National Institute for Health and Clinical Excellence

Abatacept for the treatment of rheumatoid arthritis after the failure of conventional disease-modifying anti-rheumatic drugs

Royal College of Nursing

Introduction

The Royal College of Nursing (RCN) was invited to review the Appraisal Consultation Document (ACD) for Abatacept for the treatment of rheumatoid arthritis after the failure of conventional disease modifying anti-rheumatic drugs

The RCN Rheumatology Forum, a professional interest group of nurses caring for people with rheumatoid arthritis reviewed the appraisal document on behalf of the RCN.

Appraisal Consultation Document – RCN Response

The Royal College of Nursing welcomes the opportunity to review this document. The RCN's response to the four questions on which comments were requested is set out below:

Has all the relevant evidence been taken into account?

The ERG notes that people included in the trials had not had rheumatoid arthritis (RA) for as long or had as many conventional DMARDs as those in clinical practice. We would argue that the shorter time on a conventional DMARD and the use of fewer DMARDs reflects current clinical practice and reflects NICE guidance (CG79) on the treatment of RA (NICE 2009). Clinicians are starting biologic therapies sooner in the disease history than in the past.

The ERG assumes the sharing of vials in larger organisations. The sharing of vials is poor clinical practice and is strongly advised against by our pharmaceutical colleagues due to the risk of cross infection.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence and are the preliminary views on the resource impact and implications for the NHS appropriate?

The ERG states that an improvement of HAQ of 0.3 is not clinically significant. The RCN Rheumatology Forum (RCN RF) would argue that this can mean a huge improvement in function for some patients and therefore is clinically significant.

The value of the ICERS is similar to biologic therapies already in use and approval of those drugs was based on the optimistic scenario. We feel that the same should be applied in the use of Abatacept. This would give a QALY of £27, 157 (ScHARR) pg 133-134 based on no vial sharing.

Are the provisional recommendations a sound and suitable basis for guidance to the NHS?

No. The proposals appear to disregard the fact that Abatacept targets a different cytokine (T cells) to the other biologic therapies. By not recommending this treatment for use, NICE is depriving those patients who clinicians feel would not respond to current biologic therapy the chance of using Abatacept as a first choice.

RA is a heterogeneous condition and the need for access to drugs that work on different aspects of the inflammatory pathway is vital in treating and controlling this condition. Abatacept appears to work equally well in people who are sero positive or sero negative. Clinicians need to gain experience of using other drugs than TNF inhibitors as first line treatment after the failure of conventional DMARDs.

THE RCN RF feels strongly that there is sufficient evidence to approve this drug for use after conventional DMARDS.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of gender, race, disability, age, sexual orientation, religion or belief?

We are not aware of any specific issue at this stage. We would however, ask that any guidance issued should show that an analysis of equality impact have been considered and that the guidance demonstrates an understanding of issues concerning patients' age, faith, race, gender, disability, cultural and sexuality where appropriate. Any guidance on the use of this technology should also be mindful of the impact it may have on reducing socio-economic inequalities.