Summary of DIPS

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| Citation | Drug Interaction Probability Scale | Chemotherapy Medications |
| 2016 Okada | 4 (authors calculated 7) | **Ifosphamide/etoposide** + alternating with other regimen |
| 1984 Ward | 3 | vindesine/etoposide/cisplatin |
| 1990 Hall case 1 | 3 | **etoposide/cisplatin/ifosfamide/mesna** |
| 1990 Hall case 2 | 2 | doxorubin/ifosfamide/mesna |
| 1990 Hall case 3 | 5 | doxorubin/ifosfamide/mesna/vincristine |
| 1997 Le | 1 | carboplatin/etoposide |

Assumptions for above DIPS.

* Unknown mechanism of action so questions 2 and 3 are always unknown Authors of Okada likely answered yes.

Dexamethasone is a potential confounder based on what appeared to be reasonable evidence in Lexicomp. Okada doesn’t mention dexamethasone as a potential confounder

Expert Feedback on the Interaction/Decision Tree

In general we consider warfarin and ifos or etoposide to be a drug interaction and just monitor the INR appropriately. We check the INR daily while they are hospitalized and adjust the warfarin dose as needed but if they remain outpatient for chemo then I’m not entirely sure if the providers set up appointment to have the INR monitored more frequently. I’m also not sure that many of the inpatient pharmacists also recommend more frequent INRs for 2weeks post chemo (since elevations were reported up to 16days post etoposide administration). I think having a guideline recommending more frequent INR monitoring (like 2x/wk for 2weeks following IE chemo) would be helpful rather than just empirically dose reducing warfarin for a few days around chemo administration.