Editorial

Forward, fracture fighters!

In this issue of *Acta Orthopaedica* (pages 3–8), Åstrand et al. report their experiences from a fracture liaison service. This is an important article. We orthopedic surgeons should have a key role in the care of patients with fragility fractures: they are our patients! We must take our responsibility seriously. Can you imagine that a stroke patient would be sent home from hospital without his/her blood pressure and cholesterol being checked? That would be an outrage! Unfortunately, this is what we are doing all the time with our fracture patients. The paper also focuses on the fact that fracture is the only clinically relevant effect of osteoporosis. It is fracture that is the disease—not osteoporosis per se: if bones did not break, it would only be an advantage to have a lighter skeleton.

Now, why should orthopods bother? Don't we have enough to do already? This is the crunch. For one thing, if we don't take the initiative, we will have very little time in the future for many other deserving activities—we will have to allocate most of our resources to mending patients with bones like shrimp shells. (In fact, in many countries we are almost at that stage already). Secondly, we are the first and often the only doctors the patients meet. Unlike other diagnoses, eg, diabetes and stroke—where teamwork and multidisciplinary projects have proven to be so successful—we orthopedic surgeons have kept an uncharacteristically low profile. We are in a unique position to influence patients, to inform them about fracture risk, and to coordinate secondary prevention.

Fragility fractures constitute a major public healthcare problem, with an enormous impact in terms of suffering and cost. The in-hospital costs for all fracture treatment in Sweden almost equal the hospital costs for stroke. Osteoporotic fractures take the lion's share of the total hospital cost, and hip fractures alone take 50%.

Risk assessment, i.e. the fracture risk for an individual patient, is important. WHO will soon publish an algorithm for estimating the 10-year fracture risk, and this will be of great practical value regarding decision-making about treatment. No doubt, the risk factors used and the intervention thresholds will vary considerably between countries and regions. In another paper in this issue, Haara and coworkers (pages 9–14) present a result that indicate that analysis of plain hand radiographs can be used to predict hip fracture risk. This method may be of great value in regions where bone mineral scanners are scarce. In the future, the focus will be directed on fracture risk assessment rather than osteoporosis diagnosis.

It is important, though, to realize that the magnitude of the problem makes it necessary to form teams—as, for example, in diabetes care—where the orthopedist is just one cog in the machinery. The paper of Åstrand et al. is one good example of how a fracture liaison service can be organized. It is mainly an organizational and political problem: how to make all health care workers—e.g. general practitioners, orthopedists, nurses, physiotherapists, geriatricians—walk in step and in the same direction, towards an efficacious secondary fracture prophylaxis. Forward, fracture fighters!

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