BCCA Protocol Summary for Treatment of Advanced Indolent Lymphoma using Cyclophosphamide, vinCRISTine, predniSONE and riTUXiMab (CVP-R)

**Protocol Code**  
LYCVPR

**Tumour Group**  
Lymphoma

**Contact Physician**  
Dr. Laurie H. Sehn

**ELIGIBILITY:**
- Indolent lymphoma (Follicular lymphoma, grade 1,2 or 3, Lymphoplasmacytic lymphoma, Marginal zone lymphoma or lymphoma not otherwise classifiable, grade 1)
- advanced stage at diagnosis
- at relapse if patient not refractory (previous response greater than 6 months)
- Small lymphocytic lymphoma/chronic lymphocytic leukemia, at relapse (note: small lymphocytic lymphoma is a variant of CLL, see LYFLUDR)

**TESTS:**
- Baseline (required before first treatment): CBC and 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): LDH, HBsAg, HBcoreAb
- Before each treatment: CBC and diff, platelets

**PREMEDICATIONS:**

For CVP Portion:
- ondansetron 8 mg PO pre-chemotherapy
- dexamethasone 12 mg PO pre-chemotherapy

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 to 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 LYCVPR 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 CVP, 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>vinCRIStine</td>
<td>1.4 mg/m² on day 1 (no maximum dose)</td>
<td>IV in 50 mL NS over 15 mins</td>
</tr>
<tr>
<td>cyclophosphamide</td>
<td>1000 mg/m² on day 1</td>
<td>IV in 100 to 250 mL* NS over 20 min to 1 hour *Use 250 mL for dose greater than 1000 mg.</td>
</tr>
<tr>
<td>predniSONE</td>
<td>100 mg starting on day 1</td>
<td>PO daily in am with food x 5 consecutive days</td>
</tr>
<tr>
<td>riTUXimab**</td>
<td>375 mg/m² on day 1 or 2 whenever possible but not later than 72 h after CVP</td>
<td>IV in 250 to 500 mL NS over 1 hour 30 min to 8 hours* (doses between 500 to 1000 mg can be prepared in either 250 mL or 500 mL NS)</td>
</tr>
</tbody>
</table>

*Start the riTUXimab (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 of 250 mL bag (or 100 mL of 500 mL bag) of the dose over 30 minutes then infuse the remaining 200 mL of 250 mL bag (or 400 mL of 500 mL bag) (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.

Repeat every 21 or 28 days (see dose modifications) for 8 cycles. For further use, CAP approval is required.

** The risk of cytokine release syndrome is low but is increased when the peripheral blood lymphocyte count is greater than 30 to 50 x 10⁹ /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.

DOSE MODIFICATIONS:

1. Hematological:

<table>
<thead>
<tr>
<th>ANC (x 10⁹/L)</th>
<th>Platelets (x 10⁹/L)</th>
<th>Dose Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 1,2</td>
<td>or</td>
<td>delay x 1 week</td>
</tr>
<tr>
<td>less than 100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. 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>
PRECAUTIONS:

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

2. **Extravasation**: vinCRIStine causes pain and tissue necrosis if extravasated. Refer to BCCA Extravasation Guidelines.

3. **Hypersensitivity**: 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).

4. **Fatal Cytokine Release Syndrome** has been reported. It usually occurs within 1 to 2 hours of initiating the first riTUXimab 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.

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

6. **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.

7. **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. Laurie H. Sehn or tumour group delegate at (604) 877-6000 or 1-800-663-3333 with any problems or questions regarding this treatment program.

Date activated: 13 August 2004 (as ULYCVPR)

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