Transcript Details

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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Osteoporosis in Postmenopausal Women: Sequencing Strategies and Challenges

Announcer:
You're listening to *On the Frontlines of Osteoporosis* on ReachMD. On this episode, we'll hear from Dr. Felicia Cosman, who's a Professor of Medicine at Columbia University and a co-author of a recent study that focused on sequencing osteoporosis treatment in postmenopausal women. Here's Dr. Cosman now.

Dr. Cosman:
The main objective of our literature review was to focus on how we sequence osteoporosis treatment in postmenopausal women. When osteoporosis medications are stopped, bone loss occurs, and this can be rapid. In some cases, for example, when denosumab is stopped, the bone loss can be particularly rapid, or the bone loss might be very slow after stopping, and that's the case with discontinuation of bisphosphonate treatments, especially after intravenous zoledronic acid. That's why we really can only consider a medication holiday in patients who've been on a bisphosphonate. And in the case of all other medications, we need to sequence to a different therapy.

The second key point is that for women who have mild osteoporosis or even osteopenia with bone density very close to osteoporosis range and no fractures, we can use antiresorptive medications in a logical order, usually beginning with estrogens in women early after menopause, followed by something like raloxifene subsequently. And then later in life, mid-60s and beyond, maybe switch to bisphosphonates, and those bisphosphonates can be used intermittently with pauses in the medicine.

We also highlighted in the paper some of the medication transitions that are particularly challenging. I think one of the most important is discontinuing denosumab because when denosumab is stopped, there's a pretty marked increase in the rate of bone remodeling. Bone turnover markers go up dramatically, and that's associated with rapid bone loss and an increased risk of multiple vertebral fractures. And the risk of these is higher in patients who've been on denosumab for longer periods of time—three or more years, for example—and also the risk is higher in people who have had vertebral fractures before, and that even includes vertebral fractures that were asymptomatic and found only on an x-ray. And I think that's why it's very good management to check a thoracic and lumbar spine x-ray—lateral is all that's needed—in all patients who are being considered for stopping denosumab to determine if there are any fractures present. Patients who have fractures and also women who've been on long-term denosumab treatment at the time that discontinuation is being considered need particularly careful management after stopping.

Another area of the paper was the importance of treatment sequence involving anabolic agents—the bone-building medications romosozumab, teriparatide, and abaloparatide. For women who present at very high risk because of recent fractures or because of multiple fractures, women who have fractures and T scores below -2.5—so below the osteoporosis range—or even women who have very low BMD without a fracture history, the best strategy is to treat with an anabolic agent first, followed by an antiresorptive, and this will provide the best fracture risk reduction and the best gain in bone density.

Announcer:
That was Dr. Felicia Cosman talking about osteoporosis treatment sequencing in postmenopausal women. To access this and other episodes in our series, visit *On the Frontlines of Osteoporosis* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!