Pedometer assessed physical activity of people with metabolic syndrome in Poland

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INTRODUCTION

Physical activity remains an important part of the management of metabolic syndrome and favourably affects lipid disorders, supports the treatment of diabetes or hypertension. Numerous studies have shown the impact of physical exercise of the appropriate frequency, length and intensity to reduce morbidity and mortality related to cardiovascular diseases, osteoporosis and metabolic disorders, among others [1, 2, 3, 4, 5, 6].

Data from Poland indicate that around 2.5–64% of adult Poles systematically take part in various forms of physical activity. These differences in percentage are the result of the application of different methods of measuring physical activity, and assuming different ‘values’ of physical activity at a recommended dose [7, 8].

Technology development and industrialization have significantly contributed to the elimination of physical activity, not only in everyday life, but also in many occupations. For many people who lead a sedentary lifestyle, physical activity during their leisure time and commuting are the only forms of physical activity [9]. An appropriate level of systematic physical activity is necessary in order to maintain or improve health. Therefore, increasing physical activity is one of the main objectives of modern public health strategy [10]. WHO experts emphasize that improving physical activity levels of society is as important as treating hypertension, lipid metabolism disorders, and smoking addiction.

The main aim of the study was evaluation of the physical activity of people with metabolic syndrome.

MATERIALS AND METHOD

Study group. The study consisted of a total of 100 people aged 35–70 years (mean age 54.6, median 55 years, interquartile range – 16.75 RQ), with women predominating (70%). Most (40%) declared having a secondary education, 23% college level or higher and 37% primary. Almost half (45%) were pensioners or retirees, 32% manual workers, 15% white-collar workers and 8% were unemployed. The majority of respondents (66%) lived in blocks of flats and 34% lived in own home.

The study was conducted in two general practice clinics in Poland between June 2009 – October 2010. Adults visiting their general practitioner who met the following criteria were included:
1) age: 35–70 years old;
2) criteria fulfilled for metabolic syndrome according to the International Diabetes Federation (IDF);
All patient consented to participate in the study.
Patients with musculoskeletal impairments substantially limiting their physical activity, pregnant women, persons with acute infections, who were recommended to stay at home, were excluded from the study.

Study protocol. After obtaining informed consent to participate in the study, measurements of body weight, height, waist and hip circumference were taken. For evaluation of type of fat distribution, the Waist to Hip Ratio (WHR) was calculated using the formula: WHR = waist circumference (cm)/hip circumference (cm). Body mass index BMI (BMI = body weight (kg)/[height (m)2]) and body fat percentage (% Fat) were calculated using the Omron BF306 Body Fat Monitor (Omron Healthcare Co., Ltd. Kyoto, Japan).

Results of biochemical tests were obtained from patient medical records. New Lifestyles NL-2000 (New-Lifestyles, Inc. Lee’s Summit, MO, USA) pedometers were used for the study of physical activity during the entire week. The patients were informed about how to use the pedometer. The device was placed at the waist and attached to the belt. The participants were asked to wear the pedometer at all times during the day, but not during sleep. After seven days of physical activity registration, a researcher read directly from the pedometer the number of steps, jumps and changes in body position during physical activity.

The study was approved by the Bioethics Committee of the Medical University of Białystok on 30 March 2009 (Approval No. R-I-002/197/2009).

Statistical analysis of results. Arithmetic mean, standard deviation and minimum and maximum values for measurable characteristics consistent with normal distribution were assessed using the Shapiro-Wilk test. For characteristics inconsistent with this distribution, the median and interquartile range (RQ) was calculated. Qualitative data were presented as their quantity and percentage distribution.

For characteristics consistent with normal distribution, the Student’s t-test or one-way analysis of variance (ANOVA) were used for comparisons between the groups. For features inconsistent with the normal distribution, the Mann-Whitney or Kruskal-Wallis test were used, respectively. The Chi² test was used to compare qualitative characteristics between the groups. Pearson’s correlation coefficients was also calculated for characteristics consistent with normal distribution, or Spearman’s for the characteristics of different distribution.

A level of p < 0.05 was considered statistically significant. Calculations were performed using the SPSS statistical package.

RESULTS

Presence of metabolic syndrome criteria. Of the 100 participants with metabolic syndrome, the great majority – 97 patients (97%) – had arterial blood pressure ≥ 130/85 mmHg or being treated for hypertension; 93 (93%) were diagnosed with TG ≥ 150 mg/dl or were being treated for hypertriglyceridaemia; 85 patients (85%) were diagnosed with HDL (males < 40 mg/dl, females < 50 mg/dl or treatment of hypo HDL). The least frequently occurring metabolic syndrome criterion was glycaemia ≥ 100 mg/dl or previously diagnosed diabetes – 45 patients (45%).

Most people in the study group (40% of all respondents) had Iº obesity; their body mass index (BMI) ranged between 30.0–34.9 kg/m². A quarter of the respondents (25%) were overweight (Tab. 1). Average body weight among the participants was 94.5 kg (median 95; RQ 20.5) and ranged from 65–158 kg, while the average BMI was 33.8 kg/m² (median 32.7; RQ 7.95), and ranged from 24.5 kg/m² – 54.1 kg/m².

Table 1. BMI classification categories according to WHO (1998) and number of respondents in each category

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>BMI (kg/m²)</th>
<th>N=100 n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.5</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Proper weight</td>
<td>18.5–24.9</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0–29.9</td>
<td>25 (25.3)</td>
</tr>
<tr>
<td>Iº Obesity</td>
<td>30.0–34.9</td>
<td>40 (40.4)</td>
</tr>
<tr>
<td>IIº Obesity</td>
<td>35.0–39.9</td>
<td>18 (18.2)</td>
</tr>
<tr>
<td>IIIº Obesity</td>
<td>≥40</td>
<td>16 (16.2)</td>
</tr>
</tbody>
</table>

Anthropometric measurements. Table 2 presents the results of anthropometric measurements: waist circumference, hip circumference, percentage of body fat in terms of gender of participants. Mean waist circumference for men was 111.7 cm (median 110; RQ 16.3), and 103.9 cm for women (median 102.5; RQ 14.3).

Table 2. Results of anthropometric examinations and gender

<table>
<thead>
<tr>
<th>Sex</th>
<th>Waist circumference (cm)</th>
<th>Hip circumference (cm)</th>
<th>Percentage of body fat (%)</th>
<th>Percentage of body fat (%) (skinfold caliper)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>102.5</td>
<td>113.5</td>
<td>42.8</td>
<td>44.5</td>
</tr>
<tr>
<td>M</td>
<td>111.7</td>
<td>112.6</td>
<td>33.4</td>
<td>35.8</td>
</tr>
<tr>
<td>N=70</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Min.</td>
<td>83</td>
<td>96</td>
<td>33.8</td>
<td>36.7</td>
</tr>
<tr>
<td>Max.</td>
<td>130</td>
<td>150</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>SD</td>
<td>11.4</td>
<td>12.7</td>
<td>4.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Median</td>
<td>102.5</td>
<td>113.5</td>
<td>42.8</td>
<td>44.5</td>
</tr>
<tr>
<td>RQ</td>
<td>14.3</td>
<td>19.0</td>
<td>7.0</td>
<td>5.3</td>
</tr>
<tr>
<td>N=30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Min.</td>
<td>95</td>
<td>100</td>
<td>25.1</td>
<td>28.2</td>
</tr>
<tr>
<td>Max.</td>
<td>133</td>
<td>130</td>
<td>42</td>
<td>43.6</td>
</tr>
<tr>
<td>SD</td>
<td>10.6</td>
<td>8.2</td>
<td>4.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Median</td>
<td>110</td>
<td>112</td>
<td>33.3</td>
<td>37.4</td>
</tr>
<tr>
<td>RQ</td>
<td>16.3</td>
<td>11.8</td>
<td>6.2</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Weekly physical activity. Mean weekly physical activity of the 100 participants was about 6,261 steps/day and ranged from 1,781–15,169. The largest number of steps was 23,347/day (the participant confirmed a very high level of physical activity), while the lowest was 409 steps/day. There were no significant differences between the number of steps on weekdays and weekends (average of 6,676/day and 6,913/day, respectively) (Tab. 3). Average daily number of steps for females (n=70) was 6,906±3,030 (median 5,969; RQ 4992–8283), and for men (n=30) – 6,534 ± 2,786 (median 6,846; RQ 4039–8330).

Only 16 people (16%), of whom the majority (68.8%) were within the age group <= 50 years, represented the group of
active people. The average number of steps per week in this
group was equal to or greater than 10,000. Eighty-four people
(84%) were less active, i.e. their average number of steps was
less than 10,000. Respondents aged 50–59 (70.2%) dominated
in this group. The percentage of people with >=10,000 steps
in the age group <= 50 years was 68.8%, and in the age group
> 50 years – 31.3% (p <0.05).

Figure 1 shows the correlation between the age and physical
activity of the participants with metabolic syndrome.
A statistically significant negative correlation (r= –0.29)
was found between age and physical activity (Fig. 1).

Analyzing the physical activity of participants based on
gender, it appeared that in the group of 70 females (70%),
the great majority (81.4%) presented physical activity of less
than 10,000 steps/day. A similar situation occurred among
the males: from a group of 30 respondents, 90% were active
below the recommended level. The percentage of females
with >=10,000 steps was 18.6%, and men – 10%.

A statistically significant negative correlation (r = –0.226)
was found between the average daily number of steps during
the week and BMI (Fig. 2), and a statistically significant
negative correlation (r = –0.201) between the average daily
number of steps and WHR (Fig. 3).

In the studied group, 61 people (61%) represented low
or sedentary type of activity. Table 4 outlines the types of
activities and the corresponding number of steps with the
number of persons qualified to each of these levels.

**DISCUSSION**

Recently, physical activity levels are increasingly assessed
using objective methods such as pedometers, which are
already widely available devices for calculating the daily
number of steps.

On the basis of measurement of the number of steps taken
during the day, the patient can be qualified to a group with
a specific degree of physical activity. The classification,
based on the number of steps, takes into account 5 types
of physical activity. On the scale of spontaneous physical
activity, proposed by Tudor-Locke and Bassett [11, 12], people

![Figure 1. Correlation between average daily number of steps and age (years)](image1)

![Figure 2. Correlation between the average daily number of steps and BMI (kg/m²)](image2)

![Figure 3. Correlation between average daily number of steps and WHR](image3)

**Table 3.** Average daily number of steps measured by pedometer on
weekdays and weekends

<table>
<thead>
<tr>
<th>Time of measurement</th>
<th>Average</th>
<th>SD</th>
<th>Median</th>
<th>Min.</th>
<th>Max.</th>
<th>RQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>6,453.6</td>
<td>3,652.5</td>
<td>5,726.5</td>
<td>409</td>
<td>18,312</td>
<td>4,614</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7,118.0</td>
<td>4,282.3</td>
<td>6,305.5</td>
<td>1,014</td>
<td>20,338</td>
<td>6,038.8</td>
</tr>
<tr>
<td>Wednesday</td>
<td>6,401.3</td>
<td>4,059.6</td>
<td>5,284.5</td>
<td>861</td>
<td>23,347</td>
<td>4,916.5</td>
</tr>
<tr>
<td>Thursday</td>
<td>6,892.5</td>
<td>3,963.5</td>
<td>6,123</td>
<td>841</td>
<td>19,858</td>
<td>4,903</td>
</tr>
<tr>
<td>Friday</td>
<td>6,456.1</td>
<td>3,996.9</td>
<td>5,377</td>
<td>1,130</td>
<td>18,894</td>
<td>5,446</td>
</tr>
<tr>
<td>Mon-Fri</td>
<td>6,676.1</td>
<td>2,963.8</td>
<td>6,307.8</td>
<td>1,014</td>
<td>14,791</td>
<td>3,952.3</td>
</tr>
<tr>
<td>Saturday</td>
<td>7,356.0</td>
<td>4,506.4</td>
<td>6,434</td>
<td>853</td>
<td>2,041</td>
<td>5,231.5</td>
</tr>
<tr>
<td>Sunday</td>
<td>6,470.4</td>
<td>3,583.9</td>
<td>5,889</td>
<td>875</td>
<td>16,010</td>
<td>4,312</td>
</tr>
<tr>
<td>Sat-Sun</td>
<td>6,913.2</td>
<td>3,474.1</td>
<td>6,343</td>
<td>1,526</td>
<td>16,191</td>
<td>4,470.8</td>
</tr>
<tr>
<td>Whole week</td>
<td>6,743.8</td>
<td>2,883.7</td>
<td>6,261.6</td>
<td>1,781</td>
<td>15,169</td>
<td>3,656.4</td>
</tr>
</tbody>
</table>

**Table 4.** Types of activity and corresponding number of steps among
100 people with metabolic syndrome

<table>
<thead>
<tr>
<th>Type of physical activity</th>
<th>Sedentary type (N, %)</th>
<th>Low activity type (N, %)</th>
<th>Negligible activity type (N, %)</th>
<th>Active type (N, %)</th>
<th>Highly active type (N, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5,000 steps</td>
<td>27 (34)</td>
<td>34 (33)</td>
<td>23 (23)</td>
<td>11 (11)</td>
<td>5 (5)</td>
</tr>
<tr>
<td>5,000–7,499 steps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7,500–9,999 steps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 10,000 steps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 3.** Average daily number of steps measured by pedometer on
weekdays and weekends
with high levels of activity achieved > 12,500 steps/day. In contrast, for people leading a sedentary lifestyle, this figure was <5,000 steps/day, and in this group all activities leading to an increase in activity gave the best results and health benefits (reduction in blood pressure, BMI improvement). It is widely recognized that the target number of steps important for prophylaxis and/or treatment is 10,000 per day (a distance of 8 km). The range of 10,000–12,499 steps taken per day characterizes a person leading an active lifestyle. Highly active types are people whose daily number of steps taken is equal to or greater than 12,500. It is worth noting that physical activity that causes weight loss is between 12,000–15,000 steps per day [11, 12, 13].

In the group of 100 participants, 61 persons (61%) represented low or sedentary type of activity, while nearly a quarter of respondents – 23 (23%), were classified as negligible activity type. The average weekly physical activity of the participants was 6,743 (in 100 people) steps/day and ranged from 1,781–15,169; however, a great variation was observed in the study group. The largest number of steps taken was 23,347/day, while the smallest was 409 steps/day. These results are similar to the results of other researchers. In studies conducted in Łódź, Poland, the average number of steps in a group of healthy adult males aged 45–64 years was 6,707/day. The largest number of steps taken was 12,080/day, while the lowest was 2,191 steps/day [13]. Other authors present the results of studies in healthy individuals representing the general population aged 18–60 years, where the average number of steps taken measured with a pedometer was 6,838/day (the lowest number of steps taken was 5,766 on a Sunday, but the greatest number of steps was taken on a Tuesday – 7234) [14]. Tudor-Locke et al. [15] obtained values of 7,370±3,080 steps/day in a group of 109 healthy persons, in which the average age was 44.9±15.8.

However, in the long-term monitoring of physical activity, Tudor-Locke et al. [16] achieved higher values; the average number of steps taken by the respondents was 10,082±3,319/day.

Le Masurier et al. [17] observed that patients with chronic diseases tend to reach only 3500–5500 steps/day. The study by Nowicki et al. [18] demonstrated that chronically dialyzed patients took approximately 3450 steps during daily physical activity. The cross-sectional study conducted in a group of 60 chronically hemodialyzed patients and 16 healthy persons showed that the proportion of physically active people also changed with the age of the respondents. The authors observed that the proportion of physically active people also changed with the age of the respondents. The authors observed that the majority (68.8%) was within the age group <= 50 years. Eighty-four people (84%) were less active, i.e. their average number of steps was less than 10,000. Respondents aged 50–59 (70.2%) dominated in this group. A statistically significant negative correlation was found between age and physical activity.

Age correlated negatively with physical activity of patients in the study by Zahiri et al. [22]. Persons < 60 years old took an average of 5,933 steps/day and were about 34% more active than patients ≥ 60-years-old, whose average daily number of steps was 4,434. In another study, the number of physically active people also changed with the age of the respondents. The authors observed that the proportion of women exercising decreased with age from 37.62% to 28.92% (in the age groups ≤ 40 years and > 40 years, respectively) [10]. Also, Sequeira et al. [20] observed that the number of steps/day depended on the age of the respondents – the lowest recorded was in the oldest age group of 65–74 years of age.

Based on analysis of 42 studies carried out using a pedometer, Bohannon [23] reports that a higher average daily number of steps was reached in a group of people younger than 65, (9,448) compared with a group of people aged 65 and over (6,565). Thus, mainly people aged 65 and older were characterized by taking fewer steps than the recommended 10,000 steps a day.

The study by Stel et al. [24], conducted among 439 elderly people aged 69–92, showed that the average daily number of steps measured by pedometer was 3,577±2,255, but showed great variation in the study group. The greatest number of steps taken was 9,980/day, while the lowest was 21 steps/day.

Tudor-Locke et al. [15] demonstrated that physical activity decreases with increasing BMI and percentage of body fat.
The average number of steps performed by a person with a BMI <25 (percentage of body fat = 24.8) was 8,325/day, while the results of overweight and obese people were 7,035 steps per day (percentage of body fat = 28.3) and 6,006 steps per day (percentage of body fat = 38.3), respectively. In the present study, it was found that the highest percentage of persons with physical activity >10,000 steps/day were overweight, (20%) and the lowest among those with second degree obesity (11.1%). A statistically significant negative correlation was found between the average daily number of steps and BMI, as well as a statistically significant negative correlation between the average daily number of steps and WHR. Studies conducted among people with diabetes also show that physical activity decreases with increasing BMI [3]. The authors of the cited study found significant differences in the number of steps/day between the BMI categories (from normal weight to third degree obesity). These differences were most apparent between higher degrees of obesity (2nd and 3rd) and normal weight. Nowicki et al. also found statistically significant correlations between the number of steps during the period between dialysis and body weight, BMI, lean body mass and body fat [18]. Another study proved that the percentage of physically active respondents decreased with increasing BMI (from 35 to 31%) [10]. The number of steps/day measured with a pedometer was negatively correlated with BMI in the study by Chan et al. [19]. The authors of the cited study also observed that a smaller number of steps/day was associated with elevated BMI and higher waist circumference. The respondents' physical activity decreased with increasing BMI in other studies in which the average daily number of steps in persons with normal weight, overweight and obesity was 12,640, 12,155 and 8,923, respectively.

The results of the study by Clemens et al. [25], in which a pedometer was used as a research tool, clearly indicate the preference of a sedentary lifestyle among overweight people during days off from work, in which the average daily number of steps within five working days amounted to 10,350, and decreased to 9,100 during the two days off work. Clemens et al. demonstrated that a group of overweight people displayed a significantly lower average daily number of steps compared to a group of people of normal weight (10,002 and 11,273, respectively). Comparing the two studied groups in terms of average daily number of steps appropriate for each day of the week, the presented study was unable to show significant differences, except Sunday, when the group of overweight people displayed significantly lower number of steps compared to those of normal weight.

It is worth noting that the relationship between obesity and physical activity has a two-sided character – reduced activity leads to obesity, but obesity may result in limitation of physical activity. Chan et al. [19] also obtained the consistent observation that patients taking > 9,000 steps/day are more often of normal weight and people taking < 5,000 steps/day are more likely to be obese.

In Poland, studies of physical activity were previously performed with the use of the International Questionnaire of Physical Activity (IPAQ) in different population groups (young people, pregnant women, women at reproductive age) [26, 27, 28, 29]. Studies using objective measurements (pedometers, accelerators) are needed to validate those questionnaires.

CONCLUSIONS

1. The majority of people with metabolic syndrome represent a low or sedentary activity type.
2. There is a wide variety of physical activity among those with metabolic syndrome.
3. Decrease of physical activity corresponds to increasing age, BMI and WHR, but the presented study did not find differences between males and females.
4. No significant differences in physical activity were observed between working days and free days (weekends).

Acknowledgement

The study was funded by a Grant from the Medical University of Białystok, Poland.

REFERENCES