Bone density at the os calcis: reference values, reproducibility, and effects of fracture history and physical activity


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Aims: To establish reference values for bone mineral density (BMD) measured at the os calcis (OC) in healthy UK Caucasian children. Secondary objectives were to assess the reproducibility of the measurement and the effects of fracture history and habitual physical activity.

Methods: A total of 403 children aged 5–18 were studied. Main outcome measures were: BMDOC measured by peripheral DXA, total BMD measured by whole body axial scanner, age, anthropometry, pubertal status, self-reported fracture history, and physical activity (PA) expressed as a three point score.

Results: Complete data were available on 171 girls and 123 boys free of a history of fracture. BMDOC was related positively to age, body size, and total BMD, and could be predicted using a proportional model based on height alone (R²: 65% girls, 77% boys). Mean BMDOC appears to plateau in girls at 15 years and attain a value that concurs with the mean peak value in adult women. The 95% limits of agreement in repeated measures were −0.029 to 0.029 g/cm² (n = 53). Compared with sedentary children, those doing regular sports or PA for more than five hours a week had an increased BMDOC (by about 0.03 g/cm² or about 7% of the overall mean). A history of fracture (n = 81) was associated with a reduced BMDOC in boys but not in girls, though our study may have been underpowered for a subgroup analysis.

Conclusions: BMDOC can be measured easily and quickly in children older than 5 years and provides an objective measure of areal bone density for clinical and research studies using a reference range derived from its relation to height.

**METHODS**

Healthy children aged 5–18 years were recruited from schools and community advertisements in Teesside. A research nurse visited schools to discuss the study and distributed information to the children. Later, and in the presence of a parent, a detailed explanation of the study was provided and consent obtained from the parent and child. Examinations were made in the hospital. Date of birth, ethnic origin, medical history, and details of medications were collected by questionnaire.

Children were also rated on a three point physical activity (PA) score (little or no activity outside school, sports or PA at least 3 hours per week, sports regularly over 5 hours per week, for example in clubs). Height and body mass were measured and compared with UK growth reference ranges.24 Pubertal stage was determined by a trained nurse using photographs25 to assess pubic hair, genitalia stage, and breast development, and a Prader orchidometer to assess testicular volume (self-reported). Children were classified as pre-pubertal, peri-pubertal, or post-pubertal. “No signs of puberty” were taken as pre-pubertal. Tanner stage 1 was coded pre-pubertal, stages 2–4 were coded peri-pubertal, and stage 5 was considered post-pubertal. Stage 5 in boys was based on a combination of testicular size, pubic hair, and genitalia stage. When staging was not available, girls at least two years post-menarche were coded as post-pubertal (stage 5).

Peripheral bone mineral density (pDXA) at the right os calcis (BMDOC) was measured in a region of interest (ROI).
using a Lunar PIXI (peripheral instantaneous x-ray imaging) densitometer. The BMDoc was re-measured about 30 minutes later in a subgroup of 53 consecutive children to assess precision. Total bone mineral content and density were measured by a Lunar pencil beam DPX-L scanner (version 4.6) using the appropriate software depending on child size, as recommended by the manufacturer. The effective radiation dose for the whole body scan was about 0.02 mSv and was about a tenth of this for the peripheral scan.

Data were analysed using SPSS with simple linear and stepwise multiple regression analyses and analysis of covariance. In analyses of the effects of physical activity and fracture history, the data of boys and girls were expressed as a height adjusted Z-score ([observed value – present reference value]/residual standard deviation of the reference equation derived from the present study). Comparison of means was by t test or one way analysis of variance. The 5% level was accepted as indicating statistical significance.

The study was approved by the South Tees Acute Hospitals NHS Trust research ethics committee.

RESULTS
A total of 403 children were seen, but data from 28 were discarded; 24 children had pDXA or total body scans that were technically unsatisfactory, three children were non-Caucasian, and one child had a growth disorder. Hence, complete data were obtained on 375 children (218 girls and 157 boys). Of these, 47 girls (22%) and 34 boys (22%) had a history of fracture. A preliminary analysis showed that the BMDoc adjusted for body size was reduced significantly in these children compared with children with no history of fracture, so they were excluded from the analysis to derive reference equations.

Eleven per cent of girls (n = 19) and 16% of boys (n = 20) were being treated for asthma, but none were taking oral steroids or had taken oral steroids in the six months before the scan; the preliminary analysis did not reveal a difference in BMDoc related to asthma treatment.

In the repeatability study BMDoc was measured twice on 53 children. The mean and SD of the difference between measures was 0.0001 and 0.015 g/cm²; the 95% limits of agreement between repeat measures were −0.029 to +0.029 g/cm². The difference was unrelated to mean BMDoc of the two measures (Bland-Altman plot, fig 1).

Table 1 presents mean and SD for age, and anthropometry and densitometry data of the reference population. On average, the children were taller and heavier than the national reference data compiled in 1990.

The distribution of the BMDoc was parametric. BMDoc was related positively to age, height, and total BMD (table 2). When matched for height the difference in mean BMDoc between boys and girls was minimal in young children, but increased with age at and beyond puberty. The Pearson correlation coefficients of BMDoc for age, height, and total BMD were 0.78, 0.78, and 0.82 in girls, and 0.85, 0.87, and 0.88 in boys (p<0.001 in all cases). In boys and girls BMDoc was linearly related to body mass index (body mass/height²) (p<0.001), but the correlation coefficients were weaker (0.64 in girls and 0.63 in boys).

Reference values for BMDoc
Mean BMDoc appeared to plateau at about age 15 in girls, but not in boys (table 2). The variability in BMDoc increased with increasing age and height (table 2) and was

What is already known on this topic

- A measurement of BMD os calcis (BMDoc) can be used in adults for predicting fracture risk
- Lack of reference data adds to the uncertainty of how such measures should be used in paediatric practice

What this study adds

- BMDoc can be measured easily and simply by pDXA in children and has a reproducibility equivalent to that of adults
- In children aged 5–18 years BMDoc is strongly related to total BMD and can be predicted with reasonable accuracy using a proportional model based on height alone
- BMDoc in girls may peak at about age 15 years
- BMDoc is greater in those children who report higher levels of habitual physical activity

Figure 1  Bland-Altman plot of the difference between repeat measures of BMDoc in 53 children.

Figure 2  Relation of ln (BMDoc) with ln (height) in boys (closed circles, solid line) and girls (open circles, dashed line).
proportional to its absolute value. A power relation to height
\( (BMDOC = a \times \text{height}^b) \), or \( \ln(BMDOC) = \ln(a) + b \ln(\text{height}) \)
explained more variance than either a linear, logarithmic,
or quadratic model. However, the slope of the relation
between \( \ln \text{BMD} \text{OC} \) and \( \ln \text{height} \) was significantly
different between boys and girls (\( p = 0.003 \), fig 2).
Accordingly, sex specific equations were derived (table 3).
The residuals were normally distributed and were unrelated
to age (Pearson correlation coefficients not significantly
different from zero, \( p > 0.05 \)) but were weakly related to
body mass in girls (\( r = 0.16, p = 0.04 \)) and to BMI in both
sexes (girls: \( r = 0.32, p < 0.001 \); boys: \( r = 0.24, p = 0.007 \)).
However, BMI was not independent of height (\( r = 0.56 \) in
girls, \( r = 0.58 \) in boys, \( p < 0.001 \)). Figures 3 and 4 show
centile charts for BMDOC based on height alone.

**Effect of habitual physical activity level on BMD os calcis**

Data on weekly activity level were available for 287 children
without a history of fracture. The BMDOC expressed as a
height adjusted Z-score (see methods) was related positively
to the level of physical activity (PA) outside school (table 4).
The average difference between doing little or no exercise
outside school and doing sports or physical activity regularly
for >5 hours per week was equivalent to a BMDOC height
adjusted Z-score of about 0.6 units in boys and girls. This
approximated to about 0.03 g/cm\(^2\) in both sexes.

**Effect of a history of fracture on BMD os calcis**

A history of fracture was associated with a significantly
reduced BMDOC compared with that predicted in boys (mean

### Table 1 Descriptive statistics for age, anthropometry, and densitometry data by sex

<table>
<thead>
<tr>
<th>Units</th>
<th>Girls (n=171)</th>
<th>Boys (n=123)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>146.8</td>
<td>19.0</td>
</tr>
<tr>
<td>Z-score height*</td>
<td>-</td>
<td>0.36</td>
</tr>
<tr>
<td>Body mass (kg)</td>
<td>42.2</td>
<td>15.6</td>
</tr>
<tr>
<td>Z-score body mass*</td>
<td>-</td>
<td>0.30</td>
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<tr>
<td>Total BMD (g/cm(^2))</td>
<td>0.96</td>
<td>0.13</td>
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<tr>
<td>Total BMC (g)</td>
<td>1562</td>
<td>597</td>
</tr>
<tr>
<td>Total Area (cm(^2))</td>
<td>1569</td>
<td>415</td>
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<tr>
<td>BMDOC (g/cm(^2))</td>
<td>0.414</td>
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</tr>
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</table>


*Table 2 Mean and SD for height, BMD os calcis, and total BMD in children by sex and age group

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>Height (cm) Mean</th>
<th>SD</th>
<th>BMD os calcis (g/cm(^2)) Mean</th>
<th>SD</th>
<th>Total BMD (g/cm(^2)) Mean</th>
<th>SD</th>
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<td>5-6</td>
<td>8</td>
<td>113.2</td>
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<td>6-7</td>
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<td>119.3</td>
<td>3.9</td>
<td>0.287</td>
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<td>0.828</td>
<td>0.047</td>
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<tr>
<td>7-8</td>
<td>20</td>
<td>124.9</td>
<td>4.7</td>
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<td>0.842</td>
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<td>8-9</td>
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<td>0.854</td>
<td>0.034</td>
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<td>9-10</td>
<td>11</td>
<td>137.4</td>
<td>3.8</td>
<td>0.381</td>
<td>0.044</td>
<td>0.872</td>
<td>0.057</td>
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this difference in expectation may relate to the principal
density at axial sites appears to peak in the third decade, and
was not a consequence of short stature (fig 5) and amounted
95% CI
0.005) but not in girls (mean height adjusted Z-score = 0.19,
95% CI = −0.08 to 0.46, p = 0.16). The reduced BMDoc in boys
was not a consequence of short stature (fig 5) and amounted
to about 0.03 g/cm² or about 7% of the mean.

Effect of pubertal stage on BMD os calcis
An estimate of pubertal stage was possible in all the girls and
in 114 (93%) of the boys. The BMDoc expressed as a height
adjusted Z-score was unrelated to stage of puberty in either
boys (F = 0.02, p = 0.97) or girls (F = 0.6, p = 0.53).

DISCUSSION
Statement of principal findings
Bone density measured at the os calcis is easily measured in
children and has a reproducibility equivalent to that in adults
for which the standard deviation of repeated measures is
about 0.010 g/cm² (manufacturer’s literature). The procedure
takes less than a minute and is suitable for most children
aged 5 and above with no need to immobilise the child for
10–15 minutes as may be required for axial scanning.
Technical difficulties obtaining os calcis measurements were
encountered in nine children who had feet too small for the
software to locate a “region of interest”. But, in the main,
where there were problems with obtaining scan data, this
was usually with the whole body scan and arose from the
inability of some children to remain still for a prolonged
period.

The BMDoc is linearly and strongly related to total BMD
and to body size in children aged 5–18 years of age. Over this
range the BMDoc of boys continues to increase with age, but
that in girls appears to plateau at about age 15, attaining
average values of about 0.49 g/cm² that concur with those in
a local population of women in their third decade. Bone
density at axial sites appears to peak in the third decade, and
this difference in expectation may relate to the principal
compartment of the os calcis being cancellous rather than
cortical bone.

The BMDoc can be described with reasonable accuracy
using a power relation with height. Use of additional terms
such as BMI could have improved the accuracy of the
prediction equation by about 4% in girls and 2% in boys, but
in this study, BMI was not independent of height.
Furthermore, BMI may be affected clinically in nutritional
disorders, so, for these reasons, may not be considered an
appropriate reference variable suitable for all circumstances.

In boys and girls BMDoc is related positively to habitual
physical activity when expressed as a simple three point
score. BMDoc was marginally less in boys, but not in girls
with a history of fracture.

Strengths and weaknesses of the study
We are not aware of similar, published studies reporting
reference data for BMDoc in childhood. The present study
was cross-sectional and subjects were self-selected, being
recruited from the community. They were not chosen at
random from the population. Hence, the relations we
describe may not be representative of the general population
of healthy Caucasian children. A further limitation was that
pubertal status, physical activity level, and history of fracture
were self-reported. In particular, we did not ask about type of
exercise undertaken, and although we asked about fracture
site we did not collect data on the age at fracture or on its
nature (for example, low trauma). Furthermore, we acknowl-
edge that our study was not powered for determining the
effect of fracture history on the BMDoc, so the negative
finding in girls may have been attributed to a type II error
(false negative), or the positive finding in boys to a type I
error (false positive).

Whole body DXA scanning has been used in studies of
healthy children.13–15 Our findings using pDXA have shown
correlations between BMDoc and age, height, and body mass,
which are similar to those among BMD measured at axial sites.

We found a graded response in BMDOC with levels of regular physical activity. This effect was seen in boys as well as girls. A dose-response relation between physical activity measured in minutes/week and age adjusted BMD at the lumbar spine and total body has been observed in boys, but not in girls. Type of exercise and timing with respect to sexual maturation is important. Bone mass at the hip and spine can be increased by a short programme of regular daily jumping, and the effects appear to be maintained at least for the hip at 7 months post-intervention. A cross-sectional study of young female gymnasts and runners reported increased calcaneal quantitative ultrasound measurements compared with controls.

Implications for clinicians and policy makers

The portability of the pDXA scanner, speed of scan, and low radiation dose makes it an ideal instrument for use in either clinical studies or in field studies monitoring, for example, changes in bone density associated with sports activities. The present normative centile charts for BMDOC may be used by clinicians in managing patients, particularly where there is no access, or only limited access to axial scanners. The BMDOC should not be used for diagnosis, but could be used for monitoring children taking drugs with a potential effect on bone mineral accretion, such as anticonvulsants and corticosteroids. However, the evidence that the os calcis is an appropriate site for this role has yet to be established. The more likely role for pDXA would be investigation of children at risk of low bone mass, including conditions such as malabsorption syndromes.

A reduced bone density in childhood appears to be associated with an increase in fracture risk, as it is in adulthood. In practice, the incidence of fractures in childhood is low and maximal in the early teens. In osteogenesis imperfecta they may occur, depending on the particular subtype, in fetal life, early infantile life, or throughout infancy. Although criteria for the diagnosis of osteoporosis and osteopenia are well established in adults, the criteria for defining these states in children are not established, and age related Z-scores are usually employed. Measurement of total body BMD has shown that every standard deviation decline in BMD is associated with a doubling of risk of fractures in girls, a risk similar to that seen in adult women.

The relation between fracture risk and BMDOC warrants investigation. However, the main importance of defining bone mass attainment in childhood may be as a predictor of peak bone density for which studies have shown that BMD of adolescents “tracks” into adulthood. This evidence of tracking is encouraging, though the follow up of axial bone density in young children can be compromised by use of different, size related software as the child grows. This restriction does not apply to the peripheral scanner which uses one set of software for children and adults. However, prospective studies describing the longitudinal change in the BMDOC are required before recommending use of this measure as a screening tool for poor bone mineral attainment.

As a guide to use in clinical practice, we suggest that a child’s height should be assessed for biological age (if available), then the BMDOC compared to that predicted from its relation with height. A low BMDOC relative to predicted may indicate a low total BMD and need for axial scanning.

Unanswered questions and future research

The observation that girls of 15 or more appear to reach levels of BMDOC similar to those found in women aged 20–30 suggests that BMDOC may peak in the late teens. This is in keeping with one study of BMD of the total body, lumbar spine, and femoral neck, but at variance with the observation of Hadjidakis and colleagues who suggested that BMDOC in women peaked in the third decade, although they did not measure BMD in women younger than 20. If confirmed by longitudinal study, this observation could justify use of the portable equipment to screen girls in their last year at school to identify those with reduced bone density. This may be of particular value when targeted at girls with a maternal family history of bone disorders or fractures.

In summary, BMDOC can be measured simply and easily in children using a portable pDXA scanner. Normative data have been established based on height. The reference charts can be used in clinical practice, in screening for reduced bone density in childhood, and in further research. The equipment has particular merit for use in field studies.

ACKNOWLEDGEMENTS

We thank the children and parents for their time, the local Teeside Osteoporosis Group for some funding, and Dr AH Al-Shirawi for help with data collection.

Table 4 Habitual physical activity and BMD os calcis by sex

<table>
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<tr>
<th>Activity</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>BMD os calcis (Z-scores)</td>
</tr>
<tr>
<td>Little or no activity outside school</td>
<td>22</td>
<td>-0.42 (–0.83 to –0.02)</td>
</tr>
<tr>
<td>Sports or PA at least 3 hours per week</td>
<td>39</td>
<td>0.19 (–0.13 to 0.52)</td>
</tr>
<tr>
<td>Sports regularly, &gt;5 hours per week</td>
<td>57</td>
<td>0.19 (–0.08 to 0.45)</td>
</tr>
<tr>
<td>F statistic (p)</td>
<td>3.4 (0.036)</td>
<td></td>
</tr>
</tbody>
</table>

Results expressed as mean (95% CI).

Figure 5 Z-score BMD os calcis in boys with (closed circles) and without (open circles) a history of fracture plotted against height expressed as a Z-score using UK reference data.

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REFERENCES

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