COHORT PROFILE

Cohort Profile: The Health2006 cohort, Research Centre for Prevention and Health

Betina H Thuesen,1* Charlotte Cerqueira,1 Mette Aadahl,1 Jeanette Frost Ebstrup,1 Ulla Toft,1 Jacob P Thyssen,2 Runa Vavia Fenger,1 Lars-Georg Hersoug,1 Jesper Elberling,1 Oluf Pedersen,4,5,7 Torben Hansen,5,6 Jeanne Duus Johansen,2 Torben Jørgensen1 and Allan Linneberg1

1Research Centre for Prevention and Health, Copenhagen University Hospital Glostrup, The Capital Region of Denmark, Denmark, 2National Allergy Research Centre, Department of Dermato-Allergology, Copenhagen University Hospital Gentofte, Denmark, 3Danish Research Centre for Chemical Sensitivities, Gentofte University Hospital, University of Copenhagen, Copenhagen, Denmark, 4Hagedorn Research Institute and Steno Diabetes Centre, Gentofte, Denmark, 5The Novo Nordisk Foundation Centre for Basic Metabolic Research, Faculty of Health Sciences, University of Copenhagen, Copenhagen, Denmark, 6Faculty of Health Sciences, University of Southern Denmark, Odense, Denmark and 7Faculty of Health Sciences, University of Aarhus, Aarhus, Denmark

*Corresponding author. Research Centre for Prevention and Health, Glostrup University Hospital, Nordre Ringvej 57, build. 84/85, DK-2600 Glostrup, Denmark. E-mail: betina.heainsbaek.thuesen@regionh.dk

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Introduction

The Health2006 cohort was set up to address research questions dealing with lifestyle-related chronic diseases such as coronary heart disease, diabetes, musculoskeletal disorders, asthma, allergy, chronic lung diseases and mental disorders. The participants in the Health2006 cohort were drawn as a random sample from the background population aged 18–69 years living in the south-western part of the greater Copenhagen area. A total of 3471 persons (participation rate of 44.7%) entered the study and participated in a health examination between June 2006 and June 2008. Five-year follow-up examinations are ongoing. Two questionnaires were completed by all participants, covering a broad range of questions about symptoms and diagnoses of diseases, physical activity, smoking, alcohol, eating habits, perceived stress, five-factor personality traits, mental problems, quality of life, socioeconomic variables and many other issues. The physical examination included measurements of cardio-respiratory fitness, muscle strength, lung function, allergy and anthropometric measures. In addition, collection of blood samples was used for genotyping and measurements of metabolic and nutritional biomarkers.

Why was the cohort set up?

Since 1964, general population-based cohorts have been examined at the Research Centre for Prevention and Health (RCPH). The first study, initiated in 1964 by Leif Hagerup, investigated coronary risk factors in 50-year-olds.1 Since then, several new cross-sectional and prospective cohort studies have been performed at the RCPH and these cohorts were recently described.2 The Health 2006 study was initiated by principle investigators Allan Linneberg and Torben Jørgensen to continue the collection of data and obtain biological material for the biobank for future research. The Health2006 study aimed to address research questions dealing with lifestyle-related chronic diseases. The main focus of most previous studies at the RCPH was on coronary heart disease (CHD) and diabetes risk factors. The Health2006 study was also designed to cover CHD-related health issues, but in contrast to most previous studies, the Health2006 study was designed to investigate chronic disease in a broader sense. Besides CHD and diabetes, the study focused on asthma, allergy, chronic lung diseases, eczemas, chemical intolerance, musculoskeletal disorders, osteoporosis and mental disorders. In addition, the aim was to create a solid foundation for future research by assessing a number of phenotypic descriptions of the individuals. The phenotypic descriptions cover five components:

- Morphological component, which comprises measures as regards weight, amount of fat, fat distribution, bone density and calcium metabolism (PTH, Ca++, D-vitamin).
- Cardio-respiratory component, which comprises general fitness (maximal or submaximal fitness tests), blood pressure, pulse and lung function.
• Muscle component, which comprises muscle power and strength.
• Mental component, which comprises personality, intelligence, social network, coping characteristics, vulnerability, general self-efficacy and anxiety of the individual, and stress hormones.
• Metabolic components, which comprises a number of biomarkers within different areas [e.g. lipid metabolism (cholesterol, free fatty acids, apolipoproteins), glucose metabolism (glucose, insulin, C-peptide, proinsulin) and thyroid metabolism (thyroid-stimulating hormone, free thyroxine 3 and 4 and anti-thyroperoxidase)].

The main questionnaire on lifestyle factors and general health used in this cohort is also used in the more recent Health2008 (n = 795) and Health2010 (n = 1522) cohorts. In addition, most procedures from the physical examination in Health2006 are also included in these cohorts. Since the participants in the Health2008 and Health2010 cohorts are drawn from the same background population as the Health2006 cohort, data from the Health2006 can be supplied with corresponding data from the recent cohorts to achieve more power for some research questions. For example, in genetic studies it is also possible to use data from the Health2006 cohort in combination with data from some of our older cohorts like the Inter99 cohort or the Monica cohorts. However, one should then be aware that there might be disagreements between the wordings used in the questionnaires and that the procedures used at the physical examinations may have changed over time. It is also important to note that a small number of individuals may by chance have been included in more than one cohort since the cohorts are random samples drawn from the same background population. By combining data from the Health2006 cohort with data from other of our cohorts it is possible to identify participants who are found in more than one cohort.

Who is in the cohort?
The participants in the Health2006 cohort were drawn as a random sample from the background population aged 18–69 years, living in 11 municipalities in the south-western part of the greater Copenhagen area. In February 2006, a sample of 7931 persons with Danish citizenship and born in Denmark was obtained from the Danish Central Personal Register, Ministry of Internal Affairs. Of the 7931 persons in the sample, 161 were not eligible for invitation because of, for example, death or emigration, and hence 7770 persons were invited by mail to participate in the study. The invitation included information on the physical examination and a short description of the tests that were going to take place. A total of 3471 persons (44.7%) entered the study and participated in the health examinations at the RCPH, which took place between June 2006 and June 2008. Participants were asked to meet fasting at RCPH at the day of examination, and to refrain from smoking at least 1 h prior to the examination. In addition, users of antihistamine medication were asked not to use their medication 3 days prior to the examination and users of inhaled (inhalers) medications for lung disease were asked to avoid use of the inhalers on the day of examination. Pregnant women were excluded. A written informed consent form was obtained from all participants and the study was approved by the Ethical Committee of Copenhagen County (KA-20060011) and the Danish Data Protection Agency.

How often have they been followed up?
A 5-year follow-up examination of all participants in the Health2006 cohort has been initiated in 2011 and is scheduled to terminate in November 2012. In addition, the national registers will be used to follow the
participants and to evaluate potential differences between those who attend the re-examinations and those who have been lost to follow-up. Due to the high quality and extended use of nation-wide registries in Denmark, only potential emigrants will be lost due to follow-up in the national registries.

What has been measured?
The data collected from the Health2006 cohort are summarised in Table 2.

Questionnaires
Two questionnaires were answered by all participants in the Health2006: a main questionnaire on lifestyle factors and general health and a supplementary questionnaire on mental health. The main questionnaire will be available in an English version by February 2013. Participants answered a broad range of questions about symptoms and diagnoses of diseases, perceived stress, five-factor personality traits, mental problems, lifestyle, quality of life, socioeconomic variables and many other issues. The main questionnaire included validated questions for assessment of upper and lower airways symptoms as well as atopic dermatitis and hand eczema. The main questionnaire was also used for assessment of physical activity. Participants were asked to categorize themselves into one of four groups of leisure time activity. In addition, all participants answered a more detailed questionnaire on physical activity by filling in the amount of time spent in different physical activity MET (metabolic equivalent) intensity levels during leisure time and commuting and at work. The activities also included sleep and sedentary behaviour, e.g. TV-viewing and sitting during work, and provide detailed information on the type, duration and intensity of physical activity. A 24-hMET-score can be calculated by multiplying time spent on an activity level by an assigned MET-value and adding the activity levels. The questionnaire is a revised version of the Physical Activity Scale that has previously been validated against activity diary and objective measures such as accelerometry and maximum oxygen uptake.

Dietary intake was measured using a self-administered 48-item food frequency questionnaire (FFQ). From this the Dietary Quality Score (DQS) was calculated. Briefly, the DQS was developed as a crude index of the overall quality of dietary habits. The score was based on questions regarding the intake of fruits, vegetables, fish and different types of fat. The FFQ and the development and validation of the DQS have previously been described in detail.

Table 1 Register-based characteristics of responders and non-responders

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Measure</th>
<th>Responders (n = 3471)</th>
<th>Non-responders (n = 4299)</th>
<th>Test for difference between responders and non-responders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Men</td>
<td>44.7%</td>
<td>53.9%</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Age</td>
<td>Mean</td>
<td>49.4 years</td>
<td>45.7 years</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Education</td>
<td>Prevalence of persons with middle school as highest educational level&lt;sup&gt;a&lt;/sup&gt;</td>
<td>22.6% (776/3442)</td>
<td>36.1% (1529/4236)</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td></td>
<td>Prevalence of persons with higher education&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6.3% (215/3442)</td>
<td>4.1% (174/4236)</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Family status</td>
<td>Prevalence of persons living alone (with or without children)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>20.7% (720/3471)</td>
<td>34.0% (1460/4299)</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Socioeconomic position</td>
<td>Prevalence of persons with a low socioeconomic position&lt;sup&gt;c&lt;/sup&gt;</td>
<td>6.5% (226/3471)</td>
<td>13.7% (288/4299)</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Income</td>
<td>Mean&lt;sup&gt;d&lt;/sup&gt;</td>
<td>305,184 dkr</td>
<td>260,381 dkr</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Prevalence of hospitalization</td>
<td>One or more days during year 2005</td>
<td>9.0% (30/3471)</td>
<td>10.4% (44/4299)</td>
<td>P = 0.031</td>
</tr>
<tr>
<td>Prevalence of use of prescription drugs</td>
<td>One or more daily doses during year 2005</td>
<td>70.4% (2437/3471)</td>
<td>64.8% (2775/4299)</td>
<td>P &lt; 0.0001</td>
</tr>
<tr>
<td>Prevalence of contacts to general practitioners</td>
<td>One or more contacts during year 2005</td>
<td>87.2% (3057/3471)</td>
<td>80.4% (3426/4299)</td>
<td>P &lt; 0.0001</td>
</tr>
</tbody>
</table>

All register information relates to the calendar year 2005 where the random sample of potential participants was obtained from the Danish Central Personal Register, Ministry of Internal Affairs.<sup>a</sup>Based on information from the national register of education.<sup>b</sup>Based on information from the Denmark Statistics.<sup>c</sup>Low socioeconomic position defined as being unemployed and dependent on benefit payments.<sup>d</sup>Gross income.
Table 2 Summary of data collected

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthropometric measures and assessment of obesity</strong></td>
<td>Height, weight, waist and hip circumference, impedance and intraperitoneal fatness</td>
</tr>
<tr>
<td><strong>Fitness and muscle strength</strong></td>
<td>Cardio-respiratory fitness, hand-grip strength, lower leg extension power (in a subgroup only), 24-h MET score, sitting time</td>
</tr>
<tr>
<td><strong>Lung function measurements</strong></td>
<td>FEV$<em>1$, FVC, FE$</em>{NO}$</td>
</tr>
<tr>
<td><strong>Measurement of allergy</strong></td>
<td>Specific serum IgE (cat, dog, birch, house dust mite), skin prick test, patch testing</td>
</tr>
<tr>
<td><strong>Metabolic and nutritional biomarkers</strong></td>
<td>Blood: glucose, insulin, glycated haemoglobin, lipids (cholesterols and triglycerides), 25-hydroxy vitamin D$<em>3$, albumin, calcium, folate, vitamin B$</em>{12}$, creatinine, alanine transaminase, ferritine, anti-thyroperoxidase parathyroid hormone, thyroid-stimulating hormone and free thyroxine.</td>
</tr>
<tr>
<td><strong>Genetics</strong></td>
<td>20 000 single nucleotide polymorphisms</td>
</tr>
<tr>
<td><strong>Cardiovascular function</strong></td>
<td>Systolic and diastolic blood pressure, resting pulse</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>Perceived stress, five-factor personality traits, mental problems, quality of life</td>
</tr>
<tr>
<td><strong>Diet</strong></td>
<td>48-item food frequency questionnaire, Dietary Quality Score</td>
</tr>
<tr>
<td><strong>Other questionnaire-based information</strong></td>
<td>Symptoms and diagnoses of diseases, smoking, alcohol, socioeconomic status</td>
</tr>
</tbody>
</table>

**Anthropometric measures and assessment of obesity**

Height and weight were measured wearing light clothes and no shoes. Waist circumference (WC) was measured directly on the body surface midway between the lower rib margin and the iliac crest. The hip circumference was measured over light clothing at the widest girth of the hip. Additionally, all participants underwent measurement of impedance (body fat) and intraperitoneal fatness (assessed by ultrasound).

**Fitness and muscle strength**

The health examination included estimation of cardio-respiratory fitness by a performance-based progressive step test, the Danish step test (www.healthcalc.com/fitness-tests/the-danish-step-test). The step test has been validated against a Wattmax test, an indirect maximal ergometer cycle test based on workload. Muscle fitness was measured by hand grip strength in all participants using a Jamar dynamometer (Sammons Preston Rolyan, Chicago, IL, USA). In addition, lower leg extension power was measured in a sub-sample ($n = 438$) of the participants by using a leg-extensor power rig (Medical Engineering Unit, University of Nottingham Medical School, Nottingham, UK).

**Lung function measurements**

Lung function was measured by spirometry according to international standards using the SpiroUSB (Micro-Medical Ltd, Rochester, UK). In addition, lower airway inflammation, as reflected by exhaled nitrogen oxide (FE$_{NO}$), was measured according to international guidelines by using the hand-held Niox-Mino (Aerocrine AB, Stockholm, Sweden). FE$_{NO}$ is an accepted biomarker of allergic asthma and lower airways inflammation and oxidative stress. Lung function measurements in the Health2006 have previously been described in more detail.

**Measurement of allergy**

Measurement of specific IgE in serum is considered the gold standard for assessment of type I respiratory allergy in large-scale epidemiological studies. In the Health2006, all serum samples were analysed for the four most important inhalant allergens [birch, grass, cat and house dust mite (Dermatophagoides pteronyssinus)] by using the ADVIA Centaur assay (Siemens, Deerfield, IL, US). Furthermore, skin prick test reactivity against a panel of 10 inhalant allergens was performed on 2393 consecutive participants by using the Solu-prick (ALK-Abelló A/S, Hørsholm, Denmark).

A total of 3460 persons were patch tested for measurement of type IV allergy. Patch testing was performed by using panel 1 and 2 from the standardised ready-to-apply Thin-layer Rapid Use Epicutaneous (TRUE)-test (Mekos Laboratories, Hillerød, Denmark). Directions to apply the patch test panels to the upper back 2 days before examination were mailed together with the patch test. At the day of examination, they were read and photographed 1-1.5 h after removal by trained healthcare personnel. Photos were later reviewed by experts in dermatology. This was done to secure that the International Contact Dermatitis Research Group (ICRDG) criteria were used. Contact allergy was defined as a positive (at least grade 1+) according to ICRDG patch test reaction to at least one allergen or mix of hapten.
Biobank

Fasting venous blood samples from all participants were taken on the day of examination and were left to coagulate for 2 h. The serum was then separated by centrifugation at 3000 r.p.m. for 10 min and frozen immediately afterward. Serum samples from all participants were stored in the biobank at RCPH (at both -20°C and −80°C) for future analyses of biomarkers. The buffy coat was frozen for DNA extraction, and later genomic DNA was extracted using a Qiagen AutoPure LS system. In addition, the biobank contains urine samples from all participants.

Metabolic and nutritional biomarkers

Fasting blood samples were analysed for glucose, insulin, glycated haemoglobin (HbA1c) and lipids (cholesterols and triglycerides), and urine samples for urine albumin/creatinine ratio at the Steno Diabetes Center. In addition, serum levels of 25-hydroxy vitamin D₃ (25-OH-D₃), albumin, calcium, folate, cobalamin (vitamin B₁₂), creatinine, alanine transaminase (ALAT), ferritine, anti-thyroid peroxidase (anti-TPO), parathyroid hormone (PTH), thyroid-stimulating hormone (TSH) and free thyroxine (fT₄) were measured at the Institute of Clinical Chemistry and Laboratory Medicine, University of Medicine, Greifswald, Germany.

Genetics

The following genetic variations have been genotyped: the two most common filaggrin null mutations in Caucasians R501X and 2282del4 and the three GST mutations (GSTP1, GSTT1 and GSTM1). The study is part of the LuCamp study (www.LuCamp.org), in which about 20,000 single nucleotide polymorphisms (SNPs) have been genotyped in all participants of the Health2006 cohort. In addition, an aliquot of DNA from all participants is stored at KBiosciences (www.kbioscience.co.uk) for further rapid genotyping of SNPs by the PCR KASPar genotyping system (KBiosciences, Hoddesdon, UK).

What are the main strengths and weaknesses?

The main strengths of this study are the objective measurements of muscle strength, cardio-respiratory fitness, lung function, allergy and biomarkers of chronic diseases in combination with questionnaire-data-based information on a wide range of lifestyle factors. Another major strength of this study is the possibility of linkage to national registries, whereby data from clinical examinations and questionnaires can be associated with register-based information, e.g. future diagnoses of chronic disease. As illustrated in Table 1, register data for non-responders also are available on, for example, use of prescription drugs, hospital episodes and mortality, which makes it possible to compare responders with non-responders. Another strength of this study is the biological material stored in our biobank that offers the opportunity to perform specialized measurements on different biomarkers in the future.

The main weaknesses of the Health2006 study are the relatively low rate of participation and the documented differences between responders and non-responders that may limit the validity of generalizations made from Health2006 results. These differences should also be considered when discussing potential bias of associations found in data from the study. Furthermore, the size of the population does not allow us to study rare outcomes.
Can I get hold of data and where can I find more?

Access to data and biological material for research projects can be granted by the board of the RCPH. Any application must be accompanied by a research protocol that must comply with Danish regulations on ethical approval and data protection. Data are presently available only in Danish. However, relevant data from the Health2006 cohort will be translated if data are included as part of international studies. For more information, please contact principal
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Conflict of interest: None declared

References


