Renal Safety in Patients Treated With Bisphosphonates for Osteoporosis: A Review

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ABSTRACT

Bisphosphonates are widely used for the treatment of osteoporosis and are generally well tolerated. However, the United States Food and Drug Administration safety reports have highlighted the issue of renal safety in bisphosphonate-treated patients. All bisphosphonates carry labeled "warnings" or a contraindication for use in patients with severe renal impairment (creatinine clearance <30 or <35 ml/min). Data from pivotal trials and their extension studies of bisphosphonates approved for the management of osteoporosis were obtained via PubMed, and were reviewed with support from published articles available on PubMed. Renal safety analyses of pivotal trials of oral alendronate, risedronate, and ibandronate for postmenopausal osteoporosis showed no short-term or long-term effects on renal function. Transient postinfusion increases in serum creatinine have been reported in patients receiving intravenous ibandronate and zoledronic acid; however, studies showed that treatment with these agents did not result in long-term renal function deterioration in clinical trial patients with osteoporosis. All bisphosphonate therapies have "warnings" for use in patients with severe renal impairment. Clinical trial results have shown that even in elderly, frail, osteoporotic patients with renal impairment, intravenous bisphosphonate therapy administration in accordance with the prescribing information did not result in long-term renal function decline. Physicians should follow guidelines for bisphosphonate therapies administration at all times. © 2013 American Society for Bone and Mineral Research.

KEY WORDS: BISPHOSPHONATES; RENAL IMPAIRMENT; OSTEOPOROSIS; ZOLEDRONIC ACID; RENAL SAFETY

Introduction

Osteoporosis is a major public health concern with rising prevalence resulting from the increasing longevity in many regions.12 A number of pharmacological options are available for the management of osteoporosis. They include bisphosphonates (alendronate, ibandronate, risedronate, and zoledronic acid), estrogens (estrogen and/or hormone therapy), estrogen agonist/antagonist (raloxifene), parathyroid hormone (PTH[1–34], teriparatide), and the receptor activator of NF-κB (RANK) ligand inhibitor, denosumab.2 Available in both oral and parenteral preparations, bisphosphonates are widely regarded as the drug class of choice for the prevention of fractures in postmenopausal women.12 This class of drug constitutes the focus of this review.

Bisphosphonates effectively reduce fracture risk and have a high benefit-to-risk ratio for the treatment of osteoporosis. Bisphosphonates are commonly used in an aged population who often present with concomitant kidney diseases or age-related reductions in estimated glomerular filtration rate (eGFR). Given that bisphosphonates are eliminated from the body through the kidneys, it is important to understand the effect of long-term use of bisphosphonates on renal function. A U.S. Food and Drug Administration (FDA) safety newsletter reported 24 cases of renal impairment and acute renal failure between April 2007 and February 2009, associated with the use of zoledronic acid 5 mg in patients with osteoporosis.23 A second FDA drug safety communication reported an additional 11 cases of fatal acute renal failure and nine cases of renal injury requiring dialysis after zoledronic acid infusion between March 2009 and April 2011.24 Subsequently, the prescribing information for zoledronic acid 5 mg was revised to include postmarketing surveillance data to reinforce existing warnings regarding renal safety, and to add a

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statement that zoledronic acid 5 mg is contraindicated in patients with creatinine clearance (CrCl) <35 mL/min and in those with evidence of acute renal impairment (the FDA accepted eGFR calculated by the Cockcroft-Gault formula in lieu of a 24-hour urine collection for calculation of CrCl). (46-48)

As a result of the mechanism of bisphosphonate excretion via the kidney, and the lack of clinical trial data in patients with osteoporosis and severe renal impairment (CrCl <30 mL/min), the oral bisphosphonates alendronate, risedronate, and ibandronate and the intravenous (IV) bisphosphonates ibandronate and zoledronic acid all carry warnings regarding their use in patients with CrCl <30 mL/min (risedronate, oral and IV ibandronate) or <35 mL/min (alendronate) and recently for zoledronic acid, a "contraindication" for CrCl <35 mL/min. (48-50)

As both osteoporosis and renal insufficiency become more prevalent with age and bisphosphonates are the most widely prescribed treatment for osteoporosis, it is important for physicians to understand the impact of bisphosphonate therapies in osteoporotic patients with different levels of renal function. The aim of this review is to examine clinical data regarding renal safety in patients with osteoporosis treated with bisphosphonates and to discuss considerations for bisphosphonate use in patients who have osteoporosis and chronic kidney disease (CKD) (but who do not require renal dialysis). Data from pivotal trials (including post hoc analyses) and their extension studies of approved bisphosphonates were obtained via PubMed, and were reviewed and discussed with support from published literature available on PubMed. A comprehensive search of postmarketing surveillance data was also performed through the European Medicines Agency (EMA) and FDA websites.

**Bisphosphonates and the Renal System**

Bisphosphonates are stable analogues of the inorganic compound, pyrophosphate, in which the P-O-P backbone of the molecule has been replaced by P-C-P. (51) The presence of a carbon atom allows for the attachment of side chains, the modification of which differentiates first-generation and second-generation bisphosphonates (eg, clodronate and pamidronate, respectively) from third-generation compounds (eg, zoledronic acid). (51) Third-generation bisphosphonates typically contain a heteroaromatic ring with at least one nitrogen atom as part of their side chains and have improved antiresorptive effect compared with early generations. (51) These nitrogen-containing bisphosphonates have improved potency over early generations because their antiresorptive effect is mediated via inhibition of the mevalonate pathway, whereas the non-nitrogen-containing bisphosphonates act by interfering with adenosine triphosphate-dependent intracellular pathways. (51-52)

Bisphosphonates are not metabolized. Between 27% and 62% of the drug binds to bone mineral and the rest is excreted via the kidneys, predominantly within hours after administration. (53-54) Renal excretion occurs by both passive glomerular filtration and active transport in renal proximal tubular cells. (55-56)

In humans, early use of bisphosphonates to treat hypercalcemia due to malignancy highlighted three cases of renal failure following IV administration of high doses of etidronate and clodronate. (57) Such cases of nephrotoxicity may occur secondary to the formation of aggregates within the blood. (58-59) Renal impairment such as acute tubular necrosis, tubulointerstitial damage, or focal segmental glomerulosclerosis have also been reported following IV administration of the third-generation bisphosphonate, zoledronic acid, every 3 to 4 weeks in patients with multiple myeloma or Paget's disease (Table 1). (60-65) In contrast to the mechanism by which first-generation bisphosphonates lead to renal failure, it is believed that the nephrotoxicity that may occur secondary to administration of third-generation bisphosphonates is caused—at least in part—by inhibition of the mevalonate pathway. (60-66) All reported cases of zoledronic acid–associated renal impairment involved the dosing regimen of zoledronic acid 4 mg once every 3 to 4 weeks, which is higher than the 3 mg once per year dosing for patients with osteoporosis. (67) Moreover, cancer patients (eg, patients with multiple myeloma or some advanced solid tumors) are known to be at risk of renal failure from compromised kidney function and hypercalcemia. (57-59)

Clinical data suggest that any potential renal damage associated with IV bisphosphonates may be infusion time-related or dose-related. In a study comparing zoledronic acid with pamidronate in patients with bone lesions secondary to cancer, the dosing schedule of zoledronic acid was amended from 4 or 8 mg via a 5-minute infusion once every 3 or 4 weeks, to 4 mg via a 15-minute infusion. (68) This change was made because of the high incidence of increased serum creatinine (SCR) levels among patients receiving zoledronic acid via a 5-minute infusion. (69) After the amendments, no significant differences in changes in renal function were seen between the zoledronic acid 4 mg–treated and the pamidronate 90 mg–treated groups during the 25-month treatment period. (70) A prostate cancer prevention trial also showed that a slower zoledronic acid infusion rate (15 minutes) may improve renal safety compared with a rapid (5-minute) infusion. (71)

Concerns about the potential impact on renal function of bisphosphonates led to exclusion of patients above a predefined SCR threshold in earlier studies: SCR > 2.5 mg/dL for the Fracture Intervention Trial (FIT) of alendronate (72); SCR > 1.1 times the upper limit of normal for the Vertebral Efficacy with Risedronate Treatment Multinational (VERT-MN) and VERT-North America (VERT-NA) studies of risedronate (73); and SCR > 2.4 mg/dL for the Oral Ibandronate Osteoporosis Vertebral Fracture Trial in North America and Europe (BONE) (74) the Monthly Oral Ibandronate in Ladies (MOBILE) trial (75) and the Dosing Intravenous Administration (DNA) study of IV ibandronate. (76) These early bisphosphonate trials excluded patients on the basis of SCR rather than GFR because, at the time, it was not appreciated that SCR—which is derived from skeletal muscle—is an inadequate means of estimating GFR. More recent clinical trials have used eGFR or actual GFR in the study inclusion/exclusion criteria. For example, patients with an estimated CrCl <30 mL/min were excluded from the Health Outcomes and Reduced Incidence with Zoledronic Acid Once Yearly (HORIZON) clinical trial program of zoledronic acid (77-79) and those with an actual GFR <35 mL/min were excluded from the Designed for Intravenous (IV) Ibandronate Renal Safety Evaluation (DIVINE) study. (80)
Table 1. Case Reports of Renal Events in Patients Receiving Zoledronic Acid

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Renal-Related Comorbidities</th>
<th>Zoledronic Acid Treatment</th>
<th>SCr at Baseline (mg/dL)</th>
<th>SCr at Follow-Up (mg/dL)</th>
<th>Clinical Presentation and Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>75-year-old male with multiple myeloma</td>
<td>75</td>
<td>acute renal failure</td>
<td>no</td>
<td>ZPA 90 mg monthly for 13 months then switch to ZA 4 mg monthly</td>
<td>1.5</td>
<td>3.8</td>
<td>SCr increased from 1.5 to 3.8 mg/dL; 24-hour urine protein, 2.6 g/dL; biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>65-year-old male with multiple myeloma</td>
<td>65</td>
<td>long-standing renal insufficiency</td>
<td>no</td>
<td>PAM 90 mg monthly for 2 years and 9 months then switch to ZA 4 mg monthly</td>
<td>1.6</td>
<td>3.8</td>
<td>SCr increased from 1.6 to 3.8 mg/dL; 24-hour urine protein, 2.6 g/dL; biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>74-year-old male with bone metastases</td>
<td>74</td>
<td>acute renal failure</td>
<td>no</td>
<td>PAM 90 mg monthly for 22 months then switch to ZA 4 mg monthly</td>
<td>1.0</td>
<td>3.8</td>
<td>SCr increased from 1.0 to 3.8 mg/dL; 24-hour urine protein, 2.6 g/dL; biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>57-year-old male with multiple myeloma</td>
<td>57</td>
<td>acute renal failure</td>
<td>no</td>
<td>ZPA 90 mg monthly for 13 months then switch to ZA 4 mg monthly</td>
<td>1.6</td>
<td>3.8</td>
<td>SCr increased from 1.6 to 3.8 mg/dL; 24-hour urine protein, 2.6 g/dL; biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>85-year-old male with multiple myeloma</td>
<td>85</td>
<td>multiple myeloma</td>
<td>no</td>
<td>ZA 4 mg infused over 15 minutes every 3-4 weeks for 14 months</td>
<td>1.4</td>
<td>1.7</td>
<td>SCr increased from 1.4 to 1.7 mg/dL (levels continued to increase to 2.6 mg/dL after treatment discontinuation for 2 months); analysis showed absence of protein, biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>73-year-old female with Paget's disease</td>
<td>73</td>
<td>acute renal failure</td>
<td>no</td>
<td>ZA 4 mg (9 doses), 3.3 mg (1 dose)</td>
<td>1.6</td>
<td>3.8</td>
<td>SCr increased from 1.6 to 3.8 mg/dL; 24-hour urine protein, 2.6 g/dL; biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>66-year-old male with multiple myeloma</td>
<td>66</td>
<td>acute renal failure</td>
<td>no</td>
<td>ZA 4 mg infused over 15 minutes every 3-4 weeks for 14 months</td>
<td>1.4</td>
<td>1.7</td>
<td>SCr increased from 1.4 to 1.7 mg/dL (levels continued to increase to 2.6 mg/dL after treatment discontinuation for 2 months); analysis showed absence of protein, biopsy revealed toxic ATN</td>
</tr>
<tr>
<td>72-year-old female with multiple myeloma</td>
<td>72</td>
<td>acute renal failure</td>
<td>no</td>
<td>ZA 4 mg (9 doses), 3.3 mg (1 dose)</td>
<td>1.6</td>
<td>3.8</td>
<td>SCr increased from 1.6 to 3.8 mg/dL; 24-hour urine protein, 2.6 g/dL; biopsy revealed toxic ATN</td>
</tr>
</tbody>
</table>

SCr = serum creatinine; ATN = acute tubular necrosis; NR = not reported; CrCl = creatinine clearance.
Clinical Evidence of the Effect of Bisphosphonates on Renal Function in Patients Treated for Osteoporosis

Oral bisphosphonates

Alendronate was studied in the FIT and the FLEX studies but renal safety data were not specifically discussed in the primary publications of these studies. However, a post hoc analysis of the FIT study of alendronate in women with postmenopausal osteoporosis showed that alendronate (5 mg/d for 2 years and 10 mg/d for the third year) had no negative effect on renal function, even in patients with eGFR as low as 15 mL/min (Table 2). No differences were found in bone mineral density (BMD) increases and antifracture efficacy for vertebral and all clinical fractures by renal function. The odds ratio (OR) for clinical fracture after alendronate therapy was 0.84 (95% confidence interval [CI], 0.45-1.54) in patients with eGFR <45 mL/min compared with 0.74 (95% CI, 0.61-0.91) in those with moderately reduced or normal eGFR (≥45 mL/min) (interaction p = 0.72). For spinal fractures, the OR was 1.01 (95% CI, 0.29-3.6) for those with eGFR <45 mL/min and 0.62 (95% CI, 0.36-1.10) for those with moderately reduced or normal eGFR (interaction p = 0.49).

For risedronate, renal safety results were not discussed specifically in the VERT-NA study publication, but a retrospective pooled analysis of phase III trials of risedronate 5 mg showed no significant differences between placebo and risedronate groups in changes from baseline in SCr at 6, 12, or 24 months (Fig. 1). The overall incidence of renal function-related adverse events did not differ statistically or clinically either within or between treatment groups in those patients with severe (CrCl <30 ml/min; risedronate versus placebo 3% versus 3%; relative risk [RR], 0.90; 95% CI, 0.31-2.04), moderate (CrCl 30-< 50 ml/min; 1% versus 2%; RR, 0.88; 95% CI, 0.53-1.45), or mild (CrCl >50-< 80 ml/min; 1% versus 2%; RR, 0.63; 95% CI, 0.37-1.07) renal impairment. The incidence of new vertebral fractures in risedronate-treated patients was also similar (p = 0.124) across subgroups of patients with different levels of renal impairment (eGFR using the Cockcroft-Gault formula). These data demonstrate that the renal antifracture efficacy of risedronate was not affected by these degrees of renal impairment. Additionally, a prospective, randomized trial in women with osteoporosis or osteopenia found no significant differences in blood urea nitrogen (BUN), SCr, and eGFR between baseline and 12 months for patients receiving risedronate, alendronate, or raloxifene. Moreover, between baseline and 12 months, the mean value of SCr remained unchanged and mean eGFR increased in all three treatment groups. These results suggest that use of these agents in patients with osteoporosis did not cause a change in renal function.

The BONE study of oral ibandronate (2.5 mg daily or 20 mg every other day for 12 doses every 3 months) in patients with postmenopausal osteoporosis did not report any clinically relevant changes in laboratory markers (including renal function tests) for the placebo or ibandronate treatment groups over a 3-year period (Table 2). Renal safety results were not included in the publication of the MOBILE study. None of the oral bisphosphonate registration trials included patients with an eGFR <15 ml/min, so there are no data on patients with National Kidney Foundation (NKF)-defined stage 5 CKD.

IV bisphosphonates

In the randomized, double-blind, 2-year DIVA study, 1395 women with postmenopausal osteoporosis received intermittent IV ibandronate (2 mg every 2 months or 3 mg every 3 months) or daily oral ibandronate 2.5 mg. At baseline, CrCl values (estimated using the Cockcroft-Gault formula) were <90 mL/min in 95.0% of patients and <60 mL/min in 50.5% of patients. The proportion of patients with a decline in CrCl at any time point was similar between the three treatment groups (daily oral ibandronate 2.5 mg, 41%; 2 mg every 2 months, 14.1%; 3 mg every 3 months, 17.3%) and the overall incidence of renal adverse events was low and similar across the treatment groups (daily oral ibandronate 2.5 mg, 2%; 2 mg every 2 months, 5%; 3 mg every 3 months, 2%). No cases of acute renal failure were reported. After 2 years of treatment, 12 patients experienced clinically relevant changes in Scr but none of these cases was considered to be treatment-related. The effect of IV ibandronate on renal function has also been compared with that of oral alendronate. In the prospective, randomized open-label DIVINE study, 801 postmenopausal women considered to be at increased risk for renal disease received IV ibandronate (3 mg every 3 months) given by bolus injection or 15-minute infusion, or oral alendronate (70 mg/week). The effects of the three therapies on renal function were similar (percentage change from baseline in GFR at month 9: ibandronate bolus, -1.3% ± 7.14%; oral ibandronate, -0.5% ± 7.86%; oral alendronate, -1.6% ± 5.89%), suggesting that injection and slow infusion of ibandronate had similar renal safety profiles.

In the HORIZON-Pivotal Fracture Trial (PFT), 7765 women with postmenopausal osteoporosis (mean age, 73 years) were randomized to receive zoledronic acid 5 mg once yearly (IV infusion of zoledronic acid had similar renal safety profiles. Patients were excluded from the trial if they had an estimated CrCl <30 ml/min by the Cockcroft-Gault formula at baseline or urine dipstick results of more than 2+ for protein, without evidence of contamination or bacteruria. A detailed analysis of the safety population showed no association between annual infusions of zoledronic acid 5 mg and long-term deterioration of renal function in patients with postmenopausal osteoporosis, and a similar frequency of long-term (3-year) changes from baseline in renal adverse events, impairments and function in the zoledronic acid-treated and placebo-treated groups (increase in serum creatinine >0.5 mg/100 mL; zoledronic acid, 36/3022 [1.19%]; placebo, 38/3066 [1.24%]; p = 0.907; estimated CrCl <30 mL/min; zoledronic acid, 97/2994 [3.24%]; placebo, 96/3035 [3.16%]; p = 0.884). A gradual deterioration of renal function with time was observed in both the treatment and placebo groups, consistent with age-related renal deterioration. SCR measurements were taken 9 to 11 days after each infusion (n = 5035). Transient but significant increases inSCR were observed in 12 patients in the zoledronic acid group after the second infusion, compared with one patient in the placebo group (p < 0.002; Fig. 2A). The proportion of patients
Table 2. Clinical Evidence of the Effect of Bisphosphonates on Renal Function²²−²⁴,²⁶−²⁸,³³−³⁵

| Type of Bisphosphonate | Study Details | Dosage | Renal Function Effects
|------------------------|--------------|--------|------------------------
| Oral Bisphosphonates   |              |        |                        |
| FIT subanalysis in women with postmenopausal osteoporosis (n = 6438)³²| Alendronate versus placebo; 3-year follow-up | Small significant increase in SCr from baseline to 3 years in both groups |
| Risedronate pooled analysis of Phase III studies (n = 9883) in women with osteoporosis (91% renal impairment at baseline, subdivided into severe, moderate, and mild)³³| Risedronate 5 mg daily or placebo for up to 3 years | No significant difference in SCr changes between placebo and risedronate groups; overall incidence of renal function-related adverse events similar across all renal impairment subgroups |
| BONE study in women with postmenopausal osteoporosis (n = 2946)³⁴| Oral ibandronate 2.5 mg daily or 20 mg every other day for 12 doses every 3 months | No clinically relevant changes in laboratory markers (including renal function tests) reported for placebo or ibandronate groups over 3 years |
| Postmenopausal women with osteoporosis or osteopenia (n = 127)³⁵| Alendronate 70 mg weekly, risedronate 35 mg weekly or raloxifene 60 mg daily for 12 months | No significant differences in blood urea nitrogen, creatinine, and eGFR seen between baseline and 12 months |
| IV Bisphosphonates     |              |        |                        |
| DIVA study in women with postmenopausal osteoporosis (n = 1395)³⁶,³⁷| Intermittent IV ibandronate (2 mg every 2 months or 3 mg every 3 months) or daily oral ibandronate (2.5 mg) for 2 years (only 1-year data are shown) | Low incidence of renal adverse events; no acute renal failure reported; 12 cases of clinically relevant changes in SCr from baseline but none was considered to be treatment-related |
| HORIZON-PFT: Women with postmenopausal osteoporosis (n = 7765)³⁷,³⁸| Zoledronic acid 5 mg once yearly (IV infusion over 15 minutes) or placebo for 3 years | No significant between-group differences in SCr or CrCl at 3 years; no association between zoledronic acid 5 mg and long-term renal function deterioration; age-related deterioration of renal function over time observed in both zoledronic acid and placebo groups |
| HORIZON-RFT: Men and women with low-trauma hip fracture (n = 2127)³⁹| Zoledronic acid 5 mg once yearly (IV infusion over 15 minutes) or placebo | Clinical adverse events similar across zoledronic acid 5 mg and placebo groups |
| HORIZON-GIO: Men and women with glucocorticoid-induced osteoporosis (n = 833); Prevention/treatment cohorts³⁰| Once-yearly zoledronic acid 5 mg (IV infusion over 15−20 minutes) or daily risedronate 5 mg for 1 year | Clinically significant renal events in 2% zoledronic acid patients + 1.4% risedronate patients; three cases acute renal failure related to underlying disease |
| Study in men with osteoporosis (n = 1199)³⁰,³¹| Once-yearly zoledronic acid 5 mg (IV infusion over 15−30 minutes) | Increased in SCr >0.5 mg/dL occurred in 2.4% (14/584) patients receiving zoledronic acid, and 3.0% (18/610) patients receiving placebo; CrCl < 30 mL/min at any time during the study was reported in 0.5% (3/557) zoledronic acid−treated patients, and 1.6% (9/577) placebo−treated patients; CrCl was calculated using the Cockroft-Gault formula³¹ |

FIT = Fracture Intervention Trial; SCr = serum creatinine; eGFR = estimated glomerular filtration rate; PFT = Pivotal Fracture Trial; CrCl = creatinine clearance; RFT = Recurrent Fracture Trial; GIO = Glucocorticoid-Induced Osteoporosis Trial.³¹

*Conversion factor for SCr from mg/dL to µmol/L is 88.4.
experiencing an increase >0.5 mg/100 mL from the preinfusion value in the zoledronic acid group was greatest in those with baseline estimated CrCI between 30 and 34 mL/min. Follow-up of these patients showed that SCr returned to within 0.5 mg/100 mL of preinfusion values within 12 months. There was also no significant difference between the zoledronic acid and placebo groups after the first or third infusions (13 versus 6, 8 versus 13, respectively). In the subsequent extension study, significantly more patients experienced short-term increases in SCr 9 to 11 days after infusion in the group that received zoledronic acid for 6 years than those who received zoledronic acid for 3 years followed by placebo for 3 years (n = 18 versus n = 4; p = 0.002); however, these increases were transient and resolved with no overall long-term impact on renal function (Fig. 2B). These data demonstrated that three annual infusions of zoledronic acid have no significant effect on eGFR and that any effect on SCr—even in patients who have received six annual zoledronic acid infusions—is transient.

In the HORIZON-Recurrent Fracture Trial (RFT), 2127 men and women who had experienced a recent, low-trauma hip fracture received zoledronic acid 5 mg once yearly (IV administration over 1 minute) or placebo (Table 2). SCr levels were measured at baseline and within 4 weeks before each annual infusion of the study drug. Approximately 75% of patients were female and the average age of the total population was 74 years, an older population than in the PFT. Coexisting conditions reported by trial participants included: hypertension, coronary artery disease, osteoarthritis, previous stroke, depression, and diabetes mellitus. Following treatment, the incidence of renal adverse events was similar across the zoledronic acid–treated and placebo–treated groups (increase in SCr >0.5 mg/dL, 6.2% versus 5.6%; calculated CrCl <30 mL/min, 8.2% versus 7.3%).

In the HORIZON-Glucocorticoid-Induced Osteoporosis (GIO) study, 833 men and women with glucocorticoid-induced osteoporosis were randomized to receive once-yearly zoledronic acid 5 mg (IV administration over 15–20 minutes) or daily risedronate 5 mg for 1 year (Table 2). Renal function was assessed by monitoring serum creatinine and calculated CrCl before treatment; 9 to 11 days after treatment had started, and at 3, 6, and 12 months. Patients in this study had coexisting conditions, with rheumatoid arthritis the most common (~40%).

The numbers of patients with an SCr increase of >44 μmol/L (zoledronic acid, n = 8; placebo, n = 6) or CrCl <30 mL/min (zoledronic acid, n = 4; placebo, n = 4) after drug administration...
were comparable between the two groups (p = 1.00 for both). Adjudicated clinically significant renal events occurred in nine patients receiving zoledronic acid and six receiving risendronate. Acute renal failure was reported for two patients in the risendronate group and one patient in the zoledronic acid group; all cases were considered to be related to underlying diseases.[39]

Adding to data from the HORIZON-PFT, HORIZON-RFF, and HORIZON-GIO studies are the results from the zoledronic acid male fracture study, in which there were no significant differences in long-term parameters of renal function (Table 2).[52] As in the HORIZON clinical trial program, patients with a baseline eGFR <30 mL/min were excluded from this study.

Postmarketing Evidence of the Effect of Bisphosphonates on Renal Function

Clinical trials have the advantage that all safety outcomes are recorded, follow-up is good, and the risks of particular adverse events can be calculated. Postmarketing surveillance reports, on the other hand, may reflect the real-world situation in clinical practice, in which patients may have more comorbidities than subjects randomized into clinical trials. Subsequent to the approval of zoledronic acid 5 mg in 2007 for the treatment of postmenopausal osteoporosis, by April 2011, the FDA Adverse Event Reporting System had received 44 evaluable spontaneous postmarketing cases of renal impairment and acute renal failure associated with zoledronic acid 5 mg.[54] Details of these cases have been reported in full in the FDA reports and are detailed below. More than one-half of the patients described in the first report (14/24) had underlying medical conditions that may have contributed to their risk of renal impairment or acute renal failure, or had concurrent exposure to known nephrotoxic medications (eg, nonsteroidal anti-inflammatory drugs). Thirteen cases had documented transient increases in SCr following drug administration. Most patients improved following IV fluid administration or other supportive care. Four patients died from acute renal failure; however, these patients also had other comorbidities (such as chronic diabetic renal disease, chronic pulmonary obstructive disease, or hypertension) that may have contributed to death due to acute renal failure.[55] These data led to the revision of the prescribing information for zoledronic acid 5 mg in the United States.[56] A similar process led to updating of the Summary of Product Characteristics in Europe in response to postmarketing reports.[53]

Discussion

Bisphosphonates, when used in accordance with the prescribing information, have demonstrated favorable renal safety results in clinical studies in patients with osteoporosis. Although cases of acute renal failure reported in postmarketing reports are important, there are a number of factors related to renal function that should be taken into consideration in treating patients with osteoporosis. Renal function is known to decline with age; the reduction in GFR usually begins after 30 to 40 years of age and has the potential to decline at a faster rate after 50 to 60 years of age.[54] This decline is associated with structural and functional changes in the kidneys.[54] There may also be differences in the pathophysiology of age-related reductions in GFR compared with reductions in GFR due to intrinsic renal disease, proteinuria, or ongoing kidney damage.[53] Recent studies have indicated that combining proteinuria with eGFR may provide a better predictive model for progression of CKD than assessment of GFR alone.[56] In addition, the NKF classification of CKD categorizes eGFR >50 mL/min (up to 110 mL/min) as stage 1 and 90 to 60 mL/min as stage 2, only if the patient also has proteinuria.[57] However, data on proteinuria have not been included in the publications of the pivotal trials of bisphosphonates.

Regardless of treatment, data from the third National Health Assessment and Nutritional Examination Survey (NHANES III) indicate that impaired renal function is seen in a high proportion of both men and women aged ≥20 years who have osteoporosis.[10] Early CKD (eGFR <60 mL/min) may also be associated with an approximate doubling of the hazard ratio for hip fractures as compared with patients (age-adjusted) exhibiting normal renal function.[58-60] The reasons why fracture risk appears to be greater in early stages of CKD (eGFR <60 mL/min) are unknown, but the effect of elevated PTH levels,[11] and early phosphorus retention on bone might, in part, explain the increase in bone resorption or altered bone strength in these patients.[62-64] In addition, fibroblast growth factor 23, which rises in serum in early CKD before PTH increases and is a strong risk factor for all-cause mortality, may impart bone mineralization and be an additional factor explaining the greater fracture risk in early CKD.[65-67] Hypothetically, these are interesting associations because fracture risk reduction as well as reduction in all-cause mortality has been observed with bisphosphonates even in an elderly and frail population.[65-67]

In patients with severe CKD, clinicians should also be aware of the possibility of adynamic bone disease, a low bone turnover bone disease that shares many clinical features with osteoporosis such as low bone mass and increased risk of fractures, but is associated with low PTH and low bone turnover.[69-70] In these cases, further suppression of bone turnover may not be recommended, because there is a hypothetical link between lowering bone turnover and increasing vascular calcification.[63,69-70] Calcium and vitamin D treatment must also be used judiciously because they may enhance vascular calcification in these patients, who have very low capacity for calcium uptake in the bone compartment.[72] Given that BMD is poorly correlated with fracture risk in patients with stage 4 to 5 CKD[69,70] measurement of PTH and bone-specific alkaline phosphatase (BSAP) and/or histomorphometry assessment may be needed in selected patients with CKD stage 4 to 5 (eGFR <30 mL/min) in order to discriminate between osteoporosis and adynamic bone disease.[63,71] A recent comprehensive review of quantitative histomorphometry and PTH/BSAP values suggests that combining PTH and BSAP may offer a higher positive predictive value for adynamic bone disease than measuring either PTH or low BSAP alone.[72]

Potential management of adynamic bone disease includes reduction of calcium and vitamin D load to restore parathyroid activity, and prevention of other risk factors known to induce PTH oversuppression.[69,72]
Data from the NHANES surveys suggest that the prevalence of moderate renal impairment is underestimated when SCr is used instead of eGFR to screen for CKD. Use of eGFR may, therefore, be of particular importance in older adults who are more likely to have lower creatinine values due to lower muscle mass or poor protein intake. Many commercial laboratory reports automatically report eGFR using the Modification of Diet in Renal Disease (MDRD) equation. Both the Cockroft-Gault formula and the MDRD are accurate, practical predictors of eGFR but neither has a linear relationship to the most accurate eGFR measurements. Inulin clearance or iothalamate determinations, if either eGFR result needs clinical confirmation, well-hydrated and carefully collected 24-hour urine for CrCl could be considered. A recently developed Chronic Kidney Disease Epidemiology Collaboration eGFR equation has shown to have improved precision, accuracy, and mortality risk prediction compared with MDRD, and is recommended for routine clinical use.

Given the prevalence of kidney impairment in patients with osteoporosis, it is critical that clinicians know which patients are suitable for treatment with specific bisphosphonates. Although the oral bisphosphonates carry warnings on their use in patients with severe renal impairment, renal function did not change between treatment and placebo groups in clinical studies on alendronate, risedronate, and oral ibandronate. A recent retrospective cohort study in 122,727 patients aged >66 years with a fragility fracture also found that oral bisphosphonate use was not associated with acute kidney injury.

Clinical studies of IV bisphosphonates reported cases of acute and transient increases in SCr following drug administration but no long-term impact in kidney function has been reported. For zoledronic acid, similar incidences of renal adverse events, impairments, and function were reported for the zoledronic acid-treated and placebo-treated groups over the duration of the trials, even in an older study population and in those who had received IV zoledronic acid for up to 6 years. Because none of the patients in the zoledronic acid pivotal studies had biochemical changes that could suggest CKD—mineral and bone disorder (MBD), it is unknown whether the responses observed in these trials would vary in patients with known intrinsic kidney disease or unresolved secondary hyperparathyroidism. Although the renal tissue half-life of ibandronate is shorter than zoledronic acid (24 versus 150–200 days), no data comparing the renal effects of IV ibandronate with IV zoledronic acid in a randomized population have been published, and there is no scientific evidence establishing any differences on renal effects between these two bisphosphonates.

Clinicians wishing to prescribe bisphosphonates to patients with osteoporosis are advised to check their patients’ CrCl or eGFR prior to initiating treatment and ensure that they adhere to prescribing instructions. We recommend that in patients with marginal eGFR values, a well-hydrated 24-hour CrCl should be performed for GFR calculation before clinical management decisions are made with regard to bisphosphonate use. For zoledronic acid, IV administration should be over a period of no less than 15 minutes and patients must be adequately hydrated prior to the infusion. In addition, clinicians should make an assessment of any concomitant medication that a patient may be taking, with special regard to potentially nephrotoxic therapies.

### Conclusion

Bisphosphonates—a class of drug that is available in both oral and parenteral preparations—have historically been associated with a low incidence of renal adverse events. This review of clinical trial and postmarketing surveillance data has shown that, if used with care and in accordance with the prescribing information, these agents can be administered to patients with various degrees of renal impairment, with no long-term decline in renal function. This applies to both oral and IV bisphosphonates. Clinical trials have shown little evidence of an association between oral bisphosphonate administration and renal impairment, and these medications are effective in reducing fracture risk and increasing BMD in patients (by post hoc analysis) with eGFR >15 ml/min. Moreover, results from clinical trials of IV bisphosphonates have shown that, even in elderly osteoporotic patients with existing fracture, administration in accordance with the prescribing information does not result in long-term renal function decline and is efficacious in preventing fracture at all skeletal sites over 6 years of administration.

Although bisphosphonates are generally well tolerated in clinical studies, the low incidence of renal adverse events has led to the inclusion of “warnings” on the prescribing information of all bisphosphonates regarding the use of these agents in patients with severe renal impairment (CrCl <30 or <35 ml/min). For IV zoledronic acid, this warning constitutes a “contraindication” in the registration label for patients with eGFR <35 ml/min. This contraindication—which does not alter the positive benefit-to-risk balance for the product—is primarily a result of the way bisphosphonates are excreted from the body, via glomerular filtration and tubular secretion. The parenteral formulations of therapies for postmenopausal osteoporosis are invaluable for patients intolerant to oral bisphosphonates, patients with preexisting esophageal disease, and those in whom there is uncertainty regarding gastrointestinal absorption. In view of their efficacy in preventing osteoporotic fractures, bisphosphonates are clearly beneficial in these patient groups. However, as with any drug, it is important that physicians follow the prescribing information for administration at all times, in order to maximize the benefit-to-risk ratio associated with administration.

This review has clearly shown that the benefit-to-risk ratio for all bisphosphonates is very favorable when they are used according to the label in the right patient populations for the right duration, and that IV bisphosphonates—which have an established renal safety profile when used according to prescribing information—can even be used in the majority of patients, including those who are elderly, as long as their eGFR is >35 ml/min. These drugs therefore constitute an important and effective part of the physician’s pharmacological armamentarium.

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