BC Cancer Protocol Summary for Primary Treatment of Invasive Epithelial Ovarian, Fallopian Tube and Primary Peritoneal Cancer, with No Visible Residual Tumour (Moderate-High Risk) using CARBOplatin and DOCEtaxel

**Protocol Code:** GOOVCADM

**Tumour Group:** Gynecology

**Contact Physician:** Dr. Anna Tinker

**Contact Pharmacist:** Winnie Cheng

**ELIGIBILITY:**
- invasive epithelial ovarian, fallopian tube and primary peritoneal cancer, with no visible residual tumour
- FIGO Ia: Grade 2 or 3
- FIGO Ib: Grade 2 or 3
- FIGO Ic, II, or III: any Grade

**Note:** The GOOVCATM and GOOVCADM regimens are alternatives. The clinician’s selection should be based upon the patient’s circumstances. The DOCEtaxel-containing combination produces more neutropenic complications, diarrhea, edema and hypersensitivity; the PACLItaxel-containing combination produces more peripheral neurotoxicity, arthralgia, myalgia, and alopecia. A maximum of 6 cycles* of taxane treatment will be reimbursed for each line of therapy. However, a patient who had previously responded to 6 cycles* of say, a PACLItaxel-based regimen may be retreated with another 6 cycles* of a taxane-based regimen.

* may extend to 9 cycles if the patient has not achieved a complete response but is continuing to improve

**EXCLUSIONS:**
- visible residual tumour

**RELATIVE CONTRAINDICATIONS:**
- relative contraindications to radiotherapy: adhesions, vasculitis, inflammatory bowel disease (contact radiation oncologist to discuss)
- as GOOVCADM may be more myelotoxic than GOOVCATM, the latter may be preferred pre-radiotherapy.

**TESTS:**
- Baseline: CBC & diff, platelets, creatinine, tumour marker (CA 125, CA 15-3, CA 19-9), LFT’s, chest X-ray, abdominopelvic imaging, camera nuclear renogram for GFR (if available)
- Day 7 and 14 after first cycle (and in subsequent cycle if dose modification made): CBC & diff; once nadir pattern established, check CBC & diff at that point only
- Before each treatment: CBC & diff, creatinine, any initially elevated tumour marker; if clinically indicated: LFT’s.

**PREMEDICATIONS AND ANTIEMETIC THERAPY:**
- dexamethasone 8 mg PO BID for 3 days, starting one day prior to each DOCEtaxel administration; patient must receive minimum of three doses pre-treatment
- ondansetron 8 mg PO 30 minutes pre-CARBOplatin
- dimenhydrINATE 50 to 100 mg PO pm after treatment
DOCEtaxel-induced onycholysis and cutaneous toxicity of the hands may be prevented by wearing frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing to ensure they remain cold during the entire DOCEtaxel infusion.

**SYSTEMIC TREATMENT (give DOCEtaxel first):**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting Dose</th>
<th>BC Cancer Administration Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCEtaxel</td>
<td>75 mg/m² *</td>
<td>IV in 250 mL** NS or D5W over 1 hour (see Precaution #2) Use non-DEHP equipment</td>
</tr>
<tr>
<td>CARBOplatin</td>
<td>Dose = AUC*** x (GFR +25)</td>
<td>IV in 250 mL NS over 30 minutes</td>
</tr>
</tbody>
</table>

* Use 60 mg/m² if patient has a history of neutropenic complications following chemotherapy or prior extended field radiotherapy. In patients greater than 75 years of age, begin at 60 mg/m², with subsequent escalation to 75 mg/m² if tolerated.

** If dose is 75 to 185 mg, use 250 mL dilution. If greater than 185 mg, use 500 mL dilution.

*** use AUC of 5. If patient has received extensive prior radiation therapy, use AUC of 4

Measured GFR (e.g. nuclear renogram) is preferred whenever feasible, particularly in circumstances of co-morbidity that could affect renal function (third-space fluid accumulations, hypoproteinemia, potentially inadequate fluid intake, etc.). The lab reported GFR (MDRD formula) may be used as an alternative to the Cockcroft-Gault estimate of GFR; the estimated GFR reported by the lab or calculated using the Cockcroft-Gault equation should be capped at 125 mL/min when it is used to calculate the initial CARBOplatin dose. When a nuclear renogram is available, this clearance would take precedence.

Cockcroft-Gault Formula

\[
GFR = \frac{1.04 \times (140 - \text{age in years}) \times \text{wt (kg)}}{\text{serum creatinine (micromol/L)}}
\]

Note: The same method of estimation should be used throughout the treatment course (i.e. if lab reported GFR was used initially, this should be used for dosing in all subsequent cycles and not the Cockcroft-Gault estimate).

Repeat every 21 days* for:

- 3 cycles, followed in 3 to 4 weeks by abdominopelvic irradiation (see "Radiation Treatment" section below). May extend to 9 cycles if the patient has not achieved a complete response but is continuing to respond.

*If a delay due to hematologic recovery has occurred, extend all future cycles to 28 day intervals.
RADIATION TREATMENT:
 3 to 4 weeks after 3rd cycle of systemic treatment
 relative contraindications to radiotherapy: adhesions, vasculitis, inflammatory bowel disease (contact radiation oncologist to discuss)
 2250 in 10# to pelvis
 2250 in 22# to whole abdomen

DOSE MODIFICATIONS:
1. Hematology:
   a) on treatment day if patient has never had neutropenic sepsis on DOCEtaxel:

<table>
<thead>
<tr>
<th>ANC (x 10^9/L)</th>
<th>Platelets (x 10^9/L)</th>
<th>Doses (both drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than or equal to 1.5 and greater than or equal to 100</td>
<td>treat as per nadir</td>
<td></td>
</tr>
<tr>
<td>1.0 to less than 1.5 and greater than or equal to 100</td>
<td>DOCEtaxel 60 mg/m²; CARBOplatin per nadir counts</td>
<td></td>
</tr>
<tr>
<td>less than 1.0 or less than 100</td>
<td>delay until recovery</td>
<td></td>
</tr>
</tbody>
</table>

   b) on treatment day if patient has had neutropenic sepsis on DOCEtaxel:

<table>
<thead>
<tr>
<th>ANC (x 10^9/L)</th>
<th>Platelets (x 10^9/L)</th>
<th>Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than or equal to 1.5 and greater than or equal to 100</td>
<td>DOCEtaxel 60 mg/m²; CARBOplatin per nadir counts</td>
<td></td>
</tr>
<tr>
<td>1.0 to less than 1.5 and greater than or equal to 100</td>
<td>DOCEtaxel 60 mg/m²; CARBOplatin per nadir counts</td>
<td></td>
</tr>
<tr>
<td>less than 1.0 or less than 100</td>
<td>Delay until recovery</td>
<td></td>
</tr>
</tbody>
</table>

   c) at nadir:

<table>
<thead>
<tr>
<th>ANC (x 10^9/L)</th>
<th>Platelets (x 10^9/L)</th>
<th>DOCEtaxel</th>
<th>CARBOplatin</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than or equal to 0.5 and greater than or equal to 75</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>less than 0.5 and less than or equal to 75</td>
<td>80%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>less than 0.5 and greater than or equal to 75</td>
<td>80%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>greater than or equal to 0.5 and less than or equal to 75</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>febrile neutropenia at any time</td>
<td>75%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

As noted above, if a delay due to hematologic recovery has occurred, extend all future cycles to 28 day intervals.

BC Cancer Protocol Summary GOOVADM
Activated: 1 Aug 2003 Revised: 1 May 2019 (remove carboplatin escalation)
Warning: The information contained in these documents is a statement of consensus of BC Cancer professionals regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult these documents is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient’s care or treatment. Use of these documents is at your own risk and is subject to BC Cancer’s terms of use available at www.bccancer.bc.ca/legal.htm
2. **Renal dysfunction**: If significant increase (greater than 20%) in creatinine, repeat nuclear renogram (if available) and recalculate CARBOplatin dose using new GFR.

3. **Hepatic dysfunction**:

<table>
<thead>
<tr>
<th>Alkaline Phosphatase</th>
<th>AST +/or ALT</th>
<th>DOCEtaxel Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 2.5 x ULN</td>
<td>and less than or equal to 1.5 x ULN</td>
<td>100%</td>
</tr>
<tr>
<td>2.5 to 5 x ULN</td>
<td>1.6 to 6 x ULN</td>
<td>60 mg/m²</td>
</tr>
<tr>
<td>greater than 5 x ULN</td>
<td>or greater than 5 ULN</td>
<td>discuss with contact physician</td>
</tr>
</tbody>
</table>

ULN= Upper limit of normal range

**PRECAUTIONS**:

1. **Fluid Retention**: Dexamethasone premedication must be given to reduce incidence and severity of fluid retention.

2. **Hypersensitivity** reactions to DOCEtaxel are common but it is not necessary to routinely initiate the infusion slowly. If slow initiation of infusion is needed, start infusion at 30 mL/h x 5 minutes, then 60 mL/h x 5 minutes, then 120 mL/h x 5 minutes, then complete infusion at 250 mL/h (for 500 mL bag, continue 250 mL/h for 5 minutes and then complete infusion at 500 mL/h). Refer to BC Cancer Hypersensitivity Guidelines.

3. **Extravasation**: DOCEtaxel causes pain and may cause tissue necrosis if extravasated. Refer to BC Cancer Extravasation Guidelines.

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

5. **Hepatic Dysfunction**: DOCEtaxel undergoes hepatic metabolism. Hepatic dysfunction (particularly elevated AST) may lead to increased toxicity and usually requires a dose reduction. Baseline liver enzymes are recommended before Cycle 1 and then if clinically indicated (e.g. – repeat liver enzymes prior to each treatment if liver enzymes are elevated, liver metastases are present or there is severe toxicity such as neutropenia). If liver enzymes are normal and there is no evidence of liver metastases or severe toxicity, check liver enzymes after three cycles (i.e. – at Cycle 4). Note: this information is intended to provide guidance, but physicians must use their clinical judgement when making decisions regarding monitoring and dose adjustments.

Call Dr. Anna Tinker or tumour group delegate at (604) 877-6000 or 1-800-663-3333 with any problems or questions regarding this treatment program.

**References**