Mone y is tight in the NHS and we are facing the greatest financial challenge that many of us can remember. It is timely, therefore, that the issue around the treatment of wet age-related macular degeneration (wet AMD) has reared its head again.

Ensuring that every NHS pound is spent to best effect involves clinicians in CCGs and the front line making complex decisions on the allocation of resources and the relative availability of treatments. Clinicians leading commissioning organisations have responsibility for balancing the needs of the individual with the needs of the wider community.

So, what is it about this issue that has so incensed clinicians that 120 CCGs, co-ordinated by NHS clinical commissioners, have written to the secretary of state, the GMC and Simon Stevens at NHS England, to call for a concerted effort to find a solution?

**Saving millions**

Finding a way around the rules could net us, collectively, in excess of £100 million, which could be spent on improving care for patients. Surely we can’t let this go back onto the “too difficult” pile.

The issue relates to the drugs, ranibizumab (Lucentis) and aflibercept (Eylea), which have both received positive NICE technology appraisals for the treatment of wet AMD, and a third drug bevacizumab (Avastin), that is not licensed for treatment of the eye and that, therefore, cannot be subject to a NICE technology appraisal.

Bevacizumab is licenced for use in bowel cancer but it has been used “off licence” to treat wet AMD in a wide range of settings since 2005. However, the manufacturer of bevacizumab, subsequently developed the related product ranibizumab and successfully obtained a licence for this latter product to be used in patients with wet AMD. Roche, which now owns bevacizumab, has decided not to apply for a licence for bevacizumab to treat any eye conditions.

**Clinicians assume the risk**

Thus once ranibizumab became available in the UK and received positive NICE TA as the only product licensed in the market for this indication, it became the default option for treatment. None of this would matter if it were not for the fact that the manufacturer priced ranibizumab at between 10–20 times as much as the original drug bevacizumab.

Commissioners are obliged to enact NICE TA, and NICE has not considered bevacizumab for wet AMD. Doctors can prescribe unlicensed treatments if those treatments meet the needs of individual patients but the GMC states that this can only happen if “there is no suitably licensed medicine that will meet the patient’s need”. This is clearly not the case with bevacizumab and the current situation means that, without explicit support from the GMC, individual clinicians are assuming the risk if they use bevacizumab to treat AMD. Where these issues don’t exist, ophthalmologists are happy to use bevacizumab in the eye, indeed in the USA bevacizumab is the leading drug for treatment of AMD.

So, is bevacizumab safe and effective? A Cochrane review examined nine studies comparing bevacizumab with ranibizumab for treatment of AMD and found no differences between the two from a safety perspective. The IVAN study is a two-year RCT funded by the National Institute for Health Research Health Technology Assessment (NIHR HTA) and led by a team of scientists and eye specialists from 23 hospitals and UK universities. It has been investigating whether ranibizumab and bevacizumab are equally effective and safe. The trial included 610 people and is one of the largest ever carried out in the field of eye disease in the UK. The study shows sight to be equally well preserved with either of the two drugs and there were no dissimilarities between the two drugs with regards to serious adverse events.

**Must find a way**

So, what are we left with? The manufacturer (understandably has to make a profit) doesn’t want to apply for a licence for bevacizumab, NICE can’t appraise it if it is unlicensed and the GMC only supports the use of unlicensed medications for individual patients if no suitably licensed medication is available but will not support the use of an unlicensed drug over a licensed one simply because it is cheaper.

Surely there must be a way. We must, as a system, be able to find a way to work together to get around these rules. The NHS can’t afford to do anything else and members of the public would be baffled if they knew the sums of money being spent on expensive drugs when there is an alternative available that is cheaper and as effective.

**References**


**Declaration of interests**

None to declare.

*Dr Amanda Doyle is Chief Clinical Officer, NHS Blackpool CCG and Co-Chair, NHS Clinical Commissioners*