NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Secondary Fracture Prevention After Hip Fracture for Women 75 and Over

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	2
Does this version include changes to clinical advice:	Yes
Date Approved:	23rd January 2019
Date of Next Review:	19th January 2022
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Approval Group:	Medicines Utilisation Subcommittee

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Introduction

Note: This guidance only applies to women age 75 years and over after hip fracture. Separate guidance for starting bisphosphonates for longer term treatment of osteoporosis under other circumstances is available on StaffNet.

Hip fractures are amongst the most common osteoporosis associated fractures seen in clinical practice. Hip fractures are associated with significant morbidity and mortality. Patients who present with hip fracture are at very high risk for further osteoporosis associated fractures, including second hip fractures.

Bisphosphonates

Bisphosphonates remain the standard treatment to reduce fracture risk. Oral therapy with generic alendronic acid is considered first line in NHS GGC. Risedronate can be considered for patients who either fail to tolerate alendronic acid because of gastrointestinal side effects, or when alendronic acid is considered inappropriate because of existing active dyspeptic symptoms. Oral bisphosphonate dosing instructions require them to be taken on an empty stomach with water, while the patient then remains upright for 30 minutes afterwards without eating or drinking anything else. If adherence to oral therapy instructions is proven or expected to be poor (for instance cognitively impaired patients living alone) or the drug is not tolerated due to gastrointestinal side effects, intravenous therapy with zoledronic acid should be considered. It is clear some patients respond less well to oral bisphosphonate therapies in terms of fracture risk reduction than to intravenous therapy (specifically zoledronic acid). Furthermore, zoledronic acid is the only drug treatment that has been shown to reduce future fracture risk when given to patients presenting with a primary hip fracture

The purpose of this guidance is to support prescribers in decision making as to when to use oral bisphosphonate therapy and when to start IV zoledronic acid.

Using the Guidance

To use this guidance the user should note whether the patient is already taking an oral bisphosphonate and the duration of use. The algorithm should then be followed.

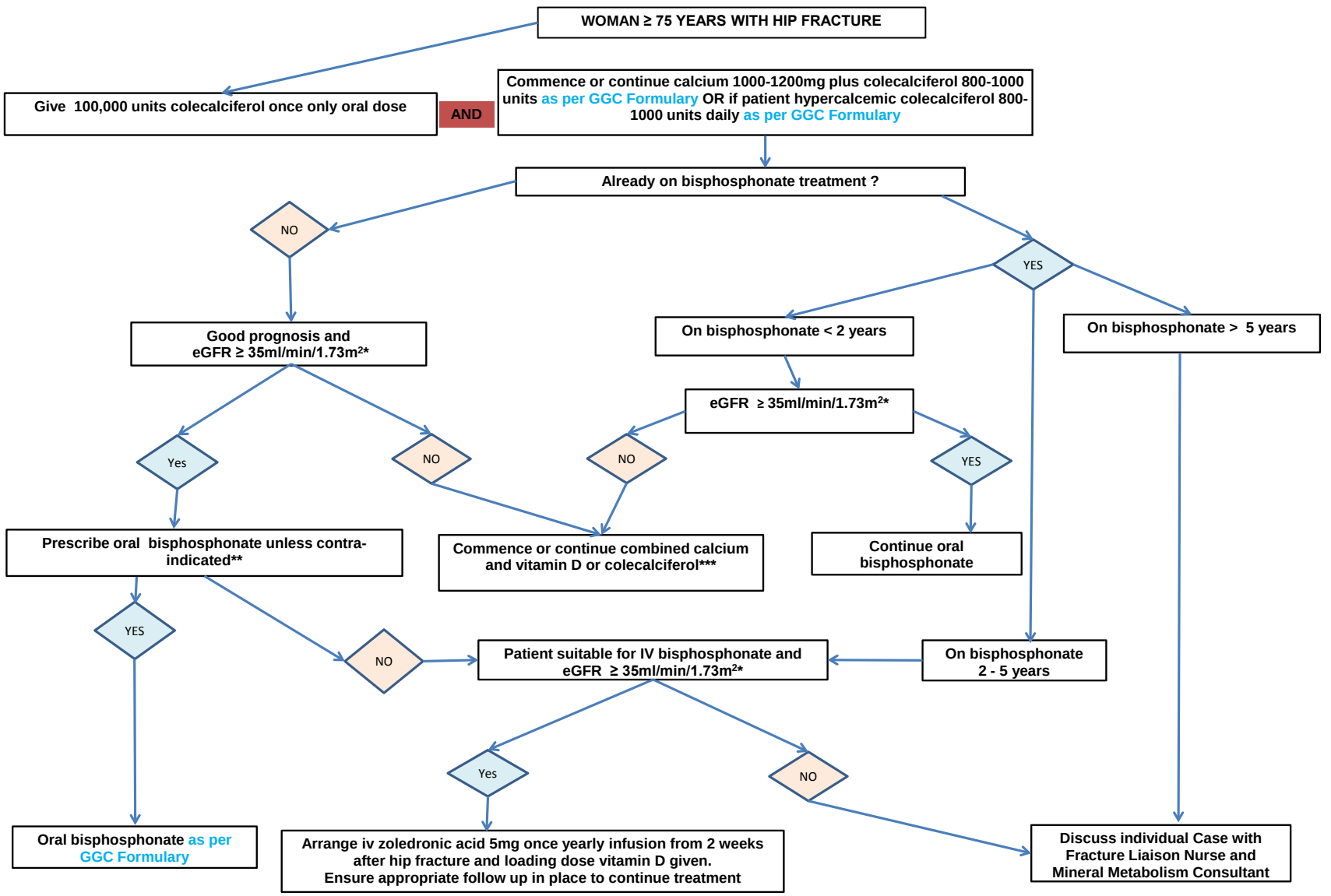
Primary care colleagues should be advised by letter if IV zoledronic acid has been administered. This information should also be recorded in primary care within the patient's electronic record, preferably within medication history. Zoledronic acid is usually administered for three doses at annual intervals.

When it is commenced, the prescriber should ensure appropriate follow up is in place to continue treatment.

Where a patient is thought to have limited life expectancy, consideration should be given as to whether continuing bisphosphonate therapy is of significant clinical benefit.

Falls risk assessments/interventions are also important in the overall treatment aimed at reducing fracture risk.

SECONDARY FRACTURE PREVENTION AFTER HIP FRACTURE FOR WOMEN 75 YEARS AND OVER



*Consider formal calculation of Creatinine Clearance - especially in patients weighing <55kg. Creatinine Clearance Calculator for adult patients is available on StaffNet

**See Bisphosphonate for suitability

*** If patient not suitable for bisphosphonate consider denosumab with specialist input (Fracture Liaison Nurse and Mineral Metabolism Consultant).