

## **Society for Endocrinology**

### **NICE Appraisal of strontium ranelate for the prevention of osteoporotic fractures in postmenopausal women.**

#### **Comments on the ScHARR assessment report**

**17 August 2005**

The Society for Endocrinology welcomes the opportunity to comment on the institute's guidance regarding the use of strontium ranelate in postmenopausal osteoporosis.

We have several comments to make regarding the assessment document:

1. The cost effectiveness of strontium ranelate will be highly dependent upon the actual reduction in fracture which is ascribed to it. It is therefore unfortunate that we are not able to see the values that have been used in the analysis (tables 13, 21 and 26). We presume that this is the result of the use of commercially sensitive information but nonetheless feel that it has substantially inhibited our ability to make meaningful comments upon the whole economic analysis.
2. Whilst we welcome the use of clinical risk factors as a means of identifying patients the way in which the data has been presented in the report is very cumbersome and would not be of practical use in a clinical setting. It would therefore be very helpful if some way could be found of grouping the clinical risk factors together and perhaps giving a clinical risk factor score.
3. It is confusing to find both fracture risk (given as a %) and T score threshold given in the same table. Surely the whole idea of giving a fracture percentage risk was to get away from the slavish application of T score thresholds when any given level of risk could be reached from an infinite combination of different clinical factors and different bone density levels.
4. We are surprised that the utility loss associated with a clinical vertebral fracture is greater than that associated with a hip fracture (table 23).
5. Whilst we understand that on the current modelling assumptions strontium ranelate does not appear to be as cost-effective as alendronate (although data for other bisphosphonates has not been shown in this document) we are concerned by the statement in the executive summary that "strontium ranelate is not expected to be the first line therapy". Our own clinical

experience would lead us to believe that when a treatment has been relegated to second line status then it is increasingly difficult to get approval from formulary committees and PCTs for its use. As strontium ranelate has a totally different mechanism of action from other available therapies and a very different side-effect profile we would be very anxious to see a means whereby it is not denied to patients who would benefit from it if the committee to decide to afford it second line status. To this end we would urge the committee to think carefully about the wording of any such advice to make it clear that this is a reasonable option where bisphosphonates are unsuitable.

If you require any more information, please contact the Society for Endocrinology