Lancashire & South Cumbria Cancer Network
Systemic Anticancer Treatment Protocol

Drug regimen
Gemcitabine

Indications for use
Adjuvant treatment of resected carcinoma of the pancreas
Locally advanced or metastatic carcinoma of the pancreas
Platinum resistant ovarian/fallopian/primary peritoneal cancer

Regimen

Day	DRUG	FLUID	TIME
1,8 & 15	Gemcitabine 1000mg/m²	250mls 0.9% sodium chloride	30 Mins

(Also give on day 22 of cycle 1 in metastatic pancreatic cancer only)

Given every 28 days for 6 cycles in adjuvant treatment, or until disease progression for metastatic disease

Investigation prior to initiating treatment
FBC
Biochemistry including LFTs

Cautions
Raised bilirubin or AST

Investigations and consultations prior to each cycle
FBC and U and Es
LFTs (These should be obtained once a week for the first cycle and then once a month thereafter unless jaundice is suspected)

The liver function test may be retrospectively looked at (i.e. after the chemotherapy treatment) **unless** they are known to be abnormal then they need to be repeated the day before so that the results are available pre-chemotherapy

Consultation day 1 of each cycle

Side Effects
Myelosuppression – all cell lines
Occasionally: rash and mild SOB, 'flu like' symptoms
Rarely: severe dyspnoea, ARDS, haemolytic ureaemic syndrome - discontinue treatment if these occur

Acceptable limits for treatment to proceed (if outside these delay one week or contact consultant)
Neutrophils $\geq$ 1.5 and platelets $\geq$ 100

Dose Modification Criteria
Haematological Toxicity: Anaemia, leucopaenia and thrombocytopaenia can occur but are usually mild to moderate. Dose modifications are as follows:
Day 1
• If neutrophils between 1.0-1.5 or platelets <100 delay treatment by one week.

• If there is recovery after one week then continue at 100% dose.

• If no recovery after 2 weeks or if neutrophils on day 1 <1.0 then delay by one week and reduce dose to 75%

Days 8 or 15
If neutrophils <1 or platelets <100; omit the dose and give future doses at 75%

Neutropenic Sepsis: Following an episode of fever associated with a WBC of $<2.0 \times 10^9$ /L subsequent courses should be given at 75% dose.

Non-haematological Toxicity
Modifications are not required normally. In exceptional cases treatment delay may be necessary until the toxicity has resolved. If this happens then a 25% reduction should be made for subsequent courses
The maximum allowable treatment delay is 3 weeks. Any patient whose treatment is delayed for longer than three weeks should discontinue therapy

Liver transaminases: Abnormalities of liver transaminases occur in up to two-thirds of patients but changes are not progressive and rarely cause problems

Nausea and Vomiting: This occurs in about 30% of patients and responds to standard anti-emetics

Skin rash: This is seen in about 25% of patients, mild, and responds to topical preparations

Flu-like illness: This occurs in about 20% of patients and is normally mild

Oedema: Peripheral oedema has been seen in up to 30% of patients and normally responds to stopping treatment. Pulmonary oedema has been reported rarely

Severe dyspnoea, ARDS, haemolytic ureaemic syndrome: discontinue treatment

Specific Information on Administration
30-minute infusion in 0.9% Sodium Chloride 250mls (longer infusion times lead to increased toxicity)

THIS PROTOCOL HAS BEEN DIRECTED BY DR MITCHELL, THE DESIGNATED LEAD CLINICIAN FOR UPPER GI CANCER

RESPONSIBILITY FOR THIS PROTOCOL LIES WITH THE HEAD OF SERVICE

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