

Commentary

Osteoporosis: a survey of consultant ophthalmologists

A questionnaire designed to elicit corticosteroid prescribing habits and subsequent osteoporosis prophylaxis was sent to all consultant ophthalmologists in the United Kingdom. Replies were received from 467/560 (81%). Corticosteroids at doses greater than 5 mg per day were used for 3 months or more by 343/460 (75%) and no advice on osteoporosis prevention was given by 260 (75%) of this group.

Currently there is a lack of clear recommendations on osteoporosis prophylaxis for patients on steroids. However, as bone densitometry is becoming more readily available, prophylaxis is becoming more popular. The Chief Medical Officer's Advisory Group on osteoporosis reported¹ that patients taking oral steroids equivalent to 5 mg prednisolone or more daily for longer than 3 months are at risk of osteoporosis and should undergo bone densitometry. It is also now recognised that these patients are at risk of significant fractures in later years.² There may soon be medicolegal implications if advice is not given at the onset of corticosteroid treatment. Advice needs to be explicit and not just implied. Prophylactic therapy at an early stage in steroid treatment has been suggested.³

If these same criteria are applied to all patients taking steroids as recommended in the report¹ there are far wider reaching implications. Because so many patients are involved with steroids taken for a wide variety of reasons, there are enormous cost implications of the increase in bone densitometry and osteoporosis screening on an already stretched service. Provision needs to be made for this increasing service in future thinking and planning.

There are currently several therapeutic agents available for the treatment and prevention of osteoporosis: calcitonin; bisphosphonates; calcium supplements; vitamin D analogues; and hormone replacement therapy (HRT) in post-menopausal women (natural and post surgical). The role and use of many of these options is uncertain although the routine use of calcium supplementation¹⁻⁵ and HRT⁶ (for post-menopausal women) in patients on oral corticosteroids is now widely accepted.

While co-managing patients on oral corticosteroids with physicians would seem to be the ideal, unless the physician involved has a direct input into the clinical problem this could lead to difficulties. Referral to a physician with an interest in osteoporosis with the stated role of monitoring the osteoporosis status and other side effects would be one option. It is crucial to liaise with the general practitioner who is well aware of the implications and problems associated with steroid use. In isolated ophthalmic cases general practitioners are readily available to offer the best advice and counsel on osteoporosis prophylaxis or the use of HRT.

It needs to be emphasised that there are dangers and very serious side effects associated with prolonged courses of corticosteroids. Alternative and additional immunosuppression should be considered in these patients to reduce the side effects as well as gaining greater control of the disease process. There is understandable hesitancy to use this type of treatment because of its toxicity. However, Hemady *et al*⁷ and, recently, Tamesis *et al*⁸ have indicated that when treatment is monitored adequately immunosuppressive agents are safe. The serious side effects of steroids must be balanced against the reversible side effects of immunosuppressants which are often easily monitored.

We would recommend all patients commencing oral steroids should receive the following:

- (1) Direct osteoporosis advice in the form of a discussion and a leaflet at that first visit; simple measures such as calcium supplementation in the diet—for example, milk, dairy products, and fish. Post-menopausal women should consider starting HRT.
- (2) A letter to the general practitioner stating directly the potential of this problem.
- (3) If the course of steroid treatment is likely to be prolonged or, indeed, if the patient has already been treated for some time, provision should be made for bone densitometry measurement and further treatment if necessary. This may involve referral to another service, directly or via the general practitioner.

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