BONE AND MINERAL METABOLISM IN PRIMIPAROUS WOMEN AND ITS RELATIONSHIP WITH BREASTFEEDING: A LONGITUDINAL STUDY

MARIELA GLEREAN1, AIDA FURCI2, ANA MARIA GALICH1, BRUNO FAMA3, LUISA PLANTALECH1

1Servicio de Endocrinología, Metabolismo y Medicina Nuclear, Hospital Italiano de Buenos Aires; 2Laboratorio Díaz Vélez, Buenos Aires; 3Servicio de Obstetricia, Hospital Italiano de Buenos Aires

Abstract

The aim of this study was to evaluate the changes in bone metabolism in breastfeeding women (BF). We selected 30 primiparous women and compared them to 31 nulliparous women. We assessed bone mineral density (BMD) in the lumbar spine (LS), femoral neck (FN) and trochanter (TROC), biochemical parameters of bone turnover and hormone and cytokine levels at the puerperium, 6 months and 12 months after delivery. A trend to lower BMD of LS was seen at initial evaluation in BF. BMD in LS, FN, and TROC were increased 12 months after delivery. Baseline body mass index was higher in puerperal women (p = 0.02) and correlated with an increased FN and TROC BMD one year post delivery (p = 0.001 and p = 0.003). An increase in bone remodeling markers, and lower urinary calcium was observed; after 12 months these values normalized. Prolactin, parathormone related peptide (PTHrP) and IL-6 were enhanced during the first six months of breastfeeding. We conclude that calcium for breastfeeding was obtained by transient mobilization of calcium deposits from the trabecular bone, and urinary calcium sparing induced by calcitrophic hormones and cytokines. Body weight is an important factor in proximal femur BMD.

Key words: breastfeeding, bone metabolism, bone mineral density, serum calcium, PTHrP, interleukin 6

During pregnancy, postpartum and breastfeeding, the maternal skeleton undergoes mobilization of calcium deposits, to provide calcium for the mineralization of the fetal skeleton and milk production. Such changes are regulated by different hormonal systems1-4. Milk production during a 3 to 4 month-breastfeeding period extracts 30 g of calcium2. Cumulative calcium deficit during pregnancy and lactation is estimated to be about 6% of the total bone mineral content5, 6. The mechanism by which calcium requirements are met during this period involves a transient skeletal demineralization. Several authors conclude that the maternal skeleton works as a calcium-buffer system in which the low density bone and osteoid rapidly exchange minerals and contribute additional calcium to that provided by supplements in the diet1, 4.

Ferretti et al4 have described that the total mineral content of the skeleton in relation to lean body mass is...
higher in pre-menopausal women than in post-menopausal women, suggesting that the relative “excess” during the reproductive age ensures the preservation of maternal skeletal health during the mineralization of the fetal skeleton and lactation. Breastfeeding produces an extraction of nutrients from the mother that favors the loss of bone mass and osteoporosis during the reproductive period5, 6.

The aim of this study was to document the changes in bone and mineral metabolism, as well as the hormonal variations related to breastfeeding.

Materials and Methods

We selected 30 women in their first pregnancy (breastfeeding women: BF) followed at the Division of Obstetrics of the Hospital Italiano de Buenos Aires. Women who were younger than 21 or older than 40 years, or had a history of renal lithiasis, known bone disease, prolonged amenorrhea, diabetes mellitus, endocrine diseases, chronic alcoholism, or taking medications that modified mineral metabolism were excluded. Twenty-two primiparous women (73.3%) completed the longitudinal study. The study group was compared to 31 nulliparous women (C) who fulfilled similar exclusion criteria. A medical history was obtained and the following data were recorded: age, body mass index (BMI: kg/m²); gynecological and obstetrical history, -age at menarche (years), -weight gain during pregnancy (kg), -duration of breastfeeding (months) and post-partum amenorrhea (months); physical activity (yes or no for programmed physical activity: minimum twice a week), smoking history (yes or no), family history of osteoporosis (yes or no), weekly hours of sun exposure and calcium intake [-null, scarce (< 1 g/day), moderate (1 g/day) and high (> 1 g/day)]. Nutritional status was evaluated with serum albumin levels and BMI.

The following parameters were measured in serum: 1- Ionized calcium (ICa, normal value –nv-: 1.135 mmol/l); 2- Phosphorus (P, nv: 2.5-4.5 mg/dl); 3- Creatinine (Cr, nv: 0.5-1.2 mg/dl); 4- Albumin (Alb, nv: 3.5-5 g/dl); 5- Total alkaline phosphatase (Alk P, nv: 40-190 U/l) 6 and 6- Tartrate-resistant acid phosphatase (TRAP, nv: 1.8-4.4 U/l).7-Fasting urinary calcium/creatinine ratio (uCa/Creat) was assessed in the morning after 500 ml water ingestion (nv: ≤ 0.1).

Parathormone-related peptide (PTHrP by IRMA method, nv: 0.2-1 pg/ml)10; prolactin (PRL)11 by RIA method (nv: 5-25 ng/ml); estradiol (E2) by RIA (nv: 50-400 pg/ml)12 and interleukin 6 (IL-6) by IRMA method (nv: 0.3-10 pg/ml)13 were measured in only 19 women, at delivery and at 3 and 6 months thereafter.

We performed a bone mineral densitometry (BMD) of the lumbar spine (LS), femoral neck (FN) and trochanter (TROC) with a Lunar DPX densitometer at baseline of puerperium, at 6 and 12 months postpartum. BMD was expressed in g/cm².

Statistical analysis

The SPSS statistical software, version 10F, was used for data analysis. Differences were considered to be statistically significant when the probability (P) was < 0.05. The ANOVA, Mann-Whitney and chi-square tests were used for parametric and non parametric variables, respectively. Linear regression was applied for BMI and BMD correlations.

Results

Characteristics of primiparous women at delivery and controls are shown in Table 1. Primiparous’s mean age was 29.0 ± 3.5 years. The duration of breastfeeding (6.2 ± 2.6 months) matched the period of amenorrhea. Their BMI was higher than controls at initial evaluation but no significant differences were observed 12 months postpartum (not shown). No differences between groups were found with regard to physical activity, family history of osteoporosis, smoking habit, milk intake or hours of exposure to sunlight. Sixty one and fifty three percent of

| TABLE 1.– Characteristics of controls (C) and breastfeeding women (BF) at delivery (mean ± SD) |
|------------------|------------------|------------------|
|                  | C               | BF at delivery   |
| Age (range)      | 27 ± 4 (21 - 38) | 29 ± 3.5 (21 - 38) | ns   |
| BMI (range)      | 23.8 ± 4.0 (18 - 36) | 26 ± 4 (21 - 37) | 0.02 |
| Physical activity (Y/N) | 13/18 | 14/16 | ns   |
| Smoking (Y/N)    | 7/24            | 8/22            | ns   |
| Calcium intake: Scarce (< 1 g/day) | 19 | 16 | ns   |
| Moderate (1 g/day) | 9   | 12  | ns   |
| Plentiful (> 1 g/day) | 3  | 2   | ns   |
| Familial osteoporosis (Y/N) | 13/18 | 12/18 | ns   |
| Solar exposure (h/week) | 2.5 ± 2.2 | 3 ± 2 | ns   |
| Menarche (years) | 12 ± 1.2 | 12.4 ± 1.3 | ns   |
| End Pregnancy weight gain (kg) | – | 16.3 ± 4 | – |
| Months of breastfeeding | – | 6.2 ± 2.6 | – |
| Post-partum amenorrhea (months) | – | 6.0 ± 2.4 | – |

Y: yes/ N: no; ns: non significant; BMI: body mass index
control and breastfeeding women, respectively, had scarce calcium intake (< 1 g/d).

At delivery, ionized calcium, serum phosphorus, alkaline phosphatase and tartrate-resistant alkaline phosphatase (TRAP) were increased compared to control values, whilst uCa/Creat ratio and albumin levels were decreased in breastfeeding women. At 12 months postpartum, all variables were similar to those of the control group, except Alk P values which continued to be elevated (Table 2).

Prolactin and PTHrP showed a marked increase at early postpartum and reached normal levels by the third month (Fig. 1). Estradiol levels were not significantly dif-

TABLE 2.– Biochemical parameters of bone and mineral metabolism in controls (C) and breastfeeding women (BF) at delivery, and at 6 and 12 months (mean ± SD)

<table>
<thead>
<tr>
<th></th>
<th>C</th>
<th>BF</th>
<th>BF</th>
<th>BF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n: 31</td>
<td>At delivery</td>
<td>6 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Ionized Ca (Mmol/l)</td>
<td>1.12 ± 0.07</td>
<td>1.16 ± 0.05 **</td>
<td>1.18 ± 0.03 *</td>
<td>1.13 ± 0.06 ^</td>
</tr>
<tr>
<td>P (mg/dl)</td>
<td>3.60 ± 0.81</td>
<td>3.99 ± 0.60 **</td>
<td>3.85 ± 0.61</td>
<td>3.48 ± 0.56 ^</td>
</tr>
<tr>
<td>uCa/Creat</td>
<td>0.15 ± 0.17</td>
<td>0.08 ± 0.10 **</td>
<td>0.09 ± 0.04</td>
<td>0.19 ± 0.32 ^</td>
</tr>
<tr>
<td>Alk P (UI/l)</td>
<td>96.20 ± 27.00</td>
<td>174.00 ± 60.00***</td>
<td>141.20 ± 32.01 #</td>
<td>106.11 ± 30.00 ^^</td>
</tr>
<tr>
<td>TRAP (UI/l)</td>
<td>2.98 ± 0.43</td>
<td>3.4 ± 0.70 **</td>
<td>2.58 ± 0.50 #</td>
<td>2.31 ± 0.40 ^</td>
</tr>
<tr>
<td>Alb (g/dl)</td>
<td>4.42 ± 0.18</td>
<td>4.09 ± 0.49 **</td>
<td>4.50 ± 0.21 #</td>
<td>4.43 ± 0.30 #</td>
</tr>
</tbody>
</table>

*p < 0.05 vs. C, **p < 0.01 vs. C, ***p < 0.001 vs C
^p < 0.01 vs. at delivery BF, #p < 0.001 at delivery and 6 months BF.

uCa/Creat: urinary calcium/creatinine ratio; AlkP: Alkaline phosphatase; TRAP: 6-tartrate-resistant acid phosphatase.
different between groups, even though there was a non-
significant trend to lower levels at delivery and 3 months.
IL-6 levels in women who breastfed were higher than
controls throughout the study period and declined at six
months vs initial evaluation (p < 0.01) (Fig. 2).

Mean lumbar spine BMD was reduced 5.2% in primiparous women compared to controls at initial evaluation
but these values did not reach statistical significance. No
significant differences were observed in FN and TROC
(Table 3). An increase in BMD was observed at twelve
months compared to BMD at delivery and at 6 months, in
the three sites assessed (Table 3).

Early post partum BMI of BF women, correlated posi-
tively with BMD in the FN and TROC at one year (p =
0.001 and 0.003, respectively, Fig. 3).

We did not observe any correlation between BMD
changes and months of breastfeeding (not shown).

**Discussion**

We selected women in their third and fourth decades of
life, in order to avoid the influence of physiological changes
observed during the second decade when peak bone
mass is attained and the fifth, when bone loss increases14,15.
All of them were primiparous, because it is well known
that bone mass is affected by successive pregnancies5, 6,16,17.
We should emphasize that calcium intake in both groups
was low, and this is in agreement with previous studies
from Argentina which showed that mean consumption for
this age and sex was 600 mg/day18. The population stud-
ied was adequately nourished, as expressed by BMI and
albumin levels. Serum albumin levels were lower in the
puerperium, and this was attributed to the hemodilution
observed in pregnancy. The BMI was higher in puerperal
women and was attributed to the residual excess weight
acquired during pregnancy.

There was an increase in bone remodeling, expressed
by high biochemical markers during puerperium and the
sixth months of breastfeeding, which returned to values
similar to those of non-pregnant women at 12 months.
However, Alk P levels did not return to normal levels in
the period evaluated. It is well known that bone formation
occurs after resorption and that the cycle of the remodeling

---

**TABLE 3.– Bone mineral densitometry at three skeletal sites in controls (C) and breastfeeding women (BF) during the year of postpartum (mean ± SD)**

<table>
<thead>
<tr>
<th></th>
<th>Control (C)</th>
<th>BF at delivery</th>
<th>BF 6 months</th>
<th>BF 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2-L4 (g/cm²)</td>
<td>1.211 ± 0.136</td>
<td>1.148 ± 0.142</td>
<td>1.149 ± 0.147</td>
<td>1.203 ± 0.143</td>
</tr>
<tr>
<td>FN (g/cm²)</td>
<td>0.958 ± 0.155</td>
<td>0.943 ± 0.129</td>
<td>0.943 ± 0.144</td>
<td>0.972 ± 0.141</td>
</tr>
<tr>
<td>Troc (g/cm²)</td>
<td>0.754 ± 0.123</td>
<td>0.743 ± 0.980</td>
<td>0.752 ± 0.117</td>
<td>0.780 ± 0.111</td>
</tr>
</tbody>
</table>

^ p < 0.001 vs. BF at delivery and six months
L2-L4: Lumbar L2-L4 vertebrae; FN: femoral neck; Troc: trochanter.
unit requires 3 to 4 months. Hence, bone formation persists even after 12 months post-partum. The calcium proceeding from bone deposits and renal tubular resorption is destined to milk production 15.

A hyperprolactinemic, hypoestrogenic amenorrheic state was showed at the beginning of breastfeeding. In our study, prolactin levels were highest during the first month post-partum, and returned to normal levels at the third month. At the same time, there was an initial increase in parathormone-related peptide or PTHrP, which then decreased gradually to normal levels in the 6th month. Prolactin is known to induce PTHrP production by the mammary gland, which stimulates bone remodeling, calcium transport in the mammary gland and maturation of the neonate’s gut 19. The presence of high circulating levels of PTHrP is associated with high bone resorption and low renal calcium excretion 19-21. An increase in bone remodeling, induced by the PTHrP, and/or cytokines, has been postulated 22. Hypoestrogenism also increases bone loss mediated by cytokines (TNF, IL-1, IL-6) 22-26.

We found high levels of IL-6 in serum during the first semester associated to amenorrhea. It is possible that the role of IL-6 in the stimulation of osteoclastogenesis is the link to high bone turnover found during breastfeeding 23. We postulate a biphasic mechanism of high bone turnover: PTHrP action would drive the high turnover state of early puerperium, whilst persistent hypoestrogenism and associated high cytokines levels would explain negative bone balance during the subsequent months.

BMD in the lumbar spine and trochanter decreased during breastfeeding compared to baseline, and recovered at 12 months. Our observation agrees with those of other controlled and uncontrolled studies 27-34. Trabecular bone undergoes a greater degree of bone remodeling than cortical bone. However, in our observational study the trochanter was not markedly affected compared to the lumbar region. In fact, we did not detect any significant differences with controls in the immediate post-partum period. We attribute this to the effect of mechanical load on the trochanter at the end of pregnancy.

Cortical bone was mobilized in a different manner during this period. The BMD of the femoral neck during the first month post-partum was similar to that of control women and increased significantly at the end of the breastfeeding period. Removal of cortical bone was poor and BMD in femoral neck increased 3%, this agrees with Naylor and Black AJ studies 35, 36. The periostial remodeling induced by growth factors such as IGF1 and growth hormone, secreted by the placenta explain the positive bone balance 35.

Furthermore, a direct relationship was observed between BMI at the end of pregnancy and recovery of BMD in the FN and TROC. According to current consensus the activity of the osteocytes would “sense” an increase in load, and stimulate new bone tissue formation 37, 38. Prenancy per se would have this additional effect on the proximal femur. The importance of calcium intake during breastfeeding has been evaluated in several studies 39-41.

Randomized studies do not show any additional effects of calcium supplementation during pregnancy and breastfeeding on bone remodeling or BMD, although a mild improvement during the weaning period has been described 40-42. In our study, fifty three percent of breastfeeding women had a calcium intake < 1gr and no differences were evidenced with the control group.

In the present study we have observed mobilization of calcium deposits from trabecular bone, with “restitution ad integrum” by the end of breastfeeding. The increase in BMD of the proximal femur depends on the body weight attained at the end of pregnancy. High bone turnover and urinary calcium sparing could be related to high levels of PTHrP in puerperium and increased levels of IL-6 during the later period of breastfeeding.

**Acknowledgements:** We thank María Fabiana Russo Picasso, MD, for the English translation.

**Conflict of interest:** None to declare.

**References**
