Dear Kate,

My apologies for the delay in sending this to you. I do hope you will be able to accept the response from The British Pain Society. Please confirm.

There is too much uncertainty about this treatment for widespread use within the NHS at present. It may be better to negotiate a risk sharing scheme with the company: drug cost for all those who fail to respond (satisfy the negative stopping rule) should be paid for by the company. For those who fulfil the positive stopping rule (change from chronic to episodic migraine) but refuse to stop having injections, the company should also pay for their drugs. This will also help us to see in a prospective manner how many is in each category.

If we set up such an observational study, we may not be able to calculate ICER but if data is collected and compared to each patient's historical course of illness, it will provide better information and answer some of the uncertainties raised. The cost-effectiveness of this treatment can also be gauged: not only in direct medical costs but also other things such as loss of productivity, etc. Whatever other health utility measures that we need can be built into this study so that the appropriate data is collected.

The HTA committee may just say no to this treatment but make a research recommendation that can be beneficial to the NHS and also get more information to help other health economies to decide on utility of this treatment. This way, Botox can be used in a controlled manner with centres set up all over the country and patients will benefit as well. Some of these sites could be joint collaborations between Neurology and Pain services pooling their expertise. It will also ensure that the appropriate levels of expertise are defined, the use of Botox can be audited and a lot more information about utility of this treatment can collected.

Regards,

[redacted]

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