Dear Christopher,

Please pass on the following comments to the Chairman and Committee,

Dear Sirs,

I read with disappointment the decision to delay the final decision of the NICE committee on the new kidney cancer drugs. I would like to make the following comments,

(1) If NICE is considering new data then the patient & clinical experts should be invited back for the final meeting in January 2009.

(2) Within the new ACD I have the following comments,
- Who or what is the DSU (Decision Support Unit), and what is their relationship to NICE?
- On page 50 (Document 5) the Committee states that it feels that it is not plausible that the "overall survival of people who only received sunitinib was now higher than those people who received sunitinib as well as further treatments". However, as a clinician this is perfectly plausible because the trial has effectively selected for the group of patients who responded well to sunitinib, whereas the group requiring second line therapies might be expected to have more aggressive disease and a less good prognosis. This is a critical issue because it led the Committee to reject using the sunitinib data from the "no post study treatment group" and instead use the data from the full ITT population.

(3) The recently published paper by Professor Mike Richards, "Improving Access to Medicines for NHS Patients" is highly pertinent and I would like clarification from the Committee on how it is complying with the following recommendations made in the paper which has been adopted in its entirety by the Minister for Health. I made specific reference to these issues at the time of the original meeting back in July 2008
- Recommendation 1; Timeliness of NICE decisions. By the time of the final decision in January 2009 it will have been nearly two years since the original scoping exercise.
- Recommendation 5; The DoH should work with NICE to "make available drugs used near the end of life which do not currently meet the cost-effectiveness criteria currently applied to all drugs". The proposed new NICE criteria for such drugs, such as less than 7000 cases per year and survival benefit of more than 3 months, could almost have been written for the new kidney cancer drugs!
- Recommendation 6; "The DoH should urgently undertake further work to investigate the extent and causes of international variations in drug usage" The submissions have already included ample evidence that these drugs have been widely adopted across all the First World Countries which the UK claims to belong to. If one needs further evidence of the global standing of the UK in terms of how it treats its kidney cancer patients then consider this; the most recent international drug trial for kidney cancer offered to me is one using interferon and the only other countries being offered this trial include China, India and Mexico.

The recent approval of "top up payments" can and will do nothing to reduce health inequalities within the NHS, and it is clear that NICE has a critical role in promoting equality through the elimination of the "post code lottery". I would urge the Chairman and Committee to take the initiative with these new recommendations and to approve the kidney cancer drugs as soon as possible. If there is anything which I might be able to help the Committee with to expedite the approval of these new drugs then I am at your disposal.

Sincerely,

David Chao