NICE Health Technology Appraisal
Ranibizumab and Pegaptanib for the Treatment of Age-related Macular Degeneration

Response to Additional Analysis

SP Harding, Consultant Ophthalmologist/Honorary Professor,
[redacted]

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Thank you for circulating the results of further analyses commissioned by NICE in response to consultation after the ACD of July 2007.

Southampton Health Technology Assessments Centre

The assumptions used in the modelling process (pages 9-11) appear to be reasonable although the estimates of number of assessments with OCT and angiography (page 11) are probably an underestimate.

A range of ICERs are presented in several scenarios and cost profiles across 67 tables. The tables are difficult to interpret - the legends do not give full details and the cost difference column gives no comparator. No conclusions or recommendations are made by the authors. It appears that the ICER may be under the £30,000 threshold for several of the scenarios presented.

A summary should be prepared and circulated clearly answering the following questions based on the most likely treatment scenarios:

- What are the ICERs across a range of injection strategies, all disease subtypes combined, disease modifying effect for 2 years, account for mortality, RCOphth costs corrected for reduced cost associated with reduced number of injections, compared to best supportive care, both eyes treated
- What are the ICERs across a range of injection strategies, all disease subtypes combined, disease modifying effect for 2 years, account for mortality, RCOphth costs corrected for reduced cost associated with reduced number of injections, one eye treated

The average number of ranibizumab injections likely to be administered remains an uncertainty. In my previous comments I indicated that 8 in year 1 and 6 in year 2 was reasonable. With more experience in clinical treatment with this drug I feel that the number of injections is likely to be less than this.

NICE Decision Support Unit

An ICER of less than £30,000 were only identified for pegaptanib treated patients with baseline VA of 6/12 to >6/24. A significant number of patients will fall into this group and so the availability of this drug will be useful.

An interesting review of utility studies and the influence of contrast sensitivity on QOL in AMD is presented. As the authors state there is little new evidence to aid the decision of The Appraisal Committee.

Summary comments

In considering my previous recommendations to the Appraisal Committee it appears that there is no clear new information which would change my recommendations as set out in my personal statement of April 2007 and my comments on the ACD in July 2007. With minor rewording these are:

1. Ranibizumab should be introduced into the NHS for patients with active neovascular age-related macular degeneration for all disease subtypes and for first or second eye involvement.
2. Pegaptanib should be available for eyes in which ranibizimab therapy proves clinically problematic.
3. Treatment should be delivered in dedicated facilities by experts in the management of macular disease supported by ETDRS vision assessment, optical coherence tomography and stereoscopic angiography.
4. Robust data should be collected on adverse events and outcomes in routine clinical practice.

SP Harding 25.10.07