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Medial Cartilage Surface Integrity as a Surrogate Measure for Incident Radiographic Knee Osteoarthritis following Weight Changes

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Keywords
cartilage cavity, surrogate biomarker, weight loss

Introduction

Since OA is a slowly developing disease, surrogate outcome measures are essential for clinical trials to reduce required sample sizes, duration, and costs.1 Following the BIPED criteria, a surrogate outcome must demonstrate a statistically significant relationship with relevant clinical or radiographic OA outcomes.2

This study, among overweight/obese women free of knee OA at baseline, women with a decrease in body weight showed a significant reduction in cartilage cavity on magnetic resonance imaging (MRI) after 2.5 years (adjusted odds ratio [OR] 0.55, 95% confidence interval [CI] 0.37-0.83). An increase in body weight was not significantly associated to cartilage cavity (adjusted OR 0.84, 95% CI 0.56-1.26). Subsequently, the change in cartilage cavity over 2.5 years was significantly associated to incident radiographic (adjusted OR 1.65, 95% CI 1.29-2.11), but not incident clinical (adjusted OR 1.11, 95% CI 0.86-1.44) knee OA after 6.5 years. Herewith, cartilage cavity meets the criteria for an efficacy of intervention or surrogate biomarker, which is deemed highly desirable for the short-term evaluation of potential interventions for OA.

Method, Results, and Discussion

The current study used data from the PROOF study (ISRCTN 42823086).3 The study was approved by the Medical Ethical Committee of Erasmus MC and all participants gave written informed consent.

In short, women aged 50 to 60 years registered with the 50 participating general practitioners in the Rotterdam area in the Netherlands were invited for baseline measurements. For further PROOF details, see elsewhere.3

At baseline, 2.5 years, and 6.5 years, the following measurements were obtained: age, knee symptoms (“pain in or around the knee in the past 12 months”) and history of knee injury using questionnaires, a standardized semiflexed posterioranterior radiograph of both knees to assess Kellgren and Lawrence (KL) grade, physical examination to determine body weight and height for BMI calculation, and a multispectral MRI of both knees using a 1.5-T scanner.2 Additionally, body weight was measured at 6, 12, 18, and 24 months.

PROOF used different 1.5T Siemens Symphony/Magnetom Essenza and Philips Intera scanners using sagittal 3-dimensional (3D) sequences with water excitation. The voxel sizes differed between scanner models: Siemens Symphony had 1.5×0.42×0.42 mm, Siemens Magnetom Essenza had 1.5×0.5×0.5 mm, and Philips Intera had 1.5×0.31×0.31 mm. For a subset of 25 knees, the medial tibial and femoral and the patellar cartilage compartments were manually segmented on a sagittal 3D water selective...
Subsequently, the 2.5 years change in normalized cavity from baseline to 2.5 years was split into tertiles and used as independent variable to study its effect on the two outcome measures, using generalized estimated equations adjusted for covariates, as well as weight loss group from the latent growth curve analysis.

For comparison, the change in cartilage thickness was also compared between the body weight trajectories and the association between 2.5-year change in cartilage thickness and subsequent knee OA development was evaluated, using identical statistics.

A total of 456 knees were available. Mean age was 55.8 ± 3.2 years and mean BMI was 31.9 ± 3.8 kg/m². At baseline, only BMI was slightly different between those selected for the current analyses and the individuals without complete follow-up data (31.9 ± 3.8 vs. 33.0 ± 4.7 kg/m²).

Mean change in normalized cartilage cavity score from baseline to 2.5 years for the 3 body weight groups and corresponding adjusted odds ratios are presented in Table 1. Compared with the group with stable body weight, the 2.5-year change in normalized cartilage cavity score was significantly lower in the group with a decreased body weight (P = 0.005).

The change in normalized cartilage cavity score was significantly associated to clinical relevant weight loss and to subsequent knee OA development after 6.5 years.

<table>
<thead>
<tr>
<th>Mean change in normalized cavity score</th>
<th>Increased Body Weight</th>
<th>Decreased Body Weight</th>
<th>Stable Body Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.29 ± 0.97; −2.1 to 3.3</td>
<td>0.30 ± 1.75; −10.4 to 3.2</td>
<td>0.29 ± 1.76; −7.6 to 21.1</td>
<td></td>
</tr>
<tr>
<td>Adjusted odds ratio (95% CI)</td>
<td>0.84 (0.56 to 1.26)</td>
<td>0.55 (0.37 to 0.83)</td>
<td>Reference</td>
</tr>
<tr>
<td>P</td>
<td>0.41</td>
<td>0.01</td>
<td>—</td>
</tr>
</tbody>
</table>

| Mean change in cartilage thickness | 0.00 ± 0.15; −0.37 to 0.48 | 0.01 ± 0.11; −0.23 to 0.24 | 0.01 ± 0.14; −0.65 to 1.16 |
| Adjusted odds ratio (95% CI) | 1.00 (0.96 to 1.04) | 0.98 (0.95 to 1.02) | Reference |
| P | 0.89 | 0.28 | — |

*Adjusted for baseline body mass index, presence of knee symptoms, history of knee injury, baseline Kellgren-Lawrence grade, and baseline score.
development of radiographic knee OA among a high-risk group of overweight/obese women free of knee OA. The association between change in cartilage cavity and subsequent clinical OA development was not statistically significant \((P = 0.42)\), with only a statistically nonsignificant trend in the lowest tertile of 2.5-year cavity change \((P = 0.11)\). Clinically relevant weight changes were not associated to significant changes in cartilage thickness over time in the present study.

Although biomarkers that respond to treatment have been reported in OA before (e.g., markers of matrix turnover and inflammation after diet and exercise\(^{10}\), biochemical markers of cartilage degeneration after resondronate administration\(^{11}\) and bone marrow lesions after a brace intervention\(^{12}\)), the association of the change in these markers to future OA development, and thus the clinical relevance of the change in the biomarker, has not been studied widely. Moreover, the evaluation of these intervention effects and the association to future OA has hardly been studied within the same cohort. The current results warrant external validation to confirm cartilage cavity as an efficacy biomarker, which is deemed highly desirable for the short-term evaluation of potential interventions for OA.

Table 2. Associations Between Tertiles of Change in Cartilage Cavity Score Over 2.5 Years and Incident Knee Osteoarthritis (OA) after 6.5 Years.

| Highest tertile of cartilage cavity change \((\geq 0.44)\) | Incidence of Radiographic Knee OA | 30/141 (21%) | Reference | 31/150 (21%) | Reference | Adjusted Odds Ratio\(^a\) | 0.5 (0.26 to 0.99) |
| Mid tertile of cartilage cavity change | 18/138 (13%) | 0.50 | 24/150 (16%) | 0.75 (0.43 to 1.32) | Adjusted Odds Ratio\(^a\) | 0.3 (0.16 to 0.66) |
| Lowest tertile of cartilage cavity change \((\leq -0.23)\) | 15/141 (11%) | 0.32 | 24/148 (16%) | 0.59 (0.31 to 1.13) | Adjusted Odds Ratio\(^a\) |Reference |

\(^a\)Adjusted for baseline body mass index, presence of knee symptoms, history of knee injury, baseline Kellgren-Lawrence grade, weight loss groups from latent growth curve analyses, and baseline cavity score.

In conclusion, clinically relevant weight loss among a high-risk population of middle-aged women free of knee OA resulted in a significant reduction in the cartilage cavity score over 2.5 years. The change in cartilage cavity score was significantly associated to radiographic knee OA development in the subsequent period of 4 years. Herewith, cartilage cavity meets the criteria for an Efficacy of intervention or surrogate biomarker, which is deemed highly desirable for the short-term evaluation of potential interventions for OA.

Authors’ Note

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Author Contributions

All authors contributed to the conception and design of the study, interpretation of data, revising the manuscript critically for important intellectual content and approved the final version of the manuscript as submitted. JR, SMAB-Z, and EBD were responsible for acquisition of the data. JR performed the data analysis and drafted the manuscript. JR, SMAB-Z, and EBD take responsibility for the
integrity of the work as a whole, from inception to finished article.

Declaration of Conflicting Interests
The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: Erik B. Dam is a Biomediq shareholder. The other authors declare no conflicts of interest.

Ethical Approval
The study was approved by the Medical Ethical Committee of Erasmus MC (MEC-2014-333).

Informed Consent
All participants gave written informed consent.

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References