

I am grateful for the opportunity of commenting on the new cost-effectiveness analysis of osteoporosis treatments and the systematic review of adverse events and persistence with bisphosphonate therapy. These comprehensive documents represent a large amount of work and provide a lot of useful information. Although I have only had little time to review these documents, because of annual leave, I should like to make the following comments:

1. It appears appropriate to me to pool the anti-fracture efficacy of alendronate and risedronate and to separate this from etidronate. The cost-effectiveness modelling for the two potent bisphosphonates uses the mean price of alendronate and risedronate. Although this is reasonable when the costs are similar, this will be less appropriate when the cost of generic alendronate falls, as prescribers will be under considerable pressure to prescribe the cheaper option. The greater the disparity between the cost of branded risedronate and generic alendronate, the more inaccurate the cost-effectiveness modelling will be, when the mean price is used. Although scenario 16 of the sensitivity analyses (Table 2) models the impact of a halving of the mean costs, it would have been useful to model the effect of the cost of generic alendronate falling by 50%, 75% and 90%.
2. Scenario 5 of the sensitivity analyses on Table 2 uses the assumption that the anti-fracture efficacy of osteoporosis treatment is only proven in patients with low BMD or a prior fracture. Although data from the Fracture Intervention Trial (FIT) suggests that this may be correct in postmenopausal osteoporosis, this is not necessarily the case in patients on oral glucocorticoids, where studies with fracture as an outcome measure have recruited patients with a range of BMD measurements. Furthermore, the Royal College of Physicians guidelines on glucocorticoid-induced osteoporosis concluded that patients on oral glucocorticoids fractured at a higher BMD than women with postmenopausal osteoporosis.
3. The cost-effectiveness modelling examines the impact of opportunistic assessment and the use of self-identifying risk factors such as recent fracture or rheumatoid arthritis. Looking at the different scenarios outlined on page 16, BMD scanning strategies are cost effective in women with low trauma fracture from the age of 55 years in the base-case scenario or from an older age in some of the scenarios. As the Technology Appraisal of the secondary prevention of fractures (TAG 87) has been increasingly been implemented over the past 18 months, I hope the Appraisal Committee will not raise the lower threshold for BMD measurement in patients with a low trauma fracture, where currently measurement is advocated in postmenopausal women up to the age of 75 years.
4. In the systematic review of adverse events and persistence with therapy, the executive summary suggests that persistence may be improved by weekly rather than daily treatment. Prescribing data from three UK GP databases (GPRD, MEDIPLUS and DIN-LINK) indicates that this is the case (Brankin et al, *Curr Med Res Op* 2006; 7: 1249-1256).