NHS Devon

NICE Update Bulletin: June 2023

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

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2. **Upadacitinib for previously treated moderately to severely active Crohn's disease TA905**
3. **Pembrolizumab with lenvatinib for previously treated advanced or recurrent endometrial cancer TA904**
4. **Darolutamide with androgen deprivation therapy and docetaxel for treating hormone-sensitive metastatic prostate cancer TA903**
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Technology Appraisals (TAs)

Deucravacitinib for treating moderate to severe plaque psoriasis TA907

Recommendations

Deucravacitinib is **recommended** as an option for treating moderate to severe plaque psoriasis in adults, only if:

- the Psoriasis Area and Severity Index (PASI) score is 10 or more and the Dermatology Life Quality Index (DLQI) score is more than 10
- the condition has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated
- the company provides deucravacitinib according to the commercial arrangement.

Consider stopping deucravacitinib between 16 weeks and 24 weeks if there has not been at least a 50% reduction in the PASI score (PASI 50) from when treatment started.

Consider stopping deucravacitinib at 24 weeks if the psoriasis has not responded adequately. An adequate response is defined as:

- a 75% reduction in the PASI score (PASI 75) from when treatment started or
- a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.

If people with the condition and their clinicians consider deucravacitinib to be 1 of a range of suitable treatments, 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.

Take into account how skin colour could affect the PASI score and make any adjustments needed.

Take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and make any adjustments needed.

These recommendations are not intended to affect treatment with deucravacitinib 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

Plaque psoriasis is an inflammatory skin condition characterised by an accelerated rate of turnover of the upper layer of the skin. This leads to an accumulation of skin cells forming raised plaques on the skin. These plaques can be flaky, scaly, itchy and red or a darker colour to the surrounding skin. Plaque psoriasis may affect the scalp, elbows, knees and lower back and sometimes the face, groin, armpits or behind the knees. Although it is a chronic, persistent, severe condition, its course may be unpredictable, with flare-ups and remissions.

Psoriasis is generally graded as mild, moderate or severe and takes into account the location, surface area of skin affected and the impact of the psoriasis on the person. The Psoriasis Area and Severity Index (PASI) is an index of disease severity in adults and takes into account the size of the area covered with psoriasis as well as redness, thickness and scaling. In addition, the Dermatology Life Quality Index (DLQI) is a validated tool that can be used to assess the impact of psoriasis on physical, psychological and social wellbeing.

There is no cure for psoriasis but there is a wide range of topical and systemic treatments that can manage the condition. Most treatments reduce the severity of psoriasis flares rather than prevent episodes. Psoriasis has to be treated continually and on a long-term basis.

Deucravacitinib is a selective TYK2 enzyme inhibitor which binds to the pseudo-kinase domain on TYK2 and selectively blocks the TYK2 enzyme targeting specific cytokine pathways. It is administered orally.

Financial Factors

This technology is commissioned by ICBs.

Clinical trial evidence shows that deucravacitinib improves symptoms of plaque psoriasis compared with placebo and apremilast. Deucravacitinib was indirectly compared with apremilast, dimethyl fumarate and several systemic biological treatments. The indirect comparison suggests it improves symptoms better than apremilast and dimethyl fumarate and works as well as some biological treatments but not as well as others.

The cost-effectiveness estimates for deucravacitinib compared with apremilast, dimethyl fumarate and most biological treatments are within the range that NICE normally considers an acceptable use of NHS resources. So, deucravacitinib is recommended.

NICE estimate that in Devon 411 people will be eligible for treatment.

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

Upadacitinib for previously treated moderately to severely active Crohn's disease TA905

Recommendations

Upadacitinib is **recommended** as an option for treating moderately to severely active Crohn's disease in adults, only if:

- the disease has not responded well enough or lost response to a previous biological treatment or
- a previous biological treatment was not tolerated or
- tumour necrosis factor (TNF)-alpha inhibitors are contraindicated.

Upadacitinib is only recommended if the company provides it according to the commercial arrangement.

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

These recommendations are not intended to affect treatment with upadacitinib 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

Crohn's disease is a chronic inflammatory condition of the gastrointestinal tract that may affect any part of the gut from the mouth to the anus. People with Crohn's disease have recurrent relapses, with acute exacerbations in between periods of remission or less active disease. These flares may affect any part of the gut and are defined by location, or by the pattern of the disease.

The clinical features of Crohn's disease are variable and are determined partly by the site of the disease. Common symptoms include diarrhoea, abdominal pain, extreme tiredness, unintended weight loss and blood and mucus in stools. Other symptoms may include fever, nausea, vomiting, arthritis, inflammation and irritation of the eyes, mouth ulcers and areas of painful, red and swollen skin.

Crohn's disease can be complicated by the development of strictures, obstructions, fistulae and perianal disease. Other complications include acute dilation, perforation and massive haemorrhage, and carcinoma of the small bowel or colon.

Crohn's disease is not medically or surgically curable. Treatment aims to reduce symptoms, promote mucosal healing and maintain or improve quality of life while minimising drug-related toxicity. Clinical management depends on disease activity, site, behaviour of disease, response to previous treatments, side-effect profiles of treatments and extra-intestinal manifestations, such as uveitis and arthritis.

NICE recommend several options for treating Crohn's disease, including, infliximab and adalimumab (TA187), vedolizumab (TA352), ustekinumab (TA456) and risankizumab (TA888).

NG129 recommends monotherapy with a glucocorticosteroid to induce remission in people with a first presentation or a single inflammatory exacerbation of Crohn's disease in a 12-month period. Budesonide or 5-aminosalicylates are considered for some people who decline, cannot tolerate or in whom a conventional corticosteroid is contraindicated. When 2 or more inflammatory exacerbations are experienced in a 12-month period, azathioprine, mercaptopurine and methotrexate may be considered as add-on treatments to conventional glucocorticosteroids or budesonide to induce remission of Crohn's disease.

Upadacitinib is a selective and reversible Janus-kinase (JAK) 1 inhibitor that blocks the JAK-signal transducer and activator of transcription (STAT) pathway and inflammatory responses. It is administered orally.

Financial Factors

This technology is commissioned by ICBs.

Clinical trial evidence shows that upadacitinib increases the likelihood of disease remission compared with placebo. Indirect comparisons of upadacitinib with ustekinumab and vedolizumab suggest that it is as effective.

A cost comparison suggests that upadacitinib has a similar or lower cost than vedolizumab and ustekinumab. Therefore, upadacitinib is recommended.

NICE estimate that 591 people in Devon that have treatment failure on biologic treatment are eligible for treatment, of which 89 people will choose treatment with upadacitinib.

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

Pembrolizumab with lenvatinib for previously treated advanced or recurrent endometrial cancer TA904

Recommendations

Pembrolizumab plus lenvatinib is **recommended**, within its marketing authorisation, for treating advanced or recurrent endometrial cancer in adults:

- whose cancer has progressed on or after platinum-based chemotherapy and
- who cannot have curative surgery or radiotherapy.

Pembrolizumab plus lenvatinib is recommended only if the companies provide them according to the commercial arrangements.

The Technology

Endometrial cancer is a cancer of the lining of the womb, known as the endometrium. It is the most common type of womb cancer and often diagnosed in the earlier stages.

When diagnosed, endometrial cancer is categorised between stage 1 and 4. Advanced endometrial cancer is defined as stage 3 or 4, where the cancer has spread outside the womb. In stage 3 the spread of cancer is contained within the pelvis, once the cancer has spread into another area of the body it is classed as stage 4 or metastatic.

Recurrent endometrial cancer is when the cancer returns after primary treatment. The cancer can recur anywhere, common areas include the abdominal cavity, lymph nodes, lung and vagina. The symptoms of recurrence are variable but include abdominal pain, bloating, nausea, shortness of breath, vaginal bleeding and changes in bowel or bladder habits.

The first treatment for endometrial cancer is usually removal of the womb as well as both fallopian tubes and ovaries. In advanced endometrial cancer, debulking surgery may be carried out to remove as much of the cancer as possible. Radiotherapy may be used for people who cannot have surgery, or alongside surgical treatment. Platinum-based chemotherapy can be used as an adjunct to surgery for people with stage 2 to 4 disease. Hormone therapy with progestins, or platinum-based chemotherapy may be used for cancer that has metastasised or relapsed.

Pembrolizumab is a humanised, anti-programmed cell death 1 (PD1) antibody involved in the blockade of immune suppression and the subsequent reactivation of anergic T-cells. It is administered intravenously. Lenvatinib is a multiple receptor tyrosine kinase inhibitor that selectively inhibits vascular endothelial growth factor (VEGF) receptors and other receptor tyrosine kinases that are involved in tumour proliferation. It is administered orally.

Financial Factors

This technology is commissioned by NHS England.

Evidence from a clinical trial suggests that pembrolizumab plus lenvatinib increases the time until the cancer gets worse and how long people live compared with non-platinum-based chemotherapy. But the results are uncertain because treatments not used in the NHS were used after non-platinum-based chemotherapy in the trial, therefore the results may not apply to UK clinical practice.

Pembrolizumab plus lenvatinib meets NICE's criteria to be considered a life-extending treatment at the end of life. There is some uncertainty in the economic model about how long the effect of treatment lasts after people stop taking pembrolizumab at 2 years. But the cost-effectiveness estimates are within the range considered acceptable for an end-of-life treatment. Pembrolizumab plus lenvatinib is therefore recommended.

NICE estimate that in Devon, 19 people will be eligible for second line treatment. Of these, 15 people with choose treatment with pembrolizumab plus lenvatinib.

The companies have commercial arrangements. These make pembrolizumab and lenvatinib available to the NHS with discounts.

Darolutamide with androgen deprivation therapy and docetaxel for treating hormone-sensitive metastatic prostate cancer TA903

Recommendations

Darolutamide with docetaxel is **recommended**, within its marketing authorisation, as an option for treating hormone-sensitive metastatic prostate cancer in adults. Darolutamide is only recommended if the company provides it according to the commercial arrangement.

The Technology

Prostate cancer is a condition in which tumours develop in the prostate, a gland in the male reproductive system. The exact cause is unknown but environmental and genetic factors are associated with an increased risk of developing prostate cancer.

NG131 classifies localised prostate cancer to be at low, intermediate or high risk of progression based on prostate-specific antigen concentration, Gleason score and clinical stage.

People with intermediate or high risk non-metastatic prostate cancer may be offered hormone therapy (also called androgen deprivation therapy [ADT]). Prostate cancer may initially respond to hormone therapy but eventually become resistant to it. This clinical condition is described as ‘hormone-relapsed’ prostate cancer.

For newly diagnosed metastatic prostate cancer, NG131 recommends starting docetaxel chemotherapy within 12 weeks of starting ADT. For metastatic prostate cancer, the guideline recommends offering bilateral orchidectomy as an alternative to continuous luteinising hormone-releasing hormone agonist therapy. For people who are willing to accept the adverse impact on overall survival and gynaecomastia in the hope of retaining sexual function, the guideline recommends offering anti-androgen monotherapy with bicalutamide.

The description 'hormone-sensitive metastatic prostate cancer' refers to a population that includes people with metastatic prostate cancer who have not had androgen deprivation therapy, or whose disease is continuing to respond to androgen deprivation therapy.

Financial Factors

This technology is commissioned by ICBs.

Clinical trial evidence shows that, compared with taking placebo plus ADT and docetaxel, people taking darolutamide plus ADT and docetaxel live longer and have longer before their cancer gets worse or stops responding to ADT. There is also an indirect comparison comparing darolutamide plus ADT and docetaxel with usual treatment. The results suggest that darolutamide increases how long people live and how long they have before their cancer gets worse or stops responding to ADT.

The cost-effectiveness estimates are within what NICE considers an acceptable use of NHS resources. Darolutamide is therefore recommended.

NICE estimate that in Devon, 134 people will be eligible for treatment and 33 people with start treatment with darolutamide with ADT and docetaxel.

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

Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction TA902

Recommendations

Dapagliflozin is **recommended**, within its marketing authorisation, as an option for treating symptomatic chronic heart failure with preserved or mildly reduced ejection fraction in adults.

The Technology

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

disease, atrial fibrillation, valve disease, hypertension, diabetes, chronic obstructive pulmonary disease and asthma.

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

Most people with chronic heart failure with preserved ejection fraction also have symptomatic treatments for comorbidities, including angiotensin-converting enzyme (ACE) inhibitors, angiotensin-receptor blockers (ARBs), betablockers or mineralocorticoid receptor antagonists (MRAs).

Dapagliflozin is a sodium-glucose co-transporter 2 (SGLT2) inhibitor. It is administered orally.

Financial Factors

This technology is commissioned by ICBs.

Current standard care for heart failure with preserved or mildly reduced ejection fraction is loop diuretics and treatment for other conditions the person may have. These manage symptoms, but do not reduce hospitalisations for heart failure.

Clinical trial evidence shows that dapagliflozin plus standard care reduces the combined risk of dying from cardiovascular causes or likelihood of first hospitalisation for heart failure compared with placebo plus standard care. Evidence suggests that dapagliflozin could reduce the chance of dying from cardiovascular or other causes.

The cost-effectiveness estimates are below what NICE considers an acceptable use of NHS resources. Therefore, dapagliflozin is recommended.

NICE estimate that in Devon 4,079 people will be eligible for treatment and 1,224 people will receive dapagliflozin plus standard care.

Cemiplimab for treating recurrent or metastatic cervical cancer *(terminated appraisal)* TA901

NICE is **unable to make a recommendation** on cemiplimab for treating recurrent or metastatic cervical cancer in adults because the company did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Tixagevimab plus cilgavimab for preventing COVID-19 TA900

Recommendations

Tixagevimab plus cilgavimab is **not recommended**, within its marketing authorisation, for the pre-exposure prophylaxis of COVID-19 in adults who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to someone infected with SARS-CoV-2, and:

- who are unlikely to have an adequate immune response to COVID-19 vaccination, or
- for whom COVID-19 vaccination is not recommended.

The Technology

COVID-19 is predominantly an acute respiratory illness caused by infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease refers to any symptom resulting from the infection and these can vary widely in clinical severity. People who become critically ill may develop acute respiratory distress syndrome (ARDS), the leading cause of mortality among patients with COVID-19.

Data from the UK suggest that mortality due to COVID-19 is strongly associated with older age, male gender, deprivation and Black, Asian and minority ethnic family background. Disabled people, people with a learning disability and people with pre-existing conditions, including people with dementia and Alzheimer's disease, diabetes, heart disease or obesity, are more at risk from dying from COVID-19.

COVID-19 has a diverse range of clinical manifestations, ranging from mild infection to severe disease accompanied by high mortality. It begins with infection, or the viral replication phase, with symptoms such as cough, fever and breathlessness. This disease stage is when viral shedding occurs and people are at the peak of infectiousness. Some people may also develop post-COVID syndrome where symptoms continuing for more than 12 weeks after the initial COVID-19 infection.

Vaccination is the primary pharmaceutical intervention for preventing COVID-19.

Tixagevimab and cilgavimab are monoclonal antibodies used in combination. Tixagevimab and cilgavimab are administered as 2 separate, sequential intramuscular injections.

Financial Factors

This technology is commissioned by ICBs.

The results of clinical studies of tixagevimab plus cilgavimab suggest it reduces infection with SARS-CoV-2 compared with no preventative treatment. But these studies were done early in the pandemic when different variants of the virus were circulating. More recent studies done in laboratories report that tixagevimab plus cilgavimab is unlikely to prevent infection with most of the variants circulating when this guidance was produced.

Because of the lack of evidence of clinical effectiveness, the cost-effectiveness estimates for tixagevimab plus cilgavimab are highly uncertain. They are also likely to be much higher than what NICE considers an acceptable use of NHS resources. Therefore, tixagevimab plus cilgavimab is not recommended. Further research is recommended to address some of the uncertainties in this rapidly changing disease area.

Esketamine for treating major depressive disorder in adults at imminent risk of suicide *(terminated appraisal)* TA899

NICE is **unable to make a recommendation** on esketamine for treating major depressive disorder in adults at imminent risk of suicide because the company did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Dabrafenib plus trametinib for treating BRAF V600 mutation-positive advanced non-small-cell lung cancer TA898

This guidance updates and replaces TA564 (published February 2019).

Recommendations

Dabrafenib plus trametinib is **recommended** as an option for treating BRAF V600 mutation-positive advanced non-small-cell lung cancer (NSCLC) in adults, only if:

- it is used as first-line treatment of advanced stage cancer, and
- the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with dabrafenib plus trametinib 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

Lung cancer falls into 2 main histological categories: around 80–85% are non-small cell lung cancers (NSCLC) and the remainder are small cell lung cancers.

NSCLC can be further classified into 3 main histological sub-types of:

1. large-cell undifferentiated carcinoma
2. squamous cell carcinoma
3. adenocarcinoma.

Most lung cancers are diagnosed at an advanced stage, when the cancer has spread to lymph nodes and other organs in the chest or to other parts of the body. BRAF is a protein which is part of the mitogen activated protein kinase signalling pathway, which helps to regulate cell proliferation, differentiation and death.

Current clinical management for advanced or metastatic (stage 3 or 4) NSCLC typically aims to control the cancer for as long as possible and help with symptoms. Treatment generally includes surgery, chemotherapy, radiotherapy, chemoradiation or targeted small molecule and immunotherapy drugs. Treatment choices are influenced by the histology of the condition (squamous, or non-squamous) and by previous treatments.

Choices are also influenced by the presence of certain biomarkers such as the programmed cell death-ligand 1 (PD-L1) or mutations affecting proteins such as epidermal growth factor receptor (EGFR), anaplasticlymphoma kinase (ALK) or the ROS-1 and KRAS receptors.

Dabrafenib is a selective inhibitor of BRAF V600E kinase activity. Trametinib is an inhibitor of MEK1 and MEK2 activity. BRAF V600E and MEK proteins work in a chain to send signals to encourage cell growth, by blocking these proteins these drugs cause cancer cells to stop growing and die. Both treatments are administered orally.

Financial Factors

This technology is commissioned by NHS England.

The clinical effectiveness results of clinical trials are uncertain; therefore, the cost-effectiveness estimates are also uncertain. Also, there was no cost-effectiveness evidence provided for dabrafenib plus trametinib used after other treatments have not worked in people with advanced NSCLC.

After taking into account the available evidence and impact of the uncertainty, the cost-effectiveness estimates are likely to be within the range that NICE considers an acceptable use of NHS resources in people with untreated advanced NSCLC. Dabrafenib plus trametinib is therefore recommended for this group.

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

Daratumumab with bortezomib and dexamethasone for previously treated multiple myeloma TA897

This guidance replaces TA573 (published April 2019).

Recommendations

Daratumumab with bortezomib and dexamethasone is **recommended** as an option for treating multiple myeloma in adults, only if they have had just 1 previous line of treatment and:

- it included lenalidomide or
- lenalidomide is unsuitable as a second-line treatment and
- the company provides it according to the commercial arrangement.

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

The Technology

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

Multiple myeloma is an incurable disease. Therapy aims to prolong survival and maintain a good quality of life by controlling the disease and relieving symptoms. If the disease progresses after initial treatment, the choice of subsequent therapy is influenced by previous treatment and response to it, duration of remission, comorbidities and patient preference.

For people whose disease is relapsed or refractory after at least 1 prior therapy:

- TA129 recommends bortezomib monotherapy
- TA657 recommends carfilzomib in combination with dexamethasone
- TA171 recommends lenalidomide in combination with dexamethasone
- TA380 recommends panobinostat in combination with bortezomib and dexamethasone
- TA427 recommends pomalidomide in combination with dexamethasone
- TA783 recommends daratumumab monotherapy

Financial Factors

This technology is commissioned by NHS England.

This evaluation reviews the evidence for daratumumab with bortezomib and dexamethasone from TA573. It also reviews new data collected as part of the managed access agreement.

The most likely cost-effectiveness estimates for daratumumab with bortezomib and dexamethasone are below what NICE considers an acceptable use of NHS resources. Because no comparison was done with lenalidomide treatments, daratumumab with bortezomib and dexamethasone is only recommended for people who cannot have lenalidomide as a second treatment. This includes people who had lenalidomide as their first treatment, or when lenalidomide is unsuitable as a second-line treatment.

The company has a commercial arrangement. This makes daratumumab with bortezomib and dexamethasone available to the NHS with a discount.

Bulevirtide for treating chronic hepatitis D TA896

Recommendations

Bulevirtide is **recommended** as an option for treating chronic hepatitis D in adults with compensated liver disease only if:

- there is evidence of significant fibrosis (METAVIR stage F2 or above or Ishak stage 3 or above) and
- their hepatitis has not responded to peginterferon alfa-2a (PEG-IFN) or they cannot have interferon-based therapy.

  Bulevirtide is only recommended if the company provides it according to the commercial arrangement.

This recommendation is not intended to affect treatment with bulevirtide 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

Hepatitis D, also known as hepatitis Delta, is an infectious disease of the liver caused by the hepatitis D virus (HDV). It only affects people infected with hepatitis B, as it needs the hepatitis B virus (HBV) to be able to survive in the body. Infection may be acquired along with HBV (co-infection) or after HBV infection (superinfection). Similarly, to hepatitis B, it usually spreads through blood-to-blood contact or sexual contact. It is also transmitted from mother to child during birth and delivery. Chronic HDV/HBV infection is the most severe form of viral hepatitis, with an increased risk of cirrhosis, liver decompensation, hepatocellular carcinoma and mortality.

The aim of treatment is to prevent transmission, cirrhosis, hepatocellular carcinoma and liver failure. CG165 recommends a 48-week course of peginterferon alfa-2a for people co-infected with chronic hepatitis B and hepatitis D infection who have evidence of significant fibrosis (METAVIR stage greater than or equal to F2 or Ishak stage greater than or equal to 3).

Bulevirtide is an HBV/HDV entry inhibitor that binds and blocks the jointly used sodium taurocholate co-transporting polypeptide (NTCP) receptor on liver cells. It misdirects HBV and co-infecting HDV to an unproductive pathway and prevents an infection of the cell. Bulevirtide is delivered subcutaneously.

Financial Factors

This technology is commissioned by NHS England.

Clinical trial evidence shows that bulevirtide is effective compared with standard care despite some uncertainties around how long it works for. Despite the uncertainties in the clinical trial evidence, the cost-effectiveness estimates are within the range NICE normally considers an acceptable use of NHS resources. Therefore, bulevirtide is recommended.

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

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

Axicabtagene ciloleucel for treating relapsed or refractory diffuse large B-cell lymphoma after first-line chemoimmunotherapy TA895

Recommendations

Axicabtagene ciloleucel is **recommended** for use within the **Cancer Drugs Fund** as an option for treating diffuse large B-cell lymphoma in adults when an autologous stem cell transplant is suitable if it:

- has relapsed within 12 months after first-line chemoimmunotherapy or
- is refractory to first-line chemoimmunotherapy.

  It is recommended only if the conditions in the managed access agreement for axicabtagene ciloleucel are followed.

This recommendation is not intended to affect treatment with axicabtagene ciloleucel 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

Lymphomas are cancers of the lymphatic system, which is a part of the immune system. Lymphomas are divided into Hodgkin lymphoma and non-Hodgkin lymphoma.

Non-Hodgkin lymphomas (NHL) are a diverse group of conditions categorised according to the cell type affected (B-cell or T-cell), as well as the clinical features and rate of progression of the disease. The most common B-cell lymphomas are follicular lymphoma, a slow growing, low grade form of NHL, and diffuse large B-cell lymphoma (DLBCL), a fast-growing, high-grade form of NHL. Some follicular lymphomas transform into high grade DLBCL (transformed high grade follicular lymphoma).

The symptoms differ depending on which organ or tissues are affected by the lymphoma. NHL often presents as painless lumps in the neck, armpit or groin but it can start in other parts of the body such as the stomach or bowel. People may have loss of appetite, tiredness or night sweats.

The most widely used first-line treatment for DLBCL is R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone). Sometimes etoposide is added to this regimen.

Axicabtagene ciloleucel is a type of immunotherapy that uses autologous T cells directed against the tumour antigen CD19. It is administered intravenously.

Financial Factors

This technology is commissioned by NHS England.

The resource impact of axicabtagene ciloleucel will be covered by the Cancer Drugs Fund budget. More evidence on axicabtagene ciloleucel is being collected until the final results of the ZUMA-7 trial are available. After this, NICE will decide whether or not to recommend it for use on the NHS and update the guidance.

It is estimated that around 540 people per year in England with diffuse large B-cell lymphoma are eligible for treatment with axicabtagene ciloleucel.

Axicabtagene ciloleucel for treating relapsed or refractory follicular lymphoma TA894

Recommendations

Axicabtagene ciloleucel is **not recommended**, within its marketing authorisation, for treating relapsed or refractory follicular lymphoma after 3 or more systemic treatments in adults.

This recommendation is not intended to affect treatment with axicabtagene ciloleucel 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

Lymphomas are cancers of the lymphatic system, which is part of the body's immune system. They are divided into Hodgkin and non-Hodgkin lymphomas.

Non-Hodgkin lymphomas are a heterogeneous group of conditions ranging from 'indolent' (low grade) to 'aggressive' (high-grade) depending on the rate at which the abnormal lymphocytes divide. Indolent lymphomas are slow growing, with long median survival times but are less likely to be cured by treatment.

Follicular lymphoma is the most common type of indolent non-Hodgkin lymphoma. Patients with follicular lymphoma typically present with painless, swollen lymph nodes in the neck, armpit or groin. Lymphomas are commonly staged I to IV. The stage of the lymphoma reflects how many groups of lymph nodes are affected, where they are in the body, and whether other organs such as the bone marrow or liver are affected. Most people present with advanced disease.

Marginal zone lymphoma is another type of indolent non-Hodgkin lymphoma that develops from B lymphocytes that are normally found at the edge of areas of lymph node tissue. Mucosa associated lymphoid tissue (MALT) lymphoma is the most common type of marginal zone lymphoma and it most commonly affects the stomach. Nodal marginal zone lymphoma starts in the lymph nodes and splenic marginal zone lymphoma starts in the spleen but can also be found in the bloodstream.

Axicabtagene ciloleucel is a type of immunotherapy that uses autologous T cells directed against the tumour antigen CD19. It is administered intravenously.

Financial Factors

This technology is commissioned by NHS England.

Axicabtagene ciloleucel does not meet NICE's criteria to be considered a life-extending treatment at the end of life. There are uncertainties in the economic model and because of this, the cost-effectiveness estimates are also uncertain. Further, they are all above the range NICE normally considers to be an acceptable use of NHS resources. The evidence suggests that axicabtagene ciloleucel is not likely to be cost effective. Therefore, axicabtagene ciloleucel is not recommended for use in the Cancer Drugs Fund.

Brexucabtagene autoleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people 26 years and over TA893

Recommendations

Brexucabtagene autoleucel is **recommended** for use within the **Cancer Drugs Fund** as an option for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people 26 years and over. It is recommended only if the conditions in the managed access agreement for brexucabtagene autoleucel are followed.

This recommendation is not intended to affect treatment with brexucabtagene autoleucel 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

Acute lymphoblastic leukaemia (ALL) is a cancer of lymphocyte-producing cells. Lymphocytes are white blood cells that are vital for the body's immune system. In ALL there is an excess production of immature lymphocyte-precursor cells, called lymphoblasts or blast cells, in the bone marrow. This affects the production of normal blood cells and there is a reduction in the number of red cells, white cells and platelets in the blood.

ALL can be classified into 3 groups based on immunophenotyping:

1. B-precursor ALL (also known as precursor-B-cell ALL)
2. Mature B-cell ALL
3. T-cell ALL. In adults, around 75-80% of ALL cases are classified as B-precursor ALL.

B-precursor ALL is characterised by the presence of cytoplasmic immunoglobulins and CD10, CD19, CD22 and CD79a expression. A specific chromosomal abnormality known as the 'Philadelphia chromosome' is present in 20 to 30% of adults with ALL.

ALL is most common in children, adolescents and young adults, with around 65% of cases diagnosed in people aged under 25. A second increase in incidence is observed in people aged over 60. It is also more common in men than women.

The aim of treatment in ALL is to achieve a cure. Treatment for newly diagnosed ALL can take up to 3 years to complete and is generally divided into 3 phases: induction, consolidation and maintenance.

Autologous anti-CD19-transduced CD3+ cells is a type of immunotherapy that uses autologous T cells directed against the tumour antigen CD19. The technology is administered intravenously as a single infusion.

Financial Factors

This technology is commissioned by NHS England.

The most likely cost-effectiveness estimates are uncertain and some of them are higher than what NICE considers an acceptable use of NHS resources. Therefore, brexucabtagene autoleucel cannot be recommended for routine use.

The resource impact of brexucabtagene autoleucel will be covered by the Cancer Drugs Fund budget. More evidence on brexucabtagene autoleucel is being collected until the final results of the ZUMA-3 trial are available. After this, NICE will decide whether or not to recommend it for use on the NHS and update the guidance.

It is estimated that around 90 people per year in England, with relapsed or refractory B-cell acute lymphoblastic leukaemia who are 26 years and over are eligible for treatment with brexucabtagene autoleucel.

Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 (UPDATE) TA878

This guidance was published in March 2023. In June 2023 NICE added a section with supporting information on risk factors for progression to severe COVID-19. This supporting information was provided by the independent advisory group commissioned by the Department of Health and Social Care.

Highly Specialised Technology Guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Caesarean birth (UPDATE) NG192

This guideline covers when to offer and discuss caesarean birth, procedural aspects of the operation, and care after caesarean birth. It aims to improve the consistency and quality of care for women and pregnant people who are thinking about having a caesarean birth or have had a caesarean birth in the past and are now pregnant again.

June 2023: NICE have reviewed and updated the recommendations on maternal choice for caesarean birth by expert opinion and consensus. The evidence has not been reviewed.

Early and locally advanced breast cancer: diagnosis and management (UPDATE) NG101

This guideline covers diagnosing and managing early and locally advanced breast cancer. It aims to help healthcare professionals offer the right treatments to people, taking into account the person's individual preferences.

June 2023: NICE have reviewed the evidence and updated the recommendations on dose fractionation for external beam radiotherapy. NICE also updated some recommendations for style and consistency, or to reflect current practice.

Atopic eczema in under 12s: diagnosis and management (UPDATE) CG57

This guideline covers diagnosing and managing atopic eczema in children under 12. It aims to improve care for children with atopic eczema by making detailed recommendations on treatment and specialist referral. The guideline also explains how healthcare professionals should assess the effect eczema has on quality of life, in addition to its physical severity.

June 2023: NICE reviewed the evidence on emollient bath additives and updated their recommendations on emollients.

NICE Rapid COVID-19 Guidelines

COVID-19 rapid guideline: managing COVID-19 (UPDATE) NG191

This guideline covers the management of COVID-19 for babies, children, young people and adults in all care settings. It brings together our existing recommendations on managing COVID-19, and new recommendations on therapeutics, so that healthcare staff and those planning and delivering services can find and use them more easily.

June 2023: NICE updated the recommendations on nirmatrelvir plus ritonavir and sotrovimab to link to section 5 of TA878. The linked section provides supporting information on risk factors for progression to severe COVID-19 provided by the independent advisory group commissioned by the Department of Health and Social Care.

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)

Radiofrequency denervation for osteoarthritic knee pain IPG767

Recommendations

Radiofrequency denervation for osteoarthritic knee pain may be used if **standard arrangements** are in place for clinical governance, consent and audit.

The procedure should only be done by clinicians with specific training and experience in this procedure.

For auditing the outcomes of this procedure, the main efficacy and safety outcomes identified in this guidance can be entered into NICE's interventional procedure outcomes audit tool (for use at local discretion).

The Condition

Osteoarthritis is characterised by localised loss of cartilage, remodelling of adjacent bone and associated inflammation. Knees are one of the most affected joints, with pain being a significant symptom.

Various treatments are available for pain caused by knee osteoarthritis, including non-pharmacological pharmacological and surgical approaches (such as knee arthroplasty). When non-pharmacological and pharmacological interventions do not work or symptoms are severe, surgery may be needed.

The Procedure

This procedure is often done in 2 stages. Both are done under fluoroscopic or ultrasound guidance. First, to assess suitability for radiofrequency denervation, people are given a diagnostic nerve block by injecting a local anaesthetic to the target nerves. If the diagnostic nerve block relieves the pain, the person is a candidate for radiofrequency denervation.

A probe is introduced to the treatment site. Several targets have been described, including the genicular nerves, the saphenous nerve, and the articular cavity. Radiofrequency energy is used to denervate the target nerves. The radiofrequency energy can be delivered as conventional radiofrequency, cooled radiofrequency or pulsed radiofrequency. The aim is to reduce pain and delay the need for knee arthroplasty.

Botulinum toxin type A injections into the urethral sphincter for idiopathic chronic non-obstructive urinary retention IPG766

Recommendations

For people with idiopathic chronic non-obstructive urinary retention caused by external urethral sphincter dysfunction (also known as Fowler's syndrome in younger women and people with female anatomy, primary disorder of urethral sphincter relaxation or high-tone non-relaxing urethral sphincter), botulinum toxin type A injections into the urethral sphincter should only be used with **special arrangements** for clinical governance, consent, and audit or research.

Clinicians wanting to do botulinum toxin type A injections into the urethral sphincter for idiopathic chronic non-obstructive urinary retention because of external urethral sphincter dysfunction should:

- Inform the clinical governance leads in their healthcare organisation.
- Ensure that people and their families understand the procedure's safety and efficacy, and any uncertainties about these.
- Take account of NICE's advice on shared decision making, including NICE's information for the public.

- Audit and review clinical outcomes of everyone having the procedure. The main efficacy and safety outcomes identified in this guidance can be entered into NICE's interventional procedure outcomes audit tool (for use at local discretion).
- Discuss the outcomes of the procedure during their annual appraisal to reflect, learn and improve.

Healthcare organisations should:

- Ensure systems are in place that support clinicians to collect and report data on outcomes and safety for everyone having this procedure.
- Regularly review data on outcomes and safety for this procedure.

Patient selection should be done by a multidisciplinary team.

The procedure should only be done in a specialist centre by clinicians with expertise in managing the condition.

For people with idiopathic chronic non-obstructive urinary retention from all other causes, botulinum toxin type A injections into the urethral sphincter should be used only in research.

Further research should ideally be in the form of randomised controlled trials. Details of patient selection, the procedure and long-term outcomes should be reported.

The Condition

Idiopathic non-obstructive urinary retention is the inability to completely empty the bladder when there is no physical obstruction to normal urine flow. It can be caused by urethral sphincter dysfunction. This can be because of dysfunctional voiding, urethral sphincter hyperactivity or inadequate relaxation of the urethral sphincter (for example, Fowler's syndrome in younger women and people with female anatomy), or bladder functional problems. But the specific underlying cause of the condition is unknown. Idiopathic non-obstructive urinary retention is often asymptomatic, but some people have lower abdominal discomfort and pain. Also, it can cause complications such as recurrent urinary tract infections and chronic kidney disease.

Current treatments for non-obstructive urinary retention include urotherapy (education and rehabilitation for bladder and bowel management), an alpha-adrenoreceptor blocker medicine, urethral dilatation or clean intermittent catheterisation. When the condition is refractory to these treatments, it may be treated with sacral nerve stimulation or urinary diversion procedures.

The procedure

Botulinum toxin type A injection into the urethral sphincter for idiopathic chronic non-obstructive urinary retention is usually done as an outpatient procedure with the person awake and lying in the lithotomy position. A local anaesthetic is used on either side of the external meatus. Botulinum toxin type A diluted with normal saline is injected directly into the external urethral sphincter using

a syringe needle. A transperineal route is used in women and a transurethral route is used in men.

The dose and number of injections used, and the depth and the position of injections on the endoscopic ultrasound, vary and depend on the discretion of the clinician. People have oral antibiotics for a week. The aim of the procedure is to relax the sphincter muscle and restore voiding function. It may be repeated every few months.

Minimally invasive fusionless posterior-approach surgery to correct idiopathic scoliosis in children and young people IPG765

Recommendations

Minimally invasive fusionless posterior-approach surgery to correct idiopathic scoliosis in children and young people should be used only in **research**.

Further research should include:

- patient selection in terms of age, skeletal maturity and site and degree of scoliosis
- the technique and device (including version) used
- patient-reported outcomes
- potential damage from local inflammatory processes (including metallosis) and systemic metal poisoning
- long-term movement in the thoracic spine
- long-term complications for the lifetime of the device.

The Condition

Scoliosis is a 3-dimensional change to the spine in the coronal, sagittal and axial planes. It causes the bones of the spine to twist or rotate so that the spine curves sideways. Scoliosis curves most commonly occur in the thoracic spine but can also occur in the lumbar spine. Occasionally, they occur in both the thoracic and lumbar spine.

Adolescent idiopathic scoliosis (AIS) is the most common type of scoliosis in children and young people. It is progressive and the exact cause is unknown. Mild to moderate spinal curvature does not cause any health problems but can cause cosmetic concerns. Severe spinal curvature with secondary rib changes can also cause significant pain and lung problems.

Treatment of AIS depends on several factors, including skeletal maturity, location of the spinal curve, speed of curve progression and size of the curve. Conservative treatments for mild to moderate AIS include routine surveillance and physical therapy. For severe AIS, interventions include casting or bracing or spinal fusion surgery with various instrumented metallic fixation techniques and grafting to fuse vertebrae. Minimally invasive growth modulating and fusionless

surgical techniques to correct idiopathic scoliosis include vertebral body stapling, vertebral body tethering, magnetically controlled growing rods and sublaminar polyester bands. These are also used for AIS in some people. The aim is to correct the scoliosis, prevent progression, restore balance and reduce pain and morbidity.

The procedure

Minimally invasive fusionless posterior-approach surgery to correct idiopathic scoliosis is intended to treat AIS in selected people aged 8 years to 17 years whose bones have not fully matured. It is mainly used to correct flexible single curves with a Cobb angle of up to 60 degrees that reduces to 30 degrees or less on lateral side-bending radiographs and thoracic kyphosis of less than 55 degrees (as measured from T5 to T12).

The procedure is done under general anaesthesia and fluoroscopic guidance using a posterior unilateral approach. The concave side of the spinal curve is exposed through an incision around the apex of the curve. Two pedicle screws are inserted into the vertebral bodies through the pedicle above and below the apex of the spinal curvature to serve as anchor points. A ratchet rod with an extender and 2 polyaxial joints is then fixed to the spine with pedicle screws that are implanted around the apex of the curve. Distraction during surgery is applied with a manual instrument to expand the rod and to straighten the spine. After the procedure, people are allowed to weight bear during everyday activities.

About 2 to 3 weeks after surgery, people are advised to exercise daily. This is to allow the rod additional unilateral elongation so there may be further gradual straightening of the spine while the person continues to grow. Because the procedure does not involve any spinal fusion, spinal motion is preserved. This minimises length of hospital stay and recovery time.

Endoscopic ultrasound-guided gallbladder drainage for acute cholecystitis when surgery is not an option IPG764

Recommendations

Endoscopic ultrasound-guided gallbladder drainage for acute cholecystitis can be used when surgery is not an option, if **standard arrangements** are in place for clinical governance, consent and audit.

For auditing the outcomes of this procedure, the main efficacy and safety outcomes identified in this guidance can be entered into NICE's interventional procedure outcomes audit tool (for use at local discretion).

This technically challenging procedure should only be done in specialist centres by clinicians trained and experienced in using this procedure for gallbladder drainage.

The Condition

Acute cholecystitis is inflammation of the gallbladder. The most common cause of acute cholecystitis is gallstones blocking the duct that drains the gallbladder. This means bile cannot drain from the gallbladder, causing pain, nausea, vomiting and fever.

Acalculous cholecystitis is a less common, but usually more serious, cause of acute cholecystitis. It usually develops as a complication of a serious illness, infection or injury that damages the gallbladder. It can be caused by accidental damage to the gallbladder during major surgery, serious injuries or burns, sepsis, severe malnutrition, or HIV or AIDS.

Initial treatment usually involves fasting, pain relief, and antibiotics if there is an infection. The gallbladder can be surgically removed to prevent acute cholecystitis re-occurring and to reduce the risk of developing complications, such as gangrenous cholecystitis and peritonitis.

People who cannot have surgery may be able to have percutaneous cholecystostomy. This involves inserting a drainage catheter in the gallbladder through a small entry hole made in the abdominal wall. Endoscopic transpapillary gallbladder drainage is a less common alternative. It involves inserting a plastic stent through the ampulla and cystic duct into the gallbladder endoscopically.

The Procedure

Endoscopic ultrasound-guided gallbladder drainage for acute cholecystitis is typically done under sedation or general anaesthesia using a specialist endoscope with an ultrasound probe and fluoroscopic guidance. Imaging is used before the procedure to determine its feasibility. An anastomotic tract is created into the gallbladder through either the wall of the antrum of the stomach or the wall of the duodenum. A stent is inserted to establish biliary drainage into the gut and relieve the gallbladder obstruction. Occasionally, the anastomotic tract may be created between the gallbladder and jejunum if the anatomy has been altered by previous surgery.

Different technologies are used to create the anastomotic tract and deploy the stent, and stents can be made of different materials. Single-step devices allow for single-step delivery of the stent without the need to change instruments for track dilation. Multistep devices need track dilation with a cystotome and a biliary balloon.

The aim is to drain bile from the gallbladder and avoid the need for emergency cholecystectomy, particularly in people for whom surgery poses a high risk.

Intraoperative electron beam radiotherapy for locally advanced and locally recurrent colorectal cancer IPG763

Recommendations

Evidence on the safety of intraoperative electron beam radiotherapy for locally advanced and locally recurrent colorectal cancer is adequate. Evidence on efficacy is inadequate in quality and quantity. Therefore, this procedure should only be used in the **context of research**.

Further research should preferably be in the form of suitably powered randomised controlled trials and should report details of patient selection (including tumour type and staging), the technique of radiotherapy and the extent of surgery undertaken, and key outcomes.

Patient selection and the procedure should only be done in specialist centres by a multidisciplinary team experienced in managing colorectal cancer. The multidisciplinary team should include a colorectal surgeon, a clinical oncologist, a medical physicist, a radiographer and an anaesthetist with specialist training in the procedure.

The Condition

Colorectal cancer is a common cancer. It typically occurs in people older than 50, with the risk increasing with age. About 5% to 20% of people with colorectal cancer have locally advanced disease, in which the cancer has invaded nearby tissues. After primary resection to remove the tumour, it returns in the same place in about 5% to 20% of people.

There are various treatments for colorectal cancer, including resection, chemotherapy and radiotherapy. Treatment choice depends on the type of cancer, location and staging. The radicality of resection is the most important prognostic factor for survival. Resection is referred to as: R0, when there are clear margins around the tumour; R1, when there are microscopically involved margins and R2, when there are macroscopically involved margins or gross residual disease.

The Procedure

The procedure is done during surgery for locally advanced or locally recurrent colorectal cancer. Once the tumour is resected, the patient is positioned to receive a megavoltage electron dose from a linear accelerator. This can happen in the operating theatre if it is equipped with a stationary linear accelerator. Otherwise, the person is transferred to a dedicated room, or a mobile linear accelerator is brought into the theatre. Radiation-sensitive organs surrounding the tumour site can be displaced or shielded from the intraoperative electron beam radiotherapy (IOERT) field. A single large fraction of radiation is then delivered by an applicator directly to the tumour bed. The aim is to improve local control and increase survival rates.

There are several techniques for delivering intraoperative radiotherapy, including IOERT, high dose rate brachytherapy, and orthovoltage. This guidance relates to IOERT only, not high dose rate brachytherapy or orthovoltage techniques.

Medical Technologies Guidance (MTGs)

None published this month.

Diagnostics Guidance (DGs)

FibroScan for assessing liver fibrosis and cirrhosis outside secondary and specialist care DG48

Recommendations

FibroScan is **recommended** as an option for assessing liver fibrosis or cirrhosis outside secondary and specialist care if:

- each FibroScan device is expected to be used for at least 500 scans per year, typically requiring use in locations which cover larger populations, such as community diagnostic hubs
- this is likely to improve access to testing for underserved groups
- it is used in accordance with national guidelines
- a clear care pathway with guidance for healthcare professionals doing the test on what to do based on a FibroScan result is established locally through collaboration between primary or community care and secondary or specialist care providers
- there is training for healthcare professionals on how to do the test, and
- the company provides supporting materials to make sure people using the test continue to use it correctly.

The Tests

Liver fibrosis happens when persistent inflammation of the liver causes excessive scar tissue to build up in the organ and nearby blood vessels. The presence of scar tissue can impair overall liver function and limit blood flow which may lead to the death of liver cells. Advanced liver fibrosis can develop into cirrhosis, liver failure, portal hypertension and possibly needing a liver transplant. Liver fibrosis is caused by hepatitis, non-alcoholic fatty liver disease and alcohol-related liver disease.

Cirrhosis is a late-stage liver disease that happens when inflammation and fibrosis has spread throughout the liver and disrupts the shape and function of the liver. Cirrhosis usually develops silently after exposure to 1 or more risk factors such as alcohol misuse and hepatitis B or C which cause inflammation in the liver, or obesity, although, not everyone with inflammation of the liver will eventually develop cirrhosis. Untreated cirrhosis can cause liver failure, liver cancer or death.

FibroScan is a non-invasive medical device that assesses liver fibrosis and cirrhosis by measuring the degree of liver stiffness. It can distinguish normal liver or minimal fibrosis from cirrhotic livers.

FibroScan uses proprietary vibration-controlled transient elastography to quantify liver stiffness, which is essentially a measure of the extent of liver scarring.

Financial Factors

This technology is commissioned by ICBs.

There is some uncertainty about the overall long-term costs of using the test outside secondary and specialist care. However, it is likely that if each device is used frequently, the immediate costs of doing a test in the community will be lower than the cost of referring a person for testing in secondary or specialist care. Therefore, FibroScan is recommended as an option for assessing liver fibrosis and cirrhosis outside secondary and specialist care.

Transperineal biopsy for diagnosing prostate cancer DG54

Recommendations

Local anaesthetic transperineal (LATP) prostate biopsy using the freehand needle positioning device PrecisionPoint is **recommended** as an option for diagnosing prostate cancer.

Although there is considerably less evidence and therefore greater uncertainty of clinical benefit for them, the following freehand needle positioning devices are expected to have similar cancer detection rates and adverse events to those of PrecisionPoint:

- EZU-PA3U device
- Trinity Perine Grid
- UA1232 puncture attachment.

  There are technical differences between them, but they all work in a similar way using the same biopsy technique. So, these devices are **recommended** as options for diagnosing prostate cancer.

Centres are encouraged to take part in research and data collection, including the randomised controlled trial of transrectal biopsy compared with LATP biopsy (the TRANSLATE trial) to help refine clinical practice.

There is **not enough evidence to recommend** double freehand LATP prostate biopsy using the CamPROBE device. Further research is recommended to understand its clinical effectiveness.

The Tests

Prostate cancer is the most commonly diagnosed cancer in men in the UK. It mainly affects people over 50 and the risk is higher for people of African family background and people with a family history of prostate cancer.

Prostate cancer can be slow or quickly growing. If it is growing quickly, it is more likely to spread and may require treatment, which includes radiotherapy, chemotherapy, surgery or a combination of these.

NG131 recommends that after someone is referred to secondary care with suspected clinically localised prostate cancer, they should be offered a multiparametric MRI (mpMRI) test. The results of this MRI should be reported using a 5-point Likert scale. People with a Likert score of 3 or more should be offered an mpMRI-influenced prostate biopsy.

The current standard prostate biopsy is mpMRI-influenced local anaesthetic transrectal ultrasound (LA-TRUS) biopsy or mpMRI-influenced local anaesthetic transperineal (LATP) biopsy. Both routes use a transrectal ultrasound probe inserted into the anus to image the prostate. Both approaches are done in an outpatient setting.

In a TRUS prostate biopsy, samples of prostate tissue are collected using a biopsy needle inserted through the rectal wall via the anus. The disadvantage of this method is that some people get serious infections, including sepsis, requiring hospital admission and antibiotics. In LATP biopsy, the needle enters the body through the perineum, the skin area between the anus and the scrotum. This could greatly reduce the risk of biopsy-related sepsis compared with a TRUS biopsy, and therefore may reduce hospital admissions and the need for preventative antibiotics.

Financial Factors

This technology is commissioned by ICBs.

The evidence suggests no significant difference in cancer detection rates between LATP biopsy and LA-TRUS biopsy, but it suggests lower rates of infection and sepsis after LATP biopsies. More evidence on their differences will come from the ongoing TRANSLATE trial, which may help refine clinical practice.

Most of the clinical evidence for freehand needle positioning devices is on the PrecisionPoint device. There is no comparative evidence for the EZU-PA3U, UA1232, or Trinity Perine Grid devices, but experts suggest that cancer detection rates and adverse events are expected to be similar for the different freehand devices. This is because they all function in a similar way, in that they attach to the ultrasound probe and keep the needle in line with it. The biopsy technique is the same.

The most likely cost-effectiveness estimates for freehand needle positioning devices are within what NICE considers an acceptable use of NHS resources. Therefore, LATP biopsy using a freehand needle positioning device is recommended.

There is no comparative evidence on the CamPROBE device, which uses a double freehand technique. Experts said that because the double freehand technique is different to using the freehand needle positioning devices, more research is needed to understand the cancer detection rates, adverse events and cost effectiveness.

NICE estimate that in Devon, 1,084 people will be eligible for transperineal biopsy and 1,030 will receive a LATP prostate biopsy.

Health Technology Evaluations (HTE)

None published this month.

NICE Quality Standards

Depression in adults (UPDATE) QS8

This quality standard covers the clinical assessment and management of depression in adults aged 18 and over. It describes high-quality care in priority areas for improvement.

June 2023: NICE updated and replaced the previous version published in 2011. The topic was identified for update following a review of quality standards. The review identified updated guidance on depression in adults.

Current NICE Consultations

Title/link	End date of consultation
Olaparib in combination with bevacizumab for maintenance treatment of advanced ovarian, fallopian tube and peritoneal cancer after response to first-line platinum-based chemotherapy with bevacizumab [Review of TA693] [ID4066]	12/07/2023
Epilepsies in children, young people and adults (update)	13/07/2023
Tirzepatide for treating type 2 diabetes [ID3938]	18/07/2023
Biodegradable subacromial spacer insertion for rotator cuff tears	19/07/2023
Secukinumab for treating moderate to severe hidradenitis suppurativa [ID4039]	19/07/2023
Extracorporeal carbon dioxide removal for acute respiratory failure	26/07/2023