NHS
Calderdale
Clinical Commissioning Group

Commissioning Policy

Treatment (brand name, manufacturer if applicable)	Lanreotide (Somatuline®, Ipsen Limited)
For the treatment of	Acromegaly & neuroendocrine tumours
Background	PbR excluded treatment Lanreotide is an octapeptide analogue of natural somatostatin. Like somatostatin, lanreotide is an inhibitor of various endocrine, neuroendocrine, exocrine and paracrine functions. Lanreotide has a high affinity for human somatostatin receptors (SSTR) 2 and 5 and a reduced binding affinity for human SSTR1, 3, and 4. Activity at human SSTR 2 and 5 is the primary mechanism believed responsible for GH inhibition. Lanreotide, like somatostatin, exhibits a general exocrine anti-secretory action. It inhibits the basal secretion of motilin, gastric inhibitory peptide and pancreatic polypeptide, but has no significant effect on fasting secretin or gastrin secretion. Lanreotide markedly inhibits meal-induced increases in superior mesenteric artery blood flow and portal venous blood flow. It also significantly reduces prostaglandin E1-stimulated jejunal secretion of water, sodium, potassium and chloride, and reduces prolactin levels in acromegalic patients treated long term. Lanreotide has a UK marketing authorisation for the treatment of; • Acromegaly when the circulating levels of growth hormone (GH) and/or Insulin-like Growth Factor-1 (IGF-1) remain abnormal after surgery and/or radiotherapy. • Thyrotrophic adenomas when the circulating level of thyroid stimulating hormone remains inappropriately high after surgery and/or radiotherapy. • Neuroendocrine tumours to relieve symptoms associated with neuroendocrine (particularly carcinoid) tumours.
Commissioning position	NHS Calderdale CCG ***routinely commissions*** Lanreotide only for the following conditions:: 1. Acromegaly when the circulating levels of growth hormone (GH) and/or Insulin-like Growth Factor-1 (IGF-1) remain abnormal after surgery and/or radiotherapy. 2. Neuroendocrine tumours to relieve symptoms associated with neuroendocrine tumours. (this includes carcinoid, VIPomas, glucagonoma, and carcinoid syndrome) 3. Lanreotide (depot) injection should only be considered for patients responding to and stabilised on subcutaneous octreotide, and who require injections more than once a day. In this situation octreotide **or** lanreotide depot injections may be considered. The treatment with the lowest acquisition cost should normally be used. When commencing treatment with the depot preparations, the subcutaneous octreotide should be continued after the first injection of depot until the depot injection becomes effective. Only clinicians with experience in managing these conditions should initiate and

	monitor treatment with lanreotide. Patients on long term treatment should be assessed at 3 months, and then six monthly thereafter. Growth-hormone secreting tumours can expand causing serious complications, patients receiving somatostatin analogues should be monitored for signs of tumour expansion. NHS Calderdale CCG does ***not routinely commission*** lanreotide for the treatment of thyrotrophic adenomas when the circulating level of thyroid stimulating hormone remains inappropriately high after surgery and/or radiotherapy, or for any other conditions not listed in points 1 and 2 above.
Effective from	01/10/2011
Summary of evidence/rationale	SMC guidance November 2006 (re use in thyrotrophic adenomas).
Date	September 2011
Policy to be reviewed by	September 2013
Contact for this policy	Helen Foster - Medicines Management Lead