REVIEW OF TA111 (ACD)

In my view the committee have examined the available evidence and have adapted their findings to take account of the most recent updates of their cost effectiveness model. Input has been received from a wide variety of consultees and reflects a broad spectrum of opinion, knowledge, expertise and experience from a number of sources.

The clinical effectiveness of these drugs has not been a source of major dispute for several years and effects are generally acknowledged to be modest. However the effects of almost every well researched intervention for dementia is also modest and there is a huge variety in the standard of supportive care across the UK. Should NICE choose to confirm their recommendations, as detailed in the consultation document, my belief is that this would represent a major boost to services who are trying to implement the National Dementia Strategies. Wider availability of these drugs will have the effect of attracting more people with dementia into contact with services with much more appropriate care planning as a consequence. Earlier intervention will reduce the degree of adverse change in the relationship between a person with dementia, their carers, family and social networks. This will allow other recommendations of the strategy to be implemented.

I am aware that commissioners may react badly to the suggestion that more money should be spent on medication in this time of financial crisis. However it is well established that the costs of severe dementia greatly exceed the per capita costs of mild or moderate form of the disease. Anything which helps stabilise a patient in the earlier stages will be of ultimate benefit. I suspect that many professionals will be concerned that commissioners will use the guidance to spend less money on supportive care and yet it is the careful integration of interventions, each of which might have modest benefit, which ultimately leads to the best outcome for an individual. Commissioners should be reassured by the fact that generic versions of cholinesterase inhibitors will be available within 18 months which should keep costs down.

1.1

In the main the provisional recommendations are appropriate though some alterations are suggested below. I believe that NICE have taken the correct step in recommending that cholinesterase inhibitors and Memantine are used within their UK licence indications. In clinical practice the cholinesterase inhibitors all seem to have equal effects and it appears reasonable to treat these as a class rather than look for individual differences.

Continuing to include the statement about initiation by specialists is likely to be controversial amongst primary care colleagues. However dementia strategies recommend comprehensive and competent specialist assessment and I believe this continues to be appropriate. The key is in getting the patient into specialist services at as early a stage as possible to allow comprehensive multidisciplinary and multi-agency care planning to take place.

By contrast there are significant disadvantages in continuing to insist on 6 monthly assessments. The danger here is that formal clinic appointments become clogged up with relatively routine reviews. This can impair the ability of services to see new patients. This might become more difficult still if the number of people on cholinesterase inhibitors and Memantine continues to grow. From experience there is little doubt that many patients become acutely distressed at the realisation that they are performing more poorly on intellectual tests, whereas relatives become concerned that drugs might be removed and tend to under-report the degree of problems they are experiencing day-to-day. Although general practitioners are now paid to review patients on a Primary Care Dementia Register every 15 months there is no service specification for the nature of that review. NICE may consider either making review of cholinesterase inhibitors and Memantine part of the specification for GP review or alternatively recommend that patients taking these drugs should be in contact with a specialist Older Peoples Mental Health Team rather than fixing timescales for review.

I wonder if it is still reasonable to consider acquisition cost as the primary driver if other issues such as environmental costs are taken into account. In reality there is very little difference between the cost of initiating each of the drugs as the number of clinic appointments, length of assessment, utilisation of neuro-imaging and access to multidisciplinary care are all broadly similar for each patient but costs will vary significantly from provider to provider. The committee has accepted that an alternative cholinesterase inhibitor could be prescribed under certain circumstances but I wonder if there is any real benefit from keeping the recommendation about acquisition costs.

1.2

The document makes several references to the lack of evidence for additional benefit from the combination of a cholinesterase inhibitor plus Memantine by comparison with either drug used as monotherapy, but there is no specific recommendation about using the combination or about how changeover of the two drugs should be accomplished. In reality it would be very difficult to justify the discontinuation of a cholinesterase inhibitor in someone who had previously been a good responder and then commence a drug of which the prescriber might have little experience. Almost inevitably there is going to be some overlap and this should be acknowledged. It may be necessary to state that a period of a cholinesterase inhibitor being co-prescribed with Memantine will be necessary in any cases where changeover of drugs is being considered. More information should come from the results of the DOMINO-AD Study though even this may not give a definitive answer.

1.3

While it is obviously appropriate to mention Learning Disability there was a view in some quarters that TA111 discriminated against people who were cognitively normal prior to developing dementia despite evidence for efficacy being very much more robust in that group than in those with learning disability who develop dementia. The reason for this was that drugs could be prescribed to people with learning disability on the basis of clinical assessment, yet people who were cognitively normal had to have a particular value in a relatively narrow range on a single scale. I am pleased to see that this has been removed from the consultation document.

1.4

It is never appropriate to use a cognition score alone for assessing the severity of dementia. Dementia is a multi-faceted illness including functional and behavioural domains as well as carer interactions. All of these need to be considered when determining severity of dementia whether or not a patient is being treated with medication.

Healthcare professionals, particularly those less experienced in the use of assessment scales, such as GPs, should be aware of the inter-rater variability of scoring on basic scales such as the MMSE. As with blood pressure major changes in a patient's regime should not be undertaken on the strength of a single assessment. This is particularly important when considering criteria for withdrawing the drugs. As an example, I provide training sessions on the use of the MMSE and a 7-9 point range in scoring amongst people watching the same interview is not exceptional.

Other

In the economic models institutionalisation is taken as equivalent to severe Alzheimer's disease. I recognise that duration of treatment has the greatest impact on the cost effectiveness model but it would be important to be explicit about not equating institutionalisation with severe dementia in clinical practice. People with dementia enter institutional care for a number of reasons and many people, particularly those who live alone, tend to enter full time care at an MMSE score considerably in excess of 10. It would be important that medication was not routinely discontinued

in this population. Indeed this may be construed as direct discrimination i.e. a person was being restricted access to effective treatment on the grounds of where they resided.

Peter J Connelly
NHS QIS nominated specialist consultee

6 October 2010