Key: SH = stakeholder, NICE=internal,

National Institute for Health and Clinical Excellence

Acute Chest Pain Consultation Table
14th September – 12th October 2007

Type	Stakeholder	No.	Section number	**Comments** Please insert each new comment in a new row.	**Developer's Response** Please respond to each comment
SH	Abbott Vascular			This organisation was approached but did not respond.	No response needed.
SH	Action Heart	1	4.3.1e	Action Heart would encourage the Institute to include in this section (if not already intended) the education of the general public with respect to recognising chest pain of potentially cardiac origin. It is accepted that the delay in the call for help of individuals with chest pain is still a major concern and it may be helpful to identify 'organisational' responsibilities for spreading the required education/information.	This was discussed in the preparation of the Scope and we have noted the specific need for information for patients, in particular the information to be given on action for any subsequent chest pain/discomfort. However, this is a clinical guideline and does not have the remit for a wider public health message.
SH	Addenbrookes Hospital, Cambridge University Hospital NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	Aintree University Hospitals NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.
SH	Ambulance Service Association			This organisation was approached but did not respond.	No response needed.
SH	Arrhythmia Alliance			This organisation was approached but did not respond.	No response needed.
SH	Association for Clinical Biochemistry			This organisation was approached but did not respond.	No response needed.
SH	Association of the British Pharmaceuticals Industry,(ABPI)			This organisation was approached but did not respond.	No response needed.
SH	AstraZeneca UK Ltd	1	General	Following discussion at the stakeholder meeting on 24.09.07, and similarly to the ACS guidelines, AstraZeneca would like to highlight the comments made regarding consistency of available guidelines. As mentioned there are already numerous guidelines available in this treatment area and AstraZeneca supports integration of these NICE ACP guidelines into existing treatment guidelines already available – for example the ALS, pre-hospital, ambulance, ESC and also the AHA guidelines.	We will work to usual NICE processes and will ensure consistency where appropriate.
SH	AstraZeneca UK Ltd	2	General	AstraZeneca welcomes the suggested close working between the two GDGs relating to the ACP and ACS guidelines – this will be essential to ensure that NICE provides consistent clinical recommendations in this area. We suggest that the ACP guidelines focus on the pre-hospital and hospital care setting, whilst the ACS guidelines focus on initial management and subsequent hand-over to primary care.	Noted and the specifics of the overlap and working remits will be agreed in detail between the groups.
SH	Avon, Gloucestershire & Wiltshire Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Bard Electrophysiology			This organisation was approached but did not respond.	No response needed.
SH	Barnsley Hospital NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.

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SH	Bedfordshire PCT			This organisation was approached but did not respond.	No response needed.
SH	BHF Care & Education Research Group, University of York	1	General	The scope appears to concentrate on people presenting with acute chest pain of very recent duration (people with ?Acute Coronary Syndrome [ACS]). However, at the scope meeting it was stated that the scope should cover people with chest pain of a far longer duration who are likely to be referred to Rapid Access Chest Pain Clinic through general practice. Yet the assumption was that this guideline should feed directly into the new ACS guideline. This gives a confusing message. The title of the guideline should be changed from "acute chest pain" if it is to include people with more medically stable symptoms. The length of time since onset of chest pain symptoms that the guideline will cover should perhaps be made overt.	The GL will include assessment of people with more stable chest pain/discomfort which may be cardiac, but for which a diagnosis has not yet been made, as well those with acute chest pain/discomfort. We have also revised the title accordingly to reflect this (recent onset).
SH	BHF Care & Education Research Group, University of York	2	4.3.1 (d and e)	For patients who do not become part of the acute coronary syndrome pathway (i.e. those assessed as having stable angina) the role of angina management programmes (such as the Angina Plan) or cardiac rehabilitation programmes should be made overt.	The management of stable angina is outside the remit of this guideline, noting that angina may be a future topic for a clinical guideline.
SH	BHF Care & Education Research Group, University of York	3	4.3.1 (d and e)	For patients who do not become part of the acute coronary syndrome pathway (i.e. those assessed as having stable angina) the role of primary care secondary prevention programmes should also be explored.	The management of stable angina is outside the remit of this guideline, noting that angina may be a future topic for a clinical guideline.
SH	Birmingham, Sandwell and Solihull Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Black Country Cancer and Cardiac network			This organisation was approached but did not respond.	No response needed.
SH	Black Country Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Boehringer Ingelheim Ltd			This organisation was approached but did not respond.	No response needed.
SH	Bolton Council			This organisation was approached but did not respond.	No response needed.
SH	Boston Scientific Limited	1		Boston Scientific has no comments to make on the Chest Pain clinical guideline draft scope.	Noted with thanks.
SH	Bristol-Myers Squibb Pharmaceuticals Ltd			This organisation was approached but did not respond.	No response needed.
SH	British Association for Counselling and Psychotherapy (BACP)			This organisation was approached but did not respond.	No response needed.
SH	British Association of Cardiac Rehabilitation			This organisation was approached but did not respond.	No response needed.
SH	British Association of Stroke Physicians (BASP)			This organisation was approached but did not respond.	No response needed.
SH	British Cardiac Patients Association			This organisation was approached but did not respond.	No response needed.
SH	British Cardiovascular Society	1	4.3.1b	Consideration should be given to alternatives to myocardial perfusion imaging, particularly stress echocardiography and cardiac magnetic resonance imaging. Stress echocardiography and myocardial perfusion imaging are equally effective techniques and cardiac MR is developing rapidly. All three techniques are currently underprovided across the country. It would be useful if guidance were provided on appropriate waiting times for functional cardiac imaging within the context of the 18 week wait. It would also be helpful if the guidance included statements about which groups of patients are appropriate for functional imaging in the context of the recently published	We will look at all appropriate investigative options, as agreed with the GDG. The scope includes examples, but the list is not intended as exhaustive and we recognise there are other imaging modalities to be included. It is not within the remit of the clinical guideline to give guidance on waiting times but such issues may be raised as part of the NICE Implementation

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				pathways for the management of suspected angina.	process. We will review the evidence as described in the NICE process and will be guided by the published evidence in this area.
SH	British Cardiovascular Society	2	4.3.1 (b)	A major criticism of the previous NICE document on myocardial perfusion imaging for the assessment of coronary artery disease was that alternative imaging modalities weren't in the specification and so weren't considered. It would be important to add in stress echocardiography to the spec. I would suggest altering the section to: "Diagnostic tests, such as exercise testing, stress echocardiography and myocardial perfusion scanning in patients requiring further cardiac assessment"	We will look at all appropriate investigative options, as agreed with the GDG. The scope includes examples, but the list is not intended as exhaustive and we recognise there are other imaging modalities to be included..
SH	British Heart Foundation	1	General	The BHF has reviewed this document and has no comments to make at this time.	Noted with thanks.
SH	British Institute of Musculoskeletal Medicine			This organisation was approached but did not respond.	No response needed.
SH	British National Formulary (BNF)			This organisation was approached but did not respond.	No response needed.
SH	British Nuclear Cardiology Society	1		**For chest pain scope:** Section 4.3.1b Assessment of patients Myocardial perfusion imaging is mentioned as a test in those patients requiring further assessment, presumably those with negative acute markers but still the suspicion of underlying IHD. This is quite appropriate. No mention is made of triaging patients using acute myocardial perfusion imaging with the tracer being injected in A+E. This approach has been widely adopted in the USA and data are available as to efficacy and cost effectiveness, and could be provided to the writing group as required. This approach is seldom used in the UK but it may be helpful for the group to consider its applicability to UK practice.	The guideline will consider all the appropriate published evidence for assessment and investigation of patients presenting with chest pain/discomfort.
SH	British Nuclear Cardiology Society	2	4.3.1b	Myocardial perfusion imaging is mentioned as a test in those patients requiring further assessment, presumably those with negative acute markers but still the suspicion of underlying IHD. This is quite appropriate. No mention is made of triaging patients using acute myocardial perfusion imaging with the tracer being injected in A+E. This approach has been widely adopted in the USA and data are available as to efficacy and cost effectiveness, and could be provided to the writing group as required. This approach is seldom used in the UK but it may be helpful for the group to consider its applicability to UK practice.	See response above.
SH	British Paramedic Association			This organisation was approached but did not respond.	No response needed.
SH	British Society of Echocardiography	1	General	On behalf of the BSE I would like to comment on the draft acute chest pain proposal. We welcome the aim to provide guidance in this area. Section 4.3.1 4.3.1 Areas that will be covered b) Assessment and investigation of people with suspected chest pain of cardiac origin at initial presentation including: • cardiovascular risk factor assessment (such as family history, age and gender) • signs and symptoms • early biochemical markers for the diagnosis of acute coronary syndrome	We will look at all appropriate investigative options, as agreed with the GDG The scope includes examples, but the list is not intended as exhaustive and we recognise there are other imaging modalities to be included..

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				and MI • cardiac investigations (such as electrocardiogram and chest X-ray) for the diagnosis of acute coronary syndrome and MI • diagnostic tests, such as exercise testing and myocardial perfusion imaging, in patients requiring further cardiac assessment. We would ask to have the diagnostic tests line changed to diagnostic tests, such as exercise testing, myocardial perfusion imaging and stress echocardiography, in patients requiring further cardiac assessment. This would then represent the full spectrum of evidence based diagnostic tests for chest pain. It would emphasise that options are available as alternatives to, or for patients unsuitable for, exercise testing and myocardial perfusion imaging.	
SH	British Society of Echocardiography	2	4.3.1	We would ask to have the diagnostic tests line changed to diagnostic tests, such as exercise testing, myocardial perfusion imaging **and stress echocardiography**, in patients requiring further cardiac assessment. This would then represent the full spectrum of evidence based diagnostic tests for chest pain. It would emphasise that options are available as alternatives to, or for patients unsuitable for, exercise testing and myocardial perfusion imaging.	See response above.
SH	Calderdale PCT			This organisation was approached but did not respond.	No response needed.
SH	Cheshire and Merseyside Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Coast to Coast Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Commission for Social Care Inspection			This organisation was approached but did not respond.	No response needed.
SH	Connecting for Health			This organisation was approached but did not respond.	No response needed.
SH	Conwy LHB			This organisation was approached but did not respond.	No response needed.
SH	Cordis	1		Thank you for the opportunity to comment. Cordis agree with the draft scope as it stands and do not have any specific comments to make.	Noted with thanks.
SH	Coventry and Warwickshire Cardiac Network			Not everybody presents with acute chest pain and it is necessary to consider cardiac symptoms as a whole as a presentations for acute coronary syndromes.	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this.
SH	Daiichi Sankyo UK Ltd			This organisation was approached but did not respond.	No response needed.
SH	Department of Health	1	4.2. b Healthcare setting	It would be helpful if the scope could be more specific about the range of settings? In our opinion, there are quite a lot of first contact staff who should be included for example: NHS Direct call handlers and nurse/ medical staff, ambulance control staff and medical advisers, hospital based telephone triage staff. Also ambulance crews are not specifically mentioned.	Noted and we have revised this section to reflect the wider applicability of these guidelines.
SH	Department of Health, Social Security and Public Safety of Northern Ireland			This organisation was approached but did not respond.	No response needed.
SH	Derbyshire Mental Health Services NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	Doncaster PCT			This organisation was approached but did not respond.	No response needed.
SH	Dudley Group of			This organisation was approached but did not respond.	No response needed.

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	Hospitals NHS Trust				
SH	Eli Lilly and Company Limited			This organisation was approached but did not respond.	No response needed.
SH	Essex Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	GE Healthcare			This organisation was approached but did not respond.	No response needed.
SH	GlaxoSmithKline UK	1	General	GlaxoSmithKline endorse the need for and development of a clinical guideline for acute chest pain which will complement the guidelines for acute coronary syndromes.	Noted with thanks.
SH	GlaxoSmithKline UK	2	General	GSK request that consideration is given to patients with acute coronary syndromes who may not present with chest pain or have a confirmed diagnosis of acute coronary syndromes and hence clarity is required about which guideline would be most applicable to this group of patients.	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this.
SH	Greater Manchester and Cheshire Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Health Commission Wales			This organisation was approached but did not respond.	No response needed.
SH	Healthcare Commission			This organisation was approached but did not respond.	No response needed.
SH	Heart of England NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.
SH	Herefordshire & Worcestershire Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Hyperlipidaemia Education & Atherosclerosis Research Trust			This organisation was approached but did not respond.	No response needed.
SH	Institute of biomedical Science			This organisation was approached but did not respond.	No response needed.
SH	Joint Royal Colleges Ambulance Liaison Committee	1		The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) is a group of over forty healthcare representatives, nominated by their respective specialties, and observers. The members are drawn from a wide spread of the medical and associated healthcare professions and funded by the Department of Health. JRCALC provides medical guidance to UK ambulance services through the development, publication and circulation of its Clinical Practice Guidelines and also gives ongoing direction on specific healthcare matters relating to ambulance service practice as they arise. JRCALC works closely with the Department of Health, professional bodies, voluntary organisations and interested parties on a wide range of issues to deliver world-class first-contact patient care. JRCALC welcomes the proposal to provide recommendations on this important topic.	Noted with thanks.
SH	Joint Royal Colleges Ambulance Liaison Committee	10	4.3.1.c	See 4.2.c above. Also need to reflect current question regarding use of oxygen.	We have noted that the effectiveness and safety of early treatment with oxygen will be included.
SH	Joint Royal Colleges Ambulance Liaison Committee	2	3	We agree with the clinical need as stated and to links with the Acute Coronary Syndromes (ACS) guideline development. Chest pain can remain an important symptom even in those without coronary heart disease and this fact must not be	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than

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				overlooked, neither should the group with ACS who do not complain of chest pain on presentation.	the initial presentation of an ACS. We have made changes also to the title to clarify this. Detailed guidance on the long term management of chest pain/discomfort of non-cardiac origin, although important, is not within the scope of this guideline
SH	Joint Royal Colleges Ambulance Liaison Committee	3	3.c, d	It should be acknowledged that the current low threshold for responding to chest pain (on behalf of ambulance services) is in recognition of this important potential threat of ACS and myocardial infarction.	Noted
SH	Joint Royal Colleges Ambulance Liaison Committee	4	4.1.1	See above. Given the reported poor outcomes in the 20% of 'atypical' ACS patients, it will be important to include them if possible in one or other guideline (acute coronary syndromes or acute chest pain).	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this. If a patient has a confirmed diagnosis of ACS they will fall under appropriate ACS guidelines, but the ACP guideline will give guidance on information to be given to patients on action to be taken if a subsequent episode of chest pain/discomfort occurs.
SH	Joint Royal Colleges Ambulance Liaison Committee	5	4.1.2 .a	It will be important to define this group as precisely as possible.	Noted
SH	Joint Royal Colleges Ambulance Liaison Committee	6	4.2 .b	"…where appropriate, other settings": an exemplar ambulance Trust control may receive 1000 chest pain calls per month (or 3.3% of total) which represents a "setting" that merits detailed acknowledgement.	Noted and we have revised this section to reflect the wider applicability of these guidelines.
SH	Joint Royal Colleges Ambulance Liaison Committee	7	4.2.c	See 4.2.b above. Consideration should be given here to telephone pre-arrival instructions.	Noted and we have revised this section to reflect the wider applicability of these guidelines.
SH	Joint Royal Colleges Ambulance Liaison Committee	8	4.3.1.a	"Initial presentation": the word 'initial' here needs definition. Is this the call to ambulance control, or the first face-to-face presentation in another setting?	Noted and we have revised this section to reflect the wider applicability of these guidelines and different routes of presentation..
SH	Joint Royal Colleges Ambulance Liaison Committee	9	4.3.1.b	In assessment, we would suggest the addition of history i.e. the time of onset of pain, precipitant etc to "signs and symptoms".	Noted and added
SH	KCI Medical Ltd			This organisation was approached but did not respond.	No response needed.
SH	Kent Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Lancashire and South Cumbria Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Leeds PCT			This organisation was approached but did not respond.	No response needed.
SH	LNR Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	London Ambulance Service NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	Luton & Dunstable Hospital NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.
SH	Medicines and Healthcare Products Regulatory Agency			This organisation was approached but did not respond.	No response needed.

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	(MHRA)				
SH	Medtronic Ltd			This organisation was approached but did not respond.	No response needed.
SH	Merck Sharp & Dohme Limited			This organisation was approached but did not respond.	No response needed.
SH	Milton Keynes PCT			This organisation was approached but did not respond.	No response needed.
SH	Milton Keynes PCT			This organisation was approached but did not respond.	No response needed.
SH	National Patient Safety Agency			This organisation was approached but did not respond.	No response needed.
SH	National Pharmacy Association			This organisation was approached but did not respond.	No response needed.
SH	National Public Health Service - Wales			This organisation was approached but did not respond.	No response needed.
SH	Newcastle upon Tyne NHS Hospitals Trust			This organisation was approached but did not respond.	No response needed.
SH	Newcastle upon Tyne NHS Hospitals Trust			This organisation was approached but did not respond.	No response needed.
SH	Newham University Hospital NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	NHS Direct			This organisation was approached but did not respond.	No response needed.
SH	NHS Pathways	1	4.1.2 c, Groups who will not be covered	Suggest adding 'Further management' of people who have a confirmed diagnosis of acute coronary syndrome or MI	This has been clarified.
SH	NHS Pathways	2	4.2 Healthcare Setting	Consider adding to c, This to include specifically initial ambulance management of acute chest pain	Noted and we have revised this section to reflect the wider applicability of these guidelines.
SH	NHS Pathways	3	4.2 Healthcare Setting	Consider moving current d, to e, and having as new d, Telephone triage assessment and its role in risk stratification. This is important as the majority of acute chest pain presentations are currently managed initially over the telephone; by ambulance services, NHS Direct, Out of hours GP cooperatives or GP surgeries in daytime	Noted and we have revised this section to reflect the wider applicability of these guidelines.
SH	NHS Pathways	4	4.3.1 c, Clinical management – early pharmacological intervention	Consider the evidence supporting or contradicting the administration of aspirin to people who are suspected of having a myocardial infarction and who are already taking oral anticoagulants. Currently, caution is advised in the JRCALC/ASA clinical guidelines to ambulance services and this has been interpreted as administration should only occur after ambulance arrival at the scene. If this action proved beneficial, or at least did not increase the risk of bleeding side effects, it would allow call handlers at the earliest opportunity to instruct such people to take aspirin and not await ambulance attendance. This in turn would also reduce the tasks to be undertaken by the crew at the scene and speed onward referral/probable thrombolysis.	We will look at both the effectiveness and safety and make recommendations on the appropriate use of aspirin, including the timing in the care pathway.
SH	NHS Pathways	5	4.3.1 f, Ineffective intervention identification	Consider adding to this section 'including the appropriate and inappropriate use of Category A Ambulance dispatch for acute chest pain presentations' The reason for this suggestion, is that the current DOH guidance is for emergency ambulance dispatch for all over 35 yr olds with chest pain; regardless of whether further concise questioning would make it very unlikely that acute ischaemic heart disease is the causation. Figures from the North East of England seem to show a very significant over-dispatch of Cat A ambulances, based on age alone. This is potentially both ineffective and costly as an intervention for acute chest pain. It also results in fewer ambulances being available for other emergencies at a time when most trusts are only able to hit less than 80% of their 8 minute target.	This is standard wording and we will be guided by the evidence as to which, if any, recommendations on ineffective care will be made.
SH	NHS Plus			This organisation was approached but did not respond.	No response needed.
SH	NHS Quality			This organisation was approached but did not respond.	No response needed.

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	Improvement Scotland				
SH	NHS South Central vascular Network			This organisation was approached but did not respond.	No response needed.
SH	North and East Yorkshire & Northern Lincolnshire Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	North East London Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	North Tees PCT			This organisation was approached but did not respond.	No response needed.
SH	North West London Cardiac Network	1	General	The scope of the guidance seems appropriate	Noted with thanks.
SH	North West London Cardiac Network	2	General	Models of care: transfer of all chest pain to "ACS centres" versus local DGH needs to either be in this document or in the Acute Coronary Syndrome scope.	Detailed service delivery recommendations on models of care are outside the Scope of this guideline, but we will make recommendations on the appropriate interventions and investigations that need to be provided to people with acute chest pain of suspected cardiac origin.
SH	North West London Cardiac Network	3	4.3.1 (d)	This is welcome to support communication and raise awareness of appropriate action with at risk groups. It may help reduce inequalities.	Noted with thanks.
SH	P.M.S (Instruments) Ltd			This organisation was approached but did not respond.	No response needed.
SH	Papworth Hospital NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	Peninsula Clinical Managed Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	PERIGON Healthcare Ltd			This organisation was approached but did not respond.	No response needed.
SH	Primary Care Pharmacists Association			This organisation was approached but did not respond.	No response needed.
SH	PRIMIS+			This organisation was approached but did not respond.	No response needed.
SH	Respironics UK			This organisation was approached but did not respond.	No response needed.
SH	Resuscitation Council (UK)			This organisation was approached but did not respond.	No response needed.
SH	Royal Brompton & Harefield NHS Trust	1	4.3.1 b) Assessment and investigation of people with suspected chest pain of cardiac origin at initial presentation including: • cardiac investigations (such as electrocardiogram and chest X-ray) for the	They don't even mention non invasive coronary angiography using Multislice CT which is the test with the highest negative predictive value offering the possibility to exclude pulmonary embolism and aortic dissection as well	We will look at all appropriate investigative options, as agreed with the GDG. The scope includes examples, but the list is not intended as exhaustive and we recognise there are other imaging modalities to be included.

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			diagnosis of acute coronary syndrome and MI • diagnostic tests, such as exercise testing and myocardial perfusion imaging, in patients requiring further cardiac assessment.		
SH	Royal College of General Practitioners	1	General	The scope of the proposed Guideline is, in my view comprehensive and appropriately inclusive and exclusive.	Noted with thanks.
SH	Royal College of Midwives			This organisation was approached but did not respond.	No response needed.
SH	Royal College of Nursing	1	General	With a membership of over 395,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.	No response needed.
SH	Royal College of Nursing	2	General	The proposed guideline is timely and welcome.	Noted with thanks.
SH	Royal College of Nursing	3	3	Agree with clinical need as broadly stated and to links with ACS guideline development (although not all patients with ACS will have chest pain – around 20% in the EMMACE study did not have chest pain). BUT the vast majority of patients with acute chest pain who call 999 do not have ACS. Since acute chest pain in practice tends to be 'cardiac until proven otherwise', particularly in the emergency setting, there is a need to give more thought to those with undifferentiated chest pain who account for considerable resource use and do not always have good experience/outcome. And there are several non-ACS causes of chest pain that may be life threatening, so 3d is important.	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this. We recognize that there are other important, and potentially life threatening causes of chest pain/discomfort and reference will be made to these as the GDG feel appropriate. However, it is outside the scope of this guideline to include detailed guidance on management of these conditions,.
SH	Royal College of Nursing	4	4.11	See above. Given the reported poor outcomes in the 20% 'atypical' ACS patients, it will be important to include them if possible in one or other guideline (ACS or chest pain).	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this. If a patient has a confirmed diagnosis of ACS they will fall under appropriate ACS guidelines, but the ACP guideline will give guidance on information to be given to patients on action to be taken if a subsequent episode of chest pain/discomfort occurs.
SH	Royal College of Nursing	5	4.1.2	See above	See above
SH	Royal College of	6	4.1.2	We are concerned about the statement 'people who have chest pain of definite non-	Noted, however the remit of this guideline is to

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	Nursing			cardiac origin' - Whilst we accept there are people in whom a cardiac cause for the pain can be readily excluded, there are groups, specifically women who are known to present with very atypical symptoms and are therefore often under investigated.	give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this.
SH	Royal College of Nursing	7	4.2 b	Need to explicitly include the ambulance (pre-hospital) setting and other first responder organisations, which is where much early assessment and treatment commences. There are currently important differences between ambulance and hospital guidelines which require clarification.	Noted and we have revised this section to reflect the wider applicability of these guidelines.
SH	Royal College of Nursing	8	4.3	Agree a, b, c (but should include pre-hospital/ambulance elements) and d, e and good to see consideration of oxygen as there are concerns that this widely used and recommended treatment may actually be harmful (Cochrane review underway). And use of clopidogrel in the ambulance setting remains controversial with uneven application across the NHS currently –the ambulance sub-study of CLARITY had a mere 200 (or thereabouts) patients, so not yet compelling.	Noted and we have revised this section to reflect the wider applicability of these guidelines. Re early treatment, both effectiveness and safety will be considered.
SH	Royal College of Nursing	9	General	Will there be an explicit link to DUETS as the development team identify uncertainties?	The guideline will identify areas for future research
SH	Royal College of Paediatrics and Child Health			This organisation was approached but did not respond.	No response needed.
SH	Royal College of Pathologists	1		The Royal College of Pathologists have no comments to submit at this stage.	Noted with thanks.
SH	Royal College of Physicians of London	1		The Royal College of Physicians is grateful for the opportunity to respond to these two Guideline consultations. In so doing, we wish to endorse the comments submitted by the British Cardiovascular Society and the British Nuclear Cardiology Society.	Noted with thanks – and see responses to those comments.
SH	Royal Society of Medicine			This organisation was approached but did not respond.	No response needed.
SH	SACAR			This organisation was approached but did not respond.	No response needed.
SH	Salford PCT			This organisation was approached but did not respond.	No response needed.
SH	Sanofi-Aventis			This organisation was approached but did not respond.	No response needed.
SH	School of Health and Related Research (ScHARR)			This organisation was approached but did not respond.	No response needed.
SH	Scottish Intercollegiate Guidelines Network (SIGN)			This organisation was approached but did not respond.	No response needed.
SH	Sedgefield PCT			This organisation was approached but did not respond.	No response needed.
SH	Servier Laboratories	1		Servier Laboratories has no comments on the scope for the Guideline or on the scope for the Acute Chest Pain Guideline. Thank you for the opportunity to comment on these documents.	Noted with thanks.
SH	Sheffield PCT			This organisation was approached but did not respond.	No response needed.
SH	Sheffield Teaching Hospitals NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.
SH	Shropshire and Staffordshire Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Siemens Medical Solutions Diagnostics			This organisation was approached but did not respond.	No response needed.

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SH	Social Care Institute for Excellence (SCIE)			This organisation was approached but did not respond.	No response needed.
SH	Society for Cardiothoracic Surgery in GB and Ireland	1	General	Aortic dissection often presents as chest pain and mimics the symptoms of cardiac pain. Type A aortic dissection (involving the ascending aorta) requires emergency surgery and type B dissection (arch and descending aorta) requires controlled 'hypotension' whilst there is also a role for possible aortic stenting. Although these pathologies are uncommon compared to cardiac chest pain we hope this consultation will recognise the importance of excluding aortic dissection, when the evidence for other diagnoses is equivocal – ie the need for CT scan with contrast +/- echocardiography.	We recognize there are other important, and potentially life threatening causes of chest pain/discomfort. The guideline will include the importance of excluding other serious pathologies such as aortic dissection, but it is outside the scope to include detailed management of these conditions
SH	South Asian Health Foundation	1	General	One assumes this guideline will attempt to confront inequalites in cardiovascular disease by addressing why current disparities in access to healthcare exist and establish guidance to ameliorate these.	Noted and we have revised the Scope to explicitly state that this will be covered in the context of a clinical guideline, but it is outside the Scope to consider why these disparities occur in the wider setting.
SH	South Asian Health Foundation	2	General	The efficacy of rapid access chest pain clinics should be assessed as a means of evaluating the current mechanisms for the diagnosis of chest pain aetiology.	Detailed service delivery recommendations on models of care are outside the Scope of this guideline, but we will make recommendations on the appropriate interventions and investigations that need to be provided to people with acute chest pain of suspected cardiac origin.
SH	South Asian Health Foundation	3	General	There are a significant proportion of patients who do not manifest their coronary heart disease with chest pain. Silent ischaemia, for example in the diabetic patient or in many south Asians, is an important presentation to address and these high risk patients must not be ignored if presenting with atypical symptoms (e.g. autonomic symptoms alone). The medical profession needs to be made aware of the need for a lower threshold for clinical suspicion in south Asinas in particular in order to enable the attrition of health inequalites with respect to CHD.	Noted, however the remit of this guideline is to give guidance on the investigation and assessment of chest pain/discomfort, rather than the initial presentation of an ACS. We have made changes also to the title to clarify this. Please also see the Scope for details of the specific ub-groups to be covered.
SH	South Central Ambulance Service NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	South East London Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	South Staffordshire PCT			This organisation was approached but did not respond.	No response needed.
SH	South West London Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	Sudden Adult Death Trust, SADS UK			This organisation was approached but did not respond.	No response needed.
SH	Sussex Heart Network			This organisation was approached but did not respond.	No response needed.
SH	The Afiya Trust			This organisation was approached but did not respond.	No response needed.
SH	The British Dietetic Association			This organisation was approached but did not respond.	No response needed.
SH	The British Pain Society	1	General	The scope document itself recognises that "Chest pain is caused by CHD in only a minority of cases, and guidance on the assessment of chest pain will aid in making an accurate diagnosis, avoiding inappropriate diagnoses and treatment, and reducing unnecessary referral and admission to secondary care." This differentiation is largely a matter of proper history taking and examination. For the proposed guideline to have	This GL is addressing the assessment of patients with chest pain/discomfort which may be cardiac. Other guidelines should then be referred to when the cause of the chest pain/discomfort is known.

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				any relevance chest pain of cardiac origin must have already been ruled in. Thus there seems little point in having a separate ACS guideline unless this guideline focuses on risk assessment and the need for referring to specialist care. (see below Chronic Refractory Angina Guidelines)	
SH	The British Pain Society	2	4.3.1b	Working diagnosis. Emphasis must be given to the importance of making clear the difference between a 'working' diagnosis and a final diagnosis. Later management is much more difficult when patients are told there is only a minor problem or that there is 'nothing wrong' after they have been given the clear impression that they have a potentially life threatening cardiac condition during the early diagnostic stage.	Noted and we have clarified this where appropriate.
SH	The British Pain Society	3	4.3.1 c	Analgesia and Pain management. It should be understood that modern pain management involves optimising the psychological status of the patient and carer by dealing with misconceptions and offering alternative explanations for the symptoms as well as providing analgesia. Specific symptomatic treatment with analgesia should be mentioned with reference to current pain management guidelines.	Noted but we are only covering initial pharmacological interventions in the management of people with chest pain/discomfort of suspected cardiac origin, such as oxygen, anti-platelet therapy and pain relief before a cause is known, not ongoing management of chronic pain.
SH	The British Pain Society	4	4.3.1.d	Psychological factors. It should be acknowledged that the psychological status of the pain has a huge influence on the pain experience. Similarly the pain experience has a feedback effecting on psychological status. Patients with chest pain are easily frightened and this impairs their cognitive function. In turn, this impairs their capacity to give consent and advice should be given to ensure that patients are given time to properly consider medical advice before giving consent to procedures.	Noted and we have invited expertise (in the GDG) on illness behaviour, misconceptions and related psychological factors for people with suspected cardiac problems.
SH	The British Pain Society	5	4.3.1e	Education. This section mentions education. It is important to note that whilst extant angina guidelines mention the critical importance of education/rehabilitation at the outset of care they leave the reader to track down the relevant guidelines. In this regard the Cheshire and Merseyside and North Wales Cardiac Network Stable Angina Guidelines are to be recommended (link http://www.cmcn.nhs.uk/guidelines/stable_angina.html) This guideline should not repeat the mistake of assuming that colleagues will read and implement the relevant guidance on education. Harmful misconceptions are extremely common and there is good evidence that patient education (as opposed to giving patients information) is amongst the most neglected areas of clinical care.	Noted with thanks and we will make recommendations on appropriate patient education based on the available evidence.
SH	The British Pain Society	6	4.3.1.e	How is education to be delivered-by whom and in what form? How is consistency to be assured?	We will make recommendations on appropriate patient education based on the available evidence. We would not specify who should deliver this (as we are not writing detailed service guidance) and how to assure consistency (appropriate professional organisations would be expected to develop standards). but such issues can be fed into the NICE Implementation process later in the guideline development.
SH	The British Pain Society	7	4.3.1.e	Behavioural and lifestyle advice should be defined. Otherwise practitioners are likely to default to non-evidence based prejudices such as advising patients to give up work and risky activities. Without clear explanations this often leads to excessive anxiety and harmful behaviours.	Noted with thanks and we will make recommendations on appropriate behavioural and lifestyle advice
SH	The British Pain Society	8	General	The scope ignores patients with chest pain of cardiac origin for whom revascularisation is not an option either because it is not clinically appropriate or the patient refuses. The British Pain Society sponsored UK National Refractory Angina guideline was introduced for such a situation in 1998. The guideline has been endorsed by the British Pain Society angina special interest group (SIG), our parent body (IASP) angina SIG	The GL will include assessment of those with and without known coronary disease, but it is beyond the scope to make recommendations for the management of angina poorly controlled with medical treatment, either in those who do not

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				and the British Cardiovascular Intervention Society. We urge NICE to take account of these longstanding and widely used guidelines when considering how to manage this complex and difficult clinical problem. Contact Prof M Chester, guideline chairman, for further details: NRAC, RLBUHT, Thomas Drive, Liverpool 14 3PE. Tel 0151 600 1244/1448 email chester@angina.org	wish revascularisation or in whom revacularisation is not possible.
SH	The British Psychological Society			This organisation was approached but did not respond.	No response needed.
SH	The Chartered Society of Physiotherapy			This organisation was approached but did not respond.	No response needed.
SH	The Society and College of Radiographers			This organisation was approached but did not respond.	No response needed.
SH	Trent Cardiac Network			This organisation was approached but did not respond.	No response needed.
SH	University College London Hospitals NHS Foundation Trust	1	4	Please confirm that the scope will include both patients presenting to secondary care (A&E) and existing in-patients, including the surgical / post-operative population	Noted and the recommendations will be applicable to any one who presents in any health care setting.
SH	University College London Hospitals NHS Foundation Trust	2	4.3.1	Will the guideline address other non-invasive imaging such as CTA?	All appropriate imaging modalities will be considered.
SH	University Hospital Birmingham NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.
SH	University Hospital of South Manchester NHS Foundation Trust			This organisation was approached but did not respond.	No response needed.
SH	University of North Tees and Harlepool NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	Welsh Assembly Government	1		Thank you for giving the Welsh Assembly Government the opportunity to comment on the above draft scope. We are content with the technical detail of the evidence supporting the consultation and have no further comments to make at this stage.	Noted with thanks.
SH	Welsh Scientific Advisory Committee (WSAC)			This organisation was approached but did not respond.	No response needed.
SH	West & East & North Hertfordshire PCTs			This organisation was approached but did not respond.	No response needed.
SH	West Midlands Specialised Commissioning Team			This organisation was approached but did not respond.	No response needed.
SH	West Surrey Cardiac Network	1	4.3.1 b	Under cardiovascular risk factor assessment could you include use of a risk score such as TIMI or GRACE?	We have not defined the detailed tools to be used and will review the evidence as per the usual NICE process. TIMI and GRACE scores are for those diagnosed with ACS and are not appropriate for inclusion in this guideline
SH	West Surrey Cardiac Network	2	4.2 a	Will this include commencing treatment at first contact with any health professional, e.g. General Practitioner	Yes
SH	West Yorkshire Cardiac Network			This organisation was approached but did not respond.	No response needed.

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SH	Wiltshire PCT			This organisation was approached but did not respond.	No response needed.
SH	York Hospital NHS Trust			This organisation was approached but did not respond.	No response needed.
SH	Yorkshire Ambulance Service			This organisation was approached but did not respond.	No response needed.
SH	Yorkshire and the Humber Specialised Commissioning Group			This organisation was approached but did not respond.	No response needed.