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OSTEOPOROSIS EVALUATION: SECONDARY CAUSES COMMON

We believe that comprehensive evaluation of patients with Osteoporosis prior to starting sex Hormone Replacement Therapy (sHRT) is essential especially since they may be on longterm therapy up to 40 years or more. Our view is further supported by a recently published study from the USA (1). Of 300 patients scanned using a similar Dual Photon Bone Densitometer to that at EDC, **60% had Osteoporosis** of which **46%** had a secondary cause. The largest single group was comprised of patients with past or present exposure to **corticosteroids 14%** and **early menopause without sHRT in 9%** (before the age of 40 years). Other contributory causes were low serum vitamin D levels, thyroid disease, diabetes mellitus, hyperparathyroidism, malignancy (e.g. multiple melanoma), gastro-intestinal disease, alcohol abuse and other rarer causes: sarcoidosis. From our own experience careful gynaecological assessment including mammography, ovarian ultrasound, colposcopy and cervical smear may reveal other significant pathology which would not have been found on routine clinical examination and may have been wrongly attributed to sHRT, causing confusion of the known benefits with potential side effects of such treatment (2).

BONE DENSITY SCAN £175.00. ELIGIBLE FOR BUPA etc.

OSTEOPOROSIS AND MENOPAUSE CLINIC.

Family history and prevalence of Osteoporosis on Bone Density Screening

Of the first 108 patients who were scanned at EDC we found that a family history was the most compelling reason for attendance in 42%. On scanning of this **High Risk Family History Group 71%** (32/45) had Osteoporosis. This emphasises the priority which should be given to Osteoporosis Screening of patients with a family history of the condition.

Further evidence in support of Minimum Effective Dose of Oestrogen (MEDO) Therapy

We believe that the serial measurement of oestradiol 17B levels in patients on Oral Conjugated Oestrogens (e.g. Prempak C, Premarin), Estraderm patches and especially following High Dose Implants (with or without Testosterone) is mandatory (3, 4). Our view has been further supported in a recent paper which recorded grossly supraphysiological levels of plasma oestradiol 17B levels in women with oestradiol implants (5). The authors describe menopausal symptoms actually returning despite levels of oestradiol 17B greater than 150-440pmol/L (the Minimum Effective Dose of Oestrogen) probably related to the rate of fall of oestrogen levels from high to lower but nevertheless supraphysiological levels. The influence of these high levels of oestrogen in causing perineuronal gliosis and glial thickening within

the hypothalamus (6) and even initiating bone resorption (i.e. actually reversing the known beneficial effect of MEDO therapy on Osteoporosis) has been implicated also (7).

References

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4. Mortimer C H, Perry W (1989) EDC Newsletter: March 1989 sHRT and Osteoporosis: Overdosing on oestrogen?

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