Make the First Osteoporotic Fracture the Last!

Osteoporosis Risk Assessment, Diagnosis and Management

(Abbreviated excerpt from the RACGP Guidelines for Postmenopausal Osteoporosis[1])

Diagnosis

- A minimal trauma fracture of the hip or spine in a person older than 50 years of age is presumptive of osteoporosis;
- Treatment may be initiated without confirmation of low bone mineral density.

Assessing absolute fracture risk

Use the Garvan Fracture Risk Calculator (www.garvan.org.au/bone-fracture-risk) to assess the need for treatment in individuals who do not clearly fit established criteria. Calculator estimations assist, but do not replace clinical judgement.

Falls prevention

A full falls risk assessment should be conducted in any person who has fallen twice or more in the previous 12 months or is having difficulty with walking or balance.

Exercise

Leisure walking, swimming and cycling do not improve bone density. Prescribe regular, varied, high-intensity resistance training and progressive balance training. High-impact activities should be avoided by individuals at high risk of fracture.

Calcium and vitamin D supplementation

Routine supplementation in non-institutionalised individuals is not recommended. Those at risk of deficiency may benefit from 500–600 mg/day of elemental calcium. Calcium supplements are recommended for people taking osteoporosis treatments if dietary calcium intake is below 1300 mg/day and vitamin D if serum 25(OH) vitamin D level is below 50 nmol/L.

Bisphosphonates such as alendronate, risedronate or zoledronic acid are recommended for reducing the risk of vertebral and non-vertebral fractures in postmenopausal women and men over 50 years at high risk of fracture (i.e. those with a prior minimal trauma fracture).

Denosumab is recommended for the treatment of osteoporosis in postmenopausal women at risk of minimal trauma fracture. Denosumab should be considered as an alternative to bisphosphonates for the treatment of men at increased risk of minimal trauma fracture.

Consider **oestrogen replacement** therapy to reduce the risk of fractures in postmenopausal women. Long-term use is not recommended.

Selective oestrogen receptor modulators (SERMs; Raloxifene) should be considered as a treatment option for postmenopausal women with osteoporosis where vertebral fractures are considered to be the major osteoporosis risk and where other agents are poorly tolerated.

Duration of therapy

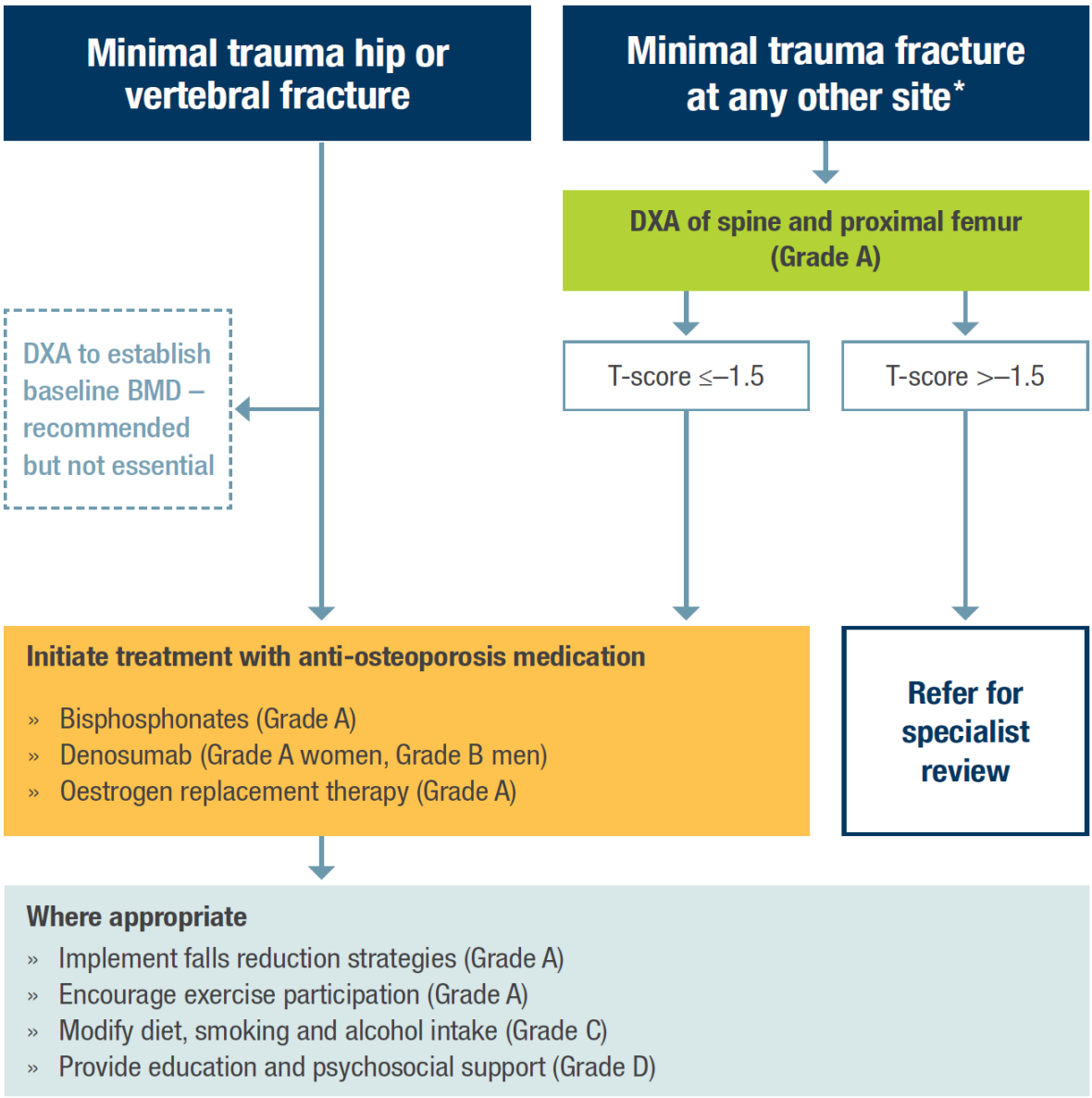
If the T-score remains below –2.5, and/or there are incident vertebral fractures, continue treatment. Reconsider therapy after 5–10 years in individuals with T-score better than –2.5 and no recent fractures. Restart treatment if there is bone loss or a further fragility fracture.

[1] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/osteoporosis

Fracture Alliance
Making the first break the last

Referral to a medical specialist
Refer to a specialist or a specialist bone centre according to individual need, or when there is restricted access to appropriate resources or required expertise.

Flow diagram for patients who have been diagnosed with a fracture



Local information is available from **HealthPathways**