Adverse muscle composition is linked to poor functional performance and metabolic comorbidities in NAFLD

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Supplementary materials

Protocol description for recording of hand grip strength in UK Biobank (UK Biobank Field IDs 46, 47)

(Cited. [http://biobank.ndph.ox.ac.uk/showcase/docs/Gripstrength.pdf,](http://biobank.ndph.ox.ac.uk/showcase/docs/Gripstrength.pdf) Accessed April 2019)

- 1. The staff member explains that the first measure will be of grip strength (indicating the Jamar dynamometer device to be used) and that strength in both hands will be measured in turn.
- 2. The participant is asked to sit upright in a chair and place their forearms on armrests. With dynamometer handle set to the second incremental slot the participant is asked to hold it first in their right hand. For participants with very large hands the handle is moved to the third slot.
- 3. The participant's elbow of the arm hßolding the dynamometer is against their side and bent to a 90° angle so that their forearm is pointing forwards with their thumb uppermost. Their wrist is straight so that their hand is either pointing forwards or bent slightly outwards.
- 4. The staff member supports the dynamometer lightly with one hand and rotates the red peak-hold needle anti-clockwise to zero. They explain to the participant that the adjustable handle of the dynamometer does not move while they are gripping it, but it will measure the strength of their grip. The participant is asked to squeeze the handle of the dynamometer as strongly as they can for about 3 seconds. They are given encouragement while doing so.
- 5. After 3 seconds the participant is asked to stop, the dynamometer is taken from them and the maximum hand grip strength is read in whole kilogram force units as indicated on the outer aspect of the dial by the red peak-hold needle. This value is entered into the computer (see below).

MRI scanning protocol and image analysis

The subjects were scanned in supine position in a Siemens MAGNETOM Aera 1.5 T MRI scanner (Siemens, Erlangen, Germany) using the dual-echo Dixon Vibe protocol covering neck to knees. Common parameters for all slabs were: flip angle=10°, TR=6.69 ms, TE=2.39/4.77 ms, and bandwidth=440 Hz. The first slab, over the neck, consisted of 64 slices, voxel size $2.23 \times 2.23 \times 3$ mm³, and 224×168 matrix; slabs two to four were acquired during 17-second expiration breath-holds with 44 slices, voxel size 2.23×2.23×4.5 mm³, and 224×174 matrix; slab five consisted of 72 slices, voxel size $2.23 \times 2.23 \times 3.5$ mm³, and 224×162 matrix; slab six of 64 slices, voxel

size $2.23 \times 2.23 \times 4$ mm³, and 224×156 matrix.

For liver proton density fat fraction (PDFF) quantification, nine regions of interest (ROI) were placed while avoiding major vessels and bile ducts (see figure to the right). The liver water, fat and T2* of each ROI were computed by magnitude-based chemical shift technique¹ with a 6-peak lipid model². To correct for T1bias, caused by differences in water and fat T1, a correction factor was applied to the water signal. The correction factor was computed using the body Dixon images of the first 3,000 scanned UK Biobank participants as reference. The liver ROIs were transferred to, and compared with, the fat Dixon images intensities, which were calibrated using the adipose tissue as an intensity reference^{3,4} and corrected using the liver T2*, a process which results in T1 insensitive fat measurements⁵.

For whole body measurements, the image analysis consisted of (1) image calibration, (2) fusion of image stacks, (3) image segmentation, and (4) quantification of fat and muscle volumes^{4,6-9} and included manual quality

control by an analysis engineer. Muscle volumes were calculated as fat-tissue free muscle volumes⁴. MFI was calculated as the average $T2^*$ -corrected fat value and converted to proton density fat fraction (PDFF)².

Translation of current sarcopenia thresholds from DXA to MRI

Methods: To leverage the full dataset (N=9,545) for sarcopenia assessment, sex-specific thresholds for low muscle quantity based on DXA (ALM/height² <6.0/7.0 kg/m² (females/males)) were translated to MRI (thigh FFMV/height²) utilizing the subset with DXA and hand grip strength data available (N=4,553). Thresholds were determined by optimizing sensitivity and specificity for detecting individuals with low muscle quantity. Diagnostic performance (area under receiver operator characteristic (AUROC) curve), sensitivity, and specificity for sarcopenia detection were determined using derived FFMV/height² thresholds compared to ALM/height² thresholds.

Results: The correlation between ALM/height² and thigh FFMV/height² was 0.93 (95% CI: 0.92-0.93). Resulting thresholds for thigh FFMV/height² were $3.0/3.6$ L/m² (females/males). Sensitivity and specificity for sarcopenia detection using MRI-measured thigh FFMV/height² instead of DXA-measured ALM/height² were 0.93 and 0.99, respectively. AUROC was 0.96 (95% CI: 0.93-0.98). Applying sarcopenia-detection thresholds based on DXA-based ALM/height² and hand grip strength stratified 101 (2.2%) participants from the DXA subset. Applying derived MRI-based thigh FFMV/height² and hand grip strength thresholds for sarcopenia detection stratified 241 (2.5%) participants from the whole cohort. Supplemental material includes a comparison between characteristics for the DXA subset and the whole cohort (**Table S1** below).

Table S1. Cohort characteristics comparing complete dataset (whole cohort) to DXA subset. Values are mean (standard deviation). For liver fat, median (interquartile range) is shown. VCG, virtual control group adjusted. Low hand grip defined as below $16/27$ kg (females/males). [†] Data extracted from baseline assessment (years 2006–2010).

Regression modelling of muscle biomarkers and functional performance

Logistic regression modelling was used to investigate the associations between each outcome and muscle volume (FFMV_{VCG}) and muscle fat (MFI) as continuous variables. Results showed both FFMV_{VCG} and MFI were significantly associated with low hand grip strength, slow walking pace, CHD and T2D within NAFLD. Differences between variables were found for stair climbing (FFMV_{VCG} significant; MFI nonsignificant) and falls (MFI significant; FFMV_{VCG} nonsignificant). Table S2 presents summary of results below.

Table S2. Results from logistic regression modelling within the NAFLD population using fat-tissue free muscle volume z-score (FFMV_{VCG}) and muscle fat infiltration_{adj} (MFI_{adj} – sex-adjusted MFI) as predictors respectively. Models adjusted for sex, age, BMI and liver fat. VCG, virtual control group adjusted.

Medications

Insulin: Participants taking insulin were identified using UK Biobank field IDs 6153 'Medication for cholesterol, blood pressure, diabetes, or take exogenous hormones', 6177 'Medication for cholesterol, blood pressure or diabetes' (gathered through touchscreen questionnaires). Participants reporting using of insulin at any of the visits were considered currently on insulin treatment.

Statins: Participants taking statins were identified by searching UK Biobank field ID 20003 'Treatment/medication code' (gathered through verbal interview with a trained nurse) for the UK brands listed below. Participants with any of the corresponding codes reported were considered currently on statin treatment.

Supplementary results

Table S3 Comparison of population characteristics between different muscle composition groups within NAFLD: (1) adverse muscle composition (AMC), (2) low FFMV_{VCG} only, (3) high MFI only, and (4) moderate to high FFMV_{VCG} and low to moderate MFI (normal muscle composition). Factor shows difference in mean between the two groups. p-values shown for unadjusted and adjusted (sex, age, BMI, liver fat) modelling. FFMV, fat-tissue free muscle volume; MFI, muscle fat infiltration; PDFF, proton density fat fraction; VCG, virtual control group adjusted.

Table S4 Comparison between different muscle composition groups within NAFLD: (1) adverse muscle composition (AMC), (2) low FFMV_{VCG} only, (3) high MFI only, and (4) moderate to high FFMV_{VCG} and low to moderate MFI (normal muscle composition). Factor shows difference in prevalence of outcomes between the two groups. p-values shown for unadjusted and adjusted (sex, age, BMI, liver fat) modelling. FFMV, fat-tissue free muscle volume; MFI, muscle fat inifiltration; VCG, virtual control group adjusted. Low hand grip defined as below 16/27 kg (females/males).

Table S5 Comparison for the biomarker panel between different muscle composition groups within NAFLD: (1) adverse muscle composition (AMC), (2) low FFMV_{VCG} only, (3) high MFI only, and (4) moderate to high FFMV_{VCG} and low to moderate MFI (normal muscle composition). Factor shows difference in mean of outcomes between the two groups. p-values shown for unadjusted and adjusted (sex, age, BMI, liver fat) modelling. † Data extracted from baseline assessment (years 2006-2010). FFMV, fat-tissue free muscle volume; MFI, muscle fat infiltration; VCG, virtual control group adjusted

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