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UK rheumatologists go beyond NICE guidance on cost when treating RA patients

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The results of a study presented today at the European League Against Rheumatism Annual Congress (EULAR 2016) showed that a range of factors other than just cost may influence the prescribing of TNF inhibitors for patients with rheumatoid arthritis (RA). Although clinical guidance produced by the National Institute for Health and Care Excellence (NICE) recommends that RA patients in England should be treated with the lowest cost anti-TNF, in practice, the findings from this English study suggest that a number of other factors may influence treatment choice.

"With so many factors for a consultant rheumatologist to consider when he or she is choosing which anti-TNF therapy to prescribe, this is likely to contribute to a wide variability in treatment received by RA patients in England," said lead author Dr Sean Gavan of the Manchester Centre for Health Economics, United Kingdom.

"Emergence of evidence, interpretation of clinical guidelines, patient involvement in decision making, desire for clinical autonomy and the involvement of clinical service commissioners have all been identified as influencing factors. We now need further research to explore whether these deviations from NICE guidance lead to differences in patient outcomes, or cost-effectiveness of care," Dr Gavan concluded."

Currently, there are several different anti-TNF therapies recommended by NICE as options for treating RA.2 Treatment is usually in combination with methotrexate (assuming it is tolerated and not

contraindicated), but only if there is evidence of severe disease (DAS28 disease activity score greater than 5.1), and the disease has not responded to intensive therapy with a combination of conventional disease modifying antirheumatic drugs (DMARDs).

The cost of most of these anti-TNF therapies are just over £9,000 for a one year course; however, there are some differences in price between different brands, and this may be accentuated by the existence of patient access schemes operating in different parts of the country.

When asked to discuss influences on key treatment decisions, a cross-section evaluation of UK consultant rheumatologists claimed that cost was rarely a factor to influence their choice of first-line anti-TNF, unless use of the least-expensive anti-TNF was imposed by local service commissioners. In contrast, cautious optimism was expressed towards using anti-TNF biosimilars first-line on the grounds of potential cost savings. Patient involvement in decision-making was perceived to be sacrificed in those units where using the cheapest anti-TNF was enforced.

Interpretation of NICE guidance2 varied, with some of the rheumatologists interviewed claiming it was too restrictive, and others seeing benefits in the flexibility it provides. Careful manipulation of the DAS28* disease activity score was cited by many of the interviewees as a way to maintain clinical autonomy and prescribe anti-TNF therapy if they believed it to be clinically appropriate in those RA patients whose disease didn't meet the NICE threshold.

Negotiated local exceptions to NICE guidance also facilitated clinical autonomy, with the use (and success) of individual funding requests for treatments varying between interviewees. Often advances in clinical evidence were used to justify deviations from guidelines. However, the influence of clinical evidence had a lesser role in dose-optimisation

decisions in those RA patients in remission in whom evidence to guide such decisions is limited.

Provided by European League Against Rheumatism