National Institute for Health and Clinical Excellence

Acute heart failure
Scope Consultation Table
20 July - 17 August 2012

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	4.5	It was suggested that an Intensive Care Nurse would be an asset to the Group and this aspiration should not be disregarded at this stage	Thank you for your comment. We will co-opt an intensive care nurse if needed.
SH	Arrhythmia Alliance	1	general	Arrhythmia Alliance is happy with the proposed scope for consultation on acute heart failure. We would be keen to see that the availability of facilities and technologies for diagnosing acute heart failure become more consistent across the country, ensuring that patients (regardless of where they live) have equal access to treatment options for the condition.	Thank you for your comment.
SH	Atrial Fibrillation Association (AFA)	1	General	AFA has reviewed the draft guidelines and supports the comments and guidance included believing it is full and reflective of all key areas.	Thank you for your comment.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	1	General	There is considerable emphasis on the first 24 hours, and this is important in terms of making an accurate diagnosis which should be confirmed within this period. Early appropriate treatment within this period is also important BUT the subsequent ongoing care and daily review and modification of drugs will contribute as much to the reduction in mortality both as an inpatient and at 12 months. The guidance needs to ensure	Thank you for your suggestion. We will consider this in consultation with the GDG. We are covering specialist management units under 4.3.1c.

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				the entire admission is effective. I think this latter point is not adequately emphasised although there is modest reference to the organisation of care – this needs to take centre stage. Many of the interventions alluded to are important for a few patients (renal replacement, NIV etc) and they may be life saving. However for the generality of patients admitted with acute HF it is addressing organisation of inpatient care throughout the admission which may have the most impact on mortality, readmissions and costs to the NHS.	
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	2	3.1	I am not sure of the data source used for the age and sex of patients admitted to hospital but the data does not appear to reflect what is currently happening in terms of acute HF admissions across England Wales. Here the National HF Audit for 2010-11, which reflects over 36,000 patients admitted with acute heart failure, suggests the average age is rather older than those given in the scope. The mean age at admission is between 75 and 80, rather than the quoted age range of 70 to 75. Men are usually admitted at an age 5 years younger than women – these findings apply to both a first admission and a readmission. Thus there tend to be more men than women admitted until the age of 85 when the pattern reverses.	Thank you for your comment. The scope has been amended accordingly.
SH	British Society	3	3.2	I am a little perplexed by the statement in 3.2a.	Thank you for your comment. The scope has

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	for Heart Failure Royal College of Physicians (London) British Cardiovascular Society			The limitation in diagnosis is around access to diagnostic blood tests and echocardiography alongside Specialist clinical assessment, rather than around methodology, with the need to be as cost effective as possible within the NHS, an additional issue.	been amended accordingly.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	4	4.1.1 b	I would also add specific consideration given to the decompensated CHF – this group may not be so critical but they still need optimum care from the point of presentation. The scope suggests patients with acute RHF are to be included – does it intend to include those with right problems secondary to left heart problems only, or to include those secondary to hypoxic lung disease also and other causes of raised pulmonary pressures? The document needs to be more explicit in this respect. It would seem reasonable not to exclude acute right heart failure due to pulmonary problems but to specify that the guidance would not address the chronic management (as with some of the other categories discussed at the scoping meeting).	Thank you for your comment. We intend to include acute decompensated heart failure and have amended the scope accordingly. We realise that there are many different opinions about subcategories of acute heart failure. We intend to focus on four main groups (acute heart failure with pulmonary oedema, cardiogenic shock, acute right-sided heart failure and acute decompensated heart failure to include those patients with peripheral fluid overload) in the scope.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	5	4.3.1	The scope says it will address patients with acute right sided heart failure - if this is to include those with primary hypoxic lung disease there should be reference to long term oxygen therapy. If it is not the intention to include those patients it should be explicit under 4.1 (see also earlier comments). An alternative is simply to include this group in the acute care but to omit	Thank you for your comment. We will not be covering the chronic management of right-sided heart failure.

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				chronic management.	
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	6	4.3.1 c	It needs to be quite explicit that settings for care describes the entire inpatient stay – you might choose to add something here on organisation of inpatient care, and to include access to health care personnel.	Thank you for your comment. We have included specialist management units under 4.3.1c in the scope to consider the entire inpatient stay.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	7	4.3.1 e	This should also include specific reference to diuretic use, including time and mode (IV, oral, bolus or infusion) of delivery	Thank you for your suggestion. We will consider this in consultation with the GDG.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	8	4.3.1 h	This should also include something around optimisation of these medications – in the scoping document there is reference to the chronic HF guidance but in the hospital setting ACEI, beta-blockers and aldosterone antagonists can be introduced much more rapidly and the sequence may vary. The HF audit tells us that the drugs at discharge correlate well with 12 month mortality outcomes as do drug dosage.	Thank you for your suggestion, we will consider this in consultation with the GDG.
SH	British Society for Heart Failure Royal College of Physicians (London)	9	4.3.1 k	Organisation of care - there should be specific reference to this throughout the inpatient stay. To some extent the transition to primary care and community involvement is covered by the chronic HF guidance and the related NICE Quality	Thank you for your comment. We have amended the scope to cover hospital and community settings. We are covering specialist management units under section 4.3.1c in the scope. Post-discharge management is covered

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	British Cardiovascular Society			standards. It would be useful to flag the role of cardiology follow up alongside Primary care and community input.	in the existing NICE clinical guideline on chronic heart failure.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	10	4.4 c	I would specify early readmissions rather than all readmissions – there is growing evidence that timely readmissions amongst survivors can be life transforming whereas early readmissions suggest less than adequate care during the index admission. Cumulatively LOS and repeated admissions will together provide bed days, however a longer index admission may translate into reduced bed usage which may not emerge if LOS alone is considered.	Thank you for your comment. This section lists the main outcomes. We will specify the details, such as length of outcome follow-up, in the review protocols.
SH	British Society for Heart Failure Royal College of Physicians (London) British Cardiovascular Society	11	6	You might wish to include reference to the NICE HF Quality Standards for CHF here.	Thank you for your comment. We will include reference to the NICE quality standards on heart failure in the scope.
SH	Cardiomyopathy Association	1	3.2 a	We need to see clearer agreement between healthcare professionals on the best combination of methods to diagnose the condition as there is with chronic heart failure management	Thank you for your comment. We will address this.
SH	Cardiomyopathy Association	2	4.4 e	Under Quality of Life we are very keen to see cardiac rehabilitation and patient support strategies given a high priority	Thank you for your comment. This section lists the main outcomes. We will specify the details, such as the particular aspect of quality of life, in the review protocols.
SH	Cardiomyopathy	3	general	We would like to see patients given more advice	Thank you for your comment. This is covered in

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	Association			about when and how to take their various drugs.	the existing NICE clinical guideline on chronic heart failure. There is also NICE guidance available on Medicines adherence which provides advice on this topic.
SH	Department of Health	1	3.1 b	Regarding the epidemiological statement "Acute heart failure can be grouped into the following categories: acute heart failure with pulmonary oedema, cardiogenic shock and acute right-sided heart failure", I would point out that pulmonary oedema may not necessarily be detectable clinically (on examination) and so by this "grouping" patients without clinically apparent pulmonary oedema might be considered not to have acute heart failure and may therefore fall outside the scope. I would suggest that the statement might better read: *"Acute heart failure can be grouped into the following categories: acute* ***left*** *heart failure (with* ***or without clinically overt*** *pulmonary oedema), cardiogenic shock and acute right-sided heart failure"*. Also, section 4.1b refers to *"specific consideration being given to.."* and then uses the same wording as in 3.1b. In other words, it implies that special consideration will be given to patients with acute heart failure, which seems a tautology given that the guideline's whole purpose is to consider this.	Thank you for your comment. We realise that there are many different opinions about subcategories of acute heart failure. We intend to focus on four main groups (acute heart failure with pulmonary oedema, cardiogenic shock, acute right-sided heart failure and acute decompensated heart failure to include those patients with peripheral fluid overload) in the scope. We acknowledge that pulmonary oedema might be missed and the guideline will aim to optimise correct recognition. In section 4.1b subgroups are specified since different treatments may only apply to certain categories of patients.
SH	Department of Health	2	3.2 d	This is poorly worded, and could be rewritten to give greater clarity.	Thank you for your comment. This section has been re-written for greater clarity.

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SH	Department of Health	3	4.3.1 f	Whilst it is not really renal support, I wonder whether the GDG are planning to consider the technique of ultrafiltration (a means of removing fluid) or whether they consider this only a technique for use in chronic heart failure? Also, whilst infrequently used, acute venesection can be used in the emergency treatment of severe acute heart failure and I wonder whether the GDG might consider commenting on this, although the scientific evidence for its use will probably be non-existent.	Thank you for your comment. We have amended the scope to clarify that we will cover ultrafiltration. Since the frequency of acute venesection is small it was not seen as a priority to be included in the scope.
SH	Department of Health	4	4.3.1 g	They refer to mechanical support with intra-aortic balloon pumps but I wonder if they should re-phrase this to read *"**such as circulatory pumps** and ventricular assist devices"* to give them the option to consider other percutaneous support devices such as the Impella, as well as intra-aortic balloons.	Thank you for your comment. We feel there is variation in practice regarding intra-aortic balloon pumps. Due to the rarity of use of other circulatory pump devices we do not consider these to be a priority in the scope.
SH	Department of Health	5	General	I would congratulate the GDG in taking on such a broad scope, and would simply reflect that the evidence base for some of these topics could be very large so they need to feel sure that it is manageable.	Thank you for your comment.
SH	East & North Hertfordshire NHS Trust	1	3.1	I completely agree with taking the viewpoint of an Emergency Department presentation. We do see a few malignant hypertensive cases, but categories I (Acute heart Failure with Pulmonary	Thank you for your comment. We realise that there are many different opinions about subcategories of acute heart failure. We intend to focus on four main groups (acute heart failure

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				Oedema) and II (Cardiogeneic Shock) are easily definable populations in the ED. 'Acute Right-Heart Failure' is an entity that rarely exists in isolation and is mainly a component of (sub)massive PE (and its guideance). I am glad to see that there is no sugegstion of sub-categorising into 'Systolic Dysfunction' and 'Diastolic Dysfunction' - which ultimately by presentation are usually both in existence to a degree.	with pulmonary oedema, cardiogenic shock, acute right-sided heart failure and acute decompensated heart failure to include those patients with peripheral fluid overload) in the scope. We acknowledge that acute right-sided heart failure is uncommon and we recognise that the management is distinct from the other presentations.
SH	East & North Hertfordshire NHS Trust	2	3.2	It may be better to consider the split between Pre-Hospital (which would include Primary Care setting) and Hospital settings. The pre-hospital / emergency medical services research (often overlooked) is compelling and indicates a clear consequence of inaccurate diagnosis / treatment. It can be difficult to disinguish pulmonary oedema in a COPD patient from a non-infective / infective exacerbation without clear pyrexia: Giving Furosemide / Morphine for 'pulmonary oedema' has a clear mobidity/mortality consequence even if the diagnosis is accurate, and worse if patients are mis-diagnosed as acute heart failure (viz being given Nitrates). Conversely, patients with acute heart failure mis-diagnosed as an exacerbation of airways disease and given bronchodilators will not be significantly disadvantaged. Pre-hospital consideration also provides the platform to consider the benefits of NIV.	Thank you for your comment. The scope has been amended to cover hospital and community settings.

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SH	East & North Hertfordshire NHS Trust	3	4.2	As with 3.2 - Pre-Hospital / Hospital management would be a better categorisation - to involve the emergency services etc	Thank you for your comment. We have amended the scope to cover hospital and community settings.
SH	East & North Hertfordshire NHS Trust	4	general	The 'traditional' emergent treatment for acute heart failure still includes immediate / early use of Furosemide (fortunately Morphine usage has declined) with an abundancy of evidence to indicate that it should really be a 3rd line / delayed intervention. Ealy Nitrates +/- ACE Inhibitors should be the mainstay of treatment (+/- NIV). ~50% of patients are euvolaemic - the use of diuretics is either inappropriate or used in excess... Morphine/Opiates have no role outside of a requirement for analgesia for chest pain etc.	Thank you for your comment. We intend to cover all these issues.
SH	East & North Hertfordshire NHS Trust	5	general	Please find below a partially referenced series of slides for Acute Heart Failure management in the ED from August 2010 (selected slides only. Clearly some items - such as opiate use etc are now not considered 1st line etc) for your consideration. I appreciate that scope has already been defined - but I hope that these items can be considered. This does not include references to intra-aortic interventions, specific treatments for arrythmias / ACS / AMI / tamponade etc or ultrafiltration as is really concentrating on the point of contact in community / ED.	Thank you for sending these slides. These have been helpful.

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SH	ELCENA JEFFERS FOUNDATION	1	general	We agree with the whole document and look forward to working with you.	Thank you for your comment.
SH	Faculty of Sport and Exercise Medicine	1	3.2 a and c	Should the areas of agreement be stressed rather than mention differences?	Thank you for your comment. The guideline addresses areas of current variation in practice. This is why differences are highlighted here.
SH	Faculty of Sport and Exercise Medicine	2	4.1.1 a	The age of transfer of adult congenital patients from paediatrics is 16 years. They like pregnant patients have particular challenging problems. Should the age be 16 or over?	Thank you for your comment. Under-18s represent a very small percentage of the overall acute heart failure population and we cannot cover all age groups. The scope will cover adults 18 years and older.
SH	Faculty of Sport and Exercise Medicine	3	4.3.1	Should arrhythmias be be mentioned or are they covered by general investigations.	Thank you for your comment. Acute heart failure due to arrhythmias is not excluded from the scope.
SH	MHRA	1	general	We will not be commenting on the draft scope.	Thank you for your comment.
SH	NHS Improvement	1	General	The draft scope talks about 'heart failure' as though it was a diagnosis in itself, whereas it is an end result of a number of different cardiac conditions. The danger of this approach is that the clinicians managing the condition may not realise that they should be looking for a diagnosis as well as managing the acute deterioration. The true underlying diagnosis should be looked for in all patients and in a proportion the management of the underlying diagnosis is more important than the heart failure that results from it (eg infective endocarditis).	Thank you for your comment. The diagnosis of underlying cause of acute heart failure is a key element of the guideline.
SH	NHS Improvement	2	4.3.1 e	I am not sure if nitrates are included in vasodilators	Thank you for your comment. Vasodilators include nitrates.
SH	NHS Improvement	3	4.3.1 g	Is there a place for CRT (P/D) devices also here?	Thank you for your comment. Please see section 5.1.3 which refers to the NICE technology

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					appraisal guidance TA120 (2007) *'Cardiac resynchronisation therapy for the treatment of heart failure'*. Please refer to the NICE website for updates on the review status of this appraisal.
SH	NHS Improvement	4	4.3.1 c	Settings for management should include home. Increasingly where there is a strong community heart failure service patients can be managed at home (even with intravenous diuretics at home) by heart failure specialist nurses. Patients arriving in A&E depts. may be sent home to be looked after by the HF community team if their underlying disease is understood and they are already known to the service. This also brings in end-of-life care and the patient's wishes to be admitted to hospital.	Thank you for your comment. We have amended the scope to cover hospital and community settings.
SH	North Trent Network of Cardiac Care	1	General	Seems fairly equitable	Thank you for your comment.
SH	North Trent Network of Cardiac Care	2	General	Wasn't able to contribute as much as I wanted to due to the medical and technical terminology used throughout – not my normal language	Thank you for your comment.
SH	North Trent Network of Cardiac Care	3	4.1.1	fine	Thank you for your comment.
SH	North Trent Network of Cardiac Care	4	4.1.2	fine	Thank you for your comment.
SH	North Trent Network of Cardiac Care	5	4.2	Scope should be inclusive of residential care/nursing homes /care in the community/GP practices	Thank you for your comment. We have amended the scope to cover hospital and community settings.
SH	North Trent	6	4.3.1 a	Timeliness is a key issue which should be	Thank you for your comment. We recognise this

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	Network of Cardiac Care			specifically addressed within the scope	is an important issue and will consider it in the development of the guideline.
SH	North Trent Network of Cardiac Care	7	4.3.1 b	The effects of this interfering with the pts quality of life needs to be considered within the scope	Thank you for your comment. Quality of life will be an outcome that we will consider for all review topics.
SH	North Trent Network of Cardiac Care	8	4.3.1 c	Economic considerations of mobile/peripatetic specialists and utilisation of ambulance/emergency response teams need to be considered within the scope	Thank you for your comment. Mobile/peripatetic specialists will not be covered in the scope.
SH	North Trent Network of Cardiac Care	9	4.3.1 e	The timing and frequency of monitoring needs to be included within the scope	Thank you for your comment. Level of monitoring will include timing and frequency.
SH	North Trent Network of Cardiac Care	10	4.3.1 f	The need for early investigation and continued monitoring to be included within the scope	Thank you for your comment. We intend to cover early investigation and monitoring in section 4.3.1 a and b.
SH	North Trent Network of Cardiac Care	11	4.3.1 h	Regular monitoring to ensure early identification and minimise unwelcomed drug side effects to be included within the scope	Thank you for your comment. Monitoring is covered in the scope under 4.3.1b.
SH	North Trent Network of Cardiac Care	12	4.3.1 i	Cost benefit analysis vs quality of life should be considered	Thank you for your comment. We will review the economic evidence available for this section.
SH	North Trent Network of Cardiac Care	13	4.3.1 j	this is an important issue within the scope it is likely to be more economic and improve quality of life	Thank you for your comment.
SH	North Trent Network of Cardiac Care	14	4.3.1 k	The effects of transfer on primary care teams and carers should be within the scope.	Thank you for your comment. Post-discharge management is covered in the chronic heart failure guideline.
SH	Novartis Pharmaceuticals	1	3.1 b	The AHF categories do not seem to be comprehensive (quid AHF in the absence of symptomatic overload). Also, maybe 'acute heart	Thank you for your comment. We have added decompensated heart failure. We think the categories are now comprehensive. We will

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				failure with pulmonary oedema' can be changed into 'acute heart failure with dyspnoa'?	consider patients with dyspnoea.
SH	Novartis Pharmaceuticals	2	3.2 a	We feel that obtaining family history is an important component of the diagnosis	Thank you for your comment. We assume that there is no variation in current practice and that family history would routinely be collected. Therefore it is not included in the scope.
SH	Novartis Pharmaceuticals	3	3.2 c	We feel that 'There is a difference of opinion among healthcare professionals about the use of 'should be replaced with 'there is a lack of evidence and a difference of opinion among...'	Thank you for your comment. Unless we have searched for the evidence we want to refrain from making such a statement.
SH	Novartis Pharmaceuticals	4	3.2 d	'hypotension': could you please clarify what threshold NICE would consider for hypotension?	Thank you for your comment. This section has been re-worded and 'hypotension' is no longer mentioned.
SH	Novartis Pharmaceuticals	5	4.1.1 a	We feel it would be appropriate that patients with co-morbidities (such as hypertension, chronic kidney disease, diabetes etc..) need to be included	Thank you for your comment. These groups are not excluded from the scope (only the long-term management of comorbidities is excluded).
SH	Novartis Pharmaceuticals	6	4.2 a	We think that this needs to be further separated in emergency care and hospital care settings	Thank you for your comment. We have amended the scope to cover hospital and community settings. We will focus on the emergency management available in these settings.
SH	Novartis Pharmaceuticals	7	4.3.1 e	'drug therapy': could it be considered to add 'and new drugs in development for Acute Heart Failure'?	Thank you for your comment. NICE clinical guideline recommendations will normally fall within licensed indications. Exceptionally, and only if clearly supported by evidence, use of a drug outside a licensed indication may be recommended.
SH	Novartis Pharmaceuticals	8	4.3.1 h	'drug therapy': could it be considered to add 'and new drugs in development for Acute Heart Failure'?	Thank you for your comment. NICE clinical guideline recommendations will normally fall within licensed indications. Exceptionally, and

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					only if clearly supported by evidence, use of a drug outside a licensed indication may be recommended.
SH	Novartis Pharmaceuticals	9	4.3.1 h	'ACE inhibitors': would it be considered to change that into 'RAAS inhibitors'. This way ACE inhibitors, ARBs and MRAs would be included. In addition, pharmacological treatment of acute decompensation of chronic heart failure should be included in this section.	Thank you for your comment. The existing NICE clinical guideline on Chronic heart failure prioritised use of ACE inhibitors over ARBs. We will cross-refer to this guidance. We are focusing on ACE inhibitors, beta-blockers and MRAs post-stabilisation.
SH	Novartis Pharmaceuticals	10	4.3.1 k	the scope should consider transition of care from emergency to ICU/CCU or admission to cardiology ward. It would also be important to focus on patient education on HF and post discharge management	Thank you for your comment. We are covering specialist management units under section 4.3.1c in the scope. Post-discharge management is covered in the existing NICE clinical guideline on chronic heart failure.
SH	Novartis Pharmaceuticals	11	4.4	We feel it would be appropriate to include 'days alive out of hospital' and 'renal function' when measuring outcomes.	Thank you for your comment. This section lists the main outcomes. We will specify the details, or any additional outcomes, in the review protocols.
SH	Novartis Pharmaceuticals	12	4.4 a	Could it be specified which mortality is to be measured – CV or all cause, as well as the timeframe after admission (30 day, 60 day, 6 months etc...)	Thank you for your comment. This section lists the main outcomes. We will specify the details, such as length of outcome follow-up, in the review protocols.
SH	Novartis Pharmaceuticals	13	4.4 c	'Length of stay' needs to be specified according to the ward type/department and the 'underlying condition' that might have caused the admission (for example in a case of an acute coronary syndrome event)	Thank you for your comment. This section lists the main outcomes. We will specify the details, such as type of department, in the review protocols.
SH	Novartis Pharmaceuticals	14	4.4 e	We feel that 'quality of life' data should be collected as close as possible to the admission as impact of therapy is mostly seen in the first few hours. It's also important to collect this data	Thank you for your comment. This section lists the main outcomes. We will specify the details, such as length of outcome follow-up, in the review protocols.

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				over time but this can be a difficult task. How are you planning to gather any long term information?	We use the available evidence; it is not possible to collect quality of life data ourselves.
SH	Novartis Pharmaceuticals	15	4.5	We feel it is important to have length of stay data from different ward to have a better idea of the cost burden of acute heart failure	Thank you for your comment. Length of stay data will be part of the economic considerations/evidence when comparing different strategies. However, the aim of the economic review and analysis in the guideline is not to provide an estimate of the cost burden of the disease.
SH	Orion Pharma (UK) Ltd	1	General	European Guidance on this subject has been published. We would recommend that the European Society of Cardiology (ESC) guidance on the treatment of Acute Heart Failure be considered during this review. http://www.escardio.org/guidelines-surveys/esc-guidelines/Pages/acute-chronic-heart-failure.aspx	Thank you for your comment. We are taking this into consideration.
SH	Pfizer	1	4.3.1 h	Pfizer welcome the inclusion of mineralocorticoid receptor antagonists in the draft scope. To address one of the research recommendations in CG48 (What is the clinical and cost effectiveness of treatment with spironolactone compared with eplerenone in patients with heart failure early after an MI?) research from York University, published in May 2010, shows that compared with usual care alone, eplerenone is more cost effective in a post-MI heart failure patient population, whereas	Thank you for your comment. We intend to cover MRAs in this section.

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				spironolactone was not. We hope that this evidence is considered in this guideline, as it was no mentioned in the recent update the clinical guideline for secondary prevention of MI.	
SH	Pfizer	2	4.3.1 k	Pfizer welcome the inclusion of organisation of care as a key issue in the draft scope, specifically the transition from hospital to primary care after the acute phase. Pfizer suggest that medicines optimisation (that is to say, guidance to ensure that patients receive the optimal dose of all prescribed medicines, perhaps through the development of a minimum information requirement for discharge summaries) should be a priority area of consideration for this section. If the optimal doses of ACE-inhibitors and beta-blockers are not achieved, for instance, the opportunity to initiate a mineralocorticoid receptor antagonist may be lost.	Thank you for your comment. Discharge planning and optimisation of medicines is covered in the existing NICE clinical guideline on chronic heart failure and we will be cross-referring to this guidance.
SH	Pfizer	3	4.5	It will be important to account the patent expiry of eplerenone in 2014 in any economic analyses of mineralocorticoid receptor antagonists. Failure to account for expected changes in pricing will lead to decisions based on unrealistic analyses.	Thank you for your comment. We use up-to-date data and cannot foresee changes in cost. Therefore, the current prices of all drugs and treatments will be used. Sensitivity analyses could be conducted to explore the impact of the changes in cost to the results and conclusions of original analyses.
SH	Royal Brompton	1	3.1 b	This simple classification does not include one of	Thank you for your comment. We intend to

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	and Harefield NHS Trust			the most common forms of acute (decompensated) heart failure - where the patient has large amounts of peripheral fluid retention but the underlying cause is left heart failure (not right). Acute right sided failure is very uncommon and usually relates to either RV infarction or massive pulmonary embolism – this could be included but the scope MUST also include the class of patients with peripheral fluid retention due to LV dysfunction - 40 years ago this was termed right heart failure, but this is most usually not the cause. Suggest the following categories: pulmonary oedema, peripheral fluid retention, cardiogenic shock, and acute right ventricular failure.	include acute decompensated heart failure and have amended the scope accordingly. We realise that there are many different opinions about subcategories of acute heart failure. We intend to focus on four main groups (acute heart failure with pulmonary oedema, cardiogenic shock, acute right-sided heart failure and acute decompensated heart failure to include those patients with peripheral fluid overload) in the scope.
SH	Royal Brompton and Harefield NHS Trust	2	3.1 c	UK epidemiology suggests average age is now between 75 and 80, not 70 and 75.	Thank you for your comment. The scope has been amended accordingly.
SH	Royal Brompton and Harefield NHS Trust	3	3.2 c	'Emergent' is a rather old fashioned term and not quite what is meant here – presumably you actually mean the 'acute' phase, or when care is delivered as an emergency?	Thank you for your comment. The scope has been amended accordingly.
SH	Royal Brompton and Harefield NHS Trust	4	4.1.1 b	See coment to 3.1 c) – this needs to be corrected, otherwise the old fashioned nomenclature of 'right sided failure' will be applied to anyone with peripheral fluid retention and raised JVP – in 90% of cases this is due to LV failure.	Thank you for your comment. We realise that there are many different opinions about subcategories of acute heart failure. We intend to focus on four main groups (acute heart failure with pulmonary oedema, cardiogenic shock, acute right-sided heart failure and acute decompensated heart failure to include those patients with peripheral fluid overload) in the scope.

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SH	Royal Brompton and Harefield NHS Trust	5	4.3.1 a	Natriuretic peptide is a blood test, but can be done in the laboratory or as a near patient test. Would be better just to state that the scope includes blood tests (biochemistry, full blood count, natriuretic peptides) and not to narrow down to 'laboratory' tests.	Thank you for your comment. The scope has been amended accordingly.
SH	Royal Brompton and Harefield NHS Trust	6	4.3.1 b	Invasive monitoring should also mention pulmonary artery catheter, as this is mentioned earlier in the scoping document	Thank you for your comment. The scope has been amended accordingly.
SH	Royal Brompton and Harefield NHS Trust	7	4.3.1 d	O2 therapy is not always necessary, so statement needs to include guidance as to how and when it is appropriate to use supplementary oxygen, ventilatory support (CPAP), or non-invasive (NIPPV) or invasive ventilation.	Thank you for your comment. The scope has been amended accordingly.
SH	Royal Brompton and Harefield NHS Trust	8	4.3.1 g	Should also include advice on when to refer for transplantation or VAD as bridge to transplant (VAD is not permitted as destination therapy currently in the UK).	Thank you for your comment. A recommendation for specialist referral for transplantation is included in the chronic heart failure guideline. Advice on referral will be considered by the GDG. Other NHS guidance on transplantation is already available.
SH	Royal Brompton and Harefield NHS Trust	9	4.3.1 h	Drug therapy at stabilisation applies equally to new onset as to decompensated chronic heart failure – optimisation needs to occur so 'new-onset' needs to be removed.	Thank you for your comment. We have amended the scope accordingly. In this section we did not include people with decompensation of chronic heart failure since their treatment would be covered by the chronic heart failure guideline.
SH	Royal College of Nursing	1	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is timely. The draft scope seems comprehensive.	Thank you for your comment.

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	Royal College of Nursing	2	4.1.1 b	Perhaps the specific consideration should include Valvular heart disease?	Thank you for your comment. Acute heart failure due to valvular heart disease is not excluded from the scope.
SH	South Asian Health Foundation	1	General	The variability in approach to managing acute heart failure makes this an important guideline to produce and we commend NICE for taking this on.	Thank you for your comment.
SH	South Asian Health Foundation	2	General	It must be stressed that heart failure is a syndrome and not a diagnosis and therefore one must strive to diagnose the cause of heart failure as early as possible, then treat not only the consequences of the heart failure syndrome, but the aetiology and precipitants of the syndrome. Too often the consequences are treated but the aetiology and precipitants are not, which provides a suboptimal level of care. We believe the acute HF guideline should explicitly differentiate between aetiology, precipitant and the HF syndrome per se.	Thank you for your comment. The diagnosis of underlying cause of acute heart failure is a key element of the guideline.
SH	South Asian Health Foundation	3	General	Outcomes are improved when patients are managed by those expert in the field of HF and therefore we believe the guideline should identify when patients should be referred to a cardiologist with a specialist interest in HF.	Thank you for your comment. We intend to cover specialist management in 4.3.1c.
SH	South Asian Health Foundation	4	4.3.1	Just as coronary revascularisation is identified as a treatment after stabilisation, there are many other causes for decompensation which require identification and treatment too e.g. arrhythmias, hypertension, non cardiac causes etc. These should be listed in order to guide optimal care.	Thank you for your comment. Patients with acute heart failure due to these causes are not excluded from the scope.

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SH	University of Glasgow	1	General – drugs	Diuretics The most commonly used drugs in acute heart failure. Initially given intravenously. The questions re IV diuretics are: a) route – IV bolus or continuous IV infusion b) dose – what daily dose compared to background oral dose (if on regular diuretic). In patients not responding to IV diuretics, one approach is to add an oral diuretic acting on a different part of the kidney tubule to amplify the dieresis. Which one and how much?	Noted. Thank you for your comment.
SH	University of Glasgow	2	General – drugs	Nitrates Many guidelines recommend the routine addition of intravenous nitrate (glyceryl trinitrate/nitroglycerin or isosorbide dinitrate) to diuretics. Is there evidence to justify this i.e. are meaningful clinical outcomes improved? If so, is this in all patients or selected patients? Who should get and when i.e. what signs, symptoms, clinical findings are an indication for these drugs? How should they be used (dose, duration, monitoring, adverse effects)?	Noted. Thank you for your comment.

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SH	University of Glasgow	3	General – drugs	Oxygen Although oxygen is often routinely administered to patients with heart failure, it is known to have potentially harmful haemodynamic effects and should probably be used more selectively. Is this correct? Who should get oxygen – what are the indications?	Noted. Thank you for your comment.
SH	University of Glasgow	4	General – drugs	Dobutamine (and other inotropic drugs?) These drugs are usually a last resort for patients with a low blood pressure or shock. Who should get and when i.e. what signs, symptoms, clinical findings are an indication for these drugs? How should they be used (dose, duration, monitoring, adverse effects)?	Noted. Thank you for your comment
SH	University of Glasgow	5	General – drugs	Dopamine This drug is often used in low ("renal") doses (by intravenous infusion) to stimulate urine production. Does it work? Who should get it and when i.e. what	Noted. Thank you for your comment

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				signs, symptoms, clinical findings are an indication for this drug? What dose? How long for? How should it be used (dose, duration, monitoring, adverse effects)?	
SH	University of Glasgow	6	General – drugs	Norepinephrine/epinephrine These drugs may be last resort for patients with a low blood pressure or shock. Who should get and when i.e. what signs, symptoms, clinical findings are an indication for these drugs? How should they be used (dose, duration, monitoring, adverse effects)?	Noted. Thank you for your comment
SH	University of Glasgow	7	General – drugs	Background regular drugs In patients taking regular medication for heart failure, should any treatments be altered if acute worsening of heart failure occurs e.g. reduce dose of or withhold a beta-blocker (a commonly asked clinical question)?	Thank you for your comment. We intend to address this issue in the guideline.
SH	University of Glasgow	8	General – drugs	Medication for chronic heart failure/long-term	Thank you for your comment. The management of chronic heart failure is the topic of the existing

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				secondary prevention If a patient has newly diagnosed HF and got over the acute episode, what chronic disease modifying treatments should be started before discharge? What doses should be aimed at?	NICE clinical guideline on chronic heart failure, and is outside the scope of this guideline on acute heart failure.