

Photodynamic therapy for bile duct cancer

Interventional procedures guidance

Published: 27 July 2005

[nice.org.uk/guidance/ipg134](https://www.nice.org.uk/guidance/ipg134)

Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

1 Guidance

- 1.1 Current evidence on the safety and efficacy of photodynamic therapy (PDT) for bile duct cancer does not appear adequate for this procedure to be used without special arrangements for consent and for audit or research.
- 1.2 Clinicians wishing to undertake PDT for bile duct cancer should take the following actions.

- Inform the clinical governance leads in their Trusts.
- Ensure that patients understand the uncertainty about the procedure's safety and efficacy and provide them with clear written information. Use of the Institute's [information for the public](#) is recommended.
- Audit and review clinical outcomes of all patients having PDT for bile duct cancer.

1.3 Publication of safety and efficacy outcomes will be useful. A randomised trial ([PHOTOSTENT 2](#)) is in progress and clinicians are encouraged to enter patients in this trial. The Institute may review the procedure upon publication of further evidence.

2 The procedure

2.1 *Indications*

2.1.1 Bile duct cancer may prevent bile flowing from the liver to the intestine. Early cancers are often asymptomatic, but as the disease advances patients may experience symptoms from biliary obstruction, such as jaundice, itchy skin, abdominal discomfort, loss of appetite, loss of weight and fever. PDT is a palliative treatment option for bile duct cancer.

2.1.2 Treatment options depend on the stage, size, position and type of tumour. Bile duct cancer is not usually diagnosed before the symptoms of biliary obstruction occur, by which time the cancer may be too advanced for curative surgical resection. Options for palliative treatment include surgical bypass of the bile duct or the insertion of a stent using surgical, endoscopic or percutaneous techniques. The benefits of other palliative treatments such as radiotherapy, chemotherapy and brachytherapy are still being investigated.

2.2 *Outline of the procedure*

2.2.1 PDT produces localised tissue necrosis. A photosensitising agent is applied that is absorbed into the tumour tissue. The area is then exposed to laser light of an appropriate wavelength.

2.2.2 PDT is usually administered in conjunction with a biliary stenting procedure. The photosensitising agent is injected intravenously and photoactivation is

performed approximately 48 hours later. A laser is inserted through a translucent endoscopic catheter situated close to the tumour, or it is placed directly across the tumour. Radiological control is used to ensure correct positioning of the laser fibre. Patients remain in subdued lighting for about 3 days after injection to avoid skin photosensitivity and are then gradually readapted to light. The treatment can be repeated.

2.3 *Efficacy*

- 2.3.1 A randomised controlled study of 39 patients reported that those treated with PDT and biliary stenting had a significantly longer median survival time than patients treated with biliary stenting alone (493 days versus 98 days, $p < 0.0001$). This study was terminated prematurely because PDT was so superior to stenting alone. Several quality-of-life scores were significantly improved after PDT, including global quality of life, fatigue, itching and weight loss. No significant improvements in quality-of-life scores were reported for the patients receiving biliary stenting alone. A non-randomised study of 44 patients reported that the mean survival after PDT and biliary stenting was 16 months, compared with 12.5 months after biliary stenting alone. For more details, refer to the Sources of evidence.
- 2.3.2 The Specialist Advisors considered that there is not yet enough data to draw clear conclusions about the effect of PDT on survival. One Specialist Advisor stated that this procedure is only effective for tumours that are in visual proximity to the light source.

2.4 *Safety*

- 2.4.1 The most common complications were cholangitis, affecting between 15% (3/20) and 56% (13/23) of patients, and photosensitivity, which was reported in 0% (0/8) to 33% (2/6) of patients. Other reported complications included bilioma, cholecystitis, stenosis and haemobilia. For more details, refer to the Sources of evidence.
- 2.4.2 The Specialist Advisors stated that potential adverse effects of the procedure include cholangitis, photosensitivity, stenosis of the biliary tree, biliary perforation, acute pancreatitis, bleeding and pain.

2.5 *Other comments*

- 2.5.1 It was noted that efficacy may depend on the particular photosensitising agent used.
- 2.5.2 The initial evidence suggests that PDT may be an efficacious palliative technique in patients with bile duct cancer.

Andrew Dillon
Chief Executive
July 2005

3 Further information

Sources of evidence

The evidence considered by the Interventional Procedures Advisory Committee is described in the following document.

['Interventional procedure overview of photodynamic therapy for bile duct cancer'](#), October 2004.

Information for patients

NICE has produced [information on this procedure for patients and carers](#). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

4 Changes since publication

The guidance was considered for reassessment in July 2008 and it was concluded that NICE will not be updating this guidance at this stage. However, if you believe there is new evidence which should warrant a review of our guidance, please [contact us](#).

23 January 2012: minor maintenance.

5 About this guidance

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions

are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedure guidance](#) process.

We have produced a [summary of this guidance for patients and carers](#). Information about the evidence it is based on is also [available](#).

Your responsibility

This guidance represents the views of NICE and was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

Copyright

© National Institute for Health and Clinical Excellence 2005. All rights reserved. NICE copyright material can be downloaded for private research and study, and may be reproduced for educational and not-for-profit purposes. No reproduction by or for commercial organisations, or for commercial purposes, is allowed without the written permission of NICE.

Contact NICE

National Institute for Health and Clinical Excellence
Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT

www.nice.org.uk

nice@nice.org.uk

0845 033 7780

Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.