PPI Use, Fracture Risk Tied to Other Risk Factors

BY DENISE NAPOLI

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Hip fracture patients were 30% more likely to have a long-term history of proton pump inhibitor use, compared with controls, Dr. Douglas A. Corley and his colleagues reported.

Moreover, the association was found to be stronger with higher doses of PPIs, and the link diminished after PPI discontinuation, the researchers wrote.

“These findings do not recommend against acid suppression for persons with clear indications and at the lowest effective dose,” wrote Dr. Corley, a researcher with Kaiser Permanente Northern California (Gastroenterology July [doi: 10.1053/j.gastro.2010.03.055]). However, “they do advise appropriate vigilance in prescribing these medications to persons with defined indications and at the lowest effective dose.”

Dr. Corley and his colleagues looked at 33,752 adult members of the Kaiser Permanente Northern California integrated health care delivery system who had an incident diagnosis of a hip fracture between January 1995 and September 2007. To be included in the study, patients had to have been in the Kaiser Permanente Northern California system for at least 2 years prior to their fracture. Patients who had a previous hip or femur fracture diagnosis were excluded.

Patients were roughly matched in a 4:1 ratio with demographically comparable controls, also from the Kaiser Permanente Northern California system. Controls had no history of hip fracture, and had also been in the Kaiser system for at least 2 years.

Patients were predominately women (65.7%, 70 years of age or older (69.4%), and white (79.6%), according to the authors. Roughly 40% had received a prescription for a proton pump inhibitor while in the Kaiser Permanente Northern California system.

According to Dr. Corley, patients whose records indicated “long-term” use of PPIs (defined by the authors as greater than 2 years) had an odds ratio of having a fracture within the study period of 1.30, compared with nonusers (95% confidence interval, 1.21-1.39).

However, all of the increased risk for fracture was present only in patients who had at least one other risk factor for fracture, such as smoking, dementia, arthritis, or visual impairment. Indeed, among patients with none of these risk factors, the odds ratio for fracture among PPI users was 0.66 (95% CI, 0.38-1.12).

The researchers also found a trend toward increased fracture risk among subjects taking higher daily doses of PPIs. For example, among patients taking an average of 0.01-0.74 pills/day, for a duration between 2 and 5 years, the OR for a fracture, compared with nonusers, was 1.23 (95% CI, 1.08-1.39); among users taking 0.75-1.49 pills/day, for the same duration of time, the OR was 1.43 (95% CI, 1.28-1.60), and for more than 1.49 pills/day the OR was 1.41 (95% CI, 1.21-1.64).

Despite the association with PPI dosage, there was no link between duration of PPI use and fracture risk.

The researchers also found that “the strength of the association between PPI use and hip fracture was greatest among current users and diminished after discontinuation of PPI use.” For example, while the OR for current users was 1.30 (95% CI, 1.21-1.41), it was 1.24 for patients who were most recently prescribed PPIs (OR, 1.01-1.9 years before the index date (95% CI, 0.90-1.72), and dropped to 1.09 for patients whose last PPI prescription was 2.0-2.9 years before the index date (95% CI, 0.64-1.85).

Dr. Corley proposed several mechanisms by which acid inhibition could influence fracture risk. For one, he said, acid inhibition could directly influence calcium absorption: he pointed to a small, randomized trial in which omeprazole decreased the absorption of radio-labeled calcium pills by 61%, compared with placebo (Am. J. Med. 2005;118:778-81).

“Second,” he wrote, “acid inhibition may induce hyperparathyroidism, which directly decreases bone mineral density, through hypergastrinemia, although this is controversial.”

Finally, he suggested that fracture risk may be mediated by interference with PPIs and bone remodeling. However, he added, “none of these mechanisms are proven.”

Fracture risk also was increased in patients using histamine2-receptor antagonists, another class of drugs that inhibit acid secretion (OR, 1.18). However, the authors concluded that acid inhibition might raise fracture risk in persons already at risk for osteoporosis, although confounding cannot be excluded.

PPI-Associated Adverse Effects Are Overstated, Expert Says

BY CAROLINE HELWICK

From the annual Digestive Disease Week

NEW ORLEANS — Adverse effects attributed to proton pump inhibitors, including a risk for adverse interactions with clopidogrel, have probably been overstated.

Dr. Michael F. Vaezi, professor of medicine and clinical director of the division of gastroenterology at Vanderbilt University Medical Center in Nashville, Tenn., told attendees that although there are “interesting epidemiologic associations” that may have “some biologic plausibility,” the associations are weak in magnitude and are based on inconsistent findings from heterogeneous studies with a high potential for confounding.

Issues With Clopidogrel

The potential for an interaction with clopidogrel—that is, whether PPIs (specifically, omeprazole) inhibit the anticoagulation effect of clopidogrel so that it is less effective in preventing cardiovascular injury—has been a “huge issue,” because cardiologists, or patients themselves, are discontinuing proton pump inhibitors (PPIs) that they were using for reflex disease.

A number of studies have suggested harmful interactions, Dr. Vaezi said. One study showed a reduction in the platelet reactivity index, indicating poor response to clopidogrel, in 61% of patients who received omeprazole vs. 26% of patients in a placebo group, a highly significant difference (J. Am. Coll. Cardiol. 2008;51:256-60).

In a retrospective Department of Veterans Affairs cohort study, all-cause mortality was significantly increased in patients on PPIs plus clopidogrel vs. clopidogrel alone (JAMA 2009;301:957-44). But a recent meta-analysis of 23 studies comparing PPIs and clopidogrel in 93,927 patients, showed no excess risk for cardiovascular events for PPIs that were used with clopidogrel in observational studies (odds ratio, 1.15) among propensity-matched, randomized-controlled participants (Aliment. Pharmacol. Ther. 2010;31:810-23). No significant association was found between PPI use and overall mortality, noted Dr. Vaezi.

“The most recent analysis asked the right question: If you are not on a PPI but are on clopi- dogrel, what is the risk of bleeding?” he said. A recent study examined a database of more than 20,000 patients (including 7,593 concurrent users of clopidogrel and PPIs) who were hospitalized for gastrointestinal bleeding and serious cardiovascular disease (Ann. Intern. Med. 2010;152:337-45). The adjusted incidence of hospitalization for bleeding in concurrent users was 1.7 times lower than it was in nonusers of PPIs who were taking clopidogrel. For patients at highest risk for bleeding, PPI use was associated with an absolute reduction of 28.5 per 1,000 person-years, the study found.

Despite this concern, Dr. Vaezi said that in patients with serious coro- nary heart disease that was treated with clopidogrel, concurrent PPI use was associated with reduced hospitalizations for gastroesophageal bleeding, and the corresponding point estimate for serious cardiovascular disease was not increased.

“But we are left with the [Food and Drug Administration] warnings about using omeprazole and esomeprazole, though the data are not strong,” Dr. Vaezi maintained. In his practice, he keeps patients on omeprazole and clopidogrel and prefers not to switch to another PPI, having observed that some such patients stop responding to PPIs altogether. It may be prudent, however, to give one drug at night and the other in the morning, he added.

Hips

PPIs have been associated with a risk for hip fracture, but a nested, case-control study from the U.K. General Practice Research Database, including 13,556 cases and 135,386 controls, showed an odds ratio of approximately 2.0 in the crude analysis. But concerns were cast about whether some patients stop responding to PPIs altogether. It may be prudent, however, to give one drug at night and the other in the morning, he added.

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Disclosures: Dr. Vaezi reported receiving research funds and consulting fees from Takeda Pharmaceutical Co., and research funds from AstraZeneca.