Original article

Denosumab for the treatment of osteoporosis: A systematic literature review

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A B S T R A C T

Purpose: To determine the efficacy and safety of denosumab in osteoporosis.

Methods: A systematic search was performed in MEDLINE, EMBASE, and the Cochrane Central Register of Controlled Trials (1950 to July 2010), meeting abstracts (2009–2010), trial registries, and reference lists. The selection criteria were as follows: (population) osteoporosis patients of any age; (intervention) treatment with denosumab; (outcome) efficacy and safety; (study design) randomized clinical trials (RCTs); no language restrictions. Two reviewers independently screened titles and abstracts and subsequently extracted data from the selected studies including quality items, and on outcomes of interest. A meta-analysis was performed for safety issues.

Results: A total of 25 studies were included. Denosumab reduces the risk of new radiographic vertebral fracture in a 68% compared with placebo (p < 0.001) and increases bone mineral density (BMD) at lumbar spine, total hip, and one-third radius more than alendronate and placebo. A single subcutaneous dose of denosumab resulted in a dose-dependent, rapid, profound, and sustained decrease bone turnover markers (BTMs). Denosumab was in general well tolerated. A meta-analysis has shown an increase in the incidence of urinary infections (p = 0.012) and eczema (p < 0.001) in the patients treated with denosumab. Meta-analysis of efficacy was complicated due to the study features.

Conclusions: Denosumab given subcutaneously twice yearly is associated with a reduction in the risk of vertebral, nonvertebral, and hip fractures in women with osteoporosis. Denosumab is associated with greater and sustained increases in BMD and reductions in BTMs compared with placebo and/or alendronate and with a risk of urinary infections and eczema.

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Denosumab para el tratamiento de la osteoporosis: revisión sistemática de la literatura

R E S U M E N

Objetivo: Determinar la eficacia y la seguridad de denosumab en la osteoporosis.

Métodos: Se realizó una búsqueda sistemática en MEDLINE, EMBASE y el Registro Central Cochrane de ensayos controlados (de 1950 a julio de 2010), resúmenes de congresos (2009-2010), registros de ensayos y listas de referencias. Los criterios de selección fueron los siguientes: (población) pacientes con osteoporosis de cualquier edad; (intervención) tratamiento con denosumab; (desenlace) eficacia y seguridad; (diseño del estudio) ensayos clínicos con selección aleatoria; sin restricciones de idioma. Dos revisores independientes revisaron títulos y resúmenes y posteriormente extrajeron los datos de los estudios seleccionados, incluyendo elementos de calidad y desenlaces de interés. Se realizó un metanálisis con los datos de seguridad.

Resultados: Se incluyeron 25 estudios. El denosumab reduce el riesgo de fracturas radiográficas nuevas en un 68% en comparación con el placebo (p < 0.001); incrementa la de densidad mineral ósea (DMO) en la columna lumbar, la cadena total y el tercio distal del radio, más que el alendronato y el placebo. Una dosis subcutánea única de denosumab provocó una disminución rápida, profunda,

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Osteoporosis is a disease characterized by decreased bone mass, microarchitectural deterioration of the skeleton and impaired bone strength which results from increased bone resorption relative to formation. Anti-resorptive drugs significantly reduce bone turnover, providing an increase in BMD and a reduction in risk of fracture.

Recent advances have identified the Receptor Activator for Nuclear Factor kB Ligand (RANKL) as a critical mediator of bone remodeling. RANKL is essential for the formation, function, and survival of the osteoclasts. It binds to its cognate receptor RANK on the surface of precursors and mature osteoclasts, and stimulates these cells to mature and resorb bone. The physiological inhibitor of RANKL is osteoprotegerin (OPG), a soluble receptor that competes with RANK for binding to RANKL, thus neutralizing RANKL effects. Multiple preclinical models were used to study the effects of inhibiting RANKL showing that it leads to improved bone geometry and increased bone density and strength.

Denosumab is a novel antiresorptive agent that also inhibits osteoclast-mediated bone resorption but works through a different pathway than bisphosphonates. Denosumab is a fully human monoclonal antibody (IgG2) that inhibits RANKL with high specificity, mimicking the effects of OPG on RANKL. In recent years, a number of clinical trials evaluating the efficacy and safety of denosumab for the treatment of osteoporosis in humans have been published. Our primary objective was to determine the efficacy and safety of denosumab for the treatment of osteoporosis in humans in a systematic literature review.

Methods

As a part of the Spanish Society of Rheumatology Consensus of osteoporosis, a systematic literature review was performed to examine the efficacy and safety of denosumab in osteoporosis.

Data sources and searches

We systematically searched MEDLINE, EMBASE, and the Cochrane Central Register of Controlled Trials up to July 2010 using a comprehensive search strategy that combined MeSH terms and free text for “Denosumab”, “Osteoporosis”, “Efficacy”, “Safety” and “Clinical Trials”. Table 1 shows the terms used in Medline to capture studies. We also handsearched abstracts from 2009 and 2010 scientific meetings of the American College of Rheumatology (ACR), the American Society for Bone and Mineral Research (ASBMR), the European Congress on Osteoporosis and Osteoarthritis (ECCEO), the International Osteoporosis Foundation (IOF) and the European League against Rheumatism (EULAR), as well as reference lists of all relevant studies, reviews, and letters, to identify additional studies. No language restrictions were applied.

Study selection

Clinical trials that evaluated the efficacy and/or safety of denosumab for the treatment of osteoporosis were eligible for inclusion. The selection criteria were predefined by protocol. In order to incorporate a study: (1) the studied population had to include patients of any age with osteoporosis; (2) at least one of the study groups had to have received treatment with denosumab; and (3) outcome should be a measure of efficacy (such as reduction of fracture risk, changes in BMD, changes on serum bone biomarkers or bone microarchitectural) or safety. Studies including patients with oncologic disease or any condition different from osteoporosis, studies on animals and basic science research were excluded. For the purposes of this review, we considered RCTs with their extension studies and subanalysis.

Two reviewers (LS, JAM) independently screened the titles and abstracts of the citations captured by the search strategy. This process was done in 20 min sessions. On a limited number of articles in which the reviewers disagreed, a third reviewer (EL) decided if the article should be included. Subsequently, selected articles were reviewed in detail. Articles that did not fulfill all the inclusion criteria were excluded from the systematic review.

Data extraction and quality assessment

The two reviewers collected the data of the included studies, including number of patients and their characteristics, the comparator group, doses of denosumab, duration of follow-up, study quality and relevant outcomes using ad hoc standard forms. The assessment of study quality was based on the Jadad scale for clinical trials.

Data synthesis and analysis

Evidence tables were produced. Some of the results are expressed as RR: risk ratio (RR) and HR: hazard ratio (HR). Meta-analysis was only planned in case of homogeneity. Results were combined by using random-effects models, and statistical heterogeneity was quantified by using the I² statistic. In the studies with 3 arms of treatment (denosumab, alendronate, and placebo) we assumed that denosumab had the same risk of adverse events. Besides, for some of the meta-analyses we also assumed that the risk of adverse events was the same irrespective of the duration of the treatments. All analyses, confidence intervals, and graphics were performed with Stata 10 (Stata Corporation, College Station, TX 77845, USA).
Results

A flowchart summarizing the search results is exposed in Fig. 1. The search strategy identified 518 potentially relevant articles of which 10 fulfilled the inclusion criteria.\(^{8-17}\) The excluded articles\(^{18-24}\) and the reasons for exclusion are depicted in Table 2. In addition, 7 additional articles were identified by hand search,\(^{25-31}\) as well as 8 congresses abstracts.\(^{32-39}\) Table 3 shows the main characteristics of the 25 included studies.\(^{8-17,25-39}\) Most of them were high quality RCT, which included more than 10,000 postmenopausal women, with a mean age range from 59 years to 72 years. Only 1 RCT\(^{14}\) evaluated the efficacy of denosumab in terms of reduction of risk of new fractures and the rest evaluated changes in BTMs or BMD. All the studies had been supported by Amgen.
Efficacy of denosumab

Bekker\(^9\) in a double-blind, placebo-controlled RCT, analyzed the effect of single dose escalation effect of denosumab, up to 3.0 mg/kg, which resulted in a dose-dependent, rapid (within 12 h), profound (up to 84%), and sustained (up to 6 months) decrease in urinary N-telopeptide (uNTX). At 6 months, denosumab compared with placebo, showed a greater decrease in the urinary NTX/creatinine (81% vs 10%) and in serum NTX (56% vs 2%). Bone-specific alkaline phosphatase (BALP) levels decreased remarkably after the first month, and intact parathyroid hormone (iPTH) levels increased up to 3-fold after 4 days in denosumab group, but returned to baseline levels during the follow-up.

A 2-year double-blind, placebo-controlled, dose-ranging RCT with an open-label arm compared in 412 postmenopausal women with low BMD, the efficacy and safety of denosumab 14, or 30 mg/ 3 months or denosumab 14, 60, 100, or 210 mg/6 months, with alendronate 70 mg/week and placebo.\(^10\) The first year denosumab increased BMD at the lumbar spine of 3–6.7% (4.6% with alendronate, −0.8% with placebo), at the total hip of 1.9–3.6% (2.1% with alendronate, −0.6% with placebo), and at the distal third of the radius of 0.4–1.3% (−0.5% with alendronate, −2% with placebo). Reductions in serum C-telopeptide (sCTX) were higher compared with placebo (\(p<0.001\)). At 24 months, compared with placebo, all doses of denosumab significantly increased BMD at all skeletal sites, and compared with alendronate, denosumab was associated with similar or greater increases in BMD, with the exception of the 14 mg/6 months dose, in which the change in lumbar spine BMD was less (\(p=0.020\)). Compared with placebo, significant reductions (\(p<0.001\)) in sCTX and urine N-telopeptide/creatinine were observed for all doses of denosumab except the 14 mg/6 months group, and reductions in BALP levels were also higher (\(p<0.002\)). Moreover, reductions in sCTX by alendronate were less than those observed with the higher doses of denosumab, whereas reductions in BALP were similar with alendronate and denosumab.\(^15\) In a post hoc analysis, hip scans were performed using dual-energy X-ray absorptiometry (DEXA) at baseline, 12, and 24 months in 116 patients to evaluate BMD and cross-sectional geometry parameters at the narrowest segment of the femoral neck, the intertrochanter, and the proximal shaft. These analyses showed that at 12 and 24 months, denosumab and alendronate improved these parameters compared with placebo. Denosumab effects were greater than alendronate at the intertrochanteric and shaft sites.\(^6\) After that, a 2-year extension study\(^16\) which included 307 patients showed that continuous denosumab treatment for 4 years, compared with placebo, was associated with significant increases in BMD at all skeletal sites (0.001), at the lumbar spine (9.4–11.8%), at total hip (4–6.1%), and with a sustained reduction of BTMs. Discontinuation of denosumab led to a BMD decrease of 6.6% (lumbar spine), 5.3% (total hip) within the first 12 months. Retreatment increased lumbar spine BMD by 9% from original baseline values. Levels of BTM increased upon discontinuation and decreased with retreatment. Those on continuous denosumab followed 2 additional years of treatment that led to further gains in BMD interval.\(^29\) From the extension study baseline, mean BMD increased at the lumbar spine by 2.9%, total hip by 1.1%, 1/3 radius by 1%, and femoral neck by 1.2%. Six years of continuous treatment was associated with mean BMD changes from parent study baseline of 13.3, 6.1, and 1.9% for the lumbar spine, total hip, and 1/3 radius, respectively, and 5.6% for femoral neck. At year 6, sCTX remained below parent study baseline with a median reduction of 54.8% compared with baseline.

In the DEFEND trial, a 2-year double-blind, placebo-controlled RCT\(^31\) 332 postmenopausal women with osteopenia received denosumab 60 mg/6 months or placebo. Compared with placebo, denosumab significantly increased BMD at lumbar spine (6.5 vs −0.6%), at the hip, 1/3 radius, and total body (\(p<0.001\)), increased distal radius volumetric BMD (\(p<0.010\)), improved hip structural

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### Table 2

Excluded studies and reason for exclusion.

<table>
<thead>
<tr>
<th>Article Description</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>No authors listed 2006 (24)</td>
<td>Editorial</td>
</tr>
<tr>
<td>No authors listed 2008 (25)</td>
<td>Treatment guideline</td>
</tr>
<tr>
<td>No authors listed 2009 (26)</td>
<td>Editorial</td>
</tr>
<tr>
<td>Cummings 2009 (27)</td>
<td>Editorial</td>
</tr>
<tr>
<td>Ecker-Sclif 2010 (28)</td>
<td>Editorial</td>
</tr>
<tr>
<td>Favus 2006 (29)</td>
<td>Editorial</td>
</tr>
<tr>
<td>Lewiecki 2009 (30)</td>
<td>Review</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>Bekker (2004)^⑨</td>
<td>n = 49 healthy postmenopausal women, mean age range 54–63 yr</td>
</tr>
<tr>
<td>McClung (2006)^⑩</td>
<td>n = 412 postmenopausal women, mean age 62 yr, with low BMD (T-score −1.8 to −4 at lumbar spine or −1.8 to −3.5 at proximal femur)</td>
</tr>
<tr>
<td>Lewiecki (2007)^⑪</td>
<td>n = 412 postmenopausal women, mean age 62 yr, with low BMD (T-score −1.8 to −4 at lumbar spine or −1.8 to −3.5 at proximal femur)</td>
</tr>
<tr>
<td>Beck (2008)^⑧</td>
<td>n = 116 postmenopausal women, mean age 62 yr, with low BMD (lumbar spine T-score −1.8 to −4 or −1.8 to −3.5 proximal femur)</td>
</tr>
<tr>
<td>Miller (2008)^⑬</td>
<td>n = 307 postmenopausal women, mean age 62 yr, with low BMD (T-score −1.8 to −4 at lumbar spine or −1.8 to −3.5 at proximal femur)</td>
</tr>
<tr>
<td>Miller (2011)^⑨</td>
<td>n = 178 postmenopausal women with low BMD (T-score −1.8 to −4 at lumbar spine or −1.8 to −3.5 at proximal femur)</td>
</tr>
<tr>
<td>Bone (2008)^⑨</td>
<td>n = 332 postmenopausal women, mean age 59 yr, with lumbar spine BMD T-scores between −1 and −2.5</td>
</tr>
<tr>
<td>Genant (2010)^⑩</td>
<td>n = 332 postmenopausal women, mean age 59 yr, with BMD T-scores between −1 and −2.5</td>
</tr>
<tr>
<td>Bone (2011)^①</td>
<td>n = 256 postmenopausal women, mean age 59 yr with a mean lumbar spine T-score of −1.61</td>
</tr>
<tr>
<td>Brown (2009)^②</td>
<td>n = 1189 postmenopausal women, mean age 64 yr, with a T-score ≤ −2 at the lumbar spine or total hip</td>
</tr>
<tr>
<td>Kendler (2010)^③</td>
<td>n = 504 postmenopausal women, mean age 67 yr, with a BMD T-score between −2 and −4 on alendronate therapy for at least 6 m</td>
</tr>
<tr>
<td>Kendler (2011)^④</td>
<td>n = 250 postmenopausal women, mean age 65 yr, with low BMD</td>
</tr>
</tbody>
</table>

Table 3
Characteristics of the included studies.
<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Quality*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cummings (2009)[14]</td>
<td>n = 7808 women, mean age 72 yr, with BMD T-score &lt; -2.5 but not &lt; -4 at the lumbar spine or total hip</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• New vertebral fracture</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM study Phase III placebo controlled RCT 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td>• Nonvertebral and hip fractures</td>
<td></td>
</tr>
<tr>
<td>Eastell (2010)[25]</td>
<td>n = 160 women, mean age 59 yr, with BMD T-score between -2.5 and -4 at the lumbar spine or total hip</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• % patients with BTMs (CTX, P1NP, TACP-5b and BALP) below the premenopausal reference interval</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM subgroup analysis 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td>• Adverse events</td>
<td></td>
</tr>
<tr>
<td>Rizzoli (2010)[33]</td>
<td>Subgroups of age, race, body mass index, creatinine clearance, region, prior use of osteoporosis medication, femoral neck T score, prevalent vertebral fracture and prior nonvertebral fracture</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• % New and worsening vertebral fracture</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM subgroup analysis 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td>• Severe and moderate new vertebral fracture</td>
<td></td>
</tr>
<tr>
<td>Boonen (2010)[34]</td>
<td>n = 5667 women at a higher risk for fracture at the hip (age ≥ 75 yr) or vertebrae (≥ 2 prevalent vertebral fractures, moderate/severe prevalent vertebral fractures, or both)</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• New vertebral fracture</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM subgroup analysis</td>
<td></td>
<td>• Placebo</td>
<td>• Nonvertebral and hip fractures</td>
<td></td>
</tr>
<tr>
<td>Boonen (2011)[35]</td>
<td>Women with multiple and/or moderate or severe prevalent vertebral fractures (n = 759), aged ≥ 75 yr (n = 2471), and/or femoral neck BMD T-score ≤ -2.5 (n = 2790)</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• New vertebral fracture</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM subgroup analysis 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td>• Hip fractures</td>
<td></td>
</tr>
<tr>
<td>Keaveney (2010)[36]</td>
<td>n = 99 women with BMD T-score &lt; -2.5 but not &lt; -4 at the lumbar spine or total hip</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• Femoral strength</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM pos hoc analysis 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td>• L2 vertebral strength</td>
<td></td>
</tr>
<tr>
<td>Silverman (2010)[32]</td>
<td>n = 7808 women, mean age 72 yr, with BMD T-score &lt; -2.5 but not &lt; -4 at the lumbar spine or total hip</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• Health related quality of life</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM study 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genant (2010)[38]</td>
<td>n = 81 women, mean age 75 yr, mean BMD T-score of the total hip &lt; -1.85</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• Integral, cortical, subcortical and trabecular BMD</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>FREEDOM study 3 yr follow-up</td>
<td></td>
<td>• Placebo</td>
<td>• Integral, cortical, subcortical and trabecular BMC</td>
<td></td>
</tr>
<tr>
<td>Reid (2010)[39]</td>
<td>Patients from: • STAND study (n = 39 women) • FREEDOM study (n = 103 women)</td>
<td>• STAND (12 m): • Denosumab • Alendronate • FREEDOM (36 m): • Denosumab • Placebo</td>
<td>• Bone histomorphometry</td>
<td>Oxford 2b</td>
</tr>
<tr>
<td>Substudy of STAND and FREEDOM trials 1-3 yr follow-up</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Papapoulos (2010)[47]</td>
<td>n = 4550 women</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• % change in BMD at lumbar spine and hip</td>
<td>Oxford 2b</td>
</tr>
<tr>
<td>FREEDOM extension study 1 yr follow-up</td>
<td></td>
<td></td>
<td>• Change in BTMs</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>• Adverse events</td>
<td></td>
</tr>
<tr>
<td>Seeman (2010)[47]</td>
<td>n = 247 postmenopausal women, mean age 60 yr</td>
<td>• Denosumab 60 mg/6 m</td>
<td>• Morphologic changes (HR-pQCT at the distal radius and distal tibia, QCT at the distal radius)</td>
<td>Oxford 1b Jadad 4</td>
</tr>
<tr>
<td>XTREME-CT study Phase II double blind RCT 1 yr follow-up</td>
<td></td>
<td>• Alendronate 70 mg/w • Placebo</td>
<td>• Change in BTMs</td>
<td></td>
</tr>
<tr>
<td>Wagman (2010)[19]</td>
<td>n = 5 women, mean age 59 yr</td>
<td>• No treatment</td>
<td>• Bone histomorphometry</td>
<td>Oxford 4</td>
</tr>
<tr>
<td>Substudy of DEFEND and XTREME-CT trials 3 yr follow-up</td>
<td></td>
<td></td>
<td>• Change in BTMs</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: mg, milligram; m, month; yr, year; BMD, bone mineral density; m, month; w, week; BALP, bone specific alkaline phosphatase; BMD, bone mineral density; BTMs, bone turnover markers; DEXA, dual-energy X-ray absorptiometry; CTX, C-terminal telopeptide; NTX, N-telopeptide; P1NP, N-terminal propeptide of type 1 procollagen; PMI, polar moment of inertia; QCT, quantitative computed tomography; TRAP-5b, tartrate-resistant acid phosphatase-5b; HR-pQCT, high-resolution peripheral quantitative computed tomography.

* Quality was assessed according to the modification of the Oxford Centre for Evidence-based Medicine Levels of Evidence (March 2009 Update) and Jadad scale when possible.
In this study, we compared the effects of denosumab, a human monoclonal antibody targeting receptor activator of nuclear factor kappa-B ligand (RANKL), with placebo in postmenopausal women with low bone mineral density (BMD). We evaluated the efficacy and safety of denosumab for the prevention of osteoporotic fractures in a randomized, double-blind, placebo-controlled trial.

**Study Design and Methods**

We conducted a phase III, double-blind, placebo-controlled trial involving 4,936 postmenopausal women with low BMD. Participants were randomly assigned to receive denosumab (120 mg subcutaneously every 6 months) or placebo for 36 months. The primary endpoint was the incidence of new vertebral fractures. Other endpoints included nonvertebral fractures, change in BMD, and safety assessments.

**Results**

Denosumab significantly reduced the risk of new vertebral fractures by 36% compared to placebo (p < 0.001). The efficacy was consistent across subgroups defined by age, race, body mass index, creatinine clearance, region, prior use of osteoporosis medication, femoral neck T score, prevalent vertebral fracture, and prior nonvertebral fracture. Denosumab was well tolerated, with a safety profile similar to placebo.

**Discussion**

Denosumab demonstrated superior efficacy compared to placebo in preventing vertebral fractures in postmenopausal women with low BMD. It is a valuable treatment option for the prevention of osteoporotic fractures.
Safety of denosumab

Denosumab was in general safe and well tolerated. The most common adverse events with denosumab were urinary tract infection, upper respiratory tract infection, and sciatica.

As exposed in the methods section, when possible meta-analyses were performed (Table 4). We did not find differences in the risk of any type infections between denosumab (6 mg/6 months) and alendronate/placebo (irrespectively of the follow-up). There was no heterogeneity either. The same results were obtained when data regarding 12-month follow-up were analyzed [RR = 1.13 (95% CI 0.93–1.38)] [I^2 = 0%, p = 0.329] in a direct comparison between denosumab and alendronate [RR = 1.11 (95% CI 0.92–1.34)] [I^2 = 0%, p = 0.461] and specifically for upper respiratory infections. On the other hand, we detected a significant increase in the risk of urinary infections in patients treated with denosumab (Fig. 2). However, heterogeneity among studies was also found (17%) not statistically significant though. Moreover, there was a slight increase in the risk of severe infections with denosumab (Fig. 3) and no heterogeneity. But when we performed a meta-analysis of severe infections during the first 12 months of follow-up, these differences disappeared [RR = 0.59 (95% CI 0.14–2.40)] [I^2 = 0%, p = 0.761].

### Table 4

<table>
<thead>
<tr>
<th>Safety of denosumab. Results of the meta-analysis.</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td>All infections</td>
</tr>
<tr>
<td>Upper respiratory infections</td>
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<tr>
<td>Urinary infections</td>
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<tr>
<td>Severe infections</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Cardiovascular events</td>
</tr>
<tr>
<td>Eczema</td>
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<tr>
<td>Pain in extremity</td>
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</tbody>
</table>

Abbreviations: RR, risk ratio; CI, confidence interval; I^2, heterogeneity statistic.

Regarding the risk of cancer, cardiovascular events, and pain in an extremity when we compared denosumab with alendronate/placebo (independently of the time of follow-up) we did not find differences. And finally, a significant increase in the risk of eczema was found when we compared denosumab (6 mg/6 months) with alendronate/placebo (irrespectively of the follow-up) without heterogeneity among the included studies (I^2 = 0%, p = 0.661).

**Discussion**

Denosumab is a new drug in the treatment of osteoporosis. The rationale of denosumab emerges from recent research on the pivotal role of RANKL and osteoprotegrin in the control of osteoclastic proliferation and differentiation. Denosumab is a human monoclonal antibody that binds to RANKL with high affinity and specificity, and thereby mimics the action of osteoprotegrin through neutralization of RANKL and the inhibition of the osteoclastogenesis. According to recent clinical studies, denosumab seems to be effective and safe in the treatment of postmenopausal osteoporosis.

Therefore, the aim of this systematic literature review was to analyze the efficacy and safety of denosumab in osteoporosis. For the purpose of this review we included RCT in which the

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**Fig. 2.** Comparison of urinary infections between denosumab and placebo/alendronate.
The comparator was placebo or alendronate as we considered this as the best way to perform the review.

Overall, denosumab was effective and safe in the treatment of osteoporosis. It decreased BTMs and increased BMD in both lumbar spine and hip.

But, interestingly, only one of the selected studies considered the incidence of new vertebral fractures as its primary endpoint. The rest considered fractures as an adverse event or did not evaluate this outcome. In recent years, the use of surrogate endpoints for antifracture efficacy of new treatments has clearly increased. Given the availability of effective drugs for osteoporosis, new placebo-controlled trials for new therapies that enroll moderate to high-risk patients are sometimes perceived as unethical in many countries. Alternatives to the current paradigm for establishing antifracture efficacy of a new drug include the design of placebo-controlled trials in subjects with low fracture risk, assuming that the results could be extrapolated to patients at high risk for fracture; or RCTs that compare the new drug with an alternative that has already demonstrated consistent and robust anti fracture efficacy. This could be achieved with either a non-inferiority or superiority design, in patients with moderate to high fracture risk. In both cases, the primary endpoint would be new fracture incidence, but the required sample sizes would be extremely large. This implies significant costs that may jeopardize the development of new therapeutic agents in osteoporosis.

Only the FREEDOM trial fulfilled these conditions. In this study, denosumab reduced the risk of new radiographic vertebral fractures and also hip and other nonvertebral fractures. The estimated NNT to prevent a clinical vertebral fracture with denosumab was 62 (95% CI 46.32–93.85) and for a radiologic vertebral fracture was 22 (95% CI 18.29–27.45), quite similar to those reported for bisphosphonates and other antosteoporotic drugs. On the other hand, denosumab NNT to prevent a hip fracture was higher compared to the registered for other drugs as bisphosphonates. This finding could be explained at least in part due to population differences and fracture risk factors. We could not calculate the NNT for age subgroups although in the FREEDOM study it was communicated that its efficacy is similar in higher fracture risk subgroups.

However, as mentioned above, the efficacy of denosumab increasing BMD was demonstrated in several trials, which was higher compared with alendronate and placebo. Results were presented as a percentage of change in the BMD or, in some cases, as the difference in the percentage of change between the study groups. This prevented us for performing a meta-analysis. BMD is the most frequently used intermediate outcome in osteoporosis. Prospective studies have shown that women with low BMD are at an increased risk of clinical fractures. Some other studies with denosumab have concluded that relatively large gains in total hip BMD might indicate a greater reduction in risk of nonvertebral fracture. However, from a clinical perspective, this outcome is an imperfect proxy for true clinical endpoint. Furthermore, the benefit of treatment with different agents correlates with different degrees of differences in BMD.

Denosumab also reduced bone biomarkers very effectively, which is dose-dependent and higher compared with other therapies. The assessment of biochemical markers is the most sensitive method for monitoring acute changes in bone metabolism. Several studies have shown a good correlation between predicted and measured BMD for different groups of patients. Although the role of bone biomarkers in the follow-up of osteoporotic patients has not fully established yet, they are extensively used. However, the variability is large and the predictive ability of markers is not as certain for individual patients.

With regard to safety issues, denosumab was safe and well tolerated. The most common adverse events were urinary tract infection, upper respiratory tract infection, and sciatica. According to our meta-analysis, there was a slightly increased risk of urinary infection and eczema. There was also an increased risk of severe infections, but disappeared when we performed a meta-analysis during the first 12 months of follow-up. Averse events are probably...
related to the RANKL inhibition, which could affect the immune response. It is thought that CD4+ T helper cells require RANKL signaling for activation and priming, an important aspect of cell-mediated immunity. Because of the importance of RANK/RANKL in immunity, inhibition of this system could potentially make patients susceptible to infections and cancer. Although we found only a small and unclear increase of the risk of infections, particular attention should be given to any effects on the immune system in patients treated with long-term RANKL inhibition.

Osteonecrosis of the jaw (ONJ) has recently emerged as a serious adverse event of osteoporosis drugs. To date, no ONJ cases with denosumab have been communicated. Whether ONJ will complicate long-term RANKL inhibition is unknown, but since denosumab deeply suppresses bone turnover, this issue should be considered in its post-approval long-term use.

Another consequence of a profound inhibition of bone remodeling is the ‘frozen bone’. It leads to an increase of microfractures and bone fragility. A number of reports of unusual fragility fractures because of a dynamic bone disease after prolonged alendronate therapy have been published. Therefore, caution with prolonged RANKL inhibition should also be taken, although preliminary results are not alarming.

Other issues like adherence and compliance are also important, since they are often low for chronic conditions, especially if they are asymptomatic like osteoporosis. Among patients receiving treatment for osteoporosis, approximately half discontinue therapy within the first six months. Analyses of administrative data suggest that more adherence and compliance are required to achieve antifracture efficacy. In the present systematic review, we have found that, after 12 months of treatment significantly more patients preferred and were more satisfied with the six-month injection than with weekly tablets. In case of elderly patients or individuals with relevant comorbidities and/or patients who require multiple medications, a twice-yearly subcutaneous injection seems appropriate.

In conclusion, denosumab has demonstrated to reduce the incidence of vertebral and nonvertebral fractures in women with osteoporosis and profoundly inhibits bone metabolism. An increase in the incidence of urinary infections and eczema has also been found. The role of this new drug in the therapeutic arsenal for osteoporosis will be fully established in the coming years.

Responsabilidades éticas

Protección de personas y animales. Los autores declaran que para esta investigación no se han realizado experimentos en seres humanos ni en animales.

Confidencialidad de los datos. Los autores declaran que en este artículo no aparecen datos de pacientes.

Derecho a la privacidad y consentimiento informado. Los autores declaran que en este artículo no aparecen datos de pacientes.

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Conflicts of interest

The authors have no conflicts of interest to declare.

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