Renal Stones: scope workshop discussions – Group ____ Date: 08 December 2015		
Scope details (Numbers correspond to numbered sections in the scope)	**Questions for discussion**	**Stakeholder responses**
1. Why the guideline is needed: Current practice (line 30) states: Ongoing treatment of renal stone disease is dependent on the site and size of the stone (<10 mm; 10-20 mm; >20 mm; staghorn stones).	The measurements provided are examples only, do you agree with the range of renal stone sizes mentioned? (Would you like to include: <5mm, 5-10mm?)	• The group suggested that an extra category of stones less than 5 mm should be included as guidance on the management of people with renal stones <5mm would be welcome. The group agreed that the list of sizes should include: less than 5, 5-10 and 10-20, and staghorn. •
3.1 Who is the focus: **Groups that will be covered:** • Adults (18 and over) with renal stones (kidney and ureteric stones) **Groups that will not be covered:** • Children (under 18 years of age) with renal stones	The Department of Health has asked NICE to develop a clinical guideline on the assessment and management of renal stones. • Are there any specific subgroups that have not been mentioned (in either list)?	• The group placed strong emphasis on the inclusion of children. They highlighted, continuity of care as a service wide problem and shared the following further views on the inclusion of paediatrics: o In large cities e.g. London or Birmingham there is a higher incidence of children with renal stones as the Indian/Pakistani community is larger in these areas and children in these communities are more likely to have renal stone disease. o Guidance around anaesthesia for paediatrics would be welcome. o Paediatric urologists may not be aware of endoscopic solutions. o Nationwide, only a tiny percentage of the Renal Stones population are paediatric, but it was felt that this was not managed effectively. o Metabolic work-up is not always identical in paediatrics and adults o 75% of paediatric Renal Stones have a metabolic cause o Imaging and surgery different for paediatrics compared to adults (e.g. open surgery more common in children) o Finally, there are differences between children and adults regarding imaging and metabolics.

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		• Pregnant women were suggested as an additional subgroup.
3.2. Settings **Settings that will be covered** • All settings in which NHS-commissioned care is provided.	• Are the listed settings appropriate? • Are there other settings that should be considered? •	• Nothing noted
3.3 Activities, services or aspects of care: **Key areas that will be covered** 1 Imaging for the diagnosis and assessment of renal stones (for example CT, ultrasound) 2 Management of asymptomatic renal stones (for example, Extracorporeal Shock Wave Lithotripsy (ESWL), ureteroscopy, metabolic advice) 3 Pharmacological management of symptomatic renal stones (for example, NSAIDs, opioids, alpha blockers, calcium channel blockers) 4 Surgical interventions for symptomatic renal stones (for example, for upper/lower pole renal stones, upper/lower ureteric stones) 5 Management of obstructed infected kidney secondary to renal stones (for example, drainage techniques) 6 Follow-up management in people with a history of renal stones	These are the key clinical areas that have been prioritised for inclusion in the guideline. • Do you think that these prioritised areas are appropriate for the topic? • Are the excluded areas appropriate? • Have any areas not been mentioned?	• Key areas were welcomed by the group – no objections or additions given generally
3.3 Areas that will not be covered: • Bladder stones • Open surgery for renal and ureteric stones.	<u>Areas not covered:</u>	• Nothing noted
1.4 Economic Aspects An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Which practices will have the most marked/**biggest cost** implications for the NHS? • Are there any **new practices** that might **save the NHS money** compared to existing practice?	• The group highlighted the availability of lithotripsy equipment likely to be an issue • The group suggested that low dose CT scans are unlikely to be available in the DGH setting. • The group thought that recommendations for metabolic work ups and management following this may lead to savings

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3.5 Key issues and questions This section expands upon the areas mentioned in section 1.3. This section should therefore give more of the detail of what the key issues are within that area and what questions will be asked to address those issues.		
1 Imaging for the diagnosis and assessment of renal stones 1.1 What is the most clinically and cost-effective diagnostic imaging technique for people with suspected renal stones?	• Are these the correct questions? • Are there any questions missing?	• The group thought that repeat imaging is standard practice, however, they would welcome guidance on the best type of imaging (e.g. low dose CT scan for adults and children), how often imaging should take place (first assessment? Follow up?) and how patients should be followed up. • The group agreed that focus is needed on this area. • Specifically, the group mentioned the importance of knowing the best time to image at 1st presentation, and what kind of imaging is best?
2 Management of asymptomatic renal stones 2.1 What is the most clinically and cost-effective management (for example Extracorporeal Shock Wave Lithotripsy (ESWL), ureteroscopy) in people with asymptomatic renal stones?	• Are these the correct questions? • Are there any questions missing?	• The group felt that there would be little evidence around this topic, and it will be conflicting due to differences in current practice. • Participants suggested that dietary advice may be important and that burden of disease would influence clinical management. • Patient factor important (e.g. patients with only one kidney left). • Participants discussed instances where the need for further imaging may or may not be required (for example if stones have been identified through imaging for other medical reason and stone seen, should imaging be repeated?) Note: Group also asked that this question be moved to lower down on the list.

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3 Pharmacological management of symptomatic renal stones 3.1 What is the clinical and cost-effectiveness of analgesics in managing pain in people with symptomatic renal stones? 3.2 What is the clinical and cost-effectiveness of pharmacological treatments other than analgesics in people with symptomatic renal stones?	• Are these the correct questions? • Are there any questions missing? (For question 3.1 we aim to compare NSAIS vs opioids, please comment on this.)	• The group discussed current pharamacological practice and raised the following: ○ Nurofen and paracetamol are primarily being prescribed. ○ NSAIDs not prescribed for children 1st line, only morphine and paracetamol ○ Diclofenac used to be the drug of choice, but there is an MHRA blanket ban due to cardiac risk – but the group thought this is the most effective drug, and for acute pain (short term use) shouldn't put patients at risk ○ Common/recommended use of opioids ○ Questions that are important here are: which NSAID is best? And opioids should be included. ○ BMJ paper comparing NSAIDs vs. opioids has been published ○ UK approach to alpha blockers use is established (big UK study published) and may not need further recommendations. The group noted the UK/USA divide in this approach
4 Surgical intervention for symptomatic renal stones 4.1 What is the most clinically and cost-effective length of time to manage symptomatic renal stones conservatively before intervention? 4.2 What are the most clinically and cost-effective surgical treatment options for people with symptomatic renal stones?	• Are these the correct questions? • Are there any questions missing?	• The group agreed that a recommendation standardising pre-op testing of urine would be welcome – checking for infection prior to surgery to avoid complications/further infection • Evidence on timing may be limited • Common practice for people admitted in A&E to be given a stent and then at a later date receive elective surgery. • There was a suggestion that the categories should be more specific (not only upper/lower pole renal stones, upper/lower ureteric stones)

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5 Management of obstructed infected kidney secondary to renal stones 5.1 What is the most clinically and cost-effective intervention for managing obstructed infected kidney secondary to renal stones?	• Are these the correct questions? • Are there any questions missing?	• The group mentioned mortality and noted that there were 160 deaths a year due to kidney stones – It was felt that many patients don't believe the importance/seriousness of stones and that this needs to be conveyed to people with renal stone disease. • The group agreed that there was unlikely to be much evidence and that evidence of equivalence would be important
6 Follow-up management in people with a history of renal stones 6.1 What is the clinical and cost-effectiveness of performing imaging in the follow up of people with a history of renal stones? 6.2 Which metabolic investigations, if any, should be performed in people with a history of renal stones?	• Are these the correct questions? • Are there any questions missing?	• The group noted that although economic and observational studies exist, this evidence would probably be a 'mixed bag'. • The group discussed whether or not everyone should have a 24-hour urine test or the proportion of people with a history of renal stones that should have it? • Main points stressed were: What do you do? When do you do it? And how long do you do it for? • The group acknowledged the huge variation in practice, they suggested that GPs would benefit from guidance in this area. • Metabolic investigations are important for cystinuria, may prevent dialysis, which would be a huge saving.
6.3 What are the most clinically and cost-effective pharmacological treatments to reduce the risk of future stones in people with a history of renal stones?	• Are these the correct questions? • Are there any questions missing? (Thiazides only or other drugs as well)	• The group felt it was key for clinicians to understand what type of stone has been presented before prescribing/recommending pharmacological treatments. • Potassium citrate tablet is prescribed on a case by case basis, but procured from the U.S – not licenced here

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		• Other patients on liquid potassium citrate – unpleasant for the patient to drink – must be drunk in large quantities • People with metabolic cause for renal stones gain more from pharmacological management
6.4 What is the clinical and cost-effectiveness of dietary and other lifestyle interventions to reduce the risk of future stones in people with a history of renal stones?	• Are these the correct questions? • Are there any questions missing? (Should we look at fluids only or include: salt, citrate and protein intake). • (lifestyle will also include weight loss and exercise)	• Calcium is needed to absorb the oxalate that causes the formation of stones. Long term data may not be available • Emphasis is needed on dietary change – this question needs to be asked • Alkiline diet helps prevent stone formation – high animal protein-rich diet causes stone formation – too acidic • salt/fizzy drinks/alcoholic drinks all need to be avoided • drink more is standard practice and advice – all present would advise their patients of this. The group agreed that high fluid intake is so obvious that there is no need for a recommendation. • Current practice is to give dietary advice (can be given by consultant urologists). Those with a poor diet may be referred to a dietician. • High intake of calcium, citrics, vitamin D. • Low intake of salt, oxalate, protein, soft drinks (e.g cola)..
3.6 Main Outcomes 1.Quality of life 2.Stone-free rate 3.Recurrence rate 4.Mortality 5.Pain intensity 6.Adverse events	• Is the list of outcomes appropriate? • Are any key outcomes missing?	• General discussion prior to breakout group recommended the following two outcomes to be included: kidney function and kidney failure.

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7.Use of healthcare services (including, for example, re-admission rates following interventions)		
<u>GC Membership</u> Full Committee Members: Chair: Consultant Urological Surgeon 2 Urologists 1 Radiologist 2 Renal Physicians OR 1 Renal Physician and 1Clinical chemical pathologist 2 Patient Carer/Members 1 Specialist Nurse 2 General Practitioners Cooptee 1 Dietician	• Do you have any comments on the proposed membership of the committee?	Suggested additional members discussed by the group include: • Paediatric urologist • Stone-specific urgologist, not just general urologist • Biochemist • Pharmacists cooptee • A&E physician cooptee

Further questions:	Stakeholder responses
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to **patient care**?	• No comments
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?	• No comments
3. Are there areas of **diverse or unsafe practice** or uncertainty that require addressing?	• No comments
We will need to access published evidence linked to clinical and cost-effective services in order to make recommendations. In the absence of published evidence, we are able to 'call for evidence'. Do you think that would be helpful in this context? Are you aware of any centres of good practice in terms of supportive and palliative care services who could provide this evidence?	• No comments
6. As a group, if you had to **rank** the issues in the Scope in order of importance what would the order be?	• No comments
7. Are there any areas that you think should be included for the purposes of the **quality standard**? Are there any **service delivery** or service configuration issues that you think are important?	• No comments
8. Any other issues raised during subgroup discussion for noting:	• No comments