Osteoporosis, a metabolic skeletal disease characterised by decreased bone mass and increased fracture risk, is a growing public health problem. Among the various risk factors for osteoporosis, calcium and vitamin D have well-established protective roles, but it is likely that other nutritional factors are also implicated. This review will explore the emerging evidence supporting a role for certain B-vitamins, homocysteine and the 677C→T polymorphism in the gene encoding the folate-metabolising enzyme methylenetetrahydrofolate reductase, in bone health and disease. The evidence, however, is not entirely consistent and as yet no clear mechanism has been defined to explain the potential link between B-vitamins and bone health. Coeliac disease, a common condition of malabsorption, induced by gluten ingestion in genetically susceptible individuals, is associated with an increased risk both of osteoporosis and inadequate B-vitamin status. Given the growing body of evidence linking low bone mineral density and/or increased fracture risk with low B-vitamin status and elevated homocysteine, optimal B-vitamin status may play an important protective role against osteoporosis in coeliac disease; to date, no trial has addressed this possible link.

B-vitamins and bone in health and disease: the current evidence

M. Clarke¹, M. Ward¹, J. J. Strain¹, L. Hoey¹, W. Dickey² and H. McNulty¹*

¹Northern Ireland Centre for Food and Health, University of Ulster, Coleraine BT52 1SA, UK
²Department of Gastroenterology, Altnagelvin Hospital, Londonderry BT47 6SB, UK

Osteoporosis, a metabolic skeletal disease characterised by decreased bone mass and increased fracture risk, is a growing public health problem. Among the various risk factors for osteoporosis, calcium and vitamin D have well-established protective roles, but it is likely that other nutritional factors are also implicated. This review will explore the emerging evidence supporting a role for certain B-vitamins, homocysteine and the 677C→T polymorphism in the gene encoding the folate-metabolising enzyme methylenetetrahydrofolate reductase, in bone health and disease. The evidence, however, is not entirely consistent and as yet no clear mechanism has been defined to explain the potential link between B-vitamins and bone health. Coeliac disease, a common condition of malabsorption, induced by gluten ingestion in genetically susceptible individuals, is associated with an increased risk both of osteoporosis and inadequate B-vitamin status. Given the growing body of evidence linking low bone mineral density and/or increased fracture risk with low B-vitamin status and elevated homocysteine, optimal B-vitamin status may play an important protective role against osteoporosis in coeliac disease; to date, no trial has addressed this possible link.

B-vitamins: homocysteine: MTHFR 677C→T polymorphism: bone: coeliac disease

Osteoporosis, a metabolic skeletal disease characterised by reduced bone mass and deterioration of bone micro-architecture, predisposes affected individuals to an increased risk of fragility fracture(1). It is a major public health problem, recently estimated to cost £5.5 billion in the UK alone(2), with one in two women and one in five men over the age of 50 years expected to experience an osteoporotic fracture(3). Bone is a dynamic tissue in a constant state of remodelling. Bone formation generally outweighs bone resorption in the first three decades of life, and peak bone mass (i.e. the maximum bone mass achieved in adulthood) is accrued during this period. After this time, bone resorption is favoured and bone loss ensues, which in turn predisposes older individuals to weaker bones and increased risk of fracture(4). The most common osteoporotic fracture sites are at the spine, hip and wrist, with both spine and hip fractures accompanied by considerable disability and increased morbidity and mortality(5).

The measurement of bone mineral density (BMD) through dual-energy X-ray absorptiometry scanning is currently the basis of diagnosing osteoporosis. The WHO defines osteoporosis as a BMD of less than or equal to 2.5 SD below the reference mean of a young adult with peak bone mass (i.e. a T-score of ≤−2.5 SD), and osteopenia (the precursor stage to osteoporosis) as a BMD of less than 1 SD but greater than 2.5 SD below the reference mean (i.e. a T-score between −1 and −2.5 SD)(6). A BMD greater than or equal to 1 SD below the reference mean (i.e. a T-score of ≥−1 SD) according to the WHO criteria(6). Each SD fall in BMD (i.e. per unit T-score) below the reference mean corresponds to an estimated 2-fold increase in fracture risk(7,8). While low BMD is an important predictor of osteoporosis, fracture incidence is the most important clinical end point for osteoporosis. In recent years, the FRAX® tool, an algorithm used to assess the fracture probability by integrating weighted clinical risk factors.

Abbreviations: BMD, bone mineral density; CD, coeliac disease; MTHFR, methylenetetrahydrofolate reductase; RCT, randomised controlled trials.

*Corresponding author: Professor H. McNulty, fax +44 28 70124965, email h.mcnulty@ulster.ac.uk
factors of disease (with or without BMD), was developed by the WHO and has been used to assess osteoporotic fracture risk\(^9\).

The aetiology of osteoporosis is multi-factorial, with genetic heritability estimated to account for approximately 30% of osteoporotic fracture risk\(^10\). Non-modifiable factors including age, parental history of hip fracture and genetically determined traits, such as Caucasian ethnicity and female sex, increase risk\(^2\). Similarly, various modifiable factors such as low body weight, physical inactivity, smoking, excessive alcohol intake and the long-term use of certain medications (e.g. glucocorticoids and some anti-convulsant drugs) increase the risk of osteoporosis. Considering the general trend towards ageing populations, and the corresponding increases in osteoporosis-related costs\(^2\), investigation of modifiable risk factors, along with the development of intervention strategies to reduce the incidence of disease, is vital. In terms of nutritional intervention, combined calcium and vitamin D supplementation are proven to reduce bone loss and fracture incidence\(^11\). However, it is also possible that the nutritional factors not typically linked to bone health could play protective roles. Emerging evidence in generally healthy cohorts worldwide suggests a protective effect of certain B-vitamins, and a detrimental effect of homocysteine and the $677C\rightarrow T$ polymorphism in the gene encoding the folate-metabolising enzyme methylenetetrahydrofolate reductase (MTHFR), on bone health and fracture risk\(^12,13\).

**Role of B-vitamins in homocysteine metabolism**

The major determinant of plasma homocysteine concentration is the biomarker status of the metabolically related B-vitamins, primarily folate, and to lesser extent vitamins B\(_{12}\) and B\(_{6}\) (Fig. 1). Homocysteine is formed by the demethylation of dietary methionine. Homocysteine may then be metabolised to form cystathionine as the part of the trans-sulphuration pathway, requiring a vitamin B\(_{6}\) co-factor, or regenerate methionine, and in turn $S$-adenosyl methionine (a universal methyl donor). The latter reaction is catalysed by methionine synthase and requires 5-methyltetrahydrofolate, the principal circulating form of folate and vitamin B\(_{12}\) in its co-factor form, methylcobalamin. The formation of 5-methyltetrahydrofolate is catalysed by the enzyme MTHFR, which has the riboflavin-derived FAD as a prosthetic group. Supplementation with folic acid can lower homocysteine concentrations by an estimated 25%, with vitamins B\(_{12}\) and B\(_{6}\) having additional homocysteine lowering effects (i.e. by a further 7% each) in

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**Fig. 1.** (Colour online) The metabolism of homocysteine. MTHFR, methylenetetrahydrofolate reductase; DMG, dimethylglycine.
The 677C→T polymorphism in MTHFR is widely reported as the most common genetic determinant of mildly elevated plasma homocysteine concentrations in healthy populations. Individuals with the homozygous mutant TT genotype experience a decrease in MTHFR enzyme activity, believed to be through the loss of FAD, leading to hyperhomocysteinemia (>15 μmol/l) and low erythrocyte folate concentrations. Riboflavin supplementation has however been shown to significantly lower homocysteine concentrations specifically in individuals with the MTHFR 677TT genotype. The frequency of the MTHFR 677TT genotype varies greatly worldwide, ranging from 4 to 18% in the US populations, 10% in many European populations and up to 32% in Mexico.

Hyperhomocysteinemia mainly reflects low or deficient status of the relevant B-vitamins, or the MTHFR genotype, but it can also reflect a decline in renal function with age.

### B-vitamins, homocysteine and bone health

**Historical evidence**

Homocystinuria, a rare autosomal recessive disease, is a condition in which the metabolism of homocysteine is severely impaired leading to excessive accumulation of homocysteine in the blood (>100 μmol/l) and urine. The most common cause of homocystinuria is cystathionine-β-synthase deficiency. Among the major clinical features of the disease (including mental retardation and severe occlusive vascular disease) premature osteoporosis is well described, and homocystinuric patients are reported to have a 50% increased risk of developing osteoporosis by the age of 16.

Early studies in patients with pernicious anaemia provided the first evidence to support a specific role for vitamin B12 deficiency in osteoporosis. One small study in post-menopausal women with pernicious anaemia (n = 21) reported lower BMD in patients compared with controls. Further evidence from a slightly larger cohort of post-menopausal women (n = 131) demonstrated an almost 3-fold increase in the risk of osteoporotic fracture among pernicious anaemia patients compared with the general community.

**Evidence from observational studies**

In the past decade, numerous large observational studies have provided evidence to support a role for homocysteine and/or low B-vitamin status in fracture risk (Table 1). In 2004, two landmark studies performed in the Netherlands and the USA produced consistent findings in terms of the magnitude of increased risk of fracture associated with mild elevations in homocysteine. In subsequent years, further studies from...
Table 2. Observational evidence to support a role for homocysteine (Hcy) and B-vitamin status in low bone mineral density (BMD) and bone loss

<table>
<thead>
<tr>
<th>Author, Country</th>
<th>Sample size, age, gender</th>
<th>Design</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim et al. [38], Korea</td>
<td>n 460, ≥30 years, male/female</td>
<td>Longitudinal study</td>
<td>Significantly greater bone loss in highest Hcy quartile compared with lowest in pre-menopausal women and men</td>
</tr>
<tr>
<td>Zhu et al. [39], Australia</td>
<td>n 1213, 70–85 years, female</td>
<td>Longitudinal study</td>
<td>Significantly greater bone loss in highest Hcy tertile compared with the middle and lowest</td>
</tr>
<tr>
<td>Gjesdal et al. [40], Norway</td>
<td>n 5329, 47–50, 71–75 years, male/female</td>
<td>Cohort study</td>
<td>OR 2.19 (95% CI 1.48, 3.25) and 1.55 (95% CI 1.07, 2.23) for low BMD among subjects in highest quartile compared with lowest quartile of Hcy and lowest quartile compared with highest quartile of folate, respectively, in women only</td>
</tr>
<tr>
<td>McLean et al. [41], USA</td>
<td>n 714, mean 75 years, male/female</td>
<td>Longitudinal study</td>
<td>Participants with deficient plasma vitamin B&lt;sub&gt;12&lt;/sub&gt; (&lt;20 nmol/l) had greater mean bone loss compared with those with normal status</td>
</tr>
<tr>
<td>Morris et al. [42], USA</td>
<td>n 1550, &gt;55 years, male/female</td>
<td>Cohort study</td>
<td>Serum vitamin B&lt;sub&gt;12&lt;/sub&gt; related to BMD in a dose response fashion to 220 pmol/l. Hcy level (≥20 μmol/l) compared with low level (&lt;10 μmol/l) associated with lower BMD</td>
</tr>
<tr>
<td>Tucker et al. [43], USA</td>
<td>n 2576, mean 58 years, male/female</td>
<td>Cohort study</td>
<td>Low vitamin B&lt;sub&gt;12&lt;/sub&gt; (&lt;148 pmol/l) associated with lower average BMD than those with vitamin B&lt;sub&gt;12&lt;/sub&gt; above this cut-off</td>
</tr>
<tr>
<td>Cagnacci et al. [44], Italy</td>
<td>n 161, mean 53 years, female</td>
<td>Cross-sectional study</td>
<td>Folate but not Hcy/B&lt;sub&gt;12&lt;/sub&gt;, was associated with BMD</td>
</tr>
</tbody>
</table>

In the Australian study [38,39]. In terms of the B-vitamins and BMD, analysis of the Hordaland Homocysteine Study found low plasma folate to be associated with low BMD among Norwegian women [40]. Furthermore, the analysis of data from the Framingham Offspring Osteoporosis Study (n = 2576), a large USA cohort, demonstrated a relationship between low vitamin B<sub>12</sub> status and low BMD [43]. Findings from the USA National Health and Nutrition Examination Survey (n = 1550), also demonstrated that poorer vitamin B<sub>12</sub> (but not folate) status was associated with lower BMD [42]. Additionally, a study of 714 older American men and women showed that the participants with deficient plasma vitamin B<sub>12</sub> concentrations (<20 nmol/l) had greater mean annual bone loss than those with normal B<sub>12</sub> concentrations [41].

Some studies, however, have not reported associations between B-vitamins status (and/or homocysteine) and BMD [45], suggesting that the increased osteoporotic fracture risk may be independent of an effect on BMD. Indeed, Van Meurs et al. [36] found a significant increase in fracture risk associated with the highest (compared with the lowest) quartile of homocysteine concentrations, but no significant differences in BMD values across homocysteine quartiles. Conversely, some studies have found an association of B-vitamin biomarkers with high but not with fracture risk. For example, the analysis of an Australian population by Zhu et al. demonstrated a significant association of homocysteine with BMD but not with fracture risk; although the latter study, however, may have lacked sufficient statistical power to observe an effect on fracture [39]. Additionally, some studies have found an effect on bone (through fracture risk and/or BMD) for folate but not for vitamin B<sub>12</sub> [33,44] or an effect for vitamin B<sub>12</sub> but not for folate [42]. Perhaps any beneficial effect of the B-vitamins may be the most evident in those with compromised status, and therefore the B-vitamin (i.e. folate or vitamin B<sub>12</sub>) that emerges as a risk factor may be more reflective.
of the presence of sub-optimal vitamin status in the population being studied. For instance, folate status may vary greatly between populations dependent on whether the folic acid fortification policy in place is mandatory (e.g. USA), voluntary (e.g. most European countries) or not permitted on any basis (e.g. Scandinavia). Apart from differences in the vitamin status, disparities in findings between studies may reflect fundamental differences in the populations under investigation including, although not limited to, differences in ethnicity, sex, age and menopausal status. Furthermore, methodological constraints pertaining to sample size, inclusion and exclusion criteria, methods of measuring B-vitamin status (such as the use of dietary intake data as opposed to more robust blood biomarker measures) and choice of outcome measures, may also contribute to inconsistent findings among studies.

Genetic evidence

Epidemiological studies investigating the relationship between the MTHFR 677C→T polymorphism and bone health add further evidence to support the view that impaired folate metabolism (and the related phenotypes of elevated homocysteine and lower folate concentrations) may be implicated in adverse outcomes (Table 3).

Convincingly evidence from a recent meta-analysis of twenty studies (3525 cases and 17909 controls) found that the 677C→T polymorphism was associated with BMD at all measured sites, and with a 23 % increased risk for all fractures in individuals with the MTHFR 677TT genotype compared with those with the CT or CC genotypes. In 2000, the first report linking the 677C→T polymorphism in MTHFR with low BMD was published. This study of 307 healthy post-menopausal Japanese women demonstrated that those with the TT genotype (18.6 % of participants) had lower BMD than those with the CC genotype. Confirming these findings in a European population, the Danish Osteoporosis Prevention Study demonstrated that among 1748 post-menopausal Danish women, BMD at the spine and hip were significantly lower, and fracture incidence more than two times greater, in individuals with the TT genotype (affecting 8.7 % of participants) compared with the CT or CC genotypes.

One subsequent study reported that individuals with the TT genotype and low folate status (<9nmol/l), had a lower BMD compared with those with the CC or CT genotypes and low folate status, suggesting an important gene–nutrient interaction. Furthermore, Gjesdal et al. in 2007 reported an almost 3-fold increased risk of fracture among Norwegian men and women with the TT genotype and low folate status (<9nmol/l), had a lower BMD compared with those with the CC or CT genotypes and low folate status, suggesting an important gene–nutrient interaction.

Considering that riboflavin plays an integral role in homocysteine metabolism specifically in those with the MTHFR 677TT genotype, riboflavin intakes have also been investigated in relation to this polymorphism and bone health. In a longitudinal study, involving a subset of 1241 Scottish women from the Aberdeen Osteoporosis Screening Study, low riboflavin intake in combination with the TT genotype had an adverse effect on femoral neck BMD, at baseline and after a mean follow-up of 6-6 years. In support of these findings, further analysis of the Danish Osteoporosis Prevention Study cohort concluded that the BMD in individuals with the TT genotype was only significantly reduced.

Table 3. The relationship between the 677C→T polymorphism in MTHFR and bone health outcomes bone mineral density (BMD) and fracture risk

<table>
<thead>
<tr>
<th>Author, Country</th>
<th>Sample size, age, gender</th>
<th>Design</th>
<th>Main findings; risk of fracture (95 % CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zhu et al.</td>
<td>n 1213, 70-85 years, female</td>
<td>Cohort study</td>
<td>No relationship between the polymorphism and BMD or fracture, even after stratification by dietary folate, riboflavin and erythrocyte folate</td>
</tr>
<tr>
<td>Yazdanpanah et al.</td>
<td>n 5035, ≥55 years, male/female</td>
<td>Cohort study</td>
<td>In the lowest quartile of riboflavin intake, RR 1.80 (1.20, 2.90) and 2.60 (1.30, 5.10) for osteoporotic and fragility fracture, respectively, in women with TT compared with CC genotype</td>
</tr>
<tr>
<td>Hong et al.</td>
<td>n 1899, mean 54 years, female</td>
<td>Cohort study</td>
<td>RR 2.50 (1.20, 4.90) in the CT/TT genotype compared with the CC genotype. No relationship between the polymorphism and BMD</td>
</tr>
<tr>
<td>Abrahamsen et al.</td>
<td>n 1700, mean 50 years, female</td>
<td>Cohort study</td>
<td>BMD associated with the TT genotype in the lowest quartile of riboflavin intake. Similar threshold effects were shown for folate, vitamins B12 and B6</td>
</tr>
<tr>
<td>MacDonald et al.</td>
<td>n 1241, 45-54 years, female</td>
<td>Cohort study</td>
<td>A significant interaction among quartile of energy-adjusted riboflavin intake, the TT genotype, and BMD (P=0.01 for baseline femoral neck, P=0.02 at follow-up)</td>
</tr>
<tr>
<td>McLean et al.</td>
<td>n 1632, mean 59 years, male/female</td>
<td>Cohort study</td>
<td>Individuals with the TT genotype and low folate status had lower BMD than those with the TT genotype and higher folate status</td>
</tr>
<tr>
<td>Abrahamsen et al.</td>
<td>n 1748, mean 51 years, female</td>
<td>Prospective study</td>
<td>The TT genotype was associated with significantly lower BMD and a 2-fold increase in fracture risk</td>
</tr>
<tr>
<td>Miyao et al.</td>
<td>n 307, 46-91 years, female</td>
<td>Cohort study</td>
<td>BMD significantly lower in individuals with the TT genotype compared with the CC genotype (P&lt;0.05)</td>
</tr>
</tbody>
</table>

MTHFR, methylenetetrahydrofolate reductase; RR, relative risk.
The TT and CT genotypes refer to individuals homozygous and heterozygous for the 677C→T polymorphism in MTHFR respectively, whereas the CC genotype refers to homozygosity for the wild type.

The relationship between the 677C→T polymorphism in MTHFR and bone health outcomes bone mineral density (BMD) and fracture risk
with low dietary intakes of several B-vitamins including folate, B12, B6 and riboflavin49. In terms of fracture risk, evidence from the Rotterdam Study (n 5035) demonstrated that women with the TT genotype in the lowest quartile of riboflavin intakes had 1·8 times greater risk of osteoporotic fracture, and 2·6 times greater risk of fragility fracture (defined as a fracture at the hip, pelvis or proximal humerus), than those in the same quartile of riboflavin intakes with the CC genotype47. Such findings provide evidence to support a detrimental effect of the polymorphism combined with low B-vitamin intakes on robust bone health outcomes (i.e. BMD and fracture risk), and indicate that B-vitamins may have the potential to modulate any negative effect of this polymorphism on bone health.

To date the majority of bone studies that have considered gene–nutrient interactions have stratified B-vitamin status using dietary intake data, which are prone to a number of sources of error39,48. For instance, Hong et al. in 2007 reported an increased fracture risk associated with the MTHFR 677TT genotype, but no effect of the polymorphism on BMD, even after stratification using food groups representative of B-vitamin intakes48. Additionally Zhu et al. in 2009 failed to find an interactive effect of the polymorphism combined with low B-vitamin intakes on BMD or indeed fracture risk39. Perhaps these null findings might be explained by the inadequacy of B-vitamin intakes to accurately represent B-vitamin status. Other factors, such as differences in ethnicity (considerable variation in the frequency of this polymorphism between populations) and variation in the age of the populations investigated, may also contribute to inconsistencies among studies. Unfortunately, however, a recent meta-analysis showing an association between the MTHFR 677TT genotype and BMD and fracture risk, did not address any potential interactive effects of the polymorphism with low B-vitamin status and/or intakes, as most of the studies included did not provide the relevant data to allow this sub-analysis to be performed13.

Randomised controlled trials

Evidence in the form of randomised controlled trials (RCT) is limited. One notable RCT, however, found a 75% reduction in the risk of hip fractures among 628 post-stroke Japanese patients in response to combined folic acid and vitamin B12 supplementation for 2 years, despite no statistical differences in the number of falls experienced in both the treatment and placebo groups54. Conversely one RCT investigating osteoporotic fracture in stroke patients treated with B-vitamins for more than 2 years, and performed as part of the VITATOPS (VITamins to Prevent Stroke) study, reported no benefit of B-vitamin treatment on osteoporotic fracture55. As acknowledged by the authors however, this trial was insufficiently powered to detect any potential beneficial effect due to the small number of fracture events55. Another RCT, using participants with pre-existing CVD from the Heart Outcomes Prevention Evaluation 2 trial, failed to find a beneficial effect of B-vitamin supplementation on fracture risk56. It is important to note however, that the folate levels were approximately five times higher in the Heart Outcomes Prevention Evaluation 2 trial participants than in the Japanese stroke patients and so perhaps additional folate was unlikely to confer any further benefit to these individuals56. It is possible that certain B-vitamins, particularly folate in countries with no folic acid fortification policy, can exert protective effects on bone health that are related to, or independent of, their homocysteine lowering effects.

Potential mechanisms linking B-vitamin biomarkers with bone

There is currently no clear mechanism to explain the potential role of the B-vitamins and/or homocysteine in bone health, however various hypotheses have been investigated.

Evidence to support an effect of homocysteine on bone

Evidence from a rat model suggests that hyperhomocysteinemia induces accumulation of collagen-bound homocysteine in bone resulting in decreased bone strength57. In support of this relationship, an early hypothesis by McKusick suggested homocysteine had a detrimental effect on bone strength by way of disrupting collagen cross-linking (integral to bone strength)58. Consistent with McKusick’s theory, an in vitro study by Kang & Trelstad in 1973, found that homocysteine interfered with collagen cross-links from purified rat skin collagen59 and this is supported by a recent cell study demonstrating a mechanistic effect of homocysteine on lysyl oxidase (an enzyme required for collagen cross-linking)60. Additionally, a small study in homocystinuric patients (n 10) and controls provided evidence that premature osteoporosis among patients could be explained by disruption of collagen cross-linking as opposed to a reduction in collagen synthesis58. A case–control study by Saito et al. in 2006 comparing bone biopsies from twenty-five hip fracture cases and twenty-five post-mortem age- and sex-matched controls found significantly higher homocysteine concentrations, lower vitamin B6 concentrations and lower collagen cross-links in the hip fracture cases compared with controls61. However, while convincing, evidence to support a role for elevated homocysteine in the reduction of collagen cross-links as a causal mechanism in fracture risk remains inconclusive.

In vitro studies have also investigated a potential effect of homocysteine on bone turnover. Evidence exists to support a stimulatory effect of mildly elevated homocysteine concentrations (as low as 10 μmol/l) on osteoclastic activity, thereby increasing bone resorption62,63 and an inhibitory effect of homocysteine on bone formation64. Consistent with such in vitro evidence, plasma homocysteine was shown to correlate positively with markers of bone resorption, but not bone formation, in peri- and post-menopausal women65. Further
observational evidence to support a relationship between homocysteine and markers of bone resorption has been described. More recently, evidence from a rat model suggests homocysteine induces a reduced bone blood flow and therefore ability to repair micro-damage in bone. Additionally, evidence to support a relationship between elevated homocysteine and impaired physical function suggests that homocysteine could act independently of bone, by increasing fracture risk through poor physical ability.

**Evidence to support an effect of folate on bone** While folate has been linked to BMD and a reduced fracture risk, there is limited evidence to support a direct mechanistic effect of folate on bone, although one study reported a reduced trabecular thickness of bone in individuals with low folate status vs. those with higher status. Folate could have an indirect role on bone remodelling cells via its metabolic link (as a methyl source) to the methylation of DNA, proteins and other molecules and there is evidence, albeit somewhat inconsistent, to support a reduced methylation capacity as a pathomechanism responsible for poor bone health. Alternatively, folate may exert a protective effect on bone through its homocysteine lowering effect.

**Evidence to support an effect of vitamins B12 and B6 on bone** Findings from a small clinical trial showed significantly lower alkaline phosphatase (a marker of bone formation) in vitamin B12 deficient patients compared with the controls, and a subsequent rise in alkaline phosphatase following B12 supplementation in the deficient patients but not in the controls. Additionally, evidence from an in vitro study showed a stimulatory effect of vitamin B12 on alkaline phosphatase. Such findings suggest a protective effect of vitamin B12 on bone formation. However, a large retrospective study of 9506 pernicious anaemia patients in the UK, which showed a 74% increased fracture risk in patients v. healthy controls, reported that the increased fracture risk remained after correction of the vitamin B12 deficiency, thereby suggesting a detrimental effect of pernicious anaemia on bone not related to low vitamin B12 status. Low vitamin B6 status was found to be associated with decreased concentrations of bone formation markers in an animal model. However, trials involving supplementation of folate, vitamins B12 and B6, and thereby lowering homocysteine concentrations, have failed to find a beneficial effect on bone turnover; suggesting that if a benefit of B-vitamin supplementation, or homocysteine lowering, on bone health exists, it is independent of any effect on bone turnover. Interestingly, vitamin B6 acts as an essential co-enzyme for lysyl oxidase, an enzyme required for collagen cross-linking; suggesting that low vitamin B6 may be detrimental for collagen cross-linking and result in poorer bone mechanical performance.

It is apparent that the interrelationship between the B-vitamins, homocysteine and bone health is complicated, and probably multi-factorial, with further trials needed to fully elucidate potential mechanisms.

**Bone health in coeliac disease**

**Coeliac disease**

Coeliac disease (CD) is a common autoimmune, inflammatory condition in genetically predisposed individuals and is induced by the ingestion of ‘gluten’, a generic term used to describe the disease activating proteins and peptides found in wheat, barley, rye and sometimes in oats. The mainstay treatment of CD is the gluten-free diet. Untreated CD is characterised by villous atrophy, leading to malabsorption of nutrients, and is responsible for many of the traditional clinical manifestations of disease including diarrhoea, weight loss and vitamin deficiencies in iron, folate and calcium. The gold standard diagnosis of CD is based on the presence of villous atrophy (or more mild features of enteropathy) as determined by a well-orientated biopsy of the small intestine, with the presence of autoantibodies to gluten (endomysial antibodies and tissue transglutaminase antibodies) being screened for in the first instance.

**Osteoporosis in coeliac disease**

CD patients are well known to be at a higher risk of osteoporosis compared with the general population. A recent review reported that 38–72% of CD patients have significantly lower BMD at presentation than non-CD populations matched for age and sex. The gluten-free diet is expected to alleviate mucosal damage, and the corresponding malabsorption of calcium and other nutrients, and thereby results in higher BMD. The evidence, however, suggests that the CD patients still fail to achieve the BMD of healthy controls. Additionally, a meta-analysis involving eight studies and approximately 21,000 CD patients reported a 43% increased fracture risk among patients compared with controls. Although the aetiology of poor bone health in CD is unclear, various factors, including calcium and vitamin D malabsorption, resultant secondary hyperparathyroidism and the inability to reach peak bone mass in young adulthood, are reported to play a role. More recently, a negative impact of pro-inflammatory markers (such as TNF-α and interferon-γ), which are chronically released during gut inflammation and associated with bone loss, are also believed to contribute to poor bone health in CD. Additionally, a lower ratio of osteoprotegerin (known to protect against excessive bone resorption) to receptor activator of NF-κB-ligand (RANKL; associated with bone resorption activity) found in treated CD patients (with recovered mucosa) compared with healthy controls, and a positive correlation between the osteoprotegerin : RANKL ratio and BMD, suggests a damaging effect of a low ratio on BMD even in treated CD patients.

It is also possible that nutrients not typically linked to bone health, such as the B-vitamins, contribute a
protective effect on bone in these patients. Low folate and vitamin B12 status, accompanied by elevated concentrations of homocysteine, are well described among CD patients\(^{90}\). Given the emergence of evidence to support a protective role of B-vitamins and a detrimental effect of homocysteine on bone health, it is possible that B-vitamin inadequacies and/or elevated concentrations of homocysteine, play a role in osteoporosis development in CD. Indeed, given the much higher incidence both of osteoporosis and B-vitamin deficiencies, CD patients comprise a unique ‘at-risk’ group to investigate in terms of a potential link between B-vitamins and bone health. A 2-year RCT supplementing CD patients with folic acid and vitamin B12 and measuring BMD (by dual-energy X-ray absorptiometry scans) pre- and post-intervention is currently underway at our centre with results expected in 2014. This trial will likely shed light as to whether a causal relationship between the B-vitamins and/or homocysteine and BMD exists.

**Conclusion and future work**

There is consistent observational evidence of an association of homocysteine related B-vitamins with bone health. This epidemiological evidence is further strengthened by genetic studies showing an important association between the common MTHFR 677C→T polymorphism and osteoporosis risk. However, confirmation of a causal link between B-vitamins and bone health from RCT is lacking. Further trials to investigate fracture risk or other robust outcomes such as BMD should focus on various ‘at-risk’ population groups (such as CD patients, post-menopausal women or individuals with the MTHFR 677TT genotype). Such evidence will confirm whether low B-vitamin status is causally associated with osteoporosis risk and whether there are beneficial effects of B-vitamin supplementation in bone health.

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**Conflicts of Interest**

None.

**Authorship**

M. M. C. drafted the manuscript. H. McN., M. W., J. J. S. and W. D. critically revised the manuscript for important intellectual content. All authors have read and approved the final manuscript.

**References**


