

DRUG NAME: Carboplatin**SYNONYM(S):** CBDCA, JM8, NSC 241240**COMMON TRADE NAME(S):** PARAPLATIN®, PARAPLATIN-AQ®**CLASSIFICATION:** Alkylating agent*Special pediatric considerations are noted when applicable, otherwise adult provisions apply.***MECHANISM OF ACTION:**

Carboplatin is an analog of cisplatin. Like cisplatin, it contains a platinum atom surrounded in a plane by two ammonia groups and two other ligands in the *cis* position. The other two ligands in carboplatin are present in a ring structure rather than as two chloride atoms in cisplatin. This difference makes carboplatin more stable and has less nephrotoxicity, neurotoxicity, ototoxicity and emetogenesis.^{1,2} The exact mechanism of action of carboplatin is not known. Carboplatin undergoes intracellular activation to form reactive platinum complexes which are believed to inhibit DNA synthesis by forming interstrand and intrastrand cross-linking of DNA molecules. Carboplatin is a radiation-sensitizing agent.^{3,4} It is cell cycle-phase nonspecific.²

PHARMACOKINETICS:

Interpatient variability	2- to 3-fold variability in AUC with BSA-based dosing. ^{5,6} Variability can be reduced with Calvert AUC-based dosing formula. ^{5,7}	
Oral Absorption	poorly absorbed; oral route not used clinically ⁸	
Intraperitoneal Absorption	peak plasma level within 2-4 h after intraperitoneal instillation with 65% of dose absorbed over 4 h of dwelling ^{2,9}	
Distribution	widely distributed, mostly in kidney, liver, skin, tumour tissue; also in erythrocytes	
	cross blood brain barrier?	yes
	volume of distribution ¹⁰	ultrafilterable platinum*: 17 ± 2 L/1.73 m ²
	plasma protein binding	carboplatin: minimal ^{2,11} platinum: 87%, ^{2,12}
Metabolism	undergoes intracellular hydrolysis to form reactive platinum complexes	
	active metabolite(s)	platinum complexes
	inactive metabolite(s)	no information found
Excretion	renal excretion via glomerular filtration; extensively removed by hemodialysis.	
	urine	71% within 24 h
	terminal half life	5.8 ± 1.6 days (total platinum*) ^{1,10} platinum elimination from erythrocytes: 12 days
	clearance	1.38 ± 0.36 L/h/1.73 m ² (total platinum*) ¹⁰
Gender	no information found	
Elderly	clearance may be reduced due to age-related renal function impairment ^{2,11}	
Children	similar to adults ^{6,13}	
Ethnicity	no information found	

Adapted from reference² unless specified otherwise.*Ultrafilterable platinum consists of carboplatin and free carboplatin metabolites; total platinum consists of protein bound and free platinum. Pharmacokinetics of ultrafilterable platinum is clinically more useful as only free platinum species are cytotoxic.²

USES:**Primary uses:**

Brain tumours¹¹
 Endometrial cancer¹¹
 Germ cell tumours¹¹
 Head and neck cancer^{2,11}
 *Ovarian cancer^{1,11}

Other uses:

Bladder cancer¹¹
 Breast cancer²
 Cervical cancer²
 Ewing's sarcoma⁵
 Leukemia, acute lymphocytic⁵
 Lung cancer, non-small cell^{2,11}
 Lung cancer, small cell^{2,11}
 Lymphoma, non-Hodgkin's¹⁴
 Melanoma¹¹
 Neuroblastoma^{2,5}
 Osteosarcoma^{5,15}
 Rhabdomyosarcoma⁵
 Retinoblastoma^{2,5}
 Testicular cancer^{2,11}
 Wilms' tumour²

*Health Canada Therapeutic Products Programme approved indication

SPECIAL PRECAUTIONS:

Contraindication: Manufacturer states that carboplatin is contraindicated in patients with known hypersensitivity to carboplatin, other platinum agents (eg, cisplatin) or mannitol.¹² However, with appropriate precautions, rechallenging with carboplatin or switching to cisplatin has been tolerated by some patients with hypersensitivity reactions to carboplatin.^{2,16,17}

Geriatrics: Incidence of peripheral neuropathy is increased and myelosuppression may be more severe in patients older than 65 years of age. In addition, elderly patients are more likely to have age-related renal function impairment, which may require dosage reduction and careful monitoring of blood counts.^{2,11}

Prior exposure to cisplatin: increases the risk and severity of toxicities (eg, myelosuppression, nausea, vomiting, peripheral neuropathy, ototoxicity).¹²

Carcinogenicity: has not been fully studied, but drugs with similar mechanisms of action and mutagenicity have been reported to be carcinogenic.¹²

Mutagenicity: mutagenic in both *in vitro* and *in vivo* studies.¹¹

Fertility: may cause gonadal suppression (amenorrhea, azoospermia) which is generally related to dose and length of therapy and may be irreversible.¹¹

Pregnancy: FDA Pregnancy Category D.¹¹ There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk (eg, if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective).

Breastfeeding is not recommended due to the potential secretion into breast milk.¹¹

SIDE EFFECTS:

The table includes adverse events that presented during drug treatment but may not necessarily have a causal relationship with the drug. Because clinical trials are conducted under very specific conditions, the adverse event rates observed may not reflect the rates observed in clinical practice. Adverse events are generally included if they were reported in more than 1% of patients in the product monograph or pivotal trials, and/or determined to be clinically important.

ORGAN SITE	SIDE EFFECT
Clinically important side effects are in <i>bold, italics</i>	
allergy/immunology	hypersensitivity (2-30%) ¹⁸⁻²⁰
auditory/hearing	ototoxicity (tinnitus, visual and taste disturbances) (1%)
blood/bone marrow febrile neutropenia	<i>anemia</i> (71%)
	<i>leukopenia</i> (severe 14%); nadir 21 days, recovery 30 days ¹¹
	<i>neutropenia</i> (severe 18%); nadir 21-28 days, recovery 35 days ¹¹
	<i>thrombocytopenia</i> (severe 25%); nadir 21 days, recovery 30 days ¹¹
constitutional symptoms	asthenia (8%)
dermatology/skin	<i>extravasation hazard: nonvesicant</i>
	alopecia (3%)
gastrointestinal	<i>emetogenic potential: high moderate</i>
	constipation (6%)
	diarrhea (6%)
	nausea (15%)
	vomiting (64%)
hepatic	elevated alkaline phosphatase (24%)
	elevated AST (15%)
	elevated bilirubin (5%)
infection	infections (4%)
metabolic/laboratory	hypocalcemia (22%)
	hypomagnesemia (29%)
	hypokalemia (20%)
	hyponatremia (29%)
	increased BUN (14%)
	increased uric acid (5%)
neurology	CNS symptoms (5%) ²
	peripheral neuropathy (4%)
ocular/visual	visual disturbances (rare) ²
pain	abdominal pain (17%)
renal/genitourinary	acute renal failure (rare) ²
	decreased creatinine clearance (27%)
	increased serum creatinine (6%)
syndromes	hemolytic-uremic syndrome (rare)

Adapted from reference¹² unless specified otherwise.

Myelosuppression is the dose-limiting toxicity, usually manifested as thrombocytopenia and less commonly as leukopenia, neutropenia and anemia. Risk factors include prior cytotoxic therapy (especially cisplatin), poor performance status, old age, impaired renal function and concurrent myelosuppressive therapy.^{2,12} Myelosuppression is dose dependent, closely related to the renal clearance of carboplatin, and minimized by using the Calvert AUC-based dosing formula.^{7,12} Anemia is more common with increased carboplatin exposure and blood transfusions may be needed during prolonged carboplatin therapy (eg, more than 6 cycles).²

Hypersensitivity has been reported in 2% of patients receiving carboplatin alone and in 9-30% patients receiving carboplatin with other cytotoxic drugs.¹⁸⁻²⁰ Reactions are similar to those seen with other platinum agents (eg, cisplatin) and include anaphylaxis and anaphylactoid reactions.² Symptoms may vary in severity and include pruritus, rash, palmar erythema, fever, chills, rigors, swelling (face, tongue, infusion arm), GI upset, dyspnea, wheezing, tachycardia, and hypertension or hypotension.^{16,19} Reactions can develop during or several hours to days after carboplatin administration. The risk of reactions increases with repeated exposure to platinum agents,^{18,19} particularly after 7 courses of carboplatin or receiving the second course of carboplatin after prior platinum therapy.^{16,19} The hypersensitivity appears to be mainly an IgE-mediated type I immediate reaction but may also involve direct histamine release. Some reactions may also be due to the mannitol present in some carboplatin formulations.² Management includes prompt treatment of anaphylaxis (see BCCA Hypersensitivity Guidelines) and oral diphenhydramine 25-50 mg every 4-6 hours for minor delayed reactions.¹⁹ In some cases, carboplatin therapy may be continued with prophylactic corticosteroid and antihistamine and/or desensitization.^{17,19}

Nausea and vomiting usually begin within 6-12 hours after administration and may persist up to 24 hours or longer. Acute vomiting appears to be mediated by local GI and central serotonin mechanisms and is most common in patients with prior emetogenic cytotoxic therapy or receiving concurrent emetogenic agents. The incidence and severity of vomiting may be reduced by prophylactic antiemetics. There is some evidence that the incidence of nausea and vomiting is reduced when carboplatin is given as a 24-hour continuous IV infusion or in divided doses over 5 consecutive days.²

Neurotoxicity such as peripheral sensory neuropathy (eg, paresthesia) is less frequent or severe than with cisplatin. Peripheral neuropathy is more common in patients over 65, receiving prolonged carboplatin therapy or with prior cisplatin therapy. Patients with pre-existing cisplatin-induced peripheral neurotoxicity generally do not worsen during carboplatin therapy.² Neurologic evaluations should be performed regularly.²¹

Nephrotoxicity: is less common or severe than with cisplatin; concomitant IV hydration and diuresis generally are not needed with carboplatin.^{1,2} The risk and severity of nephrotoxicity are increased with high dose carboplatin regimen, especially when given concurrently with other nephrotoxic chemotherapy.^{22,23}

INTERACTIONS:

AGENT	EFFECT	MECHANISM	MANAGEMENT
aminoglycosides (eg, amikacin, gentamycin, tobramycin) ²	increased risk of carboplatin nephrotoxicity and ototoxicity	additive	use with caution during concurrent therapy
phenytoin ^{24,25}	decreased serum phenytoin level	possibly decreased absorption or increased metabolism of phenytoin	monitor serum phenytoin level carefully during and after carboplatin therapy; adjust phenytoin dose as needed
warfarin ^{25,26}	increased anticoagulant effect of warfarin	unknown; possibly decreased protein binding or decreased metabolism of warfarin	monitor INR carefully during and after carboplatin therapy; adjust warfarin dose as needed

SUPPLY AND STORAGE:

Injection: Hospira Healthcare Corporation supplies carboplatin as 50 mg/5 mL, 150 mg/15 mL, 450 mg/45 mL, and 600 mg/60 mL single use (preservative free) vials in a concentration of 10 mg/mL. Store at room temperature. Protect from light.²⁷

For basic information on the current brand used at the BC Cancer Agency, see [Chemotherapy Preparation and Stability Chart](#) in Appendix.

SOLUTION PREPARATION AND COMPATIBILITY:

For basic information on the current brand used at the BC Cancer Agency, see [Chemotherapy Preparation and Stability Chart](#) in Appendix.

Additional information:

Compatibility: consult detailed reference

PARENTERAL ADMINISTRATION:

BCCA administration guideline noted in **bold, italics**

Subcutaneous	no information found
Intramuscular	no information found
Direct intravenous	no information found
Intermittent infusion	over 30 min; can also be given over 15-60 min ^{2,12}
Continuous infusion	over 24 h²
Intraperitoneal	infuse into abdominal cavity as rapidly as possible by gravity^{9,28,29}
Intrapleural	no information found
Intrathecal	no information found
Intra-arterial	investigational, 600 mg/m ² in NS 500 mL infused over 1 h ¹⁵
Intravesical	no information found

DOSAGE GUIDELINES:

Refer to protocol by which patient is being treated. Numerous dosing schedules exist and depend on disease, response and concomitant therapy. Guidelines for dosing also include consideration of absolute neutrophil count (ANC). Dosage may be reduced, delayed or discontinued in patients with bone marrow depression due to cytotoxic/radiation therapy or with other toxicities.

Adults:

BCCA usual dose noted in **bold, italics**

Intravenous: Cycle Length: 2-4 weeks: **AUC-based carboplatin dose IV for one dose on day 1**

Calculate carboplatin dose with Calvert formula:

$$\text{Dose (mg)} = \text{AUC} \times (\text{GFR} + 25)^{7,8,30}$$

where AUC = 4-7; GFR obtained from nuclear renogram (preferred) or approximated by CrCl calculated from serum creatinine using the Cockcroft-Gault formula³¹:

BCCA usual dose noted in **bold, italics**

Cycle Length:

$$\text{GFR (mL/min)} = \frac{\text{N} \times (140 - \text{Age}) \times \text{weight (kg)}}{\text{serum creatinine } (\mu\text{mol/L)}}$$

where N = 1.04 for females and 1.23 for males

Estimated GFR (reported by lab as eGFR) or calculated creatinine clearance (using Cockcroft Gault formula) should be **capped** at 125 mL/min when used to calculate the **initial** dose of carboplatin using the Calvert Formula (AUC(GFR+25)).³²

Note that the Cockcroft-Gault formula overpredicts CrCl in certain conditions (eg, muscle wasting, obesity, ascites). Lean or ideal body weight may be used to correct for excess fat or fluid.³³ Repeat renogram to modify dose if > 20% increase in serum creatinine during treatment.^{34,35}

Calvert AUC-based dosing formula is not recommended with GFR or CrCl < 20 mL/min.^{2,7}

3-4 weeks^{1,12}: 300 mg/m² (range 200-400 mg/m²) IV for one dose on day 1

Bone marrow transplant:

higher doses are used for tumour ablation prior to bone marrow transplant, e.g.,
266-666 mg/m²/day IV for 3 days;
200-500 mg/m²/day IV for 4 days;
175-400 mg/m²/day IV for 5 days^{22,36,37}

Concurrent with radiation:

investigational, 30 mg/m² IV once daily on days 1-5 in weeks 1-4 has been used as radiosensitizer³

Dosage in myelosuppression:

modify according to protocol by which patient is being treated; if no guidelines available, refer to Appendix 6 "Dosage Modification for Myelosuppression".

Dosage in renal failure:

adjustment required when BSA-based dosing (mg/m²) is used:

CrCl (mL/min)	Starting dose (mg/m ²)
> 60	no dose reduction
41-59	250
16-40	200
≤ 15	no information available

$$\text{CrCl (mL/min)} = \frac{\text{N} \times (140 - \text{Age}) \times \text{weight (kg)}}{\text{serum creatinine } (\mu\text{mol/L)}}$$

where N = 1.04 for females and 1.23 for males

adjust subsequent dose according to hematological toxicity to previous dose^{2,12}

BCCA usual dose noted in ***bold, italics***

<i>Dosage in hepatic failure:</i>	Cycle Length:	no adjustment required
<i>Dosage in dialysis:</i>	Hemodialysis:	Supplement with 50% of the dose after dialysis. ³⁸ In dialysis-dependent chronic renal failure, a fixed dose of 100 mg (previous platinum treatment) or 150 mg (no previous platinum treatment) may be used, with dialysis performed 24 h after carboplatin administration. ³⁹

Children:

<i>Intravenous:</i>	Cycle length:	
	3-4 weeks:	400 mg/m ² IV once daily for 2 consecutive days starting on day 1 (total dose per cycle 800 mg/m ²) ⁴⁰
	4 weeks ⁵ :	560 mg/m ² IV for one dose on day 1
	4 weeks:	80-216 mg/m ² IV once daily for 5 consecutive days starting on day 1 (total dose per cycle 400-1080 mg/m ²) ^{5,41}

Some investigators calculate carboplatin dose with modified Calvert formula: (GFR is obtained from nuclear renogram.^{40,42})

$$\text{Dose (mg)} = \text{AUC} \times \left[\frac{\text{GFR} \times \text{BSA}}{1.73} + (15 \times \text{BSA}) \right]$$

$$\text{where GFR in mL/min/1.73 and AUC}^{40,42} = 6-7$$

or

$$\text{Dose (mg)} = \text{AUC} \times \{ \text{GFR} + [0.36 \times \text{weight (kg)}] \}$$

$$\text{where AUC}^{6,43} = 2-7$$

<i>Bone marrow transplant:</i>	higher doses are used for tumour ablation prior to bone marrow transplant, eg, 100-800 mg/m ² /day IV for 3 days 250-300 mg/m ² /day IV for 4 days 250-350 mg/m ² /day IV for 5 days ⁵
--------------------------------	---

REFERENCES:

1. Go RS, Adjei AA. Review of the comparative pharmacology and clinical activity of cisplatin and carboplatin. *Journal of Clinical Oncology* 1999;17(1):409-22.
2. McEvoy GK, editor. AHFS 2000 Drug Information. Bethesda, Maryland: American Society of Health-System Pharmacists, Inc.; 2000.
3. Atagi S, Kawahara M, Ogawara M, et al. Phase II trial of daily low-dose carboplatin and thoracic radiotherapy in elderly patients with locally advanced non-small cell lung cancer. *Japanese Journal of Clinical Oncology* 2000;30(2):59-64.
4. Groen HJ, van der Leest AH, de Vries EG, et al. Continuous carboplatin infusion during 6 weeks' radiotherapy in locally inoperable non-small-cell lung cancer: a phase I and pharmacokinetic study. *British Journal of Cancer* 1995;72(4):992-7.
5. Gaynon PS. Carboplatin in pediatric malignancies. *Seminars in Oncology* 1994;21(5 Suppl 12):65-76.
6. Newell DR, Pearson AD, Balmanno K, et al. Carboplatin pharmacokinetics in children: the development of a pediatric dosing formula. The United Kingdom Children's Cancer Study Group. *Journal of Clinical Oncology* 1993;11(12):2314-23.
7. Calvert AH. Dose optimisation of carboplatin in adults. *Anticancer Research* 1994;14(6A):2273-8.

8. Duffull SB, Robinson BA. Clinical pharmacokinetics and dose optimisation of carboplatin. *Clinical Pharmacokinetics* 1997;33(3):161-83.
9. Elferink F, van der Vijgh WJ, Klein I, et al. Pharmacokinetics of carboplatin after intraperitoneal administration. *Cancer Chemotherapy and Pharmacology* 1988;21(1):57-60.
10. van der Vijgh WJ. Clinical pharmacokinetics of carboplatin. *Clinical Pharmacokinetics* 1991;21(4):242-61.
11. USP DI. Volume 1. Drug information for the health care professional. Update monographs. Carboplatin. Micromedex, Inc., Available at: www.micromedex.com, 25 July 2000.
12. Bristol-Myers Squibb. Paraplatin-aq product monograph. Montreal, Quebec; 9 March 1994.
13. Riccardi R, Riccardi A, Lasorella A, et al. Clinical pharmacokinetics of carboplatin in children. *Cancer Chemotherapy and Pharmacology* 1994;33(6):477-83.
14. Moskowitz CH, Bertino JR, Glassman JR, et al. Ifosfamide, carboplatin, and etoposide: a highly effective cytoreduction and peripheral-blood progenitor-cell mobilization regimen for transplant-eligible patients with non-Hodgkin's lymphoma. *Journal of Clinical Oncology* 1999;17(12):3776-85.
15. Petrilli AS, Kechichian R, Broniscer A, et al. Activity of intraarterial carboplatin as a single agent in the treatment of newly diagnosed extremity osteosarcoma. *Medical & Pediatric Oncology* 1999;33(2):71-5.
16. Weidmann B, Mulleneisen N, Bojko P, et al. Hypersensitivity reactions to carboplatin. Report of two patients, review of the literature, and discussion of diagnostic procedures and management. *Cancer* 1994;73(8):2218-22.
17. Broome CB, Schiff RI, Friedman HS. Successful desensitization to carboplatin in patients with systemic hypersensitivity reactions. *Medical & Pediatric Oncology* 1996;26(2):105-10.
18. Schiavetti A, Varrasso G, Maurizi P, et al. Hypersensitivity to carboplatin in children. *Medical & Pediatric Oncology* 1999;32(3):183-5.
19. Markman M, Kennedy A, Webster K, et al. Clinical features of hypersensitivity reactions to carboplatin. *Journal of Clinical Oncology* 1999;17(4):1141-1145.
20. Yu DY, Dahl GV, Shames RS, et al. Weekly dosing of carboplatin with vincristine increases risk of allergy in children with brain tumors. *Proc Am Soc Clin Oncol* 2000;19:abstract 2311-Proc Am Soc Clin Oncol 2000;abstract 2311.
21. Welbanks L, editor. *Compendium of Pharmaceutical Specialties*. 35th ed. Ottawa, Ontario: Canadian Pharmacists Association; 2000. p. 263-264, 1186-1187.
22. Grigg A, Szer J, Skov K, et al. Multi-organ dysfunction associated with high-dose carboplatin therapy prior to autologous transplantation [see comments]. *Bone Marrow Transplantation* 1996;17(1):67-74.
23. Beyer J, Rick O, Weinknecht S, et al. Nephrotoxicity after high-dose carboplatin, etoposide and ifosfamide in germ-cell tumors: incidence and implications for hematologic recovery and clinical outcome. *Bone Marrow Transplantation* 1997;20(10):813-9.
24. Dofferhoff AS, Berendsen HH, v.d. Naalt J, et al. Decreased phenytoin level after carboplatin treatment [letter]. *American Journal of Medicine* 1990;89(2):247-8.
25. Carboplatin. Drug interaction facts [book on CD-ROM]. St Louis, Missouri: Facts and Comparisons; January 2000.
26. Le AT, Hasson NK, Lum BL. Enhancement of warfarin response in a patient receiving etoposide and carboplatin chemotherapy. *Annals of Pharmacotherapy* 1997;31(9):1006-8.
27. Hospira Healthcare Corporation. CARBOPLATIN® injection product monograph. Saint-Laurent, Quebec; 1 June 2007.
28. BC Cancer Agency Gynecology Tumour Group. (GOOVIPPC) BCCA Protocol Summary for Primary Treatment of Stage III less than or equal to 1 cm Visible Residual Invasive Epithelial Ovarian Cancer or Stage I Grade 3 or Stage II Grade 3 Papillary Serous Ovarian Cancer Using Intravenous and Intraperitoneal Paclitaxel and Intraperitoneal Carboplatin. Vancouver, British Columbia: BC Cancer Agency; 1 June 2010.
29. Fujiwara K, Yamauchi H, Suzuki S, et al. Survival of patients with epithelial ovarian cancer after intraperitoneal carboplatin-based chemotherapy. *Proceedings of the American Society of Clinical Oncology* 2000;19:401a (abstract 1587).
30. de Lemos ML. Application of the area under the curve of carboplatin in predicting toxicity and efficacy. *Cancer Treatment Reviews* 1998;24(6):407-14.
31. B.C. Cancer Agency Head and Neck Tumour Group. BCCA protocol summary for in-house phase II pilot study using carboplatin with 24-hr 5-fluorouracil infusion (HNCARFU). Vancouver, British Columbia: BC Cancer Agency; 6 January 1998.
32. U.S. Food and Drug Administration, Center for Drug Evaluation and Research. Carboplatin dosing. Silver Spring, Maryland, USA; 08 October 2010.
33. Cockcroft D, Gault M. Prediction of creatinine clearance from serum creatinine. *Nephron* 1976;16:31-41.
34. B.C. Cancer Agency Gynecology Tumour Group. BCCA protocol summary for primary treatment of invasive epithelial ovarian, fallopian tube and primary peritoneal cancer, with no visible residual tumour (moderate-high risk) (GOOVICATM). Vancouver, British Columbia: BC Cancer Agency; 1 October 1999.
35. Tonda ME, Heideman RL, Petros WP, et al. Carboplatin pharmacokinetics in young children with brain tumors. *Cancer Chemotherapy and Pharmacology* 1996;38(5):395-400.
36. Wandt H, Birkmann J, Denzel T, et al. Sequential cycles of high-dose chemotherapy with dose escalation of carboplatin with or without paclitaxel supported by G-CSF mobilized peripheral blood progenitor cells: a phase I/II study in advanced ovarian cancer. *Bone Marrow Transplantation* 1999;23(8):763-70.
37. Leukemia/Bone Marrow Transplantation Program of British Columbia. Bone marrow transplant protocol for high-dose chemotherapy with autologous HSCT for high-risk nonseminomatous germ cell tumour (BMT 88-02). Vancouver, British Columbia: BC Cancer Agency; 22 February 2000.
38. Aronoff GR, Bennet WM, Bernes JS. *Drug prescribing in renal failure: dosing guidelines for adults*. 4th ed. Philadelphia, Pennsylvania: American College of Physicians; 1999.
39. Chatelut E, Rostaing L, V G, et al. Pharmacokinetics of carboplatin in a patient suffering from advanced ovarian carcinoma with hemodialysis-dependent renal insufficiency. *Nephron* 1994;66(2):157-61.

40. B.C. Children's Hospital. Children's Cancer Group (CCG) protocol. Vancouver, British Columbia: BC Children's Hospital; 16 June 2001.
41. Frappaz D, Michon J, Hartmann O, et al. Etoposide and carboplatin in neuroblastoma: a French Society of Pediatric Oncology phase II study. *Journal of Clinical Oncology* 1992;10(10):1592-601.
42. Mann JR, Raafat F, Robinson K, et al. The United Kingdom Children's Cancer Study Group's second germ cell tumor study: carboplatin, etoposide, and bleomycin are effective treatment for children with malignant extracranial germ cell tumors, with acceptable toxicity. *Journal of Clinical Oncology* 2000;18(22):3809-18.
43. Bin P, Boddy AV, English MW, et al. The comparative pharmacokinetics and pharmacodynamics of cisplatin and carboplatin in paediatric patients: a review. *Anticancer Research* 1994;14(6A):2279-83.