4-year surveillance 2016 – Stable angina: management (2011) NICE guideline CG126

Appendix B: stakeholder consultation comments table

Consultation dates: 3/2/16 – 27/2/16

Type	Stakeholder	Do you agree with the proposal not to update the guideline?	Comments Insert each new comment on a new row	NICE response
SH	A. Menarini	Disagree	A. Menarini supports the consultation on the potential update to CG126 Stable Angina management and welcomes the opportunity to contribute. A. Menarini believes that the guideline requires updating for three key reasons: 1. Significant safety concerns have evolved around certain stable angina medications since the guidelines was last updated: • Ivabradine – A. Menarini supports the recommended guideline addition around the need to inform healthcare professionals involved in the treatment of stable angina about the increase in mortality identified in the SIGNIFY trial (Fox et al. Ivabradine in Stable Coronary Artery Disease without Clinical Heart Failure. N Engl J Med 2014; 371:1091-1099) • Nicorandil – A. Menarini believes there is a requirement to update the guideline with respect to	Thank you for your comment. The SIGNIFY trial has been identified and included in the surveillance review. None of the new evidence is deemed sufficient to change or remove any recommendation in the guideline. However, topic experts agree that the safety risks identified by the SIGNIFY trial need to be acknowledged in the guideline. The surveillance review decision is to add a footnote to the recommendations to make a reference to the drug safety update on ivabradine. The drug safety update on nicorandil has now been added to the decision matrix for the clinical question 'What is the clinical/cost effectiveness of nicorandil for the management of stable angina?' The

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			the MHRA Direct Healthcare Professional Communication letter issued 12 November 2015 on the potential serious health complications and important restrictions to the indications for nicorandil in the treatment of stable angina • Long-acting Nitrates – A. Menarini believes there is a requirement to consider the safety and efficacy concerns around the use of long-acting nitrates in the treatment of stable angina highlighted by Steinhorn et al in the New England Journal of Medicine publication, published in July 2015 (Steinhorn et. Nitroglycerin and Nitric Oxide—A Rondo of Themes in Cardiovascular Therapeutics. NEJM 2015; 373:277-80)	surveillance review decision has been amended to include a footnote to the recommendations to make a reference to the drug safety update on nicorandil. The reference you refer to by Steinhorn 2015 was not included in the surveillance review as it is not a primary study or systematic review so does not meet the surveillance review criteria. All new and relevant evidence on long-acting nitrates was considered during the guideline surveillance review and was not found to affect recommendations.
SH	A. Menarini	Disagree	2. The guideline should be updated to reflect differential medical treatment of stable angina patients with diabetes: • This cohort of patients is estimated to comprise 40 to 60% of the overall stable angina population in England and Wales • This cohort of patients is less suitable for revascularisation due to increased mortality and	Thank you for your comment. The original scope of CG126 includes people with diabetes as a subgroup who may need special consideration. Evidence for this population was considered during the development of the CG126 guideline and during the 4-year surveillance review. Both CG126 and ESC guidelines

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			morbidity as outlined in the ESC guidelines and therefore as a result more dependent on optimal medical therapy for the treatment of their stable angina (2013 ESC guidelines on the management of stable coronary artery disease—addenda. Eur Heart J. ESC Guidelines Addenda; 1-32: www.escardio.org/ static_file/ Escardio/Guidelines/publications/ANGINA2013_ Stable_Coronary_Artery_Disease_web_addenda.pdf) • The 2013 ESC guideline for the management of stable coronary artery disease (stable angina) recognise the need to treat this cohort of patients differently and make recommendations accordingly. (2013 ESC guidelines on the management of stable coronary artery disease. Eur Heart J 2013. doi:10.1093/eurheartj/eht296)	considered the BARI-2D trial results which indicate comparable outcomes with medical treatment or revascularisation for this population. Also, the recommendations in CG126 and the ESC guideline consider ACE inhibitors for people with diabetes and stable angina as secondary prevention treatment (1.3.6). The search dates for the 4-year surveillance review were 10 May 2012 to 26 August 2015. The ESC guidelines in the comment are based on evidence published prior to 2013. The latest evidence found from the surveillance review support the CG126 guideline recommendations to offer medical treatment as first line and consider revascularisation when symptoms are not controlled with medical therapy for this population. The ESC guideline was not included in the surveillance review as surveillance reviews do not consider other guidelines only published primary studies and

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				systematic reviews. Based on the evidence, the surveillance review decision is not to update the recommendations.
SH	A. Menarini	Disagree	3. There have been several significant publications on the treatment of stable angina since the surveillance review cut-off date of 26 August 2015 which should be taken into consideration when making recommendations on the cost-effective treatment of stable angina in England and Wales. Three of relevance are presented below. • Coleman et al. Ranolazine for the treatment of chronic stable angina: a cost-effectiveness analysis from a UK perspective. BMJ Open 2015 Nov 6;5(11):e008861. doi: 10.1136/bmjopen-2015-008861. In this study, ranolazine added to standard care was compared with standard care alone. In conclusion, the analysis suggest ranolazine added to standard care in patients with weekly or daily angina is likely cost-effective from a UK health system perspective. • Page RL et al. Comparative Effectiveness of Ranolazine Versus Traditional Therapies in Chronic	Thank you for your comment. Coleman 2015 has been added to the decision matrix under the clinical question 'What is the clinical/cost effectiveness of ranolazine for the management of stable angina?' The results of this analysis support the recommendations to offer standard therapy as first line and consider an additional drug if symptoms are not controlled with monotherapy (1.4.12). The surveillance review decision remains unchanged from no update in this section. Page 2015 has not been included in the decision matrix as it does not fit the inclusion criteria of the surveillance review. Sedlis 2015 has been added to the decision matrix under the clinical

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			Stable Angina Pectoris and Concomitant Diabetes Mellitus and Impact on Health Care Resource Utilization and Cardiac Interventions; Am J Cardiol 2015;116(9):1321-8.. The major finding of this study of 8008 subjects over 12 months is that patients receiving BBs, CCBs, and LANs experienced a greater need for PCI across all study time points compared to those receiving ranolazine. • Sedlis et al. Effect of PCI on Long-Term Survival in Patients with Stable Ischemic Heart Disease. N Engl J Med 2015;373(20):1937-46. This is a 15 year follow-up of the COURAGE trial of 2287 patients with stable ischaemic heart disease who underwent either optimal medical therapy alone (medical-therapy group) or optimal medical therapy plus PCI (PCI group). At 15 years, there was no difference in survival between the groups.	question 'What is the clinical/cost effectiveness of medical interventions versus PCI in people with stable angina?' The results of this trial support the evidence identified in the surveillance review and the recommendations (1.3.1, 1.3.2, 1.5.1, 1.5.2, 1.5.11–1.5.14). The surveillance review decision remains unchanged from no update in this section.
SH	British Cardiovascular Society	Agree		Thank you for your response.
SH	The Royal College of Physicians	Agree	Email received to confirm that the RCP wishes to endorse the response submitted by the British Cardiovascular Society.	Thank you for your response.

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SH	The Royal College of Pathologists	Agree		Thank you for your response.
SH	NHS England		I wish to confirm that NHS England has no substantive comments to make regarding the update of this guideline.	Thank you for your response.
SH	Royal College of Nursing		No comments to submit	Thank you for your response.

Type	Stakeholder	Do you have any comments on equality issues or areas excluded from the original scope?	NICE response
SH	A. Menarini	A. Menarini believes that the exclusion of recommendations around the treatment of stable angina patients with diabetes presents an equality issue with respect to this sizeable cohort who suffer from a long-term chronic condition. Diabetes is particularly prevalent in Asian and Afro-Caribbean populations within England and Wales.	Thank you for your comment. The original scope of CG126 includes people with diabetes as a subgroup who may need special consideration. Evidence for this population was considered during the development of the CG126 guideline. The surveillance review considered all relevant evidence on treatment of stable angina in people with diabetes and people from different ethnic groups. The surveillance review found no new evidence to suggest a change in the treatment of symptoms of stable angina in people with

			diabetes or in people from different ethnic groups. A recommendation in CG126 states that symptoms of stable angina should not be investigated or treated differently in different ethnic groups (1.3.2). Please see the decision matrix and the full guideline for further information on how the recommendations were reached.
SH	British Cardiovascular Society	I am not aware of any compelling new evidence that has arisen since the initial guideline was written which should result in a change to this guidance. However, there remain several areas of uncertainty in the management of patients with stable angina such as the optimal management of patients with evidence of myocardial ischaemia but few/no symptoms, which patients with little/no angina should undergo myocardial revascularisation to improve their prognosis, and whether or not patients with an abnormal pressure wire assessment should undergo revascularisation of the relevant artery irrespective of symptoms. The contrasting recommendations regarding myocardial revascularisation to improve prognosis from NICE and from the European Society of Cardiology place UK cardiologists in a quandary. Should they refer only patients with left main stem disease and/or proximal three vessel disease for revascularisation as NICE recommends or should they also refer patients with a lower burden of coronary artery disease if the proximal left anterior descending artery is affected, particularly if there is evidence of myocardial ischaemia? Patients with stable angina who have disease involving the proximal left anterior descending artery are less likely to be referred for revascularisation if they are managed according to NICE guidance compared with ESC guidance.	Thank you for your comment. The surveillance review found no new evidence on the optimal management of stable angina in patients with less severe symptoms. The scope of CG126 includes invasive and non-invasive assessments to assess prognosis and plan management for this population. The recommendations (1.5.11 – 1.5.14) consider the use of invasive functional testing to determine the benefit of revascularisation including for people with anatomically less complex disease and for people whose symptoms are controlled with optimal medical treatment. During development of the guideline, the Guideline Development Group made a recommendation that additional testing, including pressure wire assessment, may be required to evaluate angiographic findings and guide treatment decisions. Please see the full guideline for further information on how the recommendations

			were reached. The ESC guideline was not included in the surveillance review as surveillance reviews do not consider other guidelines only published primary studies and systematic reviews, however, this will be considered again at the next surveillance review.
SH	The Royal College of Physicians	Email received to confirm that the RCP wishes to endorse the response submitted by the British Cardiovascular Society.	Thank you for your response.