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

Name	[redacted]
Role	NHS Professional
Location	England
Conflict	no
Notes	I am an expert in the care of vasculitis patients
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Clinical experts disagree with this conclusion. The introduction of rituximab has proved a reliable treatment for those failing standard of care, an alternative to those in whom cyclophosphamide avoidance is desirable and is reshaping approaches to disease management. Â There is data on long-term safety and efficacy of RTX from several studies in a wide range of patients with connective tissue disease, idiopathic thrombocytopenia and lymphoma. The malignancy risk has been examined in rheumatoid arthritis, an inflammatory autoimmune disease with similarities to AAV, and is low[6, 7]. There is emerging data on rituximab use in and before pregnancy from rheumatoid arthritis, SLE and AAV[8, 9]. The rituximab global drug safety database reports 231 pregnancies associated with maternal rituximab exposure, of those pregnancies with known outcomes no safety signal was identified[8]. The long-term infective risk of rituximab appears low in rheumatoid arthritis, and it has been preferred to cyclophosphamide in AAV in the presence of severe infection
Section 5 (Implementation)	Clinical experts agree there are substantial uncertainties within the economic modelling. The model used to generate the ICER is questioned by clinical experts. There is concern about the plausibility of the utility values placed on the remission and non-remission health states. The costs for the long-term toxicities of cyclophosphamide are not included. Short-term costs acquired from University Hospitals Birmingham and Addenbrookes Hospital have estimated that a cycle of 2g rituximab compared with a course of cyclophosphamide (10 pulses) is equivalent. The ICER quote a cycle of cyclophosphamide, which includes 10 infusions, as Â£1802. This significantly underestimates NHS treatment costs.
Date	10/19/2013 1:47:00 PM

Dear Sir/Madam

On behalf of the consultants in the multidisciplinary vasculitis clinic at Hammersmith Hospital, Imperial College Healthcare NHS Trust, I am writing to add our unanimous support to the case for the use of Rituximab as primary therapy in patients with ANCA-associated vasculitis. Without doubt, Rituximab has been a step change in the management of AAV, and we are incredulous that the NICE panel might suggest otherwise.

We have a large clinic and see approximately 20 new cases of active AAV per year, with over 250 patients under active follow up. We frequently use Rituximab as first line management of AAV (new diagnoses and relapses), and have given 153 courses of treatment to 110 patients between December 2004 and January 2013. Rituximab has been demonstrated to be more effective than cyclophosphamide for inducing remission in relapsing patients. We have extensive experience of the complications of cyclophosphamide including the long term risks of malignancy (especially bladder and haematological), which are well documented but may not always be captured by clinical trial results where follow up is short. We do not believe that there is a 'safe' dose of cyclophosphamide and seek to minimize its use wherever possible. In addition, ANCA vasculitis affects patients of all ages including patients of childbearing age, and the impact of infertility and the costs of management of infertility in patients should not be underestimated.

For these reasons, we have been using Rituximab first line to manage our patients with ANCA vasculitis, and any change to this would adversely affect our ability to give optimum treatment to our patients, which we strongly oppose.

Yours sincerely

Vasculitis specialists working in the Hammersmith Hospital Vasculitis clinic:
namely, in alphabetical order:

[redacted]