

# Breaking Point

**BONES OF CONTENTION**  
DOCTORS ARE BEGINNING TO RE THINK WHEN AND HOW TO CHECK FOR OSTEOPOROSIS.

SLENDER AND AT RISK FOR OSTEOPOROSIS, PATRICIA MORRISROE BEGAN TAKING MEDICINE DAILY. NOW, TEN YEARS LATER, SHE WONDERES: DID THE DRUGS DO MORE HARM THAN GOOD?

implying that my bones were dangerously delicate, I'd come to think of my skeleton as I did my Baccarat crystal—elegant but not for everyday use.

My life as a fragile person began in the late nineties, when I went to see a new gynecologist for an annual checkup. After the usual prodding and poking, he ushered me into his inner office and said, "I'm worried about your bones." I was then in my 40s, in excellent health, and I'd been working out regularly. What could possibly be wrong with my bones?

"You're tall and very slender," he explained. (I'm five feet eight, 123 pounds.)

"Thank you," I said, waiting for the bad news. But in the world of bones, if nowhere else, slender is the bad news. The doctor explained that my body type placed me at risk for developing osteoporosis, a serious condition that increases the chance of fracture. He urged me to have a bone-density test. I thought he was crazy and never went back.

Several years later, my internist gave me a urine test that indicated I was losing bone—common around menopause, when estrogen levels drop. (Estrogen helps protect bones.) She, too, urged me to have a bone-density exam, which I scheduled along with my annual mammogram and breast sonogram. "Your mammogram looks fine," the radiologist said, after the interminable waiting period, "but your bone density shows osteopenia." Though I'd been planning to buy a new pair of shoes—my reward for a clean mammogram—I walked up Madison Avenue in a state of mild shock. Osteopenia. It sounded dreadful.

Osteopenia is a condition in which bone mass is lower than normal but not low enough to qualify as osteoporosis. Doctors used to treat it with osteoporosis drugs in the hopes of preventing


  
**N**obody would ever call me a daredevil—reading is my favorite pastime—but over the years I've tried skiing, surfing, gliding, and horse jumping, and once rode a camel across a tiny swath of the Sahara. Yet when my husband recently suggested we go biking in Central Park, I replied, "Are you crazy? I could break a bone." He reminded me that I'd already narrowed my athletic pursuits to walking and Pilates, and that the only bone I'd ever broken was my little toe. "You can't worry about something that may never happen," he said. I knew he was right, but after twelve years of listening to doctors

further loss, but that approach has begun to change. Today osteopenia is no longer viewed as a problem that automatically warrants medication, except in rare cases. People with osteopenic bones have such a low fracture rate that it doesn't make sense to put them on a drug to prevent something that may not happen for several decades—if at all. "Basically, the drug companies' marketing created awareness of osteopenia," says Susan Ott, M.D., a bone specialist at the University of Washington in Seattle. "They were on it from the beginning, and no one challenged them."

But now, with new concerns about the long-term safety of the current drugs, doctors are looking at them with a more critical eye. Even the screening method used to detect osteoporosis has been called into question. How early and how often should a woman take the test? Is it, in fact, even valuable? And what, exactly, is osteoporosis? Over the years the definition keeps evolving. It was once diagnosed only after someone had sustained a fragility fracture, but in 1994, after the World Health Organization convened a meeting of experts, osteoporosis was defined by bone mineral density—the one measure of bone health available. "Normal" bones were those of a 30-year-old woman. Anyone who deviated 2.5 or more below that standard had osteoporosis; anyone who fell in between had osteopenia—a condition that was created on the spot. "Osteopenia isn't a disease," says Ethel Siris, M.D., the director of the Toni Stabile Osteoporosis Center at Columbia University Medical Center in New York. "It's a somewhat arbitrary level of bone density."

New data from the U.S. Preventive Services Task Force, an independent panel that develops recommendations for disease prevention, indicated no solid evidence that testing a patient's bone density helped her avoid fracture. Experts have long known that density is only one part of the picture; bone quality is determined by other components, such as the micro-architecture of the bone and its capacity for self-repair. "Over half of all women who experience an osteoporotic fracture do not have an 'osteoporotic' bone density," says Susan E. Brown, Ph.D., the director of the Better Bones Foundation, a nonprofit research and education organization

in East Syracuse, New York. Another problem is that many small-boned people have lower readings on the machines. "You may have perfectly good bone," says Siris. "Just less of it."

**T**oday, the National Osteoporosis Foundation recommends that women wait until they're 65 to have a bone-density test, unless they have certain risk factors, such as a previous fracture, steroid use, or low weight. "Between 60 and 65, age is a risk factor for a fracture," says Siris, "so it makes sense to do it around then." In the meantime, Siris believes that women should keep an ongoing dialogue with their doctor regarding the state of their bone health. "At any point from 45 onward, if you break a bone, except for your fingers, toes, and face, you should do the bone-density test," she says. "At perimenopause, you should have a conversation with your doctor to discuss your risk factors. If you don't have any, don't do the test." If you have osteoporosis, Siris strongly believes in treating it with medication. "With the drugs, you're restoring a healthier pattern of bone behavior," she says. "We see fewer fractures." One of Siris's main concerns is that people who shouldn't be on medication are taking it, while others who need the drugs aren't getting tested. "We're undertreating the worst cases," she says. "People are breaking hips."

While most doctors believe in treating osteoporosis with medication, osteopenia remains a gray area. Osteoporosis drugs are far from perfect. They have significant side effects, most commonly gastrointestinal problems, and reports of atypical thigh fractures recently prompted the FDA to order the makers of the most commonly prescribed osteoporosis drugs, Fosamax, Actonel, and Boniva, to carry a warning label. "These drugs get deposited in the bone and accumulate for years," says Ott. "This could ultimately lead to bones that are more brittle. We simply don't know as much about these drugs as we should, because there haven't been any long-term studies." More and more doctors are now advocating "drug holidays" of six months to a year after five years of use.

I wish I had known all this in 2000,

when my internist urged me to go on daily Fosamax. Since I respect her judgment, I filled the prescription, but right from the start, I was wary. Fosamax, which is classified as a bisphosphonate, isn't one of those pills you can simply pop in your mouth and go about your day. After you take it—first thing in the morning, on an empty stomach—you have to remain upright for 30 minutes as it can be highly irritating to the esophagus. I spent two years walking around my apartment like a robot, and then I went for my follow-up bone density. There was a 3 percent improvement in my spine—within the machine's margin of error—and no improvement in my hip. I didn't think these were impressive results, but my internist advised me to stick with the plan.

Ultimately, I switched to once-a-week Fosamax and then once-a-month Boniva. Five years later, I'd developed a case of acid reflux and stopped taking the drugs. My internist sent me to a gastroenterologist, who, after sedating me, inserted an endoscope down my throat to see my upper GI tract. He noticed some inflammation, told me to stay off the bisphosphonates, and then put me on anti-reflux medication, which I later discovered is linked to a higher incidence of hip fracture.

For the next three years I stopped obsessing about my bones and simply went about my life. I exercised, took calcium and vitamin D, and ate a healthy diet with plenty of green vegetables. I was feeling pretty good until my internist urged me to have another bone-density test. Though it remained basically unchanged, she wanted me to go back on medication, telling me that I could take Reclast, a once-a-year injection. "I'm afraid you're going to break a hip," she said. I countered, "My mother is 90. She hasn't broken a hip." The doctor chalked it up to luck and gave me the name of a bone specialist.

That's how I wound up at the Toni Stabile Osteoporosis Center, where I met with Shonni Silverberg, M.D., who specializes in calcium and bone disorders. She told me that my blood and 24-hour urine tests indicated primary hyperparathyroidism, a disorder of the parathyroid glands that causes bones to lose calcium. It's been nicknamed "moans, groans, stones, bones, and psychic" (continued on page 144)

## BALANCING ACT

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still laid low on her cheeks. "When we try to fit our bodies into an idea, it's dangerous. We stop feeling from the inside, and take cues from the outside about what we should be doing. This can lead to injury, and, even worse, to dissatisfaction."

Sitting there in lotus, with my ankle twisted and torqued, and my hip knotted, I tried to listen to what Fran was saying, even though it made no sense to me. I also checked myself in the mirror. I wanted to see if I looked anything like Elizabeth. I looked pretty good, quite yoga-ish, in fact.

"Close your eyes," said Fran. "Stop looking in the mirror. Just feel the pose." Damn! How did she know I was looking in the mirror? "One of the eight limbs of yoga is *pratyahara*," she said. "It's a quality of inwardness, of contemplation. Fall is a great time to practice *pratyahara*, as the year is dying." Have I mentioned that Fran was really into the seasons? "As you do the rest of your poses today, and as you go back into the world, practice *pratyahara*. Try to feel from within, rather than judging and looking at what's on the outside. Just try it."

My basic attitude toward Fran was, If you say so. She was my teacher, and she was funny, and smart, and beautiful, and could do full splits. So I trusted her. Her words about inwardness were as incomprehensible to me as a foreign currency. The coin Fran was handing me might have been Etruscan, or Finnish; I had no idea how to spend it. But I guessed there was some value, some currency, in there somewhere.

Until then, I would fake it. □

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## BREAKING POINT

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overtone," because its symptoms include stomach pain, kidney stones, osteoporosis, and depression. The main treatment is surgery to remove the parathyroid glands. After reassembling me that the condition is rarely

cancerous, she said there was no rush. First, though, she told me to retake the blood tests, in case the lab had made a mistake.

Two weeks later, I got a message from Silverberg on my answering machine. She told me that my second blood tests were perfectly normal, which means I probably don't have hyperparathyroidism. I decided to find out if there was another way to test the quality of my bones. The World Health Organization has now developed FRAX, an online assessment formula that determines a person's fracture risk over ten years. It's not perfect, but at least it takes into account one's age, weight, diseases, and habits, such as smoking and alcohol use. "We're finding that it's very helpful," says Bess Dawson-Hughes, M.D., the director of the Bone Metabolism Laboratory at Tufts University in Boston. "If your risk of hip fracture is 3 percent, that's one thing. If it's 8 percent, you might want to seek treatment." Mine is 1.6 percent, which means I have a 98.4 percent chance of *not* breaking my hip within the next decade.

For now, I'm going to think positive. After a dozen years of tests and drugs and vague diagnoses, I "have" what I was born with: small bones. □

## ABOUT FACE

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infectious, and I'm enthralled by his saying that I won't have to have any follow-up needlework. "Nothing I do should require maintenance," he says.

Jessica Lattman, M.D., his wife, an oculoplastic surgeon who shares the office with him, comes in. They discuss whether or not my surgery should include an endoscopic brow lift. "A lot of people will say you don't need a brow lift," he says. "You know what? I'm going to do it," he continues, making up his mind. "I want to do the brow, too. I'm going to make you amazing. As long as you say, 'Dave, I can handle it. I'm a tough chick.'"

My next appointment, that same afternoon, is with Haideh Hirmand, M.D., a tall and beautiful Harvard-educated plastic surgeon whom I've interviewed before. "Why do you want to do this?" she asks. "Why now?" We talk about that, and she tells me that my goal should not be to look the way

I did at 30, because "it will only look like you *want* to look like that. You have a small face, and you've lost a lot of volume. If you did any tightening, it would have to be very minimal, and in conjunction with filler." Hirmand does not do deep-plane surgery. She uses the classic SMAS technique, the face- and neck lift that tightens the subcutaneous layer of muscles without cutting into them. "There's never been a shred of real proof that deep-plane face-lifting gives any better or longer-lasting results," she says. "To me, the benefits of going into the nerve layer don't justify the risks." When I bring up the question of a brow lift, she says I don't need it. "In fact, I really prohibit you from doing a brow lift. I'm a surgeon, and I'm saying you don't need surgery. Just do some fillers. I know you don't like needles, but you do need volume."

Joel Kassimir, M.D., who trained with the famous Norman Orentreich, is a very busy dermatologist with original ideas on almost everything. When I finally get in to see him, late one Saturday afternoon—after weeks of trying—he's just finished an eight-hour hair-transplant procedure. Talking a blue streak, he tells me that he's working on a process to eliminate baldness, using stem cells found in the hair shaft. He's also working on a time-release Botox using nanotechnology, whose effects he believes would last twice as long as the original. Then he's on to the Harvard plastic surgeon Joel Feldman, whose pioneering method for doing neck lifts combined with fillers can make facial surgery unnecessary.

But what about me? "Do a mid-facial with a SMAS, a vertical lift," says Kassimir, using the medical shorthand in which I'm becoming more and more fluent. "Nothing major, just a conservative tweak." A year after that, he says, he would use Juvéderm, a hyaluronic acid-based filler, if necessary, to erase my "flying buttresses" and crevices, "like spackling." I tell him about my needle phobia. He promises, with gentle and convincing assurance, that this won't be a problem. "There's a new numbing cream, which you put on half an hour before you come in. We reapply it when you get here and put fabric tape over it so it gets absorbed better,