Description of problem	Description of proposed amendment	Result of amended model or expected impact on the result (if applicable)
Most patients who are eligible for anti-TNF therapy will not continue to take such for a year. A 10+ year time horizon is unrealistic. We anticipate 1/3-1/2 of patients who receive induction therapy will go on to receive maintenance therapy: the majority of failures will undergo surgery.	Ensure clarity that fewer patients go into maintenance phase 1.	Reduced cost of anti-TNF therapy
Many patients (1/3-1/2) of those who are given maintenance will lose response during the first year: some may switch to another anti-TNF – but ultimately most will undergo surgery within 12 months of secondary failure.	Suggest reducing the number of patients who reach the end of the first year on maintenance anti-TNFs.	Reduced cost of anti-TNF therapy
Of the patients who have a sustained remission to one year, we would anticipate many will stop therapy: patients with UC with sustained remission have a lower incidence of relapse than those who have recently flared.	Suggest all patients undergo clinical review after 12 months: only those in 'response' continue therapy while those in remission stop therapy. Thus, reduce the proportion of patients in phase 2	Reduced cost of anti-TNF therapy
Most patients will not receive anti-TNF for more than a year, certainly not 10+ years, but a colectomy is a life-long state.	Ensure biological time horizon is appropriate and the post -surgical costs are not time-limited.	Reduced cost of anti-TNF therapy and increased surgical costs
Conventional treatment costs: We note mesalazine preparations used are the cheapest, and used at doses that is relatively low. This may concur with NICE, but does not reflect clinical	Double the dose of oral mesalazine and consider using drugs that reflect market share (Ferring and Warner Chilcott dominate): the cost should be a least doubled.	An increase in the cost of conventional treatment

reality: oral therapy for UC of this type would be 4-4.8g per day; the optimum dose of rectal therapy is 1g, not 250mg.	Suppository therapy should be 1g: the cost should increase 4-fold. Again note market share when determining the choice of drug to give a more realistic cost.	
All patients in the UK with this kind of UC will have 2- or 3- stage surgery.	The cost of the operation should be increased 2-3 fold.	An increase in the cost of surgical treatment
All these will have stoma-related costs for 6-12 months while waiting for the final operation.	The annual cost of stoma appliances is ~£2000.	An increase in the cost of surgical treatment
Anastomotic leaks and pelvic abscesses are common.	These costs should be added. This is not 'a week under a gastroenterologist'	An increase in the cost of surgical treatment
Obstruction and or high-output stoma leads to admission	These could equate to 1-2 admissions per year.	An increase in the cost of surgical treatment
Most/all patients used large amounts of loperamide to manage their stoma and or their pouch.	The OTC cost of maintenance loperamide is £6.49 for 12 tablets, if just 4 tablets were taken daily, this would costs £780 per year – for as long as the patient had a stoma: for 50 years.. £39,000.	An increase in the cost of surgical treatment
20-30% of patients undergoing colectomy will keep their stoma in the medium to long term because preference, risk of impotence/retrograde ejaculation, reduce fecundity or for surgical reasons.	Many patients will be 20-30 when they have surgery. Taking a 50 year horizon, the combined cost of drugs and stoma supplies will be ~£3000x50 = £150,000 per patient.	An increase in the cost of surgical treatment
The real cost of Biosimilars is not known: experience form Hungary is that they are substantially cheaper than the originator drugs.	Seek advice from EU contracts re pricing of Biosimilar and assume a large market share of new patients.	Reduced cost of anti-TNF therapy and increased surgical costs
The data used is very limited and questionable: the QoL of patients after surgery is not a good as the model suggest.	A greater range of QOL data should be sough and or modelled.	Reduced cost of anti-TNF therapy and increased surgical costs.