



HEALTH TECHNOLOGY APPRAISAL

THE CLINICAL EFFECTIVENESS AND COST EFFECTIVENESS OF TECHNOLOGIES FOR THE PRIMARY PREVENTION OF OSTEOPOROTIC FRACTURES IN POSTMENOPAUSAL WOMEN

and

THE CLINICAL EFFECTIVENESS AND COST EFFECTIVENESS OF STRONTIUM RENEATE FOR THE SECONDARY PREVENTION OF OSTEOPOROTIC FRACTURES IN POSTMENOPAUSAL WOMEN

Thank you for the opportunity to comment on the above two appraisal consultation documents.

The Society and College of Radiographers accepts that the primary prevention approach of treatment of basis of fracture risk and not solely to T-score for BMD is probably a realistic one. Nevertheless it seems that the risk factors used are an incomplete list and will result in the exclusion of some individuals from treatment unless the T-score is extremely low. This does not seem to fit the definition of primary prevention as intended.

The Royal College of Physicians criteria for referral for scanning individuals is far more comprehensive and this should be the list used when assessing treatment options and not the severely truncated list shown on the documents. (Para 4.3.6)

It is difficult to accept that women aged less than 70 will not be offered BMD assessment despite heavy clinical risk factors (pate 28 of overview). It may not be cost effective to treat all this age group but the outcome per individual who fractures without preventative treatment is devastating.

In the recommendations for primary prevention (para 1.1) shows treatment options. It would seem that the thresholds for T-score for BMD are disproportionately low (i.e. -3.5 SD or below) when compared to Para 2.3 states the thresholds for established osteoporosis is a T-score of -2.5 SD or below.

This seems to suggest that we diagnose that the patient has established osteoporosis by WHO definition but do not offer treatment until the BMD drops to -3.5 SD or the patient sustains a fracture.

This is not prevention in the primary stage but treatment in the secondary stage.

13th October 2005