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|---|---|
| **Indication** | Upper GI<br>Head and Neck: Malignant salivary gland tumours |
| **Treatment Intent** | Upper GI: Neo-Adjuvant, Peri-operative, Adjuvant, Palliative<br><br>Head and Neck: Palliative |
| **Frequency and number of cycles** | Every 21 days<br>Upper GI:<br>Neo-Adjuvant: 3 cycles<br>Peri-operative: 3 cycles pre surgery and 3 cycles post surgery<br>Adjuvant: 6 cycles<br>Palliative: 6-8 cycles<br><br>Head and Neck: Palliative 6 cycles |
| **Monitoring Parameters pre-treatment** | • ECG should be checked prior to cycle 1.<br>• EDTA should be used to measure GFR prior to cycle 1 or 2.<br>• C+G may be used to estimate CrCl if there is a delay in obtaining EDTA result. If CrCl <30ml/min stop platinum.<br>• Monitor LFTs and serum creatinine at each cycle.<br>• If CrCl <50ml/min dose reduce capecitabine (see SPC).<br>• If neuts 1.0-1.4 and PLT $\geq$100 d/w consultant. If neuts <1.0 or Plts <100 delay one week<br>• Dose reduction should be considered if grade 3 or 4 non-haematological toxicity or repeat appearance of grade 2 (except N&V and alopecia). Delay until resolution of toxicity to $\leq$ grade 1<br>• **DPD testing**: It is highly recommended that DPD testing is undertaken before starting treatment; the result must be checked before treatment is started.<br>• **Cardiotoxicity**: Caution in patients with prior history of coronary heart disease, arrhythmias and angina pectoris.<br>• Maximum recommended cumulative dose epirubicin 900mg/m2.<br>• **Skin reactions:** Capecitabine can induce severe skin reactions such as Stevens-Johnson syndrome and Toxic Epidermal Necrolysis. Patients should be informed of the possibility of such reactions and informed to seek urgent medical advice should any symptoms of a severe skin reaction occur. Treatment should be permanently discontinued in affected patients.<br>• **Drug interactions:** Capecitabine must not be given with concurrent sorivudine or derivatives (e.g brivudine), see SPC. Monitor PT and INR regularly in patients taking coumarin-derivative anticoagulants. Monitor phenytoin levels with concomitant use. Caution with folinic acid or folic acid – potential for increased toxicity. Avoid concomitant allopurinol. |
| **References** | SPCs for epirubicin and capecitabine accessed online 29/10/2018 KMCC SACT proforma UGI-003 v4 |

NB For funding information, refer to the SACT funding spreadsheet

**Repeat every 21 days**

| Day | Drug | Dose | Route | Infusion Duration | Administration |
|---|---|---|---|---|---|
| 1 | Dexamethasone | 8mg | PO | | |
| | Ondansetron | <75yrs 16mg<br>≥75yrs 8mg | IV | 15 min | Sodium Chloride 0.9% 50ml |
| | **EPIRUBICIN** | **50mg/m$^2$** | IV | Slow bolus | Through the side of a fast running Sodium Chloride 0.9% intravenous infusion |
| | **CARBOPLATIN** | **(AUC=5)**<br>**Dose = (GFR + 25) x AUC 5** | IV | 30 min | In Glucose 5% 500ml |
| TTO | Drug | Dose | Route | | Directions |
| | **CAPECITABINE** | **1250mg/m$^2$/day**<br><br>In 2 divided doses | PO | | **Continuous for 21 days**, take within 30 mins after food and approximately every 12 hours.<br>**available as 500mg & 150mg** |
| | Dexamethasone | 6mg | PO | | OM for 3 days |
| | Metoclopramide | 10mg | PO | | 3 times a day for 3 days, then 10mg up to 3 times a day when required.<br>Do not take for more than 5 days continuously. |