Indication	Second line palliative treatment of oesophageal cancer (algorithm deviation) Palliative treatment of colorectal cancer.
Treatment Intent	Palliative
Frequency and number of cycles	14 day cycle Assess every 12 weeks

Monitoring Parameters pre-treatment	• ECG prior to cycle 1
	• **DPD testing:**
	It is highly recommended that DPD testing is undertaken before starting treatment; the result must be checked before treatment is started.
	• **Cardiotoxicity:** caution in patients with prior history of coronary heart disease, arrhythmias and angina pectoris.
	• At each cycle monitor FBC, LFT's & U&Es.
	• If neuts 1.0-1.4 and/ or Plts 75-100 d/w consultant.
	• If neuts <1.0 or PLT <75 defer 1 week.
	• Impaired **liver and renal function** d/w consultant
	  o Before starting treatment GFR (C+G) should be ≥ 50ml/min
	  o If CrCl <50ml/min dose reduce capecitabine (see SPC)
	  o Capecitabine is contraindicated if CrCl <30ml/min.
	• **Interrupt treatment** in the event of >/= grade 2 non-haematological toxicity (with the exception of side effects such as alopecia, alteration in taste etc, considered to be not serious) until resolution to grade 0-1.
	• **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 ≤ grade 1
	• Patients with **persistent diarrhoea** for ≥ 24hrs should have a FBC and if neutropenic start a broad spectrum antibiotic in line with Trust antibiotic policy.
	• **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.
	• **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	KMCC SACT proforma COL-014v4 and UGI-057v1

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

Repeat every 14 days

Day	Drug	Dose	Route	Infusion duration	Administration
1	Ondansetron	<75yrs 16mg ≥75yrs 8mg	IV	15 min	Sodium chloride 0.9% 50ml
	Dexamethasone	8mg	PO		
	Atropine	0.25mg	SC	bolus	If required for acute cholinergic syndrome.
	IRINOTECAN	**180mg/m²**	IV	30 min	In 250ml Sodium Chloride 0.9%
TTO	Drug	Dose	Route		Administration
	CAPECITABINE	**1600mg/m²/day** In 2 divided doses	PO		**for 9 days** (1st dose will be taken as the evening dose on day 1 and the last dose is taken the morning of day 10, followed by a 5 day rest period). Take within 30 mins after food and approximately every 12 hours
	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 as required. Do not take for more than 5 days continuously.
	Loperamide	2mg	PO		Take 2 capsules immediately then 1 capsule every 2 hours for at least 12 hours or until 12 hours after the last liquid stool (**max. 48 hours)**
	Dioralyte	1 sachet	PO		Take the contents of ONE sachet dissolved in 200mls of water after each loose stool

Protocol No	Multi-014	Kent and Medway SACT Protocol Disclaimer: No responsibility will be accepted for the accuracy of this information when used elsewhere.	
Version	V1	Written by	M.Archer
Supersedes version	Replaces UGI-057 v1 And COL-014 v4	Checked by	B.Willis E.Parry
Date	09/05/2019	Authorising consultant (usually NOG Chair)	T.Sevitt R.Raman