

British Association of Dermatologists

Comments on the appraisal consultation document and evaluation report relating to the use of belimumab for antibody positive systemic lupus erythematosus.

Belimumab, a BlyS specific inhibitor, is licensed in the US for use in antibody positive SLE. A European license has been applied for, and this NICE appraisal is examining the potential role of belimumab in a sub-group of SLE with higher disease activity. I have the following comments:

1. The applicability of combining data from 2 studies in different patient groups from different geographical areas where the characteristics of the patient groups may be different. I agree that this is the case, and the more impressive results from South America etc may well be dependent upon the characteristics of the different patient cohorts. Whether this has relevance to multi-cultural UK is more difficult to say, since non-caucasian patients are very well represented in most LE clinic populations
2. The overall results largely depend on the non-white groups for their positivity, and if the BLISS 76 study is taken alone, there would be little benefit in having belimumab available.
3. The standard of care chosen suggests that cyclophosphamide is not used except for the treatment of nephritis. This is incorrect; it is used for vasculitis and severe skin disease as well. As a consequence, the background therapy used for comparison is too limited. This has particular relevance since the major systems to be benefitted by belimumab in the trials included musculo-skeletal and muco-cutaneous.
4. The descriptive comparisons with rituximab are interesting and valuable, but serve to point out the difficulties of current practice, where clinical trials fail to demonstrate effectiveness of rituximab, but it is a drug still widely used in the management of patients with more severe and persistent disease activity, including vasculitis and particular types of skin involvement, based on a widely held perception that the trials were unreliable and do not reflect experience. In practice, drugs of this nature are funded where clinicians are suitably persuasive on their patients behalf, a situation NICE appraisal was meant to avoid. This leaves NICE with an interesting problem as far as belimumab is concerned, and suggests that their decision, in whichever direction, should be definitive.
5. Even allowing for PAS reductions, this is an expensive drug, and the assumptions made by the manufacturers are all in a direction favourable to its use. It is likely that the impact on additional years of life is less than that assumed, with similar smaller impacts on systems involvement. Against this, the effect on those systems e.g. skin, that do not affect survival, but have a significant effect on quality of life, is under-represented by the NICE analysis, and from a dermatological point of view, this is an area for which there are few effective treatments. The available studies do not adequately define which forms of skin disease may respond, since it is unlikely to be all of them
6. The target group is a post-hoc selection, based on those patients who appeared to respond best. This really needs a further study. It would also be interesting to know if there is a dose response in the activity against skin disease, since if there is, and the 1mg dose was effective, there would be around a 10 fold reduction in cost which would bring the drug into more reasonable costing areas.

7. For what it is worth, I personally doubt if there are currently sufficient supporting data, particularly on cost effectiveness, to justify belimumab's use.

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On behalf of the British Association of Dermatologists