

# NICE Appraisal – Cinnacalcet

## Kidney Alliance Response

Alongside vascular access, hyperparathyroid renal bone disease ranks equally as the major scourge of the patient surviving with end-stage renal failure. While phosphate binders and vitamin D preparations are employed successfully in early hyperparathyroidism, the treatment of disease when the glands have become autonomous – tertiary hyperparathyroidism- is a very different. The renal community has waited for many years for a new weapon in the armamentarium to combat this destructive disease. The Kidney Alliance think that the NICE appraisal of Cinacalcet is harsh and based on a flawed analysis, which misunderstands the natural history of tertiary parathyroidectomy after surgery. It also fails to address the central issue of patient *choice* i.e. is the avoidance of unnecessary neck surgery in high-risk patients.

The Kidney Alliance is concerned about the central assumption that parathyroidectomy (PTx) is a successful procedure which expects to normalise parathyroid hormone (PTH) levels thereby curing the disease. This is probably true for neck surgery in primary hyperparathyroidism but in tertiary hyperparathyroidism, surgery, while it may temporarily relieve bone pain and reduce serum calcium, generally doesn't work. Possibly a majority of patients will end up with too low PTH levels which leads to adynamic bone disease and there is a high incidence of recurrent hyperparathyroidism in about 15% patients. Both these outcomes are associated with continuing destruction of the skeleton. Re-exploration of the neck in recurrent disease is notoriously difficult, carries high risk and is often unproductive.

The nature of PTx itself has not been fully appreciated in this appraisal. Patients undergoing surgery for primary hyperparathyroidism usually have single organ disease and tend to be otherwise well. Not so in ESRF patients. Many being put forward for PTx have had renal failure for a number of years, have multiple co-morbidities, are at hugely increased risk from cardiovascular events and are therefore “high-risk” surgical patients. Indeed there is a sub-group in whom the risks of surgery are too high and desperate measures such as chemical ablation are occasionally attempted. The Informed Kidney Patients of the Kidney Alliance wish to raise the important concept of Choice in a patient centred health service when there is now a potential alternative to neck surgery, the latter often being a last ditch option which has uncertain results. This is particularly the case in recurrent disease. It should be borne in mind that many of these patients will already have had multiple general anaesthetic operations along their ESRF pathway and unnecessary surgery is an emotive issue. Extension of life (and hence the QUALY) is not necessarily a meaningful parameter on which to base judgements of benefit in patients with chronic disease for whom relief of suffering (include unnecessary surgery) may be of greater import.

Finally, the analysis assumes that the patients given this drug receive it indefinitely. This does not sit well with clinical reality when using expensive drugs. In practice the drug will be stopped in non-responders and this needs to be taken into account.

The Kidney Alliance, while accepting that Cinacalcet should not be used for all cases of hyperparathyroidism, urge NICE to carry out a re-appraisal examining particularly its administration to a subgroup of patients with tertiary (including recurrent tertiary) hyperparathyroidism and those in whom surgery is too risky while taking into account early cessation of the drug in non-responders and the choice which patients could reasonably expect to avoid neck surgery for which the evidence shows, poor outcomes in the majority.