Appraisal Consultation Documents

Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women

and

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Response on behalf of the Bone Research Society

The working group to review the Appraisal Consultation Documents (ACDs) and its preliminary recommendations included academics and clinicians with specialised interest in osteoporosis, and also covered a wide range of medical sub-specialities. Our response to these documents is given below.

1. Comments on the revised recommendations for secondary prevention

It would have been helpful if the changes from the published guidance could have been highlighted (NICE Technology Appraisal No 87). This would have aided an efficient review of the document. Could this be included in future drafts?

4.3.21
The clinical risk factors for teriparatide appear to differ from those recommended for bisphosphonates and strontium ranelate. This should be clarified. Use of corticosteroids should not be included as this is not covered by this guidance.

4.1.10.5
Teriparatide is licensed as a 20μg daily dose. The guidance should report on side-effects related to this dose rather than a higher dose that is not used in clinical practice.

4.3.14 and 4.3.15
The Committee should demonstrate on what grounds they believe the hip fracture data for strontium ranelate is “less robust” than for bisphosphonates.

2. Comments on the preliminary recommendations for primary prevention

3.2
The draft guidance does not take into account the fact that generic alendronate is now available in the UK. It is proposed that the guidance will be reviewed in March 2009, during which time the price of generic alendronate (and possibly other bisphosphonates) will fall. This will greatly impact on the cost-effectiveness of treatment. It would be helpful if the authors were able to provide a drug cost for which the cost of treatment would be cost-effective. This would ensure that patients not be potentially denied access to drugs when cheaper versions becoming available during the next 4 years.

4.2.1
We strongly urge the Committee to ensure that the economic model used by the Assessment Group is published in a peer-review journal. This will ensure that the model can be critically appraised. This is important, as the model appears at odds with the data and preliminary recommendations from the WHO.

4.2.9
The Committee should provide evidence that women without fracture do not present to clinicians. Many postmenopausal women will be accessing healthcare facilities for mammography and for cervical screening. Women with conditions associated with bone loss (i.e. rheumatoid arthritis) will also be under regular care in either primary or secondary care.

4.2.25
If DXA scanning is undertaken, it appears that there are only two risk factors being included-parental history of hip fracture and medical conditions associated with bone loss. In these instances, the Committee should advise on how three risk factors are to be identified.

4.2.27
We assume that in all chronic diseases, poor compliance with therapy will have an adverse effect on the cost-effectiveness of treatment. The Committee should offer a balanced view on this area, and only comment on this if it is unique to the primary prevention of osteoporotic fracture.

The Committee also does not take into preliminary research findings that demonstrate follow-up with a nurse at 3 months appears to improve compliance with therapy. The Committee should encourage research in this area (Section 5).

4.3.7
The Committee discounts the use of current smoking and alcohol intake > 2 units/day as risk factors. We cannot support this omission. Current smoking is simple to assess in clinical practice, and is widely used as a risk factor for cardiovascular disease and for use of statin therapy. Current smoking has also been shown to be associated with an increased risk of hip fracture (RR=1.84), which is partially independent of BMD (Kanis et al. Osteoporos Int 2005; 16: 155-62.)

The Committee give mention to conditions independently associated with bone loss, and quotes only rheumatoid arthritis. To enable patients to benefit from access to

therapy, we believe it would be useful if this guidance listed the other conditions that had been agreed with the Clinical Guideline Development Committee.

4.3.9

The decision to use a cost per QALY of £20,000 cannot be supported. As noted above in response to 4.2.9, we believe that many women will already be under some form of medical care even at younger ages. The report also does not take into account that women with a positive family history (one of the clinical risk factors with respect to family history of hip fracture), will often have a degree of anxiety and may not be considered as "healthy".

4.3.18

We are disappointed that the Committee has decided to remove raloxifene, a licensed drug, for the management of osteoporosis in women who have not sustained a fracture. There will be some patients who would prefer to take this form of medication, particularly in the younger patients (aged < 65 yrs) with a family history of breast cancer. We are removing the aspect of patient choice in the decision making process regarding treatment options.

4.3.19

The Committee should provide guidance how calcium intake should be assessed in daily clinical practice. The definition for "vitamin D replete" should also be given.