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3 **Long-term effect of asthma on the development of obesity among adults: an international**  
4 **cohort study, ECRHS**  
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## KEY MESSAGES

- **What is the key question?**

Is asthma a risk factor for the development of obesity in adults?

- **What is the bottom line?**

Asthmatics, particularly those who were non-atopic, had longer disease duration or were on oral corticosteroids, were at a higher risk of developing obesity later in life. This association was not mediated by physical activity.

- **Why read on?**

Although an association between obesity and asthma has been well established, whether asthma can relate to increased risk of future obesity has been only studied in children. Understanding the link between asthma and obesity is key for a proper asthma management.

**ABSTRACT**

**Introduction:** Obesity is a known risk factor for asthma. Although some evidence showed asthma causing obesity in children, the link between asthma and obesity has not been investigated in adults.

**Methods:** We used data from the European Community Respiratory Health Survey (ECRHS), a cohort study in 11 European countries and Australia in 3 waves between 1990 and 2014, at intervals of approximately 10 years. We considered two study periods: from ECRHS I ( $t$ ) to ECRHS II ( $t+1$ ), and from ECRHS II ( $t$ ) to ECRHS III ( $t+1$ ). We excluded obese ( $\text{BMI} \geq 30 \text{kg/m}^2$ ) individuals at visit  $t$ . The relative risk (RR) of obesity at  $t+1$  associated with asthma at  $t$  was estimated by multivariable modified Poisson regression (lag) with repeated measurements. Additionally, we examined the association of atopy and asthma medication on the development of obesity.

**Results:** We included 7,576 participants in the period ECRHS I-II (51.5% female, mean (SD) age of 34 (7) years), and 4,976 in ECRHS II-III (51.3% female, 42 (8) years). 9% of participants became obese in ECRHS I-II and 15% in ECRHS II—III. The risk of developing obesity was higher among asthmatics than non-asthmatics (RR: 1.22, 95%CI: 1.07 to 1.38), and particularly higher among non-atopic than atopic (1.47; 1.17 to 1.86 vs 1.04; 0.86 to 1.27), those with longer disease duration (1.32; 1.10 to 1.59 in  $>20$  years vs 1.12; 0.87 to 1.43 in  $\leq 20$  years), and those on oral corticosteroids (1.99; 1.26 to 3.15 vs 1.15; 1.03 to 1.28). Physical activity was not a mediator of this association.

**Conclusion:** This is the first study showing that adult asthmatics have a higher risk of developing obesity than non-asthmatics, particularly those non-atopic, of longer disease duration or on oral corticosteroids.

**Keywords:** Asthma, ECRHS, Obesity, Oral corticosteroids, Physical activity

## INTRODUCTION

Several studies demonstrating the co-existence of obesity and asthma across the world suggest the presence of common aetiological factors between these conditions.[1-5] Asthma and obesity share some common socioeconomic, behavioural, and environmental risk factors, all of which could trigger the expression of genes, leading to the development of either of these diseases. Previous studies focussed mainly on the mechanisms by which obesity could lead to asthma. Several obesity-associated biological phenomena have been proposed, such as by altering the lung compliance (causing airflow limitation), increasing the synthesis of immune-modulators, affecting the sympathetic nervous system, or by modulating gene function.[1, 2] The inverse relationship, i.e., whether asthma is a risk factor for later obesity had not received much attention until recently.

In a longitudinal cohort study of kindergarten and first-grade children, Chen and colleagues (2017) observed that the non-obese children who were diagnosed with asthma during the recruitment phase were at increased risk of developing obesity during the 10-years follow up.[6] This was confirmed in a pooled analysis of 18 European cohorts associating physician diagnosed asthma at 3-4 years with incident obesity at 8 years, the risk being higher among children with active asthma symptoms.[7] Another recent study demonstrated a link between high peak flow variability in childhood and a steeper increase of body mass index (BMI) in adulthood.[8] Despite studies on children and young adolescents, whether and to what extent asthma increased the risk for subsequent obesity among adults remained unclear. Asthma in adults may be causally and aetiologically more complex than childhood asthma (which is predominantly allergic asthma), therefore, the magnitude of the asthma-obesity risk is likely to be different in adults.

In line with the previously reported observations, we hypothesized that asthma could be a risk factor for obesity at a later stage of life. Therefore, we aimed to investigate the occurrence of obesity attributable to asthma in participants of the European Community Respiratory Health Survey (ECRHS) over two period of 10 years.

## METHODS

### Design and participants

ECRHS is a population-based cohort study initiated in 1990-94 (ECRHS-I) with over 18,000 participants aged between 20 and 44 years from 30 centres in 14 countries, which had two follow-up rounds at approximately 10-year intervals (ECRHS-II in 1999-2003 and ECRHS-III in 2010-2014). In the recruitment phase, a postal questionnaire was sent containing items about asthma symptoms and exacerbation history in the last 12 months, current medication, and allergic conditions such as nasal symptoms and hay fever. From those who responded to the postal questionnaire, participants were either selected from a random sample or a symptomatic sample and were invited for more detailed investigation that included an interviewer-administered questionnaire and lung function testing.[9, 10] The questionnaires and clinical investigations were repeated in the next follow-ups (ECRHS-II and III).

The design and selection of participants of the present study are presented in **Figure 1**. We considered two study periods: from ECRHS I ( $t$ ) to ECRHS II ( $t+1$ ), and from ECRHS II ( $t$ ) to ECRHS III ( $t+1$ ). At each period we classified the participants as “no asthma” or “current asthma” (see definitions below). To study only incident obesity, we excluded individuals who were obese (BMI  $\geq 30\text{kg/m}^2$ ) at visit  $t$ . To avoid misclassification in the definition of the ‘current asthma’ and ‘no asthma’ groups, we excluded participants with inactive asthma (i.e. self-reported doctor diagnosed asthma, with no respiratory symptoms within the last 12 months). We finally excluded subjects with missing asthma or obesity information at either  $t$  or  $t+1$ , giving a total of 8,716 participants from 26 centres of 11 European countries and Australia. Ethical approval of the study was obtained from the ethical review boards or committees of the respective centres. All participants provided signed informed consent. Detailed information about the ethical approval, informed consent and data management were described elsewhere.[10]

- Figure 1

### Definition of asthma-related variables

Asthma-related information was collected at each survey. We defined current asthma as giving a positive answer to the questions “Have you ever had asthma?” and “Was this confirmed by a

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3 doctor?”, and having reported at least one of the following in the last 12 months: waking up by an  
4 attack of shortness of breath, any asthma attack, or use of asthma medications.[11-13] Asthma  
5 duration at  $t$  was derived as the number of years between age at  $t$  and reported age at first asthma  
6 onset. Atopy was defined as a serum specific IgE antibody concentration of  $\geq 0.35$  kU<sub>A</sub>/L to at  
7 least one of four common allergens (house dust mite, cat, timothy grass or *Cladosporium*  
8 *herbarum*), as defined previously.[14] We also obtained information on asthma drug treatment  
9 from the questions “Have you used any pills, capsules, tablets or medicines, other than inhaled  
10 medicines, to help your breathing at any time in the last 12 months?”, and defined whether each  
11 patient took inhaled (ICS) oral corticosteroids (OCS) or both during the last 12 months. Only at  
12 ECRHS II, information was collected on whether OCS were used continuously, for a short-course,  
13 or as rescue medication. The modified Medical Research Council (mMRC) Dyspnoea Scale was  
14 used to define dyspnoea (considered if they had mMRC grade  $\geq 2$ ).[15]

### 25 26 27 28 **Obesity**

29 Height and weight of all participants were measured by physical examination during the clinical  
30 visit at each survey. BMI was calculated as weight in kilograms divided by the square of height in  
31 metres. Obesity was defined as  $BMI \geq 30 \text{ kg/m}^2$ . [16]

### 32 33 34 35 36 37 **Other relevant information**

38 At each study wave, we collected data on socio demographic and other clinical factors using  
39 questionnaires. These included sex, age, education (age at which the participants finished their  
40 formal education) and smoking status (never, former and current) and intensity (pack-years).

41 Information about physical activity of the participants was obtained at ECRHS-II and III from a  
42 self-completed questionnaire in which they were asked about the weekly frequency and duration  
43 of vigorous physical activity.[17-19] Those who exercised at least two times a week for at least 1  
44 hour were considered physically active.

### 45 46 47 48 49 50 51 52 53 54 55 **Statistical analyses**

56 Relative risks (RR) and 95% confidence intervals (CIs) for the association of current asthma,  
57 asthma with atopy, asthma duration, and asthma with medication (ICS, OCS or both), with new  
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3 obesity onset were estimated using modified Poisson regression for repeated measures with time  
4 of follow-up as offset.[20] Exposure was the asthma status at the survey time  $t$  (lag1) and outcome  
5 was obesity at subsequent time  $t+1$ . Therefore, participants could contribute with one or two  
6 observations, i.e., from ECRHS-I to ECRHS-II and/or from ECRHS-II to ECRHS-III (Figure 1).  
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8 Multivariate models were fitted after testing the following potential confounders: education, sex,  
9 age, smoking status, and physical activity (between ECRHS-II and III only). Only those variables  
10 associated (i.e., p-value <0.05) both with asthma and obesity were retained. Hence, the final  
11 models were adjusted for age, sex, and smoking status at time  $t$ . Subjects nested in centre were  
12 included as random effects to account for the repeated data design.  
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22 Models were presented overall and separately by sex. We performed meta-analysis to determine  
23 if there was any heterogeneity between the participating countries and between centres.  
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28 Two secondary analyses were performed: (1) to determine if physical activity could be a mediator  
29 in the asthma-obesity association, we tested 3 paths separately: physical activity at ECRHS-II  
30 mediating the relationship between asthma at ECRHS-I and obesity at ECRHS-II (path 1),  
31 physical activity at ECRHS-II mediating the relationship between asthma at ECRHS-I and obesity  
32 at ECRHS-II (path 2), and physical activity at ECRHS-III mediating the relationship between  
33 asthma at ECRHS-II and obesity at ECRHS-III (path 3); and (2) to estimate the impact of smoking  
34 cessation on the association between asthma and new obesity onset, we stratified our models by  
35 active smokers (at time  $t$ ), smokers who quit during the study (between ECRHS-I and II, and  
36 ECRHS-II and III), and never smokers.  
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47 Some sensitivity analyses were performed to check the robustness of our results. We repeated  
48 our analyses: (1) excluding those who did not take part in all three ECRHS waves; (2) excluding  
49 participants who reported avoiding physical activity because of respiratory symptoms; (3)  
50 excluding those who reported dyspnoea at time  $t$ ; (4) defining current asthma as the a self-report  
51 of doctor's diagnosis and at least one of the following within the last 12 months: waking up by an  
52 attack of shortness of breath, any asthma attack, use of asthma medications, wheeze, shortness  
53 of breath, waking up with chest tightness or attack of cough; and (5) using BMI change between  
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3  $t$  and  $t+1$  as the outcome variable in linear mixed regression. All analyses were performed in  
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5 STATA (version 12.1, STATA Corp. College Station, Texas, USA).  
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## 8 9 **RESULTS**

10 Distribution of the participants included in this analysis is presented in Table 1. We studied 7,576  
11 participants in the period ECRHS I-II (51.5% female, mean (SD) age of 34 (7) years at ECRHS  
12 I), and 4,976 participants in the period ECRHS II-III (51.3% female, 42 (8) years at ECRHS II).  
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14 Current smokers decreased during follow-up (30% in ECRHS I-II vs. 19% in ECRHS II-III). The  
15 relative number of participants with current asthma remained the same across the study waves.  
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17 Overall, 9% of participants became obese from ECRHS-I to ECRHS-II and this proportion rose to  
18 15% from ECRHS II to ECRHS-III. We observed that 37% of the study population was physically  
19 active at ECRHS-II which increased slightly to 42% at ECRHS-III.  
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- 28 • Table 1

31 The association between asthma and obesity is presented in **Supplementary Table E1** and  
32 **Figure 2**. Compared to 8.4% and 14.6% of non-asthmatics who developed obesity at ECRHS-II  
33 and ECRHS-III respectively, 10.7% and 16.9% asthmatics developed obesity at ECRHS-II and  
34 III. The absolute risk difference in asthmatics vs no asthmatics was 2.3% (95% CI 0.8 to 3.9%)  
35 and the relative risk (RR) was 1.21 (95%CI: 1.07 to 1.37). After adjusting for potential confounders  
36 (age, sex and smoking status at time  $t$ ), the association between asthma and the development of  
37 obesity remained significant (1.22; 1.07 to 1.38). The association was stronger among asthmatics  
38 without atopy (1.47; 1.17 to 1.86), asthmatics with longer disease duration (1.32; 1.10 to 1.59),  
39 asthmatics who used oral corticosteroids (1.99; 1.26 to 3.15) and those who used both oral and  
40 inhaled corticosteroids (2.07; 1.19 to 3.59).  
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- 52 • Figure 2

53 We conducted post hoc analyses to understand better the association between oral  
54 corticosteroids intake and incident obesity. The comparison between patients on continuous,  
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3 short-course or use as rescue medication of OCS suggested a higher risk of obesity among those  
4 using continuously, but very small sample size precluded any kind of statistical testing  
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7 **(Supplementary Table E2)**.

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10 The association of asthma and obesity was similar in males (1.27; 1.06 to 1.51) and females  
11 (1.20; 1.01 to 1.42, **Supplementary Table E3**). The association of asthma with new onset obesity  
12 was homogeneous across the participating countries (**Figure 3**) and centres (**Supplementary**  
13 **Figure E1**). The overall estimates from the meta-analyses were similar to that reported in the  
14 main analysis and there was no statistical evidence of heterogeneity ( $I^2=0$ , p-values for  
15 heterogeneity were 0.70 and 0.96 for country and centre, respectively).  
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- 24 • Figure 3

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27 No evidence of physical activity as a mediator in the asthma-obesity association was observed  
28 (**Supplementary Table E4**). When stratified by smoking status, the risk of becoming obese in  
29 asthmatics was higher among current smokers (1.46, 1.12 to 1.90) and among never smokers  
30 (1.27, 1.08 to 1.49), while no association between asthma and obesity was observed among those  
31 who stopped smoking (0.95; 0.65 to 1.37) (**Supplementary Table E5**). In the sensitivity analyses,  
32 the estimates were comparable to the main analyses (**Supplementary Tables E6, E7, E8, E9**  
33 **and E10**).  
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## 43 **DISCUSSION**

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45 In this prospective cohort study, we found that individuals with active asthma were at higher risk  
46 of developing obesity compared to individuals without asthma, that this association was higher  
47 among non-atopic asthmatics, those with long disease duration or those using oral  
48 corticosteroids, and that the association was not mediated by physical activity levels.  
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55 Our observation of accelerated weight gain among asthmatics is supported by a previous  
56 prospective study that demonstrated asthma to be associated with increased weight gain at a  
57 later stage in women,[21] although unlike our results, they did not find any such association in  
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3 men. Two recent longitudinal studies in children, one of them including more than 21,000 children  
4 from 16 European cohorts, showed that childhood asthma was a risk factor for obesity at a later  
5 age.[6, 7] Another recent report also demonstrated that children with high peak flow variability  
6 were on a steeper increase of BMI up to young adult life that was not associated with asthma.[8]  
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8 This evidence suggests that asthma and obesity share several common physiological pathways  
9 and a bi-directional association between asthma and obesity is plausible.  
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16 It has been debated whether there is any association between atopy and increased body  
17 weight.[22] While several reports support this association, [23, 24] other studies have shown that  
18 the risk of being overweight is higher among the non-atopic than those with marked allergic  
19 sensitization.[25, 26] Our observation of a greater risk of obesity among non-atopic asthmatics  
20 indicates that allergic sensitization is unlikely to explain the association between asthma and  
21 obesity.  
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30 We observed that the risk of developing obesity was more pronounced among asthmatics who  
31 were on oral corticosteroids than those who were not, in agreement with previous reports, in  
32 adults and children with asthma, relating the intake of oral corticosteroids with abnormal weight  
33 gain.[27-30] Unfortunately we could not test the role of corticosteroids dose or duration due to  
34 small sample size of OCS users. The effects of long term use of oral corticosteroids on weight  
35 gain are well established in asthma and general population,[27, 31] and supported by several  
36 mechanisms, including but not limited to increased lipid uptake from the gut and storing in the  
37 peripheral tissues,[30] or increased insulin resistance.[32] However, we also found an increased  
38 and statistically significant risk of obesity among asthmatics who reported not having taken OCS.  
39 One could argue that, if asthma really causes weight gain, this effect would be higher among  
40 those with severe asthma, so the higher risk observed among OCS users is actually the result of  
41 confounding by indication and not a result of the treatment itself.[33] This is supported by our  
42 findings of higher obesity risk among asthmatics of longer disease duration..  
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56 A potential explanation for asthma causing weight gain is through the reduction of physical activity  
57 levels. Patients with chronic respiratory diseases tend to be less physically active due to recurrent  
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3 episodes of breathlessness or persistent wheezing.[34] However, our analyses do not support  
4 this hypothesis, as physical activity was not mediating the asthma-obesity association and this  
5 association remained after excluding those participants who did not perform physical activity due  
6 to breathlessness, in line with the previously mentioned study among asthmatic children who  
7 developed obesity on follow-up independent of physical activity.[6]  
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14 Another potential explanation would be via a role of smoking. Smoking cessation has been  
15 observed to augment weight gain at least in the short term.[35, 36] However, we found no  
16 association between asthma and incident obesity among participants quitting smoking. On the  
17 contrary, we observed greater relative risks among current smokers and non-smokers. Smoking  
18 has been observed to reduce the efficacy of steroid treatment in asthma [37-39], so it could be  
19 argued that asthmatics who smoke are at a higher risk of the effects of asthma (such as obesity)  
20 because of worse disease control. Altogether suggests that there may be mechanisms other than  
21 OCS use, reducing physical activity and smoking cessation, linking asthma to obesity, but these  
22 are yet unknown.  
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34 Our study outcomes are of significant clinical importance. First, our observation of higher obesity  
35 risk in asthmatics who took oral corticosteroids, advocates the minimal and precise use of oral  
36 corticosteroids in asthma.[40] Albeit current recommendations of oral corticosteroids for asthma  
37 management, several reports also indicate that oral steroids are still prescribed indiscriminately  
38 in asthma, sometimes, even without diagnosing the severity of the disease properly.[41-43] This  
39 could result in an increasing burden of adverse health effects in asthma, obesity being one of the  
40 major consequences. Secondly, the observation of a greater risk of obesity among non-atopic  
41 asthmatics directs our attention towards adult-onset asthma and supports increasing attention to  
42 the reduction of adult risk factors, such as occupational exposures that account for up to 25% of  
43 adult-onset asthma.[44] Thirdly, we also observed a higher risk of obesity among asthmatics who  
44 were smokers. Although smoking cessation programmes have now become a part of the clinical  
45 management of respiratory and cardiovascular diseases, evidence shows that not all patients  
46 benefit from them, particularly in primary care.[45, 46] Advice on smoking cessation along with its  
47 plausible consequences (such as temporary weight gain) should also be discussed with the  
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3 patients. Finally, although we did not find any evidence of physical activity mediating the asthma-  
4 obesity interaction, it must be noted that lifestyle factors also significantly influence weight gain.  
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6 Thus, advice on healthy diet, proper physical activity and lifestyle modification should be  
7  
8 warranted as part of asthma management.  
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12 The strengths of our study included its longitudinal design, allowing the exclusion of obese  
13 subjects at baseline, with a large cohort that was followed over a long period of time. Furthermore,  
14 we performed several sensitivity analyses to test the robustness of our results against  
15 assumptions about asthma or obesity miss-classification, residual confounding or model miss-  
16 specification. Lastly, the results were homogeneous across the participating countries which  
17 indicate that study findings can be extrapolated to other populations.  
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26 A limitation in this study is the potential bias in defining asthma and obesity status, given the lack  
27 of information on when events happened during the 10 years follow-up period. However, our  
28 results were robust to several sensitivity analyses. Although we were able to consider plausible  
29 known confounders, the effect of other lifestyle factors (such as diet, only available in a subsample  
30 of ECRHS at one single time point), psychosocial attributes, or genetic predisposition could not  
31 be analysed. Finally, we were limited to explore in detail the role of OCS on obesity risk because  
32 of the lack of detailed information on dosage, duration or their use for other diseases than asthma.  
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## 41 **CONCLUSION**

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43 In summary, we demonstrated that participants with asthma were at a higher risk of developing  
44 obesity later in life and the risk was more pronounced among those asthmatics who were non-  
45 atopic, those with asthma of longer duration and those on oral corticosteroids. These results  
46 support earlier results in children and warrant further clinico-epidemiological and experimental  
47 research, in order to determine the mechanisms through which asthma could trigger obesity risk  
48 among adults.  
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## **AUTHOR CONTRIBUTIONS**

S Moitra, A-E Carsin, M Kogevinas, and J Garcia-Aymerich conceived the study design, analysed the results, interpreted the data, and drafted the manuscript. S Guerra interpreted the data; drafted the article or revised it; provided intellectual content of critical importance to the work described. All other authors revised the manuscript and provided critical comments. The joint first authors and the last author take the responsibility for the data integrity.

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## 10 11 12 **CONFLICT OF INTEREST**

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## 41 **DATA SHARING POLICY**

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43 The datasets used and analysed during the current study are available from the authors upon  
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**Table 1: Demographic profile of the study participants in ECRHS I-II and in ECRHS II-III**

	<b>ECRHS I-II n=7576</b>	<b>ECRHS II-III n=4976</b>
Sex (female), n (%)	3905 (51.5%)	2555 (51.3%)
Age <i>t</i> (years), mean (SD)	34.0 (7.1)	41.5 (7.8)
Age <i>t+1</i> (years), mean (SD)	42.7 (7.2)	53.9 (7.1)
Education, n (%)		
Low	813 (10.8%)	409 (8.5%)
Medium	2715 (36.0%)	1675 (34.7%)
High	4024 (53.3%)	2744 (56.8%)
Country, n (%)		
Australia	387 (5.1%)	212 (4.3%)
Belgium	528 (7.0%)	287 (5.8%)
Estonia	250 (3.3%)	132 (2.7%)
France	862 (11.4%)	737 (14.8%)
Germany	534 (7.0%)	545 (11.0%)
Iceland	434 (5.7%)	320 (6.4%)
Italy	512 (6.8%)	210 (4.2%)
Norway	500 (6.6%)	298 (6.0%)
Spain	1353 (17.9%)	806 (16.2%)
Sweden	1231 (16.2%)	749 (15.1%)
Switzerland	483 (6.4%)	403 (8.1%)
UK	502 (6.6%)	277 (5.6%)
Smoking status <i>t</i> , n (%)		
Never	3272 (43.3%)	2201 (44.4%)
Former	2043 (27.0%)	1814 (36.6%)
Current	2247 (29.7%)	939 (19.0%)
Current asthma <i>t</i> , n (%)		
No asthma	6859 (90.5%)	4495 (90.2%)
Current asthma, all	717 (9.5%)	490 (9.8%)
Current asthma, <i>without atopy</i>	271 (3.6%)	190 (3.8%)
Current asthma, <i>with atopy</i>	446 (5.9%)	300 (6.0%)
Current asthma, <i>≤20 years since onset</i>	406 (5.4%)	218 (4.4%)
Current asthma, <i>&gt;20 years since onset</i>	308 (4.1%)	266 (5.3%)
Current asthma, <i>no ICS</i>	494 (6.5%)	260 (5.2%)
Current asthma, <i>with ICS</i>	223 (2.9%)	230 (4.6%)
Current asthma, <i>no OCS</i>	664 (8.8%)	454 (9.1%)
Current asthma, <i>with OCS</i>	53 (0.7%)	36 (0.7%)
Current asthma, <i>only ICS</i>	183 (2.4%)	199 (4.0%)
Current asthma, <i>ICS &amp; OCS</i>	40 (0.5%)	31 (0.6%)
BMI <i>t</i> (kg/m <sup>2</sup> ), mean (SD)	23.3 (2.8)	24.1 (2.9)
BMI <i>t+1</i> (kg/m <sup>2</sup> ), mean (SD)	25.0 (3.6)	26.0 (3.8)
Obesity (yes) <i>t+1</i> , n (%)	655 (8.6%)	736 (14.8%)
Dyspnoea (yes) <i>t</i> , n (%)	256 (3.4%)	182 (3.7%)
Physical Activity (yes) <i>t+1</i> , n (%)	2627 (37.0%)	2029 (41.8%)

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3 ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral  
4 corticosteroids; BMI: body mass index.

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7 Current asthma defined as a self-report of a doctor's asthma diagnosis and at least one of the following,  
8 within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of  
9 asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current  
10 symptoms) were excluded from the study (see Methods).  
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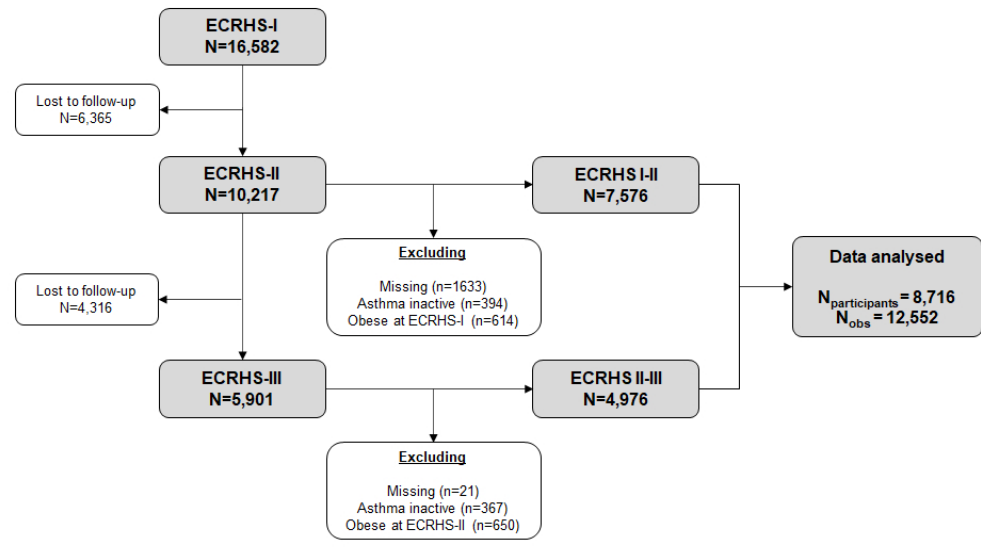
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7 **Figure 1: Schematic representation of the study design**  
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10 **Figure 2: Association between asthma, asthma with atopy, asthma duration, and asthma**  
11 **with medication at  $t$  and incident obesity at  $t+1$ .** Data presented as relative risk (RR) and 95%  
12 confidence interval (95%CI). RR was calculated from modified Poisson regression with robust  
13 standard errors and subjects nested in centre as random effects. All models (for all participants)  
14 were adjusted for age, sex and smoking status at time  $t$ . See full figures in Supplementary Table  
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24 **Figure 3: Meta-analysis results of the association between asthma at  $t$  and obesity at  $t+1$**   
25 **by country**  
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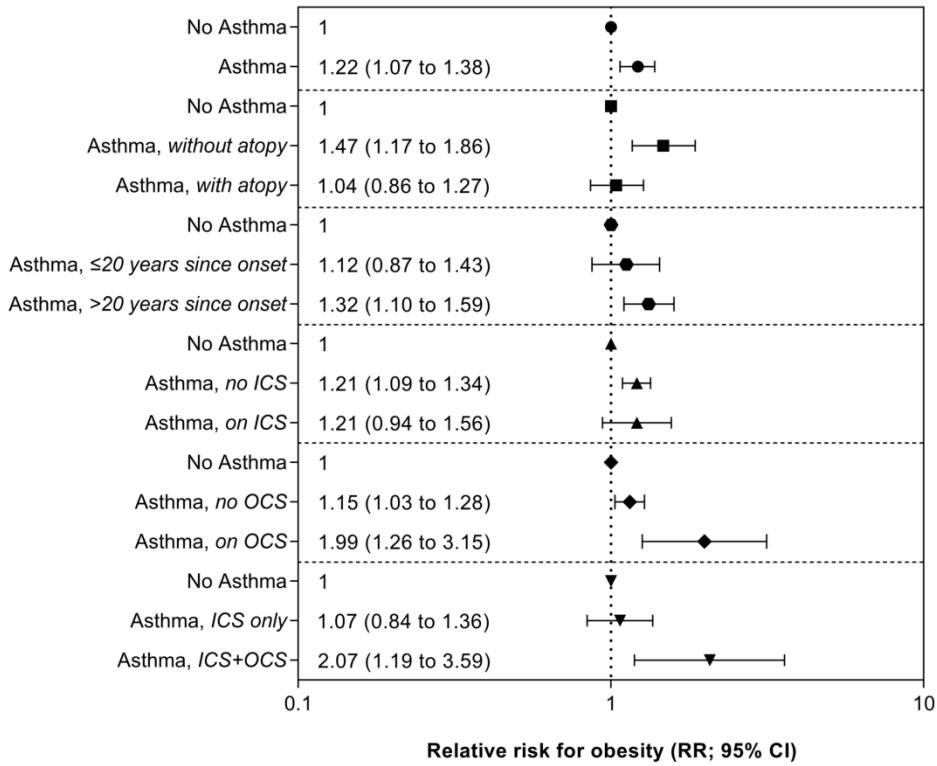
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**Figure 1: Schematic representation of the study design**

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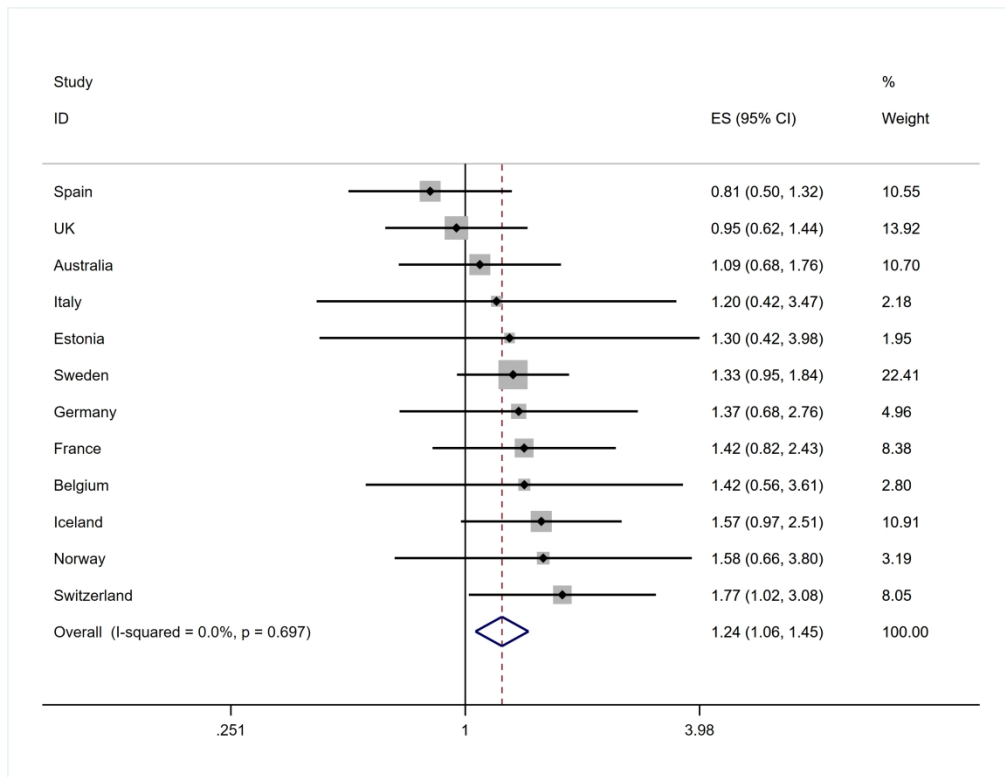


**Figure 2: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at t and incident obesity at t+1.**

Data presented as relative risk (RR) and 95% confidence interval (95%CI). RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time t. See full figures in Supplementary Table E1.

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**Figure 3: Meta-analysis results of the association between asthma at t and obesity at t+1 by country**

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## Long-term effect of asthma on the development of obesity among adults: an international cohort study, ECRHS

Subhabrata Moitra, Anne-Elie Carsin, Michael J Abramson, Simone Accordini, André FS Amaral, Josep M Antó, Roberto Bono, Lidia Casas Ruiz, Isa Cerveri, Leda Chatzi, Pascal Demoly, Sandra Dorado-Arenas, Bertil Forsberg, Frank D Gilliland, Thóraninn Gíslason, José A. Gullón, Joachim Heinrich, Mathias Holm, Christer Janson, Rain Jõgi, Francisco Gomez Real, Deborah Jarvis, Bénédicte Leynaert, Dennis Nowak, Nicole Probst-Hensch, José Luis Sánchez-Ramos, Chantal Raheison Semjen, Valérie Siroux, Stefano Guerra, Manolis Kogevinas, Judith Garcia-Aymerich

### List of Supplementary Tables and Figures

- Supplementary Table E1: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$
- Supplementary Table E2: Association between OCS dosage at  $t$  and obesity at  $t+1$  in asthmatics
- Supplementary Table E3: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , stratified by sex
- Supplementary Table E4: Mediation analyses testing the mediating role of physical activity on the association between asthma and incident obesity
- Supplementary Table E5: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , stratified by smoking pattern.
- Supplementary Table E6: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , including only participants who took part in all the three waves of ECRHS I, II and III.
- Supplementary Table E7: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , excluding the participants who reported avoiding physical activity because of wheezing/asthma.
- Supplementary Table E8: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , excluding the participants with dyspnoea at  $t$ .
- Supplementary Table E9: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , using a broader asthma definition.
- Supplementary Table E10: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and BMI changes between  $t$  and  $t+1$ .
- Supplementary Figure E1: Meta-analysis of the association between asthma at  $t$  and obesity at  $t+1$  by ECRHS centre.



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**Supplementary Table E1: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at *t* and incident obesity at *t+1***

	Obesity at visit, % (n/N)		RR (95%CI)	
	ECRHS II	ECRHS III	Unadjusted	Adjusted
No asthma	8.4% (578/6859)	14.6% (653/4486)	1	1
Asthma	10.7% (77/717)	16.9% (83/490)	<b>1.21 (1.07 to 1.37)</b>	<b>1.22 (1.07 to 1.38)</b>
No asthma	8.4% (578/6859)	14.6% (653/4486)	1	1
Asthma, without atopy	12.9% (35/271)	21.0% (40/190)	<b>1.46 (1.16 to 1.85)</b>	<b>1.47 (1.17 to 1.86)</b>
Asthma, with atopy	9.4% (42/446)	14.3% (43/300)	1.05 (0.86 to 1.28)	1.04 (0.86 to 1.27)
No asthma	8.4% (578/6859)	14.6% (653/4486)	1	1
Current asthma, ≤20 years since onset	10.3% (42/406)	16.7% (31/218)	1.17 (0.96-1.42)	1.12 (0.87-1.43)
Current asthma, >20 years since onset	11.4% (35/308)	19.2% (51/266)	<b>1.36 (1.11-1.65)</b>	<b>1.32 (1.10-1.59)</b>
No asthma	8.4% (578/6859)	14.6% (653/4486)	1	1
Asthma, no ICS	9.1% (45/494)	18.8% (49/260)	<b>1.22 (1.09 to 1.35)</b>	<b>1.21 (1.09 to 1.34)</b>
Asthma, on ICS	14.4% (32/223)	14.8% (34/230)	1.20 (0.93 to 1.55)	1.21 (0.94 to 1.56)
No asthma	8.4% (578/6859)	14.6% (653/4486)	1	1
Asthma, no OCS	10.2% (68/664)	16.1% (73/454)	<b>1.15 (1.03 to 1.28)</b>	<b>1.15 (1.03 to 1.28)</b>
Asthma, on OCS	17.0% (9/53)	27.8% (10/36)	<b>1.98 (1.26 to 3.11)</b>	<b>1.99 (1.26 to 3.15)</b>
No asthma	8.4% (578/6859)	14.6% (653/4486)	1	1
Asthma, ICS only	13.1% (24/183)	13.1% (26/199)	1.06 (0.83 to 1.35)	1.07 (0.84 to 1.36)
Asthma, on OCS & ICS	20.0% (8/40)	25.8% (8/31)	<b>2.05 (1.18 to 3.56)</b>	<b>2.07 (1.19 to 3.59)</b>

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor’s asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time *t*.

**Supplementary Table E2. Association between OCS dosage at *t* and obesity at *t*+1 in asthmatics**

	n* at ECRHS II	New obesity at ECRHS III	RR (95%CI)
Asthma - no OCS	405	15%	
Asthma – OCS as rescue medication	9	11%	Not computable
Asthma – OCS for a short course	14	14%	
Asthma – OCS continuously	4	100%	

\* Numbers do not add to the total due to missing or inconsistent data in asthma treatment

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**Supplementary Table E3: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at *t* and incident obesity at *t+1*, stratified by sex**

	Male			Female		
	Obesity at visit, % (n/N)		RR (95% CI)	Obesity at visit, % (n/N)		RR (95% CI)
	ECRHS II	ECRHS III	Adjusted	ECRHS II	ECRHS III	Adjusted
No asthma	8.7 (292/3347)	14.6 (320/2196)	1	8.1 (286/3512)	14.6 (334/2293)	1
Asthma	9.9 (32/324)	18.4 (42/228)	<b>1.27 (1.06 to 1.51)</b>	11.4 (45/393)	15.6 (41/262)	<b>1.20 (1.01 to 1.42)</b>
No asthma	8.7 (292/3347)	14.6 (320/2196)	1	8.1 (286/3512)	14.6 (334/2293)	1
Asthma, no atopy	12.9 (13/101)	24.2 (16/66)	<b>1.62 (1.06 to 2.49)</b>	12.9 (22/170)	19.4 (24/124)	<b>1.38 (1.06 to 1.79)</b>
Asthma, with atopy	8.5 (19/223)	16.0 (26/162)	1.11 (0.83 to 1.46)	10.3 (23/223)	12.3 (17/138)	1.04 (0.78 to 1.39)
No asthma	8.7 (292/3347)	14.6 (320/2196)	1	8.1 (286/3512)	14.6 (334/2293)	1
Current asthma, ≤20 years since onset	8.9 (14/158)	15.9 (14/88)	1.16 (0.80-1.68)	11.3 (28/248)	13.1 (17/130)	1.22 (0.98-1.51)
Current asthma, >20 years since onset	11.0 (18/164)	19.6 (27/138)	1.36 (1.10-1.66)	11.8 (17/144)	18.8 (24/128)	1.32 (1.01-1.72)
No asthma	8.7 (292/3347)	14.6 (320/2196)	1	8.1 (286/3512)	14.6 (334/2293)	1
Asthma, no ICS	7.9 (19/242)	21.1 (28/133)	<b>1.26 (1.04 to 1.52)</b>	10.3 (26/252)	16.5 (21/127)	1.22 (0.99 to 1.52)
Asthma, on ICS	15.8 (13/82)	14.7 (14/95)	1.28 (0.87 to 1.86)	13.5 (19/141)	14.8 (20/135)	1.17 (0.86 to 1.59)
No asthma	8.7 (292/3347)	14.6 (320/2196)	1	8.1 (286/3512)	14.6 (334/2293)	1
Asthma, no OCS	9.6 (30/311)	17.3 (37/214)	<b>1.20 (1.00 to 1.45)</b>	10.8 (38/353)	15.0 (36/240)	1.14 (0.97 to 1.33)
Asthma, on OCS	15.4 (2/13)	35.7 (5/14)	<b>2.45 (1.45 to 4.13)</b>	17.5 (7/40)	22.7 (5/22)	<b>1.81 (1.01 to 3.24)</b>
No asthma	8.7 (292/3347)	14.6 (320/2196)	1	8.1 (286/3512)	14.6 (334/2293)	1
Asthma, ICS only	15.3 (11/72)	11.9 (10/84)	1.11 (0.71 to 1.73)	11.7 (13/111)	13.9 (16/115)	1.04 (0.79 to 1.37)
Asthma, on OCS & ICS	20.0 (2/10)	36.4 (4/11)	<b>2.62 (1.62 to 4.24)</b>	20.0 (6/30)	20.0 (4/20)	1.81 (0.91 to 3.59)

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor’s asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time *t*.

**Supplementary Table E4: Mediation analyses testing the mediating role of physical activity on the association between asthma and incident obesity**

Mediator tested	Mediation path tested	n	Direct Effect	Average mediation	Total Effect	% mediated
Active/inactive at ECRHS II	Asthma I → PA II → OBE II	7098	*0.02111	-0.000185	0.020926	-0.82%
Active/inactive at ECRHS II	Asthma I → PA II → OBE III	4449	0.01856	0.000496	0.01906	1.67%
Active/inactive at ECRHS III	Asthma II → PA III → OBE III	4863	0.01852	-0.00037	0.0181	-1.50%

PA: Physical Activity. OBE: new obesity onset. I, II and III: ECRHS I, ECRHS II and ECRHS III

Mediator and outcome modelled as binary.

\* p<0.05.

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**Supplementary Table E5: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at *t* and incident obesity at *t+1*, stratified by smoking pattern.**

	Current smoker (N=2214)			Quitters (N=1303)			Never smoker (N=3846)		
	Obesity at visit, %			Obesity at visit, %			Obesity at visit, %		
	ECRHS	ECRHS	RR (95% CI)	ECRHS	ECRHS	RR (95% CI)	ECRHS	ECRHS	RR (95% CI)
	II	III		II	III		II	III	
No asthma	7.6	12.7	1	11.5	19.6	1	8.0	13.2	1
Asthma	13.1	13.9	<b>1.46 (1.12 to 1.90)</b>	12.2	17.1	0.95 (0.65 to 1.37)	11.1	15.6	<b>1.27 (1.08 to 1.49)</b>
No asthma	7.6	12.7	1	11.5	19.6	1	8.0	13.2	1
Asthma, without atopy	14.1	13.9	<b>1.53 (0.93 to 2.52)</b>	20.0	19.4	1.14 (0.69 to 1.91)	12.7	20.7	<b>1.52 (1.13 to 2.04)</b>
Asthma, with atopy	12.2	13.9	<b>1.38 (0.96 to 1.99)</b>	8.8	15.0	0.79 (0.42 to 1.50)	10.3	12.8	1.12 (0.91 to 1.39)
No asthma	7.6	12.7	1	11.5	19.6	1	8.0	13.2	1
Current asthma, ≤20 y since onset	14.0	8.6	1.42 (0.84-2.39)	11.5	17.1	0.92 (0.48-1.76)	9.2	13.0	1.07 (0.80-1.41)
Current asthma, >20 y since onset	11.8	19.4	<b>1.55 (1.03-2.33)</b>	13.0	17.5	0.99 (0.58-1.67)	14.0	17.5	1.48 (1.15-1.91)
No asthma	7.6	12.7	1	11.5	19.6	1	8.0	13.2	1
Asthma, no ICS	11.7	15.9	<b>1.46 (1.03 to 2.05)</b>	8.3	18.9	0.91 (0.59 to 1.39)	9.8	16.9	<b>1.27 (1.06 to 1.54)</b>
Asthma, on ICS	17.6	10.7	1.46 (0.73 to 2.93)	23.1	15.4	0.99 (0.55 to 1.80)	14.0	14.0	1.25 (0.92 to 1.71)
No asthma	7.6	12.7	1	11.5	19.6	1	8.0	13.2	1
Asthma, no OCS	13.3	12.1	<b>1.45 (1.08 to 1.96)</b>	12.8	17.1	0.96 (0.66 to 1.39)	10.8	15.3	<b>1.24 (1.06 to 1.45)</b>
Asthma, on OCS	10.0	33.3	2.17 (0.88 to 5.36)	0.0	16.7	0.77 (0.11 to 5.14)	15.4	18.8	1.62 (0.72 to 3.64)
No asthma	7.6	12.7	1	11.5	19.6	1	8.0	13.2	1
Asthma, no ICS	11.7	15.9	<b>1.47 (1.07 to 2.02)</b>	8.3	18.9	0.91 (0.59 to 1.39)	9.8	16.9	<b>1.27 (1.05 to 1.54)</b>
Asthma, on ICS only	17.9	12.5	1.59 (0.87 to 2.92)	25.0	14.7	1.00 (0.53 to 1.86)	12.9	13.0	1.14 (0.87 to 1.51)
Asthma, on ICS & OCS	16.7	0.0	1.69 (0.39 to 7.25)	0.0	20.0	0.96 (0.15 to 6.01)	19.0	21.4	1.91 (0.84 to 4.31)

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

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3 Current asthma defined as a self-report of a doctor's asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of  
4 breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from  
5 the study (see Methods).  
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7 RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were  
8 adjusted for age, sex and smoking status at time  $t$ .  
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**Supplementary Table E6: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , including only participants who took part in all the three waves of ECRHS I, II and III.**

	Obesity at visit, %		RR (95% CI)
	ECRHS II	ECRHS III	
No asthma	8.1	13.7	1
Asthma	11.9	15.6	<b>1.25 (1.04 to 1.51)</b>
No asthma	8.1	13.7	1
Asthma, without atopy	14.5	19.0	<b>1.52 (1.12 to 2.07)</b>
Asthma, with atopy	10.4	13.5	1.09 (0.87 to 2.07)
No asthma	8.1	13.7	1
Current asthma, $\leq 20$ years since onset	10.0	12.3	1.05 (0.75-1.47)
Current asthma, $>20$ years since onset	14.4	18.0	1.43 (1.15-1.79)
No asthma	8.1	13.7	1
Asthma, no ICS	8.7	17.6	<b>1.22 (1.00 to 1.50)</b>
Asthma, on ICS	19.0	13.3	1.29 (0.97 to 1.72)
No asthma	8.1	13.7	1
Asthma, no OCS	11.2	15.1	<b>1.19 (1.00 to 1.42)</b>
Asthma, on OCS	19.4	21.9	<b>1.97 (1.14 to 3.39)</b>
No asthma	8.1	13.7	1
Asthma, no treatment	8.7	17.6	<b>1.22 (1.00 to 1.49)</b>
Asthma, on ICS only	17.2	12.1	1.13 (0.85 to 1.51)
Asthma, on ICS & OCS	25.9	21.4	<b>2.21 (1.22 to 4.00)</b>

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor's asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time  $t$ .

**Supplementary Table E7: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , excluding the participants who reported avoiding physical activity because of wheezing/asthma.**

	Obesity at visit, %		
	ECRHS II	ECRHS III	RR (95% CI)
No asthma	8.2	14.2	1
Asthma	9.9	15.3	1.14 (0.96 to 1.34)
No asthma	8.2	14.2	1
Asthma, without atopy	12.0	19.6	<b>1.40 (1.02 to 1.92)</b>
Asthma, with atopy	8.9	12.6	0.98 (0.79 to 1.22)
No asthma	8.2	14.2	1
Current asthma, $\leq 20$ years since onset	9.2	13.2	1.03 (0.77-1.37)
Current asthma, $>20$ years since onset	11.1	17.0	1.25 (1.00-1.56)
No asthma	8.2	14.2	1
Asthma, no ICS	7.5	17.6	1.10 (0.97 to 1.24)
Asthma, on ICS	15.7	12.2	1.20 (0.88 to 1.63)
No asthma	8.2	14.2	1
Asthma, no OCS	9.6	14.6	1.09 (0.93 to 1.27)
Asthma, on OCS	15.6	27.3	<b>2.02 (1.00 to 4.10)</b>
No asthma	8.2	14.2	1
Asthma, no treatment	7.5	17.6	1.10 (0.97 to 1.24)
Asthma, on ICS only	14.7	10.4	1.06 (0.79 to 1.42)
Asthma, on ICS & OCS	21.7	27.8	<b>2.37 (1.12 to 4.99)</b>

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor's asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time  $t$ .



**Supplementary Table E8: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , excluding the participants with dyspnoea at  $t$ .**

	Obesity at visit, %		
	ECRHS II	ECRHS III	RR (95% CI)
No asthma	8.2	14.4	1
Asthma	9.7	15.9	1.14 (1.00 to 1.30)
No asthma	8.2	14.4	1
Asthma, without atopy	12.0	19.8	<b>1.41 (1.15 to 1.72)</b>
Asthma, with atopy	8.4	13.6	0.98 (0.78 to 1.24)
No asthma	8.2	14.4	1
Current asthma, $\leq 20$ years since onset	8.8	13.2	1.01 (0.78-1.31)
Current asthma, $>20$ years since onset	11.1	17.9	1.27 (1.02-1.59)
No asthma	8.2	14.4	1
Asthma, no ICS	8.1	18.7	<b>1.18 (1.07 to 1.31)</b>
Asthma, on ICS	13.7	12.3	1.08 (0.80 to 1.46)
No asthma	8.2	14.4	1
Asthma, no OCS	9.4	15.6	1.11 (0.97 to 1.26)
Asthma, on OCS	14.3	20.0	<b>1.58 (1.05 to 2.37)</b>
No asthma	8.2	14.4	1
Asthma, no ICS	8.1	18.8	<b>1.18 (1.07 to 1.31)</b>
Asthma, ICS only	13.1	11.8	1.01 (0.74 to 1.37)
Asthma, on OCS & ICS	16.7	16.0	1.52 (0.89 to 2.59)

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor's asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time  $t$ .

**Supplementary Table E9: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and incident obesity at  $t+1$ , using a broader asthma definition.**

	Obesity at visit, %		
	ECRHS II	ECRHS III	RR (95% CI)
No asthma	7.9%	14.3%	1
Asthma	10.1%	15.5%	<b>1.16 (1.04-1.30)</b>
No asthma	7.9%	14.3%	1
Asthma, without atopy	12.3%	18.0%	<b>1.38 (1.10-1.71)</b>
Asthma, with atopy	8.8%	14.0%	1.03 (0.86-1.24)
No asthma	7.9%	14.3%	1
Current asthma, $\leq 20$ years since onset	9.8%	13.5%	1.09 (0.92-1.28)
Current asthma, $> 20$ years since onset	10.2%	17.2%	<b>1.24 (1.03-1.48)</b>
No asthma	7.9%	14.3%	1
Asthma, no ICS	8.5%	16.5%	<b>1.13 (1.01-1.27)</b>
Asthma, on ICS	15.0%	13.5%	1.24 (0.99-1.54)
No asthma	7.9%	14.3%	1
Asthma, no OCS	9.4%	14.7%	1.09 (0.97-1.23)
Asthma, on OCS	22.0%	27.8%	<b>2.41 (1.61-3.61)</b>
No asthma	7.9%	14.3%	1
Asthma, no ICS	8.5%	16.5%	<b>1.13 (1.01-1.26)</b>
Asthma, ICS only	13.3%	11.6%	1.06 (0.85-1.32)
Asthma, on OCS+ICS	24.2%	26.7%	<b>2.41 (1.43-4.01)</b>

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor's asthma diagnosis as having reported an asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack, use of asthma medications, wheeze, shortness of breath, waking up with chest tightness or attack of cough. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex and smoking status at time  $t$ .

**Supplementary Table E10: Association between asthma, asthma with atopy, asthma duration, and asthma with medication at  $t$  and BMI changes between  $t$  and  $t+1$ .**

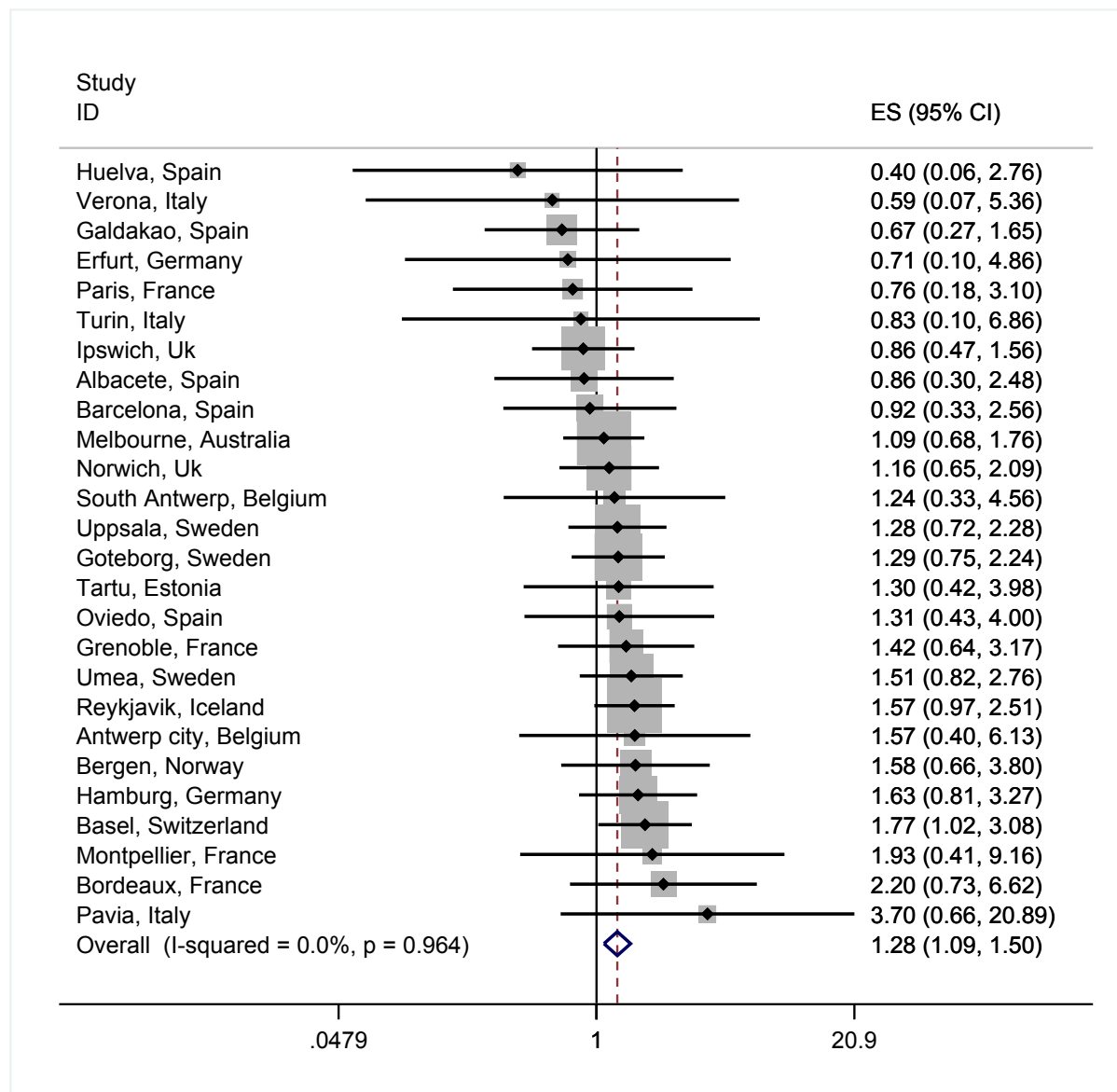
	BMI change (kg/m <sup>2</sup> ), m (SD)		Beta (95% CI)*
	ECRHS I-II	ECRHS II-III	
No asthma	1.55 (2.2)	1.86 (2.6)	
Asthma	1.78 (2.2)	1.66 (2.7)	<b>0.20 (0.01 – 0.38)</b>
No asthma	1.55 (2.2)	1.86 (2.6)	
Asthma, without atopy	2.05 (2.3)	1.85 (2.9)	<b>0.48 (0.17-0.78)</b>
Asthma, with atopy	1.64 (2.1)	1.56 (2.5)	0.04 (-0.19-0.27)
No asthma	1.55 (2.2)	1.86 (2.6)	
Current asthma, $\leq 20$ years since onset	1.91 (2.2)	1.61 (2.8)	<b>0.25 (0.01-0.49)</b>
Current asthma, $>20$ years since onset	1.61 (2.2)	1.71 (2.6)	0.12 (-0.15-0.39)
No asthma	1.55 (2.2)	1.86 (2.6)	
Asthma, no ICS	1.70 (2.1)	1.81 (2.84)	0.11 (-0.10 – 0.33)
Asthma, on ICS	1.97 (2.3)	1.49 (2.41)	<b>0.39 (0.07 – 0.71)</b>
No asthma	1.55 (2.2)	1.86 (2.6)	
Asthma, no OCS	1.76 (2.2)	1.62 (2.6)	0.17 (-0.02 – 0.36)
Asthma, on OCS	2.12 (2.7)	2.10 (2.8)	0.56 (-0.10 – 1.22)
No asthma	1.55 (2.2)	1.86 (2.6)	
Asthma, no treatment	1.70 (2.1)	1.81 (2.8)	0.11 (-0.10 – 0.32)
Asthma, on ICS only	1.95 (2.2)	1.44 (2.4)	<b>0.37 (0.02 – 0.72)</b>
Asthma, on ICS & OCS	2.09 (2.9)	1.77 (2.4)	0.53 (-0.26 – 1.31)

ECRHS: European Community Respiratory Health Survey; ICS: inhaled corticosteroids; OCS: oral corticosteroids; RR: relative risk.

Current asthma defined as a self-report of a doctor's asthma diagnosis and at least one of the following, within the last 12 months: waking up by an attack of shortness of breath, any asthma attack or use of asthma medications. Individuals with inactive asthma (reporting asthma diagnosis without any current symptoms) were excluded from the study (see Methods).

Coefficients estimated from linear mixed regression with subjects nested in centre as random effects. All models (for all participants) were adjusted for age, sex, smoking status and BMI at time  $t$ , and an interaction term for period.

**Supplementary Figure E1: Meta-analysis of the association between asthma at  $t$  and obesity at  $t+1$  by ECRHS centre.**



RR was calculated from modified Poisson regression with robust standard errors and subjects nested in centre as random effects. All models were adjusted for age, sex and smoking status at time  $t$ .

I-squared: variation in estimated effect attributable to heterogeneity. ES: effect estimate.