Optimising treatment for Australian melanoma patients can save taxpayers millions of dollars annually

To the Editor: Patients with BRAF-mutated metastatic melanoma benefit greatly from the novel BRAF inhibitor dabrafenib and the checkpoint inhibitor ipilimumab, recently listed under the Australian Pharmaceutical Benefits Scheme (PBS). Dabrafenib results in rapid responses; but the cancer later adapts, and patients relapse rapidly. Conversely, ipilimumab slowly reactivates anticancer immunity, meaningfully improving long-term survival (up to around 20% at 5 years).

The costs of these drugs are substantial. Dabrafenib costs A$8759 per month, and median duration of therapy is 9.4 months.1 The Australian price of ipilimumab is confidential, but potentially up to A$190,000 per patient, depending on weight. The 2014 year-to-September PBS cost of ipilimumab was $68,456,890 (data from https://www.medicareaustralia.gov.au/statistics/pbs_item.shtml).

Current PBS approval mandates that dabrafenib may only be used as first-line therapy. Commencing treatment with dabrafenib then switching to ipilimumab when the disease progresses may inadvertently deliver worse outcomes than using the slower but longer acting immunotherapy followed by the potent but impermanent BRAF inhibitor.2,3 After a BRAF inhibitor fails, there is often insufficient time to deliver the full course of ipilimumab, let alone for the immune system to reactivate. While some patients’ symptoms necessitate a BRAF inhibitor upfront, most are well enough to take ipilimumab first, with dabrafenib in reserve.4

Formal randomised trials of these sequences are underway (NCT01940809, NCT01673854, NCT02224781) but our clinical experience and two international case series reinforce that administering ipilimumab then a BRAF inhibitor is very likely to be superior. (Patients treated with BRAF inhibitor then ipilimumab: objective response rate, 0%; stable disease, 6%; progressive disease, 94%.)3 BRAF inhibitor then ipilimumab v ipilimumab then BRAF inhibitor: overall survival, 9.9 months v 14.5 months; P = 0.04.3)

In the absence of a formal economic analysis, we assume most of the approximately 1500 Australian patients who will die with metastatic melanoma every year accept treatment.3 Forty-six per cent of these patients have BRAF-mutated melanoma;4 and of these, 85% are well enough to defer treatment with a BRAF inhibitor. Thus, about 385 patients receive a potentially inferior treatment sequence, and around $36 million per annum of otherwise effective treatment is administered inefficiently.

Other countries with publicly funded health care (eg, the United Kingdom) do not restrict treatment sequences in metastatic melanoma. We argue that, until randomised trials identify inferior or superior sequences, Australian melanoma patients and taxpayers would benefit from flexibility in prescribing these breakthrough treatments.

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Competing interests: No relevant disclosures.
doi: 10.5694/mja14.01202

Termination of pregnancy: a long way to go in the Northern Territory

To the Editor: The Northern Territory’s reproductive health services are fraught with access problems due to remoteness and disadvantage. Staff shortages and high staff turnover in the health workforce are well known.1 With the recent resignation from the public health system of the main termination of pregnancy provider in the Top End of Australia, women’s access to basic reproductive health services could be severely diminished and complicated.

Each year, about 1000 women undergo a termination of pregnancy in the NT. The only...