Early Childhood Obesity: I don’t understand it!

B. Alex Foster, MD, MPH
Assistant Professor of Pediatrics
UT Health Science Center at San Antonio

Conflicts of Interest and Disclosure

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Learning Objectives

At the end of this presentation the participant will be able to:
1. List the adverse consequences of obesity related to hospitalization
2. Discuss the challenges in our current approach to treating obesity
3. Compare current recommendations and practice on treating early childhood obesity with the evidence and recent research findings

Quick Survey

- I understand what causes early childhood obesity and can manage it well in my practice
- I understand what causes early childhood obesity but don’t feel I can manage it well in my practice
- I don’t fully understand what causes early childhood obesity but I feel I do a reasonable job despite that uncertainty
- I don’t understand what causes early childhood obesity and feel unsure of how to manage these patients

The greater the ignorance the greater the dogmatism – William Osler, MD
Story 1: Nasreddin Hodja

Story 2: My story – why obesity?

Story 3: A patient

Story 4: Adolphe Quetelet

Story 5: John Snow

Back to the patient

Goal of this grand rounds

Early Childhood Obesity

1. Obese children have longer length of stay for burns, longer length of intubation (all causes in ICU)
2. Obese children more likely to die post-resuscitation
3. Issues around drug dosing, mechanics of CPR, defibrillation charge: AOR: 0.62 (0.38–0.93)
4. Mixed data on risk for infections in children
5. Mixed data on mortality
6. Longer length of stay in asthma


Story 2: why is a hospitalist interested in childhood obesity?

- Physician first – obesity is a major problem and obese kids die earlier
- Always interested in addressing inequities
- Medical institution will be our standard of measurement: we will weigh life for life and see where the dead lie heavier, among the workers or among the privileged – Rudolph Virchow, MD
- Obesity affects most conditions children are hospitalized for (infections, respiratory illnesses, trauma)
- Hospital (as physical location) is not the place to address a chronic disease
- Debate on boundaries of hospital medicine

Story 3: Our patient

- 3.5 year old boy comes to clinic after 10 day hospitalization for asthma exacerbation
- Asthma under control, currently asymptomatic, mother notes that hospital doctor said he should “lose weight” and wants your opinion
- His height and weight place him at the 98.9th percentile for BMI by the CDC growth charts
- Mother reports most people in the family, including herself, are “big” but healthy
- You pull out a prescription for healthy living and do some motivational interviewing during which the mother identifies wanting to increase the whole family’s vegetable intake as a short-term goal
- You order some labs and schedule a follow-up for 6 months

Case Assumptions

1. You have a problem
2. I have a good idea of what is causing your problem
3. I know how to fix the problem
Assumption 1: You have a problem

- Early childhood weight predicts early adult weight


Story 4: Adolphe Quetelet

- Pioneer of statistics and social physics
- Proposed that social phenomenon could be predicted and measured (not purely a reflection of religion)
- Attempted to define average man (not at all interested in obesity)
- If man increased equally in all dimensions, his weight at different ages would be as the cube of his height. Now, this is not what we really observe. The increase of weight is slower, except during the first year after birth; then the proportion we have just pointed out is pretty regularly observed. But after this period, and until near the age of puberty, weight increases nearly as the square of the height. The development of weight again becomes very rapid at puberty, and almost stops after the twenty-fifth year...”

1796 - 1874


1972: Quetelet index becomes BMI

- Ancel Benjamin Keys, PhD
- Developed K-rations, led Minnesota Starvation Experiment
- Promoted Mediterranean diet based on observations in southern Italy
- First cohort examining coronary disease

1904 - 2004


Limitations of BMI: Adult data

- Fat distribution in subjects with a BMI of 25:

<table>
<thead>
<tr>
<th>%</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>4.56</td>
<td>3.45</td>
</tr>
<tr>
<td>30</td>
<td>34.65</td>
<td>34.53</td>
</tr>
<tr>
<td>45</td>
<td>26.45</td>
<td>26.14</td>
</tr>
</tbody>
</table>

  - Sensitivity to detect high adiposity in males: 0.67 (95% CI: 0.56-0.76)
  - Specificity of 0.74 (95% CI: 0.84-0.88)
  - Sensitivity to detect high adiposity in females: 0.71 (95% CI: 0.62-0.79)
  - Specificity of 0.95 (95% CI: 0.88-0.98)

Limitations of BMI: Child data

- Sensitivity to detect high adiposity in males: 0.67 (95% CI: 0.56-0.76)
- Specificity of 0.74 (95% CI: 0.84-0.88)
- Sensitivity to detect high adiposity in females: 0.71 (95% CI: 0.62-0.79)
- Specificity of 0.95 (95% CI: 0.88-0.98)
Alternatives to BMI/BMI z-score
- The International Obesity Task Force reference
- WHO Data >1SD (overweight) and >2SD (obese) (84th and 98th percentiles)
- Dual-energy X-ray absorptiometry (DEXA)
- Bioelectrical impedance
- Water submersion (hydrostatic weighing)
- Air displacement plethysmograph (bod-pod, pea-pod)
- Skinfolds
- Waist circumference

Assumption #2: I have a good idea of what is causing your problem

Story 5: John Snow

Known contributors to obesity
- Genetics
- Perinatal influences (maternal diet, stress axis of mother)
- Infancy (breastfeeding, sleep etc)
- Microbiome (establishment, antibiotics)
- Early childhood feeding context & environment
- Physical activity & built environment
- Food insecurity
- Social context

Assumption #3: I know how to fix the problem
- Consume ≥5 servings of fruits and vegetables every day... from 2 cups per day for 2-year-old children to 4.5 cups per day for 17- and 18-year-old youths (mixed evidence)
- Minimize sugar-sweetened beverages, such as soda, sports drinks, and punches (mixed evidence)
- Decrease television viewing (and other forms of screen time) to ≤2 hours per day (consistent evidence)
- Be physically active ≥1 hour each day (mixed)
- Prepare more meals at home rather than purchasing restaurant food (mixed)


Current guidelines cont.
- Eat at the table as a family at least 5 or 6 times per week (mixed)
- Consume a healthy breakfast every day (mixed)
- Involve the whole family in lifestyle changes (consistent)
- Allow the child to self-regulate his or her meals and avoid overly restrictive feeding behaviors (consistent)


Implementation of guidelines
- Stage 1 (Prevention Plus)
  - Frequency undefined, done by primary physician
- Stage 2 (Structured Weight Management)
  - Monthly visits, include referral to dietician, more structured goals
- Stage 3 (Comprehensive Multidisciplinary Intervention)
  - Weekly for 8-12 weeks, then monthly, multidisciplinary team with dietitian, physical activity, behavioral counseling
- Stage 4
  - Weekly or potential inpatient, restrictive diet, gastric bypass, medications

So what works in early childhood?
- 2 clinical trials with intensive (weekly visits for 2-3 months) interventions using psychologists, nutritionists, physical therapists/exercise experts showed a significant effect
- 3 large-scale interventions in clinic settings using motivational interviewing around current guidelines
  - 2 showed no effect, 1 showed an effect on adiposity
- Difference between them: INTENSITY – even in the study which showed a difference, only seen in group with PCP + RD doing MI with up to 10 interactions over 2 years
- 1 clinical trial with education provided to both (10 sessions, focused on parent) and tested personal coaching (phone call follow-up after session)
- 1 clinical trial with dietary education alone (Iran study)


How are we doing?
- University Health System data
  - Selected for those overweight or obese at entry and followed over time
  - About 5-10% had a negative BMI z-score slope over time

If they can get you asking the wrong questions...
- Guidelines largely based on answers to this question:
  - What is working for those of whom it should be working?
Then they don’t have to worry about answers.

Instead, we tried asking:

- What is working for those of whom it should NOT be working?

Positive Deviance

- In any high risk group, a few do better than predicted, despite the same risk factors and with the same resources as their neighbors.

A different approach to problem solving

**Traditional**

1. Study the sick
2. Identify risk factors
3. Try to reduce risk factors or their impact

**Positive Deviance**

1. Study the well
2. Identify protective behaviors
3. Spread those behaviors that have already been shown to work

Findings

- 40 parent-child dyads interviewed and completed surveys in homes in the lower Rio Grande valley (40% early childhood overweight/obesity prevalence).
- Positive deviants defined as low-income, Latino children at a healthy weight by BMI percentile.
- Comparison of similar children who were obese by BMI percentile.
- 87% at less than 200% FPL, 67% using food stamps, 15% food insecure, mean BMI of all parents was obese (31.7).
- Overall mean fruit and vegetable intake of 2.8 (SD 1.6) servings per day (no difference between groups).
- Trend (p=0.05) of increased yogurt consumption.
- Similar descriptions of activity (parental report)


**Behavioral strategies:**

- "Maybe just some juice... but that's pretty much it. I don't just resort to food as a comfort. That's what I see a lot of my friends do with their kids, oh, here eat this and it's like every time they give them a piece of candy or something, and that leads to something else." – NW parent

**Internal motivation:**

- "He's above, I don't want her to be above. My husband drinks a lot of coke. Because he comes from diabetes, I don't want her to run that risk either. So I just sort of stay away from it so that she doesn't get hooked at such an early age." – NW parent

**Organization and control:**

- "Usually I plan it out ahead. I have several things that I can make like chicken parmesan, spaghetti, because they all—my kids are kind of picky when it comes to some things, and I like to make things that we'll eat to make my life a little easier." – NW parent

**Perceptions of weight:**

- "Q. How do you know that's a healthy child? A. Well, until now the docto[r]'s haven't told me otherwise." – OB parent

**Snacking strategies:**

- "We leave it accessible for her. Like the strawberries, she just comes to you and she'll ask you to wash them for her, or a banana so that you can cut it open. But the yogurt, also I leave the carton open, and she just goes and gets it." – NW parent

**Yogurt??

Translating these findings

- No clear dietary or activity pattern emerged from this sample of data.
- Minor variations in strategies around diet and activity did.
- Lessons from intervention studies that work show:
  - Need fairly intensive (at least monthly) intervention.
  - Behavioral intervention or coaching plays a strong role.
  - Need to engage entire family.
Parent mentors:

- Have been used in multiple contexts recently (HIV, malnutrition, asthma, insurance)
- Intensely personal and cultural interactions involved with feeding
- Parent mentors have potential to provide multiple interactions across settings and encourage small changes
- Potentially sustainable and can lead to empowerment and engagement
- Address key component of constant behavioral coaching

Study design:

- Train parents to be mentors
- Randomize parents of obese children 2-5 years of age (≥95th percentile BMI) to:
  1. parent mentor trained in positive deviance strategies (de-emphasized recommendations)
  2. a promotora using EatPlayGrow education emphasizing recommendations
- Intensity:
  - Parent 4 personal interactions over 6 months with promotora
  - 4 personal interactions over 6 months with parent mentor + 6 phone calls and a home visit

Outcome measures:

- Comprehensive Feeding Practices Questionnaire
- Pediatric Quality of Life Scale
- Dietary intake (Block Food Frequency Questionnaire)
- Parental report of sleep, activity, screen time
- Weight and height (BMI z-score)
- Stool samples

Our study protocol:

Baseline data:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All (N=59)</th>
<th>Controls (N=29)</th>
<th>Intervention Group (N=30)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child age, months, mean (SD)</td>
<td>52.3 (7.6)</td>
<td>50.5 (6.9)</td>
<td>53.8 (8.0)</td>
<td>0.09</td>
</tr>
<tr>
<td>Child sex, % female (n)*</td>
<td>42.4% (25)</td>
<td>48.3% (14)</td>
<td>36.7% (11)</td>
<td>0.37</td>
</tr>
<tr>
<td>Child BMI z-score, mean (SD)</td>
<td>2.7 (0.8)</td>
<td>2.7 (0.9)</td>
<td>2.8 (0.7)</td>
<td>0.77</td>
</tr>
<tr>
<td>Parental age, years, mean (SD)</td>
<td>31.1 (7.2)</td>
<td>31.5 (6.9)</td>
<td>30.7 (7.6)</td>
<td>0.66</td>
</tr>
<tr>
<td>Preferred language, % English (n)*</td>
<td>55.9% (33)</td>
<td>55.2% (16)</td>
<td>56.7% (17)</td>
<td>0.91</td>
</tr>
</tbody>
</table>

Baseline demographics:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All (N=59)</th>
<th>Controls (N=29)</th>
<th>Intervention</th>
<th>Employment, % (n)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income, % (n)*</td>
<td></td>
<td></td>
<td></td>
<td>0.76</td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>30.5% (18)</td>
<td>31.0% (9)</td>
<td>30.0% (9)</td>
<td></td>
</tr>
<tr>
<td>$10,000-$25,000</td>
<td>35.6% (21)</td>
<td>41.4% (12)</td>
<td>30.0% (9)</td>
<td></td>
</tr>
<tr>
<td>$25,000-$50,000</td>
<td>8.5% (5)</td>
<td>6.9% (2)</td>
<td>10% (3)</td>
<td></td>
</tr>
<tr>
<td>Greater than $50,000</td>
<td>1.7% (1)</td>
<td>0% (0)</td>
<td>3.3% (1)</td>
<td></td>
</tr>
<tr>
<td>Don’t know/not sure</td>
<td>23.7% (14)</td>
<td>20.7% (6)</td>
<td>26.7% (8)</td>
<td></td>
</tr>
<tr>
<td>Employment, % (n)*</td>
<td></td>
<td></td>
<td></td>
<td>0.43</td>
</tr>
<tr>
<td>Employed/self-employed</td>
<td>55.0% (33)</td>
<td>63.3% (19)</td>
<td>46.7% (16)</td>
<td></td>
</tr>
<tr>
<td>Unemployed/unable to work/student</td>
<td>25.0% (15)</td>
<td>20.0% (6)</td>
<td>30.0% (9)</td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>20.0% (12)</td>
<td>16.7% (5)</td>
<td>23.3% (7)</td>
<td></td>
</tr>
<tr>
<td>Education, % (n)*</td>
<td></td>
<td></td>
<td></td>
<td>0.66</td>
</tr>
<tr>
<td>Less than high school education</td>
<td>45.5% (27)</td>
<td>46.7% (14)</td>
<td>43.3% (13)</td>
<td></td>
</tr>
<tr>
<td>High school graduate/GED</td>
<td>18.1% (11)</td>
<td>20.0% (6)</td>
<td>13.3% (4)</td>
<td></td>
</tr>
<tr>
<td>Some college or technical school/college graduate</td>
<td>36.4% (23)</td>
<td>33.3% (10)</td>
<td>43.3% (13)</td>
<td></td>
</tr>
</tbody>
</table>
Baseline screen time, activity, sleep

<table>
<thead>
<tr>
<th>Screen time, hours, all</th>
<th>Control</th>
<th>Intervention</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD)</td>
<td>3.0 (2.1)</td>
<td>2.0 (2.6)</td>
<td>3.5 (1.8)</td>
</tr>
</tbody>
</table>

| Play time, minutes per day, mean (SD) | 120.0 (90.0) | 120.0 (90.0) | 120.0 (90.0) | 0.83 |

| Sleep, hours per day, mean (SD) | 10.7 (1.4) | 10.6 (1.4) | 10.7 (1.4) | 0.90 |

Baseline diet information

<table>
<thead>
<tr>
<th>Dietary Item</th>
<th>All subjects (59)</th>
<th>Control (29)</th>
<th>Intervention (30)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit (cups)</td>
<td>1.1 (1.0)</td>
<td>1.1 (0.6)</td>
<td>1.1 (1.0)</td>
<td>0.86</td>
</tr>
<tr>
<td>Vegetables</td>
<td>0.3 (0.3)</td>
<td>0.3 (0.3)</td>
<td>0.3 (0.3)</td>
<td>0.36</td>
</tr>
<tr>
<td>Potatoes, including French fries (cups)</td>
<td>0.1 (0.2)</td>
<td>0.1 (0.2)</td>
<td>0.1 (0.2)</td>
<td>0.69</td>
</tr>
<tr>
<td>Whole grains (ounces)</td>
<td>0.2 (0.5)</td>
<td>0.1 (0.2)</td>
<td>0.3 (0.5)</td>
<td>0.01</td>
</tr>
<tr>
<td>Saturated fat (grams)</td>
<td>11.4 (8.0)</td>
<td>9.9 (8.7)</td>
<td>11.4 (8.9)</td>
<td>0.90</td>
</tr>
<tr>
<td>Meat, poultry, fish (ounces)</td>
<td>1.3 (1.0)</td>
<td>1.3 (1.2)</td>
<td>1.3 (1.0)</td>
<td>0.90</td>
</tr>
<tr>
<td>Dairy (cups)</td>
<td>1.4 (1.0)</td>
<td>1.2 (0.8)</td>
<td>1.5 (1.2)</td>
<td>0.15</td>
</tr>
<tr>
<td>Legumes (cups)</td>
<td>0.1 (0.2)</td>
<td>0.2 (0.2)</td>
<td>0.1 (0.2)</td>
<td>0.37</td>
</tr>
<tr>
<td>Sugar added to foods/drink (tsp)</td>
<td>4.2 (4.3)</td>
<td>3.8 (4.3)</td>
<td>4.3 (4.9)</td>
<td>0.69</td>
</tr>
<tr>
<td>Energy intake (kcals)</td>
<td>841 (560)</td>
<td>795 (668)</td>
<td>955 (480)</td>
<td>0.36</td>
</tr>
<tr>
<td>Protein (grams)</td>
<td>38 (23)</td>
<td>33 (23)</td>
<td>39 (24)</td>
<td>0.69</td>
</tr>
<tr>
<td>Fat (grams)</td>
<td>32 (24)</td>
<td>30 (27)</td>
<td>34 (23)</td>
<td>0.69</td>
</tr>
<tr>
<td>Carbohydrate (grams)</td>
<td>106 (64)</td>
<td>104 (62)</td>
<td>111 (74)</td>
<td>0.36</td>
</tr>
<tr>
<td>Fiber (grams)</td>
<td>8 (6)</td>
<td>8 (6)</td>
<td>9 (6)</td>
<td>0.69</td>
</tr>
<tr>
<td>Sugars occurring in foods, juice (grams)</td>
<td>55 (30)</td>
<td>55 (29)</td>
<td>60 (45)</td>
<td>0.69</td>
</tr>
<tr>
<td>Energy from sugary beverages (kcals)</td>
<td>14 (51)</td>
<td>14 (58)</td>
<td>14 (51)</td>
<td>0.88</td>
</tr>
<tr>
<td>Sugary beverages (servings)</td>
<td>0.1 (0.5)</td>
<td>0.1 (0.4)</td>
<td>0.1 (0.5)</td>
<td>0.88</td>
</tr>
<tr>
<td>Yogurt (containers per week)</td>
<td>2.5 (3.2)</td>
<td>2.1 (3.5)</td>
<td>2.9 (3.0)</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Results thus far:
- 94% retention at 3 months, 6 month data this week suggest ~90% follow-up
- Strong, positive feedback from parents and mentors
- Intervention group:
  - BMI z-score 2.74 to 2.47 (p<0.001)
- Control group:
  - BMI z-score 2.72 to 2.42 (p<0.001)

Back to the patient:
- Not just scientists, doctors with patients in front of us
- BMI has significant limitations that are important to be aware of in applying this population measure to individuals
- For early childhood, intensive interventions seem to work (at least in short-term)
- Basically unavailable for most children
- Motivational interviewing may work if done frequently
- Positive deviance may provide clinic and community-based solutions

Follow-up Survey
- I understand what causes early childhood obesity and can manage it well in my practice
- I understand what causes early childhood obesity but don’t feel I can manage it well in my practice
- I don’t fully understand what causes early childhood obesity but I feel I do a reasonable job despite that uncertainty
- I don’t understand what causes early childhood obesity and feel unsure of how to manage these patients
- I don’t see early childhood obesity as a problem for my practice
Acknowledgements

- Parents and children who participated in the research
- NINOS Inc. leadership and staff on partnership on current parent mentor study to address obesity (Ms. Rendon, Ms. Luci, Dr. Gorra in particular)
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- Dr. Tapangan of Tapangan Pediatrics
- Funding sources: ReACH Center, National Institutes of Health, grant KL2 1800118, The San Antonio Area Foundation
- Deborah Parra-Medina, PhD
- Daniel Hale, MD

Comments and Questions

Extra slides

- Perceptions of weight
- Microbiome
- Genetics
- History of obesity
- Early childhood feeding practices
- Breastfeeding
- Global data

Perceptions of weight:

- Many studies (over 30) examining this issue
- Mothers asked about weight status compared with actual weight or shown images
- Overall, about 50-60% of the time, parents misclassify their child by weight (think normal when not)
- Higher in younger children (80-90%)
- Example: preschool children in Los Angeles (mostly Latino)


Perceptions of weight: Local Data

- Parents of normal weight, overweight and obese 2-5 year olds from the lower Rio Grande Valley shown pictograms
- 77% of parents of overweight children misclassified their child’s current weight status as normal
- 40% of parents of obese children misclassified as normal


Perceptions of weight: providers

- Only 15% of providers identified the obese child correctly
- 21% of providers identified the overweight child
- 68% of providers identified the normal weight child
- In another study, overweight/obesity identified in 27% of children who were overweight and 86% of children who were obese by BMI percentile

A brief history of obesity

- Chronic malnutrition and food shortage was the norm for much of human history
- Corpulence prized
- Miserly Scrooge, Jolly Santa Claus
- Medical consequences:
  - Noted by William Cullen in 1700s as fatigue, gout, breathing
  - Pickwickian syndrome coined in 1956
  - William Cullen (1700s): “overeating, a vice which is more prevalent than any other; a little behind over-sleeping in its disastrous effects
  - A little excess “Thick” recommended by physicians to ensure vitality in case of illness
- Follow the money: insurance
  - Metropolitan Life Insurance Company (1937) noted excess weight to increased mortality

Breastfeeding:

- Epidemiologic evidence suggests protective effect
- More recent evidence shows that breastfed infants who are overweight early in life are at risk of becoming obese later regardless of feeding type

Breastfeeding effect:

- Data from Bogalusa Heart Study:

Genetics – in brief

- 3 primary sources of data:
  - Mouse models (leptin, melanocortin receptor pathway)
  - Syndromes associated with severe obesity (Prader-Willi etc)
  - Meta-genetics (population association studies)
- Strong evidence from twin studies on role of genetics
- Emerging evidence on role of genetics in regulating intake and fat cell growth and development
- Genetics involved are likely not “hard-wired” – can be overcome with lifestyle changes
- Inspiring patterns change with weight loss in adults

Global trends:
Early Childhood Feeding and Environment

- Parent controls
  - "what" food is offered
  - "where" food is eaten
  - "when" food is eaten
  - Allows the child to decide
  - "whether to eat"
  - "what" to eat
  - "how much" to eat of the food offered

Microbiome: twin studies


Microbiome: data from transplants


Microbiome – antibiotics:


Cancer and obesity

- Baillargeon J et al: no effect (UTHSCSA study) of obesity at diagnosis on outcomes in pre-B ALL
- Lange BJ et al: significant effect on mortality by underweight and overweight in AML
- Inaba H et al: significant effect of underweight/overweight (see fig)

BMI Percentiles/z-scores

- From 1946–1976, the Stuart/Meredith Growth Charts were widely used.
  - These were derived from stature and weight measurements taken on white children living near Iowa City, Iowa, or in Boston, Massachusetts, from 1930 to 1943.
  - The sample sizes were relatively small and the smoothed percentile lines were recorded based on mathematical approximations of curves smoothed by hand
- 1977 Charts: Data from the National Health Examination Survey (NHES) II (1963–65) for ages 6–11 years, NHES III (1966–70) for ages 12–17 years, and the first National Health and Nutrition Examination Survey (NHANES I) (1971–74) for ages 1–17 years were used to develop these charts

Applying positive deviance to early childhood obesity

- Mia (3 years old) lives with mom, dad, two sibs (1 and 5), grandpa, grandma, aunt, uncle in small house outside Harlingen, Texas
- Dad employed off and on with delivery, mom stays at home
- Eats all meals in front of TV
- Otherwise stays home and plays all day
- Breakfast at noon, eggs and beans usually
- Snacks of yogurt and fruit
- Lunch at 4pm, usually meat and rice
- Snacks of yogurt and fruit
- Dinner at 8pm, always Ramen noodles only