27th January 2012

RE: Atrial fibrillation (stroke prevention) – rivaroxaban Comment on ACD

Thank you for your invitation to the second appraisal meeting on the 15th February. Unfortunately I am unable to attend, but would like the following points to be taken into account:

1. I understand from the literature that the average visits per year are approximately 20 per year (NICE costing report). Therefore £242 per year would seem low (£242/12 months equals approx £12.10 per visit). It is not clear whether this takes into account other costs during such visits, for example blood taking by clinic nurses, travel costs, time absent from work etc. Furthermore, there are a significant number of patients who have difficulties managing their INR with a wide variation in the numbers between centres in the UK. Such patients could visit up to once per week, making 30 plus visits per year not unusual.

2. Patient groups report that patients are worried or anxious about staying within the INR range because of the consequences of being out of range. In my experience they are concerned about the effects of other changes in medication that may affect INR, diet, alcohol intake etc, and this should be taken into account in the appraisal.

3. There is no reason to believe that the results of the ROCKET trial should not be applicable to all patients eligible for an OAC, but not currently taking warfarin (i.e. patients with mental impairment and difficulties with dose adjustments). At this time, aspirin is the only other option to manage these patients. It has been shown in the literature in analyses undertaken in other trials, such as RELY and ARISTOTLE, that the treatment effect of the new OACS is independent of baseline CHADS risk.

I hope this information is of help. I am happy to be contacted if any clarification is needed.

Yours sincerely

Professor John Potter