NOFSA 2023 MASTERCLASS SERIES

CELEBRATING 30 YEARS

EPISODE 1

Osteoporosis as a life-time disease; how to manage expectations

QUESTION	ANSWER
How effective, compared to medications, can physical activity be on the treatment of osteoporosis?	Weightbearing exercise should always be part of lifestyle changes that accompanies bone specific medications. Although exercise has been shown to increase BMD and decrease fracture it is not enough in the person at high risk of fracture
I would like to know if the initiation of long term treatment with bisphosphonates in a pre-menopausal, borderline osteoporotic woman could limit treatment options later on in life.	Any form of bone specific medication is hardly ever indicated in premenopausal women except in the face of fragility fractures
Please explain dosages of bisphosphonates and calcium and D3 at varying ages for aging females who had early hysterectomies. What are alternatives?	Calcium and Vit D will be fully discussed in our next webinar. Bisphosphonates should be used only in the dosages as approved based on clinical trial data. Be aware that in the case of alendronate and zolendronate (Zol) there are half-dosage trial data for prevention of bone loss. Best treatment for prevention of bone loss after early hysterectomy and BSO is unopposed estrogen treatment. Early hysterectomy alone does not increase the risk of bone loss.
Should we institute HRT for all post-menopausal women, even if no menopausal symptoms, in order to preserve bone? What is the window - eg if they are 2-3 yrs post-menopausal without HRT, can one still initiate HRT? I further have a 16 yr old Turner syndrome patient, hysterectomy and bilateral ooforectomy, FSH decreased from 84 to 54 after one year on Estrofem 1mg. Should Estrofem be increased to 2mg and aim for normal FSH?	HRT should not be given to all postmenopausal women without a specific indication. Low bone density with increase risk of fracture is an indication. Generally speaking HRT should be started within 10 years of menopause or before age of 60 based on cardiovascular safety. It will however be effective in the prevention of bone loss at any age. In cases of POI such as Turners and other women younger than 50, the standard dose of E2 is 2mg (orally). Do not chase the FSH or treat to ant number
Young 30-40yr old female after breast cancer and mastectomy on hormone therapy with osteopenia. Zoledronic Acid reaction moderate to severe. Your approach to management.	Alendronate or Denosumab
Please share some guidelines for duration of treatment for osteoporosis in patients with liver failure and post liver transplantation.	Osteoporosis is a potential complication of liver failure and transplantation. This likely relates to the use of glucocorticoids, immunosuppressants, Vit D deficiency, hyperparathyroidism and pre existing bone disease. Bisphosphonates and denosumab are not metabolised in the liver and can be used after treatment of all other secondary causes. Duration of treatment must be individualised as in other patients with osteoporosis. Expect it to be a life long process of possibly intermittent treatment.
Does a fragility fracture immediately push somebody into the same risk as osteoporosis? How many times can yearly Zoledronic acid IV be given?	Any fragility fracture is an indication of the need for therapy regardless of BMD. Zol is generally given in 3-year cycles
How does long term cortisone use influence bone density. How does the benefits of it (management of an inflammatory disease) out weight the negatives.	Corticosteroids at a dosage of 7.mg daily for more than 3 months can cause rapid bone loss and fractures by interfering with the osteoblast. The negative aspects can be prevented by bone specific medication such as the bisphosphonates and denosumab.
If a woman is perimenapausal and not taking HRT, what over the counter medication can she opt for to maintain bone density and lower bone loss?	Maintaining normal Calcium and Vit D intake, preferably by diet and sun exposure is all that is needed
Is there a difference between 4mg Zol versus 5mg zol use	For the treatment of osteoporosis there is no data on the effectiveness of any dosage but 5 mg
Do you see Romosozumab coming to SA soon?	Unfortunately no
Once a patient has been started on Denosumab, is there much point in continuing 2-3 yearly DEXA scans? Or only repeat once has to stop (for whatever reason)?	As denosumab generally keep on improving BMD, repeat DXA makes sense as we generally aim for a target of -1.5 (T-score)
Do you consider high risk patients any fragility fracture, as distal radio fracture or humerus fractures? or only vertebral or hip fracture? Thanks	Any fracture should be a red light
Thank you Prof. When do you advise Dexa post forteo initiation? And what if very little increase in bmd	As the indicated length of treatment is 18-24 months, there is not much of a point in doing DXA sooner. More conservative increases in DXA is found after preceding bisphosphonate
How commonly do you see side effects or reactions with IV Zoledronate infusions and how often would these be serious?	I administer ZOL between 2-4 times per week for many years and have not seen any serious AE's.
I do not know if I may name a trade name. Zobone is cheaper than Zoledronic acid-acclasta. Is it registered for fragility fracture in patient admitted to hospital.	Zobone comes in 4 mg dosage and has oncological indications. No fracture data. My advise is to stick to 5 mg.
how likely are patients on long term alendronate to suffer atypical fractures	It is indeed not common. Generally less than 1:200 which is far less than the typical fractures prevented, AFF van be avoided drug holidays after 3 years(iv) or 5 years (oral). This worth the effort as AFF can be difficult to treat and often occur bilaterally
Nowadays women live long, into their 90s. How would an example treatment plan look, for example in a woman that is started in her 50s with MHT?	My choice would be HRT, followed by denosumab, followed by Zol. The exact duration and sequencing will differ between individuals
Will any of these drugs have an affect on Post Menopausal women that had spinal surgery(fusion) with bone graft to enhance healing?	No
Evening! Thank you for a great talk! As a private GP, I find so much resistance to getting the mediccal aids to give appropriate treatment on "chronic". How many of the non bisphosphonate drugs are easily prescribable by GPs?	Yes it remains a huge problem as osteoporosis is not regarded as a chronic condition (ridiculous) and thus does not qualify as a PMB. Whether GP or specialist, try to talk to the medical officer in charge and do not just accept the admin process that is driven by non-medical practitioners
Would you use bisphosphonates for treatment of stress fractures in athletes?	If normal BMD, BP's will not have any effect as they essentially act by slowing down bone-turnover
Does the fact that a patient is on an aromatase inhibitor influence the treatment choice or does the protocol remain the same?	Obviously no HRT. BP's or denosumab can be used
Do you consider high risk patients anyone with fragility fracture, as distal radio fracture or humerus fractures? or only patients with vertebral or hip fracture? Thanks	All fragility fractures at any site
Which antiresorptive therapy do you prefer in women with premature ovarian insufficiency and with one vertebral fragility fracture ? MHT or biphosphonates ?	HRT will give the best yield as it will also act against the other hypo-estrogenic conditions. BP's will work great but only for bone
Can long term Inhaled corticosteroid use cause osteoporosis	no
If you have had the max recommended Z acid treatments (5 doses over several years) and then go onto Denosumab - but find significant side effects and have to stop - can you do additional Z acid treatment to stop the bone loss.	Zol should be interrupted after a 3-year cycle but can be recommenced after the 2-3 year holiday. If used in this way, there is no limit on total Zol infusions
Would a stress fracture from long distance running be considered a 'fragility fracture', given that stress fractures are common among marathon runners? This is if osteopenia is present,	I must admit that I personally see very few stress fractures. As I understand it the cause of stress fractures are generally mechanical in origin and not related to low BMD as we would expect in someone who does regular weight bearing exercise . Treatment is generally rehabilitation by sports science persons and does not involve any of the bone specific medications that we have discussed. Be aware though that they may have exercise induced hypothalamic hypo-gonadothropic amenorrhea that will need a different approach.