

<b>Indication</b>	<p><b>Colorectal cancer:</b> First line treatment for metastatic colorectal cancer in young, fit patients with PS0-1</p> <p><b>Rectal cancer:</b> For the treatment of rectal cancer in young fit patients with PS0-1</p>
<b>Treatment Intent</b>	<p>Palliative: colorectal cancer</p> <p>Neoadjuvant: rectal cancer</p>
<b>Frequency and number of cycles</b>	<p>Repeat every 14 days.</p> <p>Palliative: Continue until disease progression or unacceptable toxicity or patient choice to stop treatment.</p> <p>Neo-adjuvant: 6 cycles</p>
<b>Monitoring parameters</b>	<ul style="list-style-type: none"> <li>• <b>Virology screening:</b> All new patients referred for systemic anti-cancer treatment should be screened for hepatitis B and C and the result reviewed prior to the start of treatment. Patients not previously tested who are starting a new line of treatment, should also be screened for hepatitis B and C. Further virology screening will be performed following individual risk assessment and clinician discretion.</li> <li>• <b>ECG</b> prior to cycle 1.</li> <li>• <b>DPD testing:</b> DPD testing must be undertaken in all patients before starting treatment; the result must be checked before treatment is started.</li> <li>• Monitor FBC, LFTs and U&amp;Es at each cycle.</li> <li>• <b>Palliative:</b> If neuts <math>\geq 1.5</math> and / or PLTS <math>\geq 100</math> proceed with treatment, otherwise delay.</li> <li>• <b>Neo-Adjuvant</b></li> <li>• Neuts <math>&gt;1</math> and PLTS <math>&gt;75</math> proceed with treatment otherwise delay.</li> <li>• <b>Hepatic Impairment:</b> <ul style="list-style-type: none"> <li>○ <b>Fluorouracil:</b> In moderate hepatic impairment consider reducing the dose by 30% and for severe impairment by 50%. If the bilirubin is <math>&gt;85\mu\text{mol/L}</math> and / or AST <math>&gt;180</math> fluorouracil is contra-indicated.</li> <li>○ <b>Irinotecan:</b> Consider dose reduction if bilirubin <math>\geq 26\mu\text{mol/L}</math>. Bilirubin <math>&gt;51\mu\text{mol/L}</math> clinical decision.</li> </ul> </li> <li>• <b>Renal Impairment:</b> <ul style="list-style-type: none"> <li>○ <b>Oxaliplatin:</b> If CrCl <math>&lt;30\text{ml/min}</math> consider 50% of original dose.</li> <li>○ <b>Fluorouracil:</b> consider dose reduction in severe renal impairment.</li> </ul> </li> <li>• <b>Management of adverse reactions and dose adjustments:</b> <ul style="list-style-type: none"> <li>○ Dose reduction should be considered if any other grade 3 or 4 non-haematological toxicity or repeat appearance of grade 2 (except N&amp;V and alopecia). Delay until resolution of toxicity to <math>\leq</math> grade 1.</li> <li>○ Patients with persistent diarrhoea for <math>\geq 24\text{hrs}</math> should have an FBC and if neutropenic start a broad-spectrum antibiotic in line with Trust antibiotic policy.</li> <li>○ <b>OXALIPLATIN</b></li> <li>○ <b>For guidance on the assessment and management of oxaliplatin induced neuropathy see KMCC website:</b> <a href="https://www.kmcc.nhs.uk/medicines-and-prescribing-incorporating-sact-pathways/guidelines-for-the-management-of-sact-induced-adverse-reactions/">https://www.kmcc.nhs.uk/medicines-and-prescribing-incorporating-sact-pathways/guidelines-for-the-management-of-sact-induced-adverse-reactions/</a></li> <li>○ Symptoms of sensory or functional neuropathy may include tingling or numbness which may persist to the next pre-chemotherapy assessment.</li> <li>○ This guidance is for patients receiving treatment outside the context of a clinical trial. For patients being treated within a clinical trial setting, follow trial protocol. (using <i>KMCC guidance</i>)</li> </ul> </li> </ul>

Protocol No	COL-030	Kent and Medway SACT Protocol Disclaimer: No responsibility will be accepted for the accuracy of this information when used elsewhere.	
Version	V3	Written by	M. Archer
Supersedes version	V2	Checked by	C. Waters J. Sanders V2.4 approved at NOG with addition of GCSF
Date	05.05.2026	Authorising consultant (usually NOG Chair)	M. Durve and Colorectal NOG

	<p><i>on the assessment and management of oxaliplatin induced neuropathy as far as possible).</i></p> <ul style="list-style-type: none"> <li>○ Do not assess oxaliplatin induced neuropathy using CTC toxicity criteria.</li> <li>○ Dysaesthesia in the jaw is an unpleasant sensation and/or pain in the jaw.</li> <li>○ Laryngopharyngeal spasm is a sensation of difficulty in swallowing / breathing.</li> <li>○ Neurology referral should be considered in severe cases of oxaliplatin induced neuropathy.</li> <li>○ Dose reductions should be at a 25% level and if there is no improvement or worsening symptoms, based on an assessment of risk and benefit, consider further dose reduction. Once reduced, doses should not be re-escalated.</li> </ul> <ul style="list-style-type: none"> <li>• <b>Common drug interactions (for comprehensive list refer to BNF/SPC):</b> <ul style="list-style-type: none"> <li>○ <b>5FU:</b> 5FU must not be given with concurrent sorivudine or derivatives (e.g. brivudine), see SPC.</li> <li>○ Monitor PT and INR regularly in patients taking coumarin-derivative anticoagulants.</li> <li>○ Monitor phenytoin levels with concomitant use.</li> <li>○ Caution with folinic acid or folic acid – potential for increased toxicity.</li> <li>○ <b>Oxaliplatin:</b> Caution is advised when oxaliplatin treatment is co-administered with other medicinal products known to cause QT interval prolongation. In case of combination with such medicinal products, the QT interval should be closely monitored.</li> <li>○ Caution is advised when oxaliplatin treatment is administered concomitantly with other medicinal products known to be associated with rhabdomyolysis.</li> <li>○ <b>Irinotecan:</b> St. John's Wort should not be administered with irinotecan. Concurrent administration with strong inhibitors (e.g. ketoconazole, itraconazole, clarithromycin) or inducers (e.g. phenytoin, rifampicin, carbamazepine, phenobarbital) of cytochrome P450 3A4 (CYP3A4) may alter the metabolism of irinotecan and should be avoided.</li> </ul> </li> <li>• <b>Driving and machinery:</b> Patients should be warned about the potential for dizziness or visual disturbances which may occur within 24 hours following treatment, and advised not to drive or operate machinery if these symptoms occur.</li> </ul>
<b>Reference(s)</b>	KMCC protocol V2 NOG reviewed 10.02.26 neo-adjuvant bloods approved and add GCSF

NB For funding information, refer to CDF and NICE Drugs Funding List

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Repeat every 14 days

Day	Drug	Dose	Route	Infusion Duration	Administration Details	
<b>1</b>	Aprepitant	125mg	PO		Take one 125mg capsule <b>one hour prior to chemo</b> on Day 1	
	Ondansetron	<75yrs 16mg ≥75yrs 8mg	IV	15 min	Sodium chloride 0.9% 50ml	
	Dexamethasone	8mg	PO			
	<b>Flush with 5% glucose before and after oxaliplatin administration</b>					
	<b>OXALIPLATIN</b>	<b>85mg/m<sup>2</sup></b>	IV	2 - 6hrs	250-500ml 5% glucose (to give a concentration between 0.2 mg/ml and 0.70 mg/ml)	<b>Can be run concurrently</b>
	<b>CALCIUM FOLINATE (folinic acid)</b>	350mg	IV	2 hrs	Glucose 5% 250ml	
	Atropine	0.25mg	S/C	bolus	if required for acute cholinergic syndrome.	
<b>IRINOTECAN</b>	<b>165mg/m<sup>2</sup></b>	IV	60- 90 min	Sodium chloride 0.9% 250ml		
<b>1-2</b>	<b>5-FLUOROURACIL</b>	<b>3200mg/m<sup>2</sup>/over 48 hrs</b>	IV	<b>48 hr pump</b>	continuous infusion	
TTO	Drug	Dose	Route	Directions		
<b>Day 1</b>	Loperamide	2mg	PO	take 2 after first loose stool then one every 2 hrs for at least 12 hrs or until 12 hrs after last loose stool (for a maximum of 48 hrs)		
	Dioralyte Sachets	1 sachet	PO	after each loose motion		
	Dexamethasone	6mg	PO	OM for 3 days		
	Metoclopramide	10mg	PO	10mg TDS for 3 days, then 10mg up to 3 times a day as required. Do not take for more than 5 consecutive days		
	Aprepitant	80mg	PO	Take one 80mg capsule each morning on day 2 and day 3 only		
	Filgrastim	300 micrograms or consider dose of 480 micrograms if patient > 80kg	SC	OD starting on day 5 for 5 days		

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