NHS ENGLAND SPECIALISED SERVICES

CLINICAL PANEL REPORT

Date: 16 July 2025

Intervention: Lanreotide or octreotide as a monotherapy

Indication: symptomatic non-localised autosomal dominant polycystic liver disease (adults)

URN: 2422

Gateway: 2, Round 1

Programme: Internal Medicine

CRG: Hepatobiliary and Pancreas

Information provided to the Panel

Policy Proposition

Two Rapid Evidence Reviews

Evidence to Decision (EtD) Summary

Equalities and Health Inequalities (EHIA) Assessment

Patient Impact Assessment

Blueteq® Forms – Initiation form and continuation form for adults

Blueteq® Forms – Initiation form and continuation form for post-pubescent children

Policy Working Group (PWG) Appendix

CPAG Summary Report

Change of Policy Title Report

This Policy Proposition recommends the off-label use of lanreotide or octreotide as a monotherapy for symptomatic non-localised autosomal dominant polycystic liver disease (PLD) in adults. PLD is a rare genetic disease that exists in two forms, autosomal dominant polycystic kidney disease (ADPKD) or in isolation as autosomal dominant polycystic liver disease (ADPLD). It is characterised by the formation of multiple cysts that cause progressive liver enlargement. The majority of people with PLD are asymptomatic but those with symptoms may experience pain, gastric pressure symptoms, acid reflux, malnutrition and shortness of breath, as well as impaired quality of life. Current treatment for PLD is based upon this but little is offered for those with diffuse (non-dominant) PLD. Injectable lanreotide or octreotide aims to reduce total liver volume (TLV) growth rate and reduce symptom burden associated with PLD. There are approximately 250 patients that meet the inclusion criteria for this policy proposition in England.

Two evidence reviews were conducted by the National Institute for Health and Care Excellence (NICE) examining the clinical effectiveness, safety and cost effectiveness of lanreotide or octreotide compared with supportive treatment, each other or liver transplant.

No evidence was found comparing lanreotide and octreotide. No evidence was found comparing lanreotide or octreotide to liver transplantation. In those studies that had a comparator, it was either placebo or standard care. No cost effectiveness evidence was found.

The key critical outcome was reduction in liver volume, which is seen as a treatment success. Symptom control and quality of life were also critical outcomes. Imaging changes, patient adherence to treatment, the need for liver transplantation and renal function were important outcomes for decision making.

The evidence review examining lanreotide included five study papers. A meta-analysis of 2 randomised controlled trials (RCTs) provided high certainty evidence of a small but statistically significantly reduction in total liver volume with lanreotide when compared to placebo and standard of care. Although low certainty evidence from a RCT showed no difference in symptomatic control assessed using an unvalidated tool, very low certainty evidence from a prospective observational study showed that treatment with lanreotide improved control of various symptoms assessed using the disease-specific POLCA questionnaire. Moderate certainty evidence from one RCT showed no statistically significant difference in quality of life between lanreotide and standard care at 120 weeks.

The evidence review examining octreotide included four papers. A meta-analysis of 3 RCTs provided high certainty evidence of no statistically significant difference in total liver volume between octreotide and placebo. Low certainty evidence from 1 RCT also showed no statistically significant difference in symptom control or quality of life between octreotide and placebo, although very low certainty evidence from an extension study found that social functioning and mental health were improved following octreotide treatment at 36 months.

Panel members discussed moderate certainty evidence from 1 RCT indicating a potentially clinically significant reduction in the risk of kidney failure or doubling of serum creatinine with octreotide treatment compared with placebo. However, it was concluded that other treatment options are already available for this subgroup of patients with renal failure risk and hence that this benefit was insufficient to recommend octreotide given the paucity of evidence supporting the critical outcomes selected.

Panel members were informed that the PWG proposed routine commissioning of both lanreotide and octreotide in this Policy Proposition to enable two options rather than one to be available to patients that have exhausted all other available interventions. Further, lanreotide is injected subcutaneously, which might be considered to be a simpler form of self-administration, compared to octreotide which is administered intramuscularly.

There was an extensive discussion over the inclusion criteria, which includes patients "*who decline, are unsuitable for, or show incomplete response to, aspiration sclerotherapy, fenestration, surgical resection or transplantation OR are awaiting transplantation"*. Panel members considered the wording regarding transplantation was confusing as this proposed treatment is to delay the need for a transplantation.

EHIA – it was noted that this reflects that women are more likely to have symptomatic and more severe disease. No amendments requested.
PIA – no amendments requested.

Recommendation

Clinical Panel recommends that the proposition for lanreotide only should progress as a routine commissioning policy proposition. The amendments requested will be subject to Chair approval and checked with the Clinical Panel member who presented the item.

Why the panel made these recommendations

Panel members agreed that although the evidence base for this proposition is generally of very low certainty, there is stronger evidence on clinical benefit for lanreotide, particularly relating to reduced liver volume.

Documentation amendments required

General:

- Update the policy proposition and supporting documents based on the recommendation to progress for lanreotide only.

Policy Proposition:

- Amend the inclusion criteria to remove the reference to transplantation. The sentence should stop after 'surgical intervention'.

Declarations of Interest of Panel Members: Two declarations received. One member declared a commercial conflict of interest and another member declared a conflict of interest relating to clinical practice.

Panel Chair: Anthony Kessel, Deputy National Medical Director (Specialised Services)

Post Panel Amendments

Panel comment	Amendment	Page number (if applicable)
Policy proposition		
Amend the inclusion criteria to remove the reference to transplantation. The sentence should stop after 'surgical intervention'.	The PWG acknowledge this change and have removed the reference of transplantation from the inclusion criteria as well as changing the pathway.	Page 3: About lanreotide & Page 4: Inclusion criteria
N/A	To prevent duplication and improve the simplicity of the criteria, the PWG propose the removal of 'Patients with...' in the exclusion criteria	Page 5: Exclusion criteria
N/A	Update to definition of somatostatin analogues and simplified wording in the inclusion/exclusion criteria	Page 11: Definitions
N/A	To align with the Blueteq, the questionnaires have been added to the starting criteria	Page 5: Starting criteria
Blueteq/M4C		

N/A	To better communicate the change from baseline with the questionnaire scores, the continuation sheets now state 'Updated scores'	Page 2: Continuation sheet
General		
Update the policy proposition and supporting documents based on the recommendation to progress for lanreotide only.	The policies have been separated into two policies with a 'Not for routine commissioning' document developed for octreotide.	
N/A	Update to definition of somatostatin analogues	