Shared Care Guideline for Lanreotide & Octreotide Long Acting Injection in Acromegaly (GP Summary)

It is essential that a transfer of care only takes place with agreement of the GP and when sufficient information has been received. If the GP does not agree to share care they will inform the Consultant responsible for the patient's care

Basingstoke, Southampton & Winchester District Prescribing Committee

Specialist Contact Details	**Patient ID Label**
Name:_____	**Surname:**_____
Location:_____	**Forename:**_____
Date:_____	**NHS Number:**_____
Tel:_____	**Date of Birth:**_____

Indications	**Licensed : Acromegaly**
	• Prior to pituitary surgery
	  o Patients with severe symptoms secondary to growth hormone (GH) excess
	  o If risks associated with surgery may be reduced as a result of prior therapy eg in those with significant cardiomyopathy or hypertension where GH excess may be a contributing factor
	• Patients where surgical treatment is not being considered or where surgery has failed to result in adequate control of GH/IGF-1 levels
	
	(Note: NHS England is the commissioner responsible for use in gastro-enteropancreatic tumors. Use for this indication falls outside of this guidance)

Dose & response	**Lanreotide (Somatuline Autogel)** **Starting dose: 60-90mg every 28days by deep subcutaneous injection into superior, external quadrant of buttock, or outer thigh if self-administering.** May be adjusted up to 120mg (by specialist) according to biochemical and clinical response. **Octreotide (Sandostatin LAR)** **Starting dose: 20mg every 4 weeks by deep intramuscular injection into gluteal muscle.** May be adjusted between 10-30mg (by specialist) according to biochemical and clinical response. Choice of agent is usually governed by patient preference (subcutaneous vs IM administration), dose required, dose titration options, and cost. In some clinical circumstances, on the advice and under supervision of the specialist, it may be feasible to extend the frequency between injections beyond 28 days in patients with stable and well controlled disease.
GP Responsibilities	GPs will only be approached to share care once patients have been stabilised on a long acting formulation. • Provide patients with prescriptions for lanreotide or octreotide • Monitor patients' overall health and assist in ongoing monitoring of glycaemic status. • Inform specialist of abnormal results and relevant health concerns. • Oversee the administration of treatment by practice nurse. Training and advice on administration can be provided by the specialist endocrine nurse or Pharma company.
Monitoring Required in Primary Care	No specific biochemical monitoring is required by the GP. However, somatostatin analogues are known to cause impaired insulin and/or glucagon secretion and GPs should have an increased awareness of onset or worsening control of diabetes.
Contra-indications	• Known hypersensitivity to lanreotide, octreotide or related peptides

Date approved: April 2014
Review date: April 2016

Cautions	• **Pituitary Tumors** (GH secreting) - can expand causing serious complications. • **Insulinoma** - an increase in depth & duration of hypoglycaemia may occur • **Diabetes mellitus** – anti-diabetic therapy may require adjustment • **Pregnancy –** possible effect on fetal growth. Discuss risks and benefits with specialist and patient. • **Breastfeeding -** present in milk in animal studies. Avoid if possible. .
Adverse Effect Management	**Common** • **Gastrointestinal:** (30% patients) steatorrhoea, diarrhoea, abdominal pain, flatulence - often subside with continued therapy. • **Injection site reactions**: local pain and, rarely, swelling and rash; • **Gallstones:** 15-30% patients develop gallstones (usually asymptomatic) secondary to reduced gall bladder motility. Ultrasound scan should be considered if symptoms compatible with cholecystitis. • **Glycaemic Control:** (15% patients) glycaemic control may worsen in patients with pre-existing diabetes, necessitating adjustment of diabetes therapy**.** However, glycaemic control usually improves in patients with diabetes secondary to GH excess due to the greater effect of GH suppression on glucose levels. **Uncommon** • **Hypothyroidism:** somatostatin analogues have an inhibitory effect on TSH secretion and deiodinase activity. This is usually of no clinical significance, but there are rare reports of hypothyroidism. • **Hypoglycaemia:** Rarely reported in patients with insulinoma and type 1 diabetics may occasionally need reduction in insulin doses.
Drug Interactions	**Main interactions:** • **Beta blockers – Caution**. May have an additive effect on the slight reduction of heart rate associated with lanreotide. Dose adjustment may be necessary. • **Bromocriptine- Caution**. Octreotide increases plasma concentration of bromocriptine • **Carbamazepine- Caution.** Somatostatin analogues might decrease the metabolic clearance of compounds known to be metabolized by cytochrome P450 enzymes, which may be due to the suppression of growth hormone • **Ciclosporin**- **Caution**. Somatostatin analogues reduce plasma concentration of cliclosporin • **Digoxin- Caution**. Somatostatin analogs might decrease the metabolic clearance of compounds known to be metabolized by cytochrome P450 enzymes, which may be due to the suppression of growth hormone • **Warfarin- Caution.** Somatostatin analogs might decrease the metabolic clearance of compounds known to be metabolized by cytochrome P450 enzymes, which may be due to the suppression of growth hormone
Patient information links	**Lanreotide LA:** **http://www.medicines.org.uk/emc/medicine/25519/XPIL/Somatuline+Autogel+60mg%2c+Somatuline+Autogel+90mg%2c+Somatuline+Autogel+120mg+New+device/** **Octreotide LAR: http://www.medicines.org.uk/emc/medicine/4102/PIL/Sandostatin+LAR/**

This guidance should be read in conjunction with the BNF.

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