# 07.01.75 Vertebral Augmentation

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### Summary

### Description

Vertebral augmentation such as percutaneous balloon kyphoplasty, percutaneous vertebroplasty, radiofrequency kyphoplasty, mechanical vertebral augmentation, radiofrequency-vertebral augmentation/radiofrequency kyphoplasty, percutaneous sacroplasty, and use of expandable interbody implants are techniques which have been investigated to provide mechanical support and symptomatic relief in patients with osteoporotic vertebral compression fractures or those with osteolytic lesions of the spine (eg, multiple myeloma, metastatic malignancies); as a treatment for sacral insufficiency fractures; and as a technique to limit blood loss related to surgery.

### Summary of Evidence

For individuals who have symptomatic osteoporotic vertebral fractures between 6 weeks and 1 year old who receive vertebroplasty, the evidence includes 2 randomized sham-controlled trials, nonblinded randomized controlled trials (RCTs) comparing vertebroplasty with conservative management, and several meta-analyses. Relevant outcomes are symptoms, functional outcomes, quality of life,

hospitalizations, medication use, and treatment-related morbidity. Despite the completion of multiple RCTs, including 2 with sham controls, the efficacy of vertebroplasty for painful osteoporotic compression fractures remains uncertain. Two meta-analysis studies, which included the 2 sham-controlled trials, have demonstrated mixed results. The 2 studies had methodologic issues, including the choice of sham procedure and the potential of the sham procedure to have a therapeutic effect by reducing pain. Questions have also been raised about the low percentage of patients screened who participated in the trial, the volume of polymethylmethacrylate injected, and the inclusion of patients with chronic pain. One network meta-analysis found that relative to conservative treatment, vertebroplasty provided short-term and long-term improvements to pain relief and disability scores. Other meta-analyses had numerous limitations due to the heterogeneity of included studies or not specifying the timeframe for osteoporotic vertebral compression fractures. Overall, conclusions about the effect of vertebroplasty remain unclear. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome. However, even though there is a paucity of data in the peer-reviewed scientific literature based on clinical input and relevant professional society guidelines in which this therapy is supported in select individuals who have symptomatic osteoporotic vertebral fractures between 6 weeks and 1 year old who receive vertebroplasty may be considered medically necessary when the criteria below are met, see Policy.

For individuals with symptomatic osteoporotic vertebral fractures less than 6 weeks old who receive vertebroplasty, the evidence includes a randomized sham-controlled trial and nonblinded RCTs comparing vertebroplasty with conservative management. Relevant outcomes are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. For acute fractures, conservative therapy consisting of rest, analgesics, and physical therapy is an option, and symptoms will resolve in a large percentage of patients with conservative treatment only. However, a sham-controlled randomized trial in patients who had severe pain of fewer than 6 weeks in duration found a significant benefit of vertebroplasty for the treatment of osteoporotic vertebral fracture at the thoracolumbar junction. Other RCTs without sham controls have reported that vertebroplasty is associated with significant improvements in pain and reductions in the duration of bed rest. Given the high morbidity associated with extended bed rest in older adults, this procedure is considered to have a significant health benefit. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with sacral insufficiency fractures who receive sacroplasty, the evidence includes 3 prospective cohort studies and a case series. Relevant outcomes are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. No RCTs have been reported. The prospective cohort studies and retrospective series of 243 patients have reported rapid and sustained decreases in pain following percutaneous sacroplasty. Additional literature has mostly reported immediate improvements following the procedure. However, due to the small size of the evidence base, the harms associated with sacroplasty have not been adequately studied. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have osteoporotic vertebral compression fracture who receive balloon kyphoplasty, or mechanical vertebral augmentation, the evidence includes an Agency for Healthcare Research and Quality (AHRQ) comparative effectiveness review, randomized controlled trials (RCTs), and meta-analyses. Relevant outcomes include symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity. The AHRQ review concluded that vertebroplasty was probably more effective at reducing pain and improving function in patients > 65 years of age, but benefits were small. Kyphopasty was found to be probably more effective than usual care for pain and function in older patients with vertebral compression fracture at up to 1 month and may be more effective at > 1 month to ≥ 1 year but has not been compared against sham therapy. A meta-analysis and moderately sized unblinded RCT have compared kyphoplasty with conservative care and found short-term benefits in pain

and other outcomes. One systematic review of RCTs found no significant difference in subsequent fracture between vertebroplasty and conservative treatment, and another systematic review of prospective and retrospective studies reported improved mortality with either vertebroplasty or balloon kyphoplasty compared with conservative treatment. A network meta-analysis found that relative to conservative treatment, kyphoplasty provided short-term and long-term improvements to pain and disability scores. Other RCTs, summarized in a meta-analysis, have reported similar outcomes for kyphoplasty and vertebroplasty. A systematic review that compared mechanical vertebral augmentation (Kiva or SpineJack) with kyphoplasty have reported similar outcomes for both procedures. A major limitation of the available RCTs is the lack of a sham procedure. Due to the possible sham effect observed in the recent trials of vertebroplasty, the validity of the results from non-sham-controlled trials is unclear. Therefore, whether these improvements represent a true treatment effect is uncertain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome. However, even though there is a paucity of data in the peer-reviewed scientific literature based on clinical input and relevant professional society guidelines in which this therapy is supported in select individuals who have osteoporotic vertebral compression fracture who receive balloon kyphoplasty, or mechanical vertebral augmentation may be considered medically necessary when the criteria below are met, see Policy.

For individuals who have osteolytic vertebral compression fracture who receive balloon kyphoplasty or mechanical vertebral augmentation, the evidence includes RCTs, case series, and systematic reviews of these studies. Relevant outcomes include symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity. Two RCTs have compared balloon kyphoplasty with conservative management, and another has compared Kiva with balloon kyphoplasty. Results of these trials, along with case series, would suggest a reduction in pain, disability, and analgesic use in patients with cancer-related compression fractures. However, because the results of the comparative studies of vertebroplasty have suggested possible placebo or natural history effects, the evidence that these studies provide is insufficient to warrant conclusions about the effect of kyphoplasty on health outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome. However, even though there is a paucity of data in the peer-reviewed scientific literature based on clinical input and relevant professional society guidelines in which this therapy is supported in select individuals who have osteolytic vertebral compression fracture who receive balloon kyphoplasty or mechanical vertebral augmentation may be considered medically necessary when the criteria below are met, see Policy.

For individuals who have osteoporotic or osteolytic vertebral compression fracture who receive radiofrequency kyphoplasty, the evidence includes a systematic review, and RCT. Relevant outcomes include symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity. The only RCT (N=80) identified showed similar results between radiofrequency kyphoplasty and balloon kyphoplasty. The systematic review suggested that radiofrequency kyphoplasty is superior to balloon kyphoplasty in pain relief, but the review itself was limited by the inclusion of a small number of studies as well as possible bias. Corroboration of these results in a larger number of patients would be needed to determine with greater certainty whether radiofrequency kyphoplasty provides outcomes similar to balloon kyphoplasty. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a traumatic fracture who receive an expandable interbody implant, the evidence includes one small retrospective, noncomparative observational study. Relevant outcomes include symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity. No RCTs evaluating an expandable interbody implant in individuals needing a traumatic fracture repair and interbody fusion were identified. Although the expandable interbody implant resulted in an improvement in pain and physical activity scores in 17 individuals, a significant loss of correction was also observed.

Large prospective trials are needed to adequately evaluate the potential health benefits and harms of expandable interbody implants in individuals with traumatic fractures. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

### Additional Information

Not applicable.

## OBJECTIVE

The objective of this evidence review is to evaluate whether vertebroplasty, balloon kyphoplasty, mechanical vertebral augmentation, percutaneous vertebroplasty, radiofrequency-assisted vertebral augmentation/radiofrequency kyphoplasty, percutaneous sacroplasty, or expandable interbody implants improve the net health outcomes in individuals with osteoporotic or osteolytic vertebral compression fractures or sacral insufficiency fractures.

## PRIOR APPROVAL

Not applicable.

## POLICY

### Medically Necessary

Vertebral augmentation (percutaneous vertebroplasty, kyphoplasty or mechanical vertebral augmentation) using an FDA cleared device may be considered **medically necessary** for individuals with persistent, debilitating pain resulting from **one of the following (1-8)** :

1. Aggressive space-occupying lesions of a vertebral body (e.g., hemangioma/eosinophilic granuloma); **or**
2. Multiple myeloma; or
3. Primary malignant neoplasm of bone or bone marrow; **or**
4. Osteonecrotic (e.g., Kummel disease) vertebral compression fracture; **or**
5. Secondary osteolytic metastasis, excluding sacrum and/or coccyx; **or**
6. Steroid-induced vertebral compression fracture that have failed to respond to optimal conservative therapy**; or**
7. Symptomatic osteoporotic compression fractures that have failed to respond to optimal conservative therapy which may or may not be caused by trauma; or
8. Symptomatic osteoporotic compression fractures which may or may not be caused by trauma that are less than 6 weeks duration that has led to hospitalization or persist at level that prevents ambulation (exempt from 6 weeks of optimal conservative care).

*And* only for painful, debilitating osteoporotic acute (0-6 weeks) or subacute (> 6 weeks) compression fractures or steroid-induced fractures, when ***all* of the following criteria** have been met:

- The pain is localized to the level of the pathology being treated; **and**
- Other causes of pain such as spinal stenosis or herniated intervertebral disk have been ruled out by computed tomography or magnetic resonance imaging; **and**
- Significant pain or loss of mobility that cannot be relieved by a minimum of 6 weeks of optimal conservative therapy; **and**
- The affected vertebra has not been extensively destroyed and is at least 1/3 of its original height.

### Experimental and Investigational

Vertebral augmentation (percutaneous vertebroplasty, kyphoplasty or mechanical vertebral augmentation) are considered **investigational** when not meeting the above criteria and all other indications including but not limited to the following because the evidence is insufficient to determine the technology results in an improvement in the net health outcomes.

- non-painful/non-aggressive vertebral hemangioma;
- vertebrae of the cervical spine and thoracic levels T1-T4
- stabilization of insufficiency fractures or lesions of the sacrum (sacroplasty) coccyx (coccygeoplasty)
- prophylactic treatment for osteoporosis of the spine
- prophylactic treatment for chronic back pain of long-standing duration (greater than six months), even if associated with old compression fracture(s)

The following are considered **investigational** for all indications because the evidence is insufficient to determine the technology results in an improvement in the net health outcomes.

- Radiofrequency-Assisted Augmentation/ Radiofrequency kyphoplasty
- Percutaneous Sacroplasty
- Expandable Interbody Implant

## POLICY GUIDELINES

### Conservative Therapy

Optimal conservative therapy would include the following, *unless contraindicated*:

- prescription-strength analgesics, steroids, and/or NSAIDs for ≥ six weeks; **and**
- Bracing for ≥ six weeks; **and**
- provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for ≥ six weeks.

*Note: Conservative treatment is only required for painful, debilitating osteoporotic acute (0-6 weeks) or subacute (> 6 weeks) collapse/compression fractures or steroid-induced fractures.*

### Significant Pain

Significant pain is defined as:

- Pain rating scale (e.g., visual analog scale (VAS)/number rating scale (NRS)) ≥ 7; **or**
- Severe, disabling, crippling, or incapacitating pain.

### Required Documentation

The individual's medical records submitted for review should document the above medical necessity and should include information such as the following, *when applicable*:

- Onset of the condition, length, and duration
- Documentation of the individual's symptoms, pain, location, and severity including functional impairment interfering with activities of daily living (e.g., meals, walking, getting dressed, driving)
- History and co-morbid medical condition(s)
- No evidence of spinal cord compression
- Treatments tried and failed to include the length of time the treatment was trialed
- Completed report(s) of diagnostic imaging

### Coding

See the Codes table for details.

# BACKGROUND

## Treatment of Vertebral Compression Fracture

Chronic symptoms do not tend to respond to the management strategies for acute pain such as bed rest, immobilization or bracing device, and analgesic medication, sometimes including narcotic analgesics. The source of chronic pain after vertebral compression fracture may not be from the vertebra itself but may be predominantly related to strain on muscles and ligaments secondary to kyphosis. This type of pain frequently does not improve with analgesics and may be better addressed through exercise or physical therapy. Improvements in pain and ability to function are the principal outcomes of interest for the treatment of osteoporotic fractures.

## Treatment of Sacral Insufficiency Fractures

Similar interventions are used for sacral fractures and include bed rest, bracing, and analgesics. Initial clinical improvements may occur quickly; however, resolution of all symptoms may not occur for 9 to 12 months.

## Vertebral and Sacral Body Metastasis

Metastatic malignant disease of the spine generally involves the vertebrae/sacrum, with pain being the most frequent complaint.

### Treatment of Vertebral and Sacral Body Metastasis

While radiotherapy and chemotherapy are frequently effective in reducing tumor burden and associated symptoms, pain relief may be delayed days to weeks, depending on tumor response. Further, these approaches rely on bone remodeling to regain strength in the vertebrae/sacrum, which may necessitate supportive bracing to minimize the risk of vertebral/sacral collapse during healing. Improvements in pain and function are the primary outcomes of interest for treatment of bone malignancy with percutaneous vertebroplasty or sacroplasty.

## Surgical Treatment Options

### Percutaneous Vertebroplasty and Kyphoplasty

Vertebroplasty is a surgical procedure that involves the injection of synthetic cement (e.g., polymethylmethacrylate, bis-glycidal dimethacrylate [Cortoss®]) into a fractured vertebra. It has been suggested that vertebroplasty may provide an analgesic effect through mechanical stabilization of a fractured or otherwise weakened vertebral body. However, other mechanisms of effect have been postulated, including thermal damage to intraosseous nerve fibers.

Balloon kyphoplasty is a variant of vertebroplasty and uses a specialized bone tamp with an inflatable balloon to expand a collapsed vertebral body as close as possible to its natural height before injection of polymethyl methacrylate. Radiofrequency kyphoplasty (also known as radiofrequency targeted vertebral augmentation) is a modification of balloon kyphoplasty. In this procedure, a small diameter articulating osteotome creates paths across the vertebra. An ultra-high viscosity cement is injected into the fractured vertebral body, and radiofrequency is used to achieve the desired consistency of the cement. The ultra-high viscosity cement is designed to restore height and alignment to the fractured vertebra, along with stabilizing the fracture.

### Percutaneous Sacroplasty

Sacroplasty evolved from the treatment of insufficiency fractures in the thoracic and lumbar vertebrae with vertebroplasty. The procedure, essentially identical to vertebroplasty, entails guided injection of

polymethylmethacrylate through a needle inserted into the fracture zone. Although first described in 2000 as a treatment for symptomatic sacral metastatic lesions, it is most often described as a minimally invasive alternative to conservative management for sacral insufficiency fractures.

### Mechanical Vertebral Augmentation

Kiva is a mechanical vertebral augmentation technique that uses an implant for structural support of the vertebral body to provide a reservoir for bone cement. The Kiva vertebral compression fractures treatment system consists of a shaped memory coil and an implant, which is filled with bone cement. The coil is inserted into the vertebral body over a removable guide wire. The coil reconfigures itself into a stack of loops within the vertebral body and can be customized by changing the number of loops of the coil. The implant, made from PEEK-OPTIMA™, a biocompatible polymer, is deployed over the coil. The coil is then retracted, and polymethyl methacrylate is injected through the lumen of the implant. The polymethyl methacrylate cement flows through small slots in the center of the implant, which fixes the implant to the vertebral body and contains the polymethyl methacrylate in a cylindrical column. The proposed advantage of the Kiva system is a reduction in cement leakage.

SpineJack is a mechanical vertebral augmentation technique that utilizes bipedicular 4.2 mm to 5.0 mm self-expanding jacks to restore vertebral height. Placement of the titanium devices are verified in anteroposterior and lateral view prior to expansion. Once the devices are expanded, a proprietary bone cement is injected. The proposed benefit is greater control over expansion and greater restoration of vertebral height compared to balloon kyphoplasty. The procedure requires good bone quality.

Pain and function are subjective outcomes and, thus, may be susceptible to placebo effects. Furthermore, the natural history of pain and disability associated with these conditions may vary. Therefore, controlled comparison studies would be valuable to demonstrate the clinical effectiveness of vertebroplasty and sacroplasty over any associated nonspecific or placebo effects and to demonstrate the effect of treatment compared with alternatives such as continued medical management.

In all clinical situations, adverse events related to complications from vertebroplasty, kyphoplasty, sacroplasty, and mechanical vertebral augmentation are the primary harms to be considered. Principal safety concerns relate to the incidence and consequences of leakage of the injected polymethyl methacrylate or another injectate.

### Radiofrequency Vertebral Augmentation

Radiofrequency kyphoplasty (RFK), also known as radiofrequency-targeted vertebral augmentation, is a procedure intended as an alternative to a percutaneous balloon kyphoplasty. In a radiofrequency kyphoplasty, a surgeon uses a navigational cannula to create small pathways in the vertebra before injecting a proprietary ultra-high viscous bone cement, which is intended to restore height and alignment to the fractured vertebra, along with stabilizing the fracture. The surgeon uses radiofrequency heating pulses to control the cement's viscosity during injection; this in turn allows the surgeon to restore the vertebra's height with the injection alone, without the need for a balloon. The radiofrequency kyphoplasty procedure is also intended to preserve healthy tissue by creating smaller pathways in the vertebra than traditional percutaneous balloon kyphoplasty, reduce cement leak risks, and reduce procedure time. The surgeon mixes immediately before injection. The cement polymerizes as it passes through the radiofrequency heater.

### Expandable Interbody Implant

Use of an expandable interbody implant is a newer minimally invasive procedure similar to vertebroplasty currently being researched. The procedure includes a graft consisting of mesh filled with bone chips instead of the traditional cement used to fix a fracture. The Optimesh Multiplanar Expandale Interbody

System was designed, “for use as an adjunct to fusion in an intervertebral body fusion at one level in the lumbar spine from L2 to S1 in skeletally mature patients with degenerative disc disease (DDD) with up to Grade I spondylolisthesis at the involved level.”

## Regulatory Status

### Vertebroplasty

Vertebroplasty is a surgical procedure and, as such, is not subject to U.S. Food and Drug Administration (FDA) approval.

### Bone Cement

Polymethylmethacrylate bone cement was available as a drug product before enactment of the FDA's device regulation and was at first considered what the FDA terms a "transitional device." It was transitioned to a class III device requiring premarketing applications. Several orthopedic companies have received approval of their bone cement products since 1976. In 1999, polymethylmethacrylate was reclassified from class III to class II, which requires future 510(k) submissions to meet "special controls" instead of "general controls" to assure safety and effectiveness. Thus, use of polymethylmethacrylate in vertebroplasty represented an off-label use of an FDA-regulated product before 2005. In 2005, polymethylmethacrylate bone cements such as Spine-Fix® Biomimetic Bone Cement and Osteopal® V were cleared for marketing by the FDA through the 510(k) process for the fixation of pathologic fractures of the vertebral body using vertebroplasty procedures.

The use of polymethylmethacrylate in sacroplasty is an off-label use of an FDA-regulated product (bone cements such as Spine-Fix® Biomimetic Bone Cement [Teknimed] and Osteopal® V [Heraeus]) because the 510(k) approval was for the fixation of pathologic fractures of the vertebral body using vertebroplasty procedures. Sacroplasty was not included. FDA product code: NDN.

In 2009, Cortoss® (Stryker) Bone Augmentation Material was cleared for marketing by the FDA through the 510(k) process. Cortoss® is a nonresorbable synthetic material that is a composite resin-based, bis-glycidyl dimethacrylate. The FDA classifies this product as a polymethylmethacrylate bone cement.

In 2010, the Parallax® Contour® Vertebral Augmentation Device (ArthroCare) was cleared for marketing by FDA through the 510(k) process. There have been several other augmentation and bone expander devices (eg, Balex® Bone Expander System, Arcadia® Ballon Catheter, Kyphon Element® Inflatable Bone Tamp) that were also cleared for marketing by FDA through the 510(k) process. These devices create a void in cancellous bone that can then be filled with bone cement. FDA product code: HXG.

Bone cement has received marketing clearance by the FDA through the 510(k) process are seen in the table below. *This table is not intended to be an all-inclusive list.*

**Table 1: Bone Cement Cleared by the U.S. Food and Drug Administration**

| Device | Manufacturer | Date Cleared | 510(k) No. | Indication |
|---|---|---|---|---|
| Cortoss® Bone Augmentation Material | Stryker | 2009 | K080108 | Cortoss® is a nonresorbable synthetic material that is a composite resin-based, bis-glycidyl dimethacrylate. The FDA |

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|---|---|---|---|---|
| | | | | classifies this product as a polymethylmethacrylate bone cement. |
| KYPHON® HV-R® Bone Cement | Medtronic | 2016 | K160983 | the fixation of pathologic fractures of the vertebral body using vertebroplasty or kyphoplasty procedures. |
| KyphX® HV-RTM | Medtronic | 2004 | K033801 | process for the treatment of pathologic fractures of the vertebral body due to osteoporosis, cancer, or benign lesions using a balloon kyphoplasty procedure. |
| Osteopal® V | Heraeus | 2010 | K050085 | Bone cement which is indicated for the treatment of pathological fractures of the vertebral body due to osteoporosis, cancer, or benign lesions using a vertebroplasty or balloon kyphoplasty. |
| Parallax® Contour® Vertebral Augmentation Device | ArthroCare | 2011 | K110183 | Used to disrupt cancellous bone and create a void in the vertebral body and fill the void during kyphoplasty or vertebral augmentation procedures. |
| Spine-Fix® Biomimetic Bone Cement | Teknimed S.A. | 2005 | K043593 | Used for the fixation of pathological fractures of the vertebral body using vertebroplasty or kyphoplasty procedures. Painful vertebral compression fractures may result from osteoporosis, benign lesions (hemangioma), and malignant lesions (metastatic cancers, myeloma). |

### Kyphoplasty and Mechanical Vertebral Augmentation Devices

Kyphoplasty is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration (FDA). Polymethyl methacrylate bone cement was available as a drug product before enactment of the FDA's device regulation and was at first considered what the FDA termed a "transitional device." It was transitioned to a class III device and then to a class II device, which required future 510(k) submissions to meet "special controls" instead of "general controls" to assure safety and effectiveness. In July 2004, KyphX® HV-RTM bone cement was cleared for marketing by the FDA through the 510(k) process for the treatment of pathologic fractures of the vertebral body due to osteoporosis, cancer, or benign lesions using a balloon kyphoplasty procedure. Subsequently, other products such as Spine-Fix® Biomimetic Bone Cement, KYPHON® HV-R® Bone Cement, KYPHONTM VuETM Bone Cement, Osteopal® V (Heraeus), and VertehighFix (Xelite Biomed) have received 510(k) marketing clearance for the fixation of pathologic fractures of the vertebral body using vertebroplasty or kyphoplasty procedures.

Balloon kyphoplasty requires the use of an inflatable bone tamp. In July 1998, one such tamp, the KyphX® inflatable bone tamp (Medtronic), was cleared for marketing by the FDA through the 510(k) process. Additional devices for balloon kyphoplasty are listed in Table 2.

There are several mechanical vertebral augmentation devices that have received marketing clearance by the FDA through the 510(k) process; these are listed in Table 2.

StabiliT® Vertebral Augmentation System (Merit Medical) for radiofrequency vertebral augmentation was cleared for marketing in 2009.

FDA product code: NDN.

**Table 2. Kyphoplasty and Mechanical Vertebral Augmentation Devices Cleared by the U.S. Food and Drug Administration**

| Device | Manufacturer | Date Cleared | 510(k) No. | Indication |
|---|---|---|---|---|
| **Balloon Kyphoplasty** | | | | |
| Balloon Inflation System | Ningbo Biotechnology Co. Ltd | 2/29/2024 | K232842 | Reduction of fractures and/or creation of a void |
| Renova Spine Baloon Catheter | Biopsybell S.R.L. | 10/30/2023 | K231340 | Reduction of fractures and/or creation of a void |
| TRACKER Plus Kyphoplasty System | GS Medical Co., Ltd | 10/28/2021 | K211797 | Reduction of fractures and/or creation of a void |
| Joline Kyphoplasty System Allevo | Joline GmbH & Co. | 5/27/2020 | K192449 | To repair vertebral compression fractures |
| TRACKER Kyphoplasty System | GS Medical Co., Ltd | 12/4/2019 | K192335 | Reduction of fractures or creation of a void |
| Stryker iVAS Elite Inflatable Vertebral Augmentation System (Stryker iVAS Elite Balloon Catheter) | Stryker Corporation | 12/21/2018 | K181752 | To repair vertebral compression fractures |
| SpineKure Kyphoplasty System | Hanchang Co. Ltd. | 5/29/2018 | K172871 | To repair vertebral compression fractures |
| Modified Winch Kyphoplasty (15 and 20 mm) 11 Gauge Balloon Catheters | G-21 s.r.l. | 8/23/2017 | K172214 | To repair vertebral compression fractures |

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|---|---|---|---|---|
| 13G InterV Kyphoplasty Catheter (Micro) and 11G InterV Kyphoplasty Catheter (Mini-Flex) | Pan Medical Ltd. | 11/1/2016 | K162453 | To repair vertebral compression fractures |
| MEDINAUT Kyphoplasty System | Imedicom Co. Ltd. | 7/29/2016 | K153296 | To repair vertebral compression fractures |
| AVAflex Vertebral Balloon System | Carefusion | 11/24/2015 | K151125 | To repair vertebral compression fractures |
| Osseoflex SB Straight Balloon 10g/4ml Osseoflex SB Straight Balloon 10g/2ml | Osseon LLC | 4/9/2015 | K150607 | To repair vertebral compression fractures |
| InterV Kyphoplasty Catheter (Balloon Length: 1015 and 20mm) InterV Kyphoplasty Catheter (Mini) (Balloon Length: 10 15 and 20mm) | Pan Medical Ltd. | 3/6/2015 | K150322 | To repair vertebral compression fractures |
| GUARDIAN-SG Inflatable Bone Expander System | BM Korea Co. Ltd. | 1/16/2015 | K143006 | To repair vertebral compression fractures |
| ZVPLASTY | Zavation LLC | 9/12/2014 | K141419 | To repair vertebral compression fractures |
| **Mechanical Vertebral Augmentation** | | | | |
| Kiva VCF Treatment System | Benvenue Medical Inc. | 8/14/2014 | K141141 | To repair vertebral compression fractures |
| SpineJack Expansion Kit | Vexim SA | 8/30/2018 | K181262 | To repair vertebral compression fractures |
| V-Strut Vertebral Implant | Hyprevention SAS | 3/5/2020 | K191709 | Treatment of vertebral fractures in the thoracic and lumbar spine |

### Expandable Interbody Implant

The FDA granted 510(k) premarket approval for the OptiMesh® Expandable Interbody Fusion System in November 2003, to maintain the bone grafts relative position of material within a vertebral body defect without impact to the stability of the vertebral body. This does not include the vertebral endplates. Available at: https://www.accessdata.fda.gov/cdrh_docs/pdf/K014200.pdf.

OptiMesh® Expandable Interbody Fusion System was granted De Novo classification in September 2020 for additional indications allowing the use with bone graft and supplemental posterior fixation in lumbar interbody fusion. Available at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/denovo.cfm?id=DEN200010 .

*Please note the above information is not intended to be all inclusive.*

## RATIONALE

This evidence review was created in April 2017 and has been updated regularly with searches of the PubMed database. The most recent literature update was performed through June 2025.

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

The natural history of pain and disability associated with vertebral compression fractures vary. Also, pain and functional ability are subjective outcomes, susceptible to placebo effects. Nonspecific or placebo effects can be quite large for an invasive procedure such as kyphoplasty for which there is no blinding. The placebo effect may be on the order of 6 to 7 mm on a 100-mm scale, for invasive procedures, and even larger effects (10%) have been observed in the sham-controlled vertebroplasty trials. Therefore, sham-controlled comparison studies are important to demonstrate the clinical effectiveness of kyphoplasty over and above any associated nonspecific or placebo effects. Adverse effects related to kyphoplasty are the primary harms to be considered. Principal safety concerns relate to the incidence and consequences of leakage of the injected polymethyl methacrylate.

### Percutaneous Vertebroplasty for Vertebral Compression Fractures of Between 6 Weeks and 1 Year Old

### *Clinical Context and Therapy Purpose*

Osteoporotic compression fractures are common. It is estimated that up to one-half of XX individuals and approximately one-quarter of XY individuals will have a vertebral fracture at some point in their lives. However, only about one-third of vertebral fractures reach clinical diagnosis, and most symptomatic fractures will heal within a few weeks or 1 month with medical management. Nonetheless, some individuals with acute fractures will have severe pain and decreased function that interferes with the ability to ambulate and is not responsive to usual medical management. Also, a minority of patients will exhibit chronic pain following osteoporotic compression fracture that presents challenges for medical management.

The purpose of vertebroplasty is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with symptomatic osteoporotic or osteolytic vertebral fractures between 6 weeks and 1 year old.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with symptomatic osteoporotic or osteolytic vertebral fractures between 6 weeks and 1 year old. With acute fractures, these individuals experience severe pain, decreased ambulatory function, and a lessened response to conservative medical management. Risk factors for osteoporotic or osteolytic vertebral fractures can include osteopenia, osteoporosis, advanced age, inactivity, corticosteroid use, female sex, and depression.

### *Interventions*

The therapy being considered is vertebroplasty, a procedure for stabilizing compression fractures in the spine, during which bone cement is injected into the fractured vertebra through a small hole in the skin in order to relieve back pain.

### *Comparators*

Comparators of interest include conservative management. Conservative management includes measures to reduce pain and improve mobility. Physical therapy, analgesics, narcotics, and hormone treatments can be prescribed to achieve this. Bed rest and braces may also be utilized as conservative management; however, these modalities are associated with prolonged immobilization which can further exacerbate bone loss and fail to relieve systems.

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. Negative outcomes can include complications with sedation, further injury during transfer to the radiology table, and the possibility of abuse after the prescription of narcotics. The outcomes of interest for vertebroplasty as a treatment for symptomatic vertebral fractures have varying follow-up times to fully examine the impact on the patient, ranging from shorter term outcomes like medication use to outcomes that require extended follow-up, such as functional outcomes. Given that the existing literature evaluating vertebroplasty as a treatment for symptomatic vertebral fractures between 6 weeks and 1 year old has varying lengths of follow-up, ranging from 6 months to 2 years, follow-up timing of 1 year is appropriate to demonstrate efficacy.

Disability, a major factor on quality of life, is measured using various tools throughout the literature. Three such tools include the Roland-Morris Disability Questionnaire, the visual analogue scale, and QUALEFFO (a quality-of-life questionnaire in patients with vertebral fractures). The Roland-Morris Disability Questionnaire is a self-administered disability measure in which greater levels of disability are reflected by

higher numbers on a 24-point scale and on visual analogue scale. The Roland-Morris Disability Questionnaire has been shown to yield reliable measurements, which are valid for inferring the level of disability, and to be sensitive to change over time for groups of patients with low back pain. Visual analogue scale is commonly used as the outcome measure for such studies. It is usually presented as a 100-mm horizontal line on which the patient's pain intensity is represented by a point between the extremes of "no pain at all" and "worst pain imaginable." With QUALEFFO (a quality-of-life questionnaire in patients with vertebral fractures), quality of life is measured by the scale 0 to 100, higher scores indicating worse quality of life.

### Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

This evidence review was informed by a TEC Assessment (2000), which was updated periodically through 2010. Subsequent evidence includes a number of RCTs, 2 of which included a sham control, and numerous RCTs that compared vertebroplasty with conservative management.

### Review of Evidence

### Systematic Reviews

In March of 2017 Hayes completed a Health Technology Assessment which was last reviewed in April 2021 on percutaneous kyphoplasty for osteoporotic vertebral compression fractures. For percutaneous kyphoplasty (KP) in individuals with osteoporotic vertebral compression fractures with medically refractory pain Hayes provided a C rating. According to Hayes a C rating indicates, “potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns."

Buchbinder et al (2018) published a Cochrane review of the literature up to November 2014. Studies compared vertebroplasty versus placebo (2 studies with 209 randomized participants), usual care (6 studies with 566 randomized participants), and kyphoplasty (4 studies with 545 randomized participants). The majority of participants were female, between 63.3 and 80 years of age, with symptom duration ranging from 1 week to more than 6 months. At 1 month, disease-specific quality of life measured by the QUALEFFO (a quality-of-life questionnaire in patients with vertebral fractures; scale 0 to 100, higher scores indicating worse quality of life) was 0.40 points worse in the vertebroplasty group. Based upon moderate quality evidence from 3 trials (1 placebo, 2 usual care, 281 participants) with up to 12 months follow-up, it is unclear if vertebroplasty increases the risk of new symptomatic vertebral fractures. Similarly, based upon moderate quality evidence from 2 placebo-controlled trials, it is unclear to what extent risk of other adverse events exists. There were 3/106 adverse events observed in the vertebroplasty group compared with 3/103 in the placebo group (risk ratio [RR] 1.01; 95% confidence interval [CI], 0.21 to 4.85). Serious adverse events that have been reported with vertebroplasty included osteomyelitis, cord compression, thecal sac injury, and respiratory failure.

Staples et al (2011) conducted a patient-level meta-analysis of the 2 sham-controlled trials to determine whether vertebroplasty is more effective than sham in specific subsets of patients. This subset analysis focused on duration of pain (≤6 weeks vs. >6 weeks) and severity of pain (score <8 or ≥8 on an 11-point numeric rating scale). The analysis included 209 participants (78 from the Australian trial, 131 from the U.S. trial); 27% had pain of recent onset and 47% had severe pain at baseline. The primary outcome measures (pain scores and function on the Roland-Morris Disability Questionnaire [RMDQ] at 1 month) did not differ significantly between groups. Responder analyses were also conducted based on a 3-unit improvement in pain scores, a 3-unit improvement in RMDQ scores, and a 30% improvement in each of the pain and disability outcomes. The only difference observed between groups was a trend in the vertebroplasty group to achieve at least 30% improvement in pain scores (relative risk, 1.32; 95% CI, 0.98 to 1.76; p=0.07), a result that may have been confounded by the greater use of opioid medications in that group.

Xie et al (2017) in a meta-analysis of RCTs, evaluated the efficacy and safety in percutaneous vertebroplasty and conservative treatment for patients with osteoporotic vertebral compression fractures. Thirteen studies were selected (N =1231 patients; 623 to vertebroplasty, 608 to conservative treatment). Outcomes included pain relief (from 1 week to 6 months), quality of life assessments, and the rate of adjacent-level vertebral fracture. Vertebroplasty was superior for pain relief at 1 week and at 1 month. It was inferior to conservative treatment for pain relief at 6 months. Vertebroplasty showed improvement over conservative treatment for quality of life, as measured using the Quality-of-Life Questionnaire of the European Foundation for Osteoporosis. No statistically significant differences were found between treatments for the rate of adjacent-level vertebral fractures. Limitations included the inclusion of several studies with inadequate blinding and heterogenous reporting of patient characteristics outcomes.

Hinde et al (2020) in a meta-analysis of retrospective and prospective cohort studies, assessed the mortality outcomes of vertebral augmentation versus nonsurgical management in patients with osteoporotic vertebral compression fractures. The meta-analysis included 7 studies (N=2,089,944; 382,070 treated with vertebral augmentation and 1,707,874 treated with nonsurgical management). Vertebral augmentation improved mortality compared with nonsurgical management at both 2- and 5-year follow-up. Limitations included heterogeneity in the number of enrolled patients in included studies as well as differences in health status.

Zhang et al (2020) in a meta-analysis of RCTs, assessed the efficacy of percutaneous vertebroplasty versus conservative treatment for patients with osteoporotic vertebral compression fractures. Ten studies were included, and outcomes consisted of pain relief at 1 week, 1 month, and 6 months; quality of life assessments; and the rate of new vertebral fractures. Compared with conservative treatment, percutaneous vertebroplasty was superior for pain relief at 1 week and 1 month, but not at 3 months. Results varied for quality-of-life assessments with similar outcomes between percutaneous vertebroplasty and conservative treatments on the Roland-Morris Disability Questionnaire. Limitations included an imbalance in baseline demographics and the clinical characteristics of patients in included studies.

Chang et al (2021) in a meta-analysis of RCTs and cohort studies, evaluated the effectiveness and safety of various interventions, including vertebroplasty versus kyphoplasty or conservative treatment, for treating osteoporotic vertebral compression fractures. Thirty-nine studies included vertebroplasty as a comparative arm. Outcomes included scores based on the visual analog scale and Oswestry Disability Index. Vertebroplasty decreased scores on the visual analog scale and Oswestry Disability Index compared with conservative treatment, but had similar outcomes compared with kyphoplasty. The rate of new fractures was similar for vertebroplasty versus conservative treatment and vertebroplasty versus kyphoplasty. Limitations consisted of the differences in indications, data types, follow-up times, and variables in included studies.

A network meta-analysis of RCTs conducted by Liu et al (2023) assessed the safety and efficacy of 12 interventions, including vertebroplasty, compared to conventional and sham treatments for osteoporotic vertebral compression fractures. The analysis included 34 RCTs, encompassing a total of 4,383 participants with an average age of 73.4 years. Each study required a control group and an intervention group and reported on outcomes measured by the VAS pain scale or the Oswestry Disability Index. The authors included several sub-groups of vertebroplasty (vertebroplasty with facet joint injection, unilateral vertebroplasty, and curved vertebroplasty), which are not discussed here. Improvements compared to conservative treatment were observed in both short-term and long-term VAS and ODI scores. Compared to sham treatment, no significant difference was noted in short-term VAS scores; however, a notable improvement favoring the vertebroplasty group was observed in long-term VAS outcomes, as well as in both short-term and long-term ODI outcomes. No significant differences were observed in the relative risk of new fractures between vertebroplasty and the sham or conservative control groups. Limitations consisted of differences in indications and follow-up times, significant heterogeneity across study findings, and more than 50% of included studies having been assessed with a moderate or high risk of bias.

**Table 3: Characteristics of Systematic Reviews and Meta-Analyses on Percutaneous Vertebroplasty for Vertebral Compression Fractures of Between 6 Weeks and 1 Year Old**

| Study | Dates | Trials | Participants | Intervention | N (Range) | Design |
|---|---|---|---|---|---|---|
| Buchbinder et al (2018) | 2007-2016 | 21 | Patients with osteoporotic vertebral fractures (mean age ranged from 63.3 to 80 years); symptom duration ranged from 1 week to ≥6 months. | Vertebroplasty | 2862 (46-404) | RCT |
| Staples et al (2011) | NR | 2 | Participants with 1-2 painful osteoporotic vertebral fractures >12 months duration and unhealed, as confirmed by MRI, were randomly assigned to vertebroplasty or to a sham procedure. | Vertebroplasty vs. placebo (5 studies); kyphoplasty (7 studies); facet joint steroid injection (1) | 209 (78-131) | RCT |
| Xie et al (2017) | NR-2017 | 13 | Patients with OVCFs | PVP vs. conservative treatment | 2561 (NR) | RCT |
| Hinde et al (2020) | NR-2018 | 7 | Patients with OVCFs | Vertebral augmentation (vertebroplasty or balloon kyphoplasty) vs. | 2,089,944 (NR) | Retrospective and propspective cohort studies |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | nonsurgical management | | |
| Zhang et al (2020) | NR-2018 | 10 | Patients with OVCFs | PVP vs. conservative treatment | NR | RCT |
| Chang et al (2021) | NR-2020 | 56 | Patients with OVCFs | Vertebroplasty vs. conservative treatment (15 studies); kyphoplasty (24 studies) | 6974 (14-191) | RCT, cohort studies |
| Liu et al (2023) | NR-2023 | 34 | Patients with OVCFs | Network meta-analysis of kyphoplasty, curved kyphoplasty, conservative treatment, sham procedure, pedicle screw fixation/fusion with or without vertebral augmentation, vertebroplasty with facet joint injection, vertebroplasty, unilateral vertebroplasty, curved vertebroplasty, kyphoplasty with facet joint injection, vertebral augmentation devices, unipedicular kyphoplasty | 4384 (39-661) | RCT |

NR: not reported; OVCF: osteoporotic vertebral compression fracture; PVP: percutaneous vertebroplasty; RCT: randomized controlled trial.

**Table 4: Results of Systematic Reviews and Meta-Analyses on Percutaneous Vertebroplasty for Vertebral Compression Fractures of Between 6 Weeks and 1 Year Old**

| Study | Quality of Life | New Fractures |
|---|---|---|
| | **QUALEFFO** | |
| Buchbinder et al (2018) | | |
| Placebo group at 1-month, score (n) | 4.58 (71) | NR |
| Vertebroplasty group at 1-month, score (n) | 5.38 (71) | NR |
| Absolute change between groups | 0.4% worse (5% worse-5% better [n=71]) | NR |
| Relative change between groups | 0.7% worse (9% worse-8% better [n=71]) | NR |
| Intervention group, n (%) | NR | 28 (19.58) |
| Placebo group, n (%) | NR | 19 (50.00) |
| RR (CI) | NR | 1.47 (0.39 to 5.50) |
| | **Duration of Pain** | |
| Staples et al (2011) | | |
| Mean change score (SD) of pain, at 2 weeks, PVP vs. placebo | 2.2 (2.8) vs. 2.5 (3.0) | NR |
| Adjusted between group difference (CI) at 2 weeks | - 0.2 (- 0.9 to 0.6) | |
| Mean change score (SD) of pain, at 1 month, PVP vs. placebo | 2.08 (3.0) vs. 2.2 (3.2) | NR |
| Adjusted between group difference (CI) at 2 weeks | 0.6 (- 0.2 to 1.4) | |
| | **Pain relief** | |
| Xie et al (2017) | N=1231 | NR |
| At 1-week (vertebroplasty superior), MD (CI) | 1.36 (0.55 to 2.17) | NR |
| At 1-month (vertebroplasty superior), MD (CI) | 1.56 (0.43 to 2.70) | NR |
| At 6-months (vertebroplasty inferior), MD (CI) | -1.59 (-2.9 to -0.27) p<.05 | NR |

| | | |
|---|---|---|
| Total (vertebroplasty superior), MD (CI) | -5.03 (7.94 to -2.12) | NR |
| | **Mortality** | |
| Hinde et al (2020) | | |
| Mortality, 2-year follow up, HR (CI), vertebral augmentation vs. nonsurgical management | 0.70 (0.69 to 0.71) | NR |
| Mortality, 5-year follow up, HR (CI), vertebral augmentation vs. nonsurgical management | 0.79 (0.62 to 0.9999) | NR |
| | **Pain relief and quality of life** | |
| Zhang et al (2020) | | |
| Pain relief at 1 week (PVP superior), MD (CI) | 1.67 (0.84 to 2.51)<br>p<.0001 | |
| Pain relief at 1 month (PVP superior), MD (CI) | 1.98 (0.61 to 3.36)<br>p=.005 | |
| Pain relief at 3 months, MD (CI) | −0.44 (−2.03 to 1.15) | OR, 1.09 (0.72 to 1.64) |
| EuroQol questionnaire (PVP superior), MD (CI) | 0.11 (0.01 to 0.20)<br>p=.03 | |
| Quality of Life Questionnaire of the European Foundation for Osteoporosis, MD (CI) | −7.29 (−12.60 to −1.99) | |
| Roland-Morris Disability Questionnaire, MD (CI) | 0.66 (−2.00 to 3.33) | |
| | **Pain and disability relief** | |
| Chang et al (2021) | | |
| Treatment effect for VAS, mean (CI), vertebroplasty vs. conservative treatment | -0.66 (-1.10 to -0.21) | OR, 1.09 (0.79 to 1.50) |
| Treatment effect for VAS, mean (CI), vertebroplasty vs. kyphoplasty | 0.28 (-0.06 to 0.61) | OR, 0.99 (0.74 to 1.33) |
| Treatment effect for ODI, mean (CI), vertebroplasty vs. conservative treatment | -5.27 (-9.19 to -1.35) | |
| Treatment effect for ODI, mean (CI), vertebroplasty vs. kyphoplasty | 1.23 (-1.59 to 4.04) | |

| | | |
|---|---|---|
| Liu et al (2023) | | |
| Short-term follow-up VAS, mean (CI), vertebroplasty vs. conservative treatment | 3.14 (2.31 to 3.98) | |
| Short-term follow-up VAS, mean (CI), vertebroplasty vs. sham treatment | 0.17 (-1.19 to 0.86) | |
| Long-term follow-up VAS, mean (CI), vertebroplasty vs. conservative treatment | 1.08 (0.62 to 1.55) | |
| Long-term follow-up VAS, mean (CI), vertebroplasty vs. sham treatment | 0.76 (0.07 to 1.45) | |
| Short-term follow-up ODI, mean (CI), vertebroplasty vs. conservative treatment | 14.13 (11.5 to 16.8) | |
| Long-term follow-up ODI, mean (CI), vertebroplasty vs. conservative treatment | 8.69 (3.16 to 14.21) | |
| New fracture, RR (CI), vertebroplasty vs. conservative treatment | 1.28 (0.8 to 2.03) | |
| New fracture, RR (CI), vertebroplasty vs. sham treatment | 1.18 (0.53 to 2.62) | |

CI: 95% confidence interval; HR: hazard ratio; MD: mean difference; NR: not reported; ODI; Oswestry Disability Index; OR: odds ratio; PVP: percutaneous vertebroplasty; QUALEFFO: a quality-of-life questionnaire in patients with vertebral fractures; RR: relative risk; SD: standard deviation.

## Randomized Controlled Trials

### Vertebroplasty versus Medical Management with Sham Controls

Three sham-controlled trials compared vertebroplasty with medical management using a sham control (that included local anesthetic), which mimicked the vertebroplasty procedure up to the point of cement injection. Buchbinder et al (2009) reported on results for a 4-center, randomized, double-blind, sham-controlled trial with 78 patients with 1 or 2 painful osteoporotic vertebral fractures with a duration of less than 1 year. Patients were assigned to vertebroplasty or sham procedure (i.e., injection of local anesthetic into the facet capsule and/or periosteum). Ninety-one percent of participants completed 6 months of follow-up. The participants, investigators (other than the radiologists performing the procedure), and outcome assessors were blinded to the treatment assignment. Kroon et al (2014) reported results of the same trial at 12 and 24 months, maintaining blinding throughout the follow-up period. The primary outcome was overall pain measured on a visual analogue scale from 0 to 10, with 1.5 points representing the minimal clinically important difference. For the primary outcome, reviewers reported no significant differences in visual analogue scale pain score at 3, 12, or 24 months. With reductions in pain and improvements in quality of life observed in both groups, the authors concluded routine use of vertebroplasty provided no benefit.

Kallmes et al (2009) conducted a multicenter, randomized, double-blind, sham-controlled, investigational vertebroplasty safety and efficacy trial in which 131 participants with 1 to 3 painful osteoporotic vertebral fractures were assigned to vertebroplasty or sham procedure (injection of local anesthetic into the facet capsule and/or periosteum). Participants had back pain for no more than 12 months and had a current pain rating of at least 3 on visual analogue scale at baseline. Participants were evaluated at various time

points to 1 year post procedure. Ninety-seven percent completed a 1-month follow-up; 95% completed 3 months. The primary outcomes were RMDQ scores and average back pain intensity during the preceding 24 hours at 1 month, with a reduction of 30% in RMDQ and visual analogue scale pain scores considered a clinically meaningful difference.

For the primary endpoints at 1 month, there were no significant between-group differences. There was a trend toward a higher clinically meaningful improvement in pain at 1 month (30% reduction from baseline) in the vertebroplasty group (64% vs. 48%, respectively; p=.06). At 3 months, 51% from the control group and 13% in the vertebroplasty group crossed over (p<.001). Comstock et al (2013) reported on patient outcomes at 1 year, at which point 16% of patients who underwent vertebroplasty and 60% of control subjects had crossed over to the alternative procedure (p<.001). The as-treated analysis found no significant difference in RMDQ or pain scores between the 2 groups. Intention-to-treat analysis found a modest 1-point difference in pain rating and no significant difference in RMDQ score. There was a significant difference in the percentage of patients showing a 30% or greater improvement in pain (70% of patients randomized to vertebroplasty vs. 45% of patients randomized to the control group). One limitation of this study is that at 14 days, 63% of patients in the control group correctly guessed they had the control intervention, and 51% of patients in the vertebroplasty group correctly guessed they had the vertebroplasty.

Firanescu et al (2018) published the results of a randomized, double-blind, sham-controlled clinical trial performed in 4 community hospitals in the Netherlands from 2011 to 2015.[,] The main outcome measured was mean reduction in VAS scores at 1 day, 1 week, and 1, 3, 6, and 12 months. The mean reduction in VAS score was statistically significant in the vertebroplasty and sham procedure groups at all follow-up points after the procedure compared with baseline. These changes in VAS scores were not statistically significant between the groups during 12 months of follow-up.

**Table 5. Summary of Characteristics of Key Randomized Controlled Trials Comparing Vertebroplasty versus Medical Management with Sham Controls**

| Study | Countries | Sites | Dates | Participants (N) | Interventions | |
|---|---|---|---|---|---|---|
| | | | | | Active (n) | Comparator (n) |
| Buchbinder et al (2009) | US | 4 | 2003-2008 | Patients with 1-2 painful OVC F, duration <1 year | Vertebroplasty (38) | sham procedure[1] (40) |
| Kallmes et al (2009) | US, UK, Aus | 10 | 2004-2008 | Participants with 1-3 painful OVC F, pain ≤ 12 mo, current pain VAS ≥ 3 | Vertebroplasty (68) | sham procedure[1] (63) |
| Firanescu et al (2018) | Netherlands | 4 | 2011-2015 | Participants with acute OVC F | Vertebroplasty (91) | sham procedure[1] (89) |

OVCF: osteoporotic vertebral compression fracture; VAS: visual analogue scale.
[1] Injection of local anesthetic into the facet capsule and/or periosteum.

**Table 6: Summary of Results of Key Randomized Controlled Trials Comparing Vertebroplasty Versus Medical Management with Sham Controls**

| Study | VAS | RMDQ |
|---|---|---|
| Buchbinder et al (2009) | N=73, at 3-months | |
| Intervention (mean±SD) | Reduction: 2.6±2.9 | |
| Control (mean±SD) | Reduction: 1.9±3.3 | |
| Adjusted between-group difference (CI) | 0.6 (-0.7 to 1.8) | |
| Kallmes et al (2009) | | |
| Day 14 Mean difference between groups (CI) | 0.1 (-0.8 to 1.1) | -0.6 (-2.4 to 1.2) |
| p-value | .77 | .35 |
| Month 1 Mean difference between groups (CI) | 0.7 (-0.3 to 1.70) | 0.7 (-1.3 to 2.8) |
| p-value | .19 | .49 |
| Firanescu et al (2018) | N=180 | |
| Day 1 Mean difference between groups (CI) | -0.43 (-1.17 to 0.31) | |
| Week 1 Mean difference between groups (CI) | -0.11 (-0.85 to 0.63) | |
| Month 1 Mean difference between groups (CI) | 0.41 (-0.33 to 1.15) | |
| Month 3 Mean difference between groups (CI) | 0.21 (-0.54 to 0.96) | |
| Month 6 Mean difference between groups (CI) | 0.39 (-0.33 to 1.15) | |
| Month 12 Mean difference between groups (CI) | 0.45 (-0.37 to 1.24) | |

CI: 95% confidence interval; RMDQ: Roland-Morris Disability Questionnaire; SD: standard deviation; VAS: visual analogue score.

**Table 7: Study Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow-up[e] |
|---|---|---|---|---|---|
| Buchbinder et al (2009) | | | | | |
| Kallmes et al (2009) | | | | 3. No reporting of harms.<br>5. Investigator | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | modified pain window from 6 to 9 weeks. | |
| Firanescu et al (2018) | 2. Lack of screening for co-occurring pain conditions.<br>2. MRI was not conducted. | | | 5. Investigator modified pain window from 6 to 9 weeks. | |

MRI: magnetic resonance imaging
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other

### Table 8: Study Design and Conduct Limitations

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Follow-Up[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Buchbinder et al (2009) | | | 2. 30% of eligible participants declined to participate, selection bias cannot be ruled out. | | | |
| Kallmes et al (2009) | | 1. At 14 days, > 50% of participants in either arm correctly identified their intervention assignment. | | 4. Due to high crossover the group differences in outcomes were complicated. | | |
| Firanescu et al (2018) | 4. Screening logs not retained. | | | | | |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[d] Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
[f] Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4.Comparative treatment effects not calculated.

### Vertebroplasty Versus Medical Management Without Sham Controls

Chen et al (2014) reported on a nonblinded RCT comparing vertebroplasty with conservative management. The trial included 89 patients with chronic compression fractures confirmed by magnetic resonance imaging and persistent severe pain for 3 months or longer. The evaluation was performed at 1 week and 1, 3, 6, and 12 months. Over the course of 1 year, pain scores decreased from 6.5 to 2.5 in the vertebroplasty group and from 6.4 to 4.1 in the control group (p<.001). Complete pain relief was reported by 84.8% of patients in the vertebroplasty group and 34.9% of controls. The final Oswestry Disability Index (ODI) score was 15.0 in the vertebroplasty group and 32.1 in the conservative management group (p<.001), and the final RMDQ score was 8.1 for vertebroplasty and 10.7 for controls (p<.001).

Farrokhi et al (2011) reported on a blinded RCT that compared vertebroplasty with optimal medical management in 82 patients. Patients had painful osteoporotic vertebral compression fractures that were refractory to analgesic therapy for at least 4 weeks and less than 1 year. Control of pain and improvement in quality of life were measured by independent raters before treatment and at 1 week and 2, 6, 12, 24, and 36 months after treatment began. Radiologic evaluation to measure vertebral body height and correction of deformity was performed before and after treatment and after 36 months of follow-up. Adverse events include new symptomatic adjacent fractures in 1 patient in the treatment group and 6 in the control group. Additionally, 1 patient experienced epidural cement leakage, which caused severe lower extremity pain and weakness, and had to be treated with bilateral laminectomy and evacuation of the bone cement.

**Table 9: Summary of Key Randomized Controlled Trial Characteristics - Vertebroplasty Versus Medical Management Without Sham Controls**

| Study | Countries | Sites | Dates | Participants (N) | Interventions | |
|---|---|---|---|---|---|---|
| | | | | | *Active* | *Comparator* |
| Chen et al (2014) | China | 1 | 2007-2012 | Patients with chronic compression fractures confirmed by MRI and persistent severe pain for <3 months (89) | Vertebroplasty | Conservative Management |
| Farrokhi et al (2011) | Iran | 1 | 2004-2005 | Patients with painful osteoporotic vertebral compression | Vertebroplasty | Optimal Medical Management |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | fractures refractory to analgesic therapy for >4 months, but <1 year (82) | | |

MRI: magnetic resonance imaging;.

**Table 10: Summary of Key Randomized Controlled Trial Results**

| Study | Pain Score | ODI score | RMDQ |
|---|---|---|---|
| | Overall pain (scale 0-10) | | |
| Chen et al (2014) (N=89) | | | |
| Intervention Group, Pooled at 1-year | 2.5 | 15.0 | 8.1 |
| Control Group, Pooled at 1-year | 4.1 | 32.1 | 10.7 |
| p -value | <.001 | <.001 | <.001 |
| Farrokhi et al (2011) | VAS Score | | |
| Week 1 Mean difference between groups (CI); p-value | -3.1 (-3.72 to -2.28); <.001 | -14.0 (-15.00 to -12.82); <.028 | |
| Month 2 Mean difference between groups (CI); p-value | -2.9 (-4.9 to -0.82); <.011 | -15.0 (-16.76 to -13.24); <.019 | |
| Month 6 Mean difference between groups (CI); p-value | -1.9 (-3.25 to -0.55); <.021 | -11.0 (-12.17 to -7.83); <.011 | |
| Month 12 Mean difference between groups (CI); p-value | -1.9 (-2.9 to 0.9); <.11 | -12.0 (-13.5 to -11.5); <.021 | |

CI: confidence interval; ODI: Oswestry Disability Index; RMDQ: Roland-Morris Disability Questionnaire; VAS: visual analogue scale.

**Table 11: Study Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow-Up[e] |
|---|---|---|---|---|---|
| Chen et al (2014) | | | 3. Investigator modified duration of the conservative therapy from 6 to 4 weeks | | |
| Farrokhi et al (2011) | | | | 4. Language translation of Oswestry scale not validated. | |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.

[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.

[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other

### Table 12: Study Design and Conduct Limitations

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Follow-Up[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Chen et al (2014) | | 1,2. This study was not blinded. | | | | |
| Farrokhi et al (2011) | | | | | | |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[d] Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
[f] Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4.Comparative treatment effects not calculated.

### Nonrandomized Comparative Studies

Edidin et al (2011, 2015) reported on mortality risk rates in Medicare patients who had vertebral compression fractures and were treated with vertebroplasty, kyphoplasty, or nonoperatively. These studies were industry funded. In the 2015 report, they identified 1,038,956 patients who had vertebral compression fractures between 2005 and 2009. The dataset included 141,343 kyphoplasty patients and 75,364 vertebroplasty patients. The matched cohort included 100,649 nonoperated patients, 36,657 kyphoplasty patients, and 24,313 vertebroplasty patients. Survival was calculated from the index diagnosis date until death or the end of follow-up (up to 4 years). Analysis of the whole data set before matching indicated that patients in the nonoperated cohort had a 55% (95% CI, 53% to 56%; p<.001) higher risk of mortality than the kyphoplasty cohort and a 25% (95% CI, 23% to 26%; p<.001) higher mortality risk than the vertebroplasty cohort. After propensity matching, the risk of mortality at 4 years was 47.2% in the nonoperated group compared with 42.3% in the kyphoplasty group (p<.001) and 46.2% in the vertebroplasty group (p<.001).

Lin et al (2017) reported on mortality risk in elderly patients (>70 years old) who had vertebral compression fractures and were treated with early vertebroplasty (within 3 months) or conservative therapy. The data set consisted of 10,785 Taiwanese patients who were selected through the National Health Insurance Research Database, of whom 1773 patients received vertebroplasty, and 5324 did not; a minority of these patients had osteoarthritis. The authors found that a "significant difference in survival curves of mortality and respiratory failure" existed between both groups of patients (p<.05). The incidence of death at 1 year in the vertebroplasty group was 0.46 per 100 person-months (95% CI, 0.38 to 0.56). The incidence of death at 1 year in the nonvertebroplasty group was 0.63 per 100 person-months (95% CI, 0.57 to 0.70). With regard to respiratory failure, hazard ratio (HR) between groups was 1.46 (95% CI, 1.04 to 2.05; p=.028). Limitations of this study included the broad selection of the population, which was

not restricted only to patients with osteoporotic lesions. Also, authors were limited by the database, which did not report on pain or functional outcomes.

### Section Summary: Percutaneous Vertebroplasty for Vertebral Compression Fractures of Between 6 Weeks and 1 Year Old

Despite evidence from numerous RCTs, including several with sham controls, the efficacy of vertebroplasty for painful osteoporotic compression fractures of less than 1 year remains uncertain. Seven meta-analyses have been published, but all of them have numerous limitations due to heterogeneity of included studies. Another major limitation to several meta-analyses is that they do not specify the timeframe for osteoporotic vertebral compression fractures. There remains some uncertainty related to the interpretation of these conclusions. While the use of a sham procedure is a major methodologic strength to control for nonspecific (placebo) effects, the sham used is controversial, given that the effect of injecting local anesthetic in the facet capsule and/or periosteum is unknown. Also, the appropriateness of outcome measures used to detect clinically meaningful differences in pain might not have been optimal, because the studies were underpowered to detect differences in clinical response rates. Questions have also been raised about the low percentage of individuals screened who participated in the trial, the volume of polymethylmethacrylate injected, and the inclusion of individuals with chronic pain.

## Percutaneous Vertebroplasty for Vertebral Compression Fractures of Less Than 6 Weeks Old

### *Clinical Context and Therapy Purpose*

The purpose of vertebroplasty is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conservative management, in individuals with symptomatic osteoporotic vertebral fractures less than 6 weeks old.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with symptomatic osteoporotic vertebral fractures less than 6 weeks old. With acute fractures, these individuals experience severe pain, decreased ambulatory function, and a lessened response to conservative medical management.

### *Interventions*

The therapy being considered is vertebroplasty.

### *Comparators*

Comparators of interest include conservative management. A detailed review of the comparators is listed in the above indication.

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. Symptoms can include back pain and demonstrated fracture on radiography. The most current research available tracks follow-up to 12 months or more. A number of studies have longer term follow-up at more than 5 years, which is ideal for understanding all of the outcomes, particularly the occurrence of new vertebral compression fractures after vertebroplasty.

### Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

### Review of Evidence

### Randomized Controlled Trials

### Vertebroplasty versus Medical Management with Sham Controls

Clark et al. (2016) reported on results from the Safety and Efficacy of Vertebroplasty of Acute Painful Osteoporotic Fractures (VAPOUR) trial (see the table below). VAPOUR was a multicenter, double-blind trial of vertebroplasty in 120 patients with vertebral fractures of less than 6 weeks in duration and back pain of at least 7 out of 10 on a numeric rating scale. This trial followed a similar protocol as that used in the Kallmes et al. (2009) trial (discussed above). The primary outcome (the percentage of patients with a numeric rating scale score <4 out of 10 at 14 days post procedure) was met in a greater percentage of patients in the vertebroplasty group (44%) than in the sham control group (21%). This between-group difference was maintained through 6 months.

Other outcome measures were significantly improved in the vertebroplasty group at 1 or both of the time points (see the table below). The benefit of vertebroplasty was found predominantly in the thoracolumbar subgroup, with 48% (95% CI, 27% to 68%) more patients meeting the primary endpoint (61% in the vertebroplasty group vs. 13% in the control group). The investigators commented that the thoracolumbar junction is subject to increased dynamic load, and fractures at this junction have the highest incidence of mobility. No benefit from vertebroplasty was found in the non-thoracolumbar subgroup. Postprocedural hospital stay was reduced from a mean of 14 days in the control group to 8.5 days after vertebroplasty, even though physicians who determined the discharge date remained blinded to treatment. In the vertebroplasty group, there were 2 serious adverse events due to sedation and transfer to the radiology table. In the control group, 2 patients developed spinal cord compression; 1 underwent decompressive surgery and the other, not a surgical candidate, became paraplegic.

### Vertebroplasty Versus Medical Management Without Sham Controls

Klazenet al (2010) reported on the vertebroplasty versus conservative treatment in acute osteoporotic vertebral compression fractures, an open-label randomized trial of 202 patients at 6 hospitals in the Netherlands and Belgium. Of 431 patients eligible for randomization, 229 (53%) had spontaneous pain relief during assessment. Participants with at least 1 painful osteoporotic vertebral fracture of 6 weeks or less in duration were assigned to vertebroplasty or conservative management. The primary outcome was pain relief of 3 points measured on a 10-point VAS at 1 month and 1 year.

A total of 101 subjects were enrolled in the treatment group and the control arm; 81% completed 12-month follow-up. There were no significant differences in the primary outcome (pain relief of 3 points) measured at 1 month and 1 year. Vertebroplasty resulted in greater pain relief than did medical management through 12 months ($p<.001$); there were significant between-group differences in mean VAS

scores at 1 month or at 1 year. Survival analysis showed significant pain relief was quicker (29.7 days vs. 115.6 days) and was achieved by more patients after vertebroplasty than after conservative management.

Yi et al (2014) assessed the occurrence of new vertebral compression fractures after treatment with cement augmenting procedures (vertebroplasty or kyphoplasty) versus conservative treatment in an RCT with 290 patients (363 affected vertebrae). Patients treated conservatively had a mean length of stay of 13.7 days. Return to usual activity occurred at 1 week for 87.6% of operatively treated patients and 2 months for 59.2% of conservatively treated patients. All patients were evaluated with radiographs and magnetic resonance imaging at 6 months and then at yearly intervals until the last follow-up session. At a mean follow-up of 49.4 months (range, 36 to 80 months), 10.7% of patients had experienced 42 new symptomatic vertebral compression fractures. There was no significant difference in the incidence of new vertebral fractures between the operative (18 total; 9 adjacent, 9 nonadjacent) and conservative (24 total; 5 adjacent, 16 nonadjacent, 3 same level) groups but the mean time to a new fracture was significantly shorter in the operative group (9.7 months) than in the nonoperative group (22.4 months).

Leali et al (2016) published a brief report on a multicenter RCT enrolling 400 patients with osteoporotic thoracic or lumbar vertebral compression fractures who were treated with vertebroplasty or conservative therapy. Fractures were treated within 2 weeks of pain onset. Details of randomization and rates of follow-up were not reported. At 1 day after treatment, the vertebroplasty group had a reduction in pain scores and improvement in physical function, with visual analogue scale pain scores decreasing from 4.8 (maximum, 5.0) to 2.3 (p=.023) and Oswestry Disability Index scores improving from 53.6% to 31.7% (p=.012). Sixty-five percent of patients treated with vertebroplasty had stopped all analgesic use within 48 hours. The conservatively managed group showed no benefit in the first 48 hours, but by 6 weeks visual analogue scale and Oswestry Disability Index scores were described as similar in both groups (specific data not reported). Evaluation of this trial was limited by incomplete reporting.

Yang et al (2016) compared vertebroplasty with conservative therapy in 135 patients over 70 years of age with severe back pain due to an osteoporotic vertebral fracture after minor or mild trauma. Vertebroplasty was performed at a mean of 8.4 days after pain onset. Patients in the conservative therapy group were placed on bed rest and analgesics for at least 2 weeks after diagnosis, followed by bracing and assistive devices. All patients receiving vertebroplasty could stand and walk with a brace at 1 day posttreatment, while only 12 (23.5%) patients in the control group could stand up and walk after 2 weeks of bed rest. The average duration of bed rest from pain onset was 7.8 days (range, 2 to 15 days) in the vertebroplasty group compared with 32.5 days (range, 14 to 60 days) in the conservative therapy group. At 1-year follow-up, there was a similar percentage of additional compression fractures but a significantly higher complication rate in the conservative therapy group (35.3%) than in the vertebroplasty group (16.1%; p<.001). Complications included pneumonia, urinary tract infection, deep vein thrombosis, depression, and sleep disorders.

**Table 13: Summary of Key Randomized Controlled Trial Characteristics Involving Vertebroplasty Versus Medical Management without Sham Controls**

| Study; Trial | Countries | Sites | Dates | Participants (N) | Interventions | |
|---|---|---|---|---|---|---|
| | | | | | *Active (n)* | *Comparator (n)* |
| Klazen et al (2010) | EU | 6 | 2005-2008 | Patients >50 years with radiographically confirmed VCF, back | Vertebroplasty (101) | Medical management |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | pain for <6 weeks, VAS >5 | | without sham controls (101) |
| Yi et al (2014) | China | 1 | 2005-2009 | Patients with OVCF | PVP or PKP(169) | Conservative treatment (121) |
| Leali et al (2010) | International | 4 | NR | Post-menopausal women with 1 thoracic or lumbar symptomatic OVCF caused by primary or secondary osteoporosis. | PVP including analgesic and osteoporosis medication (200) | Conservative care including analgesic and osteoporosis medication (200) |
| Yang et al (2015) | China | 1 | 2009-2011 | Patients >70 years with acute OVCF, severe pain from minor or mild trauma | PVP (56 at 1 y) | Conservative treatment (51 at 1 y) |

NR: not reported; OVCF: osteoporotic vertebral compression fractures; PKP: percutaneous kyphoplasty; PVP: percutaneous vertebroplasty; VCF: vertebral compression fracture; VAS: visual analogue scale.

**Table 14: Summary of Key Randomized Controlled Trial Results Involving Vertebroplasty Versus Medical Management without Sham Controls**

| Study | VAS | Quality of Life | Refracture Rate |
|---|---|---|---|
| Klazen et al (2010) | | | |
| Mean difference between groups in reduction of mean VAS score from baseline | | RMDQ[1] | Median follow-up of 12.0 months (range: 1 to 24) |
| Month 1 (CI) | 2.0 (1.13 to 2.80) | PVP: 12.5 | PVP: 18 (16.48%) |
| p-value | <.0001 | Control: 13.5 | Control: 30 (24.71%) |
| Month 12 (CI) | 2.0 (1.13 to 2.80) | PVP: 9 | |
| p-value | <.0001 | Control: 12 | |
| Yi et al (2014) | | | |
| Month 12 (%) | - | - | PVP/PKP: 18 (8.28%) |
| | - | - | Control: 24 (19.83%) |
| | - | - | Time interval of recompression |
| Intervention | - | - | 9.7 ± 17.8 months |
| Control | | | 22.4 ± 7.99 months |
| p-value | | | .017 |
| Leali et al (2016) | | ODI, % | |
| Intervention 24 hours after surgery, mean | 2.3 | 31.7 | - |

| | | | |
|---|---|---|---|
| p-value | ≤.023 | ≤.012 | |
| Yang et al (2015) | | | |
| Analysis of variance models, Month 1 (SD) | PVP: 2.4±1<br>Control: 4.8±1 | PVP: 48±10<br>Control: 71±7 | |
| Analysis of variance models, Month 12 (SD)<br>p-value | PVP: 1.8±0.3<br>Control: 3±0.5 | PVP: 30±5<br>Control | PVP: 5 (8.9%)<br>Control: 4 (7.8); <.0001 |

CI: 95% confidence interval; ODI: Oswestry Disability Index; PKP: percutaneous kyphoplasty; PVP: percutaneous vertebroplasty; RMDQ: Roland-Morris Disability Questionnaire; VAS: visual analogue scale; SD: standard deviation.
[1]The RMDQ results from the Klazen paper are based on estimates due to the graphical presentation of the results, rather than the reporting of the numerical values.
[2] The results from the Yang paper are based on estimates due to the graphical presentation of the results; numerical results not reported.

### Table 15: Study Relevance Limitations

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow-Up[e] |
|---|---|---|---|---|---|
| Klazen et al (2010) | | | | 3. None reported | |
| Yi et al (2014) | 4. Selection criteria for PVP or PKP unclear, some patients had > fracture | | | | |
| Leali et al (2010) | 1. Limited to post-menopausal women | | | | 1,2 Follow-up period limited to < 6 months |
| Yang et al (2015) | 4. Study population limited to > 70 years of age at single spine center | | | | |

PKP: percutaneous kyphoplasty; PVP: percutaneous vertebroplasty;
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other

### Table 16: Study Design and Conduct Limitations

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Follow-Up[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Klazen et al (2010) | | 1,2. No masking | | | | |
| Yi et al (2014) | | | | | | |
| Leali et al (2010) | | 1,2,3, unclear if masking occurred | 2. Outcomes beyond 48 hours post-surgery not reported | | | |
| Yang et al (2015) | | 1,2,3 No masking | | | | 3. Results reported only in graphic form |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[d] Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
[f] Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4.Comparative treatment effects not calculated.

### Section Summary: Percutaneous Vertebroplasty for Vertebral Compression Fractures of Less Than 6 Weeks Old

In a sham-controlled randomized trial, where no anesthetic was injected into the periosteum, there was a significant benefit of vertebroplasty in individuals who had severe pain of fewer than 6 weeks in duration following vertebral fracture at the thoracolumbar junction. Other RCTs without sham controls have reported that vertebroplasty is associated with significant improvements in pain, earlier improvements in function, and reductions in the duration of bed rest compared with conservatively managed individuals.

## Percutaneous Sacroplasty

### *Clinical Context and Therapy Purpose*

Sacral insufficiency fractures are the consequence of stress on weakened bone and often cause low back pain in the elderly population. Osteoporosis is the most common risk factor for sacral insufficiency fractures. Lourie (1982) described spontaneous fracture of the sacrum in individuals with osteoporosis as presenting as lower back and buttock pain with or without referred pain in the legs. Although common, sacral insufficiency fractures can escape detection due to low provider suspicion and poor sensitivity on plain radiographs, slowing the application of appropriate intervention.

The purpose of sacroplasty is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conservative management, in individuals with sacral insufficiency fractures.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with sacral insufficiency fractures. Sacral insufficiency fractures are a stress fracture, resulting from a regular stress applied to a bone with reduced elasticity.

Often, these fractures are associated with underlying metabolic bone disease condition like osteoporosis. Examples of risk factors include corticosteroid therapy use, female sex, pelvic radiation, rheumatoid arthritis, and hyperparathyroidism.

### *Interventions*

The therapy being considered is sacroplasty, a minimally invasive procedure for treating pathological fractures of the sacral vertebral body or sacral ala. The procedure involves percutaneous insertion of 1 or more bone needles into the sacrum and injection of bone cement under fluoroscopy and/or computed tomography visual guidance.

### *Comparators*

Comparators of interest include conservative management. Conservative management includes physical therapy, analgesics, narcotics, and hormone treatments. Examples of conservative management for sacral insufficiency fractures are varied and can include bed rest and pain medication to early physical therapy.

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. Possible negative outcomes include complications with sedation, cement leakage into the presacral space, spinal canal, sacral foramen, or sacroiliac joint, and possible spinal compression due to extravasation of cement. At least 1 year of follow-up is desirable to adequately evaluate outcomes.

## Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

## Review of Evidence

## Observational Studies

Sacroplasty is an evolving technique achieved using numerous methods (short-axis, long-axis, balloon-assisted short-axis, iliosacral screws). No randomized trials of sacroplasty were identified. Frey et al (2008) conducted the largest prospective observational cohort study, assessing 52 consecutive patients undergoing sacroplasty for sacral insufficiency fractures using the short-axis technique. Patients had a mean age of 75.9 years, mean duration of symptoms of 34.5 days (range, 4 to 89 days), and mean visual analogue scale score of 8.1 at baseline. Improvements in visual analogue scale (VAS) scores were measured at 30 minutes and 2, 4, 12, 24, and 52 weeks postprocedure. At each interval, statistically significant improvements over baseline were observed and maintained through 52 weeks.

Kortman et al (2013) reported on the largest series, a retrospective multicenter analysis. They evaluated 204 patients with painful sacral insufficiency fractures and 39 patients with symptomatic sacral lesions treated with the short-axis or long-axis technique. One hundred sixty-nine patients had bilateral sacral insufficiency fractures, and 65 patients had additional fractures of the axial skeleton. VAS scores improved from 9.2 before treatment to 1.9 after treatment in patients with sacral insufficiency fractures

and from 9.0 to 2.6 in patients with sacral lesions. There was 1 case of radicular pain due to extravasation of cement requiring surgical decompression.

Frey et al (2017) reported on patients treated with percutaneous sacroplasty, particularly the long-term efficacy of sacroplasty versus nonsurgical management. This prospective, observational cohort study spanned 10 years and comprised 240 patients with sacral insufficiency fractures. Thirty-four patients were treated with nonsurgical methods, and 210 patients were treated with sacroplasty. Pain, as measured by VAS, was recorded before treatment and at several follow-ups. Mean pretreatment VAS for the sacroplasty group was 8.29; for the nonsurgical treatment group, it was 7.47. Both forms of treatment resulted in significant VAS improvement from pretreatment to the 2-year follow-up (p<.001). However, the sacroplasty treatment group experienced significant VAS score improvement consistently at many of the follow-up points (pretreatment to post [p<.001]; posttreatment through 2 weeks [p>.001]; 12 weeks through 24 weeks [p=.014]; 24 weeks through 1 year [p=.002]). Meanwhile, the group with nonsurgical treatment only experienced 1 significant pain improvement score, which was at the 2-week follow-up posttreatment (p=.002). One major limitation of this study was that the nonsurgical treatment group was not followed up at the 10-year mark whereas the sacroplasty group did receive follow-up.

Beall and colleagues (2023) published interim findings on patients who underwent percutaneous sacroplasty. These patients were part of a prospective registry study conducted across multiple centers, which aimed to assess the effectiveness of sacroplasty in treating sacral insufficiency fractures. Pain improvement according to the numeric rating scale (NRS) showed a significant reduction from a mean of 7.8 (standard deviation [SD], 2.4) at baseline to 0.9 (SD, 2.2; p<.001) with 92% showing a clinically meaningful reduction in pain at 6 months follow-up. Rolland-Morris Disability Questionnaire (RMDQ) scores also significantly decreased from baseline levels from a mean of 17.7 (SD 6.4) to 5.2 (SD, 5.2; p<.001) at 6 months follow-up, with 84% achieving a clinically meaningful reduction. One patient had a new neurologic deficit due to cement extravasation, but no other adverse events were reported. A major limitation of this study is an imbalance in baseline characteristic and at the time of publication only 48% of patients had 6-month follow-up data.

Sarigul et al (2024) retrospectively described a single-center's experience with treating sacral insufficiency fractures with sacroplasty (n=83) or conservative treatment (n=102). Participants had a mean age of 69.2 years and required 5 years of follow-up to be included in the study (mean follow-up time was 7.2 years). At baseline, both VAS (8.82 vs. 4.18) and ODI (68.6 vs. 51.8) were significantly higher in the sacroplasty group than those conservatively treated. By 1 year follow-up, mean VAS scores had significantly decreased in the sarcoplasty group to 1.5 and was favored over conservative treatment, which had a reduction to 2.82 (p<.001); a similar trend was observed for ODI, which showed a decrease to 8.4 in the sarcoplasty group compared to 21.2 in the conservative treatment group (p<.001). Cement leaks were identified in 2 patients, but no postoperative radiculopathy or pulmonary embolism were reported. Despite requiring 5-year data for all participants, only 1-year outcomes were reported by the authors.

There are several retrospective reviews with roughly 50 patients per publication. One reported by Dougherty et al (2014) described a series of 57 patients treated with sacroplasty for sacral insufficiency fractures. The short- or the long-axis approach was dictated by the length and type of the fracture and patient anatomy. Follow-up data at 2.5 weeks were available for 45 (79%) patients, and the outcome measures were inconsistent. For example, activity pain scores were collected from 13 patients, and rest pain scores were collected from 29 patients. Of the 45 patients with outcomes data, 37 (82%) had experienced a numeric or descriptive decrease from initial pain of at least 30%.

## Adverse Events

There are complications related to cement leakage with sacroplasty that are not observed with vertebroplasty. Leakage of polymethylmethacrylate into the presacral space, spinal canal, sacral foramen, or sacroiliac joint may result in pelvic injection of polymethylmethacrylate, sacral nerve root or sacral spinal canal compromise, or sacroiliac joint dysfunction. Performing sacroplasty only on zone 1 fractures can minimize these risks.

### Section Summary: Percutaneous Sacroplasty

No RCTs evaluating percutaneous sacroplasty for sacral insufficiency were identified. The available evidence includes 2 prospective cohort studies and several retrospective series. These studies have reported rapid and sustained decreases in pain following percutaneous sacroplasty. Additional reports are mostly consistent in reporting immediate improvement following the procedure. Due to the limited number of patients and the retrospective nature of the evidence base, harms associated with sacroplasty have not been adequately studied. The small numbers of treated patients leave uncertainty regarding the impact of sacroplasty on health outcomes.

## Kyphoplasty or Mechanical Vertebral Augmentation for Osteoporotic Vertebral Compression Fractures

### *Clinical Context and Therapy Purpose*

The purpose of balloon kyphoplasty or mechanical vertebral augmentation is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with osteoporotic vertebral compression fractures.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with osteoporotic vertebral compression fracture.

### *Interventions*

The therapy being considered is balloon kyphoplasty or mechanical vertebral augmentation. The intervention involves the fluoroscopically guided injection of polymethyl methacrylate into a cavity created in the vertebral body with a balloon or mechanical device to provide support and symptomatic relief in patients.

Balloon kyphoplasty is a variant of vertebroplasty and uses a specialized bone tamp with an inflatable balloon to expand a collapsed vertebral body as close as possible to its natural height before injection of polymethyl methacrylate. Radiofrequency kyphoplasty (also known as radiofrequency targeted vertebral augmentation) is a modification of balloon kyphoplasty. In this procedure, a small diameter articulating osteotome creates paths across the vertebra. An ultra-high viscosity cement is injected into the fractured vertebral body, and radiofrequency is used to achieve the desired consistency of the cement. The ultra-high viscosity cement is designed to restore height and alignment to the fractured vertebra, along with stabilizing the fracture.

Kiva is another mechanical vertebral augmentation technique that uses an implant for structural support of the vertebral body to provide a reservoir for bone cement. The Kiva vertebral compression fractures treatment system consists of a shaped memory coil and an implant, which is filled with bone cement. The coil is inserted into the vertebral body over a removable guide wire. The coil reconfigures itself into a stack of loops within the vertebral body and can be customized by changing the number of loops of the coil. The implant, made from PEEK-OPTIMA™, a biocompatible polymer, is deployed over the coil. The coil is then retracted, and polymethyl methacrylate is injected through the lumen of the implant. The

polymethyl methacrylate cement flows through small slots in the center of the implant, which fixes the implant to the vertebral body and contains the polymethyl methacrylate in a cylindrical column. The proposed advantage of the Kiva system is a reduction in cement leakage.

SpineJack is a mechanical vertebral augmentation technique that utilizes bipedicular 4.2 mm to 5.0 mm self-expanding jacks to restore vertebral height. Placement of the titanium devices are verified in anteroposterior and lateral view prior to expansion. Once the devices are expanded, a proprietary bone cement is injected. The proposed benefit is greater control over expansion and greater restoration of vertebral height compared to balloon kyphoplasty. The procedure requires good bone quality.

### *Comparators*

Comparators of interest include conservative care. Treatment includes bed rest, local and systemic analgesia, and bracing. Conventional vertebroplasty procedures may also be used to treat this condition.

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity. Kyphoplasty may also restore lost vertebral body height and reduce kyphotic deformity. Potential health outcomes related to kyphotic deformity include pulmonary or gastrointestinal compression and associated symptoms, and vertebral compression fractures may be associated with lower health-related quality of life (e.g., European Quality of Life-5 Dimensions).

The existing literature evaluating balloon kyphoplasty or mechanical vertebral augmentation as a treatment for osteoporotic vertebral compression fractures has varying lengths of follow-up, ranging from 1 month to 4 years.

### Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

## Review of Evidence

The Agency for Healthcare Research and Quality (AHRQ) published a comparative effectiveness review on selected interventional treatments for acute and chronic pain in September 2021. The review included 37 RCTs for 10 interventional procedures and conditions that evaluated pain, function, health status, quality of life, medication use, and harm. Results of the review concluded that vertebroplasty (13 trials) was probably more effective at reducing pain and improving function in patients > 65 years of age, but benefits were small (<1 point on a 10-point pain scale). Benefits of vertebroplasty appeared smaller in sham-controlled trials compared with trials involving usual care as a control and larger in trials involving patients with more acute symptoms. Vertebroplasty was also found to be probably not associated with an increased risk of incident vertebral fracture. Kyphoplasty (2 trials) was concluded to probably be more effective than usual care for pain and function in older patients with vertebral compression fracture at up to 1 month and may be more effective at >1 month to ≥1 year but has not been compared against sham therapy. The evidence regarding the risk of incident fracture with kyphoplasty was conflicting. The overall evidence base for vertebroplasty had several limitations including variations in patient selection criteria,

technical factors such as volume of polymethyl methacrylate, and sham interventions. Usual care interventions were also not well standardized or defined, and the majority of results were based on mean differences in outcomes. Few trials reported the likelihood of achieving a clinically relevant response and data on long-term outcomes were limited. For kyphoplasty, a major limitation is the absence of sham-controlled trials.

In December of 2016 Hayes completed a Health Technology Assessment which was last reviewed in May 2021 on the comparative effectiveness of percutaneous vertebroplasty versus sham, conservative treatment, or kyphoplasty for osteoporotic vertebral compression fractures. Hayes rated percutaneous vertebroplasty (VP) in adult patients with medically refractory pain due to osteoporotic vertebral compression fractures who have no specific contraindications to the procedure a C. According to Hayes a C rating indicates, “potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns."

## Kyphoplasty or Vertebroplasty versus Conservative Treatment

### Meta-analyses

In a Bayesian network meta-analysis, Zhao et al (2017) examined the efficacy and safety of vertebroplasty, kyphoplasty, and conservative treatment for the treatment of osteoporotic vertebral compression fracture. Sixteen RCTs were identified (N=2 046 participants: vertebroplasty, n=816; kyphoplasty, n=478; conservative treatment, n=752). Eleven of the RCTs compared vertebroplasty with conservative treatment; 2 RCTs compared kyphoplasty with conservative treatment, and 3 RCTs compared kyphoplasty with vertebroplasty. Each trial assessed at least 1 of the following: VAS, the RMDQ, the European Quality of Life-5 Dimensions, and the observance of any new fractures. No significant difference was found between kyphoplasty and vertebroplasty for pain relief, daily function, and quality of life. Network meta-analysis demonstrated that kyphoplasty was superior to conservative therapy as assessed by VAS (mean difference, 0.94; 95% CI, -0.40 to 2.39), European Quality of Life-5 Dimensions (mean difference -0.10; 95% CI, -0.17 to -0.01), and RMDQ (mean difference 5.72; 95% CI, 1.05 to 10.60). Insufficient data were present to complete pairwise comparison of kyphoplasty with conservative treatment for some metrics. Kyphoplasty was associated with the lowest risk of new fractures. This review was limited by significant heterogeneity across measured outcomes and length of follow-up in studies; the presence of performing and reporting bias in studies was also a concern.

Hinde et al (2020) performed a meta-analysis of 7 studies on the effect of vertebral augmentation (either vertebroplasty and/or balloon kyphoplasty) compared with nonsurgical management in over 1.5 million patients with osteoporotic vertebral compression fractures. Compared with nonsurgical management, vertebral augmentation reduced risk of mortality (hazard ratio [HR], 0.78; 95% CI, 0.66 to 0.92). These benefits remained significant in stratified analyses of mortality over periods of 2 years (HR, 0.70; 95% CI, 0.69 to 0.71) and 5 years (HR, 0.79; 95% CI, 0.62 to 1.00). Most studies were rated with scores of 7 to 9 on the Newcastle-Ottawa rating scale.

Sun et al (2020) performed a meta-analysis of 32 studies (N=945) in patients with osteoporotic vertebral compression fracture treated with vertebral augmentation or conservative treatment. No significant differences were observed in the risk of clinical fracture (risk ratio [RR], 1.22; 95% CI, 0.70 to 2.12) or radiological fracture (RR, 0.91; 95% CI, 0.71 to 2.12). Overall, 10 studies were rated as high quality, and the remainder were rated as low quality. Results remained consistent when stratified by RCTs and non-RCTs.

Halvachizadeh et al (2021) conducted a systematic review and meta-analysis comparing vertebroplasty, kyphoplasty, and nonoperative management in patients with osteoporotic vertebral compression fractures. A total of 16 RCTs (N=2731 patients) were included with 11 trials comparing vertebroplasty to nonoperative management, 1 trial comparing kyphoplasty to nonoperative management, and 4 comparing kyphoplasty and vertebroplasty. Surgical intervention was associated with greater improvement of pain as compared to nonoperative management and was unrelated to the development of adjacent level fractures or quality of life. Of the trials comparing kyphoplasty and vertebroplasty, no significant differences in outcome measures were observed. Fourteen of the 16 trials provided some concern for bias, and the remaining 2 trials provided a high concern for bias. The authors noted the heterogeneity of the included studies as a limitation. Nonoperative management was not standardized, and the majority of studies failed to provide evidence of osteoporosis despite indicating that the treated fractures were osteoporotic vertebral fractures.

A network meta-analysis of RCTs conducted by Liu et al (2023) assessed the safety and efficacy of 12 interventions, including kyphoplasty, compared to conventional and sham treatments for osteoporotic vertebral compression fractures. The analysis included 34 RCTs, encompassing 4,383 participants with an average age of 73.4 years. Each study required a control group and reported on outcomes measured by the VAS pain scale or the Oswestry Disability Index (ODI). The authors included several sub-groups of kyphoplasty (kyphoplasty with facet joint injection and curved kyphoplasty), which are not discussed further here. Improvements compared to conservative treatment were observed in both short-term and long-term VAS and ODI scores. Compared to sham treatment, no significant difference was noted in short-term VAS scores. However, a notable improvement favoring the kyphoplasty group was observed in long-term VAS outcomes, as well as in both short-term and long-term ODI outcomes. No significant differences were observed in the relative risk of new fractures between kyphoplasty and the sham or conservative control groups. Limitations consisted of differences in indications and follow-up times, significant heterogeneity across study findings, and more than 50% of included studies having been assessed with a moderate or high risk of bias. The tables below present a comparison of studies included in the systematic reviews, review characteristics, and results, respectively.

**Table 17. Comparison of Studies Included in Systematic Reviews & Meta-analyses on Percutaneous Kyphoplasty for Vertebral Compression Fractures**

| Study | Zhao et al (2017) | Hinde et al (2020 | Sun et al (2020) | Halvachizadeh et al (2021) | Liu et al (2023) |
|---|---|---|---|---|---|
| Chen (2013) | ● | ● | ● | | ● |
| Blasco (2012) | ● | | ● | ● | |
| Boonen (2011) | ● | | | | |
| Farrokhi (2011) | ● | | ● | ● | ● |
| Klazen (2010a) | ● | | ● | ● | ● |
| Klazen (2010b) | | | ● | | |
| Rousing (2009) | ● | | ● | ● | ● |

| | | | | | |
|---|---|---|---|---|---|
| Kallmes (2009) | ● | | | ● | |
| Buchbinder (2009) | ● | | ● | ● | ● |
| Voormolen (2006) | ● | | | ● | |
| Liu (2009) | ● | | | | |
| Endres (2012) | ● | | | | ● |
| Dohm (2014) | ● | | | ● | ● |
| Clark (2016) | ● | | ● | ● | ● |
| Staples (2015) | ● | | ● | | |
| Yang (2015) | ● | | | | |
| Berenson (2011) | ● | | | | |
| Ong (2018) | | ● | | | |
| Edidin (2015) | | ● | | | |
| Edidin (2011) | | ● | | | |
| McCullough (2013) | | ● | | | |
| Lin (2017) | | ● | | | |
| Zampini (2010) | | ● | | | |
| Lange (2014) | | ● | | | |
| McDonald (2011) | | ● | | | |
| Lavelle (2008) | | ● | | | |
| Gerling (2011) | | ● | | | |
| Becker (2011) | | ● | | | |
| Levy (2012) | | ● | | | |

| | | | | | |
|---|---|---|---|---|---|
| Diamond (2016) | | ● | | | |
| Klezl (2012) | | ● | | | |
| Liu (2015) | | ● | | | |
| Bornemann (2012) | | | ● | | |
| Kroon (2013) | | | ● | | ● |
| Diamond (2003) | | | ● | | |
| Firanescu (2018) | | | ● | ● | ● |
| Giannotti (2012) | | | ● | | |
| Grafe (2005) | | | ● | | |
| Kasperk (2010) | | | ● | | |
| Klazen (2010) | | | ● | | |
| Lee (2012) | | | ● | | |
| Rousing (2010) | | | ● | | |
| Voormolen (2007) | | | ● | | |
| Wang (2016) | | | ● | ● | ● |
| Wang (2010) | | | ● | | |
| Wardlaw (2009) | | | ● | ● | |
| Boonen (2011) | | | ● | | ● |
| Van Meirhaeghe (2013) | | | ● | | |
| Yang (2016) | | | ● | | ● |
| Yi (2014) | | | ● | | |
| Martinez-Ferrer (2013) | | | ● | | |

| | | | | | |
|---|---|---|---|---|---|
| Kroon (2013) | | | ● | | |
| Diamond (2006) | | | ● | | |
| Kasperk (2005) | | | ● | | |
| Lee (2012) | | | ● | | |
| Chen (2014) | | | ● | ● | ● |
| Du (2018) | | | ● | | |
| Firanescu (2019) | | | ● | | |
| Kroon (2014) | | | ● | | |
| Movrin (2012) | | | ● | | |
| Voormolen (2007) | | | ● | | |
| Evans (2016) | | | | ● | ● |
| Korovessis (2013) | | | | ● | ● |
| Liu (2010) | | | | ● | ● |
| Carli (2023) | | | | | ● |
| Lv (2023) | | | | | ● |
| Shi (2023) | | | | | ● |
| Dang (2022) | | | | | ● |
| Xu (2021) | | | | | ● |
| Wang (2021) | | | | | ● |
| Geng (2021) | | | | | ● |
| Noriega (2019) | | | | | ● |
| Li (2017) | | | | | ● |
| Zhang (2015) | | | | | ● |

| | | | | | |
|---|---|---|---|---|---|
| Gu (2015) | | | | | ● |
| Tutton (2015) | | | | | ● |
| Wang (2015) | | | | | ● |
| Yan (2014) | | | | | ● |
| Comstock (2013) | | | | | ● |
| Bae (2010) | | | | | ● |
| Chen (2010) | | | | | ● |

**Table 18: Systematic Reviews & Meta-Analyses Characteristics**

| Study | Dates | Trials | Participants | N (Range) | Design |
|---|---|---|---|---|---|
| Zhao et al (2017) | 2006-2016 | 16 | Patients with OVCFs | 2046 (34 to 381) | RCTs |
| Hinde et al (2020) | 2010-2018 | 7 | Patients with OVCFs | 1,649,247 (40 to 378,988) | Retrospective and prospective |
| Sun et al (2020) | 2005-2019 | 32 | Patients with OVCFs | 945 (34 to 300) | Prospective and RCTs |
| Halvachizadeh et al (2021) | 2006-2019 | 16 | Patients with OVCFs | 2731 (34 to 381) | RCTs |
| Lu et al (2023) | NR-2023 | 34 | Patients with OVCFs | 4384 (39 to 661) | RCTs |

OVCF: osteoporotic vertebral compression fracture; RCT: randomized controlled trial.

**Table 19: Systematic Reviews & Meta-Analyses Results**

| Study | VAS | EQ-5D | RMDQ | New Fractures | Mortality |
|---|---|---|---|---|---|
| Zhao et al (2017) | | | | | |
| MD (95% CI) CT vs. KP | 0.94 (-0.40 to 2.39) | -0.10 (-0.17 to -0.01) | 5.72 (1.05 to 10.60) | 1.11 (0.46 to 2.86) | |

| Study | VAS | EQ-5D | RMDQ | New Fractures | Mortality |
|---|---|---|---|---|---|
| MD (95% CI) KP vs. Vertebroplasty | 0.05 (-0.18 to 0.27) | -0.02 (-0.06 to 0.02) | -2.50 (-3.40 to -1.60) | 1.29 (0.84 to 1.99) | |
| Hinde et al (2020) | | | | | |
| HR (95% CI) VA vs. CT | | | | | 0.78 (0.66 to 0.92) |
| HR (95% CI) Balloon KP vs. Vertebroplasty | | | | | 0.77 (0.77 to 0.78) |
| Sun et al (2020) | | | | | |
| RR (95% CI) VA vs. CT | | | | Clinical fracture: 1.22 (0.70 to 2.12) Radiological fracture: 0.91 (0.71 to 2.12) | |
| Halvachizadeh et al (2021) | | **Adjacent level fractures** | | | |
| VAS change: short-term; long-term (95% CI) Vertebroplasty or KP vs. CT | 1.31 (0.41 to 2.21); 0.89 (0.16 to 1.62) | | | | |
| p value | <.0001; <.0001 | | | | |
| $I^2$ | 99.8%; 99.2% | | | | |
| VAS change: short-term; long-term (95% CI) KP vs. Vertebroplasty | -0.20 (-0.34 to -0.05); -0.30 (-0.98 to 0.37) | | | | |
| p value | .90;.02 | | | | |
| $I^2$ | 0%; 81.9% | | | | |
| log OR (95% CI) Vertebroplasty or KP vs. CT | | -0.16 (-0.83 to 0.50) | | | |

| Study | VAS | EQ-5D | RMDQ | New Fractures | Mortality |
|---|---|---|---|---|---|
| MD (95% CI) Vertebroplasty or KP vs. CT | | | 1.7 (0.01 to 3.47) | | |
| Liu et al (2023) | **VAS** | **ODI** | **New Fractures** | | |
| Short-term follow-up, mean (CI), KP vs c CT | 3.32 (2.32 to 4.31) | 15.93 (1.32 to 19.54) | | | |
| Short-term follow-up, mean (CI), KP vs sham treatment | -0.34 (-1.66 to 0.98) | | | | |
| Long-term follow-up, mean (CI), KP vs CT | 1.17 (0.63 to 1.72) | 10.46 (3.52 to 17.40) | RR: 1.16 (0.73 to 1.82) | | |
| Long-term follow-up, mean (CI), KP vs sham treatment | 0.86 (0.04 to 1.67) | | RR: 0.93 (0.37 to 2.38) | | |

CI: confidence interval; CT: conservative therapy; EQ-5D: European Quality of Life-5 Dimensions; HR: hazard ratio; KP: kyphoplasty; MD: mean difference; OR: odds ratio; RMDQ: Roland–Morris Disability Questionnaire; RR: relative risk; VA: vertebral augmentation; VAS: visual analog score.

### Observational Studies

Edidin et al (2011) reported on mortality risk in Medicare patients who had osteoporotic vertebral compression fractures and had been treated with vertebroplasty, kyphoplasty, or nonoperatively. Using the U.S. Medicare dataset, the authors identified 858,978 patients who had vertebral compression fractures between 2005 and 2008. The dataset included 119,253 kyphoplasty patients and 63,693 vertebroplasty patients. Survival was calculated from the index diagnosis date until death or the end of follow-up (up to 4 years). Cox regression analysis was used to evaluate the joint effect of multiple covariates, which included sex, age, race/ethnicity, patient health status, type of diagnosed fracture, site of service, physician specialty, socioeconomic status, year of diagnosis, and census region. After adjusting for covariates, patients in the surgical cohorts (vertebroplasty or kyphoplasty) had a higher adjusted survival rate (60.8%) than patients in the nonsurgical cohort (50.0%) and were 37% less likely to die. The adjusted survival rates for vertebroplasty or kyphoplasty were 57.3% and 62.8%, respectively, a 23% lower relative risk for kyphoplasty. As noted by the authors, a causal relationship could not be determined from this study.

An industry-sponsored analysis by Ong et al (2018) evaluated the effect of the sham-controlled vertebroplasty trials on utilization of kyphoplasty/vertebroplasty, morbidity, and mortality in the Medicare population. Using the complete inpatient/outpatient U.S. Medicare data set from 2005 to 2014, the investigators evaluated utilization of vertebral augmentation procedures in patients with osteoporotic vertebral compression fractures who were treated in the 5-year period before 2009 and those who were treated in the 5 years after the sham-controlled trials were published. Use of the 2 procedures peaked at 24% of the osteoporotic vertebral compression fracture population in 2007 to 2008, then declined to 14% of osteoporotic vertebral compression fracture patients in 2014. Compared to patients with osteoporotic

vertebral compression fractures treated non-surgically, the kyphoplasty cohort (n=261,756) had a 19% (95% CI, 19 to 19) lower propensity-adjusted 10-year mortality risk. Compared to patients with osteoporotic vertebral compression fracture treated with vertebroplasty (n=117,232), the kyphoplasty cohort had a 13% (95% CI, 12 to 13) lower propensity-adjusted 10-year mortality risk. The study also found that patients treated with non-surgical management were more likely to be discharged to nursing facilities. Although the analysis did adjust for possible confounding factors, the observational nature of the study precludes any inference of causality.

### Balloon Kyphoplasty versus Conservative Care

The largest trial of kyphoplasty versus conservative care is by Wardlaw et al (2009), who reported the Fracture Reduction Evaluation (FREE) trial, a nonblinded, industry sponsored, multisite RCT involving 300 adults with 1 to 3 painful osteoporotic vertebral compression fractures of less than 3 months in duration. Twenty-four-month results were reported by Boonen et al (2011) and by Van Meirhaeghe et al (2013). Scores for the primary outcome, 1-month change in the 36-Item Short-Form Health Survey Physical Component Summary score, were significantly higher for those in the kyphoplasty group. The difference between groups was 5.2 points (95% CI, 2.9 to 7.4; p<.001). Kyphoplasty was associated with greater improvements in the 36-Item Short-Form Health Survey Physical Component Summary scores at 6-month follow-up (3.39 points), but not at 12- or 24-month follow-ups. Greater improvement in back pain was observed over 24 months for kyphoplasty (-1.49 points) and remained statistically significant at 24 months. Participants in the kyphoplasty group also reported greater improvements in quality of life and Roland-Morris Disability Questionnaire scores at short-term follow-up. At 12 months, fewer kyphoplasty patients (26.4% vs. 42.1%) had received physical therapy or walking aids, back braces, wheelchairs, miscellaneous aids, or other therapy. Fewer kyphoplasty patients used opioid medications through 6 months (29.8% vs. 42.9%) and fewer pain medications through 12 months (51.7% vs. 68.3%). Other differences between groups were no longer apparent at 12 months, possibly due to natural healing of fractures. Tables 5 and 6 summarize the key characteristics and results of the FREE trial. The tables below detail the relevance and design/conduct limitations of the study.

**Table 20: Summary of Key  Randomized Controlled Trial Characteristics**

| Study | Countries | Sites | Dates | Participants | Interventions | |
|---|---|---|---|---|---|---|
| | | | | | Active | Comparator |
| Wardlaw et al (2009), Boonen et al (2011), Van Meirheghe et al (2013) | EU | 21 | 2003-2005 | Patients with 1 to 3 vertebral fractures | Balloon kyphoplasty (n=149) | Non-surgical care (n=151) |

EU: European Union;

**Table 21: Summary of Key Randomized Controlled Trial Results**

| Study | Mean SF-36 PCS Score Improvement at 1 mo (95% CI) | Difference in SF-36 Scores between Groups at 24 mo | Serious Adverse Events within 30 days | Serious Adverse Events within 12 mo | Serious Adverse Events within 24 mo |
|---|---|---|---|---|---|
| Wardlaw et al(2009), Boonen et al (2011), Van Meirheghe et al (2013) | | | | | |
| Kyphoplasty | 7.2 (5.7 to 8.8) | | 24 (16.1%) | 58 (38.9%) | 74 (49.7%) |
| Control | 2 (0.4 to 3.6) | | 17 (11.3%) | 54 (35.8%) | 73 (48.3%) |
| MD (95% CI) | | 3.24 (1.47 to 5.01) | | | |
| p value | <.0001 | .0004 | | | |

CI: confidence interval; MD: mean difference; SF-36 PCS: 36-Item Short-Form Physical Component Score.

**Table 22: Study Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow Up[e] |
|---|---|---|---|---|---|
| Wardlaw et al (2009), Boonen et al (2011), Van Meirheghe et al (2013) | | | 3. Non-surgical treatment was not standardized | | 2. 24 mo. follow-up |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.
c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.
d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

**Table 23: Study Design and Conduct Limitations**

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Data Completeness[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Wardlaw et al (2009), Boonen et al (2011), Van Meirheghe et al (2013) | 3. Allocation concealment unclear | 1,2. Not blinded | | | | |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

## Mechanical Vertebral Augmentation (e.g., Kiva or SpineJack)

### Systematic Review

In December of 2016 Hayes completed a Health Technology Assessment which was last reviewed in December 2018 on Kiva VCF Treatment System for treatment of vertebral compression fractures. Hayes rated the Kiva VCF Treatment System to treat symptomatic vertebral compression fractures (VCFs) due to osteoporosis with symptoms refractory to conservative care a C. According to Hayes a C rating indicates, “potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns." Hayes rated Kiva VCF Treatment System to treat symptomatic VCFs due to spinal metastasis with symptoms refractory to conservative care a D2 . “is Rating reflects the paucity of available evidence. Definitive evidence-based conclusions cannot be made regarding the efficacy and safety of the Kiva system in this patient population.”

## Mechanical Vertebral Augmentation (e.g., Kiva or SpineJack) versus Balloon Kyphoplasty

### Systematic Reviews

Macciacchera et al (2024) conducted a systematic review and meta-analysis that compared mechanical vertebral augmentation versus balloon kyphoplasty in patients with osteoporotic thoracolumbar compression fractures. The 6 included RCTs had a total of 1024 patients. There were no differences between the treatments in midline vertebral body height ratio, cement extravasation, new fractures, adjacent fractures, 6-month and final VAS pain scores, ODI scores at 6 months and final follow-up, total complications, or device-related complications (all p>.05).

**Table 24. Comparison of Trials/Studies Included in Systematic Reviews/Meta-Analyses**

| Study | Macciacchera et al (2024) |
|---|---|

| | |
|---|---|
| Noriega et al (2019) | ● |
| Noriega et al (2016) | ● |
| Tutton et al (2015) | ● |
| Korovessis et al (2013) | ● |
| Werner et al (2013) | ● |
| Vanni et al (2012) | ● |

**Table 25. Systematic Review and Meta-Analysis Characteristics**

| Study | Dates | Trials | Participants | N (Range) | Design | Duration |
|---|---|---|---|---|---|---|
| Macciacchera et al (2024) | 2012-2019 | 6 | Patients with osteoporotic compression fractures of the thoracolumbar region | 1024 (30 to 285) | RCT | 12 to 14 months |

RCT: randomized controlled trial.

**Table 26. Systematic Review & Meta-Analysis Results**

| Study | Vertebral Body Height | Adjacent Fractures | Total complications | Cement Extravasation |
|---|---|---|---|---|
| Macciacchera et al (2024) | | | | |
| | 809 | 490 | 866 | 1038 |
| Pooled effect (95% CI) | SMD: 0.51 (-0.56 to 1.58) | RR: 0.78 (0.47 to 1.32) | RR: 0.53 (0.10 to 2.92) | RR: 0.73 (0.18 to 2.89) |
| $I^2$ (p) | 66% (.18) | 0% (.23) | 60% (.36) | 61% (.58) |

CI: confidence interval; RR: relative risk; SMD: standard mean difference.

**Randomized Controlled Trials**Vertebral augmentation with the Kiva vertebral compression fractures system was compared with balloon kyphoplasty in a pivotal noninferiority RCT reported by Tutton et al (2015). This industry-sponsored, multicenter, open-label, Kiva safety and effectiveness trial was conducted in 300 patients with 1 or 2 osteoporotic vertebral compression fractures. Included were patients with visual analog scale scores for back pain of at least 70 mm (out of 100 mm) after 2 to 6 weeks of conservative care or visual analog scale scores of at least 50 mm after 6 weeks of conservative

care, and Oswestry Disability Index scores of at least 30%. The primary composite endpoint at 12 months was a reduction in fracture pain by at least 15 mm on the visual analog scale, maintenance or improvement in function on the Oswestry Disability Index, and absence of device-related serious adverse events. The primary endpoint was met by 94.5% of patients treated with Kiva and 97.6% of patients treated with kyphoplasty (Bayesian posterior probability of 99.92% for noninferiority, using as-treated analysis). In the 285 treated patients, Kiva resulted in a mean improvement of 70.8 points in visual analog scale scores, compared with a 71.8-point improvement for kyphoplasty. There was a 38.1-point improvement in Oswestry Disability Index score for the Kiva group compared with a 42.2-point improvement for the kyphoplasty group. There were no device-related serious adverse events. The total volume of cement was 50% less with Kiva, and there was less cement extravasation (16.9%) compared with kyphoplasty (25.8%).

Korovessis et al (2013) reported on a randomized trial of 180 patients with osteoporotic vertebral compression fractures that compared mechanical vertebral augmentation with the Kiva device with balloon kyphoplasty in 180 patients with osteoporotic vertebral compression fractures. The groups showed similar improvements in visual analog scale scores for back pain, 36-Item Short-Form Health Survey scores, and Oswestry Disability Index scores. For example, there was a more than 5.5-point improvement in visual analog scale scores in 54% of patients in the Kiva group and 43% of patients in the balloon kyphoplasty group. Radiologic measures of vertebral height were similar in both groups. Kiva reduced the Gardner kyphotic angle, while residual kyphosis of more than 5° was more frequently observed in the balloon kyphoplasty group. Patients and outcome assessors were reported to be unaware of group assignments, although it is not clear if the Kiva device was visible on radiographs. Cement leakage into the canal only occurred in 2 patients treated with balloon kyphoplasty, necessitating decompression, compared with none following the Kiva procedure.

Noriega et al (2019) reported the pivotal multicenter non-inferiority trial of the SpineJack vertebral augmentation system. Patients (N =152) with osteoporotic vertebral compression fractures less than 3 months old were randomized to treatment with SpineJack or balloon kyphoplasty. The primary outcome was a composite measure that included improvement in visual analog scale for pain of greater than 20 mm, maintenance or improvement in Oswestry Disability Index, and lack of adverse events. Vertebral height was prespecified to be included if the primary outcome was achieved. Non-inferiority was achieved with 89.8% of SpineJack patients achieving the composite of clinical success compared to 87.3% for balloon kyphoplasty (Table 10). When including the restoration of vertebral body height, the SpineJack procedure was found to be superior to balloon kyphoplasty at 6 months (88.1% vs. 60.9%) and 12 months (79.7% vs. 59.3%, p<.001). There was also a reduction in adjacent vertebral fractures with the mechanical augmentation system (12.9% vs. 27.3%; p=.043). Interpretation of this study is limited by the lack of a sham control group.

The tables below summarize the key characteristics and results of these RCTs and details study design and conduct limitations.

**Table 27: Summary of Key Randomized Controlled Trial Characteristics**

| Study | Countries | Sites | Dates | Participants | Interventions | |
|---|---|---|---|---|---|---|
| | | | | | Active | Comparator |
| Tutton (2015) | US, EU | 21 | 2010-2013 | Patients with OVCF | Kiva (n=153) | BK (n=147) |

| Study | Countries | Sites | Dates | Participants | Interventions | |
|---|---|---|---|---|---|---|
| Korovessis (2013) | Greece | 1 | 2010-2011 | Patients with OVCF | Kiva (n=82 patients, 133 fractures) | BK (n=86 patients, 122 fractures) |
| Noriega et al (2019) | EU | 13 | 2015-2017 | Patients with OVCF aged <3 mo and loss of height ≥15% but ≤40%, VAS ≥50 mm and ODI ≥30% | SpineJack (n=77, 68 in mITT) | BK (n=75, 73 in mITT) |

BK: balloon kyphoplasty; mITT: modified intention-to-treat; ODI: Oswestry Disability Index; OVCF: osteoporotic vertebral compression fracture; VAS: visual analog score.

**Table 28: Summary of Key Randomized Controlled Trial Results**

| Study | Improvement in VAS Score at 12 mo | Improvement in ODI at 12 mo | | Restoration of VBH | Percent Success |
|---|---|---|---|---|---|
| | | | | Anterior | VAS Improvement of 5.5 Points |
| Tutton (2015) | | | | | |
| Kiva | 70.8 | 38.1 | | | |
| BK | 71.8 | 42.2 | | | |
| Korovessis (2013) | | | | | |
| Kiva | | | | 24% | 44 (54%) |
| BK | | | | 23% | 37 (43%) |
| p value | | | | .97 | |
| | Improvement in VAS at 1 mo ± SD | Improvement in ODI at 1 mo ± SD | Improvement in EQ-5D at 1 mo ± SD | Midline ± SD | Percent Achieving CCS[a] (95% CI) |
| Noriega et al (2019) | | | | | |
| Spine-Jack | 56.4 ± 20.3 | 44.2 ± 21.2 | 0.45 ± 0.29 | 1.31 ± 2.58 | 89.8% (82.1 to 97.5 ) |
| BK | 47.8 ± 25.7 | 39.9 ± 23.7 | 0.42 ± 0.29 | 0.10 ± 2.34 | 87.3% (78.5 to 96.1 ) |
| p value | .029 | .321 | .598 | .0035 | .0016 |

BK: balloon kyphoplasty; CCS: composite clinical success; CI: confidence interval; EQ-5D: EuroQol 5-domain questionnaire; ODI: Oswestry Disability Index; SD: standard deviation; VAS: visual analog scale; VBH: vertebral body height.

a Composite clinical success included greater than 20 mm improvement in VAS, maintenance or improvement in ODI, and absence of adverse events.

### Table 29: Study Design and Conduct Limitations

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Data Completeness[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Tutton (2015) | 2. Allocation not concealed throughout study | 1,2. Patients only blinded prior to procedure performance | | | 2. Study not powered for primary or secondary endpoint | |
| Korovessis (2013) | | 1,2. Not blinded | | | | |
| Noriega et al (2019) | | 1. Not blinded for patient-reported outcomes. Radiographic assessments were blinded. | | | | |

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

### Section Summary: Osteoporotic Vertebral Compression Fractures

An AHRQ review concluded that vertebroplasty was probably more effective at reducing pain and improving function in patients > 65 years of age, but benefits were small (<1 point on a 10-point pain scale). Kyphopasty was found to be probably more effective than usual care for pain and function in older patients with vertebral compression fracture at up to 1 month and may be more effective at > 1 month to ≥ 1 year, but has not been compared against sham therapy. The review found that the overall evidence base for vertebroplasty had several limitations while the absence of sham-controlled trials is a major limitation for kyphoplasty. A network meta-analysis found that relative to conservative treatment kyphoplasty provided short-term and long-term improvements to pain and disability scores.

A moderately-sized, unblinded RCT reported short-term benefits of kyphoplasty for pain and other outcomes in patients with painful osteoporotic fractures compared with conservative care. One systematic review of RCTs found no significant difference in subsequent fracture between vertebroplasty and conservative treatment, and another systematic review of prospective and retrospective studies reported improved mortality with either vertebroplasty or balloon kyphoplasty compared with conservative

treatment. Other relevant studies, including additional RCTs and meta-analyses, found similar outcomes for kyphoplasty and vertebroplasty.

For mechanical vertebral augmentation with Kiva and SpineJack, the evidence includes a systematic review, industry-sponsored, multicenter investigational device exemption trials and a large independent randomized trial. The systematic review did not find any differences between mechanical vertebral augmentation and kyphoplasty. The randomized comparative trials showed outcomes similar between Kiva and kyphoplasty. Mechanical vertebral augmentation with SpineJack was found to be non-inferior to balloon kyphoplasty for success on a composite outcome measure and superior to balloon kyphoplasty when vertebral height restoration was included in the composite. A major limitation of all these RCTs is the lack of a sham procedure. Due to the possible sham effect observed in the trials of vertebroplasty, the validity of the results from non-sham-controlled trials is unclear. Therefore, whether these improvements represent a true treatment effect is uncertain.

## Osteolytic Vertebral Compression Fractures

### *Clinical Context and Therapy Purpose*

The purpose of balloon kyphoplasty or mechanical vertebral augmentation is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conservative care, in individuals with osteolytic vertebral compression fractures.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with osteolytic vertebral compression fractures.

### *Interventions*

The therapy being considered is balloon kyphoplasty or mechanical vertebral augmentation. The intervention involves the fluoroscopically guided injection of polymethyl methacrylate into a cavity created in the vertebral body with a balloon or mechanical device to provide support and symptomatic relief in individuals.

### *Comparators*

Comparators of interest include conservative care. Treatment includes bed rest, local and systemic analgesia, and bracing.

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life (table below), hospitalizations, and treatment-related morbidity.

**Table 30: Outcomes of Interest for Individuals with Osteolytic Vertebral Compression Fractures**

| Outcomes | Details |
|---|---|
| Quality of life | Reduced pain, disability, and analgesic use in patients |

The existing literature evaluating balloon kyphoplasty or mechanical vertebral augmentation as a treatment for osteolytic vertebral compression fracture has varying lengths of follow-up. At least 1 year of follow-up for the primary outcome is necessary to adequately assess outcomes.

## Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

## Review of Evidence

## Systematic Reviews

In a systematic review, Health Quality Ontario (2016) assessed vertebral augmentation for cancer-related vertebral compression fractures. The assessment identified 33 reports with 1 690 patients who were treated with kyphoplasty for spinal metastatic cancers, multiple myeloma, or hemangiomas. For cancer-related vertebral compression fractures, there were 5 case series (110 patients) on multiple myeloma and 6 reports (2 RCTs, 4 case series; 308 patients) on mixed cancers with spinal metastases. Vertebral augmentation resulted in reductions in pain intensity scores, opioid or other analgesic use, and disability scores. One RCT (N=129) compared kyphoplasty with nonsurgical management for cancer-related vertebral compression fractures, reporting that pain scores, pain-related disability, and health-related quality of life were significantly improved in the kyphoplasty group than in the usual care group. The second RCT compared the Kiva device with kyphoplasty in 47 patients with cancer-related compression fractures, finding no significant differences between groups for improvements in visual analog scale pain and Oswestry Disability Index scores.

Mattie et al (2021) conducted a systematic review and meta-analysis of 7 RCTs (N=476) that compared the magnitude and duration of pain relief with vertebral augmentation (i.e., balloon kyphoplasty or percutaneous vertebroplasty), with or without additional therapy, to any other intervention or placebo/sham for the treatment of cancer-related vertebral compression fractures. In 5 of the 7 studies, vertebral augmentation alone comprised 1 group; comparative treatments included nonsurgical management, Kiva implantation, and combinations of percutaneous vertebroplasty and radiofrequency therapy, chemotherapy, instrasomatic steroid injection, or $^{125}$I seeds. Results revealed an overall positive and statistically significant effect of vertebral augmentation for the management of cancer-related vertebral compression fractures. This effect was particularly pronounced when comparing vertebral augmentation to nonsurgical management, radiofrequency ablation, or chemotherapy alone. The authors noted that there was much heterogeneity among the included studies regarding the treatment methods in the control groups, and 1 study allowed patients to crossover to the intervention group, potentially leading to biased results.

## Randomized Controlled Trials

The only RCT to compare kyphoplasty to non-surgical management was an international multicenter study reported by Berenson et al (2011). The trial enrolled 134 patients with cancer who had at least 1 and not more than 3 painful osteolytic vertebral compression fractures. The primary outcome was change in functional status from baseline at 1 month as measured by the Roland-Morris Disability Questionnaire. Treatment allocation was not blinded, and the primary outcome at 1 month was analyzed using all participants with data both at baseline and at 1 month. Participants needed to have a pain score of at least 4, on a 0-to-10 scale. Crossover to the balloon kyphoplasty arm was allowed after 1 month. Reviewers reported scores for the kyphoplasty and nonsurgical groups of 17.6 and 18.2 at baseline, respectively, and 9.1 and 18.0 at 1-month follow-up (between-group difference in scores, $p < .001$).

Korovessis et al (2014) compared the efficacy of Kiva and kyphoplasty in an RCT with 47 participants with osteolytic vertebral compression fractures. Oswestry Disability Index scores improved by 42 and 43 points in the kyphoplasty and Kiva groups, respectively. Pain scores improved by 5.1 points in both groups, from baseline mean scores of 8.1 (kyphoplasty) and 8.3 (Kiva).

### Section Summary: Osteolytic Vertebral Compression Fractures

Results of an RCT, systematic reviews, and case series suggest vertebral augmentation reduces pain, disability, and analgesic use in patients with cancer-related compression fractures. However, because the results of the comparative studies of vertebroplasty have also suggested a possible placebo effect, the evidence is insufficient to warrant conclusions about the effect of kyphoplasty on health outcomes.

## Radiofrequency Kyphoplasty

### *Clinical Context and Therapy Purpose*

The purpose of radiofrequency kyphoplasty is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conservative care, in individuals with osteoporotic or osteolytic vertebral compression fractures.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals with osteoporotic or osteolytic vertebral compression fractures.

### *Interventions*

The therapy being considered is radiofrequency kyphoplasty. The intervention uses radiofrequency energy to ablate metastatic malignant lesions in a vertebral body to provide symptomatic relief.

### *Comparators*

Comparators of interest include conservative care. Treatment includes bed rest, local and systemic analgesia, and bracing. ,

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity.

**Table 31. Outcomes of Interest for Individuals with Osteoporotic or Osteolytic Vertebral Compression Fractures**

| Outcomes | Details |
|---|---|
| Quality of life | Reduced pain, disability, and analgesic use |

The existing literature evaluating radiofrequency kyphoplasty as a treatment for osteoporotic or osteolytic vertebral compression fractures has varying lengths of follow-up, ranging from 36 to 80 months. While studies described below all reported at least one outcome of interest, longer follow-up is necessary to fully observe outcomes.

### Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

### Review of Evidence

### Meta-analysis

Feng et al (2017) performed a meta-analysis comparing radiofrequency kyphoplasty with balloon kyphoplasty in patients with vertebral compression fractures. Six studies (N=833 patients) evaluating vertebral compression fractures were identified. The main outcomes were pain relief (visual analog scale), functionality improvement (Oswestry Disability Index), operation time, reduction of deformity (i.e., the restoration of vertebral height and kyphosis angle), and incidence of cement leakage. Visual analog score improved for both groups after the respective procedure; however, visual analog scale score dropped 3.96 points more in the radiofrequency kyphoplasty group (95% CI, 1.67 to 6.24; p=0.001), with improvement persisting until the 12-month mark. While functionality improvement was initially improved more after radiofrequency kyphoplasty than balloon kyphoplasty (p=0.04), the difference between the 2 groups was not significant after a year (p=0.6). No significant difference in cement leakage between groups was observed. This review was limited by the small number of studies included as well as the presence of significant bias within these studies.

### Randomized Controlled Trials

Petersen et al (2016) reported on an RCT with 80 patients that compared radiofrequency kyphoplasty with balloon kyphoplasty. Patients had been admitted to the hospital for severe back pain and met criteria for surgery after failed conservative treatment. All had osteoporotic compression fractures. Before treatment, visual analog scale pain scores on movement were similar in both groups (8.4 in the balloon kyphoplasty group vs 8.0 in the radiofrequency kyphoplasty group). Postoperatively, visual analog scores improved by 4.6 after balloon kyphoplasty and 4.4 after radiofrequency kyphoplasty (p=not significant). Pain at 12 months also did not differ significantly between both groups, with 58% of patients in the balloon kyphoplasty group and 66% of patients in the radiofrequency kyphoplasty group reporting no to mild pain on movement (p=not significant). There was a trend for greater restoration of the kyphosis angle.

### Section Summary: Radiofrequency Kyphoplasty

For radiofrequency kyphoplasty, the evidence includes a meta-analysis and an RCT. While the RCT showed similar results compared with balloon kyphoplasty, an improvement in immediate pain relief after RCT was noted in the meta-analysis. Further high-quality studies are needed to determine with greater certainty whether radiofrequency kyphoplasty has outcomes similar to balloon kyphoplasty.

## Adverse Events

Yi et al (2014) assessed the occurrence of new vertebral compression fractures after treatment with cement augmenting procedures (vertebroplasty or kyphoplasty) versus conservative treatment in an RCT with 290 patients (363 affected vertebrae). Surgically treated patients were discharged the next day. Patients treated conservatively (pain medication, bed rest, a body brace, physical therapy) had a mean length of stay of 13.7 days. Return to usual activity occurred at 1 week for 87.6% of surgically treated patients and 2 months for 59.2% of conservatively treated patients. All patients were evaluated with radiographs and magnetic

resonance imaging at 6 months and then at yearly intervals until the last follow-up session. At a mean follow-up of 49.4 months (range, 36 to 80), 10.7% of patients had experienced 42 new symptomatic vertebral compression fractures. There was no significant difference in the incidence of new vertebral fractures between the operative (n=18; 9 adjacent, 9 nonadjacent) and conservative (n=24; 5 adjacent, 16 nonadjacent, 3 same level) groups, but the mean time to a new fracture was significantly shorter in the surgical group (9.7 months) compared with the nonoperative group (22.4 months).

## Expandable Interbody Implant

### *Clinical Context and Therapy Purpose*

The purpose of an expandable interbody implant is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conservative care, in individuals needing a traumatic fracture repair and interbody fusion.

The following PICO was used to select literature to inform this review.

### *Populations*

The relevant population of interest is individuals needing a traumatic fracture repair.

### *Interventions*

The therapy being considered is the use of an expandable interbody implant.

The OptiMesh® is designed to contain impacted granular bone chips and allows it to be deployed to the area needing repair.

### *Comparators*

Comparators of interest include conservative care. Treatment includes bed rest, local and systemic analgesia, and bracing, in a home setting as well as an outpatient clinical setting by a primary care provider.

### *Outcomes*

The general outcomes of interest are symptoms, functional outcomes, quality of life, hospitalizations, and treatment-related morbidity.

**Table 32: Outcomes of Interest**

| Outcomes | Details |
|---|---|
| Quality of life | Reduced pain, disability, and analgesic use in patients |

### Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

### Review of Evidence

No RCTs or comparative nonrandomized studies were identified that evaluated an expandable interbody implant in individuals needing a traumatic fracture repair.

Schulz et al (2015) reported on a retrospective study of 17 patients with acute type A3.1 fractures of the thoracic or lumbar spine underwent stand-alone augmentation with mesh and allograft bone expandable interbody implant (OptiMesh®) and were followed up for one year. Study participants had a median age of 34 years and were 65% male. Although the expandable interbody implant resulted in an improvement in pain and physical activity scores, it was also associated with a significant loss of correction.

### Section Summary: Spineoplasty / Expandable Interbody Implant

No RCTs evaluating an expandable interbody implant in individuals needing a traumatic fracture repair and interbody fusion were identified. The available evidence includes 1 small retrospective, noncomparative study of 17 individuals. Although the expandable interbody implant resulted in an improvement in pain and physical activity scores, a significant loss of correction was also observed. Large prospective trials are needed to establish benefit to net health outcomes.

## SUPPLEMENTAL INFORMATION

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

### Clinical Input from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

#### *2014 Input*

In response to requests, input was received from 2 physician specialty societies and 3 academic medical centers while this policy was under review in 2014. Input was sought on the treatment of acute vertebral fractures when there is severe pain that has led to hospitalization or persists at a level that prevents ambulation, and on the treatment of traumatic fractures that have remained symptomatic after 6 weeks of conservative treatment. Input on these issues was mixed.

#### *2008 Input*

In response to requests, input was received from 5 physician specialty societies and 2 academic medical centers while this policy was under review in 2008. Unsolicited input was received from a sixth physician specialty society. All reviewers disagreed with the proposed policy and provided references in support of the use of vertebroplasty. Vertebroplasty has been investigated as an intervention to provide mechanical support and symptomatic relief in patients with an osteoporotic vertebral compression fracture and in those with osteolytic lesions of the spine (i.e., multiple myeloma, metastatic malignancies). Clinical input obtained in 2008 provided uniform support for the use of vertebroplasty in painful osteoporotic fractures. Reconsideration of the available evidence (consistent results of numerous case series, including large prospective reports) and evaluation of the input led to a conclusion that the evidence was sufficient to determine that vertebroplasty is a reasonable treatment option in patients with vertebral fractures who

have failed to respond to conservative treatment (at least 6 weeks with analgesics, physical therapy, and rest). It is also clinically reasonable to consider the evidence supporting the clinical benefit of vertebroplasty in the osteoporotic vertebral fracture to support its use in osteolytic lesions of the spine (e.g., multiple myeloma, metastatic malignancies).

### Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

#### *American College of Radiology (ACR)*

In 2014, the ACR and 7 other surgical and radiologic specialty associations published a joint position statement on percutaneous vertebral augmentation. This document stated that percutaneous vertebral augmentation using vertebroplasty or kyphoplasty and performed in a manner consistent with public standards is a safe, efficacious, and durable procedure in appropriate patients with symptomatic osteoporotic and neoplastic fractures. The statement also indicated that these procedures be offered only when nonoperative medical therapy has not provided adequate pain relief or pain is significantly altering the patient's quality of life.

A joint practice parameter for the performance of vertebral augmentation was updated in 2017.

In 2022, the American College of Radiology (ACR) revised its Appropriateness Criteria for the use of percutaneous vertebral augmentation in the management of vertebral compression fractures.[1] The table below shows the appropriateness categories for each variant.

**Table 33: American College of Radiology Appropriateness Criteria for the Use of Percutaneous Vertebral Augmentation for the Management of Vertebral Compression Fractures**

| Variants | Appropriateness Category |
|---|---|
| "Asymptomatic, osteoporotic VCF. Initial treatment" | Usually Not Appropriate |
| "Symptomatic osteoporotic VCF with bone marrow edema or intravertebral cleft. Initial treatment" | Usually Appropriate |
| "New symptomatic VCF. History of prior vertebroplasty or surgery. Initial treatment." | Usually Appropriate |
| "Benign VCF with worsening pain, deformity, or pulmonary dysfunction. Initial treatment" | Usually Appropriate |
| "Pathological VCF with ongoing or increasing mechanical pain. Initial treatment" | Usually Appropriate |

VCF: vertebral compression fracture.

#### *American Academy of Orthopaedic Surgeons (AAOS)*

In 2011, the American Academy of Orthopaedic Surgeons (AAOS) published practice guidelines on the treatment of osteoporotic spinal compression fractures. The AAOS approved "a Strong recommendation

was made against the use of vertebroplasty for patients who present with an acute osteoporotic spinal compression fracture and are neurologically intact."

### *American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology (ACE)*

In 2020, the American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology (ACE) published a clinical practice guideline for the diagnosis and treatment of postmenopausal osteoporosis which stated, “Vertebroplasty and kyphoplasty are not recommended as first-line treatment of vertebral fractures, given an unclear benefit on overall pain and a potential increased risk of vertebral fractures in adjacent vertebrae (Grade A, BEL 1).”

### *American Society of Pain and Neuroscience*

In 2021, the American Society of Pain and Neuroscience (ASPN) published practice guidelines for the interventional management of cancer-associated pain. The guideline included a best practice statement that stated, "vertebral augmentation should be strongly considered for patients with symptomatic vertebral compression fractures from spinal metastases (evidence level 1-A)." However, ASPN noted that there is little data to suggest the superiority of either vertebroplasty or kyphoplasty when treating malignant vertebral compression fractures.

### *National Comprehensive Cancer Network (NCCN)*

The National Comprehensive Cancer Network (NCCN) published a Clinical Practice Guidelines on Oncology (NCCN Guidelines) Bone Cancer (Version 2.2025) **and Survivorship (Version 1.2025) that** provided no recommendation for the use of vertebral augmentation, vertebroplasty, kyphoplasty or sacroplasty were identified in this guideline.

The NCCN published a Clinical Practice Guideline on Multiple Myeloma (Version2.2025) that recommended to, “Consider vertebroplasty or kyphoplasty for symptomatic vertebral compression fractures.”

### *National Institute for Health and Care Excellence (NICE)*

In 2003, NICE concluded in its guidance on percutaneous vertebroplasty that the current evidence on the safety and efficacy of vertebroplasty for vertebral compression fractures appeared "adequate to support the use of this procedure" to "provide pain relief for people with severe painful osteoporosis with loss of height and/or compression fractures of the vertebral body…." The guidance also recommended that the procedure be limited to patients whose pain is refractory to more conservative treatment. In 2023, NICE issued guidance on the diagnosis and management of adults with spinal metastases and metastatic spinal cord compression. This guidance indicated that vertebroplasty or kyphoplasty should be considered for "patients who have spinal metastases and no evidence of metastatic spinal cord compression if they have: suspected or confirmed spinal instability, or pain uncontrolled by analgesia.” Other options for this population include radiofrequency ablation, surgical stabilization, or spinal surgery to prevent metastatic cord compression.

The NICE (2013) issued a guidance that recommended percutaneous vertebroplasty and percutaneous balloon kyphoplasty as treatment options for osteoporotic vertebral compression fractures in persons having severe, ongoing pain after a recent unhealed vertebral fracture, despite optimal pain management, and whose pain has been confirmed through physical exam and imaging at the level of the fracture. This guidance did not address balloon kyphoplasty with stenting, because the manufacturer of the stenting system (Synthes) stated there is limited evidence for vertebral body stenting given that the system had only recently become available.

### *Society of Interventional Radiology*

In a 2014 quality improvement guideline for percutaneous vertebroplasty from the Society of Interventional Radiology, failure of medical therapy was defined as follows:

- "For a patient rendered nonambulatory as a result of pain from a weakened or fractured vertebral body, pain persisting at a level that prevents ambulation despite 24 hours of analgesic therapy;
- For a patient with sufficient pain from a weakened or fractured vertebral body that physical therapy is intolerable, pain persisting at that level despite 24 hours of analgesic therapy; or
- For any patient with a weakened or fractured vertebral body, unacceptable side effects such as excessive sedation, confusion, or constipation as a result of the analgesic therapy necessary to reduce pain to a tolerable level."

### Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review can be located at clinicaltrials.gov.

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## CODES

To report provider services, use appropriate CPT codes, HCPCS codes, Revenue codes, and/or ICD diagnosis codes.

| Codes | Number | Description |
|---|---|---|
| CPT | | |
| | 22510 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic |
| | 22511 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral |
| | 22512 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure) |
| | 22513 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic |
| | 22514 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar |
| | 22515 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) |
| | 22899 | Unlisted procedure, spine (e.g., *may be utilized for Expandable Interbody Implant*) |

| | | |
|---|---|---|
| | 0200T | Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed |
| | 0201T | Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed |
| | | |
| HCPCS | | |
| | C1062 | Intravertebral body fracture augmentation with implant (e.g., metal, polymer) |
| | C7504 | Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance |
| | C7505 | Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance |
| | C7507 | Percutaneous vertebral augmentations, first thoracic and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance |
| | C7508 | Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance |
| | | |
| Type of Service | Radiology | |
| Place of Service | Inpatient/Outpatient | |

## POLICY HISTORY

| Date | Action | Action |
|---|---|---|
| June 2025 | Annual Review | Policy Renewed |
| June 2024 | Annual Review | Policy Revised |
| June 2023 | Annual Review | Policy Revised |
| April 2022 | Annual Review | Policy Revised |
| April 2021 | Annual Review | Policy Revised |
| June 2020 | Interim Review | Policy Revised |
| April 2020 | Annual Review | Policy Revised |
| April 2019 | Annual Review | Policy Revised |
| April 2018 | Annual Review | Policy Revised |
| April 2017 | | New Policy |

New information or technology that would be relevant for Wellmark to consider when this policy is next reviewed may be submitted to:

Wellmark Blue Cross and Blue Shield
Medical Policy Analyst
PO Box 9232
Des Moines, IA 50306-9232

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