

## Update of the Consensus on Osteoporosis of the Spanish Society of Rheumatology: A Lost Opportunity<sup>☆</sup>

### Actualización del Consenso de Osteoporosis de la Sociedad Española de Reumatología: una oportunidad perdida

To the Editor,

For some years we have experienced major conceptual changes in the field of osteoporosis. A better understanding of the epidemiology of fragility fractures, the identification of predictive risk factors and the safety of approved drugs, along with the marketing of new ones with more sophisticated mechanisms of action, have made a huge difference in addressing this disease in all countries. In this sense, the Spanish Society of Rheumatology has promoted the Osteoporosis Consensus update conducted in 2006 and published in the November issue of this journal<sup>1</sup> as a reference to assist in treatment decisions. We are the country that consumes the greatest number of drugs for osteoporosis<sup>2</sup> and incidence of hip fractures has not decreased in these years.<sup>3,4</sup> Therefore, developing a consensus document from our partnership with “explicit” recommendations based on the best available and/or “implied” evidence, supported by common sense and experience of the experts is an a priori necessary initiative and a unique opportunity to gain leadership in the knowledge and management of this condition.

However, the consensus document does not meet the expectations offered in its introduction and objectives, which is advertised as a consensus but becomes “corporate thinking” and end up in the discussion as an “update”. But if we go on reading the text, apart from terminological considerations (not least because it involves different methodologies) the uncertainty increases and the key issues on which recommendations are made are treated as shallow and contradictory.

By way of example, in the section on risk assessment it talks about high and moderate risk factors (Table 1). High risk of fracture is considered when there are 2 high risk factors, but at what age? Then FRAX is postulated as the most recommended tool for calculating the risk of fracture, considering more than 15% specific for osteoporosis fracture risk (densitometric?). The authors then suggest a high fracture risk profile of greater than 20%. Calculated with the FRAX or if not, what? It concludes with the recommendation for the use of FRAX when performing densitometry, or when establishing a treatment. Is it not the other way around?

As for densitometry (DEXA), the indication is still considered as a separate recommendation, when it should already be integrated in the assessment of risk.<sup>5</sup> Is the decrease in bone mineral density not a risk factor, with a known gradient of risk, covered in the FRAX?<sup>6</sup>

DEXA is recommended in early menopause as a first indication (considered by the panelists as a moderate risk factor), plus the presence of a major risk factor. Should we assume that smoking would also be another risk factor? The document

does not explain why this and not another “moderate” or referenced in the bibliography risk factor is chosen specifically. Finally, the vagueness of consensus regarding the request by the patient enough for the indication of DEXA is also striking, if not disturbing.

With regard to treatment, it not only indicates is indicted in densitometric osteoporosis, but it is also advised for treatment of young women with “intense” osteopenia and major risk factors. What treatment is approved for the new term of “intense” osteopenia?

Recommendations are established for first and second line drugs, but no criteria are specified in cases where performance is the same (Effectiveness? Security? Cost?), as well as in the case of drugs for prevention and/or treatment. It states that “Calcitonin can be administered preemptively...”, while “Raloxifene is recommended as a second line treatment...”. In all age groups? Why when calcitonin has shown that it offers no proven prevention compared to raloxifene?

I could go on and on, because the “new” Osteoporosis Consensus of the SER reflects corporate influence, but does not collect, nor even attempt to address the uncertainties that we face as rheumatologists every day in our practice. Far from achieving uniformity in the management of our patients, it invites variability and an “anything goes” attitude, especially in a specialty, with rigorous concerns and with a disease so prevalent.

## References

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<sup>☆</sup> Please cite this article as: Aguado Acín MP, Vázquez Díaz M. Actualización del Consenso de Osteoporosis de la Sociedad Española de Reumatología: una oportunidad perdida. *Reumatol Clin.* 2012;8:230.