Cardiovascular fitness modifies the associations between physical activity and abdominal adiposity in children and adolescents: the European Youth Heart Study

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ABSTRACT
Objective To examine the associations between physical activity (PA) and abdominal adiposity, as measured by waist circumference, in children and adolescents, and to test whether cardiovascular fitness (CVF) modifies these associations.

Methods PA components were measured by accelerometry in 1075 individuals aged 9 or 15 years old. CVF was measured by a maximal cycling test. Self-reported maternal educational level, body mass index, children’s birth weight and television viewing were used as confounders.

Results Linear regression did not show any association between the PA variables and waist circumference, after controlling for sex, age and height. When stratifying by CVF level (low/high), time spent at vigorous PA was inversely associated with waist circumference (p < 0.05) in the low CVF group. Unexpectedly, in the high CVF group, the PA variables were positively associated with waist circumference (p < 0.05). In both groups, the results were unchanged after controlling for the confounders. CVF was inversely associated with waist circumference, after controlling for all PA variables (p < 0.01) and confounders (p < 0.01).

Conclusion CVF is inversely associated with abdominal adiposity and seems to modify the associations between PA and abdominal adiposity. In low-fit children and adolescents, time spent in vigorous PA seems to be the key component linked to abdominal adiposity. This finding should be considered in further development of lifestyle intervention strategies. The results found in the high-fit group need to be confirmed.

Abdominal adiposity, as measured by waist circumference, is associated with a range of risk factors for cardiovascular disease in young people, even within a given body mass index (BMI) category. Factors related to abdominal adiposity should be identified for more efficient health promotion.

Physical activity (PA) is potentially related to abdominal adiposity, but the associations reported so far in this regard are contradictory. Even those studies using objective methods for assessing PA have shown contradictory results in relation to abdominal adiposity.

Cardiovascular fitness (CVF) reflects the overall capacity of the cardiovascular and respiratory systems and the ability to carry out prolonged exercise. The maximal oxygen consumption (VO2max) has long been considered by the World Health Organization as the single best indicator of CVF. CVF seems to be an interacting factor in the relationships between PA and other health outcomes, for example, metabolic risk factors. Whether CVF also interacts in the associations between objectively measured PA and abdominal adiposity remains to be clarified.

CVF has an important genetic component. People genetically predisposed towards having a better fitness level may also be predisposed towards having a lower adiposity status, with PA being less influential. The main hypothesis tested in this study is that those children and adolescents with a low CVF will show a stronger association between PA and abdominal adiposity than their peers with a high CVF level. The purpose of this study was to examine the associations between objectively measured PA and abdominal adiposity in children and adolescents, and to test whether CVF levels modify these associations. Whether the association of CVF with abdominal adiposity is independent of objectively measured PA was also studied.

METHODS
Study population
A total of 557 children aged 9.5 (0.3) years and 518 adolescents aged 15.6 (0.4) years from the Swedish part of the European Youth Heart Study had valid data for waist circumference. Of these subjects, 96% had complete and valid data for sexual maturation status, 88% for maternal educational level, 90% for birth weight, 94% for objectively measured PA and 75% for CVF (ml/min/kg). Study design, sampling procedures, participation rates and study protocol have been reported elsewhere. The study was approved by the Research Ethics Committees of Örebro County Council and Huddinge University Hospital. Written informed consent was obtained from the parents of the children and from both the parents of the adolescents and also from the adolescents themselves.

Physical examination
BMI was calculated as weight/height squared (kg/m2) and used to define overweight (including obesity).
Waist circumference (cm) was measured with a metal anthropometric tape midway between the lower rib margin and the iliac crest, at the end of gentle expiration. The individuals were classified as having a high or low metabolic risk (hereinafter called high-risk/low-risk waist circumference), according to sex and age-specific waist circumference cutoff values.

Skinfold thicknesses were measured with a Harpenden caliper (Baty International, Burgess Hill, UK), according to the criteria described by Lohman et al. Slaughter’s equations were used to calculate the percentage of body fat. Being above the sex-specific and age-specific 85th percentile of body fat percentage was used as a cutoff value for defining individuals with an excess of total adiposity. Fat-free mass (FFM) was derived by subtracting fat mass from total body weight.

Pubertal stage was assessed by a trained researcher of the same sex as the child, using brief observation, according to Tanner and Whitehouse. Breast development in girls and genital development in boys were used for pubertal classification.

Objectively measured PA
PA was measured over four consecutive days (at least two weekdays and at least one weekend day) with an activity monitor (MTI model WAM 7164, Manufacturing Technology, Fort Walton Beach, Florida) worn at the right hip. At least 3 days of recording, with a minimum of 10 h registration per day, was set as an inclusion criterion. The epoch duration was set at 1 min.

Total PA was expressed as the total counts recorded, divided by the total daily registered time (counts/min). The time engaged in moderate and vigorous PA was calculated and presented as the average time per day during the complete registration (min/day). Moderate PA (3–6 metabolic equivalents (METs)) and vigorous PA (>6 METs) intensities were based upon cutoff limits published elsewhere. Also, the time spent in at least moderate intensity PA (>3 METs) was calculated (min/day, MVPA).

The accelerometer (CSA/MTI/Actigraph) and the cutoff limits used in this study have shown to be valid for estimating time spent in moderate and vigorous PA in children and adolescents.

Cardiovascular fitness
CVF was determined by a maximal cycle ergometer test. The work rate was preprogrammed on a computerised cycle ergometer (Monark 829E Ergomedic, Vansbro, Sweden), to increase every third minute until exhaustion, as follows: (1) In children (boys and girls) with a body weight of 50 kg or more, the initial work rate was set at 25 W increasing by 25 W every third minute, whereas in those children with a body weight lower than 30 kg, the initial work rate was set at 20 W increasing by 20 W every third minute. (2) In adolescent boys, the initial work rate was set at 50 W, increasing by 50 W every third minute, while in adolescent girls, the initial work rate was set at 40 W, increasing by 40 W every third minute. Heart rate was registered continuously by telemetry (Polar Sport Tester, Kempele, Finland). The criteria for exhaustion were a heart rate ≥185 beats per minute and a subjective judgment by the test leader that the adolescent could no longer keep up, even after vocal encouragement. The power output (Watts = W) was calculated as = W1–γ(W2 × t/180), where W1 is a work rate at the last fully completed stage, W2 is the work rate increment at final incomplete stage, and t is time in seconds at final incomplete stage. The Hansen formula for calculating VO2max (ml/min) was 12 × calculated power output +5 × body weight (in kg). For the analysis, CVF normalised by FFM (ml/min/kgFFM) was used.

Confounders
The time spent in TV viewing was self-reported by means of the question “How many hours of TV do you usually watch?” The answer was classed as either <2 h/day or ≥2 h/day. Parents reported their children’s birth weights, and subjects were classed as ≤2500 g, between 2500 and 4000 g or >4000 g. Maternal height and weight were self-reported, and BMI was calculated. The validity of BMI based on self-reported weight and height in adults has been documented elsewhere. The socioeconomic status was defined by the maternal educational level as below university education and university education.

Statistical analysis
The differences between sex and age groups on continuous variables were assessed by two-way ANOVA (with sex and age as fixed factors). After square root transformation of the vigorous PA and total PA, all the residuals showed a satisfactory pattern. Nominal variables were analysed by χ² tests.

Multiple regression analyses were used to study the associations of PA variables and CVF with waist circumference. Interaction factors (ie, sex×main exposures and age×main exposures) were considered to evaluate whether age and sex modified the associations of PA variables and CVF with waist circumference. Since no interaction was found, all sex and age groups were analysed together. Height influences the observation of fat accumulation and/or distribution, and it should be accounted for when analysing the associations between any factor and waist circumference. Multicollinearity among the exposures was not found in any of the models (variance inflation factor was <10 and averaged variance inflation factor ~1). The PA variables were analysed one by one in all the models to avoid multicollinearity. The statistical analysis performed for this study was split into three steps:

1. The basic model was composed of sex, age group and height. The PA variables or CVF were added to the basic model in separate models to examine the associations between the PA variables and CVF with waist circumference, controlling for sex, age and height.

2. The PA variables were consecutively entered into the models together with CVF to examine whether the associations of PA and CVF with waist circumference were independent of each other. Additionally, interaction factors between the main exposure variables (ie, PA variables ×CVF) with waist circumference were also analysed.

3. Finally, the associations between PA variables and waist circumference were separately analysed by CVF levels (low/high), and those associations in which interactions found were graphically shown. CVF level was dichotomised (low/high) when being below/above the sex- and age-specific median. All the data were analysed in their continuous form, although data were stratified by quartiles of PA (sex- and age-specific) only for illustrative purposes. In the final model, the analyses were additionally controlled for other potential confounders, such as maternal educational, maternal BMI, birth weight and TV viewing.

All calculations were performed using SPSS V.15.0 software for Windows. For all analyses, the significance level was 5%.
RESULTS
The descriptive characteristics of the participants are shown in table 1. Boys were more physically active and had a higher CVF level than girls. Compared with girls, boys spent 46% more time in vigorous PA and 14% more time in moderate PA.

Standardised regression statistics reporting the associations of either PA variables or CVF with waist circumference, after controlling for sex, age and height, are shown in table 2. No significant association was found between any of the PA variables and waist circumference, after controlling for sex, age and height. This association was unaffected when sexual maturation status instead of age was controlled for (data not shown).

Regression analysis statistics when both PA variables and CVF were entered together into the model are shown in table 3. When CVF was in the model, moderate PA and MVPA were positively associated with waist circumference (p = 0.010 and p = 0.031, respectively). Neither vigorous PA nor total PA were associated with waist circumference, but significant interactions with CVF were found for these variables (p = 0.005 and p = 0.022, vigorous PA and total PA, respectively). The associations between these two variables and waist circumference by levels of CVF are shown in fig 1. CVF remained negatively associated with waist circumference, after controlling for all PA variables (p values ranging from 0.005 to 0.014).

Table 4 shows the association between PA variables and waist circumference when stratifying by CVF levels. In individuals with a low CVF level, vigorous PA was inversely associated with waist circumference (p = 0.044), while total PA showed a borderline inverse association (p = 0.080). In individuals with a high CVF level, all the PA variables studied were positively associated with waist circumference (p values ranging from 0.025 to < 0.001). The results did not substantially change when the analyses were controlled for maternal educational level, birth weight or TV viewing. Likewise, CVF remained inversely associated with waist circumference after controlling for these confounders (all p < 0.01). All the results remained unaffected after controlling for maternal BMI (data not shown).

The prevalence of being overweight (IOTF cutoff values), having an excess of total fatness (>85th percentile of body fat) and having a high-risk waist circumference (the Bogalusa study cutoff values) were significantly lower in the high CVF group than in the low CVF group (all p < 0.05; data not shown).

DISCUSSION
Young people with low fitness and high fatness levels have an increased risk for metabolic disease and require special attention. In this study, the prevalence of being overweight, having an excess of total fat and having a high-risk waist circumference was greater in the low CVF group than in the high CVF group. The group classified as low CVF was actually a low-fit/high-fat group. In this specific group of individuals, high levels of vigorous PA were associated with a lower abdominal adiposity, independently of sex, age and height. This association

Table 1 Descriptive characteristics of the participants

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th></th>
<th>Adolescents</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys (n = 269)</td>
<td>Girls (n = 288)</td>
<td>Boys (n = 238)</td>
<td>Girls (n = 280)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>9.5 (0.3)</td>
<td>9.5 (0.4)</td>
<td>15.6 (0.4)</td>
<td>15.5 (0.4)</td>
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<td>Sexual maturation status (%),†</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I</td>
<td>99</td>
<td>57</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Stage II</td>
<td>1</td>
<td>40</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Stage III</td>
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<tr>
<td>Stage IV</td>
<td>0</td>
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<td>17</td>
<td>45</td>
</tr>
<tr>
<td>Stage V</td>
<td>0</td>
<td>0</td>
<td>79</td>
<td>50</td>
</tr>
<tr>
<td>Weight (kg)†</td>
<td>33.4 (6.2)</td>
<td>33.7 (6.7)</td>
<td>64.2 (10.7)</td>
<td>57.8 (8.8)</td>
</tr>
<tr>
<td>Height (cm)†</td>
<td>139 (6)</td>
<td>139 (7)</td>
<td>176 (7)</td>
<td>165 (6)</td>
</tr>
<tr>
<td>Body mass index (kg/m²)†</td>
<td>17.2 (2.4)</td>
<td>17.3 (2.4)</td>
<td>20.7 (2.8)</td>
<td>21.2 (2.7)</td>
</tr>
<tr>
<td>Prevalence of overweight (including obesity) (%)</td>
<td></td>
<td></td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Waist circumference (cm)†,‡</td>
<td>60.7 (6.0)</td>
<td>60.2 (6.1)</td>
<td>73.8 (7.1)</td>
<td>70.0 (6.7)</td>
</tr>
<tr>
<td>High-risk waist circumference (%)‡</td>
<td>27.2</td>
<td>28.6</td>
<td>17.4</td>
<td>30.1</td>
</tr>
<tr>
<td>Body fat (%)‡</td>
<td>16.1 (6.3)</td>
<td>18.6 (5.6)</td>
<td>14.0 (6.5)</td>
<td>23.4 (5.5)</td>
</tr>
<tr>
<td>Fat-free mass (kg)‡,§</td>
<td>27.7 (3.4)</td>
<td>27.0 (3.8)</td>
<td>54.9 (7.3)</td>
<td>43.9 (5.4)</td>
</tr>
<tr>
<td>Total PA level (counts/min)‡,§</td>
<td>805 (259)</td>
<td>665 (189)</td>
<td>557 (199)</td>
<td>490 (154)</td>
</tr>
<tr>
<td>Moderate PA (min/day)‡,§</td>
<td>185 (50)</td>
<td>159 (41)</td>
<td>65 (31)</td>
<td>58 (22)</td>
</tr>
<tr>
<td>Vigorous PA (min/day)‡,§</td>
<td>35 (23)</td>
<td>24 (15)</td>
<td>16 (12)</td>
<td>11 (10)</td>
</tr>
<tr>
<td>Moderate–vigorous PA (min/day)‡,§</td>
<td>220 (65)</td>
<td>182 (51)</td>
<td>81 (38)</td>
<td>69 (28)</td>
</tr>
<tr>
<td>VO₂max (l/min)‡,§</td>
<td>1.38 (0.2)</td>
<td>1.23 (0.2)</td>
<td>3.27 (0.5)</td>
<td>2.29 (0.4)</td>
</tr>
<tr>
<td>VO₂max (ml/min/kg)‡,§</td>
<td>42.3 (6.9)</td>
<td>36.7 (5.3)</td>
<td>51.0 (6.7)</td>
<td>40.2 (5.9)</td>
</tr>
<tr>
<td>VO₂max (ml/kg/min)‡,§</td>
<td>50.1 (6.8)</td>
<td>45.2 (5.4)</td>
<td>59.3 (6.0)</td>
<td>52.0 (7.1)</td>
</tr>
</tbody>
</table>

FFM, fat-free mass; PA, physical activity; VO₂max, maximal oxygen consumption.
Values are mean (SD), unless otherwise stated.
*Sex differences were analysed by two-way ANOVA.
†Age group differences were analysed by two-way ANOVA.
‡Sex differences were found only in adolescents.
§Squared-root transformed data were used in the analysis, but raw data are presented.
Collectively, the available information suggests that changes in body composition (ie, decreases in percentage body fat) have shown to be associated with a lower total adiposity, (fat). High levels of vigorous PA, rather than light/moderate PA, could have lower relevance for the youths’ cardiovascular health than in the low CVF level group. The fact that no interaction by sex or age was found suggests that the associations observed in this study are consistent for children and adolescents, and for boys and girls. The sex differences in the association between PA and abdominal adiposity reported elsewhere is not supported by our results. Methodological differences, such as the different accelerometers used in both studies (uniaxial vs triaxial), might explain the discrepancies.

The findings also indicate that CVF is inversely associated with abdominal adiposity, independently of sex, age, height and all the PA variables. We observed similar results in Spanish adolescents from the AVENA study, yet in that case, PA was self-reported. The fact that CVF is associated with abdominal adiposity in children and adolescents, independently of their

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**Table 2** Associations of objectively measured physical activity (PA) variables and cardiovascular fitness (CVF) with waist circumference in children and adolescents

<table>
<thead>
<tr>
<th>Models/exposures</th>
<th>β</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic model (BM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (0 = girls, 1 = boys)</td>
<td>0.018</td>
<td>0.411</td>
</tr>
<tr>
<td>Age (0 = children, 1 = adolescents)</td>
<td>0.014</td>
<td>0.787</td>
</tr>
<tr>
<td>Height (cm) 0.706</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>BM + main exposures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate PA (min)</td>
<td>0.073</td>
<td>0.103</td>
</tr>
<tr>
<td>Vigorous PA (min)*</td>
<td>-0.033</td>
<td>0.263</td>
</tr>
<tr>
<td>MVPA (min)</td>
<td>0.040</td>
<td>0.340</td>
</tr>
<tr>
<td>Total PA (counts/min)*</td>
<td>-0.009</td>
<td>0.771</td>
</tr>
<tr>
<td>CVF (ml/min/kgFFM)</td>
<td>-0.092</td>
<td>0.002</td>
</tr>
</tbody>
</table>

* Standardised linear regression coefficients. MVPA, moderate to vigorous PA. FFM, fat-free mass.

was not affected by other confounders, such as maternal educational level, birth weight or TV viewing. Maternal adiposity is a more important determinant factor predisposing for abdominal fatness than paternal adiposity at childhood and adolescence. After additional controlling for maternal BMI, similar trends were observed. The fact that vigorous PA might benefit the abdominal adiposity status in those children and adolescents at a higher metabolic risk may have implications for the development and testing of lifestyle intervention models.

Follow-up data support that, in obese children and adolescents, exercise is an effective way to promote favourable changes in body composition (ie, decreases in percentage body fat). High levels of vigorous PA, rather than light/moderate PA, have shown to be associated with a lower total adiposity, estimated from skinfold thicknesses in children and adolescents. Collectively, the available information suggests that PA of high intensity could play a key role in the associations between PA and adiposity, both total and abdominal, in young people.

The interactions between CVF and PA in relation to abdominal adiposity found in this study suggest that CVF modifies the associations between PA and abdominal adiposity. This is the first study examining how CVF can influence the associations between objectively measured PA and abdominal adiposity in young people. The high CVF level group showed a lower prevalence of being overweight/obese, having an excess of total fat and having a high-risk waist circumference. Our hypothesis was that in this group of people that already had higher fitness and lower fatness, a weak or even no association between PA and adiposity, both total and abdominal, in young people.

The fact that no interaction by sex or age was found suggests that the associations observed in this study are consistent for children and adolescents, and for boys and girls. The sex differences in the association between PA and abdominal adiposity reported elsewhere is not supported by our results. Methodological differences, such as the different accelerometers used in both studies (uniaxial vs triaxial), might explain the discrepancies.

The findings also indicate that CVF is inversely associated with abdominal adiposity, independently of sex, age, height and all the PA variables. We observed similar results in Spanish adolescents from the AVENA study, yet in that case, PA was self-reported. The fact that CVF is associated with abdominal adiposity in children and adolescents, independently of their
techniques, including dual energy X-ray absorptiometry and MRI. Therefore, the use of waist circumference as a surrogate measurement of abdominal adiposity, and as a powerful index of CVF was still significantly associated with abdominal adiposity. The inverse association between physical fitness and abdominal adiposity in young people has been consistently reported. It seems to be independent of the total PA and different intensity levels of PA, as measured by objective methods.

Waist circumference has shown to be an accurate marker of abdominal fat accumulation and visceral adiposity in young people. In addition, waist circumference seems to explain the variance in a range of cardiovascular disease risk factors to a similar extent as measurements involving high-technology methods or anthropometry, the physical fitness testing (running or biking tests) and the physical fitness components used (CVF, muscular fitness or speed/agility). This study contributes to the previous literature by reporting that these associations seem also to be independent of the abdominal adiposity measurement method used (high technology methods or anthropometry), sex, age group and height. Therefore, the use of waist circumference as a surrogate measurement of abdominal adiposity, and as a powerful index associated with metabolic risk in young people, seems to be appropriate for epidemiological studies.

**Table 3** Independent associations of objectively measured physical activity (PA) variables and cardiovascular fitness (CVF) with waist circumference in children and adolescents

<table>
<thead>
<tr>
<th>Basic model−CVF+</th>
<th>Main exposures</th>
<th>β</th>
<th>p (β coefficient)</th>
<th>p Value (interaction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate PA</td>
<td>CVF (ml/min/kgFFM)</td>
<td>−0.102</td>
<td>0.005</td>
<td>0.428</td>
</tr>
<tr>
<td></td>
<td>Moderate PA (min)</td>
<td>0.129</td>
<td>0.010</td>
<td></td>
</tr>
<tr>
<td>Vigorous PA</td>
<td>CVF (ml/min/kgFFM)</td>
<td>−0.091</td>
<td>0.014</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Vigorous PA (min)*</td>
<td>0.011</td>
<td>0.731</td>
<td></td>
</tr>
<tr>
<td>MVPA</td>
<td>CVF (ml/min/kgFFM)</td>
<td>−0.102</td>
<td>0.005</td>
<td>0.257</td>
</tr>
<tr>
<td></td>
<td>MVPA (min)</td>
<td>0.101</td>
<td>0.031</td>
<td></td>
</tr>
<tr>
<td>Total PA</td>
<td>CVF (ml/min/kgFFM)</td>
<td>−0.095</td>
<td>0.011</td>
<td>0.022</td>
</tr>
<tr>
<td></td>
<td>Total PA (counts/min)*</td>
<td>0.027</td>
<td>0.425</td>
<td></td>
</tr>
</tbody>
</table>

MVPA, moderate to vigorous PA.
β Standardised linear regression coefficients. Basic model is composed of sex, age group and height.

**Practical implications**

The present study shows that vigorous PA is associated with lower abdominal adiposity in low-fit children and adolescents. Previous studies have demonstrated that meeting the current PA recommendations, that is, 60 min/day of MVPA, is associated with a healthier CVF level but not a lower risk of having high levels of total and central adiposity. However, additional analyses support the hypothesis that 60 min or more of daily PA could be enough to achieve a healthier fitness and adiposity status, if enough vigorous PA is accumulated during that period.

New PA recommendations adapted to young people, and taking into account the evidence-based importance of vigorous PA, are needed. In this context, sex-specific and age-specific cutoff values for vigorous PA associated with a lower risk of being overweight and having a high-risk waist circumference have been reported by Ortega et al. New PA recommendations adapted to young people, and taking into account the evidence-based importance of vigorous PA, are needed. In this context, sex-specific and age-specific cutoff values for vigorous PA associated with a lower risk of being overweight and having a high-risk waist circumference have been reported by Ortega et al. New PA recommendations adapted to young people, and taking into account the evidence-based importance of vigorous PA, are needed. In this context, sex-specific and age-specific cutoff values for vigorous PA associated with a lower risk of being overweight and having a high-risk waist circumference have been reported by Ortega et al. These associations are supported by longitudinal data.

Finally, data from epidemiological studies using objective methods for assessing PA and findings from randomised controlled trials support the idea that high-intensity PA is associated with higher physical fitness and also that physical

**Table 4** Associations between objectively measured physical activity (PA) variables and waist circumference in children and adolescents, stratifying by cardiovascular fitness (CVF) level

<table>
<thead>
<tr>
<th>Basic model</th>
<th>+Maternal education</th>
<th>+Birth weight</th>
<th>+Television viewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low CVF</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Moderate PA (min)</td>
<td>−0.016</td>
<td>0.824</td>
<td>−0.031</td>
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<tr>
<td>Vigorous PA (min)*</td>
<td>−0.097</td>
<td>0.044</td>
<td>−0.116</td>
</tr>
<tr>
<td>MVPA (min)</td>
<td>−0.046</td>
<td>0.498</td>
<td>−0.063</td>
</tr>
<tr>
<td>Total PA (counts/min)*</td>
<td>−0.084</td>
<td>0.080</td>
<td>−0.113</td>
</tr>
<tr>
<td>High CVF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate PA (min)</td>
<td>0.258</td>
<td>&lt;0.001</td>
<td>0.270</td>
</tr>
<tr>
<td>Vigorous PA (min)*</td>
<td>0.101</td>
<td>0.027</td>
<td>0.101</td>
</tr>
<tr>
<td>MVPA (min)</td>
<td>0.224</td>
<td>0.001</td>
<td>0.231</td>
</tr>
<tr>
<td>Total PA (counts/min)*</td>
<td>0.111</td>
<td>0.015</td>
<td>0.110</td>
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</table>

MVPA, moderate to vigorous PA.
β Standardised linear regression coefficients. Basic model is composed of sex, age group and height. Maternal education, birth weight and television viewing were one by one sequentially added to the basic model.

+ Squared root transformed.

Table 4 shows the associations between objectively measured physical activity (PA) variables and waist circumference in children and adolescents, stratifying by cardiovascular fitness (CVF) level. The associations are presented for low and high CVF levels, along with the standardized coefficients and p-values for each variable. The table includes data for moderate, vigorous PA, MVPA, and total PA, as well as the corresponding waist circumference measurements. The results indicate a consistent inverse association between PA and waist circumference, with higher levels of PA being associated with lower waist circumference, especially in the high CVF group.
exercise programs, properly designed and controlled, improve physical fitness in children and adolescents, independently of age, maturation and sex. High-intensity PA seems to be a key element for physical fitness enhancement in young people.

Limitations
The present work, as with any other cross-sectional study, only provides suggestive evidence concerning the causal relationship between PA or CVF and abdominal adiposity. The direction of the cause can be suggested but never certainly stated.

The accelerometers do not compensate for the relative increase in energy expenditure by increase in body size and non-weight-bearing activities such as swimming or cycling are not properly measured by the accelerometers. This could also have been a contribution factor to the unexpected results shown in the high-fit individuals.

The method used for assessing CVF has two main limitations: (1) An inherent error must be assumed when \( \text{VO}_{\text{max}} \) is indirectly estimated. In addition, CVF was expressed as \( \text{mL} / \text{min} / \text{kg}^{\text{FFM}} \) in this study, and FFM was also indirectly estimated from skinfold thicknesses. (2) Cycling tests give a lower \( \text{VO}_{\text{max}} \) value than running tests. A possible explanation is that on the cycling tests, the limiting influence of undeveloped knee extensor muscle mass induces local muscle fatigue, with subsequent early end of the test. Also, some youths have difficulty maintaining the proper pedal rate.

Strengths
Despite the limitations highlighted above, accelerometry has proven to correlate reasonably with doubly labelled water-derived energy expenditure and is considered nowadays a method of choice for objectively measuring PA in free-living children and adolescents. The fact that a relatively large sample of children and adolescents were assessed by means of accelerometry in relation to abdominal adiposity, taking into account CVF measured under well-standardised laboratory conditions and a set of relevant confounders, is a notable strength of this study.

CONCLUSION
CVF seems to modify the associations between PA and abdominal adiposity. In low-fit children and adolescents, time spent in vigorous PA seems to be the key PA component linked to abdominal adiposity. This finding may have important implications for further development of lifestyle intervention strategies, since our data suggest that the individuals with a low CVF are actually a high-risk group. Further research examining genetic and dietary factors, in addition to objectively measured PA and CVF, is still needed for a better understanding of the associations between PA and adiposity in young people. Also, the results found in the high-fit group need to be confirmed or disproved in future studies. Finally, our results show that CVF is inversely and consistently associated with abdominal adiposity, independently of the time spent at different intensities of PA and total PA levels.

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Competing interests
None.

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