NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	Asthma			
Key audiences for the guideline:	General practitioners Primary healthcare nurses Pharmacists			
Existing Australian guidelines:				
Guideline	**Approved by**	**Funded by**	**When approved**	**Expiry date**
Australian Asthma Handbook, version 1.1: Australia's National Guidelines for Asthma Management [1]	National Asthma Council Australia		April 2015	
Acute Asthma – Clinical Practice Guidelines [2]	The Royal Children's Hospital Melbourne		May 2015	
Proposed guideline format (if known):				

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. ***How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?***

   Difficulties in diagnosis and poor asthma control can lead to reduced health, quality of life and even death. Poulos, et al. report that confidently identifying asthma poses difficulties due to often intermittent symptoms, including wheezing, coughing and shortness of breath, which are not unique to asthma. Furthermore the available objective tests to provide a definitive diagnosis are not often used in clinical practice with children [3].

   While the mortality rate associated with asthma reduced by 45 per cent between 1997 and 2009 [4], Australia continues to have one of the highest mortality rates due to asthma in the world. Australia reported the highest incidence of doctor diagnosed asthma out of 70 counties participating in the World Health Survey [5].

   It is estimated that only 20 per cent of people over the age of 15 have a written asthma action plan [6]. Effective management of asthma can reduce the risk of hospitalisation and death due to asthma [6, 7].

2. ***Provide information to show that the clinical area is:***

   a. ***high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations) and / or***

Asthma is a common allergic condition, affecting one in ten children and adults – which represents over two million people [8]. Data are available to indicate the 14-16 per cent of Australian children have a persistent asthma problem and that children under five years of age, boys and indigenous children in urban areas have higher rates of asthma [8].

Key facts on asthma include [6]:

Incidence:

- In 2012/13 asthma was the principal diagnosis for 37,500 hospitalisations; with 168 admissions/100,000 population.

Prevalence

- One in ten Australians has been diagnosed with and is living with asthma.
- Asthma affects as many as one in four Australian primary school children [9].

Mortality

- In 2012, there were 394 deaths due to asthma – a mortality rate of 1.5/100,000.
- Death rates due to asthma across all ages declined between 1997 and 2003, and then remained fairly constant between 2003 and 2012.
- Asthma mortality rates tend to be higher for people in living in rural and remote areas.
- Mortality rates due to asthma were 2.3 times higher among Indigenous Australians (4.0/100,000) than among non-Indigenous Australians (1.7/100,000) for the period 2007 to 2011.

Burden of disease

- World Health Organization burden of disease measures indicated that for 2012 in Australia, there were 121,400 DALYs due to asthma [10].

b. imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and /or

Cost

An estimated $655 million was spent in 2008/9 on asthma assessment and management – representing 0.9 per cent of all direct health expenditure on diseases. Of this expenditure, 50 per cent was associated with prescription pharmaceuticals, 30 per cent on out-of-hospital medical services and 20 per cent on admitted patient costs [6].

Asthma is a high prevalence condition with significant burden of disease. The majority of asthma deaths are eminently preventable. Maintaining good asthma control in community dwelling adults is a key focus of any national strategic asthma management plan.

c. is a Government health priority topic.

Asthma was added as a National Health Priority Area in 1999 [9].

3. ***How would this guideline:***

   a. ***reduce risks and harms to consumers/ patients/ health service users***

      Clinical guidelines could serve to ensure that more people are correctly diagnosed with asthma and have a written management plan to which they commit. While it may be expected that this will lead to an increase in the number of diagnosed cases and an associated increase in pharmaceutical costs, it is probable that better management will lead to a reduction in hospitalisations as well as deaths due to asthma.

   b. ***reduce unwarranted variation in prevention, diagnosis or treatment***

      Children with asthma-like symptoms without a formal diagnosis of asthma essentially go untreated for the condition with substantial health consequences, including absence from school, sleep disturbances, and emergency department attendance.

   c. ***derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value***

      As pharmaceutical management is a primary aspect of asthma management, it could be expected that new treatments or new evidence on existing drugs will be continually emerging. A brief review of the literature, however, has not located any recent systematic reviews or meta-analyses.

   d. ***provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?***

      Not that we can find.

4. ***Are there any other current, valid or relevant guidelines available or applicable to the Australian context?***

   UK: National Institute for Health and Care Excellence (NICE): Asthma (2013) NICE Quality Standard [Q25] [11].

   USA: National Heart, Lung and Blood Institute: Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (2007) [12].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Brain Cancer**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Radiologists** **Pathologists** **Cancer nurses** **Neurosurgeons** **Neurologists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
NIL				

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Brain cancer is typically treated with a craniotomy combined with radiotherapy and chemotherapy. Improvements in all three areas and particularly in combination therapy have the potential to improve patient care and health outcomes.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

- In 2011, there were 1,724 new cases of brain cancer in Australia (1,010 new cases in men and 714 new cases in women), accounting for 1.5 per cent of all new cancers [1].
- In 2015, about 1,820 Australians (1,080 men and 740 women) are expected to be diagnosed with brain cancer [2].
- In 2020, an estimated 2,055 Australians are expected to be diagnosed with brain cancer [2].

- Brain cancer is more common in men:
    - in 2011, the age-standardised incidence rate of brain cancer was 8.8 cases per 100,000 men, compared with 5.8 cases per 100,000 women [1, 3].
- In 2011, the average age of brain cancer diagnosis was 58.7 years [3].
- The risk of developing brain cancer increases with age [1].
- In 2011, the risk of developing brain cancer before the age of 85 was 1 in 118 [1, 3].
- Incidence rates for brain cancer have remained fairly stable in recent years. The incidence rate was 6.3 cases per 100,000 people in 1982 and 7.3 cases per 100,000 people in 2011 [1].

Prevalence

- At the end of 2009, it was estimated that there were 6,206 people in Australia who were diagnosed with brain cancer in the previous 28 years, including 2,756 people diagnosed in the previous 5 years [3].

Mortality

- In 2012, there were 1,241 deaths from brain cancer (737 men and 504 women), accounting for 2.9 per cent of all cancer deaths in Australia [1].
- The age-standardised mortality rate for brain cancer is higher for men:
    - in 2012, there were 6.2 deaths per 100,000 men from brain cancer, compared with 3.9 deaths per 100,000 women [1].
- Between 1982 and 2011, the age-standardised mortality rate for brain cancer has remained fairly stable. There were 5.0 deaths per 100,000 in 1982 and 5.0 deaths per 100,000 in 2012 [1].
- In 2012, the risk of dying from brain cancer before the age of 85 was 1 in 159 [1, 3].

Survival

- Relative survival rates for brain cancer have remained fairly stable over recent years in Australia:
    - between the periods 1982–1986 and 2007–2011, five-year relative survival increased from 19.8 per cent to 21.6 per cent in Australia [3].

Hospitalisation

Brain cancer is generally treated with surgery, radiotherapy, chemotherapy or steroid therapy, or a combination of these treatments. Surgery will always require admission as an in-patient. The other treatments are usually undertaken day stay or out-patient. Detailed data on brain cancer hospitalisations was not discovered.

Burden of disease

- Cancer is estimated to be a leading cause of the burden of disease in Australia [3].
- In 2012, brain cancer was estimated to account for 21,500 disability adjusted life years (DALYs*) in Australia; of these, 20,200 were years lost due to premature death and 1,300 were years of healthy life lost due to disease, disability or injury [4].

*DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury. This is the basis unit used in burden of disease or injury estimates [3].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Brain cancer is not individually listed on the World Health Organization's estimated DALYs by cause, sex and member state [5].

AIHW estimates costs for brain cancer in 2000-01 to be $55 million of which $44 million was on admitted patient care [6].

c) is a Government health priority topic.

Cancer control is one of the federal government's original national health priorities established in 1996. However brain cancer is not particularly amenable to control at this time.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Brain cancer has a relatively low five year survival rate among all cancers of 20 per cent (average 66 per cent) [7]. The primary treatment risk is from neurosurgery/craniotomy.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Any standardisation of neurosurgery, i.e. craniotomy might improve patient outcomes, but only marginally.

New data from research on the molecular make up of brain tumours may improve treatment specificity [8, 9].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Unlikely to improve the situation

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Unlikely to improve the situation

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

European clinical practice guidelines for high-grade glioma published in 2014 [10].

The USA National Comprehensive Cancer Network has published 2015 CNS cancer guidelines (V.1) – note only available once registered on their website [11].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Breast Cancer**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Radiologists** **Medical oncologists** **Surgical oncologists** **Breast surgeons** **Breast care nurses** **Pathologists** **Cancer nurses** **Oncoplastic surgeons**

Existing Australian guidelines

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Practice Guidelines for the Management of Early Breast Cancer - Second Edition [1]	**NHMRC**		**2001**	**2006**
Clinical Practice Guidelines for the Management of Advanced Breast Cancer [2]	**NHMRC**		**2001**	**2006**
Recommendations for the management of early breast cancer in women with an identified BRCA1 or BRCA2 gene mutation or at high risk of a gene mutation [3]	**RACS*** **RANZCR*** **MOGA***	**Cancer Australia**	**2014**	
Recommendations for follow-up of women with early breast cancer [4]	**RACS*** **RANZCR*** **RACGP*** **RACP*** **BCNA***	**Cancer Australia**	**2010**	
***Royal Australian College of Surgeons** ***Royal Australia New Zealand College of Radiographers** ***Medical Oncology Group of Australia** ***Royal Australian College of General Practitioners** ***Royal Australasian College of Physicians** ***Breast Cancer Network Australia**				

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Breast cancer is the most prevalent form of cancer in women with a high burden of disease. It is also a significantly emotive cancer with high public visibility via a number of NGOs and high profile people living with the condition.

Better management of breast cancer will reduce the stigma and suffering from the disease. Greater uptake of breast screening will increase the rate of early detection and thus of earlier and therefore more successful treatment.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

- In 2010, breast cancer was the most common cancer in Australian women (excluding non-melanoma skin cancer), accounting for 28 per cent of all new cancers in women [5].
- In 2010, there were 14,181 new cases of breast cancer in women and 127 new cases in men [5].
- In 2009, the average age of breast cancer diagnosis was 60.7 years [6].
- The risk of developing breast cancer increases with age:
  - in 2010, 22.9 per cent of new breast cancer cases diagnosed were in women younger than 50 years; 52.5 per cent in women aged 50–69 years; and 24.6 per cent in women aged 70 years and over [5].
- In 2010, the risk of developing breast cancer before the age of 85 in women was 1 in 8 [5].
- The incidence of breast cancer in Australia is increasing:
  - in 2010, the number of new cases of breast cancer diagnosed in women increased to 14,181, from 5,303 in 1982 [5].
  - in 2014, about 15,270 Australian women are expected to be diagnosed with breast cancer [7].
  - in 2020, it is estimated that there will be 17,210 new cases of breast cancer diagnosed in women [7].
- Between 1982 and 1995, the age-standardised incidence rate of breast cancer in women increased from 81.0 to 116.1 per 100,000 women. After this time the rate has remained fairly stable, with the rate in 2010 equalling 116.4 per 100,000 women [5].
- In 2010, the number of men diagnosed with breast cancer in Australia increased to 127, from 61 in 1982 [5].

Prevalence

- At the end of 2008, it was estimated that there were 159,325 Australian women alive who had been diagnosed with breast cancer in the previous 27 years, including 57,327 women diagnosed in the previous 5 years [8].

Survival

- Relative survival rates after diagnosis of breast cancer in women have increased in recent years. Between the periods 1982–1987 and 2006–2010, five-year relative survival increased from 72 per cent to 89.4 per cent in Australian women [8].
- For 1997-2006, five-year relative survival for breast cancer was 98.2 per cent for women with 0–10 mm tumours, 94.7 per cent for women with 11–15 mm tumours, 93 per cent for women with 16–19 mm tumours, 87.9 per cent for women with 20–29 mm tumours, and 73.1 per cent for women with tumours 30 mm or greater [8].

Mortality

In 2011, breast cancer was the second leading cause of cancer-related death in Australian women, accounting for 15.6 per cent of all cancer deaths in women [5].

- In 2011, there were 2,937 deaths from breast cancer (2,914 women and 23 men) [5].
- Between 1994 and 2011, the age-standardised mortality rate for breast cancer in women decreased by 30 per cent (from 30.9 deaths per 100,000 women in 1994 to 21.9 deaths per 100,000 women in 2011) [5].

Burden of disease

- Cancer is estimated to be the leading cause of the burden of disease in Australia [6].
- In 2012, breast cancer was the leading cancer cause of the burden of disease in women in Australia, estimated to account for 61,400 disability-adjusted life years (DALYs**). Of these, 40,900 were years lost due to premature death and 20,500 were years of healthy life lost due to disease, disability or injury [6]. This is considered a high burden of disease.

** DALYs = Disability adjusted life years

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

According to the AIHW's Health system expenditures on cancer and other neoplasms in Australia, 2000-01, the average lifetime cost of a case of breast cancer to the health system was $111,897 [9]. Breast cancer has the second highest prescription cost rate after prostate cancer (these two cancers are

much higher than all others) and breast cancer had the highest 'other' cost rate (much higher than all others) [9(p.17)].

The most recent data on expenditure on breast cancer shows information for 2004-05. Health expenditure was $339 million which comprised 24% of all cancer expenditure. However, $118 million (36%) of this was spent on screening mammography services [8].

c) is a Government health priority topic

Cancer control (including breast cancer) is one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Given the high incidence and prevalence of breast cancer, it is surprising that there is no up-to-date set of clinical guidelines on treatment and management. Newer and safer treatment regimens are being researched constantly and should be incorporated into new clinical guidelines.

b) reduce unwarranted variation in prevention, diagnosis or treatment

There are a 160 registered clinical trials on various aspects of breast cancer recorded as underway, completed or planned in Australia [10]. The results of these trials need to be incorporated into any new guidelines.

NSW Bureau for Health Information data shows considerable variation between hospital emergency departments in the median time to start treatment. For example, among principal referral and major hospitals the median time to start treatment for people with cancer ranged from two to 12 minutes for triage 2, from 11 to 41 minutes for triage 3, from 16 to 60 minutes for triage 4 and from four to 49 minutes for triage 5 [11].

Aboriginal people have lower rates of access to acute care investigations and procedures and a lower likelihood of being treated for and surviving cancer. Between 2006-2012 the gap between Indigenous and non-Indigenous cancer mortality has widened while the gap in death rates from other chronic diseases has declined [12] (p.7).

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Any new clinical guidelines for breast cancer will need to provide a strong focus on reviewing treatments which have changed since the last guidelines were published in 2001.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

There are a 160 registered clinical trials on various aspects of breast cancer recorded as underway, completed or planned in Australia [10]. The results of

these trials need to be incorporated into any new guidelines. New monoclonal antibody medications have been coming to market with the expectation that they will improve treatment outcomes.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

The UK National Institute for Health and Care Excellence (NICE) has three clinical guideline documents relating to breast cancer:

- Advanced breast cancer (update) 2014 [13]
- Early and locally advanced breast cancer 2009 [14]
- Familial breast cancer 2014 [15]

Healthcare Improvement Scotland: treatment of primary breast cancer [16]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Cataracts**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Ophthalmologists** **Optometrists** **Orthoptists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Specialist eye health guidelines for use in Aboriginal and Torres Strait Islander populations - part 1: cataract [1]	Royal Australian and New Zealand College of Ophthalmologists	Depart-ment of Health (OATSIH)	2001	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

Cataracts are predominantly an issue for older people and become more prevalent as we age. However there are also a few cases of congenital cataracts each year, although disability from this is much more common in developing countries without adequate postnatal screening processes. The incidence of congenital cataracts is estimated to be 2.2 per 10,000 live births [2].

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Detection and treatment are key to improved health outcomes and prevention of vision impairment and blindness from cataract. Once the disease is established it can be addressed with surgery, replacing the clouded lens with a plastic one. Cataracts cause visual disability including blurred vision, reduced night vision and sensitivity to glare. Cataracts can affect driving ability.

   Key areas for potential improvement are

   - Community awareness – particularly among older people
   - Regular eye checks for at risk populations
   - Patient education re prevention protecting the eyes from UV light, smoking cessation and diabetes management.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

As the Australian population ages, there will be an inevitable increase in the number of people living with cataracts. It is expected that nearly everyone will have some degree of cataract formation by the age of 80. As cataract is a very slow growing condition, it is not possible to indicate incidence rates.

Prevalence

It is estimated by AIHW that there were around 1.5 million Australians aged 55 or older living with untreated cataract in 2004, but that most of these people are not yet clinically advanced enough to warrant surgical intervention. This equates to 31 per cent of that age cohort [3].

It was estimated in 1999 that 12.6 per cent of Victorians aged 40 years and older head nuclear cataract and 4.93 per cent had posterior subcapsular cataract [4]. These numbers will have increased in the past 16 years due to the ageing of the population.

Cataracts accounted for eight per cent of legal blindness and nine per cent of the 400,000 people who had less than 'driving' vision [5].

We are aware that the 2015-16 national eye health survey was launched on 12 June 2015 by Vision2020Australia. This will provide baseline prevalence data about the various eye conditions affecting the eyesight of Australians. (www.vision2020australia.org.au/media/2015-06-12/testing-gets-underway-as-national-eye-health-survey-launches)

Mortality

Cataract is not a fatal condition.

Survival

Cataract is not a fatal condition.

Burden of disease

WHO does not report estimated DALYs from cataract in Australia [6].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [7].

Hospitalisations

Over 160,000 cataract procedures are carried out per year in Australia, making it the most common eye procedure in hospitals [8]. There were 64,770 cataract extractions reported in Australian hospitals in 2012-13 [9].

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

While glaucoma is not particularly preventable, it is treatable with little risk. As such, investment in specialist and hospital capacity to undertake treatment will be worthwhile as the demand for treatment will grow in line with the ageing of the population.

Detailed costs are not known as reports on the amount of surgery undertaken are not readily available but it may be around $2,500 per eye.

c) is a Government health priority topic.

Eye health is not a government health priority but the federal government did establish a national framework for action to promote eye health and prevent avoidable blindness in 2005. The second progress report in 2012 outlines the key action areas of

- Reducing the risk of eye disease and injury
- Increasing early detection
- Improving access to eye health services
- Improving the systems and quality of care
- Improving the underlying evidence base [10]

WHO has been working with the Australian government to develop further information regarding eye health data collections [11].

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Driving with significant impairment by cataracts is a risk to road users.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Better structured detection would reduce the burden of cataracts. This is particularly important in remote and Aboriginal and Torres Strait Islander communities.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

A quick literature search demonstrates that there is no compelling evidence of a need to change cataract treatments beyond maintaining awareness of emerging research evidence regarding new surgical techniques.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Researchers at Tufts University claim to have established that a breakdown in communication between two biochemical pathways in the eye is involved in causing cataracts. This new information could help researchers develop pharmaceutical and dietary approaches to delay the onset of cataracts [12].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

- USA clinical guidelines from the American Optometric Association date 1995 with a revision in 1999 and a review in 2004 [13]
- New UK guidelines are being developed by NICE due in mid-2017. Previous guidelines date from 2007-8 are are no longer available online (https://www.nice.org.uk/guidance/conditions-and-diseases/eye-conditions/cataracts)

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Colorectal Cancer** Colorectal cancer refers to cancer of the colon, rectosigmoid junction, rectum, anus and anal canal (IC10 C18-C21)
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Oncologists** **Colorectal surgeons** **Colonoscopists** **Radiologists** **Pathologists** **Proctologists** **Cancer nurses** **Stomal therapy nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer [1]	**NHMRC**	**Department of Health**	**2005** **(Guide for GPs updated 2008)**	**2010**
Clinical practice guidelines for Surveillance Colonoscopy [2]	**NHMRC**	**Department of Health**	**2011**	**2016**

Proposed guideline format (if known):

Cancer Guidelines WIKI	**Cancer Council Australia**			

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

The possibility of improved patient care is low except in relation to early identification (and thus earlier treatment) and palliative care. Bowel cancer is one of the most preventable cancers if detected early but the second biggest cancer killer if not.

The national bowel cancer screening program offers a major gateway to improved early case detection via a mail-to-the-home faecal occult blood test for the entire Australian population of specific ages, increasing from only those 55 years and 65 years old in 2007 to biennially for all Australians from age 50-74 by 2019 [3]. The more people take advantage of the national screening program, the more early treatment there will be with concomitantly more favourable outcomes.

Surveillance colonoscopy has a relatively recent set of guidelines, albeit not NHMRC approved, primarily updates of several sections of the 2005 guidelines [4].

2. Provide information to show that the clinical area is:

a) high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)

Incidence

- In 2012, there were 15,840 new cases of bowel cancer in Australia, accounting for 12.7 per cent of all new cancers, excluding non-melanoma skin cancer [5, 6].
- In 2014, about 16,980 Australians are expected to be diagnosed with bowel cancer. An estimated 19,960 are expected to be diagnosed in 2020 [7]. Bowel cancer is more common in men:
    - in 2010, the age-standardised incidence rate of bowel cancer was 73.7 cases per 100,000 men, compared with 51.1 cases per 100,000 women [6].
- In 2009, the average age of bowel cancer diagnosis was 69.3 years [8].
- The risk of developing bowel cancer increases with age [6].
- In 2010 the risk of developing bowel cancer before the age of 85 was 1 in 12 [6].
- Between 1982 and 2010, incidence rates for bowel cancer in men have increased from 66.5 cases per 100,000 men in 1982 to 73.7 cases per 100,000 men in 2010, whereas incidence rates for bowel cancer in women have remained stable (51.9 cases per 100,000 women in 1982 and 51.1 cases per 100,000 women in 2010) [6].

Prevalence

- At the end of 2007, it was estimated that there were 105,144 people in Australia who were diagnosed with bowel cancer in the previous 26 years, including 45,763 people diagnosed in the previous 5 years [9].

Mortality

- In 2011, there were 3,999 deaths from bowel cancer (2,219 men and 1,780 women), accounting for 9.3 per cent of all cancer deaths in Australia [6].
- The age-standardised mortality rate for bowel cancer is higher for men:
    - in 2011, there were 19.7 deaths per 100,000 men from bowel cancer, compared with 12.7 deaths per 100,000 women [6].
- Between 1982 and 2011, the age-standardised mortality rate for bowel cancer has decreased from 31.5 deaths per 100,000 in 1982 to 15.9 deaths per 100,000 in 2011 [6].
- In 2011, the risk of dying from bowel cancer before the age of 85 was 1 in 46 [6].

Survival

- Five-year relative survival for bowel cancer for the period 2006-2010 in Australia was 65.3 per cent for men and 67.1 per cent for women [9].
- Relative survival rates for bowel cancer have increased in recent years:
    - between the periods 1982–1987 and 2006-2010, five-year relative survival increased from 48.0 per cent to 66.2 per cent [9].

Burden of disease

- Cancer is estimated to be the leading cause of the burden of disease in Australia [8].
- In 2012, bowel cancer was estimated to account for 13 per cent of the burden of disease due to cancer in Australia [8].
- In 2012, bowel cancer was estimated to account for 69,400 disability adjusted life years (DALYs); of these 56,900 were years lost due to premature death and 12,500 were years of healthy life lost due to disease, disability or injury [8].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Colorectal cancer is one of the most common forms of cancer and the second biggest killer after lung cancer. However, it is much more treatable than lung cancer particularly if detected early. In terms of trade-off, investment in colorectal cancer is very worthwhile.

Colorectal cancer was the fourth most expensive cancer in Australia. Total costs were estimated by AIHW to be $235 million in 2000-01 [10]. Treatment costs were proportionately less given the large expenditure on screening: $18,246 per case [10].

c) is a Government health priority topic

Cancer control (including colorectal cancer) is one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Updated guidelines will continue to emphasise early detection as treatment for early colorectal cancer is relatively successful compared to many other cancers. Treatment options including the use of keyhole surgery (laparascopic resection) have gained in popularity in recent years.

Clinical and treatment trials are underway in Australia on a number of fronts, but appear mainly to be focussing on better ways of applying current treatment mixes rather than introducing brand new treatment modalities.

b) reduce unwarranted variation in prevention, diagnosis or treatment,

Prevention of colorectal cancer has tended to have a strong public health focus and as such does not lend itself to clinical guidelines.

The majority of diagnosis of colorectal cancer takes place in primary care with access to pathology testing which should not be subject to unwarranted variation. The key issue is the knowledge, attitude and practice of general practitioners in case finding and advocating to their patients to undertake screening procedures.

The majority of treatment takes place in tertiary hospital settings, so should be amenable to efforts to minimise unwarranted variation via well collected, analysed and disseminated statistics on treatment and outcome variations.

Colorectal cancer is a cancer which demonstrated significantly different survival rates by socioeconomic status as designated by the area of residence at diagnosis in the period 2006–2010. 5-year survival was significantly higher in the highest socioeconomic status quintile compared with the lowest quintile [11].

NSW Bureau for Health Information data shows considerable variation between hospital emergency departments in the median time to start treatment. For example, among principal referral and major hospitals the median time to start treatment for people with cancer ranged from two to 12 minutes for triage 2, from 11 to 41 minutes for triage 3, from 16 to 60 minutes for triage 4 and from four to 49 minutes for triage 5 [12].

Aboriginal people have lower rates of access to acute care investigations and procedures and a lower likelihood of being treated for and surviving cancer. Between 2006-2012 the gap between Indigenous and non-Indigenous cancer mortality has widened while the gap in death rates from other chronic diseases has declined [13] (p.7).

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

The majority of treatment takes place in tertiary hospital settings, so should be amenable to deriving better quality and value care via well collected, analysed and disseminated statistics on treatment and outcome variations.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

There are a number of Australian clinical trials in various stages of development. These are coordinated via the Australasian Gastro-intestinal Trials Group [14]. The results of these and other international trials should be incorporated into any new guidelines.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

Bowel Cancer Australia has a number of resources available for health professionals once they have registered on their website [15].

The Royal College of Pathology of Australasia has a number of resources regarding gastrointestinal cancer reporting protocols [16], e.g. Polypectomy and local resection of the colorectum structured reporting protocol [17].

The Gastroenterological Society of Australia has a number of other resources pertaining to endoscopy as well as a clinical update on the early detection, screening and surveillance for bowel cancer [18].

The Royal Australian College of General Practitioners publishes its Guidelines for preventive activities in general practice (now 8th edition), known as the Red Book. It contains detailed advice regarding colorectal cancer [19].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Congenital Conditions**
Key audiences for the guideline:	**Obstetricians** **Midwives** **Neonatologists** **Paediatricians** **General Practitioners** **General practice nurses** **Paediatric Cardiologists** **Cardiac Nurses** **Ultrasonographers**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Routine newborn assessment [1]	Queensland Clinical Guidelines Steering Committee Statewide Maternity and Neonatal Clinical Network	Queensland Health	2014	2019
Clinical Practice Guidelines: Antenatal Care – Module 1 [2]	NHMRC	Department of Health	2012	2017
Prenatal assessment of fetal structural abnormalities [3]	RANZCOG*		2015	2018
Prenatal Screening and Diagnosis of Chromosomal and Genetic Abnormalities in the Fetus in Pregnancy [4]	RANZCOG*			
Prenatal Screening for Fetal Abnormalities [5]	RANZCOG*			

Proposed guideline format (if known):

*RANZCOG = The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Congenital conditions cover more than 120 different diseases and syndromes, a large proportion of which are very rare. Some are genetically transmitted, some due to parental lifestyles, but the aetiology of most is unknown.

   Pre-natal screening is increasingly effective in identifying conditions which allows expecting parents to make decisions to abort a pregnancy or for pre- or peri-natal medical intervention where feasible and/or receive counselling.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

The overall incidence reported in 2002-3 was 308 per 10,000 births [6].

The most common congenital conditions are:

Condition	**1 in x births**	**Rate per 10,000 births**
Heart defects (many different types)	1 in 128	78 [7]
Cerebral palsy	1 in 500	20 [8]
Clubfoot	1 in 1000	10 [9]
Cleft lip / palate	1 in 800	9.2 [6]
Trisomy 21 (Down syndrome)	1 in 900	11.1 (26.3 when abortions included) [6]
Hydrocephaly		4.8 (6.8 when abortions included) [6]
Developmental dysplasia of the hip	1 in 1,000	10 [10]
Anancephaly (Neural tube defects including spina bifida)	1 in 3,000	4.2 (9.8 when abortions included) [6]
Congenital hypothyroidism	1 in 3,500	2.8
Foetal alcohol spectrum disorder	Not known	
Spina bifida		2.7 [6]

Cystic fibrosis	1 in 2,500	4 [11]

Prevalence

There were 15,251 women who gave birth to babies with one or more congenital anomaly in 2002-03. This represented 3.1% of the total number of women who had given birth. Of the births with congenital anomalies 95% babies were born alive [6].

Mortality

Given the increased availability of prenatal screening, there is a relatively high level of <20 week abortions of babies identified as having major congenital conditions. Another 5 per cent of babies born with congenital abnormalities are still births [6].

Survival

Unknown

Burden of disease

This information is impossible to provide accurately given the breadth of the issues covered. However IHME estimate 2010 DALYs as follows caused by:

Pre-term birth complications 40,476
Congenital anomalies 43,467 [12]

WHO estimates DALYs from a combination of congenital anomalies for 2012 at 62,800 [13].

Hospitalisations

This information is impossible to provide given the breadth of the issues covered.

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Congenital conditions attract a high rate of intensive intervention in paediatric ICUs. The costs are not known as the diversity of conditions precludes useful combination of data.

c) is a Government health priority topic.

Congenital conditions are not a government health priority topic.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The primary preventable congenital conditions are those which are caused by the consumption of alcohol during pregnancy, by the lack of relevant immunisations and by child-bearing in older women.

b) reduce unwarranted variation in prevention, diagnosis or treatment

People should be given the opportunity to have foetal screening and appropriate counselling if an abnormal condition is discovered.

Aboriginal communities in particular should be given more education on foetal alcohol spectrum disorder.

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

Research into the survival rates of neonates in ICU might provide guidance regarding clinical decisions to invest in hopeless cases. However this is an emotionally fraught area for parents.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

This area is complex given that there are so many conditions covered. It has not been possible to identify advice in this context.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

South Australian Perinatal Practice Guidelines Massive blood transfusion [14]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Chronic Obstructive Pulmonary Disease**
Key audiences for the guideline:	General practitioners Primary healthcare nurses Pharmacists Respiratory physicians Respiratory nurses Respiratory educators Geriatricians Physiotherapists

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
The COPD-X Plan: Australia and New Zealand Guidelines for the management of chronic obstructive pulmonary disease [1]	Lung Foundation Australia, The Thoracic Society of Australia and New Zealand		2104	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. ***How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?***

   Chronic obstructive pulmonary disease (COPD) is a progressive disabling disease that mainly affects older people and is characterised by severe episodes of coughing and shortness of breath. It includes emphysema and chronic bronchitis [2]. COPD, predominantly managed by general practitioners, is a complex disease in terms of diagnosis due to many co-morbidities [1].

   Assisting smokers to quit is the main intervention to slow the long term deterioration in lung function associated with COPD [3]. Other interventions for COPD that can help maintain quality of life are medications (e.g. long acting bronchodilators) [4], oxygen therapy [2, 5] and pulmonary rehabilitation [2]. An important aspect of diagnosing and managing COPD is to prevent comorbid conditions such as influenza, which can have severe, even fatal consequences for the COPD sufferer [1].

   COPD can be diagnosed via a diagnostic test called "spirometry". Diagnosis is important in order to manage, and therefore slow, the condition and monitor or prevent potentially fatal comorbidities including heart failure [6].

   Provide information to show that the clinical area is:

a. high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations) and / or

Incidence

- In 2012/13 COPD was the principal diagnosis for 59,700 hospitalisations; with 1,052 admissions/100,000 population [2].

Prevalence

- It is estimated that one in seven Australians over the age of 40 (or 1.45 million people) have some form of COPD [7].
- 7.5% of Australians over the age of 40 have COPD with symptoms to the extent it is affecting their quality of life [7].
- Prevalence estimates of COPD in indigenous Australians, generally based on non-spirometry measures, have ranged from 15% to 39.5% [8] . ABS data suggest that COPD is 2.5% higher among indigenous than non-indigenous Australians [9]. However, a study using spirometry-based diagnosis reported no significant differences in the prevalence of COPD between indigenous and non-indigenous Australians in one areas of the Kimberly district, Western Australia [8].

Mortality

- In 2012, there were 5,923 deaths due to COPD, making it the fifth leading cause of death in Australia [2].

Survival

- People can live for many years with COPD but tend to do so with increasing levels of impairment and handicap.

Burden of disease

- In terms of disability adjusted life years (DALYs), COPD ranked as the third leading health problem in Australia and New Zealand in 2010 [10], and in terms of years of life lost (YLL) it ranked seventh (3.6% of all YLL)[10].
- WHO analysis indicated that there were 188,000 DALYs lost due to COPD in Australia in 2012 [11].
- COPD is the second leading cause of avoidable hospital admissions in Australia [7].

b. imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and /or

Hospitalisations

Cost

- An estimated $929 million was spent in 2008/9 – representing 1.3% of all direct health expenditure on diseases. Of this expenditure, 57% was on admitted patient costs, 23% was associated with prescription pharmaceuticals, 19% on out-of-hospital medical services [2].

c. is a Government health priority topic.

Not to date.

2. ***How would this guideline:***

   a. ***reduce risks and harms to consumers/ patients/ health service users***

   Clinical guidelines could serve to ensure that COPD sufferers are correctly diagnosed and managed so that progress can be slowed by a number of measures [2]. There is evidence that the earlier the intervention, including smoking cessation and pharmacotherapy, the better the lung function outcomes [4]. The majority of COPD sufferers do not seek medical assistance until their reduced lung function interferes with their daily life. Earlier intervention potentially stemming from general practitioners raising the issue of shortness of breath or activity impairment with patients who are smokers, could result in improved patient outcomes [4]. A systematic review of the literature concluded that early management in terms of treating patients with symptoms of activity limitations can positively impact the progression of the disease [12].

   Importantly, precautions such as annual flu shots and monitoring for development of chronic heart failure (CHF) can reduce the exacerbating effects of such comorbid conditions which can cause severe symptoms or even death [1, 6].

   b. ***reduce unwarranted variation in prevention, diagnosis or treatment***

   There is some evidence that more than 40% of people diagnosed with COPD may not have the condition [13]. There are significant implications for management including the administration of pharmacotherapy to treat COPD for people who do not have the condition, plus the potential to not provide the appropriate treatment for conditions such as asthma which are misdiagnosed as COPD [13].

   c. ***derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value***

   This has not been identified as an issue.

   d. ***provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?***

   None found.

3. ***Are there any other current, valid or relevant guidelines available or applicable to the Australian context?***

   UK: National Institute for Health and Care Excellence (NICE): Chronic obstructive pulmonary disease quality standard (2011) NICE Quality Standard [QS10] [14]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Delirium**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Geriatricians** **Psycho-geriatricians** **Aged care nurses** **All hospital staff**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Delirium Care Pathways [1]	AHMAC	Department of Health	2010	
Clinical Practice Guidelines for the Management of Delirium in Older People[2]	Vic Dept Health & Human Services	AHMAC	2006	expired

Proposed guideline format (if known):

We are aware that the Australian Commission on Safety and Quality in Health Care is undertaking a consultation on a draft Delirium Clinical Care Standard [3].

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Delirium is not a disease per se, but a clinical syndrome which can be brought on due to a variety of causes, from medication reaction to acute infections. It is defined by a rapid (hours or days) loss of and change to mental capacity encompassing disturbances in cognition, attention, mood, language, and psychomotor changes.

   Delirium may be diagnosed in primary care, in acute care (particularly in ICU) [4] and is common in residential aged care.

   It is most commonly observed in older people.

   Key areas for potential improvement are

   a) better identification of delirium and any pre-cursors

b) better prevention of the conditions known to precipitate delirium

c) better assessment and management of behaviours of concern.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

No national data could be discovered, but it is estimated that up to 30 per cent of acute care admissions have some form of cognitive impairment. While a significant percentage of this is due to dementia, many people with dementia also present with symptoms of delirium [5].

Prevalence

As above

Mortality

Delirium is considered a dangerous and potentially life-threatening condition if it is not identified and treated. No useful national mortality data could be identified. ABS reports 185 deaths from delirium in 2013, but this figure should be treated with caution as it is clearly understated [6]. A customised data request of AIHW could yield results. A number of smaller studies have shown that delirium was associated with increased mortality at discharge from hospital and at 12 months [7].

Survival

No national data could be identified.

Burden of disease

WHO does not report estimated DALYs* from delirium in Australia in 2012 [8].

The Institute for Health Metrics and Evaluation (IHME) does not report on delirium, which, given its prevalence, is further indication of a lack of useful reporting mechanisms.

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [9].

Hospitalisations

AIHW hospital statistics for 2011-12 only reported on delirium in its table on 'Separations for the 5 most common principal diagnoses in 3-character ICD-10-AM groupings for other sub- and non-acute care separations, public and private hospitals': there were 993 such separations [10] (p. 257).

Cost

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

No national Australian data could be identified, but in the USA it is estimated that the annual cost of delirium ranges from $38 - 152 billion (AUD$193.5 bn) [11]. As a very rough rule of thumb, Australian costs might be expected to be nine per cent of USA costs based on our 23 million population vs. their 250 million. The upper figure of AUD$17.4 billion is however likely to be an overestimate. The lower end of the range would equate to AUD$4.4 bn.

c) is a Government health priority topic.

No

3. *How would this guideline:*

a) reduce risks and harms to consumers/ patients/ health service users

Better identification of those at risk of delirium and better management of those affected are both priorities for risk reduction for patients, carers and health and aged care staff.

b) reduce unwarranted variation in prevention, diagnosis or treatment

The main driver of unwarranted variation appears to be the capability / capacity of acute care staff to recognise and manage delirium, particularly in patients with existing cognitive impairment [12].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Delirium appears to be a predictor of increased length of stay in hospitals, particularly if it is present on admission and has not resolved by discharge [13].

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Cost-effective care of patients with delirium may involve both pharmacologic and non-pharmacologic interventions. It may also include ceasing drugs which may be contributing to symptoms.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

UK – NICE: Delirium: diagnosis, prevention and management 2010 [14]
Delirium: evidence update 2012 [15]

American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults [16]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Dementia / Alzheimer's**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Geriatricians** **Psycho-geriatricians** **Aged care nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Dementia Risk Reduction: A Practical Guide for General Practitioners [1]		Department of Health		
Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) A Handbook for NSW Health Clinicians [2]	NSW Health	NSW Health	2013	
Dementia Behaviour Management Advisory Service and Dementia Collaborative Research Centres [3]		Department of Health	2012	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Dementia (of which around 70 per cent is due to Alzheimer's disease) is a progressive and usually irreversible condition characterised by increasing cognitive decline. Dementia affects thinking, behaviour and the ability to perform activities of daily living. There are currently no drugs which reverse the progression and only a handful which temporarily reduce symptoms.

   Key areas for potential improvement are

   a) earlier detection in primary care

   b) better management of Behavioural and Psychological Symptoms of Dementia (BPSD), also known as behaviours of concern.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

The risk of developing dementia roughly doubles for each additional five years of age after 65. It has been estimated that there will be 93,600 new diagnoses of dementia in 2015 [4]. It is uncommon in people under 65, but is thought to affect around 25,000 Australians in this age range [4, 5].

Dementia has grown rapidly as the population ages.

Mortality

Dementia is the third leading cause of deaths, accounting for six per cent of all Australian deaths in 2010 [5].

Survival

Dementia can progress at different rates. Formal diagnosis is on average three years after carers first become alert to symptoms and the brain normally starts undergoing clinical changes well before the onset of symptoms. The disease may continue for 12 or more years in a person who is otherwise physically well. However unless another disease kills the person first, dementia will ultimately prove fatal once the autonomic nervous system is sufficiently damaged.

Prevalence

AIHW estimates that there are more than 342,800 Australians living with dementia in 2014 with the number expected to increase to 400,000 by 2025 [6].

Burden of disease

WHO reported an estimated 197,900 DALYs* from Alzheimer's disease and other dementias in Australia in 2012 [7].

AIHW estimates of burden of disease suggest that dementia was the fourth leading cause of overall burden of disease in Australia [5].

IHME data show Alzheimer's disease has moved from 26th to 9th between 1990 and 2010. This change is largely explained by the ageing of the population. Alzheimer's disease is estimated to have contributed 57,750 years of life lost in 2010 [8]. If we assume that Alzheimer's comprises only 70 per cent of dementias, then the YLL figure for dementia may be as high as 82,500.

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [9].

Hospitalisations

Dementia is poorly identified and reported in acute care settings. An AIHW hospital dementia study estimated that people with dementia accounted for 12 per cent of the total cost of hospital care although dementia was not the only reason for treatment. Where dementia was the principal diagnosis, the average cost was $14,434 per episode compared with $5,010 for people without dementia (2.7 times higher). [10]

b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Total direct health and aged care system expenditure on people with dementia was at least $4.9 billion in 2009–10, of which about $2.0 billion was directly attributable to dementia. Of this, $1.1 billion was for permanent residents in residential aged care facilities and $408 million was for community aged care services [5].

c) *is a Government health priority topic.*

Dementia became a national health priority in 2012.

3. *How would this guideline:*

a) *reduce risks and harms to consumers/ patients/ health service users*

Australian research has shown that GPs are often unskilled and unwilling to make an early diagnosis of dementia [11]. It is increasingly accepted that early diagnosis is likely to improve the quality of life for the person living with dementia and their families and carers. The Dementia Collaborative Research Centres (CRC) has invested in a reliable, valid and efficient screen for dementia in primary care settings [12] and in training for GPs to better understand the reasons for and practicalities of screening, diagnosing and treating dementia.

b) *reduce unwarranted variation in prevention, diagnosis or treatment*

As above, unwarranted delays in diagnosing dementia due to physicians' views that there is 'no point' are not helpful to the person living with the condition or their family carers.

Prevention of dementia does not yet have a strong scientific base, but it is very reasonable to assume that maintaining good health and avoiding other chronic diseases such as diabetes and heart disease will reduce risk [13]. Obesity and diabetes are known risk factors for Alzheimer's disease [14].

The quality of care of people with psychological and behavioural symptoms of dementia has been the focus of two recent Australian guideline documents but this continues to be a challenging area for clinicians, particularly in busy acute care settings.

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

There is growing evidence that physical activity is beneficial both in reducing the risk of dementia but also in slowing the progression of the condition [15].

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

There is no indication of any imminent break-through in treatment, either pharmacological or non-pharmacological.

There is evidence of over-medication with psycholeptic agents of people living with dementia who demonstrate behaviours of concern [16, 17].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

Guidelines from overseas countries are generally dated. For example, UK Nice guidelines date from 2007 and US guidelines from 2002 [18, 19].

This dearth of new guidelines may demonstrate that there have been few changes in the management of the condition in the past decade. International guidelines can be referenced from the DCRC website (http://gpcog.com.au/guidelines.php#Australia).

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Diabetes Mellitus (Type 1, Type 2 and Gestational)**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Endocrinologists** **Diabetes educators** **Podiatrists, dieticians, exercise physiologists** **Pathologists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Guidelines for the Management of **Diabetic Retinopathy** [1]	NH&MRC	Department of Health	2008	current on NHMRC website
National Evidence Based Guideline for the **Primary Prevention** of Type 2 Diabetes [2]	NH&MRC	Department of Health	2009	2014
National Evidence Based Guideline for **Case Detection and Diagnosis** of Type 2 Diabetes [3]	NH&MRC	Department of Health	2009	2014
National Evidence Based Guideline for **Patient Education** in Type 2 Diabetes [4]	NH&MRC	Department of Health	2009	2014
National Evidence Based Guideline for **Blood Glucose Control** in Type 2 Diabetes [5]	NH&MRC	Department of Health	2009	2014
National Evidence Based Guideline for **Diagnosis, Prevention and Management of Chronic Kidney Disease** in Type 2 Diabetes [6]	NH&MRC	Department of Health	2009	2014
National Evidence-Based Guideline: **Prevention, Identification and Management of Foot Complications** in Diabetes [7]	NH&MRC	Department of Health	2011	2016
National Evidence-Based Clinical Care Guidelines for **Type 1 Diabetes for Children, Adolescents and Adults** [8]	NH&MRC	Department of Health	2011	2016
General Practice Management of Type 2 Diabetes [9]	Diabetes Australia, RACGP	Diabetes Australia	**n/a**	**n/a**

Proposed guideline format (if known):

We are aware that BakerIDI Heart & Diabetes Research Institute in partnership with The George Institute have recently been contracted by the Department of Health to review and update four type 2 diabetes guidelines for clinicians and other health professionals as part of the evolving national diabetes strategy.

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?

Type 1 diabetes is an auto-immune disease which compromises the body's ability to manufacture insulin. It is normally a fairly rapid onset condition with peak incidence in teenage years although it can strike at any age. A multiple daily insulin regime is required for the rest of one's life. There are around 130,000 Australians living with type 1 diabetes and around. The incidence is around 11 cases per 100,000 people, with 2,367 new diagnoses in 2011 [10].

Type 2 diabetes is a chronic disease normally with slow onset and with great potential for both primary and secondary prevention. It mainly affects older people but is increasingly seen in younger adults and teenagers, typically who are also obese.

Gestational diabetes is diagnosed when higher than normal blood glucose levels first appear during pregnancy. Between 3 and 8% of pregnant women will develop gestational diabetes around the 24th to 28th week of pregnancy, however, some may be earlier.

Pre-diabetes It has been estimated that there are two million Australians with 'pre-diabetes' who are at high risk of developing the disease within the next five years. Preventive action is in the form of significant lifestyle changes has the potential to avoid progression to diabetes for a large proportion of these people [11].

A significant proportion of people with diagnosable type 2 diabetes do not know that they have the condition. It has been estimated that, in Australia, for every 5 diagnosed cases of diabetes, there are 4 undiagnosed cases [12]. This implies that 799,000 Australians have undiagnosed diabetes. This proportion is slowly decreasing, as data from the first AusDIAB study in 2000 shows a 1:1 ratio [11]. Improved levels of case detection will mean earlier treatment, better management of the disease and reduced risk of serious complications which include cardiovascular disease, lower limb amputation, blindness from diabetic retinopathy, renal disease and death.

It is estimated that 999,000 Australians have diabetes [10]. Better management of all three types of the disease, implying good blood glucose control and regular screening to identify early signs of the late complications of diabetes, has a significant potential to avoid, delay and reduce the impact of late complications (including cardiovascular disease, lower limb amputation, blindness from diabetic retinopathy, renal disease and death).

2. Provide information to show that the clinical area is:

a. high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations) and / or

The incidence and prevalence of Type 2 diabetes in Australia are both growing according to many reports [13]. It is estimated that 4.6% of the Australian population (999,000 people) have diabetes. Of these the vast majority have type 2 diabetes. The incidence of type 1 diabetes is stable [14].

There are over 1.1 million Australians registered on the National Diabetes Services Scheme (NDSS) database , although the official AIHW diabetes prevalence estimates are around 10% lower than this figure, at 999,000 in 2011-12 [13].

Diabetes Australia / NDSS data shows the following number of registrants (4.6% of the population) [15]

Prevalence of diabetes in Australia according to the NDSS

Type 1	Type 2	Gestational	Total
129,000	956,000	23,600	1,108,600

The prevalence of type 2 diabetes is significantly higher in lower SES populations (twice as high) [16] (p.13), and in Aboriginal and Torres Strait Islander communities (three times higher) [17].

b. imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and /or

Diabetes must be managed by sufferers on a daily if not hourly basis in order to achieve good glycaemic control.

Daily costs for those registered with the National Diabetes Services Scheme are subsidised, e.g. glucose testing strips, needles and syringes for those administering insulin, but the subsidised cost is simply transferred to the government / taxpayer, at a cost of around $200m per annum. Most people with diabetes are taking daily medications, either metformin (low cost) or combination therapy, or eventually insulin. All those with type 1 diabetes must inject daily insulin for the rest of their lives. The cost to the PBS is not known but would be substantial.

In 2013-14 nearly 18.2 million GP items were claimed on the MBS in relation to diabetes. This number is equivalent to 4.2% of all GP items claimed. The proportion has increased from 3.2% in 2004-05, an additional 2.5 million annual contacts. BEACH data indicates that the leading reason why pathology tests are ordered by GPs relates to the diagnosis or management of diabetes [18].

Diabetes is one of the leading causes of avoidable hospitalisations and is the leading cause among those suffering chronic disease. For 2013-14, the AIHW estimated there were 40,829 potentially preventable hospitals in public and private hospitals related to diabetes. These admissions relate to patients where the primary diagnosis relates to diabetes. There are many more admissions in which:

- the admission relates to a late complication of diabetes (e.g. heart disease, stroke, peripheral vascular disease, neuropathy, renal failure, blindness)
- admitted treatment provided is complicated by the presence of diabetes as a complication [19].

Diabetes is considered to be the most rapidly growing chronic disease in Australia [20]. Renewed emphasis on guideline development and particularly on comprehensive guideline implementation will be a worthwhile investment of resources.

A major areas for focus in guideline development will be methods to support behaviour change in diabetic and pre-diabetic patients towards healthier lifestyles (weight loss, increased exercise, reduced sedentary behaviour, smoking cessation),

improved medication adherence for diabetic patients, and better adherence to screening for late complications of diabetes which include diabetic retinopathy limb amputation, cardiovascular disease, neuropathy, renal disease and death.

c. is a Government health priority topic.

Type 2 Diabetes was the first additional health priority to be added in 1997 to the original set of national health priorities established in 1996.

3. How would this guideline:

a. reduce risks and harms to consumers/ patients/ health service users

Good implementation of diabetes management guidelines requires a commitment from the medical and allied health professions as well as from individual consumers (and their families) working as partners.

Sixty percent of people with diabetes also have cardiovascular disease. Strokes and heart disease are four times more likely in people with diabetes than in people without the disease, so it is important that other chronic disease states are taken into account [13] [21].

Hyperglycaemia in pregnancy, including gestational diabetes, is associated with an increased risk of maternal and infant adverse outcomes [22] [23].

Adverse outcomes for women with gestational diabetes	
Pregnancy associated hypertension	Caesarean section
3rd and 4th degree perineal tear	Operative vaginal birth
Type 2 diabetes in later life	Preterm labour
Postpartum haemorrhage	Polyhydramnios
Adverse outcomes for infants born to women with gestational diabetes	
Shoulder dystocia	Bone fractures, nerve palsy
Macrosomia	Large for gestational age
Hypoglycaemia	Hyperbilirubinaemia
Congenital malformation	Small for gestational age
Respiratory distress syndrome	Stillbirth
Overweight and childhood obesity	Type 2 diabetes in later life
Metabolic syndrome in later life	

Source: NZ Ministry of Health: Screening, Diagnosis and Management of Gestational Diabetes in New Zealand A clinical practice guideline [24]

b. reduce unwarranted variation in prevention, diagnosis or treatment

As discussed above, there is a very high prevalence of people both with pre-diabetes and with un-diagnosed type 2 diabetes. As such, a guideline which emphasised the need to prevent progression to diagnosable diabetes and the need for earlier diagnosis to ensure timely treatment is very desirable. This needs to be coupled with enhanced efforts to educate and motivate the general public at risk community.

Structured lifestyle intervention programs to support people with pre-diabetes have been found to reduce diabetes risk by between 43–58% across several international trials (USA, China, Finland and India) [25] [26] [27].

The ANDIAB 2010 Quality Assurance of Patient Practices and Diabetes Centre Care report shows that only two thirds of people with type 2 diabetes have had a session with a diabetes educator within the previous 12 months [28].

Treatment for diabetes is highly dependent on patient preferences regarding self-management expectations.

Diabetes is up to five times more prevalent in Aboriginal and Torres Strait Islander communities than in non-indigenous communities, with striking increases with remoteness, where nearly 21 per cent of the indigenous population was found to have diabetes [29].

c. *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

In the case of type 2 diabetes, it is clear that under-utilisation of diabetes education and of co-ordinated care by a team of health professionals can have a major impact on the health outcomes of a person who does not self-manage their condition well.

Medication non-adherence is known to be a common problem in people living with type 2 diabetes [30].

Better management of glucose control will result in improved health outcomes and fewer preventable hospitalisations, reduced years of disability and

Diabetes patients are encouraged to have their eyes checked at least bi-annually for signs of diabetic retinopathy. They are also encouraged to have their feet checked six-monthly by a qualified podiatrist.

d. *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

In the case of type 2 diabetes, advice about more aggressive treatment might be of value.

Guidelines may need to be enhanced to provide guidance on screening for undetected diabetes in general practice.

The AUSDIAB study which has been following a large cohort of Australians since 2001 (last report 2012) clearly shows how sustained intervention by clinicians with their diabetic patients has a positive impact [16].

'There are more cost-effective interventions with a ***moderate impact*** on population health (between 10,000 and 100,000 DALYs prevented per intervention). The main missed opportunities at the national level among these are screening programs for **pre-diabetes**, chronic kidney disease and low bone mineral density in elderly women [31].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

Guidelines for the Assessment and Management of Absolute Cardiovascular Risk [32].

UK Diabetes in Pregnancy [33]

NZ Gestational Diabetes [24]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Glaucoma**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Ophthalmologists** **Optometrists** **Orthoptists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Guidelines for the screening, prognosis, diagnosis, management and prevention of glaucoma [1]	NHMRC		2010	2015
A guide to glaucoma for primary health care providers [2]	NHMRC		2011	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Early detection and treatment is key to improved health outcomes and prevention of blindness from glaucoma. Once the disease is established it cannot be reversed, but medication or laser surgery can delay or slow further progression.

   Key areas for potential improvement are

   - Community awareness – particularly among older people
   - Regular eye checks for at risk populations
   - Patient education and follow-up re medication adherence

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

As the Australian population ages, there will be an inevitable increase in the number of people living with glaucoma. An Italian study by Cedrone et al shows an annual incidence of glaucoma of 0.32 per cent [3]. Similar Australian data could not be found.

Prevalence

It is estimated that there are 300,000 Australians living with glaucoma, but that half of this number is unaware of their disease [4]. AIHW puts the number at 200,000 but does not indicate whether these are formally diagnosed or not [5].

Mortality

Glaucoma is not a fatal condition.

Survival

Glaucoma is not a fatal condition.

Burden of disease

WHO does not report estimated DALYs from glaucoma in Australia [6].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [7].

Hospitalisations

We have been unable to source specific data regarding glaucoma hospitalisations, however specialist hospitals such as the Sydney Eye Hospital, a quaternary referral unit, provide surgical and medical management of glaucoma, among other eye conditions. Treatment includes laser surgery and drainage surgery which is also available privately.

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Advanced glaucoma is largely preventable, through active screening and good patient follow-up / medication adherence. As such, investment in community awareness, GP and optometrist training and in mechanisms to facilitate patient follow-up should pay dividends.

The cost of glaucoma surgery such as Selective Laser Trabeculoplasty is quick and relatively simple [8]. Costs are not known as reports on the amount of surgery undertaken are not readily available.

c) is a Government health priority topic.

Eye health is not a government health priority but the federal government did establish a national framework for action to promote eye health and prevent avoidable blindness in 2005. The second progress report in 2012 outlines the key action areas of

- Reducing the risk of eye disease and injury

- Increasing early detection
- Improving access to eye health services
- Improving the systems and quality of care
- Improving the underlying evidence base [9]

WHO has been working with the Australian government to develop further information regarding eye health data collections [10].

3. *How would this guideline:*

   a) *reduce risks and harms to consumers/ patients/ health service users*

   Better structured detection would reduce the burden of glaucoma.

   b) *reduce unwarranted variation in prevention, diagnosis or treatment*

   Telemedicine is a growing option for increasing numbers of people living in remote or inaccessible areas (including residential aged care). Tele-ophthalmology machines are now available which allow ophthalmologists to make diagnoses using high definition telephotography and other electronic measuring tools [11].

   c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

   A quick literature search demonstrates that there is no compelling evidence of a need to change glaucoma treatments beyond maintaining awareness of emerging research evidence regarding new surgical techniques.

   More importantly, ensuring strong community and health provider awareness of glaucoma and the opportunity to delay its progression is a most important aspect of glaucoma control.

   d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

   Laser surgery techniques include

   - Laser trabeculoplasty – small areas of the trabecular meshwork are treated to improve drainage
   - Laser ididotomy – a small hole is made in the iris to allow aqueous humour to flow more freely
   - Cyclophotocoagulation – parts of the ciliary body are destroyed so that less aqueous humour is produced [12].

   These techniques are likely to be refined over coming years.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

   - Canadian and USA guidelines date from 2009 and 2010 respectively [13] [14].
   - UK guidelines were also published in 2009 [15].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	Hospital acquired infection (HAI) prevention			
Key audiences for the guideline:	Paramedics Clinical educators All hospital staff			
Existing Australian guidelines:				
Guideline	**Approved by**	**Funded by**	**When approved**	**Expiry date**
Australian Guidelines for the Prevention and Control of Infection in Healthcare [1]	NHMRC	Australian Commission on Safety and Quality in Health Care	2010	2015
Proposed guideline format (if known):				

1. ***How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?***

There are guidelines (as noted above) that are now five years old and therefore expiring.

Hospital patients who acquire infections such as *Staphylococcus aureus* bacteraemia (SAB) in the course of their hospital stay are more likely to develop complications that result in a longer stay in hospital. These infections are associated with increased costs, and serious infections can result in death [2]. The prevention of hospital acquired infections has significant potential to reduce hospital costs, decrease patient pain and suffering and save lives.

Of recent concern is the increase in multidrug-resistant (MDR)gram-negative bacilli (GNB) [3]. Harris et al report that bloodstream infections caused by antibiotic-resistant GNB have been associated with high mortality rates [3]. With still limited availability of new antibiotics that can successfully combat MDR GNB, it is imperative that we have an agreed and coordinated approach to their prevention and control, including enhanced surveillance, screening of at-risk patients and improved infection control practices [3].

It has been estimated that a reduction of even just one percent of HAIs would mean a reduction in over 150,000 hospital bed days [4].

2. ***Provide information to show that the clinical area is:***

   a. ***high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)***

Incidence

Healthcare-associated infections can be bloodstream infections or localised infections, such as those associated with surgical sites [2]. Such infections are the most common complication stemming from hospital stays, and represent 200,000 events each year [5]. Other nosocomial infections such as influenza have been reported as not being common, but can be significantly increase the length of stay and in rare cases can be fatal, primarily due to comorbidities [6].

HAIs cause patients pain and suffering, prolonging hospital stays and increasing costs to the healthcare system [1,7].

Graves et al, who developed a quantitative algorithm for public hospital health-care acquired infection and resultant bed-days lost annually, estimated that approximately 175,000 cases occur annually among admitted patients in Australian public hospitals [4].

Prevalence

European, British and Australian point prevalence studies have shown prevalence to be in the range of 2.3 – 10.8 per cent [8, 9, 10]. The British study provided a breakdown of the most common HAI system infections as follows:

- gastrointestinal (20.6%)
- urinary tract (19.9%)
- surgical site (14.5%)
- pneumonia (14.1%)
- skin and soft tissue (10.4%)
- primary bloodstream (7.0%)

Prevalence of Methicillin-resistant Staphylococcus aureus (MRSA) was 1.15% with MRSA being the causative organism in 15.8% of all system infections. Prevalence of Clostridium difficile was 1.21% [10] .

AIHW reports on the prevalence of SAB in public hospitals. In 2013–14, SAB rates ranged from 0.56 cases per 10,000 days in South Australia to 1.05 cases per 10,000 in the Northern Territory. The national SAB rate decreased from 1.1 cases to 0.87 cases per 10,000 days of patient care [2].

Between 2010–11 and 2012–13, the national rates of SAB decreased from 1.1 cases per 10,000 patient days under surveillance to 0.9 cases per 10,000. Rates decreased in New South Wales and the Northern Territory, rose in the Australian Capital Territory, and fluctuated or remained about the same in the other states.

Mortality

There is no national reporting of mortality from HAI in Australia. As such, extrapolations would need to be undertaken from small studies such as one in 2012 comparing factors influencing mortality, length of stay and cost of hospitalisation in two Melbourne hospitals [11]. It is understood that in the UK 5,000 people die from antibiotic resistant infections each year and across Europe this number is reported to be 25,000 [12] .

Survival

There were 1,724 cases of SAB reported in Australian public hospitals in 2011-12, of which 77% were methicillin sensitive, and therefore treatable with commonly used antibiotics [2].

Burden of disease

There is no national reporting of burden of disease from HAI. As such, extrapolations would need to be undertaken from small studies such as one in 2012 comparing factors influencing mortality, length of stay and cost of hospitalisation in two Melbourne hospitals [11].

Hospitalisations

The additional length of stay as a result of these infections, has been estimated to account for approximately an additional 854,300 bed days in Australian public hospitals. As these infections are preventable, Graves et al indicate, this translates to an additional 38,500 patients could be admitted to hospital each year, if these bed days were eliminated [4].

b) *it imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Graves et al have indicated that based on 2004-05 figures the gross economic burden of HAI was over $942 million (95% confidence interval $695 million to $1.2 billion) [4]. While the researchers report that this figure should be treated with caution - there is little doubt that the cost to the health system is huge.

A 2013 report to the Australian Commission on Safety and Quality in Health Care by Health Policy Analysis indicated that costs are estimated for specific infections acquired during hospitalisation added an estimated $7,615 per episode [13].

c) is a Government health priority topic.

Injury prevention and control was chosen as a national health priority in the initial round in 1996. However, HAI is not currently an explicit health priority topic.

d) How would this guideline:

a. reduce risks and harms to consumers/ patients/ health service users

Prevention methods include administrative controls, barrier methods and administering flu vaccines to patients and staff [6].

Since the national introduction of standardised HAI surveillance in 2008, rates have reduced significantly [14].

b. *reduce unwarranted variation in prevention, diagnosis or treatment*

While there are limitations in current surveillance of nosocomial infections, a quick review of the literature does suggest unwarranted variation in diagnosis or treatment is an issue, with SAB infection rates significantly lower in South Australia than all other jurisdictions [15].

c. *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

The recent reduction in HAI from 1.10 to 0.87 cases per 10,000 days of patient care is a welcome development, but it must be maintained as a priority, given the real risk of increasing antibiotic resistance [15].

d. *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

There does not appear to new evidence, but there are a very strong indications that improving known current poor practices will lead to a significant reduction in HAI. Much effort is being expended on developing new classes of antibiotics which will be effective against currently resistant bacteria.

e) *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

Australian Commission on Safety and Quality in Health Care. *Recommendations for the control of Multi-drug resistant Gram-negatives: carbapenem resistant Enterobacteriaceae* [16]

UK: National Institute for Health and Care Excellence (NICE): Diagnosis and management of community- and hospital-acquired pneumonia in adults. December 2014 [17]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Ischaemic heart disease (IHD)**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Occupational Therapists** **Cardiac Surgeons** **Cardiac Nurses** **Physiotherapists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Guidelines for the assessment and management of absolute cardiovascular disease risk [1]	NHMRC RACGP	Depart-ment of Health	2012	2017
Reducing risk in heart disease - an expert guide to clinical practice for secondary prevention of coronary heart disease [2]	RACGP, ACRA, IMSANZ, Royal Coll Nursing Australia		2012	
Guidelines for the management of acute coronary syndromes [3] [4]	NHF CSANZ		2006 (with 2011 addendum)	
The Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (2nd edition) [5] [6]	NHF CSANZ		2012	
Acute Coronary Syndromes Clinical Care Standard [7]	Australian Commission on Safety and Quality in Health Care		2014	

Proposed guideline format (if known):

* RACGP = Royal Australian College of General Practitioners; ACRA = Australian Cardiovascular Health and Rehabilitation Association; IMSANZ = Internal Medicine Society of Australia & New Zealand; NHF = National Heart Foundation; CSANZ = Cardiac Society of Australia & New Zealand

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   The best acute myocardial infarction (AMI) treatment outcome relies on minimising the 'golden hours' from first onset of symptoms to being treated in a tertiary care facility. This implies a focus for community awareness of symptoms, ambulance service efficiency and emergency department capacity.

   The other main focus of IHD management (or secondary prevention) is on rehabilitation which may be both lengthy and limited in outcome as many patients do not adhere to rehabilitation or medication regimens [8].

   A focus on risk reduction (diet, exercise, smoking, alcohol, obesity, hypertension, hyperlipidemia /dyslipidemia) and earlier detection will be of practical benefit for both primary and secondary prevention.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

While there are no accurate incidence data on in Australia, AIHW estimates 47,400 people aged 40-90 had a heart attack in 2009 with men twice as likely as women to suffer an event [9, 10].

Prevalence

AIHW estimated three per cent of the population (around 685,000 people) have IHD in 2007-08 of whom 350,000 have suffered an AMI [9]. By comparison, around 999,000 people have type 2 diabetes.

Mortality

In 2013 Ischaemic heart disease was Australia's leading cause of death [11]. ABS data for 2004, 2008 and 2013 shows IHD as the leading cause of death in Australia, but with reducing numbers over the time span [11].

Cause of death & ICD code	2004	rank	2008	rank	2013	rank
Ischaemic heart diseases (I20-I25)	24 576	1	23 813	1	19 766	1
Cerebrovascular diseases (I60-I69)	12 041	2	11 979	2	10 549	3
Dementia and Alzheimer disease (F01, F03, G30)	4 606	5	8 172	3	10 993	2

Survival

It was expected that around 10,000 deaths would occur from AMI in 2009. It has been estimated that 76 per cent of AMI deaths occurred prior to admission to hospital [12]. This translates to a survival rate of 79 per cent.

Burden of disease

WHO estimates Australian DALYs* in 2012 from ischaemic heart disease at 362,700 [13].

Australian data published in 2015 by AIHW do not differentiate ischaemic heart disease from other cardiovascular diseases, but this could be requested [14].

IHME data show ischaemic heart disease ranks no. 1 in 2010 with an estimated 342,182 Years of Life Lost in Australia [15]. It has shown the largest decrease of all diseases measured between 1990 and 2010, falling by 28 per cent [15].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [16].

Hospitalisations

According to AIHW, 34 per cent of cardiovascular disease hospitalisations were due to IHD, a rate of approximately 1,450 per 100,000 population [17].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Due to the need for urgent acute care treatment for everyone who suffers IHD, it is a relatively high cost condition. Those who survive are normally prescribed a range of medications including beta blockers as well as a cardiac rehabilitation regimen.

c) is a Government health priority topic.

Cardiovascular disease was one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The National Vascular Disease Prevention Alliance has taken a strong leading role in developing and promulgating clinical guidelines. The Foundation has made it clear that the promulgation and implementation of guidelines is every bit as important as their development. In the context of IHD, primary and secondary prevention should be strongly emphasised in primary care settings.

b) reduce unwarranted variation in prevention, diagnosis or treatment

People living in rural and remote areas will always have a worse prognosis from AMI if they cannot be transported to tertiary care centres within a sufficiently short time frame.

Death rates from heart disease are substantially higher among Aboriginal and Torres Strait Islander Australians, ranging from 1.5 to 3 times higher than in non-Indigenous Australians [18].

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

Ensuring speedy access to tertiary medical carer for acute myocardial infarction, and effective access to rehabilitation for those recovering from it are seen as the best mechanisms for reducing the impact of IHD.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

By undertaking a detailed literature search, a new set of clinical guidelines would ensure that Australia is up to date with best practice in the rest of the developed world. There are no obvious changes which need to be urgently adopted base on a quick literature review. Controversy regarding potential interactions between the antiplatelet effect of clopidogrel and proton pump inhibitors remains, without firm conclusions on clinical implications [19] (p 2605).

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

- UK national clinical guideline diagnosing and managing acute heart failure [20]
- USA Management of stable ischemic heart disease: summary of a clinical practice guideline [21]
- European Society of Cardiology Guidelines [22]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Kidney Cancer**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Pathologists** **Cancer nurses** **Nephrologists** **Urologists** **Urologic oncologists** **Medical oncologists** **Surgeons**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
NIL				

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Kidney cancer is typically treated with surgical resection combined with targeted therapy such as antiangiogenic therapy. Improvements in both areas and particularly in targeted therapy have the potential to improve patient care and health outcomes.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

- In 2010, there were 2,712 new cases of kidney cancer in Australia (1,709 new cases in men and 1,003 new cases in women), accounting for 2.3 per cent of all new cancers [1].

- In 2014, about 3,330 Australians (2,290 men and 1,040 women) are expected to be diagnosed with kidney cancer [2].
- In 2020, an estimated 4,130 Australians are expected to be diagnosed with kidney cancer [2].
- Kidney cancer is more common in men:
    - in 2010, the age-standardised incidence rate of kidney cancer was 15.1 cases per 100,000 men, compared with 8.1 cases per 100,000 women [1].
- In 2009, the average age of kidney cancer diagnosis was 63.4 years [3].
- The risk of developing kidney cancer increases with age [1].
- In 2010, the risk of developing kidney cancer before the age of 85 was 1 in 70 [1].
- Incidence rates for kidney cancer have increased in recent years, from 6.2 cases per 100,000 people in 1982, to 11.4 cases per 100,000 people in 2010 [1].

Prevalence

- At the end of 2007, it was estimated that there were 18,934 people in Australia who were diagnosed with kidney cancer in the previous 26 years, including 8,582 diagnosed in the previous 5 years [4].

Mortality

- In 2011, there were 877 deaths from kidney cancer (557 men and 320 women), accounting for 2.0 per cent of all cancer deaths in Australia [1].
- The age-standardised mortality rate for kidney cancer is higher for men:
    - in 2011, there were 4.9 deaths per 100,000 men from kidney cancer, compared with 2.3 deaths per 100,000 women [1].
- Between 1982 and 2011, there was little change in the age-standardised mortality rate for kidney cancer. There were 3.9 deaths per 100,000 in 1982, and 3.5 deaths per 100,000 in 2011 from kidney cancer [1].
- In 2011, the risk of dying from kidney cancer before the age of 85 years was 1 in 218 [1].

Survival

- Relative survival rates for kidney cancer have increased in recent years in Australia:
    - between the periods 1982–1987 and 2006-2010, five-year relative survival increased from 47.4 per cent to 71.9 per cent [4].

Burden of disease

- Cancer is estimated to be the leading cause of the burden of disease in Australia [3].
- In 2012, kidney cancer was estimated to account for 14,300 disability-adjusted life years (DALYs*) in Australia; of these 12,200 were years lost due to premature death and 2,100 were years of healthy life lost due to disease, disability or injury [3].

*DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury. This is the basis unit used in burden of disease or injury estimates [3].

b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Kidney cancer is not individually listed on the World Health Organization's estimated DALYs by cause, sex and member state [5].

c) *is a Government health priority topic.*

Cancer control is one of the federal government's original national health priorities established in 1996. Kidney cancer is amenable to improved control via increased early detection. Survival rates have grown significantly over the past 26 years from 47 per cent to 72 per cent largely through improved detection [4].

3. *How would this guideline:*

a) *reduce risks and harms to consumers/ patients/ health service users*

Kidney cancer has a relatively high five year survival rate among all cancers of 72 per cent (average 66 per cent) [4]. The primary treatment risk is from complications from or ineffective resection surgery.

b) *reduce unwarranted variation in prevention, diagnosis or treatment*

Any standardisation of surgery might improve patient outcomes, but only marginally. A focus on earlier detection will add significantly to better patient outcomes. A focus on reducing the known risk factor of long-term pain mediation use may also improve prevention outcomes.

NSW Bureau for Health Information data shows considerable variation between hospital emergency departments in the median time to start treatment. For example, among principal referral and major hospitals the median time to start treatment for people with cancer ranged from two to 12 minutes for triage 2, from 11 to 41 minutes for triage 3, from 16 to 60 minutes for triage 4 and from four to 49 minutes for triage 5 [6].

Aboriginal people have lower rates of access to acute care investigations and procedures and a lower likelihood of being treated for and surviving cancer. Between 2006-2012 the gap between Indigenous and non-Indigenous cancer mortality has widened while the gap in death rates from other chronic diseases has declined [7] (p.7).

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

Developments in monoclonal antibody treatments (e.g. Sunitinib) may well offer useful new therapeutic opportunities to treat kidney cancer [8].

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

Monoclonal antibody treatment is showing significant potential to provide a new level of treatment to this condition.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

The European Society for Medical Oncology published clinical practice guidelines in 2014 [9].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	LRTI / Pneumonia
Key audiences for the guideline:	General practitioners Primary healthcare nurses Pharmacists Emergency Department physicians

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Adult pneumonia guideline (community and hospital acquired) [1]	Hunter New England Local Health District (NSW)		2012	
Clinical practice guidelines - pneumonia in a previously well child aged more than one month [2]	The Royal Children's Hospital Melbourne		n.d.	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. ***How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?***

Pneumonia is characterised by an acute inflammation of the lungs in response to viral or bacterial infection. Air sacs become flooded with fluid and affected areas of the lung become solid

General practice managed respiratory problems more than any other condition.

AIHW report on combined influenza and pneumonia data in their standard reporting.

2. ***Provide information to show that the clinical area is:***
   a. ***high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations) and / or***

Incidence

According to AIHW there is no comprehensive data on the incidence of pneumonia.

Prevalence

Mortality

Influenza or pneumonia was the underlying cause of 2,715 deaths (1,220 males and 1,495 females) in 2006, two per cent of all deaths. The death rate was higher amongst males (14.1) than females (10.2) [3].

In 2006, in addition to the deaths where influenza or pneumonia was reported as the underlying cause, there were 14,069 deaths where influenza or pneumonia was considered contributory [3].

Men over 85 had the highest death rate from influenza or pneumonia reported to be 560 per 100,000 in 2006 [3].

Hospitalisations

In 2006–07, influenza and pneumonia were reported as the principal diagnoses during 61,014 hospitalisations. This was 280 per 100,000 people and 0.8 per cent of the 7.3 million total hospitalisations in the year. In addition to the hospitalisations where influenza or pneumonia was recorded as a primary diagnosis, there were 45,706 hospitalisations where they were recorded as at least one of the additional diagnoses [3].

Burden of disease

- World Health Organization burden of disease measures indicated 37,300 DALYs due to LRTI [4].

- 42,507 DALYs were caused by LRTI in Australia in 2010 according to the Global Burden of Disease data presented by IHME [5].

b. imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and /or

Cost

The cost of managing LRTIs and pneumonia is a particular challenge for acute care hospitals during winter months. If there is an influenza epidemic, the rate of hospitalisation and of hospital acquired infections will have a significant impact on bed availability. Actual cost data was not readily available, but savings could result from reduced rates of hospitalisation, where appropriate, both for LRTI/pneumonia and for other causes which result in hospital acquired infection. This would however require improved resourcing of primary and aged care to compensate.

c. is a Government health priority topic.

LRTI and pneumonia are not National Health Priorities.

3. How would this guideline:

a. reduce risks and harms to consumers/ patients/ health service users

Clinical guidelines could serve to ensure that more people are correctly diagnosed with LRTI or pneumonia in order that treatment commence as soon as possible. Pneumonia is a significant cause of mortality of older people whose immune systems are compromised by other chronic respiratory conditions.

b. reduce unwarranted variation in prevention, diagnosis or treatment

A reduction in both passive and active smoking will have a positive effect on the risk of developing LRTI or pneumonia. The winter seasonal spikes in pneumonia and LRTI hospital separations mirror those of COPD, indicating the potential links between the acute and chronic conditions [3].

Data regarding Aboriginal and Torres Strait Islander hospitalisations for pneumonia demonstrate a rate four times higher than for other Australians from 2004-06 [3].

c. derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

A brief review of the literature has not located any recent systematic reviews or meta-analyses.

Immunisation against streptococcus pneumoniae is targeted at children under 6 months and people over 65 years who are additionally at risk due to other chronic diseases, smoking, or Aboriginality [3].

Due to the relationship between influenza and pneumonia and other LRTIs, vaccination against influenza is an important prevention strategy which could be more actively promoted, particularly among the older population and other at risk groups such as pregnant women.

d. provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Not that we can find.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

UK: Guidelines for the management of adult lower respiratory tract infections [6]

USA:

The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of Age: Clinical Practice Guidelines [7]

Consensus Guidelines on the Management of Community-Acquired Pneumonia in Adults [8]

American Family Physician has an extensive pneumonia topic collection on its website [9]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	Lung cancer
Key audiences for the guideline:	General practitioners General practice nurses Oncologists Oncology nurses Thoracic surgeons

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Practice Guidelines for the Prevention, Diagnosis and Management of Lung Cancer [1]	Cancer Council Australia		2004	
Investigating symptoms of lung cancer: a guide for GPs [2]	RACGP	Cancer Australia	2012	
Clinical practice guidelines for the treatment of lung cancer [3]	Cancer Council Australia	Cancer Australia	2012*	
Guidelines for the Diagnosis and Treatment of Malignant Pleural Mesothelioma [4]	NHMRC Cancer Institute NSW	Biaggio Signorelli Foundation; Cancer Institute NSW and Cancer Council NSW	2013	2018
Supporting smoking cessation: a guide for health professionals [5]	RACGP	RACGP	2014	

Proposed guideline format (if known):

* The scope of the current revision of the 2004 guidelines is limited to the treatment of non-small cell and small cell lung cancer (chapters 5 and 6 respectively), supportive care and palliative care (chapters 4, 7 and 8) [6].

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. ***How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?***

Prevention should be a major focus given the significant proportion of lung cancers which are related to smoking

Lung cancer generally has a very poor prognosis, but a focus on palliation and psycho-oncology can assist patients, families and health providers. Surgical resection and/or lobectomy show good evidence in improving survival rates in non-small cell lung cancer which comprise around 85 per cent of all lung cancers.

2. *Provide information to show that the clinical area is:*

a. *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Lung cancer is more prevalent among smokers than non-smokers. As the prevalence of smoking is higher in lower SES groups, and particularly high in Aboriginal & Torres Strait Islander communities [7] and in migrants from middle-eastern backgrounds [8], the burden of this disease will be disproportionately large in the above populations.

b. *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Key facts on lung cancer [9] include:

Incidence:

- In 2010, there were 10,296 new cases of lung cancer diagnosed (6,251 in men; 4,045 in women). For men and women separately, lung cancer is the 4th most commonly diagnosed cancer for men (after prostate, bowel and melanoma of the skin) and for women (after breast, bowel and melanoma of the skin).
- In 2010, the risk of developing lung cancer before the age of 85 was 1 in 16.
- The number of people with a lung cancer diagnosis is projected to increase as follows:
    - 2014 - 11,550 people
    - 2020 - 13,640 people
- The incidence of people diagnosed with lung cancer in Australia has:
    - decreased for men from 85.0 to 56.4 cases per 100,000 between 1982 and 2010
    - Increased for women from 18.1 to 31.7 cases per 100,000 between 1982 and 2010.
- In 2009, the average age of first diagnosis of lung cancer was 71.0 years for men and 69.9 years for women. The risk of developing lung cancer increases with age.

Prevalence

- At the end of 2007, it was estimated that there were 19,854 people alive who had been diagnosed with lung cancer in the previous 26 years, including 12,606 people diagnosed in the previous 5 years.

Mortality

- In 2011, lung cancer was the most common cause of cancer death for men and women (8,114 deaths overall: 4,959 in men; 3,155 in women), accounting for 18.8 per cent of all cancer deaths.
- In 2011, the age-standardised mortality rate was 32.6 deaths per 100,000 people (43.8 deaths per 100,000 for men and 23.7 deaths per 100,000 for women).
- Between 1982 and 2011, mortality rates for lung cancer:
    - decreased in men (from 78.9 to 43.8 deaths per 100,000.

- increased in women (from 15.4 to 23.7 deaths per 100,000.
- In 2011, the risk of dying from lung cancer before the age of 85 was 1 in 21.[1]
- It was estimated for 2008, that the age-standardised mortality rate from lung cancer in Australia was significantly lower than the rates for Northern America, Northern Europe and Eastern Asia.

Survival

- Lung cancer is an expensive disease to treat.
- Survival rates for lung cancer are poor. The five-year relative survival for 2006-2010 for lung cancer in Australia was 14.1 per cent; the rate was higher for women (16.5 per cent) than for men (12.6 per cent).
- There was an increase in five-year relative survival for lung cancer from 8.7 per cent for the period 1982-1987 to 14.1 per cent for 2006-2010.

Burden of disease

- Cancer is estimated to be the leading cause of the burden of disease in Australia.
- In 2012, lung cancer was expected to be the leading cause of burden of disease due to cancer among men (57,300 DALYs, accounting for 19 per cent of the total cancer burden).
- In 2012, lung cancer was expected to be the second highest burden of disease due to cancer among women (43,400 DALYs, accounting for 17 per cent of the total cancer burden).

Hospitalisations

- Lung cancer was the seventh most common reason for hospitalisation with a principal diagnosis of cancer in 2010-11 [10].

Cancer type	Same day	Overnight	Total
Lung cancer	3,887	13,845	17,732

c. is a Government health priority topic.

Cancer control (including lung cancer) is one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a. reduce risks and harms to consumers/ patients/ health service users

A focus on prevention of lung cancer through smoking cessation is of primary importance

b. reduce unwarranted variation in prevention, diagnosis or treatment

The updated guidelines could articulate optimal regimens for chemotherapy and radiotherapy for all stages of the disease. They could also provide more guidance on improving multi-disciplinary teamwork in cancer care. Access to psychological and palliative care services, which is variable across the country, could be emphasised.

NSW Bureau for Health Information data shows considerable variation between hospital emergency departments in the median time to start treatment. For example, among principal referral and major hospitals the

median time to start treatment for people with cancer ranged from two to 12 minutes for triage 2, from 11 to 41 minutes for triage 3, from 16 to 60 minutes for triage 4 and from four to 49 minutes for triage 5 [11].

Aboriginal people have lower rates of access to acute care investigations and procedures and a lower likelihood of being treated for and surviving cancer. Between 2006-2012 the gap between Indigenous and non-Indigenous cancer mortality has widened while the gap in death rates from other chronic diseases has declined [12] (p.7).

c. *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

The updated guidelines make a number of suggestions based on B grade evidence for non-treatment with radiotherapy or chemotherapy in specific situations.

d. *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

The updated guidelines make a number of suggestions based on B grade evidence for non-treatment with radiotherapy or chemotherapy in specific situations.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

- Royal College of Pathologists of Australasia, Lung cancer structured reporting protocol [13]
- South Australian Lung Cancer Pathway [14]
- Cancer Institute New South Wales Oncology Group – Lung:
  - Treatment Algorithms for the Management of Lung Cancer in NSW - Guide for clinicians [15]
  - Management of Non-Small Cell Lung Cancer - Guide for general practitioners [16]
  - Management of Non-Small Cell Lung Cancer - Guide for consumers [17]
- USA National Cancer Institute: Non-Small Cell Lung Cancer Treatment –for health professionals [18]
- Health Improvement Scotland: Management of lung cancer – a national clinical guideline [19]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Lymphoma**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Oncology nurses** **Haematologists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Practice Guidelines for the Diagnosis and Management of Lymphoma [1]	NHMRC	Department of Health	2005	2010

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Lymphoma is a cancer of the lymph glands. It is sub-classified into Hodgkin and non-Hodgkin with the latter accounting for around 90 per cent of lymphomas, and 3.8 per cent of all new cancers while Hodgkin lymphoma accounts for 0.5 per cent of all new cancers [2].

   Early detection and treatment is, like all cancers, the key to improved health outcomes and survival rates.

   A key area for potential improvement is

   - Detection by General Practitioners in primary care

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Non-Hodgkin lymphoma

Incidence

- In 2010, there were 4,462 new cases of non-Hodgkin lymphoma in Australia (2,545 new cases in men and 1,918 new cases in women), accounting for 3.8 per cent of all new cancers [3].
- In 2014, about 5,030 Australians (2,870 men and 2,160 women) are expected to be diagnosed with non-Hodgkin lymphoma [4].
- In 2020, an estimated 5,950 Australians are expected to be diagnosed with non-Hodgkin lymphoma [4].
- Non-Hodgkin lymphoma is more common in men:
    - In 2010, the age-standardised incidence rate of non-Hodgkin lymphoma was 22.6 cases per 100,000 men, compared with 15.2 cases per 100,000 women [3].
- In 2009, the average age of non-Hodgkin lymphoma diagnosis was 64.7 years [5].
- In 2010, the risk of developing non-Hodgkin lymphoma before the age of 85 was 1 in 42 [3].
- Between 1982 and 2010, the age-standardised incidence rate for non-Hodgkin lymphoma increased from 12.6 to 18.7 cases per 100,000 people [3].

Prevalence

- At the end of 2007, it was estimated that there were 30,646 people in Australia who were diagnosed with non-Hodgkin lymphoma in the previous 26 years, including 14,029 diagnosed in the previous 5 years [6].

Mortality

- In 2011, there were 1,371 deaths from non-Hodgkin lymphoma (772 men and 599 women), accounting for 3.2 per cent of all cancer deaths in Australia [3]. This increased to 1,471 by 2013 [7].
- The age-standardised mortality rate for non-Hodgkin lymphoma is higher for men:
    - In 2011, there were 7.0 deaths per 100,000 men from non-Hodgkin lymphoma, compared with 4.3 deaths per 100,000 women [3].
- In 2011, the risk of dying from non-Hodgkin lymphoma before the age of 85 was 1 in 126 [3].
- Between 1982 and 2011, the age-standardised mortality rate for non-Hodgkin lymphoma decreased overall from 6.5 to 5.5 per 100,000 people [3].

Survival

- Relative survival rates for non-Hodgkin lymphoma have increased in recent years in Australia:
    - Between the periods 1982-1987 and 2006-2010, five-year relative survival increased from 46.6 per cent to 70.6 per cent [6].

Hospitalisations

Non-Hodgkin lymphoma was the sixth most common reason for hospitalisation with a principal diagnosis of cancer in 2010-11 [8].

Cancer type	Same day	Overnight	Total
Non-Hodgkin lymphoma	8,759	10,238	18,997

Hodgkin lymphoma (also known as Hodgkin's lymphoma)

Incidence

- In 2010, there were 572 new cases of Hodgkin lymphoma in Australia (324 new cases in men and 248 new cases in women), accounting for 0.5 per cent of all new cancers [3].
- In 2014, about 560 Australians (300 men and 260 women) are expected to be diagnosed with Hodgkin lymphoma [4].
- In 2020, an estimated 625 Australians are expected to be diagnosed with Hodgkin lymphoma [4].
- In 2010, the age-standardised incidence rate of Hodgkin lymphoma was 2.9 cases per 100,000 men, compared with 2.2 cases per 100,000 women [3].
- In 2009, the average age of Hodgkin lymphoma diagnosis was 40.0 years [5].
- In 2010, the risk of developing Hodgkin lymphoma before the age of 85 was 1 in 434 [3].
- Between 1982 and 2010, the age-standardised incidence rate for Hodgkin lymphoma increased from 2.2 to 2.6 cases per 100,000 people [3].

Prevalence

- At the end of 2007, it was estimated that there were 7,168 people in Australia who were diagnosed with Hodgkin lymphoma in the previous 26 years, including 2,200 diagnosed in the previous 5 years [6].

Mortality

- In 2011, there were 72 deaths from Hodgkin lymphoma (38 men and 34 women), accounting for 0.2 per cent of all cancer deaths in Australia [3].
- In 2011, there were 0.3 deaths per 100,000 men from Hodgkin lymphoma and 0.3 deaths per 100,000 women [3].
- In 2011, the risk of dying from Hodgkin lymphoma before the age of 85 was 1 in 2,430 [3].
- Between 1982 and 2011, the age-standardised mortality rate for Hodgkin lymphoma decreased from 0.9 to 0.3 per 100,000 people [3].

Survival

- Relative survival rates for Hodgkin lymphoma have increased in recent years in Australia:
- Between the periods 1982-1987 and 2006-2010, five-year relative survival increased from 71.5 per cent to 87.2 per cent [6].

Burden of disease

- Cancer is estimated to be the leading cause of the burden of disease in Australia [5].
- In 2012, lymphoma (which includes Hodgkin and non-Hodgkin lymphoma) was estimated to account for 27,200 disability-adjusted life years (DALYs*) in Australia; of these, 23,400 were years lost due to premature death and 3,800 were years of healthy life lost due to disease, disability and injury [5].

WHO reported estimated 51,900 DALYs* from lymphomas (including multiple myeloma)in Australia in 2012 [9].

IHME estimates 35,176 years of life lost from non-Hodgkin lymphoma and 3,144 from Hodgkin lymphoma in Australia in 2010 [10].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [5].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Lymphoma has a relatively high survival rate and people living in remission can continue their lives largely unaffected by disability. The ability to cover the high cost of new drugs such as monoclonal antibodies will affect the treatment decisions of patients if these are not covered by the PBS.

c) is a Government health priority topic.

Cancer (including lymphoma) is a national health priority.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Better detection rates will improve health outcomes as earlier treatment is generally more likely to succeed. The possibility of replacing at least some of the radiotherapy and chemotherapy treatments with monoclonal antibodies and targeted therapies will reduce harms e.g. potential loss of fertility in younger women with Hodgkin lymphoma.

b) reduce unwarranted variation in prevention, diagnosis or treatment

As the cause of lymphoma is largely unknown, prevention is not a priority. The extent of variation is diagnosis and treatment in Australia can be extrapolated from NSW Central Cancer Registry data which shows remoteness of residence generally increases five-year relative excess risk [11].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

The increasing introduction of monoclonal antibodies and other targeted therapies is helping to increase survival rates [12].

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

None found.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

UK NICE: Guidance on Cancer Services Improving Outcomes in Haematological Cancers - The Manual [13]

European Society for Medical Oncology (ESMO) Clinical Practice Guidelines: Haematological Malignancies [14]

- Hodgkin's lymphoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up [15]
- Diffuse large B-cell lymphoma (DLBCL): ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up [16]

USA National Comprehensive Cancer Network

- Hodgkin Lymphoma 2015 [17]
- Non-Hodgkin's Lymphoma 2015 [18]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Melanoma**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Dermatologists** **Radiologists** **Radiation oncologists** **Medical oncologists** **Surgical oncologists** **Pathologists** **Cancer nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand [1]	NHMRC		2008	2013

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Melanoma is one of the more preventable cancers. Its treatment is well established but also rapidly developing in areas such as genetic research, immunotherapy and targeted therapy.

2. *Provide information to show that the clinical area is:*
   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

- In 2010, melanoma of the skin was the 4th most commonly diagnosed cancer in Australia (after prostate, bowel and breast cancer), accounting for 9.8 per cent of all new cancers, excluding non-melanoma skin cancer [2].
- In 2010, there were 11,405 new cases of melanoma of the skin in Australia (6,700 new cases in men and 4,705 new cases in women) [2].
- In 2014, about 14,240 Australians (8,540 men and 5700 women) are expected to be diagnosed with melanoma of the skin [3].
- In 2020, an estimated 17,570 Australians are expected to be diagnosed with melanoma of the skin [3].
- Melanoma of the skin is more common in men:
    - In 2010, the age-standardised incidence rate of melanoma of the skin was 59.9 cases per 100,000 men, compared with 38.9 cases per 100,000 women [2].
- In 2009, the average age of melanoma of the skin diagnosis was 60.8 years [4].
- The risk of developing melanoma of the skin increases with age [2].
- In 2010, the risk of developing melanoma of the skin before the age of 85 was 1 in 18 [2].
- Between 1982 and 2010, the age-standardised incidence rate for melanoma of the skin increased from 26.7 to 48.5 cases per 100,000 people [2].

Prevalence

- At the end of 2007, it was estimated that, there were 136,016 people in Australia who were diagnosed with melanoma of the skin in the previous 26 years, including 45,753 people diagnosed in the previous 5 years [5].

Mortality

- In 2011, there were 1,544 deaths from melanoma of the skin (1,071 men and 473 women), accounting for 3.6 per cent of all cancer deaths in Australia [2].
- The age-standardised mortality rate for melanoma of the skin is higher for men:
    - In 2011, there were 9.5 deaths per 100,000 men from melanoma of the skin, compared with 3.5 deaths per 100,000 women [2].
- In 2011, the risk of dying from melanoma of the skin before the age of 85 was 1 in 123 [2].
- Between 1982 and 2011, the age-standardised mortality rate for melanoma of the skin increased from 4.7 to 6.2 deaths per 100,000 people [2].

Survival

- Relative survival rates for melanoma of the skin are higher for women than for men in Australia:
    - The five-year relative survival from melanoma of the skin for 2006-2010 was 88.5 per cent for men and 93.6 per cent for women [5].
- Relative survival rates for melanoma of the skin have increased in recent years in Australia:
    - Between the periods 1982–1987 and 2006–2010, five-year relative survival increased from 85.8 per cent to 90.7 per cent [5].

Burden of disease

- In 2012, melanoma of the skin was estimated to account for 22,800 disability adjusted life years (DALYs*) in Australia; of these, 17,200 were years lost due to premature death and 5,600 were years of healthy life lost due to disease, disability or injury [6].

*DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury. This is the basis unit used in burden of disease or injury estimates [6].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Due to its high incidence and high survival rate, melanoma is one of the more expensive cancers to treat. Given its relatively high preventability, a greater investment in prevention and early detection will reap economic as well as health outcome benefits.

c) is a Government health priority topic.

Cancer control (including melanoma) is one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Melanoma has one of the highest survival rates of any cancer. It is relatively easy to detect and has been the subject of a significant investment in community awareness. However its incidence is growing faster than most other cancers and more investment is needed in community prevention awareness campaigns. Incidence has increased by 151% in males and 46% in females between 1982 and 2007, though it is unknown what proportion of this increase is due to an increase in the underlying disease, and how much is due to improved detection methods [3].

b) reduce unwarranted variation in prevention, diagnosis or treatment

Melanoma prevention is relatively well established in the Australian community but there has been a significant increase in its incidence over the past two decades. Melanoma should be detected as early as possible via monthly skin self-examination. Fortunately the mortality rate has been stable over the same period.

Surgical treatment regimens for melanoma are well established.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Melanoma treatments are mostly not controversial. Research into immunotherapy and targeted genetic treatments have shown good promise. These treatments are more expensive than traditional therapies, particularly as they tend to be given in addition to rather than in lieu of other therapies [7]. Ipilimumbab (Yervoy) was listed on the Australian PBS in mid-2013. It was the first in a new class of medicines for melanoma and the first effective treatment in over a decade according to the then Minister for Health, Hon. Tanya Plibersek [8].

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Melanoma is, like many other cancers, increasingly being investigated from a genetic perspective. About half of all melanomas have mutations in the BRAF gene [7]. New drugs which target target the BRAF gene are showing promise [9].

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context.

The European Society for Medical Oncology has published its clinical practice guidelines for melanoma in the Annals of Oncology [10].

The USA National Comprehensive Cancer Network has published its 2015 melanoma guidelines (V.3) – note only available once registered on their website [11].

The UK National Institute for Health and Care Excellence (NICE) is expecting to publish new guidance on melanoma in July 2015 [12].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Non-diabetic renal disease**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Nephrologists** **Renal nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Guidelines for the assessment and management of absolute cardiovascular disease risk [1]	NHMRC RACGP	Department of Health	2012	2017
Chronic Kidney Disease (CKD) Management in General Practice Guidance and clinical tips to help identify, manage and refer patients with CKD in your practice [2]	RACGP,		2014	
KHA-CARI guideline: Early chronic kidney disease: detection, prevention and management [3]	Kidney Health Australia		2013	
KHA-CARI guideline: biochemical and haematological targets: haemoglobin concentrations in patients using erythropoietin-stimulating agents [4]	Kidney Health Australia		2012	
Adaptation of the KDIGO Clinical Practice Guideline for the Care of Kidney Transplant Recipients [5]	Kidney Health Australia		2012	
There are a number of other KHA-CARI guidelines available at www.cari.org.au				

Proposed guideline format (if known):

RACGP = Royal Australian College of General Practitioners; KHA-CARI = Kidney Health Australia - Caring for Australians with Renal Impairment

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Up to 90 per cent of kidney function can be lost before symptoms of kidney disease appear. As kidney disease is most commonly caused by diabetes and/or hypertension, prevention is a realistic proposition by modifying risk factors such as smoking and obesity.

   End stage kidney disease is a high treatment area of medicine with dialysis or transplant the primary modalities. Kidney Health Australia has a large number of guidelines (not NHMRC endorsed) which it has developed with an internal organisation called Caring for Australians with Renal Impairment (CARI).

   Home haemodialysis is now preferred where possible over hospital based treatment at considerable savings to the health system ($49,000 p.a. vs. $79,000 p.a.) and increased patient well-being [6].

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

According to the USA National Institute of Diabetes and Digestive and Kidney Diseases, 43.8 per cent of chronic kidney disease is due to diabetes, which leaves 56.2 per cent caused by other factors including hypertension, glomerulonephritis, cystic diseases, urologic diseases and 'other' [7].

Prevalence

There are few studies of renal disease prevalence. An AusDiab study published in 2003 suggests that 16 per cent of the Australian adult population some form of measurable kidney damage [8].

Kidney Health Australia claims that approximately 1.7 million Australian adults (10 per cent of the population) have indicators of chronic kidney disease (CKD) [9] [10].

In a recent survey of Aboriginal and Torres Strait Islanders adults, 17.9 per cent were found to have signs of chronic kidney disease [11].

Mortality

CKD was the underlying cause of 3,068 deaths, 2.1% of all deaths. It was an underlying or associated cause of 14,842 deaths, or 10% of all Australian deaths [12]. However CKD was under-reported in that fewer than half (44%) of persons who died between 2003 and 2007 who were receiving kidney replacement therapy had end-stage kidney disease listed as the underlying cause of death [12].

Survival

Renal disease which progresses to end stage kidney disease is Kidney transplants are the most common organ transplant in Australia with 904 (63 per cent of all transplants) recorded in 2014 [13] . Survival rates are world class. The survival rate following a kidney transplant is high - 98% of recipients are alive at 1 year, and 89% are alive at 5 years [9].

Burden of disease

WHO reported an estimated 59,100 DALYs* from kidney diseases in Australia in 2012 [14].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [15].

Hospitalisation

In 2012–13, there were 1.5 million hospitalisations where CKD was recorded as the principal and/or an additional diagnosis. Dialysis accounted for the great majority - almost 1.3 million hospitalisations - and was the most common reason for hospitalisation in Australia. Around 274,090 other hospitalisations for CKD (as the principal and/or an additional diagnosis, excluding dialysis) were also recorded. Of these hospitalisations, 14 per cent had the principal diagnosis of CKD [16].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Due to the need for intensive renal replacement treatment for everyone who suffers end stage kidney disease, it is a high cost condition to manage. Renal haemodialysis costs between $49,000 and $79,000 p.a. [6]. An increase in home based haemodialysis will drive the costs towards the lower figure.

c) is a Government health priority topic.

Renal disease is not one of the federal government's national health priorities.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Since case detection is relatively poor, a stronger focus on early detection I primary care will result in a greater proportion cases with earlier and thus more chance of successful treatment.

If CKD is detected early and managed appropriately, then the otherwise inevitable deterioration in kidney function can be reduced by as much as 50 per cent and may even be reversible [10].

b) reduce unwarranted variation in prevention, diagnosis or treatment

People living in rural and remote areas have a worse prognosis from CKD as do Aboriginal and Torres Strait Islanders. This is due to poorer access to health care services at all points in the progression of the disease as well as a greater propensity to have more of the risk factors which are likely to precipitate the disease.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

A quick literature search demonstrates that guideline development and use in Australia is very active for CKD and end stage kidney disease.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

It is unlikely that a new set of clinical guidelines would ensure that Australia is any more up to date with best practice than the rest of the developed world. There are no obvious changes which need to be urgently adopted based on a quick literature review.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

UK NICE Guidelines: Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care [17]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Osteoarthritis**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Rheumatologists** **Orthopaedic surgeons** **Physiologists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Evidence-based management of acute musculoskeletal pain [1]	NHMRC & Australian Acute Musculoskeletal Pain Guidelines Group		2003	
Guideline for the non-surgical management of hip and knee osteoarthritis [2]	NHMRC	Department of Health	2009	
Clinical guideline for the diagnosis and management of juvenile idiopathic arthritis [3]	NHMRC	Department of Health	2009	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Osteoarthritis is a major disease affecting up to eight per cent of the Australian population and radiologically present in up to 50 per cent of people aged 60 and over (in the USA) [4]. It is safe to assume that Australian rates are similar.

   It is a major source of pain, disability and socioeconomic cost.

   A key area for potential improvement is reducing the known risk factors for osteoarthritis burden, being obesity, repetitive strain on key major joints and lack of exercise.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

The incidence of osteoarthritis is difficult to establish as it is a slowly developing condition with radiological confirmation of the condition not always commensurate with reported symptomatology, that is, a minority of people experience pain and disability with little radiological evidence of osteoarthritis, while others with radiological evidence experience few symptoms.

An older report for AIHW by Mathers et al (1999) suggested on the basis of international radiological survey data, that there were some 27,000 new cases of radiological osteoarthritis among women each year (peak rate of onset of 13.5 per 1000 population in the 65–74 years age group) and about 15,500 new cases among men (peak rate of 9.0 per 1000 in those aged 75 years and over) [5].

Prevalence

According to AIHW, approximately 1.8 million Australians have osteoarthritis which equates to 8 per cent of the population. Around 66 per cent are female [6].

Mortality

Osteoarthritis is not a fatal condition.

Survival

Osteoarthritis is not a fatal condition.

Hospitalisations

- there were 103,763 hospitalisations with a principal diagnosis of osteoarthritis
- there were more hospitalisations for osteoarthritis per 100,000 population for females (425 per 100,000) than males (386 per 100,000) [6].
- The primary reason for hospitalisation is hip and knee replacement. The rate of knee replacements has increased over the 10 years to 2012-13 from 197 to 156 per 100,000 population. The rate of hip replacements has grown more slowly over the same period from 84 to 98 per 1000,000 population.
- In 2012–13, 65,424 total joint replacements were performed in people with a principal diagnosis of osteoarthritis (40,255 knee replacements and 25,169 hip replacements).

Burden of disease

WHO reported estimated 53,400 DALYs* from osteoarthritis in Australia in 2012 [7].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [8].

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

People living with osteoarthritis are increasingly disabled by the condition. However the growth in total hip and knee replacement surgery is seen as a cost-effective way of treating severe disease. The costs of osteoarthritis are shared between the health system, the broader economy and consumers/patients who live with the physical and emotional cost of severe chronic pain.

Cost

About 2.3 per cent of total health expenditure by governments, individuals and industry in Australia is for osteoarthritis, at $1.2 billion in 2000-1 [9]. This is broken down to

- Hospital services $567 M
- Residential aged care $266 M
- Medications $148 M

Joint replacement is considered a cost-effective intervention for people with severe osteoarthritis. A 2007 report indicated that the Department of Health estimated a total hip replacement in a public hospital cost around $14,000 [9].

There are many other indirect costs associated with mobility impairment, OTC medications, early retirement etc.

c) is a Government health priority topic.

Osteoarthritis is a national health priority. It was added in 2002 as a sub-set of musculoskeletal conditions.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Better integration of care by general practitioners may improve health maintenance outcomes [10]. As osteoarthritis is a progressive condition with no known cure, pain management and maintenance of mobility are two key aims of medical treatment.

According to CareTrack, 57 per cent of people with osteoarthritis do not receive appropriate care according to current guidelines [11].

Harms from prescribing NSAIDs are well known.

b) reduce unwarranted variation in prevention, diagnosis or treatment

As the biological cause of osteoarthritis is largely unknown, medical prevention is not a priority except to the extent of minimising risk by encouraging exercise and maintaining a healthy body weight. Other ways to help prevent osteoarthritis are avoiding joint injury and repetitive use of joints, such as kneeling, heavy lifting and squatting.

Access to major joint replacement surgery is increasingly taking place in the private sector as public hospital capacity has not kept pace with growing demand [12].

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

The use of arthroscopy to treat osteoarthritis of the knee is increasing in spite of the lack of evidence of its efficacy [13]. It is still reimbursed by most private health insurers.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

There has been an increasing focus on disease prevention and early treatment with a view to joint preservation. This is partly a response to the growing burden of this disease and to the fact that there has been no significant breakthrough in understanding its aetiology which is a mixture of genetic, biological and bio-mechanical components [14].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

American Academy of Orthopaedic Surgeons – Treatment of osteoarthritis of the knee: evidence based guideline 2013 [15]

British Orthopaedic Association - Primary total hip replacement: a guide to good practice 2006 [16]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Pancreatic Cancer**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Radiologists** **Medical oncologists** **Surgical oncologists** **Pathologists** **Cancer nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
NIL				

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Pancreatic cancer has one of the least favourable prognoses of any cancer. It is usually only diagnosed when well progressed and often when it has metastasised into other parts of the body.

There are no great expectations of improvements in health outcomes beyond better psycho-social and palliative care.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

- In 2010, there were 2,663 new cases of pancreatic cancer in Australia (1,408 new cases in men and 1,254 new cases in women), accounting for 2.3 per cent of all new cancers [1].

- In 2014, about 2,890 Australians (1,450 men and 1,440 women) are expected to be diagnosed with pancreatic cancer [2].
- In 2020, an estimated 3,460 Australians are expected to be diagnosed with pancreatic cancer [2].
- Pancreatic cancer is more common in men:
    - In 2010, the age-standardised incidence rate of pancreatic cancer was 12.7 cases per 100,000 men, compared with 9.5 cases per 100,000 women [1].
- In 2009, the average age of pancreatic cancer diagnosis was 70.9 years [3].
- The risk of developing pancreatic cancer increases with age [1].
- In 2010, the risk of developing pancreatic cancer before the age of 85 was 1 in 64 [1].
- Between 1982 and 2010, the age-standardised incidence rate for pancreatic cancer has remained fairly stable. The incidence rate for pancreatic cancer was 10.0 cases per 100,000 people in 1982 and 11.0 cases per 100,000 people in 2010 [1].

Prevalence

- At the end of 2007, it was estimated that, there were 2,633 people in Australia who were diagnosed with pancreatic cancer in the previous 26 years, including 1,863 diagnosed in the previous 5 years [4].

Mortality

- In 2011, there were 2,416 deaths from pancreatic cancer (1,218 men and 1,198 women), accounting for 5.6 per cent of all cancer deaths in Australia [1].
- The age-standardised mortality rate for pancreatic cancer is higher for men:
    - In 2011, there were 10.7 deaths per 100,000 men from pancreatic cancer, compared with 8.7 deaths per 100,000 women [1].
- In 2011, the risk of dying from pancreatic cancer before the age of 85 was 1 in 73 [1].
- Between 1982 and 2011, the age-standardised mortality rate for pancreatic cancer has remained fairly stable. The mortality rate for pancreatic cancer was 9.8 deaths per 100,000 in 1982 and 9.7 deaths per 100,000 in 2011 [1].

Survival

- Survival rates for pancreatic cancer are poor. In recent years, relative survival rates for pancreatic cancer have increased in Australia, but remain low:
    - Between the periods 1982–1987 and 2006–2010, five-year relative survival increased from 3.0 per cent to 5.2 per cent [4].

Burden of disease

- In 2012, pancreatic cancer was estimated to account for 25,500 disability adjusted life years (DALYs*) in Australia; of these 24,800 were years lost due to premature death and 660 were years of healthy life lost due to disease, disability or injury [3].

*DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury. This is the basis unit used in burden of disease or injury estimates.

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs

incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Pancreatic tumors are resistant to treatment with chemotherapy and radiation. Surgery is only an option if the cancer is small and has not metastasised [5]. The low proportion of DALYs due to disease as opposed to early death means that not a lot can be done to improve the situation until a way is found to detect this condition much earlier in its pathogenesis.

c) is a Government health priority topic.

Cancer control is one of the federal government's original national health priorities established in 1996. However pancreatic cancer is not particularly amenable to control at this time.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Unlikely to improve the situation

b) reduce unwarranted variation in prevention, diagnosis or treatment

Any standardisation of pancreatic surgery, i.e. resection might improve patient outcomes, but only marginally.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Unlikely to improve the situation

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Unlikely to improve the situation

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

Pancreatic adenocarcinoma: ESMO–ESDO Clinical Practice Guidelines for diagnosis, treatment and follow-up 2012 [6]

USA National Comprehensive Cancer Network Pancreatic Adenocarcinoma Clinical Practice Guidelines 2015 [7]

Guidelines for the management of patients with pancreatic cancer periampullary and ampullary carcinomas 2005 [8]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Prematurity**
Key audiences for the guideline:	**Obstetricians** **Midwives** **Neonatologists** **Paediatricians** **General Practitioners** **General practice nurses** **Paediatric Cardiologists** **Cardiac Nurses** **Ultrasonographers**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Care around preterm birth [1]	NHRMC		1996	2001

Proposed guideline format (if known):

*RANZCOG = The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Prematurity is defined as neonates being born at less than 37 weeks' gestation.

   It is an area with wide variations in health care practice, and it imposes major burdens on families and the community. Intensive and special care of preterm infants is one of the largest expenditures in the Australian health care system.

   As the average age of women giving birth increases and the use of IVF becomes more widespread, the proportion of premature births will increase in association with both age and multiple births.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

AIHW reported nine per cent of births were preterm in 2012, with six per cent of live-born babies with low birthweight (<2,500 grams) [2]. This percentage is an increase over 1998 data when 6.8 per cent of births were preterm [3].

The US Centres for Disease Control and Prevention (CDC) report that 11 per cent of USA babies born in 2012 were premature [4].

Prevalence

There was no data readily available to indicate the longer term sequelae of premature births as they fall into many different categories. It is generally acknowledged that prevalence of prematurity will increase with increased age of pregnancy, increasing use of assisted conception and increasing levels of obesity in mothers. It is not clear whether levels of longer term disability will match this growth.

Mortality

See survival below.

Survival

Premature babies born in 2000 had the following chance of survival [5].

Gestational age	Per cent chance of survival
23	18
24	52
25-26	81
27-28	91

Burden of disease

WHO reported 40,476 DALYs due to pre-term birth complications in Australia in 2012 [6].

Hospitalisations

This information is not readily available nationally.

A 2014 Western Australian retrospective study of 233,850 infants born between 1993-2003 compared singletons, twins and higher order multiple births (HOMs). The latter were 3.4 and 9.6 times, respectively, more likely to be stillborn and were 6.4 and 36.7 times, respectively, more likely to die during the neonatal period. Twins and HOMs were 18.7 and 525.1 times, respectively, more likely to be preterm, and 3.6 and 2.8 times, respectively, more likely to be small for gestational age. The mean hospital costs of a singleton, twin, and HOM child to age 5 years were $2,730, $8,993, and $24,411 (in 2009-2010 US dollars), respectively, with cost differences concentrated in the neonatal period and during the first year of life [7].

b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Premature babies attract a high rate of intensive intervention in paediatric ICUs. The costs are not readily available as the diversity of conditions precludes useful combination of data. AIHW has not publicly reported on these costs.

In 1996 over $122 million was spent in Australian hospitals on low birthweight babies, most of whom are preterm [1]. This figure will undoubtedly be much higher today as our capacity for high technology intervention has increased almost exponentially.

c) is a Government health priority topic.

Prematurity is not a government health priority topic.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The primary conditions associated with prematurity are death, intellectual disability, cerebral palsy, respiratory problems, visual problems, hearing loss and digestive problems.

Risk factors for prematurity include older maternal age, assisted contraception, multiple births and obesity.

Greater community education regarding the risks of delaying pregnancy may reduce the average age of pregnancy.

A focus on single egg transfer technology in assisted fertilisation may reduce the proportion of multiple births.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Aboriginal women generally have a higher incidence of preterm births than non-Indigenous women, and their babies are therefore more likely to be low birthweight [1].

Obesity in pregnancy contributes to higher rates of stillbirth and neonatal death [2].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Given the increased rate of women becoming pregnant in their mid to late 30s, including through IVF, there is an expectation of growing numbers of premature babies. As neonatal ICUs become more accomplished, there will also be more very premature (<28 weeks gestation) babies who are given intensive support, so rates of perinatal care may increase. It is presumed the survival rate will improve over time, but the long-term disabilities of very premature babies may also increase as a result.

Research into the survival rates of neonates in neonatal intensive care units (NICUs) and at what cost might provide guidance regarding clinical decisions to invest in hopeless or marginal cases. However this is an emotionally fraught area for parents.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence

Technological developments in NICU operations should be carefully monitored.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

A Clinical Guideline for Implementation of Kangaroo Care With Premature Infants of 30 or More Weeks' Postmenstrual Age [8]

NICE clinical guidelines on multiple pregnancy [9]

Medscape: prematurity practice essentials [10]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Prostate Cancer**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Radiologists** **Medical oncologists** **Surgical oncologists** **Pathologists** **Cancer nurses** **Urologists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical practice guidelines PSA Testing and Early Management of Test-Detected Prostate Cancer [1]	**Cancer Council Australia**		**Submitted to NHMRC early 2015**	
Management of locally advanced and metastatic prostate cancer [2]	**Cancer Council Australia**	**Prostate Cancer Foundation of Australia, Andrology Australia, Cancer Council NSW, Australian Cancer Network**	**April 2010**	**2015**
Prostate-Specific Antigen (PSA) testing in asymptomatic men [3]	**NHMRC**	**Department of Health**	**2014**	
Clinical Practice Guidelines: Evidence-based Information and Recommendations for the Management of Localised Prostate Cancer [4]	**NHMRC**		**2002**	**2007**

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

There is significant confusion among patients and general practitioners regarding the detection, treatment and management of prostate cancer. Evidence-based guidelines for all these aspects of prostate cancer care will improve the overall outcomes for all parties. However new clinical guidelines may also increase the detection rate of slow growing and asymptomatic prostate cancers.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Prostate cancer is the most commonly diagnosed cancer in Australia, and is the second most common cause of cancer death in Australian men (after lung cancer). It also affects Australian men's lives by causing illness and disability.

Incidence

There were 21,808 men diagnosed with prostate cancer in 2009. The risk of diagnosis before age 85 was 0.4 per cent or 1 in 25 [5].

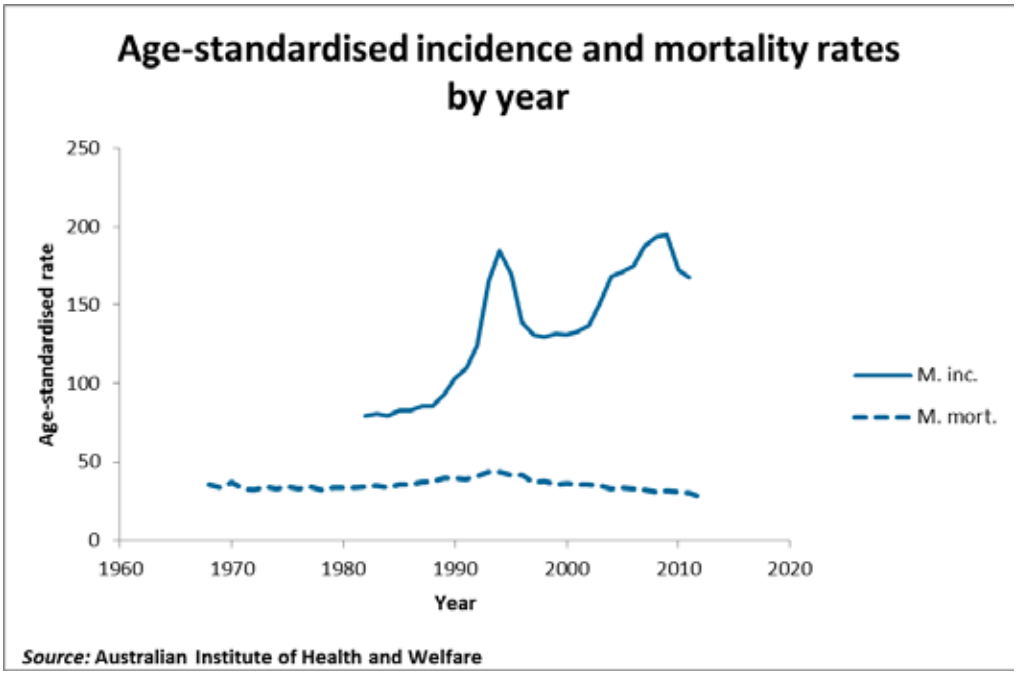
- Prostate cancer incidence ranked first in males (excepting NMSC) and accounted for 34 per cent of all new cancer cases in males in 2009.
- Incidence rates of prostate cancer have increased significantly over the last 10 years in parallel with population ageing together with increased case detection through PSA testing.
- The majority of new prostate cancer cases were diagnosed in males aged 60 years and over (80 per cent) [6].

Prevalence

Prostate cancer was the third most prevalent cancer, largely owing to its high incidence and high survival rate. At the end of 2007, there were nearly 130,000 men in Australia who had been diagnosed with prostate cancer in the previous 26 years. This equated to 1.2% of the total male population - including 12% of all men aged 80 and over having a history of prostate cancer in the previous 26 years [7].

Mortality

Prostate cancer is the second most common cause of cancer death in men (after lung cancer). More men die of prostate cancer than do women of breast cancer. Although the age-standardised incidence is increasing rapidly, the age standardised mortality is falling slightly [8]. Note that the peak in incidence in the early 1990s relates to the introduction of PSA testing.



Survival

Prostate cancer has experienced one of the largest gains in survival rates over the period 1982-2010. Current data show a five year survival rate of 92 per cent [7].

Burden of disease

In 2012, prostate cancer was estimated to account for 15 per cent of the total burden of cancer in men in Australia, second only to lung cancer [9].

In 2012, prostate cancer was estimated to account for 44,300 disability adjusted life years (DALYs*) in Australia; of these, 28,500 were years lost due to premature death and 15,700 were years of healthy life lost due to disease, disability or injury [9].

*DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury. This is the basis unit used in burden of disease or injury estimates [9].

Hospitalisation

- Prostate cancer was the third most common most common reason for hospitalisation with a principal diagnosis of cancer in 2010-11 [10].

Cancer type	Same day	Overnight	Total
Prostate cancer	18,241	16,935	35,176

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Prostate cancer has a high incidence and a low mortality rate which means that there are many people living with prostate cancer for long periods of time. However there are more male deaths from prostate cancer than any other type of cancer except lung cancer and it is the fourth leading cause of death of males [11].

The extent of disability of people living with prostate cancer will depend on the aggressiveness of treatment, with prostatectomy frequently leading to urinary incontinence, sexual dysfunction.

Health-care expenditure on prostate cancer was estimated to be $349 million in 2008–09, an increase of 23% on expenditure in 2004–05. This increase in expenditure on prostate cancer corresponds with the increase in new cases of prostate cancer identified between 2002 and 2008 [11].

c) is a Government health priority topic.

Cancer control (including prostate cancer) is one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The major potential harm in prostate cancer is overly aggressive treatment of cancers which may be slow growing and relatively asymptomatic. How to balance this with the desire of patients and the need of physicians to provide appropriate and successful treatment is a continuing conundrum.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Given the very wide variability regarding treatment options from 'do nothing' to 'treat aggressively', a commonly accepted set of guidelines will support a more consistent approach to all facets of this disease.

NSW Bureau for Health Information data shows considerable variation between hospital emergency departments in the median time to start treatment. For example, among principal referral and major hospitals the median time to start treatment for people with cancer ranged from two to 12 minutes for triage 2, from 11 to 41 minutes for triage 3, from 16 to 60 minutes for triage 4 and from four to 49 minutes for triage 5 [12].

Aboriginal people have lower rates of access to acute care investigations and procedures and a lower likelihood of being treated for and surviving cancer. Between 2006-2012 the gap between Indigenous and non-Indigenous cancer mortality has widened while the gap in death rates from other chronic diseases has declined [13] (p.7).

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

An international literature review would form the basis of new clinical guidelines. Given the evolving debate around detection and treatment of this cancer, a consensus set of clinical guidelines will assist the medical profession to determine which treatments are of value and which are not.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

According to the Australia New Zealand clinical trials registry there are 269 prostate cancer related clinical trials planned, underway or recently completed. The results of these and other international trials should be incorporated into any new guidelines.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context.

The USA's National Cancer Institute has a website with regularly updated information on prostate cancer treatment for health professionals [14]. Given the survival rates in the USA are better than Australia's, it is worth paying attention to their documentation.

The European Society of Medical Oncology published a set of consensus guidelines in 2012 [15].

The UK National Collaborating Centre for Cancer published a clinical guideline in 2014 [16].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Retinopathy**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Optometrists** **Ophthalmologists** **Diabetes Educators**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Guidelines for the assessment and management of absolute cardiovascular disease risk [1]	NHMRC RACGP	Department of Health	2012	2017
Guidelines for the Management of Diabetic Retinopathy [2]	NHMRC	Department of Health	2008	
General Practice Management of Type 2 Diabetes [3]	Diabetes Australia, RACGP	Diabetes Australia	2014	Up-dated ann-ually

Proposed guideline format (if known):

RACGP = Royal Australian College of General Practitioners

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Retinopathy is the leading cause of blindness in Australian adults of working age. The majority of retinopathy is a consequence of poorly controlled diabetes combined with hypertension and hyperlipidaemia [4]. It has been estimated that the risk of developing type 2 diabetes can be reduced by up to 60 per cent with appropriate and sustained lifestyle changes [5].

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

Around 100,000 people are diagnosed with diabetes each year in Australia. Of these, around 85 per cent have type 2, ten per cent type 1 and five per cent gestational diabetes. There are no accurate data on the incidence of retinopathy in Australia but research from the UK is likely to be broadly comparable: 36 per cent of people had retinopathy at four years post diagnosis of diabetes [6].

Mortality

Retinopathy causes blindness rather than death. Other complications of diabetes will usually be considered as contributing causes of mortality.

Survival

Not applicable

Prevalence

AIHW does not have accurate prevalence data for eye disease in general. Hospital separation data are published for diabetes-related conditions and for diseases and disorders of the eye but not for retinopathy [7].

Burden of disease

We have been unable to source data on years of life lost or disability burden for retinopathy.

Javit et al suggest that active screening for diabetic retinopathy is very cost-effective in the USA [8].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Blindness or substantial loss of vision in working age adults has a significant impact on their ability to generate income and pay income tax. Given the rapid increase in the incidence and prevalence of largely preventable type 2 diabetes, this condition merits strong clinical and preventive attention.

c) is a Government health priority topic

Diabetes was added as one of the federal government's national health priorities in 1997. Retinopathy is primarily an outcome of poorly managed diabetes.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Primary and secondary prevention of retinopathy should be strongly emphasised in primary care settings, including regular ophthalmology visits.

b) reduce unwarranted variation in prevention, diagnosis or treatment

A small study in Central Australia found no significant difference between retinopathy rates and severity of disease when compared to a similar study in Newcastle NSW. It should be noted however that the prevalence rate of diabetes in Aboriginal communities is up to three times higher than in non-indigenous communities [9].

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

A quick literature search demonstrates that under treatment is a common issue, in part because symptoms often present after the disease is well established and partly because there is a significant cohort of people living with poorly controlled diabetes.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

By undertaking a detailed literature search, a new set of clinical guidelines would ensure that Australia is up to date with best practice in the rest of the developed world. There are no obvious changes which need to be urgently adopted base on a quick literature review.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

UK: The Royal College of Ophthalmologists' clinical guidelines for diabetic retinopathy [10]

USA: American Diabetes Association: Standards of medical care in diabetes [11]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Stomach (gastric)**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Gastroenterologists** **Radiologists** **Radiation oncologists** **Medical oncologists** **Surgical oncologists** **Pathologists** **Cancer nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Nil				

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Stomach cancer is often diagnosed fairly late in the progression of the disease which means that the likelihood of metastasis to other body parts is increased. Treatment is thus likely to be more complicated and thus less successful. A focus on risk reduction (diet, smoking, obesity) and earlier detection will be of potential benefit.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

- In 2010, there were 1,999 new cases of stomach cancer in Australia (1,314 new cases in men and 685 new cases in women), accounting for 1.7 per cent of all new cancers [1].
- In 2014, about 2,015 Australians (1,300 men and 715 women) are expected to be diagnosed with stomach cancer [2].
- In 2020, an estimated 2,080 Australians are expected to be diagnosed with stomach cancer [2].
- Stomach cancer is more common in men:
    - In 2010, the age-standardised incidence rate of stomach cancer was 11.9 cases per 100,000 men, compared with 5.2 cases per 100,000 women [1].
- In 2009, the average age of stomach cancer diagnosis was 69.6 years [3].
- The risk of developing stomach cancer increases with age [1].
- In 2010, the risk of developing stomach cancer before the age of 85 was 1 in 87 [1].
- Between 1982 and 2011, the age-standardised incidence rate for stomach cancer has decreased from 15.7 to 8.3 cases per 100,000 people [1].

Prevalence

- At the end of 2007, it was estimated that there were 7,792 people in Australia who were diagnosed with stomach cancer in the previous 26 years, including 3,592 diagnosed in the previous 5 years [4].

Mortality

- In 2011, there were 1,140 deaths from stomach cancer (715 men and 425 women), accounting for 2.6 per cent of all cancer deaths in Australia [1].
- The age-standardised mortality rate for stomach cancer is higher for men:
    - In 2011, there were 6.4 deaths per 100,000 men from stomach cancer, compared with 3.1 deaths per 100,000 women [1].
- In 2011, the risk of dying from stomach cancer before the age of 85 was 1 in 163 [1].
- Between 1982 and 2011, the age-standardised mortality rate for stomach cancer decreased from 12.3 to 4.6 deaths per 100,000 people [1].

Survival

- Relative survival rates for stomach cancer have increased in recent years in Australia:
    - Between the periods 1982–1987 and 2006–2010, five-year relative survival increased in Australia from 17.2 per cent to 26.7 per cent [4].

Burden of disease

- Cancer is estimated to be the leading cause of the burden of disease in Australia [3].
- In 2012, stomach cancer was estimated to account for 13,900 disability adjusted life years (DALYs*) in Australia; of these 12,600 were years lost due to premature death and 1,300 were years of healthy life lost due to disease, disability or injury [3].

*DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury. This is the basis unit used in burden of disease or injury estimates [3].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Due to its lower incidence (12th of of all cancers) and relatively low (although improving) survival rate (9th of all cancers) [4], stomach cancer is one of the less expensive cancers to treat. Given its relatively low preventability and typically later diagnosis, a greater investment in prevention and early detection will not reap significant economic or health outcome benefits at this stage.

AIHW estimates costs for stomach cancer in 2000-01 to be $44 million of which $36 million was on admitted patient care [5].

c) is a Government health priority topic.

Cancer control (including melanoma) is one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The key to reducing risks and harms from the treatment of stomach cancer is early detection. Currently there is no population based stomach cancer screening in Australia.

In Japan, where gastric (stomach) cancer is the leading cause of death from cancer, screening for all residents over the age of 40 using photofluorography was recommended following a review of all screening types [6]. However to make the most of its limited resources for gastric cancer screening, especially at a time when gastric cancer incidence is decreasing to the point where mass screening of the general population will inefficient in the near future, the country is currently moving away from population-based screening with barium radiography. Instead, Japan is adopting an approach that harnesses the screening effectiveness of endoscopy. Individuals in the general population who are at increased risk for gastric cancer are sifted out by testing for *Helicobacter pylori* antibodies and if positive then for serum pepsinogen. Those who test positive are referred for screening endoscopy, thereby focusing resources on individuals at high risk who warrant endoscopy and intensive surveillance and, in turn, driving down overall costs [7].

b) reduce unwarranted variation in prevention, diagnosis or treatment

In the period 2006–2010, stomach cancer had higher 5-year survival in major cities compared with some or all areas outside major cities [4]. Access to palliative care for cancer patients is likely to show similar variability.

NSW Bureau for Health Information data shows considerable variation between hospital emergency departments in the median time to start

treatment. For example, among principal referral and major hospitals the median time to start treatment for people with cancer ranged from two to 12 minutes for triage 2, from 11 to 41 minutes for triage 3, from 16 to 60 minutes for triage 4 and from four to 49 minutes for triage 5 [8].

Aboriginal people have lower rates of access to acute care investigations and procedures and a lower likelihood of being treated for and surviving cancer. Between 2006-2012 the gap between Indigenous and non-Indigenous cancer mortality has widened while the gap in death rates from other chronic diseases has declined [9] (p.7).

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

A quick literature search demonstrates that there is no compelling evidence of a need to change stomach cancer treatments beyond maintaining awareness of emerging research evidence regarding new treatments.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

By undertaking a detailed literature search, a new set of clinical guidelines would ensure e.g. note is taken of controversies in adjuvant therapy regarding choice of chemotherapeutic regimens, the use of radiation therapy and the selection of patients likely to benefit from different therapies [10].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

The European Society for Medical Oncology has published its clinical practice guidelines for gastric cancer in the Annals of Oncology [11].

The USA National Comprehensive Cancer Network has published 2015 gastric cancer guidelines (V.3) – note only available once registered on their website [12].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Stroke**
Key audiences for the guideline:	**General Practitioners** **General practice nurses** **Occupational Therapists** **Speech Pathologists** **Neurologists** **Neurointerventional Surgeons** **Vascular Neurosurgeons** **Physiotherapists** **Clinical Stroke Nurses** **Psychologists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Guidelines for Stroke Management [1]	NHMRC		2010	2015
Emergency department stroke and transient ischaemic attack care bundle [2]	NHMRC		2009	2014
Guidelines for the assessment and management of absolute cardiovascular disease risk [3]	NHMRC		2012	2017
Acute Stroke Clinical Care Standard [4]	Australian Commission on Safety and Quality in Health Care		2015	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

The best acute stroke outcome relies on the 'golden hours' from first onset of symptoms to being treated in a stroke speciality care centre. This is a focus for community awareness, ambulance services and emergency departments.

The other main focus of stroke management is on rehabilitation which may be lengthy and limited in outcome.

A focus on risk reduction (diet, exercise, smoking, alcohol, obesity, hypertension, hyperlipidemia /dyslipidemia) and earlier detection will be of practical benefit.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

While there are no accurate incidence data on stroke in Australia,

Two population-based studies in Perth and N.E. Melbourne provide the best data for extrapolation. Age adjusted incidence rates fell by 25 per cent between 1997 and 2009. The National Stroke Foundation estimates there are around 60,000 new or recurrent strokes per annum with about 50 per cent of these in people 75 years of age or more.

Prevalence

AIHW calculated that in 2009 375,800 had had a stroke at some time in their lives, up from [5], up from 346,700 in 2003 [6]. ABS estimated 381,400 Australians (1.8 per cent of the population) had suffered a stroke at some point in their lives in 2009. Of these almost 70 per cent were aged 65 or older [7].

The increase in prevalence over time is primarily due to population ageing [6].

Mortality

In 2013 stroke was Australia's third biggest killer after coronary heart disease and dementia [8] and is also the sixth leading cause of profound/severe disability (3.1 per cent) [9].

Survival

Stroke mortality has reduced significantly over the past 30 years. AIHW estimates age-adjusted death rates fell by 70 per cent between 1979 and 2010 [6]. This improvement is attributed to the growth in the number of specialised stroke care facilities. Earlier and better treatment has also seen the disability rate from stroke fall from 45 per cent to 35 per cent [5]. This is still high however.

Burden of disease

Stroke is frequently a very disabling condition, with partial to extensive paralysis affecting around 146,400 Australians in 2003. There were 25,800 hospitalisations for stroke rehabilitation in 2009-10 [6].

In 2009, it was estimated that just over a third (131,130) of people with stroke had a disability that resulted from their stroke [5].

WHO estimates Australian DALYs* due to stroke in 2012 to be 166,300 [10].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [11].

Hospitalisations

In 2007–08, there were 34,945 acute hospitalisations in Australia with a principal diagnosis of stroke (0.4 per cent of all hospitalisations). Around half were treated in a specialised stroke unit [12]. Deaths in hospital from stroke amounted to 11 per cent of all stroke in-patient episodes [12].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Due to the need for urgent acute care treatment for everyone who suffers stroke, combined with the high likelihood of substantial disability and rehabilitation for survivors, stroke is a high cost condition. In addition, the cost to patients and their family carers is very significant given that people surviving stroke with a disability are normally unable to undertake a number of the activities of daily living independently.

c) is a Government health priority topic.

Cardiovascular diseases (including stroke) were one of the federal government's original national health priorities established in 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The National Stroke Foundation has taken a strong leading role in developing and promulgating clinical guidelines. The Foundation has made it clear that the promulgation and implementation of guidelines is every bit as important as their development.

b) reduce unwarranted variation in prevention, diagnosis or treatment

People living in rural and remote areas will always have a worse prognosis from stroke attacks if they cannot be transported to specialist stroke centres within a sufficiently short time frame to take advantage of thrombolysis, a drug used very early after stroke (within first few hours) to dissolve the clot causing the stroke.

National Health Survey data show those in the lowest socio-economic group are 1.8 times more likely to have had a stroke as those in the highest group [12].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

A quick literature search demonstrates that there is no compelling evidence of a need to change stroke treatments beyond maintaining awareness of emerging research evidence regarding new treatments.

More importantly, ensuring speedy access to stroke centres for acute stroke, and effective access to rehabilitation for those recovering from stroke are seen as the best mechanisms for reducing the impact of stroke.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

By undertaking a detailed literature search, a new set of clinical guidelines would ensure that Australia is up to date with best practice in the rest of the developed world. There are no obvious changes which need to be urgently adopted base on a quick literature review.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

- American Heart Association / American Stroke Association Guidelines for the Primary Prevention of Stroke [13]
- UK 2013 Stroke rehabilitation guidelines [14]
- UK national clinical guideline for diagnosis and initial management of acute stroke and TIA [15]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Trauma / Falls**
Key audiences for the guideline:	**General practitioners** **Paramedics** **Emergency Nurse Practitioners** **Emergency Medical Practitioners** **Trauma Surgeons**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Falls				
ANZ Guideline for hip fracture care: improving outcomes in hip fracture management of Adults [1]	Australian and New Zealand Hip Fracture Registry Steering Group	NHMRC	2014	2019
Implementation Guide for Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals and Residential Aged Care Facilities [2]	Australian Commission on Safety and Quality in Health Care		2009	
Preventing Falls and Harm From Falls in Older People Best Practice Guidelines for Australian Community Care [3]	Australian Commission on Safety and Quality in Health Care		2009	
Preventing Falls and Harm From Falls in Older People Best Practice Guidelines for Australian Residential Aged Care Facilities [4]	Australian Commission on Safety and Quality in Health Care		2009	
Other causes of trauma				
Adult Trauma Clinical Practice Guidelines: Initial Management of Closed Head Injury in Adults [5]	NSW Ministry of Health	NSW Ministry of Health	2011	
Clinical guidelines for best practice management of acute and chronic whiplash-associated disorders [6]	NHMRC	S.A. Centre for Trauma & Injury Recovery	2008	

Guidelines for the management of acute whiplash-associated disorders for health professionals, 3rd edition [7]	NSW Motor Accidents Authority		2014	
Emergency Care Acute Pain Management Manual [8]	NHMRC		2011	
Clinical Practice Guidelines: Burn Patient Management [9]	Agency for Clinical Innovation	NSW Agency for Clinical Innovation	2014	
Clinical Practice Guidelines: Trauma/Chest Injuries [10]	Queensland Ambulance Service	Queensland Government	2015	
Adult Trauma Clinical Practice Guidelines: Emergency Airway Management in the Trauma Patient [11]	NSW Institute of Trauma and Injury Management	NSW Health	2007	
Adult Trauma Clinical Practice Guidelines, Management of Hypovolaemic Shock in the Trauma Patient [12]	NSW Institute of Trauma and Injury Management	NSW Health	2007	
The Management of Haemodynamically Unstable Patients with a Pelvic Fracture [13]	NSW Institute of Trauma and Injury Management	NSW Health	2007	
Falls Prevention Model of Care [14]	Western Australia Department of Health		2014	
Proposed guideline format (if known): We are aware that the Australian Commission on Safety and Quality in Health Care is consulting on a draft Hip Fracture Care Clinical Care Standard [15].				

1. ***How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?***

Falls

There are recent (2014) clinical management guidelines for this (see above table). These guidelines address the major health burden associated with injuries to older people.

2. ***Provide information to show that the clinical area is:***

   a. ***high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)***

Incidence

NSW estimates of the incidence of falls in 2006-7 in that state to be 251,000 people aged 65 or older (27 per cent of the older NSW population). In total there were an estimated 507,000 falls, and of these 28 per cent resulted in injuries requiring some form of medical treatment [16]. It is accepted that three times the NSW number will be an approximation of national figures.

Prevalence

As falling is an episode rather than a disease or condition, the incidence of falling is a more significant measure than the prevalence. As noted above in the section on incidence, on average those older people who fell in a given year did so twice.

Mortality

Although this reference is old, it gives a sense of the very high mortality rate from falls at home in older people who lie on the floor for an hour or more after falling [17].

Survival

Survival from falls in older people depends on how quickly they can get up and whether they have fractured any bones, in particular their neck of femur, pelvis or hip.

Hospitalisation

Falls are the leading cause of hospital-treated injuries in Australia, and represent a significant burden to the health system [18]. In 2010-11 fall related injuries accounted for 277,054 hospital separations [19].

For the period 2000/01 to 2010/11, the 65 and over age group represented 84 per cent of fall-related injury admitted to hospital and subsequently admitted for subacute and non-acute care [20].

Burden of disease

WHO classification of injuries are by cause (DALYs, 2012 - Australia, all ages, both genders)*:

· Road injury	123.5
· Poisonings	14.1
· Falls	161.9
· Fire, heat and hot substances	9.2
· Drowning	11.8
· Other unintentional injuries	73.7
· Self-harm	127.3
· Interpersonal violence	19.4

*DALYS: As a point of comparison, Breast cancer is 87.9 (WHO, 2012)

b. imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning

resources to the development of one particular guideline and the potential consequences for not supporting another)

There appears to be no one data source or report that compares different types of traumatic injury in terms of their cost of treatment or care. It is thus our view that the most costly types of trauma are:

- **Falls**

  The burden of falls is of particular concern for older Australians (65 years and over), in which they represent 76 per cent of injury hospitalisations [19]. With our ageing population, the size of the problem is rising annually. Mitchell et al observed, for this age group, a 9.1 per cent annual increase in fall-related inpatient rehabilitation episodes for the period 1998 to 2011 [20]. Their data projections indicated that by 2020 there are likely to be around 50,000 admissions annually for this age group alone [20]. The length of stay for a fall related admission is greatest among this age group, with an average of nine days [19]. Falls are a major precipitating factor for the transition to nursing home care [21], and result in over 2,600 deaths in older people (people aged 65 years or over) in Australia each year, with around 1,450 of these deaths having hip fracture as the underlying cause [21].

  As previously noted, there are recent (2014) clinical management guidelines for hip fracture in older people (see above table).

- **Traumatic Brain Injury** - for 2004, hospital separations were estimated at 22,710 [22]. There are NSW Health 2011 guidelines for management of close head trauma. This does not include brain injury acquired as a result of drowning or suffocation.
- **Spinal Cord Injury** - for 2008, the number of new cases: paraplegia was 137, quadriplegia was 136 [22]
- **Whiplash** - There recent (2014) guidelines developed by the NSW Motor Accidents Authority, NSW (see above table)
- **Burns-** there are recent (2014) clinical management guidelines for this (see above table)

c. is a Government health priority topic.

Injury prevention and control was chosen as a national health priority in the initial round in 1996.

3. How would this guideline:

a. reduce risks and harms to consumers/ patients/ health service users

The burden associated with falls in older people is significant and increasing annually [20]. There is considerable potential to improve outcomes, including a reduction of deaths and transition to residential care, in this vulnerable population group. No new developments in the field have been identified since the release of the NHMRC endorsed ANZ Guideline for hip fracture care: improving outcomes in hip fracture management of Adults [1].

b. reduce unwarranted variation in prevention, diagnosis or treatment

A quick review of the literature does not indicate any evidence of such variations since the release of the NHMRC endorsed ANZ Guideline for hip fracture care: improving outcomes in hip fracture management of adults [1].

c. derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

No new developments in the field have been identified since the release of the NHMRC endorsed ANZ Guideline for hip fracture care: improving outcomes in hip fracture management of Adults [1].

d. provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

No new developments in the field have been identified since the release of the NHMRC endorsed ANZ Guideline for hip fracture care: improving outcomes in hip fracture management of adults [1].

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

UK: National Institute for Health and Care Excellence (NICE): Hip fracture – The management of hip fracture in adults. Issued in 2001, last modified March 2014 [23]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic	**Venous thromboembolism prevention**
Key audiences for the guideline:	**All hospital staff** **General Practitioners** **General practice nurses** **Occupational Therapists** **Surgeons** **Physiotherapists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical Practice Guideline For the Prevention of Venous Thromboembolism in Patients Admitted to Australian Hospitals [1]	NHMRC		2009	2014
Stop the Clot: integrating VTE prevention guideline recommendations into routine hospital care [2]	NHMRC		2011	
Prevention of Venous Thromboembolism - Policy Directive [3]	NSW Health		2014	2019

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   Deep vein thrombosis (DVT)—the formation of a blood clot in a deep vein - and its serious complication, pulmonary embolism (PE), together comprise the most common preventable cause of hospital-related death. Known as venous thromboembolisms (VTE), they are a significant risk for surgical and medical hospital patients. Efforts to ensure rigorous assessment and management of risk of VTE have good potential to benefit health outcomes and reduce morbidity and mortality. Other major risks include major trauma, spinal cord injury.

2. *Provide information to show that the clinical area is:*

a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence

There is no readily available national data on VTE incidence. However it is an acute event, so hospitalisation data can act as a proxy for incidence although it may be understated since some VTE would occur in e.g. aged care and not be hospitalised. Access Economics' report suggests a rate of 67.7 separations for VTE per 100,000 population [4]. Data from a Western Australia study in 1999-2001 suggests an age standardised incidence of 56.6 per 100,000 [5].

Prevalence

There is no readily available national data on VTE prevalence. Access Economics estimates prevalence in 2008 was 14,716 [4].

Mortality

VTE claimed an estimated 2,000 lives a year between 1999-2001 [6].

VTE is estimated to have been responsible for 5,285 deaths in Australia in 2008 [4]. Up to ten per cent of hospital deaths may be attributed to VTE. The increase in estimated mortality over less than a decade deserves further research as Australia's reported rate is still lower than that of the USA. It has recently been estimated that 60-100,000 per annum people die from VTE in the USA [7, 8]. Given the population of the USA is roughly ten times greater than Australia's, there may be some merit in exploring the large differential.

AIHW reported that thromboembolism was the second leading cause of maternal deaths in Australia between 2008-12 [9].

Survival

VTE mortality did not reduce significantly between 2006-12 [10]. Survival rates improve significantly after 12 months from the acute event. First year survival rate is estimated at 85.4% for DVT and 47.7% for PE [4].

Hospitalisations

VTE was estimated to have led to around 30,000 hospitalisations per annum in 2000, with the majority related to previous admission for surgery or acute illness [5]. It has been suggested in a recent meta-analysis of paediatric VTE risk that VTE is on the rise in hospitalised paediatric populations [11]. Hospitalised patients are 100 times more likely to develop VTE compared with the rest of the community [1].

Burden of disease

WHO does not provide estimates of Australian DALYs* due to VTE [12].

Access Economics estimated Years of Life Lost due to VTE in 2008 at 78,190 DALYs [4].

* DALYs are years of healthy life lost, either through premature death or through living with disability due to illness or injury.
This is the basis unit used in burden of disease or injury estimates [13].

b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs*

incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

VTE is a high cost condition given the high levels of mortality and morbidity associated with the condition. Given the expectation that a good proportion of VTE can be prevented if risks are correctly assessed and well managed, it is certainly worth updating these guidelines and reporting on variations in mortality and morbidity across Australia's hospitals.

Access Economics estimated the direct health system cost of VTE in 2008 was $148 million [4].

c) *is a Government health priority topic.*

VTE is part of cardiovascular disease, albeit a relatively under-recognised component. Cardiovascular diseases were one of the federal government's original national health priorities established in 1996.

3. *How would this guideline:*

a) *reduce risks and harms to consumers/ patients/ health service users*

The rigorous implementation of VTE prevention protocols in all hospitals is the primary mechanism to reduce risks and harms. A guideline on its own cannot achieve this, but the work of the Australian Commission for Safety and Quality in Health Care is an important contribution to this process [2].

b) *reduce unwarranted variation in prevention, diagnosis or treatment*

International evidence of the increased risk of subsequent hospitalisation due to acute arterial cardiovascular events demonstrates the need for post VTE vigilance in primary care [14].

Variation in hospital administration of risk assessment and management protocols is a recurring theme in the literature.

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

A quick literature search demonstrates that there is no compelling evidence of a need to change VTE treatments beyond maintaining awareness of emerging research evidence regarding new treatments.

More importantly, ensuring implementation of current guidelines is a key measure to improve outcomes, and effective access to prevention of a second episode for those recovering from VTE is seen as the best mechanism for reducing its longer term impact.

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

By undertaking a detailed literature search, a new set of clinical guidelines would ensure that Australia is up to date with best practice in the rest of the

developed world. There are no obvious changes which need to be urgently adopted base on a quick literature review.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

- 2010 SIGN Prevention and management of venous thromboembolism: a national clinical guideline [15]
- NICE guidelines 2010 with 2015 update [16, 17]
- 2010 AAOS guideline on preventing VTE in hip and knee arthroplasty [18]
- 2014 US Agency for Healthcare Research & Quality: VTE prophylaxis [19]
- 2015 Thrombosis Canada has an extensive set of current clinical guidelines relating to every aspect of VTE [20]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic: Drug addiction / Dependence

Key audiences for the guideline:	Primary health care providers Drug and Alcohol rehabilitation providers Medical practitioners treating patients with drug dependencies Health care workers, particularly prescribers of opioid treatments Social workers

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
National Guidelines for Medication-Assisted Treatment of Opioid Dependence [1]	Department of Health	--	2014	--
NHMRC Australian Guidelines to reduce health risks from Drinking Alcohol[2]	NHMRC	--	2009	--
NHMRC Consensus-Based Clinical Practice Guideline for the management of Volatile Substance use in Australia [3]	NHMRC	--	2011	--
NSW Ministry of Health Drug and Alcohol Withdrawal Clinical Practice Guidelines [4]	NSW Ministry of Health	NSW Health	2008	2016
WA Government Drug and Alcohol Office, A brief guide to Assessment and treatment of alcohol Dependence [5]	Government of WA drug and alcohol office	--	2015	--
Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (National Comorbidity Clinical Guidelines).[6]			2009	

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Drug and alcohol dependence has huge implications across the Australian population, with heightened effect in a number of sub groups and disease populations.

There is a role to play in each part of the health care system, however primary care screening and diagnosis then referral to subsequent drug and alcohol rehabilitation are the current major health care sections with potential to improve outcomes.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and Prevalence

- Around 8 per cent of people in Australia aged 16–85 years have had a drug use disorder (including harmful use/abuse and/or dependence) in their lifetime.
- It is estimated that 50 per cent of people with mental illness also have an AOD dependency [7].
- Indigenous Australians represent 14 per cent of AOD treated patients [8].
- Approximately one in 24 Australians aged 14 years or older (4.2 per cent) had used pharmaceuticals for non-medical purposes in the 12 months previous to 2010 [9].

Mortality

- 976 deaths were attributable to illicit drugs among Australians in 2007 [9].
- 15,512 deaths attributable to tobacco in Australia in 2003 [9].
- 5554 deaths are attributable to alcohol in Australia in 2010 [10].

Burden of disease

- Alcohol was estimated to be responsible for the loss of 136,982 Disability Adjusted Life Years in 2010 [10].
- Drug use attributable to 101,100 DALY in 2012 [11].
- Almost 8 per cent of Australia's total burden of disease was attributable to tobacco smoking in 2003 [9].
- 12 per cent of the total burden of disease for Aboriginal and Torres Strait Islander people was attributable to tobacco smoking in 2003 [9].
- Illicit drug use accounted for 2.0 per cent of Australia's total burden of disease in 2003 [9].

- Alcohol also accounted for 2.0 per cent of Australia's total burden of disease in 2003 [9].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Cost

Tobacco smoking cost Australian society an estimated $31.5 billion in 2004–05 [12]

The total societal cost of alcohol is estimated at $14.352b annually [13].

a. $6.05b in productivity
b. $3.66b traffic accidents
c. $2.95b in criminal justice
d. $1.68b direct to the health system

The needs of those seeking AOD services are multiple and complex. Individuals often present with multiple severe and complex problems in addition to their substance disorders, for example serious mental illness, and as a consequence place heavy demands on the healthcare system, in particular, acute medical services such as presentations to emergency departments, ambulance call-outs, and inpatient admissions [14] [15]. As such, it is difficult to signal specific areas that represent better or worse "value" apart from the fact that early screening, identification and intervention cold reduce the strain on acute healthcare in problem alcohol and drug use episodically. Additionally, there is increasing recognition that substance use disorders should be treated like chronic health problems. Ongoing management and monitoring have potential to reduce episodic relapse and may be less system intensive and patient disruptive over the long term [14].

c) is a Government health priority topic.

The importance placed on this area is highlighted by the fact the Australian Government National Drug Strategy has been operating in Australia in various forms since 1985.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Ongoing management like other chronic disease to minimise relapse.

b) reduce unwarranted variation in prevention, diagnosis or treatment

NIL

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value and/or

Ongoing management like other chronic disease to minimise relapse and the cost of acute treatment.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

NIL

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment [16]

Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings [17]

Drug Misuse and Dependence: UK Guidelines on Clinical Management [18]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Anaemia**
Key audiences for the guideline:	General Practice Dietitians Oncologists Nephrologists Nurses Midwives Obstetricians Paediatricians

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
The Royal Children's Hospital Melbourne – Anaemia [1]	Royal Children's Hospital	--		
Patient blood management The GP's guide, RACGP 2013 [2]	RACGP	--	2013	
Clinical guidelines, National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, Child health, anaemia [3]	RACGP	NACCHO RACGP	2012	
Anaemia in Pregnancy – King Edward Memorial Hospital [4]	OGCCU *		2013	March 2016

Proposed guideline format (if known):

* Obstetrics and Gynaelcology Clinical Guidelines Unit

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

The diagnosis and management of iron deficiency anaemia (IDA) in Australia has been described as challenging. It is seen as an important public health problem in

Australia, as the World Health Organization wave estimated within Australia 8 per cent of preschool children, 12 per cent of pregnant women and 15 per cent of non-pregnant women (of reproductive age) have anaemia, with iron deficiency anaemia as the major cause [5].

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

- 760,000 people aged 18 years and over (4.5 per cent) are at risk of anaemia [6].
- women more likely to be at risk than men (6.4 per cent compared with 2.5 per cent) [6].
- 16.0 per cent of Australians aged 75 years and older are at risk of anaemia [6].
- 3.6 per cent of Australians aged less than 75 years are at risk [6].

World Health Organization (WHO) estimate [5]:

- 8 per cent of preschool children in Australia have anaemia
- 12 per cent of pregnant women have anaemia
- 15 per cent of non-pregnant women of reproductive age have anaemia.

Mortality

N/A

Survival

N/A

Burden of disease

WHO DALY population: 40,100 [7]
Males: 16,300 [7]
Females: 23,800 [7]

Hospitalisations

No data available. However iron deficiency anaemia figures in the list of potentially avoidable hospitalisations due to chronic illness [8].

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Cost

No Australian data available. A large 2005 US study showed the cost of anaemic patients was US $14,535 as compared to $9,451 for non-anaemic patients. After adjusting for age and other co-morbidities, anaemic patients had average costs more than twice as high as non-anaemic patients [9].

c) *is a Government health priority topic.*

Anaemia is not a government health priority topic.

3. *How would this guideline:*

a) *reduce risks and harms to consumers/ patients/ health service users*

Anaemia caused by factors other than diet may need long term treatment and regular monitoring. Guidelines would help to standardise treatment.

b) *reduce unwarranted variation in prevention, diagnosis or treatment*

Anaemia caused by dietary deficiency is certainly a candidate for preventive action including better consumer education, reduction in consumption of junk food and improved diet.

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

Research has shown that anaemia is associated with diabetes and chronic kidney disease [6].

- 12.6 per cent of those at risk of anaemia had diabetes compared with 4.7 per cent of those not at risk [6].
- They were also more likely to have abnormal eGFR, 16.1 per cent compared with 3.1 per cent [6].

Consensus on methods for the administration of IV iron products is needed to improve the utilisation in Australia and reduce inappropriate blood transfusion [5].

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

Red cell transfusion is inappropriate therapy for Iron deficiency anaemia unless an immediate increase in oxygen delivery is required, such as end-organ compromise (e.g. angina pectoris or cardiac failure) or acute ongoing bleeding [5].

New-generation IV products may facilitate rapid administration of higher doses of iron, and should be investigated for use in routine care [5].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

Anaemia Management in Chronic Kidney Disease, partial update 2015, UK [10]

Diagnosis and management of iron deficiency anaemia: a clinical update [5]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic: Depression				
Key audiences for the guideline:	General Practice Mental Health Clinicians Psychologists Psychiatrists Nurses Psychiatric nurses Allied health Social Workers Consumers/families/carers			
Existing Australian guidelines:				
Guideline	**Approved by**	**Funded by**	**When approved**	**Expiry date**
Clinical practice guidelines - depression in adolescents and young adults [1]	**NHMRC**	**beyondblue**	**2011**	
Clinical practice guidelines for depression and related disorders - anxiety, bipolar disorder and puerperal psychosis - in the perinatal period. A guideline for primary care health professionals [2]	**NHMRC**	**NHMRC**	**2011**	
Australian and New Zealand clinical practice guidelines for the treatment of depression [3]	**RANZCP**	National Mental Health Strategy (Australia) and the New Zealand Ministry of Health	**2004**	

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Clinical depression is an emotional, physical and cognitive state that is intense and long-lasting and has negative effects on a person's day-to-day life. That said, depression itself is somewhat of an umbrella term under which sit many different sub types of depression [2]. Given the number of subcategories as well as the highly individualised and variable nature of depression, highlighting or pinpointing specific areas to improve health outcomes across the depression spectrum is difficult.

Much work needs to be done to improve the recognition of and to remove the stigma attached to depression in the community [1]. As far as clinical practice goes, screening for and identification of depression can help initiate and facilitate appropriate intervention.

The report released by the National Mental Health Commission: '*National Review of Mental Health Programmes and Services'* stated that the mental health system as a whole had '*fundamental structural shortcomings'* primarily around '*planning and system integration* [4]. This report suggests that a clinical guideline with a focus on service integration may work to improve the health outcomes of Australians living with depression.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

- Approximately one in five people will experience an episode of clinical depression in their lifetime [5].
- One million people in Australian currently suffer from depression and 2.3 million suffer from anxiety [6].
- Postnatal depression effects almost 16 per cent of women whom have given birth in Australia [5].
- The prevalence of depression in an Australian sample group increased in the ten years to 2008 from 6.8 per cent to 10.3 per cent [7].

Mortality

- Suicide ranks as the fourteenth leading cause of all death in 2011, with 2,273 deaths from suicide registered [8]. It is assumed that a significant proportion of suicide is due to depression but the exact figure is unascertainable.

Burden of disease

WHO DALY rating for depression: [9]

- Population: 190,900
- Male: 72,000
- Female: 119,000

Hospitalisations

AIHW data for 2013-14 indicate that there were 96,000 hospital separations where the principal diagnosis was depression [10].

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs*

incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Cost

- Depression-associated disability costs the Australian economy $14.9 billion annually [7].
- In Australia more than 6 million working days are lost each year [7].
- Depression costs the Australian community over $600 million each year in treatment costs [7].
- Depression costs the Australian economy approximately $12.6 billion per year [11].

c) is a Government health priority topic.

Mental Health has been a national priority area since the initiative commenced in 1996. It is a continuing area of focus for the government highlighted by the establishment of the National Mental Health Commission in 2012.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users, and/or

Clear screening and referral pathways and the initiation of timely intervention can prevent symptoms for escalating. These would have flow on effects of reducing suicide, self-harm, alcoholism and substance abuse. Greater integration of care between specialist mental health services, primary health care services and other community services such as housing are very likely to improve health outcomes for people with depression.

b) reduce unwarranted variation in prevention, diagnosis or treatment, and/or

Patient centred and integrated care models and routine screening for depressive symptoms should be a focus of models of primary care.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value and/or

Use the platform of the National Mental Health Commission in addressing systemic structural shortcomings through prescribed referral pathways to specialist and/or allied health services.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Nil

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context.

A consensus statement for safety monitoring guidelines of treatments for major depressive disorder Australasian Society for Bipolar and Depressive Disorders 2011 [12]

Effectiveness of music listening in reducing depressive symptoms in adult: Joanna Briggs Institute 2011 [13]

Manipulating the sleep-wake cycle and circadian rhythms to improve clinical management of major depression 2013 [14]

Pharmacological treatment of bipolar disorder in primary care 2010 [15]

Screening, referral and treatment for depression in patients with coronary heart disease 2013 National Heart Foundation[16]

Therapeutic guidelines psychotropic Version 7 2013 Therapeutic Guidelines [17]

A practical guide to the use of repetitive transcranial magnetic stimulation in the treatment of depression 2012 [18]

Depression: the NICE guideline of the treatment and management of depression in adults [19]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Inflammatory Bowel Disease (IBD)**
Key audiences for the guideline:	General Practice Gastroenterologists Physicians Radiologists Dietitians Psychologists

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Inflammatory Bowel Disease [1]	Gasteroenterological Society of Australia	Digestive Health Foundation	2013	
Practical guidelines for treating inflammatory bowel disease safely with anti-tumour necrosis factor therapy in Australia [2]	Gasteroenterological Society of Australia		2010	
Clinical Practice guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease [3]	Cancer Council Australia	National Bowel Cancer Screening Program	2011	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Although literature suggests that IBD is on the increase, there are no current calls to radically change the Australian system or to overhaul guidelines. From the literature it seems IBD is relatively well treated in Australia. If there are to be improvements made it may be in the area of diagnosis as symptoms of Crohn's disease or ulcerative colitis which can be commonly confused with other diseases or infections making it necessary to rule the possibilities out before a diagnosis in IBD can be made [4].

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

- Australia has one of the highest incidence and prevalence rates in the world for IBD with approximately 1 in 250 people aged 5 – 49 nationally having inflammatory bowel disease [5].
- It was estimated that about 75,000 people in Australia were living with IBD in 2013 [5].
- The number of people hospitalised for ulcerative colitis and Crohn disease (the two most common forms of IBD) has almost doubled in the past decade [6].
- Symptoms of IBD are experienced by about 1 in 10 people, likely under-reported [6].

Mortality

Typically mortality as a result of IBD is low, however complications can arise as a result of surgery which accounts for the higher risk profile than the general population.

Survival

N/A

Burden of disease

DALY for Crohn's: 7,211 [7].
DALY for Ulcerative Colitis: 7,392 [7].

Hospitalisations

- In 2009–10, there were about 27,000 hospitalisations where Crohn's disease or ulcerative colitis was recorded as the principal diagnosis [6].
- The average length of stay was 6.2 days for Crohn's disease and 7.4 days for ulcerative colitis [6].

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and /or*

Cost

- Inflammatory Bowel Disease were estimated by Access Economics in 2007 as costing the economy $2.7 billion [7].
- The allocated health costs arising from IBD were estimated to be $68.0 million including $33.9 million for Crohn's and $34.1 million for ulcerative colitis [7].

- The overall figure equates to $1,114 per person with IBD per annum, nationally - $1,210 pp with Crohn's and $1,033 pp ulcerative colitis [7].

c) is a Government health priority topic.

No

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users, and/or

b) reduce unwarranted variation in prevention, diagnosis or treatment,

Although IBD is on the rise in western countries it is still rare in Aboriginal and Torres Strait Islander peoples [8].

Rural and remote workforce development was a recommendation stemming from the Access Economics report in 2007. It highlighted the need for improved access to endoscopy in the public sector to be a particular focus [7].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

There is nothing in the literature to suggest that any treatment is over or under utilised in Australia. The focus for improved outcomes is increased funding to improve education and access to medical care [5].

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

None apparent from the literature appropriate in the Australian context.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context.

- Inflammatory bowel disease: a global perspective, 2009 [9]
- Management of Crohn's Disease in Adults (USA) [10]
- British Dietetic Association evidence-based guidelines for the dietary management of Crohn's disease in adults [11]
- NICE clinical guideline (CG152): the management of Crohn's disease in adults, children and young people [12]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic: Leukaemia				
Key audiences for the guideline:	**General practice** **Oncologists** **Haematologists** **Oncological nurses** **Surgeons** **Palliative care** **Allied health**			
Existing Australian guidelines:				
Guideline	**Approved by**	**Funded by**	**When approved**	**Expiry date**
NIL				
Proposed guideline format (if known):				

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

It is quite surprising to find that there are no clinical guidelines for the treatment of any form of Leukaemia developed for the Australian context.

Such a guideline would help clinicians and patients navigate the health system and would support collaborations for multidisciplinary patient care.

Leukaemia occurs when abnormal cells within the bone marrow grow in an uncontrolled way, affecting the production of white blood cells.

White blood cells develop from stem cells that are produced by the bone marrow. There are two types of stem cells that can form white blood cells – lymphoid stem cells and myeloid stem cells [1]. Leukaemia can affect either of these types of cells and is named accordingly [1]:

- Acute lymphoblastic leukaemia (ALL), also known as acute lymphocytic leukaemia, affects lymphoid stem cells and grows quickly; it is the most common type of leukaemia in children.
- Chronic lymphocytic leukaemia (CLL) affects lymphoid stem cells and usually grows slowly; it is the most common type of leukaemia in adults.
- Acute myeloid leukaemia (AML) affects myeloid stem cells and grows quickly.

- Chronic myeloid leukaemia (CML) affects myeloid stem cells and grows slowly.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

- 2774 people in Australia were diagnosed with leukaemia in 2011 [2]
- Chronic lymphocytic leukaemia is the most common type of leukaemia in Australia, with 1174 people diagnosed in 2011 [2]
- 913 people diagnosed with acute myeloid leukaemia [2]
- 334 with chronic myeloid leukaemia [2]
- 353 with acute lymphocytic leukaemia in [2]

Mortality

- In 2012, there were 1368 deaths due to all 4 types of leukaemia [2]
- Acute myeloid leukaemia was highest with 813 deaths [2]
- Chronic lymphocytic leukaemia caused 342 deaths [2]
- Chronic myeloid leukaemia caused 102 deaths [2]
- Acute lymphocytic leukaemia caused 111 deaths [2].

Survival

An individual's prognosis depends on the type and stage of cancer as well as their age and general health at the time of diagnosis.

For most children and many adults who achieve remission, the leukaemia may be cured with peripheral blood stem cell or bone marrow transplantation and chemotherapy.

Australian five year survival rate:

- 73% Chronic lymphocytic leukaemia [2]
- 24% Acute myeloid leukaemia [2].

Burden of disease

WHO DALY population: 38,200 [3]
Males: 22,900 [3]
Females: 15,300 [3]

Hospitalisations

In 2010-11, of all cancer types, acute myeloid leukaemia was responsible for the longest average hospital stay at 17.5 days [4]. There were 21,782 hospitalisation for leukaemia in 2012-13 [5].

   b) *imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

Cost

The estimated treatment cost for leukaemia was approximately $51,000 per case in 2001 74 [6].

c) is a Government health priority topic.

Cancer control including leukaemia is a government health priority.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

b) reduce unwarranted variation in prevention, diagnosis or treatment

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

This brief investigation failed to uncover any clinical guidelines for the treatment of any form of leukaemia in Australia which may in itself present a risk.

Treatment of Leukaemia can be very subjective and dependant on stage of disease and severity of symptoms. A guideline could aid in applying more objective tests to how and when to treat and or wait watchfully.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

Acute lymphoblastic leukaemia (ALL):

- Acute Lymphoblastic Leukemia (ALL) Guidelines [7]
- Guideline for the Management of Acute Lymphoblastic Leukaemia (ALL) in Adults, Pan Birmingham NHS [8]

Chronic lymphocytic leukaemia (CLL):

- Chronic Lymphocytic Leukemia: ESMO Clinical Practice Guidelines 2011 [9]
- Chronic Lymphocytic Leukemia Treatment Protocols [10]

Acute myeloid leukaemia (AML):

- Acute Myeloblastic Leukaemia in Adult Patients: ESMO Clinical Practice Guidelines [11]
- Pediatric Acute Myelocytic Leukemia [12]

Chronic myeloid leukaemia (CML):

- Chronic Myeloid Leukemia: ESMO Clinical Practice Guidelines[13].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Cirrhosis**
Key audiences for the guideline:	Gastroenterologists General Practice Nursing Surgeons

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Cirrhosis referral and management guidelines [1]	Southern Adelaide Local Health Network		2013	
AHA Practice Standards [2]	Australasian Hepatology Association		2014	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

There are currently no nationally endorsed guidelines for the treatment of Cirrhosis or liver disease more generally.

2. *Provide information to show that the clinical area is:*
   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

Liver disease affects over 6 million Australians [3].

Following colorectal cancer, liver cirrhosis is the next leading cause of digestive disease–related mortality in Australia [4].

In Australia the most common causes of liver cirrhosis are:

- Non-alcoholic fatty liver disease (NAFLD) through obesity and T2 diabetes [4]

- Viral hepatitis from hepatitis B virus (HBV) or hepatitis C virus (HCV)[4]
- Alcoholic fatty liver. [4]

Mortality

- Over 7,000 deaths per annum from chronic liver disease [5]

Survival

Survival depends on the severity of disease and is measured using the Child-Pugh Classification [6]. The classification assigns a point weighting according the presence and degree of a number of disease parameters. These include Ascites, Bilirubin, Albumin, Prothrombin time (seconds over control), *or* INR and Encepalopathy.

A total score of 5–6 is graded 'A' or disease present with liver compensating well.

- 100% 1 year expected survival rate
- 85% 2 year expected survival rate

A total score of 7–9 is graded as 'B' or disease with significant functional compromise present.

- 80% 1 year expected survival rate
- 60% 2 expected survival rate

A total score of 10–15 is graded 'C' or decompensated liver disease where the liver is no longer able to function normally.

- 45% 1 year expected survival rate
- 35% 2 year expected survival rate

Burden of disease

WHO DALY population: 35,800 [7]
Males: 24,900 [7]
Females: 10,900 [7]

Hospitalisations

- 13,555 hospitalisations for diseases of the liver were recorded in year 2009-10 [3].
- 64 per cent were male [3].
- The total number of patient days was 86,863 [3].
- Average length of stay was 6.4 days [3].
- Liver disease is responsible for one quarter of all organ transplants.

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Cost

Total cost of Liver disease in Australia $50.7 billion [3, 5]

- $5.4 billion in health care costs [3, 5]
- $45.3 billion in socio-economic costs [3, 5]

c) *is a Government health priority topic.*

Liver disease is not a government health priority.

3. *How would this guideline:*

a) *reduce risks and harms to consumers/ patients/ health service users*

Non-alcoholic fatty liver disease is very strongly associated with obesity and type 2 diabetes, both of which are largely preventable. A focus on improving lifestyle choices by those at risk will reduce the harms of this type of liver disease.

Other causes of liver disease are hepatitis B and C and alcohol abuse, all of which are also largely preventable.

b) *reduce unwarranted variation in prevention, diagnosis or treatment*

Public and professional education regarding the risks of liver disease will be of value in preventive initiatives.

Alcoholic liver disease is a significant contributor (11.3 per cent) to the gap in life expectancy between Aboriginal & Torres Strait Islander people and other Australians [8].

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

There is a lack of evidence to suggest the over or underutilisation of treatments within directly attributable to liver disease, however it is suggested that pharmacotherapy is underutilised in the treatment of alcohol dependence [9].

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

New research out of Europe is suggesting non-invasive tests to determine the extent of liver disease. It argues that biopsy size is not necessarily sufficient to represent the whole liver as cell heterogeneity is not assured (except in Cirrhosis). Biopsy is also a costly and invasive procedure that carries with it inherent risk of complications that are potentially life threatening [10]. Non-invasive tests include Serum Biomarkers and liver stiffness tests [10].

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

- Prescribing in patients with abnormal liver function tests [11]
- Fatty liver disease: a practical guide for GPs [12]
- EASL-ALEH Clinical Practice Guidelines: Non-invasive tests for evaluation of liver disease severity and prognosis [10]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Musculoskeletal pain**
Key audiences for the guideline:	**General Practitioners** **General Practice Nurses** **Physiotherapists** **Psychologists** **Exercise Physiologists** **Pain Management Specialists** **Neurologists** **Anaesthetists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Evidence-based management of acute musculoskeletal pain [1]	NHMRC & Australian Acute Musculoskeletal Pain Guidelines Group		2003	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

   The '*Evidence-based management of acute musculoskeletal pain'* [1] guide published in 2003, is referred to and referenced widely within the pain community. The fact that this document is so heavily referenced both in Australia and aboard attests to the fact that many groups see the value in it and would no doubt welcome a revised or updated edition.

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and Prevalence

- 67 per cent or 11.1 million people aged >15 years reported experiencing bodily pain in the previous four weeks [2].
- 9 per cent Australians experienced severe or very severe levels of pain [2].
- The likelihood of experiencing severe or very severe pain increased with age [2].
- People aged >45 years are nearly twice as likely to experience severe/very severe pain compared with those under 45 (13 per cent compared with 7 per cent).
- The highest rates of severe/very severe pain were reported by those aged 75 years and over (14 per cent of men and 19 per cent of women).

Mortality

N/A except for the unknown number of people who commit suicide due to unbearable pain.

Survival

N/A

Burden of disease

WHO DALY population for neck and back pain: 236,600
Males: 118,600
Females: 117,900

- 90 per cent of people with severe/very severe pain reported some level of interference with their normal work in the previous four weeks so the impact on the economy is significant.

Hospitalisations

AIHW data indicate that there were 521,000 hospital separations for musculoskeletal conditions in 2013-14 [3]. This is 0.054 per cent of all hospitalisations. It is reasonably safe to assume that the vast majority of these cases had associated pain.

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Cost

No Australian data are available attributable to musculo-skeletal pain alone. Chronic pain more broadly is estimated to cost $34.3 billion in 2007, or $10.847 per person living with chronic pain [4].

c) is a Government health priority topic

Arthritis and musculoskeletal conditions became a national health priority area in 2002.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

b) reduce unwarranted variation in prevention, diagnosis or treatment

Musculoskeletal pain is often under-diagnosed and also often over-managed. The view is increasingly being taken by insurers (e.g. workers compensation) that aggressive early treatment of pain will facilitate an early return to work as opposed to the development of chronic pain and consequent risk of medical retirement [5].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Analgesia, particularly NSAIDs should be carefully monitored due to the risks associated with long-term use.

Addiction to opiates is a common problem for people suffering musculoskeletal pain.

Private health insurance rebates for chiropractic, osteopathy and acupuncture should be evidence-based.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

New guides could address:

- Updated criteria for prescription re specific classes of analgesia
- Diagnosis and assessment guidelines including imaging
- Recovery timeframes and reassessment
- Allied health referral pathways.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

- Acute pain management - scientific evidence (third edition) 2010, Australian and New Zealand College of Anaesthetists [6]
- The Australian Pain Society Position Statement on the role of, and Standards for, Interventional Pain Management Procedures [7]
- Australian Physiotherapy Association Position Statement – Pain Management 2012 [7]
- Emergency Care Acute Pain Management Manual National Institute of Clinical Studies & NHMRC 2011 [8]
- Current management of acute musculoskeletal pain in the ambulatory care setting [9]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Personality Disorder**
Key audiences for the guideline:	**General practice** **Psychologists** **Mental health workers** **Psychiatric nurses** **Allied health**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Managing borderline personality disorder and substance use - an integrated approach 2011 [1]	**NHMRC**	**Department of Health**	**2011**	**2016**
Clinical Practice Guideline for the Management of Borderline Personality Disorder [2]	**NHMRC**	**Department of Health**	**2012**	**2017**

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Recent clinical guidelines have been developed to address borderline personality disorder (BPD) by the NHMRC:
A clinical practice guideline for the management of borderline personality disorder 2012 [2].

The real challenge now is to publicise the guideline and let medical staff know that borderline personality disorder if highly treatable with an excellent prognosis.

2. *Provide information to show that the clinical area is:*

a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

- The prevalence of BPD in Australian adults is estimated at approximately 1 per cent [3].
- Between two and five per cent of the population are affected by BPD at some stage in their lives [4].
- Women are three times more likely to be diagnosed with BPD than men [4].
- BPD traits are highest among adolescents and young adults [5].
- BPD is the most common and serious of the personality disorders, affecting up to 10 per cent of psychiatric outpatients and 20 per cent of in-patients [6].

Prognosis

- A recent study showed that 85 per cent of patients diagnosed with BPD will undergo remission within 10 years [7].
- The same study assessed relapse rates at 12 per cent.

Mortality

- Rates of suicide amongst those diagnosed with BPD can be as high as 10 per cent [8].

Burden of disease

AIHW reported 16,339 DALYs caused by personality disorders in women in 2003 [9]. Given that women with BPD are estimated to outnumber men [10], it can be assumed that the total number of estimated DALYs caused by BPD in 2003 was less than 32,000.

WHO reported 6,500 DALYs were lost in Australia due to 'other mental and behavioural disorders' in 2010 [11].

There is also significant cross over with suicide and self-harm as a result of BPD.

Hospitalisations

No Australian data available although significant cross over with suicide and self-harm as a result of BPD.

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Cost

No Australian data available.

c) is a Government health priority topic.

Mental health has been a federal health priority area since 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

The risk of self-harm to people living with BPD is significant, so a greater focus on treatment and support following more recent understanding of effective treatment modalities will reduce the risk of self-harm by people with the condition.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Adherence to medication regimes is poor in this population as might be expected. Greater support from primary health care and mental health teams would expect to improve treatment outcomes.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

There are very few specialised services for BPD in Australia. They are listed in South Australian Health's report on BPD (p.12-13) [10].

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

The recent report of the *National Review of Mental Health Programmes and Services* has recommended a stronger focus on person-centred care and on moving care from hospitals to the community. Clinical guidelines may need to be adapted to address these recommendations [12].

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

- Obsessive-compulsive disorder: The role of the GP, 2013 [13]
- Practice Guideline for the Treatment of Patients With Borderline Personality Disorder 2010, American Psychiatric Association [14]
- Borderline personality disorder: the NICE guideline on treatment and management [15]

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Rheumatoid Arthritis**
Key audiences for the guideline:	General practice Physiologists Occupational therapists Pharmacists Rheumatologists

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical guideline for the diagnosis and management of early rheumatoid arthritis [1]	NHMRC	NHMRC	2009	2014
Rheumatology version 2 [2]	Australian Rheumatology Association, RACGP, RCNA		2010	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Rheumatoid arthritis is an autoimmune disease which usually appears in middle age. It cannot be cured. Untreated rheumatoid arthritis will often result in joint damage and deformities. In advanced cases it can lead to severe deformities, especially of the hands, feet and knees. Early diagnosis and medical intervention are critical to improving the outcome [3].

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and prevalence

- 428,000 Australians reported having rheumatoid arthritis in 2007–08 [3].

- Rheumatoid arthritis is the second most common type of arthritis affecting approximately 2 per cent of the entire Australian population [4].
- Rheumatoid arthritis is more common in those aged 55 and older [4].
- Rheumatoid arthritis is 1.6 times more common in women than in men [4].

Mortality

N/A

Survival

N/A

Burden of disease

WHO DALY population: 34,200 [5]
Males: 7,900
Females: 26,300

Hospitalisations

- In 2010–11, 9,864 hospitalisations were attributed to rheumatoid arthritis among patients aged 16 years and over [4].

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)

Cost

- In 2008–09, the estimated total direct health expenditure on rheumatoid arthritis was $318.7 million [4].
- Of this, 86% or $273.6 million was for prescription medicines [4].

c) is a Government health priority topic.

Rheumatoid arthritis is included under musculoskeletal conditions as a national health priority.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Self-management is an important component of treatment. Generally strategies to manage the condition will need to be coordinated or discussed with the GP or rheumatologist.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Aboriginal and Torres Strait Islanders have roughly double the rate of rheumatoid arthritis as the non-Indigenous population [4]. While it is not known why this is the case, the data does point to the need to ensure greater attention is paid to case detection and treatment in Aboriginal communities.

c) *derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value*

There is recent Australian research into rheumatoid arthritis which aims to treat the condition using an antibody that block the action of a molecule from guiding inflammatory cells into tissues [6].

d) *provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?*

The expiration date on the '*Clinical guideline for the diagnosis and management of early rheumatoid arthritis*'[1] has passed. The guideline itself suggested yearly reviews. NHMRC still lists this guide as current. As such it is still relied upon by clinicians and health workers across Australia. As this guide is the only one of its type readily accessible in Australia, an update in line with its own recommendations would be advantageous.

4. *Are there any other current, valid or relevant guidelines available or applicable to the Australian context?*

American College of Rheumatology Recommendations for the Use of Disease-Modifying Antirheumatic Drugs and Biologic Agents in the Treatment of Rheumatoid Arthritis [7]

EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2013 update [8]

Rheumatoid arthritis: The management of rheumatoid arthritis in adults, 2009 NICE (UK) [9]

References

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Schizophrenia**
Key audiences for the guideline:	**Psychiatrists** **Psychiatric Nurses** **General practitioners** **Psychologists** **Social workers** **Case managers** **Nurses** **Pharmacists**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Clinical practice guidelines for the treatment of schizophrenia and related disorders [1]	**Royal Australian and New Zealand College of Psychiatrists**	**National Mental Health Strategy**	**26 August 2004**	**--**
The Australian Clinical Guidelines for Early Psychosis [2]**.**	**Orygen youth research centre**		**2010**	**--**
Clinical Practice Guideline for Schizophrenia and Related Disorders [3]**.**	**Royal Australian and New Zealand College of Psychiatrists**	**??**	**2015** **Currently out for comment**	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Schizophrenia is a chronic, severe, and disabling mental disorder characterised by deficits in thought processes, perceptions, and emotional responsiveness. Schizophrenia is the most severe of the mental illnesses and can affect all spheres of life, including perception, thought, judgement, mood, drive and ultimately, personality.

Schizophrenia is characterised by a retreat from reality with delusion formation, hallucinations, emotional dysregulation and disorganised behaviour. There are also

more subtle signs that develop over time – slow decline in mental function and social relationships leading to personality change, social isolation and occupational disability.

Many of those affected do not receive medical help in the early stages and as a result may not access appropriate treatment for two or more years from the first onset of symptoms [4].

2. Provide information to show that the clinical area is:

a) high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations) and / or

Incidence and prevalence

- Schizophrenia prevalence is currently estimated at 1.1 per cent or 280,000 Australians.
- Usually life-long with onset is typically between the ages of 15 and 30 [4].
- Schizophrenia is thought to be just as prevalent (if not more so) throughout Aboriginal and Torres Strait Islander peoples than the white population. Current prevalence is believed to be underreported and underestimated [5].

Morbidity and Mortality

- Schizophrenia is a major cause of suicide with up to 50 percent of people with schizophrenia attempting and 5 per cent completing suicide [4].
- People with schizophrenia have 2.5 times the death rate of the general population through all causes, and life expectancy is reduced by up to 18 years [4].
- The largest single contributor to this excess is death is physical diseases such as heart disease and diabetes. In this population cardiometabolic diseases occur at an earlier age, are recognised later and not as aggressively treated as they are in the general population [6, 7].

Prognosis

Schizophrenia is commonly a lifelong or chronic condition, however outcomes can vary from mild impairment to full recovery in an estimated 21-57 per cent of people with schizophrenia [10].

Burden of disease

WHO Disability Adjusted Life Year (DALY) rating 2012 [8]:

Total Australian population: 57,300 years

Male population: 31,200 years

Female population: 26,100 years

b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs

incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and /or

Cost Burden:

SANE Schizophrenia estimated costs in 2002 to be [9]:

- Direct health system costs due to schizophrenia were $661 million in 2001, including 60 per cent hospital costs, 22 per cent community mental health services, 6 per cent medical costs (GPs and specialists), 2 per cent pharmaceuticals.
- This represented nearly $18,000 per person with schizophrenia, over six times the spending on the average Australian's health care and 1.2 per cent of national health spending.
- Real financial costs of the illness totalled $1.85 billion in 2001, about 0.3 per cent of GDP and nearly $50,000 on average for each of more than 37,000* Australians with the illness.
- Over one third of this cost is borne by people with the illness and their carers.

* NOTE: It is now understood that approximately 1 in 100 Australians will develop schizophrenia in their lifetime [4].

Real indirect costs were $722 million including: [9]

- $488 million of lost earnings from people unable to work due to the illness
- $94 million due to premature death (the net present value of the mortality burden)
- $88 million of carer costs
- $52 million of prison, police and legal costs
- $190 million of lost tax revenue (patients and carers)
- $274 million in welfare payments, primarily comprising disability support pensions.

More contemporary sources place schizophrenia cost to the Australian community at approximately $2.6 billion per annum in both direct health costs as well as loss of productivity, as 85 per cent of sufferers receive welfare benefits. [4]

c) is a Government health priority topic.

Government Health Priority area

Schizophrenia falls under the Governments Health Priority Area of Mental Health and has been there since 1996.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users, and/or

A guideline could

- deal with the role clinicians play in plugging the gaps in regard to the physical health of persons with schizophrenia, reducing comorbid health burden.
- remove some of the stigma attached.

b) reduce unwarranted variation in prevention, diagnosis or treatment

Guidelines up to now have done a reasonably good job in maintaining consistency around pharmacotherapy. Updates in guidelines would obviously look to maintain this. Parameters with regard to physical health markers need to be addressed and made consistent.

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Guidelines could indicate the effectiveness of allied health and multi-disciplinary team based interventions in the area.

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Guidelines could indicate the effectiveness of allied health based interventions in the area along with early intervention strategies, both of which have shown promise with regard to:

- reduced hospitalisation
- reduced or prevented psychotic episodes or flair ups
- reduced morbidity and mortality from co-morbid conditions, e.g. cardiometabolic disease.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

On the evidence freely available, the last iteration of clinical guidelines in this area was accepted in 2004 and published in 2005 by the Royal Australian and New Zealand Collage of Psychiatrists. Indications are that updated guidelines are currently out for comment.

"Meta-guidelines" for the management of patients with schizophrenia [11].

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NATIONAL GUIDELINE PRIORITISATION EXPRESSION OF INTEREST FORM

Guideline Topic:	**Suicide Prevention**
Key audiences for the guideline:	**General practitioners** **Psychologists** **Psychiatrists** **Psychiatric Nurses** **Social workers** **Case managers** **Nurses**

Existing Australian guidelines:

Guideline	Approved by	Funded by	When approved	Expiry date
Guidelines for Working with the Suicidal Person [1]	**SA Health**	**SA Health**	**2012**	**2016**
Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services [2]	**Vic Health**		**2010**	
Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour [3]	**NSW Health**		**2005**	**2012**
Suicide Prevention and Recovery Guide: a resource for mental health professionals [4]	**SANE Australia**	**DoHA, National Suicide Prevention Programme**	**2013**	

Proposed guideline format (if known):

Please provide the following information to support the guideline topic to demonstrate that the topic meets the December 2014 AHMAC endorsed criteria for national clinical practice guidelines.

1. *How does the clinical area have the potential to significantly benefit the quality of patient/ consumer care and health outcomes?*

Suicide and suicidal behaviour arise from complex social, situational, biological and other individual causes which isolate people and erode their hope. Understanding risk and protective factors for different groups and environments is vital to effective response [5].

2. *Provide information to show that the clinical area is:*

   a) *high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations)*

Incidence and Prevalence and Mortality

Suicide ranks as the fourteenth leading cause of all deaths in 2011, with 2,273 deaths from suicide registered [6].

Male suicide occurs at a much higher rate than that for females. Of all deaths classified as suicide in 2013, nearly three-quarters (74.4%) were male, making suicide the 10th leading cause of death in males [6]. In 2013, the age standardised male suicide rate was 16.8 deaths per 100,000 compared to the female rate of 5.5 deaths per 100,000 [7].

While suicide accounts for a relatively small proportion (1.7%) of all deaths in Australia, it accounts for a greater proportion of deaths from all causes within specific age groups.

For example, in 2013, over a quarter of deaths of males in the 15-19, 20-24 and 25-29 year age groups were due to suicide (34.8%, 31.0% and 27.0%, respectively). Similarly for females, suicide deaths comprise a higher proportion of total deaths in younger age groups compared with older age groups (26.1% of deaths of 15-19 year olds and 26.3% of deaths of 20-24 year olds) [6].

The median age at death for suicide in 2013 was 44.5 years for both genders. In comparison, the median age for deaths from all causes in 2013 was 78.4 years for males and 84.6 years for females [6].

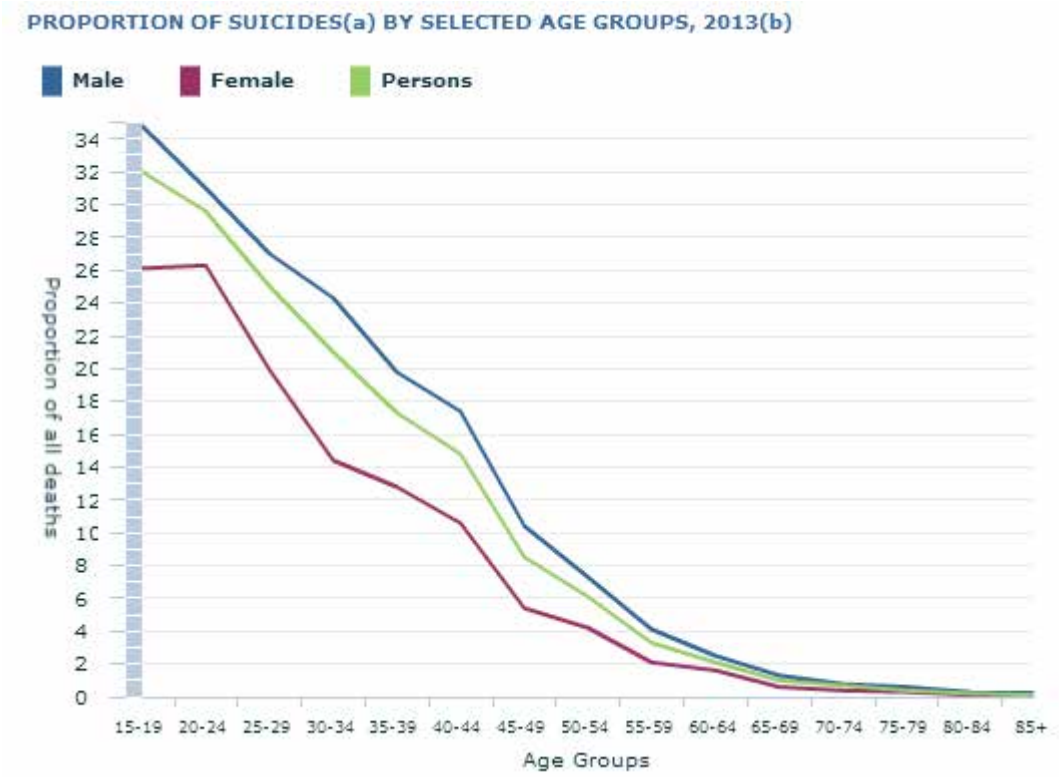


Figure 1: Australian Bureau of Statistics 2015 % of suicide by age group.

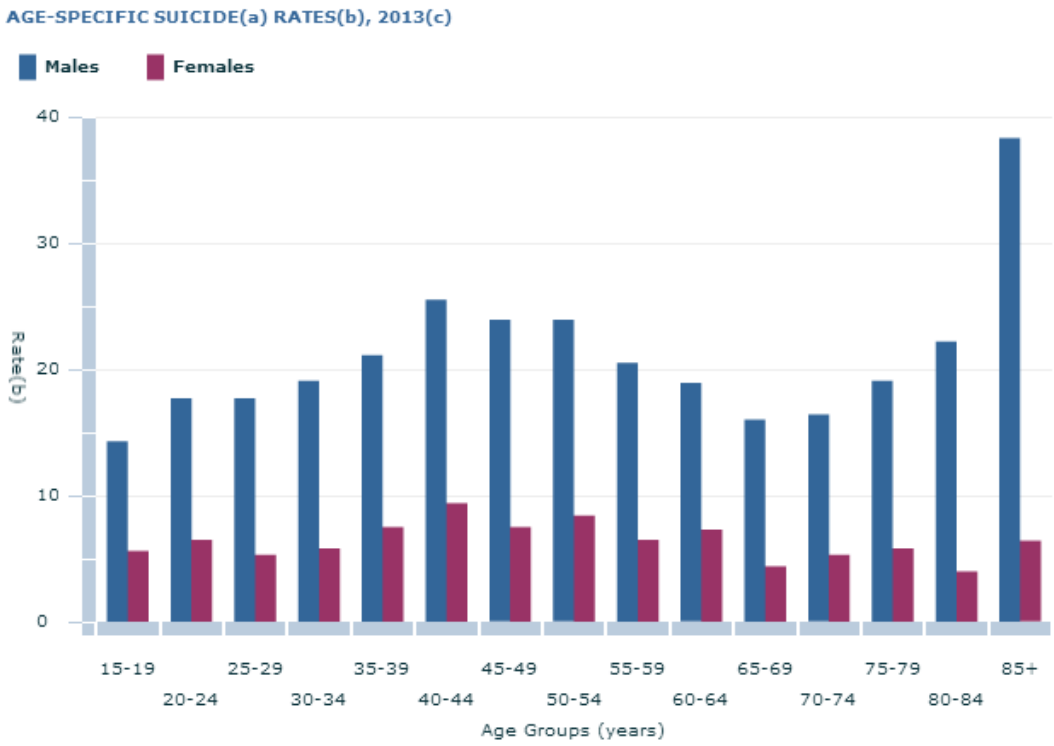


Figure 2: Australian Bureau of Statistics 2015 Suicide rate per 100000 population.

Disease Burden

WHO DALY rating for intentional injury by self-harm [8]
Population – 127,300
Male: 95,700
Female: 31,700

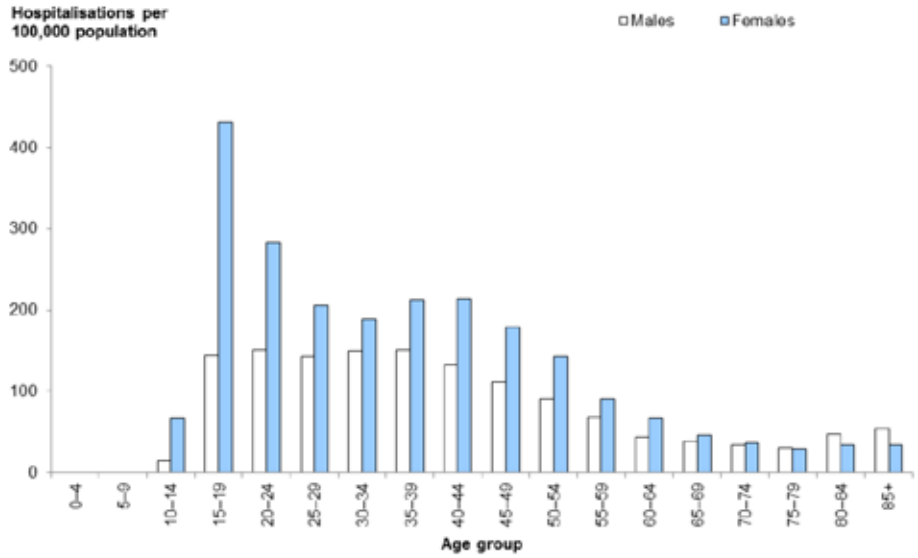
> *b) imposes high costs on health service funders, users (consumers/ patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another)*

A report compiled for Lifeline Australia places the cost of suicide and self-harm to the Australian economy between $13.57 and $17.5 billion. The majority of this is due to the base Value of a Statistical Life set at $6million, with the direct cost of attempted suicide and self-harm to the health system of $133.3 million annually [9].

Hospitalisations

All graphs are sourced from AIHW: Harrison JE & Henley G (2014), 'Suicide and hospitalised self-harm in Australia: trends and analysis. Canberra AIHW.

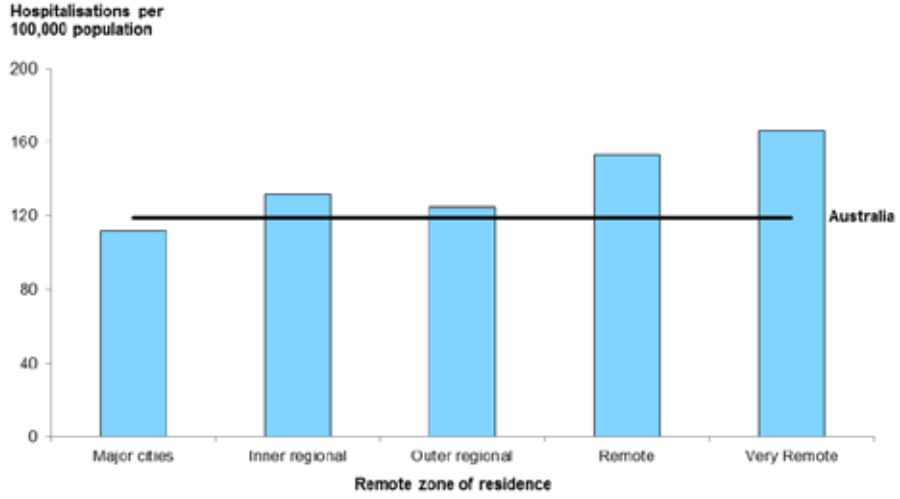
Hospitalisation by age group in 2010-11



Note: Rates for ages 0–4 and 5–9 not reported.

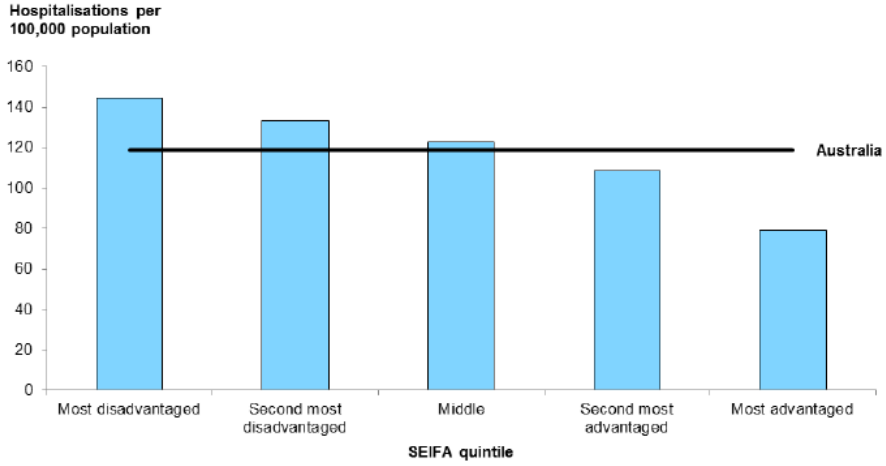
Source: AIHW National Morbidity Database.

Hospitalisation by remoteness of residence 2010-11



Source: AIHW National Morbidity Database.

Hospitalisation by socioeconomic status 2010-11



Source: AIHW National Morbidity Database.

a) is a Government health priority topic.

Government Health Priority Area

Suicide has significant cross over into National Health Priority area of Mental Health. The National Suicide Prevention Strategy (NSPS) was established in 1999 to address this health area with the National Suicide Prevention Program (NSPP) as the operational arm. Taking Action to Tackle Suicide (TATS) was established in 2010 to provide further support to the NSPP.

3. How would this guideline:

a) reduce risks and harms to consumers/ patients/ health service users

Greatest potential for harm in suicide is continued stigmatisation. There is a call for suicide prevention focus to be "Everyone's business, whether it is directed towards individuals at high risk, communities and groups at potential risk, or the whole of the population" [5].

b) reduce unwarranted variation in prevention, diagnosis or treatment

Age, sex and culturally specific guidelines or interventions would help to reduce variation in practice, prevention and intervention outcomes [4].

c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value

Specific protocols, uniform suicide risk assessment and management framework supported by training programs for the Health system would enhance the capacity of health workers to assess and effectively manage people who may be at risk of suicide [1, 3].

d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence?

Suicide prevention and on-going treatment of suicide ideation are matters for psychiatrists, psychologists and other mental health workers. The evidence is more about the need for investment in on-going, person-centred care and support than in any new treatment regimes.

4. Are there any other current, valid or relevant guidelines available or applicable to the Australian context?

Suicide Risk Assessment and Management in Practice: The Quintessential Clinical Activity [10].

References

1. SA Health. Guidelines for Working with the Suicidal Person. South Australian Health 2012.

2. Vic Health. Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services. Melbourne: Mental Health, Drugs & Regions branch, Victorian Government Department of Health,, 2010.

3. NSW Health. Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour. NSW Health, 2005 Contract No.: PD2005_121.

4. SANE Australia. Suicide Prevention and Recovery Guide: A resource for mental health professionals. South Melbourne: Sane Australia 2013.

5. Suicide Prevention Australia Suicide Prevention Australia - About Us [cited 2015 15 June]. Available from: http://suicidepreventionaust.org/about/.

6. ABS. Causes of Death, Australia, 2013. Canberra Australian Bureau of Statistics, 2015 Contract No.: 3303.0.

7. ABS. Gender Indicators, Australia, Feb 2015 Canberra Australian Bureau of Statistics 2015 Contract No.: 4125.0.

8. World Health Organisation. Global Helath Estimates Summary Tables In: World Health Organisation, editor. 2012.

9. Mendoza J, Rosenberg, S,. Suicide and Suicide Prevention in Australia Life Line Australia, The Inspire Foundation, OzHelp Foundation, Centre for Mental Health Research ANU, Suicide Prevention Australia, The Salvation Army, Brain and Mind Research Institute. , 2010.

10. Fochtmann LJ, Jacobs, Douglas G.,. Suicide Risk Assessment and Management in Practice: The Quintessential Clinical Activity. Acad Psychiatry. 2015:1-2.