Hip fracture (standing committee update)

Consultation on draft guideline - Stakeholder comments table
18/01/17 to 15/02/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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12	Bone Joint & Muscle Trauma Cochrane Review Group	Full	9	19	Presumably the first recommendation will replace current Recommendation 1.6.2 in CG124. If so will Recommendation 1.6.4 be left unaltered? Is Recommendation 1.6.4 within the scope of the update – reading the opening discussion in RQ1 it would seem that options for treatment of the displaced intracapsular fracture (internal fixation, hemiarthroplasty and total arthroplasty) would include the selection of a type of arthroplasty – if so then there is a new study which has been completed and is relevant here http://www.bjr.boneandjoint.org.uk/content/5/1/18	Thank you for your comment, the updated guidance will replace recommendations 1.6.2 and 1.6.3. Recommendation 1.6.4 is outside the scope of this update and will be left unaltered. We will pass the reference supplied onto the NICE Surveillance team, who are responsible for informing which parts of NICE guidance need to be updated.
13	Bone Joint & Muscle Trauma Cochrane Review Group	Full	11	33	The protocol in both update questions does not include reference to the published Core Outcome Set for hip fracture which is the best guide we have for appropriate Outcomes and measurement instruments for use in this population. http://www.bjj.boneandjoint.org.uk/content/jbjsbr/96-B/8/1016.full.pdf http://www.comet-initiative.org/studies/details/274	Thank you for your comment. The committee agreed that it was important to consider the Core Outcome Set (COS) for hip fracture in their deliberations on outcomes to consider (section 2.4 evidence to recommendations). The Hip fracture COS was funded by the NIHR and involved carer organisation/ support group representatives, clinical experts, patient/ support group representatives, regulatory agency representatives, researchers and service commissioners. Of the five domains listed in the referenced paper (mortality, pain, activities of daily living, mobility, and health-related quality of life), the committee included mortality and health related quality of life. The committee agreed that functional status would encompass activities of daily living and mobility while pain is included in the

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						health related quality of life measure used in the studies (EQ-5D)
14	Bone Joint & Muscle Trauma Cochrane Review Group	Full	38	12	Research recommendation 4.3 from CG124 has been removed without explanation. It would be helpful for the reader to understand why the GDG made this decision. There are two recent publications which might support the discussion: 1: Griffin XL, Parsons N, Achten J, Costa ML. A randomised feasibility study comparing total hip arthroplasty with and without dual mobility acetabular component in the treatment of displaced intracapsular fractures of the proximal femur : The Warwick Hip Trauma Evaluation Two : WHiTE Two. Bone Joint J. 2016 Nov;98-B(11):1431-1435. 2: Huxley C, Achten J, Costa ML, Griffiths F, Griffin XL. A process evaluation of the WHiTE Two trial comparing total hip arthroplasty with and without dual mobility component in the treatment of displaced intracapsular fractures of the proximal femur: Can a trial investigating total hip arthroplasty for hip fracture be delivered in the NHS? Bone Joint Res. 2016 Oct;5(10):444-452.	Thank you for your comment. The research recommendation in question (What is the clinical and cost effectiveness of large-head total hip replacement versus hemiarthroplasty on functional status, reoperations and quality of life in patients with displaced intracapsular hip fracture?) was removed as this update included a study commissioned by the NIHR based on the research recommendation. The committee considered that the existing evidence base is such that further trials on this topic would not be of sufficient use to justify a research recommendation. Furthermore, it was the committee's view that investment in further trials would not be necessary to inform recommendations for practice in this area. The studies referenced in the comment would not meet the inclusion criteria specified in the review protocol as two methods of total hip replacement were compared to one another which was not the subject of this update.
15	Bone Joint & Muscle Trauma Cochrane Review Group	Full	39	17	This implies that all hip fractures are diagnosed with a minimum of two plain radiographic views. This is not the case in some centres in the UK. If the GDG feels that two views are necessary to judge displacement of a fracture, then in order that the update and CG124 are consistent, there should be a NICE recommendation for the plain radiographic diagnosis of a fracture which should be explicitly added in the update. Currently diagnostic	Thank you for your comment. The committee were concerned that studies based on single views may not be 'truly' undisplaced and as such agreed to specify 'use of both anterior-posterior and lateral views as part of the inclusion criteria for this review.

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					requirements are restricted to the imaging modality for occult fractures.	We will forward your suggestion for recommendations for the plain radiographic diagnosis to the NICE Surveillance team as this topic was outside the scope of this update.
17	Bone Joint & Muscle Trauma Cochrane Review Group	Full	41	1	Lapidus 2013 is missing from Table 10.	Thank you for spotting this omission. The details from Lapidus (2013) has now been included in Table 10.
18	Bone Joint & Muscle Trauma Cochrane Review Group	Full	45	1	Quality of evidence. Whilst case series are inherently limited as an experimental design the GDG did make a decision to include them in this update. The GDG state that the quality of these available series was limited despite predominantly positive outputs from the JBI tool. In addition two of the larger series have a good report from the tool excepting one domain which has been appraised to be uncertain despite clear study reporting: Bjorgul 2007 In Fig 1 of the paper CIs are reported for the principal risk factors identified by the model. Lapidus 2013 Clearly report the unit of analysis as the hip rather than the participant.	Thank you for spotting these errors. We have amended the quality appraisal for Bjorgul 2007as the outcomes of interest were reported clearly. The original appraisal of 'No confidence intervals reported' was incorrect as the outcomes reported were mortality and revision and are presented as count data. We have noted in the appraisal for Lapidus 2013 that the outcomes were reported per hip rather than per person and we have separated out this data in the GRADE profile accordingly. Despite making these corrections, the committee didn't feel the evidence was good enough to make a recommendation.
19	Bone Joint & Muscle Trauma Cochrane Review Group	Full	46	8	We also know that the main driver of cost and morbidity in this group of patients is revision surgery. In all series the revision risk was high. A trial of an intervention which may have a lower revision risk (arthroplasty in the order of 5%) is likely to show very substantial effects. The GDG might usefully add some of this context here.	Thank you for your comment. In the economic model a baseline revision rate for hemiarthroplasty in the first year after surgery of 3.7% was used. This rate was discussed with the guideline committee, who felt that it was generally reflective of clinical practice. An exploratory sensitivity analysis was

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						also conducted in which the baseline rate of revision in the first year after surgery was first halved and then doubled. In both scenarios total hip replacement remained the most cost effective strategy.
22	Bone Joint & Muscle Trauma Cochrane Review Group	Full	46	9	Given that there are ten series reporting data from across several settings from several hundred patients with clearly reported inclusion criteria it is unclear why the GDG have recommended that a further observational study would be helpful. The case series are of good quality according to the JBI tool assessment and are likely to yield similar estimates of revision and mortality risks to any future observational study. Such a study is unlikely to be good value-for-money. The RCT identified by the GDG is the most appropriate study to address the selection bias that the GDG highlight that is inherent in the case series. If the GDG agree that an observational study is unlikely to be more informative then the population eligibility criteria may be simplified to those with an undisplaced fracture. This population is well described in the included case series. Since the criteria for the selection of total hip arthroplasty are described elsewhere in this update it would be reasonable that clinicians would use similar decision-making here. Therefore the test intervention might better be described as 'appropriate arthroplasty'.	Thank you for your comment. The committee noted that the current evidence base (only case-series) is limited and so drafted a research recommendation for a randomised controlled trial to compare the interventions of interest. The observation part of the research recommendation is to provide information on the population with 'true' undisplaced intracapsular hip fractures.
36	British Geriatrics Society				Overall the British Geriatrics Society welcome the clarification and additional economic evidence for something we recognise as important to outcome for our patients, however would like to add that we contest the view the hip fracture program team (HFPT) has clinical and governance responsibility for all stages of care and rehab including community". We do not feel that this is workable, or appropriate. Services are usually not commissioned in this way and the HFPT in the acute hospital cannot "own" what happens in a different trust	Thank you for your comment. This topic is outside the scope of this update and we will pass your comment on to the NICE Surveillance team.

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					within the community. We need to be pushing for community trusts to recognise the need for robust rehab programs for post-acute hip fracture patients. There should be correlation between the acute HFPT and community providers to ensure robust clinical pathways.	
27	British Nuclear Medicine Society	Short	5	2	We are concerned that CT is chosen as the second line investigation over isotope bone scan without good evidence. Further many nuclear medicine departments now offer bone scan with SPECT CT, combining a bone scan and a CT scan, so best of both, and surely this should be at least a legitimate alternative to CT alone.	This recommendation is outside the scope of this update and we will pass your comment on to the NICE Surveillance team
1	British Orthopaedic Association	General	General	General	The BOA supports the draft addendum to the Hip fracture: Management guideline.	Thank you
11	British Orthopaedic Association: Research Committee	Full	8	10	You have not referenced the study that identified the poor compliance with the guideline – "Inequalities in use of total hip arthroplasty for hip fracture: population based study, BMJ 2016."	Thank you for your comment. In the Update information section of the addendum we have linked to the NICE Surveillance report which explains the rationale for the update. This report is available here (http://www.nice.org.uk/guidance/cg124/evidence/surveillance-review-decision-december-2015-2190593773) We have also added a reference to the Perry et al 2016 study which reported poor compliance with the CG124 guideline.
20	British Orthopaedic Association: Research Committee	Full	46	9	The Research Recommendations proposed a nested trial – is this nested within NHFD? I am still not clear what you are looking for in the "epidemiological assessment of the clinical characteristics of undisplaced intracapsular hip fracture". I don't understand how this is going to help with	Thank you for your comment. The committee considered that there were two questions which required further research: 1) What features should be used to characterise non-displaced intracapsular hip fracture 2) What are the optimal clinical and

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					part two – i.e. the RCT.	cost-effective management strategies The proposed study design to answer these questions was, respectively, an epidemiological assessment of clinical characteristics of undisplaced intracapsular fracture, within which an RCT of effectiveness of interventions is nested. In order to make the recommendation less prescriptive, the reference to a 'nested' design has now been removed.
21	British Orthopaedic Association: Research Committee	Full	46	9	The COMET core outcomes for hip fractures should be included. Consider changing the outcome of 'surgical revision' more to that listed in the large Canadian HEALTH study - unplanned secondary procedure within 2 years of the initial hip replacement surgery - http://bmjopen.bmj.com/content/5/2/e006263#T1 Full economic evaluation is also presumably needed as an outcome.	Thank you for your comment. We have added the COMET core outcome set to the research recommendations outcomes as suggested. The committee coupled surgical revision with re-treatment in the draft research recommendation and we have now separated these two outcomes.
8	Department of Health	General	General		Thank you for the opportunity to comment on the draft addendum to the above clinical guideline. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you
9	NHS England	General	General		Thank you for the opportunity to comment on the above Clinical Guideline.	Thank you

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					We can confirm that there are no comments to be made on behalf of NHS England.	
10	Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland	Full	General	General	We are unable to comment upon important issues, such as hypotension developing during anaesthesia or Bone Cement Implantation syndrome (BCIS) as these issues have not been included in this update. It appears that the only issues that have been considered are surgical.	Thank you. Recommendation 1.6.5 on cemented implants has been amended in the NICE guideline with a footnote making reference to a safety guideline from the Association of Anaesthetists of Great Britain and Ireland, British Orthopaedic Association and British Geriatric Society (2015). This safety guideline in not NICE accredited. These additions have also been made to the NICE Addendum to the Clinical Guideline.
29	Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland	Short	6	8	Should not comment on this, as it is from 2011, BUT nerve blocks should be offered BEFORE opioids, to reduce delirium.	Thank you for your comment. This recommendation is outside the scope of this update and we will pass your comment on to the NICE Surveillance and Commissioning teams.
30	Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland	Short	6	21	Again, this is from 2011 so should not comment, BUT nerve blocks should be administered to all patients undergoing anaesthesia for hip fracture repair.	Thank you for your comment. This recommendation is outside the scope of this update and we will pass your comment on to the NICE Surveillance and Commissioning teams.
32	Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland	Short	7	11	"Medically fit for anaesthesia and the procedure". This is for a 2017 recommendation concerning the treatment of displaced intracapsular fractures. There is no mention of risk assessment before the procedure, this should be mandatory and recorded in the anaesthesia record and the NHFD, which at present, it is not. The wording / concept of 'fit for anaesthesia' is unhelpful. We operate on 98% of patients with hip fracture – many of	Thank you for your comment. We have not reviewed the evidence for a pre-surgery risk assessment as this is outside the scope of this update. We will forward your comment on to the NICE Surveillance team.

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					whom are relatively high risk, but the benefit is (rightly) felt to outweigh the risks. Perhaps this should be reworded towards something like: • Have had their perioperative risks (including death) assessed, documented and discussed and believed to be in favour of total hip replacement	
33	Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland	Short	7	11	There is no mention of extra postoperative facilities that may be required, such as high dependency or even intensive care, if more total hip replacements are going to be performed on hip fracture patients. This should probably be in the economic evaluation.	Thank you for your comment. Intervention costs in the health economic analysis accounted for resource usage during the initial hospital stay, and therefore took account of all costs accrued during this period. The potential for differences in readmission rates to high dependency and intensive care units in patients with different prostheses was discussed with the committee. It was felt that there would be no significant differences in admission rates between patients with a total hip replacement and hemiarthroplasty beyond revision procedures (which are also accounted for by the economic model).
35	Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland	Short	14	18	Research recommendations Anaesthesia. Although this is from 2011, so no comments should be made, the research statement now looks dated. More specific studies should focus on control of blood pressure during hip fracture surgery. Avoidance of delirium, by using anaesthesia techniques that do not include sedation should also be included as research recommendations. Focused risk assessment and use of HDU/ITU should also be added. There doesn't appear to have been any consideration of the changing evidence around anaesthesia.	Thank you for your comment. This recommendation is outside the scope of this update and we will pass your comment on to the NICE Surveillance team.
2	Royal College of	General	General	General	The Royal College of Nursing welcomes the addendum to	Thank you

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	Nursing				the Hip Fracture guidelines. The RCN invited members who care for people with hip fracture to review and comment on this document. The comments reflect the views of our reviewers.	
3	Royal College of Nursing	General	General	General	We feel that this guideline is excellent and covers both the personal and organisational aspects of hip fracture.	Thank you
26	Royal College of Nursing	Short	5	1 (1.1)	The imaging recommendation may be a developmental recommendation for the way forward but may not be achievable in all acute trusts. Imaging is dependent on availability and variation in demand from other departments.	Thank you for your comment. This recommendation is outside the scope of this update and we will pass your comment on to the NICE Surveillance team.
28	Royal College of Nursing	Short	5	1.2 – 1.8	Overall, we feel that an excellent standard of surgery is being recommended and is very positive for patient care.	Thank you
34	Royal College of Nursing	Short	9	11 (1.8.5)	Could the standards recommend that Intermediate Care services are facilitated to have the skill and expertise to manage acute hip fracture post-surgery? Evidence shows that older people rehabilitate better out of the hospital environment and those living with Frailty make up a large number of hip fracture patients. If unable to be discharged home, suitable and effective Intermediate Care is therefore a key requirement for many people post hip fracture.	Thank you for your comment. This recommendation is outside the scope of this update and we will pass your comment on to the NICE Surveillance team.
4	Royal College of Physicians	General	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Falls and Fragility Fracture Audit Programme (FFFAP) and would like to make the following comment.	Thank you
31	Royal College of Physicians	Short	7	4-11	The NHFD has documented progressive improvement in the provision of THR to patients with displaced intracapsular fracture who met the eligibility criteria set out in CG124. However, our reports continue to identify significant variation in performance between hospitals. The RCP therefore welcomes this Update's improved	Thank you for outlining your ongoing work in this important area.

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					evidence base, and welcomes the fact that the eligibility criteria have not been changed in the Update. This means that the NHFD can continue to monitor year on year changes in practice in different units, and encourage compliance with what we agree is an important marker of the quality of surgical care offered to this group of patients.	
5	The Society and College of Radiographers	General	General		The Society and college of Radiographers considers this review is timely as it re-visits areas where there has been an increase in controversy over patient management since previous guidelines were issued.	Thank you
6	The Society and College of Radiographers	General	General		Did the committee consider the implications of co-morbidities upon the selection of treatment? For example, diabetes and occurrence of post operative infection rates, mental health status, arterial disease, osteopenia. What is the guidance where fracture is pathological; for example in cases of metastasis? What is the procedure for post-operative surveillance e.g. imaging at two days? Followed by what interval of time? or any imaging at another point?	Thank you for your comment. The committee requested a number of sub-group analyses looking at some of these areas (for example, mental health status, ASA physical health status) which would have been carried out if data were available. Data was available to conduct sub-group analysis by age (older or younger than 80 years of age) and by level of cognition (impaired and unimpaired cognition). Pathological fractures are outside the scope of this guideline, please see scope for CG124 (https://www.nice.org.uk/guidance/CG124/documents/hip-fracture-final-scope2) section 4.1.2 (Groups that will not be covered) b which states "People with fractures caused by specific pathologies other than osteoporosis or osteopaenia (because these would require more condition-specific guidance)."

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						Post-operative surveillance is outside the scope of this update, and therefore no recommendations on this have been made. Your suggestion has been passed onto the NICE Surveillance team who are responsible for informing which parts of NICE guidance need to be updated.
7	The Society and College of Radiographers	General	General		The areas for further research refer to the investigation of intensive rehabilitation therapy – this is an important area and one which could perhaps be tied to the question with regards to procedures for post-operative surveillance. A question of procedure for suspected occult fracture is referred to in the areas for further research and this should be encouraged with cost analysis; there will be implications for cross-sectional imaging departments and workforce.	Thank you for your comment. Intensive rehabilitation therapy is outside the scope of this update. Your suggestion has been passed onto the NICE Surveillance team who are responsible for informing which parts of NICE guidance need to be updated.
16	University of Oxford	Full	39	17	Not all UK Trauma Centres use two radiographs in the assessment of patients with hip fracture. Some centre use only an AP pelvis view. Others supplement the plain radiographs with cross-sectional imaging i.e. MR or CT	Thank you for your comment. The committee were concerned that studies based on single views may not be 'truly' undisplaced and as such agreed to specify 'use of both anterior-posterior and lateral views as part of the inclusion criteria for this review.
23	University of Oxford	Full	46	9	Why is a 'nested' trial design specified in the Research Recommendation? We agree that a randomised trial is required in this area, but are not sure why this should be nested.	Thank you for your comment. The logic behind this research recommendation was to allow a single study to answer two questions: an epidemiological assessment to determine which features should be used to characterise a non-displaced intracapsular fracture, within which an RCT is nested to determine the optimal clinical and cost-effective management strategies.

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						In order to make the recommendation less prescriptive, the reference to a 'nested' design has been removed.
24	University of Oxford	Full	46	9	Why do the outcome measures for the Research Recommendation not include the UK Core Outcome Set for Hip Fracture Trials?: *Haywood KL, Griffin XL, Achten J, Costa ML. Developing a core outcome set for hip fracture trials. Bone Joint J. 2014 Aug;96-B(8):1016-23* This Hip Fracture COS was developed after extensive Patient and Public Involvement using the established methodology of the COMET group. The OTS supports the use of Core Outcome Sets improve reporting and facilitate evidence synthesis.	Thank you for your comment, We have added the COMET core outcome set to the research recommendations outcomes as suggested.
25	University of Oxford	Full	46	9	Given the high mortality, morbidity and cost associated with revision surgery in the frail hip fracture population, should cost effectiveness not be a key part of the research recommendation?	Thank you for your comment. We have included cost effectiveness in the research recommendation "For people with what was traditionally described as non-displaced intracapsular hip fracture, what features should be used to characterise the injury and what are the optimal clinical and cost-effective management strategies? "

**None of the stakeholders who commented on this clinical guideline have declared any links to the tobacco industry.*