Royal College of Nursing

National Institute for Health and Clinical Excellence

Tumour necrosis factor alpha (TNF a) inhibitors - infliximab (review and adalimumab) for Crohn's disease

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Introduction

With a membership of over 400,000 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.

Appraisal Consultation Document – RCN Response

The Royal College of Nursing welcomes the opportunity to review the Appraisal Consultation Document (ACD) of the technology appraisal of Tumour necrosis factor alpha (TNF a) inhibitors - infliximab (review and adalimumab) for Crohn's disease. This document was reviewed by nurses working in this area and in the IBD Network. The RCN's response to the four questions on which comments were requested is set out below:

i) **Has the relevant evidence been taken into account?**

There are no further comments to make this section as the relevant evidence seemed to have been taken into consideration.

ii) **Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence, and are the preliminary views on the resource impact and implications for the NHS appropriate?**

With respect to the real cost of Infliximab v Adalimumab - it is important to note loss of response can occur in both infliximab and adalimumab, which may necessitate escalation of biologic therapy. This may be based upon a number of approaches, either progression to either 40mg weekly of adalimumab, a single dose of 10mg/k of infliximab to recapture and the reverting to 5mg/k afterwards in addition some patients benefit for a reduction in the infusion intervals of infliximab. It is difficult to obtain precise numbers of patients who receive dose escalation of both adalimumab and infliximab in clinical practice; however the practice does seem to be wide spread suggesting that the true price of both therapies is much higher. We think that this is factored into the cost analysis.

Wastage of Infliximab is an issue that may need to be explored. Vial optimisation is a practice taken up in some centres but not throughout the UK. This reflects recommendations of the NPSA, and the support for centres to develop infusion clinics which see multiple patients receiving infusions at the same time. This could ultimately reduce drug costs and provide support from other patients who receive biologic therapy.

Also there does not appear to be any mention of the importance of smoking cessation in maximizing achievement remission. We believe that the promotion of smoking cessation services and ongoing smoking cessation support is vital to optimizing therapy.

iii) **Are the provisional recommendations of the Appraisal Committee sound and do they constitute a suitable basis for the preparation of guidance to the NHS?**

Ultimately, we consider that clinicians and patients should have a choice with respect to which anti-TNF Alpha product is used. This could be based upon individual clinical need and also on cost effectiveness issues.

iv) **Are there any equality related issues that need special consideration that are not covered in the ACD?**

There do not appear to be any equality issues that have been missed otherwise at this stage.

Conclusion

We would welcome the issuance of guidance to the NHS on the use of this health technology.