Notification: update to haematological dose modifications for eviQ medical oncology protocols – May 2018

The haematological dose modifications in all applicable eviQ medical oncology treatment protocols (curative and palliative) will be updated to reflect current clinical practice.

These changes have been decided following consultation with medical oncologists across Australia. More than 400 MOGA members and 180 eviQ reference committee members were surveyed on their current practice for dose modification and treatment delay for haematological toxicity. There were 156 respondents covering all states and territories and metropolitan, regional, public and private settings.

Please note that these changes are ONLY for medical oncology treatment protocols. The eviQ Haematology reference committee was consulted and the decision was not to adopt these changes at this stage.

These changes will begin to be made in the relevant protocols from **Tuesday 8th May 2018**.

While the changes reflect consensus of current practice, evidence for dose modifications is limited and the **eviQ dose modifications are intended as a guide only**. Any dose modification should be based on clinical judgement, and the individual patient's situation.

Summary of changes

Curative protocols (adjuvant/neoadjuvant)
(please refer to example below)

- Reduce the cut off for treatment delay for platelets from 100 x 10^9/L to 75 x 10^9/L with recommendation *'Refer to local institution guidelines; it is the view of the expert clinicians that treatment should continue if the patient is clinically well.'*
- Stipulate that results refer to pre-treatment blood tests

Palliative protocols (recurrent/advanced/metastatic)
(please refer to example below)

- Reduce the cut off for treatment delay for neutrophils from 1.5 x 10^9/L to 1.0 x 10^9/L with the recommendation: *'Refer to local institution guidelines; it is the view of the expert clinicians that treatment should continue if the patient is clinically well.'*
- Reduce the cut off for treatment delay for platelets from 100 x 10^9/L to 75 x 10^9/L with the recommendation: *'The general recommendation is to delay; however if the patient is clinically well it may be appropriate to continue treatment; refer to treating team and/or local institution guidelines.'*
- Stipulate that results refer to pre-treatment blood tests

For all protocols, the dose modifications disclaimer will also be updated as below.

Example of curative (adjuvant/neoadjuvant) protocol:

Haematological toxicity	
ANC x 10^9/L (pre-treatment blood test)	
0.5 to less than 1.0	Delay treatment until recovery
less than 0.5	Delay treatment until recovery and consider reducing capecitabine by 25% for subsequent cycles
Febrile neutropenia	Delay treatment until recovery and consider reducing capecitabine by 25% for subsequent cycles
Platelets x 10^9/L (pre-treatment blood test)	
75 to less than 100	Refer to local institutional guidelines; it is the view of the expert clinicians that treatment should continue if the patient is clinically well
50 to less than 75	Delay treatment until recovery
less than 50	Delay treatment until recovery and consider reducing capecitabine by 25% for subsequent cycles

Note: All dose reductions are calculated as a percentage of the starting dose

Example of palliative (recurrent/advanced/metastatic) protocol:

Haematological toxicity	
ANC x 10^9/L (pre-treatment blood test)	
1.0 to less than 1.5	Refer to local institutional guidelines; it is the view of the expert clinicians that treatment should continue if the patient is clinically well.
0.5 to less than 1.0	Delay treatment until recovery
less than 0.5	Delay treatment until recovery and consider reducing capecitabine by 25% for subsequent cycles
Febrile neutropenia	Delay treatment until recovery and consider reducing capecitabine by 25% for subsequent cycles
Platelets x 10^9/L (pre-treatment blood test)	
75 to less than 100	The general recommendation is to delay, however if the patient is clinically well it may be appropriate to continue treatment; refer to treating team and/or local institutional guidelines.
50 to less than 75	Delay treatment until recovery
less than 50	Delay treatment until recovery and consider reducing capecitabine by 25% for subsequent cycles

Note: All dose reductions are calculated as a percentage of the starting dose

Dose modifications Disclaimer
Additional text as highlighted in yellow:

Evidence for dose modifications is limited, and the recommendations made on eviQ are intended as a guide only. They are generally conservative with an emphasis on safety. Any dose modification should be based on clinical judgement, and the individual patient's situation including but not limited to treatment intent (curative versus palliative), the antineoplastic regimen (single versus combination therapy versus chemotherapy versus immunotherapy), biology of the cancer (site, size, mutations, metastases), other treatment related side effects, additional co-morbidities, performance status and patient preferences. Suggested dose modifications are based on clinical trial findings, product information and reference committee consensus. Non-haematological gradings are based on Common Terminology Criteria for Adverse Events (CTCAE) unless otherwise specified. Renal and hepatic dose modifications have been standardised where possible. For more information see dosing considerations & disclaimer.