NICE Multiple Technology Appraisal: Adalimumab, (etc), for the treatment of rheumatoid arthritis (review of TA guidance 130, etc)

Arthritis Care patient expert submission

ARTHRITIS CARE'S PATIENT EXPERT, INTRODUCTORY COMMENT

Our patient expert (PE) is a - nearly 80 year old - gentleman. He is a retired legal bill writer. Subsequent to retirement he has participated and then delivered in a number of patient – centred courses, i.e.:

- The Expert Patient programme, a self – management course, run by the Expert Patient Community Interest Company ltd.
- A telephone based self – management course, on behalf of the Community Network.
- Arthritis Care's "Challenging Pain" course.

He has experience of being prescibed **adalimumab.**

This submission is based on our interviews with him, with assistance from Professor John Isaacs, Director of Newcastle University's Institute of Cellular Medicine, and Dr Richard Hull, chair of Arthritis Care's Clinical and Medical Advisory Board.

HISTORY OF RA, AND TREATMENT PRE ADALIMUMAB

Pre diagnosis

PE was diagnosed with rheumatoid arthritis (RA) in 1992. He estimates that he had RA for approximately 5 – 6 years prior to diagnosis. During that time he visited his GP on several occasions, who prescribed him painkillers. A change in GPs resulted in PE being referred to a rheumatology consultant, followed by blood tests, and a subsequent RA diagnosis. At this time he was approaching retirement.

On diagnosis PE had the following symptoms:

- Pains and stiffness in most if not all joints, especially the R knee, and including all knee, ankle, elbow and wrist joints.
- Flare ups (FU), approximately 2 – 3 times a year, resulting in substantially increased pain and swelling in joints, which in turn caused limited mobility, e.g. inability to hold a pen or paintbrush (PE paints watercolours as a hobby), and on occasions having to use a stick to walk. Despite PE having a generally positive, upbeat personality, he found the FUs to be so debilitating and painful that they made him depressed.

- In between FUs, general aches, pains & stiffness, e.g. stiffness in the mornings for a 10 minute period. PE described the symptoms during non - FU period as manageable, leaving him with a reasonable degree of functionality, e.g. he would be able to play with his grandchildren. PE had significant flexibility over his working hours: during FUs he would work less, and then consequently more when he improved, thus enabling him to work his required hours.

1992 - 2006

In this period PE was prescribed a number of pharmaceutical interventions, which were tried in a variety of different dosages and combinations, i.e.:

Painkillers: including zydol, tramadol and others.

DMARDS: including sulphasalazine and methotrexate. EP commenced DMARDS in approximately 2000 and was prescribed them for the majority of that decade. From 2004 onwards he was prescribed methotrexate. They were at times prescribed in combination with NSAIDS. EP feels that they helped to control the pain and also improved movement, e.g. he found he could bend his arm, thus enabling him to wash his hair and shave, when previously he would have been unable to do so when having a FU.

NSAIDS: including diclofenac and meloxicam. . EP took NSAIDS until the advent of DMARDS in the early 2000s, after which their use was tapered off. He was prescribed them intermittently, and there were periods when he was not taking them at all. EP feels that although they afforded him some pain relief, although the effect was not substantial.

Steriods: EP commenced them in from early 2000s. They were prescribed intermittently, sometimes for months at a time, sometimes for shorter periods. They were administered both orally and by injection. By 2006 EP was being prescribed prednisolone, by tablet, every 3 – 4 weeks. He feels that they made a big difference, as they reduced both the pain and the inflammation. EP found that he could walk for much further distances as a result of them, i.e. 2 - 3 times further, before pain made him incapable of walking (approximately one a quarter of a mile). EP is a blue badge holder.

At same time as administering steroid injections, EP's GP would **siphon off synovial fluid from his knee and elbow** joints. He found that this would improve joint movement.

2006 - 2009

EP recalls a gradual improvement across the last decade in both pain and mobility. In 2004 he commenced making written notes of his treatment. By July 2006 he was taking the following medications:

- NSAID: fenactol
- DMARD: salazopyrine
- Steriod: prednisolone, taken during FUs, i.e. every 3 – 4 weeks. (The frequency of EP's FUs has not changed throughput the years).

From approximately this period onwards EP's NSAID prescriptions were tapering off, ultimately to nil.

HISTORY OF TREATMENT POST ADALIMUMAB

2009 – October 2010

Between July 2008 and April 2009 EP undertook Disease Activity Score Tests. He required a score of >5.1 to be recommended for Adalimumab: he scored 6+

June 2009: EP's consultant started him on a course of fortnightly Adalimumab injections. In addition, EP was prescribed the following:

- Methotrexate
- folic acid
- DMARD: Sulphasalazine, (i.e. salazopyrine)
- NSAID: called meloxicam.

He had ceased taking steroids (Prednisolone).

Within days of commencing Adalimumab EP felt a lot more movement than before, e.g. he could move his fingers and arms up and down, hold pens, walk more freely, and lift his R leg easier than previously. He swiftly commenced painting again (previously his condition had forced him to cease painting for months at time); he felt both a physical and huge psychological relief: "this simple injection once a fortnight into my thigh really did change my life around. I felt I was getting absolute benefit from this and it made me happy."

July 2010: EP started seeing a new consultant. He informed her that was feeling as good as he had ever done since his diagnosis, felt psychologically brighter, and his family reported that was better to live with than previously.

October 2010 – August 2012

October 2010: EP went on holiday to Tunisia for a week. He returned a week later and was immediately rushed to hospital with Legionnaires disease. He was in hospital, including an initial stint in intensive care, for 8 weeks. Whilst in hospital he developed double pneumonia, was diagnosed with Crohn's disease a tumour was diagnosed in his large intestine. (He was later informed he had a 3 / 10 chance of survival). He had the tumour surgically removed, and an ileostomy. The growth of the tumour had been masked by the medication he had been taken. EP left hospital in Christmas 2010.

17th December 2010: PE was discharged from hospital. On discharge, his only medication was azathioprine (for Crohn's disease and RA), as it was felt that his Crohn's condition would render any other medication intolerable. For the next 2 ½ months azathyoprine was the only drug he took.

January 2011: EP had a routine 6 month appointment with his RA consultant, which included a blood test, which revealed liver problems. As a result the course of azathyoprine was stopped and he was unable to take any other medication.

March 2011: EP saw his GP due to FU affecting all his knees and elbows. It was agreed that he would go back on a low dose of azathyoprine and a steroid (Prednisolone), but no adalimumab, as the potential compromise it presented to his immune system presented too great a risk, given his current health. Weekly blood tests were scheduled to see how liver was coping with this drug regime.

July 2011: saw his RA consultant and had more blood tests. As a result the azathyoprine prescription was increased and steroids were phased out over a period of months.

Nov 2011: EP's RA was getting worse. He saw his GP, who prescribed painkillers, increased the azathyoprine and confirmed he could resume steroids in tablet form for FUs. He subsequently saw his RA consultant who put him back on daily doses of Prednisolone (a steroid).

Early 2012: EP was diagnosed with osteoporosis.

May 2012: EP saw his GP, as he experienced a lot of pain for the past 2 months and was regularly having synovial fluid drained from his joints and steroid injections. He was advised to resume adalimumab.

August 2012 – current status

In August 2012 EP resumed adalimumab, which has continued to the present day. EP injects himself once a fortnight. Again, he reports that "I am as good now as I have ever been during the period I've had RA." He reports that he can move all his limbs freely, hold a pen, paintbrushes, use an I Pad keyboard and mobile phone and has substantially reduced levels of pain.

EP still has the occasional steroid injection during FUs, but post resuming adalimumab they are infrequent; the most recent one being August 2012, albeit they when they do they are just as severity in their symptoms as they have always been.

Subsequent to resuming adalimumab, EP has recorded a Disease Activity Score of 3.

Presently, EP's only other medications are as follows:

- azathyoprine, for Crohnes disease
- alendronic acid and occasional calcium tablets, both of which are for osteoporosis, which may well have been caused by steroids use.

ARTHRITIS CARE CONCLUSION

It was very clear from our interview with our EP that adalumumab had made a significantly greater improvement to his quality of life than any other drug intervention. He talked of how its use has "changed his life around", and wents into detail as to exactly how, e.g. he described the substantially improved pain relief, reduced swelling, and consequent improved functionality, such as being able to paint once again.

His final summary of adalumumab's effects is unambiguous: "It has made a hell of a difference. I am as good now as I have ever been during the period I've had RA. It works for me."