NICE National Institute for Health and Care Excellence

Economic plan

This plan identifies the areas prioritised for economic modelling. The final analysis may differ from those described below. The rationale for any differences will be explained in the guideline.

1 Guideline

Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (update)

2 List of modelling questions

Review questions by scope area	**RQ 1.2 – In people with suspected DVT, what is the diagnostic accuracy of point-of-care D-dimer tests compared with laboratory tests to identify DVT?** **RQ 2.3 – In people with suspected PE, what is the diagnostic accuracy of point-of-care D-dimer tests compared with laboratory tests to identify PE?**
Population	People with suspected DVT or PE with an unlikely 2-level Wells score
Interventions and comparators considered for inclusion	Point-of-care D-dimer test versus laboratory D-dimer test
Perspective	NHS/PSS
Outcomes	Costs related to the testing pathway and outcomes in terms of the number of true positive (TP), false negative (FN), true negative (TN), and false positive (FP) test results
Type of analysis	Cost-consequences analysis
Issues to note	Suspected DVT and suspected PE are modelled separately

Review questions by scope area	**RQ 2.1 – In people with suspected PE, what is the diagnostic accuracy of the pulmonary embolism rule-out criteria (PERC)?**
Population	People with suspected PE at low risk of PE (according to clinical gestalt)
Interventions and comparators considered for inclusion	PERC as an initial test at the beginning of the diagnostic pathway vs. no PERC
Perspective	NHS/PSS

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Outcomes	Costs related to the testing pathway and outcomes in terms of the number of true positive (TP), false negative (FN), true negative (TN), and false positive (FP) test results for the entire diagnostic pathway
Type of analysis	Cost-consequences analysis

Review questions by scope area	**RQ 3.1 – What is the clinical and cost effectiveness of different pharmacological treatments for people with a confirmed diagnosis of DVT?** **RQ 3.2 – What is the clinical and cost effectiveness of different pharmacological treatments for people with a confirmed diagnosis of PE?**
Population	People with a confirmed diagnosis of DVT or PE
Interventions and comparators considered for inclusion	**Base-case analysis (7 treatment strategies)** People remain on the same treatment for both the initial and extended treatment phases: 1. Low-molecular-weight heparin (LMWH)/vitamin K antagonist (VKA) 2. Unfractionated heparin/VKA 3. Fondaparinux/VKA 4. Apixaban 5. Dabigatran 6. Edoxaban 7. Rivaroxaban **Sequencing analysis (70 treatment strategies)** This analysis considers different sequences of initial and extended treatment. People start treatment on 1 of the 7 comparators listed in the base-case analysis above and can switch to any of the following 10 comparators for the extended treatment phase: 1. No treatment 2. VKA low dose (INR 1.5 to 2.0) 3. VKA standard dose (INR 2.0 to 3.0) 4. Aspirin 5. Apixaban (2.5 mg twice daily) 6. Apixaban (5 mg twice daily) 7. Dabigatran 8. Edoxaban 9. Rivaroxaban (10 mg) 10. Rivaroxaban (20 mg) **Cancer subgroup analysis (8 treatment strategies)** People remain on the same treatment for both the initial and extended treatment phases: 1. LMWH/VKA 2. LMWH alone 3. Unfractionated heparin/VKA 4. Fondaparinux/VKA 5. Apixaban

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	6. Dabigatran 7. Edoxaban 8. Rivaroxaban
Perspective	NHS/PSS
Outcomes	Quality-adjusted life years
Type of analysis	Cost-utility analysis
Issues to note	DVT and PE index events are modelled separately