Spotlight on breast cancer therapy

Cost aside, there are a number of other factors that could promote the delivery of new treatments

Oncologists, clinical leads, pharmacists and research fellows at the Breast Cancer Drugs Funding and Trials event earlier this year discussed how effective the current breast cancer drugs regimen is and how the NHS can ensure new drugs reach patients.

 Britain’s breast cancer patients are losing out, breast cancer charity Pink Ribbon Foundation warned. Current therapies for breast cancer are inadequate and, in the past year, patients have lost out on treatment options as rising costs make breast cancer drugs unaffordable for stretched NHS budgets.

Not cost-effective

As an example, in April, the drug nivolumab was not considered a cost-effective use of NHS resources at £63,200 a year per patient despite being clinically effective, Imperial College London junior research fellow Aleksandra Filipovic informed attendees.

While in December 2016, NICE ruled that the cost of chemotherapy drug Kadcyla (ado-trastuzumab emtansine) at £90,000 a year per patient was too high to justify.

In the future, combination therapy will become the mainstay of cancer treatment says Ms Filippovic.

‘You can’t tackle cancer with one drug,’ she said, adding: ‘Immuno-oncology will activate your own immune system to target cancer cells and your immune system, like a vaccine, to protect you. If there’s a flare up in your body, your immune system will remember to attack it.’

Chair of the NHS England chemotherapy clinical reference group and national clinical lead at the Cancer Drugs Fund (CDF) Peter Clark discussed the new CDF and whether it could lead to earlier patient access.

The CDF has recently made progress – since 1 April 2016, 18 new cancer drug indications have either received positive final guidance from NICE and are now in baseline commissioning, or have received positive provisional recommendations and thus are receiving CDF interim funding.

But changes to NICE’s appraisal process have consequences for NHS England, Professor Clark said. Under NICE’s latest process, NHS England will have the power to delay the introduction of new medicines that cost more than £20 million per year. This could lead to costs being renegotiated or phased introduction of new cancer drugs, Professor Clark suggested.

He discussed the dangers of the restrictions to cancer patients: ‘If a drug comes in with a highly effective cost-effectiveness proposal, it’ll be fast-tracked through, but it won’t apply to any cancer drugs as cancer drugs are priced relatively highly.’

There must be a ‘robust conversation’ between NHS England and pharmaceutical companies on how to manage the introduction of a drug, Professor Clark believes.

He questioned how the national chemotherapy service could be structured and commissioned to be sustainable in the future, and outlined NHS England’s plans to commission with systematic therapy treatment algorithms to reduce variation and improve outcome.
Patient Alison Dagul argued that screening could be crucial to identifying genetic cancer problems such as a potential BRCA gene. Ms Dagul was diagnosed with breast cancer at the age of 52 and discovered she had inherited the BRCA1 gene from her father.

Ms Dagul argued for BRCA screening to be available for all breast cancer patients to pick up BRCA-positive relatives’ pre-cancer to allow preventive surgery. She said lower screening costs would mean it is a more cost-effective option than subsequently treating cancer.

Patient Jo Taylor voiced concerns regarding the inadequate use of data to facilitate research into cure. She stated that having comprehensive statistics and data collection will increase knowledge of prevalence, aid lobbying and facilitate effective drug research.

Ms Dagul added that there is a need for comprehensive statistics and data collection to facilitate effective drug research. She said without knowing the prevalence of breast cancer, there isn’t an option for a ‘sensible plan for treating it’.

**Improving analysis**

A complete and detailed collection of data about every type of cancer is ‘central to our understanding of this complex disease’, said Public Health England national head of cancer registration Rachael Brock.

The National Cancer Registration and Analysis Service (NCRAS) run by Public Health England offers information about the symptoms people have, how their cancer is diagnosed, how they respond to treatment and analyses how their own cancer progresses over time.

‘With a large dataset you get to see the bigger picture because you can compare not just tumour characteristics, but also how certain cancers respond to treatments in people of similar age, gender and so on,’ Dr Brock said.

Cancer patient data are crucial to help with evaluating how particular treatments perform, giving clinicians and commissioners vital information on efficacy to inform their decisions, she added.

‘It allows us to see trends and regional variations in prevalence, outcomes and quality of care. This all helps us increase standards of care nationally,’ she added.

The National Cancer Registration and Analysis Service is starting to collect data on molecular abnormalities with details about individual treatment and prognosis while making the data available to specialists in cancer care.