Editorial paper

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Osteoporosis treatment in Poland in 2026



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For years, osteoporosis has been discussed as a major public health challenge, primarily linked to the aging of populations, especially in highly developed countries. Today, with a broader perspective, a larger arsenal of medications, and a deeper understanding of the causes and risk factors of osteoporosis, it remains surprising that we still find ourselves calling for better diagnosis, more timely referrals, and prompt treatment. Although it should be self-evident that therapy ought to be initiated – ideally – before a serious complication such as a low-energy (fragility) fracture occurs, this is still not the case in clinical practice. The statistics remain alarming: only a small proportion of patients (approximately 25%, depending on the study or analysis) who suffer an osteoporotic fracture are subsequently referred to specialists for further treatment and monitoring [1]. We are well aware that the risk of a subsequent fracture increases several-fold within the first 1–2 years following an initial fracture [2]. Furthermore, a fracture – particularly one involving the femoral neck – carries a significant risk of mortality (approximately 20%), especially among men with osteoporosis; however, recent studies indicate some improvement in this respect in some European regions [3, 4].

Before discussing progress in osteoporosis management, it is worth analyzing the reasons for delays in the diagnosis and treatment of this disease.

First and foremost, there is a persistent lack of public awareness regarding the seriousness of this condition, which often only becomes symptomatic when a fracture occurs.

Symptoms such as pain, loss of height, and a deterioration in posture are not always identified – either by primary care physicians or by subsequent specialists, including orthopedists, neurologists, anesthesiologists, or even rheumatologists. While managing symptoms such as pain is important – especially to prevent it from becoming chronic, at which the pain itself may become a distinct clinical problem – it is not sufficient; patients must also undergo diagnostic testing for osteoporosis.

A second point worth noting is the tendency to focus primarily on the postmenopausal period, which often leads to other types or causes of osteoporosis being overlooked – such as long-term glucocorticosteroids (GC) therapy, the use of other medications that may affect bone health (e.g., anticoagulants or antidepressants), the presence of inflammatory conditions (such as rheumatoid arthritis and other inflammatory autoimmune diseases), endocrine disorders, or cancer. While age serves as an important factor in interpreting bone mineral density (BMD) measurements obtained by dual-energy X-ray absorptiometry (DXA), it is not the sole criterion for identifying affected individuals.

A third issue concerns reduced bone density in younger people and children; a separate, albeit rare, condition is pregnancy-associated osteoporosis. Today's younger population is frequently exposed to factors – such as eating disorders, physical inactivity, and substance use – that hinder the attainment of optimal peak bone mass, potentially increasing the risk of osteoporosis and fractures later in life.

It is estimated that a significant number of people worldwide currently live with osteoporosis, yet only a tiny proportion receive proper treatment. Fractures remain a major clinical manifestation of the disease, and public awareness campaigns – aimed at both physicians and patients – have proven insufficient and lack the necessary "appeal" to be truly effective. The designation of October 20th as World Osteoporosis Day is another attempt to draw attention to this issue, featuring messages such as: build strong bones through a balanced diet and healthy habits, protect your bones by learning about the risks of osteoporosis, and strengthen your bones if you have osteoporosis or have experienced a fracture [5]. One might ask why this happens – is awareness regarding the seriousness of the disease still marginal, or is it perhaps being disregarded? Alternatively, because the disease may develop asymptomatically for years – with subtle symptoms sometimes appearing before a fracture occurs – the earlier stages (which do not yet

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significantly impact a patient's quality of life) may go unnoticed, or may be (incorrectly) considered unrelated to declining health. It is also possible that medical education on osteoporosis is insufficient, with the topic being overshadowed by other conditions that affect a patient's life more rapidly.

It seems essential to consider all known risk factors for osteoporosis to modify one's lifestyle in a timely manner, and to take every available step to minimize the risk of the disease.

A relatively new approach to treating osteoporosis involves basing therapeutic decisions more on an assessment of fracture risk, rather than relying solely on BMD measured by DXA and the associated T-score. While this approach appears sound, the question remains: does the risk calculation fully account for or personalize the specific, real-world situation of the individual patient? Should such calculations not incorporate a broader range of data? There have also been proposals to eliminate the term "osteopenia" and replace it with "low bone mass" [6].

For years, in many countries, limited access to certain medications and their high cost meant that treatment regimens were based primarily on anti-resorptive agents. Treatment recommendations now include sequential therapy, in which an anabolic agent is followed by an anti-resorptive treatment [7]. This key recommendation is primarily intended for patients at very high risk of subsequent fractures, including some patients who have recently sustained a fragility fracture.

The goals of osteoporosis treatment have also been subject to re-evaluation. One key, yet exceptionally challenging, objective is the prevention of osteoporosis itself – a goal fundamentally addressed through lifestyle modifications, dietary adjustments, the correction of vitamin D and calcium deficiencies, and the identification of underlying conditions that predispose individuals to the disease.

Another clear objective is the prevention of subsequent fractures in patients diagnosed with osteoporosis following an initial fracture.

A third scenario concerns patients treated with GCs for more than 3 months. In this group, the evidence is definitive – rather than merely suggestive – that long-term GC use increases the risk of GC-induced osteoporosis [8].

All clinical guidelines for osteoporosis must grapple with ongoing debates regarding the choice of anabolic or anti-resorptive agents, the optimal duration of therapy, and the feasibility of "drug holidays." While such breaks may be appropriate for certain medications (e.g., bisphosphonates), discontinuing others – even after achieving the desired therapeutic effect – can trigger rapid bone loss and an increased risk of vertebral fractures; this is particularly relevant to denosumab [9].

The recent expansion of the range of osteoporosis treatments available in Poland – which includes bisphosphonates, denosumab, romosozumab (for a specific subset of patients), and the less frequently used raloxifene – represents a long-awaited advancement. This development moves beyond mere conceptual novelty, enabling a sequential approach to therapy involving anabolic and anti-resorptive agents. Discussions will continue regarding combination therapy and the analysis of the specific characteristics or phenotypes of target groups that derive particular benefit from a given treatment [10]. There is a need for recommendations from professional societies and guidance from experts – resources designed to assist physicians in making therapeutic decisions and to serve as a basis for discussions among healthcare system stakeholders, with the aim of improving the management of osteoporosis.

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