

Capecitabine 830mg/m² and Radiotherapy – 7 day

INDICATIONS FOR USE:

INDICATION	ICD10	Regimen Code	HSE approved reimbursement status*
Locally advanced pancreatic cancer after induction chemotherapy	C25	00523a	N/A

*This is for post 2012 indications only

TREATMENT:

The starting dose of the drugs detailed below may be adjusted downward by the prescribing clinician, using their independent medical judgement, to consider each patients individual clinical circumstances.

Capecitabine is administered twice daily on day 1-5 of each cycle (one cycle is equal to 7 days). Radiotherapy is given concurrently on day 1-5 of each cycle up to a maximum of 5-6 cycles.

Day	Drug	Dose	Route	Cycle
1-5	Capecitabine	830mg/m ² Twice Daily ^{1, 2, 3}	PO with food	Every 7 days for up to 6 cycles with radiotherapy
¹ The dose to be administered should consider the available tablet strengths. Reference to the NCCP DOSE BANDING TABLES for dosing of capecitabine - available on the NCCP website . Capecitabine tablets should be swallowed whole with plenty of water with food or within 30 minutes of eating. The tablets should not be crushed or cut. ² (total daily dose = 1660mg/m ²) ³ See dose modifications section for patients with identified partial dihydropyrimidine dehydrogenase (DPD) deficiency.				

ELIGIBILITY:

- Indications as above
- ECOG status 0-2

EXCLUSIONS:

- Hypersensitivity to capecitabine or any of the excipients
- Known complete dihydropyrimidine dehydrogenase (DPD) deficiency
- History of severe and unexpected reactions to fluoropyrimidine therapy
- Pregnancy and lactation
- Recent or concomitant treatment with brivudine

PRESCRIPTIVE AUTHORITY:

The treatment plan must be initiated by a Consultant Medical Oncologist.

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TESTS:

Baseline tests:

- FBC, renal and liver profile
- DPD testing prior to first treatment with capecitabine using phenotype and/or genotype testing unless patient has been previously tested
 - In patients with moderate or severe renal impairment, blood uracil levels used for DPD phenotyping should be interpreted with caution, as impaired kidney function can lead to increased uracil blood levels. Consequently, there is an increased risk for incorrect diagnosis of DPD deficiency, which may result in under dosing of 5-Fluorouracil or other fluoropyrimidines, leading to reduced treatment efficacy. Genotype testing for DPD deficiency should be considered for patients with renal impairment.

Regular tests:

- FBC, renal and liver profile prior to each cycle.

Disease monitoring:

Disease monitoring should be in line with the patient’s treatment plan and any other test/s as directed by the supervising Consultant.

DOSE MODIFICATIONS:

- Any dose modification should be discussed with a Consultant.
- Consider a reduced starting dose in patients with identified partial DPD deficiency.
 - Initial dose reduction may impact the efficacy of treatment. In the absence of serious toxicity, subsequent doses may be increased with careful monitoring.

Haematological:

Table 1: Dose modification of capecitabine based on haematological toxicity

ANC (x 10 ⁹ /L)		Platelets(x 10 ⁹ /L)	1st Event Dose	2 nd Event Dose	3 rd Event Dose	4 th Event Dose
≥ 1.5	and	≥ 75	100%	100%	100%	100%
1-1.49	or	50 – 74.9	Delay* then 100%	Delay* then 75%	Delay* then 50%	Discontinue
0.5-0.99	or	25- 49.9	Delay* then 75%	Delay* then 50%	Discontinue	Discontinue
< 0.5	or	< 25	Discontinue or delay* then 50%	Discontinue	Discontinue	Discontinue

*Delay until ANC ≥ 1.5x 10⁹/L and platelets ≥ 75x10⁹/L

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Renal and Hepatic Impairment:

Table 2: Dose modification of capecitabine in renal and hepatic impairment

Renal Impairment		Hepatic Impairment
CrCl (mL/min)	Dose	No dose adjustment is needed
51-80	No dose adjustment is needed	
30-50	75% of the original dose	
<30	Not recommended	
Haemodialysis	Not recommended	
Reference Table 6 for dose modification of capecitabine in treatment related hepatotoxicity.		
Renal and hepatic dose modifications from Giraud et al 2023		

Management of adverse events:

Table 3 shows the recommended dose modifications of capecitabine for those toxicities which are not individually specified:

Table 3: Capecitabine dose reduction schedule based on toxicity (Any)

Toxicity grades*	Dose changes within a treatment cycle	Dose adjustment for next cycle/dose (% of starting dose)
Grade 1	Maintain dose level	Maintain dose level
Grade 2		
• 1 st appearance	Interrupt until resolved to grade 0-1	100%
• 2 nd appearance		75%
• 3 rd appearance		50%
• 4 th appearance	Discontinue permanently	
Grade 3		
• 1 st appearance	Interrupt until resolved to grade 0-1	75%
• 2 nd appearance		50%
• 3 rd appearance	Discontinue permanently	
Grade 4		
• 1 st appearance	Discontinue permanently or If consultant deems it to be in patient's best interest to continue, interrupt until resolved to grade 0-1	50%
• 2 nd appearance		

*Common Terminology Criteria for Adverse Events (CTCAE) version 4.0.

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Table 4: Dose modification of capecitabine for diarrhoea

Grade	Diarrhoea	Dose changes within a treatment cycle	Dose adjustment for next cycle/dose (% of starting dose)
0-1	Increase of 2 to 3 stools/day or nocturnal stools	Maintain dose level	Maintain dose level
2	Increase of 4 to 6 stools/day or nocturnal stools	Interrupt until resolved to grade 0-1	
	• 1 st appearance		100%
	• 2 nd appearance		75%
	• 3 rd appearance	50%	
	• 4 th appearance	Discontinue permanently	
3	Increase of 7 to 9 stools/day or incontinence and malabsorption		
	• 1 st appearance	Interrupt until resolved to grade 0-1	75%
	• 2 nd appearance		50%
	• 3 rd appearance	Discontinue permanently	
4	Increase of 10 or more stools/day or grossly bloody diarrhoea; may require parenteral support		
	• 1 st appearance	Discontinue permanently or If consultant deems it to be in patient's best interest to continue, interrupt until resolved to grade 0-1	50%
	• 2 nd appearance	Discontinue permanently	

Hand foot syndrome:

Table 5: Dose modification of capecitabine in hand foot syndrome

Toxicity Grade		Dose Modification
Grade 1	Skin changes (eg, numbness, dysesthesia, paresthesia, tingling, erythema) with discomfort not disrupting normal activities.	100% Dose
Grade 2	Skin changes (eg, erythema, swelling) with pain affecting activities of daily living.	Withhold treatment until event resolves or decreases in intensity to grade 1.
Grade 3	Severe skin changes (eg, moist desquamation, ulceration, blistering) with pain, causing severe discomfort and inability to work or perform activities of daily living.	Withhold treatment until event resolves or decreases in intensity to grade 1. Subsequent doses of capecitabine should be decreased.

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Treatment related hepatotoxicity

Table 6: Dose modification of capecitabine in treatment related hepatotoxicity

Bilirubin		ALT, AST	Dose Modification
> 3.0 x ULN	or	> 2.5 x ULN	Withhold treatment until bilirubin decreases to ≤ 3.0 x ULN or ALT, AST decrease to ≤ 2.5 x ULN.

SUPPORTIVE CARE:

EMETOGENIC POTENTIAL

- As outlined in NCCP Classification Document for Systemic AntiCancer Therapy (SACT) Induced Nausea and Vomiting - [available on the NCCP website](#)

Capecitabine : Minimal to Low (Refer to local policy)

For information:

Within NCIS regimens, antiemetics have been standardised by Medical Oncologists and Haemato-oncologists and information is available in the following documents:

- NCCP Supportive Care Antiemetic Medicines for **Inclusion in NCIS** (Medical Oncology) - [available on the NCCP website](#)
- NCCP Supportive Care Antiemetic Medicines for **Inclusion in NCIS** (Haemato-oncology) - [available on the NCCP website](#)

PREMEDICATIONS: Not usually required

OTHER SUPPORTIVE CARE:

Medication may be required for management of diarrhoea, e.g. loperamide (4mg at first onset followed by 2mg after each loose stool (max 16 mg /day) or see local policy.

ADVERSE EFFECTS

- Please refer to the relevant Summary of Product Characteristics (SmPC) for details.

REGIMEN SPECIFIC COMPLICATIONS:

- DPD deficiency:** DPD is an enzyme encoded by the DPYD gene which is responsible for the breakdown of fluoropyrimidines. Patients with DPD deficiency are therefore at increased risk of fluoropyrimidine-related toxicity, including for example stomatitis, diarrhoea, mucosal inflammation, neutropenia and neurotoxicity. Treatment with 5-Fluorouracil, capecitabine or tegafur-containing medicinal products is contraindicated in patients with known complete DPD deficiency. Consider a reduced starting dose in patients with identified partial DPD deficiency. Initial dose reduction may impact the efficacy of treatment. In the absence of serious toxicity, subsequent doses may be increased with careful monitoring. Therapeutic drug monitoring (TDM) of 5-Fluorouracil may improve clinical outcomes in patients receiving continuous 5-Fluorouracil infusions.

DRUG INTERACTIONS:

- Current SmPC and drug interaction databases should be consulted for information.

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Version	Date	Amendment	Approved By
1	07/11/2018		Prof Maccon Keane
2	30/01/2019	Updated dosing recommendations in renal impairment.	Prof Maccon Keane
3	20/08/2020	Updated exclusion criteria, baseline testing, dose modifications and adverse events with respect to DPD deficiency as per DHPC from HPRA June 2020 Updated Adverse events regarding palmar-plantar erythrodysesthesia.	Prof Maccon Keane
4	10/02/2021	Added to exclusion criteria, amended emetogenic potential and added to drug interactions.	Prof Maccon Keane
5	27/01/2025	Reviewed. Updated exclusions section and baseline tests. Updated renal and hepatic dose modifications to align with Giraud et al 2023. Updated regimen in line with NCCP standardisation.	Prof Maccon Keane

Comments and feedback welcome at oncologydrugs@cancercontrol.ie.

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