Comments by British Orthopaedic Association Patient Liaison Group on

Total hip replacement and resurfacing arthroplasty for the treatment of pain or disability resulting from end stage arthritis of the hip (Review of technology appraisal guidance 2 and 44). Assessment Report

General

- We would like to extend our congratulations to the authors for the thoroughness of the MTA
- is there an opportunity for a Patient Version (much reduced and similar to the NJR's version) as there are now many well informed patients ?

Objectives (page 18)

- The objectives are quite precise:-
  - The main aim was to undertake a clinical and cost-effectiveness analysis of different types of THR and RS for the treatment of pain and disability in people with end stage arthritis of the hip. Specific objectives were the following:
  - To compare the clinical and cost-effectiveness of:
  - Different types of primary THR compared with RS for people in whom both procedures are suitable
  - Different types of primary THR compared with each other for people who are not suitable for hip RS
- Given these objectives, it's not surprising the full patient journey has been omitted and the focus is just on the replacement operation as it's unlikely these would vary according to whether RS or THR is the intervention or according to type of prosthesis. However it's likely that the provision – or lack – of physio, during and after stay in hospital, pre-op advice and preparation etc. can make a lot of difference to outcomes. So if there is an opportunity to state on behalf of patients that research has indicated that these additional interventions can contribute considerably to outcomes, reduce length of stay and the focus on types of prosthesis is missing an important aspect of the intervention (in the section Recommendations for Research – page 335).

Warwick Economic Assessment (page 224 & f)

- The models are a very thorough piece of work and it is great that the NJR and PROMS data make the modelling work possible. The many and varied analyses are very useful and informative. However, it appears that not as much effort has been put into costing out the operations and hospital stays. They concentrate on one main cost variable – namely the cost of the prostheses. There are many other high cost items for both THR RS as an intervention and including these may well change the results for some of the cost effectiveness analyses and outcomes.
- Cost of the surgery for both THR and RS (ref Table 76 and associated text) is taken from standard sources. There is a body of literature that states

with good evidence that the NHS tariff and standard sources of the cost of the surgery itself is not a reasonable representation of the cost of THR. The evaluation has used costs that are easy to access may not be entirely appropriate; surgical time can vary up to 20 minutes or so for cemented vs. cementless operations. There may also be other factors associated with the type of primary and revision replacement operation used and prosthesis used that will impact and cause variation in (costly) theatre time.

- Furthermore, it is believed that it is relatively easy to get data on theatre time for the operations and a standard cost for theatre time by the minute. Even if primary data are not available to the Warwick team, they should use sensitivity analysis to test the relative impact of a variety of the costs on the analysis. Varying theatre time (e.g. 20 minutes) for the different operations would test the impact of this. Given the immense effort spent on the modelling and analysis of NJR data, it was surprising to see the very limited attention to resource use and costs used in the evaluations and limited sensitivity analysis using some informed assumptions.
- Length of stay is another variable that did not seem to have been explored - it may be that the mean/median is standard no matter what operation and would have no significant impact on the comparison between the different operations/prostheses. But this was not discussed in the report and there was no sensitivity analysis.
- Is there a case for RS evaluations being a preferred intervention for a certain type of patient, despite the outcomes of these analyses?

Recommendations for Research (page 335)

- There is a difficulty in doing such trials under Recommendation No. 1 because manufacturers are constant in their striving to modify devices driven by competition and need to increase prices - long term studies are unlikely to be achievable and useful.
- Why are so many devices not supported by ODEP ratings?
- From the long -term results, is it possible to make the common cemented stem and poly cup the default for patients aged 80+? This may limit surgeon choice but may shift the emphasis onto the young adult for good clinical evidence.

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