



Arthritis and Musculoskeletal Alliance

Bride House, 18-20 Bride Lane, London, EC4Y 8EE

Tel: [REDACTED] Fax: [REDACTED]

E-mail: arma@rheumatology.org.uk

Internet: www.ama.uk.net

Dr Carole Longson
Director, Centre for Health Technology Evaluation
National Institute for Health and Clinical Excellence
Mid-city Place
High Holborn
London

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Dear Dr Longson,

Adalimumab, etanercept, infliximab, rituximab and abatacept for the treatment of rheumatoid arthritis after the failure of a TNF inhibitor: Assessment Report

The Arthritis and Musculoskeletal Alliance fully support the British Society for Rheumatology (BSR) comments on RA MTA Assessment Report and furthermore we are pleased to add the perspective of the broader musculoskeletal community including people with arthritis.

For many people, being able to move to a different treatment for RA and to do so promptly can make the difference between being able to have a degree of autonomy and independence and to carry out everyday tasks on one hand, and living in chronic, debilitating pain and isolation on the other. This has with the obvious implications for higher levels of dependency on the health service and higher levels of co-morbidities, including high priority physical co-morbidities such as cardiovascular problems and mental co-morbidity including anxiety and depression.

While we appreciate that the role of NICE is to make evidence based decisions on distribution of health resources, the extent to which drugs such as TNF inhibitors can change the lives of people with RA cannot be underestimated in human terms, as illustrated below. This remains the case in people who have already failed a TNF blocker, a proportion of whom will experience similar profound benefits.

Example:

"I was diagnosed with RA in 1997. It came on really suddenly and I was in real agony. Until 1999 I went through a lot of the conventional treatments on offer – steroid injections, sulphasalazine and gold. Then my rheumatologist put me antiinflammatories until I began anti-TNF treatment in April 2003.

Before that I'd been referred to Cambridge hospital by my GP, but at the time they didn't have the money for the treatment. I just couldn't get off the prednisolone and I had a number of painful joints, which meant that I qualified. All this took about nine months.

Now, I have infliximab administered by a two-hour infusion at the hospital with a one-hour wait after that to make sure that there are no side effects. I still take methotrexate too. After the initial session I had another after two weeks, another after a month and now I have it every two months. Within 6-7 weeks of starting the treatment I felt a massive improvement. The pain in my fingers, wrists, shoulders and elbows gradually disappeared. It was amazing. After three months I was completely back to normal apart from my knee. It's terrible that not everyone who needs it has access to this." – Janet Murnal

We would urge that NICE considers the following in its appraisal.

- a) that a proportion of patients failing TNF blockade in the first attempt will experience significant benefits when treated with a second agent,
- b) that the benefits of TNF therapy to people with RA and society exceed the direct health costs and extend into the impact on social care dependency, work retention and broader quality of life,
- c) the original NICE technology appraisal included a call for further research and also recommended NHS supply of TNF blockers for patients participating in research and we would endorse both of these recommendations.

I hope these comments are of assistance.

Yours sincerely



ARMA