NHS Devon

# NICE Update Bulletin: October 2025

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

1. **Clascoterone for treating acne vulgaris in people 12 years and over (terminated appraisal) TA1105**
2. **Sarilumab for treating polyarticular or oligoarticular juvenile idiopathic arthritis in people 2 to 17 years (terminated appraisal) TA1104**
3. **Lorlatinib for ALK-positive advanced non-small-cell lung cancer that has not been treated with an ALK inhibitor TA1103**
4. **Iptacopan for treating complement 3 glomerulopathy (terminated appraisal) TA1102**
5. **Garadacimab for preventing recurrent attacks of hereditary angioedema in people 12 years and over TA1101**
6. **Mirabegron for treating neurogenic detrusor overactivity in people 3 to 17 years (terminated appraisal) TA1100**
7. **Durvalumab for treating limited-stage small-cell lung cancer after platinum-based chemoradiotherapy TA1099**
8. **Sparsentan for treating primary IgA nephropathy TA1074 (UPDATE)**
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# Technology Appraisals (TAs)

## Clascoterone for treating acne vulgaris in people 12 years and over (terminated appraisal) TA1105

NICE is **unable to make a recommendation** on clascoterone for treating acne vulgaris in people 12 years and over. This is because the company did not provide an evidence submission.

## Sarilumab for treating polyarticular or oligoarticular juvenile idiopathic arthritis in people 2 to 17 years (terminated appraisal) TA1104

NICE is **unable to make a recommendation** on sarilumab for treating polyarticular or oligoarticular juvenile idiopathic arthritis in people 2 to 17 years. This is because the company did not provide an evidence submission.

## Lorlatinib for ALK-positive advanced non-small-cell lung cancer that has not been treated with an ALK inhibitor TA1103

### Recommendation

Lorlatinib **can be used** as an option for ALK-positive advanced non-small-cell lung cancer in adults who have not had an ALK inhibitor. Lorlatinib can only be used if the company provides it according to the commercial arrangement.

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

### The Technology

Lung cancer falls into two main histological categories: around 80 to 85% are non-small-cell lung cancers (NSCLC) and the remainder are small cell lung cancers. NSCLC can be further classified into squamous cell carcinoma and non-squamous cell carcinoma. Approximately 70% of NSCLC are of non-squamous histology and can be either large-cell undifferentiated carcinoma or adenocarcinoma. Most lung cancers are diagnosed at an advanced stage, when the cancer has spread to lymph nodes and other organs in the chest (locally advanced disease; stage 3) or to other parts of the body (metastatic disease; stage 4).

In 2022, 90% (around 33,200) of people diagnosed with lung cancer in England and Wales had NSCLC. Of these people, 50% had stage 4 disease. Lung cancer caused approximately 35,000 deaths in the UK between 2017-2019. 48% of people with lung cancer survive for more than 1 year after diagnosis. It is estimated that around 2 to 6% of NSCLCs have an ALK fusion genetic alteration. This alteration inhibits processes which stop lung cells dividing and can lead to cancer. ALK fusions can occur in any type of NSCLC, but are most likely to occur in adenocarcinoma histology.

About 5% of people with NSCLC have mutations in the anaplastic lymphoma kinase (ALK) gene. People with ALK-positive advanced NSCLC tend to be younger and are less likely to have a history of smoking than the wider NSCLC population.

Treatment for ALK-positive advanced NSCLC usually includes ALK tyrosine kinase inhibitors (TKIs). There are 4 ALK TKIs available for first-line treatment: alectinib, brigatinib, ceritinib and crizotinib. The clinical experts explained that crizotinib and ceritinib are rarely used in the NHS since alectinib and brigatinib, which are 'second-generation' ALK TKIs, became available.

Lorlatinib is indicated for the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive advanced non-small-cell lung cancer (NSCLC) previously not treated with an ALK inhibitor or whose disease has progressed after prior treatment with an ALK inhibitor.

The comparator treatments for the eligible population are alectinib or brigatinib. Lorlatinib is already used after alectinib or brigatinib. Lorlatinib, alectinib and brigatinib are all oral treatments.

### Financial Factors

This technology is commissioned by NHS England.

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

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

There is not expected to be a difference in monitoring requirements between lorlatinib, alectinib or brigatinib while on treatment. If people have lorlatinib as first-line treatment then they would not be eligible to have second-line treatment with lorlatinib, which may constitute a saving in the treatment pathway.

Lorlatinib has a different toxicity profile to those of alectinib and brigatinib and has greater potential for causing central nervous system-related adverse effects. Healthcare professionals in the NHS have experience of managing adverse effects when using lorlatinib at second line. So, although adverse effects can substantially affect quality of life, they are often manageable with supportive care or by dose reductions.

NICE estimate that in year 5, 7 people in Devon will be eligible for treatment, with 3 people choosing lorlatinib.

## Iptacopan for treating complement 3 glomerulopathy (terminated appraisal) TA1102

NICE is **unable to make a recommendation** on iptacopan for treating complement 3 glomerulopathy in adults. This is because the company has withdrawn from the appraisal.

## Garadacimab for preventing recurrent attacks of hereditary angioedema in people 12 years and over TA1101

### Recommendation

Garadacimab **can be used** as an option to prevent recurrent attacks of hereditary angioedema in people 12 years and over, only if:

- they have 2 or more attacks a month, and
- the company provides garadacimab according to the commercial arrangement.

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

### The Technology

Hereditary angioedema is a rare genetic disorder. It is almost always caused by a mutation affecting the C1-esterase inhibitor (C1-INH) gene, known as type 1 or type 2 hereditary angioedema. Hereditary angioedema affects at least 1 in 59,000 people in the UK and usually develops between ages 8 and 12 years. It is a chronic condition involving recurrent unpredictable attacks of swelling in areas of the skin and submucosal tissue. The swelling may happen in the fingers and toes, face, mouth, abdomen, genitalia, gut or airway, and can cause severe pain. Swelling of the airway (laryngeal attacks) can be life threatening.

Many angioedema attacks are associated with trauma, medical procedures, emotional stress, menstruation, oral contraceptive use, infections, or the use of medications such as ACE inhibitors. But often, a specific trigger cannot be identified. Attacks are unpredictable; severity and frequency of previous attacks do not predict severity and frequency of future attacks. Attacks usually last approximately 2 to 5 days before resolving spontaneously.

Garadacimab is indicated for the routine prevention of recurrent attacks of hereditary angioedema in adult and adolescent patients aged 12 years and older.

The comparator treatments for the eligible population and their associated administration methods are lanadelumab (subcutaneous injection), berotralstat (oral) and C1-esterase inhibitors (Cinryze and Berinert, both by intravenous infusion).

- berotralstat was modelled for people having 2 or more attacks a month
- C1-esterase inhibitors (Cinryze and Berinert) and lanadelumab were modelled for people having 2 or more attacks a week.

### Financial Factors

This technology is commissioned by NHS England.

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

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

There may be a capacity benefit from a reduction in the frequency or severity of hereditary angioedema attacks.

No significant capacity implications are anticipated in relation to clinic appointments, as all treatments need the same number of appointments in year 1 and subsequent years. Also, all treatments are delivered through homecare services.

When people switch from Berinert, homecare costs may reduce when moving from an intravenous treatment to a prefilled pen or syringe. Cinryze, lanadelumab and berotralstat homecare is funded by their respective companies. So, it is assumed that homecare for these treatments has no capacity impact on the NHS.

NICE estimate that in year 5, 9 people in Devon will be eligible for treatment.

## Mirabegron for treating neurogenic detrusor overactivity in people 3 to 17 years (terminated appraisal) TA1100

NICE is **unable to make a recommendation** on mirabegron for treating neurogenic detrusor activity in people 3 to 17 years. This is because the company did not provide an evidence submission.

## Durvalumab for treating limited-stage small-cell lung cancer after platinum-based chemoradiotherapy TA1099

### Recommendation

Durvalumab **can be used**, within its marketing authorisation, as an option to treat limited-stage small-cell lung cancer that has not progressed after platinum-based chemoradiotherapy in adults.

Durvalumab can only be used if the company provides it according to the commercial arrangement.

### The Technology

Small-cell lung cancer (SCLC) is an aggressive type of lung cancer that grows rapidly and spreads quickly to other areas of the body. In most people diagnosed with SCLC, the cancer has already

spread (metastasised). But in about 30% of people, the cancer is contained in a single area that can be treated with radiotherapy. This is known as limited-stage SCLC (LS-SCLC).

There were around 37,000 new lung cancer cases and 27,000 deaths from lung cancer in England in 2020.

As a result of the NHS targeted Lung Health Check programme which is being rolled out in the UK, it is expected that lung cancer will increasingly be diagnosed at an earlier stage, when treatment may be more successful.

Durvalumab is indicated as monotherapy for the treatment of adults with LS-SCLC whose disease has not progressed following platinum-based chemoradiation therapy.

Durvalumab is used in addition to active monitoring when the cancer has not progressed. It is administered intravenously.

### Financial Factors

This technology is commissioned by NHS England.

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

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

NICE estimate that in year 5, 12 people in Devon will be eligible for treatment.

## Sparsentan for treating primary IgA nephropathy TA1074 (UPDATE)

**October 2025: NICE updated recommendations 1.1 and 1.2 to change the unit for urine protein-to-creatinine ratio (UPCR) to mg/mmol from g/g. A UPCR of 85 mg/mmol or more equates to the 0.75 g/g or more measurement specified in the marketing authorisation indication for sparsentan. A UPCR of 199 mg/mmol or more equates to 1.76 g/g or more**.

### Recommendation

Sparsentan **can be used** as option to treat primary immunoglobulin A nephropathy (IgAN) in adults with a:

- urine protein-to-creatinine ratio (UPCR) of 85 mg/mmol, or
- urine protein excretion of 1 g/day or more.

It can only be used if the company provides it according to the commercial arrangement.

Sparsentan should be stopped after 36 weeks if a person's UPCR:

- is 199 mg/mmol or more, and

- has not reduced by 20% or more since starting sparsentan.

These recommendations are not intended to affect treatment with sparsentan 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 healthcare professional consider it appropriate to stop.

## The Technology

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

There is no cure for IgA nephropathy. The aim of current treatment is to prevent or delay kidney failure and associated complications. Initial treatment focuses on reducing protein levels in the urine and blood pressure. Antihypertensives such as angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) are given at the maximum tolerated licensed doses. Second-line treatments are offered to people with more than 1 gram of proteinuria per day. Second-line treatments may include glucocorticoids, sodium-glucose cotransporter-2 (SGLT2) inhibitors or entry into a clinical trial.

Sparsentan is indicated for the treatment of adults with primary IgAN with a urine protein excretion ≥ 1.0 g/day (or urine protein-to-creatinine ratio ≥ 0.75 g/g).

The comparator treatment for the eligible population is irbesartan. Clinical trial evidence shows that sparsentan reduces urine protein-to-creatinine ratio more than irbesartan. Evidence also suggests that sparsentan is better at maintaining kidney function than irbesartan.

## Financial Factors

This technology is commissioned by ICBs.

The company has a commercial arrangement which makes sparsentan available to the NHS with a discount.

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

NICE estimate that at year 5, 97 people in Devon will be eligible for treatment and 20 people will choose sparsentan, having achieved a market share of 20.7%.

## Targeted-release budesonide for treating primary IgA nephropathy TA937 (UPDATE)

**October 2025: NICE updated recommendation 1.1 to change the unit for urine protein-to-creatinine ratio (UPCR) to mg/mmol from g/g. A UPCR of 170 mg/mmol or more equates to the 1.5 g/g or more measurement specified in the marketing authorisation indication for targeted-release budesonide.**

### Recommendation

Targeted-release budesonide is **recommended** as an option for treating primary immunoglobulin A nephropathy (IgAN) when there is a risk of rapid disease progression in adults with a urine protein-to-creatinine ratio of 170 mg/mmol or more. Targeted-release budesonide is recommended only if:

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

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

### The Technology

Immunoglobulin A nephropathy (IgAN) is a progressive chronic kidney disease (CKD). It is caused by IgA antibodies building up in the kidney causing inflammation and scarring, which can lead to kidney failure (end-stage renal disease). In primary IgAN there is no obvious initiating or underlying cause, but genetic and environmental factors such as exposure to toxins are thought to be contributing factors in some cases. Disease progression is defined by estimated glomerular filtration rate (eGFR)-based CKD stages. The eGFR shows how well the kidneys are filtering waste products from the body. eGFR is categorised from stage 1 (eGFR of more than 90 ml/min/1.73 $m^2$), defined as no reduction in kidney function, to stage 5 (eGFR of less than 15 ml/min/1.73 $m^2$), defined as kidney failure. Progression to kidney failure typically happens at a substantially earlier age with IgAN than other types of CKD, although the disease can be highly variable.

In most people, IgAN progresses to kidney failure within 10 to 15 years after diagnosis, with higher proteinuria (high levels of protein in urine) being a key risk factor for faster progression. The degree of proteinuria is usually defined by urine protein-to-creatinine ratio (UPCR).

Targeted-release budesonide is indicated for the treatment of primary immunoglobulin A (IgA) nephropathy (IgAN) in adults at risk of rapid disease progression with a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/gram.

### Financial Factors

This technology is commissioned by ICBs.

The company has a commercial arrangement (simple discount patient access scheme). This makes targeted-release budesonide available to the NHS with a discount. The size of the discount is commercial in confidence.

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

NICE expect the resource impact of implementing the recommendations in England will be less than £5 million per year (or approximately £8,800 per 100,000 population, based on a population for England of 56.6 million people).

## Highly Specialised Technology Guidance (HSTs)

None published this month.

## NICE Guidelines (NGs)

**Rehabilitation for chronic neurological disorders including acquired brain injury NG252**

This guideline covers rehabilitation in all settings for children, young people and adults with a chronic neurological disorder, neurological impairment or disabling neurological symptoms due to acquired brain injury, acquired spinal cord injury, acquired peripheral nerve disorder, functional neurological disorder or progressive neurological disease.

## NICE Rapid COVID-19 Guidelines

None published this month.

## Public Health Guidelines

None published this month.

## Antimicrobial Prescribing Guidelines

None published this month.

## Social Care Guidelines

None published this month.

# Interventional Procedures Guidance (IPGs)

## VA ECMO for extracorporeal cardiopulmonary resuscitation (ECPR) in adults with refractory cardiac arrest IPG808

This guidance replaces NICE interventional procedures guidance on extracorporeal membrane oxygenation (ECMO) for acute heart failure in adults (IPG482).

### Recommendations

**For refractory cardiac arrest with a shockable heart rhythm or reversible causes**

Venoarterial extracorporeal membrane oxygenation (VA ECMO) for extracorporeal cardiopulmonary resuscitation (ECPR) **can be used** as an option to manage in-hospital and out-of-hospital refractory cardiac arrest in adults with a shockable heart rhythm or reversible causes.

**For refractory cardiac arrest with a non-shockable heart rhythm or irreversible causes**

**More research is needed** on VA ECMO for ECPR to manage in-hospital and out-of-hospital refractory cardiac arrest in adults with a non-shockable heart rhythm or irreversible causes, before it can be used in the NHS. This procedure should only be done as part of formal research and an NHS research ethics committee needs to have approved its use.

### The Condition

Cardiac arrest is when normal blood circulation suddenly stops because the heart does not contract effectively. The underlying abnormal cardiac rhythms most associated with cardiac arrest are ventricular fibrillation, asystole, pulseless electrical activity, and pulseless ventricular tachycardia. Cardiac arrest leads to loss of consciousness, respiratory failure and, ultimately, death. Refractory cardiac arrest is defined as the lack of return of spontaneous circulation after 30 minutes of appropriate CPR, in the absence of hypothermia.

### The Procedure

Extracorporeal cardiopulmonary resuscitation (ECPR) is a type of CPR that uses a venoarterial extracorporeal membrane oxygenation (VA ECMO) machine to help people when conventional CPR does not work. The goal of ECPR is to restore circulation and gas exchange, and to allow time for other interventions.

In VA ECMO, blood is taken from the venous system (usually from the femoral vein or the right atrium) and pumped through an oxygenator, where oxygen and carbon dioxide are exchanged. It is then returned to the arterial system, usually through the femoral or axillary artery, or the ascending aorta. People are usually given a continuous infusion of an anticoagulant, usually heparin, to prevent blood clotting in the extracorporeal system. ECPR is used when conventional CPR is unable to restore spontaneous circulation.

## VA ECMO for severe acute heart failure in adults IPG807

This guidance replaces NICE interventional procedures guidance on extracorporeal membrane oxygenation (ECMO) for acute heart failure in adults (IPG482).

### Recommendations

**As a bridge to recovery, heart transplant or implanted LVAD**

Venoarterial extracorporeal membrane oxygenation (VA ECMO) **can be used** as an option for severe acute heart failure in adults as a bridge to recovery, a heart transplant or an implanted left ventricular assist device (LVAD).

**When the potential for functional recovery is low or uncertain, and a heart transplant or implanted LVAD is unsuitable**

**More research is needed** on VA ECMO for severe acute heart failure in adults when the potential for functional recovery is low or uncertain, and a heart transplant or an implanted LVAD is unsuitable, before it can be used in the NHS.

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

### The Condition

Acute heart failure is a complex clinical syndrome of symptoms and signs that happen when the efficiency of the heart as a pump is impaired. It can lead to reduced blood flow to the body and increased filling pressures in the heart. Cardiogenic shock is the most severe form of acute heart failure, with short-term mortality between 30% and 50%. It can be caused by a heart attack, heart failure, inflammation of the heart muscle, drug overdoses and poisoning, and blood clots in the lungs. Severe acute heart failure in pregnancy is relatively uncommon but rates are increasing, particularly in the postpartum period.

### The Procedure

Venoarterial extracorporeal membrane oxygenation (VA ECMO) can be used for adults with severe acute heart failure as a bridge to recovery, or to having a heart transplant or an implanted left ventricular assist device.

In VA ECMO, blood is taken from the venous system (usually from the femoral vein or directly from the right atrium) and pumped through an oxygenator, where oxygen and carbon dioxide are exchanged. It is then returned to the arterial system, usually through the femoral or axillary artery, or the ascending aorta. People are usually given a continuous infusion of an anticoagulant, usually heparin, to prevent blood clotting in the extracorporeal system. For people with poor kidney function, a haemofiltration unit may be added to the circuit.

## Medical Technologies Guidance (MTGs)

None published this month.

## Diagnostics Guidance (DGs)

None published this month.

## Health Technology Evaluations (HTE)

**Artificial intelligence (AI) technologies to aid opportunistic detection of vertebral fragility fractures: early value assessment HTE34**

### Recommendations

Five artificial intelligence (AI) technologies **can be used** in the NHS during the evidence generation period as options to aid the opportunistic detection of vertebral fragility fractures (VFFs). The technologies are:

- BriefCase-Triage
- CINA-VCF Quantix
- HealthVCF
- HealthOST
- IB Lab FLAMINGO.

These technologies can only be used:

- within their indicated populations as outlined in their instructions for use and with consideration of the risk groups as recommended in NICE's guideline on assessing the risk of fragility fracture in osteoporosis
- if the evidence outlined in the evidence generation plan is being generated
- as long as they have appropriate regulatory approval, including NHS England's Digital Technology Assessment Criteria (DTAC) approval.

Commissioners should take into account whether a technology is likely to remain available on the UK market and supported by its company when entering into a contract.

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

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

**More research is needed** on the following AI technologies that aid the opportunistic detection of VFFs before they can be funded by the NHS:

- Annalise Enterprise CXR/Annalise Container CXR
- BoneView
- TechCare Spine.

## The Technologies

The technologies included in this early value assessment use artificial intelligence (AI) algorithms to assist the opportunistic detection of vertebral fragility fractures (VFFs) on X-ray images and CT scans involving the spine. They are intended to be used as decision aids for healthcare professionals interpreting the X-ray or CT scan.

Some companies provide the software directly, whereas others provide it through multivendor platforms. The technologies use X-ray or CT scans in digital imaging and communications in medicine (DICOM) format, which are stored on the hospital's picture archiving and communications system (PACS).

Different technologies report and display results in different ways including as annotated images within PACS Viewers, DICOM Secondary Captures or through standalone applications. Some also have notifications or summary reports.

Some of the technologies have additional functionalities, such as vertebral labelling, bone mass density assessment, prioritisation tools or the ability to detect other pathologies. This early value assessment has assessed the clinical and cost effectiveness of the technologies only for the opportunistic detection of VFFs.

The comparator is standard care, where the reporting practitioner interprets the radiograph without AI assistance, usually within 24 hours of the image being taken.

## Financial Factors

This technology is commissioned by ICBs.

The following are the benefits attributed to the implementation of the AI technologies:

- The AI technologies may help opportunistically detect VFFs that would otherwise have been missed. This could help identify more people with a VFF who need treatment to improve their quality of life and reduce the risk of future fractures.
- Reducing the risk of further fractures may lead to a reduction in the number of hospital attendances or admissions, which may include demand on other costly services, such as those needed to manage hip fractures.

The following are the capacity and financial implications of implementing the AI technologies:

- Implementing the AI technologies could have a significant impact on radiology services, such as increasing the amount of imaging data that needs to be reviewed by a radiologist and the number of dual-energy X-ray absorptiometry (DEXA) scans that need to be done.
- Other services may be impacted when a VFF is identified, such as GP services, fracture liaison services and rheumatology departments.
- The use of treatments for osteoporosis may increase if more people with a VFF are identified.

Clinical experts explained that there is no clear pathway for people with VFFs and there is variation across the NHS. Where available, people are referred to fracture liaison services.

Implementation of the AI technologies will incur additional costs to the NHS. These costs may vary depending on the number of scans. There may also be additional maintenance, implementation and setup costs associated with the technologies relating to training and integration.

## NICE Quality Standards

### Head injury QS74

This quality standard covers assessment, early management and rehabilitation following head injury in adults, young people and children. It describes high-quality care in priority areas for improvement.

**October 2025: Changes have been made to align this quality standard with NICE's guideline on rehabilitation for chronic neurological disorders. Statement 6 has been removed because the source guidance, SIGN guideline 110 on early management of patients with a head injury, was withdrawn. Statement 7 source guidance has been changed to include NICE's guideline on rehabilitation for chronic neurological disorders. The target population for this statement has been extended to include children and young people aged under 16. Statement 8 has been removed because it is no longer needed. This placeholder statement was originally added because no source guidance existed for post-acute phase rehabilitation for children and young people. NICE's guideline on rehabilitation for chronic neurological disorders now covers this population, and statement 7 has been amended accordingly.**

## Current NICE Consultations

| Title/link | End date of consultation |
|---|---|
| Digital technologies for managing mild to moderate symptoms of hip or knee osteoarthritis: early-value assessment | 04/11/2025 |
| Vorasidenib for treating astrocytoma or oligodendroglioma with IDH1 or IDH2 mutations after surgery in people 12 years and over [ID6407] | 04/11/2025 |
| Leadless cardiac pacemaker implantation for bradyarrhythmias | 11/11/2025 |
| Pulmonary artery pressure technologies for remote monitoring of chronic heart failure | 11/11/2025 |
| Percutaneous insertion of a catheter-based intravascular microaxial flow pump for cardiogenic shock | 25/11/2025 |
| Transvenous embolisation for treating cerebrospinal fluid-venous fistula associated with spontaneous intracranial hypotension | 25/11/2025 |
| Surgical insertion of a catheter-based intravascular microaxial flow pump for cardiogenic shock | 25/11/2025 |