Hours of work and the risk of developing impaired fasting glucose or type 2 diabetes mellitus in Japanese male office workers

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Abstract

Objective—To investigate the association between duration of overtime and the development of impaired fasting glucose (IFG) or type 2 diabetes mellitus (DM).

Methods—A cohort of 1266 Japanese male office workers aged 35–59 years and free of IFG (fasting plasma glucose concentration 6.1–6.9 mmol/l), type 2 DM (fasting plasma glucose concentration of 7.0 mmol/l or more or taking hypoglycaemic medication), history of diabetes, or medication for hypertension were re-examined over 5 successive years after their initial examinations in 1994.

Results—138 men developed IFG or type 2 DM during the 5736 person-years of follow up. After controlling for potential predictors of diabetes, the relative risks of IFG or type 2 DM, compared with those who worked <8.0 hours a day, were 0.82 (95% confidence interval 0.54 to 1.26), 0.69 (95% CI 0.38 to 1.26), 0.63 (95% CI: 0.37 to 1.09), and 0.50 (95% CI: 0.25 to 0.98) for those who worked 8.0–8.9, 9.0–9.9, 10.0–10.9, and of 11.0 hours or more a day, respectively (p for trend=0.200). 87 and 54 men developed IFG and type 2 DM during the 5817 and 5937 person-years of follow up, respectively. The multivariate adjusted relative risks of IFG tended to decrease with an increase in hours of overtime work a day, but did not reach significance (p for trend=0.202). On the other hand, the multivariate adjusted relative risks of type 2 DM significantly decreased with an increase in hours of overtime work a day (p for trend=0.014).

Conclusion—Longer overtime is a negative risk factor for the development of IFG or type 2 DM in Japanese male office workers.

Keywords: long overtime; impaired fasting glucose; type 2 diabetes mellitus

Type 2 diabetes mellitus (DM), which affects 7 million Japanese people over the age of 20 years, is a complex disorder characterised by impaired secretion of insulin and increased resistance to insulin, and is associated with an increased risk of coronary heart disease, peripheral vascular disease, renal failure, and blindness. Although age, obesity, and a family history of diabetes are well established risk factors for this condition, evidence is increasing that type 2 DM shares common causal factors with cardiovascular disease and in particular with coronary heart disease. Previous studies have shown that alcohol intake, cigarette smoking, reduced physical activity, diets with a high glycaemic load and a low cereal fibre content, and psychological factors are associated with the risk of type 2 DM.3–16 Furthermore, certain risk factors for coronary heart disease such as hypertension and dyslipidaemia are also known to be associated with the risk of type 2 DM.17–20 As many of these factors are influenced not only by personal circumstances but also by work environments, it is reasonable to consider that working conditions are related to the development of type 2 DM.

The association between working conditions and the risk of type 2 DM has been reported showing that air traffic controllers who engaged in a high demand job had a higher prevalence of diabetes than other workers.21 It was also reported that job strain and job stressors including a lack of worksite social support were associated with increased concentrations of glycosylated haemoglobin among non-diabetic populations.22 Experimental studies in both animals and humans have also reported that psychological stress increases blood glucose and decreases insulin activity, which then could lead to glucose intolerance.23–26 If it is assumed that long overtime is a major source of occupational stress, it is reasonable to expect an association between long overtime and the development of type 2 DM.

This study therefore prospectively examined the relation between duration of overtime and the development of impaired fasting glucose (IFG) or type 2 DM (as diagnosed with the new revised criteria of the American Diabetes Association (ADA) in 199727 for epidemiological studies) in normoglycaemic Japanese male office workers over a 5 year observation period.

Methods

STUDY COHORT

To evaluate the association between long overtime and the development of IFG or type 2 DM, a surveillance of the incidence of the two diseases was conducted between 1994 and 1999 among Japanese male office workers, not working in a shift system. One of the biggest building contractors in Osaka, Japan. All Japanese male office workers aged 35–59 in May 1994 were invited to attend a
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Weight and height were measured in light

examining physicians. Family history of

drugs were assessed for each subject by the

have been published elsewhere.11 24 Medical

behaviour. Additional details of the study items

measurements, biochemical measurements,

and a questionnaire on job and health related

measurements, blood pressure

The health examinations at entry included a

STUDY ITEMS

Fasting plasma glucose concentrations were measured at each annual health examination in May in the years 1994–9. The participants were asked to fast for at least 8 hours and to avoid smoking and heavy physical activity for more than 2 hours before the examinations. Fasting blood samples were drawn from an antecubital vein for the measurement of fasting plasma glucose concentration. Fasting plasma glucose concentrations were measured by the glucose dehydrogenase spectrophotometry method with an Olympus AU-5000 in 1994 and an Olympus AU-5200 in 1995–9 (Olympus Japan, Tokyo, Japan). Quality control of the laboratory was maintained internally, and the coefficients of variation between

STATISTICAL ANALYSIS

The statistical differences of the characteristics at enrollment relative to hours of work a day were examined with the χ² test and one way analysis of variance (ANOVA). For each subject, person-years of follow up were counted from the date of enrollment to the date of the first incidence of IFG or type 2 DM or the date of follow up, whichever came first. Those who had been transferred to another locality or had retired during the follow up period had their observation time censored as did those members of the cohort who were still in T Corporation, Osaka, at the end of follow up and who had no incidence of IFG or type 2 DM. The follow up rate was 95.6% of total potential person-years of follow up. Cox’s proportional hazards models were used to evaluate the association between hours of work a day and the development of IFG or type 2 DM. Data were adjusted firstly for age alone, then for multiple covariates including age, occupation, position, body mass index, cigarette smoking, alcohol intake, eating breakfast,
Table 1 Baseline characteristics of 1266 Japanese male office workers, by hours of work a day*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>&lt;8.0 (n=358)</th>
<th>8.0–8.9 (n=339)</th>
<th>9.0–9.9 (n=220)</th>
<th>10.0–10.9 (n=175)</th>
<th>&gt;11.0 (n=174)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>48.5 (6.0)</td>
<td>47.6 (5.6)</td>
<td>46.1 (5.9)</td>
<td>44.4 (5.4)</td>
<td>44.3 (6.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Occupation (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Architect or research worker</td>
<td>49.4</td>
<td>64.9</td>
<td>57.7</td>
<td>67.4</td>
<td>69.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Manager</td>
<td>61.5</td>
<td>60.5</td>
<td>56.8</td>
<td>47.4</td>
<td>45.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>23.3 (2.6)</td>
<td>23.1 (2.6)</td>
<td>22.6 (2.6)</td>
<td>22.8 (2.5)</td>
<td>23.1 (2.6)</td>
<td>0.015</td>
</tr>
<tr>
<td>Cigarette smoking (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cigarettes currently</td>
<td>52.8</td>
<td>51.9</td>
<td>45.0</td>
<td>51.4</td>
<td>52.9</td>
<td>0.406</td>
</tr>
<tr>
<td>Alcohol intake (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consuming alcohol every day</td>
<td>62.0</td>
<td>64.6</td>
<td>63.2</td>
<td>68.6</td>
<td>52.9</td>
<td>0.035</td>
</tr>
<tr>
<td>Not eating breakfast every morning</td>
<td>12.8</td>
<td>15.0</td>
<td>14.9</td>
<td>15.5</td>
<td>20.7</td>
<td>0.229</td>
</tr>
<tr>
<td>Vegetable consumption (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not eating vegetables every meal</td>
<td>52.8</td>
<td>47.2</td>
<td>43.6</td>
<td>50.3</td>
<td>52.9</td>
<td>0.190</td>
</tr>
<tr>
<td>Fruit consumption (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not eating fruit every day</td>
<td>72.3</td>
<td>70.2</td>
<td>70.9</td>
<td>68.0</td>
<td>80.5</td>
<td>0.082</td>
</tr>
<tr>
<td>Physical exercise (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercising less than once a week</td>
<td>46.9</td>
<td>44.0</td>
<td>44.1</td>
<td>45.7</td>
<td>57.5</td>
<td>0.044</td>
</tr>
<tr>
<td>Family history of diabetes (%)</td>
<td>8.1</td>
<td>7.7</td>
<td>7.3</td>
<td>10.9</td>
<td>11.5</td>
<td>0.417</td>
</tr>
<tr>
<td>Systolic blood pressure (mm Hg)</td>
<td>129.1 (14.9)</td>
<td>129.0 (15.0)</td>
<td>128.8 (15.3)</td>
<td>125.0 (14.5)</td>
<td>125.6 (14.8)</td>
<td>0.004</td>
</tr>
<tr>
<td>Diastolic blood pressure (mm Hg)</td>
<td>77.7 (11.2)</td>
<td>77.1 (11.2)</td>
<td>77.8 (11.0)</td>
<td>75.1 (10.8)</td>
<td>75.6 (10.6)</td>
<td>0.029</td>
</tr>
<tr>
<td>Fasting plasma glucose (mmol/l)</td>
<td>5.05 (0.38)</td>
<td>5.07 (0.45)</td>
<td>5.05 (0.41)</td>
<td>5.01 (0.42)</td>
<td>4.99 (0.46)</td>
<td>0.277</td>
</tr>
<tr>
<td>Total cholesterol (mmol/l)</td>
<td>5.06 (0.82)</td>
<td>5.11 (0.85)</td>
<td>5.08 (0.82)</td>
<td>5.00 (0.72)</td>
<td>5.02 (0.82)</td>
<td>0.643</td>
</tr>
<tr>
<td>High density lipoprotein cholesterol (mmol/l)</td>
<td>1.38 (0.34)</td>
<td>1.39 (0.32)</td>
<td>1.38 (0.27)</td>
<td>1.43 (0.34)</td>
<td>1.38 (0.27)</td>
<td>0.335</td>
</tr>
<tr>
<td>Triglycerides (mmol/l)</td>
<td>1.59 (1.23)</td>
<td>1.51 (1.30)</td>
<td>1.36 (0.89)</td>
<td>1.35 (0.93)</td>
<td>1.37 (0.90)</td>
<td>0.031</td>
</tr>
</tbody>
</table>

*Unless otherwise indicated, values are expressed as the mean (SD).

Results
Table 1 shows the baseline characteristics of 1266 Japanese male office workers according to hours of work a day. Means of age, body mass index, systolic blood pressure, diastolic blood pressure, and triglycerides, and the percentages of those who were architects or research workers, managers, drank alcohol every day, and exercised less than once a week differed significantly among the five groups according to hours of work each day. Subjects who worked 10.0 hours or more a day were younger than those who worked <10.0 hours a day. The percentage of those who were architects or research workers tended to increase with an increase in hours of work a day. On the other hand, the percentage of those who were managers decreased with an increase in hours of work a day. Those who worked 9.0–10.9 hours a day had a lower body mass index. The percentage of those who drank alcohol every day was lowest and the percentage who exercised less than once a week was highest among those who worked 10.0 hours a day or more. Systolic and diastolic blood pressure were lower among those who worked 10.0 hours a day or more than among those who worked <10.0 hours a day. The concentration of triglycerides was lower among those who worked 9.0 hours a day or more than among those who worked <9.0 hours a day. The means of fasting plasma glucose, total cholesterol, and high density lipoprotein cholesterol, and the percentages of those who smoked cigarettes currently, did not eat breakfast every day, did not eat vegetables every meal, did not eat fruit every day, and had a family history of diabetes did not differ significantly among the five groups according to hours of work a day.

During the 5 year follow up period 138 men developed IFG or type 2 DM (5736 person-years, table 2). The multivariate adjusted relative risks of IFG or type 2 DM, compared with those who worked <8.0 hours a day, were 0.82 (95% confidence interval (95% CI) 0.54 to 1.26), 0.69 (95% CI 0.38 to 1.26), 0.63 (95% CI 0.37 to 1.09), and 0.50 (95% CI 0.25 to 0.98) for those who worked 8.0–8.9, 9.0–9.9, 10.0–10.9, and 11.0 hours or more a day, respectively. The test for trend across increasing categories of hours of work a day reached significance (p=0.020). Eighty seven men developed IFG during the 5 year follow up period (5817 person-years). The multivariate adjusted relative risks of IFG, compared with those who worked <8.0 hours a day, were 0.74 (95% CI 0.43 to 1.28), 0.77 (95% CI 0.37 to 1.62), 0.69 (95% CI 0.35 to 1.33), and 0.61 (95% CI 0.26 to 1.40) for those who worked 8.0–8.9, 9.0–9.9, 10.0–10.9, and 11.0 hours or more a day, respectively. The test for trend across increasing categories of hours of work a day did not reach significance (p=0.022). Fifty four men were diagnosed as having type 2 DM during the 5 year follow up period (5937 person-years). The multivariate adjusted relative risks of type 2 DM, compared with those
who worked <8.0 hours a day, were 0.90 (95% CI 0.46 to 1.74), 0.50 (95% CI 0.18 to 1.42), 0.49 (95% CI 0.19 to 1.26), and 0.30 (95% CI 0.09 to 0.94) for those who worked 8.0–8.9, 9.0–9.9, 10.0–10.9, and 11.0 hours or more a day, respectively (p for trend=0.014).

**Discussion**

Although long overtime has received increasing attention for its adverse effects on health, evidence linking long work hours to the risk of development of diabetes is very limited. To the best of our knowledge, only one longitudinal study in Japan has reported that long overtime is a risk factor of type 2 DM among industrial male workers. In the present study, the risk of developing IFG or type 2 DM decreased in a dose-dependent manner with an increase in hours of overtime work a day among Japanese male office workers. This association remained significant after controlling for other covariates relevant to the development of IFG or type 2 DM—that is, age, occupation, position, obesity, smoking, alcohol drinking, eating breakfast, consumption of vegetables and fruit, regular physical activity, family history, blood pressure, fasting plasma glucose, and serum lipids. Furthermore, the relative risks of both IFG and type 2 DM tended to decrease with increasing categories of hours of work a day and the negative association between hours of work a day and the risk of diabetes was more pronounced for the development of type 2 DM. These results suggest that long overtime is associated with a decreased risk of IFG or type 2 DM among Japanese male office workers.

The discrepancies found between a previous study in Japan and our study might be derived from the different work environments and personal circumstances of these two populations. In the previous study, the percentages of blue collar workers—such as mechanic or machine operators, and rotating shift labourers—were 69.7% and 46.3%, respectively. The percentages of those who had 13 years of education and were physically inactive (hardly any) were 14.5% and 37.0%, respectively. The means (SDs) for body mass index, alcohol consumption, and cigarettes smoked were 22.0 (2.4) kg/m², 15.9 (22.0) g of ethanol a day, and 12.9 (12.1) cigarettes a day, respectively. On the other hand, in our study, all the participants were white collar workers, not working in a shift system, and 60.3% of the participants were architects or research workers. The percentages of those who had 13 years of education, regular physical exercise, family history of diabetes, systolic and diastolic blood pressures, fasting plasma glucose, total cholesterol, high density lipoprotein cholesterol, and triglycerides at entry.
DM is uncertain. In this population, to measure the physical activity of participants, their major physical activities were recorded every 15 minutes during an ordinary day and the 24-hour energy expenditure was calculated. There were significant differences in mean (SD) (p<0.001, ANOVA) among the 24-hour energy expenditure values for the five subgroups of hours of work a day (2317 (284) kcal/day for <8.0 hours worked in a day, 2412 (292) for 8.0–9.9 hours, 2488 (293) for 9.0–9.9 hours, 2510 (258) for 10.0–10.9 hours, and 2611 (293) for 11.0 hours). Although this is of course unlikely to explain fully the decreased risk found in those who worked longer overtime, the negative association between hours of work each day and the development of IFG or type 2 DM might be derived from the high energy expenditure related to long working hours. However, those who worked 11.0 hours or more a day showed maladaptive lifestyle factors such as less frequent physical exercise and vegetable consumption in this study. As working long hours may influence many lifestyle factors related to IFG or type 2 DM, further research is needed to establish whether long overtime affects the development of IFG or type 2 DM independently.

There are several limitations to this study. One is that we assessed participants’ working hours by their subjective reporting. However, because a questionnaire used in this study was confidential and data on daily working hours were only used for health management, over or underreporting their daily working hours is unlikely to have occurred.

The second limitation is that hours of work during the follow up were not included. Spearman’s rank correlation coefficient was 0.586 (p<0.001) for hours of work a day between baseline and the end of follow up among 1056 subjects (83.4%) who could be followed up (p<0.001) for hours of work a day between baseline and the end of follow up among 1056 subjects (83.4%) who could be followed up among 1056 subjects (83.4%) who could be followed up. This indicates that those who worked longer overtime at entry tended to do so during the follow up period. The observed associations between hours of work a day at baseline and the decreased risk of the development of IFG or type 2 DM may reflect the effects of long working hours over a 5 year observation period. Furthermore, we did not assess participants’ health related behaviour, blood pressure, and serum lipids during the follow up period. As obesity, alcohol intake, cigarette smoking, reduced physical activity, hypertension, and dyslipidaemia are known to be associated with the risk of type 2 DM, health related behaviour, blood pressure, and serum lipids during the follow up period may also be associated with the risk of IFG or type 2 DM. Further research is needed to clarify the causal association between working hours and the risk of IFG or type 2 DM.

The third limitation is that in the present study, we could not evaluate job strain, job stressors, or social support at work. However, the percentages of men with subjective symptoms—such as headache, ear noises, general fatigue, loss of appetite, loss of sleep, dizziness, constipation, fatigue of the eyes, and stiff shoulders—did not differ significantly among the five groups of hours of work a day. These results suggest that long overtime did not strongly affect subjective symptoms and might be unlikely to induce job stress in this population.

The final limitation is that the normoglycaemic cohort in this study, particularly in older age groups, may not be typical of the general population. The percentages of those who had IFG, type 2 DM, a history of diabetes, or medication for hypertension increased with age in this population. People whose plasma glucose concentration was already increased beyond the borderline, who had a history of diabetes, or who reported having taken drugs for hypertension during the initial examination were excluded from this survey. Thus, a healthy worker effect may exist in this study. Furthermore, as a cohort of this study is a restricted social class group of white collar workers, the results in this study could not be generalised to a national population.

Despite these potential limitations, our findings, obtained from a cohort of middle-aged Japanese male office workers, indicate that working longer overtime is negatively associated with the risk of the development of IFG or type 2 DM as diagnosed with the new criteria for epidemiological studies.

We thank all the employees and the Medical Office of the Osaka Main Office of Takenaka Corporation for their valuable cooperation for this study. We are also grateful to Ryuichi Kaneko and his colleagues at the Japan Labor and Welfare Association for collecting and coding the data accurately and consistently for 5 years. This study was supported in part by grant in aid for the prevention of lifestyle related diseases from the Atherosclerosis Prevention Association, Tokyo, Japan.

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