ovacome..

Multiple Technology Appraisal (MTA)

Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for the treatment of recurrent ovarian cancer (including review of technology appraisal no. 91 and technology appraisal no. 222)

Following consultation with our members, Ovacome wishes to submit the following comments to NICE in its consideration of the above technologies.

The majority of women with ovarian cancer will experience relapse following first line chemotherapy. Relapsed disease is widely considered to be incurable, and a marker that the woman will eventually die from the disease. Many women describe the diagnosis of relapse as being more distressing than the initial diagnosis.

Women diagnosed with relapsed ovarian cancer expect that proposed treatments are based on their individual disease profile, medical history, previous experience of chemotherapy and particular lifestyle rather than on nationally prescribed guidance. Ovacome is therefore keen to ensure that this TA facilitates a breadth of practice which will allow clinicians and women to select the right treatment at the right time for the circumstances, experiences and preferences of the individual woman.

Considerations when choosing which treatment is preferred include progression free survival, overall survival, side effect profiles, timing/scheduling and route of delivery of the treatment (oral vs. IV etc) as well as other individual considerations.

Where clear evidence demonstrates survival benefit, women are generally keen to be able to access that treatment. Side effect issues are less significant that generally supposed, with more severe side effects tolerated for survival benefit than believed by clinicians. (Slevin 1990)

The extent to which first line chemotherapy negatively impacts on womens quality of life varies widely, with some women experiencing very few side effects and continuing to work with minimal disruption, whilst others describe extensive problems which have wide ranging negative consequences. These experiences will have a significant part to play in the decision making process when considering relapse treatment.

This MTA is assessing a significant number of active agents. Some are in common use and have existing NICE approval, whilst others do not. All have proven benefit in varying clinical scenarios; therefore Ovacome would welcome a final determination in which all the agents being considered are approved and available at the discretion of the oncologist.

Discovering that treatment is not that which might be optimal is described by one woman as being:

"…devastating. I felt I couldn't trust my doctors and the NHS anymore. It was like having the floor disappear beneath me. I don't think my husband and son will ever get over it, and we will always wonder if I might have beaten this if I had been treated elsewhere."

There is a sense among women with relapsing ovarian cancer and their clinicians that the NHS is letting women die unnecessarily. This comes from studies that clearly show how English survival

is one of the worst in Europe (M P Coleman et al) and that there are 500 women dying unnecessarily each year. A widely held belief that this is due to late diagnosis has been proven false by a recent study. (Maringe et al)

"Our research is the first population-based study to examine whether low ovarian cancer survival in the UK is due to more women being diagnosed with advanced disease, or to the outcome of treatment in the UK being inferior at each stage. The results show that the proportion of women with advanced disease is similar to that in other countries, but that survival for women with advanced disease is much lower. This suggests that the success of treatment is lower in the UK, and more effort should be made to ensure that UK women with ovarian cancer have the same access to the best treatments." Dr Bernard Rachet

Access to chemotherapeutic agents is one element of this, and this study investigated women being treated during the lifetime of NICE. We therefore believe that it is critical to improving UK survival that clinicians are given the freedom to prescribe as they think is appropriate, and not be restricted in the provision of what they consider to be the best treatment for their patient. We understand that the NHS rightly requires cost effective treatments; however it is a matter of great concern that women in the UK may be dying as a consequence of the current guidance, and we hope that the new appraisal will allow for greater prescribing freedom.

References

Attitudes to chemotherapy: comparing views of patients with cancer with those of doctors, nurses, and general public.

Slevin ML et al. BMJ. 1990 Jun 2;300(6737):1458-60.

MP Coleman - http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62231-3/fulltext

Maringe et al - Stage at diagnosis and ovarian cancer survival: Evidence from the International Cancer Benchmarking Partnership. Gynecologic Oncology Volume 127, Issue 1, October 2012, Pages 75–82

Dr Bernard Rachet - http://www.cancerresearchuk.org/cancer-info/news/archive/pressrelease/2012-10-03-differences-in-ovarian-cancer-treatment-put-uk-behind-other-countries