

HumiGard for preventing inadvertent perioperative hypothermia

HealthTech guidance

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This guidance replaces MTG31.

1 Recommendations

More research is needed

- 1.1 HumiGard shows promise for preventing hypothermia during abdominal surgery. There is, however, insufficient robust evidence to support the case for routine adoption, particularly on using HumiGard to avoid important adverse outcomes and on how it affects resource use in open and laparoscopic surgery.

What research is needed

- 1.2 Research is recommended on HumiGard compared with standard insufflation gases in patients having laparoscopic or open surgery alongside general measures to reduce the risk of perioperative hypothermia described in [section 2.5](#). Research should report on the comparative rate of surgical site infections and other complications associated with hypothermia and normothermia, as well as related resource use.

2 The technology

Description of the technology

- 2.1 HumiGard (Fisher and Paykel Healthcare) is designed to humidify and heat carbon dioxide (CO₂) gas, which is routinely used to fill the peritoneal cavity during laparoscopic abdominal surgery. The intention is to reduce the negative effects associated with the use of dry, unwarmed CO₂ gas, namely tissue desiccation and intra-operative hypothermia. HumiGard is designed to be used both independently and in addition to other warming measures that are applied to the external body surfaces and extremities, such as forced air warming. HumiGard comprises a humidifier and consumable tubing set. It humidifies and warms the CO₂ by passing the gas over a reservoir of water. The heated, humidified gas is then passed along a sterile tube for delivery into the abdominal cavity through a needle cannula. HumiGard can also be applied to open surgical wounds using a bespoke patient interface diffuser to effectively immerse the open surgical wound cavity in warmed, humidified CO₂ gas.
- 2.2 HumiGard received a class 2a CE mark in April 2013. It is indicated for use in laparoscopic or open abdominal surgery when CO₂ insufflation gas is used.
- 2.3 The list prices (excluding VAT) for the components of HumiGard are as follows.
- Capital costs:
 - MR860AEU humidifier: £895.
 - Consumables:
 - For laparoscopic surgery: ST310 humidified and heated tubing kit: £75 per patient.
 - For open surgery: ST310 humidified and heated tubing kit plus VITA diffuser (ST300 DF): £99 per patient.
- 2.4 The claimed benefits of HumiGard in the case for adoption presented by the

company are:

- Decreased incidence of intra-operative and post-operative hypothermia through less evaporative cooling.
- Decreased incidence of surgical site infections because of improved intra-operative temperature maintenance.
- Improved post-operative recovery and faster discharge.
- Reduced overall costs as a result of better patient outcomes including fewer surgical site infections, less time spent in hospital for surgery, and less time in post-operative recovery.

Current management

- 2.5 [NICE's guideline on hypothermia](#) recommends that all patients intended for surgery be assessed for risk of perioperative hypothermia. All patients should receive warmed intravenous fluids and blood products; patients identified as being at higher risk should be warmed intraoperatively using a forced air warming device, as should any patient having anaesthesia for more than 30 minutes. Regular temperature measurement is recommended before, during and after surgery, and forced air warming is recommended for any patient whose core temperature drops below 36°C.
- 2.6 [NICE's guideline on hypothermia](#) relates to the general prevention of hypothermia during surgery and does not make any specific recommendations about the warming of insufflation gas. Unwarmed, dry insufflation gas is used routinely in laparoscopic surgery.
- 2.7 NICE's previous guidance on the Inditherm patient warming mattress (MTG7; now replaced by [NICE's guideline on hypothermia](#)) recommended this device as a cost-effective alternative to forced air warming.

3 Clinical evidence

Summary of clinical evidence

3.1 The key clinical outcomes for HumiGard presented in the decision problem were:

- incidence of hypothermia during and after surgery (defined as a core body temperature of less than 36°C)
- incidence of surgical site infections
- length of stay in post-operative recovery
- total length of hospital stay
- device-related adverse events
- patient-reported pain.

3.2 The company carried out separate literature searches for laparoscopic and open surgery, encompassing both published and unpublished studies. Its submission included 24 studies, 20 involving laparoscopic surgery and 4 involving open surgery. The company used a checklist to determine if studies were generalisable and presented 16 (of the total 24) involving other humidification devices. The external assessment centre (EAC) considered that humidification systems other than HumiGard were beyond the scope of the evaluation and that those 16 studies should be excluded. The EAC's independent literature searches did not identify any additional studies on HumiGard. It judged that 7 studies provided relevant evidence: 5 on laparoscopic surgery (Herrmann and De Wilde 2015, Manwaring et al. 2008, Sammour et al. 2010, Yu et al. 2013 and Mason et al. 2016) and 2 on open surgery (Frey et al. 2012 and Weinberg et al. 2014).

Laparoscopic surgery

3.3 Hermann and De Wilde (2015) reported on a double-blind randomised controlled trial that compared HumiGard with unwarmed, dry CO₂ gas in patients aged

18 years or over with benign uterine diseases having gynaecological laparoscopic surgery. Randomisation led to 52 patients receiving warm ($35\pm 2^{\circ}\text{C}$), humidified (98% humidity) CO_2 with HumiGard and 52 patients receiving standard room temperature, dry (0% humidity) CO_2 . The primary outcome was post-operative pain at 2, 4, 6, 24 and 48 hours as measured by a visual analogue scale (VAS). Secondary outcome measures were morphine consumption and demand and post-operative, patient-controlled analgesia, including rejected boli delivery (not delivered when request was made within 10 minutes of the previous bolus), temperature change during surgery, length of time spent in the recovery room and length of inpatient stay. The results showed a significant difference in total shoulder tip pain ($p=0.037$), which was one of a number pain outcomes and differences in some indicators of morphine consumption. There were no other statistically significant difference in any of the other outcome measures specified in the scope.

- 3.4 Manwaring et al. (2008) reported on a randomised controlled trial that compared HumiGard with unwarmed, dry CO_2 gas in women aged 18 to 55 years having gynaecologic laparoscopic surgery. Randomisation led to 30 patients receiving warmed, humidified CO_2 with HumiGard, and 30 patients receiving standard room temperature, dry CO_2 . The primary outcome was shoulder tip pain at 4 hours after surgery. Secondary outcome measures were time in recovery room, nausea, post-operative temperature and pelvic pain. The results showed a significant difference in change in core temperature from theatre to recovery ($p=0.027$) but no other statistically significant difference in the other outcome measures specified in the scope.
- 3.5 Sammour et al. (2010) reported a double-blind randomised controlled trial that compared HumiGard with unwarmed, dry CO_2 gas in patients aged 15 years or older having elective laparoscopic colonic resection. Randomisation led to 41 patients receiving warm (37°C), humidified (98% humidity) CO_2 with HumiGard, and 41 patients receiving room temperature, dry CO_2 . The primary outcome was total opiate analgesia used during inpatient stay. Secondary outcome measures were post-operative pain (measured on a VAS) at 2, 4, 8 and 12 hours and 1, 2, 3, 7, 14, 30 and 60 days after the operation. Other secondary outcome measures were intra-operative core temperature, cytokine response and length of inpatient stay. Six patients in the HumiGard group and 2 in the control group were excluded from the analysis with reasons given. The results showed that HumiGard had a

significant effect on post-operative pain at rest on day 1 ($p=0.01$) and post-operative pain on moving on day 1 ($p=0.018$). The results showed no statistically significant difference in the other outcome measures specified in the scope.

- 3.6 Yu et al. (2013) reported on a double-blind randomised controlled trial that compared HumiGard with unwarmed, dry CO₂ gas in children aged 8 to 14 years having an acute laparoscopic appendectomy. Randomisation led to 95 patients receiving warm (37°C), humidified (98% humidity) CO₂ with HumiGard and 95 patients receiving room temperature, dry CO₂. The primary outcome was post-operative pain (analgesic use) in the recovery room and at days 1 and 2 after the operation. Secondary outcome measures were pain intensity scores, intra-operative core temperature and post-operative recovery and return to normal activities. Two patients in the HumiGard group and 3 in the control group were excluded from the analysis with reasons given. The authors provided only graphical data for pain perceived at rest and on moving (VAS), but no differences were reported between the groups at any of the time points studied (0, 2, 4, 6, 8, 10, 12, 24 and 48 hours). The results showed no statistically significant difference in the other outcome measures specified in the scope.
- 3.7 Mason et al. (2016) was a retrospective cohort trial, done in a single UK centre, including patients having laparoscopic colorectal resections. The trial included 246 consecutive patients (mean age 68 years) with equal numbers having HumiGard or standard care. Outcome measures included incidence of surgical site infections, incidence of post-operative pneumonia, perioperative hypothermia, number of bed days, length of time in theatre recovery and cost. Body temperature was routinely measured tympanically on arrival to the post-anaesthetic recovery suite. The measurement of temperature intraoperatively was not standardised and therefore could not be included in the analysis. The results showed significant differences in perioperative hypothermia ($p\leq 0.001$), post-operative hypothermia on arrival in the recovery suite ($p<0.001$) and incidence of surgical site infections when hypothermic ($p=0.02$). There was a significant difference in overall incidence of surgical site infections ($p=0.04$) but not in length of hospital stay.
- 3.8 The EAC concluded that the clinical evidence on HumiGard for laparoscopic surgery was of relatively good quality: there are 4 randomised controlled trials and 1 retrospective cohort study in appropriate patients, all of which compared

HumiGard with standard unwarmed, dry CO₂ gas. However, the EAC also concluded that the cohort study (Mason et al. 2016) should be interpreted with caution, because of possible confounding factors arising from its design and uncertainty about the significance of its findings because of an incomplete description of regression and model development methods, regression diagnostics, any missing data and choice of final model.

Open surgery

- 3.9 Frey et al. (2012) reported on a randomised controlled trial that compared HumiGard with no insufflation in patients over 18 years (mean age 63.5 years) having elective open colonic surgery. Randomisation led to 42 patients receiving warm (37°C), humidified (100% humidity) CO₂ gas with HumiGard and 41 patients receiving no insufflation. The primary outcome was intra-operative core and wound temperature and the secondary outcome measure was length of hospital stay. Two patients in the HumiGard group and 2 in the control group were excluded from the analysis with reasons given. The results showed significant benefits for the HumiGard group in terms of the proportion of patients with core temperature <36.0°C at end of surgery (p=0.005), the proportion of patients with core temperature <36.5°C at end of surgery (p=0.001), reduced core temperature at end of surgery (p≤0.001), reduced core temperature during surgery (p≤0.001), reduced wound area temperature during surgery (p≤0.001) and reduced wound edge temperature during surgery (p≤0.001). The results showed no statistically significant difference between the groups for length of stay.
- 3.10 Weinberg et al. (2014) reported on a prospective pilot randomised controlled trial published as an abstract that compared HumiGard and standard care (predetermined temperatures for infused fluid, ambient air and heating mattress temperature) with standard care alone in adult patients having primary orthotopic liver transplantation. No details were provided regarding number of patients in each group, but 22 patients were randomised to the intervention or control. The primary outcome was intra-operative core temperature before reperfusion and at completion of surgery. No secondary outcomes were reported. The core temperature immediately before reperfusion (°C, nasopharyngeal probe) was significantly higher in the HumiGard group (p=0.02). No statistically significant differences were reported for core temperature on wound closure (°C,

nasopharyngeal probe), core temperature immediately before reperfusion (°C, pulmonary artery catheter), core temperature on wound closure (°C, pulmonary artery catheter), core temperature immediately before reperfusion (°C, bladder probe) and core temperature on wound closure (°C, bladder probe).

- 3.11 The clinical evidence submitted for open surgery was based on 2 small randomised controlled trials, 1 of which was a small pilot study published in abstract form only. The EAC concluded that there was insufficient information to critically appraise the Weinberg et al. (2014) abstract and Frey et al. (2012) was of reasonable quality.

Adverse events

- 3.12 Two randomised controlled trials involving laparoscopic abdominal surgery (Herrmann and De Wilde 2015, Sammour et al. 2010), included device-related adverse events as an outcome measure. Both studies reported no adverse events associated with the use of HumiGard. The other 3 studies on laparoscopic surgery did not report device-related adverse events. None of the studies on open abdominal surgery reported device-related adverse events.

Committee considerations

- 3.13 The committee noted that there is good evidence that perioperative hypothermia is associated with poor patient outcomes, such as surgical site infections. Experts were in agreement and advised the committee that maintaining perioperative normothermia is now an established aim of clinical practice.
- 3.14 The committee considered that the clinical evidence supported the effectiveness of HumiGard in reducing hypothermia during laparoscopic and open abdominal surgery, noting that the evidence base was more substantial for laparoscopic surgery than for open surgery. The committee also noted the lack of high-quality direct comparisons supporting the use of HumiGard to avoid the adverse outcomes of hypothermia following surgery.
- 3.15 The committee noted that only 1 of the included studies involved children, and

that in this study outcomes did not improve. The clinical experts advised that heat loss is partly determined by the ratio of body surface area to body mass. Because this is larger in children, overheating through the use of warming strategies can also be a concern. The committee concluded that there was insufficient evidence to recommend the use of HumiGard in children.

3.16 The committee heard from the clinical experts that total length of hospital stay after abdominal surgery has been reduced through the implementation of enhanced recovery programmes. Historically, length of stay after colorectal surgery was 7 to 9 days but this has now been reduced to approximately 4 to 5 days through the use of such programmes. This change makes it difficult to demonstrate how a single technology such as HumiGard affects total length of stay but the committee accepted that interventions which reduce surgical site infections would be beneficial.

3.17 The committee heard from the clinical experts that wound orientation is unlikely to affect the use and effectiveness of HumiGard. The committee was also advised that the presence of intra-abdominal sepsis would not be a barrier to its safe use.

4 NHS considerations

System impact

- 4.1 During abdominal surgery, HumiGard is used in combination with other warming measures (such as forced air warming) in patients at high risk of developing hypothermia. This includes patients having surgical procedures with anaesthesia for more than 30 minutes. During laparoscopic surgery, HumiGard replaces standard insufflation equipment. For open surgery, HumiGard is connected to standard sources of theatre-piped gas. If piped gas is unavailable, the company is able to provide a gas supply stand that delivers CO₂ to HumiGard. Clinical experts with experience in the use of HumiGard stated that minimal training is needed to introduce it into clinical practice.

Committee considerations

- 4.2 The committee was informed by the clinical experts that HumiGard can be set up in approximately 1 minute.
- 4.3 The committee heard from 2 expert advisers that HumiGard has become a well-accepted part of standard theatre practice in their centres. One expert adviser added that HumiGard has been introduced as a part of their enhanced recovery programme and subsequently adopted by every theatre in the hospital.
- 4.4 The committee heard from the clinical experts that they had experienced no safety issues with HumiGard.

5 Cost considerations

Cost evidence

- 5.1 The company identified 2 studies that incorporated a cost-effectiveness analysis. The external assessment centre (EAC) judged that the company's search strategy was highly sensitive and well-constructed, and that the selection criteria reflected the NICE scope. The EAC carried out its own economic search and found no additional studies.
- 5.2 Both of the identified studies were published as conference abstracts and compared HumiGard with standard care in the UK. The company provided unpublished, academic-in-confidence draft manuscripts relating to both abstracts.
- 5.3 The abstract by Jenks et al. (2015) reported on a cost-utility analysis using a decision analytic model of HumiGard compared with standard care open or laparoscopic colorectal surgery. This showed that HumiGard dominated standard care in both open and laparoscopic surgery (that is, it was both less costly and more effective than standard care). The full manuscript by Jenks et al. provided further detail on the study and was available to the EAC. Effectiveness data for open surgery were derived from Frey et al. (2012; [section 3.9](#)). Data on the probability of complications related to hypothermia were taken from a published retrospective study (Billeter et al. 2014) and linked to the data from Frey et al. (2012). The effectiveness data for laparoscopic surgery were taken from a retrospective cohort study reported in a conference abstract (Noor et al. 2015). The costs of myocardial infarction, stroke, sepsis and pneumonia were taken from NHS reference costs 2013/14. The cost of surgical site infections was derived from the [NICE quality standard on surgical site infection](#). The results presented in the full manuscript matched those reported in the abstract.
- 5.4 The study by Mason et al. 2016 ([section 3.7](#)) also reported a cost-benefit analysis of HumiGard compared with standard care in patients having laparoscopic colorectal surgery. The EAC was unable to replicate the cost analysis from this study.

Cost model

- 5.5 The company presented a de novo economic model adapted from Jenks et al. estimating mean cost savings per patient in open and laparoscopic colorectal surgery. The model assumed a 70:30 split for the use of HumiGard in laparoscopic and open surgery respectively. It comprised 2 decision trees incorporating complications associated with hypothermia and related NHS costs for each kind of surgery. The model runs over 1 year; horizons up to 5 years were reported in scenario analyses, but because these extend post-myocardial infarction and stroke costs they affect only open surgery. The model was based on 3 studies: Noor et al. 2015 (laparoscopic surgery: incidence of surgical site infections and pneumonia), Frey et al. 2012 (open surgery: proportion of patients with hypothermia at the end of surgery) and Billeter et al. 2014 (open surgery: incidence of myocardial infarction, stroke, sepsis, pneumonia, surgical site infection and mortality).
- 5.6 The company's scenario analyses included exploring the use of alternative sources of clinical effectiveness, a univariate deterministic sensitivity analysis and a probabilistic analysis of the base-case results. For open surgery, it used 3 alternative sources for the proportion of patients experiencing complications (Kurz et al. 1996, Flores-Maldonado et al. 2001, Anannamcharoen et al. 2012). For laparoscopic surgery, the company presented 2 scenario analyses that used data on the proportion of patients with hypothermia linked with complications associated with open surgery (Billeter et al. 2014). The first of these used data from Mason et al. (2016) whereas the second used data from Sammour et al. (2010). The analyses showed that the costs for treating stroke (£2,715 to £13,858) and surgical site infections (£2,100 to £10,500) had the largest effects on the results.
- 5.7 The company's base case showed that, overall, HumiGard costs £419 per patient compared with £724 per patient for standard care. The company therefore estimated that using HumiGard would save £305 per patient. Most cost savings (69%) come from fewer surgical site infections after laparoscopic surgery (with cost savings of £20 per patient in open surgery and £428 per patient in laparoscopic surgery).
- 5.8 Sensitivity analyses showed that HumiGard becomes cost incurring when the

absolute difference in infection risk is 0.3% (for example, 4.7% versus 5%). For open surgery, using data from Frey et al. (2012), HumiGard was associated with a modest additional cost (using complication data from Billeter et al. 2014 or Flores-Maldonado et al. 2001).

- 5.9 The company's probabilistic sensitivity analysis found that HumiGard was cost saving in 97.4% of iterations and the average probabilistic cost savings were £302 per patient. The company noted that the results of its probabilistic sensitivity analysis have a skewed distribution and stated that this is because of the distribution of costs of complications within the model (which have a gamma distribution bounded by 0, but no upper limit).

Additional work by the external assessment centre

- 5.10 The EAC re-ran the company's base case and univariate sensitivity analyses for open and laparoscopic surgery separately, and conducted additional analyses using its preferred estimates. The main changes to the company's model were:
- including updated NHS reference costs for pneumonia, acute myocardial infarction and sepsis
 - annuitising the capital cost of HumiGard
 - re-estimating the costs of 'post-myocardial infarction' to reflect current drug prices
 - using alternative costs of treating stroke and surgical site infections
 - using a 5-year time horizon and including data on hypothermia from the randomised control trial in laparoscopic surgery linked to data on complications from the retrospective cohort study (laparoscopic surgery only).
- 5.11 The EAC re-ran univariate sensitivity analyses for open and laparoscopic surgery, including updated costs for adverse events and a discount rate for HumiGard of 3.5% over 5 years. In addition to this for laparoscopic surgery, the EAC took hypothermia data from Sammour et al. (2010) and risk of complications data from Billeter et al. (2014). The EAC considered that because stroke and myocardial

infarction have long-term resource implications, a longer time horizon was preferable. However, the model incorporates this by simply adding in additional costs to later years, so the EAC also conducted analyses using a 1-year time horizon. Additional EAC sensitivity analyses included an alternative estimate for the cost of treating surgical site infections (£5,164, based on Jenks et al. 2015) and laparoscopic surgery complication data from Noor et al. (2015).

- 5.12 For open surgery, the results of the EAC's analysis suggest that HumiGard is cost saving compared with standard care, with an average saving per patient of £209. This is a larger cost saving than that identified in the company's model because of the longer (5-year) time horizon. The probability that HumiGard is cost saving was 98% in the sensitivity analysis. The results for a 1-year time horizon were broadly similar to those reported by the company (an average cost saving of £28 per patient).
- 5.13 For laparoscopic surgery, the EAC concluded that savings were lower than in the company model (an average of £77 per patient) because the EAC used data from Sammour et al. (2010) rather than Mason et al. (2016). The probabilistic analysis found that HumiGard was cost saving in 67.5% of iterations. Using a 1-year time horizon, HumiGard was associated with a small additional cost of £11 per patient.
- 5.14 The committee was uncertain about assumptions and parameters in the cost modelling which could not be addressed by the evidence presented. The committee noted that the effect of hypothermia on the risk of stroke during abdominal surgery, the incidence of surgical site infection and the cost of a surgical site infection to the NHS were parameters associated with most uncertainty. The EAC was asked to make further changes to the model to better inform the economic analysis (sections 5.15 to 5.19).
- 5.15 The committee was advised by clinical experts that the risk of stroke during abdominal surgery is very low. In the context of elective colorectal surgery, the experts estimated it to be less than 1%. Hospital Episode Statistics data were presented to the committee on perioperative stroke rates for England. The data represented selected abdominal procedures that were done in April 2014 and were followed by a primary diagnosis of a stroke at any time during the 2014/15 financial year. The relevant procedures were selected following expert advice. The stroke rates were 0.4% for laparoscopic surgery and 0.6% for open surgery.

- 5.16 The EAC reviewed the [NICE guideline on hypothermia](#) to identify additional data on the associated complications. The guideline cited a study by Frank et al. (1997), as well as 2 studies (Kurz 1996 and Flores-Maldonado 2001) used in the company's model (section 5.6). Nevertheless, following the review, the EAC re-affirmed its view that Billeter et al. (2014) was most relevant to the decision problem.
- 5.17 The EAC used 2 sources (Sammour et al. 2010 and Mason et al. 2016) of clinical-effectiveness data to better characterise the remaining uncertainties in further cost analyses for laparoscopic surgery. The EAC used data in a personal communication from Mason et al. (2016) to calculate adjusted risks for hypothermia and surgical site infections, taking into account the population characteristics in each study arm. The EAC also used data in a personal communication from Sammour et al. (2010) to assess hypothermia risk with and without HumiGard.
- 5.18 The EAC used a range of additional analyses to assess how different stroke rates, surgical site infection costs and sources of effectiveness data affect HumiGard's potential cost savings.
- 5.19 For open surgery (using data from Frey et al. 2012 data on hypothermia risk and Billeter et al. 2014 data on risk of complications), HumiGard appears to be associated with a cost saving for scenarios when the difference in risk of stroke between hypothermic and normothermic patients is greater than 0.75% to 1.25% (depending on the cost of surgical site infections). At a stroke risk difference below this range, HumiGard is associated with a modest increase in mean cost per patient.
- 5.20 For laparoscopic surgery (using data from Billeter et al. 2014 and Sammour et al. 2010), HumiGard is cost saving only if the difference in stroke risk between hypothermic and normothermic patients is greater than 1.75% to 2.25% (depending on the cost of surgical site infections). Additional analyses using the data from Mason et al. (2016; and the updated predicted risk data calculated by the EAC) suggest that HumiGard is cost saving regardless of the cost of surgical site infections and stroke risk when using a range of complications data from Billeter et al. (2014), but cost saving or cost neutral when using only direct data on surgical site infection complications. However, the EAC was unable to fully

appraise these models because of incomplete information from Mason et al. (2016).

Committee considerations

- 5.21 The committee was informed by the clinical experts that the 5.5% stroke risk extrapolated from Billeter et al. (2014) in the company's cost model was an overestimate of the risk in current UK NHS practice, and that this is more likely to be less than 1%. The committee concluded that this distinction is likely to be very influential in the outcome of cost modelling. The committee was informed by the EAC that reducing the stroke risk to 0% in the cost model would make the use of HumiGard cost incurring. The committee concluded that the use of HumiGard was unlikely to reduce stroke rates for patients having abdominal surgery in the NHS.
- 5.22 The committee was informed that the NHS costs associated with surgical site infections were uncertain and that published estimates vary. The committee noted that the average cost used in the EAC cost analysis was reflective of current practice. Expert advice stated that surgical site infection costs vary considerably in colorectal surgery.

6 Conclusions

- 6.1 The committee concluded that there is good evidence to support the use of measures to prevent hypothermia during abdominal surgery and that, in this regard, HumiGard shows promise. However, it considered that there is insufficient evidence to demonstrate that HumiGard has a substantial effect on reducing adverse outcomes for patients having abdominal surgery.
- 6.2 The committee concluded that the cost consequences of using HumiGard in abdominal surgery are very uncertain, and that further research is needed on resource use.
- 6.3 The committee recommended conducting research in collaboration with the company and with clinical and academic partners. NICE will update this guidance if new and substantive evidence becomes available.

7 Committee members and NICE project team

Committee members

This topic was considered by the medical technology advisory committee which is a standing advisory committee of NICE.

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that evaluation.

The minutes of each committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

NICE project team

Each medical technology appraisal is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the appraisal) and a technical adviser.

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