Physiological factors associated with low bone mineral density in female endurance runners

M Burrows, A M Nevill, S Bird, D Simpson

Objective: To explore potential factors that could be associated with low bone mineral density (BMD) in female endurance runners.

Methods: Fifty-two female endurance runners (1500 m to marathon), aged 18–44 years, took part. Body fat percentage, lumbar spine BMD, and femoral neck BMD were measured using the Hologic QDR 4500w bone densitometer. Data on training, menstrual cycle status, osteoporosis, and health related factors were obtained by questionnaire. Dietary variables were assessed from a prospective seven day dietary record of macronutrients and micronutrients.

Results: The mean (SD) lumbar spine and femoral neck BMD were 1.11 (0.11) and 0.89 (0.12) g/cm² respectively. A backward elimination regression analysis showed that age, body mass, body fat, distance run, magnesium, and zinc intake were the variables significantly associated with BMD. Lumbar spine BMD (g/cm²) = −1.90 + (0.0486 × age (years)) + (0.342 × log mass (kg)) − (0.000861 × age² (years)) + (0.00128 × distance (km/week)), with an R² = 30.1% (SEE = 0.089 (95% confidence interval (CI) 0.05 to 0.23); p<0.001). Femoral neck BMD (g/cm²) = −2.51 – (0.00989 × age (years)) + (0.720 × log mass (kg)) + (0.000951 × magnesium [mg/day]) − (0.0289 × zinc [mg/day]) − (0.00821 × body fat (%)) − (0.00226 × distance (km/week)), with an R² = 50.2% (SEE = 0.100 (95% CI 0.06 to 0.22); p<0.001). The negative association between skeletal BMD and distance run suggested that participants who ran longer distances had a lower BMD of the lumbar spine and femoral neck. Further, the results indicated a positive association between body mass and BMD, and a negative association between body fat and BMD.

Conclusions: The results suggest a negative association between endurance running distance and lumbar spine and femoral neck BMD, with a positive association between body mass and femoral neck and lumbar spine BMD. However, longitudinal studies are required to assess directly the effect of endurance running and body mass on BMD, and to see if the addition of alternative exercise that would increase lean body mass would have a positive effect on BMD and therefore help to prevent osteoporosis.
0–9 cycle a year; amenorrhoeic = 0–3 cycles a year; eumenor-
rhoeic ⩾ 10 cycles a year). The questionnaires collected information on the history of the menstrual, training, and dietary status, as well as any recent changes (within the last year). A prospective, seven day dietary record was also completed, from which average energy (MJ/day), zinc (mg/day), magnesium (mg/day), phosphorus (mg/day), and calcium (mg/day) intake over this period was assessed (Dietmaster, version 4.0; Swift Computers Ltd, Phoenix, Arizona, USA).

Participants were weighed (wearing minimal clothing) to the nearest 0.1 kg (Balance Beam Scale; Seca, Germany), and height recorded to the nearest centimetre (stadiometer attached to Balance Beam Scale). Bone densitometry was used to assess body fat percentage and BMD. BMD was measured at the lumbar spine (L2–L4) and the femoral neck, and body fat was assessed during a whole body scan, using dual energy x-ray absorptiometry (Hologic, QDR 4500w; Hologic Inc, Waltham, Massachusetts, USA). The standard Hologic protocol for bone mineral measurement and density was employed. Bone mineral results were expressed as BMD (g/cm²). All scans were conducted and analysed in the osteoporosis unit at the Kent and Canterbury Hospital. The in vivo precision of dual energy x-ray absorptiometry for BMD in the laboratory was less than 1% for both the lumbar spine and femoral neck.

Statistical analysis was carried out using the Minitab statistical package (version 12.1). A backward elimination log-linear regression model was used beginning with a saturated model incorporating all possible covariates and then sequentially eliminating the least important variables (based on the size of the t statistic), to assess the impact of all the variables on bone density at the femoral neck and lumbar spine sites. On the basis of proportional models proposed by Nevill and Holder,11 the following multiplicative model was proposed for BMD of the lumbar spine (L2–L4) and femoral neck:

\[
\text{BMD} = \text{weight}^k \times \exp(c + (d \times \text{age}) + (e \times \text{age}^2)) \times \varepsilon
\]

The model can be linearised with a log transformation:

\[
\log_e(\text{BMD}) = k \times \log(\text{weight}) + c + (d \times \text{age}) + (e \times \text{age}^2) + \varepsilon,
\]

and, provided that the error term \(\varepsilon\) has a normal distribution, linear regression can be used to estimate the parameters \(k\), \(c\), \(d\), and \(e\). Note that the proportional error ratio term in equation (1) is dimensionless—that is, a percentage error. Clearly, there is some operational advantage to incorporating age and \(e\) within an exponential term in equation (1), as well as providing a more plausible asymptotic decline for BMD with age. If a significant \(e\) parameter “\(e\)” was found, a peak in BMD had been identified, suggesting that BMD rises and peaks at age \(-d/2e\) (using elementary differential calculus) and subsequently declines. The model can be developed to incorporate other factors of interest (within the exponential term) such as body fat, dietary micronutrients and macronutrients, and the distance walked a week (km).

To assess the assumption of normality, an Anderson-Darling normality test and a Box-Cox transformation were used. Box and Cox14 suggested transforming the dependent variable (Y) using either \(Y' = (Y^p-1)/\lambda\) if \(\lambda = 1\) or \(Y' = \log(Y)\) if \(\lambda = 0\), the value of the parameter \(\lambda\) being chosen to maximise the log-likelihood function. The transformation then provides residuals that best approximate to a normal distribution with constant variance. In the case of BMD of the lumbar spine (L2–L4) and the femoral neck, the optimal transformation parameter \(\lambda\) was \(\lambda = 0.09\) respectively, which were not significantly different from \(\lambda = 0\), confirming that a log transformation of BMD was near optimal.

BMD values were compared with the Hologic normal range for the lumbar spine15 and the National Health and Nutritional Examination Survey16 for the femoral neck.

Pearson’s product-moment correlations were performed between dependent and independent variables to assess the relations. Alpha was set at 0.05 for all statistical procedures.

**RESULTS**

Table 1 summarises the participant characteristics for all variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Female runners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>31 (5)</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>165 (6)</td>
</tr>
<tr>
<td>Body mass (kg)</td>
<td>57.3 (6)</td>
</tr>
<tr>
<td>Body fat (%)</td>
<td>20 (6)</td>
</tr>
<tr>
<td>Age at onset of training (years)</td>
<td>23 (8)</td>
</tr>
<tr>
<td>Distance run (km/week)</td>
<td>51 (28)</td>
</tr>
<tr>
<td>Training per week (hours)</td>
<td>8 (5)</td>
</tr>
<tr>
<td>Years training</td>
<td>8 (6)</td>
</tr>
<tr>
<td>Sessions per week</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Time off training (months)</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Menarcheal age (years)</td>
<td>14 (2)</td>
</tr>
<tr>
<td>Gynaecological age (years)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Cycle frequency/year</td>
<td>11 (2)</td>
</tr>
<tr>
<td>Cycle flow (days)</td>
<td>5 (1)</td>
</tr>
<tr>
<td>OCA (months)</td>
<td>57 (34)</td>
</tr>
<tr>
<td>Average energy intake (MJ/day)</td>
<td>7.5 (2)</td>
</tr>
<tr>
<td>Calcium (mg/day)</td>
<td>831 (257)</td>
</tr>
<tr>
<td>Magnesium (mg/day)</td>
<td>257 (61)</td>
</tr>
<tr>
<td>Zinc (mg/day)</td>
<td>7.5 (0.7)</td>
</tr>
<tr>
<td>Phosphorus (mg/day)</td>
<td>1166 (260)</td>
</tr>
<tr>
<td>Spinal BMD (g/cm²)</td>
<td>1.12 (0.1)</td>
</tr>
<tr>
<td>Femoral neck BMD (g/cm²)</td>
<td>0.9 (0.1)</td>
</tr>
</tbody>
</table>

Values are mean (SD). Gynaecological age is years since menarche; cycle flow is average length of menstrual flow; cycle frequency/year is average menstrual cycles experienced each year; OCA, Length of oral contraceptive use in months; BMD, bone mineral density.

Of the 52 participants, the menstrual questionnaire classified 12 (23%) as oligo/amenorrhoeic (only one participant was amenorrhoeic), and 40 (77%) as eumenorrhoeic. Further, 46 (88%) had or were currently using various forms of oral contraceptives over a period of 59 (54) months. The daily energy intake for all participants over the seven day period was 7.5 (2) MJ/day, which placed them below the reference nutrient intake for some vitamins and minerals (table 1). There was no significant correlation (\(r = 0.04\)) between energy intake and distance run per week.

The mean (SEM) BMD for all participants at the lumbar spine and femoral neck were 1.11 (0.11) and 0.89 (0.12) g/cm² respectively. The BMD values for the lumbar spine and femoral neck were on average −0.45 and + 0.45 SD from those of age matched participants in the databases. Of the cohort, two and one of the participants were classified as osteopenic at the lumbar spine and femoral neck respectively. Osteopenia was diagnosed in nine and six of the participants at the lumbar spine sites. On the basis of proportional models proposed by Nevill and Holder,11 the following multiplicative model was proposed for BMD of the lumbar spine (L2–L4) and femoral neck:
is associated with lumbar spine BMD. Distance run was negatively associated with lumbar spine BMD, with participants who ran the longer distances appearing to have a lower BMD (lower by 1% in participants running a further 10 km/week) (fig 1).

Log transformed femoral neck BMD was significantly associated with distance (km/week) (p = 0.006), age (years) (p = 0.002), log body mass (kg) (p = 0.000), magnesium intake (mg/day) (p = 0.006), zinc intake (mg/day) (p = 0.009), and body fat percentage (p = 0.019). The regression model indicated that magnesium intake (mg/day) was positively related, whereas zinc intake (mg/day) was negatively related to femoral neck BMD. Distance run (km/week) was negatively associated with femoral neck BMD, with participants who ran the longer distances appearing to have a lower BMD (lower by 2% in participants running a further 10 km/week). A significant age related decline in femoral neck BMD was observed but the quadratic age parameter was not significant, suggesting that a peak in femoral neck BMD might have occurred in late adolescence (the teenage years) rather than early adulthood. Once again, body mass was positively associated with BMD, whereas body fat percentage was negatively associated with BMD, suggesting that it may be the lean component of body mass that was positively associated with BMD at this site (fig 2).

The resulting regression equations were:

\[
\log \text{femoral neck BMD} = -2.51 + (0.00989 \times \text{age (years)}) + (0.720 \times \log \text{mass (kg)}) + (0.000951 \times \text{magnesium (mg/day)}) - (0.0289 \times \text{zinc (mg/day)}) - (0.00821 \times \text{body fat (%)} - (0.00226 \times \text{distance (km/week)})
\]

\[R^2 = 30.1\%; \text{SEE} = 0.089 (95\% \text{CI 0.05 to 0.23}); p = 0.002\]

Note that by taking antilogs of the SEEs for lumbar spine and femoral neck BMD regression models, we obtained percentage errors of 9.3% (95% CI 5.1 to 25.8%) and 10.5% (95% CI 6.1 to 24.6%) respectively.

DISCUSSION

It has been thought that physical activity may help to offset the bone loss in female runners with low-energy diets, and it has been shown to exert a positive effect on BMD in postmenopausal women. As the frequency, duration, and intensity of the training regimens of endurance athletes far exceed the exercise of most postmenopausal women, one may expect the activity to exert a protective effect against bone loss in such athletes. However, in this study, after controlling for differences in body size and age, distance run per week was negatively associated with lumbar spine and femoral neck BMD. The regression analysis indicated that participants who ran longer distances had a lower femoral neck and lumbar spine BMD (refer to the negative beta weights in the regression equations; p<0.05) than those who ran shorter distances. Indeed, the association suggested that participants who ran 10 km/week further than other participants had a 1% lower lumbar spine BMD and a 2% lower femoral neck BMD, regardless of the age of training onset. As there is evidence to suggest that low BMD is associated with increased fracture risk, such runners may be at an increased risk of fracture. However, these results should be interpreted with caution because the study was cross sectional and does not show a cause and effect relation. Further longitudinal studies are therefore required to support such claims.

Research has also suggested that long distance runners may have more dietary deficiencies, and that this may affect BMD more than the training per se. However, none of the dietary variables measured here were significantly associated with lumbar spine BMD. This agrees with previous findings, which suggests that only abnormal and restrictive eating behaviours are related to low BMD and future fracture risk. However, other studies have suggested that low energy intake can alter luteinising hormone pulsatile activity and decrease BMD levels. Such a mechanism may be site specific, for, although we did not find any direct relation between energy intake and BMD at any site, femoral neck BMD was significantly associated with magnesium and zinc intake, with higher magnesium and lower zinc intakes related to higher femoral neck BMD values. However, the low magnesium and zinc intakes recorded may reflect an undernourished state of the runners (7.5 (2) MJ/day while running 51 (28) km/week) and thus the effect of a low energy intake on BMD. Indeed, the dietary intakes were measured by a seven day prospective dietary intake record which relies heavily on the honesty and accuracy of the participants reporting, so the results need to be interpreted with some caution until further studies are completed. However, if the micronutrients are looked at individually, low levels of magnesium could downregulate parathyroid hormone secretion, decreasing calcium uptake and altering the bone remodelling process. However, the role of zinc in regulating BMD is less clear. Zinc was previously thought to exert a positive influence on BMD and to be essential for bone metabolism. Thus the negative influence of zinc on femoral neck BMD in this study was surprising. One possible clue may come from the way zinc affects the immune system by increasing osteoclastic activity.
Another aspect to consider is the actual forces applied to the limbs during running, as previous research has suggested that they are crucial to BMD.27 Athletes involved in sports and training where forces applied to limbs are in excess of 10 times body weight (gymnastics, weightlifting, and volleyball) have been found to have higher BMD than those involved in sports where forces are only in the range of 5–10 times body weight, such as endurance running.28 29 It seems that, although running includes many more cycles of foot strike and thus force application than these other sports, the lower loads are not as stimulatory to bone accretion. This may explain our findings that long running distances appear to be associated with low BMD, because the longer distances covered would be associated with lower intensity exercise and thus lower forces being applied to the limbs. This supports the theory of Frost,28 29 in which a minimum force is required to elicit a bone remodelling response, and forces above this threshold would stimulate modelling at bone sites, resulting in a net bone gain. Therefore, magnitude of loading to the bone may be more important than the number of cycles, repetitions, or exercise mode.30

One would therefore expect body mass to have a positive effect on BMD. Indeed, this study suggests that body mass has a positive association with lumbar spine and femoral neck BMD. However, the regression analysis indicates that it is body mass, independent of body fat percentage, that is positively associated with BMD. Indeed, lean body mass has been found to correlate with appendicular28 and axial29 bone mass in previous studies. Further muscle strength and lean mass have been reported to be positively associated with bone mass in a variety of weight bearing and non-weight bearing sports.30 31 Thus the force exerted by the muscle pull on the skeleton during muscular contraction may be a powerful osteogenic stimulus,32 although it has been suggested that, for the osteogenic stimulus to have an effect on BMD, a regular menstrual cycle may need to be present.7 33–35 However, we found no significant association between menstrual irregularity and BMD at the lumbar spine or femoral neck. Moreover, there was no significant association between oral contraceptive use and BMD at the lumbar spine or femoral neck from 1–192 months of use. This agrees with the findings of Prior et al.36 that use of oral contraceptives did not affect bone density. However, other studies have reported positive37 and detrimental38 effects of oral contraceptive use on bone mass and fracture risk.39 These negative findings need further rigorous scientific studies because of a number of methodological deficiencies, such as not controlling for confounding variables in the study protocols—for example, smoking and endocrine status.

A major variable shown to influence BMD is age. BMD at the lumbar spine and femoral neck has been reported to peak between the third and fourth decades of life,20 the second and third decades of life,40 or as early as 18 years.39 The age at which this peak occurs and the factors affecting it are of utmost importance in reducing fracture risk.41 We observed that BMD was not significantly associated with age, with lumbar spine BMD peaking at 28 years, after which it declined with age. However, there was no evidence of an age related peak in femoral neck BMD, with a negative exponential decline apparent across the whole age range. This difference may be due to the lower amount of trabecular bone in the femoral neck (25%) compared with the lumbar spine (35%), promoting earlier accretion of bone mineral in the former.42

Conclusion
We observed a negative association between endurance running distance and BMD, and a positive association between body mass and BMD. This suggests that increasing body mass (independently of body fat percentage) may benefit BMD, and that long distance running may be associated with low BMD. As BMD is an important factor in the prediction of fracture risk, recommendations on exercise mode and the resulting effects on body composition may need to be considered. The association between distance run and BMD is a relatively exciting and novel finding which needs to be further investigated through longitudinal research.

Take home message
It may not be the exercise mode alone that affects BMD but the force applied to the limbs during such exercise and the resulting effects on body composition. Therefore planning of exercise regimens may need to consider the type and intensity of exercise undertaken and the subsequent impact on body composition.

Authors’ affiliations
M Burrows, University of East London, School of Health and Biosciences, Stratford Campus, Romford Road, London E15 4LZ
A M Nevill, S Bird, University of Wolverhampton, School of Sport, Performing Arts, and Leisure, Gorway Road, Walsall, West Midlands WS1 3BD, UK
Z Simpson, Department of Nuclear Medicine, Kent and Canterbury Hospital, Canterbury, Kent CT1 3NG, UK

REFERENCES
Osteoporosis and female endurance runners
