Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February 2018 – 19 March 2018

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Action on Smoking and Health	General	General	The Scope lists those sections of other guidelines which it will incorporate on P5-6. In each of the three guidelines being amalgamated the acknowledgement of smoking as a serious risk factor for acute coronary syndromes and the advice given is insufficient, but no update to these sections is intended. In both CG94 and CG172 the inclusion of smoking cessation is brief and while referring to NICE PH1 and PH10, do not state the need for clinicians to ask all patients about their smoking status. The guidelines both state that smokers should be advised to quit and support given in line with public health guidelines. However as the British Thoracic Society's 2016 audit of hospitals found, nearly 1 in 4 patients were not asked if they smoke and 3 out of 4 smokers were not asked if they would like to quit [1]. Further despite advice to clinicians that they make referrals to smoking cessation services, only 1 in 13 patients who smoke were referred to a hospital or community-based smoking cessation services [1]. It is therefore necessary for the guideline to include and emphasize the need for clinicians to ask all patients about their smoking status and that the delivery of support to smokers is an essential part of their treatment rather than an add on. CG167 does not include specific reference to smoking cessation in the guideline, rather it includes hyperlinks to other NICE guidance. This is not sufficient when smoking was estimate to cause over 16,400 or 13% of deaths from circulatory disease in 2016 [2] and smokers have 2-4 times increased risk of heart disease and strokes compared to non-smokers [3]. The Scope should therefore consider addressing these parts of the other guidelines to	Thank you for your comment. We agree that smoking cessation is critically important for people with coronary artery disease but note that it is covered in several other NICE guidelines. Asking people about their smoking status is a routine part of clinical history taking. However, we will pass on your concerns to the committee for consideration. We will also look to see if there is a better way to link to existing NICE guidelines on smoking cessation.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			ensure there is proper consideration of smoking, and smoking cessation, within the new guidance. [1] British Thoracic Society. Smoking Cessation Audit Report: Smoking cessation policy and practice in NHS Hospitals. December 2016. [online] Available at: https://www.brit-thoracic.org.uk/media/315359/BTS-Smoking-Cessation-Audit-Report-7-December-2016-final.pdf [2] NHS Digital (2017). Statistics on Smoking: England: 2017. [online] Available at: http://content.digital.nhs.uk/catalogue/PUB24228/smok-eng-2017- rep.pdf [3]US Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Office on Smoking and Health, 2004. Available at: https://www.ncbi.nlm.nih.gov/pubmed/20669512	
Bayer plc	General	General	We note that that it is intended that this new guideline will cover the secondary prevention of acute coronary syndromes, and that it will update and amalgamate several guidelines including CG172 – 'cardiac rehabilitation and	Thank you for your comment. We will incorporate the technology appraisal on rivaroxaban (TA335), subject to agreement with the NICE technology appraisals programme.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			prevention of further cardiovascular disease'. However we are concerned that it does not appear to be planned that the updated guideline will incorporate current technology appraisals relating to preventing adverse outcomes after the acute management of ACS. We suggest that it is important that the prevention of further cardiovascular disease continues to be covered as part of this guideline, as some measures may be initiated in primary care after discharge and it is essential that care is coordinated. We suggest that the following technology appraisal should be incorporated unchanged into this clinical guideline: Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome (2015) NICE technology appraisal guidance 335. The current NICE pathway, Myocardial infarction: rehabilitation and preventing further cardiovascular disease, that is largely based on CG172 incorporates this (and other relevant) technology appraisal(s). If the prevention of further cardiovascular disease after acute management is not covered by this guideline it is critical that information is provided as to which clinical guideline incorporates this important aspect of the patient's management so that it does not slip through the net.	

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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Bayer plc	General	General	As part of the guideline, we suggest that the management plan for patients with ACS should include risk assessment on an ongoing basis with an appropriate validated tool such as QAdmissions (as recommended in the multi-morbidity guideline), or the SMART Risk Score, a tool to estimate 10-year risk for recurrent vascular events in patients with manifest cardiovascular disease https://www.escardio.org/Education/ESC-Prevention-of-CVD-Programme/Risk-assessment/SMART-Risk-Score. This is important because as seen in an English database study,[1] UK survivors of either a first or a recurrent AMI remain at a significantly higher risk of death compared with the general population over at least 7 years, and a substantial proportion of 30-day survivors of first AMI experience a second AMI over this timeframe. (1) Smolina K, Wright FL, Rayner M, Goldacre MJ. Long-term survival and recurrence after acute myocardial infarction in England, 2004 to 2010. *Circ Cardiovasc Qual Outcomes* 2012; 5(4):532-540.	Thank you for your comment. QAdmissions is a general risk tool for primary care and not specifically relevant to this guideline. The study you cite is not designed to show that changes to management based on risk scores makes a difference to outcomes. This has not been selected as a high priority area for the scope.
Boston Scientific	4	12-15	We are pleased to see NICE is updating the guideline on acute coronary syndromes and we would suggest including some evidence on drug-eluting stent in adults with acute coronary syndromes. Please find two relevant trials below:	Thank you for your comment and for highlighting these trials. We will pass them on to the committee for consideration when reviewing the evidence.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			• SYNTAX II Trial: This study is a multicenter, all-comers, open-label, single-arm trial that investigated the impact of a contemporary PCI strategy on clinical outcomes in patients with 3VD (3 vessel disease) in 22 centers from four European countries (n=454 patients). At 1 year, the SYNTAX-II strategy was superior to the equipoise-derived SYNTAX-I PCI cohort, significant reduction in MACCE was observed and this difference was driven by a significant reduction in the incidence of myocardial infarction (MI) and revascularization. The rate of definite stent thrombosis was significantly lower in SYNTAX-II. The results of the trial also demonstrated no difference in MACCE at 1-year in the exploratory comparison between CABG and PCI as opposed to the superiority shown for CABG in the SYNTAX-I Trial (Clinical Outcomes of State-of-the-Art Percutaneous Coronary Revascularization in Patients With De Novo Three Vessel Disease: 1-Year Results of the SYNTAX II Study. Eur Heart J 2017;Aug 26:[Epub ahead of print]). • Senior trial: the aim of this study was to compare outcomes between bare-metal stents (BMS) and drug-eluting stents (DES) with a short duration of double antiplatelet therapy (DAPT) in elderly patients (n= 1 200 patients ≥75 years with CAD). DES reported significantly lower MACCE at 1-year compared to BMS in elderly patients who received tailored short DAPT. Bleeding	

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			complications and stent thrombosis were exceptionally lower in both groups. Stent thrombosis rate was much lower in the DES group compared to the BMS group (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32713-7/fulltext). Overall, the results in both studies suggest potential savings with DES due to better procedure outcomes such as adverse events reduction.	
British Cardiovascular Society	8-9	General	BCS suggests that the evidence is reviewed and recommendations made in relation to the most appropriate anti-thrombotic regimen for patients with ACS who require oral anticoagulant therapy.	Thank you for your comment. We agree that the issue of the optimal combination of antiplatelets and anticoagulants in people with an indication for oral anticoagulation (such as atrial fibrillation) is an important area. This was reviewed in CG172. We note that new studies have recently been published relating to this and we therefore agree this should be updated in the guideline. We have added the following question to the scope: 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?
British Cardiovascular Society	8-9	General	BCS suggests that the evidence is reviewed and recommendations are made regarding the earliest duration of hospital stay following which patients can be discharged	Thank you for your comment. We are unaware of any trial data specifically testing this question and, although there are observational

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			safely after different types of ACS, including patients treated by primary percutaneous coronary intervention for ST elevation myocardial infarction.	studies, some of these are old (before the widespread adaption of early angiography & PCI). This question has therefore not been prioritised for inclusion.
British Cardiovascular Society	7	20-21	It is stated that NICE guidance regarding the use of Rivaroxaban for preventing cardiovascular events after ACS is "related guidance". BCS suggests that evidence regarding the use of other direct oral anticoagulants (DOACs) in combination with anti-platelet therapy in ACS management is reviewed and recommendations regarding their use in ACS are included in the new guideline.	Thank you for your comment. TA335 'Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome' makes recommendations about use for secondary prevention in the general ACS population. This guidance will be incorporated in the updated guideline (scope has been updated). Reviewing the use of other oral anticoagulants for secondary prevention in the general ACS population has not been prioritised for this update. Other agents are not licensed for this indication and we do not believe there to be a large body of evidence for their use. We agree that the issue of the optimal combination of antiplatelets and anticoagulants in people with an indication for oral

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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				anticoagulation (such as atrial fibrillation) is an important area. This was reviewed in CG172. We note that new studies have recently been published relating to this and we therefore agree it should be this should be updated in the guideline. We have added the following question to the scope: 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?
Department of Health and Social Care			I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation	Thank you for taking the time to review the scope.
Novo Nordisk Limited		General	It makes good sense to incorporate entire relevant guidelines into another when appropriate; we would just like to comment that it is important to ensure the guideline inserted is up-to-date, particularly the parts which are relevant to the guideline being updated. This comment relates to both of the more detailed comments below.	Thank you for your comment. The development of the scope was based on the findings of a surveillance review which identified areas within the guideline that needed to be updated: the assumption is that areas not prioritised for update remain valid. The committee will ensure that any recommendations relating to the updated questions are still relevant and up-to-date and that the final guideline is as coherent as possible.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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Novo Nordisk Limited	5	Within the table	The draft scope suggests incorporation of CG172: Myocardial infarction: cardiac rehabilitation into this guideline. While the section relating to treatment with beta blockers will be reviewed the draft scope has recommended no additional reviews within this guideline. As it stands, CG172 has not been updated for almost 6 years. Selected patient subgroups in CG172 currently include those with hypertension and those with left ventricular systolic dysfunction; arguably, diabetes should feature as an important group within this section. The prevalence of diagnosed diabetes in those who have an acute coronary event is between 16-35% and additionally there is a high incidence of diabetes diagnosis occurring at the time of an acute coronary event or soon after. Evidence clearly demonstrates the importance of diabetes control in these individuals to prevent further CVD events and additionally there is new published evidence on cardiovascular outcome trials in diabetes relating to optimal drug treatment in these individuals. We would suggest that this scope is extended to include a review of the section: Myocardial infarction: cardiac rehabilitation (CG172): selected patient subgroups, and that people with diabetes are included here as an	Thank you for your comment. We agree that people with diabetes are an important group. Identification and management of diabetes, including cardiovascular complications, is covered by existing NICE guidance NG17 Type 1 diabetes in adults and NICE guidance NG28 Type 2 diabetes in adults and we will refer to these in this update.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			important sub-group within this guideline, to ensure optimisation of diabetes as an effective way to reduce risks of further ACS	
Novo Nordisk Limited	6	Within the table	"Hyperglycaemia in acute coronary syndromes (CG130): identifying patients at high risk of developing diabetes " was published in 2011 and has not been updated since. We note that 3 previous surveillance decisions have concluded not to update as it was considered that there had been no significant new evidence. Prevention of diabetes is a major public health concern and follow-up of high risk individuals is essential. As it stands, CG130 provides insufficient guidance to ensure that these high risk individuals receive the appropriate management, which might include referral to a structured education course as part of the Diabetes Prevention Programme or prevention treatment with Metformin. The guideline does not signpost to PH38 "Type 2 diabetes: prevention in people at high risk" and in addition the guideline contains no advice on what to do if diabetes is diagnosed. We suggest that this scope is extended to ensure people at high risk of diabetes are signposted appropriately and we would suggest not incorporating in its totality a	Thank you for your comment. CG130 is "Hyperglycaemia in acute coronary syndromes: management" (not identification). CG130 is intentionally focused on management within the first 48 hours and does not cover the issues to which you refer. CG130 gives appropriate advice about diagnosis of diabetes in this group. Management of diabetes is covered by other NICE guidance: NG17 Type 1 diabetes in adults and NICE guidance NG28 Type 2 diabetes in adults. As you point out, diabetes prevention is already covered in PH38 Type 2 diabetes: prevention in people at high risk: we will refer to all three of these guidelines in this update.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			guideline which does not reference the most recent NICE advice for high risk individuals.	
Roche Diagnostics Limited	1	12	An update to CG172 (Myocardial infarction: cardiac rehabilitation) is considered within the scope of the proposed update. Currently CG172 recommends monitoring blood pressure, renal function and drug treatment, but does not mention the use of biomarkers. There is growing evidence of the prognostic value of serial measurement of both new and well established biomarkers in the months and year following a myocardial infarction, therefore the scope should be widened to ensure these are considered in the update.	Thank you for your comment and for highlighting the growing evidence for biomarkers. However, there is considered to be insufficient evidence at present to justify inclusion in this update.
Roche Diagnostics Limited	3	18 – 21	The draft scope states that the update will explore different settings that provide early management of acute coronary syndromes. There is evidence to support alternative models of care, which will be discussed further in comments 2, 3 and 4.	Thank you for your comment. The guideline will not be looking for evidence that compares different settings. The settings mentioned in the scope are the settings that are relevant in the implementation of the guideline.
Roche Diagnostics Limited	4	3-5	Point of care testing is another setting to consider for the early management of acute coronary syndromes. Pre-hospital cardiac biomarker testing using point of care testing to risk stratify NSTEMI patients for early revascularisation should be considered. Please see the references below which support this:	Thank you for your comment and for highlighting these studies. Point of care testing is interesting but could not be recommended without evidence of its utility in improving outcomes when compared to traditional management pathways without point of care testing.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			1. Stengaard C., Sørensen J. T., Rasmussen M. B., Sondergaard H. M., et al. Acute versus subacute angiography in patients with non-ST-elevation myocardial infarction – the NONSTEMI trial phase I. European Heart Journal: Acute Cardiovascular Care. 2016;6(6):490-499. 2. Rasmussen M. B., Stengaard C., Sørensen J. T., Riddervold I. S., Hansen T. M., Giebner M., et al. Predictive value of routine point-of-care cardiac troponin T measurement for prehospital diagnosis and risk-stratification in patients with suspected acute myocardial infarction. European Heart Journal: Acute Cardiovascular Care. 2017.	
Roche Diagnostics Limited	4	1 – 2	The draft scope suggests that a key area to be investigated in the guideline includes the choice of antiplatelet agents in unstable angina or NSTEMI and in STEMI. Both hs-TnT and GDF-15 have been shown to be useful biomarkers in personalising antiplatelet treatment in patients with ACS. Please see the references below which provides evidence to support this: 1. Wallentin L., Lindholm D., Siegbahn A., Wernroth L., Becker R. C., Cannon C. P., et al. Biomarkers in Relation to the Effects of Ticagrelor in Comparison With Clopidogrel in Non-ST-Elevation Acute Coronary Syndrome Patients Managed With	Thank you for your comment. GDF-15 is not currently available for routine use in the NHS, and at present there is a lack of evidence for the use of biomarkers to guide the choice of anti-platelet agent. This may be an area for future updates but has not been prioritised for inclusion in this iteration of the guideline.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			or Without In-Hospital Revascularization: A Substudy From the Prospective Randomized Platelet Inhibition and Patient Outcomes (PLATO) Trial. Circulation. 2013;129(3):293–303. 2. Hagström E., James S. K., Bertilsson M., Becker R. C., Himmelmann A., Husted S., et al. Growth differentiation factor-15 level predicts major bleeding and cardiovascular events in patients with acute coronary syndromes: results from the PLATO study. European Heart Journal. 2015;37(16):1325–33.	
Roche Diagnostics Limited	4	3 – 5	New algorithms for decision support in ACS are currently under evaluation. These include biomarkers such as troponin and GDF-15, which show a significant interaction with the effects of an early invasive treatment strategy. GDF-15 has been recognised as a consistent biomarker of mortality and CV events in patients with ACS or stable CAD. Thresholds for biomarkers offer a convenient way to classify patients into risk categories and therefore help to inform treatment decisions. GDF-15 may be incorporated as a continuous variable into established or novel risk scores that can be presented as nomograms or applications on (handheld) electronic devices.	Thank you for your comment. GDF-15 is not currently available for routine use in the NHS, and at present there is not a strong evidence base for the use of biomarkers to guide the choice of anti-platelet agent. This may be an area for future updates but has not been prioritised for inclusion in this iteration of the guideline.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			Evidence suggests utilising the cardiac biomarker, GDF-15 to risk stratify patients to early invasive treatment vs conservative treatment in NSTEMI. Please see the references below which provide the evidence to support this: 1. Wollert K. C., Kempf T., Lagerqvist B., Lindahl B., Olofsson S., Allhoff T., et al. Growth Differentiation Factor 15 for Risk Stratification and Selection of an Invasive Treatment Strategy in Non ST-Elevation Acute Coronary Syndrome. Circulation. 2007;116(14):1540–8. 2. Wallentin L., Lindhagen L., Ärnström E., Husted S., Janzon M., Johnsen S. P., et al. Early invasive versus non-invasive treatment in patients with non-ST-elevation acute coronary syndrome (FRISC-II): 15 year follow-up of a prospective, randomised, multicentre study. The Lancet. 2016;388(10054):1903–11.	
Royal College of General Practitioners			NEWS2 and risk stratification scoring Increasingly the Updated National Early Warning Score (NEWS2) will be come relevant in the management of adult patients in whom Acute Coronary syndrome is suspected. The study by Smith et al analysed the ability of	Thank you for highlighting these interesting studies. Risk assessment and stratification have not been identified as priorities for inclusion in this guideline and therefore we will be unable to consider them for this update.

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			the NEWS to identify patients in hospital who were at risk of significant clinical deterioration – comparing the performance of the NEWS with 33 other EWS systems that were in use at the time of the study. This study examined almost 200,000 observations from a large vital signs database from over 35,000consecutive acute medical admissions to a UK hospital. The study concluded that NEWS was superior to all of the other EWSs at identifying patients at risk of the combined outcomes of cardiac arrest, Smith GB, Prytherch DR, Meredith P, Schmidt PE, Featherstone PI. The ability of the National Early Warning Score (NEWS) to discriminate patients at risk of early cardiac arrest, unanticipated intensive care unit admission, and death. Resuscitation 2013;84:465–70. https://doi.org/10.1016/j.resuscitation.2012.12.016 Other supporting studies include Spagnolli W, Rigoni M, Torri E, Cozzio S, Vettorato E, Nollo G. Application of the National Early Warning Score (NEWS) as a stratification tool on admission in an Italian acute medical ward: A perspective study. Int J Clin Pract. 2017 Mar;71(3–4).	NICE guideline CG50 Acutely ill patients in hospital provides guidance on identification of patients at risk of deterioration and use of track and trigger systems. We also note that the NEWS score has already been widely adopted

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			This recent study from Nature uses a risk stratfication tool based on the full blood count on admission to predict a Major Cardiac Adverse event (MACE) in the first year. After discharge back to the community primary care doctors have little information to startify the risk of a major cardiac adverse event. Niu X, Liu G, Huo L, Zhang J, Bai M, Peng Y, et al. Risk stratification based on components of the complete blood count in patients with acute coronary syndrome: A classification and regression tree analysis. Scientific Reports. 2018 Feb 12;8(1):2838.	
Royal College of General Practitioners	3	18	The RCGP is surprised that primary care settings are excluded from the scope of this review as most ACS will occur in the community and not all patients will contact 999/ Ambulances initially. Many people will refuse initially to either call 999 or allow the GP practice to call 999 without first seeing a GP.	Thank you for your comment. Secondary prevention in primary care is included in the scope of this update. The NICE guideline CG95 Chest pain of recent onset gives guidance on people presenting with acute chest pain.
Royal College of General Practitioners	7	8	The polypharmacy burden of Ischaemic heart disease / secondary disease prevention can be substantial particularly in older people. The limits of the evidence should be explicitly discussed (how relevant are studies / recommendation to older populations/ whether studies / guidance are relevant to multi morbid populations).	Thank you for highlighting this. We will pass it on to the committee for consideration when reviewing the evidence and making recommendations. The limitations of evidence are always considered within each evidence

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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			There needs to a clear statement linking this guidance to NICE multi-morbidity guidance NG56)	review (in the section entitled "The committee's discussion of the evidence").
Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes proposals to update the Acute Coronary Syndromes guideline. The RCN invited members who care for people with cardiac condition to review the draft scope on its behalf. The comments below reflect the views of our reviewers.	Thank you for your comment and for taking the time to review the scope.
Royal College of Nursing	General	General	An update on this guideline is needed and we, therefore support the proposed plan from NICE for an update. There are several areas, which would benefit from updated evidence especially 'culprit' versus 'complete' revascularisation and also the duration of beta-blocker therapy. Combining the various guidelines also seems sensible.	Thank you for your comment and for taking the time to review the scope.
Royal College of Nursing	1	7-12	Incorporating cardiac rehabilitation is welcomed	Thank you for your comment.
Royal College of Nursing	3	23	Should role of Intra Aortic Balloon Pump and choice of inotropes to support cardiac output be discussed?	Thank you for your comment. The role of Intra Aortic Balloon Pump and the choice of

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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				inotropes to support cardiac output were not identified as priorities for inclusion in this update of the guideline. The need for inotropes or balloon pumps is patient-specific and decisions about their use need to be made on an individual basis.
Royal College of Nursing	3	23	Role of Statins? When to start?	Thank you for your comment. It is routine clinical practice to offer statins to patients during admission, the priority being that the patient has statins at the point of discharge. We think this is adequately covered in the existing guidance (CG172) and that current practice is in line with this guidance, therefore an update of this area is not a priority.
Royal College of Nursing	3	23	Should it have a guideline on patient information – what patients should be told? What advice should be given following ACS relating to rehabilitation?	Thank you for your suggestion. There are already numerous recommendations within CG172 relating to information for patients. NICE guideline NG138, Patient experience in adult services, is also relevant so this topic has not been prioritised for this update.
Royal College of Nursing	3	23	Role of Echocardiogram	Thank you for your comment. CG172 includes recommendations based on left ventricular function, and although it does not specifically say that all patients should have an

Acute coronary syndromes

Consultation on draft scope
Stakeholder comments table

19 February – 19 March 2018

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				echocardiogram (there are other methods of assessing LV function) this is clearly implied. We believe echocardiograms are being performed routinely in people with ACS and therefore this is not a high priority for this update to cover.
Royal College of Nursing	6	7	Would be interested to know why the diagnosis of myocardial infarction is not included.	Thank you for your comment. CG95 deals with assessment and diagnosis of people presenting with chest pain of suspected cardiac origin. This is a separate guideline which is not being amalgamated with the 4 included in the present update.