Effect of apolipoprotein E genotype on vitamin K status in healthy older adults from China and the UK

Liya Yan1*, Bo. Zhou2, Shailja Nigdikar1, Xiaohong Wang2, Janet Bennett1 and Ann Prentice1

1Medical Research Council Human Nutrition Research, Elsie Widdowson Laboratory, Fulbourn Road, Cambridge CB1 9NL, UK
2Department of Preventive Medicine, Shenyang Medical College, 146 Huanghe North Street, Shenyang, 110034, PR China

(Received 30 November 2004 – Revised 4 May 2005 – Accepted 14 July 2005)

The vitamin K concentration in the circulation and the availability of vitamin K to bone may be affected by factors influencing lipoprotein metabolism, such as apoE genotype. The relationships between markers of vitamin K status, bone mineral content and apoE genotype were studied in healthy older men and women aged 60–83 years, 177 from Shenyang, China, and 132 from Cambridge, UK. Fasting plasma was analysed for vitamin K1, triacylglycerol, total osteocalcin, undercarboxylated osteocalcin (ucOC) and apoE genotype. Hip bone mineral content was measured using dual-energy X-ray absorptiometry. Subjects were grouped according to apoE genotype as E2/3, E3/3 and E3/4. The mean plasma vitamin K1 concentration of the three genotype groups was significantly higher and the percentage ucOC was lower in the Chinese than in the British subjects (P<0.01). A higher vitamin K1 concentration was found in subjects with [E3/4 E4/4] than those with either E2/3 or E3/3 in Cambridge (32·2 (SE 14·6) %, P=0·03; 24·6 (SE 10·7) %, P=0·02). Similar trends were observed although were not statistically significant in Shenyang (26·5 (18·9) %, P=0·16; 23·1 (13·0) %, P=0·08). Subjects with [E3/4 + E4/4] had a lower percentage ucOC (total osteocalcin adjusted) than did those with either E2/3 or E3/3 in Shenyang (65·1 (27·2) %, P=0·02; 49·6 (19·9) %, P=0·01 respectively) but not in Cambridge. This study demonstrates that a superior vitamin K status is associated with the apoE4 genotype in healthy older individuals from China and the UK.

Apo E: Vitamin K1; Undercarboxylated osteocalcin: Bone: Older adults

Vitamin K is important for bone health through the vitamin K-dependent γ-carboxylation of the bone protein osteocalcin. The proportion of osteocalcin that is not fully γ-carboxylated is a predictor of bone mineral density and fracture incidence (Szulc et al. 1996; Booth et al. 2003), suggesting that poor vitamin K status may be a risk factor for osteoporosis (Binkley & Suttie, 1996; Vergnaud et al. 1997).

Vitamin K1 (phylloquinone), the predominant dietary and circulating form of vitamin K, is mainly transported in the circulation by triacylglycerol-rich lipoproteins (TRL; Lamon-Fava et al. 1998). It is likely that the availability of vitamin K1 to bone is affected by factors influencing lipoprotein metabolism. One of these factors is apoE, which acts as a ligand for the uptake of lipoproteins into target tissues such as liver and bone (Kohlmeier et al. 1996; Newman et al. 2002).

The apoE gene is polymorphic. Three common alleles code for three apoE isoforms: E2, E3 and E4, allowing for six possible combinations (E2/E2, E2/E3, E2/E4, E3/E3, E3/E4 and E4/E4). ApoE4 polymorphism has been linked to a lower bone mineral density and an increased risk of osteoporotic fracture (Shiraki et al. 1997; Kohlmeier et al. 1998; Cauley et al. 1999). There are, however, also studies showing a lack of association between apoE genotype and bone mineral density, bone loss or osteoporotic fracture (Booth et al. 2000; Heikkinen et al. 2000; von Muhlen et al. 2001). Research in haemodialysis patients suggested that individuals with the apoE4 genotype had an accelerated hepatic clearance of TRL-vitamin K and therefore less vitamin K available to bone (Saupe et al. 1993; Kohlmeier et al. 1996). This was, however, challenged by a later study in healthy men, which suggested that the clearance of TRL remnants was impaired in people with the apoE4/4 genotype (Bergeron & Havel, 1996).

There were very few studies on the effect of the apoE genotype on vitamin K status in healthy populations. We previously demonstrated that the incidence of hip fracture in China was low compared with that in Western countries (Yan et al. 1999). To explore whether differences in vitamin K nutrition might underlie differences in fracture incidence between Asian and European populations, we conducted two parallel studies investigating the influence of vitamin K status on bone health in older people in Shenyang, northern China, and Cambridge, UK. These studies showed that older people in Shenyang had significantly higher vitamin K1 intakes, higher plasma vitamin K1 concentrations and lower proportions of undercarboxylated osteocalcin (ucOC) compared with their British counterparts in Cambridge (Yan et al. 2004). The aim of the present study was to explore the influence of apoE genotype on markers of vitamin K status in these two groups of older people with a very different vitamin K status. In addition, the relationship between bone mineral status at the hip and apoE genotype was examined.

Abbreviations: BMC, bone mineral content; IOC, total osteocalcin; TRL, triacylglycerol-rich lipoproteins; ucOC, undercarboxylated osteocalcin.

* Corresponding author: Dr Liya Yan, fax +44 1223 437515, email liya.yan@mrc-hnr.cam.ac.uk
ApoE genotype and vitamin K status

Subject and methods

Subjects

All subjects were from a study investigating ethnic differences in bone health in older Chinese and British adults conducted collaboratively by Shenyang Medical College, Shenyang, northern China, and Medical Research Council Human Nutrition Research, Cambridge, UK (Yan et al. 2004). Shenyang is one of the largest cities in north-eastern China, as previously detailed (Yan et al. 1999, 2004).

The Chinese subjects were eighty-five men (means and standard deviations: age 66·8 (SD 4·6) years, weight 68·9 (SD 9·3) kg, height 166·9 (SD 6·1) cm) and ninety-two women (means and standard deviations: age 64·4 (SD 4·2) years, weight 60·0 (SD 10·2) kg, height 155·1 (SD 5·0) cm) recruited by posters in GP surgeries in Cambridge. The British subjects were sixty-six men (means and standard deviations: age 69·0 (SD 7·1) years, weight 78·6 (SD 9·7) kg, height 173·3 (SD 6·3) cm) and sixty-six women (means and standard deviations: age 67·9 (SD 6·5) years, weight 69·5 (SD 12·2) kg, height 159·7 (SD 7·1) cm) recruited by posters in GP surgeries in Cambridge.

All subjects were free of health problems or medications known to alter calcium or bone metabolism, such as thyroid disorders, diabetes, cancer and clotting disorders, and steroid use. Ethical approval for the Shenyang study was given by the Academic Committee of Shenyang Medical College and for the Cambridge study by the NHS Cambridge Local Research Ethics Committee. All participants provided informed written consent.

Laboratory analyses

Blood samples were collected between 07.00 h and 09.00 h after an overnight fast. Plasma was separated from blood cells by a refrigerated centrifuging (Mistral 6000, Sanyo Gallenkamp PLC, Leicester, UK) and both plasma and blood cells were stored at −80°C until analysis. Plasma samples from Shenyang were transported on dry ice to Human Nutrition Research in Cambridge for the analysis of vitamin K1, triacylglycerol, total osteocalcin (tOC) and ucOC.

ApoE genotyping was based on a previously described method (Wenham et al. 1991). DNA extracted from whole blood (Qiagen Ltd, Crawley, West Sussex, UK) was amplified using Taq polymerase (PCR Core System, Promega, UK) and thirty cycles. The 227 bp product encompassing the polymorphic nucleotides 3745 and 3883 was restricted for 4 h at 37°C with 20 units of restriction endonuclease Cfo (Promega, Southampton, UK). Genotype was determined using a 4% agarose gel (Invitrogen Ltd, Paisley, UK). The apoE genotyping of the Shenyang samples was conducted at Shenyang Medical College, and that of the Cambridge samples was conducted at Human Nutrition Research using the same procedures and materials. A cross-calibration of ten samples was performed, which confirmed that the genotyping by both laboratories was identical.

Plasma vitamin K1 concentration was measured by HPLC with fluorometric detection, as previously described in detail (Wang et al. 2004). In brief, vitamin K1 compounds were isolated from 0·25 ml plasma by liquid–liquid extraction, followed by solid-phase extraction. An internal standard of vitamin K1 (5 nmol/l) was added to each sample. The hydroxyapatite-treated sample was 0·18 ± 0·12 nmol/l. ucOC concentrations were undetectable in the samples from nineteen Chinese subjects; a nominal concentration of 0·09 ± 0·08 nmol/l was assigned for these samples. The ucOC measured was expressed as both concentration (µmol/l) and as a percentage of tOC.

Bone mineral content (BMC) and bone area at the femoral neck and trochanter were measured using dual-energy X-ray absorptiometry (DPX-L (software 1·3x) in Shenyang, and DPX MD (software 4·7 d) in Cambridge; GE Lunar, Madison, US). Cross-calibration of the two dual-energy X-ray absorptiometry machines was performed by scanning the European Spine Phantom, as previously detailed (Yan et al. 2003).

Data-handling and analysis

We previously showed that plasma vitamin K1 concentration was positively related to vitamin K1 intake and plasma triacylglycerol concentration, whereas percentage ucOC was positively related to tOC and negatively related to plasma vitamin K1 concentration (Yan et al. 2004). These factors were all considered when a possible effect of apoE genotype was examined.

Statistical analysis was performed by linear model software in Data Desk 6·1·1 (Data Descriptions, Ithaca, NY; 1995). The χ 2 test was used to examine the differences in genotype. Multiple linear regression and analysis of covariance were used to examine the relationships between plasma biochemical markers and apoE genotype adjusting for potential confounding factors such as age, sex, country and others. Interaction terms were used to examine differences (slopes) in the relationships between vitamin K1 (or percentage ucOC) and apoE genotype in the Chinese and British groups. To correct for skewed distributions and to permit an exploration of proportional relationships, all continuous variables except age were transformed to natural logarithms. In natural logarithms, group differences × 100 correspond closely to percentage differences calculated as (difference/mean) × 100 (Prentice et al. 1991).

In our data analysis, a correction was made for tOC when expressing the relative proportion of ucOC. Conventionally, this is achieved by expressing ucOC concentration as a percentage of total OC concentration ((ucOC/OC) × 100). This, however, implies a relationship between ucOC and tOC that is one of direct proportion. In the present study, this was shown not to be the case. This was because the relationship between ucOC and tOC concentration, examined by the regression analysis of...
logged variables, was not directly proportional. The coefficient for the relationship in the British population was 1·17 (SE 0·96), \( P<0·0001 \) but that in the Chinese population was 2·19 (SE 20·0, \( P<0·0001 \); Yan et al. 2004), demonstrating that ucOC and toc were related in an approximately squared manner, which meant that a 1 % increase in toc resulted in a more than 2 % increase in ucOC. In order to fully adjust for the effect of toc on ucOC, toc was included in the analysis of covariance models and removed from the model when not significant at \( P<0·05 \).

For exploring the relationship between bone mineral status and apoE genotype, BMC adjusted for bone area, body weight and height (size-adjusted BMC) was used (Prentice et al. 1994). All statistical models were set up in the same way, i.e. full models were generated and then variables \( P>0·05 \) were removed by backward elimination to provide a parsimonious model.

**Results**

The distribution of apoE genotypes was in Hardy–Weinberg equilibrium in both the Chinese and British samples. The frequency of the apoE3/3 genotype was higher in Shenyang than in Cambridge (\( P=0·002 \)). As a result, the frequency of total apoE4 allele was lower and that of total apoE3 allele higher in Shenyang than in Cambridge (\( P<0·01 \); Table 1). No individual with an apoE2/2 genotype was found in either population, and the E2/4 genotype was not present in the Chinese group. To make the investigation consistent and comparative across the two populations, the effect of apoE genotype on vitamin K status and BMC was restricted to the three common genotypes E2/3, E3/3 and [E3/4 + E4/4] (Tables 2 and 3). The five British subjects with E2/4 were therefore not included in further analyses.

The mean vitamin K1 intake and plasma vitamin K1 concentration of the three genotype groups were significantly higher in the Chinese than in the British subjects, and the plasma ucOC concentration and percentage ucOC were significantly lower in the Chinese than in the British subjects, and the plasma ucOC concentration and percentage ucOC were significantly lower in the Chinese than in the British subjects, and the plasma ucOC concentration and percentage ucOC were significantly lower in the Chinese than in the British subjects, and the plasma ucOC concentration and percentage ucOC were significantly lower in the Chinese than in the British subjects, and the plasma ucOC concentration and percentage ucOC were significantly lower in the Chinese than in the British subjects.

### Table 1. Frequency of apoE genotypes and alleles in Shenyang and Cambridge subjects†

<table>
<thead>
<tr>
<th>Genotypes</th>
<th>Shenyang (n 177)</th>
<th>Cambridge (n 132)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>ApoE2/2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ApoE2/3</td>
<td>25</td>
<td>14·1</td>
</tr>
<tr>
<td></td>
<td>5 (M2, F3)</td>
<td>3·8</td>
</tr>
<tr>
<td>ApoE2/4</td>
<td>123</td>
<td>69·5</td>
</tr>
<tr>
<td>ApoE3/3</td>
<td>28</td>
<td>15·8</td>
</tr>
<tr>
<td>ApoE3/4</td>
<td>1 (F1)</td>
<td>0·6</td>
</tr>
<tr>
<td>ApoE alleles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ApoE2</td>
<td>25</td>
<td>7·1</td>
</tr>
<tr>
<td>ApoE3</td>
<td>299</td>
<td>84·5</td>
</tr>
<tr>
<td>ApoE4</td>
<td>30</td>
<td>8·4</td>
</tr>
</tbody>
</table>

M, men; F, women.

† All distributions were in Hardy–Weinberg equilibrium. Comparisons between Shenyang and Cambridge made by \( \chi^2 \) analyses.

** \( P<0·01 \).
Table 3. Differences in plasma vitamin K1 and percentage undercarboxylated osteocalcin (%ucOC) in Chinese and British subjects with different apoE genotype (Variables transformed to natural logarithms and post hoc analysis)

<table>
<thead>
<tr>
<th></th>
<th>Chinese (n=29 v. 69)</th>
<th>British (n=34 v. 69)</th>
<th>% difference</th>
<th>SE</th>
<th>% difference</th>
<th>SE</th>
<th>% difference</th>
<th>SE</th>
<th>% difference</th>
<th>SE</th>
<th>% difference</th>
<th>SE</th>
<th>% difference</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2/3 v. E3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasma vitamin K1 (nmol/l)</td>
<td>20·4 (13·7)</td>
<td>26·1 (13·0)</td>
<td>-5·7</td>
<td>6·1</td>
<td>-26·5</td>
<td>6·5</td>
<td>-13·0</td>
<td>11·0</td>
<td>-15·3</td>
<td>11·0</td>
<td>-14·0</td>
<td>11·0</td>
<td>-13·0</td>
<td>11·0</td>
</tr>
<tr>
<td>%ucOC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese (n=29 v. 25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasma vitamin K1 (nmol/l)</td>
<td>23·1 (13·0)</td>
<td>32·2 (14·6)</td>
<td>-9·1</td>
<td>9·8</td>
<td>-24·6</td>
<td>10·7</td>
<td>-19·9</td>
<td>10·0</td>
<td>-14·0</td>
<td>10·0</td>
<td>-19·9</td>
<td>10·0</td>
<td>-14·0</td>
<td>10·0</td>
</tr>
<tr>
<td>%ucOC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British (n=34 v. 29)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasma vitamin K1 (nmol/l)</td>
<td>24·6 (13·0)</td>
<td>49·6 (19·9)</td>
<td>-25·0</td>
<td>9·8</td>
<td>-24·6</td>
<td>10·7</td>
<td>-19·9</td>
<td>10·0</td>
<td>-14·0</td>
<td>10·0</td>
<td>-19·9</td>
<td>10·0</td>
<td>-14·0</td>
<td>10·0</td>
</tr>
<tr>
<td>%ucOC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Significantly different after adjusting for vitamin K1 intake, triacylglycerol concentration and gender, P<0·05.

Discussion

The present study of healthy older men and women has shown that vitamin K status, as measured using vitamin K1 concentration and percentage ucOC in the plasma, is better in China than in Britain, and in individuals with one or two copies of the apoE4 allele, suggesting that these individuals may be at lower risk of osteoporotic fracture (Szulc et al. 1996; Vergnaud et al. 1997).

The possibility that apoE4 is a genetic risk factor for osteoporosis and fracture has been investigated in previous studies, but results are inconsistent. In contrast to our findings, some have demonstrated that older people with one or two apoE4 alleles have a lower lumbar spine bone mineral density (Shiraki et al. 1997; Cauley et al. 1999), and an increase in fracture risk (Kohlmeier et al. 1998; Cauley et al. 1999), compared with people with no apoE4 allele, but other results (Booth et al. 2000; Heikkinen et al. 2000; von Muhlen et al. 2001) do not support these findings.

Furthermore, our observation that a higher plasma vitamin K1 concentration or a lower percentage ucOC was associated with apoE4 is different from that reported in haemodialysis patients. These studies showed that plasma vitamin K1 concentration was highest among those individuals with one or two copies of the apoE2 allele, intermediate among those homozygous for apoE3, and lowest among those with one or two copies of the apoE4 allele (Saupe et al. 1993; Kohlmeier et al. 1995). It was suggested that this distribution is in accordance with the relationship between apoE genotype and the rate of hepatic clearance of chylomicron remnants from the circulation, the E4 allele being associated with the most rapid catabolism (Kohlmeier et al. 1996). However, a later study in healthy young men (Bergeron & Havel, 1996) showed that the clearance of TRL remnants was slower in subjects with the apoE3/4 compared with the apoE3/3 genotype. If this is true, the higher plasma vitamin K1 concentration and lower percentage ucOC in the subjects with E4 allele found in the present study could be due to a slower clearance of TRL remnants from the circulation, and subsequently more vitamin K1 rich- lipoprotein being available for uptake by bone.

In addition, direct evidence that apoE plays an important role in the uptake of lipoprotein-borne vitamin K1 into osteoblasts has

tOC concentration was significantly related to apoE genotype in any population. A higher plasma vitamin K1 concentration was found in subjects with [E3/4 + E4/4] than in those with either E2/3 or E3/3 in Cambridge after adjusting for vitamin K1 intake, plasma triacylglycerol concentration and gender (Table 3). Similar trends were observed although were not statistically significant in Shenyang (Table 3). The magnitude of the effect was similar in Cambridge and Shenyang (Table 3), and no interaction was found in the two-country combined data, suggesting that there was no evidence of a country difference in the relationship between apoE genotype and plasma vitamin K1 concentration (P=0·75). Subjects with [E3/4 + E4/4] had a lower percentage ucOC than those with either E2/3 or E3/3 in Shenyang (P=0·02 and P=0·01, respectively, Table 3), but these associations were not significant in Cambridge (P=0·14 and P=0·94, respectively). There was no significant interaction in this relationship between counties despite a large apparent difference in response (P=0·36). Size-adjusted BMC at the hip was not significantly related to apoE genotype at either the femoral neck or trochanter in either population (data not shown).
been reported (Newman et al. 2002). This study demonstrated that the osteoblast uptake of vitamin K was mediated by apopE in TRL-rich lipoproteins and heparan sulphate proteoglycans on the osteoblast surface. ApoE4 seems to stimulate cellular binding (Cullen et al. 1998) and uptake to a greater degree than other isoforms (Newman et al. 2002). The relationship between apopE genotype and percentage ucOC in the Chinese subjects would support this mechanism. The lack of a significant effect in British subjects may reflect their lower vitamin K status overall and consequently the smaller range of percentage ucOC observed.

The effect of apopE genotype on markers of vitamin K status in healthy populations has been little studied. The association between apopE4 and percentage ucOC adjusted for tOC found in the present study was different from that observed in a small pilot study in which a lower tOC-adjusted ucOC level was related to apopE2 in British and Chinese women (Beavan et al. 2005). The carboxylation of osteocalcin in the pilot study was investigated by RIA (Incastar Corporation, Stillwater, MN, USA). The mean tOC concentrations obtained were relatively low, 1–5 μg/l, and close to the level of detection for the assay (Beavan et al. 2005). Owing to the already low tOC, ucOC concentrations after hydroxyapatite binding were very low, being not detectable in 62% of samples. In the present study, we used a more sensitive method: ELISA (Nordic Bioscience Diagnostics). Although the absolute values cannot be compared between different assays, the mean concentrations of tOC measured by the ELISA method (15–21 μg/l) were much higher compared with the detection limit. ucOC were still undetectable in some Chinese samples, but the proportion was much lower (10–7%). We believe that the different techniques used in the two studies contributed significantly to the discrepancy between them, although other factors might also be involved.

We observed that a higher vitamin K intake was found in subjects with [E3/4 + E4/4] than in those with E3/3 in Shenyang, and in subjects with E3/3 than in those with E2/3 in Cambridge. When the effect of apopE genotype on plasma vitamin K concentration was examined, vitamin K intake was included in analysis of covariance models as one of the potentially confounding independent variables. Therefore, the effect of vitamin K intake had been eliminated. If there was anything in the British group, it should be the other way round because subjects with E3/3 had a relatively higher vitamin K intake but a lower plasma vitamin K concentration than those with [E3/4 + E4/4] (Tables 2 and 3).

We could not find any significant association between plasma triacylglycerol concentration and apopE genotype in this study, unlike some reports (Dallongeville et al. 1992). Vitamin K1 is mainly carried by chylomicron remnants after a meal (Kohlmeier et al. 1996). The blood samples in our study were collected in the early morning after an overnight fast. This could explain why the association between plasma vitamin K1 and triacylglycerol concentrations varied widely between individuals (Table 2). This variability could also mask a clear effect of apopE genotype on triacylglycerol levels.

The apopE4 allele has been associated with low bone mineral density (Shiraki et al. 1997) and bone fracture (Kohlmeier et al. 1998), which has been attributed to a modulation of vitamin K transport, although others have not been able to find these associations (Booth et al. 2000; Heikkinen et al. 2000; Stulc et al. 2000). In this study, we did not find any association between size-adjusted BMC at the hip and apopE genotype in any population. We appreciate, however, that the sample size of our study was limited for investigating a possible genotype effect on bone mineral status.

In summary, our study demonstrates that a superior vitamin K status, as demonstrated by either higher plasma vitamin K1 concentration or lower percentage ucOC, is associated with the apopE4 genotype in healthy older individuals from China and the UK. The fact that these relationships or trends of the association are seen within two populations with very different vitamin K status suggests that it is mediated through effects of apopE on vitamin K transport to and uptake into bone.

Acknowledgements

This work was funded in part by the Nestlé Foundation, Switzerland, and we are grateful for their support. We thank Dr Martin Shearer, Centre for Haemostasis and Thrombosis, St Thomas’s Hospital, London, for his expert opinion and suggestions for data analysis, Dr Gail Goldberg for commenting on the manuscript and Mr Songtao Wang for assistance in other aspects of the study. We wish also to express our gratitude to the subjects in Shenyang and Cambridge who took part in the study.

References


