Kent and Medway Network
Transition Team – Cancer

Guidance on capping of BSA for the purposes of calculating cytotoxic chemotherapy

General caveat:

- A large body size is not necessarily due to obesity and therefore some clinical discretion in prescribing is necessary.
- Clinical discretion may be used dependent on individual circumstances and therapeutic intent, but where the decision deviates from the guidance below, this should be stated on the action sheet by the consultant.

NOG	Decision of whether to cap BSA at 2
Urology	Agreed to cap at 2 with the exception of testicular teratoma protocols where BSA should be capped at 2.2
Brain & CNS	Agreed to cap at 2 with no exceptions.
Colorectal	Agreed to cap at 2 with the exception of some adjuvant treatments where it should be left to the clinicians' discretion
Lung	Agreed to cap at 2
Upper GI	Agreed to cap at 2 but some patients may be left to clinicians' discretion.
Breast	All regimes will be capped at 2 (unless there is a request to the contrary on the action sheet) except for adjuvant chemotherapy. The exception for NOT capping in adjuvant treatment will be if the patient is morbidly obese.
Gynae	Agreed to cap at 2 with no exceptions
Head & Neck, Skin & Thyroid	For patients receiving curative treatment, the consensus is to routinely exceed a BSA of 2.This is probably important for both neo-adjuvant treatment and for concurrent chemoradiation treatment. It was agreed that a maximum BSA of 2.2 should be used for curative patients with the exception of TP/TPF patients who should be capped at 2.
Haematology	All palliative regimens i.e. any patient with a life expectancy of less than 6 months should be capped at 2. All regimens given with curative intent should NOT be capped at 2.

Collated from agreements made within NOG/HOG meetings during 12/13

Circulated and ratified by NOPG May 2013, NCG, February 2013 and NOGs/HOGs 2012/13