National Institute for Health and Clinical Excellence

316/2– Percutaneous radiofrequency ablation for primary and secondary lung cancers

Consultation Comments table

IPAC date: Friday 15 October 2010

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 British Thoracic Society Lung Cancer and Mesothelioma Specialist Advisory Group	**1**	Agree	Thank you for your comment.
2	Consultee 1 British Thoracic Society Lung Cancer and Mesothelioma Specialist Advisory Group	**2.1**	Agree	Thank you for your comment.
3	Consultee 1 British Thoracic Society Lung Cancer and Mesothelioma Specialist Advisory Group	**2.2**	Agree	Thank you for your comment.

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4	Consultee 2 Boston Scientific Manufacturer	**2.2**	The first sentence in 2.2.1 is very non-specific and confusing. The words 'small' can be interpreted very differently by clinicians and lead to inconsistent care across the country. It would be valuable to give an indication of the size of tumours which can be most effectively treated by RFA. The recent article from RFA international expert Dr de BaÃ¨re states that:" It is usually thought that the number of tumors deposited per hemithorax should not be [more than] 5, and that the largest diameter should be [less than] 5 cm, and ideally [less than] 3.5 cm." Â [de BaÃ¨re T. Lung Tumor Radiofrequency Ablation: Where Do We Stand? Cardiovasc Intervent Radiol 2010 Apr 29. [Epub ahead of print] This would be a very valuable addition to the Guidance. Section 2.2.2 is also misleading as it suggests that local anaesthesia is the common practice. However general anaesthesia is also frequent and it needs to remain an individual decision, according to operator experience, and patient characteristics. The first sentence of 2.2.2 could read:" The procedure is carried out either under local anaesthesia with conscious sedation or general anaesthesia, according to tumour size and anatomy".	Thank you for your comment. The Committee considered this comment but decided there was insufficient evidence to support a change to the guidance. Section 2.2.2 of the guidance will not be changed. The article cited by the consultee was indentified in the post consultation literature search and will be added to appendix A of the overview.
5	Consultee 1 British Thoracic Society Lung Cancer and Mesothelioma Specialist Advisory Group	**2.3**	Agree. Unfortunately the data on efficacy is nearly all from case series, with no robust RCT evidence, which makes it of limited value. There is an urgent need for the practitioners to develop the evidence base with high quality research, as potentially this might be a very important treatment that should be used more widely.	Thank you for your comment. A section 1.4 will be added to the guidance, referring to the need for further research.

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6	Consultee 2 Boston Scientific Manufacturer	**2.3**	The case series of 153 patients also reports the survival rates for colorectal lung metastases and it should be added in section 2.3.1. The 1, 3, and 5 years survival for colorectal lung metastases were 87%, 57%, and 57%. Section 2.3.4 is confusing. We have assumed that it was a positive statement i.e if RFA hadn't been carried out the Quality of life would have decreased. However this needs to be confirmed.	Thank you for your comment. Section 2.3.1 of the guidance will be replaced by a study identified in the post consultation literature search. Section 2.3.4 of the guidance will not be changed.
7	Consultee 1 British Thoracic Society Lung Cancer and Mesothelioma Specialist Advisory Group	**2.4**	Agree	Thank you for your comment.
8	Consultee 2 Boston Scientific Manufacturer	**2.4**	It is important to note that in the case series of 153 patients, two out of the four patients who died were single-lung patients i.e with significantly higher risk than the 'general' lung RFA population. This could explain the higher death rate (2.6%) than usually seen in RFA case series and should be mentioned. Boston Scientific would like to draw the attention of the Committee to the fact that only half of the Specialist Advisers are performing lung RFA regularly. For this evaluation, as well as more generally for all IPAC guidance, it is critical to invite advisors who regularly practice the reviewed procedure.	Thank you for your comment. Section 2.4.1 of the guidance will be changed.