Changing lifestyle over the last few decades has contributed significantly to the rising prevalence of diabetes mellitus (DM) and other chronic diseases. Physical inactivity, increased calorie intake, and new eating habits (such as fast food or eating outside home more frequently) have significantly contributed to the increasing incidence of obesity. Obesity is the common denominator for all chronic diseases.

When data from 1960 is compared with data from 2013, it is estimated that an American person has gained 24 pounds in weight on average.1 The data shows that there has been a significant increase in the habit of eating outside home. Moreover, it is also estimated that calorie intake doubles if a person eats outside home.

The prevalence of obesity in the USA was 15% between 1976 and 1980;2 it has increased to 35.7% during the period of 2009–2010. It is forecasted that without an active and effective obesity control program, the prevalence of obesity in the USA will reach 50% among the population by year 2030.2

Physical activity has substantially deteriorated in the USA. This is deduced from the fact that 89% of students in the USA used to walk or bike to school in 1969; this has dropped down to 35% in the year 2009.3 The percentage of trips made via walking in the USA is estimated to be 10% nowadays.3

Factors that contribute to the health of an individual are: access to care (amounts to 10%), genetic makeup (amounts to 20%), environmental factors (amount to 20%) and health behavior (amounts to 50%). It is rather unfortunate that to stay healthy, we spend 88% on medical expenses, 4% on healthy behavior, and 8% on others.4

A total of 7 out of 10 deaths are caused by chronic diseases and 3 quarters of every dollar spent on medical cost is used to treat obesity-related chronic diseases.5 DM, one of the metabolic abnormalities, is a health concern and a global health challenge. Many countries are unable to cope with the increasing cost of controlling diabetes and its complications among their diabetic population.

DM is a leading cause of blindness, renal failure, amputation of the lower limbs and atherosclerotic vascular disease. At best, DM care can be described as fragmented; very few successful comprehensive DM care programs are available worldwide.

The prevalence and incidence of DM varies in different parts of the world. Most countries are witnessing a rise in prevalence and incidence, while a few have a plateau-type of incidence.6 The rise in the incidence is attributed to a change in lifestyle and an increase in the incidence and prevalence of obesity with its associated insulin resistance, particularly among the aging population.

Epidemiology of DM is the impetus for proper DM care; and for appropriate allocation of resources for its control. Moreover, it is a tool to monitor the efficiency of the DM control programs.

Saudi Arabia (SA) has witnessed a significant lifestyle shift over the last 40 years. The rapid modernization with the influx of new lifestyle habits has resulted in rapid and progressive increase in the prevalence of obesity. SA is ranked among the top 10 countries with regard to the prevalence of obesity.6 Obesity associated with physical inactivity among the genetically predisposed community has led to a rise in prevalence and incidence of DM. According to the data from the International Diabetes Federation, SA is ranked among the top 10 countries in the prevalence of diabetes as well.

This issue has a well-structured study on the epidemiology of DM in SA. It has a properly balanced
sample factoring in the age distribution of the population of SA and the urban-rural distribution ratio. It has addressed, in addition to the prevalence of DM, critical elements such as obesity and diabetes prevalence in different regions of SA.

The results are significant; 1 out of 3 among the adult population has a degree of glucose intolerance. Subjects with an impaired fasting glucose state were twice as many as those with DM. A significant proportion of those diagnosed with DM were not aware of the existence of their disease before the study was conducted.

When the results of the current study were compared with previous studies; a clear progression in the prevalence is shown. It has objectively confirmed the magnitude of DM in the Saudi community. The epidemic proportion of the prevalence of obesity exhibited in this study is a predictor for a worsening prevalence of DM in the future as people age.

It is high time that serious consideration to lifestyle modification is given. It has become obvious that the measures implemented in the past have proved to be inadequate. There is a need for a transformational change in the DM control program in SA.

DM control is a cornerstone in any future DM program. It is imperative to establish a structured program that addresses the population at different age groups and prevents obesity if the aim is to effectively impact the rising prevalence of DM. Special programs are required for those with an impaired fasting glucose state as it is the most amenable group to a prevention program.

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