

# BC Cancer Protocol Summary for Adjuvant Therapy for Breast Cancer Using Weekly PACLitaxel and Trastuzumab (HERCEPTIN)

**Protocol Code:**

**UBRAJTTW**

**Tumour Group:**

**Breast**

**Contact Physician:**

**Dr. Angela Chan**

## ELIGIBILITY:

- Overexpression of HER-2 neu
- HER-2 overexpression defined as either IHC3+, or FISH amplification ratio greater than or equal to 2 per BC Cancer central laboratory
- Tumor size less than or equal to 3 cm
- Node negative
- ECOG status 0-2
- Adequate hematopoietic and hepatic function
- BC Cancer Compassionate access program (CAP) approval required
- No clinically significant cardiac disease
- LVEF greater than or equal to 50%\*

\* If the LVEF is between 45-50%, may treat at physician's discretion

## EXCLUSIONS:

- Significant cardiovascular disease (history of symptomatic ventricular arrhythmias, congestive heart failure or myocardial infarction within previous 12 months) and/or LVEF less than 50%; if initial reading is less than 50%, physician may consider repeating for validity, or assessing LVEF by the other modality, e.g. echocardiogram instead of MUGA

## TESTS:

- Baseline: CBC & diff, platelets, total bilirubin, ALT
- Baseline if clinically indicated: cardiac function (echocardiogram or MUGA scan)
- Before each treatment: CBC & diff, platelets
- If clinically indicated: total bilirubin, ALT or cardiac function

## PREMEDICATIONS:

- Not usually required for trastuzumab
- **PACLitaxel must not be started unless the following drugs have been given:**
  - 45 minutes prior to PACLitaxel:
    - dexamethasone 10 mg IV in NS 50 mL over 15 minutes
  - 30 minutes prior to PACLitaxel:
    - diphenhydrAMINE 25 mg IV and ranitidine 50 mg IV in NS 50 mL over 20 minutes (compatible up to 3 hours when mixed in bag)

- **NOTE:** If no PACLitaxel hypersensitivity reactions occur, no premedications may be needed for subsequent Day 8 and 15 PACLitaxel doses and may be omitted at physician's discretion.
- If hypersensitivity reactions occur, premedications for re-challenge include dexamethasone 20 mg PO given 12 hours and 6 hours prior to treatment, plus IV premedications given 30 minutes prior to PACLitaxel: dexamethasone 10 mg, diphenhydramine 25 mg, and H<sub>2</sub>-antagonist (e.g., ranitidine 50 mg). If no hypersensitivity reactions occur, standard premedications (see above) will be used for subsequent PACLitaxel doses.
- Additional antiemetics not usually required.

## TREATMENT:

Cycle	1				2			3			etc
Week	1	1	2	3	4	5	6	7	8	9	
Day	1	2	8	15	1	8	15	1	8	15	
trastuzumab (HERCEPTIN)	X				X			X			
PACLitaxel		X	X	X	X	X	X	X	X	X	

**PACLitaxel is given on day 2 for cycle 1 only. In subsequent cycles, PACLitaxel is given after trastuzumab on day 1.**

**1 cycle = 3 weeks**, Repeat every 21 days x 4 cycles.

Note: Continue single agent trastuzumab after completion of cycle 4, see protocol BRAJTR – complete a total of 1 year of trastuzumab therapy.

## Cycle 1, Week 1

### Day 1

Drug	Dose	BC Cancer Administration Guideline
trastuzumab (HERCEPTIN)	8 mg/kg Day 1 only	IV in NS 250 mL over 1 hour 30 min Observe for 1 hour post-infusion

## Day 2

Drug	Dose	BC Cancer Administration Guideline
PACLitaxel	80 mg/m <sup>2</sup> Day 2 only	IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour  (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

## Cycle 1, Weeks 2 - 3

Drug	Dose	BC Cancer Administration Guideline
PACLitaxel	80 mg/m <sup>2</sup>	IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour  (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

## Cycles 2-4

Drug	Dose	BC Cancer Administration Guideline
trastuzumab (HERCEPTIN)	6 mg/kg	IV in 250 mL NS over 1 hour on the second dose, observe for 30 minutes post infusion  IV IN 250 mL NS over 30 min on all subsequent doses if no adverse reactions, observe for 30 min post infusion**  then start PACLitaxel premedications
PACLitaxel	80 mg/m <sup>2</sup>	IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks  (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

\*\*observation period not required after 3 consecutive treatments with no reaction

## DOSE MODIFICATIONS:

### 1. Trastuzumab:

#### 1a. Cardiac Dysfunction

##### Asymptomatic Patients – Trastuzumab continuation based on serial LVEFs

Relationship of LVEF to LLN	Absolute Decrease Of less than 10 points from baseline	Absolute Decrease Of 10 -15 points from baseline	Absolute Decrease Of greater than or equal to 16 points from baseline
Within Normal Limits	Continue	Continue	Hold *
1-5 points below LLN	Continue	Hold *	Hold *
greater than or equal to 6 points below LLN	Continue *	Hold *	Hold *

- \*Repeat LVEF assessment after 3-4 weeks, consider cardiac assessment
- If criteria for continuation are met – resume trastuzumab
- If 2 consecutive holds or a total of 3 holds occur, discontinue trastuzumab

#### Symptomatic Patients

- Symptomatic patients with evidence of cardiac dysfunction should have trastuzumab discontinued

For evidence of cardiac dysfunction likely related to trastuzumab and/or chemotherapy protocols, consider consulting a cardiologist, or review the following reference:  
Curr Oncol 2008;15(1):24-31.

#### 1b. Weight

Weight will be measured at each scheduled physician's visit. Dose changes based on weight will be made at this time unless the patient reports a significant weight change between physician visits.

### 1c. Treatment Interruptions

If an interruption in treatment of greater than 6 weeks occurs (ie more than 6 weeks has elapsed since the last treatment was given), occurs, consider repeating the loading dose of 8 mg/kg, and then resume usual dosing.

## 2. PACLitaxel:

### 2a. Hematological toxicity

ANC (x 10 <sup>9</sup> /L)		Platelets (x 10 <sup>9</sup> /L)	Dose	Dose after Neutropenic Sepsis
Greater than or equal to 1.5	and	Greater than or equal to 90	80 mg/m <sup>2</sup>	65 mg/m <sup>2</sup>
1.0 to less than 1.5*	or	70 to less than 90	65 mg/m <sup>2</sup>	50 mg/m <sup>2</sup>
Less than 1.0	or	Less than 70	Delay and reduce next dose to 65mg/m <sup>2</sup> or add filgrastim	delay

**\* If ANC 1.0 to less than 1.5 and patient is fit and well – can consider full dose of 80 mg/m<sup>2</sup> at discretion of physician**

### 2b. Non-hematologic toxicity

Grade	Dose
Grade 2 motor or sensory neuropathy	Decrease dose of paclitaxel by 10 mg/m <sup>2</sup>
All other grade 2 non-hematological toxicity	Hold treatment until toxicity resolved to less than or equal grade 1 Decrease subsequent doses by 10 mg/m <sup>2</sup>
Greater than or equal to Grade 3	Discontinue treatment

## 2c. Hepatic Dysfunction

ALT or AST		Total bilirubin	Dose (mg/m <sup>2</sup> )
less than 10 x ULN	and	less than or equal to 1.25 x ULN	80
less than 10 x ULN	and	1.26 to 2 x ULN	60
less than 10 x ULN	and	2.01 to 5 x ULN	40
greater than or equal to 10 x ULN	and/or	greater than 5 x ULN	not recommended

ULN = upper limit of normal

2d. **Neuropathy:** Dose modification or discontinuation may be required (see BC Cancer Cancer Drug Manual).

2e. **Arthralgia and/or myalgia:** If arthralgia and/or myalgia of grade 2 (moderate) or higher is not relieved by adequate doses of NSAIDs or acetaminophen with codeine (e.g., **TYLENOL #3®**), a limited number of studies report a possible therapeutic benefit using:

- predniSONE 10 mg po bid x 5 days starting 24 hours post-PACLitaxel
- gabapentin 300 mg po on day before chemotherapy, 300 mg bid on treatment day, then 300 mg tid x 7 to 10 days

If arthralgia and/or myalgia persist, reduce subsequent PACLitaxel doses to 65 mg/m<sup>2</sup>.

## PRECAUTIONS:

1. **Cardiac toxicity:** Trastuzumab can produce ventricular dysfunction and congestive heart failure in about 2-4% of patients. The majority of patients who develop cardiac dysfunction are symptomatic. Regular monitoring of asymptomatic patients is not routinely necessary but may be ordered within 4 to 6 months of treatment with trastuzumab. If no significant decline in cardiac function is apparent, repeated testing is not generally necessary, unless the patient's medical condition changes. Discontinue treatment for symptomatic congestive heart failure or serious cardiac arrhythmias. Most patients who develop cardiac dysfunction respond to appropriate medical therapy and in some cases (where the benefit outweighs the risk) may continue trastuzumab under close medical supervision.
2. **Trastuzumab infusion-associated symptoms,** usually chills and fever, occur in 40% of patients during the first trastuzumab infusion (infrequent with subsequent infusions). Other signs and symptoms may include nausea, vomiting, pain (sometimes at tumour sites), rigors, headache, dizziness, dyspnea, hypotension, rash and asthenia. Symptoms may be treated with acetaminophen, diphenhydramine and meperidine with or without an infusion rate reduction.

Rarely, serious infusion-related reactions have been reported (3 per 1000 patients) sometimes leading to death (4 per 10,000). Reactions include dyspnea, hypotension, wheezing, bronchospasm, tachycardia, reduced oxygen saturation and respiratory distress, and, uncommonly, allergic-like reactions. Patients experiencing dyspnea at rest due to pulmonary metastases and other pulmonary/cardiac conditions may be at increased risk of a fatal infusion reaction and should be treated with extreme caution, if at all. For serious reactions, discontinue the trastuzumab infusion and provide supportive therapy such as oxygen, beta-agonists and corticosteroids.

3. **Neutropenia:** Fever or other evidence of infection must be assessed promptly and treated aggressively.
4. **Hypersensitivity:** Reactions are common with PACLitaxel. See BC Cancer Hypersensitivity Guidelines.

<u>Mild</u> symptoms (e.g. mild flushing, rash, pruritus)	<ul style="list-style-type: none"> <li>▪ complete PACLitaxel infusion. Supervise at bedside</li> <li>▪ no treatment required</li> </ul>
<u>moderate</u> symptoms (e.g. moderate rash, flushing, mild dyspnea, chest discomfort, mild hypotension)	<ul style="list-style-type: none"> <li>▪ stop PACLitaxel infusion</li> <li>▪ give IV diphenhydrAMINE 25-50 mg and Hydrocortisone IV 100 mg</li> <li>▪ after recovery of symptoms resume PACLitaxel infusion at 20 mL/h for 5 minutes, 30 mL/h for 5 minutes, 40 mL/h for 5 minutes, then 60 mL/h for 5 minutes. If no reaction, increase to full rate.</li> <li>▪ if reaction recurs, discontinue PACLitaxel therapy</li> </ul>
<u>severe</u> symptoms (i.e. <u>one</u> or more of respiratory distress requiring treatment, generalised urticaria, angioedema, hypotension requiring therapy)	<ul style="list-style-type: none"> <li>▪ stop PACLitaxel infusion</li> <li>▪ give IV antihistamine and steroid as above. Add epinephrine or bronchodilators if indicated</li> <li>▪ discontinue PACLitaxel therapy</li> </ul>

5. **Extravasation:** PACLitaxel causes pain and tissue necrosis if extravasated. Refer to BC Cancer Extravasation Guidelines.
6. **A possible interaction with warfarin** has been reported. An increased INR and bleeding may occur in patients previously stabilized on warfarin. The interaction was noted in two patients after 8-10 doses of trastuzumab. An INR prior to starting the trastuzumab is recommended, then weekly for the first 3 months and then monthly if stable. Inform patient to watch for any bleeding. Modification of the warfarin dose may be needed. (JAMA 1999;282:2299-301)

**Call Dr. Sophie Sun or tumour group delegate at (604) 877-6000 or 1-800-663-3333 with any problems or questions regarding this treatment program.**

## References:

1. Tolaney SM, Barry WT, Dang CT, et al. Adjuvant paclitaxel and trastuzumab for node-negative, HER2-positive breast cancer. *N Engl J Med* 2015;372:134-41.
2. Slamon D, Leyland-Jones B, Shak S, Paton V et al. Addition of Herceptin™ (humanized anti-HER2 antibody) to first line chemotherapy for HER2 overexpressing metastatic breast cancer (HER2 +/MBC) markedly increases anticancer activity: a randomized, multinational controlled phase III trial. *Proc Am Soc Clin Oncol* 1998;17:98a.
3. Perez A, Rodeheffer R. Clinical Cardiac Tolerability of Trastuzumab. *J Clin Oncol* 2004;22:322-329.
4. Nissenblatt MJ, Karp GI. Bleeding risk with trastuzumab (Herceptin) treatment. *JAMA*. 1999;282(24):2299-301.
5. Mackey JR, Clemons M, Cote MA, et al. Cardiac management during adjuvant trastuzumab therapy: recommendations of the Canadian Trastuzumab Working Group. *Curr Oncol* 2008;15(1):24-31.