Response to NICE consultation Document
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Current recommendations underestimate the need for biologic monotherapy and considered biologic monotherapy as an option rather than necessity. A significant number of patients with RA have contraindication to methotrexate such as liver or lung disease. Many more developed side effects such as neutropenia so methotrexate had to be withdrawn. Large longitudinal cohort study involving 1218 patients with RA and 430 patients with PsA found that 17% of patients discontinued methotrexate within the first 6 months of initiation of therapy (Lie E et al Ann Rheum Dis 2010;69:671-676). The main reason for discontinuation was adverse events (47%). Mortality in patient who could not take methotrexate was substantially higher more than twice when compared with other non-biologic conventional DMARDs such as sulfasalazine (Choi HK et al Lancet 2002;359:1173-7). Use and duration of methotrexate reduced mortality (Wasko MC et al. Arthritis Rheum. 2013;65:334-42). Importantly all the evidence of supporting the of combination conventional non-biologic DMARD therapy includes methotrexate. Hence for patients who have contraindication to methotrexate or were intolerant of methotrexate, combination conventional DMARDs is not an option. Lastly, the model assumes HAQ progression in control arm for biologic monotherapy therapy is the same as biologic in combination with methotrexate. This is inappropriate since most of these patients will be taking methotrexate.

In addition, there are a number of factual errors:
Page 16. Section 4.1.1 TACIT was a trial comparing TNF-alpha inhibitor against a combination of conventional DMARDs

Page 17, 4.1.3
Table 3 is incorrect for AMPLE study which is a study comparing methotrexate plus adalimumab versus methotrexate plus subcutaneous abatacept

Section 6.77: If patient has a contraindication to methotrexate the option of DMARD combination or biologic combination with methotrexate does not exist.