



Response to comment on “Incidence and risk factors for osteoporotic fractures in patients with systemic lupus erythematosus versus matched controls”

Chang Seong Kim¹, Kyung-Do Han², Hong Sang Choi¹, Eun Hui Bae¹, Seong Kwon Ma¹, and Soo Wan Kim¹

¹Departments of Internal Medicine, Chonnam National University Medical School, Gwangju; ²Department of Statistics and Actuarial Science, Soongsil University, Seoul, Korea

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Correspondence to
Soo Wan Kim, M.D.

Department of Internal Medicine, Chonnam National University Medical School, 42 Jebong-ro, Dong-gu, Gwangju 61469, Korea
Tel: +82-62-220-6271
Fax: +82-62-225-8578
E-mail: skimw@chonnam.ac.kr
<https://orcid.org/0000-0002-3540-9004>

We would like to thank Shih-Wei Lai for commenting on our “Incidence and risk factors for osteoporotic fractures in patients with systemic lupus erythematosus versus matched controls” [1]. Attributable or excess risk helps you determine how much of an outcome may be attributable to a particular risk factor in a population exposed to that factor [2]. In our study, the attributable risk associated with systemic lupus erythematosus (SLE) was 126 osteoporotic fracture cases per 10,000 person-years. This means that removal of SLE diminish 126 cases of osteoporotic fracture per 10,000 person-years of follow-up (95% confidence interval [CI], 118 to 134), and that 65.8% (95% CI, 61.6% to 70.0%) of those osteoporotic fracture is attributable to SLE. Meanwhile, population attributable risk gives the added risk in relation to the total population in terms of public health perspective. Population attributable risk was 20 cases of osteoporotic fracture per 10,000 person-years, and population attributable risk percent was 23.6%. That means that 20 cases or

23.6% can be attributed to SLE out of 85 cases of osteoporotic fracture including total patients with SLE and non-SLE. Because SLE cannot be changed, identifying people at risk for osteoporotic fracture in patients with SLE provide populations for the strategies to prevent osteoporotic fracture.

Conflict of interest

No potential conflict of interest relevant to this article was reported.

REFERENCES

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