BSPAR British Society for Paediatric and Adolescent Rheumatology

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Multiple Technology Appraisal: Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis – including review of TA35 (ID783)

Introduction

The British Society for Rheumatology works nationally and internationally to promote excellence in the care of people with rheumatic and musculoskeletal disorders and to support those delivering it. Involving patients and carers at every step, the BSR works to ensure that physicians and clinicians are educated and trained to provide high quality care.

Our membership consists of clinicians looking after the whole of life, from children to adults and across the whole patient pathway. We are patient centered and clinically led, our members work in hospital and across the community diagnosing and treating people with rheumatic and musculoskeletal disorders with a range of over 200 conditions. We include rheumatologists, nurses, allied health professionals, GPs and academics, we work with other health organisations to enhance the quality of care, and promote research and innovation. We also promote evidence-based policies to government to encourage healthy lifestyles and reduce illness from preventable causes. As a leading multi-specialty umbrella organisation we present a powerful and unified voice to improve health and healthcare for people with rheumatic and musculoskeletal disorders.

Response

The report is a very accurate assessment of *most* areas of our clinical practice. The studies quoted for the effectiveness in etanercept, adalimumab , tocilizumab and abatacept are obviously those that we also refer to for clinical practice.

The reports do not tackle infliximab and anakinra use, both of which are effective treatments that are commonly used by UK paediatric rheumatologists.

The studies quoted in this report do not encompass all JIA practice. Systemic JIA is not included and these case can require biologics . Also a severe refractory persistent oligo JIA can require biologics. I understand that licenses are not provided for these and that makes it difficult for NICE to appraise this. It would be ideal if the two could be included as this would then avoid the need for further multiple IFRs. The biologic registries in UK do reflect the true use of biologics in UK, I think it would be good to see the figures of biologic use from both UK registries.

Brief reference was made to the continuation of biologics from paediatric to adult range. This should emphasised clearly in the final report. It would helpful if biologics stopped in paediatric age range can be restarted again in adult range or started for first time in adult range(for an original JIA diagnosis)

The financial reviews seemed to be based on the short time period of the clinical effectiveness studies. I don't think the long term effect of biologics in the paediatric age range has been taken into account. In the adult rheumatoid arthritis data it is clear that early effective therapy will improve the eventual outcome and reliance on future medical services and drugs for the patient lifetime. Early effective control of methotrexate resistant JIA with biologics would reduce healthcare costs in the near and distant future.

It may be reasonable to build into guidelines a period after which a patient has a trial off a biologic treatment to see if the disease can go into drug free remission. If the disease reoccurs then again the drug could be restarted for an agreed period.

Prolonged inflammation, physical inactivity and steroid use has all been linked to a greater degree of osteoporosis in JIA. Earlier effective control of refractory JIA with biologics should reduce this problem. As the accretion of final bone mineral density occurs in the first 20 years of life, the control of inflammation is crucial in this time period. The health-cost improvement of better osteoporosis control could be considered from adult models.

Similarly, growth and pubertal development is crucial in this time period. Controlling inflammation and limiting steroid use by biologic use is likely to have far reaching health impact in later life. This includes systems such as cardiovascular morbidity for which evidence is growing in relation to JIA(it exists strongly in other inflammatory conditions such as lupus). This could also translate to mental and social health and loss of adult -working hours.

In JIa-related uveitis it is acknowledged that the summary of reports shows efficacy. The SYCAMORE trial has now closed due to efficacy of adalimumab. The interim guidelines for this currently include the availability of the drug via that trial. It would help for those interim guidelines to permit the use of this drug in JIA related uveitis until the SYCAMORE data is reported.