NHS Devon

NICE Update Bulletin: July 2026

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Technology Appraisals (TAs)

Aficamten for treating symptomatic obstructive hypertrophic cardiomyopathy TA1181

Recommendation

Aficamten **can be used** as an option to treat symptomatic obstructive hypertrophic cardiomyopathy in adults with a New York Heart Association (NYHA) class of 2 to 3. It can only be used:

- as an add-on to individually optimised standard care including beta-blockers, non-dihydropyridine calcium-channel blockers or disopyramide, or
- alone if these treatments are contraindicated, and
- if the company provides it according to the commercial arrangement.

Use the least expensive option of the suitable treatments (including aficamten and mavacamten), 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.

These recommendations are not intended to affect treatment with aficamten that was started in the NHS before this guidance was published. People having treatment outside these recommendations 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

Hypertrophic cardiomyopathy (HCM) is a genetic condition that is most often caused by a change or fault (or mutation) in one or more genes and is characterised by the thickening of the muscular wall of the heart (the myocardium). Thickening of the septum (the dividing wall between the left and the right side of the heart), resulting in reduced or restricted blood flow is classified as obstructive HCM. Most people with HCM may initially have few or no symptoms. However, the disease is progressive, and symptoms may develop or worsen at any age. Common symptoms of HCM include shortness of breath, chest pain, palpitations, light headedness, and fainting. People with obstructive HCM can develop serious complications such as atrial fibrillation, heart failure, malignant ventricular arrhythmias, and sudden cardiac death.

HCM is the most common genetic cardiovascular disease and has a prevalence of around 1 in 500 people in the general population. Most people with HCM have no symptoms or feel stable throughout their life. The disease most commonly presents in the second or third decade of life but may present at any age. HCM is the most common cause of sudden unexpected death in childhood and in young athletes.

Treatment approaches vary depending on symptoms and risk of sudden disease. People with HCM may need to make lifestyle changes, such as limiting their activity to adjust for their disease,

if considered suitable by a specialist after individual evaluation. People with HCM may also have their condition monitored using echocardiographs. European Society of Cardiology (ESC) Guidelines on hypertrophic cardiomyopathy recommend that people with symptomatic disease, predominately with left ventricular outflow tract obstruction, receive beta-blockers to reduce symptoms. If beta-blockers are ineffective or contraindicated, non-dihydropyridine calcium channel blockers (such as verapamil and diltiazem) are suitable alternatives.

Aficamten is indicated for the treatment of symptomatic obstructive hypertrophic cardiomyopathy (oHCM) in adult patients.

The treatment options for the eligible population are mavacamten with standard care and standard care alone.

Financial Factors

This technology is commissioned by ICBs.

Aficamten has a list price of £1,180.52 for a 28-tablet pack.

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

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

The key drivers of the resource impact are:

- a cost comparison suggesting that the costs for aficamten are similar to or lower than those for mavacamten
- the current level of market share of mavacamten use and to what extent aficamten displaces it
- that fewer monitoring appointments and tests are needed with aficamten each year than with mavacamten
- that a CYP2C19 genotype test at the start of treatment is not needed with aficamten but is needed for mavacamten.

NICE estimate that in year 3, 148 people in Devon will be eligible for treatment with 26 having aficamten each year.

Netarsudil for treating open-angle glaucoma or ocular hypertension (terminated evaluation) TA1180

NICE is **unable to make a recommendation** on netarsudil for treating open-angle glaucoma or ocular hypertension in adults. This is because the company did not provide an evidence submission.

Lutetium-177 vipivotide tetraxetan for treating PSMA-positive hormone-relapsed metastatic prostate cancer after an anti-androgen but not a taxane (terminated evaluation) TA1179

NICE is **unable to make a recommendation** on lutetium-177 vipivotide tetraxetan for treating prostate-specific membrane antigen (PSMA)-positive hormone-relapsed metastatic prostate cancer in adults who have had anti-androgen treatment but have not had a taxane. This is because the company did not provide an evidence submission.

Deuruxolitinib for treating severe alopecia areata TA1178

Recommendation

Deuruxolitinib **can be used**, within its marketing authorisation, as an option to treat severe alopecia areata in adults. Deuruxolitinib can only be used if the company provides it according to the commercial arrangement.

Use the least expensive option of the suitable treatments (including deuruxolitinib and ritlecitinib), 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

Alopecia areata is a chronic, inflammatory, autoimmune condition affecting the hair follicles leading to a sudden onset of hair loss. It does not cause scarring or permanent damage to the hair follicles. It can affect any hair-bearing skin such as the beard, eyebrows, eyelashes, body and limbs. The most common presentation of alopecia areata is small, round or oval patches of baldness on the scalp. It may affect the whole scalp (alopecia totalis) or the entire body and scalp (alopecia universalis). For some people, patchy hair loss may continue over a long period of time, referred to as persistent patchy or chronic alopecia areata. Other types of alopecia areata are characterised by different patterns of hair loss. For example, diffuse alopecia areata is characterised by sudden thinning of the hair all over the scalp, rather than in patches. Alopecia areata ophiasis refers to hair loss from the sides and lower back of the scalp, alopecia areata sisaipho refers to hair loss from the front of the scalp, forehead and rarely the eyebrows while alopecia barbae refers to hair loss in the beard and moustache area.

Alopecia areata occurs when hair follicles change from the growth (anagen) phase to the loss (telogen) phase prematurely, but the exact cause is unknown. While there is a genetic predisposition, it can occur at any age, affecting both males and females equally. It is suggested that there may be higher incidence in children and young adults and there may also be a link to social deprivation. In the UK, it is estimated that approximately 0.58% of adults have alopecia areata4, of which 7% to 10% may have the severe form and 10 to 50% may have nail involvement. An increased prevalence in ethnic minority and deprived populations may be underestimated as these groups may be less likely to present to health services. Alopecia areata is also associated with higher rates of atopic and other autoimmune conditions.

Alopecia areata is typically diagnosed clinically based on presenting features such as patterns of hair loss, exclamation mark hairs (short, broken hairs tapering proximally) and a positive pull test. In some cases, identifying whitening of the hairs can also aid diagnosis. Prognosis is unpredictable and varies, depending on severity and duration of the condition. Spontaneous remission within one year is seen in up to 80% of people with limited patches of hair loss of less than one year duration. However, hair pattern regrowth is variable and unpredictable and when hair loss becomes extensive, spontaneous re-growth is rare. Evidence also suggests that there is a correlation between alopecia areata and depression and anxiety.

Clinical management depends on the severity of hair loss. If there is evidence of hair regrowth or there is less than 50% hair loss, management may include watchful waiting and advice on cosmetic options to camouflage hair loss, such as wigs. Treatment options in primary care may include topical corticosteroids, one of the few treatments currently licensed for use in alopecia areata. If there is no hair regrowth and more than 50% hair loss, people may be referred to a dermatologist, as well as receiving wigs. Specialist management depends on disease duration, activity, location, extent, and the person's age and individual preference.

Deuruxolitinib is indicated for the treatment of adult patients with severe alopecia areata.

Financial Factors

This technology is commissioned by ICBs.

Deuruxolitinib costs £949.41 per pack of 60×8 mg tablets

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

The comparator treatments for the eligible population are ritlecitinib and best supportive care.

Ritlecitinib is a direct alternative to deuruxolitinib while best supportive care is assumed to be given with or without either drug.

Both deuruxolitinib and ritlecitinib are oral drugs so there is no capacity impact for administration but deuruxolitinib requires a CYP2C9 genetic test performed by a simple swab prior to treatment commencement. The company has indicated they will pay for these tests.

NICE estimate that in year 3, 292 people in Devon will be eligible for treatment with 117 having deuruxolitinib.

Pembrolizumab with chemoradiotherapy for untreated locally advanced cervical cancer TA1177

Recommendation

Pembrolizumab with chemoradiotherapy (external beam radiation therapy followed by brachytherapy) **can be used**, within its marketing authorisation, as an option for untreated International Federation of Gynecology and Obstetrics (FIGO) 2014 stages 3 to 4A locally advanced cervical cancer in adults. Pembrolizumab can only be used if the company provides it according to the commercial arrangement.

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 2 main 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). The human papilloma virus (HPV) is the main cause of cervical cancer and has been detected in 99% of cases. HPV types 16 and 18 account for at least two-thirds of cases.

Locally advanced cervical cancer is characterised either by a large tumour within the cervix (more than 4 centimetres) or tumour growth into the tissues around the cervix.

There are around 3,300 new cervical cancer cases in the UK every year. In England between 2017 and 2019, there were an average of 2,688 new cases of cervical cancer per year. Between, 2017 and 2019, an average of 853 deaths were recorded in the UK because of cervical cancer per year. Around half of people diagnosed with cervical cancer in England survive their disease for 10 years or more.

Standard treatment for locally advanced cervical cancer is chemoradiation consisting of external beam radiotherapy, intracavity brachytherapy and chemotherapy with cisplatin.

Pembrolizumab in combination with chemoradiotherapy (external beam radiation therapy followed by brachytherapy), is indicated for the treatment of FIGO 2014 Stage 3 – 4A locally advanced cervical cancer in adults who have not received prior definitive therapy.

The comparator treatments for the eligible population are chemoradiotherapy, the use of chemoradiotherapy is not expected to change as it will be given with or without pembrolizumab and the treatment duration is the same. Pembrolizumab and cisplatin are both given intravenously.

Financial Factors

This technology is commissioned by NHS England.

Pembrolizumab costs £2,630 per 100-mg vial or around £91,000 for a year of treatment.

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

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

The key drivers of resource impact are that:

- Pembrolizumab is given in addition to chemoradiotherapy (cisplatin plus radiotherapy) so use of chemoradiotherapy is not expected to change.
- Pembrolizumab continues as a monotherapy beyond the usual treatment duration for chemoradiotherapy.

NICE estimate that in year 3, 6 people in Devon will be eligible for treatment with 4 having pembrolizumab each year.

Teplizumab for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1 diabetes TA1176

Recommendation

Teplizumab **can be used**, within its marketing authorisation, as an option for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1 diabetes. Teplizumab is only recommended if the company provides it according to the commercial arrangement.

The Technology

Diabetes mellitus is a chronic metabolic disorder characterised by elevated blood glucose levels (hyperglycaemia) resulting from a lack of the hormone insulin or resistance to its action. Type 1 diabetes results from the body's own immune system destroying the cells that make insulin. If not managed effectively, diabetes mellitus can lead to kidney failure, blindness, foot problems, and damage to the nervous system. People with diabetes are also more at risk of cardiovascular disease.

Type 1 diabetes progresses across the following three stages:

- Stage 1 type 1 diabetes: presence of 2 or more pancreatic islet autoantibodies, but a normal concentration of blood glucose. Clinical symptoms are not present at Stage 1.
- Stage 2 type 1 diabetes: 2 or more pancreatic islet autoantibodies and dysglycaemia (abnormalities in blood glucose levels) without reaching thresholds for hyperglycaemia. Clinical symptoms are not present at Stage 2.

- Stage 3 (symptomatic) type 1 diabetes, is defined by overt hyperglycaemia, accompanied by clinical symptoms. In Stage 3, people with type 1 diabetes will usually require lifelong insulin therapy as treatment.

In 2021-22, there were 9,760 people newly diagnosed with type 1 diabetes in England and Wales. Most people with type 1 diabetes are diagnosed in stage 3. There is no national screening programme to identify people with stage 1 or 2 type 1 diabetes. Type 1 diabetes can present at any age, peaking in presentation around age 12 years. Type 1 diabetes is slightly more common in males than females.

Teplizumab is indicated to delay the onset of Stage 3 type 1 diabetes in adult and paediatric patients 8 years of age and older with Stage 2 type 1 diabetes.

The comparator treatments for the eligible population are established clinical management

Financial Factors

This technology is commissioned by ICBs.

The list price of teplizumab is £10,939.12 for a 2-mg vial with treatment consisting of one single course of 2-mg vial intravenous infusions administered on 14 consecutive days.

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

The key driver of resource impact is that there is no alternative treatment to teplizumab that is being displaced. So, teplizumab is an add-on cost to existing established clinical management.

NICE estimate per 10,000 people who are tested, 77 will be eligible for teplizumab, with uptake raising to 80% by year 3.

Glycopyrronium bromide cream for treating severe primary axillary hyperhidrosis TA1175

Recommendation

Glycopyrronium bromide (GPB) cream **can be used** as an option to treat severe primary axillary hyperhidrosis in adults, if lifestyle advice, topical aluminium-based antiperspirants and oral antimuscarinics:

- have not controlled underarm sweating, or
- are contraindicated or not tolerated.

This recommendation is not intended to affect treatment with GPB cream 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

Hyperhidrosis is a condition in which sweating is in excess of that necessary to maintain normal body temperature. Primary (idiopathic) hyperhidrosis has no recognised cause and mainly affects focal areas of the body, such as the armpits, feet, hands or head and face. Primary axillary hyperhidrosis affects the armpits but rarely occurs in isolation and is usually associated with hyperhidrosis in other areas. Severe primary axillary hyperhidrosis can be defined as a score of 3 or 4 on the Hyperhidrosis Disease Severity Scale. Primary hyperhidrosis usually starts before the age of 18 years, although it can happen at any age. It is usually life-long, although in a few people symptoms can spontaneously improve over time. Excessive sweating can have a profound effect on quality of life, interfering with daily activities and causing anxiety and embarrassment.

The true prevalence of hyperhidrosis is unknown, as it is often under-reported by patients and under-diagnosed by healthcare professionals. Hyperhidrosis is estimated to occur in 1% to 1.6% of people in the United Kingdom.1 Around 90% of these are primary hyperhidrosis and more than half affect the axilla (armpits).

There are no NICE guidelines for treating primary axillary hyperhidrosis. First-line management of primary axillary hyperhidrosis includes lifestyle measures such as avoiding known triggers and tight clothing and using aluminium-based antiperspirants. If these do not work, then oral antimuscarinics such as propantheline bromide, off-label oxybutynin or off-label oral glycopyrronium bromide may be used. Botulinum-toxin A (botox) injection is another option that is commissioned in some parts of the UK.

Glycopyrronium bromide (GPB) cream is indicated for the topical treatment of severe primary axillary hyperhidrosis in adults.

Financial Factors

This technology is commissioned by ICBs.

The list price of glycopyrronium bromide (GPB) is £69.50 per tube. Costs may vary in different settings because of negotiated procurement discounts.

According to the dosage schedule in the summary of product characteristics for GPB cream, a patient would require approximately 4 × 50 g tubes per year.

In year 3, NICE expect 1,620 to be eligible for GPB cream, with 243 people in Devon receiving treatment. Based on a patient requiring 4 x 50 g tubes, this would be a drug cost of £67,554.00 (not factoring in cost variation in different settings due to procurement discounts).

Cemiplimab for treating recurrent or metastatic cervical cancer that has progressed on or after platinum-based chemotherapy TA1174

This guidance updates and replaces NICE technology appraisal guidance on cemiplimab for treating recurrent or metastatic cervical cancer (TA901).

Recommendation

Cemiplimab **can be used** as an option to treat recurrent or metastatic cervical cancer that has progressed on or after platinum-based chemotherapy in adults if:

- they have not had immunotherapy
- treatment is stopped after 32 cycles (each lasting 3 weeks), or earlier if the cancer progresses or there is unacceptable toxicity, and
- the company provides cemiplimab according to the commercial arrangement

This recommendation is not intended to affect treatment with cemiplimab 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

Cervical cancer develops when abnormal cells in the lining of the cervix (the entrance to the womb from the vagina) 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 2 main 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). Another subtype is called adenocarcinoma and it develops from glandular cells that produce mucus inside the cervix (endocervix). It is also possible to have cancer characterised by the presence of both squamous and glandular cells, this is adenosquamous carcinoma. The human papilloma virus (HPV) is the main cause of cervical cancer and has been detected in 99% of cases. HPV types 16 and 18 account for at least two-thirds of cases.

Cervical cancer is said to be recurrent when it has returned following treatment, and metastatic when it has spread beyond the pelvis and pelvic lymph nodes to other places in the body such as the abdomen, liver, intestinal tract, or lungs.

In England in 2022, there were 2,641 newly diagnosed cases of cervical cancer, and 737 recorded deaths from cervical cancer. Survival rates for metastatic or recurrent cervical cancer are significantly lower than for early-stage cervical cancer. About 15% of people diagnosed with stage 4 (metastatic) disease survive for 5 years or more after diagnosis compared with 95% of people diagnosed at stage 1.

Cemiplimab is indicated for the treatment of adult patients with recurrent or metastatic cervical cancer and disease progression on or after platinum-based chemotherapy.

The comparator treatments for the eligible population are single-agent chemotherapies.

Cemiplimab, paclitaxel and gemcitabine are all administered via IV infusion but paclitaxel and gemcitabine both have two administrations per cycle.

Financial Factors

This technology is commissioned by NHS England.

The list price for cemiplimab is £4,650 per 350-mg vial.

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

The key drivers of the resource impact are:

- The treatment duration of cemiplimab is longer than comparator treatments.
- The number of administrations in each cycle is less than comparator treatments.

Pirtobrutinib for treating relapsed or refractory chronic lymphocytic leukaemia after a BTK inhibitor TA1173

Recommendation

Pirtobrutinib **can be used** as an option to treat relapsed or refractory chronic lymphocytic leukaemia (CLL) in adults who have had a Bruton's tyrosine kinase (BTK) inhibitor, only if:

- retreatment with a covalent BTK inhibitor (including after fixed-duration regimens) is not clinically appropriate
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with pirtobrutinib 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 form of chronic leukaemia and is a type of cancer that affects the white blood cells. It tends to progress slowly over many years. The risk of developing CLL increases with age and is more common in men. CLL mostly affects older people and is rare in people 40 years of age and younger.1-3 Around 3,900 people are diagnosed with CLL in the UK each year.

In CLL, 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. CLL usually

progresses slowly, but 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. Small lymphocytic lymphoma (SLL) is considered the same condition as CLL, as most people with CLL or SLL have abnormal white blood cells in locations that overlap, including lymph nodes, spleen, blood and bone marrow.

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. When treatment is needed, most people will have a targeted treatment such as acalabrutinib, zanubrutinib, ibrutinib, or venetoclax. Some people may have chemoimmunotherapy. If the disease relapses, or is refractory to initial treatment, there are a number of further treatment options.

Pirtobrutinib is indicated as monotherapy for the treatment of adult patients with relapsed or refractory chronic lymphocytic leukaemia (CLL) who have been previously treated with a BTK inhibitor.

Standard treatment for relapsed or refractory chronic lymphocytic leukaemia in adults after a BTK inhibitor is venetoclax alone or venetoclax plus rituximab. Some people may have another covalent BTK inhibitor if they stopped using the first covalent BTK inhibitor either because they completed the fixed course of treatment or because of its side effects. Standard treatment for people who have tried a venetoclax regimen and a covalent BTK inhibitor is idelalisib plus rituximab.

Financial Factors

This technology is commissioned by NHS England.

The list price for pirtobrutinib is £2,081.50 for a 28-pack of 50 mg tablets and £8,325.00 for a 56-pack of 100 mg tablets.

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

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

The key drivers of the resource impact are:

- Cost comparisons suggest the costs for pirtobrutinib are similar to or lower than venetoclax alone or venetoclax plus rituximab.
- Pirtobrutinib is administered orally while venetoclax with rituximab has an intravenous component, therefore a reduction in administration appointments would be expected if pirtobrutinib displaces venetoclax with rituximab.

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 patient group.

The eligible population is estimated to be under 200 people. Because the population is small, NICE have not produced a resource impact template.

Highly Specialised Technology Guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Osteoporosis: risk assessment NG259

This guideline updates and replaces NICE guideline CG146 (August 2012).

This guideline covers identifying adults for fragility fracture risk assessment, risk assessment methods, identifying vertebral fragility fractures and treatment criteria. It also covers repeat risk assessment timing and methods for people not having treatment. It aims to provide guidance on selecting and using risk assessment tools for adults at risk of fragility fractures in all NHS settings.

Heavy menstrual bleeding: assessment and management NG88 (UPDATE)

July 2026: NICE have removed recommendation 1.2.8 that stated not to routinely test for serum ferritin in the section on laboratory tests. Based on feedback from stakeholders, NICE reviewed this recommendation from 2007. After revisiting the evidence behind it, NICE concluded that a recommendation against serum ferritin testing in women with heavy menstrual bleeding is not justified because of the risk of iron deficiency in this population.

This guideline covers assessing and managing heavy menstrual bleeding (menorrhagia). It aims to help healthcare professionals investigate the cause of heavy periods that are affecting a woman's quality of life and to offer the right treatments, taking into account the woman's priorities and preferences.

Low back pain and sciatica in over 16s: assessment and management NG59 (UPDATE)

July 2026: NICE have withdrawn the recommendations on psychological therapy for low back pain with or without sciatica, and combined physical and psychological programmes for low back pain or sciatica. NICE have also removed references to psychological therapy in recommendation 1.1.3 on risk stratification and recommendation 1.2.7 on manual therapies.

This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over. It outlines physical, psychological, pharmacological and surgical treatments to help people

manage their low back pain and sciatica in their daily life. The guideline aims to improve people's quality of life by promoting the most effective forms of care for low back pain and sciatica.

Metabolic dysfunction-associated steatotic liver disease (MASLD): assessment and management NG49 (UPDATE)

July 2026: NICE have renamed and updated this guideline to reflect that:

- **non-alcoholic fatty liver disease (NAFLD) is now called metabolic dysfunction-associated steatotic liver disease (MASLD) and**
- **non-alcoholic steatohepatitis (NASH) is now called metabolic dysfunction-associated steatohepatitis (MASH).**

NICE have also replaced references to 'fatty liver' with 'steatosis of the liver' in the section on diagnosing MASLD in children and young people and made minor changes to the terminology used in the recommendations on healthy living.

This guideline covers how to identify the adults, young people and children with metabolic dysfunction-associated steatotic liver disease (MASLD) who have advanced liver fibrosis and are most at risk of further complications. It outlines the changes to diet and physical activity, and pharmacological treatments that can manage MASLD and advanced liver fibrosis.

Public Health Guidelines

None published this month.

Antimicrobial Prescribing Guidelines

None published this month.

Social Care Guidelines

None published this month.

HealthTech guidance (HTGs)

None published this month.

NICE Quality Standards

Perioperative care in adults QS216

This quality standard covers care in adults during the preoperative, intraoperative and postoperative periods. It describes high-quality care in priority areas for improvement.

Osteoporosis QS149 (UPDATE)

July 2026: Changes have been made to align this quality standard with the updated NICE guideline on osteoporosis. Statement 1 has been updated to reflect changes to the guidance on assessment of fragility fracture risk including populations and risk factors. Statement 2 on starting drug treatment has been removed because it now doesn't align with NICE guideline recommendations. Links, definitions and source guidance sections have also been updated throughout.

This quality standard covers managing osteoporosis in adults (aged 18 and over), including assessing risk and preventing fragility fractures. It describes high-quality care in priority areas for improvement.

Lung cancer in adults QS17 (UPDATE)

July 2026: Changes have been made to align this quality standard with the updated NICE guideline on lung cancer. Statement 1 was removed as it is no longer supported by guideline recommendations. Links, definitions and source guidance sections have also been updated throughout.

This quality standard covers diagnosing and managing lung cancer in adults. It describes high-quality care in priority areas for improvement.

Current NICE Consultations

Title/link	End date of consultation
Efgartigimod for treating generalised myasthenia gravis (review of TA1069) [GID-TA12493]	04/08/2026
Pembrolizumab with chemotherapy for adjuvant treatment of newly diagnosed high-risk endometrial cancer after surgery with curative intent [ID6207]	05/08/2026
Bladder cancer: diagnosis and management (update)	06/08/2026
Setmelanotide for treating obesity and hyperphagia in Bardet-Biedl syndrome in people 6 years and over (review of HST31) [ID6598]	07/08/2026
Beremagene geperpavec for treating skin wounds associated with dystrophic epidermolysis bullosa [ID3959]	10/08/2026
Tirzepatide for reducing the risk of major adverse cardiovascular events in people with type 2 diabetes and cardiovascular disease ID6733	11/08/2026
Palopegteriparatide for treating chronic hypoparathyroidism [ID6380]	11/08/2026
Epcoritamab for treating relapsed or refractory diffuse large B-cell lymphoma after first-line systemic treatment ID6463	12/08/2026

Tozorakimab for maintenance treatment of uncontrolled chronic obstructive pulmonary disease [ID6711]	12/08/2026
Talquetamab with daratumumab for treating relapsed or refractory multiple myeloma after 1 or more treatments ID6625	13/08/2026
XVIVO Perfusion System (ex-situ machine perfusion) for assessing and reconditioning marginal lungs for transplantation: early-use assessment	17/08/2026
Mavorixafor for treating WHIM syndrome ID3946	17/08/2026
Low-dose atropine eye drops for treating myopia in people 3 to 14 years [ID6517]	19/08/2026
Intrathecal onasemnogene abeparvovec for treating spinal muscular atrophy in people 2 years and over [ID6556]	19/08/2026
Elinzanetant for treating moderate to severe vasomotor symptoms associated with menopause ID6359	19/08/2026