



## Feedback Survey

### Application 1393 – Cardiac MRI Cardiomyopathy

*Thank you for taking the time to complete this feedback form on a draft protocol to consider the options by which a new intervention might be subsidised through the use of public funds. You are welcome to provide feedback from either a personal or group perspective for consideration by the Protocol Advisory Sub-Committee (PASC) of MSAC when the draft protocol is being reviewed.*

*The data collected will be used to inform the MSAC assessment process to ensure that when proposed healthcare interventions are assessed for public funding in Australia, they are patient focused and seek to achieve best value.*

*This feedback form should take 10-12 minutes to complete.*

*You may also wish to supplement your responses with further documentation or diagrams or other information to assist PASC in considering your feedback.*

*Responses will be provided to the MSAC, its subcommittees and the applicant with responses identified unless you specifically request deidentification.*

*While stakeholder feedback is used to inform the application process, you should be aware that your feedback may be used more broadly by the applicant.*

*Please reply to the HTA Team*

*Postal: MDP 853 GPO 9848 Canberra ACT 2601*

*Fax: 02 6289 3561*

*Phone 02 6289 7550*

*Email: [HTA@health.gov.au](mailto:HTA@health.gov.au)*

*Your feedback is requested by **21 March 2015** to enable the collation of responses to be provided to PASC to consider during its deliberations.*

### PERSONAL AND ORGANISATIONAL INFORMATION

1. What is your name? **\_\_\_\_Professor Paul Bannon President ANZSCTS**
2. Is the feedback being provided on an individual basis or by a collective group?

Individual

Collective group. Specify name of group (if applicable) \_

**Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS)**

What is the name of the organisation you work for (if applicable)? **\_ANZSCTS**

4. What is your e-mail address? **\_\_\_\_[nickdanes@ascts.org](mailto:nickdanes@ascts.org)** (secretariat)

5. Are you a:

a. General practitioner

**b. Specialist – Cardiothoracic Surgeon RPAH**

c. Researcher

d. Consumer

e. Care giver

f. Other (please specify) \_\_\_\_\_



**MEDICAL CONDITION (DISEASE):**      **Non-ischemic Cardiomyopathy**

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**PROPOSED INTERVENTION:**              **Cardiac Magnetic Resonance Imaging (CMRI)**

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## CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

- 1) Describe your experience with the medical condition (disease) and/or proposed intervention relating to the draft protocol?

*CMRI is now widely used in the assessment of cardiomyopathy and in pre- cardiac surgery cohorts. Surgically it is imperative when operating on patients with cardiomyopathy to have an accurate assessment of left and right ventricular function and size – for which CMRI is superior to echocardiography. Furthermore the ability to differentiate ischaemic and non-ischaemic cardiomyopathy is crucial for risk stratifying patients undergoing cardiac surgery. There are also several pathologies for which surgical treatment is preferable such as functional mitral regurgitation, HOCM, restrictive pericarditis / cardiomyopathy for which CMRI offers gold standard imaging.*

*There is now sufficient understanding of CMRI among cardiac surgeons that it is often requested by the surgeon prior to performing an operation.*

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- 2) What do you see as the benefits of this proposed intervention for the person involved and/or their family and carers?

*The ability to accurately risk stratify patients undergoing cardiac surgery allows the patient to receive more accurate assessments of risk and avoid interventions which may in fact offer more harm than benefit. Furthermore the accurate diagnosis and imaging of various pathologies allows improved preoperative planning leading to lower risk and more successful operations.*

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- 3) What do you see as the disadvantages of this proposed intervention for the person involved and/or their family and carers?

*No disadvantage identified*

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- 4) How do you think a person’s life and that of their family and/or carers can be improved by this proposed intervention?



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*The imaging of non-ischaemic cardiomyopathy by CMRI will assist in identifying the correct diagnosis. This will in turn identify the correct course of treatment such as immunosuppression, surgery, implantable defibrillator, cardiac transplantation etc.*

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- 5) What other benefits can you see from having this proposed intervention publicly funded on the Medicare Benefits Schedule (MBS)?

*The expansion of access by an increase in the number of centres who offer CMRI will add benefit. Also the MBS funding will remove access limitations caused by the current user pays environment*

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### INDICATION(S) FOR THE PROPOSED INTERVENTION AND CLINICAL CLAIM

Flowcharts of current management and potential management with the proposed intervention for these medical conditions can be found on pages 19 (dilated cardiomyopathy), 23 (hypertrophic cardiomyopathy), 28 (arrhythmogenic right-ventricular cardiomyopathy), 32 (troponin-positive chest pain), and 35 (family history).

- 6) Do you agree or disagree with the eligible populations for the proposed intervention as specified in the proposed management flowcharts?

- Strongly agree **Yes**
- Agree
- Disagree
- Strongly disagree

Why or why not? Please specify which sub-population(s) you wish to comment on.

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- 7) Do you agree or disagree with the comparators for the proposed intervention as specified in the current management flowcharts?

- Strongly agree **Yes**
- Agree
- Disagree
- Strongly disagree

Why or why not? Please specify which comparators you wish to comment on.

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- 8) Do you agree or disagree with the clinical claims (outcomes) made for the proposed intervention?

- Strongly agree **Yes**
- Agree



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- Disagree
- Strongly disagree

Why or why not? Please specify which outcomes you wish to comment on.

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9) Have all associated interventions been adequately captured in the flowcharts?

- Yes **Yes**
- No

If not, please move any misplaced interventions, remove any superfluous intervention, or suggest any missing interventions to indicate how they should be captured on the flowcharts. Please explain the rationale behind each of your modifications.

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### ADDITIONAL QUESTIONS FOR PASC SPECIFIC TO THIS PROPOSAL.

The application notes that for some sub-populations the benefits of CMRI, in terms of any potential change in management compared to comparators, can be difficult to quantify. The benefits of the change in management to patient health outcomes are similarly difficult to define. Where possible, the applicant has provided an estimate based on clinical expertise.

- 10) Do you agree or disagree with the quantitative estimates of the impact that CMRI has on treatment outcomes in Australia for all of the sub-populations?

*We would agree. If anything it is likely underestimating its positive impact to date.*

- 11) Would you suggest any alternative estimates? Please provide sources if possible.

N/A

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The application raises concerns regarding the availability of appropriate CMRI equipment.

- 12) Please highlight specific concerns about the availability of CMRI equipment or the capacity to upgrade existing equipment with CMRI components.

N/A

- 13) Do you think that the quality of images produced using thoracic coils is equivalent to the quality of images produced using cardiac coils? If not, please indicate if there are any scenarios in which the difference would impact on clinical management.

N/A

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Public consultation feedback is sought to determine whether there is a more robust way to estimate the size of each proposed population, and to confirm whether all of the costs/resources associated with the proposed service have been captured:

- 14) It is currently unclear what the estimated utilisation of CMRI for the investigation of cardiomyopathies is likely to be, specifically in regards to the size of each proposed population. Limitations in the epidemiological data of disease incidence and prevalence make it difficult to estimate the number of new cases likely to utilise the proposed service. The population estimates for the sub-populations are based on hospital separations (see pages 9-10). There is little data available to corroborate these estimates. Do you agree or disagree with the estimates provided? Is it possible to provide a more robust estimate of the expected utilisation of CMRI in each population?



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15) It is unclear what proportion of family members will choose to undergo CMRI following a confirmed diagnosis of a familial cardiomyopathy subtype or sudden cardiac death in a first-degree relative (excluding Population Four). Is there a reliable way to estimate the size of these populations?

N/A

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16) Are there any costs or resources associated with the proposed service, comparators, or treatments that have not been captured in Table 8?

Nil

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17) Should the proposed MBS items be expanded to allow GP referral? Do you have any comments on the appropriate training requirements for referring doctors?

*No, the referral process should be specialist based. As documented above this should include both cardiologists and cardiothoracic surgeons. Education regarding the uses and benefits of CMRI is already included in the training programs of both these specialties.*

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### ADDITIONAL COMMENTS

18) Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed intervention?

*The referral for CMRI should be restricted to specialists. In the majority of cases this would be cardiologists however should also include cardiothoracic surgeons. Should surgeons not be included then the pathway to obtaining a pre-operative CMRI would require referral back to the cardiologist to obtain a scan – adding time and cost to the process.*

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19) Do you have any comments on this feedback form and process? Please provide comments or suggestions on how this process could be improved.

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***Thank you again for taking the time to provide your valuable feedback.***

*If you experience any problems completing this on-line survey please contact the HTA Team*



**Australian Government**

**Medical Services Advisory Committee**  
Protocol Advisory Sub-committee

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