New from NICE

Technology appraisal. Canagliflozin in combination therapy for treating type 2 diabetes. TA315. Recommended

NICE recommends canagliflozin (Invokana), the second SGLT2 inhibitor introduced in the UK, as a component of dual or triple therapy and in combination with insulin to treat type 2 diabetes.

As dual therapy, it may be added to metformin when a sulfonylurea is unsuitable or the person is at significant risk of hypoglycaemia or its consequences. As triple therapy it may be added to metformin combined with a sulfonylurea or pioglitazone. Canagliflozin may also be combined with insulin, with or without other glucose-lowering drugs.

NICE concluded that, as a component of dual or triple therapy, canagliflozin probably offers glycaemic control that is similar to the DPP-4 inhibitors and may offer greater weight loss and lowering of blood pressure. As dual therapy, it is probably comparable with dapagliflozin. As add-on therapy to insulin, canagliflozin possibly offers better glycaemic control and greater weight reduction than either a DPP-4 inhibitor or dapagliflozin.

The estimated cost per QALY saved with canagliflozin is similar to that of dapagliflozin and the DPP-4 inhibitors. NICE therefore concluded that it should be a treatment option when these were alternatives for dual therapy and in combination with insulin. The similarity in cost effectiveness to DPP-4 inhibitors additionally made canagliflozin an option for triple therapy, for which dapagliflozin (Forxiga) is not currently recommended. GLP-1 agonists were not considered to be alternatives to canagliflozin because they are administered by injection.

Clinical guideline. The management of atrial fibrillation. CG180.

This detailed clinical guideline updates the 2006 version, adding new recommendations for personalised care and information, specialist referral, stroke prevention, rate and rhythm control, and the management of acute atrial fibrillation. It contains nine sections covering diagnosis, care delivery, referral, assessment, stroke prevention, rate and rhythm control, the management of acutely presenting patients, and initial and postoperative management.

Most sections include recommendations relevant to prescribing. Information and practical advice about anticoagulation should be part of a personalised care package. The benefits and risks of anticoagulation should be explained as part of the assessment procedure.

Stroke prevention therapy is not recommended for people under 65 who have atrial fibrillation and no risk factors other than their sex. When the CHA$_2$DS$_2$-VASc score indicates the need for anticoagulation, apixaban (Eliquis), dabigatran (Pradaxa), rivaroxaban (Xarelto) or a vitamin K antagonist may be appropriate. The criteria for each, as specified in NICE technology appraisals, are listed. Guidance on self-management of anticoagulation with warfarin is currently being prepared but detailed criteria for the quality of coagulation control are provided. Aspirin monotherapy should not be given solely to prevent stroke.

The guideline lists the indications for rate and rhythm control. The drugs recommended for rate control are a standard...
beta-blocker (ie not sotalol), a rate-limiting calcium channel blocker (eg diltiazem) or, for sedentary individuals, digoxin. Two of these drugs may be combined if necessary.

Amiodarone should be considered for short-term use before and after cardioversion (and for patients with left ventricular impairment or heart failure) but a standard beta-blocker is the first choice for long-term rhythm control. If this is unsuccessful, dronedarone may be considered for selected patients.

Class 1c antiarrhythmic drugs – such as flecainide and propafenone (Arythmol) – should not be offered to people with known ischaemic or structural heart disease but may be used when a ‘pill-in-the-pocket’ strategy is considered for those with infrequent paroxysms and few symptoms who meet additional criteria.

Guidance on managing acute fibrillation covers the use of cardioversion and antiarrhythmic drugs, and the initiation of heparin and oral anticoagulation. The initial management of stroke and atrial fibrillation should follow published guidance (CG68, 2008). Drugs recommended to prevent postoperative atrial fibrillation are a standard beta-blocker, a rate-limiting calcium channel blocker or amiodarone (but not digoxin).

Further research is recommended on the choice of rate control drug treatment in patients aged over 75 and whether patients with poor anticoagulant control with warfarin should be switched to one of the newer oral agents.