Response on behalf of
the Lymphoma Association and Leukaemia CARE

Appraisal Consultation Document

Rituximab for the first-line treatment of stage III-IV follicular lymphoma (review of NICE technology appraisal guidance 110)

Thank you for the opportunity to comment on the Appraisal Consultation Document for stage lll-IV follicular lymphoma.

Both the Lymphoma Association and Leukaemia CARE are pleased that you intend to recommend the use of rituximab in combination with CVP, CHOP, MCP and CHVPi as an option for the treatment of symptomatic stage III and IV follicular lymphoma. This decision is very welcome and will improve the range of treatment options for the patients we represent, as well as improving their quality of life.

However there is a group of patients who we feel will not benefit from these very welcome changes - older patients. This exclusion may fall foul of your equalities policy.

While we are aware that there is a lack of clinical evidence to support the use of rituximab with other chemotherapy regimens, we are disappointed that the recommendation does not extend the use to rituximab with any chemotherapy, which would be in line with the UK marketing authorisation.

It was clear from the appraisal committee meeting that clinicians may on occasions wish to have a wider range of options, such as rituximab with chlorambucil, depending on the clinical circumstances. As patient organisations, we would support giving clinicians the wider freedom to use their clinical judgement which approval of the licensed indication would provide.

This may be of particular benefit to older patients for whom the recommended chemotherapy regimens may be unsuitable.

As follicular lymphoma is a disease of the elderly, there is a not infrequent problem of coincident diabetes which makes steroids problematic and also may prevent the use of vincristine if there is diabetic neuropathy. This is a particular problem with the increasing Asian population too. In these circumstances, chlorambucil is probably the chemotherapy of choice and it

would be illogical to deprive such patients of rituximab as the benefit of rituximab has been seen with every regimen where it has been tested and it is highly improbable that the situation would be different with the chlorambucil regimen.

We therefore ask the committee to reconsider the conclusion stated in 4.3.6 in favour of recognising that “the consistency in effect seen in clinical trials for the use of rituximab with CVP, CHOP, MCP and CHVPi **is** sufficient to generalise the outcomes to all other chemotherapy regimens used in clinical practice”.