Analgesic Subcommittee of PTAC meeting held 29 April 2010

(minutes for web publishing)

Analgesic Subcommittee minutes are published in accordance with the *Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) and PTAC Subcommittees 2008*.

Note that this document is not necessarily a complete record of the Analgesic Subcommittee meeting; only the relevant portions of the minutes relating to Analgesic Subcommittee discussions about an Application or PHARMAC staff proposal that contain a recommendation are published.

The Analgesic Subcommittee may:

(a) recommend that a pharmaceutical be listed by PHARMAC on the Pharmaceutical Schedule and the priority it gives to such a listing;
(b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or
(c) recommend that PHARMAC decline to list a pharmaceutical on the Pharmaceutical Schedule.

These Subcommittee minutes were reviewed by PTAC at its meeting on 5 & 6 August 2010, the record of which is available on the PHARMAC website.

Contents

1 Lignocaine presentations

1.1 The Subcommittee noted that PHARMAC staff were reviewing the restrictions and listings of lignocaine presentations in Section B of the Pharmaceutical Schedule and were seeking the Subcommittee's advice to help inform this review.

1.2 The Subcommittee noted that it had previously recommended that lignocaine viscous solution (2%) be listed in Section B of the Pharmaceutical Schedule without any restriction. The Subcommittee reiterated its previous comments that this presentation is difficult to use and considered that it would not be used for anything other than its current Discretionary Community Supply (DCS) list indications (head, neck and oesophageal cancer for up to 9 weeks following radiation therapy) if it was listed in Section B.

1.3 The Subcommittee considered that the restrictions that currently apply to lignocaine hydrochloride injections (0.5%, 5 ml and 1%, 5 ml and 20 ml) – "only if prescribed on a prescription for a dialysis patient or child with rheumatic fever or on a PSO for emergency use" – were historical and served no purpose. The Subcommittee noted that lignocaine hydrochloride injections were low-volume, low-cost items, and considered that if the restrictions were removed the usage would not change. The Subcommittee **recommended** that the restrictions be removed from lignocaine hydrochloride injections at the earliest opportunity.

1.4 The Subcommittee noted that it had previously considered a request for funding of a higher strength of lignocaine hydrochloride injection (2%) because of the high volumes of the 1% solution needed for syringe drivers for palliative care patients, but had deferred making a recommendation pending a review of the lignocaine hydrochloride injection restrictions. The Subcommittee supported the listing of the higher (2%) strength of lignocaine hydrochloride injection and **recommended** that it be listed at the earliest opportunity.

1.5 The Subcommittee **recommended** that all funded presentations of lignocaine injection should be available on a PSO.

1.6 The Subcommittee noted that PHARMAC staff had received a request to add lignocaine urethral syringes (with and without chlorhexidine) to the PSO list. The Subcommittee considered that this request was reasonable and would be unlikely to alter usage in the long-term. The Subcommittee **recommended** that both lignocaine urethral syringe presentations be added to the PSO list.

1.7 Members considered that it would be useful to have lignocaine 5% patches available for use in post-herpetic neuralgia, particularly in the elderly. The Subcommittee noted that this presentation was not registered for use in New Zealand.

2 Ketamine

2.1 The Subcommittee noted that it had previously recommended that ketamine injection be funded subject to Special Authority criteria restricting its use to "last-line" treatment of intractable pain in palliative care, with a high priority. The Subcommittee noted that PHARMAC staff were now seeking its advice to help inform their budget impact analysis (BIA) and cost-utility analysis (CUA).

2.2 The Subcommittee considered that the available evidence for use of ketamine in palliative care was poor, being limited to two published randomised controlled trials (RCT) in a total of 30 patients and several case studies which are likely to be subject to reporting bias (i.e., case studies showing a positive effect are more likely to be reported). The Subcommittee noted that there had been another RCT in the United Kingdom which had been stopped when ketamine was found to show no benefit over placebo, and was never published.

2.3 The Subcommittee noted that it was not unusual in palliative care for there to be limited good data on which to base decisions; however, in this case members were aware of a large ongoing RCT, led by Professor Janet Hardy in Australia, which was being conducted with the purpose of providing evidence to Australia's Pharmaceutical Benefits Advisory Committee (PBAC) around the use of ketamine burst therapy in palliative care. The Subcommittee considered that this trial would provide important information on which to base a funding recommendation and, therefore, considered that it should **defer making a recommendation** in relation to ketamine until the trial data were available.

2.4 The Subcommittee made the following comments in relation to the assumptions in the CUA:

- Most patients would get burst treatment first rather than continuous treatment;
- There is very little information to confirm that the dose regimen modelled would reflect New Zealand clinical practice;
- Patients who do not receive benefit from a first burst treatment are unlikely to be given a second burst treatment;
- Patients who have previously responded to burst treatment may receive an additional burst treatment if the effects of the first wear off;
- There are currently no good data to support a 70% response rate, although this appears to be a reasonable assumption;
- Further clinical information is needed to reliably estimate the benefit of ketamine (i.e., proportion of patients responding);
- There are currently limited data to support a specific reduction in opioid use, but a range of 0% to 25% reduction would be a reasonable assumption.

2.5 The Subcommittee considered that the patient numbers estimated in the BIA were too high, noting that some hospices were only very small. The Subcommittee considered that year one patient numbers would be more like 100–150.

2.6 The Subcommittee considered that a Special Authority would not be a significant impediment to accessing ketamine injection, noting that it would rarely be required in an emergency situation in the proposed indication.

3 Paracetamol sustained-release

3.1 The Subcommittee noted the GlaxoSmithKline, the supplier of paracetamol sustained-release 665 mg tablet (Panadol Osteo), was seeking funding for this product and had provided information for the Subcommittee's review in support of this request.

3.2 The Subcommittee considered that two paracetamol sustained-release 665 mg tablets taken three times daily provides similar efficacy to two paracetamol immediate-release 500 mg tablets taken four times daily. The Subcommittee noted that at those doses, paracetamol sustained-release tablets would cost approximately 10 times the cost of the immediate-release tablets per day.

3.3 The Subcommittee considered that compliance is not usually an issue for symptomatic conditions such as pain, and that a change from four-times-daily to three-times-daily would be unlikely to significantly affect compliance with paracetamol treatment.

3.4 The Subcommittee considered that if paracetamol sustained-release 665 mg tablets were funded they would be widely used and would largely replace the use of paracetamol immediate-release 500 mg tablets given that they were more likely to be marketed heavily than the immediate-release presentation.

3.5 The Subcommittee considered that there was no unmet clinical need for paracetamol sustained-release 665 mg tablets and that they would not provide any significant benefit over paracetamol immediate-release 500 mg tablets.

3.6 The Subcommittee **recommended** that paracetamol sustained-release 665 mg tablets be funded only if the daily cost per patient (assuming a dosing schedule of two tablets taken three times daily) was no greater than the daily cost of the equivalent dose of paracetamol immediate-release 500 mg tablets (two tablets taken four times daily).