Welcome to the last edition of JEMDSA for 2010.

This edition includes a guest editorial by Ayesha Motala on the historic Diabetes Leadership Forum that was held for the first time on African soil, in Johannesburg, in September this year. The forum emphasised that diabetes is not uncommon on this continent and that its prevalence is increasing. However, identifiable and modifiable risk factors for the development of diabetes and its complications exist and deserve our immediate attention.

The metabolic sequelae of obesity are largely dependent on the distribution of body fat, with visceral adipose tissue in particular being regarded as an important aetiological factor in obesity-related disorders. Nigel Crowther and William Ferris review the impact of genes, sex hormones, glucocorticoids, ethnicity, and, in particular, insulin resistance on body fat distribution in their article, a topic that should be of interest to most of our readers.

The unravelling of either symptom-based, but especially incidentally encountered, adrenal mass lesions has become a common conundrum in clinical endocrinology. Biochemical assessment, especially the use of fractionated normetadrenaline and metadrenaline levels, is usually said to have a high sensitivity, although this does not always appear to be the case in clinical practice. Radiological imaging has, therefore, become increasingly important in this regard. Here, Pieter Janse van Rensburg outlines a comprehensive approach to imaging pheochromocytoma and other adrenal lesions, critically comparing MRI, CT (including its pre-contrast attenuation/Hounsfield, and its intravenous contrast washout characteristics) and radionuclear medicine techniques.

JEMDSA remains the only National Department of Education-accredited journal for endocrinology, metabolism and diabetes in South Africa. In 2010, JEMDSA celebrated its 15th anniversary. At a recent editorial workshop, the vision and mission of JEMDSA was again reiterated to encompass the publication of world-class scholarly work in endocrinology, metabolism and diabetes, and to actively and aggressively pursue international indexing. In order to achieve this goal, we are indebted to local researchers and clinicians to submit original research, case studies and clinical reviews in order to establish a pipeline of peer-reviewed papers that are ready for publication. We therefore invite you to submit papers to JEMDSA at www.jemdsa.co.za, to encourage young upcoming specialists who are completing their MMed/College qualifications, to prepare papers for JEMDSA, to earn subsidies, and to put South Africa on a path of well-deserved international recognition and indexing.

Lastly, I am very pleased to announce that, after nearly 18 months of hard work, the long-awaited new NOFSA Guideline on the Diagnosis and Management of Osteoporosis is now available.

Two independent guidelines have emanated from this initiative, a full 200-page guideline with abstract (a copy of the abstract is, in fact, published in this edition of JEMDSA for your perusal) and summary of key recommendations, as well as an independent, standalone executive summary which contains all the tables, figures and recommendations of the full guideline. The former will largely feature as a reference, while the summarised format will probably function as the working guideline.

The guideline was largely funded by an unrestricted educational grant from the Corporate Advisory Board of NOFSA, consisting of Adcock Ingram, MSD, Novartis and Sanofi Aventis and Servier.

Approximately 9 000 copies of the guideline are presently being distributed to doctors and allied health professionals throughout the country. It is envisaged that these guidelines will increase awareness of osteoporosis, provide guidance on its diagnosis and management, and ultimately improve broader and better access to health care for those suffering from this disease.

The guidelines will be distributed by members of the National Osteoporosis Foundation of South Africa (NOFSA), as well as pharmaceutical representatives of Adcock Ingram, MSD, Novartis, Sanofi Aventis and Servier. Additional printed copies will be available from the NOFSA offices at 021 931 7894, or info@osteoporosis.org.za, or simply fax the order form which is printed in this edition (see pg 139).

How do the new guidelines differ from the NOFSA guidelines published in 2000?

The current guide is an update of the clinical guideline which was published by NOFSA in 2000, and adopted and published by the National Department of Health in 2001, and aims to improve the overall efficacy of the diagnosis and management of patients with, or at risk from, osteoporosis. In principle, the two guidelines are
very similar, with the major differences summarised as follows:

The original guideline was not subjected to evidence-based grading, contained fewer peer-reviewed references, and was sponsored by a single pharmaceutical company. The current guideline employs both the GRADE3,4 and the USPSTF5 grading systems, contains more than 600 carefully selected references, and was made possible by an unconditional educational grant from no less than five independent sources.

The same guideline format has been retained for the full guideline. As alluded to earlier, a summarised version has now also been developed, which will largely function as the working guide in practice.

The diagnosis of osteoporosis is based on the presence of a fragility fracture or a low bone mass (BMD). The latter is still largely based on the WHO criteria of 1994, but these were updated in 2008 to include better reference data and criteria for the diagnosis of osteoporosis in males, younger individuals, black patients and children, which are used in the new guideline. The importance of making a diagnosis of osteoporosis based on the presence of a fracture, independent of a BMD level, is strongly emphasised.

The poor sensitivity (≤50%) of DXA-based BMD measurements to detect those at risk of osteoporotic fracture and the limitations of BMD-based intervention thresholds are again highlighted, but a much more practical approach, largely involving the use of clinical risk factors in combination with BMD, is proposed to identify those in need of further intervention. This is highlighted in a management algorithm.

The limitations of biochemical markers of bone turnover and quantitative ultrasound QUS are discussed, emphasising that, despite its limitations, DXA remains the modality of choice to diagnose osteoporosis employing the WHO criteria.

Non-pharmacologic measures to prevent and manage osteoporosis are discussed in much more detail in the current document, providing practical algorithms and guidelines to utilise a healthy eating plan, exercises, prevent falls and manage bone toxins like glucocorticoids.

The pharmacotherapy of osteoporosis has been considerably adapted in the new guideline. New drugs, like teriparatide and strontium ranelate, have been added and drugs like fluoride have had to be removed because of inefficacy and/or safety issues. A best-drug scenario can, however, still not be recommended because of the heterogeneity of the disease and the lack of head–to-head studies comparing different drugs. A practical approach to drug selection is, nonetheless, provided.

The monitoring of therapy is again emphasised, but the serious limitations of routine DXA monitoring to assess the response to antiresorptive drugs are now discussed in detail.

Symptomatic treatment of osteoporosis is addressed, but now also includes recommendations on the use of vertebro- and kyphoplasty.

**What do we hope to achieve with the new guidelines?**

NOFSA plans to utilise these guidelines to increase awareness of osteoporosis, to improve broader access to health care for those suffering from this disease, to stimulate local research on the incidence and risk factors of osteoporosis, as well as normal reference data, and to encourage the formulation of a health economic strategy for the management of osteoporosis in this country.

NOFSA is, however, aware of the fact that compiling a set of guidelines is only the very beginning of the road to achieving these goals. We have taken due cognisance of the McKechnie report,7 published in 2004, that showed that only 19% of medical practitioners in the Western Cape were aware of our previous guideline and that less than 13% had read the document. We are, therefore, planning an extensive launch of the new guideline, which will include not only the distribution of the current hard copies, but also extensive web-based publication and the use of CDs.

The guidelines will also be extensively discussed during the 5th NOFSA/IOF Advanced Training Course on Osteoporosis, scheduled to be held in Cape Town, on the 11th-13th March, 2011.

We have further developed CPD/CEU booklets whereby health care professionals can obtain credits based entirely on their knowledge of the new guidelines. As illustrated elsewhere in this issue of JEMDSA, a drive to recruit new professional NOFSA members has also been launched.

Although the new guidelines have been endorsed by no less than a dozen relevant professional societies and other stakeholders, we have not yet obtained the approval of the National Department of Health. Much goodwill was, however, expressed by representatives of the NDoH who attended our Osteoporosis Indaba in Johannesburg in June 2010 when the final draft of the guideline was approved.

Meetings with both national and provincial health authorities have now become a priority. Furthermore, despite numerous discussions and meetings with the various medical aid organisations in the past, the prophylactic management of osteoporosis still does not feature on the so-called prescribed minimum benefit (PMB) list, allowing medical aid schemes to circumvent their responsibilities to reimburse osteoporosis medication. This makes little sense, since they already reimburse both the tests to diagnose the disease (DXA-BMD measurements), as well as the often very expensive management of its complications, i.e. treatment of fractures.

Clearly, there is still a very long road to travel. We do, however, believe that the current guideline is a sound scientific document, which should be put to its full use in our fight against this, still too often, neglected disease.

**Stephen Hough**
Editor: JEMDSA
Chair NOFSA
E-mail: editor@jemdsa.co.za

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