Osteoporosis, a disorder of ageing is expected to increase as populations increase their life expectancy. The expected increase in medical visits, hospitalizations, and nursing home placements related to osteoporotic fractures will contribute to a substantial economic burden.

Tools, eg FRAX, have been developed to facilitate management of osteoporosis, assist in estimating the long-term risk of suffering a fracture, advise when to initiate a treatment or even when to discontinue them.

The treatment of osteoporosis has been a roller-coaster ride – with ups and downs. We have come a long way with a therapeutic arsenal that is big and varied – the hey-days were when bisphosphonates were first launched and awareness of osteoporosis was escalating. Unfortunately, adverse media coverage and fear of the rare side effects of bisphosphonate use (eg atypical femoral fracture and ONJ) have dampened clinician prescription and patients themselves would rather take their chances with the disease than with use of these drugs. The consequence was a drastic drop in osteoporosis drug prescriptions of 50% from 2008 to 2012. Now with better understanding of these agents, clinicians have learned to finetune therapeutic choices, duration, when to consider giving a “holiday”, what to do when on and after therapy. There is a slow rebuilding of traction for appropriate treatment of osteoporosis.

Unfortunately, there have been relatively few new therapeutic modalities. Several potential molecules such as cathepsin K inhibitors (eg odanacatib) have been stillborn – due to side effects. The most likely to be introduced in the near future, is romosozumab, a humanized monoclonal antibody, a sclerostin inhibitor. This will give a boost to osteoporosis management, as this molecule appears to have both an anabolic as well as anti-resorptive effect. It has been proven to be potent with significant increase in BMD and fracture prevention. It will be a welcome addition to our armamentarium.

Despite the many advances in osteoporosis, there remains a large proportion of patients who do not receive active treatments after a fragility fracture, especially after a hip fracture. There is an urgent need for fracture liaison services that close the care gap to ensure hip fracture patients are discharged with a care plan designed to prevent future fractures.