Lung cancer: diagnosis and management (update)

Consultation on draft guideline – deadline for comments 5pm on 7 November 2018 email: LungCancerUpdate@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	The Royal College of Radiologists
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	

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NICE National Institute for Health and Care Excellence

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Name of commentator person completing form:	Emma Cooper			
Type				
Comment number	**Document** [guideline, evidence review A, B, C etc., methods or other (please specify which)]	**Page number** Or '**general**' for comments on whole document	**Line number** Or '**general**' for comments on whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Guideline	4	10-15	Reporting radiographers report chest X-rays, including those for suspected lung cancer. Evidence suggests that reporting radiographers are accurate at chest X-ray reporting [1,2] and that it is feasible for radiographers to provide immediate reports for patients' referred from primary care and to communicate reports directly to patients at the time of the chest X-ray [3] 1 - Woznitza et al *Acad Radiol* https://www.academicradiology.org/article/S1076-6332(18)30177-6/fulltext 2 - Woznitza et al *Radiography* https://www.radiographyonline.com/article/S1078-8174(18)30013-0/abstract 3 - Woznitza et al *Clin Radiol* https://www.clinicalradiologyonline.net/article/S0009-9260(17)30536-6/fulltext
2	Guideline	6	24-26	Ultrasound is rarely helpful here; we would suggest replacing 'Ultrasound' with 'MRI'.
3	Guideline	7	8-9	The statement 'Do not routinely use MRI to assess the stage of the primary tumour 8 (T-stage) in non-small-cell lung cancer (NSCLC). [2005]' may not be necessary as it is doubtful that any centre is doing this.
4	Guideline	9	3-6	We're unsure whether there's any benefit of suggesting an ultrasound of the neck if there are no nodes identified on the CT. The way it's written is for an US to be performed based upon the mediastinal nodes being > 20mm.
5	Guideline	15	15-17	The new recommendation is for neoadjuvant chemoradiation followed by surgery, based on a single trial from 2009 (Albain et al), is flawed and totally contrary to current practice and review of the wider literature for this area including meta-analyses. In particular there was no difference in the primary endpoint of overall survival between the two arms within the trial and clearly chemoRT is more cost effective than the addition of a third surgical treatment. Additional exploratory analysis and secondary endpoints (PFS) from a trial which is over 10 years old should not be used as the basis for limiting curative intent treatment options for this patient group.

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				The current draft appears to dismiss the option of surgery with adjuvant (or neoadjuvant chemotherapy) based on meta-analyses showing similar outcomes as for chemo-radiation and dismissing it on cost grounds. In fact stage IIIA(N2) patients able to undergo surgery are often a very different sub-group and certainly, based on national 'real world' NLCA outcomes reported at WCLC 2018, overall survival is better for those stage III patients undergoing surgery with chemotherapy. As a country who generally UNDERTREATS lung cancer (compared to the rest of Europe) we should not block access to a similarly effective bimodality treatment - both bimodality options (chemoRT and surgery with chemotherapy) should be considered on an individual basis through MDT discussion and joint clinic consultations. There is a very balanced BTS review of this literature by Evison et al (Thorax 2017) which concludes this. Furthermore, based on the 'real world' NLCA data presented at WCLC 2018, only 0.7% of stage III lung cancer patients diagnosed in England during 2016 received any version of 'triple' modality treatment at all (including radiotherapy delivered in the adjuvant setting), so this new recommendation for neoadjuvant chemoRT then surgery is totally unrealistic and unrepresentative. The draft is also flawed for stage III treatment recommendations because it does not take into account or discuss the newly published randomised trial of adjuvant durvalumab (Antonia NEJM) after chemoradiation for stage III patients.
6	Guideline	19	25-29	There is very strong evidence from the UK CONVERT trial that twice daily RT should be viewed as the gold standard treatment with 66/33 once daily also being acceptable. The trial data shows no difference in oesophagitis between these two arms. It is therefore wrong of the NICE committee, in their rationale, to use personal fears to dilute their recommendation. In my experience from treating patients within that trial and subsequently, twice daily RT is well tolerated as does not limit delivery of PCI any more than once daily RT.
7	Guideline	30	4-10	It's not routine to go straight to brain MRI in patients with known cancers suspected of cerebral metastases, so we're not sure about going straight to MRI in stage IIIA. It'll be small numbers, but we're not sure how interpretable the MRI would be if the CT would have been negative.
8	Guideline	General	General	The new guideline looks fairly sensible to me and should not significantly impact on workload.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF).**
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each**

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organisation.

- **Do not paste other tables into this table** – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms **do not include attachments** such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees. Further information regarding our privacy information can be found at our privacy notice on our website.