National Institute for Health and Clinical Excellence

Stable Angina: scope consultation

Scope Consultation Table

2 April 2009 – 30 April 2009

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	**Developer's Response** Please respond to each comment
SH	Action Heart	1	3.1 b	Action Heart agrees that it is important for patients to be well informed with respect to their diagnosis and that appropriate education and advice should be provided in a properly structured and relevant manner. This will take into account the sub-groups identified in 4.1.1b.	Thank you for your comment. The omission of patient education was an error on our part. We have outlined what patient programmes should include and have specified patient education as part of this.
SH	Action Heart	2	3.2 a	It is Action Heart's understanding that not many patients with stable angina will have routine access to appropriate intervention services, for example, cardiac rehabilitation programmes. It is important that such programmes are routinely available to provide patients with the appropriate information and confidence that is required to initiate successful medical/lifestyle interventions.	Thank you for your comment. As you recognise below (comment 4), rehabilitation is considered a key clinical issue to be covered. However, issues of service delivery are beyond the scope of this guideline.
SH	Action Heart	3	4.1.1 b	It is Action Heart's belief that young patients (under 50 yrs) may also warrant special consideration particularly with respect to psychological support.	Thank you for your comment. We are not aware of any evidence/reason to suggest/indicate that young patients require different levels of psychological support from patients of all ages.

SH	Action Heart	4	4.3.1 b and 4.3.1 f	It is Action Heart's belief that patients should have access to appropriate lifestyle and rehabilitation services and that appropriate funding is available to deliver such interventions.	Thank you for your comment. Service delivery is beyond the scope of this guideline.
SH	Boston Scientific	1	4.1.1 b	**We believe that patients with diabetes (mainly type 2) should be listed and considered as a subgroup that may need special consideration** The information below has been taken from the Diabetes UK website (www.diabetes.org.uk) as well as an article published in a supplement from the Guardian, describing a unique clinic in London providing early screening of coronary heart disease for patients with diabetes. This unique clinic has been set up by Dr Akhil Kapur at the London Chest. The full paper can be found on http://doc.mediaplanet.com/projects/papers/BionicsAug.pdf Pages 12-13 **Diabetes UK website, long-term complications** The term cardiovascular disease (CVD) includes heart disease, stroke and all other diseases of the heart and circulation, such as hardening and narrowing of the arteries supplying blood to the legs, which is known as peripheral vascular disease (PVD). However, heart disease and stroke are the two most common forms of CVD. People with diabetes have an up to fivefold increased risk of CVD compared with those without diabetes. The reasons are prolonged, poorly controlled blood glucose levels, which affect the lining of the body's arterial walls. This increases the likelihood of furring up of the vessels, forming a narrowing (atherosclerosis). People with Type 2 diabetes also often have low HDL cholesterol and raised triglyceride levels, which both increase the risk of atherosclerosis. High blood pressure, smoking, obesity and physical inactivity are	Thank you for your comment. It had been our intention to include people with diabetes as a subgroup and we have now specified this in the scope.

				also risk factors for CVD. **Advanced Healthcare, August 2008, Dr Akhil Kapur, pg 12-13** "The borough of Newham has the highest rate of death from coronary disease in the country. It is also considered to be the capital of diabetes in Europe. We have set up a dedicated clinic for patients who have diabetic coronary disease. The purpose of this is to diagnose these patients earlier and once diagnosed treat them aggressively. Catching these patients early has huge potential benefits. If left undiagnosed diabetic coronary disease will present acutely more often, that is, with heart attacks and even death than it does with a non acute presentation to a GP or cardiologist which is how most other coronary disease presents. Diabetic coronary disease is more difficult to diagnose because patients do not always feel chest pain. Running a clinic like this affords us the opportunity of seeing patients with diabetes who we and their GPs believe are at high risk of heart disease. Catching them early therefore allows us to institute earlier proven treatments which we know will reduce their long term risk thereby reducing their chances of having a heart attack.	
SH	Boston Scientific	2	General	If necessary we can fast track these patients to diagnostic interventions to detect their coronary disease and then if necessary on to operative procedures such as percutaneous coronary angioplasty and stenting which can relieve their coronary narrowings and blockages.	Thank you for your comment. We will be reviewing the evidence regarding indications for interventions for both short and long term outcomes.

SH	British Association for Nursing in Cardiac Care	1	General	My impression is that there will be some overlap between this guideline and the awaited guideline on chest pain. The majority of patients will be diagnosed with stable angina through Rapid Access Chest Pain Clinic's (RACPC). Their treatment regime will be started and they may well be referred on for coronary angiogram with possible PCI if their symptoms are highly suggestive of angina together with a positive ETT. Following this they may well only need to be followed-up in primary care, unless their symptoms are not controlled. This guideline on stable angina proposes to include the management of patients with a diagnosis of stable angina and therefore both guidelines would need to be consulted if their diagnosis is to be covered in the chest pain guideline. As a nurse specialist running a RACPC I would have preferred to consult a guideline that includes the diagnosis and management of stable angina. However, it would be useful to summarise, at the beginning of the guideline, tests and investigations recommended in the diagnosis of this patient group, as well as initial drug treatment regimes.	Thank you for your comment. As you mention, the scope of this guideline is limited to the management of stable angina and does not include its diagnosis. However, we recognise the issue and will discuss with NICE how best to handle "joining up" recommendations from separate guidelines.
SH	British Association for Nursing in Cardiac Care	2	4.1.1 b	Ethnic minorities – specific ethnic groups should be listed to make clinicians aware that there are now several ethnic minority groups predisposed to developing angina.	Thank you for your comment. We have now specified South Asians as an ethnic group requiring special consideration in this guideline. No other specific ethnic groups were highlighted from our review of the evidence or by stakeholders to date.
SH	British Nuclear Medicine Society	1	General	The BNMS have no further comments and support the draft in its current form	Thank you for your comment
SH	British Pain Society	1	3.1 b & epidemiology	People with angina have a low quality of life because of their lack of understanding of their condition. This is directly linked to the inadequate, and sometimes	Thank you for your comment.

				incorrect, information given to them by the health professionals delivering care. Angina patients have misunderstandings at the most fundamental level. Most patients with angina believe that each episode of angina represents progressive and ongoing damage to the myocardium, and that there is a link between cardiac risk and severity and frequency of pain episodes. Because the risks are poorly understood due to lack of education in their condition, it is likely that patients' decision-making will be hampered, and decisions about treatment options end up being relinquished to the cardiologist under whose care they remain. Patients grudgingly accept medical paternalism when they perceive no alternative, but they rarely enjoy the experience.	
SH	British Pain Society	2	3.2 a & current practice	The enthusiasm for the delivery of medical strategies over lifestyle advice is sometimes difficult for the logical mind to understand. Despite overwhelming evidence showing the positive benefits of lifestyle changes (weight loss, dietary adjustment, exercise programmes, education, smoking cessation) there is little evidence that a newly-diagnosed angina patient adopts (m)any of these simple adjustments. Because the initial presentation of angina is often dramatic, the delivery of simple (but valuable) advice may be overlooked in the heat of the moment, but there is no justification for ignoring it altogether. Angina is a chronic visceral pain problem. Health professionals managing other common painful conditions have fallen into the trap of 'chasing the lesion' in the mistaken belief that interrupting the pathological process inevitably results in resolution of the problem. A prime example is the belief through the 1970's and '80's that chronic low back pain could be cured by surgery. The untold misery created by failed back surgery left an iatrogenic legacy that will not be forgotten by a generation of pain clinicians. It wasn't until the	Thank you for your comment. We agree that information on outcomes of simple and complex interventions should be made available to patients. We will be looking at evidence of the benefits of education, pharmacological, non-pharmacological and surgical interventions to manage angina

				introduction of the bio-psycho-social model of chronic painful conditions that the complexity of conditions such as chronic low back pain were more correctly understood and thus more successfully managed in a multidisciplinary setting. An essential part of this approach is the education of patients about their condition which enables them to make rational and relevant choices about their future treatment. The modern cardiological emphasis on ‘chasing the lesion’ – ie dealing with coronary artery occlusive disease, means that many patients undergo multiple revascularisation procedures such as angioplasty and stent placement without fully understanding the risks and benefits, in the mistaken belief that their prognosis is being improved, despite there being little evidence that this is the case. If the aim of angina management is “to abolish or minimise symptoms and improve longer term outcomes such as morbidity and mortality”, the emphasis should be placed on delivering treatments that achieve these goals at low risk and low cost before attempting more expensive and higher-risk options.	
SH	British Pain Society	3	4.2 a Healthcare setting	In addition to primary and secondary care, this should be expanded to include tertiary care (specialist cardiac/cardiothoracic units). Specialist units should be just as capable of delivering simple relevant advice, and being guided by the available evidence, as primary and secondary care units.	Thank you for your comment. We have altered this to include all NHS settings where patients with angina are managed.
SH	British Pain Society	4	4.3.1 c & clinical management – key issues	“The guideline will assume that prescribers will use a drug’s summary of product characteristics to inform their decisions for individual patients” – this makes it sound as if the decision that a patient should take a drug is being made by the prescriber. This is paternalistic and is counter to the prevailing notion that fully-informed patients are equal partners in the decision-making process.	Thank you for your comment. This is standard NICE text which is used, where relevant, in all clinical guideline development. We have made an amendment to the sentence and will bring your comment to the attention of NICE.

SH	British Pain Society	5	4.3.1 d	Will revascularisation strategies be bound by the same requirement as mentioned in section 4.3.1(c) “guideline recommendations will normally fall within licensed indications; exceptionally, and only if supported by evidence, use outside a licensed indication may be recommended”? The recent example of the rapid (outside existing guideline) expansion in use of drug-eluting stents shortly after their introduction which created a furore at the European Society of Cardiology meeting last year is a prime example of therapeutic trends developing despite guideline advice to the contrary.	Thank you for your comment. The recommendations made in this guideline will be based upon reviews of the available evidence.
SH	British Pain Society	6	4.3.1 e and (f)	Condition-specific information…/rehabilitation These are vitally important components in the modern management of chronic disease, and should logically be closer to the head of the list. As it stands, in the current order it appears that rehabilitation and patient education should only be considered when revascularisation strategies have failed	Thank you for your comment. The order of the key clinical issue list was not by importance or by first line treatment. The revision of the scope has changed the order.
SH	British Pain Society	7	4.3.1 g	Chronic refractory angina – this term was coined to overcome the confusion arising from multiple nomenclatures of essentially the same clinical situation. The definition of chronic refractory angina agreed by the multidisciplinary guideline group and endorsed by the British Pain Society is: “chronic stable angina that persists despite optimal medication and when revascularisation is unfeasible or where the risks are unjustified.” The technical feasibility of revascularisation is a surgical decision, and is independent of whether the procedure is justified in an individual case. An assessment of risk must include the patient, and it is only an educated, informed patient who understands the issues for and against the procedure, and is aware of all alternative therapies (including no treatment) who can properly make the choice to undergo revascularisation. All doctors (taking	Thank you for your comment. We agree that patients should be well informed about their treatment options.

				consent for treatment) are bound by the GMC guidance outlined in the document 'Duties of a Doctor'. It therefore follows that any patient undergoing a revascularisation procedure who is not aware of all the alternative treatments and does not fully understand the prognostic implications (it is well-known that a majority of stable angina patients undergoing angioplasty and stent placement believe that their prognosis will improve as a result of the procedure, whereas there is no evidence to support that belief) has not been correctly consented, which may expose the healthcare system to avoidable medicolegal risks.	
SH	British Pain Society	8	General	My comments are regarding the constitution of the guideline development group.1. It isn't clear from the information presented whether the GDG will include XXXXXXXX and XXXX as part of the proposed membership (NICE methodologists, 2 patient reps and 6-8 other healthcare professionals). If the 6-8 other healthcare professionals are to include the disciplines suggested in the presentation, eventual GDG membership could comprise up to six cardiologists/cardiac surgeons, which would be significantly biased. This would be akin to forming a chronic low back pain guideline group with orthopaedic surgeons as the only clinical advisers, with no representation from physiotherapy, rheumatology, psychology, pain medicine or other relevant disciplines. 2. The mindset of many healthcare professionals involved in angina management is that angina equates with coronary artery disease (CAD), and many of the strategies developed for dealing with CAD are applied to patients presenting with angina symptoms. I made the point at the scoping meeting that angina is actually a chronic visceral pain syndrome, and that there is merit in treating it according to the bio-psycho-social model in a multidisciplinary setting. This requires a more diverse	Thank you for your comment. We do understand the remit and scope as primarily considering management of people with angina symptoms associated with coronary disease. We do however recognise the importance of interventions which are directed to aspects of care other than management of atherosclerotic disease. The scope has therefore been revised to indicate the inclusion of these interventions. The guideline development group will include expertise in rehabilitation and we have agreed with NICE that we may co-opt expertise in areas such as psychology and pain management.

				group than that proposed, with (as a minimum) pain medicine, psychological therapies and rehabilitation representatives included in the GDG.	
SH	British Pain Society	9	General & – re: XXXX	In her remarks about patient/carer involvement XXXX mentioned that there would not be an opportunity for a patient representative to join the GDG who was already linked to a healthcare professional GDG member. I can understand the potential for conflict of interest, but I wondered if this was an absolute decree, or subject to consideration if there were valid/potentially valuable applicants from both the healthcare professional and patient/carer groups	Thank you for your comment. Guideline group members are selected from applications received from health professionals or (for patient/carer members) through Patient and Public Involvement Programme at NICE. We have not had experience of this situation and if it arose we would consult with NICE. Generally their advice is that where there is a pre-existing relationship between a patient/carer member and a clinical member of the group, this needs to be taken into account before the selection of either the patient/carer or the health professional is confirmed – it would not automatically be the patient/carer applicant who would not be considered. Given the potential for alliances or divisions (depending on the nature of the relationship) this is an important factor to take into account when planning membership of the group.
SH	Department of Health	1	General	The Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment
SH	National Refractory Angina Centre	1	General	I attended the scoping meeting and I have taken soundings from refractory angina experts (healthcare professionals and patients). There is considerable disquiet about the plans as they stand and we welcome the opportunity to share our views with you.	Thank you for your comment
SH	National Refractory Angina Centre	2	General	The document articulates a somewhat paternalistic model of angina management and which disadvantages patients and lay users (see 3.2 and 4.3.1). This is out of step with the partnership model of medical practice now vigorously promoted by the	Thank you for your comment. The wording of these sections has been altered in the revision of the scope.

				GMC.	
SH	National Refractory Angina Centre	3	General & Composition of the development committee-Pain expertise	The plan to have four cardiologists on the guideline group was discussed at the scoping meeting. This is an angina (ischaemic cardiac pain) management guideline not a coronary artery disease management guideline. The management of coronary artery disease is certainly an important aspect of management but not the only one. Ischaemic cardiac pain (angina and refractory angina) is a visceral pain. The trigger for the pain is myocardial ischaemia but the symptom itself is the result of activation of pain pathways. Like all other chronic pain conditions, the pain pathway plays a major role in determining the patient's experience. Silent infarcts in patients who subsequently go on to develop angina with minimal ischaemia is a good example of how the absence of signal transmission during infarction can be followed by exaggerated signal transmission at a later date. Before the pain is perceived, sense must be made of the 'raw' pain signals and this is highly influenced by the beliefs about the meaning of the pain. This explains why there is poor correlation between coronary narrowings and the patient's experience of angina Pain specialists understand that pain management is more than simply trying to abolish the trigger. Traditional Angina management focuses primarily on treating the underlying trigger (ischaemia) without adequately addressing the rest of the pain processing pathway. Having four cardiologists and no pain specialist would be like inviting four orthopaedic surgeons and no pain doctors to develop back pain guidelines. The British Pain Society was the first society to sponsor guidelines for refractory angina in 1998 and has actively worked towards a coherent management approach since the	Thank you for your comment. We do understand the remit and scope as primarily considering management of people with angina symptoms associated with coronary disease. We do however recognise the importance of interventions which are directed to aspects of care other than management of atherosclerotic disease. The scope has therefore been revised to indicate the inclusion of these interventions. We have agreed with NICE that we may co-opt expertise in pain management. It should be noted that GDG members do not represent professional bodies but bring their expertise to inform recommendations made on the basis of evidence reviews.

				guidelines were first introduced. Their experience would be invaluable. We recommend that the guideline development panel has direct input from a representative of the British Pain Society.	
SH	National Refractory Angina Centre	4	General &Composition of the development committee-refractory angina expertise	It is generally accepted that angina sufferers who do not respond to traditional cardiological approaches represent a growing and difficult management problem. A range of therapies have been developed to manage the multiple problems affecting refractory angina sufferers. We recommend that at least one of the cardiologists on the development group is an expert in refractory angina management.	Thank you for your comment. We have agreed with NICE that we will co-opt expertise in management of refractory angina.
SH	National Refractory Angina Centre	5	General & Consistency with GMC Good Medical Practice and Consent guidelines	It is important that the guideline developers recognise that clinical guidelines must be consistent with doctors' overriding professional responsibility to adhere to current General Medical Council's Good Medical Practice and consent guidelines. These guidelines emphasise the importance of educating patients to enable them to participate in decisions about their care. Patient empowerment through education is a critical aspect of patient centred angina care yet it is not mentioned at all in the scoping document. We recommend this should be addressed, in particular see 1 Guideline title.	Thank you for your comment. The scope outlines the detail of what will be covered in the guideline development process. Principles of care which are important in the treatment of all patients, such as consent, are not detailed in the scope.

SH	National Refractory Angina Centre	6	General & Absence of explicit reference to the critical role of education.	There is reference to low level of factual knowledge among angina sufferers (3.1.b) but there is no mention of education in the section on current practice (3.2). Indeed education is not mentioned at all in the document. This reveals a real problem with current practice and undermines confidence among patients that their needs are not being taken seriously. Poor factual knowledge is the result of poor education. The scoping document talks of 'condition-specific information' (4.3.1 e) but this is not the same as patient education and without explanation can be very misleading. Tailored patient education is an essential part of good clinical practice (as defined by the GMC practice guidelines). In addition education about the condition is recommended at the time of diagnosis and at each stage of treatment by the ESC and AHA stable angina guidelines	Thank you for your comment. The omission of patient education was an error on our part. We have outlined what patient programmes might include and have specified patient education as part of this.
SH	National Refractory Angina Centre	7	General & Absence of explicit reference to patient centred care	Patient centred care is central to good medical practice and yet the scoping document makes no direct reference to the importance of patient centred care.	Thank you for your comment. The scope outlines the detail of what will be covered in the evidence reviews as part of the guideline development process. Principles of care which are important in the treatment of all patients are not detailed in the scope.
SH	National Refractory Angina Centre	8	1	In order to distinguish this guideline from earlier stable angina guidelines that were developed before current General Medical Council's Good Medical Practice and consent guidelines, and to demonstrate NICE's intention to develop guidelines that are internally consistent with modern patient centred principles of care, I urge to committee to consider the value of using the title **"Patient centred management of stable angina"**.	Thank you for your comment. The remit and title of the guideline come from NICE to the NCGC. The NCGC is not in a position to change the title of a commissioned guideline.

SH	National Refractory Angina Centre	9	3.2	A significant component of treatment is, or according to the current ESC stable angina guidelines, should be psychological. The ESC guidelines state that angina is frequently accompanied by anxiety and reasonable reassurance should be given. Similarly, ESC secondary prevention guidelines emphasise the importance of psychological input and we strongly recommendation that a psychologist with experience of angina management should be invited to join the guideline development group.	Thank you for your comment. We have added specific mention of psychological interventions to the Scope. Following discussion with NICE we intend to co-opt experts in psychology or other relevant areas as required by the guideline development group.
SH	National Refractory Angina Centre	10	3 & Clinical need	Refractory angina patients have been seriously neglected. Cardiologists receive no specific training and management is ad hoc and largely dependent on the interests of the clinician. A guideline is desirable to enable patients to obtain optimal care.	Thank you for your comment
SH	National Refractory Angina Centre	11	3.1 a & Epidemi ology	As a subset of angina it seems strange that there is no estimate for the prevalence of refractory angina. It suggests that refractory angina is not being taken seriously.	Thank you for your comment. We have added incidence and prevalence estimates for refractory angina. The section on epidemiology is not intended to be comprehensive.
SH	National Refractory Angina Centre	12	3.2 a & Current practice. Aim of treatme nt.	The guideline will be available to assist patients and healthcare professionals in deciding the best course of action in particular clinical circumstances. The doctor-patient partnership model has emerged to encourage healthcare professionals to share decision making with patients. The problem with the aims, as set out in the scoping document is that it is written by/for healthcare professionals, and is not easily understandable by patients and carers. In addition, as laid out in the current scoping document, the aims may be mutually exclusive. Thus, it is theoretically possible that one patient might choose to compromise life expectancy for quality of life (e.g. statin refusal because of agonising/incapacitating muscle pains), while another might sacrifice quality for quantity (e.g. an incessant cough caused by ACE inhibitors). I urge the committee to consider a simplified, patient-centred aim, written in	Thank you for your comment. NICE clinical guidance is developed for NHS health professionals. NICE publish a corresponding “Understanding NICE Guidance” version of the guideline which summarises the recommendations from the full/NICE versions in everyday language and which is written primarily for patients. NICE has also developed guidance on “Medicines Adherence: involving patients in decisions about medicines and supporting adherence” and this guideline will be referred to as appropriate. Quality of life outcomes will be examined and reported in each review as relevant

				clear language that patients recognise as important to them. This is essential if the guidelines are to be truly useful to patients. Before we set about developing a guideline for refractory angina in 1998, we asked patients what they thought the objective of the guideline should be. There was an overwhelming consensus that their priority was to improve their quality of life and if this could be achieved while extending the length of life, that would be ideal. The guideline should set out an aim that emphasises the critical importance of delivering care tailored to the needs of the individual patient. Any explanatory text should be written in lay language (i.e. not using words like morbidity, pharmacological, revascularisation).	
SH	National Refractory Angina Centre	13	4.3 & Issues to be covered & Refractory angina	The diagnosis of refractory angina is crucial. NICE's track record is not encouraging. The recent NICE guideline on the role of spinal cord stimulation in refractory angina employed a definition that I, as the national expert, did not recognise. It is generally agreed that refractory angina is stable angina that is refractory to optimal medical treatment and where the patient refuses revascularisation or where revascularisation it is technically unfeasible. During the scoping meeting it became clear that the panel did not have a clear idea when angina patients should be diagnosed as suffering with refractory angina and thereby become entitled to refractory angina services. This lack of clarity over the transition between angina and refractory angina is reflected in the failure to estimate the prevalence of the problem (3.1 a) Traditionalists consider that a patient should only have access to refractory angina services when medication fails to control symptoms and revascularisation is technically unfeasible. The patient centred perspective is fundamentally at odds with this. It argues that, consistent with GMC consent guidelines, in order for a patient to decide whether palliative revascularisation is	Thank you for your comment. No view has been taken as to when patients should have access to refractory angina services. NICE guidelines do not make recommendations for service delivery but for interventions. The guideline will examine the evidence for managing all patients and subgroups to establish which management strategies are clinically and cost effective.

				the best option it is necessary for them to be able to consider all the options available, including the treatments that in most regions are only made available to refractory angina patients. Proper consideration should be given to the management of patients with angina despite optimal medical therapy and with minimal coronary artery disease following angiographically successful revascularisation, with and without reversible ischaemia. There are many such patients and management is generally poor. Such patients are highly suited to multidisciplinary refractory angina management programmes.	
SH	National Refractory Angina Centre	14	4.3 & Issues to be covered Syndrome X and similar syndromes	Adequate management advice should be available for patients with syndrome X (angina, ischaemia and normal coronaries)	Thank you for your comment. We have clarified the subgroups which are included in the guideline.
SH	National Refractory Angina Centre	15	4.3.1 e Information Education	All existing angina guidelines emphasise the importance of patient education and even if they did not, education is a necessary stage in empowering a patient to become an active partner in their own care. Factual knowledge among angina patients is poor and this is the direct result of poor education. Cardiac misconceptions are common. The majority of angina sufferers and their carers wrongly believe that angina causes progressive damage to the heart and that angioplasty for stable angina reduces the risk of heart attack. Providing information is not the same as education.	Thank you for your comment. The omission of patient education was an error on our part. We have outlined what patient programmes should include and have specified patient education as part of this.

SH	National Refractory Angina Centre	16	4.3.1 c	The phrase "inform their decisions for individual patients" is revealing. The prescriber's role is to enable the patient to choose whether or not to accept their recommendation and then prescribe it. The language, like so much of the document, reveals a paternalistic theme.	Thank you for your comment. This is standard NICE text which is used, where relevant, in all clinical guideline development. We have altered the wording and brought this issue to the attention of NICE.
SH	National Refractory Angina Centre	17	4.3.1 d & Revasc strategie s	If the panel is serious about 4.4 it will be necessary to separately consider revascularisation for palliation (angioplasty) from revascularisation for prognosis (bypass surgery). A cardiac surgeon should be involved.	Thank you for your comment. The Guideline group will examine the evidence of both these interventions in terms of quality of life and long terms outcomes. The intention is to recruit a cardiac surgeon as a GDG member.
SH	National Refractory Angina Centre	18	4.4 Economi c aspects	This is important and the language used in the scoping document raises important issues that were briefly discussed at the scoping meeting. We agree that guideline developers are able to 'choose' what should and what should not be in a guideline, based on clinical/cost effectiveness criteria. If two interventions, A and B have been considered worthy of inclusion in the guideline, guideline developers cannot go further and insist that treatment A should be chosen in favour of treatment B. The GMC consent guidelines make it clear that the choice between A and B lies with the patient. Doctors are obliged to ensure that the patient understands their condition and all the available options (including no treatment) before the patient chooses which suits their particular circumstances best and gives consent to receive that intervention. The guideline developer can only recommend the order in which treatments should be disclosed.	Thank you for your comment. The guideline development group are required to make recommendations based on criteria of clinical and cost effectiveness. NICE Guidelines are not a substitute for professional judgement nor for full discussion of appropriate treatment options with patients.

SH	National Refractory Angina Centre	19	4.4 Economi c aspects	As discussed above, patient autonomy is enshrined in law and can only be achieved if healthcare professionals deliver tailored education relevant to the patient's particular circumstances. Educating patients is also central to proper patient centred care as defined by the GMC good medical practice guidelines. Consequently no one is seriously challenging the idea that patients should be educated about their condition and the available treatments before choosing one that suits them best. The self-evident necessity of patient education means that there is little research into the cost effectiveness of patient education compared to not delivering education. Patient education is seriously disadvantaged by dint of the fact that it is ... obvious and therefore no QALY estimation exists. To my knowledge there has been no cost impact study of the consequence of not adhering to existing clinical and consent guidelines that require patients to be educated about their condition. However, the costs of not educating patients are likely to be considerable in terms of suboptimal health behaviours (poor adherence to lifestyle advice, medication, invalid consent to avoidable interventions and consequent medicolegal vulnerability).	Thank you for your comment. We agree that all patients have the right to appropriate information to allow them to understand their condition, its management and their treatment options. The Guideline Group will examine specific programmes of education for angina patients.
SH	NHS Direct	1	General	No comments on the content. Guideline welcomed by NHS Direct	Thank you for our comment
SH	Peninsula Heart and Stroke Network	1	General	Fear and Isolation are frequently comments made by cardiac patients therefore I would strongly support the suggestion, made at the Stakeholders meeting, to include psychological issues and patient medication management .	Thank you for your comment. We have changed the wording to more clearly explain what we plan to include regarding patient education and management and have added psychological interventions to the key clinical areas we will examine
SH	Royal College of Nursing	1	General	The RCN welcomes proposals to develop this guideline. The draft scope is comprehensive.	Thank you for your comment

SH	Royal College of Nursing	2	General	What about link to health outcome indicators for patient reported health outcomes / quality of life indicators?	Thank you for your comment. The outcomes will include quality of life outcomes.
SH	Royal College of Pathologists	1	General	The Royal College of Pathologists has no comment on the above named guideline at this stage of the development process.	Thank you for your comment
SH	Sanofi-Aventis	1	General	Please note that having considered the draft scope and matrix for this guideline sanofi-aventis have no comments at this time.	Thank you for your comment
SH	Sheffield PCT	1	4.3.1	It would be helpful if the scope could explicitly incorporate psychological interventions in the management of stable angina. Although the findings of the 2008 Cochrane Review on psychological interventions for CHD were equivocal, it would be helpful to commissioners if NICE could consider the evidence for this relative to that for the other treatment options.	Thank you for your comment. We have added psychological interventions to the key clinical areas we will examine.
SH	UK Clinical Pharmacy Association	1	General	The UKCPA welcomes a NICE guideline on the management of stable angina including the involvement of refractory angina. Specifically within the guideline, we note the consideration of medication adherence and wish to highlight the specific review of medication adherence a crucial aspect within this review. Whilst we are aware of a separate publication by NICE on medication adherence, we feel it imperative that stable angina as a long term condition has much published literature around medication adherence, and would value a specific review of the medication adherence within stable angina.We also welcome the specific mention of patients with multiple morbidities and ethnic minorities as cardiovascular disease is associated with poor social economic factors and in accordance with the proposed QRISK,	Thank you for your comment. The Medicines Adherence guideline is a generic guideline and has reviewed interventions for adherence to medicines. We will cross refer to relevant recommendations in this guideline. Specific interventions for patients with angina will be reviewed as part of education programmes.

				ethnicity is also important and often in association with social economic factors.		