Role of Trabecular Microarchitecture and Its Heterogeneity Parameters in the Mechanical Behavior of Ex Vivo Human L3 Vertebrae

Julien Wegrzyn, Jean-Paul Roux, Monique E Arlot, Stéphanie Boutroy, Nicolas Vilayphioiu, Olivier Guyen, Pierre D Delmas, Roland Chapurlat, and Mary L Bouxsein

1INSERM Research Unit 831, Université de Lyon, Lyon, France
2Department of Orthopedic Surgery, Pavillon T, Hôpital Edouard Herriot, Lyon, France
3Orthopedic Biomechanics Laboratory, Beth Israel Deaconess Medical Center and Harvard Medical School, Boston, MA, USA

ABSTRACT
Low bone mineral density (BMD) is a strong risk factor for vertebral fracture risk in osteoporosis. However, many fractures occur in people with moderately decreased or normal BMD. Our aim was to assess the contributions of trabecular microarchitecture and its heterogeneity to the mechanical behavior of human lumbar vertebrae. Twenty-one human L3 vertebrae were analyzed for BMD by dual-energy X-ray absorptiometry (DXA) and microarchitecture by high-resolution peripheral quantitative computed tomography (HR-pQCT) and then tested in axial compression. Microarchitecture heterogeneity was assessed using two vertically oriented virtual biopsies—one anterior (Ant) and one posterior (Post)—each divided into three zones (superior, middle, and inferior) and using the whole vertebral trabecular volume for the intraindividual distribution of trabecular separation (Tb.Sp/C3 SD). Heterogeneity parameters were defined as (1) ratios of anterior to posterior microarchitectural parameters and (2) the coefficient of variation of microarchitectural parameters from the superior, middle, and inferior zones. BMD alone explained up to 44% of the variability in vertebral mechanical behavior, bone volume fraction (BV/TV) up to 53%, and trabecular architecture up to 66%. Importantly, bone mass (BMD or BV/TV) in combination with microarchitecture and its heterogeneity improved the prediction of vertebral mechanical behavior, together explaining up to 86% of the variability in vertebral failure load. In conclusion, our data indicate that regional variation of microarchitecture assessment expressed by heterogeneity parameters may enhance prediction of vertebral fracture risk. © 2010 American Society for Bone and Mineral Research.

KEY WORDS: OSTEOPOROSIS; VERTEBRA; BONE BIOMECHANICS; TRABECULAR MICROARCHITECTURE; HETEROGENEITY

Introduction
The risk of osteoporotic fracture is greater at skeletal sites where trabecular bone is predominant (ie, femoral neck, vertebrae, and distal radius). Current diagnostic methods for osteoporosis focus on measurement of bone mineral density (BMD) using dual-energy X-ray absorptiometry (DXA). Although low BMD is among the strongest predictors of fracture risk, it is only one aspect of bone strength, and its predictive value is correspondingly limited because many fractures occur in people with normal BMD. Similarly, in patients receiving antiresorptive treatment, the 5% to 8% improvement in spine BMD does not fully explain the observed 50% to 60% decrease in vertebral fracture incidence. These observations highlight the limitations of BMD as a predictor of fracture risk and the need to also consider other parameters, such as microarchitecture, to improve assessment of skeletal fragility.

Previous in vitro studies have demonstrated that the addition of trabecular microarchitecture to BMD improves the prediction of both trabecular bone mechanical behavior and vertebral strength. Moreover, using either histomorphometric methods or peripheral quantitative computed tomography (pQCT) or high-resolution peripheral quantitative computed tomography (HR-pQCT), previous studies have assessed the spatial variation of trabecular microarchitecture in vertebral bodies and shown that the structurally weak regions are located in the superior and anterior regions of the vertebral body. Correlations between vertebral strength and trabecular microarchitecture parameters

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Address correspondence to: Julien Wegrzyn, Department of Orthopedic Surgery, Pavillon T, Hôpital E Herriot, 5 place d’Arsonval, 69437 Lyon, France.
E-mail: julien.wegrzyn@chu-lyon.fr
*J Wegrzyn and J-P Roux contributed equally to this work.
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vary among vertebral regions, suggesting that it may be helpful to account for regional variations in trabecular microarchitecture when predicting vertebral fragility. However, despite the potential of trabecular microarchitecture heterogeneity measurements to improve fracture risk assessment, there is limited information about reliable measures of trabecular bone heterogeneity and their clinical utility. Several clinical studies have shown that assessment of the intraindividual distribution of trabecular separation (Tb.Sp SD) at the peripheral skeletal sites by HR-pQCT or MRI is useful for discrimination of previously fractured versus nonfractured controls but alternate parameters of heterogeneity have not been studied, nor have measurements of Tb.Sp SD been performed directly on whole vertebrae.

Thus the aim of this study was to assess the contribution of trabecular microarchitecture and its regional variation assessment expressed by heterogeneity parameters to the mechanical behavior of human lumbar vertebrae.

Materials and Methods

Bone specimens

Lumbar vertebrae (L3) were harvested fresh from 21 lumbar spines of human donors, including 11 men and 10 women, aged 54 to 93 years of age (75 ± 10 years for men and 76 ± 10 years for women). The absence of prevalent fractures or significant bone diseases (ie, bone metastasis, Paget disease, or major osteoarthritis) involving the lumbar spine was confirmed by high-resolution lateral radiographs of the lumbar spine (Faxitron X-Ray Corporation, Lincolnshire, IL, USA). Lumbar osteoarthritis (OA) was evaluated on lateral radiographs according to the Kellgren-Lawrence (K-L) grading scale. Severity of OA was assessed according to the presence of osteophytes and disk narrowing using a four-point scale: normal, minimal, moderate, or severe. Vertebrae with severe OA (grade 4) were excluded. Of those included in the study, 11 (52%), 8 (38%), and 2 (10%) were graded normal, minimal, and moderate OA, respectively.

Areal bone mineral density (aBMD, g/cm²) of the vertebral body was measured using DXA (Delphi W, Hologic, Waltham, MA, USA). Bone specimens were maintained frozen at −20°C wrapped in saline-soaked gauze until mechanical testing.

Trabecular microarchitecture and its heterogeneity assessment

Image acquisition of the whole frozen vertebral body was performed using HR-pQCT (XtremeCT, Scanco Medical, Basserdorf, Switzerland). A nominal isotropic voxel size of 82 μm was used (1536 × 1536 pixels; X-ray source: 60 kV, 900 μA). CT slices were perpendicular to the vertebral superoinferior axis. The trabecular region of interest was defined manually in order to exclude cortical component of the vertebral body (Fig. 1). Bone was segmented using a fixed threshold (175 mg of hydroxyapatite/cm³), and 3D trabecular microarchitectural parameters on the whole vertebral body were assessed with software developed for ex vivo analysis (Scanco Medical; bone volume fraction (BV/TV, %), trabecular thickness (Tb.Th, μm), trabecular separation (Tb.Sp, μm), trabecular number (Tb.N, number/mm), degree of anisotropy (DA, number), and structural model index (SMI, number). BV/TV measurement was based on counting voxels. Microarchitecture measurements, which were computed using direct methods (ie, distance-transformation algorithms that do not rely on assumptions about the underlying structure), were designated with an asterisk (eg, Tb.Th*, Tb.Sp*, and Tb.N*). DA is defined as the ratio of minimal eigenvalue to maximal eigenvalue and corresponds to a measure of preferential alignment of the trabeculae along a directional axis (1 = isotropic; >1 = anisotropic). SMI is calculated by means of 3D image analysis based on a differential analysis of the triangulated bone surface and reflects the rodlike versus platelike nature of the structure. For ideal plate and rod structures, the SMI values are 0 and 3, respectively.

To assess the heterogeneity of vertebral trabecular microarchitecture, microarchitecture parameters were computed for two 8.2-mm-diameter vertically oriented virtual biopsies—one located in the anterior and one in the posterior region, both located along the midline. To position these virtual cores, two lines were defined on the vertebral body—one line for the middle anteroposterior axis and one line for the middle mediolateral axis. Each line divided the vertebral body into four quadrants. Biopsies were strictly centered on the middle anteroposterior axis and on both sides of the mediolateral axis to avoid the cortical shell anteriorly and the venous plexus posteriorly by projection in the vertical direction in the HR-pQCT slice stack.

Fig. 1. HR-pQCT slice of L3 vertebra. Trabecular region of interest (ROI) was defined manually in order to exclude cortical component of the vertebral body. Virtual biopsies were positioned using two lines drawn on the vertebral body, one line for the middle anteroposterior axis and one line for the middle mediolateral axis. Each line divided the vertebral body into four quadrants. Biopsies were strictly centered on the middle anteroposterior axis and on both sides of the mediolateral axis to avoid the cortical shell anteriorly and the venous plexus posteriorly by projection in the vertical direction in the HR-pQCT slice stack.
trabecular microarchitectural parameters (posterior parameter divided by the anterior one: $\text{BV/TV}_{\text{ratio}}$, $\text{SMI}_{\text{ratio}}$, $\text{Tb.Sp}_{\text{ratio}}$, $\text{Tb.Th}_{\text{ratio}}$, $\text{Tb.N}_{\text{ratio}}$, and $\text{DA}_{\text{ratio}}$), (2) **vertical heterogeneity**, the coefficient of variation (standard deviation/mean) of the vertical three zones’ trabecular microarchitectural parameters ($\text{BV/TV}_{\text{CV}}$, $\text{SMI}_{\text{CV}}$, $\text{Tb.Sp}_{\text{CV}}$, $\text{Tb.Th}_{\text{CV}}$, $\text{Tb.N}_{\text{CV}}$, and $\text{DA}_{\text{CV}}$), and (3) **global heterogeneity**, the standard deviation of $\text{Tb.Sp}^*$ on the entire vertebral trabecular volume ($\text{Tb.Sp}^*$SD), reflecting the heterogeneity of the trabecular network.\(^{(13)}\)

**Mechanical testing**

Soft tissues and posterior arches were removed. Then the vertebral bodies were thawed and maintained moist at 4°C with Ashman’s solution until mechanical testing.\(^{(19,20)}\)

Before testing, a polyester resin interface (Soloplast V11, Vosschemie, Saint-Egre`ve, France) with a quick-setting polymer at low temperature (exothermic peak of resin polymerization ≤40°C) was applied to each endplate of the vertebral body to achieve parallel surfaces for load application. Then quasi-static uniaxial compressive testing was performed on the whole vertebral body submerged in Ashman’s solution at 37°C with a screw-driven machine (Schenck RSA-250, Darmstadt, Germany) under displacement control (0.5 mm/s) until failure. The compressive load and displacement were assessed, respectively, by a 5000-N load cell (TME, F 501 TC, Toulon, France) and a displacement transducer mounted directly on the vertebral resin endplates (Mécanium, Lyon, France). Preconditioning was performed prior to testing (10 cycles with loading at 100 N and unloading at 50 N).

The following parameters were measured from the load-displacement data: failure load (N), defined by the force at maximum on the load-displacement curve; compressive stiffness (N/mm), defined by the linear part of the load-displacement curve slope between 25% and 75% of the failure load; and work to failure (N·mm), defined by the total area under the load-displacement curve. Because of vertebral shape, measurement of the cross-sectional area was highly variable, and therefore, estimated material properties (ie, ultimate stress and Young’s modulus) were not computed.

**Statistical analysis**

Shapiro-Wilk tests were used to assess whether the variables were normally distributed. Most parameters were normally distributed, except for work to failure, $\text{BV/TV}_{\text{ratio}}$, $\text{SMI}_{\text{ratio}}$, $\text{SMI}_{\text{CV}}$ on the posterior biopsy, $\text{Tb.Th}^*$ and $\text{Tb.Sp}^*$ on the superior core of the anterior biopsy, $\text{Tb.Sp}^*$ on the inferior core of the anterior biopsy, $\text{Tb.Th}^*_{\text{CV}}$ and $\text{DA}_{\text{CV}}$ on the anterior biopsy, $\text{Tb.Sp}^*$ on anterior and posterior biopsies, and $\text{Tb.Sp}^*$SD, which were normalized using logarithmic transformation.

Data are presented as the mean ± SD. The following tests were used: (1) Mann-Whitney–Wilcoxon test for the comparison between sexes, (2) Pearson coefficients of correlation for analysis of the relationships between two variables, (3) paired t test for comparison between anterior and posterior virtual biopsy parameters, (4) Friedman ANOVA tests for analysis of the relationships among superior, middle, and inferior zones of the virtual biopsy and post hoc paired t test for vertical parameters, (5) stepwise forward multiple regression models including semipartial correlations for the selection of variables explaining mechanical testing, and (6) partial correlations with adjustments for bone mass. To adjust for multiple comparisons, the threshold for significance was fixed at a p value of .026 or less after the Holm-Bonferroni correction.\(^{(24)}\) All statistical analyses were performed using SPSS 16.0 (SPSS, Inc., Chicago, IL, USA).

**Results**

**Characteristics of samples and heterogeneity of vertebral trabecular bone**

On the whole vertebral body, BMD averaged 0.62 ± 0.12 g/cm². Mean failure load was 2615 ± 1136 N, mean stiffness was 2938 ± 1585 N/mm, and mean work to failure was 1730 ± 1129 N·mm. Descriptive statistics for trabecular microarchitectural parameters are shown in Table 1. The Kellgren-Lawrence OA score did not differ between male and female donors, and there were no significant associations between Kellgren-Lawrence grades and BMD, microarchitecture, or mechanical parameters.

There were no differences between specimens from male and female donors, except for vertical heterogeneity expressed by $\text{BV/TV}_{\text{CV}}$, which was greater in males than in females (0.36 ± 0.17 versus 0.19 ± 0.08, p = .008).

Despite our limited age range, $\text{Tb.N}^*$ on the whole trabecular area and $\text{Tb.N}^*$ and $\text{Tb.Sp}^*$ on the anterior biopsy decreased significantly with age ($r = -0.51$, −0.56, and 0.55; p = .02, .008, and .01, respectively). No significant correlation was found between age and microarchitecture parameters from the posterior region.

Trabecular architecture was more deteriorated in the anterior versus posterior region, with lower $\text{Tb.N}^*$ (p = .004) and higher $\text{Tb.Sp}^*$ (p = .0001) and DA (p = .0001) in the anterior core (Table 1).

In the anterior biopsy, the three vertical regions differed significantly for $\text{BV/TV}$ and $\text{SMI}$ (p = .0001 and .021, respectively; Table 1). Using post hoc tests on these parameters, the middle region had a higher $\text{BV/TV}$ and a lower $\text{SMI}$ than the inferior and superior regions (p = .0004 to .004).

In the posterior biopsy, the three vertical regions were significantly heterogeneous for $\text{BV/TV}$, $\text{SMI}$ $\text{Tb.N}^*$, $\text{Tb.Sp}^*$, and $\text{Tb.Th}^*$ (p = .0005 to .013; Table 1), with the middle region characterized by a higher $\text{BV/TV}$ and $\text{Tb.Th}^*$ and a lower $\text{SMI}$ than the inferior and superior regions (p = .0026 to .0005).
Table 1. Trabecular Architecture Variation in the L 3 Vertebral Body (Mean ± SD)

<table>
<thead>
<tr>
<th>Region</th>
<th>Anterior core</th>
<th>Posterior core</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior region</td>
<td>13.2 (7.2)</td>
<td>10.3 (6.1)</td>
</tr>
<tr>
<td>Middle region</td>
<td>11.4 (5.9)</td>
<td>10.8 (6.7)</td>
</tr>
<tr>
<td>Inferior region</td>
<td>11.1 (5.9)</td>
<td>10.4 (5.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Properties</th>
<th>Anterior core</th>
<th>Posterior core</th>
</tr>
</thead>
<tbody>
<tr>
<td>BV/TV (%)</td>
<td>13.5 (5.9)</td>
<td>13.2 (7.2)</td>
</tr>
<tr>
<td>SMI</td>
<td>2.61 (0.53)</td>
<td>2.90 (0.66)</td>
</tr>
<tr>
<td>Tb.Sp* (μm)</td>
<td>1363 (332)</td>
<td>1368 (382)</td>
</tr>
<tr>
<td>Tb.Th* (μm)</td>
<td>1354 (440)</td>
<td>1301 (306)</td>
</tr>
<tr>
<td>Tb.N (n/mm)</td>
<td>0.76 (0.17)</td>
<td>0.76 (0.17)</td>
</tr>
<tr>
<td>DA (n0.76)</td>
<td>1.46 (0.11)</td>
<td>1.72 (0.17)</td>
</tr>
</tbody>
</table>

Table 2. Pearson's Correlation Coefficients (r) Among Bone Mass, Trabecular Microarchitecture, and Biomechanical Properties of the Vertebral Body

<table>
<thead>
<tr>
<th></th>
<th>Failure load</th>
<th>Work to failure</th>
<th>Stiffness</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMD</td>
<td>0.66</td>
<td>0.58</td>
<td>0.54</td>
</tr>
<tr>
<td>BV/TV</td>
<td>0.73</td>
<td>0.43</td>
<td>0.66</td>
</tr>
<tr>
<td>SMI</td>
<td>-0.81</td>
<td>-0.45a</td>
<td>-0.66</td>
</tr>
<tr>
<td>Tb.Sp*</td>
<td>-0.57</td>
<td>-0.30</td>
<td>0.62</td>
</tr>
<tr>
<td>Tb.Th*</td>
<td>0.44a</td>
<td>0.39</td>
<td>0.30</td>
</tr>
<tr>
<td>Tb.N</td>
<td>0.51</td>
<td>0.23</td>
<td>0.58</td>
</tr>
<tr>
<td>DA</td>
<td>0.38</td>
<td>0.10</td>
<td>0.29</td>
</tr>
<tr>
<td>Tb.Sp SD</td>
<td>-0.36</td>
<td>-0.13</td>
<td>-0.49</td>
</tr>
</tbody>
</table>

Note: Abbreviations defined in the methods section.
Bold: \( p \leq .026; \)
\( ^a026 < p < .05. \)

superior and middle regions had a higher Tb.Sp* and a lower Tb.N than the inferior region (\( p = .026 \) to .001).

Relationship among bone mass, trabecular microarchitecture, and vertebral mechanical behavior (Table 2)

**Bone mass**

BMD and BV/TV were significantly positively correlated with failure load, work to failure, and stiffness (\( r = 0.54 \) to 0.73; \( p = .01 \) to < .0001; Table 2).

**Trabecular microarchitecture**

BV/TV, SMI, Tb.N*, and Tb.Sp* were significantly correlated with failure load and stiffness (\( r = 0.51 \) to 0.81; \( p = .019 \) to < .0001; Table 2) but were not related to work to failure.

In multiple regression models using the following equation: mechanical behavior = bone mass + microarchitecture, with mechanical behavior corresponding to failure load or stiffness or work to failure, bone mass corresponding to BMD or BV/TV, and trabecular microarchitectural parameters corresponding to SMI, DA, Tb.Sp*, and Tb.Th*, SMI appeared to be the most pertinent parameter to predict mechanical behavior because it was always the first to be included in the stepwise regression analysis.

Relationship between trabecular microarchitecture heterogeneity and vertebral body mechanical behavior

**Global heterogeneity**

Tb.Sp*SD of the entire vertebral trabecular bone region was negatively correlated with stiffness (\( r = -0.49; p = .023 \)).

**Anteroposterior heterogeneity**

For the anterior biopsy, all trabecular microarchitectural parameters except Tb.Th* and DA were correlated with failure load and stiffness (\( r = 0.50 \) to 0.74; \( p = .001 \) to < .0001; Table 3). For the posterior biopsy, only BV/TV was correlated with failure load and BV/TV and SMI with stiffness. None of the architecture parameters from the anterior and posterior cores were significantly correlated with work to failure.
In multiple regression models using the following equation: mechanical behavior = anterior microarchitecture + posterior microarchitecture, with mechanical behavior corresponding to failure load or stiffness or work to failure and microarchitecture corresponding to SMI, DA, Tb.SP, and Tb.Th, the posterior parameter was consistently excluded from the model. As a result, parameters of the anterior biopsy were the best predictors of mechanical behavior.

Considering the heterogeneity parameters, BV/TV ratio was significantly negatively correlated with failure load and work to failure (r = −0.53 and −0.57; p < .001) as the most pertinent parameter corresponding to SMI, and Tb.N ratio was also was correlated with failure load (r = −0.36; p < .001). No other anteroposterior ratios were correlated with vertebral mechanical properties.

**Vertical heterogeneity**

Since trabecular microarchitectural parameters of the anterior biopsy were the best predictors of mechanical behavior, we studied vertical heterogeneity only on the anterior biopsy.

In the superior region, BV/TV and SMI were significantly correlated with failure load and work to failure (r = 0.49 to 0.65; p < .001). Only Tb.Sp also was correlated with failure load (r = −0.61; p < .001). In the middle region, BV/TV, SMI, Tb.Sp, and Tb.Th were significantly correlated with failure load and stiffness (r = 0.48 to 0.68; p < .001). In the inferior region, all trabecular microarchitectural parameters were significantly correlated with failure load and stiffness (r = 0.52 to 0.71; p < .001) except that DA was not related to failure load and stiffness, and Tb.Th was not related to stiffness (Table 3). No significant correlations were found with work to failure.

Regarding the vertical heterogeneity parameters (BV/TV, SMI, Tb.Sp, and Tb.Th), none were significantly correlated with mechanical behavior. Relative role of bone mass parameters, trabecular microarchitecture, and its heterogeneity parameters on mechanical behavior.

To determine the relative contribution of heterogeneity parameters to vertebral mechanical behavior, we performed multiple regression models using the following equation: mechanical behavior = bone mass + trabecular microarchitectural heterogeneity, with mechanical behavior corresponding to failure load or stiffness or work to failure, bone mass corresponding to BMD or BV/TV, microarchitecture as the most pertinent parameter corresponding to SMI, and heterogeneity parameters corresponding to all anteroposterior ratios, vertical CV, and Tb.Sp SD. For mechanical behavior and heterogeneity parameters, only failure load and DA ratio presented with a significant introduction in the equations.

**Table 3. Pearson’s Correlation Coefficients Between Trabecular Microarchitecture and Anteroposterior Heterogeneity (Ratios) With Mechanical Parameters**

<table>
<thead>
<tr>
<th></th>
<th>Failure load</th>
<th>Work to failure</th>
<th>Stiffness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anterior biopsy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>microarchitecture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BV/TV</td>
<td>0.67</td>
<td>0.47a</td>
<td>0.50</td>
</tr>
<tr>
<td>SMI</td>
<td>−0.74</td>
<td>−0.46a</td>
<td>−0.55</td>
</tr>
<tr>
<td>Tb.Sp</td>
<td>−0.61</td>
<td>−0.35</td>
<td>−0.59</td>
</tr>
<tr>
<td>Tb.Th</td>
<td>0.29</td>
<td>0.34</td>
<td>0.09</td>
</tr>
<tr>
<td>Tb.N</td>
<td>0.56</td>
<td>0.30</td>
<td>0.57</td>
</tr>
<tr>
<td>DA</td>
<td>0.38</td>
<td>0.17</td>
<td>0.31</td>
</tr>
<tr>
<td><strong>Posterior biopsy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>microarchitecture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BV/TV</td>
<td>0.47a</td>
<td>0.15</td>
<td>0.51</td>
</tr>
<tr>
<td>SMI</td>
<td>−0.61</td>
<td>−0.27</td>
<td>−0.52</td>
</tr>
<tr>
<td>Tb.Sp</td>
<td>−0.35</td>
<td>−0.04</td>
<td>−0.46a</td>
</tr>
<tr>
<td>Tb.Th</td>
<td>0.42</td>
<td>0.26</td>
<td>0.39</td>
</tr>
<tr>
<td>Tb.N</td>
<td>0.27</td>
<td>0.01</td>
<td>0.39</td>
</tr>
<tr>
<td>DA</td>
<td>0.25</td>
<td>0.14</td>
<td>0.03</td>
</tr>
<tr>
<td><strong>Anteroposterior heterogeneity</strong></td>
<td></td>
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<tr>
<td>BV/TV ratio</td>
<td>−0.53</td>
<td>−0.57</td>
<td>−0.24</td>
</tr>
<tr>
<td>SMI ratio</td>
<td>0.31</td>
<td>0.29</td>
<td>0.16</td>
</tr>
<tr>
<td>Tb.Sp ratio</td>
<td>0.32</td>
<td>0.39</td>
<td>0.14</td>
</tr>
<tr>
<td>Tb.Th ratio</td>
<td>−0.13</td>
<td>−0.36</td>
<td>0.19</td>
</tr>
<tr>
<td>Tb.N ratio</td>
<td>−0.36</td>
<td>−0.39</td>
<td>−0.21</td>
</tr>
<tr>
<td>DA ratio</td>
<td>−0.10</td>
<td>−0.01</td>
<td>−0.25</td>
</tr>
</tbody>
</table>

**Bold:** p ≤ .026; “026 < p < .05.
Table 4. Pearson’s Correlation Coefficients Among Trabecular Microarchitecture, Vertical Heterogeneity (CV), and Vertebral Mechanical Properties in the Three Vertical Regions of the Anterior Biopsy

<table>
<thead>
<tr>
<th>Variables</th>
<th>Failure load</th>
<th>Work to failure</th>
<th>Stiffness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior region</td>
<td>BV/TV</td>
<td>0.49</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>SMI</td>
<td>-0.63</td>
<td>-0.65</td>
</tr>
<tr>
<td></td>
<td>Tb.Sp̂</td>
<td>-0.61</td>
<td>-0.46a</td>
</tr>
<tr>
<td></td>
<td>Tb.Tĥ</td>
<td>0.29</td>
<td>0.47a</td>
</tr>
<tr>
<td></td>
<td>Tb.N̂</td>
<td>0.57</td>
<td>0.41</td>
</tr>
<tr>
<td></td>
<td>DA</td>
<td>0.41</td>
<td>0.32</td>
</tr>
<tr>
<td>Middle region</td>
<td>BV/TV</td>
<td>0.62</td>
<td>0.34</td>
</tr>
<tr>
<td></td>
<td>SMI</td>
<td>-0.68</td>
<td>-0.40</td>
</tr>
<tr>
<td></td>
<td>Tb.Sp̂</td>
<td>-0.51</td>
<td>-0.28</td>
</tr>
<tr>
<td></td>
<td>Tb.Tĥ</td>
<td>0.36</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td>Tb.N̂</td>
<td>0.42</td>
<td>0.17</td>
</tr>
<tr>
<td></td>
<td>DA</td>
<td>0.24</td>
<td>0.06</td>
</tr>
<tr>
<td>Inferior region</td>
<td>BV/TV</td>
<td>0.71</td>
<td>0.32</td>
</tr>
<tr>
<td></td>
<td>SMI</td>
<td>-0.66</td>
<td>-0.19</td>
</tr>
<tr>
<td></td>
<td>Tb.Sp̂</td>
<td>-0.54</td>
<td>-0.22</td>
</tr>
<tr>
<td></td>
<td>Tb.Tĥ</td>
<td>0.59</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td>Tb.N̂</td>
<td>0.53</td>
<td>0.21</td>
</tr>
<tr>
<td></td>
<td>DA</td>
<td>0.13</td>
<td>-0.08</td>
</tr>
<tr>
<td>Vertical heterogeneity</td>
<td>BV/TV&lt;sub&gt;CV&lt;/sub&gt;</td>
<td>-0.29</td>
<td>-0.03</td>
</tr>
<tr>
<td></td>
<td>SMI&lt;sub&gt;CV&lt;/sub&gt;</td>
<td>0.46a</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>Tb.Sp&lt;sub&gt;CV&lt;/sub&gt;</td>
<td>-0.20</td>
<td>-0.25</td>
</tr>
<tr>
<td></td>
<td>Tb.Th&lt;sub&gt;CV&lt;/sub&gt;</td>
<td>-0.13</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>Tb.N&lt;sub&gt;CV&lt;/sub&gt;</td>
<td>-0.16</td>
<td>-0.26</td>
</tr>
<tr>
<td></td>
<td>DA&lt;sub&gt;CV&lt;/sub&gt;</td>
<td>0.13</td>
<td>0.26</td>
</tr>
</tbody>
</table>

Bold: *p* ≤ .026; †0.026 < *p* < .05.

Table 5. Multiple Regression Analysis Including the Coefficient of Determination ($R^2$), the *p* Value, and Semipartial Correlation ($r^2$) for Each Variable Included in the Models

<table>
<thead>
<tr>
<th>Variables</th>
<th>Failure load</th>
<th>Final $R^2$</th>
<th>Semipartial correlation ($r^2$)</th>
<th><em>p</em> Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior region</td>
<td>BMD</td>
<td>0.10</td>
<td>.004</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SMI</td>
<td>0.39</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DA&lt;sub&gt;ratio&lt;/sub&gt;</td>
<td>0.14</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.86</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td>Middle region</td>
<td>BV/TV</td>
<td>0.03</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SMI</td>
<td>0.11</td>
<td>.008</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DA&lt;sub&gt;ratio&lt;/sub&gt;</td>
<td>0.14</td>
<td>.003</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.80</td>
<td>&lt;.0001</td>
<td></td>
</tr>
</tbody>
</table>

Discussion

The aim of this study was to determine the contribution of trabecular microarchitecture and its heterogeneity to the mechanical behavior of human lumbar vertebrae. We assessed trabecular microarchitectural heterogeneity parameters in several ways: (1) by the ratio of anteroposterior trabecular microarchitecture values, (2) by the coefficient of variation of trabecular microarchitecture values in superior, middle, and inferior regions, and (3) by the standard deviation of trabecular separation across the entire vertebral trabecular volume.

Consistent with previous studies, we observed marked heterogeneity of vertebral trabecular architecture, with the anterior region showing impaired trabecular architecture compared with the posterior region.(8–12) Correlations between mechanical behavior and variation within vertebral regions but generally indicated that the anterior part of the lumbar vertebral body is more strongly related to vertebral mechanical properties and therefore may be a better region to measure when predicting vertebral fracture risk. We also found that in this sample of vertebrae from middle- to old-aged donors, trabecular alterations were characterized not only by a reduction in bone mass but also by changes in microarchitecture that taken together improve prediction of vertebral mechanical properties.(6,7,12) Specifically, BMD alone explained up to 44% of the variability of the mechanical behavior; BV/TV alone, up to 53%; and SMI alone, up to 66%. However, bone mass parameters (ie, BMD or BV/TV) in combination with trabecular microarchitecture (ie, SMI) and its heterogeneity (ie, DA<sub>ratio</sub>) improved the prediction of vertebral mechanical behavior markedly, together explaining up to 86% of the variability in biomechanical properties. Vertebral trabecular bone has a 3D microarchitecture that consists of interconnecting plates and rods. The plate versus rod nature of the vertebral trabecular bone can be determined using the structure model index (SMI), which has been shown previously to be correlated with mechanical properties of trabecular bone.(25–27) Moreover, in young individuals, there are twice as many vertical trabeculae than horizontal ones, and this ratio of vertical to horizontal trabeculae increases with age.(26)

Along with this relatively greater loss of horizontal trabecular is thinning of horizontal trabeculae, whereas the remaining vertical trabeculae tend to maintain their thickness with advancing age and even may increase in thickness.(25,26) In such a structure, the degree of anisotropy (DA) reflects the preferential vertical alignment of trabeculae. Thus, as bone loss progresses, the deterioration of the vertebral trabecular architecture results in a more anisotropic structure with a greater susceptibility to fracture. Interestingly, in our study, the global DA was not correlated with vertebral mechanical behavior; however, the anteroposterior heterogeneity of DA (DA<sub>ratio</sub>) was. This role of anisotropic heterogeneity appeared when the DA<sub>ratio</sub> was included in multiple regression analyses in combination with bone mass parameters and SMI. The significance of the DA<sub>ratio</sub> may be explained in part by our elderly donors, who have very low BMD and BV/TV values, perhaps providing a greater opportunity for the DA<sub>ratio</sub> to influence mechanical behavior. Altogether these findings suggest that anteroposterior variation of trabecular alignment explained mechanical behavior better than DA measured in the entire trabecular region, highlighting
the potential usefulness of $DA_{\text{ratio}}$ for predicting vertebral mechanical behavior.

In a previous study of the femoral neck using micro–computed tomography (μCT), Ciarelli and colleagues showed that patients with hip fracture had a significantly more anisotropic structure than those in a control group after adjustment for bone mass.\(^{(28)}\) Similar to conclusions of this study, we suggest that, for a population with similar bone volume fraction, the likelihood for fracture may be influenced by the heterogeneity of anisotropy in the trabecular bone structure.

In addition, our finding that Tb.Sp’ SD is negatively correlated with vertebral mechanical properties is consistent with clinical studies that have measured Tb.Sp’ SD at peripheral skeletal sites and reported higher values in women with a history of fragility fracture.\(^{(13–17)}\)

Our study had several limitations. First, trabecular bone structure was measured using an 82-μm isotropic voxel size, which may have led to an overestimation of some micro-architectural features.\(^{(29,30)}\) Because of partial-volume effects with lower-resolution images, BV/TV and Tb.Th can be overestimated and Tb.Sp underestimated when compared with “gold standard” μCT or histomorphometry.\(^{(31,32)}\) However, several studies have compared microarchitectural measurements made with an 82-μm voxel size and greater with those obtained with μCT and found very high correlations between the micro-architectural parameters.\(^{(32,33)}\) Second, we recognize that images of this high resolution are not currently used clinically in the axial skeleton. However, recent studies have shown that microarchitectural measurements acquired using high-resolution multidetector CT (MDCT) imaging available in vivo correlate strongly with those assessed using either μCT or HR-pQCT.\(^{(34,35)}\)

Accordingly, MDCT is quite promising for assessment of trabecular and cortical microarchitecture in the spine and assessment of microarchitecture and its heterogeneity as performed in our study. Indeed, our results provide a strong rationale to conduct a clinical study testing whether heterogeneity measures improve identification of patients at risk for vertebral fracture. Third, the loading mode used was uniaxial compression. Because most osteoporotic vertebral fractures are anterior wedge fractures, the response to combined compression and anteroposterior bending also may be of interest.\(^{(36)}\) It is possible that in this “physiologic” mechanical condition of compression and anteroposterior bending, BMD would be an even worse predictor of vertebral mechanical behavior with a greater contribution of trabecular microarchitecture and its heterogeneity, particularly at the anterior region. This could be assessed in further experimental studies and in those that use finite-element analysis (FEA) models to simulate different loading modes. Another limitation of our study is the inability to know how loads are distributed between cortical and trabecular bone in the tested loading conditions as well as loading conditions seen in vivo. Obviously, FEA could provide some of this information and could extend the current experimental observations. Finally, this study did not take into account other factors such as bone tissue composition (ie, degree of mineralization, collagen maturity and cross-link characteristics, and crystal size and perfection) or cortical shell morphology, which also may contribute to vertebral strength.\(^{(37–41)}\)

In conclusion, our data indicate that assessment of trabecular microarchitecture and its regional heterogeneity may enhance prediction of vertebral fracture risk, and accordingly, therapies that maintain microarchitecture and reduce heterogeneity would preserve vertebral strength to a greater extent than changes in BMD alone.

### Disclosures

All the authors state that they have no conflicts of interest.

### Acknowledgments

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### References

TRABECULAR ARCHITECTURE HETEROGENEITY IN VERTEBRAE