National Institute for Health and Clinical Excellence

OA update
Scope Consultation Table
12.12.11 – 09.01.12

Type (NB this is for internal purposes – remove before posting on web)

SH = Registered Stakeholders. These comments and responses will be posted on the NICE website after guideline development begins.
GRP = Guidelines Review Panel member. These are added to this table for convenience but will not be posted on the web.
NICE = Comments from NICE. These are added to this table for convenience but will not be posted on the web.
Non Reg = Comments from organisations and people who have not registered as stakeholder. These are added for convenience but will not be posted on the web.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Acupuncture Association of Chartered Physiotherapists	21.00	3.3.1.d)	AACP Ltd welcomes the review of Acupuncture within the scope of the document. Acupuncture research is acknowledged to be complex given that a true placebo intervention is difficult, if not impossible to obtain. It is therefore considered that RCT's may not be the most effective methodology for determining clinical benefit.	Thank you for your comment.
SH	Acupuncture Association of Chartered Physiotherapists	21.01	General	The group suggest that an acupuncture advocate (preferably from a western medical perspective) be included as a full member of the guideline development group	Thank you for your comment, but we consider that the input from a co-opted expert will provide sufficient expertise for when the evidence on the use of acupuncture is reviewed during the guideline development, given that one discrete question has been prioritised for this topic.
SH	Acupuncture Association of Chartered Physiotherapists	21.02	3.3.2	Although this section pertains to areas not going to be covered in the review, it must be noted that acupuncture within the NHS at present is predominantly delivered as an adjunct to these non-pharmacological interventions. It is suggested that the cost-effectiveness of acupuncture should be taken into context with some of these interventions: for example, exercise and manual therapy where the evidence for acupuncture is stronger than when delivered as a single therapy.	Thank you for your comment. The Guideline Development Group (GDG) will consider this when reviewing the evidence regarding acupuncture.
SH	Acupuncture Association of Chartered Physiotherapists	21.03	General	As a group, there is concern regarding timings and sequencing of interventions that may have an effect on outcome of sequential interventions, for example, surgery.	Thank you for your comment. The GDG will consider the impact of timings and sequencing of interventions during the development of the guideline.
SH	Acupuncture Association of Chartered Physiotherapists	21.04	General	With reference to CG59 (R15). If there is a similar outcome after the full review, the group felt that an asterisked comment of that significance to practice in the NHS, should be placed in the main body the document rather than in the footer.	Thank you for your comment. The guidance from NICE is to make recommendations action focussed and pertinent. The supporting information is appropriately documented within a footnote or within the Linking Evidence to Recommendations section which will be used in the update version of this guidance
SH	Arthritis Research UK	18.00	General	The scope for the update and the proposal for development of quality standards was felt to be appropriate.	Thank you for your comment.

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SH	Arthritis Research UK	18.01	2.1 b	The emphasis on data from x-ray studies was at odds with the guidance which is based on clinical diagnosis in adults 45 years and over with joint pain. We felt the guidelines should continue to emphasise the clinical diagnosis without x-ray.	Thank you for your comment. This section is intended to describe epidemiology to set context rather than indicate the focus of the work proposed. We will be highlighting clinical diagnosis in this update
SH	Arthritis Research UK	18.02	2.1 c	Very old data	Thank you for your comment. We are unaware of any published data that supersedes this.
SH	Arthritis Research UK	18.03	2.2 a	Very old data	Thank you for your comment. We are unaware of any published data that supersedes this.
SH	Arthritis Research UK	18.04	3.1.2	There was agreement on exclusions	Thank you for your comment
SH	Arthritis Research UK	18.05	3.3.1 a	In this section we felt the recommendations should: emphasise the evidence for clinical classification and diagnosis without the use of x-rays or MRI scans; clarify that OA can be considered in the absence of other obvious clinical causes of joint pain; specify red flags for osteoarthritis at different joints sites for use in primary care.	Thank you for your comment. We will be highlighting clinical diagnosis in the update
SH	Arthritis Research UK	18.06	3.3.1 a	Suggest include here the role of decision aids before making a decision on any treatments (which may or may not include surgery). Add shared decision-making around management options, for treatment including decision aids.	Thank you for your comment. We have noted this comment and removed the reference to decision aids in the context of surgery. We have now included a new section on the role of decision aids for musculoskeletal conditions.
SH	Arthritis Research UK	18.07	3.3.1 c	We strongly agree for the need to update pharmacological management. The current guidelines give detailed information on NSAIDS. More advice is needed on the other steps of pain relief, as evidence is only provided for short term efficacy. The role of NSAIDs plus PPI should be considered. Despite some emerging evidence around adverse events for paracetamol this should not be taken out of the front line pain management of OA. Additional recommendations on the tentative use of opioids and Tramadol would be helpful, with evidence on the emerging long term risks from the US e.g.*Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med2010;152:85-92* Adverse events should also consider addiction where pharmacological agents might be used in the long term.	Thank you for your comment. The guideline development group will review the latest available evidence on the role of NSAIDs and gastroprotective agents (GPA) in combination and on paracetamol when developing recommendations in these areas. This guideline update has a limited focus and will not be prioritising the review of evidence in the area of opioids as it is felt that the current recommendations are appropriate. However, as the positioning of Paracetamol in the management of pain of OA is being reviewed it is possible that some paracetamol opioid combinations may be used as comparators We have noted your comment regarding addiction and will inform the guideline development group for discussion when considering outcomes for

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					relevant clinical questions
SH	Arthritis Research UK	18.08	3.3.1 b	The evidence for smaller effects of Glucosamine is becoming stronger from recent studies and this needs to be considered. E.g. Zhang et al, 2010;Rosendaal et al 2008.	Thank you for your comment. The GDG will consider relevant evidence retrieved from the searches during the development of the evidence reviews.
SH	Arthritis Research UK	18.09	3.3.1d	The systematic review by Manheimer et al 2010 (Cochrane Collaboration) on acupuncture for peripheral joint OA demonstrates that although acupuncture is more effective than a waiting list control, it is still no better than sham acupuncture for knee pain.	Thank you for your comment. The GDG will consider relevant evidence retrieved from the searches during the development of the evidence reviews.
SH	Arthritis Research UK	18.10	3.3.1 e	Evidence is emerging to demonstrate who would benefit from surgery. Such individuals should not experience delay for surgery. The use of patient reported outcome measurements should be considered rather than success of surgery. The latest evidence on the protective role of bisphosphonates warrants investigation. As mentioned previously the role of decision aids needs to be earlier - not only focussed on surgery.	Thank you for your comment. We intend to address the consideration of the timing of surgery in this update. We are unable to prioritise the role of bisphosphonates in this update given their limited use in clinical practice. Thank you for your comment. We have noted this comment and removed the reference to decision aids in the context of surgery. We have now included a new section on the decision aids for musculoskeletal conditions.
SH	Arthritis Research UK	18.11	3.3.1 f	Follow up could be considered part of Monitoring e.g. during routine reviews after changes in meditation, annually for repeat prescriptions. Monitoring needs to be realistic for clinical practice so it can be embedded in usual practice. See Peat et al, 2008. Peat, G., Porcheret, M., Bedson, J. and Ward, A. M. (2008) Monitoring in Osteoarthritis, in Evidence-based Medical Monitoring: From Principles to Practice (eds P. P. Glasziou, L. Irwig and J. K. Aronson), Blackwell Publishing Ltd, Oxford, UK. doi: 10.1002/9780470696323.ch24	Thank you for your comment the content of which has been noted.
SH	Arthritis Research UK	18.12	4.1	We agreed that quality statement standards would be helpful. Consider systematic review of quality indicators for osteoarthritis Edwards et al. from our Research Centre (to be submitted)	Thank you for your comment. The GDG will consider relevant evidence retrieved from the searches during the development of the evidence reviews.
SH	Astrazeneca UK Ltd	19.00	General	AstraZeneca UK welcome the opportunity to comment on the draft scope of the Osteoarthritis clinical guideline.	Thank you for your comment.
SH	Astrazeneca UK Ltd	19.01	3.3.1 (C)	In considering the key issues that will be covered, we believe that an assessment of NSAID and PPI fixed combination therapy, as defined in part C, should be considered in the context of the current implementation of CG59 recommendations ...where an NSAID is obligatory, all NSAIDs used to treat OA (both coxibs and traditional NSAIDs) should be co-prescribed with a PPI (1.4.3.4)	Thank you for your comment. Recommendations pertaining to CG59 which are relevant to the scope of the update will also be considered for update.
SH	Astrazeneca UK Ltd	19.0	3.3.1 (F)	We support the inclusion of follow up as a key issue. We believe that the inclusion of a medicines review here as part of this would improve patient experience and outcomes by uncovering potential adherence issues due to	Thank you for your comment.

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		2		lack of efficacy or side effects and would uncover potential non adherence to a co prescribed PPI that would leave a patient at a greater risk of GI complications associated with their NSAID therapy	
SH	Astrazeneca UK Ltd	19.03	3.4	If considering NSAID and PPI fixed combination therapy, as defined in part C, in the context of the current implementation of CG59 recommendation 1.4.3.4 (...where an NSAID is obligatory, all NSAIDs used to treat OA (both coxibs and traditional NSAIDs) should be co-prescribed with a PPI), an important aspect in assessing outcomes would be to include an examination of concordance to NSAID and PPI therapy when co-prescribed separately.	Thank you for your comment. Recommendations pertaining to CG59 which are relevant to the scope of the update will also be considered for update.
SH	BIOIBERICA	3.00	2.1.a	The synovial membrane should also be included in the sentence: "involvement of all joint structures including the cartilage and bone" considering the recent large body of evidence of the great involvement of this organ in the osteoarthritic process.	Thank you, we agree. The scope has been amended.
SH	British Hip Society	8.00	3.1.1. e	Issues related to surgery in OA, including predictors of good outcome.	Thank you for your comment. The guideline development group will discuss issues concerning surgery, especially those related to referral.
SH	British Hip Society	8.01		The role of primary care in referral for surgical intervention is handicapped by the general absence of effective postgraduate training in OA in GP training. This means that the conventional approach of history, examination, differential diagnosis, targeted investigation and appropriate treatment is replaced by prescription of minor analgesics or NSAIDs, referral to physiotherapy and X-ray or MRI scan. Young patients especially are denied interventions that would restore their function and allow them to return to work because of outdated perceptions of their potential. This especially applies to OA of the hip. This practice is neither clinically nor cost effective	Thank you for your comment. CG59 addressed referral issues from primary care and this will be considered again in the update. Clinical diagnosis is also covered within the scope. The Guideline Development Group (GDG) is a multidisciplinary group which has representation from general practitioners and surgeons experienced in the management of OA. The GDG will develop recommendations based on the best available evidence taking into account implication for current practice. We will forward these comments to the GDG and NICE implementation team for their consideration**.** We will not look at return to work explicitly but we will look at return to usual activities (including function) as an aspect of quality of life.
SH	British Hip Society	8.02		The population is those whose symptoms of OA have failed to self limit or respond adequately to medication that is effective and can be tolerated.	Thank you for your comment the contents of which will be noted and discussed with the GDG when considering the review question related to surgical intervention for OA. We agree that this is the appropriate population for consideration of surgery but not the whole OA population to whom the guideline applies.
SH	British Hip Society	8.03		The interventions are arthroplasty, arthrodesis and osteotomy. Arthroplasty may be replacement (hip and knee>>shoulder, ankle and elbow), abrasion (knee, hip, elbow and ankle) or excision (acromioclavicular joint, carpometacarpal joint of the thumb, radiocapitellar joint of the elbow, distal radioulnar joint). Arthrodesis is the treatment of choice for metatarsophalangeal OA of the great toe, ankle, hind and midfoot and carpometacarpal joint of the thumb.	Thank you for this clarification of terminology. The GDG will consider the most relevant interventions and anatomical sites when considering the priority areas for this issue and the capacity within the development time frame.

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				Osteotomy is used in the dysplastic hip on both pelvic and femoral sides and the knee.	
SH	British Hip Society	8.04		Comparative symptoms using general health instruments (eg musculoskeletal component of the SF36) are worse in the hip and knee than the foot. The rate of recovery is quicker after replacement arthroplasty and restriction whilst recovering is an important consideration in the discomfort experienced by the patient, care required and capacity to return to work. The benefits of post operative regimens such as non weight bearing should be compared with the discomfort caused, cost of additional care and restriction of return to work It is important to compare side effects and quality of outcome of pharmacological, orthotic and surgical interventions to define the most clinically and cost effective ones	: The update will be considering issues of which patients are appropriate for referral but will not be considering or comparing surgical procedures or post-operative rehabilitation.
SH	British Hip Society	8.05		Outcome is difficult. The 'Holy Grail' would be a single outcome measure that was truly comparable for all interventions. This does not exist and even the Oxford Hip (OHS) and Knee (OKS) Scores have ceiling effects which do not capture results that meet the demands of the younger patient after intervention for OA of the hip and knee. A combination of general (eg EQ5D) and specific (eg OHS) is probably best although there is crossover in the components of the OHS and OKS so even 'specific' outcome measures are not absolute.	Thank you for your comment. We agree regarding the deficiency in existing outcome measures and when examining the efficacy of any therapies we will endeavour to include instruments covering the guideline development group agreed important domains, including symptoms and health-related quality of life
SH	British Hip Society	8.06	3.1.1. f	The clinical and cost effectiveness of patient review processes for OA. The decision process in following surgical intervention is ill defined. The current guidelines of the British and Australian Orthopaedic Associations for review after hip replacement are the best defined but are consensus rather than evidence based. Patient review should be directed by the potential for further intervention	Thank you for your comment. The scope was amended following the stakeholder workshop and for consultation was detailed as 'follow-up'. It is intended that the purpose of this issue is to define acceptable parameters for follow up of the patient with osteoarthritis rather than the patient following surgical intervention.
SH	British Pain Society	25.00	General	Involvement a Pain Consultant or/and appropriate multidisciplinary team since according to 2.2e (...up to 80% of people report constant pain and a third of these reporting their pain as unbearable).	Thank you for your comment. We will add a pain consultant to the current list of co-opted experts for the current update to the osteoarthritis guideline.
SH	British Pain Society	25.01	3.3.1	The role of other non-pharmacological pain management tools (apart from Acupuncture) - i.e. TENS, Low level Laser etc	Thank you for your comment. These areas were covered in the original clinical guideline 59 and no further evidence has been published that would warrant an update.
SH	British Pain Society	25.02	3.3.1c	The role of intra-articular steroid joint injections	Thank you for your comment. These areas were covered in the original clinical guideline 59 and no further evidence has been published that would warrant an update.
SH	British Pain Society	25.03	3.3.1c	Role of weak opiates (or even sometimes strong opiates) in pain management and combination with non-opiates	Thank you for your comment. These areas were covered in the original clinical guideline 59 and no further evidence has been published that would warrant an update. As the positioning of Paracetamol in the management of pain of OA is being reviewed it is possible that some paracetamol opioid combinations may be used as comparators

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SH	British Pain Society	25.04	3.3	The place of multimodal therapy	Thank you for your comment. We are not sure what is being referred to here as multimodal therapy. However, combination therapies were covered in the original clinical guideline 59 and no further evidence has been published that would warrant an update.
SH	British Pain Society	25.05	4.1.1 b	Methods of assessing pain	Key issues related to assessment of the patient will be considered when drafting a quality standard. Your comment is noted
SH	British Pain Society	25.06	4.1.1.e	Predicting factors about when an operation may not resolve the pain	Key issues related to surgical intervention will be considered when drafting a quality standard. Your comment is noted
SH	British Pain Society	25.07	4.1.1.a	Appropriate use of X-Rays in the diagnostic process	Key issues related to diagnosis of osteoarthritis will be considered when drafting a quality standard. Your comment is noted
SH	British Society for Rheumatology	16.00	2.1	Suggested edit: 'Osteoarthritis is the most common form of peripheral joint arthritis and cause of disability in the UK'.	Thank you for your comment. We agree with this revision and have amended the scope accordingly..
SH	British Society for Rheumatology	16.01	2.1 & 2.2	The cost & impact estimates for this important disorder are increasingly out of date. As part of the review process, it would be timely for the NCGC to commission updated UK direct & indirect cost estimates with involvement from other agencies, such as the National Audit Office & National Joint Registry, as appropriate.	Thank you for your comment. The NCGC will only be able to use the latest publicly available data during the course of the guideline development. The health economists will search for published data on cost estimates when considering evidence for clinical questions. It is not the role of the NCGC or the GDG to commission the kind of work you suggest.
SH	British Society for Rheumatology	16.02	3.3.1	As highlighted at the scoping meeting, it seems unusual to name a single coxib for consideration in the update when the key principle would appear to be including all licensed coxib & NSAID preparations & doses in the update- this might be reworded to 'changes in available NSAID & coxib preparations, including etoricoxib'. The issue of diclofenac becoming available OTC from Sept 2008 is important, as there is some evidence this has increased use (e.g.http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/11021547/diclofenac-otc-switch-confounds-efforts-to-cut-nsaid-use), so this might be considered for specific comment in the updated guidance. There is some new data on topical NSAIDs, so it would be appropriate to also update topical NSAID guidance.	Thank you for your comment. There are specific costing and dosing aspects related to only updating etoricoxib in the updated guidance. There has been no further published data on topical treatments since the original clinical guideline 59 was published that would warrant an update.
SH	British Society for Rheumatology	16.03	4.1.1 and 3.3.2	The core treatments (including exercise) are not to be covered in the scope, but are clearly included in the standard of care section. There have been studies since the last review on tai chi and the specific type of exercise for hip and knee OA (i.e. concentrating on both legs and more muscles than just those acting over a single affected knee or hip) which may be very relevant both to guideline advice and to standard of care, so these (i.e studies published since last review) should be considered for detailed assessment.	Thank you for your comment. These areas were covered in the original clinical guideline 59 and no further evidence has been published that would change the existing recommendation.

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SH	British Society for Rheumatology	16.04	4.1.2	This might be generalised to 'Any unlicensed supplements'.	Thank you for your comment. This is based on standard NICE wording.
SH	British Society of Skeletal Radiologists & Royal College of Radiologists	13.00	2.2 d	More patients referred by GPs to diagnostics (X-Ray and MRI) for opinions than ever reach orthopaedics and rheumatology, and repetitive imaging is common.	Thank you for your comment. We will be highlighting clinical diagnosis in this update to develop appropriate recommendations in this area
SH	British Society of Skeletal Radiologists & Royal College of Radiologists	13.01	3.3.1	Diagnosis, follow-up and decision aids have strong dependence on imaging and major resource implications. We would value involvement in the Guideline Development Group for this reason. Diagnosis: This section should explore and guide referral in line with The Royal College of Radiologists (RCR's) imaging referral guidelines, iRefer (formerly MBUR).	Thank you for your comment. We will be highlighting clinical diagnosis in this update to develop appropriate recommendations in this area. Should the GDG consider a need to involve a co-opted expert to discus the context of imaging in relation to this part of the guideline development process we will discuss this with our commissioners.
SH	BUPA Foundation	6.00	3.1.1	Does the diagnosis have any radiological criteria? Or, is it solely based on clinical criteria?	Thank you for your comment. The GDG will consider both clinical and radiological criteria when discussing the diagnosis of OA during the development of the updated guideline.
SH	BUPA Foundation	6.01	3.3.1c	Possible inclusion of platelet-rich plasma (PRP) injections into the knee joint for the indication of osteoarthritis or "degenerate cartilage" on MRI scan.	Thank you for your comment. This is not a high priority topic for inclusion in the scope as it is not commonly used in clinical practice in the NHS. We are aware that this area has only a small evidence base.
SH	BUPA Foundation	6.02	3.3.1e	The role of decision aids more broadly than in making choices about surgical options.	. We have noted this comment and removed the reference to decision aids in the context of surgery. We have now included a new section on the role of decision aids for musculoskeletal conditions. There are existing Cochrane review group decision aids for musculoskeletal conditions. .
SH	BUPA Foundation	6.03	3.3.1e	How do repeat knee arthroscopies for repeat partial meniscectomies prior to knee joint replacement surgery fit into the care pathway?	CG59 already commented on the role of arthroscopic debridement as an inappropriate treatment for OA. The remit of this update will not include treatment of meniscal tears.
SH	BUPA Foundation	6.04	4.1.1e	Are all new surgical and interventional procedures logged for review by relevant NICE departments? For example: experimental use of bipolar radiofrequency as a treatment for "degenerate cartilage" (MRI diagnosis); arthroscopic lateral release of the patella; unicompartmental knee replacement; various surgical cartilage repair techniques (microfracture, implants, etc).	Thank you for your comment. Please refer to the NICE website for information regarding assessment of new technologies via the Interventional procedure programme or the Medical Technologies guidance or diagnostics

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					guidance. These interventions will not be considered in this update.
SH	College of Occupational Therapists	20.00	General	The College of Occupational Therapists (COT) welcomes the opportunity to be involved as a key stakeholder, as discussed at the scoping meeting on 29th November 2011.	Thank you for your comment. If necessary we will be recruiting a co-opted expert to inform the GDG on any area related to occupational therapy .The quality standard may in due course require engagement from this professional group.
SH	College of Occupational Therapists	20.01	3.3.1.e)	We would recommend OT contribution to the section relating to hand surgery and the outcomes for function and participation.	Thank you for your comment. If necessary we will be recruiting a co-opted expert to inform the GDG on any area related to occupational therapy .The quality standard may in due course require engagement from this professional group
SH	College of Occupational Therapists	20.02	3.4. b)	COT would further suggest OT contribution towards the selection of outcome measures for function and participation with regards to large joint surgery.	Thank you for your comment. If necessary we will be recruiting a co-opted expert to inform the GDG on any area related to occupational therapy .The quality standard may in due course require engagement from this professional group
SH	Dermal Laboratories	15.00	3.3.2 c)	We note that topical treatments have been listed under Non-pharmacological management and will not be covered in the Guideline review. Is this reclassification an administrative error? If not, the listing of topical treatments as a non-pharmacological treatment causes concerns on several levels. 1. The current NICE clinical guideline 59 on Osteoarthritis includes topical NSAIDs as part of the topical treatment category (Section 1.4.2.1). As topical NSAIDs have a definite pharmacological action and are licensed medicines they should not be listed under the non-pharmacological management heading/category. 2. Topical NSAIDs are listed as a first line pharmacological treatment option alongside paracetamol in the current guideline. There is supporting clinical data for the use of topical NSAIDs in osteoarthritis, particularly if the hand or knee are affected, which forms the basis for the recommendation in the current guideline. This data has not changed and hence removal of topical NSAIDs from pharmacological management of OA, as part of the guideline review (if this is the intention), would be contrary to the principle of evidence based medicine. 3. Figure 2 in the current guideline provides a summary of recommended treatments to be considered according to individual needs, risk factors and preferences. Topical NSAIDs are included within the second ring, which contains 'relatively safe pharmaceutical options'. Even with this safety profile, it is important that topical NSAIDs continue to be recognised as an **active** pharmacological treatment with associated pharmacovigilance requirements. 4. Unless new evidence is available to the contrary we would propose that topical NSAIDs remain a pharmacological therapeutic option for managing OA as per the current guideline.	Thank you for your comment. Section 3.3.2 of the scope has been amended. Whilst not part of formal review of evidence in this update, the existing recommendations from CG59 remain extant and may inform the quality standard on osteoarthritis in due course. All existing recommendations not subject to formal evidence review will be incorporated into the updated version of CG59 and considered for inclusion in the quality standard

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SH	Dermal Laboratories	15.01	4.1.1 c)	With regard to the development of the Quality Standard for Osteoarthritis we agree that the proposed areas of care cover the main elements of managing patients with OA. As the Quality Standard will form the benchmark for assessing standards of care for patients with OA in the future it is important that all relevant management options are included. Following on from the points raised above, therefore, it is pertinent that topical NSAIDs be reinstated as a pharmacological treatment (whether omitted by accident or intentionally) as they form an important, beneficial and 'relatively safe pharmaceutical option' (as stated in the current guideline) in patients whose treatment options can be limited due to side effects, age-related risk factors or concurrent illnesses.	Thank you for your comment. All existing recommendations not subject to formal evidence review will be incorporated into the updated version of CG59 and considered for inclusion in the quality standard
SH	Genzyme Therapeutics	17.00	General	We would like to thank NICE for its work in the development of the original 2008 Osteoarthritis Guidelines and for the opportunity as a registered stakeholder to comment on the draft scope for the review of this guideline. As a stakeholder, Genzyme Therapeutics Ltd. is manufacturer and marketer of Hylan G-F 20 (Synvisc & Synvisc One), one of the viscosupplement intra-articular injections reviewed in the 2008 guideline. Synvisc is only intended for IA use by a physician to treat pain associated with OA of the knee, hip, ankle, and shoulder and Synvisc-One is only intended for IA use by a physician to treat pain associated with OA of the knee. Synvisc is currently available in 2 preparations: • 3 x 2ml (16mg) intra-articular (IA) injections given one week apart (Synvisc) • 1 x 6ml (48mg) IA injection administered as a single dose (Synvisc-One).	Thank you for your comment – hyaluronan intra-articular injections will be included in the update review.
SH	Genzyme Therapeutics	17.01	2.2 (e)	We would agree with comments in the scope that *"Although little research has been carried out in the area, conservative (non-joint replacement) management of osteoarthritis may not be satisfactory, with up to 80% of people reporting constant pain and a third of these reporting their pain as unbearable".* It is clear from current NICE recommendations in the treatment of knee osteoarthritis that there is significant unmet medical need in pain and function control for patients with knee osteoarthritis who are unable to take NSAIDs; those patients poorly controlled with NSAIDs and those who are unable to have or are inappropriate for surgery, alongside risk benefit issues associated with opioid analgesics and injectable steroids. In these patient groups only limited treatment options are available and therefore such patients may not be optimally managed. A review of the current treatment algorithm for OA from the 2008 guideline could identify effective and cost effective interventions which would address this currently unmet need. We would therefore ask NICE to consider the positioning of the Hyaluronan/hylan intra-articular injections in the above context as we believe there is an evidence based argument to support the use of Synvisc One in this positioning in the NICE treatment algorithm. We would also comment that the wording of this paragraph could be more explicit within the scope and identify	Thank you for your comment – hyaluronan intra-articular injections will be included in the update review.

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				which interventions lead to sub-optimal care and at what stage of the disease.	
SH	Genzyme Therapeutics	17.02	3.3.1 (c)	We would comment that "hyaluronan intra-articular injections" as worded in the scope would be better worded as "hyaluronan/hylan intra-articular injection" or "viscosupplements" as hyaluronan is not a fully inclusive definition of this class of treatment.	Thank you for your comment. We do not consider it necessary to change this wording. Hyaluronan is a generic term used in the literature.
SH	Genzyme Therapeutics	17.03	3.3.1 (c)	We would ask NICE to specify in the scope that the hyaluronan intra-articular injections should be differentiated by product rather than treated as a class as they were in the original 2008 guideline. Viscosupplementation therapy consists of injection(s) of hyaluronan or its derivatives in an attempt to temporarily return the elasticity and viscosity of the synovial fluid to normal or higher levels.[i] Hylan G-F 20 (Synvisc & Synvisc One) consists of cross-linked hyaluronan chains, which gives a higher molecular weight and a longer residence time than most other viscosupplementation products.[ii-vi] These differences are thought to be of importance with respect to the volume/amount and number of injections, as well as biological and clinical effects.[vii] Hylan G-F 20 is available in 2 preparations: three 2ml (16mg) intra-articular (IA) injections given one week apart (Synvisc) and one 6ml (48mg) IA injection administered as a single dose (Synvisc-One). Synvisc is only intended for IA use by a physician to treat pain associated with OA of the knee, hip, ankle, and shoulder and Synvisc-One is only intended for IA use by a physician to treat pain associated with OA of the knee.[viii] Hylan G-F 20 has a weight of clinical evidence to support its use in the management of patients with OA of the knee. Single dose hylan G-F 20 (Synvisc-One) has been demonstrated to provide comparable safety and efficacy at 6 months to the multi-dose hylan G-F 20 in a RCT of 412 patients with OA of the knee.[ix] In another non-industry funded RCT, the efficacy of hylan G-F 20 (3 injections) compared to another viscosupplementation agent demonstrated a statistically significant improvement in knee pain from baseline compared to sodium hyaluronate (a 5 course treatment regimen) at 6 months (2.5 mm, p=0.02) which was maintained throughout the study period (12 months: p=0.01).[x] Comparative data from two randomised, multi-centre studies have demonstrated that hylan G-F 20 is equivalent to or more efficacious than NSAIDs.[xi,xii] In addition, patients treated with the NSAID diclofenac had significantly more total and GI adverse events than the hylan G-F 20 (p<0.01) or control (p<0.005) groups.[xiii] A Cochrane meta-analysis of viscosupplementation therapies was conducted and included 76 trials (24 of these were hylan G-F 20 trials). The analysis generally supported the superior efficacy of viscosupplements compared to placebo.[xiv] The Cochrane review reported that hylan G-F 20 provided significant improvement vs. placebo for pain on weight bearing, pain at night, functionality, and patient global assessment. A statistically significant difference in favour of hylan G-F 20 at 5 -13 weeks and at 14-26 weeks post-injection compared to placebo was also demonstrated. Importantly a statistically significant difference in favour of hylan G-F 20 compared to other hyaluronans was demonstrated at 5 -13 weeks post-injection. Compared to NSAIDs, the analysis suggests that hylan G-F 20 is comparable in efficacy and results in significantly fewer systemic adverse events.[xv] Further, although NICE did not recommend the use of viscosupplementation, many other professional societies	Thank you for your comment. We will consider all hyaluronan products licensed according to the set terminology we use for defining products included in this update ie "licensed for use in OA" or similar.

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				have recommended its use.[xvi-xix] The availability of the hylan G-F 20 as a single dose preparation since the 2008 review was conducted will be of particular value for patients, clinicians and payers alike due to the reduction in direct and indirect costs (e.g. administration costs) and the potential for improved compliance associated with a single dose preparation vs. a multiple dose preparation. We therefore believe that there is evidence to differentiate these agents in terms of efficacy (and cost effectiveness – see later) and that they should not be reviewed as a class by NICE. This issue was also raised by several groups in summary feedback at the stakeholder meeting held on the 29th November, but has not been reflected in this version of the scope.	
SH	Genzyme Therapeutics	17.04	3.3.1 (c)	We would comment that the bulk of the use of hyaluronan intra-articular injections is in the management of osteoarthritis of the knee and that there is little new evidence since the 2008 review on the use of these agents in other joint sites. NICE could thus add the most value by focussing on reviewing use in knee OA only and the scope could thus be altered to reflect this. Again this issue was discussed at the stakeholder meeting on the 29th but has not been reflected in the final scope.	Thank you for your comment the contents of which have been noted and will be forwarded to the GDG for their consideration.
SH	Genzyme Therapeutics	17.05	3.3.1 (e)	It may be helpful to define "surgery" in this section in terms of specific types of surgical intervention, the focus of discussions at the stakeholder meeting on 29th of November was around prosthetic surgery (total hip and knee replacements primarily)	Thank you for your comment. The GDG will consider the most relevant surgical issues and prioritise them in line with the capacity to undertake evidence review in this area within a limited time frame and in the context of other NICE guidance that has been published or is in development.
SH	Genzyme Therapeutics	17.06	3.5	At the time of the 2008 review only Synvisc (as three 2ml (16mg) intra-articular (IA) injections given one week apart) was marketed in the UK and included in the review. Synvisc One was launched in the UK after the 2008 guidance was completed and as a consequence was not included in the 2008 review. The single dose formulation will be of particular value for patients, clinicians and payers, due to the reduction in direct and indirect costs (e.g. administration costs) and the potential for improved compliance associated with a single dose preparation vs. a multiple dose preparation. There is also potential for improved cost effectiveness of the single dose formulation, as a significant driver of cost effectiveness is the administration costs of these agents, which will be reduced with a single dose preparation. As a class, viscosupplements were not considered to be cost effective in the 2008 review and we note that this decision was based on NICEs own cost effectiveness analysis of multiple injection viscosupplements. We believe	Thank you for your comment. The GDG will consider all hyaluronan products licensed for use in OA.

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				that the availability of the new single injection Synvisc One formulation could have a material impact on NICEs current negative recommendations on viscosupplements through improved cost effectiveness. Consequently, Genzyme are currently completing a QALY based cost effectiveness analysis on the use of Synvisc One, both in terms of impact on pain and quality of life and its impact in delaying the time to total knee replacement. Given the timing of the guideline it is possible that we will not be able to get the model into the public domain before data lock occurs and would thus ask the NCC to consider a call for evidence on this issue in order to fully identify pharmacoeconomic data that would have a material impact on the guideline.	
SH	Genzyme Therapeutics	17.07	General	At the stakeholder meeting on the 29th November, the group facilitator suggested that we provide a list of new and important references for our products which have been published since the previous guideline in order to facilitate evidence identification. We believe this evidence would have a material impact on the 2008 recommendations and would ask NICE to review them for relevant content: • Bjordal JM, Klovning A, Ljunggren AE et al. Short-term efficacy of pharmacotherapeutic interventions in osteoarthritic knee pain: A meta-analysis of randomised placebo-controlled trials. Eur J Pain 2007; 11: 125–138 • Chevalier X, Jerosch J, Goupille P, et al. Single, intra-articular treatment with 6 mL of hylan G-F 20 in patients with symptomatic primary osteoarthritis of the knee: A randomised, multi-centre, double-blind, placebo-controlled trial. Ann Rheum Dis 2010;69:113–119 • Raman R, Day N, Das S et al. Efficacy and safety of hylan G-F 20 in knee OA: A prospective, RCT of single and multiple doses. Abstract presented at the American Academy of Orthopaedic Surgeons, March 9th -13th 2010, New Orleans, USA. • Raman R, Dutta A, Day N et al. Efficacy of Hylan G-F 20 and Sodium Hyaluronate in the treatment of osteoarthritis of the knee -- a prospective randomized clinical trial. Knee 2008; 15(4):318-324. • Dickson D, Roberts K, and Raman R. Prospective RCT comparing hylan G-F 20 and steroid following arthroscopic debridement in OA of the knee. Presented at the American Academy of Orthopaedic Surgeons, 25th -28th February, 2009, Las Vegas, USA. • Wang et al. Effects of Hylan G-F 20 supplementation on cartilage preservation detected by magnetic resonance imaging in osteoarthritis of the knee: a two-year single-blind clinical trial. BMC Musculoskeletal Disorders 2011, 12:195 • Conrozier et al. Early Effect of Hyaluronic Acid Intra-Articular Injections on Serum and Urine Biomarkers in Patients with Knee Osteoarthritis: An Open-Label Observational Prospective Study. Journal of Orthopaedic Research 2011 (published online in Wiley Online Library (wileyonlinelibrary.com). DOI 10.1002/jor.21580 • Brander VA, Stadler TS. Functional improvement with hylan G-F 20 in patients with knee osteoarthritis. Phys Sportsmed 2009; 37(3): 38-48. • Goorman SD, Watanabe TK Miller EH et al. Functional Outcome in Knee Osteoarthritis After Treatment With Hylan G-F 20: A Prospective Study Arch Phys Med Rehabil 2000; 81: 479-83. • Raman R, Dutta A, Day N et al. Safety and efficacy of repeat treatment with hylan G-F 20 in the treatment of osteoarthritis of the knee. Presentation at the Annual meeting of American Academy of Orthopaedic Surgeons, Las Vegas, Nevada, USA. Feb 25th -28th, 2009.	Thank you for submitting these references. These will be reviewed against our final scope and evidence review protocols.

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				• Raman R, Johnson GV, Day N et al. Safety and Efficacy of Repeat Treatment with Single dose Hylan G-F 20 in osteoarthritis of the knee. Presentation at the Annual meeting of American Academy of Orthopaedic Surgeons, San Diego, CA, USA. Feb 15th-19th, 2011. • Waddell DD, DeWayne C, Bricker, PA. Total Knee Replacement Delayed With Hylan G-F 20 Use in Patients With Grade IV Osteoarthritis. J Manag Care Pharm 2007;13(2)113-21. • Brander VA, Stadler TS. Functional improvement with hylan G-F 20 in patients with knee osteoarthritis. Phys Sportsmed 2009; 37(3): 38-48. • Zeni J, Axe M, Beeson H, Synder-Mackler L. Comparison of two hyaluronic acid formulations on functional outcomes in patients with knee osteoarthritis [abstract]. Osteo and Cart. 2011 Sept; 19(Suppl 1):S141. • Yu L, Yang H, Voschin E, Skrabut E. Viscoelastic properties and molecular weight of hylan G-F 20 compared with other commercial hyaluronan based viscosupplements [abstract]. Osteo and Cart. 2011 Sept;19(Suppl 1):S235. • Pavelka K, Uebelhart D. Efficacy evaluation of highly purified intra-articular hyaluronic acid (Sinovial((R))) vs hylan G-F20 (Synvisc((R))) in the treatment of symptomatic knee osteoarthritis. A double-blind, controlled, randomized, parallel-group non-inferiority study. Osteoarthritis Cartilage. 2011 Nov;19(11):1294-300. • Han C, Tran J, Nguyen C, Hirsch J. Cost-effectiveness analysis of hyalgan versus Synvisc in the treatment of osteoarthritis [abstract]. Academy of Managed Care Pharmacy's Annual Meeting 2011 Apr 27-9; Minneapolis, Minnesota; 2011. • Maheu E, Zaim M, Appelboom T, Jeka S, Trc T, Berenbaum F, et al. Comparative efficacy and safety of two different molecular weight (MW) hyaluronans F60027 and Hylan G-F20 in symptomatic osteoarthritis of the knee (KOA). Results of a non inferiority, prospective, randomized, controlled trial. Clin Exp Rheumatol. 2011 May-Jun;29(3):527-35.	
SH	Grunenthal Ltd	24.00	3.3.1c	Both the published guideline and the scope for which pharmacological management sections will be updated focus on the initial treatments for osteoarthritis (OA). Such treatments are licensed for mild to moderate pain (e.g. paracetamol), are associated with significant adverse events limiting the dose and duration of therapy (e.g. NSAIDs/COX-2 inhibitors) or are not currently recommended for use (e.g. glucosamine, chondroitin and intra-articular hyaluronan injections). The literature review which informed the decision to update the guideline identified additional safety concerns over the use of paracetamol, the need to mitigate the adverse effects of NSAID therapy with the option for NSAID and PPI fixed combination therapy and no sufficient conclusive evidence which would change the direction of the guidance for the products not currently recommended.	Thank you for your comment. CG59 supported the use of opioids in OA and recent evidence published since then would not change the original recommendation. As the positioning of Paracetamol in the management of pain of OA is being reviewed it is possible that some paracetamol opioid combinations may be used as comparators NICE does not recommend on specific doses.

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				Section 2.2e of the scope identifies that current conservative (non-joint replacement) management of OA may not be satisfactory, with up to 80% of people reporting constant pain and a third of these reporting their pain as unbearable. Despite this it is not clear in the scope whether the options for managing patients with insufficient pain relief on paracetamol and/or NSAIDs or COX-2 inhibitors will be updated. The current guideline merely states that if paracetamol or topical NSAIDs are insufficient for pain relief for people with osteoarthritis, then the addition of opioid analgesics should be considered. Given the residue burden of pain it would seem appropriate to provide further guidance on the subsequent choice of therapy, particularly for patients with severe pain.	
SH	Grunenthal Ltd	24.01		With the introduction of tapentadol (Palexia SR) not all strong centrally acting analgesics rely on the opioid receptor. Tapentadol is a strong, centrally acting analgesic combining two mechanisms of action, μ-opioid receptor agonism (MOR) and noradrenaline reuptake inhibition (NRI), in a single molecule, providing effective analgesia in both nociceptive and neuropathic pain. Palexia SR is indicated for the management of severe chronic pain in adults, which can be adequately managed only with opioid analgesics. To this end we propose the following clinical question to be addressed in the guideline:- 'In adults with osteoarthritis, what are the benefits and harms of tapentadol PR compared to i) conventional opioids or ii) placebo with respect to symptoms, function and quality of life?' A randomized, double-blind, active- and placebo controlled phase III study demonstrated that treatment with tapentadol PR 100–250mg twice daily or oxycodone HCl CR 20–50mg twice daily was effective for the management of moderate to severe chronic osteoarthritis-related knee pain, with substantially lower incidences of gastrointestinal-related TEAEs associated with treatment with tapentadol ER than with oxycodone CR. A meta-analysis of three pivotal trials in osteoarthritis and lower back pain demonstrated significantly reduced incidences of gastro-intestinal side effects (nausea, vomiting, constipation) with tapentadol PR compared with oxycodone controlled CR at doses providing similar analgesic effects. Tapentadol PR is associated with fewer treatment discontinuations and with patients remaining on therapy for longer compared to oxycodone CR. Tapentadol PR demonstrates significant improvements in patient reported quality of life outcome measures (SF-36 and EQ-5D) compared to oxycodone CR. Given the need to provide effective pain control whilst avoiding significant adverse events, in order to improve function and quality of life, it would be appropriate to include the recently introduced tapentadol prolonged release (Palexia SR) in the clinical guideline as an alternative to convention opioids. Tzschentke,T.M. et al. (2007) (-)-(1R,2R)-3-(3-dimethylamino-1-ethyl-2-methyl-propyl)-phenol hydrochloride (tapentadol HCl): a novel mu-opioid receptor agonist/norepinephrine reuptake inhibitor with broad-spectrum analgesic properties. J. Pharmacol. Exp. Ther., 323, 265-276. Tzschentke,T.M. et al. (2009) Tapentadol hydrochloride: a next-generation, centrally acting analgesic with two mechanisms of action in a single molecule. Drugs Today (Barc)., 45, 483-496.	Thank you for your comment. We disagree. Palexia SR is indicated for the management of severe chronic pain in adults, which can be adequately managed only with opioid analgesics. CG 59 makes recommendation regarding the place of opioids in the management of pain in patients with osteoarthritis. The place of this drug is therefore clear in the existing pathway and does not warrant a clinical question and will not be considered as part of the update of this guideline.

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				Summary of Product Characteristics: Palexia / Palexia SR. Grunenthal Ltd. February 2011. Accessed at www.emc.medicines.org.uk 03/06/2011 Afilalo,M. et al. (2010) Efficacy and Safety of Tapentadol Extended Release Compared with Oxycodone Controlled Release for the Management of Moderate to Severe Chronic Pain Related to Osteoarthritis of the Knee: A Randomized, Double-Blind, Placebo- and Active-Controlled Phase III Study. Clin. Drug Investig., 30, 489-505. Lange,B. et al. (2010) Efficacy and safety of tapentadol prolonged release for chronic osteoarthritis pain and low back pain. Adv. Ther., 27, 381-399	
SH	Grunenthal Ltd	24.02	4.1.1c	Given the high residual levels of pain associated with current practice (section 2.2e) it would be appropriate to set out quality statements identifying target levels of symptom management	Thank you for your comment which has been noted.
SH	HFA healthcare	5.00	3.3.1b	HFA Healthcare are pleased that the scope specifies that only licensed preparations of glucosamine and chondroitin will be covered in the guideline. We would like to highlight that currently there are only 3 licensed formulations of glucosamine products which have each been approved by the MHRA as a prescription only medicine (POM) and granted a product licence. None of these products contain chondroitin, therefore we would recommend that 3.3.1b should read: 'Licensed preparations of glucosamine i.e. which have been approved by the UK regulatory authorities (MHRA) as medicinal products and are classified as prescription only products .	Thank you for your comment. This section has been revised to say Glucosamine and chondroitin. We have also added the following wording: Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients. This is based on standard NICE wording.
SH	HFA healthcare	5.01	3.3.1c	It is not clear if the text following 3.3.1c referring to a drug's summary of product characteristics (SmPC) also refers to 3.3.1b. We would recommend that recommendations for licensed preparations of glucosamine in addition to clarification on the licence status (as per our previous comment), the scope should also specify that *'the guideline will assume that prescribers will use a licensed product's SmPC to inform decisions made with individual patients'*.	Thank you for your comment. This section has been revised to say Glucosamine and chondroitin. We have also added the following wording: Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients. This is based on standard NICE wording.
SH	HFA healthcare	5.02	4.1.1 and 4.1.2	While section 4.1.2 specifies that unlicensed preparations of glucosamine and chondroitin will not be considered with the quality standard statements, Section 4.1.1 detailing the areas of care that will be considered does not explicitly state for which categories the licensed preparations will be considered. We would recommend that for clarity a new bullet is added to the management options (4.1.1c) specifying licensed glucosamine treatments.	Thank you for your comment. We consider it appropriate that 4.1.1c suggests symptom management without being prescriptive about which agents will be covered.

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SH	HFA healthcare	5.03	3.3.2 and 4.1.2a	Clarification is required in sections 3.3.2 as to if the Institute plan to address the issue of clinicians directing patients to purchase unlicensed treatment over the counter rather than providing a licensed treatment The use of unlicensed preparations impacts on the treatment quality a patient receives and if this is severely compromised a patient cannot be assured of receiving a treatment with proven efficacy and safety. We would ask that during the development of the clinical guideline the Institute provide a statement addressing the above issue and offers clinicians' guidance relating to the situation where a patient requires glucosamine and makes specific reference to licensed glucosamines. The quality standard should also include a statement specifically on the use of glucosamines in line with final clinical guideline recommendations	Thank you for your comment which will be forwarded to the GDG for their consideration.
SH	Johnson & Johnson	12.00	1.5.1.2	Total knee replacement (TKR) and hip replacement (THR) are highly effective procedures for the treatment of severe hip and knee pain that compare well with other interventions. Although there has been a significant increase in the provision of joint replacement, since 1997 several studies published as recently as 2009, have found that there may still be some ongoing unmet need for joint replacement in the UK. These studies also found large variations in the access to treatments for joint pain, including joint replacement, across different geographic areas and social groups. Consequently, there may be large numbers of people in need of joint replacement who are not receiving any specialist medical care. Using the English Longitudinal Survey, Steel interviewed 7,101 people older than 60 about their need for hip or knee joint replacement with standard survey questions. (1) Respondents were classified as being need of joint replacement when they indicated that they were often troubled by pain, with pain in the hip or knee when walking on the flat rated as 5 or more on a scale of 0-10, or if they had difficulty in walking a quarter of a mile. This found that the prevalence of need for hip or knee replacement was 14 % (95% CI 13 - 15%) and the prevalence of existing joint replacement was 6% (95% CI 5 - 6%). Excluding patients contraindicated for surgery, the prevalent need was 6% (95% CI 5 - 6%). Similarly a survey of 15,000 people in Wiltshire and Sheffield older than 60 by Yong et al in 2004 asked about the need for knee replacement using an adapted version of the index of severity of osteoarthritis by Lequesne.(2) This found, excluding those with co-morbid factors, that the proportion of patients in need of TKR was 5.1% (95% CI 4.6 - 5.6%) for males and 10% (95% CI 9-11%) for females. However, the proportion of patients that had received a TKR was much lower, 2% (95% CI 2 - 3%) for males and 3% (95% CI 3 - 4%) for females. Furthermore, of the 574 people identified in the study as being in need of knee replacement, only 37 had received a TKR, while the majority had not received the specialist care needed. (2) In 2003 Juni et al reported on a survey of the population requirement for primary TKA in the former counties of Avon and Somerset.(3) This used the New Zealand Score to assess the need for TKR in patients that had screened for knee pain. The	Thank you for this literature. Consideration of the timing of surgery will be addressed in this update.

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				prevalence of patients with severe knee disease in need of TKR was 6.1% (95% CI 4.8 – 7.2%) in females aged 65-74, while the prevalence of TKR was only 1.5% (95% CI 1-2%). The difference in prevalent need for and prevalence of TKR was assigned not to the availability of TKR in the health service, but also a reluctance of patients and doctors to consider surgery. A common theme in these studies is the variability in the need and access to joint replacement according to age, gender, geography and deprivation. Studies by Juni, Yong, Steel, Judge and Peters all found that, older people, women and the less wealthy had a greater need for joint replacement.(1,2,3,5,6,7)	
SH	Johnson & Johnson	12.01	1.5.1.2 Continued	People in the North of England, Women and the poorest had the greatest disparity between those in need and those receiving joint replacement.(1) These population based surveys appear to indicate that there are large numbers of people in the UK in need of joint replacement who are not currently being treated. The willingness for surgery may be influenced by factors such as increasing age, female gender, and lower wealth. People in these groups may have less positive expectations of surgery and be more prepared to adopt coping strategies, creating inequalities in access to treatment. (5,6) In those candidates not treated with surgery it is also unclear whether they are receiving appropriate care.(2) There is evidence to suggest that there is a historic unmet need for treatment of severe joint pain, and information indicating whether this is being addressed by current levels of surgery is limited. Additionally, there is substantial variability in access across different groups and an increasing number of older people in which joint pain is more prevalent. These are all factors that should be considered when updating guidance on how to diagnosis, when to refer and commissioning of treatments for severe hip and knee joint pain. References: 1. Steel N, Melzer D, Gardener E, McWilliams B. Need for and receipt of hip and knee replacement-a national population survey. Rheumatology 2006;45:1437-1441 2. Yong P, Milner P, Payne J, Lewis P, Jennison C. Inequalities in access to knee joint replacements for people in need. Ann Rheum Dis 2004;63:1483–1489. 3. Juni P, Dieppe P, Donovan J, Peters T, Eachus J, Pearson N, Greenwood R, Frankel S Population requirement for primary knee replacement surgery: a cross-sectional study Rheumatology 2003;42:516–521 4. Frankel S, Eachus J, Pearson N, Greenwood R, Chan P, Peters TJ, et al. Population requirement for primary hip-replacement surgery: cross-sectional study. Lancet 1999;353:1304-9. 5. Judge A, Welton NJ, Sandhu J, Ben-Shlomo Y. Modeling the need for hip and knee replacement surgery. Part 1. A two-stage cross-cohort approach. Arthritis Rheum	Thank you for this literature. Consideration of the timing of surgery will be addressed in this update.

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				2009;61:1657-66. 6. Judge A, Welton NJ, Sandhu J, Ben-Shlomo Y Equity in access to total joint replacement of the hip and knee in England: cross sectional study. BMJ 2010;341:c4092 7. Peters T, Sanders C Dieppe P, Donovan J. Factors associated with change in pain and disability over time: a community-based prospective observational study of hip and knee osteoarthritis. British Journal of General Practice 2005; 55: 205–211.	
SH	Johnson & Johnson	12.02	1.5.1.3	We are aware of published reports that some Primary Care Trusts (PCTs) are seeking to restrict access to joint replacement based on patient specific factors. (1)It is important that any barriers to treatment based on patient specific factors are evidenced based and robustly demonstrable. Current evidence in joint replacement surgery from the national and international registries and peer reviewed studies support the current recommendation from NICE stating that patient-specific factors should not be barriers to referral for surgery.When investigating the impact of a funding restriction for Total Joint Replacement (TJR), introduced to those with a body mass index (BMI) of less than 30 kg/m^2, Davis et al, extrapolated local data to incorporate numbers that would be affected if this policy was instituted in their local PCT and nation-wide based on data from the National Joint Registry of England and Wales. They also examined the available literature to discover if there is any evidence that obesity affects outcome in hip and knee replacement surgery. (6) They found that 24% of the population undergoing total hip replacement and 38.5% of patients undergoing total knee replacement in the test population were classified as obese, so denying joint replacement to patients with a BMI > 30 kg/m2 would have represented a significant cost saving to a purchasing authority. However, they concluded that this would be done at the expense of an increase in suffering in those patients denied surgery. They could find no convincing evidence in the literature to support the policy of denying anyone a hip replacement on the grounds of obesity and that the policy they were testing discriminated not just against the overweight, but also has a greater impact on women than men. They concluded that if this policy were to be adopted nation-wide, it would lead to unnecessary suffering in over 20,000 people every year. We would urge NICE to consider the wider societal benefits of joint replacement beyond the perimeter of health budgets. A recent study by The Work Foundation showed that interventions such as total joint replacement involving medical technologies may help those individuals regain active employment status, thus contributing to the retention of skills and improved societal productivity, while reducing the demand for the government to make payments to those individuals in the form of welfare benefits. In 2009 in the region of 11,000 people in England and Wales were enabled to return to work by a hip replacement surgery, saving the UK welfare system £37.4 million each year of their working lives. Not having the intervention is often 'more of a cost' to patients, the health care system and the society. (10)	Thank you for your comment the contents of which have been noted and will be forwarded to the GDG and NICE for discussion in relation to the development of the guideline and quality standard. The benefits to society of people returning to work (referred to as productivity gains/losses or sometimes indirect costs/benefits) are not explicitly incorporated in to the analyses we produce for NICE. This is stated in the 'Methods for Technology Appraisal' (MTA), which outlines the NICE reference case. The quality of life component of the QALY which is used reflects people's ability to carry out their usual activities including returning to work. We will not look at return to work explicitly but we will look at return to

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					usual activities as an aspect of quality of life
SH	Johnson & Johnson	12.03	1.5.1.3 Continued	It is widely recognised that there are optimal timings for surgical intervention. With long term conditions such as osteoarthritis, the condition of a patient's joint will continue to deteriorate over time and the eventual outcome of delayed surgery may be poorer. (9) The Patient Liaison Group of the Royal College of Surgeon's issued a statement advising caution on delaying surgery based on patient –specific factors such as obesity for the following reasons; (9) • Waiting times for elective (planned) orthopaedic surgery are already long and weight reduction programmes, which aren't always successful, will extend this over many months or years. • It is often not within a GP's expertise, nor indeed within the expertise of other non-medically-qualified therapists, to fully assess the hip or knee condition of an obese patient. • Patient choice must also be considered, a fully informed obese patient may be happy to accept additional risk of joint replacement surgery • This directly contradicts the current DH mantra "No decision about me without me". Early intervention for osteoarthritis with total joint arthroplasty can prevent disability and allow patients to keep their jobs – 31 per cent of women and 42 per cent of men receiving an artificial hip are of working age. (10) Around 32 per cent of women and 33 per cent of men had a knee replacement procedure before they were 65 years old. (10) Further knock-on effects of treatment are associated with preserved capacity of individuals to lead independent lives and return to work: relieved burden of caregivers, improved opportunities of return to employment among patients, as well as the benefits associated with participating in family roles. (10) Ten-year survivorship figures following total joint replacement have been found to be comparable for both obese and non-obese patients (7) and there is evidence to show that joint replacements do not wear out sooner in obese patients (8). A poorer outcome is not the same as a poor outcome. (2,3) A benefit can still be substantial from the patient's point of view even if it is not the maximum achievable, and it will be easier to exercise when it has been received due to improved mobility and decreased pain. (4)	Thank you for your comment the contents of which have been noted and will be forwarded to the GDG and NICE for discussion in relation to the development of the guideline and quality standard. Please also note that the timing of surgery will be reviewed as part of the update of the guideline.
SH	Johnson & Johnson	12.04	1.5.1.3 Continued	A systematic review to determine how patient characteristics influence the outcomes of hip and knee arthroplasty considered 500 patients with osteoarthritis. It was shown that all subgroups derived benefit from total joint arthroplasty and that in no specific subgroup of patients did total joint arthroplasty appear contraindicated, suggesting that surgeons should not restrict access to these procedures based on patient characteristics.(9) Denying joint-replacement surgery to obese patients, in a short term attempt to save money is not justified and is creating inequity of access to care to people who have often put on weight as their OA has increased their disability and restricted their ability to maintain appropriate activity levels. References *(1)* Dehn T. Joint Replacement in the Overweight Patient. Ann R Coll Surg Engl. 2007 April; 89(3): 203. *(2)* Dowsey MM, Liew D, Stoney JD, Choong PF. The impact of pre-operative obesity on weight change and outcome in total knee replacement: a prospective study of 529 consecutive patients. *J Bone Joint Surg Br 2010;92-4:513*	Thank you for your comment. CG59 addressed this area and suggested patient characteristics should not restrict referral to orthopaedic surgery. The evidence in relation to the timing of surgical interventions will be reviewed in the update.

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				(3) Hamoui N, Kantor S, Vince K, Crookes PF. Long-term outcome of total knee replacement: does obesity matter? Obes Surg 2006;16:35–8.[CrossRef][Web of Science][Medline] *(4)* Symonds L. Joint Replacement in the Overweight Patient – A View from the Patient Liaison Group. Patient Liaison Group, The Royal College of Surgeons of England, London, UK Ann R Coll Surg Engl. 2007 April; 89(3): 206 *(5)* Coombes R. Rationing of joint replacements raises fears of further cuts. *BMJ.* 2005;331:1290. [PMC free article] [PubMed] *(6)* Davis W, Porteous M. Joint Replacement in the Overweight Patient: A Logical Approach or New Form of Rationing?Ann R Coll Surg Engl. 2007 April; 89(3): 203–206. *(7)* Spicer DD, Pomeroy DL, Badenhausen WE, Schaper LA, Jr., Curry JI, Suthers KE, Smith MW. Body mass index as a predictor of outcome in total knee replacement. *Int Orthop 2001;25-4:246-9.* *(8)* Wendelboe AM, Hegmann KT, Biggs JJ, Cox CM, Portmann AJ, Gildea JH, Gren LH, Lyon JL. Relationships between body mass indices and surgical replacements of knee and hip joints. *Am J Prev Med 2003;25-4:290-5.* *(9)* Santaguida PL; Hawker GA; Hudak PL. Patient characteristics affecting the prognosis of total hip and knee joint arthroplasty: a systematic review. 2008. J can Chir Vol 51. , 428436. *(10)* Bevan S, Zheltoukhova K, McGee R. Adding Value: The Economic and Societal Benefits of Medical Technology. The Work Foundation 2011	
SH	Johnson & Johnson	12.05	1.5.1.4	Caution should be exercised when interpreting PROMS scores to inform decision making on the commissioning of Total Joint Replacement Surgery for Osteoarthritis. Absence in improvement of scores does not necessarily indicate an unsuccessful outcome in treating a degenerative condition such as osteoarthritis because the intervention could in some severe cases prevent further deterioration of the disease. In addition avoidance of medication for increasing levels of pain and symptom relief, mobility aids and supportive care services is an important consideration. For example, Devlin *et al* (2009) showed that problems with anxiety/depression are very commonly reported by those awaiting hip replacement, and that alleviating this is also an important source of improvement in quality of life following surgery. It was also demonstrated that by failing to take into account that patient reported quality of life will often deteriorate over time without surgical intervention and as a result, PROMS scores underestimate the improvement in health gained for those patients.(1) Degeneration of articular cartilage in osteoarthritis is one of the most common causes of pain and disability in middle-aged and older people. There is a strong correlation between increasing age and the prevalence of osteoarthritis. Recent evidence of important age-related changes in the function of chondrocytes, suggest that these changes in articular cartilage can contribute to the development and progression of osteoarthritis irrespective of total joint surgery. (2) In some cases, health care has as its principal goal not in the improvement of health, but rather the slowing down of the rate	Thank you for your comment the contents of which have been noted and will be forwarded to the GDG and NICE for discussion in relation to the development of the guideline and quality standard. Please also note that the role of decision aids will now be looked at more generally in terms of the management of OA rather than in surgery specifically and the scope has been amended accordingly

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				of disease progression and degradation in quality of life, or the avoidance of future health problems. Patient's expectations after total hip replacement have changed. Today, quality of life issues, which sometimes include high-activity recreational interests, define their aspirations.(3) Patient satisfaction ratings often reach beyond regaining basic mobility, therefore if patient expectations haven't been adequately set regarding what a successful outcome looks like for them, measuring satisfaction has the potential to identify patients with technically successful surgery who perceive a poor outcome. Therefore dissatisfaction may be a manifestation of unrealistic expectation rather than the result of a poor outcome. (4) Informed Decision Aids should be based on robust evidence to negate the subjectivity associated with contradictory opinions. NICE should focus on recommending best practice clinical guidance to the NHS and the appropriate use of decision aids should be co-developed by patient groups and professional clinical societies such as The British Orthopaedic Association (BOA).	
SH	Johnson & Johnson	12.06	1.5.1.4 Continued	(1) Patient Reported Outcome Measures (PROMs): Report to the Department of Health. Health Services Research Unit, Health Services Research Unit, London School of Hygiene & Tropical Medicine. 12/12 2007 (2) Buckwalter JA, M. H. (1998). Articular cartilage: degeneration and osteoarthritis, repair, regeneration, and transplantation. (3) Learmonth ID, Young C, Rorabeck C. The operation of the century: total hip replacement. October 27 2007. Lancet Vol 370 , 1508-1519. (4) Wylde V, Dieppe P, Hewlett S, & Learmonth I. (2007). Total Knee Replacement: Is it really an effective procedure for all? The Knee , Vol 14; 417-423.	Thank you for submitting these references. These will be reviewed against our final scope and evidence review protocols.
SH	Liverpool Primary Care Trust	1.00	3.3.1 e)	I believe it would be helpful to address the issue of using Oxford scores as measures of appropriateness for referral to surgery from Primary care, as some PCTs now use the score to ration access. Comments on the use and shortcomings of NHS Direct's online Decision Aids would be very helpful	Thank you for your comment. We agree regarding the deficiency in existing outcome measures and when examining the efficacy of any therapies we will endeavour to include instruments covering the guideline development group agreed important domains, including symptoms and health-related quality of life. The role of decision aids generally will be considered as part of this update.
SH	Liverpool Primary Care Trust	1.01	3.3.1 c)	It would be helpful if some reference is made to the value of steroid intra-articular injections, which enjoy widespread use	Thank you for your comment. CG59 supported the use of intra-articular steroid injections as an adjunctive therapy for OA.
SH	Merck Sharp & Dohme UK Ltd	14.00	Section 2	We would like to make NICE and the Guidelines Development Group aware of an on-going non-interventional study, which is now fully recruited in the UK. The Survey of Osteoarthritis Real World Therapies (SORT) was designed to explore the treatment pathways of	Thank you for submitting this information. The GDG will consider all relevant studies retrieved from the searches according to the protocol for the evidence reviews.

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				OA patients with inadequate response (i.e. pain relief) to OA pain treatments. It is a multi-national study, conducted across 6 EU countries (France, Germany, Italy, the Netherlands, Portugal, and United Kingdom). There are approximately 300 patients enrolled in the UK, and over 1200 in the overall study. SORT aims to: • Document the clinical course of pain management in patients with OA who indicate they are not receiving adequate pain relief with their current analgesic therapy • Assess patient-reported pain relief provided by current analgesics • Characterise the clinical presentation of inadequate pain relief • Evaluate quality of life and clinical and economic outcomes associated with inadequate pain relief. An interim analysis of 205 UK patients reported that 62% of patients found their current OA treatment provided inadequate pain relief. Ref: Martin GDR, Balshaw R, Phillips C et al. Inadequate Pain Relief in Knee Osteoarthritis and Patient-Reported Outcomes: A Survey of Osteoarthritis Real World Therapies (SORT) in the United Kingdom. Poster presentation to ISPOR 14th Annual European Congress (PMS59). Available at: http://www.ispor.org/research_study_digest/details.asp	
SH	Merck Sharp & Dohme UK Ltd	14.01	3.3.1	The draft scope identifies etoricoxib as a "key issue" which will be covered during the update to CG59. We believe only a minor amendment to the current recommendation is required. During consultation on the Review Consultation Document (RCD), MSD raised concerns that recommendations in CG59 were being misinterpreted by NHS bodies (including NICE and the NPC), and were not entirely in line with SmPCs. We proposed a minor amendment to correct the source of this misinterpretation. Specifically, recommendation 1.4.3.4 of CG59 states: "*When offering treatment with an oral NSAID/COX2 inhibitor, **the first choice** should be either a standard NSAID or a COX-2 inhibitor (**other than etoricoxib 60 mg**). In either case, these should be co-prescribed with a PPI [proton pump inhibitor], choosing the one with the lowest acquisition cost.*" [Emphasis added]. The rationale for this recommendation to be considered incorrect and misleading was included in our response to the RCD, as summarised below: 1. **Exclusion of etoricoxib 60 mg was irrelevant, given it is not the authorised starting dose in OA**: It was inappropriate for CG59 to specifically recommend against the use of etoricoxib 60 mg, as a starting dose for osteoarthritis. Based on current product SmPCs, such a recommendation is inappropriate because: • **The initial dose for etoricoxib in OA is 30 mg**. It is, therefore, not appropriate to consider (and subsequently bar) etoricoxib 60 mg as an initial treatment option for OA. • **The guideline only made recommendations on the initial treatment for OA**, after the use of paracetamol and topical NSAIDs. In the scenarios where initial treatment does not provide sufficient pain relief, or the treatment is not tolerated, no recommendations were made. • **The guideline did not include a similar 'initial dose' recommendation (bar) for celecoxib 400 mg**.	Thank you for your comment. The applicability of the model will be reviewed within this guideline update. At the time the model was done there was no data on 30mg of etoricoxib.

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				The initial dose for celecoxib in OA is 200 mg, although a 400 mg dose was also considered within the 2008 guideline (similar to the starting dose [30 mg] and higher dose [60 mg] of etoricoxib). Unlike etoricoxib 60 mg, however, celecoxib 400 mg **was not** included within the economic modelling supporting CG59. Based on the assumptions made within the modelling, if included, celecoxib 400 mg would have been consistently dominated (i.e. giving a poorer health outcome at a higher cost).* 2. **Exclusion of etoricoxib 60 mg was misleading and has been misinterpreted in several NICE and NPC workflows**. Full details were provided in our response to the RCD. * The health economic modelling used to develop the draft recommendations of CG59 predated the availability of etoricoxib 30mg: at the time, the only dose of etoricoxib with a marketing authorisation for use in OA was 60 mg. Celecoxib was available at doses of 200 mg and 400 mg throughout the development of the guideline, although only the 200 mg dose was included in the modelling. (continued on next page)	
SH	Merck Sharp & Dohme UK Ltd	14.02		The model built to support development of the guideline made two important assumptions: • all treatments (and doses) provide an identical degree of symptom relief, and; • a dose:AE relationship exists, whereby halving the dose leads to a 25% reduction in AEs. The combination of these two assumptions led to celecoxib 200 mg dominating etoricoxib 60 mg. However, these assumptions also imply that, where multiple doses of any OA treatment exist, the higher doses will **always** be dominated by the lower doses, even if there is flat-pricing across the dose range. Therefore, if celecoxib 400 mg was included in the modelling, it too would have been dominated by celecoxib 200 mg. Assuming similar handling of the two COX-2 inhibitors, this would have led to a recommendation not to use celecoxib 400 mg as the first choice treatment (which would also be consistent with the SmPC). Following launch of the 30 mg dose, the 60 mg dose remained within the economic modelling, but the higher dose of celecoxib (400 mg) continued to be excluded. Due to this differential treatment of non-starting doses within the modelling, inaccurate and misleading recommendations were produced, with these being subsequently misinterpreted by NHS bodies.	Thank you for your comment. The applicability of the model will be reviewed within this guideline update.
SH	NHS Direct	9.00	General	NHS Direct welcome the guideline and have no comments on the contents.	Thank you for your comment.
SH	NHS Plus	2.00	2.1c	"In 1999/2000, 36 million working days were lost because of osteoarthritis, costing the economy nearly £3.2 billion in lost production." The scope wisely notes the substantial impact on employment. The scope should make it clear that employment issues are within the scope.	Thank you for your comment. The benefits to society of people returning to work (referred to as productivity gains/losses or sometimes indirect costs/benefits) are not explicitly incorporated in to the analyses we produce for NICE. This is stated in the 'Methods for Technology Appraisal' (MTA), which outlines the NICE reference case. The

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					quality of life component of the QALY which is used reflects people's ability to carry out their usual activities including returning to work. We will not look at return to work explicitly but we will look at return to usual activities as an aspect of quality of life
SH	NHS Plus	2.01	3.3.1	Key issues that will be covered - this should explicitly include return to usual activities (including work)	Thank you for your comment. This is a partial update of the existing OA guidance. The key issues that will be covered have been included because new evidence is available in these areas. Quality of life as an outcome which is always used in NICE guidance reflects people's ability to carry out their usual activities including returning to work. We will not look at return to work explicitly but we will look at return to usual activities as an aspect of quality of life. We are aware that NICE has further relevant information in this area of return to work. Please refer to the guideline on managing long term sickness absence http://publications.nice.org.uk/managing-long-term-sickness-absence-and-incapacity-for-work-ph19.
SH	NHS Plus	2.02	3.4	Main Outcomes - this should include employment/return to work (ideally as a separate element or included explicitly in 'Quality of life').	Thank you for your comment. Quality of life is always an important outcome in NICE guidance and the quality of life component of the QALY which is used in NICE guidance reflects people's ability to carry out their usual activities including returning to work
SH	NHS Plus	2.03	4.1.1	Areas of care that will be covered should include rehabilitation.	Thank you for your comment. If rehabilitation as mentioned here is intended to mean exercise and manual therapy then this will not be revisited as this was covered in CG59 and no further published evidence would change the existing recommendations.
SH	NHS Plus	2.04	6.2	Related NICE guidance should include long term sickness absence (PH19), physical activity and the environment (PH8), and physical activity in the workplace (PH13).	Thank you for your comment. We agree and the scope has been amended accordingly
NICE	NICE Technical Advisor	7.00		I don't have any specific comments on the content. But a minor point that I think glucosamine and chondroitin should also be classed as pharmacological therapies?	Thank you for your comment.
SH	Pfizer	26.00	3.3	Since the publication of the CG59 OA guideline in 2008, several studies have highlighted the increasing importance of lower GI events in patients on NSAIDs (Lanas A and Sopena F, 2009, Ballinger A, 2009, Chan et al, 2010). A recent study (Lanas A et al 2009) also described a significant increase in the lower GI events associated with	Thank you for your comment. While new data on the NSAIDs may have emerged in the last few years, it is unlikely to change the CG59 recommendations and therefore we do not plan to

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				NSAIDs, although the upper GI events decreased over the study period. These lower GI events were associated with a higher mortality rate (8.8% vs 5.5%), longer hospitalisation (11.6+/-13.9 vs 7.9 +/-8.8 days) and higher resource utilisation compared to upper GI events. The study by Cham et al 2009 provides the guidance to the methodology and thinking behind the CONDOR trial. As a result of the increasing knowledge in this area, we feel it is important that the scope takes into consideration adverse events in the entire GI tract when looking at risks associated with NSAIDs (as opposed to considering only the upper GI events). The inclusion of the lower GI events in the analysis might have implications for the benefit – risk and/or cost effectiveness of the NSAID in question. 1. **Lanas A and Sopena F**. Nonsteroidal anti-inflammatory drugs and lower gastrointestinal complications. Gastroenterology Clinics, North America 2009;38(2):333-52. 2. **Lanas et al**. Time trends and impact of upper and lower gastrointestinal bleeding and perforation in clinical practice. American Journal of Gastroenterology 2009; 104: 1633 – 1641. 3. **Chan FK et al**. Celecoxib versus omeprazole and diclofenac in patients with osteoarthritis and rheumatoid arthritis (CONDOR): a randomised trial. Lancet 2010; 376: 173-179 4. **Chan FK et al.** A Novel Composite endpoint to Evaluate the Gastrointestinal (GI) Effects of Non-Steroidal Anti-inflammatory Drugs through the Entire GI Tract. The Journal of Rheumatology 2009; 36:12 5. **Ballinger A**. Adverse effectss of Non steroidal anti-inflammatory drugs on the Colon. Current Gastroenterology Reports Volume 10, Number 5: 485-489.	re-visit this topic in the update.
SH	Pfizer	26.01	3.3	One of the recommendations from the OA 2008 guideline was the use of traditional NSAIDs, COX II inhibitors or opioids, if patients had insufficient pain relief following the use of paracetamol and/or topical non steroidal anti inflammatory drugs. In view of recent publications including a systematic review by the Cochrane Musculoskeletal Group (Howes F et al 2011) on the use of Opioids for patients with OA, we feel that recent evidence on Opioids is taken into consideration to specify under which circumstances they are an appropriate treatment option in patients with osteoarthritis.1. **Howes F et al**. Opioids for osteoarthritis? Weighing benefits and risks. A Cochrane Musculoskeletal Group Review. The Journal of Family Practice April 2011 Volume 60, no 4	Thank you for your comment. CG59 supported use of opioids in OA and recent evidence published since then would not change that recommendation.
SH	Pfizer	26.02	3.3	Within the last 2 years, several studies (including Trelle S et al 2011, Mc Gettigan et al 2011, Varas- Lorenzo et al 2011) have been published on the CV risks associated with NSAIDs. We feel it will be helpful if the results of these studies are taken into consideration when analysing the benefit –risk profile and/or cost effectiveness of each drug. 1. **Sven Trelle et al** .Cardiovascular safety of non-steroidal anti-inflammatory drugs: network meta-analysis. BMJ 2011; 342:c7086. 2. **Mc Gettigan et al**. Cardiovascular Risk with Non-Steroidal Anti-Inflammatory Drugs: Systematic Review of Population-Based Controlled Observational Studies. PLoS Medicine September 2011, Volume 8, Issue 9 e1001098 3. **Varas-Lorenzo et al**. Stroke risk and NSAIDs: a systematic review of observational studies. Pharmacoepidemiology and Drug Safety 2011; 20: 1225–1236	Thank you for submitting these studies. The GDG will consider all relevant studies retrieved from the searches according to the protocol for the evidence reviews.
SH	RCP	27.00		Just to confirm that the RCP is happy to endorse the comments submitted by the BSR on the above.	Thank you for your comment.
SH	Royal College of Nursing	23.00	General	The Royal College of Nursing welcomes proposals to update this guideline. It is timely. The scope appears to cover a logical approach to the planned work. It also seems comprehensive and covers areas that are important for the care and management of OA and has	Thank you for your comment.

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				some research to evaluate these issues.	
SH	Royal College of Nursing	23.01	3.3.1	There are other areas that remain as yet poorly researched. Whilst we recognise that NICE's remit does not cover research, in order to ensure better care and management of people with OA, we hope that in due course these areas will benefit from and be considered for research studies: 1. The patient's perceived benefit and cost-effectiveness of early prompt information giving using shared decision making approach. 2. The value of decision aids in enhancing patient outcomes in relation to: a) surgical b) non surgical care pathways 3. The benefits achieved through new models of community based self management programmes in reductions in pain relief and use of healthcare resources. 4. Evaluation of direct and indirect costs of sub optimal information giving and choices of treatment.	Thank you for your comment. Further research recommendations may be made following review of the evidence in this update and in discussion with the GDG. The GDG are only able to make research recommendations based on the areas covered in the evidence review and scope. In the update of the guideline the guideline development group will prioritise the top 5 list of research recommendations to go in the NICE guideline.
SH	Royal College of Nursing	23.02	3.3.2	We note that this time the guideline will not be reviewing some aspects as outlined in this section, however, the part being excluded is linked into the patient experience. As with all MSK conditions especially where an element of chronic pain can be part of the problem, it is an area that needs some strong research and relevant evidence; this would be in keeping with the NHS commitment to use patient/carers as partners in care provision. We know there are a range of separate guidelines dealing with specific issues in relation to chronic pain (e.g. behavioural interventions, issues related to mental health and wellbeing for the older patient, chronic low back pain). It would be helpful to have specific reference to other core guidelines that will support the need for great input in relation to chronic pain experienced in OA pain focussing on practical aspects. We would welcome the panel considering how these issues are currently addressed with existing guidance and if there are gaps in implementation for the management of chronic pain in OA that this be raised as an area for future research/guidance.	Thank you for your comment. The existing recommendations from CG59 in these areas will be incorporated into the updated guideline and remain valid as well as informing the quality standard on osteoarthritis.
SH	Royal College of Nursing	23.03	3.5	This is valid in the current economic climate where the financial costs are evaluated. We note the scope has specified using QALY as part of the outcome but has not specified the plans for including patients/carers views. It is important and helpful to include both here.	The NICE reference case requires that we estimate cost-effectiveness on the basis of quality of life and QALYs where possible. Principle 5 of NICE's social value judgement notes that patients' views/preferences should not take precedence over cost-effectiveness use of resources, since this will be to the detriment of other patients. However, where alternative treatments have a

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					similar level of cost-effectiveness then patient views are of course important. Patient views will inform the guideline through the GDG patient members and stakeholder consultation. In addition the GDG will consider whether a specific search of the literature for published evidence on patient views would be useful.
SH	Smith & Nephew Healthcare Ltd	11.00	3.3.1 c	Smith & Nephew are pleased to see that the updated draft scope document includes intra-articular hyaluronan injections. Since the original guideline was produced in 2008, the industry has made advances in HA technology and there are now several single-injection product options available. The 2008 guideline described a drawback to multi-injection HA products to be the cost of patients undergoing several injections per treatment episode (p.267 "Given the cost of the therapies and the increased clinician visits required") and we therefore request consideration for single injection and multi-injection HA products to undergo review as separate product categories as the cost consequence of using a single injection HA is intuitively less than that of multi-injections. Additionally, as this guidance covers multiple joints, not solely the knee, there is a request to review the recent literature concerning the use of HA in the hip and also in other smaller joints such as the ankle. More information regarding the mechanism of action has been published since February 2008 with regard to pain mediation and chondroprotection. Consideration should be given to these important pre-clinical data as there was a concern over the lack of understanding of the mechanisms of action displayed by HA in the original guideline	Thank you for your comment – hyaluronan intra-articular injections will be included in the update review. The GDG will consider all hyaluronan products licensed for use in OA.
SH	The College of Chiropractors	4.00	3.3.2c	The College of Chiropractors agrees that there is no significant new evidence to justify a review of the Exercise and Manual Therapy section of the non-pharmacological management for osteoarthritis. However, it feels that it is appropriate to offer guidance on its delivery. The main evidence relating to the effectiveness of manual therapy (Comparison on Manual Therapy and Exercise Therapy in Osteoarthritis of the Hip: A Randomized Clinical Trial, Hoeksma et al) focused on the use of "specific manipulations and mobilisation" in patients with hip osteoarthritis. Although it is acknowledged that physiotherapists use mobilisation techniques, specific manipulation is rarely provided by physiotherapists in an NHS setting but is the treatment of choice used by chiropractors. Chiropractors also routinely provide a package of care which includes exercise advice, supervision and assessment, as well as a patient-centred holistic approach to the management of osteoarthritis. It would therefore be appropriate to include a footnote in the guidelines similar to that used in the NICE clinical guideline 88 on Low Back Pain which states: "The manual therapies reviewed were spinal manipulation, spinal mobilisation and massage. Collectively these are all manual therapy. Mobilisation and massage are performed by a wide variety of practitioners. Manipulation can be performed by chiropractors and osteopaths, as well as by doctors and physiotherapists who have undergone specialist postgraduate training in manipulation" A similar such statement in the Osteoarthritis guidelines would additionally address government policy by improving both patient choice and local access for cost-effective evidence-based care. It is noted that the scope is limited to all settings where NHS care is received. Chiropractic is currently provided	Thank you for your comment. In developing the quality standard, these issues will be addressed. The existing guideline does not specify whether the interventions are provided by the NHS.

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				to some NHS patients were appropriate contracts have been established, and will continue to be available to NHS commissioning bodies through the Any Qualified Provider (AQP) route.	
SH	TRB Chemedica	22.00	3.3.1c	The current guidelines (NICE clinical guideline 59 (2008) covering the use of intra-articular infiltration of Hyaluronic Acid (Sodium Hyaluronate) do not recommend the use of IA HA, despite a host of data (both previously presented and newly emerging) which support the efficacy and safety of HA in the treatment of Osteoarthritis. A sizeable number of mainly Primary Care Trust management teams have erroneously interpreted this lack of recommendation as a proscription. The sad fact is, that due to misinterpretation of the terms and scope of CG59, many clinicians have been told by their mangers that they can no longer prescribe or administer IA HA when treating patients with confirmed OA of synovial joints because "NICE have banned it". Despite the fact that the front page of CG59 clearly states "The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer and informed by the summary of product characteristics of any drugs they are considering", the misinterpretation of CG59 has led to a marked increase in the number of patients being denied a treatment that had previously controlled their symptoms well, with no adverse effects. There seems to be little doubt that the non-recommendation of IA HA in the treatment of OA in CG59 is due to the perceived cost, I quote from previous published correspondence relating to CG59 "*It would appear that the introduction of cost factors, that by the authors own admission may not be applicable to UK health care provision, confounds the overall outcomes unnecessarily".* NICE reply*;* Thank you, we agree that this is largely a cost-effectiveness issue. Given the fact that costings relating to HA treatment cited in CG 59, by the authors' own admission, are derived from research that is neither relevant to, nor representative of current costs to the NHS, could not a qualifying statement, describing certain exceptions be added to the non-recommendation e.g. IA HA is not recommended *unless all conservative measures have been tried and proved to be less than optimal in terms of symptom control and/or tolerability, or where the patient has previously been treated with IA HA and has responded well.* The full Royal College of Physicians (*The National Collaborating Centre for Chronic Conditions*) recommendations on HA costings from which CG 59 derives states: Sensitivity analyses on the individual estimates give a consistent message: that the efficacy would have to be three to five times higher than the estimates from the trials before reaching the standard threshold for cost effectiveness to the NHS. (7.4.8 pg 267). The authors concede that their attempts to draw accurate medico economic conclusions from the data they analysed are limited. However, if they were to say that treatment with HA would need to be 3-5 times LESS EXPENSIVE than the figures cited in order to meet NHS parameters, then a meaningful examination of costs to the NHS could easily be undertaken. Again, a simple rule of exception could be added to the revised guidelines, e.g. IA HA is not recommended in the treatment of OA, where the total cost of the injectable device or drug, excluding other associated costs exceeds £100.00.	Thank you for your comment. We will consider all hyaluronan products licensed according to the set terminology we use for defining products included in this update ie "licensed for use in OA" or similar. We will take care to ensure that our assessment of these products will be based on up to date and applicable cost data.
SH	TRB Chemedica	22.01	3.3.1c	Whilst TRB Chemedica are sure that this was not NICE's intention, the blunt non-recommendation of IA HA for the treatment of OA in CG59 has lead to an increase in the number of patients suffering unnecessarily from their OA related symptoms. We have been contacted by a great many patients who have been denied on-going care	Thank you for your comment. NICE guidance is

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				by their GP due to the misinterpretation of CG59, along with a number of GPs and Solicitors who are intending to challenge the withdrawal of appropriate treatment on behalf of their patients and clients. There must be a considered qualification in the revised guidelines relating to the use of IA HA in patients with a qualified diagnosis of OA. To do nothing will not be acceptable to a growing number of patients and physicians.	developed to maximise the use of NHS resources. Recommendations are based on the best available clinical and cost-effectiveness evidence. This will be the function of the GDG in updating this guideline
SH	UK Clinical Pharmacy Association	10.00		We have no comments to make on this draft scope.	Thank you for your comment. The GDG will consider relevant evidence retrieved from the searches during the development of the evidence reviews.

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