with particulars',[4] which can only come from practice-based research.

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Medical waste

With the Chancellor's budget having been recently announced amidst the ongoing global economic downturn, I thought it an opportune moment to highlight to readers the current situation of pharmaceutical wastage in the NHS. Currently undergoing a placement in public health I was privy to witness one of many 'spot inspections' of a vehicle that was in-transit to the local waste disposal site having collected all discarded medications from a local pharmacy. The contents of the van were astounding. Inside were over 30 plastic sacs containing stacks of unopened blister packs, boxes of unused laxatives, and endless tubs of emollients, most of which were well within their expiry date. In addition, there were over a dozen large plastic tubs full of a certain well-recognised and quite pricey supplement drink, all of which had been unused and subsequently thrown out. At present, the current cost of medicines wastage in the West Midlands stands at an impressive £32 million every year,[1] while back in 2006 it was estimated that the cost of returned and unused medicines in total throughout the UK was anything up to £75 million per year.[2] Despite these huge figures it would appear that at grassroots level the problem remains largely unchecked and obviously some additional intervention is required in order to reduce this unnecessary and costly drain on our health service. Although the responsibility lies with all healthcare professionals it does appear a large source of wasted medicines, using that inspection as a basis, comes especially from local care homes. Due to the apparent failures in communication that are occurring, the current approach of allowing endless piles of unwanted medicines to accumulate, gather dust, and then be disregarded at the end of the month seems an unforgiveable and unsustainable way to manage the problem.

With the current economic climate, as well as ever-increasing demands on ever-tightening NHS budgets, it would seem prudent to emphasise that efficient medication reviews by GPs, pharmacists, and non-medical prescribers could at least, on our parts, help stem this ruinous haemorrhage of funds from our local PCTs.

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Osteoporosis guideline

Jonathan Bayly is correct in reminding us that the guidance from the National Osteoporosis Guidelines Group (NOGG) should be critically appraised.[1] It is not however, a rival to NICE but seeks to provide a user-friendly guideline to include men, steroid-induced osteoporosis, the newer bisphosphonates, recombinant human parathyroid hormone, and also to include the World Health Organisation Fracture Risk Assessment Tool (FRAX™). Since NOGG is web-based it is relatively easy to keep it constantly updated.

Guidelines are dependant upon published studies. These studies, which are expensive, at present recruit patients that are at very high risk of developing the endpoint in question, but are otherwise relatively uncomplicated. The studies are comparatively short and are not powered to study the long-term side effects.

These relatively short-term controlled studies are then extrapolated to the real world of free roaming patients, with comorbidities, co-prescribing with its associated drug interactions, and poor medication compliance. These patients may also be in a different age range to those in the randomised controlled studies. Further studies are required after the pivotal randomised controlled studies and granting of a product licence, to study medications in the true environments in which they are used.

However, because we do not have the best data this must not be an excuse to do nothing. 'The care gap is wide and not getting any narrower.'[1] We now have the opportunity with a user-friendly tool, to focus on the end organ damage of fracture remembering that osteoporosis is a very important risk factor, but nevertheless, only a surrogate marker.

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Conflict of interest
I am a member of NOGG-the National Osteoporosis Guideline Group.

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CAM

I would be interested to hear Edzard Ernst's observations on Fiona Barlow and George Lewith's 'The Ethics of Complementary Therapy Research