

Evaluation of Cinacalcet Therapy to Lower Cardiovascular Events (EVOLVE): Rationale and Design Overview

Glenn M. Chertow,* Lara B. Pupim,[†] Geoffrey A. Block,[‡] Ricardo Correa-Rotter,[§] Tilman B. Drueke,^{||} Jürgen Floege,[¶] William G. Goodman,^{+**} Gerard M. London,^{††} Kenneth W. Mahaffey,^{‡‡} Sharon M. Moe,^{§§} David C. Wheeler,^{|||} Moetaz Albizem,[†] Kurt Olson,[†] Preston Klassen,[†] and Patrick Parfrey^{¶¶}

*Departments of Medicine and Epidemiology and Biostatistics, University of California at San Francisco, San Francisco, California; [†]Amgen Inc., Thousand Oaks, California; [‡]Denver Nephrologists PC, Denver, Colorado; [§]Department of Nephrology and Mineral Metabolism, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico City, Mexico; ^{||}INSERM Unit 845 and Nephrology, Hopital Necker, Paris, France; [¶]Department of Nephrology, University Hospital, Rheinisch Westfälische Technische Hochschule University of Aachen, Aachen, Germany; ^{**}Division of Nephrology, Department of Medicine, David Geffen School of Medicine, University of California at Los Angeles, Los Angeles, California; ^{††}Service de Néphrologie Hôpital Manhès, Fleury-Mérogis, France; ^{‡‡}Duke Clinical Research Institute, Duke University Medical Center, Durham, North Carolina; ^{§§}Department of Medicine, Indiana University School of Medicine and Roudebush VAMC, Indianapolis, Indiana; ^{|||}Center for Nephrology, Royal Free and University College Medical School, London, United Kingdom; and ^{¶¶}Health Sciences Centre, Memorial University of Newfoundland, St. John's, Newfoundland, Canada

Background and Objectives: The dramatically high rates of mortality and cardiovascular morbidity observed among dialysis patients highlights the importance of identifying and implementing strategies to lower cardiovascular risk in this population. Results from clinical trials undertaken thus far, including trials on lipid reduction, normalization of hematocrit, and increased dialysis dosage, have been unsuccessful. Available data indicate that abnormalities in calcium and phosphorus metabolism, as a result of either secondary hyperparathyroidism alone or the therapeutic measures used to manage secondary hyperparathyroidism, are associated with an increased risk for death and cardiovascular events. However, no prospective trials have evaluated whether interventions that modify these laboratory parameters result in a reduction in adverse cardiovascular outcomes.

Design, Setting, Participants, & Measurements: Evaluation of Cinacalcet Therapy to Lower Cardiovascular Events is a global, phase 3, double-blind, randomized, placebo-controlled trial evaluating the effects of cinacalcet on mortality and cardiovascular events in hemodialysis patients with secondary hyperparathyroidism. Approximately 3800 patients from 22 countries will be randomly assigned to cinacalcet or placebo. Flexible use of traditional therapies will be permitted. The primary end point is the composite of time to all-cause mortality or first nonfatal cardiovascular event (myocardial infarction, hospitalization for unstable angina, heart failure, or peripheral vascular disease, including lower extremity revascularization and nontraumatic amputation).

Results: The study will be event driven (terminated at 1882 events) with an anticipated duration of approximately 4 yr.

Conclusions: Evaluation of Cinacalcet Therapy to Lower Cardiovascular Events will determine whether management of secondary hyperparathyroidism with cinacalcet reduces the risk for mortality and cardiovascular events in hemodialysis patients.

Clin J Am Soc Nephrol 2: 898-905, 2007. doi: 10.2215/CJN.04381206

Mortality and cardiovascular morbidity are unacceptably high in dialysis patients despite substantial improvements in dialysis technology and multiple efforts to standardize and improve practice (1). A large portion

of the increased mortality in the dialysis population is the result of premature cardiovascular disease (2). To date, prospective clinical trials in large dialysis populations have failed to demonstrate a meaningful benefit from hepatic hydroxymethyl glutaryl-CoA reductase inhibitors (statins), normalized hematocrit, or higher dialysis dosage, expressed as Kt/V_{urea} (3–5). Other metabolic abnormalities associated with uremia might be fruitful areas for potential interventions.

Elevations in biochemical markers of secondary hyperparathyroidism (sHPT) are associated with the risk for all-cause mortality and cardiovascular morbidity in the dialysis popula-

Received December 22, 2006. Accepted June 25, 2007.

Published online ahead of print. Publication date available at www.cjasn.org.

Address correspondence to: Dr. Patrick Parfrey, Health Sciences Centre, Memorial University of Newfoundland, St. John's, NL, Canada A1B 3V6. Phone: 709-777-7261; Fax: 709-777-6995; E-mail: pparfrey@mun.ca

tion, potentially mediated through vascular calcification, hypertension, and left ventricular hypertrophy (6–11). As modifiable cardiovascular risk factors, interventions that target biochemical markers of chronic kidney disease–mineral and bone disorder (CKD-MBD) (12) are therefore excellent candidates for clinical investigation in the dialysis population. However, no prospective trials have evaluated whether interventions that modify these laboratory parameters result in a reduction in adverse cardiovascular outcomes.

Evaluation of Cinacalcet Therapy to Lower Cardiovascular Events (EVOLVE) is a randomized clinical trial (RCT) designed to test the hypothesis that cinacalcet reduces the risk for mortality and cardiovascular morbidity compared with placebo in patients who receive maintenance hemodialysis and traditional therapy for sHPT. The purpose of this article is threefold: (1) To review the putative role of sHPT and the conventional approaches used to manage sHPT as potential contributors to mortality and cardiovascular disease among patients who receive maintenance hemodialysis, (2) to provide the rationale for conducting an RCT to test the hypothesis that treatment with cinacalcet reduces the risk for mortality and cardiovascular morbidity in patients who receive maintenance hemodialysis, and (3) to review the design of EVOLVE.

Challenges in Controlling sHPT Using Traditional Therapies

sHPT is a common and serious disease that develops relatively early in the course of CKD, often when the GFR drops below approximately 60 ml/min per 1.73 m² and long before the initiation of dialysis (13). Several factors contribute to the

pathogenesis of sHPT, including reduced synthesis of 1,25-dihydroxy vitamin D, hypocalcemia, and skeletal resistance to the calcemic action of parathyroid hormone (PTH). As CKD progresses toward end stage, the prevalence of sHPT increases, affecting nearly all patients who receive dialysis therapy. In addition, increases in serum calcium may occur as a result of traditional therapy (e.g., vitamin D derivatives, phosphate binders), together with hyperphosphatemia and increased levels of the calcium-phosphorus ion product. Traditional therapies fail to control simultaneously PTH and abnormalities of divalent ion metabolism in many patients with CKD and have the potential to aggravate complications of the disease. For example, although vitamin D derivatives (including calcitriol, alfacalcidol, doxercalciferol, and paricalcitol) efficiently reduce PTH concentrations, these agents can lead to hyperphosphatemia and relative hypercalcemia as a result of enhanced gastrointestinal absorption of phosphorus and calcium. Calcium-based phosphate binders do not efficiently control sHPT when used alone and contribute to hypercalcemia in up to 40% of patients (14), particularly when administered in conjunction with vitamin D derivatives. Calcium-free phosphate binders tend not to raise serum calcium concentrations but generally do not adequately control sHPT when used alone. Indeed, epidemiologic evidence suggests that despite the aggressive use of vitamin D derivatives and phosphate binders, fewer than 10% of hemodialysis patients achieve target concentrations for all four of the biochemical parameters recommended by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF-K/DOQI) Clinical Practice Guidelines for Bone Metabolism and Disease in Chronic Kidney Disease (10).

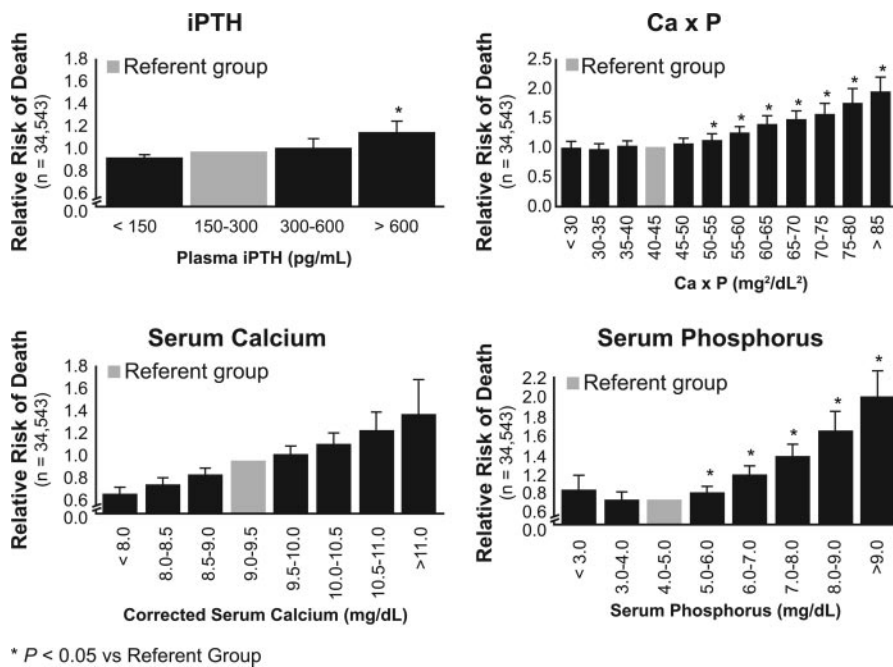


Figure 1. Associations between elevations in phosphorus, calcium, calcium-phosphorus product, and parathyroid hormone (PTH) with risk for mortality. Abbreviations: iPTH, intact PTH, Ca × P, calcium-phosphorus product. Adapted from reference (9), with permission.

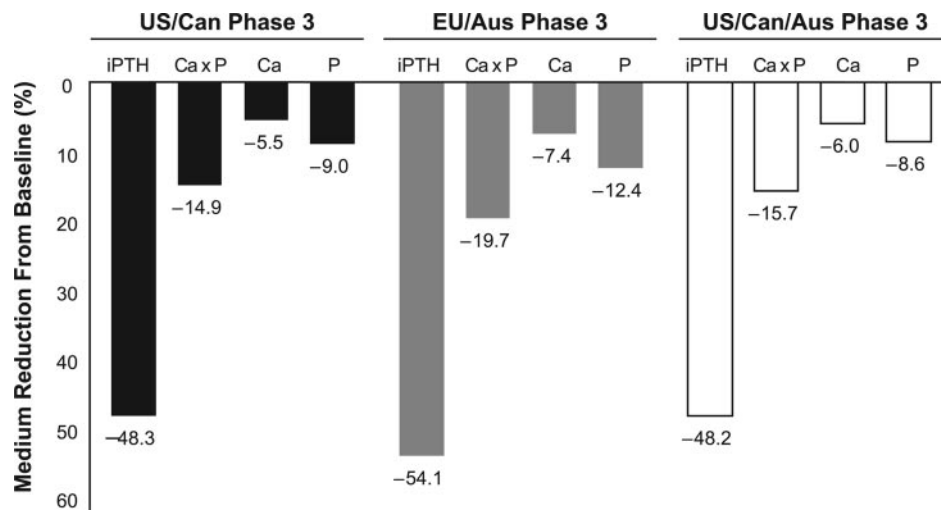


Figure 2. Effect of cinacalcet on PTH, Ca, P, and Ca \times P in phase 3 clinical trials (21,22). US, United States; EU, Europe; Aus, Australia.

sHPT, Mortality, and Cardiovascular Disease in Dialysis Patients

The clinical outcome most frequently associated with sHPT is the development of abnormal bone that can progress to osteitis fibrosa cystica, which is one of the histologic findings referred to as renal osteodystrophy (15–17). However, recent epidemiologic data demonstrate that sHPT (and more generally the biochemical abnormalities of CKD-MBD) is a risk factor for mortality and cardiovascular morbidity and therefore can be considered a nontraditional cardiovascular risk factor (12,18), which may predispose to vascular calcification (7), increased arterial stiffness, and left ventricular hypertrophy (6,8). Analyses from multiple large dialysis databases suggest that elevated serum calcium, phosphorus, calcium-phosphorus product, and PTH are associated with increased risk for all-cause and cardiovascular mortality (9–11,19) (Figure 1). Whether improvements in the control of the biochemical parameters that are associated with sHPT and the therapeutic measures that are used to manage sHPT will reduce the burden of cardiovascular disease and adverse clinical outcomes in patients who receive dialysis warrants further investigation.

Traditional risk factor modification has been unsuccessful in improving clinical outcomes (3). Therefore, there is a need to investigate other therapeutic interventions, particularly those targeted toward selected uremia-related risk factors, to test

their ability to reduce the burden of cardiovascular disease and adverse clinical outcomes in patients who receive dialysis.

Rationale for an RCT Using the Calcimimetic Cinacalcet

The calcimimetics, which include cinacalcet, are a novel class of small molecules that act as allosteric modulators of the calcium sensing receptor on the surface of parathyroid cells and cells of numerous other tissues (20). Three clinical trials that studied 1136 dialysis patients with uncontrolled sHPT (defined as PTH \geq 300 pg/ml despite conventional therapy) demonstrated that treatment with cinacalcet resulted in simultaneous reductions in serum concentrations of PTH, calcium, phosphorus, and calcium-phosphorus product (21,22) (Figure 2).

Post hoc analyses of data from four placebo-controlled RCTs, with follow-up times varying from 6 to 12 mo, showed that treatment with cinacalcet led to significant reductions in the risk for parathyroidectomy, fracture, and hospitalizations related to cardiovascular disease (Table 1) (23). Although the RCTs that were pooled in this analysis were neither designed nor powered to assess clinical outcomes, these pooled data support the safety of cinacalcet in clinical practice and generate the hypothesis that the use of cinacalcet may result in a reduction in important clinical events.

Consensus clinical practice guidelines, including the NKF-

Table 1. Key clinical event rates from *post hoc* analysis of phase 3 cinacalcet studies (24)

| Clinical Outcome | Cinacalcet (Events per 100 Patient-Years) | Control (Events per 100 Patient-Years) | HR (95% CI) ^a | P for HR |
|--------------------------------|---|--|--------------------------|----------|
| Parathyroidectomy | 0.3 | 4.1 | 0.07 (0.01 to 0.55) | 0.009 |
| Fracture | 3.2 | 6.9 | 0.46 (0.22 to 0.95) | 0.040 |
| Cardiovascular hospitalization | 15.0 | 19.7 | 0.61 (0.43 to 0.86) | 0.005 |
| Mortality | 5.2 | 7.4 | 0.81 (0.45 to 1.45) | 0.470 |

^aControl is used as the reference group. CI, confidence interval; HR, hazard ratio.

K/DOQI Clinical Practice Guidelines for Bone Metabolism and Disease in Chronic Kidney Disease (24), identify the need for a robust RCT designed to provide definitive evidence that correction of the biochemical parameters associated with sHPT exert a meaningful, beneficial effect on clinical end points in hemodialysis patients. Such information has yet to be reported with traditional therapeutic approaches, which include phosphate binders and vitamin D derivatives. In addition to clinical outcomes data, large simple pragmatic trials may provide important health economic information and valuable insights into geographic variability in patient demographics and the management of this disease state.

EVOLVE

Study Design, Participants, and Setting

EVOLVE is a multicenter, randomized, double-blind, placebo-controlled trial designed to determine the efficacy of cinacalcet compared with placebo in patients who receive maintenance hemodialysis and traditional therapy for sHPT on the primary composite end point of time to all-cause mortality or first nonfatal cardiovascular event (myocardial infarction, hospitalization for unstable angina, heart failure, or peripheral vascular disease, including lower extremity revascularization and nontraumatic amputation). EVOLVE is a global study carried out in approximately 500 sites in 22 countries: United States, Canada, Argentina, Brazil, Mexico, Australia, Austria, Belgium, Denmark, France, Germany, Hungary, Ireland, Italy, Netherlands, Poland, Portugal, Russia, Spain, Sweden, Switzerland, and United Kingdom. A study schema is provided in Figure 3. EVOLVE is conducted by a collaborative network as outlined in Table 2.

Justification for an RCT with Cinacalcet

The importance of validating therapeutic hypotheses from longitudinal studies of risk factors with RCT is exemplified by studies that have reexamined and ultimately changed standards of care. Notable examples include the Women's Health Initiative, the Hemodialysis (HEMO) Study, the Deutsche Diabetes Dialyze Studie (4D Study), and, more recently, the Ho-

mocysteine Lowering with Folic Acid and B Vitamins in Vascular Disease (HOPE 2) trial (3,5,25,26). The Women's Health Initiative was a large, randomized, placebo-controlled study that examined the effect of hormone replacement therapy (HRT) with estrogen and progestin on cardiovascular risk in postmenopausal women (25). Many questioned the ethics of this study at the time it was initiated, because HRT was part of standard of care for management of cardiovascular risk in women, based on conclusions from observational data. However, the Women's Health Initiative was stopped early because women who were randomly assigned to HRT were found to have a higher risk for cardiovascular disease than women who were randomly assigned to receive placebo.

Justification for the Use of a Placebo

The principal reason for providing placebo tablets to patients in the control arm is to ensure study blinding with regard to both investigators and patients. However, the use of a placebo control group in EVOLVE does not suggest that the control group is untreated. All EVOLVE study participants are expected to receive standard pharmacologic therapy (as tolerated) with currently available agents for the management of sHPT. EVOLVE is designed to address the question of whether cinacalcet, used in conjunction with conventional treatment, offers a meaningful benefit compared with usual therapy for sHPT. These standard therapies (*e.g.*, vitamin D derivatives, phosphate binders) will be used in both treatment groups with flexibility, allowing the physician unrestricted ability to treat the disease in accordance with national or international relevant guidelines (24).

Inclusion and Exclusion Criteria

Eligible EVOLVE participants will be ≥ 18 yr of age, have stage 5 CKD treated with maintenance hemodialysis (including hemodiafiltration) three times a week for ≥ 3 mo before randomization, have intact PTH (iPTH) ≥ 300 pg/ml (31.8 pmol/L), and have calcium-phosphorus product ≥ 45 mg²/dl² (3.63 mmol²/L²). In addition, eligible participants must have a serum calcium ≥ 8.4 mg/dl (2.1 mmol/L) and be likely to remain available during the follow-up phase of the study. Participants should agree to follow-up for the duration of the study and sign the appropriate written informed consent form before any study-specific procedure. There will be no upper limit for inclusion with regard to PTH values because there is no global consensus on what such an upper limit should be. If a parathyroidectomy is indicated for a patient according to investigator's opinion, then the patient should not be enrolled into the study. If a patient is enrolled into the study and undergoes parathyroidectomy, then the patient will no longer receive study drug but will continue to be followed.

Patients will be excluded from participation in EVOLVE when they have an unstable medical condition (in the judgment of the investigator); have had a parathyroidectomy within 12 wk of informed consent and/or the investigator anticipates that the patient will need a parathyroidectomy within 6 mo after randomization; has a life-limiting concomitant disease; received therapy with cinacalcet within 3 mo of randomization;

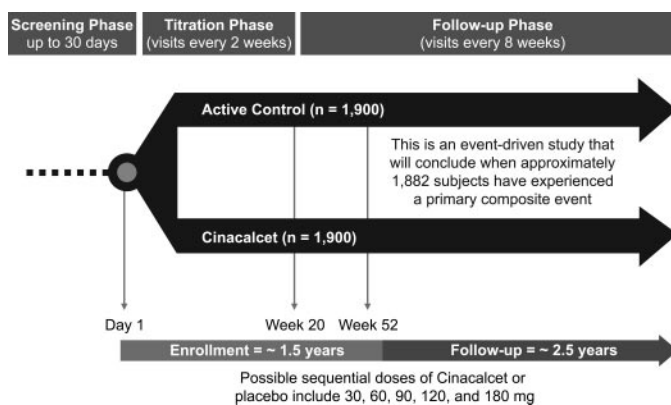


Figure 3. Schematic diagram of the Evaluation of Cinacalcet Therapy to Lower Cardiovascular Events (EVOLVE) study design.

Table 2. EVOLVE collaborative network and responsibilities^a

| Entity | Responsibilities |
|---|---|
| Amgen Inc. (study sponsor) | Develop operational strategy, oversee global study execution, and promote alignment among all regions; monitoring and site management in European Union and Australia |
| Executive Committee | Oversee the design, execution, and analysis of the study in conjunction with Amgen; report and communicate the study results in conjunction with Amgen |
| Clinical Endpoint Committee (Duke Clinical Research Institute) | Adjudicate study end points in an unbiased and consistent manner according to prespecified end point criteria |
| Data Monitoring Committee | Monitor accumulating efficacy and safety data; make recommendations to the Executive Committee and Amgen regarding study conduct |
| Independent Biostatistics Group (Frontier Science and Technology Research Foundation) | Support the study's Data Monitoring Committee through independent analyses of safety and efficacy study data |
| Clinical Research Organization (Quintiles Inc.) | Monitoring and site management in United States, Canada, Latin America, and Russia; data management and end point packages processing |
| Investigative sites | Recruitment of participants and ethical conduct of the study in accordance with the protocol and all applicable guidelines |
| Central laboratory (Covance Central Laboratory) | Specimen management; analysis and storage of laboratory samples |
| Interactive Voice Response System (ICOPhone) | Patient randomization, drug dispensation, and assignment of investigational product dosing and drug supply management |
| Dialysis Service Organizations | Facilitate site identification, contract approvals, and patient enrollment |

^aEVOLVE, Evaluation of Cinacalcet Therapy to Lower Cardiovascular Events.

were hospitalized within 12 wk of randomization for myocardial infarction, unstable angina, heart failure (including any unplanned presentation to a health care facility that would require mechanical fluid removal therapy), peripheral vascular disease (other than for a dialysis vascular access), or stroke; had a seizure within 12 wk before randomization; have a scheduled date for kidney transplantation from a known living donor; or are currently enrolled in or have not completed at least 30 d since ending other investigational device or drug trial(s), or are receiving other investigational agent(s).

Primary Composite End Point

The primary end point is the composite of time to all-cause mortality or first nonfatal cardiovascular event (myocardial infarction, hospitalization for unstable angina, heart failure, or peripheral vascular disease, including lower extremity revascularization and nontraumatic amputation). The components of this composite end point were chosen on the basis of the evaluation of appropriate pathophysiologic rationale, of the supportive observational

and prospective clinical trials data, of the biologic plausibility that the rates of the events would be decreased after therapy with cinacalcet in addition to traditional therapies for sHPT, and that the expectation that all of the components would contribute similarly to the overall end point. Causes of death will be defined and categorized into cardiovascular or noncardiovascular. All deaths will be considered cardiovascular in nature unless a noncardiovascular cause can be clearly identified. Adjudication of myocardial infarction and hospitalization for unstable angina will be based on markers of cardiac muscle damage, including troponin, creatine kinase, and creatine kinase-MB (CKMB), as well as electrocardiographic and clinical data. The main distinction between the definitions of myocardial infarction and hospitalization for unstable angina are based on the thresholds for markers of cardiac muscle damage (troponin or creatine kinase-MB more than two times laboratory upper limits of normal [ULN] for myocardial infarction and greater than ULN but less than two times ULN for unstable angina). Heart failure will be defined as an unplanned

presentation to a hospital or dialysis facility with acute symptomatic pulmonary edema and the need for mechanical ultrafiltration. Requirements for symptomatic pulmonary edema include dyspnea with at least two of the following: (1) Bilateral basilar rales on physical examination, (2) raised jugular venous pressure, (3) interstitial edema findings on chest radiography, (4) increased upper pulmonary vessel diameter noted on chest radiography, and (5) elevated left ventricular end diastolic pressure or pulmonary capillary wedge pressure. Peripheral vascular events will be assessed on the basis of hospitalization as a result of signs and symptoms of lower limb peripheral vascular disease, with documentation of tissue necrosis or the need for a therapeutic intervention (*e.g.*, amputation, revascularization). All composite cardiovascular end points and key secondary end points, including stroke, bone fracture, and parathyroidectomy, will be adjudicated by the Clinical Events Classification group at Duke Clinical Research Institute in an unbiased and consistent manner according to prespecified end point criteria.

Procedures and Assessments

This section describes key procedures and assessments during the screening, titration, and follow-up phases of the study, according to the frequency of visits and duration of study phases shown in Figure 3. Screening procedures include medical history; physical examination; electrocardiogram (ECG); serum pregnancy test for all women; and blood samples for PTH, calcium, phosphorus, and calcium-phosphorus product. Assessment of dialysis dosage (single-pool Kt/V or urea reduction ratio) and patient-reported outcomes (PRO) will also be collected during this period. At day 1 (the day of the first dose of study drug), the following will be assessed: Vital signs and blood samples for PTH, calcium, phosphorus, calcium-phosphorus product, bone-specific alkaline phosphatase (BALP), serum N-telopeptide (NTx), 25(OH)D, 1,25(OH)₂D, hematology, lipid profile, and serum chemistry. During the titration phase, serum calcium, phosphorus, and PTH will be measured at all study visits. In addition, at the 20-wk study visit, vital signs will be recorded; PRO assessment and health resource utilization questionnaires will be completed; and additional blood samples will be collected for hematology, lipid profile, biochemistry, BALP, and NTx. Dialysis dosage will also be assessed during this visit. During the course of the follow-up phase, PTH, calcium, phosphorus, and calcium-phosphorus product will be assessed at all study visits and approximately 1 to 2 wk after a dosage change in study drug; BALP, NTx, hematology, lipid profile, and biochemistry will be assessed at week 52 and approximately yearly thereafter; and PRO, physical examination with vital signs, and ECG will be performed at week 52 and approximately yearly thereafter (except for BP and weight, which will be collected every 6 mo). Patients who experience a suspected end point will have a PRO assessment at the next scheduled study visit. Assessment of dialysis dosage will be completed at week 52 and approximately every 6 mo thereafter. Finally, at end of study, physical examination with vital signs, ECG, PRO assessment, dialysis dosage, PTH, calcium, phosphorus, calcium-phosphorus product, BALP, NTx,

hematology, lipid profile, biochemistry, and serum pregnancy test (women) will be performed and assessed, as appropriate.

End of Treatment and End of Study

Patients who have study drug discontinued for any reason will continue to be followed until the completion of the trial. Patients who do not wish to continue participation in study activities will be monitored for the purposes of collection of study end point data. These patients will remain in the study and will have this information collected, typically through a review of medical records and/or telephone contact. Patients who have study drug discontinued for any reason during the course of the study and do not wish to be followed for the collection of study end point data (effectively withdrawing consent) will be permanently discontinued from study on the date of this request.

End of the study for any given patient will be defined as the date of study completion/termination communicated to sites (when 1882 patients have experienced a primary event), the date of the last study-related assessment for patients who prematurely and permanently withdraw from the study, or the date of death. End of treatment is defined as the date of the last dose of the study drug for patients who discontinue its administration.

Patients who interrupt or discontinue study drug for any reason, except for parathyroidectomy, but remain in the study may restart the blinded study drug at any time during the study. They are to reinstitute therapy at the 30-mg dosage level if discontinued for >4 wk.

Statistical Considerations

EVOLVE is event driven and will continue until approximately 1882 patients have experienced a primary event. Enrolled patients will be randomly assigned at a 1:1 ratio to cinacalcet or control group. Randomization will be stratified according to history of diabetes and by country. On the basis of a two-sided log-rank test for equality of survivor functions using a two-sided 0.049 significance level (allowing for one formal interim analysis with a significance level of 0.001), it is anticipated that a sample size of 3800 will yield the required 1882 primary events with 90% power to detect a hazard ratio of 0.80 (*i.e.*, treatment effect of 20%) over a maximum follow up of 4 yr (median follow up expected to be approximately 3 yr). The sample size estimate includes consideration of treatment effect attenuation as a result of a 10-wk delay in separation of the Kaplan-Meier curves at trial start, a lost to follow-up rate of 1% per year, a withdrawal from treatment (dropout) rate of 10% per year in the cinacalcet group, and a drop-in rate in the placebo group of 10% per year. All patients will be followed from randomization through to the date of study termination, except for patients who permanently withdraw consent. Efficacy analyses will be performed in accordance with the intention-to-treat principle.

Conclusions

The need for investigation of novel therapeutic interventions that target mortality and cardiovascular morbidity is high-

lighted by the 10- to 30-fold enhanced risk for cardiovascular events, including death, among hemodialysis patients compared with the general population (27). Prospective clinical trials in dialysis populations have failed to demonstrate a beneficial effect of some interventions to ameliorate cardiovascular risk (3–5), suggesting a need to investigate therapeutic interventions that are targeted toward nontraditional risk factors in this patient population. sHPT and the associated changes in calcium and phosphorus constitute nontraditional yet modifiable risk factors for the high mortality and cardiovascular morbidity observed in this population, yet no adequately powered clinical trials have addressed this issue. Although the complex nature of sHPT and the effects of cinacalcet on PTH, calcium, and phosphorus may not allow exact determination of the mechanism(s) of effect, EVOLVE should answer the critical question of whether an approach that targets multiple laboratory parameters of CKD-MBD results in an improvement in outcomes of importance to hemodialysis patients.

Disclosures

Lara B. Pupim, William G. Goodman, Moetaz Albizem, Kurt Olson, and Preston Klassen are employees of Amgen. Geoffrey A. Block is a recipient of research funding from Amgen, Genzyme, and Shire, and serves as an advisor for Amgen and Genzyme. Kenneth W. Mahaffey is a recipient of research funding and/or serves as a consultant/speaker for Abbott Vascular, Alexion, Amgen, AstraZeneca, Bayer, Bristol-Myers Squibb, Cardiokinetix, Cierra, Conor, Cordis, Corgentech, GE Medical Systems, Genentech, Guidant, Johnson & Johnson, ELI Lilly, Medtronic, Novartis, Ortho-Biotech, Procter & Gamble, Sanofi-Aventis, Sanofi-Synthelabo, Schering-Plough, Scios, Sichel Technologies, The Medicines Company. Sharon M. Moe is a recipient of research funding from and serves as a speaker and consultant for Amgen. Glenn M. Chertow is a recipient of research funding from and served on advisory boards for Amgen and Genzyme, and has served on advisory boards for DiObex, Fibrogen, RenaMed, and Scios. David C. Wheeler has received honoraria and travel funding from Amgen and currently serves as a consultant in his capacity as a member of the International Executive Committee of the EVOLVE study. Jürgen Floege receives consultancy and speaker honoraria from Amgen, Genzyme, and Wyeth. Ricardo Correa-Rotter receives consultancy and speaker honoraria from Amgen. Patrick Parfrey has received research funding from or served as a consultant for Amgen, Ortho Biotech, Roche, and Merck Frost. Gérard London serves as a consultant and speaker to Genzyme, Amgen, Roche, and Shire, and as a speaker for Servier. Tilman Drueke has received consulting fees and speaker fees from Hoffmann-La Roche, and consulting fees, speaker fees, and a research grant from Amgen and Genzyme.

References

1. USRDS: the United States Renal Data System. *Am J Kidney Dis* 42: 1–230, 2003
2. Samak MJ, Levey AS, Schoolwerth AC, Coresh J, Culleton B, Hamm LL, McCullough PA, Kasiske BL, Kelepouris E, Klag MJ, Parfrey P, Pfeffer M, Raij L, Spinosa DJ, Wilson PW; American Heart Association Councils on Kidney in Cardiovascular Disease, High Blood Pressure Research, Clinical Cardiology, and Epidemiology and Prevention: Kidney disease as a risk factor for development of cardiovascular disease: A statement from the American Heart Association Councils on Kidney in Cardiovascular Disease, High Blood Pressure Research, Clinical Cardiology, and Epidemiology and Prevention. *Hypertension* 42: 1050–1065, 2003
3. Wanner C, Krane V, Marz W, Olschewski M, Mann JF, Ruf G, Ritz E; German Diabetes and Dialysis Study Investigators: Atorvastatin in patients with type 2 diabetes mellitus undergoing hemodialysis. *N Engl J Med* 353: 238–248, 2005
4. Besarab A, Bolton WK, Browne JK, Egrie JC, Nissenson AR, Okamoto DM, Schwab SJ, Goodkin DA: The effects of normal as compared with low hematocrit values in patients with cardiac disease who are receiving hemodialysis and epoetin. *N Engl J Med* 339: 584–590, 1998
5. Cheung AK, Levin NW, Greene T, Agodoa L, Bailey J, Beck G, Clark W, Levey AS, Leypoldt JK, Ornt DB, Rocco MV, Schulman G, Schwab S, Teehan B, Eknoyan G: Effects of high-flux hemodialysis on clinical outcomes: Results of the HEMO study. *J Am Soc Nephrol* 14: 3251–3263, 2003
6. Abdelfatah AB, Motte G, Ducloux D, Chalopin JM: Determinants of mean arterial pressure and pulse pressure in chronic haemodialysis patients. *J Hum Hypertens* 15: 775–779, 2001
7. Goodman WG, Goldin J, Kuizon BD, Yoon C, Gales B, Sider D, Wang Y, Chung J, Emerick A, Greaser L, Elashoff RM, Salusky IB: Coronary-artery calcification in young adults with end-stage renal disease who are undergoing dialysis. *N Engl J Med* 342: 1478–1483, 2000
8. Klassen PS, Lowrie EG, Reddan DN, DeLong ER, Coladonato JA, Szczech LA, Lazarus JM, Owen WF: Association between pulse pressure and mortality in patients undergoing maintenance hemodialysis. *JAMA* 287: 1548–1555, 2002
9. Block GA, Klassen PS, Lazarus JM, Ofsthun N, Lowrie EG, Chertow GM: Mineral metabolism, mortality, and morbidity in maintenance hemodialysis. *J Am Soc Nephrol* 15: 2208–2218, 2004
10. Young EW, Akiba T, Albert JM, McCarthy JT, Kerr PG, Mendelssohn DC, Jadoul M: Magnitude and impact of abnormal mineral metabolism in hemodialysis patients in the Dialysis Outcomes and Practice Patterns Study (DOPPS). *Am J Kidney Dis* 44: 34–38, 2004
11. Slinin Y, Foley RN, Collins AJ: Calcium, phosphorus, parathyroid hormone, and cardiovascular disease in hemodialysis patients: The USRD Waves 1, 3, and 4 study. *J Am Soc Nephrol* 16: 1788–1793, 2005
12. Moe S, Drueke T, Cunningham J, Goodman W, Martin K, Olgaard K, Ott S, Sprague S, Lameire N, Eknoyan G: Definition, evaluation, and classification of renal osteodystrophy: A position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Kidney Int* 69: 1945–1953, 2006
13. Martinez I, Saracho R, Montenegro J, Llach F: The importance of dietary calcium and phosphorus in the secondary hyperparathyroidism of patients with early renal failure. *Am J Kidney Dis* 29: 496–502, 1997
14. Coburn JW, Maung HM: Calcimimetic agents and the calcium-sensing receptor. *Curr Opin Nephrol Hypertens* 9: 123–132, 2000
15. Cundy T, Hand DJ, Oliver DO, Woods CG, Wright FW, Kanis JA: Who gets renal bone disease before beginning dialysis? *BMJ (Clin Res Ed)* 290: 271–275, 1985
16. Spasovski GB, Bervoets AR, Behets GJ, Ivanovski N, Sikole

- A, Dams G, Couttenye MM, De Broe ME, D'Haese PC: Spectrum of renal bone disease in end-stage renal failure patients not yet on dialysis. *Nephrol Dial Transplant* 18: 1159–1166, 2003
17. Coen G, Mazzaferro S, Ballanti P, Sardella D, Chicca S, Manni M, Bonucci E, Taggi F: Renal bone disease in 76 patients with varying degrees of predialysis chronic renal failure: A cross-sectional study. *Nephrol Dial Transplant* 11: 813–819, 1996
 18. Suzuki T, Yonemura K, Maruyama Y, Takahashi T, Takita T, Furuhashi M, Hishida A: Impact of serum parathyroid hormone concentration and its regulatory factors on arterial stiffness in patients undergoing maintenance hemodialysis. *Blood Purif* 22: 293–297, 2004
 19. Melamed ML, Eustace JA, Plantinga L, Jaar BG, Fink NE, Coresh J, Klag MJ, Powe NR: Changes in serum calcium, phosphate, and PTH and the risk of death in incident dialysis patients: A longitudinal study. *Kidney Int* 70: 351–357, 2006
 20. Brown EM, MacLeod RJ: Extracellular calcium sensing and extracellular calcium signaling. *Physiol Rev* 81: 239–297, 2001
 21. Block GA, Martin KJ, de Francisco AL, Turner SA, Avram MM, Suranyi MG, Hercz G, Cunningham J, Abu-Alfa AK, Messa P, Coyne DW, Locatelli F, Cohen RM, Evenepoel P, Moe SM, Fournier A, Braun J, McCary LC, Zani VJ, Olson KA, Drüeke TB, Goodman WG: Cinacalcet for secondary hyperparathyroidism in patients receiving hemodialysis. *N Engl J Med* 350: 1516–1525, 2004
 22. Lindberg JS, Culleton B, Wong G, Borah MF, Clark RV, Shapiro WB, Roger SD, Husserl FE, Klassen PS, Guo MD, Albizem MB, Coburn JW: Cinacalcet HCl, an oral calcimimetic agent for the treatment of secondary hyperparathyroidism in hemodialysis and peritoneal dialysis: A randomized, double-blind, multicenter study. *J Am Soc Nephrol* 16: 800–807, 2005
 23. Cunningham J, Danese M, Olson K, Klassen P, Chertow GM: Effects of the calcimimetic cinacalcet HCl on cardiovascular disease, fracture, and health-related quality of life in secondary hyperparathyroidism. *Kidney Int* 68: 1793–1800, 2005
 24. NKF-K/DOQI clinical practice guidelines for bone metabolism and disease in chronic kidney disease. *Am J Kidney Dis* 42: S1–S201, 2003
 25. Manson JE, Hsia J, Johnson KC, Rossouw JE, Assaf AR, Lasser NL, Trevisan M, Black HR, Heckbert SR, Detrano R, Strickland OL, Wong ND, Crouse JR, Stein E, Cushman M; Women's Health Initiative Investigators: Estrogen plus progestin and the risk of coronary heart disease. *N Engl J Med* 349: 523–534, 2003
 26. Lonn E, Yusuf S, Arnold MJ, Sheridan P, Pogue J, Micks M, McQueen MJ, Probstfield J, Fodor G, Held C, Genest J; Heart Outcomes Prevention Evaluation (HOPE) 2 Investigators: Homocysteine lowering with folic acid and B vitamins in vascular disease. *N Engl J Med* 354: 1567–1577, 2006
 27. Foley RN, Parfrey PS, Sarnak MJ: Clinical epidemiology of cardiovascular disease in chronic renal disease. *Am J Kidney Dis* 32[Suppl 3]: S112–S119, 1998