



# STOP performing DXA scans in healthy, perimenopausal women

# START counseling all women on lifestyle interventions to avoid fractures

## ► EXPERT COMMENTARY



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## CASE Premature treatment for osteopenia

A 57-year-old woman presents to establish care and discuss concerns related to menopause and osteoporosis management. She is G2P2, healthy, 5 ft 6 in, and 130 lb. She underwent natural menopause at age 51; her vasomotor symptoms have been mild, and she has not used hormone therapy. Upon annual physical examination at age 52, her former physician referred her for a mammogram, bone-density assessment, and colonoscopy. Osteopenia (femoral neck T-score,  $-1.8$ ) was noted on dual-energy x-ray absorptiometry (DXA), and alendronate 70 mg per week was started.

Today, she reports 6 months of worsening vaginal dryness. In addition, she mentions concerns about taking alendronate based on recent news reports describing serious potential adverse effects.

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## This patient is taking osteoporosis medication unnecessarily

**BMD screening was not indicated in this patient at age 52.** Schnatz and colleagues found that 41% of 612 women who had been referred for and underwent DXA screening did not meet the criteria for such screening, according to the 2006 Osteoporosis Position Statement of The North American Menopause Society.<sup>1</sup> In addition, nearly 18% of those women who underwent DXA screening without the proper indications for it were being treated for osteopenia or osteoporosis with a bisphosphonate, raloxifene, or calcitonin therapy.

**These groups should be screened for BMD<sup>2-4</sup>:**

- women aged 65 and older
- women younger than age 65 who are at high risk for fracture
- adults with fracture after age 50
- adults with a medical condition or who are taking a medication that is associated with low bone mass.

**Bone-health treatment was not indicated in this patient at age 52.** The World Health Organization's fracture risk assessment tool (FRAX) indicated that the patient's risk of having a major osteoporotic fracture in the next 10 years was 5.4%, and her calculated risk of hip fracture in the next 10 years was 0.5% (FIGURE, page 34). Relying on both the patient's T-score and FRAX results, alendronate

## FAST TRACK

Many patients not indicated to undergo BMD screening are tested anyway; many are medicated without proper cause



### FRAX calculation tool



while preserving bone density and fracture risk reduction in patients at low risk for fracture. In patients at high risk for fracture, the 1- to 2-year drug holiday should occur after 10 years of bisphosphonate treatment.<sup>5,6</sup>

### Your patient's lifestyle can help her avoid fracture. Tell her.

Counsel your patients to **exercise** (30 to 45 minutes per day of weight-bearing exercise), **limit their alcohol** intake, and ensure adequate **calcium** and **vitamin D** intake. Food sources, rather than supplement sources, of calcium are better for bone health. The total daily calcium and vitamin D intake for women should be<sup>7-10</sup>:

- Calcium: Age older than 50 years = 1200 mg/d
- Vitamin D: Until age 70 = 600 IU/d; after age 70 = 800 IU/d. 🔄

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therapy should not have been initiated. **These groups meet the criteria for treatment with a prescription medication according to FRAX results<sup>4</sup>:**

- >20% risk of major osteoporotic fracture in next 10 years
- >3% risk of hip fracture in the next 10 years.

#### What now?

This patient is at low risk for osteoporosis. With an estimated rate of bone loss of 0.5% per year, over the next 8 years (from age 57 to age 65), she is unlikely to have osteoporosis at age 65. Therefore, her **next BMD screening should be when she reaches age 65**, according to current screening guidelines.<sup>4</sup>

**Treatment holiday.** Although bisphosphonate side effects, including esophageal irritation and osteonecrosis of the jaw and atypical femur fracture, are rare, it makes no sense for this patient to continue her bisphosphonate since its use was not indicated in the first place. Since bisphosphonates have been shown to accumulate in bone, their treatment effect can last up to 2 years after discontinuing therapy. Ceasing treatment for 1 to 2 years, after 3 to 5 years of continuous treatment, is a good option to minimize drug exposure and the risk of complications



**Counsel your patients to exercise, limit alcohol intake, and get enough calcium and vitamin D to limit fracture risk**