NICE Health Technology Appraisal - Appraisal Consultation Document On Rituximab for first line treatment of stage 111 – 1V follicular lymphoma	
TO: NICE	**FROM: Healthcare Improvement Scotland** **26 September 2011**

Comment provided by [redacted], Consultant Haematologist

1. Do you consider that all the relevant evidence has been taken into account? *If not, what evidence do you consider has been omitted, and what are the implications of this omission on the results?*

   I agree that the key randomised data comparing R-chemotherapy with the corresponding chemotherapy alone has been taken into account. There are key studies comparing different types of R-chemotherapy with one another. Two of these are large randomised studies (R-bendamustine v R-CHOP, and R-CVP v R-CHOP v R-FM). Both of these studies have appeared in abstract form and when fully published might suggest one form of R-chemotherapy is more clinically and/or cost effective than another. For example R-bendamustine seems non-inferior to R-CHOP but with less side effects.

2. Do you consider that the summaries of clinical and cost effectiveness are reasonable interpretations of the evidence? *If not, in which areas do you consider that the summaries are not reasonable interpretations*?

   I fully support the interpretation of the clinical and cost effectiveness summaries. It is clearly acknowledged that subsequent therapy decisions are important in this area but are not easily predicted for the whole cohort of patients. Clinicians

will choose relapsed regimens based on the initial treatment used and the initial length of the first response. It is of course assumed in the model that first line R-maintenance will have the same benefit independent of the initial R-chemotherapy. This might not be the case, with R-maintenance having more benefit following less intense regimens, such as R-CVP, than in more intense regimens such as R-CHOP.

3. Are the provisional recommendations of the Appraisal Committee sound and do they constitute a suitable basis for the preparation of guidance to the NHS? *If not, why do you consider that the recommendations are not sound?*
Yes, I think the decisions are sound and a very appropriate basis for guidance to the NHS.

4. Are the patient pathways and treatment options described in the assessment applicable to NHSScotland? *If not, how do they differ in Scotland?*

The same as for Scotland

5. Would the provisional recommendations change the patient pathways and/or patient numbers in NHSScotland?

Current SMC guidance is for Rituximab in combination with chemotherapy (not specified)(SMC 493/08). Whilst the same trials were compared in the SMC appraisal, the final guidance used the general term 'chemotherapy' and did not specify limits on which regimens could be used. The only change to Scotland would be if the NICE guidance was considered to be a multi-technology appraisal relating to the 4 named immunochemotherapy regimens and as such superseded the general term 'chemotherapy' in the SMC guidance. This would disallow useful combinations such as R-chlorambucil in older/frail patients which can currently be interpreted by clinicians and Health Boards as useable under the SMC guidance.

6. Do you think there is any reason why this provisional guidance would not be as valid in Scotland as it is in England and Wales?

No

7. Please add any other information which you think would be useful to NICE or helpful in guiding the Scottish response to this assessment

Nothing, other than to re-iterate the difference between this guidance, which specifies 4 named chemotherapy regimens and the current SMC guidance which recommends R-Chemotherapy (not specified), as discussed in 6 above.

Comment provided by Dr Anne Parker, Consultant Haematologist

1. Do you consider that all the relevant evidence has been taken into account? *If not, what evidence do you consider has been omitted, and what are the implications of this omission on the results?*

All the available published info has been taken into account. I am disappointed that they have restricted the use to certain chemotherapy regimens as I believe that this disadvantages the elderly where few clinical trials are carried out. I think rituximab should be available with first line chlorambucil

2. Do you consider that the summaries of clinical and cost effectiveness are reasonable interpretations of the evidence? *If not, in which areas do you consider that the summaries are not reasonable interpretations*? **Yes**

3. Are the provisional recommendations of the Appraisal Committee sound and do they constitute a suitable basis for the preparation of guidance to the NHS? *If not, why do you consider that the recommendations are not sound?*

They are reasonable

4. Are the patient pathways and treatment options described in the assessment applicable to NHSScotland? *If not, how do they differ in Scotland?* **Yes**

5. Would the provisional recommendations change the patient pathways and/or patient numbers in NHSScotland? *If so, please describe what these changes would be.*

Probably no major impact as I believe that most centres are using Rituximab with regimens other than RCVP

6. Do you think there is any reason why this provisional guidance would not be as valid in Scotland as it is in England and Wales? *If yes, please explain why this is the case.* **No**