Complete Summary

GUIDELINE TITLE

Stapled haemorrhoidopexy for the treatment of haemorrhoids.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Stapled haemorrhoidopexy for the treatment of haemorrhoids. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sep. 25 p. (Technology appraisal guidance; no. 128).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Hemorrhoids

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Management

CLINICAL SPECIALTY

Colon and Rectal Surgery
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To evaluate the clinical effectiveness and cost-effectiveness of stapled hemorrhoidopexy for the treatment of hemorrhoids

TARGET POPULATION

Patients with hemorrhoids

INTERVENTIONS AND PRACTICES CONSIDERED

Stapled hemorrhoidopexy using the HCS33 circular stapler

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Pain
    - Bleeding
    - Residual prolapse
    - Operating time
    - Duration of hospital stay
    - Wound healing
    - Time to first bowel movement
    - Complications
    - Need for further intervention
    - Incontinence
    - Quality of life
- Cost-effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment

report for this technology appraisal was prepared by the Centre for Reviews and Dissemination (CRD) and the Centre for Health Economics (CHE) Technology Assessment Group, University of York (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Search Strategy

The following resources were searched in order to retrieve papers relating to stapled hemorrhoidopexy (SH). No language or date restrictions were applied. However, SH was introduced in 1998, therefore trials evaluating this technology would not be located prior to this date. A range of free-text terms and subject headings were used to provide a focused strategy, and a variety of search strategies were used (details of the search strategies used are presented in Appendix 10.1 of the Assessment Report [see the "Availability of Companion Documents" field]):

Databases of Systematic Reviews

Cochrane Database of Systematic Reviews (CDSR) (Cochrane Library: http://www.library.nhs.uk/)

Database of Abstracts of Reviews of Effects (DARE) (CRD Internal Database)

Health/Medical Related Databases

BIOSIS (EDINA: discontinued 31/07/06)

CENTRAL (Cochrane Central Register of Controlled Trials) (Cochrane Library: http://www.library.nhs.uk/)

Cumulative Index to Nursing and Allied Health Literature (CINAHL) (OvidWeb: http://gateway.ovid.com/athens)

EMBASE

Health Technology Assessment Database (HTA) (CRD Internal Database)

MEDLINE

MEDLINE In Process and other non-indexed citations

Science Citation Index (SCI) (Web of Knowledge: http://wos.mimas.ac.uk/)

Databases of Conference Proceedings

ISI Proceedings: science and technology (Web of Knowledge: http://wos.mimas.ac.uk/)

Zetoc Conferences (MIMAS: http://zetoc.mimas.ac.uk/)

Databases for Ongoing and Recently Completed Research

ClinicalTrials.gov (http://www.clinicaltrials.gov/)

MetaRegister of Controlled Trials (http://www.controlled-trials.com/)

National Research Register (NRR) (http://www.update-software.com/national/)

Clinical Guidelines and Systematic Reviews Resources

Clinical Evidence (BMJ Publishing Group)

Health Evidence Bulletin Wales (http://hebw.cf.ac.uk)

National Guideline Clearinghouse (http://www.guideline.gov/)

National Institute for Health and Clinical Excellence (NICE) (http://www.nice.org.uk/)

National Library for Health (NLH) Guidelines Finder (http://www.library.nhs.uk/guidelinesfinder/)

Scottish Intercollegiate Guidelines Network (SIGN) (http://www.sign.ac.uk/)

Turning Research Into Practice (TRIP+) (http://www.tripdatabase.com/index.html)

Topic Specific Websites

American Society of Colon and Rectal Surgeons (http://ascrs.affiniscape.com/index.cfm)

Association of Coloproctology of Great Britain and Ireland (http://www.acpgbi.org.uk)

Association of Surgeons of Great Britain and Ireland (http://www.asgbi.org.uk/)

Digestive Disorders Foundation (http://www.digestivedisorders.org.uk)

Hemorrhoids File (http://www.lifestages.com/health/hemorrho.html)

Inclusion and Exclusion Criteria

Two reviewers independently screened all titles and abstracts. Full paper manuscripts of any studies thought to be potentially relevant by either reviewer were obtained. The relevance of each study was assessed according to the criteria stated below. A table of retrieved studies that appeared relevant but were excluded during the screening process, is provided in Appendix 6 of the

Assessment Report (see the "Availability of Companion Documents" field). Any discrepancies were resolved by consensus, or where consensus could not be reached, a third reviewer was consulted.

For any study retrieved only as an abstract, authors were contacted to request additional information. Where additional information was not obtained, abstracts were included only if sufficient outcome data were available. Studies of any language were included as long as a translator was available.

Study Designs

Randomised controlled trials (RCTs) with 20 or more participants were used to evaluate efficacy. Studies with fewer than 20 participants were excluded, as these are likely to be underpowered and of poorer quality.

Interventions and Comparators

Studies evaluating haemorrhoidopexy undertaken using a linear stapler were excluded. Studies evaluating either PPH01 or PPH03 (Endo Ethicon-Surgery [EE-S]) or Autosuture using the STRAM kit (Tyco Healthcare) were eligible for inclusion. No other staplers designed for SH were identified.

Population

Trials of people of any age with prolapsing haemorrhoids, including those with haemorrhoids that reduce spontaneously, for whom surgery is considered a relevant option were included in the review. Trials of patients undergoing emergency procedures for thrombosed haemorrhoids were excluded.

Outcomes

Outcomes were classified as peri-/post-operative (<6 weeks), short-term (>6 weeks to <12 months), 12 months, and long-term (>12 months). Where studies reported continuous outcomes as medians and ranges, authors were contacted for mean and standard deviation (SD). Overall patient satisfaction, indicating a preference for one or other technique or no preference, was extracted at each time point if reported. A full list of outcomes extracted at each time point is provided in Appendix 10.2 of the Assessment Report (see the "Availability of Companion Documents" field).

Refer to Section 5.1.2 of the Assessment Report for more information on inclusion and exclusion criteria.

Cost-Effectiveness

Systematic Review of Existing Cost-Effectiveness Evidence

To review the existing cost-effectiveness evidence base, papers obtained during the clinical effectiveness review were searched to check whether they included cost-effectiveness data. In addition, four economics databases were searched to

identify additional economic evaluations (refer to Appendix 10.1.2 of the Assessment Report [see the "Availability of Companion Documents" field]).

To obtain data to populate parameters of the York economic model, a series of specific searches were undertaken. These included searches for relevant data on health related quality of life (HRQoL), the incidence and prevalence of haemorrhoids, RCTs evaluating open versus closed haemorrhoidectomy, cohort studies of complications and symptoms associated with haemorrhoidal surgery and the length of hospital stay following haemorrhoidal surgery as reported in Appendix 10.1.3 of the Assessment Report (see the "Availability of Companion Documents" field).

In terms of the inclusion criteria, a broad range of studies was considered in the assessment of cost-effectiveness, including economic evaluations conducted alongside trials, modelling studies and analyses of administrative databases. Any duplicate references that were obtained were taken out and the remaining references were checked for relevance by a health economist. Studies were included in the cost-effectiveness review if they considered the costs and outcomes associated with two or more surgical procedures in the treatment of haemorrhoids. Therefore, studies based on cost-consequence analysis, cost-utility analysis, cost-effectiveness analysis, cost-minimisation and cost-benefit analysis, were eligible for inclusion.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

The electronic and hand searches retrieved 653 references. Of these, 147 full papers considered potentially relevant to the review of clinical effectiveness were retrieved and screened for relevance. Twenty seven randomised controlled trials (RCTs) reported in 35 publications, met the inclusion criteria.

Cost-Effectiveness

No formal full economic evaluations assessing the cost-effectiveness of stapled hemorrhoidopexy (SH) for the treatment of haemorrhoids were found in the published literature. One study examined the costs associated with surgical procedures for haemorrhoids in some detail.

Endo Ethicon-Surgery (EE-S) submitted an economic model.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the Centre for Reviews and Dissemination (CRD) and the Centre for Health Economics (CHE) Technology Assessment Group, University of York (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Data Extraction Strategy

All data relating to both study design and quality were extracted by one reviewer and independently checked for accuracy by a second. Disagreements were resolved through consensus, or where consensus could not be reached, a third reviewer was consulted. Foreign language studies were extracted by one reviewer along with a native speaker of that language. Where multiple publications of the same study were identified, data were extracted and reported as a single study. A list of the type of data extracted at each time point is provided in Appendix 10.2 of the Assessment Report (see the "Availability of Companion Documents" field).

Quality Assessment Strategy

The quality of the individual studies was assessed by one reviewer and independently checked by a second. Disagreements were resolved through consensus, or where consensus could not be reached, a third reviewer was consulted. The quality of randomised controlled trials (RCTs) was assessed using standard checklists adapted to incorporate topic-specific quality issues. The checklist is provided in Appendix 10.3 of the Assessment Report, together with the guidelines used to score each criterion.

Data Analysis

Odd ratios (OR) and 95% confidence intervals (CI) were calculated for dichotomous outcomes. Mean differences and 95% CI were calculated for continuous outcomes. Data are reported separately for each outcome measure. All meta-analyses were conducted in RevMan 4.2.9 (Cochrane Collaboration). Pooled OR and 95% confidence intervals (CI) were calculated for dichotomous outcomes, and weighted mean differences (WMD) and 95% CI for continuous outcomes.

Studies were pooled in primary analyses if there was no statistically significant heterogeneity between studies. A random effects model was used, unless there were three or less studies included in the analysis, in which case a fixed effect model was used. Sources of heterogeneity, such as patient population and quality

criteria were investigated by visual inspection of the forest plots and explored further using sensitivity analyses. Possible effects of study quality on the effectiveness data and review findings are discussed. For the primary outcomes (pain, prolapse, bleeding) sensitivity analyses were conducted to explore the impact of the high losses to follow-up. For both primary and secondary outcomes, sensitivity analyses were conducted to explore the impact of outlying results.

The relationship between visual analogue scale (VAS) pain score, days from primary surgery and treatment was explored further using Bayesian meta-regression (refer to Appendix 10.4 of the Assessment Report).

Refer to Section 5.1.5 of the Assessment Report (see the "Availability of Companion Documents" field) for more information.

Cost-Effectiveness

A data extraction form for use in previous Technology Assessment Reviews was used to abstract data on all economic evaluations reviewed. The quality of the cost-effectiveness studies was assessed based on a checklist updated from that developed by Drummond et al, Drummond M, Sculpher M, Torrance G, O'Brien B, Stoddart G. *Methods for the economic evaluation of health care programmes*. 3rd ed. Oxford: Oxford University Press, 2005) and which reflects the criteria for economic evaluation detailed in the methodological guidance developed by NICE (Refer to Appendices 10.3 and 10.5.2 of the Assessment Report [see the "Availability of Companion Documents" field). In addition, Endo Ethicon-Surgery (EE-S) (Johnson and Johnson) submitted an economic model.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can

comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE website. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

No published economic evaluations were identified by Ethicon Endo-Surgery or the Assessment Group.

Ethicon Endo-Surgery submitted a cost–utility analysis comparing stapled haemorrhoidopexy with Milligan-Morgan haemorrhoidectomy, using a cohort-based probabilistic model. This model included people with third- and fourth-degree haemorrhoids, and the analysis was based on the following health states: full recovery without recurrent prolapse, recurrent prolapse that can be self-treated and recurrent prolapse requiring re-surgery (the latter of which may be followed by no further prolapse or a second recurrent prolapse). Complications or symptoms other than prolapse were not included. The average time from initial

surgery to recurrence of prolapse was assumed to be 120 days and the waiting time from recurrence with severe symptoms to re-intervention was assumed to be 10 days. The model followed a 1-year time horizon and it was assumed that there was no difference in treatment effect beyond 12 months. The economic evaluation was undertaken from a UK National Health Service (NHS) perspective. Because there were no randomised controlled trials (RCTs) that recorded utility in the crucial early postoperative period, utility weights were estimated indirectly by converting Visual Analogue Scale (VAS) pain scores from one RCT and matching short form (SF)-36 health survey dimensions to utility using a cross-sectional dataset of people aged 39 to 67 who were registered with a general practitioner in Sheffield. The SF-36 data were then converted into utility values.

The Ethicon Endo-Surgery base-case resulted in an incremental cost of 191 pounds sterling and 0.009 incremental quality adjusted life years (QALY) for stapled haemorrhoidopexy compared with conventional haemorrhoidectomy, with an incremental cost-effectiveness ratio (ICER) of 22,416 pounds sterling per QALY. At a willingness to pay of 30,000 pounds sterling per QALY there was a greater than 70% probability that stapled haemorrhoidopexy was cost effective.

The Assessment Group undertook a cost–utility analysis comparing stapled haemorrhoidopexy with conventional haemorrhoidectomy. The structure of the Assessment Group's model was broadly similar to the Ethicon Endo-Surgery model, but it included a wider definition of symptoms, complications of surgery and both surgical and non-surgical re-interventions, and it considered a 3-year time horizon. As in the Ethicon Endo-Surgery model, utility weights were estimated indirectly. This was done by converting VAS pain scores from ten RCTs to SF-36 data. The SF-36 data were then converted into utility values, but using a different methodology from that used by the manufacturer. The Assessment Group used the pain dimension of the SF-36 to calculate utility values, but the manufacturer included pain and physical functioning SF-36 dimensions. The difference between the utility with stapled haemorrhoidopexy and conventional haemorrhoidectomy was smaller in the Assessment Group's model than in the Ethicon Endo-Surgery model.

The Assessment Group's base-case resulted in an incremental cost of 19 pounds sterling and 0.001 fewer QALYs for stapled haemorrhoidopexy compared with conventional haemorrhoidectomy over 3 years. Stapled haemorrhoidopexy was therefore dominated by conventional haemorrhoidectomy. In the range of willingness to pay of 20,000 pounds sterling to 30,000 pounds sterling per QALY there was a 45% probability that stapled haemorrhoidopexy was cost effective.

The Assessment Group carried out a number of one-way sensitivity analyses using both its own model and the Ethicon Endo-Surgery model, and found that the ICER was extremely sensitive to the assumptions used, with very small differences in the benefits resulting in large differences in the ICERs. Only when the Assessment Group's model was run with the Ethicon Endo-Surgery utility values was an ICER of less than 30,000 pounds sterling per QALY produced. Alternatively, when the Ethicon Endo-Surgery model was run with the Assessment Group's utility values, this gave an ICER of 383,985 pounds sterling. When the price of the device was set at the 2006 price of 420 pounds sterling rather than the estimated 2007 price of 437 pounds sterling, the total cost difference in the Assessment Group's model decreased to approximately 2 pounds sterling.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

This technology appraisal examined the currently available devices for stapled haemorrhoidopexy. The evidence considered refers to the HCS33 circular stapler (models PPH01 and PPH03, Ethicon Endo-Surgery). At the time of the technology appraisal, there was no evidence to make recommendations for the Autosuture stapler with the STRAM kit adaptor.

- Stapled haemorrhoidopexy, using a circular stapler specifically developed for haemorrhoidopexy, is recommended as an option for people in whom surgical intervention is considered appropriate for the treatment of prolapsed internal haemorrhoids.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of stapled haemorrhoidopexy in the treatment of haemorrhoids

POTENTIAL HARMS

The short-term complications of stapled haemorrhoidopexy include pain, urinary retention, bleeding, and perianal sepsis. Long-term complications may include anal fissure, anal stenosis, incontinence, fistula, and the recurrence of hemorrhoidal symptoms.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the Institute, which was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

- The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health' issued in July 2004. The Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by National Institute for Health and Clinical Excellence (NICE) technology appraisals normally within 3 months from the date that NICE publishes the guidance. Core standard C5 states that healthcare organisations should ensure they conform to NICE technology appraisals.
- 'Healthcare standards for Wales' was issued by the Welsh Assembly Government in May 2005 and provides a framework both for self-assessment by healthcare organisations and for external review and investigation by Healthcare Inspectorate Wales. Standard 12a requires healthcare organisations to ensure that patients and service users are provided with effective treatment and care that conforms to NICE technology appraisal guidance. The Assembly Minister for Health and Social Services issued a Direction in October 2003 which requires Local Health Boards and NHS Trusts to make funding available to enable the implementation of NICE technology appraisal guidance, normally within 3 months.
- NICE has developed tools to help organisations implement this guidance (listed below). These are available on NICE website (www.nice.org.uk) (see also the "Availability of Companion Documents" field below).
    - Audit criteria to monitor local practice
    - A costing statement explaining the resource impact of this guidance.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Patient Resources

Quick Reference Guides/Physician Guides
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Stapled haemorrhoidopexy for the treatment of haemorrhoids. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sep. 25 p. (Technology appraisal guidance; no. 128).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Sep

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Appraisal Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Professor Keith Abrams, Professor of Medical Statistics, University of Leicester; Dr Jeff Aronson, Reader in Clinical Pharmacology, University of Oxford; Dr Darren Ashcroft, Senior Clinical Lecturer, School of Pharmacy and Pharmaceutical Sciences, University of Manchester; Professor David Barnett (*Chair*) Professor of Clinical Pharmacology, University of Leicester; Dr Peter Barry, Consultant in Paediatric Intensive Care, Leicester Royal Infirmary; Professor Stirling Bryan, Director of the Health Economics Facility, University of Birmingham; Professor John Cairns, Public Health and Policy, London School of Hygiene and Tropical Medicine; Dr Mark Charkravarty, Head of Government Affairs and NHS Policy, Procter and Gamble Pharmaceuticals (UK) Ltd; Professor Jack Dowie, Health Economist, London School of Hygiene and Tropical Medicine; Lynn Field, Nurse Director, Pan Birmingham Cancer Network; Professor Christopher Fowler, Professor of Surgical Education, University of London; Dr Fergus Gleeson, Consultant Radiologist, Churchill Hospital; Ms Sally Gooch, Former Director of Nursing and Workforce Development, Mid Essex Hospitals Services NHS Trust; Mrs Barbara Greggains, Lay member; Mr Sanjay Gupta, Former Stroke Services Manager, Basildon and Thurrock Universities Hospitals NHS Trust; Dr Mike Laker, Medical Director, Newcastle Hospitals NHS Trust; Mr Terence Lewis, Mental Health Consultant, National Institute for Mental Health in England; Professor Gary McVeigh, Professor of Cardiovascular Medicine, Queens University, Belfast; Dr Ruairidh Milne, Senior Lecturer in Health Technology Assessment, National Coordinating Centre for Health Technology; Dr Neil Milner, General Medical Practitioner, Tramways Medical Centre, Sheffield; Dr Rubin Minhas, General Practitioner, CHD Clinical Lead, Medway PCT; Dr John Pounsford, Consultant Physician, North Bristol NHS Trust; Dr Rosalind Ramsay, Consultant Psychiatrist, Adult Mental Health Services, Maudsley Hospital; Dr Christa Roberts, UK Country Manager, Abbott Vascular; Dr Stephen Saltissi, Consultant Cardiologist, Royal Liverpool University Hospital; Dr Lindsay Smith, General Practitioner, East Somerset Research Consortium; Mr Roderick Smith, Director of Finance, West Kent Primary Care Trust; Mr Cliff Snelling, Lay member; Dr Ken Stein, Senior Lecturer, Peninsula Technology Assessment Group (PenTAG), University of Exeter; Professor Andrew Stevens, Professor of Public Health, University of Birmingham; Dr Rod Taylor, Associate Professor in Health Services Research, Peninsula Medical School, Universities of Exeter and Plymouth

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Stapled haemorrhoidopexy for the treatment of haemorrhoids. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sep. 2 p. (Technology appraisal 128). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Costing statement: stapled haemorrhoidopexy for the treatment of haemorrhoids. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sep. 2 p. (Technology appraisal 128). Available in Portable Document Format (PDF) from the NICE Web site.
- Audit criteria. Stapled haemorrhoidopexy for the treatment of haemorrhoids. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sep. 8 p. (Technology appraisal 128). Available in Portable Document Format (PDF) from the NICE Web site.
- Stapled haemorrhoidectomy (haemorrhoidopexy) for the treatment of haemorrhoids. Assessment report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Feb. 274 p. Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1334. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Stapled haemorrhoidopexy for the treatment of haemorrhoids. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Sep. 4 p. (Technology appraisal 128).

Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the NHS Response Line 0870 1555 455. ref: N1335. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI Institute on October 26, 2007.

The National Institute for Health and Clinical Excellence (NICE) has granted the National Guideline Clearinghouse (NGC) permission to include summaries of their Technology Appraisal guidance with the intention of disseminating and facilitating the implementation of that guidance. NICE has not verified this content to confirm that it accurately reflects the original NICE guidance and therefore no guarantees are given by NICE in this regard. All NICE technology appraisal guidance is prepared in relation to the National Health Service in England and Wales. NICE has not been involved in the development or adaptation of NICE guidance for use in any other country. The full versions of all NICE guidance can be found at www.nice.org.uk.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 10/13/2008