

BC Cancer Protocol Summary for Neoadjuvant-Adjuvant Treatment of Resectable Gastric, Gastroesophageal Junction and Esophageal Adenocarcinoma using Durvalumab, DOCEtaxel, Oxaliplatin, Infusional Fluorouracil, and Leucovorin

Protocol Code

GIGAJDFLOD

Tumour Group

Gastrointestinal

Contact Physician

GI Systemic Therapy

ELIGIBILITY:

Patients must have:

- Unresected histologically proven stage II to IVA gastric, GEJ or esophageal adenocarcinoma, per AJCC manual 8th edition),
- Clinical staging:
 - T3 or T4, N0 to N3, M0, or
 - T0 to T2, N1 to N3, M0
- Planned radical surgery,
- No prior anticancer therapy for current cancer

Patients should have:

- Good performance status,
- Adequate hepatic, renal, hematologic and cardiac function
- Access to a treatment centre with expertise in managing immunotherapy mediated toxicities of durvalumab

Notes:

- Patients already receiving neoadjuvant GIGFLODOC as of 1 Sep 2026 may switch to GIGAJDFLOD if progression-free and all other eligibility criteria is met. Patients that already underwent surgery and receiving adjuvant treatment are not eligible to switch
- Patients are eligible for subsequent immunotherapy treatment in the metastatic setting provided progression occurs a minimum of 6 months after completion of adjuvant treatment

EXCLUSIONS:

Patients must not have:

- Peritoneal dissemination or distant metastasis
- Adenosquamous cell carcinoma, squamous cell carcinoma or gastrointestinal stromal tumours
- Avoid oxaliplatin in patients with congenital long QT syndrome.
- Grade 2 to 4 peripheral neuropathy

CAUTIONS:

- Active, known or suspected autoimmune disease
- Patients with long term immunosuppressive therapy or systemic corticosteroids (requiring more than 10 mg prednisONE/day or equivalent),
- Patients with recent myocardial infarction, uncontrolled angina, hypertension, cardiac arrhythmias, congestive heart failure or other serious medical illness,
- Patients with symptomatic peripheral neuropathy

TESTS:

- Baseline: CBC & Diff, creatinine, ALT, alkaline phosphatase, total bilirubin, albumin, sodium, potassium, TSH, morning serum cortisol, , chest x-ray or CT chest, DPYD test (not required if previously tested, or tolerated fluorouracil or capecitabine).
- Baseline if clinically indicated: CEA, CA 19-9, GGT, ECG
- Prior to Day 1 of each cycle: CBC & Diff, creatinine, sodium, potassium, total bilirubin, ALT, TSH
- Prior to Day 15 of Cycles 1 to 4 (Neoadjuvant and Adjuvant Combination Phase): CBC & Diff, creatinine, total bilirubin, ALT
- If clinically indicated: CEA, CA 19-9, morning serum cortisol, lipase, random glucose, serum or urine HCG (required for women of childbearing potential if pregnancy suspected), free T3 and free T4, creatine kinase, troponin, serum ACTH levels, testosterone, estradiol, FSH, LH, alkaline phosphatase, albumin, GGT, ECG, chest x-ray
- For patients on warfarin, weekly INR during fluorouracil therapy until stable warfarin dose established, then INR prior to each cycle.
- Weekly telephone nursing assessment for signs and symptoms of side effects while on treatment (Optional).

PREMEDICATIONS:

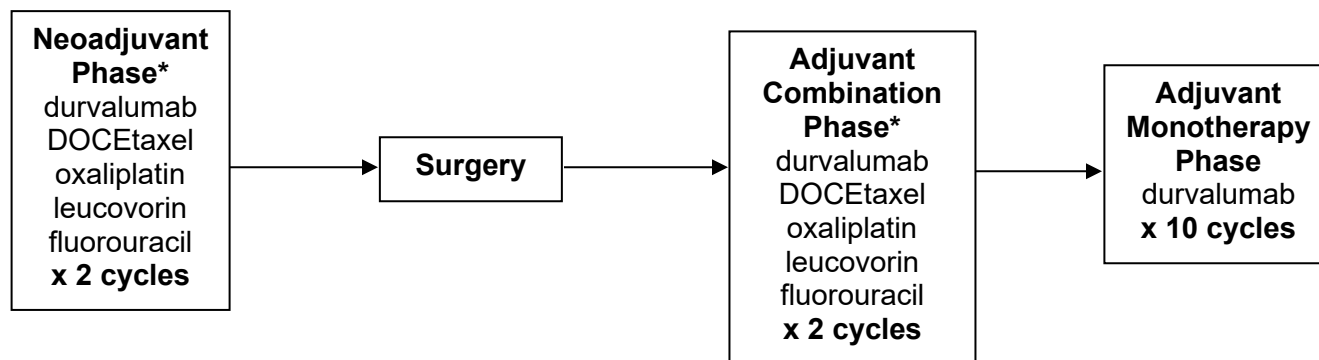
Neoadjuvant and Adjuvant Combination Phase (Cycles 1 to 4):

- Antiemetic protocol for moderately emetogenic chemotherapy (see SCNAUSEA)
- Dexamethasone 8 mg PO BID for 3 days, starting one day prior to each DOCetaxel administration. Patient must receive minimum of 3 doses pre-treatment.
- If Grade 1 or 2 oxaliplatin hypersensitivity reactions:
 - 45 minutes prior to oxaliplatin:
 - dexamethasone 20 mg IV in 50 mL NS over 15 minutes
 - 30 minutes prior to oxaliplatin:
 - diphenhydramine 50 mg IV in 50 mL NS over 15 minutes and famotidine 20 mg IV in 100 mL NS over 15 minutes (Y-site compatible)
- If prior infusion reactions to durvalumab: diphenhydramine 50 mg PO, acetaminophen 325 to 975 mg PO, and hydrocortisone 25 mg IV 30 minutes prior to treatment
- **Counsel patients to avoid cold drinks and exposure to cold air, especially for 3-5 days following oxaliplatin administration. (Frozen gloves recommendation with DOCetaxel use has been removed because of the use of oxaliplatin.)**
- **Cryotherapy (ice chips) should NOT be used as may exacerbate oxaliplatin-induced pharyngo-laryngeal dysesthesias.**

Adjuvant Monotherapy Phase (Cycles 5 onward):

- Antiemetics are usually not required. If antiemetics required, antiemetic protocol for low emetogenic chemotherapy (see SCNAUSEA)
- If prior infusion reactions to durvalumab: diphenhydramine 50 mg PO, acetaminophen 325 to 975 mg PO, and hydrocortisone 25 mg IV 30 minutes prior to treatment

TREATMENT SCHEMA:



*In each cycle, durvalumab is given on Day 1, and DOCEtaxel, oxaliplatin, leucovorin and fluorouracil are given on Days 1 and 15

TREATMENT:

1 cycle = 28 days

Neoadjuvant Phase (Cycles 1 and 2):

Drug	Dose	BC Cancer Administration Guideline
durvalumab	20 mg/kg* on Days 1 (maximum 1500 mg)	IV in 100 mL NS over 60 minutes Using a 0.2 micron in-line filter
DOCEtaxel	50 mg/m ² on Days 1 and 15	IV in 100 to 250 mL NS over 60 minutes (see Precaution #2) Use non-DEHP equipment
oxaliplatin**	85 mg/m ² on Days 1 and 15	IV in 250 to 500 mL D5W over 2 hours***
leucovorin	200 mg/m ² on Days 1 and 15	IV in 250 mL D5W over 2 hours***
fluorouracil	2600 mg/m ² on Days 1 and 15	IV over 24 hours in D5W to a total volume of 240 mL by continuous infusion at 10 mL/h via appropriate infusor device [†]
filgrastim (G-CSF) [‡]	5 mcg/kg/day (300 mcg or 480 mcg) once daily starting on Day 3 for 5 doses and once daily starting on Day 17 for 5 doses	subcutaneous

- Repeat every 28 days for 2 cycles, then proceed to surgery.
- Within 16 weeks following surgery, initiate adjuvant combination phase of treatment provided there is no evidence of progression.

Adjuvant Combination Phase (Cycles 3 and 4): starts within 16 weeks following surgery, if no progression

Drug	Dose	BC Cancer Administration Guideline
durvalumab	20 mg/kg* on Day 1 (maximum 1500 mg)	IV in 100 mL NS over 60 minutes Using a 0.2 micron in-line filter
DOCEtaxel	50 mg/m ² on Days 1 and 15	IV in 100 to 250 mL NS over 60 minutes (see Precaution #2) Use non-DEHP equipment
oxaliplatin**	85 mg/m ² on Days 1 and 15	IV in 250 to 500 mL D5W over 2 hours***
leucovorin	200 mg/m ² on Days 1 and 15	IV in 250 mL D5W over 2 hours***
fluorouracil	2600 mg/m ² on Days 1 and 15	IV over 24 hours in D5W to a total volume of 240 mL by continuous infusion at 10 mL/h via appropriate infusor device†
filgrastim (G-CSF)‡	5 mcg/kg/day (300 mcg or 480 mcg) once daily starting on Day 3 for 5 doses and once daily starting on Day 17 for 5 doses	subcutaneous

- Repeat every 28 days for 2 cycles, then proceed to adjuvant monotherapy phase

Adjuvant Monotherapy Phase (Cycles 5 to 14): starts 28 days after Cycle 4

Drug	Dose	BC Cancer Administration Guideline
durvalumab	20 mg/kg* on Days 1 (maximum 1500 mg)	IV in 100 mL NS over 60 minutes Using a 0.2 micron in-line filter

- Repeat every 28 days until disease progression or intolerable toxicity, up to a combined total of 14 cycles of durvalumab (including both neoadjuvant and adjuvant doses).

* Select dose per Dose Banding Table (appendix).

** Oxaliplatin is not compatible with normal saline. Do not piggyback or flush lines with normal saline. *Leucovorin dose remains at 200 mg/m² IV over 2 hours when concurrent oxaliplatin is omitted.*

*** Oxaliplatin and leucovorin may be infused over the same two hour period by using a Y- site connector placed immediately before the injection site. Oxaliplatin and leucovorin should not be combined in the same infusion bag.

† Alternative administration:

- To a total volume of 240 mL by continuous infusion at 10 mL/h via Baxter LV10 INFUSOR®;
- Inpatients: 2600 mg/m²/day in 1000 mL D5W by continuous infusion over 24 hours

‡ Consider Pharmacare approval for filgrastim (G-CSF) as the treatment is with curative intent. Eliminate or adjust filgrastim doses as needed depending upon next neutrophil count. Reduce filgrastim treatment duration if ANC greater than $10 \times 10^9/L$ or intolerable bone pain. Filgrastim should not be stopped before the time of the predicted nadir from chemotherapy.

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

DOSE MODIFICATIONS (Sections A, B & C):

Fluorouracil Dosing Based on DPYD Activity Score (DPYD-AS)

Refer to “Fluorouracil and Capecitabine Dosing Based on DPYD Activity Score (DPYD-AS)” in the BC Cancer Drug Manual appendix.

1. For durvalumab:

No specific dose modifications for durvalumab. Toxicity managed by treatment delay and other measures (see SCIMMUNE for management of immune-mediated adverse reactions to checkpoint inhibitor immunotherapy).

2. For DOCEtaxel, oxaliplatin and fluorouracil:

A. Dose Modifications for NEUROLOGIC Toxicity

B. Dose Modifications for HEMATOLOGIC Toxicity

C. Dose Modifications for NON-HEMATOLOGIC, NON-NEUROLOGIC Toxicity

Table 1 - Dose Levels for All Toxicity

Agent	Starting Dose	Dose Level –1	Dose Level –2*
oxaliplatin	85 mg/m ²	65 mg/m ²	50 mg/m ²
fluorouracil	2600 mg/m ²	2000 mg/m ²	1600 mg/m ²
DOCEtaxel	50 mg/m ²	40 mg/m ²	30 mg/m ²

*For any additional dose reductions, use 20% less than previous level or consider discontinuing this regimen.

A. Dose Modifications for oxaliplatin NEUROLOGIC Toxicity

(DOCEtaxel may also cause neurologic toxicity. DOCEtaxel dose reductions in addition to oxaliplatin reductions will be determined by clinician at their discretion.)

Toxicity Grade	Duration of Toxicity		Persistent (present at start of next cycle)
	1 to 7 days	Greater than 7 days	
Grade 1	Maintain dose level	Maintain dose level	Maintain dose level
Grade 2	Maintain dose level	Maintain dose level	Decrease 1 dose level
Grade 3	1 st time: ↓ 1 dose level 2 nd time: ↓ 1 dose level	1 st time: ↓ 1 dose level 2 nd time: ↓ 1 dose level	Discontinue therapy
Grade 4	Discontinue therapy	Discontinue therapy	Discontinue therapy
Pharyngo-laryngeal (see precautions)	Increase duration of infusion to 6 hours	N/A	N/A

Neuropathy may be partially or wholly reversible after discontinuation of therapy; patients with good recovery from Grade 3 (not Grade 4) neuropathy may be considered for re-challenge with oxaliplatin, with starting dose one level below that which they were receiving when neuropathy developed.

Oxaliplatin Neurotoxicity Definitions

Grade 1	Paresthesias/dysesthesias of short duration that resolve; do not interfere with function
Grade 2	Paresthesias / dysesthesias interfering with function, but not activities of daily living (ADL)
Grade 3	Paresthesias / dysesthesias with pain or with functional impairment which interfere with ADL
Grade 4	Persistent paresthesias / dysesthesias that are disabling or life-threatening
Pharyngo-laryngeal dysesthesias (investigator discretion used for grading): Grade 0 = none; Grade 1 = mild; Grade 2 = moderate; Grade 3 = severe	

B. Dose Modifications for HEMATOLOGIC Toxicity

Prior to a Cycle (Day 1)	Toxicity		Dose Level For Subsequent Cycles		
	Grade	ANC ($\times 10^9/L$)	oxaliplatin**	fluorouracil	DOCEtaxel**
- If ANC less than 1.5 on Day 1 of cycle, hold treatment.* Perform weekly CBC, maximum of 2 times. If delayed 2 weeks and on filgrastim, consider discontinuing. - If ANC is greater than or equal to 1.5 within 2 weeks, proceed with treatment at the dose level noted across from the lowest ANC result of the delayed week(s). - If ANC remains less than 1.5 after 2 weeks, discontinue treatment.	1	Greater than or equal to 1.5	Maintain dose level	Maintain dose level	Maintain dose level
	2	1.0 to less than 1.5	Maintain dose level	Maintain dose level	Maintain dose level
	3	0.5 to less than 1.0	↓ 1 dose level	Maintain dose level	↓ 1 dose level
	4	Less than 0.5	↓ 1 dose level	↓ 1 infusion dose level	↓ 1 dose level
Prior to a Cycle (Day 1)	Grade	Platelets ($\times 10^9/L$)	oxaliplatin**	fluorouracil	DOCEtaxel**
- If platelets less than 100 on Day 1 of cycle, hold treatment. Perform weekly CBC, maximum of 2 times. - If platelets greater than or equal to 100 within 2 weeks, proceed with treatment at the dose level noted across from the lowest platelets result of the delayed week(s). - If platelets remain less than 100 after 2 weeks, discontinue treatment.	1	Greater than or equal to 100	Maintain dose level	Maintain dose level	Maintain dose level
	2	50 to less than 100	Maintain dose level	Maintain dose level	Maintain dose level
	3	10 to less than 50	↓ 1 dose level	Maintain dose level	↓ 1 dose level
	4	Less than 10	↓ 2 dose levels	Maintain dose level	↓ 1 dose level

* Secondary prophylaxis with filgrastim can be used to prevent treatment delays in patients who, in a previous cycle, have experienced febrile neutropenia, Grade 4 neutropenia, or delay of scheduled treatment because of neutropenia

** Decrease DOCEtaxel and oxaliplatin to 75% of initial dose if patient experiences an episode of febrile neutropenia (despite the use of G-CSF), thrombocytopenia causing bleeding, or any other clinically significant hematologic dose limiting toxicity during the prior cycle of treatment. Subsequent hematologic dose limiting toxicities lead to a further dose reduction to 50% of the initial dose. If dose limiting toxicities reoccur at the 50% dose level, the clinician may remove one or more of the drugs.

C. Dose Modifications for NON-HEMATOLOGIC, NON-NEUROLOGIC Toxicity

Prior to a Cycle (Day 1)	Toxicity		Dose Level For Subsequent Cycles
	Grade	Diarrhea	
- If diarrhea greater than or equal to Grade 2 on Day 1 of cycle, hold treatment. Perform weekly checks, maximum 2 times. - If diarrhea is less than Grade 2 within 2 weeks, proceed with treatment at the dose level noted across from the highest Grade experienced. - If diarrhea remains greater than or equal to Grade 2 after 2 weeks, discontinue treatment.	1	Increase of 2 to 3 stools/day, or mild increase in loose watery colostomy output	Maintain dose level
	2	Increase of 4 to 6 stools, or nocturnal stools or mild increase in loose watery colostomy output	Maintain dose level
	3	Increase of 7 to 9 stools/day or incontinence, malabsorption; or severe increase in loose watery colostomy output	↓ 1 dose level of infusional fluorouracil
	4	Increase of 10 or more stools/day or grossly bloody colostomy output or loose watery colostomy output requiring parenteral support; dehydration	↓ 1 dose level of oxaliplatin and infusional fluorouracil
	Grade	Stomatitis	
- If stomatitis greater than or equal to Grade 2 on Day 1 of cycle, hold treatment. Perform weekly checks, maximum 2 times. - If stomatitis is less than Grade 2 within 2 weeks, proceed with treatment at the dose level noted across from the highest Grade experienced. - If stomatitis remains greater than or equal to Grade 2 after 2 weeks, discontinue treatment.	1	Painless ulcers, erythema or mild soreness	Maintain dose level
	2	Painful erythema, edema, or ulcers but can eat	Maintain dose level
	3	Painful erythema, edema, ulcers, and cannot eat	↓ 1 dose level of infusional fluorouracil
	4	As above but mucosal necrosis and/or requires enteral support, dehydration	↓ 1 dose level of oxaliplatin and infusional fluorouracil

Hepatic Dysfunction for DOCEtaxel:

Total Bilirubin		Alkaline Phosphatase		AST or ALT	Dose
Less than or equal to ULN	and	Less than 2.5 x ULN	and	Less than or equal to 1.5 x ULN	100%
Less than or equal to ULN	and	2.5 to 5 x ULN	and	1.6 to 6 x ULN	75%
Greater than ULN	or	Greater than 5 x ULN	or	Greater than 5 ULN	Discuss with treatment provider

ULN = upper limit of normal

Renal Function: Oxaliplatin should be omitted when creatinine clearance is below 30 mL/min

PRECAUTIONS:

1. **Fluid retention:** Dexamethasone premedication must be given to reduce incidence and severity of fluid retention due to DOCEtaxel.
2. **DOCEtaxel Hypersensitivity:** Reactions are common to DOCEtaxel 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. **Platinum hypersensitivity** can cause dyspnea, bronchospasm, itching and hypoxia. Appropriate treatment includes supplemental oxygen, steroids, epinephrine and bronchodilators. Vasopressors may be required (see table below). For Grade 1 or 2 acute hypersensitivity reactions no dose modification of oxaliplatin is required and the patient can continue treatment with standard hypersensitivity premedication. See Premedications section above. Reducing infusion rates (e.g., from the usual 2 hours to 4-6 hours) should also be considered since some patients may develop more severe reactions when rechallenged, despite premedications.
4. **Extravasation:** DOCEtaxel causes pain and tissue necrosis if extravasated. Oxaliplatin causes irritation if extravasated. Refer to BC Cancer Extravasation Guidelines.
5. **Neutropenia:** Fever or other evidence of infection must be assessed promptly and treated aggressively. Refer to BC Cancer Febrile Neutropenia Guidelines.
6. **Hepatic Dysfunction:** DOCEtaxel undergoes hepatic metabolism. Hepatic dysfunction (particularly elevated ALT) may lead to increased toxicity and usually requires a dose reduction.
7. **Pharyngo-laryngeal dysesthesia** is an unusual dysesthesia due to oxaliplatin characterized by an uncomfortable persistent sensation in the area of the laryngopharynx without any objective evidence of respiratory distress (i.e. absence of hypoxia, laryngospasm or bronchospasm). This may be exacerbated by exposure to cold air or foods/fluids. If this occurs during infusion, stop infusion immediately and observe patient. Rapid resolution is typical, within minutes to a few hours. Check oxygen saturation; if normal, an anxiolytic agent may be given. The infusion can then be restarted at a slower rate at the physician's discretion. In subsequent cycles, the duration of infusion should be prolonged (see Dose Modifications above in the Neurological Toxicity table).

Clinical Symptoms	Pharyngo-laryngeal Dysesthesia	Platinum Hypersensitivity
Dyspnea	Present	Present
Bronchospasm	Absent	Present
Laryngospasm	Absent	Present
Anxiety	Present	Present
O ₂ saturation	Normal	Decreased
Difficulty swallowing	Present (loss of sensation)	Absent
Pruritus	Absent	Present
Cold induced symptoms	Yes	No
Blood Pressure	Normal or Increased	Normal or Decreased
Treatment	Anxiolytics; observation in a controlled clinical setting until symptoms abate or at physician's discretion	Oxygen, steroids, epinephrine, bronchodilators; Fluids and vasopressors if appropriate

8. **QT prolongation and torsades de pointes** have been reported with oxaliplatin. Use caution in patients with history of QT prolongation or cardiac disease and those receiving concurrent therapy with other QT prolonging medications. Correct electrolyte disturbances prior to treatment and monitor periodically. Baseline and periodic ECG monitoring is suggested in patients with cardiac disease, arrhythmias, concurrent drugs known to cause QT prolongation, and electrolyte abnormalities. In case of QT prolongation, oxaliplatin treatment should be discontinued. QT effect of oxaliplatin with single dose ondansetron 8 mg prechemo has not been formally studied. However, single dose ondansetron 8 mg po would be considered a lower risk for QT prolongation than multiple or higher doses of ondansetron, as long as patient does not have other contributing factors as listed above.
9. Oxaliplatin therapy should be interrupted if symptoms indicative of **pulmonary fibrosis** develop – nonproductive cough, dyspnea, crackles, rales, hypoxia, tachypnea or radiological pulmonary infiltrates. If pulmonary fibrosis is confirmed oxaliplatin should be discontinued.
10. **Myocardial ischemia and angina occur 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.
11. **Venous Occlusive Disease** is a rare but serious complications that has been reported in patients (0.02%) receiving oxaliplatin in combination with fluorouracil. This condition can lead to hepatomegaly, splenomegaly, portal hypertension and/or esophageal varices. Patients should be instructed to report any jaundice, ascites or hematemesis immediately.
12. Oxaliplatin therapy should be interrupted if **Hemolytic Uremic Syndrome (HUS)** is suspected: hematocrit is less than 25%, platelets less than 100,000 and creatinine greater than or equal to 135 micromol/L. If HUS is confirmed, oxaliplatin should be permanently discontinued.
13. **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 (e.g. IMODIUM) following the manufacturer's directions or per the BC

Cancer Guidelines for Management of Chemotherapy-Induced Diarrhea. Note that diarrhea may result in increased INR and the risk of bleeding in patients on warfarin.

14. **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.
15. **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.
16. **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.
17. **Serious immune-mediated reactions to durvalumab:** can be severe to fatal and usually occur during the treatment course, but may develop months after discontinuation of therapy. They may include enterocolitis, intestinal perforation or hemorrhage, hepatitis, dermatitis, neuropathy, endocrinopathy, pneumonitis, as well as toxicities in other organ systems. Early diagnosis and appropriate management are essential to minimize life-threatening complications (see [SCIMMUNE](#) for management of immune-mediated adverse reactions to checkpoint inhibitor immunotherapy).
18. **Infusion-related reactions:** isolated cases of severe infusion reactions have been reported. For mild or moderate infusion reactions, decrease the infusion rate to 50% or temporarily interrupt infusion until the reaction has resolved. Consider premedication for subsequent infusions. Permanently discontinue durvalumab for severe reactions.
19. **Infections:** severe infections such as sepsis, necrotizing fasciitis, and osteomyelitis have been reported. Treat suspected or confirmed infections as indicated. Withhold durvalumab for severe infections.

Call the GI Systemic Therapy physician at your regional cancer centre or the GI Systemic Therapy Chair with any problems or questions regarding this treatment program.

REFERENCES:

1. Jangjigian YY, Al-Batran SE, Wainberg Za et al. Perioperative Durvalumab in Gastric and Gastroesophageal Junction Cancer. N Engl J Med. 2025 Jul 17;393(3):217-230.
2. Durvalumab (Imfinzi) CADTH [Canada's Drug Agency (CDA-AMC)] Reimbursement Recommendation. Canadian Journal of Health Technologies Apr 2026; 6(4): 1-15.

Appendix. Dose Bands

DURVALUMAB DOSE BANDING TABLE (20 mg/kg capped at 1500 mg)

Ordered Dose (mg)		Rounded dose (mg)
From:	To:	
Less than 369		Pharmacy prepares specific dose
369	440.49	400
440.5	475.49	450
475.5	555.49	500
555.5	666.49	600
666.5	777.49	700
777.5	888.49	800
888.5	999.49	900
999.5	1099.49	1000
1099.5	1199.49	1100
1199.5	1299.49	1200
1299.5	1399.49	1300
1399.5	1499.49	1400
1499.5	1500	1500