Minutes of second aHUS Rare Disease Working Group (RDWG)
Held during Complement UK meeting Thurs 24th October 2013 17.45-18.45

Attendees

TG – Tim Goodship (Chair)
PB – Paul Barlow
CH – Claire Harris
KM – Kevin Marchbank
PM – Paul Morgan
DK – David Kavanagh
AR – Anna Richards (Minutes)
NS – Neil Sheerin
LW – Len Woodward (aHUSUK)

Apologies

Terry Cook
Sally Johnson
Steve Perkins
Matthew Pickering
Marie Scully
Paul Warwicker
Aoife Waters

Agenda

Introductions
Review of minutes
Registries
Biobank
Data fields for aHUS RaDaR
Suggestions for projects by the aHUS RDWG
Fund raising
AOB

Introductions

All members of the group introduced themselves and their fields of active research interest. The group welcomed Len Woodward, a Founding Trustee and representative from the Patient and Family Support Group aHUSUK. Len described the work of aHUSUK since its inception 2 years ago. This has included creation of the aHUSUK website; submissions to AGNSS, CPAG and NICE; lobbying and media coverage of aHUS and development of a Patient Information card to alert medical practitioners to the possibility of aHUS in affected patients and family members. TG praised the significant achievements of the group.

TG summarised the current situation regarding Eculizumab availability in the UK. Eculizumab was reviewed by AGNSS under National Specialist Services scheme (England) in 2013. Its use was recommended by AGNSS but the Health Minister Lord Howe asked for more information on affordability and referred it to NICE. In April 2013, NHS England approved the interim use of Eculizumab use in new aHUS patients and in Sept 2013 it was approved for all patients who need it in England. A decision from NICE is expected in 2014. Currently some patients in Scotland and Northern Ireland are getting access to Eculizumab through Individual Patient Requests (IPRs). A paper on Eculizumab use has been submitted to the Welsh government.

Review of Minutes from meeting 1st March 2013

TG raised concern about the request for inclusion of post-transplant TMA in diagnostic criteria. NS and DK felt current screening criteria for the use of Eculizumab for NHS England would exclude inappropriate usage. This will be kept under review.

Paul Warwicker (adult nephrologist) and Len Woodward (aHUSUK representative) have accepted the invitation to join the group.

Registries

TG discussed that the main aim of RaDaR is to identify patients with rare renal diseases in the UK. 10 paediatric units are subscribed and are entering data on paediatric aHUS patients. There are 60-70 adult units and identifying rare disease patients has been much more difficult. There are currently 4 pilot adult sites (Newcastle, Exeter, Manchester, Birmingham) which have recruited only 10 aHUS patients so far. Recruitment is done by research nurses, computer system needs refining. In contrast, Alexion's International CRO Registry has recruited 41 patients in the UK. The RaDaR consent form should cover electronic transfer of data from Alexion Registry to RaDaR. If the National Service is approved for aHUS there will be a joint registry between Newcastle and a patient's base hospital.

LW emphasised that aHUSUK supports the patient registries. TG clarified that not all patients in the Registry are on Eculizumab. NS advised that patients have to be on MyRenalView (RenalPatientView) to be included.

Biobank

TG has contacted William Ouwehand and confirmed serum and DNA from aHUS patients can be placed in the central NIHR-funded Biobank in Cambridge. This is seen as the best solution and TG is working to get this set up but the registry is needed first.

Data fields for aHUS RaDaR

TG proposed that the data fields for aHUS RaDaR are Genetics/Autoantibodies/NHS Demographics. Requests were made to add renal biopsy and ADAMTS13 levels. However, TG has reviewed data entry on RaDAR. The more fields that are required, the less data is entered. NS commented that Research Nurses have stopped filling in the many MPGN Rare Disease registry fields. TG's goal is therefore to aim for 3-4 data fields to aid completeness. A National Specialist Centre for aHUS would aid and increase data completeness. TG is now focusing on Registry and Data fields for aHUS.

Suggestions for projects by the aHUS RDWG

1) TG would like to perform a clinical descriptive study of aHUS cohort patients in the UK. NS felt a more detailed data set than that outlined above will be needed to allow phenotyping of patients for such a cohort study. DK commented on the significant workload involved in collection of this data set. NS highlighted that once patients are registered in RaDaR, consent allows further contact to be made to collect additional information if necessary.

2) DK proposed studying C3NeF in aHUS patients. TG said the French cohort has already been studied.

3) KM proposed looking for autoantibodies to C3b

4) TG proposed a study specifically examining the outcome for UK patients with Factor H autoantibodies in collaboration with the British Association of Paediatric Nephrology (BAPN). The French cohort with anti-FH antibodies commonly receives immunosuppression, for example, with cyclophosphamide. This is not done routinely in the UK, and antibody titres seem to decrease over time and patients have been transplanted without problem.

Fund raising

LW highlighted that members of aHUSUK do fund raising for research for 2 charities, Kidney Research UK (KRUK) and the Foundation for Children with aHUS but members would like to do something specific for UK aHUS research. TG suggested that this could be done by ring fencing funds for aHUS within the KRUK umberella, then nationally advertising a specific call for aHUS projects to a budget of £200,000, to be peer-reviewed through KRUK. PM suggested that the Medical Research Council (MRC) would provide matched

funding and the scheme could then be matched and peer-reviewed through the MRC. This was felt to be a very attractive model. Each group member then summarised their individual area of research focus for which such funding may be sought. LW asked about collaborations. TG highlighted current collaborations such as the European Working Group in Complement and Renal Disease to which many members of this group also belong.

AOB

1) There was further discussion about the Alexion Registry. TG advised that the FDA/EMA and also NICE mandates that such long term regulatory data is collected.

2) LW discussed Genomics England call for projects for Whole Genome Sequencing. A mother/father and affected patient are screened. aHUS may be a relevant candidate condition here for patients with unidentified mutations.

3) NS discussed the NIHR Rare Diseases call. TG confirmed involvement in this and identified it as a possible source of funding for the phenotyping of aHUS patients.

4) Future meetings – it was proposed that there would be a 6 monthly Skype meeting and face to face meeting at the biennial Complement UK meetings.