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By email: emily.marschke@nice.org.uk

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Dear Emily Marschke

Bevacizumab and cetuximab for the treatment of metastatic colorectal cancer

I write in response to the Appraisal Consultation Document (ACD) for the above appraisal. Cancerbackup is very disappointed at NICE's initial decision not to recommend these technologies, and we are particularly concerned at the provisional recommendation not to make bevacizumab available on the NHS for people with metastatic colorectal cancer.

Colorectal cancer is common in England and Wales, with an estimated 30,909 new cases diagnosed each year[1]. A NICE decision not to recommend the use of these two technologies would impact greatly on the length of life of a significant number of people. Bevacizumab and cetuximab offer increased active treatment options and provide patients and physicians the potential option to extend life as well as manage symptoms, in a sizeable proportion of patients. One study showed the median survival time for bevacizumab with bolus 5-FU/FA plus irinotecan as 20.3 months, compared to 15.6 months for a placebo with bolus 5-FU/FA plus irinotecan. The median time of progression free survival was 10.6 months compared with 6.2 months with the placebo[2].

Colorectal cancer is difficult to treat once it has advanced, with a wide range of physical and psychological symptoms resulting in decreased quality of life. Targeted compounds such as bevacizumab and cetuximab have the potential to be less toxic than other treatments, and may even reverse acquired drug resistance in some patients. The side effects of both bevacizumab and cetuximab are generally mild.

[1] CancerStats Monograph 2004, Cancer Research UK
[2] Hurwitz, Fehrenbacher, Novotny et al 'Bevacizumab plus Irinotecan, Fluorouracil, and Leucovorin for metastatic colorectal cancer', the New England Journal of Medicine, 3 June 2004, Vol 350 No 23

Cancerbackup welcomes an early review of ongoing research relating to these technologies, as recommended in the ACD, to consider further evidence of clinical effectiveness. However, a decision not to recommend bevacizumab in particular would undoubtedly damage the UK's long-term ability to conduct research in this disease area.

Cetuximab
Cetuximab has already been recommended for use in the NHS in Wales. I hope that NICE will reconsider its decision to effectively withdraw this treatment from availability in Wales, and ensure its equal availability to patients across the UK.

Bevacizumab
Bevacizumab is considered to be the most beneficial technology for some years for treating colorectal cancer in a palliative setting.

Our clinical advisers tell us that some clinicians in the UK are choosing to give bevacizumab intermittently over a period of three months, rather than eight months as referred to in the ACD. NICE does not consider this in its assessment of cost effectiveness, yet a recalculation of its cost based on the shorter time period would inevitably result in greater cost effectiveness. NICE must conduct a further assessment of bevacizumab as soon as further evidence is available to evaluate its relative effectiveness.

NICE's final recommendations must reflect the significant impact that bevacizumab can have on survival time for people with metastatic colorectal cancer. Further consideration must also be given to patients' quality of life when appraising bevacizumab and cetuximab. I urge NICE to consider these points and to recommend these technologies for use in the NHS.

Yours sincerely,

Joanne Rule
Chief Executive