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The positive relationship between BMI and mortality is one of the major reasons underlying our perception of obesity as a disorder meriting both treatment and preventive efforts. Several epidemiological studies have found a linear, J – or U-shaped relationship between BMI and mortality. In the current issue of *OBESITY FACTS* Korkeila and co-workers (Finland) [1] make use of the Finnish Twin Study (FTS) to analyze BMI related mortality over a 22-year follow-up period. The study is to be commended for application of the co-twin control design and the considerable efforts taken to exclude or control for all indications of comorbidities and high-risk conditions and behaviors. The FTS included all same sexed twins born in Finland prior to 1958 and with both twins alive in 1967. The current analysis was based on those 19,993 participants aged 24–60 years in 1981 who had responded to questionnaires distributed in 1975 and 1981. The careful exclusion of all individuals diagnosed with a disease prior to 1983 and of non-working subjects left a final analysis sample of 15,424 subjects. Of these apparently healthy individuals 1,163 subjects (787 males) had died by 2003. During the 22-year follow-up period male mortality rates increased linearly with BMI as calculated from self-reported height in 1975 and weight in 1975 and 1981; coronary heart disease (CHD) was the cause of death most related to BMI. In females, however, no relationship between BMI and mortality (and death of CHD) was detected. Upon restriction of the analysis to subjects with a stable weight between 1975 and 1981 the risk of death due to CDH remained elevated. For pairs discordant for death from CHD, there was an increased risk of death associated with BMI z-score at baseline. The authors assume that their rigorous exclusion of ill and potentially ill (i.e. non-working subjects) underlies the linear relationship between BMI and mortality in men and its absence in females.

Myslobodsky and Ingraham (USA) [2] propose a strategic preventive focus on early life to combat the obesity epidemic. By dwelling on the ancient Greek parable ‘The fox knows many things, but the hedgehog knows one big thing’ the au-

thors are critical of our conception of multifactorial obesity, which leads us to conclude that there is no single solution to the obesity epidemic and to attempt to dissect all underlying etiologies and mechanisms. This conceptualization of obesity has led to several modes of treatment, none of which, however, have proven successful on a larger scale. The authors’ perspective suggests that behavior modification along with diet, exercise and drug therapy would remain the province of the fox’s trial and error anti-obesity measures. By pursuing the hedgehog strategy of early intervention, more might be gained. Nevertheless, to quote the authors, ‘the proof of this approach, of course, lies in empirical validation of successful intervention through prospective longitudinal trials’.

Myslobodsky (USA) [3] used Ingenuity Pathway Analysis as a tool for automated discovery and visualization of molecular interactions of leptin, corticotrophin-releasing factor and neuropeptide Y. In ingestion controlling networks these peptides are commonly combined into the units designated as ‘maximal motifs’. Based on his results, Myslobodsky suggests to view the three peptides as a therapeutically relevant functional unit and discusses the implications for future pharmacotherapeutic research.

Rendo et al. (Spain) [4] has reviewed the current findings pertaining to the role of *FTO* in pediatric obesity. They summarize the literature on the effects of the risk allele on anthropometry, food intake, satiety, and energy expenditure with a primary focus on young subjects. Whereas the effects of the *FTO* risk allele on childhood and adolescent BMI, waist circumference and fat mass are well documented, more research is required to pinpoint via which means these effects are induced. In most studies, the rs9939609 single nucleotide polymorphism was investigated; the frequency of the obesity risk allele ranged from 0.38 to 0.49 in different European populations. It is unclear whether or not the risk allele has an influence on weight loss during an intervention program.

Steed and coworkers (UK) [5] determined prevalence rates for overweight and obesity in the intestinal bowel disease

(IBD) community in Tayside, Scotland; previous studies had reported on a lowered prevalence of obesity in such patients. Out of a total of 1,269 IBD patients 489 fulfilled the inclusion criteria. 57 and 19% of this subgroup were classified as overweight and obese, respectively. These figures were comparable to the Scottish reference population. The BMI distribution of patients with Crohn's disease did not differ from that of patients with ulcerative colitis; surgery rates were higher in the normal-weight patients than in those being overweight or obese. The authors discuss potential implications of these findings for treatment and comorbidity of IBD patients.

According to the health belief model the practice of a health behavior can be understood by knowing whether the person perceives a health threat as well as health benefits from a particular practice to reduce that threat. Wouters et al. (the Netherlands) [6] applied this model to participation in a physical activity program by assessing 58 consecutive treatment-seeking obese individuals and an equal number of obese 'sedentary' controls. The groups did not differ significantly with respect to education level, age or BMI; however, a significantly larger proportion of the treatment seekers were female (79 vs. 55%). Fear of injury was higher and perceived health benefits were lower in the non-exercisers who also more often attributed their overweight to physical causes and believed overweight to be irreversible. Unfortunately the authors do not comment on the rates of past injuries in both groups, which conceivably may have had an influence on the results. Wouters and colleagues argue that cognitions of obese individuals need to be targeted in order to increase participation in physical activity programs.

Farah et al. (Ireland) [7] retrospectively assessed pregnancy outcomes in morbidly obese women who delivered a

baby in 2007 in a large tertiary referral university hospital in Dublin. The study was confined to women with singleton pregnancies, who delivered a baby weighing 500 g or more. Out of the 8,246 deliveries the analysis was confined to those 5,824 who had their BMI (based on measured weight and self-reported height) calculated at their first antenatal visit during the first trimester. 95 of these females had grade 3 obesity. The pregnancies of these women were complicated by hypertension in 35.8% and diabetes mellitus in 20.0%. The induction and cesarean section rates were high (42.1 and 45.3%, respectively). The authors provide detailed information on obstetric outcomes in relationship to the different weight categories. A more focused obstetric approach to this high-risk group of females is recommended.

In marked contrast to developed countries the influence of socioeconomic status on obesity in the developing countries is commonly assumed to be positive. Findings have however been inconsistent, possibly reflecting the dependency on the stage of industrial development. Mbada et al. (Nigeria) [8] now report an inverse relationship between SES and obesity in 1,067 adults aged 30–60 years from a semiurban Nigerian population. SES was assessed with both a structured questionnaire and a pictorial self-rating ladder. The prevalence rates for overweight and obesity were 19.9 and 7.1%, respectively. Among males, the risks of obesity among individuals in the lower SES were almost twice that of persons in the middle and higher SE strata. Females of lower SES had a risk of obesity three times that of females of middle SES and five times that of females of higher SES. Interestingly, mean BMI slightly decreased across 30–39, 40–49 and 50–60 year olds of low and high SES. Only those individuals of middle SES showed the increase with age typically observed in developed countries.

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