The Institute of Cancer Research

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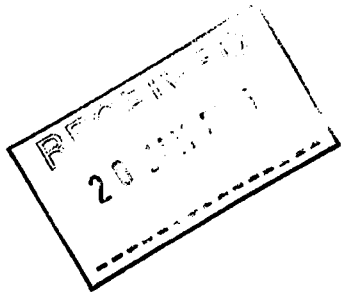


DPD/dpk

11 January 2006

Dr Carole Longson
Direction, Centre for Health Technology Evaluation
NICE
MidCity Place
71 High Holborn
London WC1V 6NA

Dear Dr Longson,

Thank you for asking The Institute of Cancer Research to comment on the Appraisal Consultation Document for the use of "Docetaxel for the treatment of hormone refractory prostate cancer".

Professor David Dearnaley MA MD FRCP FRCR
[redacted]

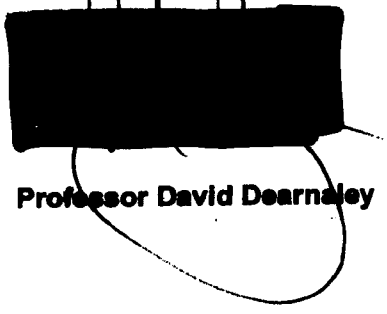
We consider that all relevant evidence has been taken into account in the production of this comprehensive and thorough report.

The summaries of clinical and cost effectiveness, as mentioned in the report, are limited by a lack of ability to include the results of the quality of life analysis using the FACT-P instrument in these estimates. It may well be that benefits in quality of life are, in fact, underestimated and the cost effectiveness analyses therefore overestimate the cost per QALY. It should also be noted that the comparison is made with chemotherapy using mitoxantrone and prednisolone rather than prednisolone alone. Although mitoxantrone is widely used within the UK, it does not have a product licence for hormone refractory prostate cancer. Mitoxantrone is certainly not routinely offered to all men in the UK with hormone refractory disease and a Karnofsky performance status of 60% or more. The report notes that mitoxantrone and prednisolone are more cost effective than prednisolone alone. A secondary conclusion from the report could therefore be that, even without the new studies with docetaxel, that mitoxantrone should have been made more widely available to UK patients. The change in service provision needed to give chemotherapy with either docetaxel or mitoxantrone are fairly similar. In our opinion, such facilities should be more widely available to men with hormone refractory prostate cancer. The consultation

document would support our views that mitoxantrone should have been more widely available. The realisation that chemotherapy is a valuable management option for men with hormone refractory disease will require the reconfiguration of service provision in that many men with hormone refractory disease have not have had adequate access to oncology rather than urology services in the past and Cancer Networks will need to design suitable patient pathways to ensure that chemotherapy provision can be made.

We consider that the provisional recommendations are sound and a good basis for preparation of guidance to the NHS. We would also recommend, however, that due emphasis is given, in the future, to developing further studies to assess both the optimal timing and duration of treatment and the most appropriate management for men who have recurred after docetaxel treatment either because of primary lack of response to the drug or who relapse after initial response.

With kindest regards,
Yours sincerely,



Professor David Dearnaley

Dr Christopher Parker

Dr Johann de Bono