A rare case of zolendronate infusion complication leading to glaucoma filtration surgery

Abstract: Zolendronic acid is a nitrogenous biphosphonate commonly used as an intravenous infusion for the management of Paget’s disease, osteoporosis, and hypercalcemia of malignancy. We report a rare and challenging complication of zolendronate infusion: unilateral acute anterior uveitis followed by persistently raised intraocular pressure despite being on four different classes of antiglaucoma medication. The challenge was that the patient required topical steroid to treat her uveitis in the background of known glaucoma with corresponding steroid response. She eventually underwent a left phacotrabeculectomy augmented with 5-fluorouracil. Four weeks postoperatively she developed an encapsulated bleb and underwent needling with 5-fluorouracil. This case highlights the importance of having a high index of suspicion for anterior uveitis in patients with a red and painful eye after initiating biphosphonate therapy. Caution should also be exercised when prescribing biphosphonates to glaucoma patients.

Keywords: biphosphonates, anterior uveitis, intraocular pressure

Introduction

Zolendronic acid is a nitrogenous biphosphonate commonly used as an intravenous infusion for the management of Paget’s disease, osteoporosis prophylaxis, and treatment of hypercalcemia of malignancy. Uveitis is an uncommon ocular complication of zolendronate. The HORIZON (Health Outcomes and Reduced Incidence with Zoledronic Acid Once Yearly) trial in postmenopausal women with osteoporosis showed an absolute increase of only 0.69% in inflammatory ocular adverse events, mainly conjunctivitis, during the first 15 days after infusion in comparison with controls, but no case of uveitis.

Nevertheless, a small number of studies have reported acute anterior uveitis following biphosphonate infusion, including zolendronate. The onset of symptoms in most cases is within 72 hours of starting therapy. The majority of cases resolve without sequelae with the administration of topical treatment and cessation of the bisphosphonate. However, in our case the acute anterior uveitis was associated with persistently raised intraocular pressure (IOP) despite maximum topical antiglaucomatous treatment, leading to glaucoma filtration surgery and subsequently needling with 5-fluorouracil. To the best of our knowledge this is the first case of this kind to be reported and highlights this rare, and potentially sight threatening, complication of zolendronate infusion.
Case presentation
This interventional case report describes a 69-year-old Caucasian lady, on adjuvant letrozole for hormone responsive breast adenocarcinoma, who was also started on the bisphosphonate zolendronate, as prophylaxis against osteoporosis. Within 48 hours of receiving her first zolendronate infusion she developed a red and painful photophobic left eye. She was diagnosed with severe anterior uveitis with corneal edema and plus three cells with a secondary rise in the IOP to 40 mmHg. She had a past history of left episcleritis and had been diagnosed with primary open angle glaucoma 11 years earlier with advanced cupping bilaterally. She had already had glaucoma surgery in her right eye and was known to be a steroid responder.

During follow-up, IOP remained high in the left eye over a 4-month period, fluctuating between 26 mmHg and 42 mmHg, despite being on four antiglaucoma medications (latanoprost, Cosopt®, acetazolomide 250 mg twice daily). The challenge was that she required topical steroid (Pred Forte®) drops to treat her uveitis in the background of osteoporosis. Within 48 hours of receiving her first zolendronate, as prophylaxis against osteoporosis, the lady developed red and painful eye for anterior uveitis after initiating bisphosphonates containing nitrogen (alendronate, pamidronate, zoledronate, risedronate), although in one report uveitis has been associated with bisphosphonates not containing nitrogen (clodronate, etidronate). The inflammatory mechanism remains unclear, but may be related in part to higher levels of proinflammatory cytokines (interleukin-6 and tumor necrosis factor-alpha) caused by bisphosphonates.

On resolution of the initial uveitic episode, various management options have been attempted. Some patients have been switched to a different drug of the same class, with some observing decreased inflammation and some not noticing any relapse at all, suggesting immunological tolerance. Recurrence of ocular inflammation has also been shown to occur on rechallenge with the same drug, and it has been suggested that the offending drug should be discontinued in order to prevent involvement of the contralateral eye and recurrent or chronic ocular inflammation. Patients who are susceptible to nitrogen-containing bisphosphonates should be switched to the non-nitrogen-containing bisphosphonates.

Conclusion
In summary, the indications for bisphosphonates are clear and their benefits proven. Our case serves to illustrate a rare complication of anterior uveitis following treatment in a patient with a known history of glaucoma and eye surgery. The management was challenging, but successful. Had the acute anterior uveitis presented in the right eye with a previous trabeculectomy, the management would have been more complicated and sight threatening. This rare case emphasizes the importance of exercising caution when prescribing bisphosphonates to glaucoma patients. A high index of suspicion is needed in patients with a red and painful eye for anterior uveitis after initiating bisphosphonate therapy.

Disclosure
The authors report no conflicts of interest in this work.
References


