Advanced glycation end products and risk of general and abdominal obesity in Iranian adults: Tehran lipid and glucose study

Parvin Mirmiran1, Hoda Hadavi1, Azadeh Mottaghi2, Fereidoun Azizi3

Received: 1 Aug 2017 Published: 25 March 2019

Abstract

Background: Advanced glycation end products (AGEs) are a heterogeneous group of macromolecules that are formed by the non-enzymatic glycation of proteins, lipids, and nucleic acids. A number of food preparation methods can increase AGEs content. The aim of the present study is to assess the relationship between dietary consumption of AGEs and the risk of obesity and central obesity.

Methods: This study was conducted within the framework of the Tehran Lipid and Glucose Study (TLGS) on 4245 subjects who participated in its fifth phase (2011 to 2014). Dietary data were collected using a validated semi-quantitative food frequency questionnaire (FFQ). Participants’ characteristics, anthropometric measures, and blood samples were also obtained by trained staff. Multivariable linear regression and Logistic regression was conducted using SPSS (Version 20; Chicago, IL), and P values < 0.05 were considered significant.

Results: Our results show that abdominal obesity was increased with higher intakes of dietary AGEs, an association which remained significant even after adjustment for potential confounders (OR=1.56 and 95% CI, 1.16 to 2.84). The relationship between abdominal obesity and dietary AGEs (dAGEs) intake was found to be independent of energy and macronutrient intake. We also found a relationship between consumption of dAGEs and a few anthropometric measurements, such that a significant positive correlation was observed between BMI, WC, BAI and higher quartiles of dAGEs intake, with the correlation being stronger for BAI (β= 0.24 (0.10-0.39)).

Conclusion: Our study emphasizes that higher intake of dAGEs increases the chance of abdominal obesity, and dAGEs might be a link between modern diets and obesity.

Keywords: General obesity, Abdominal obesity, Advanced glycation end products

Conflicts of Interest: None declared

Funding: None

*This work has been published under CC BY-NC-SA 1.0 license.


Introduction

Obesity is a major concern of most, if not all, governments who now readily accept its complexity and major public health impact (1). It is recognized as a health hazard that has reached epidemic proportions in affluent and emerging economies (2), and according to the WHO report, obesity has become a worldwide epidemic (3). In 2008, the overall prevalence of obesity in the Middle East region was estimated to be 24.5% (4), indicating that 1 in every 4 individuals living in the Middle East is obese. In a large national survey, the national estimate of overweight and obesity altogether was calculated to be 42.8% in Iranian adults. Their results also suggest that our population can expect to see a very high rate of chronic diseases, in the near future as a consequence of the high prevalence of overweight, particularly of abdominal obesity (5).

Advanced glycation end products (AGEs) are a heterogeneous group of macromolecules that are formed by the non-enzymatic glycation of proteins, lipids, and nucleic acids. AGEs are formed when food is processed at elevated temperatures, such as during grilling, broiling, roasting,
AGEs intake and risk of obesity phenotypes

Searing, and frying and also in the production of certain foods namely pasteurized dairy products, cheeses, sausages, and processed meats (6, 7). Dietary advanced glycation end products (dAGEs), which have been implicated in the development of diabetic and other vascular diseases, are known to contribute to increased oxygen-free radicals and oxidant stress and elevated inflammation in the system (7-9). AGEs have also been independently related to increased risk of a number of chronic diseases, such as insulin resistance and diabetes (10-13). Angoorani et al. observed that higher intake of AGEs was associated with higher risk of two components of MetS including abdominal obesity and hypertriglyceridemia in Iranian adults (14).

AGEs contribute to a variety of microvascular and macrovascular complications through the formation of cross-links between molecules in the basement membrane of the extracellular matrix and by engaging the receptor for advanced glycation end products (RAGE). The presence and accumulation of AGEs in many different cell types affect the extracellular and intracellular structure and function (15). Results of a recent meta-analysis showed that diets low in AGEs might be an effective strategy for improving cardiometabolic profiles in individuals with and without type 2 diabetes (16).

Although a relationship between dAGEs and increased adiposity seems plausible, the impact of consuming dAGEs on the risk of obesity and visceral obesity is unclear. The aim of the present study is to assess the relationship between dietary consumption of AGEs and the risk of obesity and central obesity.

Methods

Study population

This study was conducted within the framework of the Tehran Lipid and Glucose Study (TLGS). In brief, TLGS is a community-based prospective study being conducted to investigate non-communicable diseases, in a representative sample of residents, aged ≥ 3y, from district 13 of Tehran, the capital city of Iran. The first phase of the TLGS began in March 1999 and data collection, at three-year intervals, is ongoing (17).

For the current study, 9602 men and women aged 19 to 70 years, who participated in the fifth phase of TLGS (2011 to 2014) were recruited. We excluded participants if they lacked information on sex and anthropometric measurements (n=2004), if they were underweight (n=68), if they had no dietary intake information (n=3083), if they were under- or over-reporters of dietary intakes (< 800 kcal/day or > 4200 kcal/day, respectively; n=202). After exclusions, the final analysis was conducted on data of 4245 participants (Fig. 1).

All participants signed informed consents, and the study protocol was approved by the research council of the Research Institute for Endocrine Sciences (RIES), Shahid Beheshti University of Medical Sciences.

Dietary assessment

Dietary data were collected using a validated semi-quantitative food frequency questionnaire (FFQ) with 147 food items, developed for the TLGS. Trained dietitians completed the FFQ during face-to-face interviews, asking participants to report the frequency of consumption of

Fig. 1. Participant’s selection chart
each food item, during the past year on a daily, weekly or
monthly basis. These reports were converted to daily in-
takes. Analysis of dietary intake was done by Nutritionist
IV. The validity and reliability of the FFQ for food group
intakes were assessed and were acceptable (18). In or-
to calculate total dietary AGEs intake, we used the pub-
lished food AGEs database (7, 19) for 549 commonly
consumed food items for the Northeastern American
multi-ethnic urban population which was measured using a
validated immunoassay method, because the Iranian
Food Composition Table (FCT) has no data on AGEs con-
tent of foods. We determine the AGEs values kilo-Unit
(kU) in 100 g solid food or 100 ml liquid for 147 food
items evaluated in the FFQ of the fifth phase of TLGS.
The FFQ included questions on the frequency of con-
sumption and usual portion size of the food item. We cal-
culated the total AGEs consumption per day for each par-
ticipant and for data analysis; portion sizes of consumed
food items reported in household measures were convert-
ed to grams, and their intakes were categorized using quartile cutoffs (<4799, 4799 to 6324, 6324 to 8461,
>8461 kU/day). The amount of AGEs consumption was
adjusted for daily energy intake; AGEs values for some
Iranian specific food items, e.g. some kinds of bread and
cookies were estimated from similar food items for which
the AGEs value was available; since AGEs value was not
available for all fruits or vegetables, we used the mean
values of fruits or vegetables available to substitute for
the others (20). Finally, we obtained the AGEs values for 108
out of 147 food items in the FFQ of the fourth phase of
TLGS; 39 items, which had no similar items in the main
list, were set as missing.

**Anthropometrics and lifestyle measurements**

Trained interviewers collected the participants’ charac-
teristics using a questionnaire. Information on age (years),
educational level (illiterate, primary education and aca-
demic education), smoking status (yes/no), and physical
activity level (METHr/wk) were also assessed. Participants
who smoked daily or occasionally were considered current
smokers, and those who had never smoked or those who
stopped smoking were considered non-smokers. For as-
sessing of physical activity level, we used the Persian
translated Modifiable Activity Questionnaire (MAQ) (21).
Physical activity levels were expressed as metabolic
equivalent hours per week (METs h/wk). High reliability
and relatively moderate validity were reported for the Per-
sian translated MAQ in Tehranian adults (22).

Weight was measured while the subjects were minimal-
ly clothed without shoes, using digital scales and recorded
to the nearest 100 g. Height was measured in a standing
position, without shoes, using tape meter while shoulders
were in a normal state. Body mass index (BMI) was calcu-
lated as weight in kilogram divided by height in meters
squared.

Waist circumference was measured to the nearest 0.1
cm (at anatomical landmarks), at the widest portion, over
light clothing, using a soft, tape meter, without any pres-
sure to the body. Body adiposity index was calculated as
(hip (cm)/height (m) 1.5)-18) (23). Body mass index ≥ 30
kg/m² was classified as general obesity and waist circum-
ference ≥ 95 cm, for both sexes, was classified as abdo-
mal obesity (24).

**Statistical analysis**

All statistical analysis was conducted using SPSS (Ver-
sion 20; Chicago, IL), and P values < 0.05 were consid-
ered significant. Dietary AGEs were divided into quar-
tiles, and participant characteristics were compared across
quartile categories of AGEs intake, using one-way analy-
sis of variance (ANOVA), or the Chi-square test. Dietary
intakes of participants were compared across quartiles of
AGEs intakes, using one-way ANOVA or Kruskal-Wallis
test. The association between body mass index, waist cir-
cumference, and body adiposity index as continuous vari-
able and quartiles of AGEs intakes were determined us-
ing multiple linear regression models with adjustment for
age, sex, physical activity, smoking status, education sta-
tus and energy intake. Data are presented as β regression
and 95% confidence interval. The odds ratio (OR) of gen-
eral and abdominal obesity in each quartile of AGEs in-
take was determined using the binary logistic regression
models. Logistic regression models included a dichoto-
mous outcome (obesity (yes or no) or abdominal obesity
(yes or no)) and quartiles of AGEs intakes as the main
predictor of interest, adjusted for age, sex, physical activi-
ty, smoking status, education status, and energy intake.
Because total energy intake and macronutrients could be
in the pathway between AGEs intakes and obesity risk,
energy intake was included in an additional model. Data
are presented as OR with 95% confidence interval (CI).

**Results**

The mean±SD age of the participants was 44.9±11.7
years, 58% of participants were women and the mean
BMI was 28.1±4.9 kg/m². Mean dietary intake of AGEs
was 7043±3426 kU/day (7063 and 7028 kU/d, in men and
women, respectively). The mean consumption of AGEs in
the first to fourth quartile category was 4832, 4832-6329,
6329-8466 and 8466 kU/day, respectively. Prevalence of
general obesity in the overall population was 29% and
in case of abdominal obesity was 45%. The distribution
of general obesity across quartile of AGEs intake were sta-
tistically significant (p=0.015).

Characteristics of the study participants across quartile
categories of AGEs are shown in Table 1.

Subjects in the highest, compared to the lowest quartile
category of AGEs intake were more likely to be younger
(42.7 years vs. 46.7 years, p=0.001), more likely to be
smokers (22% vs. 30%, p= 0.024) and were more active
(2003 Met-hr/week vs. 2183 Met-hr/week, p= 0.554).
Higher intakes of AGEs were accompanied with higher
education level (p<0.001), higher BMI (0.032) and higher
waist circumference (p= 0.018).

Mean dietary intakes of participants by categories of
AGEs intake are illustrated in Table 2. Participants with
highest intake of AGEs had higher calorie intake, com-
pared to those in the lowest quartile of AGEs intake (1754
cal/day vs. 2853 kcal/day, p<0.001). Moreover, fat and

http://mjiri.iums.ac.ir
**AGEs intake and risk of obesity phenotypes**

### Table 1. Characteristics of participants by quartile of dietary AGEs intake: Tehran Lipid and Glucose Study

<table>
<thead>
<tr>
<th>Dietary AGEs intake</th>
<th>Q1 (n=1019)</th>
<th>Q2 (n=1021)</th>
<th>Q3 (n=1021)</th>
<th>Q4 (n=1019)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td><strong>&lt;4832</strong></td>
<td>4832-6329</td>
<td>6329-8466</td>
<td>&gt;8466</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>3678±876</td>
<td>5598±430</td>
<td>7294±114</td>
<td>11602±3378</td>
<td></td>
</tr>
<tr>
<td>Age (y)</td>
<td>46.7±11.9</td>
<td>46.0±11.9</td>
<td>44.3±11.5</td>
<td>42.7±11.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>25.6±4.8</td>
<td>27.4±5.1</td>
<td>28.0±4.8</td>
<td>29.5±4.9</td>
<td>0.032</td>
</tr>
<tr>
<td>Waist circumference (cm)</td>
<td>85.6±11.7</td>
<td>90.3±11.7</td>
<td>91.8±12.0</td>
<td>93.5±12.1</td>
<td>0.018</td>
</tr>
<tr>
<td>Body adiposity index (%)</td>
<td>30.5±6.0</td>
<td>30.8±6.3</td>
<td>30.4±6.1</td>
<td>30.1±5.7</td>
<td>0.250</td>
</tr>
<tr>
<td>Physical activity (Met-h/week)</td>
<td>2003</td>
<td>2048</td>
<td>2170</td>
<td>2183</td>
<td>0.554</td>
</tr>
<tr>
<td>Current smoker (%)</td>
<td>22</td>
<td>22</td>
<td>25</td>
<td>30</td>
<td>0.024</td>
</tr>
<tr>
<td>Educational status (%)</td>
<td>0.9</td>
<td>1.3</td>
<td>1.6</td>
<td>0.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Illiterate</td>
<td>68.8</td>
<td>68.7</td>
<td>60.2</td>
<td>62.7</td>
<td></td>
</tr>
<tr>
<td>Primary education</td>
<td>30.3</td>
<td>30.0</td>
<td>38.2</td>
<td>36.8</td>
<td></td>
</tr>
</tbody>
</table>

Data are mean ± SD

### Table 2. Mean dietary intakes of participants by categories of dietary AGEs intake

<table>
<thead>
<tr>
<th>Dietary AGEs intake</th>
<th>Q1 (n=1019)</th>
<th>Q2 (n=1021)</th>
<th>Q3 (n=1021)</th>
<th>Q4 (n=1019)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td><strong>&lt;4832</strong></td>
<td>4832-6329</td>
<td>6329-8466</td>
<td>&gt;8466</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>3678±876</td>
<td>5598±430</td>
<td>7294±114</td>
<td>11602±3378</td>
<td></td>
</tr>
<tr>
<td>Energy intake (kcal/d)</td>
<td>1754±520</td>
<td>2094±501</td>
<td>2449±547</td>
<td>2853±663</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Carbohydrate (% of total energy)</td>
<td>62.7±6.9</td>
<td>60.2±5.8</td>
<td>58.4±6.0</td>
<td>55.3±5.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Fat (% of total energy)</td>
<td>26.2±5.7</td>
<td>28.1±5.3</td>
<td>30.1±5.5</td>
<td>33.3±5.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Protein (% of total energy)</td>
<td>14.6±2.3</td>
<td>14.9±2.4</td>
<td>15.0±2.6</td>
<td>15.6±2.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total fiber (g/1000 kcal)</td>
<td>19.8±6.7</td>
<td>19.1±5.9</td>
<td>18.5±5.7</td>
<td>17.3±5.6</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Data are adjusted mean ± SD

### Table 3. Association between dietary AGEs intakes and anthropometric measures

<table>
<thead>
<tr>
<th>Dietary AGEs intakes</th>
<th>Body mass index</th>
<th>p</th>
<th>Waist circumference</th>
<th>p</th>
<th>Body adiposity index</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude model</td>
<td>0.12 (0.03-0.21)</td>
<td>0.062</td>
<td>0.13 (0.05-0.21)</td>
<td>0.035</td>
<td>0.18 (0.09-0.27)</td>
<td>0.023</td>
</tr>
<tr>
<td>Adjusted model</td>
<td>0.20 (0.11-0.30)</td>
<td>0.015</td>
<td>0.20 (0.09-0.30)</td>
<td>0.022</td>
<td>0.24 (0.10-0.39)</td>
<td>0.033</td>
</tr>
</tbody>
</table>

Data are β regression and 95% confidence interval estimated by using linear regression models with adjustment for age, sex, physical activity, smoking status, education status and energy intake.

### Table 4. Odds ratio and 95% confidence interval for general and abdominal obesity across quartiles dietary AGEs intakes (n = 4080)

<table>
<thead>
<tr>
<th>Quartiles of AGEs intakes</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>General obesity (BMI ≥ 30 kg/m²)</td>
<td>OR 95% CI</td>
<td>OR 95% CI</td>
<td>OR 95% CI</td>
<td>OR 95% CI</td>
</tr>
<tr>
<td>Q1 (&lt;4799 kU, reference)</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Q2 (4799-6324 kU)</td>
<td>0.89 [0.56 to 1.39]</td>
<td>0.92 [0.67 to 1.27]</td>
<td>0.78 [0.62 to 0.98]</td>
<td>0.73 [0.59 to 0.89]</td>
</tr>
<tr>
<td>Q3 (6324-8461 kU)</td>
<td>0.98 [0.62 to 1.53]</td>
<td>1.08 [0.89 to 1.31]</td>
<td>1.04 [0.83 to 1.30]</td>
<td>1.14 [0.92 to 1.42]</td>
</tr>
<tr>
<td>Q4 (&gt;8461 kU)</td>
<td>1.08 [0.89 to 1.31]</td>
<td>1.24 [1.06 to 1.47]</td>
<td>1.50 [1.23 to 1.82]</td>
<td>1.62 [1.34 to 1.96]</td>
</tr>
<tr>
<td>P for trend</td>
<td>0.156</td>
<td>0.015</td>
<td>0.282</td>
<td>0.201</td>
</tr>
</tbody>
</table>

http://mjiri.iums.ac.ir
Table 4 Ctd

<table>
<thead>
<tr>
<th>Abdominal obesity (WC≥95 cm)</th>
<th>1</th>
<th>-</th>
<th>1</th>
<th>-</th>
<th>1</th>
<th>-</th>
<th>1</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (&lt;4799, reference)</td>
<td>1.00</td>
<td>1.03</td>
<td>1.05</td>
<td>0.85 to 1.36</td>
<td>0.03</td>
<td>0.83 to 1.36</td>
<td>1.36</td>
<td>1.06 to 1.93</td>
</tr>
<tr>
<td>Q2 (4799-6324 kU)</td>
<td>0.98</td>
<td>0.76 to 1.03</td>
<td>1.05</td>
<td>0.85 to 1.36</td>
<td>0.03</td>
<td>0.83 to 1.36</td>
<td>1.36</td>
<td>1.06 to 1.93</td>
</tr>
<tr>
<td>Q3 (6324-8461 kU)</td>
<td>1.15</td>
<td>1.01 to 1.32</td>
<td>1.12</td>
<td>-0.86 to 1.36</td>
<td>0.14</td>
<td>0.93 to 1.36</td>
<td>1.42</td>
<td>1.06 to 2.32</td>
</tr>
<tr>
<td>Q4 (&gt;8461 kU)</td>
<td>1.14</td>
<td>0.92 to 1.31</td>
<td>1.36</td>
<td>-0.96 to 2.06</td>
<td>0.18</td>
<td>0.97 to 1.36</td>
<td>1.56</td>
<td>1.16 to 2.84</td>
</tr>
</tbody>
</table>

P for trend

- Model 1: Crude
- Model 2: Logistic regression model with adjustment for age and sex.
- Model 3: Additional adjustment for physical activity, smoking status and education status.
- Model 4: Additional adjustment for energy intake.

Discussion

Results of this study expand on the knowledge about the possible effects of consuming dietary AGEs on the human body. This study confirms that there is a relationship between dietary AGEs consumption and body adiposity in a way that with higher intake of dAGEs there is a significant increase in abdominal obesity. Moreover, this relationship remains significant after 2 models of adjustment for possible confounders. These results are in agreement with the findings of Hofmann et al. in mice when used two standard diets that were nutritionally equivalent and had different contents of dAGEs; they observed that despite their similar amount of food intake, the mice on low-AGEs diet lost some weight. Nevertheless, they reported an increase in HDL levels in mice on low-AGEs diet, compared to mice on high-AGEs diet(25). Our finding also confirms the finding of a cross-sectional study done by Angoorani et al., who reported that higher intake of AGEs was associated with higher risk of abdominal obesity and hypertriglyceridemia; however, their result was not independent of dietary energy and macronutrient intakes(14). Although pathways via which consumption of dAGEs could lead to greater adiposity are not yet known, one explanation could be the harmful effect of dAGEs on insulin signaling and sensitivity in the body(10, 26) that contribute to higher levels of circulating insulin. One of the roles of insulin is to promote adipocyte triglyceride stores by a number of different mechanisms(27), and therefore can lead to greater storage and adiposity. AGEs have altering effects on extracellular function by two mechanisms: (1) formation of cross-links between key molecules in the basement membrane of extracellular matrix and (2) interaction of AGEs with the receptor for advanced glycation end products (RAGE) on cell surfaces (15). AGEs can also promote dyslipidemia. AGEs can form bonds with lipids as observed in samples from people with and without diabetes(28); glycedated LDL then suppresses uptake and clearance of LDL through its receptor on endothelial cells (15, 29, 30). It has also been postulated that high plasma levels of oxidative stress markers are positively correlated with elevated plasma triglycerides (31) and AGEs are known to increase oxidative stress in the body (15).

Another finding of this study is the relationship between consumption of dAGEs and a few anthropometric measurements. After adjustment for age, sex, physical activity, smoking status, educational status, and energy intake, a significant positive correlation was observed between BMI, WC, BAI and higher quartiles of dAGEs intake, with the correlation being stronger for BAI (OR=2.21). The BAI, which is based on the measurements of hip circumference and height, has been suggested as a new index of adiposity; it could be an appropriate tool to measure adiposity due, at least in part, to the advantages over other more complex mechanical or electrical systems but it appears that it cannot overcome BMI limitations for general use(32). However, a comprehensive study published in 2012 concluded that estimates of body fat percentage based on BAI were not more accurate than those based on BMI, waist circumference, or hip circumference(33). As for BMI, a study conducted in Italy supports the use of BMI as a fatness measure in groups of children and adolescents, although it warns that interpretation of findings should be cautiously done, when comparing BMI across groups that differ in age or when predicting a specific individual's total body fat (TBF) or percent of body fat (PBF(34). Another study comparing the usefulness of BMI, WC, and waist to hip ratio (WHR) concluded that BMI and WC were found to perform well as diagnostic tests for fatness, whereas WHR was less useful(35). As stated, there are discrepancies as to whether or not a single anthropometric measure is a valid tool to estimate body fatness. Therefore, in this study, we have used three anthropometric measures, and they are all in agreement with higher dAGEs intake, more adiposity is observed.

As more studies explore AGEs and health status, more disturbing outcomes are reported. AGEs have been associated with numerous complications, namely increasing oxidative stress, diabetes, renal dysfunction, insulin resistance, cardiovascular disease and many more(10-13). Obesity and especially abdominal obesity, on the other hand, is the basis for many of the health complications in the world (36). Thus it is important for the public health sector to promote general knowledge and awareness about these components and encourage healthy meal choices and also avoiding preparation methods that contribute to higher AGEs content in foods.

The use of an FFQ that relies on the long term memory of subjects is one of the limitations of this study that can expose the outcome to memory biases and also limits food choices for individuals. As there is no AGEs content table

http://mjiri.iums.ac.ir
for Iranian foods, we were forced to use the existing AGEs content table for American foods, and as there are certain Iranian food items that do not exist in that table, a few food items had to be removed and for some food items, estimated amounts were used. Lastly, this study was limited by the use of cross-sectional data, and for that, these findings cannot be generalized to changes over time in this population.

Our large number of subjects is the main strength of this study, as is their present ability of our study population as people from all Iranian ethnic groups are known to live in the capital city of Tehran, which improves the generalizability of our findings. Furthermore, all data were collected by trained professionals and adjustments were considered for sex, age, energy intake, physical activity level, and smoking and education status to minimize the bias. The limitation of the present study is as follow. As we do not have a published food AGE database for Iranian foods, we had to apply the American published food-AGE database alternatively. Moreover, we had no accurate data on the methods of cooking which is strongly effective on the AGE contents of foods. In the present study, FFQ was used to calculate AGEs consumption over the previous year, but the likelihood of recall bias could not be ignored, which may result in misclassification of exposure.

Conclusion

Our research demonstrated that higher consumption of dietary Advanced Glycation End products in Iranian adults is associated with higher abdominal obesity, a relationship is independent of energy and macronutrient intake, which is also in agreement with the results of anthropometric measurements, such that higher quartiles of dAGEs intakes were found to be associated with greater BMI, WC, and BAI. These findings confirmed the results of another Iranian study which postulated that higher consumption of dAGEs was associated with higher risk of abdominal obesity. Our findings suggest that higher intakes of dAGEs may contribute to higher abdominal obesity.

Acknowledgments

We would like to thank the personnel of the Research Institute of Endocrine Sciences and TLGS participants. The authors wish to acknowledge Ms. N. Shiva for critical editing of English grammar and syntax of this manuscript.

Conflict of Interests

The authors declare that they have no competing interests.

References


http://mjiri.iums.ac.ir