Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

When to start osteoporosis treatment

This guidance has been written to help support decision making when starting osteoporosis treatment.

Individuals at high risk of fracture will benefit from starting oral bone protective treatment. This can help reduce their future risk of fracture by up to 45%.

Our standard 1st line treatments are bisphosphonates, which include:

Alendronic acid 70mg once weekly (oral tablet) (TLS Green)

Risedronate 35mg once weekly (oral tablet) (TLS Blue)

Ibandronic acid 150mg once a month (oral tablet) (TLS Blue)

Please refer to the formulary for further information

If unable to tolerate an oral bisphosphonate, other oral options such as strontium ranelate and raloxifene can be considered after discussion with rheumatology team.

If oral options are not suitable then consider referral to secondary care for parenteral therapy.

Recommendation 1

Individuals (between ages 40 - 90) at high risk of fracture can be highlighted using a fracture risk assessment tool such as FRAX https://www.sheffield.ac.uk/FRAX/tool.aspx

National Osteoporosis Guideline Group (NOGG) guidance can then be used to decide if the patient is:

LOW RISK: reassure, give lifestyle advice, and reassess in 5 years or less depending on the clinical context.

INTERMEDIATE RISK: measure BMD and recalculate the fracture risk to determine whether an individual's risk lies above or below the intervention threshold.

HIGH RISK: can be considered for treatment without the need for BMD, although BMD measurement may sometimes be appropriate, particularly in younger postmenopausal women.

Recommendation 2

DXA results can be incorporated into FRAX to refine fracture risk.

If an individual has a risk >20% for a major osteoporotic fracture **AND/OR** a risk >5% for a hip fracture, then consider starting treatment.

Approved at APMOC December 2023, Review December 2026

Recommendation 3

There will be some circumstances where FRAX may underestimate an individual's fracture risk:

- Recent history of low impact hip or vertebral fracture
- High dose glucocorticoids

It may be reasonable to start treatment for such patients prior to DXA or alternatively seek advice from your local rheumatology service.

- Low spinal bone mineral density and additional risk factors

FRAX risk is based upon BMD at the femoral neck. Some patients will have significant differences in their hip and spine values. Treatment can be considered in patients with low spinal BMD and other risk factors even if FRAX is not in the high risk zone.

Recommendation 4

Decision making regarding treatment for younger patients (pre-menopausal women and men <50) can be more difficult. We would not routinely recommend treatment for younger patients unless they have significant risk factors that may adversely affect their bone health e.g. recurrent fractures, high dose steroids. In these circumstances we would recommend seeking advice from your local rheumatology service.