

The 2D:4D ratio and sex difference in circulating liver enzymes in adulthood? A cross-sectional study in Ghana

ABSTRACT

Aims: The second-to-fourth digit ratio (2D:4D) and the right-left difference (Dr-l) are the putative markers of prenatal hormone exposure. These digit ratios are sexually dimorphic and are said to be positive and negative correlates, respectively, of circulating testosterone and estrogen in adulthood. There is also a sex difference in liver function in adulthood which may be due to sex differences in plasma liver enzyme activity or concentration. The observed sex difference in liver function has been attributed to the sex difference in circulating testosterone and estrogen. The study sought to determine whether prenatal hormone exposure, as indexed by the 2D:4D or Dr-l, may partly account for sex differences in circulating liver enzyme levels in adulthood.

Study design: The study was cross-sectional

Place and Duration of Study: The study was conducted from June to December 2021 at the University for Development Studies.

Methodology: There were 190 healthy participants (females=94 and males=96), between the ages of 18 and 32 years. The right-hand (2D:4DR), and the left-hand (2D:4DL) digit ratios and the right-left hand difference (Dr-l) were measured using computer-assisted analysis. Venous blood samples were collected and assayed for aspartate aminotransferase (AST), alanine aminotransferase (ALT), alkaline phosphatase (ALP) and gamma-glutamyl transferase (GGT).

Results: The adjusted odds ratio (AOR) and 95% confidence interval (CI) showed that males had greater odds of higher plasma GGT than females [AOR=1.035 (95%CI: 1.004-1.067), P=0.025]. However, there were no interactions between sex and digit ratio on adult plasma liver enzymes.

Conclusion: The 2D:4D ratio or Dr-l may not have an impact on sex differences in plasma liver enzyme levels in adulthood.

Keywords: Liver, Digit ratios, Testosterone, Estrogens, Transferases, Ghana

1.0 INTRODUCTION

Sex differences in liver function have been suggested in the literature. The expression of genes that regulate liver enzyme activity is influenced by the brain in both health and disease and has been demonstrated to be sexually dimorphic (Brie et al., 2019). Liver enzymes such as aspartate aminotransferase (AST), alanine aminotransferase (ALT), alkaline phosphatase (ALP) and gamma-glutamyl transferase (GGT) tend to be higher in males than females (Belay et al., 2020, Dillon and Miller, 2016, Dosoo et al., 2012). Moreover, the prevalence and pathophysiology of liver diseases also tend to follow a sexually dimorphic pattern although the findings are varied (Kurt et al., 2018, Lefebvre and Staels, 2021, Ballestri et al., 2017). Previous studies have demonstrated that premenopausal women are more protected from non-alcoholic liver disease (NAFLD), steatosis and hepatocellular carcinoma (HCC) than aged-matched postmenopausal women or males (Kurt et al., 2018, Lefebvre and Staels, 2021). Moreover, there are increased hepatic inflammatory changes and steatosis among ovariectomized women

and women with senescence ovaries or polycystic ovarian syndrome (PCOS). Epidemiological studies have demonstrated that the prevalence of NAFLD increases as women age but decreases as men age. It has also been observed that the prevalence of hepatocellular carcinoma ranges from a ratio of 2:1 to 7:1 for male-to-female. However, this has only been observed among premenopausal women and not postmenopausal women or women with PCOS (Kurt et al., 2018, Lefebvre and Staels, 2021). The differences between males and females regarding liver function and enzyme activity have been attributed to sex hormones. Estrogen may play a hepato-protective role due to its hypolipidemic, antioxidant, antisteatotic and antifibrogenic properties (Ballestri et al., 2017). However, studies among persons undergoing hormonal therapy for hypogonadism or sex affirmation have demonstrated both the positive and harmful effects of estrogen and testosterone although some authors have suggested that such observations could be due to differences in hormonal formulations, dosage and the route of administration (Stangl et al., 2021, Yassin et al., 2020).

The Organizational Hypothesis posits that prenatal testosterone (PT) exposure leads to sexual dimorphism in human phenotypic traits including the second-to-fourth digit ratio (2D:4D) (Breedlove, 2010). The 2D:4D is the putative marker of PT exposure. However, exposure to PT alone does not fully account for the sexual dimorphism in the 2D:4D ratio, but a balanced exposure to both PT and prenatal estrogen (PE) during a narrow window in prenatal development (Zheng and Cohn, 2011). Evidence in support of the effect of PT and PE exposure on the 2D:4D ratio has been adduced from persons with congenital adrenal hyperplasia (CAH), a condition characterized by hyperandrogenemia and also persons with Klinefelter's syndrome (KS) or complete androgen insensitivity syndrome (CAIS). Even though there has not been a consensus on them, CAH patients have lower 2D:4D while KS and CAIS patients have higher 2D:4D ratios compared to controls (Nave et al., 2021, Richards et al., 2020, Manning et al., 2013). The 2D:4D ratio and the right-left difference (Dr-I) are similar in the pattern given to the observation that a lower 2D:4D of the right hand may be associated with more masculine traits and higher ratios with feminine traits. The 2D:4D or the Dr-I are negative and positive correlates of PT and PE exposure respectively and are lower in females than males on average (Manning, 2002). They have also been found to correlate positively with circulating testosterone but negatively with circulating estrogen in adulthood, although this observation has not been universal (Manning, 2002, Richards et al., 2018, Muller et al., 2011, Hönekopp et al., 2007). Also, the use of the 2D:4D ratio or the Dr-I as putative markers of PT and PE exposure has been controversial (Leslie, 2019). However, an overview and a critical review of the available literature have provided pieces of evidence in support of their validity (Swift-Gallant et al., 2020, McCormick and Carré, 2020).

Given the above observations, it may be suggested that hyperandrogenemia or enzyme activity may be correlated with the 2D:4D ratio or the Dr-I. Although previous studies have demonstrated sex differences in liver function and enzyme activity, hitherto, no study has examined the impact of prenatal hormone exposure, as indexed by the 2D:4D ratio or Dr-I on sex differences in liver enzyme activity in adulthood, hence the aim of the study.

2.0 MATERIALS AND METHODS

21. Study design and settings

The study was cross-sectional and was carried out on the Tamale campus of the University for Development Studies between June and December 2021. The University for Development Studies is a multi-campus tertiary-level educational institution in the Northern region of Ghana

that offers both under- and post-graduate programs in the Medical, Agricultural Sciences and Education.

2.2 Study population

The study involved 190 healthy participants (females=94, males=96), who were between the ages of 18 years and 32 years. The study population was part of a larger study from which some parts have already been published (Banyeh et al., 2022a, Banyeh et al., 2022b). The participants had no known history of fractures that could markedly affect standing height and finger length measurements. They did not also have any known liver disorders such as hepatitis, steatosis or cirrhosis. Common factors that may influence liver enzyme activity such as pregnancy, childbirth, smoking, oral contraceptive use, coffee or alcohol consumption and exercise were also excluded. The study was not restricted by one's program of study, cultural, religious or political affiliations.

2.3 Variables

The dependent variables were aspartate aminotransferase (AST), alanine aminotransferase (ALT), alkaline phosphatase (ALP) and gamma-glutamyl transferase (GGT). The predictor or independent variables were the 2D:4D ratios and the right-left difference (Dr-l). The variables that were considered confounding variables were age at the time of sampling and body mass index (BMI).

2.4 Anthropometric measurements

The standing height and body weight were measured to the nearest 0.1 cm and 0.1 Kg using a stadiometer and body weighing scale respectively. The body mass index was calculated in Kg/m^2 as $\text{body weight}/(\text{height})^2$. The second and fourth finger lengths of both hands were measured from hand scans using computer-assisted analysis (Fink and Manning, 2018). Each finger length was measured from the most proximal basal crease to the tip of the finger (Manning et al., 1998). Each finger was measured twice by the same observer and then averaged (Figure 1). The right (2D:4DR) and left (2D:4DL) digit ratios were calculated as the ratio of the second-to-fourth digit lengths. The right-left 2D:4D difference (Dr-l) was calculated. The intraclass correlation coefficients (ICC) between the repeated measurements were calculated using the two-way mixed, single measures with absolute agreement technique. The ICC were 0.966 and 0.950 for the 2D:4DL and 2D:4DR respectively.

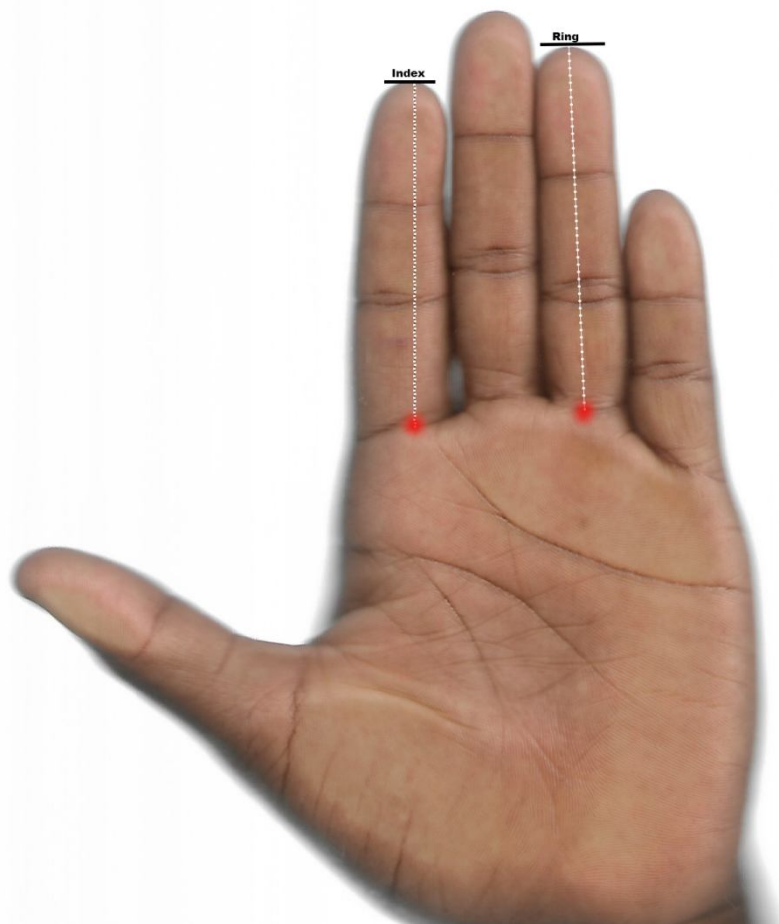


Figure 1: The scanned image of the palmar surface of the hand. The length of the second and fourth fingers was measured from the most proximal crease to the tip of the finger.

2.5 Laboratory analyses

Venous blood samples were collected into K₃EDTA anticoagulated tubes. The blood samples were centrifuged at 1500 rpm for 10 minutes to obtain plasma. The plasma samples were aliquoted and stored at -20°C and were never thawed and refrozen until analysis. The plasma samples were analyzed for AST, ALT, ALP and GGT on the BT 1500 automated biochemistry analyzer (Biotechnica Instruments, SPA, Italy) following the manufacturer's instructions and using the recommended reagents. All measurements and sample collection were performed between 8.00 AM and 12.00 PM local time to reduce diurnal variations.

2.6 Statistical analysis

All statistical analyses were performed in SPSS (v23) and GraphPad Prism (v8). The data were for normality and the presence of outliers using the Shapiro-Wilk test. The data were then summarized as mean \pm SD, separately for males and females. The differences in male and female mean values were determined using the student t-test (unpaired, 2-tailed). The Dr-I was compared to a reference value of zero for asymmetry, separately for males and females using the one-sample t-test (1-tailed). Moderated linear regression models were then formulated with liver enzymes as the dependent variables and the 2D:4D ratio as the predictor variable. The predictor variables were centered on their means by subtracting the mean value from the

variable. Two-way interaction terms were then created between sex and the centered predictor variables (e.g. Sex*2D:4DR-centered). To reduce confounding, the age at the time of sampling and the BMI were added to each model as covariates. To graphically present sex differences in liver enzyme activity, the unstandardized predicted values of the dependent variable were plotted on the y-axis against the mean-centered 2D:4D ratio or Dr-I on the x-axis while sex was made the marking variable. The assumptions of multivariable linear regression were tested using Cook's distance (Cook's D) for influential multivariable outliers, residual P-P plot for multivariable normality, residual scatter plot for homoscedasticity, the variance inflation factor for multi-collinearity and the Durbin-Watson test for autocorrelation between the independent variables (Tranmer and Elliot, 2008). A P-value <0.050 was considered statistically significant.

3.0 RESULTS

3.1 Comparison of Male and Female Variables

The male and female variables of the study population are summarized in Table 1. Male participants had a significantly higher ALT and GGT than females (P<0.050). There were no sex differences in the 2D:4D ratio. In the binary logistic regression analysis (Table 2), males had greater odds of increased GGT relative to females [AOR=1.035 (95%CI: 1.004 - 1.067), P=0.025].

Table 1. The comparison of the mean values of male and female variables of the study population

Variable	Female	Male	t statistic	P-value
Age (years)	22.3±2.45	23.3±2.60	-1.796	0.076
BMI (Kg/m ²)	23.8±3.58	21.2±4.09	3.331	0.001
AST (IU/L)	21.1±9.95	23.4±14.64	-0.891	0.375
ALT (IU/L)	17.9±11.62	23.5±12.76	-2.229	0.028
ALP (IU/L)	111.6±50.22	116.3±41.42	-0.498	0.620
GGT (IU/L)	24.5±14.52	32.1±16.43	-2.406	0.018
2D:4DR	0.935±0.036	0.935±0.035	-0.020	0.984
2D:4DL	0.937±0.038	0.935±0.033	0.217	0.828
Dr-I	-0.002±0.028	-0.000±0.004	-0.309	0.758

The results are presented as mean ± SD. The mean difference between males and females was compared using the student t-test (unpaired). The Dr-I were compared to the reference value (0) for directional asymmetry using the one-sample t-test (1-tailed). AST= aspartate aminotransferase, ALT=alanine aminotransferase, ALP=alkaline phosphatase, GGT=gamma-glutamyl transferase

Table 2. The liver enzyme concentration in males relative to females

Variable	B	AOR	95%CI of AOR		P-value
			Lower	Upper	
AST (IU/L)	0.008	1.008	0.974	1.044	0.634
ALT (IU/L)	0.027	1.028	0.987	1.070	0.185
ALP (IU/L)	0.003	1.003	0.993	1.013	0.605
GGT (IU/L)	0.035	1.035	1.004	1.067	0.025

Logistic regression analysis with females as the reference sex. The logistic regression models were adjusted for age and body mass index (BMI). AOR=adjusted odds ratio, AST= aspartate aminotransferase, ALT=alanine aminotransferase, ALP=alkaline phosphatase, GGT=gamma-glutamyl transferase

3.2 Correlation and linear relationships between the dependent and independent variables

The correlation and linear relationship between liver enzymes and digit ratios are plotted separately for females (Figure 2) and males (Figure 3). In females, the Dr-I was inversely correlated with GGT ($r = -0.36$, $P = 0.013$). Also, the Dr-I could explain about 13% of the variability of GGT in females ($R^2 = 0.13$). However, no significant correlation or relationships were observed in males.

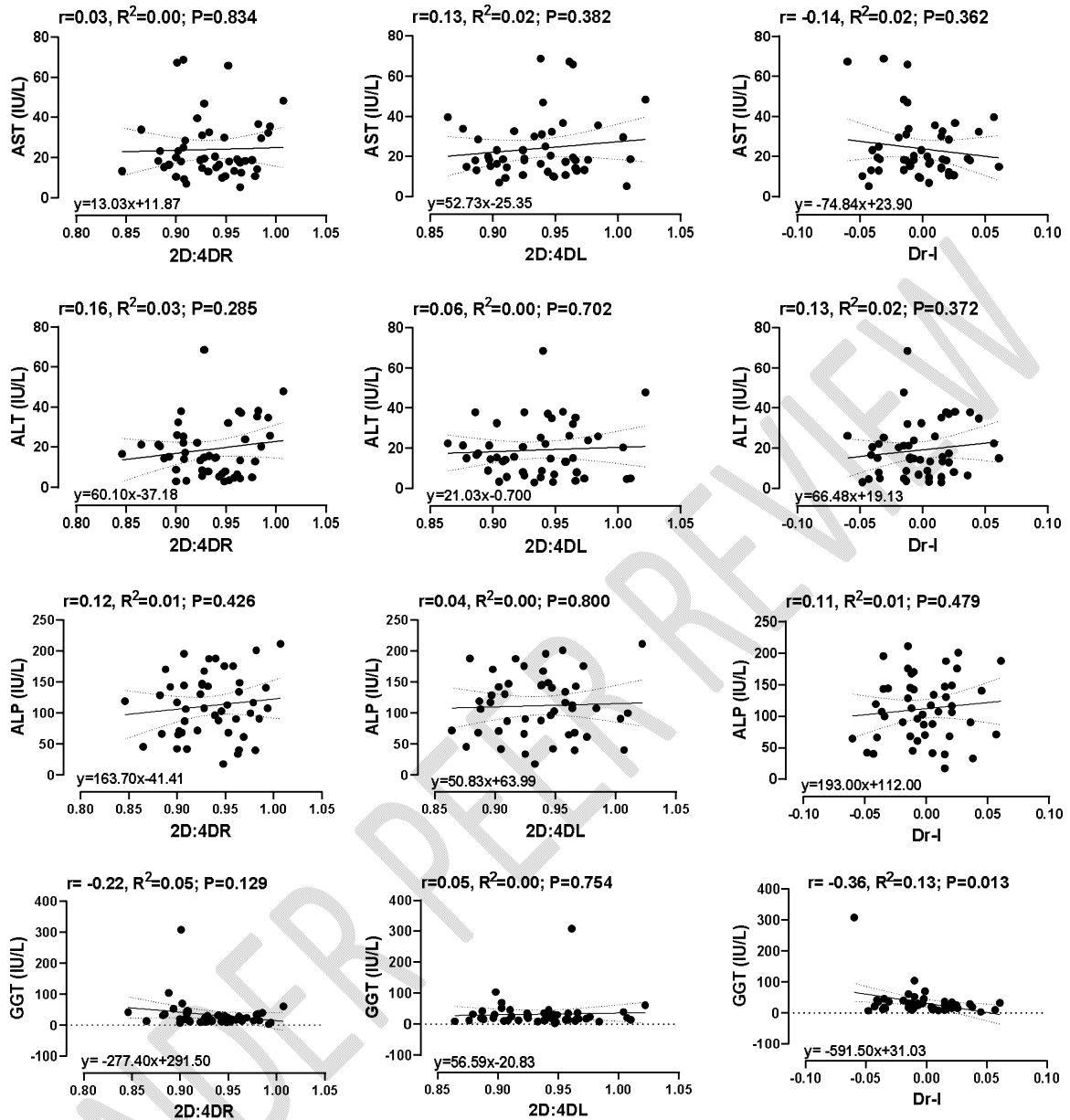


Figure 2: Correlation and linear relationship between liver enzymes and digit ratios in females. AST= aspartate aminotransferase, ALT=alanine aminotransferase, ALP=alkaline phosphatase, GGT=gamma-glutamyl transferase

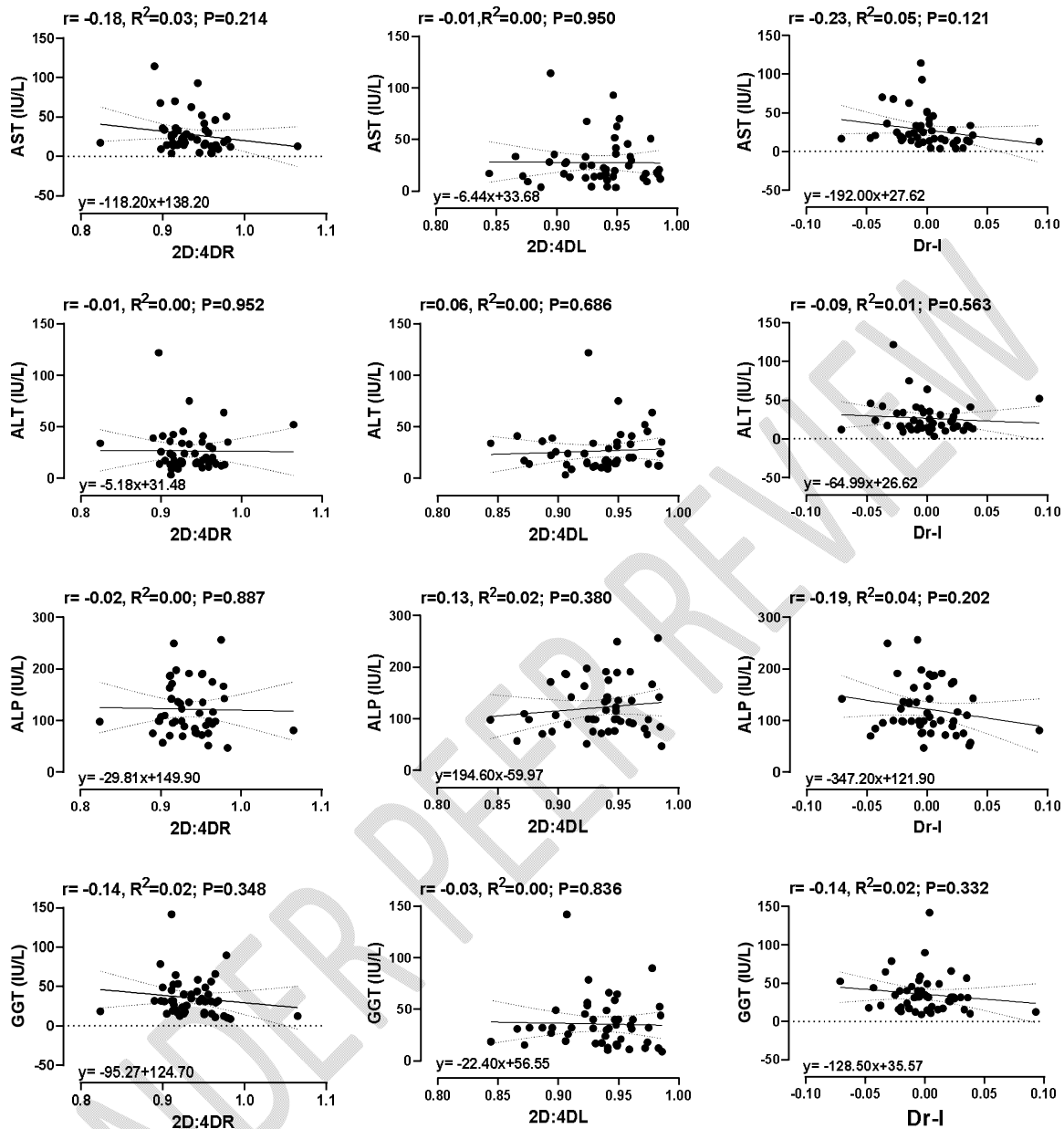


Figure 3. Correlation and linear relationship between liver enzymes and digit ratios in males. AST= aspartate aminotransferase, ALT=alanine aminotransferase, ALP=alkaline phosphatase, GGT=gamma-glutamyl transferase

3.3 Interactions between sex and digit ratios on plasma liver enzyme levels

From Tables 3 and 4, there were no significant interactions between sex and the 2D:4D ratio on adult plasma liver enzyme levels. However, sex differences in the GGT were still significant even after adjusting for age and BMI (Figure 4). The assumptions of linear regression were tested following recommended guidelines (Tranmer and Elliot, 2008, Noel et al.). The assumption of homoscedasticity was tested in the univariable regression (Supplementary

Figures S1 and S2). Also, assumptions of multivariable normality and homoscedasticity were tested (Supplementary Figure S3).

Table 3: Interactions between sex and the 2D:4D ratio on AST and ALT concentration

LR	Dependent Variable	B	95%CI		P-value
			Lower	Upper	
	AST (IU/L)				
1	(Constant)	25.270	-1.505	52.044	0.064
	Age (years)	0.158	-0.917	1.233	0.771
	BMI (Kg/m ²)	-0.323	-1.020	0.373	0.359
	Sex	1.284	-4.351	6.919	0.652
	2D:4DR	51.733	-50.825	154.292	0.319
	Sex*2D:4DR	-85.302	-232.946	62.342	0.254
2	(Constant)	27.630	0.726	54.534	0.044
	Age (years)	0.010	-1.071	1.091	0.985
	BMI (Kg/m ²)	-0.285	-0.997	0.427	0.428
	Sex	1.600	-4.060	7.261	0.576
	2D:4DL	24.736	-76.987	126.458	0.630
	Sex*2D:4DL	30.544	-123.265	184.352	0.694
3	(Constant)	25.476	-0.464	51.416	0.054
	Age (years)	0.062	-0.979	1.103	0.906
	BMI (Kg/m ²)	-0.240	-0.930	0.449	0.491
	Sex	1.668	-3.869	7.205	0.551
	Dr-I	46.544	-88.512	181.600	0.495
	Sex*Dr-I	-182.466	-372.953	8.021	0.060
	ALT (IU/L)				
1	(Constant)	28.552	3.221	53.882	0.028
	Age (years)	0.240	-0.777	1.257	0.640
	BMI (Kg/m ²)	-0.671	-1.330	-0.012	0.046
	Sex	3.585	-1.746	8.916	0.185
	2D:4DR	75.046	-21.981	172.072	0.128
	Sex*2D:4DR	-24.969	-164.649	114.712	0.723
2	(Constant)	27.032	1.287	52.777	0.040
	Age (years)	0.333	-0.701	1.368	0.524
	BMI (Kg/m ²)	-0.697	-1.378	-0.016	0.045
	Sex	3.499	-1.917	8.916	0.203
	2D:4DL	40.570	-56.771	137.911	0.410
	Sex*2D:4DL	-10.462	-157.645	136.721	0.888
3	(Constant)	24.552	-0.709	49.813	0.057
	Age (years)	0.336	-0.677	1.350	0.511
	BMI (Kg/m ²)	-0.592	-1.264	0.080	0.084
	Sex	3.633	-1.760	9.025	0.184
	Dr-I	59.197	-72.325	190.720	0.374
	Sex*Dr-I	-22.489	-207.993	163.015	0.810

Linear regression models with 2-way interaction terms. The 2D:4D were centered on their mean before analysis to reduce multicollinearity. LR=linear regression, AST= aspartate aminotransferase, ALT=alanine aminotransferase

Table 4: Interactions between sex and the 2D:4D ratio on ALP and GGT concentrations

LR	Dependent Variable	B	95%CI		P-value
			Lower	Upper	
	ALP (IU/L)				
1	(Constant)	9.697	-86.624	106.018	0.842
	Age (years)	3.563	-0.304	7.430	0.071
	BMI (Kg/m ²)	0.942	-1.564	3.448	0.457
	Sex	3.823	-16.449	24.095	0.709
	2D:4DR	121.478	-247.477	490.433	0.515
	Sex*2D:4DR	-266.620	-797.771	264.531	0.321
2	(Constant)	9.580	-87.597	106.757	0.845
	Age (years)	3.442	-0.463	7.347	0.083
	BMI (Kg/m ²)	1.058	-1.512	3.629	0.415
	Sex	4.248	-16.198	24.693	0.681
	2D:4DL	13.155	-354.269	380.579	0.943
	Sex*2D:4DL	-58.175	-613.733	497.384	0.836
3	(Constant)	11.668	-83.174	106.511	0.807
	Age (years)	3.143	-0.663	6.949	0.104
	BMI (Kg/m ²)	1.259	-1.263	3.782	0.324
	Sex	5.036	-15.209	25.281	0.622
	Dr-I	196.411	-297.384	690.206	0.431
	Sex*Dr-I	-370.397	-1066.861	326.067	0.293
	GGT (IU/L)				
1	(Constant)	21.874	-11.075	54.823	0.191
	Age (years)	0.044	-1.279	1.367	0.947
	BMI (Kg/m ²)	0.066	-0.791	0.924	0.878
	Sex	7.803	0.868	14.737	0.028
	2D:4DR	-61.916	-188.126	64.294	0.332
	Sex*2D:4DR	-31.279	-212.972	150.414	0.733
2	(Constant)	26.357	-7.244	59.958	0.123
	Age (years)	-0.168	-1.518	1.182	0.805
	BMI (Kg/m ²)	0.078	-0.811	0.967	0.862
	Sex	8.014	0.945	15.084	0.027
	2D:4DL	-4.652	-131.697	122.393	0.942
	Sex*2D:4DL	-1.530	-193.627	190.566	0.987
3	(Constant)	27.386	-4.832	59.604	0.095
	Age (years)	-0.106	-1.399	1.187	0.870
	BMI (Kg/m ²)	-0.027	-0.884	0.830	0.950
	Sex	7.897	1.020	14.774	0.025
	Dr-I	-101.470	-269.213	66.272	0.233
	Sex*Dr-I	-41.387	-277.976	195.203	0.729

Linear regression models with 2-way interaction terms. The 2D:4D were centered on their mean

before analysis to reduce multicollinearity. LR=linear regression, ALP=alkaline phosphatase, GGT=gamma-glutamyl transferase

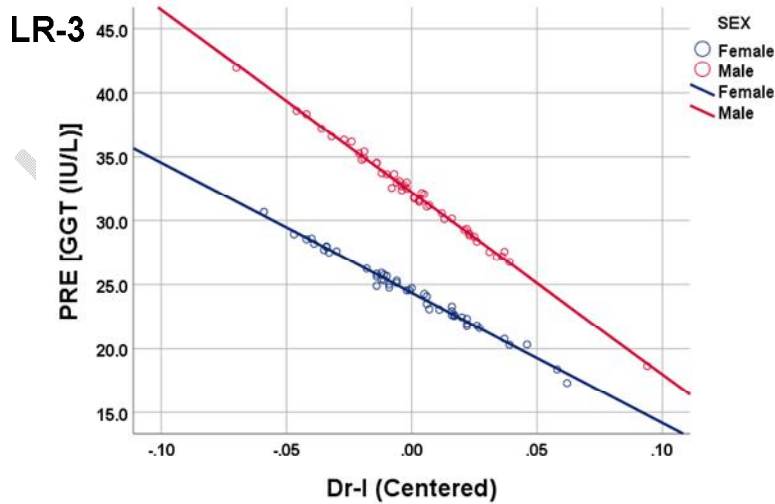
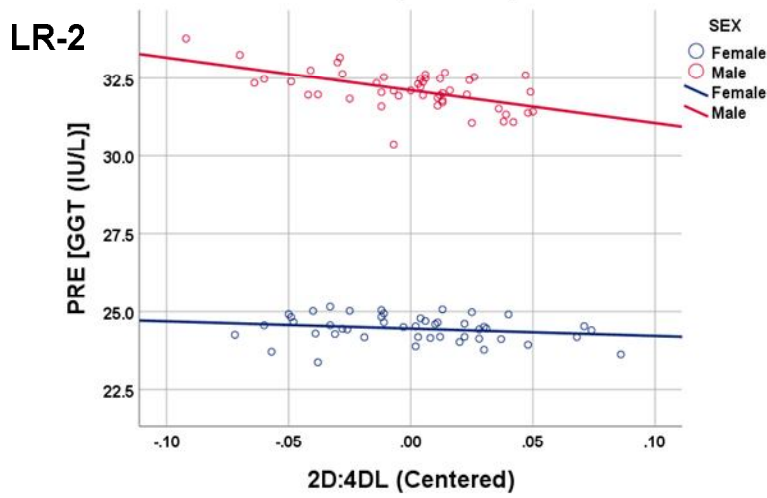
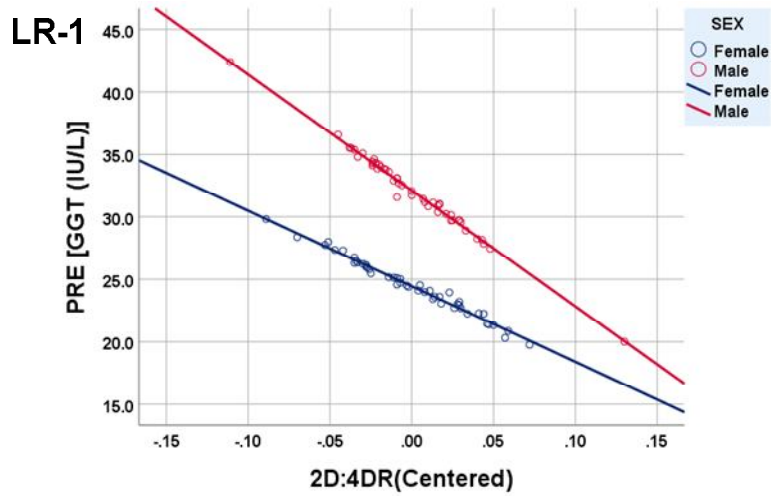


Figure 4. Moderated linear regression with two-way interaction effects. The unstandardized predicted value (PRE) of the dependent variable (GGT=gamma-glutamyl transferase) was plotted against the centered independent variable (Dr-I). LR=Linear regression

4.0 DISCUSSION

The study sought to determine whether sex differences in plasma liver enzyme levels are influenced by prenatal hormone exposure as indexed by the 2D:4D ratio. Sex difference in the 2D:4D ratio was not observed and no significant interactions between sex and the 2D:4D ratio on plasma liver enzyme levels were seen. However, males had higher GGT and ALT than females. Moreover, after controlling for age and BMI, only plasma GGT showed a significant sex difference, where males had relatively greater odds of increased GGT than females.

In this study, males had significantly higher plasma ALT and GGT than females. Similar findings have been reported from the Amhara region of Ethiopia, Kenya and Ghana (Mekonnen et al., 2017, Abebe et al., 2018, Omuse et al., 2020, Dosoo et al., 2012). However, after controlling for age and BMI, only GGT levels remained significantly higher in males. Gamma-glutamyl transferase is involved in the transfer of amino acids across cell membranes as well as the metabolism of glutathione and leukotriene (Kunutsor, 2016). The enzyme, GGT also plays a major role in the maintenance of intracellular homeostasis of oxidative stress (Dillon and Miller, 2016). The levels of GGT may rise in response to liver injury and biliary diseases such as fatty liver disease, steatosis, hepatitis and cirrhosis of the liver (Whitfield, 2001, Dillon and Miller, 2016, Brennan et al., 2022). However, among healthy adults, there are sex differences in plasma GGT levels with higher values in males than females.

The 2D:4D ratio could not account for the observed sex differences in plasma GGT levels in adulthood. This may indicate that prenatal exposure to testosterone and estrogen may have no impact on plasma GGT levels among adults. Studies have shown that GGT shows age-specific and female-male variabilities in adulthood, which are not observed in children before adolescence (Middelberg et al., 2007). This may indicate that sex differences in plasma liver enzyme levels may occur postnatally. Developmental changes during puberty and adolescence are probable explanations for sex differences in plasma liver enzyme levels. According to Tahmasebi et al. (2019), GGT activity is reduced and without sex differences until adolescence when boys tend to have higher mean values than similarly-aged girls. The genetic factors that influence GGT levels to change over time during adolescence and the impact of these changes may be more pronounced in males than females (Middelberg et al., 2007, van Beek et al., 2013). If sex differences in GGT activity occur in adolescence, it may imply that the activity of sex hormones may partly account for this observation since sex hormones, on the average, peak in adolescence (Ansah et al., 2017, Rissech et al., 2008, Kunutsor, 2016).

The evidence of the differential effect of testosterone and estrogen on plasma GGT levels has been demonstrated in persons undergoing hormonal therapy although there have been variabilities (Stangl et al., 2021, Yassin et al., 2020, Al-Qudimat et al., 2021). Persons who were undergoing estrogen therapy for gender affirmation have been found to have intrahepatic cholestasis, a condition that may be characterized by elevated plasma GGT. Another source of evidence of the effect of estrogen on plasma GGT levels is the association between pregnancy and cholestasis (Kremer et al., 2017, Piechota and Jelski, 2020). These observations are, however, contrary to previous studies that have shown that the prevalence of fatty liver disease and other liver disorders are low and their prognosis is better among premenopausal women

relative to similarly aged men, postmenopausal women or women with PCOS. These differences in disease prevalence and prognosis have been attributed to the hepato-protective effect of estrogen (Ballestri et al., 2017, Vandell et al., 2021, Kurt et al., 2018). Also, long-term testosterone therapy among men with hypogonadism, complicated by steatosis and metabolic syndrome, tends to have improved liver function with a reduction in GGT levels (Stangl et al., 2021). This observation may not be consistent as elevated levels of GGT have been found among females on cross-sex hormone therapy using testosterone (Vita et al., 2018). The use of plasma GGT as a marker of liver function is however challenged. Some authors argue that GGT cannot replace ALP in the assessment of liver function because GGT is not specific to the liver but may be found in other tissues (Stangl et al., 2021, Dillon and Miller, 2016).

Sex differences in the 2D:4D ratio were not observed and the 2D:4D did not interact with sex on liver enzyme variables. Although previous studies have demonstrated sex differences in digit ratios in human populations, this has not been universal (Marczak et al., 2018, Manning et al., 2022). Even though there are critical reviews and overviews in support of the sexual dimorphism in the 2D:4D ratio, some have described it as an allometric artefact since the male hand is usually larger than the female's. Some have also attributed sexual dimorphism in the 2D:4D ratio to poor methodology in digit length measurements (Swift-Gallant et al., 2020, McCormick and Carré, 2020, Manning, 2002, Leslie, 2019). Similarly, the suggestion that fetal and adult gonadal activities may be correlated such that the 2D:4D ratio may be a correlate of adult circulating testosterone and estrogen has not been universal (Muller et al., 2011, Hönekopp et al., 2007, Manning et al., 1998). Previous studies have sought to show that Leydig cell populations during the fetal period and in adulthood originate from different stem cell populations and that their activities may not, therefore, be correlated (Wu et al., 2007, Dong et al., 2007, Zirkin and Papadopoulos, 2018).

The current study has some strengths: Firstly, although sex differences in liver function and plasma liver enzyme levels have been demonstrated (Brie et al., 2019, Dillon and Miller, 2016), there has not been any study that has investigated the possible association between plasma liver enzyme levels and the 2D:4D ratio as a marker of prenatal androgen exposure. Secondly, digit lengths were measured by computer-assisted analysis which is a more precise method than direct techniques (Fink and Manning, 2018, Ribeiro et al., 2016). Thirdly, in the formulation of interaction terms, the predictor variables were centered on their mean to reduce possible multicollinearity and the assumptions of linear regression were also tested (Robinson and Schumacker, 2009). The authors, however, acknowledge that there are population variabilities in digit ratios and liver enzyme activity and will therefore recommend further studies.

5.0 CONCLUSION

There is sexual dimorphism in gamma-glutamyl transferase activity with higher levels in males than females, independent of age and body mass index. There was no interaction between the marker of prenatal hormone exposure (2D:4D) and sex on liver enzyme activity in adulthood. It may be suggested that sexual dimorphism in adult liver enzyme activity may not be associated with prenatal hormone exposure.

ETHICAL APPROVAL

The study involved human subjects and as such the guidelines regarding human subject studies as contained in the 1964 Declaration of Helsinki and its later amendments were followed. The study was approved by the institutional review board of the University for Development Studies

(N#: UDS/RB/003/21). Written informed consent was obtained from each participant before the study. No information that may be used to link a participant to his/her data was collected.

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