LETTER TO THE EDITORS

Probabilistic economic model to compare MRCP with ERCP for the investigation of biliary obstruction is never complete but an on-going program

Dear Editor,

In the article by Bravo Vergel et al. the authors should be congratulated for their success in cost containment and the cost-effectiveness analysis with a final-probabilistic economic model which was constructed in order to evaluate the relative cost-effectiveness of adopting magnetic resonance cholangiopancreatography (MRCP) scanning compared to diagnostic endoscopic retrograde cholangiopancreatography (ERCP) for the investigation of biliary obstruction in adults.

However, the approach is not exactly free of charge, and requires a lot effort in planning, implementation and follow-up.

As a matter of fact, a probabilistic economic model which was constructed in order to evaluate the relative cost-effectiveness of adopting MRCP scanning compared to diagnostic ERCP for the investigation of biliary obstruction in adults is never complete but rather an on-going program.

Therefore, it would be interesting to know that (a) how much resources were invested in this project; (b) how it was financed; (c) how the recurring charges will be handled; and (d) how the improvement of QOL is dependent of the clinical (not only statistical) pre-procedural base case values and parameters.

Also, there is concern over the comparability of MRCP and ERCP patients available from the systematic literature review. All the mentioned study reports are non-randomized and compared MRCP with either concurrent or historical ERCP comparison groups. The ERCP patients used as a comparison to MRCP patients generally do not present with the same prevalence of co-morbidity conditions and thus may not have similar surgical risk profiles. The lack of randomization and the reporting of non-randomized studies may have led to a selection bias towards the high surgical risk patients.

MRCP and ERCP are beneficial to relief of symptoms and improve QOL-level. However, the improvement of QOL is dependent on the pre-procedural or preoperative QOL and independent of the preoperative co-morbidities.

The clinical implication is that in patients with good QOL, even when they have a complaint of jaundice, the decision to perform MRCP or ERCP must clearly be discussed and certainly related to the conservative or operative risk. Certainly in this manuscript MRCP and ERCP patients in comparison with surgical results would be interesting.

Reference


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Author’s Reply to the “Letter to the Editor” by Dr. Narcis Hudorović

Dear Editor,

Your correspondent Dr. Hudorović raised a few points that require clarification. The article by Bravo Vergel et al. published in this journal is based on original research commissioned by the National Coordinating Centre for Health Technology Assessment (NCCHTA). The purpose of the NCCHTA HTA programme is to ensure that high quality research information on the costs, effectiveness and cost-effectiveness is produced in the most effective way for those who use, manage and provide care in the NHS. Every year the NCCHTA and its advisory panels decide which of the many suggestions received from the NHS and its users should become research priorities. The results of the independent research are