NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Consultation summary report: colorectal cancer (update)

Quality Standards Advisory Committee post-consultation meeting: 09 November 2021

1. Introduction

The draft quality standard for colorectal cancer (update) was made available on the NICE website for a 4-week public consultation period between 06 September and 11 October. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 20 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement-specific questions:

4. For draft quality statement 3: Draft quality statement 3 includes the term ‘node-positive or locally advanced rectal cancer’ to refer to rectal cancer at stage cT1-T2, cN1-N2, M0, or cT3-T4, any cN, M0. Is this an accurate term to refer to rectal cancer at these stages?

5. For draft quality statement 5: Process measure b) measures at least 2 CT scans done in the first 3 years after potentially curative surgery based on NICE’s guideline on colorectal cancer, evidence review E1. Could there be any unintended consequences from specifying this number as a minimum?

6. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* There was a mixed response to the content of the quality standard and the key areas for quality improvement.
* There were some suggestions of alternative key areas for priority.
* It should be made clear that the statements specifically apply to colorectal adenocarcinoma.
* The priority in the draft proposals is cure and survivorship. It would be refreshing to see quality of life given more attention in the planning and selection of treatments.
* Suggestion that the draft does not address the issues in management of rectal cancer and improving outcomes in rectal cancer.
* Statements assume that all patients with rectal cancer are fit and agreeable for surgery.
* The inclusion of minimally invasive procedures was welcomed.
* The quality standard should be reviewed frequently to keep up to date with changes in clinical practice.
* There were no examples of implementation of the NICE guideline from stakeholders.

### Consultation comments on data collection

* There are local structures in place to collect data.
* Systems could be adapted to collect patient perceptions, outcomes and involvement.
* The addition of further data collection and patient follow-up may put a strain on departments and require extra funding.

### Consultation comments on resource impact

* Implementation of statement 1 will result in an increase on demand for surveillance colonoscopy and there will be a need to optimise current capacity. There should be consideration of capacity in genetic services, and resources for routine genetic testing would be welcomed and required. Widespread testing for Lynch syndrome will put additional strain on the pathology laboratory services. The appropriate resources and funding should be put in place.
* It is vital that patients can discuss the implications of all treatment options throughout the course of their recovery or disease progression, but this may not be fully achievable under the current circumstances.
* For statement 3 there may be a resource impact in areas where preoperative therapy is not currently offered.
* Statement 4 may have resource implications on pathology laboratory services. It is important that adults with metastatic colorectal cancer are tested for RAS and BRAF mutations, but this may not be fully achievable under current circumstances. The impact of the COVID-19 pandemic on cases diagnosed at advanced stage is unclear and there may be an increase in adults presenting with metastatic colon cancer.
* National guidance and support are needed for the statements to be achievable by local teams.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Adults with a new diagnosis of colorectal cancer have testing to determine whether or not they have Lynch syndrome.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

Statement

* Stakeholders were supportive of this statement.
* There may be confusion when using the terms ‘testing’ or ‘molecular testing’ throughout the statement and accompanying measures. The statement and measures need to be clear that testing includes immunohistochemistry and microsatellite instability.
* The statement should recognise the importance of MMR/MSI status in oncological treatment beyond simply identifying Lynch.

Measures

* The National Bowel Cancer Audit (NBOCA) will report on testing for Lynch syndrome at provider level.
* It is not accurate to include all MMR deficient colorectal cancers in the denominator for process b) as those expressing abnormal MSH2, MSH6 or PMS2 (isolated) go straight to germline genetic testing.
* Somatic BRAF V600E testing is more widely available than MLH1 promotor hypermethylation testing so may be informative to assess separately in process b).
* It needs to be made clear that all patients should be offered BRAF testing in the first line and only methylation testing if there is no evidence of a BRAF mutation.
* There should be a registry of patients tested which will help identification of first- and second-degree relatives who may be at risk.
  1. Draft statement 2

Adults with early rectal cancer discuss the implications of each treatment with their healthcare professional and reach a shared decision on which treatment is the best option for them.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

Statement

* Stakeholders were supportive of the statement.
* There were suggestions of additional treatments that should be referenced in the statement and measures.
  + The statement should include non-surgical management such as external beam radiation therapy (EBRT), Papillon contact X-ray brachytherapy as an option for patients who are not fit for surgery, local excision or TME as in [NICE’s interventional procedures guidance IPG532](https://www.nice.org.uk/guidance/ipg532) and [NICE’s pathway for colorectal cancer](https://pathways.nice.org.uk/pathways/colorectal-cancer).
  + Randomised clinical trials have demonstrated the benefits of use of neoadjuvant treatment in expanding the options for organ preservation in the management of rectal cancer.
* A discussion should be made with regard to participation in the relevant prospective trials.
* It is important to emphasise clinical trials in this area to determine the role of minimally invasive procedures and best candidates for this treatment.
* Implementation of the statement requires development of literature to provide a clear overview of the different treatment options available including the risks and benefits of each option.

Measures

* NBOCA carries out an annual organisation survey of colorectal cancer service providers and will include a question in 2022 on whether written information is provided on treatment options.

Equality and diversity considerations

* Stakeholders welcomed the considerations on how information should be given and suggested this should also relate to expression of the issues in lay terms which may be expanded on in patient/consultant meetings.
  1. Draft quality statement 3

Adults with node-positive or locally advanced rectal cancer have preoperative radiotherapy or chemoradiotherapy.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

Statement

* There was a mixed response to this statement.
* Some stakeholders questioned the evidence base for this statement.
* Some stakeholders raised concerns about the potential for the statement to result in overtreatment of patients.
* Some stakeholders commented on the resource impact of this statement and the potential to incur delays for other cancer patients on implementation.
* The statement should use an evidence-based risk-stratified approach for the use of short course radiotherapy or chemoradiotherapy in line with European Society of Medical Oncology (ESMO) guidelines.
* There is no guidance on duration and type of radiotherapy or chemoradiotherapy.
* No mention of total neoadjuvant therapy (TNT) as an approach.
* Patients with locally advanced rectal cancer with invasion of other organs should be discussed with a multidisciplinary team (MDT) routinely treating and operating in local advanced disease/pelvic exenteration prior to neoadjuvant treatment to permit surgical planning and review.
* The concept of complete clinical response should be introduced as this can be sustained and ‘watch and wait’ protocols are options for patients.
* Some stakeholders disagreed with the population for this statement and suggested additions or alternatives:
  + The definition of node positive disease with MRI remains subjective, differs between radiology MDTs and is recognised to over-stage lymph node status.
  + There is no mention of EMVI, CRM margins or location within the rectum to guide on treatment.
  + Low rectal cancer and cancers involving CRM should be considered for neoadjuvant therapy.
  + Most surgeons would consider T3a/b N0 tumours to be resectable without neoadjuvant treatment.
  + Locally advanced rectal cancer should include low rectal tumours that when down staged may permit maintenance of intestinal continuity.
  + There is considerable difference between locally advanced rectal cancer and node positive cancer and so should not be dealt with together. Should be rephrased to include locally advanced rectal cancer and/or adverse features indicating a high likelihood of systemic disease and/or disease extending beyond standard surgical resection boundaries (beyond TME).

Measures

* NBOCA reports on rate of neoadjuvant treatment. NBOCA will assess feasibility of reporting the proportion of adults with node-positive or locally advanced rectal cancer having preoperative radiotherapy or chemoradiotherapy at provider level.

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

* The definition seems appropriate and accurate.
* cT1/cT2, cN1 or cN2 are rare but should be regarded advance stage as they are node positive. cT3 cT4 any N, cM0 are locally advanced whether node positive or not.
* It should exclude cT3a cN0 as they can be regarded as early stage and not advanced.
* Node positive rectal cancer is any T stage with N1 or N2. Locally advanced rectal cancer is T3 and T4 with any N stage.
  1. Draft quality statement 4

Adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have testing to identify tumours with RAS and BRAF V600E mutations.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

Statement

* Stakeholders were supportive of this statement.
* The statement should be amended to include the fact that testing should be completed prior to patients starting systemic anti-cancer treatment.
* It should clearly state why MMR/MSI testing has not been considered in this statement as MMR/MSI status now has a role, specifically in guiding potential immunotherapy. Statement 1 and statement 4 should be linked.
* There is no guidance on what testing is expected as a minimum. There is significant variability in codons tested nationally.

Measures

* NBOCA collects patient-level data on RAS and BRAF testing and has approval to link with NDRS to report at provider level.
* Several centres do not access testing via Genomic Laboratory Hubs (GLH) and choose rapid point of care technologies based in histopathology, therefore data not available via GLH.
  1. Draft quality statement 5

Adults who have had potentially curative surgical treatment for non-metastatic colorectal cancer have follow up for the first 3 years to detect local recurrence and distant metastases.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

Statement

* Stakeholders were supportive of this statement.
* Patients with high-risk features should have at least yearly CT scans.
* Two scans in 3 years are appropriate as a minimum. Specifying a minimum ensures a standard that all hospitals should aim for.
* Follow up should be measured for at least 3 years with longer surveillance period determined locally according to individual risk factors for recurrent disease.

Measures

* NBOCA is carrying out methodological development work to measure this at provider level.
* The denominators should make allowances for exceptions, for example patients too frail for follow up.

Audience descriptors

* Follow up in a nurse led colorectal cancer clinic is the most useful and efficient use of resources, provided robust protocols are in place.

### Consultation question 5:

Stakeholders made the following comments in relation to consultation question 5:

* A potential unintended consequence is that patients may be offered more than 2 CT scans, increasing the changes of unwarranted regional variation depending on radiological capacity.
* A potential unintended consequence of increasing exposure to radiation which may not be required to improve patient outcomes.

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Diagnostic pathway for colorectal cancer including quantitative faecal immunochemical testing, colonoscopy and surveillance post-polypectomy and post-colorectal cancer.
* Addition of the option for organ preservation for early stage or locally advance/node positive rectal cancer. Using total neoadjuvant therapy, external beam radiation therapy, contact X-ray brachytherapy, chemotherapy alone.
* Consideration of treatments such as selective internal radiation therapy (SIRT).
* Specialist palliative care access for management of pain, symptom control, psychological support and future planning.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

|  | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 1 | Association of Coloproctology of Great Britain and Ireland | General | Thank you for asking the ACPGBI to comment on this Draft Colorectal Cancer Quality Standards Document. We note with interest the five Quality Standards that have been selected by NICE. We are pleased to see that the management of Early Rectal Cancer is included as Quality Standard given the increasing detection of early disease by the national Bowel Screening Programmes but ongoing variation in management. We feel some revision of this standard may be beneficial (Refer to Statement 2).  We are interested to see that two of the five Quality Standards refer to aspects of adjuvant therapy for Colorectal Cancer, with the other two referring to Diagnosis and Follow Up. We support the testing of newly diagnosed patients for Lynch Syndrome (NICE QS Statement 1) and support the use of adjuvant therapy to improve outcomes in patients with node positive and locally advanced rectal cancer (NICE QS Statement 3). However, it is our view that NICE should further consider which areas have “the greatest potential to improve the quality of care” in Colorectal Cancer (which was the basis for opinion requested from Key Stakeholders by NICE).  The ACPGBI would suggest that there remain important areas of management which are not addressed in these Quality Standards. In particular following evaluation in a number of large, population based studies the use of Symptomatic FIT testing has been widely adopted across the UK, during the Covid Pandemic. This has provided the ability to stratify USC referral of patients with bowel symptoms with Fast Track of only those with high risk of significant bowel disease. This intervention has significant potential to improve the stage of diagnosed cancers and create a shift in survival from Colorectal Cancer in the UK. The ACPGBI would therefore suggest that Use of Symptomatic FIT testing in patient with significant bowel symptoms should be included as a NICE Quality Standard since it is not currently addressed in NICE Guidance (DG30). |
| 2 | Bowel Cancer UK | General | Bowel Cancer UK are broadly supportive of these statements, identified as areas of need for improvement, and would be interested in formally supporting this quality standard. It would be useful to understand how the areas for improvement were prioritised for the diagnosis pathway. Given recent innovations such as the roll out of the quantitative faecal immunochemical test (qFIT) to guide referral for colorectal cancer in primary care and the updated guidance for post-polypectomy and post-colorectal cancer resection surveillance, there is potential for real improvement in the implementation of these two areas which would have an overall impact on the demand for colonoscopy, allowing for more efficient and effective use of available endoscopy resources. Areas of emergent practice, such as Colon Capsule Endoscopy, will likely be implemented into clinical pathways before the NICE Quality Standards are next updated, therefore review of this standard should be considered more frequently to keep up to date with changes in clinical practice. |
| 3 | Clatterbridge Cancer Centre | General | Your draft quality statement does not address the real issues that we as clinician face in managing patients with rectal cancer. This needs revision to reflect what you intend to achieve. |
| 4 | Leeds Teaching Hospitals NHS Trust | General | No comment |
| 5 | Medtronic Ltd | General | Medtronic would like to thank NICE for the opportunity to comment on these Quality Standards. |
| 6 | MSD UK Limited | General | MSD would like to thank NICE for the opportunity to input into the Topic Engagement exercise and Quality Standard consultation for colorectal cancer. |
| 7 | Papillon Patient Support Group | General | Within the scope of PPSG, the measures proposed in the document adequately address for consideration many specific concerns as noted in Statement 2 and other general considerations such as follow-up and monitoring in Statement 5. Statement 5 as well as informing on going treatment serves as reassurance to patients and clearly acts as a safety protocol for potential treatment failure when surgical means may allow for recovery.  Whilst the clear priority in the draft proposals are cure and survivorship, the aspects of quality-of-life both during treatment and after appear not to have been given particular attention to any great extent or associated with particular treatment options. This seems to be a great failing of the proposed update and it would be refreshing to see this aspect given more attention in the overall planning and selection of particular treatments. Since QOL is a significant feature of therapies such as CXB perhaps this might be an area for development. |
| 8 | Pelican Cancer Foundation | General | I spoke and shared the information with my colleagues. The clinicians that we work with have already engaged with and responded, therefore Pelican does not have anything further to add to this. |
| 9 | Pierre Fabre Ltd | General | We agree that the proposed quality standard and associated statements accurately reflect the key areas for quality improvement. |
| 10 | Royal College of Nursing | General | No comments. |
| 11 | Royal College of Physicians and Surgeons of Glasgow | General | The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the UK. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.  The College welcomes this draft quality standard on Colorectal Cancer.  It is noted that Scotland adheres to similar guidelines (SIGN) and Scottish Colorectal Units submit outcomes data to the Scottish Colorectal Cancer Network. |
| 12 | Wales Cancer Network | General | I believe it should be made clearer throughout this is in reference to colorectal *adenocarcinoma* specifically |
| 13 | Clatterbridge Cancer Centre | Question 1 | Not fully. Your draft quality statement assumes that all patients with rectal cancer are fit and agreeable for surgery. Many patients with rectal cancer are older and not all are fit for surgery. Average age of rectal cancer is above the age of 65 years, and many has multiple comorbidities. Even if they are suitable for surgery many do not want a stoma. Your draft guidelines do not reflect the real world where many patients are not keen on surgery even local excision as it involves a general anaesthesia and a hospital stay. |
| 14 | International Contact Radiotherapy Network (ICONE) | Question 1 | Yes |
| 15 | Leeds Teaching Hospitals NHS Trust | Question 1 | No as it fails to encourage other areas of evidence-based medicine with proven associations of improved rectal cancer outcomes specifically standardised MRI staging and formalised reporting for better patient staging and selection for treatment as per the MERCURY study (Taylor et al. J Clin Oncol 2014; 32: 34–43) and standardised post-operative reporting of Total Mesorectal Excision surgical specimen quality (Quirke et al. Lancet 2009; 73(9666):821-8). |
| 16 | Medtronic Ltd | Question 1 | Medtronic welcomes the inclusion of Minimally Invasive Surgery within the Quality Standard. This is aligned with NICEs Technology Appraisal on Laparoscopic Surgery. <https://www.nice.org.uk/guidance/ta105/resources/laparoscopic-surgery-for-colorectal-cancer-pdf-82598014092229>.  Further, this measure will address the variation in the use of laparoscopic surgery between Trusts/Hospitals/MDTS across England and Wales as highlighted in the 2019 National Bowel Cancer Audit. <https://www.nboca.org.uk/content/uploads/2020/01/NBOCA-2019-V2.0.pdf> |
| 17 | Medtronic Ltd | Question 1 | Medtronic recognises that trusts widely use JAG (Joint Advisory Group on GI Endoscopy) as noted in the minutes of the 13th July 2021 and that there was little potential for quality improvement with a statement on colonoscopies. However, the early diagnosis of colorectal cancer is critical for the effective treatment of the disease. To diagnose or rule out cancer within the timeframe set out in the NHS Long Term Plan Medtronic feel that this Quality Statement should include imaging for the diagnosis of colorectal cancer. |
| 18 | MSD UK Limited | Question 1 | MSD agrees this draft quality standard reflects the key areas identified for quality improvement through the Topic Engagement exercise which sit within the scope of this Quality Standard consultation. |
| 19 | Royal College of Physicians and Surgeons of Glasgow | Question 1 | Our reviewers considered that the QS reflected the current areas for Quality improvement in the field including Lynch syndrome testing, early and advanced rectal cancer, metastatic colorectal cancer and follow up of patients after curative surgery for non-metastatic colorectal cancer. One considered the focus on locally advanced colorectal cancer and the use of neoadjuvant therapy was worthy of mention to patients in that position with large trials suggesting that chemotherapy may improve post-operative complication rate including anastomotic leak rate and resection margin status.  The concept of considering early rectal cancer separately is important. It is important to emphasise that there are still clinical trials in this area to determine the role of minimally invasive surgical procedures and the best candidates for this treatment. The definition given seems appropriate.  Locally advanced rectal cancer should include low rectal tumours that when downstaged may permit maintenance of intestinal continuity. Additionally, the concept of complete clinical response should be introduced, as we know now that this can be sustained and “watch and wait” protocols are options for patients. This should involve fully informed and consented patients.  The guideline should consider the excellent results with SCRT in the Rapido trial when drawing its conclusions.  Additionally, patients with locally advanced rectal cancer with invasion of other organs should be discussed with an MDT routinely treating and operating in locally advanced disease/pelvic exenteration prior to institution of neoadjuvant therapy to permit surgical planning and review. |
| 20 | Wales Cancer Network | Question 1 | The only addition for me would be the option of organ preservation for early stage or locally advance/node positive rectal cancer. Using TNT (Total Neoadjuvant Therapy), EBRT (+/- contact RT), chemotherapy alone. |
| 21 | Clatterbridge Cancer Centre | Question 2 | Yes, we have local structures in place to collect data for the proposed quality measures through our ‘Quality measure (Audit and statistics)’ team. |
| 22 | International Contact Radiotherapy Network (ICONE) | Question 2 | Yes |
| 23 | Leeds Teaching Hospitals NHS Trust | Question 2 | No comment |
| 24 | MSD UK Limited | Question 2 | MSD are not in a position to comment on this question. |
| 25 | Papillon Patient Support Group | Question 2 | To some extent yes there are systems in place that could be adapted to collect data regarding patient perceptions outcomes and involvement. This would involve use of the present website which already gathers and collates a range of analytics about patient observations and expectations and experiences. |
| 26 | Royal College of Physicians and Surgeons of Glasgow | Question 2 | Given the legal obligation to submit outcomes cancer data, all hospitals in the UK have systems and structures in place to collect data for these proposed quality measures. However, the addition of further data collection may put a strain on the already overstretched local audit departments. Extra funding may be needed by a number of units in order to meet the demand of additional data collection and patient follow up. |
| 27 | Boston Scientific | Question 3 | It is vital that all patients can discuss the implications of all treatment options available to them, not only in early rectal cancer, but throughout the course of their recovery or disease progression. It is also important that adults with metastatic colorectal cancer (mCRC) are tested for RAS and BRAF mutations. However, currently this is not the case and under the current circumstances not fully achievable.    Firstly, the coronavirus pandemic has presented major challenges for healthcare and cancer waiting times have greatly increased. Regarding colorectal cancer, is has been predicted that patient care may be particularly badly affected in this area due to the impact of COVID19 on NHS service provision. A lot of work is still required to ensure that capacity rebuilds as rapidly as possible to manage patients that have experienced a delay in care. Therefore, it is crucial that treatment options that expedite care and facilitate patient preferences and mutation testing are prioritized, strengthened, and supported even more than currently is the case.    This Quality Standard review should encourage the consideration of treatment options and open discussions with clinical specialists, which could result in patients receiving access to care faster. Minimally invasive techniques such as Selective Internal Radiation Therapy (SIRT) for mCRC not only offer physicians and their patients more choice, but also have the potential to allow more patients to be treated faster. Also, SIRT can be used in patients with any mutation expression, therefore not limiting treatment to the presence or absence of certain mutations. Ensuring that SIRT is discussed as a treatment option between patients and physicians would aid in lowering the elective care numbers to pre-pandemic levels as quickly as possible and prevent further delays to life saving treatment.    Secondly, NICE have encouraged industry to provide a very high level of evidence to optimally support decision making. At the 2021 European Society of Medical Oncology congress Boston Scientific announced the results of the EPOCH trial. The study investigated the impact of transarterial Yttrium-90 radioembolization (TheraSphere) in combination with second line systemic chemotherapy for colorectal liver metastases. This Randomized Controlled Trial (RCT) was powered sufficiently to show statistical significance in the two primary endpoints: Progression Free Survival (PFS) and hepatic PFS. Both primary endpoints were found to be statistically significantly better in the TheraSphere arm of the trial (1). Please find attached a copy of the published article and supplementary paper. To optimize national and local decision making, high level evidence such as EPOCH data is necessary. Therefore, now that this evidence is available, the review committee should consider revising it a priority and not wait for the allotted time outlined by the IPG group or other guideline groups.    Thirdly, effectively and fully implementing a service is difficult when the criteria for a centre is restrictive. This is the case with SIRT. SIRT is being offered by only 10 hospitals and owing to the strict criteria and very limited numbers this is resulting in centres finding it difficult to provide a competent service. These limitations do not support optimised clinical decision making and mean that there is not equitable access for patients across the UK. It is unclear and not transparent how the number of 50 patients has been reached. The single-arm SIRT CtE registry study was carried out between December 2013 and March 2017, with a total of 399 patients with colorectal cancer treated with SIRT using yttrium-90 (2). This results in roughly 119 patients per year being treated with SIRT, more than double the number of patients currently eligible. Moreover, the restrictive 50 patient cap placed on the service does not align with the UK incidence rates for mCRC and the potential patient population which could be eligible for SIRT based on the recent results of EPOCH. There are around 43 million adults England, of which 0.08% will be diagnosed with colorectal cancer, and 25% of these patients will suffer from metastasis (3, 4, 5). Of these patients with mCRC, 78% will be unresectable, and 74% will progress after 1st line chemotherapy (6, 7, 8). Of these, 60% will have liver dominant metastases in 2nd line (9). Therefore, resulting in a potential patient population for SIRT with 2nd line chemotherapy of around 2,000 patients in England.  Also, in March 2021, following a technology appraisal, NICE approved the usage of SIRT in the advanced hepatocellular carcinoma indication. Therefore, taking this into consideration, along with the new evidence from the EPOCH trial, NHS England needs to review both the criteria and patient numbers set in place.  At present SIRT will unlikely be openly or widely discussed as a treatment option between patients and healthcare professionals. This is most likely due to the present issues with accessibility resulting from the limitations set on number of patients which can receive this treatment. Some people may have difficulty in accessing SIRT due to the distance and the cost associated with transport, for example those with a disability, older people, and other socio-economic factors.    Overall, enabling SIRT to be more easily accessible should be a top priority for NICE considering: treatment choices for mCRC are still relatively limited in comparison to other tumour sites; the clinical benefits of using SIRT depicted in the EPOCH trial; the potential of cutting the waiting list times; and the chance to offer patients and physicians increased treatment options.    (1) Mulcahy, M. F., Mahvash, A., Pracht, M., Montazeri, A. H., Bandula, S., Martin, R., 2nd, Herrmann, K., Brown, E., Zuckerman, D., Wilson, G., Kim, T. Y., Weaver, A., Ross, P., Harris, W. P., Graham, J., Mills, J., Yubero Esteban, A., Johnson, M. S., Sofocleous, C. T., Padia, S. A., … EPOCH Investigators (2021). Radioembolization With Chemotherapy for Colorectal Liver Metastases: A Randomized, Open-Label, International, Multicenter, Phase III Trial. Journal of clinical oncology : official journal of the American Society of Clinical Oncology, JCO2101839. Advance online publication. https://doi.org/10.1200/JCO.21.01839  (2) Specialised Commissioning Team. (2018). Clinical Commissioning Policy: Selective internal radiation therapy (SIRT) for chemotherapy refractory/ intolerant metastatic colorectal cancer (adults). NHS England.  (3) NICE TA 439  (4) Office for National Statistics. (2017). Cancer registration Statistics, England. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/cancerregistrationstatisticscancerregistrationstatisticsengland  (5) Haraldsdottir, S., Einarsdottir, H. M., Smaradottir, A., Gunnlaugsson, A., & Halfdanarson, T. R. (2014). Krabbamein í ristli og endaþarmi [Colorectal cancer - review]. Laeknabladid, 100(2), 75–82. https://doi.org/10.17992/lbl.2014.02.531  (6) Schima, W., Kulinna, C., Langenberger, H., & Ba-Ssalamah, A. (2005). Liver metastases of colorectal cancer: US, CT or MR?. Cancer imaging : the official publication of the International Cancer Imaging Society, 5 Spec No A(Spec No A), S149–S156. https://doi.org/10.1102/1470-7330.2005.0035  (7) Tampellini, M., Di Maio, M., Baratelli, C., Anania, L., Brizzi, M. P., Sonetto, C., La Salvia, A., & Scagliotti, G. V. (2017). Treatment of Patients With Metastatic Colorectal Cancer in a Real-World Scenario: Probability of Receiving Second and Further Lines of Therapy and Description of Clinical Benefit. Clinical colorectal cancer, 16(4), 372–376. https://doi.org/10.1016/j.clcc.2017.03.019  (8) Van den Eynde, M., & Hendlisz, A. (2009). Treatment of colorectal liver metastases: a review. Reviews on recent clinical trials, 4(1), 56–62. https://doi.org/10.2174/157488709787047558  (9) Sung H, Ferlay J, Siegel RL, et al: Global cancer statistics 2020: GLOBOCAN estimates of incidence andmortality worldwide for 36 cancers in 185 countries. CA  Cancer J Clin 71:209-249, 2021 |
| 28 | Bowel Cancer UK | Question 3 | For the implementation of Statement 1 and as more patients, and their family members, are identified with Lynch syndrome it will result in an increase on demand for surveillance colonoscopy services. NHS England must consider this within modelling for future demand and work with Health Education England to ensure that a sufficient number of gastroenterologists are trained to meet this future demand. In the short-term, commissioners must consider how to effectively manage colonoscopy waiting lists, from all pathways, and develop and implement a plan of action on how to optimise current capacity within services. |
| 29 | Bowel Cancer UK | Question 3 | Consideration must also be given on the capacity in genetic services, including genetic counselling, for effective cascade testing of family members to support effective implementation of NICE NG27. |
| 30 | Bowel Cancer UK | Question 3 | The inclusion of Statement 3 as a Quality Standard might have a resource impact in areas where preoperative therapy is not currently offered and where more clinical oncologists and radiotherapy equipment and staff will be needed. |
| 31 | Bowel Cancer UK | Question 3 | The inclusion of Statement 4 as a Quality Standard might have resource implications for pathology laboratory services due to a potential increase in demand for molecular testing to identify tumours with RAS and BRAF V600E mutations in adults with metastatic colorectal cancer. It is still unclear the impact of the COVID-19 pandemic on the proportion of cases diagnosed at advanced stage, therefore they may be an increase in adults presenting with metastatic colorectal cancer as services continue to recover and reduce the cancer backlog. |
| 32 | Clatterbridge Cancer Centre | Question 3 | Draft quality standard statements will not be achievable by local team on its own. We would need national guidance and support (need more support for Guildford CXB data base). |
| 33 | International Contact Radiotherapy Network (ICONE) | Question 3 | Yes |
| 34 | Leeds Teaching Hospitals NHS Trust | Question 3 | No comment |
| 35 | MSD UK Limited | Question 3 | MSD are not in a position to comment on this question. |
| 36 | Papillon Patient Support Group | Question 3 | Beyond the scope of Papillon Patient’s Support Group (PPSG). |
| 37 | Royal College of Physicians and Surgeons of Glasgow | Question 3 | Resources for routine genetic testing would be welcome and required.  As mentioned in 3 above, some local audit units may struggle to meet the demand of additional data collection and patient follow up. Extra funding may be necessary for the improvement and upgrade of the hardware and software, and for employing the appropriate number of clerical staff and patient pathway co-ordinators. |
| 38 | Wales Cancer Network | Question 3 | The impact for me affect histopathology and genetic services on the increased numbers being tested for MMR and RAS/RAF. Also radiotherapy/chemotherapy departments with potentially more patients coming through for neoadjuvant treatment. If organ preservation was explored (1/3 patients having pCR with TNT), money could be saved by fewer operations. |
| 39 | Clatterbridge Cancer Centre | Question 4 | Patients with cT1/cT2, cN1 or cN2 are rare however, by definition these patients should be regarded as advance stage as they are node positive i.e. Dukes ‘C’ carcinoma with poor prognosis. Patients with cT3 cT4 any N, cM0 are by definition locally advanced whether the nodes are positive or not. Should exclude cT3a cN0 as they can be regarded as earlier stage rectal cancer and not advance.  CRM involvement is one of the internationally accepted MRI criteria to define rectal tumour as an advanced stage cancer and this is not included in your guidance. This should be one of the criteria for advance rectal cancer. |
| 40 | International Contact Radiotherapy Network (ICONE) | Question 4 | Yes |
| 41 | Leeds Teaching Hospitals NHS Trust | Question 4 | We would disagree with this description of locally advanced rectal cancer which seems a retrograde step in prognostic risk stratification compared to the previous NICE guideline CG131. This quality statement and NG 151 does not include validated prognostic factors for recurrence and survival such as MRI-defined extramural vascular invasion (Siddiqui et al. Br J Cancer 2017; 116: 1513–9) and surgical circumferential resection margin (also known as mesorectal fascia) involvement (Taylor et al. J Clin Oncol 2014; 32: 34–43). |
| 42 | MSD UK Limited | Question 4 | MSD are not in a position to comment on this question. |
| 43 | Papillon Patient Support group | Question 4 | Beyond the scope of Papillon Patient’s Support Group (PPSG). |
| 44 | Royal College of Physicians and Surgeons of Glasgow | Question 4 | This definition could be developed further. In quality statement 3, low rectal cancers and any cancers potentially involving the circumferential resection margin should be included in those that should be considered for neoadjuvant therapy. Most surgeons would consider T3a/b N0 tumours to be resectable without neoadjuvant therapy.  Node-positive rectal cancer is any T stage with N1 or N2. Locally advanced rectal cancer is T3 and T4 with any N stage. The addition of EMVI (extramural vascular invasion) to the staging as a marker of locally advanced cancer should be considered. |
| 45 | Wales Cancer Network | Question 4 | Yes it is an accurate term. |
| 46 | Bowel Cancer UK | Question 5 | A potential unintended consequences is some patients may be offered more than 2 CT scans, increasing the changes of unwarranted regional variation depending on radiology capacity as well as increasing exposure to radiation which may be not be required to improve patient outcomes. |
| 47 | Clatterbridge Cancer Centre | Question 5 | For patients presenting with advanced rectal cancer, there is a much higher risk of developing distant metastatic disease especially if they are mucinous, poorly differentiated or those with lympho-vascular invasion. Follow up policy should take this into account. These patients with high-risk features should have more frequent at least yearly CT scans. Two scans may not pick up distant metastases when occurs (usually in the first 2 years) in time to offer liver or lung resection which can be curative. |
| 48 | International Contact Radiotherapy Network (ICONE) | Question 5 | No |
| 49 | Leeds Teaching Hospitals NHS Trust | Question 5 | No comment |
| 50 | MSD UK Limited | Question 5 | MSD are not in a position to comment on this question. |
| 51 | Papillon Patient Support Group | Question 5 | Beyond the scope of Paillon Patient’s Support Group (PPSG). |
| 52 | Royal College of Physicians and Surgeons of Glasgow | Question 5 | Our reviewers considered that two CT scans in three years was appropriate as a minimum. Specifying a minimum of scans ensures that there is an evidence-based standard that all hospitals should aim for in order to continually improve the quality of care. However, this standard should make allowance for exceptions, as for example patients who are too frail to undergo any follow up. Therefore, the denominator should read “The number of adults who had potentially curative surgery for non-metastatic colorectal cancer and who are fit for follow up investigations”. |
| 53 | Wales Cancer Network | Question 5 | Not that I can think of. |
| 54 | Clatterbridge Cancer Centre | Question 6 | We do not have an example from our practice of implementing the NICE guidelines that underpins this quality standard as it is difficult to apply the current NICE guidelines to the real world. Your guidance as its stands does not reflect the reality of our large volume clinical day to day practice for our early rectal cancer patients and their management. Clatterbridge is one of the National referral centres for non-surgical treatment of rectal cancer using contact X-ray brachytherapy (Papillon). |
| 56 | Leeds Teaching Hospitals NHS Trust | Question 6 | No comment |
| 57 | Royal College of Physicians and Surgeons of Glasgow | Question 6 | No |
| 58 | Bowel Cancer UK | Statement 1 | Bowel Cancer UK fully supports this statement. The emphasis of a responsible clinician in each Multi-Disciplinary team (MDT) for diagnosis of Lynch syndrome reflects with our consensus statement published in the BMJ in 2017: <https://doi.org/10.1136/bmj.j1388> |
| 59 | Leeds Teaching Hospitals NHS Trust | Statement 1 | No comment |
| 60 | MSD UK Limited | Statement 1 | MSD are pleased to note the introduction of this quality statement. |
| 61 | National Bowel Cancer Audit team – Royal College of Surgeons of England | Statement 1 | Adults with a new diagnosis of colorectal cancer have testing to determine whether or not they have Lynch syndrome.  - The National Bowel Cancer Audit (NBOCA) collects patient-level data on this and is working to improve its data completeness. See https://www.nboca.org.uk/reports/annual-report-2020/ page 40. NBOCA has also gained approval to obtain linked data relating to histological and genomic tests performed within the NHS from the National Disease Registration Service. As soon as data completeness is sufficiently high, NBOCA will report on testing for Lynch syndrome at provider level. |
| 62 | Roche Diagnostics UK | Statement 1 | We believe the wording “Molecular testing” used in the “rationale” and “process” sections could be misinterpreted as only the micro-satellite instability (MSI) testing strategy and not the choice of Immunohistochemistry (IHC) or MSI testing strategies that are both recommended by NICE. We would suggest changing the wording to either specifically reference both IHC and MSI from the offset, as has been done in later sections, or to move towards a more general term such as just “testing”, as has been done in statement 1 itself. |
| 63 | Royal College of Pathologists | Statement 1 QS1b (p.5) | According to NICE DG27, only those MMR deficient CRCs with abnormal MLH1 IHC (or MSI-high tumours without MMR IHC performed) require sequential BRAF V600E and MLH1 promoter hypermethylation testing to differentiate sporadic and Lynch syndrome-associated cancers. It is therefore not accurate to include all MMR deficient CRCs in the denominator for this standard, as those expressing abnormal MSH2, MSH6 or PMS2 (isolated) go straight to germline genetic testing. |
| 64 | Royal College of Pathologists | Statement 1 QS1b (p.5) | Somatic BRAF V600E testing is more widely available than MLH1 promoter hypermethylation testing, so it may be informative to assess separately, testing by each of these methods. For example, some pathways may refer to clinical genetics, patients with dMMR cancers showing abnormal MLH1 IHC after demonstration of absent BRAF V600E mutation and without subsequent MLH1 promoter hypermethylation testing. This potentially results in a cohort of patients inappropriately referred to clinical genetics, with resultant impact on clinical genetics workload and on individual patients and their families. Without modification of this standard, such information is not assessable and this potential limitation of current pathway implementation not obvious. |
| 65 | Royal College of Pathologists | Statement 1 QS1b (p.5) | Combining above comments, I would therefore suggest considering splitting this standard into (b)1 and (b)2, as follows:  b) Proportion of adults with a new diagnosis of colorectal cancer and a tumour with deficient DNA mismatch repair who had molecular testing to differentiate sporadic and Lynch syndrome-associated colorectal cancer.  1. Numerator – the number in the denominator who had BRAF V600E testing to differentiate sporadic and Lynch syndrome-associated cancer.  Denominator – the number of adults with a new diagnosis of colorectal cancer and a tumour which was either MSI-high (no MMR IHC performed) or which displayed deficient DNA mismatch repair with abnormal MLH1 expression.  2. Numerator – the number in the denominator who had MLH1 promoter hypermethylation testing to differentiate sporadic and Lynch syndrome-associated cancer.  Denominator – the number of adults with a new diagnosis of colorectal cancer and a tumour which was either MSI-high (no MMR IHC performed) or which displayed deficient DNA mismatch repair with abnormal MLH1 expression, and was negative for subsequent BRAF 6V00E testing. |
| 66 | Royal College of Pathologists | Statement 1  Page 5 - “b) Proportion of adults with a new diagnosis of colorectal cancer and a tumour with deficient DNA mismatch repair who had molecular testing to differentiate sporadic and Lynch syndrome-associated colorectal cancer” | This only relates to patients with tumours showing MLH1 loss and not those with isolated PMS2 or MSH2/MSH6 loss. The denominator is therefore incorrect, as it should be “the number of adults with a new diagnosis of colorectal cancer and a tumour with MLH1 loss deficient DNA mismatch repair. Under the ‘data source’ it is not clear whether they understand that all such patients should be offered BRAF testing in the first line and only methylation testing if there is no evidence of a BRAF mutation (according to NICE DG27). Thus they will not all have methylation testing. It is slightly more clearly laid out on page 7 but page 5 is misleading especially with regard to the denominator. |
| 67 | Royal College of Physicians and Surgeons of Glasgow | Statement 1 | It is agreed that adults with a new diagnosis of colorectal cancer should have testing for Lynch syndrome. A registry should be kept of these patients, who would also be tested for other cancers, for example, ovary in females. A registry, set up with the collaboration of the local Genetics Unit, will also help to identify first and second degree relatives who may be at risk. Widespread testing for Lynch syndrome (as experienced in Scotland) will put additional strain on the pathology laboratory services. The appropriate resources and funding should therefore be put in place. |
| 68 | Association of Coloproctology of Great Britain & Ireland | Statement 2 | We particularly support the introduction of Statement 2 with regard to management of Early Rectal Cancer. The National Bowel Screening Programmes have produced an increased detection of Early Rectal Cancers but there is evidence of significant variation in the management of early rectal cancer across the UK. There is a need to ensure equivalent access to organ preservation by local excision and or chemo / radiotherapy.  We note that the Quality Standard recommends that “Adults with early rectal cancer should be offered access to all suitable treatments. This includes endoscopic and minimally invasive local procedures as well as rectal resection and no treatment.” Randomised clinical trials including TREC and CARTS have demonstrated the benefits of use of neoadjuvant treatment in expanding the options for organ preservation in the management of Early Rectal Cancer. Contact Radiotherapy (NICE IPG 532) should also be considered in patients who are not fit for surgery.  Given the increase in case numbers and the opportunity to reduce the morbidity of treatment for this condition with organ preservation treatment modalities, we feel that early rectal cancer is currently a key area for quality improvement but it is essential that patients are offered all treatment modalities including non-surgical options. These should be added to the Quality Standard to ensure that it is comprehensive |
| 69 | Bowel Cancer UK | Statement 2 | To support the implementation of this standard, literature must be collated and or developed to provide a clear overview of the different treatment options available for patients with early rectal cancer including the risks and benefits of each option. This literature should be easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. |
| 70 | Clatterbridge Cancer Centre | Statement 2 | 1. Stakeholders also noted the use of contact radiotherapy and the need to clarify where this fits into the pathway. Additionally, it was suggested that people who choose to defer surgery for rectal cancer should be enrolled in a trial or national registry, and this is an area for quality improvement.  1.a Contact Xray brachytherapy (CXB) is already in your care pathway in management of early rectal  cancer.  However, there was no mention of this treatment even for patients who are not fit for any form of surgery local excision or TME as both needs GA. There are many older patients with early rectal cancer who have multiple comorbidities who are not fit even for a short GA. Local excision is not an option for them.  NICE has approved CXB for patients not suitable for surgery in their IPG 532 document published in September 2015. Your current guidance (2020) contradicts your own recommendations. We have just completed recruitment into a phase 3 randomised trial OPERA for younger fitter patients with rectal cancer. Preliminary OPERA trial results were published at the GI ASCO in January 2021 and the main trial results will be published in May 2022. There is also a National registry at Guildford St Luke’s Hospital for patients treated with CXB since 2015 as recommended by NICE (IPG 532).  2.Adults with early rectal cancer should be offered access to all suitable treatments.  2a. CXB is not mentioned in your guidance (2020) as suitable treatment even for patients not fit for surgery or GA let alone patients refusing surgery of any sort local or TME as it involves GA and a hospital stay. Do these patients not have a choice? They are coerced and forced to have surgery despite their objections in many colorectal units around the country. There is no shared decision making and the patients are not treated as equal partner in their decision making. This is against NICE (2012,2020) and GMC guidance on Decision making and Consent (2020). This practice is clearly not acceptable and against the patients’ human right. This should not be a national standard in a democratic society.  3. Healthcare professionals (such as colorectal cancer specialists) are aware of all treatments for early rectal cancer, including endoscopic procedures, minimally invasive local surgical procedures, rectal resection and no treatment, and discuss the implications of all options with adults with early rectal cancer before they reach a shared decision about the best option for them.  3a. Please see above. Not common practice in NHS hospital Colorectal units at present. Non-surgical treatments with organ preservation are not usually mentioned or offer even for unfit older patients.  4. Adults with early rectal cancer have a discussion with their healthcare professional about all treatments including no treatment and procedures that do not need surgery. They feel informed to reach a decision about the best option for them.  4a. Non-surgical treatment of early rectal cancer is not usually discussed with patients as an option for their management. No information is readily offered to patient during discussions about possible treatment options even for older and unfit patients unless challenged by patients. We need to change this practice and mind set of healthcare professionals in some of the colorectal MDTs in the UK. Balance NICE guidelines can help change the attitudes and practice. |
| 71 | GEC ESTRO GI brachytherapy working group – Royal Surrey Hospitals NHS Trust | Statement 2 | NICE interventional procedures guidance IPG532 describes the use of low energy contact X-Ray brachytherapy in early rectal cancer. Our working group believes that this should also be a treatment option for early rectal cancer as laid out in statement 2. This is not preoperative radiotherapy, instead it is radiotherapy offered with the intention of organ preservation. IPG532 also recommends use of the Guildford database to record outcomes, these can using surgery or radiotherapy treatments. This database is easy to use and is available free of charge by agreement with the database holders. The database holders would be happy to modify the database to allow recording of discussion of treatment options, followed by outcome recording. This may enable monitoring of this quality standard. |
| 72 | International Contact Radiotherapy Network (ICONE) | Statement 2 | This is an important standard and emphasises patient choice and engagement in decision making as has been promoted by the GMC publication on Decision Making and Consent (September 2020). We feel it is important to mention the option of contact radiotherapy for patients, who do not wish to have TME surgery or are considered unfit for this, alongside the other options currently mentioned of local excision and no treatment. There is already a published RCT showing increased organ preservation with the addition of contact radiotherapy (Lyon 96-02 Gerard et al) with a larger RCT OPERA having completed recruitment and due to present its results in May 2022. The 4 UK contact radiotheray centres already treat over 200 patients annually in this setting but there remains issues with potentially suitable patients even being informed of this option nationally. We certainly feel it should be mentioned as part of the quality standard so patients may be informed of all the potential options available to them. It is listed as an option on the NICE care pathway but for some reason has been omitted as an option on the quality standard. |
| 73 | Leeds Teaching Hospitals NHS Trust | Statement 2 | No comment |
| 74 | MSD UK Limited | Statement 2 | MSD have no comment on this statement. |
| 75 | National Bowel Cancer Audit team – Royal College of Surgeons of England | Statement 2 | Adults with early rectal cancer discuss the implications of each treatment with their healthcare professional and reach a shared decision on which treatment is the best option for them.  - NBOCA carries out an annual organisational survey of colorectal cancer service providers. It will include a question in 2022 on whether written information is provided to rectal cancer patients on the different treatment options. |
| 76 | Papillon Patient Support Group | Statement 2 | The rationale proposes that “adults with early rectal cancer should be offered access to all suitable treatments”. This is a critical element allowing for informed treatment choices to be made by patients in conjunction with their MDT’s advice. Understandably, very often advice given to patients in good faith regarding treatment options is inevitably biased by the particular specialism of the professionals being consulted. From a patient’s perspective, a second critical element presented in the rationale is that treatment advice and options should include, “minimally invasive local procedures”. Where excessive risk is acknowledged and controlled for within the treatment protocols, these procedures in the vast majority of cases would be preferred.  Drawing on experience gained from input from current and past Papillon patients, (available on the PPSG site ( <https://www.papillonpatientsupport.com/patients-stories> ) it is notable that Papillon-Contact X-ray Brachytherapy (CXB) as a relatively non-invasive treatment option - does not appear to be widely represented in patient accessible literature or via MDT consultations. Wider recognition of the potential of this treatment as an effective patient choice is required in both these areas. By implication, this also should be a stated aim and requirement for health care professionals and consultants in the field. Unfortunately, this latter has not always been evident in the anecdotal experiences of patients as noted in PPSG and suggests an area of action.  NICE (2015) interventional procedure guidance 532 does provide information on Low-energy contact X-ray brachytherapy (the Papillon technique) for early-stage rectal cancer. [https://www.nice.org.uk/guidance/ipg532 .](https://www.nice.org.uk/guidance/ipg532) However, patient awareness of this treatment for early rectal cancer depends greatly on individual patient research of the available literature - which for non-medical non-professionals is challenging due to lack of familiarity with the terminology. It is therefore welcomed that the “Equality and Diversity Considerations” section notes that, “ Information should be in a format that suits their needs and preferences”. Whilst it is recognised that this primarily relates to spoken language and cultural background it should also relate to expression of the issues in lay terms which may be expanded upon in patient / consultant meetings.  It should be recognised that Papillon has huge potential for the treatment of those clinically eligible patients who choose to decline surgery for personal reasons or are not fit for surgery due age-related fragility or co-morbidities. Based on patient responses Papillon CXB appears to have received little attention within patient literature and MDT discussions. Since post-treatment quality-of-life is a crucial aspect across all age groups it is important that this therapy is given wider recognition for the successes that it has had for its potential for cure, organ preservation and potential for improved post-treatment quality of life. Accepting that the treatment requires certain clinical conditions be met which the PPSG is aware of but not qualified to elaborate on here, PPSG feels that this treatment (CXB) should be more widely disseminated both in the NICE published literature and in their recommendations for good practice by health professionals as an option. |
| 77 | Royal College of Physicians and Surgeons of Glasgow | Statement 2 | Adults with early rectal cancer should be given the full opportunity to discuss their diagnosis and the various ways to treat (local excision eg TART, TAMIS, TEM; radical resection; chemoradiotherapy (only if part of a trial). A discussion should also be made with regard to participation in the relevant prospective trials. |
| 78 | Wales Cancer Network | Statement 2 | In Quality Statement 2 there is no reference to non-surgical management such as radiotherapy (EBRT +/- contact RT) as definitive treatment |
| 79 | Bowel Cancer UK | Statement 3 | There is some variation in current practice among different MDTs as to who is offered preoperative therapy, therefore the inclusion of this statement in the Quality Guidance should help reduce unwarranted variation. However, the recommendation this statement is based on does not provide guidance on the duration and type of radiotherapy or chemoradiotherapy as available evidence did not show a difference between short-course and long-course radiotherapy, chemoradiotherapy with or without induction chemotherapy, or internal radiotherapy with or without external radiotherapy and external radiotherapy alone. Evidence, and outcomes, on this should be monitored to help inform future clinical practice in this area. |
| 80 | BSGAR | Statement 3 | Standard 3: there is considerable difference between locally advanced rectal cancer and ‘node positive’ cancer and the two should not be dealt with together.  Node positivity is judged by radiology preoperatively and we are notoriously average at judging this correctly (almost flipping a coin for smaller nodes).  Consequently I would rephrase to include locally advanced rectal cancer and/or adverse features indicating a high likelihood of systemic disease and/or disease extending beyond standard surgical resection boundaries (beyond TME). |
| 81 | Leeds Teaching Hospitals NHS Trust | Statement 3 | We strongly disagree with this statement and NG 151 recommending that all “Adults with node-positive or locally advanced rectal cancer have preoperative radiotherapy or chemoradiotherapy”. There is evidence for the benefit of preoperative radiotherapy or chemoradiotherapy in reducing local recurrence, but the ‘rationale’ that all of these patients benefit from pre-operative treatment is based on historic trials prior to widespread adoption of current total mesorectal excision (TME) surgery and widespread availability of MRI staging allowing better patient risk-stratification.  TME surgery-based trials have NOT demonstrated better overall survival and the majority did NOT demonstrate improvements in disease-free survival with the addition of pre-operative radiotherapy or chemoradiotherapy. A recent Cochrane review of historic trials of pre-operative radiotherapy vs TME and non-TME surgery (Abraha et al. Cochrane Database Syst Rev. 2018; 10(10):CD002102), there was little evidence for improvements in disease-free survival or overall survival if TME surgery was performed.  The definition of node-positive disease with MRI remains subjective, differs between radiology MDTs and is recognised to over-stage lymph node status (Lord et al. Curr Colorectal Cancer Rep 2019; 15: 143–8.). A blanket recommendation for all node-positive disease will result in overtreatment with an impact on patient morbidity.  We disagree with the NG 151 (pg 27) statement that “the committee did not find a difference in quality of life or treatment-related mortality between those who did or did not receive preoperative therapy” which ignores evidence of increased long-term morbidity of pre-operative radiotherapy demonstrating with increased low anterior resection syndrome (LARS), and bowel, urinary and sexual dysfunction (Peeters et al. Clin Oncol. 2005;23(25):6199–206.; Chen et al. Clin Colorectal Cancer. 2015;14(2):106-14.; Jimenez-Gomez et al. Colorectal Dis. 2017. doi: 10.1111/codi.13901., Downing et al. Int J Radiat Oncol Biol Phys. 2019; 103(5):1132-1142.).  It is recognised pre-operative radiotherapy and chemoradiotherapy use differs across the UK (Morris et al. Clin Oncol 2016; 28: 522–31.) but there remains no evidence that this has equated to differing local recurrence rates or cancer outcomes between cancer centres. Measuring the “proportion of adults with node-positive or locally advanced rectal cancer who had preoperative radiotherapy or chemoradiotherapy” would not demonstrate improvements in care or outcomes.  This quality statement and the current NG 151 guidelines will result in overtreatment of patients with no evidence of survival benefits and increased long-term morbidity for cancer survivors. The resource impact of this overtreatment on current limited radiotherapy capacity with a Covid-related backlog and national failings of meeting 62-day cancer targets, will incur indirect losses/delays for other cancer patients where the benefit of radiotherapy is clearly demonstrable.  We strongly recommend this draft quality standard and the current NICE NG 151 guidelines be re-written for an evidence-based risk-stratified approach for the use of pre-operative short course radiotherapy or chemoradiotherapy as per the previous CG 131 guideline, in line with the more recent European Society of Medical Oncology (ESMO) guidelines (Glynne-Jones et al. Ann Oncol 2017; 28: iv22–40.) and Association of Coloproctology of Great Britain & Ireland (ACPGBI) guidelines (Gollins et al. Colorectal Dis. 2017;19 Suppl 1:37-66.). |
| 82 | MSD UK Limited | Statement 3 | MSD have no comment on this statement. |
| 83 | National Bowel Cancer Audit team – Royal College of Surgeons of England | Statement 3 | Adults with node-positive or locally advanced rectal cancer have preoperative radiotherapy or chemoradiotherapy.  - NBOCA reports on rate of neoadjuvant treatment in rectal cancer patients undergoing resection at provider level. NBOCA will assess the feasibility of reporting the proportion of adults with node-positive or locally advanced rectal cancer have preoperative radiotherapy or chemoradiotherapy at provider level. |
| 84 | Papillon Patient Support Group | Statement 3 | Beyond the scope of Papillon Patient’s Support Group (PPSG). |
| 85 | Royal College of Physicians and Surgeons of Glasgow | Statement 3 | Pre-operative radiotherapy or chemoradiotherapy should be available for adults with node positive or locally advanced cancer, and not just for patients with margin-threatening cancer only. This implies that the local oncology unit will have to be prepared to meet an increased demand on its services. |
| 86 | Wales Cancer Network | Statement 3 | There is no mention of EMVI, CRM margins or location within the rectum to guide on treatment. There is no mention of TNT as an approach, We accept this encompasses RT. |
| 87 | Bowel Cancer UK | Statement 4 | Bowel Cancer UK supports this statement to ensure all metastatic colorectal cancer patients receive treatment that is most beneficial to them, especially given the recent technology appraisal for anti-systemic cancer treatment for patients with these mutations. |
| 88 | Leeds Teaching Hospitals NHS Trust | Statement 4 | No comment |
| 89 | MSD UK Limited | Statement 4 | MSD have no comment on this statement. |
| 90 | National Bowel Cancer Audit team – Royal College of Surgeons of England | Statement 4 | Adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have testing to identify tumours with RAS and BRAF V600E mutations.  - NBOCA now collects patient-level data on RAS and BRAF testing for patients diagnosed from April 2021 onwards. NBOCA has also gained approval to obtain linked data relating to histological and genomic tests performed within the NHS from the National Disease Registration Service. As soon as data completeness is sufficiently high, NBOCA will report on RAS and BRAF testing at provider level. |
| 91 | Papillon Patient Support Group | Statement 4 | Beyond the scope of paillon Patient’s Support Group (PPSG). |
| 92 | Pierre Fabre Ltd | Statement 4 | We are pleased to see the inclusion of molecular testing in line with the NICE’s clinical guideline on colorectal cancer recommendation 1.4.  In order to reflect the numerator we would like to propose that the quality statement is amended to include the fact that testing should be completed prior to patients starting systemic anti-cancer treatment i.e.  Adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have testing to identify tumours with RAS and BRAF V600E mutations prior to starting treatment |
| 93 | Royal College of Pathologists | Statement 4 QS4 | NICE Guideline NG151 is cited as a source of guidance for this QS. In NG151 it states (p.36): “The committee noted evidence that testing for deficient DNA mismatch repair may inform systemic therapy choices for those with non-metastatic colorectal cancer, but the NICE diagnostics guidance on molecular testing strategies for Lynch syndrome in people with colorectal cancer already recommends such testing for all people with colorectal cancer when first diagnosed. For this reason, no further recommendations were made about testing for deficient DNA mismatch repair.”  Assuming this at least in part explains why MMR/MSI testing is not considered under QS4, this should be clearly stated, as MMR/MSI status clearly now has a role, specifically in guiding potential immunotherapy in metastatic dMMR CRC. This role of MMR/MSI status in guiding treatment in metastatic CRC is not addressed by NG151 though may be by other NICE guidance |
| 94 | Royal College of Pathologists | Statement 4 Page 15 – “Quality statement 4: Molecular testing to guide systemic anti-cancer treatment”. | Whilst routine Lynch screening is covered in statement 1, I am surprised that there is no link up to statement 4 whereby patients with metastatic CRC showing dMMR/MSI can be offered immunotherapy under current NICE guidance put in place at the start of the COVID-19 pandemic. For such patients this is likely to be their best option rather than EGFR/BRAF inhibition. Should this not be recognised either here or in statement 1 given that NICE guidance is in place to access this treatment? Statement 1 should recognise the importance of MMR/MSI status in oncological treatment beyond simply identifying Lynch. |
| 95 | Royal College of Pathologists | Page 15-17 - “Quality statement 4: Molecular testing to guide systemic anti-cancer treatment”. | There is no guidance on what testing is expected as a minimum. To “identify tumours with RAS and BRAF V600E mutations" is rather non-specific and could mean anything from KRAS codons 12/13 + BRAF V600E testing to, what I would consider standard of care, KRAS 12/13/59/61/117/146 and NRAS 12/13/59/61. Given that there is still significant variability in codons tested nationally, leading to different mutation rates between centres, isn’t this an ideal opportunity to set the minimum standard? It may also be useful to recognise that several centres still do not access testing via GLHs, despite an NHSE to push this, instead choosing to use rapid ‘point of care’ technologies based in histopathology. They will therefore not get these data via the GLHs and an alternative mechanism will be required. |
| 96 | Royal College of Physicians and Surgeons of Glasgow | Statement 4 | This statement is agreed. In the UK, oncologists routinely request testing for RAS and other mutations prior to instituting treatment. Standardising this testing will ensure uniformity across all units. An increased demand on pathology laboratories is is to be expected. |
| 97 | Bowel Cancer UK | Statement 5 | We’re pleased to see the inclusion on an explicit statement about colonoscopy surveillance, not just CT and CEA. Colonoscopy surveillance post-CRC included in NICE accredited BSG/ACPGBI/PHE 2019 consensus guidelines, and it not performance managed well. |
| 98 | BSGAR | Statement 5 | Standard 5: given the evolving and bespoke approach to managing colorectal cancer I would phase this as ‘at least three years’ with longer surveillance period determined locally according to individual risk factors for recurrent disease. |
| 99 | Leeds Teaching Hospitals NHS Trust | Statement 5 | No comment |
| 100 | MSD UK Limited | Statement 5 | MSD have no comment on this statement. |
| 101 | National Bowel Cancer Audit team – Royal College of Surgeons of England | Statement 5 | Adults who have had potentially curative surgical treatment for non-metastatic colorectal cancer have follow up for the first 3 years to detect local recurrence and distant metastases.  - NBOCA is carrying out methodological development work to measure this at provider level. |
| 102 | Papillon Patient Support Group | Statement 5 | Beyond the scope of papillon Patient’s Support Group (PPSG). |
| 103 | Royal College of Physicians and Surgeons of Glasgow | Statement 5 | Adults who had curative surgical resection for colorectal cancer should have at least three years’ follow up, with the relevant investigations carried out. This is done in the majority of hospitals. Provided that robust protocols are in place, follow up does not need to be carried out by a consultant surgeon. A nurse-led colorectal cancer clinic is most useful and efficient use of resources. |
| 104 | Association for Palliative Medicine of Great Britain and Ireland | Additional statements | No. There should be a standard related to specialist palliative care access such as “all patients with advanced colon cancer should have access to specialist palliative care support for symptom control, psychological support and future planning”.  Pain can be present at the early stage of non-metastatic rectal cancer. There should be some recommendation about pain management and referral to appropriate supportive or palliative care services for those with difficult symptoms. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Association for Palliative Medicine of Great Britain and Ireland
* Association of Coloproctology of Great Britain & Ireland
* Boston Scientific
* Bowel Cancer UK
* British Society of Gastrointestinal and Abdominal Radiology (BSGAR)
* Clatterbridge Cancer Centre
* GEC ESTRO GI brachytherapy working group – Royal Surrey Hospitals NHS Trust
* International Contact Radiotherapy Network (ICONE)
* Leeds Teaching Hospitals NHS Trust
* Medtronic Ltd
* MSD UK Limited
* National Bowl Cancer Audit team – Royal College of Surgeons of England
* Papillon Patient Support Group
* Pelican Cancer Foundation
* Pierre Fabre Ltd
* Roche Diagnostics UK
* Royal College of Nursing
* Royal College of Pathologists
* Royal College of Physicians and Surgeons of Glasgow
* Wales Cancer Network