Heritability of Urinary Traits That Contribute to Nephrolithiasis

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Abstract

Background and objectives Kidney stones and their risk factors aggregate in families, yet few studies have systematically estimated heritabilities and genetic correlations of the numerous urinary traits associated with risk of kidney stones.

Design, setting, participants, & measurements Twenty-four–hour urine samples were collected from the Genetic Epidemiology Network of Arteriopathy cohort of families in Rochester, Minnesota, to measure urinary determinants of supersaturation. Diet was assessed using the Viocare food frequency questionnaire. Heritabilities and genetic correlations among the urinary traits were estimated using variance components methods.

Results Samples were available from 811 individuals (344 men, 467 women; mean age 66 ± 9 years). Age, sex, and weight were significantly correlated with the majority of urinary traits. Many urine excretions (calcium, magnesium, citrate excretion) had strong evidence for heritability (P < 0.01) both before and after adjusting for the identified covariates. Among significantly heritable urinary traits, genetic factors explained 20%–36% of inter-individual variation after adjustment for covariates. Urinary calcium excretion was significantly genetically correlated with urinary magnesium and with urinary citrate excretion (P < 0.05). Although eGFR influenced many urinary traits, controlling for eGFR did not greatly affect estimated heritabilities.

Conclusions Evidence from this cohort suggests a strong heritable component to many urinary nephrolithiasis risk factors. Further study of genetic influences on urinary traits relevant for kidney stone pathogenesis is warranted.

Materials and Methods

This study was approved by the Mayo Clinic Institutional Review Board.

GENOA Cohort

GENOA, a member of the Family Blood Pressure Program, recruited non-Hispanic white hypertensive sibships from Rochester, Minnesota, for linkage and association studies to investigate the genetic underpinnings of hypertension in phase I (1996–2001) (4). In phase II (2000–2004), 1241 Rochester participants were successfully re-recruited to measure potential target organ damage as a result of hypertension (5).
The Genetic Determinants of Urinary Lithogenicity (GDUL) study (2006–2012) is an ancillary study of the phase III GENOA Genetics of Chronic Kidney Disease study conducted in GENOA participants (5). Participants in the Rochester GENOA cohort were invited to participate in this study, which consisted of 24-hour urine collections and a diet food frequency questionnaire (FFQ; Viocare Technologies, Princeton, NJ) completed at 1–3 visits between the CKD and GDUL studies. Participants were excluded from this study if they were in end stage renal failure (stage 5 CKD).

Study Visit
After they provided informed consent, participants completed one or preferably two 24-hour urine collections (6,7) and the FFQ. A total of 333, 295, and 183 participants had a total of one, two, or three urine collections, respectively. For individuals with two or three urine collections, values used were averaged. The mean time between the earliest (CKD) and last (GDUL) urine collections was 1.73 years (range, 0.9–3.6 years). The average time between the two GDUL collections was 22 days. Intraclass correlation coefficients (ICCs) for urine factors across collections revealed that the majority of urine measures were relatively stable across time. Of the urine factors, chloride had the lowest ICC (0.41) and calcium had the highest ICC (0.73).

Participants also completed a detailed kidney stone questionnaire, and data from the GENOA CKD study questionnaire were also available.

Urine Collection
Urine was collected with toluene as a preservative. Twenty-four-hour urinary concentrations of oxalate, calcium and other determinants of supersaturation were measured in the Mayo Clinic Renal Testing Laboratory. Supersaturation was calculated using the EQUIL2 program (8).

Total Urine Protein Isolation
An aliquot of a 24-hour urine collection was spun at 3600 rpm, 4°C, for 10 minutes to remove cells and debris and stored at −80°C until use. At the time of inhibition assays, the sample was thawed, spun at 1400 rpm at 4°C for 5 minutes to further remove cells and debris, and rinsed twice with a Vivaspur concentrator (5000 molecular weight cutoff; Sartorius, Goettingen, Germany) using PBS containing Roche Complete protease inhibitor (one tablet per 1000 ml). The protein concentration in the final concentrate (approximately 200 μl) was measured using a bicinchoninic acid assay kit ( Pierce, Rockford, IL) and PBS added to achieve a final concentration of 1 mg/ml.

Crystal Growth Inhibition Assay
Calcium oxalate (CaOx) monohydrate crystal growth inhibition was measured using a modification of the seeded crystal growth assay described by Nakagawa and colleagues (9). The upper limit of metastability (ULM) of CaOx and calcium phosphate (CaP) in human urine was measured using a modification of the method of Asplin and colleagues (10). Sequential aliquots of calcium chloride (CaP ULM) or 5 μl oxalic acid solution (CaOx ULM) were added to urine in a temperature-controlled cuvette under constant stirring, and the point of precipitation was assessed at a wavelength of 620 nm using a Cary Bio 50 UV-Visible spectrophotometer (Agilent Technologies, Inc., Santa Clara, CA). Supersaturation for CaOx and CaP in the native urine sample and at the final concentration at which the threshold absorbance was reached or exceeded (ULM) were calculated using EQUIL2 (8). To reduce within-patient variability, values for replicate measures were averaged. Crystallization measures were only performed at the two GDUL visits.

Statistical Analyses
Data management and statistical analyses were conducted in SAS software (version 9.3; SAS Institute, Inc., Cary, NC) and R software (version 12.1.2; R Core Development Team, Vienna, Austria) (11). Most urine and dietary measures appeared to have relatively normal distributions; thus, no variable transformations were applied. ULM CaP and ULM-supersaturation CaP were not normally distributed and were thus transformed by taking the natural logarithm of the variable plus one before analyses; values that were <0 were also removed before analysis (n=28 for ULM-supersaturation CaP). Values that were ≥4 SDs from the mean of any urine or diet measure were removed. We conducted t tests for the urine and diet measures to test whether there were significant differences between men and women.

Correlation and Association Testing
Correlations were estimated using Pearson’s product moment correlation on the full GENOA sample (N=811). Because we tested for correlation in many pairs of traits, we used the Benjamini–Hochberg method to account for multiple testing in the correlation analysis (12). This technique controls the proportion of falsely rejected null hypotheses (false discovery rate) by adjusting the P values for each test based on the number of tests conducted as well as the dependency structure between the test statistics.

Next, we conducted linear mixed models that included age, sex, height, and weight as predictor variables to explore the relationships between these variables and each urine and diet measure. Linear mixed-effects (LME) modeling (13) with family as a random intercept was used to account for the sibship structure among GENOA participants while retaining a valid type I error rate. LME correlated data will have less variability than uncorrelated data and statistical tests of the regression coefficients will have inflated P values, resulting in a higher type I error rate. Removing the variability due to family structure adjusts the degrees of freedom so that the SEMs of the regression coefficients represents the number of independent observations, thus stabilizing the type I error rate. This technique is optimized under a balanced design (when the number of siblings per sibship is the same across all sibships). In our study, 47% of the sibships were composed of singletons, whereas 53% of the sibships had at least two siblings. R² values for the LME models were calculated based on the likelihood ratio (14). The modeling was repeated by including the same predictor variables plus eGFR, calculated by the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) creatinine equation (15).
Biometrical Genetic Modeling

We used variance components modeling to estimate the heritability of urinary factors, both before and after accounting for covariates (age, sex, height, and weight). After accounting for phenotypic variation due to the covariates, the phenotypic covariance between sibling pairs was partitioned into additive genetic covariance and variance not explained by additive genetic effects (error covariance), as follows:

\[ \Omega = 2\Phi \sigma_g^2 + I \sigma_e^2, \]

where \( \sigma_g^2 \) represents the genetic variance due to additive genetic factors and \( \sigma_e^2 \) is the error variance. The kinship matrix, \( \Phi \), represents the Mendelian expectation that sibling pairs, on average, share one half of their genetic variation. Sequential oligogenic linkage analysis routines (SOLAR) modeling (16) was used to implement the variance component modeling based on maximum likelihood estimation. Heritability (\( h^2 = \sigma_g^2 / \sigma_T^2 \)), the proportion of total phenotypic variance that is attributable to genetic variance, was tested for significance by comparing the log-likelihood of the model in which heritability is estimated to that of the model in which heritability is fixed to 0. All GENOA participants (\( N = 811 \)) were included in the SOLAR modeling. Although the 208 singletons are not used by SOLAR to estimate the genetic contribution to trait variation, they are used for estimation of overall trait variation. Because we tested the heritabilities of several traits, we used the Benjamini–Hochberg method to account for multiple testing in the heritability analysis (12). We performed sensitivity analysis by reestimating heritability for urinary traits that demonstrated significant heritability after adjustment for age, sex, height, and weight. For these traits, we additionally adjusted for dietary factors that were significant predictors of the urinary trait. Finally, we estimated heritability for these traits in the subset of the sample that had no history of kidney stones (\( n = 585 \)).

SOLAR was also used to perform bivariate analysis for pairs of traits that had significant heritabilities after accounting for age, sex, height, and weight (\( h^2 > 0.05 \)). In this bivariate modeling framework, the phenotypic covariance between two traits is decomposed into genetic correlation due to additive genetic effects influencing both traits and correlation due to environmental effects influencing both traits, according to the following model:

\[ \Omega_{12} = 2\Phi \rho_g \sigma_g^2 \sigma_g^2 \rho_e \sigma_e^2 \sigma_e^2, \]

where 1 and 2 are the two traits of interest, \( \rho_g \) is the additive genetic correlation between the traits and \( \rho_e \) is the correlation due to unmeasured environmental effects. The genetic correlation provides an estimate of the proportion of genetic effects shared between the two traits. SOLAR estimates phenotypic correlation using family relationships among the participants. The formula for calculating total phenotypic correlation is as follows:

\[ \rho_{12} = \rho_e \sqrt{h_1^2 h_2^2} + \rho_g \sqrt{(1 - h_1^2)(1 - h_2^2)} \]

where \( \rho_{12} \) is the phenotypic correlation between traits 1 and 2, \( h_1^2 \) is the heritability of trait 1, and \( h_2^2 \) is the heritability of trait 2. The genetic and environmental correlations between the traits estimated in SOLAR, \( \rho_g \) and \( \rho_e \), were tested for significance by comparing the log-likelihood of the model in which the parameter of interest is estimated to the log-likelihood of the model in which the parameter is fixed to 0.

Results

A total of 811 individuals from 446 sibships participated in this study. The sibship structure of the sample was as follows: 208 singletons, 164 sibpairs, 49 sibships with 3 siblings, and 25 sibships with 4 or more siblings. The mean age was 66±9 years and 57.6% of participants were women. Most of the 24-hour urine traits and diet measures summarized in Table 1 differed significantly between men and women. Only 619 of the 811 participants (76%) completed the FFQ. The sex distribution did not differ substantially between those who did or did not provide diet information, although those who completed the questionnaire were slightly younger (mean age 65.3 versus 66.9 years; \( P = 0.04 \)), and certain urine analytes subtly differed in a direction consistent with the overall effect of age on specific factors (e.g., urine calcium of 160 mg/d [completed questionnaire] versus 141 mg/d [did not complete questionnaire]; \( P < 0.001 \)).

Many urinary traits and dietary measures were also influenced by additional demographic factors, including age and weight (Supplemental Table 1). Those participants with a history of kidney stones (\( n = 88 \); 13.1%) tended to have a higher body weight, urine calcium excretion, and lower dietary calcium intake (Supplemental Table 2). Several individual dietary components, including sodium, total protein, and net alkali absorption (calculated by the method of Oh (Urine(Na+K+Ca+Mg)–(Cl+1.8 Pi)) (17), also influenced many urinary traits (Table 2). However, dietary fructose (18) did not significantly correlate with key urinary measures including urine pH, oxalate, or uric acid, but was weakly correlated with calcium (\( r = 0.10 \); \( P < 0.05 \)) and citrate (\( r = 0.08 \); \( P < 0.05 \)). After correction for multiple testing, 39 of the 42 significant correlations (\( P < 0.05 \)) remained significant. Many urinary traits correlated with each other (e.g., calcium with magnesium, and calcium with citrate) (Supplemental Table 3).

Estimated heritabilities are listed in Table 3. Heritabilities were statistically significantly different from zero and moderate in magnitude for urinary excretion of calcium (\( h^2 = 0.41 \); SEM 0.10), magnesium (\( h^2 = 0.34 \); SEM 0.09), pH (\( h^2 = 0.35 \); SEM 0.10), citrate (\( h^2 = 0.39 \); SEM 0.09), and volume (\( h^2 = 0.30 \); SEM 0.11) (all \( P < 0.01 \)), and lower in magnitude for urinary sulfate excretion (\( h^2 = 0.15 \); SEM 0.08) (\( P < 0.05 \)). Covariates accounted for 8%–32% of the variance in these urinary measures; however, after adjustment, heritabilities for six of seven quantitative urinary traits remained statistically significant. In addition, heritabilities remained significant after Benjamini–Hochberg adjustment for multiple testing (Supplemental Table 4). Heritabilities did not differ between the entire GENOA cohort and the subset of nonstone formers (Supplemental Table 5). Estimates of the heritabilities of urinary crystallization measures were not significantly different from 0 after adjustment for age, sex, height, and weight.

To assess the effect of diet, analyses were repeated for those urine factors that had a significant heritability (\( P < 0.05 \))
in adjusted models. Incorporating those dietary factors that correlated with urinary traits (Table 2) into the model had little effect on the estimated heritabilities (Table 4). Many urine analytes also correlated with eGFR, age, sex, height, and weight (results not shown). However, when heritabilities were re-estimated controlling for eGFR, age, sex, height, and weight they did not appreciably change (Supplemental Table 6).

Genetic correlations were examined for urinary traits with highly significant heritabilities after accounting for covariates (P<0.01). Moderately positive genetic correlations were observed between urinary magnesium and calcium excretions \((\rho_g=0.56; P<0.05)\) and between urinary magnesium and citrate excretions \((\rho_g=0.44; P<0.05)\). Positive environmental correlations were observed among four urinary traits: calcium, magnesium, pH, and citrate \((\rho_e=0.18–0.48; P<0.05)\) (Table 5).

### Discussion

This study estimated heritabilities of a large panel of urinary measures that are commonly used to assess risk of kidney stones, and demonstrated that many but not all conventional measures of urinary lithogenicity have statistically significant and substantial heritable components. Urinary calcium and magnesium excretions were most notably for strong heritability, whereas urine oxalate excretion was most notable for lack of heritability. These results suggest that efforts to understand the genetics underlying stone risk factors should focus on those urinary nephrolithiasis risk factors with greatest heritability. Such efforts could help elucidate kidney stone pathogenesis and reveal new targets for prevention efforts.

Kidney stones develop approximately 3-fold more frequently in individuals with a positive family history, and a family history of nephrolithiasis has been reported in 4%–12% of healthy controls compared with 16%–23% of...
affected individuals (19–22). Two published estimates of the heritability (h²) for stone disease are 63% ± 14% and 46% ± 9% (21,22). Indeed, the familial clustering index, one epidemiologic indicator of disease heritability, is greater for nephrolithiasis (2.5–4) than for diabetes mellitus (2.0) or hypertension (2.0) (23). A study of isolated Croatian island groups provided additional evidence of a strong genetic component due to differences in stone prevalence between low (1.5%), moderate (2.3%), and high (5.4%) inbreeding villages (24).

Hypercalciuria is the best established risk factor for calcium urolithiasis, present in up to 50% of cases (25,26).

Table 2. Correlation matrix of dietary measures and key 24-hour urine measures

<table>
<thead>
<tr>
<th>Trait (24-h Urine Measures)</th>
<th>Net Alkali Absorption</th>
<th>Dietary Total Protein</th>
<th>Dietary Animal Protein</th>
<th>Dietary Calcium</th>
<th>Dietary Oxalate</th>
<th>Dietary Fructose</th>
<th>Dietary Sucrose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium</td>
<td>0.28&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.20&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.20&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.17&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.07</td>
<td>0.10&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.07</td>
</tr>
<tr>
<td>Magnesium</td>
<td>0.48&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.20&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.17&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.13&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.11&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.13&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.05</td>
</tr>
<tr>
<td>pH</td>
<td>0.37&lt;sup&gt;a&lt;/sup&gt;</td>
<td>−0.05&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.17&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.06</td>
<td>0.05</td>
<td>0.03</td>
<td>0.13&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Osmolality</td>
<td>0.02</td>
<td>0.15&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.21&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.04</td>
<td>−0.04</td>
<td>0.04</td>
<td>−0.09&lt;sup&gt;b,d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sodium</td>
<td>0.59&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.15&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.17&lt;sup&gt;a&lt;/sup&gt;</td>
<td>−0.02</td>
<td>−0.01</td>
<td>−0.07</td>
<td>−0.15&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sulfate</td>
<td>0.45&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.36&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.39&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.19&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.12&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.06</td>
<td>−0.06</td>
</tr>
<tr>
<td>Citrate</td>
<td>0.50&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.12&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.13&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.07</td>
<td>0.06</td>
<td>0.08&lt;sup&gt;b,d&lt;/sup&gt;</td>
<td>0.03</td>
</tr>
<tr>
<td>Oxalate</td>
<td>0.39&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.13&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.09&lt;sup&gt;b&lt;/sup&gt;</td>
<td>−0.03</td>
<td>0.10&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.04</td>
<td>−0.01</td>
</tr>
<tr>
<td>Uric acid</td>
<td>0.60&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.19&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.19&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.03</td>
<td>0.07</td>
<td>0.02</td>
<td>−0.03</td>
</tr>
<tr>
<td>Volume</td>
<td>0.35&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.14&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.09&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.10&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.14&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.01</td>
<td>0.06</td>
</tr>
</tbody>
</table>

<sup>a</sup>P<0.001.  
<sup>b</sup>0.01<P<0.05.  
<sup>c</sup>0.001<P<0.01.  
<sup>d</sup>Not significant at P<0.05 after adjustment for multiple testing.
The incidence of hypercalciuria in first-degree relatives of hypercalciuric stone formers was 43%, with a suggested autosomal dominant pattern of inheritance (27). Overall, the heritability of urinary calcium excretion has been estimated at approximately 40% (28). Data from the male Health Professionals Follow-Up Study (29) and a French Canadian nephrolithiasis cohort (30) also strongly support hypercalciuria as a heritable stone risk factor. Among the French Canadian kidney stone families, heritability attributed to a single major gene for calcium excretion was 0.58 (31). Data from other populations suggest that hypercalciuria is a polygenic disorder (32), but the exact molecular defects contributing to it remain incompletely defined. In a smaller twin study (12 sets), heritability was relatively high for calcium, but was also $0.90$ for oxalate, uric acid, and citrate (33). Other family studies support a genetic contribution to urinary oxalate (34), citrate (35), and uric acid (20) excretion, albeit of a lesser magnitude.

In this study, adjusted models found evidence for significant heritability of citrate (0.36) and calcium (0.25), but not for oxalate or uric acid. The estimated heritabilities were much less than those in the twin study (33) or in the French Canadian study (31). However, for the first time, our study also suggested a heritable component for urinary magnesium excretion (0.34). Indeed, the thick ascending limb is a site of robust calcium and magnesium reabsorption (36), and a previous genome-wide association study implicated CLDN14 in kidney stone risk and reduced bone density (although urinary calcium excretion data were not available) (37). To the best of our knowledge, this is also the first study to suggest a genetic component for urinary pH regulation in a sampling of the population without a systemic acid base disorder (e.g., renal tubular acidosis). Importantly, both extremes of urinary pH increased propensity for kidney stones, but of different types (i.e., low urinary pH is associated with uric acid stones, whereas high urinary pH is associated with calcium phosphate stones). In addition, we detected significant heritability for urinary osmolality and volume, which could implicate genetic regulation of thirst. This may not be entirely surprising, because low urinary volume has been a consistent risk factor for stone disease in many studies over the years (38).

Table 4: Heritabilities of 24-hour urine measures adjusted for diet

<table>
<thead>
<tr>
<th>Trait (24-h Urine Measures)</th>
<th>$h^2$ Unadjusted</th>
<th>$h^2$ Unadjusted $p$ Value</th>
<th>$h^2$ Adjusted for Age, Sex, Height, and Weight</th>
<th>$h^2$ Adjusted for Age, Sex, Height, Weight, and Dietary Covariates$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium, mg</td>
<td>0.41$^b$</td>
<td>$&lt;0.001$</td>
<td>0.25$^c$</td>
<td>0.27$^d$</td>
</tr>
<tr>
<td>Magnesium, mg</td>
<td>0.34$^b$</td>
<td>$&lt;0.001$</td>
<td>0.25$^b$</td>
<td>0.27$^b$</td>
</tr>
<tr>
<td>pH</td>
<td>0.35$^b$</td>
<td>$&lt;0.001$</td>
<td>0.27$^c$</td>
<td>0.30$^c$</td>
</tr>
<tr>
<td>Citrate, mg</td>
<td>0.39$^b$</td>
<td>$&lt;0.001$</td>
<td>0.36$^b$</td>
<td>0.32$^c$</td>
</tr>
<tr>
<td>Osmolality, mOsm/kg</td>
<td>0.26$^c$</td>
<td>0.002</td>
<td>0.20$^d$</td>
<td>0.26$^d$</td>
</tr>
<tr>
<td>Urine volume, ml</td>
<td>0.30$^c$</td>
<td>0.002</td>
<td>0.24$^d$</td>
<td>0.35$^c$</td>
</tr>
</tbody>
</table>

$^a$Dietary covariates included for each outcome measure were based on the correlations between the urinary measures and the dietary measures (Table 2). Dietary covariates are as follows: for urinary calcium, dietary protein, animal protein, calcium, and fructose; for urinary magnesium, dietary protein, animal protein, calcium, oxalate, and fructose; for pH, animal protein and sucrose; for citrate, dietary protein, animal protein, and fructose; for osmolality, dietary protein, animal protein, and sucrose; for urine volume, dietary protein, animal protein, calcium, and oxalate.

$^bP<0.001$.

$^c0.001<P<0.01$.

$^d0.01<P<0.05$.

$^eP<0.01$.

Table 5: Genetic and environmental correlations among pairs of urine traits with highly significant heritabilities

<table>
<thead>
<tr>
<th>Trait (24-h Urine Measures)</th>
<th>Calcium, mg</th>
<th>Magnesium, mg</th>
<th>pH</th>
<th>Citrate, mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium, mg</td>
<td>0.25$^a$</td>
<td>0.38$^{b,c}$</td>
<td>0.22$^{b,d}$</td>
<td>0.48$^{b,c}$</td>
</tr>
<tr>
<td>Magnesium, mg</td>
<td>0.56$^{d,e}$</td>
<td>0.25$^a$</td>
<td>0.18$^{b,d}$</td>
<td>0.19$^{b,d}$</td>
</tr>
<tr>
<td>pH</td>
<td>$-0.20^e$</td>
<td>0.08$^d$</td>
<td>0.27$^a$</td>
<td>0.37$^{b,c}$</td>
</tr>
<tr>
<td>Citrate, mg</td>
<td>0.35$^e$</td>
<td>0.44$^{d,e}$</td>
<td>$-0.35^e$</td>
<td>0.36$^a$</td>
</tr>
</tbody>
</table>

$^a$Heritabilities from univariate polygenic analysis ($h^2$).

$^b$Environmental correlations ($r_e$).

$^cP<0.001$.

$^d0.01<P<0.05$.

$^eGenetic correlations ($r_g$).
some evidence for heritability of the two indices of urinary inhibition we studied in this cohort, a seeded CaOx crystal growth assay and the ULM. However, the heritability was not present in models after adjustment for age, sex, and weight. Although it is possible that other indices of crystal growth inhibition might have stronger heritable components, the role of inhibitors as a genetically influenced risk for stone disease remains unclear.

The sibship structure of our sample also allowed us to mathematically estimate the portion of the correlation between urinary traits that was a result of apparent genetic effects, with the remainder assumed to be environmental (Table 4). There was moderate genetic correlation between urinary calcium and magnesium excretion ($r_e = 0.56; P = 0.03$). Genetic variation of renal proteins important for the reabsorption of both divalent cations in the thick ascending limb may be logical candidates to implicate (36). Environmental correlations between urinary calcium, magnesium, pH, and citrate ($r_e$ from 0.18 to 0.48; $P$ values from 0.03 to $1.5 \times 10^{-6}$) may represent the joint effect of dietary patterns (e.g., low vegetable/fruit intake with high meat intake).

Our study also has potential weaknesses. Human epidemiologic studies have demonstrated an association between hypertension and kidney stones (42–44). Moreover, hypercalciuria, a common risk factor for nephrolithiasis, has also been associated with high BP in humans (45–47), implicating altered calcium metabolism as a common feature. Because GENOA cohort members were selected on the basis of hypertensive sibships, their stone risk may be higher and they may also be enriched for nephrolithiasis risk factors such as the ones we studied. In addition, the participants were limited to Caucasians and of a relatively older age when studied. Thus, findings may not be directly transferable to the general population.

In conclusion, evidence from this relatively large cohort suggests a strong heritable component to many urinary traits that impart nephrolithiasis risk. This study supports an underlying genetic component to stone disease that could act via physiologic control of urinary composition.

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Disclosures

None.

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