Top Ten Things To Know
Identification of Obesity and Cardiovascular Risk in Ethnically and Racially Diverse Populations

1. This statement is focused on racial and ethnic groups within the United States, although many of our conclusions are either drawn from or applicable to related populations around the world.

2. Although the statement is intended to encompass the full racial and ethnic diversity of the United States, there are specific groups that make up a large or growing segment of the population and also suffer disproportionately from obesity and CVD. Groups that are the focus of the statement’s discussion include:
   a. Blacks, non-Hispanic blacks, and those who identify as such and have primary or partial ancestry in sub-Saharan Africa representing 42 million Americans (13.6% of the population).
   b. Hispanic or Latinos (eg, people of Puerto Rican, Mexican, or Dominican origin), a group of diverse racial and ethnic origins that includes >50 million Americans (16.3% of the total population).
   c. Asian Americans, the largest composite group of immigrants to the United States; this group, together with descendants, includes 17.3 million people (5.6% of the American population).

3. This statement is intended to provide practical guidance for clinicians and therefore emphasizes simple anthropometric measures, including body mass index (BMI) and waist circumference (WC), alone or in combination with other measures of overall cardiovascular (CV) risk.

4. Applying common anthropometric measures with uniform standards to minority populations has limitations as evidence shows that current BMI cutoffs do not accurately measure obesity or predict the presence of CV risk factors or the incidence of heart disease in diverse populations.

5. Misclassification of obesity can result in missing obesity in large numbers of people, misclassification of CV risk, inaccurate self-perception of weight status, or the failure to offer appropriate screening for obesity-related conditions and treatments for obesity in specific populations.

6. BMI alone, even with lower thresholds, is a useful but not an ideal tool for identification of obesity or assessment of CV risk in Asian populations because of its lack of sensitivity. The value of BMI is also questionable in other populations, including blacks, Hispanics, and Pacific Islanders.

7. In combination with BMI, WC can be measured using a standardized technique and recommended thresholds to better gauge CV risk in diverse populations.

8. Given the infrequency of WC measurement in clinical practice, more training for healthcare professionals on the clinical importance and correct standard measurement technique is needed.

9. For assessing CV risk, the well-established Framingham Risk Score has been shown to provide a reasonably accurate risk estimate in a number of different ethnic and racial minority groups. Newer risk assessment tools, including the ACC/AHA ASCVD Risk Calculator is useful for risk assessment in non-Hispanic blacks, however, needs further validation for use in other racial or ethnic minorities living in the United States.

10. More research is needed on the usefulness of emerging imaging or other noninvasive anthropometric measurement techniques at assessing obesity and the utility of incorporating into CV risk prediction models for racially or ethnically diverse populations.