Minerals and Bone Mineral Density in Inflammatory Bowel Diseases

Calcium (Ca) is responsible for proper inflammatory bowel diseases (BMD), blood coagulation, and the proper functioning of the cardiovascular system. In the human body, more than 99% of Ca is stored in bones. Therefore, a decreased serum calcium level leads to its release from bones and causes bone tissue resorption. Furthermore, an insufficient calcium intake causes hormonal disorders, leading to a higher risk of fractures. Calcium can be found in such sources as milk, dairy products, and green leafy vegetables. Additionally, the human body contains about 700 g of phosphorus (P), which is mainly stored in bones (80–90%). Hence, both its excessive and inadequate intake can develop osteoporosis. Phosphorus deficiency, or its insufficient supply to calcium supply ratio, causes bone resorption and inhibits bone mineralization and bone formation. On the other hand, an oversupply of P, particularly with insufficient Ca intake, results in excessive parathormone excretion and the loss of bone mass.

The insufficient intake of calcium was estimated in 80–86% of IBD patients, who avoid milk and dairy products due to lactose intolerance. Patients with IBD have lower calcium and phosphate levels in comparison with healthy individuals.

Another cause of calcium malabsorption is the use of steroids as well as the occurrence of diarrhoea. The supplementation of calcium in a 1000–1500 mg/day dose is recommended for most patients with inflammatory bowel diseases. Furthermore, patients treated with steroids require calcium and vitamin D supplementation. Calcium intake was correlated negatively with the femoral neck BMD but not with the lumbar spine BMD in IBD patients. Premenopausal women suffering from IBD consumed insufficient amounts of calcium and vitamin D, and their intake of Ca and vitamin D was correlated. Moreover, a low calcium serum level was observed in patients more frequently than in the control group, although it was insignificant. Additionally, the Ca serum level was negatively correlated with steroids.
vitamin D) did not alter the risk of femoral neck fractures in both sexes [8]. The study revealed that an increased intake of calcium by every 300 mg decreased the risk of fractures, although it was nonlinear. The highest risk was found in the intake below 751 mg of calcium. The fracture risk was unchanged in the intakes of more than 1137 mg and 882–996 mg of calcium [9]. Gutiérrez et al. demonstrated that a one-week diet rich in phosphorus (1677 ± 167 mg/day) increased Fibroblast Growth Factor 23 (FGF23), osteocalcin, and osteopontin levels. The aforementioned results suggest that a phosphorus-rich diet negatively affects health [10], and that women over 45 years of age, both with and without osteoporosis, consume similar amounts of calcium. Thus, Ca intake was not associated with the incidence of fractures [11].

### Magnesium

Magnesium (Mg) is absorbed in the small intestine, and its absorption ranges from 30% to 80%. Bones store about 60% of the total body magnesium. The main sources of Mg are legumes, seeds, nuts, almonds, spinach, and buckwheat. Not only is this element responsible for the stability and permeability of cell membranes but it also maintains the DNA double helix integrity and regulates the activity of about 300 enzymes [12]. On the other hand, magnesium deficiency causes decreased osteoblast and osteoclast activity, resulting in bone metabolism disorders [13]. Chronic hypomagnesemia leads to the disturbance of parathyroid hormone production, leading to hypocalcaemia [14].

Patients with UC and CD consumed a lower amount of Mg than healthy adults. CD patients consumed 60–63% of the daily magnesium requirement [15][16]. Magnesium intake correlated with BMD, with a stronger correlation found in men than in women [13]. Postmenopausal women who consumed 422.5 mg and more of Mg per day presented a higher hip and total body BMD by 3% and 2%, respectively, than the individuals supplying <206.5 mg Mg/day. No association was observed between magnesium intake and the risk of fractures. On the other hand, a high magnesium dose was associated with a higher risk of forearm and wrist fractures in comparison with a low Mg intake. The authors paid attention to the subjects with a high supply of magnesium, since they reported much physical activity, which increases the frequency of falls [17]. The supplementation of magnesium (106 mg) and calcium (1200 mg) for 4 weeks in postmenopausal women did not change the serum parathyroid hormone level both in the study and the control group. However, the supplementation increased the serum CTX (C-terminal telopeptide) level—i.e., a bone resorption marker [18]. A conducted meta-analysis indicated that a high magnesium intake was not associated with a lower risk of hip fractures. On the other hand, magnesium dose was connected with the hip and femoral neck BMD, although no association was found with the lumbar spine BMD [19].

### Sodium (Na)

The absorption of water and electrolytes, including sodium (Na), takes place in the colon. The lymphatic function of the large intestine can be impaired in the course of the mucosal inflammation [20].

In spite of the fact that the human body contains as much as 105 g of sodium, the intake of Na in the population is still too high, with some people consuming 9–12 g salt per day, which results in numerous disorders and also affects bones [21]. Na is known to improve taste and preserve products [22]; it is usually found in salt (40% of mass), meat and its preparations, grains, milk, and dairy products. This element constitutes the main extracellular cation excreted in urine and sweat. Moreover, sodium is responsible for the maintenance of the acid-base balance, cell work, and the transmission of nerve impulses. Although a normal sodium Na⁺ level is 135–145 mmol, both too high and too low Na concentration levels constitute a threat to health and life. In fact, hypernatremia causes weakness, headache, vomiting, loss of appetite, weak nerve reflexes, and cardiac disorders. On the other hand, hyponatremia induces neuromuscular excitability, confusion, and cardiac arrest.

Patients with UC in remission consumed non-significantly lower sodium amounts than healthy individuals [23]. The sodium intake was lower in malnourished subjects than in properly nourished patients [24].

---

Encyclopedia 2020 doi: 10.32545/encyclopedia202006.0012.v1
The Korea National Health and Nutrition Examination Survey indicated that osteoporosis was observed more frequently in postmenopausal women consuming ≥ 4001 mg of salt per day than in those consuming ≤ 2000 mg/day. A salt intake of ≥ 5001 mg was associated with a higher risk of osteoporosis in the femoral neck compared to the consumption of ≤ 2000 mg/day [25]. A sodium-rich diet (11.2 g of salt per day) increased calcium excretion in urine and changed the serum NTX (N-terminal telopeptide) level in comparison with a low salt intake (3.9 g). However, there was no significant change in the concentration of Pyr (pyridoxine) and Dpyr (deoxypyridoline) [26]. A meta-analysis demonstrated that a high intake of Na is a factor associated with a higher risk of osteoporosis. There was no significant correlation between the amount of calcium excretion in urine and bone mineral density [27].

A low sodium diet (2 g salt/day) for 6 months decreased calcium excretion with urine in patients who consumed 3.4 g or more salt per day and reduced the concentration of P1NP (propeptide of type 1 collagen). There was no significant change in the serum NTX level.

On the other hand, a low-sodium diet (2 g salt/day) of 6-month duration in persons consuming 3.4 g or more salt per day increased the amount of excreted calcium and the serum P1NP level. The authors did not observe any changes in the serum NTX level [28].

References

5. Iwona Krela-Kaźmierczak; Aleksandra Szymczak; Maciej Tomczak; Liliana Lykowska-Szuber; Krzysztof Linie; Piotr Eder; Calcium and phosphate metabolism in patients with inflammatory bowel diseases.. Polish Archives of Internal Medicine 2015, 125, 588-590, 10.20452/pamw.2981.
9. Eva Warenjsö; Liisa Byberg; Håkan Melhus; Rolf Gedeborg; Hans Mallmin; Alicja Wolk; Karl Michaëllson; Dietary calcium intake and fracture of osteoporosis: prospective longitudinal cohort study. BMJ 2011, 342, d1473-d1473, 10.1136/bmj.d1473.
10. Orlando M. Gutiérrez; Alexandra Luzuriaga-McPherson; Yiming Lin; Linda C. Gilbert; Shin-Woo Ha; George R. Beck; Impact of Phosphorus-Based Food Additives on Bone and Mineral Metabolism.. The Journal of Clinical Endocrinology & Metabolism 2015, 100, 4264-71, 10.1210/jc.2015-2279.
11. Patrice Fardeleine; François-Emery Cotté; Christian Roux; E. Lespessailles; Florence Mercier; Anne-Françoise Gaudin; Calcium intake and the risk of osteoporosis and fractures in French women. Joint Bone Spine 2010, 77, 154-158, 10.1016/j.jbspin.2009.08.007.
13. Ailsa Welch; Jane Skinner; Mary Hickson; Dietary Magnesium May Be Protective for Aging of Bone and Skeletal Muscle in Middle and Younger Older Age Men and Women: Cross-Sectional Findings from the UK Biobank Cohort. Nutrients 2017, 9, 1189, 10.3390/nu9111189.
14. Masahiro Yamamoto; Toru Yamaguchi; Mika Yamauchi; Shozo Yano; T. Sugimoto; Acute-onset hypomagnesemia-

15. Azita Hekmatdoost; Farhad Vahid; Samaneh Rashvand; Mahya Sadeghi; The association between index of nutritional quality and ulcerative colitis: A case-control study. *Journal of Research in Medical Sciences* 2018, 23, 67, 10.4103/jrms.JRMS_555_17.

16. Lorain Taylor; Abdulelah Almutairdi; Nusrat Shoomu; Richard Fedorak; Subrata Ghosh; Raylene A. Reimer; Remo Panaccione; Maitreyi Raman; Cross-Sectional Analysis of Overall Dietary Intake and Mediterranean Dietary Pattern in Patients with Crohn's Disease. *Nutrients* 2018, 10, 1761, 10.3390/nu10111761.

17. Tonya S Orchard; Joseph C Larson; Nora Alghothani; Sharon Bout-Tabaku; Jane A Cauley; Zhao Chen; Andrea Z Lacroix; Jean Wactawski-Wende; Rebecca D. Jackson; The association between index of nutritional quality and ulcerative colitis: A case–control study. *Journal of Research in Medical Sciences* 2018, 23, 67, 10.4103/jrms.JRMS_555_17.


21. Salt Reduction . WHO. Retrieved 2020-6-12

22. Kamila Fijorek; Mirosława Püsküllüoğlu; Dorota Tomaszewska; Roman Tomaszewski; Anna Glinka; Sebastian Polak; Serum potassium, sodium and calcium levels in healthy individuals - literature review and data analysis. *Folia medica Cracoviensia* 2014, 54, 53-70.

23. Dominika Głabska; Dominika Guzek; Gustaw Lech; Lech; Analysis of the Nutrients and Food Products Intake of Polish Males with Ulcerative Colitis in Remission. *Nutrients* 2019, 11, 2333, 10.3390/nu11102333.

24. Hee-Sook Lim; Hwa Jong Kim; Su Jin Hong; Soonkyung Kim; Nutrient Intake and Bone Mineral Density by Nutritional Status in Patients with Inflammatory Bowel Disease. *Journal of Bone Metabolism* 2014, 21, 195-203, 10.11005/jbm.2014.21.3.195.


**Keywords**

sodium, dietary; magnesium; calcium; phosphates; bone mineral density; osteoporosis; inflammatory bowel diseases

© 2020 by the author(s). Distribute under a Creative Commans CC BY license