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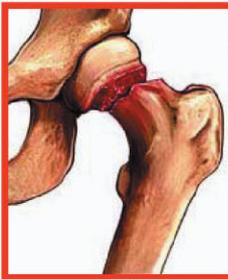
Journal Médical Libanais

VOLUME 55 N° 4

Octobre-Décembre 2007
October-December 2007

Lebanese Medical Journal

LMJ



World Osteoporosis Day Oct. 20, 2007

“Beat the Break”

**FIRST UPDATE
OF THE
LEBANESE
GUIDELINES
FOR
OSTEOPOROSIS
ASSESSMENT
& TREATMENT**



المجلة الطبية اللبنانية

Publication du Comité Scientifique de l'Ordre des Médecins du Liban
Publication of the Scientific Committee of the Lebanese Order of Physicians

ISSN 0023-9852 Indexed by • Index Medicus • Embase (Excerpta Medica)
Cab Abstracts and Global Health - CABI Publishing

www.lebanesemedicaljournal.org

FIRST UPDATE OF THE LEBANESE GUIDELINES FOR OSTEOPOROSIS ASSESSMENT AND TREATMENT

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El-Hajj Fuleihan G, Baddoura R, Awada H, Arabi A, Okais J. First update of the Lebanese guidelines for osteoporosis assessment and treatment. *J Med Liban* 2007 ; 55 (4) : 176-191.

ABSTRACT • With the ageing of the population worldwide, the human, social and economic costs of osteoporosis will continue to rise. It is estimated that the magnitude of the problem is larger in developing countries, including those in the Middle East. In April 2002, a multidisciplinary panel of experts met and discussed practice guidelines for osteoporosis assessment and treatment in Lebanon : “Who to test, what measures to use, and when to treat ?”

They were subsequently endorsed by the Lebanese scientific societies of Endocrinology, Rheumatology, Orthopedics, Obstetrics & Gynecology, Radiology and by the Eastern Mediterranean Regional Office (EMRO), branch of the World Health Organization (WHO).

In April 2006, the Guidelines Committee and the Lebanese Society for Osteoporosis and Metabolic Bone Disorders (OSTEOS) led an initiative to update several recommendations detailed in the original guidelines document, based on relevant new local and international data. Revisited guidelines included recommendations regarding the normative database to be used, the specific skeletal sites to be evaluated, recommendations in men and recommendations in premenopausal women. The experts also sought an evaluation of the relevance of the specific risk factors, used in the WHO fracture risk assessment model, to fracture risk assessment in the Lebanese.

The purpose of the update of the guidelines was to reevaluate the rationale for the recommendations using further evidence when available and to position the Lebanese Osteoporosis Guidelines in relation to the WHO initiative for global fracture risk assessment.

INTRODUCTION

Osteoporosis is a major public health problem projected to generate an increasingly heavier social and economic toll in view of the ageing population worldwide, in general,

and in developing countries, including the Middle East, in particular. In the Eastern Mediterranean region, the high prevalence of osteoporosis risk factors (high smoking rates and low vitamin D levels), and the expected further increase in life expectancy underscore the pressing need to provide guidance to address a foreseeable epidemic of this disease in the next fifteen to twenty years.

In an effort to optimize the quality of care of osteoporosis in Lebanon, an initiative was launched in Beirut in the spring of 2002, which led to the development of Lebanese Guidelines for Osteoporosis Assessment and Treatment [1]. These guidelines provided a structural framework – based on the evidence then available – on which to build sound clinical decision-making in the management of the patient at risk or with osteoporosis [2]. They were meant to re-enforce uniformly high standards of care for patients with osteoporosis [3], but were not to be considered rigid yardsticks for management. They were drafted with the intention of periodic reviews and updates as our knowledge based on this challenging silent disease continues evolving globally, regionally and, last but not least, nationally.

The purpose of the current initiative was to revisit several of the original recommendations based on new local data and assess their relevance to the applicability of the WHO global fracture risk assessment model.

METHODS

In 2002, the core expert panel originally involved in the generation of the first guidelines document included specialists in the field of osteoporosis, faculty members of two major university-affiliated medical centers in Beirut : the American University of Beirut Medical Center and Hôtel-Dieu de France Hospital at St. Joseph University. The original guidelines addressed three essential questions for the management of the patient at risk or with osteoporosis : “Who to test, what measures to use and when to treat ?” A Medline internet search, current to July 2003 was performed entering the two key words “guidelines” and “osteoporosis” [2]. The guidelines for “who to test” and “when to treat” were stratified into three categories, based on the strength of the evidence available at the time the guidelines were drafted.

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The guidelines were reviewed and endorsed by the Lebanese scientific societies of Endocrinology, Orthopedics, Obstetrics & Gynecology, Radiology, Rheumatology, and subsequently by the Eastern Mediterranean Region Organization of the World Health Organization.

They were submitted to the AGREE appraisal instrument (www.agreecollaboration.org), and have been posted on the website of the International Osteoporosis Foundation since then (<http://www.iofbonehealth.org/health-professionals/national-regional-guidelines/references>). The guidelines were disseminated through interactive case-based discussions with membership of the five concerned medical specialties and with physicians affiliated with the Lebanese Society of General Medicine.

The expert panel was since extended to involve other members from the multidisciplinary Lebanese Scientific Society for Osteoporosis and Metabolic Bone Disorders "OSTEOS", that encompasses all medical specialties that endorsed the Lebanese Guidelines including Endocrinology, Rheumatology, Radiology, Orthopedics and Obstetrics & Gynecology.

The specific guidelines to be revisited were pre-specified by the core panel of national experts.

These were :

- A. Which database should be used : local or universal western database ?
- B. Should a gender-specific database be used in men ?
- C. How many skeletal sites should be measured ?
- D. What is the relevance of universally used risk factors in the Lebanese ?
- E. Recommendations in premenopausal women.

An update on the previous Medline search was conducted through a similarly targeted search for years 2003-2006 (current till Feb 2006). Also considered were any articles relevant to the topic up to the time of submission of this document for publication, provided by the national and guest international experts who contributed to this initiative. The panel of local experts composed a report outlining the rationale and/or evidence for the specific recommendations ; these were circulated to an international expert panel (Drs Juliet Compston, John Kanis, and Michael McClung) for input. The update was first discussed in a closed meeting between founding members of OSTEOS and the international panel, and presented and discussed in an open meeting to members of the five founding societies the following day. Members of the international expert panel gave presentations on the process of guidelines development (Juliet Compston), on the clinical relevance of osteoporosis guidelines (Michael McClung) and on the WHO global fracture risk assessment model (John Kanis).

Members of OSTEOS presented the suggested update and recommendations : for "which database to use and how many skeletal sites to measure" (Ghada El-Hajj Fuleihan), for "should a gender-specific database be used in men and relevant national risk factors" (Rafic Baddoura) and for "recommendations in premenopausal women" (Hassane Awada). The guidelines were revised again based on the open meeting discussions, submitted for endorsement by the five scientific societies and for re-review by the international expert panel in parallel. The current document summarizes the update/recommendations endorsed by the five Lebanese scientific societies, OSTEOS, WHO Lebanon and the Ministry of Health. This initiative again will be followed by a national dissemination effort for the updated guidelines over one year, with an audit to assess its impact [3], similarly to what was achieved after the endorsement of the original Lebanese Guidelines.

A. WHICH DATABASE SHOULD BE USED : LOCAL OR UNIVERSAL WESTERN DATABASE ?

It is generally agreed that the relationship between BMD and fracture risk is an inversely exponential one. As BMD decreases, fracture risk increases ; expressed differently, for each SD decrease in BMD, fracture risk almost doubles. This assessment was derived from several large epidemiologic studies conducted mostly on Caucasian populations : SOF in the United States [4], the Rotterdam study in the Netherlands [5], EPIDOS in France [6] and the osteoporosis study in Hawaii [7], although scarcer data on other races are available [8].

At present, fracture risk can be expressed in one of two ways :

1. As an *absolute risk*, either a lifetime, a 10-year or a 5-year risk, for a specific BMD at a certain age (since age is another independent predictor of fractures), such as provided in the Rotterdam and the Swedish studies [5, 9]. The expression of risk in absolute terms, i.e. as probability of fracture in a discrete time frame is more relevant clinically, and has the added advantage of giving a unified output regardless of the technique or site of assessment used for risk estimates [9].
2. More commonly, at least for now, but in less practical terms, as a *relative risk* expressed as relative risk per standard deviation (RR/SD) decrease in BMD. Therefore, an individual with a T-score (or Z-score) of -3 has a fracture risk that is twice that of an individual with a T-score of -2, four times that of an individual with a T-score of -1 and eight times that of an individual with a T-score of zero. Such assessment is less useful in the clinical set-

ting, as it expresses risk in relative rather than in absolute terms [4, 6, 10-12], and the absolute risk in the comparative arm in relation to which the RR is expressed often is not readily available.

Very few studies have expressed absolute fracture risk as a function of BMD, as in the Rotterdam and the Swedish studies [5, 9]. However, since the value of BMD measured in gm/cm^2 may vary depending on the central DXA manufacturer, appropriate conversions have to be implemented before such data can be used [13]. In view of the paucity of absolute fracture risk data published in the past, the practice has been to try to use the more abundant data using RR/SD decrease in BMD, and hence the practice to use T-scores to assess fracture risk and to establish T-score based thresholds for intervention.

Two important points are to be made at this juncture : the WHO T-score cut-points for the diagnosis of osteoporosis were originally derived to be applied to bone density data derived mainly from central DXA devices, and to be used as diagnostic but not therapeutic thresholds in postmenopausal Caucasian female subjects only [14].

The second issue of relevance to non-Western countries, such as Lebanon, is whether the BMD-fracture relationship derived from European and American Caucasian subjects applies to populations from the Middle East in general, and Lebanon in particular. This raises the question of how absolute BMD/fracture curves compare across populations within the same racial category, because for the purposes of this debate Lebanese are considered White Caucasians [15]. A comparison of absolute BMD vs. fracture risk across various Caucasian populations would be needed to address that question and such data are not available to-date for populations from the Middle East. Therefore, resorting to T-scores was the next available strategy to assess fracture risk expressed as RR/SD decrease in individuals in the Middle East. This would be a sound approach if the following two conditions were met :

1. The absolute BMD/fracture relationship is the same in all Caucasians regardless of the specific population. We had previously suggested that there was no a priori reason to think differently [1]. Indeed, analyses of recently available national data, presented herein (*see below*), demonstrate that the BMD/fracture relationship is similar in the Lebanese to that of Western populations, confirming the above presumption.
2. The appropriate device and database in which the BMD-fracture relationship and therefore T-score cut-off was derived are used. These would be a central DXA device, and the Caucasian postmeno-

pausal female normative database, (at least in women, *see section B below*), on which the WHO operational definition for osteoporosis was based. We had previously detailed the rationale for such a recommendation [1]. This document now presents recent national data that shows that the use of a standard universal western database in elderly Lebanese subjects is as good, if not superior, in identifying elderly patients with prevalent vertebral fractures, to the use of a local Lebanese database (*see below*).

Peak BMD in subjects from the Middle East has been studied mostly in non-population-based [16-20] and in few population-based samples [21-23]. The above studies reveal that peak BMD may be slightly lower than or equal to that of European and American Caucasians. This might be explained by differences in body size, chronic vitamin D deficiency, lower calcium intake and physical activity and genetic factors [21-22, 24-27]. However, the prevalence of vertebral fractures in postmenopausal women and hip fracture rates are comparable to those for Western counterparts [28-31]. Finally, as importantly, mean BMD in Lebanese subjects with hip fracture is comparable to that in hip fracture subjects from the West [30, 32]. The latter information suggests that the absolute BMD-fracture relationship may be the same in the Middle East as it is in the West. It is less certain whether the same is true for other races such as Asians or African-Americans. There is a wide variation in practice patterns regarding the selection of databases to analyze bone mineral density between densitometry centers across Lebanon. Some centers use a Lebanese non-population-based database, some use a western Spanish or French database as provided by the densitometer manufacturer, while others use a western universal densitometer database for spine and forearm, and the NHANES total hip database for the hip, in accordance with the recommendations of the Lebanese Guidelines [1-2] and the IOF [33-34].

Do Lebanese subjects have the same BMD/Fracture risk relation (RR/SD) as Western Caucasian subjects ?

In order to investigate the applicability of estimates of fracture risk expressed as RR/SD decrease in BMD derived from Western populations on the identification of elderly Lebanese patients with osteoporosis, we took advantage of a study evaluating BMD and vertebral fracture prevalence in a population-based sample of 460 elderly Lebanese [35]. The study was conducted on a random sample of the Greater Beirut population using geographical maps. Greater Beirut is quite representative of the whole Lebanese population. Indeed, as result of

recent and seasonal migrations from the countryside due to urbanization and war, inhabitants of that area represent the various communities in the country [35].

BMD at the spine, hip and forearm were measured by DXA [35]. Lateral radiographs of the thoraco-lumbar spine were assessed using the semi-quantitative method of Genant [36]. Mild fractures were excluded. Fifty-six women (19%) and 18 men (12%) had at least one vertebral morphometric compression fracture. Analyses were performed to assess the ability of BMD to predict the patients with prevalent fractures using a logistic regression model adjusting for age. BMD was expressed as T-score, Z-score, or absolute BMD gm/cm². T-scores derived from a gender-specific Lebanese population-based peak database [21], and T-scores derived from the densitometer using a gender-specific western database (Hologic for spine and NHANES for hip) were used. Primary hyperparathyroidism was suspected in 11 subjects and their data were not used in the analyses. Therefore, data from 449 subjects (292 women and 157 men) were included in the analyses.

As detailed in Table I, the ability of BMD to identify patients with prevalent vertebral fractures, expressed as RR/SD decrease, was comparable in the Lebanese subjects to other similarly derived estimates from Western studies. Our findings are comparable to similar estimates in the literature demonstrating that the RR/SD decrease does not vary widely within large racial groups [12, 37].

This was true whether spine, hip or forearm BMD measurements were used.

These new analyses based on local data validate the recommendation in the original set of guidelines to apply fracture risk assessment estimates, i.e. RR/SD, derived from Western Caucasian populations to the Lebanese [1-2].

Is the selection of a universal western database, NHANES for hip, for the BMD-based diagnosis of osteoporosis, preferable to the selection of a Lebanese database in the identification of Lebanese subjects with vertebral fractures ?

Taking advantage of the same dataset in the Lebanese elderly, ages 65-85 yrs, the ability of BMD to predict prevalent vertebral fractures, expressed as RR/SD decrease, was investigated with the use of peak BMD in the Lebanese BMD [21] or the peak BMD in the western database (NHANES for hip, [35]). As shown in Table II, RR/SD decrease in BMD was similar or a bit higher when using the western peak BMD database, as compared to the Lebanese peak BMD database, in women using hip or forearm BMD. Conclusive statements could not be made in men due to the smaller sample size, low number of vertebral fractures, and therefore wide confidence intervals. A related methodology to RR/SD decrease estimates is deriving estimates for sensitivity,

TABLE I

AGE-ADJUSTED OR [95% CI] FOR VERTEBRAL FRACTURE PER SD DECREASE IN BMD* IN LEBANESE ELDERLY SUBJECTS ACCORDING TO SITE, AND COMPARISON TO SIMILARLY DERIVED ESTIMATES IN CAUCASIANS FROM WESTERN COUNTRIES

| SITE | OR/SD decrease in Lebanese elderly using western database n = 292 women (56 fractures) and n = 157 men (18 fractures) | Western meta-analyses ♦ Women only Based on 90,000 person-years | Western ♦ n = 2067 women & 317 men |
|----------------|---|---|---------------------------------------|
| WOMEN | | | |
| Spine | 1.22 [0.91 ; 1.6] | 2.3 [1.9 ; 2.3] | 1.36 [1.26 ; 1.47] |
| Hip | 1.61 [1.16 ; 2.2] | 1.8 [1.1 ; 2.7] | 1.66 [1.5 ; 1.8] |
| Forearm | 1.58 [1.23 ; 2.05] | 1.7 [1.4 ; 2.1] | — |
| MEN | | | |
| Spine | 0.99 [0.89 ; 2.1] | — | 1.20 [0.99 ; 1.45] |
| Hip | 1.59 [0.93 ; 2.71] | — | 1.37 [1.08 ; 1.7] |
| Forearm | 0.99 [0.73 ; 1.33] | — | — |
| OVERALL | | | |
| Spine | 1.32 [1.04 ; 1.68] | — | — |
| Hip | 1.67 [1.27 ; 2.19] | — | — |
| Forearm | 1.31 [1.09 ; 1.56] | — | — |

* T-score was derived using NHANES database for the hip and the manufacturer database for spine and forearm.

♦ Marshall et al., BMJ 1996 ; 18 : 1254-9. [12]

♦ Cauley et al., Osteoporos Int 2004 ; 15 : 32-7. [37]

TABLE II
 AGE-ADJUSTED FOR VERTEBRAL FRACTURE OR [95% CI] PER SD DECREASE IN BMD
 IN LEBANESE ELDERLY SUBJECTS USING WESTERN OR LOCAL DATABASE.*
 THE ELDERLY LEBANESE GROUP CONSISTED OF 292 WOMEN (56 WITH VERTEBRAL FRACTURES)
 AND 157 MEN (18 WITH VERTEBRAL FRACTURES)

| SITE | RR/SD decrease in BMD using western database | RR/SD decrease in BMD using Lebanese database |
|----------------|--|---|
| WOMEN | | |
| Spine | 1.22 [0.91 ; 1.6] | 1.16 [0.90 ; 1.50] |
| Hip | 1.61 [1.16 ; 2.2] | 1.49 [1.14 ; 1.95] |
| Forearm | 1.58 [1.23 ; 2.05] | 1.47 [1.19 ; 1.82] |
| MEN | | |
| Spine | 0.99 [0.89 ; 2.1] | 1.37 [0.86 ; 2.19] |
| Hip | 1.59 [0.93 ; 2.71] | 1.66 [0.93 ; 2.94] |
| Forearm | 0.99 [0.73 ; 1.33] | 0.99 [0.70 ; 1.39] |
| OVERALL | | |
| Spine | 1.32 [1.04 ; 1.68] | 1.26 [1.03 ; 1.56] |
| Hip | 1.67 [1.27 ; 2.19] | 1.52 [1.25 ; 1.96] |
| Forearm | 1.31 [1.09 ; 1.56] | 1.35 [1.16 ; 1.58] |

* Western database NHANES for hip, densitometer for spine and forearm.
 Local database from El-Hajj Fuleihan G et al., Bone 2002 Oct ; 31(4) : 520-8. [21]

specificity, PPV, NPV and area under the ROC of BMD measurements to identify subjects with prevalent vertebral morphometric fracture, using the western and local databases. As shown in Table III, the area under the ROC for detecting patients with prevalent vertebral fractures was the same or even a bit higher using the NHANES database compared to local database, for both genders. These differences may be partially explained by differing SDs in the two datasets, and perhaps argue for an international reference standard, possibly NHANES, in view of its sampling technique, sample size, and stable

SDs. Similarly, the sensitivity for detecting vertebral fractures was higher using the western as opposed to the local database in both genders ; as anticipated the specificity was lower (Table III). Moreover, with NHANES database and a total hip T-score -2.5 for osteoporosis diagnosis, osteoporosis was present in 51.8% of women and 38.9% of men with prevalent vertebral fracture compared to 24.6% in women and 11.1% in men had we used the population-based database. These new data demonstrate that the use of universal NHANES database is as good, if not better than the use of a Lebanese database for identifying subjects with prevalent vertebral fractures [35], thus trading increased sensitivity for a slightly lower specificity. Furthermore, the application of a validated universal standard database, such as NHANES, would provide a unified basis for osteoporosis evaluation, and forego contradicting BMD-based diagnoses that are due to the differing practices of the densitometry centers in Lebanon.

TABLE III

SENSITIVITY, SPECIFICITY, PPV, NPV & AREA UNDER THE ROC
 FOR BMD MEASUREMENTS OF THE HIP
 USING NHANES OR THE LEBANESE DATABASE*
 TO IDENTIFY PATIENTS WITH VERTEBRAL FRACTURES

| | STUDY GROUP | | | |
|---------------------|-------------|-------|---------|-------|
| | WOMEN | | MEN | |
| Number | 292 | | 157 | |
| Vertebral fractures | 56 | | 18 | |
| | Western | Local | Western | Local |
| Sensitivity | 51 | 26 | 38 | 11 |
| Specificity | 71 | 89 | 79 | 99 |
| PPV | 30 | 35 | 20 | 66 |
| NPV | 86 | 83 | 90 | 89 |
| ROC (area) | 0.65 | 0.57 | 0.64 | 0.57 |

* El-Hajj Fuleihan G et al., Bone 2002 Oct ; 31 (4) : 520-8. [21]

In summary, data from the Lebanese elderly population-based survey validate the application of western standards, i.e. NHANES for hip database and densitometer database for the spine, for the BMD-based diagnosis of osteoporosis, and also validate the use of western fracture risk estimates (RR/SD), for the assessment of fracture risk in Lebanese subjects [35]. Finally, they will provide the basis to apply the upcoming unified paradigm for fracture risk assessment worldwide [38].

We anticipate that similar recommendations would apply

to subjects from other countries in the Middle East, although this has not been demonstrated. The above evidence-based recommendations [35] are consistent with the recommendations from the International Osteoporosis Foundation [33-34, 39], the International Society of Densitometry [40] and the WHO global fracture risk assessment model [38, 41].

Finally, the similarity of results between our population-derived estimates and the universal Western population and NHANES driven estimates provide the ground for applying the upcoming unified paradigm for fracture risk assessment as recommended by the WHO [38].

B. SHOULD A GENDER-SPECIFIC DATABASE BE USED IN MEN ?

The gender difference in the incidence of fractures varies with age and site of fracture. In young adults, the incidence of fractures is higher in men than women, and after the age of 50 the trend is inverted at all sites, and incidence rates increase with age but increments vary by the site of fracture [42-43].

It remains a matter of debate whether to use gender-specific databases. We screened the available literature as it pertains to three questions :

1. Is the BMD-fracture relationship similar in men and women ?
2. Do men and women fracture at the same BMD ?
3. How does the database selection (men vs. women database) affect the diagnosis of osteoporosis and approximate fracture risk ?

1. Is the BMD-fracture relationship similar in men and women ?

There is disagreement whether the BMD-fracture relationship in women and men is the same.

The association between total hip BMD and risk of non-vertebral fractures, namely hip fracture, was stronger in men (Mr Os) than in women (SOF), 3.2 versus 2.1 fold increase risk per sex-specific SD decrease in BMD, $p < 0.001$ for interaction [44]. The use of 0.1 g/cm^2 instead of sex-specific SD did not alter the results [44]. The approximate 3-year risk of non-vertebral fractures based on sex, age and total hip T-score was higher in women than in men, a finding that was consistent whether sex-specific or female database were used [44]. These results were however based on post-hoc analyses of two different studies.

Conversely, similarities in the relationship between hip fracture and BMD among men and women were reported in the Rotterdam study [5, 45]. This was further confirmed by Johnell [8], who studied over 9000 men

and 29,000 women from 12 different cohorts from Europe, Canada, the United States, Asia, and found that at the age of 65 years, risk ratio of hip fracture increased by 2.94 (95% CI = 2.02-4.27) in men and by 2.88 (95% CI = 2.31-3.59) in women for each SD decrease in BMD. Moreover, at the age of 65 years, the risk of any osteoporotic fractures increased in men by 1.41 per SD decrease in BMD (95% CI = 1.33-1.51) and in women by 1.38 per SD (95% CI = 1.28-1.48) [8]. The authors concluded that the age specific gradient of risk of hip fracture in men seems to be similar in women of the same age.

2. Do men and women fracture at the same BMD ?

Studies have demonstrated that men fracture at higher BMD than women. This was evident in epidemiological studies [46-48] as well as in interventional studies [49]. In the Dubbo study, men with fragility fractures had higher average BMD at the spine and at the hip by approximately 20% than those of women with fragility fractures [46]. Similarly, in the Rotterdam study, men with hip fracture had a BMD that was on the average 0.07 gm/cm^2 higher than that in women with hip fractures ; but fracture risk was the same in men and women for the same absolute BMD [50]. Orwoll compared data in placebo arms of several interventional trials (FIT, MORE and Alendronate in men), where all BMD were measured using densitometers from the same manufacturer [49].

The mean ages in the three trials were 71 years, 69 years and 62 years respectively. Although men were younger and had higher average lumbar spine and femoral neck BMD than women, their fracture rates were higher [49].

3. How does the database selection affect the diagnosis of osteoporosis and approximate fracture risk ?

In the Rochester study, the overall prevalence of osteoporosis in men when a women database was used was only 3%. This prevalence increased to 13% when the 20 to 24-year-old male reference range was used and to 19% when the 20 to 29-year-old male reference range was used [51]. The lifetime risk of any fracture of the hip, spine, or distal forearm in white men is about 13% over the age of 50 years [11] and about 25% over the age of 60 years [49]. Thus, using a gender-specific database better approximates the lifetime fracture risk estimates in men. However, the lifetime risk may not be the appropriate fracture risk tool in clinical management of osteoporosis following the paradigm of the high risk case-finding strategy. Conversely, for any given BMD the probability of hip fracture is comparable between men and women [50].

De Laet demonstrated that a larger proportion of frac-

TABLE V
SENSITIVITY, SPECIFICITY, PPV, NPV AND AREA UNDER THE CURVE FOR IDENTIFYING SUBJECTS AT RISK FOR VERTEBRAL FRACTURES USING ONE OR TWO SKELETAL SITES AND A GENDER-SPECIFIC WESTERN DATABASE

| | SENSITIVITY | SPECIFICITY | PPV | NPV | ROC | 95% CI |
|---------------------------|-------------|-------------|-----|-----|------|-----------|
| WOMEN | | | | | | |
| Lumbar spine (LS) | 59 | 49 | 19 | 85 | 0.59 | 0.49-0.68 |
| Total hip (TH) | 51 | 71 | 30 | 86 | 0.65 | 0.56-0.73 |
| Femoral neck (FN) | 80 | 37 | 23 | 88 | 0.65 | 0.56-0.73 |
| TH and FN (average T) | 64 | 56 | 26 | 86 | 0.65 | 0.57-0.74 |
| LS, TH and FN (average T) | 59 | 50 | 20 | 85 | 0.63 | 0.53-0.73 |
| LS, TH and FN (lowest) | 83 | 27 | 19 | 88 | 0.53 | 0.43-0.63 |
| MEN | | | | | | |
| Lumbar spine (LS) | 46 | 68 | 16 | 91 | 0.60 | 0.43-0.76 |
| Total hip (TH) | 38 | 79 | 20 | 90 | 0.64 | 0.50-0.79 |
| Femoral neck (FN) | 83 | 31 | 14 | 93 | 0.67 | 0.53-0.80 |
| TH and FN (average T) | 66 | 61 | 19 | 93 | 0.66 | 0.52-0.80 |
| LS, TH and FN (average T) | 40 | 68 | 14 | 89 | 0.60 | 0.44-0.75 |
| LS, TH and FN (lowest) | 86 | 25 | 13 | 93 | 0.57 | 0.42-0.72 |
| OVERALL | | | | | | |
| Lumbar spine (LS) | 56 | 56 | 18 | 87 | 0.60 | 0.52-0.68 |
| Total hip (TH) | 48 | 74 | 27 | 87 | 0.65 | 0.58-0.72 |
| Femoral neck (FN) | 81 | 35 | 20 | 90 | 0.65 | 0.58-0.72 |
| TH and FN (average T) | 64 | 58 | 23 | 89 | 0.66 | 0.59-0.73 |
| LS, TH and FN (average T) | 54 | 56 | 18 | 87 | 0.63 | 0.55-0.71 |
| LS, TH and FN (lowest) | 84 | 26 | 17 | 90 | 0.54 | 0.46-0.62 |

porosis compared to the use of the NHANES female database (23% vs 5.1%).

Similarly, the use of the Lebanese gender-specific database provided slightly higher prevalence of osteoporosis based on DXA, compared to the use of Lebanese female database (2.5% vs 1.9%). Thus the use of a gender-specific database would increase sensitivity at the expense of specificity.

In subjects with vertebral fractures, the prevalence of osteoporosis was 39% when the NHANES gender-specific database was used vs 16.7% when the NHANES female database was used ; again increasing sensitivity at the expense of specificity.

Conversely, the prevalence of osteoporosis was similar whether using the Lebanese female or sex-specific database (11.1% in both cases). Finally, the relative risk of vertebral fracture per SD decrease in BMD was quite similar across databases : 1.43 (0.95 ; 2.16) using the women's database vs 1.66 (0.93 ; 2.94) using the gender-specific database.

The update of the guidelines for men recommends :

1. The use of a universal NHANES for the hip and densitometer based western reference-database for the spine (consistent with the IOF recommen-

dations), similar to recommendations in women, as per previous 2002 Lebanese Guidelines.

2. The use of a gender-specific western database for men for T-score derivation.

The recommendations for men remain unchanged from 2002 guidelines. Because fracture risk is the same for men and women at the same BMD, as demonstrated in the analyses of Johnell et al. combining several large cohorts [8], the use of absolute BMD (as opposed to T-score) in the WHO paradigm will resolve the dilemma of database selection in men [38].

C. WHICH SKELETAL SITE(S) SHOULD BE MEASURED ?

In order to address this question, one needs to consider the specific purpose for measuring BMD. Three possibilities arise :

1. Diagnosis of subjects with osteoporosis, based on BMD : A DXA-based BMD T-score -2.5 is the diagnostic threshold for osteoporosis [14].
2. Estimation of fracture risk to ultimately derive intervention thresholds : The latter are to be distinguished from the above diagnostic threshold.
3. Monitoring of BMD changes in response to therapy.

1. Diagnosis of subjects with osteoporosis

The BMD-based definition for osteoporosis developed by a World Health Organization (WHO) working group used a set of operational criteria that apply to postmenopausal Caucasian women [14]. The BMD value of an individual is expressed in terms of the number of standard deviations from the mean of a healthy young adult reference population, commonly referred to as the T-score [14].

Osteoporosis was defined as a T-score that is equal to or less than -2.5 , based on measurements at the lumbar spine, hip using DXA, or forearm using SPA [14]. This diagnostic threshold does not apply to non DXA-based devices [53-55]. As an example, a woman 60 years of age may have a T-score that varies between -0.7 to -2.5 depending on the technique and device used. The WHO working group did not specify which region of interest (ROI) within a skeletal site should be used for diagnosis [56].

2. Evaluation of fracture risk

It is generally agreed that the relationship between BMD and fracture risk is an inverse exponential one, as BMD decreases fracture risk increases; expressed differently for each SD decrease in BMD fracture risk increases by 1.6-3.0 fold. This range is due to variations in the skeletal site used to estimate fracture risk (L2-L4, hip, forearm, etc.), variations in the standard deviations of BMD for that skeletal site by densitometer, and variations according to the specific fracture outcome of interest (wrist, hip, or vertebral fracture). Several risk estimates have been derived to evaluate fracture risk. These include global or any fracture risk, and site-specific fracture risk estimates.

Global risk of fracture : Several studies have established that the global relative risk of fracture, i.e. the relative risk of developing an osteoporotic fracture anywhere in skeleton is the same 1.4-1.6/SD decrease in BMD as measured at any site in the skeleton [12].

Site-specific fracture risk : Although site-specific fracture risk assessment can be estimated by measuring BMD at any skeletal site, the predictive value is higher if a site-specific assessment is conducted : e.g. whereas spine, hip and forearm all predict fracture risk at the hip and spine, the predictive value (RR/SD) is higher using a hip BMD for hip fracture and spine BMD for vertebral fracture [4, 11-12].

A large meta-analysis of 11 cohort studies from 1985 to 1994, which included 90,000 person-years and > 2000 fractures and in which BMD was measured using central DXA, provided the following estimates for site-specific fracture risk [12] :

RR/SD decrease in BMD

| | |
|------------------------------------|---------------|
| Spine BMD for vertebral fractures | 2.3 [1.9-2.8] |
| Femoral neck BMD for hip fractures | 2.6 [2.0-3.5] |
| Distal radius for wrist fractures | 1.7 [1.4-2.0] |

3. Monitoring BMD

The spine is the skeletal site most responsive to pharmacologic intervention and may be the best site to monitor the response to therapy [57]. Measuring two skeletal sites has the additional advantage of not losing the ability to monitor an individual site due to worsening osteoarthritis or fracture.

In addition, the following observations are relevant when making recommendations with regards to the number of skeletal sites to measure, whether it is for diagnosis of osteoporosis, fracture risk assessment, or monitoring :

- Although there is a correlation in BMD between sites (typically $r = 0.4-0.6$), it is not perfect. Therefore, measuring only one site may underestimate a subject's osteoporosis risk [54, 58-59]. However, measurement of multiples sites while increasing sensitivity would decrease the specificity of the test.
- There is site-specificity for BMD in predicting fractures. Risk estimates are higher using hip BMD for hip fracture and spine BMD for vertebral fractures, compared to the use of other skeletal sites when measuring BMD [12]. The situation may be different in the elderly, where hip BMD is a better predictor of vertebral fractures than spine BMD, due to degenerative changes (*see below*). Most studies have however evaluated the utility of the femoral neck, rather than total hip, in fracture prediction.
- At menopause, bone loss is greater at the spine than at the hip; measuring only hip BMD, therefore, may miss reduced bone mass at the spine particularly in younger postmenopausal women [60].
- Aging results in degenerative changes at the spine that may falsely increase BMD [61-62]. Scoliosis, extraskeletal calcification and vertebral fracture may have the same effect. Measuring the hip in the elderly is therefore of particular importance.
- Forearm : Some clinical conditions, such as primary or secondary hyperparathyroidism, may result in differential bone loss in the forearm [63]. In patients with these conditions, a forearm measurement is indicated. A forearm measurement is also indicated in the very obese patient, in whom a spine or hip measurement cannot be performed because of large size [56].

Summary of international guidelines regarding specification of skeletal site to be measured

IOF position • The IOF currently recommends the use of the hip to apply the WHO criteria for the diagnosis of osteoporosis (femoral neck or total hip), outlining that this skeletal site would also predict osteoporotic fractures as well as for any other skeletal sites [34].

ISCD position • The ISCD recommends measuring the spine and hip for all patients. Non-dominant forearm is to be added if one of the above two skeletal sites cannot be used, if the patient has suspected hyperparathyroidism, or if the patient is obese. The updated recommendation from the ISCD Position Development Conference held in Vancouver in July 2005 is essentially unchanged and summarized as follows : “The lowest BMD of either the PA spine or hip should be used to make the diagnosis of osteoporosis provided that the scans are technically valid ... and low bone mass is not owing to some other localized pathology” [56]. Total body BMC measurement is recommended in children [64].

NOF position • The NOF recommends measuring the hip. Indeed, NOF cost-effectiveness was all based on BMD measurement at the hip [65].

Few studies have evaluated the discriminative ability of single vs multiple BMD measurements at several skeletal sites to either identify subjects with osteoporosis, or estimate fracture risk [57-66].

Our group evaluated the discriminative ability of BMD measurements, when performed at the spine, hip or both sites, in identifying elderly subjects with prevalent vertebral fractures in the population-based elderly sample [67]. The scans were reassessed independently by two ISCD certified readers (AA, GE-HF), in order to exclude any artifactual effect of degenerative changes on BMD measurements at the spine, using the criteria pro-

posed by the ISCD [68]. These were : 1) focal structural defect, 2) unusual discrepancy in T-score between two adjacent vertebrae, 3) lack of increase in BMC or bone area when proceeding caudally from L1 to L4. When scans of the spine were reassessed according to ISCD criteria, there was inter-reader disagreement in 71 cases (15%). The scans were judged unreadable in 50 women (16%) and 24 men (15%). The lumbar spine was assessable in its totality from L1 to L4 in only 91/301 women (30%) and 57/151 men (36%).

In both genders, there was no difference in mean lumbar spine BMD or lumbar spine T-score between subjects with and those without vertebral fractures (Table IV). Conversely, BMD and T-score values at the hip, both total hip and the femoral neck, were lower in subjects who had vertebral fractures than those who did not (Table IV, $p < 0.001$ in women, and $p = 0.05-0.06$ in men). In both genders, the best identification of subjects with a prevalent vertebral fracture, as assessed by the use of ROC curves, using T-scores at a single site, was obtained at the hip site (either total hip or femoral neck, Table V), in the overall group and in both genders. The risk of vertebral fracture for each SD decrease in bone density, according to the skeletal site, before and after adjustment for age, is shown in Table VI. In both genders, the hip site had the best discriminative ability to identify subjects with vertebral fractures (Table VI). In women, the age-adjusted OR/SD decrease in BMD for identifying a subject with a vertebral fracture was highest for the femoral neck. The estimates are as follows : • femoral neck OR = 1.79 [1.22-2.62] • total hip OR = 1.58 [1.15- 2.19], and for the • spine OR = 0.99 [0.99-1.50] (Table VI). These estimates are consistent with similarly derived estimates for identifying patients with vertebral fractures, from the placebo arm of the risendronate trial, mean age 69 yrs [69]. Indeed, OR values of 2.47 [1.79-3.42] were obtained for the femoral neck, and 1.84 [1.19-2.85] for the lumbar spine [69]. In our study,

TABLE VI
OR OF VERTEBRAL FRACTURES PER SD DECREASE IN BMD* BEFORE AND AFTER ADJUSTMENT FOR AGE.
THERE WERE 292 WOMEN, 56 WITH VERTEBRAL FRACTURES, AND 157 MEN, 18 WITH VERTEBRAL FRACTURES

| | WOMEN | | MEN | |
|--------------|-----------------------------------|---------------------------------|-----------------------------------|---------------------------------|
| | OR [95% CI] Unadjusted for age | OR [95% CI] Adjusted for age | OR [95% CI] Unadjusted for age | OR [95% CI] Adjusted for age |
| Lumbar spine | 1.30 [0.96 ; 1.7] | 1.22 [0.91 ; 1.6] | 1.39 [0.97 ; 2.1] | 0.99 [0.89 ; 2.1] |
| Total hip | 1.78 [1.3 ; 2.4] | 1.61 [1.16 ; 2.2] | 1.65 [0.97 ; 2.7] | 1.59 [0.93 ; 2.71] |
| Femoral neck | 2.0 [1.4 ; 2.8] | 1.98 [1.0 ; 3.9] | 1.98 [1.0 ; 3.9] | 1.91 [0.96 ; 3.8] |

* T-score was based on the NHANES database for hip and densitometer database for spine and forearm.

combining sites, i.e. spine and hip, using either a mean T-score for both sites or the lowest T-score of both, did not improve the discriminative ability of DXA measurements to identify subjects with prevalent fractures (Table VI), similar to what has been previously reported [69].

In summary, in the Lebanese elderly, mean age 74 yrs, the usefulness of spine BMD measurements were limited. It could not be used in 15% of elderly men or women, and all four lumbar vertebrae could be used in only 1/3 of subjects due to degenerative changes and osteoarthritis, as previously reported [70]. Hip BMD, and specifically femoral neck BMD, showed better ability than spine BMD in identifying elderly subjects with prevalent vertebral fractures [67].

Similarly, a much larger study evaluating 19,071 individuals from six prospective large population-based cohorts (68% women), revealed that global fracture risk, expressed as RR for any osteoporotic fracture/SD decrease in BMD, was similar when using the spine or the femoral BMD [57], although higher fracture risk gradients were observed for hip fracture when using hip as opposed to spine BMD, confirming previous observations [12]. More importantly, the study concluded that the use of the lowest T-score of either spine or hip measurement did not further increase the predictive ability of BMD testing [57], as demonstrated in the Lebanese elderly, although sensitivity increased at the expense of specificity [57]. This large cohort was relatively young, with a mean weighted age of 62 years. Missing from such analyses was the predictive ability of combined BMD measures as opposed to hip only in predicting vertebral fractures, in this younger group of subjects at higher risk of vertebral compression fractures than of hip fractures [57].

Finally, analyses from the Manitoba Bone Density Program, based on data in over 16,505 women, 50 years of age or older, revealed that although age-adjusted fracture risk increased as the number of osteoporotic sites increased, the number of osteoporotic sites was no longer an independent predictor after total hip BMD was included in the model [66].

It is therefore clear from the above studies that the measurement of spine in addition to hip BMD does not further improve the discriminative ability in predicting the risk of fractures, at least in elderly subjects. Similarly, measurement of both spine and hip, as opposed to hip only, does not improve the discriminative ability in predicting the patient at risk for any osteoporotic or for a hip fracture, even in a younger age group of men and women (age range 52-70 yrs, mean age 62 yrs). However, spine measurements have a better discriminative ability in detecting patients with vertebral fractures, in relatively younger patients [12].

The following regarding selection of skeletal site for BMD measurement is recommended :

- Spine and hip for younger subjects < 65 years in whom degenerative changes are less likely and in whom bone loss at the spine may exceed that at the hip.
- Hip only in elderly subjects > 65 years.
- Non-dominant forearm is added in the following situations :
 - _ When one skeletal site cannot be used (arthritis, prosthesis, etc.).
 - _ When hyperparathyroidism is suspected.
 - _ When the patient is obese and exceeds the weight limit recommended by the manufacturer.

As per ISCD recommendations, for spine, we recommend the use of L1-L4 ; and for the hip, the use of the lowest T-score of the two hip sites (total hip, femoral neck [56]).

D. WHAT ABOUT CLINICAL RISK FACTORS IN THE LEBANESE ELDERLY POPULATION ?

Clinical risk factors for fragility fractures that are partially or totally independent of BMD have been clearly recognized. Epidemiologically, only 44% of all non-vertebral fractures occur in women with a T-score below -2.5. This percentage is lower in men (21%). These findings underscore the importance of these risk factors in both genders and in men in particular [71].

Is the relationship between clinical risk factors and fracture similar in men and women ?

The male cohorts "Mr Os" [72-73] addressed some of these issues. These cohorts include around 6000 men in the US [73], 3000 men in Sweden [8] and 2000 men in Hong Kong [74]. Participants were aged 65 years and above, with independent ambulation and reflected the local community. The evidence available so far from these data suggests some gender specific issues :

- Non-BMD factors may be more important in men than in women. The vast majority of men with fractures do not have BMD levels in the osteoporotic range.
- There is a wide variation in male femoral neck size and biomechanical properties even after adjustment for height and weight and this may modulate BMD-fracture relationship.
- Weight loss is associated with bone loss, even in overweight men.
- Hormones levels : both free estradiol and free testosterone levels are correlated with fracture risk in men.

The strength of association between fracture and risk factors other than BMD may vary by risk factor [75]. For

instance, the RR per unit change in BMI is similar in men and women in 12 prospective cohort studies [76] while RR related to smoking is significantly higher in men [77]. Conversely, the evidence from the literature suggests gender similarities regarding common risk factors for osteoporosis including age, anthropometry, alcohol consumption, dietary calcium intake and physical activity. The evidence for gender similarity in the RR of fracture with some variations in the strength of association for some risk factors has been documented in the European Prospective Osteoporosis Study [78]. In that study, the relative risks of prevalent vertebral fracture in men and women were as follows :

Women

| | |
|---------------------------------|--------------------------------------|
| Age | 1.67 [1.46, 1.93] per decade |
| Height loss | 1.06 [1.03, 1.10] per cm decrease |
| Self-reported spine fracture | 7.52 [5.52, 10.23] |
| History of other major fracture | 1.83 [1.46, 2.28] |
| Body weight | 0.86 [0.79, 0.95] per 10-kg increase |

Men

| | |
|---------------------------------|--------------------------------------|
| Age | 1.32 [1.18, 1.49] per decade |
| Height loss | 1.06 [1.04, 1.09] per cm decrease |
| Self-reported spine fracture | 5.05 [3.69, 6.90] |
| History of other major fracture | 1.42 [1.12, 1.81] |
| Body weight | 0.86 [0.79, 0.94] per 10-kg increase |

The clinical determinants of fragility fracture including age, height loss, self-reported history of spine fracture, history of other major fracture and body weight are similar between genders. The strength of association was also quite similar between genders for many of these clinical determinants. However, whether BMD-fracture relationship adjusted for clinical determinants other than age is similar in both genders remains debatable.

What does the Lebanese elderly data tell us regarding risk factors ?

Regarding clinical risk factors, age, height, weight, BMI, smoking, physical activity, dietary intake of dairy products, previous falls, previous fragility fracture, and family history of fragility fracture were studied in the Lebanese.

Correlation between prevalent vertebral fracture and age, height, physical activity and previous fragility fracture was statistically significant in women in univariate analyses. Similar trends were found in men. Smoking did not predict osteoporosis in our population. This may be explained by a relatively small sample size. Alcohol was not included since the prevalence of alcohol consumption in our adult population is low and very low among the elderly.

In multivariate analysis using logistic regression with radiographic vertebral fracture as the dependent variable, significant predictors in women were age, self-reported fragility fracture and total hip T-score. In men, only total hip T-score remained significantly correlated with prevalence of vertebral fracture. When osteoporosis was defined as a T-score -2.5 at any site, age and weight remained significant predictors in women but only weight was significant in men.

E. RECOMMENDATIONS IN PREMENOPAUSAL WOMEN

Because of the wide use of densitometry testing in premenopausal women and of unindicated pharmacologic therapy in this group [29], recommendations in premenopausal women were reiterated in this update.

Who to test ?

It is generally agreed that the relationship between BMD and fracture risk is an inversely exponential one. In postmenopausal women, as BMD decreases, fracture risk increases. There are no data available for such estimations in premenopausal women. Moreover, in healthy premenopausal women, the absolute 10-year risk for a specific BMD is very low [39]. For all these reasons, the WHO T-score-based criteria are not applicable to premenopausal women [14, 64]. The guidelines for premenopausal women are very conservative and essentially unchanged from the 2002 Lebanese Guidelines.

Diagnosis in premenopausal women

- The WHO BMD-based criteria for the diagnosis of osteoporosis should not be applied to premenopausal women.
- The diagnosis of osteoporosis may be considered if a premenopausal woman has a low BMD with :
 - secondary causes (e.g., glucocorticoid therapy, hypogonadism, hyperparathyroidism)
 - risk factors for fracture
 - a fragility fracture.

BMD testing is not indicated in apparently healthy premenopausal women.

When to treat ?

General or universal measures

The following universal measures are recommended independent of BMD measurement :

- Maintain a physically active lifestyle with adequate exposure to sunlight.
- Avoid smoking and high alcohol intakes.

- Maintain a total dietary calcium intake of around 1.5 gm of elemental calcium in postmenopausal estrogen-deficient women or men > 65 years, as well as a vitamin D intake of 600 to 800 IU/day, even under the sun drenched latitudes of Lebanon. Provide calcium and vitamin D supplementation to the elderly.
- Avoid a low weight < 60 kg in men or < 50 kg in women or a low body mass index (BMI) of < 20 kg/m².
- The prevention of osteoporosis begins with optimal bone mass acquisition during growth and adolescence.

Pharmacological interventions

Most approved pharmacologic therapies were studied exclusively in postmenopausal women ; therefore their efficacy in premenopausal women in large part is unknown. Thus, in the absence of any established treatment for normally menstruating premenopausal women with low bone density, such patients should be referred to specialized centers for investigation of underlying causes and advice on further management. Treatment should not be started in such patients before appropriate investigations and diagnoses are achieved.

There are no data on the use of antiresorptive therapies in normally menstruating premenopausal women with the exception of selective estrogen-receptor modulators and corticosteroid-induced osteoporosis. Bisphosphonates do prevent bone loss and may increase BMD in young women but their effect on fracture risk reduction in this group is unknown because of the lack of well powered studies in this population [79]. They may be used when the steroids are given at high doses and for a long period of time, especially in the presence of other fracture risk factors such as low BMD [79]. Even in this case, such a treatment has to be put in a balance with the possibility of a future pregnancy and the risk of a potential harm inherent to such treatment. Indeed, long-term safety of bisphosphonates, either on bone or on fetal growth in a potentially child bearing group, is a concern. Selective estrogen receptor modulators such as tamoxifen and raloxifene, decrease BMD in premenopausal women [80-81]. Finally, available data on current treatments do not exceed 7 to 10 years of use. Discontinuing pharmacologic therapy will result in a resolution of the bone preserving effect, if any, within months to years. So, it would be totally unclear as to what recommendations should be given after stopping treatment, if such treatment was to be given in premenopausal women. Because of all these considerations, the use of anti-resorptive therapy in premenopausal women is not recommended.

To summarize, the population-based data in the Lebanese demonstrated the following :

- First, among Caucasian populations, the use of the NHANES database is associated with greater sensitivity for predicting prevalent radiographic vertebral fracture than a local population specific database.
- Second, our data do not provide evidence for the use of a female database in men, recognizing however that the numbers for the study in men were small to derive definite conclusions.
- Third, among common clinical risk factors, age, self-reported fragility fracture and height were significant predictors of prevalent radiographic vertebral fracture among women with similar trends in men.

The above guidelines target specific points reinforcing or updating previous recommendations [1-2]. Recommendations regarding guidelines not revisited herein remain unchanged. It is anticipated that the T-score anchored recommendations, on which the Lebanese guidelines and many other international osteoporosis guidelines were based will gradually be replaced by an absolute fracture risk assessment model incorporating risk factors with or without BMD [9, 38]. This forthcoming model spearheaded by the WHO initiative, under the leadership of Professor Kanis, is anticipated to provide a common platform for global fracture risk assessment, that is insensitive to database selection (since absolute BMD will be used) and can form the basis for the derivation of intervention thresholds that will incorporate the health priorities and financial constraints of individual countries [38].

The additional local Lebanese data detailed herein provide the evidence and rationale supporting the anticipated alignment with the WHO global fracture risk assessment model. The Lebanese Guidelines are intended to provide a structural framework for high standards of care for the physician treating the patient at risk of or with osteoporosis. They are not intended to supersede the ultimate decision of the practicing physician. In the case of rare and/or difficult cases, referral to an osteoporosis specialist is highly recommended. We anticipate continued periodic updates of these guidelines by the concerned societies under the leadership of OSTEOS and with continued support from the Ministry of Health and the World Health Organization.

ACKNOWLEDGEMENTS

The authors thank the following presidents and constituents of the Lebanese societies for their time and input in reviewing and endorsing the current guidelines : Elie Gharios, MD, Georges Halaby, MD, Pierre Najm, MD, and

Charles Saab, MD (Lebanese Society of Endocrinology) ; Walid El-Saghir, MD, Georges Kaadeh, MD, Faysal El-Kak, MD, and Muhieddine Seoud, MD (Lebanese Society of Obstetrics and Gynecology) ; Nadim Afeiche, MD, and Assaad Taha, MD (Lebanese Society of Orthopedics) ; Antoine Haddad, MD, Assaad Mhanna, MD, and Naji Atallah, MD (Lebanese Society of Radiology) ; Jad Okais, MD, Abdel Fattah Masri, MD, and Said Atweh, MD (Lebanese Society of Rheumatology) ; Georges Saadeh, MD, Jaouad Mahjour, MD (World Health Organization) and the Lebanese Minister of Health, Dr Mohammad Khalifeh.

Special thanks to the panel of international experts, Professor Juliet Compston (University of Cambridge School of Medicine, Cambridge, United Kingdom), Dr Michael McCung (Oregon Osteoporosis Center, Portland, USA) and Professor John Kanis (WHO Collaborating Center for Metabolic Bone Diseases, University of Sheffield Medical School, Sheffield, United Kingdom) for their contribution during the open and closed debates of the guidelines and their suggestions for this final document.

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