Comments on the ACD Received from the Public through the NICE Website

Name	[redacted]
Role	Private Sector Professional
Other role	
Location	England
Conflict	
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Target Ovarian Cancer would like to comment on the MTA for topotecan, PLDH, paclitaxel, trabectedin and gemcitabine for the treatment of recurrent ovarian cancer. We are highly concerned that excluding treatments, previously available, reduces the choice of drug availability for women with platinum resistant or platinum refractory disease. Â This is of great concern given the very limited options available in this clinical scenario, and severely restricts a woman's ability to have any choice over which drug may suit her best. This lack of choice for both women and clinicians is only intensified by the recent announcement that the production of PLDH has been halted, with no certainty of production resuming. See http://www.doxil.com/sites/default/files/DOXIL_DHCP_Letter_25_SEP_2013.pdf for more information. This situation fundamentally threatens the ability of the NHS or clinicians to access the drug. In addition, the exclusion of carboplatin and gemcitabine, would reduce the option of a therapeutic intervention without hair loss, a factor that is considered important by women during treatment of recurrent ovarian cancer, and although not previously approved by NICE we are aware there is a body of evidence that expresses the benefit of gemcitabine in clinical practice. With no new life extending treatments being approved in 20 years, the reduction in treatment options as defined by this MTA is not only a very negative step backwards, but one, combined with the current difficulties in access to PLDH, which will threaten progress made in recent years.

Name	[redacted]
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Section 4 (Consideration of the evidence)	The oncologist expert consulted in this document have explained the day to day practice with patients with advanced ovarian cancer, who is in general and at least for a certain period of time, is sensitive to chemotherapy. It is essential for some patients to have most of the available drugs to maintain prolong disease free survival. In my practice, as ovarian cancer specialist (which is in common with most other specialists) patients can benefit from Gemcitabine, Topotecan and Trabectidine in sequence. This is impossible to quantify from clinical trials. The point made of cost effectiveness can not be captured exactly from the clinical trials mentioned. Clinical practice is different where patients receive several lines of chemotherapy. Denying these patients the use of Gemcitabine, Trabectidine and Topotecan, might mean early death and shorter survival for very significant proportion. I will find this very difficult to justify to my patients and would be very grateful to your committee to review these decisions and take in consideration patients and oncologists views.

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Section 4 (Consideration of the evidence)	I understand that in this day and age one has to be absolutely sure that treatment offered is cost effective and for that clinical trials are best to provide data but it is important to keep in mind that only small proportion of patients participate in trials and every day clinic practise is very different than trial patients. As a clinician I find it disappointing to find out that in partial platinum sensitive cases only treatment that has shown significant impact (Trabectedin and PLDH) is not being approved by NICE and I think this is disservice to our patients