Latest guidance updates

NICE published 30 separate pieces of guidance between June and the beginning of August 2018, including five guidelines, 11 technology appraisals, three quality standards, eight pieces of guidance on interventional procedures or diagnostics, and three medtech innovation briefings. Several, such as new guidelines on the management of dementia and rheumatoid arthritis, were major updates of past work with wide implications for prescribing in primary and secondary care; detailed summaries will be published in Prescriber. Others were highly specialised—for example, the recommendations on using a graft for superior capsular augmentation for massive rotator cuff tears in adults. Some, however, were relevant to aspects of general practice and are summarised here.

**Pembrolizumab and atezolizumab for urothelial cancer**

Pembrolizumab (Keytruda), which binds to the programmed cell death-1 (PD-1) receptor, and atezolizumab (Tecentriq), which binds to the programmed death-ligand 1 (PD-L1) itself, are monoclonal antibody immune checkpoint inhibitors that reactivate a key step in the T cell response against tumour cells. NICE already recommends them for several indications but its latest advice (TA492 and TA522), based on early evidence, covers them as treatment options within the Cancer Drugs Fund for patients with untreated PD-L1-positive locally advanced or metastatic urothelial cancer when cisplatin-containing therapy is unsuitable. Both are ‘life-extending end-of-life treatments’. Life expectancy with carboplatin plus gemcitabine, previously the only treatment option, is 10–13 months. The available data suggest that pembrolizumab increases median overall survival by 11 months and atezolizumab by at least seven months.

**Pembrolizumab for NSCLC**

Pembrolizumab is also recommended for untreated PD-L1-positive metastatic non-small cell lung cancer (NSCLC; TA531) in adults whose tumours express PD-L1 with at least 50% tumour proportion score and have no epidermal growth factor receptor (EGFR)- or anaplastic lymphokinase (ALK)-positive mutations. This is usually treated with platinum-based chemotherapy; pembrolizumab offers a further 16 months’ survival. For both this indication and urothelial cancer, NICE says that treatment with pembrolizumab must be stopped after two years or if disease progression occurs.

**Niraparib for ovarian, fallopian tube or primary peritoneal cancer**

Niraparib (Zejula) is “an extremely promising and innovative” inhibitor of poly (ADP-ribose) polymerase (PARP), a group of enzymes involved in DNA repair. NICE recommends it, within the Cancer Drugs Fund, for selected patients with relapsed, platinum-sensitive high-grade serous epithelial ovarian, fallopian tube or primary peritoneal cancer (TA528). Niraparib is recommended for use after two previous courses of platinum-based chemotherapy whereas use of the related PARP inhibitor olaparib requires at least three previous courses. A clinical trial has indicated that niraparib can extend progression-free survival, but it is still unclear whether it improves overall survival.

**Brain tumours in adults**

A new guideline on the diagnosis and management of primary and secondary brain tumours in adults (NG99) includes recommendations on investigation, management and follow-up of glioma, meningioma and brain metastases. One section is devoted to the unique care needs of people with a brain tumour, whose behaviour, cognition and personality may be affected.

**Medicines management for people receiving social care**

In 2017, NICE published a guideline (NG67) to support the safe use of medicines by adults receiving social care in the community, covering how to assess need, who should provide support, and collaboration between health and social care staff. It complemented the social care guideline on managing medicines in care homes (SC1) and the guideline on home care for older people (NG21).

There is now a quality standard (QS171) for NG67, with four statements covering needs assessment, communication between health and social care staff, appropriate record-keeping and managing problems arising from medicines use. NICE notes that clear lines of communication and accountability must be established before introducing the quality standard.

**Remote ECG interpretation services**

New technology has been identified as one of the means by which the NHS will meet demand for patient care within resource constraints. One innovative approach to reducing patient referrals is the use of remote ECG interpretation consultancy services for cardiovascular disease. In a Medical Innovation Briefing (MI152), NICE reviews six consultancy services—five in the UK, one in India—that provide the GP with an interpretation of an ECG and avoid the need for the patient to travel to a clinic.

The high level of expertise offered by the service should additionally reduce unnecessary referrals. The cost of a report ranges from £10 to £25 for a 12-lead ECG up to £195 for a seven-day Holter monitor analysis. Provided a service can link with the NHS communication network, no additional infrastructure is necessary.

These services are already in use in the UK. Pilot studies suggest that annual savings of £730,000–£1.816 million are possible for a 60-practice CCG but evidence of cost effectiveness is available for only one service and there is currently no evidence on clinical outcomes.

**Hearing loss in adults**

The charity Action on Hearing Loss (www.actiononhearingloss.org.uk) estimates that one in six people in the UK have...
hearing loss. NICE’s guideline on assessing and managing hearing loss in adults within primary, community and secondary care (NG98) aims to help healthcare staff to assess hearing difficulty and make appropriate referrals for audiological or specialist assessment, as well as manage the more mundane and common problem of earwax.

Early investigation is critical to exclude serious underlying disorders, including stroke and acoustic neuroma, and many of the recommendations in the guideline cover assessment by specialist services. Ear wax, however, falls within the domain of primary and community care, and removal should be offered if it is contributing to hearing loss or other symptoms. Trained staff should use an electronic irrigator, microsuction or a probe after pretreatment with a softening agent. Manual syringing should not be offered, and DIY wax removal is not recommended.

**Dupilumab for moderate to severe atopic dermatitis**

NICE would have recommended the monoclonal antibody dupilumab (Dupixent) for moderate to severe atopic dermatitis earlier in the year but for the price: its appraisal consultation stated that the range of cost per QALY estimates for dupilumab plus topical steroids was £29,792 to £77,701; above the threshold of £20,000–£30,000 normally applied.

NICE subsequently agreed a discount scheme with the manufacturer, which reduced the cost per QALY to £27,410 to £28,495 and dupilumab is now recommended as an option for moderate to severe atopic dermatitis when the disease has not responded to at least one other systemic therapy (such as ciclosporin, methotrexate, azathioprine or mycophenolate mofetil) or if they are unsuitable (TA534). Defined targets for improvements in skin condition and quality of life must be met if treatment is to continue beyond 16 weeks.

Dupilumab is administered by subcutaneous injection once every two weeks. It is usually offered alongside topical corticosteroids.