General practice prescription of oral bisphosphonates: review flowchart and operationalisable audit criteria for drug holidays: Version 2, October 2017

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Points at which the NICE multimorbidity guidance, quality standards, and the NOGG guidance are at some degree of variance are marked with ; author opinion is marked with ß.

Decision to start oral bisphosphonate for treatment of osteoporosis

Review for side effects and concordance early ß (3 months) and annually

New fragility fracture >1y after initiation

YES:
- Check concordance
- Consider tests for secondary osteoporosis
- Repeat DXA

Refer to bone clinic if
- a drop in BMD
- 2 or more fractures

High risk:
- Age ≥ 75y
- Previous hip or vertebral fracture
- Glucocorticoids at equivalent of prednisolone ≥ 7.5mg/day
- New fragility fracture on treatment (assuming 80% treatment concordance)

High risk

Low risk

Arrange DXA

BMD T score ≤ -2.5 at hip/femoral neck

Yes

No

Consider withdrawing treatment if life expectancy <1 year

Consider treatment break. Restart:
- Pragmatically after 2 years ß
- On new fracture
- On DXA T score ≤ -2.5

After 10 years, there is little evidence to guide treatment. Treatment decisions should be individualised and balance a presumed continued benefit on fracture risk against the small risk of osteonecrosis of the jaw or atypical femoral fractures. Expert opinion is that most people should have treatment stopped at 10 years unless they have fractured on treatment, with repeat DXA in 2 years as deemed appropriate.
Proposed audit criteria

1. % patients initiated on an oral bisphosphonate with a review at 1 month to assess concordance and side effects
2. % patients prescribed oral bisphosphonates with a medication review in the previous 12 months specifically addressing concordance and side effects
3. % patients prescribed oral bisphosphonates for at least 12 months who have sustained a fracture referred for DXA or to the bone clinic
4. % patients prescribed oral bisphosphonates for 5 years who have a review of treatment continuation and risk assessment
5. % patients at low risk who are offered a bisphosphonate ‘holiday’
6. % patients at low risk taking a bisphosphonate holiday who are reassessed at 2 years to consider restarting for a further 5 years
7. % patients at low risk taking a bisphosphonate holiday whose repeat DXA T score is ≤ -2.5 at the hip/femoral neck who restart treatment
8. % patients at high risk who continue oral bisphosphonates to 10 years
9. % patients prescribed oral bisphosphonates for more than 10 years who have a documented review with fracture risk assessment and discussion about potential continuation
10. % patients on the palliative care register who are assessed for oral bisphosphonate deprescribing

References


