

AFP Clinical Answers

Osteoporosis, Childhood Bullying, Rheumatoid Arthritis, Diabetes Counseling, Inhaled Steroids

What therapies are recommended for osteoporosis?

According to the American College of Physicians, alendronate, risedronate, zoledronic acid, and denosumab reduce risk of hip, nonvertebral, and vertebral fracture in women with osteoporosis. Pharmacologic treatment should continue for five years. Hormone therapy with estrogen or estrogen/progestogen, or raloxifene should not be used to treat women with osteoporosis. Current evidence does not indicate benefit of bone mineral density monitoring during pharmacologic treatment.

<https://www.aafp.org/afp/2018/0301/p352.html>

How should childhood bullying be evaluated?

Physicians should ask about bullying when children present with multiple somatic problems, school avoidance, or incidents of self-harm. Questions about their online lives should be included in the history for children and adolescents. Patients who are being bullied or are identified as bullies should be screened for psychiatric comorbidities.

<https://www.aafp.org/afp/2018/0201/p187.html>

How should rheumatoid arthritis be treated?

Patients with rheumatoid arthritis should be treated as early as possible to have the best chance of remission. Methotrexate should be the first-line disease-modifying antirheumatic drug in patients with rheumatoid arthritis unless there are contraindications. Patients who are in remission from rheumatoid arthritis for more than six months and on stable medication regimens are candidates for tapering or discontinuing disease-modifying antirheumatic drugs or biologic treatment.

<https://www.aafp.org/afp/2018/0401/p455.html>

Does counseling by a diabetes educator improve A1C levels in patients with type 2 diabetes mellitus?

Counseling by a diabetes educator or a team of educators delivered in a variety of formats may reduce A1C levels by 0.2% to 0.8% compared with usual care alone. Diabetes educators should be considered for patients who have higher baseline A1C levels (8% to 9%) because this group had greater improvement in glycemic control after diabetes self-management education.

<https://www.aafp.org/afp/2018/0215/p269.html>

When taking an inhaled steroid and seeking better asthma control, should the steroid dose be increased or should a LABA/steroid combination be used?

In a Cochrane review, one in 73 patients in the long-acting beta agonist (LABA)/steroid group avoided a mild asthma attack (defined as requiring three to five days of oral steroids). However, adding a LABA did not reduce hospitalizations, deaths, or severe attacks. Adding a LABA also improved symptoms more than increasing the steroid dose, but at levels modest enough that asthma-related quality of life was unchanged. Two large reviews found that LABAs increase fatalities even when combined with steroids, suggesting approximately one in 1,400 patients will experience an asthma-related death. LABA/steroid combination therapy was designated as red (no benefits) according to the NNT Group rating system because of a small potential benefit of questionable clinical utility (avoiding a brief burst of oral steroids) and the possibility of a fatal harm.

<https://www.aafp.org/afp/2018/0301/od1.html>

Tip for Using AFP at the Point of Care

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