FFN Newsletter

FFN
Fragility Fracture Network

Issue 1, February, 2012

FFN Global Congress — September 6 to 9, 2012 in Berlin

by Karsten Dreinhöfer – Congress Chair of FFN

Are looking for a meeting provides the most up to date information on fragility fractures with an emphasis on setting up systems to change practices and stop re-fractures in your health care setting? In September 2012 FFN will hold its first global congress in Berlin with interactive workshops, controversial cases and updates on various topics.

The FFN Global Congress 2012 from September 6 to 9, 2012 in Berlin will provide a state-of-the-art up-date on the latest global practices in this rapidly changing area. Attendees will be exposed to a range of practical content delivered by key opinion leaders in areas such as how to set up a fracture liaison service, how to develop an integrated fracture pathways, recent research findings on the best rehabilitation programs, and scientific advances in bone healing, all delivered in an environment conducive to dialogue, debate and networking.

The FFN Global Congress provides a platform for interaction with leading orthopaedic surgeons, rheumatologists, anaesthesiologists, radiologists, geriatricians, rehabilitation experts, osteoporosis experts, primary care doctors, nurses and allied health professionals from all over the world.

The program contains variable sessions with a focus on multidisciplinary interactions and updates on:

- Peri-operative management
- Fracture management
- Rehabilitation after fracture – functional and social
- Prevention of new fractures
- Research in fragility fractures
- Changing policy

Sick of the talk and want to help stop re-fractures? Then join the Fragility Fracture Network and come to Berlin in September 2012.

www.ffn-congress.com
www.ff-network.org

Clinical Corner – What is your opinion?

by Adriana Braga de Castro Machado – Vice-President of FFN

This section of our newsletter will be open for colleagues who want to bring their view for controversial or difficult cases regarding fragility fractures. The appropriate treatment for secondary prevention after a fragility fracture is well established for most of the population, but there are cases that challenge you to find alternative ways or to assume that drug treatment may not, in specific cases, be the best approach.

To open this corner I will present a common case in a fracture liaison service, but with controversial issues. In our website you will be able to leave your opinion and your likely conduct, as a contribution to a discussion forum during the next two weeks. After that we will summarize the opinions.

G.C. is an 88 year old Caucasian man that had an appointment in a fracture liaison service. Two months ago, he had a trochanteric fracture in his left hip, when he fell from his bed. One week after the surgery, he had a DVT in the contralateral leg, even after using prophylactic treatment with enoxaparin. After two weeks he was discharged from the hospital to his home, where Mrs. M.C., his 82 years wife, looks after him.

Eight years ago Mr. G.C. was diagnosed with Alzheimer Disease, and for two years he has been bedridden and totally dependent and with severe cognitive impairment. During this time, he had some incidence of pressure ulcer in sacrum area and two subsequent pneumonias.

He is currently taking daily: rivastigmine 12 mg, risperidone 0.5 mg, losartan 50mg and warfarin 2.5 mg. His recent blood test was normal for electrolytes, glucose, creatinine: 1.4 mg/dL, CBC with lightly decreased hemoglobin (11mg/dL), vitamin D 25 (OH): 13 ng/mL. His DXA results are: L2-L4- BMD 0.578 g/cm2 (T-score of -4.3) and right hip: Neck – 0.380 g/cm2 (T-score of -4.2) Total Hip: 0.462 g/cm2 (T-score of -3.9).

What are your considerations about Mr. G.C. treatment?

Click here and join our discussion online!

(Login with your Facebook, Google or any other account)

Some highlights to consider during the management decision in this case: A hip fracture patient, in an advanced stage of Alzheimer Disease who is bedridden and diagnosed with a recent deep vein thrombosis and pneumonia:

- High Risk Patient for Re-fracture
- Secondary Fracture Prevention workup
- Oral bisphosphonates for a bedridden person
- Deep vein thrombosis treatment
- May consider Teriparatide or Zoledronic acid
- Cost and administration of treatments and benefits
- Comorbidities

The President's Message

Welcome to the first Newsletter of the Fragility Fracture Network.

Why is the FFN needed? Because our two, equally important, main messages need to be globally spread and acted upon if we are to survive the demographic tidal wave of fragility fractures:

-Every fragility fracture is an opportunity to prevent the next one!

-Patients with life- and independence-threatening fragility fractures need multidisciplinary acute care from physicians and other staff skilled in the care of older people, in partnership with orthopaedic surgeons!

Why is the Newsletter needed? Because colleagues in many countries are doing brilliant things to improve services and knowledge. Their experience needs to be shared internationally, continuously, not just at the Global Congress. Please do not keep this Newsletter to yourself. Forward it to anyone you know who may not have received it but is an activist in improving the prevention or treatment of fragility fractures anywhere in the world. If you have any experience to share, let us know and we will include it in the next Newsletter.

David Marsh, President of FFN

Inside this issue:

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NAON POSITION STATEMENT ON OSTEOPOROSIS AND BONE HEALTH

Issue: The incidence of osteoporosis, a disease characterized by low bone mass and deterioration of bone tissue leading to increased risk of fracture, is rising along with the costs related to medical care and loss of productivity associated with increasing fracture rates. The call to action and challenges of responding to the osteoporosis epidemic has been outlined in Bone Health and Osteoporosis: A Report of the Surgeon General (U S Department of Health and Human Services, 2004). Key stakeholders have been slow in responding to the Surgeon General's recommendations to increase awareness of effective strategies for preventing and treating osteoporosis (National Coalition for Osteoporosis and Related Bone Disease, 2008). In addition, recognition of fragility fractures as "red flags" signaling the indication for bone health screening and treatment when indicated has not become the standard of care as recommended by the surgeon general. Screening and management of osteoporosis following a fracture occurs in only 20.7% (National Committee for Quality Assurance, 2010). Osteoporosis-related fractures cost our health care system over $19 billion each year (American Academy of Orthopaedic Surgeons, 2008). Early diagnosis and treatment of osteoporosis can dramatically reduce fracture rates, generate substantial savings and improve the quality of life of millions of Americans (Dell,
Greene, Schelkun, & Williams, 2008).

Position: The National Association of Orthopaedic Nurses (NAON) supports the development and implementation of programs which focus on bone health and osteoporosis related education, prevention and research, which would allow for educational outreach to nurses, patients, and other health care providers. This includes actions such as referring first time fragility fracture patients for osteoporosis diagnostic testing and treatment and including the FRAX assessment in
musculoskeletal assessments. Additionally, NAON supports the development of comprehensive bone health, osteoporosis and related bone disease surveillance and prevention programs, and expanded research activities for osteoporosis prevention and treatment. Furthermore, NAON recognizes these efforts are best implemented in partnership with other interested stakeholders. Consequently NAON supports membership in The U.S. Bone and Joint Initiative and organizational alliance with Own The BoneTM.

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FFN FACTS & FIGURES

Foundation of FFN:	August 18, 2011	Contact:
Number of members for 2011:	75	FFN Central Office
Number of members for 2012:	176	c/o MCI Schweiz AG Flughofstrasse 54
Executive Committee:	7 members	8152 Glattbrugg
Board:	15 members	Tel: +41 44 809 42 80 Fax: +41 44 809 42 01
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NATIONAL BONE HEALTH ASSOCIATION—A PORTRAIT

The National Bone Health Alliance (NBHA or Alliance) is a public-private partnership that brings together the expertise and resources of partners from the non-profit, public and for-profit sectors.

The NBHA is a platform that allows all voices in the bone health community to harmonize to deliver clear, concise messages about bone health by facilitating ongoing dialogue among interested individuals and organizations engaged in bone health activities and identifying shared priorities and projects that can become reality through pooled funding.

NBHA is developing three initial projects: a secondary fracture prevention initiative, public and health professional awareness campaign, and bone turnover marker standardization project. In addition, NBHA serves as an advocate for topics important to bone health, most notably Vitamin D, Calcium, dual energy x-ray absorptiometry (DXA) reimbursement and utilization and the long-term use of bisphosphonates and other therapies.

The members of the Alliance are working from a shared vision: to improve the overall health and quality of life of all Americans by enhancing their bone health.

The NBHA's areas of focus include:

- *Promote bone health and prevent disease*
- *Improve diagnosis and treatment*

Enhance research, surveillance and evaluation

NBHA News

Read the NBHA's written comments submitted in support of the September 9 joint meeting of the FDA Reproductive Health Drugs and Drug Safety and Risk Management Advisory Committees on the benefits and risks of the long-term use of bisphosphonates. - Download

Read the second issue of the NBHA newsletter, Eye on Bone Health. - Download

The National Bone Health Alliance (NBHA) was launched in late 2010 in response to the recommendations from the 2004 Surgeon General's Report on Bone Health and Osteoporosis and the June 2008 Summit for a National Action Plan for Bone Health. The NBHA is a public-private partnership that brings together the expertise and resources of its partners from the public, private and non-profit sectors to collectively promote bone health and prevent disease; improve diagnosis and treatment of bone disease; and enhance bone research, surveillance and evaluation.

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The Patient's Perspective on the Decision to Take Osteoporosis Medication

By Joanna E.M. Sale1,2 and Dagmar K. Gross3

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For over one-half of patients with a fragility fracture who are at high risk for another fracture, the decision to take, or not take, an osteoporosis (OP) medication is an easy one, made at the time the prescription is given. However, nearly half of such high risk patients find the decision to take OP medication a 'difficult' one, requiring time and consideration of several factors. The patient's health care provider (specialist or primary care physician) is influential, both positively and negatively, in the decision to take OP medication. And for many patients, this decision is not permanent, regardless of whether it was an easy or difficult one. These were the results of a recent study that examined the experiences of fragility fracture patients at high risk for future fracture with the decision to take OP medication (1).

In the real world, adherence to OP medication in patients who have sustained a fracture is low. Six months following a physician's recommendation for antiresorptive medication, up to 58% of fragility fracture patients are not taking the medication (2), and at 12 months approximately 74% of fracture patients have discontinued the medication (3). The experiences of 21 patients (15 women, 6 men) with their actual decision to take prescribed OP medication were recently explored through semi-structured interviews (1). The patients had been screened for OP in a Canadian university teaching hospital after sustaining a fragility fracture within the last 5 years and had been prescribed OP medication. All patients were over age 65, so that cost of treatment was covered by the provincial drug plan and was not a barrier to accepting treatment. At the time of the interview, two-thirds of patients were taking a bisphosphonate; the remainder were taking no OP medication.

The decision to take, or not take, OP medication was an easy one, required minimal contemplation or distress, and occurred at the time the prescription was given for 12 of 21 interviewed participants. Their decisions were based on trust in their health care provider and focused on the benefits of the medication. Ten of the 12 patients were taking OP medication.

For the remaining 9 patients interviewed for the study, the decision was more difficult and required considerable contemplation. These patients needed ample discussion, to have their questions answered and concerns addressed, and to be convinced by the health care provider to take the medication. If unconvinced, they sought other sources of information (friends, family, pamphlets, other physicians) that usually resulted in a decision to not take OP medication. These patients also engaged in risk-benefit analyses and expressed concerns about potential and actual side effects. Four of nine patients were taking OP medication; five were not.

The decision to take OP medication was not permanent for many participants, regardless of whether the decision was 'easy' or difficult'. Patients indicated they might be persuaded to start or stop taking medications, depending on a number of circumstances. Since their decisions may change over time, patients could benefit from ongoing discussions with their physicians, to assess their willingness to continue the medication, to ensure they understand the benefits of taking medication over the long term, and to potentially influence the decision to initiate or resume medication.

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National Bone Health Association—A Portrait

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The NBHA provides a platform:

- *To provide its collective, unbiased voice to weigh in on subjects important to bone health, particularly Vitamin D, Calcium, Dual-energy X-ray Absorptiometry (DXA) reimbursement and utilization, and the benefits and risks associated with the use of bisphosphonates and other therapies;*
- *For ongoing communication among individuals and organizations interested in bone health;*
- *For shared priorities and projects to become reality through pooled funding and expertise; and*
- *For stakeholders to work together towards the goals and recommendations of the National Action Plan for Bone Health.*

Among the projects that the NBHA is initially developing:

- *Public/Health Professional Awareness Campaign on Bone Health: An awareness campaign around bone diseases was launched in May 2011 with the inclusion of a print public health announcement in three national women's magazines (Better Homes and Gardens, Family Circle and Ladies Home Journal) additional awareness efforts will be undertaken in 2012.*
- *Secondary Fracture Prevention Initiative: A project proposal is being developed for potential funding by the Centers for Medicare & Medicaid Services which would support a 70-site "fracture liaison service" (FLS) demonstration. This FLS would be responsible for ensuring fragility fracture patients receive appropriate diagnosis and coordination of in-patient and out-patient care. The goals of this demonstration project include improved outcomes and decreased overall health care expenditures in the Medicare population.*
- *Bone Turnover Marker Standardization Project: This project would develop reference standards for two bone markers. Among the project goals would be to reduce laboratory variation in sample collection and analysis, in addition to establishing a standardized U.S. reference range that the various laboratory vendors could agree on.*

In addition to these projects, NBHA is identifying additional project areas to move forward.

The current list of the 32 NBHA members (11 private sector organizations and 22 non-profits) is available at http://www.nbha.org/members/currentmembers).

In addition, liaisons representing the National Institutes of Health and Food and Drug Administration also participate.

For more information about the NBHA, do not hesitate to contact David Lee, MPA, NBHA director, at david.lee@nbha.org., www.nationalbonehealthalliance.org

FRAGILITY FRACTURE: PROGRAMS, INITIATIVES, AND ACTIONS IN ITALY

By Umberto Tarantino, Nominations Committee Member of FFN - Full Professor in Orthopaedics and Traumatology - Musculoskeletal Apparatus Diseases at Tor Vergata University in Rome and Chairman of Surgical Department at "Policlinico Tor Vergata" Foundation in Rome.

Over recent years in Italy osteoporosis and fragility fractures are emerging as dominant themes in the Orthopaedic scene.

In our country, the Ministry of Health is emphasizing the problem of the osteoporosis and fragility fractures and is acting with the aim to reduce their incidence.

In Italy there are more than 270'000 fragility fractures per year and of these more than 50% are not admitted to the hospital ward. The fractures are treated only under emergency measures and are not included the total population, giving us only a partial number compared to the actual number. Thus, the Ministry of Health formed a dedicated multidisciplinary working group on osteoporosis and fragility fracture that advises on methods to evaluate the real burden of osteoporosis fractures and indication and on how to prevent them. This is clearly indicating that the Italian government is now considering fragility fractures as a high priority in the national health system.

In 2010 this group brought a 'Health book' that identified the need for action on tertiary prevention on fragility fractures. To testify the importance that the ministry is giving to the problem of fragility fractures, there is the phrase of the health minister Ferruccio Fazio, who, in the introduction to the 'Health book', wrote: "The fragility fracture constitutes a major challenge for health systems of Western countries, for their growing number associated to a constant increase in old aged population ".

The primary goal of the working group was to create 'indicators' that would allow the ministry of the health to follow the evolution of the fragility fracture incidence in a timely and appropriate manner.

The ministry was therefore advised to create the RIFF (Italian Registry of Fragility Fractures) that will be populated with data provided by emergency departments in order to identify those fragility fractures that do not result in hospitalization and are not traceable via the dismissal diagnosis system such as vertebral fractures.- Starting from a pilot study that will involve different regions we will record all the fractures whose anamnestic framework indicates that the fracture was due to a low energy trauma.

With regard to actions that are being implemented in Italy for the prevention of fragility fractures, we are aiming to establish a Fragility Fracture Unit (FFU) that sees many specialists involved (radiologists, endocrinologists, physiatrists…), who may act together with the orthopaedic surgeon to best treat the fragility fractures.

In Italy, the SIOT (Società Italiana di Ortopedia e Traumatologia - Italian Society of Orthopaedics and Traumatology) has also established a 'Commission on osteoporosis and bone fragility', of which I am honoured to be the Coordinator, and which deals with projects and initiatives on the prevention and treatment of this disease . An example is the 'Recommendations for the management and prevention of fragility fractures' presented to SIOT national congress in 2009.

Furthermore a special project called 'STOP alle fratture' – 'STOP to fractures', that involved different societies as GISOOS (Gruppo Italiano di Studio in Ortopedia dell'Osteoporosi Severa), ORTOMED (Società Italiana di Ortopedia e Medicina), SIOMMMS (Società Italiana dell'Osteoporosi, del Metabolismo Minerale e delle Malattie dello Scheletro), SIOT and SIR (Società Italiana di Reumatologia), recently started in several Italian regions. Its aim is to reduce the risk of a new fracture after a first hip fracture, raising the population to the problem through the media.

Several Italian societies are on the frontline to make aware orthopaedic specialists to the need to treat the patient not only from a surgical point of view but also for the problems related to diagnosis and treatment of fragility fractures. Among them GISOOS, which I chair, has got for many years as a primary objective to create and organize frequent educational projects to improve the appropriateness of the diagnosis and treatment of fragility fractures through the formative project GOST (Gestione dell'Osteoporosi Severa in Traumatologia - Management of Severe Osteoporosis in Traumatology).

Finally, to demonstrate the attention on this area, I'll be at the head of the organization of the hundredth SIOT National Congress in 2015 in Rome where one of the two main topics will be entirely dedicated to fragility fractures in metabolic bone diseases.

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