Clinical Specialist Statement Template

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

About you

Your name: Dr Neil Sulke

Name of your organisation: NHS (East Sussex Hospitals Trust)

Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology?✓
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)? ✓
- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc.)?
- other? (please specify)

Appendix D – Clinical specialist statement template

What is the expected place of the technology in current practice?

How is the condition currently treated in the NHS? Is there significant geographical variation in current practice? Are there differences of opinion between professionals as to what current practice should be? What are the current alternatives (if any) to the technology, and what are their respective advantages and disadvantages?

Are there any subgroups of patients with the condition who have a different prognosis from the typical patient? Are there differences in the capacity of different subgroups to benefit from or to be put at risk by the technology?

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional professional input (for example, community care, specialist nursing, other healthcare professionals)?

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

Please tell us about any relevant **clinical guidelines** and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.

The anti-arrhythmic drug Dronedarone has a place in the management of atrial fibrillation, the commonest cardiac arrhythmia. It has been shown in 3 prospective randomised trials (Andromeda, Dionysis and Athena most recently) to both suppress paroxysms of atrial fibrillation, revert persistent atrial fibrillation, and rate control persistent and permanent atrial fibrillation.

This drug is about half as efficacious as Amiodarone and certainly has fewer side effects. However, the drug is not without its side effects which include diarrhoea for a week due to its action on the large bowel as well as other far less common side effects including skin rashes and transient elevation of creatinine.

In my opinion this drug can be used first or second line in the management of paroxysmal, persistent and permanent atrial fibrillation as shown by the above trials.

In my opinion it is safe to start in general practice although this is not the wish of the manufacturers. The only proviso is that the patient must not be in NYHA IV heart failure as the Andromeda study showed that the drug worsened prognosis. My reasons for suggesting that patients with mild to moderate heart failure, paroxysmal or persistent atrial fibrillation should be treated with this drug is that the Athena trial showed that there was decreased mortality and improved prognosis.

There may be a potential for specialist clinics to commence this drug in a primary care setting in my opinion.

The NICE AF guidelines do not significantly discuss Dronedarone but it will certainly have a place in the drug therapy of atrial fibrillation and will be discussed again by the AF guideline development group in due course.

The advantages and disadvantages of the technology

NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?

If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.

If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?

What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?

The advantages of this drug are that it is clinically proven in patients with mild to moderate heart failure in atrial fibrillation with a superior side effect spectrum to Amiodarone a close clinical analogue. Its disadvantages are early diarrhoea which should resolve in most patients, a raised creatinine which requires monitoring. The other disadvantage is that it is approximately half as efficacious as Amiodarone and is comparable to Sotalol, Flecainide and Propafenone in similar patients with atrial fibrillation.

It is my opinion that the clinical trials that have been undertaken with the drug so far do represent clinical practice but the only trial with a direct comparison of Drondedarone and Amiodarone, in my opinion, did not carry enough statistical power nor did it ask the right question and nor was the follow up long enough. The composite end point whilst clinically appropriate was not the most clinically appropriate in my opinion (Dionysis study). As it did not directly compare the anti-arrhythmic efficacious of the two drugs.

It is my opinion that this drug has a satisfactory side effect profile within the provisos set out above and should be useable in a primary care as well as secondary and tertiary care settings.

I do not know of any adverse effects from this drug that have become apparent since completion of the above clinical trials and I do know that further clinical trials with the drug are ongoing and projected.

Any additional sources of evidence

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

There are several ongoing trials with this drug that will provide further evidence but I am not aware of any completed or interim results that effect the technology focus systematic review.

Implementation issues

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that have been recommended by NICE technology appraisal guidance. This provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within 3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

NICE guidance would affect the delivery of care using this drug dependent on whether the drug treatment is started in the primary, secondary or tertiary care setting i.e by GPs, general cardiologist or cardiac arrhythmia specialist only.

I am unaware of the projected cost of this drug but I suspect that it will be the most expensive anti-AF drug available. Its widespread use will have to take this into account.

Staff training will be relevant only as would be required by the use of any new anti-arrhythmic drug, the main requirement being recurrent checking of serum creatinine as described above.