Response to Health Technology Appraisals on the primary and secondary prevention of osteoporotic fragility fractures in postmenopausal women

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Dear Carole,

In response to your letter of July 31st, please find my comments on these appraisals set out below. Given the constraints on time and my input into more detailed responses I am restricting my comments to major issues.

1. A general point is that it is difficult to know how to respond to this document since it contains no explicit recommendations but presents a range of options in the form of the sensitivity analyses (which presumably might be combined to form the basis of subsequent recommendations). The new groupings and analyses suggest that the current guidance on secondary prevention will be replaced but this is not explicitly stated.
2. Although the appraisals still contain the terms primary prevention and secondary prevention in their titles, this does not accurately reflect the new grouping into self-identification and opportunistic categories. It appears that only those with "acute" fracture are being considered as eligible for secondary prevention, whereas those with a past (and possibly recent) history of fracture are now being considered in the primary prevention category. This is scientifically incorrect and results in thresholds for women with previous fracture that are over-conservative and clinically inappropriate – for example, no woman below the age of 70 can be considered for treatment, even if she has sustained several fragility fractures.
3. The re-setting of the CPQ at £20,000 for secondary prevention is neither discussed nor justified.
4. Women on high doses (not defined) of glucocorticoids and those with rheumatoid arthritis are now included in the same category as those with an acute fracture, further confusing the issue of secondary prevention. Previously all glucocorticoid use was assigned to the GDG, but this appears to have been changed without consultation.
5. The analyses for women with "acute" fracture are now considerably more conservative than those used for the initial guidance on secondary prevention, mainly as a result of progressive lowering of the relative risk reduction for hip fracture (from 0.46 in the initial analysis to 0.71), and use of the lower CPQ threshold. Given that the existing guidance for secondary prevention is now being implemented across the UK it is difficult to see how this substantial change can be justified to the wider community in the absence of new evidence.
6. The analyses in this document have been performed on the basis that all women require BMD before they can have treatment. This is illogical and impracticable – doing DXA measurements in elderly hip fracture patients is often difficult or

impossible and the point of using independent risk factors to assess fracture risk is that the need for BMD measurements is reduced.

7. The situation regarding clinical risk factors is unclear. I understand (although this is not explicitly stated) that the WHO risk factors have been used in the analyses but since BMD is a prerequisite for treatment, risk factors for low BMD also become important for example untreated premature menopause, the use of aromatase inhibitors and low BMI. It is uncertain how these are to be used in the scenarios outlined in the document.
8. In view of the recent drop in price of generic alendronate, there can be no justification for failing to adopt the sensitivity analyses outlined in Tables 16.1 and 16.2.

With best wishes