Indication	**Colorectal:** • Adjuvant use in Stage III and high-risk Stage II colon and rectal cancer. • First-line or subsequent use for metastatic colorectal cancer. **Upper GI:** • Peri-operative chemotherapy for adenocarcinoma of the oesophagus or Type 1,2 or 3 gastro-oesophageal junction or gastric cancer. • 1st line palliative treatment for oesophageal cancer and type 1, 2 or 3 gastro-oesophageal junction or gastric cancer. • 2nd / 3rd line palliative treatment for pancreatic cancer. • 1st line palliative treatment for small bowel carcinoma.
Treatment Intent	Adjuvant / Palliative / Peri-operative (UGI)
Frequency and number of cycles	Repeat every 14 days **Adjuvant (colorectal):** 6 cycles for low risk and 12 cycles for high risk disease. **Peri-operative (UGI):** 4 cycles pre-operative and 4 cycles post-operative. **Palliative:** **Colorectal** continue until disease progression or unacceptable toxicity or patient choice to stop treatment. Review after 6 cycles. **UGI** • Oesophageal cancer and type 1, 2 or 3 gastro-oesophageal junction or gastric cancer or small bowel carcinoma 6 to 12 cycles or until disease progression or unacceptable toxicity or patient choice to stop treatment. • Pancreatic cancer continue until disease progression or unacceptable toxicity or patient choice to stop treatment. Review after 6 cycles. NB patients may have breaks from treatment where clinically appropriate.
Monitoring Parameters pre-treatment	• **Virology screening:** All new patients referred for systemic anti-cancer treatment should be screened for hepatitis B and C and the result reviewed prior to the start of treatment. Patients not previously tested who are starting a new line of treatment, should also be screened for hepatitis B and C. Further virology screening will be performed following individual risk assessment and clinician discretion. • **DPD testing** must be undertaken in all patients before starting treatment; the result must be checked before treatment is started. • **ECG** prior to cycle 1. • **Cardiotoxicity:** caution in patients with prior history of coronary heart disease, arrhythmias and angina pectoris. • Monitor FBC, LFTs and U&Es prior to treatment and every 2 weeks thereafter. • If neuts <1.5 and/ or Plts <100 delay one week. If neuts >/=1.5 and/ or Plts >/=100 continue with treatment. • **Renal Impairment:** o Oxaliplatin: No dose reduction needed if CrCl >/=30ml/min. If CrCl <30ml/min d/w consultant. o Fluorouracil, consider dose reduction in severe impairment. • **Hepatic Impairment:** o Oxaliplatin- no dose adjustments recommended.

	○ Fluorouracil - In moderate hepatic impairment consider reducing the dose by 30% and for severe impairment by 50%. If the bilirubin is >85umol/L and / or AST >180 fluorouracil is contra-indicated. • **Dose Modification:** ○ Refer to KMCC website for oxaliplatin induced neuropathy guidance https://www.kmcc.nhs.uk/medicines-and-prescribing-incorporating-sact-pathways/guidelines-for-the-management-of-sact-induced-adverse-reactions/ ○ Dose reduction should be considered if any other grade 3 or 4 non-haematological toxicity or repeat appearance of grade 2 (except N&V and alopecia). Delay until resolution of toxicity to < grade 1. • **Common drug interactions (for comprehensive list refer to BNF/SPC):** • 5FU ○ 5FU must not be given with concurrent sorivudine or derivatives (e.g. brivudine), see SPC. Monitor PT and INR regularly in patients taking coumarin-derivative anticoagulants. ○ Monitor phenytoin levels with concomitant use. ○ Caution with folinic acid or folic acid – potential for increased toxicity. • Oxaliplatin ○ Caution is advised when oxaliplatin is co-administered with other medicinal products known to cause QT interval prolongation. ○ Caution is advised when oxaliplatin treatment is administered concomitantly with other medicinal products known to be associated with rhabdomyolysis. • **Driving:** Oxaliplatin may cause dizziness, fatigue and nausea. Patients should be aware this may affect their ability to drive or operate machinery.
References	KMCC proforma COL-019 V6 Colorectal NOG 23.01.2023 ARIA regimen UGI-046 V1 KMCC proforma UGI-046 v2

NB For funding information, refer to CDF and NICE Drugs Funding List

Repeat every 14 days

Day	Drug	Dose	Route	Infusion Duration	Administration
1	Dexamethasone	8mg	PO		
	Ondansetron	<75yrs 16mg >/=75yrs 8mg	IV	15min	Sodium chloride 0.9% 50ml
	FLUSH WITH 5 % GLUCOSE BEFORE AND AFTER ADMINISTRATION OF OXALIPLATIN				
	OXALIPLATIN	**85mg/m²**	IV	2- 6 hrs	250-500ml 5% glucose (to give a concentration between 0.2 mg/ml and 0.70 mg/ml) Can be run concurrently with Calcium Folinate.
	CALCIUM FOLINATE (flat dose) (calcium leucovorin)	**350mg**	IV	2 hrs	Glucose 5% 250ml Can be run concurrently with oxaliplatin.
	5-FLUOROURACIL	**400mg/m²**	IV	slow bolus	Through a fast running Sodium chloride 0.9% intravenous infusion
	5-FLUOROURACIL	**2400mg/m² over 46 hrs**	**IV**	46 hr pump	Continuous infusion
TTO	Drug	Dose	Route	Directions	
Day 1	Dexamethasone	6mg	PO	OM for 3 days	
	Metoclopramide	10mg	PO	10mg TDS for 3 days then 10mg up to 3 times a day as required. Do not take for more than 5 days continuously.	