

NICE Update Bulletin January 2014 for guidance issued Wednesday 22nd January 2014

Hyperlinks to the relevant NICE web page are included, to activate link left click on your mouse. Details are also available from the NICE website
(<http://www.nice.org.uk>)

Type	Guidance title and reference number
Technology Appraisals (TAs)	<p><u>Multiple sclerosis (relapsing) – teriflunomide TA303</u></p> <p><u>Recommendations</u></p> <p>Teriflunomide is recommended for treating adults with active relapsing–remitting multiple sclerosis (normally defined as 2 clinically significant relapses in the previous 2 years), only if</p> <ul style="list-style-type: none"> • they do not have highly active or rapidly evolving severe relapsing–remitting multiple sclerosis and • the manufacturer provides teriflunomide with the discount agreed in the patient access scheme. <p><u>The technology</u></p> <p>Teriflunomide is an immunomodulatory disease-modifying therapy. It has a UK marketing authorisation for 'the treatment of adult patients with relapsing remitting multiple sclerosis'. It is anti-inflammatory and works by blocking proliferation of stimulated lymphocytes. The exact mechanism of action for teriflunomide is not fully understood. It is thought to reduce the number of activated lymphocytes, which would cause inflammation, and damage myelin in the central nervous system. Teriflunomide is taken orally as a 14 mg tablet once daily.</p>
Clinical Guidelines (CGs)	<p><u>Triage, assessment, investigation and early management of head injury in children, young people and adults CG176</u></p> <p>This guideline updates and replaces 'Head injury' (NICE clinical guideline 56)</p> <p><u>Background information</u></p> <p>For the purposes of this guideline, head injury is defined as any trauma to the head other than superficial injuries to the face. Head injury is the commonest cause of death and disability in people aged 1–40 years in the UK. Each year, 1.4 million people attend emergency departments in England and Wales with a recent head injury. Between 33% and 50% of these are children aged under 15 years.</p> <p>Annually, about 200,000 people are admitted to hospital with head injury. Of these, one-fifth have features suggesting skull fracture or have evidence of brain damage. Most patients recover without specific or specialist intervention, but others experience long-term disability or even die from the effects of complications that could potentially be minimised or avoided with early detection and appropriate treatment.</p> <p><u>The key priorities for implementation are</u></p> <ul style="list-style-type: none"> • Transport to hospital • Assessment in the emergency department • Criteria for performing a CT head scan • Investigating injuries to the cervical spine • Discharge and follow-up <p><u>The recommendations in full cover</u></p> <p>1.1 Pre-hospital assessment, advice and referral to hospital</p> <p>1.2 Immediate management at the scene and transport to hospital</p>

- 1.3 Assessment in the emergency department
- 1.4 Investigating clinically important brain injuries
- 1.5 Investigating injuries to the cervical spine
- 1.6 Information and support for families and carers
- 1.7 Transfer from hospital to a neuroscience unit
- 1.8 Admission and observation
- 1.9 Discharge and follow-up

Prostate cancer: diagnosis and treatment CG176

Background information

Prostate cancer is the most common cancer in men and makes up 26% of all male cancer diagnoses in the UK. In 2008, 34,335 men were diagnosed with prostate cancer and there were 9,632 deaths in 2010. Prostate cancer is predominantly a disease of older men (aged 65–79 years) but around 25% of cases occur in men younger than 65. There is also higher incidence of and mortality from prostate cancer in men of black African-Caribbean family origin compared with white Caucasian men.

Prostate cancer is usually diagnosed after a blood test in primary care has shown elevated prostate-specific antigen (PSA) levels. A number of treatments are available for localised disease, including: active surveillance, radical prostatectomy, external beam radiotherapy and brachytherapy. Hormone therapy (androgen deprivation or anti-androgens) is the usual primary treatment for metastatic prostate cancer, but is also increasingly being used for men with locally advanced, non-metastatic disease.

Key priorities for implementation are

- Information and decision support for men with prostate cancer, their partners and carers
- Assessment
- Localised and locally advanced prostate cancer

The recommendations in full cover

- 1 Information and decision support for men with prostate cancer, their partners and carers
- 2 Assessment
- 3 Localised and locally advanced prostate cancer
- 4 Men having hormone therapy
- 5 Metastatic prostate cancer

Public Health Guidance

Behaviour change: individual approaches PH49

This guidance makes recommendations on individual-level behaviour change interventions aimed at changing the behaviours that can damage people's health. It includes a range of approaches for people aged 16 and over, from single interventions delivered as the opportunity arises to planned, high intensity interventions that may take place over a number of sessions.

The guidance aims to help tackle a range of behaviours including alcohol misuse, poor eating patterns, lack of physical activity, unsafe sexual behaviour and smoking. These behaviours are linked to health problems and chronic diseases.

The recommendations in full cover

- 1 Develop a local behaviour change policy and strategy
- 2 Ensure organisation policies, strategies, resources and training all support behaviour

	<p>change</p> <p>3 Commission interventions from services willing to share intervention details and data</p> <p>4 Commission high quality, effective behaviour change interventions</p> <p>5 Plan behaviour change interventions and programmes taking local needs into account</p> <p>6 Develop acceptable, practical and sustainable behaviour change interventions and programmes</p> <p>7 Use proven behaviour change techniques when designing interventions</p> <p>8 Ensure interventions meet individual needs</p> <p>9 Deliver very brief, brief, extended brief and high intensity behaviour change interventions and programmes</p> <p>10 Ensure behaviour change is maintained for at least a year</p> <p>11 Commission training for all staff involved in helping to change people's behaviour</p> <p>12 Provide training for behaviour change practitioners</p> <p>13 Provide training for health and social care practitioners</p> <p>14 Assess behaviour change practitioners and provide feedback</p> <p>15 Monitor behaviour change interventions</p> <p>16 Evaluate behaviour change interventions</p> <p>17 National support for behaviour change interventions and programmes</p>
<p>Medical Technologies Guidance</p>	<p>None published so far this month</p>
<p>NICE Quality Standards</p>	<p>Autism QS51</p> <p>This quality standard covers autism in children, young people and adults, including both health and social care services.</p> <p>Peripheral arterial disease QS52</p> <p>This quality standard covers the diagnosis and management of lower limb peripheral arterial disease in adults aged 18 years and over. It does not cover acute ischaemia of the lower limb</p>
<p>Interventional Procedures Guidance (IPGs)</p>	<p>Arthroscopic trochleoplasty for patellar instability IPG474</p> <p><u>Recommendations</u></p> <p>1.1 Current evidence on the safety and efficacy of arthroscopic trochleoplasty for patellar instability is inadequate in quantity and quality. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.</p> <p>1.2 Clinicians wishing to undertake arthroscopic trochleoplasty for patellar instability should take the following actions:</p> <ul style="list-style-type: none"> • Inform the clinical governance leads in their NHS trusts. • Ensure that patients understand the uncertainty about the procedure's safety and efficacy and provide them with clear written information. In addition, the use of NICE's information for the public is recommended. • Audit and review clinical outcomes of all patients having arthroscopic trochleoplasties (see section 7.1). <p>1.3 Patient selection should be done by surgeons with expertise in managing patellar instability.</p> <p>1.4 The procedure should be undertaken by surgeons with experience in open trochleoplasty and in arthroscopic procedures on the knee.</p> <p>1.5 NICE encourages further research into arthroscopic trochleoplasty for patellar</p>

instability, including publication of consecutive patient series. Patient selection should be described in detail. Reported outcomes should include functional and quality-of-life measures, as well as reoperation rates.

The procedure

Arthroscopic trochleoplasty aims to deepen the trochlea in the same way as open trochleoplasty but with less soft tissue trauma, which should reduce postoperative pain and allow more rapid recovery. Arthroscopic trochleoplasty is done with the patient under general or regional anaesthesia. Using an arthroscopic approach, the articular cartilage of the trochlea is raised as a flap. A round burr shaver is then used to deepen the trochlear groove. The articular cartilage is then returned to the deepened groove and fixed in place.

[Insertion of prostatic urethral lift implants to treat lower urinary tract symptoms secondary to benign prostatic hyperplasia IPG475](#)

Recommendations

1.1 Current evidence on the efficacy and safety of insertion of prostatic urethral lift implants to treat lower urinary tract symptoms secondary to benign prostatic hyperplasia is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.

1.2 During the consent process clinicians should, in particular, advise patients about the range of possible treatment options and the possible need for further procedures if symptoms recur.

1.3 The procedure should only be carried out by clinicians with specific training in the insertion of prostatic urethral lift implants.

1.4 NICE encourages further research and publication of results from consecutive case series of patients having this procedure. Details of patient selection should be clearly documented. Reported outcomes should include the effects of the procedure on symptoms and quality of life, the duration of benefits, and the need for further procedures. All complications should be reported. NICE may review this procedure in the light of longer-term outcomes.

The procedure

The aim of insertion of prostatic urethral lift implants is to secure the prostatic lobes in retracted positions such that the lumen of the urethra is increased. The procedure is designed to cause less tissue injury than surgical resection or thermal ablation, and it is claimed to reduce the risk of complications such as sexual dysfunction and incontinence.

The procedure is undertaken transurethrally with the patient under local or general anaesthesia. A pre-loaded delivery device is passed through a rigid sheath under cystoscopic visualisation.

[Radiofrequency ablation of the soft palate for snoring IPG476](#)

Recommendations

1.1 Current evidence suggests that there are no major safety concerns associated with radiofrequency ablation of the soft palate for snoring. The evidence on the short-term efficacy of the procedure is adequate, although uncertainties remain about its efficacy in the longer term. Therefore this procedure may be used with normal arrangements for clinical governance, consent and audit.

1.2 During the consent process clinicians should, in particular, inform patients of the uncertainty about the procedure's long-term efficacy and of the possible need for further procedures if symptoms recur.

1.3 Patient selection is important: the sound of snoring can arise from several different levels in the upper airway and this procedure should only be used for patients whose snoring has been shown to be caused by abnormal movement of the soft palate and in whom sleep apnoea has been excluded.

1.4 NICE encourages further research into radiofrequency ablation of the soft palate for snoring. This could take the form of data collection, with the specific aim of documenting long-term outcomes and the need for further treatment.

The procedure

	<p>The procedure is usually done using local anaesthesia in outpatients. An electrode delivery device is introduced into the mouth and directed upwards towards the soft palate. A needle tip makes a series of punctures in the underlying muscle. Radiofrequency energy is delivered at each puncture site. The intention is to scar and tighten the soft palate. If necessary the procedure can be repeated several weeks later, it is often carried out 2 or 3 times.</p> <p>Transcranial magnetic stimulation (TMS) for treating and preventing migraine IPG477</p> <p><u>Recommendations</u></p> <p>1.1 Evidence on the efficacy of TMS for the treatment of migraine is limited in quantity and for the prevention of migraine is limited in both quality and quantity. Evidence on its safety in the short and medium term is adequate but there is uncertainty about the safety of long-term or frequent use of TMS. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research.</p> <p>1.2 Patient selection should normally be done in specialist headache clinics and the procedure should only be used under the direction of clinicians specialising in the management of headache.</p> <p>1.3 Patients should be informed that TMS is not intended to provide a cure for migraine and that reduction in symptoms may be modest.</p> <p>1.4 Clinicians wishing to undertake TMS for treating and preventing migraine should take the following actions.</p> <ul style="list-style-type: none"> • Inform the clinical governance leads in their NHS trusts. • Ensure that patients understand the uncertainty about the procedure's safety and efficacy and provide them with clear written information. In addition, the use of NICE's information for the public is recommended. • Audit and review clinical outcomes of all patients having TMS for the treatment and prevention of migraine. <p>1.5 NICE encourages further research on TMS for treating and preventing migraine. Data should be collected for all patients not entered into controlled trials. Studies should describe clearly whether its use is for treatment or prevention. They should report details of patient selection and the dose and frequency of use. Outcome measures should include the number and severity of migraine episodes, and quality of life in both the short and long term. The development of any neurological disorders (such as epilepsy) in the short or longer term after starting treatment should be documented.</p> <p><u>The procedure</u></p> <p>TMS is given using a tabletop or handheld device that delivers a predetermined level of magnetic pulse or pulses to the head. The device is placed on the scalp and either single (sTMS) or repeated (rTMS) magnetic pulses are delivered. The frequency, intensity, duration and interval times of pulses can be varied. Treatments can be automatically recorded by the device in an integrated headache diary, which can be used to identify headache patterns and trigger factors.</p>
NICE Pathways	These pathways are not guidance in themselves but a way of displaying online the various guidance that exists around a subject.
Commissioning Guides	None published so far this month
Diagnostics Guidance	None published so far this month
Public health briefings for local government	<p>Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups LGB13</p> <p>This briefing summarises NICE's recommendations for local authorities and partner organisations on the use of body mass index (BMI) as a signal for preventive action against long-term medical conditions. The focus is on people from black, Asian and other minority ethnic. It is particularly relevant to health and wellbeing boards.</p>

[Improving access to health and social care services for people who do not routinely use them LGB14](#)

This briefing summarises NICE's recommendations for local authorities and partner organisations on improving access to health and social care services for vulnerable people who do not routinely use them, promoting equitable access for all. It is particularly relevant to health and wellbeing boards. People who do not routinely access standard health and social care services are at increased risk of poor health, which can accumulate through life and lead to increased demand on services and increased health and social care costs.

Current NICE consultations with links and start and finish dates for stakeholders to make contribution

Title / link	Start date of consultation	Finish date of consultation
Sarcoma: surveillance review proposal consultation	13/01/2014	24/01/2014
Managing long-term sickness and incapacity for work: review proposal consultation	20/01/2014	03/02/2014
Quality outcomes framework indicators	06/01/2014	03/02/2014
Arrhythmias - ICDs & Heart failure - cardiac resynchronisation: appraisal consultation	20/01/2014	10/02/2014
Transition between health and social care: scope consultation	14/01/2014	11/02/2014
Atrial fibrillation (update): guideline consultation	15/01/2014	26/02/2014
Technology Appraisal process guides consultation	06/01/2014	28/03/2014
Fertility problems: topic engagement exercise - Quality standard	13/01/2014	27/01/2014
Head injury: topic engagement exercise - Quality Standard	13/01/2104	27/01/2014

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