Spruce Street Osteoporosis Center
Promoting Bone Health in Boulder County

Newsletter
AUTUMN 2006
Number 8

Our Facility

We use a state of the art GE Lunar Prodigy densiometer with the capacity for vertebral fracture assessment (VFA).

If you, or your staff, are interested in trying this technology for yourself, please schedule with Patty von Grueningen, our office manager.

She can also provide you with brochures, script pads or whatever other information you might need.

You can reach Patty at ext. 102.

Spruce Street Osteoporosis Center

2575 Spruce St.
Boulder, CO
80302

303.449.3594
fax 447.0462

Medical Director: Hillary L. Browne, MD, FACP

Weight Loss & Osteoporosis

Did you know that weight loss, both intentional and unintentional, is a risk factor for osteoporosis and hip fracture in menopausal women? In a study of almost 7,000 white women, a loss of 5% of body weight increased rates of hip-bone loss and led to a two-fold risk of subsequent hip fracture, regardless of initial BMI (body mass index)(J Am Geriatr Soc **51**:1740-1747, 2003).

Bariatric surgery in obese patients is also strongly correlated with loss of bone density. Although there are no clear guidelines or protocols, in patients over 40, it makes sense to get a bone density a year or so after weight loss surgery.

Severe obesity (BMI>40) can interfere with bone density measurements both because of attenuation of bone density through adipose tissue, as well as the weight and size limitations of the bone densitometer table. For example, we limit bone density measurements to people who weigh less than 255 pounds. For severely obese patients, if bone density testing is warranted, a peripheral wrist measurement may need to suffice.

Patients who have undergone bariatric surgery may not be able to tolerate oral bisphosphonate therapy. For those patients quarterly I.V. ibandronate, or Boniva, is a great alternative. We have been giving this in our office with no adverse effects to date.

Osteonecrosis of the Jaw

Osteonecrosis of the jaw (ONJ) is a rare complication of bisphosphonate (BP) therapy that has filtered through both the medical and lay literature in the past year. The lack of clear information has been a dilemma for those of us who counsel patients about osteoporosis prevention and treatment.

Diagnostic criteria are still evolving. ONJ may occur spontaneously or at the site of recent dental surgery. It may be asymptomatic, presenting with persistent rough spots on gums or may be accompanied by pain, soft tissue swelling, tooth loosening, drainage.

Findings may include exposed bone, infections, fistulas, necrotic soft and hard tissue. ONJ may occur spontaneously or at the site of recent dental surgery.

"To date, a true cause and effect relationship has not been established." ONJ occurs spontaneously, but rarely, in non-BP treated people.

As of March 31, 2006, the total number of possible ONJ associated with BP is:

Alendronate	170
Risedronate	20
Ibandronate	1

For alendronate (the most commonly prescribed oral BP) this translates to less than 1 case per 100,000 person years of exposure.

94% of published cases are in cancer patients receiving IV BP therapy; in such patients, the median time from starting therapy to developing ONJ is 25 months.

The most common dental comorbitity in these patients is chronic, severe periodontitis.

Balance risk for osteoporotic fracture (50% lifetime risk for average 50 year old) with rare risk of ONJ treated with oral BP.

Report suspected cases to www.fda.gov/Medwatch?report.htm.FDA.1088 and refer promptly to an oral surgeon for evaluation and