

Arthritis Care

Response to: *Rheumatoid arthritis – drugs for treatment after failure of a TNF inhibitor: appraisal consultation document*

March 2010

Arthritis and Arthritis Care

1. Arthritis is the biggest cause of physical disability in the UK, affecting up to 10 million people, including 12,000 children, and accounting for 30% of GP visits. It carries a huge economic as well as human and social cost, estimated at £7 billion annually in terms of lost labour in 2007.
2. Arthritis Care is the UK's leading organisation working with and for people with all forms of arthritis. We offer people with arthritis the information and support they need to make informed choices about managing their arthritis, to reach their potential in society and to fully participate in their communities.
3. We believe that people with arthritis are entitled to receive the best available treatment and medication, and to have their voice heard in decisions affecting their health – as enshrined in the NHS Constitution.

Rheumatoid arthritis

4. Rheumatoid arthritis (RA) is a lifelong, progressive, musculoskeletal condition that causes severe pain, swelling and inflammation of the joints, and can lead to reduced joint function and disability. Approximately 10% of people with RA have the condition in a particularly severe form, manifesting itself as relentless pain and swelling, often in multiple joints. This causes severe disability and loss of function, meaning that simple daily tasks, including self-care, can become impossible without assistance.
5. Severe RA is extremely serious. 30% of people with untreated severe RA will die within 5 years, a figure comparable with triple vessel Coronary Heart Disease or stage III Hodgkin's Disease¹. While someone with RA can expect to live 5 years less than someone without it on average, much of this is accounted for by the massively reduced life expectancy of the population with severe RA.
6. A recent report by the National Audit Office (NAO) on services for people with RA² revealed that the number of people with RA is much higher than previously thought, estimated at 580,000 people in England

¹ New England Journal of Medicine (Review): 1999; 340; No. 24

² http://www.nao.org.uk/publications/0809/rheumatoid_arthritis.aspx

alone, with 26,000 new cases diagnosed each year. It also found that RA has annual healthcare costs of £560 million to the NHS, with costs to the economy of £1.8 billion in sick leave and work-related disability.

7. The NAO report clearly emphasised the importance of aggressively treating RA within three months from the onset of symptoms, as this can stop the development of the condition in its tracks and lead to remission. After the first three months, the impact of any treatment or medication is vastly reduced.
8. The report also found an enormous variation in spending across PCTs in England, amounting to a postcode lottery. Those that do receive treatment for RA often do not receive sufficiently high-quality treatment.
9. The Public Accounts Committee released a report in February this year reaffirming the findings and endorsing the recommendations of the NAO report.
10. What these findings demonstrate is that very large numbers of people are living in often severe and debilitating pain because they are not getting the services and the treatment they need. Central to this is prompt access to the best available medication, including anti-TNFs.
11. NICE's position regarding the availability of anti-TNF medication and the ability of clinicians to prescribe more than one particular anti-TNF for sequential treatment, based on the patient's responsiveness to it, should therefore be viewed with this context, and these findings, firmly in mind.

General observations on the preliminary findings

12. Arthritis Care is extremely disappointed with the preliminary findings of this consultation, which do not reflect the majority of medical opinion on anti-TNF treatment for RA and which do not seem to take any account of either the real experience or indeed the wishes of people with RA, whom these treatments are intended to serve.
13. The preliminary findings appear to entirely ignore the patient dimension of RA, and sit decidedly at odds with the growing consensus on the importance of a more patient-centred health service, patient involvement in decisions affecting their health and patient choice – all of which are enshrined in numerous and varied high-profile documents, from the NHS Constitution to *High Quality Care for All* to the World Class Commissioning Framework.
14. NICE's own guideline on the management of RA in adults, issued in February 2009, emphasises the importance of person-centred care: "*Treatment and care should take into account peoples' needs and preferences. People with RA should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.*" (p.6)

15. The preliminary findings, however, appear to negate this, as they unduly restrict the options available to both clinicians and people with RA, and therefore the real choice available to people with RA with respect to their health needs.
16. Far from helping to provide a more efficient or better quality service to the over half a million people with RA in England, these findings, if implemented, will impact severely on the health and quality of life of many thousands of people, and the overall effect will be entirely counterproductive in terms of the long-term or indeed short-term gains, economic or otherwise.
17. There is abundant evidence, including a very large number of firsthand testimonies from clinicians and people with RA, who are best placed to know how any specific treatment is or is not helping them, which demonstrates that different anti-TNFs work differently for different people, and it is only by being able to try different treatments that many people are able to find the one that actually works for them. This for them is not a whim; it is a need.
18. Additionally, there is no clinical, anecdotal or practical evidence to support the decision to allow the use of rituximab in combination with methotrexate but not anti-TNFs for sequential use. Each anti-TNF is different and will work for some people but not others. For many, rituximab simply does not work.
19. Lord Darzi made it clear that quality is the unifying principle behind the NHS. Surely, therefore, any decision on the availability and sequential use of anti-TNFs must be taken with the best interests of the population at heart, and should only consider cost issues in this light, i.e. where they do not impact negatively on the overall quality of service for the people the NHS is there to serve.
20. Arthritis Care therefore urges NICE to review its preliminary findings, taking account of the clinical evidence which exists on the real use and impact of anti-TNF treatment, and which clearly demonstrates the importance of a wide range of options for sequential anti-TNF treatment. We also urge NICE to consider this evidence in light of the fundamental importance of person-centred care and of ensuring the best possible outcomes for people with RA, based on their needs and their wishes.

Background to the current consultation

21. The current NICE consultation on anti-TNF treatments is the latest in a long line of deliberations on the issue of anti-TNFs. Most recently, NICE announced its intention to restrict the sequential use of anti-TNFs 2008, in much the same way as at present.

22. At the time, the Arthritis and Musculoskeletal Alliance (ARMA), also speaking on behalf of Arthritis Care, described NICE's proposal as a "prescription for pain," on the grounds that it withdrew available treatment options and condemned many people with RA to a life of debilitating pain.
23. ARMA also made a detailed submission to Dr. Carole Longson, Director of the Centre for Health Technology Evaluation, regarding NICE's proposals, the substance of which is still equally valid in relation to the current preliminary findings. We are attaching a copy of this submission, for your reference and information.

The importance of sequential use of anti-TNFs

24. Between 20,000 and 40,000 people in England and Wales are taking an anti-TNF at any one time, and 50% have needed to switch treatments at least once.
25. In order for people with RA to receive the treatment that actually works for them, and clinicians need access to the widest possible range of treatments in order to provide the best possible care for patients. The British Society for Rheumatology Biologics Register shows that 70% of patients who switch anti-TNFs derive a benefit from the second one, and this has been established good practice in the UK for some years. These therapies are already available for clinicians to use sequentially across Europe, and it is perverse that they should not be available in the UK.
26. Clinicians themselves stress the importance of being able to try different anti-TNF treatments for individual patients. Professor Rob Moots, a clinician and Professor of Rheumatology at the University of Liverpool, for example, has said that "it's almost impossible to know which anti-TNF will work for a patient at the outset." He has described NICE proposals to restrict the options for anti-TNF treatment available to clinicians, as "flying in the face of clinical judgement", stating that "many patients will be left in astonishing pain", while clinicians will be left knowing that they haven't explored all the options for them.
27. The importance of this is illustrated very clearly and very powerfully by the firsthand testimonies of people with RA themselves, many of whom have had to try a number of different anti-TNFs before they could find one that worked for them, and many of whom have yet to find the one that does because they have been unable to try more treatments so far. In some cases, certain anti-TNFs have worked initially but then ceased to work, and in other cases certain anti-TNFs which did not work originally seemed to work better only after the person had gone on to try another. In almost all cases, however, the difference which finding the right anti-TNF treatment has made to that person's life has been transformational. Very often, this has made the difference between having a good-quality life and being able to live independently

and remain in or return to work, and living in chronic, debilitating pain and being reliant on others and the health sector for basic needs.

28. Arthritis Care has collated a number of personal testimonies from people with RA in the attached Appendix. We urge NICE to read these testimonies to gain an accurate picture of the real experiences – and the real needs - of people with RA, and what this means for the regulation of anti-TNF treatment.
29. The fact that the side effects of anti-TNF treatment can also be quite significant is another reason why people with RA should be allowed to try more than one – this is in fact the basis on which many PCTs operate.
30. The decision to allow rituximab but not anti-TNFs for sequential use is not based on good evidence and appears to have been made without due consideration of the context and effect on patient pathways. Given the current lack of clarity around patient access to a second anti-TNF therapy, this decision is flawed.
31. Under the preliminar findings, the only way patients would be able to try more than one anti-TNF would be by entering into a clinical trial, which clearly would be available only to a tiny fraction of people with RA. This would also lead to people choosing to enter into clinical trials for the wrong reasons.

Cost-effectiveness

32. The figures mentioned above demonstrate that any cost saving achieved by a restrictive - and short-sighted - approach to the sequential use of anti-TNFs will be very quickly and very clearly outweighed by the numerous negative implications which this decision would have, not only for people with RA but for the NHS and the UK economy.
33. People denied clinically effective anti-TNF treatments will not cease requiring treatment or accessing NHS services. On the contrary, if denied a treatment which could slow the progress of the disease, many people will inevitably rely much more heavily on NHS resources, including, for example, cases where lack of appropriate treatment leads people with RA to require expensive – and preventable – joint surgery, and greater use of palliative care.
34. It is important to take a broad view of the costs involved, beyond the financial costs to secondary care. The NAO has clearly highlighted that non-biological treatment of RA carries significant costs to primary and secondary care, in addition to the person with RA. On the other hand, recent evidence compiled by the NAO shows that biological treatment of RA saves money, e.g. in terms of reduced emergency admissions and less reliance on the health sector generally.

35. The NAO has also developed an economic model in connection to its aforementioned report on services for people with RA. This model states that the analyses conducted “have provided clear evidence that better value for money could be achieved by providing more rapid treatment for people with early onset rheumatoid arthritis,” improving patients’ quality of life and delivering productivity gains for the economy.
36. The document goes on to say that “although it could increase the cost to the NHS in the short-term, it would be cost effective, and could be cost saving in the longer-term”. Finally, it states that “the analyses also confirm the NICE conclusion that intensive early treatment with step-down strategy is more cost effective than current routine practice in terms of sequential DMARD treatment (which is dominated by mono switch treatment strategy), and suggest that potential cost savings to the NHS could be realised in the medium to long-term.”

Conclusion

37. Arthritis Care feels strongly that the preliminary findings do not reflect the existing medical evidence, expert clinical opinion and patient views, and are not at all in the best interests of people with RA.
38. Where a clinically effective treatment is available, it is unacceptable – and medically pointless - to deny people with RA this option, forcing them to return to treatments which they and their health professionals know to be ineffective.
39. Crucially, being able to access the best treatments – and find the anti-TNF treatment which works for each individual person with RA – helps to keep people independent, allows them to remain in or return to work, and ultimately saves the NHS and the UK economy vast sums of money.
40. The outcome of this long and difficult appraisal process must not be another “prescription for pain”. This would be perverse, counterproductive and self-defeating. On the contrary, it must be an outcome which has the best interests of people with RA at heart.
41. We therefore urge NICE to review its preliminary findings in light of the information in this document, taking much greater account of not only the existing clinical evidence for the need for a wide availability of anti-TNF treatment, but also of patient experience and patient choice as a fundamental and essential driver of decisions regarding people’s health.
42. Key to the above is to base any decision on anti-TNF treatment on a genuine, open and honest discussion with a wide range of key stakeholders, including clinicians, people with RA and user-led organisations.

**APPENDIX:
Testimonies of anti-TNF use from people with RA**

I have Rheumatoid Idiopathic Arthritis and have had since the tender age of 3. Due to all the medications over the years for my arthritis, I now also have osteoporosis in my back which means no fun rides on rollercoasters or the dodgems with my friends. The high doses of steroids used to treat my arthritis over the years have also caused me to have stunted growth.

Among my long list of medicines is the wonder drug anti-TNFs and they have transformed my life. I started receiving these drugs at the age of 10, before that I lived in constant pain with a wheelchair as my only real aid to mobility. Needless to say, my life has changed drastically. Although I do have the odd flare-up every now and then, I am delighted to have regained a proper quality of life – which I never really had before.

I have been on 3 different strains of the drug, as my body seemed to grow accustomed to each one after about a year or so. I've come full circle and am back on the first one I was prescribed and thankfully it seems to be working even better second time around

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- I cannot contemplate how horrific day to day life would be without Humira. When I have to come off my anti TNF for infections etc my flares are awful. It is much more cost effective to give people this treatment than it is to pay for costly surgeries and benefits. I am a British citizen currently living in the Republic of Ireland. I have been here for ten years, would like to move back but sadly cannot as I am so concerned about these developments. My treatment is funded here and I have been assured that if this second anti TNF fails, I will be provided with another medication to try. This at least gives me hope. NICE are condemning people with RA and related conditions to a life of excruciating pain and suffering.
- Anti-TNFs saved me from a horrendous quality of life and being in constant pain in my early 30's. This decision flies in the face of the government's plans to get people off sickness/incapacity benefits and back to work.
- My 11-year-old son had his first Enbrel jab yesterday, as methotrexate not working alone, so we're now trying them together, hopefully this will help, but he's not great with needles & neither am I!!
- This medicine [Humira] has totally changed my life at a time I was ready to give up due to the pain and lack of mobility, 36 years old and unable to go to the toilet by myself and now I can walk, go shopping and smile. I missed me and this medicine has given me my life back.
- I have recently been able to return to work, if I didn't have the anti-TNF I am sure this would be impossible due to pain, immobility and fatigue.

- I have waited 7 years to be put on this treatment [anti-TNF] and was told if it did not work I had more choices. I have tried all other known forms of treatment and none were successful. I would at least like to have the chance to see if there is one out there that will work for me and the only way to do so is by trying them all. If I couldn't, I would be back to square one and really do not know what I would do. I would like my life back and have the possibility of walking again.
- I would not be able to teach or look after my child. My husband would become more of a carer. Would feel very depressed and desperate, which would affect my family and be constantly in a lot of pain.
- This treatment [infliximab] worked so well that it changed my life completely. I could train again, I could get a good night's sleep without having to rely on painkillers to get me through the next day. I even phoned my mum just to tell her I'd had a bath – I had been resigned to showering for years but now I could lower myself into the bath on my own – I would never take anything for granted again. However 3 years ago the treatment stopped working and life got a lot worse again. I couldn't even get out of bed and was in agony for months. After having to come off all medications for a while I was put on Enbrel, unfortunately it didn't work very well for me, as I needed large doses of anti-inflammatories along with it. Luckily there was a third option and my rheumatologist was keen to try it. I am now on my third strain of anti-TNF treatment (humira) which is working really well for me right now.
- The impact would be very serious for me. I would be unable to do very much and be in a lot of pain. In fact the pain and fatigue would be unbearable. I have to take prednisolone with the anti TNF as well as methotrexate, of course. Humira did not work at all but the Etanercept does alongside the other medication.
- I have RA and was first given Humira on its own but the treatment failed. I then tried Humira with methotrexate – this also failed. At the time, I was told I couldn't try another anti-TNF so I came off all drug treatment completely as there was nothing else available for me. Since then, I've not been on any drug treatment. My condition has not improved at all and my joints have been damaged significantly. It was really important for me as a patient to have choice over different drug treatments, especially since previously treatments have failed.
- I'm a 38 yr-old mother of 4 and would be devastated if I was told there were no further treatments to be offered to me. I have been off work for 18 months now as my mobility is impaired as is my personal care and I am in a lot of pain daily and pain killers make me drowsy. I am on my 3rd treatment now and as it hasn't worked I will be looking for another treatment plan next month. I have been on Humira, then etanercept, now abatacept infusions. None so far have worked. I also take

methotrexate alongside these. The other DMARDS had no effect on my disease process.

- If this treatment does not work and I can not try another, basically NICE is condemning me to a life of no hope, pain, suffering and depression as well as my friends and family having to see me like that.
- I started on Enbrel in January 2009 but reacted to it and after re-challenging it I finally stopped it in July 2009. I commenced on Humira in September 2009 and again reacted badly to it and was finally stopped administering it in January 2010. Now waiting to find out what next - have to wait 12 weeks to get to see the consultant to discuss, in the meantime I am in the process of what seems to be my biggest flare ever - been off work since 25th January and not been offered any alternative.
- Humira is my wonder drug. After over 10years of failed DMARDS for PsA I went on a Clinical Trial for Humira and 6 1/2years later I've never looked back. I'm not symptom free but I've got a good quality of life back thanks to it.
- I couldn't imagine living my life like this forever and I am only staying 'positive' as I am sure they will find a treatment that improves my life quality sometime in the near future. With restrictions such as NICE suggest my treatment options would be very limited and I would be extremely depressed and feel my future hopeless.
- I was on infliximab for over 6 years and did well, but then had a "funny turn" during an infusion so was taken off it. Tried Etanercept last year but had a severe reaction so I'm now on Humera - 2 injections so far. I hope it's a miracle cure as I'm currently having the worst flare-up of my life!
- I have Psoriatic arthritis with spondyloarthropathy and enthesitis (inflammation of the insertion of tendons into bone). I was diagnosed in 2005/6. Initially I was prescribed methotrexate with is a DMARD but it wasn't enough and I've since been through all 3 anti-tnf drugs available for PSA, now on Humira which is not really working very well but there are no other options... The enthesitis is troublesome for me - nothing shows on x-rays or blood tests so it can be difficult to get people to understand how much it affects me - I don't even get much visible swelling of joints in the traditional RA style. But I manage to work and have a semblance of a social life - I've learned to pace myself better and take rests lots.