Item 4.2

NHS ENGLAND SPECIALISED SERVICES

CLINICAL PANEL REPORT

Date: August 2019

Intervention: Percutaneous Left Atrial Catheter Ablation (CA)

Indication: Paroxysmal and Persistent Atrial Fibrillation (AF)

ID: 1903

Gateway: 2 Round 1

Programme: Internal Medicine

CRG: Cardiac Surgery

Information provided to the panel

PPP Clinical Panel Report

Two Evidence Reviews undertaken by Solutions for Public Health – Paroxysmal AF and Persistent AF

Two Clinical Priorities Advisory Group Summary Reports – Paroxysmal AF and Persistent AF

Policy Proposition

Key elements discussed

This proposition is proposed for routine commissioning for these two types of AF. Treatment in general for AF is medical (anti-arrhythmic medicines). CA is a minimally invasive technique.

Two evidence reviews undertaken.

Paroxysmal AF – five studies included which compared ablation with medical therapy in the main. There was moderate quality evidence for the effectiveness of CA compared with medical therapy and very limited data compared with surgical ablation. Improved outcomes were demonstrated with CA. There was some improvement in AF freedom which could be sustained at five years. However, there were no differences seen in terms of all-cause mortality (beyond 30 days), quality of life or left ventricular ejection fraction. Surgical ablation appears to be more effective at maintaining AF freedom and reducing recurrent of any form of atrial arrhythmias included symptomatic AF. However, complication rates appear higher with surgical ablation.

Requirement for re-ablation was shown to vary – 12.5% - 49%.

Persistent AF – four studies included. Moderate quality evidence was found for the effectiveness of CA compared with medical therapy, and very limited data compared with surgical ablation. Evidence demonstrated that there was improved AF freedom, reduced need for cardioversion post procedure, length of hospital admission/readmission was reduced in CA. Left ventricular ejection fraction was significantly improved. There were no benefits demonstrated in terms of all-cause mortality.

The quality of evidence comparing CA with surgical ablation was weaker but suggested that surgical ablation may be more effective than CA at establishing and maintaining sinus rhythm although had high bleeding rates. There was however no difference in overall and procedure related death.

Panel considered that this will affect very high numbers of patients.

In the evidence base, there was no consistent follow up, so the Panel were unsure how many re-do's may be required which raised the question regarding longevity of procedure outcomes/effects. Shared decision making will be required with the patients.

The Panel observed that there was a lot of criteria in the proposition and it wasn't clear how they all related back to the evidence studies, for example, BMI level, the Rockwood criteria. The Rockwood criteria should not be used as a threshold, that is not the intention of it. This needs to be addressed.

Panel were concerned about the age of eligibility in the proposition – 18 years and over. It was highlighted that it is unusual in children and if AF is present then the child has a congenital heart problem and is treated through that clinical pathway.

The Panel were unsure why completing a PROMS form was included as an entry criterion and require the context for this.

Recommendation

Clinical Panel recommended that this proposition continue as a for routine policy proposition however it needs to be revised to take into consideration all the amendments required. To return to a future Panel meeting.

Why the panel made these recommendations

The Clinical Panel considered the evidence base demonstrated that catheter ablation was clinically effective and safe, and supported a routine commissioning position.

Documentation amendments required

Proposition:

- Criteria:
    - Age of eligibility – Programme of Care to check with the Congenital Heart team regarding the wording that should be used.
    - Split the age limit and the Rockwood criteria into different bullet points. Review how the Rockwood criteria is used in the proposition.
    - BMI – wording to be changed as currently reads as if those patients exceeding a BMI of 40 don't have to have undergone any weight management.
    - Review all access criteria and ensure what is included is taken from the evidence base. If it is by clinical consensus then it needs to be clear how this was established and agreed.
    - Establish criteria for when the need for a redo is needed
    - Review and make it clear why completing a PROMS form should be included as an entry criteria
    - A shorter list for exclusion criteria is needed.

CPAG report:

- To be reviewed by Clinical Effectiveness Team to combine into one comparative report and make relevant changes as stated.

Declarations of Interest of Panel Members: None.

Panel Chair: James Palmer, Medical Director