Early and locally advanced breast cancer: diagnosis and management - Neoadjuvant chemotherapy and ovarian function suppression (update)

Consultation on draft scope
Stakeholder comments table

27/03/24 to 19/04/24

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Document	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
1	SH	Breast Cancer Now	Scope	4	20, 24	We support NICE in exploring recommendation of further treatment options for men with breast cancer, as we know that this population has limited options for endocrine therapy at present.	Thank you for your comment and support in this matter.
2	SH	Breast Cancer Now	Scope	10	5, 9 and 13	We support a review of the evidence and the potential introduction of new options into the treatment pathway. However, we have some concerns that if, through this development process, treatments are found to be less clinically or cost effective than others they may be removed from the recommendations. This may not be in the best interests of patients. Different treatments may have different side effect profiles that make them more suitable for some patients. We would wish to retain these treatments as options within the	Thank you for your comment and support in this matter. As part of this update, we will be aiming to incorporate breast cancer treatments recommended through the NICE technology appraisal guidance. This means that we will not be revisiting the clinical and cost-effectiveness evidence for these treatments. The focus of this part of the update will be on the chemotherapy 'backbones' to treatment regimens and where they might have the most benefit based on breast cancer subtype. As part of our review of clinical effectiveness we will look at the adverse events associated with each chemotherapy option. The

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						guidance to offer the maximum choice for patients and clinicians.	breast cancer committee includes patients who play an integral part in decision making, bring patient perspectives to the discussions and are involved in drafting suitable recommendations.
3	SH	Breast Cancer Now	Scope	10	19	We support a review of the evidence and the potential introduction of new options into the treatment pathway. However, we have some concerns that if, through this development process, treatments are found to be less clinically or cost effective than others they may be removed from the recommendations. This may not be in the best interests of patients. Different treatments may have different side effect profiles that make them more suitable for some patients. We would wish to retain these treatments as options within the guidance to offer the maximum choice for patients and clinicians.	Thank you for your comment and support in this matter. As part of our review of clinical effectiveness we will look at the adverse events associated with each treatment option. The breast cancer committee includes patients who play an integral part in decision making, bring patient perspectives to the discussions and are involved in drafting suitable recommendations.

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4	SH	Clinical Programmes Team, NHS England	scope			I am pleased that the purpose is to review and update neoadjuvant SACT for breast cancer and agree with the review focusing on carboplatin use for the triple negative and certain Her2 positive patients.	Thank you for your comment and support in this matter.
5	SH	Clinical Programmes Team, NHS England	scope			I think the wording is a bit odd as in both cases the carboplatin is given with the taxane drug part of the neoadjuvant regimen rather than the anthracycline part. I would have said something like 'add platinum to an anthracycline and taxane containing neoadjouvant regimen…'.	Thank you for your comment and support on this matter. We have discussed this with the committee and have now amended the wording of the questions to take into account your suggestion.
6	SH	Clinical Programmes Team, NHS England	scope			Why is immunotherapy with pembrolizumab/atezolizumab for triple negative breast cancer neoadjuvant SACT not being reviewed? Pembrolizumab is already funded by the CDF for higher risk patients in this group concomitantly with the anthracycline-taxane chemotherapy.	Thank you for your comment and support in this matter. As part of this update, we will be aiming to incorporate breast cancer treatments recommended through the NICE technology appraisal guidance. Pembrolizumab is recommended for early and locally advanced breast cancer through NICE technology appraisal

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							TA851. This will be incorporated into the guideline. Atezolizumab with chemotherapy for neoadjuvant treatment of resectable early or locally advanced invasive triple-negative breast cancer has been discontinued in the NICE technology appraisal programme.
7	SH	Clinical Programmes Team, NHS England	scope			The inclusion of BRCA status is important which is mentioned	Thank you for your comment and support in this matter.
8	SH	Clinical Programmes Team, NHS England	scope			I am happy with the part about gonadal function suppression – it is really important that this section is updated. Great that men will be included too.	Thank you for your comment and support in this matter.
9	SH	Clinical Programmes Team, NHS England	scope			I would support the proposed outline for the work.	Thank you for your comment and support in this matter.

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10		Test Evaluation Team Genomics Unit NHS England	Scope			In terms of the scope of the update we do have a concern that whilst the update will include reviewing: "Neoadjuvant chemotherapy regimens 1.2 What is the clinical and cost effectiveness of a platinum-containing neoadjuvant chemotherapy regimen compared to a non-platinum containing neoadjuvant chemotherapy regimen in people with invasive breast cancer of any receptor subtype and BRCA germline mutations." this does not appear to include reviewing germline BRCA (gBRCA) testing at the same time. We believe that the cost effectiveness calculations should include consideration of gBRCA testing as for NAC platinum therapies	Thank you for your comment. You are correct that the review question does not include direct consideration of gBRCA testing and we will not be reviewing the evidence about what genetic tests should be carried out and when as part of this current piece of work. The timing of genetic testing for gBRCA mutations is covered by the NICE guideline on Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer (CG164). NICE are considering reviewing the evidence for genetic testing and updating existing recommendations as part of a future planned update. We discussed your comment with the committee and they agreed that it would be necessary to know gBRCA status earlier than happens in

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						we believe that there will be a need for the gBRCA result to be turned round more quickly than current turn around times for this testing. The current standard turn around time for a gBRCA test where the patient with breast cancer meets the eligibility criteria as set out in the National Genomics Test Directory (please see Clinical Indication R208) is 42 days. A faster turn around time for gBRCA testing will mean that the test will cost more as samples cannot be batched. Therefore, we would suggest that the costs of gBRCA need to be included in the calculations alongside the costs of the drugs when considering the cost effectiveness between the two regimens.	current practice if we made recommendations for different chemotherapy regimens based on this, and that this could have cost implications if samples cannot be batched. They therefore agreed that the issue of when to test for gBRCA status applied more widely and would be better considered as part of the potential update to the familial breast cancer guideline as mentioned above. The timing and content of this update has yet to be decided but we will pass your comment onto the team who will determine this.