Commentary on Guidelines on Menopause and Postmenopausal Osteoporosis: Indian Menopause Society

In a world of rapidly changing medical evidence, guidelines published by medical societies provide a very useful local interpretation of that information and allow its distillation into best practice guidance for their members. This is particularly valuable in countries where access to medication and screening may differ from the USA and Europe.

The Indian Menopause Society (IMS) has recently updated their guidelines on both postmenopausal osteoporosis and menopause, providing graded levels of evidence to back up their recommendations. The statements also highlight best practices as endorsed by international scientific societies. This has then been adapted for the Indian environment where risk factors may be different. For instance, the osteoporosis guideline lists a range of indications for dual-energy X-ray (DXA) bone density assessment. These recommend assessing bone density at a much earlier age than we would see in Europe, the USA, or Australasia.[1] However, this is based on the unique risk factors seen in India, including earlier onset of menopause, reduced life expectancy, and earlier age at first fracture.

The management of osteoporosis is discussed in detail. The algorithm for managing bone health provides clear guidance for the appropriate management of osteoporosis and those patients with fragility fractures.

Since the last guideline, there has, in some sectors, been ongoing controversy about the role and safety of calcium supplements.[2] Increasingly, health-care practitioners are choosing to advise on dietary calcium options and to use Vitamin D alone. The use of Vitamin D would still be widely endorsed for elderly patients with limited mobility. Now that we have much clearer information about the risks and benefits of hormone therapy, this should be considered as an option in women at menopause who present for osteoporosis treatment.[3] It can be seen as a time consuming and difficult option by practitioners not familiar with its use, but it can serve the dual purpose of symptom management and bone protection for women at menopause.

The concept of a bisphosphonate drug holiday is also undergoing some reconsideration as we now see an increase in clinical and vertebral fracture risk following discontinuation of a bisphosphonate.[4] A drug holiday is not an approach we take with the management of most other chronic diseases, but the aim has been to maintain the benefits of these drugs and minimize the side effects related to total cumulative dose. However, each patient must be considered as an individual, and therapy should not automatically be stopped after 5 years of alendronate or 3 years of Zoledronate. A review of their ongoing fracture risk is vital, such that persistent evidence of osteoporosis or new significant fractures should indicate an ongoing need for therapy.

Vertebroplasty is a technique that initially appeared to offer an option to manage acute fracture pain and improve functional capacity. Providers of the service have often been its biggest advocates despite studies over the years, debating its safety and efficacy.[5] The Cochrane Collaboration published a review of available data in 2018 and concluded that "high-quality evidence shows that vertebroplasty does not provide more clinically important benefits than placebo."

For those providing expert opinion when reporting bone density scans and managing osteoporosis, these guidelines should be used in tandem with those from the International Society of Clinical Densitometry.[1] This ensures we maintain a consistent international standard and referrers receive accurate results from service with known precision and accuracy. The technology continues to improve and we are seeing more widespread uptake of new tools such as trabecular bone score, which captures information related to trabecular microarchitecture. This is associated with fracture risk and can now be incorporated into the calculation of FRAX®.

The updated menopause guideline encompasses a large body of evidence on how best to manage midlife women's health. Access to hormone therapy and medical care varies across the diverse nation of India, but the IMS provides a solid foundation for good practice even in areas with limited resources. The guideline discusses the symptoms that may be seen at menopause, including those often overlooked, such as musculoskeletal aches. It addresses the, often confusing, area of contraception, and most importantly, it highlights all the long-term health issues associated with menopause.

The biggest hurdle many women face as they contemplate using hormone therapy is the concern about any potential risk of breast cancer.[6] It is, therefore, reassuring to see updated analyses from

the Women's Health Initiative Study showing no significant increase in breast cancer risk among treatment naïve women using combined hormone therapy for up to 7 years.[7] The statistically significant reduction in breast cancer incidence (hazard ratio 0.77, 95% confidence interval 0.65–0.92. $P = 0.005$) and mortality seen among users of unopposed estrogen has been highlighted at the 2019 San Antonio Breast Cancer Symposium.[7]

The benefits of hormone therapy in reducing the risk of coronary heart disease and reducing fractures are now clearly documented. These are often overlooked because of a greater perception among women of risk. It is clear that for young women at the time of menopause or within 10 years of their last menstrual period, the benefits of hormone therapy outweigh the risks.[3] Menopause can have large and important effects on a woman's quality of life, so a better understanding of the options available to manage her health is vital.

Summary

Osteoporosis and menopause have substantial impacts on the individuals affected, their family, workplace, and the community. The updated IMS Guidelines provide practitioners in India with a sound basis for best practice in these important areas of healthcare.

Anna Fenton

Gynaecological Endocrinologist, Clinical Leader for the Canterbury District Health Board Bone Density Service, Past President of the Australasian Menopause Society,

Past co-editor-in-chief of Climacteric

Address for correspondence: Dr. Anna Fenton, 51 Chapter Street, St Albans, Christchurch 8052, New Zealand. E-mail: a_fenton@xtra.co.nz

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