HealthCare
Corporation of St. John's

Calcium and Bone Clinic
Christopher S. Kovacs, MD, FRCPC, FACP

March 28, 2001

Dr. Cherry Pike
Eastgate Medical Centre
279 Portugal Cove Road
St. John's, NF
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Re: Joanne Parsons
MCP: [redacted]
Clinic Date: March 27, 2001

Dear Dr. Pike,

I saw Joanne Parsons in the Osteoporosis Clinic today. As noted in my previous letter, she had to leave before being seen at the first visit. Today, she had the unfortunate circumstance of being told by someone at the patient registration that I did not have a clinic today. She returned to work and upon telephoning the clinic to clarify the situation, found out that the clinic in fact was already in progress and we were wondering why she was not in attendance. Consequently, I saw her later in the day than scheduled.

She is presently 48 years of age and has been post-menopausal by symptoms for the past several years. She had had a hysterectomy and removal of one ovary at age 27 for endometriosis. Beginning about five years ago she began having hot flashes, but her gonadotrophin and estradiol levels were normal. In late 1998, her LH and FSH levels were frankly elevated and they have been that way ever since. Her hot flashes have lessened in the past six months and are essentially absent now. She stated that she had been battling Dr. Tennant for the past ten years, refusing his orders that she go on hormone replacement therapy because she felt that she did not need it and she was concerned about the potential complications of hormone replacement therapy. She had a bone mineral density study completed in June 2000, which showed osteopenia of the hip, prompting this consultation.

She has suffered no fragility fractures. She is aware of a family history of osteoporosis involving her mother, who has systemic lupus as well as other health problems that have clearly impacted on her bone status. This lady's menarche was at age 13 and she had regular menses after that until the surgical end at age 26 or 27. She had two pregnancies resulting in the birth of two children. She has previously been treated with oral contraceptives which cause side effects of headaches, bloating, weight gain and mood swings.

She is aware of a family history of breast cancer involving both of her grandmothers. She has had a mammogram 3-4 years ago which was normal and her last Pap test was in January of 1999 and this was also normal. Her past history is otherwise unremarkable. She is hearing impaired on the left side. Her medications include calcium supplement, a multivitamin and vitamin C. She works as an office worker. She smokes about 15-20 cigarettes per day. She consumes alcohol only rarely. She exercises in the form of aerobics every week.

Assessment by the dietician at the previous visit determined that this lady's dietary calcium intake is about 300 mg. with an additional 1200 mg. through supplements. Her vitamin D intake is about 100 IU through diet and 400 IU through supplements. Thus, her combined intake is approximately1500 mg. of calcium and 500 IU of vitamin D per day. Her calcium intake is in the ideal range, whereas her vitamin D intake is a little low in comparison to the approximately 800 IU that are recommended for her situation. She has been previously instructed about ways of increasing her vitamin D intake accordingly.

The bone mineral density study completed in June 2000, showed the lumbar spine bone density to be 1.10 gm/cm^2 which is 0.8 standard deviations below peak mass and in the normal range. The left femoral neck bone density was 0.746 gm/cm^2 which is 1.9 standard deviations below peak mass and in the range of osteopenia.

Screening blood work obtained prior to the previous assessment showed normal parathyroid hormone, calcium, vitamin D metabolites, serum protein electrophoresis, alkaline phosphatase and TSH.

This woman has mild osteopenia of the femoral neck with normal bone density of the lumbar spine. She is clearly post-menopausal and can be expected to lose bone density if maintained solely by calcium and vitamin D replacement. I explained to her that calcium and vitamin D supplementation, combined with exercise and healthy lifestyle, will slow the loss of bone density, but will not stop it. The only thing that can more substantially decrease the loss of bone density or stop the decrease in bone density are estrogen or Evista, or bisphosphonates (Actonel, Fosamax and Didrocal) or nasal Calcitonin (Miacalcin).

She is very reluctant to take any medications unless there is an absolute need. She understands the issues having read much about the nature of osteopenia and osteoporosis. She would prefer to see evidence that she is losing bone fast before agreeing to take any medication. Accordingly, and as I agree with her reasoning, I am going to arrange for another bone density to be done which will likely be in October of this year. That will allow us to determine how much bone density has been lost after more than one year.

Should it show little or no decrease in bone density, then she could be followed by intermittent bone density readings until such time as she has begun approaching the osteoporotic range of bone density. On the other hand, if there has been a significant decrease, and in particular a rapid decrease of bone density, then treatment would definitely be indicated and she would be agreeable to undertake it.

I will therefore see her again in the fall or early winter for review, following the bone density appointment.

Sincerely,

Christopher S. Kovacs, MD, FRCPC, FACP
Division of Endocrinology
CSK/lb
cc: Dr. W. Button, Cowan Ave. Medical Clinic, 510 Topsail Rd., St. John's, A1E 2C2