National Institute for Health and Care Excellence

Clinical Guideline: Colorectal Cancer Guideline Update

Stakeholder Scoping Workshop

7th July 2017

Presentations
The group were welcomed to the meeting and informed about the purpose of the day. The Stakeholder Scoping Workshop is an opportunity for stakeholders to review the draft scope and give their input into whether it is clinically appropriate. The group received presentations about NICE's work, the work of the National Guideline Alliance (NGA) and the work of the public involvement programme. The Topic Advisor of the Guideline Committee also presented the key elements of the draft scope. Following questions, the stakeholder representatives were then divided into four groups which included a facilitator and a scribe. Each group had a structured discussion around the key issues.
Scope
General comments
• The inclusion of the aspirin in prevention was unanimously questioned by the stakeholders. They questioned its role in this guideline and if it would cause issues with other high risk populations or other possible preventative approaches. • Diagnosis and staging are unchanged over the last 5 years and clinically undebated, therefore, the guideline would benefit from focusing on the management and follow up rather than these two topics. • Biomarkers should be considered in the guideline. • There was some varying views on if neoplasms of the appendix should be included in the guideline. Generally it was thought that it can be excluded.
Section 1.1 Population
• Stakeholders questioned if under 18s should be included in this guideline but agreed colorectal cancer was very rare in this population. • Agreed that anal cancer should be excluded. • Exclude squamous cells carcinoma.
Equalities
The specific equalities issues discussed regarding colorectal cancer included: • Some Asian and Pakistani populations are less likely to seek treatment or enter the care pathway. • Geographic variation in access to treatment – e.g. resection of oligometastatic

disease.

- Socio-economic status – social deprivation related to poorer outcomes.
- Age – extent of staging for older patients – they receive fewer investigations and have lower surgery rates. Particular issues re older people with long term conditions/co-morbidities

But they agreed that all these were not unique to colorectal cancer and can be applied to other conditions.

Section 1.2 Setting

The key comments were:

- it should state "where NHS care is provided and/or delegated" to include services which are commissioned to provide NHS services or care,
- possibly important to consider hospice and end of life care settings which aren't always provided by NHS.

1.4 Key areas that will be covered

The Stakeholders discussed the proposed key areas in the scope. There was general agreement that the key areas include the important areas in colorectal cancer. A few changes were suggested, notably:

- Prevention was a misleading title since the review question only covered a very specific intervention and population. The review question about aspirin was not thought to fit within this guideline. It would be best placed in another guideline or extended to include other interventions (mainly other anti-inflammatory agents) and be more expansive than just people with Lynch Syndrome. Prevention was generally not thought to fit a clinical guideline but rather a public health guideline.
- Diagnosis and staging are unchanged in the last 5 years and clinically not debated and the guideline may benefit from focusing in greater depth on other areas.
- Some relatively novel diagnostic tests/techniques such as capsule colonoscopy and qFIT were discussed, however, it was noted that currently there is no evidence for a meaningful review.
- Biomarkers/immunohistochemistry/molecular profiling should be included in the guideline.
- The guideline should use the TNM Classification of malignant tumours.
- A review of PET-CT in staging may be useful to include in the guideline if the staging section is retained.
- Restaging/reassessment after neoadjuvant treatment was missing from the section on locally advanced disease.
- Management of metastatic disease should include: oligometastatic disease in the liver, lung, peritoneum and lymph node.
- Ongoing care and support shouldn't just focus on information needs in relation to altered bowel function and may be more valuable to focus on the management of treatment related conditions such as stoma care.

- Agreed that service delivery was an important section – if effective service delivery was implemented it may address issues which are raised as part of ongoing care and follow-up.

1.5 Areas that will not be covered

Stakeholders discussed how the areas that are not covered are likely to be on guideline topics where there are cross-referrals or where there is no clinical uncertainty.
General comments from the stakeholders included:

- If aspirin for prevention was proven to be effective it would be hard to not include some comment on surveillance.
- They agreed that prevention, diagnosis and staging could be excluded in favour of other topics identified above.

Section 1.6 Main outcomes

Overall, the stakeholders were satisfied with the outcomes suggested, however felt that the following could be included:

- Progression free survival, but agreed this may be implied by disease free survival

If diagnosis is retained include diagnostic effectiveness in addition to diagnostic accuracy

Section 1.7 Key issues and questions

Overall, the stakeholders agreed with the review questions. Their general comments included:

- if the diagnosis question is retained it should be more about identifying colorectal cancer in people as opposed to specific diagnostic approaches as it is too broad for the guideline to cover all diagnostic methods.
- Review questions need to keep colon and rectal cancer separated
- The question about “watch and wait” needs to be clarified, what role it plays after full clinical response has been achieved is a more appropriate way of considering it.
- Questions regarding chemotherapy may not be needed as it is unchanged in the last 5 years.
- Potentially include a question on sequencing for local and systemic treatment for any metastatic treatment not just hepatic metastatic.
- Include management of treatment related issues into the ongoing care section rather than information needs in relation to altered bowel function.
- Mixed views on the value of service delivery – some agreed it was very important and underpinned several other issues which arise in the management of colorectal cancer (primarily ongoing care and follow up), whereas other agreed there would be limited evidence available and as a result would add little value to the guideline and other areas should be prioritised.

Section 1.8 Economic aspects
Stakeholders did not raise any comments on this section
Guideline Committee composition
• Primary care representative/GP needed. • Interventional radiologist (co-opted) – in relation to stenting • Molecular biologist (co-opted) – in relation to biomarkers • Gastroenterologist might be useful to have as full committee member, not just co-opted. • Thoracic surgeon (co-opted) in relation to the lung metastases question • Pathologist (co-opted) • Dietitian/Nutritionist/Physiotherapist could be included • Palliative care professional could be included