NHS Devon

NICE Update Bulletin: January 2026

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

1. **Natalizumab (originator and biosimilar) for treating highly active relapsing–remitting multiple sclerosis after disease-modifying therapy TA1126**
2. **Pembrolizumab with pemetrexed and platinum-based chemotherapy for untreated unresectable advanced malignant pleural mesothelioma (terminated appraisal) TA1125**
3. **Concizumab for treating haemophilia A or B in people 12 years and over with factor inhibitors (terminated appraisal) TA1124**
4. **Depemokimab for treating chronic rhinosinusitis with nasal polyps in adults (terminated appraisal) TA1123**
5. **Amivantamab with lazertinib for untreated EGFR mutation-positive advanced non-small-cell lung cancer TA1122**
6. **Acoramidis for treating transthyretin amyloidosis with cardiomyopathy TA1121**
7. **Avelumab with axitinib for untreated advanced renal cell carcinoma TA1120**
8. **Venetoclax with obinutuzumab for untreated chronic lymphocytic leukaemia TA1119**
9. **Entrectinib for treating NTRK fusion-positive solid tumours in people 12 years and over (terminated appraisal) TA1118**
10. **Sirolimus for treating facial angiofibroma caused by tuberous sclerosis complex in people 6 years and over (terminated appraisal) TA972**
11. **Overweight and obesity management NG246 (UPDATE)**
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13. **Digital self-help for eating disorders: early value assessment HTG76811**
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Technology Appraisals (TAs)

Natalizumab (originator and biosimilar) for treating highly active relapsing–remitting multiple sclerosis after disease-modifying therapy TA1126

Recommendation

Natalizumab (subcutaneous originator or intravenous biosimilar) **can be used** as an option to treat highly active relapsing–remitting multiple sclerosis (RRMS) in adults, only if:

- it has not responded to a full and adequate course of at least 1 disease-modifying therapy
- the characteristics of the person and the activity of their MS mean that cladribine is not suitable.

Natalizumab (subcutaneous originator or intravenous biosimilar) can only be used if the companies have an agreed price within the Medicines Procurement and Supply Chain.

Offer people having natalizumab regular anti-John Cunningham human polyomavirus (JCV) antibody level tests before and during treatment. Use the test specific to the brand being used when starting, or switching to, natalizumab (originator or biosimilar).

The Technology

Multiple sclerosis is a chronic neurological condition which affects the brain and spinal cord. It often results in progressive neurological impairment and severe disability. Multiple sclerosis has an unpredictable course which varies in severity and rate of progression. Symptoms can include pain, disturbance to muscle tone including weakness or spasticity, chronic fatigue, unsteady gait, speech problems, incontinence, visual disturbance and cognitive impairment. Relapsing-remitting multiple sclerosis is the most common clinical form of multiple sclerosis. It is characterised by periods of remission (where people may have no symptoms, or they may be relatively stable) followed by relapses (which may or may not result in residual disability). Relapsing–remitting multiple sclerosis can progress to secondary progressive multiple sclerosis, which is characterised by more persistent or gradually increasing disability; some people with secondary progressive disease continue to have relapses.

Over 130,000 people in the UK have multiple sclerosis, and about 7,000 people are diagnosed each year. Approximately 85% of people are diagnosed with relapsing–remitting multiple sclerosis, and around 50% of people transition to secondary progressive multiple sclerosis within 20 years. A small number of people are diagnosed with secondary progressive multiple sclerosis without a previous diagnosis of relapsing–remitting multiple sclerosis.

Current pharmacological management of relapsing–remitting multiple sclerosis includes disease-modifying agents to reduce the frequency and severity of relapses and the rate of disease progression.

NICE recommends the following treatment options for previously treated highly active relapsing–remitting multiple sclerosis:

- Ponesimod and ofatumumab for active relapsing–remitting multiple sclerosis (NICE TA767 and NICE TA699)
- Cladribine tablets for treating highly active multiple sclerosis only if the person has rapidly evolving severe relapsing–remitting disease or disease that has responded inadequately to treatment with disease-modifying therapy (NICE TA616).
- Ocrelizumab and ofatumumab for active relapsing–remitting multiple sclerosis only if alemtuzumab is contraindicated or otherwise unsuitable (NICE TA533 and NICE TA706)
- Alemtuzumab for highly active relapsing–remitting multiple sclerosis despite a full and adequate course of treatment with at least 1 disease-modifying therapy (NICE TA312)
- Fingolimod for highly active relapsing–remitting multiple sclerosis in adults who have an unchanged or increased relapse rate or ongoing severe relapses compared with the previous year despite treatment with beta interferon (NICE TA254)

Natalizumab originator and natalizumab biosimilar are indicated as a single disease-modifying therapy in adults with highly active relapsing–remitting multiple sclerosis (RRMS) for the following patient groups:

- Patients with highly active disease despite a full and adequate course of treatment with at least one disease-modifying therapy (DMT)

or

- Patients with rapidly evolving severe RRMS defined by 2 or more disabling relapses in one year, and with 1 or more Gadolinium enhancing lesion on brain Magnetic Resonance Imaging (MRI) or a significant increase in T2 lesion load as compared to a previous recent MRI.

Usual treatment for highly active RRMS after at least 1 disease-modifying therapy includes ocrelizumab, ofatumumab, ublituximab or cladribine.

The dosing schedule for natalizumab is 300 mg every 4 weeks.

Financial Factors

This technology is commissioned by NHS England.

The companies that make the natalizumab originator and the natalizumab biosimilar have agreed a nationally available price reduction for natalizumab with the Medicines Procurement and Supply Chain. The prices agreed through the framework are 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.

NICE estimate that in year 3, 978 people in Devon will be eligible for treatment.

Pembrolizumab with pemetrexed and platinum-based chemotherapy for untreated unresectable advanced malignant pleural mesothelioma (terminated appraisal) TA1125

NICE is **unable to make a recommendation** on pembrolizumab with pemetrexed and platinum-based chemotherapy for untreated unresectable advanced malignant pleural mesothelioma in adults. This is because Merck Sharpe & Dohme will not be proceeding with the evidence submission for the appraisal.

Concizumab for treating haemophilia A or B in people 12 years and over with factor inhibitors (terminated appraisal) TA1124

NICE is **unable to make a recommendation** on concizumab for treating haemophilia A or B in people 12 years and over with factor inhibitors. This is because the company did not provide an evidence submission.

Depemokimab for treating chronic rhinosinusitis with nasal polyps in adults (terminated appraisal) TA1123

NICE is **unable to make a recommendation** on depemokimab for treating chronic rhinosinusitis with nasal polyps in adults. This is because the company did not provide an evidence submission.

Amivantamab with lazertinib for untreated EGFR mutation-positive advanced non-small-cell lung cancer TA1122

Recommendation

Amivantamab plus lazertinib **can be used**, within its marketing authorisation, as an option for untreated advanced non-small-cell lung cancer (NSCLC) in adults whose tumours have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations.

Amivantamab and lazertinib can only be used if the company provides them according to their commercial arrangements.

The Technology

Lung cancer is the third most common cancer and the most common cause of cancer death in the UK, accounting for 10% of all new cancer cases and 20% of all cancer deaths in 2020. There were around 37,000 new lung cancer cases and 27,000 deaths from lung cancer in England in 2020. Most lung cancers are diagnosed at an advanced stage, when the cancer has spread to lymph nodes and other organs in the chest (locally advanced disease; stage 3) or to other parts of the body (metastatic disease; stage 4). In 2021, 91% (around 31,000) of people diagnosed with lung cancer in England had NSCLC. Around 12 to 14% of people with NSCLC in Europe have mutations in the gene coding the epidermal growth factor receptor (EGFR).

The treatment pathway for NSCLC can be divided into interconnected decision points based on the number staging system and line of therapy. Treatment choices are influenced by the presence

of biological markers (including programmed cell death 1 ligand PD-L1 status), oncogenic driver genetic alterations, histology (squamous or non-squamous) and previous treatment.

Amivantamab plus lazertinib is indicated for the first-line treatment of adult patients with advanced non-small-cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) Exon 19 deletions or Exon 21 L858R substitution mutations.

The comparator treatments for the eligible population are osimertinib alone, or with pemetrexed and platinum-based chemotherapy.

Amivantamab is administered subcutaneously or intravenously. It is assumed that subcutaneous amivantamab will be preferred.

Financial Factors

This technology is commissioned by NHS England.

The company has commercial arrangements that make amivantamab and lazertinib available to the NHS at a discount.

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

The key driver of resource impact is that, assuming a subcutaneous formulation of amivantamab is administered, it will reduce the need for intravenous infusions when used instead of osimertinib plus chemotherapy.

NICE estimate that in year 3, 25 people in Devon will be eligible for treatment, with 6 receiving having amivantamab with lazertinib each year.

Acoramidis for treating transthyretin amyloidosis with cardiomyopathy TA1121

Recommendation

Acoramidis **can be used**, within its marketing authorisation, as an option to treat wild-type or hereditary transthyretin amyloidosis with cardiomyopathy in adults. Acoramidis can only be used if the company provides it according to the commercial arrangement.

Use the least expensive option of the suitable treatments (including acoramidis and tafamidis), having discussed the advantages and disadvantages of the available treatments with the person with the condition. Take account of administration costs, dosages, price per dose and commercial arrangements.

The Technology

Transthyretin amyloidosis (ATTR) is caused by abnormal transthyretin (TTR) proteins being produced by the liver, which accumulate as amyloid deposits (fibrils) in the tissues of the body. These amyloid fibrils can disrupt the structure and damage the function of the affected tissues. ATTR can be associated with either cardiac symptoms (cardiomyopathy) or neurological symptoms (polyneuropathy) but some people can have both. Transthyretin amyloidosis cardiomyopathy (ATTR-CM) is a type of transthyretin amyloidosis in which most fibrils accumulate in the heart, causing the heart tissue to thicken and stiffen. There are two types of ATTR-CM:

- Wild-type ATTR-CM is the more common of the 2 types. It mostly affects older individuals and is more commonly diagnosed in men than women.
- Hereditary ATTR-CM (also known as familial or variant amyloid cardiomyopathy) is caused by inherited mutations in the TTR gene. The most prevalent variant in the UK is Val122Ile (15% of all TTR mutations) and less commonly Thr60Ala (2%) and Val30Met (1%). People with African or Caribbean family backgrounds are more likely to have the Val122Ile variant. Among people with hereditary ATTR-CM, the poorest survival is seen in people with the Val122Ile variant.

Symptoms of ATTR-CM can include shortness of breath, palpitations and abnormal heart rhythms (most frequently atrial fibrillation or atrial flutter), ankle swelling, fatigue, fainting and chest pain.

ATTR-CM is a progressive disease with symptoms usually starting after the age of 70 years in people with wildtype ATTR-CM, after the age of 60 years in people with the Val122Ile and Thr60Ala variants or after the age of 30 in people with the Val30Met variant. Death in most people with ATTR-CM is from sudden death and progressive heart failure. In England, around 1,500 people have been diagnosed with ATTR-CM.

Acoramidis is indicated for the treatment of wild-type or variant transthyretin amyloidosis in adult patients with cardiomyopathy (ATTR-CM).

The comparator treatments for the eligible population are tafamidis, which is an oral treatment, and vutrisiran which is administered subcutaneously. Acoramidis is administered orally.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement. This makes acoramidis available to the NHS at a discount.

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

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 costs for acoramidis are similar to or lower than tafamidis and vutrisiran.

NICE estimate that in year 3, 31 people in Devon will be eligible for treatment, with 5 receiving acoramidis.

Avelumab with axitinib for untreated advanced renal cell carcinoma TA1120

Recommendation

Avelumab plus axitinib **can be used** as an option for untreated advanced renal cell carcinoma (RCC) in adults, only if:

- They have a favourable-risk status, as defined in the International Metastatic Renal Cell Carcinoma Database Consortium criteria, and
- The company provides avelumab according to the commercial arrangement

This recommendation is not intended to affect treatment with avelumab plus axitinib 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

Renal cell carcinoma (RCC) is a cancer that usually originates in the lining of the tubules of the kidney (the smallest tubes inside the nephrons) that help filter the blood and make urine. RCC is the most common type of kidney cancer (more than 80% of the cases). There are several types of RCC. The main ones are clear cell (accounting for approximately 75% of cases),papillary and chromophobe.

Early small RCC tumours are usually asymptomatic; the diagnosis of early RCC is often incidental after abdominal scans for other reasons. The most common presenting symptoms of advanced RCC are blood in the urine (haematuria), a palpable mass in the flank or abdomen and abdominal pain. Other non-specific symptoms include fever, night sweats, malaise and weight loss. RCC is graded into stages I to IV. Stage III denotes disease that is locally advanced and/or has spread to regional lymph nodes. Metastatic RCC, in which the tumour has spread beyond the regional lymph nodes to other parts of the body, is defined as stage IV. Localised radical approaches including nephron-sparing surgery, radical nephrectomy and ablative therapies may be curative in people with localised tumours. However, around half of those who have surgery develop advanced disease later on.

In 2016, 10,609 new kidney cancer cases were diagnosed in England. In 2015, approximately 44% of people diagnosed with kidney cancer had stage III or IV disease and 25% to 31% had metastases. The 5-year relative survival rate for stage IV RCC is approximately 6%.

Avelumab with axitinib is indicated for the first-line treatment of adult patients with advanced renal cell carcinoma.

The comparator treatments for the eligible population are sunitinib, pazopanib and tivozanib, which are oral tyrosine kinase inhibitors (TKIs). Avelumab is an intravenous immunotherapy and axitinib is an oral TKI.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement that makes avelumab available to the NHS at a discount. The list price for axitinib is confidential and may vary in different settings because of negotiated procurement discounts.

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

Avelumab plus axitinib has been available through the Cancer Drugs Fund since 2020. Its uptake is not expected to change. So, the financial impact will be because of the switch from funding in the Cancer Drugs Fund to routine commissioning. A capacity impact is not expected because the number of administration appointments and subsequent treatments should remain the same.

More administration appointments are needed with avelumab plus axitinib compared with comparators. But trial data suggests that people have fewer subsequent treatments after avelumab plus axitinib than after comparator treatments.

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 any cost is likely to be offset by savings and benefits.

NICE estimate that in year 3, 13 people in Devon will be eligible for treatment, with 2 receiving avelumab with axitinib each year.

Venetoclax with obinutuzumab for untreated chronic lymphocytic leukaemia TA1119

Recommendation

Venetoclax plus obinutuzumab **can be used**, within its marketing authorisation, as an option for untreated chronic lymphocytic leukaemia (CLL) in adults. It can only be used if the companies provide the technologies according to the commercial arrangements.

The Technology

Chronic lymphocytic leukaemia (CLL) is a malignant disorder of white blood cells (lymphocytes). It causes anaemia, swollen lymph nodes, spleen enlargement, weight loss and increased susceptibility to infection. People with CLL may live with a considerable burden of symptoms impacting on their quality of life, whether or not they have received treatment.

In England there were 3,157 new cases of CLL in 2017. The risk of developing CLL increases with age and is more common in men.

Treatment options for untreated CLL depend on factors such as stage of disease, performance status and co-morbidities. Most people will not have symptoms when they first receive a diagnosis and will not need any treatment, if they don't have any symptoms. Approximately 5% to 10% of people diagnosed with CLL are considered to have 'high-risk' disease, characterised by the presence of cytogenetic mutations or abnormalities (that is, 17p deletion or TP53 mutation). The presence of 17p deletion or TP53 mutation can increase both the rate of cell growth and the resistance of the disease to treatment.

Venetoclax in combination with obinutuzumab is indicated for the treatment of adult patients with previously untreated chronic lymphocytic leukaemia.

The comparator treatment for the eligible population is venetoclax with ibrutinib.

Venetoclax with obinutuzumab has a shorter treatment duration than the comparator treatment. Venetoclax has a fixed duration of treatment of 12 cycles in both regimens. But in the comparator, the ibrutinib element of the regimen is given for 3 cycles without venetoclax at the start of treatment. Obinutuzumab is the only intravenously administered drug used in this population. Venetoclax and ibrutinib are both oral tablets.

Financial Factors

This technology is commissioned by NHS England.

The company has a commercial arrangement. This makes venetoclax with obinutuzumab available to the NHS at a discount.

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

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 technology is an additional treatment option and the overall cost of treatment will be similar for this population.

The drug is already available to the NHS through the Cancer Drugs Fund (CDF) so NICE do not anticipate practice will change substantially as a result of this guidance, other than being available through routine commissioning rather than the CDF.

The key drivers of the resource impact are that:

- The treatment duration of venetoclax with obinutuzumab is shorter than comparator treatments
- The number of administrations in each cycle is more than comparator treatments
- The administration time for obinutuzumab is longer than other treatments because it is administered intravenously, rather than orally for the other drugs
- There are reduced monitoring requirements for venetoclax with obinutuzumab because of cardiac monitoring requirements for venetoclax with ibrutinib.

NICE estimate that in year 3, 16 people in Devon will be eligible for treatment, with 4 receiving venetoclax with obinutuzumab each year.

Entrectinib for treating NTRK fusion-positive solid tumours in people 12 years and over (terminated appraisal) TA1118

NICE is **unable to make a recommendation** on entrectinib for treating neurotrophic tyrosine receptor kinase (NTRK) fusion-positive solid tumours in people 12 years and over. This is because Roche did not provide a complete evidence submission.

Sirolimus for treating facial angiofibroma caused by tuberous sclerosis complex in people 6 years and over (terminated appraisal) TA972

NICE is **unable to make a recommendation** on sirolimus for treating facial angiofibroma caused by tuberous sclerosis complex in people 6 years and over. This is because Plusultra pharma did not provide an adequate evidence submission for committee decision-making.

Highly Specialised Technology Guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Overweight and obesity management NG246 (UPDATE)

Update January 2026: NICE have amended recommendations 1.10.5, 1.10.10 and 1.10.11 and the corresponding rationale sections to clarify that height-to-weight ratios should only be used to classify the degree of central adiposity in children and young people aged 5 years and over.

This guideline covers the prevention and management of overweight, obesity and central adiposity in children, young people and adults. It brings together and updates all NICE's previous guidelines on overweight and obesity. It does not cover pregnancy.

Suspected cancer: recognition and referral NG12 (UPDATE)

Update January 2026: NICE have removed an incorrect recommendation on blood tests for myeloma.

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)

Digital self-help for eating disorders: early value assessment HTG768

Recommendations

Overcoming Bulimia Online **can be used** in the NHS during the evidence generation period as an option to treat the following conditions in adults:

- Binge eating disorder
- Bulimia nervosa
- Other specified feeding or eating disorder (OSFED) with similar features to binge eating disorder or bulimia nervosa
- Disordered eating with similar features to binge eating disorder or bulimia nervosa.

It can only be used:

- If the evidence outlined in the evidence generation plan for Overcoming Bulimia Online is being generated
- As long as it has appropriate regulatory approval including NHS England's Digital Technology Assessment Criteria (DTAC) approval.

Overcoming Bulimia Online should only be used:

- After an initial eating disorder assessment in primary care or further assessment by specialist eating disorder services
- Alongside usual waiting list care, such as regular check-ins and routine physical monitoring.

The company must confirm that agreements are in place to generate the evidence. It should contact NICE annually to confirm that evidence is being generated and analysed as planned. NICE may revise or withdraw the guidance if these conditions are not met.

At the end of the evidence generation period (2 years), the company should submit the evidence to NICE in a format that can be used for decision making. NICE will review the evidence and assess if the technology can be routinely adopted in the NHS.

The Technologies

This assessment included 3 technologies that can be used to offer NICE-recommended, evidence-based, eating-disorder-focused cognitive behavioural therapy-based self-help in a digital format.

In eating disorder services, guided self-help programmes are currently the first treatments to offer or consider for:

- All people with binge eating disorder type conditions
- Adults with bulimia nervosa type conditions.

Guided self-help involves working through a self-help book or online programme about binge eating or bulimia nervosa, and having brief, usually virtual, supportive sessions intended to support adherence.

The 3 included technologies can be used with guidance, but they are also designed to work as unguided self-help. This assessment is of their use as independent, unguided self-help therapies.

Technology (provider), regulatory status	Intended age group	Format	License cost
Digital CBTe (Credo Therapies) Class I UKCA mark	18 years and over	Smart phone app and online	£95.00 per person

Technology (provider), regulatory status	Intended age group	Format	License cost
Overcoming Bulimia Online (Five Areas Ltd) The company has stated that the technology does not need medical device regulatory approval	16 years and over	Online	£19.34 per person (2 to 5 licences) £13.44 per person (6 to 10 licences) £10.75 per person (11 to 25 licences) £9.14 per person (26 to 50 licences) £7.79 per person (51 to 99 licences) £6.72 per person (100 to 499 licences) £5.91 per person (for 500 or more licenses, used in the health economic model)
Worth Warrior (stem4) The company has stated that the technology does not need medical device regulatory approval	12 years and over (under 12 with adult guidance)	Smart phone app	£12,000 per year for a primary care network-level licence in year 1, plus £6,500 per year after that Per-person costs (calculated based on the prevalence of bulimia nervosa and binge eating disorder): £18.99 for year 1 and then £10.28 per year for binge eating disorder £71.43 for year 1 and then £38.69 per year for bulimia nervosa

Financial Factors

This technology is commissioned by ICBs.

Because Overcoming Bulimia Online (OBO) is intended to be used alongside usual waiting list care, such as regular check-ins and routine physical monitoring, the licensing costs will be an additional cost.

The cost-effectiveness analysis compared OBO only with usual care for adults with bulimia nervosa and showed a potential saving per person of £5.52 (in a primary care setting) and £39.86 (in specialist eating disorder services). Costs savings were mainly from healthcare contacts avoided because of a higher probability of remission with OBO than with usual care while waiting.

Because OBO is recommended for use while people wait for treatment, it may help to reduce potential downstream healthcare costs. Based on the external assessment group (EAG) report, potential downstream healthcare costs that could be reduced include:

- GP or nurse visits
- Blood tests
- Emergency department attendance and hospitalisations
- Referrals to specialist eating disorder services for assessment or treatment

Because of the lack of evidence regarding the resource and care pathway impact, the EAG report highlighted that the size of cost savings that might be achieved is subject to substantial uncertainty.

Balloon cryoablation for Barrett's oesophagus IPG811/HTG767

Recommendations

More research is needed on balloon cryoablation to treat Barrett's oesophagus in adults before it can be used in the NHS.

This procedure should only be done as part of formal research and a research ethics committee needs to have approved its use.

The Condition

The oesophagus is a muscular tube connecting the mouth and stomach. In Barrett's oesophagus, the cells lining the lower part of the oesophagus change, becoming more like the cells lining the intestines (intestinal metaplasia). The changed cells can become abnormal (dysplastic) over time. There is a small risk of the abnormal cells becoming cancerous. Treatment may be offered to try to remove the affected tissue. This aims to reduce the cancer risk.

The Procedure

Balloon cryoablation for Barrett's oesophagus aims to destroy the abnormal cells lining the oesophagus. Sedation is usually used, which is commonly conscious sedation but may be general anaesthesia. A balloon catheter is inserted through an endoscope, aligned with the abnormal tissue and inflated. Nitrous oxide gas is then sprayed through a radial diffuser head within the balloon, which is aimed at the abnormal tissue. The balloon freezes and the extreme cold destroys the abnormal tissue. The nitrous oxide gas remains fully contained within the balloon, which exits the body through the proximal end of the catheter.

The ablation sequence is repeated until all the abnormal tissue is destroyed. Multiple ablations can be done in 1 session without removing the balloon. Repeat endoscopy is usually scheduled 8 to 12 weeks after the procedure to check whether the abnormal tissue has been destroyed. If any abnormal tissue is found, retreatment may be considered.

The procedure is usually done in an outpatient setting but is sometimes done in an inpatient setting. The choice of setting may vary by care provider and patient needs.

Medicines such as a histamine2-receptor antagonist or proton pump inhibitor may be recommended for some people having cryoablation. The aim of this medication is to improve the success rate of the procedure. It may also help reduce the risk of Barrett's oesophagus returning in the long term.

Digital technologies for managing mild to moderate symptoms of hip or knee osteoarthritis: early value assessment HTG766

Recommendations

Eight digital technologies **can be used** in the NHS during the evidence generation period as options to manage mild to moderate symptoms of hip or knee osteoarthritis in adults. The technologies are:

- getUBetter
- Good Boost
- Hinge Health
- Joint Academy
- Phio Engage
- re.flex
- Sword Thrive
- TrackActive Me.

These technologies can only be used:

- If the evidence outlined in the evidence generation plan for digital technologies for managing mild to moderate symptoms of hip or knee osteoarthritis is being generated
- As long as they have appropriate regulatory approval, including NHS England's Digital Technology Assessment Criteria (DTAC) approval.

The companies must confirm that agreements are in place to generate the evidence. NICE will contact the companies annually to confirm that evidence is being generated and analysed as planned. NICE may revise or withdraw the guidance if these conditions are not met.

At the end of the evidence generation period (3 years), the companies should submit the evidence to NICE in a format that can be used for decision making. NICE will review the evidence and assess if the technologies can be routinely adopted in the NHS.

The Technologies

This assessment considered 11 digital technologies for managing mild to moderate symptoms of hip or knee osteoarthritis. The technologies are accessed through a web or smartphone application. They aim to give people the knowledge, skills and confidence to manage their condition when it is convenient for them. Each technology includes the following components:

- Information, education and advice on managing hip or knee osteoarthritis
- A personalised therapeutic exercise programme
- Signposting to appropriate support services when needed.

The technologies vary in terms of their delivery, access route, intended population, professional involvement, additional features, current NHS use and costs (see table). The costs and durations of use vary. Some technologies have an annual cost, whereas others have a cost based on how long they are expected to be used.

ESCAPE-pain and Physio Wizard are no longer available to the NHS, so the committee could not make a recommendation on these digital technologies.

Technology	Regulatory status	Indication	Healthcare professional communication	Additional features	Programme adjustments	Cost
getUBetter (getUBetter)	Class 1	Hip and knee	No direct communication	No	Based on user feedback	£18.86 (annual)
Good Boost (Good Boost Wellbeing)	Class 1	Hip and knee	One way (professional to user)	Optional classes	Automated based on user feedback	£46.15 (annual)
Hinge Health (Hinge Health)	Class 1	Hip and knee	No direct communication	Motion tracking	Automated based on user feedback	£296.25 (annual)
Joint Academy (Artho Therapeutics)	Class 1	Hip and knee	Two way (messaging and video with company specialist)	No	By company physiotherapist and semi-automated based on user feedback	£112.50 (12 weeks)
Pathway Through Arthritis (Wellmind health)	Class 1	Hip and knee	One way (user to professional)	Unclear	Unclear	Unclear
Phio Engage (EQL)	Not a medical device	Hip and knee	Two way (messaging with company or NHS specialist)	No	By physiotherapist	£45.28 (annual)
re.flex (Kineto tech rehab)	Class 1	Knee	No direct communication	Wearable sensor with motion tracking	Automated based on sensor feedback	£229.50 (12 weeks)
Sword Thrive (Sword Health)	Class 1	Hip and knee	Two way (messaging and video with company specialist)	Wearable sensor with motion tracking	By physiotherapist	£250 (annual)

Technology	Regulatory status	Indication	Healthcare professional communication	Additional features	Programme adjustments	Cost
TrackActive Me (Active Health Tech)	Class 1	Hip and knee	One way (user to professional)	No	Automated based on user feedback	Confidential

Financial Factors

This technology is commissioned by ICBs.

Supplier costs vary because of differences in delivery models, access routes, target user groups, levels of professional input needed and additional features across the technologies. Resource impact will be influenced by local commissioning decisions, negotiated pricing agreements and the level of adoption of each technology.

Further resources may be needed to support access for groups such as older adults, people in deprived areas and people who do not have suitable devices or a stable internet connection.

The guidance says the technologies are not meant to replace face-to-face care, but they may help reduce the number of appointments with a GP or first-contact practitioner, and this could free up staff time. But there is still uncertainty about how cost effective the technologies are because the available evidence is limited. The committee agreed that better data for each technology would be needed to estimate cost effectiveness more accurately in future.

NICE Quality Standards

None published this month.

Current NICE Consultations

Title/link	End date of consultation
Suspected Cancer: recognition and referral (update)	02/02/2026
Anaphylaxis: assessment and referral after emergency treatment	03/02/2026
Zanidatamab for treating HER2-positive advanced biliary tract cancer after 1 or more systemic treatments [ID6388]	03/02/2026
Upadacitinib for treating giant cell arteritis [ID6299]	04/02/2026
Daratumumab with bortezomib, lenalidomide and dexamethasone for untreated multiple myeloma when an autologous stem cell transplant is suitable [ID6249]	04/02/2026
Perioperative care in adults	06/02/2026
MRI-guided focused ultrasound thalamotomy for treatment-resistant essential tremor	09/02/2026
Baxdrostat for treating uncontrolled or resistant hypertension [ID6623]	09/02/2026
Decitabine–cedazuridine with venetoclax for treating acute myeloid leukaemia when intensive induction chemotherapy is unsuitable [ID6601]	11/02/2026
Pirtobrutinib for untreated chronic lymphocytic leukaemia or small lymphocytic lymphoma [ID6397]	11/02/2026
Cemiplimab for adjuvant treatment of high-risk cutaneous squamous cell carcinoma after surgery and radiotherapy ID6659	12/02/2026
Pimicotinib for treating tenosynovial giant cell tumours when systemic treatment is needed [ID6647]	12/02/2026
Inhaled treprostinil for treating pulmonary hypertension with interstitial lung disease [ID6459]	13/02/2026
Guidance on the use of electroconvulsive therapy	16/02/2026
Apadamtase alfa for treating congenital thrombotic thrombocytopenic purpura caused by ADAMTS-13 deficiency ID6192	18/02/2026
Enfortumab vedotin with pembrolizumab for neoadjuvant and adjuvant treatment of muscle-invasive bladder cancer ID6607	20/02/2026
Osteoporosis: risk assessment, treatment, and fragility fracture prevention (update)	23/02/2026