

kneeling and squatting were significantly associated with KL  $\geq 3$  knee OA, but not with KL  $\geq 2$  knee OA<sup>25</sup>. Considering the definition of the KL grade<sup>26</sup>, this difference may suggest distinct risk factors between osteophytosis and joint space narrowing. However, we cannot clarify whether osteophytosis and joint space narrowing have distinct risk factors, because osteophytosis and joint space narrowing are not separately defined according to the KL grade. In addition, a recent cross-sectional study has shown that osteophytosis was unrelated not only to joint space narrowing on plain radiographs, but also to cartilage loss measured by quantitative magnetic resonance imaging<sup>27</sup>. Furthermore, our study on an experimental mouse model for OA has identified a cartilage-specific molecule, carminerin, that regulates osteophytosis without affecting joint cartilage destruction during OA progression<sup>28,29</sup>. This accumulating evidence has indicated that joint space narrowing and osteophytosis may have distinct etiologic mechanisms and their progression may be neither constant nor proportional. Thus, to examine factors associated with knee OA, these two OA features should be assessed separately. However, to the best of our knowledge, there are no large population-based studies that investigate occupational factors associated with joint space narrowing and osteophyte formation separately.

In the present study, we measured medial minimum joint space width (mJSW) and osteophyte area (OPA) in the large-scale population-based cohort study called the Research on Osteoarthritis Against Disability (ROAD). The purpose of the present study was to investigate the association of job title and occupational activity with joint space narrowing and osteophytosis at the knee separately, and to clarify which kinds of occupational activities were associated with joint space narrowing and osteophytosis. Furthermore, we aimed to clarify whether the association of each occupational activity with joint space width and OPA was different.

## Subjects and methods

### Subjects

The ROAD study is a nationwide prospective study to establish epidemiologic indexes for evaluation of clinical evidence for the development of a disease-modifying treatment for bone and joint diseases (with OA and osteoporosis as the representative bone and joint diseases) consisting of population-based cohorts in several communities in Japan. As a detailed profile of the ROAD study has been described in detail elsewhere<sup>4,5,30,31</sup>, only a brief summary is provided here. To date, we have completed creation of a baseline database including clinical and genetic information on 3,040 inhabitants (1,061 men and 1,979 women) ranging in age from 23 to 95 years (mean, 70.6 years) who were recruited from listings of resident registrations in three communities: an urban region in Itabashi, Tokyo; a mountainous region in Hidakagawa, Wakayama; and a seacoast region in Taiji, Wakayama. All participants provided written informed consent, and the study was conducted with the approval of ethics committees of the University of Tokyo and the Tokyo Metropolitan Institute of Gerontology. Information collected about job title and occupational activity included a lifetime occupational history with details of seven types of specific workplace physical activities: sitting on a chair, kneeling, squatting, standing, walking, climbing, and heavy lifting. Participants were asked whether they engaged in the following activities: sitting on a chair for  $\geq 2$  h/day, kneeling for  $\geq 1$  h/day, squatting for  $\geq 1$  h/day, standing for  $\geq 2$  h/day, walking for  $\geq 3$  km/day, climbing up slopes or steps for  $\geq 1$  h/day, and lifting loads weighing  $\geq 10$  kg  $\geq 1$  time/week. Information on these activities was obtained for the principal job, defined as the job at which the participant had worked longest. These definitions were chosen to be similar to definitions used in previous

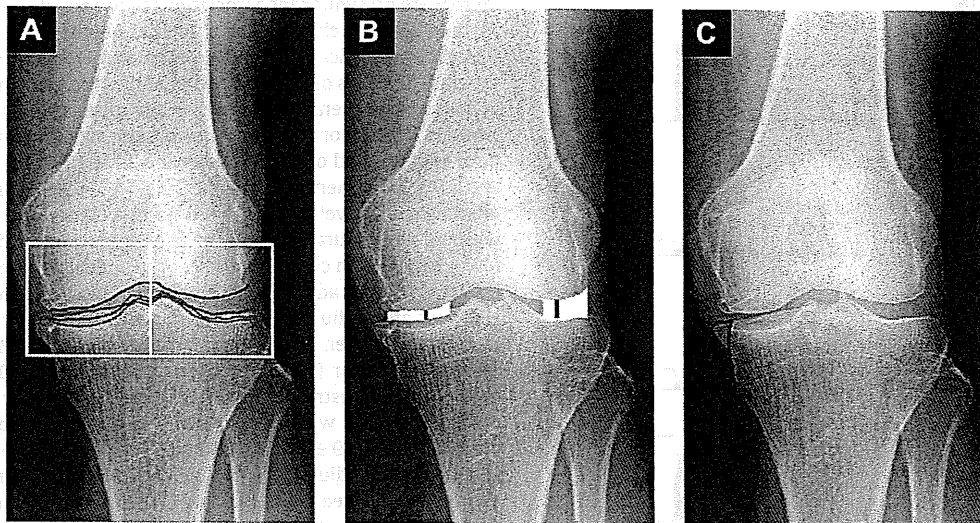
studies of occupations and OA<sup>22,23,25</sup>. Anthropometric measurements included height and weight, and body mass index (BMI; weight [kg]/height<sup>2</sup> [m<sup>2</sup>]) was calculated. From baseline data of all participants, the present study analyzed 1,402 participants (512 men and 890 women) aged  $\geq 50$  years living in mountainous and seacoast cohorts, after excluding 69 subjects with lateral knee OA.

### Radiographic assessment

All participants had radiographic examination of both knees using an anterior–posterior view with weight-bearing and foot map positioning. The beam was positioned parallel to the floor with no angle and aimed at the joint space. To visualize the joint space properly and to make the patella centralized over the lower end of the femur, we used fluoroscopic guidance with an anterior–posterior X-ray beam. The images were downloaded into Digital Imaging and Communication in Medicine (DICOM) format files. mJSW in the medial compartment and OPA at the medial tibia were measured by the KOACAD (knee osteoarthritis computer-aided diagnosis) system, and a knee with the lower mJSW was defined as the designated knee of a participant. The KOACAD system has been described in detail elsewhere<sup>32</sup>, and is summarized here only briefly. The KOACAD system can quantify the major features of knee OA on standard radiographs and allows objective, accurate, simple, and easy assessment of the structural severity of knee OA in general clinical practice. This system was programmed to measure mJSW in the medial and lateral compartments and OPA at the medial tibia using digitized knee radiographs. Initially, correction for radiographic magnification was performed based on the image size of a rectangular metal plate. Next, to determine the region of interest (ROI), the center of the tibiofemoral joint was determined as follows. A vertical neighborhood difference filter, that vertically scanned digital images to detect the margins of the tibial and femoral condyles, was applied to identify points with high absolute values for difference of scale, and then the center of all points was calculated, that was defined as the center of the tibiofemoral joint, and a  $480 \times 200$  pixels of rectangle with the center was decided as the ROI (Supplementary Figure). Within the ROI, the outline of the femoral condyle was designated as the upper rim of the joint space by vertical filtering with the  $3 \times 3$  square neighborhood difference filter. The both ends of the upper rim were determined using a Canny's filter to remove the noise associated with lines, and vertical lines from the ends were designated as the outside rims of the joint space. Outlines of anterior and posterior margins of the tibial plateau were drawn similarly to that of the femoral condyle, and the middle line between the two outlines was designated as the lower rim of the joint space [Fig. 1(A)]. A straight regression line for the lower rim outline was then drawn, and the intersection of the lower rim outline and the regression line was designated as the inside rim. Medial and lateral joint space areas were determined as areas surrounded by the upper, lower, inside, and outside rims as defined above. Medial and lateral mJSWs were further determined as the minimum vertical distances in the respective joint space area [Fig. 1(B)]. To measure the OPA, medial and lateral outlines of the femur and tibia were drawn. Inflection points for these outlines were then calculated. The medial outline of the tibia from the inflection point was drawn upward to the joint level, and the area that was medially prominent over the smoothly extended outline was designated as the OPA [Fig. 1(C)]. We have previously published reference values of joint space width and OPA by gender and age strata in Japan using the KOACAD system<sup>33</sup>.

### Statistical analysis

The differences of age, height, weight, BMI, mJSW, and OPA at the designated knee between men and women were examined by



**Fig. 1.** Schema of image processing by KOACAD (cited from reference number<sup>9</sup>). (A). Outlines of anterior and posterior margins of the tibial plateau. The middle line between the two outlines is defined as the lower rim of the joint space. (B). Medial and lateral mJSWs were defined as the minimum vertical distances in the joint space area. (C). OPA (red area) that is medially prominent over the smoothly extended outline of the tibia.

the non-paired Student's *t*-test. The percentage of each occupational activity was compared between men and women by chi-square test. To determine the association of job title with mJSW and OPA, the Tukey Honestly Significant Differences (HSD) test was used after adjustment for age, gender, and BMI in the overall population and after adjustment for age and BMI in men and women. To determine the association of mJSW and OPA with each occupational activity separately after adjustment for age, gender, and BMI in the overall population, multiple regression analyses were used with age, gender, BMI, and each occupational activity as independent variables in the overall populations. Further, to determine the association of mJSW and OPA with each occupational activity separately after adjustment for age and BMI in men and women, multiple regression analyses were used with age, BMI, and each occupational activity as independent variables. Next, to determine the independent association of occupational activities with mJSW, multiple regression analysis was used with age, gender, BMI, and all significantly associated occupational activities in the overall subjects, and with age, BMI and all significantly associated occupational activities in men and women, as explanatory variables, statistical analyses were performed using SAS version 9.0 (SAS Institute Inc., Cary, NC).

**Results**

Characteristics of the 1,402 participants aged  $\geq 50$  in the mountainous and seacoast cohorts of the ROAD study are shown in

**Table I**  
Characteristics of participants

	Overall	Men	Women
Number of subjects	1,402	512	890
Age, years	68.2 $\pm$ 9.2	68.9 $\pm$ 9.1	67.7 $\pm$ 9.2*
Height, cm	154.4 $\pm$ 9.3	162.4 $\pm$ 6.9	149.9 $\pm$ 7.2*
Weight, kg	55.3 $\pm$ 10.5	61.0 $\pm$ 10.3	52.0 $\pm$ 9.1*
BMI, kg/m <sup>2</sup>	23.1 $\pm$ 3.4	23.1 $\pm$ 3.1	23.1 $\pm$ 3.5
mJSW, mm	2.5 $\pm$ 1.1	2.9 $\pm$ 1.0	2.3 $\pm$ 1.1*
OPA, mm <sup>2</sup>	3.0 $\pm$ 7.9	1.4 $\pm$ 4.4	3.9 $\pm$ 9.3*

Values are mean  $\pm$  SD except where indicated. mJSW, minimum joint space width.

\* *P* < 0.05 vs men by non-paired *t* test.

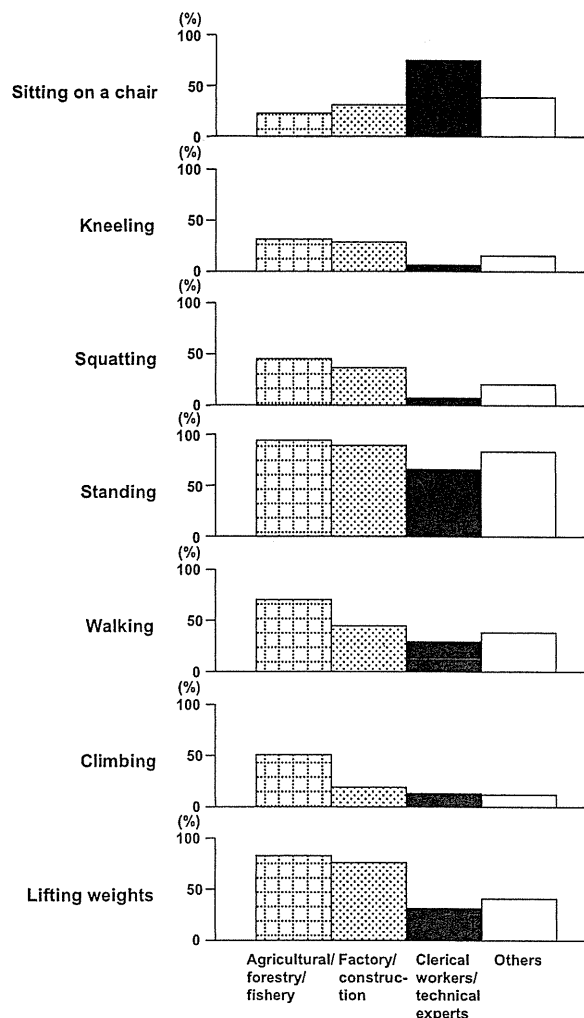
Table I. mJSW was significantly lower in women than in men, whereas OPA was significantly higher in women compared with men. OPA was moderately associated with mJSW ( $R^2 = 0.21$ ,  $P < 0.05$ ) by linear regression analysis. When we analyzed the association of height with mJSW, the  $R^2$  was 0.027 and 0.076 in men and women, respectively ( $P < 0.05$ ). With regards to OPA, the  $R^2$  was 0.01 and 0.006 in men and women, respectively ( $P < 0.05$ ).

There was great diversity in job titles of study participants (Table II). Although a substantial proportion included clerical workers and technical experts, there were many agricultural, forestry, and fishery workers. Among various occupational activities, agricultural, forestry, and fishery workers had the highest rates of kneeling, squatting, standing, walking, climbing, and lifting weights, and the lowest rates for sitting on a chair, whereas clerical workers and technical experts had the lowest rates for the former activities and the highest rates for the latter activity (Fig. 2).

**Table II**  
Number (percentage) of participants with job title and occupational activity reported as the principal job

	Overall	Men	Women
<b>Job titles, n (%)</b>			
Clerical workers/technical experts	350 (25.0)	164 (32.0)	186 (20.9)
Agricultural/forestry/fishery workers	299 (21.3)	158 (30.9)	141 (15.8)
Factory/construction workers	148 (10.6)	67 (13.1)	81 (9.1)
Shop assistants/managers	124 (8.8)	24 (4.7)	100 (11.2)
Housekeepers	118 (8.4)	0 (0.0)	118 (13.3)
Teachers	80 (5.7)	40 (7.8)	40 (4.5)
Dressmakers	46 (3.3)	1 (0.2)	45 (5.1)
Clinical workers	40 (2.9)	1 (0.2)	39 (4.4)
Hairdressers	17 (1.2)	6 (1.2)	11 (1.2)
Others (cook, taxi driver, etc.)	70 (5.0)	21 (4.1)	49 (5.5)
No answer	110 (7.8)	30 (5.9)	80 (9.0)
<b>Occupational activities, n (%)</b>			
Sitting on a chair $\geq 2$ h/day	629 (44.9)	247 (48.2)	382 (42.9)
Kneeling $\geq 1$ h/day	280 (20.0)	92 (18.0)	188 (21.1)
Squatting $\geq 1$ h/day	368 (26.2)	127 (24.8)	241 (27.1)
Standing $\geq 2$ h/day	1,179 (84.0)	439 (85.7)	740 (83.1)
Walking $\geq 3$ km/day	638 (45.5)	255 (49.8)	383 (43.0)
Climbing $\geq 1$ h/day	325 (23.2)	175 (34.2)	150 (16.9)*
Lifting weights $\geq 10$ kg $\geq 1$ time/week	750 (53.5)	336 (65.6)	414 (46.5)*

\* *P* < 0.05 vs men by chi-square test.



**Fig. 2.** Percentage of participants engaged in each occupational activity: sitting on a chair  $\geq 2$  h/day, kneeling  $\geq 1$  h/day, squatting  $\geq 1$  h/day, standing  $\geq 2$  h/day, walking  $\geq 3$  km/day, climbing  $\geq 1$  h/day, or lifting weights  $\geq 10$  kg  $\geq 1$  time/week among agricultural, forestry, and fishery workers; factory and construction workers; clerical workers and technical experts; and others.

Mean  $\pm$  standard deviation (SD) values of mJSW (mm) in agricultural, forestry, or fishery workers; factory or construction workers; clerical workers or technical experts; and other workers were  $2.4 \pm 1.2$ ,  $2.5 \pm 1.1$ ,  $2.8 \pm 1.0$ , and  $2.4 \pm 1.1$ , respectively. Tukey HSD test after adjustment for age, gender, and BMI showed that

there were no significant associations between job titles and mJSW. Further, because characteristics such as height, weight, mJSW and OPA differ significantly between men and women, we conducted separate analyses of the association of job title with mJSW and OPA in men and women. mJSW (mm) in agricultural, forestry, or fishery workers; factory or construction workers; clerical workers or technical experts; and other workers were  $2.7 \pm 1.1$ ,  $2.9 \pm 0.9$ ,  $3.0 \pm 0.9$ , and  $2.9 \pm 1.0$  in men and  $2.0 \pm 1.1$ ,  $2.2 \pm 1.1$ ,  $2.6 \pm 0.9$ , and  $2.3 \pm 1.1$  in women respectively. There were no associations in men, but for women, agricultural, forestry, or fishery workers had significantly lower mJSW than clerical workers or technical experts using Tukey HSD test without adjustment. To adjust for body size, we used Tukey HSD test after adjustment for height, and the results were similar ( $P < 0.05$ ). Further, after adjustment for age and BMI, the results were also similar ( $P < 0.05$ ). Mean  $\pm$  SD values of OPA ( $\text{mm}^2$ ) in agricultural, forestry, or fishery workers; factory or construction workers; clerical workers or technical experts; and other workers were  $2.9 \pm 6.5$ ,  $2.9 \pm 6.8$ ,  $1.6 \pm 4.0$  and  $3.9 \pm 10.2$ , respectively. Tukey HSD test after adjustment for age and BMI showed no significant association between job titles and OPA in either men or women.

Tables III and IV show the mean values of mJSW and OPA according to occupational activity. SD for OPA was quite a large in the present study, because the range was 0–121.5  $\text{mm}^2$  and 1,055 (75.2%) had no osteophytes. Sitting was associated with higher mJSW and lower OPA by linear regression analysis without adjustment; after adjustment for age, gender, and BMI, the significance disappeared. Kneeling and squatting were significantly associated with lower mJSW as well as higher OPA. Walking and lifting weights were significantly associated with lower mJSW, but not with OPA. When we analyzed the association of occupational activities with mJSW and OPA in men and women separately, the results in women were similar to results in the overall population, but there were few factors associated with mJSW or OPA in men (Supplementary Tables I and II).

To determine independent associations of the significant occupational factors shown in Table III with mJSW, multiple regression analysis was performed with age, gender, BMI, and the significant occupational factors as independent variables. Because chi-square test showed that squatting was strongly associated with kneeling (odds ratio 139.5,  $P < 0.0001$ ), we used kneeling when both squatting and kneeling were significantly associated KOACAD parameters. Squatting, kneeling, walking, and lifting weights were significantly associated with mJSW by the abovementioned analysis (Table III); thus, when we used age, gender, BMI, kneeling, walking, and lifting weights as independent variables, multiple regression analysis showed that kneeling was independently associated with mJSW (regression coefficient  $-0.17$ , 95% confidence interval [CI]  $-0.30$  to  $-0.04$ ,  $P = 0.01$ ), and lifting weights tended to be independently associated with mJSW (regression coefficient  $-0.11$ , 95% CI  $-0.22$  to  $0.002$ ,  $P = 0.055$ ), but walking was not

**Table III**  
mJSW according to occupational activity

Occupational activity	Occupational activity		Crude regression coefficient (95% CI)	P value	Adjusted regression coefficient* (95% CI)	P value
	No	Yes				
Sitting on a chair $\geq 2$ h/day	$2.4 \pm 1.2$	$2.6 \pm 1.0$	0.22 (0.11–0.33)	0.0002	0.08 (–0.02 to 0.19)	0.117
Standing $\geq 2$ h/day	$2.6 \pm 1.1$	$2.3 \pm 1.2$	$-0.33$ (–0.47 to –0.19)	$<0.0001$	$-0.21$ (–0.34 to –0.09)	0.0009
Kneeling $\geq 1$ h/day	$2.6 \pm 1.0$	$2.3 \pm 1.1$	$-0.36$ (–0.49 to –0.23)	$<0.0001$	$-0.24$ (–0.35 to –0.12)	$<0.0001$
Squatting $\geq 1$ h/day	$2.7 \pm 0.9$	$2.5 \pm 1.1$	$-0.19$ (–0.34 to –0.03)	0.016	$-0.06$ (–0.21 to 0.08)	0.364
Walking $\geq 3$ km/day	$2.6 \pm 1.0$	$2.4 \pm 1.2$	$-0.20$ (–0.32 to –0.09)	0.0005	$-0.11$ (–0.21 to –0.002)	0.046
Climbing $\geq 1$ h/day	$2.5 \pm 1.0$	$2.5 \pm 1.2$	$-0.06$ (–0.20 to 0.07)	0.038	$-0.02$ (–0.15 to 0.11)	0.733
Lifting weights $\geq 10$ kg $\geq$ once/week	$2.6 \pm 1.0$	$2.5 \pm 1.1$	$-0.10$ (–0.21 to 0.01)	0.08	$-0.16$ (–0.26 to –0.06)	0.003

Values are mean  $\pm$  SD.

\* Adjusted regression coefficient was calculated using multiple regression analysis after adjustment for age, gender, and BMI.

**Table IV**  
OPA according to occupational activity

	Occupational activity		Crude regression coefficient (95% CI)	P value	Adjusted regression coefficient* (95% CI)	P value
	No	Yes				
Sitting on a chair $\geq 2$ h/day	3.5 $\pm$ 8.8	2.4 $\pm$ 6.7	-1.06 (-1.89 to -0.22)	0.013	-0.39 (-1.19 to 0.41)	0.339
Kneeling $\geq 1$ h/day	2.5 $\pm$ 6.9	4.8 $\pm$ 10.9	2.25 (1.22 to 3.29)	<0.0001	1.62 (0.65–2.60)	0.0011
Squatting $\geq 1$ h/day	2.5 $\pm$ 6.8	4.3 $\pm$ 10.5	1.72 (0.78 to 2.66)	0.0004	1.03 (0.13–1.92)	0.025
Standing $\geq 2$ h/day	2.1 $\pm$ 5.6	3.2 $\pm$ 8.3	1.02 (-0.12 to 2.16)	0.079	0.25 (-0.84 to 1.33)	0.657
Walking $\geq 3$ km/day	3.0 $\pm$ 8.7	3.0 $\pm$ 7.0	0.05 (-0.79 to 0.88)	0.912	-0.56 (-1.37 to -0.24)	0.170
Climbing $\geq 1$ h/day	3.1 $\pm$ 8.4	2.7 $\pm$ 6.2	-0.39 (-1.38 to 0.59)	0.434	-0.78 (-1.76 to 0.20)	0.119
Lifting weights $\geq 10$ kg $\geq$ once/week	3.0 $\pm$ 8.1	3.0 $\pm$ 7.8	0.04 (-0.79 to 0.88)	0.920	0.20 (-0.60 to 1.00)	0.624

Values are mean  $\pm$  SD.

\* Adjusted regression coefficient was calculated using multiple regression analysis after adjustment for age, gender, and BMI.

(regression coefficient -0.055, 95% CI -0.164 to 0.054,  $P=0.32$ ). Further, when we analyzed the independent associations of occupational activities with mJSW in women in the same way, kneeling was independently associated with mJSW (regression coefficient -0.20, 95% CI -0.36 to -0.03,  $P=0.02$ ), and walking tended to be independently associated with mJSW (regression coefficient -0.13, 95% CI -0.27 to 0.005,  $P=0.058$ ), but lifting weights were not (regression coefficient -0.09, 95% CI -0.23 to 0.05,  $P=0.22$ ).

## Discussion

The present study is the first epidemiologic study using a large-scale, population-based cohort to determine the association of job title and occupational activity with joint space narrowing and osteophytosis separately. These variables were estimated not by categorical grade but by continuous values such as mJSW and OPA at the knee. In the present study, kneeling, squatting, walking, and heavy lifting were significantly associated with mJSW. For OPA, kneeling and squatting were significantly associated with higher OPA, whereas other activities were not.

Although agricultural, forestry, and fishery workers have been historically among the first to be identified in relation to knee OA in Caucasians<sup>34,35</sup>, no studies have focused on mJSW or OPA separately. The present study is the first to examine the association of characteristic features of knee OA such as mJSW and OPA separately with job title, and clarified that, among women, agricultural, forestry, and fishery workers had significantly lower mJSW compared with clerical workers and technical experts. As other authors have hypothesized, the combination of intense exposure to heavy labor of varied nature and repeated local stresses, especially at a young age, could contribute to some systemic mechanism in the development of OA<sup>36</sup>. This argument would support the implementation of preventive measures as a priority to reduce the intensity of physical labor in this sector—particularly for young female farm workers. In contrast, there were no associations between job titles and mJSW in men. Because men are known to have greater muscle strength than women at all ages<sup>37</sup>, and muscle strength has a protective effect on knee OA<sup>38,39</sup>, it might be that the greater muscle strength obscures the harmful effects of agricultural, forestry, and fishery work, leading to lower risk for knee OA in men.

For kneeling and squatting, studies in Caucasians have suggested that these occupational activities, and job titles that require them, are associated with knee OA<sup>19–24</sup>, whereas our previous study showed that these activities were significantly associated with severe knee OA. However, in all previous studies, knee OA was diagnosed by KL grade or whether subjects had undergone total knee arthroplasty. The present study was the first to clarify the association of kneeling and squatting with joint space narrowing and osteophytosis separately. In addition, these variables were not estimated using a categorical method but rather with continuous values such as mJSW and OPA. This study clarified that kneeling and

squatting were significantly associated with decreased mJSW as well as increased OPA. There were no occupational activities associated with both joint space narrowing and osteophytosis except for kneeling and squatting; in addition, kneeling had a larger impact on mJSW than lifting weights. Thus, these occupational activities must be strongly associated with knee OA.

Walking and lifting weights were associated with joint space narrowing but not with osteophytosis in the present study. This discrepancy may be partly explained by the high prevalence of osteophytosis in Japan. In fact, our previous study<sup>4</sup> showed that KL = 2 OA, which consists of definite osteophytosis but no definite joint space narrowing, was high in subjects in Japan compared with studies in Caucasians<sup>40,41</sup>, whereas KL = 3 OA, which consists of definite joint space narrowing, did not differ significantly between these two ethnic groups. The higher prevalence of osteophytosis in Japan could be due to lifestyle factors, because the Japanese traditional lifestyle includes sitting on the heels on a mat and using Japanese-style lavatories; these positions may cause mechanical stress to the knee joint and possibly lead to acceleration of osteophytosis. The burden on the knee associated with walking and lifting weights may be weaker compared with the burden associated with kneeling and squatting; thus, the association between osteophytosis and occupational activities of walking and lifting weights may be obscured by the traditional Japanese lifestyle. In addition, the separate associations of walking and lifting weights with joint space narrowing and osteophytosis suggest that these two features of knee OA may have distinct etiological mechanisms. In fact, a recent cross-sectional study has shown that osteophytosis was unrelated not only to joint space narrowing on plain radiographs, but also to cartilage loss measured by quantitative magnetic resonance imaging<sup>27</sup>. The present study also showed that mJSW and OPA were significantly correlated, but each predicted only 21% of the variation in the other. Furthermore, our study on an experimental mouse model for OA has identified a cartilage-specific molecule, carminerin, that regulates osteophytosis without affecting joint cartilage destruction during OA progression<sup>28,29</sup>.

In the present study, we found gender differences regarding the association of occupational activities with mJSW. In women, kneeling, squatting, walking, and lifting weights were significantly associated with mJSW, whereas in men, only squatting was significantly associated with mJSW. This difference may be partly explained by muscle strength in men. Because men are known to have greater muscle strength than women at all ages, and muscle strength has a protective effect on knee OA<sup>37–39</sup>, it might be that the greater muscle strength obscures the harmful effects of occupational activities on knees in men.

Our technique to measure mJSW is a little different from many other methods (Ref) in that the tibia margin is defined using both the tibial plateau (bright band) and the rim, whereas other methods use the tibial plateau alone<sup>42,43</sup>. However, our preparatory examination showed higher reproducibility in “the middle line between

the anterior and posterior margins of the tibial plateau"<sup>32</sup>. In fact, in our previous study<sup>32</sup>, to decide the ideal algorithms for the measurements, we initially evaluated the reproducibility of "the tibial plateau alone" and "the middle line between the anterior and posterior margins of the tibial plateau" by an intraclass coefficient of correlation (ICC) on radiographs of 20 individuals taken at a 2-week intervals with various knee flexion angles (0, 10, 20, and 30°) and X-ray beam angulations (0, 5, 10, and 15°). Results showed higher reproducibility in "the middle line between the anterior and posterior margins of the tibial plateau" at each condition.

There were several limitations to the present study. First, this is a cross-sectional study on factors associated with knee OA, so a causal association with occupational activity could not be determined. However, information collected included a lifetime occupational history and details of specific workplace physical activities; therefore, ample evidence on the background of joint space narrowing and osteophytosis at the knee could be obtained. Second, a rotation of the knee could cause a large error, especially in OPA, which could hide associations of independent variables with this metric. However, the patella was centralized over the lower end of the femur with the aid of fluoroscopy when we took X-rays; thus the rotational error is likely to be small and have minimal effects on the results of the present study.

In conclusion, the present cross-sectional study using a large-scale population from the ROAD study revealed distinct risk factors of occupational activities for joint space narrowing and osteophytosis in Japanese subjects. Other occupational activities of kneeling and squatting were associated with joint space narrowing as well as osteophytosis. Walking and heavy lifting were associated with joint space narrowing, but not with osteophytosis. Further studies, along with longitudinal data from the ROAD study, will elucidate the environmental background of OA and help clarify clinical evidence for the development of disease-modifying treatments.

#### Author contributions

All authors have made substantial contributions to all three of sections (1), (2) and (3) below;

(1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data

(2) drafting the article or revising it critically for important intellectual content

(3) final approval of the version to be submitted.

#### Competing interest

There are no competing interest.

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#### Supplementary material

Supplementary data related to this article can be found online at doi:10.1016/j.joca.2011.03.008.

#### References

- Sharma L, Kapoor D. Epidemiology of osteoarthritis. In: Moskowitz RW, Altman RD, Hochberg MC, Buckwalter JA, Goldberg VM, Eds. *Osteoarthritis: Diagnosis and Medical/Surgical Management*. 4th edn. Philadelphia: Lippincott Williams & Wilkins; 2007:3–26.
- Guccione AA, Felson DT, Anderson JJ, Anthony JM, Zhang Y, Wilson PW, et al. The effects of specific medical conditions on the functional limitations of elders in the Framingham study. *Am J Public Health* 1994;84:351–8.
- Felson DT, Zhang Y. An update on the epidemiology of knee and hip osteoarthritis with a view to prevention. *Arthritis Rheum* 1998;41:1343–55.
- Muraki S, Oka H, Akune T, Mabuchi A, En-yo Y, Yoshida M, et al. Prevalence of radiographic knee osteoarthritis and its association with knee pain in the elderly of Japanese population-based cohorts: the ROAD study. *Osteoarthritis Cartilage* 2009;17:1137–43.
- Yoshimura N, Muraki S, Oka H, Mabuchi A, En-yo Y, Yoshida M, et al. Prevalence of knee osteoarthritis, lumbar spondylosis and osteoporosis in Japanese men and women: the research on osteoarthritis/osteoporosis against disability (ROAD). *J Bone Miner Metab* 2009;27:620–8.
- Ministry of Health, Labour and Welfare. The outline of the results of National Livelihood Survey 2007. Available at: <http://www.mhlw.go.jp/toukei/list/20-19-1.html>.
- Jackson JP. Degenerative changes in the knee after meniscectomy. *Br Med J* 1968;2:525–7.
- Fairbank TJ. Knee joint changes after meniscectomy. *J Bone Joint Surg Br* 1948;30:664–70.
- Jacobsen K. Osteoarthritis following insufficiency of the cruciate ligaments in man. A clinical study. *Acta Orthop Scand* 1977;48:520–6.
- Sommerlath K, Gillquist J. The long-term course of various meniscal treatments in anterior cruciate ligament deficient knees. *Clin Orthop Relat Res* 1992;283:207–14.
- Neyret P, Donell ST, Dejour H. Results of partial meniscectomy related to the state of the anterior cruciate ligament. Review at 20–35 years. *J Bone Joint Surg Br* 1993;75:36–40.
- Felson DT. Epidemiology of hip and knee osteoarthritis. *Epidemiol Rev* 1988;10:1–28.
- Kellgren JH, Lawrence JS. Rheumatism in miners. II. X-ray study. *Br J Ind Med* 1952;9:197–207.
- Partridge RE, Duthie JJ. Rheumatism in dockers and civil servants. A comparison of heavy manual and sedentary workers. *Ann Rheum Dis* 1968;27:559–68.
- Lindberg H, Montgomery F. Heavy labor and the occurrence of gonarthrosis. *Clin Orthop Relat Res* 1987;214:235–6.
- Kohatsu ND, Schurman DJ. Risk factors for the development of osteoarthritis of the knee. *Clin Orthop Relat Res* 1990;261:242–6.
- Vingård E, Alfredsson L, Goldie I, Hogstedt C. Occupation and osteoarthritis of the hip and knee: a register-based cohort study. *Int J Epidemiol* 1991;20:1025–31.
- Vingård E, Alfredsson L, Fellenius E, Hogstedt C. Disability pensions due to musculo-skeletal disorders among men in heavy occupations. *Scand J Soc Med* 1992;20:31–6.
- Anderson JJ, Felson DT. Factors associated with osteoarthritis of the knee in the first national health and nutrition examination survey (HANES I). Evidence for an association with

- overweight, race, and physical demands of work. *Am J Epidemiol* 1988;128:179–89.
20. Felson DT, Hannan MT, Naimark A, Berkeley J, Gordon G, Wilson PW, et al. Occupational physical demands, knee bending, and knee osteoarthritis: results from the Framingham study. *J Rheumatol* 1991;18:1587–92.
  21. Cooper C, McAlindon T, Coggon D, Egger P, Dieppe P. Occupational activity and osteoarthritis of the knee. *Ann Rheum Dis* 1994;53:90–3.
  22. Coggon D, Croft P, Kellingray S, Barrett D, McLaren M, Cooper C. Occupational physical activities and osteoarthritis of the knee. *Arthritis Rheum* 2000;43:1443–9.
  23. Sandmark H, Hogstedt C, Vingard E. Primary osteoarthrosis of the knee in men and women as a result of lifelong physical load from work. *Scand J Work Environ Health* 2000;26:20–5.
  24. Manninen P, Heliövaara M, Riihimäki H, Suoma-Iaininen O. Physical workload and the risk of severe knee osteoarthritis. *Scand J Work Environ Health* 2002;28:25–32.
  25. Muraki S, Akune T, Oka H, Mabuchi A, En-yo Y, Yoshida M, et al. Association of occupational activity with radiographic knee osteoarthritis and lumbar spondylosis in elderly patients of population-based cohorts: a large-scale population-based study. *Arthritis Rheum* 2009;61:779–86.
  26. Kellgren JH, Lawrence JS, Eds. *The Epidemiology of Chronic Rheumatism: Atlas of Standard Radiographs of Arthritis*. Oxford: Blackwell Scientific; 1963
  27. Jones G, Ding C, Scott F, Glisson M, Cicuttini F. Early radiographic osteoarthritis is associated with substantial changes in cartilage volume and tibial bone surface area in both males and females. *Osteoarthritis Cartilage* 2004;12:169–74.
  28. Yamada T, Kawano H, Koshizuka Y, Fukuda T, Yoshimura K, Kamekura S, et al. Carminerin contributes to chondrocyte calcification during endochondral ossification. *Nat Med* 2006;12:665–70.
  29. Kamekura S, Kawasaki Y, Hoshi K, Shimoaka T, Chikuda H, Maruyama Z, et al. Contribution of runt-related transcription factor 2 to the pathogenesis of osteoarthritis in mice after induction of knee joint instability. *Arthritis Rheum* 2006;54:2462–70.
  30. Muraki S, Oka H, Mabuchi A, Akune T, En-yo Y, Yoshida M, et al. Prevalence of radiographic lumbar spondylosis and its association with low back pain in the elderly of population-based cohorts: the ROAD study. *Ann Rheum Dis* 2009;68:1401–6.
  31. Yoshimura N, Muraki S, Oka H, Kawaguchi H, Nakamura K, Akune T. Cohort profile: research on osteoarthritis/osteoporosis against disability study. *Int J Epidemiol* 2010;39:988–95.
  32. Oka H, Muraki S, Akune T, Mabuchi A, Suzuki T, Yoshida H, et al. Fully automatic quantification of knee osteoarthritis severity on plain radiographs. *Osteoarthritis Cartilage* 2008;16:1300–6.
  33. Oka H, Muraki S, Akune T, Nakamura K, Kawaguchi H, Yoshimura N. Normal and threshold values of joint space width, joint space area, osteophyte area and fibro-tibial angle using a computer-assisted measuring system (KOACAD) to evaluate knee osteoarthritis: the ROAD study. *J Orthop Sci* 2010;15:781–9.
  34. Rosignol M, Leclerc A, Allaert FA, Rozenberg S, Valat JP, Avouac B, et al. Primary osteoarthritis of hip, knee, and hand in relation to occupational exposure. *Occup Environ Med* 2005;62:772–7.
  35. Walker-Bone K, Palmer KT. Musculoskeletal disorders in farmers and farm workers. *Occup Med (Lond)* 2002;52:441–50.
  36. Felson DT, Lawrence RC, Dieppe PA, Hirsch R, Helmick CG, Jordan JM, et al. Osteoarthritis: new insights. Part 1: the disease and its risk factors. *Ann Intern Med* 2000;133:635–46.
  37. Sinaki M, Nwaogwugwu NC, Phillips BE, Mokri MP. Effect of gender, age, and anthropometry on axial and appendicular muscle strength. *Am J Phys Med Rehabil* 2001;80:330–8.
  38. McAlindon TE, Cooper C, Kirwan JR, Dieppe PA. Determinants of disability in osteoarthritis of the knee. *Ann Rheum Dis* 1993;52:258–62.
  39. O'Reilly SC, Jones A, Muir KR, Doherty M. Quadriceps weakness in knee osteoarthritis: the effect on pain and disability. *Ann Rheum Dis* 1998;57:588–94.
  40. Felson DT, Naimark A, Anderson J, Kazis L, Castelli W, Meenan RF. The prevalence of knee osteoarthritis in the elderly. The Framingham osteoarthritis study. *Arthritis Rheum* 1987;30:914–8.
  41. Jordan JM, Helmick CG, Renner JB, Luta G, Dragomir AD, Woodard J, et al. Prevalence of knee symptoms and radiographic and symptomatic knee osteoarthritis in African Americans and Caucasians: the Johnston County osteoarthritis project. *J Rheumatol* 2007;34:172–80.
  42. Piperno M, Hellio Le Graverand MP, Conrozier T, Bochu M, Mathieu P, Vignon E, et al. Quantitative evaluation of joint space width in femorotibial osteoarthritis: comparison of three radiographic views. *Osteoarthritis Cartilage* 1998;6:252–9.
  43. Schmidt JE, Amrami KK, Manduca A, Kaufman KR. Semi-automated digital image analysis of joint space width in knee radiographs. *Skeletal Radiol* 2005;34:639–43.

## EPIDEMIOLOGY

## Health-Related Quality of Life in Subjects With Low Back Pain and Knee Pain in a Population-Based Cohort Study of Japanese Men

*The Research on Osteoarthritis Against Disability Study*

Shigeyuki Muraki, MD, PhD,\* Toru Akune, MD, PhD,\* Hiroyuki Oka, MD,† Yoshio En-yo, MD,‡ Munehito Yoshida, MD, PhD,‡ Akihiko Saika, MD, PhD,‡ Takao Suzuki, MD, PhD,§ Hideyo Yoshida, MD, PhD,§ Hideaki Ishibashi, MD, PhD,§ Fumiaki Tokimura, MD, PhD,§ Seizo Yamamoto, MD, PhD,§ Kozo Nakamura, MD, PhD,¶ Hiroshi Kawaguchi, MD, PhD,¶ and Noriko Yoshimura, MD, PhD,†

**Study Design.** Cross-sectional surveys of health-related quality of life (QOL) in subjects with low back pain and knee pain using a population-based cohort.**Objective.** The purpose of the present study was to clarify the impact of low back pain and knee pain on QOL in men. In addition, we analyzed the impacts of vertebral fracture (Vfx), lumbar

From the \*Department of Clinical Motor System Medicine, 22nd Century Medical & Research Center, Faculty of Medicine, University of Tokyo, Tokyo, Japan; †Department of Joint Disease Research, 22nd Century Medical & Research Center, Faculty of Medicine, University of Tokyo, Tokyo, Japan; ‡Department of Orthopaedic Surgery, Wakayama Medical University, Wakayama, Japan; §Tokyo Metropolitan Institute of Gerontology, Tokyo, Japan; and ¶Department of Sensory & Motor System Medicine, Faculty of Medicine, University of Tokyo, Tokyo, Japan.

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The present study was conducted with the approval of ethical committees of the University of Tokyo and the Tokyo Metropolitan Institute of Gerontology.

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Address correspondence and reprint requests to Shigeyuki Muraki, MD, PhD, 22nd Century Medical and Research Center, Faculty of Medicine, University of Tokyo, 7-3-1 Hongo, Bunkyo-ku, Tokyo 113-8655, Japan; E-mail: murakis-ort@h.u-tokyo.ac.jp

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spondylosis, and knee osteoarthritis (OA) on the magnitude of QOL loss in men with low back pain and knee pain.

**Summary of Background Data.** Low back pain and knee pain are major public health issues causing disability among the elderly men, but there were no population-based studies to compare the impact of low back pain on QOL with that of knee pain in Japanese men.

**Methods.** From 3040 participants in the Research on Osteoarthritis Against Disability study, data from 767 men older than 40 years who completed questionnaires (mean age = 69.7 years) were examined. To carry out the QOL assessment, the Medical Outcomes Study Short Form 8 (SF-8) and EuroQol (EQ-5D) were used. We examined the association of low back pain and knee pain with QOL. Furthermore, we also examined the presence of Vfx and the severity of lumbar spondylosis and knee OA with the magnitude of QOL loss in men with low back pain and knee pain, respectively.

**Results.** The impact of low back pain on QOL was larger than that of knee pain. In men with low back pain, there were few associations between Kellgren-Lawrence grade and QOL, whereas Vfx was associated with physical QOL. For men with knee pain, Kellgren-Lawrence grade equal to 4 knee OA was associated with QOL.

**Conclusion.** This study revealed that low back pain has a larger impact than knee pain on QOL. Furthermore, low back pain with Vfx is strongly associated with physical QOL loss.

**Key words:** knee pain, low back pain, osteoarthritis, quality of life, vertebral fracture. **Spine 2011;36:1312-1319**

Low back pain and knee pain are major public health issues causing disability among the elderly in most developed countries.<sup>1-3</sup> The prevalence of low back pain and knee pain is high in the elderly in Japan, ranging from 25% to 30%.<sup>2,3</sup> According to the recent National Livelihood Survey of the Ministry of Health, Labour, and Welfare in Japan, low back pain is rated first among symptoms that send men to the hospital.<sup>4</sup> Thus, it is important to clarify the impact of low back pain and knee pain on quality of life (QOL). Several studies have focused on the association of low back pain with

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QOL in whites,<sup>5-8</sup> but for knee pain, there are few studies regarding its association with QOL.<sup>9</sup> Furthermore, to the best of our knowledge, there are no population-based studies that examine the impact of low back pain and knee pain on QOL in the same population using the same tool, although low back pain and knee pain may not be independent. Furthermore, the presence of pain at both sites may have more impact on QOL than pain at a single site. One of the main causes of low back pain in the elderly is vertebral fracture (VFX).<sup>10</sup> Low back pain is also believed to be one of the principal clinical symptoms of lumbar spondylosis, although the magnitude of the impact of lumbar spondylosis on low back pain is not as strong as one would expect.<sup>2,11,12</sup> A significant part of knee pain is caused by knee osteoarthritis (OA),<sup>13,14</sup> and the prevalence of knee pain increases as knee OA becomes more severe.<sup>3</sup> Thus, the impact of pain on QOL may differ on the basis of the cause and severity of the underlying disease. However, to the best of our knowledge, there are no population-based studies that examine the association of pain with QOL according to the cause or severity of the underlying disease.

Furthermore, sex differences have been observed in low back pain and knee pain. The prevalence of low back pain and knee pain differs between men and women,<sup>2,3</sup> and low back pain is rated as the first symptom that sends men to the hospital, although it is rated as the second symptom for women.<sup>4</sup> Thus, the impact of this pain on QOL may be stronger in men than in women. Although studies have examined the association of low back pain<sup>5-8</sup> or knee pain<sup>9</sup> with QOL, neither men nor women were analyzed separately<sup>5,6,9</sup> or the studies focused only on women.<sup>7,8</sup> There are no large-scale population-based studies examining the impact of low back pain or knee pain on QOL in men alone.

The objective of the present study was to clarify the independent association of low back pain and knee pain with QOL among 767 men using cohorts from Research on Osteoarthritis Against Disability (ROAD). We also examined whether the presence of both low back pain and knee pain had a larger impact on QOL than pain at only one site. Furthermore, we analyzed the impact of VFX, lumbar spondylosis, and knee OA on the magnitude of loss of QOL in men with low back pain and knee pain.

**MATERIALS AND METHODS**

**Subjects**

The ROAD study is a nationwide prospective study for bone and joint diseases (with OA and osteoporosis as the representative bone and joint diseases) consisting of population-based cohorts established in several communities in Japan. As detailed profile of the ROAD study has been described elsewhere,<sup>15,16</sup> and only a brief summary is provided here. To date, we have completed the creation of a baseline database including clinical and genetic information of 3040 inhabitants (1061 men and 1979 women) aged 23 to 95 years (mean = 70.6 years), who were recruited from listings of resident registrations in three communities: an urban region in Itabashi, Tokyo; a mountainous region in Hidakagawa,

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Wakayama; and a seacoast region in Taiji, Wakayama. All participants provided written informed consent, and the study was conducted with the approval of ethical committees of the University of Tokyo and the Tokyo Metropolitan Institute of Gerontology. Participants completed an interviewer-administered questionnaire of 400 items that included lifestyle information such as smoking habits, alcohol consumption, family history, and health-related QOL. We also examined the presence of cerebral stroke, diabetes mellitus, cardiac disease, and hypertension using an interviewer-administered questionnaire, as QOL may be affected by these comorbidities. Furthermore, because a lower level of physical activity may affect the association of pain with QOL, we obtained a history of leisure physical activity, including information on participation in sports and the frequency and duration of other leisure activities such as walking, jogging, swimming, playing tennis, playing baseball, playing golf, and muscle strength training. Anthropometric measurements included height and weight, and body mass index (BMI; weight [kg]/height<sup>2</sup> [m<sup>2</sup>]) was calculated. All subjects were interviewed by experienced orthopedists regarding low back pain and knee pain and were asked, “Have you experienced low back pain on most days in the past month, in addition to now?” and “Have you experienced knee pain on most days in the past month, in addition to now?,” respectively. Those who answered yes were defined as having pain. From the baseline data of the overall participants, the present study analyzed 767 men aged 40 years or older who completed a questionnaire of the Medical Outcomes Study Short Form 8 (SF-8) and the EuroQol (EQ-5D).

**Radiographic Assessment**

All participants underwent radiographic examination of the lumbar spine including intervertebral levels L1-L2 to L5-S with anteroposterior and lateral views, and both knees using anteroposterior and lateral views with weight-bearing and foot map positioning. Lumbar spine and knee radiographs were read without knowledge of participant clinical status by a single experienced orthopedist (S. M.). VFX was assessed by lateral radiographs of the lumbar spine (L1-L5) in terms of a wedge, biconcave, or crush appearance according to the Japanese Society of Bone and Mineral Research criteria<sup>17</sup> (Figure 1). Lumbar spondylosis and knee OA were assessed using the Kellgren-Lawrence (KL) radiographic atlas, and the

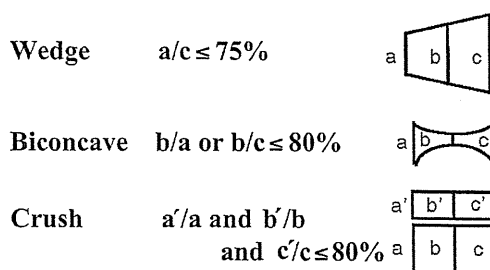


Figure 1. Diagnostic criteria for vertebral fractures according to the Japanese Society for Bone and Mineral Research.

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severity was determined by KL grading.<sup>18</sup> We defined lumbar spondylosis and knee OA as KL 2 or more in at least one knee and one intervertebral level, respectively.

### Instruments

The SF-8 scale was used for the QOL assessment. The SF-8 was constructed to provide a shorter alternative to the SF-36,<sup>19</sup> the most widely used patient-based health status survey, for use in large population-based surveys of general and specific populations. The SF-8 measures eight concepts: general health (GH), physical function (PF), role physical (RP), bodily pain (BP), vitality (VT), social function (SF), mental health (MH), and role emotional (RE). The SF-8 was scored by assigning the mean SF-36 scale score from the 2002 general Japanese population to each response category of the SF-8 measuring the same concept, and then weighting each SF-8 item to compute aggregate physical component scores (PCS) and mental component scores (MCS) summary scale measures. The SF-8 can be scored using a published algorithm for Japanese versions of the SF-8, which have been well-validated.<sup>20</sup> We also used the EuroQol (EQ-5D) questionnaire,<sup>21</sup> which was translated into Japanese.<sup>22</sup> The five-dimensional health care classification includes questions on the status of morbidity, self-care, usual activities, pain/discomfort, and anxiety/depression. Participants were asked to indicate current health status by choosing the most appropriate of the three statements about each of the five QOL dimensions. Each statement represents an increasing degree of severity. These results were coded and converted to a score of utility using a table of values.<sup>22</sup>

### Statistical Analysis

We used the nonpaired student *t* test to examine differences between subjects with and without low back pain and knee pain. To determine the independent impact of low back pain and knee pain on QOL, multiple regression analysis was used with age, BMI, low back pain, and knee pain as independent variables. Furthermore, to examine the impact of the presence of both low back pain and knee pain on QOL, QOL scores in subjects with both low back pain and knee pain, with low back pain only, with knee pain only, and without these conditions were compared using the Tukey Honestly Significant Difference (HSD) test after adjustment for age and BMI. We further examined the association of KL grade at the lumbar spine and knee with the magnitude of QOL loss in subjects with low back pain and knee pain, respectively, using the Tukey HSD test after adjustment for age and BMI. If a subject had pain in both knees, the more severe KL grade was used for that subject. For the lumbar spine, the most severe KL grade among all intervertebral spaces was used. We also examined the association of the presence of Vfx with the magnitude of QOL loss in subjects with low back pain using multiple regression analysis after adjustment for age, BMI, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension. The association of physical activity with the magnitude of QOL loss in subjects with low back pain and in those with knee pain was determined using multiple

regression analysis after adjustment for age, BMI, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension. Data analyses were performed using SAS version 9.0 (SAS Institute Inc., Cary, NC).

### RESULTS

Characteristics of the 767 participants aged 40 years and older in the ROAD study are shown in Table 1. The prevalence of low back pain and knee pain was approximately 15% and 21%, respectively. The prevalence of lumbar spondylosis and knee OA was 80% and 42%, respectively, which was high compared with that of Vfx.

**TABLE 1. Characteristics of Participants**

N	767
Age, yr	69.7 ± 10.5
Height, cm	162.8 ± 6.7
Weight, kg	61.5 ± 10.8
BMI, kg/m <sup>2</sup>	23.1 ± 3.4
Low back pain, %	15.4
Knee pain, %	20.6
Vertebral fracture, %	11.6
Lumbar spondylosis, %	80.0
Knee osteoarthritis, %	42.1
Comorbidities, %	
Cerebral stroke	5.8
Diabetes mellitus	13.8
Cardiac disease	13.4
Hypertension	41.1
Medical Outcomes Study Short Form 8	
GH	50.2 ± 5.5
PF	49.9 ± 6.2
RP	50.2 ± 6.7
BP	50.4 ± 9.2
VT	50.4 ± 6.3
SF	52.4 ± 5.5
MH	54.4 ± 5.3
RE	52.0 ± 5.2
PCS	47.4 ± 6.8
MCS	53.4 ± 5.3
EQ-5D	0.91 ± 0.14
<i>Values are mean ± SD unless otherwise indicated.</i>	
<i>BMI indicates body mass index; BP, bodily pain; EQ-5D, EuroQol; GH, general health; MCS, mental component summary; MH, mental health; PCS, physical component summary; PF, physical function; RE, role emotional; RP, role physical; SF, social function; VT, vitality;</i>	

**TABLE 2. Mean (SD) Scores of All Domains, PCS, and MCS in the SF-8 and EQ-5D in Men with and Without Low Back Pain and Knee Pain**

	Low Back Pain			Knee Pain		
	No	Yes	Adjusted Beta*	No	Yes	Adjusted Beta*
<b>Medical Outcomes Study Short Form 8</b>						
GH	50.5 (5.4)	48.3† (5.6)	-0.105‡	50.5 (5.4)	49.1† (5.5)	-0.100‡
PF	50.5 (5.8)	47.0† (7.5)	-0.135‡	50.4 (5.7)	48.2† (7.6)	-0.085‡
RP	50.7 (6.4)	47.4† (7.7)	-0.102‡	50.7 (6.2)	48.7† (7.9)	-0.073‡
BP	51.4 (9.2)	44.6† (7.2)	-0.235‡	51.1 (9.2)	47.6† (8.7)	-0.119‡
VT	50.8 (6.3)	48.4† (5.8)	-0.110‡	50.8 (6.1)	49.0† (6.5)	-0.109‡
SF	52.8 (5.0)	50.5† (7.5)	-0.100‡	52.5 (5.3)	52.4 (5.8)	0.028
MH	54.6 (5.1)	53.1† (6.0)	-0.078‡	54.4 (5.2)	54.6 (5.3)	0.034
RE	52.3 (4.9)	50.6† (5.5)	-0.087‡	52.1 (4.9)	51.9 (6.2)	-0.0001
PCS	48.2 (6.5)	43.3† (7.2)	-0.191‡	48.1 (6.5)	44.8† (7.2)	-0.147‡
MCS	53.4 (5.1)	53.1 (6.3)	-0.010	53.2 (5.2)	54.2 (5.6)	0.076‡
<b>EQ-5D</b>	0.93 (0.13)	0.83† (0.17)	-0.180‡	0.92 (0.13)	0.87† (0.16)	-0.099‡

*Values are mean (SD) unless otherwise indicated.*

*\*The adjusted beta values are shown using multiple regression analysis after adjustment for age, body mass index, the other pain, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension.*

*†P < 0.05 versus subjects without the corresponding pain by nonpaired student t test.*

*‡P < 0.05 by multiple regression analysis.*

*BP indicates bodily pain; EQ-5D, EuroQol; GH, general health; MCS, mental component summary; MH, mental health; PCS, physical component summary; PF, physical function; RE, role emotional; RP, role physical; SF, social function; SF-8, 8-Item Short Form Health Survey; VT, vitality.*

Table 2 shows the scores for all domains in the SF-8 and the EQ-5D utility score by the presence of low back pain and knee pain. We further examined the independent association of low back pain and knee pain with QOL using multiple regression analysis after adjustment for age, BMI, cerebral stroke, diabetes mellitus, cardiac disease, hypertension, and the other pain. Low back pain was significantly associated with lower QOL scores in all the domains of the SF-8 except for MCS, and in the EQ-5D utility scores, whereas knee pain was associated with lower scores of GH, PF, RP, BP, VT, and PCS in the SF-8 and the EQ-5D utility score, but not with SF, MH, and RE. For the MCS, knee pain was associated with higher scores. The adjusted beta values of low back pain were larger than those of knee pain in almost all QOL domains.

To examine the impact of the presence of both low back pain and knee pain on QOL, we next compared the QOL scores in the subjects with both low back pain and knee pain, only low back pain, only knee pain, and without any pain (Table 3). The Tukey HSD test after adjustment for age, BMI, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension showed that the scores for almost all physical domains in the SF-8 were significantly lower in subjects with both low back pain and knee pain, only low back pain, and only knee pain than in those without pain. The EQ-5D utility score was also significantly lower in subjects with both low back pain

and knee pain, those with only low back pain, and those with only knee pain than in those without pain. There were no significant differences in any domains between subjects with both low back pain and knee pain and those with only low back pain. Some domains tended to be lower in subjects with pain in both sites than in those with only knee pain, but differences were not significant.

Next, to clarify the impact of VFX and lumbar spondylosis on the magnitude of QOL loss in men with low back pain, we examined the association of KL grade of lumbar spine and the presence of VFX with QOL in the subjects with low back pain (Table 4). In men with low back pain, there were no associations of KL grade with any domain of the SF-8 and the EQ-5D utility scores, whereas the RP and PCS scores were significantly lower in subjects with VFX than in those without fracture.

Likewise, we examined the association of KL grade of knee with QOL in the subjects with knee pain (Table 5). After adjustment for age and BMI, the Tukey HSD test showed that the PCS in the SF-8 was significantly lower in men with KL 4 knee OA than in those with KL 0 or 1.

We next analyzed the association of physical activity with QOL in subjects with low back pain and in those with knee pain (see Table, Supplemental Digital Content 1, <http://links.lww.com/BRS/A519>). Multiple regression analysis

**TABLE 3. Mean (SD) Scores of All Domains, PCS, and MCS in the SF-8 and EQ-5D in Men by the Combination of Low Back Pain and Knee Pain**

	Low Back Pain and Knee Pain	Only Low Back Pain	Only Knee Pain	No Low Back Pain or Knee Pain
Prevalence, %	5.2	9.8	15.5	69.6
<b>Medical Outcomes Study Short Form 8</b>				
GH	48.2* (5.4)	48.7* (5.7)	49.3* (5.5)	50.8 (5.3)
PF	47.7* (6.2)	46.8* (8.2)	48.4* (8.1)	50.9 (5.0)
RP	48.0 (6.9)	47.6* (8.0)	49.0* (8.3)	51.1 (5.8)
BP	45.3* (7.7)	44.6* (6.9)	48.4* (8.9)	52.1 (9.1)
VT	47.9* (6.1)	48.8* (5.7)	49.3* (6.6)	51.1 (6.1)
SF	51.1 (6.5)	50.7 (7.9)	52.8 (5.5)	52.8 (4.8)
MH	54.4 (4.8)	52.7* (6.4)	54.7 (5.4)	54.6 (5.0)
RE	51.6 (5.0)	50.4* (7.2)	52.0 (6.5)	52.3 (4.4)
PCS	43.4* (6.5)	43.5* (7.5)	45.3* (7.4)	48.8 (6.1)
MCS	54.1 (5.6)	53.0 (6.7)	54.3 (5.5)	53.2 (5.0)
EQ-5D	0.82* (0.17)	0.84* (0.16)	0.88* (0.15)	0.94 (0.12)

Values are mean (SD) unless otherwise indicated.

\*Significantly lower than that of subjects with no low back pain or knee pain by the Tukey Honestly Significant Difference test after adjustment for age, body mass index, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension.

BP indicates bodily pain; EQ-5D, EuroQoL; GH, general health; MCS, mental component summary; MH, mental health; PCS, physical component summary; PF, physical function; RE, role emotional; RP, role physical; SF, social function; SF-8, 8-Item Short Form Health Survey; VT, vitality.

after adjustment for age, BMI, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension showed that physical activity was not associated with any QOL parameter in subjects with low back pain or in those with knee pain.

**DISCUSSION**

This is the first large-scale, population-based cohort study in Japanese men that examined the impact of low back pain and knee pain on QOL measured by the SF-8 as well as the EQ-5D. In the present study, low back pain and knee pain were significantly associated with QOL in men, and multiple regression analysis showed that the adjusted beta values of low back pain were larger than that of knee pain in almost all QOL domains. Furthermore, in men with low back pain, VFx was significantly associated with QOL loss. For men with knee pain, KL 4 knee OA was strongly associated with magnitude of QOL loss compared with KL 0 or 1.

Previous studies showed that low back pain was associated with QOL,<sup>5-8</sup> but no studies focused on men, although sex differences were found in low back pain.<sup>2,4</sup> In addition, although low back pain and knee pain may not be independent, and the presence of pain at both sites may have more impact on QOL loss than pain at one site, no studies have examined the impact of low back pain and knee pain on QOL simultaneously in the same population. In the present study, low back pain and knee pain were significantly associated with lower QOL scores in men. The adjusted beta values of low back

pain were higher than that of knee pain in almost all QOL domains, suggesting that low back pain had more impact on QOL loss than knee pain, although we did not evaluate the pain severity of low back pain and knee pain. Furthermore, the pain thresholds and pain onset in daily living in low back pain are not the same as in knee pain, so strict comparisons between low back pain and knee pain are limited, even though we examined the association of low back pain and knee pain with QOL in the same populations using the same method. The presence of both low back pain and knee pain was also significantly associated with QOL loss compared with no low back pain or knee pain, whereas there were no differences in QOL parameters between subjects with both low back pain and knee pain and those with only low back pain. These findings suggest that when both low back pain and knee pain exist, the combination may not result in any additional impact on QOL than pain in single site; it is possible that the impact of knee pain on QOL may be obscured by low back pain, because the impact of low back pain on QOL was larger than that of knee pain.

Previous clinical studies showed that strong impacts of clinical VFx on QOL were observed.<sup>23,24</sup> The present study also clarified that VFx had significant associations with the magnitude of QOL loss measured by RP and PCS of the SF-8 in subjects with low back pain, indicating that low back pain with VFx has a more severe impact on physical QOL than low back pain without VFx in men. This means that VFx may not

**TABLE 4. Mean (SD) Scores on the SF-8 and EQ-5D by Vertebral Fracture and Kellgren-Lawrence Grade in Subjects with Low Back Pain**

Prevalence, %	Vertebral Fracture			Lumbar Spondylosis		
	No	Yes	KL 0,1	KL 2	KL 3	KL 4
	18.6	81.4	16.2	35.0	28.2	20.5
<b>Medical Outcomes Study Short Form 8</b>						
GH	48.6 (5.6)	47.2 (5.9)	46.8 (6.8)	49.9 (5.3)	47.8 (5.4)	47.4 (5.3)
PF	47.5 (7.6)	44.8 (7.0)	48.6 (5.7)	49.4 (5.7)	43.6 (9.6)	46.3 (6.7)
RP	48.1 (7.3)	44.3* (8.7)	49.1 (6.9)	49.3 (6.9)	45.5 (8.5)	45.5 (8.2)
BP	44.9 (7.4)	43.2 (6.2)	42.3 (4.9)	46.2 (7.6)	45.2 (6.8)	43.2 (8.2)
VT	48.7 (6.0)	47.0 (5.0)	47.6 (7.7)	48.8 (5.3)	47.9 (5.5)	48.9 (5.6)
SF	50.4 (7.8)	51.2 (6.2)	49.4 (8.8)	52.6 (4.9)	49.6 (8.4)	49.0 (8.4)
MH	52.5 (6.1)	55.4 (4.5)	51.7 (7.6)	55.3 (4.0)	51.6 (6.1)	52.0 (6.4)
RE	50.2 (6.9)	52.2 (3.6)	49.0 (8.3)	52.6 (3.3)	49.1 (8.3)	50.5 (5.6)
PCS	44.2 (6.6)	39.4* (8.2)	44.0 (5.0)	44.9 (7.1)	41.9 (8.0)	42.0 (7.5)
MCS	52.4 (6.2)	56.4 (5.8)	51.0 (8.5)	54.9 (4.5)	52.2 (6.1)	52.8 (6.7)
<b>EQ-5D</b>	0.82 (0.17)	0.85 (0.16)	0.86 (0.15)	0.87 (0.14)	0.78 (0.17)	0.80 (0.19)

Values are mean (SD) unless otherwise indicated.

\* $P < 0.05$  versus no vertebral fracture by the Tukey Honestly Significant Difference test after adjustment for age, body mass index, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension.

BP indicates bodily pain; EQ-5D, EuroQOL; GH, general health; MCS, mental component summary; MH, mental health; PCS, physical component summary; PF, physical function; RE, role emotional; RP, role physical; SF, social function; SF-8, 8-Item Short Form Health Survey; VT, vitality.

only be a cause of low back pain but also worsen the severity of low back pain. Meanwhile, the severity of lumbar spondylosis was not significantly associated with magnitude of QOL loss in subjects with low back pain. This finding may be partly explained by the weak association between lumbar spondylosis and low back pain reported by us and others.<sup>2,11,12</sup> Indeed, disc degeneration was reported to be detected by magnetic resonance imaging in at least one lumbar level in all but one asymptomatic volunteer in a group with volunteers aged 60 to 80 years.<sup>25</sup> Regarding the knee, the adjusted beta values of knee pain on QOL were weak compared with low back pain, whereas the KL 4 knee OA was significantly associated with magnitude of PCS loss in subjects with knee pain compared with KL 0 or 1. The PCS in subjects with KL 2 knee OA were similar to those with KL 0 or 1. Considering the definition of the KL grade, this may also mean that osteophytosis and joint space narrowing, which are representative features of knee OA, have a different impact on QOL; that is, osteophytosis may have a weak impact on QOL, whereas joint space narrowing may have a strong impact.

As measured by MCS of the SF-8, low back pain was not significantly associated with lower scores in the present study, whereas knee pain was significantly associated with higher scores on MCS, and significantly lower PCS scores. Several factors may contribute to the dissociation between MCS and PCS for low back pain and knee pain. First, MCS questions

within the SF-8 include generic questions about energy levels, feelings of being “downhearted and blue,” and interference in daily activities as a result of emotional problems. These questions are less sensitive to the presence of mental health issues than disease-specific scales such as the Kessler psychological distress scale.<sup>26</sup> In fact, Hill et al<sup>27</sup> showed that psychological distress has been shown to be significantly more frequent in those with arthritis than those without, although scores on MCS were not significantly different between these two groups. Second, the dissociation may be due to a disability paradox,<sup>28</sup> which suggests that people with chronic disabilities report serious limitations in Activities of Daily Living (ADL) and problems in performing social roles, yet state that they have excellent or good QOL. Low back pain and knee pain lead to functional impairment. This may be associated with lower PCS scores, but the individual may not feel that the impairment of social activity or ADL was due to mental factors. Particularly in elderly individuals, pain may be considered a natural consequence of being elderly and thus may not lead to lower MCS.

There are several limitations to the present study. First, this is a large-scale population-based study, but a cross-sectional study of baseline data, so a causal relationship could not be determined. The ROAD study is a longitudinal survey, so further progress will elucidate any causal relationships. Second, among the 1047 men 40 years or older in the ROAD

**TABLE 5. Mean (SD) Scores of the SF-8 and EQ-5D by KL Grade in Subjects with Knee Pain**

	KL 0,1	KL 2	KL 3	KL 4
<b>Prevalence, %</b>	<b>57.9</b>	<b>30.1</b>	<b>7.8</b>	<b>4.2</b>
<b>Medical Outcomes Study Short Form 8</b>				
GH	48.8 (5.2)	50.0 (4.8)	49.2 (6.5)	47.3 (6.9)
PF	49.4 (6.1)	48.9 (7.2)	47.0 (10.1)	43.6 (9.3)
RP	49.6 (7.5)	49.5 (6.9)	46.2 (12.0)	46.2 (6.7)
BP	47.5 (8.2)	50.1 (8.6)	43.8 (8.2)	44.8 (9.5)
VT	49.8 (5.7)	49.6 (7.1)	47.1 (7.4)	46.2 (6.3)
SF	53.5 (4.2)	51.2 (6.8)	51.9 (7.2)	52.3 (6.0)
MH	54.9 (5.1)	54.2 (5.0)	54.2 (6.6)	55.4 (5.5)
RE	52.7 (3.9)	51.3 (6.6)	50.9 (9.9)	51.6 (7.0)
PCS	45.4 (6.6)	46.7 (6.3)	42.2 (9.6)	40.3* (6.8)
MCS	54.8 (4.7)	52.9 (5.2)	54.4 (7.3)	55.8 (6.8)
<b>EQ-5D</b>	<b>0.90 (0.15)</b>	<b>0.88 (0.16)</b>	<b>0.81 (0.20)</b>	<b>0.80 (0.17)</b>

Values are mean (SD) unless otherwise indicated.

\*P < 0.05 versus KL 0,1 by the Tukey Honestly Significant Difference test after adjustment for age, body mass index, cerebral stroke, diabetes mellitus, cardiac disease, and hypertension.

BP indicates bodily pain; EQ-5D, EuroQol; GH, general health; KL, Kellgren-Lawrence; MCS, mental component summary; MH, mental health; PCS, physical component summary; PF, physical function; RE, role emotional; RP, role physical; SF, social function; SF-8, 8-Item Short Form Health Survey; VT, vitality.

study, 767 men had completed questionnaires for both the SF-8 and the EQ-5D, so the response rate was 73.7%. Subjects who completed questionnaires may have had better QOL than those who did not, so our results regarding QOL may have represented overestimations. Third, we did not include the onset of VFx in the analysis, although the severity of low back pain often appears to be associated with the interval from onset of VFx. In terms of clinical fractures, we examined the history of fracture, including VFx, in the ROAD study by self-report, and no clinical VFx occurred within the 1 month before baseline examination. However, we could not compare radiographs of the lumbar spine at baseline examination with those before the examination, as subjects had not undergone radiography of the lumbar spine before that examination. We were therefore unable to assess the incidence of subclinical fracture within the 1 month before baseline examination, although clinical and subclinical fractures are associated with lower QOL in women.<sup>29</sup> However, the association between severity of low back pain and the interval from onset of subclinical VFx may be weaker than that for clinical VFx, so the absence of data on the incidence of subclinical VFx may not strongly affect the present results.

In conclusion, the present study revealed that the impact of low back pain was larger than that of knee pain in almost all QOL domains. In men with low back pain, VFx had some association with physical QOL loss. In men with knee pain, KL 4 knee OA was strongly associated with QOL loss. Further progress will elucidate the backgrounds of low back pain and knee pain.

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### Key Points

- ❑ Low back pain and knee pain are major public health issues causing disability among the elderly men, but there were no population-based studies to compare the impact of low back pain on QOL with that of knee pain in Japanese men.
- ❑ The objective of the present study was to clarify the independent association of low back pain and knee pain with QOL among 767 men using cohorts from ROAD.
- ❑ The impact of low back pain on QOL was larger than that of knee pain. In men with low back pain, there were few associations between KL grade and QOL, whereas VFx was associated with physical QOL, indicating that low back pain with VFx is strongly associated with physical QOL loss.

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### References

1. Dawson J, Linsell L, Zondervan K, et al. Impact of persistent hip or knee pain on overall health status in elderly people: a longitudinal population study. *Arthritis Rheum* 2005;53:368-74.
2. Muraki S, Oka H, Akune T, et al. Prevalence of radiographic lumbar spondylosis and its association with low back pain in the elderly of population-based cohorts: the ROAD study. *Ann Rheum Dis* 2009;68:1401-6.

3. Muraki S, Oka H, Akune T, et al. Prevalence of radiographic knee osteoarthritis and its association with knee pain in the elderly of Japanese population-based cohorts: the ROAD study. *Osteoarthritis Cartilage* 2009;17:1137-43.
4. Ministry of Health, Labour, and Welfare in Japan. The Outline of the Results of National Livelihood Survey 2007. Available at <http://www.mhlw.go.jp/toukei/list/20-19-1.html>. Accessed April 4, 2010.
5. Horng YS, Hwang YH, Wu HC, et al. Predicting health-related quality of life in patients with low back pain. *Spine* 2005;30:551-5.
6. Kovacs FM, Abaira V, Zamora J, et al. Correlation between pain, disability, and quality of life in patients with common low back pain. *Spine* 2004;29:206-10.
7. Leidig-Bruckner G, Minne HW, Schlaich C, et al. Clinical grading of spinal osteoporosis: quality of life components and spinal deformity in women with chronic low back pain and women with vertebral osteoporosis. *J Bone Miner Res* 1997;12:663-75.
8. Silverman SL, Piziak VK, Chen P, et al. Relationship of health related quality of life to prevalent and new or worsening back pain in postmenopausal women with osteoporosis. *J Rheumatol* 2005;32:2405-9.
9. Hopman-Rock M, Kraaijaat FW, Bijlsma JW. Quality of life in elderly subjects with pain in the hip or knee. *Qual Life Res* 1997;6:67-76.
10. Ross PD. Clinical consequences of vertebral fractures. *Am J Med* 1997;103:30S-42S.
11. O'Neill TW, McCloskey EV, Kanis JA, et al. The distribution, determinants, and clinical correlates of vertebral osteoporosis: a population based survey. *J Rheumatol* 1999;26:842-8.
12. Symmons DP, van Hemert AM, Vandenbroucke JP, et al. A longitudinal study of back pain and radiological changes in the lumbar spines of middle aged women. II. Radiographic findings. *Ann Rheum Dis* 1991;50:162-6.
13. Bagge E, Bjelle A, Eden S, et al. Osteoarthritis in the elderly: clinical and radiographic findings in 79 and 85 year olds. *Ann Rheum Dis* 1991;50:535-9.
14. Dekker J, Boot B, van der Woude LHV, et al. Pain and disability in osteoarthritis: a review of biobehavioral mechanisms. *J Behav Med* 1992;15:189-214.
15. Yoshimura N, Muraki S, Oka H, et al. Prevalence of knee osteoarthritis, lumbar spondylosis, and osteoporosis in Japanese men and women: the Research on Osteoarthritis/osteoporosis Against Disability (ROAD). *J Bone Miner Metab* 2009;27:620-8.
16. Yoshimura N, Muraki S, Oka H, et al. Cohort profile: research on Osteoarthritis/Osteoporosis Against Disability study [published online ahead of print September 11, 2009]. *Int J Epidemiol* 2010;39(4):988-95.
17. Inoue T. Clinical features and findings: osteoporosis [in Japanese]. *Bone* 1990;4:39-47.
18. Kellgren JH, Lawrence JS, eds. *The Epidemiology of Chronic Rheumatism: Atlas of Standard Radiographs of Arthritis*. Oxford, United Kingdom: Blackwell Scientific; 1963.
19. Ware JE, Snow KK, Kosinski M, et al. *SF-36 Health Survey Manual and Interpretation Guide*. Boston, MA: The Health Institute, New England Medical Centre; 1993.
20. Fukuhara S, Suzukamo Y. *Manual of the SF-8 Japanese Version* [in Japanese]. Kyoto, Japan: Institute for Health Outcome and Process Evaluation Research; 2004.
21. Dolan P. Modeling valuations for EuroQol health states. *Med Care* 1997;35:1095-108.
22. Japanese EuroQol Translation Team. The development of the Japanese EuroQol instrument [in Japanese]. *J Health Care Soc* 1997;8:109-23.
23. Lips P, Cooper C, Agnusdei D, et al. Quality of life in patients with vertebral fractures. Validation of the Quality of Life Questionnaire of the European Foundation for Osteoporosis (QUALEFFO). *Osteoporos Int* 1999;10:150-60.
24. Silverman SL, Minshall ME, Shen W, et al. The relationship of health-related quality of life to prevalent and incident vertebral fractures in postmenopausal women with osteoporosis: results from the Multiple Outcomes of Raloxifene Evaluation Study. *Arthritis Rheum* 2001;44:2611-9.
25. Boden SD, Davis DO, Dina TS, et al. Abnormal magnetic-resonance scans of the lumbar spine in asymptomatic subjects. A prospective investigation. *J Bone Joint Surg Am* 1999;72:403-8.
26. Kessler RC, Andrews G, Colpe LJ, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychol Med* 2002;32:959-76.
27. Hill CL, Gill T, Taylor AW, et al. Psychological factors and quality of life in arthritis: a population-based study. *Clin Rheumatol* 2007;26:1049-54.
28. Albrecht G., Devlieger P. The disability paradox: high quality of life against all odds. *Soc Sci Med* 1999;48(8):977-88.
29. Adachi JD, Ioannidis G, Pickard L, et al. The association between osteoporotic fractures and health-related quality of life as measured by the Health Utilities Index in the Canadian Multicentre Osteoporosis Study (CaMos). *Osteoporos Int* 2003;14:895-904.

## Changes in serum levels of biochemical markers of bone turnover during 10 years among Japanese men and women: associated factors and birth-cohort effect. The Taiji Study

Noriko Yoshimura · Shigeyuki Muraki ·  
Hiroyuki Oka · Hiroshi Kawaguchi ·  
Kozo Nakamura · Toru Akune

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**Abstract** We aimed to clarify changes in biochemical markers of bone turnover (BTMs) over 10 years, associations with changes in bone mineral density (BMD), and birth-cohort effects in a Japanese community. We randomly selected 400 individuals (age, 40–79 years; 50 of each gender and age stratum) from a list of registered residents in 1993. We measured BMD of the spine and hip, and serum concentrations of total osteocalcin (OC), beta-C-terminal cross-linking telopeptide of type I collagen (beta-CTX), and N-terminal cross-linking telopeptide of type I collagen (NTX), in 1993 and 2003. Of the 400 subjects, 322 (153 men, 169 women) completed the 10-year follow-up. Mean change rates (standard deviation) for serum total OC, beta-CTX, and NTX over 10 years were  $-1.00$  ( $3.74$ )/year,  $5.10$  ( $22.48$ )/year, and  $0.40$  ( $3.41$ )/year, respectively, in men, and  $0.02$  ( $5.32$ )/year,  $5.53$  ( $14.54$ )/year, and  $0.62$  ( $3.26$ )/year, respectively, in women. Change rates of BTMs were higher for women in their forties than for women in their fifties to seventies

( $P < 0.05$ ), and higher in the menstrual transition group than in pre- and postmenopausal groups ( $P < 0.001$ ). Changes in levels of BTMs over 10 years in women were significantly associated with change rates of BMDs at L2–L4 and total hip after adjusting for potential confounders. A significant birth-cohort effect was observed among women in their fifties. We concluded that change rates of BTMs during the 10 years were influenced by menstrual transition, age, and sex and associated with bone loss at L2–L4 and total hip.

**Keywords** Biochemical markers of bone turnover · Bone loss · Menstrual transition · Birth-cohort effect

### Introduction

In Japan, about 10 million patients are estimated to have osteoporosis (OP) [1], and osteoporotic fractures are ranked fifth among the diseases responsible for causing disabilities requiring support [2]. Moreover, the number of cases of hip fracture has increased steeply in the past 20 years with the rapid aging of the population [3]. Early detection of OP to reduce the risk of osteoporotic fractures is therefore an urgent issue in terms of maintenance of quality of life in the elderly and containment of medical costs required for their care.

Biochemical markers of bone turnover (BTMs) are widely used in clinical situations to evaluate the efficacy of treatments for OP [4–6]. Several epidemiological studies have shown that BTMs can predict bone loss in women [7–10], but few reports appear to have examined trends in BTMs during more than one decade. In addition, few reports have clarified associations between changes in levels of BTMs and bone loss, particularly in men [11, 12].

N. Yoshimura (✉) · H. Oka  
Department of Joint Disease Research, 22nd Century Medical  
and Research Center, Graduate School of Medicine,  
The University of Tokyo, 7-3-1 Hongo, Bunkyo-ku,  
Tokyo 113-8655, Japan  
e-mail: yoshimuran-ort@h.u-tokyo.ac.jp

S. Muraki · T. Akune  
Department of Clinical Motor System Medicine,  
22nd Century Medical and Research Center,  
Graduate School of Medicine, The University of Tokyo,  
Tokyo, Japan

H. Kawaguchi · K. Nakamura  
Department of Orthopaedic Surgery, Faculty of Medicine,  
The University of Tokyo, Tokyo, Japan

Moreover, observation over the course of a decade enables comparison of values at the same age strata among different birth cohorts. We have already identified a birth-cohort effect in values of bone mineral density (BMD) using data from 1990 and 2000 in another cohort established in Wakayama Prefecture, a mountainous area in Japan [13]. In that study, values of bone mineral density (BMD) for women in their fifties and for men in their sixties were significantly higher for the younger than for the older birth cohort [13].

We established a cohort comprising men and women in a rural area in Japan and followed this cohort for 10 years. The present study was performed for the purpose of clarifying three issues: (1) changes in BTMs over 10 years in men and women as classified by age and menstrual transition; (2) associations between increases in BTMs and bone loss over 10 years in both men and women; and (3) effects of birth cohort on BTMs among general inhabitants, namely, whether differences in BTMs exist between birth cohorts for a given age stratum in both men and women.

## Materials and methods

### Cohort profile and eligible participants

The survey was performed in the Japanese town of Taiji. The Taiji cohort has been profiled in detail elsewhere [14–16] and so is only described briefly here. Taiji is located in the southern coastal area of Wakayama Prefecture, Japan. A list of all inhabitants born between 1913 and 1952, and therefore between 40 and 79 years old in 1993, was compiled on the basis of resident registrations as of the end of 1992. A cohort of 2,261 inhabitants (1,028 men, 1,233 women) was identified, and all members of the cohort completed a self-administered, 125-item questionnaire addressing lifestyle factors such as dietary habits, smoking habits, alcohol consumption, and physical exercise (whole cohort).

From this total cohort, 50 men and 50 women from each of four age groups (total, 400 participants) between 40 and 79 years by decade of birth year (1913–1922, 1923–1932, 1933–1942, and 1943–1952) were selected randomly and underwent BMD measurement in 1993. At this time, blood samples were taken from all participants (BMD cohort, baseline study). Background data including physical characteristics and mean BMD values for all 400 participants at baseline are shown in Table 1.

Among the 400 participants, 21 individuals (4 men, 17 women) had been diagnosed with osteoporosis in the past, but none had been treated using bisphosphonates, raloxifene, or calcitonin. Among the female participants,

of 100 female participants in their forties and fifties at baseline, 41 women (41.0%) were premenopausal with regular periods, 14 (14.0%) were premenopausal with irregular periods, and the remaining 45 (45.0%) were postmenopausal.

Among the 400 participants at baseline, 322 (80.5%; 153 men, 169 women) participated in the examination held after 10 years. Loss of 78 participants at the 10-year follow-up was explained as follows: 52 participants had died (33 men, 19 women); 14 participants had moved (6 men, 8 women); 6 participants were ill (4 men, 2 women); 3 participants refused to participate (2 men, 1 woman); and 3 participants were away from the area at the time of follow-up (2 men, 1 woman).

During the 10 years, 37 new fragile fractures (10 men, 27 women), including 5 spinal fractures (1 man, 4 women), were reported in the interviewer-administered questionnaire surveys.

All examinations were performed with the full consent of participants. These study protocols were approved by the ethics committees of both Wakayama Medical University and the University of Tokyo.

### BMD measurements

Baseline BMD was measured in 1993 using dual-energy X-ray absorptiometry (DXA) (QDR 1000; Hologic, Bedford, MA, USA). At baseline, all 400 participants (200 men, 200 women) underwent measurement of BMD from anteroposterior images of lumbar vertebrae L2–L4 and the proximal femur (femoral neck, Ward's triangle, trochanter, and total hip). These measurements were repeated on the same participants after 10 years.

To control the precision of DXA, the equipment was checked at every examination in 1993 and 2003 using the same phantom, and values for BMD of the phantom under DXA were regulated to  $1.030 \pm 0.016 \text{ g/cm}^2$  (1.5%) during all examinations. All BMD measurements were performed by the same medical doctor (N.Y.). To clarify the coefficient of variation (CV) for BMD measurements from DXA scans by the investigator, the same phantom was measured seven times in 1 day, then once a day at the same time every day for 5 days, and once a week at the same time and same day of the week for 4 weeks. CVs of intraday, interday, and interweek variability for this investigator were 0.13%, 0.39%, and 0.42%, respectively [17].

### Measurements of BTMs

Blood examinations both at baseline and at the 10-year follow-up were performed in June. All blood samples were



**Table 1** Summary characteristics for participants at baseline classified by age and gender

Birth cohort	Age group (years)	<i>n</i>	Age (years)	Height (cm)	Weight (kg)	BMI (kg/m <sup>2</sup> )	L2–L4 BMD (g/cm <sup>2</sup> )	Femoral neck BMD (g/cm <sup>2</sup> )	Total hip BMD (g/cm <sup>2</sup> )
<b>Men</b>									
1943–52	40–49	50	44.2 (2.6)	168.8 (5.2)	69.0 (10.4)	24.2 (3.2)	1.05 (0.15)	0.86 (0.09)	1.00 (0.12)
1933–42	50–59	50	54.8 (2.7)	165.6 (5.0) <sup>a</sup>	63.5 (9.4) <sup>a</sup>	23.1 (2.9)	0.98 (0.17)	0.80 (0.13) <sup>a</sup>	0.94 (0.14)
1923–32	60–69	50	64.6 (2.5)	163.0 (4.8) <sup>a</sup>	62.9 (9.6) <sup>a</sup>	23.6 (3.2)	1.04 (0.21)	0.77 (0.11) <sup>a</sup>	0.92 (0.12) <sup>a</sup>
1913–22	70–79	50	74.0 (2.7)	160.7 (5.4) <sup>a,b</sup>	57.5 (8.3) <sup>a,b,c</sup>	22.2 (2.8)	0.97 (0.19)	0.71 (0.08) <sup>a,b,c</sup>	0.83 (0.09) <sup>a,b,c</sup>
1913–52	40–79	200	59.4 (11.4)	164.5 (5.9)	63.2 (10.2)	23.3 (3.1)	1.01 (0.18)	0.79 (0.12)	0.92 (0.13)
<b>Women</b>									
1943–52	40–49	50	44.0 (2.8)	154.4 (5.0)	54.1 (8.3)	22.7 (3.1)	1.07 (0.14)	0.79 (0.10)	0.90 (0.11)
1933–42	50–59	50	55.8 (2.8)	154.9 (5.3)	59.4 (10.0) <sup>a</sup>	24.8 (4.0) <sup>a</sup>	0.92 (0.16) <sup>a</sup>	0.70 (0.11) <sup>a</sup>	0.81 (0.12) <sup>a</sup>
1923–32	60–69	50	64.8 (2.6)	151.1 (4.6) <sup>a,b</sup>	52.1 (9.1) <sup>b</sup>	22.8 (3.5) <sup>b</sup>	0.78 (0.17) <sup>a,b</sup>	0.62 (0.09) <sup>a,b</sup>	0.71 (0.10) <sup>a,b</sup>
1913–22	70–79	50	74.4 (2.8)	147.7 (5.4) <sup>a,b,c</sup>	48.4 (8.2) <sup>a,b</sup>	22.2 (3.4) <sup>b</sup>	0.77 (0.12) <sup>a,b</sup>	0.59 (0.10) <sup>a,b</sup>	0.66 (0.12) <sup>a,b</sup>
1913–52	40–79	200	59.7 (11.6)	152.0 (5.8)	53.5 (9.7)	23.1 (3.6)	0.89 (0.19)	0.68 (0.13)	0.77 (0.14)

Values are given as mean with standard deviation in parentheses

*BMI* body mass index, *BMD* bone mineral density, *n* number of participants

<sup>a</sup> Significantly different ( $P < 0.05$ ) from values of participants in their forties

<sup>b</sup> Significantly different ( $P < 0.05$ ) from values of participants in their fifties

<sup>c</sup> Significantly different ( $P < 0.05$ ) from values of participants in their sixties

obtained between 0900 and 1500 in both surveys. Subjects who provided consent to participate in the blood examination were randomly allocated a specific time to undergo sampling, with times set at 15-min intervals between 0900 and 1500. Participant samplings could not be adjusted according to time after eating.

After centrifugation of blood samples, serum samples were immediately placed in dry ice and transferred to a deep freezer within 24 h. These samples were kept at  $-80^{\circ}\text{C}$  until assay. BTMs collected in 1993 were measured after 7 years, when the methods for measurement of novel BTMs were introduced. Samples collected in 2003 were used for measurement within 1 year. Samples in 1993 and 2003 were measured using the same assay.

From the serum samples of participants in the baseline study, total osteocalcin (OC) was measured as a marker of bone formation. OC level was measured using an electrochemiluminescent immunoassay (ECLIA) (Elecys N-MID Osteocalcin; Roche Diagnostics, Mannheim, Germany) [18]. Intraassay CV was 0.5% and sensitivity was 0.5 ng/ml. To monitor bone resorption, a beta-isomerized C-terminal cross-linking telopeptide of type I collagen (beta-CTX) and an N-terminal cross-linking telopeptide of type I collagen (NTX) were used. Serum beta-CTX was measured using an ECLIA (Elecys beta-CrossLaps; Roche Diagnostics). Intraassay CV was 2.0% and sensitivity was 0.01 ng/ml [18]. Serum NTX was

measured using an enzyme-linked immunosorbent assay (Osteomark NTX serum; Ostex International, Seattle, WA, USA) [19, 20]. Intraassay CV was 4.6% and sensitivity was 3.2 nM bone collagen equivalents (BCE/l).

#### Statistical analysis

All statistical analyses were performed using STATA statistical software (College Station, TX, USA). Differences in values of BMDs, BTMs, and change rates of BMDs and BTMs were tested for significance using analysis of variance (ANOVA) for comparisons among multiple groups and Scheffe's least significant difference test for pairs of groups. Correlation coefficients were estimated to identify associations between changes in levels of BTMs and BMD over 10 years. After controlling for the potential confounders listed in the Results section, multivariate regression analysis was performed using rates of change for BMDs at each site such as L2–L4, femoral neck, and total hip as an objective factor, and rates of change for each BTM such as total OC, beta-CTX, and NTX as explanatory factors and standardized partial regression coefficients were estimated. To address cohort effects on the values of BTMs, BTM levels of subjects in their fifties, sixties, and seventies in 1993 were compared to those of subjects in their fifties, sixties, and seventies in 2003 using a nonpaired *t* test.

**Table 2** Annual change rate (%/year) in bone mineral density (BMD) over 10 years, classified by age and gender

Birth cohort	Age group (years)	<i>n</i>	L2–L4 BMD	Femoral neck BMD	Total hip BMD
<b>Men</b>					
1943–1952	40–49	43	–0.02 (0.59)	–0.15 (1.09)	–0.11 (0.71)
1933–1942	50–59	46	0.16 (0.8)	–0.30 (0.70)*	–0.30 (0.50)*
1923–1932	60–69	41	0.23 (0.94)	0.03 (1.25)	–0.36 (0.81)*
1913–1922	70–79	23	–0.15 (0.90)	0.66 (1.62) <sup>b</sup>	–0.24 (1.30)
1913–1952	40–79	153	0.08 (0.81)	–0.03 (1.17)	–0.26 (0.80)*
<b>Women</b>					
1943–1952	40–49	47	–1.14 (1.01)*	–0.86 (0.96)*	–0.68 (0.84)*
1933–1942	50–59	47	–0.79 (1.18)*	–0.64 (0.94)*	–0.70 (0.84)*
1923–1932	60–69	44	–0.32 (0.78)* <sup>a</sup>	–0.57 (0.89)*	–0.73 (0.80)*
1913–1922	70–79	31	–0.60 (0.92)*	–0.61 (1.08)*	–0.90 (0.68)*
1913–1952	40–79	169	–0.73 (1.03)*	–0.68 (0.96)*	–0.74 (0.80)*

Values are given as mean with standard deviation in parentheses

BMD bone mineral density; *n* number of subjects

\* Significantly different ( $P < 0.01$ ) for changes over 10 years

<sup>a</sup> Significantly different ( $P < 0.05$ ) from values of subjects in their forties

<sup>b</sup> Significantly different ( $P < 0.05$ ) from values of subjects in their fifties

## Results

### Eligible participants and changes in BMD over 10 years

Over the 10 years, 322 of the 400 participants at baseline (80.4%; 153 men, 169 women) completed baseline and follow-up measurements. Among these, one man in his sixties declined to undergo baseline blood examination for BTMs. Evaluations of changes in BTMs were thus performed using the remaining 321 subjects (80.3%; 152 men, 169 women).

Rates of change for BMD during the 10-year period, classified by age and gender, are shown in Table 2. For men, BMD at L2–L4 in their fifties and sixties had increased slightly by the 10-year follow-up but had decreased slightly in their forties and seventies. BMD at the femoral neck had decreased in their forties and fifties and had increased in their seventies. BMD at the total hip had decreased in all age strata. These changes were significant at the femoral neck for men in their fifties ( $P < 0.01$ ) and at the total hip for men in their fifties and sixties ( $P < 0.01$ ). No significant differences were apparent between age strata except at the femoral neck between men in their fifties and those in their seventies ( $P < 0.05$ ).

For women, BMD at the lumbar spine L2–L4, femoral neck, and total hip had decreased in all age strata over the 10 years, similar to findings in men at the total hip. These changes were significant ( $P < 0.01$ ). However, no

significant differences in rates of change were seen across age strata, with the exception of women in their forties and sixties at L2–L4.

### Mean levels at baseline and comparative changes over 10 years in BTMs

Age–gender distributions of mean BTM levels at the initial survey are shown in Table 3. No significant difference was seen among the age groups for BTM levels in men, whereas significant differences were seen for each marker between women in their forties and women in their fifties to seventies ( $P < 0.05$  each). Table 3 also shows the changes in serum total OC, beta-CTX, and NTX over 10 years in men and women. In men, in general, levels of serum total OC significantly decreased ( $P < 0.05$ ) and those of beta-CTX significantly increased ( $P < 0.05$ ), but no significant difference was identified in the rate of change for BTMs among any age strata. Serum levels of total OC, beta-CTX, and NTX for women in their forties were significantly lower than those of women in their fifties to seventies ( $P < 0.05$ ) and change rates over 10 years for women in their forties were significantly higher ( $P < 0.05$ ).

Rates of change of BTMs and BMDs over 10 years were compared by menstrual status over 10 years (Table 4). Among 94 female subjects in their forties and fifties, 52 women (55.3%) were premenopausal at baseline. During

**Table 3** Mean values at baseline and annual change rate (%/year) of biochemical markers of bone turnover (BTMs) over 10 years, classified by age and gender

Birth cohort	Age group (years)	Total OC (ng/ml)		Beta-CTX (ng/ml)		NTX (nmol BCE/l)	
		Baseline	Change rate (%/year)	Baseline	Change rate (%/year)	Baseline	Change rate (%/year)
<b>Men</b>							
1943–1952	40–49	18.8 (7.5)	−1.54 (4.80)*	0.190 (0.107)	1.66 (8.00)	13.3 (2.8)	−0.04 (3.44)
1933–1942	50–59	19.7 (18.3)	−1.21 (2.41)*	0.197 (0.162)	4.48 (17.33)	14.0 (6.0)	−0.04 (3.19)
1923–1932	60–69	16.4 (6.1)	−0.20 (3.93)	0.174 (0.107)	4.82 (10.72)*	13.6 (4.1)	0.53 (3.32)
1913–1922	70–79	18.9 (8.1)	−0.95 (3.45)	0.187 (0.099)	13.35 (49.33)	13.5 (3.4)	1.88 (3.76)*
1913–1952	40–79	18.5 (11.1)	−1.00 (3.74)*	0.187 (0.121)	5.10 (22.48)*	13.6 (4.2)	0.40 (3.41)
<b>Women</b>							
1943–1952	40–49	14.9 (5.7)	4.24 (6.94)*	0.103 (0.066)	16.84 (20.55)*	11.6 (2.3)	2.63 (3.29)*
1933–1942	50–59	28.1 (8.8) <sup>a</sup>	−1.08 (3.83) <sup>a</sup>	0.255 (0.121) <sup>a</sup>	1.35 (8.77) <sup>a</sup>	15.4 (3.3) <sup>a</sup>	−0.23 (3.59) <sup>a</sup>
1923–1032	60–69	32.6 (12.4) <sup>a</sup>	−2.06 (2.99)*, <sup>a</sup>	0.301 (0.136) <sup>a</sup>	1.28 (8.71) <sup>a</sup>	17.8 (4.4) <sup>a,b</sup>	−0.25 (2.23) <sup>a</sup>
1913–1022	70–79	28.3 (10.3) <sup>a</sup>	−1.73 (3.21)*, <sup>a</sup>	0.275 (0.153) <sup>a</sup>	1.13 (6.77) <sup>a</sup>	16.0 (3.2) <sup>a</sup>	0.11 (2.66) <sup>a</sup>
1913–1052	40–79	26.0 (11.6)	0.02 (5.32)	0.234 (0.145)	5.53 (14.54)*	15.2 (4.0)	0.62 (3.26)*

Values are given as mean with standard deviation in parentheses

BTMs, biochemical markers of bone turnover; OC, osteocalcin; beta-CTX, beta-isomerized C-terminal cross-linking telopeptide of type I collagen; NTX, N-terminal cross-linking telopeptide of type I collagen; BCE, bone collagen equivalents

\* Significantly different ( $P < 0.05$ ) for changes over 10 years

<sup>a</sup> Significantly different ( $P < 0.05$ ) from values of subjects in their forties

<sup>b</sup> Significantly different ( $P < 0.05$ ) from values of subjects in their fifties

**Table 4** Mean values at baseline and annual change rate of BTMs over 10 years, classified by menstrual status in women

Menstrual status over 10 years	<i>n</i>	Age (years)	Total OC (ng/ml)		Beta-CTX (ng/ml)		NTX (nmol BCE/l)	
			Baseline	Change rate (%/year)	Baseline	Change rate (%/year)	Baseline	Change rate (%/year)
Premenopause	12	41.3 (1.3)	13.7 (5.3)	0.96 (7.53)	0.101 (0.059)	9.63 (24.49)	11.8 (2.5)	0.83 (3.13)
Transition to menopause	40	46.3 (3.6)	16.7 (7.3) <sup>b</sup>	4.40 (6.49)*, <sup>b</sup>	0.120 (0.090) <sup>b</sup>	15.16 (18.21)*, <sup>b</sup>	11.7 (2.3) <sup>b</sup>	2.76 (3.30)*, <sup>b</sup>
Postmenopause	117	63.9 (7.9)	29.5 (9.6) <sup>a</sup>	−1.57 (3.50)*	0.281 (0.136) <sup>a</sup>	1.86 (9.69)*	16.6 (3.7) <sup>a</sup>	−0.13 (2.94)
Total	169	58.1 (11.1)	25.4 (10.9)	0.02 (5.32)	0.231 (0.144)	5.53 (14.54)*	15.1 (4.1)	0.62 (3.26)*

Values are given as mean with standard deviation in parentheses

BMD, bone mineral density; BTMs, biochemical markers of bone turnover; *n*, number of subjects; OC, osteocalcin; beta-CTX, beta-isomerized C-terminal cross-linking telopeptide of type I collagen; NTX, N-terminal cross-linking telopeptide of type I collagen; BCE, bone collagen equivalents

\* Significantly different ( $P < 0.05$ ) for changes over 10 years

<sup>a</sup> Significantly different ( $P < 0.001$ ) from values of participants in the premenopausal group

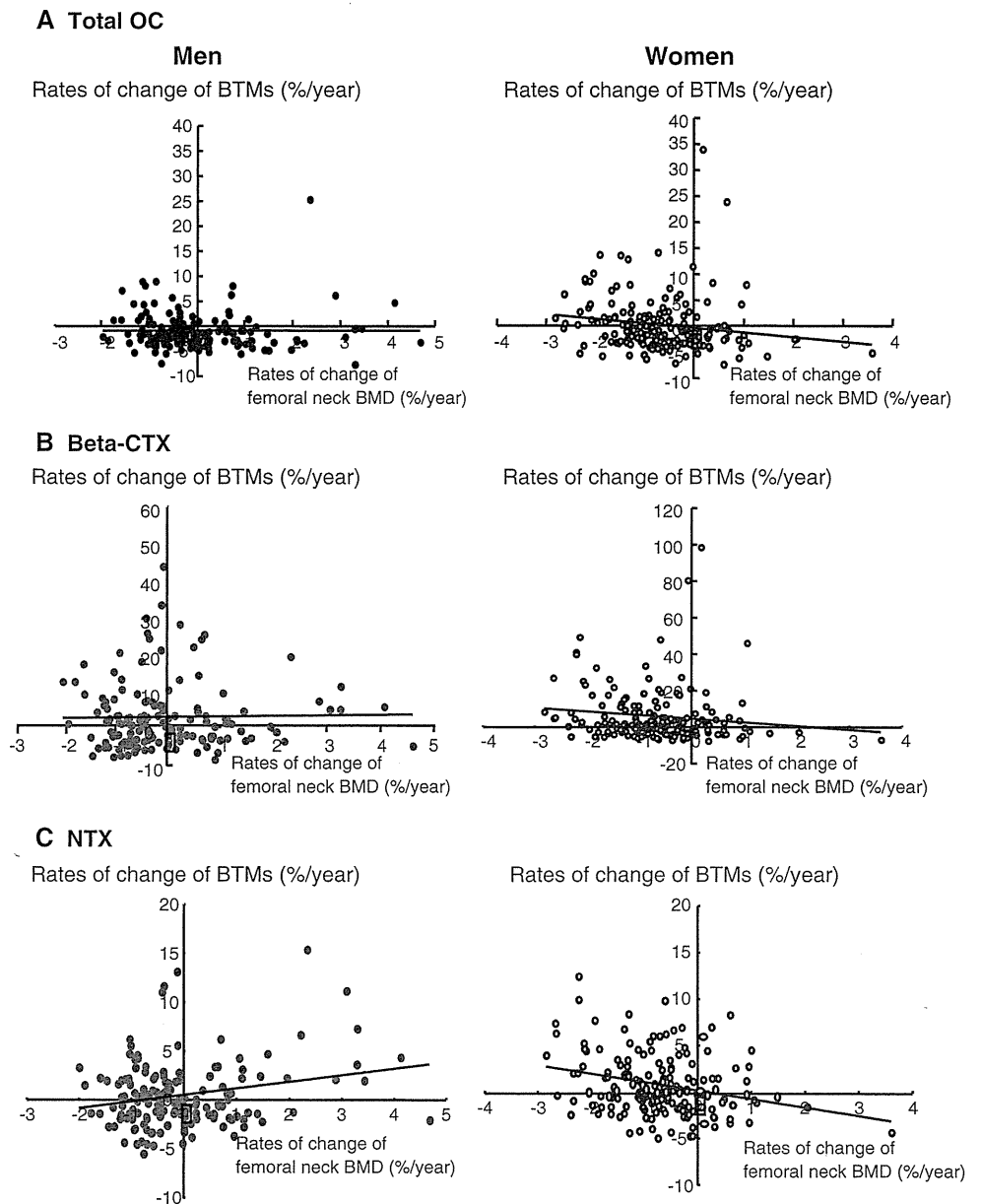
<sup>b</sup> Significantly different ( $P < 0.001$ ) from values of participants in the postmenopausal group

the 10-year observation, 12 (12.8%) remained premenopausal, but 40 (42.6%) progressed into menopause. Table 4 shows that rates of change for all BTMs over the 10 years were significantly increased in the group with transition into menopause ( $P < 0.05$ ). Change rates were significantly higher in women with transition into menopause compared to postmenopausal women ( $P < 0.001$ ).

Association between changes in BTMs and changes in BMD over 10 years

Associations between changes in BTMs and changes in BMD were analyzed. Correlation coefficients of changes to L2–L4 BMD and changes to OC, beta-CTX, and NTX were  $-0.12$  ( $P = 0.16$ ),  $0.04$  ( $P = 0.66$ ), and  $-0.08$  ( $P = 0.35$ ),

**Fig. 1** Association between rates of change of biochemical markers of bone turnover and rates of change of bone mineral densities at the femoral neck. *OC*, total osteocalcin (a); *BTM*, biochemical markers of bone turnover; *beta-CTX*, beta-isomerized C-terminal cross-linking telopeptide of type I collagen (b); *NTX*, N-terminal cross-linking telopeptide of type I collagen (c)



respectively, in men, and  $-0.20$  ( $P = 0.01$ ),  $-0.16$  ( $P = 0.04$ ), and  $-0.29$  ( $P = 0.0002$ ), respectively, in women. Correlation coefficients of changes to femoral neck BMD and changes to OC, beta-CTX, and NTX were  $-0.003$  ( $P = 0.98$ ),  $0.19$  ( $P = 0.02$ ), and  $0.23$  ( $P = 0.004$ ), respectively, in men, and  $-0.15$  ( $P = 0.04$ ),  $-0.13$  ( $P = 0.09$ ), and  $-0.27$  ( $P = 0.0005$ ), respectively, in women. Correlation coefficients of changes to total hip BMD and changes to OC, beta-CTX, and NTX were  $-0.16$  ( $P = 0.05$ ),  $-0.07$  ( $P = 0.39$ ), and  $-0.02$  ( $P = 0.86$ ), respectively, in men and  $-0.19$  ( $P = 0.01$ ),  $-0.12$  ( $P = 0.12$ ), and  $-0.28$  ( $P = 0.0002$ ), respectively, in women. These findings indicate that increased BMD at the femoral neck in men correlated significantly with increased serum levels of beta-CTX

and NTX. By contrast, decreased BMD at all sites (that is, L2–L4, femoral neck, and total hip) in women was significantly related to increased serum levels of BTMs. Figure 1 shows scatter plots for changes in total OC, beta-CTX, and NTX and changes to BMD at the femoral neck in both men and women. At the femoral neck, the direction of association between changes of bone resorption markers and BMDs differed between men and women, although the direction of association of changes to BTMs and BMD in both men and women were similar at L2–L4 and total hip.

To clarify associations between changes in BTM and BMD after adjusting for confounders, multivariate regression analysis was performed. Regarding the change of values of BMD at L2–L4, multivariate regression analysis