

# National Institute for Health and Clinical Excellence

## 304 – Percutaneous cementoplasty for palliative treatment of bony malignancies

### Comments table

IPAC date: 13 April 2006

<b>Consultee name and organisation</b>	<b>Section no.</b>	<b>Comment no.</b>	<b>Comments</b>	<b>Response</b> Please respond to all comments
Individual respondent - Clinician		1	Little data available. Have treated 2 benign acetabular cysts and 1 glenoid cyst. Pain relief in hip patients within 24 hours and glenoid within 7 days. The glenoid case needed definitive surgery and joint replacement due to advancing joint disease. Acetabular patients remain pain free at 18 months. As the presence of cement in these patients did not affect further surgical management then it was considered on clinical grounds to treat with cementoplasty and delay the need for formal surgical procedure if possible	Outside remit of guidance, which, based on the available data, exclusively focuses on malignant disease. Sections 2.3.4 and 2.5.1 discuss the potential utility of the procedure in benign disease. No changes required.
BUPA	1	2	BUPA hasn't been asked about sites other than vertebrae, but by extrapolation, this recommendation seems appropriate.	Noted

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Individual respondent - Clinician	<b>2.2</b>	3	Cementoplasty or vertebroplasty performed following radiotherapy may lead to increased cement leakage (personal experience and verbal advice from other UK operators) CT guidance combined with fluoroscopy is often needed to allow accurate needle placement particularly around the shoulder and the pelvis. Different cements have potential advantages i.e small volume or large volume required to fill defect or whether early weight bearing required. The operator should have knowledge and access to different types of cement to maximise the efficacy of cementoplasty.	A comment shall be added to section 2.5 stating that different types of cement are available.

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Specialist Advisor	<b>2.2.3</b>	4	In 2.2.3 "The cement is mixed with barium sulphate or another radiopaque agent." This is misleading. All cements that are licensed come ready mixed and must not have anything else added. ie the barium is already there and must not be added by the clinician. The section just needs minor editing otherwise all is fine	The first sentence of 2.2.3 will be amended to read 'Cement containing a radiopaque agent is used for this procedure'.
Individual respondant - Clinician	<b>2.3</b>	5	The degree of filling on post procedural CT bears little relationship to outcome in my experience and the benefit of the injection is not purely related to fill volume. The inherent strength of the lesion may be more dependant on the distribution and fill completion. In the 8 patients I have treated the efficacy based on pain relief showed marked early improvement within 3 days of treatment.	No reviewed evidence relates the degree of filling of the lesion to outcome. No changes required.
Individual respondant - Clinician	<b>2.4</b>	6	The procedure if performed with CT and fluoroscopic guidance in my experience led to no clinically significant leak in any patient treated ( 4 pelvis, 2 shoulder, 2 sacral)	Noted

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BUPA	2.4	7	Given the problem with leakage and its complications, might you edge to the boundaries of your remit and mention that there is currently a UK multicentre randomised trial recruiting comparing external beam radiotherapy with ibandronate for pain from bony mets (you'll find it easily on the NRR)? If either of these is shown to be impressively safe and efficacious, percutaneous cementoplasty may become irrelevant, or even something to be discouraged	Noted. This is outside the programme's remit.