



**STAKEHOLDER MEETING MINUTES
TRANSCATHETER OCCLUSION OF THE LEFT ATRIAL APPENDAGE (LAA)
Friday, 5 June 2015**

Attendees

Members of the Medical Services Advisory Committee (MSAC), clinicians with experience in managing patients with non-valvular atrial fibrillation (NVAF) and expertise in treating the condition, representatives of Boston Scientific and St Jude Medical Australia, and the Department of Health were in attendance.

1: Meeting open

The MSAC Chair opened the meeting at 1.30pm.

The Chair thanked participants for attending and clarified that the Stakeholder meeting was not an MSAC decision making forum, but would inform the issues considered by MSAC following its November 2014 consideration of application 1347 (transcatheter occlusion of the left atrial appendage for patients with non-valvular atrial fibrillation). The key objective of the meeting was to ensure that those with knowledge of these devices could be involved in discussing the issues raised by the November 2014 MSAC meeting, particularly the appropriate patient population and comparator, to provide a basis for any re-application of a public funding proposal.

The Chair noted that the final minutes of the Stakeholder meeting would be provided to all attendees for input prior to publication on the MSAC website. The Chair indicated that these minutes would not attribute any of the discussion to any identified individual.

Conflicts of interest

The Chair noted the conflicts of interests declared.

2: Background

At its November 2014 meeting, MSAC considered a proposal to publicly fund transcatheter left atrial appendage closure (LAAC) for patients who are contraindicated for oral anticoagulant therapy (OAT) (Application 1347). The application was not supported due to uncertain comparative safety and clinical effectiveness in the short and long term and uncertain cost-effectiveness.

The key areas of uncertainty were the comparative safety and clinical effectiveness of LAAC compared to current standard of care with OAT or oral antiplatelet therapy (OAP).

The meeting noted that Boston Scientific's application to MSAC was seeking a professional service to be listed on the MBS that generically covers for transcatheter occlusion of the left atrial appendage. However, it was raised that there are also non-transcatheter methods of occluding the left atrial appendage. The meeting did not resolve whether these additional interventions should be incorporated into the proposed item descriptor.

3: Discussion

What is the appropriate patient population?

The eligible population proposed in the application was patients with non-valvular atrial fibrillation (NVAf) who are contraindicated for OAT and who have one or more risk factors for developing a stroke. Once the device is implanted, these patients generally also receive clopidogrel 75mg daily and aspirin 300-325mg daily for 6 months post-implant and then remain on aspirin indefinitely.

In discussion, the meeting acknowledged that contraindications to life-long OAT could include both absolute contraindications and relative contraindications. It was considered that relative contraindications were more difficult to establish particularly whether there was true intolerance to therapy or just reflected patient preference. Absolute contraindications were considered to include experiencing a previous major bleeding complication on OAT, a blood dyscrasia or vascular abnormality and that these would be the patients with an existing unmet clinical need who would be most likely to benefit from treatment with the left atrial appendage closure device.

There was concern that a patient at high risk of bleeding on warfarin or the new oral anticoagulants (NOACs) such as apixiban, dabigatran, rivaroxaban would also be at a similar elevated bleeding risk with OAP which is the proposed post-implant treatment. There was discussion on what would be the likely clinical management for this patient population following device implantation. There was particular discussion on what the pathways of care and clinical experiences were in regard to use of the NOACs in relation to the device. Several case studies of patients who have received the device or who are candidates to receive the device were presented. The meeting noted that it was important to restrict the procedures to centres with on-site cardiac surgery to avoid an unsuccessful outcome from an elective procedure.

It was noted that the European Society of Cardiology guidelines recommend use of the CHADS₂ or CHA₂DS₂-VASc scores¹ to determine the risk for stroke and systemic embolism and the HAS-BLED² score to determine bleeding risk. However, the meeting noted the HAS-BLED score was not widely used in Australian clinical practice. After reviewing the scoring system, the meeting also concluded that the score would identify a broader population than the proposed eligible patient population.

Overall, consensus at the meeting was that relevant eligible populations for consideration of public funding of left atrial appendage closure should comprise either:

- any patient who has a contraindication to life-long oral anticoagulation (NOAC or warfarin) or dual antiplatelet therapy because of:
 - (i) a previous major bleeding complication experienced whilst undergoing treatment

1 CHADS₂ and CHA₂DS₂-VASc are scoring systems developed to determine stroke risk in patients with NVAf.

2 HAS-BLED is a scoring system which allows clinicians to assess an individual's risk of bleeding based on comorbidities.

with OAT,
(ii) a blood dyscrasia, or
(iii) a vascular abnormality;
OR

- any patient who has a life-long indication for dual oral anti-platelet therapy.

What is the appropriate comparator?

OAT, particularly warfarin and increasingly the NOACs, is considered the standard of care for stroke prevention.

The current European Society of Cardiology guidelines recommend that patients with AF who have a low risk of stroke should receive either no therapy or aspirin (75mg – 325mg daily). The use of anticoagulation or antiplatelet therapy is not recommended in this patient group. For patients with AF who have a moderate to high risk of stroke, OAT is recommended.

For patients with AF who have a moderate to high risk of stroke and for whom OAT is contraindicated, current standard treatment usually consists of either OAP (either combination aspirin-clopidogrel or aspirin alone) or no OAP (if the clinical circumstances are such that they prohibit the use of any OAP, including aspirin). Noting that the evidence for stroke prevention with aspirin alone in the AF population is weak, combination OAP therapy is likely to be more effective than aspirin alone. However, it was acknowledged that some patients may be at intolerably high risk of bleeding with combination OAP therapy (which would probably be the case in patients with a life-long contraindication to OAT because of increased bleeding risk), therefore are likely to be given aspirin alone.

Taking into account that the appropriate main comparator is generally the medical service that health care providers would most likely replace with the proposed medical service if MBS or other public funding is agreed, consensus at the meeting was that relevant comparators for the proposed eligible populations should be:

- best supportive care (BSC) with or without aspirin – for a patient who has a contraindication to life-long oral anticoagulation (NOAC or warfarin) or dual antiplatelet therapy because of: (i) a previous major bleeding complication experienced whilst undergoing treatment with OAT; OR (ii) a blood dyscrasia; OR (iii) a vascular abnormality; and
- BSC (includes aspirin) – for those patients who have a life-long indication for dual oral anti-platelet therapy.

Trial update

An update on the PREVAIL trial data was presented; it was noted that these data were not meant to be considered as standalone, but would need to be considered in conjunction with any updates from other relevant trials.

4: Outcome

It was agreed that there is an unmet clinical need in the following populations.

The consensus of the meeting was that there were two relevant patient groups with NVAF, each with different comparators, for whom public funding related to the left atrial appendage closure device should be considered:

1. Any patient who has a contraindication to life-long oral anticoagulation (NOAC or warfarin) or dual antiplatelet therapy because of:
 - a previous major bleeding complication experienced whilst undergoing treatment with OAT;
 - a blood dyscrasia; or
 - a vascular abnormality.

The comparator for these patients is best supportive care (BSC) with or without aspirin.

2. Any patient who has a life-long indication for dual oral anti-platelet therapy.
The comparator for these patients is BSC (which includes aspirin, ie aspirin is in both the comparator arm and the LAAC arm).

5: Meeting close

Participants were thanked for their valuable insights and it was hoped that they found the meeting informative.

The meeting closed at 4.00pm.