LOW DOSE ORAL CYCLOPHOSPHAMIDE

Palliative use in metastatic hormone-resistant prostate cancer

Palliative use in multiply-relapsed advanced ovarian cancer, where nausea is not a component in patient's symptoms

Drugs / Dosage:	Cyclophosphamide	50mg/m^2	PO	once daily continuous
	$BSA < 1.5m^2$	prescribe 50mg daily		
	$BSA\ 1.5 – 1.8m^2$	prescribe 100mg/50mg on alternate days		
	$BSA > 1.8m^2$	prescribe 100mg daily		

Administration: Cyclophosphamide is only available as 50mg tablets, which should be swallowed whole with a full glass of water.
Patients should be encouraged to increase fluid intake while on this treatment.

Frequency: Review patient every month.
Continue to a minimum of 6 months if showing PR, or if improved biochemical parameters.

Main Toxicities: myelosuppression; alopecia; haemorrhagic cystitis

Anti–emetics: mildly emetogenic

Regular Investigations:	FBC	every 4 weeks
	LFTs	baseline, then every 8 weeks
	U&Es	every 4 weeks
	PSA (prostate)	every 8 weeks
	CA 125 (ovary)	every 8 weeks

Dose Modifications

Haematological Toxicity: Neutrophils ≤ 1.5×10^9/l or Platelets ≤ 100×10^9/l — Delay for 1 week. Repeat FBC- if within normal parameters, resume treatment.

If lymphocytes < 0.2×10^9, then stop treatment until recovered, and re-introduce with a 25% dose reduction.

Renal Impairment: EDTA is not routinely performed for patients on this regimen. Patients should be initiated with full-dose treatment unless serum creatinine > 120 μmol/l.
If serum creatinine > 120 μmol/l, dose adjustments for cyclophosphamide should be made using Cockcroft and Gault and the guidelines below. EDTA should be requested so that doses can be re-adjusted if necessary, according to EDTA result.

CrCl (ml/min)	Cyclophosphamide Dose
> 20	Give 100%
10 – 20	Give 75%
< 10	Give 50%

References: Lord, R et al; J Urol 2007; 117 (6); 2136 – 2140 (prostate)
Chung, V et al; JCO 2008; 26; 15S: abstract 16555 (ovary)

Reason for Update: ovary indication added	Approved by Consultant: Dr A Michael
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