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DOI:10.1503/cmaj.1041238

Seeking clarification of osteoporosis guidelines

The recent statement of the Canadian Task Force on Preventive Health Care regarding prevention of osteoporosis and osteoporotic fractures in postmenopausal women¹ contains some confusing information. One example is the statement that "Although there is no direct evidence that screening reduces fractures, there is good evidence that screening is effective in identifying postmenopausal women with low bone mineral density and that treating osteoporosis can reduce the risk of fractures in this population." This wording appears to have been chosen to obfuscate the meaning, since low bone mineral density, particularly in the younger population, does not strongly correlate with fracture risk or osteoporosis.^{2,3}

Other parts of the recommendation statement do not appear particularly practical. For example, the algorithm shown in Fig. 1 of the article¹ suggests that all women 65 years of age or older should undergo repeat dual-energy x-ray absorptiometry (DEXA) every 1 to 2 years, regardless of the result of initial DEXA (even if that result is normal). Admittedly, this agrees with the guidelines of the US Preventive Services Task Force⁴ and the Osteoporosis Society of Canada,² but what does it mean for those of us providing primary care? Should we in fact send *all* of our female patients over age 65, including those in

rest homes, for DEXA screening? Would it not be adequate to suggest to women in this age group that they try to exercise regularly and take adequate amounts of vitamin D and calcium?

Also of great concern are the potential medicolegal implications if clinicians do not follow guidelines developed by authoritative bodies such as the Task Force.

Do the *CMAJ* editors accept guidelines and protocols produced by distinguished Canadian associations (often sponsored by drug companies) without the benefit of peer review or editing?

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Competing interests: None declared.

DOI:10.1503/cmaj.1040991

The recommendation statement from the Canadian Task Force on Preventive Health Care about preventing osteoporosis and osteoporotic fractures in postmenopausal women¹ mentions oral pamidronate as a second-line drug choice. However, to the best of my knowledge, oral pamidronate is not available in Canada.

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Competing interests: None declared.

DOI:10.1503/cmaj.1040953

[The lead author and the chair of the Task Force respond:]

The recent recommendation statement concerning the prevention of osteoporosis and osteoporotic fractures in postmenopausal women¹ was developed after a detailed process of identifying the appropriate analytic framework, systematically reviewing the literature, discussing the evidence at multiple Task Force meetings and subjecting the statement to 2 levels of peer review (internal peer review within the Task Force and external peer review organized by the Task Force).

On the basis of our analytic framework and the evidence available, we concluded that there is no *direct* evidence that screening reduces fractures. In other words, there were no acceptable randomized controlled trials that directly evaluated routine screening linked to treatment compared with usual care. However, there *is* evidence that screening is effective in identifying postmenopausal women with osteoporosis. There is also evidence that treating osteoporosis can reduce the risk of fractures in postmenopausal women. Because the evidence that supports fracture reduction through screening is therefore indirect, our overall recommendation was grade B, rather than grade A. Currently, there is much controversy as to what the treatment threshold should be. Most experts agree that postmenopausal women with osteoporosis (*T* score at or below -2.5) should be treated with pharmacologic therapies, because there is good to fair evidence from randomized controlled trials that such treatment will reduce osteoporotic fractures in this population. Some of these trials have included women with *T* scores between -2.0 and -2.5 .

There is a strong correlation be-