Royal College of Nursing

National Institute for Health and Clinical Excellence

Adalimumab, etanercept, infliximab, rituximab and abatacept for the treatment of rheumatoid arthritis after the failure of a TNF inhibitor

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Assessment Report – RCN Response

The Royal College of Nursing was invited to give initial comments on the technical contents of the Assessment Report of the health technology appraisal of Adalimumab, etanercept, infliximab, rituximab and abatacept for the treatment of rheumatoid arthritis after the failure of a TNF inhibitor. The RCN welcomes the opportunity to review this document. Members of the RCN Rheumatology Nursing Forum reviewed this document on behalf of the College.

The report is very comprehensive and appears to have covered a wide range of analysis to review the clinical effectiveness of these therapies.

We do not have the expertise to fully comment on the data regarding the economic analysis, particularly as the studies report on the different models used to determine cost effectiveness. We, agree that some assessment of quality of life is important but are unsure that the conversion of HAQ scores to EQ-5D scores or HU13 scores as stated in pages 195 and 204 of the report are adequate in this respect, we still feel that there are challenges in representing the real impact on health related quality of life factors despite the use of the EQ-5D. We also agree with the BSR comments on the HAQ being a poor indicator of disease improvement in patients with more established disease.

With regards to Rituximab, it is our view that this may have to be looked at again especially as current practice is changing to re infusion at 6 months (we note that the 6 month data is presented on page 200) more routinely now, rather than waiting till flare or retreating at 9 - 12 months, which puts the cost per QALY up to £27.161, almost the same as anti TNF.

Finally, we recognise there is insufficient data to enable the model to adequately explore the wider context of costs that we as nurses are so well aware of, in the sense of reduction in costs. Although it is difficult to reflect in current modelling, there appears to be recognition in the discussions but there is no qualification of the limitations of the data when making consideration on cost effectiveness. We would like the model to look at this from the patient experience and from what nurses see in sense of changes in outcomes such as, reduction in bed days, patients being able to maintain /able to work, quality of life and also results of poor coding. Poor coding fails to account in these economic models for patients admitted via other routes for example respiratory, cardiac and other conditions that are not necessarily attributed to the underlying pathology of RA, particularly as stated in the report, that heart disease is the principle reason for approximately 60% increased mortality rate in RA. We consider that this point should also be emphasised in the background information of the clinical features of RA, particularly as the prevention and treatment of CHD is high on the agenda when treating patients. We also consider that orthopaedic surgery including, joint replacement for both large and small joints need to be taken into consideration. These all adds to the cost of the treatment of individuals with RA. With appropriate treatment, treatment and rehabilitation of RA patients is reduced and really complex disabled patients are seen less often and less hospital days in-patient bed are required.