Survivorship – Gynecologic Cancer: Bone Health

Baseline BMD and 25-OH Vitamin D

Age greater than or equal to 50 years or post-menopausal with any risk factor?

Yes

No

Baseline BMD and 25-OH Vitamin D

BMD normal (T-score greater than or equal to -1.0)

BMD abnormal (T-score between -1.0 and -2.5)

BMD abnormal (T-score less than or equal to -2.5)

25-OH Vitamin D abnormal (less than 30 ng/mL)

Medical therapy not initiated

Medical therapy chosen

BMD stable?

Repeat BMD in 2 years

Repeat in 2 years

Reinforce universal recommendations

Consider medical therapy based on risk factors (FRAX)

Reinforce universal recommendations

Repeat BMD in 1 year

Start medical therapy

Reinforce universal recommendations

Repeat calcium, albumin, and Vitamin D on next visit

Vitamin D abnormal?

Yes

No

Continued medical therapy

Refer to Bone Health Specialist

Continue Ergocalciferol 50,000 units once a month

Repeat calcium, albumin, and Vitamin D in 1 year

BMD stable?

Repeat BMD in 2 years

Repeat BMD in 1 year

Medical therapy not initiated

Medical therapy not initiated

Reinforce universal recommendations

Universal recommendations:

- Calcium 1,200 mg/day
- Vitamin D 800 units/day
- Exercise (see Physical Activity Algorithm)
- Avoid tobacco (see Tobacco Cessation Algorithm)

- Limit alcohol
- Limit caffeine

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BMD = bone mineral density

1 Risk factors:
- Low body weight
- Prior bone fracture
- Family history of hip fracture
- High risk medical condition
- History of prior steroid use of 3 months or longer

2 25-OH Vitamin D: 25-hydroxyvitamin D (hydroxycholecalciferol, calcidiol), the main vitamin D circulating in plasma

3 Stable BMD = same T-score or improvement

4 Abnormal BMD: Osteopenia T-score between -1.0 and -2.5

5 Osteoporosis T-score less than or equal to -2.5

6 FRAX - WHO Fracture Risk Assessment Tool at www.shef.ac.uk/frax

7 Consider bisphosphonate, denosumab, raloxifene or if clinically indicated

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.
SUGGESTED READINGS


A consensus position statement from a UK expert group. *Cancer Treatment Reviews*, 34(1), S3-S18. doi:10.1016/j.ctrv.2008.03.007


This survivorship algorithm is based on majority expert opinion of the Gynecologic Survivorship work group at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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