National Institute for Health and Clinical Excellence

Health Technology Appraisal

The use of Oxaliplatin and Capecitabine for the adjuvant treatment of colon cancer

Assessment Report - Submission by Olive Craven (Nurse Clinician)

Introduction

With a membership of over 370,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes the opportunity to comment on this report.

Comments on Assessment Report

This report provides a comprehensive, rigorous and objective appraisal of the current clinical evidence base in relation to the adjuvant use of Capecitabine and Oxaliplatin.

Factors relevant to the NHS

The importance of patient education is mentioned in relation to Capecitabine but equally imperative is the need to ensure thorough professional training if patients are to be seen in outreach clinics and subsequently managed by GPs or admitted to DGHs or community hospitals in the event of toxicity. It is unclear how much of the current use of Capecitabine, in the metastatic setting is managed by cancer centres where systems are in place to deal with adverse effects. However, if approved in the adjuvant setting, the convenience of establishing outreach clinics to treat patients raises important questions in relation to who will assume responsibility for the monitoring, advising and management of patients 24 hours a day.

Adjuvant usage of Oxaliplatin would undoubtedly impact on pharmacy services in terms of infusion preparation time. It is unclear at this point what percentage of adjuvant patients would be treated with either Capecitabine or Oxaliplatin (or indeed both as suggested by [redacted]) but there would clearly be less time spent on preparing bolus 5FU. Also the practice of

‘rounding doses’, in conjunction with the current 7 day expiry once the drug has been reconstituted, facilitates both the postponement of treatment for up to a week and allows treatment to be relabelled for other patients, thus reducing potential wastage.

Assumption underlying economic model

The difficulty with estimating the long-term cost effectiveness of both drugs is the lack of long-term follow-up from the two main studies (MOSAIC and X-ACT), and the uncertainty around the future costs of Oxaliplatin once the patent has expired.

Clearly the research ‘efficacy versus effectiveness’ distinction needs to be considered in relation to both the clinical and cost analysis (i.e. the discrepancy in age of the trial patients as opposed to those in routine clinical practice). There needs to be an acknowledgement that while the MOSAIC and X-ACT studies provide a robust measure of how these drugs *might* work in practice, true clinical and cost effectiveness will only become apparent if or when these drugs are made freely available in the adjuvant treatment of colorectal cancer.