

Indication	Colorectal: • Neo-Adjuvant for non-metastatic disease. • Adjuvant use in Stage III and high-risk Stage II colon and rectal cancer. • First-line or subsequent use for metastatic colorectal cancer. Upper GI: • Peri-operative chemotherapy for adenocarcinoma of the oesophagus or Type 1, 2 or 3 gastro-oesophageal junction or gastric cancer. • 1st line palliative treatment for oesophageal cancer and type 1, 2 or 3 gastro-oesophageal junction or gastric cancer. • 2nd / 3rd line palliative treatment for pancreatic cancer. • 1st line palliative treatment for small bowel carcinoma.		
Treatment Intent	Adjuvant / Palliative / Peri-operative (UGI)		
Frequency and number of cycles	Repeat every 14 days Neo-Adjuvant (colorectal): 6 cycles Adjuvant (colorectal): 6 cycles for low risk and 12 cycles for high risk disease. Peri-operative (UGI): 4 cycles pre-operative and 4 cycles post-operative. Palliative: Colorectal continue until disease progression or unacceptable toxicity or patient choice to stop treatment. Review after 6 cycles. UGI • Oesophageal cancer and type 1, 2 or 3 gastro-oesophageal junction or gastric cancer or small bowel carcinoma 6 to 12 cycles or until disease progression or unacceptable toxicity or patient choice to stop treatment. • Pancreatic cancer continue until disease progression or unacceptable toxicity or patient choice to stop treatment. Review after 6 cycles. NB patients may have breaks from treatment where clinically appropriate.		
Monitoring Parameters pre-treatment	• Virology screening: 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. • DPD testing must be undertaken in all patients before starting treatment; the result must be checked before treatment is started. • ECG prior to cycle 1. • Cardiotoxicity: caution in patients with prior history of coronary heart disease, arrhythmias and angina pectoris. • Monitor FBC, LFTs and U&Es prior to treatment and every 2 weeks thereafter. • Haematological parameters: • Peri-operative (UGI), palliative and adjuvant: If neuts ≥ 1.5 and/ or PLTS ≥ 100 continue with treatment. • Neo-Adjuvant (Non-metastatic CRC): Neuts >1 and PLTS >75 proceed with treatment otherwise delay.		
Protocol No	MULTI-032	Kent and Medway SACT Protocol Disclaimer: No responsibility will be accepted for the accuracy of this information when used elsewhere.	
Version	V2	Written by	M.Archer
Supersedes version	V1	Checked by	C. Waters V2 B. Willis V1 V2 updated as per colorectal NOG
Date	04.11.2025	Authorising consultant (usually NOG Chair)	Colorectal NOG V2

	• Renal Impairment: ○ Oxaliplatin: No dose reduction needed if CrCl ≥ 30 ml/min. If CrCl < 30 ml/min d/w consultant. ○ Fluorouracil, consider dose reduction in severe impairment. • Hepatic Impairment: ○ Oxaliplatin- no dose adjustments recommended. ○ Fluorouracil - In moderate hepatic impairment consider reducing the dose by 30% and for severe impairment by 50%. If the bilirubin is > 85 μmol/L and / or AST > 180 fluorouracil is contra-indicated. • Dose Modification: ○ Refer to KMCC website for oxaliplatin induced neuropathy guidance https://www.kmcc.nhs.uk/medicines-and-prescribing-incorporating-sact-pathways/guidelines-for-the-management-of-sact-induced-adverse-reactions/ ○ Dose reduction should be considered if any other 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. • Common drug interactions (for comprehensive list refer to BNF/SPC): • 5FU ○ 5FU 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. • Oxaliplatin ○ Caution is advised when oxaliplatin is co-administered with other medicinal products known to cause QT interval prolongation. ○ Caution is advised when oxaliplatin treatment is administered concomitantly with other medicinal products known to be associated with rhabdomyolysis. • Driving: Oxaliplatin may cause dizziness, fatigue and nausea. Patients should be aware this may affect their ability to drive or operate machinery.
References	KMCC protocol MULTI-032 V1 Bloods agreed at CRC NOG February 2025

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
1	Dexamethasone	8mg	PO		
	Ondansetron	<75yrs 16mg ≥75yrs 8mg	IV	15min	Sodium chloride 0.9% 50ml
	FLUSH WITH 5 % GLUCOSE BEFORE AND AFTER ADMINISTRATION OF OXALIPLATIN				
	OXALIPLATIN	85mg/m²	IV	2- 6 hrs	250-500ml 5% glucose (to give a concentration between 0.2 mg/ml and 0.70 mg/ml) Can be run concurrently with Calcium Folate.
	CALCIUM FOLINATE (flat dose) (calcium leucovorin)	350mg	IV	2 hrs	Glucose 5% 250ml Can be run concurrently with oxaliplatin.
	5-FLUOROURACIL	400mg/m²	IV	slow bolus	Through a fast running Sodium chloride 0.9% intravenous infusion
	5-FLUOROURACIL	2400mg/m² over 46 hrs	IV	46 hr pump	Continuous infusion
TTO	Drug	Dose	Route	Directions	
Day 1	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 days continuously.	

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