NHS Devon

NICE Update Bulletin: December 2023

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

1. **Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes TA943**
2. **Empagliflozin for treating chronic kidney disease TA942**
3. **Ravulizumab for treating AQP4 antibody-positive neuromyelitis optica spectrum disorder (*terminated appraisal*) TA941**
4. **Ravulizumab for treating generalised myasthenia gravis (*terminated appraisal*) TA940**
5. **Pembrolizumab plus chemotherapy with or without bevacizumab for persistent, recurrent or metastatic cervical cancer TA939**
6. **Dupilumab for treating eosinophilic oesophagitis in people 12 years and over (*terminated appraisal*) TA938**
7. **Targeted-release budesonide for treating primary IgA nephropathy TA937**
8. **Secukinumab for treating moderate to severe hidradenitis suppurativa TA935**
9. **Risdiplam for treating spinal muscular atrophy TA755 (UPDATE)**
10. **Velmanase alfa for treating alpha-mannosidosis HST29**
11. **Cardiovascular disease: risk assessment and reduction, including lipid modification NG238**
12. **Acne vulgaris: management (UPDATE) NG198**
13. **Bipolar disorder: assessment and management (UPDATE) CG185**
14. **Middle meningeal artery embolisation for chronic subdural haematomas IPG779**
15. **Digitally enabled therapies for adults with anxiety disorders: early value assessment HTE9 (UPDATE)**
16. **Digitally enabled therapies for adults with depression: early value assessment HTE8 (UPDATE)**
17. **Epilepsies in children, young people and adults QS211**
18. **Transition from children's to adults' services QS140 (UPDATE)**
19. **Current NICE Consultations**

Technology Appraisals (TAs)

Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes TA943

This guidance updates and replaces DG21 (published February 2016).

Recommendations

Hybrid closed loop (HCL) systems are **recommended** as an option for managing blood glucose levels in type 1 diabetes for adults who have an HbA1c of 58 mmol/mol (7.5%) or more, or have disabling hypoglycaemia, despite best possible management with at least 1 of the following:

- continuous subcutaneous insulin infusion (CSII)
- real-time continuous glucose monitoring
- intermittently scanned continuous glucose monitoring.

HCL systems are only recommended if they are procured at a cost-effective price agreed by the companies and NHS England and implemented following NHS England's and NHS Wales' implementation plans.

HCL systems are recommended as an option for managing blood glucose levels in type 1 diabetes for children and young people. HCL systems are only recommended if they are procured at a cost-effective price agreed by the companies and NHS England and implemented following NHS England's and NHS Wales' implementation plans.

HCL systems are recommended as an option for managing blood glucose levels in type 1 diabetes for women, trans men and non-binary people who are pregnant or planning to become pregnant. HCL systems are only recommended if they are procured at a cost-effective price agreed by the companies and NHS England and implemented following NHS England's and NHS Wales' implementation plans.

Only use HCL systems with the support of a trained multidisciplinary team experienced in CSII and continuous glucose monitoring in type 1 diabetes.

Only use HCL systems if the person or their carer:

- is able to use them, and
- is offered approved face-to-face or digital structured education programmes, or
- is competent in insulin dosing and adjustments.

These recommendations are not intended to affect use of HCL systems that was started in the NHS before this guidance was published. People using HCL systems outside these recommendations may continue until they and their NHS clinician consider it appropriate to stop. For children and young people, this decision should be made jointly by them, their clinician and their parents or carers.

The Technology

In type 1 diabetes, a person's blood glucose level becomes too high (hyperglycaemia) because there is no, or very little, production of insulin by the pancreas. Blood glucose levels can only be regulated by giving insulin to prevent hyperglycaemia. If type 1 diabetes is not well controlled, people are at increased risk of long-term complications of hyperglycaemia, including microvascular damage such as retinopathy and blindness, nephropathy and neuropathy. They are also at increased risk of macrovascular complications such as ischaemic heart disease, stroke and peripheral vascular disease.

The goal of treating type 1 diabetes is to keep blood glucose within a healthy range by providing the body with supplemental insulin. If the level of circulating insulin becomes too high, blood glucose levels can become too low leading to hypoglycaemia (also known as a hypo).

Blood glucose monitoring can be done by self-monitoring (capillary blood testing), or by real-time continuous (rtCGM) or intermittently scanned continuous glucose monitors (isCGM). Long-term monitoring of blood glucose control can be done by measuring HbA1c level, which reflects the average plasma glucose over the last 8 to 12 weeks. Time in range is a measure of blood glucose control that shows the percentage of time a person spends within a target glucose range (3.9 to 10 mmol/litre). Time below range (less than 3.9 mmol/litre) is associated with increased risk of severe hypoglycaemia. Time above range (more than 10 mmol/litre) indicates increased risk of complications and diabetic ketoacidosis.

NICE's recommendations on blood and plasma glucose in type 1 and type 2 diabetes in children and young people (NG18), type 1 diabetes in adults (NG17) and diabetes in pregnancy (NG3) recommend that people with type 1 diabetes should aim for a target HbA1c level of 48 mmol/mol (6.5%) or lower, or an individualised target set in pregnancy, to minimise the risk of long-term complications from diabetes. In practice, an individualised HbA1c target, taking into account the risk of hypoglycaemia, may be agreed with people with diabetes and carers.

HCL systems use a mathematical algorithm to deliver insulin automatically in response to continuously monitored interstitial fluid glucose levels. They use a combination of real-time glucose monitoring from a CGM device and a control algorithm to direct insulin delivery through CSII. Different HCL systems are available and some are built by combining interoperable components from different companies.

The choice of components or system is based on a person's preference and whether the system has the appropriate licence for use. Whether HCL systems are licensed for use in pregnancy or in children or young people may differ. Any future systems comprised of components from different manufacturers must show interoperability and be equivalent to current systems in terms of patient benefits.

Financial Factors

This technology is commissioned by ICBs.

Clinical trial and real-world evidence shows that HCL systems are more effective than standard care at maintaining blood glucose levels within a healthy range.

There is uncertainty in the economic model, so the systems need to be procured at a cost-effective price agreed by the companies who manufacture HCL systems and NHS England.

NICE estimate that 2,627 adults in Devon will be eligible to receive a HCL system and that 6 people will receive these. NICE estimate that 552 children in Devon will be eligible and that 43 children will receive a HCL system.

Access to hybrid closed loop systems will be through a 5-year phased roll out in line with NHS England's and NHS Wales' implementation plans

Empagliflozin for treating chronic kidney disease TA942

Recommendations

Empagliflozin is **recommended** as an option for treating chronic kidney disease (CKD) in adults, only if:

- it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
- people have an estimated glomerular filtration rate of:
  - 20 ml/min/1.73 m^2 to less than 45 ml/min/1.73 m^2 or
  - 45 ml/min/1.73 m^2 to 90 ml/min/1.73 m^2 and either:
    - a urine albumin-to-creatinine ratio of 22.6 mg/mmol or more, or
    - type 2 diabetes.

If people with the condition and their clinicians consider empagliflozin to be 1 of a range of suitable treatments (including dapagliflozin), after discussing the advantages and disadvantages of all the options, use the least expensive. Take account of administration costs, dosage, price per dose and commercial arrangements

This recommendation is not intended to affect treatment with empagliflozin 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 clinician consider it appropriate to stop.

The Technology

Chronic kidney disease (CKD) is a condition where the kidneys do not work as well as they should and it is linked with adverse outcomes including cardiovascular disease.

People with CKD do not usually have symptoms during the early stages of the disease but symptoms including weight loss and poor appetite, swollen ankles, feet or hands, shortness of breath, tiredness, feeling sick and blood in the urine can develop as the disease progresses. The severity of CKD is determined by the estimated glomerular filtration rate (eGFR), with 6 categories ranging from normal to kidney failure, and the albumin to creatinine ratio (ACR), with 3 categories (normal to mild increase, moderate increase and severe increase). An ACR of more than 3 mg/mmol (a moderate or severe increase) is an indicator for albuminuria, when albumin, a protein that is normally found in the blood, is found in the urine. CKD can progress to kidney failure in a small but significant percentage of people, which may require dialysis or a kidney transplant.

High blood pressure is a common cause of kidney failure, whilst diabetes has been established as a cause in around a quarter of all CKD cases. CKD occurs more frequently in women than in men. Prevalence also increases with age and around 30% of people aged 75 and over will have stage 3 to 5 CKD. Estimates suggest that antihypertensive medicines are taken in about half of all CKD cases.

Treatment aims to prevent or delay progression of CKD, reduce or prevent complications, and reduce the risk of cardiovascular disease. Options include a sodium glucose co-transporter 2 (SGLT2) inhibitor, such as dapagliflozin or
canagliflozin.

Empagliflozin is an SGLT2 inhibitor.

Financial Factors

This technology is commission by ICBs.

The cost-effectiveness estimates for empagliflozin compared with standard care are within the range NICE normally considers an acceptable use of NHS resources. Also, a cost comparison suggests that empagliflozin has similar costs to dapagliflozin. Therefore, empagliflozin is recommended.

NICE estimate that in Devon, 10,136 adults are eligible for treatment with empagliflozin and that 1,110 of these adults will receive empagliflozin plus standard care (790 will receive dapagliflozin plus standard care and 8,236 will receive standard care alone).

Ravulizumab for treating AQP4 antibody-positive neuromyelitis optica spectrum disorder (*terminated appraisal*) TA941

NICE is **unable to make a recommendation** on ravulizumab for treating AQP4 antibody-positive neuromyelitis optica spectrum disorder in adults. This is because the company withdrew its evidence submission. NICE will review this decision if the company decides to make a submission.

Ravulizumab for treating generalised myasthenia gravis (*terminated appraisal*) TA940

NICE is **unable to make a recommendation** on ravulizumab for treating generalised myasthenia gravis in adults. This is because the company withdrew its evidence submission. NICE will review this decision if the company decides to make a submission.

Pembrolizumab plus chemotherapy with or without bevacizumab for persistent, recurrent or metastatic cervical cancer TA939

This guidance updates and replaces TA885 (published May 2023)

Recommendations

Pembrolizumab plus chemotherapy with or without bevacizumab is **recommended** as an option for treating persistent, recurrent or metastatic cervical cancer in adults whose tumours express PD-L1 with a combined positive score of at least 1. It is recommended only if:

- pembrolizumab is stopped at 2 years of uninterrupted treatment, or earlier if the cancer progresses, and
- the company provides it according to the commercial arrangements.

This recommendation is not intended to affect treatment with pembrolizumab plus chemotherapy with or without bevacizumab 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 clinician consider it appropriate to stop.

The Technology

Cervical cancer develops when abnormal cells in the lining of the cervix grow in an uncontrolled way and eventually form a tumour. It can start from different types of cells in different parts of the cervix, which gives rise to two subtypes of cancer. The most common subtype, called squamous cell carcinoma, develops from skin-like cells present on the outer surface of the cervix (ectocervix). The other subtype is called adenocarcinoma and it develops from glandular cells that produce mucus inside the cervix (endocervix). Infection with human papillomavirus (HPV) is associated with the development of cervical cancer. It has been detected in 99.7% of cases. HPV types 16 and 18 are considered high risk for cervical cancer and cause about 75% of cases.

Cervical cancer is defined as recurrent when it has returned following treatment and as persistent when it does not respond to treatment. Cervical cancer is defined as metastatic when it has spread beyond the cervix to other places in the body such as the abdomen, liver, gut, or lungs (stage 4B). Locally advanced cervical cancer (between stages 1B2 and 4A) is characterised either by a large tumour within the cervix (more than 4 centimetres) or tumour growth into the tissues around the cervix.

For people with recurrent, persistent or metastatic cervical cancer the aim of treatment is to relieve symptoms and improve quality of life. Treatment options may include chemotherapy with paclitaxel plus either cisplatin or carboplatin. NICE recommends topotecan in combination with cisplatin as an option for treating recurrent or stage 4B cervical cancer in people who have not previously received cisplatin (TA183). Bevacizumab in combination with paclitaxel and either cisplatin or carboplatin is also available via the Cancer Drugs Fund (CDF) for untreated recurrent or metastatic cervical cancer. When chemotherapy is not suitable, people may be offered best supportive care or palliative radiotherapy.

Pembrolizumab is a humanised monoclonal antibody which binds to the programmed cell death-1 (PD-1) receptor and blocks its interaction with ligands PD-L1 and PD-L2, to promote an anti-tumour immune response. It is administered intravenously.

Financial Factors

This technology is commissioned by NHS England.

Currently around 480 people per year in England are treated with pembrolizumab plus chemotherapy (with or without bevacizumab) in the CDF and this was expected to increase to around 620 if the treatment had remained in the CDF. After rapid review the use of pembrolizumab plus chemotherapy with or without bevacizumab in routine commissioning is expected to continue to increase until a steady state is reached.

The funding of the drug will move from the CDF to routine commissioning. As the number of people treated with pembrolizumab plus chemotherapy instead of chemotherapy alone increases, the number of annual administrations will also increase as pembrolizumab plus chemotherapy has a longer treatment duration. The increase in administrations is equivalent to around 4 per person treated on average.

NICE estimate that in Devon, 21 people will be eligible for treatment.

The company has a commercial arrangement. This makes pembrolizumab available to the NHS with a discount

Dupilumab for treating eosinophilic oesophagitis in people 12 years and over (*terminated appraisal*) TA938

NICE is **unable to make a recommendation** on dupilumab for treating eosinophilic oesophagitis in people 12 years and over. This is because Sanofi did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Targeted-release budesonide for treating primary IgA nephropathy TA937

Recommendations

Targeted-release budesonide is **recommended** as an option for treating primary immunoglobulin A nephropathy (IgAN) when there is a risk of rapid disease progression in adults with a urine protein-to-creatinine ratio of 1.5 g/g or more. Targeted-release budesonide is recommended only if:

- it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with targeted-release budesonide 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 clinician consider it appropriate to stop.

The Technology

IgA nephropathy (also known as Berger's disease) is a chronic autoimmune kidney disease. It causes a build-up of IgA containing immune complexes in the glomeruli of the kidneys. This causes inflammation and damage in the glomeruli and reduces their function, eventually leading to scarring of the whole kidney.

In IgA nephropathy, both kidneys are affected equally. The condition is commonly classified as primary or secondary, with secondary disease associated with comorbidities such as IgA vasculitis and chronic liver disease. The presentation of IgA nephropathy varies considerably and in its early stages, may have no symptoms. The most common symptoms are blood or protein in the urine. IgA nephropathy is also associated with complications from reduced kidney function including high blood pressure, high cholesterol and cardiovascular problems. The rate of progression is variable, although ongoing decline in glomerular function may eventually lead to kidney failure, requiring transplant or life-long dialysis. A particularly severe form of the disease known as rapidly progressive IgA nephropathy has been reported in a small proportion of people.

There is no cure for IgA nephropathy. The aim of current treatment is to prevent or delay kidney failure and associated complications. Initial treatment focuses on reducing protein levels in the urine and blood pressure. Antihypertensives such as angiotensin-converting enzyme (ACE)

inhibitors or angiotensin receptor blockers (ARBs) are given at the maximum tolerated licensed doses.

Supportive care also includes dietary modification and exercise with or without diuretics to remove extra fluid from the blood and reduce cholesterol levels. Some people remain at high risk of progression despite optimised supportive care with lifestyle modifications and the maximum tolerated licensed doses of ACE inhibitors or ARBs.

Second-line treatments are offered to people with more than 1 gram of proteinurea per day. Second-line treatments may include glucocorticoids, sodium-glucose cotransporter-2 (SGLT2) inhibitors or entry into a clinical trial. Clinical experts explained that the use of glucocorticoids is rare or limited because of safety concerns associated with systemic use. SGLT2 inhibitors are being increasingly used since TA775 (Dapagliflozin for treating chronic kidney disease) was published. People with severely reduced kidney function may need dialysis or a kidney transplant.

Financial Factors

This technology is commissioned by ICBs.

Clinical trial evidence suggests that targeted-release budesonide plus standard care is more effective than standard care alone. Also, it is the first licensed treatment that specifically treats the condition, increasing the likelihood that people may avoid or delay the need for dialysis or a kidney transplant.

The most likely cost-effectiveness estimate for targeted-release budesonide is within the range that NICE considers an acceptable use of NHS resources, therefore it is recommended.

Secukinumab for treating moderate to severe hidradenitis suppurativa TA935

Recommendations

Secukinumab is **recommended** as an option for treating active moderate to severe hidradenitis suppurativa (acne inversa) in adults when it has not responded well enough to conventional systemic treatment, only if:

- adalimumab is not suitable, did not work or has stopped working
- the company provides secukinumab according to the commercial arrangements.

Assess response to secukinumab after the first 16 weeks of treatment and only continue if there is clear evidence of a response, defined as:

- a reduction of 25% or more in the total abscess and inflammatory nodule count, and
- no increase in abscesses and draining fistulas.

This recommendation is not intended to affect treatment with secukinumab 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 clinician consider it appropriate to stop.

The Technology

Hidradenitis suppurativa (HS), also known as acne inversa or Verneuil's disease, is a chronic disorder of the skin. HS is caused by blocked hair follicles which are connected to apocrine sweat glands. This stops sweat from escaping onto the skin and leads to the formation of pus-filled abscesses. These are painful and can cause itching, redness, burning and eventually scarring, which can limit function and may require surgery to reverse. In severe cases the pus tunnels deep under the surface of the skin and forms widespread networks of interconnected channels that can break out on the surface and leak pus. Symptoms begin around puberty and most commonly appear in the second or third decade of life. The disease affects areas with apocrine sweat glands such as the groin and genitals, buttocks and inner thighs, armpits and below the breasts. The cause of HS is unclear but may be hormonal or the result of an underlying autoimmune disorder.

There are no tests used to diagnose HS and a diagnosis is usually based on the typical signs or symptoms of the disease, although a GP may do tests to rule out other conditions with similar signs and symptoms. The British Association of Dermatologists guidelines recommend initial treatment with oral tetracyclines (such as doxycycline or lymecycline), followed by combination treatment with oral clindamycin and rifampicin in people whose disease has not responded. Retinoids (such as acitretin) and dapsone are recommended for people whose disease does not respond to antibiotic therapy. TA392 recommends adalimumab as an option for treating active moderate to severe HS in adults whose disease has not responded to conventional systemic therapy. Surgery may also be considered for people with chronic HS that cannot be controlled by medicine.

Secukinumab is administered by subcutaneous injection.

Financial Factors

This technology is commissioned by NHS England.

NICE do not expect this guidance to have a significant impact on resources. This is because the population size is small. Clinical experts estimate the eligible population is between 400 and 800 people in England.

Evidence shows that compared to best supportive care secukinumab improves symptoms of moderate to severe hidradenitis suppurativa.

The company has a commercial arrangement. This makes secukinumab available to the NHS with a discount.

Risdiplam for treating spinal muscular atrophy TA755 (UPDATE)

December 2023: The Medicines and Healthcare products Regulatory Agency approved a licence extension for risdiplam to include people of all ages (previously 2 months and over). NICE updated the recommendation and information in section 2 to account for this extension to the marketing authorisation.

Recommendation

Risdiplam is **recommended** as an option for treating 5q spinal muscular atrophy (SMA) in people **of all ages** with a clinical diagnosis of SMA types 1, 2 or 3 or with pre-symptomatic SMA and 1 to 4 SMN2 copies. It is recommended only if the conditions of the managed access agreement are followed.

Financial Factors

This technology is commissioned by NHS England.

Risdiplam is available to the NHS in line with the managed access agreement with NHS England. As part of this, NHS England and the company have a commercial access agreement that makes risdiplam available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence. The managed access agreement includes the collection of more data to address uncertainties in the evidence.

NICE estimate that around 1,500 children and adults in the UK are currently living with types 1, 2 and 3 SMA or pre-symptomatic SMA and 1 to 4 SMN2 copies SMA. The NICE guidance does not restrict use from the licence, therefore all patients covered by the marketing authorisation for risdiplam are eligible for treatment.

Highly Specialised Technology Guidance (HSTs)

Velmanase alfa for treating alpha-mannosidosis HST29

Recommendations

Velmanase alfa is **recommended** as an option for treating the non-neurological signs and symptoms of mild to moderate alpha-mannosidosis, only if:

- treatment is started in people under 18 years (it can be continued in people who turn 18 while on treatment)
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with velmanase alfa 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 clinician consider it appropriate to stop. For children and young people, this decision should be made jointly by them, their clinician, and their parents or carers.

The Technology

Alpha-mannosidosis is a rare genetic disease caused by the deficiency of an enzyme called alpha-mannosidase. It is inherited as an autosomal recessive disorder, which means that both chromosome copies carry mutations in the alpha-mannosidase gene MAN2B1 and both parents may be unaffected carriers. Alpha-mannosidase breaks down oligosaccharides and in the absence of this, oligosaccharides accumulate inside cells, resulting in damage of tissues and organs and leading to cell death. This is characterised by skeletal changes, deterioration of bones and joints, muscle weakness, hearing loss, recurring infections and developmental impairment.

Alpha-mannosidosis can present at infancy, childhood or early adolescence. The onset and severity of symptoms varies widely across a broad spectrum. The most severe forms of alpha-mannosidosis manifest during infancy and are typically characterised by enlargement of the liver, severe infections and poor survival rates. More moderate disease is associated with slow progression but the characteristics of alpha-mannosidosis are evident and have a substantial impact on physical and mental wellbeing. These characteristics may be absent in people with mild disease.

The MPS Society has identified 30 people with alpha-mannosidosis in the UK, although it is expected that there may be more patients whose disease has not been diagnosed. There are currently no pharmacological treatments for alpha-mannosidosis. Treatment options are aimed at managing symptoms, delaying progression and improving quality of life. Allogeneic haematopoietic stem cell transplant (HSCT) from a family member or unrelated donor is a treatment option for some patients when clinically indicated, although there are significant risks associated with allogeneic HSCT.

Velmanase alfa is a long-term enzyme replacement therapy for people with alpha-mannosidosis. It is administered by intravenous infusion.

Financial Factors

This technology is commissioned by NHS England.

Clinical trial evidence suggests that velmanase alfa may lead to improvements in functions such as walking, stair climbing and lung capacity, and quality of life, for people with alpha-mannosidosis. But the size and nature of these benefits are highly uncertain because of the ultra-rare nature of the condition, which makes evidence generation difficult.

The most likely cost-effectiveness estimate for velmanase alfa is around what is considered value for money in the context of a highly specialised service. Although there are some uncertainties in the economic model, when taking into account all the evidence and the factors affecting the decision, velmanase alfa is recommended.

NICE Guidelines (NGs)

Cardiovascular disease: risk assessment and reduction, including lipid modification NG238

This guidance updates and replaces CG181 (published July 2014).

This guideline covers identifying and assessing risk of cardiovascular disease (CVD) in adults without established CVD. It covers lifestyle changes and lipid-lowering treatment (including statins) for primary and secondary prevention of CVD and includes guidance for people who also have diabetes or chronic kidney disease.

Acne vulgaris: management (UPDATE) NG198

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.

December 2023: NICE clarified their recommendations on oral isotretinoin treatment in line with the 2023 MHRA advice on the introduction of new safety measures.

Bipolar disorder: assessment and management (UPDATE) CG185

This guideline covers recognising, assessing and treating bipolar disorder (formerly known as manic depression) in children, young people and adults. The recommendations apply to bipolar I, bipolar II, mixed affective and rapid cycling disorders. It aims to improve access to treatment and quality of life in people with bipolar disorder.

December 2023: NICE amended recommendations on valproate in line with MHRA safety advice that valproate must not be started for the first time in people (male or female) younger than 55 years, unless 2 specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply.

NICE Rapid COVID-19 Guidelines

None published this month.

Public Health Guidelines

None published this month.

Antimicrobial Prescribing Guidelines

None published this month.

Social Care Guidelines

None published this month.

Interventional Procedures Guidance (IPGs)

Middle meningeal artery embolisation for chronic subdural haematomas IPG779

Recommendations

Middle meningeal artery embolisation for chronic subdural haematomas **should be used only in research.**

Further research could be analysis of registry data with long-term outcomes, randomised controlled trials or other suitably designed studies. It should report details of patient selection, technique used, rebleeding, functional outcomes, need for reintervention and length of hospital stay.

The Condition

Chronic subdural haematoma is characterised by a pathological collection of blood in the subdural space and usually has an insidious onset and progression. It may begin forming several days or weeks after bleeding initially starts. Bleeding is usually caused by a head injury, which may be minor in nature.

People who are asymptomatic or have minor symptoms with smaller haematomas are usually offered conservative treatment with careful monitoring and medical management. In contrast, people who have more severe symptoms and larger haematomas and who have acceptable surgical risks, are generally offered burr hole surgery or a craniotomy.

The Procedure

This procedure is done using general or local anaesthesia, under fluoroscopic guidance. A catheter is inserted into the common femoral or radial artery, and a microcatheter is then guided into the middle meningeal artery (MMA). Angiography is used to select MMA branches for embolisation and to detect collateral vessels.

If there are no significant collateral vessels, target branches are embolised. If there are significant collateral vessels, MMA embolisation may not be offered. If the procedure is offered, the collateral vessels are either occluded using coils before embolisation, or the microcatheter is advanced more distally to avoid them. Once there is no flow in the MMA target branches on angiography, the catheters are removed.

This procedure aims to eliminate the blood supply from the MMA to the membrane around the haematoma, to allow the eventual spontaneous resolution of the haematoma and to reduce the risk of recurrence.

Medical Technologies Guidance (MTGs)

None published this month.

Diagnostics Guidance (DGs)

None published this month.

Health Technology Evaluations (HTE)

Digitally enabled therapies for adults with anxiety disorders: early value assessment HTE9 (UPDATE)

December 2023: NICE have developed tools and resources, in association with relevant stakeholders, to help organisations put this guidance into practice, including an evidence generation plan. The evidence generation plan gives further information on the prioritised evidence gaps and outcomes, ongoing studies and potential real-world data sources. It includes how the evidence gaps could be resolved through real-world evidence studies.

Digitally enabled therapies for adults with depression: early value assessment HTE8 (UPDATE)

December 2023: NICE have developed tools and resources, in association with relevant stakeholders, to help organisations put this guidance into practice, including an evidence generation plan. The evidence generation plan gives further information on the prioritised evidence gaps and outcomes, ongoing studies and potential real-world data sources. It includes how the evidence gaps could be resolved through real-world evidence studies.

NICE Quality Standards

Epilepsies in children, young people and adults QS211

This guidance updates and replaces QS26 and QS27 (published February 2013).

This quality standard covers diagnosing and managing epilepsies in children, young people and adults. It describes high-quality care in priority areas for improvement.

Transition from children's to adults' services QS140 (UPDATE)

This quality standard covers the period before, during and after a young person moves from children's to adults' services in all settings where transitions from children's to adults' health or social care services take place. It covers all young people (aged up to 25) using children's health

and social care services who are due to make the transition to adults' services. This includes young people with mental health problems, disabilities and long-term, life-limiting or complex needs, rare diseases and those in secure settings or under the care of local authorities. It describes high-quality care in priority areas for improvement.

December 2023: NICE updated this quality standard following feedback from stakeholders.

Current NICE Consultations

Title/link	End date of consultation
Burosumab for treating X-linked hypophosphataemia in adults [ID3822]	03/01/2024
Pembrolizumab with trastuzumab and chemotherapy for untreated HER2-positive advanced gastric or gastro-oesophageal junction cancer [ID3742]	03/01/2024
Menopause: diagnosis and management	05/01/2024
Belzutifan for treating tumours associated with von Hippel-Lindau disease [ID3932]	10/01/2024
Digital pulmonary rehabilitation technologies for adults with chronic obstructive pulmonary disease: early value assessment	10/02/2024
Efgartigimod for treating generalised myasthenia gravis [ID4003]	31/01/2024
Endoscopic duodenal mucosal resurfacing for type 2 diabetes	31/01/2024
Selective internal radiation therapy (SIRT) for neuroendocrine tumours metastatic to the liver	31/01/2024
Image-guided percutaneous laser ablation for primary and secondary liver tumours	31/01/2024