Associations of Body Mass Index and Body Height With Low Back Pain in 829,791 Adolescents

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Body mass index (BMI) (calculated as weight (kg)/height (m)²) and height are linked to the pathogenesis of low back pain, but evidence-based confirmation is lacking. We examined the prevalence of low back pain in adolescents and its association with BMI and height. Disability clauses (official military limitations related to a person’s health status) indicating low back pain severity were divided according to symptoms of low back pain alone and symptoms of low back pain with objective corroborating findings. All 829,791 males and females undergoing mandatory premilitary recruitment examinations since 1998 were included. Logistic regression models assessed the relationships of BMI and height with low back pain. Prevalence of low back pain was 0.2% for both males and females with objective findings and 5.2% for males and 2.7% for females without objective findings. Higher BMI was significantly associated with low back pain in males (for overweight, odds ratio = 1.097, P < 0.001; for obese, odds ratio = 1.163, P < 0.001) and in females (for overweight, odds ratio = 1.174, P < 0.001; for obese, odds ratio = 1.211, P < 0.001). Height was associated with increased risk of low back pain in both genders. Odds ratios for low back pain in the tallest group compared with the shortest group were 1.438 (P < 0.001) for males and 1.224 (P < 0.001) for females. Low back pain with or without objective findings was associated with overweight and obesity as well as with height.

adolescents; body mass index; height; low back pain; obesity; weight

Abbreviation: BMI, body mass index.
possible associations of BMI and height with low back pain in this group.

MATERIALS AND METHODS

Source of data

At the age of 17 years, most male and female Israelis are required by law to report to the military recruiting center to undergo a rigorous medical evaluation for the purpose of military classification. The evaluation includes a medical questionnaire filled in by the candidate and a medical report signed by his or her primary care physician. Height and weight are measured by a trained medical technician. The candidates then undergo complete histories and physical examinations by physicians on the medical board and are referred to specialists or for auxiliary tests if needed.

After completing the medical evaluation, each subject is assigned a global medical profile as well as numerical codes that represent the subject’s medical status and diagnoses. These codes are defined according to the Israeli Regulations of Medical Fitness Determination, and they represent specific medical conditions.

The subject’s height and weight measurements, medical profiles, and numerical code(s) for an existing disability are stored in a central computerized database. All of the data in our study were extracted from this database with approval of the Israel Defense Forces Medical Corps institutional review board and with strict observation of patient anonymity.

Study population

The study population included 829,791 adolescents who were evaluated by the regional recruitment centers between 1998 and 2010 and whose height and weight measurements were on file.

Definitions for group assignment

BMI groups were classified according to the US Centers for Disease Control and Prevention’s age- and sex-matched percentile grading: underweight (<5%), normal weight (5%–85%), overweight (85%–95%), and obese (95%). The study population was further divided into 5 groups according to height quintiles separately for males and females. All subjects diagnosed as having low back pain were classified into 1 of 2 severity groups. Group A had no corroborative objective findings (e.g., dropfoot, weakness, urinary incontinence) in the physical examination or on imaging studies (i.e., computerized tomography, magnetic resonance imaging, myelography). Group B did have objective findings that correlated with the patient’s diagnosis (e.g., herniated disk, spinal stenosis).

Data analysis

The associations of BMI and height with low back pain were assessed by logistic regression analysis that applied the following models: binary models when low back pain was considered as a dichotomous variable and multinomial models with no low back pain as the base category for comparison when low back pain was classified into groups A and B. BMI and body height were considered as ordinal variables according to the aforementioned groups and as continuous variables. Results from logistic regression analyses were presented as odds ratios, 95% confidence intervals, and P values.

Linear regression models were performed to examine trends in obesity and overweight during the study period and to examine the trend in low back pain prevalence. We found a significant trend in obesity and overweight prevalence but not in low back pain prevalence (data not shown).

A multivariable analysis including various sociodemographic factors such as socioeconomic status, country of origin, immigration status, and intelligence quotient was also performed. The results were similar to those presented in this study, and we did not include them here.

All statistical analyses were performed by using SPSS, version 19.0, software (SPSS, Inc., Chicago, Illinois).

RESULTS

This study included 470,125 adolescent males and 359,666 adolescent females. Characteristics of the study population are presented in Tables 1 and 2. The mean BMI was 22.04 (standard deviation (SD), 3.8) for males and 21.8 (SD, 3.7) for females, and the mean height was 174.1 (SD, 6.8) cm for males and 162.1 (SD, 6.25) cm for females. Of the total population of 829,791 participants, 25,416 (5.4%) males and 10,442 (2.9%) females had low back pain. For the males, the prevalence of low back pain was 5.2% for group A and 0.2% for group B. For the females, the prevalence of low back pain was 2.7% for group A and 0.2% for group B.

Association between low back pain and BMI

The prevalence of low back pain was lowest for the underweight adolescents in group A (4.8% of males and 2.6% of females) as well as for those in group B (0.1% of males and 0.2% of females). Higher BMI was associated with low back pain (Tables 3 and 4). There was a dose-response curve between BMI and the odds ratio for low back pain among both males and females. An association between BMI and low back pain was also found when low back pain with and without objective findings on imaging studies or physical examination was analyzed separately (Tables 3 and 4). The highest odds ratios were measured for obese females in group B (odds ratio = 1.492, 95% confidence interval: 1.109, 2.009; P = 0.008).

Association between low back pain and height

Height was also positively associated with the prevalence of low back pain in both males and females. The odds ratio for low back pain in the highest quintile of height was 1.438 (95% confidence interval: 1.380, 1.499; P < 0.001) for males and 1.224 (95% confidence interval: 1.154, 1.300; P < 0.001) for females compared with the lowest quintile. There were also linear trends in the odds ratios for the height quintiles in both males and females (Tables 3 and 4). The same trends emerged when the low back pain population
was divided into groups A and B (Tables 3 and 4). The odds ratios for low back pain were positively associated with height and were even higher in group B compared with group A in all height quintiles. That is, the likelihood of experiencing low back pain with objective findings was higher among tall participants of both genders.

### Table 1. Body Mass Index and Height Categories and the Prevalence of Low Back Pain by Severity in Adolescent Males, Israel, 1998–2010

<table>
<thead>
<tr>
<th>Body mass index categoryd</th>
<th>Total No.</th>
<th>No Low Back Pain</th>
<th>Low Back Pain</th>
<th>Low Back Pain (Less Severe)a</th>
<th>Low Back Pain (More Severe)b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>31,301</td>
<td>28,211</td>
<td>6.73</td>
<td>1,545</td>
<td>6.08</td>
</tr>
<tr>
<td>Normal weight</td>
<td>357,341</td>
<td>319,285</td>
<td>76.15</td>
<td>19,028</td>
<td>74.87</td>
</tr>
<tr>
<td>Overweight</td>
<td>48,301</td>
<td>42,689</td>
<td>10.18</td>
<td>2,806</td>
<td>11.04</td>
</tr>
<tr>
<td>Obese</td>
<td>33,187</td>
<td>29,113</td>
<td>6.94</td>
<td>2,037</td>
<td>8.01</td>
</tr>
<tr>
<td>Total</td>
<td>470,125</td>
<td>419,293</td>
<td>100</td>
<td>25,416</td>
<td>100</td>
</tr>
</tbody>
</table>

Height category

| Quintile 1 (130–168 cm) | 96,034    | 91,558           | 20.59         | 4,476                       | 17.61                       |
| Quintile 2 (169–172 cm) | 97,648    | 92,672           | 20.84         | 4,976                       | 19.58                       |
| Quintile 3 (173–176 cm) | 109,424   | 103,592          | 23.29         | 5,832                       | 22.95                       |
| Quintile 4 (177–180 cm) | 89,367    | 84,337           | 18.96         | 5,030                       | 19.79                       |
| Quintile 5 (181–210 cm) | 77,652    | 72,550           | 16.31         | 5,102                       | 20.07                       |
| Total                    | 470,125   | 444,709          | 100.00        | 25,416                      | 100                         |

a Low back pain without clinical or imaging corroboration.
b Low back pain with clinical or imaging corroboration.
c Body mass index is weight (kg)/height (m)^2.
d Body mass index groups were classified according to the age- and sex-matched percentile grading of the US Centers for Disease Control and Prevention (Atlanta, Georgia): <5%, underweight; 5%–<85%, normal weight; 85%–<95%, overweight; ≥95%, obese.

### Table 2. Body Mass Index and Height Categories and the Prevalence of Low Back Pain by Severity in Adolescent Females, Israel, 1998–2010

<table>
<thead>
<tr>
<th>Body mass index categoryd</th>
<th>Total No.</th>
<th>No Low Back Pain</th>
<th>Low Back Pain</th>
<th>Low Back Pain (Less Severe)a</th>
<th>Low Back Pain (More Severe)b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>16,137</td>
<td>15,696</td>
<td>4.49</td>
<td>441</td>
<td>4.22</td>
</tr>
<tr>
<td>Normal weight</td>
<td>290,558</td>
<td>282,326</td>
<td>80.84</td>
<td>8,232</td>
<td>78.84</td>
</tr>
<tr>
<td>Overweight</td>
<td>37,903</td>
<td>36,648</td>
<td>10.49</td>
<td>1,255</td>
<td>12.02</td>
</tr>
<tr>
<td>Obese</td>
<td>15,068</td>
<td>14,554</td>
<td>4.17</td>
<td>514</td>
<td>4.92</td>
</tr>
<tr>
<td>Total</td>
<td>359,666</td>
<td>349,224</td>
<td>100</td>
<td>10,442</td>
<td>100</td>
</tr>
</tbody>
</table>

Height category

| Quintile 1 (130–168 cm) | 82,884    | 80,666           | 23.10         | 2,222                       | 21.28                       |
| Quintile 2 (158–160 cm) | 64,410    | 62,629           | 17.93         | 1,781                       | 17.06                       |
| Quintile 3 (161–164 cm) | 87,120    | 84,642           | 24.24         | 2,478                       | 23.73                       |
| Quintile 4 (165–167 cm) | 56,599    | 54,878           | 15.71         | 1,721                       | 16.48                       |
| Quintile 5 (168–210 cm) | 68,653    | 66,413           | 19.02         | 2,240                       | 21.45                       |
| Total                    | 359,666   | 349,224          | 100           | 10,442                      | 100                         |

a Low back pain without clinical or imaging corroboration.
b Low back pain with clinical or imaging corroboration.
c Body mass index is weight (kg)/height (m)^2.
d Body mass index groups were classified according to the age- and sex-matched percentile grading of the US Centers for Disease Control and Prevention (Atlanta, Georgia): <5%, underweight; 5%–<85%, normal weight; 85%–<95%, overweight; ≥95%, obese.
Table 3. Odds Ratios for Low Back Pain in Relationship to Body Mass Index and Height Category by Severity in Adolescent Males, Israel, 1998–2010

<table>
<thead>
<tr>
<th>Body mass index$^e$ category$^f$</th>
<th>Low Back Pain</th>
<th>Low Back Pain (Less Severe)$^b$</th>
<th>Low Back Pain (More Severe)$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR$^d$ 95% CI</td>
<td>P Value</td>
<td>OR$^d$ 95% CI</td>
</tr>
<tr>
<td>Underweight</td>
<td>0.923 0.875, 0.974</td>
<td>0.003</td>
<td>0.939 0.889, 0.991</td>
</tr>
<tr>
<td>Normal weight</td>
<td>1.000 Referent</td>
<td></td>
<td>1.000 Referent</td>
</tr>
<tr>
<td>Overweight</td>
<td>1.097 1.053, 1.142</td>
<td>&lt;0.001</td>
<td>1.086 1.041, 1.132</td>
</tr>
<tr>
<td>Obese</td>
<td>1.163 1.109, 1.219</td>
<td>&lt;0.001</td>
<td>1.164 1.110, 1.222</td>
</tr>
<tr>
<td>Body mass index$^g$</td>
<td>1.016 1.013, 1.2</td>
<td>&lt;0.001</td>
<td>1.015 1.012, 1.018</td>
</tr>
<tr>
<td>Quintile 1 (130–168 cm)</td>
<td>1.000 Referent</td>
<td></td>
<td>1.000 Referent</td>
</tr>
<tr>
<td>Quintile 2 (169–172 cm)</td>
<td>1.098 1.054, 1.145</td>
<td>&lt;0.001</td>
<td>1.12 1.073, 1.17</td>
</tr>
<tr>
<td>Quintile 3 (173–176 cm)</td>
<td>1.152 1.106, 1.199</td>
<td>&lt;0.001</td>
<td>1.189 1.141, 1.24</td>
</tr>
<tr>
<td>Quintile 4 (177–180 cm)</td>
<td>1.220 1.171, 1.271</td>
<td>&lt;0.001</td>
<td>1.267 1.213, 1.324</td>
</tr>
<tr>
<td>Quintile 5 (181–210 cm)</td>
<td>1.438 1.380, 1.499</td>
<td>&lt;0.001</td>
<td>1.508 1.443, 1.575</td>
</tr>
<tr>
<td>Height$^h$</td>
<td>1.019 1.017,1.022</td>
<td>&lt;0.001</td>
<td>1.018 1.016, 1.020</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; OR, odds ratio.
$^a$ Low back pain without clinical or imaging corroboration.
$^b$ Low back pain with clinical or imaging corroboration.
$^c$ Odds ratios from binary logistic regression.
$^d$ Odds ratios from multinomial logistic regression with no low back pain as the base category.
$^e$ Odds ratios from multinomial logistic regression with no low back pain as the base category.
$^f$ Body mass index groups were classified according to the age- and sex-matched percentile grading of the US Centers for Disease Control and Prevention (Atlanta, Georgia): <5%, underweight; 5%–85%, normal weight; 85%–95%, overweight; >95%, obese.
$^g$ Body mass index analyzed as a continuous variable; each increase of 1 body mass index unit was associated with increased odds of low back pain.
$^h$ Height analyzed as a continuous variable; each increase of 1 cm was associated with increased odds of low back pain.

DISCUSSION

Understanding the complicated nature of low back pain is a daunting challenge. Although low back pain is considered a common and disabling medical condition, its etiology is still not fully understood and its true prevalence throughout life and, in particular, during the first decades of life, is unknown. Possible associations of weight and height with low back pain have intrigued researchers for many years. Although low back pain pathophysiology has been associated with body measures by some experts, there is no consensus on this subject in the literature. Today, with obesity becoming a rapidly growing problem worldwide, its possible association with the development of low back pain has gained even greater importance. It has been postulated that, among other serious medical conditions, obesity could explain the concomitantly growing prevalence of low back pain among young adults (14).

Our analysis provides a detailed summary of the prevalence of low back pain in a large Israeli adolescent population (i.e., boys and girls aged 17 years) and pertinent information about its associations with BMI and height. The most intriguing findings of our study are the dose-dependent curves between low back pain and BMI or height. The odds ratios for low back pain with and without correlating objective findings increased with increasing BMI values (BMI ranging from less than 19 to more than 35) and also with increasing height (ranging from 130 to 215 cm) for both males and females (Tables 1 and 2). Our findings indicate that the prevalence of substantial low back pain might be less common than would be expected on the basis of previously published research (1). Indeed, there is a wide range of reported prevalence in the literature because of the inherent limitations of self-reporting and also because the symptoms rarely result in consultation (1).

The diagnosis of low back pain was 2.14 times as common in the young males as in the young females of our study population, although the prevalence of low back pain with objective findings was equal for both genders and rare (only 0.2% of the population). Specifically, when we refined our results by adding an objective finding to the diagnosis of low back pain, only a small fraction of our study population had objective physical examination or imaging findings that correlated with their symptoms of low back pain. Comparisons of our findings with the prevalence of low back pain in children, adolescents, and young adults as reported in the literature revealed that the reported prevalence of low back pain is slightly higher. Estimates of low back pain prevalence in children and adolescents vary widely among studies depending on the age of study participants and on methodological differences, particularly in terms of how low back pain is defined. Watson et al. (15) reported a prevalence of

24% in schoolchildren aged 11–14 years in northwest England, whereas Balagué et al. (16) reported a prevalence of 26% in schoolchildren aged 12–17 years in Switzerland. Even studies that recorded pain over a very short time interval (e.g., point prevalence) revealed that as many as 1 child in 20 may be experiencing low back pain at any given time (17–19). Some authors have reported that self-reported low back pain–related disability in childhood is common. Watson et al. (15) conducted a large community study and reported that 94% of symptomatic children aged 11–14 years reported difficulty with 1 or more of the activities listed in a modified version of the Hannover Functional Ability Questionnaire (20). However, when using a similar disability instrument, Salminen et al. (21) reported limitations in only 18% of subjects. Despite being reported as a common and often limiting experience, few children report the severity of low back pain as sufficient to prevent them from attending school or playing sports (18, 22, 23).

A comparison of the above-cited reports with our study reveals both common ground and differences. The first, and what we believe to be the most important, difference is the method used to gather information in our study, which was based on a thorough medical assessment by a physician and not on self-reported information. Our data were also supported by imaging findings and expert consultations for all subjects for whom there were objective findings. This could explain our relatively lower prevalence compared with other studies. On the other hand, only a fraction of the low back pain reported by our study participants had correlating objective findings to explain the pain, which was similar to the data in other reports. We also found more males than females to be experiencing low back pain, but the numbers were equal when we refined their low back pain symptoms with objective findings. This is in contrast to most reports, which found higher rates of low back pain among females (15, 17, 19).

The prevalence of low back pain extrapolated from the data accumulated for this article is based on a large population of adolescents, and low back pain was found to be a fairly common condition among them. Although low back pain can be associated with serious pathology, such a presentation is actually rare and symptoms are usually mild, nonspecific, and self-limiting. When we looked into the association between BMI and low back pain with and without objective findings, our main finding was a direct link between BMI and the odds ratios for low back pain symptoms among both males and females. Specifically, subjects with higher BMIs had higher odds ratios for low back pain.

An association between low back pain symptoms and increased BMI has been considered before (24), and several theories about its pathophysiology through mechanical
loading have been suggested (4–10). Theories based on metabolic activity, such as adipose tissue that is metabolically active releasing a multitude of proinflammatory cytokines, and key mediators of metabolism termed the "adipokines" have also been proposed (25). In a systematic literature review, Leboeuf-Yde (26) studied the relationships of body weight and BMI with low back pain symptoms. That author did not find a strong association between low back pain and body weight or BMI. Deere et al. (27) reported that obese adolescents were more likely to report musculoskeletal pain. In a meta-analysis from 2009, Shiri et al. (28) reported that, in a more heterogeneous population group, overweight and obesity similarly increased the risk of low back pain. In a review from 1999, Balagué et al. (29) stated that height but not body weight has been found to be significantly associated with low back pain.

Other publications further emphasize the association between BMI and low back pain symptoms and attempt to uncover its pathophysiology. Arana et al. (30) described the association between the magnetic resonance imaging findings (Modic changes and associated features) of patients with low back pain symptoms and above-normal BMI. Webb et al. (31) found BMI to be an important independent predictor of back pain and its severity. Although low back pain is discussed extensively in the literature, few studies have addressed its pathophysiology, and our understanding of the causative relationships between increased BMI or body height and low back pain remains poor.

Our study has several limitations. The main one lies in its being cross-sectional and unable to explain the pathophysiology behind the findings or to definitely establish a temporal relationship between anthropometric variables and low back pain. The second weakness is that we studied a single age group (those 17 years of age). We also report a higher rate of low back pain in males compared with females, which is the opposite finding of most published reports. The higher rates in males were in the subjective group only; the rates in males and females were equal in the objective groups. This difference might be related to the situation at the diagnosis point—a prerecruitment examination. Males might tend to report more in this situation, which might explain the difference of the subjective group but not in the objective group.

To the best of our knowledge, the current work is the largest study of its kind, and its strength lies in our access to a uniquely extensive database in which all the relevant information on a large study population is stored. We believe that the results validate the relationship between BMI and low back pain that has been suggested in the past but has not been established by such large numbers before. One explanation for this finding is that, although an elevated BMI is probably not a strong risk factor for low back pain, it is nevertheless an important one because of its growing prevalence in Western populations. The evidence of an association between low back pain and increased height or weight suggests a possible role for those body measures in the pathophysiology of low back pain. The exact mechanism leading to the relationship between body measures and low back pain symptoms has yet to be elucidated by further studies to connect our epidemiologic findings to the processes leading to the development of low back pain. We also believe that further study of the mechanism behind this relationship would help us understand the impact of weight loss as well as better ways to address taller patients with back pain.

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O. H. and A. F. contributed equally to this study, and each should be considered as first author.

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REFERENCES