Osteoarthrosis of the knee in men and women in association with overweight, smoking, and hormone therapy

Hélène Sandmark, Christer Hogstedt, Stefan Lewold, Eva Vingård

Abstract

Objectives—The aim was to examine the relation between osteoarthrosis of the knee leading to prosthetic surgery among men and women of ages 55–70 at the time of surgery. They were identified through the Swedish Knee Arthroplasty Register, which is a national register system of knee arthroplasties performed at orthopaedic units in Swedish hospitals. The register is annually updated by reports from the units. We confirmed the status of primary osteoarthrosis in an interview and in a postal questionnaire, and through checking the radiographic records from a random sample of the cases.

During the study period there were 72 units in Sweden where knee prosthetic replacement during 1991–93 because of clinically significant primary tibiofemoral osteoarthrosis. We included cases who were of ages 55–70 at the time of the sugery. They were identified through the Swedish Knee Arthroplasty Register, which is a national register system of knee arthroplasties performed at orthopaedic units in Swedish hospitals. The register is annually updated by reports from the units. We confirmed the status of primary osteoarthrosis in an interview and in a postal questionnaire, and through checking the radiographic records from a random sample of the cases.

The referents were men and women of the study base, randomly selected from the central population register in Sweden.

The referents were excluded if they reported osteoarthrosis of the knee or had experienced severe pain or dysfunction in the knees. Of

Smoking has in certain studies shown a negative association with knee osteoarthrosis, and in others no association. There are some clinical, laboratory, and epidemiological studies suggesting that there is a relation between sex hormones and the development of osteoarthrosis. However, some epidemiological investigations have concluded that oestrogen use is not associated with knee osteoarthrosis.

The aim of this study was to examine the relation between osteoarthrosis of the knee leading to prosthetic surgery among men and women, and overweight, smoking, and hormone therapy.

Methods

STUDY POPULATION AND DESIGN

The study base comprised all men and women born 1921 to 1938, and living in 14 counties in Sweden during 1991–95. The relation between constitutional and lifestyle factors and the development of severe knee osteoarthrosis in men and women was studied using the case-referent method in the study base.

The cases had undergone prosthetic knee replacement during 1991–93 because of clinically significant primary tibiofemoral osteoarthrosis. We included cases who were of ages 55–70 at the time of surgery. They were identified through the Swedish Knee Arthroplasty Register, which is a national register system of knee arthroplasties performed at orthopaedic units in Swedish hospitals. The register is annually updated by reports from the units. We confirmed the status of primary osteoarthrosis in an interview and in a postal questionnaire, and through checking the radiographic records from a random sample of the cases.

The referents were men and women of the study base, randomly selected from the central population register in Sweden.

The referents were excluded if they reported osteoarthrosis of the knee or had experienced severe pain or dysfunction in the knees. Of
course we cannot conclude they did not have symptomless radiographic knee osteoarthritis, but the aim of this study was to focus on severe, clinically significant knee osteoarthritis, with symptoms that required knee prosthetic surgery.

Both cases and controls were excluded if they reported earlier trauma or surgery to the knee or the surrounding tissues, rheumatoid arthritis or systemic disease involving the joints such as poliomyelitis or rachitis or had any musculoskeletal malformation.

In all 369 male cases and 380 female cases were invited to the study. The participation rate was 88% and 79%, respectively. The numbers among the referents were 330 male and 370 female contacted and 80% and 77%, respectively participated in the whole study (table 1).

### Table 1 Participation in the study

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Referents</th>
<th>Cases</th>
<th>Referents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invited subjects</td>
<td>369</td>
<td>330</td>
<td>380</td>
<td>370</td>
</tr>
<tr>
<td>Only telephone interview</td>
<td>33</td>
<td>40</td>
<td>58</td>
<td>25</td>
</tr>
<tr>
<td>Refusals</td>
<td>8</td>
<td>20</td>
<td>10</td>
<td>51</td>
</tr>
<tr>
<td>Too ill to answer questions</td>
<td>3</td>
<td>6</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Participation in the whole study</td>
<td>325 (88%)</td>
<td>264 (80%)</td>
<td>300 (79%)</td>
<td>284 (77%)</td>
</tr>
</tbody>
</table>

### Table 2 Relative risks (95% CI) for men and women at different ages, with medium and high BMI compared with those with low BMI, to develop knee osteoarthrosis. The relative risks are controlled for potential confounding from age, smoking, physical load, sports and hormone substitution

<table>
<thead>
<tr>
<th></th>
<th>30 years*</th>
<th>40 years†</th>
<th>50 years‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medium exposure</td>
<td>2.0 (CI 1.2, 3.2)</td>
<td>2.2 (CI 1.4, 3.7)</td>
<td>3.4 (CI 1.8, 6.3)</td>
</tr>
<tr>
<td>% exposed cases</td>
<td>35</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>high exposure</td>
<td>3.9 (CI 2.4, 6.3)</td>
<td>3.9 (CI 2.3, 6.4)</td>
<td>5.9 (CI 3.1, 11.1)</td>
</tr>
<tr>
<td>% exposed cases</td>
<td>46</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medium exposure</td>
<td>1.9 (CI 1.1, 3.1)</td>
<td>3.0 (CI 1.7, 5.3)</td>
<td>2.8 (CI 1.7, 4.8)</td>
</tr>
<tr>
<td>% exposed cases</td>
<td>28</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>high exposure</td>
<td>5.8 (CI 3.5, 9.7)</td>
<td>9.2 (CI 5.3, 16.0)</td>
<td>7.8 (CI 4.6, 13.3)</td>
</tr>
<tr>
<td>% exposed cases</td>
<td>51</td>
<td>57</td>
<td>54</td>
</tr>
</tbody>
</table>

*BMI men low –21, medium 22–23, high 24–; women low –22, medium 23–25, high 26–.
†BMI men low –22, medium 23–24, high 25–; women low –23, medium 24–25, high 26–.
‡BMI men low –23, medium 24–25, high 26–; women low –24, medium 23–25, high 26–.

EXPOSURE CLASSIFICATION

Body mass index (BMI), an indicator of overweight, was calculated as weight (kg) divided by height (m$^2$). The referent's BMI was the basis for the classification of BMI in three groups. The 25% lowest values were considered as low, and the 25% highest values as high BMI. The 50% in between were the medium BMI values. This classification was made at 30, 40, and 50 years of age. The limits for low, medium, and high BMI, respectively, varied over time because the subject average weight increased, and there were differences between men and women (table 2).

Cigarette smoking habits were calculated as pack years. One pack year is the equivalent to 20 cigarettes/day during one year. The subjects were divided into three groups: never smokers, light smokers, and smokers. Light smokers were those with 1–14 pack years and smokers those with 215 pack years.

Women who had used oestrogen for one year or more after 50, were considered exposed, and the relative risk was estimated in relation to women who had never had oestrogen therapy. The total time of oestrogen use after 50 was included in the analysis, that is for the cases that medication both before and after the surgery could be included. We did not analyse the use of oestrogen before the age of 50 because there were only 14 women who had had oestrogen substitution at an earlier age. They were excluded, however, from the 50+ analysis.

The use of oral contraceptives was divided into an exposed group where the subjects had taken pills for one year or more and an unexposed group where the subjects had taken pills less than one year or not at all.

### STATISTICAL ANALYSIS

The rate ratios for high and medium exposure compared with low or non-exposure were calculated for body mass, cigarette smoking, oestrogen therapy, and use of contraceptive pills.

The rate ratios were interpreted as estimates of the incidence rate ratios because the design was that of a population-based case-referent study. The effect on the rate ratios from potential confounding factors was considered by stratified analysis and calculating the rate ratios according to the Mantel-Haenszel method.

When body mass, cigarette smoking, and hormone therapy were analysed, each variable studied was controlled for confounding from the other two. Control of potential confounding from exposure to physical load and sports up to 50 years of age was also performed. The physical work load was classified in non/low, medium or high exposure according to the exposure in the referent group. For men, total hours in any sports were aggregated and divided in three classes, and for women it was dichotomised into ever or never being active in sports activities. However, no confounding was found.

The results of the impact on knee osteoarthrosis from physical load from occupation, housework, leisure time activities and sports are extensive, and will be reported later.
of knee osteoarthrosis does not seem to be influenced by the use of oral contraceptives for one year or more.

Discussion

The study strengthens the association between overweight at different ages and an increased risk of knee osteoarthrosis in men and women. The results demonstrate an exposure relation and the most overweight subjects had the highest risks. The relative risk is most pronounced for overweight women at the ages of 40 and 50. For women who had oestrogen therapy after the age of 50, we found an increased relative risk compared with those without such substitution. There was a negative association between cigarette smoking and severe knee osteoarthrosis in both men and women.

We shall discuss some methodological considerations and the consistency of the findings with other studies.

**Potential Misclassification, Selection Bias, and Confounding**

Potential selection for surgery could appear if subjects with other diseases, including extreme obesity, or diseases connected with heavy smoking hindered them from having surgery. Such bias would decrease the relative risk.

We analysed reported physical activity up to 50 years of age, before the onset of symptoms. Cases who had symptoms before the age of 50 were excluded from the study, which means that the included case’s overweight was not caused by a more sedentary level of activity because of knee pain.

It has been shown that people with a high body weight tend to underestimate, and lightweight people to overestimate, self-reported weight. This could lead to less pronounced differences in the reported weight compared with the real weight, and a relative risk closer to unity.

Cases and referents would probably not remember smoking, oestrogen therapy or oral contraceptives differently, as these factors do not seem to be closely associated with the disease studied.

As there are few years between the post-menopausal oestrogen therapy (ORT) and the time of prosthetic surgery for these women there is reason to question the association between oestrogen replacement and knee osteoarthrosis that we found. We investigated subjects with severe osteoarthrosis and they could possibly, as a result of contact with physicians because of their symptomatic knee osteoarthrosis, to a greater extent also be provided with ORT compared with the referents. Also, as ORT prescribed in Sweden includes a gestagen component, we cannot exclude a possible effect from this.

**Comparisons with Other Studies**

The stress and amount of force on the weight bearing joints are increased in overweight subjects. This additional physical load could cause cartilage breakdown leading to osteoarthrosis. It has also been proposed that overweight
persons have a higher bone density, which could be a risk factor.

In this study the association between overweight and severe knee osteoarthrosis was stronger in women than in men, in agreement with the Framingham study as well as studies of Cooper and coworkers and Manninen and coworkers. The sex difference indicates that other factors associated with an increased BMI but solely mechanically might affect the development of knee osteoarthrosis. In fact some studies have shown that obesity is associated with osteoarthrosis in non-weight bearing joints such as the small joints of the hand, which might indicate metabolic effects of overweight involved in the arthrotic process. However, Davies and coworkers and the Baltimore Longitudinal study did not find any association between metabolic factors such as serum cholesterol, blood pressure or diabetes, and the development of knee osteoarthrosis.

Our study showed an increased relative risk among those women who had had postmenopausal ORT. Other investigations of ORT and the development of knee osteoarthrosis have shown inconsistent results. There are four studies indicating a possible inverse relation between oestrogen intake and knee osteoarthrosis, but in all four studies the confidence intervals include unity. Spectator and coworkers recently published results from the Chingford Study where it was found that current use of oestrogen has a protective effect on knee OA. This study of Olivia and Felson a tendency of a possible inverse relation was found for past use, but new or current use in women over the age of 55 was not associated with knee osteoarthrosis. In a study of hip osteoarthrosis and the relation to oestrogen therapy by Vingård et al, a moderate protective effect was found. This study had a similar design as the present investigation, but in the analysis also oestrogen medication before 50 was considered.

As knee osteoarthrosis in women increases considerably around the menopause there is reason to believe that the decrease in endogenous oestrogen possibly could effect the disease. The effect in women from ORT on the development of osteoarthrosis is in all probability dependent on the reason why ORT is prescribed and what group of women investigated. This might explain the inconsistency in different studies of ORT and the effect on osteoarthrosis. Oestrogen replacement has an effect on bone metabolism, which results in a higher bone mass and a reduction of bone loss after the menopause. Higher bone mass because of oestrogen therapy can cause increased mechanical stress on cartilage during joint loading, which might be connected with the development of osteoarthrosis. Animal studies and laboratory trials have indicated an association between oestrogen and osteoarthrosis, although the results are inconclusive and need to be further investigated.

We found that smokers had a lower risk of severe knee osteoarthrosis compared with non-smokers, which is in agreement with some other studies. As in the Framingham study the association showed a dose response relation, and smokers were more protected than light smokers. In the cross sectional Chingford study a protective effect of smoking for radiological osteoarthrosis in the hand and knee could not be seen, but for subjects with generalised osteoarthrosis a possible inverse association was found. In the NHANES survey the rate ratios for smoking demonstrated a protective effect in men and women, and heavy smokers were more protected than light smokers.

The mechanism of a negative association between smoking and severe osteoarthrosis in the knee could either be explained by a physiological effect of smoking, or by not controlling for unidentified confounding factors. We had, however, controlled for physical work load, sports and BMI in our study. Smoking could of course not be recommended for prevention of knee osteoarthrosis, as other, harmful effects are overwhelming, but the aetiology of the potential association would be worth studying in the search for mechanisms of osteoarthrosis.

The results of this study confirm the association between overweight and knee osteoarthrosis for both men and women, with the strongest relation for women. Furthermore postmenopausal osteoarthrosis in women after the age of 50 increased the relative risk, while smoking decreased it in both men and women. Avoiding overweight could be an efficient preventive measure, while the potential effect of metabolic syndromes or factors and hormones needs to be studied further before discussing preventive measurements.

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