Indication	Gastric, gastro-oesophageal and second line pancreatic and biliary cancer.
Treatment Intent	Palliative
Frequency and number of cycles	Repeat every 21 days Continue until disease progression, intolerance or patient choice.
Monitoring Parameters pre-treatment	• ECG prior to cycle 1. • If neuts 1.0-1.4 and/or Plts 75-100 d/w consultant. • If neuts <1.0 or PLT <75 defer 1 week. • At each cycle monitor FBC, U&Es & LFTs. • Before starting treatment GFR (C+G) should be >/= 50ml/min. • **Renal Impairment:** If CrCl <50ml/min dose reduce capecitabine (see SPC) and consider dose reduction of oxaliplatin. Capecitabine is contraindicated if CrCl <30ml/min. • **Hepatic Impairment:** no recommended dose adjustment in hepatic impairment. • **DPD testing:** • DPD testing must be undertaken in all patients 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. • **Dose Modification:** • Refer to section below and Table 1 for oxaliplatin induced neuropathy guidance. • **Interrupt capecitabine** 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 of toxicity to grade 0-1. Dose reduction should be considered if any 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)** o Capecitabine must not be given with concurrent sorivudine or derivatives (e.g. brivudine), see SPC. o Monitor PT and INR regularly in patients taking coumarin-derivative anticoagulants. o Monitor phenytoin levels with concomitant use. o Caution with folinic acid or folic acid – potential for increased toxicity. o Avoid concomitant allopurinol. • **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. • Capecitabine may cause dizziness, fatigue and nausea. Patients should be aware this may affect their ability to drive or operate machinery. • For oral self-administration: refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet and Macmillan information sheet
References	KMCC SACT proforma UGI-045 v3 SPC accessed online 02.11.21 BNF accessed online 02.11.21

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

Repeat every 21 days

Day	Drug	Dose	Route	Infusion Duration	Administration
1	Dexamethasone	8mg	PO		
	Ondansetron	<75yrs 16mg >/=75yrs 8mg	IV	15 min	NaCl 0.9% 50ml
	Flush with 5% glucose before and after administration of oxaliplatin				
	OXALIPLATIN	**130mg/ m²**	IV	2-6 hrs	250-500ml 5% glucose (to give a concentration between 0.2 mg/ml and 0.70 mg/ml)
TTO	Drug	Dose	Route	Directions	
	CAPECITABINE	**1250mg/m²/day** **In 2 divided doses**	PO	**For 21 days** (the 1st dose will be taken as the evening dose on day 1 and the last dose is taken the morning of day 22). Take within 30 minutes after food, and approximately every 12 hours. **Available as 150mg and 500mg tablets**	
	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.	

Introduction

- Use the neuropathy assessment tool on KOMS at each pre-chemo review.
- Symptoms of sensory or functional neuropathy may include tingling or numbness which may persist to the next pre-chemotherapy assessment.
- 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 assessment below as far as possible).
- Do not assess oxaliplatin induced neuropathy using CTC toxicity criteria.
- Dysaesthesia in the jaw is an unpleasant sensation and/or pain in the jaw.
- Laryngopharyngeal spasm is a sensation of difficulty in swallowing / breathing.

Normal occurrence / Caution	Symptoms	Action at nurse assessment	Consultant review required / Action by consultant
Normal occurrence with oxaliplatin	Dysaesthesia (tingling in hands and feet) occurring with and up to 72 hours after infusion	No action required.	
	Dysaesthesia in the jaw (during infusion) and cold induced laryngopharyngeal spasm up to 48 hrs after infusion.	Advise patients to avoid cold drinks / cold weather. Consider administering next oxaliplatin infusion over 6 hours (SmPC).	
First caution / warning sign	Tingling persisting beyond 72 hours or painful cold-induced neuropathy	d/w consultant or clinicians authorised to prescribe chemotherapy Close monitoring at each subsequent cycle. Ask the following specific questions at each nursing assessment: 1. Is the dysaesthesia (during the infusion) and / or cold induced laryngopharyngeal spasm more severe? 2. Has the tingling continued for longer than during the previous cycle and / or is tingling still present when next cycle is due?	1. If yes, consultant review required. For consideration of DR at next cycle or omission of oxaliplatin. 2. If yes, consultant review required, for consideration of DR at next cycle or omission of oxaliplatin
Serious caution	Numbness in hands or feet Severe excitability channel neuropathy during infusion (very rare) seen as severe pain and numbness on infusion Painful neuropathy	Must be reviewed by a consultant Must be reviewed by a consultant Must be reviewed by a consultant	Consider DR or omission of oxaliplatin. Repeat consultant review before next cycle Consider DR or omission of oxaliplatin. Repeat consultant review before next cycle Consider Duloxetine. Starting at 30mg-60mg OD where available on Trust formulary. Alternatively, d/w pain management specialist.
Other cautions	A cumulative dose of 700-800mg/m^2 oxaliplatin has been reached	Must be reviewed by a consultant	
	All patients restarting oxaliplatin based chemotherapy after a break in treatment (this may be due to an intervention such as rectal cancer patients having surgery)	Must be reviewed by a consultant to assess for delayed onset neuropathy	

Assessment and action

Notes

- Neurology referral should be considered in severe cases.
- Initial dose reductions should be at a 25% level. 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.