

Osteoporosis

EDITOR.—In their article on osteoporosis Nicola Peel and Richard Eastell state that “a nasal preparation [of calcitonin] . . . is being developed.” In fact, a nasal spray formulation of salmon calcitonin was first introduced in 1987 and has since been approved and marketed in more than 60 countries. Although it is not licensed for use in the United Kingdom, it has been studied in clinical trials and was recently recommended for approval in the United States by the Food and Drug Administration’s review commission.

M AZRIA

Head of calcitonin biology and safety

Research and Development Division,
Sandoz Pharmaceuticals,
4002 Basle,
Switzerland

1 Peel N, Eastell R. ABC of rheumatology: osteoporosis. *BMJ* 1995;310:989-92. (15 April.)

Strategies for reducing coronary risk factors in primary care

EDITOR.—K Field and colleagues claim to have evaluated the cost effectiveness of intervention protocols in primary care to reduce cardiovascular disease.¹ They examined the costs of treatment with cholesterol lowering drugs (£235/year) and ignored the cost of antihypertensive treatment (£180-260/year). The costs of medical treatment for both conditions, including dietary modification of obesity and salt intake in hypertension, were roughly equivalent. Rates of therapeutically important severe hypertension (4.4%; 115/2607) and hyperlipidaemia (4.1%; 107/2607) are similar,² and some patients need treatment for both conditions. Calculations of the cost of cardiovascular screening should be based on the costs of treating both conditions with advice about lifestyle, diet, and drugs.

The authors’ clinical approach used 100 minutes of nursing time and 10 minutes of the general practitioner’s time per patient. It is odd that dietary information was gathered in preference to a family history of cardiovascular disease, which is more relevant for screening and can be obtained rapidly. Most data on risk factors can be gathered with self completion questionnaires, and two other studies have shown that intensive nursing initiatives are of minimal benefit in modifying risk factors.^{3,4} Indeed, in one study only 31% (28/90) of patients with documented severe hypercholesterolaemia and 33% (71/215) with moderate hypertension were treated for these conditions.² This suggests a need for medical rather than nursing surveillance.

The authors have neglected the additional non-cardiac morbidity and mortality added by smoking and obesity to general practice costs. Their favoured intervention protocols—no treatment and intervention at a total cholesterol concentration of >9.5 mmol/l, in which some of the 0.3% of the population with familial hypercholesterolaemia and only those with established coronary heart disease would be treated—are contrary to best practice. Heart disease costs £300/day for admission to hospital, £2500 for angioplasty, or £6000 for coronary artery bypass grafting; these sums are costed into contracts. This has to be considered in any overall analysis of cost. In patients with established coronary disease death rates from cardiovascular causes are reduced by 35%, hospital admissions by 34%, and re-intervention rates for angioplasty and coronary artery bypass grafting by 37% within five years when serum cholesterol concentrations are reduced by 28% from 8 mmol/l.⁴ This is a considerable medical (and cost) benefit of reducing cholesterol concentrations.

Though the paper is a valuable attempt to cost prevention of cardiovascular disease in primary care, a fuller, properly audited and costed survey consistent with the targets in the *Health of the Nation*⁵ is required to determine the most clinically and financially effective screening strategy.

A S WIERZBICKI

Senior lecturer in chemical pathology

United Medical and Dental Schools of Guy’s
and St Thomas’s Hospitals,
St Thomas’ Hospital,
London SE1 7EH

T M REYNOLDS

Consultant chemical pathologist

Burton Hospitals,
Burton on Trent,
Staffordshire DE13 0RB

- 1 Field K, Thorogood M, Silagy C, Normand C, O’Neill C, Muir J. Strategies for reducing coronary risk factors in primary care: which is most effective? *BMJ* 1995;310:1109-12. (29 April.)
- 2 Imperial Cancer Research Fund OXCHECK Study Group. Effectiveness of health checks conducted by nurses in primary care: final results of the OXCHECK study. *BMJ* 1995;310:1099-104. (29 April.)
- 3 Lindholm LH, Ekblom T, Dash C, Eriksson M, Tibblin G, Schersten B on behalf of the CELL Study Group. The impact of health care advice given in primary care on cardiovascular risk. *BMJ* 1995;310:1105-9. (29 April.)
- 4 Scandinavian Simvastatin Survival Study Group. Randomised trial of cholesterol lowering in 4444 patients with coronary heart disease: the Scandinavian simvastatin survival study (4S). *Lancet* 1994;344:1383-9.
- 5 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (Cm 1986.)

Smuggling of tobacco in Europe

EDITOR.—The authors of the article about smuggling of tobacco in Europe do not understand the reality of the situation in the United Kingdom.¹ Legal cross border shopping is not the main issue. It is the illegal on selling in the United Kingdom of tobacco bought in countries in the European Union that have low tobacco taxes that is so concerning. British retailers, helpless to compete, now see their business eroded by illegal practice, with one Dutch brand, which is not supposed to be sold in Britain for trademark reasons, accounting for 12% of our market in hand rolling tobacco.

Yes, tobacco products manufactured in the United Kingdom are coming back here, but it is an inefficient way of trading driven by the inequitable tax differentials. This is conspicuously illustrated by the constant flow from ferries of Transit vans packed with tobacco for selling in the United Kingdom.

The stated rate of detection by Customs and Excise is 5%, but the rate is probably as low as 1% because a pitiful 466 prosecutions in respect of both tobacco and alcohol have been recorded since the single market came into operation on 1 January 1993. Tax stamps “identifying” imports would be of no concern to either the smugglers or their customers since health warnings in a foreign language show the products’ origin anyway.

The authors’ reference to Canada relates to a unique problem because Indian reservations that straddle the border with the United States have led to vicious crime between smuggling operators vying for lucrative trade. There is no similar situation elsewhere.

The article states that the tobacco industry does not favour the proposal that member states of the European Union should raise their tobacco taxes to bring about convergence. During a select committee hearing and in submissions to the Treasury the industry has consistently asked the government to consider three things: to freeze or reduce tobacco tax in the United Kingdom (our rate is up to 215% more than the average rate in the European Union); to employ more excise verification officers (currently there are only 240 to cover the whole of the mainland); and to take an early initiative to ensure a workable formula for convergence of excise tax in the European Union.

There has been no evidence that these proposals have gained favour, although on 24 May the paymaster general told the house that he would welcome approximation, while recognising that it would be a slow process.

Meanwhile we have a smugglers’ charter hitting small retailers and causing the government to lose hundreds of millions of pounds through indifference to an endemic problem that it created and only it can resolve.

CLIVE TURNER

Executive director, industry affairs

Tobacco Manufacturers Association,
London SW1E 5AG

1 Joossens L, Raw M. Smuggling and cross border shopping of tobacco in Europe. *BMJ* 1995;310:1393-7. (27 May.)

Measurement of bone density in osteoporosis

EDITOR.—I am surprised that Nicola Peel and Richard Eastell list oestrogen deficiency and monitoring the response of osteoporosis to treatment as indications for measurement of bone density, without qualification.¹ An investigation is useful only to the extent that it affects management, and the decision to start or continue hormone replacement therapy will rarely be based on the result of a recording of bone density.

Hormone replacement therapy is indicated for women with a relative oestrogen deficiency irrespective of their bone density because of the greater attributable benefits of mortality and morbidity from cardiovascular disease. An average 50 year old woman who takes hormone replacement therapy long term may decrease her lifetime risk of ischaemic heart disease from 46% to 35% while her risk of osteoporotic hip fracture is estimated to fall from only 15% to 12.5%.² Her decision whether to use hormone replacement therapy is also likely to depend more on how she balances the relief of menopausal symptoms against the continuation of periods than on the risk of fracture in 20 years’ time.

It may be true that the correlation between bone density and risk of fracture is as strong as that between hypertension and stroke and that between cholesterol and cardiovascular disease. While lowering blood pressure and cholesterol concentration may decrease the excess risk, however, changes in bone density are not usually reversible, and very low density will be detected too late for most effective interventions.

Indications for general practitioners to have access to bone densitometry in Oxfordshire are being established by a group of general practitioners, radiologists, clinicians, and public health doctors. Our preliminary conclusions are that measurements of bone density should be considered only (1) when knowledge of the bone density would greatly influence a woman’s decision whether to start or continue hormone replacement therapy (in practice this is rarely likely to be an important factor); (2) in patients taking >7.5 mg prednisolone for six months or more; (3) to decide whether bisphosphonates are indicated in patients at high risk of established osteoporosis when this diagnosis has not already been confirmed; and (4) when a radiological suspicion of osteopenia needs to be verified before further investigation or referral. Measurements should not normally be repeated within two years as any changes seen would be likely to be within the confidence interval of the test and therefore difficult to interpret.

Osteoporosis is a major public health issue. Given the large overlap with cardiovascular and cerebrovascular disease in both the populations at risk and the treatments available, however, a more holistic approach, with advice on hormone replacement therapy, smoking, and exercise, will have more impact. Resources should not be diverted