

throughout the detoxification, and the client is accompanied to medical appointments, AA meetings, assessments for aftercare and so forth.

**Detoxification Myths**

*(‘They always relapse, so there’s no point...’)*

Of those who relapse, 40-50% show significantly reduced use/improved health over the next six months

*(‘There’s no point in forcing people...’)*

Outcomes for coerced patients are almost as good as those of voluntary patients

*(‘They have to hit rock-bottom first...’)*

Some will die. Many will be damaged irreversibly. Early intervention is both effective and ethical.

**Take Home Messages**

Nurse-supported home detoxification is effective, discreet and practical for most clients. It is acceptable to many people who would never agree to residential detoxification and/or rehabilitation in traditional treatment centres.

Most of the available forms of psychological aftercare such as 1:1 sessions, CBT, family and couples therapy and drug and alcohol counselling can be added in. Physical treatments such as anti-craving or aversive medications can also be prescribed.

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# Exactly What is Osteoporosis and Why is it Important?

**Dr. Tom Palferman FRCP**

**Osteoporosis is defined in a number of ways. Essentially, it is a skeletal disorder characterised by compromised bone strength, predisposing to increased risk of fracture. Bone strength reflects bone quality and bone density.**



The World Health Organisation categorises fracture risk according to bone density as determined by Dual Energy X-ray

Absorptiometry (DXA), traditionally of hip and lumbar spine. The T-score represents standard deviations below a young adult reference range, i.e. peak bone mass, a level of -1.0 to -2.5 being osteopenia and < -2.5 osteoporosis.

Osteoporosis and increased fracture risk are not confined to the elderly. While age is an independent risk factor for fracture, increasingly attention is directed at younger people where skeletal maturation is

potentially compromised by a range of disorders including malabsorption, anorexia and associated eating disorders, poor diet, excess exercise, and medication such as corticosteroids and depo-Provera.

The cost in human terms of fracture, particularly of hip, is acknowledged. In financial terms to the NHS it is also enormous. The £1.7 billion costs for 2001 are expected to rise to £2.1 billion by 2020. The current economic burden is, therefore, equivalent to that of coronary heart disease, and to the original estimated cost of hosting the 2012 Olympics in London.

Clinicians face significant challenges in their assessment and management of those with, or at risk from, osteoporosis.

First is the identification of vertebral fractures, the majority of which are asymptomatic, i.e. morphometric rather than

## Osteoporosis treatments

- Calcium and vitamin D
- Bisphosphonates
  - etidronate -pamidronate(iv)
  - alendronate -zoledronate(iv)
  - risedronate
  - Ibandronate-(p.o./iv)
- Calcitonin s.c./nasal
- HRT
- SERMs (raloxifene)
- Strontium ranelate
- PTH (1-34) ; PTH (1-84)

SERMs = selective oestrogen receptor modulators  
PTH = parathyroid hormone

Table 1

clinical. A number of initiatives are being developed whereby radiologists are involved in reporting vertebral fractures on X-rays performed for indications other than to seek vertebral deformity, e.g. chest X-rays and barium enemas.

In the two clinics in which I am involved in running osteoporosis services – London Medical and the Portobello – there are on-site densitometers which have the additional technology to perform rapid vertebral assessment. Observer analysis and comparison with international standards allows vertebral deformities to be unearthed, which might otherwise remain undetected. Such a finding influences decisions regarding treatment.

Second, bone density scan alone allows relative stratification of fracture risk, but a low bone density in one individual will have different implications for therapy when compared with another; where other, independent, risks for fracture are in evidence. Determination of absolute fracture risk will, of necessity, include the presence of such variables as previous fracture, a first degree family history of fracture, high alcohol intake, smoking, low body mass index, inflammatory joint disease and whether corticosteroids are being taken. The presence of any of these, separately increases the ten year probability

of osteoporotic fracture by anything from a relative risk of 1.6 to 2.3.

Third, how best to monitor response to treatment? Bone density after an interval of one to two years is still widely used and helpful. Yet, small percentage changes in bone density vary among different treatments, which all produce similar but significant reductions in fracture risk. Increasingly, biochemical markers of bone turnover are being used to assess the anti-resorptive or anabolic activities of drugs. Changes usually occur within a matter of months and provide earlier evidence that a particular treatment is proving effective – or that the patient is persevering with medication, which has been shown to be lacking after one year in the case of weekly bisphosphonates.

Finally, the range of treatments is increasing with existing developments on the horizon. The present list is shown in Table 1. Recent interest has focused on the use of annual intravenous zoledronate. The anti-fracture data are excellent and include protection against vertebral, hip and other non-vertebral fractures. In addition, a recent presentation at the American Society for Bone and Mineral Research unveiled an unexpected reduction in mortality of at least 28% over a two to three year period when intravenous zoledronate is used following

hip fracture, to prevent, successfully, fracture in the contralateral hip. The reduction in mortality has yet to be explained fully, but appears over and above that which is to be expected from preventing hip fracture alone.

The next development in the treatment of osteoporosis is likely to see the introduction of drugs which target, selectively, aspects of bone remodelling, these somewhat analogous to anti-TNF Alpha and other biologic agents used for inflammatory joint diseases. Modulating the osteoclast by altering the balance of RANK-ligand and osteoprotegerin looks particularly promising, and trials are nearing completion which should bring this group of drugs into clinical use in the near future – whether NICE will be as excited remains to be seen, since they, undoubtedly, will be expensive.

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## Dr Michael Paul, GP

**I gave a short talk at the recent IDF study weekend on ways of paying for independent health care, focusing on Credit Unions. In summary:**

**A Credit Union (CU) exists to offer a saving account and a borrowing loan facility to a specified group of people such as members of the IDF and their patients. It is a non profit financial co-operative run by the members who elect a board of directors and acting officers, all unpaid volunteers.**

**Members save on a regular basis and can receive a return on their savings of up to 8% a year.**

**Members can then borrow from the CU to meet medical costs against a multiple of their savings, normally three times, and pay interest at a maximum of 1% a month on the outstanding balance.**

**So if a member had savings of £5,000, they would be able to borrow up to £15,000 for an approved expense paying interest at 12% APR whilst still receiving 8% interest on their existing £5,000 savings.**

**At any time a member can leave the CU and withdraw all their savings with no loss of premiums.**

**If you would like further details about how Credit Unions work and how they can be better for some people than a straight forward deposit account or Private Medical Insurance where you pay non returnable premiums, please email me at [michael.paul@msaco.co.uk](mailto:michael.paul@msaco.co.uk)**