

by
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The Wellness Column

Drugs, diagnostics, and what the system has left behind

When I received my osteoporosis diagnosis, I was referred - not to a bone specialist - but to two rheumatologists. That surprised me until I discovered why. Despite **osteoporosis affecting one in three women over fifty** - and **osteopenia one in two** - there are remarkably few dedicated osteoporosis specialists within mainstream healthcare.

What the system does have, almost without exception, is a prescription pad.

Much of the research underpinning conventional treatment has been funded by the pharmaceutical industry - not a conspiracy, but economics. With little commercial incentive to study nutrition, exercise or hormone optimisation, the result is a system that often reaches for medication before other options are explored.

The practitioners doing this pioneering work - blood-marker analysis, nutrition, hormones, resistance training - operate largely outside mainstream medicine. **This is the gap 1:3 women over 50 are falling into it.**

To help navigate the evidence, I spoke with Dr Franziska Meuschel, founder of More Than Health, a London-based physician specialising in functional and longevity medicine.

A live feed of your bones

The standard diagnostic tool is the DEXA scan, a bone-density X-ray that typically takes 12 to 24 months to show meaningful change. By the time a DEXA reflects your progress, you may already be well into either success - or failure.

There is, however, a faster way to understand what is happening inside your bones. **Two blood markers**, rarely discussed in routine practice, provide a real-time picture of bone metabolism.

Before my diagnosis, neither had ever been mentioned to me. My DEXA scan was performed only because of a swollen finger suspected to be arthritic, as a precautionary measure. I was then handed the bombshell of a T-score of -3.2 - yet nobody asked whether the result reflected the woman sitting in front of them - my general health, lifestyle, exercise habits or what was actually happening in my bone metabolism. There was no other choice given - merely "take the drugs!"

The blood markers

P1NP (procollagen type 1N-terminal propeptide) is released by osteoblasts as they build new bone. It measures the activity of your bone builders.

CTX (C-telopeptide) is released when osteoclasts break down bone. It measures the activity of the demolition crew.

According to Dr Doug Lucas - The Osteoporosis Breakthrough: The Natural Way to Reverse Causes of Bone Loss and Build Strong Bones - what matters is the ratio between them - P1NP to CTX. Research across more than 1,200 patients at The



Above: Bone consultation and blood tests. Below: DEXA scan and drugs and Dr Franziska Meuschel.



Canberra Hospital and Australian National University Medical School (2017, refined 2018) established practical zones: below 100 is high fracture risk; 100-130 uncertain; 130-150 stable; above 150, bone is building; above 200, strongly so - months before a DEXA scan would show any change.



OSTEOPOROSIS: PART THREE The gap nobody talks about

These inexpensive blood tests are most valuable early - ideally from the mid-thirties onwards. Bone loss often tracks the gradual decline in oestrogen, years before perimenopause is recognised. Many mainstream doctors dismiss them as unreliable - they are, when done incorrectly. Done properly, they're among the most useful tools available.

Ask your doctor about P1NP and CTX, alongside vitamin D, parathyroid hormone (PTH), C-reactive protein (CRP to assess systemic inflammation) and estradiol. Together they provide a far more complete metabolic picture of bone health.

The fuller diagnostic picture

Alongside DEXA, REMS uses ultrasound to assess not only bone density but bone quality - the internal architecture that determines whether bone holds or fractures - and can allow earlier detection than DEXA.

Orthopaedic surgeon **Dr Andy Bush**, who describes his career shift as moving from "fracture fixation to fracture prevention", offers perhaps the simplest explanation:

"You can do a DEXA on a piece of chalk. Chalk is four times denser than wood. But nobody builds houses out of chalk - it's structurally useless. Wood is less dense but structurally strong. Dense does not mean strong."

The **FRAX tool** (fraxplus.org) adds another



layer: it estimates your ten-year fracture probability by combining bone density with age, weight, previous fractures and other factors - because the same T-score means something very different at 55 than at 75.

As Dr Meuschel puts it:

"One number, from one tool, is not necessarily a verdict. It is the beginning of a conversation."

The drugs: an honest map

If your doctor recommends medication, it's important to understand the two main approaches.

Antiresorptive drugs slow bone breakdown. Bisphosphonates - alendronate (Fosamax), risedronate (Actonel) - are most widely prescribed but are not intended as lifelong treatment. After three to five years, benefits and risks should be reassessed; ask about a "drug holiday" if you've been taking them for several years.

Prolia (denosumab) is more potent but comes with an important caveat: stopping it abruptly can trigger rapid rebound bone loss. Any decision to discontinue it should be carefully planned with medical supervision.

Anabolic drugs - teriparatide (Forteo), abaloparatide (Tymlos), romosozumab (Evenity) - stimulate new bone formation. Largely reserved for severe cases on grounds of cost, and more recent to the market, some clinicians argue they may be more effective when used sooner. Evidence also suggests that starting with antiresorptive drugs may reduce the effectiveness of anabolics introduced later.

Dr Meuschel takes a balanced view:

"Drugs have a place. But in an ideal world they would not be prescribed before looking seriously at nutrition, movement, hormones and vitamin D status."

The bone thieves nobody mentions

Before treatment, consider the medications and habits that may already be weakening your bones.

Acid suppressing drugs or Proton pump inhibitors (PPIs), including omeprazole, should be recommended as short-term intervention (under 6 months), but when taken long-term (over 2-3 years) they can interfere with nutrient absorption. They have been linked in UK data to a meaningfully higher hip-fracture risk - around 20-25% across several analyses - with longer-term use. Stomach acid is needed for mineral absorption. Block the acid, and you risk reducing calcium uptake.

Antidepressants or SSRIs and SNRIs - often prescribed for menopausal symptoms - also deserve attention. A 2024 UK study of menopausal women found that the first month of SSRI or SNRI use was associated with a 38% increase in fracture risk, rising to 58% over the following two months. Excess serotonin appears to disrupt both bone-building and bone-remodeling cells.

Research on prolonged **systemic corticosteroid use** (steroids) have shown more than double fracture risk to the spine and hip. **Smoking** significantly reduces bone density; regularly consuming more than **2-3 units of alcohol daily** impairs calcium absorption and suppresses bone formation.

Dr Meuschel is also concerned about the widespread use of **GLP-1 weight-loss drugs**, including semaglutide (Ozempic/Wegovy), calling them **"a ticking time bomb."**

Evidence supports that view: a randomised trial found that after a year of semaglutide, bone density at both the hip and lumbar spine was lower than placebo, with increased bone resorption. These drugs can suppress appetite dramatically, reducing food variety and key nutrients simultaneously - with some loss of lean mass alongside fat. For menopausal women, the impact is even more accelerated.

"Millions of women who are losing weight are also at risk of losing bone silently, and nobody is measuring it," says Dr Meuschel. *"If we ignore these warning signs now, we may find ourselves facing the consequences years down the line."*

The questions to take with you

None of this means abandoning your GP or self-prescribing. It means arriving at your next appointment with better questions.

Ask whether P1NP, CTX, vitamin D, PTH, CRP and estradiol have been assessed. Could arthritis, calcification or positioning have affected your DEXA result? If medication is recommended, what is the long-term treatment plan? And have nutrition, hormone status and exercise capacity been fully considered before reaching for a prescription?

The gap between mainstream medicine and the functional approach is real. But it is not impassable.

As Dr Meuschel says:

"Women deserve to know what is happening in their bodies while there is still time to change it."

Part Four: What your bones are actually hungry for - and why the answer is far more interesting than most of us have been told.

For Osteoporosis Part 1 & 2, sources and more information - mallorcawellnessliving.com by Amanda J Butler