[redacted]

Colistimethate sodium powder and tobramycin powder for inhalation for the treatment of pseudomonas lung infection in cystic fibrosis

Consultation on technical content of assessment report for NICE technology appraisal

Response from Royal College of Paediatrics and Child Health

With thanks to:

[redacted]

Section number Indicate **section number** -or- **"general"** if your comment relates to the whole report	**Comments** If possible, please provide evidence (citations) to support your statements
General	Support conclusions' note that there are key uncertainties regarding DPI although both DPI formulations are non-inferior to nebulised tobramycin. Also note the cost-effectiveness.
General	There are only 2 phase III clinical studies, and 1 of these is not published. Although there are methodological problems, both equivalence between nebulised tobramycin and dry powder tobramycin or colistin over a 24 week period. There a methodological flaws in both studies. The bulk of the analysis is taken up with an attempt at cost analysis. This is limited by the lack of long term outcome benefit. It is also limited by the unknown price of colobreathe. If we assume that the dry powder drugs are in fact equivalent to nebulised tobramycin, then whether they are used or not comes down to patient preference – they have been promoted as more convenient and quicker for patients. It is disappointing to note in this regard that compliance with colobreathe was lower than that for nebulised tobramycin (67% versus 71% took more than 75% of doses). The biggest missing piece of information is and efficacy comparison between the dry powder antibiotics and nebulised colistin. This is the most widely used treatment of chronic pseudomonas in the UK. It is also the cheapest by quite a long way (over 3 times cheaper than nebulised tobramycin). Forest are looking to be cost neutral with nebulised tobramycin. If all patients switched over to dry powder antibiotics, then there would be considerable increase in the cost to PCTs. The most

	likely default will be that most patients will continue to use the cheapest treatment. There appears to be no mention of this in the cost analysis.

If you have any queries about this response, please contact [redacted] on [redacted]