If there is no fracture, treatment is recommended in all patients aged over 65 years, those taking more than 15 mg/day of prednisolone, and others with strong risk factors (premature menopause, a low trauma fracture, family history, immobility, low body weight) or low bone mineral density. Given the characteristics of people treated with corticosteroids this means that three in every four patients should be treated.[2]

The treatment options are sex steroids, bisphosphonates, or calcitriol. In opting for bisphosphonates as the first choice the consensus group has made the right decision on the basis of evidence from randomised double blind controlled trials. The decision has probably been difficult since bisphosphonates are especially recommended for "those who are eugonadal or unable or unwilling to take hormone replacement therapy." All men and premenopausal women should be investigated for hypogonadism and, if this is confirmed, should be treated appropriately. However, the guidelines are ambiguous about hormone replacement therapy, which "should be offered to postmenopausal women." The evidence for hormone replacement therapy is less robust (comparative studies), making it an alternative only when bisphosphonates are not tolerated. In my opinion there is no reason to combine hormone replacement therapy and bisphosphonates unless the response to bisphosphonates is insufficient. When patients cannot tolerate bisphosphonates or there are concerns about safety (in younger patients) calcitriol may be considered. Here again the evidence is less robust. One randomised trial with calcitriol showed protection against bone loss in the spine but not in the hip.[9] Monitoring of bone mineral density after one year's treatment is advised in all patients. This implies that a baseline bone mineral density should be obtained in all patients, although the algorithm does not actually state this.

When the patient is younger than 65 years, the prednisolone dose is less than 15 mg/day, and there are no strong risk factors, a bone mineral density measurement at baseline and at one year is advised. If significant bone loss occurs treatment should be started. The guidelines end with special recommendations for children.

The strength of these guidelines is that they state exactly what to do and who should do it. The doctor prescribing corticosteroids should play an active part from the start—by instituting prophylactic treatment in most patients after investigations, including a bone mineral density measurement, or measuring bone mineral density at baseline and at one year in low risk patients.

How do the guidelines reach the general public and the patients? The National Osteoporosis Society will distribute the key messages widely. A suitable way to reach individual patients might be through pharmacies: every first prescription of corticosteroids could be accompanied by a leaflet on the risks of osteoporosis and the new guidelines. The initiative of these guidelines should be widely followed in other countries.

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Waiting in the dark: cataract surgery in older people

We need better means of assessing priorities for surgery

Cataract extraction is the most common elective surgical procedure performed in older people, with over 105 000 NHS operations each year. Advances in surgical and anaesthetic techniques over the past 15 years have transformed it into a day case procedure using local anaesthetic. These advances, combined with an ageing population and higher patient expectations, mean that demand continues to rise, with increasing numbers waiting for cataract surgery. The effectiveness of first eye cataract surgery is well established. However, up to a third of current cataract operations in the United Kingdom are done on second eyes, and now there is evidence that the outcome is better when they are done soon after the first procedure rather than later.[1] Given these demands, how are ophthalmologists to prioritorise their waiting lists?

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In a randomised trial of expedited second eye surgery (within six weeks of the first) versus routine surgery (within 7-12 months of the first) Laidlaw et al in Bristol reported major benefits in terms of objective measures of visual function and reported visual symptoms and quality of life.[1] This study supports the need for second eye surgery, but how may this affect patients awaiting first eye surgery? Public concern is increasing that the outcome of first eye cataract surgery may be adversely influenced by delays, either before referral or before operation.[2] In the absence of accurate data from well designed prospective studies such concerns may be valid.

Although symptoms arising from cataract are diverse and insidious, patients' interpretation of such symptoms undoubtedly depends on their ocular morbidity, visual and social function, employment, and

quality of life before they developed their cataract. Inevitably those with the greatest need for and expectation of preserved visual function experience symptoms at an earlier stage. For an ageing population there is clearly a problem. The more vociferous fit elderly will lead demand for cataract surgery, at the expense of frail elderly people. Older people often present late with disease, and visual impairment associated with cataracts may be associated with functional decline and increased dependency. For a patient needing surgery there will inevitably be a waiting time, which may result in further deterioration in function.

Is there any evidence that delayed referral and increased waiting times for surgery confer a poor outcome for individual patients? Cataracts are progressive and visual acuity declines over time. Mordue showed that visual acuity deteriorated between listing for surgery and operation in 38% of patients.[3] Furthermore, these patients had actually waited longer than those whose acuity plateaued. In the absence of coexistent ocular disease, most patients will show substantial improvements in visual acuity after surgery, achieving levels of 6/6-6/12.[4] This is usually associated with rapid enhancement in visual function in the first four months after operation.[5]

Evidence on whether surgery improves quality of life or restores social functioning is conflicting. Although one study of first eye surgery reported gains in health related quality of life (using the sickness impact profile) four months after operation,[5] another found a worsening in mean scores on seven of eight SF-36 subscales (perceived health status) one year after operation.[6] The Bristol study of second eye surgery reported significant gains in five of seven quality of life questions, but not in perceived health (SF-36).[1]

How are patients selected for cataract surgery? Patients' perceived symptoms or the incidental finding of cataract and referral by a healthcare professional influence access to specialists. Patients who are referred to ophthalmologists represent only a proportion of those with visual symptoms. Reidy's study in north London found that 88% of older people with visual impairment due to cataract had not seen a specialist.[7] In current practice monocular visual acuity is used as the primary assessment for judging the need for cataract surgery as well as a tool for evaluating the outcome.[8 9] Yet patients with cataracts and significant symptoms may have relatively normal visual acuity on formal testing. Furthermore, patient selection for surgery varies widely between consultants. A study in northern England found a wide range of visual acuity (6/6 to the ability to perceive light only) at the time of listing patients for surgery.[3] Other factors such as symptom severity, visual and social disability, psychological factors, and cognitive function influence the decision, but there is no uniformity.

Attempts to improve assessment for surgery have included the development of quantitative scales of visual function such as the VF14 and activities of daily vision scale. These assess patients' problems with near and distance vision, glare disability, night and day time driving, and activities of daily living. Unfortunately these North American scales have limitations for use in the United Kingdom, with a disproportionate emphasis on visual skills needed for driving. Until recently there have been no scales for assessing visual function specifically designed for UK practice.[10] A recent survey of British ophthalmologists found that most persisted in using distance visual acuity testing to plan management.[9] Furthermore, they lacked awareness of existing generic or vision specific quality of life instruments that could be used to assess the results of healthcare interventions and prioritise funding.

Previous studies have identified factors associated with reduced recovery of visual function after surgery, including ocular comorbidity (glaucoma, macular degeneration, and retinopathy), increasing age, and pre-existing cognitive impairment. Factors such as age and cognition may also influence recovery of activities of daily living, thus contributing to overall dependency. Achieving optimal outcomes from cataract surgery is not as simple as merely reducing waiting times but must also focus on ensuring the early identification and prioritisation of patients at risk of functional decline and dependency due to visual symptoms. Current means of assessing patients for cataract surgery do not provide enough information objectively to assess need and thus priority. Much more emphasis must be placed on visual symptoms and how these influence social functioning and independence. Studies are required to determine the impact of waiting times on surgical outcomes, thereby enabling timely intervention in patients at maximal risk of functional dependence. Without a sustained increase in the availability of cataract surgery or the development of new technologies we must assume that rationing of cataract surgery will continue. Slavish adherence to reducing waiting times for all will result in poorly targeted surgery for those who have most to gain but are least able to shout loudly.

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