Professional organisation 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:
[redacted]

Name of your organisation
Royal College of Pathologists and the BSH

Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology? Yes
- 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)

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?

Follicular lymphoma is the second most frequent non-Hodgkin Lymphoma (NHL). Approximately 80 % patients present with stage III or IV disease. Previous studies have demonstrated no survival benefit in treating asymptomatic follicular lymphoma patients with advanced disease. Patients are therefore managed with an expectant approach with active surveillance until they develop symptoms requiring treatment. The prognosis and management also varies with histological grade (WHO classification grades I, II, IIIA and IIIB). Histological staging can be difficult and recent BCSH guidelines recommend that lymph node biopsies should be reviewed by a designated specialist in haematopathology. However, there is geographical variation in the availability of histopathologists experienced in lymphoma reporting, immunocytochemistry and cytogenetics. Follicular lymphoma can also undergo transformation to diffuse large B-cell lymphoma, a high grade lymphoma, which requires treatment as for DLBCL. The accurate diagnosis of this will depend on purposeful lymph node biopsies.
For those patients requiring treatment, immune-chemotherapy (R-chemo) has been the standard of care for several years. Rituximab has been successfully combined with CVP, CHOP and fludarabine based combinations (Marcus, Blood 2005, Hiddenmann Blood 2005, Forstpointner Blood 2004, Zinzani JCO 2004). Rituximab in combination with single chemotherapy agents such (chlorambucil, bendamustine or fludarabine) shows promise although phase III data is often lacking. The most appropriate first-line treatment for follicular lymphoma patients should be risk adapted and individualised taking into account clinical features and co-morbidities.

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)?

Rituximab in combination with chemotherapy should generally be used in the secondary care setting particularly during initial treatment. This should be in a day ward or in-patient setting where nursing staff are familiar with administration and managing infusion reactions. R-CVP is recommended in the NICE guidance TA110 and routinely given in the UK. It is unlikely that there will be any day ward capacity issues if rituximab was combined with an alternative chemotherapy combination.

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?

Although the rituximab UK marketing authorisation for this indication has been extended from R-CVP to R-chemotherapy, other chemotherapy combinations with rituximab are not widely used in the UK outside clinical studies as they are generally not funded. However, there is likely to be some geographical variation within the NHS according to local cancer network policies and funding approval.

*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.*

BCSH guidelines: April 2010 Best Practise in Lymphoma Diagnosis and Reporting, Parker et al
NICE guidelines on Follicular lymphoma

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?

There is wide experience of giving R-CHOP to DLBCL patients who are a similar age so it is unlikely to represent any technical administration problems to a unit experienced in managing lymphoma patients. Rituximab with fludarabine combinations may be easier to use as the fludarabine can be administered orally.

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?

Progression free survival and overall survival are appropriate outcomes. The UK population is an aging population and the incidence of follicular lymphoma increases with age. Older patients, particularly those with co-morbidities are under-represented in clinical trials and less likely to tolerate the more intensive combination chemotherapy regimens. Rituximab in combination with single agent chemotherapy may be more appropriate for these individuals. Expansion of the NICE guidance to include any chemotherapy regimen will allow individual clinicians and patients to choose individualised and risk adapted therapy based on co-morbidity, tolerance and patient choice.

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?

Side effects previously documented extensively.

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.

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)?

No extra facilities or equipment would be required but in the current financial climate PCT budgetary constraints would be likely to affect any NICE implementation as has recently occurred in some cancer networks for other NICE guidance on cancer drugs.