THE HEPATITIS C TRUST

27 CROSBY ROW, LONDON SE1 3YD

Tel: +44 (0)20 7089 6220 Fax: +44 (0)20 7089 6201

Website: www.hepctrust.org.uk

Submission to NICE for Peginterferon alfa and ribavirin for the treatment of chronic hepatitis C (Part-review of TA75 and TA106)

The Hepatitis C Trust, as a patient organisation, is making this submission to represent the views and concerns of patients. It does not address the issues of clinical effectiveness or cost effectiveness, except peripherally but seeks to present the patient perspective as it applies to the three populations this part review is considering:

Adults with chronic hepatitis C who have been previously treated with peginterferon alfa and ribavirin in combination.

We warmly welcome NICE's decision to give guidance on this subject as retreatment has become the single biggest issue for the Trust's advocacy service with PCTs often unwilling to provide funding. Crucially, in the majority of cases patients report that they received sub-optimal treatment the first time. It has now been clearly shown that dose reductions reduce the efficacy of therapy and it is well established that the original recommendations for dose reductions were unduly conservative leading to many patients receiving therapy in the past that was less effective than current regimes. These are typical examples:

- There was a dose reduction or treatment discontinuation for clinical reasons, for example anaemia or low white cell counts, which might have been avoided, if ,say, erythropoietin had been administered or if the consultant had not taken such a conservative view of low neutrophils.
- The patient did not adhere fully to the treatment regime as, from time to time, they felt overwhelmed by the side-effects, a reaction they attribute to being pressured into doing treatment at an inappropriate period of their life and/or to poor information and preparation prior to treatment and/or insufficient support during it, all of which they would be able to rectify if offered retreatment

In our experience at the Trust, through our helpline, email help desk and advocacy service, the majority of those most anxious to be retreated are those with significant and advancing liver damage. For them the many new compounds in development may not be available in time or may not be effective for their genotype (most new compounds are designed primarily to improve the response in genotype 1 patients). Given that the cost per QALY of retreatment is likely to be lower for those with existing significant liver disease, we would like to ask NICE to assess the cost effectiveness separately for this particular group.

However, we would also like to stress that there are many reasons for patients to want to 'cure' hepatitis C, aside from issues of morbidity and mortality and therefore to have the opportunity of retreatment. Reasons for antiviral therapy include:

- Having children. There is a 6% risk of an infected mother passing hepatitis C to her child at birth[i]. This is worse than a 1 in 17 chance and is not acceptable to many mothers who would prefer to eradicate the virus before conception.
- Being infectious. There is a tremendous stress for some in knowing that their blood is infectious (this emerged from a questionnaire we carried out into many aspects of hepatitis C). This is particularly true in the home and around partners and children with the need to be constantly vigilant about blood spillages.
- Sexual transmission. The single most commonly asked question to our helpline on the subject of infectivity is whether hepatitis C is transmissible sexually. This is a major source of anxiety both for those infected and for their partners. Even though we do not believe there is any significant risk for sex between monogamous couples where blood is not involved[ii], some sexual practices, especially amongst MSMs, do appear to carry a significant risk of transmission[iii].
- Discrimination. We have come across people who have lost their jobs as a result of their hepatitis C status becoming known. Extraordinarily, we have come across 2 cases in the last year where people were ejected from a Job Centre because of having hepatitis C. We continue to hear of cases of discriminatory treatment of HCV patients by NHS staff outside of liver centres.
- Stigma. This is still a highly stigmatised disease. This is largely because HCV is linked with intravenous drug use. In an ONS survey for the Royal College of Psychiatrists, drug addiction was found to be the most stigmatised of the 7 mental illnesses they looked at[iv].
- Financial costs. There is a significant financial cost to having hepatitis C and therefore a corresponding gain to having successful treatment. For example, life assurance may be unobtainable or only available with a large weighting. This may make it impossible to obtain a mortgage.

For these reasons the Trust would like to see retreatment made available to anyone who wishes it. The side-effects of treatment are often severe and rarely negligible so patients are unlikely to opt for retreatment unless they feel there is a reasonable chance of success. Deciding on whether there is a reasonable chance of success is best left to the patient and physician who can take into account the patient's individual circumstances.

However, since NICE has to rule on cost-effectiveness we would ask for 3 things:

1. Retreatment to be available to anyone for whom previous courses were sub-optimal.
2. Cost effectiveness to be calculated separately for those with existing moderate to severe liver damage
3. Clear guidelines on when to stop the retreatment if it is not working, both to protect the patient from unnecessary hardship and to lower the overall cost of retreatment.

Adults with chronic hepatitis C who meet the criteria within the marketing authorisation for receiving shortened courses of peginterferon alfa and ribavirin in combination (for example, patients with specific genotypes)

Given that:

1. Shorter courses of treatment do not increase the chances of a SVR, at best offering equivalence; and
2. NICE has already provided guidance (TA106) showing that current treatment courses are cost-effective
3. Even a shorter course of treatment lasts for 3 months and may be hard to tolerate and patients should therefore be given the best chance of SVR the first time they do treatment; and
4. There are so many factors that appear to affect SVR, including race, sex, and, on a sliding scale, age and amount of liver damage, that trials cannot provide data that covers individual cases,

we would ask NICE to provide guidance in such a way that the final decision on whether a shortened course of treatment is appropriate is left to the clinician and patient and not to PCTs.

Adults with chronic hepatitis C and HIV co-infection

We would ask NICE to take 2 factors into consideration:

1. While it is well accepted that HCV progresses faster in those with HIV co-infection, there is now evidence that HCV increases the risk of HIV progressing to AIDS[v]. Thus the mortality and morbidity associated with HCV is far greater in co-infected individuals than those mono-infected.
2. The reason for delaying treatment most often given to the Trust by those co-infected is the expectation that new, better drugs will soon be available. This often emanates from clinicians. While we all hope this is true, there is currently no evidence that these new compounds, although clearly effective in those mono-infected, will improve outcomes for those co-infected. Furthermore, the complications of assessing the drug-drug interactions with HAART regimes is likely to delay their introduction considerably.

---

[i] NICE HTA 75

[ii] Carmen Vandelli and others. *Lack of Evidence of Sexual Transmission of Hepatitis C among Monogamous Couples: Results of a 10-Year Prospective Follow-Up Study*. American Journal of Gastroenterology 99(6): 855-859. May 2004.

[iii] Matthews GV et al. *Further evidence of HCV sexual transmission among HIV-positive men who have sex with men: response to Danta et al*. AIDS 45: 2112 – 2113, 2007.

[iv] Report of the research carried out in July 1998 and July 2003 by the Office for National Statistics (ONS) on behalf of the Royal College of Psychiatrists' Changing Minds Campaign, page 3

[v] Monteforte A d'A et al. *Risk of developing specific AIDS-defining illnesses in patients coinfected with HIV and hepatitis C virus with and without liver cirrhosis*. Clin Infect Dis 49: 612-622, 2009.