# Patient/carer organisation statement template

Thank you for agreeing to give us your views on the technology and the way it should be used in the NHS.

Patients and patient advocates can provide a unique perspective on the technology, which is not typically available from the published literature.

To help you give your views, we have provided a template. The questions are there as prompts to guide you. You do not have to answer every question. Please do not exceed the 8-page limit.

**About you**

**Your name: Judith Robinson**

**Name of your organisation:**

Sarcoma UK. GIST Support UK (GSUK) is a sub-group of Sarcoma UK focussing on the information, support and advice needs of patients with GIST. GSUK holds a database of some 200 GIST patients, plus their carers and families.

**Are you (tick all that apply):**

- ✓ a patient with the condition for which NICE is considering this technology?
- \- a carer of a patient with the condition for which NICE is considering this technology?
- \- an employee of a patient organisation that represents patients with the condition for which NICE is considering the technology? If so, give your position in the organisation where appropriate (e.g. policy officer, trustee, member, etc)
- ✓ other? (please specify)

I am a patient who has had a high-grade large GIST resected 7 years ago and who has not had to face metastasis or recurrence.

I am chair of GIST Support UK and a Trustee of The Sarcoma Trust. I was also one of the patients who worked on the NICE Improving Outcomes Guidance for People with sarcoma

**What do patients and/or carers consider to be the advantages and disadvantages of the technology for the condition?**

1. **Advantages**

(a) Please list the specific aspect(s) of the condition that you expect the technology to help with. For each aspect you list please describe, if possible, what difference you expect the technology to make.

*GIST patients for whom sunitinib is an appropriate treatment are in one of a small number of sub-groups of the main GIST patient cohort. This main cohort are treated with imatinib at 400mg/d for unresectable or metastatic GIST and can achieve long periods of stable disease or complete remission. Sunitinib becomes an option because:*

- *Disease progresses (failure of imatinib at 400mg/d or at 800mg/d)*
- *Mutation analysis reveals rare KIT mutation (or no mutation) known to be resistant to imatinib*
- *Clinical assessment indicates influence of other mutations (eg PDGFR)*

*The broad inhibitor activity of sunitinib has been shown to be effective in restoring control of tumours in these situations, although as patient numbers are so small the data from research are sparse and largely confined to small case series.*

(b) Please list any short-term and/or long-term benefits that patients expect to gain from using the technology. These might include the effect of the technology on:

- the course and/or outcome of the condition
- physical symptoms
- pain
- level of disability
- mental health
- quality of life (lifestyle, work, social functioning etc.)
- other quality of life issues not listed above
- other people (for example family, friends, employers)
- other issues not listed above.

*Patients for whom sunitinib is appropriate are likely to be suffering symptoms of tumour growth which can include pain, abdominal distension, fatigue, and symptoms associated with liver disorder. Response to treatment can alleviate many of these symptoms within days and where there is significant tumour response, symptoms may disappear completely. This is a treatment for advanced disease so tumour clearance is unlikely.*

*Most patients taking sunitinib are among the younger and fitter members of the advanced GIST cohort and although side effects may inhibit quality of life most patients taking sunitinib continue to have a full social life.*

*Extended response to sunitinib is known – we have one patient who has been taking it for 40 months, time during which his liver has re-generated following successive surgeries, and another patient who is approaching 20 months.*

**What do patients and/or carers consider to be the advantages and disadvantages of the technology for the condition? (continued)**

2. **Disadvantages**
Please list any problems with or concerns you have about the technology.

*The main disadvantages of sunitinib are the side effects. While not usually life-threatening they are common and can be difficult to tolerate. Side effects are the principle cause of dose reduction from the standard dose of 50mg/d to 37.5mg/d or even 25mg/d (with, it must be said, consequent financial savings).*

*Side effects include rash, hand-foot-syndrome, discolouration (affecting skin, hair etc), fatigue, nausea and diarrhoea, oedema, blood pressure, and joint pain. The range of side-effects each patient suffers vary. Patients will usually be able to handle the side-effects if they can cope with the first two six-week cycles of treatment and see a tumour response, even with a dose reduction, but a noticeable number find them hard to tolerate and withdrawal from treatment is not uncommon.*

*Our own review of patient members receiving sunitinib suggests that younger and fitter patients tolerate this treatment better.*

3. Are there differences in opinion between patients about the usefulness or otherwise of this technology? If so, please describe them.

*No patient with advanced cancer denies the potential usefulness of a treatment. The wish for extended life means that any treatment which offers the chance of life will be considered. We know of no cases, in UK or elsewhere, where a patient offered sunitinib for advanced GIST has refused this treatment.*

4. Are there any groups of patients who might benefit **more** from the technology than others? Are there any groups of patients who might benefit **less** from the technology than others?

*Reporting the KIT mutations present in a resected GIST is not yet standard practice in many treatment centres despite the fact that the mutation information has proven prognostic value and can influence treatment decisions.*

*The principle mutations are at exon 11, exon 9 and wild-type (no KIT mutation). It is known that exon 11 mutations will respond well to imatinib. Exon 9 mutations are less responsive at standard dose imatinib, and wild-type will fail imatinib fairly quickly. Sunitinib provides a second-line therapy for such failure, with good response seen in wild-type GIST in particular. Wild-type is more common in younger people (it is the usual form of paediatric GIST) most of whom are female.*

*Many patients failing imatinib have secondary mutations at other KIT exon locations which, if they can be analysed (this requires tissue), can indicate a possible response to sunitinib. These other locations are occasionally and very rarely seen as primary mutations (exon 13 and exon 17). It is known that these patients will not respond to imatinib and it is an inappropriate treatment, whereas they will respond to sunitinib.*

**Comparing the technology with alternative available treatments or technologies**

NICE is interested in your views on how the technology compares with with existing treatments for this condition in the UK.

(i) Please list any current standard practice (alternatives if any) used in the UK.

*Many patients failing imatinib at 400mg/d will respond to an escalated dose (600mg/d or 800mg/d) for a period. Thus it may be a short/medium term alternative to sunitinib and is usually a precursor. The combination of escalated dose imatinib followed by sunitinib is standard practice almost everywhere else in the world for GIST refractory to imatinib at 400mg/d.*

*In the UK so-called 'standard practice' is best supportive care (itself a misnomer). It is the treatment currently indicated by NICE TA86 for patients failing first-line imatinib. It will be the probable treatment for patients with a poor performance status, although some patients will have surgery, some will gain high dose imatinib or sunitinib through PCT exceptional circumstances provisions, and some will enter clinical trials of new agents.*

(ii) If you think that the new technology has any **advantages** for patients over other current standard practice, please describe them.

*The advantage which sunitinib offers is hope and life. While not clinically suitable for every patient, not every patient taking it responds, and not every patient can tolerate the treatment, to be offered a therapy with a known effectiveness for patients in your personal situation, has great impact and is of undeniable importance to patients and their families.*

*Our experience running a patient support group which has had a total of over 250 GIST patients (including those now deceased) suggests that around 35-40% of patients proving refractory to imatinib in first-line are suitable for sunitinib. Others will respond well to higher dose imatinib, have further surgery (few), move onto experimental therapies, or enter a palliative care pathway.*

*For these few the availability of sunitinib is of paramount importance. Even those who take it and do not respond or who have to withdraw due to intolerance state that it is a treatment option they do not regret taking.*

(iii) If you think that the new technology has any **disadvantages** for patients compared with current standard practice, please describe them.

*There are no disadvantages for patients, with one proviso. Clinical diligence with regard to side effects and the suitability of the treatment for the individual patient, given the known side-effects, is a necessary precaution. This is not a drug which should be prescribed by GIST-naive oncologists outside a specialist treatment centre.*

**Research evidence on patient or carer views of the technology**

If you are familiar with the evidence base for the technology, please comment on whether patients' experience of using the technology as part of their routine NHS care reflects that observed under clinical trial conditions.

*There has only been one significant clinical trial for this treatment. This was a double blind randomised study which was terminated at the interim review because of exceptional response in the active treatment arm. All patients on placebo were crossed-over to active treatment. Data from this study led to the award of the marketing authorisation in most parts of the world.*

*Our impression is that median response intervals seen in the study are borne out in practice when the patient cohort is viewed as a whole. However there are important outlying exceptions, one patient responding well and living a full and active life after 40 months on treatment, and younger patients with wild-type GIST.*

Are there any adverse effects that were not apparent in the clinical trials but have come to light since, during routine NHS care?

*No.*

Are you aware of any research carried out on patient or carer views of the condition or existing treatments that is relevant to an appraisal of this technology? If yes, please provide references to the relevant studies.

*No. This is a very rare condition (ultra-orphan) and research opportunities of this kind are limited.*

**Availability of this technology to patients in the NHS**

What key differences, if any, would it make to patients and/or carers if this technology was made available on the NHS?

*The 100-120 patients a year for whom this treatment is likely to be appropriate will have the benefit of knowing they have a further chance for longevity. The seriousness and the distress caused by this condition cannot be understated.*

*It should be noted that in making it available the standard dose of 50mg/d (4wkly with 2 wks off treatment) is rarely followed by patients for very long. Most reduce dose to 37.5mg/d (continuous) or even further to 25mg/d (continuous) – with a few alternating between dose levels.*

What implications would it have for patients and/or carers if the technology was **not** made available to patients on the NHS?

*The choice is between treatment and a rapid decline to death. If this treatment is not made available there will be more patients seeking to enter early phase trials, more patients appealing to PCTs under exceptional circumstances (as they do currently) and there will be an increase in those seeking to top-up. The fact that this treatment is seen as standard of care in most countries of the world is not invisible to UK patients.*

Are there groups of patients that have difficulties using the technology?

*Only as stated above.*

**Other Issues**

Please include here any other issues you would like the Appraisal Committee to consider when appraising this technology.

*At the heart of this appraisal lies the question of decision-making about the appropriate treatment for each individual patient, not looking at the 'average' situation. We highlight the following.*

*Mutation Analysis*

*Research on GIST during 2000-2002 demonstrated that imatinib is an effective first-line treatment but continuing research since has complemented that with much more knowledge that must be considered during this appraisal.*
*We now understand:*
*- The value of primary mutation analysis as a prognostic indicator*
*- The nature of secondary mutations*
*- The response of different primary and secondary mutations to different treatments*

*We believe that the NICE Appraisal Committee should make mutation analysis a requirement at diagnosis so that the knowledge can be used to provide patient benefit and specifically to help define the patients for whom sunitinib would be most beneficial.*

*Size of Patient Cohort*

*All this will help us to understand the tiny patient group for which sunitinib is an appropriate treatment, while the growing knowledge of sunitinib in clinical practice will continually refine that group.*

*We also feel that the wild-type GIST sub-group (approximately 4% of all patients) and the patients with very rare primary mutations (about 1%) which are known to respond to sunitinib need special consideration. For these patients it is the appropriate treatment.*

*Cost of Treatment*

*The fact that reduced dose treatment among patients taking sunitinib for GIST is significant is a further factor which must also be considered. The NHS cost per full dose is not applicable in the economic analysis for this condition.*

*Expert Centres*

*We have an ongoing concern that GIST patients are not all treated at specialist sarcoma centres, or at centres which consult with sarcoma specialists. This is most important for a patient who has relapsed on first-line imatinib and when sunitinib*

*might be considered. We know that inexperienced oncologists treating only one or two GIST patients a year may even be unaware that mutation analysis offers valuable prognostic information.*

*The DH Cancer Action Team is now seeking to implement the NICE Improving Outcomes Guidance for People with Sarcoma but we have strong anecdotal evidence from both patients and clinicians that the Guidance is sometimes being ignored, that some networks are resisting the advice, and that some patients are receiving inappropriate information and treatment. While we recognize that the IOG implementation is not yet finally in place we believe that this appraisal gives the Institute the opportunity to reinforce in no uncertain terms the guidance given in the IOG and in TA86 (Imatinib for unresectable/metastatic GIST) about the importance of patients seeing a specialist who frequently sees patients with this disease.*

*The Seriousness of the Condition*

*We draw the attention of the Appraisal Committee to the deliberations of the NICE Citizens' Council about considering the seriousness of the condition when making their recommendations. Advanced GIST is not only a life-threatening condition, it is a distressing one for patients and their families.*