IV Ibandronate Bolsters Bone as Well as Oral Form

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BOSTON — Intermittent intravenous ibandronate is at least as effective as daily oral ibandronate for increasing bone mineral density and may be preferable to oral dosing in patients with esophageal disease or compliance problems.

There are no fracture data for the intravenous dosing schedule, but the risk reduction that has been shown with oral ibandronate can probably be extrapolated to the intravenous form of the drug, Dr. Mone Zaidi said at the annual meeting of the Endocrine Society.

Oral ibandronate has been shown to reduce the risk of new vertebral fractures by up to 60% (Curr. Med. Res. Opin. 2005; 21:391-401; J. Bone Miner. Res. 2004; 19:1241-9).

He presented 2-year bone mineral density (BMD) data from the ibandronate Dosing Intravenous Administration trial, a Roche-sponsored phase III study that compared two doses of intravenous ibandronate (2 mg every 2 months and 3 mg every 3 months) with the approved oral dosing schedule (2.5 mg daily). The study group included 1,400 postmenopausal women with low bone mass (T-scores of –3.3 for total spine and –2 for hip).

After 2 years, BMD at the lumbar spine increased significantly more in both intravenous groups than in the oral group (mean increase 6.4% for the 2-mg IV dose, 6.3% for the 3-mg IV dose, and 4.8% for the oral dose). BMD increased similarly at all sites measured, said Dr. Zaidi, director of the Mount Sinai Bone Program, Mount Sinai School of Medicine, New York.

At 2 years, the incidence of adverse events was similar across all groups. Flu-like illnesses and gastrointestinal intolerance were seen primarily in the first year, with only slight increases in cumulative numbers during the second year.

Intravenous ibandronate would be especially useful in patients with contraindications to oral therapy or clinical or biochemical evidence of noncompliance, Dr. Zaidi said. "I would use this in patients who are intolerant to the oral form or who have problems like a bleeding ulcer, stricture, or dysmotility. It would also be useful for those who can't sit upright, such as bedridden nursing home patients." The intermittent dosing would also be "a great way" to ensure compliance, he added. ■

Chemotherapy Raises Risk of Osteoporosis

GLASGOW, SCOTLAND — Chemotherapy for lymphoma should be recognized as a risk factor for the development of osteoporosis, Dr. Bhaskar Dasgupta reported in a poster session at the annual meeting of the British Society for Rheumatology.

Patients with lymphoma have greatly improved survival rates because of advances in treatment, but their quality of life may be compromised by long-term complications of chemotherapy, reported Dr. Dasgupta, director of rheumatology, Southend Hospital NHS Trust, Westcliff on Sea, England. Osteoporosis is one such potential complication that can result from treatment with alkylating agents and the steroids that are often given with chemotherapy.

Height loss as a surrogate marker for vertebral osteoporosis was evaluated in a study of patients attending a lymphoma clinic. A total of 25 patients, 8 with Hodgkin's and 17 with non-Hodgkin's lymphoma, were enrolled. Mean age was 57.6 years, and 13 of the patients were female, reported Dr. Dasgupta. Exclusion criteria included a previous osteoporosis diagnosis, lymphoma with spinal involvement, and previous corticosteroid treatment.

When baseline height was compared with height 24 months or more after chemotherapy, the mean loss was found to be 22.8 mm, according to Dr. Dasgupta.

The degree of height loss increased with age—every 10-year increase in age was associated with a 5.2-mm decrease in height, he reported. No association was seen between height loss and gender, and none of the patients had other risk factors for osteoporosis.

No height loss association was found with either cumulative steroid dose or the type of chemotherapy received.

—Nancy Walsh