BCCA Protocol Summary for Curative Combined Modality Therapy for Carcinoma of the Anal Canal using CISplatin, Infusional Fluorouracil and Radiation Therapy

Protocol Code: GIFUPART

Tumour Group: Gastrointestinal

Contact Physician: GI Systemic Therapy

ELIGIBILITY:
- Squamous cell or Cloacogenic carcinoma of the anal canal
- T any, N any, M0
- At increased risk of hematologic toxicity from Mitomycin C, including known HIV infection
- ECOG performance status less than or equal to 2
- Adequate marrow reserve (ANC greater than or equal to 1.5 x 10^9/L, platelets greater than 100 x 10^9/L)
- Adequate renal (Creatinine less than or equal to 1.5 x ULN) and liver function (bilirubin less than or equal to 26 micromol/L; AST/Alkaline Phosphatase less than or equal to 5 x ULN)

EXCLUSIONS:
- Uncontrolled high blood pressure, unstable angina, symptomatic congestive heart failure, myocardial infarction within the preceding 6 months, serious uncontrolled cardiac dysrhythmia

TESTS:
- Baseline: CBC, diff and platelets, bilirubin, creatinine
- During chemotherapy treatment: CBC, diff and platelets, creatinine, electrolytes before chemotherapy Weeks 1 and 5
- During radiation therapy: CBC, Diff and platelets weekly
- For patients on warfarin, weekly INR during fluorouracil therapy until stable warfarin dose established, then INR prior to each cycle.

PREMEDICATIONS:
Treatment is high to moderately emetogenic. See SCNAUSEA protocol.
TREATMENT:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose/m²</th>
<th>BCCA Administration Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>CISplatin</td>
<td>60 mg/m² on Day 1 Week 1 &amp; Week 5</td>
<td>Prehydrate with 1000 mL NS over 1 hour, then give CISplatin IV in 500 mL NS with 20 mEq potassium chloride, 1g magnesium sulfate, 30 g mannitol over 1 hour</td>
</tr>
<tr>
<td>fluorouracil</td>
<td>1000 mg/m²/day for 4 days (Days 1-4 on Weeks 1 and 5) (total dose = 4000 mg/m² over 96 h)</td>
<td>IV in D5W to a total volume of 192 mL by continuous infusion at 2 mL/h via appropriate infusor device*</td>
</tr>
</tbody>
</table>

*Inpatients: 1000 mg/m²/day in 1000 mL D5W by continuous infusion daily over 24 h for 4 days

Patients with PICC lines should have a weekly assessment of the PICC site for evidence of infection or thrombosis.

<table>
<thead>
<tr>
<th>Week</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>1/2</td>
</tr>
<tr>
<td>Radiation therapy**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infusional fluorouracil</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Days 1-4</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>CISplatin</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td></td>
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</tr>
</tbody>
</table>

** Radiotherapy: 50.4Gy in 28 fractions (over 5 ½ weeks, no gap)

DOSE MODIFICATIONS:

1. Hematological

<table>
<thead>
<tr>
<th>ANC (x 10⁹/L)</th>
<th>Platelets (x 10⁹/L)</th>
<th>Dose (both drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than or equal to 1.5 and greater than 100 1-1.49 or 75-100  less than 1 or less than 75</td>
<td>100% 75% delay</td>
<td></td>
</tr>
</tbody>
</table>

2. Renal dysfunction

<table>
<thead>
<tr>
<th>Calculated Cr Clearance (mL/min) by Cockcroft/Gault formula</th>
<th>CISplatin dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than or equal to 60</td>
<td>100%</td>
</tr>
<tr>
<td>45-59</td>
<td>75%</td>
</tr>
<tr>
<td>less than 45</td>
<td>Hold CISplatin or delay with additional IV fluids</td>
</tr>
</tbody>
</table>

Cockcroft/Gault formula:

\[
\text{Estimated creatinine clearance:} = \frac{\text{N (140-age) wt (kg)}}{\text{Serum creatinine (micromol/L)}}
\]

N = 1.23 male
N = 1.04 female

3. Hepatic dysfunction: Omit fluorouracil if bilirubin greater than 85 micromol/L unless secondary to biliary obstruction (BCCA Cancer Drug Manual).
**PRECAUTIONS:**

1. **Neutropenia:** Fever or other evidence of infection must be assessed promptly and treated aggressively.

2. **Renal Toxicity:** Nephrotoxicity is common with CISplatin. Encourage oral hydration. Avoid nephrotoxic drugs such as aminoglycoside antibiotics.

3. **Ototoxicity** and **sensory neural damage** should be assessed by history prior to each cycle.

4. **Myocardial ischemia and angina occurs rarely in patients receiving fluorouracil or capecitabine.** Development of cardiac symptoms including signs suggestive of ischemia or of cardiac arrhythmia is an indication to discontinue treatment. If there is development of cardiac symptoms patients should have urgent cardiac assessment. Generally re-challenge with either fluorouracil or capecitabine is not recommended as symptoms potentially have a high likelihood of recurrence which can be severe or even fatal. Seeking opinion from cardiologists and oncologists with expert knowledge about fluorouracil / capecitabine toxicity is strongly advised under these circumstances. The toxicity should also be noted in the patient’s allergy profile.

5. **Diarrhea:** Patients should report mild diarrhea that persists over 24 hours or moderate diarrhea (4 stools or more per day above normal, or a moderate increase in ostomy output). Mild diarrhea can be treated with loperamide (eg. IMODIUM®) following the manufacturer’s directions or per the BCCA Guidelines for Management of Chemotherapy-Induced Diarrhea. Note that diarrhea may result in increased INR and the risk of bleeding in patients on warfarin.

6. **Dihydropyrimidine dehydrogenase (DPD) deficiency** may result in severe and unexpected toxicity to fluorouracil-stomatitis, diarrhea, neutropenia, neurotoxicity-secondary to reduced drug metabolism. This deficiency is thought to be present in about 3% of the population. Fluorouracil should be permanently discontinued in patients exhibiting exaggerated or prolonged neutropenia, mucositis, and diarrhea.

7. **Possible drug interaction with fluorouracil and warfarin** has been reported and may occur at any time. For patients on warfarin, weekly INR during fluorouracil therapy is recommended until a stable warfarin dose is established. Thereafter, INR prior to each cycle. Consultation to cardiology/internal medicine should be considered if difficulty in establishing a stable warfarin dose is encountered. Upon discontinuation of fluorouracil, repeat INR weekly for one month.

8. **Possible drug interaction with fluorouracil and phenytoin and fosphenytoin** has been reported and may occur at any time. Close monitoring is recommended. Fluorouracil may increase the serum concentration of these two agents.
Call the GI Systemic Therapy physician at your regional cancer centre or Dr. JP McGhie at (250) 519-5500 or 1-800-670-3322 with any problems or questions regarding this treatment program.

Date activated: February 1, 2009
Date revised: 1 Nov 2015 (addition of Diarrhea Precaution)

REFERENCES: