# National Institute for Health and Clinical Excellence

## 340 – Photodynamic therapy for early-stage oesophageal cancer

## Comments table

## IPAC date: 15 September 2006

| Consultee name and organisation | Section no. | Comment no. | Comments | Response<br>Please respond to all comments |
|---|---|---|---|---|
| Individual respondent – clinician | **2.1 – Indications** | 1 | Adenocarcinoma now more common, Scotland has highest incidence in world | The second sentence of section 2.1 was amended to read: 'The most common histological types are adenocarcinoma and squamous cell carcinoma.' |
| Oesophageal Patients Association | **2.1 – Indications** | 2 | Advice to patients with advanced oesophageal cancer must be from experience of the use of PDT for those in this condition. Emphasis must be on quality of life aspects for whatever time is left. The possibility of light sensitivity for some considerable time may not enhance Q of L. The age of the patient may well influence the palliative treatment given with hope in the minds of younger patients that new treatments may yet prove substantially better than expected. | Thank you for your comment. Section 2.1.2 states that 'PDT is one of a range of palliative treatment options'. |

| Consultee name and organisation | Section no. | Comment no. | Comments | Response<br>Please respond to all comments |
|---|---|---|---|---|
| Individual respondent – clinician | **2.2 – Outline of the procedure** | 3 | Only licenced treatment for oesophageal cancer palliation in UK is sodium porfimer (photofrin) All our patients are in-patients | Thank you for your comment. The Committee chose not to distinguish photosensitising products, supposing that responsible clinicians would use only licensed products. |
| Individual respondent – clinician | **2.3 – Efficacy** | 4 | PDT is an established therapy and should not be regarded as experimental | Thank you for your comment. The recommendation for 'normal arrangements' is based on efficacy in symptom improvement. |
| Individual respondent – clinician and Specialist Adviser | **2.3 – Efficacy** | 5 | I am concerned that in 2.3.2 the implication is that PDT has a higher response rate than laser. In the study concerned, measurements were made 4 weeks after treatment. In all the older literature on laser therapy, the duration of response was only 4 weeks but when added to radiotherapy, the response was 9 weeks fore xternal beam or 18 weeks for brachy (data from our group - search on SG Bown, senior author on all the papers). the way this is written is misleading, although technically correct,. | The first sentence of section 2.3.2 was amended to read: 'In a randomised controlled trial, the response rate was significantly higher after PDT (32%) than after laser ablation (20%) ($p < 0.05$) at 1-month follow-up.' |
| Individual respondent – clinician and Specialist Adviser | **2.4 - Safety** | 6 | Again, in 2.4.2 the fact that laser in that study had a perforation rate of 7% is misleading. In our hands (and in many published series) laser has a perf rate of 1%. This statement is therefore misleading because it ignores a large amount of other data which do not fit with the study quoted. | The Committee added a new section 2.5.1: 'It was noted that the available evidence only compared PDT with laser.' |