NHS Devon

NICE Update Bulletin: August 2026

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

1. **Dostarlimab for previously treated advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency TA1189**
2. **Brensocatib for treating non-cystic fibrosis bronchiectasis in people 12 years and over (terminated evaluation) TA1188**
3. **Rilzabrutinib for treating persistent or chronic immune thrombocytopenia (terminated evaluation) TA1187**
4. **Acalabrutinib with venetoclax with or without obinutuzumab for untreated chronic lymphocytic leukaemia TA1185**
5. **Acalabrutinib with bendamustine and rituximab for untreated mantle cell lymphoma TA1184**
6. **Donidalorsen for preventing recurrent attacks of hereditary angioedema in people 12 years and over TA1183**
7. **Finerenone for treating chronic heart failure with preserved or mildly reduced ejection fraction TA1182**
8. **12 SQ-Bet SLIT for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen in people 5 years and over TA1087 (UPDATE)**
9. **12 SQ-HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites TA1045 (UPDATE)**
10. **Multiple sclerosis in adults: management NG220 (UPDATE)**
11. **This guideline covers diagnosing and managing multiple sclerosis in people aged 18 and over. It aims to improve the quality of life for people with multiple sclerosis by promoting prompt and effective symptom management and relapse treatment, and comprehensive reviews**
12. **Acne vulgaris: management NG198 (UPDATE)**
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15. **Current NICE Consultations**

Technology Appraisals (TAs)

Dostarlimab for previously treated advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency TA1189

This guidance updates and replaces NICE TA779 on dostarlimab for previously treated advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency, which was available through the Cancer Drugs Fund.

Recommendation

Dostarlimab **can be used** as an option to treat advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency that has progressed on or after platinum-containing chemotherapy in adults, only if:

- dostarlimab is stopped after 3 years, or earlier if the cancer progresses or there is unacceptable toxicity, and
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with dostarlimab that was started in the Cancer Drugs Fund before this guidance was published and that is not covered by the recommendation above. For those people, dostarlimab will be funded by the company until they and their NHS healthcare professional consider it appropriate to stop.

The Technology

Endometrial cancer is a cancer of the lining of the womb (uterus), known as the endometrium. It is the most common type of uterine cancer, often diagnosed in the earlier stages. When diagnosed, endometrial cancer is categorised between stage 1 and 4. Advanced endometrial cancer is defined as stage 3 or 4, where the cancer has spread outside the womb. In stage 3, the spread of cancer is contained within the pelvis. Once the cancer has spread into another area of the body, it is classed as stage 4 or metastatic. Recurrent endometrial cancer is when the cancer returns after primary treatment. The cancer can recur anywhere, commonly in the abdominal cavity, lymph nodes, lung and vagina. The symptoms of recurrence and advanced stage disease are variable but include abdominal pain, bloating, nausea, shortness of breath, vaginal bleeding and changes in bowel or bladder habits. The mismatch repair (MMR) system recognises and repairs genetic mismatches generated during DNA replication in cells. Around 26% of endometrial tumours have a defect in the MMR system. Tumours with MMR deficiency can develop microsatellite instability, which is a change in the length of repetitive sequences in tumour DNA compared with normal DNA.

In 2022, there were 8,556 new cases of endometrial cancer in England. Around 79% of people have early-stage disease and around 21% have advanced or metastatic disease on diagnosis. Around 13% of people with early-stage disease have a recurrence after initial treatment.

Dostarlimab is indicated as monotherapy for the treatment of adult patients with mismatch repair deficient (dMMR) / microsatellite instability-high (MSI-H) recurrent or advanced EC [endometrial cancer] that has progressed on or following prior treatment with a platinum containing regimen.

The treatment options for the eligible population are pembrolizumab, pembrolizumab with lenvatinib and chemotherapy. Pembrolizumab was considered the most relevant comparator by the committee.

Dostarlimab, pembrolizumab and chemotherapy are all administered by IV infusion, lenvatinib is an oral tablet. Pembrolizumab and dostarlimab are both 30-minute infusions, chemotherapy administration time varies by regimen, carboplatin and paclitaxel regimen has been included resource impact template but there is space for regimens used locally to be added.

Financial Factors

This technology is commissioned by ICBs.

Dostarlimab has a list price of £5,887.33 per 500-mg vial.

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

The key drivers of the resource impact are:

- Dostarlimab has been available through the Cancer Drugs Fund (CDF) for cancer that progressed on or after a platinum-containing regimen (TA779). So the cost of dostarlimab is moving from CDF to routine commissioning.
- The use of immunotherapy such as dostarlimab and pembrolizumab-based regimens in this indication is declining as their use in earlier treatment lines increases.
- The administration time for dostarlimab is similar to pembrolizumab.
- Dostarlimab and pembrolizumab have stopping rules of 3 years and 2 years respectively, or earlier if the cancer progresses or there is unacceptable toxicity.

NICE estimate that in year 3, 6 people in Devon will be eligible for treatment.

Brensocatib for treating non-cystic fibrosis bronchiectasis in people 12 years and over (terminated evaluation) TA1188

NICE is **unable to make a recommendation** on brensocatib for treating non-cystic fibrosis bronchiectasis in people 12 years and over. This is because the company did not provide an evidence submission.

Rilzabrutinib for treating persistent or chronic immune thrombocytopenia (terminated evaluation) TA1187

NICE is **unable to make a recommendation** on rilzabrutinib for treating persistent or chronic immune thrombocytopenia in adults. This is because the company did not provide an evidence submission.

Lisocabtagene maraleucel for treating relapsed or refractory follicular lymphoma after 2 or more lines of systemic treatment (terminated evaluation) TA1186

NICE is **unable to make a recommendation** on lisocabtagene maraleucel for treating relapsed or refractory follicular lymphoma in adults after 2 or more lines of systemic treatment. This is because the company did not provide an evidence submission.

Acalabrutinib with venetoclax with or without obinutuzumab for untreated chronic lymphocytic leukaemia TA1185

Recommendation

Acalabrutinib plus venetoclax **can be used** as an option for untreated chronic lymphocytic leukaemia (CLL) in adults. It can only be used:

- without obinutuzumab, and
- if the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with acalabrutinib plus venetoclax 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

Chronic lymphocytic leukaemia (CLL) is the most common type of chronic leukaemia and is a type of cancer that affects the white blood cells. CLL occurs when the material found inside some bones (bone marrow) produces too many white blood cells, called lymphocytes, that aren't fully developed and don't work properly. It tends to progress slowly over many years.

CLL mostly affects people 60 years of age and over and is rare in people 40 years of age and younger. The risk of developing CLL increases with age, is more common in men, those of white ethnicity, and have a family history of CLL. There were 2,936 new cases of CLL (ICD-10 code C91.1: CLL of B-cell type) in England in 2021. Of these, 1,820 were male and 1,116 were female.

CLL usually progresses slowly, but some people may have rapidly progressive disease. Over time people can develop anaemia, swollen lymph nodes, spleen enlargement and unexplained weight loss. People with CLL may live with a considerable burden of symptoms and an increased susceptibility to infection impacting on their quality of life, whether or not they have had treatment.

The British Society of Haematology defines people with 'high risk' CLL as those with previously untreated CLL associated with a 17p deletion or TP53 mutation. The presence of 17p deletion or TP53 mutation influences the rate of cell growth and is associated with resistance of the disease to conventional chemotherapy treatments4. The presence of 17p deletion or TP53 mutation can be used as markers to predict the prognosis of people with CLL. The presence of an immunoglobulin heavy chain gene (IgHV) mutation and complex karyotypes (defined as more than 3-5 chromosome aberrations) may also impact treatment decisions and affect clinical outcomes.

Treatment of CLL is complex and depends on several factors such as stage of disease, previous treatment, patient's age, symptoms, and general state of health. Many people with CLL will not have symptoms when they are first diagnosed and will have a period of active surveillance. The disease is monitored for progression and treatment is initiated upon progression. Targeted therapies are often the first choice of treatment. Targeted therapies, such as zanubrutinib, acalabrutinib, ibrutinib, venetoclax and idelalisib are particularly useful in people with a poor prognosis, such as those with 17p deletion or TP53 mutation. Immunotherapies, such as rituximab, have been shown to improve survival and remission rates, particularly when combined with chemotherapy. Chemoimmunotherapy (CIT) and chemotherapy may be appropriate for some people depending on their genetic profile. CIT can achieve complete remission, but the disease may eventually relapse. Treatments may be for a fixed duration (also called time-limited) with scheduled treatment breaks, or continuous therapy for as long as appropriate.

Acalabrutinib in combination with venetoclax, with or without obinutuzumab, is indicated for the treatment of adult patients with previously untreated chronic lymphocytic leukaemia (CLL).

Financial Factors

This technology is commissioned by NHS England.

The list price for acalabrutinib is £5,059.00 for a 60-tablet pack of 100-mg tablets. The list price of venetoclax varies depending on the pack size and dose.

The companies have commercial arrangements. These make acalabrutinib plus venetoclax available to the NHS with a discount. The sizes of the discounts are commercial in confidence. It is the companies' responsibility to let relevant NHS organisations know details of the discounts.

Acalabrutinib with bendamustine and rituximab for untreated mantle cell lymphoma TA1184

Recommendation

Acalabrutinib plus bendamustine and rituximab **can be used**, within its marketing authorisation, as an option for untreated mantle cell lymphoma in adults who are not eligible for an autologous stem cell transplant. Acalabrutinib plus bendamustine and rituximab can only be used if the

The Technology

Lymphomas are cancers of the lymphatic system, which is a part of the immune system. Lymphomas are divided into Hodgkin lymphoma and non-Hodgkin lymphoma. Non-Hodgkin lymphomas (NHL) are a diverse group of conditions which are categorised according to the cell type affected (B-cell or T-cell), as well as the clinical features and rate of progression of the disease. Mantle cell lymphoma is a rare and often aggressive type of NHL which affects B-cells.

There are around 590 new cases of mantle cell lymphoma diagnosed in the UK each year (comprising around 5% of all non-Hodgkin lymphoma cases). Mantle cell lymphoma usually occurs in older adults and is more common in men than women at a ratio of 2.4:1. Data from the UK between 2010 to 2019 indicates that the 5-year survival rate is 47%.

Acalabrutinib plus bendamustine and rituximab is indicated for the treatment of adult patients with previously untreated mantle cell lymphoma (MCL) who are not eligible for autologous stem cell transplant (ASCT).

The treatment options for the eligible population are BR or R-CHOP. All treatment options include an IV component in administration.

Having acalabrutinib plus BR at first line would change second-line treatment to R-CHOP. Current second-line treatment for people having BR or R-CHOP at first line is zanubrutinib or ibrutinib. Acalabrutinib is the same class of drug (Bruton tyrosine kinase [BTK] inhibitor) as zanubrutinib and ibrutinib, and clinical opinion is that retreatment with a BTK inhibitor would not happen in clinical practice.

Financial Factors

This technology is commissioned by NHS England.

The list price of acalabrutinib is £5,059.00 per 60-pack of 100-mg tablets. The list prices for bendamustine and rituximab vary by pack size and dose.

The key drivers of resource impact are that:

- The treatment duration for acalabrutinib plus bendamustine and rituximab is longer than that of comparator treatments.
- During additional cycles, acalabrutinib is administered alone and taken orally.
- Bendamustine and rituximab (BR) and acalabrutinib plus BR have an additional IV administration per cycle in comparison to R-CHOP.
- Clinical trial evidence shows that acalabrutinib plus BR increases how long people have before their condition gets worse compared with usual treatment.
- The resource impact template assumes that second-line treatment occurs outside the 3-year assessment period. However, some people are likely to start second-line treatment within this period, which may underestimate comparator costs.

NICE estimate that in year 3, 8 people in Devon will be eligible for treatment with 5 starting acalabrutinib with BR each year.

Donidalorsen for preventing recurrent attacks of hereditary angioedema in people 12 years and over TA1183

Recommendation

Donidalorsen **can be used** as an option to prevent recurrent attacks of hereditary angioedema (HAE) in people 12 years and over, only if:

- they have 2 or more attacks a month, and
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with donidalorsen 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. For young people, this decision should be made jointly by the healthcare professional, the young person, and their parents or carers.

The Technology

Hereditary angioedema (HAE) is a rare genetic disorder, associated with a deficiency or dysfunction of the protein C1-esterase inhibitor, which regulates inflammatory pathways. Usually, C1-esterase inhibitor controls enzyme cascade reactions to prevent uncontrolled swelling of the subcutaneous and submucosal tissues. In people with HAE, particularly during times of physiological or psychological stress, the function of the C1-esterase inhibitor is insufficient, resulting in the accumulation of excessive fluid (oedema) and localised oedematous swellings. The swellings often occur in the mouth (which may cause difficulty with eating and speaking), the gut (which may affect the submucosal tissues and cause abdominal pain, nausea, or vomiting), and the airway (which may lead to breathing difficulties or potential asphyxia). The swellings can also affect the deep tissues of the skin (involving the dermis and subcutaneous tissues), with significant impact, especially when the hands, feet or genitals are involved. HAE attacks are associated with disfiguration, severe pain, an inability to perform daily activities and feelings of fear and anxiety.

Many angioedema attacks are associated with triggers such as trauma, medical procedures, emotional stress, menstruation, oral contraceptive use, infections, or the use of medications such as ACE inhibitors. But often, a specific trigger cannot be identified. Attacks are unpredictable and the severity and frequency of previous attacks do not predict future attacks. Attacks typically last 2 to 5 days before resolving spontaneously.

There are 3 types of HAE. Types I (85%) and II (15%) are a result of a known genetic mutation and account for almost all cases of HAE:

- type I is characterised by low levels of C1-esterase inhibitor in the plasma.
- type II is characterised by normal level of a dysfunctional C1-esterase inhibitor in the plasma.
- HAE with normal C1-esterase inhibitor (previously referred to as type III) is a group of very rare disease and is not a result of the deficiency or dysfunction of the C1-esterase inhibitor protein. However, it is known that oestrogen has a role not yet fully understood.

It is estimated that type I and type II HAE affect at least 1 per 59,000 of the UK population and can affect people of any ethnic group or gender. HAE usually presents in childhood, with the mean age of onset being between 8 and 12 years.

Donidalorsen is indicated for routine prevention of recurrent attacks of hereditary angioedema (HAE) in adults and adolescents aged 12 years and older.

Usual treatment to prevent recurrent attacks of hereditary angioedema includes berotralstat, C1-esterase inhibitors, garadacimab and lanadelumab.

Financial Factors

This technology is commissioned by NHS England.

The list price of the 80-mg donidalorsen prefilled pen is confidential.

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

The key drivers of the resource impact are:

- No significant difference in anticipated adverse events is expected.
- Donidalorsen can be given every month or every 2 months. The resource impact assessment pragmatically assumes that 100% of people have monthly dosing. This assumption can be amended in the resource impact template.
- Lanadelumab can be given every 2 or 4 weeks. Clinical expert opinion suggests an equal split between dosing schedules, so the resource impact template assumes administration every 3 weeks.
- There may be a capacity benefit and reduced costs from reducing the frequency or severity of hereditary angioedema attacks. These have not been modelled in the resource impact template because of underlying commercial-in-confidence data.

NICE expect that the resource impact of implementing the recommendations in England will be less than £5 million per year (or about £8,700 per 100,000 people in the population, based on a population in England of 57.7 million people). This is because the overall cost of treatment will be similar for this population and the population size is small.

NICE estimate that in year 3, 13 people in Devon will be eligible for treatment with 4 having donidalorsen each year.

Finerenone for treating chronic heart failure with preserved or mildly reduced ejection fraction TA1182

Recommendation

Finerenone **can be used**, within its marketing authorisation, as an option to treat symptomatic chronic heart failure with preserved or mildly reduced ejection fraction in adults.

The Technology

Heart failure is a complex clinical syndrome of signs and symptoms, generally defined as the inability of the heart to supply sufficient blood flow to meet the body's needs. It is caused by structural or functional abnormalities of the heart, commonly resulting from coronary artery disease. Other conditions that can increase the risk of heart failure include: atrial fibrillation, valve disease, hypertension, amyloidosis, anaemia, and thyroid gland diseases.

The European Society of Cardiology (ESC) defines 3 types of chronic heart failure based on left ventricular ejection fraction (LVEF), a measurement of how much blood the left ventricle pumps out with each contraction. The ESC defines heart failure with reduced ejection fraction as a LVEF of 40% or less; mildly reduced ejection fraction as a LVEF between 41% and 49%; and preserved ejection fraction as a LVEF of 50% or more with evidence of structural and/or functional cardiac abnormalities and/or raised natriuretic peptides.

NICE guideline 106 for chronic heart failure in adults (NG106) states that heart failure with preserved ejection fraction is usually associated with impaired left ventricular relaxation, rather than left ventricular contraction, and is characterised by normal or preserved LVEF with evidence of diastolic dysfunction. Symptoms of heart failure commonly include breathlessness, fatigue and ankle swelling. Quality of life is affected by the physical limitations imposed by the symptoms.

In 2023/24, there were more than 650,000 people in England registered as having heart failure, with around 50% expected to have preserved or mildly reduced ventricular ejection fraction. However, registrations may underestimate the true prevalence due to underdiagnosis or cases not being coded in primary care. There were 104,336 hospitalisations in England for heart failure in 2023/24. Both the prevalence and incidence of heart failure increase with age. Around 24% of people diagnosed with heart failure die within the first year, with a 5-year mortality rate of about 55%.

TA902 recommends dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction. TA929 recommends empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction. NG106 recommends low to medium dose loop diuretics for people with chronic heart failure with preserved ejection fraction. Specialist advice is needed if the disease does not respond. People with chronic heart failure with preserved ejection

fraction may also have symptomatic treatments for comorbidities, including angiotensin-converting enzyme (ACE) inhibitors, angiotensin-receptor blockers (ARBs), or beta-blockers.

Finerenone is indicated for the treatment of symptomatic chronic heart failure with left ventricular ejection fraction (LVEF) ≥40% in adults.

Financial Factors

This technology is commissioned by ICBs.

The list price of 10 mg, 20 mg and 40 mg finerenone is £36.68 per 28-tablet pack.

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:

- Cost comparisons suggest the costs for pirtobrutinib are similar to or lower than venetoclax alone or venetoclax plus rituximab.
- The current level of market share of spironolactone and to what extent finerenone displaces it.
- The number of heart failure events avoided resulting from finerenone use verses current standard of care.
- The future estimated market share for finerenone.
- Evidence for spironolactone in the relevant population is limited and uncertain. The resource impact template assumes equivalent heart failure event rates, which may result in the benefits of finerenone not being fully captured.

Finerenone is administered in addition to standard of care, apart from spironolactone, which it would be used instead of.

NICE estimate the prevalence of heart failure in Devon to be 1.72% (18,441 people).

In year 3, NICE estimate 1,859 people in Devon to be receiving finerenone each year.

12 SQ-Bet SLIT for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen in people 5 years and over TA1087 (UPDATE)

August 2026: NICE updated recommendation 1.1 to expand the population in line with the marketing authorisation to include people aged 5 to 17 years. We also updated related sections to reflect this expanded population.

NICE updated the technology name to '12 standardised quality betula verrucosa pollen sublingual lyophilisate (12 SQ-Bet SLIT)' to more closely reflect the name of the medicinal product in the summary of product characteristics. The title of this guidance has been

updated to include '12 SQ-Bet SLIT' and to include 'in people 5 years and over' in line with the marketing authorisation.

Recommendation

12 standardised quality betula verrucosa pollen sublingual lyophilisate (12 SQ-Bet SLIT) **can be used**, within its marketing authorisation, as an option to treat moderate to severe allergic rhinitis or conjunctivitis caused by pollen from the birch homologous group of trees in people aged 5 years and over with:

- symptoms despite using symptom-relieving medicines
- a positive sensitisation test (skin prick test or specific immunoglobulin E) to a member of the birch homologous group.

The Technology

Birch pollen allergy is an immunoglobulin E (IgE)-mediated hypersensitive reaction to the pollen of birch trees and related species. When a person with an allergy comes into contact with birch pollen, the immune system recognises it as a threat and produces antibodies. Further contact with the pollen then results in the release of inflammatory substances such as histamine, which leads to the typical allergic symptoms, including rhinitis and conjunctivitis.

Allergic rhinitis is inflammation of the nose that occurs when the nasal mucosa becomes exposed and sensitised to allergens. Depending on the nature of the allergen, allergic rhinitis has traditionally been categorised as either seasonal allergic rhinitis (e.g., induced by pollen) or perennial allergic rhinitis (e.g., induced by animals or dust mites). Rhinitis typically causes symptoms such as sneezing, nasal discharge, itching, and congestion. It may also lead to complications such as sinusitis or middle ear infections as well as the worsening of asthma symptoms.

Allergic conjunctivitis is the inflammation of the conjunctiva, the mucous membranes that line the inside of the eyelids and the sclera, the white part of the eye. Symptoms can include itchy and reddened eyes, swollen conjunctiva and watery discharge, which may be thickened with mucous.

Symptoms of rhinoconjunctivitis (commonly referred to as hay fever) may be intermittent or chronic during the pollen season. Rhinoconjunctivitis can be further categorised as either ‘mild’, ‘moderate’ or ’severe’. The definition of moderate disease from the European Academy of Allergy and Clinical Immunology is that symptoms are “bothersome”. Severe rhinoconjunctivitis occurs when symptoms become hard to tolerate, disrupting daily activities or sleep.

Although allergic rhinitis and allergic conjunctivitis are common conditions, current epidemiological estimates remain imprecise because of a paucity of recent studies, heterogenous terminology and diagnostic criteria, and widespread self-medication practices that contribute to underdiagnosis. It is estimated that about 10% of 6 and 7-year-olds and 15% to 19% of 13 and 14-year-olds are affected by allergic rhinitis in England, based on a UK primary healthcare database review (1999–2005). It is suggested that new cases of seasonal allergic rhinitis increase by a constant rate of around 2% per year between the ages of 3 and 12 years. About 30% to 71%

of people with allergic rhinitis may also be affected by allergic conjunctivitis or conjunctival symptoms. The International Study of Asthma and Allergy in Childhood found that in Western Europe, allergic rhinoconjunctivitis in 6- to 7-year-olds was estimated to be about 7% and 14% in 13- to 14-year-olds.

There is no alternative NICE guidance for treating allergic rhinitis or conjunctivitis or both in people 5 to 17 years old. In practice, initial treatment may involve allergy avoidance. This can be followed by pharmacotherapy aimed at symptom control, which may include antihistamines, ocular mast cell stabilisers, topical nasal corticosteroids, and leukotriene receptor antagonists (if asthma is also present). For severe allergic rhinitis that does not respond to usual pharmacotherapy, specific desensitisation with immunotherapy may be considered. Skin prick or specific IgE tests can be used to establish which allergens trigger the immune response if immunotherapy is being considered.

12 standardised quality betula verrucosa pollen sublingual lyophilisate (12 SQ-Bet SLIT) is indicated in adults and children (5 years or older) for the treatment of moderate-to-severe allergic rhinitis and/or conjunctivitis induced by pollen from the birch homologous group. Itulazax is indicated in patients with a clinical history of symptoms despite use of symptom-relieving medication and a positive test of sensitisation to a member of the birch homologous group (skin prick test and/or specific IgE).

Usual treatment for moderate to severe allergic rhinitis and conjunctivitis caused by pollen from the birch homologous group of trees includes symptom-relieving medicines such as antihistamine tablets and corticosteroid nasal sprays. It may also include subcutaneous immunotherapy if people have symptoms despite using symptom-relieving medicines.

Financial Factors

This technology is commissioned by ICBs.

The list price of 12 SQ-Bet SLIT is £80 per pack of 30 tablets. Costs may vary in different settings because of negotiated procurement discounts.

Clinical-trial evidence shows that 12 SQ-Bet SLIT, a sublingual immunotherapy, reduces the severity of allergic rhinitis and conjunctivitis symptoms compared with placebo (both with symptom-relieving medicines). There is no direct evidence comparing 12 SQ-Bet SLIT with subcutaneous immunotherapy, but clinical expert opinion is that they may have similar effectiveness.

Treatment with 12 SQ-Bet SLIT may reduce specialist appointments compared with established clinical management alone. However, an additional outpatient appointment will be required in year 1 to initiate 12 SQ-Bet SLIT.

NICE estimate that in year 3, 60 people in Devon will be eligible for treatment with 13 having 12 SQ-Bet SLIT each year.

12 SQ-HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites TA1045 (UPDATE)

August 2026: NICE updated recommendation 1.1 to expand the population in line with the updated marketing authorisation to include people aged 5 to 11 years with moderate to severe house dust mite allergic rhinitis. NICE also updated related sections to reflect this expanded population.

Recommendation

Allergic Rhinitis

12 standard quality house dust mite sublingual lyophilisate (12 SQ-HDM SLIT) **can be used**, within its marketing authorisation, as an option to treat moderate to severe house dust mite allergic rhinitis in people aged 5 to 65 years if it is:

- diagnosed by clinical history and a positive test of house dust mite sensitisation (skin prick test or specific immunoglobulin E [IgE]), and
- persistent despite using symptom-relieving medicine.

Allergic Asthma

12 SQ-HDM SLIT **should not be used** to treat house dust mite allergic asthma in people aged 18 to 65 years if it is:

- diagnosed by clinical history and a positive test of house dust mite sensitisation (skin prick test or specific IgE)
- associated with mild to severe house dust mite allergic rhinitis, and
- not well controlled by inhaled corticosteroids.

This recommendation is not intended to affect treatment with 12 SQ-HDM SLIT 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

House dust mites (HDM) are microscopic organisms found in dust that builds up in the house. House dust mite allergy is an immunoglobulin E (IgE)-mediated hypersensitive reaction to proteins in the droppings of dust mites. These proteins can act as allergens (cause an allergic reaction) in the upper or lower respiratory tract causing the symptoms of rhinitis and asthma.

Allergic rhinitis is inflammation of the nose that occurs when the nasal mucosa becomes exposed and sensitised to allergens. Depending on the nature of the allergen, allergic rhinitis has traditionally been categorised as either seasonal allergic rhinitis (e.g., induced by pollen) or

perennial allergic rhinitis (e.g., induced by animals or dust mites). In the United Kingdom, the most common allergic trigger for perennial allergic rhinitis is the house dust mite. Rhinitis typically causes symptoms such as sneezing, nasal discharge, itching, and congestion. It may also lead to complications such as sinusitis or middle ear infections as well as the worsening of asthma symptoms.

Allergic rhinitis can be further categorised as either ‘mild’, ‘moderate’ or ’severe’. The definition of moderate disease from the European Academy of Allergy and Clinical Immunology is that symptoms are “bothersome”. Severe rhinitis occurs when symptoms become hard to tolerate, disrupting daily activities or sleep.

Although allergic rhinitis is a common condition, current epidemiological estimates remain imprecise because of a paucity of recent studies, heterogenous terminology and diagnostic criteria, and widespread self-medication practices that contribute to underdiagnosis. It is estimated that about 10% of 6 and 7-year-olds and 15% to 19% of 13 and 14-year-olds are affected by allergic rhinitis in England, based on a UK primary healthcare database review (1999–2005).

Usual treatment for moderate to severe allergic rhinitis and conjunctivitis caused by pollen from the birch homologous group of trees includes symptom-relieving medicines such as antihistamine tablets and corticosteroid nasal sprays. It may also include subcutaneous immunotherapy if people have symptoms despite using symptom-relieving medicines.

12 standard quality house dust mite sublingual lyophilisate (12 SQ-HDM SLIT) is indicated in adult patients (18-65 years) diagnosed by clinical history and a positive test of house dust mite sensitisation (skin prick test and/or specific IgE) with at least one of the following conditions:

- persistent moderate to severe house dust mite allergic rhinitis despite use of symptom-relieving medication
- house dust mite allergic asthma not well controlled by inhaled corticosteroids and associated with mild to severe house dust mite allergic rhinitis. Patients' asthma status should be carefully evaluated before the initiation of treatment.

12 SQ-HDM SLIT is also indicated 'in children (5 to 17 years) diagnosed by clinical history and a positive test of house dust mite sensitisation (skin prick test and/or specific IgE) with persistent moderate to severe house dust mite allergic rhinitis despite use of symptom-relieving medication.

Usual treatment for moderate to severe allergic rhinitis caused by house dust mites includes symptom-relieving medicines such as antihistamine tablets and corticosteroid nasal sprays.

Financial Factors

This technology is commissioned by ICBs.

The list price of 12 SQ-HDM SLIT is £80.12 per pack of 30 tablets. Costs may vary in different settings because of negotiated procurement discounts.

Clinical trial evidence suggests that, compared with placebo plus usual treatment, 12 SQ-HDM SLIT plus usual treatment reduces rhinitis symptoms and medicine use in people with house dust mite allergic rhinitis.

Treatment with 12 SQ-HDM SLIT may reduce specialist appointments compared with established clinical management alone. However, an additional outpatient appointment will be required in year 1 to initiate 12 SQ-HDM SLIT.

NICE estimate that in year 3, 117 people in Devon will be eligible for treatment with 26 having 12 SQ-HDM SLIT each year.

Highly Specialised Technology Guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Multiple sclerosis in adults: management NG220 (UPDATE)

August 2026: NICE have withdrawn the recommendation on fampridine because there is now an NHS England clinical commissioning policy on prolonged-released fampridine for treating walking impairments associated with MS in adults.

This guideline covers diagnosing and managing multiple sclerosis in people aged 18 and over. It aims to improve the quality of life for people with multiple sclerosis by promoting prompt and effective symptom management and relapse treatment, and comprehensive reviews.

Acne vulgaris: management NG198 (UPDATE)

August 2026: NICE have withdrawn the recommendation on triamcinolone acetonide injections. See the surveillance decision for details. NICE have amended references to polycystic ovary syndrome because this condition is now called polyendocrine metabolic ovarian syndrome (PMOS). The name change for the condition was agreed by global consensus and reflects the fact that it is a whole-body metabolic and hormonal condition, not a disease defined by ovarian cysts.

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.

Public Health Guidelines

None published this month.

Antimicrobial Prescribing Guidelines

None published this month.

Social Care Guidelines

None published this month.

HealthTech guidance (HTGs)

Ex-situ machine perfusion devices to preserve deceased donor livers for transplantation HTG780

This guidance replaces NICE's HealthTech guidance 496 on ex-situ machine perfusion for extracorporeal preservation of livers for transplantation and NICE's medtech innovation briefing on OrganOx metra for liver transplantation (MIB275).

Recommendations

Four ex-situ machine perfusion devices can be used in the NHS as options to preserve livers from deceased donors for people who need a liver transplant. The technologies are:

- Liver Assist
- metra
- PerLife Pro
- VitaSmart Hypothermic Oxygenated Perfusion System.

This recommendation does not cover the use of ex-situ machine perfusion devices during transportation of a donor liver.

The Technologies

Ex-situ machine perfusion devices preserve a donor liver outside of the body before it is transplanted. There are several devices available. The precise configuration of each device varies. But they typically include a reservoir, a pump, an oxygenator, and a warming or cooling unit. The donor liver is placed into the device, which pumps a specially formulated solution through the liver's blood vessels. The circulating perfusion solution also clears, and prevents accumulation of, waste products. Machine perfusion is typically done at hypothermic (0°C to 12°C) or normothermic (around 37°C) temperatures. The liver can be perfused for several hours (duration varies depending on the technology and perfusion method) before being transplanted into the transplant recipient. The viability of the donor liver can be assessed during normothermic perfusion. Some devices can slowly rewarm livers from hypothermia to normothermia (known as 'controlled oxygenated rewarming') and some can provide a platform for liver splitting during machine perfusion.

Ex-situ machine perfusion devices may offer better liver preservation compared with static cold storage, with the aims of increasing the number of livers that can be transplanted and improving outcomes for transplant recipients. They can extend how long a donor liver can be preserved, which may allow more flexibility with logistics. Some devices also allow assessment of liver functionality, which may increase the number of available donor livers that can be safely transplanted.

Details of the 4 technologies included in this assessment are in the table below. Organ Care System (OCS) Liver was removed from the assessment after TransMedics advised that it would not be making the system available to the NHS for the use case outlined in the scope. So, the committee was unable to make a recommendation on this technology.

Technology	Intended population (transplant recipients)	Perfusion strategy	Liver function and viability assessment	Regulatory status (machine unit) and use in NHS
Liver Assist (XVIVO BV)	Children, young people, adults	• HOPE • NMP • COR	Yes, during NMP	• CE marked class IIb • Currently used in the NHS
metra (OrganOx Ltd)	Adults	• NMP	Yes	• UKCA marked class IIa (CE class IIb) • Currently used in the NHS
PerLife Pro (Aferetica Srl)	Children, young people, adults	• HOPE • NMP • COR	Yes, during NMP	• CE marked class IIa • Not currently used in the NHS
VitaSmart Hypothermic Oxygenated Perfusion System (Bridge to Life Ltd)	Children, young people, adults	• HOPE	No	• CE marked class IIb • Currently used in the NHS

Financial Factors

These technologies are commissioned by ICBs.

The key drivers of resource impact are:

- Most UK liver transplant centres already use ex-situ machine perfusion devices. But practice differs across centres, and funding is often from local charities rather than the NHS. This recommendation means that ex-situ machine perfusion devices should be routinely available across the NHS and paid for using core NHS funding.
- Evidence suggests that, compared with static cold storage alone, ex-situ machine perfusion devices improve clinical outcomes for people who have a liver transplant. The devices may also increase the number of donor livers that proceed to transplantation.

- Safe and effective use of these technologies requires a highly skilled workforce. A dedicated perfusion team may be needed to deliver the machine perfusion procedure, although requirements are likely to vary by NHS trust and evolve over time.
- Changes to the national liver transplantation pathway are in progress. This includes the routine use of in-situ normothermic regional perfusion (NRP) in livers donated after circulatory death and the introduction of a national network of assessment and recovery centres. The routine use of ex-situ machine perfusion devices at liver transplant centres will likely be of continued benefit to people waiting for a liver transplant.

Virtual reality technologies for treating agoraphobia or agoraphobic avoidance: early value assessment HTG701

August 2026: NICE removed Amelia Virtual Care from recommendation 1.4 because it is no longer available in the UK.

Recommendations

gameChangeVR (a virtual reality [VR] technology) **can be used** in the NHS while more evidence is generated, to treat severe agoraphobic avoidance in people with psychosis aged 16 and over. It should be used with the support of a mental health professional.

The company must confirm that agreements are in place to generate the evidence (as outlined in NICE's evidence generation plan) and contact NICE annually to confirm that evidence is being generated and analysed as planned. NICE may withdraw the guidance if these conditions are not met.

At the end of the evidence generation period (3 years, or sooner if enough evidence is available), the company should submit the evidence to NICE in a form that can be used for decision making. NICE will review the evidence and assess if the technology can be routinely adopted in the NHS.

Can only be used in research

More research is needed on the following VR technologies:

- gameChangeVR to treat mild to moderate agoraphobic avoidance in people with psychosis
- XR Therapeutics to treat agoraphobia.

Access to the technologies for the indications in section 1.4 should be through company, research, or non-core NHS funding, and clinical and financial risks should be appropriately managed.

The technologies can only be used once they have appropriate regulatory approval.

Evidence generation and research

More evidence generation and research are needed on:

- clinical effectiveness, including long-term benefits and who may benefit most from using VR technologies
- rates of relapse or worsening of symptoms, including use and effectiveness of extra VR therapy sessions
- adverse effects
- resource use, including maintenance and lifespan of the hardware, and mental health professional grade and time needed to deliver treatment or support.

The Technologies

Virtual reality (VR) is a simulated environment with scenes and objects that people can explore while wearing a headset or viewing a screen. This creates an immersive experience that can trigger emotional responses like those in real-world situations. Some VR technologies are designed to be used by a qualified therapist as a tool in therapy sessions to support the delivery of face-to-face or remote cognitive behavioural therapy (CBT). Other VR technologies are designed to be a standalone digital intervention that can be used with the support of a wider range of mental health professionals, such as assistant psychologists, peer support workers or therapists. VR technologies can help deliver treatments such as exposure therapy, by allowing people to immerse themselves in real-world situations while being in the safety of their home or clinic. Virtual environments can be adjusted based on a person's needs and individual treatment plan. This could allow more gradual exposure to stressful situations and increased comfort in completing interventions.

NICE has assessed 2 VR technologies for treating agoraphobia (Amelia Virtual Care and XR Therapeutics), and 1 VR technology for treating agoraphobic avoidance in people with psychosis (gameChangeVR). The assessment included VR technologies that are designed to be used as tools in therapy sessions and VR technologies that are standalone digital interventions. The criteria for including technologies in this assessment are in the final scope for this guidance on the NICE website. The technologies are:

- Amelia Virtual Care (Amelia Virtual Care) for treating mental health conditions including agoraphobia. This is a software-only VR technology that delivers VR therapy using a VR headset. It is designed to be used by qualified therapists as a tool to support treatment in clinics or at home. Amelia Virtual Care helps therapists to deliver evidence-based treatment including gradual exposure, mindfulness-based cognitive therapy and desensitisation.
- gameChangeVR (Oxford VR) for people with schizophrenia spectrum disorders or affective disorders with psychotic symptoms, who have agoraphobic avoidance (difficulties leaving home because of anxiety). This is a software-only VR technology that delivers VR therapy using a VR headset. The intervention is delivered in around 6 weekly 30-minute sessions. There is an automated virtual therapist within the VR environment

that guides the person through the treatment for agoraphobic avoidance using CBT techniques. This is supported by a mental health professional remotely or in person.

- XR Therapeutics (XR Therapeutics) for treating anxiety disorders including agoraphobia. This uses a fully immersive screen-based VR studio and is delivered in person by a qualified therapist in combination with face-to-face CBT. It allows therapists to tailor digital scenes to a person's individual needs. Treatment can be adapted in real time, allowing therapists to manage the rate of exposure and the intensity of situations.

During scoping, NICE also identified Invirto (Invirto) for treating anxiety disorders including agoraphobia. The company did not respond to requests for information, and no evidence was identified. So, this technology was not assessed and was excluded from recommendations.

The Technologies

Mental health services are commissioned by NHS England and ICBs.

NHS Digital's Quality and Outcomes Framework 2022–23 has the mental health (mental health and neurology group) prevalence in England of around 622,000 people. It is not known how many of these have a diagnosis of psychosis. It is estimated that 2 in 3 people with psychosis struggle with agoraphobia.

The clinical and patient experts advised that agoraphobia is often untreated or undertreated especially when its symptoms occur with other mental health conditions, such as agoraphobic avoidance in people with psychosis. Access to psychological interventions such as cognitive behavioural therapy (CBT) for treating psychosis varies and is limited for some people. gameChangeVR technology offers a treatment option for people aged 16 and over who have psychosis and severe agoraphobic avoidance, who would otherwise not have psychological treatment.

Based on the economic evidence supporting gameChangeVR, the resources needed for implementation include the licence fee per person, per course of treatment, the virtual reality (VR) headset, clinical psychologist time, mental health worker time, and training. The mental health professional salary band, and the time needed to deliver or support therapy sessions varies across the country. Therapy is delivered in around 6 weekly 30-minute sessions. The cost per session, and for a course of treatment, would depend on local service configuration and should be assessed at that level. The annual licence fee is commercial in confidence.

Implementing this guidance may:

- Enable people to seek treatment. Because gameChangeVR can be delivered remotely, it may enable some people to get help in their homes. This is important for people who may not be able to attend face-to-face treatment in a clinic. Clinical and patient experts suggest that this could be a first step to getting further help and accessing other healthcare services in the future if needed.

- Allow people with agoraphobic avoidance to safely encounter threatening situations and challenge their fear response. Therefore, improving their social engagement, daily living and overall wellbeing.
- Increase the number of people accessing treatments. Access to therapy may be limited by NHS workforce pressures, including not having enough trained staff to deliver CBT in community mental health teams. Because gameChangeVR can be delivered and supported by a wider range of mental health professionals than standard care, more people could have access to treatment.

NICE Quality Standards

None published this month.

Current NICE Consultations

Title/link	End date of consultation
Artificial intelligence (AI) technologies to help detect prostate cancer on MRI	01/09/2026
Tislelizumab with platinum-based chemotherapy for neoadjuvant treatment then alone for adjuvant treatment of resectable non-small-cell lung cancer at high risk of recurrence ID6708	01/09/2026
Belzutifan with pembrolizumab for adjuvant treatment of clear cell renal cell carcinoma after nephrectomy ID6645	02/09/2026
Talazoparib with enzalutamide for treating hormone-sensitive metastatic prostate cancer with a homologous recombination repair mutation ID6460	02/09/2026
Encorafenib with cetuximab and FOLFOX for untreated BRAF V600E mutation-positive metastatic colorectal cancer ID6734	02/09/2026
Enlicitide decanoate for treating primary hypercholesterolaemia or mixed dyslipidaemia ID6656	07/09/2026
Head injury (QS74) update	07/09/2026
Sugemalimab for consolidation treatment of locally advanced unresectable non-small-cell lung cancer after chemoradiotherapy ID6737	09/09/2026
Sugemalimab with chemotherapy for untreated stage 4 non-small-cell lung cancer ID6758	09/09/2026
Disease-specific reference case extension: treatment for liver fibrosis related to metabolic dysfunction-associated steatohepatitis (MASH)	09/09/2026
Nerandomilast for treating idiopathic pulmonary fibrosis or progressive pulmonary fibrosis [ID6446]	10/09/2026

Pirtobrutinib for treating relapsed or refractory mantle cell lymphoma [ID3975]	11/09/2026
Staged bilateral MRI-guided focused ultrasound thalamotomy for medication-refractory essential tremor	15/09/2026
Unilateral MRI-guided focused ultrasound thalamotomy for medication-refractory essential tremor	15/09/2026
Obicetrapib and obicetrapib–ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia [ID6519]	16/09/2026
Aggressive behaviour in people receiving NHS or social care	16/09/2026
Aggressive behaviour in people receiving NHS or social care: prevention and management	16/09/2026
Toripalimab with chemotherapy for untreated recurrent or metastatic nasopharyngeal cancer [ID6406]	18/09/2026
Remdesivir and tixagevimab plus cilgavimab for treating COVID-19 [ID6261]	24/09/2026
Molnupiravir for treating COVID-19 [ID6340]	24/09/2026
Nirmatrelvir plus ritonavir for treating COVID-19 (Partial Rapid Review of TA878) [ID6262]	24/09/2026