IRINOTECAN

Monotherapy for 2nd line use in metastatic colorectal cancer
(generally reserved for patients with a contra-indication to fluoropyrimidines)

Drug/Dosage:	**Age < 70 years:**	Irinotecan	350mg/m^2	IV	Day 1
	Age 70 years +:	Irinotecan	300mg/m^2	IV	Day 1

Administration: in 250ml 0.9% sodium chloride over 60 - 90 minutes

Frequency: 3 weekly cycle
Up to 8 cycles if still responding

Main Toxicities: myelosuppression; diarrhoea (see Comments); alopecia; cholinergic syndrome – during administration; ovarian failure/infertility

Anti-emetics: highly emetogenic

Extravasation: non-vesicant

Regular Investigations:	FBC	Day 1, plus weekly for first 2 cycles (see below)
	LFTs	Day 1
	U&Es	Day 1
	CEA	Day 1
	FBC / assessment	weekly for first 2 cycles (see Comments)

Comments:

Cholinergic syndrome can be controlled by giving atropine 0.25mg subcutaneously at time of irinotecan administration. Should the syndrome develop, a further dose of atropine may be given.

Diarrhoea may occur within 30 – 90 minutes of infusion, or may be delayed. Once a liquid stool occurs, loperamide 4mg should be taken immediately, followed by one tablet 2 hourly for at least 12 hours, and for 12 hours following the last liquid stool. Patients should be instructed to drink large volumes of water / electrolytes. Concomitant fever or vomiting will require hospitalisation for IV hydration.
If diarrhoea persists for 24 hours despite the loperamide, a prophylactic course of ciprofloxacin 250mg po bd for 7 days should be started.
After 48 hours of persistent diarrhoea, the patient should be hospitalised for parenteral support, further management of diarrhoea and review of treatment.

N.B. Loperamide and ciprofloxacin must be dispensed to patients on discharge, and patients should be given an "Information about Irinotecan" leaflet and counselled to ensure they know how and when to use them.

Ciprofloxacin prophylaxis (250mg po bd) should be commenced in patients with neutrophils < 0.5 x 10^9/l, even in the absence of diarrhoea. Patients who develop severe neutropenia are especially at risk of infection if they are also suffering from diarrhoea.

Due to the specialist nature of this treatment and the associated risks, all patients should have weekly FBC and assessment in SLCC (by experienced nurse or doctor) for the first two cycles of treatment. It is not appropriate for patient to be managed by GP or another hospital.

Reason for Update: overdue for review	Approved by Consultant: Dr S Essapen
Version: 3	Approved by Lead Chemotherapy Nurse: P Deery
Supersedes: Version 2	Date: 11.2.15
Prepared by: S Taylor	Checked by: C Tucker

Dose Modifications:

Neutrophils < 1.5 x 10^9/l
or
Platelets < 100 x 10^9/l — Delay for 1 – 2 weeks until recovered.
or
Diarrhoea ≥ Grade 1

If patient has an episode of Grade 3 febrile neutropenia or Grade 4 neutropenia or Grade 3/4 diarrhoea:

- reduce irinotecan to 300mg/m^2 for subsequent cycles (or reduce to 250mg/m^2 if start dose was 300mg/m^2)
- if the criteria described above recur, reduce by a further 50mg/m^2
- if there is still significant toxicity at this dose, a change of treatment should be considered.

Renal Impairment:

If CrCl < 30ml/min, irinotecan should be used with caution, as there is no information in this setting.

Hepatic Impairment:

Bilirubin (µmol/l)	**Irinotecan Dose (mg/m^2)**
< 26	350
26 – 51	200
> 51	Clinical decision

References:

Cunningham, D et al, Lancet 1998; Vol 352: 1413 – 1418
Rougier et al, Lancet 1998; Vol 352; 1407 - 1412