Barrett's oesophagus: ablative therapy

Consultation on draft scope
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British Society of Gastrointestinal and Abdominal Radiology	General	General	BSGAR are supportive of this guideline. This is an important topic for NICE to consider. Early disease detection and treatment of Barrett's oesophagus and stage 1 adenocarcinoma will arguably achieve the greatest benefits for patients.	Thank you for your comment.
NHS England and Improvement	General	General	Worth pointing out that the prevalence of BO is likely to be increasing as it is caused by chronic acid induced inflammation as a result of prolonged reflux (GORD). This is increased greatly by being overweight and obese (which is increasing exponentially) and smoking. Also, with gastric sleeve surgery (as a treatment for obesity) there is an increased risk of GORD and BO. (AMH)	Thank you for this information. We have added further information to this section.
Medtronic	General	General	Medtronic would like to thank NICE for the opportunity to comment on the draft scope and would like to note our support particularly in expanding the scope of the current Barrett's Oesophagus guidelines to include people with Barrett's oesophagus and related early neoplasia. We are also in agreement with: who the guideline is for, what it will cover, and the related NICE quality standards and pathways that may need to be revised or updated following this guideline publication.	Thank you for your comment.
The Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcome the proposal to develop NICE guidance for Barrett's oesophagus: ablative therapy. The RCN invited members who work with people in these setting to review and comment on the draft scope.	Thank you for your approach to your members.

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			The comments below, reflect the views of our reviewers.	
The Royal College of Nursing	General	General	The scope looks entirely appropriate.	Thank you for your comment.
British Society of Gastrointestinal and Abdominal Radiology	3	5	Good to include patients with stage 1 adenocarcinoma. Of course, stage 1 includes T1aN0M0 and T1bN0M0 disease, the latter has increased risk of lymph node metastases compared to the former. In this group, radiological staging becomes more critical, with management dependent on the accuracy of staging.	Thank you for your comment.
NHS England and Improvement	3	13	Under medical management I think it is worth looking at the evidence for and against medical treatment. GPs are constantly advised to rationalise medicines and reduce or stop PPIs because of the increased risk of low magnesium and osteoporosis and fracture and GPs do like to have evidence when they make decisions. (AMH)	Thank you for your comment. We routinely look for benefits and harms of interventions when examining the evidence. The detail of outcomes included will be agreed by the guideline committee.
NHS England and Improvement	3	18	Endoscopic surveillance and follow up intervals - this will mostly be led by secondary care but where patients get lost to follow up or when patients move and change GP/hospital it is important to have the notes flagged. Is it	Thank you for your comment. Appropriate coding of Barrett's oesophagus and the consequences of inappropriate coding are appropriate for implementation of the

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			worth considering asking primary care to carry a register of all patients with Barrett's oesophagus? Barrett's oesophagus has a prevalence of about 1.6% so in a practice of 10k patients there would be probably less than 20 patients to keep track of. (AMH)	guideline. We will flag this issue with the NICE. implementation team for consideration following guideline development.
British Society of Gastrointestinal and Abdominal Radiology	3	20	Important to evaluate radiological staging of suspected stage 1 adenocarcinoma. Accurate staging is vital as has implications for effective treatment selection.	Thank you for your comment.
Pentax Medical	3	25	In the past years, numerous Cryo ablative modalities have been commercially released in the UK and worldwide with very limited clinical evidence and showing limited degrees of efficacy in the eradication of Barrett's Oesophagus (BO) and unclear safety profile. The draft scope is currently mentioning in the section 3.3 (page 3) line 25 'cryoablation' within the endoscopic treatments to be used alone or in combination. We would propose to consider in the scope a differentiation between CryoBalloon ablation and other Cryo treatments to ensure a proper distinction based on current clinical and pipeline data could be available.	Thank you for your comment. We have altered the reference to these modalities and now use the term cryotherapy techniques. The guideline committee will further define this term when developing the evidence review protocol.
British Society of Gastrointestinal	3	26	An important consideration given the risk of lymph node metastases in T1b disease. Endoscopic management	Thank you for your comment.

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and Abdominal Radiology			versus oesophagectomy is an important comparison to make.	
British Society of Gastrointestinal and Abdominal Radiology	3	29	It is currently unknown whether radiological follow-up after surgical resection should be performed. As adjuvant treatments become used more widely, this will be an important consideration.	Thank you for your comment. Radiological follow up is included in the scope.
NHS England and Improvement	5	23	Medical management - also worth including lifestyle advice: getting back to a healthy weight, stopping smoking and reducing/stopping alcohol. (AMH)	Thank you for your comment. We have considered your suggestion but have decided not to include this area in the scope. We have prioritised areas where we are likely to find evidence and are not aware of evidence indicating lack of progression or remission of Barrett's on basis of lifestyle changes. We plan to include a dietician in the committee to inform advice following diagnosis.
Medtronic	6	1 - 3	For adults with Barrett's oesophagus, when considering the scope re; clinical and cost effectiveness of different endoscopic surveillance techniques, you may wish to consider the inclusion of Cytosponge (biomarkers TFF3, atypia and p53) as currently part of an Innovate UK funded evaluation for surveillance (namely DELTA project). Published data are already available from the BEST3 trial (The Lancet	Thank you for your comment. We have added the term 'non endoscopic surveillance techniques' to explore the place of Cytosponge and biomarkers as surveillance options. The NICE surveillance team have also been alerted to the developing evidence base in this area.

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			Gastro & Hepatol 2020), and data expected to be available from DELTA mid-late 2022. Also NHSE are in the process of launching a prospective evaluation for Cytosponge c/o the following use case – 'Patients who have been referred to secondary care with reflux symptoms are currently at risk of waiting a significantly long time for a gastroscopy to be available. Cytosponge has been prioritised by the NHS Cancer Programme because of its potential to improve early diagnosis and reduce the demand on upper GI endoscopy services. By offering low risk eligible patients on the secondary care waiting list a Cytosponge diagnosis test, Cytosponge has the potential to rapidly prioritise BO more at risk patients, and maximise the use of scarce resources.' I am a member of NHSE's evaluation workstream for this prospective evaluation, if you wish to learn more on this.	
British Society of Gastrointestinal and Abdominal Radiology	6	6	Could be more specific and include the diagnostic accuracy of different radiological staging techniques. Important to ascertain the value of radiological staging, which includes endoscopic ultrasound (EUS), an invasive procedure requiring specialist expertise.	Thank you for your comment. We have clarified the question to include diagnostic accuracy of different endoscopic and radiological staging techniques.

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Medtronic	6	11 - 12	In relation to question 4.1 in section 4 *"for adults with Barrett's oesophagus, what is the clinical and cost effectiveness of different endoscopic therapies alone or in combination?"*, Medtronic would like to highlight there is published evidence to support in answering this question. Specifically, a cost-effectiveness analysis (reference below) demonstrated that endoscopic eradication therapy (EET) for patients with low and high grade dysplasia arising in Barrett's oesophagus, is cost-effective compared to endoscopic surveillance alone. • Vicki Pollit, David Graham, Catherine Leonard, Alexandra Filby, Jessica McMaster, Stuart J. Mealing, Laurence B. Lovat & Rehan J. Haidry (2019) A cost-effectiveness analysis of endoscopic eradication therapy for management of dysplasia arising in patients with Barrett's oesophagus in the United Kingdom, Current Medical Research and Opinion, 35:5, 805-815, DOI: 10.1080/03007995.2018.1552407 If you require access to the complete operating health economic model for the development of these guidelines, this can be facilitated if needed.	Thank you for this information and your offer of access to the model. The health economics team have been made aware of this model.

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British Society of Gastrointestinal and Abdominal Radiology	6	25 - 31	Important to evaluate radiological follow-up in this setting given the risk of undetected lymph node metastases increasing likelihood of recurrence after treatment.	Thank you for your comment. Radiological follow up is included in the scope.
British Society of Gastrointestinal and Abdominal Radiology	7	10	Consider including diagnostic test accuracy as an outcome.	Thank you for this suggestion. The scope outlines the main outcomes which will be considered for the questions. However, diagnostic accuracy measures will be considered as outcomes for the relevant questions.