National Institute for Health and Clinical Excellence

Health Technology Appraisal

Adalimumab, Etanercept, Infliximab, Rituximab and Abatacept for the treatment of rheumatoid arthritis after the failure of a TNF inhibitor (part review of TA36, review of TA126 and 141)

The British Health Professionals in Rheumatology (BHPR) are a group of health professionals currently in practice caring for people with inflammatory arthritis. BHPR members work in a variety of hospital and community settings and promote patient and allied health professional interests on a wide range of issues by working closely with the Department of Health and other national and European professional bodies and voluntary organisations.

1. **Whether we consider that all the relevant evidence has been taken into account**

There are some challenges when considering the evidence for this appraisal and this is apparent as the social and care costs are not included in the evidence.

2. **whether we consider that the summaries of the clinical effectiveness and cost effectiveness are reasonable interpretations of the evidence**

There appear to be some inconsistency regarding interpretation of QALY's - abatacept now appears to have the same QALY as etanercept yet etanercept is recommended and abatacept is not – we would appreciate clarification on this point.

There are now NICE guidelines for the management of RA and we wondered whether these had been taken into account during the BRAM analysis

It is becoming more apparent that RA will become divided into different subtypes and depending on the heterogeneity of the patient we will be able to use the best drug for those patients most likely to derive benefit. However, as the NHS is restricting the use of biologic therapies the rheumatology world will be unable to pursue this line of treatment in the future as UK patients won't have been exposed to the same therapies as the rest of Europe. This is likely to decrease innovation and investment in UK based clinical research and reduces the amount and quality of UK based cost effectiveness data.

Has the committee taken into account the length of time between rituximab infusions - the consesus of opion suggests that these should be given 6 monthly.

3. **Are the provisional recommendations sound and a suitable basis for guidance to the NHS?**

Has the effectiveness of DMARDs been addressed for those patients that fail one TNF and don't go onto rituximab (sero negative) or fail rituximab due to adverse event.

4. **Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of gender, race, disability, age, sexual orientation, religion or belief?**

This guidance does not recognise patients as individuals but reflects a class effect of the drugs. Patients who have a sero negative arthritis are unlikely to respond to rituximab and therefore have no where else to go in their patient pathway. Would this be classed as discrimination for these patients?