Osteoporosis prophylaxis for glucocorticoid-treated patients

Consider osteoporosis risk in all patients treated with glucocorticoids

Oral prednisolone at any dose likely to continue for 3 months +

- <65 years
  - Adcal D3 two caplets bd
  - Refer for fracture risk assessment as GC treatment started
- >65 years and postmenopausal women with history of fragility fracture
  - Start osteoporosis prophylaxis
    - Risedronate 35 mg once a week and Adcal D3 two caplets bd
  - Refer for fracture risk assessment (DXA)
    - Unless clinical reason why inappropriate

IV glucocorticoids (+/- oral prednisolone) and not already taking oral bisphosphonate

High risk

- Men and women >65 years
- Postmenopausal women <65 with history of fragility fracture
- Men > 50 with history of fragility fracture
  - Oral colecalciferol 100 000 IU
  - IV zoledronic acid 5 mg over 15 min
  - Adcal D3 2 caplets bd
  - Refer for fracture risk assessment and decision about ongoing prophylaxis

Medium risk

- Postmenopausal women <65 years with no history of fragility fracture
- Men 50 to 65 years with no history of fragility fracture
  - Risedronate 35 mg once a week and Adcal D3 two caplets bd
  - Refer for fracture risk assessment and decision about ongoing prophylaxis

Low risk

- Premenopausal women
- Men <50
  - Adcal D3 caplets 2 bd
  - Refer for fracture risk assessment
Considerations

- Oral and IV bisphosphonate contraindicated in:
  - Hypocalcaemia
  - Untreated vitamin D deficiency
  - Renal impairment
    - eGFR <30 ml/min for risedronate or <35 ml/min for zoledronic acid
  - Discuss management with MBC

- Oral bisphosphonates contraindicated by
  - oesophageal stricture, Barratt’s oesophagus or moderate/severe symptoms of reflux

- Oral risedronate is poorly absorbed and must be taken:
  - At least 30 min before first food and drink of the day
  - With large glass of tap water
  - Patient should
    - Not lie down for at least 30 min after taking
    - Delay calcium supplements for >3 hours

- When referring to MBC for fracture risk assessment it is important to indicate if the patient has received treatment with IV zoledronic acid and/or high dose colecalciferol to avoid the risk of duplication

- Calcium and vitamin D supplementation should be prescribed to all patients receiving glucocorticoid therapy unless:
  - Contraindications, eg hypercalcaemia
  - There is no doubt that the patient is vitamin D replete and has an adequate dietary calcium intake

- Adcal D3 caplets which can be swallowed are generally better tolerated than chewable preparations – note that correct dose is 2 caplets bd

- Vitamin D should be measured and deficiency corrected prior to bisphosphonate therapy in any patients with risk factors for deficiency
  - www.sth.nhs.uk/metabolic-bone Information for healthcare professionals

- Rationale for risedronate rather than alendronic acid
  - There are slightly stronger data supporting the efficacy of risedronate in glucocorticoid-induced osteoporosis
  - As is the case for alendronic acid, risedronate is no longer under patent and is now available at low acquisition cost