SPECIALISED COMMISSIONING - CLINICAL EVIDENCE EVALUATION CRITERIA FOR A PROPOSITION FOR A CLINICAL COMMISSIONING POLICY FOR ROUTINE COMMISSIONING

URN: 1771
TITLE: Selective internal radiation therapy (SIRT) with yttrium-90 microspheres for unresectable primary intrahepatic cholangiocarcinoma who are chemotherapy-refractory or chemotherapy-intolerant

CRG: Cancer
NPOC: Radiotherapy
Lead: Nicola McCulloch
Date: 18/07/18

This policy is being considered for:	For routine commissioning		Not for routine commissioning	X
Is the population described in the policy the same as that in the evidence review including subgroups?	Yes. Panel were aware of the poor prognosis for patients with unresectable primary intrahepatic cholangiocarcinoma who are chemotherapy-refractory or chemotherapy-intolerant.			
Is the intervention described in the policy the same or similar as the intervention for which evidence is presented in the evidence review?	Yes. The Panel noted that the policy proposition considered the yttrium-90 microspheres made of glass or resin. It was noted that there may be more than one manufacturer of SIRT microspheres and that it is possible to use other radioactive isotopes. SIRT is defined as the use of microspheres containing a radioactive substance to deliver a targeted dose of radiation to a tumour in order to destroy it. The Panel agreed that it could not be certain that treatments using different radioisotopes with differing half lives and rates of decay could be considered equivalent i.e. that the effectiveness of holmium 166 based treatments could not be assumed solely on the basis of the evidence available for yttrium 90.			
Is the comparator in the policy the same as that in the evidence review? Are the comparators in the evidence review the most plausible comparators for patients in the English NHS and are they suitable for informing policy development?	The studies are uncontrolled and no comparative studies were identified. It was difficult to determine whether there was any significant effectiveness demonstrated by the intervention in comparison to best supportive care. Median overall survival was 8.7 months (95% CIs 5.3-12.1) and survival at 12 months following SIRT was 37%. Median progression-free survival was 2.8 months (95% CIs 2.6-3.1) and median liver-specific progression-free survival was 3.1 months (95% CIs 1.3-4.8).			
Are the clinical benefits demonstrated in the evidence review consistent with the eligible population and/or subgroups presented in	Clinical Panel noted the results of the Commissioning through Evaluation (CtE) Scheme which were conducted in real life NHS settings. The results were worse than those reported in the research studies. Three studies reported median overall survival of between 14 and 22 months. The CtE reported a median overall survival of 8.7 months. Quality of life was not			

the policy? Are the clinical harms demonstrated in the evidence review reflected in the eligible and /or ineligible population and/or subgroups presented in the policy?	measured in the studies and in the CtE quality of life benefit was demonstrated. Adverse events were not well reported in the studies. In the CtE we noted that there were significant harms associated with treatment. In the CtE one patient experienced severe harm. 49% of patients experienced an adverse event, of which 7% of the events were grade 3 and above (severe).		
Rationale Is the rationale clearly linked to the evidence?	The rationale for not routinely commissioning this intervention was clearly demonstrated by the research evidence and CtE.		
<u>Advice</u> The Panel should provide advice on matters relating to the evidence base and policy development and prioritisation. Advice may cover: • Uncertainty in the evidence base • Challenges in the clinical interpretation and applicability of policy in clinical practice • Challenges in ensuring policy is applied appropriately • Likely changes in the pathway of care and therapeutic advances that may result in the need for policy review.	Published research did not represent a convincing body of evidence on the benefits of the use of SIRT. The CtE demonstrated 'worse' outcomes than the reported studies and treatment was associated with significant toxicity including potentially serious treatment related adverse events. The Panel supported the not for routine commissioning positon given the lack of clearly demonstrated improvement in quality of life or survival and the potentially significant risk of adverse events.		
Overall conclusion	This is a proposition for routine commissioning and	Should proceed for routine commissioning	
		Should reversed and proceed as not for routine commissioning	
	This is a proposition for not routine commissioning and	Should proceed for not routine	

		commissioning	
		Should be reconsidered by the PWG	

Overall conclusions of the panel Report approved by:
David Black
Clinical Panel Chair
23/07/18

Post meeting note (March 2019): A revision to the section 'Is the intervention described in the policy the same or similar as the intervention for which evidence is presented in the evidence review?' was agreed by the Clinical Panel Chair to reflect the discussion by Panel.

The wording 'Panel considered that the model of action and effectiveness is likely to be very similar between radioisotopes and that the results for yttrium would be expected to be similar to results using other isotopes.' should be read 'The Panel agreed that it could not be certain that treatments using different radioisotopes with differing half lives and rates of decay could be considered equivalent i.e. that the effectiveness of holmium 166 based treatments could not be assumed solely on the basis of the evidence available for yttrium 90.' The above report has been amended.