Fingolimod for the treatment of relapsing-remitting multiple sclerosis
Appraisal consultation document, November 2011

Comments from Prof Carolyn Young

1. Use of only Avonex (a form of beta interferon) as comparator treatment

I agree with the concerns of the Committee that this was not the best comparator, given that the subgroup 1b had been defined by inadequate treatment response on beta interferon ("highly active disease that has remained unchanged or worsened despite treatment with beta interferon"). However, I disagree that "best supportive care" should be the choice of comparator as patients with inadequate response to beta interferon may be switched to another disease modifying treatment *in addition* to best supportive care.

2. Option of best supportive care

I am not aware of any evidence base for the assertion that the "ERG … clinical advisers had estimated that approximately one-third of people with relapsing–remitting multiple sclerosis whose disease has a suboptimal response to beta-interferon treatment will receive best supportive care in the UK (4.18)."

My information and experience about management of people with RRMS whose disease has had a suboptimal response to beta-interferon does not include best supportive care. Instead such patients may remain on their existing DMT, or be switched to another first line agent, or be changed to natalizumab, or sometimes mitoxantrone or alemtuzumab; details as laid out in my written submission to NICE (May 2011) or my previous comments (August 2011) or in my verbal evidence as summarised in paragraph 4.3 and reproduced below.

> *The Committee heard from the clinical specialists that after a suboptimal response to the first disease-modifying treatment used, clinicians are likely to either offer a different beta interferon or glatiramer acetate, or offer the patient a higher dose of beta interferon (such as Rebif-44). The Committee also heard that clinicians are generally reluctant to stop treatment altogether after a suboptimal response.*

3. *"approximately one-third of people with relapsing–remitting multiple sclerosis whose disease has a suboptimal response to beta-interferon treatment will receive best supportive care in the UK. The Committee heard from the clinical specialists at the meeting that this estimate was likely to be correct."*

The clinical specialists are unspecified but I do not recollect concurring with this assertion, please see above for my written and verbal evidence on management for people with a suboptimal response to beta-interferon treatment. I would also not anticipate that a MS specialist nurse would agree with this estimate on use of best supportive care in place of disease modifying therapy.

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