

Invited Speaker Abstract

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Osteoporosis in men

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Osteoporosis in men continues to be underdiagnosed and undertreated. One-third of all hip fractures worldwide occur in men and more men than women die in the year following a hip fracture, with a mortality rate in men of up to 38%. Vertebral fractures are also common among elderly men; however, incidence rates in men decline at older ages (with many earlier fractures possibly due to trauma), and rates in men over age 65 are only half those in women. The majority (70-85%) of vertebral fractures are painless, but associated morbidities include height loss, reduced quality of life, respiratory dysfunction and social withdrawal. Secondary causes of osteoporosis are common in men, the most frequent being glucocorticoid use, excessive alcohol use, and hypogonadism. These should be carefully sought and addressed. In up to 40% of cases of osteoporosis in men, no cause is identified (primary or idiopathic osteoporosis). In contrast to women, who lose trabeculae with age, bone loss in men occurs by trabecular thinning secondary to reduced bone formation. Men aged ≥ 70 years, or younger men with clinical risk factors for osteoporosis should have bone densitometry and vertebral fracture assessment, measured by DXA. A calcium intake of 1300 mg/d and vitamin D supplementation ≥ 800 IU/day are recommended, as should regular weight-bearing exercise. The presence of a bone density T-score < -2.5 , or a prior minimal trauma fracture, would be an indication for pharmacologic therapy. Although all studies of osteoporosis treatment in men do not include fractures as primary endpoints, oral bisphosphonates are currently considered first-line treatment of osteoporosis in men, however, patients should also be warned about potential side effects, including the rare possibility of osteonecrosis of the jaw. Treatment with teriparatide is also an option, while testosterone should be reserved for hypogonadal symptoms. New initiatives are required to highlight this public health problem.