NHS
Devon
Clinical Commissioning Group

NICE Update Bulletin: November 2019

Hyperlinks to the relevant NICE web page are included below.

Technology Appraisals (TAs)

Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema in phakic eyes after an inadequate response to previous therapy TA613

This guidance partially updates NICE technology appraisal guidance 301 on fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema after an inadequate response to prior therapy.

Recommendations

Fluocinolone acetonide intravitreal implant is **not recommended** as an option for treating chronic diabetic macular oedema that is insufficiently responsive to available therapies in an eye with a natural lens (phakic eye).

This recommendation is not intended to affect treatment with fluocinolone acetonide intravitreal implant 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

Fluocinolone acetonide intravitreal implant is indicated for the treatment of vision impairment associated with chronic diabetic macular oedema, (DMO) considered insufficiently responsive to available therapies.

Fluocinolone acetonide intravitreal implant is administered through intravitreal injection. Each implant contains 0.19 mg of fluocinolone acetonide and releases fluocinolone acetonide for up to 36 months.

Financial factors

This technology is commissioned by CCGs.

NICE has said that because of the lack of clinical evidence, the cost-effectiveness estimates for fluocinolone acetonide intravitreal implant are uncertain. Even the lowest clinically plausible cost-effectiveness estimates are substantially higher than what NICE normally considers an acceptable use of NHS resources. Therefore, fluocinolone acetonide intravitreal implant is not recommended for treating chronic diabetic macular oedema that is insufficiently responsive to available therapies in an eye with a natural lens (phakic eye).

Neratinib for extended adjuvant treatment of hormone receptor-positive, HER2-positive early stage breast cancer after adjuvant trastuzumab TA612

Recommendations

Neratinib is **recommended** as an option for the extended adjuvant treatment of hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-positive early stage breast cancer in adults who completed adjuvant trastuzumab-based therapy less than 1 year ago only if:

- trastuzumab is the only HER2-directed adjuvant treatment they have had, and
- if they had neoadjuvant chemotherapy-based regimens, they still had residual invasive disease in the breast or axilla following the neoadjuvant treatment, and
- the company provides neratinib according to the commercial arrangement.

This recommendation is not intended to affect treatment with neratinib 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

Neratinib is indicated for the extended adjuvant treatment of adults with early stage hormone receptor-positive, HER2-overexpressed/amplified breast cancer and who are less than 1 year from the completion of prior adjuvant trastuzumab-based therapy.

Neratinib is administered orally. The recommended dose is 240 mg neratinib, administered as 6×40-mg tablets taken once daily and continually for 1 year.

Financial factors

This technology is commissioned by NHS England.

Neratinib has an agreed patient access scheme which makes it available with a commercial-in-confidence discount to the list price.

NICE estimates that 500 people in England with early breast cancer are eligible for treatment with neratinib and 400 people with have neratinib from year 3 onwards once uptake has reached 80%.

Rucaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer TA611

Recommendations

Rucaparib is **recommended for use within the Cancer Drugs Fund** as an option for maintenance treatment of relapsed platinum-sensitive high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer that has responded to platinum-based chemotherapy in adults, only if the conditions in the managed access agreement for rucaparib are followed.

This recommendation is not intended to affect treatment with rucaparib 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

Rucaparib is indicated as monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy.

Rucaparib is taken orally as tablets. The recommended dosage is 600 mg (2 × 300-mg tablets) twice daily, with or without food (1,200 mg total daily dose).

Interruption of treatment or dose reduction can be considered for adverse event management (600 mg to 500 mg [2 × 250-mg tablets] to 400 mg [2 × 200-mg tablets] to 300 mg [1 × 300-mg tablet]).

Patients should start maintenance treatment no later than 8 weeks after completion of their final dose of the platinum-containing regimen.

Financial factors

This technology is commissioned by NHS England.

NICE estimates that around 1,350 people per year with platinum-sensitive epithelial ovarian fallopian tube or peritoneal cancer that has responded to platinum-based chemotherapy are eligible for treatment with rucaparib.

Rucaparib will be available to the NHS in line with the managed access agreement with NHS England. As part of this, NHS England and Clovis Oncology have a commercial access agreement that makes rucaparib available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

The resource impact of rucaparib will be covered by the Cancer Drugs Fund budget. The guidance will be reviewed by the date the managed access agreement expires when the final analysis of the overall-survival data from the ARIEL3 trial is available. The aim of the review is to decide whether or not the drug can be recommended for routine use.

Pentosan polysulfate sodium for treating bladder pain syndrome TA610

Recommendations

Pentosan polysulfate sodium is **recommended** as an option for treating bladder pain syndrome with glomerulations or Hunner's lesions in adults with urinary urgency and frequency, and moderate to severe pain, only if:
their condition has not responded to an adequate trial of standard oral treatments

- it is not offered in combination with bladder instillations
- any previous treatment with bladder instillations was not stopped because of lack of response
- it is used in secondary care and
- the company provides pentosan polysulfate sodium according to the commercial arrangement.

This recommendation is not intended to affect treatment with pentosan polysulfate sodium 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

Pentosan polysulfate sodium has a marketing authorisation for treating bladder pain syndrome characterised by either glomerulations or Hunner's lesions in adults with moderate to severe pain, urgency and frequency of micturition.

The dosage in the marketing authorisation is 300 mg/day taken as 1 × 100-mg capsule orally 3 times daily. Treatment is stopped if no improvement is reached 6 months after starting treatment. In people whose condition responds, treatment should be continued as long as the response is maintained. Response to treatment should be reassessed every 6 months.

Financial factors

This technology is commissioned by CCGs.

NICE does not expect this guidance to have a significant impact on resources. The technology is a further treatment option after standard oral treatments have been unsuccessful. The overall cost of treatment is not deemed to be significant because there is a reduction in the number of patients requiring bladder instillations.

Pentosan polysulfate sodium has a discount that is commercial in confidence.

Highly specialised technology guidance (HSTs)

Cerliponase alfa for treating neuronal ceroid lipofuscinosis type 2 HST12

Recommendations

Cerliponase alfa is **recommended** as an option for treating neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency, only if the conditions in the managed access agreement are followed.

This recommendation is not intended to affect treatment with cerliponase alfa that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop. For children or young people, this decision should be made jointly by the clinician and the child or young person, or the child's or young person's parents or carers.

The technology

Cerliponase alfa is an enzyme replacement therapy consisting of a recombinant form of human tripeptidyl peptidase 1. It is expected to restore deficient tripeptidyl peptidase 1 (TPP1) activity in the brain caused by the genetic mutation. Cerliponase alfa has a UK marketing authorisation granted under 'exceptional circumstances' for the treatment of neuronal ceroid lipofuscinosis type 2 (CLN2) disease, also known as TPP1 deficiency.

Cerliponase alfa is administered into the cerebrospinal fluid by infusion via a surgically implanted intracerebroventricular access device (reservoir and catheter). It must only be given in a healthcare setting by a trained healthcare professional knowledgeable in intracerebroventricular infusion administration. The recommended dose is 300 mg cerliponase alfa once every other week, but lower doses are recommended in patients under 2 years.

Financial factors

This technology is commissioned by NHS England.

NICE recognised that CLN2 is a rare, devastating condition, that there is a substantial unmet need for an effective treatment, and that there are benefits beyond direct health benefits not captured in the economic analysis.

Taking all factors into account, cerliponase alfa could provide value for money within the context of a highly specialised service. However, there is substantial clinical uncertainty and a high financial risk to the NHS. Therefore, a managed access agreement is needed to ensure the financial risk is addressed while allowing people expected to benefit most from cerliponase alfa access to it as further data are collected.

NICE Guidelines (NGs)

Diverticular disease: diagnosis and management NG147

This guideline covers the diagnosis and management of diverticular disease in people aged 18 years and over. It aims to improve diagnosis and care and help people get timely information and advice, including advice about symptoms and when to seek help.

This guideline includes recommendations on:

- management and advice for people with diverticulosis
- diverticular disease, including symptoms and signs, management and advice
- acute diverticulitis, including symptoms and signs, non-surgical management and surgery
- information for people with diverticulosis, diverticular disease and acute diverticulitis

Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer CG164 (update)

This guideline covers care for people with a family history of breast, ovarian or another related (prostate or pancreatic) cancer. It aims to improve the long-term health of these families by describing strategies to reduce the risk of and promote early detection of breast cancer (including genetic testing and mammography). It also includes advice on treatments (tamoxifen, raloxifene) and surgery (mastectomy).

In November 2019, NICE updated the recommendation on topics that should be discussed with a person before making a decision on whether to have annual mammographic surveillance and added a link to patient decision aids.

Thyroid disease: assessment and management NG145

This guideline covers investigating all suspected thyroid disease and managing primary thyroid disease (related to the thyroid rather than the pituitary gland). It does not cover managing thyroid cancer or thyroid disease in pregnancy. It aims to improve quality of life by making recommendations on diagnosis, treatment, long-term care and support.

This guideline includes recommendations on:

- information for people with thyroid disease
- investigating suspected thyroid dysfunction or enlargement
- managing, follow-up and monitoring of primary hypothyroidism
- managing and monitoring of subclinical hypothyroidism
- managing thyrotoxicosis and follow-up and monitoring of hyperthyroidism
- managing and monitoring of subclinical hyperthyroidism
- diagnosing, managing and monitoring thyroid enlargement with normal thyroid function

Multiple sclerosis in adults: management CG186 (update)

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

In November 2019, NICE replaced the recommendation on using Sativex (a THC:CBD spray) to treat spasticity in people with multiple sclerosis with a cross-reference to recommendations on THC:CBD spray in the NICE guideline on cannabis-based medicinal products.

Cannabis-based medicinal products NG144

This guideline covers prescribing of cannabis-based medicinal products for people with intractable nausea and vomiting, chronic pain, spasticity and severe treatment-resistant epilepsy.

This guideline includes recommendations on:

- Intractable nausea and vomiting
- Chronic pain
- Spasticity
- Severe treatment-resistant epilepsy
- Prescribing

Fever in under 5s: assessment and initial management NG143

This guideline covers the assessment and early management of fever with no obvious cause in children aged under 5. It aims to improve clinical assessment and help

healthcare professionals diagnose serious illness among young children who present with fever in primary and secondary care.

This guideline includes new recommendations on Kawasaki disease. These supplement the existing recommendations on:

- thermometers and the detection of fever
- clinical assessment of children with fever
- management by remote assessment
- management by non-paediatric practitioners
- management by paediatric specialists
- antipyretic interventions
- advice for home care

Public Health Guidelines

Workplace health: long-term sickness absence and capability to work NG146

This guideline updates and replaces NICE guideline PH19 (March 2009).

This guideline covers how to help people return to work after long-term sickness absence, reduce recurring sickness absence, and help prevent people moving from short-term to long-term sickness absence.

This guideline includes new and updated recommendations on:

- workplace culture and policies
- assessing and certifying fitness for work
- statement of fitness for work
- making workplace adjustments
- keeping in touch with people on sickness absence
- early intervention
- sustainable return to work and reducing recurrence of absence

It also includes recommendations on:

- people with a health condition or disability who are not currently employed

Antimicrobial prescribing guidelines

None published this month.

Social Care guidelines

None published this month.

Interventional Procedures Guidance (IPGs)

Irreversible electroporation for primary liver cancer IPG664

This guidance replaces NICE interventional procedures guidance on irreversible electroporation for treating primary liver cancer (IPG444).

Recommendations

Evidence on the safety of irreversible electroporation for primary liver cancer shows serious but infrequent and well-recognised complications. Evidence on its efficacy is inadequate in quantity and quality. Therefore, this procedure should only be used in the context of **research**.

Patient selection should be done by a multidisciplinary team.

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

Further research could be in the form of case series or registry-based research. It should include: details of patient selection; tumour position and size; long-term outcomes including overall survival, progression-free survival and tumour regression; and patient-reported outcomes including quality of life.

The condition

The most common primary liver cancers are hepatocellular carcinoma and cholangiocarcinoma.

Treatment for primary liver cancer depends on several factors, including the exact location and stage of the cancer, the patient's liver function and any patient-related comorbidities. For most patients, treatment with curative intent is not possible. The treatment options include surgical excision, chemotherapy, transarterial chemo-embolisation, percutaneous ethanol injection, and thermal ablation techniques such as cryotherapy, radiofrequency and microwave ablation. Liver transplantation (with curative intent) may be appropriate for some patients.

The procedure

The aim of irreversible electroporation (IRE) is to destroy cancerous cells by subjecting them to short pulses of high-voltage direct current. This creates multiple holes in the cell membrane, irreversibly damaging the cell's homeostasis mechanisms and leading to cell death.

IRE for primary liver cancer is done with the patient under general anaesthesia. A neuromuscular blocking agent is used to prevent muscle spasms. Needle-like electrodes are introduced percutaneously into the tumour under imaging guidance (either CT or, less commonly, ultrasound). The distance between the electrodes is confirmed by imaging. This is to ensure that the electrodes are correctly placed parallel to each other, and that enough current flow would be generated to ensure IRE.

The procedure may also be done through an open surgical or laparoscopic approach, although the percutaneous route is the most common. Electrodes are repositioned under imaging guidance to extend the zone of electroporation until the entire tumour and an appropriate margin have been ablated. The number of ablations is determined by the volume of the target tumour. When the ablation procedure is completed, further imaging may be done to confirm the extent of the ablation.

Medical Technologies Guidance (MTGs)

None published this month.

Diagnostics Guidance (DGs)

Rapid tests for group A streptococcal infections in people with a sore throat DG38

Recommendations

Rapid tests for strep A infections are **not recommended** for routine adoption for people with a sore throat. This is because their effect on improving antimicrobial prescribing and stewardship, and on patient outcomes, as compared with clinical scoring tools alone, is likely to be limited. Therefore, they are unlikely to be a cost-effective use of NHS resources.

The technologies

Sore throat is characterised by inflammation of the pharynx (pharyngitis) or inflammation of the tonsils (tonsillitis). Symptoms of a sore throat include pain in the throat, fever and a headache. Other symptoms could also include nausea, vomiting, abdominal pain, muscle pain, and rashes.

The most common cause of bacterial infection is strep A, accounting for about 80% of bacterial infections. The remaining 20% of bacterial infections are usually caused by group C and G streptococcus. Strep A throat infections are more common in children than adults and the incidence of strep A infections is highest in winter and spring.

Most cases of strep A infection resolve without complications. However, rarely complications can develop, such as rheumatic fever (affecting the heart), post-streptococcal glomerulonephritis (affecting the kidneys), or necrotising fasciitis (a severe infection of soft tissue). Strep A can also cause scarlet fever and invasive group A strep infections. Invasive group A strep infections happen when the bacteria move from the throat into other parts of the body. This can lead to sepsis or streptococcal toxic shock syndrome. The risk of invasive group A strep infections is usually very low but is higher in older people (aged over 75 years), in whom the risk of associated mortality is also higher.

The assessment included 21 rapid tests for strep A, of which 17 tests use immunoassay detection methods (rapid antigen detection tests) and 4 use molecular methods (polymerase chain reaction [PCR] or isothermal nucleic acid amplification).

Point-of-care creatinine devices to assess kidney function before CT imaging with intravenous contrast DG37

Recommendations

Point-of-care creatinine devices ABL800 FLEX, i-STAT Alinity and StatSensor, which calculate estimated glomerular filtration rate (eGFR), are **recommended** to assess kidney function to guide decisions on whether to use intravenous contrast during an outpatient CT scan in adults.

They should only be used when current practice is that a recent eGFR result must be available before a person has a CT scan with intravenous contrast and if all the following apply:

- a person presents for a CT scan without a recent eGFR result
- the person has risk factors for acute kidney injury
- clear governance structures for point-of-care testing are in place.

Take age, sex and ethnicity into account when assessing risk of acute kidney injury using a questionnaire-based tool.

Point-of-care creatinine devices ABL90 FLEX PLUS, Dri-chem NX500, epoc Blood Analysis System, and Piccolo Xpress are **not recommended** to assess kidney function to guide decisions on whether to use intravenous contrast during an outpatient CT scan. This is because there are insufficient data to assess their diagnostic accuracy.

Further research is recommended to:

- better understand the level of risk of contrast-induced acute kidney injury
- identify the most appropriate tool for identifying risk factors
- monitor the effect of implementation on patient experience and efficiency in radiology departments.

The technologies

Point-of-care (POC) creatinine devices allow rapid measurement of creatinine levels and calculation of estimated glomerular filtration rate (eGFR). This can show whether the kidneys are working properly. The focus of this assessment is POC creatinine testing to assess kidney function before people have intravenous contrast for CT imaging.

Intravenous iodine-based contrast agents used in CT scans can cause acute kidney injury (AKI), particularly in people who are at high risk and those with known kidney dysfunction. If a person has a low eGFR, intravenous hydration can be offered before the scan to reduce the risk of AKI. If a person does not have a recent eGFR measurement, their CT scan could be cancelled and rescheduled while a creatinine test is processed in the laboratory.

Using POC creatinine tests before outpatient contrast-enhanced CT scans in the radiology department could minimise the risk of kidney injury. It could also reduce the number of cancelled scans, which is important for patients.

The POC creatinine devices are CE marked and measure creatinine using an enzymatic method. Devices are either handheld, table-top or portable and need very small samples of whole blood from either finger-prick or venous or arterial samples. Creatinine can be measured either as one component of a panel of parameters, or as a single measurement on a test card or cartridge specific for creatinine or kidney function.

Financial factors

This technology is commissioned by CCGs.

NICE does not expect this guidance to have a significant impact on resources. Point-of-care creatinine devices are already used in some NHS radiology departments. The additional number of NHS providers expected to start using these devices, as a result of this guidance, is small. The incremental cost of testing will be around £9 per test for an estimated additional 37,700 tests per year.
Providers currently not using the technology will incur a cost for the initial purchase of the equipment, this cost is included in the above incremental cost per test.

NICE Quality Standards

None published this month.

Current NICE consultations

Title / link	End date of consultation
Human and animal bites: antimicrobial prescribing	03/12/2019
Decision-making and mental capacity	04/12/2019
Renal and ureteric stones	04/12/2019
Pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy [ID1536]	05/12/2019
PneuX for preventing ventilator-associated pneumonia in intensive care	06/12/2019
Fremanezumab for preventing migraine [ID1368]	06/12/2019
Heavy menstrual bleeding (QS update)	16/12/2019
Artificial iris implant insertion for acquired aniridia	19/12/2019
Artificial iris insertion for congenital aniridia	19/12/2019
Intravascular lithotripsy for calcified coronary arteries during percutaneous coronary intervention	19/12/2019
Insect bites and stings: antimicrobial prescribing	20/12/2019
Meningitis (bacterial) and meningococcal septicaemia: recognition, diagnosis and management	24/12/2019
Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (2019)	24/12/2019
Management of gout	03/01/2020