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LETTER

The US FRAX® filter: avoiding confusion or hindering progress?

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I don't do quagmires

Donald Rumsfeld
US Department of Defence News Briefing, July 2003

"The leadership of NOF and ISCD has decided after long and careful consideration that a FRAX® filter should be available, and this will happen in the USA." So speak the proponents of the US FRAX® filter. Unfortunately, the careful consideration appears to have been driven more by threat than opportunity. In the absence of publication of the in-depth reasons, the only argument, regrettably, appears to be that of maintaining the status quo, justified under the flag of minimising confusion. The question remains as to who is confused? The concept of combining risk factors to provide an estimate of risk that can then drive intervention is well established in many disease areas, particularly in cardiovascular disease. Most clinicians, even "non-expert" ones, understand this and it has made a dramatic impact on health outcomes.

The failure to perceive FRAX® not only as a risk calculator but also an educational tool that opens access to better management implies that the NOF and ISCD regard clinicians in the US as less capable than elsewhere. If their purpose is to eliminate uncertainty, then it follows that information on BMD at sites other than the femoral neck or lumbar spine should be filtered in all bar exceptional circumstances. It also follows that BMD should not be reported in patients on treatment, nor T-scores in premenopausal women. The list is endless. An alternative interpretation is that they espouse protectionism over a disease that should lie within the remit of every capable clinician to manage appropriately, referring to expert centres when necessary.

The objective of FRAX®, conceived and developed in close collaboration with the NOF and ISCD, is to provide clinicians and patients with information on fracture risk that adds to that derived from BMD alone. For the NOF to retreat from this by only partially implementing FRAX® seems both short sighted and misguided. There is no gold standard and to regard BMD thresholds as such does the whole field a disservice. Of course, it is true that situations will arise where the calculated fracture probability might suggest that guidance based on BMD alone is misleading. This scenario is equally likely, if not more so, to represent the shortcomings of the use of BMD alone rather than the use of fracture probabilities. Drs Cummings and Bauer eloquently illustrate such a clinical scenario in their arguments against applying the filter [1]. Indeed, it is the discrepancies that highlight the purpose of FRAX®, educate the physician and the patient and, it is hoped, better inform and direct management decisions. The quagmire only arises if we lose sight of these goals.

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1. [No named authors] (2010) Filtering FRAX®. Osteoporosis Int 21:537–541. (doi:10.1007/s00198-009-1104-x)