Skin cancers including Melanoma: assessment and management

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British Dermatological Nursing Group and the British Association of Skin Cancer Specialist Nurses	6	General	**Cost savings and innovative approaches** Organisation of skin cancer service: this needs updating but it is essential that the organisation of the service is described (as this is the only document that will do so), including the roles of LSMDT, SSMDT and core team members. It is an opportunity to look at the role of the Skin Cancer CNS, who in many settings provides an autonomous, cost effective and patient focused service including : diagnosis in 2 WW clinics, Delivery of diagnosis & further treatment planning, follow up clinics , referral, surgery etc. You were asking for ideas of making services cost effectiveness and we feel increased roles of CNS's, with the appropriate clinical & academic experience, is key to this.	Thank you for your comment. The guideline committee will consider your views on the recommendations in CSG8 guidelines: Improving outcomes for people with skin tumours including melanoma (2006) and The management of low-risk basal cell carcinomas in the community (2010) when deciding whether recommendations should be removed or retained. It is outside of NICE's remit to include recommendations about the specific role individual specialties should have in the healthcare service.
British Dermatological Nursing Group and the British Association of Skin Cancer Specialist Nurses	9	General	The guideline should retain the sections on "patient information &communication & support needs" and consider in the same section, support for patients receiving extensive treatments and survivorship.	Thank you for your comment. The guideline committee will consider your views on the recommendations in CSG8 guidelines: Improving outcomes for people with skin tumours including melanoma (2006) and The management of low-risk basal cell carcinomas in the community (2010) when deciding whether recommendations should be removed or retained. During the scoping of this update and the surveillance review of the NICE guideline NG14 Melanoma: assessment and management (2015) no new evidence was identified that would impact on the current recommendations for patient information, communication and support needs. The original recommendations, 1.1.1 -1.1.5, published in NG14 (2015) remain valid and will appear in the updated guideline. Therefore, area 1.1, Communication and

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				Support, will not be included in this update. However, we note that issues related to 'survivorship' are of increasing importance and will highlight this area to the surveillance team for consideration at the next surveillance review.
British Dermatological Nursing Group and the British Association of Skin Cancer Specialist Nurses	10	General	Excision: should new evidence re excision margins in melanoma be considered?	Thank you for your comment. Following stakeholder consultation, we have amended the scope to include reviewing the evidence for excision for stage 0 to 2 melanoma and updating existing recommendations 1.6.1 – 1.6.4 as needed. The following draft question will be considered in the guideline update: 3.1 What are the most effective surgical and histological excision margins for stage 0 to 2 melanoma?
British Gynaecological Cancer Society	General	General	Having looked at the scoping document, my opinion is that vulval and vaginal cancers lie outside of the scope of this NICE guidance and should be specifically excluded. There are recent national guidelines on mucosal melanomas (which include vaginal and vulval and cervical melanomas) and the aetiology and treatment of vulval/peri-anal SCC is very different to other skin cancers. There is minimal overlap in terms of evidence and clinical trials between cutaneous skin cancers and gynae skin cancers.	Thank you for this information. The scope sets out the groups the guideline will and will not cover. People with vulval and vaginal cancers are excluded from the scope of this guideline under "people with melanoma arising from mucosal sites", the scope does not list specific mucosal sites as it would not be possible to list all mucosal sites in the scope.

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British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	9	General	**Assessing Melanoma** Eyelid melanoma can be assessed using slit-lamp biomicroscopy, especially for those melanomas which involve the eyelid margin where dermatoscopy is not possible or practical. The advantage of the slit-lamp is that it is binocular. Both low and high-power magnification can be used to look at the three-dimensional overview and deeper features respectively. The neutral density/grey filter should be used and the unfiltered/high beam lightening avoided to prevent bleaching of the lesion with the risk of missing colour heterogeneity. The ABCDE pneumonic is still used in eyelid lesions namely asymmetry (3D Asymmetry), border, colour, diameter and evolving.	Thank you for your comment. During the scoping of this update and the surveillance review of the NICE guideline NG14 Melanoma: assessment and management (2015) no new evidence was identified that would impact on the current recommendations for assessing melanoma. Therefore, area 1.2, Assessing melanoma - Dermoscopy and other visualisation techniques, will not be included in this update. The original recommendations, 1.2.1 and 1.2.2, published in NG14 (2015) remain valid and will appear in the updated guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	9	General	**Photography** • Good quality photography is also needed for eyelid melanoma and this can include anterior segment camera setting on a fundal/fluorescein camera/imaging machine if this achieves a better-quality photograph of the eyelid margin. • A ruler should be placed next to the lesion to help determine evolution over time as different camera users or setting may be used at subsequent visits.	Thank you for your comment. During the scoping of this update and the surveillance review of the NICE guideline NG14 Melanoma: assessment and management (2015) no new evidence was identified that would impact on the current recommendations for photography. Therefore, area 1.2, Assessing melanoma - Dermoscopy and other visualisation techniques, will not be included in this update. The original recommendation, 1.2.3, published in NG14 (2015) remains valid and will appear in the updated guideline.

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British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	9	General	**Managing suboptimal Vitamin D Levels** • Measure vitamin D levels at diagnosis in secondary care in all people with melanoma • High dose vitamin D is recommended to be taken as a supplement as long as there is no contraindication such as pregnancy, breastfeeding or metabolic disorders.(1)	Thank you for your comment. The current NICE guideline NG14 Melanoma: assessment and management (2015) includes a cross reference to NICE guideline PH56 Vitamin D: supplement use in specific population groups. During the scoping of the update for this guideline (skin cancer including melanoma) no evidence was identified to suggest the cross reference to PH56 should be amended. PH56 was reviewed in July 2017 and no new evidence was identified that affected the current recommendations. The cross referral in NG14 (2015) to PH56 remains valid and will appear in the updated guideline. Therefore, this area will not be included in this update.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	9	General	**Sentinel Lymph node biopsy** The eyelid comprises the thinnest skin on all of the body (0.6 to 0.8 mm thick including epidermis and dermis) and as a result has less travel for the tumour to get to deeper structures such as lymph gland or bloods vessels.(2) In theory, eyelid melanomas have the potential to spread quicker than the same size lesion within a thicker skin region. Coupled with this are the availability of stage 3 disease treatment modalities. We therefore support the use of SLNB for thinner tumours less than 0.8mm displaying features of ulceration, lymphovascular invasion or $\geq$ 2/mm2 mitotic rate.(3)	Thank you for this suggestion. The scope notes that the evidence will be reviewed for sentinel lymph node biopsy. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. We

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			• Consider the use of SLNB for thinner tumours less than 0.8mm displaying features of ulceration, lymphovascular invasion or ≥ 2/mm2 mitotic rate • Patients with a pT1b primary melanoma should be considered for SLNB.	will keep in mind the suggestion you have raised when developing the guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	10	General	**Advantage of sentinel lymph node biopsy** By identifying stage III disease, SLNB becomes a treatment instigating tool allowing patient access to improved overall disease-free survival.	Thank you for this suggestion. The scope notes that the evidence will be reviewed for sentinel lymph node biopsy. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. We will keep in mind the suggestion you have raised when developing the guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	15	General	1.1.3 b extra With eyelid melanoma, skin protection can be problematic with the potential for sunscreen protection to go into the eye, especially in children. High SPF lipsalve can be used	Thank you for your comment. It is outside the remit of NICE guideline NG14 Melanoma: assessment and management (2015) to give guidance on applying skin cream, therefore this area will not be included in this update. However, the updated guideline will have the opportunity to cross-refer to related NICE guidelines as

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			to cover both the upper and lower eyelid with minimal risk to the ocular surface.(4)	needed, including Sunlight exposure: risks and benefits (NG34) which covers approaches to protecting skin.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	15	General	**1.2.1 b extra** Eyelid melanoma can be assessed using the slit-lamp biomicroscopy, especially those which involve the eyelid margin where dermatoscopy is not possible or practical. (refer to p9 section assessing melanoma – see comment on Assessing Melanoma)	Thank you for your comment. During the scoping of this update and the surveillance review of the NICE guideline NG14 Melanoma: assessment and management (2015) no new evidence was identified that would impact on the current recommendations for dermoscopy. Therefore, area 1.2, Assessing Melanoma – Dermoscopy and other visualisation techniques, will not be included in this update. The original recommendations, 1.2.1-1.2.2, published in NG14 (2015) remain valid and will appear in the updated guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	17	General	**1.5.1** We do not agree with this comment and would approve an edited version as per comment 5) and written as follows: • Do not offer SLNB to people with stage 1A with a Breslow thickness of < 0.8mm and have no features of lymphovascular invasion, ulceration or mitotic index of ≥ 2/mm2.	Thank you for your comment. The scope notes that the evidence will be reviewed for sentinel lymph node biopsy. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. We

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				will keep in mind the suggestion you have raised when developing the guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	17	General	**1.5.2** We do not agree with this comment and would approve an edited version encompasses comments 5 and 8: • Consider SLNB as a staging and treatment instigating tool for people with Beslow <0.8mm displaying features of lymphovascular invasion, ulceration or mitotic index ≥ 2/mm2.This size is particularly pertinent for the thin eyelid skin whereby the average thickness is between 0.6 to 0.8mm.(2)	Thank you for your comment. The scope notes that the evidence will be reviewed for sentinel lymph node biopsy. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. We will keep in mind the suggestion you have raised when developing the guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	18	General	**1.5.3** We would recommend the modification of this comment by adding the PET to the CT scan as follows: • Offer PET-CT staging to people with stage Ic melanoma who have not undergone SLNB, and to people with stage III disease or suspected stage IV melanoma.	Thank you for your comment. The scope notes that the evidence will be reviewed for imaging. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in

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				the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. We will keep in mind the suggestion you have raised when developing the guideline.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	19	General	**Excision 1.6** We note that you mention the following against the excision subsection 'no evidence review: retain recommendation from existing guideline'. We appeal that we can have an amendment in reference to eyelid melanoma only as outlined below. Otherwise, ophthalmologists will be forced to practise outside of these guidelines to save patients sight. In terms of evidence, we list two articles below and results from unpublished data in the subsequent comments below [confidential comments redacted]. In addition, there is a NIHR portfolio registered study (Eyelid Melanoma and version 1.2 IRAS ID252915 / CPMS ID 42288) running over the next 5 years looking into the management of eyelid melanoma and we will report on the outcomes of this in due course which include the aims of identifying excision margins used. We strongly disagree with the application of these excision margins to the periocular region (eyelid	Thank you for your comment and information. Following stakeholder consultation, we have amended the scope to include reviewing the evidence for excision for stage 0 to 2 melanoma and updating existing recommendations 1.6.1 – 1.6.4 as needed. The following draft question will be considered in the guideline update: 3.1 What are the most effective surgical and histological excision margins for stage 0 to 2 melanoma? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.

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			melanoma) where the eyelids are essential to protect the eyeball and maintain vision. Loss of an excessive amount of eyelid can lead to visual loss. Good quality evidence for the use of arbitrary excision margin of 1 or 2 cm is poor and non-existent in the periocular region. Application of the current excision margin for cutaneous melanoma elsewhere does not have evidence base either, however, we will not comment on recommended margins in cutaneous melanoma not within the periocular region. We are supportive of en-face margin-controlled excision (mainly paraffin) to remove eyelid melanoma to ensure removal whilst reducing tissue loss rather than an arbitrary excision margin. Pilot data from a single centre melanoma referral unit supporting the use of a smaller than 1cm margin in eyelid melanoma whilst maintaining survival rates similar to cutaneous melanoma elsewhere.	
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	19	General	**1.6.1 b** Consider for eyelid melanoma, a clinical margin of 3mm or en-face margin-controlled excision to remove stage 0 (melanoma in-situ) in order to preserve as much normal eyelid as possible to protect vision.(1, 5)	Thank you for your comment. Following stakeholder consultation, we have amended the scope to include reviewing the evidence for excision for stage 0 to 2 melanoma and updating existing recommendations 1.6.1

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				– 1.6.4 as needed. The following draft question will be considered in the guideline update: 3.1 What are the most effective surgical and histological excision margins for stage 0 to 2 melanoma? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	19	General	**1.6.3** Consider for eyelid melanoma, a clinical margin of 5mm or en-face margin-controlled excision for stage I or II in order to preserve as much normal eyelid as possible to protect vision.(1, 5)	Thank you for your comment. Following stakeholder consultation, we have amended the scope to include reviewing the evidence for excision for stage 0 to 2 melanoma and updating existing recommendations 1.6.1 – 1.6.4 as needed. The following draft question will be considered in the guideline update: 3.1 What are the most effective surgical and histological excision margins for stage 0 to 2 melanoma?

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				The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	19	General	**Completion lymphadenectomy** The MSLT-2 and DeCOG trials both randomised patients with a positive sentinel node either to observation with close radiological imaging or to a completion lymph node dissection (CLND). Incorporation of these findings is recommended into the guidelines.	Thank you for this information. The scope notes that the evidence will be reviewed for completion lymphadenectomy. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can

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				be made to practitioners, commissioners of services and others.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	22	General	**Systemic anticancer treatment** Consider incorporated data from the following studies: (6, 7) 6. K. D. Lewis et al., Impact of depth of response on survival in patients treated with cobimetinib +/- vemurafenib: pooled analysis of BRIM-2, BRIM-3, BRIM-7 and coBRIM. British journal of cancer 121, 522-528 (2019). 7. D. Schadendorf et al., Patient-reported outcomes in patients with resected, high-risk melanoma with BRAF(V600E) or BRAF(V600K) mutations treated with adjuvant dabrafenib plus trametinib (COMBI-AD): a randomised, placebo-controlled, phase 3 trial. The Lancet. Oncology 20, 701-710 (2019).	Thank you for this information. The scope notes that the evidence will be reviewed for systemic anticancer treatment. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	22	General	**Targeted treatments** Consider incorporated data from the following studies: (6, 7) 6. K. D. Lewis et al., Impact of depth of response on survival in patients treated with cobimetinib +/- vemurafenib: pooled analysis of BRIM-2, BRIM-3, BRIM-7 and coBRIM. British journal of cancer 121, 522-528 (2019).	Thank you for this information. The scope notes that the evidence will be reviewed for targeted treatments. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you

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			7. D. Schadendorf et al., Patient-reported outcomes in patients with resected, high-risk melanoma with BRAF(V600E) or BRAF(V600K) mutations treated with adjuvant dabrafenib plus trametinib (COMBI-AD): a randomised, placebo-controlled, phase 3 trial. The Lancet. Oncology 20, 701-710 (2019).	refer to meets the review protocol, this will be considered by the guideline committee during the update. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
British Oculoplastic Surgical Society and the Royal College of Ophthalmologists	22	General	**Immunotherapy** Consider incorporated data from the following studies: (6, 7) 6. K. D. Lewis et al., Impact of depth of response on survival in patients treated with cobimetinib +/- vemurafenib: pooled analysis of BRIM-2, BRIM-3, BRIM-7 and coBRIM. British journal of cancer 121, 522-528 (2019). 7. D. Schadendorf et al., Patient-reported outcomes in patients with resected, high-risk melanoma with BRAF(V600E) or BRAF(V600K) mutations treated with adjuvant dabrafenib plus trametinib (COMBI-AD): a randomised, placebo-controlled, phase 3 trial. The Lancet. Oncology 20, 701-710 (2019).	Thank you for this information. The scope notes that the evidence will be reviewed for immunotherapy. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
Melanoma Focus	General	General	Melanoma Focus have reviewed the draft scope consultation and we confirm that we support the guideline scope for 'skin tumours including melanoma (update)'.	Thank you for your comment. We appreciate your support for this scope and update of the guideline.
Merck Sharp & Dohme Limited	10	General	In the proposed outline for the National Institute for Health and Care Excellence (NICE) guideline NG14, there is no	Thank you for your comment. The scope notes that when the guideline is updated a link will be added between the

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			item listed under the section "1.7 Managing stage III melanoma" that explicitly covers adjuvant therapy in treating stage III melanoma as described in the NICE Pathways at: https://pathways.nice.org.uk/pathways/melanoma/treating-stage-iii-melanoma#content=view-node%3Anodes-adjuvant-therapy While there is the item for "Adjunctive systemic therapy" under the section "1.7 Managing stage III melanoma" of the proposed outline for NICE guideline NG14, it is not clearly described what is meant by adjunctive in this context and whether this will cover adjuvant therapy. As NICE recommendations for adjuvant therapies for treating stage III melanoma (NICE Technology Appraisal Guidance 544, 553, and 558) have been published since the July 2015 publication date of the current NG14 guideline, it is important to ensure that these new recommendations are included in the updated NG14 guideline.	guideline and the NICE pathway to all current NICE technology appraisal guidance for adjunctive systemic therapy including NICE technology appraisal guidance 554, 553 and 558.
North of England Dermatopathology Service and the	Invited comments on CSG8	General	This NICE guidance remains essential to the basic day to day clinical work and quality of many aspects of UK dermatological and histopathological practice. Without this guidance , there will be a gradual slippage in their use	Thank you for your comment. The guideline committee will consider your views on the recommendations in CSG8 guidelines: Improving outcomes for people with skin tumours including melanoma (2006) and The

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British Association of Dermatologists			and a gradual reduction in quality. The problem arises in that many were incorporated into the NHS Peer Review Programme as essential quality standards, but over time the importance of this programme itself has increasingly slipped and is now largely ineffective. Therefore, to remove these areas will mean that there is no surviving national guidance supporting these vital clinical and quality standards. Important examples are referenced below from the pages of the current scope.	management of low-risk basal cell carcinomas in the community (2010) when deciding whether recommendations should be removed or retained.
North of England Dermatopathology Service and the British Association of Dermatologists	General	General	NICE Melanoma NG14 provided guidance on excision of melanoma (p 10 Section 1.6 Managing stage 0 -II melanoma) In general, however, the NG14 guidance of excising melanomas to provide clinical margins of 5, 10 and 20 mm dependent purely on Stage is becoming increasingly archaic, resulting in nearly unthinking automatic surgical practice. Part of this guidance was based on past studies resulting from the use of old-fashioned histopathological examination of specimens, where margins were assessed suboptimally requiring greater clinical margins. All this , however, has now changed in the last 5-10 years with new exacting national standards for RCPath UK methods of specimen examination and reporting. The time has now come to use a personalised approach to clinical management where in many instances already achieved histological margins of	Thank you for your comment. Following stakeholder consultation, we have amended the scope to include reviewing the evidence for excision for stage 0 to 2 melanoma and updating existing recommendations 1.6.1 – 1.6.4 as needed. The following draft question will be considered in the guideline update: 3.1 What are the most effective surgical and histological excision margins for stage 0 to 2 melanoma? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you

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			1mm will suffice. This is both cost saving in reducing unnecessary further surgical time, innotative for improved clinical care as much less surgery will be required for the patient and large numbers of reexcision specimens will no longer require the time and cost of histological examination. **See Critical Review Weyers W Personalised Excision of Malignant Melanoma. - Need for a Paradigm shift in the beginning era of personalised medicine Amer J of Dermtopathology 2019 Vol 41 884-896** This whole area requires review by NICE and potential radicle rethink on its current guidance. Unfortunately, however, review of melanoma excision is not for some reason specifically listed in the Scope. It should be noted that 1mm histological margins are now deemed adequate for many BCCs and SCCs and the same (with some provisos) is equally applicable for melanoma.	refer to meets the review protocol, this will be considered by the guideline committee during the update. The guideline committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
North of England Dermatopathology Service and the British Association of Dermatologists	**3**	4 - 6	This states the 8th edition of AJCC. This is inaccurate and should more accurately state the 8th edition of Tumour Node Metastasis (TNM) . AJCC is only one version of TNM8 and is primarily for use in the USA. Indeed use of AJCC by any official body outside the USA e.g. NICE , NHS even requires a licence fee! The version of TNM8	Thank you for your comment. The scope has been amended and now refers to the 8th edition of the Union for International Cancer Control (UICC) Tumour Node Metastasis (TNM) staging system for melanoma as well as the 8th edition of the AJCC.

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			used internationally outside the USA and by WHO is that by the Union for International Cancer Control (UICC8) . Public Health England (thereby including National Cancer Registration and Analytical Services with associated PHE/NHS Clinical Outcomes and Services Datasets), the Royal College of Pathologists UK, British Association of Dermatologists and Melanoma Focus (for its recent Mucosal Melanoma Guideline) have all endorsed the use of the UICC8 version of TNM8. In reality, UICC and AJCC work closely together and their final TNM8 is identical. The only problem is that the original publication of UICC8 had some typographical errors that were later corrected, and these are only available on the web/from UICC not yet published in a revised edition. For the UK , the final corrected version of UICC8 (identical to AJCC8) is available in the RCPath Dataset for the histological reporting of melanoma and lymph nodes (www.rcpath.org). It is vital NICE also endorses UICC8 and NOT AJCC8 for UK conformity.	
North of England Dermatopathology Service and the British Association of Dermatologists	6	General	**Organisation of Cancer Services LSMDTs and SSMDTs.** Must retain details of role and organisation of LSMDTs and SSMDTs. This is now the only national document providing this vital guidance.	Thank you for your comment. The guideline committee will consider your views on the recommendations in CSG8 guidelines: Improving outcomes for people with skin tumours including melanoma (2006) and The management of low-risk basal cell carcinomas in the

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				community (2010) when deciding whether recommendations should be removed or retained.
North of England Dermatopathology Service and the British Association of Dermatologists	7	General	**Management of special groups Cutaneous lymphoma and cutaneous sarcoma.** Must retain. In particular PRIMARY cutaneous lymphoma and skin sarcoma. This is now essentially the only document providing this vital practical and quality guidance. It must be noted however that PRIMARY cutaneous lymphoma (largely CTCL) is now also covered by the BAD and UKCLC guidance for the management of cutaneous lymphoma 2018. Without this guidance ALL cases of cutaneous lymphoma could to be taken over inappropriately by haematologists/ haematopathologists with a reduction in patient care quality (due to over usage of chemotherapy for early disease). These cases must go to the SSMDT or supranetwork SSMDT in the first instance. This is the only guidance to state that primary skin sarcoma above the fascia should be managed in the first instance by a SSMDT . In the absence of such guidance cases could go inappropriately to sarcoma MDTs	Thank you for your comment. The guideline committee will consider your views on the recommendations in CSG8 guidelines: Improving outcomes for people with skin tumours including melanoma (2006) and The management of low-risk basal cell carcinomas in the community (2010) when deciding whether recommendations should be removed or retained.
North of England Dermatopathology	9	General	**Quality Assurance Histopathology**	Thank you for your comment. The guideline committee will consider your views on the recommendations in

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Service and the British Association of Dermatologists			Must retain as this is now the only national document containing this vital practical and quality guidance. These are covered in p 84 and 85 under Recommendations: Investigation and Diagnosis of the original document. Especially: All cases referred to the SSMDT should have a specialist histopathological review. All skin cancer cases should be reported histologically using the RCPath Skin Cancer datasets. All excised skin specimens should be sent for histological examination Histopathologists should participate in appropriate EQA schemes. For SSMDT membership this is the National Specialist Dermatopathology EQA scheme. All melanomas should be double reported with respect to diagnosis and stage.	CSG8 guidelines: Improving outcomes for people with skin tumours including melanoma (2006) and The management of low-risk basal cell carcinomas in the community (2010) when deciding whether recommendations should be removed or retained.
Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes proposals to develop NICE Skin tumours including Melanoma: assessment and management guidelines.	Thank you for your comment. We appreciate your support for this scope and update of the guideline.
Royal College of Nursing	5	6	We are in support of areas identified in the draft scope for improving outcomes for people with skin tumours including melanoma.	Thank you for your comment. We appreciate your support for this scope and update of the guideline.

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Royal College of Nursing	17	1	The key issues and draft questions are relevant thus supporting patient safety and care.	Thank you for your comment. We appreciate your support for this scope and areas identified for update in the guideline.
Royal College of Paediatrics and Child Health	General	General	The reviewer is happy with the remit of the draft scope.	Thank you for your comment. We appreciate your support for this scope and update of the guideline.
Royal College of Physicians	General	General	The RCP is grateful for the opportunity to respond to this consultation. We would like to endorse the responses submitted by the British Association of Dermatologists (BAD) and the Royal College of Paediatrics and Child Health (RCPCH).	Thank you for your comment.