Dear Kate

As below thanks.

- Has all of the relevant evidence been taken into account? YES
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

I recognise that the relevance of persistence and compliance has quite rightly been included in the manufacturer's cost effectiveness modelling. These variables cannot be underestimated in real world use. It is less clear however whether NICE has factored in such variables in their modelling and how much weight these variables carry. Could this be clarified please?

- Are the provisional recommendations sound and a suitable basis for guidance to the NHS?

No. Lack of a clinical guideline to support the real world clinical use of this information makes it practically very diffficult to deliver NICE guidance in the NHS. It is not tenable for patients to be eligible for generic alendronate, be intolerant to it and then be informed there is no seamless link to the next available drug. There is a perception that the patient's condition would have to 'deteriorate' in terms of BMD or CRFs before next level treatment (denosumab in this instance) can be prescribed. A clinical guideline is required to effectively 'join up' management of real world patients with osteoporosis and high fracture risk.

- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of gender, race, disability, age, sexual orientation, religion or belief?

Yes. There is mention that older people may have problems administering s/c injections. I am concerned that this is an over-generalisation and in real world experience of usage of s/c anabolic drugs (e.g. teriparatide), patients with visual failure and patients with rheumatoid disease, who are perceived to have poor dexterity, have managed their (daily in the case of teriparatide) injections admirably.

Thanks for the opportunity to comment
BW

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