Obese Children and Adolescents

A Risk Group for Low Vitamin B₁₂ Concentration

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Objective: To assess whether overweight children and adolescents are at an increased risk for vitamin B₁₂ deficiency.

Design: Prospective descriptive study.

Setting: Two pediatric endocrine centers in Israel.

Participants: Three hundred ninety-two children and adolescents were divided into 2 groups as follows: the normal-weight group had body mass indexes, calculated as weight in kilograms divided by height in meters squared, under the 95th percentile (≤1.645 standard deviation scores; n=228); the obese group had body mass indexes equal to or above the 95th percentile (>1.645 standard deviation scores; n=164).

Intervention: We measured vitamin B₁₂ concentrations. Low serum B₁₂ was defined as a B₁₂ concentration less than 246 pg/mL, and vitamin B₁₂ deficiency was defined as a concentration below 211 pg/mL.

Main Outcome Measure: Vitamin B₁₂ concentrations corrected for body mass index standard deviation scores, age, and sex.

Results: Median concentration of serum B₁₂ in normal-weight children was 530 pg/mL and in obese children, 400 pg/mL (P<.001). Low B₁₂ concentrations were noted in 10.4% of the obese children compared with only 2.2% of the normal weight group (P<.001). Vitamin B₁₂ deficiency was noted in 12 children, 8 (4.9%) of the obese subjects and 4 (1.8%) of the normal weight group (P=.08). After we adjusted for age and sex, obesity was associated with a 4.3-fold risk for low serum B₁₂, and each unit increase in body mass index standard deviation score resulted in an increased risk of 1.24 (95% confidence interval, 0.99-1.56).

Conclusions: Obesity in children and adolescents was associated with an increased risk of low vitamin B₁₂ concentration. We recommend that dietary assessment of obese children should include an estimation of vitamin B₁₂ intake. The possibility of vitamin B₁₂ deficiency in addition to other micronutrient deficiencies should be considered in obese children.

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In general, food habits of adolescents are characterized by an irregular meal pattern with skipped meals. In a national survey among youth in the United States, the percentage of youth meeting national dietary recommendations was approximately 30% for the fruit, grain, meat, and dairy pyramid groups. Sixteen percent of youth did not meet any recommendations, and only 1% met all dietary recommendations. Dietary intakes of several micronutrients were found to be inadequate among adolescents in several studies.

Although it is hard to conceive of a nutritional deficiency occurring in subjects with excessive dietary and caloric intake, obese children tend to consume foods rich in carbohydrates and fat and thus may be at increased risk of micronutrient deficiency. For example, obesity has been associated with poor dietary calcium intake both in adults and in children. We have reported that 38.8% of obese children had low iron levels compared with only 4.4% of normal-weight children. Iron levels showed a significant negative correlation with greater standard deviation scores (SDSs) of body mass index (BMI), calculated as weight in kilograms divided by height in meters squared. Similarly, the National Health and Nutrition Examination Survey III (1988 through 1994), providing cross-sectional data on iron deficiency among children aged 2 to 16 years, showed that the prevalence of iron deficiency increased with increasing BMI and iron deficiency was particularly common among obese adolescents (9.1% compared with 3.5% in nonobese adolescents).

Vitamin B₁₂, also known as cobalamin, is a required nutrient; its main source...
is from foods of animal origin. Vitamin B₁₂ deficiency is associated with hematologic, neurologic, and psychiatric manifestations. Furthermore, vitamin B₁₂ deficiency results in hyperhomocystinemia, which is an independent risk factor for atherosclerotic disease. This study aimed to assess whether obese children are at increased risk for vitamin B₁₂ deficiency.

**METHODS**

The study population comprised 392 children and adolescents aged 6 to 19 years of Sephardic and Ashkenazi Jewish origin. One hundred sixty-four were obese subjects referred to the obesity clinics of 2 endocrine centers in Israel. Two hundred twenty-eight were normal weight children referred to endocrine clinics because of familial short stature, precocious or delayed puberty, or hirsutism and in whom no endocrine disorder was subsequently detected. Celiac disease was excluded in 103 of 128 children with short stature. We excluded children who had chronic diseases, those using vitamin supplements, those who were declared vegetarians, and those treated with metformin.

Subjects were divided into 2 groups on the basis of BMI for age and sex according to the National Institutes of Health data as follows: the normal weight group had BMIs under the 95th percentile, and the obese group had BMIs at or above the 95th percentile.

The study protocol was approved by the human experimentation committee of Sheba and Schneider medical centers (Tel Hashomer and Petah Tikva, Israel, respectively). Written parental informed consent and child assent were obtained from obese participants. Serum B₁₂ concentrations were routinely taken from patients as part of initial blood test screening following an overnight fast. Serum B₁₂ concentration was measured using the ADVIA Centaur System, a competitive immunnoassay using direct chemiluminescent technology (Bayer Diagnostics, Tarrytown, NY). Serum B₁₂ concentrations above 246 pg/mL were deemed normal, results between 211 and 246 pg/mL borderline were considered low, and concentrations less than 211 pg/mL indicated a B₁₂ deficiency as recommended by the manufacturer.

Data were analyzed with SAS software version 8.0 (SAS Institute, Cary, NC). Variables were compared using a x² test for discrete variables and t test or Wilcoxon rank sum test for continuous variables. All tests were 2-tailed and P values below .05 were considered statistically significant. Adjusted odds ratios and 95% confidence intervals were obtained from logistic regression models with low serum B₁₂ concentration (<246 pg/mL) as a dependent variable and age, sex, and obesity as predictors. Goodness-of-fit of the models was estimated by a Hosmer-Lemeshow test and c statistics.

**RESULTS**

Of 392 study participants, 228 were of normal weight, and 164 were obese. Age and sex distribution, BMI, and vitamin B₁₂ concentrations of each group are shown in Table 1. The median serum B₁₂ concentration of obese children was significantly lower than that of normal weight children; 400 vs 530 pg/mL, respectively (P<.001). This difference was especially marked in children aged 12 years and older.

Low vitamin B₁₂ concentrations (<246 pg/mL) were present in 22 subjects (5.6%), 17 (10.4%) of whom were obese and 5 (2.2%) of whom were normal-weight children (P<.001). Vitamin B₁₂ concentrations below 246 pg/mL were noted in 18 (9.7%) of 186 children older than 12 years of age compared with 4 (1.9%) of 206 children aged 6 to 11 years (P=.001). The percentages of boys (4.5%) and girls (6.4%) with B₁₂ concentrations below 246 pg/mL were not statistically different.

Vitamin B₁₂ deficiency (<211 pg/mL) occurred in 12 children, 8 of whom were aged 12 to 19 years. Vitamin B₁₂ deficiency was present in 8 (4.9%) of the obese subjects and in 4 (1.8%) of the normal weight group (P=.08).

On multivariable analysis (Table 2), obesity was associated with an excess risk for low vitamin B₁₂ levels (odds ratio, 4.33) after adjustment for age and sex. The Hosmer-Lemeshow goodness-of-fit test and c statistics showed that the model fitted well (P=.90, c=0.77). A similar model was conducted with BMI SDSs and age as continuous vari-

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**Table 1. Age, Sex, and Vitamin B₁₂ Levels According to Weight Status**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Normal Weight (n = 228)</th>
<th>Obese (n = 164)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean ± SD, y</td>
<td>11.4 ± 2.7</td>
<td>12.4 ± 3.3</td>
<td>.002</td>
</tr>
<tr>
<td>Age, No. (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;12 y</td>
<td>137 (60.1)</td>
<td>69 (42.1)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>≥12 y</td>
<td>91 (39.9)</td>
<td>95 (57.9)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Body mass index, median (interquartile range)*</td>
<td>16.8 (15.2-18.7)</td>
<td>31.5 (27.0-38.3)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Sex, No. (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>86 (37.7)</td>
<td>70 (42.7)</td>
<td>.32</td>
</tr>
<tr>
<td>Female</td>
<td>142 (62.3)</td>
<td>94 (57.3)</td>
<td></td>
</tr>
<tr>
<td>Vitamin B₁₂ concentration, median, pg/mL (interquartile range)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>530 (410-663)</td>
<td>400 (304-518)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Boys</td>
<td>526 (384-695)</td>
<td>410 (304-520)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Girls</td>
<td>530 (420-635)</td>
<td>396 (304-504)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Age &lt;12 y</td>
<td>541 (425-709)</td>
<td>490 (401-598)</td>
<td>.02</td>
</tr>
<tr>
<td>Age ≥12 y</td>
<td>504 (385-614)</td>
<td>337 (279-439)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Body mass index is calculated as weight in kilograms divided by height in meters squared.

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**Table 2. Multivariate Analysis for Low Serum Vitamin B₁₂ Levels**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Low B₁₂, No. (%)</th>
<th>Adjusted OR (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI SDSs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>228</td>
<td>5 (2.9)</td>
<td>1</td>
</tr>
<tr>
<td>Obese</td>
<td>164</td>
<td>17 (10.4)</td>
<td>4.33 (1.54-12.2)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;12 y</td>
<td>206</td>
<td>4 (1.9)</td>
<td>1</td>
</tr>
<tr>
<td>≥12 y</td>
<td>186</td>
<td>18 (9.7)</td>
<td>4.46 (1.46-13.6)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>156</td>
<td>7 (4.5)</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>236</td>
<td>15 (6.4)</td>
<td>1.67 (0.46-5.31)</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); CI, confidence interval; OR, odds ratio; SDSs, standard deviation scores.

<sup>*Serum B₁₂ concentration was less than 246 pg/mL.</sup>
Our results show that obese children and adolescents had significantly lower B12 concentrations than normal-weight children and that 10% of obese children had low serum B12 concentrations. Obesity was associated with a greater than 4-fold risk for low vitamin B12 concentrations, and for each unit increase in BMI SDS, there was a 24% increase risk of low serum B12 concentrations. To the best of our knowledge, this is the first report of low B12 concentrations in obese children. Lower serum B12 concentrations were detected in overweight Brazilian adolescents compared with those of normal-weight adolescents; however, this difference did not reach statistical significance.10 Among Thai adults, no statistically significant difference in vitamin B12 concentrations was found in overweight and obese subjects compared with normal control subjects.11 Among adult Turkish patients with metabolic syndrome, serum B12 concentrations were significantly lower than those of healthy subjects.12

Vitamin B12 deficiency results from decreased intake, abnormal nutrient absorption, and rare inborn errors of vitamin B12 metabolism.13-15 Abnormal absorption may be due to medications that decrease gastric acid secretion, pernicious anemia, infection with giardia lamblia, and any disruption of the ileal mucosa such as Crohn and celiac disease. Because obese children gain weight easily, there is no reason to suspect they have a problem with absorption. Although declared vegetarians were excluded from our study, dietary habits of obese children may be high in carbohydrate and fat and low in proteins from animal sources that contain vitamin B12. Indeed in a recent study, low-nutrient-density foods contributed more than 30% of daily energy intake,16 and intake of micronutrients related inversely to intake of low-nutrient-density foods. In the present study, although obese children were new to our clinic and had not yet been started on a weight-loss diet, it is possible that some of them had tried unbalanced diets prior to their referral to the clinic. Furthermore, it is possible that obese children have increased vitamin B12 needs compared with nonobese children because of their increased growth and body surface area.17 Finally, B12 concentrations noted reflect the status in Israeli children and may not be comparable with data from other countries. For example, in our cohort, the mean B12 concentration of normal-weight children aged 6 to 11 years was 541 pg/mL in the 12- to 18-year-old group, 504 pg/mL, compared with 708 and 528 pg/mL in same age groups in the United States.18

Vitamin B12 is a cofactor in the synthesis of methionine from homocysteine; therefore, deficiency in vitamin B12 leads to hyperhomocysteinemia. Longitudinal cohort studies have established that even mild hyperhomocysteinemia both predicts and precedes the development of cardiovascular morbidity and mortality.19,20 Hyperhomocysteinemia correlated with insulin resistance in obese prepubertal children.21 Among adults with the metabolic syndrome, levels of homocysteine were significantly higher and levels of vitamin B12 were significantly lower compared with those of healthy subjects.12 Homocysteine-lowering treatments have resulted in improvement of cardiovascular reactivity and coagulation factors.22 It is thus possible that vitamin B12 deficiency may further contribute to the high risk of developing cardiovascular disease among obese children. Folate and vitamin B12 treatment improved insulin resistance and endothelial dysfunction, along with decreasing homocysteine levels, in patients with metabolic syndrome.23
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REFERENCES


