NHS Devon

NICE Update Bulletin: April 2026

This bulletin includes details of the following new and updated NICE guidance – click on the titles below for further details:

1. **Belantamab mafodotin with bortezomib and dexamethasone for previously treated multiple myeloma TA1149**
2. **Vorasidenib for treating astrocytoma or oligodendroglioma with IDH1 or IDH2 mutations after surgery in people 12 years and over TA1147**
3. **Ripretinib for treating advanced gastrointestinal stromal tumours after 3 or more kinase inhibitors TA1146**
4. **Pembrolizumab for neoadjuvant and adjuvant treatment of resectable locally advanced head and neck squamous cell carcinoma TA1145**
5. **Subcutaneous spesolimab 1-ml formulation for preventing generalised pustular psoriasis flares in people 12 years and over (terminated appraisal) TA1144**
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7. **Ovarian cancer: recognition and initial management CG122 (UPDATE)**
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Technology Appraisals (TAs)

Belantamab mafodotin with bortezomib and dexamethasone for previously treated multiple myeloma TA1149

Recommendation

Belantamab mafodotin plus bortezomib and dexamethasone **can be used** as an option to treat multiple myeloma in adults if:

- they have only had 1 previous line of treatment, and
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with belantamab mafodotin plus bortezomib and dexamethasone that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Multiple myeloma is a form of cancer that arises from plasma cells (a type of white blood cell) in the bone marrow. Myeloma cells produce large quantities of an abnormal antibody, known as paraprotein. Unlike normal antibodies, paraprotein has no useful function and lacks the capacity to fight infection. Myeloma cells supress the development of normal blood cells that are responsible for fighting infection (white blood cells), carrying oxygen around the body (red blood cells) and blood clotting (platelets). The term multiple myeloma refers to the presence of more than one site of affected bone at the time of diagnosis. People with multiple myeloma can experience bone pain, bone fractures, tiredness (due to anaemia), infections, hypercalcaemia (too much calcium in the blood) and kidney problems.

Approximately 5,000 people are diagnosed with multiple myeloma in England each year (2016 to 2018 data). Five-year prevalence of multiple myeloma in the UK is estimated to be 26 per 100,000. It is most frequently diagnosed in older people, with about 43% of new cases of multiple myeloma in England in people aged 75 years or older. The 10-year survival rate for people with multiple myeloma in England is estimated to be 29%. The incidence rates are reported to be lower in the Asian ethnic group, higher in the Black ethnic group, and similar in people of mixed or multiple ethnicity, compared with the White ethnic group, in England (2013-2017 data).

The main aims of therapy are to prolong survival and maintain a good quality of life by controlling the condition and relieving symptoms. If the condition progresses after initial treatment, the choice of subsequent therapy is influenced by previous treatment and response to it, duration of remission, comorbidities and patient preference.

Belantamab mafodotin in combination with bortezomib and dexamethasone is indicated for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.

Usual treatment for multiple myeloma at second line includes:

- daratumumab plus bortezomib and dexamethasone, when lenalodomide is not an option
- carfilzomib plus dexamethasone
- carfilzomib plus lenalidomide and dexamethasone
- selinexor plus bortezomib and dexamethasone, if the multiple myeloma is refractory to both daratumumab and lenalidomide.

Financial Factors

This technology is commissioned by NHS England.

The list price for belantamab mafodotin is £16,848 per 100-mg vial and £11,784 per 70-mg vial.

The company has a commercial arrangement. This makes belantamab mafodotin available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

Evidence shows that belantamab mafodotin plus bortezomib and dexamethasone increases how long people have before their condition gets worse compared with daratumumab plus bortezomib and dexamethasone. The evidence also suggests that people live longer. But the trial is ongoing, so this is uncertain.

There will be additional capacity needs because the NHE England Cancer Drugs Fund clinical lead highlighted that everyone must have in the first year of treatment:

- an ophthalmic eye exam before each of the first 4 doses of belantamab mafodotin
- subsequent monitoring for eye-related adverse events.

There may be a capacity savings because fewer administrations are needed for belantamab mafodotin plus bortezomib and dexamethasone than with daratumumab plus bortezomib and dexamethasone.

NICE estimate that in year 3, 37 people in Devon will be eligible for treatment, with 9 having belantamab mafodotin with bortezomib and dexamethasone each year.

Sodium zirconium cyclosilicate for treating hyperkalaemia TA1148

This guidance updates and replaces NICE technology appraisal guidance on sodium zirconium cyclosilicate for treating hyperkalaemia (TA599).

Recommendation

Sodium zirconium cyclosilicate **can be used** as an option for treating hyperkalaemia in adults only if used:

- in emergency care for acute life-threatening hyperkalaemia alongside standard care or
- for persistent hyperkalaemia in people with chronic kidney disease stage 3b to 5 or heart failure, if they:
    - have confirmed serum potassium level of at least 5.5 mmol per litre and
    - because of hyperkalaemia, are not taking an optimised dosage of renin-angiotensin aldosterone system (RAAS) inhibitor and
    - are not on dialysis.

This recommendation is not intended to affect treatment with sodium zirconium cyclosilicate that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Hyperkalaemia refers to an abnormally high level of potassium in the blood (normal range 3.5 to 5.0 millimoles per litre [mmol/L]). The European Resuscitation Council classifies hyperkalaemia as mild (serum potassium level of 5.5 to 5.9 mmol/l), moderate (6.0-6.4 mmol/l) or severe (6.5 mmol/l and above). Many people with hyperkalaemia may not have any symptoms, while some people may have muscle weakness, muscle stiffness or fatigue. Severe hyperkalaemia can cause irregular heart beat (arrhythmia) leading to cardiac arrest and death.

Hyperkalaemia usually occurs in people with impaired kidney function which may be caused by acute kidney injury or chronic kidney disease. Chronic kidney disease is prevalent among people with diabetes or chronic heart failure. Hyperkalaemia is common among people with end-stage renal disease and in older people. The risk of hyperkalaemia is increased further by medicines such as potassium supplements, inhibitors of renin–angiotensin–aldosterone system that include angiotensin converting-enzyme inhibitors (ACE), angiotensin II receptor blockers (ARB) and potassium-sparing diuretics. These medicines are used to treat high blood pressure and heart failure in people with chronic kidney disease. Some people with chronic kidney disease have chronic acidosis, which is treated using sodium bicarbonate which would lower the risk of hyperkalaemia.

The prevalence of hyperkalaemia in adults is about 6% while the incidence is 2.8 cases per 100 person-years. The prevalence of adult hyperkalaemia in outpatient or primary care settings is about 5%. Between 1% and 10% of hospital inpatients have hyperkalaemia. Hyperkalaemia is observed in about 10% of people using ACE inhibitors and ARBs.

Treatment options for mild and moderate hyperkalaemia include a low-potassium diet and stopping medicines that cause hyperkalaemia.

Sodium zirconium cyclosilicate is indicated for the treatment of hyperkalaemia in adult patients.

Usual treatment for persistent hyperkalaemia with a serum potassium level between 5.5 mmol per litre and up to 6.0 mmol per litre is:

- dietary changes to maintain normal potassium levels, and
- reducing the dosage of medicines being taken for chronic kidney disease or heart failure, such as RAAS inhibitors.

Financial Factors

This technology is commissioned by ICBs.

The list price of sodium zirconium cyclosilicate is £10.40 per 10-g sachet or £5.20 per 5-g sachet, with a year 1 treatment cost of £2,151 per patient, and £2,088 for subsequent years.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

Sodium zirconium cyclosilicate is an oral treatment and NICE do not expect additional costs of prescribing as this is covered in the outpatient care management costs for a hyperkalaemia event.

Clinical trial evidence suggests that people having sodium zirconium cyclosilicate are less likely to have to reduce their renin-angiotensin aldosterone system (RAAS) inhibitor dosage than people making dietary changes alone. The evidence also suggests that sodium zirconium cyclosilicate may lower the chance of adverse outcomes, such as hospitalisation, major adverse cardiac events and death.

NICE estimate that in year 3, 270 people in Devon will be eligible for treatment, with 162 people having sodium zirconium cyclosilicate each year.

Vorasidenib for treating astrocytoma or oligodendroglioma with IDH1 or IDH2 mutations after surgery in people 12 years and over TA1147

Recommendation

Vorasidenib **can be used** as an option to treat grade 2 astrocytoma or oligodendroglioma in people 12 years and over when:

- the cancer has a susceptible isocitrate dehydrogenase (IDH) 1 or IDH2 mutation
- the person has had surgery and does not immediately need chemotherapy or radiotherapy, and
- the company provides vorasidenib according to the commercial arrangement.

Stop vorasidenib if the cancer progresses and in line with the stopping criteria in the marketing authorisation.

This recommendation is not intended to affect treatment with vorasidenib that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Gliomas are the most common type of primary brain tumour. They develop from the glial stem cells that support the nerve cells of the brain and spinal cord. The 3 main types of glioma in adults are astrocytoma (IDH mutant), oligodendroglioma (IDH mutant) and glioblastoma (IDH wildtype). Astrocytomas can be categorised into grade 2, 3 or 4, depending on how quickly they are likely to grow, and oligodendrogliomas can be categorised into grade 2 or 3. IDH mutant means that there are mutations in the IDH (isocitrate dehydrogenase) gene. There are 2 main types of IDH mutation that are found in gliomas. These are IDH1 and IDH2 mutations, which can be found in nearly 80% of grades 2 and 3 oligodendrogliomas and astrocytomas.

There are around 12,700 new cases of brain tumour each year in the UK. In England, between 1995 and 2017, around 9% of brain tumours diagnosed were astrocytomas,4 and around 3% diagnosed were oligodendrogliomas. 10-year survival for people with a brain tumour is 11%.

Treatment for glioma depends on the grade of the tumour, where the tumour is in the brain, if it is possible to remove the tumour with surgery, age and if symptoms are present.

Vorasidenib is indicated for the treatment of Grade 2 astrocytoma or oligodendroglioma with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation or isocitrate dehydrogenase-2 (IDH2) mutation in adults and paediatric patients 12 years and older, who are not in need of immediate chemotherapy or radiotherapy following surgical intervention.

Usual care for grade 2 astrocytoma or oligodendroglioma with an IDH1 or IDH2 mutation for people whose cancer has not progressed (got worse) and who do not immediately need chemotherapy or radiotherapy after surgery is active surveillance.

Financial Factors

This technology is commissioned by NHS England.

The list price of a 30-tablet pack of vorasidenib is £15,000 for 40-mg tablets and £7,500 for 10-mg tablets.

The company has a commercial arrangement. This makes vorasidenib available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on the technology being classified as high cost.

Clinical trial evidence shows that vorasidenib increases how long people have before their cancer gets worse compared with placebo. But it is uncertain whether vorasidenib affects how long people live. People in the clinical trial stopped treatment with vorasidenib when the cancer got worse.

There will be a capacity benefit due to a reduction in seizure management in people having vorasidenib.

Ripretinib for treating advanced gastrointestinal stromal tumours after 3 or more kinase inhibitors TA1146

This guidance updates and replaces NICE technology appraisal guidance on ripretinib for treating advanced gastrointestinal stromal tumour after 3 or more treatments (TA881).

Recommendation

Ripretinib **can be used**, within its marketing authorisation, as an option to treat advanced gastrointestinal stromal tumours (GISTs) in adults after 3 or more kinase inhibitors, including imatinib. Ripretinib can only be used if the company provides it according to the commercial arrangement.

The Technology

Gastrointestinal stromal tumours (GIST) are a rare type of soft tissue sarcoma (a cancer of mesenchymal cells which are undifferentiated cells that give rise to most tissues, such as skin, blood or bone), which develops in the digestive tract (most frequently in the stomach and small intestine but can arise anywhere along the gastrointestinal tract). GIST are aggressive tumours and in advanced GIST the tumours will have begun to spread to other parts of the body (such as the liver or peritoneum). In over 85% of cases, the cancer cells associated with GIST are found with an activating mutation in either the tyrosine kinase CD117 (KIT) or platelet derived growth factor receptor alpha (PDGFRA) gene.1 There are around 900 new cases of GIST each year in the UK.2 Although GIST can occur at any age, the median age at diagnosis is around 60 to 65 years.

The preferred treatment used for GIST when appropriate is surgery to remove the tumour. However drugs known as tyrosine kinase inhibitors can be used to treat tumours that are too large to be removed safely, or those that have already spread to other parts of the body. There are several pharmacological options for advanced GIST.

Ripretinib is indicated for the treatment of adult patients with advanced gastrointestinal stromal tumour (GIST) who have received prior treatment with three or more kinase inhibitors, including imatinib.

Financial Factors

This technology is commissioned by NHS England.

The list price of ripretinib is £18,400 per 30-day supply (excluding VAT; company submission). This is based on a 150-mg dose once daily (3 x 50-mg tablets).

The company has a commercial arrangement. This makes ripretinib available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on whether the technology is classified as high cost.

The key drivers of resource impact are:

- Usual treatment for advanced gastrointestinal stromal tumours (GISTs), after the tyrosine kinase inhibitors imatinib, sunitinib and regorafenib, is best supportive care. Before this recommendation, there were no lines of pharmacological treatment recommended after third-line treatment. Ripretinib introduces a fourth-line treatment option, so will result in additional drug costs.
- Ripretinib is an oral treatment but will need outpatient monitoring. Because the patient population is small, the impact on oncology clinics will be negligible.

Pembrolizumab for neoadjuvant and adjuvant treatment of resectable locally advanced head and neck squamous cell carcinoma TA1145

Recommendation

Pembrolizumab **can be used**, within its marketing authorisation, as an option to treat resectable locally advanced head and neck squamous cell carcinoma in adults whose tumours express PD-L1 with a combined positive score of 1 or more:

- as neoadjuvant monotherapy
- then as adjuvant treatment with radiotherapy, with or without cisplatin
- then as monotherapy.

Pembrolizumab can only be used if the company provides it according to the commercial arrangement.

The Technology

Head and neck cancer is a heterogenous group of malignant tumours that arise in the head and neck at the following sites: skin and lip, oral cavity, oropharynx, larynx, hypopharynx, nasopharynx, salivary glands, nasal cavity and paranasal sinuses, and external auditory meatus and middle ear. The most common histological type of head and neck cancer is squamous cell carcinoma (approximately 90%), particularly that affecting the oral cavity, oropharynx and larynx. Although the local metastases of head and neck cancer occur frequently (usually spreading through the lymphatic system in the neck), distant metastases are less common.

In 2022, there were approximately 11,417 cases of head and neck cancer diagnosed in England. The development of head and neck cancer is associated with tobacco, alcohol and other environmental and dietary factors. Survival depends on several factors, mainly the origin of the cancer and the stage of the disease at diagnosis. In 2020, there were 2,669 deaths from head and neck cancer in England.

Pembrolizumab as monotherapy is indicated for the treatment of resectable locally advanced head and neck squamous cell carcinoma as neoadjuvant treatment, continued as adjuvant treatment in combination with radiation therapy with or without concomitant cisplatin and then as monotherapy in adults whose tumours express PD-L1 with a CPS ≥ 1.

Financial Factors

This technology is commissioned by NHS England.

The list price is £2,630.00 per 100 mg vial.

The company has a commercial arrangement. This makes pembrolizumab available to the NHS with a discount. The size of the discount is commercial in confidence.

The payment mechanism for the technology is determined by the responsible commissioner and depends on whether the technology is classified as high cost.

The key drivers of the resource impact are:

- The recommendation introduces a neoadjuvant treatment option for resectable locally advanced head and neck squamous cell carcinoma in adults whose tumours express PD-L1 with a combined positive score of 1 or more and so changes the treatment pathway, with the introduction of immunotherapy treatment prior to surgery.
- The recommendation introduces an option to use pembrolizumab in the adjuvant setting alongside radiotherapy with or without cisplatin and then as a monotherapy. Radiotherapy with or without cisplatin is the current established adjuvant treatment option, so the addition of pembrolizumab will increase adjuvant drug and administration costs. Clinical teams have significant experience in the delivery of pembrolizumab and management of people having treatment with immunotherapy.

- There will be an increased need for PD-L1 testing and it will need to be done earlier in the treatment pathway because this is needed before treatment with pembrolizumab. Because NICE technology appraisal guidance 661 already recommends pembrolizumab for untreated metastatic or unresectable recurrent head and neck squamous cell carcinoma, there is already some PD-L1 testing being done, which may offset the numbers being tested because of this recommendation.

NICE estimate that in year 3, 35 people in Devon will be eligible for treatment.

Subcutaneous spesolimab 1-ml formulation for preventing generalised pustular psoriasis flares in people 12 years and over (terminated appraisal) TA1144

NICE is **unable to make a recommendation** on subcutaneous spesolimab (Spevigo) 1-ml formulation for preventing generalised pustular psoriasis flares in people 12 years and over. This is because the company did not provide an evidence submission.

Highly Specialised Technology Guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Acne vulgaris: management NG198 (UPDATE)

April 2026: NICE amended recommendations 1.5.19 and 1.5.20 to remove the need for 2 independent healthcare professionals to approve the use of isotretinoin in people under 18 years because this is no longer a regulatory requirement. Instead, the Medicines and Healthcare products Regulatory Agency (MHRA) has introduced alternative risk minimisation measures. Links to MHRA safety advice and the isotretinoin acknowledgement of risk form have been updated accordingly.

This guideline covers management of acne vulgaris in primary and specialist care. It includes advice on topical and oral treatments (including antibiotics and retinoids), treatment using physical modalities, and the impact of acne vulgaris on mental health and wellbeing.

Ovarian cancer: recognition and initial management CG122 (UPDATE)

April 2026: Recommendations in section 1.1 on the detection of ovarian cancer in primary care have been removed from this guideline because they have been updated in section 1.5 of the NICE guideline on suspected cancer.

NICE also added links to relevant technology appraisal guidance in the section on managing advanced (stage 2 to 4) ovarian cancer and simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines.

This guideline covers detecting, diagnosing and treating women (aged 18 and over) who have, or are suspected of having, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer or borderline ovarian cancer. It aims to enable earlier detection of ovarian cancer and improve initial treatment.

Menopause: identification and management NG23 (UPDATE)

April 2026: NICE amended recommendation 1.8.4 and added a new recommendation (1.8.5) to align with the advice on unscheduled vaginal bleeding while taking systemic HRT in NICE's guideline on suspected cancer.

This guideline covers identifying and managing menopause, including in people with premature ovarian insufficiency. It aims to improve the consistency of support and information provided to people experiencing menopause.

Suspected cancer: recognition and referral NG12 (UPDATE)

April 2026: In the gynaecological cancers section, NICE reviewed the evidence and amended recommendations 1.5.6 to 1.5.9, and 1.5.11 on ovarian cancer age and serum CA125 thresholds, and recommendations 1.5.12, 1.5.14 and 1.5.15 on endometrial cancer.

In the symptoms of concern in adults section, NICE reviewed the evidence and amended recommendation 1.13.2 on non-site-specific weight loss.

This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer.

Public Health Guidelines

None published this month.

Antimicrobial Prescribing Guidelines

None published this month.

Social Care Guidelines

None published this month.

HealthTech guidance (HTGs)

Transvenous embolisation for spontaneous intracranial hypotension caused by a cerebrospinal fluid–venous fistula HTG777

Recommendations

Transvenous embolisation **can be used** in the NHS during the evidence generation period as an option to treat spontaneous intracranial hypotension caused by a cerebrospinal fluid (CSF)–venous fistula. There must be enhanced informed consent and auditing of outcomes.

The Condition

A CSF–venous fistula is an abnormal connection between the CSF space surrounding the brain and spinal cord, and the venous system. This abnormal connection allows CSF to leak into the venous system, causing spontaneous low pressure in the brain, a condition called spontaneous intracranial hypotension. CSF–venous fistula was first described and recognised as a cause of spontaneous intracranial hypotension in 2014.

Spontaneous intracranial hypotension can present with a variety of symptoms. These include orthostatic headache, which typically worsens upon standing and gets better when lying down; neck stiffness; nausea; vomiting; vertigo; tinnitus; visual disturbances; dizziness and imbalance.

The Procedure

Transvenous embolisation is typically done under general anaesthesia but can also be done under local anaesthesia or conscious sedation. Venous access is achieved through the common femoral or internal jugular vein. A guiding catheter is navigated into the superior vena cava and then into the azygos vein or other relevant venous drainage pathway. Alternative pathways can include the hemiazygos vein, ascending lumbar veins or vertebral veins depending on the location of the fistula. A hydrophilic or stiff wire is often needed for access. Once the catheter has reached the appropriate venous system, a microcatheter is advanced over a fine wire to selectively catheterise the foraminal or paraspinal vein that contains the fistula.

Venography is done to confirm the location of the fistula and see the venous drainage pattern. Venography is an imaging technique that uses contrast dye to visualise the veins under X-ray. The fistula is then embolised using a liquid embolic agent. A high-viscosity formulation is injected to create a proximal plug and then a low-viscosity formulation is injected which flows across the fistula or fistulous network.

The success of the procedure is judged by clinical follow-up and imaging follow-up with MRI. A post-procedure CT myelogram or digital subtraction myelography may be done to assess the distribution of the embolic agent and the extent to which the fistula has sealed. But, this is not done routinely for this purpose, because it is invasive.

Digital technologies for applying algorithms to spirometry to support asthma and COPD diagnosis in primary care and community diagnostic centres: early-use assessment HTG776

Recommendations

Surgical insertion of a catheter-based left ventricular microaxial flow pump **can be used** in the NHS during the evidence generation period as an option to manage cardiogenic shock. There must be enhanced informed consent and auditing of outcomes.

The Technologies

The technologies included in this early-use assessment apply algorithms (artificial intelligence [AI]-derived or rules-based algorithms) to spirometry to support the diagnosis of lung conditions, alongside other clinical factors. They can be used by healthcare professionals in primary care and community diagnostic centres. The technologies provide algorithmic support for spirometry by:

- quality assessing spirometry performance
- interpreting spirometry results (for example, recognising whether the spirometry trace is obstructive, restrictive, or otherwise)
- suggesting a diagnosis based on spirometry results and other clinical factors.

Technologies included in this guidance may have additional functions or use cases that are outside of the scope of this assessment. The recommendations in this guidance do not apply to the technologies when used to support other aspects of the diagnostic, prognostic or care pathways for asthma and COPD that are out of scope for this assessment.

All technologies (ArtiQ.Spiro, EasyOne Connect, GoSpiro and LungHealth) are software, but do require spirometry hardware (a spirometer) to obtain spirometry readings. The most up-to-date information on spirometer compatibility may be available on request from manufacturers. Spirometry hardware that is compatible with software for applying algorithms to spirometry is out of scope for this assessment. Additional software that can be integrated with digital technologies for applying algorithms to spirometry to support other aspects of the diagnostic pathway (for example, to enhance data management and workflow) is also out of scope for this assessment. As such, the recommendations do not apply to the use of spirometer hardware for obtaining spirometry readings, or additional software that can be integrated.

Financial Factors

Respiratory services are commissioned by ICBs.

The key drivers of resource impact are that:

- ArtiQ.Spiro could help staff with different levels of experience to perform diagnostic spirometry and interpret results. This could increase access to spirometry because people would not have to wait for an appointment in secondary care. It is unknown whether this

could affect variation in the quality of spirometry and accuracy of interpretation, and subsequent diagnosis following clinical review.

- The technology may increase the number of primary care settings and community diagnostic centres that are able to offer diagnostic spirometry as part of their service.
- Earlier and improved diagnosis could lead to earlier access to appropriate treatment, which may have long-term benefits and save healthcare resources.
- Algorithmic support may improve the quality of spirometry and accuracy of the subsequent diagnosis made alongside other clinical factors. This could potentially reduce the number of people referred to secondary care because of doubts in diagnosis, or because of an exacerbation after misdiagnosis, unnecessary treatment or a lack of treatment.

Algorithm outputs from ArtiQ.Spiro may support healthcare professionals to make diagnoses, but do not replace clinical judgement or the need for a clinical assessment. The diagnostic accuracy (including the number of false-positive and false-negative results) when the technology is used in primary care and community diagnostic centres is currently unclear.

Digital technologies for managing non-specific low back pain: early value assessment HTG712 (UPDATE)

April 2026: NICE removed Kaia from recommendation 1.1 because it is no longer available to the NHS.

Early value assessment (EVA) guidance on digital technologies for managing non-specific low back pain in people 16 years and over.

NICE Quality Standards

Ovarian Cancer QS18 (UPDATE)

April 2026: This quality standard was updated, and the placeholder statement (statement 2) prioritised in 2025 was updated alongside the publication of updated recommendations in NICE's guideline on suspected cancer to support it.

This quality standard covers the identification and management of familial and genetic risk and the recognition and management of ovarian, fallopian tube and primary peritoneal cancer or borderline ovarian cancer in women, trans men and non-binary people aged 18 and over with female reproductive organs (ovaries, fallopian tubes or a uterus). It describes high-quality care in priority areas for improvement.

Current NICE Consultations

Title/link	End date of consultation
Elranatamab for treating relapsed and refractory multiple myeloma after 3 or more treatments (managed access review of TA1023) [ID6653]	01/05/2026
Zanidatamab for treating HER2-positive advanced biliary tract cancer after 1 or more lines of systemic treatment [ID6388]	06/05/2026
Obsessive-compulsive disorder and body dysmorphic disorder	07/05/2026
Pirtobrutinib for treating relapsed or refractory chronic lymphocytic leukaemia after a BTK inhibitor [ID6269]	11/05/2026
Efgartigimod for treating chronic inflammatory demyelinating polyneuropathy [ID6409]	18/05/2026
NICE-wide Topic Prioritisation: the manual (PMG46) 2026 Update Consultation	19/05/2026
Ruxolitinib for treating moderate atopic dermatitis ID6602	20/05/2026
Donidalorsen for preventing recurrent attacks of hereditary angioedema in people 12 years and over [ID6457]	21/05/2026
Oveporexton for treating type 1 narcolepsy [ID6622]	21/05/2026
Histamine dihydrochloride with interleukin-2 for maintenance treatment of acute myeloid leukaemia [ID1627]	22/05/2026
Prostate cancer: diagnosis and management (update)	27/05/2026
Modular update to NICE manuals: EQ-5D-5L value set	27/05/2026