NICE National Institute for Health and Care Excellence

Consultation on draft guideline
Stakeholder comments table

03/09/15 to 15/10/15

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association for Palliative Medicine of Great Britain & Ireland (APM)	Short	General	General	We are disappointed that, apart from the paragraph about breathing difficulties, there is no mention of palliative care for patients with upper aerodigestive tract cancer. Such patients often have more symptoms that just breathlessness. We would suggest the guideline would be improved by a brief paragraph saying along the lines of "in advanced upper aerodigestive tract cancer patients may experience a range of physical and psychological symptoms. If these are proving complex to control, then the advice of a palliative care team should be sought." It is important that the guideline is clear that not all patients with upper aerodigestive tract cancer will need referral to specialist palliative care services. Referral should be needs-based rather than be diagnosis- or prognosis-based.	The GC focussed the question on breathing difficulties rather than other aspects of palliative care. This does not preclude patients from being referred to palliative care. We were not able to include every aspect of care due to time and resource limitations and the topic chosen was considered to be the most important. NICE is currently scoping an update to the 2004 NICE guideline on 'Improving Supportive and Palliative Care'.
Association for Palliative Medicine of Great Britain & Ireland (APM)	Short	8	6-7	We welcome the inclusion of palliative care in the guideline for the palliation of breathing difficulties.	Thank you.

Association of Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC)	Full	General	General	A fantastic acknowledgement of shoulder dysfunction despite preservation of the spinal accessory nerve as suggested by the literature and seen empirically. No further comments on this. We agree that further research is required into the most effective interventions for shoulder rehabilitation following neck dissection	Thank you for your comment.
Association of Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC)	Full	General	General	A general comment about breathlessness is that focus is generally around surgical management. There is no mention of pharmaceutical interventions (such as steroids) or non-pharmaceutical (such as relaxation, acupuncture) for breathlessness. There is literature around pharmaceutical interventions but we would suggest a call to research into non-pharmaceutical management of breathlessness.	Although not named explicitly as one of the interventions in the clinical question, evidence on pharmaceutical and non-pharmaceutical interventions would have been considered eligible for inclusion under "other systemic therapies (see page 415 of Appendix H) ". However, we did not identify any comparative studies for any of these interventions. Recommendations 1.4.10 and 1.4.11 cover people for whom surgical management is not appropriate. The Guideline Committee did not consider this is an area of priority for a research recommendation because they did not believe that it would be feasible to recruit the sample size needed to resolve the question
Association of Chartered Physiotherapists in Respiratory Care	Full	93	3	From research that has been carried out we would recommend that all patient who have an form of selective neck dissection should be seen by physiotherapy for assessment of reduction in function and ongoing treatment if necessary *B. Scott et al. / Physiotherapy 93 (2007) 102–109*	Shoulder rehabilitation following neck dissection is covered in chapter 7. We did not investigate the use of rehabilitation in asymptomatic patients and therefore are not able to make recommendations in this area.
Association of Chartered	Full	235	25	Physiotherapy intervention should be a	We have recommended mouth

Physiotherapists in Respiratory Care				considered due to what is actually causing the Trismus. Currently Anitree see all Trismus patients for either stretches, TMJ mobs, or spatula or therabite interventions and prescribe pre-treatment mouth opening exercises when able. Scott et al Oral Oncology (2008) 44, 430– 438	opening exercises but have left it to clinical judgment as to how these are given and by whom.
Association of Chartered Physiotherapists in Respiratory Care	Full	270	10	*B. Scott et al. / Physiotherapy 93 (2007) 102–109* showed that Cervical spine and shoulder dysfunction is evident in the post-operative selective neck dissection patient. The shoulder domain of the UW-QoL questionnaire can assist physiotherapists in the screening of dysfunction, therefore allowing the opportunity of further assessments and possible treatment.	Thank you for this information. We recognise the importance of assessing shoulder function following neck dissection and our recommendations do not preclude the use of a variety of assessment tools. However, because the review question is to address which are the most effective interventions for shoulder rehabilitation following neck dissection, the review question does not include addressing which are the best assessment tools.
British Dental Association	Short	10-11		The BDA is concerned that there is no mention of dental rehabilitation, which is integral to optimising rehabilitation and function.	The pre- and post-treatment assessment and optimisation of oral health was not included in the scope of this guideline. A restorative dentist is a core member of the multidisciplinary team and the Guideline Committee agreed that this practice was already well established. Other topics were therefore considered a higher priority for investigation. We have added text to the background section for the management of osteoradionecrosis to emphasise the importance of restorative dentistry.
British Dietetic Association – Oncology Sub-group	Full	General	General	Supports the need for more high quality research in nutrition support for this patient group as majority of the evidence presented is moderate quality.	Thank you for your comment.

British Dietetic Association – Oncology Sub-group	Full	229	5-6	Could we incorporate a line here that the role of the dietitian is well established in the multidisciplinary team (MDT) as per existing NICE guidance (Improving Outcomes in Head and neck Cancer, NICE 2004).	We have added text highlighting the importance of the dietitian to the background section.
British Dietetic Association – Oncology Sub-group	Full	229	7	Could 'used' be changed to 'considered'.	We have made this change.
British Dietetic Association – Oncology Sub-group	Full	229	37	Typo: Change 'that' to 'than'.	We have made this change.
British Dietetic Association – Oncology Sub-group	Full	230	37	There is no reference for the one observational study mentioned. Does 'compared with no radiotherapy' mean patients undergoing surgery alone? A reference would be helpful.	We have made a change to make this clearer
British Dietetic Association – Oncology Sub-group	Full	231	41	Could wording be changed from 'mouth floor tumour' to 'floor of mouth tumour'.	We have made this change.
British Dietetic Association – Oncology Sub-group	Full	232	30	Recommendations: Could we re-word 1st line to read, 'Assessment of need for enteral nutrition at diagnosis by a dietitian in an MDT setting. This should include consideration of prophylactic tube placement…'	This question did not look at who should do the assessment and therefore we are unable to make this change to the recommendation.
British Dietetic Association – Oncology Sub-group	Full	233	1	In the research recommendation, could another outcome of interest be quality of life? Should further research also include timing of commencing enteral nutrition as well as comparing enteral nutrition with oral nutrition. Need evidence for effectiveness of early prophylactic feeding compared to commencement of feeding during treatment.	This is not an exhaustive list and therefore this does not preclude quality of life being included. The focus of this question was which patients should receive enteral nutrition and not the timing. Therefore timing could not be included in the research recommendation.
British Dietetic Association – Oncology Sub-group	Full	233	30	In section on trade-off between clinical benefits and harms, could we add 'improved treatment tolerance' after	We have made this change.

				'better quality of life clinical outcomes'?	
British Dietetic Association – Oncology Sub-group	Full	233	30	In section on trade-off between net health benefits and resource use, could we add in that an outcome of dietetic assessment at diagnosis and decision to enteral feed would result in the cost incurred from that procedure (i.e. placement of the nasogastric/ gastrostomy tube and associated costs).	It is true that there would be costs associated with enteral feeding. However, it is not clear whether the recommendation to assess the nutrition needs of patients would lead to an increase or decrease in enteral feeding. Indeed, one of the benefits of the recommendation was thought to be the avoidance of feeding tube placement in patients that do not require enteral feeding. The trade-off section has been updated to make it clear that the GC did consider the costs of enteral feeding but were unsure whether there would be a net increase or decrease in its use.
British Dietetic Association – Oncology Sub-group	Full	269	2	There appears to be an assumption in this section that speech and language therapy (SLT) interventions directly influence nutrition outcomes in isolation without the consideration of dietetic interventions. It is important that any influence on nutrition outcomes acknowledge the influence of dietetic interventions. Two options for making this clear would be to either: 1. Ensure 'dietetic interventions' is added to the research question for impact on nutrition outcomes or, 2. There is a clear statement in the background to the research question that dietetic interventions need to be included and evaluated to measure nutrition outcomes. This will give clarity that the research question in a research study would require joint	This question focussed specifically on speech and language therapy interventions. Whilst we do not dispute the importance of dietetic interventions it is not possible to include them here.

				collaboration between SLT and dietetics.	
British Society for Oral and Maxillofacial Pathology	Full	148	16	There is a recent study that has just been published that could be considered in this section: Mirghani H, Casiraghi O, Amen F, He M, Ma XJ, Saulnier P, Lacroix L, Drusch F, Ben Lakdhar A, Saint Guily JL, Badoual C, Scoazec JY, Vielh P. Diagnosis of HPV-driven head and neck cancer with a single test in routine clinical practice. Mod Pathol. 2015 Sep 25. doi: 10.1038/modpathol.2015.113. [Epub ahead of print]. Whilst the 'analytical reference test' (qRTPCR for E6/E7 HPV on fresh frozen tissue) has been considered as the standard against which tests on formalin-fixed paraffin-embedded clinical samples should be measured, it has some disadvantages that should be acknowledged. The 'analytical reference test' identifies the majority of high-risk HPV infections (typically probes directed at HPV-16, -18 and -33), but may miss-classify samples that contain other high risk HPV genotypes (producing false negatives). The 'analytical reference test' is a manual test that is subject to inherent methodological errors and potential assay failure. It could be argued that the ability of the clinical tests to stratify patients into favourable and unfavourable prognostic groups is the most clinically relevant measure and as such any research in this area should address the prognostic value of such tests. It is possible that when	This research was published after our cut-off date for inclusion in the evidence review, therefore we are unable to consider it. This study will be forwarded to NICE Surveillance Programme to be included in the next guideline review. We acknowledge that this question did not take into consideration clinical outcomes. This is because we were not looking at the use of tests to provide prognostic information. The question investigated was to find the most effective test to identify an HPV positive tumour in people with cancer of the upper aerodigestive tract. Therefore a laboratory 'analytical standard' was the more appropriate comparator. Probes directed at HPV types 16, 18 and 33 will cover greater than 98% of genotypes associated with oropharyngeal squamous cell carcinoma. False negatives arising from other HPV genotypes are likely to be negligible. Our research recommendation allows for evaluation of a test against clinical outcomes.

				clinical trials recruiting patients with known HPV status report, that these clinical tests will evolve into 'predictive' tests used for directing treatment. In this context, it will be important to determine which laboratory tests are fit for this purpose. We agree that currently 'de-escalation' of treatment for patients with HPV positive oro-pharyngeal squamous cell carcinoma should not be recommended outside a clinical trial.	Thank you for your comment.
British Society of Dental Hygiene and Therapy (BSDHT)	Short	3	General	Patient support should include continuing with their dental visits. Many HNC are first spotted in these familiar surroundings, by familiar people and they have the ability to help keep the patient comfortable throughout treatment and after. The pastoral care element and continuity of this is very important.	The need to have regular dental visits is covered by recommendation 1.1.1 in the short version – the information and support is tailored to the persons needs.
British Society of Dental Hygiene and Therapy (BSDHT)	Short	10	15	Has there been any research into the level of xerostomia (dry mouth) and how it impacts nutrition? Most HNC patients have greatly reduced saliva flow post therapy and need advice and monitoring in order to help maintain swallow from Dental Health Professionals. It also impacts on the level of decay rates post therapy which again makes eating very difficult.	We did not find any evidence on xerostomia as a predictive factor for nutritional status and therefore have not included it in our recommendations.
Cancer laryngectomee trust	Full	268	6-7	We feel that voice therapy is a critical part of continuing life after having a total laryngectomy, the current guidance seems apply to those who have had a voice change in general and states speech therapy should be considered. We would consider the offer of speech	The use of the term consider in the recommendation reflects the strength of the evidence appraised. The recommendation on voice therapy relates to voice change following radiotherapy and larynx

				therapy to be essential rather than a consideration after laryngectomy. A separate statement for laryngectomy voice therapy may be appropriate. Common sense of clinicians would hopefully see that this happens but a stronger statement in this guidance would support the provision of services under scrutiny by commissioners. A survey of our members supports the pivotal role speech and language therapists play in the recovery after laryngectomy, we can supply a manuscript of survey results or data if required. In addition we recognise that efficient provision of services can be enhanced by creation of high volume specialist units and digital healthcare is expanding in other conditions. Research into telerehabilitation/remote digital services for voice therapy may be rewarding area of research.	preserving surgery. It is recognised that surgical voice restoration is an established standard of care in patients post-laryngectomy. Telerehabilitation and remote digital services for voice therapy were not included as interventions in this clinical question. Therefore we have not looked at the evidence base and are unable to make research recommendations in this area.
Department of Health	General	General		Thank you for the opportunity to comment on the draft for the above clinical guideline. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
Hywel dda university health board	Short	4	19	We offer MRI and CT scans to locate the primary prior to offering the PET scan	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial radiological investigation.
Hywel dda university health board	Short	5	11	We offer chest x ray to early stage carcinoma	Based on the available evidence and health economic analysis the GC agreed that early stage carcinoma should not be

					systemically staged.
Hywel dda university health board	Short	5	19	PET in Wales is funded and recommended for two reasons in CUADT i.e. recurrence diagnosis and occult primary	This will be a matter for commissioners when implementing the guideline
National Association of Laryngectomee Clubs	Short	3	17-18	We welcome the recommendation for patients to receive details of peer support services, as we did when a similar recommendation was made in the report from the Independent Cancer Taskforce in July. Successive patient experience surveys show little change in the percentage of patients receiving such information, with 1 in 6 patients missing out and in the worst-performing trusts this increases to 4 in 10. Additionally, what these statistics do not reveal is the quality of the information, for example the inclusion of both local and national groups.	Thank you for your comment. We hope this guideline helps improve this provision.
National Association of Laryngectomee Clubs	Short	5 6	23-26 1-6	It would be a very welcome development if all patients diagnosed with early stage cancer of the larynx have the choice of transoral laser microsurgery or radiotherapy. Whilst having successful treatment may be the most important consideration, research evidence does not appear to favour either treatment. A patient making an informed choice may take into account the potential late-effects of radiotherapy and hence the option of TLM will be important. It will not be an easy task to provide that choice nationwide. Recent head and neck audit reports have shown an increase in the proportion of patients receiving TLM. However the variations remain wide, with in some networks, persistently low	We hope that our recommendations will reduce variation in practice and increase the number of patients receiving TLM for early laryngeal cancer.

				percentages of patients treated by surgery.	
National Association of Laryngectomee Clubs	Short	15 16	17-29 1-2	NALC is pleased to see the recommendation for research into follow-up of people who are disease-free after treatment for UATC. Hopefully this area will be looked at in the widest terms. A very significant proportion has functional problems after treatment and these are subject to change even after many years have elapsed.	Thank you
National Cancer Research Institute / Royal College of Physicians / ACP	Short	5	9	Has the effect on TNM coding been considered? Will M0 status therefore be assumed or just not recorded? How will this sit with databases? Will there be any different recommendation if patient has had previous malignancy irrespective of site? We are seeing more and more patients on their second & third malignancies and the evidenced reviewed for this recommendation will predate these changes.	The GC did not consider there was likely to be a significant effect on TNM coding as a result of our recommendation not to offer systemic staging T1N0 or T2N0 cancer of UAT. They considered that implementation of their recommendations was likely to improve the consistency of staging data for the vast majority of patients with UAT. M0 status will therefore be assumed and recorded as such. We have not made any recommendations on patients with a previous malignancy.
National Cancer Research Institute / Royal College of Physicians / ACP	Short	5	19	*This is considered to be a very sensible recommendation*	Thank you
National Cancer Research Institute / Royal College of Physicians / ACP	Short	5	25	This would potentially include disease at the anterior commissure of the larynx and so we wonder whether a rider should be added to ensure this is considered specifically and the specific hazards when the disease is extending to the anterior commissure? Also what is the recommendation re repeat laser procedures and functional outcomes?	The evidence related to T1a disease did not enable the GC to make recommendations for the anterior commissure. We have not made any recommendations about repeat laser procedures.

				My concern would be that for the minority, where there is repeated recurrence, albeit of localised disease, repeated laser resection followed by RT gives poorer voice outcomes	
National Cancer Research Institute / Royal College of Physicians / ACP	Short	7	10	We wish to ask why organ preservation been suggested for those patients with retained function at diagnosis? Especially as in 1.4.4 it is recommended in locally advanced hypopharynx? Also there is an issue about accuracy of determining T4 status i.e. often overcall thyroid cartilage invasion at initial staging investigation and then downstaged pathologically post laryngectomy. Is there a need for an imaging trial? Is there a role for USS?	1.4.3. does not recommend organ preservation for people with T4a squamous cell carcinoma of the larynx. This is based on evidence, that surgery in this patient group improves survival outcomes. However there was no evidence of an equivalent survival benefit from surgery in hypopharynx. We have not looked at local staging for either laryngeal or hypopharangeal cancer and are therefore not able to make any recommendations on this issue.
National Cancer Research Institute / Royal College of Physicians / ACP	Short	8	22	We are very pleased that this important issue has ben highlighted and agree with this recommendation.	Thank you
National Cancer Research Institute / Royal College of Physicians / ACP	Short	11	12	Given the evidence from the PETNECK Trial, presented at ASCO this year, we are very concerned that this has not been considered in this section. We wish to suggest that all patients treated with primary chemoradiotherapy for N2-N3 disease should be seen and have FDG-PET CT carried out between 10-12 weeks after completion of treatment. WE will be very pleased to provide further information if this would be helpful. Very specifically, we are concerned that funders will refuse to provide PET CT for this patient group if it is not part of the NICE guideline	This abstract was published after our evidence cut-off date (see methodology section in the full guideline) and therefore has not been included in the guideline. This study will be forwarded to NICE Surveillance Programme to be included in the next guideline review.
NHS England	General	General		Thank you for the opportunity to comment on the above Clinical Guideline. I wish to	Thank you for your comment.

				confirm that NHS England has no substantive comments to make regarding this consultation.	
NIHR Clinical Research Network (Cancer)	Full	312	Research rec 1	The guidelines call for a prospective RCT into the value of HBO in ORN. There is an existing NIHR portfolio trial which appears to be have been overlooked by the report. The DAHANC21 trial is a protocol which has a striking similarity to what is recommended by the draft guidance. It is an international effort led by the prestigious Danish DAHANCA group, and for which UK recruitment has been commenced, has been supported by CRUK and is led from a CTU in the UK: http://www.cancerresearchuk.org/science/research/who-and-what-we-fund/browse-by-location/liverpool/university-of-liverpool/Grants/richard-shaw-12123-cruk-11-042-dahanca-21-hyperbaric-oxygen http://public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=13565 https://www.lctu.org.uk/LCTU_NET/frontend/core/Features/trialinfo.aspx?Data=W1tWSEpwWVd4SGNtOTFjQT09XV1bTXc9PV1bW1ZISnBZV3hKUkE9PV1dW056az1dW1tiRzlqWVd4bF1dW01RPT1d Bearing in mind the meagre NHS support for this exisiting trial (With >70 patients recruited, but less than a handful so far from the UK), perhaps the recommendations would emphasise the role of the NHS to support this research?	Thank you for highlighting this ongoing research. As a result we have removed our research recommendation about HBO. Unfortunately we are not able to recommend recruitment to specific trials but have added a reference to the study in the Linking Evidence to Recommendations section. This study will be forwarded to NICE Surveillance Programme to be included in the next guideline review.

				Would it be reasonable for the NICE commissioners to ask for someone to look at the NIHR portfolio at least once when writing a 312 page report?	
NIHR Clinical Research Network (Cancer)	Full	312	Research rec 1	"Whilst some clinicians are currently investigating the use of hyperbaric oxygen in the prophylaxis of ORN no well designed trial has yet been undertaken to consider its use in established cases. " This is factually some way off: "Some clinicians" are the NCRI H&N CSG! – the HOPON trial has randomised >135 patients - so this is already the largest RCT in the use of HBO in late radiation toxicity for any anatomical site every conducted, worldwide. Bearing in mind the efforts made on HOPON & DAHANCA21, the recommendations should highlight these trials and recommend recruitment to both as the most useful intervention	This text has now been removed following deletion of the research recommendation. Unfortunately we are not able to recommend recruitment to specific trials but have added a reference to the DAHANC21 study in the Linking Evidence to Recommendations section. These studies will be forwarded to NICE Surveillance Programme to be included in the next guideline review.
NIHR Clinical Research Network (Cancer)	Full	General	General	It is surprising that NICE would not support registering all free flap reconstructions on the UKNFR, bearing in mind there is a well known volume/ quality relationship... and the level of complexity / high cost of these interventions for H&NSCC	The guideline does not contain any recommendations on free flap reconstructions.
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	19 Algorithm	4	We are concerned to note no mention of Restorative Dentistry assessment / dental stabilisation following confirmation of diagnosis and staging of a tumour or post treatment oral care. We would regard this as an essential element of patient assessment at this time, of equal	The pre- and post-treatment assessment and optimisation of oral health was not included in the scope of this guideline. A restorative dentist is a core member of the multi disciplinary team and the Guideline Committee agreed that this practice was already well established. Other

				importance to dietary and nutritional assessment. It should be undertaken by an appropriately trained clinician, namely a consultant in Restorative Dentistry. It is important that it is undertaken promptly at the time of diagnosis in order that any dental pathology including the need for dental extractions is managed in a timely fashion to avoid any delays in progressing formal cancer treatment and to minimise the impact of dental pathology during treatment or the increased risk of it on recovery and rehabilitation post-treatment. Longer term post-treatment follow up is also recommended.	topics were therefore considered a higher priority for investigation. We have added text to the background section for the management of osteoradionecrosis to emphasise the importance of restorative dentistry. The algorithm is not a pathway of care but a pictorial representation of the recommendations in this guideline. Therefore we are unable to include Restorative Dentistry in the algorithm where you suggest.
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	20	1	This section relates a number of issues regarding patient information and support and mentions matters such as oral health and functional impairment (line 23) speaking and swallowing (line 41) as well as salivary issues (P 21 line 23) and dental health and chewing issues (lines 24/5). The fact that nowhere else in the document is dental support and restorative dentistry input mentioned gives our association cause for significant concern.	The pre- and post-treatment assessment and optimisation of oral health was not included in the scope of this guideline. A restorative dentist is a core member of the multi disciplinary team and the Guideline Committee agreed that this practice was already well established. Other topics were therefore considered a higher priority for investigation. We have added text to the background section for the management of osteoradionecrosis to emphasise the importance of restorative dentistry.
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	229	1	We feel that there is scope for potential inclusion of a number of factors in oral rehabilitation which appear not to have been considered. A well maintained and functional dentition or prosthetic replacement for missing or lost teeth will aid nutrition, phonation and also quality of life. Methods of rehabilitation by way of	Oral rehabilitation was not included as an intervention in this question. Therefore we are unable to make recommendations in this area.

				dental implants and consideration of the benefits or risks of placement at primary surgery or in irradiated bone should be considered.	
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	233	Research recommendations	We would strongly recommend that Dental Health outcomes be considered.	Thank you for this suggestion, however we do not think dental health outcomes are relevant to this particular research question.
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	233	30	The increased risk of rapid widespread caries development with oral nutritional support must be considered versus the reduced risk when exclusively tube fed.	This was not a factor that was considered relevant for this question as the GC believed that the other factors looked at were more important than the risk of widespread decay. They also believed that a patient would prefer the risk of decay rather than the permanent loss of swallowing function associated with exclusive tube feeding.
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	235	25	Trismus / mouth opening is measured and managed by the Restorative Dentist as well as SALT. It could be argued that it is more pertinent to this specialty input as it has a profound impact in clinical and health economic terms on maintenance of dental health, delivery of dental care and oral rehabilitation.	We have recommended mouth opening exercises but have left it to clinical judgment as to how these are given and by whom.
RD-UK – Renamed in 2015 from Association of Consultants and Specialists in Restorative Dentistry	Full	289	1	This section relates to follow up of patients and management of osteoradionecrosis. It does not appear to consider prevention of development of ORN. A lack of regular dental follow up and maintenance is likely to increase the risk of ORN development. Accordingly we would suggest that consideration be given to the effectiveness of dental follow up in addition to the other aspects identified, as	The recommendations made were about the management of ORN. This is because the topic in the scope was about the management of side effects of treatment rather than their prevention.

				we would regard it as fundamental to the main thrust of this section, namely "Ensure people with cancer of the upper aerodigestive tract and their carers have tailored information about … late effects of treatment at the end of curative therapy"	
Royal College of General Practitioners	General	General		The term 'aerodigestive' is new terminology for most GPs and secondary care. It refers to the combined organs and tissues of the respiratory tract and the upper part of the digestive tract (including the lips, mouth, tongue, nose, throat, vocal cords, and part of the oesophagus and windpipe). The definition needs to be clearly stated at the start of the guideline.	*Thank you for your comment. The definition has been added in section 1.1.1 of the full guideline.* Thank you.
Royal College of General Practitioners	General	General		The algorithm on page 19 is not corrected. After a suspicious neck lump has an FNA and it is reported to the GP as suspicious or squamous cell cancer, the GP needs to order a MRI of neck and referral to ENT to visually check for the primary. The MRI needs to be before the ENT surgeon biopsies.	The algorithm is not a pathway of care but a pictorial representation of the recommendations in this guideline. The scope of this guideline starts after the patient has been referred from primary care with suspected CUADT, therefore we are not able to make the change you suggest of ordering an MRI before the ENT surgeon biopsy of the neck and for a referral to ENT In addition when a patient has an FNA they are under secondary care when the imaging is decided
Royal College of Nursing	General	General		This is to inform you that the Royal College of Nursing have no comments to submit to inform on the above guideline consultation at this time. Thank you for the opportunity to participate.	Thank you for your comment.
Royal College of Pathologists	Short	4	16	The majority of our cytology specimens	We appreciate that there is a

				are ultrasound guided, and inadequacy rates are very low. The cost of having a member of staff to review or assess adequacy at the time of procedure is too great for minimal benefit.	variation in practice hence the need for guidance. Our recommendation looks to improve the quality of the diagnostic service, reducing inadequacy rates and the need for re-sampling, and potential treatment delay. Based on the high sample inadequacy rates, the GC recommended the presence of an experienced cytopathologist or biomedical scientist to ensure the sample is adequate at the first attempt and to reduce the potential need to recall the patient. The GC anticipated that the following potential costs and savings will result from the recommendations: • costs of staff (e.g. the requirement for a cytologist/biomedical scientist at clinics) • savings from reduced re-testing • potential savings from earlier diagnosis and treatment of disease. Based on their clinical experience the GC agreed that the presence of a cytologist/biomedical scientist at clinics may already reflect current practice in some areas. Therefore the GC considered that any increased costs may be modest.
Royal College of Pathologists	Short	4	19	It is our practise to undertake imaging and upper aerodigestive pan-endoscopy with multiple biopsies & tonsillectomies. This with immunohistochemistry for presence or absence of HPV identifies most primary lesions.	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial investigation.
Royal College of Pathologists	Short	4	19	If definite squamous carcinoma on FNA, then a selective or radical neck depending	This recommendation focuses on the identification of the unknown

				on extent of neck disease.	primary. Our recommendations on treatment are in 1.6.5 to 1.6.7.
Royal College of Pathologists	Short	4	19	The upper aero-digestive biopsies and selective (usually) neck dissection may be done together if the FNA cytology is definite squamous carcinoma.	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial investigation. This recommendation focuses on the identification of the unknown primary. Our recommendations on treatment are in 1.6.5 to 1.6.7.
Royal College of Pathologists	Short	4	19	If at FNA it has been possible to make a cell block, then p16 & HPV status would be undertaken. This might influence surgical upper aero-digestive biopsy range, but not overall management.	Thank you for this information. Our recommendations on HPV testing are in 1.5.1 and 1.5.2.
Royal College of Pathologists	Short	4	19	PET imaging is sometimes undertaken for unknown primaries, but not routinely. It would occur after routine imaging, panendoscopy & upper aero-digestive biopsies including tonsillectomy.	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial radiological investigation.
Royal College of Pathologists	Short	4	23	Narrow band imaging endoscopy is not used by our radiologists.	After looking at the evidence base the GC were convinced that narrow band imaging endoscopy has a role to play in the investigation of unknown primary cancers.
Royal College of Pathologists	Short	4	11 + 13	Virtually all neck lumps are offered FNA, but especially those where the risk of malignant disease is increasing (age/smoking); sometimes cores composed of residual tissue in the FNA needle are sent, which may be valuable for making a cell block which allows immunohistochemistry – this is not the same as a formal fine needle core biopsy.	Thank you for supporting our recommendations.
Royal College of Pathologists	Short	5	1	If upper aero-digestive biopsies are negative, we would proceed to neck dissection, limited to single level if differential on cytology & radiology is a	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial radiological investigation. Following this if the

				branchial cyst.	primary site has not been identified the evidence base suggested that surgical assessment is performed. Our recommendations on treatment are in 1.6.5 to 1.6.7.
Royal College of Pathologists	Short	5	1	If upper aero-digestive biopsies are negative, we would proceed to selective neck dissection, levels depending on imaging if FNA cytology unequivocal metastatic squamous carcinoma.	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial radiological investigation. Following this if the primary site has not been identified the evidence base suggested that surgical assessment is performed. Our recommendations on treatment are in 1.6.5 to 1.6.7.
Royal College of Pathologists	Short	5	1	If after neck dissection and upper aero-digestive biopsies, the primary is still unknown, then assessment of HPV status of the metastatic disease would be undertaken – if +ve this helps narrow the field to oropharynx for the radiotherapy adjuvant treatment to the primary site.	Thank you for this information. Our recommendations on HPV testing are in 1.5.1 to 1.5.2. Our recommendations on radiotherapy planning are covered by 1.6.7.
Royal College of Pathologists	Short	5	6	CT imaging is undertaken as part of the search for the primary – this would usually occur after ultrasound and FNA.. MRI imaging is sometimes undertaken to help plan radiotherapy	After looking at the evidence base the GC were convinced that performing a FDG PET-CT was the most appropriate initial radiological investigation. Thank you for supporting our recommendation 1.2.8 on MRI imaging.
Royal College of Pathologists	Short	5	9	Systemic staging might be offered to T1 N0 or T2 N0 in a small proportion of patients – usually if the surgeon was concerned about clinical behaviour.	Based on the available evidence and health economic analysis the GC agreed that this patient group should not be systemically staged.
Royal College of Pathologists	Short	5	11 +13	Systemic staging, eg. CT head, neck, chest & upper abdomen would be undertaken for all T3, T4 and N+ squamous carcinomas	Thank you for supporting our recommendation
Royal College of Pathologists	Short	5	19 +21	Apart from post-treatment PET, it is our practice to undertake PET for locally advanced disease, especially if there is	The cost effectiveness analysis undertaken, showed that the use of PET-CT was only cost effective in

				level IV or V nodal disease. Quite a number of patients have hand tailored investigations/treatment, and we are planning to review our criteria for PET.	certain patient groups and this is what we have recommended.
Royal College of Pathologists	Short	6	9	Selective neck dissections for patients with c+rT1 No or T2 N0 oral squamous carcinoma depends on clinical behaviour of the primary tumour or histopathological characteristics, greater depth of invasion and other adverse features would receive/be offered a neck dissection.	On the basis of the clinical evidence and health economic analysis, the GC recommended sentinel lymph node biopsy instead of elective selective neck dissection in patients with early oral cavity cancer.
Royal College of Pathologists	Short	6	11	We never undertake sentinel lymph node biopsy in the c+rT1/2 N0 clinical situation; it would either be interval neck surveillance with ultrasound +/- FNA or a selective neck dissection.	On the basis of the available clinical evidence and health economic analysis, the GC recommended sentinel lymph node biopsy instead of elective selective neck dissection in patients with early oral cavity cancer.
Royal College of Pathologists	Short	8	22	We do not offer de-intensification of treatment in HPV +ve tumours, unless it was a trial criterion.	Thank you for your comment
Royal College of Pathologists	Short	8	15 + 19	P16 & HPV in-situ hybridisation are undertaken on all oropharyngeal squamous carcinomas, although the HPV technique is at times problematic.	Thank you for your comment
Royal College of Radiologists	Full Short	19 38 36 38 4	8,9 10-17	1) We note there is no mention of primary or neck nodal staging with imaging. Although it is appreciated that this may not be within the scope of the document, it is integral to the subsequent discussion and judgement on whether systemic staging is required. Accurate primary and nodal staging is required and ultrasound, CT and MRI should be considered. 2) We suggest there should be much greater emphasis on the use of ultrasound guided FNA and biopsy.	Primary or neck nodal staging with imaging was not prioritised for investigation in this guideline because the Guideline Committee did not feel there was widespread variation in practice in this area. The use of the term ‘consider adding ultrasound-guided FNA’

				The wording of “consider” is not sufficiently strong. The GC only evaluates the sensitivity and specificity of non-image-guided versus ultrasound guided FNA when discussing the relative merits. There are additional benefits of using ultrasound guidance including: the ability to avoid biopsy (of normal nodes), reduce complications such as haematoma (which may also complicate subsequent imaging appearances), to guide the use of FNA versus core biopsy (e.g. appearances suggestive of lymphoma) and to combine with nodal staging. *Sharma SD. Subspecialty radiologist increases FNA adequacy.Otolaryngol H&N Surg 2014* *A systematic review of ultrasound-guided FNA of lesions in the head and neck—focusing on operator, sample inadequacy and presence of on-spot cytology service BJR 2014. 87; 1044.* The model of the rapid access clinic for neck lump assessment should be more critically reviewed with recognition of the added value provided by a specialist ultrasound service. An audit (Evaluation of Enhanced Modernize Collaborative Management of Neck Lumps.	reflects the strength of the evidence base upon which the recommendation was made, in line with NICE methodology. The quality of evidence in this area was not strong enough to make this an ‘offer’ recommendation. The GC discussed a variety of issues before making this recommendation however, as documented in the Linking Evidence to Recommendations section, the decision on what to recommend was most influenced by the higher specificity and sensitivity of ultrasound-guided FNAC and core biopsy. The GC did not consider (given the potential resource implications) that its routine use was warranted. Sharma 2014 was identified during the evidence search but was not included in the evidence base because it was not relevant to the question being asked (please see the list of excluded studies and reason for exclusion on page 123 of Appendix H). We searched for evidence on the most effective model for delivering a rapid access clinic. Unfortunately, we did not find any evidence and as a result based our recommendations on the diagnostic utility data available. This audit was not identified by our

				Proceedings RSNA 2013- Dr K. Chow) shows approximately 30% of patients do not need to attend the rapid access clinic with the screening of alternative pathology. Ultrasound, which cost £51.91 per case (RA23Z) for screening of neck lump may be more cost effective. It is an established and effective model of referral in many centres and its inclusion is necessary to allow for commissioning of such services. This should be further evaluated and should be listed under the key research recommendations. **3)** We feel there is a probable overestimation of the number of 'one stop' neck lump clinics that have a cytologist present. Do the GC have evidence for the statement :'The presence of a cytologist/biomedical scientist at clinics may already reflect current practice in some areas so the GC noted that increased costs are likely to be modest.' ? This would have significant implications on pathology services.	literature searches. The conference abstract was not included because it does not provide sufficient information for critical appraisal and quality assessment**.** We have amended the Linking Evidence to Recommendations section to clarify that the statement about the presence of a cytologist/biomedical scientist at clinics may already reflect current practice in some areas was based on the GC's clinical experience.
Royal College of Radiologists	Full	19		It should be indicated that cancer is confirmed on cytology before PET is requested for an "unknown primary".. It is presumed that staging of the neck is not in the draft scope. Although it is indicated that the p19 algorithm is not a "pathway of care" it would be helpful to state explicitly that staging of the neck is a deliberate omission.	We do not think this needs to be specified because it is extremely unlikely that a FDG PET-CT would be undertaken before establishing a diagnosis of cancer. Primary or neck nodal staging with imaging was not prioritised for investigation in this guideline because the GC did not feel there was widespread variation in practice in this area. Unfortunately we are

					unable to put every omission of the pathway into the algorithm.
Royal College of Radiologists	Full	37	6	This should read “CT guided FNA”	The comparison in this study was CT versus histopathological diagnosis and not CT-guided FNA. Therefore the text is correct and we are unable to make this change.
Royal College of Radiologists	Full	40 41	25	The paucity of evidence does not seem to be adequate to recommend FDG-PET as a first investigation in an unknown primary. Since there is a recommendation to consider a subsequent CT/MRI for radiotherapy planning it seems more cost efficient for this to be done first. The unknown primary tumour is not unknown until we have a normal standard CT or MRI. There are frequent cases where MRI detects the primary tumour and PET is not required. The MR guides biopsy, doesn't use radiation and is much less expensive than PET-CT. There are implications for the adequate provision (skills and resources) of the limited PET-CT services? What is not clear in any of the evidence is whether the PET CT studies utilised high res CT with IV contrast, or the older generation of PET CT scanners with anatomical unenhanced CT scans. There is a move towards the new generation of scanners being diagnostic quality, and having IV contrast. Even the papers presented do not make this distinction, so a comparison between standard imaging and PET CT is not possible.	We disagree that the primary is not defined as unknown until a CT or MRI has been performed. Based on the evidence the GC recommended FDG PET-CT as the first investigation to identify the occult primary as the sensitivity and specificity data was demonstrably higher than other imaging. Although the GC had recommended FDG PET-CT to identify the occult primary they were aware that this imaging modality does not provide enough anatomical detail to assist with radiotherapy treatment planning. Based on their clinical experience they recommended the use of MRI and CT for this purpose. This took into consideration the relatively low diagnostic accuracy reported for these techniques in the context of identifying the unknown primary. There is uncertainty around the cost-effectiveness of the recommendation to consider PET-CT. While the upfront cost of PET-CT is undoubtedly much higher than more conventional imaging, such as CT or MRI, its superior diagnostic accuracy could lead to cost savings and potentially improved effectiveness. Most notably, the greater chance of detecting the unknown primary by using the most

					accurate test first should reduce the need for subsequent tests (whereas patients receiving CT or MRI first would be more likely to undergo multiple subsequent tests, including PET-CT). The earlier detection of primary tumours could lead to effectiveness benefits with appropriate treatment initiated sooner. We have changed this recommendation to 'consider' rather than 'offer'. There were 5 FDG PET-CT studies included in the evidence base for this question, all but one of which was published in the last five years. However the studies did not differentiate which type of PET scan was used and hence there is a lack of published evidence to make this differentiation in the recommendations.
Royal College of Radiologists	Full	44	39-40	We suggest it should be clarified whether the data presented from the National Head and Neck cancer Audit refers to patients who have undergone full systemic staging (and with which modality) as this will affect the detection rate. If it is ambiguous (as is implied in lines 29-32) then this casts doubt on the validity of these data. It is noted that there is also no reference to synchronous malignancy in these data (ie it is the % with M1 disease). This is important as these data are used as the basis for the economic model.	The GC were aware of the lack of complete information on the methods used to determine M stage. It was assumed that minor variations exist across centres and this was acknowledged as a potential limitation of the evidence. This limitation is noted in text of the full guideline. However, because the variations were thought to be minor their impact was considered to be negligible in the model. The percentage of M1 disease was discussed in both the clinical and health economic analyses.

Royal College of Radiologists	Full	45	27-44	It is stated that there is improved sensitivity of PET CT/PET versus conventional imaging for patients with NPC. However the conventional imaging arm differs for the NPC group (CXR/ultrasound/bone scan versus CT). Since the conventional imaging approach for NPC is likely to be less sensitive, the benefits of PET/PET CT may be exaggerated.	It is true that conventional imaging differed in the NPC and non-NPC arms. This difference was included in the economic model. It is also true that the evidence for patients with NPC showed the sensitivity of FDG PET-CT to be superior. The economic model has included the available evidence but we do not consider that this exaggerates the benefits of FDG PET-CT.
Royal College of Radiologists	Full	45	13	The economic model does not consider the other benefits of systemic staging such as detection of synchronous tumours or other significant non neoplastic disease which frequently influence clinical management.	The economic model did not consider the detection of synchronous tumours or other abnormalities as the evidence base was insufficient to adequately capture their benefits. The GC was aware of this limitation and took it into account when agreeing their recommendations.
Royal College of Radiologists	Full	46	18	The imaging costs in the economic model fail to include the cost of the (often frequent and multiple) follow up imaging studies for indeterminate abnormalities.	It was not possible to fully capture indeterminate diagnosis using the available evidence base as the results were not reported to that level of detail. However, the issue was partially captured by the use of an additional parameter in the model that specified the proportion of distant disease sites that could be biopsied (and so obtaining a definitive diagnosis would not be possible). Due to the lack of evidence, the value of this parameter (90%) was based on an estimate by the guideline committee. In cases where the diagnosis was indeterminate, the guideline committee thought that the most likely course of action would be to continue with the planned treatment of curative intent and check on the potential site of distant

					disease in subsequent scans. Therefore, in the model, it was assumed that there was no benefit for these patients (as unnecessary treatment would not be avoided). The cost of subsequent scans was not incorporated as it was thought likely that these would be used following treatment anyway – in pre and/or post treatment scans. So these scans would not represent an additional cost in comparison to the other arms of the model where patients would also undergo such scans.
Royal College of Radiologists	Full	46	32	Biopsies of distant sites detected by systemic imaging are unlikely to be under ultrasound guidance but rather under CT guidance.	Thanks for your comment. There is no specific cost code for CT guided biopsies. Therefore, we have used what appears to be the most relevant cost code (which we think might include CT biopsies as well as ultrasound). The text in the guideline has been updated to reflect the uncertainty in this area and further sensitivity analyses were undertaken to investigate the impact of using alternative biopsy costs (including an estimate of £150 from the radiologist on the guideline committee).
Royal College of Radiologists	Full	51	15-25	The evidence for optimal strategy from the base case analysis is stated to be in the full economic report which is not made available. Since this is critical to the recommendations it would be helpful to have more information on the strength of the evidence.	The full economic report is available in appendix A. An executive summary of the economic analysis is also presented in the guideline. The analysis showed that conventional imaging (consisting of a chest CT with or without an abdominal CT for most patients and a chest radiography, abdominal ultrasonography, and bone scan in nasopharyngeal cancer patients) was cost-effective in the majority of

					patient populations with the exception of T1N0, T2N0, N3, T4 hypoharyngeal and T4 nasopharyngeal cancer. No imaging was found to be the optimal strategy in T1N0 and T2NO patient subgroups because of the low number of patients with systemic disease. The use of PET-CT was found to be cost-effective in patients with N3 disease at any subsite or T4 nasopharyngeal or T4 hypopharyngeal cancer. In these groups, the use of PET-CT was justified because of the higher risk of distant metastases.
Royal College of Radiologists	Full	52	7	Full staging is recommended in addition to neck for T1/2 larynx cancers given the high prevalence of second primaries. The additional radiation exposure will be justified under IR(ME)R with minimal additional cost to staging primary site.	The GC chose to recommend systemic staging only in patients considered at risk. Based on the best available evidence the risk of systemic disease in any N0 disease is not high enough to justify staging these patients. Specific analysis of the N0 subgroup of larynx patients would have involved very small patient numbers, thus introducing uncertainty (this is acknowledged as a limitation of the evidence).
Royal College of Radiologists	Full	54	1	We suggest NICE considers availability of PET for all NPC stages to identify occult metastatic disease, along with EBV titres. Shown to be a biomarker across stages for NPC (Xiao et al, Oral Oncology 2015). It has been shown to be more sensitive in detecting metastases (approx. 15% detection rate) and within a meta analysis studies were not restricted to early stage alone (Chang E J Rad 13). This applies to undifferentiated EBV associated disease only which represents a very small number of patients in the UK. To	The vast majority of patients with nasopharyngeal cancer will present with N+ disease and will be staged under the existing recommendations. The Chang et al (2013) systematic review in the European Journal of Radiology was included as evidence (it is in the reference list on p. 75). The Xiao paper (Positron emission tomography-computed tomography before treatment is highly prognostic of distant metastasis in nasopharyngeal carcinoma patients

				achieve outcomes comparable international outcomes	after intensity-modulated radiotherapy treatment: a prospective study with long-term follow-up.Xiao W, Xu A, Han F, Lin X, Lu L, Shen G, Huang S, Fan W, Deng X, Zhao C. Oral Oncol. 2015 Apr;51(4):363-9.) looked at pre-treatment PET-CT to predict long term outcome, and is not a staging study. Therefore it was not included as evidence. EBV was not included as an intervention in this question as the question was about staging rather than diagnostic, and therefore we cannot make recommendations on its use.
Royal College of Radiologists	Full	74	43	When performing cost evaluation for T1a larynx carcinoma consideration should be given to a 16 fraction schedule. NICE may wish to reevaluate cost using 16fractions as an acceptable regimen. (50Gy in 16 Fractions)	We have investigated the effect of using a 16 fraction schedule in a sensitivity analysis. However using this schedule did not make a difference to the conclusions of the economic analysis.
Royal College of Radiologists	Full	199	7	Carcinoma of the paranasal sinuses encompasses considerable pathological heterogeneity. We suggest a clear statement should be made regarding the need for management within specialist skull base MDTs with access to full range of modern surgical and non-surgical techniques. This includes access to neurosurgery. Although conclusions are reasonable for adenocarcinoma (surgery first or neo adjuvant (chemo)radiotherapy if inoperable) this may not apply to all pathology. For example sinonasal undifferentiated carcinomas at the small	This question focussed on the appropriate interventions to manage carcinoma of the paranasal sinuses and not service organisation. Therefore we are not able to make recommendations about service delivery. There was insufficient data in the evidence base to make specific recommendations about histological subtypes.

				cell end of the spectrum are more likely to respond to chemotherapy and chemoradiotherapy. In selected cases induction chemotherapy may be reasonable. The evidence is poor making it very difficult to make firm statements in the boxes/summary. It also may restrict treatment options for selected patients or lead to inappropriate surgical attempts. However if there is a preference to do this then it may have to be restricted to selected pathology rather than referring to the whole group as carcinomas of the paranasal sinuses. A literature review has also suggested superior outcomes with proton therapy. Emerging data from USA suggest favourable outcomes with altered fractionation proton therapy and chemotherapy regardless of surgical extent. However evidence in this area remains limited.	Proton therapy is not currently available in the UK and was therefore not included as an intervention in this question.
Royal College of Radiologists	Full	222	7	Results (including a meta analysis) remain mixed with respect to the role of adjuvant radiotherapy for mucosal melanoma. Therefore the benefit for adjuvant radiotherapy remains debated by some. As currently worded there is a suggestion that adjuvant radiotherapy is recommended in all cases post surgery. Although the details in the document clearly outline the limitations in quality of evidence the conclusion statements are firm and we feel may benefit from some	The limitations of the evidence are reflected by our use of the term 'consider' (instead of the term 'offer') in the recommendation

				qualification.	
Royal College of Radiologists	Short	5	9	It should be clarified whether CXR is indicated in cases of T1-2 N0 tumours? Does the subsequent p staging also indicate whether systemic staging is then required? The recommendation for not performing systemic screening for T1-2 NO disease requires clarification. It is presumed this refers to the final c staging (which includes that information provided by the imaging of the primary and neck). This will prove difficult in practice. It is likely that imaging of the neck will subsequently upstage or downstage the clinical stage. Hence patients may undergo unnecessary systemic imaging or may have to be recalled for further imaging (hence resulting in treatment delays and an inefficient imaging service). This need to be reconsidered-discussion with imaging representatives from a number of MDMs in the UK have implied that such guidance is unlikely to be followed.	The GC considered CXR to be part of clinical staging and therefore it is not recommended for patients with cT1N0 or cT2N0 UAT. We are unable to make reference to this as the review question which this recommendation refers to looked at who to systemically stage rather than how to do it. If, on the basis of pathological assessment, patients remain T1N0 or T2N0, systemic staging is not required. To clarify if they are cT1-2N0 at presentation then systemic staging is not required. If after surgery this is not the case then they should be systemically staged appropriately.(The GC are aware that a small percentage of patients who are clinically N0 on presentation and subsequently upstaged radiologically to N+ will need to be re-called for systemic staging.) The GC believe that the majority of patients will benefit from these recommendations.
Royal College of Radiologists	Short	11	General	Consideration should be given to stating 3 month post chemoradiotherapy assessment in advanced disease. Recent randomised data from the UK PET NECK Study (ASOC 15) supports PET evaluation at 3 months in N2/3 disease to identify those curative intent patients that would benefit from a neck dissection. Use of PET may also reduce the need for unnecessary intervention.	This abstract was published after our evidence cut-off date (see methodology section in the full guideline) and therefore has not been included in the guideline. This study will be forwarded to NICE Surveillance Programme to be included in the next guideline review.
The Society and College of Radiographers	General	General		**18 Identifying the occult primary** 19 1.2.4 Offer a fluorodeoxyglucose positron emission tomography (FDG 20	

				PET)-CT scan as the first investigation to detect the primary site in 21 people with metastatic nodal squamous cell carcinoma of unknown 22 origin that is thought to arise from the upper aerodigestive tract. **Access to sufficient PET-CT may impact on the ability to deliver this. Further work on predicted demand and known capacity may be useful.** 8 Systemic staging – who and how? 9 1.2.9 Do not offer systemic staging to people with T1N0 or T2N0 cancer 10 of the upper aerodigestive tract. 11 1.2.10 Offer systemic staging to people with T3, T4 or N+ cancer of the 12 upper aerodigestive tract. 13 1.2.11 Offer conventional imaging to people with cancer of the upper 14 aerodigestive tract that is: 15 • T1N1-2 (all sites) 16 • T2N1-2 (all sites) 17 • T3N1-2 (all sites) 18 • T4N1-2 (all sites except the nasopharynx and hypopharynx). 19 1.2.12 Offer FDG PET-CT to people with T4 cancer of the hypopharynx or 20 nasopharynx. 21 1.2.13 Offer FDG PET-CT to people with N3 cancer of the upper 22 aerodigestive tract. **As above, predicted demand v current capacity would help with planning service. The Society and College of Radiographers suspect this may be a**	Access to FDG PET-CT will be a matter for commissioners when implementing this guideline. Since this recommendation is for detecting the primary site in people with metastatic nodal squamous cell carcinoma of unknown origin, it will only affect approx 2% of patients with CUADT. We therefore do not think that the impact on FDG PET-CT services will be significant.

				fall in demand for full staging scans.	Thank you for your response. We acknowledge that there may be challenges with implementing this recommendation and have passed your comments to the NICE implementation support team to inform their support activities for this guideline.
The Society and College of Radiographers	Full	4		10 Assessment of neck lumps 11 1.2.1 Offer fine-needle aspiration cytology to people with a neck lump 12 that is suspected of being cancer of the upper aerodigestive tract. 13 1.2.2 Consider ultrasound-guided fine-needle aspiration cytology or 14 ultrasound-guided core biopsy for people with a neck lump that is 15 suspected of being cancer of the upper aerodigestive tract. 16 1.2.3 Consider having a cytopathologist or biomedical scientist assess 17 the cytology sample adequacy when the procedure is carried out. **Access to the relevant clinical scientist or cytopatholigist for these fina or biopsies is likely to be a challenge for the workforce and may add delay to diagnosis. Most biopsy/fina is medically led and has limited flexibility on timetables. Development of these skills in a multi disciplinary team may**	Thank you for your response. We acknowledge that there may be challenges with implementing these recommendations and have passed your comment to the NICE

				help.	implementation support team to inform their support activities for this guideline.
The Society and College of Radiographers	Full	24 32	10 7	E-cigarettes were not included as they did not meet the inclusion criteria which is challenging for clinical practitioners as this is a key question for a significant number of service users.	When the question was set the GC did not include E-cigarettes in the literature search as they did not believe there would be sufficient evidence in this area due to their relatively new existence.
The Society and College of Radiographers	Full	268		Recommendations Consider swallowing-exercise programme people having radiotherapy. Consider mouth-opening exercises for pe having radiotherapy who are at risk of redu mouth opening. Consider voice therapy for people whose v has changed **As identified within the document the evidence base for this is for the majority very poor.** *As identified line 2 the research recommendation is:* Research recommendation Why this is important	Thank you. We agree with your comment and this is why the recommendation used the term 'consider' rather than 'offer'.

				This does not promote who will take this forward. Will there be opportunities for Head & Neck site specialists to promote / collaborate with the speech and language profession?	It is not within the remit of NICE guidelines to specify who will take the research forward.
UCLPartners – London Cancer	Full	General	General	London Cancer are concerned that there is not a single reference to Restorative Dentistry for UATC patients either in relation to pre Ca treatment assessment and optimisation of oral health or post Ca treatment rehabilitation. Oral health and function is a priority for UATC patients. There are controversies and continue to be inequalities in the delivery of Restorative Dental care across the UK for these patients. The only mention of the word "dental" in the entire guidance occurs on P21 line 24 in relation to Kanatas et al 2013 Patient Concerns Inventory where "….patients consistently reported issues concerning dental health and chewing" but there is no elaboration on this.	The pre- and post-treatment assessment and optimisation of oral health was not included in the scope of this guideline. A restorative dentist is a core member of the multi disciplinary team and the Guideine Committee agreed that this practice was already well established. Other topics were therefore considered a higher priority for investigation. We have added text to the background section for the management of osteoradionecrosis to emphasise the importance of restorative dentistry.
UCLPartners – London Cancer	Full	19	Algorithm	At the very least Restorative Dentistry should feature alongside Information Support/Smoking Cessation/Nutrition/SALT in the Algorithm	The algorithm is not a pathway of care but a pictorial representation of the recommendations in this guideline. Therefore we are unable to include Restorative Dentistry in the algorithm where you suggest.
UCLPartners – London Cancer	Full	229	Optimising function and rehabilitation	The need for oral rehabilitation provided by a Consultant in Restorative Dentistry and its impact on quality of life should feature in this section. Oral rehabilitation with implants, including patients who have had radiotherapy needs further exploration.	The need for oral rehabilitation was not included in the scope of this guideline. A restorative dentist is a core member of the MDT and the GC agreed that this practice was already well established. Other topics were therefore considered a higher priority for investigation.
UCLPartners – London Cancer	Full	233	Research	There are other opportunities for research in Restorative Dentistry such as	The topic on enteral nutrition did not include restorative dentistry as an

				quantifying and reducing risks of future dental disease in patients having newer types of radiotherapy. Further collaborative research with SALT is needed into risk of aspiration pneumonia and poor oral health. There is no mention of work such as that by Langmore that identifies dental caries and poor oral hygiene as increasing risk of aspiration pneumonia. Given that 1.4.4 states that aspiration pneumonia may be a contraindication to certain treatments as an example, Restorative Dentistry is vital in reducing such complications.	intervention. We are therefore unable to include this in the research recommendation as we did not look at the evidence in this area.
UCLPartners – London Cancer	Full	235	Trismus	This should include the importance of Restorative Dentistry and liaison with SALT with regard to use of a Therabite- joint working is often required to maximise effectiveness and safety when using the device in practice given the complex dentition and surgical work we encounter in this patient group.	This question focussed on identifying the most effective speech and language therapy interventions to use, rather than how to give them. We are therefore unable to make recommendations on this.
UCLPartners – London Cancer	Full	301	Management of ORN	The role of the Restorative Dental pre Ca treatment assessment and appropriate ongoing dental care in the prevention of dental disease and development of ORN deserves some mention in this section. The economics of this should also be considered.	The recommendations made were about the management of ORN. This is because the topic in the scope was about the management of side effects of treatment rather than their prevention.
UCLPartners – London Cancer	Short	General	General	There is very little mention of SLT throughout the document compared with the 2004 document. As SLTs often need to use such guidelines to justify services, some more specifics would be helpful. For example 1.7.3-5 suggests that the only SLT interventions provided should be prophylactic swallowing exercises, trismus work, and voice therapy. There is no	The 2004 document is service guidance and is not being replaced by this guideline. Therefore the recommendations in the 2004 guideline are still extant.

				mention of speech difficulties throughout the document for example, or about surgical voice restoration management among others. Given the national trend towards cancer survivorship, there should also be mention here about the role of SLT in supporting patients at the 'activity' and 'participation' levels of rehabilitation, and not solely impairment based therapies. The concern is that the document may paint a very narrow view of the role of the SLT in terms of the interventions we provide. It may also suggest that we only become involved in rehab rather than information giving/ diagnostics/ treatment option decision-making/ survivorship and so on throughout the entire pathway.	We have only included topic areas and made recommendations where there is known variation in practice or uncertainty. These were consulted on during scoping and the SLT topic was the topic prioritised by stakeholders. At consultation of the scope it was requested that acute effects were included in the support of people having treatment topic (which previously only referred to dietetic support) – we therefore included speech and language therapy support here A suggested review questionwas added: What is the most effective protocol for speech and language support in people having treatment for upper airways tract cancer?
UCLPartners – London Cancer	Short	7 and 10	1.4.2 line 8 and 1.7.1 line 15	The document states that patients should be given information about likely swallowing and voice function after treatment, and also that pre-existing dysphagia indicates the need for consideration of alternative feeding. However, it does not mention the need for SLT specifically in either of these cases. Given the evidence for poor self-reporting of aspiration in this population, along with poor identification of aspiration on clinical swallowing assessment, there should be some mention of the need for access to specialist assessment in these cases by SLT i.e. videofluoroscopy and FEES. In some head and neck diagnostic centres	We did not look at who should provide specialist assessment/support and so are not able to make any recommendations on this. However we would anticipate that SLT and other allied health professionals would be involved in this assessment.

				there is still no access to such assessments and these are key to informing the provision of the treatments and interventions this document recommends; as well as measuring outcomes.	