NHS
Maidstone and Tunbridge Wells
NHS Trust

HIP FRACTURE

Information for patients, relatives and carers

This leaflet aims to provide helpful information following a hip fracture.

Treatment is always planned on an individual basis, so some details may differ.

Staff members are happy to help so if you have any concerns, please do not hesitate to contact us and ask questions. We have a dedicated hip fracture specialist nurse to support you, and a multi-disciplinary team who are happy to help: their contact details are at the back of this leaflet.

Maidstone and Tunbridge wells NHS trust offers an 'open visiting' policy from 8am-8pm daily.

Protected mealtime: Relatives and carers are welcome to visit at meal times to assist with feeding as required, however please check with ward staff before giving assistance. Otherwise we ask visitors come out outside of mealtimes.

Orthopaedic Surgeon: …………………………………………………

Orthogeriatric Consultant: ……………………………………………

Ward Doctors: ……………………………………………………………..

Physiotherapist: …………………………………………………………...

Occupational Therapist: …………………………………………….....

WHO WILL BE INVOLVED IN MY CARE?

You will be under the care of a multi-disciplinary team (MDT) whilst receiving treatment for your hip fracture. The team meet each morning to discuss each patient on the ward. We welcome any further information or concerns that you may have particularly in planning for discharge

These are the healthcare professionals you will meet:

Orthopaedic Surgeons: Doctors specialising in the mechanics of the bones and joints. These doctors are surgeons, performing operations and checking for wound healing and bone stability afterwards.

Ortho-geriatric Doctors: These are medical doctors, experienced in the complex medical problems particularly affecting older patients in the context of an admission with a hip fracture. Their role includes an assessment of bone health and a review of falls.

Consultant: This is the senior doctor who is in overall charge of your care. You will have two Consultants, an orthopaedic and ortho-geriatric Consultant.

Ward Doctors: These doctors work alongside the Consultant to manage your care.

Nursing Staff: A team of both qualified nurses and health care assistants who assist patients in meeting their care needs whilst in hospital. There will be a nurse in charge of your care each shift as well as a senior nurse for any further enquiries or concerns.

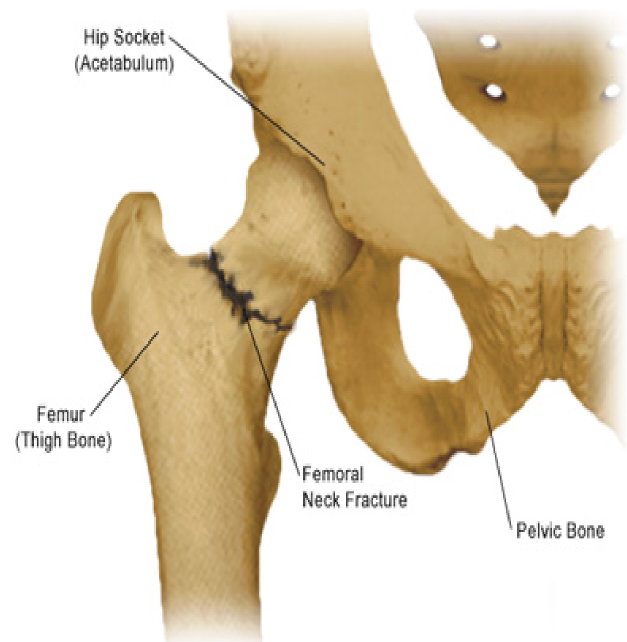
Neck of femur Specialist Nurse; These nurses support and assist patient, families and nursing staff in the care of hip fracture patients.

Physiotherapists: Therapists who work with patients after their operation to improve balance, strength and mobility.

Occupational Therapists: Therapists who promote independence and assess a patient's ability to manage everyday activities, helping to predict what level of care or assistance will be needed upon discharge.

WHAT IS A HIP FRACTURE?

The hip joint is an example of a “ball and socket” joint, involving the femur and acetabulum. A hip fracture refers to a break at the top of the femur bone, and rarely involves the socket. The majority are usually the result of a fall and are likely to require surgery. The particular type of surgery depends on where the bone has broken, and the number of broken fragments



UK Facts and Figures

70, 000 people in the UK sustain a hip fracture each year.70% are over 80 years of age. Hip fractures are common in the frail elderly. However, they can occur in patients who are otherwise healthy and independent. Patients who are fit, well and active prior to surgery often recover well. However, not all patients get back to their previous level of independence, and may require a walking aid afterwards. Those previously requiring a walking aid may struggle to mobilise; and may need some assistance with activities of daily living afterwards (e.g. dressing, toileting, meal times). Hip fractures are common in frail, elderly patients in their last year of life, where medical problems are exacerbated following their fall and fracture.

Sources: National Osteoporosis Society and National Hip Fracture Database. Please talk to your doctor if you are worried about how this may apply to you.

YOUR JOURNEY THROUGH HOSPITAL

WHAT CAN I EXPECT IN A&E?

Patients are usually admitted via A&E and initially seen by a team of doctors and nurses who take a brief history of the events leading to your admission. If appropriate, they will refer you on to the orthogeriatric team. An x-ray will be taken of your hip and chest. Fluids and medication are given intravenously (by drip) as required. You will be given pain medication, usually Paracetamol via injection and can have oral morphine in addition. You may also be offered an injection of local anaesthetic into the groin area to numb the nerves in the hip region (also known as a fascia iliaca compartment block). Routine blood tests are taken and a tracing of your heart (ECG) will be performed. You will have a urinary catheter until after the surgery. You will be assigned a ward: usually ward 31 or 30 on level 3 via the orange lifts.

WHY DO I NEED AN OPERATION?

Surgery is usually performed to reduce pain, to allow early mobilisation and to reduce deformity.

DOES EVERY PATIENT HAVE SURGERY OR IS THERE AN ALTERNATIVE?

The vast majority of patients with a hip fracture will require an operation. There are a few exceptions where hip fractures are managed without an operation but this is unusual and will be discussed in detail if relevant to your circumstances. Occasionally undisplaced stable fractures are managed without surgery but there is a risk of displacement ie where the pieces of bone move apart. This can lead to an unstable fracture which will then require surgery.

WHAT ARE THE RISKS OF NOT HAVING SURGERY?

The main risks are ongoing pain and the potentially life-threatening complications associated with long periods of bed-rest and immobility (e.g. chest infections, blood clots and pressure sores).

WHAT ARE THE RISKS ASSOCIATED WITH SURGERY?

The risks of surgery will be discussed with you when your orthopaedic doctor takes your consent. The main risks associated with the operation itself include blood loss, infection of the wound site and difficulty in establishing a good fixation especially in poor quality bone. The risks of an anaesthetic are usually related to underlying medical conditions such as heart disease, lung problems and risk of stroke. Most of the complications that develop after surgery result

from immobility. We will aim to reduce your risk by getting you up as soon as possible after your surgery.

YOUR CONSENT

It is important that you understand the operation, the risks of surgery and what this entails before signing your consent form. If you are unable to give consent, your consultants can make this decision for you in your best interests, following discussion with your next of kin where possible.

WHAT WILL HAPPEN BEFORE MY SURGERY?

You may need further blood tests or other investigations. You will be unable to eat for at least six hours before your surgery. You will have fluid through a drip during this time and you will be offered a carbohydrate drink called Nutricia Pre-op. This will help to prevent you from feeling thirsty and may enhance your recovery after your operation.

Many patients are anxious about how much pain they will experience. You will be offered regular analgesia (pain medication) but please let the nurses know if it is not adequate or if you need additional medication in between.

An anaesthetist will see you prior to your operation. There are two main types of anaesthetic: a general anaesthetic involves deep sedation and support of breathing with a tube into the airway or a spinal anaesthetic preventing sensation from the waist down which can be done awake or with mild sedation.

We aim to get you to surgery as soon as possible. If you are admitted late in the day, your surgery is likely happen the following day. In most cases your operation will be within 36 hours of admission. Common reasons why surgery is delayed:

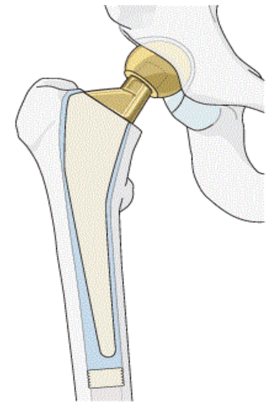
- If you are medically unwell and need further treatment prior to surgery.
- If you are on blood-thinning medication (e.g Warfarin) which must be reversed prior to surgery to prevent excessive blood loss.
- If there are other people waiting for emergency surgery with life threatening injuries.
- If you require a specialist operation such as a total hip replacement.

N.B. When surgery is delayed, patients will be given food and drink as soon as possible and we will endeavour to keep both you and your family informed.

WHAT OPERATION WILL I HAVE?

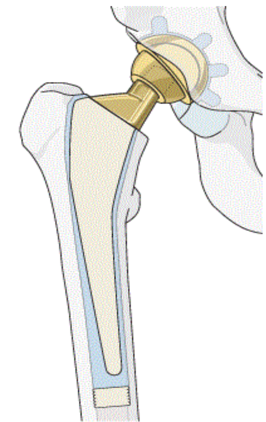
Your orthopaedic doctor will explain to you how your hip fracture will be treated and what this involves. Most patients require an operation with one of four types of hip surgery.

Your surgery has been marked below ☑



☐ **Hemiarthroplasty:**

When the fracture involves the head of the femur, the broken piece of bone is removed and replaced with a metal prosthesis. In effect, this is half a hip replacement: only the ball part of the joint is replaced.



☐ **Total Hip Replacement:**

When the fracture involves both the head of the femur and the acetabulum; or if the joint is likely to be affected by osteoarthritis via wear-and-tear in the near future, a total hip replacement is considered. Both the ball and socket are removed and replaced by a metal ball and stem, and a plastic cup respectively.

☐ **Dynamic Hip Screw (DHS):**

This is a large stainless steel screw which fixes the fracture and is held in place by a plate and a number of smaller screws. It holds the bones in position whilst they knit back together.

☐ **Intramedullary Nail:**

Fractures which extend down the femur need to be fixed with a metal rod passed down the middle of the bone, with additional screws to hold it in position.

WHAT WILL HAPPEN AFTER MY SURGERY?

Once you have initially recovered from your anaesthetic, you will be transferred back to the ward. You will be offered regular pain medications and can ask for more as required. Hip operations are associated with significant blood loss (about two units on average). If you are vulnerable to anaemia you may require a blood transfusion in the first few days. As soon as you feel able you may try something to eat and drink. If you feel sick, please tell the nurse who can give you medication to help. You may need to have more blood tests taken and another x-ray of your leg after surgery. The orthopaedic and ortho-geriatric doctors will see you regularly. They will also complete a 'falls risk assessment' over the period of your stay and begin the process for optimising your bone health. The nurses will help you with personal care and at mealtimes; but you will be encouraged to do as much for yourself as you can. The drip may be removed as soon as you are eating and drinking as normally.

NUTRITION

It is important to eat well during this recovery time to aid healing. Poor appetite is common after surgery. If you or your family are concerned about your food intake, please speak to a nurse. Family are welcome to bring you in fruit and snacks and to come and assist at mealtimes.

PAIN RELIEF

A hip fracture is often painful, but this should improve after your operation. You are likely to require regular painkillers for the first few weeks. It is very important that you take them regularly, as this will help you to be able to move more easily and participate in physiotherapy which will speed up your recovery. You will have painkillers prescribed. Please let the nurses know if you continue to be in pain: you do not have to wait until the next drug round.

COMMON PROBLEMS AFTER A HIP FRACTURE

Bleeding: You may lose some blood during your surgery. Some people may require a blood transfusion or a course of iron tablets post-operatively.

Infection: The orthopaedic team will monitor your wound for any signs of infection, which rarely requires further treatment.

Chest infection/Pneumonia: Bed rest increases the risk of developing pneumonia. Getting out of bed, even upright in a chair, allows the lungs to work much better. You will be encouraged to sit in a chair as soon as possible and to breathe deeply and to cough to clear your chest frequently. A chest infection will require treatment with antibiotics and may slow down progress after an operation.

Confusion (Delirium): This is not unusual following surgery and can be distressing for you and your relatives. Previous short-term memory problems or a history of dementia are associated with a high risk of post-operative confusion and disorientation. This can be worsened by:

- Medication: pain killers and anaesthetic drugs
- Infection
- Low oxygen levels
- Unfamiliar surroundings.

Confusion often worsens in the evenings. Relatives are encouraged to speak to the nursing staff about how they can help with delirium by re-orientating and bringing in familiar items. Relatives may also assist with feeding or taking part in physiotherapy sessions.

Constipation: This is a common problem, exacerbated by reduced mobility, medication, dehydration and hospital diet. The nurses will monitor this daily. You will be offered regular laxatives and encouraged to take them. Increasing your fluid intake will also help. The nurses can assist you in bringing a bed pan or a commode for the first few days after the operation so please do not worry about not being able to get to the toilet.

Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE): DVT (a blood clot in the calf) may occur in patients after a hip fracture. Rarely, a clot can break off and travel to the lungs (PE). Immobility, dehydration and other underlying illnesses increase the risk of clots. Blood-thinning

medication, either as a daily injection or as a daily tablet is given to reduce this risk, and is usually continued for 28 days following surgery.

Leg swelling: This is common in the operated leg and can take several months to subside. It will improve as your mobility improves, but try to elevate the leg when you are sitting down. If your leg becomes hot, red or increasingly painful please let your doctor know immediately.

Pressure Ulcers (bed sores): Lying on a bed can lead to pressure building up in certain areas of the body. This pressure stops the blood flow to the skin by closing off tiny blood vessels. Pressure sores are more likely to occur if pain from your hip fracture prevents you from moving, and the pressure stays constant in one area. The pressure causes the skin to die, in a similar way to a burn. First the area hurts, and then begins to blister, before turning into an open sore. These can become infected, and are difficult to heal if they are large. Prevention of pressure sores is key. Your nurses will encourage you to turn regularly, and will assist you if you are unable to manage yourself.

Dislocation: this is an occasional complication with hemi-arthroplasty or total hip replacement. Those undergoing total hip replacement will be given certain precautions to prevent dislocation. Information on these precautions will be provided to you by your therapy team.

Complex fractures: sometimes fractures may not mend fully (this is called non-union) or the metal implant may fail, requiring further surgery. These fractures can be difficult to fix. Rarely patients may not be allowed to put weight through the leg for up to six weeks, to allow the bone to start healing.

PHYSIOTHERAPY

WHAT PHYSIOTHERAPY WILL I NEED?

You will be seen by a member of the physiotherapy team the day after your surgery. They will assess the safest way for you to transfer with the nursing staff and also teach you some exercises to aid your recovery. It is important you sit out in the chair every day; the multi-disciplinary team will be able to help you with this and will continue with your rehabilitation as advised by the physiotherapy team.

The physiotherapy team will review you on a regular basis and aim to progress your transfers and walking with the appropriate aids.

On your return home it is important you continue to stay mobile and do the exercises you have been shown.

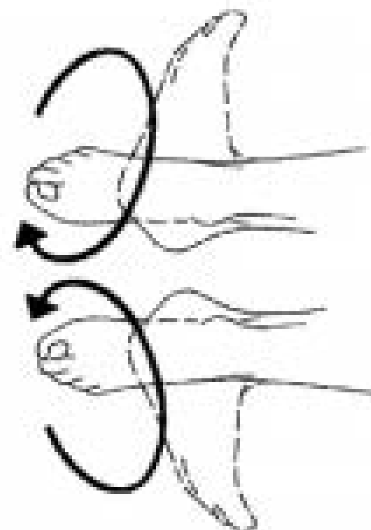
EXERCISES FOLLOWING HIP SURGERY

You will be taught exercises to aid circulation, help get your hip moving and improve your muscle strength. You will be expected to complete these exercises outside of your physiotherapy sessions; you may need a relative/friend to help you with these.

BED EXERCISES:

ANKLE PUMPS/ ROTATIONS

Point your toes towards the end of the bed and then pull them up towards your head. Rotate your feet in circular motions. Repeat these little and often throughout the day.



SUPPORTED KNEE BENDS

Bend your knee and try to slide your heel towards your buttocks. Do not let your knee roll inward. Repeat 10 times, 3 - 4 times a day.

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STATIC GLUTES/ BUTTOCK CONTRACTIONS

Tighten your buttock muscles and hold for 5 seconds. Repeat 10 times, 3 - 4 times a day.

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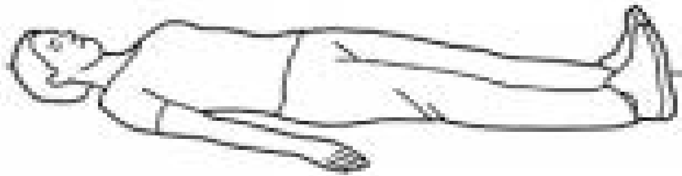
STATIC QUADRICEPS

Keeping your leg straight, pull your toes up towards your head and push your knee into the bed. Hold for 5 - 10 seconds. Repeat 10 times, 3 - 4 times a day.

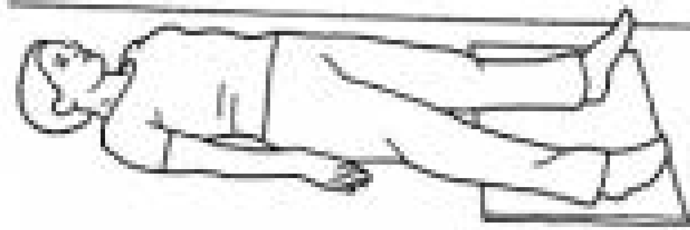


INNER RANGE QUADRICEPS

Roll up a towel and put it under your knee. Push your knee down into the towel, the bottom half of your leg should lift up away from the bed. Hold for 5 - 10 seconds. Repeat 10 times, 3 - 4 times a day.

HIP ABDUCTION

Slide your leg out to the side of the bed and then bring it back into the middle, be careful not to cross your leg over the midline. Repeat 10 times, 3 - 4 times a day.



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STRAIGHT LEG RAISE

Keep your leg straight, tighten your thigh muscle and lift your leg off the bed. Hold for 5 seconds and lower slowly. Repeat 10 times, 3 - 4 times a day.

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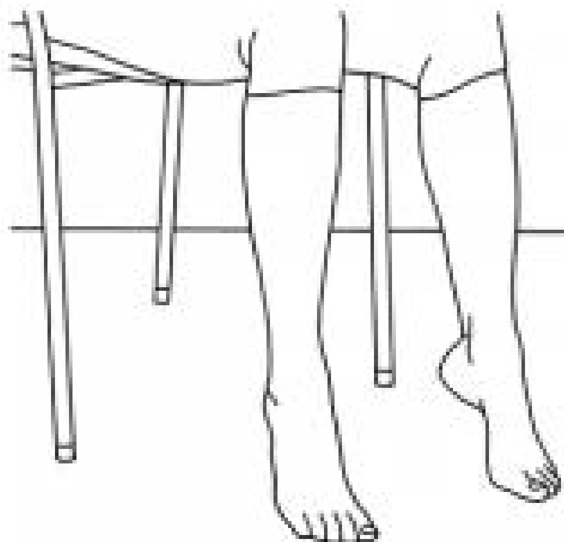
SEATED EXERCISES:

ANKLE PUMPS

Bend and straighten your ankles. Repeat 10 times, 3 - 4 times a day.



KNEE EXTENSION

Straighten your leg and hold it out in front of you for 5 seconds. Repeat 10 times, 3 - 4 times a day.

HIP ABDUCTION

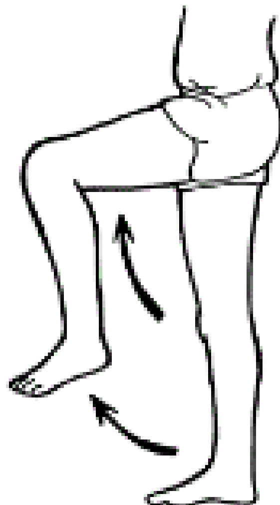
Keep your feet on the floor and move your knees out to the side. You can use your hand on the outside of your knee to add some resistance. Repeat 10 times, 3 - 4 times a day.

STANDING EXERCISES:

You will need to hold onto something for support i.e. a sturdy chair, kitchen worktop or walking frame.

KNEE RAISES

Lift your operated leg towards your chest; do not lift your knee higher than your waist. Then slowly lower it back to the floor. Repeat 10 times, 3 - 4 times a day.



HIP ABDUCTION

Keeping your trunk straight, lift your leg out to the side as far as you can. Slowly bring your leg back to the middle. Repeat 10 times, 3 - 4 times a day.

HIP EXTENSION

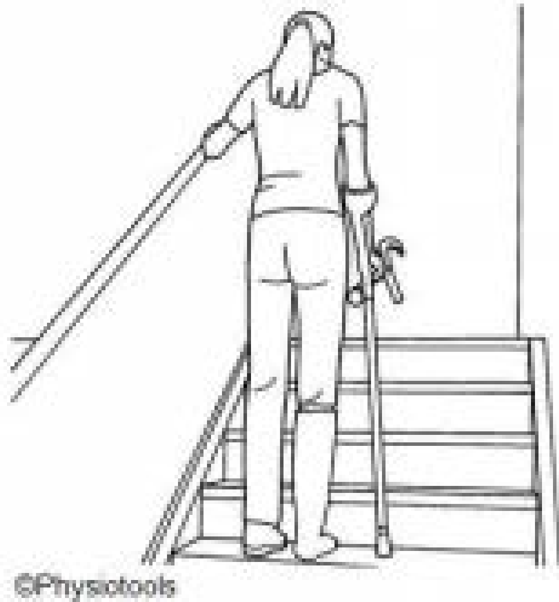
Keeping your trunk straight, lift your leg behind you as far as you can. Slowly bring your leg back to the middle. Repeat 10 times 3-4 times a day.

STAIRS

GOING UPSTAIRS

Take one step at a time.

Unoperated leg first, followed by operated leg and then walking aid.



GOING DOWNSTAIRS

Take one step at a time.

Walking aid first, followed by the operated leg and then the unoperated leg.

OCCUPATIONAL THERAPY (OT)

WHAT OCCUPATIONAL THERAPY WILL I NEED?

Occupational Therapists assess your ability to manage everyday activities.

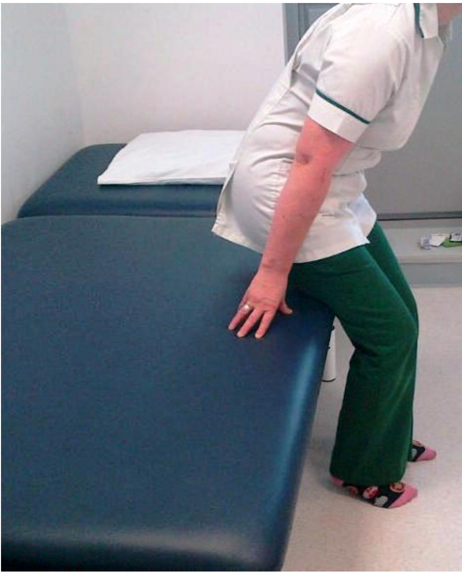
Your Occupational Therapist will meet with you on the ward following your surgery and will talk to you about your home set up and how you were managing prior to your admission to hospital.

As your mobility begins to improve, the Occupational Therapy team will continue their assessments and make recommendations about how to manage your daily activities once you return home. We may suggest minor changes to your home environment, loan of basic equipment and referrals to other services for support at home if required.

Whether you are discharged directly from Tunbridge Wells Hospital or from the Community Hospital, the Occupational Therapists will ensure you are safely set up and able to manage as independently as possible before you are discharged home.

ADVICE FOR MANAGING YOUR DAILY TASKS

TRANSFERRING ON AND OFF THE BED



Position yourself at the side of the bed, two thirds of the way up. Make sure you can feel the bed on the back of your legs before you try to sit down.

Try to get onto the bed leading with your non-operated leg if possible.

Support your upper body with your arms and slide your bottom as far back onto the bed as you can. Bring your non-operated leg onto the bed.

Bring the operated leg up onto the bed gradually and use your upper body to move yourself further up the bed.

Try to get out of bed on the same side, this time leading with your operated leg.

TRANSFERRING ON AND OFF THE CHAIR

- Position yourself in front of the chair so that you can feel it on the back of your legs.
- Reach back for the arms of the chair. Straighten your operated leg out in front of you and lower yourself down gently into the chair.
- When getting out of the chair, shuffle your bottom forwards and push up using both hands. Make sure you are balanced before taking your hands off the chair and onto your walking aid.

DRIVING AND GETTING IN OR OUT OF THE CAR

You cannot drive for at least 6 weeks after surgery. We would advise you discuss driving with your consultant and you will need to contact your insurance company to inform them of your recent surgery.

When transferring in or out of a car as a passenger, we advise:

- The passenger seat should be slightly reclined and as far back as possible to allow for maximum leg room. If necessary put a cushion on the seat to raise it.
- Sit on the seat before lifting your legs into the foot well. You may find it useful to grip the door frame whilst someone holds the door steady so you can lower yourself gently onto the seat.

GETTING IN/ OUT OF THE BATH OR SHOWER

Following hip surgery, you may find it difficult to get in/ out of the bath. Your ability to use a shower safely will depend on the style of your shower, equipment available and what walking aids you are using. Please discuss further with your Occupational Therapist.

For safety and independence, it is usually advised that you strip wash initially on discharge and sit to dress. The following page contains some guidelines on dressing post hip surgery.

HOW TO USE LONG HANDLED AIDS FOLLOWING HIP SURGERY

You can purchase the following aids which may be helpful after your surgery:

Helping hand

Long handled shoe horn

Long handled sponge

Sock aid (please note this cannot be used with surgical stockings)

We recommend sitting on a suitable height chair or perching stool to wash and dress. Always dress your operated leg first for ease.

To use long handled aids to dress your lower half:

- Hold the waist band of your clothing with the helping hand and lower to the floor. You can use the hooked end of a long handled shoe horn to open the leg hole of the clothing
- Using the helping hand, guide the clothing over your leg and up to your knees, where you can safely reach it
- You can now carefully stand to a walking aid to finish dressing your lower half
- Undress your non- operated leg first

NOTE - You will be wearing your surgical stockings for 6 weeks after surgery. You are likely to need assistance with putting these on and taking them off so please consider who might be able to help you when you are discharged. Please discuss further with your Occupational Therapist if necessary.

MANAGING KITCHEN TASKS

Your Occupational Therapist will discuss how you are going to manage your kitchen tasks safely on discharge. It is advised that you use easy meals initially and build up gradually to your usual cooking routine.

You are likely to be discharged home using a walking aid which will affect your ability to carry items. Your Occupational Therapist will discuss the set- up of your kitchen at home and identify any equipment that may help to increase your safety and independence with manging your food and drink preparation.

MANAGING HOUSEHOLD TASKS

During your recovery period, you will need some help with managing household tasks such as housework, laundry and gardening. If you do not have any family or friends that may be able to help, please discuss with your Occupational Therapist as they may be able to signpost you to suitable charities and services who can provide this type of support on discharge.

REDUCING TRIP HAZARDS

Most hip fractures occur as the result of a simple fall. Falling is not an inevitable result of ageing, but the risk of falls increases as we get older. During your admission, your orthogeriatric doctor will have carried out a fall's risk assessment: trying to uncover any medical problem which might make you more likely to fall (e.g. abnormal heart rhythms, fall in blood pressure on standing). Environmental changes may be suggested by your Occupational Therapist to reduce your risk of further falls. This advice may include;

- Ensuring you are using the correct walking aid to provide stability when mobilising
- Removing or securing any rugs or loose fitting carpet
- Ensuring non slip mats are used in bathroom
- Removing or securing any loose wires
- Ensuring lighting is adequate, particularly for night time toileting
- Reducing clutter
- Wearing appropriate footwear
- Organising your home to reduce the need to bend, stretch and climb
- Advice on installation of emergency buttons (lifeline) to quickly alert others in event of fall
- Ensuring you have regular eye tests

For further information on falls please see the Falls Information leaflet

HOW LONG WILL I BE IN HOSPITAL?

You will be transferred to Tonbridge Community Hospital when deemed medically stable to transfer, usually around three days after the operation.

If it is anticipated that you are unlikely to be able to return to living independently in your own home further assessments of care needs will need to be done which often extend the admission. Similarly individuals from residential homes with increasing care needs may need reassessment and occasionally re-settlement.

Where possible we try to predict length of stay from the point of admission and set an estimated date of discharge for all parties to work towards. This may need to be adjusted depending on progress.

WHAT CAN I EXPECT AFTER DISCHARGE?

Realising your limitations after surgery is often quite a shock when you get home. It is important to continue to stay mobile and do the exercises you have been shown. At this stage, most patients will continue to improve, and do not require on-going physiotherapy. If you are concerned about your progress, you may wish to discuss this with your GP.

Patients with hip fracture are at increased risk of blood clots, and blood thinning medication should continue for most patients for 28 days following surgery. This is commonly a daily injection, which you or a family member can be taught to administer. Alternatively, a district nurse will visit you after discharge to help with this.

You are likely to be discharged on calcium and vitamin D supplements. Both are difficult for most people to get in adequate amounts in their normal diet. It is important to continue taking these to improve stability and help strengthen your bones. If you are having difficulty chewing these chalky tablets, discuss with your GP about changing to the dissolvable powder or to caplet form. Many patients are also started on another drug to strengthen their bones and prevent further fractures. Often this involves taking a tablet once a week (Alendronate) for about five years. Please discuss with your GP if you are having difficulty taking it. Alternatives including six monthly injections (Denosumab) are available for those unable to manage this.

WHAT FOLLOW UP WILL I NEED ON DISCHARGE?

Most patients do not require further X-Rays, nor any follow-up with the orthopaedic team. If you have concerns about the operation, or develop increasing pain, you should seek advice from your GP.

All patients are routinely followed up via a telephone clinic at three months and a year following hip fracture. You can expect a telephone call to enquire about your progress and ensure you are managing bone health tablets

WHAT IS OSTEOPOROSIS?

Bone is made of collagen fibres (tough, elastic fibres) and minerals (gritty, hard material). Bone is a living tissue and contains cells that constantly build new bone, whilst breaking down the old. Up to our mid- 20s the construction cells are working to strengthen our skeleton. After our mid-40s, the demolition cells become more active, and we begin to lose bone density. Osteoporosis is a silent disease in which there is gradual loss of bone tissue or bone density that makes bones fragile so that they may break under the slightest strain.

WHO IS AT RISK?

We all have some risk of developing osteoporosis with age, though it is more common in women. The following increase your risk of developing osteoporosis:

- Early menopause
- Previous fracture after a minor fall or accident
- Family history
- BMI <19 (severely underweight)
- Immobility or sedentary lifestyle
- Steroid therapy (e.g. Prednisolone)
- Smoking
- High alcohol intake
- Lack of Vitamin D (likely due to little sunlight exposure, poor diet)
- Medical conditions including: overactive thyroid, or those that affect mobility including stroke.

HOW IS OSTEOPOROSIS DIAGNOSED?

Osteoporosis is often first diagnosed when you break a bone after a fall from a standing height. You may be referred for a DEXA (Dual Energy X-ray Absorptiometry) scan that uses special X-ray machines to check the bone density and confirm osteoporosis. This may be unnecessary after a hip fracture in a woman over 75 years for whom the diagnosis may be made clinically. We routinely refer all men and women under the age of 75 years for a DEXA scan. Your orthogeriatric consultant who will arrange to see you in clinic or write to you. The 15 minute scan of your hip and lumbar spine is done at St Peters as well as the Nuffield Hospital and Mount Alvernia usually 6-8 weeks after discharge. You will receive an appointment in the post. The results will usually be sent to your orthogeriatric consultant who will write to you and your

GP with advice about any further treatment. What are the symptoms and problems of osteoporosis? What are the symptoms and problems of osteoporosis? There are no true symptoms of osteoporosis rather, it presents itself after fractures (commonly in the wrist, hip and spine) following falls. Compressed bones in the spine (vertebral fractures) can lead to loss of height and a stooped posture, and can happen spontaneously, without a fall. What can I do to overcome the onset of Osteoporosis? Regular “weight-bearing” exercise can help to prevent or slow down bone loss. Adequate calcium and vitamin D are important for healthy bones. If you smoke, you should make every effort to stop, and cut down on alcohol if you drink heavily

WHAT ARE THE TREATMENTS FOR OSTEOPOROSIS?

The treatment of osteoporosis depends on a number of factors including your age, sex and medical history. The aim is to strengthen existing bone, prevent further bone loss, and reduce the risk of broken bones. Once medication for osteoporosis is started, it is likely that you will need it for at least five years and sometimes lifelong. If you experience any side-effects please discuss with your doctor before stopping medication. An alternative drug may be more suitable for you.

a) The bisphosphonates are a group of drugs that include weekly Risedronic acid (Risedronate). These are the most commonly used drugs to treat osteoporosis, and work on the bone-making cells. The most common side-effect is indigestion.

b) Strontium ranelate (Protelos) appears to affect both cells that build bone and those that break it down. It is a useful alternative drug for some patients when bisphosphonates are not suitable. The most common side-effect is diarrhoea in the initial period after starting the drug, which settles in most patients.

c) Denosumab (Prolia) is a monoclonal antibody, which is a protein that targets specific cells in the body. It works to block the cells that break down bone, allowing the bone-making cells to build up bone mass. It is given as a 6 monthly injection, which can be given at your GP practice d) Calcium and vitamin D tablets are commonly prescribed in addition to one of the above drugs. Some treatments for osteoporosis are very rarely associated with a complication involving bone loss in the jaw bone, known as osteonecrosis. If you need to have any dental work (especially surgery), tell the dentist ahead of time that you are receiving treatment for osteoporosis. You may need to stop using the medicine for a short time.

Further information is available from The Royal Osteoporosis Society.

USEFUL CONTACTS

☎ **NOF Nurse 01892 638189**

☎ **Ward 31 01892 635626**

☎ **Physiotherapy Tunbridge Wells 01892 635298**

☎ **Occupational Therapy Tunbridge Wells 01892 635608**

☎ **Tonbridge Cottage Hospital 01732 353653**

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Patient Advice and Liaison Service (PALS)
If you would like to raise any concerns, make comments and suggestions or require information on Trust services, you can contact **PALS**. Office opening times are Monday to Friday 10.00am to 4.00pm. Both offices offer a 24 hour answering machine. Messages will be responded to within one working day, so please do leave a contact number.

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