Table 7: Monitoring of therapy in postmenopausal females and males aged 50 years and older who receive anti-osteoporosis medication*

Recommendations	Strength of recommendation and certainty of evidence†
6. Monitoring	
6.1. We suggest BMD measurement 3 yr after initiating pharmacotherapy. Remarks: BMD measurement may be repeated at a shorter interval in people with secondary causes of osteoporosis, new fracture or new clinical risk factors associated with rapid bone loss.‡	Conditional recommendation; very low-certainty evidence
6.2. Three years after stopping bisphosphonate therapy (i.e., drug holiday), we suggest repeating BMD measurement and clinical assessment of fracture risk to determine the need for resumption of therapy. We suggest following the recommendations for risk assessment and initiation of pharmacotherapy. Remark: A shorter interval for reassessment to resume therapy may be appropriate in people with higher risk of fracture (such as previous hip fracture or high FRAX or CAROC score), secondary causes of osteoporosis, new fracture or new clinical risk factors associated with rapid bone loss.‡	Conditional recommendation; very low-certainty evidence
6.3. We suggest against monitoring using bone turnover markers for fracture prevention or for deciding on resumption of therapy in people who have stopped bisphosphonates (drug holiday).	Conditional recommendation; very low-certainty evidence
6.4. We suggest against using a fracture risk assessment tool (FRAX or CAROC) for monitoring response to pharmacotherapy.	Conditional recommendation; very low-certainty evidence
6.5. Good practice includes regular clinical assessment for new fractures and new or active risk factors such as falls, as well as adherence to therapy, tolerability and adverse effects. Remark: Adherence to osteoporosis medications is known to be low and may be lower in people who have multiple comorbidities or medications, adverse effects, no drug coverage or misconceptions about osteoporosis therapy.	Good practice statement
6.6. Good practice includes counselling on and monitoring for symptoms of AFF and ONJ with bisphosphonates or denosumab therapy. Remark: Risk factors for AFF include glucocorticoid use, longer duration of therapy. The risk is also higher in females who self-report Asian race or ethnicity. Unexplained thigh or groin pain should be evaluated. Poor dental health, invasive dental surgery and glucocorticoid use are risk factors for ONJ; oral cavity lesions should be evaluated by a dentist.	Good practice statement

Note: AFF = atypical femur fracture, BMD = bone mineral density, CAROC = Canadian Association of Radiologists and Osteoporosis Canada tool, FRAX = Fracture Risk Assessment Tool, ONJ = osteonecrosis of the jaw.
*See Figure 1 and Figure 2 for integrated approaches.
†See Table 1 for definitions.
‡See risk factors in Figure 1 and Appendix 1, Supplementary Table 5 (causes of secondary osteoporosis), available at www.cmaj.ca/lookup/doi/10.1503/cmaj.221647/tab-related-content

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3.7. We suggest that for individuals who do not meet the threshold for initiating pharmacotherapy or choose not to initiate therapy, BMD testing can be repeated at: a. 5–10 yr if the risk of major osteoporotic fracture is < 10% b. 5 yr if the risk of major osteoporotic fracture is 10%–15% c. 3 yr if the risk of major osteoporotic fracture is > 15%. Remark: A shorter retesting interval may be appropriate for those with secondary osteoporosis or new clinical risk factors, such as a fracture.	Conditional recommendation; low-certainty evidence (females), very low-certainty evidence (males)