NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Rivaroxaban for the prevention of adverse outcomes in patients after the acute management of acute coronary syndrome [ID532]

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

About you

Your name: [redacted]

Name of your organisation BCIS

Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology? Yes
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)? Yes
- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc.)?
- other? (please specify) I am an NHS Cardiologist

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There are currently robust treatment pathways in the UK for the treatment of patients with acute coronary syndromes (ACS). Current practice involves medical therapy with anti-thrombotics, antiplatelet agents and other anti anginal medications , with or without early revascularisation with percutaneous coronary intervention (PCI) or coronary artery bypass grafting (CABG). Most services in the UK have their own protocols for the treatment of ACS, often informed by the European (ESC) and or American (AHA/ACC) guidelines.
Since the expansion of invasive cardiac services and the development of primary angioplasty services over the past decade, there are not great problems of inequity of treatment for ACS in the UK.

The case for the addition of the Xa inhibitor rivaroxaban to current therapy following a diagnosis of ACS is largely based on the findings of the ATLAS ACS TIMI 51 trial.
This trial randomised 15,526 subjects with ASC (half with STEMI) to one of two low doses of rivaroxaban (2.5mg bd and 5 mg bd)in addition to standard therapy. 100% were given aspirin and 93% the thienopyridine, clopidogrel. Patients with previous stroke or TIA were excluded.

There was a 16% reduction in the primary endpoint of CV death/MI and stroke in the rivaroxaban arm but with a 300% increase in intracranial and TIMI major bleeds. Fatal bleeding was not different between groups.

Interestingly there was also a reduction in all-cause mortality in the rivaroxaban arm. The lower of the two doses had the most favourable results, driven by a reduction in bleeding.

The study participants were largely younger ACS patients with a minority of elderly, who might suffer even worse bleeding complications than those seen in the trial. Also there were relatively few with renal dysfunction.

A major problem, other than the marked increase in bleeding complications, is that clopidogrel, whilst used for ACS in the UK is rapidly being replaced by ticagrelor and prasugrel, more potent P2Y12 inhibiting agents with higher bleeding complications. Therefore there is a risk that rivaroxaban would be used in groups of patients poorly represented in the trial and in conjunction with more potent antiplatelet drugs leading to a worse outcome.
I f approved the study drug would probably be initiated in hospital. In the trial the mean start of treatment was 4.6 days. In the UK the majority of STEMI and unstable angina/ NonSTEMI patients are discharged before this time-point making replication of the trial conditions difficult. It would not be reasonable to expect this agent to be started in primary care.
Current treatment protocols mean that ACS patients are already discharged on 5 separate drugs. There is an anxiety that the addition of another bd agent will lead to problems with adherence to other evidence based treatments.

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There are grounds for significant anxiety about the increase in bleeding with the addition of rivaroxaban to standard ACS therapy.