Letters to the Editor

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This series is coordinated by Kenny Lin, MD, MPH, Associate Deputy Editor for AFP Online.

Expanding on Risk Factors and Response to Therapy for Osteoporosis

Original Article: Diagnosis and Management of Osteoporosis
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See additional reader comments at: http://www.aafp.org/afp/2015/0815/p261.html

TO THE EDITOR: Dr. Jeremiah and colleagues did an excellent job reviewing the basic issues related to the diagnosis and management of osteoporosis. However, three issues are more nuanced than indicated in the article.

First, caffeine intake does not increase fracture risk. The original study showing that more than 2.5 units of caffeine daily may increase the risk of fracture was published in 1990, and it commented that because caffeine use may be associated with other behavioral risk factors for fracture, the association may be indirect.1 Since that time, more rigorous studies have found no increased risk with caffeine intake.2 Tea consumption does not increase fracture risk3 and may even increase bone density.4

Second, an indication for denosumab (Prolia) therapy is for patients who have failed other osteoporotic therapies. The article, however, says the indication is for patients who did not improve with bisphosphonate therapy. Lack of improvement with bisphosphonate therapy has not been defined or studied. Bisphosphonates reduce fracture risk even if the bone mineral density does not improve or even decreases.5 Failure of other osteoporotic therapies would more likely be caused by inability to tolerate or unwillingness to comply with therapy.

Third, the need for or benefit of a repeat dual energy x-ray absorptiometry (DEXA) scan after starting treatment for osteoporosis has not been shown.6 No evidence-based answer exists for what to do with repeat DEXA results. Less expensive ways to assess medication nonadherence include asking the patient if he or she is taking the medication and monitoring whether the medication has been refilled.

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REFERENCES


IN REPPLY: We appreciate the thoughtful letter from Dr. Muncie. In reference to his point about caffeine intake and its possible impact on osteoporosis, we agree that this is a nuanced issue and that the literature is mixed. Dr. Muncie cites studies that did not show an increase in fracture risk with increased caffeine intake, although the largest study (n = 61,433 women) did show an increased incidence of osteoporosis.1 In contrast, a large study of postmenopausal women (n = 34,703) showed a modest increase in fracture risk associated with higher intake of caffeine.2 We suspect that there may be a dose-dependent effect that may also depend on genotype. Additional studies have suggested possible mechanisms of action.3,4 Future studies may clarify how to best guide our patients on caffeine intake with regard to osteoporosis.
Concerning the indications for denosumab use, we agree that “failure of other therapies” should include experiencing additional fractures while taking bisphosphonates or the inability to take any of the first-line medications.

Finally, regarding the need for follow-up DEXA screening after treatment initiation, we agree that benefit has not been shown and did not endorse this in our article. We did address the question of follow-up DEXA for screening purposes to diagnose osteoporosis if the previous study result was negative. This remains controversial, but we suggest an interval of four years between screenings based on referenced studies.

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