Indication	Sunitinib is indicated as 1st line treatment for advanced or metastatic RCC.
Treatment Intent	Palliative
Frequency and number of cycles	Repeat every 6 weeks. Sunitinib is to be continued until loss of clinical benefit or unacceptable toxicity or patient choice to stop treatment, or sunitinib can be stopped for a planned treatment break following the protocol used in the STAR trial; i.e. following 24 weeks of continuous therapy, and if there is no evidence of disease progression on therapy, patients and clinicians may choose to stop treatment for a planned drug free interval/treatment break and then restart sunitinib on disease progression. (Further planned treatments breaks following the same strategy are allowed).
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. • **Blood pressure (BP**) should be well controlled prior to treatment. BP should be monitored every 2 weeks for the first 2 months and then before each cycle thereafter or at each dispensing episode if >28 days treatment is supplied (stable patients only). • **ECG** prior to cycle 1 and then as clinically indicated, monitor patients for symptoms of cardiac dysfunction throughout treatment. • **ECHO:** at baseline for at risk patients, then every 6/12 when clinically indicated. Use sunitinib with caution in patients with a known history of QT prolongation, pre-existing cardiac disease or bradycardia. • **Thyroid function** must be assessed at baseline then every 12 weeks. • **Blood glucose** levels in diabetic patients should be checked regularly. • Monitor FBC, LFT's and U&E's prior to each cycle or at each dispensing episode if >28 days treatment is supplied (stable patients only). • If neuts <1.0 and/or PLT <50 d/w consultant. • **Hepatic impairment:** No dose reduction required in mild to moderate hepatic impairment. Severe hepatic impairment d/w consultant. • **Renal impairment:** No dose reduction required in renal impairment if CrCl >42ml/min. If <42ml/min d/w consultant. • **Management of adverse reactions** • **Dermatological effects:** Patients should be advised that depigmentation of the hair or skin may occur during treatment with sunitinib. Other possible dermatological effects may include dryness, thickness or cracking of the skin, blisters, or rash on the palms of the hands and soles of the feet. Patients should be advised to moisturize regularly, and creams containing 10% urea are recommended. Severe cutaneous reactions have been reported, including erythema multiforme (EM), Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN). If signs or symptoms of SJS, TEN, or EM are present, sunitinib treatment should be discontinued. If the diagnosis of SJS or TEN is confirmed, treatment must not be restarted. • **Osteonecrosis of jaw (ONJ)** has been observed in patients treated with sunitinib. The majority of cases were reported in patients who had received prior or concomitant treatment with intravenous bisphosphonates. Caution should be exercised when sunitinib and intravenous bisphosphonates are administered simultaneously or

	sequentially. A dental examination and appropriate preventive dentistry should be considered prior to starting the treatment. In patients who have previously received or are receiving intravenous bisphosphonates invasive dental procedures should be avoided, if possible. Patients should be advised on oral hygiene practice. Reference should be made to the UK chemotherapy board guidance on medication related osteonecrosis of the jaw: https://www.rcplondon.ac.uk/guidelines-policy/medication-related-osteonecrosis-jawguidance-oncology-multidisciplinary-team. • **Tumour lysis syndrome (TLS)** Cases of TLS have been observed in patients treated with sunitinib. • Sunitinib may adversely affect **wound healing.** Temporary interruption of sunitinib therapy is recommended in patients undergoing major surgical procedures. The decision to resume sunitinib therapy following a major surgical intervention should be based upon clinical judgment of recovery from surgery. • **Cardiac disorders:** Discontinue sunitinib in the case of clinical manifestations of CHF. The administration of sunitinib should be interrupted and/or the dose reduced in patients without clinical evidence of CHF but with an ejection fraction <50% and >20% below baseline. • **Dose Modification:** ○ Dose modifications in 12.5 mg steps may be applied based on individual safety and tolerability. Daily dose should not exceed 75 mg or be decreased below 25 mg. Dose interruptions may be required based on individual safety and tolerability. • **Common drug interactions (for comprehensive list refer to BNF/SPC):** • Avoid concomitant treatment with potent CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, clarithromycin, erythromycin) or inducers (e.g. rifampicin, dexamethasone, phenytoin, carbamazepine). If it is not possible to avoid concurrent administration with a potent CYP3A4 inhibitor, the dose of sunitinib may need to be reduced to a minimum of 37.5 mg. Similarly, if concurrent potent CYP3A4 inducers are used, a dose increase may be required, see SPC. • Patients on anti-coagulants (e.g., warfarin, acenocoumarol) should be closely monitored (INR/PT). • **Missed dose:** If a dose is missed the patient should not take an additional dose, take next dose at usual time**.** • **Driving and operating machinery:** Patients should be advised to be cautious when driving or using machines in case they experience fatigue or dizziness during treatment. • For oral self-administration: refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet and Cancerbackup information sheet.
References	KMCC proforma RCC-002 V5 ARIA regimen V2 SPC accessed online 02.10 2024 MSN Laboratories Europe Ltd.

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

Repeat every 6 weeks

TTO	Drug	Dose	Route	Directions
Day 1	**SUNITINIB**	**50mg**	PO	Each day **for 4 weeks followed by a 2-week rest period. Not to be taken with grapefruit juice.** Available as 12.5mg, 25mg, and 50mg capsules For patients who are stable on treatment a maximum of 3 months supply can be dispensed.
	Metoclopramide	10mg	PO	10mg up to TDS when required dispense 28 tablets on cycle 1, then only if specified. Do not take for more than 5 days continuously.
	Loperamide	2mg-4mg	PO	Take two capsules (4mg) initially, then one capsule (2mg) after each loose stool when required (max. 8 capsules a day) Dispense 30 capsules on cycle 1, then only if specified.