Thematic report 'Gaps and solutions in bone health: A global framework for improvement'

Clinical commentary from Osteoporosis New Zealand

A number of medicines which play a critical role in managing other diseases can have an adverse effect on bone health. Common examples include:

- corticosteroids
- gonadotropin-releasing hormone agonists (GnRH)
- aromatase inhibitors.

Given the use of corticosteroids in the management of many chronic medical and rheumatological conditions, it is no surprise they are the leading cause of secondary osteoporosis.

With regard to bone health and prostate cancer, men treated with GnRHs experience higher rates of any clinical fracture, vertebral fractures and hip/femur fractures. Aromatase inhibitors currently represent the gold standard adjuvant treatment for post-menopausal women with hormone receptor-positive breast cancer. Women taking AIs experience elevated rates of bone loss compared to healthy post-menopausal women.

The World Osteoporosis Day report highlights a plethora of guidelines relating to the management of osteoporosis for people who take these medicines.

Many diseases predispose an individual to lose bone mass and/or suffer fragility fractures, including autoimmune, digestive and gastrointestinal, endocrine and hormonal, haematological, neurological, mental illness, cancer and AIDS/HIV.

The report summarises what is known about osteoporosis and fracture incidence for several common disorders. Where clinical guidelines are available in the context of the particular disorder, these are highlighted. Where guidance is not currently available, a call to action is made for its development.

Clearly, for any approach to chronic disease management to be effective, patients must be fully engaged to initiate a programme of care in the first place, and adhere to a plan of care in the long term. In this regard, a number of studies suggest that awareness of osteoporosis and associated fracture risk is low in many countries. As with other chronic conditions, such as hypertension or hypercholesterolaemia, adherence to osteoporosis treatment is reported to be low in routine clinical practice. Strategies to overcome these challenges are considered.

Significant progress has been made in New Zealand in recent years. In 2012, Osteoporosis New Zealand published *BoneCare 2020*, which called for a multi-sector effort to develop and implement a systematic approach to hip fracture care and prevention for New Zealand.

The Australian and New Zealand Hip Fracture Registry (ANZHFR) is now established and clinical standards for Fracture Liaison Services (FLS) were recently published and endorsed by 15 leading organisations, including ACC and the Commission. More information can be found on the ANZHFR website http://anzhfr.org/.

In July, ACC announced a major investment aimed at reducing the number of falls and fractures older people suffer. The Australian Commission on Safety and Quality in Health Care (the Australian Commission) developed a clinical care standard for hip fracture care. The Commission in New Zealand worked in partnership with the Australian Commission to support the consultation process and was pleased to support the final document which was

published in September. More information is available here https://www.safetyandquality.gov.au/our-work/clinical-care-standards/hip-fracture-care-clinical-care-standard/.

Health professionals play a vital role in reducing the burden that osteoporosis, falls and fractures imposes upon our older people, their friends and family, and our health and social care budgets.

We encourage you all to read more about World Osteoporosis Day at www.osteoporosis.org.nz and implement its recommendations in your practice.