Public Health Intervention Guidance

Skin Cancer Prevention: Information, Resources and Environmental Changes - Consultation on Review Proposal Stakeholder Comments Table

2nd April – 13th April 2012

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
All Party Parliamentary Group on Skin	General		The All Party Parliamentary Group on Skin (APPGS) supports the BAD's position on the recommended minimum Sun Protection Factor (SPF) level. Given the evidence, we firmly support a minimum recommended SPF level of 30 in all public health guidance relating to skin cancer. We believe that NICE has failed to properly weigh the evidence in this area. The importance of the new evidence submitted by the BAD appears to have been dismissed and underrated. Furthermore, we believe NICE has given stakeholders insufficient time to reply to this consultation (11 days, only 7 of which were not bank holidays or weekends). This short consultation period does not allow for proper consideration of what NICE has reviewed. We hope that in future, NICE will allow sufficient time for comment.	Thank you. The Public Health Interventions Advisory Committee (PHIAC) reaffirm that the original referral from Ministers had not asked to determine the effectiveness or the efficacy of different sun factors. However they agreed that a recent referral received by NICE 'Sunlight exposure: benefits and safety' provides an opportunity to ((as you suggest) undertake a fuller review of the evidence. Further details can be found at: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13796 Thank you we have fed back your concern about consultation time to the Director of CPHE.

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All Party Parliamentary Group on Skin	2		The *Review Proposal* consultation document states: *'Whilst the expert paper* (BAD, 2009) *recommended the use of SPF 30, PHIAC's final wording took account of the need to achieve a balance between the risks and benefits of exposure to the sun and to ensure consistency with current advice from Cancer Research UK (currently expressing the use of SPF 15 on their website)….* *'…PHIAC considered that the new evidence submitted* (in October 2011) *did not add substantive information to that already contained in the BAD expert paper'.*[1] The APPGS believes that the new evidence (submitted by the BAD in October 2011) adds significant weight to the conclusions contained within the original 2009 expert paper; conclusions which were not fully acknowledged in the 2011 PH32 guidance. The BAD's expert paper clearly states that: *'If applied adequately, then SPF 15 is sufficient'*[2]. However, it also states that: '*People should select sunscreens with SPF 30 or higher (Palm and O"Donoghue, 2007). This is because people generally do not apply sufficient quantities of the product… The recommended SPF 30 takes into account these behavioural factors that lead to a reduced level of protection'*[3]	Thank you. PHIAC maintain that the new evidence submitted did not add substantive information to that already contained in the BAD expert paper. However it has been agreed to move the footnote into the main text. In addition please see response above regarding a recent new referral.

[1] NICE, *Review Proposal: New evidence submitted consultation document – review of Public Health Guidance (PH32)*, Centre for Public Health Excellence (March 2012) p.5
[2] BAD, *A summary of key messages to be included in public information resources for the primary prevention of skin cancer* (2009) p. 17
[3] Ibid., p. 17

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			These behavioural concerns were not acknowledged in the main body of the PH32 guidance. Instead, they were relegated to a footnote. In light of the new evidence, the APPGS believes that a greater emphasis should be placed on behavioural factors and a minimum recommended SPF level of 30. De Villa D et al (2011), demonstrate that sunscreen users typically apply sunscreen in a non-uniform fashion. Even after re-application, there is often no difference in the level of uniformity; a point that was also raised in the June 2011 *Drug and Therapeutics Bulletin*. Encouraging the public to re-apply sunscreen regularly is a step in the right direction, but it has been proven that this alone does not necessarily increase the level of protection. Both publications recommend the use of SPF 30 to offset any behavioural factors that might impact upon protection. The APPGS supports this recommendation and the position of the BAD.	
All Party Parliamentary Group on Skin	3		According to the *Review Proposal* consultation document, in the initial referral to NICE, the PHIAC was not asked by ministers '*to determine the effectiveness or the efficacy of different sun factors or to advise on these'.*[4] Yet the PH32 guidance published in January 2011, contains the following recommendation: *'Sunscreens should not be used as an alternative to clothing and shade, rather they should offer additional protection. (Note, no sunscreen product provides 100% protection against the sun.) Choose a 'broad spectrum' sunscreen which offers both UVA and UVB protection.* ***It should be at least***	Thank you. PHIAC maintain that the new evidence submitted did not add substantive information to that already contained in the BAD expert paper. Also stakeholder responses to this

[4] NICE, *Review Proposal: New evidence submitted consultation document – review of Public Health Guidance (PH32)*, Centre for Public Health Excellence (March 2012) p.5

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			SPF 15 *to protect against UVB and offer high UVA protection (in the UK, this is indicated by at least four stars and the circular UVA logo). Use water resistant products if sweating or contact with water is likely.*[5] (Emphasis added) The APPGS believes that the above recommendation constitutes an assessment of different SPF ratings. By recommending a minimum SPF rating of 15, the guidance *is* effectively advising on the effectiveness and efficacy of different sun factors. PHIAC has a responsibility to ensure this recommendation correlates with the most up-to-date evidence available. The *Review Proposal* consultation document states '*that if a specific review of sunscreens is required then a new referral from ministers would be needed*'[6]. Given the fact that the PHIAC has already assessed the effectiveness and efficacy of different sun factors within the PH32 guidance, the APPGS does not believe that a new referral would be required for any subsequent review of this particular recommendation.	consultation also indicate that there is no consensus amongst experts. However PHIAC agreed that a recent referral received by NICE 'Sunlight exposure: benefits and safety' provides an opportunity to undertake a fuller review of the evidence. Further details can be found at: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13796
Almirall Ltd	General		Actinic (or solar) Keratosis (AK) is a common skin lesion, caused by chronic sun exposure, with the potential to transform into squamous cell carcinoma. In Ireland and the UK, the prevalence of AK in the over 60-years old was found to be around 20%	Thank you

[5] NICE, PH32: Skin Cancer: prevention using public information, sun protection resources and changes to the environment (January 2011) p.13

[6] NICE, *Review Proposal: New evidence submitted consultation document – review of Public Health Guidance (PH32)*, Centre for Public Health Excellence (March 2012) p.5

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			Reference D de Berker, JM McGregor, BR Hughes. Guidelines for the management of actinic keratosis. Br J Dermatol. 2007;156:222-30	
Cancer Research UK	General		**Cancer Research UK does not currently believe a change is warranted from the recommendation that sunscreen should be at least SPF 15 to protect against UVB.** Having considered the existing body of scientific literature in this field, including the three pieces of new evidence supplied by the BAD, we feel that there is conflicting evidence as to whether a recommendation of SPF 15 or 30 would confer the biggest public health benefit to the UK population. It seems that for people receiving UV exposure non-intentionally (eg gardening, sport, travel) a recommendation of SPF 30 would be preferable[1]. If SPF 15 was applied correctly it should be sufficient to protect people in these situations from overexposure to UVB, however using this quantity of sunscreen may be unachievable in practice[2]. Pragmatically, a recommendation of SPF 30 may partially compensate for under-application during non-intentional exposures. During intentional sun exposure (eg sunbathing) any use of sunscreen, but in particular use of sunscreen with a higher SPF, tends to influence behaviour to increase the length of time spent in the sun with no reduction in sunburn frequency[3]. Therefore for people intentionally exposing themselves to the sun a recommendation of a higher SPF may lead to a higher dose of UV overall and consequently a net health harm. Therefore, considering the complexity of the evidence at the current time, Cancer Research UK does not believe a change is warranted from the recommendation that sunscreen should be at least SPF 15 to protect against	Thank you for your comments

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			UVB. We have not been able to identify evidence about the proportion of sun exposure which is received intentionally versus unintentionally. We therefore call for more research in this area to allow us to understand better the balance of harms and benefits associated with the use of sunscreens of different SPFs in the UK population as a whole. Cancer Research UK would like to re-emphasise the importance of focusing on shade and clothing as the most effective methods of sun protection, with sunscreen used mainly to protect areas that cannot practically be protected in other ways. 1. Editorial 2011. Do sunscreens have a role in preventing skin cancer? *Drug and Therapeutics Bulletin*. 49 (6) 69-72. 2. De Villa D et al. 2011. Re-application improves the amount of sunscreen, not its regularity, under real life conditions. *Photochemistry and Photobiology*. 87. 457-60. 3. Autier, P et al. 2007. Sunscreen use and increased duration of intentional sun exposure: Still a burning issue. *International Journal of Cancer*. 121. 1-5.	
Health Protection Agency	General		The Health Protection Agency supports the view of PHIAC not to amend the guidance concerning the SPF of sunscreen. The recommendation "*at least SPF 15 to protect against UVB and offer high UVA protection"* should be adequate for most situations. It is accepted that application in practice may not give the level of protection indicated by the test method used to determine SPF. However, the variability in actual skin exposure to solar UV during normal activities is usually much greater, unless a person is deliberately sunbathing. It should also be noted that the test method has larger uncertainties as the SPF is increased due to lower levels of spectral irradiance	Thank you for your comments

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			transmitted through samples. We continue to support the approach used in PH32 to encourage the use of protection measures other than sunscreen where possible.	
Health Protection Agency	General		When PH32 is reviewed as part of the normal 3-year cycle, the Health Protection Agency suggests that the guidance should consider differences between solar UV exposure in the UK and sunnier climates overseas. For a UK population in the UK, temperature provides a reasonable indicator of the solar UV Index. However, in other parts of the world, a low temperature may still mean a high solar UV Index. Examples are during skiing holidays in the winter months and spring time in places like Australia.	Thank you for this suggestion. Please also note the new referral mentioned above. Details can be found at: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13796
Health Research Forum	Section 2		PHIAC's recommendation number 3 on sunscreen application suggests that sunscreen should be applied liberally half an hour before and after going out in the sun. I do not agree with this advice because sunscreen blocks UVB which is necessary for vitamin D synthesis. Unnecessary use of sunscreen will deplete the body of vitamin D and thus may have serious adverse health consequences for people of all ages and may indeed make skin cancer more, not less, likely. Except for people with established sun sensitivity, sunscreen should not be applied until after some sun exposure has been obtained. The optimum healthy interval between going out in the sun and putting on sunscreen will vary with individuals, time of day, and season of the year. At the beginning and end of the summer season most people will be able tolerate at least half an hour in the sun without any burning and so need not apply sunscreen until they have been in the sun for this time. This will give them substantial health benefit from a gain in vitamin D. It must be remembered that the majority of people in the UK have sub-optimal levels of vitamin D and so any gain in the vitamin may be considered beneficial. The optimum interval of sun exposure may be shorter for some and will certainly be much longer for others. It is a	Thank you. The 2 new referrals received by NICE on Vitamin D (http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13795) and Safe Sun Exposure (http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13796) provide an opportunity to assess the issues. As part of the standard NICE process –existing published guidance will be superseded if new advice emerges from the evidence.

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			mistake to try and over simplify this as cancer charities and BAD have done in the past. The PHIAC advice is actually out of date. We now know that people who spend weekends outdoors are less likely to get melanoma than people who don't (Julia Newton-Bishop European Journal of Cancer 47 (2011) 732 –741). This is consistent with vitamin D having an important function in prevention of cancer as much evidence now suggests. It has also been known for a long time that outdoor workers get less melanoma than indoor workers. It is important not to confuse this issue by considering all skin cancers together in one group since the commonest cancers, often found in outdoor workers, are rarely lethal and are responsive to treatment.	
Health Research Forum	Section 2 continued		Advice on sun exposure needs to be gleaned from a balancing of risks with benefits. Past outdated advice, which is being drawn on by PHIAC, does not consider the general benefits of sun exposure and has ignored evidence suggesting that the benefits of sun in the form of vitamin D actually prevent sun-induced skin cancers. It also needs to be remembered in drawing the equation balancing risk with benefit that this may be very different for the UK and Australia. In the past Australain advice has had an excessive influence on advice given to people in the UK by BAD and Cancer Research UK. Indeed Australian advice has now changed and Australians are now advised to go out in the sun before putting on suncream.	PH32 did note that the risks and benefits of sun exposure were complex and that a balance needs to be struck to attain an adequate vitamin D status without increasing the risk of skin cancer. Given that the main aim of the guidance was to assess the most effective ways of delivering health information, a full review of the benefits of Vitamin D was not undertaken.

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				However the new referrals received by NICE (see above for links) provide an opportunity to examine the issues you raise.
Health Research Forum	Section 3		This section shows that the advice is largely drafted with "expert" advice from BAD. BAD are known for an approach which focuses on risks of sun exposure and until recently disregarded benefits. Benefits are now mentioned by BAD but do not appear to be properly understood or given sufficient weight. This advice should be suspended until more expert advice is obtained from individuals and bodies knowledgeable about vitamin D.	Thank you for your comment.
Health Research Forum	Section 5		I have seen no mention of skin colour and no variation of advice for people of different skin colours. Melanoma is rare in people with naturally pigmented skin which is brown or black. However people with darker skin make vitamin D much more slowly than white skinned people. Therefore they need to remain in the sun much longer to obtain the vitamin D they need for full health. I have been unable to find any advice in your document directed at them and so believe that this advice does not comply with anti-discrimination and equality legislation. Expert advice needs to be sought on this point and your advice to the public redrafted to meet the needs of people of all skin colours..	Thank you. Recommendation 2 refers to variation in risk for different types and links the reader to more detailed advice given by Cancer Research UK. There will be an opportunity to look at this issue in more detail in the new referrals to NICE outlined above.
Health Research Forum	Section 6		I disagree with this conclusion. The advice should be updated and redrafted with a much broader base of medical and scientific advice. Advice from BAD has been given excessive weight and is in any case outdated	Thank you. The new referrals provide an opportunity to review the evidence relating to vitamin D in more depth

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NCRI Melanoma Clinical Studies Group/RCP/RCR/ACP/JCCO	General		The NCRI/RCP/RCR/ACP/JCCO are grateful for the opportunity to comment on this review proposal. We would like to make the following joint response. It is the view of our experts that there is sufficient evidence to support a recommendation to use sunscreen SPF 30 rather than 15. There are now several published studies (conducted in daily life as well as in the laboratory) all consistently showing sunscreens are not applied anywhere near the manufacturer's test density of 2mg/cm^2. In fact, both the healthy public and patients are shown to apply ⅓ to ½ of this recommended amount (which is in fact unrealistic to apply during daily life), meaning the SPF achieved is much lower than desired. It is also our understanding that the Cancer Research UK website was intended to be updated from SPF 15 to 30, but that the older information was retained in 2011 in order to keep this consistent with the NICE recommendations. Therefore, our firm advice is that the paragraphs in section 2, at the end of page 3 and start of page 4, are amended from SPF 15 to SPF 30. Having had sight of the submission of the British Association of Dermatologists we are aware that they also strongly support this position. It would be extremely disappointing if the above is not rectified. However, if it is felt that this is not possible then we would suggest moving the text from the footnote mentioned on page 4 to the main text, to give the public a better opportunity to be aware of the whole (and realistic) picture.	Thank you. Please see comments received by Cancer Research UK. It has been agreed to move the footnote into the main text
NHS Bradford and Airedale	General comment - Will these		Please can the advice on exposure of skin to sunlight be consistent with that provided within the recent consensus statement from the British Association of Dermatologists, Cancer Research UK, Diabetes UK, the Multiple Sclerosis Society, the National Heart Forum, the National Osteoporosis Society and the	Thank you. Please see the comments from these organisations in this document.

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	guidelines address the risk of vitamin D deficiency due to excess sun-screen> Can we have guidance on the whether the lower SP factors (<15) inhibit vitamin D production similarly to that of the sun screen blocks?		Primary Care Dermatology Society. "The time required to make sufficient vitamin D is typically short and less than the amount of time needed for skin to redden and burn. Regularly going outside for a matter of minutes around the middle of the day without sunscreen should be enough. When it comes to sun exposure, little and often is best, and the more skin that is exposed, the greater the chance of making sufficient vitamin D before burning. However, people should get to know their own skin to understand how long they can spend outside before risking sunburn under different conditions. "	The two new referrals received by NICE (http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13795 And http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13796 provide an opportunity to consider the complex issue of risk and benefits in more depth.
Royal College of Nursing	3		There is mention of applying sunscreen before going out in the sun, "but this does not replace clothing", however some key factors seem to be missing: • No mention of hats or sunglasses • There is no mention of the time of day and as we know there is a generally accepted higher risk between the hours of 10am/3pm. • The season also has a bearing on the strength of the sun. • There is no mention of the effects of surface "reflection" from water/snow/sand which means the effect reaches more skin • No mention of the possibility of photosensitivity for people on medication e.g. doxycycline for skin ailments or malaria prophylaxis if they have	Thank you. These important issues (your bullets) will be useful for the full review of the guidance in January 2014.

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			returned from abroad. • Also it would be good to highlight the ageing effects on the skin! For UK travellers going abroad although we would suggest that parents keep very young children out of the sun we would recommend a higher factor for children and probably SPF 50 especially if they are very fair skinned or have red hair.	
Royal College of Nursing	3		We would have thought that a sun cream with an SPF of 30 is better than an SPF of 15 but note and that this recommendation is in line with Cancer Research UK (CRUK)'s recommendation.	Thank you – PHIAC have now agreed that the footnote in recommendation 3 should be brought into the main text to clarify the link between sunscreens and behavioural factors.
The British Association of Dermatologists	2.		Expert advice provided by the BAD and based on a number of research papers was discounted in favour of information provided on a charity website. Expert advice presenting new and substantial evidence should have been adhered to unless formal consultation comments argued against it. Furthermore, CRUK also supported the SPF30 guidance in the original consultation even though their website suggested otherwise.	Thank you. We value all our stakeholders. Evidence reviews and other inputs such as expert papers are submitted to PHIAC for their consideration. The process of drafting recommendations is carried out according to Chapter 7 of the Public Health methods manual

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				- available at: www.nice.org.uk/phmethods2009 PH32 aimed to reflect the views of all stakeholders by striking a balance between the risks and benefits of the sun. PHIAC have agreed to move text relating to behavioural issues into the main text to make clear the links between SPF and behavioural issues as reflected in the BAD expert paper. .
The British Association of Dermatologists	3.		Further evidence was presented by the BAD to reinforce the expert evidence that had been ignored in the original consultation. And which further supported SPF30 rather than SPF15 as the suggested adequacy.	Thank you. PHIAC maintain that the new evidence submitted did not add substantive information to that already contained in the BAD expert paper. However it has been agreed to move the footnote into the main text. They also agreed that a recent referral received by NICE 'Sunlight exposure: benefits and safety' provides an

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				opportunity to undertake a fuller review of the evidence. Further details can be found at: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13796
The British Association of Dermatologists	3.		Point: "PHIAC noted that the purpose of the original expert paper from BAD that is considered when the recommendations were developed was to summarise current expert knowledge on the advice that should be included in any information resource" – this summary of current expert knowledge concluded that the advice should be for a suggested minimum of SPF30 rather than SPF15. However NICE chose to reject this advice. The BAD has not received or seen further expert advice (from NICE or other consultees) that would justify disregarding the original summary. The BAD would therefore suggest that the NICE guidance should be changed to reflect this expert advice as no contrary expert opinion has been given to suggest that SPF15 is preferable.	Evidence reviews and other inputs such as expert papers are submitted to PHIAC for their consideration. The process of drafting recommendations is carried out according to Chapter 7 of the Public Health methods manual - available at: www.nice.org.uk/phmethods2009 It is normal NICE procedure for PHIAC to

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				discuss and amend guidance via email post the last committee meeting and for the Guidance Executive of NICE to give final approval. Whilst the guidance did not implement the recommendation of BAD in their final report – the exact words used in the expert paper relating to SPF and sun protection have been used and will now appear together in an updated version of the guidance. Also comments received by other stakeholders in this consultation reaffirm the complex nature of the issue, which PHIAC hope can be further considered by the new referrals - see above comments
The Society and College of Radiographers	General		The Society and College of Radiographers I agree with the views of the Public Health	Thank you for your comments

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			Intervention Advisory Committee (PHIAC) when they state that the original remit of developing the NICE Skin cancer guideline did not include recommendations on the use of non-information related resources alone (such as protective clothing or sunscreen) - it tended to focus on information conveyance via media etc. This was because at the time when the guidance was developed no evidence existed regarding use of sunscreens. The cancer research campaign website mentions use of at least 15SPF – but nothing about re-applying etc. The use of a minimum of SPF15 in sun protection information campaigns is good but we believe there needs to be more such as information on various behaviours in the sun.	
The Society and College of Radiographers			We do feel there needs to be more information on the use of higher SPF factors – for children it tends to be at least 30SPF – is this effective though? Or does it cause other problems (i.e. the lack of Vitamin D absorption)? There is confusion about this and most parents will use a high SPF in the products they put on their child so should 30SPF or 50SPF be used for children and why? We are not sure if the new evidence identified by BAD details this but PHIAC stated that it did not affect their current (2011) guideline. The Feb 2012 meeting of PHIAC mentioned that if a specific review of sunscreens is required then a new referral from ministers would be needed. We do feel this is needed now.	Please see details above relating to the new referrals - this provides an opportunity to consider these important issues in more detail.
University of Newcastle-on-Tyne	General		The new documentation that has been considered appears to be of relatively minor importance and published in “minor” journals. By contrast, there has been total failure to update the guidance in relation to the very high risk of inducing adverse health consequences through promoting reductions in UVB exposure for children living in the UK.	Thank you for your comment.
University of Newcastle-on-Tyne			The following facts are known:	Thank you. Please see further details of the new

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				referral on vitamin D at: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13795 and register as a stakeholder so that this information can be considered during stakeholder consultations
University of Newcastle-on-Tyne			1. Vitamin D is a steroid-hormone-like molecule that appears to be crucial to bone health and immune surveillance. *Pearce & Cheetham, BMJ, 2009.*	See above comment
University of Newcastle-on-Tyne			2. The dominant human source is through photosynthesis in bare skin exposed to UVB 300nm (typically only available around noon in the UK, between April and September of each year). *Pearce & Cheetham, BMJ, 2009.*	See above comment
University of Newcastle-on-Tyne			3. Even adopting the most stringent criteria, vitamin D deficiency (<25nmol/L) appears to be widespread even among healthy Caucasia men. *Hypponen & Power, Am J Clin Nutr. 2007.*	See above comment
University of Newcastle-on-Tyne			4. Among the UK's increasingly multi-ethnic children reported cases of clinically overt rickets, the most severe form of vitamin D deficiency, have been increasing year by year, up to 800 cases for 2011. *Pearce & Cheetham, BMJ, 2009; Mughal, Endocrine Society Abstracts, 2012.*	See above comment
University of Newcastle-on-Tyne			5. SPF-sunscreens are highly-effective at blocking vitamin D photosynthesis, except where they are being used to enable extended time in the sunshine without burning. *ie.* sunbathing behaviour. *Pearce & Cheetham, BMJ, 2009.*	See above comment
University of Newcastle-on-Tyne			6. Low ambient UVB during early childhood and *in utero* is a major risk factor for the development of multiple sclerosis (MS) in later life. MS now affected around 1-in-250 adults in the West of Scotland and is a fatal debilitating disease with immense healthcare-related costs. Whether low vitamin D is the molecule that links UVB exposure to immunological attack on myelinated	See above comment

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			neurons is still debated, so vitamin D supplementation may not be able to compensate for the increased risk accruing to low childhood or (whilst *in utero*) maternal skin UVB exposure. *Ramagopalan, et al, Neurology, 2011.*	
University of Newcastle-on-Tyne			7. CRUK's recommendations for healthy sun exposure have been proven to be totally inadequate for the purpose of maintaining adequate vitamin D photosynthesis, especially among UK children of Asian origin. *Rhodes, J Invest Dermatol, 2010; Farrar, et at, Am J Clin Nutr, 2011.*	See above comment
University of Newcastle-on-Tyne			8. Whilst UVB skin exposure is unquestionably associated with skin ageing and non-melanoma skin cancer, such an association in relation to melanoma is not found anywhere except for ethnic Scots & English living in northern Australia. Evidence from more representative populations confirms past unburn to be a melanoma risk factor, but suggests that regular sunshine exposure is associated with a lower risk of melanoma, possibly due to direct immune effects, enhancement of vitamin D photosynthesis, or to skin photoadaptation. *Newton-Bishop, European Journal of Cancer, 2011*	See above comment
University of Newcastle-on-Tyne			Therefore, until further research is done, it does not seem sensible to impose on UK children any topical treatments or behaviours that might further reduce their exposure to ambient UVB light.	Thank you for your comment.
University of Newcastle-on-Tyne			There should be a simple, unde=rstandable and evidence-based public health message: "Don't burn", and leave it at that.	Thank you for your comment.

Document processed	Stakeholder organisation	Number of comments extracted	Comments
All Party Parliamentary Group on Skin.doc	All Party Parliamentary Group on Skin	3	
Almirall Ltd.doc	Almirall Ltd	2	

Public Health Intervention Guidance

Skin Cancer Prevention: Information, Resources and Environmental Changes - Consultation on Review Proposal Stakeholder Comments Table

2nd April – 13th April 2012

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Cancer Research UK.docx	Cancer Research UK	1	
Health Protection Agency.doc	Health Protection Agency	2	
Health Research Forum.doc	Health Research Forum	5	
NCRI Melanoma Clinical Studies Group, RCP, RCR, ACP, JCCO.doc	NCRI Melanoma Clinical Studies Group/RCP/RCR/ACP/JCCO	1	
NHS Bradford and Airedale.doc	NHS Bradford and Airedale	1	
Royal College of Nursing.doc	Royal College of Nursing	2	
The British Association of Dermatologists.doc	The British Association of Dermatologists	3	
The Society and College of Radiographers.doc	The Society and College of Radiographers	2	
University of Newcastle-on-Tyne.doc	University of Newcastle-on-Tyne	12	