Trastuzumab Subcutaneous 21 days - Metastatic Breast Cancer

INDICATIONS FOR USE:

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>ICD10</th>
<th>Regimen Code</th>
<th>Reimbursement Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>HER2 positive metastatic breast cancer (MBC)</td>
<td>C50</td>
<td>00272a</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

As monotherapy for the treatment of those patients who have received at least two chemotherapy regimens for their metastatic disease. Prior chemotherapy must have included at least an anthracycline and a taxane unless patients are unsuitable for these treatments. Hormone receptor positive patients must also have failed hormonal therapy, unless patients are unsuitable for these treatments.

In combination with PACLitaxel for the treatment of those patients who have not received chemotherapy for their metastatic disease and for whom an anthracycline is not suitable.

In combination with DOCEtaxel for the treatment of those patients who have not received chemotherapy for their metastatic disease.

In combination with an aromatase inhibitor for the treatment of postmenopausal patients with hormone-receptor positive MBC, not previously treated with trastuzumab.

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 patient’s individual clinical circumstances.

Treatment administered once every 21 days until disease progression or unacceptable toxicity develops.

Facilities to treat anaphylaxis MUST be present when trastuzumab is administered.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Cycle</th>
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</thead>
<tbody>
<tr>
<td>Trastuzumab</td>
<td>600mg</td>
<td>SC over 2-5mins</td>
<td>Every 21 days</td>
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</table>

The injection site should be alternated between the left and right thigh. New injections should be given at least 2.5 cm from the old site and never into areas where the skin is red, bruised, tender, or hard. During the treatment course with trastuzumab subcutaneous formulation other medicinal products for subcutaneous administration should preferably be injected at different sites.

Patients should be observed for at least six hours after the first injection and for two hours after subsequent injections for signs or symptoms of administration-related reactions. Any deviation should be noted in local policies.
ELIGIBILITY:
- Indications as above
- HER-2 positive tumour as demonstrated by a validated test method.
- Life expectancy > 3 months
- ECOG 0-3

EXCLUSIONS:
- Clinically significant cardiac disease (history of symptomatic ventricular arrhythmias, congestive heart failure or myocardial infarction within previous 12 months).
- Hypersensitivity to trastuzumab or any of the excipients.
- Patients experiencing dyspnoea at rest due to complications of advanced malignancy and comorbidities may be at increased risk of a fatal infusion reaction.

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

TESTS:

Baseline tests:
- Blood renal and liver profile
- Cardiac function (LVEF using ECHO or MUGA scan)

Regular tests:
- Blood renal and liver profile every 6 weeks
- Cardiac function every 12 weeks. Where there are signs of cardiac impairment four to eight weekly checks may be more appropriate.

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.
- None usually recommended. Discontinue if unacceptable toxicity occurs.
- If the patient misses a dose of subcutaneous trastuzumab it is recommended to administer the next 600mg dose (i.e. the missed dose) as soon as possible. The interval between consecutive trastuzumab subcutaneous formulation administrations should not be less than three weeks.
Renal and Hepatic Impairment:

<table>
<thead>
<tr>
<th>Renal impairment</th>
<th>Hepatic impairment</th>
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<tbody>
<tr>
<td>No dedicated studies of trastuzumab in patients with renal impairment have been conducted.</td>
<td>No dedicated studies of trastuzumab in patients with hepatic impairment have been conducted. Probably no dose reduction necessary</td>
</tr>
<tr>
<td>Based on a population pharmacokinetic (PK) analysis renal impairment was not shown to affect trastuzumab disposition</td>
<td></td>
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</table>

Management of adverse events:

<table>
<thead>
<tr>
<th>Table 1. Recommended dose modification for trastuzumab in patients with renal or hepatic impairment</th>
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<table>
<thead>
<tr>
<th>Adverse reactions</th>
<th>Recommended dose modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVEF drops 10 ejection fraction points from baseline and to below 50%</td>
<td>Withhold treatment. Repeat LVEF after 3 weeks. No improvement or further decline consider discontinuation. Discuss with consultant and refer to cardiologist.</td>
</tr>
<tr>
<td>Symptomatic heart failure</td>
<td>Discontinue</td>
</tr>
<tr>
<td>Grade 4 hypersensitivity reactions</td>
<td>Discontinue</td>
</tr>
<tr>
<td>Haematological</td>
<td>Treatment may continue during periods of reversible, chemotherapy-induced myelosuppression. Monitor carefully for any complications of neutropenia.</td>
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</table>

*NCI CTAE Grading*

SUPPORTIVE CARE:

EMETOGENIC POTENTIAL: Minimal (Refer to local policy).

PREMEDICATIONS: Not usually required unless the patient has had a previous hypersensitivity. Paracetamol and antihistamine cover should be considered.

OTHER SUPPORTIVE CARE: No specific recommendations.
ADVERSE EFFECTS / REGIMEN SPECIFIC COMPLICATIONS:

The adverse effects listed are not exhaustive. Please refer to the relevant Summary of Product Characteristics for full details.

- **Cardiac toxicity:**
  - Trastuzumab has been associated with moderate to severe cardiac failure. Baseline and 3 monthly cardiac function tests are required during treatment especially for those with prior anthracycline exposure.
  - If LVEF drops 10 ejection fraction (EF) points from baseline AND to below 50 %, treatment should be withheld and a repeat LVEF assessment carried out within approximately 3 weeks. If LVEF has not improved, or declined further, discontinuation of trastuzumab should be strongly considered, unless the benefits for the individual patient are deemed to outweigh the risks. All such patients should be referred for assessment by a cardiologist and followed up.
  - Trastuzumab and anthracyclines should not be given concurrently in combination due to cardiotoxicity risk.
  - The half-life of trastuzumab is approximately 4-5 weeks

- **Administration-related reactions (ARRs):** Cases of ARRs have been reported with trastuzumab subcutaneous formulation. Patients should be observed for ARRs for six hours after the first injection and for two hours after subsequent injections. They can be treated with an analgesic/antipyretic such as paracetamol, or an antihistamine such as diphenhydramine. Pre-medication may be used to reduce risk of occurrence of ARRs.

- **Pulmonary events:** Caution is recommended with trastuzumab subcutaneous formulation as severe pulmonary events have been reported with the use of the intravenous formulation in the post-marketing setting. These events have occasionally been fatal and may occur as part of an infusion-related reaction or with delayed onset. Caution should be exercised for pneumonitis, especially in patients being treated concomitantly with taxanes.

**DRUG INTERACTIONS:**

- 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 every 2 weeks 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.(1)

- Current drug interaction databases should be consulted for more information.

**ATC CODE:**

Trastuzumab - L01XC03

**REFERENCES:**

1. Nissenblatt MJ, Karp GI. Bleeding risk with trastuzumab (Herceptin) treatment JAMA 1999;282:2299-301

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Amendment</th>
<th>Approved By</th>
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<tbody>
<tr>
<td>1</td>
<td>15/9/2015</td>
<td></td>
<td>Prof Maccon Keane</td>
</tr>
<tr>
<td>2</td>
<td>20/09/2017</td>
<td>Clarification of dosing in renal and hepatic impairment. Updated</td>
<td>Prof Maccon Keane</td>
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<tr>
<td></td>
<td></td>
<td>emetogenic potential Formatting in new NCCP Regimen Template</td>
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<tr>
<td>3</td>
<td>21/09/2019</td>
<td>Updated adverse events and reimbursement status</td>
<td>Prof Maccon Keane</td>
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Comments and feedback welcome at oncologydrugs@cancercontrol.ie.