NICE National Institute for Health and Care Excellence

NICE Pathways

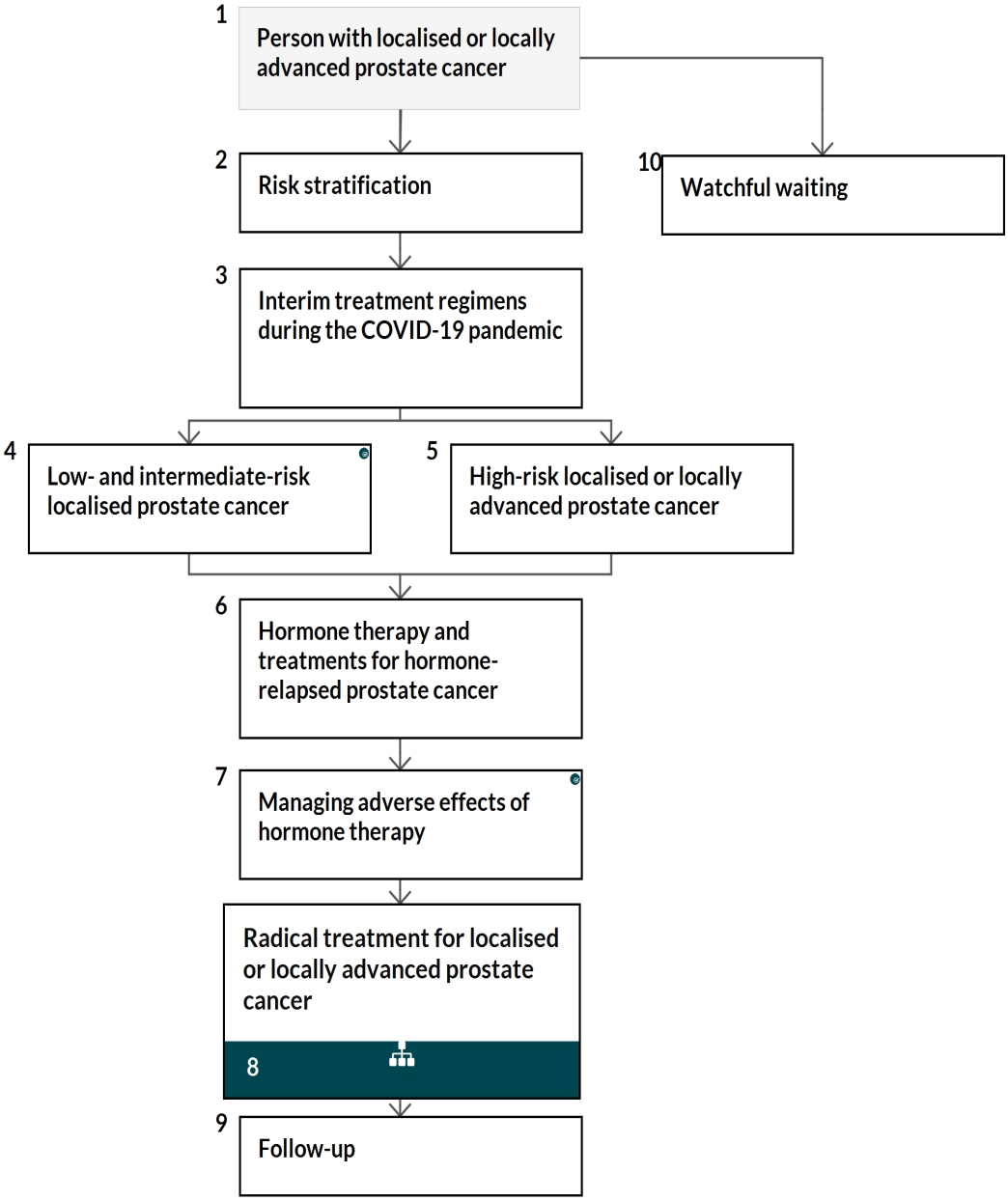
# Managing localised or locally advanced prostate cancer

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/prostate-cancer
NICE Pathway last updated: 25 November 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



## 1 Person with localised or locally advanced prostate cancer

No additional information

## 2 Risk stratification

Urological cancer MDTs should assign a risk category (see table below) to all newly diagnosed people with localised prostate cancer.

| **Level of risk** | PSA **(ng/ml)** | | **Gleason score** | | **Clinical stage** |
|---|---|---|---|---|---|
| Low risk | <10 | and | ≤6 | and | T1 to T2a |
| Intermediate risk | 10–20 | or | 7 | or | T2b |
| High risk[a] | >20 | or | 8–10 | or | ≥T2c |
| [a] High-risk localised prostate cancer is also included in the definition of locally advanced prostate cancer. | | | | | |

NICE has published a medtech innovation briefing on the Prolaris gene expression assay for assessing long-term risk of prostate cancer progression.

## 3 Interim treatment regimens during the COVID-19 pandemic

A table of NHS England interim treatment regimens gives possible alternative treatment options for use during the COVID-19 pandemic to reduce infection risk. This may affect decisions for people with cancer. See the COVID-19 rapid guideline: delivery of systemic anticancer treatments for more details.

## 4 Low- and intermediate-risk localised prostate cancer

### Low-risk

Offer a choice between active surveillance [See page 22], radical prostatectomy [See page 22] or radical radiotherapy to people with low-risk localised prostate cancer for whom radical treatment is suitable. Use the table on factors to consider when discussing active surveillance, radical prostatectomy or radical radiotherapy as treatment options for people with low-risk or intermediate-risk localised prostate cancer, using evidence from a large UK trial [See page 17] to discuss the benefits and harms with them.

Offer multiparametric MRI to people having active surveillance who have not had an MRI previously. If the MRI results do not agree with the biopsy findings, offer a new MRI-influenced biopsy.

### Padeliporfin

The following recommendations are from NICE technology appraisal guidance on padeliporfin for untreated localised prostate cancer.

Padeliporfin is not recommended, within its marketing authorisation, for untreated, unilateral, low-risk prostate cancer in adults.

This recommendation is not intended to affect treatment with padeliporfin that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

See why we made the recommendations on padeliporfin [See page 21].

NICE has written information for the public on padeliporfin.

### Intermediate-risk

For people with intermediate-risk localised prostate cancer

- offer radical prostatectomy or radical radiotherapy **and**
- consider active surveillance (see protocol for active surveillance below) for people who choose not to have immediate radical treatment.

Use the table on factors to consider when discussing active surveillance, radical prostatectomy or radical radiotherapy as treatment options for people with low-risk or intermediate-risk localised prostate cancer, using evidence from a large UK trial [See page 17] to discuss the benefits and harms of each option.

Do not offer bisphosphonates for the prevention of bone metastases in people with prostate cancer.

**Protocol for active surveillance**

Consider using the protocol in the table below for people who have chosen active surveillance.

| Timing | Tests[a] |
|---|---|
| Year 1 of active surveillance | Every 3 to 4 months: measure PSA[b]<br><br>Throughout active surveillance: monitor PSA kinetics[c]<br><br>At 12 months: DRE[d]<br><br>At 12 to 18 months: multiparametric MRI |
| Year 2 and every year thereafter until active surveillance ends | Every 6 months: measure PSA[b]<br><br>Throughout active surveillance: monitor PSA kinetics[c]<br><br>Every 12 months: DRE[d] |

[a] If there is concern about clinical or PSA changes at any time during active surveillance, reassess with multiparametric MRI and/or re-biopsy.

[b] Could be carried out in primary care if there are agreed shared-care protocols and recall systems.

[c] Could include PSA density and velocity.

[d] Should be performed by a healthcare professional with expertise and confidence in performing DRE. In a large UK trial that informed this protocol, DREs were carried out by a urologist or a nurse specialist.

**Proceeding from active surveillance to radical treatment**

If a person wishes to move from active surveillance to radical treatment at any stage in their care, make a shared decision to do so based on the person's preferences, comorbidities and life expectancy.

Offer radical treatment to people with localised prostate cancer who had chosen an active surveillance regimen and who now have evidence of disease progression.

**Rationale and impact**

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

## Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

2. Treatment options

## 5 High-risk localised or locally advanced prostate cancer

Do not offer active surveillance [See page 22] to people with high-risk localised prostate cancer.

Offer radical prostatectomy [See page 22] or radical radiotherapy to people with high-risk

localised prostate cancer when it is likely the person's cancer can be controlled in the long term.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Do not offer bisphosphonates for the prevention of bone metastases in people with prostate cancer.

NICE has published an evidence summary on triptorelin (Decapeptyl SR).

**Docetaxel chemotherapy**

Discuss the option of docetaxel chemotherapy with people who have newly diagnosed non-metastatic prostate cancer[1] who:

- are starting long-term androgen deprivation therapy **and**
- have no significant comorbidities **and**
- have high-risk disease, as shown by:
  - T3/T4 staging **or**
  - Gleason score 8 to 10 **or**
  - PSA greater than 40 ng/ml.

Explain the benefits and harms (see the table on factors to consider when discussing the option of docetaxel chemotherapy for people with high-risk, non-metastatic prostate cancer [See page 16]) and make a shared decision about whether the person should have this treatment.

For people having docetaxel chemotherapy:

- start treatment within 12 weeks of starting androgen deprivation therapy
- use six 3-weekly cycles at a dose of 75 mg/m$^2$ (with or without daily prednisolone).

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

## 6 Hormone therapy and treatments for hormone-relapsed prostate cancer

Consider intermittent therapy for people having long-term androgen deprivation therapy (not in the adjuvant setting). Discuss with the person (and their partner, family or carers if they wish):

[1] At the time of publication (May 2019), docetaxel only has UK marketing authorisation for hormone-refractory metastatic prostate cancer. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's prescribing guidance: prescribing unlicensed medicines for further information.

- the rationale for intermittent therapy
- the limited evidence for reduction in side effects from intermittent therapy
- the effect of intermittent therapy on progression of prostate cancer.

For people who are having intermittent androgen deprivation therapy:

- measure PSA every 3 months **and**
- restart ADT if PSA is 10 ng/ml or above, or if there is symptomatic progression.

**Hormone-relapsed non-metastatic prostate cancer**

**Darolutamide with androgen deprivation therapy**

The following recommendations are from NICE technology appraisal guidance on darolutamide with androgen deprivation therapy for treating hormone-relapsed non-metastatic prostate cancer.

Darolutamide with androgen deprivation therapy (ADT) is recommended, within its marketing authorisation, as an option for treating hormone-relapsed prostate cancer in adults at high risk of developing metastatic disease. It is recommended only if the company provides darolutamide according to the commercial arrangement.

See why we made the recommendations on darolutamide with ADT.

NICE has written information for the public on darolutamide with ADT.

**Enzalutamide**

The following recommendations are from NICE technology appraisal guidance on enzalutamide for hormone-relapsed non-metastatic prostate cancer.

Enzalutamide is not recommended, within its marketing authorisation, for treating high-risk hormone-relapsed non-metastatic prostate cancer in adults.

This recommendation is not intended to affect treatment with enzalutamide that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

See why we made the recommendations on enzalutamide.

NICE has written information for the public on enzalutamide.

## 7 Managing adverse effects of hormone therapy

For information on neutropenic sepsis in people having anticancer treatment see the NICE Pathway on neutropenic sepsis.

### Hot flushes

Offer medroxyprogesterone[1] (20 mg per day), initially for 10 weeks, to manage troublesome hot flushes caused by long-term androgen suppression. Evaluate the effect at the end of the treatment period.

Consider cyproterone acetate (50 mg twice a day for 4 weeks) to treat troublesome hot flushes if medroxyprogesterone is not effective or not tolerated.

Tell people that there is no good-quality evidence for the use of complementary therapies to treat troublesome hot flushes.

### Sexual dysfunction

Before they start androgen deprivation therapy, tell people and, if they wish, their partner, that long-term androgen deprivation will cause a reduction in libido and possible loss of sexual function.

Advise people and, if they wish, their partner, about the potential loss of ejaculation and fertility associated with long-term androgen deprivation and offer sperm storage. For more information see cryopreservation to preserve fertility in people diagnosed with cancer in the NICE Pathway on fertility.

Ensure that people starting androgen deprivation therapy have access to specialist erectile dysfunction services.

Consider referring people who are having long-term androgen deprivation therapy, and their partners, for psychosexual counselling.

Offer PDE5 inhibitors to people having long-term androgen deprivation therapy who experience

[1] At the time of publication (May 2019), medroxyprogesterone did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's good practice in prescribing and managing medicines and devices for further information.

loss of erectile function.

If PDE5 inhibitors fail to restore erectile function or are contraindicated, offer a choice of:

- intraurethral inserts
- penile injections
- penile prostheses
- vacuum devices.

NICE has published an evidence summary on erectile dysfunction: avanafil.

**Osteoporosis**

Do not routinely offer bisphosphonates to prevent osteoporosis in people with prostate cancer having androgen deprivation therapy.

Consider assessing fracture risk in people with prostate cancer who are having androgen deprivation therapy, in line with assessing the risk of fragility fracture in the NICE Pathway on osteoporosis.

Offer bisphosphonates to people who are having androgen deprivation therapy and have osteoporosis.

Consider denosumab for people who are having androgen deprivation therapy and have osteoporosis if bisphosphonates are contraindicated or not tolerated.

**Gynaecomastia**

For people starting long-term bicalutamide monotherapy (longer than 6 months), offer prophylactic radiotherapy to both breast buds within the first month of treatment. Use a single fraction of 8 Gy using orthovoltage, or electron beam radiotherapy.

If radiotherapy does not prevent gynaecomastia, consider weekly tamoxifen[1].

**Fatigue**

Tell people who are starting androgen deprivation therapy that fatigue is a recognised side effect of this therapy, and might not be because of their prostate cancer.

Offer people who are starting or having androgen deprivation therapy supervised resistance and aerobic exercise at least twice a week for 12 weeks to reduce fatigue and improve quality of life.

[1] At the time of publication (May 2019), tamoxifen did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's good practice in prescribing and managing medicines and devices for further information.

## Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

4. Managing adverse effects of treatment

## 8 Radical treatment for localised or locally advanced prostate cancer

See Prostate cancer / Radical treatment for localised or locally advanced prostate cancer

## 9 Follow-up

A urologist or specialist nurse should discuss the purpose, duration, frequency and location of follow-up with each person with localised and locally advanced prostate cancer, and if they wish, their partner or carers.

A urologist or specialist nurse should advise people with prostate cancer about potential longer-term adverse effects of treatment and when and how to report them.

Check PSA levels for all people with prostate cancer who are having radical treatment no earlier than 6 weeks after treatment, at least every 6 months for the first 2 years, and then at least once a year after that.

Do not routinely offer digital rectal examination to people with localised prostate cancer who are not on active surveillance [See page 22] while their PSA remains at baseline levels.

After at least 6 months' initial follow-up, consider a remote follow-up strategy for people with a stable PSA who have had no significant treatment complications, unless they are taking part in a clinical trial that needs formal clinic-based follow-up.

**People who have chosen a watchful waiting regimen**

Follow up people with prostate cancer who have chosen a watchful waiting [See page 22] regimen with no curative intent in primary care only if protocols for this have been agreed between the local urological cancer MDT and the relevant primary care organisation(s). Measure their PSA at least once a year.

**Rationale and impact**

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

## 10 Watchful waiting

People with localised prostate cancer who have chosen watchful waiting [See page 22] and who have evidence of significant disease progression (that is, rapidly rising PSA level or bone pain) should have their situation reviewed by a member of the urological cancer MDT.

Follow up people with prostate cancer who have chosen a watchful waiting [See page 22] regimen with no curative intent in primary care only if protocols for this have been agreed between the local urological cancer MDT and the relevant primary care organisation(s). Measure their PSA at least once a year.

See the NICE guideline to find out why we made this recommendation and how it might affect practice.

## Factors to consider when discussing the option of docetaxel chemotherapy for people with high-risk, non-metastatic prostate cancer

| | |
|---|---|
| What does treatment with docetaxel involve? | Docetaxel chemotherapy is given at 6 appointments, each 3 weeks apart. It is given as an intravenous infusion that takes about 1 hour. |
| What are the benefits of docetaxel treatment for people with high-risk, non-metastatic prostate cancer? | • There is clear, high-quality evidence that docetaxel chemotherapy delays disease progression in people with high-risk, non-metastatic disease.<br>• In a large UK randomised trial[a], the average person who did not receive docetaxel experienced disease progression about 5 years after the start of the trial, whereas the average person receiving docetaxel experienced disease progression after about 6 years.<br>• We do not yet know whether docetaxel improves survival in people with high-risk, non-metastatic disease and we will only be confident about whether it does when trials have been running for longer.<br>• In a large UK randomised trial, 80 out of 100 people with high-risk disease who did not receive docetaxel were still alive after 5 years compared to 84 out of 100 people who did. However, this difference could be because of chance. |
| What are the risks associated with docetaxel treatment? | A large UK randomised trial found that:<br>• 15 out of 100 people who took docetaxel developed febrile neutropenia (that is, they got a fever because the chemotherapy had reduced their white blood cells' ability to fight infection).<br>• 1 out of 100 people who took docetaxel died because of infections that, in the opinion of the investigators, they might not have developed if they had not received docetaxel.<br>• 8 out of 100 people who took docetaxel felt unusually weak or tired.<br>• 8 out of 100 people who took docetaxel experienced gastrointestinal symptoms (including diarrhoea, abdominal pain, constipation and/or vomiting). |

| | |
|---|---|
| | • 5 out of 100 people who took docetaxel experienced respiratory symptoms (including breathlessness and/or chest infections).<br>• 4 out of 100 people who took docetaxel experienced problems with their nervous systems (for example, numbness or weakness).<br>• 1 out of 100 people who took docetaxel experienced problems with their nails that were serious enough to interfere with their daily lives. |
| [a]James ND, Sydes MR, Clarke NW et al. (2016) Addition of docetaxel, zoledronic acid, or both to first-line long-term hormone therapy in prostate cancer (STAMPEDE): survival results from an adaptive, multiarm, multistage, platform randomised controlled trial. Lancet 387(10024): 1163–77. | |

## Factors to consider when discussing active surveillance, radical prostatectomy or radical radiotherapy as treatment options for people with low-risk or intermediate-risk localised prostate cancer, using evidence from a large UK trial

| | |
|---|---|
| What are the treatment options for people with localised prostate cancer? | There are 3 options for treatment:<br>• active surveillance [See page 22][a]<br>• radical prostatectomy [See page 22]<br>• radical radiotherapy. |
| **Effects on survival and disease progression at 10 years** | |
| What effect does each treatment option have on survival? | The evidence does not show a difference in the number of deaths from prostate cancer among people offered active surveillance, prostatectomy or radical radiotherapy.<br>People who had not died of prostate cancer were:<br>• 98 out of 100 patients offered active surveillance |

| | |
|---|---|
| | • 99 out of 100 patients offered radical prostatectomy<br>• 99 out of 100 patients offered radical radiotherapy. |
| What effect does each treatment option have on disease progression[b]? | There is good evidence that both prostatectomy and radiotherapy reduce disease progression compared with active surveillance.<br><br>Signs of disease progression were reported in:<br><br>• 21 out of 100 patients offered active surveillance<br>• 8 out of 100 patients offered radical prostatectomy<br>• 8 out of 100 patients offered radical radiotherapy. |
| What effect does each treatment option have on the rate of development of distant metastases? | There is good evidence that both prostatectomy and radiotherapy reduce the rate of development of distant metastases compared with active surveillance.<br><br>Distant metastases were developed in:<br><br>• 8 out of 100 patients offered active surveillance<br>• 3 out of 100 patients offered radical prostatectomy<br>• 3 out of 100 patients offered radical radiotherapy. |
| **Potential side effects of treatment** | |
| What effect does each treatment option have on urinary function? | There is some evidence that urinary function is better for people offered active surveillance or radiotherapy than those offered prostatectomy. |
| | Problems with urinary continence:<br><br>At 6 months, problems were reported in:<br><br>• 39 out of 100 patients offered active surveillance<br>• 71 out of 100 patients offered radical prostatectomy |

| | |
|---|---|
| | • 38 out of 100 patients offered radical radiotherapy.<br><br>At 6 years, problems were reported in:<br><br>• 50 out of 100 patients offered active surveillance<br>• 69 out of 100 patients offered radical prostatectomy<br>• 49 out of 100 patients offered radical radiotherapy. |
| | Moderate to severe urinary incontinence problems:<br><br>At 6 months, problems were reported in:<br><br>• 4 out of 100 patients offered active surveillance<br>• 19 out of 100 patients offered radical prostatectomy<br>• 6 out of 100 patients offered radical radiotherapy.<br><br>At 6 years, problems were reported in:<br><br>• 8 out of 100 patients offered active surveillance<br>• 13 out of 100 patients offered radical prostatectomy<br>• 5 out of 100 patients offered radical radiotherapy. |
| What effect does each treatment option have on erectile dysfunction? | There is some limited evidence that sexual function is better for people offered active surveillance or radiotherapy than those offered prostatectomy.<br><br>Erectile dysfunction, moderate or severe problems:<br><br>At 6 months, problems were reported in:<br><br>• 29 out of 100 patients offered active surveillance<br>• 66 out of 100 patients offered radical prostatectomy<br>• 48 out of 100 patients offered radical radiotherapy.<br><br>At 6 years, problems were reported in:<br><br>• 40 out of 100 patients offered active surveillance |

| | |
|---|---|
| | • 50 out of 100 patients offered radical prostatectomy<br>• 36 out of 100 patients offered radical radiotherapy. |
| What effect does each treatment option have on bowel function? | There is some evidence that bowel function is better for people offered active surveillance or prostatectomy than those offered radiotherapy in the short term. |
| | Problems with faecal incontinence more than once per week:<br><br>At 6 months, problems were reported in:<br><br>• 2 out of 100 patients offered active surveillance<br>• 1 out of 100 patients offered radical prostatectomy<br>• 5 out of 100 patients offered radical radiotherapy.<br><br>At 6 years, problems were reported in:<br><br>• 3 out of 100 patients offered active surveillance<br>• 2 out of 100 patients offered radical prostatectomy<br>• 4 out of 100 patients offered radical radiotherapy. |
| | Moderate to severe impact of bowel habits on quality of life:<br><br>At 6 months, it was reported in:<br><br>• 3 out of 100 patients offered active surveillance<br>• 3 out of 100 patients offered radical prostatectomy<br>• 10 out of 100 patients offered radical radiotherapy.<br><br>At 6 years, it was reported in:<br><br>• 4 out of 100 patients offered active surveillance<br>• 3 out of 100 patients offered radical prostatectomy<br>• 2 out of 100 patients offered radical radiotherapy. |

[a] The trial used the intention-to-treat method of analysis and some of the patients in the active surveillance arm may therefore have undergone prostatectomy or radiotherapy during the follow-up period.

[b] The trial defined disease progression as:

- evidence of metastases **or**
- diagnosis of clinical T3 or T4 disease **or**
- need for long-term androgen deprivation therapy **or**
- rectal fistula or the need for a urinary catheter owing to local tumour growth.

Disease progression was suspected if there was:

- any rise in PSA >20% between consecutive measures at any time during follow-up **or**
- any rise in PSA level of 50% or greater in any 12-month period confirmed by repeat tests **or**
- any indication of the appearance of symptomatic systemic disease.

## Rationale: padeliporfin

Current treatments for low-risk prostate cancer include active surveillance and, for people whose disease has progressed (usually beyond low-risk disease), radical therapies such as surgery and radiotherapy. Focal therapies such as cryotherapy and high-intensity focused ultrasound can also be used, but are not routinely available.

Professional organisations and NHS England say that there is a growing trend for people with low-risk disease to have active surveillance rather than radical therapy. This is because long-term studies show that people with low-risk disease live as long whichever they have, but radical therapies are associated with long-term, severe side effects. Also, improvements in diagnostic tests mean that low-risk disease can be more accurately identified.

The company proposes padeliporfin as an option for people with low-risk disease who choose not to have active surveillance and so would otherwise have radical therapies. There is no clinical evidence on how effective padeliporfin is at slowing the disease compared with radical therapies. Also, there is no evidence to support the company's assumption that the length of time people live with padeliporfin is the same as with radical therapies.

Clinical trial evidence comparing padeliporfin with active surveillance does show that, at 2 years, it is more effective at slowing prostate cancer. However, it is unclear whether the benefit seen at 2 years leads to people living longer. Also, it is unclear whether some of the people in the trial would have had intermediate-risk prostate cancer.

Professional organisations and NHS England do not support using padeliporfin for low-risk prostate cancer because, like radical therapies, it is associated with long-term side effects, without supporting evidence of long-term clinical benefit.

The company's cost-effectiveness analyses compare padeliporfin with radical therapies. However, because there is no clinical-effectiveness evidence comparing padeliporfin and radical therapies, it is not possible to consider these analyses. Therefore, padeliporfin cannot be recommended for untreated, unilateral, low-risk prostate cancer.

For more information see the committee discussion in the NICE technology appraisal guidance on padeliporfin for untreated localised prostate cancer.

Surgery to remove part, or all of the prostate gland. Radical prostatectomy aims at the removal of the entire prostate gland and lymph nodes. This can be performed by an open approach or by keyhole technique (laparoscopic or robotically assisted laparoscopic prostatectomy).

This is part of a strategy for 'controlling' rather than 'curing' prostate cancer and is aimed at people with localised prostate cancer who do not ever wish to have curative treatment, or it is not suitable for them. Instead, it involves the deferred use of hormone therapy. Watchful waiting avoids the use of surgery or radiation, but implies that curative treatment will not be attempted.

This is part of a 'curative' strategy and is aimed at people with localised prostate cancer for whom radical treatments are suitable, keeping them within a 'window of curability' whereby only those whose tumours are showing signs of progressing, or those with a preference for intervention are considered for radical treatment. Active surveillance may thus avoid or delay the need for radiotherapy or surgery.

## Glossary

### DRE

digital rectal examination

**Localised prostate cancer**

(cancer that has been staged as T1 or T2 [confined to the prostate gland])

**Locally advanced prostate cancer**

(this includes: high-risk localised prostate cancer [PSA over 20 ng/ml, or Gleason score 8 to 10, or clinical stage T2c or more]; T3b and T4, N0 prostate cancer; and any T, N1 prostate cancer)

**MDT**

multidisciplinary team

**MDTs**

multidisciplinary teams

**Multiparametric MRI**

(an MRI study that incorporates anatomical and functional information about the prostate; the minimum functional information includes T2-weighted, diffusion-weighted imaging and dynamic contrast enhanced imaging)

**PDE5**

phosphodiesterase type 5

**PSA**

prostate-specific antigen

## Sources

Prostate cancer: diagnosis and management (2019) NICE guideline NG131

Darolutamide with androgen deprivation therapy for treating hormone-relapsed non-metastatic prostate cancer (2020) NICE technology appraisal guidance 660

Enzalutamide for hormone-relapsed non-metastatic prostate cancer (2019) NICE technology appraisal guidance 580

Padeliporfin for untreated localised prostate cancer (2018) NICE technology appraisal guidance 546

## Your responsibility

### Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

### Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to

make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

**Medical technologies guidance, diagnostics guidance and interventional procedures guidance**

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.