

Stroke and transient ischaemic attack in over 16s

**Consultation on draft guideline - Stakeholder comments table
14/02/22 to 28/02/22**

Stakeholder	Document	Page No	Line No	Comments	Developer's response
Association of British Neurologists	Guideline	004	General	<p>Rec 1.5.6 The rapid reduction of 60mmHg within one hour is associated with potential harm, so specifying to avoid this magnitude of drop in the first hour seems reasonable. However, it is not clear that completely removing the lower limit of 130mmHg is appropriate, as the avoidance of a 60mmHg drop will not completely safeguard against the BP dropping to a dangerously low level. For example, a patient with BP 150mmHg at presentation could still have their BP lowered as far as 90mm Hg and still be in line with the revised recommendations. It is understood that the previous target range of 130-140mmHg within the first hour might be difficult to achieve in practice.</p> <p>It would be reasonable, based on the data from the Moullaali et al IPDMA to suggest that, in addition to avoiding a drop of =60mm Hg in the first hour, the BP should not be lowered beyond 120mmHg.</p> <p>The guideline does not give guidance about patients with blood pressures of 200mmHg or greater, in whom a target of less than 140mmHg is impossible to achieve without a drop of 60mmHg. The recommendation needs careful clarification to avoid confusion.</p> <p>The committee may also wish to make it clear that only a minority (33.4%) of participants in the INTERACT2 trial achieved the target of 140mmHg within 1 hour.</p>	<p>Thank you for your response. The committee considered the inclusion of a lower limit and decided against it for the following reasons:</p> <ul style="list-style-type: none"> • a lower limit would be too restrictive in practice. • the general pattern from the pooled analysis of patient level data from the two largest trials of blood pressure lowering treatment was that lower categories of achieved systolic blood pressure seemed to be associated with better outcomes, (down to 120–130 mmHg). <p>Thus, it was considered reasonable to only include a target of 140 or lower. They agreed that avoiding a drop of 60mmHg or more within 1 hour will help avoid the potential harm associated with this reduction in systolic blood pressure within the first hour. The main aim of this stipulation was primarily to address the proven risk of cardiorenal adverse events associated with intensive blood pressure management.</p> <p>The committee decided to remove the given timeframe to achieve the target SBP so that a drop of 60mmHg in SBP can also be avoided while achieving the target SBP. This is to avoid the cardiorenal risk associated with a SBP drop of greater than 60mmHg.</p> <p>Thank you for highlighting that only a minority (33.4%) of participants in the INTERACT2 trial achieved the target of 140mmHg within 1 hour. We have added this to the rationale of this guideline update.</p>

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Association of British Neurologists	Guideline	006	003	Recommendation for research It is not clear why the research recommendation is related to cognition rather than the full spectrum of health outcomes that may be important to survivors of intracerebral haemorrhage.	Thank you for your comment. With regards to the suggested expansion of the 2nd research recommendation this was considered by the committee. It was agreed to update the recommendation with the suggested expansion.
Association of British Neurologists	Guideline	006	014	In the "Why the committee made the recommendations" the current wording implies that there was no doubt about the data from INTERACT-2 suggesting modest benefit. The wording should clearly mention that the committee were influenced by the statistically non-significant evidence of modest benefit for intensive blood pressure lowering suggested by INTERACT2. The INTERACT2 trial was neutral for its primary endpoint.	Thank you for your comment. This section of the guideline has been updated to include a statement about the continued uncertainty in the evidence and how the committee came to make the recommendation.
British and Irish Association of Stroke Physicians	Guideline	005	General	Recommendations for research May be worth suggesting a lower limit in BP to avoid adverse outcomes	Thank you for your comment. Recommendation 1.5.6 outlines - aim to reach a systolic blood pressure target of 140mmHg or lower.
British and Irish Association of Stroke Physicians	Guideline	005	General	Recommendations for research Age and frailty should be treated as two separate entities	Thank you for your comment. Your feedback was considered by the committee who agreed that age and frailty should not be conflated. The rationale for the research recommendation has been amended accordingly.
British and Irish Association of Stroke Physicians	Guideline	005	General	Recommendations for research It is not clear why the research recommendation on outcome was limited to cognition only.	Thank you for your comment. The committee has discussed your comment and agreed that the research recommendation should include functional ability and quality of life so that it is not limited to cognitive function only.
British and Irish Association	Guideline	005	General	Recommendations for research Perhaps there should also be a research recommendation around the choice of agent.	Thank you for your comment. The committee discussed this and did not consider that this was an area that should be prioritised for further research.

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British Geriatrics Society	Comments form question	001	Question 1	<p>Q1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.</p> <p>Hyperacute management of intracerebral haemorrhage (ICH) represents a major shift in practice. For context, at present in the UK usual practice would be to admit the patient to a dedicated stroke ward and offer general supportive care. To implement these recommendations would require ICH to be treated with the same urgency and time/staff investment as a stroke requiring mechanical thrombectomy or thrombolysis. Achieving a target blood pressure of 140mmHg within one hour of presentation often requires large doses of intravenous antihypertensives. Maintaining blood pressure within the therapeutic window requires intensive monitoring (either intra-arterial or frequent manual blood pressure checks). This requires a level two (HDU) care environment.</p>	<p>Thank you for your comments about challenges for implementation. The new recommendations of '1.5.6 When rapidly lowering blood pressure in people with acute intracerebral haemorrhage, aim to reach a systolic blood pressure target of 140mmHg or lower while ensuring that the magnitude drop does not exceed 60mmHg within 1 hour of starting treatment.' are minor changes to the current NICE guideline recommendations of 'Aim for a systolic blood pressure target of 130 to 140 mmHg within 1 hour of starting treatment and maintain this blood pressure for at least 7 days.' The criteria for when this should be targeted has not changed. The changes to the recommendations as a result of this update represent minor changes to current recommended practice which may be variably implemented, and our committee feels that the resources required for intensive stroke management is representative of care that is currently received and reduce variability in practice. Therefore, it is the committee's view that the changes made to the guideline do not constitute any major impact to practice. We understand that there is current variation in practice in the management of patients with acute ICH but that the majority of stroke centres have implemented our current guidance on acute ICH management. We are sympathetic to the resource constraints of our healthcare system and intend that this guidance will help to drive changes in staffing levels and equipment in stroke units for those</p>

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British Geriatrics Society	Comments form question	001	Question 2	<p>Q2. Would implementation of any of the draft recommendations have significant cost implications?</p> <p>The materials presented only consider the medications in the assessment of cost. For the reasons outlined above, implementation of these recommendations would have major economic and opportunity cost implications. A large stroke centre would see 2-3 persons with ICH potentially eligible for this therapy each week. Thus, implementation would need investment in nursing staff and infrastructural costs around high dependency care and associated monitoring.</p>	<p>Thank you for your comments about challenges for implementation. The new recommendations of '1.5.6 When rapidly lowering blood pressure in people with acute intracerebral haemorrhage, aim to reach a systolic blood pressure target of 140mmHg or lower while ensuring that the magnitude drop does not exceed 60mmHg within 1 hour of starting treatment.' are minor changes to the current NICE guideline recommendations of 'Aim for a systolic blood pressure target of 130 to 140 mmHg within 1 hour of starting treatment and maintain this blood pressure for at least 7 days.' The criteria for when this should be targeted has not changed. The changes to the recommendations as a result of this update represent minor changes to current recommended practice which may be variably implemented, and our committee feels that the resources required for intensive stroke management is representative of care that is currently received and reduce variability in practice. Therefore, it is the committee's view that the changes made to the guideline do not constitute any major impact to practice. We understand that there is current variation in practice in the management of patients with acute ICH but that the majority of stroke centres have implemented our current guidance on acute ICH management. We are sympathetic to the resource constraints of our healthcare system and intend that this guidance will help to drive changes in staffing levels and equipment in stroke units for those</p>

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British Geriatrics Society	Comments form question	001	Question 3	<p>Q3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)</p> <p>Guidance on how to lower BP to target and how to maintain this pressure and how to monitor blood pressure is needed. There is substantial uncertainty and variation in practice at present.</p> <p>There are areas of good practice in ICH management in the UK, for example the care bundle approach being developed in Manchester. These consider many aspects of ICH care and are not limited to blood pressure.</p>	<p>Thank you for your comment. Guidance on how to lower blood pressure to target and how to maintain this was considered beyond the scope of this guideline. This will be decided at an individual and local level based on the needs of the person and local prescribing protocols.</p> <p>Thank you also for your response for examples of good practice. Our committee agrees that a whole system approach is imperative for good stroke care.</p>
British Geriatrics Society	Comments form question	001	Question 4	<p>Q4. The guideline currently contains a research recommendation for the following question "How safe and effective is the early manipulation of blood pressure after stroke?". We are proposing to remove that research recommendation from the guideline – please can you indicate if you agree or disagree with that proposal.</p> <p>Disagree. As outlined in our response above, we still lack definitive evidence that this intervention has a benefit on important functional outcomes.</p>	<p>Thank you for your response. The committee discussed this question and agreed the two additional research recommendations included as part of this update, address this question more specifically and, therefore it would be appropriate to remove the previous research recommendation on 'How safe and effective is the early manipulation of blood pressure after stroke?'</p>
British Geriatrics Society	Guideline	004	005 - 009	<p>The recommendation 1.5.4 does not seem in keeping with the evidence synthesis presented. The data collated by the guideline group do not show a convincing effect on functional outcome. There is an effect on haematoma</p>	<p>Thank you for your comment. The committee considered this issue and agreed that recommendation 1.5.4 did reflect the evidence base and the need to consider rapid blood pressure</p>

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				<p>expansion, but this is a surrogate outcome and the relationship to outcomes is far from clear. As it stands this recommendation is not aligned with other guidelines looking at the same question, for example the European Stroke Organisation (ESO) guidance.</p> <p>The proven cardiorenal risks of the intervention do not seem to have been considered in the formulation.</p> <p>The uncertainty is partly conveyed in the phrasing 'consider...', but we suggest more emphasis is required on the lack on any compelling outcome data. We agree that, for selected patients, hyperacute blood pressure lowering can be of benefit. However, the remit of NICE is to offer an objective and evidence-based recommendation – and we consider that such evidence is lacking in this case at present.</p>	<p>lowering. The committee checked the European Stroke Organisation (ESO) guidance on blood pressure (BP) management in acute ischaemic stroke and intracerebral haemorrhage (ICH) they suggest for patients with acute (less than 24 hours) ICH: to lower BP to below 140 mmHg (and to keep it above 110 mm Hg). This is broadly in line with the proposed NICE recommendations.</p> <p>The committee acknowledge that there is uncertainty in the data and that the end points in the trials suggest neutral endpoints. The data base also show there is modest benefit for some outcomes such as hematoma expansion and quality of life, which were important outcomes to consider.</p> <p>The cardiorenal risk associated with intensive blood pressure reduction has been carefully considered and the committee included a stipulation to avoid these adverse events.</p>
British Geriatrics Society	Guideline	004	010 - 014	As written, recommendation 1.5.5 appears to be completely at odds with current evidence and practice. It should be acknowledged there is limited available evidence in this subgroup.	Thank you for your comment. The committee considered this issue and agreed that there is uncertainty in the evidence base but recommendation 1.5.5 does reflect current practice and other guidance. The committee checked the European Stroke Organisation (ESO) guidance on blood pressure (BP) management in acute ischaemic stroke and intracerebral haemorrhage (ICH) and they suggest for patients with acute (less than 24 hours) ICH: to lower BP to below 140 mmHg (and to keep it above 110 mm Hg).

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					This is broadly in line with the proposed NICE recommendations.
British Geriatrics Society	Guideline	004	016	Recommendation 1.5.6 needs reworded to avoid confusion as blood pressures of 200mmHg or greater are common and in this situation a target of less than 140mmHg cannot be achieved without a drop of 60mmHg. Suggested re-phrasing "...haemorrhage, aim to reach a systolic blood pressure target of 140mmHg or lower within 1 hour of starting to treat whilst ensuring the magnitude drop does not exceed 60mmHg within this timeframe."	Thank you for your comment. The committee have considered your feedback and the recommendations have been redrafted to address the contradiction. The committee decided to remove the target timeframe to achieve the target systolic blood pressure (SBP) so that a drop of 60mmHg in SBP can also be avoided while achieving the target SBP.
British Geriatrics Society	Guideline	005	013 - 016	<p>Research Recommendation 1 Older, frailer people.</p> <p>The title conflates ageing with frailty, but these are distinct constructs. The focus of the supporting text is more about frailty than age. Perhaps head this section as People with Frailty and remove the references to older people.</p> <p>The supporting text implies that pre-stroke frailty is routinely assessed by a frailty index. This is not the case in UK practice and the use of frailty index-based measures in acute stroke have been criticised. We support the case for further research to assess whether people living with advanced frailty should have a different stroke pathway, but this should not be limited to blood pressure lowering in intracerebral haemorrhage.</p>	Thank you for your comment. Your feedback was considered by the committee who agreed that age and frailty should not be conflated. The rationale for the research recommendation has been amended accordingly.
British Geriatrics Society	Guideline	006	001 - 005	Research Recommendation 2. Cognitive function.	Thank you for your comment. We have made a correction to the statement regarding 'cognitive function index' in stroke. With regards to the suggested expansion of the 2 nd research

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				<p>Suggest this is expanded to " long-term effects on cognitive function, functional ability, and quality of life of intensive interventions...." as this more fully reflects the range of clinical outcomes of interest.</p> <p>The supporting text describes the use of a 'cognitive function index' in stroke. There is no such measure. We agree with the sentiment that the longer-term changes in cognition following stroke are under researched but are unclear why describing cognitive change would be a particular priority in the context of hyperacute blood pressure lowering.</p> <p>The main RCTs in this area collected data on modified Rankin measure (a composite of physical and cognitive function), the EQ-5D (contains data on self-care and mood), need for care-home and incident dementia (through serious adverse event reporting). It is arguable what more would be added to this data by a trial looking specifically at cognition.</p> <p>Recent recommendations from European Stroke Organisation and European Academy of Neurology call for all stroke trials to have a cognitive measure as a secondary outcome – which we fully support. However, in a landscape of reduced research funding, we are</p>	<p>recommendation this was considered by the committee. It was agreed to update the recommendation with the suggested expansion.</p>

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				doubtful that a trial with a specific focus on cognitive outcomes in hyperacute blood pressure lowering is a good use of limited research funding resource.	
British Society of Rehabilitation Medicine	Guideline	006	001 - 005	Research recommendation Recommendations for BP control after traumatic brain injury rely on research that is based on mean arterial pressure. Given concern about effect of drops in blood pressure on 'watershed areas' future stroke research might also consider focusing on mean arterial rather than systolic pressure	Thank you for your comment. The committee discussed this issue and considered that this was not a research priority in relation to this update.
British Society of Rehabilitation Medicine	Guideline	006	001 - 005	Research recommendation Assessment of the severity and length of post stroke delirium might give an indication of future cognitive impairment	Thank you for your comment. The committee considered this issue and agreed this was not a research priority in relation to this update.
British Society of Rehabilitation Medicine	Guideline	006	001 - 005	Research recommendation What is important in the long term is the disability caused by cognitive impairment rather than just the results of cognitive testing, which does not always reflect the impact on daily life, particularly in executive function	Thank you for your comment. Your comments have been considered by NICE while redrafting the research recommendations. The committee discussed this issue and agreed that there are benefits of assessing both measures.
NHS England and Improvement	General	General	General	On review of the recommendations there appears to be nothing of concern for primary care physicians. As highlighted in the recommendations, the small change is really regarding ensuring blood pressure does not drop too quickly within the first hour of treatment and this is likely for acute stroke which will be managed in secondary care for the vast majority of patients. This should therefore have little to no impact on primary care.	Thank you for your comment and useful feedback on the impact of these updated recommendations on primary care.
Royal College of Nursing	Guideline	General	General	We do not have any comments on this consultation. Thank you for the opportunity to contribute	Thank you for your comment.
Royal College of	Guideline	004	004 - 009	Appendix Acute assessment (Chapter 5.1)	Thank you for your response. The committee considered this issue. Our guideline is for people aged

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Paediatrics and Child Health				<p>Consider the cause and necessity of treating hypertension in HS on a case-by-case basis</p> <p>Children and young people with AIS should only receive blood pressure-lowering treatment in the following circumstances: - in patients who are otherwise eligible for intravenous (IV) thrombolysis but in whom systolic blood pressure exceeds 95th percentile for age by more than 15% - hypertensive encephalopathy - end organ damage or dysfunction, e.g. cardiac or renal failure.</p> <p>Microsoft Word - 20160314 Full recommendations v0.1 (purple) (rcpch.ac.uk)</p> <p>RCPCH guideline covers young people until age 18. The advice used for BP management is fundamentally different to the advice stated in this guideline. Either this guideline should cede to the RCPCH guideline and should only be for over 18s or the RCPCH guideline needs a full revamp. There isn't any good quality research on the topic of rapid lowering of blood pressure but the conventional wisdom in paediatric neurology is to lower the BP over 24-48 hours to the 95th centile for height and age.</p>	16 and over however the included studies in the evidence review only included subjects aged 18 years and over. We acknowledge there is a gap in the research and the committee agreed to make an additional recommendation outlining when considering blood pressure lowering in young people aged 16 or 17 with acute intracerebral haemorrhage who do not have any of the exclusions listed in recommendation 1.5.7, seek advice from a paediatric specialist.
Royal Devon and Exeter Hospital NHS Trust	Guideline	004	010 - 014	<p>1.5.5 This contradicts 1.5.6. If systolic BP is greater than 220mmHg aiming to reduce it to 140mmHg is immediately >a drop of 60mmHg in magnitude (trials indicate harmful). No evidence for what to drop to/by if SBP>220mmHg</p>	Thank you for your comment. The committee have considered your feedback and the recommendations have been redrafted to address the contradiction. The committee decided to remove the target timeframe to achieve the target systolic blood pressure (SBP) so that a drop of 60mmHg in SBP can also be avoided while achieving the target SBP.

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Royal Devon and Exeter Hospital NHS Trust	Guideline	005	001 - 002	1.5.6 " Maintain this blood pressure for at least 7 days". The evidence to support such time frame is weak if at all existing. Further this will create a problem with patient flow in the stroke units as patient who have an ICH but have minimal physical disability and could usually go home will be kept in hospital for further intensive BP management (including IV treatment) if their BP is not controlled to the target recommended by NICE. This will clearly have an impact on patient flow, bed management and resources in the NHS which is already under immense pressure with bed shortages. Maintaining BP for up to 7 days, if possible, would be more sensible	Thank you for your comment. After discussion with the committee, they agreed that the evidence to support maintaining the target blood pressure for at least 7 days is weak. The committee were also concerned about the potential impact on patient flow, bed management and resources in the NHS, so removed the timeframe previously included in recommendation 1.5.4.and 1.5.5. The committee acknowledged that there remains uncertainty over how long to continue acute treatment. However, the evidence review is primarily concerned with treatment within the first 24 hours. The committee highlighted that blood pressure should still remain lowered after acute treatment which is designed to reduce the effects of the ICH. It was also agreed people receiving intensive blood pressure treatment would not need to stay in hospital for acute management for 7 days. This can be managed through secondary prevention, which can be indicated by when treatment is changed from intravenous to oral route of administration. The committee also noted that longer term management of blood pressure can be managed by primary care.
The Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the UK. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.	Thank you for your comment.

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The Royal College of Physicians and Surgeons of Glasgow	Guideline	008	008	We welcome the research recommendations on the cognitive effects of these treatments and also their impact on frail older patients, since both these areas are relatively lacking in research investment.	Thank you for your comment.
The Royal College of Physicians and Surgeons of Glasgow	Guideline	008	021	One of our reviewers noted that notwithstanding the exclusion of patients about to have haematoma evacuation, it is likely that for most patients there will now be more intensive monitoring within the first hour if giving iv bp reduction therapy than would be expected for these patients otherwise. It would not be usual practice for these patients to have continuous bp monitoring or 15-minute neuro observations in the first hour.	Thank you for your comment. We understand that there is current variation in practice in the management of patients with acute ICH but that the majority of stroke centres have implemented our current guidance on acute ICH management. We are sympathetic to the resource constraints of our healthcare system and intend that this guidance will help to drive changes in staffing levels and equipment in stroke units for those centres that do not currently have capacity to implement this guidance.
UK Neurointerventional Group	Guideline NG128	General	General	1.2.1 It is possible that the recommendation: 1.2.1 "Do not offer CT brain scanning to people with a suspected TIA unless there is clinical suspicion of an alternative diagnosis that CT could detect." could be too strong in light the relative lack of evidence in this arena and the fact that CT is used regularly in clinical practice to identify signs of prior ischaemic injury and alternative diagnoses. This is particularly relevant where the clinical assessment is not made by an	Thank you for your comment. These were beyond the scope of this guideline update. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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UK Neurointerventional Group	Guideline NG128	General	General	<p>1.2.3 1.2.3 "Everyone with TIA who after specialist assessment is considered as a candidate for carotid endarterectomy should have urgent carotid imaging. [2008, amended 2019]"</p> <p>There is no mention in this section of carotid stenting. This intervention is being increasingly used in many Neurointerventional units as part of treatment of tandem lesions during stroke thrombectomy. Additionally, there is evidence that carotid stenting is a safe procedure and that it may be preferable to endarterectomy in some patient groups. For this reason, this needs to be mentioned in the guidelines as an option or a potential choice for some patients.</p> <p>A multidisciplinary team should manage/oversee this process and should be mentioned – e.g., referred to the relevant carotid multidisciplinary team by an agreed pathway</p>	Thank you for your comment. These were beyond the scope of this guideline update. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
UK Neurointerventional Group	Guideline NG128	General	General	<p>1.2.4</p> <p>The recommendation 1.2.4 that patients:</p> <ul style="list-style-type: none"> • "are assessed and referred urgently for carotid endarterectomy to a service following current national 	Thank you for your comment. These were beyond the scope of this guideline update. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				standards (NHS England's service specification on Neurointerventional services for acute ischaemic and haemorrhagic stroke)" This point Includes a link to Neurointerventional service specification whereas it should apply to either vascular services for carotid endarterectomy or interventional/Neurointerventional services for carotid stenting.	
UK Neurointerventional Group	Guideline NG128	General	General	1.3 Specialist care for people with acute stroke "1.3.3 Perform scanning as soon as possible and within 24 hours of symptom onset in everyone with suspected acute stroke without indications for immediate brain imaging. [2008] NHS England and NHS Improvement have produced the National Stroke Service Model, which contains an updated patient-centred national optimal stroke imaging pathway." The link to the NOSIP pathway from the NICE guidelines is confusing as this includes a framework or model of imaging that is not universally accepted or wholly evidence based. NOSIP has not been endorsed by the Radiology SIG or the RCR. Leaving the link suggests that NICE has fully endorsed this but clearly this has not gone through the rigorous evidence review that is used for all other NICE guidance.	Thank you for your comment. These were beyond the scope of this guideline update. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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