National Institute for Health and Clinical Excellence

Ranibizumab and pegaptanib for the treatment of age-related macular degeneration

Comments provided by Jenny Nosek on behalf of the Royal College of Nursing Ophthalmic Nursing Forum

Introduction

With a membership of over 395,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The Royal College of Nursing welcomes the opportunity to comment on the Assessment Report on the technology appraisal of the use of ranibizumab and pegaptanib for the treatment of age-related macular degeneration.

RCN Response

Overall this is a very comprehensive analysis of the current evidence base. It is very pleasing to see that the health economic data demonstrated the cost effective of both drugs.

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We are advocates for the need for continuing research in this field of medicine, but why has 'Avastin' been mentioned as a research priority in this document? The same goes for genetic research. It is important that this type of research is carried out but the remit of this appraisal is to assess the clinical effectiveness and cost-effectiveness of ranibizumab and pegaptanib for subfoveal CNV associated with wet AMD.

We would challenge the statement that there is limited experience in providing intravitreal injections. The practice of administering intravitreal injections is within the capability of any general ophthalmologist and therefore there would not be the need for additional training. But as these treatments will most likely be provided in outpatient settings on a much larger scale, healthcare professionals will have to adapt their practice from that of carrying out the procedure in a theatre setting.

We agree that current services will find it a major challenge to cope with the increased workload and perhaps some consideration should be given to the development of regional treatment centres totally dedicated to 'retinal screening and treatments' similar to centres that were developed for high volume cataract surgery, otherwise the increased workload will have an effect on a department's ability to deliver general ophthalmic services. These proposed centres will need a dedicated multi-disciplinary team of ophthalmologists, specialist nurses, optometrists and technicians. The increase in patient load and frequency of assessment associated with these new and existing treatment modalities will also require additional specialist imaging equipment (for fluoroscein angiography and optical coherence tomography) as well as provision of dedicated 'clean rooms' for performing the injection procedure.

It is suggested in the document that there is uncertainty over treatment patterns using these drugs. Is this not always the case with any new therapy? We consider that this should not hinder their introduction into the NHS. Despite the need to use randomised clinical trials data to advise clinicians on best practice, research protocols are always difficult to replicate in general practice due to resource issues. Over time, as the clinicians' knowledge and experience develop, as with photodynamic therapy, the frequency and duration of injections will most likely be less than demonstrated in the trials. We need to capture and monitor this change of practice to ensure the most effective outcomes are achieved for our patients.

The national VPDT study has been a very useful model for studying the introduction of a new treatment into general ophthalmic practice. This national data base has lots of advantages both to clinicians and providers but it also has had some disadvantages which NICE should consider if they wish to advocate another study for the introduction of these new agents into the NHS.

The one major disadvantage, which has been voiced by many clinicians, is the difficulty with collecting ‘extensive data sets’ on every patient that receives NHS treatment as there are no available resources dedicated to a funded research trial. Perhaps a modified set or a random sample of patients would be more manageable yet still produce meaningful outcomes without diverting much needed clinical resources into the administration of data collection.

We urge NICE to look favorably on the new treatment modalities. We are already seeing dramatic results in clinical practice. Our patients are not only getting stability but improvement in vision when VegFs are used. We owe it to these vulnerable elderly patients to allow them the dignity to remain as independent as possible for their remaining years by providing them access to all the appropriate treatments available on the NHS.