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Dear Carole

Technology Appraisals of Primary and Secondary Prevention of Osteoporotic Fractures in Postmenopausal Women

Thanks you for asking for my comments on the documents that are to be put to the Appraisal Committee on 6 September. I will make some general points here which are a little limited given the timing of this consultation process but will be happy to amplify and extend these as necessary at the committee meeting.

Cost effectiveness report

1) I thought that agreement had been reached that the results of this analysis would be presented as absolute fracture risk and yet see this no where in the report.

2) I am concerned that this has been presented in a way that slavishly assumes an absolute cost per QALY threshold of £20k. This has two consequences:

    a) It appears to downgrade the importance of the problem of osteoporosis compared to other technologies. I thought that the whole idea of using the metric of cost per QALY was to allow comparisons between disparate technologies. If the threshold is arbitrarily changed then it appears to me that it is giving the message that osteoporosis is not “as serious” as other diseases that may have been considered by the Institute. Moreover this change (as compared with TA87) makes it look as if you could be moving towards a much more restrictive set of recommendations which again would give the impression that the Institute is downplaying the importance of osteoporosis. I would ask the committee to consider what sort of message they would send out to the clinical community if they make substantial changes to the TA87 guidance that is currently in the process of implementation in many health economies.

    b) When something is excluded from the report as presumably not cost effective we have no idea as to whether it is actually very close to the arbitrary line of £20k or a long way above it. It may very well be that there are thresholds that the committee might wish to consider recommending that are hidden within the very black and white approach that this report has taken.

3) The committee is probably aware that the NHS price of alendronic acid is now reduced in the August drug tariff and so I presume the committee will use the reduced cost sensitivity analysis as the revised base case.

4) Although the splitting of cases into self presenting and those needing identification makes sense from the point of view of analysis of cost of diagnosis it bears little relationship to clinical reality. How do we deal with the situation where osteoporosis is generally accepted as an important consequence of a disease? How do we deal with the patient who asks whether the fracture she had two years age puts her at increased risk?

5) The question of risk factors involved has been a long standing bone of contention between the committee and the GDG. If the current analysis was undertaken using all the WHO risk factors then any arbitrary removal of individual risk factors by the committee will require a total reanalysis with that factor excluded as the basis of patient identification will be entirely changed.

6) I am not convinced about the analysis of side effects:

    a) In clinical practice the usual response to GI side effects is not to persist with the bisphosphonate and hide the symptoms with another drug but rather to stop treatment and see what happens. This does not appear to have been modeled.

    b) I know of no-one who would use an H2 agonist in these circumstances.

    c) The estimated cost of PPI is way too high (see PPA web site)

7) In the previous guidance it was possible, given high enough fracture risk, to access therapy without recourse to DXA. This possibility does not appear to have been modeled here; why not? This would appear to fly in the face of upcoming WHO recommendations that will advise the use of risk factors to identify groups of high and low risk patients (who need and do not need treatment respectively) and only advocate DXA where the risk status is not clear clinically. This is of course exactly analogous to the situation with cardiovascular risk prevention and it seems strange that a different approach is being advocated here.

Systematic Review of Adverse Effects and Persistence with Therapy

This seems a very balanced and helpful document. I have no comments.

Yours sincerely