

**Washington State Health Care Authority, HTA Program**  
**Final Key Questions**  
**Vertebroplasty, Kyphoplasty and Sacroplasty**  
**(Percutaneous vertebral and sacral surgery)**

**Introduction**

HTA has selected Vertebroplasty, Kyphoplasty and Sacroplasty to undergo a health technology assessment where an independent vendor will systematically review the evidence available on the safety, efficacy, and cost-effectiveness. HTA posted the topic and gathered public input on all available evidence. HTA published the Draft Key Questions to gather public input about the key questions and any additional evidence to be considered in the evidence review. Key questions guide the development of the evidence report. HTA seeks to identify the appropriate topics (e.g. population, indications, comparators, outcomes, policy considerations) to address the statutory elements of evidence on safety, efficacy, and cost effectiveness relevant to coverage determinations.

Vertebroplasty, kyphoplasty and sacroplasty, (collectively, percutaneous vertebral and sacral surgery) are surgical procedures used to treat spinal pain believed to be caused by fractures in the vertebra.

***Key Questions***

When used in patients with spinal pain due to vertebral fracture:

1. What is the evidence of efficacy and effectiveness of vertebroplasty, kyphoplasty or sacroplasty? Including consideration of:
  - a. Short-term and long-term outcomes
  - b. Impact on Function, Pain, quality of life
  - c. Other reported measures including: use of pain medications and opioids, return to work
  
2. What is the evidence of the safety of vertebroplasty, kyphoplasty or sacroplasty? Including consideration of:
  - a. Adverse events type and frequency (mortality, major morbidity, cement leakage, dural tears, adjacent vertebral fracture, other)
  - b. Revision/re-operation rates (if not addressed in efficacy)
  
3. What is the evidence that vertebroplasty, kyphoplasty or sacroplasty has differential efficacy or safety issues in sub populations? Including consideration of:
  - a. Gender
  - b. Age
  - c. Psychological or psychosocial co-morbidities
  - d. Diagnosis or time elapsed from fracture
  - e. Other patient characteristics or evidence based patient selection criteria

- f. Provider type, setting or other provider characteristics
  - g. Payor/ beneficiary type: including worker's compensation, Medicaid, state employees
4. What evidence of cost implications and cost-effectiveness of vertebroplasty, kyphoplasty and sacroplasty? Including consideration of:
- a. Costs (direct and indirect) in short term and over expected duration of use
  - b. Replacement

*Policy Context:*

**Technology Description:** Percutaneous vertebral and sacral surgeries are minimally invasive procedures proposed to relieve back pain thought to be caused by fracture. Vertebroplasty involves injection of bone cement into a partially collapsed vertebral body, while Kyphoplasty involves expansion of the partially collapsed vertebral body with an inflatable bone tamp, in an effort to relieve pain and provide stability. Sacroplasty involves surgical treatment that attempts to repair sacral insufficiency fractures using bone cement.

**Issues:** These surgical procedures are less invasive than other spinal surgical procedures, but more invasive than conservative medical therapy. Significant questions remain about the safety, efficacy and effectiveness (particularly long term and appropriate selection and therapy phase), and the cost effectiveness of vertebroplasty, kyphoplasty and sacroplasty.

**Public Comment and Response**

HTA received one timely public comment and input from the technology assessment center. HTA reviewed the public comments, consulted technology assessment centers, and gathered follow up information from the nominating agencies. A summary of the input and modification to key questions is below.

*Overall topic:* One commenter felt that the key questions should be separated by each surgical type (e.g. separate key questions for vertebroplasty, kyphoplasty, and sacroplasty).

The related procedures are commonly grouped together, percutaneous injections of bone bonding cement to treat bone fractures thought to cause back pain. It is unnecessary to separate key questions, though descriptions will include key differentiators, evidence based findings that distinguish surgical types will be reported, and functionally, evidence is gathered on each surgical type. Report structure (e.g. separate or combined findings) will be determined by the vendor after reviewing the identified literature base and its similarities or differences.

*Introduction:* One commenter felt that "due to vertebral fracture" should be added to the introductory clause.

The introductory clause is modified.

# BRIAN M. DREW

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## Education

Spine fellowship program  
University of Calgary  
Date of Completion: June 2003

Fellow Royal College of Physicians and Surgeons of Canada: July 2002

Orthopaedic Residency Training Program  
Graduated: June 2002  
McMaster University, Hamilton, Ontario

Doctor of Medicine, 1997  
McMaster University, Hamilton, Ontario

B.H.Sc. PT, 1990  
McMaster University, Hamilton, Ontario  
Faculty of Health Sciences, Physiotherapy Program

Diploma in Physiotherapy, 1987-1990  
Mohawk College, Hamilton, Ontario

Physical Education, 1985-1987  
McMaster University, Hamilton, Ontario  
Completed first two years of undergraduate study

## Professional and Work Experience

**Orthopaedic Surgeon;** Assistant Clinical Professor  
Hamilton General Hospital  
Orthopaedic Chief at Hamilton General Hospital  
Medical Director of Spine Unit  
Clinical Teaching Unit Director  
Specializing in Adult Spinal Surgery  
2003-Present

**Physiotherapist, 1990-1994**  
Woodall Physiotherapy Clinic  
Chatham, Ontario

### **Administrative Committees:**

Medical Director Spine Unit--Hamilton Health Sciences  
Orthopaedic Chief at Hamilton General Hospital  
Clinical Teaching Unit Director  
Residence Education Committee  
Environmental Scan Committee  
PERIOP Focus Group  
Spine Steering Committee  
Inpatient/Outpatient Committee  
Cervical Spine Clearance Task Force  
Spine Unit Leadership Team Committee  
Neuro/Trauma Medical Leadership Committee  
Orthopaedic Expert panel—Ontario Wait Times Initiative

### **Supervisorships**

Darryl Collings—Senior Thesis Bachelor Health Sciences

### **Research Completed to Date**

#### *Publications:*

Chaudhary A, **Drew B**, Orr RD, Farrokhyar F. Management of type II odontoid fractures in the geriatric population: Outcome of treatment in a rigid cervical orthosis. *Journal of Spinal Disorders and Techniques*. 2010; 23(5):317-320.

Busse JW, Jacobs C, Ngo T, Rodine R, Torrance D, Jim J, Kulkarni AV, Petrisor B, **Drew B**, Bhandari M. Attitudes Toward, Chiropractic: A Survey of North American Orthopedic Surgeons. *Spine* (Phila Pa 1976). 2009;34(25):2818-2825.

Victoria G, Petrisor B, **Drew B**, Dick, D. Bone stimulation for fracture healing: What's all the fuss? *Indian Journal of Orthopaedics*, 2009;43(2):117-120.

Bhandari M, Petrisor B, Busse JW, **Drew B**. Does lumbar surgery for chronic low-back pain make a difference? *CMAJ*. 2005;173(4):365-6.

**Drew B**, Bhandari M, Kulkarni AV, Reddy K, Louw D, Dunlop RB. Reliability in Grading the Severity of Lumbar Spinal Stenosis. *Journal of Spinal Disorders*. 2000;13:253-258.

**Drew B**, Bhandari M, Orr D, Reddy K, Dunlop, RB. Surgical Preference in Anterior Cervical Discectomy: A National Survey of Canadian Spine Surgeons. *Journal of Spinal Disorders and Techniques*. 2002;15(6):454-457.

*In Progress:*

Goldstein C, Bhandari M, Petrisor B, Drew B. A Meta-Analysis of Electrical Stimulation for Spine Fusions. Submitted for publication.

**Co-Investigator--** FLOW---Fluid Irrigation Techniques in Patients with Open Fractures Wounds. A Multi-Center Blinded Randomized Controlled Trial

**Co-Investigator--** PRAISE (PRevalence And Intimate Partner Violence Surgical Evaluation) study

**Co-Investigator**—Lumbar Spine Fusion Survey, currently formatting survey

**Local Principle Investigator**—GRASSP, REB Approval

*Posters:*

Tsui D, MacRae L, **Drew B**, OSCIR Research Team. Ontario Spinal Cord Injury Registry & Rick Hansen Spinal Cord Injury Registry: Hamilton Health Sciences Pilot Project

Tsui D, MacRae L Bugaresti J, **Drew B**. Hamilton Health Sciences Pilot Project of the Rick Hansen Spinal Cord Injury Registry

- 15<sup>th</sup> Interurban Spinal Cord Injury Conference Research to Reality, Hamilton, Oct, 2007.

Nicosia S, **Drew B**, Bugaresti J, Kachur E. Evidence Based Practice: Approach to Patients with Spinal Cord Injuries

- 2<sup>nd</sup> Annual Spinal Cord Injury conference, Toronto, Oct, 2006.

Collings D, **Drew B**, Zywine B, Antoni K, Nicosia S, Bhandari M. An Evidence Based, Time Effective Protocol for Cervical Spine Clearance

- Annual Health Sciences Thesis Presentations, Hamilton, 2006

*Presentations:*

Invited Lecturer: Topic: Cancer Induced Compression Fractures. JCC Rounds Feb 5<sup>th</sup>, 2009.

Invited Lecturer: Topic: Kyphoplasty, Hamilton Academy Annual Clinical day. Jan 28, 2009.

Invited Lecturer: Topic: spinal fractures in Your Practice; A Minimally Invasive Approach, Balloon Kyphoplasty. Sept 24<sup>th</sup>, 2008.

Invited Lecturer: Topic: Advanced Discussion on BKP, Rheumatology group. July 30<sup>th</sup> 2008.

Course Instructor: Kyphoplasty Basic Training Course. Toronto, April 2008.

Invited Lecturer: Topic: Managing Vertebral Fractures. Faculty of Health Sciences, Continuing Health Sciences Education. November 2007.

Invited Lecturer: Topic: Surgical Aspects of Neurological Recovery. 15<sup>th</sup> Interurban Spinal Cord Injury Conference Research to Reality, Hamilton, Oct, 2007.

Invited Lecturer: Topic: The Management of Compression & Burst Fractures. Focus on Neuro Trauma Conference. Sept 2007.

Invited Lecturer: Topic: Burst Fractures. For the 7<sup>TH</sup> Annual Discharge & Beyond Spinal Cord Injury Symposium. September, 2007

Co-Chair—Advanced Concepts in Vertebral Compression Fractures, Niagara-on-the-Lake, September 2006

Kyphoplasty, Introduction of Procedure and Basic Indications, Osteoporosis Education day, Hamilton YWCA, Spring, 2006

Lumbar Spine Surgery. Patient Selection. For the 2006 Sport Med Symposium, Toronto, January, 2006

Kyphoplasty, Patient Selection and Surgical Indications, Stoney Creek, October, 2005

Kyphoplasty, Surgical Indications. Hamilton. September, 2005

Invited Lecturer: Topic: The Rick Hansen Registry. For the 6<sup>TH</sup> Annual Discharge & Beyond Spinal Cord Injury Symposium. September,, 2006

Invited Lecturer: Topic: Central Cord Syndrome. For the 5<sup>TH</sup> Annual Discharge & Beyond Spinal Cord Injury Symposium. September, 16, 2005

Invited Lecturer: Topic: Odontoid and Hangmans Fractures. For the 4<sup>TH</sup> Annual Discharge & Beyond Spinal Cord Injury Symposium. September, 12, 2004

**Drew B, Hurlbert J.** A Comparison of Percutaneous Endoscopic Thoracic Discectomy versus Thoracotomy for the Treatment of Thoracic Disc Herniation. 2002

- 3<sup>rd</sup> Annual Meeting of the Canadian Spine Association. March 2003

**Drew B, Orr D.** Non-operative Versus Operative Treatment of Odontoid Fractures in the Elderly.

- 2<sup>nd</sup> Annual Meeting of the Canadian Spine Association March 2002
- McMaster University Orthopaedic Surgery Residents Conference, October, 2001

**Drew B, Bhandari M, Orr D, Reddy K, Dunlop, RB.** Surgical Preference in Anterior Cervical Discectomy: A National Survey of Canadian Spine Surgeons. *The Journal of Spinal Disorders and Techniques*. 2002;15(6):454-457.

- 2<sup>nd</sup> Annual Meeting of the Canadian Spine Association. March 2002
- McMaster University Orthopaedic Surgery Residents Conference, Oct. 2000
- McMaster University Neurosurgery Surgery Residents Conference, Dec. 2000

**Drew B, Bhandari M, Kulkarni AV, Reddy K, Louw D, Dunlop RB.** Reliability in Grading the Severity of Lumbar Spinal Stenosis. *Journal of Spinal Disorders*. 2000;13:253-258.

- 1st Annual Meeting of The Canadian Association of Spinal Disorders. Mar, 2000
- McMaster University Orthopaedic Surgery Residents Conference, October, 1999

**Kontio K, Drew B, DeBeer J.** Simultaneous versus Staged Bilateral Total Knee Arthroplasty: Comparison of Complications and a patient satisfaction survey. 1996

- McMaster University Orthopaedic Surgery Residents Conference, May, 1997

## **Completed Courses and Conferences**

Contemporary Spine Techniques(MIS), Toronto, May 2010

Canadian Spine Society Annual Meeting, Lake Louise, March 2010

MIS TLIF and DLIF “Skin to Skin” Course NASS, Chicago, April 2009

Canadian Spine Society Annual Meeting, Ottawa, March 18-20<sup>th</sup> 2009

Longitude MIS Pedicle Screw Course, March 2009

North American Spine Society 23<sup>rd</sup> Annual Meeting, Toronto, Oct 14-18, 2008

Spinefest Toronto, April 18<sup>th</sup>, 2008

Spine Solutions Study Group, Kyphon, May 2007

Dynamic Stabilization Training Course, March 2006

Canadian Spine Society Annual Meeting, Lake Louise, March 2006

The Thoracolumbar Stabilization Training Course, January, 2006

Advanced Concepts in Minimally Invasive Vertebral Compression Fracture Management, July 2005

Lumbar and Cervical Disc Arthroplasty Course, May 2005

Kyphoplasty Certification Course, July 2004

AO ASIF Advanced Controversies in Fracture Care Course, June, 2004

AO ASIF Comprehensive Spine Course, February, 2003

Western Canadian Spine Workshop, November, 2002

St.Justin’s Pediatric Orthopaedic Review Course, April, 2002

Maine Orthopedic Review Course, June/July 2001

AO ASIF Principles of Fracture Management Course, November 16-19, 2000

Canadian Orthopaedic Association 12<sup>th</sup> Annual Basic Science Course, November 1999



Table Instructor for AO Spine Instrumentation for Operating Room Staff, August, 1999

Advanced Trauma Life Support, 1997

Advanced Cardiac Life Support, 1997

Robin McKenzie Part A - Assessment and treatment of the lumbar spine. Instructed by:  
Phil Burchell, Spring, 1994

Completion of Manual Therapy Syllabus coursed to fulfill requirements for challenging  
Part A Manipulative Therapy Examination in Physiotherapy, 1991-1993

### **Membership in Professional Organizations**

College of Physicians and Surgeons of Ontario	Current
Ontario Medical Association (OMA)	Current
Canadian Medical Association (CMA)	Current
Fellow Royal College of Physicians and Surgeons of Canada (FRCSC)	Current
Canadian Orthopedic Association (COA)	Current
Canadian Spine Society	Current

### **Extra-curricular Activities and Volunteer Experience**

McMaster University Varsity Tennis Team, 1994-1995

Golf, Hockey, Downhill Skiing, Running



Washington State  
Health Care Authority

## Participant Conflict Disclosure

### Introduction

The HTCC Workgroup is a public service workgroup established to safeguard the public interest by identifying medical tests and treatments where evidence shows they are safe, effective, and cost-effective. Balance, independence, objectivity and scientific rigor are a basis for public trust and crucial to the credibility and integrity of decisions.

### Guiding Principle

Conflict of Interest decisions must be disclosed and balanced to ensure the integrity of decisions while acknowledging the reality that interests, and sometimes even conflicting interests, do exist. Individuals that stand to gain or lose financially or professionally, or have a strong intellectual bias need to disclose such conflicts.

*For example, the fact that a member or stakeholder is a health care provider that may use a service under review creates a potential conflict. However, clinical and practical knowledge about a service is also useful, and may be needed in the decision making.*

### Procedure

Declaration of real or potential conflicts of interest, professional, intellectual, or financial is required prior to membership or provision of written or verbal commentary. Participants must sign a conflict of interest form; stakeholders providing comment must disclose conflicts.

The HTCC Chair or HCA Administrator shall make a decision, in his/her sole discretion, as to whether a conflict of interest rises to the level that participation by the conflicted participant could result in a loss of public trust or would significantly damage the integrity of the decision.

HCA defines conflict of interest as any situation in which a voting member or anyone who provides written or verbal testimony regarding products, services, or technologies discussed or voted on during the workgroup meeting, has a relationship with a manufacturer of any commercial products and / or provider of services discussed or voted on during the meeting. Relationship extends to include immediate family member(s) and / or any entity in which the member or person testifying may have an interest.

A relationship is considered as:

1. Receipt or potential receipt of anything of monetary value, including but not limited to, salary or other payments for services such as consulting fees or honoraria in excess of \$10,000.
2. Equity interests such as stocks, stock options or other ownership interests in excess of \$10,000 or 5% ownership, excluding mutual funds and blinded trusts.
3. Status of position as an officer, board member, trustee, owner or employee of a company or organization representing a company, association or interest group.
4. Loan or debt interest, or intellectual property rights such as patents, copyrights and royalties from such rights.
5. Manufacturer or industry support of research in which you are participating.
6. Any other relationship that could reasonably be considered a financial, intellectual, or professional conflict of interest.
7. Representation: if representing a person or organization, include the organization's name, purpose, and funding sources (e.g. member dues, governmental/taxes, commercial products or services, grants from industry or government).
8. Travel: if an organization or company has financially paid your travel accommodations (e.g. airfare, hotel, meals, private vehicle mileage, etc).



**Disclosure**

Any unmarked topic will be considered a "Yes"

Potential Conflict Type		Yes	No
1.	Salary or payments such as consulting fees or honoraria in excess of \$10,000		<input checked="" type="checkbox"/>
2.	Equity interests such as stocks, stock options or other ownership interests		<input checked="" type="checkbox"/>
3.	Status or position as an officer, board member, trustee, owner		<input checked="" type="checkbox"/>
4.	Loan or intellectual property rights		<input checked="" type="checkbox"/>
5.	Research funding		<input checked="" type="checkbox"/>
6.	Any other relationship, including travel arrangements		<input checked="" type="checkbox"/>

If yes, list name of organizations that relationship(s) are with and for #6, describe other relationship:

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Potential Conflict Type		Yes	No
7.	Representation: if representing a person or organization, include the name and funding sources (e.g. member dues, governmental/taxes, commercial products or services, grants from industry or government).		<input checked="" type="checkbox"/>

7. If yes, Provide Name and Funding Sources: \_\_\_\_\_

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If you believe that you do not have a conflict but are concerned that it may appear that you do, you may attach additional sheets explaining why you believe that you should not be excluded.

I certify that I have read and understand this Conflict of Interest Form and that the information I have provided is true, complete, and correct as of this date.

x Brian Dren      Nov 3/10      Brian Dren  
Signature                      Date                      Print Name

FOR QUESTIONS: Denise Santoyo, Health Care Authority, 360-923-2742, PO Box 42712, Olympia, WA 98504-2712



## **Scheduled Public Comments:**

### **With PowerPoint Slides –**

1. Medtronic
  - Dr. Evert Jan Verschuyf (5 minutes)
  - Dr. Neil Shonnard (5 minutes)

### **No PowerPoint Slides –**

1. Society of Interventional Radiology
  - Dr. Kenneth Symington (5 minutes)
  - Dr. R. Torrance Andrews (5 minutes)
2. Stryker Corporation
  - Dr. James Schamacher (5 minutes)
3. Dr. Oliver Ochs (5 minutes), representing himself
4. Dr. Rober Osnis, Interventional Radiologist (5 minutes)
5. Valley Medical Center
  - J. Scott Bowen (5 minutes)

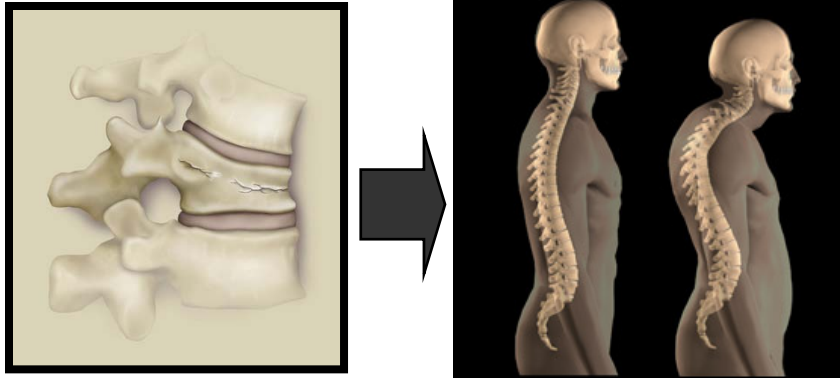
*Total Scheduled Public Comments = 35 minutes*



Clinical Evidence Demonstrating  
The Safety and Effectiveness of  
Balloon Kyphoplasty In The Treatment  
of Vertebral Compression Fractures

December, 2010

## Vertebral Compression Fractures (VCFs) Afflict Thousands of Individuals in Washington Each Year.



Estimated Clinically Diagnosed VCFs in Washington during 2010

- 2,100 under 65 years
- 5,200 over 65 years
- 7,300 Total per Year

Sources:

1. Washington Office of Financial Planning Population Estimate
2. Cooper - J Bone Miner Res, 1992

## VCF-Related Pain and Deformity Dramatically Reduce Quality of Life and Survival



Graphic courtesy of National Osteoporosis Foundation

- Lower Quality of Life Than:
  - Cancer
  - Congestive Heart Failure,
  - Arthritic Knee Replacement(Fanuele - Spine 2000; Wardlaw - Lancet 2009)
- Mortality Similar to Hip Fracture  
(Cauley - Osteoporos Int 2000)



# VCF Treatment Options

Treatment	Description	Goal of Therapy
<b>Open surgery</b>	Deformity correction through use of orthopedic hardware	<ul style="list-style-type: none"><li>• Alleviate Pain</li><li>• Reduce Deformity</li><li>• Improve Quality of Life</li></ul>

**But**

Highly invasive and seldom performed in osteoporotic patients

(Taylor – *Spine* 2006)

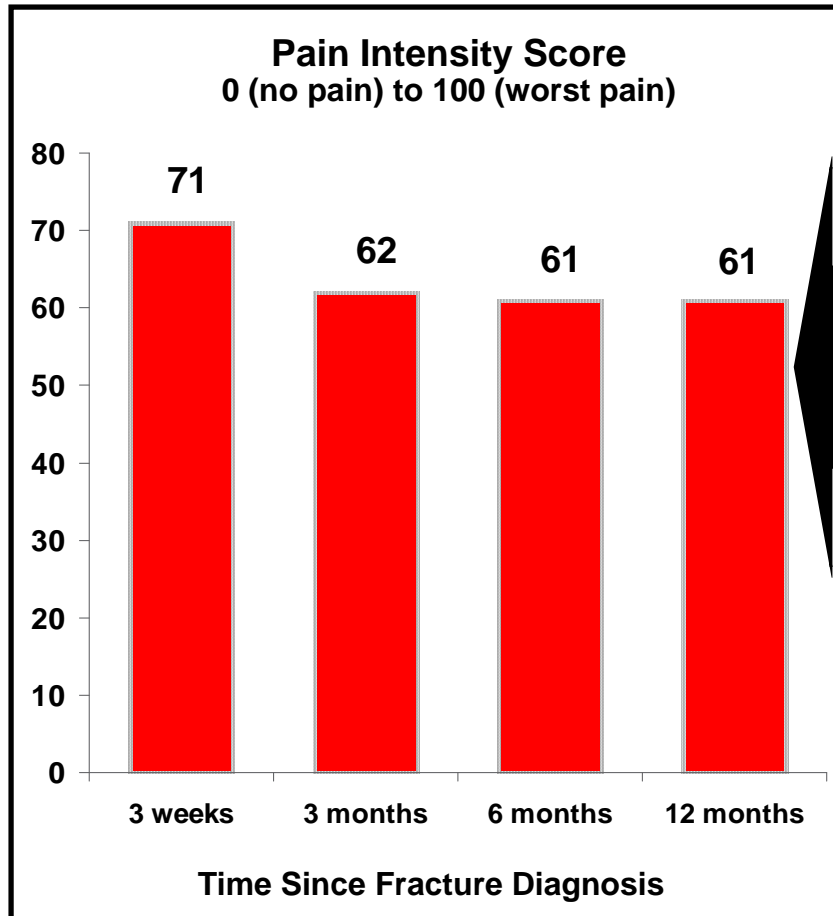
# VCF Treatment Options

Treatment	Description	Goal of Therapy
<b>Non-surgical Management</b>	<ul style="list-style-type: none"> <li>• Bed rest</li> <li>• Analgesics</li> <li>• Back braces</li> <li>• Physical therapy</li> </ul> <p>(Taylor – <i>Spine</i> 2006)</p>	<ul style="list-style-type: none"> <li>• Alleviate Pain</li> <li>• Reduce Deformity</li> <li>• Improve Quality of Life</li> </ul>

**But**

- Strong opiates not tolerated or ineffective in 44% of pts  
(Noble – *Cochrane* 2010)
- Back braces provide no deformity correction  
(Stadhouder – *J Orthop Trauma* 2009)
- Bed rest can result in 4%-10% bone loss per month and deconditioning  
(Hansson – *Acta Orthopaedica Scandinavica* 1975)



## VCF-Related Pain Remains Severe After 12 months of Conservative Treatment



For 12 months, VCF-related pain on conservative care was just as severe as seen in patients awaiting surgery for **disk herniation or lumbar spinal stenosis**

(Suzuki – Eur Spine J 2008)

## VCF Treatment Options (cont.)

Treatment	Description	Goal of Therapy
<p><b>Kyphoplasty</b></p> <p>Minimally Invasive Procedure</p>  <p>Two 1-cm incisions</p>	<p><b>Inflation of Bone Tamp Followed by Cement Injection</b></p> <p>Balloon Inflation      Balloon Removal, Cement Injection</p> 	<ul style="list-style-type: none"> <li>• Alleviate Pain</li> <li>• Reduce Deformity</li> <li>• Improve Quality of Life</li> </ul> <p><b>AND</b></p> <p>Demonstrated By Large Body of Peer-Reviewed Clinical Evidence</p>

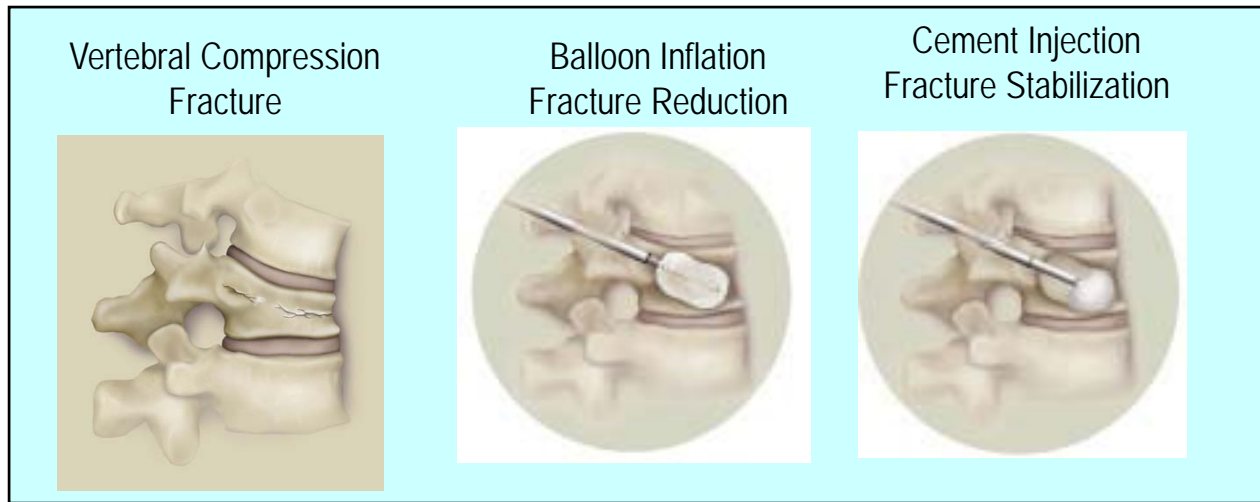
## Kyphoplasty Recognized By Major Medical Societies:

- American Academy of Orthopedic Surgeons
- American Association of Neurological Surgeons
- American Medical Directors Association
- American Society of Anesthesia
- American Society of Interventional Pain Physicians
- American Society of Interventional and Therapeutic Neuroradiology
- American Society of Regional Anesthesia and Pain Medicine
- American Society of Spine Radiology
- North American Spine Society
- Congress of Neurological Surgeons
- International Multiple Myeloma Foundation
- International Osteoporosis Foundation
- Society of Interventional Radiology

## Positive Balloon Kyphoplasty Health Technology Assessments Include:

- American Academy of Orthopedic Surgeons - 2010<sup>1</sup>
- California Technology Assessment Forum - 2009
- Noridian Administrative Services, LLC – 2008<sup>1</sup>
- Regence - 2010
- Ontario Health Technology Assessment Forum – 2010<sup>1</sup>

1. AAOS, Noridian and OHTAC were not considered in the HTA conducted by Spectrum Research Inc.



## Kyphoplasty Clinical Evidence

Rapid, Significant and Sustained  
Improvement in Pain and Quality of Life

Neal Shonnard, MD  
December 10, 2010

# Kyphoplasty Randomized Controlled Trials

## Rapid and Sustained Pain Relief & Quality of Life Improvement

Description	Goal of Therapy		
	Significant Pain Relief	Sustained Pain Relief	Improved Quality of Life
<p><b>Fracture Reduction Evaluation Trial (Free) – Lancet 2009</b></p> <p>300 osteoporotic VCF patients from 21 sites in 8 countries randomized to BKP or NSM</p>	At 7 day Follow-up	12 months	12 months
<p><b>Cancer Fracture Evaluation Trial (CAFE)<sup>1</sup> – <a href="http://www.clinicaltrials.gov">www.clinicaltrials.gov</a>;</b></p> <p><b>American Society of Hematology 2009, North American Spine Society 2009</b></p> <p>129 patients with VCFs due to cancer from 22 sites in 8 countries were randomized to BKP or NSM</p>	At 7 day Follow-up	12 months	12 months

1. CAFE was not considered in the HTA conducted by Spectrum Research Inc.



# Kyphoplasty Prospective Comparative Trials

## Rapid and Sustained Pain Relief & Quality of Life Improvement

Description	Goal of Therapy		
	Significant Pain Relief	Sustained Pain Relief	Improved Quality of Life
<b>Kasperk et al. – J Vas Interv Radiol 2010</b> 60 osteoporotic VCF patients treated with either BKP (40) or NSM (20)	<b>At Post-Op Follow-up</b>	<b>3 Years</b>	<b>3 Years Mobility Improvement</b>
<b>Komp et al – J Miner Stoffwechs 2004<sup>1</sup></b> 36 osteoporotic VCF patients treated with either BKP (19) or NSM (17)	<b>At 24 Hour Follow-up</b>	<b>6 months</b>	<b>6 months Disability Improvement</b>

**1. Komp was not considered in the HTA conducted by Spectrum Research Inc.**

# Kyphoplasty Prospective Case Series

## Rapid and Sustained Pain Relief & Quality of Life Improvement

Description	Goal of Therapy		
	Significant Pain Relief	Sustained Pain Relief	Improved Quality of Life
<b>Diel et al. – Spine J 2010<sup>1</sup></b> Swiss Registry of all 331 BKP procedures performed from May 2005 thru June 2008.	<b>At 3 Month Follow-Up</b>	<b>1 Year</b>	<b>1 Year</b>
<b>Garfin et al. – Spine 2006<sup>1</sup></b> 155 osteoporotic VCF patients from 19 clinical sites within the US treated with BKP	<b>At 7 day Follow-up</b>	<b>2 Years</b>	<b>2 Years</b>

**1. Diel and Garfin were not considered in the HTA conducted by Spectrum Research Inc.**

# Kyphoplasty Demonstrated To Relieve Pain, Restore Function, and Improve Quality of Life

Description	Goal of Therapy Immediate, Marked, and Sustained Improvement In:		
	Pain	Back Function	Quality of Life
As of 9/30/2010, 105 unique studies were identified with cohorts of > 10 patients reporting outcomes of 6,734 patients treated with Balloon Kyphoplasty <sup>1</sup>	<b>90 of 90 Studies Positive Results Following Kyphoplasty</b>	<b>36 of 36 Studies Positive Results Following Kyphoplasty</b>	<b>17 of 17 Studies Positive Results Following Kyphoplasty</b>

**1. 89 of the 105 kyphoplasty studies were not considered in the HTA conducted by Spectrum Research Inc.**

# Balloon Kyphoplasty vs. Non-Surgical Management

5,766 Patients Hospitalized Due to Severe VCF-Related Pain were retrospectively studied from a Nation-wide Inpatient Sample (2005)

## Kyphoplasty Patients



**2.5x More likely to Be Routinely Discharged To Home**

**1.5x More likely to Be Discharged To Home with Homecare**

## Conservative Care Patients



**62% More Likely To Be Discharged to a Skilled Nursing Facility**

**59% More Likely To Be Discharged to Another Institution**

**52% More Likely To Die During Their Hospital Stay**

Zampini – Clin Orthop Relat Res 2010<sup>1</sup>

1. Zampini was not considered in the HTA conducted by Spectrum Research Inc.

# Summary



Kyphoplasty Provides Immediate, Significant and Sustained Pain Relief and Quality of Life Improvement To VCF Patients

- Demonstrated in both Randomized and Non-Randomized Clinical Studies
- Demonstrated in Studies Performed Worldwide
- Confirmed by National Inpatient Data Analysis

# References

1. CAFE Results:
  - 1.1 [www.clinicaltrials.gov](http://www.clinicaltrials.gov)
  - 1.2 Berenson [P2873] Blood (American Society for Hematology Annual Meeting Abstracts) 2009;114(22):2873.
  - 1.3 Vrionis F, Tillman J, Hussein M, et al. Balloon kyphoplasty improves Roland-Morris Disability Scores and bone pain among cancer patients with vertebral compression. Proceedings of the NASS 24th Annual Meeting. Spine J. 9 (2009) 1S-205S.
2. Diel P, Reuss W, Aghayev E, et al. SWISSspine-a nationwide health technology assessment registry for balloon kyphoplasty: methodology and first results. Spine J. 2010 Nov;10(11):961-71.
3. Garfin SR, Buckley RA, Ledlie J; et al. Balloon kyphoplasty for symptomatic vertebral body compression fractures results in rapid, significant, and sustained improvements in back pain, function, and quality of life for elderly patients. Spine. 2006 Sep 1;31(19):2213-20.
4. Kasperk C, Grafe IA, Schmitt S, et al. Three-year outcomes after kyphoplasty in patients with osteoporosis with painful vertebral fractures. J Vasc Interv Radiol. 2010 May;21(5):701-9.
5. Komp M., Ruetten S., Godolias G. Minimally invasive therapy for functionally unstable osteoporotic vertebral fracture by means of kyphoplasty: prospective comparative study of 19 surgically and 17 conservatively treated patients. J Miner Stoffwechs 2004: 11 (Suppl 1):13-15.
6. Wardlaw D, Cummings SR, Van Meirhaeghe, J et al. Efficacy and safety of balloon kyphoplasty compared with nonsurgical care for vertebral compression fracture (FREE): a randomized controlled trial. Lancet 2009;373:1016-24.
7. Zampini JM, White AP, McGuire KJ. Comparison of 5766 vertebral compression fractures treated with or without kyphoplasty. Clin Orthop Relat Res. 2010 Jul;468(7):1773-80.



# Agency Medical Director Comments

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Agency Experience:

Kyphoplasty, Vertebroplasty,  
Sacroplasty

December, 2010

# Vertebral compression fractures (VCFs) and sacral insufficiency fractures (SIF) : Background

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Fracture or compression result in considerable pain, loss of function, and decreased quality of life.

- Vertebroplasty involves injection of bone cement into a partially collapsed vertebral body
- Kyphoplasty expands the partially collapsed vertebral body with an inflatable balloon before the injection of bone cement.
- Sacroplasty involves the injection of bone cement into the sacrum to repair sacral insufficiency fractures.





# Agency Concerns

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## Safety Concerns (Medium)

Therapies have risks of infection and cement embolism

## Efficacy Concerns (Medium)

Short term, modest pain relief, no clear improvement in function; no evidence of longer term improvement in pain or function; RCTs shams studies show no differential benefit in pain

## Cost Concerns (Medium)

Usage and costs are escalating



# Coverage Overview

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- Currently covered by PEBB
- Not covered by Medicaid, Labor and Industries (L&I)
  - Averaged 10 and 1 procedure(s)/year respectively
  - Original non-coverage (L&I) based on safety concerns- continued monitoring of literature has not supported policy change

# UMP Spends and Trends

Figure 1. UMP/PEP\* Vertebral Augment (VA) Costs (+/- 3 day costs related by diagnosis)

Vertebral Augment Costs	2006	2007	2008	2009	Grand Total
Total Vertebral Augment Costs (3 day window of related charges)	\$70,095	\$156,750	\$323,617	\$318,081	\$868,543*
Average Costs (UMP primary only)	\$5,199	\$11,516	\$13,423	\$10,837	\$11,648
Minimum (UMP primary only)	\$290	\$722	\$491	\$1075	\$290
Maximum	\$11,815	\$45,016	\$42,130	\$34,474	\$45,016

\* DSHS/DLI do not cover these procedures, and averaged 10 and 1 procedure(s)/year respectively.

# UMP Utilization by Procedure\*

Some patients had both types of procedures within the same hospital or outpatient encounter.

Vertebral Augments	2006	2007	2008	2009	Overall
<b><u>Vertebroplasty</u></b>					
Procedures	25	31	53	55	164
Members	19	20	39	42	116
Total Costs	\$16,590	\$45,583	\$99,705	\$211,833	\$373,711
Cost/Proc	\$664	\$1,470	\$1,881	\$3,852	\$2,279*
<b><u>Kyphoplasty</u></b>					
Procedures	58	46	84	65	253
Members	45	26	53	45	170
Total Costs	\$58,529	\$121,275	\$232,905	\$273,983	\$686,692
Cost/Proc	\$1,009	\$2,636	\$2,773	\$4,215	\$2,714*
<b>All Augments Summary</b>					
Procedures	83	77	137	120	417
Members	64	46	92	87	286
Annual Cost	\$70,095	\$156,750	\$323,617	\$318,081	\$868,543
Cost/Proc	\$845	\$2,036	\$2,362	\$2,651	\$2,083

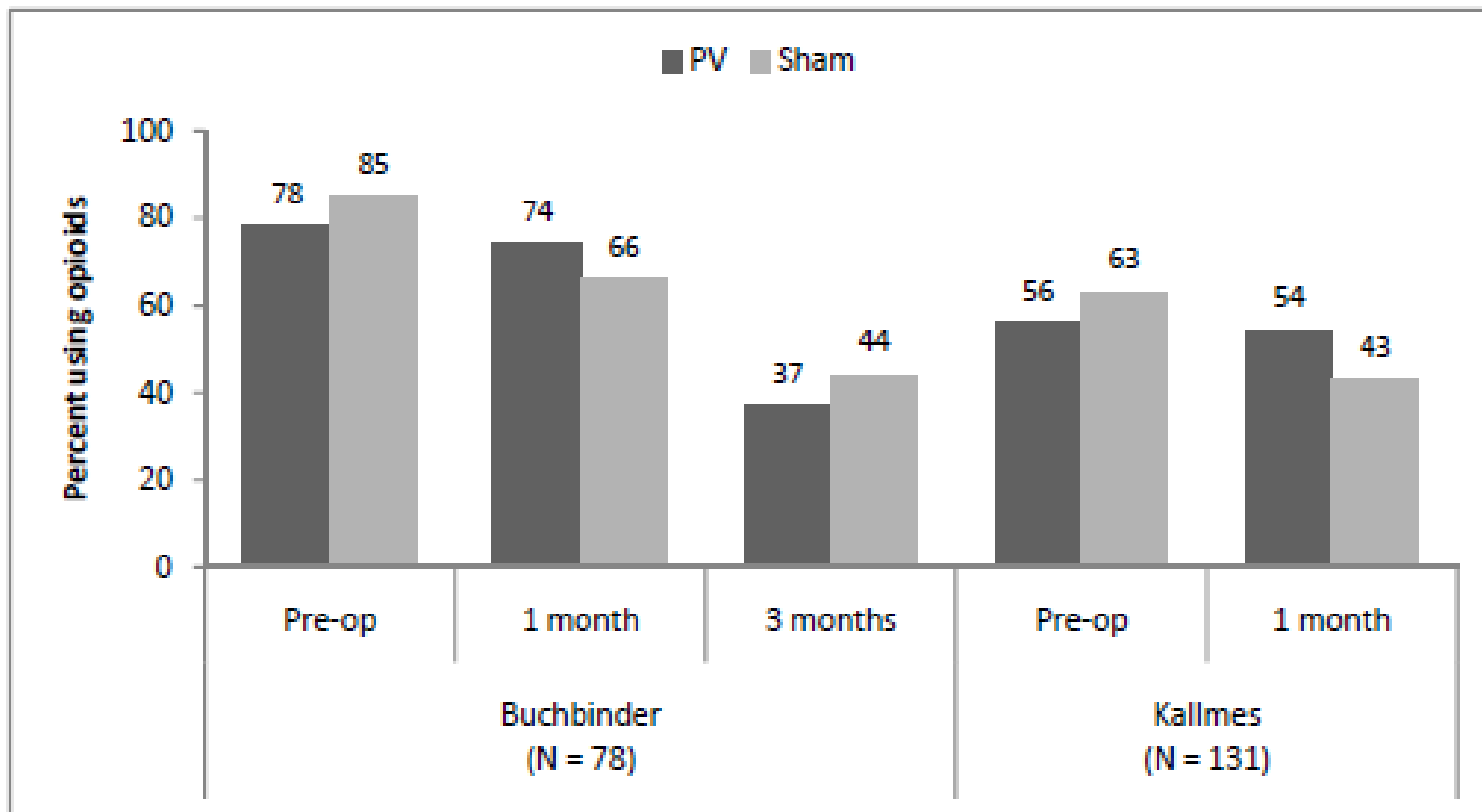
# UMP Claims based Outcomes\*

UMP/PEP Repeat Procedures and Readmits within 30 days

Vertebral Augment Repeats	Repeat Procedure Count	% of total Procedures (417 total)	% of VA Patients (286)	Avg Days to Repeat/Readmit	Max	Min
Readmits in 30 days	6	1.4%	2.1%	10	13	3
Repeated Procedures	58	13.9%	20.3%	194.7	1079	1

# Evidence RCT/Sham vs. Observational Data

Figure 3: Percent of patients using opiate medication in studies comparing vertebroplasty with sham surgery



Should observational studies be considered when Sham surgery shows no difference ?

# Hayes: Considerations

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## **Percutaneous Vertebroplasty**

- **C - patients with medically refractory pain due to osteoporotic vertebral compression fractures (VCFs)**
- **D - patients with medically refractory pain due to VCFs associated with malignancy.**
- **D - patients with specific contraindications, (infection at site, coagulation disorders, unstable vertebral fractures, retropulsed tissue, vertebral fractures with bone fragments, acute burst fracture, high-energy fractures, or pregnancy).**

## **Percutaneous Kyphoplasty**

- **C - medically refractory pain due to vertebral compression fractures caused by osteoporosis or osteolytic processes.**
- **D - patients with specific contraindications, (infection at site, coagulation disorders, unstable vertebral fractures, retropulsed tissue, vertebral fractures with bone fragments, acute burst fracture, high-energy fractures, or pregnancy).**



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## **Percutaneous Vertebroplasty or Kyphoplasty for Vertebral Fractures Caused by Osteoporosis**

Vertebroplasty for vertebral fractures from osteoporosis improves health outcomes has not yet been established in the investigational setting: vertebral fractures from osteoporosis does not meet the TEC criteria.

Kyphoplasty for vertebral fractures from osteoporosis improves health outcomes has not yet been established in the investigational setting: vertebral fractures for osteoporosis does not meet the TEC criteria.



# Other Considerations- Vertebroplasty

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## Vertebroplasty-

- Effect-size has diminished as quality of research has improved until no effect versus sham in 2 RCTs (editorial: Carragee EJ. The vertebroplasty affair: the mysterious case of the disappearing effect size. Spine J 2010;10: 191-192).
- Placebo effect is real/statistically significant.

“Control patients guessing vertebroplasty had significantly greater pain improvement at days 14 and 30 than did those guessing control (day 14,  $P = .02$ ; day 30,  $P < .001$ ). In the vertebroplasty group, no relationship between change in pain and patient guess was noted.”

From: Investigational Vertebroplasty Efficacy and Safety Trial: detailed analysis of blinding efficacy. Brinjikji W, Comstock BA, Heagerty PJ, Jarvik JG, Kallmes DF. Radiology. 2010 Oct;257(1):219-25.

# Other Considerations- Kyphoplasty

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- Kyphoplasty evolved from vertebroplasty
- More costly, less evidence
- Highest quality evidence shows kyphoplasty no better than vertebroplasty, AND
- Best studies show vertebroplasty outcomes do not differ from sham
- No evidence on sacroplasty



# AMDG: Recommendations

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## Kyphoplasty, Vertebroplasty, Sacroplasty

- The evidence for effectiveness is lacking.
- There are safety concerns.
- There are sham RCTs showing no differences

The AMDG recommends a non-covered decision due to the afore mentioned issues



# Vertebroplasty, Kyphoplasty, and Sacroplasty

Health Technology Clinical Committee Meeting  
Washington State Health Technology Assessment Program

*Barbara C. Leigh, PhD, MPH*

*Andrea C. Skelly, PhD, MPH*

*Nora B. Henrikson, PhD, MPH*

*Lisa Kercher, PhD, MPH*

*Megan Skinner, MPH*

## Scope of report and presentation

- The aim of this report is to systematically review, critically appraise, and analyze relevant published research comparing the efficacy, effectiveness, and safety of vertebroplasty, kyphoplasty and sacroplasty with other surgical and non-surgical treatment options.
- Sacroplasty: Very limited evidence from 9 case series of  $\geq 5$  patients (N = 141) is described in the report. In the absence of comparative studies no conclusions can be drawn regarding efficacy, effectiveness or safety. This presentation will focus on evidence related to vertebroplasty and kyphoplasty.

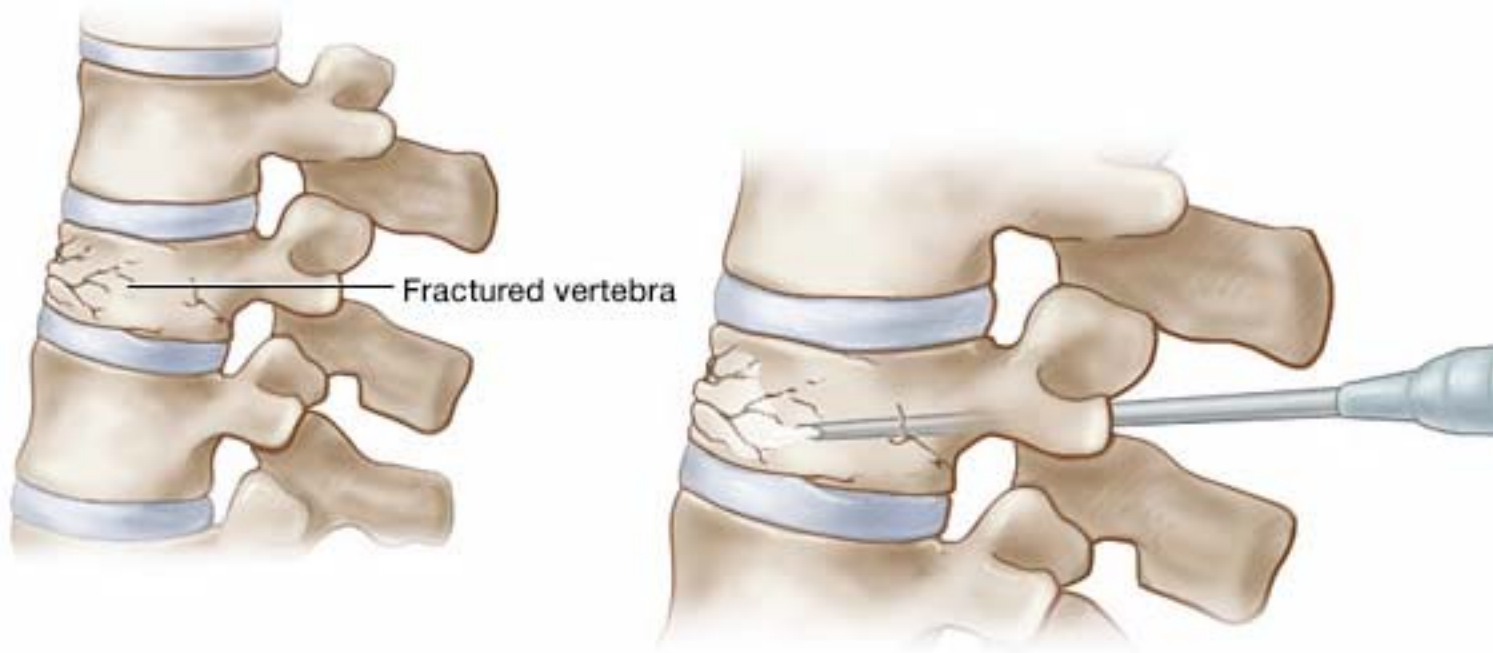
# Background

- Vertebroplasty, kyphoplasty, and sacroplasty are surgical procedures used to treat spinal pain believed to be caused by fractures in the vertebra or sacrum
- Cementoplasty techniques are intended to stabilize the fractured vertebra(e)
  - Stabilization is thought to relieve pain, although mechanism is not clear
- Less invasive than alternative spinal surgical procedures, but more invasive than conservative medical therapy
- Indications
  - Osteoporosis
  - Malignancy
  - Traumatic fracture (not included; contraindication listed by FDA)

# Background

## Percutaneous vertebroplasty (PV)

Injection of bone cement into partially collapsed vertebral body under computed tomography or fluoroscopic guidance



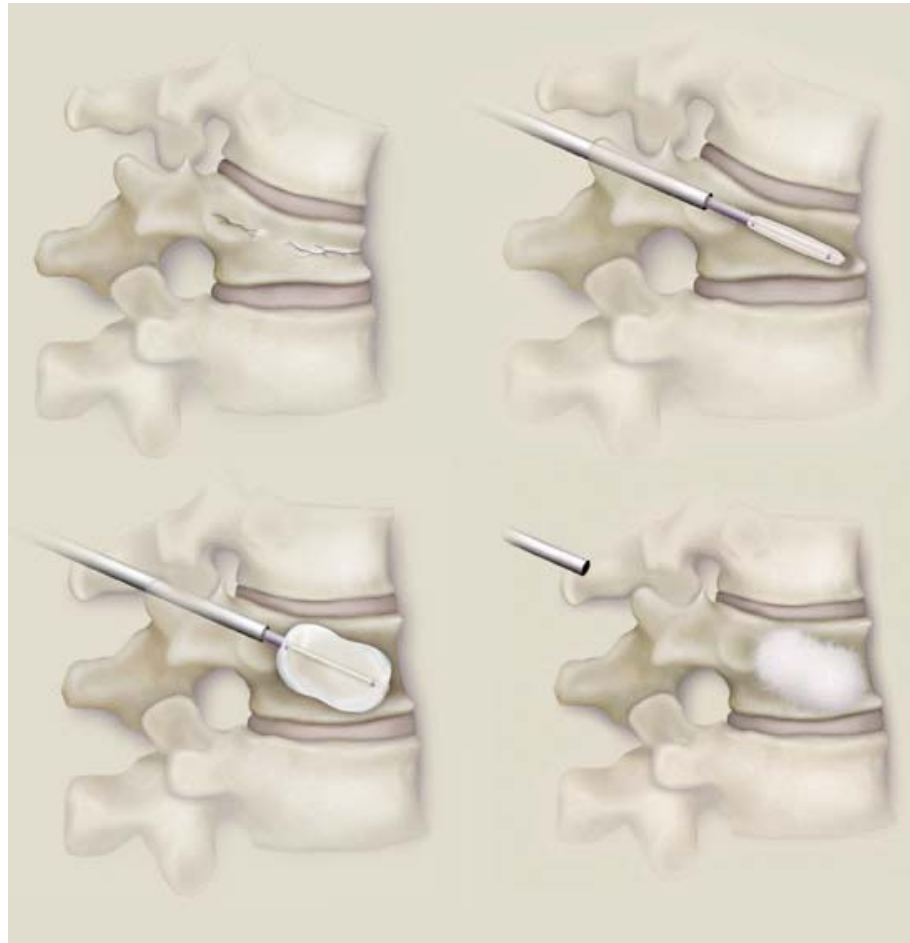
Quick setting bone cement injected into fractured vertebra



# Background

## Balloon kyphoplasty (KP)

Inflatable balloon is used to expand the collapsed body before injection of cement into the expanded cavity



## Key questions

When used in patients with spinal pain *due to vertebral fracture*:

1. What is the evidence of efficacy and effectiveness of vertebroplasty, kyphoplasty or sacroplasty?
2. What is the evidence of the safety of vertebroplasty, kyphoplasty or sacroplasty?
3. What is the evidence that vertebroplasty, kyphoplasty or sacroplasty has differential efficacy or safety issues in sub populations?
4. What is the evidence of cost implications and cost effectiveness of vertebroplasty, kyphoplasty or sacroplasty?

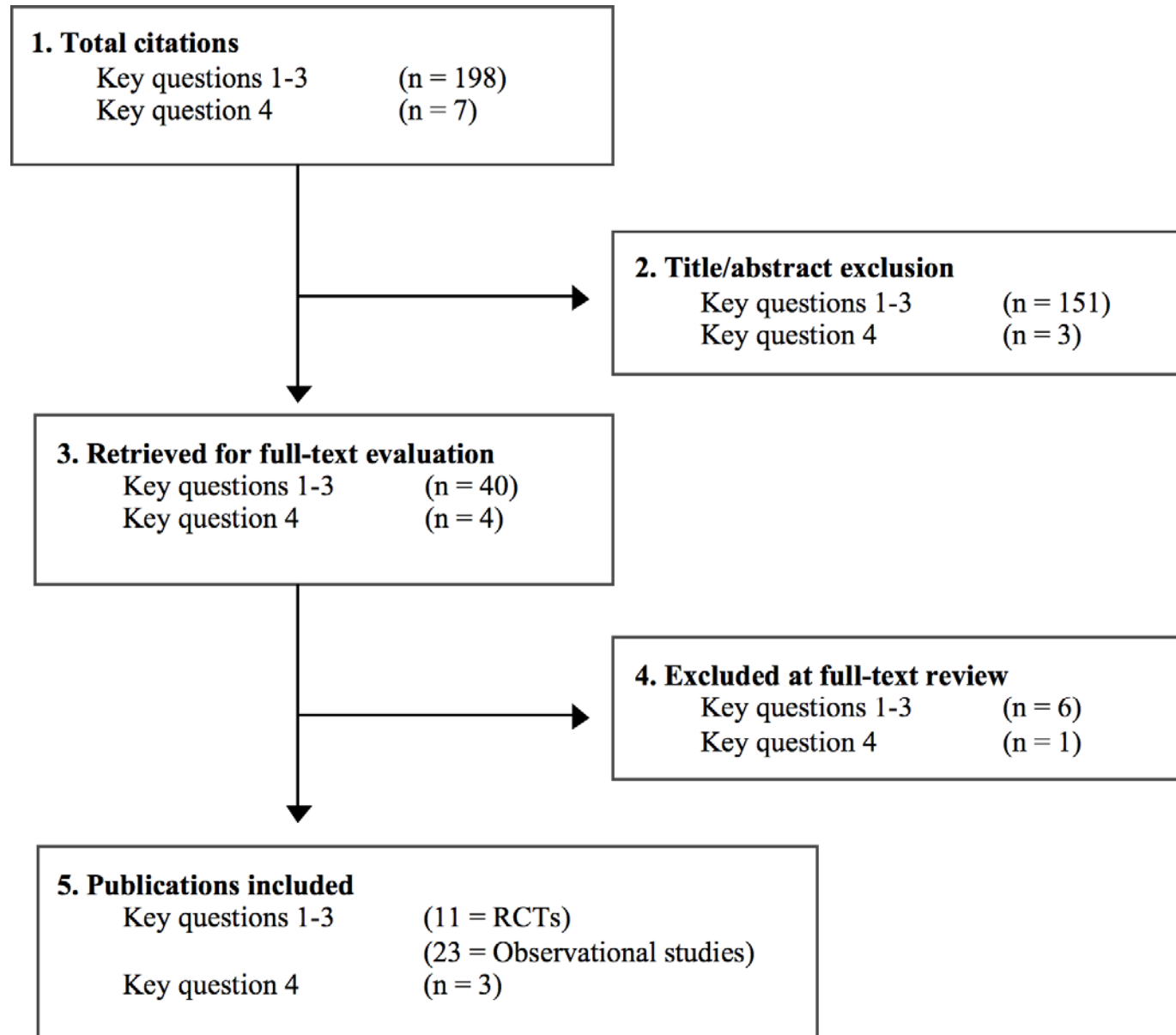
# Study inclusion

- Population
  - Patients with spinal pain due to vertebral fracture secondary to osteoporosis or malignancy (high-energy traumatic fractures excluded)
- Intervention
  - Vertebroplasty, kyphoplasty, or sacroplasty
- Comparators
  - Conservative care
  - Surgical procedures
  - Vertebroplasty vs. kyphoplasty

# Outcomes

- Efficacy/effectiveness: primary measures
  - Pain (various protocols for measurement)
    - 0 - 10 scale (0 = no pain; 10 = worst pain ever)
  - Functional outcomes
    - Roland-Morris Disability Questionnaire (RDQ)
    - Oswestry Disability Index (ODI)
  - Quality of life
    - European Quality of Life - 5 Dimensions (EQ-5D)
    - Short Form General Health Survey (SF-36)
- Safety
  - Incident fractures
  - Cement leakage
  - Cement embolism
  - Procedure-related complications
  - Mortality

# Literature search



# Organization of results

- Key Question 1: Efficacy (RCTs)
  - Vertebroplasty vs. sham surgery
  - Vertebroplasty vs. conservative medical treatment
  - Kyphoplasty vs. conservative medical treatment
  - Vertebroplasty vs. kyphoplasty
- Key Question 1: Effectiveness (nonrandomized studies)
  - comparisons as above
- Key Question 2: Safety
- Key Question 3: Differential efficacy/effectiveness/safety
- Key Question 4: Cost effectiveness

# Summary of Key Question 1: Efficacy/effectiveness-Vertebroplasty

- ***Strength of evidence – Vertebroplasty***
  - *Efficacy: low*
  - *Effectiveness: low*
- 5 RCTs – osteoporotic fractures
  - PV vs. sham surgery (2 LoE II studies)
    - No statistically significant differences in pain or functioning in 2 RCTs (*ns* 78, 131)
    - Trend toward greater proportion of PV patients achieving clinically significant improvement in pain
  - PV vs. CMT (3 LoE II studies)
    - One large, adequately powered RCT (*n* = 188) reported PV significantly more effective than CMT for pain and functioning
    - In two small RCTs (*ns* 34, 50), PV and CMT patients comparable in pain relief, with inconsistent findings for functional outcomes
- 4 cohort (LoE III) studies (*ns* 60-143)
  - Pain relief and functioning improved more rapidly following PV
  - PV and CMT patients comparable after 6-12 months

# Summary of Key Question 1: Efficacy/effectiveness Kyphoplasty

- ***Strength of evidence – Kyphoplasty***
  - *Efficacy: low*
  - *Effectiveness: Very low*
- One LoE II RCT ( $n = 300$ )
  - Significantly more initial improvement in pain and functioning after KP than CMT
  - KP and CMT similar outcomes by 12 months
- Two LoE III cohort studies ( $ns = 45, 60$ )
  - KP reduced pain significantly more than CMT up to 3 years
  - KP improved a limited set of functional outcomes more than CMT



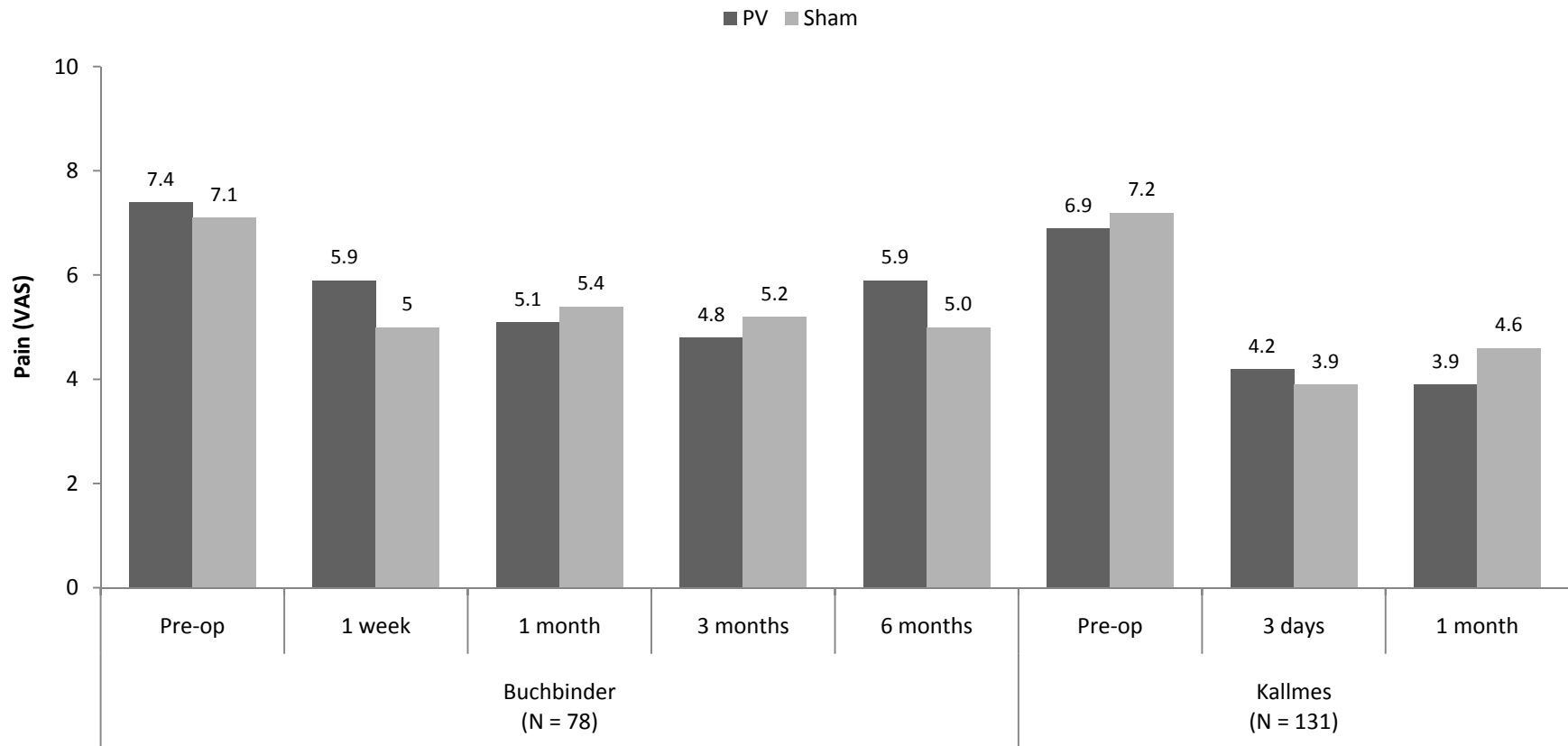
# Summary of Key Question 1: Efficacy/effectiveness Vertebroplasty vs. kyphoplasty

- ***Strength of evidence – Vertebroplasty vs. kyphoplasty***
  - *Efficacy: very low*
  - *Effectiveness: low*
- One RCT (LoE II) ( $n = 100$ ) and 10 cohort studies (LoE III) ( $ns = 20-54$ )
- PV and KP reduced pain by comparable amounts at follow-up periods up to 2 years
- PV and KP showed comparable improvements on the Oswestry Disability Index

# Key question 1: SoE low

## Efficacy of vertebroplasty (PV) vs. sham surgery: Pain

Mean pain (VAS) in studies comparing vertebroplasty with sham surgery



Scale: 0-10; higher scores *worse*  
No statistically significant group differences

# Key question 1: Efficacy of vertebroplasty (PV) vs. sham surgery: Clinically significant improvement in pain

	Definition	PV	Sham	Follow-up
Buchbinder (2009)	≥ 2.5 points reduction	38%	38%	1 week
		51%	42%	1 month
		52%	35%	3 months
		54%	42%	6 months
Kallmes (2009)	30% reduction from baseline	64%	48%	1 month

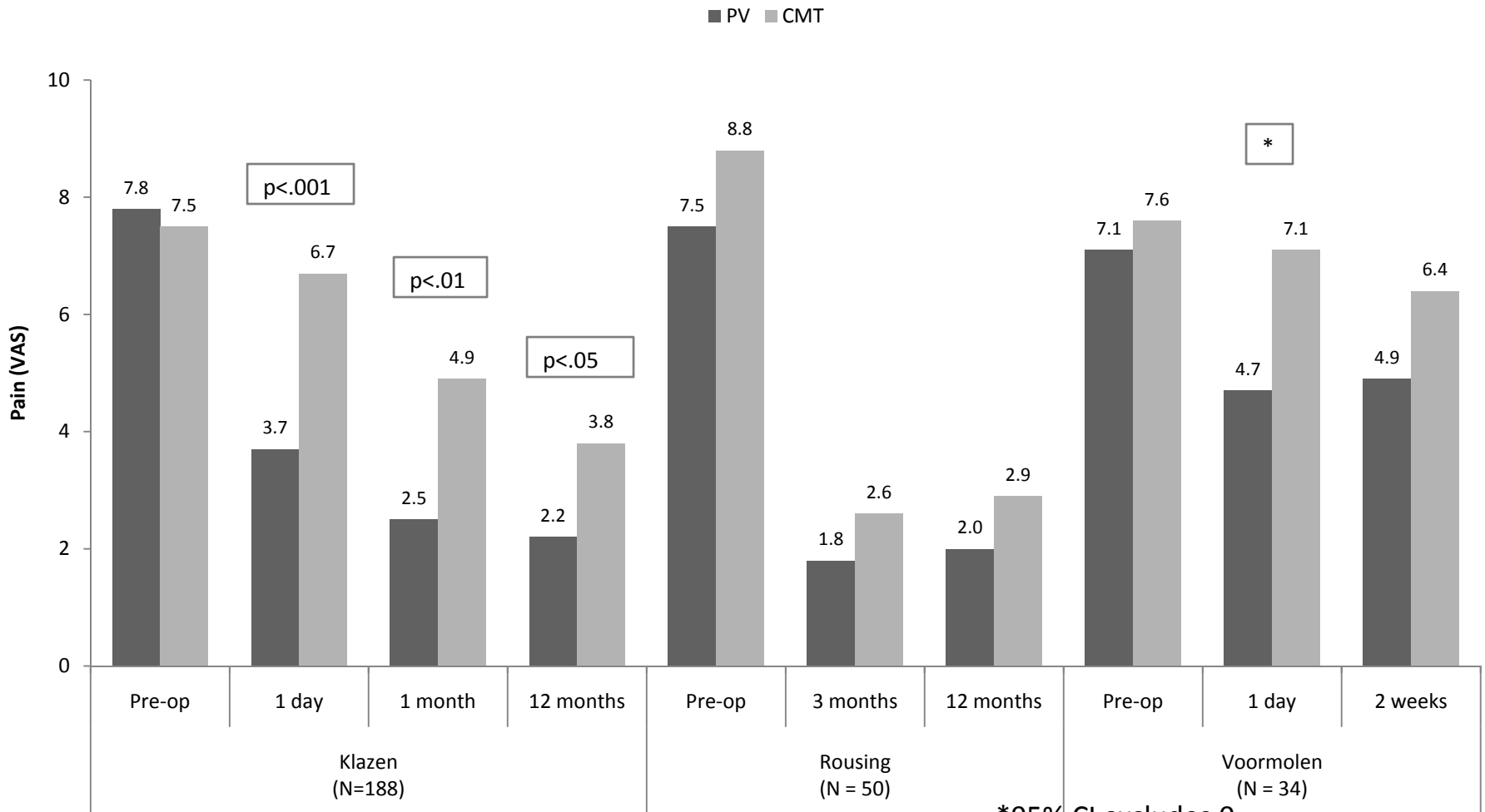
# Key question 1: Efficacy of PV vs. sham surgery: Function and Quality of Life

	PV	Sham	<i>p</i> value	Follow-up
Roland-Morris Disability Questionnaire (RDQ) (scale 0-23; higher scores <i>worse</i> )				
Buchbinder (2009)	13.6	12.0	ns	3 months
Kallmes (2009)	12.0	13.0	ns	1 month
European Quality of Life - 5 Dimensions (EQ5D) (scale 0-1; higher scores <i>better</i> )				
Buchbinder (2009)	0.50	0.48	ns	3 months
Kallmes (2009)	0.70	0.60	ns	1 month
Short Form General Health Survey (SF-36): Physical (scale 0-100; higher scores <i>better</i> )				
Kallmes (2009)	29.7	28.7	ns	1 month
Short Form General Health Survey (SF-36): Mental (scale 0-100; higher scores <i>better</i> )				
Kallmes (2009)	46.9	45.6	ns	1 month

Key question 1: (SoE low)

# Efficacy of PV vs. conservative medical treatment (CMT): Pain

Mean pain (VAS) in studies comparing vertebroplasty with conservative treatment



\*95% CI excludes 0

# Key question 1: Efficacy of PV vs. CMT: Function and Quality of Life

	PV	CMT	p value	Follow-up
Roland-Morris Disability Questionnaire (RDQ) (scale 0-23; higher scores <i>worse</i> )				
Klazen (2010) <sup>^</sup>	9.9	12.2	#	3 months
	<9	10.5	#	12 months
Voormolen (2007)	13	18	CI excludes 0	2 weeks
Short Form General Health Survey (SF-36): Physical (scale 0-100; higher scores <i>better</i> )				
Rousing (2010)	32.1	30.5	ns	12 months
Short Form General Health Survey (SF-36): Mental (scale 0-100; higher scores <i>better</i> )				
Rousing (2010)	48.7	49.0	ns	12 months
Quality of Life Questionnaire of European Foundation for Osteoporosis (QualEFFO) (scale 0-100; higher scores <i>worse</i> )				
Klazen (2010) <sup>^</sup>	40	44	#	3 months
	39	41	#	12 months
Voormolen (2007)	53	67	CI excludes 0	2 weeks

<sup>^</sup> Means interpolated from graphs

# Overall ANOVA (repeated measures) for all time periods  $p < 0.001$

Key question 1: (SoE low)  
Efficacy of kyphoplasty (KP) vs. CMT: Pain

(Wardlaw 2009; LoE II RCT,  $n = 300$ )

- Pain decreased significantly more in KP patients than in CMT patients over 12 months of follow-up
  - One week: 2.2 points differential improvement ( $p < 0.001$ )
  - 12 months: 0.9 points differential improvement ( $p < 0.01$ )
  - Early improvements in KP group followed by slower rate of improvement

# Key question 1: Efficacy of KP vs. CMT: Function and Quality of Life

## Wardlaw RCT (LoE II, SoE low)

Differential improvement	<i>p</i> value	Follow-up
Roland-Morris Disability Questionnaire (RDQ) (scale 0-23)		
4.0	<.001	1 month
2.6	<.01	12 months
Short Form General Health Survey (SF-36): Physical (scale 0-100)		
5.2	<.001	1 month
3.2	<.01	6 months
0.9	ns	12 months
European Quality of Life - 5 Dimensions (EQ5D) (scale 0-1)		
.18	<.001	1 months
.12	<.05	12 months



# Key question 1: Efficacy of PV vs. KP

(Liu 2010; LoE II RCT;  $n=100$ )

PV	KP	<i>p</i> value	Follow-up
Pain (0-10); higher scores <i>worse</i>			
7.9	8.0	ns	Pre-op
2.3	2.6	ns	3 days
2.6	2.6	ns	6 months

Pain decreased approximately 68% in PV and KP groups  
over 6 months of follow-up

– No significant differences between PV and KP groups

SoE is very low (very poor quality study)

## Key question 1: Effectiveness of PV vs. CMT

	PV	CMT	Follow-up (range)
Pain (scale 0-10; range of means)			
4 cohort studies ( <i>ns</i> 60-143)	0.8 - 3.0	1.2 - 3.5	1-2 years
Oswestry Disability Index (scale 0-100; higher scores <i>worse</i> )			
1 cohort study ( <i>n</i> = 128)	17.0	11.0	12 months

- In 3 of the 4 studies, PV patients reported significantly less pain up to 6 months, but pain levels were comparable at 1 year.
- SoE is low

# Key question 1: Effectiveness of KP vs. CMT

	KP	CMT	<i>p</i> value	Follow-up
Pain (scale 0-10; higher scores <i>worse</i> )				
Kasperk (2010) <i>n</i> =60	5.5	6.4	<.01	3 years
An (2008) <i>n</i> =45	3.2	4.5	<.05	1 year
European Vertebral Osteoporosis Study Questionnaire (EVOS) (scale 1-100; higher scores <i>better</i> )				
Kasperk (2010)	54.2	43.6	<.001	3 years

- In both cohort studies, KP patients improved significantly more than CMT patients
  - KP pain decrease: 25% and 62% in the two studies
  - CMT pain decrease: 0 and 43% in the two studies
- SoE is very low

## Key question 1: Effectiveness of PV vs. KP

	PV	KP	Follow-up (range)
Pain (scale 0-10; range of means; higher scores <i>worse</i> )			
10 cohort studies ( <i>ns</i> 20-154)	0.6 - 4.6	0.7 - 3.7	1 day - 3 years
Oswestry Disability Index (scale 0-100; range of means; higher scores <i>worse</i> )			
5 cohort studies ( <i>ns</i> 20-154)	6.7 - 52	4.8 - 56	6 months - 2 years

- In 8 of the 10 studies that measured pain, no significant PV-KP differences were reported
- In 4 of the 5 studies that measured ODI, no significant PV-KP differences were reported.
- SoE is low

- ***Strength of evidence: very low***
- New fractures
  - Rates varied across studies
  - No consistent pattern for PV, KP, or CMT
  - New fractures occur in the absence of cement augmentation
- Cement leakage
  - Asymptomatic leakage common
  - More likely in PV (19.7% - 79.0%) vs. KP (0.51% -11.2) – pooled estimates
  - Pooled rates-symptomatic leakage low (PV, 0.5% -1.6% ; 0% -0.3%, KP)
- Cement embolism
  - 26%, asymptomatic, systematically assessed in 1 RCT
  - Pooled estimates: 1.6% asymptomatic (62/3774); 1.1% symptomatic (16/1431) in SR of case series; where symptoms unknown 0.4%-1.6%
- Mortality
  - Perioperative: KP, 0.01% (11 case series); PV, 2.1% (57 case series)
  - Overall mortality difficult to interpret: patient characteristics and timing

## Key Question 2: (SoE very low) Safety outcomes of PV and KP

	PV	KP	CMT or sham surgery	Risk difference (range)	Follow-up (range)
Percent of patients with any new fracture (range)					
7 RCTs	0 - 30.4	4.0 - 33	0 - 25.3	-2.5 - 12.3	3 - 12 mo
11 cohort studies	0 - 31.3	0 - 41.2	4.7 - 71.4	-30.2 - 19.6	3 mo - 3 yrs
Systematic reviews	18 - 19.7	7 - 17			
Proportion of new fractures that were adjacent to treated vertebra					
1 RCT	38%		37%	12 mo	
Systematic reviews	52%	75%			

## Key Question 2: (SoE very low) Safety outcomes of PV and KP

	PV	KP	Risk difference (range)	Follow-up (range)
Percent of patients with asymptomatic cement leakage (range)				
3 RCTs	37 - 80	27		12 mo
11 cohort studies	0 - 87.5	0 - 49.3	-1.4 - 50	1 - 3 yrs
Systematic reviews	20 - 79	13 - 14		
Percent of patients with symptomatic cement leakage (range)				
Systematic reviews	0.5 - 1.6	0 - 0.3		
Percent of patients with pulmonary cement embolism				
1 RCT	26 (asymptomatic)			12 mo
Systematic reviews	0.9 – 1.6*	0.1 – 0.4		variable

\*Pooled : 1.6% case series-asymptomatic; 1.1% - those reporting symptomatic; range in individual studies (any PCE) 3.5%-23%, some with very small N

## Key Question 2: SoE very low Safety outcomes of PV and KP

	PV	KP
Percent with procedural complications (range) (fracture, neurological, dural tear, infection, subcutaneous hematoma, balloon rupture)		
Systematic reviews	2.4 – 3.8	0.4 – 0.6
Percent with medical complications (range) (respiratory, cardiovascular, stroke, pneumonia, fever)		
Systematic reviews	0.4 – 2.8	0.9 – 3.2
Percent mortality (perioperative)		
Systematic reviews	2.1% (14/680)	0.01% (1/406)
Percent mortality (unspecified time period)		
Systematic reviews	0.6 - 2.1	2.3 - 3.2%



## Key question 3: Differential effectiveness, efficacy, and safety

- ***Strength of evidence: very low***
- No comparative studies assessing differential outcomes of PV and KP by gender, age, comorbidities
- No comparative studies assessing differential outcomes by fracture etiology (osteoporotic or tumor-related)
  - majority of comparative studies included only patients with osteoporotic fractures
- No studies were designed to compare outcomes for patients with different fracture ages
  - Post-hoc analyses in 2 RCTs indicated that pain outcomes did not differ significantly for patients with acute vs. chronic fractures; Low power for this analysis
  - Largest RCT of PV vs. CMT included only acute fractures, conclusions about efficacy for different fracture ages cannot be drawn
  - 4 cohort studies: Conflicting results on fracture age – 2 studies of pain duration  $\leq 6$ wks pain, PV significantly  $\downarrow$  pain vs. CMT; 2 with longer duration ( $\leq 3$  or 12 mos) also reported pain improvement with PV

## Key question 4: Cost effectiveness

- ***Strength of evidence: very low***
- Three studies incorporated economic evaluations
  - 2 studies looked at PV versus CMT, 1 at KP versus CMT
    - All were of populations with osteoporotic fractures
    - None were from the United States, therefore applicability unclear
    - Incremental cost effectiveness ratios (ICER) at one year ranged from €22,685 per QALY (PV, Klazen, funding-Cook Medical) to £8840 per QALY( KP, Ström, funded by Medtronic) vs. conservative treatment
    - Masala study: Cost/patient for one-point improvement (11-point pain scale) at one year slightly lower for PV (€529) than CMT (€632)
  - Data only available up to 12 months
  - Efficacy/effectiveness in high quality studies is uncertain making cost-effectiveness unclear

# Issues to consider

- Most data are from osteoporotic fractures; less is known about fractures due to malignancy
- Longer term outcomes are unknown
  - Most comparative studies have relatively short follow-up periods
  - Age of patient population complicates the examination of longer-term outcomes
- Clinically meaningful improvement (Pain, RMDQ)
  - Statistically significant differences may not represent clinically meaningful change
  - Definition of meaningful improvement not settled
- Outcomes measures, definitions varied across studies making summary and comparison across studies challenging
- Detection of adverse events
  - Fractures and cement emboli may go undetected outside of a clinical trial with systematic assessment;
  - Differing perspectives on significance of asymptomatic events
  - Sensitivity of diagnostic tools for embolism (CT vs. radiographs, fluoroscopy)



WASHINGTON STATE HEALTH CARE AUTHORITY

## Health Technology Assessment Program

# Peer Review and Public Comments and Responses

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Vertebroplasty, Kyphoplasty and Sacroplasty

**Date: November 4, 2010**

# Health Technology Assessment

**Vertebroplasty, kyphoplasty, and sacroplasty**

**Peer Review and Public  
Comments and Responses**

November 4, 2010

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*Note: Spectrum is an independent vendor contracted to produce evidence assessment reports for WA HTA program. For transparency, all comments received during the comments process are included. However, comments related to program decisions, process, or other matters not pertaining to the report are acknowledged through inclusion, but are not within the scope of response for report accuracy and completeness.*

## **Spectrum Research response to peer review comments**

### **Michael J. Lee, M.D., Assistant Professor, Department of Orthopedics and Sports Medicine, University of Washington**

*Comment 1 response (p. 32):* Added additional statement that fractures are multi-factorial in origin and occur in the absence of cement augmentation.

*Comment 2 response (p. 33):* Added additional statement that surgical failures are of concern in patients with low bone mineral density.

### **Jeffrey G. Jarvik, M.D., MPH, Professor, Department of Radiology, University of Washington**

*Comment 1 response (p. 28):* Deleted statements about kyphoplasty requiring general anesthesia and overnight hospital stay.

*Comment 2 response (p. 30):* ADR has been corrected to ACR.

*Comment 3 response (p. 20):* This error in numbering of the key questions has been corrected.

*Comment 4 response:* Co-interventions include ancillary treatments such as physical therapy and pain medications. Because such treatments can influence pain and functional outcomes, they should be comparable in both arms of the trial. In order to meet the criterion for equivalent co-interventions, the published paper should state that supplementary treatment is applied equally to treatment and control groups. In the Kallmes paper, no description of how co-interventions (including pain mediation) were applied was included. The Buchbinder paper stated that treatment decisions were made at the discretion of the treating physician, which implies that co-interventions were not standardized.

*Comment 5 response (p. 50):* In the INVEST trial, local anesthetic was used in both treatment and control groups, and was therefore a constant. In the Australian trial, local anesthetic injection was not used (see next response).

*Comment 6 response (p. 56):* As stated by Buchbinder and Kallmes in a published comment:

The assertion that in both trials vertebroplasty was not compared with a true placebo or sham procedure is not correct. As is clearly described in our published protocol and results papers, a dry needle was inserted in the Australian trial; no anesthetic was injected into the facet joint



or periosteum. (pp. 242-243 in Buchbinder, R, Kallmes, DF (2010). *Vertebroplasty: when randomized placebo-controlled trial results clash with common belief*. Spine J. 10(3): 241-3.)

*Comment 7 response (p. 77):* See responses to comments 5 & 6.

*Comment 8 response (p. 79):* Revised the text to remove the reference to decreased opiate use in all groups.

*Comment 9 response (p. 113):* We noted in the report that there were no statistically significant group differences in either pain or functional outcomes in these two RCTs, and that there was a trend toward greater achievement of a clinically important reduction in pain in the vertebroplasty group. We have added a short discussion of potential unblinding in the Kallmes study and its potential effect on perceived pain.

*Comment 10 response (p. 121):* As there are significant differences in study design between the sham controlled trials (Kallmes, Buchbinder) and trials comparing vertebroplasty to conservative treatment (Klazen, Rousing, Voormolen), it was not appropriate to consider them together. Separate statements for the sham controlled studies and the studies comparing vertebroplasty with conservative care have been added. The overall strength of evidence for both categories of study is low.

**Brian M. Drew, M.D., Assistant Clinical Professor, Department of Surgery,  
McMaster University, Medical Director, Hamilton General Hospitals Spine Unit**

*Comment 1 response (pp. 26-29):* We have discussed issues regarding complications associated with non-surgical management in the section entitled Alternative Treatments.

*Comment 2 response (p. 28):* See response to Jarvik comment #1.

*Comment 3 response (p. 29):* We revised this section to state that the only significant difference in the two procedures is the additional equipment and operative time.

*Comment 5 response (pp. 32-33):* We have attempted to address some of the issues about timing of surgery in the discussion of Key Question 3 (differential efficacy) in the discussion of acute vs. chronic fractures.

*Comment 6 response (p. 56):*

- Sham surgery: see response to Jarvik comment #5 & 6.
- Proportion of eligible patients enrolled: according to the enrollment numbers given in the published papers describing these RCTs, 35.4% of eligible patients were enrolled in the Buchbinder study, and 30.4% of eligible patients were enrolled in the Kallmes study.

## Spectrum Research response to public comments

### Clinician/professional organizations

#### Society of Interventional Radiology (SIR)

Comments are attached in the Appendix. No apparent issues were raised that are specific to the content of this HTA.

#### North American Spine Society (NASS)

Comments are attached in the Appendix. No apparent issues were raised that are specific to the content of this HTA.

### Industry

#### Stryker Instruments

*Comment regarding recruitment biases for sham-controlled randomized controlled trials:* The potential for recruitment bias is not limited to sham-controlled RCTs. We noted in the report that from 30-35% of eligible patients were enrolled in the sham-controlled RCTs. These proportions were similar in unblinded RCTs: the FREE and VERTOS 2 studies reported enrollment of 32% and 33% of eligible patients, respectively.

*Comment regarding need for confirmatory studies in addition to the FREE study:* The determination of strength of evidence used in the technology assessment is based on several criteria: quantity and quality of studies, and consistency of findings (see Appendix D). Using this framework, more than one confirming study is needed to meet the quantity criterion.

*Comment regarding restriction to comparative studies:* The scope of the report was largely focused on comparative studies, since issues of efficacy and effectiveness can only be addressed with studies that compare an intervention to an alternative treatment. Non-comparative studies were only considered for descriptions of safety outcomes (since comparative studies may not capture these) or for procedures for which no comparative studies were found (sacroplasty).

#### Medtronic, Inc.

*Comment 3:* Our report covers information about effectiveness and safety extensively. The AAOS document was not available in time for inclusion into the HTA. It is noted that while kyphoplasty is recommended as an option in this document, the strength of recommendation is rated as “weak.”

*Comment 4:* See response to Jarvik comment #1.

*Comment 5:* Findings from the CAFE trial do not meet our inclusion criteria (full-length studies published in peer-reviewed journals).

*Comment 6:*

- The Kumar study was not yet published at the time of our literature search.
- The Komp study does not meet our inclusion criteria, as it is not published in English.
- The Dong study was missed by our literature search. After reviewing the study, we concluded that we would have excluded it from our report because it includes no comparisons of vertebroplasty to kyphoplasty with respect to reported pain. In our report, we focused on summarizing commonly-studied outcomes across studies, and this study did not include analyses of our primary outcomes of interest (pain and physical functioning); its primary purpose was to examine lung function. Addition of this small, low-quality, nonrandomized study would not change our conclusions or strength of evidence.

*Comment 8:* As described in the report, we did not include studies that used administrative databases. The reasoning for exclusion of such studies is outlined on page 56 of the report.

*Comment 9:* The Edidin study did not meet our inclusion criteria (full-length studies published in peer-reviewed journals).

*Comment 10:* The Hulme review was not included because additional, higher quality comparative studies than those that were included in that report were available. As stated in the methods section, “Reports that were published between 2007 and 2010 and whose search ending dates were 2006 or later were considered for inclusion, given that additional comparative studies have been published since 2007.”

*Comment 13:*

- Additional HTAs not included:
  - The CTAF HTAs are summarized in section 1.4 of the report.
  - The Ontario evidence update (October 2010) was not available at the time of our search.
  - The reports by Hayes and ECRI are not publicly available.
- Medicare coverage: Reporting of the National Coverage Determination (NCD) is required for Washington State HTAs, and local coverage determinations (LCD) are not. The LCD for the region which includes Washington State is logically the most relevant to the Washington State HTA process.
- Inclusion of policies of additional payers: Reporting on policies of two bellwether payers is required by the Washington State HTAP. Policies for Cigna and Aetna were included in the report.

- Errors in description of Regence policy: The description of the Regence policy for coverage of vertebroplasty and kyphoplasty has been corrected.

## Peer review comments

**Michael J. Lee, M.D., Assistant Professor, Department of Orthopedics and Sports Medicine, University of Washington**

### INTRODUCTION Comments

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Overview of topic is adequate?
- Topic of assessment is important to address?
- Public policy and clinical relevance are well defined?

The overview of this topic is adequate. The topic of assessment, particularly in light of recent literature is very important to address. Public policy and clinical relevance are well defined.

### BACKGROUND Comments

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Content of literature review/background is sufficient?
- 

The content of this literature review is sufficient.

### Content of literature

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**Page 32**      **Line**

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Regarding statements of new fracture after percutaneous cement augmentation, it should be emphasized that new fragility fractures of the spine occur after conservative treatment of fracture. The etiology of new osteoporotic compression fracture after initial fracture is multi-factorial whether or not the fracture has been treated with cement augmentation. The rates of new fracture after percutaneous cement augmentation need to be compared to the rates of new fracture after conservative treatment in a controlled fashion to determine if there is an associative relationship.

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**Page 33**      **Line**

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Regarding the risks of lumbar fusion for the treatment of osteoporotic compression fractures: In addition the inherent risks and costs of invasive surgery, it should be noted that these risks are particularly elevated in this patient population. From a technical perspective, it is challenging to

obtain surgical fixation in the osteoporotic spine. It has been shown in a multitude of studies that pedicle screw fixation is much less rigid in specimens with lower bone mineral density. Thus, there is a substantial concern for possible screw pullout, other failures of fixation, or junctional failure. Any of these complications can lead to additional surgery. The invasiveness of these surgeries and the elevated medical and surgical risks inherent to this patient population have led clinicians to seek out less invasive approaches to treating these fractures.

### **REPORT OBJECTIVES & KEY QUESTIONS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Aims/objectives clearly address relevant policy and clinical issue?
- Key questions clearly defined and adequate for achieving aims?

Aims clearly address relevant policy and clinical issues. Key questions are clearly defined.

### **METHODS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Method for identifying relevant studies is adequate?
- Criteria for the inclusion and exclusion of studies is appropriate?
- Method for Level of Evidence (LoE) rating is appropriate and clearly explained?
- Data abstraction and analysis/review are adequate?

Methods are adequate, and description of all studies described is detailed and exhaustive. Level Of Evidence is clearly explained. Analysis and review are adequate.

### **RESULTS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Amount of detail presented in the results section appropriate?
- Key questions are answered?
- Figures, tables and appendices clear and easy to read?
- Implications of the major findings clearly stated?
- Have gaps in the literature been dealt with adequately?
- Recommendations address limitations of literature?

The detail presented is thorough and exhaustive. Key questions are answered and figures, tables and appendices are easy to read, though they are many in number. Gaps in the literature have been appropriately addressed, and recommendations do address the limitations of the literature.

### **CONCLUSIONS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Are the conclusions reached valid?

The conclusions reached are valid. They well represent the current literature

### **OVERALL PRESENTATION and RELEVANCY Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Is the review well structured and organized?
- Are the main points clearly presented?
- Is it relevant to clinical medicine?
- Is it important for public policy or public health?

This is an exhaustive detailed report which dissects the literature in this topic. The main points are clearly presented. In light of recent literature, it is of clear relevance to clinical medicine and for public policy and public health.

While the literature at this time is insufficient to conclude unequivocally on the clinical effectiveness, clinical efficacy or cost effectiveness of percutaneous cement augmentation, it is important to note that failure of proof is not synonymous to proof of failure.

Further research is needed to better define the roles these procedures may play in clinical medicine.

### **QUALITY OF REPORT**

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#### **Quality Of the Report**

(Click in the gray box to make your selection)

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**Superior**

**Good**

**Fair**

**Poor**

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**Jeffrey G. Jarvik, M.D., MPH, Professor, Department of Radiology, University of Washington**

### **INTRODUCTION Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Overview of topic is adequate?
- Topic of assessment is important to address?
- Public policy and clinical relevance are well defined?

The overview is very good. The authors describe the 3 augmentation procedures being considered. The key questions follow and in the next section, the methods for evaluating comparative effectiveness are concisely described.

### **BACKGROUND Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Content of literature review/background is sufficient?
- 

The authors review the rapid rise in both the number of vertebral augmentation procedures as well as the cost of those procedures to Washington State. The authors make a clear case as to why this is an important topic.

It identifies all of the major scientific studies investigating vertebral augmentation, highlighting the two recent pivotal studies that demonstrated no benefit of vertebroplasty when compared with local anesthetic injection.

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**Page 28      Line 12**

Kyphoplasty is now being performed as an outpatient procedure without general anesthesia.

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**Page 30      Line 18**

Under “Contraindications for vertebroplasty, kyphoplasty and sacroplasty”, the “ADR” is listed multiple times, but this should probably be the “ACR.”

### **REPORT OBJECTIVES & KEY QUESTIONS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Aims/objectives clearly address relevant policy and clinical issue?
- Key questions clearly defined and adequate for achieving aims?

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**Page 19**      **Line bottom**

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The report's objectives/aims are clearly stated on p. 19. The key questions are well defined and appropriate for achieving the aims.

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**Page 20**      **Line**

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It's not clear why the key questions, when they are repeated here, have different numbers than when they are listed in the table from p14-18, or when listed in the text from p. 9-13.

### **METHODS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Method for identifying relevant studies is adequate?
- Criteria for the inclusion and exclusion of studies is appropriate?
- Method for Level of Evidence (LoE) rating is appropriate and clearly explained?
- Data abstraction and analysis/review are adequate?

Overall, the methods for identifying studies was appropriate and adequate. As far as I could tell, no important studies were left out of the review. The inclusion and exclusion criteria were appropriate. The methods for LoE rating were fairly clearly explained in Appendices D and E. However, the authors could better clarify what is meant by "co-interventions applied equally" as is listed in Appendix D, p. 8. This is important because it is the only criterion that the RCTs of Buchbinder and Kallmes fail to meet. The description of the data abstraction and analysis/review are adequate, except as noted below.

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**Page 50**      **Line**

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2.1.1 Comparator: The authors mention that sham treatment was a comparator, but do not describe other injection treatments, which was the comparator in the two NEJM RCTs. While the Australian RCT describes this comparator as a "sham", the INVEST trial does not, and in fact, local anesthetic injection may be regarded as a viable alternative treatment, not a sham, and worthy of consideration for comparative effectiveness evaluations.

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**Page 56**      **Line**

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Section 2.2.2 Critical appraisal: I believe that the authors are incorrect in describing the Buchbinder trial as not having used local anesthetic. It clearly states in their methods paper (BMC Musculoskeletal Disorders 9; 156, 2008) that the sham procedure was identical to the actual vertebroplasty up to the placement of the trocar against the lamina. Thus, lidocaine was infiltrated subcutaneously and probably deeper, including the laminar periosteum. The authors of



the review could clarify this point with Dr. Buchbinder. In addition to p. 56, the section “Buchbinder 2009” on p. 57 also needs to be amended to reflect this correction.

## RESULTS Comments

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Amount of detail presented in the results section appropriate?
- Key questions are answered?
- Figures, tables and appendices clear and easy to read?
- Implications of the major findings clearly stated?
- Have gaps in the literature been dealt with adequately?
- Recommendations address limitations of literature?

The amount of detail presented is appropriate and all the key questions are addressed. The figures/tables and appendices are clear, easy to read and helpful. Gaps in the literature were clearly acknowledged.

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**Page 77**      **Line**

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The authors of the report repeatedly use the term “sham” to describe the comparator in both the Buchbinder and Kallmes trials, yet, as described above, the comparator in both trials consisted of a local anesthetic injection that should be considered a viable clinical alternative and not a sham. Their report should be amended to reflect this.

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**Page 79**      **Line**

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The authors describe a similar decrease in opiate use in both the vertebroplasty and control groups for the Kallmes study, but this was not the case. As can be seen from their figure on p.79, opiate use in the vertebroplasty group remained essentially unchanged at 1 month (56% vs. 54%) while it decreased in the control group (63% to 43%). This is important, because higher opiate use could influence pain perception.

## CONCLUSIONS Comments

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Are the conclusions reached valid?
- In general, the conclusions are valid. See below for some specific comments

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**Page 113**      **Line**

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Key question 1: Vertebroplasty efficacy

The authors do not mention that the RCTs by Kallmes and Buchbinder were much less ambiguous regarding the lack of functional improvement as compared with pain. Their

conclusion should reflect this difference between pain and functional outcomes. This is potentially important since pain may be much more influenced by unblinding, which could have accounted for at least a portion of the greater improvement in pain in the Kallmes study,

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**Page 121**      **Line**

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It's not clear why the evidence for vertebroplasty is rated as low and not moderate. The criteria for evidence quality, as described in Appendix D, p.9, indicates that both the quality and quantity criteria were met. However, the summary of evidence table on p.121 indicates that the quantity criteria were not met. The quantity criterion is that there be at least 3 adequately powered studies. The RCTs by Kallmes, Buchbinder and Klazen were all adequately powered, although not consistent in their conclusions (understandably because of differences in study design). Nonetheless, they should have satisfied the quantity criterion and thus, with 2 of 3 criteria satisfied, merited a moderate SoE.

### **OVERALL PRESENTATION and RELEVANCY Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Is the review well structured and organized?
- Are the main points clearly presented?
- Is it relevant to clinical medicine?
- Is it important for public policy or public health?
- 

The review is quite well structured and the main points are clearly presented. The review is extremely relevant to clinical medicine and highly important for public policy.

### **QUALITY OF REPORT**

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#### **Quality Of the Report**

(Click in the gray box to make your selection)

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**Superior**

**Good**

**Fair**

**Poor**

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**Brian M. Drew, M.D., Assistant Clinical Professor, Department of Surgery,  
McMaster University, Medical Director, Hamilton General Hospitals Spine Unit**

### **INTRODUCTION Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Overview of topic is adequate?
- Topic of assessment is important to address?
- Public policy and clinical relevance are well defined?

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**Page 6-10**      **Line**

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The review of compression fractures and osteoporosis was accurate. The summary of the various cementoplasty techniques and procedures was also accurate and well done.

The efficacy and effectiveness issues are essential for clinicians to understand. Clinicians can then understand what the potential benefits will be for their patients. These issues were introduced concisely and accurately.

The introduction to the issues regarding safety was well done. It was comprehensive. Accurate and objective knowledge of the safety of the 3 procedures will assist clinicians in helping patients make informed decisions when deciding whether to proceed with a procedure or when consenting for a procedure.

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**Page 19**      **Line**

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It was important to highlight that the patient population has specific health issues and morbidities that pre-date the fracture or occur as a result of the fracture. It was equally important to comment of the potential consequences of leaving a fracture untreated. It was also mentioned that the cementoplasty techniques are not indicated for osteoporosis alone but also for certain tumor-related fractures.

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**Page**      **Line**

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Overall, the clinical relevance of the various cementoplasty procedures were designed to address was outlined well and accurately represented.

### **BACKGROUND Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Content of literature review/background is sufficient?

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**Page 26-29**    **Line**

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The review of osteoporotic and malignant fractures was reviewed well.

I think the issues concerning conventional treatment need to be highlighted or emphasized to a greater degree. Particularly the complications and morbidity associated with the various form of non-surgical management.

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**Page 28**    **Line**

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The technology paragraph states that kyphoplasty almost always requires general anaesthesia and at least one overnight stay. Consideration should be given to the fact that 1 and sometimes 2 level disease can be accomplished under local anaesthesia and conscious sedation. Lumbar and lower thoracic spine fractures can be treated under spinal anaesthesia. At my institution it is very rare that a patient stays overnight, most go home the same day. This occurs with most single level fractures and often with 2 or 3 level fractures. The patient's co-morbidities may dictate admission for an overnight stay but this is the exception and not the rule for most of the kyphoplasties that are done at my institution.

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**Page 29**    **Line 2<sup>nd</sup> paragraph**

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See above comments regarding the need for general anaesthesia and an overnight stay. Also while I agree that the kyphoplasty procedure requires the inflatable bone tamp, the other steps in the procedure are essentially similar to vertebroplasty. The placement of the osseous introducers or cannulae are very similar as is the cement injection steps. The addition of the bone tamp is really the only significant difference. So the ease vertebroplasty over kyphoplasty is relatively small.

### **REPORT OBJECTIVES & KEY QUESTIONS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Aims/objectives clearly address relevant policy and clinical issue?
- Key questions clearly defined and adequate for achieving aims?

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**Page 31-32**    **Line**

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The issues with regard to cement leakage were reviewed well.

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**Page 32-33**    **Line**

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The topic of conservative treatment was highlighted fairly well for fractures that do not heal. This could be expanded on more as this is for the most part the indication for the cementoplasty techniques and ill defined in the literature as to the timing of surgery.

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**Page 47-51**    **Line**

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This section reviews the various studies that are currently underway. This adds to the health technology assessments comprehensiveness and will hopefully assist in the future with helping to answer some of the key questions.

**METHODS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Method for identifying relevant studies is adequate?
- Criteria for the inclusion and exclusion of studies is appropriate?
- Method for Level of Evidence (LoE) rating is appropriate and clearly explained?
- Data abstraction and analysis/review are adequate?

The method in which the systematic literature review was done was quite comprehensive. The tables and flow charts assisted as a good summary tool.

The LoE was excellent and the summary in Appendix D was helpful.

2.2.1 demonstrated the relationship of the LoE to the key questions nicely.

2.2.2 and 2.3.1 This was the section discussing vertebroplasty compared to sham surgery. It was important to raise the issue of whether the local anaesthesia was truly a sham. Also the assessment quoted that 30-36% of eligible patients were enrolled. I have heard that this was as low as 20%. The authors that quoted this number may have been wrong as I am not sure of their source.

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**Page 57-62**    **Line**

The review of the RCT's was comprehensive and accurate.

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**Page 62-64**    **Line**

The more brief review of the cohort studies was appropriate in length and depth.

**RESULTS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Amount of detail presented in the results section appropriate?
- Key questions are answered?
- Figures, tables and appendices clear and easy to read?
- Implications of the major findings clearly stated?
- Have gaps in the literature been dealt with adequately?
- Recommendations address limitations of literature?

The amount of detail presented was comprehensive, summarizing a large body of literature but in a succinct manner. The various figures, tables and appendices summarized the topics well and were easy and clear to read.

The strengths and limitations in the literature were clearly identified. The major points and the conclusions of the higher quality studies were repetitively commented on. This added to the clarity of the assessment. All gaps in the literature were identified. The section on studies that are currently underway addresses some of the gaps in the literature.

**CONCLUSIONS Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Are the conclusions reached valid?

Based on the available evidence reviewed, the conclusions that were presented are fair and valid. They accurately reflect the current literature. The review was objective and systematic in its analysis. The more significant clinical conclusions regarding efficacy, effectiveness and safety of the three procedures were reviewed in more depth which appropriately reflects their importance.

**OVERALL PRESENTATION and RELEVANCY Comments**

**While reviewing this section please keep the following questions in mind, but please comment on any point:**

- Is the review well structured and organized?
- Are the main points clearly presented?
- Is it relevant to clinical medicine?
- Is it important for public policy or public health?

The review was well structured and organized. The table of contents and list of figures and tables made it easy to locate content. The subheadings also assisted in locating content and read.

I had some difficulty with the sections listed for the reviewers to evaluate. There was a background, results and methods (under evidence) section that were clearly titled. The form or guide with the questions listed to keep in mind also seemed to indicate that would be a conclusion section which I realized did not exist as I finished reading the report. The reviewers guide stated “while reviewing this section”. This was only slightly and temporarily confusing and overall did not take away from the organization of the document as a whole.

The main points were presented in a clear fashion. They were repeated several times in various sections which added strength to it.

I believe this topic is extremely relevant. Vertebral compression fractures are a public health issue which is large now and will increase and the population ages. Current medical or non-surgical treatments are failing to prevent or significantly reverse osteoporosis. The morbidity of untreated fractures should not be overlooked. The dangers of prolonged bed rest or immobility, spinal deformity, pain, psychological impacts like patient depression and caregiver stress can not be overlooked. I think this issue could be emphasized to a greater degree in the assessment.

Despite the lack of strong trials, physicians tend to believe in the effectiveness and safety of these procedures. More patients and their families are beginning to advocate for their own care. The issues such as pain, stress, and depression tend to push patients and their families to request physicians to perform these procedures. Upcoming trials will help answer some of the question regarding effectiveness and safety etc. but until then physicians are left with the art of treating these patients so the review of this topic is timely and of great importance.

## **QUALITY OF REPORT**

I could not click in the gray box above but rated the report as superior.

## **Public comments**

### **Clinician/professional organizations**

**Society of Interventional Radiology (SIR): See Appendix pages 1-29**

**North American Spine Society (NASS): See Appendix pages 30-35**

### **Industry**

**Stryker Instruments: See Appendix pages 36-41**

**Medtronic, Inc.: See Appendix pages 42-267**



October 22, 2010

Health Technology Assessment Program  
Washington State Health Care Authority  
P.O. Box 42712  
Olympia, WA 98504-2712

*Submitted electronically at: [shtap@hca.wa.gov](mailto:shtap@hca.wa.gov)*

**RE: Draft Assessment- Vertebroplasty, Kyphoplasty, Sacroplasty**

Dear Colleague,

The Society of Interventional Radiology (SIR) appreciates the opportunity to express our views in regard to the referenced draft technology assessment. At least one of our members will be present at the December 10<sup>th</sup> public meeting on this assessment.

The American College of Radiology (ACR) endorses the opinions expressed in this letter.

The Washington State Radiology Society (WSRS) has also reviewed this letter. Acting President Justin P. Smith, MD, has communicated to SIR that the WSRS endorses the views expressed herein.

The SIR is a professional association that represents 4,700 members who are practicing in the specialty of vascular and interventional radiology. The Society is dedicated to improving public health through pioneering advances in minimally-invasive, image-guided therapy. Our members are at the forefront of new and minimally invasive therapies to treat an array of diseases and conditions without surgery. Interventional radiology treatments have become first-line care for a wide variety of conditions and patients, including osteoporosis patients with spinal fractures, peripheral arterial disease, deep vein thrombosis, uterine fibroids, and stroke patients.

The 34,000 members of the ACR include radiologists, radiation oncologists, medical physicists, interventional radiologists and nuclear medicine physicians. For over three quarters of a century, the ACR has devoted its resources to making imaging safe, effective and accessible to those who need it. The mission of the ACR is to serve patients and society by maximizing the value of radiology, radiation oncology, interventional radiology, nuclear medicine and medical physics by advancing the science of radiology, improving the quality of patient care, positively influencing the socio-economics of the practice of radiology, providing continuing education for radiology and allied health professions and conducting research for the future of radiology.



October 22, 2010

This comment letter is organized into four sections:

- Past Research
- 2009 clinical trials published in the *New England Journal of Medicine*
- New and Ongoing Research
- Summary and our clinical suggestions

We are also attaching to this letter several documents that are materially relevant to our position, and might add to your review.

### ***Past Research***

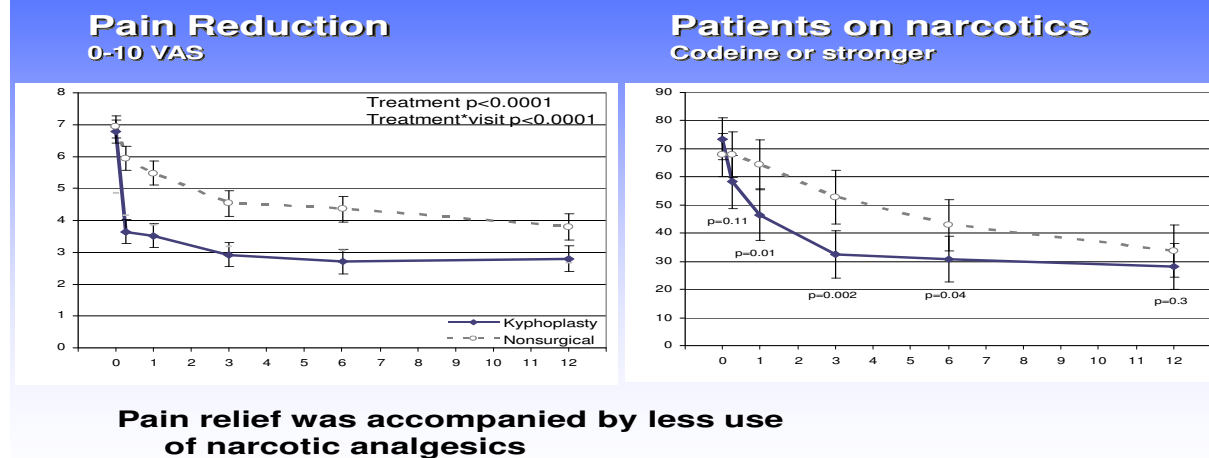
Vertebral Compression Fractures (VCF) are a significant health burden on the Medicare population. Estimates are that over 700,000 VCFs occur annually in the United States as a result of osteoporotic disease (Melton, et al, 1989). The devices/cement used in vertebroplasty and kyphoplasty are FDA- approved, and the procedures have gained wide acceptance in the treatment of patients with painful VCFs caused by osteoporosis, multiple myeloma, vertebral hemangiomas, or metastases. Beyond pain and immobility, other clinical consequences of VCFs include pulmonary dysfunction, chronic spinal deformity, chronic pain, and depression. (Silverman, 1992). Past analysis has shown that mortality risk increases by 23% following the onset of a VCF(s) (Kado, et al 1999).

To date, several key studies have shown that vertebral augmentation procedures result in greater pain relief than conservative medical management. Typical of these studies, Diamond, et al (2006) concluded that “the analgesic benefit of percutaneous vertebroplasty and the low complication rates suggest that it is a useful therapy for acute painful osteoporotic vertebral fractures.”

McGraw, et al (2002), followed 100 patients who underwent vertebroplasty over a 35-month period. Ninety-seven patients (97%) reported significant pain relief 24 hours after treatment. Mean follow-up duration was 21.5 months (6-44 mo) in 99 patients. Ninety-two patients (93%) reported significant improvement in back pain previously associated with their compression fractures as well as improved ambulatory ability. Before vertebroplasty, the VAS score for the 99 patients was 8.91 +/- 1.12 compared to a score of 2.02 +/- 1.95 at follow-up. The mean difference in VAS scores was significant (P <.0001).

In the FREE Trial, Wardlaw and colleagues prospectively randomized 300 patients into two groups: kyphoplasty treatment and conservative care. Patients in the kyphoplasty group showed an average VAS improvement of 5.2 points at 1-month vs the conservative care group. They also show sustained improvements at 3 months, 6 months and 12 months. The kyphoplasty group also required less narcotic use to control their pain than the conservative care group. According to lead researchers Wardlaw and Van Meirheeghe, the two year results of FREE will soon be available and will include information on restoration of height by kyphoplasty.

## FREE Secondary Endpoints: Back Pain and Analgesics



Ashraf, Unpublished Presentation, 2010

The available scientific literature demonstrates that in appropriate patients, vertebroplasty and kyphoplasty are effective treatments for osteoporotic vertebral fractures. However, we acknowledge that performing a randomized control trial is difficult with this procedure, and with this patient population. Accordingly, we believe it is incumbent to look closely at the 2009 studies of Dr. Kallmes and Dr. Buchbinder cited in your review.

### ***2009 New England Journal of Medicine Studies***

In the draft assessment, the HTA notes the two studies by researchers David F. Kallmes, MD and Rachelle Buchbinder, PhD that were published in the August 6, 2009, edition of the *New England Journal of Medicine*. The Society endorses the value of evidence-based medicine and randomized control trials, but we also are of the opinion that weakness in the design of these two NEJM studies, past studies indicating that vertebroplasty is effective, new research, and clinical experience need to be considered also. In sum, our position is that it is very premature- and possibly incorrect- to conclude that vertebroplasty is no better than a control sham procedure (trigger point, facet injection) in treating patients.

We respectfully urge the HTA to review these studies in the context of a much greater body of evidence that supports the efficacy and safety of vertebral augmentation.

In 2007, the *Society's Journal of Vascular Interventional Radiology* originally published the "Position Statement on Percutaneous Vertebral Augmentation: A Consensus Statement Developed by the American Society of Interventional and Therapeutic Neuroradiology, Society of Interventional Radiology, American Association of Neurological Surgeons/Congress of Neurological Surgeons, and American Society of Spine Radiology" on the safety and efficacy of

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spine augmentation, and specifically vertebroplasty and kyphoplasty provided to appropriate patients when performed according to published standards (2007; 18:325-330). SIR is also currently working with other societies to update this 2007 Consensus Position Statement, and a revised Position Statement is expected to be public in early 2011, possibly by the end of this year.

With respect to the two recent studies questioning vertebroplasty, in a November 24, 2009, SIR Commentary on Vertebroplasty and the August Studies in the *New England Journal of Medicine*, SIR states “that several important factors need to be considered prior to accepting these two studies as fact negative (that vertebroplasty is no better than a sham control in relieving pain in patients with symptomatic compression fractures).” Criticisms of both studies include the small numbers of patients treated; the small percentage of eligible patients who were actually enrolled in the trial; inclusion of patients with milder degrees of pain and disability than are usually treated in a typical practice; the small amount of cement injected; treatment of patients with chronic compression fractures; the incomplete use of MRI or CT to confirm that the fracture was the likely source of pain; and the high rate of crossover from placebo to vertebroplasty in one of the studies.

Criticism has also come from one of the studies’ investigators. William Clark, MD, St. George Private Hospital, Sydney, Australia, and an investigator with the Kallmes study, said he regarded that study as “meaningless.” In addition, he called the Buchbinder study “a rush to judgment on ‘science-based medicine’ without applying scientific technique in appraising the studies” in comments posted to the Arthritis Today Web site. Clark noted numerous flaws in the studies, indicating they had “inappropriate patient selection, terrible recruitment and selection bias with the majority not followed.”

SIR believes that the results of these trials are discordant with the more than 15 years of accumulated medical literature clinically confirming the benefits of spine augmentation, specifically vertebroplasty; many of which were large prospective trials. Hundreds of thousands of patients have greatly benefited from vertebroplasty with almost complete resolution of their pain. Tens of thousands of patients on intravenous narcotics have been promptly discharged from the hospital virtually pain free following their treatment. Because the Kallmes and Buchbinder studies are so discordant with the body of literature and personal experience of most physicians who treat patients with painful compression fractures, closer scrutiny of the two studies is warranted.

### ***New and Ongoing Research***

On August 10, 2010, the results of the VERTOS II open-label randomized control trial were published online in *The Lancet*. VERTOS II provides markedly different results from Kallmes and Buchbinder.

In their findings, the VERTOS II authors note that vertebroplasty resulted in better pain relief after one, three, and six months and one year ( $P<0.001$ ,  $P<0.001$ ,  $P=0.025$ , and  $P=0.014$ ,

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respectively) over conservative treatment. No serious complications or adverse events were reported. The incidence of new compression fractures was lower in the vertebroplasty group, although not significantly different from the conservative care (control) group.

The VERTOS II study additionally notes that vertebroplasty appears to be a cost effective treatment. The “adjusted trial-based incremental cost-effectiveness ratio for vertebroplasty, as compared to conservative treatment, was €22,685 per QALY gained.” While we concur that many VCFs heal on their own through conservative treatment, the long term costs of conservative care, pain narcotics, extended hospitalizations, risks of deep vein thrombosis, pressure sores, and often the need for skilled nursing (or extensive family care) must be acknowledged as costs of conservative care. As one of our Washington state member physicians communicated to SIR, “the typical patient is discharged from the hospital the next day after vertebroplasty. At our hospital, the hospitalists rely on this procedure to get their patients out of bed and discharged.” This is a major cost benefit compared to conservative care.

The principle limitation of the VERTOS II study is the lack of a sham control. However, this limitation deserves closer analysis. In fact, Dr. Kallmes has recently stopped using the term sham for patients that receive medial branch block and has changed it to “control intervention.” However, we in the medical provider community would comment that it is extremely difficult to recruit patients to a sham controlled trial, and it may not be feasible to conduct a study of this type. Of note, in the Kallmes study, many US institutions would not endorse sham trials and many investigators remain wary of sham trials.

Therefore, the VERTOS II study represents the highest quality of data regarding percutaneous vertebroplasty for symptomatic vertebral compression fractures. The strength of this study is the on-going positive benefit at the one year follow up period. In addition to long term pain relief, this study demonstrated a very rapid pain relief. Short term pain outcome is vitally important in and of itself as patients with disabling acute pain are at significant risk of further complications and are not candidates for long term conservative therapy.

Ongoing analysis of Medicare claims data also indicates that patients who do not receive surgical care appear to have an increased risk of death in the period after a VCF (Edidin, et al 2010). Using Medicare claims data, 81,662 patients that had a vertebroplasty or kyphoplasty procedure had a higher survival rate at 24 months than non-operated patients: 74.8% versus 67.4% for non-operated patients. Vertebral augmentation patients were 44% less likely to die than non-operated VCF patients (adjusted OR=0.56, p<0.0001). This data underscores that conservative treatment does indeed carry genuine risks to elderly patients, many of whom have other co-morbidities such as diabetes, COPD, or cardiovascular disease.

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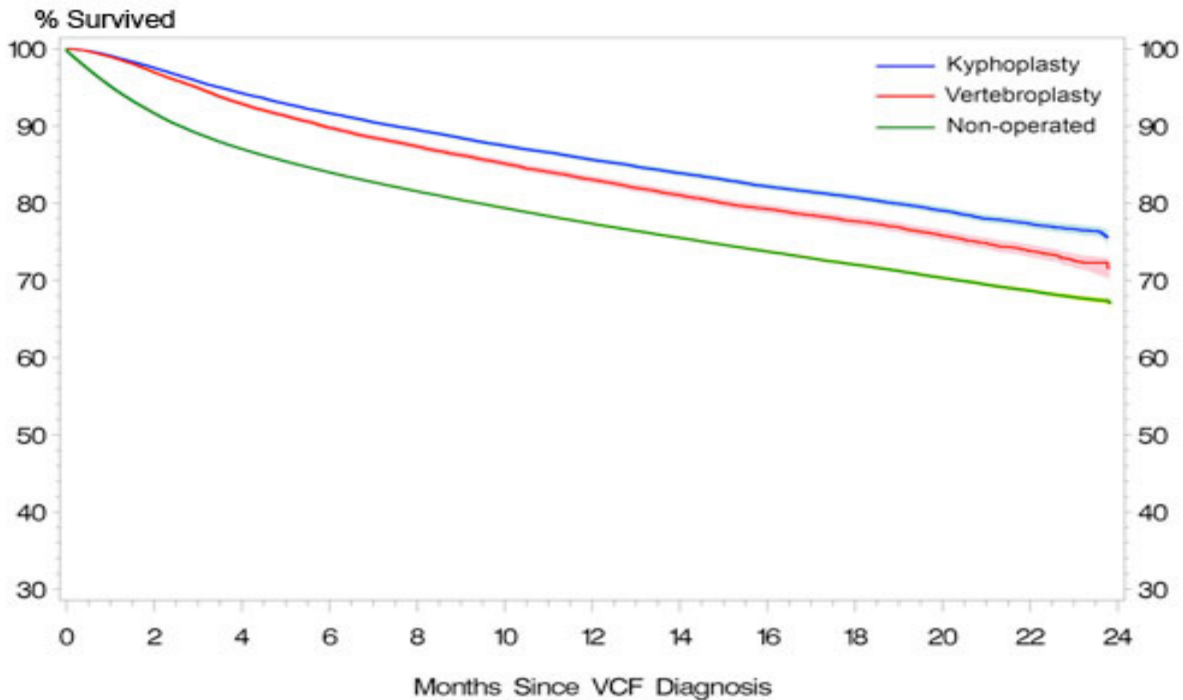


Fig. 1: Survivorship of non-operated VCF patients and VCF patients who underwent vertebroplasty or kyphoplasty between 2006 and 2007, following VCF diagnosis.

*Edidin, et al 2010*

SIR will be part of future trials of vertebroplasty that may confirm or contradict these studies or may identify subsets of patients more likely to benefit from vertebral augmentation. The SIR remains an active participant in trials, and we anticipate that spinal procedures will once again be highlighted at the SIR's Annual Scientific Meeting in March, 2011.

## **Summary**

In our professional forums, and at our annual meetings, we take great care to ensure that the clinical training and symposia offered to our members reflect the highest standard of medical evidence and optimum patient care practices. The SIR's revised Position Statement will again emphasize the evidence-based course of care for VCF patients, to include a physical exam, imaging to confirm an acute/subacute fracture(s) with anatomy appropriate for vertebroplasty, patient documentation, explanation of risks, benefits, and alternatives to the patient and family, follow up care protocol including osteoporosis evaluation, and detailed post-procedure correspondence with the referring physician. The American College of Radiology guidelines are currently being updated as well and will have updated patient selection appropriateness criteria.

We recognize and encourage preoperative evaluation and management for all of these patients with appropriate physical examination and additional imaging studies as indicated to best define the clinical diagnosis of vertebral compression fractures. In the setting of fractures establishing

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the diagnosis of osteoporosis, the treating physician will also coordinate with the primary provider to help initiate the work-up and treatment of osteoporosis consistent with National Osteoporosis Foundation (NOF) guidelines and PQRI. SIR also recognizes the interventional radiologist has the requisite clinical acumen to make appropriate treatment decisions in this set of patients. In our clinical opinion, SIR recommends that follow-up appointments should be scheduled either with the operating or referring physician by 2 weeks. The patient should be instructed to contact either physician sooner if other symptoms occur. Discussion with the patient and family should review other important symptoms including: Increased pain, extreme fever, numbness or tingling in limbs, and finally any neurologic complications, etc.

In sum, based on medical evidence, SIR considers percutaneous vertebroplasty or kyphoplasty as medically appropriate treatment when standard medical therapy has failed to relieve symptoms and any of the following criteria is met:

- osteoporotic, osteolytic, osteonecrotic (i.e., Kummell disease), or steroid-induced vertebral compression fracture(s) with persistent, debilitating pain unresponsive to conservative medical management. Clinical questions to consider with regard to timing intervention include the patient's ability to accomplish activities of daily living (ADLs), excessive pain requiring high or IV narcotic dosages, skilled care needs, occurrence of additional fracture, and the risk of further vertebral collapse
- back pain secondary to destruction of vertebral body due to osteolytic vertebral metastasis or multiple myeloma
- acute compression fractures so painful that hospitalization is required
- painful and/or aggressive hemangioma or eosinophilic granuloma of the spine

We believe that the scientific evidence supporting the continued payer coverage of vertebroplasty and kyphoplasty is strong, and that in our opinion, the procedures are cost-effective in that they allow many patients to recover at home, instead of a potential lengthy hospital stay. Many patients are benefiting from vertebral augmentation procedures every day and enjoying a more active lifestyle with fewer complications as a result of the procedures.

We thank you for the opportunity to express our opinion on the technology assessment. If the SIR can be of any assistance during your review, please do not hesitate to contact Tricia McClenny, Interim Executive Director at (703) 460-5565, or [tmccclenny@sirweb.org](mailto:tmccclenny@sirweb.org).

October 22, 2010

Sincerely,



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Encl: 1) 2007 Position Statement on Percutaneous Vertebral Augmentation: A Consensus Statement Developed by the American Society of Interventional and Therapeutic Neuroradiology, Society of Interventional Radiology, American Association of Neurological Surgeons/Congress of Neurological Surgeons, and American Society of Spine Radiology

2) November 24, 2009 Society of Interventional Radiology Commentary on Vertebroplasty and the August Studies in the New England Journal of Medicine

3) William Clark, M.D., St George Private Hospital, Sydney, Australia: "I was the Australian operator in Kallmes et al and regard the study as meaningless. I have conveyed this to Dr. Kallmes." <http://www.arthritistoday.org/news/vertebroplasty-no-benefit.php> (Arthritis Today, Sept. 5, 2009) (Link accessed 8/11/10)

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cc: Gerald Niedzwiecki, MD, FSIR, Chair, SIR Economics Committee  
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October 22, 2010

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## **North American Spine Society Newly Released Vertebroplasty RCTs: A Tale of Two Trials**

### **Summary**

On August 6, 2009, the *New England Journal of Medicine* published two randomized controlled trials on vertebroplasty: *A Randomized Trial of Vertebroplasty for Painful Osteoporotic Vertebral Fractures* [1] and *A Randomized Trial of Vertebroplasty for Osteoporotic Spinal Fractures* [2]. As the only multidisciplinary organization representing spine care providers, the North American Spine Society (NASS) has reviewed the studies and crafted the following comments on these important new studies and their significance to patient care.

A common initial reaction to the findings of these two prospective randomized controlled trials (PRCTs) has been surprise and even disbelief. A prominent, respected academician-surgeon who is an internationally respected leader in the field of osteoporosis research had described the procedure as “an opportunity to do something really good for patients [3].” Numerous large case series, both prospective and retrospective, had demonstrated very encouraging results with dramatic pain relief in appropriately selected patients. Even higher level data derived from a prospective comparative cohort study indicated a clear benefit over nonoperative treatment [4]. Moreover, for any physician who has performed vertebral augmentation procedures for osteoporotic compression fractures, experience has indicated that patients have dramatic pain relief, often within hours of the intervention. Some of the authors have personally seen these seemingly miraculous cases in which a bed-bound elderly person has had one or two vertebrae augmented after which they become nearly pain free and ambulatory. The evidence and experience up to the publication of the studies by Buchbinder et al. and Kallmes et al. have been overwhelmingly positive. Spine care providers are now, however, faced with a large chasm between these previous data and experiences and the latest, highest quality data.

The two PRCTs in question could be scrutinized. Like any attempt at comparing two treatments in a systematic and controlled manner, there are inevitably biases and factors that can favor one treatment over another. However, there is no such thing as an infallible PRCT. That being said, any group who undertakes such a task should be praised.

The intent of this analysis is not to in any way defame the studies or question the integrity of the authors. Instead, it is to perhaps help explore why there is such a seeming disconnect between the conclusions of these two PRCTs and previous experience and data. Without being overly critical and judgmental, there are a number of key factors that should be noticed.

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## **Patient Selection**

### *Fracture Acuity*

The acuity of osteoporotic vertebral compression fractures (VCFs) has long been thought to influence the results of cement augmentation. Using a bone scan as a measure of fracture acuity, one study, of which Dr. Kallmes was a coauthor, concluded that “increased activity ... is highly predictive of positive clinical response to percutaneous vertebroplasty [5].” While bone scans are no longer commonly used in the diagnostic evaluation of vertebral compression fractures, magnetic resonance imaging (MRI) scans are. Extrapolating from the scintigraphic data, it is generally believed that fracture edema, defined as increased signal on a fat-suppressed image or decreased signal on a T1-weighted image, noted on an MRI would be similarly predictive of a positive response to vertebral augmentation.

In fact, Buchbinder et al. utilized fracture edema or a fracture line detected on an MRI as part of the inclusion criteria. Buchbinder et al. further validated that “bone marrow edema indicates an acute fracture.” However, by their description, a detectable fracture line sufficed for inclusion in the study. It is possible that the presence of a fracture line might indicate a cleft of nonunited bone, but it is unclear if this is a sign of an acute fracture. In contrast, Kallmes et al. utilized MRI or bone scan only in cases in which the fracture age was uncertain.

Both groups indicated that eligible patients had to have a fracture that was less than one year old. However, a fracture age of one year or less is not generally described as acute. In fact, most would define a maximum age of four to six weeks as the definition of an acute fracture [6, 7]. Thus, there appears to be some inconsistency between previous literature and the current studies in the description of a fracture as acute. Furthermore, it would seem that chronological age of the fracture is difficult to measure by radiographic means and would be more aptly “measured” by patient history (i.e., time elapsed since the pain started).

It should be noted that many of the patients in both the Buchbinder et al. and the Kallmes et al. studies had fractures that were less than six weeks old. In the former, 32 percent were less than six weeks old. In the latter study, 44 percent of fractures were one to fourteen weeks old. Admittedly, subgroup calculations did not demonstrate statistically significant differences between older and younger fractures with the available numbers.

Regarding fracture acuity, it is useful to consider a recently published, non-industry sponsored, non-randomized prospective double-cohort study that compared vertebroplasty to nonoperative treatment for VCFs [4]. While this study found statistically significant differences at three months follow-up, there was no difference at six months and one year follow-up. This study provides compelling evidence that pain from osteoporotic VCFs substantially diminishes over time. Furthermore, it would be reasonable to conclude that sometime between three months and six months fracture pain reduces to a level equivalent to the pain reduction that might be observed with vertebroplasty. Thus, the results of the Kallmes et al. and Buchbinder et al. studies are not surprising at all. The plurality of fractures was greater than three months old suggesting that fracture pain should have been substantially reduced. It is possible that this group was self-selecting as they may have been the most willing to be randomized to a so-called sham procedure.

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### *Enrollment*

Enrolling patients in a PRCT is a difficult task. Trying to explain to someone who is in excruciating pain that he or she will be assigned, at random, to either the group getting the new, promising procedure or to the group getting a sham injection is a difficult task. By the very nature of this conversation, many patients will not consent to the study, representing a selection bias. It is reasonable to think that patients in severe pain would more often opt to decline the study and proceed with vertebroplasty. It would have been useful to see the outcomes of this group of patients; similar to that published by Weinstein et al. in the recently published Spine Patient Outcomes Research Trial (SPORT) studies for lumbar degenerative disorders [8].

This pattern seemed to have been the case with the two studies in question. In the Kallmes et al. study, 1812 patients were initially screened, yet only 131 were entered into the study. The most common reason for not being entered into the study was patient refusal. Similarly, Buchbinder et al. required 4.5 years to accrue 78 patients at four high volume centers, reporting that 141 who satisfied all inclusion criteria declined randomization. The pain severity and functional compromise of the groups of patient who refused participation were not reported. Thus, there exists an unquantifiable selection bias in the final patient group.

### *Control Group*

The control groups in both of these studies underwent supposed sham procedures. However, this was not so much a sham procedure as it was an alternative intervention. Injection of anesthetic into the facet capsule and/or periosteum may have had a plausible mechanism of pain relief in this patient population, albeit not fracture pain relief. While it is stated in both studies that patients had back pain, it is unclear if the origin of the back pain was the osteoporotic VCF or other common reasons for back pain in the elderly, such as arthritis facet pain. By nature of the patient population studied, “sham” facet injections may have led to decreased facet pain. Perhaps a sham procedure in which a dry needle was inserted might have been a more appropriate control.

### *Outcomes*

In the Kallmes et al. study, the investigators stated that back pain was measured. However, there did not appear to be an effort to determine if reported back pain indeed originated from the osteoporotic fracture site. In the experience of some spine care providers, related to vertebral augmentation, it has been found useful to percuss or palpate the spinous processes systematically in order to find a level of maximal tenderness. This can then be marked with a radiographic marker to help localize the region of pain to a specific fractured vertebra. It is not uncommon for a patient to have pain that is distant from the fracture site, which would greatly diminish confidence that the perceived pain was originating from the fracture site. A bit more confusing was the assessment of “overall pain” in the Buchbinder study. It is unclear if this was an assessment of back pain or a more general measure of patients’ bodily pain.

Another important observation concerns the pain reduction observed in these two PRCTs. In the Kallmes et al. study, the authors reported an average reduction of three Visual Analog Scale (VAS) points at one month follow-up. In the Buchbinder et al. study, an average reduction of 2.3 was reported. In a recently published, industry-sponsored, PRCT comparing kyphoplasty (a comparable vertebral augmentation procedure to vertebroplasty) to nonoperative treatment, an average pain reduction of 3.5 VAS points was

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reported [1]. The results of these three PRCTs do not appear to be dissimilar, notwithstanding other differences in the study.

### **A Look to the Future**

Both groups of authors should be congratulated for undertaking the onerous task of performing high-level studies on an imminently important clinical disorder in our aging population. It is hoped that these data will help better define the indications for this potentially beneficial procedure. In addition, future PRCTs might benefit from a more strict mechanism by which patients with truly acute pain relatable to an osteoporotic VCF are enrolled. As both the Buchbinder et al. and Kallmes et al. study have taught us, this is likely to be a difficult task that may take a long period of time.

### **Conclusion**

Beyond the lay press releases which claim “Vertebroplasty found to be useless for osteoporotic fracture and disc pain,” [9] it is time for cooler heads to prevail. The medical literature thirsts for evidence. The data from these two studies must be considered carefully and thoughtfully. As discussed above, the findings of these investigations are not surprising and indeed not that dissimilar to previous data. The conclusions drawn by the authors, however, may not be as decisive as they appear. More practical conclusions should be made based on a thorough and systematic review of *all* the literature in order to better define the subgroup of patients for which vertebroplasty might be most appropriate.

*On Behalf of the North American Spine Society*

*Christopher Bono, MD  
Evidence-based Compilation & Analysis Director  
Evidence-based Guideline Development Committee Chair*

*Michael Heggeness, MD, PhD  
Former Research Council Director*

*Charles Mick, MD  
Health Policy Council Director*

*Daniel Resnick, MD  
Clinical Research Development Director*

*William C. Watters, III, MD  
Research Council Director*

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Disclosures:

Christopher Bono, MD

Current Royalties: Life Spine (Level B );  
Consulting: Depuy Spine (Level B), Medtronic Sofamor Danek (Level B);  
Speaking and/or Teaching Arrangements: Depuy Spine (Level C); Stryker Spine (Level B)  
Boards of Directors: North American Spine Society  
Other Offices: Applied Spine (Level B, Adverse Events Panel)  
Research Support: Staff and/or materials: Archus Orthopedics (Level B); Synthes Spine (Level D)  
Grants: Stryker Spine (Level D)  
Fellowship Support: Depuy Spine (Level E)

Michael Heggeness, MD, PhD

Current Royalties: Relieva Medsystems (Level C)  
Stock Ownership: Relieva Medsystems (Level D)  
Consulting: Relieva Medsystems (Level D 2008, None 2009)  
Boards of Directors: North American Spine Society  
Research Support: Investigator Salary: Department of Defense (Level E)  
Grants: Department of Defense (Level I, not directly related to the spine)

Charles Mick, MD

Current Boards of Directors: North American Spine Society

Relationships Outside the One Year Requirement

DePuy (Level A), Synthes (Level A), St Francis Medical (Level A) (Other [NASS Board, Coding Committee, Performance Measure Committee, Advocacy Council Chair, Annual Meeting, NASS RUC Rep])

Daniel Resnick, MD

Current Boards of Directors: North American Spine Society

Relationships Beyond One Year Requirement

Medtronic (Consultant 2003-2006, minimal-less than Level B over entire duration)

William C. Watters, III, MD

Current Consulting: Stryker (Level C)  
Boards of Directors: North American Spine Society  
Scientific Advisory Board: Intrinsic Therapeutics (Nonfinancial, Stock Options (No current value))  
Others: Blackstone Medical Inc. (Financial, Clinical Events Committee for clinical trial)

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Range Key:

Level A. \$100 to \$1,000

Level B. \$1,001 to \$10,000

Level C. \$10,001 to \$25,000

Level D. \$25,001 to \$50,000

Level E. \$50,001 to \$100,000

Level F. \$100,001 to \$500,000

Level G. \$500,001 to \$1M

Level H. \$1,000,001 to \$2.5M

Level I. Greater than \$2.5M

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**To: Washington State Health Care Authorities**

**Date: October 20, 2010**

**Re: Washington Health Technology Assessment on Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty**

Stryker is pleased for the opportunity to submit comments on the draft technology assessment on percutaneous vertebroplasty (PV), kyphoplasty and sacroplasty. We are a global leader in medical technology and offer products and services which span a broad range of medical specialties. Among these, are products used to perform PV and kyphoplasty. The Washington health technology assessment of these procedures primarily focuses on an analysis of the efficacy based on randomized studies and an analysis of the effectiveness based on nonrandomized observational studies. The results of this analysis suggest that the Health Technology Clinical Committee will consider both vertebroplasty and kyphoplasty investigational and shift the existing coverage guideline to one that precludes coverage. However, we feel strongly that such a shift from coverage to non-coverage for an accepted standard of care requires robust data *disproving* effectiveness in specific patient populations and this level of robust data does not exist. To the contrary, we believe that there is adequate evidence proving the effectiveness and benefit of both treatments. We, therefore, believe it is appropriate for the Health Technology Clinical Committee to consider this assessment in a manner similar to any other medical reference, integrating the information with all other pertinent information to allow physician providers to make decisions within the context of individual patient circumstances and resource availability.

Our comments are summarized below with more detailed discussion in the following sections.

**In brief:**

- In 2009, the publication of two sham controlled randomized studies of PV prompted many health policy makers to reconsider the existing positive coverage of PV and kyphoplasty.
  - While these randomized studies have been characterized as “negative,” the Washington health technology assessment correctly concludes that these studies are merely inconclusive.
  - Therefore, there is no strong data to show that PV is ineffective.
- While sham controlled studies are considered the highest form of evidence, it has been extremely difficult to enroll adequate numbers of patients, as reflected in the small size and poor accrual to the recent studies.
  - This situation suggests that an evidence requirement calling for sham controlled studies is not feasible.
  - Sham controlled studies are also associated with a selection bias as patient enrollment is influenced by the design.
- The VERTOS II trial and the FREE study of kyphoplasty are unblinded, randomized studies comparing PV and kyphoplasty, respectively, to medical management.

- These studies represent the best available data; however, the technology assessment devalued these positive results due to the absence of a sham control.
- Given that PV and kyphoplasty are considered standards of care, it is appropriate to consider the overall weight of the evidence, including data from retrospective and prospective case series that consistently reports the clinical benefit of the two procedures.
  - All of the private payers cited in the technology assessment consider PV and kyphoplasty as medically necessary based on this weight of the evidence.
    - These policies reviewed the two sham controlled trials and noted the data is inadequate to reverse the existing coverage policies.
- Based on these considerations, we encourage the Health Technology Clinical Committee to recommend continued coverage for PV and kyphoplasty thus ensuring patients of Washington state agencies continued access to these procedures.

### **Sham Controlled Randomized Studies**

As noted in the technology assessment, two recently published sham controlled randomized studies of percutaneous vertebroplasty (Buchbinder 2009, Kallmes 2009) “did not have adequate power to detect differences in the proportion of patients with clinically meaningful improvement.” The inability to enroll large number of patients in a sham controlled study is a common problem for all surgical procedures, particularly for percutaneous vertebroplasty, which is considered a standard of care by many physicians.

While randomized controlled trials are considered the highest form of evidence, the biases inherent in recruiting patients into a sham controlled randomized study must be recognized. Patients in acute or subacute pain would be unlikely to enroll in a trial without an active treatment arm. However, these are the patients who may be the most likely to benefit from percutaneous vertebroplasty, as noted in a commentary by the National Association of Spine Surgeons (NASS) and in letters to the editor in the *New England Journal of Medicine*. Therefore, not surprisingly, the majority of patients enrolled in these trials had chronic pain, a patient group less likely to benefit from percutaneous vertebroplasty.

The only conclusion that can be drawn from these two sham studies is that the randomized studies were inadequately powered to show a treatment effect, a conclusion which is correctly stated in the technology assessment. *However, it is important to note the lack of data does not mean that there is a lack of benefit. Instead, the randomized studies reflect the difficulty of performing sham controlled studies of an accepted standard of care.*

### **Unblinded Randomized Studies**

The technology assessment also reviews the recently published VERTOS II study (Klazen 2010), a randomized study comparing PV with continued medical management. This study is the only randomized study of PV that has enrolled patients with acute osteoporotic fractures. As noted in the technology assessment, this study “demonstrated



statistically significant improvement in pain scores that was sustained to the 12 month follow up.”

The technology assessment correctly notes the “extent to which lack of patient blinding and possible placebo effect may contribute to the findings is not clear,” reflecting the lack of a sham control. However, given the extreme difficulty in enrolling patients to a sham controlled trial, the VERTOS II study represents the highest quality data regarding PV for acute fractures. Part of the strength of this study is the persistent benefit at the 1 year follow up, *which would surpass the duration of any possible placebo effect*. In addition to long term pain relief, this study demonstrated a very rapid pain relief; this short term outcome is very important in and of itself because patients with debilitating acute pain are not candidates for long term conservative therapy. Essentially, prompt relief of pain is one of the most basic principles of medicine.

*It is certainly true that a sham-controlled trial provides the highest quality data, but alternative data, such as the VERTOS II study should not be dismissed because it does not meet an unrealistic standard. In addition, the technology assessment included three other studies that consistently reported that percutaneous vertebroplasty was associated with improved pain relief compared to conservative medical management.*

The technology assessment also reviewed a large randomized trial (the FREE study) comparing kyphoplasty to medical management in 300 patients with acute osteoporotic vertebral fractures. (Wardlaw 2009) Compared to the control group, the balloon kyphoplasty patients showed:

- Greater improvement in SF-36 physical component summary score at one month that was maintained on average over the 12-month period.
- More improvement in back function as measured by the *Roland-Morris Back Function Scale* at one month and at 12 months. Additionally, they reported fewer days of limited activity due to back pain and less walking aid usage over the 12-month period.
- Less back pain and reduced usage of analgesics over the 12-month period.

Regarding this trial, the technology assessment noted “only one RCT compared kyphoplasty with conservative treatment, reporting that while pain was reduced more rapidly in kyphoplasty patients, this advantage over conservative treatment was diminished by the one year follow up. Because of the paucity of RCTs comparing kyphoplasty to conservative treatment, the overall strength of evidence is low and effect estimated may change with additional research.”

*This conclusion of the technology assessment implies that multiple randomized trials are needed. The FREE study was a large RCT of 300 patients performed in 21 institutions. While confirmatory studies may be appropriate for small randomized trials, the large size and multiple institutions participating in the FREE study mitigates the need for multiple confirmatory studies. Additionally, the assessment cites two additional non-randomized studies that consistently reported improved pain relief associated with kyphoplasty.*

## The Weight of the Evidence

The study selection criteria of the technology assessment were limited to studies that compared vertebroplasty or kyphoplasty with a comparison group using a randomized controlled trial or cohort study design. As noted above, randomized controlled trials of standards of care are difficult if not impossible to conduct and the technology assessment concluded that the absence of a sham control makes limits any possible conclusions. These parameters essentially guaranteed the literature would be considered inadequate.

In this situation, it is important to consider the weight of the evidence from the overall body of literature. The assessment did consider systematic reviews, which included a broader selection of studies, but only in the context of safety. In general, these studies published by a number of institutions within and outside the United States have consistently reported favorable outcomes for both PV and kyphoplasty. A summary of the efficacy outcomes in these studies can be found in Tables 6 and 7 in the 2010 Blue Cross Blue Shield Association Technology Assessment.

It is evident that payers have considered the positive weight of the evidence in the development of their existing coverage policies. All of payer coverage policies cited in the technology assessment state that PV and kyphoplasty are considered medically necessary, i.e. not investigational. Many of these policies note the absence of high quality clinical trials but point to the consistent results of prospective and retrospective cases series, studies that were excluded from the Washington health technology assessment. In addition, many of these payers reviewed the two sham controlled studies of percutaneous vertebroplasty published in 2009 (Kallmes 2009, Buchbinder 2009) and concluded that the inconclusive results of these studies are inadequate to overturn the existing positive coverage policy. The Anthem medical policy provides a representative sample:

“Evidence regarding efficacy of percutaneous vertebroplasty (PV) comes from a number of prospective, uncontrolled trials, case series reports, and several retrospective studies. Two large case series (total of 421 participants) indicated percutaneous vertebroplasty (PV) was highly effective in significantly reducing pain and increasing mobility in over 70% of individuals with vertebral body lesions with minimal complications. Additionally, a number of smaller prospective, uncontrolled studies and several retrospective studies (total of 564 participants) all reported that PV significantly reduced pain and improved mobility in the majority of participants, with few individuals experiencing persistent mild pain. Results from the majority of these studies indicate PV can produce significant pain relief, increase mobility, and improve quality of life in 70% to 80% of individuals with osteolytic lesions from hemangiomas, metastases or myeloma, or osteoporotic compression fractures. In these studies, pain relief was apparent within 1 to 2 days after injection and persisted for at least several months and up to several years. Complications were relatively rare with a higher rate in individuals with malignant processes, due primarily to leakage of cement from extensive lytic regions in the vertebral bodies and to the poor overall health status of these individuals.

...Given the subjective outcome of pain, a placebo effect is expected with both vertebroplasty and kyphoplasty. Therefore, a placebo-controlled randomized controlled trial would ideally confirm that the treatment effect surpasses the placebo effect. Although such a study has not been done, the reported cases series from multiple different institutions have consistently reported statistically significant reductions in pain compared to baseline. When long term results are reported, the treatment effect appears to be durable. Based on this data, both kyphoplasty and vertebroplasty have emerged as an accepted option for those with vertebral lesions that have not responded to conservative therapy. However, individuals who undergo either procedure should be informed of a significant risk of subsequent spinal fracture. Whether this risk is greater than the natural history of the treated condition as a result of the procedure is not known.”

In summary, we respect the thorough technology assessment commissioned by the Washington State Health Care Authority, but contend that as a standard of care, any assessment of PV or kyphoplasty must consider the overall weight of the evidence rather than invoking an evidences standard of sham controlled randomized studies which, based on the poor enrollment of such studies, has been shown to not be feasible. A preponderance of private payers have considered the weight of the evidence, which includes the large number of retrospective and prospective cases that have consistently reported positive results, and concluded that percutaneous vertebroplasty and kyphoplasty are medically necessary and not investigational.

We thank you for the consideration of our comments on this topic.

Sincerely,

Dr. Rodney Parker  
Sr. Regulatory Affairs Manager, Clinical Affairs  
Stryker Instruments

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## Appendix A

NASS comment

Evidence of the Clinical Effectiveness  
and Safety of Kyphoplasty in the  
Treatment of Vertebral Compression Fractures

*Medtronic, Inc. Response to the  
State of Washington Health Care Authority  
Health Technology Assessment  
On Vertebroplasty, Kyphoplasty and Sacroplasty*

October 20, 2010

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**1. PURPOSE**

The purpose of this document is to provide the Washington State Health Care Authority with additional evidence demonstrating the clinical effectiveness, safety, and coverage of kyphoplasty in the treatment of vertebral compression fractures (VCFs) that were not included in the Health Technology Assessment (HTA) dated October, 7, 2010. In addition, corrections to certain mischaracterizations that appear within the HTA are submitted for consideration.

In addition, three appendices are referenced that contain supplemental material as described below:

1. Appendix 1 lists and summarizes the 97 peer reviewed publications reporting original data on the treatment outcomes of cohorts of 10 or more patients treated with kyphoplasty based on a literature search conducted April 5, 2010
2. Appendix 2 reviews the safety of kyphoplasty and compares it to a different procedure, vertebroplasty
3. Appendix 3 contains information on existing health technology assessments (HTAs), national payer coverage policies, and CMS local coverage decisions (LCDs) that were not addressed by the Washington State Health Care Authority HTA and submits corrections to information that was mischaracterized.

**2. Vertebral Compression Fractures – Increased Deformity, Morbidity and Mortality**

The presence of vertebral deformities and/or kyphosis has been shown in multiple studies published in the last two decades to profoundly impact the health, quality of life, and survival of patients with VCF. All of these studies were performed on patients who were medically stable but showed evidence of vertebral deformity on plain film X-ray, and/or had measurable kyphosis.

Osteoporotic spinal deformity alone is associated with severe health consequences – reduced pulmonary function, reduced physical function, appetite loss resulting in physical frailty, gait alterations that impair mobility and balance, chronic back pain related to facet tension and/or paraspinal muscle fatigue associated with compensatory posture, loss of quality of life, increased risk of future fracture, and decreased survival.<sup>1,2,3</sup> These effects are related to the severity of the spinal deformity and are independent of acute fracture pain.<sup>4</sup>

<b>Clinical Study Documented Health Effects of VCF Related Deformity</b>
1. Even one deformed vertebral body detected radiographically reduces physical function in elderly women. <sup>5</sup>
2. Patients experience a 9% reduction in forced vital capacity for each thoracic prevalent VCF. <sup>6</sup>
3. Patients with 3 or more prevalent VCFs lose quality of life similar to patients with cardiac disease, peripheral disease, and diabetes mellitus. <sup>7</sup>
4. Vertebral compression fracture excess mortality is similar to that of hip fracture. <sup>8</sup>
5. Community-dwelling elderly subjects with spinal hyperkyphosis were 50% more likely to die within four years than the population in general. <sup>9</sup>
6. VCFs beget more VCFs – future fracture risk roughly doubles with every two prevalent (chronic) fractures. <sup>10</sup>

These documented effects are also predicted by spinal biomechanics. The collapse of the anterior spine decreases patient height and tilts the patient’s trunk forward, increasing the forward bending moment on the front of the spine. This increases anterior loads, predicting increased fracture risk with increasing deformity. It also reduces thoracic space, affecting pulmonary function, and decreases abdominal space, reducing appetite. Hamstring foreshortening leads to the altered gait and mobility loss.<sup>11</sup> Sources of chronic back pain include paraspinal muscle firing to maintain a compensatory stance for upright posture and/or tension on the facets due to abnormal forward curves, as well as rib-on-pelvis pain in severe deformity.<sup>12</sup>

All of the effects of uncorrected vertebral deformity predicted by the biomechanics of the spine have been documented in osteoporotic patients with prevalent VCFs and/or spinal deformity in the absence of acute back pain. Table 2 provides the mechanism for the sequelae observed in patients who undergo non-surgical management, resulting in spinal deformity.<sup>12</sup>

Table 2	
Mechanical Effect of VCF	Predicted Clinical Consequences
↓ Thoracic space	↓ Pulmonary function
↓ Abdominal space	↓ Appetite → ↑ frailty, ↑ GI effects
↑ Force on anterior vert. body	↑ Future VCF risk
Center of gravity shifts anterior	Forward force → compensatory stance to stand upright
Kyphosis, compensatory stance	Hamstring foreshortening → ↓ Gait velocity, distance → ↓ Mobility Paraspinal muscle firing to maintain stance → Chronic back pain

This large literature, developed over the last three decades, strongly supports the need for deformity correction. The profound clinical impact of VCFs treated with nonsurgical management, and the downward spiral of afflicted patients, are also described below, presented through the eyes of health care givers who treat patients with, and study the impact of, osteoporotic spinal deformity:

*“The greater the deformity, the greater the likelihood of pain and disability. As height is lost, patients experience discomfort from the rib cage pressing downward on the pelvis. Patients develop a thoracic kyphosis, a lumbar lordosis, and a protuberant abdomen with prominent horizontal skin creases. The reduced thoracic space may result in decreased exercise tolerance and reduced abdominal space may give rise to early satiety and weight loss. Sleep disorders may occur. Patients lose self-esteem. Self care may become difficult. They are often depressed. They become fearful of future fracture. They have distorted body image and poor health perception. Patients with one vertebral fracture are at increased risk of peripheral fracture and further vertebral fracture.” (p.S27)<sup>13</sup>*

This description is consistent with the additional observation that:

*“Patients who suffer clinical vertebral fractures experience an abrupt descent into disease and disability.”(p. 867).<sup>14</sup>*

### 3. Kyphoplasty is Far More Than A Modification of Vertebroplasty

There are important differences between vertebroplasty and kyphoplasty that go beyond the HTA’s portrayal of kyphoplasty as “a modification of vertebroplasty that expands the partially collapsed vertebral body with an inflatable balloon before the injection of bone cement”. Key characteristics of the kyphoplasty procedure and their importance in the treatment of vertebral compression fractures (VCFs) are discussed in Figure 2 below:

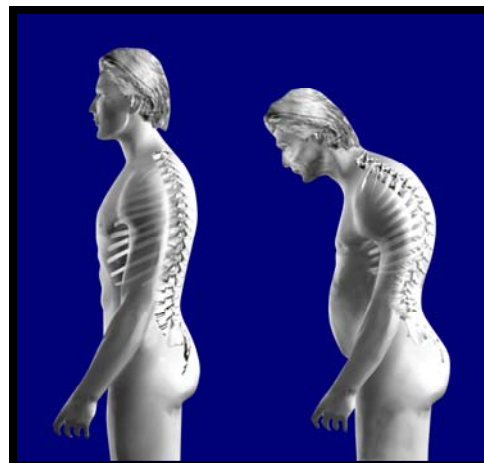


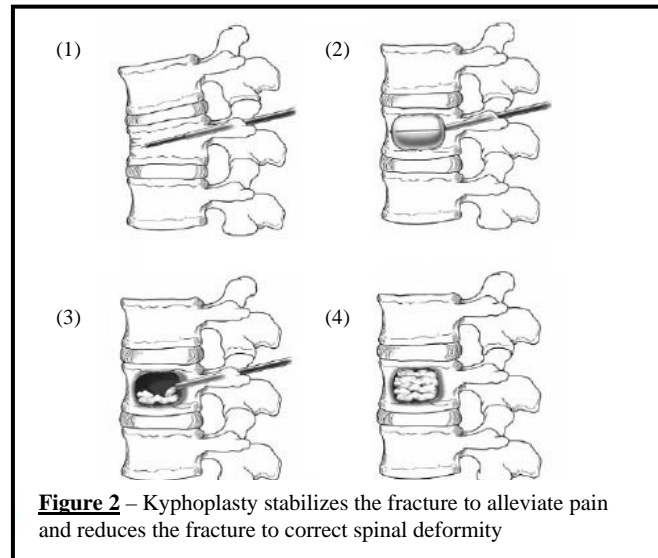
Figure 1 – Spinal Deformity Resulting From Vertebral Compression Fracture



(1) The bipedicular introduction of cannulae through two 1-cm incisions (also see Figure 2) into the fractured vertebral body under image guidance.

(2) The insertion of an inflatable bone tamp to elevate the vertebral body endplates and reduce spinal deformity. The inflation of the bone tamp compacts the cancellous bone, fills fracture lines and creates a void within the vertebral body.

(3-4) The controlled filling of the void with high viscosity bone cement under low pressure to distribute the cement across the vertebral body for reliable fracture stabilization. The advantages of void creation are a defined location with a known volume for cement placement along with the reduced potential for the fixation material to extend beyond the region of its intended application.<sup>15</sup>



The role of the void in kyphoplasty is critical to bone cement control and distribution. The lack of a void during vertebroplasty means that the practitioner must force bone cement into crushed bone. This is why vertebroplasty requires relatively liquid bone cement and higher injection pressures compared with kyphoplasty. Balloon inflation during kyphoplasty packs bone into fracture lines and disrupts the internal venous plexus, reducing leak pathways, as demonstrated by Phillips *et al.*<sup>16</sup> This creates an environment in which leaks are less likely to occur through fractures in the vertebral cortex or injection into the vertebral venous system. In order to minimize the risk of cement extravasation, vertebroplasty practitioners attempt to stop further cement injection once it is evident that cement has passed outside the vertebra. Nevertheless, cement leakage can still occur due to the surgeon's reaction time between visualization of the cement leak and cessation of the injection. Premature cessation of cement injection can also lead to inadequate cement filling of the fractured vertebra.<sup>16</sup>

3.1 The differences between kyphoplasty and vertebroplasty in the clinical literature have been recognized by the Technology Assessment Committee of the Society for Interventional Radiology:

*"The most significant differences between the two procedures is the restoration of vertebral body height, thus reducing kyphosis at the treated level; and the associated long-term complications. Another potential benefit to kyphoplasty is the lower reported rate of cement extrusion. It has been shown that kyphoplasty may seal osseous defects and venous pathways, thereby preventing cement from leaking."*<sup>17</sup>

3.2 The increased rate of cement leaks documented with the vertebroplasty technique compared to kyphoplasty predicts a higher rate of cement-related complications as well. This includes nerve root injury from foraminal leaks, cord/cauda equina compression from epidural leaks, as well as pulmonary emboli from venous leaks. While only large RCTs directly comparing the two procedures can definitely demonstrate safety differences, systematic literature reviews analyzing cement leaks and adverse events support this hypothesis.

- In the most recent meta-analysis comparing the incidence of complications in VCF patients treated with kyphoplasty (n=2,794 levels treated) vs. vertebroplasty (n=7,184 levels treated), Lee and colleagues found that vertebroplasty had a significantly higher rate of both total cement leaks (43% vs. 8.8%, p<0.001) and symptomatic cement leaks (1.08% vs. 0.04%, p<0.001) than kyphoplasty.<sup>18</sup>

- This result is consistent with previous formal analyses, documenting a higher pooled risk of pulmonary and neurologic complications during vertebroplasty than kyphoplasty.<sup>19,20</sup>

3.3 After compilation of the Washington State Health Care Authority's HTA, the American Academy of Orthopaedic Surgeons released its "Guidelines and Evidence Report on the Treatment of Symptomatic Osteoporotic Spinal Compression Fracture" – it can be downloaded from the AAOS website at: <http://www.aaos.org/Research/guidelines/SCFguideline.pdf>.

The AAOS made the following recommendation in these guidelines:

*"Kyphoplasty is an option for patients who present with an osteoporotic spinal compression fracture on imaging with correlating clinical signs and symptoms and who are neurologically intact."*

It should be noted that kyphoplasty is the ONLY therapy for the treatment and reduction of vertebral compression fractures recommended by the AAOS in this just released guideline.

#### 4. Kyphoplasty – Correction of HTA Mischaracterization

The HTA stated that "Kyphoplasty almost always requires general anesthesia and at least one overnight stay in the hospital" (p28).

In fact, kyphoplasty can be done under local or general anesthesia and on either an inpatient or an outpatient basis<sup>21</sup> depending on the medical need of the patient as determined by the treating physician.<sup>22 23</sup>

4.1 For example, Chung et al.<sup>24</sup> have reported on their VCF patient outcomes following treatment with kyphoplasty in which only local anesthesia was utilized while Wardlaw et al.<sup>25</sup> report results using general anesthesia for most patients.

4.2 Based on CMS MEDPAR data for calendar year 2009, approximately one-half of all kyphoplasty procedures are done on an inpatient basis, one-half are performed on an outpatient basis.<sup>26</sup>

#### 5. The randomized controlled Cancer Fracture Evaluation (CAFE) Trial results should additionally be considered by the Washington State Health Care Authority in its assessment of kyphoplasty.

The Washington State Health Care Authority HTA considered the Fracture Reduction Evaluation (FREE) trial in its assessment of kyphoplasty. FREE is a randomized controlled trial comparing kyphoplasty to nonsurgical management (NSM) in the treatment of osteoporotic vertebral compression fractures (VCFs). Patients treated with kyphoplasty were found to experience statistically significant improvements in their quality of life and mobility and statistically significant reductions in their disability, pain and narcotic pain medication compared to patients in the NSM control group.<sup>25</sup>

In addition to FREE, the randomized controlled Cancer Fracture Evaluation (CAFE) trial has been completed and the results on its primary endpoint have been posted on the FDA/NIH [www.clinicaltrials.gov](http://www.clinicaltrials.gov) website; reported at the 2009 American Society of Hematology Annual Meeting and posted on its website, <http://ash.confex.com/ash/2009/webprogram/Paper24340.html>; and published in abstract form in a journal supplement to Blood.<sup>27</sup>

In CAFE, 134 adult patients from 21 sites diagnosed with a variety of cancers and 1 to 3 painful VCFs (VAS ≥ 4) were randomly assigned. The primary outcome of the study was the one-month difference between groups in change from disability baseline scores using the Roland-Morris Disability Questionnaire (RMDQ). The RMDQ is a 0- (no disability) to 24-point (maximum disability) instrument validated for assessing back-specific physical functioning. Secondary measurements included back function and pain, quality of life, change in ambulation, pain medications and daily activities at baseline, and 1, 3, 6 and 12 months. Patients were randomized to kyphoplasty (N=70) or nonsurgical management (N=64), had an average age of 64 years, and 58% were female. Patients had multiple myeloma (38%), cancer of the breast (22%) or other cancers.

- RMDQ disability scores at pretreatment baseline were similar between the kyphoplasty (17.6) and nonsurgical management (18.2).
- At one month, there was an improvement for patients randomized to kyphoplasty of -8.3 points whereas those receiving nonsurgical management showed no significant change (0.1 points). The difference between the two groups was statistically significant,  $p < 0.0001$ .
- At one month, the kyphoplasty patients also showed significant improvement in their back pain (-3.8) whereas the nonsurgical management control group patients experienced no significant change (-0.3). The difference between the two groups was statistically significant,  $p < 0.0001$ .
- For kyphoplasty patients, the improvements in back pain and disability were sustained throughout the 12-month study period.
- Adverse events were similar between the two groups.
- One serious adverse event in the form of an intra-operative non-Q-wave myocardial infarction resolved and was attributed to anesthesia. One patient with a cement leakage to the disc had an adjacent fracture occur 1 day after the index procedure; the local investigator judged this to be device-related. However, at 1-month there was no difference in the number of patients with new radiographic or clinical fractures.

The CAFE authors concluded that cancer patients with VCFs treated with kyphoplasty had superior outcomes compared to those treated with nonsurgical management as measured by the primary endpoint and, as measured by other pain, and quality of life assessments; the results support the benefits of kyphoplasty in the management of cancer patients with VCFs.

Medtronic believes that the findings of the CAFE randomized controlled trial, in addition to those of FREE, should be thoroughly considered by the Washington State Health Care Authority in its assessment of kyphoplasty.

**6. Prospective non-randomized comparative studies that have been published in peer-reviewed journals and should additionally be considered by the Washington State Health Care Authority in its assessment of kyphoplasty are noted below:**

- 6.1 Kumar et al.<sup>28</sup> reported on a prospective study comparing patients with osteoporotic VCFs treated with either vertebroplasty ( $n = 28$ ) or kyphoplasty ( $n=24$ ). Patients in both groups experienced a statistically significant reduction in pain as measured by the visual analogue scale (VAS), a statistically significant reduction in disability as measured by the Oswestry Disability Index (ODI), and a statistically significant improvement in quality of life based on the Euroqol-5D (EQ\_5D) and Short-Form 36 Health Survey (SF-36). At last follow-up (mean = 42 weeks), patients in the kyphoplasty group experienced statistically significantly greater improvements in VAS, ODI, EQ-D, and physical component dimensions of the SF-36 than did patients treated with vertebroplasty.
- 6.2 Komp et al.<sup>29</sup> prospectively evaluated patients with radiologically verified osteoporotic VCFs who chose to be treated either with kyphoplasty ( $n=21$ ) or nonsurgical management ( $n=19$ ) and followed them for 6 months. The investigators found statistically significant improvement ( $p < 0.05$ ) in VAS pain and ODI disability scores at the 1-week, 6-week and 6-month follow-up in the kyphoplasty treatment group but no significant improvement in the nonsurgical management control group.
- 6.3 Dong et al.<sup>30</sup> measured thoracic kyphotic angle, local kyphotic angle, pain scores and pulmonary function parameters in 38 older women with osteoporotic VCFs before, three days after and three months after operation with kyphoplasty ( $n=20$ ) or vertebroplasty ( $n=18$ ).
  - Vital capacity, forced vital capacity and maximum voluntary ventilation significantly increased three days after operation ( $P < 0.01$ ), while maximum voluntary ventilation went on to improve three months later ( $P < 0.01$ )
  - Thoracic kyphotic angle had a significant ( $p < 0.001$ ) negative correlation with vital capacity. That is to say, the greater the thoracic deformity, the greater the loss of the lung's vital capacity

- Patients treated with kyphoplasty achieved significantly greater vertebral body height restoration and correction of local kyphotic angle than those treated with vertebroplasty ( $p < 0.01$ ) at each follow-up.
- In the thoracic subgroups, improvement of the local kyphotic angle was significantly correlated with increased lung vital capacity and kyphoplasty was found to increase vital capacity significantly more than vertebroplasty ( $P < 0.01$ )

**7. The Body of Clinical Evidence for kyphoplasty is consistent with the findings of the FREE and CAFE Randomized Controlled Trials**

The results of the FREE and CAFE randomized controlled trials are consistent with the findings of a recent comprehensive review of the clinical literature. Based on a search of the U.S. National Library of Medicine database conducted on April 5, 2010, there have been a total of 97 publications (containing cohorts of 10 or more patients) in which 12,194 patients were enrolled. The search criteria employed, a summary of each paper, and a bibliography providing full citations for each publication is provided in Appendix 1. The published studies are noteworthy in that they uniformly show consistently positive results for VCF patients treated with kyphoplasty – see Table 3 below.

<b>Table 3</b>		
<b>Summary of Journal Publications on the Use of Kyphoplasty in the Treatment of Vertebral Compression Fractures</b>		
<b>Endpoint</b>	<b># of Studies Reporting on this Endpoint</b>	<b># of Studies with Positive Kyphoplasty Results</b>
Pain (NRS, VAS, others)	82	82
Ambulation, Activities of Daily Living	37	37
Disability (ODI, RMDQ)	30	30
Quality of Life Health Survey	13	13
Vertebral Height Restoration	58	60
Angular Deformity Correction	58	58

Based on a U.S. National Library of Medicine Literature Search as of April 05, 2010. See Appendix 1.

**8. Peer-reviewed journal publications reporting findings of analyses of the National Inpatient Sample on individuals with vertebral compression fractures that should additionally be considered by the Washington State Health Care Authority in its assessment of kyphoplasty are noted below:**

Background<sup>31</sup>:

The Nationwide Inpatient Sample (NIS) is one in a family of databases and software tools developed as part of the Healthcare Cost and Utilization Project (HCUP). A Federal-State-Industry partnership sponsored by the Agency for Healthcare Research and Quality, HCUP data inform decision making at the national, State, and community levels. NIS data are used by a variety of non-profit and for-profit organizations, including:

- Actuarial firms
- Accrediting bodies
- State and Federal Government agencies
- Health care consultants
- Health professions societies
- Health services researchers and policy analysts
- Hospital information system firms
- Hospitals and health care systems

- Health and life insurance companies
- Investment firms
- Managed care organizations
- Pharmaceutical and medical product manufacturers and marketing firms
- Schools of business
- Schools of public health
- Utilization review organizations.

NIS comparative data on the treatment of VCFs has been reported in two peer-reviewed journals.

8.1 Lad et al.<sup>32</sup> evaluated the 2004 NIS database to assess differences in the utilization and outcomes of vertebroplasty and kyphoplasty – each appearing for the first time under separate ICD-9 codes. The investigators reported that of the 23, 691 hospital inpatients with VCFs who were treated with either kyphoplasty or vertebroplasty, that those patients treated with kyphoplasty were more likely to have a shorter length of stay and were more likely to be discharged to their home (vs. an institution) than patients treated with vertebroplasty, while average hospital charges were similar. See data in Table 4 below.

<b>Table 4</b>		
Total Inpatient Admissions for Vertebroplasty and Kyphoplasty in 2004 In the NIS database = 23, 691	Kyphoplasty (57%)	Vertebroplasty (43%)
% discharged to home	77%	50%
% discharged to institution	23%	50%
Length of Hospital Stay	3.7 days	7.3 days
Mean Hospital Charges	\$30,144	\$29,517

8.2 Zampini et al.<sup>33</sup> analyzed the 2005 NIS database to determine if differences existed in the outcomes of 5,766 patients admitted to the hospital via the emergency department due to painful VCFs based whether they were treated with kyphoplasty (15%) or with nonsurgical management (85%).

The investigators found that:

- VCF patients in the kyphoplasty and nonsurgical management groups had similar comorbidity profiles.
- No significant between group differences existed in the overall rate of VCF patient complications
- Accelerating their return to function, VCF patients treated with kyphoplasty were found to be:
  - 2.59 times more likely to be discharged to their homes than patients treated with nonsurgical management (odds ratio 2.59; p<0.001)
  - 38% less likely to be discharged to a skilled nursing facility than VCF patients treated with nonsurgical management (odds ratio 0.62, p<0.001)
  - 48% less likely to experience in-hospital mortality than VCF patients treated with nonsurgical management (odds ratio = 0.52, p=0.003)
- Kyphoplasty treated patients were found to have a longer length of hospital stay (0.7 day) and higher hospital charges than patients treated nonsurgically

The authors concluded that kyphoplasty for the treatment of VCFs may accelerate the return to independent patient function and that the initially higher cost of treatment may be offset by the reduced use of medical resources after hospital discharge.

9. **A recently published abstract of a U.S. Medicare Based VCF survivorship study reports that kyphoplasty is associated with reduced mortality compared to nonsurgical management and vertebroplasty and should additionally be considered by the Washington State Health Care Authority in its assessment of kyphoplasty.**

9.1 Previous researchers have shown that onset of a VCF compression fracture is associated with increased mortality, presumably both due to the direct effects of the VCF (immobility and nutritional changes) and to a VCF being a general marker of poorer health.<sup>34</sup> Since about the year 2000 surgical interventions, vertebroplasty (VP) and kyphoplasty (BKP) have been available in the U.S. market. Specific CPT codes delineating each procedure have been available since 2001; unique ICD-9 codes were introduced in Q4 2004.

Scientists at Drexel University, Exponent and Medtronic used the 100% Inpatient and Outpatient Medicare dataset obtained for the years 2005 to 2007 to estimate the survivorship of patients diagnosed with a VCF (ICD-9-CM 733.13, and 805.0,2,4,6 or 8).<sup>35</sup> Patients diagnosed during this time period could have been managed nonsurgically, or been treated with VP or BKP. Survivorship was compared at up to two years follow-up using Cox regression adjusted by a selected set of common comorbidities to account for incoming health status. In an attempt to primarily follow the course of index fractures, patients included in the overall dataset could not have had a VCF in the twelve months prior to diagnosis. The robustness of this assumption was subsequently tested using a two-year window and no measurable changes were observed.

Kaplan-Meier survivorship curves and adjusted odds ratios were used to compare 1) surgical intervention (BKP or VP) vs. nonsurgical management (NSM) and 2) BKP vs. VP vs. NSM. The Medicare denominator file was used to determine survivorship through the study period. The overall study included 410,965 patients divided into 53,820 kyphoplasty (KP) patients, 27,842 vertebroplasty (VP) patients, and 329,303 nonsurgically managed (NSM) patients.

At up to 24 months follow-up, patients that underwent surgical intervention had a higher survival rate of 74.8% compared to 67.4% for NSM patients ( $p < 0.0001$ ). VP or KP patients were 44% less likely to die by the end of the study than NSM patients (adjusted hazard ratio, HR = 0.56,  $p < 0.0001$ ). Furthermore, the survival rates for VCF patients followed VP or KP were 72.3% and 76.2% respectively. Overall, the risk of mortality was 12.5% lower for KP patients than for VP patients (adjusted HR=0.87,  $p < 0.0001$ ).

The data from this study strongly suggest that surgical intervention following a VCF diagnosis is warranted and valuable to the patient when mortality is used as the outcome metric. These data also suggest that the KP intervention is advantageous over the VP procedure although both have value over NSM.

The survival advantage with kyphoplasty (whose goal is to correct anatomy where possible) compared to vertebroplasty (which does not have a goal of anatomy restoration) is predicted by the poorer outcomes of elderly patients with vertebral deformities, including excess pulmonary deaths described by Kado et al.<sup>36</sup>

9.2 ***Embargoed confidential data follow. Not to be reproduced or transmitted in any form***<sup>37</sup>.

Subsequent to the two-year analysis, the authors performed a four-year analysis using the same methodology and covering the years 2004-2008. These data are still preliminary, but indicate two overall trends. First, the difference between patients undergoing surgical treatment vs. those not receiving surgical intervention continues to be statistically significant and in the favor of intervention at up to four years follow-up. Second, the difference between the intervention and non-intervention has widened such that at up to four years follow-up, BKP patients were 35% less likely to die by the end of the study, whereas VP patients were only 25% less likely to die on an adjusted hazard ratio basis. Alternatively stated, the overall risk of mortality was 17% lower for BKP patients than for VP patients (adjusted HR= 0.83,  $p < 0.0001$ ). ***These four-year data are preliminary and strictly under embargo as a full manuscript is under preparation for submission to a major medical journal in the next few weeks.***

In addition to carrying out the mortality analysis to four years, the research team has also performed a life-expectancy analysis using the Medicare data (Parts A & B, 5% cull) as the input to a Weibull model. While still preliminary, the initial results suggest that performing a surgical intervention following a VCF *substantially increases* life expectancy overall and that performed a BKP rather than a VP *has a measurable and significant improvement on life expectancy*. These findings were true *regardless of the age of the patient*. The overall Hazard Ratio comparing Operated (any procedure) to Non-operated patients was  $1.82 \pm 0.13$ . As in previous analyses, the life expectancy analysis was performed using a set of twelve common comorbidities to account for incoming health status.

**10. One additional systematic review of observational studies reporting data on the safety and effectiveness kyphoplasty that should be considered by the Washington State Health Care Authority in its assessment of kyphoplasty.**

Hulme et al.<sup>38</sup> evaluated the safety and efficacy of vertebroplasty and kyphoplasty using the data presented in published clinical studies thru June 2005 with respect to patient pain relief, restoration of mobility, restoration of vertebral body height, complication rates, and incidence of new fractures. The authors noted that cement leakage rates were higher for vertebroplasty (41%) than kyphoplasty (9%).

**11. Kyphoplasty – Safety Confirmed By Clinical Evidence**

**11.1 Kyphoplasty Devices and Procedure – Design Minimizes the Risk of Adverse Events**

The synthesis of available evidence reveals the excellent safety profile of kyphoplasty in the treatment of vertebral compression fractures. This profile is a direct result of the purposeful design of the devices that comprise the kyphoplasty procedure that enable this minimally invasive technique to be conducted safely in the fragile elderly osteoporotic and/or cancer VCF patient population. Table 5 below describes how kyphoplasty is designed to minimize the potential adverse events that may accompany this procedure.

<b>Table 5</b>	
<b>Kyphoplasty - Potential Perioperative Adverse Events</b>	<b>Kyphoplasty Adverse Event Risk Minimization</b>
Needle injuries resulting in local (typically neurologic) damage, often with no clinical consequence	To minimize such injury, placement of the kyphoplasty introducer cannulae is guided by antero-posterior and lateral fluoroscopic guidance
Bone cement extravasation may cause neurologic syndromes or pulmonary embolism.	<ol style="list-style-type: none"> <li>1. The use of an inflatable bone tamp during kyphoplasty compacts the cancellous bone and creates a void</li> <li>2. The compaction of the cancellous bone disrupts internal venous pathways, fills in fracture lines, and reduces cement leak pathways</li> <li>3. The void allows the physician to deliver a predictable volume of highly viscous cement</li> <li>4. Since bone cement is radiopaque, the likelihood of extravasation can be limited by the use of fluoroscopy.</li> </ol> <p><b>NOTE:</b> These aspects of kyphoplasty are thought to reduce cement extravasation rates and are not available during a vertebroplasty procedure which does not employ an inflatable bone tamp.</p>

This overview is based on an evaluation of available clinical data, including medical literature, to assess the safety of kyphoplasty for treating vertebral compression fractures. Five sources have been employed for this purpose: independent meta-analyses published in peer review

journals; device vigilance on an ongoing basis to estimate risk; network meta-analysis recently conducted of the best comparative evidence; FDA device MAUDE database descriptive review for unanticipated serious device or procedure related adverse events; and adverse events reported in sponsored randomized clinical trials. These data are summarized in sections 11.2 thru 11.5 below.

11.2 Kyphoplasty demonstrates a low rate of cement extravasations and complications in published meta-analyses.

The data from several recent meta-analyses support the safety of kyphoplasty and are summarized in the table below – for purposes of reference, those data reported for vertebroplasty in these studies are also provided.

<b>Table 6</b>		
<b>Cement Leaks and Complications</b>	<b>Kyphoplasty</b>	<b>Vertebroplasty</b>
Extravertebral Cement Extravasations (Most with no clinical consequences)	7 – 9% <sup>39,40,41,42,</sup>	20 – 41% <sup>40,41,42</sup>
Serious and Symptomatic Complications	2% <sup>40,43</sup>	3.9% <sup>40</sup>
Symptomatic Cement Leakage	0% – 0.3% <sup>39,42</sup>	1.6% – 3% <sup>39,42</sup>

11.3 Kyphoplasty found to have a low rate of complications in the large body of peer-reviewed clinical evidence.

The results of the meta-analyses are in agreement with that of an internal Medtronic safety analysis in which 97 unique kyphoplasty cohort (n ≥10 pts.) studies were identified using the U.S. National Library of Medicine’s MEDLINE® database as of April 5, 2010. The following data were obtained based on 6,426 subjects who underwent kyphoplasty:

- Total procedure-related severe adverse event rate = 1.18% (76 out of 6,426 patients)
- Rate of cement related symptomatic adverse events = 0.22% (14 out of 6,426 patients)
- Post-operative medical complications - not thought to be procedure related = 0.67% (43 of 6,426 cases)

11.4 Kyphoplasty found to have a low adverse event rate in multicenter prospective randomized controlled trials.

The low adverse event rate described in published meta-analyses is also consistent with results from two multicenter randomized controlled trials of kyphoplasty.

1. In the Fracture Reduction Evaluation (FREE) trial, 300 patients at 21 sites with VCFs due to osteoporosis were randomized to either kyphoplasty or nonsurgical management. In the kyphoplasty treatment group, there were 3/149 patients (2.0%) who had 4 device or procedure-related serious adverse events: a patient with a hematoma; a patient with a post-operative urinary tract infection and spondylitis; and a patient with an anterior cement migration after 1 year of index treatment.
2. In the Cancer Patient Fracture Evaluation (CAFE) Study, 134 patients at 21 sites with VCFs due to cancer were randomized to receive either kyphoplasty or nonsurgical management. In the kyphoplasty treatment group, there were 2/70 patients (2.9%) who had device or procedure-related serious adverse events: a patient with an intra-operative non-Q wave myocardial infarction with intermittent atrial fibrillation that was attributed to anesthesia and resolved; and a patient with a cement leakage to the disc had an adjacent fracture that occurred 1 day after the kyphoplasty procedure.

Regarding fractures considered to be device related by study investigators, there was no difference in the number of patients with subsequent fractures when compared to the control



group in either the FREE or CAFE trial, suggesting that new fractures are not related to treatment with kyphoplasty.

#### 11.5 Kyphoplasty found to have a low adverse event rate based on search of the MAUDE database.

The results stemming from a search of FDA's MAUDE database for kyphoplasty adverse events is also consistent with literature results. There were 309 (4.4 per 10,000 cases) unique events reported to the FDA; the majority of events were cardiopulmonary or neurologic in nature. No unanticipated serious device or procedure related adverse events were reported which are not already mentioned in the instructions for use. Given that approximately 700,000 fractures have been treated with kyphoplasty to date, this rate is also low.

In all cases, the published medical literature and data submitted to FDA's MAUDE database support the safe use of kyphoplasty and PMMA-based bone cements for the indications for use. The review of the combined data supports an acceptable safety profile for kyphoplasty. See Appendix 2

## **12. Kyphoplasty Is Widely Recognized By Professional Medical Societies**

12.1 In view of the strong and consistently positive clinical evidence of its safety and effectiveness, kyphoplasty has been recognized for its role in the treatment of VCFs by major medical societies including:

- American Academy of Orthopedic Surgeons<sup>44</sup>
- American Association of Neurological Surgeons<sup>45</sup>
- American Medical Directors Association<sup>46</sup>
- American Society of Anesthesia<sup>47</sup>
- American Society of Interventional Pain Physicians<sup>48</sup>
- American Society of Interventional and Therapeutic Neuroradiology<sup>45</sup>
- American Society of Regional Anesthesia and Pain Medicine<sup>47</sup>
- American Society of Spine Radiology<sup>45</sup>
- North American Spine Society<sup>49</sup>
- Congress of Neurological Surgeons<sup>45</sup>
- International Multiple Myeloma Foundation<sup>50</sup>
- International Osteoporosis Foundation<sup>51</sup>
- Society of Interventional Radiology<sup>45</sup>

- 12.2 On September 3, 2010, The Society of Interventional Radiology (SIR) and the American College of Radiology, in a letter endorsed by the Washington State Radiological Society to Noridian LLC, a Medicare contractor, stated their societies' position that the clinical evidence supporting kyphoplasty (and vertebroplasty) was strong and made the following points regarding their medical necessity.<sup>52</sup>

In sum, based on medical evidence, SIR considers percutaneous vertebroplasty or kyphoplasty as medically appropriate treatment when standard medical therapy has failed to relieve symptoms and any of the following criteria is met:

- osteoporotic, osteolytic, osteonecrotic (i.e., Kummell disease), or steroid-induced vertebral compression fracture(s) with persistent, debilitating pain unresponsive to conservative medical management. Clinical questions to consider with regard to timing intervention include the patient's ability to accomplish activities of daily living (ADLs), excessive pain requiring high or IV narcotic dosages, skilled care needs, occurrence of additional fracture, and the risk of further vertebral collapse
- back pain secondary to destruction of vertebral body due to osteolytic vertebral metastasis or multiple myeloma
- acute compression fractures so painful that hospitalization is required
- painful and/or aggressive hemangioma or eosinophilic granuloma of the spine

- 12.3 In addition, on September 24, 2010, the American Academy of Orthopaedic Surgeons released its *Guidelines and Evidence Report on the Treatment of Symptomatic Osteoporotic Spinal Compression Fracture*". These Guidelines can be downloaded from the AAOS website at: <http://www.aaos.org/Research/guidelines/SCFguideline.pdf>.

The AAOS made the following recommendation in these guidelines:

*"Kyphoplasty is an option for patients who present with an osteoporotic spinal compression fracture on imaging with correlating clinical signs and symptoms and who are neurologically intact."*

It should be noted that kyphoplasty is the ONLY therapy for the treatment and reduction of vertebral compression fractures recommended by the AAOS in this just released guideline.

### 13. Payer Technology Assessment and Policies – Additions and Corrections to HTA Section 1.4

Medtronic has noted that commonly accepted health technology assessments and influential national payer coverage policies were not addressed by the HTA and that incorrect information has been included within the HTA review. Copies of these policies and non-confidential HTAs are provided in Appendix 3 and summarized below in Table 7 and Table 8. Medtronic believes that these HTAs and national payer coverage policies should additionally be considered by the Washington State Health Care Authority in its assessment of kyphoplasty - corrections to mischaracterizations have been highlighted in red. Specifically:

- 13.1 The HTA review did not include the June 2009 California Technology Assessment Forum (CTAF) HTA entitled, "*Balloon Kyphoplasty as a Treatment for Vertebral Compression Fracture*"; it only considered the Vertebroplasty HTA conducted by (CTAF). After a critical review of the literature, CTAF determined that Kyphoplasty **met** criteria 1-2 and for criteria 3-5 it **too met criteria** for recent osteoporotic vertebral compression fractures, while criteria was not met for chronic osteoporotic, pathologic or traumatic vertebral compression fractures.
- 13.2 Consideration should also be given to an updated assessment conducted by the Ontario Health Technology Advisory Committee. While WA State's review of this HTA cited it being reviewed in 2004, a recent review of the procedures was done in July and August 2010

(attached in Appendix 3). The Ontario HTA concluded that, while evidence did not support the use of vertebroplasty in patients with VCFs, it did allow for kyphoplasty as a treatment after a period of failed conservative therapy.

- 13.3 Two U.S.-based HTA's were not included; the ECRI (Percutaneous Balloon Kyphoplasty for the Treatment of Vertebral Fractures- March 2006) and Hayes (Percutaneous Kyphoplasty Feb 28, 2008) reports. Both of these assessments are not publically available and must be purchased however the ECRI assessment deemed the clinical evidence for Kyphoplasty strong to moderate when evaluating the effectiveness of the therapy.

Additionally, Medtronic would like to submit that clarifications should be made to the Washington State Health Care Authority's HTA statement concerning kyphoplasty coverage by the Centers for Medicare and Medicaid services (CMS). While it is on the list of potential NCDs, **kyphoplasty is currently allowed and has positive coverage by all local Medicare Administrative Carriers (MACs) nationwide**. Indeed, all but two MACs **have published, active positive LCD's**, one has an active published article, and one has coverage via a fee schedule.

Listed below are the positive LCDs which Medtronic believes should be recognized by the HTA in its evaluation of kyphoplasty coverage:

- Cahaba- LCD # L30062 and draft LCD # 31425
- Cigna- LCD#31349
- First Coast Option- LCD # L20209
- Highmark- fee schedule
- NGS- retired LCD, Article # A45937
- NHIC- LCD # 11417
- Noridian- LCD # DL24383 and draft LCD # DL24383
- Palmetto- LCD # 27595
- Trailblazer- LCD # L27595
- WPS- LCD # L16088, L16089, L16090, L16091

When considering commercial payer coverage, it is common place to consider the larger most influential payers (Aetna, Wellpoint, United Healthcare and Cigna) – see highlights in Table 8 and the contents of the policies in Appendix 3.

- The WA State review only took into consideration Aetna and Cigna and to truly understand the coverage environment for kyphoplasty one should consider the other payers as well.
- For example, Wellpoint is the largest BCBS system in the United States. It has a current positive (dated 2010-Percutaneous Spinal Procedures: Vertebroplasty, Kyphoplasty and Sacroplasty) coverage policy for the therapies in question.
- United Health Care who has been a leader in strong clinical data analysis also has a positive coverage policy (Percutaneous Vertebroplasty and Kyphoplasty #20007T0300D).
- Lastly and of particular importance, Table 8 describes a Regence (BCBS WA) coverage policy that has been included in the HTA but does not even apply to these therapies. The appropriate policy which should be reviewed and given consideration is their Percutaneous Vertebroplasty and Kyphoplasty policy (2010 draft and 2009 Surgery Policy # 107).

Appendix 3 contains the majority of these coverage policies and non-confidential HTA's. While each of them varies slightly in its selection and treatment criteria, each has recognized the need to have kyphoplasty made an available treatment to patients to treat their VCFs. This has been done by allowing a fair and complete review of the current evidence and allowing coverage.

**Table 7**

**Previous Systematic Reviews/Technology Assessments**

Assessment (year)	Lit Search Dates	Procedure Evaluated	Evidence Base Available	Critical Appraisal	Comments	Primary Conclusions
<p><b>The California Technology Assessment Forum (CTAF)</b>                      Balloon Kyphoplasty as a Treatment for Vertebral Compression Fractures;                      6/17/2009</p>	Through 4/2009	Kyphoplasty	See Appendix 3	Yes	<p>Kyphoplasty <b>DOES meet</b> criteria 1-2.</p> <p>Kyphoplasty <b>DOES meet</b> criterion 3-5 for recent osteoporotic vertebral compression fractures. Criterion 3-5 is <b>not met</b> for chronic osteoporotic, pathologic or traumatic vertebral compression fractures.</p>	See Appendix 3
<p>Ontario Health Assessment  <i>Balloon Kyphoplasty</i>  <b>UPDATED:</b>  <i>July &amp; August 2010- see OTAC website</i></p>					<ul style="list-style-type: none"> <li>• Vertebroplasty not supported in use of patients with VCFs.</li> <li>• Kyphoplasty- the OTAC recommended conservative treatment which allows the fracture to heal naturally; initiation of management of the underlying condition; patient monitoring including bone mineral density testing; and, patient education about the course of natural healing and <b>alternative treatment options such as kyphoplasty if</b> there is no response to conservative treatment within an appropriate time."</li> </ul>	
<p><b>ERCI</b>  <i>Percutaneous Balloon Kyphoplasty for the treatment of Vertebral Fractures</i>                      March 2006</p>		Document is not to be duplicated-confidential			Technology is effective with strong to moderate rated evidence	
<p><b>Hayes</b>  <i>Percutaneous Kyphoplasty</i>                      Feb 28, 2008</p>		Document is not to be duplicated-confidential				

**Table 8 - CMS**

<b>Payer Technology Assessments and Policies</b>				
<b>Payer (year)</b>	<b>Lit Search Dates</b>	<b>Evidence Base Available</b>	<b>Policy</b>	<b>Rationale/ Comments</b>
<b>Centers for Medicare and Medicaid Services (CMS)</b>	N/A See PDF file of composition of LCD policies in Appendix 3	N/A See PDF file of composition of LCD policies in Appendix 3	<p>No NCDs or LCDs. However, vertebroplasty and kyphoplasty are potential NCD topics. <b>(INCORRECT STATEMENT- SEE CORRECT DATA BELOW)</b></p> <ul style="list-style-type: none"> <li>• <b>National CMS-</b> vertebroplasty and kyphoplasty are potential NCD topics</li> <li>• <b>First Coast Option LCD #L20209</b> (coverage allowed)</li> <li>• <b>Cahaba LCD#L30062 &amp; Draft LCD #31425</b> (coverage allowed)</li> <li>• <b>Highmark- fee schedule only</b> (coverage allowed)</li> <li>• <b>NGS- Article #A45937</b> (coverage allowed)</li> <li>• <b>NHIC LCD #11417</b> (coverage allowed)</li> <li>• <b>Noridian LCD #DL24383 &amp; Draft LCD #DL24383</b> (current- coverage allowed, draft open)</li> <li>• <b>Palmetto LCD #27595</b> (coverage allowed)</li> <li>• <b>Trailblazer LCD #L26701</b> (coverage allowed)</li> <li>• <b>WPS LCD #L16088, L16089, L16090, L16091</b> (coverage allowed)</li> </ul>	N/A See PDF file of composition of LCD policies in Appendix 3

**Table 8 - Regence**

**Payer Technology Assessments and Policies**

Payer (year)	Lit Search Dates	Evidence Base Available	Policy	Rationale/ Comments
<p>Regence (2009) <i>Computer assisted navigation for orthopedic procedures of the pelvis and appendicular skeleton.</i></p> <p>Percutaneous Vertebroplasty and Kyphoplasty (2010 Draft) &amp; (2009 Policy) Surgery #107</p>	<p>Through 2009</p> <p>Through 2010; See Appendix 3</p>	<p>2007 BCBS Tec Assessment</p> <ul style="list-style-type: none"> <li>• 1 prospective multicenter study</li> <li>• 1 meta-analysis</li> </ul> <p>See Appendix 3</p>	<ul style="list-style-type: none"> <li>• Computer assisted navigation for orthopedic procedures involving the pelvis and appendicular skeleton is considered investigational</li> <li>• Percutaneous vertebroplasty or kyphoplasty may be considered <b>medically necessary</b> for the treatment of the following:               <ul style="list-style-type: none"> <li>A. Symptomatic osteoporotic (compression) vertebral fractures of the thoracic or lumbar spine that have failed to respond to conservative treatment (e.g., analgesics, physical therapy and rest) for at least 6 weeks, or</li> <li>B. Severe pain due to osteolytic lesions of the spine related to multiple myeloma, or primary or metastatic spinal malignancies</li> </ul> </li> <li>II. Percutaneous vertebroplasty or kyphoplasty is considered <b>investigational</b> for all other indications, including but not limited to the following:               <ul style="list-style-type: none"> <li>A. Vertebral hemangioma</li> <li>B. Acute vertebral fractures due to osteoporosis or trauma</li> <li>C. Stabilization of insufficiency fractures or lesions of the sacrum (sacroplasty) or coccyx (coccygeoplasty)</li> </ul> </li> </ul>	<p>Recent RCTs with short to mid-term follow-up have not shown improved health outcomes with CAN.</p> <p>See Appendix 3</p>

**Table 8 – Anthem Wellpoint**

**Payer Technology Assessments and Policies**

Payer (year)	Lit Search Dates	Evidence Base Available	Policy	Rationale/ Comments
<p><b>Anthem Wellpoint (2010)</b></p> <p><i>Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty and Sacroplasty)</i> SURG.00067</p>	<p>See Appendix 3</p>	<p>See Appendix 3</p>	<p>Percutaneous vertebroplasty or kyphoplasty of the cervical, lumbar or thoracic region is considered <b>medically necessary</b> after failure of standard medical therapy when <b>any</b> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Osteolytic vertebral metastasis or myeloma with severe back pain related to destruction of the vertebral body <b>not</b> involving the major part of the cortical bone, and chemotherapy and radiation therapy have failed to relieve symptoms; <b>OR</b></li> <li>2. Vertebral hemangiomas with aggressive clinical signs (severe pain or nerve compression) or aggressive radiological signs, and radiation therapy has failed to relieve symptoms; <b>OR</b></li> <li>3. Osteoporotic vertebral collapse with persistent debilitating pain which has not responded to accepted standard medical therapy as documented in the medical records. Standard medical therapy may include initial bed rest with progressive activity, analgesics, physical therapy, bracing and exercises to correct postural deformity and increase muscle tone, salmon calcitonin, bisphosphonates and calcium supplementation; <b>OR</b></li> <li>4. Painful vertebral eosinophilic granuloma with spinal instability; <b>OR</b></li> <li>5. Traumatic or steroid-induced vertebral fracture with persistent debilitating pain, which has not responded to standard medical therapy. Percutaneous sacroplasty is considered investigational and not medically necessary for all indications</li> </ol>	<p>See Appendix 3</p>

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# HTCC Coverage and Reimbursement Determination Analytic Tool

HTA's goal is to achieve *better health care outcomes* for enrollees and beneficiaries of state programs by paying for proven health *technologies that work*.

To find best outcomes and value for the state and the patient, the HTA program focuses on these questions:

1. Is it safe?
2. Is it effective?
3. Does it provide value (improve health outcome)?

The principles HTCC uses to review evidence and make determinations are:

## Principle One: Determinations are Evidence based

HTCC requires scientific evidence that a health technology is safe, effective and cost-effective<sup>1</sup> as expressed by the following standards.<sup>2</sup>

- Persons will experience better health outcomes than if the health technology was not covered and that the benefits outweigh the harms.
- The HTCC emphasizes evidence that directly links the technology with health outcomes. Indirect evidence may be sufficient if it supports the principal links in the analytic framework.
- Although the HTCC acknowledges that subjective judgments do enter into the evaluation of evidence and the weighing of benefits and harms, its recommendations are not based largely on opinion.
- The HTCC is explicit about the scientific evidence relied upon for its determinations.

## Principle Two: Determinations result in health benefit

The outcomes critical to HTCC in making coverage and reimbursement determinations are health benefits and harms.<sup>3</sup>

- In considering potential benefits, the HTCC focuses on absolute reductions in the risk of outcomes that people can feel or care about.
- In considering potential harms, the HTCC examines harms of all types, including physical, psychological, and non-medical harms that may occur sooner or later as a result of the use of the technology.
- Where possible, the HTCC considers the feasibility of future widespread implementation of the technology in making recommendations.
- The HTCC generally takes a population perspective in weighing the magnitude of benefits against the magnitude of harms. In some situations, it may make a determination for a technology with a large potential benefit for a small proportion of the population.
- In assessing net benefits, the HTCC subjectively estimates the indicated population's value for each benefit and harm. When the HTCC judges that the balance of benefits and harms is likely to vary substantially within the population, coverage or reimbursement determinations may be more selective based on the variation.
- The HTCC considers the economic costs of the health technology in making determinations, but costs are the lowest priority.

<sup>1</sup> Based on Legislative mandate: See RCW 70.14.100(2).

<sup>2</sup> The principles and standards are based on USPSTF Principles at: <http://www.ahrq.gov/clinic/ajpmsuppl/harris3.htm>

<sup>3</sup> The principles and standards are based on USPSTF Principles at: <http://www.ahrq.gov/clinic/ajpmsuppl/harris3.htm>

## Using Evidence as the basis for a Coverage Decision

Arrive at the coverage decision by identifying for Safety, Effectiveness, and Cost whether (1) evidence is available, (2) the confidence in the evidence, and (3) applicability to decision.

### 1. *Availability of Evidence:*

Committee members identify the factors, often referred to as outcomes of interest, that are at issue around safety, effectiveness, and cost. Those deemed key factors are ones that impact the question of whether the particular technology improves health outcomes. Committee members then identify whether and what evidence is available related to each of the key factors.

### 2. *Sufficiency of the Evidence:*

Committee members discuss and assess the evidence available and its relevance to the key factors by discussion of the type, quality, and relevance of the evidence<sup>4</sup> using characteristics such as:

- Type of evidence as reported in the technology assessment or other evidence presented to committee (randomized trials, observational studies, case series, expert opinion);
- the amount of evidence (sparse to many number of evidence or events or individuals studied);
- consistency of evidence (results vary or largely similar);
- recency (timeliness of information);
- directness of evidence (link between technology and outcome);
- relevance of evidence (applicability to agency program and clients);
- bias (likelihood of conflict of interest or lack of safeguards).

Sufficiency or insufficiency of the evidence is a judgment of each clinical committee member and correlates closely to the GRADE confidence decision.

<b>Not Confident</b>	<b>Confident</b>
Appreciable uncertainty exists. Further information is needed or further information is likely to change confidence.	Very certain of evidentiary support. Further information is unlikely to change confidence

### 3. *Factors for Consideration - Importance*

At the end of discussion at vote is taken on whether sufficient evidence exists regarding the technology's safety, effectiveness, and cost. The committee must weigh the degree of importance that each particular key factor and the evidence that supports it has to the policy and coverage decision. Valuing the level of importance is factor or outcome specific but most often include, for areas of safety, effectiveness, and cost:

- risk of event occurring;
- the degree of harm associated with risk;
- the number of risks; the burden of the condition;
- burden untreated or treated with alternatives;
- the importance of the outcome (e.g. treatment prevents death vs. relief of symptom);
- the degree of effect (e.g. relief of all, none, or some symptom, duration, etc.);
- value variation based on patient preference.

<sup>4</sup> Based on GRADE recommendation: <http://www.gradeworkinggroup.org/FAQ/index.htm>

## Medicare Coverage and Guidelines

Organization	Date	Outcome	Evidence Cited?	Grade / Rating
CMS National Policy Decisions – WA HTA  Centers for Medicare and Medicaid Services		<ul style="list-style-type: none"> <li>The Centers for Medicare and Medicaid Services have no published National (NCD) or Local coverage determinations (LCD) for vertebroplasty, kyphoplasty or sacroplasty. However, vertebroplasty and kyphoplasty are potential NCD topics.</li> </ul>		N/A
		<p><b>No specific guidelines were found that addressed vertebroplasty, kyphoplasty, or sacroplasty for the treatment of vertebral compression fractures due to osteoporosis or malignancy.</b> Two guidelines mentioned vertebroplasty and kyphoplasty as part of the assessment and management of spinal cord compression and chronic pain.</p> <ul style="list-style-type: none"> <li>Institute for Clinical Systems Improvement (ICSI), 2008</li> <li>National Collaborating Centre for Cancer, National Institute for Health and Clinical Excellence (NICE), 2008</li> </ul>		
Guidelines – WA HTA Page: 32  <i>American Society of Interventional and Therapeutic Neuroradiology, Society of Interventional Radiology, American Association of Neurological Surgeons / Congress of Neurological Surgeons, and American Society of Spine Radiology</i>		<p>A consensus statement on percutaneous vertebral augmentation was developed:</p> <ul style="list-style-type: none"> <li>“It is the position of the Societies that vertebral augmentation with vertebroplasty or kyphoplasty is a medically appropriate therapy for the treatment of painful vertebral compression fractures refractory to medical therapy when performed for the medical indications outlined in the published standards<sup>1-3</sup>.”</li> </ul>		
Guidelines – WA HTA Page: 32  <i>American Association of Orthopaedic Surgeons (AAOS)</i>		<p>We recommend against vertebroplasty for patients who present with an osteoporotic spinal compression fracture on imaging with correlating clinical signs and symptoms and who are neurologically intact. <i>Strength of Recommendation: Strong</i></p> <p>Kyphoplasty is an option for patients who present with an osteoporotic spinal compression fracture on imaging with correlating clinical signs and symptoms and who are neurologically intact. <i>Strength of Recommendation: Weak</i></p>		

## HEALTH TECHNOLOGY EVIDENCE IDENTIFICATION

Discussion Document: What are the key factors and health outcomes and what evidence is there?

<b>Vertebroplasty, Kyphoplasty and Sacroplasty</b>	
<b>Safety Outcomes</b>	<b>Safety Evidence</b>
Mortality	
Morbidity	
New Fractures (adjacent or non adjacent)	
Cement Leakage	
Pulmonary cement embolism	
Procedure Related Complications	
Medically-related Complications	
Other Adverse Events	
<b>Efficacy – Effectiveness Outcomes</b>	<b>Efficacy / Effectiveness Evidence</b>
Functional Outcomes	
Pain Relief / Reduction	
Quality of Life	
Patient Satisfaction	
Radiographic Outcomes	
Medication Usage	
Other Patient Outcomes	
<b>Special Population / Considerations Outcomes</b>	<b>Special Population Evidence</b>
Psychological or psychosocial co-morbidities	
Diagnosis (cancer or non-cancer) or time elapsed from fracture (acute, subacute, chronic)	
Provider Characteristics	

Patient Selection	
Payer or Beneficiary Type	
<b>Cost</b>	<b>Cost Evidence</b>
Cost Implications	
Direct and indirect <ul style="list-style-type: none"> <li>- Short terms</li> <li>- Over expected duration of use</li> </ul>	
Reoperation or revision	
Cost Effectiveness	

## Clinical Committee Evidence Votes

### First voting question

The HTCC has reviewed and considered the technology assessment and information provided by the administrator, reports and/or testimony from an advisory group, and submissions or comments from the public. The committee has given greatest weight to the evidence it determined, based on objective factors, to be the most valid and reliable.

**Is there sufficient evidence under some or all situations that the technology is:**

	<b>Unproven</b> (no)	<b>Equivalent</b> (yes)	<b>Less</b> (yes)	<b>More</b> (yes)
<b>Effective</b>				
<b>Safe</b>				
<b>Cost-effective</b>				

### Discussion

Based on the evidence vote, the committee may be ready to take a vote on coverage or further discussion may be warranted to understand the differences of opinions or to discuss the implications of the vote on a final coverage decision.

- Evidence is insufficient to make a conclusion about whether the health technology is safe, efficacious, and cost-effective;
- Evidence is sufficient to conclude that the health technology is unsafe, ineffectual, or not cost-effective
- Evidence is sufficient to conclude that the health technology is safe, efficacious, and cost-effective for all indicated conditions;
- Evidence is sufficient to conclude that the health technology is safe, efficacious, and cost-effective for some conditions or in some situations

A straw vote may be taken to determine whether, and in what area, further discussion is necessary.

### Second vote

Based on the evidence about the technologies' safety, efficacy, and cost-effectiveness, it is

\_\_\_\_\_ Not Covered. \_\_\_\_\_ Covered Unconditionally. \_\_\_\_\_ Covered Under Certain Conditions.

### Discussion Item

Is the determination consistent with identified Medicare decisions and expert guidelines, and if not, what evidence is relied upon.



## Clinical Committee Findings and Decisions

### **Next Step: Cover or No Cover**

If not covered, or covered unconditionally, the Chair will instruct staff to write a proposed findings and decision document for review and final adoption at the following meeting.

### **Next Step: Cover with Conditions**

If covered with conditions, the Committee will continue discussion.

- 1) Does the committee have enough information to identify conditions or criteria?
  - Refer to evidence identification document and discussion.
  - Chair will facilitate discussion, and if enough members agree, conditions and/or criteria will be identified and listed.
  - Chair will instruct staff to write a proposed findings and decision document for review and final adoption at next meeting.
- 2) If not enough or appropriate information, then Chair will facilitate a discussion on the following:
  - What are the known conditions/criteria and evidence state
  - What issues need to be addressed and evidence state

The chair will delegate investigation and return to group based on information and issues identified. Information known but not available or assembled can be gathered by staff ; additional clinical questions may need further research by evidence center or may need ad hoc advisory group; information on agency utilization, similar coverage decisions may need agency or other health plan input; information on current practice in community or beneficiary preference may need further public input. Delegation should include specific instructions on the task, assignment or issue; include a time frame; provide direction on membership or input if a group is to be convened.

### **Efficacy Considerations:**

- What is the evidence that use of the technology results in more beneficial, important health outcomes? Consider:
  - Direct outcome or surrogate measure
  - Short term or long term effect
  - Magnitude of effect
  - Impact on pain, functional restoration, quality of life
  - Disease management
- What is the evidence confirming that use of the technology results in a more beneficial outcome, compared to no treatment or placebo treatment?
- What is the evidence confirming that use of the technology results in a more beneficial outcome, compared to alternative treatment?
- What is the evidence of the magnitude of the benefit or the incremental value
- Does the scientific evidence confirm that use of the technology can effectively replace other technologies or is this additive?
- For diagnostic tests, what is the evidence of a diagnostic tests' accuracy
  - Does the use of the technology more accurately identify both those with the condition being evaluated and those without the condition being evaluated?
- Does the use of the technology result in better sensitivity and better specificity?
- Is there a tradeoff in sensitivity and specificity that on balance the diagnostic technology is thought to be more accurate than current diagnostic testing?
- Does use of the test change treatment choices

### Safety

- What is the evidence of the effect of using the technology on significant morbidity?
  - Frequent adverse effect on health, but unlikely to result in lasting harm or be life-threatening, or;
  - Adverse effect on health that can result in lasting harm or can be life-threatening.
- Other morbidity concerns
- Short term or direct complication versus long term complications
- What is the evidence of using the technology on mortality – does it result in fewer adverse non-fatal outcomes?

### Cost Impact

- Do the cost analyses show that use of the new technology will result in costs that are greater, equivalent or lower than management without use of the technology?

### Overall

- What is the evidence about alternatives and comparisons to the alternatives
- Does scientific evidence confirm that use of the technology results in better health outcomes than management without use of the technology?