National Institute for Health and Clinical Excellence

Strontium ranelate for the prevention of postmenopausal osteoporotic fractures – health technology appraisal

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Royal College of Nursing

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Introduction

With a membership of over 370,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Comments on the Assessment Report

The RCN welcomes the opportunity to comment on the Assessment Report for Strontium Ranelate (primary and secondary prevention) and the Addendum to the Assessment Report for the use of bisphosphonates and selective oestrogen receptor modulators (SERMs) for primary prevention.

The comments below refer mainly to secondary prevention of osteoporosis but are also applicable to primary prevention of osteoporosis.

- **Comments on the interpretation of the evidence base, particularly with regard to the clinical effectiveness**

This appears to be a very thorough analysis - although there did not seem to be an analysis looking at QALYs related to the burden of pain and disability related to vertebral fractures.

This is a very comprehensive and thorough analysis which appears to have a good evidence base. Although it is disappointing to note that there is no reference to the burden of disease, regarding how patients suffer in relation to pain, disability relating to vertebral fractures and social status within the QALYs assessment. This group of patients suffer significantly and in our experience the patient can rapidly become disabled and dependent. Its inclusion here would formulate a more holistic approach to the impact of this disease. Also the inclusion of fractures other than hip, vertebrae

and wrist will also direct clinicians in assessing those people who may be at risk. It is interesting to see how parental fracture has been included with the CRF, and not just maternal.

- **Has any relevant evidence been left out**

Although costs were analysed to consider the costs of women following fracture to be admitted to a nursing home, there was no consideration of staying at home with carer and community costs related to the disability and costs related to this analysis. Also see comments above, plus the inclusion of nurse specialists (as below on the assumptions underlying the economic model)

- **How should the clinical results be interpreted in the context of current clinical practice**

It appears that patients who have an absolute risk factor of between 8 - 10% or more become cost effective (based upon this analysis) for these therapies.

The results in the report will assist in establishing which patients should be treated and when.

It is understood that for DXA scanning it is proposed that in the future scans will be reported in terms of fracture risk instead of T and Z scores. It is felt this will be a better way of presenting the information particularly as more patients will be under the care of their GP in the future rather than secondary care.

With reference to the information on page 60 regarding levels on non continuance of medication, the most interesting point regarding current clinical practise was the evidence that Teriparatide appears to be more effective when used prior to the use of a Bisphosphonate. Obviously, as Teripartide is a new drug it is currently being given to some patients who have taken Bisphosphonates in the past, but will be a matter for serious consideration for patients in the future who may have a better response to treatment if Teriparatide is given as first line treatment assuming that the individual fulfils the criteria this preparation.

- Comments on the assumptions underlying the economic model

The economics of the assessment appear clear, however within the calculating the cost of selective case finding and patient follow up, in our view, an opportunity has been missed for the inclusion of osteoporosis nurse specialists within the algorithm (pg 100). Clinical Nurse Specialists (CNS) and Allied Health Professionals could utilise this model at a lower cost. The saving that could be made could be offset against the CNS seeing the patient at a later date to check compliance. Overall the cost would not increase, but the patient experience would be improved.

Also see earlier comments regarding other costs related to the individual when disabled by osteoporosis.

Expensive drugs such as Teriparatide may be rationed and it is known from current clinical practise that it is problematic to get this treatment funded. There is confusion over who is responsible for the funding, primary or secondary care.

In the document, at one point, there seemed to be a difference of opinion over the number of patients who need to be cared for in a nursing home after they have had a hip fracture.

It is felt that there will be economic implications if DXA scanning is offered more routinely to people either because of age or clinical risk factors but that this will always be off set by savings , both financial and in human terms if fractures can be avoided.