THALIDOMIDE

Salvage therapy for relapsed or refractory myeloma
May be particularly appropriate for patients who relapse following transplant, or those who cannot tolerate steroids

Drug/Dose: **Thalidomide** start dose 50 - 100mg po nocte
The dose may be increased every 2 - 4 weeks to a usual maximum of 200mg po nocte if tolerated well at each increment.

Other drugs: Laxative as required for thalidomide-induced constipation.
Thromboprophylaxis, according to unit practice, is recommended in the absence of specific contraindication.

Administration: Thalidomide is available as 50mg capsules. The daily dose should be taken at bedtime to avoid problems with day-time sedation. Patients should be advised not to drive or operate machinery for 8 hours after each dose.

Length of Therapy: Thalidomide should be taken continuously if tolerated and responding. Response is usually seen within 4 weeks. If no benefit has occurred within 12 weeks the drug should be stopped. In responding patients, treatment should be continued until relapse or side effects occur.

Main Toxicities: teratogenicity (see Comments); sedation (take thalidomide at bedtime); constipation (often requiring laxatives); peripheral neuropathy; bradycardia and syncope; dizziness; dry skin or rash; increased risk of thromboembolic events

Regular Investigations:		
	FBC	every month
	U&Es & LFTs	every month
	Paraprotein	every month
	Pregnancy test	every month for women of child bearing potential

Comments: Thalidomide is highly teratogenic:

- women of child bearing potential must have a negative pregnancy test within 3 days prior to starting treatment. Pregnancy testing should be repeated monthly thereafter until one month after stopping thalidomide (or every 2 weeks in women with irregular menstrual cycles). If a woman taking thalidomide thinks she may be pregnant she must stop the drug immediately.
- men taking thalidomide must use a barrier method of contraception throughout treatment and for one week after stopping, if their partner is capable of bearing children.
- women of child-bearing potential must use one agreed effective method of contraception for at least 4 weeks before starting thalidomide, while on thalidomide and for one month after. (The combined oral contraceptive pill is not recommended due to the increased risk of thromboembolism)

Thalidomide is supplied through the Celgene Pregnancy Prevention Programme.
All aspects of the programme should be followed, including completion of an authorisation form by both doctor and pharmacist with every cycle.

Reason for Update: updated to Celgene	Approved by Chair of Alliance TSSG: Dr A Laurie
Version: 4	Date: 12.12.14
Supersedes: Version 3	Review Date: January 2018
Prepared by: S Taylor	Checked by: C Tucker

Dose Modifications	If not tolerated at 50mg/day, alternate day administration may be tried. If in doubt, discuss with Consultant.
Neuropathy:	Mild neuropathy is very common and, in the absence of progression of the neuropathy, the thalidomide dose may be kept the same. If the symptoms begin to worsen, consider a dose reduction of up to 50%. For Grade 2 neuropathy, a dose reduction of up to 50%, or a break in treatment, is required. If neuropathy does not improve, discontinue thalidomide permanently. If neuropathy resolves to Grade 1 or better, continue with the 50% dose if risk/benefit favourable. In more severe cases (Grade 3 – 4), it is recommended that thalidomide should be permanently discontinued. However, if symptoms do resolve, re-introducing thalidomide at a lower dose may be considered. However, neuropathy is often not reversible.
Drowsiness:	If patient experiences problems with drowsiness despite taking the thalidomide at night, a dose reduction may be considered
Renal and Hepatic Impairment:	No dose modifications required
Patient Information:	Macmillan leaflet for Thalidomide Celgene Pregnancy Prevention Programme Booklet "Thalidomide and Myeloma" Infoguide produced by Myeloma UK (available at www.myelomaonline.org.uk) is also recommended
References:	Singhal, S et al; NEJM (1999); 21: 341 MRC Myeloma IX trial (2004)