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## Physical activity is associated with improved bone health in children with inflammatory bowel disease.

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1 **Article title:** Physical activity is associated with improved bone health in children with  
2 inflammatory bowel disease

3 **Short running head:** Bone health and physical activity

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7

8

9 **Abbreviations:** Body Mass Index (BMI), Bone Mineral Density (BMD), Crohn's Disease  
10 (CD), Inflammatory Bowel Disease (IBD), Physical Activity (PA), Moderate-to-Vigorous  
11 Physical Activity (MVPA), Ulcerative Colitis (UC).

12 † This work is dedicated to the memory of Dr Laurent Michaud.

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15

16

**Abstract**

17 **Background & Aims:** Bone health is an important concern in patients with inflammatory  
18 bowel disease (IBD). Low bone mineral density (BMD) is a powerful predictor of fracture  
19 risk in IBD patients. Physical activity (PA) plays an important role in bone health. However,  
20 PA data for children and adolescents with IBD are scarce. The primary aim is to evaluate the  
21 relationship between PA and BMD in children with IBD. The secondary aim was to assess the  
22 relationship between PA and quality of life.

23 **Methods:** Eighty-four IBD pediatric patients (45 boys) aged  $14.3 \pm 2.7$  years were included  
24 (disease activity: (i) remission, n=62; (ii) mild, n=18; (iii) severe disease, n=1). BMD was  
25 measured using dual-energy X-ray absorptiometry and expressed as age- and sex-based Z-  
26 scores. Each patient wore a triaxial accelerometer for seven consecutive days for objective PA  
27 quantification. Quality of life was assessed using the PedsQL™ and energy intake was  
28 assessed prospectively for three days using a dietary diary.

29 **Results:** BMD Z-score was  $-0.96 \pm 1.11$ . Only five patients (6%) fulfilled the  
30 recommendation of 60 min of daily moderate-to-vigorous PA (MVPA). The proportion of  
31 children with osteopenia and osteoporosis was 51% and 4%, respectively. After adjustment  
32 for confounders (pubertal status and body mass index), total PA and time in MVPA were  
33 positively associated with BMD (regression coefficient per one standard deviation increase in  
34 PA parameters=0.26;  $P<0.05$ ). There was no association between time spent in MVPA and  
35 total PA, and total quality of life score.

36 **Conclusions:** PA likely is associated with improved bone health in IBD children. Intervention  
37 studies investigating a causal relationship between PA and BMD in pediatric patients with  
38 IBD are warranted.

39 **Keywords:** Lifestyle habits, bone mineral density, pediatrics, inflammation.



## 41 INTRODUCTION

42 Inflammatory bowel diseases (IBDs), including Crohn's disease (CD), ulcerative colitis (UC)  
43 and IBD-unclassified (IBD-U), are characterised by chronic inflammation of the  
44 gastrointestinal tract. Over the past 50 years, the incidence of IBD has increased globally,  
45 with the highest increase in industrialised countries [1]. During the last 25 years, the incidence  
46 of IBD has increased dramatically among teenagers in northern France, with an increase of  
47 126% and 156% for CD and UC, respectively [2].

48 Bone mass acquisition during childhood and adolescence is a major determinant of skeletal  
49 health later in life [3]. Bone health is an important concern in patients with IBD. The  
50 prevalence of low bone mineral density (BMD) in children and adolescents with IBD ranges  
51 from 8% to 65% [4-6]. Bone mineralisation abnormalities in paediatric IBD are associated  
52 with the use of corticosteroids, disease activity, low body weight, young age at onset, pubertal  
53 delay, vitamin D deficiency, low calcium intake and intestinal malabsorption [7-9]. Low  
54 BMD is a powerful predictor of fracture risk in IBD patients [10].

55 Physical activity (PA), widely recognised as an important health determinant, plays an  
56 important role in growth and development. Increased participation in moderate-to-vigorous  
57 PA (MVPA) has major health benefits, including a lower risk of cardiovascular and  
58 pulmonary disease, musculoskeletal disorder, psychiatric, neurological and metabolic disease  
59 as well as cancer [11]. According to international PA recommendations, 60 min of MVPA  
60 daily are needed to positively impact child and adolescent health [12]. In contrast, a sedentary  
61 lifestyle is associated with adverse health consequences and increased morbidity and mortality  
62 in adulthood [13]. However, PA data for children and adolescents with IBD are scarce.

63 Thus, the primary aim of the study was to evaluate the relationship between PA and bone  
64 health in IBD paediatric patients. The secondary aim was to assess the relationship between  
65 PA and quality of life.

66

## 67 **SUBJECTS AND METHODS**

### 68 **Study design**

69 From October 2014 to March 2017, consecutive paediatric patients with IBD who were  
70 followed in hospitals in northern France were invited to participate in this prospective study.  
71 Inclusion criteria were: (i) age 6–18 years; (ii) informed consent signed by the patient and  
72 his/her parents; (iii) IBD diagnosis (CD, UC, IBD-U) at least six months prior; and (iv) not  
73 currently participating in another biomedical study. Exclusion criteria were: (i) acute or  
74 chronic disease (other than IBD) associated with a decrease in PA; and (ii) any recent event  
75 ( $\leq 15$  days) that could affect PA. Eighty-four patients were included.

76 Before participating, the study aims and objectives were carefully explained to, and written  
77 informed consent obtained from, each patient and his/her parents. The study was approved by  
78 the Research Ethics Committee of the University of Lille (Comité de Protection des  
79 Personnes, Nord Ouest IV, Lille, France). All procedures were performed according to the  
80 ethical standards of the Helsinki Declaration of 1975, as revised in 2008, and European Good  
81 Clinical Practice.

82

### 83 **Measurements**

84 *Physical activity*

85 PA was assessed using accelerometry, an objective method for use with youth [14]. The  
86 triaxial accelerometer was the ActiGraph<sup>®</sup> Monitor (Model GT3X; ActiGraph, Pensacola,  
87 CA, USA), with dimensions 46 × 33 × 15 mm and weight 19 g. The accelerometer measures  
88 acceleration in three spatial dimensions according to vertical (x), antero-posterior (y) and  
89 medio-lateral (z) vectors. The vector magnitude (VM) was calculated as:  $VM = \sqrt{x^2+y^2+z^2}$ .  
90 The epoch length was set at 1 sec. A computer was used to initialise and synchronise the  
91 accelerometer, which was calibrated based on patient age, height and weight. The GT3x  
92 accelerometer has been validated for measuring PA against oxygen consumption and heart  
93 rate [15]. The inter-instrument reliability for this device is better for moderate and vigorous  
94 activity than for sedentary activity [16]. Consistent with consensus recommendations for  
95 assessing PA in youth, patients who did not report at least three days with a minimum of 10  
96 hours of PA per day were excluded from analyses [17]. PA activity levels were classified as:  
97 sedentary (0–180 counts.15sec<sup>-1</sup>); light (181–757 counts.15sec<sup>-1</sup>); moderate (758–1112  
98 counts.15sec<sup>-1</sup>); and vigorous (>1112 counts.15sec<sup>-1</sup>) [15].

99 Patients wore the accelerometer on their lower back, beneath their clothing, using an elastic  
100 belt with adjustable buckle. They were asked to follow their normal daily routine and  
101 instructed to remove the device during contact sports, water-based activities (e.g., swimming,  
102 showering, bathing) and overnight. The accelerometer was used to record activity over seven  
103 consecutive days during free-living conditions. In addition, patients and parents were  
104 instructed to keep a PA diary while the patient wore the accelerometer.

105

#### 106 *Bone mineral density and body composition*

107 BMD and body composition (fat mass and fat free mass) were measured with dual-energy X-  
108 ray absorptiometry (DEXA; Hologic Corp., Discovery Type, Software 12.6, Bedford, MA,

109 USA). Patients were scanned in the supine position at high resolution. BMD, fat mass and fat  
110 free mass were determined based on whole body scan analyses.

111 Because BMD measurements are age- and sex-specific, standardised Z-scores were calculated  
112 by subtracting the age- and sex-specific mean and dividing by the standard deviation.  
113 According to World Health Organisation recommendations, normal BMD T-scores are  $\geq -1$   
114 standard deviation (SD), osteopenia T-scores  $< -1$  to  $> -2.5$  SD and osteoporosis T-scores  
115  $\leq -2.5$  [18].

116

### 117 *Quality of life*

118 The IMPACT III was not used herein because it has not been validated among French youth.  
119 Instead, quality of life was assessed with the Pediatric Quality of Life Inventory (PedsQL™)  
120 (Version 4.0), which is divided into age groups 5–7 years, 8–12 years and 13–18 years. Each  
121 age group version has 23 questions comprising four dimensions: (i) physical functioning; (ii)  
122 emotional functioning; (iii) social functioning; and (iv) school functioning. The PedsQL™  
123 provides a total score and two subscale dimensions: (i) physical health (physical functioning  
124 scale score); and (ii) psychosocial health (emotional, social and school functioning scale  
125 scores). For children 8 to 18 years, each question is scored using a 5-point Likert scale  
126 ranging from 0 (never) to 4 (almost/always). Appropriate items were reverse scored and total  
127 scores were linearly transformed to a 0–100 scale where: 0 = 100; 1 = 75; 2 = 50; 3 = 25; and  
128 4 = 0. For children 5 to 7 years, each question is scored using a 3-point Likert scale ranging  
129 from 0 (not at all), 2 (sometimes) and 4 (a lot). Higher scores indicate a better quality of life.  
130 Based on scoring recommendations, patients replied to at least 50% of the questions.  
131 Patients were asked to complete the age-appropriate PedsQL™ forms and rate the degree to  
132 which each item had been a problem for them during the past month, on a 5-point Likert scale



133 for children 8 to 18 years and a 3-point Likert scale for children 5 to 7 years. Total score and  
134 subscale dimensions are expressed as percentages of the maximum points possible.

135

#### 136 *Energy intake*

137 Energy intake was assessed using a prospective dietary diary for three consecutive days,  
138 including one weekend day. Patients were interviewed about the types of foods consumed  
139 during the three 24-hour periods. For the greatest precision possible, patients could complete  
140 the dietary diary with their parents. The same dietitian reviewed all dietary diaries. Patients  
141 were assisted by an instruction manual for food codification, including validated photographs  
142 of more than 250 foods represented in three different portion sizes. Foods were presented in  
143 three sizes permitting, with intermediate and extreme positions, seven choices of the amount  
144 [19]. All quantities were then calculated using KIDMENU<sup>®</sup> software (SHS, Paris, France) to  
145 compute energy intake using food composition tables from the French Food Safety Agency  
146 [20].

147

#### 148 *Clinical assessment*

149 Each patient underwent a detailed medical examination. Pubertal status was assessed by direct  
150 observation according to Tanner and Whitehouse [21]. Body mass was measured to the  
151 nearest 0.1 kg using an electronic scale (Seca, Hamburg, Germany) after removal of shoes and  
152 heavy outer garments. Height was measured to the nearest 0.1 cm using a stadiometer (Seca,  
153 Hamburg, Germany). Body mass index (BMI) was calculated as weight (kg) divided by  
154 height<sup>2</sup> (m<sup>2</sup>). Patients had a plain radiograph of the left hand; wrist and bone age were  
155 expressed in years using the Greulich and Pyle atlas [22]. In addition, 25(OH)vitamin D,  
156 haematocrit, C-reactive protein, albumin and erythrocyte sedimentation rate were measured to

157 assess inflammation and calculate disease activity. The Pediatric CD Activity Index (PCDAI)  
158 was used for patients with CD and the Pediatric Ulcerative Colitis Activity Index (PUCAI) for  
159 patients with UC [23-24]. The PCDAI comprises three domains: (i) history (one-week recall  
160 of abdominal pain, stools, patient functioning, general well-being); (ii) laboratory results  
161 (haematocrit, erythrocyte sedimentation rate, albumin); and (iii) physical examination  
162 (weight, height, abdomen, perirectal disease, extra-intestinal manifestations). The PUCAI  
163 comprises six domains: (i) abdominal pain; (ii) rectal bleeding; (iii) stool consistency; (iv)  
164 number of stools per 24 hours; (v) nocturnal stools; and (vi) activity level. Remission was  
165 defined as scores  $<10$  and mild activity as scores 10–27.5 on the PCDAI and 10–34 on the  
166 PUCAI. Values  $>37.5$  on the PCDAI or  $>34$  on the PUCAI indicated moderate to severe  
167 activity. Drug therapy, including 5-ASA, corticosteroids, immunomodulators (azathioprine,  
168 methotrexate) and anti-TNF therapy (infliximab, adalimumab) was recorded.

169

### 170 *Sample size calculation and statistical analysis*

171 The study objective was to evaluate the association between PA and BMD in children with  
172 IBD. Classification of correlation coefficients was based on Cohen's rule, where  $<0.3$  is weak,  
173  $0.3$ – $0.6$  moderate and  $>0.6$  high [25]. Sample size calculation was based on:  $H_0$ :  $r = 0$  (no  
174 correlation between parameters) vs.  $H_1$ :  $r = 0.3$  (average correlation between parameters). For  
175  $\alpha = 5\%$  and power = 80%,  $N = 84$  participants were needed.

176 Data are presented as counts (percentages) for categorical variables and mean $\pm$ SD or median  
177 [range] for quantitative variables. Normality of distribution was assessed visually using  
178 histograms and by using the Shapiro–Wilk test. Associations of PA parameters with outcomes  
179 (BMD Z-score and quality of life) were analysed using linear regression models with and  
180 without adjustment for confounding factors. For each outcome, confounding factors were

181 selected according to bivariate analyses ( $p < 0.10$ ). Associations of each outcome with  
182 potential confounding factors were assessed using Student's *t*-test for categorical confounding  
183 factors and Pearson (or Spearman's rank) correlation coefficients for quantitative (or ordinal)  
184 confounding factors. All statistical tests were done at the two-tailed  $\alpha$  level of 0.05. Data were  
185 analysed using SAS software version 9.4 (SAS Institute Inc., Cary, NC, USA).

186

## 187 **RESULTS**

188 Sample characteristics are presented in Table 1. Mean BMD Z-score ( $\pm$ SD) was  $-0.96 \pm 1.11$ .  
189 The computer analysis of the accelerometer data showed that 82 participants wore the  
190 accelerometer during at least three days with a minimum of 10 hours of PA per day. Two  
191 participants were excluded from the analysis because of monitoring failure. Only five patients  
192 (6%) fulfilled the recommendation of 60 min of MVPA daily. The prevalence of osteopenia  
193 and osteoporosis was 51% and 4%, respectively. Drug therapy is also depicted in Table 1.

194

195 Bivariate analyses assessing the relationships between BMD-Z score and potential  
196 confounding factors are shown in Table 2. BMI and pubertal status (Tanner grade) were  
197 positively associated with BMD Z-score ( $p < 0.05$  for both associations).

198 As shown in Table 3, BMD was not significantly related to any of the PA parameters in  
199 bivariate analyses. However, after adjustment for confounding factors, total PA and time  
200 spent in MVPA were positively associated during the weekdays with BMD ( $p = 0.041$  and  
201  $p = 0.046$ , respectively).

202 The PedsQL<sup>TM</sup> total score ( $\pm$ SD) was  $81.6 \pm 13.4$ . Associations of quality of life score and  
203 potential confounding factors are presented in Table 4. A positive significant association was  
204 found between pubertal status and quality of life ( $r = 0.23$ ).

205 As shown in Table 5, no significant association was found between time spent in MVPA/total  
206 PA and quality of life in multivariable linear regression models adjusted for pubertal status.

207

## 208 **DISCUSSION**

209 Osteoporosis is a common skeletal disease and is associated with high morbidity and  
210 mortality in adulthood [26]. Even if our study shows that mean BMD Z-score of IBD  
211 paediatric patients was within normal range, it is of note that osteopenia was found in half of  
212 the patients while osteoporosis was rare. BMD-Z score and quality of life score did not differ  
213 significantly according to disease severity. Only a non-significant higher quality of life score  
214 in children in remission was found compared to children with mild or severe disease (mean:  
215  $83 \pm 13$  vs.  $76 \pm 15$ ;  $p=0.058$ ). In relation to our primary objective, the present study shows a  
216 positive association between BMD and both amount of PA and time spent in MVPA. This  
217 result is consistent with those reported for healthy children [27-28]. Vicente-Rodriguez et al.  
218 observed a negative association between sedentary lifestyle and bone health in healthy  
219 adolescents. More than three hours daily of sedentary behaviour (e.g., watching TV) was  
220 associated with increased risk for low bone mineral content in males [27]. In healthy young  
221 adults, PA is associated with improved BMD independent of gender and vitamin D status  
222 [28]. To our knowledge, the only study assessing bone health and PA in IBD has been  
223 performed in adult patients [29]. Patients were randomised to a control group or a low-impact  
224 exercise program with increasing intensity across a 12-month period [29]. In patients who  
225 were able to fully comply with the exercise program, the only significant BMD gain was  
226 observed at the greater trochanter (+4.7%); these findings were independent of changes in  
227 potential confounding variables (e.g., steroid dose, weight, diet).

228 IBD have a well-known negative impact on health-related quality of life (HRQoL) [30]. Ng et  
229 al studied PA as non-pharmacological approach in the management of IBD for improving or  
230 maintaining HRQoL [31]. Another study showed that adult patients engaged higher volumes  
231 of MVPA above 150 min/week and walking, particularly above 60 min/week, improved their  
232 quality of life [32]. Similar results have been found in people with other chronic diseases or in  
233 healthy people [33-35]. Results from our study do not concur with previous research.

234 According to youth PA guidelines, children and adolescents should accumulate a minimum of  
235 60 min of MVPA daily through transportation, physical education, sports, free play and  
236 planned exercise for positive health outcomes [12]. A very low proportion of our study  
237 sample followed this recommendation. These data are alarming in relation to studies of  
238 healthy children [36-37]. In 2004, among 2185 children and adolescents assessed with  
239 accelerometry, 90% of boys and 80% of girls achieved health-related PA recommendations  
240 [36]. In a population of 2200 European adolescents, 57% of boys and 28% of girls followed  
241 the PA recommendations, based on accelerometer [37]. Wekstetter et al. compared PA levels  
242 between IBD paediatric patients and healthy controls [38]. The differences in PA duration and  
243 number of steps between groups did not reach statistical significance; however, female  
244 patients had a significantly shorter duration of PA (in total and moderate level). In our study,  
245 between patients in remission and patients with mild or severe disease activity, no difference  
246 was found in total PA (158.1 vs 176.4 counts.min<sup>-1</sup>, p = 0.40) and time spent in MVPA (44.8  
247 vs 42.9 min.day<sup>-1</sup>, p = 0.47).

248 It has been hypothesized that PA could be associated with an increased risk for exacerbation  
249 of inflammation [39]. Ploeger et al examined inflammatory cells and cytokines in response to  
250 acute bouts of moderate intensity continuous exercise and high intensity intermittent exercise  
251 in youth with CD and in healthy matched controls [39]. In CD patients, both types of exercise  
252 increased immune cells. Moderate intensity exercise induced a significantly greater increase

253 in leukocytes, neutrophils, lymphocytes, monocytes, IL-6 and IL-17, compared with high  
254 intensity exercise. TNF- $\alpha$  did not change significantly with either exercise. These preliminary  
255 results suggest that moderate PA of short duration is not associated with a deleterious effect  
256 on inflammatory parameters. However, further studies are needed to assess the effects of  
257 regular exercise on inflammation in IBD pediatric patients.

258 The current study has both strengths and limitations. Importantly, strong objective methods  
259 were used to assess both PA (using accelerometry) and bone health (using DEXA).  
260 Additionally, confounding factors were accounted for in the statistical analyses. The study  
261 limitations include its observational design, which means that associations cannot be  
262 interpreted as causal. Moreover, the sample size did not allow to study the impact of gender  
263 on PA, quality of life and BMD-Z score, and to test the heterogeneity in PA and BMD score  
264 according to disease severity. Regarding the multiple testing issue, we could not exclude false  
265 positive findings. Moreover, we could not exclude bias in estimates due to missing data. In  
266 addition, the thresholds used to classify PA may have affected the results, as previously  
267 described [40]. Variations in weather conditions (e.g., wind, rain, sunshine) during PA  
268 assessments were not recorded but may also have affected our results. Another limitation of  
269 our study is the lack of information on the type of PA. Animal data showed that mechanical  
270 stress (*i.e.*, mechanical loading) on bone can enhance bone mass [41-44]. Results in healthy  
271 adolescents concur with animal studies. PA involving weight bearing (e.g walking, running) is  
272 more beneficial to bone mass as compared to PA with minimal weight bearing (e.g cycling,  
273 swimming) [45-46]. Another limitation of the current study is that the small sample size did  
274 not allow to compare CD patients and UC patients.

275 In summary, PA was found to be positively associated with BMD in paediatric patients with  
276 IBD. Intervention studies investigating a causal relationship between PA and BMD are thus  
277 warranted in order to determine whether IBD paediatric patients could benefit from PA

278 promotion programs. In addition, these studies should aim at determining the most adequate  
279 PA, including type, intensity, duration and frequency.

280

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287

**288 Conflict of interest**

289 The authors do not have any competing interests.

290

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430 **Legends**

431 **Table 1.** Characteristics of the study patients

432 **Table 2.** Associations between  $BMD_{wb}$  Z-score and potential confounding factors

433 **Table 3.** Associations between  $BMD_{wb}$  Z-score and physical activity

434 **Table 4.** Associations between quality of life and potential confounding factors

435 **Table 5.** Associations between quality of life and physical activity

436



**Table 1.** Characteristics of the study patients

	N	Values
Boys	84	45 (53.6)
Age ( <i>years</i> )	84	14.3 ± 2.7
Height ( <i>cm</i> )	84	160 ± 15
Height-Z score ( <i>mean ± SD</i> )	84	0.38 ± 1.6
Weight ( <i>kg</i> )	84	50 ± 15
Weight-Z score ( <i>mean ± SD</i> )	84	0.4 ± 1.2
Body mass index ( <i>kg.m<sup>-2</sup></i> )	84	19.5 ± 3.4
Body mass index-Z score ( <i>mean ± SD</i> )	84	0.21 ± 1.3
Pubertal status (Tanner grade)	82	
I		17 (21%)
II		11 (13%)
III		12 (15%)
IV		26 (32%)
V		16 (20%)
Age at diagnosis ( <i>years</i> )	83	10.9 ± 2.8
Disease duration ( <i>months</i> )	83	34 [range: 17-65]
IBD diagnosis	84	
Crohn's disease		58 (69%)
Ulcerative colitis		16 (19%)
Inflammatory bowel disease-unclassified		10 (12%)
Vitamin D ( <i>ng.mL<sup>-1</sup></i> )	83	25 [range: 18-32]
C-reactive protein ( <i>mg.L<sup>-1</sup></i> )	83	2 [range: 2-8]
BMD <sub>wb</sub> Z-score	78	-0.96 ± 1.11
BMD <sub>wb</sub> ( <i>g.cm<sup>-2</sup></i> )	79	0.93 ± 0.14
Fat mass (%)	79	22.4 ± 7.9
Fat free mass (%)	79	77.6 ± 7.9
Bone age ( <i>years</i> )	82	13.7 ± 2.8
Intensity of disease	81	
I (remission)		62 (77%)
II (mild activity)		18 (22%)
II (moderate to severe activity)		1 (1%)
Corticosteroids ever	84	35 (42%)
Corticosteroids lifetime	83	
I (ever use or usage ≤ 3 months)		55 (66%)
II (usage > 3 months)		28 (34%)
Drug therapy during the study period	84	
Corticosteroids		4 (5%)
5-ASA		28 (33%)
Azathioprine		14 (17%)
Methotrexate		6 (7%)
Anti-TNF therapy		36 (43%)
Energy intake ( <i>Kcal.day<sup>-1</sup></i> )	82	1748 [range: 1399-2212]
Calcium intake ( <i>mg.day<sup>-1</sup></i> )	82	580 [range: 429-844]
Phosphorus intake ( <i>mg.day<sup>-1</sup></i> )	82	652 [range: 481-941]
Fruits and vegetables ( <i>Portion.day<sup>-1</sup></i> )	82	1.7 [range: 1.0-2.7]
Total PA ( <i>counts</i> )	82	163 [range: 124-217]
Sedentary time ( <i>min.day<sup>-1</sup></i> )	82	554 [range: 488-599]
MVPA ( <i>min.day<sup>-1</sup></i> )	82	45 [range: 33-66]
Fulfilling PA recommendations	82	5 (6%)
PedsQL <sup>TM</sup> total score	84	84.8 [range: 75.0-91.3]

437 Values are expressed as count (percentage), mean ± SD or median [IQR].

438 Abbreviations: IBD= Inflammatory bowel diseases ; IQR=interquartile range; BMDwb= Bone  
439 Mineral Density of whole body, MVPA= Moderate to Vigorous Physical Activity; PA=physical  
440 activity; SD=standard deviation.  
441

442

**Table 2.** Associations between BMD<sub>wb</sub> Z-score and potential confounding factors

	<b>Values</b>	<b>P</b>
Age ( <i>years</i> )	-0.04	0.76
Sex		
Boys	-0.91 ± 1.04	0.70
Girls	-1.01 ± 1.20	
Body mass index	<b>0.54</b>	<b>&lt;0.001</b>
Intensity of disease		
Remission	-0.88 ± 1.12	0.22
Mild to severe activity	-1.25 ± 1.11	
Pubertal status (Tanner grade)	<b>0.27</b>	<b>0.019</b>
Corticosteroids lifetime		
Ever use or usage ≤ 3 months	-0.93 ± 1.10	0.49
Usage > 3 months	-1.11 ± 1.03	
Anti-inflammatory therapy		
No	-0.84 ± 1.34	0.74
Yes	-0.93 ± 0.14	
Age at diagnosis ( <i>years</i> )	0.02	0.85
Energy intake ( <i>Kcal.day<sup>-1</sup></i> )	0.11	0.33
Calcium intake ( <i>mg.day<sup>-1</sup></i> )	0.09	0.45
Phosphorus intake ( <i>mg.day<sup>-1</sup></i> )	0.11	0.34
Fruits and vegetables ( <i>Portion.day<sup>-1</sup></i> )	0.05	0.66
Fat mass (%)	<0.01	0.99
Fat free mass (%)	<0.01	>0.99
Bone age ( <i>years</i> )	0.14	0.23
Disease duration ( <i>months</i> )	<0.01	0.95
Vitamin D ( <i>ng.mL<sup>-1</sup></i> )	-0.02	0.85
C-reactive protein ( <i>mg.L<sup>-1</sup></i> )	-0.02	0.84

443 Values are mean ± standard deviation for categorical variables and correlation coefficient  
444 for continuous variables.

445 BMD<sub>wb</sub>: Bone Mineral Density of whole body

446

447

**Table 3.** Associations between BMD<sub>wb</sub> Z-score and physical activity

	Unadjusted			Adjusted*		
	$\beta$ (95%CI)	P	R <sup>2</sup> (%)	$\beta$ (95%CI)	P	R <sup>2</sup> (%)
<b>All days</b>						
MVPA	0.11 (-0.16 to 0.38)	0.41	0.9	0.19 (-0.05 to 0.44)	0.13	2.5
Sedentary	0.18 (-0.08 to 0.44)	0.16	2.6	0.15 (-0.10 to 0.40)	0.25	1.5
Counts	0.05 (-0.22 to 0.32)	0.72	0.2	0.15 (-0.10 to 0.41)	0.24	1.5
<b>Week days</b>						
MVPA	0.20 (-0.07 to 0.47)	0.14	3.0	<b>0.26 (0.01 to 0.51)</b>	<b>0.041</b>	<b>4.6</b>
Sedentary	0.20 (-0.06 to 0.46)	0.14	3.0	0.18 (-0.08 to 0.44)	0.19	1.9
Counts	0.16 (-0.11 to 0.43)	0.23	1.9	<b>0.26 (0.005 to 0.52)</b>	<b>0.046</b>	<b>4.3</b>
<b>Week end days</b>						
MVPA	0.05 (-0.21 to 0.30)	0.71	0.2	0.15 (-0.08 to 0.39)	0.21	1.7
Sedentary	0.16 (-0.09 to 0.42)	0.21	2.1	0.09 (-0.14 to 0.33)	0.42	0.7
Counts	-0.04 (-0.30 to 0.21)	0.74	0.2	0.07 (-0.17 to 0.31)	0.57	3.6

448 Data analysis was performed on 76 patients without missing data on BMD<sub>wb</sub> Z-score and physical  
449 activity parameters.

450 Abbreviations: BMD<sub>wb</sub>= Bone Mineral Density of whole body; CI= confidence interval; MVPA=  
451 moderate to vigorous physical activity

452  $\beta$  indicate regression coefficient per one standard deviation increase in PA parameters. R<sup>2</sup>  
453 indicates the squared semi-partial correlation coefficient.

454 \* Adjusted for between-group difference in potential confounding factors at p<0.10 in bivariates  
455 analyses (body mass index and Tanner grade).

456

457

**Table 4.** Associations between quality of life and potential confounding factors

	Values	P
Age ( <i>years</i> )	0.16	0.14
Sex		0.16
Boys	83.6 ± 10.3	
Girls	79.3 ± 16.1	
Body mass index	0.11	0.32
Intensity of disease		0.058
Remission	83.0 ± 12.7	
Mild to severe activity	76.3 ± 15.5	
Pubertal status (Tanner grade)	<b>0.23</b>	<b>0.039</b>
Corticosteroids lifetime		0.96
Ever use or usage ≤ 3 months	81.4 ± 13.4	
Usage > 3 months	81.5 ± 16.7	
Anti-inflammatory therapy		0.19
No	87.2 ± 10.3	
Yes	81.0 ± 13.6	
Age at diagnosis ( <i>years</i> )	0.14	0.19
Energy intake ( <i>Kcal.day<sup>-1</sup></i> )	0.01	0.91
Fruits and vegetables ( <i>Portion.day<sup>-1</sup></i> )	0.08	0.46
Fat mass (%)	-0.18	0.11
Fat free mass (%)	0.18	0.11
Disease duration ( <i>months</i> )	0.11	0.34

458 Values are mean ± standard deviation for categorical variables and correlation  
459 coefficient for continuous variables.

460

461

**Table 5.** Associations between quality of life and physical activity

	Unadjusted			Adjusted*		
	$\beta$ (95%CI)	P	R <sup>2</sup>	$\beta$ (95%CI)	P	R <sup>2</sup>
<b>Total score</b>						
MVPA	-2.09 (-5.04 to 0.85)	0.16	0.025	-1.47 (-4.61 to 1.67)	0.35	0.011
Counts	-2.71 (-5.63 to 0.21)	0.069	0.041	-2.01 (-5.24 to 1.24)	0.22	0.019
<b>Dimension I</b>						
MVPA	-2.75 (-5.72 to 0.22)	0.069	0.041	-1.73 (-4.83 to 1.38)	0.27	0.015
Counts	<b>-2.98 (-5.94 to -0.03)</b>	<b>0.048</b>	<b>0.048</b>	-1.64 (-4.86 to 1.59)	0.31	0.013
<b>Dimension II</b>						
MVPA	-1.75 (-5.05 to 1.55)	0.30	0.014	-1.34 (-4.87 to 2.20)	0.45	0.007
Counts	-2.56 (-5.83 to 0.71)	0.12	0.029	-2.20 (-5.85 to 1.45)	0.23	0.019

462 Data analysis was performed on 82 patients without missing data on PedsQL<sup>TM</sup> total and

463 physical activity parameters (calculated for all days).

464 Abbreviations: CI= confidence interval; MVPA= moderate to vigorous physical activity.

465 Dimension I: physical health comprising of the physical functioning scale score

466 Dimension II: psychosocial health comprising of the emotional, social and school functioning scales score

467  $\beta$  indicates regression coefficient per one standard deviation increase in PA parameters.

468 \* Adjusted for between-group difference in potential confounding factors at  $p < 0.10$  in bivariate

469 analyses (Tanner Grade and Intensity of disease)

470