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Dr C M Longson
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23rd April 2008

Dear Dr Longson

Re: Health Technology Appraisals for

Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women

and

Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women

Thank you for your letter dated 27th March 2008 inviting comments on the Appraisal Consultation Documents (ACDs) for the above appraisals. Novartis' comments fall under two main headings.

1. **Complexity of Recommendations and Sequencing of Treatment**
Given the scope of the appraisals, a recommendation for generic alendronate as the initial treatment option for primary and secondary prevention appears to be reasonable. However, we have several concerns about the draft guidance on subsequent treatment post-alendronate. Firstly, the use of treatment threshold tables based on T-score, age and number of independent clinical risk factors introduces a significant level of complexity that will inhibit widespread implementation of the guidance by clinicians and local NHS organisations. Secondly, it is likely that many patients who require an alternative treatment following alendronate (i.e. those who are unable to comply or who are contraindicated/intolerant) will be ineligible for subsequent treatment until their underlying condition worsens to a point where they meet a T-score threshold for use of a second-line therapy. The ethical basis for providing a first line-treatment then withholding a subsequent treatment until a patient's condition worsens is highly questionable. Thirdly, the sequencing of treatments as it stands in the current ACDs appears to be incomplete. For patients who are either unable to comply with etidronate or who are contraindicated/intolerant, there appears to be no subsequent recommended treatment. Sections 1.3 and 1.4 only refer to treatment options available after alendronate and risedronate.

2. **Need for a Comprehensive Osteoporosis Clinical Guideline**

Due to the considerable length of time that has elapsed since these appraisals began, the final guidance resulting from the ACDs will not cover all relevant treatment options. Since the scope of the appraisals was finalised, four new treatments have become available in the UK (zoledronic acid 5 mg [marketed by Novartis], ibandronic acid p.o., ibandronic acid i.v. and parathyroid hormone). These newer treatments offer the possibility of monthly, quarterly or annual administration, which represents an advance over the daily and weekly administration of the products covered by the ACDs. Whilst we appreciate that new drugs can occasionally become available during the course of an appraisal, this draft guidance now covers only a small proportion of the currently available treatment options, making it of limited value to clinicians and patients.

Given this recent proliferation of treatment options and the complexity of the disease area, a clinical guideline that includes all of the currently available treatment options for all patient segments at risk of osteoporotic fracture (not only post-menopausal women) would be of greater value to clinicians than narrowly focussed technology appraisals. The NICE clinical guideline on osteoporosis is now "suspended" pending completion of the technology appraisals. However, we urge NICE to redouble their efforts to finalise and publish this guideline even in the absence of final technology appraisal guidance. NICE have focussed on clinical guidelines for a number of other complex, largely primary care managed conditions where multiple, relatively low-cost treatment options are available (e.g. hypertension, diabetes and COPD). We believe that clinical guidelines are also the most appropriate medium for dissemination of advice on the management of osteoporosis. In the absence of a timely and comprehensive national guideline on the risk assessment, diagnosis and management of patients at risk of osteoporotic fractures, there is potential for patients to receive suboptimal care.

I hope that these comments are of value. If you require any further clarification, please do not hesitate to contact me.

Yours sincerely