EUnetHTA JA3 WP4 - Other technologies, OTCA07
Fact check by manufacturers of the draft Project Plan for Relative effectiveness assessment of femtosecond laser-assisted cataract surgery (FLACS) compared to standard cataract surgery

Comments should be submitted not later than *Friday 26 January 2018*

1. Please put each new comment in a new row.
2. Please insert the page number and section number on which your comment applies. If your comment relates to the document as a whole, please put **'general'** in this column.
3. Please provide a description of your comment as specific as possible and preferably also provide a suggestion for rewording. If you wish to draw our attention to published literature, please supply the full reference.

The draft Project Plan of the Rapid Assessment of femtosecond laser-assisted cataract surgery (FLACS) compared with standard cataract surgery is open to review until 26/01/2018.

Comment from *Insert your name and organisation*	**Page number** *Insert 'general' if your comment relates to the whole document*	**Line/ section number**	**Comment and suggestion for rewording** *Please insert each new comment in a new row.*	**Character of comment** • 'major'[a] =1 • 'minor'[b] = 2 • 'linguistic'[c] =3 *Please indicate your choice by writing the according number in this field, e.g. for major choose "1".*	**Author's reply**
Alcon	7		Typo error: "RELAUNCH OF LITERATURE SEARCH AND UPADATING"	3	OK thank you
Alcon	9	*Table 2-1*	It is outlined in list of project objectives that ≥2 local (e.g. national or regional) reports based on the collaboratively produced Assessment will be undertaken. Does the author have any clarity on the localities that will be involved and also the associated timeframe?	1	Not at this moment. Informal commitment has been expressed by Eunethta partners
Alcon	10	Table 2-2:	We would like the author to clarify why non-randomised controlled clinical studies are deemed to be acceptable as a source of evidence to assess the safety of FLACS but the same conclusion wasn't reached with respect to clinical effectiveness.	1	RCTs provide the most robust evidence for comparative effectiveness (see also Eunethta guidelines). From an overview of the literature there are several RCTs and systematic reviews of RCTs available, plus several RCTs

Please add extra rows as needed.

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			It is our view that a more holistic approach should be taken when considering the evidence, as in the case of medical devices, traditional clinical trials may be challenging or impractical to conduct. This is true due to the realities of medical device innovation and development cycles, ethical issues that may arise with treatment assignment, and other similar challenges in executing traditional trials (Food and Administration, 2016). Indeed and according to the FDA, analyses of Real World Evidence, using appropriate methods, may in some cases provide similar information with comparable or even superior characteristics to information collected through a traditional clinical trial (Food and Administration, 2016). It is therefore our considered opinion that terms of the study design for assessing clinical effectiveness should also be expanded to include non-randomised clinical studies		ongoing. It would cause unnecessary lowering of quality of evidence to include non randomized studies when better quality of evidence is available. Non randomized studies will be considered for outcomes requiring 6 months or more follow up (and in case no RCTs are retrieved)
Alcon	14	Table 2-5	It is outlined that the target disease is age-related cataract, while the target population is adult patients (>18 years) affected by cataract and it is the case that "Young Adult" is included as a MeSH term. We would like the authors to clarify if the review will focus solely on age-related cataract?	2	The population will only be age related cataract
Alcon	14-15	Table 2-5	The claimed benefits of FLACS are outlined at the beginning of the outcomes section, however it is unclear whether these outcomes will be assessed as part of the review, as they are not made explicit under the headings (safety, clinical effectiveness or other outcomes) that follow. We are of the considered view that the following outcomes should also be	1	ECL and CCT have now been included among the SAF outcomes following suggestions from external experts. Procedural times will include all timing breakdowns retrieved in the studies.

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			included in the assessment: • **<u>Safety</u>** ➢ **Endothelial cell loss (ECL)** ECL is a serious concern regarding the successful outcome of cataract surgery. Damage to the endothelium is induced by the surgical procedure and is influenced by various preoperative and intraoperative factors. Endothelial cell loss, can increase the risk of corneal integrity disruption and reduced visual acuity (Walkow et al., 2000, Asena and Kaskaloglu, 2017) ➢ **Central corneal thickness (CCT)** The corneal endothelium plays an important role in maintaining corneal transparency and normal thickness. Central corneal thickening always accompanies endothelial cell loss and reflects the development of central corneal edema after cataract surgery (Chen et al., 2016, Asena and Kaskaloglu, 2017). • **<u>Other outcomes</u>** ➢ Effective phacoemulsification time (EPT) ➢ Cumulative dissipated energy (CDE) ➢ Mean phacoemulsification power (MP) **Phacoemulsification time and energy** are known to directly cause		CDE, phaco energy and circularity of capsulotomoy will be addressed in the TECH domain, but not in EFF and SAF domains

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			endothelial cell loss (Cho et al., 2010, Walkow et al., 2000, Hayashi et al., 1996). Reducing effective phacoemulsification time (EPT) and the required phacoemulsification energy, is associated with diminishing corneal endothelial injury (Abell et al., 2013, Conrad-Hengerer et al., 2013, Asena and Kaskaloglu, 2017). Injury reduction of corneal endothelial cells contributes to shorten the recovery period and improve visual outcomes (Roberts et al., 2013, He et al., 2011). • **Circularity of capsulotomy** ➢ Evidence suggests that improved quality of capsulotomy enables improved capsule overlap, better intraocular lens (IOL) placement and centration of the IOL. These advantages improve post-operative visual and refractive outcomes (Nagy et al., 2014). Indeed, it is the case that the above outcomes are included in two out of the four reviews that "constitute the starting point for this assessment" (as detailed in the project plan), namely: Chen et al. (2016), (Popovic et al., 2016)		

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