Improved management of patients with osteoporosis

To the Editor: We commend Professor Davey’s pleas\(^1\) for greater awareness and improved management of patients suffering from osteoporosis or osteopenia and those with fragility fractures, particularly the elderly.

We contend that this disease is not optimally managed locally and is often still regarded as an inevitable part of the ageing process, not amenable to treatment. The facts that 20% of hip fracture victims die within one year of the event and that less than 50% are capable of leading an independent life are often ignored. Moreover, the fact that fracture risk can be halved when lifestyle measures and appropriate bone-active drugs are employed also seems to go unrecognised. The National Osteoporosis Foundation South Africa (NOFSA) published a guideline on the diagnosis and management of osteoporosis in 2010 that is available in print and also freely available on our website, either as a full guideline or an executive summary.\(^2\)

Unfortunately, osteoporosis medication is still not freely available to sufferers from this common disease, which affects one out of every four postmenopausal women and 20% of elderly men. The essential drugs list (EDL) published in June 2012\(^3\) suggests that only patients with a bone mineral density (BMD) T-score of -2.5 standard deviations plus a fracture should be considered for treatment with bone-active medication. This is analogous to recommending that you should first have a stroke before your hypertension is eligible for treatment, or have a myocardial infarction before your dyslipidaemia is deserving of a statin! Clearly these EDL recommendations are embarrassingly out of touch with reality. There also appear to be regional differences in the availability of bone-active drugs in the public sector which is particularly problematic in the Western Cape, where NOFSA is frequently approached by patients and doctors unable to obtain justifiable osteoporosis treatment from a clinic or hospital. Moreover, unlike other provinces where access to modern intravenous bisphosphonates, strontium ranelate and even teriparatide can be made available – Cape are ‘fortunate’ when daily generic alendronate is made available – other chronic non-communicable diseases. Patients are requested to make co-payments and the doctor’s ability to prescribe a particular drug is often severely limited, regardless of motivation and good scientific evidence of benefit.

Several new osteoporosis drugs, ranging from specific monoclonal antibodies against RANKL (e.g. denosumab, already launched elsewhere)\(^*\) to inhibitors of cathepsin K (e.g. odanacatib)\(^6\) to potent bone formation stimulating agents (e.g. anti-sclerostin antibodies)\(^7\) will hit our markets in the foreseeable future, resulting in what Professor Davey terms “… widening the therapeutic horizons”. Although it might be a while before we have access to these exciting agents, it is NOFSA’s firm belief that every effort should be made to provide sufferers from this crippling disease rightful access to available effective therapy, in both the private and the public sectors.

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