NHS
Devon
Clinical Commissioning Group

NICE Update Bulletin: September 2020

Hyperlinks to the relevant NICE web page are included below.

NICE rapid COVID-19 guidelines

COVID-19 rapid guideline: dialysis service delivery NG160 (update)

The purpose of this guideline is to maximise the safety of patients on dialysis, while protecting staff from infection. It will also enable dialysis services to make the best use of NHS resources and match the capacity of dialysis services to patient needs if these become limited because of the COVID-19 pandemic.

September 2020: NICE clarified their guidance for organisations on planned procedures and emergency pathways for creating dialysis access sites for patients with advanced or end-stage kidney disease.

COVID-19 rapid guideline: critical care in adults NG159 (update)

The purpose of this guideline is to maximise the safety of patients who need critical care during the COVID-19 pandemic, while protecting staff from infection. It will also enable services to make the best use of NHS resources.

September 2020: NICE added guidance on treatment with corticosteroids for people with severe or critical COVID-19, in line with their prescribing briefing on dexamethasone and hydrocortisone.

Technology Appraisals (TAs)

Naldemedine for treating opioid-induced constipation TA651

Recommendations

Naldemedine is **recommended**, within its marketing authorisation, as an option for treating opioid-induced constipation in adults who have had laxative treatment.

The technology

The treatment of opioid-induced constipation depends on whether the opioid is the only cause of the constipation or if there are other contributing factors. Treatment may include a peripherally acting mu-opioid receptor antagonist (PAMORA) alone. But, commonly a PAMORA and a conventional laxative are used together.

Naldemedine has a marketing authorisation in the UK for the treatment of opioid-induced constipation in adult patients who have previously been treated with a laxative.

The clinical evidence shows that naldemedine increases the frequency of bowel movements compared with no treatment and other PAMORAs.

Financial factors

This technology is generally commissioned by CCGs. NHS England commissions services for patients with constipation only when referral to a specialist centre is required.

NICE does not expect this guidance to have a significant impact on resources because naldemedine is a further treatment option and the overall cost of treatment will be similar to the current treatment options available.

Pembrolizumab with axitinib for untreated advanced renal cell carcinoma TA650

Recommendations

Pembrolizumab with axitinib is **not recommended**, within its marketing authorisation, for untreated advanced renal cell carcinoma in adults.

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

The technology

Renal cell carcinoma (RCC) is a cancer that usually originates in the lining of the tubules of the kidney that help filter the blood and make urine. RCC is the most common type of kidney cancer.

RCC is classified into stages I to IV. Stage III denotes disease that is locally advanced and/or has spread to regional lymph nodes. Metastatic RCC, in which the tumour has spread beyond the regional lymph nodes to other parts of the body, is defined as stage IV. Surgery, including nephron-sparing surgery, radical nephrectomy and ablative therapies, is the main treatment for localised and metastatic RCC. However, around half of those who have surgery for localised RCC develop metastatic disease later on. The aim of systemic treatment with biological therapies for advanced disease is to stop the growth of new blood vessels within the tumour and to modulate the immune system to attack tumour.

Pembrolizumab, in combination with axitinib, is indicated for the first-line treatment of advanced renal cell carcinoma (RCC) in adults.

Financial factors

This technology is commissioned by NHS England.

Short-term clinical trial evidence shows that pembrolizumab with axitinib is more effective than sunitinib for people with untreated renal cell carcinoma, but it is uncertain if there is a long-term benefit. This means the cost-effectiveness estimates are uncertain.

Pembrolizumab with axitinib is not suitable for use in the Cancer Drugs Fund because it is unlikely to be cost effective at its current price (even if the uncertainty about its effectiveness is reduced).

Pembrolizumab with axitinib does not meet NICE's criteria to be a life-extending treatment at the end of life. The cost-effectiveness estimates are higher than what NICE normally considers an acceptable use of NHS resources. Therefore, pembrolizumab with axitinib is not recommended.

Polatuzumab vedotin with rituximab and bendamustine for treating relapsed or refractory diffuse large B-cell lymphoma TA649

Recommendations

Polatuzumab vedotin with rituximab and bendamustine is **recommended**, within its marketing authorisation, as an option for treating relapsed or refractory diffuse large B-cell lymphoma in adults who cannot have a haematopoietic stem cell transplant. It is recommended only if the company provides polatuzumab vedotin according to the commercial arrangement.

The technology

There is no standard treatment for relapsed or refractory diffuse large B-cell lymphoma in people who cannot have a haematopoietic stem cell transplant but bendamustine with rituximab is the most frequently used treatment in the NHS.

People with relapsed or refractory diffuse large B-cell lymphoma who cannot have a haematopoietic stem cell transplant have very short life expectancy and polatuzumab vedotin in combination with bendamustine and rituximab (P+BR) has been demonstrated to extend life in this population.

Financial factors

This technology is commissioned by NHS England.

NICE estimates that 650 people in England with relapsed or refractory diffuse large B-cell lymphoma are eligible for treatment with P+BR, and 580 people will have P+BR from year 2 onwards once uptake has reached 90%.

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

Dupilumab for treating chronic rhinosinusitis with nasal polyps TA648 (terminated appraisal)

NICE is **unable to make a recommendation** on dupilumab (Dupixent) for treating chronic rhinosinusitis with nasal polyps because Sanofi did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Eculizumab for treating relapsing neuromyelitis optica TA647 (terminated appraisal)

NICE is **unable to make a recommendation** on eculizumab (Soliris) for treating relapsing neuromyelitis optica because Alexion Pharma UK did not provide an

evidence submission. NICE will review this decision if the company decides to make a submission.

Glasdegib with chemotherapy for untreated acute myeloid leukaemia TA646 (terminated appraisal)

NICE is **unable to make a recommendation** on glasdegib with chemotherapy for untreated acute myeloid leukaemia because Pfizer did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Avelumab with axitinib for untreated advanced renal cell carcinoma TA645

Recommendations

Avelumab with axitinib is **recommended for use within the Cancer Drugs Fund** as an option for untreated advanced renal cell carcinoma in adults. It is recommended only if the conditions in the managed access agreement for avelumab with axitinib are followed.

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

The technology

Avelumab is an anti-PD-L1 monoclonal antibody with a dual mechanism of action. It aims to bind and block the inhibitory signalling through PD-1/PD-L1 resulting in the activation of T-cells and cell mediated immune responses against tumour cells or pathogens. Avelumab is administered by intravenous infusion.

Axitinib is an oral multi-targeted kinase receptor inhibitor with anti-tumour activity. It inhibits vascular endothelial growth factor receptor (VEGFR) -1, -2 and -3, platelet-derived growth factor receptor (PDGFR), and c-kit, which may result in inhibition of angiogenesis in tumours.

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

Financial factors

This technology is commissioned by NHS England.

It is estimated that around 1,600 people per year with untreated advanced renal cell carcinoma are eligible for treatment with avelumab with axitinib.

Avelumab with axitinib will be available to the NHS in line with the managed access agreement with NHS England. As part of this, there is a commercial access agreement that makes avelumab with axitinib available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

The resource impact of avelumab with axitinib will be covered by the Cancer Drugs Fund budget. The guidance will be reviewed by the date the managed access agreement expires, July 2023, or when the results of the managed access agreement

data collection are available, whichever is sooner. The aim of the review is to decide whether or not the drug can be recommended for routine use.

Highly specialised technology guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Neuropathic pain in adults: pharmacological management in non-specialist settings CG173 (update)

This guideline covers managing neuropathic pain (nerve pain) with pharmacological treatments (drugs) in adults in non-specialist settings. It aims to improve quality of life for people with conditions such as neuralgia, shingles and diabetic neuropathy by reducing pain and promoting increased participation in all aspects of daily living. The guideline sets out how drug treatments for neuropathic pain differ from traditional pain management.

September 2020: NICE reviewed the evidence on treating sciatica and added new recommendations on pharmacological treatment to the NICE guideline on low back pain and sciatica. They updated the research recommendations on sciatica in the full version of this guideline.

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

This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over. It outlines physical, psychological, pharmacological and surgical treatments to help people manage their low back pain and sciatica in their daily life. The guideline aims to improve people's quality of life by promoting the most effective forms of care for low back pain and sciatica.

September 2020: This guideline includes new and updated recommendations on pharmacological management of sciatica.

These supplement the existing recommendations on:

- assessment of low back pain and sciatica
- non-invasive treatments for low back pain and sciatica
- invasive treatments for low back pain and sciatica

Suspected cancer: recognition and referral NG12 (update)

This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer.

September 2020: NICE clarified when to offer faecal testing for colorectal cancer to adults without rectal bleeding.

Public Health Guidelines

None published this month.

Antimicrobial prescribing guidelines

Insect bites and stings NG182

This guideline sets out an antimicrobial prescribing strategy for insect and spider bites and stings in adults, young people and children aged 72 hours and over, including those that occurred while travelling outside the UK. It aims to limit antibiotic use and reduce antibiotic resistance.

This guideline includes recommendations on:

- assessment and advice
- treating a local inflammatory or allergic skin reaction
- treating an infected insect bite or sting
- reassessment
- referral and seeking specialist advice

Social Care guidelines

None published this month.

Interventional Procedures Guidance (IPGs)

Transcranial magnetic stimulation for auditory hallucinations IPG680

Recommendations

Evidence on the safety of transcranial magnetic stimulation for auditory hallucinations is adequate and raises no major safety concerns. However, evidence on its efficacy is inadequate in quantity and quality. Therefore, this procedure should only be used in the **context of research**.

Further research should be in the form of randomised controlled trials and should use well described treatment protocols. Studies should report details of patient selection including specific psychopathology, underlying disease and other treatments, the area of brain treated and the imaging used to target it, and long-term outcomes for at least 1 year.

The condition

Auditory hallucinations are when you hear sounds that do not exist (such as hearing voices). They are often symptoms of mental health problems such as schizophrenia, bipolar disorder, major depression and post-traumatic stress disorder. However, they may also be symptoms of temporal lobe epilepsy, dementia, neurological infections

and brain tumours. And they are sometimes caused by lack of sleep, extreme hunger, or the use of recreational or prescribed drugs.

The treatment options for auditory hallucinations depend on the underlying cause. For example, antipsychotic medication may help with hallucinations for people living with schizophrenia. Some people find strategies such as learning to understand their voices, taking control and keeping busy are helpful in managing the condition.

The procedure

Transcranial magnetic stimulation is typically done with the patient awake and sitting in a chair. The operator places an electromagnetic coil against the scalp, over a specific region of the brain, usually the left temporoparietal area. Pulses of electrical current in the coil generate rapidly pulsating magnetic fields that pass through the skull and meninges and into the targeted area of the brain. The magnetic field is relatively powerful but short lived (milliseconds). The precise mechanism of action is unclear but it produces both excitatory and inhibitory effects on cortical neurons. The amount of stimulation and the target area is adjusted for each patient. Treatment usually comprises daily or twice daily sessions lasting about 20 minutes. The number of sessions varies but it could be up to 30 sessions. The aim is to stop or reduce the auditory hallucinations.

Stimulation can be repetitive, with pulses of magnetic energy delivered at various frequencies or stimulus intensities. In the standard repetitive technique, individual pulses are repeated at a pre-set interval (repetition of pulses). In the theta-burst technique, short bursts of pulses are repeated at a pre-set interval (repetition of bursts). In the deep repetitive technique, deeper and broader brain regions are stimulated than in the standard technique.

Medical Technologies Guidance (MTGs)

Axonics sacral neuromodulation system for treating refractory overactive bladder MTG50

This guidance replaces the NICE medtech innovation briefing on Axonics sacral neuromodulation system for overactive bladder and faecal incontinence (MIB164).

Recommendations

Evidence **supports the case** for adopting Axonics sacral neuromodulation (SNM) system for treating refractory overactive bladder in the NHS. Axonics SNM system improves symptoms and quality of life. It also has a longer battery life than the non-rechargeable system used in NHS clinical practice.

Axonics SNM system should be considered as an option for people with refractory overactive bladder, that is, when conservative treatment or treatment with medicine has not worked, in line with NICE's guidelines on urinary incontinence and pelvic organ prolapse and lower urinary tract symptoms. Axonics SNM system is small and does not need to be removed for most types of MRI scans, so it may be useful for people with a low body mass index (BMI) or when an MRI is likely.

Cost modelling estimates that, over 15 years, Axonics SNM system is cost saving compared with the non-rechargeable system by about £6,025 per person. Cost

savings are estimated to begin 6 years after implant. This is because the device needs to be replaced less frequently than the non-rechargeable system, assuming Axonics has a life span of at least 15 years.

The technology

Axonics sacral neuromodulation (SNM) system stimulates the sacral nerve through an implantable pulse generator implanted subcutaneously in the upper buttock. Lead electrodes implanted through the corresponding sacral foramen transmit pulses from the stimulator to the sacral nerves. The stimulator is powered by a rechargeable battery.

A handheld remote control activates the stimulator, adjusts the stimulation amplitude, and checks the battery status. A wireless charger, attachable to the skin over the implanted stimulator, is used to charge the stimulator. The company claims that the battery needs recharging every 1 to 2 weeks for 30 minutes to 1 hour. The implanted device is programmed by a clinician in an outpatient setting using a portable tablet. Axonics SNM system received a CE mark as a class 3 medical device in June 2016.

The Axonics SNM system is intended to treat symptoms of overactive bladder, urinary retention and chronic faecal incontinence, specifically when conservative treatment and treatment with medicine have not worked or are not suitable.

Financial factors

Sacral nerve stimulators fall within high-cost devices and listed procedures. These are commissioned by NHS England.

NICE does not expect this guidance to have a significant impact on resources. This is because the modelling estimates that annual incremental costs incurred in each of the next 5 years are under £1 million in England. The cost modelling compared Axonics sacral neuromodulation (SNM) system with the current standard of care in the NHS: non-rechargeable SNM systems; it did not compare the costs of Axonics with any other rechargeable SNM system.

The modelling estimates that cost savings begin 6 years after implant because the device needs to be replaced less frequently than the non-rechargeable system.

Diagnostics Guidance (DGs)

Implantable cardiac monitors to detect atrial fibrillation after cryptogenic stroke DG41

This guidance replaces the NICE medtech innovation briefing on Reveal LINQ insertable cardiac monitor to detect atrial fibrillation after cryptogenic stroke (MIB141).

Recommendations

Reveal LINQ is **recommended** as an option to help to detect atrial fibrillation after cryptogenic stroke, including transient ischaemic attacks (TIA), only if:

- non-invasive electrocardiogram (ECG) monitoring has been done and
- a cardiac arrhythmic cause of stroke is still suspected.

Clinicians should consider if disabled people may need support from a carer to help set up the MyCareLink Patient Monitor, to ensure data from Reveal LINQ are transmitted for review.

There is not enough evidence to recommend the routine adoption of BioMonitor 2-AF (or its successor device BIOMONITOR III) or Confirm Rx to help to detect atrial fibrillation after cryptogenic stroke. Further research is recommended to assess the diagnostic yield (a measure of how many people with atrial fibrillation are diagnosed) of these devices for atrial fibrillation when used in people who have had a cryptogenic stroke.

The tests

Atrial fibrillation is a type of arrhythmia that causes an irregular or abnormally fast heart rate. It is the most common arrhythmia. When someone has atrial fibrillation, the upper chambers of their heart (the atria) beat irregularly, which makes the heart less effective at moving blood into the ventricles. This can cause clots to form in the blood, which may cause a stroke. The abnormal electrical impulses in the heart muscle that cause atrial fibrillation can be persistent, permanent or intermittent. Paroxysmal atrial fibrillation involves intermittent episodes that usually last less than 2 days and stop without treatment.

Cryptogenic strokes (including transient ischaemic attack [TIA]) have no identified probable cause after diagnostic assessment, and account for around 15% to 40% of ischaemic strokes. When people have treatment for stroke, they are tested for atrial fibrillation. However, if they have paroxysmal atrial fibrillation, it may not happen during the initial assessment, or during subsequent diagnostic tests. Further longer-term testing can potentially detect it, for example by using heart rhythm monitors that can be worn, or implanted. These continuously monitor the heart's electrical activity while a person goes about their daily routine.

Implantable cardiac monitors are also known as implantable loop recorders or insertable cardiac monitors. They monitor heart rhythm for longer than heart rhythm monitors that are worn externally (for example, Holter monitors) and can therefore be used for long-term monitoring (potentially over years, rather than days) for suspected atrial fibrillation. Implantable cardiac monitors can identify atrial fibrillation and could be particularly helpful for identifying paroxysmal atrial fibrillation in people who have had a cryptogenic stroke. If people are diagnosed with atrial fibrillation, they can then be offered anticoagulant therapy to reduce the risk of having another stroke or TIA.

The monitors are implanted under the skin of the person's chest using a small incision under local anaesthetic. They can continuously monitor heart rhythm for several years, and they record information if the device detects an arrhythmia. The devices use algorithms based on electrocardiogram (ECG) features to detect potential atrial fibrillation. The algorithm parameters can be varied to adjust the ECG features identified and flagged as potential atrial fibrillation. Recorded ECGs are remotely transmitted to clinicians, who determine if the person has had atrial fibrillation. They then decide to either continue to monitor or to treat.

Financial factors

The technology is commissioned by CCGs.

NICE does not expect this guidance to have a significant impact on resources because it is not thought practice will change substantially as a result of this guidance; this technology (implantable cardiac monitor) is increasingly in routine use in the NHS.

In areas where implantable cardiac monitors are not currently used, commissioners should be advised that the tariff, which covers the cost of both the procedure and the Reveal LINQ device, is around £2,300. Most people will have their Reveal LINQ device removed within 3 years and the cost of removing the device is around £500.

Current practice in these areas involves limited testing for atrial fibrillation if this is not detected by short-term non-invasive electrocardiogram (ECG) monitoring after cryptogenic stroke, with people potentially receiving single time point ECG at around £120 per test, along with, in some cases, outpatient appointments at around £80 each.

NICE Quality Standards

None published this month.

Current NICE consultations

Title / link	End date of consultation
The PLASMA system for transurethral resection of the prostate (MT217)	09/10/2020
Carfilzomib with dexamethasone and lenalidomide for treating multiple myeloma after at least 1 previous therapy [ID1493]	13/10/2020
Diabetes in pregnancy: management from preconception to the postnatal period	21/10/2020
Diabetes (type 1 and type 2) in children and young people: diagnosis and management (update)	21/10/2020
Transcervical ultrasound-guided radiofrequency ablation for symptomatic uterine fibroids	22/10/2020
Extracorporeal whole liver perfusion for acute liver failure	22/10/2020
Leukomed Sorbact for preventing surgical site infection (MT496)	23/10/2020
V.A.C. VERAFLO Therapy System for acute infected or chronic wounds that are failing to heal (MT471)	23/10/2020
QAngio XA 3D QFR and CAAS vFFR imaging software for assessing coronary stenosis during invasive coronary angiography	23/10/2020
Integrated health and care for people who are homeless through being roofless	02/11/2020
Atrial fibrillation: management	04/11/2020