Submission to the National Institute for Health and Clinical Excellence's Appraisal of Erlotinib and Gefitinib for treating non small cell lung cancer that has progressed following prior chemotherapy

This response is submitted by Roy Castle Lung Cancer Foundation

---

We are dismayed that this appraisal is being undertaken and at a time of financial austerity, we believe it to be a waste of scarce public sector resource.

1. **Review of Gefitinib**
   We do not understand the rationale for the inclusion of Gefitinib in this appraisal. Gefitinib is not licenced for second line use in non small cell lung cancer (nsclc). It is licenced (and has received a positive NICE recommendation) only for the treatment of locally advanced or metastatic nsclc with activating mutations of EGFR-TK. Thus, should be given in the first line setting, in appropriate patients. In very unusual cases, it may be given after first line chemotherapy, where the health system has failed to ensure timely diagnostic testing – these small numbers of patients represent a failure in the lung cancer treatment pathway. Thus, Gefitinib is not a second line treatment option and as such, it is difficult to understand how an appraisal will be undertaken. It can be of no practical value.

2. **Review of Erlotinib**
   Erlotinib is now standard practice as a second line option in the treatment of nsclc. Since the original appraisal of Erlotinib versus Docetaxel, we are aware of only one study, which has been peer reviewed and published. This is not something which would change clinical practice – and indeed, it has not.

   In undertaking this review, we hope that the Appraisal Committee will recognise that Erlotinib is not simply an alternative chemotherapy to Docetaxel, but a totally different type of therapy.
   - The side effects of Erlotinib are much less significant than Docetaxel – for which severe neutropenia can be life threatening.
   - Many patients comment on the 'toxic' nature of Docetaxel – we have heard it referred to as "*doceterrible*" by patients. In this group of patients, at a second line treatment stage, there would be a significant number, who would be unable to tolerate Docetaxel but, in which Erlotinib would be an option.
   - As an oral medication, Erlotinib does not involve repeated day case admissions for iv administration – offering a much greater prospect of treatment closer to home. We are ever mindful that, in the main, this group of patients has a short life expectancy. It is important to ensure that they are able to spend as much time as possible away from the hospital setting.

   We understand from discussions with clinicians and patients, that the toxic nature of Docetaxel, means that, in practice, it is no longer offered in the second line setting. Across the globe, Erlotinib has become the second line standard of care for nsclc. Clearly, we do not wish to see the NHS in England deprive lung cancer patients of therapies routinely available elsewhere.

   We are aware that Docetaxel is now 'off patent'. It is extremely worrying that, with no new body of clinical evidence, cost will form the core of this appraisal. We are unaware of any other NICE re-appraisal having been undertaken when an older therapy has come 'off patent'. Together with the rest of the cancer community, we are very concerned at this precedent being established and its effect on future patient care.

We urge the Committee to recommend that Erlotinib be made available in this indication.

Jesme Fox
Medical Director
Roy Castle Lung Cancer Foundation
July 2013