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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Consensus development conferences on osteoporosis

SIR,—The consensus statement on the prophylaxis and treatment of osteoporosis (10 October, p 914) prompts us to comment and raise some questions that merit consideration.

In the past four years three consensus development conferences on osteoporosis have been organised. The first was held in the United States, organised by the National Institutes of Health, and published in an internationally accessible journal.[1] In The Netherlands a similar conference was organised by the National Organisation for Quality Assurance in Hospitals and published in a Dutch journal.[2] The main reason for organising a Dutch consensus conference was to attain professional consensus among doctors and the other health care workers concerned. This contributes to peer review and quality assurance and is vital for the eventual implementation of the consensus guidelines.[3] The results of a similar conference in Denmark have now been published, three and a half years after the American consensus development conference. We have analysed the consensus procedure and the statements of the three successive meetings.

Our general impression is that despite the varying cultural settings and methods for consensus development (table), the main conclusions are similar: osteoporosis is a major public health problem; prevention of fracture in susceptible patients is the primary goal of intervention; and strategies include ensuring oestrogen replacement in postmenopausal women, adequate nutrition including an elemental calcium intake of 800 to 1500 mg/day, and a programme of modest weight bearing exercise. There are also some differences, however. In the American consensus statement oestrogen replacement treatment is not only recommended for women whose ovaries are removed before the age of 50 but should also be considered for women who have had a natural menopause. Another notable difference concerns the therapeutic approach: the use of fluoride, vitamin D, anabolic steroids, and calcitonin (table). In this respect the American and Dutch consensus statements are more restrictive than the recent Danish version. The scientific data that would support a modification of the point of view of the first two are lacking in the Danish statement.

We also have some questions. Why did the European Foundation for Osteoporosis and Bone Disease organise a consensus development conference so soon after the American conference, the statements of which have both been published in

Differences in methods of consensus development and in recommended therapeutic approach between consensus conferences on osteoporosis in United States, The Netherlands, and Denmark

	USA	Netherlands	Denmark
		Methods	
Attendees	?	200	700
Consensus reached by	Panel of experts and lay public from USA, with little input from mainly professional audience	Panel of experts and professional audience from The Netherlands	Panel of experts from Europe, USA, and Australia, with almost no input from professional audience
Speakers	Experts from USA	Same experts as panel members	Experts from Europe, USA, and Australia
Draft consensus statement	Not available	Spread among participants 12 days before the meeting	Not spread among participants?
Consensus statement presented	On last day of conference	4 Months after conference	On last day of conference
		Therapeutic approach	
Treatment			
Oestrogens:			
Indication	Postmenopausal women	Postmenopausal women at risk	Postmenopausal women at risk
Duration	No limit	At least 6 years	At least 10 years
Start therapy	No limit	Generally not after 65 years	Not later than 15 years after menopause
Administration	Cyclic	Cyclic in combination with progestogens	Cyclic in combination with progestogens
Fluoride	Experimental	Experimental	For severe vertebral osteoporosis
Vitamin D	For some high risk patients: not more than 600-800 IU	For some high risk patients: not more than 400 IU	Not indicated
Calcitonin	Not indicated	Not indicated	For some high risk patients who are not candidates for oestrogens
Anabolic steroids	Not indicated	Experimental	For some high risk patients (glucocorticoid mediated osteoporosis)