

Professional organisation statement template

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.

<p>About you</p> <p>Your name: Dr Hazel Bell</p> <p>Name of your organisation British Association of Dermatologists</p> <p>Are you (tick all that apply):</p> <ul style="list-style-type: none">- a specialist in the treatment of people with the condition for which NICE is considering this technology? <input checked="" type="checkbox"/>- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)?- 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)

What is the expected place of the technology in current practice?

How is the condition currently treated in the NHS?

Chronic hand eczema (CHE) is largely treated by general practitioners. In occupational disease about 15% of patients are referred to a specialist so this is likely to be similar for all cases. There is a perception that little can be done and consequently patients and GPs may not seek specialist treatment. Response to treatment is often partial.

Correct diagnosis is important as other conditions can masquerade as hand dermatitis including psoriasis and fungal infections. In cases where an allergic cause is suspected, patch testing is required to identify relevant allergens.

Management in primary care consists of explanation about hand protection, avoiding irritants, using soap substitutes, using appropriate gloves for some tasks and frequently and regularly applying emollients. Topical corticosteroids of appropriate strength are normally used for treatment of the inflammatory component. These are frequently of the potent strength, running the risk of skin atrophy. The majority of hand eczema can be successfully managed in this way especially exogenous dermatitis with a remediable causative factor.

Those referred in to secondary care who have failed to respond to topical treatments may be treated with topical Psoralen UVA treatment or systemic therapy. The former requires twice weekly visits to secondary care throughout the two to three month treatment course

Systemic treatments include azathioprine which induces immunosuppression with all it's risks. Patients need regular monitoring as haematopoiesis and liver function tests may be impaired

Ciclosporin is an alternative systemic treatment but lacks a long term licence and is significantly nephrotoxic. It also is immunosuppressive and may cause hypertension and so requires regular hospital monitoring .

Other immunosuppressants include methotrexate and mycophenolate mofetil. Results with immunosuppressant agents are usually adequate but in the most severe chronic cases can be disappointing.

Acitretin is used in hyperkeratotic CHE but is less useful in vesicular CHE. It may cause hyperlipidaemia, hypertriglyceridaemia and is teratogenic so is contra indicated in women of child-bearing potential.

Alitretinoin is a systemic retinoid drug. Dermatologists are familiar with other retinoids acitretin and isotretinoin. They are trained in their use and competent in managing oral retinoids. Particular concern exists around teratogenesis. General practitioners including most General Practitioners with special interest are not so trained or accredited although guidelines in progress will be receptive to special local arrangements under consultant supervision.

Is there significant geographical variation in current practice?

We are not aware of significant variations in practice. However there is no guideline or evidence to direct choice of immunosuppressant agent and dermatologists will vary depending on their experience and familiarity with different interventions.

The only geographic variation may be due to access to PUVA (available only in secondary dermatology care).

Are there differences of opinion between professionals as to what current practice should be?

Not to our knowledge

What are the current alternatives (if any) to the technology, and what are their respective advantages and disadvantages?

See above

Are there any subgroups of patients with the condition who have a different prognosis from the typical patient? Are there differences in the capacity of different subgroups to benefit from or to be put at risk by the technology?

Patients with occupational factors who are unable to modify or leave their current occupation (including homemakers and carers) for socioeconomic reasons are significantly disadvantaged by this condition. They could benefit from this technology

Patients in ethnic groups with a higher incidence of hypertension or renal disease would benefit from a drug that does not risk these side effects.

Patients with atopic eczema may potentially suffer more from the drying effects on the skin.

The pivotal study indicates better responses for hyperkeratotic and finger tip disease 44% and 49% compared to pompholyx 33%, these response rates are however quite consistent with predicted outcomes with the alternative therapies. There is much overlap between different types of hand dermatitis.

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional professional input (for example, community care, specialist nursing, other healthcare professionals)?

Secondary care:.. Access to patch testing in assessing patients for the technology would be important as would access to Occupational Health professionals. Shared care protocols for ongoing therapy to maintain improvement would be appropriate but initial therapy and monitoring would be best done by specialists. Because of teratogenicity, treatment should be restricted to secondary care / consultant dermatology supervision (as for isotretinoin). Ideally, care could be shared with a specialist dermatology nurse for supervision of pregnancy avoidance.

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

The technology has only recently been licensed and so we are not aware of any patient outside a study who has been treated to date. It remains to be seen whether this drug will find a place in other retinoid responsive dermatoses. Depending on cost it may be used if it has a more favourable side effect profile than acitretin in psoriasis/ichthyosis or as an alternative to isotretinoin in acne, however evidence would need to show benefits first.

Please tell us about any relevant **clinical guidelines** and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.

We are not aware of any guideline that addresses either the condition specifically or this technology

The advantages and disadvantages of the technology

NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?

Advantages

No risk of skin cancer compared to PUVA
No risk of hypertension
No risk of nephrotoxicity
No long term immunosuppression
No long term cancer risk
Less frequent visits to hospital than PUVA, ciclosporin or other immunosuppressants (very important in patient of working age)
Longer term licence than ciclosporin
Less frequent monitoring than ciclosporin or other immunosuppressants
Longer treatment course than PUVA
Does not require specialist operator for therapy compared to PUVA

Disadvantages

Hyperlipidaemia (will require monitoring of fasting lipids)
Hypertriglyceridaemia

Thyroid dysfunction (will require monitoring)

Teratogenicity (The MHRA should determine safe practice in the label but this is likely to take the form of a pregnancy prevention plan as exists with isotretinoin currently. Dermatologists are familiar with this.)

If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.

See above: will require less frequent visits and monitoring than many existing treatment options. Possibility of using same group of patients as in the drug trials to position the therapy ie failure of 8 weeks of steroids 4 of which are with highly potent steroids

If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?

The two main studies recruited large numbers of patients in several countries and accurately reflected clinical practice in the UK. Trials appear to have selected an appropriate definition of disease that reflects the heterogeneity of hand dermatitis. Patients were probably commenced on the technology far sooner than they might have received second line therapy under the National Health Service. Patients were accurately and thoroughly assessed and outcomes included quality of life and patient assessment scores. Clear and almost clear are the most relevant outcomes and these were measured.

What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?

The retinoid group of drugs have a long track record in dermatology. Most anticipated side effects apart from that on bone density were anticipated and looked for. Existing retinoids are associated with osteoporosis after long term treatment but this side effect appears to be very rare

A E MacBeth, GA Johnston Twenty-one years of oral retinoid therapy in siblings with nonbullous ichthyosiform erythroderma. *Clinical and Experimental Dermatology* 2008;33:101-191

Headache is a worrying adverse event given that retinoids can increase intra-cranial pressure. Other expected retinoid effects of dry skin, mucosal drying and hyperlipidaemia appear to be of low incidence compared to current retinoids.

Hyperlipidaemia and hypertriglyceridaemia are managed in current patients on existing retinoids with dose alteration, dietary measures and statins.
Those developing thyroid dysfunction would have therapy stopped
There was no evidence of depression with the numbers involved, however this would not rule out rare idiosyncratic depression which is seen with other retinoids.

Any additional sources of evidence

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

Apart from manufacturers data there is no other source of data on this. Some examination of the epidemiology of patients with this severity of hand dermatitis may be found from systematic searching of the literature. However, estimates of dermatitis vary widely and estimates of 7-12% are reasonable.

Implementation issues

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that have been recommended by NICE technology appraisal guidance. This provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within 3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

NICE guidance could greatly improve management of this condition by supplying advice on the specific treatment of CHE
This technology could replace ciclosporin and possibly azathioprine in the management of CHE. Therefore the on-costs to the NHS would be similar, as the cost of the drug (roughly equivalent to ciclosporin) would be offset by decreased visits and monitoring. However there will be a significant number of responders who will need prolonged ongoing monitoring that would have been discharged as "nothing could be done". These patients will benefit in quality of life, employability and productivity but the numbers of return patients seen in dermatology clinics would be increased proportionately to the uptake of the therapy. Response is slow but the mean time to relapse of 5-6 months suggests that the treatment could be discontinued on clearance sparing cost and side effects.

Dermatologists would obtain training through the normal CPD mechanism: no additional resources should be required
Existing dermatology units would have all the expertise and facilities to provide care for these patients who would normally be under hospital care anyway