VERTEBRAL FRACTURES

→ Consider Physical Therapy and Exercise
→ Calcitonin significantly reduces pain and facilitates earlier mobilization for up to four weeks
→ Medications facilitate patient mobility and participation in physical therapy, and should be tapered slowly as pain improves
→ consider Physical Therapy and Exercise
→ Acetaminophen: 500 to 1,000 mg every four to eight hours (maximum 3 g per day)
→ Calcitonin: 200 IU per day intra-nasally
→ Lidocaine 5% patch: Apply to affected area for 12 hours
→ Muscle relaxants (e.g., cyclobenzaprine): 10 mg every eight hours

First: oral Bisphosphonates

→ Alendronate (oral 5 or 10 mg once daily, or 70 mg once weekly),
→ Ibandronate 150mg per month
→ risedronate (oral 5 mg daily or 35 mg one weekly)

Then consider IV bisphosphonates

→ zoledronate (intravenous infusion 5 mg once yearly)
→ Clacitonin: 50 to 100 IU per day intramuscularly or 200 IU per day intra-nasally
→ calcium (1200 mg/d or 500 mg twice daily)
→ Vitamin D analogs: alfacalcidol – calcitriol
→ Estrogen agonist/antagonist (raloxifene): 60mg / day

second line treatment or incase patient is intolerant to biphosphonates

→ Parathyroid hormone (teriparatide): 20 mcg per day subcutaneously for up to 24 months
→ RANKL inhibitor (denosumab): 60 mg per day subcutaneously every six months

Hormone replacement therapy

Hormone replacement therapy and testosterone therapy have therefore been found to increase lumbar spine BMD in hypogonadal patients on glucocorticoid therapy.

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