National Institute for Health and Clinical Excellence

248/2 – Radiofrequency ablation for colorectal metastases in the liver

Consultation Comments table

IPAC date: Thursday 15th October 2009

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 NHS Professional	**1**	This guidance is appropriate	Thank you for your comment.
2	Consultee 2 NHS Professional	**1**	Agree	Thank you for your comment.
3	Consultee 3 Beating Bowel Cancer	**1**	As an organisation committed to working for the best possible outcomes for those diagnosed with bowel cancer, Beating Bowel Cancer believes it is integral that all patients who are diagnosed with secondary bowel cancer in the liver are automatically referred for review at their nearest geographical MDT which includes a hepatobiliary surgeon, a radiologist and an oncologist. Once reviewed as appropriate for treatment for the secondary bowel cancer in the liver, appropriate treatments including radiofrequency ablation can be selected.	Thank you for your comment. Section 1.2 of the guidance states that a multidisciplinary team should carry out patient selection for this procedure.
4	Consultee 4 NHS Professional	**1**	Patients suitable for RFA should be formally discussed at a network recognised hepato pancreato biliary (HPB) multidisciplinary group. This would ensure appropriate selection of patients for this procedure.	Thank you for your comment. Section 1.2 of the guidance will be changed.

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
5	Consultee 1 NHS Professional	**2.1**	Alcohol (alone) is ineffective in the treatment of colorectal metastases	Thank you for your comment. Section 2.1.2 previously stated that chemo-embolisation with alcohol was a treatment option. This will be changed.
6	Consultee 2 NHS Professional	**2.1**	Agree	Thank you for your comment.
7	Consultee 3 Beating Bowel Cancer	**2.1**	Historically, treatment for patients with liver metastases from colorectal cancer was usually palliative. However, whilst the treatment of a large number of patients continues to be palliative, medical advances have been made in the treatment of secondary bowel cancer in the liver. These advances allow patients the potential to improve survival and their quality of life for their remaining months, and for many people, the chance of a cure. For patients diagnosed once their cancer has spread to the liver from the site of origin, it is imperative that they are fully assessed by specialist hepatobiliary teams for appropriate treatment options. In a time of huge medical advances, it is no longer appropriate for specialists in colorectal surgery to be making 'gate-keeping' decisions regarding who is suitable for treatment for bowel cancer secondaries in the liver, and what that treatment might be.	Thank you for your comment. The list of current treatments and alternatives is not intended to be definitive. The scope for this guidance did not stipulate treatment intent as being palliative or curative and thus literature searching has been inclusive of both.
8	Consultee 4 NHS Professional	**2.1**	1) As a substitute for hepatic resection (first treatment or after previous liver resection) in patients who are not considered fit for liver resectional surgery, after discussion at a specialist HPB mdt group. 2) As an additional procedure in patients with bilateral liver metastases where one or two lesions are not deemed to be resectable mainly due to the location of these lesions within the liver. In this situation RFA would be carried out as an open or laparoscopic procedure.	Thank you for your comment. Section 2.1.2 of the guidance will be changed.

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9	Consultee 1 NHS Professional	**2.2**	This treats percutaneous and intraoperative radiofrequency ablation (RFA) as equivalent procedures. This is potentially misleading and inappropriate. RFA often needs to be repeated. Repeat percutaneous procedures carried out under local anaesthesia have very different implications to peroperative procedures under general anaesthesia. Also, most units tend to rely on CT guidance to a significant extent, as it is usually more accurate than ultrasound guidance. CT cannot be used for peroperative procedures. In my opinion, it is important to focus on percutaneous RFA. Peroperative RFA is appropriate only in very limited and clearly defined circumstances, e.g. when a hepatic resection is being undertaken and a small metastasis, easily seen on peroperative ultrasound, is present in the contralateral lobe.	Thank you for your comment. The scope for this guidance review (in line with original guidance) did not stipulate mode of delivery of RF ablation and thus literature searching has been inclusive of both. Section 2.2.1 of the guidance will be changed.
10	Consultee 2 NHS Professional	**2.2**	Agree	Thank you for your comment.
11	Consultee 5 Manufacturer	**2.2**	Boston Scientific team has a wide experience of RFA procedures. The majority of the cases performed by a Radiologist use CT, or a combination of CT and ultrasound for tumour visualisation and needle placement which means that very few (10% at a guess) use ultrasound alone. Â It is the combined surgical and RFA procedures that use solely ultrasound as it is obviously impossible to CT scan a patient who is mid liver resection.	Thank you for your comment. Section 2.2.1 of the guidance will be changed.

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12	Consultee 1 NHS Professional	**2.3**	The surgical and RFA groups are very different in the extent of the disease. Recurrence rates obtained from non-randomised studies cannot be relied upon.	Thank you for your comment. Section 2.3.1 of the guidance will be changed to highlight the difference between RF ablation and surgery treatment groups and 2.5.1 reiterates this. However, the overview provides more details about individual studies including baseline clinical characteristics of study populations.
13	Consultee 2 NHS Professional	**2.3**	Agree	Thank you for your comment.
14	Consultee 1 NHS Professional	**2.4**	There is a big difference in complications seen in large centres undertaking these procedures frequently and figures reported in small series from centres undertaking a small volume of procedures.	Thank you for your comment. Insufficient data were available to be able to provide specific recommendations with regard to the influence of surgical experience
15	Consultee 2 NHS Professional	**2.4**	Agree	Thank you for your comment.
16	Consultee 1 NHS Professional	**2.5**	This is correct.	Thank you for your comment.
17	Consultee 2 NHS Professional	**2.5**	Agree	Thank you for your comment.

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18	Consultee 5 Manufacturer	**2.5**	This is an important point to consider when comparing RFA with surgical resection. Â Surgery is considered to be the gold standard treatment, however if a patient is not suitable it is generally due to the fact that the disease has progressed to an extent where a resection is not possible and which is when RFA becomes a viable option. Â As a result, the RFA patients included in the trials generally have disease that is significantly more advanced than those patients in the surgical arms, inevitably therefore the RFA patients will have a poorer prognosis and a shorter life expectancy at the time of treatment due to the more advanced nature of the disease, in comparison to a patient who is diagnosed early and is suitable for surgery. Â In summary the time of treatment and extent of disease often governs the outcome of any selected treatment.	Thank you for your comment. The overview describes the patient inclusion criteria for all included studies and discusses the evidence in terms of respectability in the 'Validity and generalisability' section on page 14.
19	Consultee 6 NHS Professional SPECIALIST ADVISER	**ALL**	This looks good at present. My only additional comment would be that all cases which might be considered for RFA MUST go through a HPB (liver) surgery MDT. There are cases of metastatic disease in the private sector being treated without recourse to this where profit is obviously a potential confounding factor	Thank you for your comment. Section 1.2 of the guidance will be changed.