Response by Arrhythmia Alliance to NICE Appraisal of
Dabigatran Etexilate for the Prevention of Stroke and Systemic Embolism in Atrial Fibrillation

Stakeholder Organisation:	Arrhythmia Alliance (A-A)
Name of commentator:	

Executive summary of points:	**Have all the relevant evidence been taken into account?**	**Are the summaries of clinical cost effectiveness reasonable interpretations of the evidence?**	**Are the provisional recommendations sound and a suitable basis for guidance to the NHS**	**Groups who need particular consideration ensure avoidance of unlawful discrimination?**
A-A calls upon NICE to consider the wider cost model of '**the patient health outcomes relative to the total costs**.'	Audits from stroke admissions of people in AF show that 8% of those presenting with stroke have warfarin within therapeutic range and only 27% were receiving warfarin in any form. NICE figures highlight 166,000 high risk AF patients should be on warfarin, but evidence shows that only one third of warfarin treated patients are within therapeutic range. So current models are not successful at reducing risk or stroke and thus cannot be considered cost-effective.	AFA is mindful that budgetary pressures within the NHS are ever-present and inevitable, and as a result, financial pressure demands sound reasoning and compelling arguments before new therapies can be recommended. To this end, part of 'efficiency' is cost. However, as recommended in the QIPP, Right Care programme, 'Commissioning for Value': '*value must also be measured by outputs, not inputs. Hence it is patient health results that matter.'*	To deny recommendation of Dabigatran would be to allow risk to continue. A national audit in England has demonstrated that the quoted prevalence of AF is below that originally thought (1.2% against 1.7%). Despite NICE Guidance 2006, and update of QOF, the level of intervention for patients with AF and at risk of stroke is largely unchanged. A-A believes this is primarily due to resistance to warfarin.	

Executive summary of points:	Have all the relevant evidence been taken into account?	Are the summaries of clinical cost effectiveness reasonable interpretations of the evidence?	Are the provisional recommendations sound and a suitable basis for guidance to the NHS	Groups who need particular consideration ensure avoidance of unlawful discrimination?
AFA believes that the draft negative appraisal has not considered the costs incurred by this failure to treat and protect due to the fear of complications in the management of warfarin.	Atrial Fibrillation (AF) is the highest single risk factor for stroke. AF is known to be responsible for 45% of all embolic strokes, resulting in more than 12,500 strokes per year in England and Wales. AF-related strokes are usually more severe, leading to greater rates of death and disability. The current leading oral anticoagulant can lead to a stroke risk reduction of 50%-70%. However, the existing therapy (warfarin) is simply not achieving its potential. This is due to a reluctance to prescribe warfarin, due to the complexity of its management and fear of associated risks. Therefore warfarin's level of effectiveness is not achieved for the majority of AF patients at risk of stroke. Evidence[i] shows that only 18% of patients are adequately treated:		A-A calls for the Appraisal Committee to reconsider the draft decision to be mindful to deny guidance, in light of this evidence.	

Executive summary of points:	Have all the relevant evidence been taken into account?	Are the summaries of clinical cost effectiveness reasonable interpretations of the evidence?	Are the provisional recommendations sound and a suitable basis for guidance to the NHS	Groups who need particular consideration ensure avoidance of unlawful discrimination?
A-A suggests that if stroke reduction is not successfully managed, then existing treatment therapy cannot be considered cost effective.	The medical cost of a single stroke in first year is £9,500 - £14,000. Hospital admission costs following a stroke are £103 million and post-discharge care £45 million. These costs do not include continuing costs after the first year, nor do they include costs associated with long term disability or the human-social cost, which is incalculable. A-A suggests that failure to adequately reduce stroke risk, which is well documented and results in thousands of preventable ischemic strokes attributable to AF, should be factored into the QAL.		A-A does not believe that the provisional recommendations are sound or of a suitable basis for guidance to the NHS.	

Executive summary of points:	Have all the relevant evidence been taken into account?	Are the summaries of clinical cost effectiveness reasonable interpretations of the evidence?	Are the provisional recommendations sound and a suitable basis for guidance to the NHS	Groups who need particular consideration ensure avoidance of unlawful discrimination?
A-A asks that that the Committee consider a QAL model for this group of patients who would have far longer years of QAL and for whom a validated risk stratification schema has been endorsed by leading international and national professional bodies (CHA_2DS_2VASc).	Although A-A is aware that this is qualitative data from a relatively small number of AF patients, a recent survey amongst highlighted that 54% of the AF patients asked, (who are still in employment) reported that warfarin had a very high impact on their job and employment. A-A strongly believes that denial of a new, safe and more effective treatment for this group of AF patients would discriminate against their opportunity to access work, maintain employment and succeed in promotion, regardless of ability, due to INR testing requirements.	The RE-LY trials showed a reduction in relative risk when compared with warfarin of 10% in the 110mg dose arm, and 35% in the 150mg dose. While the ERG had been tasked to consider QAL for AF patients 75yrs+, NICE guidance also indicates anticoagulation for some at: *'age 65 years or over with one of the following: diabetes mellitus, coronary artery disease, or hypertension'*.		A-A asks the committee to be mindful to the fact that the average age of UK AF patients is not 77 years, as indicated by the ERG models, but indeed far younger. The models presented by the ERG do not represent current clinical practice.

Executive summary of points:	Have all the relevant evidence been taken into account?	Are the summaries of clinical cost effectiveness reasonable interpretations of the evidence?	Are the provisional recommendations sound and a suitable basis for guidance to the NHS	Groups who need particular consideration ensure avoidance of unlawful discrimination?
A-A asks the Committee to consider AF patients with either poor control on warfarin (<60%) in therapeutic range, making warfarin useless in reducing the risk of stroke, or a non-bleeding contraindication to warfarin.		A-A believes that the cost effectiveness comparison for these patients should be without anticoagulation or aspirin.		Denial of guidance to Dabigatran would be discriminatory towards those AF patients who are poorly controlled/ are difficult to control on warfarin.
A-A calls upon the Committee to include representation from Primary Care and Commissioners.	Oral anticoagulants are largely prescribed by and managed by Primary Care physicians, however in reviewing Dabigatran, this group of specialists was not represented. Neither were Commissioners who, without guidance issued by NICE, will face considerable pressure.			

Executive summary of points:	Have all the relevant evidence been taken into account?	Are the summaries of clinical cost effectiveness reasonable interpretations of the evidence?	Are the provisional recommendations sound and a suitable basis for guidance to the NHS	Groups who need particular consideration ensure avoidance of unlawful discrimination?
A-A calls upon the Committee to issue guidance on Dabigatran with consideration to the points A-A has highlighted in its response to the Appraisal Consultation document.		An NHS priority is to reduce the number of strokes suffered. The current guidance acts against this, despite trial evidence (RE-LY) and expert witness statements, given prior and at the Appraisal meeting. A-A believes that this will result in: - Continued rise in the event of strokes due to AF - Conflicts between patients and clinicians - No local guidelines, leading to inequality of services and care and cost inefficiencies - Promotion of unwarranted inequalities in stroke risk reduction	A-A does not believe that the current recommendations are sound and act as a suitable basis for guidance to the NHS.	

Closing date: 5pm on 8th September 2011

References:

[i] Baruch L, Gage BF, Horrow J et al. Can patients at elevated risk of stroke treated with anticoagulants be further risk stratified? Stroke 2007;38: 2459–63

2 National Institute for Health and Clinical Excellence. Atrial fibrillation: the management of atrial fibrillation. Costing report; Implementing NICE guidance in England. July 2006. www.nice.org.uk/nicemedia/live/10982/30061/30061.pdf

3 McBride D, Bruggenjurgen B, Roll S et al. Anticoagulation treatment for the reduction of stroke in atrial fibrillation: a cohort study to examine the gap between guidelines and routine medical practice. J Thromb Thrombolysis 2007;24:65–72