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Runhaar, Jos; Dam, Erik B; Oei, Edwin H G; Bierma-Zeinstra, Sita M A

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

Jos Runhaar¹, Erik B. Dam²,³, Edwin H.G. Oei⁴, and Sita M.A. Bierma-Zeinstra⁵

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 to 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 multisegmentation MRI of both knees using a 1.5-T scanner.⁴ 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 criteria were included.

¹Department of General Practice, Erasmus MC University Medical Center Rotterdam, Rotterdam, the Netherlands
²Machine Learning Section, Department of Computer Science, University of Copenhagen, Kobenhavns, Denmark
³Biomediq A/S, Copenhagen, Denmark
⁴Department of Radiology & Nuclear Medicine, Erasmus MC University Medical Center Rotterdam, Rotterdam, the Netherlands
⁵Department of General Practice, and the Department of Orthopedics, Erasmus MC University Medical Center Rotterdam, Rotterdam, the Netherlands

Corresponding Author:
Jos Runhaar, Department of General Practice, Erasmus MC University Medical Center Rotterdam, PO-Box 2040, Room NA 1911, Rotterdam, 3000 CA, the Netherlands. Email: j.runhaar@erasmusmc.nl
Table 1. Change (± Standard Deviation; Minimum to Maximum) in Normalized Cartilage Cavity Score and Cartilage Thickness (Baseline to 2.5 Years) for Subgroups of Patients and Corresponding Adjusted Odds Ratios.

<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>Adjusted odds ratio (95% CI)&lt;sup&gt;a&lt;/sup&gt;</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>

<table>
<thead>
<tr>
<th>Mean change in cartilage thickness</th>
<th>Increased Body Weight</th>
<th>Decreased Body Weight</th>
<th>Stable Body Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted odds ratio (95% CI)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.00 ± 0.15; −0.37 to 0.48</td>
<td>0.01 ± 0.11; −0.23 to 0.24</td>
<td>0.01 ± 0.14; −0.65 to 1.16</td>
</tr>
<tr>
<td>P</td>
<td>1.00 (0.96 to 1.04)</td>
<td>0.98 (0.95 to 1.02)</td>
<td>Reference</td>
</tr>
<tr>
<td></td>
<td>0.89</td>
<td>0.28</td>
<td>—</td>
</tr>
</tbody>
</table>

<sup>a</sup>Adjusted for baseline body mass index, presence of knee symptoms, history of knee injury, baseline Kellgren-Lawrence grade, and baseline score.

(WATS) sequence with fat saturation. These segmentations were used for training of the Knee Imaging Quantification (KIQ) framework that automatically segmented all baseline and 2.5-year MRIs. KIQ provided cartilage thickness maps from which we quantified the mean thickness over the total area of bone and the cartilage cavity as the total volume of indentations/lesions for each compartment. These indentations were detected as deviations from a smoothly varying thickness map using multiscale anisotropic blob detection. The resulting cavity estimate is measured as the total volume (in mm<sup>3</sup>) of the indentations and was normalized for total cartilage volume (in %). This method was previously validated on artificial lesions demonstrating high correlation with ground truth and against radiologist lesion scores. 

For the grouping of subjects, previously reported subgroups of patients with comparable evolution of body weight over 2.5 years were used; a group that gained weight (7.2 ± 4.1 kg after 2.5 years), a relatively stable group (0.6 ± 3.4 kg), and a group that lost weight (−7.7 ± 6.3 kg). The change in the normalized cavity score from baseline to 2.5 years served as outcome for the evaluation of the differences between the groups of body weight evolution. For the subsequent incidence of knee OA after 6.5 years, knee OA was defined using radiographic (incident KL ≥ 2) and clinical definitions (incident clinical knee OA according to the clinical and radiological ACR criteria). 

For the present study, all subjects with baseline and 2.5-year MRIs and OA incidence measure available after 6.5 years were selected for analyses. Baseline characteristics were compared between the entire cohort and the current selection to evaluate possible selective drop-out using t tests for continuous and chi-square tests for dichotomous variables. Using generalized estimated equations to account for the correlation between knees within subjects (unstructured correlation matrix), the change in normalized cavity from baseline to 2.5 years was compared between groups, with the “stable” group as reference. Parameter estimates were adjusted for covariates. Subsequently, the 2.5 years change in normalized cavity was 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/m<sup>2</sup>. 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/m<sup>2</sup>). 

Mean change in normalized cartilage cavity 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 was significantly associated to clinical relevant weight loss and to subsequent knee OA development after 6.5 years (adjusted OR of 1.11, 95% CI 0.86 to 1.44; P = 0.42). 

Additionally, the change in normalized cartilage cavity from baseline to 2.5 years was split into tertiles and used as predictor for incident radiographic and clinical knee OA (see Table 2). 

There were no significant associations between the 2.5-year change in cartilage thickness and radiographic (adjusted OR 0.12, 95% CI 0.003 to 5.12, P = 0.26) or clinical knee OA (adjusted OR 0.20, 95% CI 0.03 to 1.32, P = 0.09) development after 6.5 years. 

As required by the definition of an efficacy of intervention biomarker, the current results showed that the change in cartilage cavity over the first 2.5 years was significantly associated to clinical relevant weight loss and to subsequent
latent growth curve analyses, and baseline cavity score. A limitation of our validation of associations between weight loss and clinical and structural OA development.13,14 A limitation of our validation of associations between weight loss and clinical and structural 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 resorionate administration,11 and bone marrow lesions after a brace intervention12), the association of the change in there 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.

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
The work presented here was done in collaboration between the Department of General Practice of Erasmus MC University Medical Center Rotterdam and Biomediq A/S.

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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

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

<table>
<thead>
<tr>
<th>Tertile of Cartilage Cavity Change</th>
<th>Incidence of Radiographic Knee OA</th>
<th>Adjusted Odds Ratio</th>
<th>Incidence of Clinical Knee OA</th>
<th>Adjusted Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest tertile (≥0.44)</td>
<td>30/141 (21%)</td>
<td>Reference</td>
<td>31/150 (21%)</td>
<td>Reference</td>
</tr>
<tr>
<td>Mid tertile (&lt;0.44, ≥−0.23)</td>
<td>18/138 (13%)</td>
<td>0.50 (0.26 to 0.99)</td>
<td>24/150 (16%)</td>
<td>0.75 (0.43 to 1.32)</td>
</tr>
<tr>
<td>Lowest tertile (&lt;−0.23)</td>
<td>15/141 (11%)</td>
<td>0.32 (0.16 to 0.66)</td>
<td>24/148 (16%)</td>
<td>0.59 (0.31 to 1.13)</td>
</tr>
</tbody>
</table>

*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.
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.

**ORCID iD**
Jos Runhaar https://orcid.org/0000-0002-6293-6707

**References**