Osteoporosis Workflow:
We should order bone densities on female patients starting at age 65 and earlier for patients with risk factors (anticonvulsants, chronic steroid use, smokers, premature ovarian failure, chronic alcohol use, IBD/celiac, history of fractures, history of disordered eating, family history)

See nutrition information to share with patients about dietary recommendations. Attached and on our website under patient information-nutrition.

Bone density results-Note to patient:
Osteopenia: Check Frax if not already done. 10-year probability of a hip fracture ≥ 3% or a 10-year probability of a major osteoporosis-related fracture ≥ 20% based on the US-adapted WHO algorithm indicates potential treatment benefits.

Low frax: use macro: .vmg_osteopenia_no_treat
High Frax: use macro:.vmg_osteopenia_highfrax_treat
Osteoporosis: vmg_osteoporosis_new_dx
Consider FDA-approved medical therapies in postmenopausal women and men aged 50 years and older, based on the following:

- *A hip or vertebral (clinical or morphometric) fracture*
- *T-score ≤ -2.5 at the femoral neck or spine after appropriate evaluation to exclude secondary causes*
- *Low bone mass (T-score between -1.0 and -2.5 at the femoral neck or spine) and a 10-year probability of a hip fracture ≥ 3% or a 10-year probability of a major osteoporosis-related fracture ≥ 20% based on the US-adapted WHO algorithm*
- *Clinicians judgment and/or patient preferences may indicate treatment for people with 10-year fracture probabilities above or below these levels*

When you are seeing patients for Osteoporosis visit:
Use: Osteoporosis EP (language and labs ordered)
Notes from Dr Chipkin:
For ALL meds that have risk of osteonecrosis (ONJ)- I've suggested that patients contact their dentist to ask them if there are suggestions that they might need more invasive dental work (extractions, implants, etc.) over the next 6-12 months. Please note that this is not just for bisphosphonates.

The GI problems of oral bisphosphonates are usually esophageal, not gastric. If they don't tolerate, I tend to look to switch to Reclast or Prolia or have another discussion about anabolics

For "severe" osteoporosis, might be worth referring. Especially if the question regards anabolics (Forteo/Tymlos or Evenity)

Referrals might also be appropriate if patient has "failed" therapy (worsening BMD at follow-up)

If you feel patient needs to see endocrine for evaluation/management please refer to our Osteoporosis SMA: Please make sure to add the macro to the referral order and complete:
.vmg_osteoporosis_SMA_referral

Why is patient being referred:
Patient diagnosed with osteoporosis on bone density: (date/location) is study in chart?
Patient has been treated for osteoporosis previously with following medications:
Patient has been taking vitamin D regularly: dose: duration:
Patient has a history of fragility fracture: If yes, please document age/date and facture
Relevant PMH significant for:
(Include any history of IBD, RA, PMR-duration of steroids, chronic steroid use, kidney stones, chronic PPI, malabsorption, PTH surgery)
Has patient been on Hormone therapy: duration:
Is there a history of hormone blockers (breast/prostate cancer):
Is there a history of premature ovarian failure:
Is patient on chronic anti-seizure meds:
Current or former smoker: PYH
History of bone cancer/metastatic bone cancer:
Labs in chart: TSH, vitamin D, PTH, bmp, Phos (spep/magnesium)