

# The GeriJournal



Dexter

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## **Fosamax – How Long?**

It had to happen. I was walking Dexter the other night and made my customary call to my mother. Before Dexter had a chance to so much as lift his leg, out came the question. Should I keep taking my Fosamax®? Dexter and I were in for an extra-long walk as I navigated the controversy surrounding this topic.

First, a little history on the patient... While I'm prohibited from mentioning her age, I can say that she is about 35 years older than me and that I was witness to the Leafs winning their last Stanley Cup (not many of us are left). She has taken Fosamax® (alendronate) for ten years and is concerned about two nasty adverse effects, atypical thigh fractures and osteonecrosis of the jaw. She has also heard that Fosamax® remains bound to the bones several years after it is completed and continues to work even after it is stopped.

First, I referred my mom to the most recent *Canadian Osteoporosis Guidelines*, released in 2011. They state that "individuals at high risk

for fracture should continue osteoporosis therapy without a drug holiday". My mother has had a fragility fracture of the wrist and experienced height loss (vertebral + multiple fractures = high risk). I don't know her bone density. If it is more than 2.5 SD below that of an average young adult, she would be pushed further into the high risk category.

The *FLEX* study (*JAMA* 2006) is particularly supportive of continuation. A group of women who took Fosamax® for ten years was compared to a group who took it for only five. Vertebral fractures increased in the five-year group and bone density decreased, though it remained above pretreatment levels.

Although some residual effect remains after Fosamax® or Actonel® (bisphosphonates) are stopped, bone loss does resume. Facility residents with prior fractures are almost always high risk, so treatment should be continued in the vast majority of cases. Atypical thigh fractures (not definitively linked to bisphosphonates) and osteonecrosis of the jaw are extremely rare and do not outweigh the benefit of these drugs. In the end, Dexter and I told my mother that she should keep taking her Fosamax®.

## **Lipid Guidelines**

The *Canadian Cardiovascular Society* has just updated its

lipid guidelines for CV disease prevention. This is a good time to review some of the key points and changes that may impact the elderly.

The need for cholesterol reducing drugs, statins, is usually determined by one's Framingham Risk Score (FRS). Factors such as increased age, weight or blood pressure; diseases such as diabetes or active coronary artery disease, increase the risk of cardiac events, such as heart attack or stroke and increase FRS score. Smoking, excessive alcohol consumption and family history of CV disease are also contributors.

Higher FRS scores correlate with earlier statin therapy. High risk patients (> 20% risk of major CV event in the next 10 years) must have LDL lowered to less than 2 mmol/L. Lower risk levels equate to higher allowable LDL levels. Individuals with risk from 5-9% were not covered in past guidelines, but are to be investigated further now. Diabetics are to be treated earlier. Most importantly, the close relationship between renal impairment and CV disease has been recognized. Patients with creatinine clearances below 45ml/min are now considered high risk. Roughly half our residents are in this category, so statin therapy should be considered after weighing other factors.