National Institute for Health and Clinical Excellence

Metastatic malignant disease of unknown primary origin
Stakeholder Comments

Please enter the name of your registered stakeholder organisation below.

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Stakeholder Organisation:	British Association of Dermatologists
Name of commentator:	Dr David Eedy and Dr Catriona Irvine BAD Skin Cancer Services Sub-committee

Order number *(For internal use only)*	Document Indicate if you are referring to the **Full** version **NICE** version or the **Appendices**	Section Number **Number only** (do not write the word ósectionô). Alternatively write **ógeneralô** if your comment relates to the whole document	Page Number **Number only** (do not write the word ópage/pgô). Alternatively write **ógeneralô** if your comment relates to the whole document	**Comments** **Please insert each new comment in a new row.** **Please do not paste other tables into this table, as your comments could get lost – type directly into this table.**
Example	Full	3.4.6	45	My comments are as follows é é
PROFORMAS THAT ARE NOT CORRECTLY SUBMITTED AS DETAILED ABOVE MAY BE RETURNED TO YOU				
1			19	The definition of CUP is inconsistent. Even on page 19 two definitions are used within a paragraph or two. It needs to be clearly stated whether the definition is ñCancerô of UP or ñCarcinomaô of UP.
2			19	The statement: ñCUPé is the third most common cause of cancer death in England and Walesôseems unbelievable, given the large numbers of deaths from know cancers such as breast, lung, and GI, and considering less that 10,000 new cases of CUP were registered in 2006.
3			32 & 33	The CUP team structure seems appropriate with oncologist, palliative care physician and CNS. Rather than try to set up a CUP MDT would patients not be better served by having CUP cases added to the upper GI MDT ï since most cases are likely to be GI or lung.
4			33	With the relatively low number of patients and the fact that they are usually of advanced age, making the MDT óspecialistô and óregionalô level might disadvantage patients and delay investigation and treatment. Why can these MDTs not be at local level, added to an established site specialist MDT as stated above? The small number shold not interfere with the site specific MDT too much.
5			37	*ì We were ...??NOT… told the implications…'.* This quote from a patient/carer looks as if it should have the ónotô in the first sentence.

6			39	The comprehensive history and physical examination should include thorough examination of the skin: 1. A comprehensive physical examination of the skin, to include the buccal and genital mucosa is absolutely essential and ideally should be performed by a dermatologist. This is not mentioned in the guidance. While not in the remit of the British Association Dermatologists (BAD), where biopsy of the secondary suggests that the primary may be of malignant melanoma origin, then an ophthalmologist should also examine the ocular system, and in females a gynaecologist should examine the vaginal mucosa. Given how easy these screening investigations can be carried out at low cost, it is surprising they have not been considered as essential practice. 2. The BAD is surprised that invasive and low-yield procedures such as endoscopy are considered, whereas a low cost, non-invasive and quite high yield skin examination is not specifically mentioned. 3. The BAD is surprised by the lack of emphasis on a full physical examination of the skin and mucus membranes, which are not specifically mentioned as among the investigations to be offered to every patient with a CUP. This should be done in every case, and would preferably be carried out by a dermatologist. Certainly where any undiagnosed skin lesion is found, a dermatology opinion should be considered essential. 4. The skin is a relatively easy organ to screen and should be cost effective. It gives rise to many carcinomata which can metastasise to include commonly melanoma, squamous cell carcinoma as well as rarer sarcomas and merkel cell carcinoma. These can arise in sites not routinely looked at such as umbilicus, buccal mucosa, vulval skin and scalp and can also arise in apparently innocuous skin lesions such as sebaceous cysts. In examining the skin it is possible to pick up evidence both primary and metastatic tumours but also non-metastatic effects such as rashes, thickening of the skin and other changes some of which are rare but

				specific and may help towards diagnosis of the underlying cancer. (eg rash typical of pancreatic tumour - necrolytic migratory erythema, eruption of warts in GI cancer etc)
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Closing date: 5pm on 1st February 2010

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