



## ALDH2 polymorphism rs671 and alcohol consumption: possible explanatory factors for race/ethnic differences in bone density

Mikiko Tokiya<sup>1</sup> · Takaomi Kobayashi<sup>2,3</sup> · Mizuho A. Kido<sup>4</sup> · Akiko Matsumoto<sup>1</sup>

Received: 19 July 2023 / Accepted: 31 August 2023 / Published online: 11 September 2023  
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Dear Editor,

We read the recently published article by Morin et al. with interest [1]. Fracture prevention in the elderly is an important concern for Japan, the world's oldest society. The authors analyzed the effect of race on bone mineral density (BMD) in Canadians. The linear regression model estimated that Black and South or Southeast Asian presented higher BMD values than White participants (model 4 in Table 4 [1]). The effect of East Asian ethnicity was less documented, yet this was the only race with inconsistent partial regression coefficients ( $\beta$ ) across the four statistical models. Despite the positive  $\beta$  estimated for model 4, negative  $\beta$  was estimated for models 1 and 2 ( $\beta = -0.020$  to  $-0.031$  and  $-0.028$  to  $-0.039$  for femoral neck BMD [FNBMD] and total hip BMD [THBMD], respectively, compared to White participants).

We expected such association, which can be justified by rs671, a genetic polymorphism of aldehyde dehydrogenase 2 (ALDH2) unique to East Asians; approximately

half the Japanese and southern Chinese population carry this variant [2, 3]. ALDH2's enzymatic activity is < 20% in heterozygous and 0% in homozygous carriers [4–7]. rs671 presents extremely strong and diverse phenotypes and is useful genetic information for personalized medicine [8–12].

Epidemiological studies have associated rs671 with an increased osteoporosis and hip fractures risk [13, 14], with supporting findings being reported in animal models. In *Aldh2* knockout mice bone metabolism in response to ethanol or mechanical stress differ from the wild-type mice [15–18]. Administration of an ALDH inhibitor also provoked bone loss in rats by inducing osteoblast apoptosis via G1 arrest, with a high degree of ALDH2 dependence in osteoblasts being a possible involved mechanism [19].

In the linear regression model 3 for BMD estimation in the report by Morin et al. [1], the effect of East Asian ethnicity disappeared ( $\beta = 0.019$  [95% CI,  $-0.003$  to  $0.041$ ] and  $0.012$  [ $-0.006$  to  $0.031$ ] for FNBMD and THBMD, respectively). The  $\beta$  was estimated slightly more positively for model 4 with additional adjustment for grip strength and physical performance score ( $\beta = 0.022$  [95% CI,  $0.000$  to  $0.045$ ] and  $0.016$  [ $-0.002$  to  $0.035$ ] for FNBMD and THBMD, respectively). Among the additional factors, body mass index and grip strength have been negatively associated with the rs671 variant [20–26]. Therefore, the negative association between BMD and East Asian ethnicity could be obscured by adjustment for such rs671-related factors.

Ethanol loading decreases bone mass [27, 28] via mechanisms such as inhibition of osteoblast differentiation and calcification [28–31]; tobacco smoking is another risk factor [32]. In the study by Morin et al. [1], current smoking and alcohol intake (> 3 servings/day) were more prevalent in White participants than in other groups (Table S1), which may explain the low BMD in White participants. East Asians consume less alcohol [6, 33, 34] due to discomfort symptoms arising after its ingestion [35]. If alcohol consumption had been included in the models, BMD might have been estimated even lower for East Asians.

✉ Mikiko Tokiya  
sx4932@cc.saga-u.ac.jp  
Takaomi Kobayashi  
takaomi\_920@yahoo.co.jp  
Mizuho A. Kido  
kido@cc.saga-u.ac.jp  
Akiko Matsumoto  
matsumoa@cc.saga-u.ac.jp

<sup>1</sup> Department of Social and Environmental Medicine, Faculty of Medicine, Saga University, 5-1-1 Nabeshima, Saga 849-8501, Japan

<sup>2</sup> Department of Preventive Medicine, Faculty of Medicine, Saga University, 5-1-1 Nabeshima, Saga 849-8501, Japan

<sup>3</sup> Department of Orthopaedic Surgery, Faculty of Medicine, Saga University, Saga 849-8501, Japan

<sup>4</sup> Department of Anatomy and Physiology, Faculty of Medicine, Saga University, 5-1-1 Nabeshima, Saga 849-8501, Japan

**Supplementary Information** The online version contains supplementary material available at <https://doi.org/10.1007/s00198-023-06909-1>.

**Acknowledgements** We would like to thank Miyuki Fuchigami for providing administrative support.

**Funding** This study was supported by a research grant 21K19652 from the Japanese Ministry of Education, Culture, Sports, Science and Technology.

## Declarations

**Conflicts of interest** None.

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