Lymphoma bendamustine and rituximab

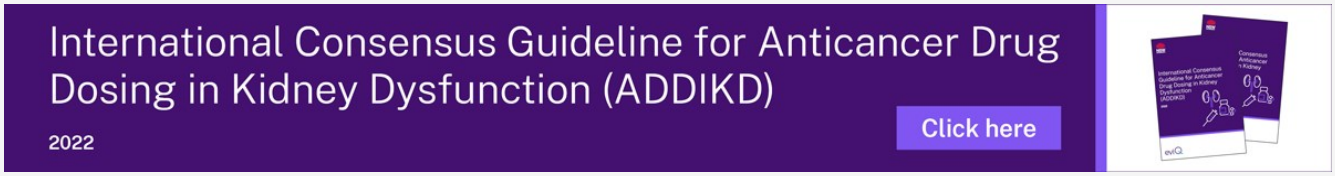
ID: 3794 v.7 **Endorsed** Essential Medicine List

The CLL indication was removed from this multi indication protocol so the correct dose of rituximab from cycle 2 could be given, see ID 3811 Chronic lymphocytic leukaemia bendamustine and rituximab for further information.

Patients with lymphoma should be considered for inclusion into clinical trials. Link to ALLG website, ANZCTR website and Lymphoma Australia website.

Some indications in this protocol are based on limited evidence; please refer to the individual evidence sections for more information.

The anticancer drug(s) in this protocol may have been included in the ADDIKD guideline. Dose recommendations in kidney dysfunction have yet to be updated to align with the ADDIKD guideline. Recommendations will be updated once the individual protocol has been evaluated by the reference committee. For further information refer to the ADDIKD guideline. To assist with calculations, use the eviQ Estimated Glomerular Filtration Rate (eGFR) calculator.



Treatment schedule - Overview

Cycle 1 to 6

Drug	Dose	Route	Day
Rituximab	375 mg/m^2	IV infusion	1
Bendamustine *	90 mg/m^2	IV infusion	1 and 2

*Bendamustine doses in this protocol are expressed as bendamustine hydrochloride

Frequency: 28 days

Cycles: 6 unless disease progression or unacceptable toxicity

Drug status: **Bendamustine**: (PBS authority)

Rituximab: is on the PBS general schedule

Cost: ~ $2,370 per cycle

Treatment schedule - Detail

The supportive therapies (e.g. antiemetics, premedications, etc.), infusion times, diluents, volumes and routes of administration, if included, are listed as defaults. They may vary between institutions and can be substituted to reflect individual institutional policy.

*Antiemetics if included in the treatment schedule are based upon recommendations from national and international guidelines. These are **defaults only** and may be substituted to reflect individual institutional policy. Select here for recommended doses of alternative antiemetics.*

Cycle 1 to 6

Day 1		

Day 1		
Paracetamol	1,000 mg (PO)	60 minutes before treatment
Loratadine	10 mg (PO)	60 minutes before treatment
Hydrocortisone	100 mg (IV)	30 minutes before treatment
Rituximab	375 mg/m^2 (IV infusion)	in 500 mL sodium chloride 0.9% as per graded administration rate
Palonosetron	0.25 mg (IV bolus)	30 minutes before chemotherapy
Bendamustine	90 mg/m^2 (IV infusion)	in 500 mL sodium chloride 0.9% over 30 to 60 minutes *

Day 2		
Dexamethasone	8 mg (PO)	ONCE a day with or after food (or in divided doses).
Bendamustine	90 mg/m^2 (IV infusion)	in 500 mL sodium chloride 0.9% over 30 to 60 minutes *

Day 3 and 4		
Dexamethasone	8 mg (PO)	with or after food (or in divided doses). Note: dexamethasone doses on day 3 and 4 may not be required and may be reduced or omitted at the clinician's discretion. **

*Bendamustine doses in this protocol are expressed as bendamustine hydrochloride

** Link to ID 7 Prevention of chemotherapy induced nausea and vomiting

Frequency: 28 days

Cycles: 6 unless disease progression or unacceptable toxicity

Indications and patient population - Indolent Non-Hodgkin lymphoma

- Previously untreated indolent CD20-positive non-Hodgkin lymphoma (NHL)
- Relapsed or refractory indolent CD20-positive non-Hodgkin lymphoma (NHL)

Indications and patient population - Mantle cell lymphoma

- Previously untreated CD20-positive, stage III-IV mantle cell lymphoma (MCL) in patients ineligible for autologous stem cell transplant

Clinical information

Venous access required	IV cannula (IVC) or central venous access device (CVAD) is required to administer this treatment. Read more about central venous access device line selection
Hypersensitivity/infusion related reaction	High risk with bendamustine and rituximab Read more about Hypersensitivity reaction
Premedication	The product information states that premedication is required for this treatment. Please refer to the treatment schedule for suggested premedication regimen. This may be substituted to reflect institutional policy.

Emetogenicity MODERATE	Suggested default antiemetics have been added to the treatment schedule, and may be substituted to reflect institutional policy. A steroid has been included both as an antiemetic and premedication for hypersensitivity in this protocol. Ensure that patients also have sufficient antiemetics for breakthrough emesis: Metoclopramide 10 mg three times a day when necessary (maximum of 30 mg/24 hours, up to 5 days) OR Prochlorperazine 10 mg PO every 6 hours when necessary. Read more about preventing anti-cancer therapy induced nausea and vomiting
Cardiac toxicity	In patients with cardiac disorders the concentration of potassium in the blood must be closely monitored and ECG measurement must be performed during treatment with bendamustine. Potassium supplementation must be given when K+ < 3.5 mEq/L. Read more about cardiac toxicity associated with anti-cancer drugs
Rituximab rapid infusion	This regimen is not in line with the product monograph, however published literature indicates that it can be completed safely. Read more about the rapid infusion of rituximab
Progressive multifocal leukoencephalopathy	Use of monoclonal antibodies may be associated with an increased risk of progressive multifocal leukoencephalopathy (PML), a rare but potentially fatal opportunistic viral infection of the brain. Patients must be monitored for any new or worsening neurological symptoms. Read more about progressive multifocal leukoencephalopathy and the Therapeutic Goods Administration Medicines Safety update on progressive multifocal leukoencephalopathy from the Australian Government, Department of Health.
Central nervous system (CNS) prophylaxis	Consider CNS relapse assessment in patients with high grade lymphoma. Read more about CNS prophylaxis in diffuse large cell lymphoma
Biosimilar drug	Read more about biosimilar drugs on the Biosimilar Awareness Initiative page
Tumour lysis risk	Assess patient for risk of developing tumour lysis syndrome. Read more about prevention and management of tumour lysis syndrome.
Pneumocystis jirovecii pneumonia (PJP) prophylaxis	Read more about prophylaxis of pneumocystis jiroveci (carinii) in cancer patients
Antiviral prophylaxis	Read more about antiviral prophylaxis drugs and doses
Antifungal prophylaxis	Read more about antifungal prophylaxis drugs and doses.
Irradiated blood components	The use of irradiated of blood components is recommended for patients receiving this treatment. Read more about the indications for the use of irradiated blood components
Blood tests	FBC, EUC, eGFR, LFTs and LDH at baseline, and prior to each cycle and as clinically indicated.
Hepatitis B screening and prophylaxis	Routine screening for HBsAg and anti-HBc is recommended prior to initiation of treatment. Prophylaxis should be determined according to individual institutional policy. Read more about hepatitis B screening and prophylaxis in cancer patients requiring cytotoxic and/or immunosuppressive therapy
Vaccinations	Live vaccines are contraindicated in cancer patients receiving immunosuppressive therapy and/or who have poorly controlled malignant disease. Refer to the recommended schedule of vaccination for immunocompromised patients, as outlined in the Australian Immunisation Handbook. Read more about COVID-19 vaccines and cancer.

Fertility, pregnancy and lactation	Cancer treatment can have harmful effects on fertility and this should be discussed with all patients of reproductive potential prior to commencing treatment. There is a risk of foetal harm in pregnant women. A pregnancy test should be considered prior to initiating treatment in females of reproductive potential if sexually active. It is important that all patients of reproductive potential use effective contraception whilst on therapy and after treatment finishes. Effective contraception methods and adequate contraception timeframe should be discussed with all patients of reproductive potential. Possibility of infant risk should be discussed with breastfeeding patients. Read more about the effect of cancer treatment on fertility

Dose modifications

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 vs palliative), the anti-cancer 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, published guidelines and reference committee consensus . The dose reduction applies to each individual dose and not to the total number of days or duration of treatment cycle unless stated otherwise. 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 .

The dose recommendations in kidney dysfunction (i.e.renal impairment) displayed may not reflect those in the ADDIKD guideline and have been included for historical reference only. Recommendations will be updated once the individual protocol has been evaluated by the reference committee, with this version of the protocol then being archived. Clinicians are expected to refer to the ADDIKD guideline prior to prescribing in kidney dysfunction.
International Consensus Guideline for Anticancer Drug Dosing in Kidney Dysfunction (ADDIKD).

Note:

- Dose modifications are as per product information
- All dose reductions are calculated as a percentage of the starting dose

Haematological toxicity	
ANC x 10^9/L (pre-treatment blood test)	
less than 1.0	Delay treatment until recovery
Platelets x 10^9/L (pre-treatment blood test)	
less than 75	Delay treatment until recovery to greater than 100

Renal impairment	
Creatinine clearance (mL/min)	
greater than 10	No dose reduction

There is limited data available in patients with severe renal impairment

Hepatic impairment*	
Serum bilirubin (micromol/L)**	
20 to 51	Consider reducing bendamustine dose by 30%
greater than 51	Bendamustine not recommended as there is no data is available

** Based on the exclusion of other causes of hepatic impairment (e.g. Gilbert's syndrome, haemolysis)*
*** Units converted from mg/dL to micromol/L to reflect common reporting parameters used in Australia*

Non-haematological toxicity	
Grade 3	Delay treatment until recovery and consider reducing bendamustine dose by 50%. If the toxicity resolves and the previous dose is tolerated the reduced dose may be increased again
Grade 4	Withhold treatment

Interactions

Drug interactions in eviQ protocols are under review and being updated to align with current literature. Further site-wide updates and changes will occur in due course. ***References & Disclaimer***

The drug interactions shown below are not an exhaustive list. For a more comprehensive list and for detailed information on specific drug interactions and clinical management, please refer to the specific drug product information and the following key resources:

- *MIMS - interactions tab (includes link to a CYP-450 table) (login required)*
- *Australian Medicines Handbook (AMH) – interactions tab (login required)*
- *Micromedex Drug Interactions (login required)*
- *Cancer Drug Interactions*
- *Cytochrome P450 Drug Interactions*

Bendamustine
No specific clinically significant drug-drug interactions. No formal clinical drug interaction studies with bendamustine have been conducted however there is potential for CYP1A2 inhibitors (e.g. aciclovir, ciprofloxacin and fluvoxamine).

Rituximab		
	Interaction	**Clinical management**
Antihypertensives	Additive hypotensive effect	Consider withholding antihypertensive medications 12 hours prior to the rituximab infusion
Immunosuppressants (eg. abatacept and baricitinib etc.)	Increased risk of infection	Concurrent use not recommended. If an immunosuppressant must be used, monitor closely for signs of infection

General		
	Interaction	**Clinical management**
Warfarin	Anti-cancer drugs may alter the anticoagulant effect of warfarin.	Monitor INR regularly and adjust warfarin dosage as appropriate; consider alternative anticoagulant.
Direct oral anticoagulants (DOACs) e.g. apixaban, rivaroxaban, dabigatran	Interaction with both CYP3A4 and P-gp inhibitors /inducers. DOAC and anti-cancer drug levels may both be altered, possibly leading to loss of efficacy or toxicity (i.e. increased bleeding).	Apixaban: avoid concurrent use with strong CYP3A4 and P-gp inhibitors. If treating VTE, avoid use with strong CYP3A4 and P-gp inducers. Rivaroxaban: avoid concurrent use with strong CYP3A4 and P-gp inhibitors. Dabigatran: avoid combination with strong P-gp inducers and inhibitors. If concurrent use is unavoidable, monitor closely for efficacy/toxicity of both drugs.
Digoxin	Anti-cancer drugs can damage the lining of the intestine; affecting the absorption of digoxin.	Monitor digoxin serum levels; adjust digoxin dosage as appropriate.
Antiepileptics	Both altered antiepileptic and anti-cancer drug levels may occur, possibly leading to loss of efficacy or toxicity.	Where concurrent use of an enzyme-inducing antiepileptic cannot be avoided, monitor antiepileptic serum levels for toxicity, as well as seizure frequency for efficacy; adjust dosage as appropriate. Also monitor closely for efficacy of the anti-cancer therapy.
Antiplatelet agents and NSAIDs	Increased risk of bleeding due to treatment related thrombocytopenia.	Avoid or minimise combination. If combination deemed essential, (e.g. low dose aspirin for ischaemic heart disease) monitor for signs of bleeding.
Serotonergic drugs, including selective serotonin reuptake inhibitors (SSRIs e.g. paroxetine) and serotonin noradrenaline reuptake inhibitors (SNRIs e.g. venlafaxine)	Increased risk of serotonin syndrome with concurrent use of 5-HT3 receptor antagonists (e.g. palonosetron, ondansetron, granisetron, tropisetron, dolasetron, etc.)	Avoid combination. If combination is clinically warranted, monitor for signs and symptoms of serotonin syndrome (e.g. confusion, agitation, tachycardia, hyperreflexia). For more information link to TGA Medicines Safety Update
Vaccines	Diminished response to vaccines and increased risk of infection with live vaccines.	Live vaccines (e.g. BCG, MMR, zoster and varicella) are contraindicated in patients on immunosuppressive therapy. Use with caution in patients on non-immunosuppressive therapy. For more information; refer to the recommended schedule of vaccination for cancer patients, as outlined in the Australian Immunisation Handbook

Administration

eviQ provides safe and effective instructions on how to administer cancer treatments. However, eviQ does not provide every treatment delivery option, and is unable to provide a comprehensive list of cancer treatment agents and their required IV line giving set/filter. There may be alternative methods of treatment administration, and alternative supportive treatments that are also appropriate. Please refer to the individual

product information monographs via the TGA website for further information.

Day 1

Approximate treatment time: 8 hours (initial); 4 to 6 hours (subsequent)

Safe handling and waste management

Safe administration

General patient assessment prior to each day of treatment.

Any toxicity grade 2 or greater may require delay of treatment and review by medical officer before commencing treatment.

Prime IV line(s).

Insert IV cannula or access TIVAD or CVAD.

- baseline weight

Hydration if prescribed.

Treatment - Time out

Rituximab

Prior to administration:

- check baseline observations
- check for previous adverse events during previous infusions
- verify premedication has been taken. If not, administer 30 to 60 minutes prior to rituximab administration:
  - paracetamol 1000 mg orally AND
  - loratadine 10 mg orally (or similar antihistamine)
  - a steroid may also be included as a premed according to local guidelines

Initial infusion:

- **commence rituximab** infusion at 50 mg/hr for 30 minutes
- repeat observations prior to each rate increase
- **increase rate** by 50 mg/hr every 30 minutes, up to a maximum of 400 mg/hr if observations are stable
- flush with ~ 50 mL of sodium chloride 0.9%

If an infusion reaction occurs, temporarily discontinue the infusion and notify medical officer

- when symptoms have completely resolved, recommence the infusion at half the rate prior to the reaction
- for severe reactions **stop** infusion and manage as per emergency

Transient hypotension may occur. Consider withholding antihypertensive medication for 12 hours before and during infusion.

Subsequent infusions:

If an adverse event was experienced with initial infusion recommence infusion at the same rate as initial infusion

- **commence** rituximab infusion at 100 mg/hr
- repeat observations prior to each rate increase
- increase rate by 100 mg/hr increments every 30 minutes to a maximum of 400 mg/hr if observations are stable
- flush with ~ 50 mL of sodium chloride 0.9%

If an infusion reaction occurs, temporarily discontinue the infusion and notify medical officer

- when symptoms have resolved, recommence the infusion at **half the rate** prior to the reaction
- for severe reactions **stop** infusion and manage as per emergency

Read more about rapid infusion rituximab

Pre treatment medication

Verify antiemetics taken or administer as prescribed.

Chemotherapy - Time out

Bendamustine

Prior to administration check:

- blood pressure (hypertensive crisis has been reported with bendamustine, hypertension should be well controlled prior to treatment with bendamustine)
- baseline ECG, then regularly throughout treatment for patients with cardiac disorders
- monitor potassium levels throughout treatment, potassium supplements must be given when K+ < 3.5 mEq/L.

Administer bendamustine (irritant with vesicant properties):

- via IV infusion over 30 to 60 minutes
- flush with ~ 100 mL of sodium chloride 0.9%

Stop infusion at first sign of reaction:

- if symptoms are mild and resolve when infusion is stopped, consider recommencing infusion after review by medical officer at a slower rate.
- for severe reactions seek medical assistance immediately and do not restart infusion
- hypersensitivity are more common after the first cycle

Remove IV cannula and/or deaccess TIVAD or CVAD.

Continue safe handling precautions until 7 days after completion of drug(s)

Day 2

Approximate treatment time: 60 minutes

Safe handling and waste management

Safe administration

General patient assessment prior to each day of treatment.

Any toxicity grade 2 or greater may require delay of treatment and review by medical officer before commencing treatment.

Prime IV line(s).

Insert IV cannula or access TIVAD or CVAD.

Hydration if prescribed.

Pre treatment medication

Verify antiemetics taken or administer as prescribed.

Chemotherapy - Time out

Bendamustine

Prior to administration check:

- blood pressure (hypertensive crisis has been reported with bendamustine, hypertension should be well controlled prior to treatment with bendamustine)
- baseline ECG, then regularly throughout treatment for patients with cardiac disorders
- monitor potassium levels throughout treatment, potassium supplements must be given when K+ < 3.5 mEq/L.

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- via IV infusion over 30 to 60 minutes
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- if symptoms are mild and resolve when infusion is stopped, consider recommencing infusion after review by medical officer at a slower rate.

- for severe reactions seek medical assistance immediately and do not restart infusion
- hypersensitivity are more common after the first cycle

Remove IV cannula and/or deaccess TIVAD or CVAD.

Continue safe handling precautions until 7 days after completion of drug(s)

Discharge information

Antiemetics

- Antiemetics as prescribed.

Prophylaxis medications

- Prophylaxis medications (if prescribed) i.e. tumour lysis prophylaxis, PJP prophylaxis, antifungals, antivirals.

Patient information

- Ensure patient receives patient information sheet.

Side effects

The side effects listed below are not a complete list of all possible side effects for this treatment. Side effects are categorised into the approximate onset of presentation and should only be used as a guide.

Immediate (onset hours to days)	
Extravasation, tissue or vein injury	The unintentional instillation or leakage of a drug or substance out of a blood vessel into surrounding tissue. This has the potential to cause damage to affected tissue. Read more about extravasation management
Flu-like symptoms	
Headache	
Hypersensitivity reaction	Anaphylaxis and infusion related reactions can occur with this treatment. Read more about hypersensitivity reaction
Nausea and vomiting	Read more about prevention of treatment induced nausea and vomiting
Taste and smell alteration	Read more about taste and smell changes

Early (onset days to weeks)	
Neutropenia	Abnormally low levels of neutrophils in the blood. This increases the risk of infection. Any fever or suspicion of infection should be investigated immediately and managed aggressively. Read more about immediate management of neutropenic fever
Thrombocytopenia	A reduction in the normal levels of functional platelets, increasing the risk of abnormal bleeding. Read more about thrombocytopenia
Abdominal pain	Dull ache, cramping or sharp pains are common with some anti-cancer drugs. These are caused by either increased or decreased gastrointestinal motility and can be associated with diarrhoea or constipation.
Anorexia	Loss of appetite accompanied by decreased food intake. Read more about anorexia
Arthralgia and myalgia	Generalised joint pain or and/or stiffness and muscle aches, often worse upon waking or after long periods of inactivity. Can improve with movement. May be mild or severe, intermittent or constant and accompanied by inflammation. Read more about arthralgia and myalgia
Constipation	
Diarrhoea	Read more about treatment induced diarrhoea
Fatigue	Read more about fatigue
Fluid retention and oedema	An excess amount of fluid around the cells, tissues or serous cavities of the body, leading to swelling.
Skin rash	Anti-cancer drugs can cause a number of changes in the skin with maculo-papular rash the most common type of drug-induced skin reaction. Read more about skin rash

Late (onset weeks to months)	
Anaemia	Abnormally low levels of red blood cells (RBCs) or haemoglobin in the blood. Read more about anaemia
CD3+ and CD4+ T-cell suppression	Long-lasting suppression of CD3+ and CD4+ T-cells is commonly found after treatment with bendamustine. This may predispose to recurrent infection which can occur in the late follow up phase.
Progressive multifocal leukoencephalopathy (PML)	A rare opportunistic viral infection of the brain, usually leading to death or severe disability, can occur with monoclonal antibodies (e.g. rituximab, obinutuzumab, ofatumumab, brentuximab vedotin) and other targeted therapies (e.g. ibrutinib, ruxolitinib, idelalisib). Onset may occur up to months after the final dose. Read more about progressive multifocal leukoencephalopathy (PML)

Evidence

Efficacy

In the 2013 StiL study by Rummel et al., in previously untreated patients with stage 3 or 4 CD20 positive indolent non-Hodgkin lymphoma (NHL) or mantle cell lymphoma, rituximab and bendamustine (BR) was compared with rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisolone (R-CHOP). The BR arm produced superior response rates.[1] While the 2014 Bright study by Flinn et al. compared BR with R-CHOP or rituximab, cyclophosphamide, vincristine, and prednisolone (R-CVP), BR was non-inferior.[2] Progression-free survival (PFS) was superior in the BR arms in both studies, including the mantle cell lymphoma subgroup. However, no significant overall survival (OS) was observed. A phase-3 study compared BR with fludarabine and rituximab in relapsed indolent and mantle cell lymphoma. PFS, with a median follow up of 96 months, was superior for BR (34 months) compared to fludarabine plus rituximab (11.7 months) ($p < 0.0001$).[3]

Specific to follicular lymphoma, the 2017 GALLIUM study by Marcus et al.[4, 5] randomised the CD20 monoclonal antibody rituximab

or obinutuzumab during induction and maintenance in combination with the treating centres choice of bendamustine, CHOP or CVP, in which bendamustine was used in 57%. Overall, the use of obinutuzumab chemotherapy improved PFS compared with rituximab chemotherapy. The improved PFS with obinutuzumab over rituximab persisted in the subgroup of patients receiving bendamustine though there was no difference in response rates. The efficacy of the chemotherapy backbones were not compared in this study, though patients receiving CHOP had higher Follicular Lymphoma International Prognostic Index (FLIPI) scores and more bulky disease.

Paper	Study Phase	Patient population	Comparator	Patient Number	% MCL	PFS (months)	CR
Rummel et al.[1] **2013**	3	Previously untreated stage 3 or 4 low grade NHL or mantle cell lymphoma requiring treatment	BR vs R-CHOP	514	BR:18% R-CHOP: 19%	BR: median 69.5 R-CHOP: median 31.2 p<0.001	BR: 40% R-CHOP: 30% p<0.021
Flinn et al.[2] **2014**	3	Previously untreated stage 2 to 4 low grade NHL or mantle cell lymphoma requiring treatment	BR vs R-CVP or R-CHOP	447	BR: 16% R-CHOP/ CVP: 17%	5-yr PFS BR: 65.5% R-CHOP/CVP: 55.8% p=0.0025	BR: 31% R-CHOP/CVP: 25% p<0.1269
Rummel et al.[3] **2016**		Relapsed indolent NHL and mantle cell lymphoma	BR vs fludarabine plus rituximab (FR)	230	BR: 21% FR: 22%	At median follow up 96 months BR 34 months FR 11.7 months P<0.0001	BR 40% FR 17% P=0.0002
Marcus et al.[4, 5] **2017**	3	Previously untreated stage 3-4 or bulky stage 2 follicular lymphoma requiring treatment	Bendamustine/CHOP/CVP + rituximab vs obinutuzumab + maintenance	1202 (BR 341)	N/A	3 yr PFS BR: 76% R-CHOP: 76%	BR: 77% R-CHOP: 69% At end of induction by Lugano 2014[6] criteria

Toxicity

The 2013 study by Rummel et al. reported BR to be better tolerated than R-CHOP (see tables below). There were lower rates of alopecia (0% vs 100%; p<0.0001), haematological toxicity (30% vs 68%; p<0.0001), infections (37% vs 50%; p=0.0025), peripheral neuropathy (7% vs 29%; p<0.0001) and stomatitis (6% vs 19%; p<0.0001). BR was associated with more erythematous skin reactions (16% vs 23% p=0.024).[1]

Table 1: Haematological toxic events in patients receiving at least one dose of study treatment[1]

	Grade 1		Grade 2		Grade 3		Grade 4		Grade 3–4	
	R-CHOP	B-R	R-CHOP	B-R	R-CHOP	B-R	R-CHOP	B-R	R-CHOP	B-R
Leucocytopenia	13 (5%)	52 (19%)	39 (15%)	80 (30%)	110 (44%)	85 (32%)	71 (28%)	13 (5%)	181 (72%)*	98 (37%)*
Neutropenia	6 (2%)	30 (11%)	19 (8%)	61 (23%)	70 (28%)	53 (20%)	103 (41%)	24 (9%)	173 (69%)*	77 (29%)*
Lymphocytopenia	12 (5%)	14 (5%)	72 (29%)	38 (14%)	87 (35%)	122 (46%)	19 (8%)	74 (28%)	106 (43%)	196 (74%)
Anaemia	115 (46%)	102 (38%)	84 (33%)	44 (16%)	10 (4%)	6 (2%)	2 (<1%)	2 (<1%)	12 (5%)	8 (3%)
Thrombocytopenia	89 (35%)	104 (39%)	20 (8%)	19 (7%)	11 (4%)	15 (6%)	5 (2%)	2 (<1%)	16 (6%)	13 (5%)

B-R=bendamustine plus rituximab. R-CHOP=CHOP plus rituximab. *p<0·0001 between groups.

Table 3: **Haematological toxic events in patients receiving at least one dose of study treatment**

Table 2: All grades of non-haematological toxic events in patients receiving at least one dose of study treatment[1]

	B-R (n=261)	R-CHOP (n=253)	p value
Alopecia	0	245 (100%)*	<0·0001
Paresthesia	18 (7%)	73 (29%)	<0·0001
Stomatitis	16 (6%)	47 (19%)	<0·0001
Skin (erythema)	42 (16%)	23 (9%)	0·024
Skin (allergic reaction)	40 (15%)	15 (6%)	0·0006
Infectious episodes	96 (37%)	127 (50%)	0·0025
Sepsis	1 (<1%)	8 (3%)	0·019

B-R=bendamustine plus rituximab. R-CHOP=CHOP plus rituximab. *Includes only patients who received three or more cycles.

Table 4: **All grades of non-haematological toxic events in patients receiving at least one dose of study treatment**

Analysis of the 2017 study by Marcus et al. with chemotherapy backbone showed more serious adverse events (AE's) prior to the next line of treatment in the BR (47%) group than the R-CHOP (33%) and RCVP (34%) groups.[1, 4, 5] Frequency of grade 3-5 AE's were higher in the R-CHOP group - due to increased cytopenias, however group 3-5 infection were higher in the BR group due to infections in the maintenance phase. Fatal AE's were higher with BR (4%) than R-CHOP (2%) or R-CVP (2%) and more common in patients age >70.

Table 3: Adverse events and serious adverse events[1]

Table 3. Adverse Events and Serious Adverse Events, According to Treatment Phase, and Selected Grade 3 to 5 Adverse Events during Treatment, According to Chemotherapy Agent and Treatment Phase in the Safety Population.*

Event	Overall Trial†		Induction Phase		Maintenance and Observation Phases		Follow-up	
	Obinutuzumab Group (N=595)	Rituximab Group (N=597)	Obinutuzumab Group (N=595)	Rituximab Group (N=597)	Obinutuzumab Group (N=548)	Rituximab Group (N=535)	Obinutuzumab Group (N=427)	Rituximab Group (N=428)
No. of events	10,311	9343	7012	6533	3002	2578	295	230
Patients with ≥1 adverse event — no. (%)								
Any event	592 (99.5)	587 (98.3)	580 (97.5)	577 (96.6)	501 (91.4)	458 (85.6)	130 (30.4)	106 (24.8)
Event of grade 3 to 5	444 (74.6)	405 (67.8)	357 (60.0)	336 (56.3)	205 (37.4)	169 (31.6)	56 (13.1)	33 (7.7)
Event of grade 5‡	24 (4.0)	20 (3.4)§	4 (0.7)	3 (0.5)	10 (1.8)	10 (1.9)	10 (2.3)	7 (1.6)
Patients with ≥1 serious adverse event — no. (%)	274 (46.1)	238 (39.9)	166 (27.9)	144 (24.1)	134 (24.5)	110 (20.6)	47 (11.0)	34 (7.9)
Treatment-related adverse event — no. (%)								
Any event	564 (94.8)	547 (91.6)	—	—	—	—	—	—
Event leading to withdrawal of treatment	75 (12.6)	65 (10.9)	—	—	—	—	—	—
Event leading to any dose reduction	103 (17.3)	89 (14.9)	—	—	—	—	—	—
Serious adverse event leading to withdrawal of treatment — no. (%)	44 (7.4)	36 (6.0)	—	—	—	—	—	—
Serious adverse event leading to dose reduction — no. (%)	12 (2.0)	10 (1.7)	—	—	—	—	—	—
Grade 3 to 5 event, according to chemotherapy regimen — no./total no. (%)								
Neutropenia	—	—						
Bendamustine	—	—	73/338 (21.6)	87/338 (25.7)	49/312 (15.7)	29/305 (9.5)	6/270 (2.2)	1/263 (0.4)
CHOP	—	—	124/193 (64.2)	103/203 (50.7)	36/179 (20.1)	26/187 (13.9)	2/128 (1.6)	0
CVP	—	—	24/61 (39.3)	13/56 (23.2)	5/57 (8.8)	2/43 (4.7)	0	0
Infection¶	—	—						
Bendamustine	—	—	27/338 (8.0)	26/338 (7.7)	52/312 (16.7)	39/305 (12.8)	25/270 (9.3)	6/263 (2.3)
CHOP	—	—	14/193 (7.3)	13/203 (6.4)	7/179 (3.9)	11/187 (5.9)	2/128 (1.6)	2/143 (1.4)
CVP	—	—	3/61 (4.9)	4/56 (7.1)	5/57 (8.8)	1/43 (2.3)	1/44 (2.3)	2/45 (4.4)
Second neoplasm‖	—	—						
Bendamustine	—	—	0	0	21/312 (6.7)	18/305 (5.9)	14/270 (5.2)	2/263 (0.8)
CHOP	—	—	0	0	8/179 (4.5)	8/187 (4.3)	1/128 (0.8)	1/143 (0.7)
CVP	—	—	0	0	0	1/43 (2.3)	0	0

* Events included preferred terms defined with the use of the *Medical Dictionary for Regulatory Activities* (MedDRA), version 18.1. All the adverse events were assessed and graded throughout the trial (see the Supplementary Appendix). Adverse events of grade 3, 4, and 5 indicate severe, life-threatening, and fatal adverse events, respectively. Serious adverse events include fatal or life-threatening events or events that cause (or prolong) in-patient hospitalization or substantial disability or incapacity. Regardless of grading (severity), some adverse events may also meet the criteria for a serious adverse event.

† Data include adverse events occurring during the pretreatment, induction, maintenance and observation, and post-treatment follow-up phases; patients who had a given adverse event in more than one study phase are counted only once in the overall trial column. Data also include deaths in patients who had no other adverse events.

‡ Fatal adverse events (grade 5) during induction (which occurred in one patient each unless otherwise specified) were cardiogenic shock, pneumonia (in two), and dehydration in the obinutuzumab group and multiorgan failure, septic shock, and polyneuropathy in the rituximab group. Fatal adverse events that occurred after induction (in one patient each) were cardiogenic shock, gastric hemorrhage, death, pneumonia, staphylococcal bacteremia, acute lymphocytic leukemia, acute myeloid leukemia, hepatic neoplasm, acute lung injury, and respiratory failure in the obinutuzumab group and cardiac arrest, myocardial infarction, death, multiorgan failure, colon cancer, gastric cancer, lung adenocarcinoma, malignant melanoma, neuroendocrine carcinoma of the skin, and encephalopathy in the rituximab group. Fatal adverse events occurring in the follow-up phase were upper gastrointestinal hemorrhage, ill-defined disorder, pneumonia, lower respiratory tract infection, lung infection, respiratory tract infection, sepsis, non–small-cell lung cancer, and non–small-cell lung cancer of stage IV (in one patient each) and *Clostridium difficile* colitis, the myelodysplastic syndrome, and prostate cancer (all in one patient) in the obinutuzumab group; and general physical health deterioration, pneumonia, hypercalcemia, cerebral hematoma, cerebrovascular accident, ischemic stroke and chronic obstructive pulmonary disease (in one patient each) in the rituximab group.

§ Four additional deaths in the rituximab group are not included in this total. In line with the reporting rules in the protocol, they were considered to be temporally unrelated to the use of an investigational medicinal product and so were not reported as adverse events.

¶ Events were in the MedDRA system organ class "Infections and Infestations."

‖ Second neoplasm is the standardized MedDRA query for malignant or unspecified tumors that are diagnosed 6 months after the start of the study treatment.

A long term follow up study of 149 patients with relapsed NHL treated in three different clinical trials with bendamustine demonstrated an annual incidence rate of MDS/AML of 0.5%/person/year. The median time to development of MDS/AML after bendamustine was 23 months. Twelve patients had stem cell collection attempted following bendamustine, 9 of whom were collected successfully. The most common infections after bendamustine were sinopulmonary, followed by HSV/VZV, sepsis and urinary tract infection.[7]

References

1 Rummel, M. J., N. Niederle, G. Maschmeyer, et al. 2013. "Bendamustine plus rituximab versus CHOP plus rituximab as first-line treatment for patients with indolent and mantle-cell lymphomas: an open-label, multicentre, randomised, phase 3 non-inferiority trial." Lancet 381(9873):1203-1210.

2 Flinn, I. W., R. van der Jagt, B. S. Kahl, et al. 2014. "Randomized trial of bendamustine-rituximab or R-CHOP/R-CVP in first-line treatment of indolent NHL or MCL: the BRIGHT study." Blood 123(19):2944-2952.

3 Rummel, M., U. Kaiser, C. Balser, et al. 2016. "Bendamustine plus rituximab versus fludarabine plus rituximab for patients with relapsed indolent and mantle-cell lymphomas: a multicentre, randomised, open-label, non-inferiority phase 3 trial." Lancet Oncol 17(1):57-66.

4 Marcus, R., A. Davies, K. Ando, et al. 2017. "Obinutuzumab for the First-Line Treatment of Follicular Lymphoma." N Engl J Med 377(14):1331-1344.

5 Hiddemann, W., A. Barbui, M. Canales et al. 2018. "Immunochemotherapy with Obinutuzumab or Rituximab for previously untreated follicular lymphoma in the GALLIUM study: influence of chemotherapy on efficacy and safety". J Clin Oncol. 2018 Aug 10;36(23):2395-2404

6 Cheson, B. D., R. I. Fisher, S. F. Barrington, et al. 2014. "Recommendations for initial evaluation, staging, and response assessment of Hodgkin and non-Hodgkin lymphoma: the Lugano classification." J Clin Oncol 32(27):3059-3068.

7 Martin, P., Z. Chen, B. D. Cheson, et al. 2017. "Long-term outcomes, secondary malignancies and stem cell collection following bendamustine in patients with previously treated non-Hodgkin lymphoma." Br J Haematol 178(2):250-256.

History

Version 7

Date	Summary of changes
28/04/2023	Protocol reviewed and updated at the Haematology Reference Committee meeting. Updates include: • Stages removed from previously untreated indolent CD20-positive non-Hodgkin lymphoma (NHL) indication • Relapsed or refractory indolent CD20-positive non-Hodgkin lymphoma added to the indication. • Updated dose modifications to align with the product information • Updated evidence and toxicity. • Subcutaneous rituximab information removed from the following sections – treatment schedule, clinical information, administration, patient information. • Increased to version 7.
20/06/2023	Protocol approved and published. For review in 4 years.

Version 6

Date	Summary of changes
01/09/2020	CLL indication removed from multi-indication protocol as rituximab dose was incorrect and should be increased to 500mg/m^2 from cycle 2. New protocol for CLL developed - ID 3811 Chronic lymphocytic leukaemia bendamustine and rituximab. Version number changed to V.6
15/06/2021	Evidence section updated to include results from 2017 study by Marcus et al.
01/10/2021	Drug status updated: rituximab SC is TGA registered but no longer PBS listed.
22/10/2021	Reviewed electronically by the Haematology reference committee, nil changes. Review in 2 years.

Version 5

Date	Summary of changes
14/08/2020	New multi-indication protocol developed and discussed at Haematology Reference Committee meeting in March. Protocol incorporates ID 1718 Non-Hodgkin lymphoma bendamustine and rituximab with new chronic lymphocytic leukaemia indication. Version number changed to V.5

Version 4

As ID 3794 Bendamustine and rituximab replaces the ID 1718 Non-Hodgkin lymphoma bendamustine and rituximab protocol, this History section for this protocol is included below for consistency in documentation.

ID 1718 Non-Hodgkin lymphoma bendamustine and rituximab version 3 and 4	
Date	**Summary of changes**
9/03/2020	Biosimilar rituximab added to clinical information. Version number changed to V.4

Version 3

<table>
<tr><th>Date</th><th>Summary of changes</th></tr>
<tr><td>12/06/2014 to 11/09/2015</td><td>Please note: ID 1718 collected data on CLL Bendamustine and Rituximab for the treatment schedule below prior to the 11/09/2015 Haematology Reference Committee meeting (HRCM).

Treatment Schedule Summary
<table>
<tr><th>Drug</th><th>Dose</th><th>Route</th><th>Day</th></tr>
<tr><td>Bendamustine</td><td>70 mg/m^2</td><td>IV</td><td>1 and 2</td></tr>
<tr><td>Rituximab*</td><td>500 mg/m^2</td><td>IV</td><td>1</td></tr>
</table>
* Rituximab 375 mg/m^2 for the first cycle only

Frequency: 28 days
Cycles: up to 6</td></tr>
<tr><td>11/09/2015</td><td>New protocol presented to haematology reference committee</td></tr>
<tr><td>15/10/2015</td><td>Protocol approved and published on eviQ</td></tr>
<tr><td>01/05/2016</td><td>Bendamustine approved on the PBS:
- Updated the drug status for Bendamustine
- Cost estimate updated as per the PBS costs</td></tr>
<tr><td>20/06/2016</td><td>Drug status updated as per PBS: Removed 'Note: not PBS subsidised for the MCL indication. Please check the PBS website for specific indications which are subsidised'.</td></tr>
<tr><td>31/05/2017</td><td>Transferred to new eviQ website. Version number change to V.2.</td></tr>
<tr><td>12/03/2018</td><td>Added:
Link to subcutaneous rituximab document underneath the treatment schedule.
Clinical information block on subcutaneous rituximab
Link to the subcutaneous rituximab document into administration section
Injection-site reaction side effect
Note about subcutaneous rituximab to the patient information
Version number changed to V.3.</td></tr>
<tr><td>25/05/2018</td><td>Reviewed by Haematology Reference Committee with no significant changes, review in 2 years</td></tr>
<tr><td>25/06/2018</td><td>Antiemetics updated to be in line with international guidelines. Note to dexamethasone added.</td></tr>
</table>

First approved: 14 August 2020
Last reviewed: 20 June 2023
Review due: 30 June 2027

The currency of this information is guaranteed only up until the date of printing, for any updates please check:
https://www.eviq.org.au/p/3794
26 Nov 2023

Patient information - Lymphoma - Bendamustine and rituximab

Patient's name:

Your treatment

The treatment schedule below explains how the drugs for this treatment are given.

Bendamustine and rituximab			
This treatment cycle is repeated every 28 days. You will usually have 6 cycles. Your doctor will advise you of the number of treatments you will have.			
Day	**Treatment**	**How it is given**	**How long it takes**
1	**Rituximab** (*ri-TUX-i-mab*)	By a drip into a vein	**1st cycle:** About 8 hours **Cycles thereafter:** About 4 to 6 hours
1 and 2	**Bendamustine** (*ben-da-MUS-teen*)	By a drip into a vein	About 1 hour

When to get help

Anticancer drugs (drugs used to treat cancer) can sometimes cause serious problems. It is important to get medical help immediately if you become unwell.

IMMEDIATELY go to your nearest hospital Emergency Department, or contact your doctor or nurse if you have any of the following at any time:	**Emergency contact details** Ask your doctor or nurse from your treating team who to contact if you have a problem
• a temperature of 38°C or higher • chills, sweats, shivers or shakes • shortness of breath • uncontrolled vomiting or diarrhoea • pain, tingling or discomfort in your chest or arms • you become unwell.	Daytime:..... Night/weekend:..... Other instructions:..... ....

During your treatment immediately tell the doctor or nurse looking after you if you get any of the following problems:

- leaking from the area where the drugs are being given
- pain, stinging, swelling or redness in the area where the drugs are being given or at any injection sites
- a skin rash, itching, feeling short of breath, wheezing, fever, shivers, or feeling dizzy or unwell in any way (allergic reaction).

Other information about your treatment

Changes to your dose or treatment delays

Sometimes a treatment may be started at a lower dose or the dose needs to be changed during treatment. There may also be times when your treatment is delayed. This can happen if your doctor thinks you are likely to have severe side effects, if you get severe side effects, if your blood counts are affected and causing delays in treatment, or if you are finding it hard to cope with the treatment. This is called a dose reduction, dose change or treatment delay. Your doctor will explain if you need any changes or delays to your treatment and the reason why.

Blood tests and monitoring

Anti-cancer drugs can reduce the number of blood cells in your body. You will need to have regular blood tests to check that your blood cell count has returned to normal. If your blood count is low, your treatment may be delayed until it has returned to normal. Your doctor or nurse will tell you when to have these blood tests.

Central venous access devices (CVADs)

This treatment may involve having chemotherapy through a central venous access device (CVAD). Your doctor or nurse will explain this to you. For more information, see the eviQ patient information sheets on CVADs.

Medications for blood pressure

Rituximab may lower your blood pressure. Tell your doctor if you are taking any blood pressure medications. Your doctor may advise you to temporarily stop your blood pressure medications before your rituximab infusions.

Other medications given during this treatment

- **Anti-sickness (anti-nausea) medication:** you may be given some anti-sickness medication. Make sure you take this medication as your doctor or nurse tells you, even if you don't feel sick. This can help to prevent the sickness starting.
- **Prophylaxis medication:** you may need to take some medications to prevent infection and to help prevent or reduce some of the side effects of the chemotherapy. Your doctor or nurse will tell you how and when to take these medications.
- **Rituximab premedication:** before your treatment with rituximab you will need to take some tablets called a premedication to help prevent you from having a reaction to the rituximab.

Side effects

Cancer treatments can cause damage to normal cells in your body, which can cause side effects. Everyone gets different side effects, and some people will have more problems than others.

The table below shows some of the side effects you may get with this treatment. You are unlikely to get all of those listed and you may also get some side effects that have not been listed.

Tell your doctor or nurse about any side effects that worry you. Follow the instructions below and those given to you by your doctor or nurse.

Immediate (onset hours to days)	
Pain or swelling at injection site (extravasation)	• This treatment can cause serious injury if it leaks from the area where it is going into the vein. • This can cause pain, stinging, swelling or redness at or near the site where the drug enters the vein. • If not treated correctly, you may get blistering and ulceration. • **Tell your doctor or nurse immediately if you get any of the symptoms listed above during or after treatment.**
Flu-like symptoms	• You may get: ◦ a fever ◦ chills or sweats ◦ muscle and joint pain ◦ a cough ◦ headaches. • Tell your doctor or nurse if you get any of the symptoms listed above. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you have a temperature of 38°C or higher.**
Headache	• You can take paracetamol if you have a headache. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you get a very bad headache that is not helped by pain medication.**
Allergic reaction	• Allergic reactions are uncommon but can be life threatening. • **If you feel unwell during the infusion or shortly after it, or:** ◦ **get a fever, shivers or shakes** ◦ **feel dizzy, faint, confused or anxious** ◦ **start wheezing or have difficulty breathing** ◦ **have a rash, itch or redness of the face** **While you are in hospital: Tell your doctor or nurse immediately.** **After you leave: Contact your doctor or nurse immediately, or go to the nearest hospital Emergency Department.**
Nausea and vomiting	• You may feel sick (nausea) or be sick (vomit). • Take your anti-sickness medication as directed even if you don't feel sick. • Drink plenty of fluids (unless you are fluid restricted). • Eat small meals more frequently. • Try food that does not require much preparation. • Try bland foods like dry biscuits or toast. • Gentle exercise may help with nausea. • Ask your doctor or nurse for eviQ patient information - Nausea and vomiting during cancer treatment. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you have uncontrolled vomiting or feel dizzy or light-headed.**
Taste and smell changes	• You may find that food loses its taste or tastes different. • These changes are likely to go away with time. • Do your mouth care regularly. • Chew on sugar-free gum or eat sugar-free mints. • Add flavour to your food with sauces and herbs. • Ask your doctor or nurse for eviQ patient information - Taste and smell changes during cancer treatment.
Early (onset days to weeks)	

Infection risk (neutropenia)	• This treatment lowers the amount of white blood cells in your body. The type of white blood cells that help to fight infection are called neutrophils. Having low level of neutrophils is called neutropenia. If you have neutropenia, you are at greater risk of getting an infection. It also means that your body can't fight infections as well as usual. This is a serious side effect, and can be life threatening. • Wash your hands often. • Keep a thermometer at home and take your temperature regularly, and if you feel unwell. • Do your mouth care regularly. • Inspect your central line site (if you have one) daily for any redness, pus or swelling. • Limit contact with people who are sick. • Learn how to recognise the signs of infection. • Ask your doctor or nurse for eviQ patient information - Infection during cancer treatment. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you get any of the following signs or symptoms:** ◦ **a temperature of 38°C or higher** ◦ **chills, shivers, sweats or shakes** ◦ **a sore throat or cough** ◦ **uncontrolled diarrhoea** ◦ **shortness of breath** ◦ **a fast heartbeat** ◦ **become unwell even without a temperature.**
Low platelets (thrombocytopenia)	• This treatment lowers the amount of platelets in your blood. Platelets help your blood to clot. When they are low, you are at an increased risk of bleeding and bruising. • Try not to bruise or cut yourself. • Avoid contact sport or vigorous exercise. • Clear your nose by blowing gently. • Avoid constipation. • Brush your teeth with a soft toothbrush. • Don't take aspirin, ibuprofen or other similar anti-inflammatory medications unless your doctor tells you to. • Tell your doctor or nurse if you have any bruising or bleeding. • **Tell your doctor or nurse immediately, or go to your nearest hospital Emergency Department if you have any uncontrolled bleeding.**
Stomach pain	• You may get: ◦ dull aches ◦ cramping or pain ◦ bloating or flatulence (gas). • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you have stomach pain that you are unable to control.**
Appetite loss (anorexia)	• You may not feel like eating. • Try to avoid drinking fluids at meal times. • Try to eat small meals or snacks regularly throughout the day. • Try to eat food that is high in protein and calories. • If you are worried about how much food you can eat, or if you are losing weight, ask to speak to a dietitian.
Joint and muscle pain and stiffness	• You may get muscle, joint or general body pain and stiffness. • Applying a heat pack to affected areas may help. • Talk to your doctor or nurse about other ways to manage these symptoms. You may need medication to help with any pain.

Constipation	• You may have bowel motions (stools, poo) that are less frequent, harder, smaller, painful or difficult to pass.
	• You may also get:
	  ◦ bloating, cramping or pain
	  ◦ a loss of appetite
	  ◦ nausea or vomiting.
	• Drink plenty of fluids (unless you are fluid restricted).
	• Eat plenty of fibre-containing foods such as fruit, vegetables and bran.
	• Take laxatives as directed by your doctor.
	• Try some gentle exercise daily.
	• **Tell your doctor or nurse if you have not opened your bowels for more than 3 days.**

Diarrhoea	• You may get bowel motions (stools, poo) that are more frequent or more liquid. • You may also get bloating, cramping or pain. • Take your antidiarrhoeal medication as directed by your doctor. • Drink plenty of fluids (unless you are fluid restricted). • Eat and drink small amounts more often. • Avoid spicy foods, dairy products, high fibre foods, and coffee. • Ask your doctor or nurse for eviQ patient information - Diarrhoea during cancer treatment. • **Tell your doctor or nurse immediately, or go to your nearest hospital Emergency Department if your diarrhoea is not controlled, you have 4 or more loose bowel motions per day, and if you feel dizzy or light-headed.**
Tiredness and lack of energy (fatigue)	• You may feel very tired, have no energy, sleep a lot, and not be able to do normal activities or things you enjoy. • Do not drive or operate machinery if you are feeling tired. • Nap for short periods (only 1 hour at a time) • Prioritise your tasks to ensure the best use of your energy. • Eat a well balanced diet and drink plenty of fluids (unless you are fluid restricted). • Try some gentle exercise daily. • Allow your friends and family to help. • **Tell your doctor or nurse if you get any of the symptoms listed above.**
Extra fluid in the body (fluid retention)	• You may gain weight over a short amount of time. • Your hands and feet may become swollen, appear red or feel hot and uncomfortable. • Wear loose clothing and shoes that are not too tight. • Try not to stand up or walk around too much at one time. • If your ankles or legs get swollen, try raising them. • Make sure that any cuts or areas of broken skin are treated as soon as possible. • **Tell your doctor or nurse as soon as possible if you get any of the symptoms listed above or gain 1 to 2 kg in a week.** • **Tell your doctor or nurse immediately or go to the nearest hospital Emergency Department if you become short of breath.**
Skin rash	• You may get a red, bumpy rash and dry, itchy skin. • Moisturise your skin with a gentle non-perfumed moisturising cream like sorbolene or aqueous cream. • Do not scratch your skin. • Protect your skin from the sun by wearing sun-protective clothing, a wide-brimmed hat, sunglasses and sunscreen of SPF 50 or higher. • **Talk to your doctor or nurse about other ways to manage your skin rash.**

Late (onset weeks to months)	
Low red blood cells (anaemia)	• You may feel dizzy, light-headed, tired and appear more pale than usual. • Tell your doctor or nurse if you have any of these signs or symptoms. You might need a blood transfusion. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you have any chest pain, trouble breathing, or feel like your heart is racing.**
Infection risk (lymphopenia)	• This treatment lowers the amount of white blood cells in your body even after you have finished your treatment. A type of white blood cell that helps to fight infection are called lymphocytes. Having low level of lymphocytes is called lymphopenia. If you have lymphopenia, you are at greater risk of getting an infection. It also means that your body can't fight infections as well as usual. This is a serious side effect, and can be life threatening. • Wash your hands often. • Keep a thermometer at home and take your temperature regularly, and if you feel unwell. • Do your mouth care regularly. • Inspect your central line site (if you have one) daily for any redness, pus or swelling. • Limit contact with people who are sick. • Learn how to recognise the signs of infection. • Ask your doctor or nurse for eviQ patient information - Infection during cancer treatment. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you get any of the following signs or symptoms:** ◦ **a temperature of 38°C or higher** ◦ **chills, shivers, sweats or shakes** ◦ **a sore throat or cough** ◦ **uncontrolled diarrhoea** ◦ **shortness of breath** ◦ **a fast heartbeat** ◦ **become unwell even without a temperature.**
Changes in the way your brain works [progressive multifocal leukoencephalopathy (PML)]	• This treatment can affect your central nervous system. This can be very serious. • **Tell your doctor or nurse immediately, or go to the nearest hospital Emergency Department if you get any of the following symptoms:** ◦ **trouble with your speech or vision** ◦ **confusion or memory loss** ◦ **changes in your personality** ◦ **weakness in your arms and legs** ◦ **poor balance or coordination** ◦ **fits (seizures).**

General advice for people having cancer treatment

Chemotherapy safety

- Learn how to keep you and your family safe while you are having anticancer drugs.
- See our patient information sheet - Chemotherapy safety at home.

Blood clot risk

- Cancer and anticancer drugs can increase the risk of a blood clot (thrombosis).
- Tell your doctor if you have a family history of blood clots.
- A blood clot can cause pain, redness, swelling in your arms or legs, shortness of breath or chest pain.
- If you have any of these symptoms go to your nearest hospital Emergency Department.

Medications and vaccinations

- Before you start treatment, tell your doctor about any medications you are taking, including vitamins or herbal supplements.
- Don't stop or start any medications during treatment without talking to your doctor and pharmacist first.
- Paracetamol is safe to take if you have a headache or other mild aches and pains. It is recommended that you avoid taking aspirin, ibuprofen and other anti-inflammatory type medications for pain while you are having treatment. However, if these

medications have been prescribed by your doctor, do not stop taking them without speaking with your doctor.
- Vaccinations such as flu and tetanus vaccines are safe to receive while having treatment. Do not have any live vaccines during your treatment or for 6 months after it finishes. If you are unsure, check with your doctor before you have any vaccinations.
- People you live with should be fully vaccinated, including having live vaccines according to the current vaccination schedule. Extra care needs to be taken with hand washing and careful disposal of soiled nappies for infants who have recently received the rotavirus vaccine.

Other medical and dental treatment

- If you go to hospital or any other medical appointment (including dental appointments), always tell the person treating you that you are receiving anticancer drugs.
- Before you have any dental treatment, talk to your doctor.

Diet and food safety

- While you are receiving this treatment it is important that you try to maintain a healthy diet.
- Speak to your doctor or nurse about whether drinking alcohol is safe with your treatment.
- If you have any concerns about recent weight loss or weight gain or questions about your diet, ask to speak to a dietitian.
- There are some foods that may cause infection in high risk individuals and should be avoided. For more information on foods to avoid and food hygiene please ask for a copy of the Listeria and food brochure.

Fertility

- Some cancer treatments can reduce your fertility. This can make it difficult or impossible to get pregnant or father a child.
- Talk to your doctor or nurse before you start any treatment. Depending on your situation there may be fertility sparing options available to you and/or your partner, discuss these with your doctor or nurse.

Pregnancy and breastfeeding

- Some cancer treatments can be dangerous to unborn babies. Talk to your doctor or nurse if you think there is any chance that you could be pregnant.
- Do not try to get pregnant or father a child during this treatment. Contraception should be used during treatment and after stopping treatment. Ask your doctor or nurse about what type of contraception you should use.
- If you are planning pregnancy/fatherhood after completing this treatment, talk to your doctor. Some doctors advise waiting between 6 months and 2 years after treatment.
- Do not breastfeed if you are on this treatment, as anti-cancer medications can also pass into breast milk.

Sex life and sexuality

- The desire to have sex may decrease as a result of this treatment or its side effects.
- Your emotions and the way you feel about yourself may also be affected by this treatment.
- It may help to discuss your concerns with your partner and doctor or nurse.

Quitting smoking

- It is never too late to quit smoking. Quitting smoking is one of the best things you can do to help your treatment work better.
- There are many effective tools to improve your chances of quitting.
- Talk to your treating team for more information and referral to a smoking cessation support service.

Staying active

- Research shows that exercise, no matter how small, has many benefits for people during and after cancer treatment.
- Talk to your doctor before starting an exercise program. Your doctor can advise whether you need a modified exercise program.

For more information about cancer treatment, side effects and side effect management see our Patient and carers section.

Where to get more information

Telephone support

- Call Cancer Council on 13 11 20 for cancer information and support
- Call the Leukaemia Foundation on 1800 620 420 (Mon to Fri 9am – 5pm)
- Call the Lymphoma Nurse Support Line on 1800 953 081 (Mon to Fri 9am - 5pm)
- Call the Myeloma Australia Support Line on 1800 693 566 (Mon to Fri 9am - 5pm)

Haematology, transplant and cellular therapy information

- Arrow bone marrow transplant foundation – arrow.org.au
- Australasian Menopause Society – menopause.org.au
- Chris O'Brien Lifehouse - Total Body Irradiation - mylifehouse.org.au/departments/radiation-oncology/total-body-irradiation/
- Healthy Male Andrology Australia – healthymale.org.au/
- International Myeloma Foundation – myeloma.org
- Leukaemia Foundation – leukaemia.org.au
- Lymphoma Australia – lymphoma.org.au
- Myeloma Australia – myeloma.org.au
- NSW Agency for Clinical Innovation, Blood & Marrow Transplant Network – https://aci.health.nsw.gov.au/networks/bmtct
- NSW Agency for Clinical Innovation - aci.health.nsw.gov.au/projects/immune-effector-cell-service
- NCCN Guidelines for Patients Immunotherapy Side Effects: CAR T-Cell Therapy - nccn.org/patientresources/patient-resources/guidelines-for-patients
- Talk Blood Cancer – cmlsupport.org.uk/organisation-type/social-media-groups

General cancer information and support

- Australian Rare Cancer (ARC) Portal – arcportal.org.au/
- Beyondblue – beyondblue.org.au
- Cancer Australia – canceraustralia.gov.au
- Cancer Council Australia – cancer.org.au
- Cancer Voices Australia – cancervoicesaustralia.org
- CanTeen – canteen.org.au
- Carers Australia – carersaustralia.com.au
- Carer Help - carerhelp.com.au
- eviQ Cancer Treatments Online – eviQ.org.au
- Food Standards Australia New Zealand: Listeria & Food Safety – foodstandards.gov.au/publications/pages/listeriabrochuretext.aspx
- LGBTQI+ People and Cancer - cancercouncil.com.au/cancer-information/lgbtqi
- Look Good Feel Better – lgfb.org.au
- Patient Information - patients.cancer.nsw.gov.au
- Radiation Oncology Targeting Cancer - targetingcancer.com.au
- Redkite – redkite.org.au
- Return Unwanted Medicines – returnmed.com.au
- Staying active during cancer treatment – patients.cancer.nsw.gov.au/coping-with-cancer/physical-wellbeing/staying-active

Quit smoking information and support

Quitting smoking is helpful even after you have been diagnosed with cancer. The following resources provide useful information and support to help you quit smoking. Talk to your treating team about any other questions you may have.

- Call Quitline on 13 QUIT (13 78 48)
- iCanQuit – iCanQuit.com.au
- Patient Information - patients.cancer.nsw.gov.au/coping-with-cancer/physical-wellbeing/quitting-smoking
- Quitnow – quitnow.gov.au

Additional notes:

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The currency of this information is guaranteed only up until the date of printing, for any updates please check:
https://www.eviq.org.au/pi/3794
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