National Institute for Health and Clinical Excellence

Melanoma
Scope Consultation Table
4th January 2013 – 1st February 2013

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Association of Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC)	1	4.2	Specialist palliative care can be provided within the voluntary sector that are not NHS funded	Thank you for your comment. We are only providing guidance to the NHS and Personal Social Services
SH	Association of Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC)	2	4.3.1	We feel that this is very vague, and doesn't encompass the individual needs of the patient; including the role and input from the AHP members of the MDT	Thank you for your comment. Whilst these issues are very important to melanoma patients they are generic to many cancers and are therefore not prioritised for inclusion in this guideline.
SH	Association of Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC)	3	4.3.1	We feel this needs to be more specific to include the rehabilitation needs, and identifying the risks of side effects; including lymphoedema	Thank you for your comment. Whilst these issues are very important to melanoma patients they are generic to many cancers and are therefore not prioritised for inclusion in this guideline.
SH	Association of Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC)	4	4.4	We feel that although the main outcomes cover all aspects of the patient journey and care; including living with melanoma and treatment related side effects, QoL and psychological well being. There are currently no review questions or key clinical issues within the scope targeting or addressing these areas.	Thank you for your comment. Health Related Quality of Life is considered as an outcome in each review question and therefore we believe no specific question needs to be included.
SH	Association of Chartered	5	General	We feel there needs to be more specific review questions identifying the role of specialist physiotherapy and allied health professionals within the	Thank you for your comment. Whilst these issues are very important to melanoma patients, they are

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	Physiotherapists in Oncology and Palliative Care (ACPOPC)			multidisciplinary team in managing the symptoms and side effects of melanoma and its treatment; specifically including the role of rehabilitation, exercise and lymphoedema.	common to many cancer patients and are not a priority for this guideline
SH	Bristol-Myers Squibb	1	3.2	We suggest adding in this section 'other treatments (including immunotherapy) are available for those who do not respond to initial treatment'	Thank you for your comment, a reference to this has been added within section 3.2
SH	Bristol-Myers Squibb	2	4.3.1j	We suggest replacing 'chemotherapy' with 'anticancer agents/anticancer therapy'	Thank you for your comment. This has been replaced within the scope.
SH	Bristol-Myers Squibb	3	5.1.3 bullet 7	Typo – 'inguinal'	Thank you for your comment. This has been amended.
SH	Bristol-Myers Squibb	4	5.2 bullet 2	Publication expected June 2014, as per NICE website	Thank you for your comment. This has been amended.
SH	British Association of Dermatologists	1	4.1.1	The scoping document excludes mucosal (and ocular) melanoma, but includes penile and vulval melanoma. Whilst small numbers may be involved there may be vulval/penile melanomas which are mucosal and the scoping document wording should be changed to avoid confusion.	Thank you for your comment. Our view is that the biological behaviour and treatment of ocular and mucosal melanomas is so different from cutaneous melanoma that it is outside the scope of this guideline. This is consistent with the AJCC staging in that vulval and penile melanomas are stageable by the cutaneous AJCC staging system.
SH	British Association of Dermatologists	2	5	The scoping document mentions related NICE documents, including the "Skin Tumours including melanoma. NICE cancer service guidance (2010)" document – that document is the update for BCCs and does not mention melanomas. The relevant document is "IOG Skin cancers including melanomas 2006". The scoping document states that the final guidance will not replace or incorporate other existing NICE guidance, but inevitably it will replace the melanoma section of the 'IOG Skin cancers including melanomas 2006' guidance	Thank you for your comment– this has been amended. This current guideline will complement but not replace the melanoma section within the NICE Improving Outcomes Guidance for skin cancer services (2006).

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				by being more recent and more focussed on melanoma and this should be acknowledged.	
SH	British Association of Dermatologists	3	General	We propose melanoma *in situ* should be included.	Thank you for your comment. This has not been excluded from the scope and we have amended section 4.3.1 & 4.5 to clarify this.
SH	British Association of Dermatologists	4	General	Efforts should be made to ensure the guideline covers as much of the patient journey as possible and looks at the vision of integrated services available nationally.	Thank you for your comment – we agree.
SH	British Association of Dermatologists	5	General	Overall, we felt this to be a good and thorough scoping document with most of the pertinent issues covered.	Thank you.
SH	British Association of Skin Cancer Specialist Nurses	4	3.2	Should Ipilimumamub not also be mentioned	Thank you for your comment, a reference to this has been added within section 3.2.
SH	British Association of Skin Cancer Specialist Nurses	1	3.2c	SLNB is standard of care as criteria for eligibility of Trials	Thank you for your comment. We have added relevant text to the section to explain this.
SH	British Association of Skin Cancer Specialist Nurses	2	3.2e	Laser, and ECT could also be included	Thank you for your comment. We have used the phrase 'multiple modalities', which we believe covers these issues.
SH	British Association of Skin Cancer Specialist Nurses	3	3.2g	Changes in dose and delivery may be introduced for efficacy	Thank you for your comment – this will be considered for inclusion by the GDG when they begin development of the guideline.
SH	British Association of Skin Cancer Specialist Nurses	5	4.1.2	Should Melanomas such as wild type also be included	Thank you for your comment. These are included within section 4.1.1a.
SH	British Association of Skin Cancer Specialist Nurses	6	4.3.1	Possibility of other treatment such as Hepatic radio or chemo-emobolisation	Thank you for your comment. We are not aware of any evidence that chemo-emobolisation in used within any frequency within the UK for cutaneous melanoma and therefore is not a priority for this guideline.

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SH	British Association of Skin Cancer Specialist Nurses	7	4.5o	Mention laser also	Thank you for your comment. We have included laser as a potential intervention to this question.
SH	British Association of Skin Cancer Specialist Nurses	8	4.5	When is it indicative to use PET should also be included	Thank you for your comment. We have amended the question to include this (see section 4.5j).
SH	British Association of Skin Cancer Specialist Nurses	9	4.5g	What does is considered to be sub optimal in this group	Thank you for your comment. We have removed this question
SH	British Association of Skin Cancer Specialist Nurses	10	5.1.3	PDT and Ambulight should not be mentioned in this section as it is treatment for non melanomas	Thank you for your comment. These references have been deleted.
SH	British Association of Skin Cancer Specialist Nurses	11	Adding to the list	Guidelines for steroid use, Lymphoedema management. Survivorship issues, financial implications or web-links for support/finances/health promotion issues such Cancer research UK (SUNBED issues/ Macmillan/ Marie Curie/Maggie Centre etc)	Thank you for your comment. Whilst these issues are very important to melanoma patients, they are common to many cancer patients and are not a priority for this guideline.
SH	British Dermatological Nursing Group (BDNG)	1	4.5a	Follow up as per current guidance for thin MM's, discharge after a year not always in patients' best interest, would argue for assessment by CNS at point of discharge to ascertain if suitability. Also support frameworks need to be identified after discharge to support survivorship.	Thank you for your comment. This will be considered under section 4.3.1l and review question section 4.5v.
SH	British Dermatological Nursing Group (BDNG)	2	4.5b	Dependent on knowledge, experience, training and expertise of clinician	Thank you for your comment. This will be considered.
SH	British Dermatological Nursing Group (BDNG)	3	4.5d	Photography should be offered to all patients with dysplastic naevi to help self-surveillance	Thank you for your comment. The GDG will review the evidence and make appropriate recommendations.

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SH	British Dermatological Nursing Group (BDNG)	4	4.5g	Current therapy available does improve survivorship short term, for eligible patients, which will impact on quality of life	Thank you for your comment. We have removed this question.
SH	British Dermatological Nursing Group (BDNG)	5	4.5h	Dependent on ease of access to genetic testing and time lapse to results and start of treatment.	Thank you for your comment. These are the types of issues we hope to address.
SH	British Dermatological Nursing Group (BDNG)	6	4.5i	SNB should not be available for every MM patient, this is not cost-effective and inappropriate as current evidence does not support survival benefit. Current SNB guidance >1mm /MR/Ulc should be discussed and offered to interested patients. If SNB status is a pre-requisite for clinical trials currently and in the future then this is a potential important aspect to discuss with patient	Thank you for your comment. The clinical and cost effectiveness of SNLB will be reviewed in the guideline.
SH	British Dermatological Nursing Group (BDNG)	7	4.5j	WLE local or Specialist team, dependent on patient choice : SNB psycho-social support of CNS, HNA,	Thank you for your comment. This is covered by the NICE Improving Outcomes Guidance for skin cancer (2006).
SH	British Dermatological Nursing Group (BDNG)	8	4.5k	1-2 cm current guidance	Thank you for your comment. The GDG will review the evidence and make recommendations accordingly.
SH	British Dermatological Nursing Group (BDNG)	9	4.5l	Dependent on patient presentation, CT, and other investigations, site of disease	Thank you for your comment. The GDG will review the evidence and make recommendations accordingly.
SH	British Dermatological Nursing Group (BDNG)	10	4.5m	Dependent on patient situation and choice of proposed treatments	Thank you for your comment. This is covered by the improving outcomes guidance for skin cancer.

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SH	British Dermatological Nursing Group (BDNG)	11	4.5n	No convincing evidence	Thank you for your comment. The GDG will review the evidence and make recommendations accordingly.
SH	British Dermatological Nursing Group (BDNG)	12	4.5o	All these treatments have value, ultimately this should be patient choice and depending on site etc	Thank you for your comment – the GGD will consider this in their discussions.
SH	British Dermatological Nursing Group (BDNG)	13	4.5t	MIN- Discharge following apt CNS, MM < 1mm 1-3 years depending on patient assessment. Follow up can be nurse led, should take place in secondary care. HNA prior to discharge from service supported by sound education etc	Thank you for your comment. The GDG will review the evidence and make recommendations accordingly.
SH	British Dermatological Nursing Group (BDNG)	14	4.5u	Secondary care CNS involvement important in these patients	Thank you for your comment – we agree.
SH	British Dermatological Nursing Group (BDNG)	15	4.5v	Symptoms- seizures, persistent headaches, personality change	Thank you for your comment. The question refers to asymptomatic patients.
SH	British Dermatological Nursing Group (BDNG)	16	4.5x	Contemporary concern for patients often now have levels done at GP surgery, supplementation not always consistent, review necessary, not sure if long-term research has been published yet	Thank you for your comment – the GDG will review the evidence and make recommendations accordingly.
SH	British Dermatological Nursing Group (BDNG)	17	4.5y	Supplementation vit D3 4.000iu 1/12 daily, then 2000iu- review 3/12	Thank you for your comment – the GDG will review the evidence and make recommendations accordingly.
SH	British Nuclear Medicine Society	1	3.2c	The term 'Imaging' in the sentence 'Imaging for staging purposes…' is too imprecise and needs to be made more specific. Presumably the guideline means to say	Thank you for your comment, this section has been amended to include specific examples.

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				that staging CT is not indicated in patients with stage 1 and 2 disease? However, sentinel node biopsy uses imaging (ie sentinel node lymphoscintigraphy)	
SH	British Nuclear Medicine Society	2	4.5i	Our comments are that when considering the availability of sentinel node biopsy (and therefore sentinel node lymphoscintigraphy) patients should have access to centres which have a sufficient case load (however that is defined). Will the guideline make specific recommendations regarding technique for sentinel node lymphoscintigraphy eg dynamic imaging, use of SPECT CT?	Thank you for your comment. This is not something we are currently planning to consider within the guideline. However, this will be discussed with the GDG.
SH	British Nuclear Medicine Society	3	4.5i	Sentinel node biopsy and very young children: Very young children (eg pre-teenage) who undergo sentinel node biopsy need special facilities/expertise and centres need to comply with the legislation and guidelines relevant to providing healthcare to this age group. I certainly think this should be discussed in the guidelines – but does it need a separate subgroup (as for head and neck SLNB?)	Thank you for your comment. The clinical and cost effectiveness of SNLB will be reviewed in the guideline. Children and young people are included as a population within this guideline
SH	British Society for Dermatopathology	1	3.2a	Requires qualification that melanomas are initially CLINICALLY diagnosed by dermatologists……. The final absolute diagnosis is by a histopathologist!!	Thank you for your comment. This has been amended to include the word 'clinically'.
SH	British Society for Dermatopathology	2	GENERAL	It is disappointing that Scope makes no reference to Stage 0 Melanoma (Tis) . This is unfortunate as there is considerable debate as to the most appropriate management and in particular surgical margins. There is evidence that the UK clinical guidelines are now outdated and that margins more than 5mm are required (especially for lentigo melanoma). The best treatment for LM is also hotly debated	Thank you for your comment. This has not been excluded from the scope and we have amended section 4.3.1 & 4.5 to clarify this.
SH	British Society for Dermatopathology	3	GENERAL	Patient care and management is totally dependent on an accurate histopathological diagnosis. Difficult diagnostic cases require more robust investigative input . There is significant evidence that cytogenetic testing (particularly	Thank you for your comment – we have included an additional topic see section 4.3.1c.

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				Abbott melanoma FISH probes) may have a major role in this area. This area requires updated NICE appraisal to assess whether it can be supported within the NHS. If so there are national funding implications as there are only limited regional cytogentic departments.It is wrong that the Scope deals primarily with clinical diagnostic areas as these in essence are only diagnostic impressions. It is the histopathological diagnosis that must be accurate.	
SH	British Society for Dermatopathology	4	4.5e	It is unclear whether this refers purely to BRAF or for example includes c-Kit	Thank you for your comment. We have not excluded any potentially relevant genetic mutation testing options. The GDG will review the evidence accordingly.
SH	Celgene Ltd	1	General	Celgene support the development of this guideline, and look forward to participating in further stakeholder engagement. In particular, we hope to contribute towards discussions around the future availability of new therapeutic options in this condition, which is still associated with significant unmet need.	Thank you for your comment. We look forward to your future comments.
SH	Celgene Ltd	2	3.2g & h	It may be appropriate and helpful to refer explicitly to NICE guidance on vemurafenib and ipilimumab, and their place in management within this section.	Thank you for your comment this is covered in section 5.
SH	Celgene Ltd	3	4.3.1 & 4.5o	An additional issue may be the role of adjuvant immunotherapy (eg; with interleukin or interferon) in stage III melanoma.	Thank you for your comment. This TA is not being included in the scope (see section 4.3.2) in the period before adjuvant trials mature.
SH	Celgene Ltd	4	4.4	We suggest that progression-free survival is added, as a valid outcome commonly used in clinical trials.	Thank you for your comment. We have included progression free survival in this list.
SH	Celgene Ltd	5	4.5s	The use of temozolomide in this setting is off-label. This regulatory point clearly needs to be acknowledged and discussed alongside (and independently of) its HTA	Thank you for your comment. This will be taken into consideration by the GDG.

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				status under TA guidance 316. Consequently, there is likely to be particular relevance of discussions around alternative therapeutic options in this setting. Specifically, the potential availability of future licensed agents should be highlighted.	
SH	Department of Health	1		I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you.
SH	Melanoma Focus	1	General	We note there appears to be quite extensive reference to vitamin D. Is there enough evidence to justify such emphasis in a national guidance document?	Thank you for your comment. The GDG will review the evidence and make recommendations accordingly.
SH	Melanoma Focus	2	General	Clinical research is not mentioned at all, but it has clearly contributed to a significant changes in patient management. It should therefore be included.	Thank you for your comment. The GDG will review the evidence and make research recommendations where required.
SH	Melanoma Focus	3	4.1.2	We note that ocular and mucosal melanoma are excluded from the Draft Scope, presumably because there are no guidelines on these forms of the disease. However work is well under way to produce ocular melanoma guidelines, led by Dr Paul Nathan. The document should therefore make reference to this patient group.	Thank you for your comment. Our view is that the biological and treatment of ocular and mucosal melanomas is so different that it is outside the scope of this guideline.
SH	Melanoma Focus	4	4.3.1	The following issues should be added: • Electrochemotherapy • Systemic therapy rather than chemotherapy, to include vemurafenib and ipilimumab • Adjuvant therapy – PEG Intron licensed in US,	Thank you for your comment. Electrochemotherapy is being covered by NICE thorough Interventional Procedure Guidance, and will be included in section 4.5p. We have been specific in the questions rather than using general terms.

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				AVAST-M data will be available, and meta-analyses of Interferon shows survival benefit.	We have added adjuvant immunotherapy to section 4.3.2 and will not be covered by the guideline in the period before adjuvant trials mature.
SH	Melanoma Focus	5	4.5	Temozolomide is not licensed. If non-licensed treatments are being considered, NICE may need to consider targeted therapy.	Thank you for your comment. Although this is off label usage, temozolomide is widely used for the treatment of brain metastases hence the reason for reviewing this in the guideline. New therapies, e.g. targeted therapies which are currently off label may be subject to NICE TA programme and are therefore not appropriate for inclusion in the guideline.
SH	Melanoma Focus	6	General	Frequentist analysis of surgical margins trials for melanoma shows either a small, or no, survival difference between narrow (1-2cm) and wide (3 cm or greater) margins. However, probabilistic Bayesian analysis suggests a more substantial survival difference that may well be clinically relevant. Account should be taken of this uncertainty when discussing surgical treatment of primary melanoma.	Thank you for your comment. The GDG will review the evidence and make recommendations accordingly.
SH	NCRI/RCP/ACP/JCCO	1	General	Overall, the experts of the NCRI/RCP/ACP/JCCO are content with the draft scope. Our only area of concern is that it currently includes an overly strong emphasis on the role of Vitamin D in melanoma.	Thank you for your comment – The role of vitamin D comprises of a very small part of the scope. The GDG has not yet reviewed the evidence or make any subsequent recommendations
SH	Novartis Pharmaceuticals UK Limited	1	4.4	We suggest that "Progression-free survival" should be included as a main outcome. This is a key endpoint for the Phase III clinical trials for new drugs for the	Thank you for your comment. We have included progression free survival in this list.

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				treatment of melanoma and differs from disease-free survival which is most frequently applied in the adjuvant setting.	
SH	Novartis Pharmaceuticals UK Limited	2	4.5e	We suggest that the use of companion diagnostics for treatments that target specific genetic mutations should be included as a specific review question	Thank you for your comment. We believe this will be covered within question section 4.5f.
SH	Novartis Pharmaceuticals UK Limited	3	4.5r and s	In addition to the questions on dacarbazine and temozolomide, we suggest that an additional review question on "What is the effectiveness of combination therapies?" should be included. The future direction of treatment suggests that combination treatments will become increasingly common.	Thank you for your comment. Whilst we acknowledge the issues around combination treatment options are important, inclusion of these in the guideline are limited by lack of evidence and the existing NICE TA recommendations.
SH	Roche Products Ltd.	1	3.2 (new sub-bullet)	Currently the use of immunotherapy in relapsing patients is not covered. Following the appraisal of ipilumumab (TA 268) in this setting it may be appropriate to add a statement to reflect this potential use. Could the following additional sub-bullet be added? 'Relapsing patients may be treated with immunotherapy (e.g. ipilumumab).	Thank you for your comment. We have added reference to this within section 3.2.
SH	Roche Products Ltd.	2	4.3.2c and d	The Scope refers to vemurafenib (TA269) and ipilimumab (TA268) appraisals by NICE as being on going. These appraisals have now been completed, so we believe these statements should be removed from this section.	Thank you for your comment. We have updated these sections.
SH	Roche Products Ltd.	3	4.5g	The Scope hopes to address the question '"Does genetic mutation targeted therapy improve outcomes in patients with melanoma?" This question will be difficult to address without looking at BRAF inhibitors. Zelboraf (vemurafenib) is the only approved BRAF inhibitor, and this is currently excluded from the Scope of this Guideline. We would welcome greater clarity on this question, such as the mutation targeted therapy that is being are considering. For example,	Thank you for your comment. We have removed this question

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				does this include other genetic mutation testing (e.g. unlicensed c-KIT inhibitors)?	
SH	Roche Products Ltd.	4	5.1.2 NICE guidance to be incorporated	We believe the now completed appraisals for vemurafenib (TA269) and ipilimumab (TA268) should be included in this section given their positive NICE endorsement.	Thank you for your comment. This has been amended.
SH	Royal College of Nursing	1	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is timely. The draft scope is comprehensive.	Thank you.
SH	Royal College of Nursing	2	4.5a	Should the specific information and support needs of patients and carers at the point of disease progression be included?	Thank you for your comment. This will be considered in section 4.3.1a and review question 4.5a.
SH	Royal College of Paediatrics and Child Health	1		Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft scope for Malignant melanoma. We have not received any comments on this consultation	Thank you.
SH	South West Public Health Observatory	1		I just would like to confirm that have no comment to make on the scope document	Thank you.
SH	Southampton University Hospital Trust	1	4.3.1i & j	I think the scope should include treatment for liver metastases, most, but not all of which are related to ocular melanoma metastases. The scope should include the place of localised isolated liver perfusion chemotherapy and targeted radioactive treatment with radioactive microparticles infused in the liver (delcath & sirtex). What is currently outlined & suggested might exclude this & an opertunity for careful evaluation of these new treatments in the context of advanced (non-ocular) melanoma would be lost.	Thank you for your comment. Cutaneous melanoma metastatic to the liver is rarely seen in isolation (in contrast to ocular melanoma) and therefore treatment of the liver metastases alone is not commonly considered. Ocular melanoma is not included in the scope. We agree and have amended the scope to include ablative techniques, including radioembolisation. Please see sections 4.3.1j and 4.5p.
SH	Teenagers and young adults with cancer (TYAC)	1	General	TYAC believes that all guidance with regards to malignant melanoma diagnosis and treatment should ensure that teenagers and young adults are included at every stage.	Thank you for your comment. This population is within the scope and will be covered by the guideline.

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				This includes early diagnosis and access to the very latest trials and treatment. Young people have the potential to be missed in trial recruitment because melanoma is rare in the age group. It is essential that all young people (16-24) are discussed in age appropriate MDT's and not just site specific MDT's.	The GDG will review the evidence and make research recommendations accordingly. This is already a requirement of the TYA peer review measures for England.
SH	The British Association of Skin Camouflage	1		We find no alterations necessary and accept the Scope as is.	Thank you.
SH	The Royal College of Radiologists	1.	3.1	The RCR questions whether the scope will attempt to identify reasons for UK survival variation?	Thank you for your comment. We do not feel that this is the aim of the guideline but it may be addressed within the needs assessment document which will accompany the final guideline.
SH	The Royal College of Radiologists	2.	3.2a	The RCR suggests that a breakdown of figures as to where, and by whom, (dermatologists, GPs, GPSI, secondary care, etc) melanomas are diagnosed would be helpful. We feel this is especially important with the present reconfiguration of dermatology services in the community.	Thank you for your comment. Accurate data are currently unavailable but this is being addressed by the NCIN. We will attempt to address this in the needs assessment document which will accompany the final guideline.
SH	The Royal College of Radiologists	3.	3.2f & 4.5q	The RCR suggests that if the scope is to look at surgery for oligometastatic disease, it should certainly also consider less invasive image guided ablative techniques. The available data are limited and not well controlled, but ablative techniques have often been used in conjunction with surgery and are on the whole less morbid and have already found their way into clinical practice in some centres.	Thank you for your comment. We agree and have amended the scope to include ablative techniques, including radioembolisation. Please see sections 4.3.1j and 4.5p.
SH	The Royal College	4.	4.1.1	The RCR suggests perhaps using the word 'genital' to	Thank you for your comment. We

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	of Radiologists			avoid confusion?	disagree; the words 'penile' and 'vulval' have been used to be consistent with AJCC categorisation.
SH	The Royal College of Radiologists	5.	4.3.1a	The RCR asks whether the role of the Cancer Specialist Nurse should be included? We also feel that the emphasis on the information required for informed shared decision-making should be specifically noted.	Thank you for your comment. The role of clinical nurse specialists is clearly defined in the NICE Improving Outcomes Guidance (2006) and the National peer review measures for skin cancer. The guideline will cross reference to the IOG. Thank you. we have amended section 4.3.1a to imply shared decision making will be considered.
SH	The Royal College of Radiologists	6.	4.3.1d	The RCR notes that the preferred staging method in high risk patients with CT vs PET-CT remains a subject of debate so should ideally be considered. If so, the scope will also need to acknowledge an emerging role for whole body Diffusion Weighted MRI.	Thank you for your comment. Diffusion weighted MRI is increasingly used for cancer staging and will be considered by the guideline group for inclusion in the topic on radiological staging.
SH	The Royal College of Radiologists	7.	4.3.1d	We note that ultrasound and FNA is a standard part of diagnostic work up in suspected lymph node disease so should be in the scope.	Thank you for your comment. This will be covered under the additional question added to section 4.5i
SH	The Royal College of Radiologists	8.	4.3.1d & 4.5i	The RCR notes that sentinel lymph node biopsy certainly requires close scrutiny whilst we wait for MSLT-1 to publish its 10-year results to ensure resources are efficiently channelled.	Thank you for your comment, we agree.
SH	The Royal College of Radiologists	9.	4.3.1d ii	The RCR suggests specifically the role of PET scanning in newly diagnosed and advanced melanoma should be considered here.	Thank you for your comment. This will be covered under the additional question added to section 4.5i
SH	The Royal College of Radiologists	10.	4.3.1j	The RCR suggests that this includes the use of second and third line chemotherapy regimens	Thank you for your comment. Whilst we acknowledge the issues around timing and order of systemic anti-cancer therapies, options for

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					inclusion in the guideline are limited by lack of evidence and the existing NICE TA recommendations.
SH	The Royal College of Radiologists	11.	4.5	The RCR suggests that review questions should include the role of PET scanning in Italy and advanced melanoma	Thank you for your comment. PET is now included in section 4.5i.
SH	The Royal College of Radiologists	12.	4.5	We suggest the current usage and effectiveness of second and third line non-targeted chemotherapy in advanced melanoma is included.	Thank you for your comment. Whilst we acknowledge the issues around timing and order of systemic anti-cancer therapies, options for inclusion in the guideline are limited by lack of evidence at this time and the existing NICE TA recommendations.
SH	The Royal College of Radiologists	13.	4.5t	The RCR suggests that NICE considers evidence for surveillance ultrasound of the primary site to lymph node basin based on past studies and awaited UK trial data – SUNMEL.	Thank you for your comment. This will be covered under section 4.5v
SH	The Royal College of Radiologists	14.	4.5t	We also suggest considering the role of whole body cross-sectional imaging surveillance in high risk patients (see point 7 for options). We understand there are no sound data but it is used in some centres to try to capture earlier relapse for salvage.	Thank you for your comment. This will be covered under section 4.5v
SH	The Royal College of Radiologists	15.	General	The RCR welcomes the intention to look at the role of radiotherapy in melanoma, and non-targeted systemic therapies, as part of this guideline.	Thank you.
SH	The Society and College of Radiographers	1		The scope looks very appropriate and radiotherapy is highlighted for evaluation at various stages of the disease.	Thank you.
SH	The Society and College of Radiographers	2		The ScoR would be keen to be engaged in the development of the guideline.	Thank you we look forward to your future comments.

These organisations were approached but did not respond:

Alder Hey Children's NHS Foundation Trust

Allocate Software PLC

Amgen UK

Association for Family Therapy and Systemic Practice in the UK

Association of Anaesthetists of Great Britain and Ireland

Association of British Insurers

Barnsley Hospital NHS Foundation Trust

British Association of Plastic Reconstructive and Aesthetic Surgeons

British Medical Association

British Medical Journal

British National Formulary

British Nuclear Cardiology Society

British Psychological Society

British Society for Paediatric Dermatology

Calderstones Partnerships NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Cancer Research UK

Capsulation PPS

Care Quality Commission (CQC)

Chartered Society of Physiotherapy

Clarity Informatics Ltd

Covidien Ltd.

Croydon Health Services NHS Trust

Department of Health, Social Services and Public Safety - Northern Ireland

East and North Hertfordshire NHS Trust

East Midlands Cancer Network

Factor 50

GlaxoSmithKline

Glebe Road Surgery GP

Gloucestershire Hospitals NHS Foundation Trust

Health Quality Improvement Partnership

Healthcare Improvement Scotland

Hockley Medical Practice

Institute of Biomedical Science

King's College Hospital NHS Foundation Trust

Leeds Teaching Hospitals NHS Trust

Luton and Dunstable Hospital NHS Trust

Macmillan Cancer Support

Medicines and Healthcare products Regulatory Agency

Ministry of Defence

National Clinical Guideline Centre

National Collaborating Centre for Cancer

National Collaborating Centre for Mental Health

National Collaborating Centre for Women's and Children's Health

National Institute for Health Research Health Technology Assessment Programme

National Patient Safety Agency

National Treatment Agency for Substance Misuse

NHS Commissioning Board

NHS Connecting for Health

NHS County Durham and Darlington

NHS Direct

NHS Plus

NHS Sheffield

NICE technical lead

NICE TLOC GDG

North and East London Commissioning Support Unit

North Trent Cancer Network

Northern Ireland Cancer Network

Oxford Health NHS Foundation Trust

Parenteral and Enteral Nutrition Group

Peninsula Cancer Network

Primary Care Dermatology Society

Public Health Wales NHS Trust

Public Health Wales NHS Trust

Rarer Cancers Foundation

Royal College of General Practitioners

Royal College of General Practitioners in Wales

Royal College of Midwives

Royal College of Obstetricians and Gynaecologists

Royal College of Pathologists

Royal College of Psychiatrists

Royal College of Surgeons of England

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Royal Pharmaceutical Society

Royal Surrey County Hospital NHS Trust

Sanofi

Scottish Intercollegiate Guidelines Network

Sheffield Teaching Hospitals NHS Foundation Trust

Skcin - Karen Clifford Skin Cancer Charity

Skin research specialist interest group

Social Care Institute for Excellence

Society of Chiropodists & Podiatrists

South London & Maudsley NHS Trust

South Wales Cancer Network

South West Yorkshire Partnership NHS Foundation Trust

Southport and Ormskirk Hospital NHS Trust

St Georges Healthcare NHS Trust

St Mary's Hospital

Takeda UK Ltd

UK Melanoma Study Group

university hospital southampton

Walsall Local Involvement Network

Welsh Government

Welsh Kidney Patients Association

Welsh Scientific Advisory Committee

York Hospitals NHS Foundation Trust

Yorkshire Cancer Network