td>0.77</td>
<td>54.0</td>
<td>6.7</td>
<td>100</td>
<td>11.6</td>
</tr>
<tr>
<td>Rotterdam Study</td>
<td>Rotterdam</td>
<td>The Netherlands</td>
<td>1990–1993</td>
<td>3932</td>
<td>26.2</td>
<td>3.6</td>
<td>0.90</td>
<td>67.1</td>
<td>7.6</td>
<td>58.3</td>
<td>23.4</td>
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<td>The Hellenic Study of Interactions between SNPs and Eating in Atherosclerosis Susceptibility</td>
<td>THISEAS</td>
<td>Greece</td>
<td>2006–2010</td>
<td>543</td>
<td>28.2</td>
<td>4.6</td>
<td>0.92</td>
<td>55.9</td>
<td>13.6</td>
<td>48.5</td>
<td>33.6</td>
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<tr>
<td>Uppsala Longitudinal Study of Adult Men</td>
<td>ULSAM</td>
<td>Sweden</td>
<td>1991–1995</td>
<td>932</td>
<td>26.0</td>
<td>3.2</td>
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<td>71.0</td>
<td>6.0</td>
<td>0</td>
<td>19.5</td>
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<tr>
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<td>YFS</td>
<td>Finland</td>
<td>2007</td>
<td>1709</td>
<td>25.8</td>
<td>4.5</td>
<td>0.88</td>
<td>37.8</td>
<td>5.0</td>
<td>55.4</td>
<td>28.1</td>
</tr>
</tbody>
</table>

\(^{a}\) More information on populations and study designs can be found online Supplementary Material, Table S1.

\(^{b}\) Single examinations spanned several years (single time points); see Supplementary Material, Table S1 for more information.

\(^{c}\) Largest contributing value; analysis-specific sample sizes presented in subsequent corresponding tables.

\(^{d}\) Diet score = sum of quartile ranks of nine food groups (exceptions noted in Footnote e). Favorable: whole grains, fish, fruit, vegetables, nuts = 0–3 points per ascending quartile; Unfavorable: red or processed meats, desserts and sweets, sugar-sweetened beverages, fried potatoes = 0–3 points per descending quartile.

\(^{e}\) Diet score in select cohorts is based on eight, instead of nine, food groups; no data collected on fried potatoes (InCHIANTI & Rotterdam) or nuts (GLACIER).

\(^{f}\) Sample varies widely in SNP-based analyses; see other tables.
and rationale behind the construction of the CHARGE diet score and its criterion validity for predicting fasting glucose and insulin concentrations have been described in detail (16). Intakes of foods/beverages were modeled in servings per day for all cohorts except the sample from the Uppsala Longitudinal Study of Adult Men (ULSAM), where grams per day were used. Briefly, the score is based on the cohort-specific quartile ranks of nine food/beverage groups, where favorable food groups including fruits (not including juices), vegetables (not including white potatoes), whole grains, fish and nuts were assigned values of 0–3 according to ascending quartile ranks, and unfavorable food/beverage groups including red or processed meats, desserts and sweets, sugar-sweetened beverages and fried potatoes were assigned values of 0–3 according to descending quartile ranks. The resulting score is a continuous variable with a theoretical range of 0–27, where a higher diet score represents healthier food and beverage choices (Table 4).

**SNP selection, genotyping and genetic risk scores (BMI-GRS and WHR-GRS)**

At each SNP locus, genotypes were coded as 0, 1 and 2 or imputed to indicate the number of risk alleles for the 32 and 14 variants that have been previously associated with BMI (5) and WHR (4), respectively (SNPs listed in Supplementary Material, Table S3). For each participant, a genetic risk score (GRS) was then calculated by summing up the number of risk alleles separately for the BMI and WHR SNPs. In cohorts where genotypes were directly assessed (i.e. not imputed), missing genotypes were estimated in participants with >70% genotype information available by using mean imputation, as described previously (32) (Supplementary Material, Table S1).

The BMI-GRS was not calculated in the sample from DILGOM that was genotyped using the Metabochip, owing to a high number of missing SNPs (with no suitable proxy). In three cohorts, the BMI-GRS was based on 31 SNPs [Malmö Diet and Cancer Study (MDC), the Hellenic Study of interactions between SNPs and Eating in Atherosclerosis Susceptibility (THISEAS) and Young Finns Study (YFS)], owing to the absence of one SNP. The WHR-GRS was calculated in all cohorts except those with no WHR data (GLACIER and Health ABC); in MDC, the WHR-GRS was based on 13 rather than 14 SNPs, owing to the absence of one SNP. The approximate mean (SD) across cohorts for the BMI-GRS and WHR-GRS were 28.2 (3.5) and 14.3 (2.4), respectively.

**Statistical analysis**

Statistical analyses were conducted within each study according to a uniform analysis plan and subsequently meta-analyzed (details below).

**Associations of diet score with BMI and WHR**

The associations between diet score and BMI and WHR were calculated using multivariable linear regression, with the diet score modeled as a continuous exposure, adjusting for age, sex (where relevant), energy intake (kcal/day) and study center and/or population substructure (as necessary); where WHR was the outcome of interest, BMI was included as an additional covariate (BMI-adjusted WHR). In a second model, associations were further adjusted for education, physical activity, smoking and alcohol intake. Sex-stratified analyses were also conducted using these models. Details concerning the methods used to assess and characterize lifestyle within cohorts are provided in Supplementary Material, Table S1.

**Associations of GRS and individual loci with BMI and WHR**

Associations of the individual BMI- and WHR-relevant SNPs and BMI- and WHR-GRSs with their respective outcomes were also calculated using multivariable linear regression, adjusting for age, sex and field center and/or population substructure; as with the individual SNP models, where WHR was the outcome of interest, BMI was also included among covariates (BMI-adjusted WHR). Sex-stratified analyses were also conducted for BMI and WHR-adjusted BMI traits, respectively.

**Diet score interactions with GRS and individual loci**

Interactions were assessed by including a product term (diet score × SNP or diet score × GRS) in the regression models, adjusting for age, sex, energy intake (kcal/day) and study center and/or population substructure (as needed); as above, where WHR was the outcome, models were additionally adjusted for BMI (BMI-adjusted WHR). To maximize sample size (and by proxy, statistical power) for interaction tests, sex-stratified analyses were not conducted.

**Meta-analyses.** Summary statistics from each cohort were combined using inverse variance-weighted, fixed-effects meta-analysis. Meta-analyses for the diet score associations with BMI or WHR were performed using the meta package (version 2.16) in R 2.13.1 (http://www.R-project.org/). Meta-analyses of the interactions and main effects of SNP and GRS tests were conducted using METAL (http://www.sph.umich.edu/csg/abecasis/Metal/index.html). Heterogeneity was assessed by the I² statistic (33). Meta-regression was used to explore sources of heterogeneity in the meta-analyses using the metafor package in R. Meta-regression included region (Europe versus USA) and sex ratio as cohort-specific covariates. The meta-regression did not indicate either region or sex ratio as sources of heterogeneity (P > 0.48).

**Supplementary Material**

Supplementary Material is available at HMG online.

**Conflict of Interest statement:** D.M. reports ad hoc honoraria or consulting from Nutrition Impact, Amarin, Astra Zeneca, Boston Heart Diagnostics and Life Sciences Research organization; and scientific advisory board, Unilever North America. All other authors declare no competing interests.

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**Atherosclerosis Risk In Communities (ARIC) Study**

The ARIC Study is carried out as a collaborative study supported by National Heart, Lung, and Blood Institute contracts (HHSN...
Cardiovascular Health Study (CHS)

This CHS research was supported by NHLBI Contracts HHSN 2682012000036C, HHSN268200800007C, N01HC55222, N01HC85079, N01HC85080, N01HC85081, N01HC85082, N01HC85083 and N01HC85086; and NHLBI grants U01HL080295, R01HL087652, R01HL105756, R01HL103612 and R01HL120393 with additional contribution from the National Institute of Neurological Disorders and Stroke (NINDS). Additional support was provided through RO1AG023629 from the National Institute on Aging (NIA). A full list of principal CHS investigators and institutions can be found at CHS-NHLBI.org. The provision of genotyping data was supported in part by the National Center for Advancing Translational Sciences, CTSI grant UL1TR000124, and the National Institute of Diabetes and Digestive and Kidney Disease Research Center (DRC) grant DK063491 to the Southern California Diabetes Endocrinology Research Center. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Dietary, Life style, and Genetic determinants of Obesity and Metabolic syndrome (DILGOM)

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Family Heart Study (FamHS)

FamHS was supported by NIH grants R01-HL-087700 and R01-HL-088215 (Michael A. Province, PI) from NHLBI, and R01-DK-8925601 and R01-DK-075681 (I.B.B., PI) from NIDDK.

Framingham Offspring Study and Framingham Heart Study - Third Generation Study (FHS)

FHS were conducted in part using data and resources from the Framingham Heart Study of the National Heart Lung and Blood Institute of the National Institutes of Health and Boston University School of Medicine. The analyses reflect intellectual input and resource development from the Framingham Heart Study investigators participating in the SNP Health Association Resource (SHARE) project. This work was partially supported by the National Heart, Lung and Blood Institute’s Framingham Heart Study (Contract No. N01-HC-25195) and its contract with Affymetrix, Inc. for genotyping services (Contract No. N02-HL-64278). A portion of this research utilized the Linux Cluster for Genetic Analysis (LinGA-II) funded by the Robert Dawson Evans Endowment of the Department of Medicine at Boston University School of Medicine and Boston Medical Center. N.M.M. is supported by the USDA agreement No. 1950-51530-011-00D.

Gene–lifestyle interactions and complex traits involved in elevated disease risk (GLACIER)

The GLACIER Study was funded by project grants to P.W.F. from Novo Nordisk, the Swedish Heart–Lung Foundation, the Swedish Diabetes Association, Pålshons Foundation, the Swedish Research Council, Umeå University Career Development Award and The Heart Foundation of Northern Sweden. F.R. was supported by a post-doctoral stipend from the Swedish Heart-Lung Foundation; I.B. was funded by the Wellcome Trust (WT098051). The GLACIER Study is nested within the Northern Swedish Health and Disease Study cohort and the Västerbotten Intervention Programme (VIP). The investigators are indebted to the study participants who dedicated their time and samples to these studies. GLACIER investigators also thank the VIP and Umeå Medical Biobank staff for biomedical data collection and preparation. We specifically thank John Huttiainen, Asa Agran and Sara Nilsson (Umeå Medical Biobank) for data organization; Kerstin Enquist and Thore Johansson (Västerbottens County Council) for expert technical assistance with DNA preparation; and David Hunter, Patrice Soule and Hardeep Ranu (Harvard School of Public Health) for expert assistance with planning and undertaking genotyping of GLACIER samples.

Health 2000

The Health 2000 Study was funded by the National Institute for Health and Welfare (THL), the Finnish Centre for Pensions (ETK), the Social Insurance Institution of Finland (KELA), the Local Government Pensions Institution (KEVA) and the other organizations listed on the website of the survey (http://www.terveyys2000.fi). The authors would like to thank the many colleagues who contributed to collection and phenotypic characterization of the clinical samples, and DNA extraction and genotyping of the data, especially Eija Härmäläinen, Minttu Sauramo, Outi Törnwall, Päivi Laiho and the staff from the Genotyping Facilities at the Wellcome Trust Sanger Institute. They would also like to acknowledge those who agreed to participate in the Health 2000 Study.

Health, Aging and Body Composition (Health ABC) Study

The Health ABC Study is supported by the Intramural Research Program of the National Institutes of Health, National Institute on Aging and National Institute on Aging Contracts N01-AG-6-2101, N01-AG–6-2103 and N01-AG–6-2106. The Health ABC genome-wide association study was funded by a National Institute on Aging Grant, R01-AG032098, and genotyping services were provided by the Center for Inherited Disease Research (CIDR). CIDR is fully funded through a federal contract from the National Institutes of Health to the Johns Hopkins University (Contract No. HHSN268200782096C). The work of D.K.H. was supported by a K01 training grant (K01 AG030506).
Health Professionals Follow-up Study (HPFS)
Contributions of the HPFS to this investigation were supported by grants HL071981, HL073168, CA87969, CA49449, HL34594, HL08521, U01HG004399, DK080140, DK58845 and DK46200 from the National Institutes of Health. L.Q. is a recipient of the American Heart Association Scientist Development Award (0730094N).

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The InCHIANTI Study baseline (1998–2000) was supported as a ‘targeted project’ (IC5110.1/RF97.71) by the Italian Ministry of Health and in part by the U.S. National Institute on Aging (Con- tracts: 263 MD 9164 and 263 MD 82136).

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The Malmö Diet and Cancer Study was initiated and planned in collaboration with the International Agency for Research on Cancer, the Swedish Cancer Society and Swedish Medical Research Council and the Faculty of Medicine Lund University, Sweden. The study is also funded by Region Skåne, City of Malmö, Pålhus- son Foundation and the Swedish Heart and Lung Foundation.

Multi-Ethnic Study of Atherosclerosis (MESA)
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Rotterdam Study
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The Hellenic Study of Interactions between SNPs and Eating in Atherosclerosis Susceptibility (THISEAS)
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Uppsala Longitudinal Study of Adult Men (ULSAM)
This project was supported by grants from the Swedish Research Council, the Swedish Heart-Lung Foundation, the Swedish Foundation for Strategic Research, the Royal Swedish Academy of Sciences, the Swedish Diabetes Foundation, the Swedish Society of Medicine and Novo Nordisk Fonden. Genotyping was per- formed by the SNP&SEQ Technology Platform in Uppsala (www. genotyping.se). Investigators thank Tomas Axellson, Ann-Chris- tine Wiman and Caisa Pöntinen for their excellent assistance with genotyping. The SNP Technology Platform is supported by Uppsala University, Uppsala University Hospital and the Swedish Research Council for Infrastructures.

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References


