

TRIPTORELIN SR 11.25 mg in METASTATIC PROSTATE CANCER

This bulletin supersedes Postscript Extra No 8, June 2006

- **There is no conclusive evidence to suggest one GnRH analogue is more effective or has fewer adverse events than other analogues for the treatment of metastatic prostate cancer.**
- **On the basis of patient acceptability and cost triptorelin SR 11.25 mg is the first choice GnRH analogue in all new patients who present with metastatic disease.**
- **Triptorelin is administered using a smaller needle size compared to goserelin LA (21 gauge versus 14 gauge)**
- **Existing patients with metastatic prostate cancer who are currently prescribed other GnRH analogues can be switched to triptorelin at the discretion of the prescribing physician.**
- **Goserelin should continue to be recommended for patients with locally advanced disease or those in the adjuvant & neo-adjuvant settings.**

Introduction

Triptorelin SR (Decapeptyl® SR 11.25 mg) is a 3 monthly intramuscular depot gonadorelin (GnRH) analogue licensed for the treatment of advanced prostate cancer (and for the treatment of endometriosis).¹ In NHS Greater Glasgow and Clyde (NHSGGC) it is restricted to the treatment of advanced prostate cancer in patients for whom the use of triptorelin is appropriate and who would benefit from reduced frequency of administration.² Triptorelin SR 11.25 mg is currently the first choice GnRH analogue for the treatment of metastatic prostate cancer – this recommendation has been endorsed by the *Urological Cancer MCN* and the *Cancer Medicines Group*. Two other 3-monthly gonadorelin analogues are available in the NHSGGC *Formulary* for use in advanced prostate cancer: goserelin 10.8 mg (Zoladex® LA) and leuprorelin SR 11.25 mg (Prostap 3®).

Efficacy

Orchidectomy versus triptorelin

Prostate cancer is known to be associated with circulating testosterone. Before the availability of hormonal treatment aimed at androgen depletion, orchidectomy (surgical castration) was the treatment of choice. Clinical studies have shown that monthly triptorelin³⁻⁶ (and other GnRH analogues) are as effective as orchidectomy with regard to improvements in pain, urinary symptoms and survival rate.

Comparative trials against other GnRH analogues

Unfortunately, comparative trials with GnRH analogues are lacking. Three small short-term randomised studies of

varying design evaluated the efficacy of a monthly triptorelin preparation compared with monthly leuprorelin.⁷⁻⁹ These studies showed that both treatments were effective with no significant differences in clinical outcomes, such as pain, quality of life and urinary symptoms. One study demonstrated that triptorelin was associated with an improved 9-month survival rate compared to leuprorelin (97.0% vs. 90.5%, p=0.033);⁹ however, longer-term studies are required to determine the clinical relevance of this finding.

No comparative trials of triptorelin and goserelin have been published.

Monthly preparation (triptorelin 3 mg) versus the 3-monthly preparation (triptorelin 11.25 mg)

One study has shown that a single dose of triptorelin 11.25 mg achieved the same degree of testosterone suppression and time to castration as 3 doses of triptorelin 3 mg (each dose given 28 days apart).¹⁰ Full publication of this data, including follow-up over 9 months, is awaited.

It was therefore recognised that patients who required monthly triptorelin would benefit from reduced frequency of administration with the 3-monthly preparation.¹¹

Why is triptorelin the first choice in metastatic prostate cancer only?

The consensus among clinicians is that goserelin is currently the only GnRH analogue with robust data supporting its use in the adjuvant (as a preventive measure to reduce any cancer cells that may remain after surgery) and neo-adjuvant (used before surgery with the aim of shrinking the tumor) settings and in patients with non-metastatic disease. Goserelin will continue to be recommended for these patients.

Safety

Tolerability

The incidence of adverse effects of the GnRH analogues appears to be similar. Results of clinical trials have suggested that monthly triptorelin is similar to leuprorelin in terms of tolerability.⁷⁻⁹ No evidence was found to suggest that if patients are appropriately switched from one GnRH analogue to another that tumor “flare” will occur.

Please refer to individual agents’ SPCs for a detailed list of contra-indications, cautions and adverse effects [<http://emc.medicines.org.uk>].

Administration

Unlike goserelin, which is available as a pre-filled syringe for administration, triptorelin is presented as a dry-powder for reconstitution, the reconstitution solution is provided.

Instructions on how to prepare the injection are provided.

Triptorelin may be more acceptable for patients: it is administered via a much smaller sized needle compared with goserelin LA (21 gauge versus 14 gauge) and is an intramuscular injection ideally administered into the gluteal muscles rather than a subcutaneous injection into the anterior abdominal wall.

Place in Therapy

There is no conclusive evidence to suggest one GnRH analogue is more effective or has fewer adverse events than other analogues for the treatment of **metastatic prostate cancer**. On the basis of patient acceptability and cost triptorelin SR 11.25 mg is the first choice GnRH analogue for all new patients who present with metastatic disease. Existing patients with metastatic prostate cancer who are currently prescribed other GnRH analogues can be switched to triptorelin at the discretion of the prescribing physician (urologists agreed that GPs do not need to seek the advice of the initiating specialist when switching appropriate patients). Goserelin should continue to be recommended for patients with locally advanced disease or those in the adjuvant & neo-adjuvant settings.

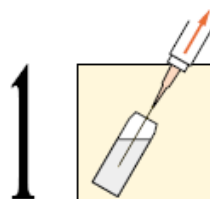
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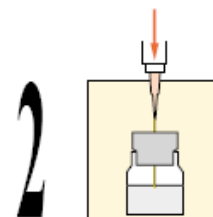
How to prepare the injection

Follow these instructions carefully.

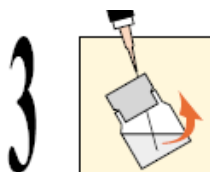
Aseptic technique should be observed during the suspension reconstitution.



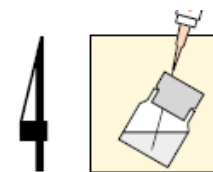
Only the provided vehicle ampoule (mannitol solution 0.8% for injection) should be used for the reconstitution. Draw up the suspension vehicle into the syringe with the **PINK** needle.



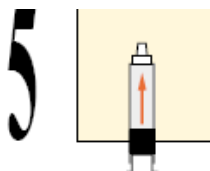
Transfer the suspension vehicle to the vial by inserting the needle through the stopper and **SLOWLY** INJECTING the suspension vehicle.



DO NOT REMOVE THE SYRINGE. Gently shake the contents of the vial from side to side, 20 to 30 times, until a milky homogeneous suspension is obtained.



DO NOT INVERT THE VIAL. This is important to ensure that most of the mixture is drawn up into the syringe. Draw up the mixture. A small amount will remain in the vial and should be discarded. An overage is included to allow for this loss.



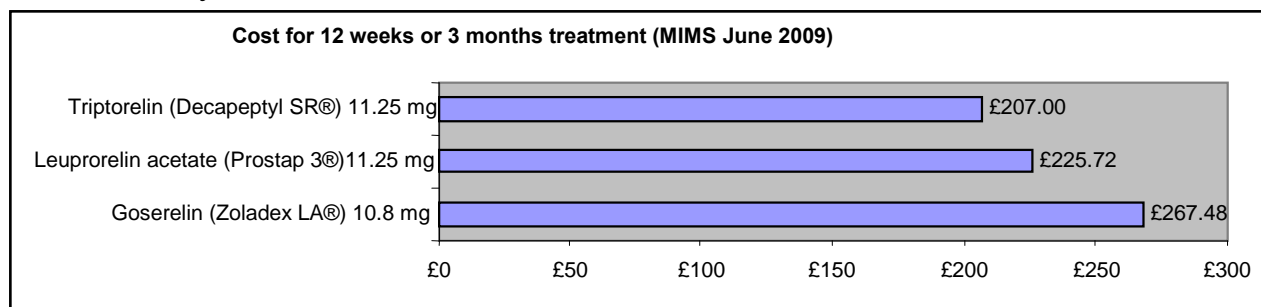
REPLACE THE **PINK** NEEDLE WITH THE **GREEN** NEEDLE.



Inject contents of the syringe **IMMEDIATELY**. The injection should be given intramuscularly at a **90 degree** angle to the skin (and not as shown), ideally in the gluteal muscles.

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How much do they cost?



NB: Doses shown are for general comparison only and do not imply therapeutic equivalence.