NICE Update Bulletin June 2016
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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)	**Belimumab for treating active autoantibody-positive systemic lupus erythematosus TA397** **Recommendations** 1.1 Belimumab is recommended as an option as add-on treatment for active autoantibody-positive systemic lupus erythematosus in adults only if all of the following apply: • There is evidence for serological disease activity (defined as positive anti-double-stranded DNA and low complement) and a Safety of Estrogen in Lupus National Assessment – Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of greater than or equal to 10 despite standard treatment. • Treatment with belimumab is continued beyond 24 weeks only if the SELENA-SLEDAI score has improved by 4 points or more. • The company provides belimumab with the discount agreed in the patient access scheme. • Under the conditions for data collection, monitoring, patient eligibility and consent, ongoing treatment, cost to the NHS, and review by NICE as laid out in the guidance. 1.2 This guidance is not intended to affect the position of patients whose treatment with belimumab was started within the NHS before this guidance was published. Treatment of those patients may continue without change to whatever funding arrangements were in place for them before this guidance was published until they and their NHS clinician consider it appropriate to stop. **The technology** Belimumab (Benlysta, GlaxoSmithKline) is a human monoclonal antibody that inhibits the activity of B-lymphocyte stimulator (BLyS). Belimumab has a marketing authorisation 'as add-on therapy in adult patients with active, autoantibody-positive systemic lupus erythematosus with a high degree of disease activity (for example, positive anti-double-stranded DNA and low complement) despite standard therapy'. **Financial factors** This technology is commissioned by NHS England. NICE states that it is unlikely that the guidance will result in a significant change in resource use in the NHS because the population eligible for treatment is low. **Ceritinib for previously treated anaplastic lymphoma kinase positive non-small-cell lung cancer TA395** **Recommendations** 1.1 Ceritinib is recommended, within its marketing authorisation, as an option for treating advanced anaplastic lymphoma kinase positive non-small-cell lung cancer in adults who have previously had crizotinib. The drug is recommended only if the company provides it with the discount agreed in the patient access scheme. **The technology** Ceritinib (Zykadia, Novartis) has a marketing authorisation in the UK for treating adult

patients with anaplastic lymphoma kinase (ALK) positive advanced non-small-cell lung cancer (NSCLC) previously treated with crizotinib. Ceritinib is an ALK inhibitor.

Financial factors

This technology is commissioned by NHS England.

Crizotinib is currently available through the Cancer Drugs Fund (CDF) but is not currently recommended by NICE. NICE states that it is unlikely that the guidance will result in a significant change in resource use in the NHS because the population size is low.

Trametinib in combination with dabrafenib for treating unresectable or metastatic melanoma TA396

Recommendations

1.1 Trametinib in combination with dabrafenib is recommended, within its marketing authorisation, as an option for treating unresectable or metastatic melanoma in adults with a BRAF V600 mutation only when the company provides trametinib and dabrafenib with the discounts agreed in the patient access schemes.

The technology

Trametinib (Mekinist, Novartis Pharmaceuticals) is an inhibitor of MEK1 and MEK2 kinases. Trametinib inhibits the action of the abnormal BRAF protein, with the aim of slowing the growth and spread of the cancer. Dabrafenib (Tafinlar, Novartis Pharmaceuticals) is a selective inhibitor of BRAF V600 kinase activity. It aims to block the activity of mutant protein kinase causing the cancer cells to stop growing and die. Trametinib and dabrafenib have marketing authorisations in the UK, as monotherapies and in combination with each other, for treating adults with unresectable or metastatic melanoma with a BRAF V600 mutation. Both trametinib and dabrafenib are taken orally.

Financial factors

This technology is commissioned by NHS England.

Adalimumab for treating moderate to severe hidradenitis suppurativa TA392

Recommendations

1.1 Adalimumab is recommended, within its marketing authorisation, as an option for treating active moderate to severe hidradenitis suppurativa in adults whose disease has not responded to conventional systemic therapy. The drug is recommended only if the company provides it at the price agreed in the patient access scheme.

1.2 Assess the response to adalimumab after 12 weeks of treatment, and only continue if there is clear evidence of response, defined as:

- a reduction of 25% or more in the total abscess and inflammatory nodule count and
- no increase in abscesses and draining fistulas.

The technology

Adalimumab (Humira, AbbVie) is an antibody that inhibits tumour necrosis factor (TNF). It is given by subcutaneous injection. Adalimumab has a marketing authorisation in the UK for treating active moderate to severe hidradenitis suppurativa (acne inversa) in adult patients with an inadequate response to conventional systemic hidradenitis suppurativa therapy. The summary of product characteristics suggests that 'continued therapy beyond 12 weeks should be carefully reconsidered in a patient with no improvement within this time period'.

Financial factors

This technology is commissioned by NHS England.

The company has agreed a complex patient access scheme with the Department of Health to provide the 40-mg prefilled pen or syringe of adalimumab at a fixed price of £284.00 for the hidradenitis suppurativa indication only.

Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia TA394

Recommendations

1.1 Evolocumab is recommended as an option for treating primary hypercholesterolaemia or mixed dyslipidaemia, only if:

- The dosage is 140 mg every 2 weeks.
- Low-density lipoprotein concentrations are persistently above the thresholds specified in table 1 despite maximal tolerated lipid-lowering therapy. That is, either the maximum dose has been reached, or further titration is limited by intolerance (as defined in NICE's guideline on familial hypercholesterolaemia).
- The company provides evolocumab with the discount agreed in the patient access scheme.

Table 1 Low-density lipoprotein cholesterol concentrations above which evolocumab is recommended

	Without CVD	**With CVD**	
		High risk of CVD[1]	**Very high risk of CVD[2]**
Primary non-familial hypercholesterolaemia or mixed dyslipidaemia	Not recommended at any LDL-C concentration	Recommended only if LDL-C concentration is persistently above 4.0 mmol/l	Recommended only if LDL-C concentration is persistently above 3.5 mmol/l
Primary heterozygous-familial hypercholesterolaemia	Recommended only if LDL-C concentration is persistently above 5.0 mmol/l	Recommended only if LDL-C concentration is persistently above 3.5 mmol/l	

[1]High risk of cardiovascular disease is defined as a history of any of the following: acute coronary syndrome (such as myocardial infarction or unstable angina requiring hospitalisation), coronary or other arterial revascularisation procedures, chronic heart disease, ischaemic stroke, peripheral arterial disease.

[2]Very high risk of cardiovascular disease is defined as recurrent cardiovascular events or cardiovascular events in more than 1 vascular bed (that is, polyvascular disease).

Abbreviations: CVD, cardiovascular disease; LDL-C, low-density lipoprotein cholesterol.

1.2 This guidance is not intended to affect the position of patients whose treatment with evolocumab was started within the NHS before this guidance was published. Treatment of those patients may continue without change to whatever funding arrangements were in place for them before this guidance was published until they and their NHS clinician consider it appropriate to stop.

The technology

Evolocumab (Repatha, Amgen) is a monoclonal antibody that inhibits proprotein convertase subtilisin/kexin type 9 (PCSK9), an enzyme involved in down-regulation of low-density lipoprotein receptors. This increases receptor density and lowers low-density lipoprotein cholesterol (LDL-C). Evolocumab has a marketing authorisation in the UK for treating adults with primary hypercholesterolaemia (heterozygous-familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet:

- in combination with a statin, or a statin plus other lipid-lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin or,
- alone or in combination with other lipid-lowering therapies in patients who cannot tolerate or cannot be given statins.

Evolocumab is given by subcutaneous injection. The recommended dose in the summary of product characteristics is either 140 mg every 2 weeks or 420 mg once monthly.

Financial factors

This technology is commissioned by CCGs.

Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia TA393

Recommendations

1.1 Alirocumab is recommended as an option for treating primary hypercholesterolaemia or mixed dyslipidaemia, only if:

- Low-density lipoprotein concentrations are persistently above the thresholds specified in table 1 despite maximal tolerated lipid-lowering therapy. That is, either the maximum dose has been reached or further titration is limited by intolerance (as defined in NICE's guideline on familial hypercholesterolaemia: identification and management).
- The company provides alirocumab with the discount agreed in the patient access scheme.

Table 1 Low-density lipoprotein cholesterol concentrations above which alirocumab is recommended

	Without CVD	**With CVD**	
		High risk of CVD[1]	**Very high risk of CVD[2]**
Primary non-familial hypercholesterolaemia or mixed dyslipidaemia	Not recommended at any LDL-C concentration	Recommended only if LDL-C concentration is persistently above 4.0 mmol/l	Recommended only if LDL-C concentration is persistently above 3.5 mmol/l
Primary heterozygous-familial hypercholesterolaemia	Recommended only if LDL-C concentration is persistently above 5.0 mmol/l	Recommended only if LDL-C concentration is persistently above 3.5 mmol/l	

[1]High risk of cardiovascular disease is defined as a history of any of the following: acute coronary syndrome (such as myocardial infarction or unstable angina requiring hospitalisation), coronary or other arterial revascularisation procedures, chronic heart disease, ischaemic stroke, peripheral arterial disease.

[2]Very high risk of cardiovascular disease is defined as recurrent cardiovascular events or cardiovascular events in more than 1 vascular bed (that is, polyvascular disease).

Abbreviations: CVD, cardiovascular disease; LDL-C, low-density lipoprotein cholesterol.

1.2 This guidance is not intended to affect the position of patients whose treatment with

	alirocumab was started within the NHS before this guidance was published. Treatment of those patients may continue without change to whatever funding arrangements were in place for them before this guidance was published until they and their NHS clinician consider it appropriate to stop. **The technology** Alirocumab (Praluent, Sanofi) is a monoclonal antibody that targets proprotein convertase subtilisin/kextin type 9 (PCSK9). It stops low-density lipoprotein receptors in the liver from degrading, helping to lower levels of low-density lipoprotein cholesterol (LDL-C) in the blood. Alirocumab has a marketing authorisation in the UK for 'adults with primary hypercholesterolaemia (heterozygous-familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet: • in combination with a statin or statin with other lipid lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin or • alone or in combination with other lipid-lowering therapies in patients who are statin-intolerant, or for whom a statin is contraindicated.' Alirocumab is given by subcutaneous injection. The recommended dose is either 75 mg or 150 mg every 2 weeks. **Financial factors** This technology is commissioned by CCGs.
Highly specialised technology guidance (HSTs)	**None published so far this month**
NICE Guidelines (NGs)	**None published so far this month**
Interventional Procedures Guidance (IPGs)	**Microstructural scaffold (patch) insertion without autologous cell implantation for repairing symptomatic chondral knee defects IPG560** **Recommendations** 1.1 The evidence on microstructural scaffold insertion without autologous cell implantation for repairing symptomatic chondral knee defects raises no major safety concerns; however, current evidence on its efficacy is inadequate in both quality and quantity. Therefore, this procedure should only be used with **special arrangements** for clinical governance, consent, and audit or research. 1.2 Clinicians wishing to do microstructural scaffold insertion without autologous cell implantation for repairing symptomatic chondral knee defects should: • 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 microstructural scaffold insertion without autologous cell implantation for repairing symptomatic chondral knee defects. 1.3 NICE encourages further data collection, including randomised controlled trials on microstructural scaffold insertion without autologous cell implantation for repairing symptomatic chondral knee defects. Studies should clearly describe patient selection, clinical indications and adjunctive treatments. Outcome measures should include symptom relief, functional ability, long-term outcomes measured by appropriate imaging techniques and patient-reported outcomes.

The procedure

Microstructural scaffold insertion without autologous cell implantation for repairing symptomatic chondral knee defects is done with the patient under general or local anaesthesia, using an open or arthroscopic approach. The damaged articular cartilage is removed and standard bone marrow stimulating procedures, such as microfracturing or Pridie drilling, are done. The microstructural scaffold is cut to fit the size of the defect and then fixed in place over the damaged area using, for example, fibrin glue, resorbable suture thread or absorbable tacks. The position of the implanted scaffold is checked by bending and extending the knee and the wound is sutured. The aim of this procedure is that the graft or patch 'captures' the bone marrow cells and stem cells released by the microfracturing, and acts as a scaffold on which new articular cartilage can grow.

Transcervical extracorporeal reverse flow neuroprotection for reducing the risk of stroke during carotid artery stenting IPG561

Recommendations

Current evidence on the safety of transcervical extracorporeal reverse flow neuroprotection for reducing the risk of stroke during carotid artery stenting shows well-documented risks. The evidence on efficacy is adequate to support the use of this procedure provided that **standard arrangements** are in place for clinical governance, consent and audit.

1.2 Patient selection should be carried out by a multidisciplinary team, which should include an interventional radiologist or a neuroradiologist, a vascular surgeon and a physician with a specialist interest in stroke.

1.3 This procedure should only be carried out by clinicians with specific training and expertise in the technique who regularly perform complex endovascular interventions.

The procedure

Transcervical extracorporeal reverse flow neuroprotection is an approach to providing proximal neuroprotection during carotid artery angioplasty and stenting. By directly accessing the carotid artery, it aims to avoid the risks of endovascular manipulation within the aortic arch that occur with a transfemoral approach, and make access possible if there is unfavourable aortic arch anatomy or iliac artery disease.

3.2 With the patient under local, regional or general anaesthesia, a small incision is made in the neck and a catheter introduced into the common carotid artery. A catheter is then placed in the femoral or jugular vein. The common carotid artery is temporarily blocked and retrograde flow is established through the stenosis in the internal carotid artery. The blood is passed through a filtering system outside the body to remove any dislodged debris. It is then returned through the femoral or jugular vein. Once blood flow is reversed, carotid artery angioplasty and stenting are done. After the stent has been successfully placed, normal blood flow to the brain is allowed to resume and the catheters are removed.

Ultrasound-guided percutaneous radiofrequency ablation for benign thyroid nodules IPG562

Recommendations

1.1 Current evidence on the safety and efficacy of ultrasound-guided percutaneous radiofrequency ablation for benign thyroid nodules is adequate to support the use of this procedure provided that **standard arrangements** are in place for clinical governance, consent and audit.

The procedure

Radiofrequency ablation is a minimally invasive technique that aims to reduce symptoms and improve cosmetic appearance, while preserving thyroid function, and with fewer complications than surgery.

3.2 Before treatment, the thyroid nodule is confirmed as benign, typically by the use of 2 fine-needle aspiration biopsies. Ultrasound-guided percutaneous radiofrequency ablation for benign thyroid nodules is usually done in an outpatient setting using local

	anaesthesia. The patient lies in the supine position with moderate neck extension. A radiofrequency electrode is inserted into the nodule using ultrasound guidance to visualise the electrode during the procedure. Once in position, the radiofrequency electrode is activated to heat and destroy the tissue.
Medical Technologies Guidance	**GreenLight XPS for treating benign prostatic hyperplasia MTG29** **Recommendations** 1.1 The case for adopting GreenLight XPS for treating benign prostatic hyperplasia is supported in non-high-risk patients. GreenLight XPS is at least as effective in these patients as transurethral resection of the prostate (TURP), but can more often be done as a day-case procedure, following appropriate service redesign. 1.2 There is currently insufficient high-quality, comparative evidence to support the routine adoption of GreenLight XPS in high-risk patients, that is those who: • have an increased risk of bleeding or • have prostates larger than 100 ml or • have urinary retention. NICE recommends that specialists collaborate in collecting and publishing data on the comparative effectiveness of GreenLight XPS for high-risk patients to supplement the currently limited published evidence. 1.3 Cost modelling indicates that in non-high-risk patients, cost savings with GreenLight XPS compared with TURP are determined by the proportion of procedures done as day cases. Assuming a day-case procedure rate of 36%, and that the GreenLight XPS console is provided at no cost to the hospital (based on a contracted commitment to fibre usage), the estimated cost saving is £60 per patient. NICE's resource impact report estimates that the annual cost saving for the NHS in England is around £2.3 million. In a plausible scenario of 70% of treatments being done as day cases, the cost saving may be up to £3.2 million. 1.4 NICE recommends that hospitals adopting GreenLight XPS plan for service redesign to ensure that day-case treatment can be delivered appropriately.
Diagnostics Guidance	**None published so far this month**
NICE Quality Standards	**Home care for older people QS123** This quality standard covers home care given to older people in their own homes to meet their assessed social care needs. An age threshold is not specified for older people. Although almost 80% of people using home care services are over 65, the quality standard may also be relevant to some people under 65 with complex needs. The quality standard does not cover intermediate care, short-term reablement, home care for younger adults or children using home care services. **Bronchiolitis in children QS122** This quality standard covers the assessment, diagnosis and management of bronchiolitis in children. **Breast cancer QS12 (updated)** This quality standard covers the management of early (ductal carcinoma in situ and invasive), locally advanced and advanced breast cancer, recurrent breast cancer and familial breast cancer in adults. This includes breast cancer identified through screening and by assessment of symptoms, and covers care from the point of referral to a specialist team. It does not cover adults with non-cancerous breast tumours. This quality standard has been updated and statements prioritised in 2011 replaced.

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

Title / link	Start date of consultation	End date of consultation
Leukaemia (chronic lymphocytic) - ibrutinib [ID749] : Appraisal consultation : 2	01/06/2016	22/06/2016
Lung cancer (non-small-cell, untreated, ALK positive) - crizotinib [ID865] : Appraisal consultation	01/06/2016	22/06/2016
Children's attachment : Quality Standard consultation	21/05/2016	23/06/2016
Severe mental illness and substance misuse (dual diagnosis) - community health and social care services : Draft guidance consultation	12/05/2016	23/06/2016
Early and locally advanced breast cancer (update) : Draft scope consultation	26/05/2016	24/06/2016
Idiopathic pulmonary fibrosis - pirfenidone (review TA282) [ID837]: : Appraisal consultation : 1	03/06/2016	24/06/2016
Single-incision short sling (mesh) insertion for stress urinary incontinence in women : Interventional procedure consultation	26/05/2016	24/06/2016
Physical health of people in prison : Draft guidance consultation	16/05/2016	27/06/2016
Asthma (eosinophilic, severe) - mepolizumab [ID798] : Appraisal consultation : 2	08/06/2016	29/06/2016
Macular oedema (branch retinal vein occlusion) - aflibercept [ID844] : Appraisal consultation	08/06/2016	29/06/2016
Post-traumatic stress disorder (update) : Draft scope consultation	07/06/2016	05/07/2016
Community pharmacy: promoting health and wellbeing : Draft scope consultation	10/06/2016	07/07/2016
Melanoma (BRAF V600, advanced, unresectable, metastatic) - cobimetinib (with vemurafenib) [ID815] : Appraisal consultation	16/06/2016	07/07/2016
Mental wellbeing and independence for older people : Quality Standard consultation	16/06/2016	14/07/2016
The XprESS Multi-Sinus Dilation System for the treatment of chronic rhinosinusitis : Draft guidance	16/06/2016	14/07/2016
Rheumatoid arthritis (update) : Draft scope consultation	17/06/2016	15/07/2016

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