News

New NICE guidance on acute coronary syndromes

A new guideline has been published by the National Institute for Health and Clinical Excellence (NICE) and the National Clinical Guidelines Centre for Acute and Chronic Conditions on the early management of unstable angina and non-ST elevation myocardial infarction (NSTEMI).

They note that although cardiovascular deaths are declining, there were still over 40,000 patients with NSTEMI acute coronary syndromes admitted to hospital in England and Wales in 2009. With worrying increases in the incidence of key risk factors – obesity, diabetes, and the tendency for people to take less exercise – the management of these conditions remains a high priority.

As its starting point, the guideline recommends that as soon as a diagnosis of unstable angina or NSTEMI has been made, and aspirin and antithrombin drugs have been offered, patients should be formally assessed for their individual risk of future adverse cardiovascular events using an established risk scoring system that predicts six-month mortality, such as the GRACE (Global Registry of Acute Coronary Events) score. Then treatments should be given according to whether the patient is at high, intermediate or low risk of future events, taking into account the risk of adverse events (particularly bleeding).

The guideline also advises that angiography should be conducted (if no contra-indications), with follow-on percutaneous coronary intervention (PCI) within 96 hours of first admission to hospital in patients who have an intermediate or higher risk of cardiac events (predicted six-month mortality above 3.0%). Angiography should be performed as soon as possible for patients who are clinically unstable or at high ischaemic risk.

Ischaemia testing should be considered before discharge for patients whose condition has been managed conservatively and who have not had coronary angiography.

The guideline also emphasises the importance of providing patients with comprehensive information about their diagnosis and arrangements for follow-up. It further recommends that patients are given advice about the provision of cardiac rehabilitation programmes and about how lifestyle changes, such as giving up smoking, being physically active and eating a Mediterranean diet, can help prevent a future cardiovascular event.

For full guidance, visit http://guidance.nice.org.uk/CG94. This guideline updates and replaces recommendations for the early management of unstable angina and NSTEMI from NICE technology appraisal guidance 47 and 80.

Other NICE updates

Dronedarone included in new appraisal consultation document

An independent Appraisal Committee has revised NICE's original recommendation that dronedarone should not be used to treat atrial fibrillation (AF) after considering comments received at public consultation on the previous draft guidance. Recent draft guidance published on 30th March recommends the limited use of the drug as a second-line treatment in people with additional cardiovascular risk factors whose AF has not been controlled by first-line therapy (usually including beta blockers).

The guidance states: "Although the committee did not change their conclusion that dronedarone is not as effective as other anti-arrhythmic drugs in preventing the recurrence of AF, it accepted evidence that the drug did not lead to an increase in the risk of mortality, unlike the anti-arrhythmics with which it was compared. The Appraisal Committee also noted comments from patients and clinical experts received during consultation on the previous draft that all current anti-arrhythmic drugs, but particularly amiodarone, had side effects which had a significant impact on quality of life with long term use. Overall, the Committee concluded that dronedarone was likely to result in fewer adverse effects than amiodarone".

NICE recommends that until it issues final guidance, NHS bodies should make decisions locally on the funding of specific treatments.

Framingham no longer superior risk assessment tool in lipid modification guideline

The National Institute for Health and Clinical Excellence (NICE) has announced that it is withdrawing advice in its in lipid modification guideline to use the Framingham risk assessment tool for cardiovascular risk assessment, saying that it is not clear that it is superior to other tools. Healthcare professionals will now instead decide which risk assessment tool is most suitable for their needs.

NICE says it was aware when the guideline was published in May 2008 that the evidence on cardiovascular risk estimation was developing rapidly, and so recommended that further research was needed on how best to estimate cardiovascular disease risk. After the publication in 2009 of more evidence comparing the QRISK tool with other risk estimation tools, it has now been decided that there is insufficient evidence to allow for a clear decision in recommending one cardiovascular risk estimation method over another.

New NICE guidance on chest pain of recent onset

It is hoped that a new National Institute for Health and Clinical Excellence (NICE) guideline on recent onset chest pain will lead to a reduction in cardiovascular deaths.

The guideline, jointly developed with the National Clinical Guidelines Centre for Acute and Chronic Conditions, represents a significant change in practice in some key areas of diagnosing acute coronary sydromes (ACS) and angina.

The focus of the new guideline is on the diagnosis of chest pain which is suspected to be of cardiac origin, so that appropriate treatment can be provided.

It notes that chest pain is experienced by some 20–40% of the general population at some time during their lives, and accounts for up to 1% of visits to GPs, approximately 700,000 visits (5%) to emergency departments and up to 25% of emergency admissions to hospital.

The guideline has two separate diagnostic pathways. The first is for patients with acute chest pain who may have an ACS and the second is for those with intermittent stable chest pain of suspected cardiac origin who may have stable angina.

Recommendations in the guideline for people with suspected ACS include:

- Take a resting 12-lead ECG as soon as possible. When people are referred, send the results to hospital before they arrive if possible. Recording and sending the ECG should not delay transfer to hospital.
- Do not exclude ACS when people have a normal resting 12-lead ECG.
- Do not routinely administer oxygen, but monitor oxygen saturation using pulse oximetry as soon as possible, ideally before hospital admission, to guide the use of supplemental oxygen.
- Do not assess symptoms of an ACS differently in different ethnic groups.

Recommendations for people with intermittent stable chest pain who may have stable angina include:

- Diagnose stable angina based on either clinical assessment alone or where there is uncertainty, clinical assessment plus diagnostic testing.
- If people have features of typical angina based on clinical assessment and their estimated likelihood of coronary artery disease (CAD) is greater than 90%, further diagnostic investigation is unnecessary and should be managed as angina.
- Unless clinical suspicion is raised based on other aspects of the history and risk factors, exclude a diagnosis of stable angina if the pain is non-anginal and first consider causes of pain other than angina (such as gastrointestinal or musculoskeletal pain).
- In people without confirmed CAD, in whom a diagnosis of stable angina cannot be made or excluded based on clinical assessment alone, estimate the likelihood of CAD, taking into account the clinical assessment and the resting 12-lead ECG. Arrange further diagnostic testing according to the estimated likelihood of CAD.
- Do not use exercise ECG to diagnose or exclude stable angina for people without known CAD.

For full guidance, visit http://guidance.nice.org.uk/CG95. This clinical guideline partially updates NICE technology appraisal guidance 73.