



U.K. Psychiatric Pharmacy Group

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Response to NICE with respect to Appraisal Consultation Document: Donepezil, rivastigmine, galantamine and memantine for the treatment of Alzheimer's disease

1 Authority of this response

1.1 This response has been written by the Committee of the United Kingdom Psychiatric Pharmacy Group and the College of Mental Health Pharmacists

1.1.1 The Group represents about 500 specialist mental health pharmacists in the United Kingdom

1.1.2 The College is the academic and practice subgroup of the UKPPG and acts as the accrediting organisation for specialist mental health pharmacists in the UK

1.1.3 The Groups represent specialist mental health pharmacists involved on a day to day basis with the clinical use of psychotropic medicines.

2 General comments to the consultation proposals

2.1 The Group is troubled that the NICE proposal directly contradicts its previous advice in 2001.

2.1.1 The Group is worried that it is a technology used to treat a mental health condition that has been targeted as one of the few examples where previous NICE technology appraisal advice may be reversed

2.1.2 We suspect that a similar decision would not even be contemplated in other clinical areas, such as cancer. Once again mental health is being stigmatised, and one of the group of patients with least ability to contest the proposal are being targeted

2.2 Your advice is counter to the extensive experience of our members

2.2.1 Specialist mental health pharmacists are aware of the wide variety of symptoms that these drugs can have an effect on.

- 2.2.2 These symptoms go beyond the traditional assessment of cognitive function
- 2.2.3 The memory drugs can improve behavioural problems, reduce anxiety, restore daily living skills as well as improve cognitive function
- 2.3 The Group is concerned that any withdrawal of the memory drugs will represent a retrograde step in service provision in the UK.
 - 2.3.1 The referral of patients will continue now that GP's are familiar with detecting the symptoms of dementia and with referral to memory clinics.
 - 2.3.2 No effective prescription medication will be available if these drugs are removed from use.
 - 2.3.3 The management of behavioural problems has recently been further complicated by the MHRA advice about discontinuing the use of the atypical antipsychotics, olanzapine and risperidone, in people with dementia due to the risk of stroke. The memory drugs have therefore been successfully used to help manage the behavioural symptoms associated with dementia.
 - 2.3.3.1 While the evidence about the atypical antipsychotics in dementia only relates to olanzapine and risperidone, this may well be a class effect with all antipsychotics. A recent independent study was pre-published on the BMJ website about the risks associated with quetiapine [Ballard C, Margallo-Lana M, Juszczak E, *et al.* Quetiapine and rivastigmine and cognitive decline in Alzheimer's disease: randomised double blind placebo controlled trial. *BMJ*, doi:10.1136/bmj.38369.459988.8F (pub 18/2/2005)]
 - 2.3.4 The Group is concerned that these circumstances will lead to an increase in the use of benzodiazepines and typical antipsychotics which would be a retrograde step.
- 2.4 The Group is concerned at the resourcing of the care required by patients who will in future not be allowed the memory drugs.
 - 2.4.1 It is accepted that where these drugs are beneficial, then residential and nursing care costs are reduced, although not eliminated
 - 2.4.2 Current resources for health and social care are already fully utilised and occupied.
 - 2.4.3 Any further pressure on the service arising from the non-use of memory drugs will increase pressure on local health and social care resources.

- 2.4.4 These increased pressures may negate any cost savings made from withdrawing the memory drugs from use.
- 2.5 The Group notes that the cost model wrongly assumed the NHS bears the full cost of institutional care (paragraph 4.2.6.1).
 - 2.5.1 Care is provided mainly by family & carers, and not the state.
 - 2.5.2 Balancing it against reducing institutional admission seems unethical.
 - 2.5.2.1 In comparable situations, the effects of chemotherapy, for example, are not balanced against an admission to a hospice.
- 2.6 The cost savings described in paragraph 6.2 are probably not going to materialise until much later than the proposed 1-2 years.
 - 2.6.1 On average patients stay on these drugs for 3-7 years. We would expect money to not be freed until later than the 1-2 years described
 - 2.6.2 While this is an issue for local negotiation, local services would need assurance that all other memory clinic services will not be affected in the same way.
 - 2.6.3 It may be anticipated that an increased level of resourcing for the memory clinics will be required as they struggle to manage their case load.
- 2.7 The Group is concerned at the stress and suffering that will be caused to current patients, their carers and families while these discussions are ongoing.
 - 2.7.1 The Group seeks as speedy a resolution to the matter as is possible to minimise the distress caused.
 - 2.7.2 The Group is concerned at the potential stress and suffering that will particularly be experienced by those currently undergoing assessment but who have not yet started on treatment.
- 2.8 The Group is aware that the assessment panel considered the evidence of the AD2000 trial [Long-term donepezil treatment in 565 patients with Alzheimer's disease (AD2000): randomised double-blind trial. *Lancet* (2004); **363**: 2105-15]
 - 2.8.1 The methodology was over complex, which lead to poor recruitment resulting in an underpowered study
 - 2.8.2 The Group wishes to remind the assessment panel that there was considerable discussion around the validity of the results in the correspondence pages of the *Lancet* and a specific warning

that the report should "... not unduly affect reappraisal of this class of drugs by NICE, since the results are atypical and are on just one drug." [Holmes C, *et al.* AD2000: design and conclusions. *Lancet* (2004); **364**: 1214]

- 2.9 The Group is troubled that this advice will put the position of the UK at odds with the rest of the developed world
- 2.10 The Group understands that in the case of the cholinesterase inhibitors only the cost effectiveness of the drug is questioned. The Group wants to understand what attempts have been made to reduce drug acquisition costs to rebalance the cost-effectiveness arguments.
- 2.11 The Group is concerned at the impact that this decision will have on the standing on the UK as a centre for future pharmaceutical research and technology advances

3 Need for future research (paragraph 5)

- 3.1 The need for more pragmatic research measures in clinical research
- 3.2 The need for simple validated quality of life measures
- 3.3 A joint industry/NICE study should be considered addressing the cost effectiveness issues highlighted
- 3.4 Efficacy of memantine
- 3.5 Efficacy of combination therapy of cholinesterase inhibitor with memantine
- 3.6 Emphasis the need for full and therefore balanced publication of study data. For example studies producing negative results are not published.

4 Further considerations

- 4.1 Despite the better judgement of the Group, if these drugs are to be discontinued then the guidance should describe
 - 4.1.1 the optimum methods of assessing the efficacy of treatment
 - 4.1.2 the means by which treatment is discontinued to minimise the risk of any discontinuation effects.

5 Conclusions

- 5.1 Your advice is counter to the extensive experience of our members
- 5.2 Many of our members have been involved with both the evaluation and the supervision of these medications.

- 5.3 The reputation of NICE will be severely undermined if it brings forward recommendation that are counter to the experts in the field
- 5.4 We cannot agree with your findings and recommendations

Written by the Committee of the
United Kingdom Psychiatric Pharmacy Group
and the Council of the
College of Mental Health Pharmacists
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