Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/frontlines-osteoporosis/treating-osteoporosis-in-elderly-patients-with-high-fall-risk/32337/

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Treating Osteoporosis in Elderly Patients with High Fall Risk

Announcer:
You're listening to *On the Frontlines of Osteoporosis* on ReachMD. On this episode, we'll hear from Dr. Cathleen Colón-Emeric, who's not only the Associate Dean for Research Mentoring, a Professor of Medicine, and the Chief of the Division of Geriatrics at the Duke Center for the Study of Aging and Human Development, but she's also a research physician at the Geriatric Research Education and Clinical Center at the Durham Veterans Administration. She'll be sharing her recommendations for assessing fall and fracture risk in elderly patients and those in long-term care. Here's Dr. Colón-Emeric now.

Dr. Colón-Emeric:
90 percent of fractures occur after a fall, so understanding that fall risk is a really critical part of deciding who warrants treatment and who doesn't. So the most widely used free fracture risk algorithm, which is called FRAX, is a tool available online that actually does not include fall history as part of the algorithm. This has been criticized by a lot of folks, and so there is a new version that does include history of falls, but unfortunately, that's only available for a fee. FRAX also doesn't include lots of other risk factors that geriatricians know increase fall risk: people with Parkinson's disease, people with prior stroke, people with dementia or on multiple fall risk increasing drugs, and so forth.

So I always advise folks to do a little bit of a geriatric adjustment to the estimate that you get from FRAX. If I have someone who's falling frequently in the past or I know to be at high fall risk based on their other risk factors, even if they're a little bit under that 20 percent major osteoporotic fracture threshold or the 3 percent hip fracture threshold, I'll likely offer them treatment anyway because I know that that FRAX estimate is probably underestimating their true risk of fracture.

Now these are situations where we don't have a lot of current randomized control trial evidence and current guidelines don't really address it clearly. So I often get questions about this from folks on the front line. First question I get both from patients and from clinicians is: when are you too old to consider screening and treatment for osteoporosis? It's important to remember that fracture risk really continues to increase exponentially as we get older, really throughout the ninth decade until folks are no longer ambulatory, and then it starts to drop off again. So if we're going to be targeting the people at the highest risk for fracture with fracture prevention therapies, it's really the folks in the 8th and 9th decade that we want to really focus on.

The next question we have to think about is: what's the lag time to benefit when we start treating osteoporosis and when we start seeing a reduction in that fracture risk? It's on the range of 6 to 12 months before we start seeing a benefit.

And then finally, we have very good evidence from meta-analyses that the drugs that we use to treat osteoporosis work equally well at older age with a similar risk reduction in fractures and actually a higher absolute risk reduction than in younger ages, again, because of the higher absolute risk of fracture. We don't see an increased risk of adverse events with osteoporosis medications with age. So with all of those things in mind, I actually continue to screen and treat people who are ambulatory really regardless of their age so long as their life expectancy is two years or more and it's consistent with their goals of care.

Long term care or nursing facility residents: this is another area I get a lot of questions about because people say, well, we just don't have the clinical trial evidence to show that it reduces fractures in that population. Nevertheless, we actually do have reasonable evidence from randomized control trials conducted in assisted living and nursing facilities that these drugs work just as well at improving bone mineral density and improving bone turnover markers as they do in community-dwelling older adults. And there's really no biologic reason to think they wouldn't have the same reduction in fracture rates.

So really, for nursing facility residents, it becomes more of a question of selecting the people who are likely to live long enough to benefit

from treatment. Unlike community dwellers, it's really the healthy, most mobile subset of folks in the nursing facility who are at higher risk for fracture, not the frailest like it is in the community. So those are the folks that I really target. I will typically offer treatment to folks who have any of the major osteoporotic fractures, the big six: hip, vertebral, wrist, humerus, femur, and pelvis. I'll offer them treatment even if I don't have a bone mineral density because I know they're high risk given their age and prior fracture.

As a geriatrician, I also want to make sure that we think about deprescribing. When is it time to back away and stop therapy in older adults? Bisphosphonates, in particular, that we use to treat osteoporosis have this very interesting property with a very long half life in bones, so they continue to reduce fracture risk for one to two years after stopping them.

So at some point when folks are no longer ambulatory, when they have a life expectancy that's two years or less, and it's no longer consistent with their goals of care, it absolutely is time to consider deprescribing these medications as well. And that's another important consideration for the older population and particularly those in nursing facilities.

Announcer:
That was Dr. Cathleen Colón-Emeric discussing recommendations for assessing fall and fracture risk in elderly patients. 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!