Article details: 2021-0038	
Title	Update to the Canadian clinical practice guideline for best-practice management of
Authors	Margaret Lynn McNeely, Susan R. Harris, Naomi D. Dolgoy, Mona M. Al Onazi,
Reviewer 1	Dr. Roger Ghys
Institution	Clinique du sein Bourassa
Reviewer comments and author response	You intend to propose updated guidelines to deal with breast cancer related lymphedema. Your introduction clearly describes this fairly common condition, often consecutive to therapeutic measures, which is generally fairly benign but can be incapacitating and for which no cure is known. I have been working as an oncologist for almost half a century and I have seen dozens of women afflicted by this condition. Almost all of them were personally and socially concerned by this problem far more than by life threatening conditions such as metastases! You also supply a list of 19 references which are relevant and up to date. A set of guidelines available to all parties concerned would be more than welcomed. What you are submitting for publication is the report of the (fairly comprehensive) preliminary work done so far, so you could get comments and suggestions from the readers and incorporate them in the final Guidelines. The appropriateness of such a paper should of course be a journal Editor decision, but, in my opinion, you should first: 1) get rid of all non relevant material (e.g. Fig. 1 giving the timetable to establish the Guidelines; I do not think potential readers would care about that.) [Editor's note: please keep Figure 1] **As per the editor's note, Figure 1 was retained.** 2) clearly describe the methodological approach. [Editor's note: the reorganization will help] **We have reorganized to better describe the methodological approach.** I stumbled over quite a few statements. 1. p. 9 ., l .24. "Published and unpublished works are eligible, with no language restriction(!). Do not my mother-tongue, but, when dealing with a medical paper, I find it normal to read it and write about it in English) . (On p. 5, l. 37 you applaud to the Health Model introduced in the Netherlands in 2016 (ref. 18). It happens that Dutch is one of several "European" languages i can read. i searched the literature: these authors' writings on the subject and the Guidelines they issued were in Dutch; ref. 18 was written in English to obtain the international recognition it deserves. Scientists in Germany or Italy would act similarly.) **We agree with the reviewer that papers are largely published in English. However, so as not to exclude any important work we opted to not limit the language.**

	2. P. 9, l. 43. "Guidelines will be considered if scoring (depending the category) is 75% or higher, 60% or higher, 50% or higher" Where does this ruling come from? Explanation and justification, please. The option to establish cut points for scoring of domains was derived from the AGREE II Tool. A priori, we felt that the quality of any existing guideline being considered for adaptation had to demonstrate quality in Rigour of Development (after discussion this was reduced to 70% for consistency with the AGREE II tool recommendations). We set thresholds for other domains (although lower), as we wanted to show transparency in decision-making around the use of any recommendations adapted from existing guidelines. 3. P. 11, l, 3. The Steering Committee will vote,,, 80% agreement will be required for the recommendation (or statement, see l. 14) to be included ...(I pity the recommendation which would be approved by 76% of voters and mercilessly rejected!) Again, where does this ruling come from? **The agreement rating of 80% is somewhat arbitrary; however, we wanted to ensure there was a high level of agreement on a given recommendation. We understand your concern re: scores approaching the cut off. Our plan is to share the reasons and arguments for, and against a given recommendation. We feel having insight into divergent views may be helpful for practitioners (as it may be patient-related) as well as identify areas in need of further research.** 4. P. 12, l. 24. " The Steering Committee will meet at 4 monthly intervals. and will include.. three graduate students.' Three. another magical number, why not 2 or 4?... and I don't think readers care about the dates of the meetings! [Editor's note: the dates of the meeting are fine to include, as mentioned earlier.] **Thank you for this comment. Two graduate students have been involved in the process (MAO, JFP) and a third graduate student has recently joined the working group (not a co-author). Two of these students do not have prior experience in the area of breast cancer related lymphedema, however, they are interested in gaining experience in a guideline development project. All three graduate students have volunteered to take part in the CPG process.** 5. A last observation: like most Authors, you use a number of acronyms for certain terms because they come repeatedly in the text, or YOU are using them frequently. So far, so good. But some of them remain quite mysterious to me and, I suspect, to potential readers. Examples: p. 19, l,5 "modified DELPHI"; p. 10, l. 49 "GRADE approach". and people like myself, in Ontario or Québec will get a little jealous that in Alberta (p. 11, l, 45) ,a "GURU" is helping you in your work. [Editor's note: after a paper is accepted, the copyeditor goes through it carefully to determine which acronyms can remain.]

	Thank you for this comment. We have removed the acronym GURU and replaced with the full name of the unit. We have also removed the acronyms for the Canadian Lymphedema Framework and Canadian Physiotherapy Association Oncology Division.
Reviewer 2	Dr. A.J. Salacinski
Institution	Westfield State University
Reviewer comments and author response	The purposed changes to the Study Protocol for Canadian Clinical Practice Guidelines (CBG) for best-practice management of Breast Cancer related Lymphedema, was very well written. Updating CPGs is a crucial process and one that entails vigorous and explicit instructions to promote valid and trustworthy guidelines. There will be a considerable amount of resources to review from the key words chosen, which were considered appropriate. However, the authors were very detailed in their process which will enhance the foundations of the CBG and increase the strength of their recommendations. Also mentioned was sharing with experts in the field or stakeholders, which will establish transparency. The authors are recommended for taking a patient-oriented approach, as mentioned in the manuscript. It is important to note that changes in guidelines should be examined when we have changes in values on outcomes. I feel in the current world climate, this is very timely. **Thank you for your supportive comments.**
Reviewer 3	Dr. Fei-Fei Liu
Institution	Princess Margaret Cancer Centre
Reviewer comments and author response	The manuscript describes a study protocol for updating Canadian clinical practice guidelines (CPGs) for lymphedema management. This protocol includes 4 stages of critical appraisal that will be overseen by relevant stakeholders in lymphedema care. [Editor's note: the points raised in the paragraphs below that require revision are numbered below.] Overall, this protocol is very comprehensive and was developed from the perspectives of many stakeholders. It is promising that the results of this CPG update will be widely disseminated and used. Major issues: None **Thank you for your supportive comments.** Minor issues: 1) As the focus of the CPG will be on Canadians with particular emphasis on self- management, it would be helpful to describe the current lymphedema management for Canadians, particularly highlighting any differences between Canadian management and management in other countries.

	Thank you for this suggestion. A discussion on the other existing CPGs across the international landscape would be helpful (Dutch, Queensland, Japan, UK, Ireland, etc.). . [Editor's note: it would be helpful to mention the existence of these other guidelines and cite them in the Introduction (if not done already), as you will be reviewing their recommendations for possible inclusion. **We have added references to other guidelines; however, as we have not formally reviewed these guidelines we feel it is premature to add discussion at this point.** The concept and benefits of a self-management approach vs. other approaches should also be described in more detail **We have added further information on the self-management in the introduction**. In the final guideline, we encourage you to add an "Other guidelines" subsection with a table showing major differences between your recommendations and those found in other guidelines, if applicable.] **Thank you for this suggestion. We have included a statement in the protocol of the inclusion of a table showing the main differences in recommendations between our guideline and other published guidelines.** 2) It would be helpful if the authors could provide more insight into why the last 7 years was chosen for the literature review vs. updating the guidelines from 2000 onwards to include all literature since the last Canadian CPG update. **The decision on a 7-year time frame was made by our team in discussion with our guideline librarian (ED). Our aim was to synthesize the evidence in the context of more recent advances in the treatment of breast cancer. Specifically, we wanted to ensure that recommendations are consistent with today's less invasive surgical and radiation therapy treatments. We also felt that many of the older studies would be included in systematic reviews and meta-analyses conducted during this time period. We chose 7 years to provide a slightly larger time frame, as the cataloguing of articles on some databases may not be up-to-date.** 3) Would other reporting guidelines be helpful for assessing the quality of different types of studies in the literature review (e.g. PRISMA)? **Yes, thank you for this comment. We anticipate that we will include use other tools to assess the quality of the different types of studies, should we need to evaluate other designs. We have included further detail in relation to any needed tools to evaluate quality.** 4) A discussion on why limb volume was selected as a primary outcome over functional or QoL outcomes would be of interest. Particularly, you have noted some additional outcomes for breast, chest wall, and truncal lymphedema. Please

	describe these outcomes in additional detail if possible. **We chose limb volume as this is the primary metric used for decision-making related to lymphedema in breast cancer. To improve clarity, we have added a brief rationale for our included outcomes in the additional table (TABLE 2). Recent evidence suggests an increased incidence of lymphedema related to the breast, trunk and chest wall following breast conserving surgery and radiation therapy; therefore, consideration was given to the need to extend recommendations related to lymphedema beyond the arm alone.**