Oesophago-gastric cancer

Consultation on draft scope
Stakeholder comments table

23/11/15 to 18/12/15

ID	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
1	Action Against Heartburn	2	48	The stage at which the cancer is diagnosed is an important issue linked to outcomes. The guidance does not intend at present to include diagnosis and surveillance of precursor conditions like Barrett's Oesophagus, and treatment of dysplasia eg by radio frequency ablation, which seems to be replacing photodynamic therapy – which itself is subject to a linkage to other guidance. So there should be a helpful cross reference to BSG Guidelines on Management of Barrett's Oesophagus, NICE Guidance on Dyspepsia & GORD and NICE Guidelines on referral for suspected cancer.	Thank you for your comment. We are unable to cross-refer to the BSG guidelines because this is outside of NICE processes. However, we have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope.
2	Action Against Heartburn	3	70	Nutritional and gastroenterological support is also very important for the late effects suffered by successfully, curatively treated post-operative patients because of long term effects of a shortened digestive system, the effects of 'dumping syndrome', insulin spikes, and increased risk of bacterial overgrowth. The Upper GI section of the Dietetics Manual may need to be reviewed.	Thank you for your comment - we agree. We are unable to amend the dietetics manual but we would hope this would be updated following the publication of this guideline.
3	Action Against Heartburn	4	87	The economic aspects should consider the relative costs of early diagnosis and treatment of high grade dysplasia as contrasted with the cost of major surgery and/or palliative care	Thank you for your comment. The management of high-grade dysplasia is covered by Barrett's oesophagus: ablative therapy (CG106) and is therefore outside the scope of this guideline.
4	Association for Palliative Medicine of Great Britain & Ireland	General	General	We are glad to see the inclusion of palliative care within this draft scope. We would wish to ensure that within the guideline it is made clear that patients should be referred to palliative care teams based on need, rather than only once disease-modifying treatments have been exhausted. Not all patients with oesophago-gastric cancer will need referral to specialist palliative care services. Referral should be needs-based rather than diagnosis- or prognosis-based. Palliative care teams work with patients with complex needs when the usual medical team is struggling. It would be unworkable and unnecessary for all patients with oesophago-gastric cancer to be seen by palliative care	Thank you for your comments. The guideline will explore the evidence base on palliative care and make appropriate recommendations based on this evidence.

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				teams (and, if this were offered to patients with oesophago-gastric cancer it would have to be offered to all patients with cancer).	
5	Association for Palliative Medicine of Great Britain & Ireland	1	12	We are unclear why palliative care professionals are termed "palliative care workers" when other professional groups are given their professional title	Thank you for your comment. We have changed this text to 'palliative care specialists'.
6	British Society of Gastroenterology	General	General	*What is the role of oesophageal stent placement before curative surgical or non-surgical therapy in patients with oesophageal cancer*	Thank you for your comment. We do not think there will be sufficient evidence to inform recommendations. Therefore this topic was not prioritised for inclusion in this guideline.
7	British Society of Gastroenterology	General	General	*Review surgical and interventional endoscopy services: catchment population, number of curative surgery and EMR*	Thank you for your comment. We think these issues would be encompassed by the questions on organisation of specialist teams and the management of oesophago-gastric cancer.
8	British Society of Gastroenterology		1.2	**Settings**: 'all settings in which NHS care is provided' ? *why are private providers in the UK excluded?*	NHS commissioned services provided in private hospitals will be covered by this guideline, but NICE guidance does not extend to privately funded healthcare.
9	British Society of Gastroenterology		1.5	**Key issues: management (staging/ treatment)** *We suggest that distinction should be made between management of different histological subtypes – adenocarcinoma, squamous carcinoma, small cell or neuroendocrine carcinoma and undifferentiated/ other*	If the evidence is available the recommendations made will distinguish between different histological subtypes of oesophago-gastric cancer. However, neuroendocrine carcinomas are specifically excluded from the scope of this guideline, as there is already national guidance on this subtype.
10	British Society of Gastroenterology		1.5	**Key issues: management (staging/ treatment)** Optimal management of T1N0 oesophageal Ca (EMR vs surgery) *?suggest comment on role of RFA/ HALO if neither EMR nor surgery is appropriate, eg portal hypertension, respiratory failure etc*	Thank you for your comment. The question has been changed to 'what is the optimal management of T1N0 oesophageal cancer'. Therefore HALO/RFA may be encompassed by this question and will be discussed by the GC when they finalise the review questions during their first few meetings.
11	County Durham and Darlington NHS Foundation Trust	8	212	Page 8 has a mention to photodynamic therapy for early oesophageal cancer which had largely been superseded by radio frequency ablation and relevant NICE guidance and this needs to be incorporated as well (Dr Anjan Dhar, Consultant Gastroenterologist)	Thank you for your comment. In line with NICE processes we have to include all published NICE guidance related to oesophago-gastric cancer in this list. Therefore we have to retain it here. However, we will forward your comment to the NICE Interventional Procedures team for consideration.
12	Department of	General	General	Thank you for the opportunity to comment on the draft scope for the above	Thank you for your comment.

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	Health			clinical guideline. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	
13	Eli-Lilly and Company Ltd	3	72	The draft scope states *"Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual patients."* We feel this group should be fully explained. That is, if a licensed drug is available in an indication, but not recommended in the guideline, NICE should be transparent in its recommendation to use an unlicensed drug based on limited evidence.	Thank you for your comment. This text describes NICE's process for highlighting recommendations for an unlicensed use of interventions. Any such recommendations made in a guideline will contain a footnote to highlight that they contain an off-license use. Equally all relevant published NICE technology appraisals will also be linked to – in line with NICE processes.
14	Eli-Lilly and Company Ltd	5	127 and 140-143	When considering the optimal choice of chemotherapy, all licensed medicines should be included. This is particularly important in the context of aggressive and difficult to treat cancers such as advanced gastric cancer, which currently has only one licensed second-line treatment option.	Thank you for your comment. This guideline will link to the NICE technology appraisal on Ramucirumab in accordance with NICE processes.
15	Eli-Lilly and Company Ltd	5	143	The draft scope currently does not mention optimal third-line, and beyond, chemotherapy for locally advanced and metastatic oesophago-gastric cancer. We feel this group should be included because the UK mortality rate is the highest in Europe for both men and women, and since many countries are treating with third-line chemotherapy regimens.	Thank you for your comment. We do not consider treatment beyond second-line chemotherapy to be a priority for inclusion in this guideline.
16	Guy's and St. Thomas' NHS Foundation Trust	3	70	Nutritional support has a distinct association with oral nutritional supplements and artificial nutrition support. However this patient not only need nutrition support but also dietetic support. I would if this should be Nutritional and Dietetic support (to encompass all the other aspects of dietetic requirements of patients)	Thank you for your comment. We anticipate this issue may be covered in the review question about organisation of specialist teams. It will be discussed by the GC when they finalise the review questions during their first few meetings
17	Guy's and St. Thomas' NHS Foundation Trust	6	146	…before and after operations, **and in survivorship**)?	Thank you for your comment. This level of detail will be discussed by the GC when they finalise the review questions and review protocols during their first few meetings.
18	Guy's and St. Thomas' NHS Foundation Trust	6	152	When looking at follow up, I also think there needs to be references to dealing with the consequences of treatment (which may be encompassed by 'what is the most effective model')	Thank you for your comment. This level of detail will be discussed by the GC when they finalise the review questions and review protocols during their first few meetings.
19	Guy's and St. Thomas' NHS	8	197	Does guidance on the post treatment side effects/consequences need to go in here e.g. http://gut.bmj.com/content/early/2011/11/04/gutjnl-2011-	Thank you for your comment. This is a list of published NICE guidance and so it is not appropriate to include

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	Foundation Trust			300563.full There is imminently a new guideline/algorithm on this topic being published (led by the Marsden)	the reference that you site in this part of the scope.
20	Guy's and St. Thomas' NHS Foundation Trust	9	220	Nutritional and dietetic interventions (for the same reasons as above this will encompass all the other aspects of dietetic management)	Thank you for your comment. This is a pathway showing published NICE guidance related to oesophago-gastric cancer therefore we are unable to make the amendment you suggest.
21	Guy's and St. Thomas' NHS Foundation Trust	11	283	Would the National Oesophagogastric Cancer Audit need to go in here? http://www.hscic.gov.uk/og	Thank you for your comment. We have added this information to the current practice section of the scope
22	Humberside Oesophageal Support Group	4	99	We have found that the information most needed by patients following surgery is regarding beginning to eat again. Patients generally hate Fortisip and similar products, so are at a loss as to how to gain the maximum protein from small amounts of food, without overdoing things and setting off a hypoglycaemic attack. We have found that dieticians seem to advise too much rich food at once which causes painful indigestion for the patient often followed by dumping. Specialist dieticians could be useful.	Thank you for your comment. The guideline will explore the evidence base on the information requirements of patients after surgery and make appropriate recommendations based on this evidence.
23	London Cancer	General	General	In section 1.5, para 4 – 'What is the most effective surgical treatment (laparoscopic v open surgery) for oesophagogastric cancer?' should be expanded somewhat to reflect current and emerging practice. The phrase 'minimally invasive surgery' should be used instead of 'laparoscopic' as it encompasses thoracoscopic approaches for resection of oesophageal cancer and includes robotic surgery. Furthermore, hybrid approaches are now commonly practiced, e.g. laparoscopic abdominal gastric mobilisation and thoracotomy for oesophageal cancer. So I would suggest the phrase 'minimally invasive, open and hybrid approaches'.	Thank you for your comment. We have made this change to the scope.
24	London Cancer	General	General	In the same section (1.5) regarding treatment, I would suggest considering another situation, which keeps cropping up in our sMDTs fairly regularly. The scenario being of a patient with OG cancer and metastatic disease which responds to chemotherapy with a 'resolution' of the metastases on subsequent imaging. Such patients, if they have a good performance status and are otherwise fit for radical surgery often ask if they could have a resection. I know from other OG surgeons round the country that this is now a relatively common scenario and one that taxes the MDT because there is no clear consensus on management. The published evidence ranges from data that indicates that metastatic disease at presentation behaves as metastatic disease even if imaging suggests resolution with	Thank you for your comment. We agree that this is an area of uncertainty but it affects a relatively small number of patients and we do not think there will be evidence of sufficient quality to inform recommendations. Therefore this topic was not prioritised for inclusion in this guideline.

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				chemotherapy to observational studies that show significant long-term survival in selected cases of resection after down staging of disease with chemotherapy.	
25	Medtronic UK	2	48	Although deemed out of scope for this guideline, may wish to reconsider and/or recommend clear link to CG 106 guideline regarding adults with suspected oesophagogastric cancer for those presenting with low or high grade dysplasia (LGD/ HGD). This is based on recent findings from National Oesophagogastric Cancer progress report; whereby 30% of HGD patients are remaining on surveillance despite BSG and NICE guidance (Gut. 2015 Aug;64(8):1192-9. doi: 10.1136/gutjnl-2014-308501). Indeed, taken from the BSG_GI 2015 guideline update, a recent multicentre RCT reported, in the surveillance arm 26% of LGD patients progressed to HGD or cancer compared with 1% in the treatment RFA arm. (Phoa et al, JAMA 2014; 311(12): pg 1209-17.	Thank you for your comment. We have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope.
26	Medtronic UK	2	50	Although deemed out of scope for this guideline, may wish to reconsider and/or recommend clear link to CG 106 guideline regarding adults with suspected oesophagogastric cancer for those presenting with low or high grade dysplasia (LGD/ HGD). This is based on recent findings from 2014 National Oesophagogastric Cancer progress report; whereby 30% of HGD patients are remaining on surveillance despite BSG and NICE guidance. Indeed, the BSG_GI 2015 guideline update, a recent multicentre RCT reported, in the surveillance arm 26% of LGD patients progressed to HGD or cancer compared with 1% in the treatment RFA arm. (Phoa et al, JAMA 2014; 311(12): pg 1209-17.	Thank you for your comment. We have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope.
27	Medtronic UK	3	65	High-grade dysplasia and intramucosal cancer arising in Barrett's oesophagus (BE) can carry a 40–60% risk of progressing to oesophageal adenocarcinoma. (http://gut.bmj.com (26/11/2015) Lesion recognition and resection prior to RFA are paramount to successful outcomes in patients with BE neoplasia. Visible and nodular lesions are more likely to harbour more advanced neoplasia, so early resection is key to both definitive staging and eradication prior to RFA. (http://gut.bmj.com (26/11/2015) Recommend better linked to CG 106 and potentially update of CG 106 (currently on static list) in view of newly published evidence	Thank you for your comment. We have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope.
28	Medtronic UK	3	68	The British Society of Gastroenterology (BSG_GI) guideline update recommends that patients with BE-related neoplasia and disease confined to the mucosa (T1a) should be offered endoscopic therapy as first-line	Thank you for this information. The guideline will be investigating the optimal management of T1N0 oesophageal cancer, which may encompass T1a.

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				treatment. (http://gut.bmj.com (26/11/2015) There is now consensus that first-line treatment for mucosal neoplasia arising in BE should be endoscopic therapy. (http://gut.bmj.com (26/11/2015)	
29	Medtronic UK	4	111-115	Assessment – when considering options re: optimal choice of staging to determine suitability for curative treatment of OG cancer consider role of EMR + RFA	Thank you for your comment. This review question is about staging investigations. EMR and RFA are treatments and therefore not appropriate to include here.
30	Medtronic UK	4	138-139	Management – consider expansion of scope from T1NO to T1A oesophageal cancer; with the subsequent exploration of the role of EMR + RFA with respect to optimal management for T1A patient cohort	Thank you for your comment. The guideline will be investigating the optimal management of T1N0 oesophageal cancer, which may encompass T1a.
31	Medtronic UK	4	85	May wish to reconsider referral to CG 106, in terms of initial diagnosis /assessment of oesophago-gastric (OG) cancer	Thank you for your comment. We have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope.
32	NHS England	General	General	Consideration of the long term effects of disease and treatment needs to be considered	Thank you for your comment. We believe that these issues will be explored by the inclusion of patient-reported outcome measures and health related quality of life as outcomes in the review questions.
33	NHS England	6	152	Follow up protocols also need to consider living with and beyond cancer / survivor ship	Thank you for your comment. Consideration of living with and beyond cancer may be encompassed by this question the most effective follow-up and will be discussed by the GC when they finalise the review questions during their first few meetings.
42	Norfolk and Norwich University Hospitals NHS Foundation Trust	1	10	It was unfortunate that the stakeholders were not told before the meeting that the clinical lead has changed the scope and the title of the consultation in advance of the meeting. Currently, a significant proportion (24%) of the cancers in the UK is diagnosed at the A&E department (see: Routes to diagnosis study, NCIN). Only 5.4% of oesophageal cancers are diagnosed as early cancers, and across the networks there is a significant variation in proportions of cancers diagnosed early (National Oesophago-Gatric Canver Audit, 2014). While it is not as appealing, as concentrating on the surgical treatment and oncology, the greatest impact on any cancer mortality and on the	Thank you for your comment. We agree that late diagnosis is an important issue, but this has already been addressed by NICE guideline 12 'Suspected cancer: recognition and referral'. We hope that the introduction of NG12 will help to reduce the number of oesophago-gastric cancers which present as an emergency. There are a number of other national guidelines that cover the diagnosis of oesophago-gastrtic cancer and therefore this was not prioritised as a topic for inclusion in this guideline.

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				success of treatment can be made if the diagnosis is made early. I feel that leaving the diagnosis of the cancer from the scope of the guideline is a mistake – as good and and organised diagnostics are key to the patient pathway, and that the patient journey and stratification for appropriate personalised treatment is done with diagnostics. The two numerical data above shows that the potential problems with diagnosis of the oesophago-gastric cancer have not been solved yet , and the patients who are presenting as an emergency will have a significantly worse ouytcome. Also, the proportion of the patients, in which the early diagnosis would result in significantly better outcome, is very low. In view of the above I would suggest that NICE re-evaluates inclusion of the diagnostics into this guideline or considers setting up a guideline on the diagnostics of these cancers.	
43	Oesophageal Cancer Westminster Campaign	2	45-55	We are concerned that the scope of the guidelines are not wide enough and should cover those at with a high risk of developing oesophageal cancer from Barrett's Oesophagus (or low or high grade dysplasia). There is currently not a clear pathway for patients with low grade dysplasia that have a significant chance of their condition progressing to cancer if endoscopic treatment is not provided. There are clear benefits to this treatment, as is highlighted in the 2014 National Oesophagogastric Cancer progress report, where 30% of high grade dysplasia patients are found to be on the surveillance list (and not receiving treatment) despite the NICE and British Society of Gastroenterology guidelines. A recognition of these patients, with a link to NICE 2010 Barrett's oesophagus guidelines (CG106) or BSG recommendations on early treatment of dysplasia (4.1), should be considered as will prevent cancers and help save lives through earlier treatment. We are aware of some of the discussions from the scoping workshop earlier this year, but think that the NICE Guidelines should include some of the wider aspects. Oesophageal adenocarcinoma is relatively unusual in having a precursor condition like Barrett's Oesophagus. There are issues	Thank you for your comment. We have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope.

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				relating to endoscopy examinations missing suspicious lesions; how Barrett's-related dysplasia is treated by gastroenterologists; the pathway links to surgical therapies; and the issue of co-location of specialists. These would suggest that it would be eminently sensible for the NICE guidelines to make cross references to these issues and therapies even if it is not accepted that they should be dealt with directly.	
44	Oesophageal Cancer Westminster Campaign	2	85	We would recommend that any guidelines on treatment should include consideration of diagnosis and in particular how to diagnosis oesophageal cancer earlier. Early diagnosis is a key part of the Independent Cancer Taskforce's recommendations and we believe that the guidelines should aim to have a system where diagnosis and treatment of cancer is more joined up.	Thank you for your comment. We agree that late diagnosis is an important issue, but this has already been addressed by NICE guideline 12 'Suspected cancer: recognition and referral'. We hope that the introduction of NG12 will help to reduce the number of oesophago-gastric cancers which present as an emergency. There are a number of other guidelines that cover the diagnosis of oesophago-gastrtic cancer and therefore this was not prioritised as a topic for inclusion in this guideline.
45	Oesophageal Cancer Westminster Campaign	3	64	Early diagnosis is essential for curative treatment to be successful and too many patients are diagnosed when cancer is in a late stage. One significant reason for this is that a substantial number of patients with dysplasia, that has a significant chance of progressing to cancer, are kept in surveillance (and therefore not treated) when their dysplasia is of a high grade. We recommend that the guidelines reference this problem and recommend early, endoscopic treatments for dysplasia as a way of preventing cancer.	Thank you for your comment. We agree that late diagnosis is an important issue, but this has already been addressed by NICE guideline 12 'Suspected cancer: recognition and referral. We hope that the introduction of NG12 will help to reduce the number of oesophago-gastric cancers which present as an emergency. There are a number of other national guidelines that cover the diagnosis of oesophago-gastrtic cancer and therefore this was not prioritised as a topic for inclusion in this guideline. The management of dysplasia is covered in the existing NICE guidance on Barrett's oesophagus: ablative therapy (CG106). We have added a cross-reference to this in section 2.2 of the scope.

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46	Oesophageal Cancer Westminster Campaign	3	68	Early diagnosis is essential for curative treatment to be successful and too many patients are diagnosed when cancer is in a late stage. One significant reason for this is that a substantial number of patients with dysplasia, that has a significant chance of progressing to cancer, are kept in surveillance (and therefore not treated) when their dysplasia is of a high grade. We recommend that the guidelines reference this problem and support the focus on early diagnosis and a focus on early endoscopic treatments for dysplasia as a way of preventing cancer.	Thank you for your comment. We agree that late diagnosis is an important issue, but this has already been addressed by NICE guideline 12 'Suspected cancer: recognition and referral. We hope that the introduction of NG12 will help to reduce the number of oesophago-gastric cancers which present as an emergency. There are a number of other guidelines that cover the diagnosis of oesophago-gastrtic cancer and therefore this was not prioritised as a topic for inclusion in this guideline. The management of dysplasia is covered in the existing NICE guidance on Barrett's oesophagus: ablative therapy (CG106). We have added a cross-reference to this in section 2.2 of the scope.
47	Oesophageal Cancer Westminster Campaign	4	110	This section should consider including assessment and treatment of Barrett's oesophagus.	Thank you for your comment. We have added a cross-reference to Barrett's oesophagus: ablative therapy (CG106) in section 2.2 of the scope. As such, making recommendations on the assessment and treatment of Barrett's oesophagus is outside the scope of this guideline.
48	Royal College of General Practitioners	4-5		The scope should consider early involvement of palliative care, including hospice referral, as early involvement can improve survival rates. It should also consider psych-social support needed for patients and their carers	Thank you for your comment.. Early involvement of palliative care was not prioritised for inclusion in this guideline. NICE has existing guidance on Supportive and palliative care which covers the psycho-social support of patients..
49	Royal College of Pathologists	General	General	RCPath oesophageal and gastric datasets have been re-written as one combined dataset. Should be out for consultation early in new year	Thank you for this information.
50	Royal College of Physicians (joint response with NCRI and ACP)	General	General	NCRI-RCP-ACP are grateful for the opportunity to respond jointly to the above consultation. In doing so, we have liaised with the British Society of Gastroenterology (BSG) and wish to fully endorse their submission. We would also like to submit the following comments:	Thank you for your comment.
51	Royal College of Physicians (joint	General	General	A comment on obtaining sufficient tissue at biopsy to enable future molecular profiling (within the context of clinical trials) would be	Thank you for your comment. We have not prioritised diagnosis in this scope (due to the existence of other

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	response with NCRI and ACP)			useful. This may be a baseline biopsy (possibly out of the scope of this guideline) or at disease relapse.	guidance on this issue). Therefore we are unable to make recommendations on biopsy.
52	Royal College of Physicians (joint response with NCRI and ACP)	General	General	No mention has been made of the role of tumour markers (Ca19.9).	Thank you for your comment. This level of detail will be discussed by the GC when they finalise the review questions and review protocols during their first few meetings.
53	Royal College of Physicians (joint response with NCRI and ACP)	General	General	The importance of the multi-disciplinary team meeting (MDT) should be considered in the key issues and questions.	Thank you for your comment. This issue will be covered by the question on organisation of specialist teams
54	Royal College of Physicians (joint response with NCRI and ACP)	General	General	It would be useful to consider the various stents available to manage dysphagia and when these may be appropriate. It would also be helpful to include other options for treating dysphagia including palliative radiotherapy and laser treatments.	Thank you for your comment. This level of detail will be discussed by the GC when they finalise the review questions and review protocols during their first few meetings.
55	Royal College of Physicians (joint response with NCRI and ACP)	General	General	Primary and secondary care of patients with suspected OG cancer should be covered in a separate document.	Thank you for your comment. Primary care of these patients is covered by NICE guideline 12 'Suspected cancer: recognition and referral'. We have not prioritised diagnosis in this scope (due to the existence of other guidance on this issue).
56	Royal College of Physicians (joint response with NCRI and ACP)	General	General	The document does not discuss the treatment of bleeding as a complication of advanced OG cancer which should be included.	Thank you for your comment. We agree that this is an important question but think that other questions within the scope are of higher priority, so we are not able to address it in the scope with current resources.
57	Royal College of Physicians (joint response with NCRI and ACP)	4	99	There is a need to consider specific information and support needs of people with OG cancer prior to surgery and for patients with advanced disease who will receive palliative care, not surgery.	Thank you for your comment. Provision of information and support prior to surgery was not prioritised for inclusion in this scope as there is existing National guidance on this issue.
58	Royal College of Physicians (joint response with NCRI and ACP)	5	124	The question regarding the optimal perioperative treatment of oesophageal cancer and gastro oesophageal junctional cancer would be better phrased like the gastric cancer question, 'optimal choice and timing of chemotherapy/chemoradiotherapy' (line 127) rather than restricting this to 'optimal neoadjuvant therapy' as there are occasions when adjuvant therapy may be considered.	Thank you for your comment. We have made this change.
59	Royal College of Physicians (joint	6	150	The optimal treatment of dysphagia for patients receiving palliative treatment is considered here but the optimal treatment of	Thank you for your comment. We do not think there will be sufficient evidence to inform recommendations.

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	response with NCRI and ACP)			dysphagia should also be considered in patients receiving curative treatment	Therefore this topic was not prioritised for inclusion in this guideline.
60	Royal College of Physicians (joint response with NCRI and ACP)	6	152	Follow up is discussed on page 6, line 152, but late treatment toxicities have not been mentioned and should be considered (from surgery/radiotherapy and chemotherapy)	Thank you for your comment. Treatment related morbidity will be included as an outcomes in relevant review questions
61	Royal College of Physicians (joint response with NCRI and ACP)	9	General	Photodynamic therapy is included in the flow diagram on page 9 but is not mentioned elsewhere.	Thank you for your comment. In line with NICE processes we have to include all published NICE guidance related to oesophago-gastric cancer in this diagram. Therefore we have to retain it here. However, we will forward your comment to the NICE Interventional Procedures team for consideration.
62	South Tees Hospitals NHS Foundation Trust	General	General	One of the enormous problems with this disease is dealing with patients who have an oesophageal cancer resected and then are found to have positive resection margins. There is a big question about what to do with patients with this problem who are at great risk of local recurrence. We feel this should be included in the scope of the NICE guidance to be produced. Practice differs so much in this regard around the country. The draft scope consultation document does not specifically mention this particular area of investigation.	Thank you for your comment. We agree that this is an area of uncertainty but we do not think there will be sufficient evidence to inform recommendations and therefore this topic was not prioritised for inclusion in this guideline.
63	South Tees Hospitals NHS Foundation Trust	General	General	We feel the scope should include what to do with patients that don't respond to neo-adjuvant chemotherapy. Many patients go on to receive further (the same) chemotherapy after surgery, which doesn't seem altogether sensible if it didn't work well before surgery and uses up a lot of resource and time.	Thank you for your comment. We agree that this is an area of uncertainty but we do not think there will be sufficient evidence to inform recommendations and therefore this topic was not prioritised for inclusion in this guideline.
64	The Royal College of Radiologists	General	General	The draft scope currently excludes patients who have tumours of the upper 1/3 of their oesophagus. It was commented in the scoping meeting that these were excluded as they were 'treated like head and neck cancer', but this is not universally the case. Discussion at the SCOPE 2 trial launch meeting showed that there was little consensus on how these cases were managed in terms of dose fractionation and target volumes. They are not currently included in the head and neck guidance and so should be included within the scope of this guidance. It should also test lower 1/3 oesophageal cancers for Her 2 as these are effectively type 1 GOJ and not unusually positive	Thank you for your comment. Patients with tumours of the upper 1/3 of their oesophagus are a relatively small population and we do not think there will be sufficient evidence to inform recommendations. Therefore this topic was not prioritised for inclusion in this guideline. As there is no licensed anti-HER-2 treatment for oesophageal cancer we do not consider that this is a priority topic for inclusion in the guideline.

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65	The Society and College of Radiographers	1	16	The Society and College of Radiographers would welcome the inclusion of 'Therapeutic Radiographers' in the list of healthcare professionals involved in the multidisciplinary care of people with oesophago-gastric cancer as there are advanced and consultation practitioners in the UK leading care and working within the multidisciplinary team during the management of these people with radiotherapy.	Thank you for your comment. We have added therapeutic radiographers to the list.
66	The Society and College of Radiographers	11	271	There is currently no reference to the use of brachytherapy as a specific radiotherapy modality in the context of palliation of oesophageal cancer. This is a very useful and effective tool in the palliative setting and if this were to be included could positively influence implementation via the oesophago-gastric cancer guideline for those that do not currently offer the service, or indeed radiotherapy centres needing to re-introduce provision.	Thank you for your comment. This is background text describing current practice –it is not making recommendations on what interventions should be used. This level of detail will be discussed by the GC when they finalise the review questions and review protocols during their first few meetings.

Registered stakeholders