Cancer Treatment-Induced Bone Loss in Patients With Breast or Prostate Cancer

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Purpose/Objectives: To review the prevalence, consequences, pathophysiology, diagnosis, and treatment of cancer treatment-induced bone loss (CTIBL) in patients with breast or prostate cancer.

Data Sources: Published articles, abstracts, book chapters, electronic resources, and manufacturer information.

Data Synthesis: CTIBL is a long-term complication associated with cancer therapies that cause hypogonadism in patients with breast or prostate cancer. Early diagnosis and treatment of CTIBL is essential to prevent bone fractures. CTIBL treatment includes modification of lifestyles that increase the risk of developing bone loss and fractures and includes the use of bone loss therapies (e.g., bisphosphonates, selective estrogen receptor modifiers, calcitonin).

Conclusions: CTIBL is becoming more common as patients with breast or prostate cancer survive longer. Identifying and treating CTIBL early are important because once bone is lost, damaged bone becomes more difficult to repair; early diagnosis and treatment also may prevent fractures.

Implications for Nursing: Nurses must be knowledgeable about CTIBL to identify high-risk patients and educate patients and their families about CTIBL, bone loss therapies, and lifestyle modifications.

Goal for CE Enrollees:

To enhance nurses’ knowledge about cancer treatment-induced bone loss (CTIBL) in people with breast or prostate cancer.

Objectives for CE Enrollees:

1. Describe factors that can place a person with breast or prostate cancer at risk for CTIBL.
2. Outline the assessment and diagnostic measures used to evaluate a person with CTIBL.
3. Discuss interventions that should be included in a plan of care for a person with CTIBL.

Key Points...

➤ Cancer treatment-induced bone loss (CTIBL) commonly occurs in patients with breast cancer with chemotherapy-induced menopause; some patients with breast cancer receiving hormonal therapy, such as aromatase inhibitors; and patients with prostate cancer receiving androgen deprivation therapy.

➤ Patients at risk for CTIBL should adopt lifestyles that preserve bone health, including smoking cessation, moderate alcohol consumption, weight-bearing exercise, adequate calcium and vitamin D intake, and measures to prevent falls.

➤ Bisphosphonates are the most effective therapies for patients with CTIBL. IV bisphosphonates are more potent, better tolerated, and less frequently administered than oral bisphosphonates.
Osteoporosis, a disease characterized by low bone mass and deterioration of bone that can lead to bone weakness and increased susceptibility to fracture, with or without trauma, is a common health problem in aging men and women (Brown & Josse, 2002; Follin, 2003). In 2002, approximately two million men and eight million women older than 50 years were estimated to have osteoporosis (National Osteoporosis Foundation [NOF], 2004a). Additionally, approximately 34 million men and women were estimated to have osteopenia—low bone mass not yet at the deficient level of an osteoporosis diagnosis—placing them at risk for developing the more pronounced bone loss associated with osteoporosis (NOF, 2004a).

Patients with breast or prostate cancer are particularly at risk for developing bone loss because their cancer therapies, such as chemotherapy or hormonal therapy, may cause or accelerate bone loss. With improved survival times in both diseases, long-term toxicities such as cancer treatment-induced bone loss (CTIBL) are beginning to have a negative impact on the quality of life of cancer survivors (Berruti, Tucci, et al., 2002; Mincey, Moraghan, & Perez, 2000). Thus, an understanding of CTIBL is necessary to determine which patients may benefit from an early assessment of risk factors and complications associated with bone loss and early intervention with bone loss therapies.

**Prevalence of Cancer Treatment-Induced Bone Loss**

**Bone Loss and Related Fractures in Healthy Adults**

Bone undergoes a continual process of loss and formation (i.e., bone remodeling) throughout its life to maintain its structural and mineral integrity (Gholz, Conde, & Rutledge, 2002). Because of the natural aging process and reduction of gonadal hormone production over time, bone loss occurs much more rapidly than bone formation in older men and women, resulting in an overall net loss of bone and an increased risk of fractures (Higano, 2003). With the cessation of estrogen production that characterizes menopause, women initially experience a sharp decrease in bone mass (as much as 30% of bone mass within five years after menopause); the loss of bone mass then becomes more gradual (Higano, 2003; Twiss et al., 2001). Men, however, experience a more gradual loss of testosterone and estrogen production and, thus, a more gradual loss of bone mass; at about 60 years of age, men and women have a similar rate of bone loss (Higano, 2003). Unless bone loss prevention or treatment strategies are implemented, many patients will progress from normal bone mass to osteopenia and, eventually, osteoporosis (Follin, 2003).

The incidence of fractures is increased in men and women who experience bone loss (Cummings & Melton, 2002). In the United States, Caucasian women older than 50 years have a 40% estimated lifetime risk of experiencing a spine, hip, or distal radius fracture; Caucasian men aged 50 years or older have a 13% lifetime risk of a fracture (Messinger-Rapport & Thacker, 2002). Additionally, adults with a history of a fracture are 50%–100% more likely to experience a second fracture (Cummings & Melton). Figure 1 lists the risk factors for developing bone loss and an increased susceptibility to fractures (Hillner et al., 2003; Messinger-Rapport & Thacker; NOF, 2004b).

<table>
<thead>
<tr>
<th>Modifiable Risk Factors</th>
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<tr>
<td>Excessive alcohol consumption</td>
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<tr>
<td>Excessive caffeine consumption</td>
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<tr>
<td>Existing low bone mass and poor bone quality</td>
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<tr>
<td>Low calcium or vitamin D intake</td>
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<tr>
<td>Low body weight or excessive weight loss</td>
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<tr>
<td>Low estrogen or testosterone levels</td>
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<tr>
<td>Sedentary lifestyle</td>
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<tr>
<td>Tobacco use</td>
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<tr>
<td>Use of certain medications*</td>
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<table>
<thead>
<tr>
<th>Unmodifiable Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic diseases*</td>
</tr>
<tr>
<td>Female gender</td>
</tr>
<tr>
<td>Height</td>
</tr>
<tr>
<td>History of fracture</td>
</tr>
<tr>
<td>History of late menarche</td>
</tr>
<tr>
<td>Impaired mental status</td>
</tr>
<tr>
<td>Impaired vision</td>
</tr>
<tr>
<td>Maternal history of fractures</td>
</tr>
<tr>
<td>Older age</td>
</tr>
<tr>
<td>Skeletal hip formation</td>
</tr>
<tr>
<td>Caucasian or Asian race</td>
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</table>

* Those that affect absorption or production of calcium or vitamin D or decrease the production of estrogen or testosterone

**Figure 1. Risk Factors for Developing Bone Loss and Fractures**

Note. Based on information from Hillner et al., 2003; Messinger-Rapport & Thacker, 2002; National Osteoporosis Foundation, 2004b.

**Cancer Treatment-Induced Bone Loss in Patients With Breast Cancer**

Patients with breast cancer are at increased risk for developing CTIBL. These patients often experience menopause, either temporary or permanent, as an adverse effect of their chemotherapy, and menopause is associated with a higher rate of bone loss than bone formation (Ramaswamy & Shapiro, 2003; Twiss et al., 2001). Significant bone loss as a result of chemotherapy-induced menopause has been reported in premenopausal patients with breast cancer as early as six months after initiation of some types of adjuvant chemotherapy, and the loss continues for several years (Ramaswamy & Shapiro).

The results of two studies evaluating the effect of adjuvant chemotherapy-induced menopause on bone loss showed that bone mineral density—the average concentration of bone mineral in a defined section of bone that is used to diagnose and monitor bone loss—decreased by 4%–7% in the spine and 2% in the femur 12 months after the initiation of adjuvant chemotherapy (Saarto et al., 1997; Shapiro, Manola, & Leboff, 2001). Additionally, bone loss continued for the next two to five years in women with permanent menopause (Saarto et al.; Vehmanen et al., 2001).

Some patients with breast cancer receiving hormonal therapy, such as tamoxifen (Nolvadex®, AstraZeneca, Wilmington, DE), also may be at increased risk for developing CTIBL. The effect of tamoxifen on bone differs in postmenopausal and premenopausal women. In postmenopausal women, tamoxifen preserves bone mineral density, increasing spine bone mineral density by 0.6%–1.2% and hip bone mineral density by 1.7% for each year of therapy (Love et al., 1992; Powles, Hickish, Kanis, Tidy, &
Ashley, 1996). In premenopausal women receiving tamoxifen, however, spine bone mineral density decreases by approximately 1.4% for each year of therapy (Powles et al.). The effects of other hormonal therapies, such as fulvestrant and aromatase inhibitors, on the development of CTIBL have been studied less. The results of preclinical trials evaluating fulvestrant (Faslodex®; AstraZeneca) have shown varying effects on bone (Ramsawamy & Shapiro, 2003). Likewise, results of preclinical trials and preliminary results of clinical trials evaluating aromatase inhibitors have suggested that non-steroidal aromatase inhibitors, such as anastrozole (Arimidex®, AstraZeneca) and letrozole (Femara®, Novartis Pharmaceuticals, East Hanover, NJ), do not prevent loss of bone mineral density, whereas the steroidal aromatase inhibitor exemestane (Aromasin®, Pfizer Inc., New York, NY) prevents bone mineral density loss (Ramsawamy & Shapiro). However, the results of clinical trials evaluating aromatase inhibitors in postmenopausal women with breast cancer have shown trends toward increased bone loss following nonsteroidal and steroidal aromatase inhibitor therapy (Coombes et al., 2004; Eastell, Hannon, Cuzick, Clack, & Adams, 2002; Goss et al., 2003). The results of a study evaluating 80 postmenopausal women who received anastrozole as adjuvant treatment for early breast cancer showed that these patients experienced a bone mineral density loss of 2.6% in the lumbar spine and 1.7% in the total hip after one year of therapy, which is similar to the average yearly loss of bone mineral density in postmenopausal women (Eastell et al.; Finkelstein, 2000). The other two clinical trials evaluating letrozole and exemestane did not measure bone mineral density but reported the incidence of newly diagnosed osteoporosis (8% and 7.4%, respectively) (Coombes et al.; Goss, 2004). In the letrozole study, osteoporosis was significantly more common in patients who received aromatase inhibitors than those who did not (8% versus 6%, p = 0.0003), but in the exemestane study, the difference was not significant (Coombes et al.; Goss). Short follow-up periods and the lack of an objective measurement of bone loss in both of these studies may have contributed to an underestimation of the incidence of bone loss that occurs with these drugs (Coombes et al.; Goss et al.). Therefore, careful monitoring of patients receiving aromatase inhibitors is warranted until the severity of bone loss that occurs with these drugs in patients with breast cancer is determined (Ramsawamy & Shapiro).

The incidence of fractures caused by chemotherapy-induced bone loss in patients with breast cancer has not been reported, but the results of three clinical trials have revealed the incidence of fractures caused by hormonal therapy-induced bone loss. In the Arimidex, Tamoxifen Alone or in Combination (ATAC) Trialists’ Group study that evaluated 9,366 postmenopausal patients with breast cancer, a higher incidence of fractures was reported in patients receiving anastrozole compared with patients receiving tamoxifen only (5.9% and 3.7%, respectively; p < 0.0001) (Baum et al., 2002). The combination of anastrozole and tamoxifen resulted in a fracture incidence of 4.6%. The results of a randomized study comparing letrozole and placebo in postmenopausal women who had received five years of tamoxifen for early-stage breast cancer showed a higher incidence of clinical fractures in patients receiving letrozole (5.3%) compared with placebo (4.6%), but the difference was not significant (p = 0.25) (Goss, 2004). Preliminary results of the randomized study evaluating exemestane after two to three years of tamoxifen therapy in postmenopausal women with primary breast cancer (X age = 64 years) suggested that patients treated with exemestane following tamoxifen therapy were more likely to have fractures than patients treated only with tamoxifen (3.1% and 2.3%, respectively, p = 0.08), but again this difference was not significant (Coombes et al., 2004). These clinical trial results suggested that all aromatase inhibitors may be associated with an increased risk for fracture; however, further evaluation is warranted. Patients receiving aromatase inhibitors should be monitored closely for fracture-related risk factors.

Cancer Treatment-Induced Bone Loss in Patients With Prostate Cancer

Patients with prostate cancer receiving androgen deprivation therapy, which is the mainstay of treatment for patients with metastatic prostate cancer or locally advanced prostate cancer accompanied by a rising prostate-specific antigen level, are at risk for developing CTIBL (Basaria et al., 2002; Berruti, Tucci, et al., 2002; Eriksson, Eriksson, Stege, & Carlstrom, 1995; Smith et al., 2001). Androgen-deprivation therapy options include the use of gonadotropin-releasing hormone agents, such as goserelin (Zoladex®, AstraZeneca) or leuprolide (Lupron®, Tap Pharmaceutical, Inc., Lake Forest, IL; Viadrus®, Alza Corporation, Mountain View, CA) with or without an antiandrogen (e.g., flutamide [Eulexin®, Schering-Plough, Kenilworth, NJ), bicalutamide [Casodex®, AstraZeneca], nilutamide [Nilandron®, Aventis Pharmaceuticals, Bridgewater, NJ), or surgical castration (Berruti, Tucci, et al.; Smith et al., 2001).

Androgen-deprivation therapy significantly decreases bone mineral density. In patients with nonmetastatic prostate cancer undergoing surgical castration, femoral neck bone mineral density decreased by 2%–10% one year after surgery (Daniell et al., 2000; Eriksson et al., 1995). Patients with nonmetastatic prostate cancer undergoing gonadotropin-releasing hormone therapy, with or without an antiandrogen, experienced spine or femoral neck bone mineral density decreases of 1%–5% within nine months to one year after initiation of androgen-deprivation therapy (Berruti, Dogliotti, et al., 2002; Higano, Jiang, Miller, Pitzel, & Jensen, 2003; Maillelfert et al., 1999; Mittan et al., 2002; Smith et al., 2001, 2003). Similarly, patients with metastatic prostate cancer undergoing gonadotropin-releasing hormone and antiandrogen therapy experienced bone mineral density decreases of 2%–7% during the first year of therapy (Diamond, Campbell, Bryant, & Lynch, 1998; Diamond et al., 2001). The loss of bone mineral density associated with androgen-deprivation therapy is greater than that associated with menopause (Smith, 2002). Furthermore, bone mineral density tends to progressively decrease and the risk of fracture increase with longer duration of androgen-deprivation therapy (Kiraliti, Srinivas, Perkash, & Terris, 2001; Oefelein et al., 2001).

Although the exact incidence of fractures associated with CTIBL in patients with prostate cancer is unknown, the results of several retrospective studies evaluating 59–224 patients have shown an osteoporotic fracture rate of 5%–14% after androgen-deprivation therapy initiation (Daniell, 1997; Hatano, Oishi, Furuta, Iwamuro, & Tashiro, 2000; Oefelein et al., 2001; Townsend, Sanders, Northway, & Graham, 1997). These rates are two to five times higher than those in healthy men (Oefelein et al.; Smith, 2002; Townsend et al.). Fracture risk also is increased after surgical castration. The results of a
recent retrospective study reported a twofold increased risk of osteoporotic fracture in patients with prostate cancer undergoing bilateral orchectomy compared with expected rates in the general community (Melton et al., 2003).

**Consequences of Cancer Treatment-Induced Bone Loss**

Although bone loss occurs more rapidly and tends to be more severe in patients with CTIBL, the clinical consequences of CTIBL are similar to those observed with osteoporosis (see Table 1 and Figure 2) (Begerow et al., 1999; Center, Nguyen, 2000). Fragility fractures resulting from CTIBL most commonly occur in the vertebrae, hip, and wrist and often have clinical sequelae.

**Table 1. Clinical Consequences of Cancer Treatment-Induced Bone Loss**

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Abdominal protrusion</td>
<td>Result of multiple vertebral fractures</td>
</tr>
<tr>
<td>Acute pain</td>
<td>Result of fracture; in vertebral fractures, pain caused by vertebral collapse may worsen with standing or sudden movement. May require inactivity or immobilization and treatment with analgesics. Typically resolves in weeks to months.</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>Result of fracture; in vertebral fractures, pain caused by vertebral collapse may worsen with standing or sudden movement. May require inactivity or immobilization and treatment with analgesics. Typically resolves in weeks to months.</td>
</tr>
<tr>
<td>Decreased functional capability</td>
<td>Result of fracture; in vertebral fractures, pain caused by vertebral collapse may worsen with standing or sudden movement. May require inactivity or immobilization and treatment with analgesics. Typically resolves in weeks to months.</td>
</tr>
<tr>
<td>Fracture</td>
<td>Result of increased bone fragility Occurs with relatively mild trauma Most common in vertebrae, hip, and wrist Hip fractures often require surgical intervention (see Figure 2). Vertebral fractures often occur without symptoms. Wrist fractures resulting from a fall on an outstretched hand are common in postmenopausal women. Risk of subsequent fracture is increased.</td>
</tr>
<tr>
<td>Height loss</td>
<td>Result of multiple vertebral fractures Loss of &gt; 1.5 inches from mature height suggests vertebral fractures.</td>
</tr>
<tr>
<td>Increased mortality rate</td>
<td>Particularly with hip and vertebral fractures 12-month mortality rate after hip fracture varies from 12%–35%; risk of death from a hip fracture is higher in older adults and men. Mortality rate after vertebral fracture is 23% higher than in healthy population.</td>
</tr>
<tr>
<td>Kyphosis</td>
<td>Result of multiple vertebral fractures If severe, may cause respiratory problems because of compression of thoracic region and poor nutrition because of abdominal compression.</td>
</tr>
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*Vertebral fractures can occur with minimal activity, such as bending or lifting.*

**Note.** Data are from healthy adults with osteoporosis. Based on information from Begerow et al., 1999; Center et al., 1999; Cooper, 1997; Cummings & Melton, 2002; Delmas, 2002; Follin, 2003; Miller & Lane, 2001; Smith, 2003b.

**Pathophysiology of Cancer Treatment-Induced Bone Loss**

The primary etiology of CTIBL in patients with breast or prostate cancer is hypogonadism caused by chemotherapy, hormonal therapy, or surgical castration (Pfeilschifter & Diel, 2000). Because estrogen and testosterone have a fundamental role in maintaining bone mass by directly or indirectly suppressing bone resorption, decreases in the levels of these hormones—as occurs with hypogonadism—results in accelerated bone loss (Hofbauer & Khosla, 1999; Oursler, Landers, Riggs, & Spelsberg, 1993; Pfeilschifter & Diel). Unless bone formation rates increase, continual loss of bone will occur, leading to osteopenia and, eventually, osteoporosis (Follin, 2003). Direct effects of chemotherapy on bone metabolism, such as decreased bone formation or increased bone resorption, also may be responsible for some bone loss, but these effects are not well described (Mincey et al., 2000; Pfeilschifter & Diel).

**Breast Cancer**

Patients with breast cancer who receive cyclophosphamide-containing regimens (e.g., cyclophosphamide, methotrexate, 5-fluorouracil [5-FU] [CMF]; 5-FU, doxorubicin, cyclophosphamide [FAC]; doxorubicin, cyclophosphamide [AC]) are at high risk for developing hypogonadism (Bines, Oleske, & Cobleigh, 1996; Bruning et al., 1990; Saarto et al., 1997; Twiss et al., 2001). The use of the alkylating agent cyclophosphamide induces hypogonadism by causing menopause as a result of ovarian damage, with ovarian damage ranging from a decreased number of secondary ovarian follicles to the total loss of follicles with accompanying ovarian fibrosis (Bines et al.; Ramaswamy & Shapiro, 2003). Cyclophosphamide-induced menopause occurs in 63%–96% of premenopausal patients with breast cancer receiving adjuvant CMF or FAC, with older patients and patients receiving higher doses of...
cyclophosphamide at highest risk (Bines et al.; Pfeilschifter & Diel, 2000; Ramaswamy & Shapiro). Use of adjuvant taxane-containing regimens (e.g., AC followed by paclitaxel) also may cause menopause, the extent and prevalence of which are unknown (Hillner et al., 2003). During menopause, an increase in osteoclast bone resorption resulting from low estrogen levels causes more bone loss than bone formation (Pfeilschifter & Diel).

Hormonal therapies used to treat breast cancer are designed to further reduce circulating estrogen levels, and some of these therapies have been shown to induce bone loss (Pfeilschifter & Diel, 2000). Tamoxifen has been shown to cause and prevent bone loss in pre- and postmenopausal women, respectively (Ramaswamy & Shapiro, 2003). The exact mechanism for the different effects is unknown, but tamoxifen may act as an estrogen agonist in postmenopausal women because of their low estrogen state but as an antagonists on the bone in premenopausal women with higher estrogen levels (Ramaswamy & Shapiro).

The bone mineral density effects of other commonly used breast cancer hormonal therapies, including selective estrogen receptor downregulators (SERDs) and aromatase inhibitors, are not as well defined. However, the mechanism of action of these drug classes suggests that both may cause bone loss in some patients. SERDs lack estrogen agonist activity; therefore, some women may experience an accelerated bone loss similar to that observed in women with early menopause (Pfeilschifter & Diel, 2000; Ramaswamy & Shapiro, 2003). Aromatase inhibitors, which decrease circulating and tissue levels of estrogen by decreasing aromatase activity and inhibiting conversion of adrenal androgens to estrogen, also may accelerate bone loss (Pfeilschifter & Diel; Ramaswamy & Shapiro). A trend toward increased bone loss and an increased incidence of fractures has been reported with each of the commercially available aromatase inhibitors (Coombes et al., 2004; Eastell et al., 2002; Goss et al., 2003; Ramaswamy & Shapiro).

Another class of hormonal drugs that induces ovarian insufficiency is gonadotropin-releasing hormone agents, such as leuprolide, in premenopausal patients with advanced breast cancer. Gonadotropin-releasing hormone agents suppress the release of luteinizing hormone, which reduces estrogen production in the ovaries (Jonat et al., 2002; Pfeilschifter & Diel, 2000). Ovarian insufficiency predisposes women to the development of accelerated bone loss.

### Prostate Cancer

As previously discussed, one of the primary therapies for patients with prostate cancer is androgen-deprivation therapy, either by surgical castration or the administration of gonadotropin-releasing hormone, which causes hypogonadism. Although the exact mechanism whereby hypogonadism induces CTIBL is unknown, one hypothesis suggests that androgens increase bone formation directly by binding to androgen receptors on osteoblasts (Chen et al., 2002). Additionally, evidence suggests that aromatization of testosterone into estrogens also is crucial in maintaining appropriate bone remodeling (Hofbauer & Khosla, 1999; Leder, LeBlanc, Schoenfeld, Eastell, & Finkelstein, 2003). Thus, in patients with prostate cancer receiving androgen deprivation therapy, circulating testosterone and estrogen levels are reduced, resulting in decreased osteoblastic bone formation activity, increased osteoclastic bone resorption activity, and, ultimately, accelerated bone loss (Gholz et al., 2002; Leder et al.). Androgen deprivation therapy-induced hypogonadism also causes a loss of muscle mass, which promotes bone mineral density loss by decreasing mechanical stretch and pressure on the bone (Chen et al.).

### Diagnosis of Cancer Treatment-Induced Bone Loss

A diagnosis of low bone mass before the occurrence of a first fracture is important because bone loss therapies are likely to be most effective in the early stages of bone loss in patients with cancer, just as these therapies are most effective in postmenopausal women when bone loss is diagnosed at an early stage (e.g., osteopenia) (Pfeilschifter & Diel, 2000). Historical and lifestyle bone loss risk factors alone do not identify patients with low bone mass (Miller & Lane, 2001). Therefore, some practitioners suggest that patients at risk for CTIBL should receive baseline and serial bone mass assessments; however, the optimal timing of bone mineral density assessments is unknown (Diamond, Higano, Smith, Guise, & Singer, 2004; Pfeilschifter & Diel). Although no technology measures bone mass specifically, bone mineral density is calculated because bone mineral density levels directly correlate with bone strength (Cummings, Bates, & Black, 2002).

Current clinical practice guidelines and recommendations for diagnosing CTIBL in patients with breast or prostate cancer are based on the World Health Organization (WHO) guidelines for diagnosing osteopenia or osteoporosis in Caucasian postmenopausal women (see Table 2). These guidelines are used widely to diagnose bone loss in many patient groups (Berruti, Tucci, et al., 2002; Diamond et al., 2004; Hillner et al., 2003; Kanis, 2002). The WHO defined four diagnostic categories of bone loss: normal bone mineral density, osteopenia, osteoporosis, and severe osteoporosis.

### Techniques to Measure Bone Mineral Density

Many techniques can be used to measure bone mineral density, including dual-energy x-ray absorptiometry (DEXA), peripheral DEXA, quantitative computed tomography, radiographic absorptiometry, and quantitative ultrasonography (Cummings et al., 2002). Bone mineral density measurement devices can assess either the central skeleton (e.g., spine, hip) or peripheral skeleton (e.g., finger, heel, tibia, wrist, forearm) (Miller & Lane, 2001). Because hip bone mineral density

### Table 2. World Health Organization Diagnostic Categories of Osteopenia and Osteoporosis

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>T Scorea</th>
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<tr>
<td>Normal bone mineral density</td>
<td>≥−1.0</td>
</tr>
<tr>
<td>Osteopenia</td>
<td>−1.0 to −2.5</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>≤−2.5</td>
</tr>
<tr>
<td>Severe osteoporosis</td>
<td>≤−2.5 with fragility fractures</td>
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</table>

a T scores represent the difference between the number of standard deviations in an individual’s bone mineral density and the average, peak bone mineral density for a group of young adults of same gender.

Note. Based on information from Berruti, Tucci, et al., 2002; Gholz et al., 2002; Kanis, 2002.
is the best predictor of hip fractures and hip bone mineral density and spine bone mineral density have similar value in predicting vertebral fractures, measuring bone mineral density at these sites is important to obtain an accurate assessment of risk (Cummings et al.). The preferred or gold-standard technique is the DEXA because of its ability to measure the bone mineral density at several different anatomic sites, including the hip and spine, and the total amount of mineral in the whole skeleton with minimal radiation exposure (Cummings et al.; Follin, 2003). DEXA results are reported as T scores, which represent the difference in the number of standard deviations between an individual’s bone mineral density and the mean value for a group of young adults of the same gender (Cummings et al.).

Other Diagnostic Evaluations

A thorough review of a patient’s history and bone loss risk factors, including previous and current cancer therapies, by a healthcare professional is important in diagnosing CTIBL and determining fracture risk (Berruti, Tucci, et al., 2002; Pfeilschifter & Diel, 2000). Additionally, a thorough physical examination, including assessment of vertebral deformities, height loss, abdominal protrusion, and paraspinal muscle pain, should be performed to rule out asymptomatic vertebral fractures (Miller & Lane, 2001). If any of these symptoms are present, vertebral radiography should be performed (Pfeilschifter & Diel).

Finally, laboratory tests should be performed to exclude any secondary causes of bone loss (Pfeilschifter & Diel, 2000; Smith, 2002). For example, serum chemistries should be measured to exclude kidney or liver disease, which may cause osteoporosis as a result of reduced vitamin D production or calcium or vitamin D malabsorption, respectively (Finkelstein, 2000; Smith, 2002). Additionally, serum levels of parathyroid hormone, thyroid-stimulating hormone, and 25-dihydroxyvitamin D should be measured to evaluate for hyperparathyroidism, hyperthyroidism, and vitamin D deficiency, respectively, each of which increases bone resorption (Finkelstein; Lips et al., 1996; Pfeilschifter & Diel). Generally, serum calcium, phosphorus, and alkaline phosphatase levels, which represent key constituents of bone, are within a normal range in patients with osteoporosis because normal feedback mechanisms are regulating these levels continually (Finkelstein; O’Connell, 1999). Fractures, however, may cause a transient increase in alkaline phosphatase levels (Smith, 2002).

Prospective studies designed to validate the clinical usefulness of measuring biochemical markers of bone turnover—enzymes or proteins secreted during bone formation (e.g., bone-specific alkaline phosphatase, osteocalcin, procollagen type I propeptides) or resorption (e.g., hydroxypropyridinium crosslinks of collagen pyridinoline and deoxypyridinoline, C-terminal crosslinking telopeptide of type I collagen, N-terminal crosslinking telopeptide of type I collagen)—in the urine or blood of patients with CTIBL have not been performed (Follin, 2003; Higano, 2004). Additionally, these markers are associated with numerous sources of biologic variability (e.g., age, gender, menopausal status), require comparison with reference ranges, and require standardization of timing and sampling conditions (Delmas, Eastell, Garnero, Seibel, & Stepan, 2000). Therefore, determining biochemical markers of bone turnover along with bone mineral density measurement to identify patients with an accelerated rate of bone turnover, and thus, at high risk for fracture, is not routinely recommended for patients with CTIBL at this time (Diamond et al., 2004; Follin; Hillner et al., 2003; Higano, 2004).

Treatment of Cancer Treatment-Induced Bone Loss

Lifestyle Changes

The primary treatment goal for CTIBL is to reduce fracture risk. Although an awareness of cancer treatment history and the potential for chemotherapy or hormonal therapy to increase bone loss is important, patients can adopt lifestyles that contribute to preserving bone health and maintaining or increasing bone mineral density. Patients should be counseled about smoking cessation, moderate alcohol consumption, and participation in a regular weight-bearing exercise program. Weight-bearing exercise should include resistance and endurance activities, such as walking or stair climbing, and patients should consult a healthcare professional before beginning an exercise program (Follin, 2003; Ramaswamy & Shapiro, 2003; Smith, 2003b; Twiss et al., 2001). In patients with prostate cancer receiving androgen-deprivation therapy, resistance-exercise activities have been shown to improve quality of life by reducing fatigue and contributing to increased muscular fitness, which indirectly reduces fracture risk (Follin; Segal et al., 2003). Resistance exercises also have been shown to be helpful in older adults. The results of a study evaluating 62 men and women aged 60–83 years showed increased bone mineral density of the femoral neck and increased bone turnover after high-intensity resistance training (Vincent & Braith, 2002).

Calcium and vitamin D intake is essential for patients with CTIBL unless a medical contraindication, such as hypercalcemia, exists (Pfeilschifter & Diel, 2000). The results of clinical trials consistently have shown that oral calcium supplementation reduces the incidence of fractures and decreases bone loss in postmenopausal women (Dawson-Hughes, Harris, Krall, & Dallal, 1997; Peacock et al., 2000; Recker et al., 1996; Reid, Ames, Evans, Gamble, & Sharpe, 1995). The adequate daily intake of calcium is 1,200–1,500 mg (Hillner et al., 2003; Ramaswamy & Shapiro, 2003; Smith, 2002). An adequate daily vitamin D intake for adults is 400 IU (Smith, 2002; Vieth, 2001); however, some clinicians recommend a daily vitamin D intake of 600–800 IU for postmenopausal women whose sun exposure is low (Messinger-Rapport & Thacker, 2002).

Safety is an additional consideration for patients with CTIBL. Preventing falls that could lead to injury or fracture is essential (Brown & Josse, 2002; Follin, 2003). If necessary, patients should use assistive devices, such as a cane or walker, to maintain balance and protect against falls (Viale & Sanchez Yamamoto, 2003).

Drug Therapies

Currently, no drugs have been approved by the U.S. Food and Drug Administration (FDA) specifically for the prevention or treatment of CTIBL; however, numerous drugs, including some bisphosphonates and selective estrogen receptor modifiers (SERMs), calcitonin (Miacalcin®, Novartis Pharmaceuticals), estrogen with or without progestin, and teriparatide (Forteo®, Eli Lilly, Indianapolis, IN), are FDA approved for preventing or treating osteoporosis in certain patients, such
as postmenopausal women or men with osteoporosis (Follin, 2003). Nonetheless, these drugs also are likely to be effective in patients with CTIBL, and several of these drugs, including etidronate, risedronate, pamidronate, tamoxifen, and zoledronic acid, have been evaluated in patients with breast or prostate cancer with CTIBL.

Although estrogen and teriparatide may be effective in preventing or treating CTIBL, these drugs are not recommended for use in patients with breast or prostate cancer (Hillner et al., 2003). Estrogen, with or without progestins, may increase the risk of breast cancer recurrence or a second primary breast cancer and has not been evaluated thoroughly in patients with prostate cancer (Hillner et al.; Taxel et al., 2002). Teriparatide may increase the risk of osteosarcoma in patients with bone metastases or hypercalcemia and therefore is not recommended for use in patients at risk of developing these complications, such as patients with breast or prostate cancer (Hillner et al.; NOF, 2003). Bisphosphonates, SERMs, and calcitonin, however, are not contraindicated in these patients. Table 3 lists the available drug therapies for the prevention and treatment of CTIBL in patients with breast or prostate cancer and their FDA-approved indications.

Bisphosphonates

Four oral bisphosphonates are available in the United States—alendronate (Fosamax®, Merck & Co., Inc., Whitehouse Station, NJ), etidronate (Didronel®, Procter & Gamble Pharmaceuticals, Cincinnati, OH), risedronate (Actonel®, Procter & Gamble Pharmaceuticals,), and tiludronate (Skelid®, Sanofi-Synthelabo, Inc., New York, NY). Alendronate and risedronate commonly are used to prevent or treat postmenopausal osteoporosis and osteoporosis in men (Berruti, Tucci, et al., 2002; USP DI® Editorial Group, 2004). Although etidronate has been evaluated as a bone-loss therapy, it is less potent than alendronate or risedronate and is not commonly used (Berruti, Tucci, et al.). Tiludronate has not been evaluated for the prevention or treatment of CTIBL. Clinical trials evaluating oral bisphosphonates in patients with breast or prostate cancer suggest that some of these drugs may be effective for the prevention or treatment of CTIBL, but the oral formulations require frequent administration without food, which may reduce compliance (Berruti, Tucci, et al.; Delmas et al., 1997; Diamond et al., 1998; Reid et al., 2002). Additionally, gastrointestinal adverse effects of oral bisphosphonates limit the administration of optimal doses and may be accentuated with the use of nonsteroidal anti-inflammatory drugs (Graham & Malaty, 2001; Reid et al., 2002). Therefore, the use of IV bisphosphonates for the prevention or treatment of CTIBL may be more appealing because these drugs can be administered less frequently without regard to timing of food intake and are more potent than oral bisphosphonates (Berruti, Tucci, et al.; Viale & Sanchez Yamamoto, 2003).

Currently, three IV bisphosphonates are available commercially in the United States—etidronate (Didronel), pamidronate (Aredia®, Novartis Pharmaceuticals) and zoledronic acid (Zometa®, Novartis Pharmaceuticals) (USP DI® Editorial Group, 2004). Only pamidronate and zoledronic acid have been shown to be effective in preventing bone loss in patients with prostate cancer at risk for developing CTIBL; IV etidronate has not been evaluated for prevention or treatment of CTIBL (Diamond et al., 2001; Smith et al., 2001, 2003). Clinical trials evaluating zoledronic acid in patients with breast or prostate cancer at risk for developing CTIBL are ongoing (ClinicalTrials.gov, 2004a, 2004b, 2004c; Gnant et al., 2002). Although IV bisphosphonate therapy is administered less frequently than oral bisphosphonate therapy, IV administration requires a visit to a healthcare practitioner. Additionally, monitoring of serum creatinine levels should be performed before each IV dose (Novartis Pharmaceuticals, 2003, 2004; Procter & Gamble Pharmaceuticals, 2003). Regular monitoring of serum calcium, magnesium, and phosphate levels following administration of pamidronate or zoledronic acid is recommended (Novartis Pharmaceuticals, 2003, 2004). Additionally, hemoglobin and hematocrit levels and complete blood count with differential should be monitored regularly in patients receiving zoledronic acid and pamidronate, respectively (Novartis Pharmaceuticals, 2003, 2004). The optimal bisphosphonate, dose, and regimen for patients with CTIBL are unknown. Therefore, clinicians should discuss available treatment options, including advantages and disadvantages, with each patient.

Selective Estrogen Receptor Modifiers

SERMs, such as tamoxifen and raloxifene (Evista®, Eli Lilly), are options for prevention or treatment of CTIBL in some patients with breast cancer. Tamoxifen is modestly effective in preventing bone loss in postmenopausal women but does not prevent bone loss in premenopausal women; therefore, it is not considered a stand-alone therapy for preventing bone loss in patients with breast cancer. Raloxifene has not been evaluated as a CTIBL therapy in patients with breast cancer, but it is effective in the treatment of postmenopausal osteoporosis (Hillner et al., 2003). Because preclinical study results have shown that raloxifene may stimulate tamoxifen-dependent cells, raloxifene should not be administered after tamoxifen therapy (Hillner et al.). Additionally, concurrent use of raloxifene and aromatase inhibitors is not recommended because the results of the ATAC trial suggest that the combination of a SERM and aromatase inhibitor in the treatment of postmenopausal women with breast cancer results in decreased antitumor efficacy compared with aromatase inhibitor therapy alone (Hillner et al.).

Calcitonin

Intranasal calcitonin is another potential option for the prevention or treatment of CTIBL, but it has not been evaluated in patients with breast or prostate cancer. Additionally, intranasal administration may reduce compliance.

Nursing Implications

Clinical Implications

With the increasing use of androgen deprivation therapy for treatment of early-stage prostate cancer and aromatase inhibitors for the treatment of postmenopausal breast cancer, CTIBL is likely to become a common problem for patients with cancer. Because bone mass is difficult to rebuild once lost, interventions should begin with early identification of high-risk patients (Twiss et al., 2001). Height should be measured regularly during follow-up visits to accurately determine any loss of height, which may suggest possible vertebral fractures or vertebral trabecular bone loss (Twiss et al.). Additionally, a clinical history assessing possible bone loss risk factors, such as past cancer therapies, current lifestyles, and menstrual history, should be obtained.
Table 3. Available Drug Therapies for Treatment of Cancer Treatment-Induced Bone Loss in Patients With Breast or Prostate Cancer

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Comments</th>
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<tr>
<td><strong>Oral bisphosphonates</strong></td>
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<tr>
<td>Alendronate</td>
<td>Prevention: 5 mg per day or 35 mg per week Treatment: 10 mg per day or 70 mg per week</td>
<td>Not evaluated in patients with breast or prostate cancer; however, has been shown to be effective for prevention and treatment of bone loss in postmenopausal women and for treatment of bone loss in men. Gastrointestinal adverse events are common and are minimized by administering with 8 ounces of water 30 minutes before eating or drinking and maintaining an upright position for 30 minutes after administration; avoid antacid or mineral supplement use.</td>
</tr>
<tr>
<td>Etidronate</td>
<td>Prevention or treatment: 400 mg every day for two weeks every three months</td>
<td>Only oral bisphosphonate evaluated in patients with prostate cancer; results of open-label, crossover study showed that six months of cyclic etidronate (400 mg every day for two weeks every three months) significantly increased spine bone mineral density and decreased amount of femoral neck bone mineral density loss in patients with prostate cancer receiving combined androgen blockade compared with placebo-treated patients. Not evaluated in patients with breast cancer. Well tolerated. Not commonly used because more potent oral bisphosphonates, such as alendronate and risedronate, are available.</td>
</tr>
<tr>
<td>Risedronate</td>
<td>Prevention or treatment: 5 mg per day or 35 mg per week</td>
<td>Only oral bisphosphonate evaluated in patients with breast cancer; not evaluated in patients with prostate cancer. Results of randomized, double-blind, placebo-controlled study showed that two years of cyclic risedronate (30 mg per day for 14 days every 12 weeks) increased spine and trochanter bone mineral density (0.3% and 0.6%, respectively) in patients with breast cancer with chemotherapy- or radiation-therapy-induced menopause compared with placebo-treated patients; bone loss recurred following discontinuation of treatment. Effective for prevention and treatment of bone loss in postmenopausal women. Gastrointestinal adverse events are common and are minimized by administering with 8 ounces of water 30 minutes before eating or drinking and maintaining an upright position for 30 minutes after administration; avoid antacid or mineral supplement use. Ongoing clinical trials are evaluating prevention of cancer treatment-induced bone loss (CTIBL) in premenopausal women with breast cancer receiving adjuvant or neoadjuvant chemotherapy and patients with prostate cancer undergoing androgen-deprivation therapy.</td>
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<tr>
<td><strong>IV bisphosphonates</strong></td>
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<tr>
<td>Pamidronate</td>
<td>Prevention or treatment: 60 mg IV every 12 weeks or 90 mg IV x 1 dose</td>
<td>Not evaluated in patients with breast cancer; however, bone mineral density increases have been observed in postmenopausal women with osteoporosis receiving pamidronate 30 mg via IV every three months or 15 mg via IV for three days every three months. Results of open-label, randomized study showed that pamidronate 60 mg via IV every 12 weeks effectively preserved bone mineral density at multiple skeletal sites in patients with prostate cancer receiving androgen-deprivation therapy. Results of randomized, double-blind, placebo-controlled study showed that one-time dose of pamidronate 90 mg via IV increased spine and femoral neck bone mineral density by 7.8% and 2%, respectively, in patients with prostate cancer receiving combined androgen blockade. Well tolerated; some patients may experience transient fevers and arthralgias after administration.</td>
</tr>
<tr>
<td>Zoledronic acid</td>
<td>Prevention or treatment: 4 mg IV every three months</td>
<td>Preliminary results of a study evaluating premenopausal women with breast cancer receiving anastrozole and tamoxifen with or without zoledronic acid (4 mg via IV every six months) showed that zoledronic acid improved lumbar spine bone mineral density.</td>
</tr>
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</table>

* These drugs are not approved by the U.S. Food and Drug Administration (FDA) for the prevention or treatment of CTIBL.

* FDA approved for treatment of male osteoporosis

* FDA approved for treatment of postmenopausal osteoporosis

* FDA approved for treatment of glucocorticoid-induced osteoporosis

* FDA approved for prevention of postmenopausal osteoporosis

* FDA approved for indications other than prevention or treatment of osteoporosis (e.g., bone metastases from solid tumor, heterotopic ossification, hypercalcemia, multiple myeloma, osteolytic metastases, Paget’s disease)

* Optimal dose is unknown.

* FDA approved for prevention or treatment of breast cancer, including in situ ductal carcinoma

Table 3. Available Drug Therapies for Treatment of Cancer Treatment-Induced Bone Loss in Patients With Breast or Prostate Cancer

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<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Comments</th>
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<tr>
<td>Selective estrogen receptor modulators</td>
<td>Prevention or treatment: 60 mg by mouth every day</td>
<td>Bone mineral density increases were observed in postmenopausal women with osteoporosis receiving various doses of zoledronic acid via IV. Results of a multicenter, randomized, double-blind, placebo-controlled study showed that zoledronic acid increased spine and femoral neck bone mineral density by 5.6% and 1.2%, respectively, in patients with nonmetastatic prostate cancer undergoing androgen-deprivation therapy. Well tolerated; some patients may experience transient arthralgias after administration. Ongoing clinical trials are evaluating CTIBL prevention in patients with breast cancer undergoing adjuvant chemotherapy and further evaluating CTIBL prevention in patients with prostate cancer undergoing androgen-deprivation therapy.</td>
</tr>
<tr>
<td>Raloxifene</td>
<td>Prevention or treatment: 10 mg by mouth twice daily</td>
<td>Effective in postmenopausal patients with breast cancer; not evaluated in patients with prostate cancer. Results of clinical trials in postmenopausal patients with breast cancer showed increases in spine and femoral neck bone mineral density (0.09%–0.61% and 1.4%, respectively). Results of a clinical trial in postmenopausal women receiving tamoxifen for breast cancer prevention showed increases in bone mineral density. Adverse events included hot flashes, leg cramps, and increased risk of venous thromboembolism.</td>
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<tr>
<td>Tamoxifen</td>
<td>Prevention or treatment: 200 IU intranasally every day</td>
<td>Effective as treatment of postmenopausal women with osteoporosis. Adverse events included rhinitis and, rarely, epistaxis.</td>
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<tr>
<td>Calcitonin</td>
<td>Prevention or treatment: 60 mg by mouth every day</td>
<td>Bone mineral density increases were observed in postmenopausal women with osteoporosis receiving various doses of zoledronic acid via IV. Results of a multicenter, randomized, double-blind, placebo-controlled study showed that zoledronic acid increased spine and femoral neck bone mineral density by 5.6% and 1.2%, respectively, in patients with nonmetastatic prostate cancer receiving androgen-deprivation therapy. Well tolerated; some patients may experience transient arthralgias after administration. Ongoing clinical trials are evaluating CTIBL prevention in patients with breast cancer undergoing adjuvant chemotherapy and further evaluating CTIBL prevention in patients with prostate cancer undergoing androgen-deprivation therapy.</td>
</tr>
<tr>
<td>Treatment: 200 IU intranasally every day</td>
<td>Effective as treatment of postmenopausal women with osteoporosis. Adverse events included rhinitis and, rarely, epistaxis.</td>
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Although no drug therapies are FDA approved for treatment of CTIBL, clinical practice guidelines provide recommendations for managing bone health in patients with breast or prostate cancer. According to the American Society of Clinical Oncology (ASCO) bone health guidelines for women with breast cancer, patients should be stratified into low- and high-risk groups depending on the presence of risk factors (Hillner et al., 2003) (see Table 4). High-risk patients, such as women aged 65 years or older, postmenopausal women receiving aromatase inhibitors, premenopausal women with therapy-induced premature menopause, and women aged 60–64 years with general osteoporosis risk factors, should undergo a baseline hip and spine bone mineral density measurement and be counseled about lifestyle changes and appropriate oral calcium and vitamin D intake (Hillner et al.). The ASCO guidelines stated that patients with a T score of −2.5 or lower should receive CTIBL treatment with alendronate, risedronate, or zoledronic acid; raloxifene also may be an option, except in patients who have received previous tamoxifen therapy or are currently receiving aromatase inhibitors; thereafter, annual bone mineral density measurement should be performed (Hillner et al.). The guidelines do not recommend bone mineral density screening for low-risk patients; instead, their risk status should be monitored annually by obtaining a clinical history, and these patients should be counseled about lifestyle changes and appropriate calcium and vitamin D intake (Hillner et al.). Other clinicians have recommended that all postmenopausal patients with breast cancer undergo baseline bone mineral density measurements of the spine, hip, and forearm, with repeat measurements performed every three to five years (Twiss et al., 2001).
ASCO guidelines for the prevention and treatment of CTIBL do not exist for patients with prostate cancer; however, a consensus group consisting of oncologists specializing in the treatment of prostate cancer (Diamond et al., 2004) recently published recommendations for the diagnosis and treatment of CTIBL in patients with prostate cancer receiving androgen-deprivation therapy. Because androgen-deprivation therapy is associated with significant loss of bone mineral density, the consensus group recommended that every patient receiving androgen-deprivation therapy undergo a baseline bone mineral density measurement and receive adequate calcium and vitamin D intake. Patients with osteoporosis (i.e., T score \( \leq -2.5 \)) fracture, or suspected vertebral fracture should receive alendronate, risendronate, pamidronate, or zoledronic acid. Measuring bone mineral density every 6–12 months during the first year of androgen-deprivation therapy and every 12–24 months thereafter also is recommended (Berruti, Tucci, et al., 2002; Diamond et al., 2004; Smith, 2003a).

Oncology nurses can play a valuable role in educating patients with breast or prostate cancer who are beginning treatment with therapies known to produce bone loss about CTIBL, its treatment options and effects, and specific lifestyle modifications that can reduce the likelihood of developing bone complications (Gholz et al., 2002). For example, patients at risk for developing CTIBL would benefit from learning about the value of regular follow-up visits with an endocrinologist or general practitioner after cancer therapy completion. Additionally, oncology nurses should reinforce the importance of calcium and vitamin D intake, lifestyle modifications, and compliance with CTIBL therapies (Follin, 2003).

### Reimbursement

Because none of the available bone loss therapies are FDA approved for the treatment of CTIBL, insurance coverage and reimbursement for CTIBL therapies vary widely among insurers. Reimbursement generally is determined using a

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**Table 4. Recommended Bone Loss Management Strategy for Patients With Breast or Prostate Cancer**

<table>
<thead>
<tr>
<th>Cancer Type and Risk Factor Status</th>
<th>Normal Bone Mineral Density (T Score &gt; –1)</th>
<th>Osteopenia (T Score = –1 to –2.5)</th>
<th>Osteoporosis (T Score &lt; –2.5)</th>
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<tbody>
<tr>
<td><strong>Breast cancer</strong></td>
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<tr>
<td>Low risk</td>
<td>Encourage lifestyle modifications.</td>
<td>Begin calcium and vitamin D therapy.</td>
<td>Encourage lifestyle modifications.</td>
</tr>
<tr>
<td>High risk</td>
<td>Perform annual bone mineral density testing.</td>
<td></td>
<td>Exclude secondary causes of bone loss.</td>
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<tr>
<td><strong>Prostate cancer</strong></td>
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<tr>
<td>Low risk</td>
<td>Encourage lifestyle modifications.</td>
<td>Assess need for daily calcium and vitamin D therapy.</td>
<td>Encourage lifestyle modifications.</td>
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<tr>
<td></td>
<td>Assess risk factors every 24 months.</td>
<td></td>
<td>Exclude secondary causes of bone loss.</td>
</tr>
<tr>
<td>High risk</td>
<td>Encourage lifestyle modifications.</td>
<td>Assess need for daily calcium and vitamin D therapy.</td>
<td>Encourage lifestyle modifications.</td>
</tr>
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</table>

Note: Based on information from Diamond et al., 2004; Higano et al., 2003; Hillner et al., 2003; Pfeilschifter & Diel, 2000; Smith, 2003b.
case-by-case review and often requires preauthorization. Because many of the oral CTIBL therapies are FDA approved for similar indications (e.g., osteoporosis), many private insurers and Medicaid programs have created formularies or preferred-drug lists that have different coverage criteria and copayments. Currently, Medicare does not cover most oral or self-administered CTIBL therapies but may cover products that require physician administration (i.e., incident to a physician’s service), such as pamidronate and zoledronic acid. For example, Wisconsin Physician Service Medicare Administrators, which is the Medicare Part B carrier for Illinois, Michigan, Minnesota, and Wisconsin, covers IV bisphosphonate drug therapy for treatment of CTIBL when appropriate documentation supporting the medical necessity of the treatment is contained in the medical record and appropriate diagnosis and service codes are used in the billing process (WPS Medicare Administrators, 2004). However, verification of the reimbursement requirements for off-label use before claim submission is recommended for all payers.

Summary

Current therapies for breast and prostate cancer have increased overall survival times; therefore, long-term toxicities, such as CTIBL, should be considered in the long-term care and follow-up of these patients. Patients with breast or prostate cancer receiving cancer therapies that cause hypogonadism are at highest risk for developing CTIBL and should receive regularly scheduled assessments of bone mass and bone loss risk factors. Additionally, patients should be instructed to optimize calcium and vitamin D intake; participate in an individualized resistance-exercise program; modify any lifestyles known to increase the risk of further bone loss, such as smoking or excessive alcohol intake; and take measures to prevent falls. Patients with breast cancer and CTIBL also should receive bone loss therapy, such as a bisphosphonate (oral or IV) or a SERM (unless on current aromatase inhibitor therapy or have been treated previously with tamoxifen); patients with prostate cancer should receive an oral or IV bisphosphonate. Although the most effective drug, dose, and regimen for the treatment of CTIBL have not been identified, IV bisphosphonates should be considered because of their potency, minimal adverse effects, infrequent administration, and likelihood of reimbursement. Ongoing clinical trials are determining the best CTIBL therapy for patients with breast or prostate cancer.

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References

ONF Continuing Education Examination

Cancer Treatment-Induced Bone Loss in Patients With Breast or Prostate Cancer

Credit hours: 1.2
Passing score: 80%
Test ID #05-32/3-05
Test processing via ONS Web site: FREE
Test processing via mail-in form: $15

The Oncology Nursing Society is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center’s Commission on Accreditation and California Board of Nursing, Provider #2850.

1. Older adults normally experience an overall loss of bone mineral density because of
   a. A tendency to become more sedentary.
   b. A lowering of thyroid output.
   c. An increased consumption of protein.
   d. A reduction in gonadal function.

2. Which unmodifiable risk factor would increase a person’s risk for developing bone fractures?
   a. History of late menarche
   b. Paternal history of fractures
   c. Impairment in vitamin A production
   d. Low body weight

3. When teaching a woman about the effects of tamoxifen on bone density, you want to remember that tamoxifen therapy
   a. Increases spine bone density by 3% annually in post-menopausal women.
   b. Has the same effect on bone density for pre- and post-menopausal women.
   c. Leads to loss of spine bone mineral density in pre-menopausal women.
   d. Has little effect on bone density during the first two years of therapy.

4. Reports about the use of aromatase inhibitors in the treatment of postmenopausal women with breast cancer indicate a trend toward which effect on bone?
   a. Increased deposition of new bone
   b. More rapid bone loss than formation
   c. Rate of bone loss similar to placebo
   d. Decreased rate of normal bone loss

5. Androgen-deprivation therapy in men with prostate cancer may be achieved through which of the following measures?
   a. Aromatase inhibitor therapy
   b. Radiation therapy to the pelvis
   c. Surgical removal of the pituitary
   d. Gonadotropin-releasing hormone therapy

6. The risk of fractures in men receiving androgen-deprivation therapy becomes higher as which of the following increases?
   a. Duration of androgen-deprivation therapy
   b. Tumor burden
   c. Bone mineral density
   d. Body weight

7. When assessing a patient with cancer treatment-induced bone loss, the most important anatomic location to evaluate for a fragility fracture would be the
   a. Skull
   b. Hip
   c. Knee
   d. Forearm

8. Estrogen and testosterone play a key role in maintenance of bone strength by
   a. Increasing deposition of new bone.
   b. Strengthening bone architecture.
   c. Decreasing excretion of calcium.
   d. Suppressing bone resorption.

9. It is most important to include bone preservation measures in education plans for women receiving which of the following chemotherapy regimens?
   a. Methotrexate and fluorouracil
   b. Vinblastine and mitomycin
   c. Dexamethasone and mitoxantrone
   d. Doxorubicin and cyclophosphamide

10. Dual-energy x-ray absorptiometry is the preferred method of bone mineral density measurement because
    a. It measures density at fracture-prone areas such as the knee.
    b. Patients undergoing the test do not receive any radiation exposure.
    c. It can evaluate the total amount of mineral in the whole skeleton.
    d. The testing equipment is portable and can be performed in any physician’s office.

11. When assessing a patient with cancer treatment-induced bone loss, a finding of abdominal protrusion most likely would indicate
    a. Asymptomatic vertebral fractures.
    b. Hypercalcemia-induced paralytic ileus.
    c. Weight gain secondary to decreased functional status.
    d. Hepatomegaly with secondary vitamin D malabsorption.

12. The education plan for a patient at risk for cancer treatment-induced bone loss should include which of the following recommendations?
    a. Smoke no more than one-half pack of cigarettes a day.
    b. Consume 600–800 mg of calcium each day.
    c. Drink only moderate amounts of alcoholic beverages.
    d. Participate only in endurance-type exercise programs.

13. The reading of your patient’s dual-energy x-ray absorptiometry scan is –2.2 standard deviations. This indicates that she has
    b. Osteopenia.
    c. Osteoporosis.
    d. Severe osteoporosis.
14. In a patient receiving an aromatase inhibitor for breast cancer, which of the following medications most likely would be used to treat her cancer treatment-related bone loss?
   a. Alendronate
   b. Estrogen
   c. Raloxifene
   d. Teriparatide

15. Education materials for patients receiving oral bisphosphonates should include instructions to
   a. Ingest with a meal containing protein.
   b. Take immediately before going to bed.
   c. Drink at least 8 ounces of water with each dose.
   d. Only use antacids that contain calcium.

16. In a patient with prostate cancer receiving zoledronic acid to treat cancer treatment-related bone loss, which of the following should be monitored regularly?
   a. Clotting times
   b. Creatinine clearance
   c. Liver function
   d. Potassium

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**Oncology Nursing Forum Answer/Enrollment Form**

**Cancer Treatment-Induced Bone Loss in Patients With Breast or Prostate Cancer**

(Test ID #05-32/3-05)

To receive continuing education (CE) credit for this issue, simply
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**Instructions**: Mark your answers clearly by placing an “x” in the box next to the correct answer. This is a standard form; use only the number of spaces required for the test you are taking.

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**Program Evaluation**

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<tr>
<th>1. How relevant were the objectives to the CE activity’s goal?</th>
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<tr>
<th>2. How well did you meet the CE activity’s objectives (see page 589)?</th>
<th>Not at all</th>
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<td>• Objective #2</td>
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<td>• Objective #3</td>
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<thead>
<tr>
<th>3. To what degree were the teaching/learning resources helpful?</th>
<th>Not at all</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too basic</td>
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<tr>
<td>Appropriately</td>
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<tr>
<td>Too complex</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Based on your previous knowledge and experience, do you think that the level of the information presented in the CE activity was</th>
<th>Not at all</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

| 5. How long did it take you to complete the CE activity? ________ minutes |
|------------------------------------------------------------------------|------------|

☐ My check or money order payable to the Oncology Nursing Society is enclosed. U.S. currency only. (Do not send cash.)

After completing this form, mail it to: **Oncology Nursing Society, P.O. Box 3510, Pittsburgh, PA 15230-3510.**

For more information or information on the status of CE certificates, call 866-257-4667, ext. 6314.