NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Osteoporosis Secondary Prevention Quick Reference Guide for postmenopausal women and men >50y old (January 2018)

Key Points

- This medicines pathway ensures that postmenopausal women and men aged > 50 years receive appropriate treatment according to their risk factors.
- Patients who have received treatment according to the pathway but are unable to tolerate these or the medication is contraindicated; referral can be made to your local rheumatology service (see checklist).

DXA /FRAX/fragility fracture history (Patients who present with, or have had recurrent falls in the past year, or demonstrate abnormalities of gait and /or balance should be offered a risk assessment)

No fracture, Lowest T-score > -2 and FRAX score low <15%

Lowest T-score -2 to -2.5 and/or FRAX >20%

Lowest T-score < -2.5 OR DXA inappropriate OR Current steroids planned for > 3 months

General guidance, weight-bearing exercise (tailored to the individual), smoking cessation, alcohol moderation, ensure calcium and vitamin D replete

BLOOD INVESTIGATIONS:
Bone profile (serum calcium, phosphate, ALP, Albumin, 25OH vitamin D), Renal profile, ALT/ AST, FBC, ESR, TSH
(Blood and urine protein electrophoresis for patients with previous fracture with T-score <-2.5 (consider if T<-2.5))

Previous fragility fracture

No → **Repeat BMD in 3-5 years or sooner if further fracture**

Yes → **Ensure calcium and vitamin D replete**

ALENDRONATE (for 5 years)

Check for swallowing, dyspepsia, ulcer
Do not use if eGFR< 35ml/min
Discuss administration /compliance
Discuss potential side effects

Review adherence at 3 months (is the patient taking every dose and taking it correctly)?

No → Intolerance/contraindicated:

- Hypersensitivity to alendronate or to any of the excipients.
- Abnormalities of the oesophagus and other factors which delay oesophageal emptying, e.g. stricture or achalasia.
- Inability to stand or sit upright for at least 30 minutes.
- Hypocalcaemia.

Yes → See Page 2

Non-adherent

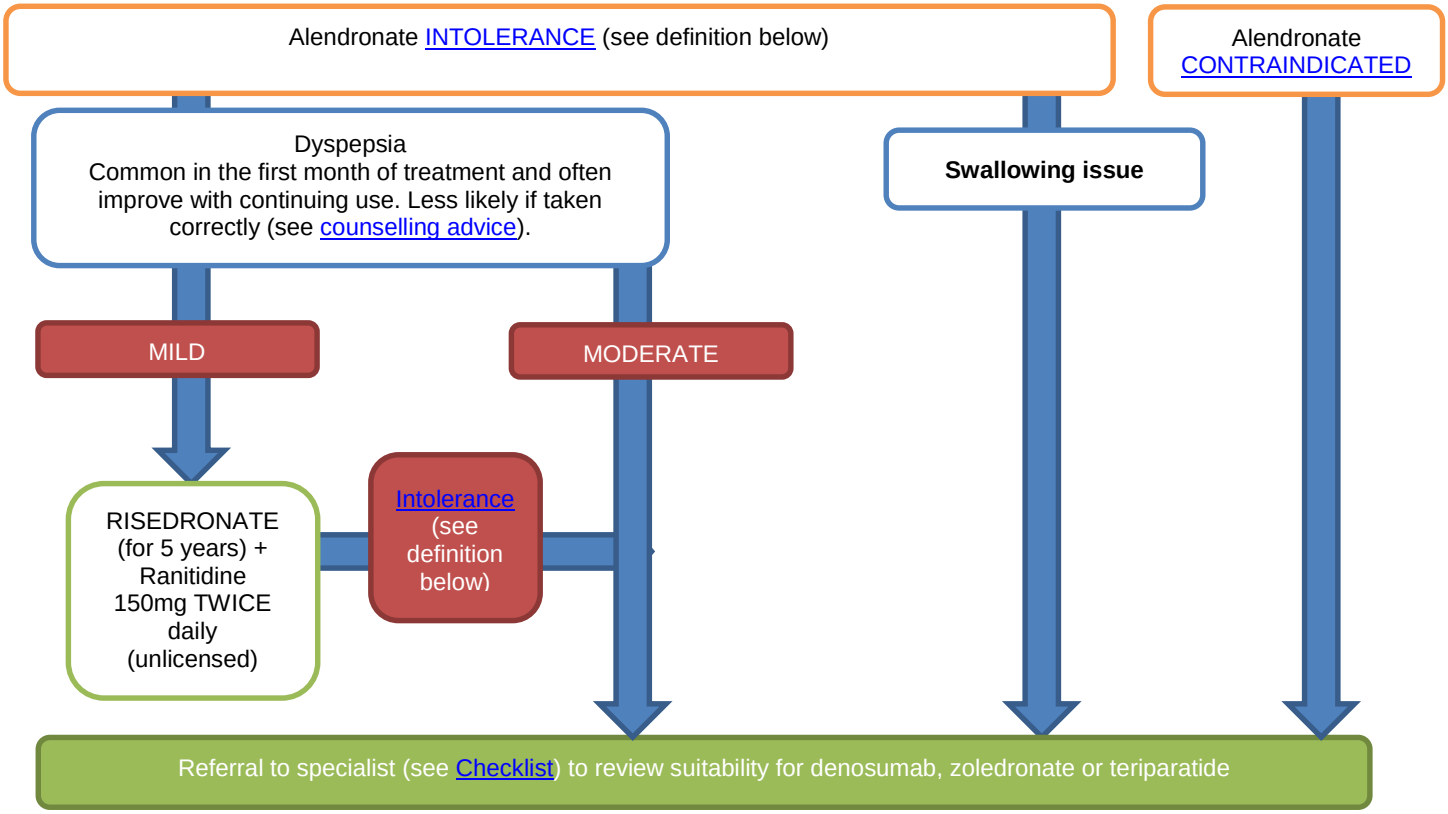
Re-education and additional patient support

Non-adherent after further 3 months

Risk assess need for treatment

Benefit of treating outweighed by poor adherence / side effects

Treat as intolerant (see Page 2)



INTOLERANCE is defined as persistent upper gastrointestinal disturbance that is sufficiently severe to warrant discontinuation of treatment, and that occurs even though the instructions for administration have been followed correctly (NICE TA161).

Counselling advice for oral bisphosphonate

Alendronate

- Swallow whole with a full glass of water while sitting or standing
- Take on an empty stomach at least 30 minutes (ideally ONE hour) before breakfast (or another oral medicine)
- Do not lie down for at least 30 minutes (ideally ONE hour) after taking tablet.
- DO NOT take calcium and vitamin D supplement on the same day as alendronate.

Risedronate

- Swallow whole with a full glass of water while sitting or standing
- Take on an empty stomach at least 30 minutes (ideally ONE hour) before breakfast (or another oral medicine) OR if taking at any other time of the day, avoid food and drink for at least 2 hours before or after risedronate (particularly avoid calcium-containing products e.g. milk; also avoid iron and mineral supplements and antacids)
- Do not lie down for at least 30 minutes (ideally ONE hour); do not take tablets at bedtime or before rising
- DO NOT take calcium and vitamin D supplement on the same day as risedronate.

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	Postmenopausal women and men (>50 years)	Postmenopausal women and men (> 50 years)
Drug	**PRIMARY CARE**	**SPECIALIST ADVICE (Local Enhanced Scheme)**
Preferred choice	**Women only:** Alendronate (oral) 70mg once WEEKLY **Women or men:** ALENDRONATE 10mg once daily	Denosumab (subcutaneous) 60mg every 6 MONTHS (NICE TA204 for postmenopausal women)
PLUS	Calcium and vitamin D3 supplementation	Calcium and vitamin D3 supplementation
		HOSPITAL ONLY
Alternative choices	Risedronate (oral) 35mg once WEEKLY	Zoledronate acid (intravenous) 5mg once YEARLY
PLUS	Calcium and vitamin D3 supplementation	Calcium and vitamin D3 supplementation
Alternative choices		Teriparatide (sub-cutaneous) 20 micrograms once DAILY (Women:(TA161): via Group Prior Approval) (Men : IFR application through NHSE)
PLUS		Calcium and vitamin D3 supplementation

Patient should **NOT** take calcium and vitamin D3 supplementation on the same day as oral bisphosphonate
N.B. Etidronate and raloxifene are alternative options for postmenopausal women as per NICE TA161

Calcium and vitamin D3 supplementation	PRIMARY CARE Licensed doses	
Self-Care	**Those at risk of osteoporosis should maintain an adequate intake of calcium and vitamin D and any deficiency should be corrected by increasing dietary intake as a first line treatment or taking supplements which can be purchased over the counter where he patient is willing and able.**	
Chewable	**Accrete D3 One a Day 1000 mg / 880 IU Chewable Tablets** (Calcium 1000mg + colecalciferol 22micrograms (880 IU)) **ONE chewable tablet ONCE daily** N.B. Patients should not take calcium and vitamin D3 supplementation on the same day as oral bisphosphonate	**Evacal D3 1500 mg/400 IU Chewable Tablets** (Calcium 600 mg + colecalciferol 10 micrograms (400 IU)) **ONE tablet TWICE a day (morning and evening)** N.B. Patients should not take calcium and vitamin D3 supplementation on the same day as oral bisphosphonate
Tablets / Sachets	**Accrete D3 film-coated tablets** (Calcium 600mg + colecalciferol 10 micrograms (400 units)) **ONE tablet TWICE a day (morning and evening)** N.B. Patients should not take calcium and vitamin D3 supplementation on the same day as oral bisphosphonate	**Calfovit D3 1200 mg/ 800 IU powder for oral suspension** (Calcium 1200mg + colecalciferol 20 micrograms (800 units)) **ONE sachet ONCE daily** N.B. Patients should not take calcium and vitamin D3 supplementation on the same day as oral bisphosphonate

References

1. NICE. Osteoporosis: assessing the risk of fragility fracture (CG146); August 2012. Accessed 16.04.15 via https://www.nice.org.uk/guidance/cg146
2. NICE. Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women (amended) (TA16); October 2008. Accessed 16.04.15 via http://www.nice.org.uk/guidance/ta160
3. National Institute for Health and Clinical Excellence (NICE). Clinical Knowledge Summaries (CKS) – Osteoporosis - prevention of fragility fractures. Last revised September 2013. Accessed 16.04.15 via http://cks.nice.org.uk
4. SIGN. Management of osteoporosis and the prevention of fragility fractures (142); March 2015. Accessed 16.04.15 via http://www.sign.ac.uk/pdf/SIGN142.pdf
5. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press; April 2015. Accessed 16.04.15 via http://www.medicinescomplete.com
6. Summary of Product Characteristics. Accessed 18.01.18 via http://www.medicines.org.uk/emc/

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Referral criteria to Rheumatology

The secondary prevention of osteoporosis for postmenopausal women and men (> 50 years) can be effectively managed in primary care. The CCG has agreed that the secondary prevention of osteoporosis for postmenopausal women and men (> 50 years) in primary care will be in line with the outlined pathway.

Please complete sections 1 and 2 of the following check list prior to referring patients to rheumatology services. Please attach this checklist to your specialist referral letter providing information regarding previous treatments of the patient.

Practice name:

Patient name: NHS Number:

	Medicines Pathway Treatment		
1	**ALENDRONATE (at least one response must be yes)**	**Yes**	**No**
a	The patient has been prescribed alendronate for at least 6 months but the benefit of treating outweighed by poor adherence / side effects.	If Y, go to 2	
b	The patient has been prescribed alendronate for at least 6 months but is not tolerated.	If Y, go to 2	
c	The patient cannot be prescribed alendronate because it is contraindicated.	If Y, go to 3	
d	The patient has been prescribed alendronate and has developed upper oesophageal pathology such as stricture or achalasia.	If Y, go to 3	
2	**RISEDRONATE (at least one response must be yes)**	**Yes**	**No**
a	The patient has been prescribed risedronate for at least 6 months but the benefit of treating outweighed by poor adherence / side effects.	If Y, go to 3	
b	The patient has been prescribed risedronate for at least 6 months but is not tolerated.	If Y, go to 3	
c	The patient cannot be risedronate because it is contraindicated.	If Y, go to 3	
d	The patient has been prescribed alendronate and has developed upper oesophageal pathology such as stricture or achalasia.	If Y, go to 3	
3	**I am referring this patient for a review by the Rheumatology Service** **Signature:** **Date:**		

Produced by the Medicines Management team, C&P CCG May 2015, minor update January 2018