National Institute for Health and Care Excellence

IP1291 – Endoscopic CO2 laser cricopharyngeal myotomy for relief of oropharyngeal dysphagia
Consultation Comments table

IPAC date: Friday 15th January 2016

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 NHS professional	**1.1**	Special arrangements seen entirely appropriate for what is an evolving technique, with a limited evidence base. This will not deter adoption but will provide appropriate safeguards.	Thank you for your comments. Consultee agrees with the IP recommendations.
2	Consultee 1 NHS professional	**1.4**	This is wise in specifying three different patient groups, likely to show differing surgical challenges and outcome prospects (Neuromuscular disease, pouch and post R?T stricture)	Thank you for your comments.
3	Consultee 1 NHS professional	**3.3**	again glad to see this stressed.	Thank you for your comments.
4	Consultee 1 NHS professional	**6.1**	again glad to see this emphasis. Well phrased.	Thank you for your comments.

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5	Consultee 2 Royal College of Speech and Language Therapist (RCSLT)	**1.4**	The RCSLT also question the exclusion of Zenkers, pharyngeal diverticulae is mentioned in 1.4.	Thank you for your comment. Section 6.1 in the guidance states that *The Committee noted that the available studies included patients with oropharyngeal dysphagia with a number of different underlying causes. It noted that the procedure could have different safety profiles for patients with and without associated pharyngeal diverticula, and that it could have relatively poor efficacy in patients with dysphagia after radiotherapy.* Section 1.4 in the guidance states that '*Reports should separate outcomes for different groups of patients; in particular for patients with primary neuromuscular dysfunction alone, those with associated phargyngeal diverticula and those with dysphagia caused by radiotherapy'.*
6	Consultee 2 Royal College of Speech and Language Therapist (RCSLT)	**2 & 3**	Very little is talked about re: the identification of CPM dysfunction – radiological examination is very important – manometry for clinical purposes is in its infancy.	Thank you for your comments. Section 2 of the guidance is a brief summary of the indication and current treatments and section 3 is a summary of the procedure. Diagnosis of CPM is outside the scope of this guidance.

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7	Consultee 2 Royal College of Speech and Language Therapist (RCSLT)	**4.5**	The term 'modified barium swallow' and 'videofluorscopy' are synonymous – it reads as if they are different assessment tools. The FOSS is not a quality of life measure. A PROM should be included in a battery of tests.	Thank you for your comments. IPAC amended section 4.5 as follows: *The specialist advisers listed key efficacy outcomes as improved swallowing and nutritional state, reduced number of aspirations and chest infections, reduced length of stay in hospital, improved patient-reported quality of life measures (e.g. EUR-QoL), and changes in modified barium swallow study**(** videofluoroscopy) or manometry.*

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8	Consultee 2 Royal College of Speech and Language Therapist (RCSLT)	**lay description**	The first box needs re-wording as it reads as if CPM dysfunction was the only cause of dysphagia – it lacks accuracy.	Thank you for your comments. IPAC amended the lay description as follows: *Difficulty in swallowing (dysphagia) can occur in conditions such as multiple sclerosis, motor neurone disease and Parkinson's disease. It can also happen after a stroke, or after radiotherapy or surgery for treating cancer in the head or neck. It **may be** caused by spasm or scarring of the cricopharyngeal muscle, which runs around the top of the gullet.* *In this procedure, an endoscope (a thin, flexible tube with a camera on the end) and a carbon dioxide laser are inserted through the mouth. The laser is used to cut through the muscle, to relieve obstruction and improve swallowing.*
			It also doesn't account for CPM dysfunction in the absence of a neurological condition/structural change i.e. head and neck cancer. It is not uncommon for speech therapists to see patients, especially the elderly, where the aetiology is unknown.	Section 2.1 in the guidance states that CPM dysfunction *'may be caused by muscular or degenerative neurological disorders, or after head and neck surgery, or it may be idiopathic'*.