BCCA Protocol Summary for Treatment of Lymphoma with DOXOrubicin, Cyclophosphamide, vinCRISTine, predniSONE and riTUXimab (CHOP-R)

Protocol Code
LYCHOPR

Tumour Group
Lymphoma

Contact Physician
Dr. Laurie H. Sehn

ELIGIBILITY:
- All stages of newly diagnosed diffuse large B-cell lymphoma
- mantle cell lymphoma, advanced stage at diagnosis

EXCLUSIONS:
- Congestive cardiac failure requiring current treatment (LYCHOPR may be used but DOXOrubicin should be omitted, see cardiotoxicity below)

TESTS:
- Baseline (required before first treatment): CBC & diff, platelets, bilirubin, AST, ALT
- Baseline (required, but results do not have to be available to proceed with first treatment; results must be checked before proceeding with cycle 2): HBsAg, HBcoreAb
- Before each treatment: CBC and diff, platelets, (and serum bilirubin if elevated at baseline; serum bilirubin does not need to be requested before each treatment, after it has returned to normal)
- Reassess all sites of disease after cycles 4 and 6 to determine duration of treatment

PREMEDICATIONS:
For CHOP portion
- Antiemetic protocol for highly emetogenic chemotherapy (see protocol SCNAUSEA)

For riTUXimab portion
- diphenhydrAMINE 50 mg PO prior to riTUXimab and then q 4 h during the IV infusion, if the infusion exceeds 4 h
- acetaminophen 650-1000 mg PO prior to riTUXimab and then q 4 h during the IV infusion, if the infusion exceeds 4 h
- predniSONE as ordered for the LYCHOPR protocol

SUPPORTIVE MEDICATIONS:
If HBsAg or HBcoreAb positive, start lamiVUDine 100 mg/day PO for the duration of chemotherapy and for six months afterwards.
TREATMENT:

Note that the riTUXimab is given once with each dose of CHOP, not weekly as is used when riTUXimab is used as single agent.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>BCCA Administration Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOXOrubicin</td>
<td>50 mg/m$^2$ on day 1</td>
<td>IV push</td>
</tr>
<tr>
<td>vinCRISTine</td>
<td>1.4 mg/m$^2$ * on day 1 (*no cap on dose)</td>
<td>IV in 50 mL NS over 15 mins</td>
</tr>
<tr>
<td>cyclophosphamide</td>
<td>750 mg/m$^2$ on day 1</td>
<td>IV in 100 to 250* mL NS over 20 min to 1 hour (*use 250 mL for doses greater than 1000 mg)</td>
</tr>
<tr>
<td>prednISONE</td>
<td>45 mg/m$^2$ **on days 1-5 (**round off dose to nearest 25mg)</td>
<td>PO in am with food (the prednISONE dose for that day should be taken on the morning of the riTUXimab infusion)</td>
</tr>
<tr>
<td>riTUXimab**</td>
<td>375 mg/m$^2$ on day 1 or 2 whenever possible but not later than 72 h after CHOP</td>
<td>IV in 250 mL NS over 1 hour 30 min to 8 hours* (doses between 500-1000 mg can be prepared in either 250 mL or 500 mL NS)</td>
</tr>
</tbody>
</table>

*Start the (first dose) initial infusion at 50 mg/h and, after 1 hour, increase by 50 mg/h every 30 minutes until a rate of 400 mg/h is reached. For all subsequent treatments, infuse 50 mL (or 100 mL) of the dose over 30 minutes then infuse the remaining 200 mL (or 400 mL) (4/5) over 1 hour (total infusion time = 1 hour 30 min). Development of an allergic reaction may require a slower infusion rate. See hypersensitivity below.

** The risk of cytokine release syndrome is low but is increased when the peripheral blood lymphocyte count is greater than 30 to 50 x 10$^9$ /L. While there is no requirement to withhold riTUXimab based on lymphocyte count, clinicians may wish to pre-medicate patients with high tumour burden with steroids prior to riTUXimab infusion or omit the riTUXimab from the first cycle of treatment.

Repeat every 21 days or when the neutrophil and platelet counts have recovered sufficiently to allow 100% dosing, if that is determined sooner than every 21 days.

Limited stage: CHOP-R x 3 cycles, followed by radiation therapy

Advanced stage: CHOP-R x 6-8 cycles (2 cycles post maximum response, minimum 6 cycles)

Discontinue if no response after 2 cycles.

CNS Prophylaxis:

Patients with paranasal sinus involvement with large cell lymphoma who have a complete response at the completion of their chemotherapy should receive intrathecal methotrexate 12 mg alternating with intrathecal cytarabine 50 mg twice weekly x 6 doses (3 doses of each over 3 weeks) starting in week 18. (See protocol LYIT for details)

DOSE MODIFICATIONS:

1. **Elderly Patients (age greater than 75 years):**

Cycle 1 doses of cyclophosphamide and DOXOrubicin should be administered at 75% doses. Further treatment should be given at the maximum dose tolerated by the patient, trying to escalate up to full 100% doses, but using the baseline experience with the 75% doses to guide these decisions.
2. **Hematological**: DOXOrubicin, cyclophosphamide and etoposide, if used, see below:

<table>
<thead>
<tr>
<th>ANC (x10⁹/L)</th>
<th>Dose Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than or equal to 0.8</td>
<td>100%</td>
</tr>
<tr>
<td>less than 0.8</td>
<td>100% plus filgrastim 300 mcg daily x 5 days, starting 7 days after each IV chemotherapy</td>
</tr>
</tbody>
</table>

The patient should be treated with filgrastim (G-CSF) in doses sufficient to allow full dose treatment on a 21 day schedule, using the above dose modifications. Note: this guideline applies only if the treatment is potentially curative and after experience with one or more cycles of treatment indicate filgrastim (G-CSF) is required. (See Pharmacare guidelines)

Transfuse as needed to keep hemoglobin greater than 90 g/L, platelets greater than 20 x 10⁹/L.

3. **Neurotoxicity**: vinCRIStine only:

<table>
<thead>
<tr>
<th>Toxicity</th>
<th>Dose Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysesthesias, areflexia only</td>
<td>100%</td>
</tr>
<tr>
<td>Abnormal buttoning, writing</td>
<td>67%</td>
</tr>
<tr>
<td>Motor neuropathy, moderate</td>
<td>50%</td>
</tr>
<tr>
<td>Motor neuropathy, severe</td>
<td>omit</td>
</tr>
</tbody>
</table>

4. **Hepatotoxicity**: DOXOrubicin only:

<table>
<thead>
<tr>
<th>Bilirubin (micromol/L)</th>
<th>Dose Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-35</td>
<td>100%</td>
</tr>
<tr>
<td>35-85</td>
<td>50%</td>
</tr>
<tr>
<td>Greater than 85</td>
<td>Omit DOXOrubicin. <strong>ADD</strong> cyclophosphamide 350 mg/m² to the dose already planned.</td>
</tr>
</tbody>
</table>

Note: This adjustment is only necessary for the initial treatment. After the hyperbilirubinemia has resolved, adjustment is only necessary if overt jaundice re-occurs. Serum bilirubin does not need to be requested before each treatment.

5. **Cardiotoxicity**: DOXOrubicin only:

When DOXOrubicin cannot be used due to proven cardiac dysfunction, it can be replaced by etoposide 50 mg/m² IV on day 1 (Use non-DEHP Equipment with in-line filter), 100 mg/m² PO on day 2 and 3.

**PRECAUTIONS**:

1. **Neutropenia**: Fever or other evidence of infection must be assessed promptly and treated aggressively.
2. **Cardiac Toxicity**: DOXOrubicin is cardiotoxic and must be used with caution, if at all, in patients with severe hypertension or cardiac dysfunction. Cardiac assessment is recommended if lifelong dose of 450 mg/m² to be exceeded. (BCCA Cancer Drug Manual)
3. **Extravasation**: DOXOrubicin and vinCRIStine cause pain and tissue necrosis if extravasated. Refer to BCCA Extravasation Guidelines.
4. **Hypersensitivity**: If applicable, monitor etoposide infusion for the first 15 minutes for signs of hypotension. Refer to BCCA Hypersensitivity Guidelines. riTUximab can cause allergic type reactions during the IV infusion such as hypotension, wheezing, rash, flushing, alarm, pruritus, sneezing, cough, fever or faintness. For first dose, patients are to be under constant visual observation during all dose increases and for 30 minutes after infusion is completed. For all subsequent doses, constant visual observation is not required. Vital signs are not required unless symptomatic. Because transient
hypotension may occur during infusion, consider withholding antihypertensive medications 12 hours prior to ritUXimab infusion. If an allergic reaction occurs, stop the infusion and the physician in charge should determine a safe time and rate to resume the infusion. A reasonable guideline is as follows. After recovery of symptoms, restart ritUXimab infusion at one infusion rate below the rate at which the reaction occurred and continue with escalation of infusion rates on the appropriate schedule above. If the infusion must be stopped a second time, restart after clearance of symptoms, at one infusion rate lower and continue at that rate without further escalation. Fatal cytokine release syndrome can occur (see below). See BCCA Hypersensitivity Guidelines.

5. **Fatal Cytokine Release Syndrome** has been reported. It usually occurs within 1-2 hours of initiating the first infusion. Initially, it is characterised by severe dyspnea (often with bronchospasm and hypoxia) in addition to fever, chills, rigors, urticaria and angioedema. Pulmonary interstitial infiltrates or edema visible on chest x-ray may accompany acute respiratory failure. There may be features of tumour lysis syndrome such as hyperuricemia, hypocalcemia, acute renal failure and elevated LDH. For severe reactions, stop the infusion immediately and evaluate for tumour lysis syndrome and pulmonary infiltration. Aggressive symptomatic treatment is required. The infusion can be resumed at no more than one-half the previous rate once all symptoms have resolved, and laboratory values and chest x-ray findings have normalized. The risk of cytokine release syndrome is low but is increased when the peripheral blood lymphocyte count is greater than 30 to 50 x 10^9 /L. While there is no requirement to withhold ritUXimab based on lymphocyte count, clinicians may wish to pre-medicate patients with high tumour burden with steroids prior to ritUXimab infusion or omit the ritUXimab from the first cycle of treatment.

6. **Rare Severe Mucocutaneous Reactions:** (similar to Stevens-Johnson Syndrome) have been anecdotally reported. If such a reaction occurs, ritUXimab should be discontinued.

7. **Hepatitis B Reactivation:** All lymphoma patients should be tested for both HBsAg and HBcoreAb. If either test is positive, such patients should be treated with lamivUDine during chemotherapy and for six months afterwards. Such patients should also be monitored with frequent liver function tests and hepatitis B virus DNA at least every two months. If the hepatitis B virus DNA level rises during this monitoring, management should be reviewed with an appropriate specialist with experience managing hepatitis and consideration given to halting chemotherapy.

8. **Gastrointestinal Obstruction or Perforation:** There have been rare reports of gastrointestinal obstruction or perforation, sometimes fatal, when ritUXimab is given in combination with other chemotherapy, occurring 1 to 12 weeks after treatment. Symptoms possibly indicative of such complications should be carefully investigated and appropriately treated.

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

Date activated: 05 Mar 2001

Date revised: 1 Sep 2016 (Class II registration deleted)

References: