NICE Update Bulletin June 2017

(issued Wednesday 28 June 2017)

Hyperlinks to the relevant NICE web page are included.

Details are also available from the NICE website (**http://www.nice.org.uk**)

Type	Guidance title and reference number
Technology Appraisals (TAs)	**Ponatinib for treating chronic myeloid leukaemia and acute lymphoblastic leukaemia TA451** **Recommendations** 1.1 Ponatinib is recommended, within its marketing authorisation, as an option for treating chronic-, accelerated- or blast-phase chronic myeloid leukaemia in adults when: • the disease is resistant to dasatinib or nilotinib or • they cannot tolerate dasatinib or nilotinib and for whom subsequent treatment with imatinib is not clinically appropriate or • the T315I gene mutation is present. 1.2 Ponatinib is recommended, within its marketing authorisation, as an option for treating Philadelphia-chromosome-positive acute lymphoblastic leukaemia in adults when: • the disease is resistant to dasatinib or • they cannot tolerate dasatinib and for whom subsequent treatment with imatinib is not clinically appropriate or • the T315I gene mutation is present. 1.3 Ponatinib is recommended only if the company provides the drug with the discount agreed in the patient access scheme. **The technology** Ponatinib has a marketing authorisation for 'adult patients with: • chronic-phase, accelerated-phase, or blast-phase chronic myeloid leukaemia who are resistant to dasatinib or nilotinib; who are intolerant to dasatinib or nilotinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation • Philadelphia-chromosome-positive acute lymphoblastic leukaemia who are resistant to dasatinib; who are intolerant to dasatinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation.' **Financial factors** This technology is commissioned by NHS England. NICE does not expect this guidance to have a significant impact on resources; it will be less than £5m per year in England (or £9,100 per 100,000 population). This is because ponatinib is a further option for the treatment of chronic myeloid leukaemia and acute lymphoblastic leukaemia in adults alongside current standard treatment options. The list price of ponatinib has a discount that is commercial in confidence.

Blinatumomab for previously treated Philadelphia-chromosome-negative acute lymphoblastic leukaemia TA450

Recommendations

1.1 Blinatumomab is recommended within its marketing authorisation as an option for treating Philadelphia-chromosome-negative relapsed or refractory precursor B-cell acute lymphoblastic leukaemia in adults, only if the company provides it with the discount agreed in the patient access scheme.

The technology

Blinatumomab is indicated for the treatment of adults with Philadelphia-chromosome-negative relapsed or refractory B-precursor acute lymphoblastic leukaemia.

Financial factors

This technology is commissioned by NHS England.

NICE does not expect this guidance to have a significant impact on resources; it will be less than £5m per year in England (or £9,100 per 100,000 population). This is because the population size is very small (the estimated number of people treated in England per year is less than 50).

Everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease TA449

The scope for this technology appraisal includes lutetium-177 dotatate (177Lu-dotatate). NICE cannot release any recommendations on 177Lu-dotatate until it has a positive opinion from the European Medicines Agency's Committee for Medicinal Products for Human Use.

Recommendations

1.1 Everolimus and sunitinib are recommended, within their marketing authorisations, as options for treating well- or moderately differentiated unresectable or metastatic neuroendocrine tumours (NETs) of pancreatic origin in adults with progressive disease.

1.2 Everolimus is recommended, within its marketing authorisation, as an option for treating well-differentiated (grade 1 or grade 2) non-functional unresectable or metastatic NETs of gastrointestinal or lung origin in adults with progressive disease.

1.3 Everolimus is recommended only when the company provides it with the discount agreed in the patient access scheme.

The technologies

Everolimus has a marketing authorisation for 'unresectable or metastatic, well- or moderately differentiated neuroendocrine tumours of pancreatic origin in adults with progressive disease' and 'unresectable or metastatic, well differentiated (grade 1 or grade 2) non-functional neuroendocrine tumours of gastrointestinal or lung origin in adults with progressive disease'.

Sunitinib has a marketing authorisation for 'unresectable or metastatic, well-differentiated pancreatic neuroendocrine tumours with disease progression in adults'.

Financial factors

These technologies are commissioned by NHS England.

NICE estimates that around 780 people are eligible to receive treatment each year with a forecast uptake of 90% (700 people).

Etelcalcetide for treating secondary hyperparathyroidism TA448

Recommendations

1.1 Etelcalcetide is recommended as an option for treating secondary hyperparathyroidism in adults with chronic kidney disease on haemodialysis, only if:

- treatment with a calcimimetic is indicated but cinacalcet is not suitable and
- the company provides etelcalcetide with the discount agreed in the patient access scheme.

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

Etelcalcetide is indicated for the treatment of secondary hyperparathyroidism in adults with chronic kidney disease on haemodialysis.

Financial factors

This technology is commissioned by CCGs.

NICE does not expect this guidance to have a significant impact on resources; it will be less than £5m per year in England (or £9,100 per 100,000 population). Etelcalcetide is a treatment option when treatment with a calcimimetic is indicated, but cinacalcet is not suitable. The population treated with etelcalcetide is estimated to be around 1,800 for England. The list price of etelcalcetide has a discount that is commercial in confidence.

Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer TA447

Recommendations

1.1 Pembrolizumab is recommended for use within the Cancer Drugs Fund as an option for untreated PD-L1-positive metastatic non-small-cell lung cancer in adults, only if:

- their tumours express PD-L1 with at least a 50% tumour proportion score and have no epidermal growth factor receptor- or anaplastic lymphoma kinase-positive mutations
- pembrolizumab is stopped at 2 years of uninterrupted treatment and no documented disease progression
- the conditions in the managed access agreement for pembrolizumab are followed.

1.2 This recommendation is not intended to affect treatment with pembrolizumab 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

Pembrolizumab has a marketing authorisation for the first-line treatment of metastatic non-small cell lung carcinoma in adults whose tumours express PD-L1 with at least a 50% tumour proportion score with no epidermal growth factor receptor or anaplastic lymphoma kinase-positive tumour mutations.

Financial factors

This technology is commissioned by NHS England.

Pembrolizumab will be available to the NHS in line with the conditions of the managed access agreement with NHS England. As part of this, NHS England and Merck, Sharp & Dohme have a commercial access agreement that makes pembrolizumab available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

The resource impact of pembrolizumab will be covered by the Cancer Drugs Fund budget. The guidance on this technology will be considered for review when the data collection period is concluded which is currently anticipated to be December 2017, when the results of KEYNOTE-024 are available. The aim of the review is to decide whether or not the drug can be recommended for routine use.

It is estimated that around 1,500 people per year with untreated PD-L1-positive metastatic non-small-cell lung cancer are eligible for treatment with pembrolizumab.

Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma TA446

Recommendations

1.1 Brentuximab vedotin is recommended as an option for treating CD30‑positive Hodgkin lymphoma in adults, only if:

- they have relapsed or refractory disease after autologous stem cell transplant and
- the company provides brentuximab vedotin at the price agreed with NHS England in the commercial access agreement.

1.2 Brentuximab vedotin is recommended for use within the Cancer Drugs Fund as an option for treating CD30‑positive Hodgkin lymphoma in adults, only if:

- they have relapsed or refractory disease after at least 2 previous therapies and
- they cannot have autologous stem cell transplant or multi-agent chemotherapy and
- the conditions of the managed access agreement are followed.

1.3 These recommendations are not intended to affect treatment with brentuximab vedotin that was started in the NHS before this guidance was published. Adults 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 clinician consider it appropriate to stop.

The technology

Brentuximab vedotin is indicated for treating relapsed or refractory CD30‑positive Hodgkin lymphoma in adults:

- after autologous stem cell transplant or
- after at least 2 prior therapies when autologous stem cell transplant or multi-agent chemotherapy is not a treatment option.

Brentuximab vedotin most recently received an extension to the marketing authorisation for treating CD30‑positive Hodgkin lymphoma in adults at increased risk of relapse or progression after autologous stem cell transplant.

Financial factors

This technology is commissioned by NHS England.

NICE does not expect recommendation 1.1 to have a significant impact on resources; it will be less than £5 million per year in England (or £9,100 per 100,000

	population). This is because this recommendation covers only a small population. Recommendation 1.2 will be covered by the Cancer Drugs Fund. NHS England will make brentuximab vedotin available according to the conditions in the managed access agreement. NHS England and Takeda have agreed a commercial access agreement that makes brentuximab vedotin available to the NHS at a reduced cost. The commercial access agreement incorporates a simple discount applied at the point of purchase or invoice of brentuximab vedotin for recommendation 1.1, but also includes additional and separate commercial arrangements that apply only to the population in the Cancer Drugs Fund for recommendation 1.2. The financial terms of the agreement are commercial in confidence.
Highly specialised technology guidance (HSTs)	**Eliglustat for treating type 1 Gaucher disease HST5** **Recommendations** 1.1 Eliglustat is recommended within its marketing authorisation for treating type 1 Gaucher disease, that is, for long-term treatment in adults who are cytochrome P450 2D6 poor, intermediate or extensive metabolisers. Eliglustat is only recommended when the company provides it with the discount agreed in the patient access scheme. **The technology** Gaucher disease is an inherited lysosomal storage disorder. It is caused by deficiency of the enzyme glucocerebrosidase. This deficiency leads to the inappropriate storage of complex lipids in some types of cell. This creates Gaucher cells, which occur throughout the liver, spleen, bone marrow and occasionally the lungs. There are 3 subtypes of Gaucher disease, of which type 1 (non-neuronopathic) is the most prevalent. All types of Gaucher disease are associated with a variety of symptoms, including pain, fatigue, anaemia, thrombocytopenia, jaundice, bone damage, and liver and spleen enlargement. Eliglustat is a substrate reduction therapy that partially inhibits the enzyme glucosylceramide synthase. This action results in reduced production of glucosylceramide and so fewer Gaucher cells. It is given orally. **Financial factors** This technology is commissioned by NHS England. The Department of Health and the company have agreed that eliglustat will be available to the NHS with a patient access scheme which makes eliglustat available with a discount. The size of the discount is commercial in confidence.
NICE Guidelines (NGs)	**Spondyloarthritis in over 16s: diagnosis and management NG65 (update)** This guideline covers diagnosing and managing spondyloarthritis that is suspected or confirmed in adults who are 16 years or older. It aims to raise awareness of the features of spondyloarthritis and provide clear advice on what action to take when people with signs and symptoms first present in healthcare settings. It also provides advice on the range of treatments available. **June 2017**: NICE updated recommendation 1.2.7 to clarify the advice on what imaging should be done. **Head injury: assessment and early management CG176 (update)** This guideline covers the assessment and early management of head injury in children, young people and adults. It promotes effective clinical assessment so that people receive the right care for the severity of their head injury, including referral directly to specialist care if needed.

	June 2017: NICE updated recommendations 1.2.8 and 1.4.12 with cross-references to related NICE guidelines, and an outdated research recommendation was deleted.
Public health guidelines (PH)	**Obesity: working with local communities PH42 (update)** This guideline covers how local communities, with support from local organisations and networks, can help prevent people from becoming overweight or obese or help them lose weight. It aims to support sustainable and community-wide action to achieve this. **June 2017**: NICE amended the wording of the section headed 'Whose health will benefit from these recommendations?' to include people with learning disabilities.
NICE Medicines Practice Guidelines (MPGs)	None published so far this month.
Interventional Procedures Guidance (IPGs)	**Uterine suspension using mesh (including sacrohysteropexy) to repair uterine prolapse IPG584** This guidance replaces NICE interventional procedures guidance on insertion of mesh uterine suspension sling (including sacrohysteropexy) for uterine prolapse repair (IPG282). **Recommendations** 1.1 Current evidence on the safety of uterine suspension using mesh (including sacrohysteropexy) to repair uterine prolapse shows there are serious and well-recognised complications. The evidence on efficacy is adequate in quantity and quality. Therefore, this procedure can be used provided that **standard arrangements** are in place for clinical governance, consent and audit. 1.2 During the consent process, clinicians should ensure that patients understand the risk of uterine prolapse happening again and of potentially serious complications, including mesh erosion (for example, into the bladder). Patients should be told about all treatment options and provided with clear written information about the procedure and its complications. In addition, the use of NICE's information for the public is recommended. 1.3 Patient selection should be done by a multidisciplinary team with experience in managing pelvic organ prolapse and urinary incontinence in women. All clinicians doing this procedure should have specific up-to-date training and do the procedure regularly. 1.4 Clinicians should enter details about all patients having mesh uterine suspension (including sacrohysteropexy) to repair uterine prolapse onto an appropriate registry (for example, the British Society of Urogynaecology database). All adverse events involving the medical devices (including mesh) used in this procedure should be reported to the Medicines and Healthcare products Regulatory Agency. **The procedure** Uterine prolapse happens when the womb (uterus) slips down from its usual position into the vagina. Uterine suspension using mesh involves attaching 1 end of the mesh to the lower part of the womb or the cervix. The other end is attached to a bone at the base of the spine or to a ligament in the pelvis. This procedure lifts the womb and holds it in a normal position. The procedure can be done through open abdominal or keyhole surgery. The aim is to support the womb.

Sacrocolpopexy using mesh to repair vaginal vault prolapse IPG583

This guidance replaces NICE interventional procedures guidance on sacrocolpopexy using mesh for vaginal vault prolapse repair (IPG283).

Recommendations

1.1 Current evidence on the safety of sacrocolpopexy using mesh to repair vaginal vault prolapse shows there are serious but well-recognised safety concerns. The evidence on efficacy is adequate in quantity and quality. Therefore, this procedure can be used provided that **standard arrangements** are in place for clinical governance, consent and audit.

1.2 During the consent process, clinicians should ensure patients understand that there is a risk of vaginal vault prolapse happening again, and of potentially serious complications, including mesh erosion (for example, into the vagina). Patients should be provided with clear written information about the procedure and its complications. In addition, the use of NICE's information for the public is recommended.

1.3 Patient selection and treatment should only be done by clinicians specialising in the management of pelvic organ prolapse and urinary incontinence in women. All clinicians doing this procedure should have specific up-to-date training and do the procedure regularly.

1.4 Clinicians should enter details about all patients having sacrocolpopexy using mesh to repair vaginal vault prolapse onto an appropriate registry (for example, the British Society of Urogynaecology database). All adverse events involving the medical devices (including mesh) used in this procedure should be reported to the Medicines and Healthcare products Regulatory Agency.

The procedure

Vaginal vault prolapse is when the upper part of the vagina slips down from its usual position. It commonly happens after hysterectomy, when the womb and cervix are removed. It can affect quality of life by causing pressure and discomfort in the pelvis, and can also affect bladder and bowel function and sex.

If the prolapse is mild or moderate and is causing symptoms, treatment can include pelvic floor muscle strengthening and creams or patches containing the hormone oestrogen. Pessaries made of rubber or silicone can be used to support the vagina. If the prolapse is severe, surgery may be needed. There are different surgical procedures available, which aim to support the pelvic organs. Some include using mesh for additional support. Sacrocolpopexy using mesh to repair vaginal vault prolapse is usually done with the patient under a general anaesthetic. It can be done by conventional (open) surgery or through small cuts in the abdomen (keyhole surgery).

The procedure aims to support the pelvic organs in their natural position. This is done by attaching a piece of mesh usually from the top, and sometimes from the front or back of the vagina, to a ligament in the pelvis at the base of the spine or to a bone at the bottom of the spine. The mesh is similar to a fine net, and is usually made of polypropylene.

Infracoccygeal sacropexy using mesh to repair uterine prolapse IPG582

This guidance replaces NICE interventional procedures guidance on infracoccygeal sacropexy using mesh for uterine prolapse repair (IPG280).

Recommendations

1.1 Current evidence on the safety of infracoccygeal sacropexy using mesh to repair uterine prolapse shows there are serious but well recognised complications. The evidence on efficacy is inadequate in quality. Therefore, this procedure should not be used unless there are **special arrangements** in place for clinical governance, consent and audit or research.

1.2 Clinicians wishing to do infracoccygeal sacropexy using mesh to repair uterine prolapse should:

- Inform the clinical governance leads in their NHS trusts.
- Ensure that patients understand the uncertainty about the procedure's safety, including the risk of mesh erosion (for example, into the vagina) and the risk of recurrence, and provide them with clear written information. In addition, the use of NICE's information for the public is recommended.

1.3 Patient selection and treatment should only be done by specialists experienced in managing pelvic organ prolapse and urinary incontinence in women. All clinicians doing this procedure should have specific up-to-date training.

1.4 Clinicians should enter details about all patients having infracoccygeal sacropexy using mesh for uterine prolapse repair onto an appropriate registry (for example, the British Society of Urogynaecology database) and the results of the registry should be published. All adverse events involving the medical devices (including the mesh) used in this procedure should be reported to the Medicines and Healthcare products Regulatory Agency.

1.5 Clinicians are encouraged to collect long-term data on clinical outcomes and patient-reported quality-of-life outcomes using validated scales. NICE may update the guidance on publication of further evidence into infracoccygeal sacropexy using mesh to repair uterine prolapse.

The procedure

Uterine prolapse happens when the womb (uterus) slips down from its usual position into the vagina. Infracoccygeal sacropexy involves inserting a piece of mesh through a small cut in 1 buttock, across the top of the vagina and out through a cut in the other buttock. This creates a sling that holds the womb in place.

Infracoccygeal sacropexy using mesh to repair vaginal vault prolapse IPG581

This guidance replaces NICE interventional procedures guidance on infracoccygeal sacropexy using mesh for vaginal vault prolapse repair (IPG281).

Recommendations

1.1 Current evidence on the safety of infracoccygeal sacropexy using mesh to repair vaginal vault prolapse shows there are serious but well-recognised complications. The evidence on efficacy is inadequate in quality. Therefore, this procedure should not be used unless there are **special arrangements** in place for clinical governance, consent, and audit or research.

1.2 Clinicians wishing to do infracoccygeal sacropexy using mesh to repair vaginal vault prolapse should:

- Inform the clinical governance leads in their NHS trusts.
- Ensure that patients understand the uncertainty about the procedure's safety, including the risk of mesh erosion (for example, into the vagina) and the risk of recurrence, and provide them with clear written information. In addition, the use of NICE's information for the public is recommended.

1.3 Patient selection and treatment should only be done by specialists experienced in managing pelvic organ prolapse and urinary incontinence in women. Clinicians doing this procedure should have specific up-to-date training.

1.4 Clinicians should enter details about all patients having infracoccygeal sacropexy using mesh for vaginal vault prolapse repair onto an appropriate registry (for example, the British Society of Urogynaecology database) and the results of the registry should be published. All adverse events involving the medical devices (including the mesh) used in this procedure should be reported to the Medicines and Healthcare products Regulatory Agency.

	1.5 Clinicians are encouraged to collect long-term data on clinical outcomes and patient-reported quality-of-life outcomes using validated scales. NICE may update the guidance on publication of further evidence. **The procedure** Vaginal vault prolapse happens when the upper part of the vagina slips down from its usual position after surgery to remove the womb or cervix. Infracoccygeal sacropexy involves inserting a piece of mesh through a small cut in 1 buttock, across the top of the vagina and out through a cut in the other buttock. This creates a sling that supports the vaginal vault.
Medical Technologies Guidance	**SecurAcath for securing percutaneous catheters MTG34** **Recommendations** 1.1 The case for adopting SecurAcath for securing peripherally inserted central catheters (PICCs) is **supported** by the evidence. SecurAcath is easy to insert, well tolerated, associated with a low incidence of catheter-related complications and does not usually need removing while the catheter is in place. 1.2 SecurAcath should be considered for any PICC with an anticipated medium- to long-term dwell time (15 days or more). 1.3 Cost modelling shows that SecurAcath is cost saving compared with adhesive securement devices if the PICC remains in place for 15 days or longer. Estimated cost savings range from £9 to £95 per patient for dwell times of 25 days and 120 days, respectively. Cost savings result from shorter maintenance times and less need for device replacement with SecurAcath. Annual savings across the NHS in England from using SecurAcath are estimated to be a minimum of £4.2 million. **The technology** SecurAcath is a single-use device to secure percutaneous catheters in position on the skin. It is intended for use in adults and children who need a central venous catheter (CVC), a long, thin, flexible tube that is inserted into a vein through the skin. It is positioned so that the distal tip lies in a large central vein, usually the superior vena cava, right atrium or inferior vena cava. It is easy to insert and well tolerated. Most devices for keeping catheters in place must be regularly removed for cleaning, but SecurAcath can usually remain in place for as long as the catheter is needed.
Diagnostics Guidance	**Multiple frequency bioimpedance devices to guide fluid management in people with chronic kidney disease having dialysis DG29** **Recommendations** 1.1 There is currently not enough evidence to recommend the routine adoption of the BCM – Body Composition Monitor to guide fluid management in people with chronic kidney disease having dialysis in the NHS. Further research is recommended to show the effect of using the BCM – Body Composition Monitor on clinical outcomes. Centres that are currently using the BCM – Body Composition Monitor to guide fluid management are encouraged to take part in research and data collection. Centres that do not currently use the BCM – Body Composition Monitor to guide fluid management should only do so as part of a research study, such as the BISTRO trial. NICE will support this guidance through a range of activities to promote the recommendations for further research.

	1.2 There is currently not enough validation or clinical-outcome data to recommend the routine adoption of the InBody S10 or the MultiScan 5000 to guide fluid management in people with chronic kidney disease having dialysis in the NHS. **The technology** Multiple frequency bioimpedance devices send small, painless electrical signals through the body by way of electrodes. The electrodes also measure the opposition to the flow of the electric current from body tissues (bioimpedance). The devices included in this guidance are portable and could be used by a healthcare professional in either a clinic or the patient's home. Built-in software uses bioimpedance values to calculate parameters relating to hydration, such as volumes of extracellular, intracellular and total body water. Based on these parameters, multiple frequency bioimpedance devices can also produce estimates of a person's target dialysis weight, using models or algorithms that differ between devices. These outputs should be used with clinical assessment to make decisions about the amount of fluid to be removed during dialysis. NICE has said that there is **not enough evidence to recommend** the routine use of the BCM Body Composition Monitor, InBody S10 or MultiScan 5000 in the NHS.
NICE Quality Standards	**Violent and aggressive behaviours in people with mental health problems QS154** This quality standard covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem. It applies to settings where mental health, health and social care services are provided. This includes community settings and care received at home. It describes high-quality care in priority areas for improvement. It does not specifically cover violence and aggression among people with a primary diagnosis of learning disability because this group has been covered in the quality standard on learning disabilities: challenging behaviour. **Multimorbidity QS153** This quality standard covers clinical assessment, prioritising and managing healthcare for adults aged 18 years and over with 2 or more long-term health conditions (multimorbidity). At least 1 of these conditions must be a physical health condition. It describes high-quality care in priority areas for improvement. It does not cover care for people who have multiple mental health problems and no physical health conditions because their care is largely delivered by psychiatric services. **Liver disease QS152** This quality standard covers identifying, assessing and managing chronic liver disease in children, young people and adults, and cirrhosis in young people and adults. It describes high-quality care in priority areas for improvement. **Oral health in care homes QS151** This quality standard covers oral health, including dental health and daily mouth care, for adults in care homes (with and without nursing provision). It describes high-quality care in priority areas for improvement. **Haematological cancers QS150** This quality standard covers diagnostic reporting and the organisation of haematological cancer services for people of all ages (children, adults and young people) and managing haematological cancers in adults and young people (aged 16 and over). It describes high-quality care in priority areas for improvement.

Current NICE consultations with links and end dates for stakeholders to contribute

Title / link	End date of consultation
Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality	03/07/2017
Glaucoma: diagnosis and management (update)	04/07/2017
Inotuzumab ozogamicin for treating relapsed or refractory acute lymphoblastic leukaemia [ID893]	04/07/2017
Neuropathic pain in adults: pharmacological management in non-specialist settings	05/07/2017
Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma [ID512]	05/07/2017
Hypertension in adults	07/07/2017
Surgical repair of vaginal wall prolapse using mesh (IP660/2)	07/07/2017
Urinary tract infection in under 16s (standing committee update)	19/07/2017
Termination of pregnancy	20/07/2017
Transcutaneous microwave ablation for severe primary axillary hyperhidrosis	20/07/2017
Processed nerve allograft to repair peripheral nerve discontinuities	20/07/2017
Flu vaccination: increasing uptake	04/08/2017

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