Comments on the ACD Received from the Public through the NICE Website

Name	[redacted]
Role	NHS Professional
Other role	BCIS lead for NICE
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	BCIS agree with this recommendation
Section 2 (The technology)	BCIS suggest no changes
Section 3 (The manufacturer's submission)	BCIS endorse the comments of our nominated experts (Curzen and Gershlick)on bleeding risk noting the excess risk of bleeding in non CABG patients.
Section 4 (Consideration of the evidence)	BCIS endorse the comments of our expert Dr Curzen on the use of CABG to treat patients with NSTEMI (about 10% of cases)and on the incoropration of bleeding in to the section on safety.
Section 5 (Implementation)	BCIS suggest no changes.
Section 6 (Proposed recommendations for further research)	BCIS agree with these comments.
Section 7 (Related NICE guidance)	BCIS have no comments
Section 8 (Proposed date of review of guidance)	BCIS have no comments
Date	21/07/2011 @ 15:07

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	Written on behallf of North East London Cardiovascular and Stroke Network
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The group have specifically been guided by the clinical trial clarification, this maybe somewhat unrealistic to apply into every day practice and scoring systems (e.g. GRACE) are in routine practice as a guide to the use of antiplatelet agents following recommendations by NICE. We would request a consideration that the position of ticagrelor in UA/NSTEMI sub-group should be determined by 6 month mortality in accordance to the recently published NICE guideline on UA/NSTEMI. We would welcome clarification on the use of ticagrelor in the use of low risk patients and in particular noting that clopidogrel is considered not appropriate in patients who have a 6 mortality of 1.5%. we request this is made explicitly clear that this is also applicable to ticagrelor.
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	
Section 4	it will helpful as part of the consideration of evidence to ensure that a duration

(Consideration of the evidence)	is explicitly recommended. Otherwise, there will be opportunity for inequity in prescribing that was seen with both clopidogrel and prasugrel. When clopidogrel TA was first published, many were prescribing for just 1 month, or 3 months following publication of SIGN. It was only when NICE published further clarification that up to 12 months meant for 12 months did care subsequently change. This variability was again recognised with the subsequent TA on prasugrel as no duration is stipulated leading to great variability in the durations of prasugrel ranging from 1 month to 15 months in accordance with the clinical trial publication. To help offer clear clarity, it will be most helpful if NICE was to offer a recommendation for duration based on evidence to guide clinical practice
Section 5 (Implementation)	
Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	
Date	20/07/2011 @ 19:07

Name	[redacted]
Role	other
Other role	General Secretary of UK Clinical Pharmacy Association - a pharmacy member organisation
Location	England
Conflict	no
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The duration is not explicitly recommended. There is therefore an opportunity for inequity in prescribing that was seen with both clopidogrel and prasugrel. When clopidogrel TA was first published, many were prescribing for just 1 month, or 3 months following publication of SIGN. It was only when NICE published further clarification that up to 12 months meant for 12 months did care subsequently change. This variability was again recognised with the subsequent TA on prasugrel as no duration is stipulated leading to great variability in the durations of prasugrel ranging from 1 month to 15 months in accordance with the clinical trial publication. To help offer clear clarity, it will be most helpful if NICE was to offer a recommendation for duration based on evidence to guide clinical practice.
Section 2 (The technology)	
Section 3 (The manufacturer's submission)	
Section 4 (Consideration of the evidence)	1. The group have specifically been guided by the clinical trial clarification. This may be somewhat unrealistic to apply into every day practice, and scoring systems (e.g. GRACE) are in routine practice as a guide to the use of antiplatelet agents following recommendations by NICE. UKCPA would request a consideration that the position of ticagrelor in UA/NSTEMI sub-group should be determined by 6 month mortality in accordance with the recently published NICE guideline on UA/NSTEMI. We would welcome clarification on the use of ticagrelor in the use of low risk patients. 2. NICE currently stipulates that any patient with UA/NSTEMI who has a 6 month mortality of 1.5% should not be offered clopidogrel as the risks potentially outweigh the benefits. We would suggest this equally applies to ticagrelor and is clarified in the recommendation.
Section 5 (Implementation)	

Section 6 (Proposed recommendations for further research)	
Section 7 (Related NICE guidance)	
Section 8 (Proposed date of review of guidance)	
Date	20/07/2011 @ 14:07