National Institute for Health and Clinical Excellence

232/2 -Photodynamic therapy for Barrett's oesophagus

Consultation Comments table

IPAC date: Thursday 15th April 2010

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 Patient	**1**	looks good on paper i wish to know how long it will take to reach the GPs? As this is the first point for many sufferers Â before being refered for further treatment to the hospital	Thank you for your comment. This guidance is expected to be published in June 2010, pending NICE's resolution process. NICE is also developing a short clinical guideline on Ablative therapy for the treatment of Barrett's oesophagus which has a planned publication date of July 2010 – more details available from www.nice.org.uk.
2	Consultee 2 NHS Professional	**1**	In my opinion, since PDT does not reliably ablate Barretts epithelium in its entirety it is not the right modality to consider to ablate non-dysplastic Barretts in any setting, unless combined with another modality.	Thank you for your comment. The Committee were less certain about the efficacy of PDT in patients with non-dysplasia and this is reflected in the recommendations for low-grade and non-dysplastic Barretts.
3	Consultee 1 Patient	**2.1**	when the patient is to recieve the treatment are the risks outlined to them before ??? What are the Â repurcussions afterwards ????	NICE is developing a document about this procedure called 'Understanding NICE guidance' Its use by healthcare professionals is recommended, but they may also wish to produce patient information that is tailored to local circumstances or patients with particular needs. 'Understanding NICE guidance' on Photodynamic therapy for Barrett's oesophagus will be published along with the guidance, and will include questions on the risks and benefits of the procedure that patients may wish to ask when they are considering whether to undergo the procedure.
4	Consultee 2 NHS Professional	**2.1**	Current evidence implies that high resolution magnification endoscopy either with chromoendoscopy or advanced imaging (AFI, NBI, FICE) should be used in patients with identified dysplasia.	Assessing appropriate imaging techniques is beyond the scope of this guidance.

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5	Consultee 2 NHS Professional	**2.1**	EMR should be used as a staging procedure prior to PDT, especially if there is a visible abnormality (eg a nodule) prior to PDT.	The Committee considered this comment but decided not to change the guidance.
6	Consultee 1 Patient	**2.2**	Does this mean that the patient will be an inpatient for A day or longer	Thank you for your comment. The guidance will be changed in Section 2.2.2 to state that For extensive Barrett's oesopagus, *further PDT treatment may be required.*'
7	Consultee 2 NHS Professional	**2.2**	Could the advisors comment on the type of photosensitiser that is best in their view (eg 5 ALA vs photoprophyrin) in terms of efficacy, cost and side effects?	Making recommendations about appropriate agents to be used in this procedure is beyond the scope of this guidance.
8	Consultee 1 Patient	**2.3**	what Staff levels are the people that do the procedure Â Are they consultant & senior nursing staff or others I take ezomeprazole 40mg Â 1 each day & have done for Â the last 8 months & am still getting reflux	Section 1.5 states that the procedure 'should only be carried out by endoscopists with specific training in the procedure.' NICE IP guidance does not state how many staff should be involved in carrying out the procedure, although it may state the types of staff that should be involved. In this guidance at section 1.5 it states that the procedure should be carried out by endoscopists with specific training in the procedure.
9	Consultee 2 NHS Professional	**2.3**	There may be other technologies that should be considered as an addition to PDT: although the guidance considers the strong evidence in relation to PDT in comparison to no endoscopic treatment or other modalities, I wonder if it would it be possible to review any evidence of combination therapy (eg EMR to remove nodules, followed by PDT PDT followed by APC to ablate residual Barretts islands)? I suspect if there is such information to consider there would be cost and efficacy considerations - it may well be cheaper for follow up therapy to use less PDT, particularly if the residual Barretts is not extensive. Should the guidance comment on costs as well?	Thank you for your comments. A short clinical guideline on the management of Barrett's oesophagus is being developed to address the clinical pathway of the treatment of Barrett's oesophagus (including high-grade dysplasia and intramucosal cancer), including the use of combination treatments. Cost-effectiveness is not part of the remit of the IP Programme. The short clinical guideline will consider cost-effectiveness.
10	Consultee 1 Patient	**2.4**	the safety aspect of the treatment leaves a lot to be desired Â but what tests are carried out before the treatment is administered?????????	The guidance gives the Committee's views on the safety of the procedure for high-grade and low grade/no dysplasia at sections 1.1 and 1.2 respectively. This guidance is not intended to describe the full treatment pathway. The short clinical guideline on Barrett's oesophagus addresses these issues (see response to comment no.1.

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11	Consultee 2 NHS Professional	**2.4**	Is there any evidence on the effects of PDT on oesophageal motility? Does this contribute to dysphagia?	Oesophageal motility is a technical outcome which was not considered by the Committee to be as important as other outcomes. Assessing any association between oesophageal motility and dysphagia is beyond the scope of this guidance.
12	Consultee 1 Patient	**general**	i have suffered from Barretts now fro 4 years & with no treatment i suffer reflux many times each day Â but my gp says watch what you eat & nothing more	Thank you for your comment.