# NICE Update Bulletin February 2014 for guidance issued Wednesday 26th February 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 |
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| **Technology Appraisals (TAs)** | **Lymphoma (non Hodgkin's, relapsed, refractory) - pixantrone monotherapy TA306**<br>**Recommendations**<br>1.1 Pixantrone monotherapy is recommended as an option for treating adults with multiply relapsed or refractory aggressive non-Hodgkin's B-cell lymphoma only if:<br>• the person has previously been treated with rituximab and<br>• the person is receiving third- or fourth-line treatment and<br>• the manufacturer provides pixantrone with the discount agreed in the patient access scheme.<br>1.2 People currently receiving treatment initiated within the NHS with pixantrone monotherapy that is not recommended for them by NICE in this guidance should be able to continue treatment until they and their NHS clinician consider it appropriate to stop.<br>**The technology**<br>Pixantrone is an aza-anthracenedione analogue and inhibitor of topoisomerase II administered intravenously. It has a conditional marketing authorisation 'as monotherapy for the treatment of adult patients with multiply relapsed or refractory aggressive non-Hodgkin B-cell lymphomas (NHL). The benefit of pixantrone treatment has not been established in patients when used as fifth line or greater chemotherapy in patients who are refractory to last therapy'.<br>**Macular oedema (central retinal vein occlusion) - aflibercept solution for injection TA305**<br>**Recommendations**<br>Aflibercept solution for injection is recommended as an option for treating visual impairment caused by macular oedema secondary to central retinal vein occlusion only if the manufacturer provides aflibercept solution for injection with the discount agreed in the patient access scheme.<br>**The technology**<br>Aflibercept solution for injection (Eylea) is a vascular endothelial growth factor (VEGF) inhibitor. It prevents the inappropriate growth of new blood vessels in the retina. Each vial of aflibercept contains a dose of 0.05 ml containing 2 mg of aflibercept. After the initial injection, treatment is given monthly.<br>**Arthritis of the hip (end stage) - hip replacement (total) and resurfacing arthroplasty (Rev TA2, TA44) TA304**<br>**Recommendations**<br>Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.<br>**The technology**<br>In total hip replacement (THR) surgery, the acetabulum (hip socket) is replaced with either a single-piece cup made from 1 material (polyethylene, ceramic or metal) or a 2-piece (modular) cup made from a metal outer shell and a polyethylene, ceramic or metal liner. The head of the femur (thigh bone) is replaced with either a single-piece metal stem and head, or a modular component consisting of a metal stem (which may consist of more than 1 piece) with a metal, ceramic or ceramicised metal head.<br>THRs vary in what fixation method is used for each component of the prosthesis. In |

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| | some THRs, all the components are fixed into position using cement. Other types of THR are designed to be used without cement); instead, they are inserted using press-fit fixation, and natural bone growth over time secures the prosthesis in place. Complications that may lead to hip replacement revision surgery include prosthesis instability, dislocation, aseptic loosening, osteolysis (bone reabsorption), infection and prosthesis failure. |
| **Clinical Guidelines (CGs)** | **Psychosis and schizophrenia in adults: treatment and management CG178**<br><br>This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term 'psychosis' is used in this guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder. The recognition, treatment and management of affective psychoses (such as bipolar disorder or unipolar psychotic depression) are covered by other NICE guidelines.<br><br>**Background information**<br><br>Psychosis and the specific diagnosis of schizophrenia represent a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). Each person will have a unique combination of symptoms and experiences.<br><br>**The key priorities for implementation are**<br><br>• Preventing psychosis<br>• First episode psychosis<br>• Subsequent acute episodes of psychosis or schizophrenia and referral in crisis<br>• Promoting recovery and possible future care<br><br>**The recommendations in full cover**<br><br>1.1 Care across all phases<br><br>1.2 Preventing psychosis<br><br>1.3 First episode psychosis<br><br>1.4 Subsequent acute episodes of psychosis or schizophrenia and referral in crisis<br><br>1.5 Promoting recovery and possible future care<br><br>**Osteoarthritis – care and management in adults CG177**<br><br>**Background information**<br><br>Osteoarthritis refers to a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life. It is the most common form of arthritis, and one of the leading causes of pain and disability worldwide. The most commonly affected peripheral joints are the knees, hips and small hand joints. Pain, reduced function and effects on a person's ability to carry out their day-to-day activities can be important consequences of osteoarthritis.<br><br>There is often a poor link between changes visible on an X-ray and symptoms of osteoarthritis: minimal changes can be associated with a lot of pain, or modest structural changes to joints can occur with minimal accompanying symptoms. Contrary to popular belief, osteoarthritis is not caused by ageing and does not necessarily deteriorate. There are a number of management and treatment options (both pharmacological and non-pharmacological), which this guideline addresses and which represent effective interventions for controlling symptoms and improving function.<br><br>Osteoarthritis is characterised pathologically by localised loss of cartilage, remodelling of adjacent bone and associated inflammation. A variety of traumas may trigger the need for a joint to repair itself. Osteoarthritis includes a slow but efficient repair process that often compensates for the initial trauma, resulting in a structurally altered but symptom-free joint. In some people, because of either overwhelming trauma or compromised |

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| | repair, the process cannot compensate, resulting in eventual presentation with symptomatic osteoarthritis; this might be thought of as 'joint failure'. This in part explains the extreme variability in clinical presentation and outcome that can be observed between people, and also at different joints in the same person.<br><br>**Key priorities for implementation are**<br>• Diagnosis<br>• Holistic approach to osteoarthritis assessment and management<br>• Education and self-management<br>• Non-pharmacological management<br>• Referral for consideration of joint surgery<br>• Follow-up and review<br>**The recommendations in full cover**<br>1.1 Diagnosis<br>1.2 Holistic approach to osteoarthritis assessment and management<br>1.3 Education and self-management<br>1.4 Non-pharmacological management<br>1.5 Pharmacological management<br>1.6 Referral for consideration of joint surgery<br>1.7 Follow-up and review |
| **Public Health Guidance** | **Domestic violence and abuse - how services can respond effectively PH50**<br>**Background information**<br>Domestic violence and abuse is a complex issue that needs sensitive handling by a range of health and social care professionals. The cost, in both human and economic terms, is so significant that even marginally effective interventions are cost effective.<br><br>Women and men can experience this type of violence in heterosexual and same-sex relationships. The prevalence of physical assaults from a partner or adult family member is higher among heterosexual women than among men. Moreover, heterosexual women experience more repeated physical violence, more severe violence, much more sexual violence, more coercive control, more injuries and more fear of their partner.<br>The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people.<br>Working in a multi-agency partnership is the most effective way to approach the issue at both an operational and strategic level. Initial and ongoing training and organisational support is also needed.<br>**The recommendations in full cover**<br>1 Plan services based on an assessment of need and service mapping<br>2 Participate in a local strategic multi-agency partnership to prevent domestic violence and abuse<br>3 Develop an integrated commissioning strategy<br>4 Commission integrated care pathways<br>5 Create an environment for disclosing domestic violence and abuse<br>6 Ensure trained staff ask people about domestic violence and abuse<br>7 Adopt clear protocols and methods for information sharing<br>8 Tailor support to meet people's needs<br>9 Help people who find it difficult to access services |

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| | 10 Identify and, where necessary, refer children and young people affected by domestic violence and abuse<br><br>11 Provide specialist domestic violence and abuse services for children and young people<br><br>12 Provide specialist advice, advocacy and support as part of a comprehensive referral pathway<br><br>13 Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition<br><br>14 Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse<br><br>15 Provide specific training for health and social care professionals in how to respond to domestic violence and abuse<br><br>16 GP practices and other agencies should include training on, and a referral pathway for, domestic violence and abuse<br><br>17 Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse |
| **Medical Technologies Guidance** | **None published so far this month** |
| **NICE Quality Standards** | **Anxiety disorders QS53**<br><br>This quality standard covers the identification and management of anxiety disorders in primary, secondary and community care for children, young people and adults. It covers a range of anxiety disorders, including generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.<br><br>**Faecal incontinence QS54**<br><br>This quality standard covers the management of faecal incontinence, defined as any involuntary loss of faeces that is a social or hygiene problem, in adults (18 years and older) in the community (at home and in care homes) and in hospital (all departments).<br><br>**Children and young people with cancer QS55**<br><br>This quality standard covers the provision of all aspects of cancer services for children and young people with cancer. For this quality standard, children are defined as aged 0–15 years and young people as 16–24 years, though this is not a formal upper age limit because the needs and circumstances of individuals will vary, including their need to access age-specific services.<br><br>**Metastatic spinal cord compression QS56**<br><br>This quality standard covers the early detection, diagnosis and management of metastatic spinal cord compression (MSCC) in adults (18 years and older). |
| **Interventional Procedures Guidance (IPGs)** | **Electrochemotherapy for primary basal cell carcinoma and primary squamous cell carcinoma IPG478**<br><br>**Recommendations**<br><br>1.1 Current evidence on the safety of electrochemotherapy for primary basal cell carcinoma (BCC) and primary squamous cell carcinoma (SCC) raises no major concerns. Evidence on its efficacy is limited in quantity and quality. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and local audit, and with submission of data to a register.<br><br>1.2 Clinicians wishing to undertake electrochemotherapy for treating primary BCC and primary SCC should take the following actions:<br><br>• Inform the clinical governance leads in their NHS trusts.<br><br>• Ensure that patients understand the uncertainty about the procedure's efficacy and why it is being offered as an alternative to other established methods of treatment, and provide them with clear written information. In addition, the use of |

NICE's information for the public is recommended.

1.3 Patient selection should be carried out by a specialist skin cancer multidisciplinary team. Patient selection is particularly important because the cure rates for established treatments in accessible sites are very high. Careful consideration should be given to the reasons for offering electrochemotherapy, especially in the context of treating primary BCC and SCC with curative intent.

1.4 This procedure should only be carried out by clinicians with specific training in the technique.

1.5 Clinicians should submit data on all patients undergoing electrochemotherapy (including details of case selection, methods of follow-up and outcomes) to the InspECT register, an international register dedicated to electrochemotherapy, and review clinical outcomes locally. Entry into research trials should also be considered, with a view to providing data about cure and about recurrence rates, compared with other forms of treatment.

**The procedure**

The procedure is performed with the patient under general or local anaesthesia with or without sedation. Chemotherapy drugs are given first, either intravenously or directly into the tumour. Drug dose is individualised based on either body surface area or tumour volume. Shortly after drug administration, brief and intense electric pulses are delivered around or directly into the tumour using either surface plates or needle electrodes. This makes the cell membranes more permeable to the chemotherapy drugs so that their cytotoxic effect is increased. Different-shaped plates or electrodes are used depending on the tumour size, extent, shape and location. Treatment duration may vary depending on the number and size of tumours. Repeated treatments can be performed if necessary (within the lifetime dose limits of the chemotherapy drugs).

**Subcutaneous implantation of a battery-powered catheter drainage system for managing refractory and recurrent ascites IPG479**

**Recommendations**

1.1 Current evidence on the safety and efficacy of subcutaneous implantation of a battery-powered catheter drainage system for managing refractory and recurrent ascites is inadequate in quantity and quality. Therefore, this procedure should only be used in the context of research.

1.2 Research (which may include observational studies) should clearly document the indications for use of the procedure and details of patient selection. Reported outcomes should include quality of life, overall survival and paracentesis-free survival, duration of function of the drainage system, nutritional parameters and any complications associated with its implantation or use.

**The procedure**

Subcutaneous implantation of a battery-powered catheter drainage system is done with the patient under general anaesthesia, usually through incisions in the abdominal wall. A battery-powered pump with internal pressure sensors is implanted on the right side above the belt line. One catheter connects the pump to the peritoneal cavity, and another connects it to the urinary bladder. The pump and both catheters are secured with sutures to prevent migration. The pump moves fluid from the peritoneal cavity (via the first catheter) into the bladder (via the second catheter). Fluid is eliminated through normal micturition. The pump is programmed to move preset volumes of ascites to the bladder. The pressure sensors prevent it from over-distending the bladder

**Endoscopic thoracic sympathectomy for primary facial blushing IPG480**

**Recommendations**

1.1 Current evidence on the efficacy and safety of endoscopic thoracic sympathectomy (ETS) for primary facial blushing is adequate to support the use of this procedure with normal arrangements for clinical governance, consent and audit.

1.2 Clinicians wishing to undertake ETS for primary facial blushing should ensure that patients understand the risks of the procedure. In particular they should explain that:

- there is a risk of serious complications
- hyperhidrosis is usual after the procedure: this can be severe and distressing

and some patients regret having had the procedure (especially because of subsequent and persistent hyperhidrosis)

- the procedure sometimes does not reduce facial blushing.

Clinicians should also provide patients considering the procedure with clear written information.

1.3 In view of the risk of side effects this procedure should only be considered in patients suffering from severe and debilitating primary facial blushing that has been refractory to other treatments.

1.4 This procedure should only be undertaken by clinicians trained and experienced in thoracic endoscopy, and there should be the capacity to deal with intraoperative complications.

1.5 Further research into ETS for primary facial blushing should include clear information on patient selection and should seek to identify which patient characteristics might predict severe side effects. All complications should be reported. Outcomes should include measurements of efficacy, including quality of life and social functioning both in the short and long term, and in particular the frequency and severity of compensatory hyperhidrosis.

**The procedure**

The aim of endoscopic thoracic sympathectomy (ETS) for primary facial blushing is to reduce the frequency and duration of blushing by dividing the sympathetic nerves that lie along the sympathetic chain beside the vertebral column. ETS is usually done with the patient under general anaesthesia. Small incisions are made in the axilla and an endoscope is inserted. The lung is partially collapsed. The sympathetic chain is visualised and the chosen part of the chain is divided by electrocautery or endoscopic scissors, or surgical clips may be applied. The extent of division varies but usually involves the part of the sympathetic chain over the second or third ribs, or both.

**Optical coherence tomography to guide percutaneous coronary intervention IPG 481**

**Recommendations**

1.1 The evidence on the safety of optical coherence tomography (OCT) to guide percutaneous coronary intervention (PCI) shows no major concerns. The evidence on efficacy is limited in quantity and quality. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research.

1.2 Clinicians wishing to undertake OCT to guide PCI should take the following actions.

- Inform the clinical governance leads in their NHS trusts.
- Ensure that patients understand the uncertainty about the procedure's efficacy and provide them with clear written information. In addition, the use of NICE's information for the public is recommended.
- Enter details about all patients undergoing OCT to guide PCI onto the UK Central Cardiac Audit Database and review local clinical outcomes.

1.3 NICE encourages further research into OCT to guide PCI compared against PCI with no intravascular imaging or PCI with intravascular ultrasound. Research outcomes should include data on medium- and long-term clinical outcomes, including the need for revascularisation.

**The procedure**

Optical coherence tomography (OCT) is usually performed using local anaesthesia. A guide wire and delivery sheath are introduced percutaneously into either the femoral or radial artery and passed into the target coronary artery using fluoroscopic image guidance. OCT imaging needs a blood-free field. This was first achieved by an occlusive technique, using an occlusion balloon with first-generation time-domain OCT (TD OCT), but this technique is no longer used in clinical practice. A non-occlusive technique is now used, involving continuous flushing of contrast with frequency-domain OCT (FD OCT). For non-occlusive OCT, a guide wire through which contrast can be injected is used. The imaging catheter is delivered over this wire. Injection of contrast and imaging take place

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| | concurrently. |
| **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** | **NICE support for commissioning for self-harm CMG50**<br>This Support for Commissioning encourages commissioners to work with clinicians and managers to commission high-quality evidence-based care for people who self-harm.<br>Making commissioning decisions based on NICE standards and guidance and other NICE accredited evidence can help commissioners use their resources effectively to improve the quality of health care for people who self-harm.<br>Commissioning services for people who self-harm in line with NICE guidance and standards should support commissioners to improve health and social care outcomes in line with the clinical commissioning group outcome indicator set and other national outcomes frameworks. |
| **Diagnostics Guidance** | **None published so far this month** |
| **Public health briefings for local government** | **Encouraging people to have NHS Health Checks and supporting them to reduce risk factors LGB15**<br>This briefing summarises NICE's recommendations for local authorities and partner organisations that could be used to encourage people to have NHS Health Checks and support them to change their behaviour after the NHS Health Check and reduce their risk factors. It is particularly relevant to health and wellbeing boards. |

**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 |
|---|---|---|
| Point-of-care coagulometers (the CoaguChek XS system and the INRatio2 PT/INR monitor) Diagnostics Consultation Document | 06/02/2014 | 27/02/2014 |
| PH4 Interventions to reduce substance misuse among vulnerable young people: review proposal consultation | 14/02/2014 | 28/02/2014 |
| NICE CCG OIS indicator consultation | 03/02/2014 | 03/03/2014 |
| Long-acting reversible contraception: surveillance review proposal consultation | 25/02/2014 | 11/03/2014 |
| Children and young people with cancer: surveillance review proposal consultation | 25/02/2014 | 11/03/2014 |
| Physical activity and the environment: review proposal consultation | 26/02/2014 | 12/03/2014 |
| Multiple sclerosis (relapsing-remitting) - dimethyl fumarate: appraisal consultation | 19/02/2014 | 12/03/2014 |
| Diabetes (type 2) - canagliflozin : appraisal consultation | 24/02/2014 | 17/03/2014 |
| Melanoma (previously untreated unresectable stage III or IV): appraisal consultation | 25/02/2014 | 18/03/2014 |
| The geko device for reducing the risk of venous thromboembolism: second medical technology consultation | 19/02/2014 | 19/03/2014 |
| Community engagement: scope consultation | 19/02/2014 | 19/03/2014 |
| Lipid Modification (update): guideline consultation | 12/02/2014 | 26/03/2014 |
| Technology Appraisal process guides consultation | 06/01/2014 | 28/03/2014 |
| NICE BNF consultation | 03/02/2014 | 31/03/2014 |
| Chronic kidney disease (update): guideline consultation | 21/02/2014 | 04/04/2014 |

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