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Jennifer E. Hagen  
*University of Maryland - Baltimore*

Anna N. Miller  
*Wake Forest Baptist Health*

Susan M. Ott  
*University of Washington - Seattle Campus*

Michael Gardner  
*Washington University School of Medicine in St. Louis*

Saam Morshed  
*University of California - San Francisco*

See next page for additional authors

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Association of Atypical Femoral Fractures with Bisphosphonate Use by Patients with Varus Hip Geometry

Jennifer E. Hagen, MD, Anna N. Miller, MD, Susan M. Ott, MD, Michael Gardner, MD, Saam Morshed, MD, Kyle Jeray, MD, Timothy B. Alton, MD, Dennis Ren, BS, W. Parker Abblitt, MD, and James C. Krieg, MD

Background: There is increasing evidence associating “atypical” femoral fractures with prolonged exposure to bisphosphonate therapy. The cause of these fractures is unknown and likely multifactorial. This study evaluated the hypothesis that patients with primary osteoporosis who sustain atypical femoral fracture(s) while on chronic bisphosphonate therapy have a more varus proximal femoral geometry than patients who use bisphosphonates for primary osteoporosis but do not sustain a femoral fracture.

Methods: The femoral neck-shaft angle was measured on the radiographs of 111 patients with atypical femoral shaft fracture(s) and thirty-three asymptomatic patients; both groups were on chronic bisphosphonate therapy. Patients with characteristic lateral cortical thickening, stress lines, and thigh pain were included in the fracture group.

Results: The mean neck-shaft angle of the patients who sustained atypical femoral fracture(s) while taking bisphosphonates (case group) differed significantly from that of the patients on bisphosphonate therapy without a fracture (129.5° versus 133.8°; p < 0.001). Fifty-three (48%) of the patients in the case group had a neck-shaft angle that was lower than the lowest angle in the control group (128°). Side-to-side comparison in patients with a unilateral pathologic involvement and an asymptomatic contralateral lower limb did not demonstrate any significant difference between the neck-shaft angles in the two limbs.

Conclusions: Patients on chronic bisphosphonate therapy who presented with atypical femoral fracture(s) had more varus proximal femoral geometry than those who took bisphosphonates without sustaining a fracture. Although no causative effect can be determined, a finding of varus geometry may help to better identify patients at risk for fracture after long-term bisphosphonate use.

Level of Evidence: Prognostic Level III. See Instructions for Authors for a complete description of levels of evidence.

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The radiographs were compiled and reviewed at three sites where the senior radiographs of 255 hips were available for measurement. All patients are female.

had a documented duration of bisphosphonate use for primary osteoporosis; radiographs not being available.

We believe that other risk factors must also be present to explain why (1) only a small percentage (0.02% to 0.2%) of patients taking bisphosphonates on a chronic basis develop these fractures and (2) atypical femoral fractures sometimes occur in patients who are not on long-term therapy. It is possible that patients who develop atypical femoral fractures have an anatomic biomechanical predisposition. We hypothesized that patients on chronic bisphosphonate therapy who sustain atypical femoral fracture(s) or display radiographic characteristics consistent with a stress fracture or “lateral cortical beaking” are more likely to have varus proximal femoral anatomy than exposure-matched controls.

Materials and Methods

We performed a multicenter retrospective case-control study of patients from six institutions. Institutional review board approval was obtained at each individual site. A series of 111 patients who had been treated for a complete or incomplete atypical femoral fracture were identified. Each patient had radiographic characteristics of the atypical femoral fracture associated with chronic bisphosphonate use. To be included in the study group, those without a complete fracture had to have thigh or hip pain in addition to radiographic evidence of either lateral cortical beaking or a transverse stress line based on ASBMR (American Society for Bone and Mineral Research) criteria. These 111 patients constituted the case group. All radiographs were reviewed and approved for inclusion by senior authors (J.C.K., A.N.M., S.M.O, S.M., K.J., and M.G.) at each institution. Exclusion criteria included bisphosphonate therapy for diseases other than primary osteoporosis, previous hip arthroplasty, and radiographs not being available.

A control group of thirty-three patients was identified. These patients had a documented duration of bisphosphonate use for primary osteoporosis; no history of fracture; no history of prodromal thigh or hip pain; and hip, pelvic, or femoral radiographs already in the medical record (Table I). One hundred and forty-four patients were included in the analysis, and radiographs of 255 hips were available for measurement. All patients are female. The radiographs were compiled and reviewed at three sites where the senior authors (J.C.K., A.N.M., and M.G.) practiced. One reviewer was a trauma trained attending surgeon. The other two were a senior resident and a medical student, who could consult with trauma trained attending surgeons for guidance. The reviewers were aware of the hypothesis of the study. A sample of radiographs was sent to all four reviewers, and the interobserver difference between the neck-shaft angle measurements was <1° (standard deviation [SD], 1.6°). Intraobserver reliability was not calculated.

Results

The mean neck-shaft angle in the case group (129.5°) was significantly lower (p < 0.001) than that in the controls (133.8°). The mean neck-shaft angle on the pathologic side(s) in the case group (129.9°) was also significantly lower (p < 0.001) than the mean angle in the control group.

### Materials and Methods

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<thead>
<tr>
<th>TABLE I Patient Characteristics</th>
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<td>No. of patients</td>
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<td>No. of hips available for measurement</td>
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<td>Mean age (range) (yr)</td>
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<td>Mean bisphosphonate exposure (range) (yr)</td>
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<td>Fracture characteristics (no. of patients)</td>
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<td>Complete</td>
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<td>Stress reaction/beaking</td>
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<td>Complete and contralateral stress</td>
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*Not quantified for thirteen patients.
Side-to-side comparison of patients with a unilateral pathologic involvement did not demonstrate any significant difference in the neck-shaft angle between the pathologic side (129.8°) and the asymptomatic, contralateral lower limb (128.2°).

The lowest recorded neck-shaft angle was 128° in the control group and 118° in the case group. Fifty-three (48%) of the patients in the case group had a neck-shaft angle of <128° on the pathologic side (Fig. 1).

**Discussion**

Atypical femoral fractures represent a challenge for patients with osteoporosis and osteopenia. Many have speculated about the etiology, and it is likely multifactorial, although no underlying mechanism has been demonstrated. This study was designed to determine if patients with atypical fractures have a more varus proximal femoral geometry than an age and exposure-matched control group. The mean neck-shaft angle of the patients with a fracture was significantly lower than that of the controls, and no control patient had a neck-shaft angle <128°. Overall, we found an association between proximal femoral geometry and the presence of atypical femoral fractures in this population.

In the recently updated ASBMR task force consensus statement, it was concluded that atypical femoral fractures may represent stress fractures that progress over time. These stress fractures are unique in that the transverse component of the fracture begins in the lateral cortex, whereas exercise-induced stress fractures typically initiate in the medial cortex. Very little is known about femoral geometry in this patient population. Proximal femoral strength is decreased with a varus mechanical axis. Biomechanical studies have shown that trochanteric and femoral shaft fractures are more common in patients with low neck-shaft angles. Koh et al. reviewed the radiographs of forty-eight patients with atypical fractures and found that the fractures clustered in the lateral cortex at the region of maximal tensile loading. Sasaki et al. measured the variations in the anatomic axes of the femora of patients with “low-energy” femoral shaft fractures. These patients were taking medications for osteoporosis but not specifically bisphosphonates. The patients with fractures had a significant increase in the lateral and anterior bow of the femur, and this geometry was thought to result in an imbalance in strains seen in the femur. We believe that this imbalance also occurs with an alteration in the mechanical axis of the lower extremity produced by a varus femoral neck.

A large number of patients in our case group had a neck-shaft angle of <128° on the pathologic side. The study was not powered to calculate the sensitivity and specificity of a neck-shaft angle of <128° predicting the risk of fracture, but studying this risk in a larger cohort would be useful.

A large proportion (38%) of the patients in our study had bilateral pathological involvement. This is consistent with the findings from the study performed by Lo and colleagues, in which 40% of the population had bilateral complete fracture, and an additional 21% had contralateral stress-reaction changes. They found a higher proportion of fractures in women of Asian descent, a factor not controlled for in our study. Nakamura et al. found that women of Japanese descent had lower neck-shaft angles than white American women, and Japanese-descent women could be an at-risk subset of the population. This stresses the importance of obtaining imaging of both femora in patients with a history of atypical femoral fracture and thigh pain.
Our study is limited by all of the factors that routinely affect retrospective reviews. We did not control for patient factors, including body mass index, smoking status, activity level, and bone mineral density. Also, we studied only a small sample of the more than 4 million women on bisphosphonate therapy in the United States.

The reliability of hip measurements has been studied with a variety of modalities in patients with various pathological conditions. In general, the reliability of the neck-shaft angle has been shown to be good. A recent study of patients with cerebral palsy showed an overall intraobserver and interobserver reliability of neck-shaft-angle measurements on hip radiographs of 0.929 and 0.912, respectively. Marmor et al. found that neck-shaft-angle measurements varied <5\(^\circ\) with <35\(^\circ\) of limb rotation, and the measurements were always greater than the true value. Thus, it is unlikely that our measurements overestimated the actual varus in our patients; if anything, they underestimated it. Many of the measurements in the group with a complete fracture were performed on injury radiographs, for which rotation is the most difficult to control, and it is likely the true neck-shaft angle in this group was in even more varus than we reported.

Bias could have been introduced into the measurements as the majority of those in the case group were done on injury radiographs or radiographs showing the stress reaction; therefore, the reviewers were not blinded to the presence of the pathological condition. It was impossible to avoid this as many of the patients had not sought treatment at our facilities prior to their injury or did not have any reason to have pelvic radiographs prior to the development of symptoms. However, there was not a significant difference between the measurements on the pathologic and non-pathologic sides of our study group, thus providing a marker for internal validity of our measurement techniques.

Another limitation of this study is that the average bisphosphonate exposure times of the study and control patients were not identical. Thirteen patients in the case group did not have numerical documentation of their duration of bisphosphonate use; charts indicated it was “long term.” Despite this, the mean exposure times for both groups were greater than those previously documented to incur risk. The link between atypical femoral fracture and bisphosphonates is an association; it has not been definitively shown to be causation. The exact duration of exposure that is needed for an increased fracture risk is unknown. Schilcher et al. found the odds ratio of fracture to be ten times higher after just two years of exposure. As our study was a retrospective analysis and we documented fracture or stress reaction in all of the patients in the case group, we can assume that it was an at-risk population. It is possible that the control group was evaluated early in the time course of their disease. We have no current method for monitoring their progression to fracture. A prospective and longitudinal study could be done in a longitudinal fashion to determine the true risk of progression to fracture. While this is likely only one piece of the picture, we think that our findings add a useful clinical marker that could help identify an at-risk subset of this population.

In conclusion, we found an association between varus proximal femoral geometry and a propensity to sustain atypical femoral fractures in patients on long-term bisphosphonate therapy. We agree with the ASBMR task force’s conclusion that more needs to be done to evaluate the impact of femoral geometry on this patient population. The neck-shaft angle is only one variable, but it appears to have a high correlation with atypical femoral fractures, and follow-up measurements are easy, low cost, and noninvasive. The strength of this study was insufficient for us to conclusively advise a change in management of these patients at this time, but we have made a strong argument to use this as a pilot study to prompt further investigation. At a minimum, patients should be counseled to be aware of symptoms that accompany these injuries. Larger studies should be done in a longitudinal fashion to determine the true risk of progression to fracture. While this is likely only one piece of the picture, we think that our findings add a useful clinical marker that could help identify an at-risk subset of this population.

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References