

PODCAST SERIES: Bare Bones: A Practical Osteoporosis Overview

Podcast 1: A Call To Action: Identifying Patients At High Risk For Osteoporosis

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Edited slightly for readability.

Christine Palmay

Welcome to this podcast series entitled, "***Bare Bones: A Practical Osteoporosis Overview,***" hosted on MDListen. This podcast series was developed by the Canadian Collaborative Research Network and is accredited. There are four podcasts in this series, each worth 0.25 Mainpro+ credits. When you complete all four podcasts, you will be eligible to claim one (1) full [Mainpro+] credit.

My name is Dr. Christine Palmay and I am delighted to be your host. Today's podcast is entitled, "**A Call to Action: Identifying Patients at High Risk for Osteoporosis.**" This is the first podcast in the series and focuses on the following learning objectives. Number one: Define the epidemiology of osteoporosis and explain the impact of fracture on quality of life; Number two: Identify appropriate screening and diagnostic testing; and Number three: Discuss guideline-based stratification of high-risk and very high-risk patients.

This program received financial support from Amgen and the planning committee took all steps necessary to mitigate potential biases. Our faculty disclosures along with other relevant information are all available on the MDLearn website under the MDListen tab. From here you can also download a handout with key messages from this session. It is my pleasure to be discussing this topic today with my colleague and excellent friend, Dr. Jonathan [Derrick] Adachi. Dr. Adachi is a rheumatologist in Hamilton, Ontario, and Professor Emeritus at St. Joseph's Healthcare [System], McMaster University, also in Hamilton. Rick, welcome.

Rick Adachi

Thank you so much. Pleasure to be here.

Christine Palmay

Delighted to have you. With our limited time, let's dive in. I just want to step back a bit and define the epidemiology of osteoporosis and explain why we are highlighting this condition and the impact of fracture on a patient's quality of life.

Rick Adachi

Osteoporosis is a common disorder associated with fractures, affecting more individuals than the combination of heart disease, stroke, and breast cancer. These fractures are associated with pain, suffering, loss of mobility and independence, leading to frailty, institutionalization, and for some, an increase in the risk of dying.

Christine Palmay

Yes, absolutely. I think that putting things into context; there is a discord between patient's ability to appreciate a fall, leading to a fracture, leading to severe health outcomes. You get this push back, "Well, Dr. Palmay, if you had fallen, you would have broken a bone too." So, having that contextual conversation is absolutely necessary. So, when a patient's in our office, how are we screening them? What diagnostic testing are we using?

Rick Adachi

There are many tools available to help with fracture-risk assessment, they include [Fracture Risk Assessment Tool] FRAX, and in Canada, [Canadian Association of Radiologists Osteoporosis Canada] CAROC. Unfortunately, in a recent audit, it is found that only around 10% of physicians use these tools. As a result, many of those who might benefit from therapy are never identified. To simplify identification, there are three factors that are important in determining fracture risk. And these are the three factors that I use in trying to assess who might benefit from therapy. The first is age >65 years. This is when people are considered seniors. The second is a [bone mineral density] BMD less than -2.5, at the spine or hip—his is the pragmatic definition of osteoporosis. And the third and most important factor is prior fracture, with those who've had a fracture within the past 2 years at greatest risk for future fracture. All fractures are important, with hip and vertebral fractures the most important.

Christine Palmay

There's an art in not only an excellent history, but asking no very specific questions: Have you fractured, yes or no? And I think in a system now when we are catching up to get ahead, everything's backlogged, we're forgetting to include osteoporosis screening. So, for our primary care audience—exceptionally busy, likely overwhelmed, and extremely fatigued—can you give some tips for some clinical interventions that we can do, or incorporate on a regular basis so these patients aren't missed?

Rick Adachi

I think that the single most important thing is to really just ask about fractures—have you had a fracture? 'Cause that's the thing that's going to point you in a direction in terms of therapy. So, if you've got somebody who's had a fracture, if their T score is less than -2.5 on testing—and we're going to be testing these people who've had fractures—and if they're over the age of 65

[years], this is going to help us to identify those who might benefit from anabolic therapy, for example, or antiresorptive therapy.

Christine Palmay

Now, let's talk about the bone mineral density test; obviously, everybody's aware of this. How are you using it? And is it absolutely necessary for every patient to make that diagnosis?

Rick Adachi

No, I think you ask a really very pragmatic question. So, if somebody's had a hip fracture, or if somebody's had multiple vertebral fractures, you really don't need to use a BMD to identify who might benefit from treatment. Indeed, these are patients who would benefit from treatment. I do use BMD though, in those who are 65 years of age or older, as a means of identifying those who might also benefit from treatment. So, if you've got somebody who's aged greater than 65 [years] and a BMD T-score of less than -2.5, those two simple things identify those who are at greater risk of fracturing. These are patients who would benefit from treatment as well.

Christine Palmay

Absolutely. So, I think the Gestalt point is that while a BMD is important, it's not the 'Holy Grail'; you have to look at the whole clinical picture. We've spoken quite a bit in the other podcasts about challenges and barriers to treatment. From your perspective, why is there, number one, a gap in care, and what are some ongoing challenges that you see clinically that prevent a patient from actually receiving the appropriate treatment?

Rick Adachi

Again, a great question. I think that a lot of this comes down to the fact that people don't understand that fractures have different implications for people who are older. When we think about fractures, we think about the days when we were younger, fall, break a wrist, and you get better. On the other hand, with older individuals, that's not the case. Even simple fractures, like a wrist fracture, a fracture of the shoulder, fractures of the tibia—they do get better, but they take time, and they take a toll on a patient. So, patients, as they get older, aren't as active, they do become frail, and we've shown that with each fracture, these people who are pre-frail, become frail. With a second fracture, virtually everybody becomes frail. It's that fact that people forget and as a result, they oftentimes decline therapy. And as you say, "you know, Doc, if you had a fall in the way I did, you would have fractured as well." I think that there's that misconception. Then, once we get people who've had these fractures—as clinicians, it's important for us to take the time to explain why we want to treat and with what we're going to treat.

Christine Palmay

Absolutely. Since this podcast is focusing on those exceptionally high-risk patients, if you could just briefly summarize stratification; we have high risk, and now newly so, high, high risk, so super high risk. Number one, how are you identifying? And maybe delineate treatment options that are different for those different groups.

Rick Adachi

Right, we stratify high-risk patients into high risk or very high risk with imminent risk of fracturing. Perhaps the key identifiers are a recent fracture, particularly of the hip or spine, but any fracture identifies those at very high risk and age >65 [years], or a BMD less than -2.5, in conjunction with a fracture, identifies those at very high risk for fracturing. Those who've not had a fracture but are older than age 65 [years] and who've had a BMD less than -2.5, they would be considered high risk. Why is this important? Well, it's important because the very high-risk or the imminent-risk patient is the patient who would probably benefit from an anabolic therapy of drug that builds new bone. On the other hand, those who are less likely to fracture but still high risk, they would be suited for antiresorptive therapy.

Christine Palmay

I think that one of the call-to-action points from this podcast is not only patient education, but as primary care physicians, really honing in on those patients most at risk. We do that for other disease states; hopefully, this is a way to provide treatments for our patients who are really at imminent risk for falls and the subsequent disaster of health consequences that ensue. Rick, can you just provide our listeners with some words of wisdom, some parting words, to take back to clinics, when that new patient shows up?

Rick Adachi

So, three things to take home: Fractures are common, and they may have devastating consequences; a recent fracture identifies those at greatest risk for fracture; and new effective therapy is available to prevent fractures, in particular, for those who are at very high risk or at imminent risk for fracture.

Christine Palmay

So obviously, I needed to diagnose osteoporosis across the spectrum, but I should identify our patients who are in those higher risk categories. Dr. Adachi, Rick, thank you so much for sharing your expertise and your wisdom with us. Just a reminder to our listeners that following the podcast, we asked you to complete the brief reflection and evaluation survey. The survey will open on your screen as the podcast ends. Following this you will receive a certificate of participation sent via email. And finally, another reminder that this recording is part of a four-part series centered on the topic of osteoporosis management in primary care. Please listen to the other podcasts to earn your one (1) full Mainpro+ credit.