

Alitretinoin for the treatment of chronic eczema of the hand, refractory to steroids

Comments on the ACD submitted by [REDACTED], [REDACTED], Royal College Physicians

Comments are made under the following general headings

- ii) Do you consider that the summaries of clinical and cost effectiveness are reasonable interpretations of the evidence, and that the preliminary views on the resource impact and implications for the NHS are appropriate?
- iii) Do you consider that the provisional recommendations of the Appraisal Committee are sound and constitute a suitable basis for the preparation of guidance to the NHS?

Alitretinoin is recommended, within its licensed indication, as a treatment option for adults with severe chronic hand eczema that has not responded to potent topical corticosteroids if:

- **the person has severe disease, as defined by the physicians global assessment (PGA) and a dermatology life quality index (DLQI) score of 15 or more, *and***

It is appropriate to use alitretinoin in patients with Chronic Hand Eczema (CHE) with severe disability. However given the restrictions below it will only be prescribed in secondary care by dermatologists. Given the current barriers to patients being referred to secondary care then, by definition, only patients with severe disability will be considered. Taking this into account the DLQI score of 15 is arguably a little high. It also appears that this has been arbitrarily selected. Might the committee need to show how this particular figure was arrived at? Existing NICE guidance for the use of anti TNFs in psoriasis is a DLQI of 10. Using this figure would demonstrate a consistent approach by NICE to the impact of differing dermatological diseases and might be perceived as “fairer” by external observers such as our patient groups.

- **the disease has not responded to a second-line treatment such as ciclosporin, azathioprine or PUVA (psoralen and long-wave ultraviolet radiation), or the person is intolerant of or has a contraindication to these treatments.**

Most units will try patients with CHE on a trial of PUVA therapy: there is at least some evidence in favour of it's efficacy.

If the NICE guidelines are to be evidence based then we would question both the committee's positioning of and recommendation of ciclosporin and azathioprine for CHE. While these treatments are indeed used in CHE (mainly because of the lack of useful alternative), efficacy is low and the evidence base is poor. In the hierarchy of evidence, should evidence-based guidance not place alitretinoin treatment after topical steroid therapy (as per the results of randomised controlled studies) and before PUVA (uncontrolled or poor quality trials) and then ciclosporine/azathioprine (expert opinion only and unlicensed for CHE).

In the long term interests of patients' health it should also be pointed out that the recommendation as it stands is that long term systemic immunosuppressive treatment takes precedence over anti epidermal proliferation/differentiation treatment. In other words there is more potential for significant harm to patients through infection and neoplasia with cyclosporine/azathioprine therapy than there is with alitretinoin.

1.2 Alitretinoin treatment should be stopped:

- **if the eczema does not show an adequate response (defined as hands clear or almost clear) within 12 weeks or**
- **as soon as an adequate response (hands clear or almost clear) has been achieved.**

Should there be a comment on restarting Alitretinoin? Or is the implication that a second course can be introduced once the clinical picture deteriorates to the NICE thresholds above

Again with the DLQI should re-treatment not be introduced at a lower threshold rather than allowing patients to deteriorate to pre treatment levels before further therapy?

We appreciate that this might be outside the remit of the existing studies and guidance.

1.3 Only dermatologists with specialist experience in managing severe hand eczema should start and monitor treatment with alitretinoin.

1.4 When using the DLQI, healthcare professionals should take into account any disabilities (such as physical impairments) or linguistic or other communication difficulties that the person may have. In such cases, healthcare professionals should ensure that their use of the DLQI continues to be a sufficiently accurate measure.