



QA WITH DR. MEDLAW

I have a patient to whom I was prescribing Prozac on a monthly basis. I last saw him 3 months ago, when I gave him a 1-month prescription as usual. After I did so, he became uncooperative and then said that he did not want another appointment, and I have not heard from him since. The pharmacy he listed with my office says that he has not filled a prescription since the last one that I gave him. He has not contacted my office about wanting a prescription. To close matters off, I will be sending him a formal termination letter. Do I have to include a prescription to avoid being charged with abandonment by this difficult patient?

No.

Let's start with the fact that you are actually not terminating him, which does carry the duty of avoiding abandonment. You will actually be memorializing the fact that he terminated you. In that setting, there is no carryover obligation, because you are not the one ending the care.

However, even if you were the one doing the termination based on his non-compliance, you not only would not be obligated to provide a prescription, you should not do so.

To avoid a claim of abandonment in the termination setting, the doctor is responsible to tide the patient over the transition period to another practice. This includes being available for emergency care during that time and prescribing enough of current medications to cover the interval specified in the termination letter.

However, this patient has already stopped the drug for 2 months. If you prescribe for him now, you would actually be starting a new course of treatment. This would be the opposite of verifying his removal from your practice and could actually be held to vitiate the ending of the physician-patient relationship, because a patient who gets a new prescription could then reasonably conclude that you were now treating them anew.

There is also a professional conduct issue to consider, since you would now be giving a psychoactive medication to someone you have had no clinical contact with for longer than your previous evaluation interval. This is different from a bridging prescription given to a terminated patient leaving active care.

Just send a letter verifying that, as per his statement that he no longer wishes to seek care with your office, that you are closing his file.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.



Osteoporosis, BMD & Fracture Risk in PLHIV



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With significant improvements in the treatment of HIV in recent years, life expectancy in patients living with HIV (PLHIV) has increased dramatically and is now near to that of the general population, data indicate. With this increasing longevity, conditions related to aging have begun to emerge in PLHIV, including osteoporosis, which is not reported as a common comorbidity in PLHIV.

A Large Meta-Analysis

For a systematic review and meta-analysis published in the *Journal of Acquired Immune Deficiency Syndrome*, we sought to assess the evidence on fracture risk in PLHIV, BMD in PLHIV compared with controls, longitudinal changes in BMD in PLHIV, and the effect of anti-osteoporosis treatment in PLHIV.

Our systematic literature review screened nearly 2,400 publications, resulting in 142 papers that were included in the systematic review, and subsequently, 84 papers including more than 60,000 PLHIV in the meta-analysis.

Key Findings

We found an increased risk of fractures in PLHIV (Figure); indeed, PLHIV had a 53% increased risk of any fracture and a 51% increased risk of a fragility fracture when compared with individuals without HIV (controls). Furthermore, the risk of a hip fracture was increased 6-fold in PLHIV when compared with controls.

In contrast, BMD was slightly decreased in PLHIV (z-score at the hip: -0.31, and at the lumbar spine: -0.36) when compared

with controls. The slight decrease in BMD could explain the 15% increased risk of any fracture and 50% increased risk of hip fracture that we found. The meta-analysis revealed a decrease in BMD of 2% to 3% within the first year after initiation of antiretroviral treatment, whereas the bone mineral loss was less during following years. We found in our meta-analysis that tenofovir disoproxil fumarate appeared to be associated with a significantly greater reduction in BMD when compared with abacavir and tenofovir alafenamide. Thus, antiretroviral treatment type appears to be of importance in the development of osteoporosis in PLHIV.

The loss of BMD does not seem to fully explain the level of fracture risk seen in PLHIV. Thus, earlier initiation of anti-

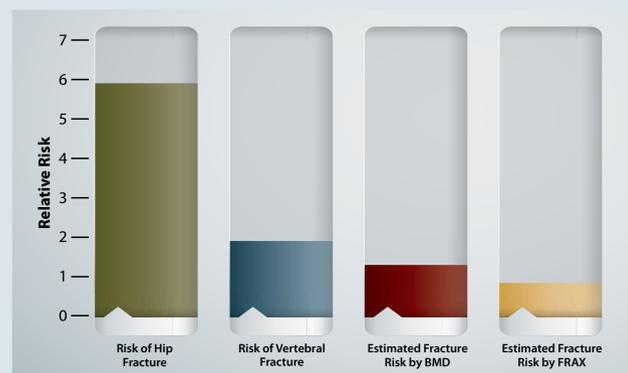
osteoporotic treatment may be useful in this patient population. In PLHIV, treatment with alendronate and zoledronate appeared to improve BMD, and some studies suggest that zoledronate abolished the bone mineral loss seen after initiation of antiretroviral treatment.

Important Implications

Physicians should be aware of the increased fracture risk in PLHIV, and thus, the importance of screening for osteoporosis and early initiation of anti-osteoporotic treatment as necessary in this patient population. As the reduction in BMD does not appear to fully explain the fracture risk seen in PLHIV, focus is also needed on other potentially contributing factors, such as falls, smoking, vitamin D insufficiency, and poor nutrition.

Figure Fracture Risk in PLHIV

The figure below shows relative risks of fracture in people living with HIV (or PLHIV) and estimated risk of fracture based on BMD and the FRAX model.



Source: Adapted from: Starup-Linde J, et al. *JAIDS*. 2020;83(1):1-8.

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Doctors and the Culture of Permission

Recently, Richard Smith, editor of the *BMJ*, called out the *NEJM* for failing to publish critical letters. His post in the *BMJ* blog network calls out *NEJM* as elitist. If electronic space is unlimited, he asks, why limit letters?

Good point. But why assume that conversation is controlled by the *NEJM*? This is a great illustration of what I have come to call medicine's culture of permission.

As physicians, we've been raised to seek approval before approaching the microphone. For hundreds of years you could only say something if someone gave you permission. It used to be that the only place we could share ideas was in a medical journal or from the podium of a national meeting. Our ideas were required to pass through someone's filter.

The angry scientists cited by Smith are of a generation when someone else decided if their ideas were worthy of discussion. They are a generation trained to contain what they think and believe. They are the medical generation of information isolation. Our culture of permission has bred a generation of obsequious followers.

When I think about my peers, I think about the remarkable mindshare that exists. Each is unique and brilliant in the way they think and see the world. Each sees disease and the human condition differently. They carry stories and experiences that can ease minds and save lives. But their brilliance and wisdom is stored away deep inside. They are human silos of unique experience and perspective.

But the way the world communicates and creates ideas is changing. The barrier to publish is effectively non-existent. The democratization of media has given every physician and scientist a platform to the world. But somehow we still believe that *NEJM* is running the show. The assumption here is that the only place for dialog and publication is within the boundaries of a paywall-controlled platform.

The problem here is not the antiquated ways of *NEJM*, but the dated, permission-based thinking of the medical public.

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In Case You Missed It

History of Falls Predicts Future Fractures in Postmenopausal Women

A history of falls, especially injurious falls, predicts subsequent fractures in postmenopausal women, according to a study recently published in *Osteoporosis International*. Researchers evaluated if a history of falls predicts future postmenopausal fractures and if this prediction varies according to the frequency, mechanism, and severity of falls or site of fractures. The analysis included 8,744 postmenopausal women (mean age, 62.2 years) surveyed at baseline in 1999 and again in 2004. The researchers found that 19.4% of women reported a fall during the preceding 12 months at the baseline survey. Falls included 812 slip falls, 654 nonslips, 379 injurious falls, and 1,308 noninjurious falls. During follow-up, 811 women (9.3 percent) sustained a fracture; of these women, 431 had major osteoporotic fractures and 380 had other fractures. Earlier falls predicted subsequent fractures compared with nonfallers (odds ratio [OR], 1.41); earlier slip falls (OR, 1.43); and earlier nonslip falls (OR, 1.35). Future fractures were also predicted by earlier injurious falls (OR, 1.64), especially other fractures (OR, 1.86), but not major osteoporotic fractures (OR, 1.37). Earlier noninjurious falls increased the risk for future falls (OR, 1.36). Findings were similar even after adjusting for other factors. "These findings are relevant in improving screening and prevention strategies for fractures," the authors write.

Osteoporosis Common in Total Shoulder Arthroplasty Patients

A significant number of patients undergoing both anatomic and reverse total shoulder arthroplasty (TSA) have a concurrent diagnosis of osteoporosis, according to a study published in *The Journal of the American Academy of Orthopaedic Surgeons*. With the goal of characterizing the incidence of osteoporosis in patients undergoing shoulder arthroplasty and to examine whether patients with osteoporosis undergoing anatomic and reverse TSA are at an increased risk of prosthetic-related complications, a study team calculated complication rates for patients with osteoporosis who underwent anatomic and reverse TSA as separate cohorts within 2 years of surgery including loosening/osteolysis, periprosthetic fracture, periprosthetic dislocation, and revision shoulder arthroplasty. Complication rates were also compared between the groups using a multivariable logistic regression analysis to control for patient demographics and comorbidities during comparisons, including the indication for reverse TSA. The prevalence of an osteoporosis diagnosis at the time of surgery was 14.3% for anatomic TSA patients and 26.2% of reverse TSA patients. Anatomic TSA patients with osteoporosis experienced significantly higher rates of periprosthetic fracture (odds ratio [OR], 1.49; P = 0.017) and revision shoulder arthroplasty (OR, 1.21; P = 0.009) within 2 years of surgery compared with matched controls without osteoporosis. Patients in the reverse TSA group with osteoporosis also had significantly higher rates of periprosthetic fracture (OR, 1.86; P = 0.001) and revision shoulder arthroplasty (OR, 1.42; P = 0.005) within 2 years of surgery compared with matched controls.

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