BC Cancer Protocol Summary for Treatment of Recurrent or Metastatic Squamous Cell Cancer of the Head and Neck with Capecitabine

Protocol Code	*HNAVCAP*
Tumour Group	*Head and Neck*
Contact Physician	*Dr. Cheryl Ho*

ELIGIBILITY:

BC Cancer protocol summary for treatment of recurrent or metastatic squamous cell cancer of the head and neck, including primary unknown, with capecitabine

- Recurrent or metastatic squamous cell cancer of the head and neck, including primary unknown
- ECOG performance status 0-2
- expected survival greater than 3 months
- patient must be able to report any severe toxicity such as diarrhea, hand/foot syndrome, severe nausea, stomatitis

EXCLUSIONS:

- severe renal impairment (calculated creatinine clearance less than 30 mL/min, see Cockcroft-Gault equation under **DOSE MODIFICATIONS**)
- progression while on fluorouracil
- suspected dihydropyrimidine dehydrogenase (DPD) deficiency (see **PRECAUTIONS**)

CAUTIONS:

- severe hepatic dysfunction (total bilirubin greater than 50 micromol/L)

TESTS:

- Baseline: CBC & diff, platelets, liver function tests (bilirubin, ALT, alkaline phosphatase), and creatinine
- Prior to each cycle: CBC & diff, platelets, creatinine
- If clinically indicated: liver function tests (bilirubin, ALT, alkaline phosphatase), BUN
- Consider weekly nursing assessment for capecitabine toxicity in first two cycles and when increasing capecitabine dose.

PREMEDICATIONS:

- not usually require; antiemetic protocol for moderately emetogenic chemotherapy (see SCNAUSEA)

TREATMENT:

Drug	Dose*	BC Cancer Administration Guideline
capecitabine	1000 to 1250 mg/m^2 BID x 14 days (d 1 to 14) (Total daily dose = 2000 to 2500 mg/m^2/day)	PO

*Starting dose of 1000 mg/m^2 bid recommended for elderly, poor performance status or extensively pretreated. Capecitabine is available as 150 mg and 500 mg tablets (refer to Capecitabine Suggested Tablet Combination Table for dose rounding).

Repeat every 21 days x 6 to 8 cycles. Responding patient may be continued on treatment at the discretion of the treating physician. Discontinue if no response after 2 cycles or unacceptable toxicity.

DOSE MODIFICATIONS:

1. Hematological

ANC (x10^9/L)		Platelets (x10^9/L)	1st Event Dose	2nd Event Dose	3rd Event Dose	4th Event Dose
greater than or equal to 1.5	and	greater than or equal to 75	100%	100%	100%	100%
1.0 to less than 1.5	or	50 to less than 75	delay* then 100%	delay* then 75%	delay* then 50%	discontinue
0.5 to less than 1.0	or	25 to less than 50	delay* then 75%	delay* then 50%	discontinue	discontinue
less than 0.5	or	less than 25	discontinue or delay* then 50%	discontinue	discontinue	discontinue

*delay until ANC greater than or equal to 1.5 x 10^9/L and platelets greater than or equal to 75 x 10^9/L

2. Hand-Foot Skin Reaction

- if treatment is interrupted due to toxicity, retain the original stop and start dates (ie, do not make up for missed doses when treatment is resumed)

Grade	Hand-Foot Skin Reaction	1st Event Dose	2nd Event Dose	3rd Event Dose	4th Event Dose
1	Skin changes with discomfort (eg, numbness, dysesthesia, paresthesia, tingling, erythema) not disrupting normal activities	100%	100%	100%	100%
2	Skin changes with pain (eg, erythema, swelling) affecting activities of daily living	delay* then 100%	delay* then 75%	delay* then 50%	discontinue
3	Severe skin changes with pain (eg, moist desquamation, ulceration, blistering) causing severe discomfort and inability to work or perform activities of daily living	delay* then 75%	discontinue or delay* then 50%	discontinue	discontinue

*stop treatment immediately and delay until resolved to grade 0 to 1

3. Other Non-Hematological Toxicity

- see next table for toxicity grading criteria for diarrhea, nausea and vomiting, and stomatitis
- if treatment is interrupted due to toxicity, retain the original stop and start dates (ie, do not make up for missed doses when treatment is resumed)

Toxicity Grade	1st Event Dose	2nd Event Dose	3rd Event Dose	4th Event Dose
0 to 1	100%	100%	100%	100%
2	delay* then 100%	delay* then 75%	delay* then 50%	discontinue
3	delay* then 75%	delay* then 50%	discontinue	discontinue
4	discontinue or delay* then 50%	discontinue	discontinue	discontinue

*stop treatment immediately and delay until toxicity resolved to grade 0 to 1

Toxicity Criteria

Grade	Diarrhea	Nausea and Vomiting	Stomatitis
0 to 1	Increase of 2 to 3 stools/day or nocturnal stools	1 vomit/day but can eat	Painless ulcers, erythema or mild soreness
2	Increase of 4 to 6 stools/day or nocturnal stools	2 to 5 vomits/day; intake decreased but can eat	Painful erythema, edema or ulcers but can eat
3	Increase of 7 to 9 stools/day or incontinence, malabsorption	6 to 10 vomits/day and cannot eat	Painful erythema, edema or ulcers and cannot eat
4	Increase of 10 or more stools/day or grossly bloody diarrhea; may require parenteral support; dehydration	10 vomits or more per day or requires parenteral support; dehydration	Mucosal necrosis, requires parenteral support

4. **Hepatic dysfunction**: Dose modification may be required. Capecitabine has not been studied in severe hepatic dysfunction.

5. **Renal dysfunction:**

Creatinine Clearance mL/min	Dose
greater than 50	100%
30 to 50	75%
less than 30	0%

Cockcroft-Gault Equation:

$$\text{Estimated creatinine clearance (mL/min)} = \frac{N\,(140 - \text{age})\,\text{wt (kg)}}{\text{serum creatinine (micromol/L)}}$$

N = 1.23 male

N = 1.04 female

PRECAUTIONS:

1. **Neutropenia**: Fever or other evidence of infection must be assessed promptly and treated aggressively.
2. **Dihydropyrimidine dehydrogenase (DPD) deficiency** may result in severe and unexpected toxicity – stomatitis, diarrhea, neutropenia, neurotoxicity – secondary to reduced drug metabolism. This deficiency is thought to be present in about 3% of the population.
3. **Possible interactions with warfarin, phenytoin and fosphenytoin** have been reported and may occur at any time. Close monitoring is recommended (eg, for warfarin, monitor INR weekly during capecitabine therapy and for 1 month after stopping capecitabine).
4. **Myocardial ischemia and angina** occur rarely in patients receiving fluorouracil or capecitabine. Development of cardiac symptoms, including signs of cardiac ischemia or new arrhythmia should prompt discontinuation of capecitabine. 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 or capecitabine toxicity is strongly advised under these circumstances. The toxicity should also be noted in the patient's allergy profile.

Call Dr. Cheryl Ho or tumour group delegate at (604) 930-2098 or 1-800-663-3333 with any problems or questions regarding this treatment program.

References:

1. Martinez-Trufero J, Isla D, Adansa JC, et al. Phase II study of capecitabine as palliative treatment for patients with recurrent and metastatic squamous head and neck cancer after previous platinum-based treatment. Br J Cancer 2010;102(12):1687–1691.
2. Péron J, Poupart M, Ceruse P, et al. Efficacy and safety of capecitabine in heavily pretreated recurrent/metastatic head and neck squamous cell carcinoma. Anticancer Drugs 2012;23(10):1107–1111.