MITOMYCIN CAPECITABINE

INDICATION (ICD10) C18, C20
Advanced colorectal cancer (unlicensed). PS 0, 1, 2

REGIMEN

Day 1	MITOMYCIN	7mg/m^2 IV bolus
Days 1 to 14	CAPECITABINE	1250mg/m^2* twice daily (2500mg/m^2/day) oral followed by a 7 day rest
Days 22 to 35	CAPECITABINE	1250mg/m^2* twice daily (2500mg/m^2/day) oral followed by a 7 day rest

*1000mg/m^2 may be used

CYCLE FREQUENCY AND NUMBER OF CYCLES
Every 42 days for 4 cycles (review after 2 cycles)

ADMINISTRATION
Tablets should be taken 12 hours apart.
Swallowed with water within 30 minutes after a meal, or dissolve in 200ml luke warm water, stir thoroughly (squash may be added if unpalatable).

ANTI-EMETICS
Low risk days 1 to 14 and 22 to 35

CONCURRENT MEDICATION REQUIRED

Capecitabine	Mouth and bowel support eg Loperamide, benzydamine mouthwash

EXTRAVASATION AND TYPE OF LINE / FILTERS
Mitomycin - vesicant

Peripheral line

INVESTIGATIONS
Blood results required before SACT administration
FBC, U&E and LFTs every 21 days
Neutrophils x 10^9/L ≥1.5
Platelets x 10^9/L ≥100
Serum creatinine - GFR every 21 days
DPD test
Baseline weight and every cycle

MAIN TOXICITES AND ADVERSE REACTIONS

Capecitabine	Palmar plantar (handfoot syndrome) causing red palms and soles – treat with pyridoxine 50mg tds Diarrhoea – treat with loperamide or codeine Cardiotoxicity – monitor cardiac function. To minimise risk of anthracycline induced cardiac failure signs of cardiotoxicity e.g. cardiac arrhythmias, pericardial effusion, tachycardia with fatigue. All patients should be told to report any cardiac symptoms immediately and should be told to stop the medication immediately if any suspicion of cardiac problems. Stomatitis

INTERACTIONS WHICH MAY REQUIRE DOSE MODIFICATIONS
(not exhaustive list check SPC/BNF/Stockleys)

Capecitabine	Brivudine and analogues should be avoided Warfarin and caution with all oral anticoagulants Phenytoin Allopurinol

DOSE MODIFICATIONS

Mitomycin maximum lifetime dose = 60mg/m^2

Non-haematological

Dose limiting toxicities include diarrhoea, abdominal pain, nausea, stomatitis and handfoot syndrome.
Toxicity can be managed by symptomatic treatment and/or modification of the dose (treatment interruption or dose reduction).
Once the dose has been reduced it should not be increased at a later time.
When capecitabine is stopped for toxicity, the doses are omitted and not delayed.

Toxicity Grades	Dose changes within a treatment cycle	Dose adjustment for next cycle/dose (% of starting dose)
Grade 2 - 1st appearance	Interrupt until resolved to grade 0-1	100%
Grade 2 - 2nd appearance	Interrupt until resolved to grade 0-1	75%
Grade 2 - 3rd appearance	Interrupt until resolved to grade 0-1	50%
Grade 2 - 4th appearance	Discontinue treatment permanently	Not applicable
Grade 3 - 1st appearance	Interrupt until resolved to grade 0-1	75%
Grade 3 - 2nd appearance	Interrupt until resolved to grade 0-1	50%
Grade 3 - 3rd appearance	Discontinue treatment permanently	Not applicable
Grade 4 - 1st appearance	Discontinue permanently OR if physician deems it to be in the patient's best interest to continue, interrupt until resolved to grade 0-1	50%
Grade 4 - 2nd appearance	Discontinue treatment permanently	Not applicable

Hepatic impairment

Capecitabine

Bilirubin of >3xULN or ALT/AST >2.5xULN	Interrupt Capecitabine Treatment may be resumed when bilirubin decreases to <3xULN or hepatic aminotransferases decrease to <2.5xULN.

Renal impairment

Capecitabine

CrCl (ml/min) >50	give 100% dose
CrCl (ml/min) 30-50	give 75% dose
CrCl (ml/min) <30	contraindicated

Mitomycin

CrCl ≥30ml/min	give 100% dose
CrCl <30ml/min	not recommended

REFERENCES

1. Br J Cancer. 2006 Mar 27;94(6):935-6