Spaceflight-induced Bone Loss:
Is there a risk for accelerated osteoporosis after return?

Jean D. Sibonga, Ph.D.
Sr. Research Scientist, USRA
HRP Bone Discipline Lead
Recommendations of Institute of Medicine - Safe Passage: Astronaut Care for Exploration Missions

- Develop and use an occupational health model for the collection and analysis of astronaut health data, giving priority to the creation and maintenance of a safe work environment.

- Incorporate an evidence-based risk assessment and communication process into the risk identification and reduction approach.
The IOM approach for Bone Discipline Evidence Base Reports

4 identified risks of an adverse outcome due to space exploration.

1. Accelerated Osteoporosis
   Long-term health
2. Formation of Renal Stones
3. Intervertebral Disc Injury (or Damage)
4. Bone Fracture

#2-4 Risk for mission but more evidence required.
Overview
Evidence Base for #1 Risk of Accelerated Osteoporosis

- Involutional Osteoporosis
- Bone remodeling process
- Skeletal adaptation to space
- Skeletal changes: space vs. ageing
  - Circumstantial Evidence
- Gaps in our knowledge base
Two Risk Statements for Accelerated Osteoporosis

**Earlier:** Bioastronautics Roadmap 2005

“Osteoporosis associated with age-related bone loss may occur at an earlier age due to failure to recover bone lost during spaceflight.”

**Current:** Risk Statement in Human Research Program

“...(If) mission-related bone loss cannot be corrected by post-mission rehabilitation; crew members could be at greater risk of osteoporosis-related fractures in later life.”

Is there recovery? Are the changes irreversible?

Overlap with involutional changes in bone.
“Involutional” Osteoporosis

The regressive alterations of a body or its parts characteristic of the ageing process

Age-related bone loss
Osteoporosis Definitions

- OLD: “...a reduced amount of bone that is qualitatively normal.”
  Albright F. Ann Intern Med. 1947

- MODERN: “...a systemic skeletal disease characterized by low bone mass and microarchitectural deterioration with a consequent increase in bone fragility with susceptibility to fracture ....”
  Am. J. Med. 1991

- NEWEST: “Osteoporosis is a skeletal disorder characterized by compromised bone strength predisposing to an increased risk of fracture. Bone strength reflects the integration of two main features: bone density and bone quality.”
  JAMA. 2001
Classifications of Osteoporosis

- **Primary Osteoporosis** - “Involutional Osteoporosis”
  - Menopause-induced Bone Loss - “Postmenopausal Osteoporosis”
  - Age-related Bone Loss - “Senile Osteoporosis”

- **Secondary Osteoporosis** - External causes
  - Glucocorticoid Medication
  - Alcohol-induced
  - Immobilization
  - Anti-seizure drugs
Bone Gain and Loss with Age is Sex-specific

Bone mass (g/calcium)

Age (yr)

Males
Females

Riggs BL, Melton LJ: Involutional osteoporosis
Oxford Textbook of Geriatric Medicine
Phase I (Bone Gain): Femoral Shaft areal BMD increases with age, but volumetric BMD is independent of age in young males and females.

Dispelling a Fallacy: NOT BMD, but Bone size increases in growing males.
Being Female is a risk factor for osteoporosis.

- Smaller bones
- Undergo two phases of bone loss: an earlier rapid phase of loss (menopause induced) followed by a slower phase of loss (induced by ageing) equivalent to the rate of bone loss in men.
How does the “Risk for Accelerated Osteoporosis” in crew members fit in with Involutional Osteoporosis?
Clarifying the “Risk for Accelerated Osteoporosis.”

1. **Accelerated**: “to bring about at an earlier time”

2. **Osteoporosis**: Occurrence of fractures under mechanical loading of normal activities “atraumatic”

3. **Evidence**: incidence of atraumatic fractures at an **earlier** age (relative to expected age of occurrence)

4. **Evidence**: **Greater** prevalence fractures in the former astronauts compared to peer group.

**A STUDY EVALUATING FRACTURE AS THE OUTCOME IN ASTRONAUTS??**
Age-Related Fractures: when and how many?

Cooper and Melton, 1992

The influence of endocortical bone loss on # hip fractures in later life.

The influence of cancellous bone loss on wrist and spine fractures.
Measuring surrogates to bone strength.

Supplementing DXA measures of areal BMD.

But, with which one?
Bone Volume Changes in the Adult Skeleton:
The Bone Remodeling Process
Changes in the skeletal tissue occur through 3 regulated processes

- **Growth** - developing skeleton (BF > BR)

- **Modeling** - shaping of bone (e.g., elongation)

- **Remodeling** - repair, renewal, calcium homeostasis
  - 10% of skeleton/year
Remodeling in Discrete Packets of Bone

(Bone Remodeling Unit BRU - Basic Multicellular Unit BMU)

A. Quiescent Bone Surface

Lining cells

Osteocytes

B. Resorption Phase

Osteoclasts

Lining cells

C. Formation Phase

Lining cells

Osteoblasts

Cement line

D. Quiescent Phase

Cement line

A

B

C

Remodeling at the level of the BRU
Specific sites of bone remodeling.

Cortical Bone

Endocortical

Intracortical

Cancellous Bone

Trabecular surface

Endocortical
Bone Remodeling of Cancellous Bone
(aka Trabecular Bone)

- For normal turnover, bone repair & tissue renewal, mineral homeostasis
- Bone Resorption (BR) precedes Bone Formation (BF)
- Time for BR < Time for BF
- Two phases of BF: matrix production and mineralization
- 4-6 months
- Bone Balance vs. Bone Coupling

Osteoporosis in the adult likely results from a perturbation in the remodeling process.
# Multiple Pathophysiology for Osteoporosis: Perturbations to Remodeling

<table>
<thead>
<tr>
<th>Osteoporosis</th>
<th>BF</th>
<th>BR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disuse* (“Skeletal unloading”)</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Aging</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Glucocorticoids</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Estrogen Deficiency</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Alcohol</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Metabolic diseases of High Bone Turnover</td>
<td>+</td>
<td>++</td>
</tr>
</tbody>
</table>
Skeletal Adaptation to Space

Evidence to Date
Early Missions: Skeletal Measurements

- **Mercury** 1961-63
- **Gemini** 1965-66
- **Apollo** 1968-72
- **Skylab** 1973-74
- **Shuttle** 1981-present
- **Intl Space Station** 2000-present

- **Early Missions:**
  - Calcium balance
  - SPA of heel and wrist
  - x-ray photodensitometry
  - Ca balance

- **Shuttle 1981-present:**
  - SPA Heel,Wrist
  - Urine, fecal Ca
  - Ca balance
  - Urinary OH-Pro
  - NTX 1998
  - DXA
  - QCT

- **Mir 1986-1996:**
  - SPA, DPA Heel
  - DXA whole body, regional
  - CT estimates of lumbar spine BMD
  - pQCT
Calcium Regulation
Skylab-Calcium balance
Bone Ca Loss ~ 250 mg/d
Bone Ca Gain ~ 100 mg/d
Recovery: 2-3 x mission

Calcium Balance

Slide courtesy of Dr. Scott M. Smith

Smith et al., 1999
Smith et al., 2005
Calcium Absorption

Spaceflight:
↓ Vitamin D stores
↓ PTH
↓ Active vitamin D
↓ Ca absorption

Smith et al., 1999
Smith et al., 2005
Skylab-BMD of Calcaneus
Bone Mineral Density
<table>
<thead>
<tr>
<th>Index DXA</th>
<th>%/Month Change ± SD</th>
<th>LeBlanc et al, 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>aBMD g/cm²</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lumbar Spine</strong></td>
<td>-1.06±0.63*</td>
<td></td>
</tr>
<tr>
<td><strong>Femoral Neck</strong></td>
<td>-1.15±0.84*</td>
<td></td>
</tr>
<tr>
<td><strong>Trochanter</strong></td>
<td>-1.56±0.99*</td>
<td></td>
</tr>
<tr>
<td><strong>Total Body</strong></td>
<td>-0.35±0.25*</td>
<td></td>
</tr>
<tr>
<td><strong>Pelvis</strong></td>
<td>-1.35±0.54*</td>
<td></td>
</tr>
<tr>
<td><strong>Arm</strong></td>
<td>-0.04±0.88</td>
<td></td>
</tr>
<tr>
<td><strong>Leg</strong></td>
<td>-0.34±0.33*</td>
<td></td>
</tr>
</tbody>
</table>

*p<0.01, n=16-18

Lumbar Spine 1% / month

Whole Body 0.3% / month

Hip 1.5% / month
**DXA (Mir) and QCT (ISS)**


<table>
<thead>
<tr>
<th>Index</th>
<th>%/Month Change ± SD</th>
<th>Index</th>
<th>%/Month Change ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>aBMD Lumbar Spine</td>
<td>1.06±0.63*</td>
<td>Integral vBMD Lumbar Spine</td>
<td>0.9±0.5</td>
</tr>
<tr>
<td>Trabecular vBMD Lumbar Spine</td>
<td></td>
<td></td>
<td>0.7±0.6</td>
</tr>
<tr>
<td>aBMD Femoral Neck</td>
<td>1.15±0.84*</td>
<td>Integral vBMD Femoral Neck</td>
<td>1.2±0.7</td>
</tr>
<tr>
<td>Trabecular vBMD Femoral Neck</td>
<td></td>
<td></td>
<td>2.7±1.9</td>
</tr>
<tr>
<td>aBMD Trochanter</td>
<td>1.56±0.99*</td>
<td>Integral vBMD Trochanter</td>
<td>1.5±0.9</td>
</tr>
<tr>
<td>Trabecular vBMD Trochanter</td>
<td></td>
<td></td>
<td>2.2±0.9</td>
</tr>
</tbody>
</table>

*p<0.01, n=16-18
T. Lang et al., JBMR 2006.

Losses in vBMD of integral femoral neck but greater % losses in trabecular compartment, significant thinning of cortex at the femoral neck during flight, and periosteal expansion during 12-month postflight period.

*: p<0.05 with respect to preflight, postflight

Pattern of cortical bone thinning as seen in beagle after 40 wks of cast immobilization.

From J.W. Jaworski
Slide Courtesy of D Carter
Use of Imaging Technology to evaluate changes in bone mass

Seeman, E. J Clin Endocrinol Metab 2001;86:4576-4584

Copyright ©2001 The Endocrine Society
Mary Bouxsein, Ph.D.

Physiological Changes in Bone Geometry

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Periosteal Apposition</th>
<th>Endosteal Apposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periosteal Diameter</td>
<td>100 %</td>
<td>110 %</td>
<td>100 %</td>
</tr>
<tr>
<td>Endosteal Diameter</td>
<td>100 %</td>
<td>100 %</td>
<td>90 %</td>
</tr>
<tr>
<td>Compressive Strength</td>
<td>100 %</td>
<td>148 %</td>
<td>125 %</td>
</tr>
<tr>
<td>Bending Strength</td>
<td>100 %</td>
<td>168 %</td>
<td>116 %</td>
</tr>
</tbody>
</table>
Bone Turnover Markers
Bone Resorption

Space Flight:
→ Urinary collagen xlinks
→ Urinary Ca
→ Urinary OH-Proline

Bone resorption is increased during flight

Smith et al., JCEM, 1998
Response of Bone Biomarkers

(Smith et al, JBMR 2005)
Bone Recovery
Consistent increase in BMD in Postflight Period
## Model for Skeletal Recovery

<table>
<thead>
<tr>
<th>Skeletal Site</th>
<th>Loss (L0) at landing (%)</th>
<th>50% Recovery Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femoral Neck</td>
<td>6.8 (5.7, 7.9)</td>
<td>211 (129, 346)</td>
</tr>
<tr>
<td>Trochanter</td>
<td>7.8 (6.8, 8.8)</td>
<td>255 (173, 377)</td>
</tr>
<tr>
<td>Pelvis</td>
<td>7.7 (6.5, 8.9)</td>
<td>97 (56, 168)</td>
</tr>
<tr>
<td>Lumbar Spine</td>
<td>4.9 (3.8, 6.0)</td>
<td>151 (72, 315)</td>
</tr>
<tr>
<td>Calcaneus</td>
<td>2.9 (2.0, 3.8)</td>
<td>163 (67, 395)</td>
</tr>
</tbody>
</table>

Sibonga et al. BONE 2007
Spaceflight Bone Loss vs. Age-related Bone Loss
BMD Loss vs. Age-matched Loss

Losses in 6 months in space far exceed 2-year losses on Earth in similarly-aged population.
Minimal BMD loss in forearms of males on earth.

Small n for females but suggest losses equivalent to postmenopausal losses on earth.
Circumstantial Evidence: Parallels
Menopause vs. SF

1. Reduction TbN, loss of connectivity in postmenopausal women (Kleerekoper, 1985)
2. Preferential cancellous bone loss (Riggs refs.)
3. BMD losses 2-3%/yr (Riggs refs)
4. Resorption on inside surface (endocortical) of cortex.
5. Activation Frequency high in postmenopausal women (Recker, 2004)

1. Biopsies after 120 days bed rest. TbN reduced (Thompsen, 2005)
2. Preferential cancellous bone loss in proximal femur (Lang, 2004)
3. Range BMD losses (3-9%) per ~6 months
4. Cortical thinning at femoral neck from endocortical surface.
5. Not quantified

Given the preferential loss in trabecular bone compartment and the rapid rate of loss in crew members, suspect that the impact on microarchitecture is at the very least equivalent to postmenopausal women.
Seventy percent reduction in remodeling rate does not look so alarming given that it results in activation frequency about equal to healthy premenopausal women.
Turnover in Crewmembers

- Loss in crewmembers at faster rate than postmenopausal females (months vs. years)
- High turnover with menopause leads to perforations of trabecular struts.
- At what time point with SF does irreversible perforation occur?
Normal vs. High Bone Turnover
Are crewmembers restored to preflight skeletal status? Recover bone that was lost in space?

- **DXA:** Restoration of areal BMD within ~ 3 years but cannot assess structure.
- **QCT:** Incomplete recovery of vBMD at 12 months postflight
- Geometrical changes at femoral neck indicate early onset of age-related changes (*Riggs, JBMR 2004; 2008*)
Histomorphometry of Bone Biopsies (Bed Rest Flight Analog)

- Vico (1987) a reduced mineralization, no change in matrix formation and increased resorption of bone (osteoclast parameters)
- Arnaud (1992) suppressed bone formation rate and reduced osteoblast activity in as short as 7 d experiment
- Zerwekh (1998) mild decrement in bone-forming osteoblasts concurrent with increased bone resorption in 12 wk study
- Thomsen (2006) deterioration of trabecular microarchitecture 120 d suggestive of aggressive resorption
Age-related Bone Loss

Sibonga et al, manuscript
Bone Gain and Loss with Age is Sex-specific

Riggs BL, Melton LJ: Involutional osteoporosis
Oxford Textbook of Geriatric Medicine
Incidence of Limb Fractures

The influence of previous bone loss on fractures in later life.

Incidences/100,000 p-y

Age group (yr)

0-4 5-14 15-24 25-34 35-44 45-54 55-64 65-74 75-84 ≥85

Females

Males
Summary: Spaceflight Evidence

- Negative calcium balance, reduced absorption and down-regulated calcitropic hormones
- Deficits in aBMD at weight-bearing sites, vBMD cancellous bone, thinning of cortical bone
- Increased bone resorption markers > formation markers
- Reductions in hip bone strength estimated by FEA, also in compressive and bending strengths at femoral neck after return
- Delayed and possibly incomplete restoration of preflight hip bone integrity.*
Summary/Conclusions

- The evidence-to-date suggests that the rapid rate of site-specific bone loss in space, due to the unbalanced stimulation of bone resorption, may predispose crew members to irreversible changes in bone structure and microarchitecture.
- No analyses conducted in the postflight period to assess microarchitectural changes.
- There is no complete analysis of skeletal recovery in the postflight period to evaluate the structural changes that accompany increases in DXA aBMD.
- Postflight analyses based upon QCT scans performed on limited crew members indicate reductions in hip bone strength and incomplete recovery at 1 year.
- No recovery of trabecular vBMD after 1 year return (HRP IWG).
- Time course of bone loss in space unknown.
Thank you.
Crew data

- LeBlanc A,


Bed rest citations


Backup slides
“Osteoporosis is a skeletal disorder characterized by compromised bone strength predisposing to an increased risk of fracture. Bone strength reflects the integration of two main features: bone density and bone quality.”

*JAMA. 2001*

“….Bone quality, in turn, is stated to refer to architecture, turnover, damage accumulation, (e.g., microfractures) and mineralization…."

*Osteoporosis Int. 2002*
Russian Data

- 0.9-19.8% losses in calcaneus after 75-84d missions (Stupakov, 1984)
- CT scans Salyut-7 crew (5-7 months) (Oganov 1990) document vertebral BMD losses of 0.3, 2.3, 6.2 and 10.8%
- Highlighted the variability in losses between crew members (as with Apollo missions)
- Losses did not correlate with flight duration
Correlations of Spaceflight-induced Changes (%) in DXA BMD to DXA Lean Muscle Mass

<table>
<thead>
<tr>
<th>Correlation BMD with Lean Muscle Mass</th>
<th>$R^2$</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvis vs. Leg Lean Mass</td>
<td>0.295</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Total Hip vs. Leg Lean Mass</td>
<td>0.053</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Trochanter vs. Leg Lean Mass</td>
<td>0.210</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Femoral neck vs. Leg Lean Mass</td>
<td>0.006</td>
<td>NS</td>
</tr>
<tr>
<td>Leg BMD vs. Leg Lean Mass</td>
<td>0.139</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Lumbar Spine vs. Trunk Lean</td>
<td>0.248</td>
<td>NS</td>
</tr>
<tr>
<td>Arm vs. Arm Lean Mass</td>
<td>0.041</td>
<td>NS</td>
</tr>
</tbody>
</table>

Note: A weak but significant correlation of hip BMD with area of muscle group attached to hip, as measured in CT scans in women without fracture compared to women with hip fracture. (Personal communication with T. Lang)
“Every change in the function of a bone is followed by certain definite changes in internal architecture and external conformation in accordance with mathematical principles"

J Wolff (1886)

Age is an Independent Risk Factor for Osteoporotic Fractures

Adapted from:
Change in BMD after Space Flight (Mir and ISS)

% Change per Month of Flight

- Lumbar Spine
- F. Neck
- Trochanter
- Pelvis
- Heel

p values based on one-tailed t-test assuming equal variances, ISS vs. Mir
For spine and hip, n = 16 ISS astronauts, 9 ISS cosmonauts, 7 Mir astronauts and 29 Mir cosmonauts (7 repeat flyers)
For pelvis, n = 16 ISS astronauts, 0 ISS cosmonauts, 7 Mir astronauts and 19 Mir cosmonauts
For heel, n = 16 ISS astronauts, 9 ISS cosmonauts, 7 Mir astronauts and 0 Mir cosmonauts
Bone Architecture in Relation to Physical Stress

**Wolff’s law.** Bony structures orient themselves in form and mass to best resist extrinsic forces (i.e., form and mass follow function).

- Greater trochanteric group
- Principal tensile group
- Secondary tensile group
- Principal compressive group
- Secondary compressive group
- Ward’s triangle

Trabecular configuration in proximal femur

Trabecular groups conform to lines of stress in weight bearing
<table>
<thead>
<tr>
<th>Feature</th>
<th>vivaCT 40</th>
<th>XtremeCT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td>in vivo (animal)</td>
<td>in vivo (human)</td>
</tr>
<tr>
<td><strong>Geometry</strong></td>
<td>Cone-Beam</td>
<td>Cone-Beam</td>
</tr>
<tr>
<td><strong>Peak/Mean Energy</strong></td>
<td>30-70 kVp / 20-50 keV</td>
<td>60 kVp / 40 keV</td>
</tr>
<tr>
<td><strong>Max. Scan Diameter</strong></td>
<td>20-38 mm</td>
<td>125 mm</td>
</tr>
<tr>
<td><strong>Max. Scan Length</strong></td>
<td>145 mm</td>
<td>150 mm</td>
</tr>
<tr>
<td><strong>Nominal Resolution</strong></td>
<td>10 μm</td>
<td>42 μm</td>
</tr>
<tr>
<td><strong>Resolution (10% MTF)</strong></td>
<td>20 mm Ø: 16 μm</td>
<td>125 mm Ø: 100 μm</td>
</tr>
<tr>
<td><strong>Slice Thickness</strong></td>
<td>10-38 μm</td>
<td>41-246 μm</td>
</tr>
</tbody>
</table>
Bone Qualities: Indices that influence bone strength.

Goldstein, “Bone Quality: A Biomechanical Perspective” May 2005
Hip Bone Strength: Use of modeling
Finite Element Models of Left Proximal Femur

## Results – Hip Strength

*N=11 crewmembers*

<table>
<thead>
<tr>
<th>Loading Condition</th>
<th>Mean (SD) Pre-flight</th>
<th>Mean (SD) Post-flight</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stance</td>
<td>13,200 N (2300 N)</td>
<td>11,200 N (2400 N)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>2.2% loss/month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>2,580 N (560 N)</td>
<td>2,280 N (590 N)</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>1.9% loss/month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**1.0-1.5% BMD loss /month**
Percentage Reduction in Hip Strength

Stance

Fall

Number of Subjects

% Reduction

0 10 20 30

% Reduction

0 -10 0 10 20
Activation Frequency requires Bone Histomorphometry

Average time that takes for a new remodeling cycle to begin on any point on a cancellous surface - an index for the rate of bone remodeling.

Not practical for site-specific bone remodeling see with mechanical unloading.
Bone Histology
Young Normal  

Osteoporotic  

Images courtesy of Ralph Müller, PhD, Switzerland
GAPS: Factors Related to Fracture Risk Besides Bone Mass

1. **Energy released by fall or “injury”** (need to identify tasks to be performed; perform modeling to predict*)
2. **Neuromuscular protection of bone** (need to preserve postural muscle mass and motor coordination)
3. **Energy absorbed by soft tissue** (need to provide adequate “protective padding,” evaluate putative osteoprotective effect of EVA suit and partial gravity)
4. **Bone Strength: Quantity & Quality** (need supplement DXA bone mass measurements)

*Carpenter JBMR, 2005*