

Association between sarcopenia and risk of major adverse cardiac and cerebrovascular events-UK Biobank database

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Abstract

Background: Few studies on the risk of incident major adverse cardiac and cerebrovascular events (MACCEs) in sarcopenia have been reported. The objective was to assess the association between presarcopenia and sarcopenia and a higher risk of MACCEs.

Methods: This study on the UK Biobank prospective cohort, used data collected between 2006 and 2021. Community-dwelling Caucasian participants aged 37 to 73 years were included if values for Handgrip Strength (HGS) and Skeletal Muscle Index (SMI) were available and if no history of MACCEs was reported. Exposure was assessed using the European Working Group on Sarcopenia in Older People 2 (EWGSOP2) criteria. Muscle strength was measured using HGS, and muscle mass using the SMI. Presarcopenia was defined through the two definitions available in the literature, as low HGS with normal SMI and as normal HGS with low SMI, whereas sarcopenia was defined as low HGS with low SMI. The main outcome was to determine whether presarcopenia and/or sarcopenia were predictors of MACCEs (composite events).

Results: A total of 406,411 included participants (women: 55.7%) were included. At baseline, there were 18,257 (4.7%) presarcopenics—subgroup n°1 (low HGS only), 7940 (2.1%) presarcopenics—subgroup n°2 (low SMI only), and 1124 (0.3%) sarcopenics. Over a median follow-up of 12.1 years (IQR: [11.4; 12.8]), 28,300 participants (7.0%) were diagnosed with at least one event. Compared to NonSarc, presarcopenic (subgroups n°1 and n°2) and sarcopenic status were significantly associated with a higher risk of MACCEs (respectively fully adjusted HRs: HR = 1.25 [95% CI: 1.19; 1.31], HR = 1.33 [95% CI: 1.23; 1.45] and HR = 1.62 [95% CI: 1.34; 1.95]).

Conclusions: In a community-dwelling population, the risk of MACCEs was higher in both presarcopenic and sarcopenic participants.

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KEYWORDS

major cardiac and cerebrovascular event, presarcopenia, sarcopenia, UK Biobank

INTRODUCTION

Context

Sarcopenia has recently been redefined by the European Working Group on Sarcopenia in Older People 2 (EWG-SOP2) guidelines.¹ It constitutes a heavy burden for public health systems.² Its late recognition as a disease in 2016 by the World Health Organization (WHO) (International Classification of Diseases, ICD-10-CM: M62.84),³ and a lack of international consensus, partly explain the current state of knowledge.

The EWGSOP2 guidelines¹ are currently the most widely used worldwide, and define 3 sarcopenic thresholds,¹ namely: (i) probable sarcopenia (low muscle strength regardless of SMI value), (ii) sarcopenia (low muscle strength and muscle mass), and (iii) severe sarcopenia (low muscle strength, muscle mass, and physical performance). A *presarcopenia* stage is also used, with various definitions in the literature, including “low muscle mass without impact on muscle strength or physical performance”,^{2,4} and “low muscle strength with normal muscle mass”.⁵

Sarcopenia is directly associated with negative outcomes, some of which are still debated⁶ (e.g., cardiac and cerebrovascular prognosis). Sarcopenia and cardiac and cerebrovascular disorders share common triggers, such as malnutrition, physical inactivity, insulin resistance, inflammation, and oxidative stress.^{7–9} There is also increasing evidence suggesting an association between biomarkers of oxidative stress and several human conditions, such as obesity, sarcopenia, and cardiovascular diseases.¹⁰ The few studies investigating the association between sarcopenia (EWGSOP2 definition¹) and cardiac and/or cerebrovascular disorders report contradictory results.^{11–13} In one study conducted on 129 dialysis patients, the authors failed to find an association between sarcopenia and cardiovascular events or all-cause mortality.¹¹ In another study on 396,707 participants from the UK Biobank database,¹² the authors reported a higher risk of cardiovascular outcomes in participants with severe sarcopenia (HR = 2.92, 95% CI = [1.50; 5.67]), but not in participants with sarcopenia.¹² In a third study on 316,980 participants from the UK Biobank database, the combination of sarcopenia/frailty was found to be associated with cardiac and neurovascular diseases (HR = 1.68, 95% CI = [1.22; 2.30]).¹³ In all three studies, the methodologies used are debatable, and none of them investigated the risk of major

Key points

- Presarcopenic status (whatever the definition used, that is, low muscle strength only or low muscle mass only) and sarcopenic status are independent risk factors for incident MACCEs in a middle-aged and older Caucasian population.

Why does this paper matter?

Due to the recognition of sarcopenia as a disease only since 2016, and due to the lack of consensus, the data currently available on this disease are poor and hardly comparable. This study uses the most widely used guidelines in the world, and a high-quality, large cohort, to study its clinical outcomes. Data from this study are intended to refine the cardiovascular and cerebrovascular prognosis of presarcopenic and sarcopenic patients, for preventive and personalized medicine.

adverse cardiac and cerebrovascular events (MACCEs) in presarcopenic participants, hence the need for further studies.

Finally, sarcopenic participants can be divided into subgroups based on comorbidities they exhibit, such as obesity. Sarcopenic obesity (SO) is commonly defined as the co-existence of obesity and sarcopenia.¹ It is already known that obesity exacerbates sarcopenia.¹ However, it is not known whether the risk of MACCEs in obese sarcopenics differs from that in non-obese sarcopenics, even if some studies, not based on EWGSOP2 criteria, have suggested that the risk is different in the two populations.¹⁴

Objectives

To date, few and hardly comparable studies are available on the risk of MACCEs in participants with presarcopenia or sarcopenia. The main purpose of this study was to investigate whether presarcopenia and sarcopenia are independently associated with a higher risk of incident MACCEs (fatal or non-fatal) in a middle-aged and older, community-dwelling population of women and men from the UK Biobank prospective cohort.

METHODS

Participants and ethical approval

We conducted a retrospective analysis on participants from the UK Biobank database, using outcome data obtained from National Health Service (NHS) records. Approximately 500,000 British, community-dwelling volunteers provided their electronic consent.^{15,16}

Data collection

Data were collected at baseline (initial assessment visit, between 2006 and 2010), and later (2012 and later, still ongoing). Participants completed a series of touchscreen computer-based questionnaires, followed by a face-to-face interview.¹⁶ All assessments were performed by trained data collectors, who followed standardized protocols using a *Seca stadiometer* for height measurements, the *Tanita BC 418 MA Body Fat Analyzer* for weight and BIA measurements, and the *Jamar hydraulic hand dynamometer (model J00105)* for handgrip strength (HGS) measurements.

Inclusion and exclusion criteria

Due to the ethnicity-specific *Janssen* equation, we used to calculate Skeletal Muscle Mass (SMM) (see below), our study included only Caucasian participants. Participants were excluded if (i) they withdrew their consent between data acquisition and the end of the study, (ii) HGS values were unavailable or null, (iii) body composition values (measured using Bioelectrical Impedance Analysis, BIA) were unavailable or null, and (iv) they had a self-reported or hospital-admission history of acute myocardial infarction (AMI), angina pectoris (stable or unstable), stroke (ischemic or hemorrhagic), or transient ischemic attack (TIA).

Principal exposure variable

The main exposure variable was the participants' sarcopenic status. Sarcopenic status was defined in terms of HGS and Skeletal Muscle Index (SMI) values, which were obtained by feature extraction.

The HGS value was defined as the highest of the right- and left-hand scores,¹⁷ and considered pathological if less than 16 kg in women and 27 kg in men.¹

The SMI value was obtained in two steps. Using BIA data, we first calculated the whole body SMM using the *Janssen* equation.¹⁸ We then calculated the SMI using the

following formula^{1,5,19,20}: $SMI = SMM/height^2$, where SMM is expressed in kg, and height in meters.

Values were considered pathological if less than 5.5 kg/m² in women and 7.0 kg/m² in men.¹

We defined three main groups according to EWG-SOP2 sarcopenia cut-offs,¹ as follows (Figure 1): (i) Sarcopenic participants (low HGS, low SMI); (ii) Presarcopenic participants: subgroup n°1 (low HGS, normal SMI), subgroup n°2 (normal HGS, low SMI), according to the definitions currently available; and (iii) Non-sarcopenics participants (normal HGS, normal SMI; referred to as the NonSarc participants).

To investigate the impact of obesity, sarcopenic and presarcopenic (subgroup n°1 and n°2) participants were merged to form a single group (PreSarc participants) due to the low number of sarcopenic participants living with obesity. Then, two main groups (NonSarc and PreSarc) were split into subgroups based on obesity status, as follows: "obese" (Body Mass Index (BMI) ≥ 30 kg/m²²¹) and "non-obese" (BMI < 30 kg/m²²¹) (Figure 1). As such, the following subgroups were available: PreSarcObese, PreSarcNonObese, NonSarcObese, and NonSarcNonObese.

Covariates

All covariates were collected at baseline. Directly available covariates were sex, age at recruitment, waist circumference (WC), Townsend Deprivation Index (TDI, measure of material deprivation within a population), smoking and alcohol status, physical activity level, medication use (cholesterol-lowering medication, blood pressure medication, insulin, hormone-replacement therapy (HRT) and oral contraception), laboratory results (albumin, C-reactive protein (CRP)), and loss to follow-up.

Covariates obtained by feature extraction were BMI and medical history. Medical histories were compiled from ICD-9, ICD-10, and self-reported data regarding type-2 diabetes, high blood pressure (HBP), dyslipidemia, chronic kidney disease (CKD), heart failure (HF), and family history of stroke or ischemic heart disease.

Outcomes

Major adverse cardiac and cerebrovascular events (MACCEs), which are composite events, were defined as fatal or non-fatal cardiovascular events (AMI, angina pectoris, and cardiac arrest), or fatal or non-fatal cerebrovascular events (ischemic and hemorrhagic stroke, and TIA). The incidence of MACCEs was compiled from

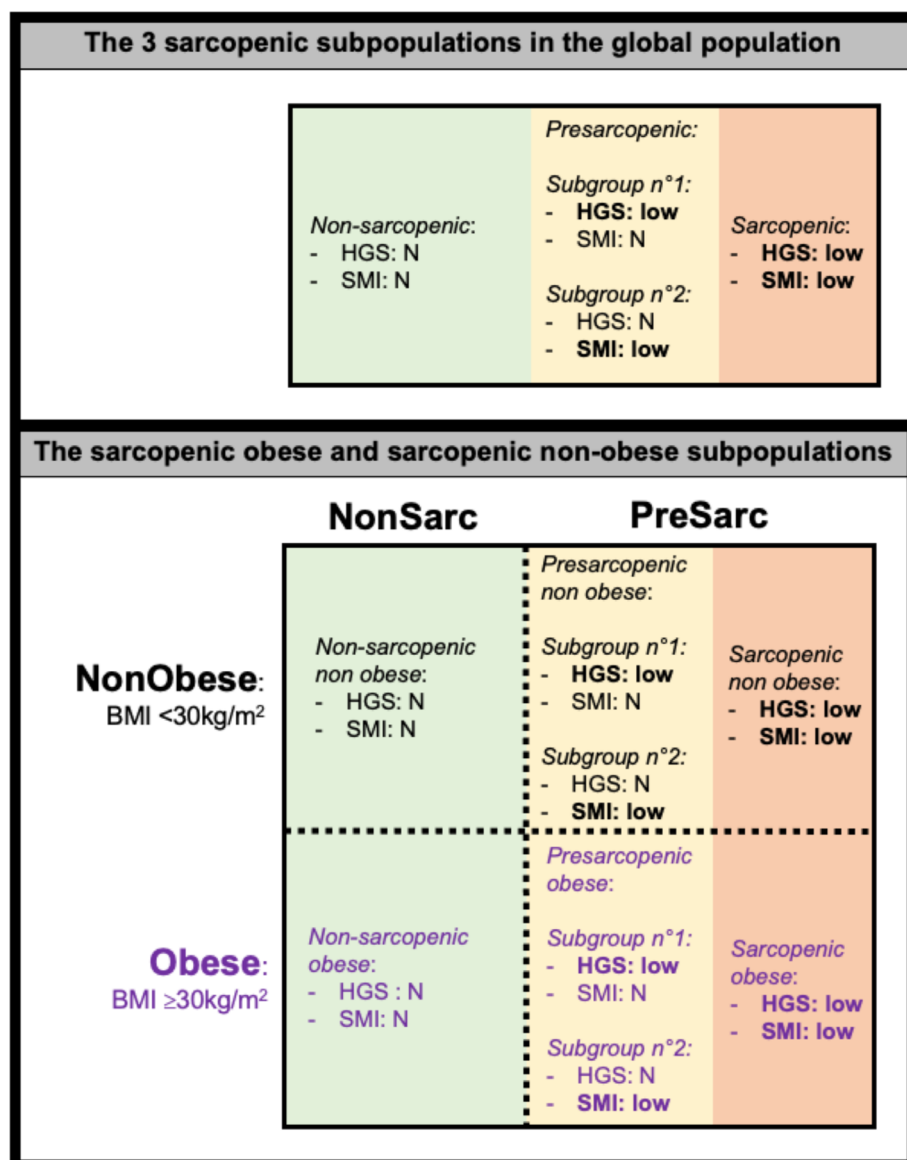


FIGURE 1 Subpopulation definitions. Non-Sarc: non-sarcopenic participants. Pre-Sarc: presarcopenic (subgroups n°1 and n°2) and sarcopenic participants. HGS: handgrip strength. SMI: skeletal muscle index. N: normal.

ICD-10 and self-reported data. No ICD-9 data were available for post-inclusion MACCEs.

Study design

We first compared the incidence of MACCEs in non-sarcopenics (reference) versus presarcopenics n°1, presarcopenics n°2, and sarcopenics). We then compared (i) the incidence of cardiovascular events and cerebrovascular events, considered independently, between those groups, still using the non-sarcopenics as the reference group, and (ii) the incidence of MACCEs, in NonSarcNonObese (reference) versus NonSarcObese, PreSarcNonObese and PreSarcObese.

Finally, we performed the following sensitivity analyses: (i) a sensitivity analysis of the main outcome in

women only, to add adjusting criteria (HRT and/or contraceptive pill use), (ii) a sensitivity analysis of the composite outcome “incident MACCEs or death from all-cause” in the global population, and (iii) a sensitivity analysis in the population younger than 58.0 years and in the population that was 58.0 years or older.

When the proportion of missing values in the global population was equal to or greater than 1%, we created a “not available” category. When the proportion of missing values in the global population was less than 1%, data were imputed based on expert opinion. Participants were followed up until the first MACCE occurred. Otherwise, they were censored at the date of death (non-MACCE-related death), the lost-to-follow-up date, or the data extraction date (2021-03-25).

We adjusted the final model by adding an increasing number of covariates. Level 1 was the minimally

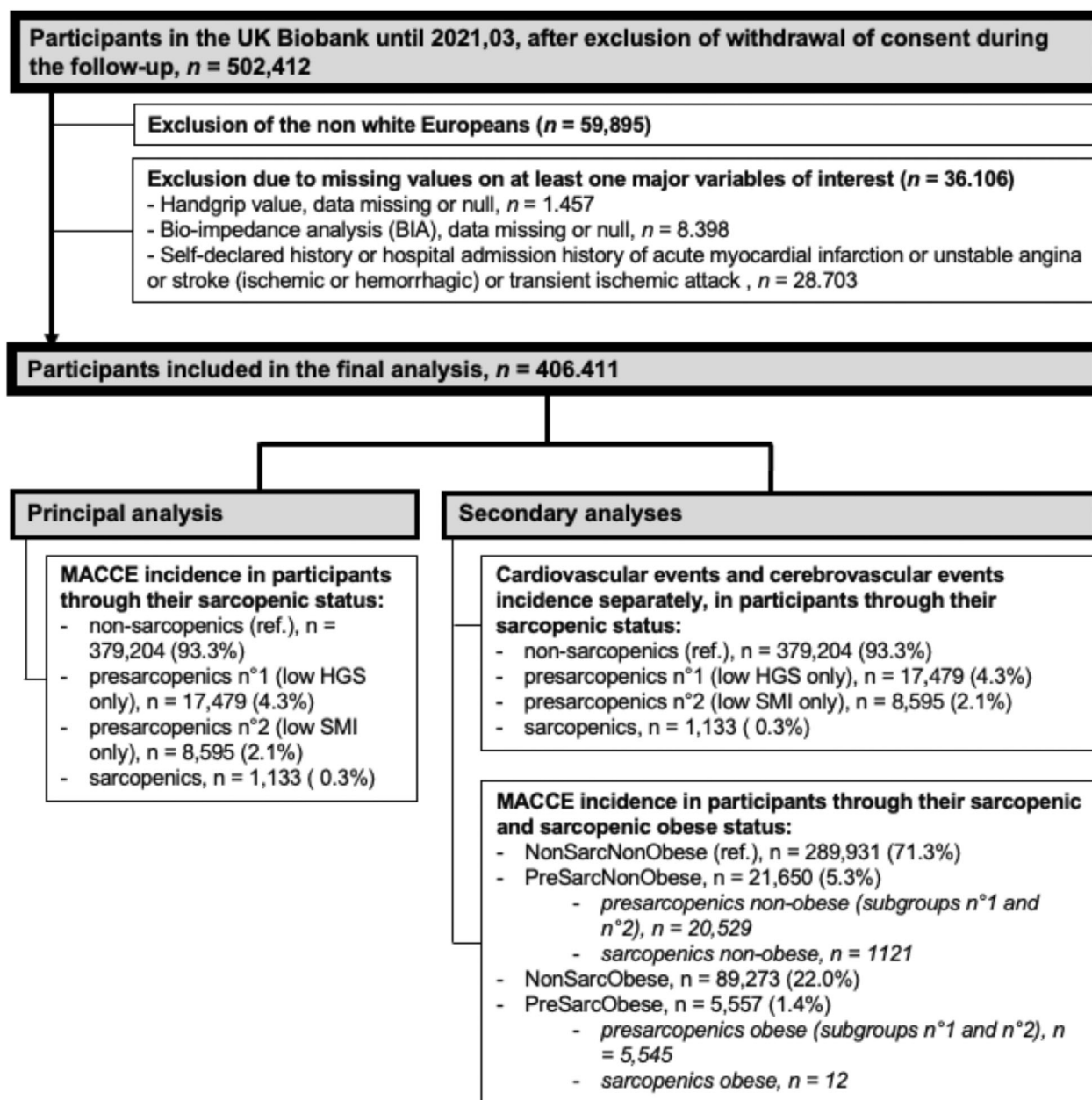


FIGURE 2 Flow-chart. NonSarcNonObese: non-sarcopenic non obese participants. NonSarcObese: non-sarcopenic obese participants. PreSarcNonObese: presarcopenic (subgroup n°1 and n°2) and sarcopenic non obese participants. PreSarcObese: presarcopenic (subgroup n°1 and n°2) and sarcopenic obese participants. Ref.: reference subgroup for statistical analyses.

adjusted model, on sex, age at recruitment, TDI, and BMI. Level 2 was the maximally adjusted model, on the same covariates as level 1, but further adjusted for WC, smoking and alcohol status, family history of stroke and/or ischemic heart disease, personal history of type-2 diabetes and/or HBP and/or dyslipidemia and/or CKD and/or HF, medication intake (cholesterol-lowering medication, blood pressure medication, insulin), physical activity group, albumin, and CRP. History of HRT and/or contraceptive pill use was added to level 2 only in the sensitivity analysis performed in women.

No stepwise procedures were performed as all the adjusting covariates are scientifically recognized.

Statistical analysis

For univariate analyses, continuous variables were expressed as mean (and standard deviation, SD), or as median (and interquartile range, IQR). Categorical variables were expressed as count (and percentage). Bivariate analyses were performed using Student's *t*-tests or Mann-Whitney-Wilcoxon tests to compare means, and Chi-2

TABLE 1 Baseline characteristics in the global population.

	Global population (<i>n</i> = 406,411)	Non-sarcopenics (<i>n</i> = 379,204, 93.3%)	Presarcopenics subgroup n°1 – low HGS only (<i>n</i> = 17,479, 4.3%)	Presarcopenics subgroup n°2 – low SMI only (<i>n</i> = 8595, 2.1%)	Sarcopenics (<i>n</i> = 1133, 0.3%)
Women, <i>n</i> (%)	226,483 (55.7)	206,057 (54.3%)	11,061 (63.3%)	8297 (96.5%)	1068 (94.3%)
Age at recruitment, years					
Median [IQR]	58.0 [50.0; 63.0]	57.0 [50.0;63.0]	61.0 [56.0;65.0]	62.0 [58.0;66.0]	64.0 [60.0;67.0]
[37, 50], <i>n</i> (%)	105,838 (26.0)	103,147 (27.2%)	2117 (12.1%)	526 (6.12%)	48 (4.24%)
[50, 60], <i>n</i> (%)	146,602 (36.1)	138,072 (36.4%)	5590 (32.0%)	2665 (31.0%)	275 (24.3%)
[60, 73], <i>n</i> (%)	153,971 (37.9)	137,985 (36.4%)	9772 (55.9%)	5404 (62.9%)	810 (71.5%)
BMI, median [IQR], kg/m ²	26.6 [24.1; 29.7]	26.7 [24.2;29.8]	27.4 [24.6;31.1]	22.4 [20.7;24.4]	22.7 [20.7;24.8]
BMI category, <i>n</i> (%), kg/m ²					
Normal weight	136,326 (33.5)	124,266 (32.8%)	4813 (27.5%)	6459 (75.1%)	788 (69.5%)
Malnutrition, thinness	2081 (0.5)	1383 (0.36%)	107 (0.61%)	503 (5.85%)	88 (7.77%)
Overweight	173,221 (42.6)	164,326 (43.3%)	7129 (40.8%)	1521 (17.7%)	245 (21.6%)
Class I & II obesity	87,554 (21.5)	82,551 (21.8%)	4881 (27.9%)	110 (1.28%)	12 (1.06%)
Class III obesity	7229 (1.8)	6678 (1.76%)	549 (3.14%)	2 (0.02%)	0 (0.00%)
WC in women, median [IQR], cm	83.0 [75.0; 92.0]	83.0 [75.0;92.0]	86.0 [78.0;96.0]	76.0 [71.0;84.0]	77.0 [71.0;84.0]
WC in men, median [IQR], cm	96.0 [89.0; 103.0]	96.0 [89.0;103]	97.0 [90.0;106]	85.0 [79.0;92.0]	85.0 [78.0;92.0]
WC category, <i>n</i> (%), cm					
Normal (<80 in women, <94 in men)	164,071 (40.0)	152,344 (40.2%)	5506 (31.5%)	5540 (64.5%)	681 (60.1%)
High (≥80 in women, ≥94 in men)	242,340 (59.6)	226,860 (59.8%)	11,973 (68.5%)	3055 (35.5%)	452 (39.9%)
Townsend deprivation index, <i>n</i> (%)					
Least disadvantaged	135,315 (33.3)	127,385 (33.6%)	4587 (26.2%)	3004 (35.0%)	339 (29.9%)
Intermediate	135,789 (33.4)	126,922 (33.5%)	5506 (31.5%)	2978 (34.6%)	383 (33.8%)
Most disadvantaged	135,307 (33.3)	124,897 (32.9%)	7386 (42.3%)	2613 (30.4%)	411 (36.3%)
Smoking status, <i>n</i> (%)					
Never	226,483 (55.7)	211,118 (55.7%)	5574 (54.8%)	5117 (59.5%)	674 (59.5%)
Former	139,199 (34.3)	130,141 (34.3%)	6120 (35.0%)	2604 (30.3%)	334 (29.5%)
Current	40,729 (10.0)	37,945 (10.0%)	1785 (10.2%)	874 (10.2%)	125 (11.0%)
Alcohol status, <i>n</i> (%)					
Never or rarely	114,064 (28.1)	103,718 (27.4%)	6985 (40.0%)	2842 (33.1%)	519 (45.8%)
Once or twice a week	107,956 (26.6)	101,264 (26.7%)	4436 (25.4%)	2013 (23.4%)	243 (21.4%)

TABLE 1 (Continued)

	Global population (n = 406,411)	Non-sarcopenics (n = 379,204, 93.3%)	Presarcopenics subgroup n°1 – low HGS only (n = 17,479, 4.3%)	Presarcopenics subgroup n°2 – low SMI only (n = 8595, 2.1%)	Sarcopenics (n = 1133, 0.3%)
Three or four times a week	98,500 (24.2)	93,278 (24.6%)	3149 (18.0%)	1900 (22.1%)	173 (15.3%)
Daily or almost daily	85,891 (21.1)	80,944 (21.3%)	2909 (16.6%)	1840 (21.4%)	198 (17.5%)
IPAQ activity group ^a , n (%)					
Low	59,895 (18.2)	55,181 (14.6%)	3262 (18.7%)	1223 (14.2%)	229 (20.2%)
Moderate	134,291 (41.0)	125,627 (33.1%)	5319 (30.4%)	2996 (34.9%)	349 (30.8%)
High	133,665 (40.8)	127,057 (33.5%)	4213 (24.1%)	2168 (25.2%)	227 (20.0%)
C-reactive protein ^b , median [IQR], mg/L					
[0; 5]	337,897 (83.1)	316,824 (83.5%)	12,997 (74.4%)	7242 (84.3%)	834 (73.6%)
[5; 20]	38,543 (9.5)	35,006 (9.23%)	2735 (15.6%)	644 (7.49%)	39 (3.44%)
[20; 80]	4111 (1.0)	3528 (0.93%)	441 (2.52%)	103 (1.20%)	158 (13.9%)
Albumin ^c , median [IQR], g/L					
[18; 40]	7149 (1.8)	6343 (1.67%)	652 (3.73%)	114 (1.33%)	40 (3.53%)
[40; 60]	342,047 (84.2)	319,681 (84.3%)	14,279 (81.7%)	7185 (83.6%)	902 (79.6%)
History of cholesterol lowering medication, n (%)	53,247 (10.0)	48,598 (12.8%)	3558 (20.4%)	928 (10.8%)	163 (14.4%)
History of blood pressure medication, n (%)	40,971 (10.1)	37,453 (9.88%)	2449 (14.0%)	922 (10.7%)	147 (13.0%)
History of insulin medication, n (%)	592 (0.2)	534 (0.14%)	52 (0.30%)	6 (0.07%)	0 (0.00%)
History of hormone-replacement therapy ^d , n (%)	88,006 (38.9)	77,048 (37.4%)	6089 (55.0%)	4265 (51.4%)	604 (56.6%)
History of oral contraception pill or minipill ^d , n (%)	5403 (1.3)	5255 (2.55%)	97 (0.88%)	48 (0.58%)	3 (0.28%)
History of diabetes, at baseline, n (%)	7418 (1.8)	6606 (1.74%)	757 (4.33%)	43 (0.50%)	12 (1.06%)
History of arterial hypertension, at baseline, n (%)	24,353 (6)	21,756 (5.74%)	2064 (11.8%)	430 (5.00%)	103 (9.09%)
History of dyslipidemia, at baseline, n (%)	5748 (1.4)	5114 (1.35%)	491 (2.81%)	117 (1.36%)	26 (2.29%)
History of chronic renal failure, at baseline, n (%)	722 (0.2)	663 (0.17%)	88 (0.50%)	17 (0.20%)	4 (0.35%)
History of heart failure, at baseline, n (%)	612 (0.2)	531 (0.14%)	61 (0.35%)	16 (0.19%)	4 (0.35%)

(Continues)

TABLE 1 (Continued)

	Global population (<i>n</i> = 406,411)	Non-sarcopenics (<i>n</i> = 379,204, 93.3%)	Presarcopenics subgroup n°1 – low HGS only (<i>n</i> = 17,479, 4.3%)	Presarcopenics subgroup n°2 – low SMI only (<i>n</i> = 8595, 2.1%)	Sarcopenics (<i>n</i> = 1133, 0.3%)
Family history of stroke and/or ischemic heart disease, <i>n</i> (%)	2096 (0.5)	1881 (0.50%)	151 (0.86%)	52 (0.61%)	12 (1.06%)
Grip strength (best value), kg, median [IQR]	30.0 [24.0; 40.0]	32.0 [26.0; 42.0]	14.0 [12.0; 22.0]	22.0 [20.0; 26.0]	12.0 [10.0; 14.0]
SMI (BIA), kg/m ² , median [IQR]	7.5 [6.47; 8.98]	7.61 [6.53; 9.02]	7.08 [6.30; 8.61]	5.34 [5.19; 5.43]	5.30 [5.14; 5.43]
Lost to follow-up, <i>n</i> (%)	844 (0.2)	796 (0.21%)	31 (0.18%)	15 (0.17%)	2 (0.18%)
Death during the follow up period, <i>n</i> (%)	24,995 (6.5%)	21,312 (5.62%)	1854 (10.6%)	718 (8.35%)	156 (13.8%)

^aSignificant number of missing values (78,560 in the global population; 71,339 in the non-sarcopenics, 4685 in the presarcopenics subgroup n°1, 2208 in the presarcopenics n°2, 328 in the sarcopenics).

^bSignificant number of missing values (25,860 in the global population; 23,846 in the non-sarcopenics, 1306 in the presarcopenics subgroup n°1, 606 in the presarcopenics n°2, 102 in the sarcopenics).

^cSignificant number of missing values (57,215 in the global population; 53,180 in the non-sarcopenics, 2548 in the presarcopenics subgroup n°1, 1296 in the presarcopenics n°2, 191 in the sarcopenics).

^dIn women only. WC: Waist circumference.

tests or Fisher's exact tests to test for independence among qualitative variables. Survival analyses were performed using Cox models. Non-adjusted hazard ratios (HR_{na}) and adjusted hazard ratios (HR_a), along with their 95% confidence intervals (95% CI), were reported. HR_{a1} denotes HR_a derived from minimally adjusted models (level 1), whereas HR_{a2} denotes HR_a derived from maximally adjusted models (level 2). Quantitative variables were always discretized. The proportional hazards assumption was checked using the Schoenfeld residuals and graphics methods. Statistical analyses were performed using R (version 4.1.2) and RStudio (version 2022.07.2 + 576), and the knitr, dplyr, lubridate, compareGroups, and survival packages. *p*-values of less than 0.05 were considered statistically significant. All tests were two-sided. When appropriate, 95% CI was computed.

RESULTS

Study flow chart

After applying the exclusion criteria, our study included 406,411 participants, of which 379,204 (93.3%) were non-sarcopenic, 17,479 (4.3%) were presarcopenic (subgroup n°1), 8595 (2.1%) were presarcopenic (subgroup n°2), and 1,133 (0.3%) were sarcopenic (Figure 2). Median follow-up was 12.1 years (IQR: [11.4; 12.8]).

Baseline characteristics

Of the included participants, 226,483 (55.7%) were women, with a median age of 58.0 [50.0; 63.0] years. Among the 1789 participants aged 70 or over, 16 (0.9%) were sarcopenics. Baseline characteristics are shown in detail in Table 1.

Primary outcome: incident MACCEs, in non-sarcopenics (reference) versus presarcopenics (n°1 and 2) and sarcopenics

Around 93.0% of the MACCEs were collected based on the ICD-10 classification (Table 2). The main analysis was performed on the global population. There were 28,300 first-time MACCEs (Table 2). The cumulative risk of incident MACCEs is shown in Figure 3.

Where the risk of MACCEs was concerned, the presarcopenic subgroup n°1 was associated with HR_{na} = 1.61 (1.54; 1.69), HR_{a1} = 1.37 (1.3; 1.43), and HR_{a2} = 1.25 (1.19; 1.31), the presarcopenic subgroup n°2 was associated with HR_{na} = 1.06 (0.98; 1.15), HR_{a1} = 1.38 (1.27; 1.50), and HR_{a2} = 1.33 (1.23; 1.45),

TABLE 2 Approximate fatal and non-fatal MACCE counts, with possible duplication of MACCEs based on ICD-10 classifications and self-reported events.

	Global ^a	Non-fatal events from self-reports	Non-fatal events from ICD-10	Fatal events from ICD-10
MACCE and all-cause deaths				
<i>n</i> (%)	47,610	1827	26,904	24,040
Delay (years), median (IQR)	7.0 [4.0; 9.7]	-	-	-
MACCE and MACCE-related death				
<i>n</i> (%)	28,300	1827	26,904	1703
Delay (years), median (IQR)	6.6 [3.5; 9.4]	-	-	-
Cardiovascular events				
<i>n</i> (%)	19,414	1220	18,519	860
Delay (years), median (IQR)	6.3 [3.3; 9.3]	-	-	-
Acute myocardial infarction				
<i>n</i> (%)	11,883	519	11,210	854
Delay (years), median (IQR)	6.9 [3.8; 9.5]	-	-	-
Angina pectoris				
<i>n</i> (%)	12,196	778	11,888	0
Delay (years), median (IQR)	6.1 [3.1; 9.0]	-	-	-
Cerebrovascular events				
<i>n</i> (%)	8169	631	7520	842
Delay (years), median (IQR)	7.3 [4.2; 9.8]	-	-	-
Ischemic stroke				
<i>n</i> (%)	6426	407	6066	335
Delay (years), median (IQR)	7.0 [4.3; 9.9]	-	-	-
Hemorrhagic stroke				
<i>n</i> (%)	1870	8	1730	507
Delay (years), median (IQR)	7.3 [4.3; 7.0]	-	-	-
Transient ischemic attack				
<i>n</i> (%)	2887	248	2677	1
Delay (years), median (IQR)	6.9 [3.7; 9.6]	-	-	-

^aWithout duplication, that is, count including only the first recorded ICD-10 and self-reported event.

and the sarcopenic group was associated with $HR_{na} = 1.53$ (1.27; 1.84), $HR_{a1} = 1.83$ (1.52; 2.20), and $HR_{a2} = 1.62$ (1.34; 1.95).

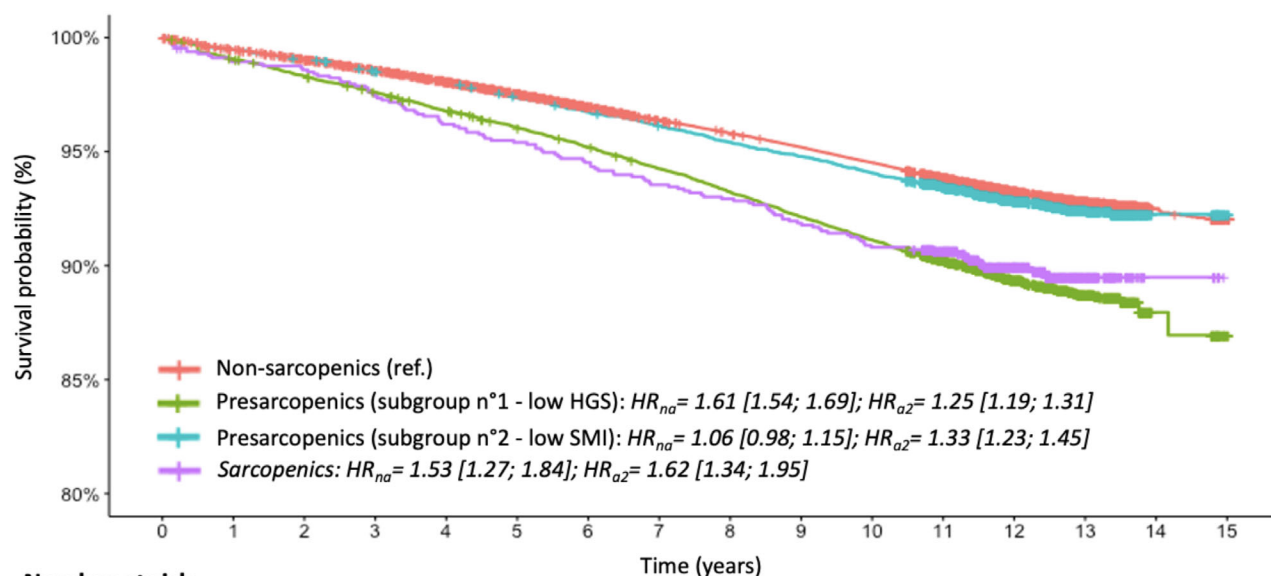
Secondary outcomes

Incident cardiovascular or cerebrovascular events, considered independently, in non-sarcopenics (reference) versus presarcopenics ($n^{\circ}1$ and 2) and sarcopenics

This secondary analysis was performed on the global population and concerned 19,414 first-time cardiovascular events, and 8169 first-time cerebrovascular events.

Where the risk of cardiovascular events was concerned (See Supplementary Figure S1.A.), the presarcopenic subgroup $n^{\circ}1$ was associated with $HR_{na} = 1.59$ (1.50; 1.69), $HR_{a1} = 1.38$ (1.30; 1.46), and $HR_{a2} = 1.24$ (1.17; 1.32), the presarcopenic subgroup $n^{\circ}2$ was associated with $HR_{na} = 0.88$ (0.79; 0.98), $HR_{a1} = 1.31$ (1.17; 1.46), and $HR_{a2} = 1.26$ (1.13; 1.40), and the sarcopenic group was associated with $HR_{na} = 1.35$ (1.07; 1.71), $HR_{a1} = 1.85$ (1.46; 2.34), and $HR_{a2} = 1.60$ (1.26; 2.03).

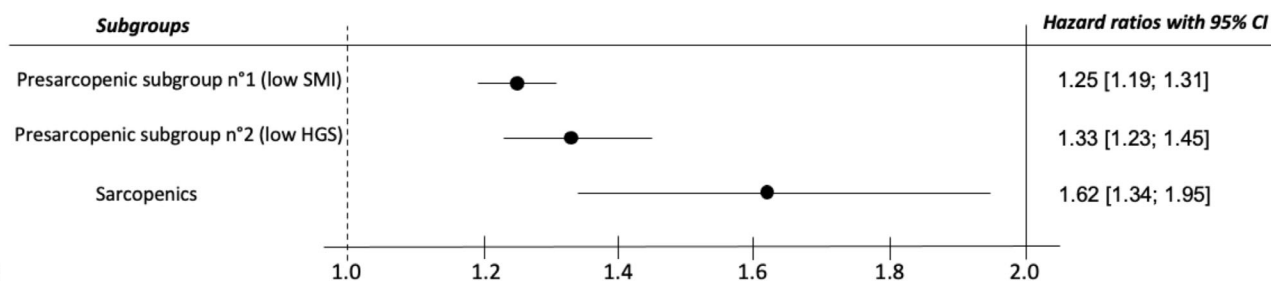
Where the risk of cerebrovascular events was concerned (See Supplementary Figure S1.B.), the presarcopenic subgroup $n^{\circ}1$ was associated with $HR_{na} = 1.69$ (1.55; 1.84), $HR_{a1} = 1.37$ (1.26; 1.50), and $HR_{a2} = 1.26$ (1.16; 1.38), the presarcopenic subgroup $n^{\circ}2$ was associated with $HR_{na} = 1.36$ (1.19; 1.55), $HR_{a1} = 1.41$ (1.23; 1.62),



Number at risk

Time (y)	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Non-sarcopenics	379,204	377,235	375,584	373,700	371,637	369,400	367,079	364,786	362,567	360,216	357,653	320,129	207,376	64,782	2,473	154
Presarcopenics n°1 (low HGS)	17,479	17,312	17,178	17,049	16,901	16,767	16,613	16,445	16,266	16,075	15,900	13,674	8,028	1,712	88	7
Presarcopenics n°2 (low SMI)	8,595	8,548	8,514	8,460	8,420	8,357	8,302	8,248	8,186	8,133	8,069	7,245	4,626	1,588	71	5
Sarcopenics	1,133	1,119	1,115	1,102	1,088	1,079	1,069	1,058	1,051	1,039	1,027	914	557	153	8	0

(A)



(B)

FIGURE 3 Non-adjusted MACCE-free survival rates (406,411 participants; 28,300 events). (A) Kaplan Meier curve. Ref.: Reference subgroup for statistical analyses. HR_{na} : Non-adjusted hazard ratio. HR_{a2} : Hazard ratio derived from maximally-adjusted models (adjustment on socio-demographical covariates (sex, age at recruitment, Townsend Deprivation Index), BMI, WC, smoking and alcohol status, family history of stroke and/or ischemic heart disease, personal history of type-2 diabetes and/or high blood pressure and/or dyslipidemia and/or chronic renal failure and/or heart failure, medication intake (cholesterol-lowering medication, blood pressure medication, insulin), physical activity group, albumin, and CRP). (B) Forest plot. *Hazard ratios with 95% CI: hazard ratio resulting in maximally adjusted models.*

and $HR_{a2} = 1.37 (1.19; 1.57)$, and the sarcopenic group was associated with $HR_{na} = 1.53 (1.09; 2.15)$, $HR_{a1} = 1.44 (1.02; 2.03)$, and $HR_{a2} = 1.29 (0.91; 1.82)$.

Incident MACCEs in NonSarcNonObese versus others

Participants were divided into 4 subgroups, based on obesity status: NonSarcNonObese (298,414 individuals, 73.4%, reference group), PreSarcNonObese (13,167 individuals, 3.2%), NonSarcObese (89,385 individuals,

22.0%), and PreSarcObese (5445 individuals, 1.4%). Survival analyses were performed on 28,300 events, including 8626 events in obese participants. Where the risk of MACCEs was concerned (See Supplementary Figure S1. C.), the NonSarcObese group was associated with $HR_{na} = 1.46 (1.42; 1.50)$, $HR_{a1} = 1.91 (0.96; 3.82)$, and $HR_{a2} = 1.71 (0.85; 3.42)$, the PreSarcNonObese group was associated with $HR_{na} = 1.41 (1.35; 1.48)$, $HR_{a1} = 1.38 (1.31; 1.45)$, and $HR_{a2} = 1.29 (1.22; 1.35)$, and the PreSarcObese group was associated with $HR_{na} = 2.27 (2.11; 2.44)$, $HR_{a1} = 2.66 (1.33; 5.34)$, and $HR_{a2} = 2.16 (1.08; 4.34)$.

Sensitivity analyses

Regarding the 226,483 women only (11,429 first-time MACCEs), with non-sarcopenics as the reference group, where the risk of MACCEs was concerned, the presarcopenic subgroup $n^{\circ}1$ was associated with $HR_{na} = 1.91$ (1.79; 2.04), $HR_{a1} = 1.43$ (1.34; 1.53), and $HR_{a2} = 1.27$ (1.19; 1.36), the presarcopenic subgroup $n^{\circ}2$ was associated with $HR_{na} = 1.48$ (1.36; 1.6), $HR_{a1} = 1.36$ (1.24; 1.48), and $HR_{a2} = 1.3$ (1.19; 1.42), and the sarcopenic group was associated with $HR_{na} = 2.11$ (1.74; 2.57), $HR_{a1} = 1.78$ (1.47; 2.17), and $HR_{a2} = 1.53$ (1.26; 1.86).

In the sensitivity analysis of the composite event “incident MACCEs or death from all-cause” (47,610 first-time events), with non-sarcopenics as the reference group, where the risk of MACCEs was concerned, the presarcopenic subgroup $n^{\circ}1$ was associated with $HR_{na} = 1.73$ (1.67; 1.79), $HR_{a1} = 1.42$ (1.37; 1.48), and $HR_{a2} = 1.29$ (1.24; 1.33), the presarcopenic subgroup $n^{\circ}2$ was associated with $HR_{na} = 1.22$ (1.15; 1.29), $HR_{a1} = 1.38$ (1.3; 1.46), and $HR_{a2} = 1.33$ (1.25; 1.41), the sarcopenic group was associated with $HR_{na} = 2.03$ (1.79; 2.3), $HR_{a1} = 2.1$ (1.84; 2.38), and $HR_{a2} = 1.83$ (1.61; 2.08).

We finally separated our population into two subgroups using a median age value of 58.0 years, considering the non-sarcopenic group as the reference group. Among participants that were strictly younger than 58.0 years ($N = 199,995$, 8143 first-time events), where the risk of MACCEs was concerned, the presarcopenic subgroup $n^{\circ}1$ was associated with $HR_{na} = 1.60$ (1.44; 1.79), $HR_{a1} = 1.43$ (1.28; 1.59), and $HR_{a2} = 1.23$ (1.10; 1.37), the presarcopenic subgroup $n^{\circ}2$ was associated with $HR_{na} = 0.93$ (0.74; 1.16), $HR_{a1} = 1.53$ (1.21; 1.94), and $HR_{a2} = 1.47$ (1.16; 1.85), the sarcopenic group was associated with $HR_{na} = 1.30$ (0.70; 2.41), $HR_{a1} = 1.88$ (1.01; 3.50), and $HR_{a2} = 1.59$ (0.85; 2.96).

Among participants that were 58.0 years or older ($N = 206,416$; 20,157 first-time events), where the risk of MACCEs was concerned, the presarcopenic subgroup $n^{\circ}1$ was associated with $HR_{na} = 1.33$ (1.26; 1.40), $HR_{a1} = 1.33$ (1.26; 1.40), and $HR_{a2} = 1.24$ (1.18; 1.31), the presarcopenic subgroup $n^{\circ}2$ was associated with $HR_{na} = 0.85$ (0.78; 0.92), $HR_{a1} = 0.85$ (0.78; 0.92), and $HR_{a2} = 1.25$ (1.14; 1.36), the sarcopenic group was associated with $HR_{na} = 1.17$ (0.97; 1.42), $HR_{a1} = 1.17$ (0.97; 1.42), and $HR_{a2} = 1.54$ (1.27; 1.87).

DISCUSSION

Main results

In this large-scale study, we found that presarcopenic (whatever the definition used) and sarcopenic participants were at higher risk of MACCEs than non-

sarcopenic participants. Furthermore, presarcopenic participants (whatever the definition used) were at higher risk of cardiovascular events and cerebrovascular events (considered independently), and that's also true for sarcopenic participants for cardiovascular events, but not for cerebrovascular events. Our study also found that the risk of MACCEs was subgroup-specific, with a higher risk in PreSarcNonObese and PreSarcObese participants, compared to the NonSarcNonObese.

Comparison with findings reported in the literature

To the best of our knowledge, few studies have investigated the risk of MACCEs in presarcopenic and sarcopenic participants compared to non-sarcopenic participants in very large cohorts, and none of them used EWGSOP2 criteria. This study is also the first to investigate the risk of MACCEs in participants with a normal HGS but a low SMI value (presarcopenic $n^{\circ}2$), whose are considered as non-sarcopenics in EWGSOP2 recommendations.¹

The number of MACCEs we found appears to be consistent with the previously reported results.¹² The prevalence of sarcopenia was lower in our cohort,¹ maybe because it was a “healthier” community-dwelling cohort.

Nevertheless, it is plausible to hypothesize that an association exists between sarcopenia and MACCEs, since the latter share common pathogenic pathways.^{7–9} Although the studies reported in the literature used different guidelines and outcomes,^{12,13} two report findings that are somewhat similar to ours.^{12,13} In one hand, the authors investigated the risk of MACCEs in sarcopenic and severe sarcopenic participants, but not in presarcopenic participants.¹² On the other hand, the authors investigate only the association between sarcopenia/frailty and MACCEs.¹³ Globally, both studies showed a higher risk of MACCEs in participants with severe sarcopenia and in frail-sarcopenic participants, but we found no large-scale studies, based on EWGSOP2 criteria, confirming a higher risk of MACCEs in PreSarc participants.

Regarding the risk of MACCEs in participants with SO, a higher risk was suggested in PreSarcNonObese and PreSarcObese, compared to NonSarcNonObese, but the authors did not use the EWGSOP2 definition of SO.¹⁴

In the studies that used muscle mass only as the exposure variable,^{22–24} a higher risk of MACCEs was found in participants with low SMI.

Study design choices

Using the highest of the right- and left-hand HGS scores seems advisable.¹⁷ To calculate an approximation

of SMM from BIA data, the EWGSOP2 guidelines recommend prioritizing the *Sergi* equation.¹ However, since “reactance” data – required in the *Sergi* equation – were not available in our dataset, we used the *Janssen* equation,¹⁸ which has also been validated by EWGSOP.² As there is no consensus on the exact list of MACCEs,^{12,25} we used the events that are most frequently considered as MACCEs, and used HF, CKD, and the conditions associated with metabolic syndrome as adjusting covariates.

Strengths and limitations of the study

Strengths

Our study was conducted on a very large prospective cohort, with good-quality data collection. There was probably no reporting bias as most of the MACCEs were collected using hospitalization data. We tried to improve on the methodologies used in recent studies^{12,13} by (i) using the highest (not the average) HGS value, (ii) excluding participants with a history of MACCEs in all main analyses, (iii) including angina pectoris and TIA in the list of MACCEs, and (iv) using 3 modes of data collection, namely ICD-9, ICD-10 and self-reports, such that our data were more exhaustive. The increased risk we found in the two age groups (participants strictly younger than 58.0 years, and those 58.0 years and older) in the sensitivity analysis, confirms that the occurrence of the MACCE outcome in presarcopenic and sarcopenic participants is not solely age-related.

Limitations

Although the UK Biobank database provided a large cohort of participants, it is limited by evidence of a “healthy responder” bias. As such, due to the low proportion of sarcopenic participants, presarcopenia (subgroup n°1 and n°2) and sarcopenia were considered as a single subgroup in our analysis of participants living or not with obesity. Only Caucasian participants were included, which limits the generalizability of our results. The fact that most of the events were recorded through hospitalization data underlines the lack of precision inherent to declarative data. In the sensitivity analysis, we found the same conclusions as for the primary outcome of the principal analysis, but the non-significant risk difference in the sarcopenic participants <58.0 years was probably linked to a lack of power in this minority subgroup ($N = 197$ sarcopenic participants aged <58.0 years). Finally, the very high proportion of women in the presarcopenic subgroup n°2 and sarcopenic groups, compared with the balanced proportion in the others, underlines the importance of choosing personalized thresholds for the calculation

of SMI, and partly explains the dispersion of confidence intervals between these four main subgroups of participants.

Perspectives

As several studies on the same subject reported divergent results and did not compare the same subgroups, future studies should (i) probably be conducted on older prospective cohorts to include more sarcopenic participants, and (ii) use the EWGSOP2 diagnostic criteria to enable their comparison.

In the same way that metabolic syndrome parameters are screened for when assessing cardiovascular risk, it would probably be useful to screen for sarcopenia as well.

The higher risk of MACCEs in participants with a low SMI only, as in those with a low HGS only, compared to non-sarcopenics, suggests that it may be useful to assess muscle mass in all patients at risk of sarcopenia, even when muscle strength is normal, which is not mentioned in the EWGSOP2 recommendations.

CONCLUSION

This study supports the hypothesis that presarcopenic (whatever the definition used) and sarcopenic status are independent risk factors for incident MACCEs in a middle-aged and older Caucasian population. To confirm these findings, further studies are needed. These should be based on EWGSOP2 criteria and conducted on database populations with more sarcopenic participants, with particular focus on obese sarcopenic participants and participants with low SMI but normal HGS.

AUTHOR CONTRIBUTIONS

Charlotte Jauffret, Emmanuel Chazard, and Julien Paccou-study conception and design, data acquisition, analysis and interpretation, manuscript drafting, revision and final approval. Renaud Périchon-data acquisition, analysis and interpretation, revision, and final approval. Antoine Lamer-analysis and interpretation, revision, and final approval. Bernard Cortet-study conception and design, revision, and final approval.

CONFLICT OF INTEREST STATEMENT

CJ, RP, AL, BC, EC, and JP have no competing interests in connection with this study.

ETHICS STATEMENT

UK Biobank was given a favorable opinion by the Northwest Multi-Centre Research Ethics Committee (Ref: 11/NW/0382). This study was conducted under UK

Biobank application number 66515. The authors certify that they comply with the ethical guidelines for authorship and publishing in the Journal of Cachexia, Sarcopenia and Muscle.

SPONSOR'S ROLE

UK Biobank receives funding from the Wellcome Trust medical charity, the Medical Research Council (MRC), the UK Department of Health, the Scottish Government, and the Northwest Regional Development Agency. It has also received funding from the Welsh Assembly Government and the British Heart Foundation. The MRC and the Wellcome Trust fund the independent Ethics and Governance Council.

However, the authors received no funding for this study, which was conducted on data obtained from the UK Biobank database (Application ID: 66515). So UK Biobank fundings had no input on the study design, data analysis or interpretation, report writing, approval of the manuscript, or the decision to submit the paper for publication.

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REFERENCES

- Cruz-Jentoft AJ, Bahat G, Bauer J, et al. Sarcopenia: revised European consensus on definition and diagnosis. *Age Ageing*. 2019;48(1):16-31. doi:10.1093/ageing/afy169
- Cruz-Jentoft AJ, Baeyens JP, Bauer JM, et al. Sarcopenia: European consensus on definition and diagnosis: report of the European working group on sarcopenia in older people. *Age Ageing*. 2010;39(4):412-423. doi:10.1093/ageing/afq034
- Anker SD, Morley JE, Haehling S. Welcome to the ICD-10 code for sarcopenia. *J Cachexia Sarcopenia Muscle*. 2016;7(5):512-514. doi:10.1002/jcsm.12147
- Tournadre A, Vial G, Capel F, Soubrier M, Boirie Y. Sarcopenia. *Joint Bone Spine*. 2019;86(3):309-314. doi:10.1016/j.jbspin.2018.08.001
- Petermann-Rocha F, Ferguson LD, Gray SR, et al. Association of sarcopenia with incident osteoporosis: a prospective study of 168,682 UK biobank participants. *J Cachexia Sarcopenia Muscle*. 2021;12(5):1179-1188. doi:10.1002/jcsm.12757
- Beaudart C, Zaaria M, Pasleau F, Reginster JY, Bruyère O. Health outcomes of sarcopenia: a systematic review and meta-analysis. Wright JM, ed. *PLoS One*. 2017;12(1):e0169548. doi:10.1371/journal.pone.0169548
- Han P, Yu H, Ma Y, et al. The increased risk of sarcopenia in patients with cardiovascular risk factors in suburb-dwelling older Chinese using the AWGS definition. *Sci Rep*. 2017;7(1):9592. doi:10.1038/s41598-017-08488-8
- He N, Zhang Y, Zhang L, Zhang S, Ye H. Relationship between sarcopenia and cardiovascular diseases in the elderly: an overview. *Front Cardiovasc Med*. 2021;8:743710. doi:10.3389/fcvm.2021.743710
- von Haehling S, Ebner N, dos Santos MR, Springer J, Anker SD. Muscle wasting and cachexia in heart failure: mechanisms and therapies. *Nat Rev Cardiol*. 2017;14(6):323-341. doi:10.1038/nrcardio.2017.51
- Frijhoff J, Winyard PG, Zarkovic N, et al. Clinical relevance of biomarkers of oxidative stress. *Antioxid Redox Signal*. 2015;23(14):1144-1170. doi:10.1089/ars.2015.6317
- Baltacı MA, Atmis V, Metin Y, et al. Sarcopenia and cardiovascular risk indices: its impact on cardiovascular events and mortality in dialysis patients. *Semin Dial*. Published online June 15, 2022;36(3):221-230. doi:10.1111/sdi.13106
- Petermann-Rocha F, Ho FK, Welsh P, et al. Physical capability markers used to define sarcopenia and their association with cardiovascular and respiratory outcomes and all-cause mortality: a prospective study from UK Biobank. *Maturitas*. 2020;138:69-75. doi:10.1016/j.maturitas.2020.04.017
- Petermann-Rocha F, Gray SR, Pell JP, Ho FK, Celis-Morales C. The joint association of sarcopenia and frailty with incidence and mortality health outcomes: a prospective study. *Clin Nutr*. 2021;40(4):2427-2434. doi:10.1016/j.clnu.2020.10.044
- Farmer RE, Mathur R, Schmidt AF, et al. Associations between measures of sarcopenic obesity and risk of cardiovascular disease and mortality: a cohort study and mendelian randomization analysis using the UK Biobank. *J Am Heart Assoc*. 2019;8(13) Accessed February 23, 2022:e011638. doi:10.1161/JAHA.118.011638
- Sudlow C, Gallacher J, Allen N, et al. UK Biobank: an open access resource for identifying the causes of a wide range of complex diseases of middle and old age. *PLoS Med*. 2015;12(3):e1001779. doi:10.1371/journal.pmed.1001779
- Collins R. UK Biobank Protocol. Published online March 2007 <https://www.ukbiobank.ac.uk/media/gnkeyh2q/study-rationale.pdf>
- Roberts HC, Denison HJ, Martin HJ, et al. A review of the measurement of grip strength in clinical and epidemiological studies: towards a standardised approach. *Age Ageing*. 2011;40(4):423-429. doi:10.1093/ageing/afq051
- Janssen I, Heymsfield SB, Baumgartner RN, Ross R. Estimation of skeletal muscle mass by bioelectrical impedance analysis. *J Appl Physiol*. 2000;89(2):465-471. doi:10.1152/jappl.2000.89.2.465
- Buckinx F, Landi F, Cesari M, et al. Pitfalls in the measurement of muscle mass: a need for a reference standard: measurement of muscle mass. *J Cachexia Sarcopenia Muscle*. 2018;9(2):269-278. doi:10.1002/jcsm.12268
- Santiago LB, Roriz AKC, de Oliveira CC, de Oliveira TM, da Conceição-Machado MEP, Ramos LB. Phase angle as a screening method for sarcopenia in community-dwelling older adults. *Rev Nutr*. 2022;35:e200243. doi:10.1590/1678-9865202235200243
- Weir CB, Jan A. BMI classification percentile and cut off points. *StatPearls*. StatPearls Publishing; 2021. <http://www.ncbi.nlm.nih.gov/books/NBK541070/>
- Kang DO, Park SY, Choi BG, et al. Prognostic impact of low skeletal muscle mass on major adverse cardiovascular events in coronary artery disease: a propensity score-matched analysis of a single center all-comer cohort. *J Clin Med*. 2019;8(5):712. doi:10.3390/jcm8050712
- Sato R, Akiyama E, Konishi M, et al. Decreased appendicular skeletal muscle mass is associated with poor outcomes after ST-segment elevation myocardial infarction. *J Atheroscler Thromb*. 2020;27(12):1278-1287. doi:10.5551/jat.52282

24. Chin SO, Rhee SY, Chon S, et al. Sarcopenia is independently associated with cardiovascular disease in older Korean adults: the Korea National Health and nutrition examination survey (KNHANES) from 2009. Gong Y, ed. *PLoS One*. 2013;8(3): e60119. doi:[10.1371/journal.pone.0060119](https://doi.org/10.1371/journal.pone.0060119)
25. Kim TN, Choi KM. The implications of sarcopenia and sarcopenic obesity on cardiometabolic disease: sarcopenic obesity and cardiometabolic disease. *J Cell Biochem*. 2015;116(7): 1171-1178. doi:[10.1002/jcb.25077](https://doi.org/10.1002/jcb.25077)

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Supplementary figure S1. Secondary analysis forest plots. (A). Incident cardiovascular events, considered

independently, in non-sarcopenics versus presarcopenics (n°1 and 2) and sarcopenics. (B). Incident cerebrovascular events, considered independently, in non-sarcopenics (reference) versus presarcopenics (n°1 and 2) and sarcopenics. (C). Incident major adverse cardiac and cerebrovascular events in NonSarcNonObese (reference) versus NonSarcObese, PreSarcNonObese, and PreSarcObese.

How to cite this article: Jauffret C, Périchon R, Lamer A, Cortet B, Chazard E, Paccou J.

Association between sarcopenia and risk of major adverse cardiac and cerebrovascular events-UK Biobank database. *J Am Geriatr Soc*. 2024;72(3): 693-706. doi:[10.1111/jgs.18664](https://doi.org/10.1111/jgs.18664)