TEMOZOLOMIDE with concurrent RT

INDICATION (ICD10) C71, C72

1. First-line treatment of patients with newly diagnosed glioblastoma (GBM) as an adjunct for radiotherapy. PS 0, 1, 2 (PS 3 due to a neurological deficit treatment may be appropriate)

REGIMEN

Days 1, 8, 15, 22*, 29* and 36*
TEMOZOLOMIDE 75mg/m^2 orally once daily for 7 days

CYCLE FREQUENCY AND NUMBER OF CYCLES

One 42 day cycle only. Patients having 6 weeks RT receive 6 weeks temozolomide.
*Patients ≥65 years with hypermethylation receiving 40Gy in 15 fractions only receive 21 days temozolomide.
*Patients ≤70 years receiving 30 fractions receive 42 days temozolomide.
After completing Temozolomide with RT and following a 4 week break start temozolomide regimen for 6 cycles.

ADMINISTRATION

Available as various strength capsules
Take on an empty stomach

ANTI-EMETICS

High emetic risk
NB patients are usually already taking dexamethasone.

CONCURRENT MEDICATION REQUIRED

Temozolomide	Prophylactic antibiotics – co-trimoxazole 960mg od three times a week during chemo radiotherapy or dapsone 100mg od if allergic to co-trimoxazole.

EXTRAVASATION AND TYPE OF LINE / FILTERS

Not applicable

INVESTIGATIONS

Blood results required before SACT administration
FBC, U&E and LFTs every 7 days
Neutrophils x 10^9/L ≥1.5
Platelets x 10^9/L ≥100
Serum creatinine every cycle
Baseline weight and every cycle

MAIN TOXICITES AND ADVERSE REACTIONS

Temozolomide	Myelosuppression, rare protracted aplastic picture can occur Hepatic toxicity – may still occur several weeks after end of treatment Renal impairment

DOSE MODIFICATIONS

Haematological

Temozolomide
Neutrophils <1.5x10^9/l and platelets <100x10^9/l then stop treatment, but continue to monitor FBC, and treatment may be restarted if levels go above thresholds.

Hepatic impairment
Temozolomide
Stop temozolomide if there is a progressive rise in transaminases eg ALT >200 or rise in bilirubin.

Renal impairment
Temozolomide
Stop temozolomide if there is a significant rise in serum creatinine (more common in patients with pre-existing renal impairment).

REFERENCES
1. CATNON trial
2. Stupp et al; NEJM February 2006