

Acute coronary syndromes

NICE guideline: methods

NICE guideline <number>

Methods

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Draft for Consultation

*Developed by the National Guideline Centre,
hosted by the Royal College of Physicians*

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1 Development of the guideline

1.1 What is a NICE guideline?

3 NICE guidelines are recommendations for the care of individuals in specific clinical
4 conditions or circumstances within the NHS – from prevention and self-care through primary
5 and secondary care to more specialised services. These may also include elements of social
6 care or public health measures. We base our guidelines on the best available research
7 evidence, with the aim of improving the quality of healthcare. We use predetermined and
8 systematic methods to identify and evaluate the evidence relating to specific review
9 questions.

10 NICE guidelines can:

- 11 • provide recommendations for the treatment and care of people by health professionals
- 12 • be used to develop standards to assess the clinical practice of individual health
13 professionals
- 14 • be used in the education and training of health professionals
- 15 • help patients to make informed decisions
- 16 • improve communication between patient and health professional.

17 While guidelines assist the practice of healthcare professionals, they do not replace their
18 knowledge and skills.

19 We produce our guidelines using the following steps:

- 20 • A guideline topic is referred to NICE from NHS England.
- 21 • Stakeholders register an interest in the guideline and are consulted throughout the
22 development process.
- 23 • The scope is prepared by the National Guideline Centre (NGC).
- 24 • The NGC establishes a guideline committee.
- 25 • A draft guideline is produced after the group assesses the available evidence and makes
26 recommendations.
- 27 • There is a consultation on the draft guideline.
- 28 • The final guideline is produced.

29 The guideline is made up of a collection of documents including this Methods report and a
30 number of evidence reports covering each of the review questions included in the guideline.
31 These can all be downloaded from NICE at www.nice.org.uk.

32 NICE also publishes a summary of the recommendation in this guideline, known as ‘the
33 NICE guideline’.

34 NICE Pathways brings together all connected NICE guidance.

1.2 Remit

36 NICE received the remit for this guideline from NHS England. NICE commissioned the NGC
37 to produce the guideline.

38 The remit for this guideline is:

39 to partially update three (currently) separate clinical guidelines:

- 40 1. Myocardial infarction with ST-segment elevation: Acute management CG167
- 41 2. Unstable angina and NSTEMI: Early management CG94

- 1 3. Myocardial infarction: Cardiac rehabilitation and prevention of further
2 cardiovascular disease CG172
3 It will also incorporate the NICE guideline on:
4 4. Hyperglycaemia in acute coronary syndromes: management CG130

1.3 Who developed this guideline?

6 A multidisciplinary guideline committee comprising health professionals and researchers as
7 well as lay members developed this guideline (see the list of guideline committee members
8 and the acknowledgements).

9 The National Institute for Health and Care Excellence (NICE) funds the National Guideline
10 Centre (NGC) and thus supported the development of this guideline. The committee was
11 convened by the NGC and chaired by Margaret Lally in accordance with guidance from
12 NICE.

13 The group met approximately every 6 weeks during the development of the guideline. At the
14 start of the guideline development process all committee members declared interests
15 including consultancies, fee-paid work, shareholdings, fellowships and support from the
16 healthcare industry. At all subsequent committee meetings, members declared arising
17 conflicts of interest.

18 Members were either required to withdraw completely or for part of the discussion if their
19 declared interest made it appropriate. The details of declared interests and the actions taken
20 are shown in the declaration of interest register for this guideline published on the NICE
21 website.

22 Staff from the NGC provided methodological support and guidance for the development
23 process. The team working on the guideline included a project manager, systematic
24 reviewers (research fellows), health economists and information specialists. They undertook
25 systematic searches of the literature, appraised the evidence, conducted meta-analysis and
26 cost-effectiveness analysis where appropriate and drafted the guideline in collaboration with
27 the committee.

1.3.1 What this guideline covers

29 The guideline covers pharmacological management including dual antiplatelet therapy and
30 interventional procedures including stents in adults (18 and over) with acute coronary
31 syndromes. For further details please refer to the scope for this guideline (published on the
32 NICE website) and the review questions in section 2.1.

1.3.2 What this guideline does not cover

34 This guideline does not cover the diagnosis of myocardial infarction.

1.3.3 Relationships between the guideline and other NICE guidance

36 **NICE technology appraisals to be updated by this guidance:**

- 37 • Bivalirudin for the treatment of ST-segment-elevation myocardial infarction. NICE
38 technology appraisal TA230 (2011).

39 **NICE technology appraisals to be partially updated by this guidance:**

- 40 • Drug-eluting stents for the treatment of coronary artery disease. NICE technology
41 appraisal TA152 (2008) (with regard to acute coronary syndromes population only)
42 • Guidance on the use of coronary artery stents. NICE technology appraisal TA71 (2008)
43 (recommendations 1.2, 1.3 and 1.4 will be updated)

1

2 ***NICE guidance that will be incorporated and contextualised in this guideline***

3 • Prasugrel with percutaneous coronary intervention for treating acute coronary syndromes.
4 NICE technology appraisal TA317(2014)

5 • Ticagrelor for the treatment of acute coronary syndromes. NICE technology appraisal
6 TA236 (2011)

7 **NICE technology appraisals to be incorporated in this guidance:**

8 • Rivaroxaban for preventing adverse outcomes after acute management of acute coronary
9 syndrome. NICE technology appraisal guidance TA335 (2015)

10 • It is proposed that this guideline will incorporate all recommendations from TA335, subject
11 to a review proposal by the technology appraisals programme.

12 **Related NICE technology appraisals:**

13 • Ticagrelor for preventing atherothrombotic events after myocardial infarction. NICE
14 technology appraisal guidance TA420 (2016)

15 • Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular
16 events. NICE technology appraisal guidance TA210 (2010)

17 • SeQuent Please balloon catheter for in-stent coronary restenosis. NICE medical
18 technologies guidance MTG1(2010)

19 • Guidance on the use of drugs for early thrombolysis in the treatment of acute myocardial
20 infarction. NICE technology appraisal guidance TA52 (2002)

21 • Guidance on the use of glycoprotein IIb/IIIa inhibitors in the treatment of acute coronary
22 syndrome. NICE technology appraisal guidance TA47 (updated 2010, first published 2002)

23 **Related NICE guidelines:**

24 • Multimorbidity. NICE guideline NG56 (2016)

25 • Medicines optimisation. NICE guideline NG5 (2015)

26 • Patient experience in adult NHS services. NICE guideline CG138 (2012)

27 • Medicines adherence. NICE guideline CG76 (2009)

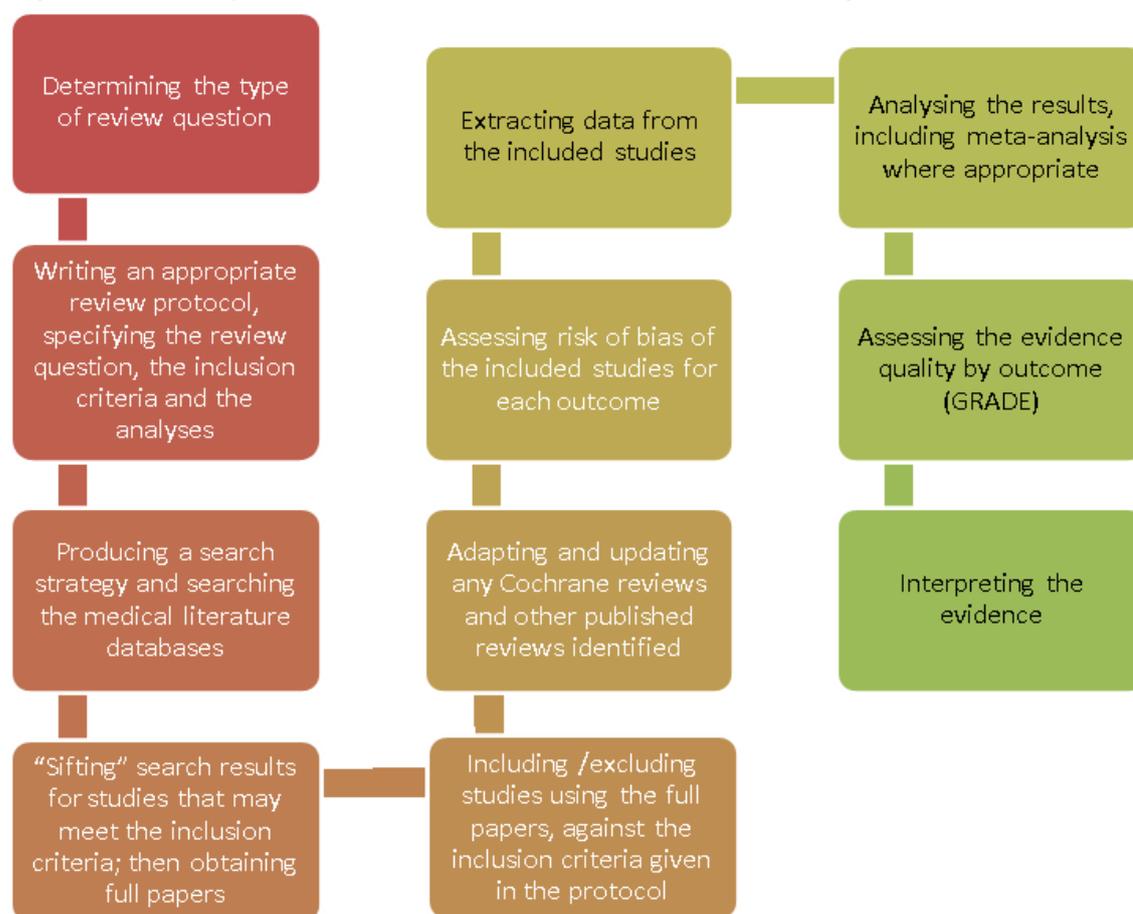
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2 Methods

2 This report sets out in detail the methods used to review the evidence and to develop the
3 recommendations that are presented in each of the evidence reviews for this guideline. This
4 guidance was developed in accordance with the methods outlined in the NICE guidelines
5 manual, 2018 version.¹¹

6 Sections 2.1 to 2.3 describe the process used to identify and review clinical evidence
7 (summarised in Figure 1), sections 2.2 and 2.4 describe the process used to identify and
8 review the health economic evidence, and section 2.5 describes the process used to develop
9 recommendations.

Figure 1: Step-by-step process of review of evidence in the guideline



2.1 Developing the review questions and outcomes

11 Review questions in this guideline were all intervention questions which were developed
12 using a PICO framework (population, intervention, comparison and outcome).

13 This use of a framework guided the literature searching process, critical appraisal and
14 synthesis of evidence, and facilitated the development of recommendations by the guideline
15 committee. The review questions were drafted by the NGC technical team and refined and
16 validated by the committee. The questions were based on the key clinical areas identified in
17 the scope.

18 A total of 8 review questions were identified.

1 Full literature searches, critical appraisals and evidence reviews were completed for all the
2 specified review questions.

3 **Table 1: Review questions**

Evidence report	Type of review	Review questions	Outcomes
A	Intervention	Which antiplatelet is most clinically and cost effective for managing unstable angina or NSTEMI or for managing STEMI in adults?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • All-cause mortality – up to 30 days • All-cause mortality at 1 year • Cardiac mortality – up to 30 days • Cardiac mortality at 1 year • Re-infarction up to 30 days • Re- infarction at 1 year • Complications related to bleeding including haemorrhagic stroke the following hierarchy of bleeding scales will be used: <ul style="list-style-type: none"> ○ BARC ○ Author’s definition ○ TIMI ○ GUSTO • Where possible, bleeding outcomes will be categorised into: <ul style="list-style-type: none"> ○ Major bleeding (including BARC 3-5, TIMI, GUSTO and as reported by author) ○ Minor bleeding (including BARC 1-2, TIMI, GUSTO and as reported by author) • Health-related quality of life including EQ5D and SF-36. <p>Important outcomes:</p> <ul style="list-style-type: none"> • Stroke (any, type not specified) • Need for revascularisation • Early and late, probably or definite stent thrombosis • Breathing adverse effects • Bradycardic adverse effects • Other adverse effects of

Evidence report	Type of review	Review questions	Outcomes
			<p>treatment</p> <ul style="list-style-type: none"> Unplanned urgent readmission within 30 days for any reason
B	Intervention	<p>In adults with unstable angina or NSTEMI does early invasive investigation (angiography), with intent to assess for (and in those deemed suitable, to perform) revascularisation, improve outcomes compared with initial conservative treatment, with or without later angiography?</p>	<p>Critical outcomes:</p> <p>Outcomes at following time intervals: in hospital, 30 days, 1 year (or closest to 1 year)</p> <ul style="list-style-type: none"> All-cause mortality Cardiac mortality Non-fatal and all (non-fatal and fatal) myocardial re-infarction Unplanned revascularisation (Where information is available we will record whether index lesion or not) Major bleeding (including BARC 3-5 and as reported by author) Minor bleeding (including BARC 2, TIMI and as reported by author). Health-related quality of life including EQ5D and SF-36 – at 1 year. <p>Important outcomes:</p> <ul style="list-style-type: none"> Length of hospital stay Refractory ischaemia <p>The following outcomes at latest time point available (>1 year)</p> <ul style="list-style-type: none"> Stroke Unplanned rehospitalisation for any reason Mortality (all-cause and cardiovascular specific) Non-fatal and all (non-fatal and fatal) myocardial re-infarction Unplanned revascularisation (Where information is available we will record whether index lesion or not)

Evidence report	Type of review	Review questions	Outcomes
C	Intervention	<p>Question in the scope: What is optimal choice of antithrombin therapy in adults with unstable angina or NSTEMI who are being considered for coronary angiography within 24 hours of admission?</p> <p>More focussed question in the review: What is the clinical and cost effectiveness of fondaparinux, with or without intra-procedural i.v. heparin compared to LMWH/UFH in the management of patients with UA or NSTEMI undergoing coronary angiography?</p>	<p>Major and minor bleeding. Intracranial bleeding recorded separately</p> <p>Critical outcomes:</p> <ul style="list-style-type: none"> • All-cause mortality – up to 30 days (or nearest time point but less than 1 year)_(specify if in hospital) • Cardiac mortality – up to 30 days • New myocardial infarction – up to 30 days • Catheter related thrombosis (during the procedure) • Complications related to bleeding including haemorrhagic stroke – up to 30 days (access bleeding and non-access bleeding need to be differentiated)- the following hierarchy of bleeding scales will be used: <ul style="list-style-type: none"> ○ BARC ○ Author's definition ○ TIMI ○ GUSTO • Where possible, bleeding outcomes will be categorised into: <ul style="list-style-type: none"> ○ Major bleeding (including BARC 3-5 and as reported by author) ○ Minor bleeding (including BARC 2, TIMI and as reported by author) • Health-related quality of life including EQ5D and SF-36. <p>Important outcomes:</p> <ul style="list-style-type: none"> • Repeat revascularisation- up to 30 days • Stent thrombosis (acute, early or late, probably or definite) up to 30 days • Stroke - up to 30 days

Evidence report	Type of review	Review questions	Outcomes
			<ul style="list-style-type: none"> Length of hospital stay
D	Intervention	What is the clinical and cost effectiveness of bivalirudin as adjunctive pharmacotherapy in adults with STEMI undergoing primary percutaneous coronary intervention?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> All-cause mortality – up to 30 days (specify if in hospital) Cardiac mortality – up to 30 days New myocardial infarction – up to 30 days Complications related to bleeding including haemorrhagic stroke – up to 30 days (access bleeding and non-access bleeding need to be differentiated)- the following hierarchy of bleeding scales will be used: <ul style="list-style-type: none"> BARC Author’s definition TIMI GUSTO Where possible, bleeding outcomes will be categorised into: <ul style="list-style-type: none"> Major bleeding (including BARC 3-5 and as reported by author) Minor bleeding (including BARC 2, TIMI and as reported by author). Health-related quality of life including EQ5D and SF-36. <p>Important outcomes:</p> <ul style="list-style-type: none"> All-cause mortality at 1 year Cardiac mortality at 1 year- Non-cardiac mortality at 1 year New myocardial infarction

Evidence report	Type of review	Review questions	Outcomes
			at 1 year <ul style="list-style-type: none"> • Repeat revascularisation • Stent thrombosis (acute, early or late) • Stroke - up to 30 days • Length of hospital stay
E	Intervention	What is the clinical and cost effectiveness of multi-vessel percutaneous coronary intervention compared with culprit-vessel only primary percutaneous coronary intervention in adults with STEMI and multi-vessel coronary disease?	Critical outcomes: <ul style="list-style-type: none"> • All-cause mortality at 30 days • Cardiovascular mortality at 30 days • All-cause mortality at 1 year • Cardiovascular mortality at 1 year • All (fatal and non-fatal) myocardial re-infarction at 30 days • Non-fatal myocardial re-infarction at 30 days • All (fatal and non-fatal) myocardial re-infarction at 1 year • Fatal myocardial re-infarction at 1 year • Non-fatal myocardial re-infarction at 1 year • Health-related quality of life including EQ5D and SF-36 Important outcomes: <ul style="list-style-type: none"> • Stroke any type – at 1 year • Contrast-induced nephropathy (also note population that goes onto dialysis/renal replacement therapy) • Hospitalisation for heart failure – 1 year • Unplanned revascularisation – 1 year • Complications related to bleeding including haemorrhagic stroke – up to 30 days (access bleeding and non-access bleeding need to be differentiated)- the following hierarchy of bleeding scales will be used: <ul style="list-style-type: none"> ○ BARC

Evidence report	Type of review	Review questions	Outcomes
			<ul style="list-style-type: none"> ○ Author's definition ○ TIMI ○ GUSTO
F	Intervention	<p>What is the clinical and cost effectiveness of drug-eluting stents in adults with acute coronary syndromes, including those with unstable angina or NSTEMI undergoing percutaneous coronary intervention and those with STEMI undergoing primary percutaneous coronary intervention?</p>	<p>Critical outcomes: Time points: early ≤ 1 year and later $>1-3$ year</p> <ul style="list-style-type: none"> ● All-cause mortality ● Cardiac mortality ● TVF- target vessel failure ● TLR and TVR – target lesion and target vessel revascularisation ● Stent thrombosis (record if assessed using optical coherence tomography (OCT), Intravascular ultrasound (IVUS) or angio) ● Myocardial infarction ● Health-related quality of life including EQ5D and SF-36 <p>Important outcomes:</p> <ul style="list-style-type: none"> ● Bleeding- Where possible, bleeding outcomes will be categorised into: <ul style="list-style-type: none"> ○ Major bleeding (including BARC 3-5 and as reported by author) ○ Minor bleeding (including BARC 2, TIMI and as reported by author) ● The following hierarchy of bleeding scales will be used: <ul style="list-style-type: none"> ○ BARC ○ Author's definition ○ TIMI ○ GUSTO

Evidence report	Type of review	Review questions	Outcomes
			<ul style="list-style-type: none"> MLD - Minimal lumen diameter (measuring how much restenosis there is)- surrogate marker for TLR and TVR
G	Intervention	What is the most clinically and cost effective combination of antiplatelet and anticoagulant therapies for people who have had an ACS and an indication for anticoagulation?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> All-cause mortality - short term (≤ 30 days) All-cause mortality- intermediate term (up to 1 year) <ul style="list-style-type: none"> All-cause mortality- long term (> 1 year) Myocardial re-infarction - short term (≤ 30 days) Myocardial re-infarction - intermediate term (up to 1 year) <ul style="list-style-type: none"> Myocardial re-infarction - short term (≤ 30 days) stroke - short term (≤ 30 days) stroke - long term (> 1 year) stroke - short term (≤ 30 days) Complications related to bleeding short term (≤ 30 days), intermediate term (up to 1 year), and long term (> 1 year) including haemorrhagic stroke – (access bleeding and non-access bleeding need to be differentiated)- the following hierarchy of bleeding scales will be used: <ul style="list-style-type: none"> BARC Author’s definition TIMI GUSTO <p>Important outcomes:</p> <ul style="list-style-type: none"> Withdrawal of study drug due to any side effects Probable and/or definite stent thrombosis at 1 year
H	Intervention	What is the optimal duration of beta-blocker therapy to improve	<p>Critical outcomes:</p> <ul style="list-style-type: none"> All cause mortality at 1 year

Evidence report	Type of review	Review questions	Outcomes
		outcomes for adults without left ventricular dysfunction after myocardial infarction?	<ul style="list-style-type: none"> • All cause mortality at > 1 year • Heart failure at 1 year • Heart failure at > 1 year • Health-related quality of life including EQ5D and SF-36. <p>Important outcomes:</p> <ul style="list-style-type: none"> • All cause mortality at 30 days • Re-infarction at 1 year • Re-infarction at > 1 year • Revascularisation at 1 year • Revascularisation at > 1 year • Cardiogenic shock • New onset diabetes at 1 year

2.2 Searching for evidence

2.2.21 Clinical and health economics literature searches

3 The full strategy including population terms, intervention terms, study types applied, the
4 databases searched and the years covered can be found in Appendix B of the evidence
5 review.

6 Systematic literature searches were undertaken to identify all published clinical and health
7 economic evidence relevant to the review questions. Searches were undertaken according to
8 the parameters stipulated within the NICE guidelines manual.¹¹ Databases were searched
9 using relevant medical subject headings, free-text terms and study-type filters where
10 appropriate. Studies published in languages other than English were not reviewed, and
11 where possible, searches were restricted to English language. All searches were updated
12 between 18 June 2109 and 22 July 2019. If new evidence, falling outside of the timeframe for
13 the guideline searches, is identified, for example in consultation comments received from
14 stakeholders, the impact on the guideline will be considered, and any further action agreed
15 between NGC and NICE staff with a quality assurance role.

16 Prior to running, searches were quality assured using different approaches; checking key
17 papers were retrieved and Medline search strategies were peer reviewed by a second
18 information specialist using a QA process based on Peer Review of Electronic Search
19 Strategies (PRESS) checklist.¹⁰ Additional studies were added by checking reference lists of
20 relevant systematic reviews, and those highlighted by committee members..

21 During the scoping stage, a search was conducted in the following databases for papers
22 reporting minimally important differences.

- 23 • Medline (Ovid)
- 24 • Embase (Ovid)

25 Searching for unpublished literature was not undertaken.

2.3 Identifying and analysing evidence of effectiveness

- 2 Research fellows conducted the tasks listed below, which are described in further detail in
3 the rest of this section:
- 4 • Identified potentially relevant studies for each review question from the relevant search
5 results by reviewing titles and abstracts. Full papers were then obtained.
 - 6 • Reviewed full papers against pre-specified inclusion and exclusion criteria to identify
7 studies that addressed the review question in the appropriate population, and reported on
8 outcomes of interest (review protocols are included in an appendix to each of the
9 evidence reports).
 - 10 • Critically appraised relevant studies using the appropriate study design checklist as
11 specified in the NICE guidelines manual.¹¹
 - 12 • Extracted key information about interventional study methods and results using 'Evibase',
13 NGC's purpose-built software. Evibase produces summary evidence tables, including
14 critical appraisal ratings. Key information about non-interventional study methods and
15 results was manually extracted onto standard evidence tables and critically appraised
16 separately (evidence tables are included in an appendix to each of the evidence reports).
 - 17 • Generated summaries of the evidence by outcome. Outcome data were combined,
18 analysed and reported according to study design. Only randomised data were included in
19 this guideline and these were meta-analysed where appropriate and reported in GRADE
20 profile tables.
 - 21 • A sample of a minimum of 10% of the abstract lists of the first 3 sifts by new reviewers
22 and those for complex review questions were double-sifted by a senior research fellow
23 and any discrepancies were rectified. All of the evidence reviews were quality assured by
24 a senior research fellow. This included checking:
 - 25 ○ papers were included or excluded appropriately
 - 26 ○ a sample of the data extractions
 - 27 ○ correct methods were used to synthesise data
 - 28 ○ a sample of the risk of bias assessments.

2.3.1 Inclusion and exclusion criteria

30 The inclusion and exclusion of studies was based on the criteria defined in the review
31 protocols, which can be found in an appendix to each of the evidence reports. Excluded
32 studies (with the reasons for their exclusion) are listed in another appendix to each of the
33 evidence reports. The committee was consulted about any uncertainty regarding inclusion or
34 exclusion.

35 The key population inclusion criterion was:

- 36 • Adults (18 and over) with acute coronary syndromes

37 The key population exclusion criterion was:

- 38 • Children and young people (younger than 18).
- 39 • People with acute heart failure not due to acute coronary syndrome.
- 40 • People with chest pain that is not thought to be due to acute coronary syndrome
41 (undifferentiated chest pain)
- 42 • People with type 2 myocardial infarction (heart attacks not caused by acute coronary
43 syndromes).

44
45 Conference abstracts, Literature reviews, posters, letters, editorials, comment articles,
46 unpublished studies and studies not in English were excluded.

2.3.2 Type of studies

2 This guideline only included intervention reviews. Therefore, parallel randomised controlled
3 trials (RCTs) were included because they are considered the most robust type of study
4 design that can produce an unbiased estimate of the intervention effects. Crossover RCTs
5 were not included for any of the review questions. If non-randomised intervention studies
6 were considered appropriate for inclusion (for example, where no randomised evidence was
7 available for critical outcomes) the committee stated a priori in the protocol that either certain
8 identified variables must be equivalent at baseline or else the analysis had to adjust for any
9 baseline differences. If the study did not fulfil either criterion it was excluded. Please refer to
10 the review protocols in each evidence report for full details on the study design of studies
11 selected for each review question.

2.3.3 Methods of combining clinical studies

2.3.3.1 Data synthesis for intervention reviews

14 Where possible, meta-analyses were conducted using Cochrane Review Manager
15 (RevMan5) ¹⁵ software to combine the data given in all studies for each of the outcomes of
16 interest for the review question.

17 For the antiplatelet review question 1.1 [A] additional stratification was used, and this is
18 documented in the individual review question protocol in the evidence report. When
19 additional strata were used this led to substrata (for example, using 2 stratification criteria
20 leads to 4 substrata) which were analysed separately.

2.3.3.1.1 Analysis of different types of data

22 Dichotomous outcomes

23 Fixed-effects (Mantel–Haenszel) techniques (using an inverse variance method for pooling)
24 were used to calculate risk ratios (relative risk, RR) for the binary outcomes, which included:

- 25 • mortality (all-cause and cardiovascular)
- 26 • adverse events, including minor and major bleeding
- 27 • length of hospital stay
- 28 • myocardial infarction
- 29 • stroke
- 30 • health-related quality of life.

31 The absolute risk difference was also calculated using GRADEpro⁹ software, using the
32 median event rate in the control arm of the pooled results.

33 For binary variables where there were zero events in either arm or a less than 1% event rate,
34 Peto odds ratios, rather than risk ratios, were calculated. Peto odds ratios are more
35 appropriate for data with a low number of events. Where there is more than one study and
36 zero events in some of the studies and this is in both or in different arms the risk difference is
37 calculated to include all the studies in the forest plot and for the committee's decision
38 making.

39

40 Continuous outcomes

41 The minimal luminal diameter outcome was analysed using an inverse variance method for
42 pooling weighted mean differences.

1 The means and standard deviations of continuous outcomes are required for meta-analysis.
2 However, in cases where standard deviations were not reported, the standard error was
3 calculated if the p values or 95% confidence intervals (95% CI) were reported, and meta-
4 analysis was undertaken with the mean and standard error using the generic inverse
5 variance method in Cochrane Review Manager (RevMan5¹⁵ software. Where p values were
6 reported as 'less than', a conservative approach was undertaken. For example, if a p value
7 was reported as 'p≤0.001', the calculations for standard deviations were based on a p value
8 of 0.001. If these statistical measures were not available then the methods described in
9 section 16.1.3 of the Cochrane Handbook (version 5.1.0, updated March 2011) were applied.

2.318.1.2 *Generic inverse variance*

11 If a study reported only the summary statistic and 95% CI the generic-inverse variance
12 method was used to enter data into RevMan5.¹⁵ If the control event rate was reported this
13 was used to generate the absolute risk difference in GRADEpro.¹⁵ If multivariate analysis
14 was used to derive the summary statistic but no adjusted control event rate was reported no
15 absolute risk difference was calculated.

2.318.1.3 *Heterogeneity*

17 Statistical heterogeneity was assessed for each meta-analysis estimate by considering the
18 chi-squared test for significance at p<0.1 or an I-squared (I²) inconsistency statistic (with an I-
19 squared value of more than 50% indicating significant heterogeneity) as well as the
20 distribution of effects. For example, if significant heterogeneity was present, predefined
21 subgrouping of studies was carried out for either:

- 22 • age category of adult (<75 years, ≥75 years)
- 23 • Glycoprotein inhibitor use
- 24 • Type of heparin (LMWH vs UFH)

25

26 If the subgroup analysis resolved heterogeneity within all of the derived subgroups, then
27 each of the derived subgroups were adopted as separate outcomes (providing at least 1
28 study remained in each subgroup. Assessments of potential differences in effect between
29 subgroups were based on the chi-squared tests for heterogeneity statistics between
30 subgroups. Any subgroup differences were interpreted with caution as separating the groups
31 breaks the study randomisation and as such is subject to uncontrolled confounding.

32 For some questions additional subgrouping was applied, and this is documented in the
33 individual review question protocols. These additional subgrouping strategies were applied
34 independently, so subunits of subgroups were not created, unlike the situation with strata.
35 Other subgrouping strategies were only used if the age category subgroup was unable to
36 explain heterogeneity, then these further subgrouping strategies were applied in order of
37 priority. Again, once a subgrouping strategy was found to explain heterogeneity from all
38 derived subgroups, further subgrouping strategies were not used.

39 If all predefined strategies of subgrouping were unable to explain statistical heterogeneity
40 within each derived subgroup, then a random effects (DerSimonian and Laird) model was
41 employed to the entire group of studies in the meta-analysis. A random-effects model
42 assumes a distribution of populations, rather than a single population. This leads to a
43 widening of the confidence interval around the overall estimate, thus providing a more
44 realistic interpretation of the true distribution of effects across more than 1 population. If,
45 however, the committee considered the heterogeneity was so large that meta-analysis was
46 inappropriate, then the results were described narratively.

47

2.3.312 Network meta-analysis

2 A network meta-analysis (NMA) was conducted for the review question on dual antiplatelet
3 therapy [A]. This type of analysis simultaneously compares multiple treatments in a single
4 meta-analysis, preserving the randomisation of RCTs included in the reviews. The aim of the
5 NMA was to include all relevant evidence in order to

- 6 • estimate the clinical effectiveness of all interventions compared to each other
7 (including for treatment comparisons which have not yet been directly compared in a
8 trial); and
- 9 • rank of treatments in terms of clinical effectiveness.

10 A hierarchical Bayesian NMA was performed using the software WinBUGS version 1.4. We
11 used statistical models that allowed inclusion of multi-arm trials and accounts for the
12 correlation between arms. These models were based on the methods of the NICE Decision
13 Support Unit.^{1-6, 8}

14 For each outcome NMA, both fixed- and random-effect models were performed. These
15 models were then compared based on residual deviance and deviance information criteria
16 (DIC). The model with the smallest DIC is estimated to be the model that would best predict
17 a replicate dataset which has the same structure as that currently observed. A small
18 difference in DIC between the fixed and random effects models (3–5 points) implies that the
19 better fit obtained by adding random effects does not justify the additional complexity.
20 Therefore, if the difference in DIC between a fixed-effect and random-effect model was
21 smaller than 5 points, then we reported the fixed-effects model results as that makes fewer
22 assumptions than the random-effect model, contains fewer parameters and is easier to
23 interpret clinically.

24 To assess the validity of an NMA it is essential to assess the extent of heterogeneity and
25 inconsistency. Heterogeneity concerns the differences in treatment effects between trials
26 within each treatment contrast, while consistency concerns the differences between the
27 direct and indirect evidence informing the treatment contrasts.⁷

28 Several methods can be used to assess inconsistency. One method involves comparing the
29 DIC of each NMA or “consistency” model (fixed or random effects) to the DIC of the
30 associated “inconsistency”, or unrelated mean effects, model.⁷ The latter is equivalent to
31 having separate, unrelated, meta-analyses for every pairwise contrast, with a common
32 variance parameter assumed in the case of random effects models. Additionally,
33 inconsistency was identified if the mean NMA estimates of the direct comparisons were
34 outside the confidence intervals of the pairwise estimates.

2.3.351 Intervention reviews

36 The evidence for outcomes from the included RCTs and, where appropriate, non-randomised
37 intervention studies, were evaluated and presented using an adaptation of the ‘Grading of
38 Recommendations Assessment, Development and Evaluation (GRADE) toolbox’ developed
39 by the international GRADE working group (<http://www.gradeworkinggroup.org/>). The
40 software (GRADEpro⁹) developed by the GRADE working group was used to assess the
41 quality of each outcome, taking into account individual study quality and the meta-analysis
42 results.

43 Each outcome was first examined for each of the quality elements listed and defined in Table
44 2.

45 **Table 2: Description of quality elements in GRADE for intervention studies**

Quality element	Description
-----------------	-------------

Quality element	Description
Risk of bias	Limitations in the study design and implementation may bias the estimates of the treatment effect. Major limitations in studies decrease the confidence in the estimate of the effect. Examples of such limitations are selection bias (often due to poor allocation concealment), performance and detection bias (often due to a lack of blinding of the patient, healthcare professional or assessor) and attrition bias (due to missing data causing systematic bias in the analysis).
Indirectness	Indirectness refers to differences in study population, intervention, comparator and outcomes between the available evidence and the review question.
Inconsistency	Inconsistency refers to an unexplained heterogeneity of effect estimates between studies in the same meta-analysis.
Imprecision	Results are imprecise when studies include relatively few patients and few events (or highly variable measures) and thus have wide confidence intervals around the estimate of the effect relative to clinically important thresholds. 95% confidence intervals denote the possible range of locations of the true population effect at a 95% probability, and so wide confidence intervals may denote a result that is consistent with conflicting interpretations (for example a result may be consistent with both clinical benefit AND clinical harm) and thus be imprecise.
Publication bias	Publication bias is a systematic underestimate or overestimate of the underlying beneficial or harmful effect due to the selective publication of studies. A closely related phenomenon is where some papers fail to report an outcome that is inconclusive, thus leading to an overestimate of the effectiveness of that outcome.
Other issues	Sometimes randomisation may not adequately lead to group equivalence of confounders, and if so this may lead to bias, which should be taken into account. Potential conflicts of interest, often caused by excessive pharmaceutical company involvement in the publication of a study, should also be noted.

- 1 Details of how the 4 main quality elements (risk of bias, indirectness, inconsistency and
- 2 imprecision) were appraised for each outcome are given below. Publication or other bias was
- 3 only taken into consideration in the quality assessment if it was apparent.

2.3.3.1.1 Risk of bias

- 5 The main domains of bias for RCTs are listed in Table 3. Each outcome had its risk of bias
- 6 assessed within each study first. For each study, if there were no risks of bias in any domain,
- 7 the risk of bias was given a rating of 0. If there was risk of bias in just 1 domain, the risk of
- 8 bias was given a 'serious' rating of -1, but if there was risk of bias in 2 or more domains the
- 9 risk of bias was given a 'very serious' rating of -2. A weighted average score was then
- 10 calculated across all studies contributing to the outcome, by taking into account the weighting
- 11 of studies according to study precision. For example if the most precise studies tended to
- 12 each have a score of -1 for that outcome, the overall score for that outcome would tend
- 13 towards -1.

14 **Table 3: Principle domains of bias in randomised controlled trials**

Limitation	Explanation
Selection bias (sequence generation and allocation concealment)	If those enrolling patients are aware of the group to which the next enrolled patient will be allocated, either because of a non-random sequence that is predictable, or because a truly random sequence was not concealed from the researcher, this may translate into systematic selection bias. This may occur if the researcher chooses not to recruit a participant into that specific group because of: <ul style="list-style-type: none"> • knowledge of that participant's likely prognostic characteristics, and • a desire for one group to do better than the other.
Performance and detection bias	Patients, caregivers, those adjudicating or recording outcomes, and data analysts should not be aware of the arm to which patients are allocated.

Limitation	Explanation
(lack of blinding of patients and healthcare professionals)	Knowledge of the group can influence: <ul style="list-style-type: none"> • the experience of the placebo effect • performance in outcome measures • the level of care and attention received, and • the methods of measurement or analysis all of which can contribute to systematic bias.
Attrition bias	Attrition bias results from an unaccounted for loss of data beyond a certain level (a differential of 10% between groups). Loss of data can occur when participants are compulsorily withdrawn from a group by the researchers (for example, when a per-protocol approach is used) or when participants do not attend assessment sessions. If the missing data are likely to be different from the data of those remaining in the groups, and there is a differential rate of such missing data from groups, systematic attrition bias may result.
Selective outcome reporting	Reporting of some outcomes and not others on the basis of the results can also lead to bias, as this may distort the overall impression of efficacy.
Other limitations	For example: <ul style="list-style-type: none"> • Stopping early for benefit observed in randomised trials, in particular in the absence of adequate stopping rules. • Use of unvalidated patient-reported outcome measures. • Lack of washout periods to avoid carry-over effects in crossover trials. • Recruitment bias in cluster-randomised trials.

2.3.3.1.2 Indirectness

2 Indirectness refers to the extent to which the populations, interventions, comparisons and
3 outcome measures are dissimilar to those defined in the inclusion criteria for the reviews.
4 Indirectness is important when these differences are expected to contribute to a difference in
5 effect size, or may affect the balance of harms and benefits considered for an intervention.
6 As for the risk of bias, each outcome had its indirectness assessed within each study first.
7 For each study, if there were no sources of indirectness, indirectness was given a rating of 0.
8 If there was indirectness in just 1 source (for example in terms of population), indirectness
9 was given a 'serious' rating of -1, but if there was indirectness in 2 or more sources (for
10 example, in terms of population and treatment) the indirectness was given a 'very serious'
11 rating of -2. A weighted average score was then calculated across all studies contributing to
12 the outcome by taking into account study precision. For example, if the most precise studies
13 tended to have an indirectness score of -1 each for that outcome, the overall score for that
14 outcome would tend towards -1.

2.3.3.1.3 Inconsistency

16 Inconsistency refers to an unexplained heterogeneity of results for an outcome across
17 different studies. When estimates of the treatment effect across studies differ widely, this
18 suggests true differences in the underlying treatment effect, which may be due to differences
19 in populations, settings or doses. When heterogeneity existed within an outcome (chi-
20 squared $p < 0.1$, or $I^2 > 50\%$), but no plausible explanation could be found, the quality of
21 evidence for that outcome was downgraded. Inconsistency for that outcome was given a
22 'serious' score of -1 if the I^2 was 50–74%, and a 'very serious' score of -2 if the I^2 was 75%
23 or more.

24 If inconsistency could be explained based on prespecified subgroup analysis (that is, each
25 subgroup had an $I^2 < 50\%$), the committee took this into account and considered whether to
26 make separate recommendations on new outcomes based on the subgroups defined by the
27 assumed explanatory factors. In such a situation the quality of evidence was not downgraded
28 for those emergent outcomes.

1 Since the inconsistency score was based on the meta-analysis results, the score
2 represented the whole outcome and so weighted averaging across studies was not
3 necessary.

2.3.3.1.4 Imprecision

5 The criteria applied for imprecision were based on the 95% CIs for the pooled estimate of
6 effect, and the minimal important differences (MID) for the outcome. The MIDs are the
7 threshold for appreciable benefits and harms, separated by a zone either side of the line of
8 no effect where there is assumed to be no clinically important effect. If either end of the 95%
9 CI of the overall estimate of effect crossed 1 of the MID lines, imprecision was regarded as
10 serious and a 'serious' score of -1 was given. This was because the overall result, as
11 represented by the span of the confidence interval, was consistent with 2 interpretations as
12 defined by the MID (for example, both no clinically important effect and clinical benefit were
13 possible interpretations). If both MID lines were crossed by either or both ends of the 95% CI
14 then imprecision was regarded as very serious and a 'very serious' score of -2 was given.
15 This was because the overall result was consistent with all 3 interpretations defined by the
16 MID (no clinically important effect, clinical benefit and clinical harm). This is illustrated in
17 Figure 2. As for inconsistency, since the imprecision score was based on the meta-analysis
18 results, the score represented the whole outcome and so weighted averaging across studies
19 was not necessary.

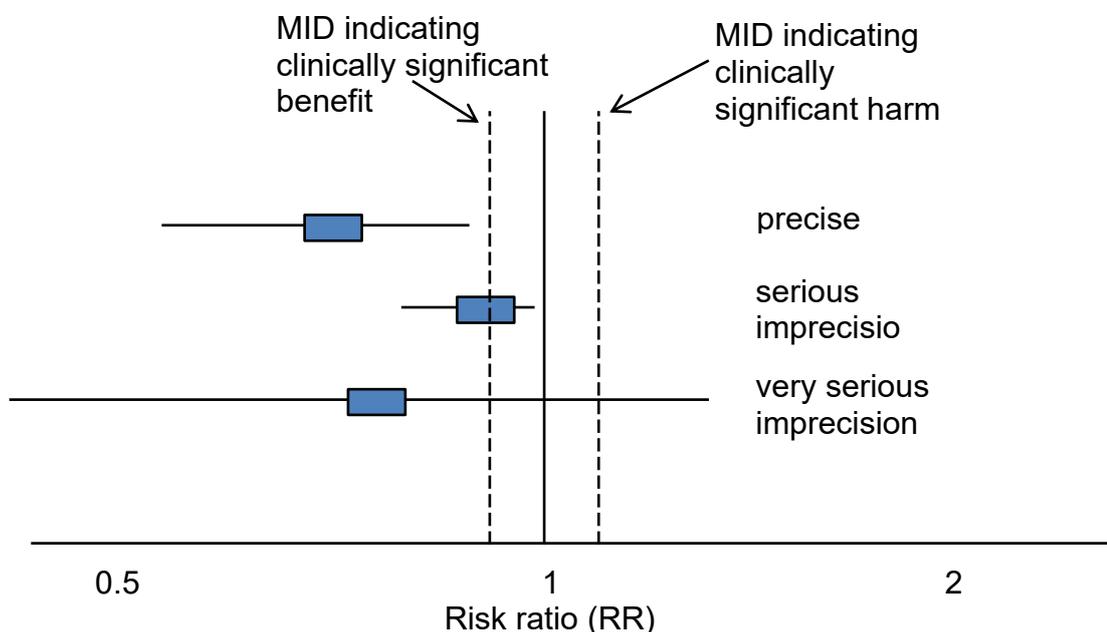
20 The position of the MID lines is ideally determined by values reported in the literature.
21 'Anchor-based' methods aim to establish clinically meaningful changes in a continuous
22 outcome variable by relating or 'anchoring' them to patient-centred measures of clinical
23 effectiveness that could be regarded as gold standards with a high level of face validity. For
24 example, a MID for an outcome could be defined by the minimum amount of change in that
25 outcome necessary to make patients feel their quality of life had 'significantly improved'.
26 MIDs in the literature may also be based on expert clinician or consensus opinion concerning
27 the minimum amount of change in a variable deemed to affect quality of life or health. For
28 binary variables, any MIDs reported in the literature will inevitably be based on expert
29 consensus, as such MIDs relate to all-or-nothing population effects rather than measurable
30 effects on an individual, and so are not amenable to patient-centred 'anchor' methods.

31 In the absence of values identified in the literature, the alternative approach to deciding on
32 MID levels is the 'default' method, as follows:

- 33 • For categorical outcomes the MIDs were taken to be a risk ratio of 0.8 and 1.25. For
34 'positive' outcomes such as 'patient satisfaction', a risk ratio of 0.8 is taken as the line
35 denoting the boundary between no clinically important effect and a clinically significant
36 harm, whilst the a risk ratio of 1.25 is taken as the line denoting the boundary between no
37 clinically important effect and a clinically significant benefit. For 'negative' outcomes such
38 as 'bleeding', the opposite occurs, so a risk ratio of 0.8 is taken as the line denoting the
39 boundary between no clinically important effect and a clinically significant benefit, whilst a
40 risk ratio of 1.25 is taken as the line denoting the boundary between no clinically important
41 effect and a clinically significant harm.
- 42 • For mortality any change was considered to be clinically important and the imprecision
43 was assessed on the basis of the whether the confidence intervals crossed the line of no
44 effect, that is whether the result was consistent with both benefit and harm.
- 45 • For continuous outcome variables the MID was taken as half the median baseline
46 standard deviation of that variable, across all studies in the meta-analysis. Hence the MID
47 denoting the minimum clinically significant benefit was positive for a 'positive' outcome (for
48 example, a quality of life measure where a higher score denotes better health), and
49 negative for a 'negative' outcome (for example, a visual analogue scale [VAS] pain score).
50 Clinically significant harms will be the converse of these. If baseline values are
51 unavailable, then half the median comparator group standard deviation of that variable will
52 be taken as the MID.

- 1 • If standardised mean differences have been used, then the MID will be set at the absolute
2 value of +0.5. This follows because standardised mean differences are mean differences
3 normalised to the pooled standard deviation of the 2 groups, and are thus effectively
4 expressed in units of 'numbers of standard deviations'. The 0.5 MID value in this context
5 therefore indicates half a standard deviation, the same definition of MID as used for non-
6 standardised mean differences.
- 7 • Where studies had zero events and the risk difference was used, imprecision was
8 assessed by calculating the optimal information size and graded as follows:
- 9 ○ <80%- very serious imprecision
10 ○ 80-90%- serious imprecision
11 ○ >90%– no imprecision
- 12 The default MID value was subject to amendment after discussion with the committee. If the
13 committee decided that the MID level should be altered, after consideration of absolute as
14 well as relative effects, this was allowed, provided that any such decision was not influenced
15 by any bias towards making stronger or weaker recommendations for specific outcomes.
- 16 For this guideline, no appropriate MIDs dichotomous outcomes were found in the literature,
17 and so the default method was adopted.

Figure 2: Illustration of precise and imprecise outcomes based on the 95% CI of dichotomous outcomes in a forest plot (Note that all 3 results would be pooled estimates, and would not, in practice, be placed on the same forest plot)



2.3.18.1.5 Overall grading of the quality of clinical evidence

- 19 Once an outcome had been appraised for the main quality elements, as above, an overall
20 quality grade was calculated for that outcome. The scores (0, -1 or -2) from each of the
21 main quality elements were summed to give a score that could be anything from 0 (the best
22 possible) to -8 (the worst possible). However scores were capped at -3. This final score was
23 then applied to the starting grade that had originally been applied to the outcome by default,
24 based on study design. All RCTs started as High and the overall quality became Moderate,
25 Low or Very Low if the overall score was -1, -2 or -3 points respectively. The significance of

1 these overall ratings is explained in Table 4. The reasons for downgrading in each case were
2 specified in the footnotes of the GRADE tables.

3 Non-randomised intervention studies started at Low, and so a score of –1 would be enough
4 to take the grade to the lowest level of Very Low. Non-randomised intervention studies could,
5 however, be upgraded if there was a large magnitude of effect or a dose-response gradient.

6 **Table 4: Overall quality of outcome evidence in GRADE**

Level	Description
High	Further research is very unlikely to change our confidence in the estimate of effect
Moderate	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
Low	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate
Very low	Any estimate of effect is very uncertain

7

2.34 Assessing clinical importance

9 The committee assessed the evidence by outcome in order to determine if there was, or
10 potentially was, a clinically important benefit, a clinically important harm or no clinically
11 important difference between interventions. To facilitate this, binary outcomes were
12 converted into absolute risk differences (ARDs) using GRADEpro⁹ software: the median
13 control group risk across studies was used to calculate the ARD and its 95% CI from the
14 pooled risk ratio.

15 The assessment of clinical benefit, harm, or no benefit or harm was based on the point
16 estimate of absolute effect for intervention studies, which was standardised across the
17 reviews. The committee considered for most of the outcomes including stroke and
18 myocardial infarction that if at least 10 more participants per 1000 (1%) achieved the
19 outcome of interest in the intervention group compared to the comparison group for a
20 positive outcome then this intervention was considered beneficial. The same point estimate
21 but in the opposite direction applied for a negative outcome. For the outcome of mortality any
22 reduction represented a clinical benefit. For bleeding complications, repeat revascularisation,
23 stent thrombosis and other adverse events 20 events or more per 1000 (5%) represented
24 clinical harm.

25 This assessment was carried out by the committee for each critical outcome, and an
26 evidence summary table was produced to compile the committee's assessments of clinical
27 importance per outcome, alongside the evidence quality and the uncertainty in the effect
28 estimate (imprecision).

2.35 Clinical evidence statements

30 Clinical evidence statements are summary statements that are included in each evidence
31 report, and which summarise the key features of the clinical effectiveness evidence
32 presented. The wording of the evidence statements reflects the certainty or uncertainty in the
33 estimate of effect. The evidence statements are presented by outcome and encompass the
34 following key features of the evidence:

- 35 • The number of studies and the number of participants for a particular outcome.
- 36 • An indication of the direction of clinical importance (if one treatment is beneficial or
37 harmful compared to the other or whether there is no difference between the 2 tested
38 treatments).

- 1 • A description of the overall quality of the evidence (GRADE overall quality).

2.4 Identifying and analysing evidence of cost effectiveness

3 The committee is required to make decisions based on the best available evidence of both
4 clinical effectiveness and cost effectiveness. Guideline recommendations should be based
5 on the expected costs of the different options in relation to their expected health benefits
6 (that is, their 'cost effectiveness') rather than the total implementation cost. However, the
7 committee will also need to be increasingly confident in the cost effectiveness of a
8 recommendation as the cost of implementation increases. Therefore, the committee may
9 require more robust evidence on the effectiveness and cost effectiveness of any
10 recommendations that are expected to have a substantial impact on resources; any
11 uncertainties must be offset by a compelling argument in favour of the recommendation. The
12 cost impact or savings potential of a recommendation should not be the sole reason for the
13 committee's decision.¹¹

14 Health economic evidence was sought relating to the key clinical issues being addressed in
15 the guideline. Health economists:

- 16 • Undertook a systematic review of the published economic literature.
17 • Undertook new cost-effectiveness analysis in priority areas.

2.4.1 Literature review

19 The health economists:

- 20 • Identified potentially relevant studies for each review question from the health economic
21 search results by reviewing titles and abstracts. Full papers were then obtained.
22 • Reviewed full papers against prespecified inclusion and exclusion criteria to identify
23 relevant studies (see below for details).
24 • Critically appraised relevant studies using economic evaluations checklists as specified in
25 the NICE guidelines manual.¹¹
26 • Extracted key information about the studies' methods and results into health economic
27 evidence tables (which can be found in appendices to the relevant evidence reports).
28 • Generated summaries of the evidence in NICE health economic evidence profile tables
29 (included in the relevant evidence report for each review question) – see below for details.

2.4.101 Inclusion and exclusion criteria

31 Full economic evaluations (studies comparing costs and health consequences of alternative
32 courses of action: cost–utility, cost-effectiveness, cost–benefit and cost–consequences
33 analyses) and comparative costing studies that addressed the review question in the relevant
34 population were considered potentially includable as health economic evidence.

35 Studies that only reported cost per hospital (not per patient), or only reported average cost
36 effectiveness without disaggregated costs and effects were excluded. Literature reviews,
37 abstracts, posters, letters, editorials, comment articles, unpublished studies and studies not
38 in English were excluded. Studies published before 2003 and studies from non-OECD
39 countries or the USA were also excluded, on the basis that the applicability of such studies to
40 the present UK NHS context is likely to be too low for them to be helpful for decision-making.

41 Remaining health economic studies were prioritised for inclusion based on their relative
42 applicability to the development of this guideline and the study limitations. For example, if a
43 high quality, directly applicable UK analysis was available, then other less relevant studies
44 may not have been included. Where exclusions occurred on this basis, this is noted in the
45 relevant evidence report.

1 For more details about the assessment of applicability and methodological quality see Table
2 5 below and the economic evaluation checklist (appendix H of the NICE guidelines manual¹¹)
3 and the health economics review protocol, which can be found in each of the evidence
4 reports.

5 When no relevant health economic studies were found from the economic literature review,
6 relevant UK NHS unit costs related to the compared interventions were presented to the
7 committee to inform the possible economic implications of the recommendations.

2.4.182 NICE health economic evidence profiles

9 NICE health economic evidence profile tables were used to summarise cost and cost-
10 effectiveness estimates for the included health economic studies in each evidence review
11 report. The health economic evidence profile shows an assessment of applicability and
12 methodological quality for each economic study, with footnotes indicating the reasons for the
13 assessment. These assessments were made by the health economist using the economic
14 evaluation checklist from the NICE guidelines manual.¹¹ It also shows the incremental costs,
15 incremental effects (for example, quality-adjusted life years [QALYs]) and incremental cost-
16 effectiveness ratio (ICER) for the base case analysis in the study, as well as information
17 about the assessment of uncertainty in the analysis. See Table 5 for more details.

18 When a non-UK study was included in the profile, the results were converted into pounds
19 sterling using the appropriate purchasing power parity.¹⁴

20 **Table 5: Content of NICE health economic evidence profile**

Item	Description
Study	Surname of first author, date of study publication and country perspective with a reference to full information on the study.
Applicability	An assessment of applicability of the study to this guideline, the current NHS situation and NICE decision-making: ^(a) <ul style="list-style-type: none"> • Directly applicable – the study meets all applicability criteria, or fails to meet 1 or more applicability criteria but this is unlikely to change the conclusions about cost effectiveness. • Partially applicable – the study fails to meet 1 or more applicability criteria, and this could change the conclusions about cost effectiveness. • Not applicable – the study fails to meet 1 or more of the applicability criteria, and this is likely to change the conclusions about cost effectiveness. Such studies would usually be excluded from the review.
Limitations	An assessment of methodological quality of the study: ^(a) <ul style="list-style-type: none"> • Minor limitations – the study meets all quality criteria, or fails to meet 1 or more quality criteria, but this is unlikely to change the conclusions about cost effectiveness. • Potentially serious limitations – the study fails to meet 1 or more quality criteria, and this could change the conclusions about cost effectiveness. • Very serious limitations – the study fails to meet 1 or more quality criteria, and this is highly likely to change the conclusions about cost effectiveness. Such studies would usually be excluded from the review.
Other comments	Information about the design of the study and particular issues that should be considered when interpreting it.
Incremental cost	The mean cost associated with one strategy minus the mean cost of a comparator strategy.
Incremental effects	The mean QALYs (or other selected measure of health outcome) associated with one strategy minus the mean QALYs of a comparator strategy.
Cost effectiveness	Incremental cost-effectiveness ratio (ICER): the incremental cost divided by the incremental effects (usually in £ per QALY gained).

Item	Description
Uncertainty	A summary of the extent of uncertainty about the ICER reflecting the results of deterministic or probabilistic sensitivity analyses, or stochastic analyses of trial data, as appropriate.

1 (a) *Applicability and limitations were assessed using the economic evaluation checklist in appendix H of the NICE*
2 *guidelines manual*¹

2.42 Undertaking new health economic analysis

4 As well as reviewing the published health economic literature for each review question, as
5 described above, new health economic analysis was undertaken by the health economist in
6 selected areas. Priority areas for new analysis were agreed by the committee after formation
7 of the review questions and consideration of the existing health economic evidence.

8 The committee identified dual-antiplatelet therapy as the highest priority area for original
9 health economic modelling. As there is variation in clinical practice regarding which second
10 dual-antiplatelet is prescribed, a recommendation for a particular agent is likely to have a
11 substantial resource impact. Also, there was no published cost effectiveness evidence which
12 included some of the latest clinical evidence identified in the systematic review. For more
13 detail see Evidence report [A]: dual-antiplatelet therapy.

14 The following general principles were adhered to in developing the cost-effectiveness
15 analysis:

- 16 • Methods were consistent with the NICE reference case for interventions with health
17 outcomes in NHS settings.^{11, 13}
- 18 • The committee was involved in the design of the model, selection of inputs and
19 interpretation of the results.
- 20 • Model inputs were based on the systematic review of the clinical literature supplemented
21 with other published data sources where possible.
- 22 • When published data were not available committee expert opinion was used to populate
23 the model.
- 24 • Model inputs and assumptions were reported fully and transparently.
- 25 • The results were subject to sensitivity analysis and limitations were discussed.
- 26 • The model was peer-reviewed by another health economist at the NGC.

27 Full methods and results of the cost-effectiveness analysis for dual-antiplatelet therapy are
28 described in a separate economic analysis report.

2.43 Cost-effectiveness criteria

30 NICE's report 'Social value judgements: principles for the development of NICE guidance'
31 sets out the principles that committees should consider when judging whether an intervention
32 offers good value for money.¹² In general, an intervention was considered to be cost effective
33 (given that the estimate was considered plausible) if either of the following criteria applied:

- 34 • the intervention dominated other relevant strategies (that is, it was both less costly in
35 terms of resource use and more clinically effective compared with all the other relevant
36 alternative strategies), or
- 37 • the intervention cost less than £20,000 per QALY gained compared with the next best
38 strategy.

39 If the committee recommended an intervention that was estimated to cost more than £20,000
40 per QALY gained, or did not recommend one that was estimated to cost less than £20,000
41 per QALY gained, the reasons for this decision are discussed explicitly in 'The committee's
42 discussion of the evidence' section of the relevant evidence report, with reference to issues

1 regarding the plausibility of the estimate or to the factors set out in 'Social value judgements:
2 principles for the development of NICE guidance'.¹²

3 When QALYs or life years gained are not used in the analysis, results are difficult to interpret
4 unless one strategy dominates the others with respect to every relevant health outcome and
5 cost.

2.4 In the absence of health economic evidence

7 When no relevant published health economic studies were found, and a new analysis was
8 not prioritised, the committee made a qualitative judgement about cost effectiveness by
9 considering expected differences in resource use between options and relevant UK NHS unit
10 costs, alongside the results of the review of clinical effectiveness evidence.

11 The UK NHS costs reported in the guideline are those that were presented to the committee
12 and were correct at the time recommendations were drafted. They may have changed
13 subsequently before the time of publication. However, we have no reason to believe they
14 have changed substantially.

2.5 Developing recommendations

16 Over the course of the guideline development process, the committee was presented with:

- 17 • Summaries of clinical and health economic evidence and quality (as presented in
18 evidence reports [A–H]).
- 19 • Evidence tables of the clinical and health economic evidence reviewed from the literature.
20 All evidence tables can be found in appendices to the relevant evidence reports.
- 21 • Forest plots (in appendices to the relevant evidence reports).
- 22 • A description of the methods and results of the cost-effectiveness analyses) undertaken
23 for the guideline (in a separate economic analysis report).

24 Recommendations were drafted on the basis of the committee's interpretation of the
25 available evidence, taking into account the balance of benefits, harms and costs between
26 different courses of action. This was either done formally in an economic model, or
27 informally. Firstly, the net clinical benefit over harm (clinical effectiveness) was considered,
28 focusing on the critical outcomes. When this was done informally, the committee took into
29 account the clinical benefits and harms when one intervention was compared with another.
30 The assessment of net clinical benefit was moderated by the importance placed on the
31 outcomes (the committee's values and preferences), and the confidence the committee had
32 in the evidence (evidence quality). Secondly, the committee assessed whether the net
33 clinical benefit justified any differences in costs between the alternative interventions.

34 When clinical and health economic evidence was of poor quality, conflicting or absent, the
35 committee drafted recommendations based on its expert opinion. The considerations for
36 making consensus-based recommendations include the balance between potential harms
37 and benefits, the economic costs compared to the economic benefits, current practices,
38 recommendations made in other relevant guidelines, patient preferences and equality issues.
39 The consensus recommendations were agreed through discussions in the committee. The
40 committee also considered whether the uncertainty was sufficient to justify delaying making a
41 recommendation to await further research, taking into account the potential harm of failing to
42 make a clear recommendation (see section 2.5.1 below).

43 The committee considered the appropriate 'strength' of each recommendation. This takes
44 into account the quality of the evidence but is conceptually different. Some recommendations
45 are 'strong' in that the committee believes that the vast majority of healthcare and other
46 professionals and patients would choose a particular intervention if they considered the
47 evidence in the same way that the committee has. This is generally the case if the benefits

1 clearly outweigh the harms for most people and the intervention is likely to be cost effective.
2 However, there is often a closer balance between benefits and harms, and some patients
3 would not choose an intervention whereas others would. This may happen, for example, if
4 some patients are particularly averse to some side effect and others are not. In these
5 circumstances the recommendation is generally weaker, although it may be possible to make
6 stronger recommendations about specific groups of patients.

7 The committee focused on the following factors in agreeing the wording of the
8 recommendations:

- 9 • The actions health professionals need to take.
- 10 • The information readers need to know.
- 11 • The strength of the recommendation (for example the word 'offer' was used for strong
12 recommendations and 'consider' for weaker recommendations).
- 13 • The involvement of patients (and their carers if needed) in decisions on treatment and
14 care.
- 15 • Consistency with NICE's standard advice on recommendations about drugs, waiting times
16 and ineffective interventions (see section 9.2 in the NICE guidelines manual¹¹).

17 The main considerations specific to each recommendation are outlined in 'The committee's
18 discussion of the evidence' section within each evidence report.

2.5.1 Research recommendations

20 When areas were identified for which good evidence was lacking, the committee considered
21 making recommendations for future research. Decisions about the inclusion of a research
22 recommendation were based on factors such as:

- 23 • the importance to patients or the population
- 24 • national priorities
- 25 • potential impact on the NHS and future NICE guidance
- 26 • ethical and technical feasibility.

2.5.2 Validation process

28 This guidance is subject to a 6-week public consultation and feedback as part of the quality
29 assurance and peer review of the document. All comments received from registered
30 stakeholders are responded to in turn and posted on the NICE website.

2.5.3 Updating the guideline

32 Following publication, and in accordance with the NICE guidelines manual, NICE will
33 undertake a review of whether the evidence base has progressed significantly to alter the
34 guideline recommendations and warrant an update.

2.5.4 Disclaimer

36 Healthcare providers need to use clinical judgement, knowledge and expertise when
37 deciding whether it is appropriate to apply guidelines. The recommendations cited here are a
38 guide and may not be appropriate for use in all situations. The decision to adopt any of the
39 recommendations cited here must be made by practitioners in light of individual patient
40 circumstances, the wishes of the patient, clinical expertise and resources.

41 The National Guideline Centre disclaims any responsibility for damages arising out of the use
42 or non-use of this guideline and the literature used in support of this guideline.

2.5.5 Funding

2 The National Guideline Centre was commissioned by the National Institute for Health and
3 Care Excellence to undertake the work on this guideline.

4

5

3 Acronyms and abbreviations

2

Acronym	Definition
ACS	Acute coronary syndromes
AF	Atrial fibrillation
AE	Adverse events
BB	Beta-blocker
BMS	Bare metal stent
BNF	British National Formulary
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CEA	Cost-effectiveness analysis
CHD	Coronary heart disease
CHF	Chronic heart failure
CG	Clinical guideline
CI	Confidence interval
CUA	Cost-utility analysis
CV	Cardiovascular
CVD	Cardiovascular disease
DAPT	Dual antiplatelet therapy
DES	Drug eluting stent
DOAC	Direct oral anticoagulant
ECG	Electrocardiogram
ECHO	Echocardiography
EF	Ejection fraction
EQ-5D	Quality of life scale
FE	Fixed effects
GC	Guideline committee
GP	General practitioner
GPI	Glycoprotein inhibitor
GRADE	Grading of recommendations assessment, development and evaluation
GRP	Guideline review panel
HCP	Healthcare professionals
HF	Heart failure
HR	Hazard ratio
HRQoL	Health related quality of life
HTA	Health technology assessment
ICER	Incremental cost effectiveness ratio
INR	International normalised ratio
ITT	Intention to treat
LMWH	Low molecular weight heparin
LV	Left ventricular
LVEF	Left ventricular ejection fraction
LVSD	Left ventricular systolic dysfunction
LYG	Life year gained

Acronym	Definition
MD	Mean difference
MI	Myocardial infarction
MID	Minimal important difference
MINAP	Myocardial infarction national audit project
MLD	Minimal luminal diameter
MRI	Magnetic resonance imaging
n/N	Number
NA	Not applicable
NGC	National Guideline Centre
NICE	National Institute for Health and Care Excellence
NOAC	New oral anticoagulant
NR	Not reported
NSAID	Non-steroidal anti-inflammatory drug
NSTEMI	Non-ST-segment elevation myocardial infarction
OAC	Oral anticoagulation
OECD	Organisation for economic co-operation and development
OR	Odds ratio
PA	Probabilistic analysis
PCI	Percutaneous coronary intervention
PPCI	Primary percutaneous coronary intervention
QALY	Quality adjusted life year
QoL	Quality of life
RCT	Randomised controlled trial
RE	Random effects
RR	Risk ratio or relative risk
SD	Standard deviation
SE	Standard error
STEMI	ST-segment- elevation myocardial infarction
TA	Technology appraisal
TVF	Target vessel failure
TVR	Target vessel revascularisation
UA	Unstable angina
UFH	Unfractionated heparin
VF	Ventricular function
Vs.	Versus

1

2

4 Glossary

2 The NICE Glossary can be found at www.nice.org.uk/glossary.

4.1 Guideline-specific terms medical terms

4

Term	Definition
ACE inhibitor	A drug used to treat hypertension (elevated blood pressure) and congestive heart failure.
Acute coronary syndrome	A spectrum of three heart acute medical conditions (unstable angina, NSTEMI, STEMI) caused by acute instability of coronary atherosclerotic plaque with resultant thrombosis which leads to reduced blood supply to heart muscle.
Angina	The symptom of discomfort or pain felt in the chest, throat, jaw and arm which occurs when heart muscle does not receive as much blood and oxygen as it needs, usually as a result of narrowing or blockage of the coronary arteries. If it occurs predictably in response to exertion it is described as stable angina, but if it occurs unpredictably or on minimal exertion it is called unstable angina
Angiography	Using x-rays to visualise blood vessels which are injected with contrast dye to detect blockages in coronary arteries due to atherosclerotic plaque build up
Angioplasty	Process of using a balloon to widen narrowed or obstructed arteries. Most modern angioplasty procedures also insert a stent at the same time to ensure the artery remains open.
Anticoagulant	A drug which reduces the ability of blood to clot by affecting the coagulation pathway.
Antiplatelet	A drug which decreases the ability of platelets to stick to one another (aggregation) and thereby inhibits thrombus formation. More effective in reducing blood clots in the arterial circulation compared to anticoagulants.
Atherosclerosis	Condition where arteries become clogged with deposits of fats and inflammatory cells called plaques or atheroma. Causes arteries to harden and can restrict blood flow if the plaque bulges into the central lumen of the artery.
Bailout glycoprotein IIb/IIIa inhibitor	Bailout glycoprotein inhibitor (GPI) refers to the use of GPI when the PCI operator has not intended to use GPI from the outset, but considers that clinical or angiographic features (such as worsening or persistent thrombus burden) have changed during the course of the procedure such that there may be benefit to giving the patient GPI.
Bare metal stent	Stents are wire mesh tubes used to widen narrowed arteries, inserted during a procedure called balloon angioplasty. Bare metal stents are not coated or treated with any drug.
Cardiac catheterisation	Invasive procedure of inserting catheter tube(s) into the heart or its blood supply. Used for both diagnostic (angiography) and treatment (angioplasty) purposes. Majority of procedures are performed by accessing the radial artery at the wrist, but can also be performed by accessing the femoral artery in the groin. Major complications (death, heart attack, stroke, major bleeding) are rare, but important.
Contrast induced nephropathy	A form of kidney damage caused by the contrast dye that is injected into the blood vessels during angiography procedures. It typically develops two to three days after the administration of contrast.
Coronary artery bypass surgery	A surgical procedure used to improve blood supply to the heart. A section of blood vessel is grafted to one or more coronary arteries

Term	Definition
	above and below the area that is narrowed or blocked by atherosclerosis.
Coronary revascularisation	Process of restoring the flow of blood to the heart undertaken for symptomatic relief and improvement in condition. Achieved by removing or bypassing blockages in coronary arteries caused by atherosclerosis
Culprit lesion	The atherosclerotic lesion (a wounded or damaged area) considered to be responsible for ACS.
Dual antiplatelet therapy	The combination of two antiplatelet drugs (usually aspirin and one of clopidogrel, prasugrel or ticagrelor)
Drug-eluting stent	Stents are wire mesh tubes used to widen narrowed arteries, inserted during a procedure called balloon angioplasty. Drug-eluting stents are stents which are coated with drugs which inhibit the smooth muscle cell proliferation process in artery walls which causes early re-narrowing (restenosis) of stents in the first 12-24 months after.
Fibrinolysis	Use of enzyme medications which break down fibrin, the protein that holds blood clots together.
Global Registry of Acute Cardiac Events (GRACE) score	A risk score for assessing future heart attack and death risk in ACS patients
Haemodynamically compromised	A physiological state in which a patient is suffering with low blood pressure as a result of reduced heart function or abnormal heart rhythm (arrhythmia)
Haemorrhagic stroke	A stroke due to bleeding within the brain. Usually occurs when a weakened blood vessel supplying the brain bursts
Inotropic agents	Drugs which improve the pumping function of the heart in patients with haemodynamic compromise
Ischaemic heart disease	Term given to heart disease caused by atherosclerosis leading to narrowed or blocked coronary arteries resulting in less blood and oxygen reaching the heart muscle. Also called coronary artery disease and coronary heart disease. Can lead to heart attack
Myocardial infarction	A serious medical condition in which death of heart muscle occurs due to reduction in its blood supply, usually known as heart attack. Often associated with chest pain or discomfort although women may have atypical symptoms. Most (but not all) MIs are due to coronary artery disease and ACS.
Non-ST elevation myocardial infarction (NSTEMI)	Type of myocardial infarction in which the ECG does not show elevation of the ST segments. Usually caused by partial, rather than complete, occlusion of a coronary artery by a thrombus at a site of atherosclerotic plaque. Heart muscle becomes ischaemic (insufficient blood and oxygen) and results in potential cell death. Usually treated with a combination of drugs and coronary revascularisation.
Percutaneous	Process of obtaining access to inner organ via needle puncture of skin rather than "open" approach of exposing organs e.g. through a scalpel. Coronary angiography, angioplasty and stenting are performed percutaneously.
Percutaneous coronary intervention PCI	Umbrella term which covers both coronary angioplasty using balloons, and stent implantation.
Primary PCI	The term used to describe a PCI procedure which is performed as the primary treatment strategy for STEMI.
Refractory angina	When patients continue to experience or have a recurrence of angina despite treatment. Does not respond to medication and can be debilitating
Restenosis	Development of recurrent narrowing within a coronary artery previously treated by angioplasty or stenting. If it occurs within the first 24 months

Term	Definition
	after stenting, it is usually due to excessive production of collagen by cells in the artery wall as a response to the local injury triggered by stent implantation. The drugs delivered by drug-eluting stents to the artery wall inhibit collagen formation thereby preventing restenosis. Restenosis which develops many years after stent implantation is more likely due to recurrent atherosclerosis within the stented segment.
ST-segment elevation myocardial infarction (STEMI)	Type of myocardial infarction which is generally the most serious. It is due to sudden complete blockage of a coronary artery by a blood clot. This produces a characteristic change in the patient's ECG, known as ST (segment) elevation. Heart muscle starts to die within a matter of minutes of losing its blood supply, so STEMI is regarded as a medical emergency.
Stenosis	Narrowing of a blood vessel, such as a coronary artery
Stent	A blood vessel scaffold that helps keep narrowed (stenosed) coronary arteries open after they have been treated by balloon angioplasty. Most stents are made of a metal alloy "mesh" which resembles chicken wire. Can be coated with drugs to reduce restenosis (and are then known as drug-eluting stents).
Stenting	Process of inserting stent(s) into the lumen of an anatomic vessel or duct to keep passage way open.
Stent thrombosis	A blood clot that forms inside a stent. Usually a sudden event which leads to heart attack or death, but relatively rare in modern clinical practice (<1% of all stents). It differs from restenosis where the stent gradually narrows down (the process that drug-eluting stents are used to reduce).
Stroke	When the normal blood supply to part of the brain is cut off and there is death of brain tissue.
Thrombin	A protein which helps clotting
Thrombolysis	Also called fibrinolytic therapy
Thrombus	The medical term for a blood clot
Troponin	Two heart-specific proteins (T and I) which are released into the blood stream when heart muscle cells die (infarct) such as occurs during a myocardial infarction. Detection of significant levels of troponin T or I can confirm that a myocardial infarction has occurred and give an indication of how much damage has been done.
Unstable angina	A clinical diagnosis made when a patient describes angina that occurs unpredictably or on minimal exertion. It is part of the spectrum of acute coronary syndromes, and by definition, the patient's troponin levels will not be elevated. If troponin is elevated and there is no ST-segment elevation on the ECG, then the diagnosis is NSTEMI.

4.2 General methodological terms

2

Term	Definition
Abstract	Summary of a study, which may be published alone or as an introduction to a full scientific paper.
Algorithm (in guidelines)	A flow chart of the clinical decision pathway described in the guideline, where decision points are represented with boxes, linked with arrows.
Allocation concealment	The process used to prevent advance knowledge of group assignment in an RCT. The allocation process should be impervious to any influence by the individual making the allocation, by being administered by someone who is not responsible for recruiting participants.

Term	Definition
Applicability	How well the results of a study or NICE evidence review can answer a clinical question or be applied to the population being considered.
Arm (of a clinical study)	Subsection of individuals within a study who receive one particular intervention, for example placebo arm.
Association	Statistical relationship between 2 or more events, characteristics or other variables. The relationship may or may not be causal.
Base case analysis	In an economic evaluation, this is the main analysis based on the most plausible estimate of each input. In contrast, see Sensitivity analysis.
Baseline	The initial set of measurements at the beginning of a study (after run-in period where applicable), with which subsequent results are compared.
Bayesian analysis	A method of statistics, where a statistic is estimated by combining established information or belief (the 'prior') with new evidence (the 'likelihood') to give a revised estimate (the 'posterior').
Before-and-after study	A study that investigates the effects of an intervention by measuring particular characteristics of a population both before and after taking the intervention, and assessing any change that occurs.
Bias	Influences on a study that can make the results look better or worse than they really are. (Bias can even make it look as if a treatment works when it does not.) Bias can occur by chance, deliberately or as a result of systematic errors in the design and execution of a study. It can also occur at different stages in the research process, for example, during the collection, analysis, interpretation, publication or review of research data. For examples see selection bias, performance bias, information bias, confounding factor, and publication bias.
Blinding	<p>A way to prevent researchers, doctors and patients in a clinical trial from knowing which study group each patient is in so they cannot influence the results. The best way to do this is by sorting patients into study groups randomly. The purpose of 'blinding' or 'masking' is to protect against bias.</p> <p>A single-blinded study is one in which patients do not know which study group they are in (for example whether they are taking the experimental drug or a placebo). A double-blinded study is one in which neither patients nor the researchers and doctors know which study group the patients are in. A triple blind study is one in which neither the patients, clinicians or the people carrying out the statistical analysis know which treatment patients received.</p>
Carer (caregiver)	Someone who looks after family, partners or friends in need of help because they are ill, frail or have a disability.
Case-control study	<p>A study to find out the cause(s) of a disease or condition. This is done by comparing a group of patients who have the disease or condition (cases) with a group of people who do not have it (controls) but who are otherwise as similar as possible (in characteristics thought to be unrelated to the causes of the disease or condition). This means the researcher can look for aspects of their lives that differ to see if they may cause the condition.</p> <p>For example, a group of people with lung cancer might be compared with a group of people the same age that do not have lung cancer. The researcher could compare how long both groups had been exposed to tobacco smoke. Such studies are retrospective because they look back in time from the outcome to the possible causes of a disease or condition.</p>
Case series	Report of a number of cases of a given disease, usually covering the course of the disease and the response to treatment. There is no

Term	Definition
	comparison (control) group of patients.
Clinical efficacy	The extent to which an intervention is active when studied under controlled research conditions.
Clinical effectiveness	How well a specific test or treatment works when used in the 'real world' (for example, when used by a doctor with a patient at home), rather than in a carefully controlled clinical trial. Trials that assess clinical effectiveness are sometimes called management trials. Clinical effectiveness is not the same as efficacy.
Clinician	A healthcare professional who provides patient care. For example, a doctor, nurse or physiotherapist.
Cochrane Review	The Cochrane Library consists of a regularly updated collection of evidence-based medicine databases including the Cochrane Database of Systematic Reviews (reviews of randomised controlled trials prepared by the Cochrane Collaboration).
Cohort study	A study with 2 or more groups of people – cohorts – with similar characteristics. One group receives a treatment, is exposed to a risk factor or has a particular symptom and the other group does not. The study follows their progress over time and records what happens. See also observational study.
Comorbidity	A disease or condition that someone has in addition to the health problem being studied or treated.
Comparability	Similarity of the groups in characteristics likely to affect the study results (such as health status or age).
Concordance	This is a recent term whose meaning has changed. It was initially applied to the consultation process in which doctor and patient agree therapeutic decisions that incorporate their respective views, but now includes patient support in medicine taking as well as prescribing communication. Concordance reflects social values but does not address medicine-taking and may not lead to improved adherence.
Confidence interval (CI)	<p>There is always some uncertainty in research. This is because a small group of patients is studied to predict the effects of a treatment on the wider population. The confidence interval is a way of expressing how certain we are about the findings from a study, using statistics. It gives a range of results that is likely to include the 'true' value for the population.</p> <p>The CI is usually stated as '95% CI', which means that the range of values has a 95 in a 100 chance of including the 'true' value. For example, a study may state that "based on our sample findings, we are 95% certain that the 'true' population blood pressure is not higher than 150 and not lower than 110". In such a case the 95% CI would be 110 to 150.</p> <p>A wide confidence interval indicates a lack of certainty about the true effect of the test or treatment – often because a small group of patients has been studied. A narrow confidence interval indicates a more precise estimate (for example, if a large number of patients have been studied).</p>
Confounding factor	<p>Something that influences a study and can result in misleading findings if it is not understood or appropriately dealt with.</p> <p>For example, a study of heart disease may look at a group of people that exercises regularly and a group that does not exercise. If the ages of the people in the 2 groups are different, then any difference in heart disease rates between the 2 groups could be because of age rather than exercise. Therefore age is a confounding factor.</p>
Consensus methods	Techniques used to reach agreement on a particular issue. Consensus methods may be used to develop NICE guidance if there is not enough good quality research evidence to give a clear answer

Term	Definition
	to a question. Formal consensus methods include Delphi and nominal group techniques.
Control group	<p>A group of people in a study who do not receive the treatment or test being studied. Instead, they may receive the standard treatment (sometimes called 'usual care') or a dummy treatment (placebo). The results for the control group are compared with those for a group receiving the treatment being tested. The aim is to check for any differences.</p> <p>Ideally, the people in the control group should be as similar as possible to those in the treatment group, to make it as easy as possible to detect any effects due to the treatment.</p>
Cost–benefit analysis (CBA)	Cost–benefit analysis is one of the tools used to carry out an economic evaluation. The costs and benefits are measured using the same monetary units (for example, pounds sterling) to see whether the benefits exceed the costs.
Cost–consequences analysis (CCA)	Cost–consequences analysis is one of the tools used to carry out an economic evaluation. This compares the costs (such as treatment and hospital care) and the consequences (such as health outcomes) of a test or treatment with a suitable alternative. Unlike cost–benefit analysis or cost-effectiveness analysis, it does not attempt to summarise outcomes in a single measure (like the quality-adjusted life year) or in financial terms. Instead, outcomes are shown in their natural units (some of which may be monetary) and it is left to decision-makers to determine whether, overall, the treatment is worth carrying out.
Cost-effectiveness analysis (CEA)	Cost-effectiveness analysis is one of the tools used to carry out an economic evaluation. The benefits are expressed in non-monetary terms related to health, such as symptom-free days, heart attacks avoided, deaths avoided or life years gained (that is, the number of years by which life is extended as a result of the intervention).
Cost-effectiveness model	An explicit mathematical framework, which is used to represent clinical decision problems and incorporate evidence from a variety of sources in order to estimate the costs and health outcomes.
Cost–utility analysis (CUA)	Cost–utility analysis is one of the tools used to carry out an economic evaluation. The benefits are assessed in terms of both quality and duration of life, and expressed as quality-adjusted life years (QALYs). See also utility.
Credible interval (CrI)	The Bayesian equivalent of a confidence interval.
Decision analysis	An explicit quantitative approach to decision-making under uncertainty, based on evidence from research. This evidence is translated into probabilities, and then into diagrams or decision trees which direct the clinician through a succession of possible scenarios, actions and outcomes.
Deterministic analysis	In economic evaluation, this is an analysis that uses a point estimate for each input. In contrast, see Probabilistic analysis
Diagnostic odds ratio	The diagnostic odds ratio is a measure of the effectiveness of a diagnostic test. It is defined as the ratio of the odds of the test being positive if the subject has a disease relative to the odds of the test being positive if the subject does not have the disease.
Discounting	Costs and perhaps benefits incurred today have a higher value than costs and benefits occurring in the future. Discounting health benefits reflects individual preference for benefits to be experienced in the present rather than the future. Discounting costs reflects individual preference for costs to be experienced in the future rather than the present.
Disutility	The loss of quality of life associated with having a disease or

Term	Definition
	condition. See Utility
Dominance	A health economics term. When comparing tests or treatments, an option that is both less effective and costs more is said to be 'dominated' by the alternative.
Drop-out	A participant who withdraws from a trial before the end.
Economic evaluation	An economic evaluation is used to assess the cost effectiveness of healthcare interventions (that is, to compare the costs and benefits of a healthcare intervention to assess whether it is worth doing). The aim of an economic evaluation is to maximise the level of benefits – health effects – relative to the resources available. It should be used to inform and support the decision-making process; it is not supposed to replace the judgement of healthcare professionals. There are several types of economic evaluation: cost–benefit analysis, cost–consequences analysis, cost-effectiveness analysis, cost-minimisation analysis and cost–utility analysis. They use similar methods to define and evaluate costs, but differ in the way they estimate the benefits of a particular drug, programme or intervention.
Effect (as in effect measure, treatment effect, estimate of effect, effect size)	A measure that shows the magnitude of the outcome in one group compared with that in a control group. For example, if the absolute risk reduction is shown to be 5% and it is the outcome of interest, the effect size is 5%. The effect size is usually tested, using statistics, to find out how likely it is that the effect is a result of the treatment and has not just happened by chance (that is, to see if it is statistically significant).
Effectiveness	How beneficial a test or treatment is under usual or everyday conditions, compared with doing nothing or opting for another type of care.
Efficacy	How beneficial a test, treatment or public health intervention is under ideal conditions (for example, in a laboratory), compared with doing nothing or opting for another type of care.
Epidemiological study	The study of a disease within a population, defining its incidence and prevalence and examining the roles of external influences (for example, infection, diet) and interventions.
EQ-5D (EuroQol 5 dimensions)	A standardised instrument used to measure health-related quality of life. It provides a single index value for health status.
Evidence	Information on which a decision or guidance is based. Evidence is obtained from a range of sources including randomised controlled trials, observational studies, expert opinion (of clinical professionals or patients).
Exclusion criteria (literature review)	Explicit standards used to decide which studies should be excluded from consideration as potential sources of evidence.
Exclusion criteria (clinical study)	Criteria that define who is not eligible to participate in a clinical study.
Extended dominance	If Option A is both more clinically effective than Option B and has a lower cost per unit of effect, when both are compared with a do-nothing alternative then Option A is said to have extended dominance over Option B. Option A is therefore cost effective and should be preferred, other things remaining equal.
Extrapolation	An assumption that the results of studies of a specific population will also hold true for another population with similar characteristics.
Follow-up	Observation over a period of time of an individual, group or initially defined population whose appropriate characteristics have been assessed in order to observe changes in health status or health-related variables.
Generalisability	The extent to which the results of a study hold true for groups that did

Term	Definition
	not participate in the research. See also external validity.
Gold standard	A method, procedure or measurement that is widely accepted as being the best available to test for or treat a disease.
GRADE, GRADE profile	A system developed by the GRADE Working Group to address the shortcomings of present grading systems in healthcare. The GRADE system uses a common, sensible and transparent approach to grading the quality of evidence. The results of applying the GRADE system to clinical trial data are displayed in a table known as a GRADE profile.
Harms	Adverse effects of an intervention.
Health economics	Study or analysis of the cost of using and distributing healthcare resources.
Health-related quality of life (HRQoL)	A measure of the effects of an illness to see how it affects someone's day-to-day life.
Heterogeneity or Lack of homogeneity	The term is used in meta-analyses and systematic reviews to describe when the results of a test or treatment (or estimates of its effect) differ significantly in different studies. Such differences may occur as a result of differences in the populations studied, the outcome measures used or because of different definitions of the variables involved. It is the opposite of homogeneity.
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of effect.
Inclusion criteria (literature review)	Explicit criteria used to decide which studies should be considered as potential sources of evidence.
Incremental analysis	The analysis of additional costs and additional clinical outcomes with different interventions.
Incremental cost	The extra cost linked to using one test or treatment rather than another. Or the additional cost of doing a test or providing a treatment more frequently.
Incremental cost-effectiveness ratio (ICER)	The difference in the mean costs in the population of interest divided by the differences in the mean outcomes in the population of interest for one treatment compared with another.
Incremental net benefit (INB)	The value (usually in monetary terms) of an intervention net of its cost compared with a comparator intervention. The INB can be calculated for a given cost-effectiveness (willingness to pay) threshold. If the threshold is £20,000 per QALY gained then the INB is calculated as: (£20,000 × QALYs gained) – Incremental cost.
Indirectness	The available evidence is different to the review question being addressed, in terms of PICO (population, intervention, comparison and outcome).
Intention-to-treat analysis (ITT)	An assessment of the people taking part in a clinical trial, based on the group they were initially (and randomly) allocated to. This is regardless of whether or not they dropped out, fully complied with the treatment or switched to an alternative treatment. Intention-to-treat analyses are often used to assess clinical effectiveness because they mirror actual practice: that is, not everyone complies with treatment and the treatment people receive may be changed according to how they respond to it.
Intervention	In medical terms this could be a drug treatment, surgical procedure, diagnostic or psychological therapy. Examples of public health interventions could include action to help someone to be physically active or to eat a more healthy diet.
Intraoperative	The period of time during a surgical procedure.
Kappa statistic	A statistical measure of inter-rater agreement that takes into account

Term	Definition
	the agreement occurring by chance.
Length of stay	The total number of days a participant stays in hospital.
Licence	See 'Product licence'.
Life years gained	Mean average years of life gained per person as a result of the intervention compared with an alternative intervention.
Likelihood ratio	The likelihood ratio combines information about the sensitivity and specificity. It tells you how much a positive or negative result changes the likelihood that a patient would have the disease. The likelihood ratio of a positive test result (LR+) is sensitivity divided by (1 minus specificity).
Long-term care	Residential care in a home that may include skilled nursing care and help with everyday activities. This includes nursing homes and residential homes.
Logistic regression or Logit model	In statistics, logistic regression is a type of analysis used for predicting the outcome of a binary dependent variable based on one or more predictor variables. It can be used to estimate the log of the odds (known as the 'logit').
Loss to follow-up	A patient, or the proportion of patients, actively participating in a clinical trial at the beginning, but whom the researchers were unable to trace or contact by the point of follow-up in the trial
Markov model	A method for estimating long-term costs and effects for recurrent or chronic conditions, based on health states and the probability of transition between them within a given time period (cycle).
Meta-analysis	A method often used in systematic reviews. Results from several studies of the same test or treatment are combined to estimate the overall effect of the treatment.
Multivariate model	A statistical model for analysis of the relationship between 2 or more predictor (independent) variables and the outcome (dependent) variable.
Negative predictive value (NPV)	In screening or diagnostic tests: A measure of the usefulness of a screening or diagnostic test. It is the proportion of those with a negative test result who do not have the disease, and can be interpreted as the probability that a negative test result is correct. It is calculated as follows: $TN/(TN+FN)$
Net monetary benefit (NMB)	The value in monetary terms of an intervention net of its cost. The NMB can be calculated for a given cost-effectiveness threshold. If the threshold is £20,000 per QALY gained then the NMB for an intervention is calculated as: $(£20,000 \times \text{mean QALYs}) - \text{mean cost}$. The most preferable option (that is, the most clinically effective option to have an ICER below the threshold selected) will be the treatment with the highest NMB.
Non-randomised intervention study	A quantitative study investigating the effectiveness of an intervention that does not use randomisation to allocate patients (or units) to treatment groups. Non-randomised studies include observational studies, where allocation to groups occurs through usual treatment decisions or people's preferences. Non-randomised studies can also be experimental, where the investigator has some degree of control over the allocation of treatments. Non-randomised intervention studies can use a number of different study designs, and include cohort studies, case-control studies, controlled before-and-after studies, interrupted-time-series studies and quasi-randomised controlled trials.
Number needed to treat (NNT)	The average number of patients who need to be treated to get a positive outcome. For example, if the NNT is 4, then 4 patients would have to be treated to ensure 1 of them gets better. The closer the

Term	Definition
	<p>NNT is to 1, the better the treatment.</p> <p>For example, if you give a stroke prevention drug to 20 people before 1 stroke is prevented, the number needed to treat is 20. See also number needed to harm, absolute risk reduction.</p>
Observational study	<p>Individuals or groups are observed or certain factors are measured. No attempt is made to affect the outcome. For example, an observational study of a disease or treatment would allow 'nature' or usual medical care to take its course. Changes or differences in one characteristic (for example, whether or not people received a specific treatment or intervention) are studied without intervening.</p> <p>There is a greater risk of selection bias than in experimental studies.</p>
Odds ratio	<p>Odds are a way to represent how likely it is that something will happen (the probability). An odds ratio compares the probability of something in one group with the probability of the same thing in another.</p> <p>An odds ratio of 1 between 2 groups would show that the probability of the event (for example a person developing a disease, or a treatment working) is the same for both. An odds ratio greater than 1 means the event is more likely in the first group. An odds ratio less than 1 means that the event is less likely in the first group.</p> <p>Sometimes probability can be compared across more than 2 groups – in this case, one of the groups is chosen as the 'reference category', and the odds ratio is calculated for each group compared with the reference category. For example, to compare the risk of dying from lung cancer for non-smokers, occasional smokers and regular smokers, non-smokers could be used as the reference category. Odds ratios would be worked out for occasional smokers compared with non-smokers and for regular smokers compared with non-smokers. See also confidence interval, risk ratio.</p>
Opportunity cost	<p>The loss of other healthcare programmes displaced by investment in or introduction of another intervention. This may be best measured by the health benefits that could have been achieved had the money been spent on the next best alternative healthcare intervention.</p>
Outcome	<p>The impact that a test, treatment, policy, programme or other intervention has on a person, group or population. Outcomes from interventions to improve the public's health could include changes in knowledge and behaviour related to health, societal changes (for example, a reduction in crime rates) and a change in people's health and wellbeing or health status. In clinical terms, outcomes could include the number of patients who fully recover from an illness or the number of hospital admissions, and an improvement or deterioration in someone's health, functional ability, symptoms or situation.</p> <p>Researchers should decide what outcomes to measure before a study begins.</p>
P value	<p>The p value is a statistical measure that indicates whether or not an effect is statistically significant.</p> <p>For example, if a study comparing 2 treatments found that one seems more effective than the other, the p value is the probability of obtaining these results by chance. By convention, if the p value is below 0.05 (that is, there is less than a 5% probability that the results occurred by chance) it is considered that there probably is a real difference between treatments. If the p value is 0.001 or less (less than a 1% probability that the results occurred by chance), the result is seen as highly significant.</p> <p>If the p value shows that there is likely to be a difference between treatments, the confidence interval describes how big the difference in effect might be.</p>

Term	Definition
Perioperative	The period from admission through surgery until discharge, encompassing the preoperative and postoperative periods.
Placebo	A fake (or dummy) treatment given to participants in the control group of a clinical trial. It is indistinguishable from the actual treatment (which is given to participants in the experimental group). The aim is to determine what effect the experimental treatment has had – over and above any placebo effect caused because someone has received (or thinks they have received) care or attention.
Polypharmacy	The use or prescription of multiple medications.
Posterior distribution	In Bayesian statistics this is the probability distribution for a statistic based after combining established information or belief (the prior) with new evidence (the likelihood).
Positive predictive value (PPV)	In screening or diagnostic tests: A measure of the usefulness of a screening or diagnostic test. It is the proportion of those with a positive test result who have the disease, and can be interpreted as the probability that a positive test result is correct. It is calculated as follows: $TP/(TP+FP)$
Postoperative	Pertaining to the period after patients leave the operating theatre, following surgery.
Post-test probability	In diagnostic tests: The proportion of patients with that particular test result who have the target disorder (post-test odds/[1 plus post-test odds]).
Power (statistical)	The ability to demonstrate an association when one exists. Power is related to sample size; the larger the sample size, the greater the power and the lower the risk that a possible association could be missed.
Preoperative	The period before surgery commences.
Pre-test probability	In diagnostic tests: The proportion of people with the target disorder in the population at risk at a specific time point or time interval. Prevalence may depend on how a disorder is diagnosed.
Prevalence	See Pre-test probability.
Prior distribution	In Bayesian statistics this is the probability distribution for a statistic based on previous evidence or belief.
Primary care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.
Primary outcome	The outcome of greatest importance, usually the one in a study that the power calculation is based on.
Probabilistic analysis	In economic evaluation, this is an analysis that uses a probability distribution for each input. In contrast, see Deterministic analysis.
Product licence	An authorisation from the MHRA to market a medicinal product.
Prognosis	A probable course or outcome of a disease. Prognostic factors are patient or disease characteristics that influence the course. Good prognosis is associated with low rate of undesirable outcomes; poor prognosis is associated with a high rate of undesirable outcomes.
Prospective study	A research study in which the health or other characteristic of participants is monitored (or 'followed up') for a period of time, with events recorded as they happen. This contrasts with retrospective studies.
Publication bias	Publication bias occurs when researchers publish the results of studies showing that a treatment works well and don't publish those showing it did not have any effect. If this happens, analysis of the published results will not give an accurate idea of how well the

Term	Definition
	treatment works. This type of bias can be assessed by a funnel plot.
Quality of life	See 'Health-related quality of life'.
Quality-adjusted life year (QALY)	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a scale of 0 to 1). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance.
Randomisation	Assigning participants in a research study to different groups without taking any similarities or differences between them into account. For example, it could involve using a random numbers table or a computer-generated random sequence. It means that each individual (or each group in the case of cluster randomisation) has the same chance of receiving each intervention.
Randomised controlled trial (RCT)	A study in which a number of similar people are randomly assigned to 2 (or more) groups to test a specific drug or treatment. One group (the experimental group) receives the treatment being tested, the other (the comparison or control group) receives an alternative treatment, a dummy treatment (placebo) or no treatment at all. The groups are followed up to see how effective the experimental treatment was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce bias.
RCT	See 'Randomised controlled trial'.
Receiver operated characteristic (ROC) curve	A graphical method of assessing the accuracy of a diagnostic test. Sensitivity is plotted against 1 minus specificity. A perfect test will have a positive, vertical linear slope starting at the origin. A good test will be somewhere close to this ideal.
Reference standard	The test that is considered to be the best available method to establish the presence or absence of the outcome – this may not be the one that is routinely used in practice.
Reporting bias	See 'Publication bias'.
Resource implication	The likely impact in terms of finance, workforce or other NHS resources.
Retrospective study	A research study that focuses on the past and present. The study examines past exposure to suspected risk factors for the disease or condition. Unlike prospective studies, it does not cover events that occur after the study group is selected.
Review question	In guideline development, this term refers to the questions about treatment and care that are formulated to guide the development of evidence-based recommendations.
Risk ratio (RR)	The ratio of the risk of disease or death among those exposed to certain conditions compared with the risk for those who are not exposed to the same conditions (for example, the risk of people who smoke getting lung cancer compared with the risk for people who do not smoke). If both groups face the same level of risk, the risk ratio is 1. If the first group had a risk ratio of 2, subjects in that group would be twice as likely to have the event happen. A risk ratio of less than 1 means the outcome is less likely in the first group. The risk ratio is sometimes referred to as relative risk.
Secondary outcome	An outcome used to evaluate additional effects of the intervention deemed a priori as being less important than the primary outcomes.

Term	Definition
Selection bias	<p>Selection bias occurs if:</p> <ul style="list-style-type: none"> a) The characteristics of the people selected for a study differ from the wider population from which they have been drawn, or b) There are differences between groups of participants in a study in terms of how likely they are to get better.
Sensitivity	<p>How well a test detects the thing it is testing for.</p> <p>If a diagnostic test for a disease has high sensitivity, it is likely to pick up all cases of the disease in people who have it (that is, give a 'true positive' result). But if a test is too sensitive it will sometimes also give a positive result in people who don't have the disease (that is, give a 'false positive').</p> <p>For example, if a test were developed to detect if a woman is 6 months pregnant, a very sensitive test would detect everyone who was 6 months pregnant, but would probably also include those who are 5 and 7 months pregnant.</p> <p>If the same test were more specific (sometimes referred to as having higher specificity), it would detect only those who are 6 months pregnant, and someone who was 5 months pregnant would get a negative result (a 'true negative'). But it would probably also miss some people who were 6 months pregnant (that is, give a 'false negative').</p> <p>Breast screening is a 'real-life' example. The number of women who are recalled for a second breast screening test is relatively high because the test is very sensitive. If it were made more specific, people who don't have the disease would be less likely to be called back for a second test but more women who have the disease would be missed.</p>
Sensitivity analysis	<p>A means of representing uncertainty in the results of economic evaluations. Uncertainty may arise from missing data, imprecise estimates or methodological controversy. Sensitivity analysis also allows for exploring the generalisability of results to other settings. The analysis is repeated using different assumptions to examine the effect on the results.</p> <p>One-way simple sensitivity analysis (univariate analysis): each parameter is varied individually in order to isolate the consequences of each parameter on the results of the study.</p> <p>Multi-way simple sensitivity analysis (scenario analysis): 2 or more parameters are varied at the same time and the overall effect on the results is evaluated.</p> <p>Threshold sensitivity analysis: the critical value of parameters above or below which the conclusions of the study will change are identified.</p> <p>Probabilistic sensitivity analysis: probability distributions are assigned to the uncertain parameters and are incorporated into evaluation models based on decision analytical techniques (for example, Monte Carlo simulation).</p>
Significance (statistical)	<p>A result is deemed statistically significant if the probability of the result occurring by chance is less than 1 in 20 ($p < 0.05$).</p>
Specificity	<p>The proportion of true negatives that are correctly identified as such. For example in diagnostic testing the specificity is the proportion of non-cases correctly diagnosed as non-cases.</p> <p>See related term 'Sensitivity'.</p> <p>In terms of literature searching a highly specific search is generally narrow and aimed at picking up the key papers in a field and avoiding a wide range of papers.</p>
Stakeholder	<p>An organisation with an interest in a topic that NICE is developing a guideline or piece of public health guidance on. Organisations that</p>

Term	Definition
	register as stakeholders can comment on the draft scope and the draft guidance. Stakeholders may be: <ul style="list-style-type: none">• manufacturers of drugs or equipment• national patient and carer organisations• NHS organisations• organisations representing healthcare professionals.
State transition model	See Markov model
Systematic review	A review in which evidence from scientific studies has been identified, appraised and synthesised in a methodical way according to predetermined criteria. It may include a meta-analysis.
Time horizon	The time span over which costs and health outcomes are considered in a decision analysis or economic evaluation.
Transition probability	In a state transition model (Markov model), this is the probability of moving from one health state to another over a specific period of time.
Treatment allocation	Assigning a participant to a particular arm of a trial.
Univariate	Analysis which separately explores each variable in a data set.
Utility	In health economics, a 'utility' is the measure of the preference or value that an individual or society places upon a particular health state. It is generally a number between 0 (representing death) and 1 (perfect health). The most widely used measure of benefit in cost–utility analysis is the quality-adjusted life year, but other measures include disability-adjusted life years (DALYs) and healthy year equivalents (HYEs).

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