

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

Protocol Code:

GOOVCAD

Tumour Group:

Gynecologic Oncology

Contact Physician:

[GO Systemic Therapy](#)

ELIGIBILITY:

- invasive epithelial ovarian, fallopian tube, or primary peritoneal cancer
 - Post-surgery with visible or no visible residual tumor
 - FIGO Ia: Grade 2 or 3
 - FIGO Ib: Grade 2 or 3
 - FIGO Ic, II, or III: any Grade
 - Relapsed tumour after remission of at least four months duration in response to primary treatment with CARBOplatin and PACLitaxel, or CARBOplatin and DOCEtaxel.
- Note: The GOOVCATM/X/R and GOOVCAD 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 alopecia¹. 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:

- ECOG PS greater than two
- Bowel obstruction

RELATIVE CONTRAINDICATIONS:

- As GOOVCAD may be more myelotoxic than GOOVCATM, the latter may be preferred pre-radiation therapy if radiation therapy is anticipated.
- Pre-existing motor or sensory neuropathy greater than grade two.

TESTS:

- Baseline: CBC & Diff, creatinine, [alkaline phosphatase](#), [ALT](#), [total bilirubin](#)
- Baseline, if clinically indicated: [sodium](#), [potassium](#), [magnesium](#), [calcium](#), [CA 125](#), [CA 19-9](#), [CA 15-3](#), [CEA](#), [SCC](#)
- Day 7 and 14 in first cycle (and in subsequent cycle(s) if dose modifications are made): CBC & diff
- Before each treatment: CBC & Diff, creatinine
- If clinically indicated: [total bilirubin](#), [alkaline phosphatase](#), [ALT](#), [sodium](#), [potassium](#), [magnesium](#), [calcium](#), [CA 125](#), [CA 19-9](#), [CA 15-3](#), [CEA](#), [SCC](#)

PREMEDICATIONS:

- 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
- Antiemetic protocol for highly emetogenic chemotherapy protocols (see [SCNAUSEA](#))
- DOCEtaxel-induced onychosis 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.

TREATMENT:

| Drug | Starting Dose | BC Cancer Administration Guideline |
|-------------|--------------------------|---|
| DOCEtaxel | 75 mg/m ² * | IV in 250 to 500 mL NS or D5W over 1 hour (see Precaution #2) Use non-DEHP equipment |
| CARBOplatin | Dose = AUC** x (GFR +25) | IV in 100 to 250 mL NS over 30 minutes |

* 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.

** 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

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

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:

- *For primary treatment with no visible residual tumour:* 3 cycles, followed in 3 to 4 weeks by abdominopelvic irradiation. May extend to 9 cycles if the patient has not achieved a complete response but is continuing to respond.
- *For primary treatment with visible residual tumour, and for treatment at relapse:* 6 cycles. 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.

DOSE MODIFICATIONS:

1. Hematology:

a) on treatment day if patient *has never had* neutropenic sepsis on DOCEtaxel:

| ANC (x 10 ⁹ /L) | | Platelets (x 10 ⁹ /L) | Doses (both drugs) |
|------------------------------|-----|----------------------------------|---|
| Greater than or equal to 1.5 | and | Greater than or equal to 100 | treat as per nadir |
| 1.0 to 1.4 | and | Greater than or equal to 100 | DOCEtaxel 60 mg/m ² ; CARBOplatin per nadir counts |
| Less than 1.0 | or | Less than 100 | delay until recovery |

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

| ANC (x 10 ⁹ /L) | | Platelets (x 10 ⁹ /L) | Doses |
|------------------------------|-----|----------------------------------|---|
| Greater than or equal to 1.5 | and | Greater than or equal to 100 | DOCEtaxel 60 mg/m ² ; CARBOplatin per nadir counts |
| 1.0 to 1.4 | and | Greater than or equal to 100 | DOCEtaxel 60 mg/m ² ; CARBOplatin per nadir counts |
| Less than 1.0 | or | Less than 100 | Delay until recovery |

c) at nadir:

| ANC (x 10 ⁹ /L) | | Platelets (x 10 ⁹ /L) | DOCEtaxel | CARBOplatin |
|---------------------------------|-----|----------------------------------|-----------|-------------|
| Greater than or equal to 0.5 | and | Greater than or equal to 75 | 100% | 100% |
| Less than 0.5 | and | Less than or equal to 75 | 80% | 80% |
| Less than 0.5 | and | Greater than or equal to 75 | 80% | 100% |
| Greater than or equal to 0.5 | and | Less than or equal to 75 | 100% | 80% |
| Febrile neutropenia at any time | | | 75% | 80% |

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

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:

| Alkaline Phosphatase | | AST +/-or ALT | DOCEtaxel Dose |
|----------------------|-----|---------------------------------|--------------------------------|
| Less than 2.5 x ULN | and | Less than or equal to 1.5 x ULN | 100% |
| 2.5 to 5 x ULN | and | 1.6 to 6 x ULN | 60 mg/m ² |
| Greater than 5 x ULN | or | Greater than 5 ULN | Discuss with contact physician |

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.

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

References

1. Vasey PA. Role of docetaxel in the treatment of newly diagnosed advanced ovarian cancer. J Clin Oncol 2003;21(90100):136s-44s.