

## Commissioning Statement

<b>Treatment</b>	<b>Phosphodiesterase type-5 inhibitor, sildenafil</b>
<b>For the treatment of</b>	<b>Penile rehabilitation post radical prostatectomy or radiotherapy</b>
<b>Commissioning position</b>	<p>Calderdale CCG commissions the use of generic sildenafil for penile rehabilitation post radical prostatectomy or prostate radiotherapy, only if the following conditions apply:</p> <ul style="list-style-type: none"> <li>• the patient has undergone radical prostatectomy or prostate radiotherapy</li> <li>• treatment must be initiated by a specialist in urology: <ul style="list-style-type: none"> <li>○ the patient is reviewed regularly</li> <li>○ once daily sildenafil (usually 50mg, can be increased to 100mg or decreased to 25mg) may be continued for up to 12 months, and prescribed 'on demand' thereafter (up to 3 per week).</li> </ul> </li> </ul> <p>Calderdale CCG does not routinely commission the use of other PDE5 inhibitors for penile rehabilitation.</p> <p>There is some evidence that PDE5 inhibitors may improve penile rehabilitation following radical prostatectomy or radiotherapy. Other PDE5 agents are restricted for use to an on required basis for erectile dysfunction.</p> <p>The criteria for NHS prescribing of PDE5 inhibitors for the management of erectile dysfunction by GPs is set out in Part XVIII B of the Drug Tariff.</p> <p>(North Kirklees CCG/Greater Huddersfield CCG/Wakefield CCG/Calderdale CCG/Bradford City CCG/Bradford Districts CCG/Airedale, Wharfedale and Craven CCG)</p>
<b>Date effective from</b>	March 2019
<b>Policy to be reviewed by</b>	<p>March 2022</p> <p>(to be reviewed earlier if NICE issues more guidance at an earlier date)</p>
<b>Background information</b>	<p>Phosphodiesterase type-5 (PDE5) inhibitors are licensed for the treatment of erectile dysfunction (ED).</p> <p>ED is a common complication following a prostatectomy due to cavernosal nerve damage, which can occur even after nerve-sparing surgery (1). Supportive therapy to rehabilitate erectile function should be started as early as possible (1;2;3). Clinical trial evidence supports the use of PDE5 inhibitors for up to 12 months after prostatectomy.</p>

	<p><b>National Guidance:</b></p> <p>The recommended dosing of sildenafil is one dose prior to sexual activity; the maximum recommended dosing frequency is 100mg once a day (2). Sildenafil can be prescribed on the NHS following prostatectomy for the treatment of impotence (4) normally allowing for one dose per week. However, the regulations allow the prescribing doctor to prescribe more than one dose a week if judged clinically appropriate (4)</p> <p><a href="#">NICE CG175</a> (5) states that men with prostate cancer who experience loss of erectile function (following prostatectomy) should be offered PDE5 inhibitors to improve their chance of spontaneous erections. PDE5 inhibitors should also be offered to men having long-term androgen deprivation therapy who experience loss of erectile function.</p> <p><b>Treatment pathway:</b></p> <p>Studies suggest that supportive therapy to rehabilitate erectile function should, ideally, be started as soon as possible following surgery. In the studies, regular PDE5 inhibitor dosing was started at around the time of catheter-removal (7-14 days following surgery) and continued for up to 12 months.</p> <p>Initiation will be under specialist supervision in secondary care, with regular follow-up to assess efficacy of treatment.</p>
<p><b>Summary of evidence/ rationale</b></p>	<p><b>Clinical effectiveness:</b></p> <p>Phosphodiesterase-5 (PDE-5) inhibitors have been used successfully post-radical prostatectomy, with greater success following nerve sparing radical prostatectomy. The efficacy of the PDE5 inhibitor depends on preservation of the nerves during surgery; without cyclic guanosine monophosphate (cGMP) there is no substrate for PDE5 to work on (6). Men undergoing bilateral, unilateral and nerve sparing prostatectomy have been shown to have a better response to a PDE5 inhibitor than those who had non-nerve-sparing surgery (7; 8; 9).</p> <p>There have been few studies comparing treatment with a PDE5 inhibitor either on-demand or daily versus placebo or a comparator. All the studies are small and of poor quality. In the studies, regular PDE5 inhibitor dosing was started at around the time of catheter-removal (7-14 days following surgery) and continued for up to 12 months. On-demand dosing was used in a few studies, started over 3 months following surgery and mainly assessed after 4-6 doses had been taken. These studies were poorly designed, with no control or placebo groups and no power calculations, or primary endpoints stated (6-9). Regular doses used were sildenafil 25-100mg nightly or 100mg three times a week. Erectile function was assessed using the International Index of Erectile Function (IIEF) and Sexual Encounter Profile (SEP) questions.</p> <p><i>IIEF scoring system</i>  1-7 = severe ED  8-11 = moderate ED  12-16 = mild to moderate ED  17-21 = mild ED</p>

Summarised details of the studies are in the following table:

Study authors, year of publication	Sample	Intervention and comparator	Duration of treatment	Outcome
Padma-Nathan et al., 2008 <sup>(4)</sup>	78 men Age not reported	Sildenafil 50mg or 100mg each night vs placebo	36 weeks beginning four weeks after surgery	Normalization of spontaneous erections: Placebo - 4% Sildenafil - 27%
McCullough et al., 2008 <sup>(10)</sup>	54 men (subset of Nathan et al) Age range: 38 to 67 years	Sildenafil 50mg or 100mg each night vs placebo	48 weeks beginning post-surgery	Percent responders: placebo – 5% sildenafil 50mg – 24% sildenafil 100mg – 33%

**Safety:**

PDE5 inhibitors have been in wide use for many years, and the side effects, precautions and contraindications are well known.

Prior to prescribing, clinicians should carefully consider whether their patients with certain underlying conditions (such as cardiac disease) could be adversely affected by the vasodilatory effects of PDE5 inhibitors, especially in combination with sexual activity. Patients with increased susceptibility to vasodilators include those with left ventricular outflow obstruction (e.g. aortic stenosis, hypertrophic obstructive cardiomyopathy), or those with the rare syndrome of multiple system atrophy manifesting as severely impaired autonomic control of blood pressure.

Serious cardiovascular events, including myocardial infarction, unstable angina, sudden cardiac death, ventricular arrhythmia, cerebrovascular haemorrhage, transient ischaemic attack, hypertension and hypotension have been reported post-marketing in temporal association with the use of sildenafil. Most, but not all, of these patients had pre-existing cardiovascular risk factors. Many events were reported to occur during or shortly after sexual intercourse and a few were reported to occur shortly after the use of a PDE5 inhibitor without sexual activity. It is not possible to determine whether these events are related directly to these factors or to other factors (2).

**Cost/resource impact:**

Generic sildenafil is significantly less expensive than other PDE5 inhibitors.

**Equity of access:**

This policy is only relevant to men who have undergone radical

	<p>prostatectomy and consequently require penile rehabilitation to improve erectile function.</p> <p>References:</p> <ol style="list-style-type: none"> <li>1. Rambhatla A, Kovanecz I, Ferrini M et al. Rationale for phosphodiesterase 5 inhibitor use post-radical prostatectomy: experimental and clinical review. <i>Int J Impot Res</i> 2008; 20:30-34.</li> <li>2. Summary of Product Characteristics for sildenafil <a href="https://www.medicines.org.uk/emc/">https://www.medicines.org.uk/emc/</a> Accessed 23.10.2018.</li> <li>3. Padma-Nathan H, McCullough AR, Levine LA et al. Randomized, double-blind, placebo-controlled study of postoperative nightly sildenafil citrate for the prevention of erectile dysfunction after bilateral nerve-sparing radical prostatectomy. <i>Int J Impot Res</i> 2008; 20:479-486.</li> <li>4. Treatment of impotence. Health Service Circular: HSC 1999/148. NHS Executive <a href="http://webarchive.nationalarchives.gov.uk/20121012055159/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012086.pdf">http://webarchive.nationalarchives.gov.uk/20121012055159/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012086.pdf</a>. Accessed 23.10.2018</li> <li>5. <a href="#">NICE CG175</a> Prostate cancer: diagnosis and treatment, Jan 2014. Accessed 23.10.2018</li> <li>6. Raina R, Lakin MM, Agarwal A et al. Long-term effect of sildenafil citrate on erectile dysfunction after radical prostatectomy: 3-year follow-up. <i>Urology</i> 2003; 62(1):110-115.</li> <li>7. Feng MI, Huang S, Kaptein J et al. Effect of sildenafil citrate on post-radical prostatectomy erectile dysfunction. <i>J Urol</i> 2000; 164:1935-1938.</li> <li>8. Lowentritt BH, Scardino PT, Miles BJ et al. Sildenafil citrate after radical retropubic prostatectomy. <i>J Urol</i> 1999; 162:1614-1617.</li> <li>9. Zippe CD, Jhaveri FM, Klein EA et al. Role of Viagra after radical prostatectomy. <i>Urology</i> 2000; 55:241-245.</li> <li>10. McCullough AR, Levine LA, Padma-Nathan H. Return of nocturnal erections and erectile function after bilateral nerve-sparing radical prostatectomy in men treated nightly with sildenafil citrate: subanalysis of a longitudinal randomized double-blind placebo-controlled trial. <i>J Sex Med.</i> 2008 Feb;5(2):476-84.</li> </ol>
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