

The Lead Education and Abatement Design Group
Working to eliminate lead poisoning globally and to protect the
environment from lead in all its uses: past, current and new uses
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## Alcohol's link to higher lead and iron levels

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Since the 1980s it has been clear there were links between higher blood lead levels and alcohol consumption (Shaper et al 1982, Hense et al 1992, Pizent et al 2001). In the USA women who were heavy alcohol consumers were 5.6 times more likely to be in the highest 10% of the population for blood lead than teetotallers [consumers of no alchohol] (Lee et al 2005). Much effort was expended in the 1990's, tracking possible sources of lead contamination in alcohol, notably lead seals on wine bottles and illicit liquor. But the overall correlations were not explainable by the degree of lead contamination (Shaper et al 1982 p301).

A clue, however, appeared in an apparent contradiction – individuals who consumed significant alcohol were likely to have higher iron levels (Whitfield 2001). Two glasses of alcohol a day reduces the risk of being iron deficient (Whitfield et al 2001 p1041) and any alcohol consumption reduced the risk of iron deficiency anaemia by up to 40% (Ioannou et al 2004). Again much research effort was spent identifying sources of contamination, notably in Africa, where beer was brewed in iron vats (Choma et al 2007). But the trend was apparent outside Africa (Whitfield et al 2001) and was the result of increased rates of iron absorption from the intestine (Duane et al 1992, Kohgo et al 2007 p4701).

The reason why higher levels of iron and lead are contradictory is that lead and iron compete for absorption. Indeed lead is only readily absorbed and distributed because body systems are unable to easily identify lead from iron, calcium and, in some cases, zinc and lead replaces these essential minerals in many key functions. Iron and lead share a common transporter within the body, DMT1, which is used for both intestinal absorption of iron (or lead) and their transfer within the body via the bloodstream. DMT1 levels are increased by iron deficiency. There is clear evidence that iron deficiency results in higher lead absorption. (Taylor 2009). This should mean that if adequate amounts of iron are absorbed, lead absorption should be restricted to some degree. For individuals who consume significant alcohol, the reverse seems true – they absorb more lead as they absorb more iron.

An explanation was not possible until the first decade of the twenty first century. In 2003-2004 the molecule that predominantly regulates iron metabolism was identified: hepcidin. The higher the iron storage levels within the body are, the more hepcidin is produced by the liver and the less iron can be absorbed (Harrison-Findik 2009). One mechanism for this is the suppression of DMT1 production which thus reduces intestinal absorption of lead (Mena et al 2008). Iron storage levels within the body have more impact on the absorption of iron than either the quantity of iron in foods consumed or the food iron's bioavailability (capacity to be absorbed) (Hunt 2001).

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It is clear that alcohol alters the rate of hepcidin production, at least partly through oxidative stress from free radicals in the body; though the range of methods by which it alters hepcidin levels is yet to be fully understood (Harrison-Findik 2009). Direct genetic impacts also occur. An intriguing study was done on the impact of ethanol (the active ingredient in alcohol) on the genes that govern hepcidin production. Ethanol reverses the impact of iron storage levels on most of these genes, so the alcohol-influenced body reacts to adequate iron as if it were iron deficient – reducing hepcidin production to increase iron absorption (Crist et al 2007). Given that iron deficiency increases lead absorption the predictable outcome should be an increase in lead absorption, which is what is found, despite the absence of actual iron deficiency.

Thus the theoretical impact reflects real world observations, but it must be emphasised far more work is needed to confirm the mechanisms by which alcohol increases both iron and lead absorption. The impacts of different ethanol doses and frequency of ethanol consumption (alcohol intakes), the relative effects on iron and lead absorption and even the confirmation that alcohol consumption leads to ethanol affecting the genes governing hepcidin, all need to be elucidated. But on present data, it would seem that alcohol greatly increases lead absorption by damaging the body's ability to regulate the absorption of iron and a fair proportion of this impact is likely to be due to impacts at the cellular level on DNA and/or RNA.

There is significant data that indicates that alcohol may also increase the susceptibility of some organs, to lead toxicity, by depleting calcium, zinc and magnesium levels (Béchetoille et al 1983, Flora et al 1991, Gupta & Gill 2000a) and some evidence alcohol could possibly magnify the impact of lead (act synergistically with lead) on organs such as the brain (Gupta & Gill 2000b). In conjunction with lead, alcohol may also increase the risk of high blood pressure among women (Hense et al 1994, Pizent et al 2001) though it must be emphasised the size of the link is not large, there is much contradictory data on links between blood lead levels and blood pressure and lead may not be a direct cause of higher blood pressure (Nawrot et al 2002, Hond et al 2003). There have been studies that have shown links between blood pressure and blood lead among US African- Americans, particularly women, but not US whites (Vupputuri et al 2003) and among Taiwanese males but not females (Chu et al 1999) while in Germany (Hense et al 1994) there was increased blood pressure among heavy female alcohol consumers but only among rural (not urban) heavy male alcohol consumers. Far more work is needed on this subject before any definitive statements can be made.

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