

OC-FLS Newsletter April 2026

News and Updates

- National OC-FLS Audit:** The new Key Performance Indicator (KPI) v 4.0 guidance document is now posted on the OC FLS Hub. **For the next national OC-FLS audit:** data will be collected from a cohort of patients enrolled into your FLS from Oct 1, 2026 to March 2027 and followed for one year after enrollment. You will be requested to submit your data by June 2028 through an on-line portal.
Support tools for the FLS audit:
 - A KPI appendix to answer frequently asked questions will be available by May 31, 2026.
 - An OC-FLS audit webinar will take place in the spring of 2026; stay tuned for date and time.
 - An updated data collection spreadsheet for FLSs will be available by June 30, 2026.
- OC-FLS registry:** Since the last newsletter, one new FLS was accepted into the OC-FLS registry in Alberta. We now have 55 FLSs in 10 provinces. [Click here to view the FLS Registry Map](#)
- Cross country check-up:** Interviews with FLSs across the country will be wrapping up by the end of June. The purpose of these check-ins was to help us understand how each FLS operates, what challenges you are encountering and how we can better support you moving forward. Thanks to all who have participated, it has been a fascinating endeavour. A report with aggregate findings will be released in fall 2026 and will guide our OC-FLS work over the next year.

New tools to support FLS education and practice

- Osteoporosis Canada exercise videos** – Many of you have reported challenges in recommending physical activity for your patients and limited access to community exercise programs. I would strongly recommend that you refer your patients to the excellent series of webinars produced by Dr. Lora Giangregorio and her team. There is something for every type of patient you may encounter. [Video Series on Exercise and Osteoporosis | Osteoporosis Canada](#)
- [Learn About Rare Bone Diseases HPP, XLH and FOP with Dr. Angela Cheung | Osteoporosis Canada](#) – This video hosted by Dr. Angela Cheung is an excellent overview of rare bone diseases that FLS's may pick up in screening blood work to rule out secondary cases of osteoporosis. These patients may require further investigation with additional blood work and genetic testing. **Of note, if you have a patient with low alkaline phosphatase and suspected hypophosphatasia do not start them on anti-resorptive agents.** Below is a table with key take away messages.

Case 1: Hypophosphatasia (HPP)

Characterized by low ALP levels. Pathogenic ALPL gene variant identified.

- Avoid potent antiresorptive therapies
- Enzyme replacement therapy (asfotase alfa) may be considered

Case 2: X-linked Hypophosphatemia (XLH)

51-year-old woman with short stature and bowed legs.

- Low phosphate levels, elevated PTH
- PHEX gene pathogenic variant
- Treatment: Burosumab (anti-FGF23 antibody)

Case 3: Fibrodysplasia Ossificans Progressiva

52-year-old with painful joint flares and stiffness.

- ACVR1 gene mutation (R206H)
- Progression: central to peripheral, back to front
- Treatment: symptom management, palovarotene, investigational therapies

A frequently asked question

Q: In my province, we now have access to the anabolic agent romosozumab for patients with fragility fractures. How should we be making treatment recommendations for romosozumab?

A: You are not restricted to recommending anabolics ONLY for patients with severe vertebral fracture (vertebral body height loss of >40%) or ≥2 vertebral fractures AND a T-score ≤ -2.5, as per the suggested OC 2023 guidelines, if your provincial medication coverage plan is more generous. The OC 2023 guideline committee limited the recommendations for anabolic agents predominantly because most provincial drug plans did not cover anabolic agents in 2023 and therefore cost was a significant barrier. All provinces except Alberta now have limited coverage for romosozumab.

Each FLS will need to determine their own guidance plan for who they will be recommending for anabolic agents. These decisions will be based on many factors including: appropriate timely cardiovascular risk assessment, determining patient selection criteria and availability of osteoporosis specialist to prescribe anabolics. Most provinces require patients to be treatment naïve in order to qualify for financial support for anabolic agents. Therefore, **DO NOT** start on an anti-resorptive agent (e.g. bisphosphonates or denosumab) prior to initiating the anabolic agent. Initiating anabolics often delays pharmacotherapy start time and the risks of delaying pharmacotherapy need to be balanced with the potential benefits of waiting to start an anabolic.

A FLS romosozumab guidance document is being developed with Dr. Sandra Kim from the Osteoporosis Canada Guideline steering committee. In the meantime, here are a few potential considerations to expand consideration for initiation of anabolic therapies:

- a. Patients with very low BMD T-scores (for example in the range of -3.5 or lower).
- b. Patients with very high FRAX scores (for example in the 30% risk of future fracture).
- c. Patients with multiple fragility fracture events.
- d. Young patients (<70 years) with significant fracture history (e.g. fragility hip or multiple fractures).

Research articles of interest

1. [Pharmacotherapy change patterns after fragility fracture in patients receiving bone-active medication.](#) This study provides some interesting insights into how patients within Ontario FLSs are being managed when they fracture on therapy.
2. [Recommendations for the optimal use of bone forming agents in osteoporosis.](#) This literature review article very nicely reviews, summarizes and provides evidence-based recommendations around the use of anabolic agents and may be of use in your FLS protocols for determining recommendations for pharmacotherapy with anabolic agents.
3. [A consensus statement on the management of vertebral fractures in CKD stages G4–G5D.](#) This is quite a detailed article and perhaps of more interest to medical leads. It tries to shed light on treatment considerations in patients with severe renal insufficiency and briefly discusses the implications for FLS. May be of help in determining your processes for patients with renal insufficiency within your FLS.