

# History, Low BMD Raise Long-Term Fracture Risk

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Low bone mineral density and a prevalent vertebral fracture were long-term independent predictors of an increased risk of vertebral fractures in women aged 65-99 who were followed for almost 15 years.

Previous studies have shown links between low BMD and an increased risk of a new vertebral fracture and between a

prevalent vertebral fracture and an increased risk of a new vertebral fracture after an average of nearly 4 years.

But this study was the first to assess the long-term absolute risk of vertebral fracture based on follow-up evaluations of community-dwelling older women (JAMA 2007;298:2761-67).

In this study, Jane A. Cauley, Dr.PH., of the department of epidemiology at the University of Pittsburgh, and her colleagues reviewed data from 2,680 white

women who took part in the longitudinal Study of Osteoporotic Fractures. The average age at baseline was 68.8 years and the average age at follow-up was 83.8 years.

After an average of 14.9 years, 487 women (18.2%) had incident vertebral fractures. This number included 163 of the 394 women (41.4%) who had a prevalent vertebral fracture at baseline and 324 of the 2,286 women (14.2%) who didn't have a vertebral fracture at baseline.

Overall, women with a prevalent frac-

ture were more than four times as likely to suffer an incident vertebral fracture during the follow-up period, compared with those with no fracture history. The association remained significant after the researchers controlled for BMD and other risk factors for vertebral fracture, and the risk was greatest in women who had at least two prevalent vertebral fractures when they enrolled in the investigation.

In addition, a low baseline BMD at several sites (the calcaneus, distal radius, total hip, femoral neck, and lumbar spine) was a significant predictor of incident vertebral fractures during the follow-up period.

After adjustment for risk factors including smoking, body mass index, and estrogen use, about a third of women with a hip BMD T score of -2.5 or less (which is considered osteoporotic) developed incident fractures during the follow-up, compared with about 10% of those with normal BMD scores.

Women with both a prevalent vertebral fracture and total hip BMD T scores of -2.5 or less had an absolute risk of an incident vertebral fracture greater than 50%, compared with a 9% risk among women with a normal BMD and no fracture history.

But women with baseline prevalent vertebral fractures were at increased risk of additional fractures during the follow-up period regardless of BMD, and the interaction between BMD and prevalent vertebral fractures was not statistically significant.

This finding suggests that the presence of a vertebral fracture may indicate deterioration in bone quality, not just bone density, the investigators wrote. "Our results support the recommendation that older women with a prevalent vertebral fracture should be treated for osteoporosis irrespective of BMD."

In addition, women who had incident fractures tended to be older, thinner, and less likely to report estrogen use. The results were consistent with the short-term findings from the Study of Osteoporotic Fractures and from other similar studies. But the study was limited by its inclusion of white women only, and the results may not be applicable to men or women of other ethnicities. Also, the absolute risk of vertebral fractures may be higher than reported because the study subjects who returned for the follow-up examinations were healthier at baseline than were patients who were lost to follow-up, the researchers noted.

Dr. Cauley has received research support from Merck & Co., Eli Lilly & Co., Pfizer Pharmaceuticals, and Novartis Pharmaceuticals. She also has received consulting fees from Novartis and Eli Lilly, and she serves on the speakers board for Merck. The Study of Osteoporotic Fractures is funded by the National Institutes of Health.



**Rx ONLY**  
**BRIEF SUMMARY.** Please see package insert for prescribing information.

**INDICATIONS AND USAGE**  
LEVEMIR is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long acting) insulin for the control of hyperglycemia.

**CONTRAINDICATIONS**  
LEVEMIR is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

**WARNINGS**  
**Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations.**

**Glucose monitoring is recommended for all patients with diabetes.**

**LEVEMIR is not to be used in insulin infusion pumps.**

**Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted.**

**PRECAUTIONS**  
**General**  
Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal.

LEVEMIR is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration.

**LEVEMIR should not be diluted or mixed with any other insulin preparations** (see PRECAUTIONS, Mixing of Insulins).

Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins.

As with all insulin preparations, the time course of LEVEMIR action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity.

Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

**Hypoglycemia**  
As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions). Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients' awareness of hypoglycemia.

The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR, dosages can be prescribed on a unit-to-unit basis; however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia.

**Renal Impairment**  
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with renal impairment.

**Hepatic Impairment**  
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with hepatic impairment.

**Injection Site and Allergic Reactions**  
As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few

weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR.

In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique.

**Systemic allergy:** Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

**Intercurrent Conditions**  
Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses.

**Information for Patients**  
LEVEMIR must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR "Patient Information" circular for additional information.

As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia.

Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy).

**Laboratory Tests**  
As with all insulin therapy, the therapeutic response to LEVEMIR should be monitored by periodic blood glucose tests. Periodic measurement of HbA<sub>1c</sub> is recommended for the monitoring of long-term glycemic control.

**Drug Interactions**  
A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring.

The following are examples of substances that may reduce the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives).

The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, fibrates, fluoxetine, MAO inhibitors, propoxyphene, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics.

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent.

The results of *in-vitro* and *in-vivo* protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein bound drugs.

**Mixing of Insulins**  
If LEVEMIR is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduction in AUC<sub>(0-2h)</sub> and C<sub>max</sub> for insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR was less than 50%.

**LEVEMIR should NOT be mixed or diluted with any other insulin preparations.**

**Carcinogenicity, Mutagenicity, Impairment of Fertility**  
Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the *in-vitro* reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the *in-vivo* mouse micronucleus test.

**Pregnancy: Teratogenic Effects: Pregnancy Category C**  
In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 nmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 nmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 nmol/kg/day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Drug-dose related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 nmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups

indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity.

**Nursing mothers**  
It is unknown whether LEVEMIR is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both.

**Pediatric use**  
In a controlled clinical study, HbA<sub>1c</sub> concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR and patients treated with NPH human insulin.

**Geriatric use**  
Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

**ADVERSE REACTIONS**  
Adverse events commonly associated with human insulin therapy include the following:

**Body as Whole:** allergic reactions (see PRECAUTIONS, Allergy).

**Skin and Appendages:** lipodystrophy, pruritus, rash. Mild injection site reactions occurred more frequently with LEVEMIR than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy).

**Other:**  
**Hypoglycemia:** (see WARNINGS and PRECAUTIONS).

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4).

**Weight gain:**  
In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

**Table 4: Safety Information on Clinical Studies**

		Weight (kg)		Hypoglycemia (events/subject/month)		
Treatment	# of subjects	Baseline	End of treatment	Major*	Minor**	
Type 1						
Study A	LEVEMIR	N=276	75.0	75.1	0.045	2.184
	NPH	N=133	75.7	76.4	0.035	3.063
Study C	LEVEMIR	N=492	76.5	76.3	0.029	2.397
	NPH	N=257	76.1	76.5	0.027	2.564
Study D	LEVEMIR	N=232	N/A	N/A	0.076	2.677
	Pediatric NPH	N=115	N/A	N/A	0.083	3.203
Type 2						
Study E	LEVEMIR	N=237	82.7	83.7	0.001	0.306
	NPH	N=239	82.4	85.2	0.006	0.595
Study F	LEVEMIR	N=195	81.8	82.3	0.003	0.193
	NPH	N=200	79.6	80.9	0.006	0.235

\* Major = requires assistance of another individual because of neurologic impairment

\*\* Minor = plasma glucose <56 mg/dL, subject able to deal with the episode him/herself

**OVERDOSAGE**  
Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/ subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid recurrence of hypoglycemia.

**More detailed information is available on request.**

**Rx only**

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