RITUXIMAB

Recurrent or refractory CD20 +ve follicular NHL Stage III and IV - NICE approved 2002
For patients considered unsuitable for chemotherapy, or in their second or subsequent relapse after chemotherapy

Drugs/Dosage: **Rituximab** 375mg/m^2 IV D1

Premedication:

Paracetamol 1000mg po	60 minutes before treatment
Chlorphenamine 10mg IV	15 minutes before treatment
Dexamethasone 8mg or Hydrocortisone 100mg IV	15 minutes before treatment

Other drugs: Allopurinol 300mg po daily, starting at least 24 hours before first dose - review after 3 weeks

Administration: Rituximab diluted in 0.9% Sodium Chloride & administered according to following instructions:

First infusion: start at 50mg/hr; escalate in 50mg/hr increments every 30 minutes to a maximum of 400mg/hr

Subsequent infusions: if no problems with first infusion, start at 100mg/hr; escalate in 100mg/hr increments every 30 minutes to a maximum of 400mg/hr
if reactions occurred with first infusion, give second infusion as for first infusion

If reactions occur at any time, stop infusion. If symptoms improve, restart at 50% dose and accelerate as tolerated

Frequency: Weekly cycle for 4 doses
A second course may sometimes be given to a patient who has responded to the first course

Main Toxicities: severe cytokine release syndrome – usually occurs within 1–2 hours of the first rituximab infusion (see Comments) and consists of fever, headache, rigors, flushing, nausea, rash, URTI symptoms;
transient hypotension and bronchospasm are usually infusion rate related. Manage as above;
tumour lysis syndrome (ensure pre-medicated with allopurinol and good hydration)

Anti- emetics: Mildly emetogenic

Extravasation: Non-vesicant

Regular Investigations:

FBC	D1
LFTs	D1
U&Es	D1
LDH	D1

Reason for Update: Hydrocortisone added as pre-med	Approved by Chair of Network TSSG: Dr A Laurie
Version: 2	Date: 22.5.06
Supersedes: Version 1	Review Date: February 2008
Prepared by: S Taylor	Checked by Network Pharmacist: pp Carolyn Tucker

Comments: Use with caution if WBC > 25 x 10^9/l, as increased risk of severe cytokine release syndrome. Consider giving with a reduced infusion rate and monitor very closely. If in doubt, check with Consultant.

Full resuscitation equipment must be available, with immediate access to clinical staff trained in resuscitation for the first hour of the first rituximab infusion. Blood pressure, pulse and respiration must be measured and recorded every 15 minutes for the first hour of the first infusion.

Dose Modifications

Haematological Toxicity: If counts become low during treatment, this may be due to marrow infiltration and should be discussed with Consultant before any further treatment is given.

Patient Information: CancerBACUP leaflet for Rituximab

References:
McLaughlin, P et al; ASCO Proceedings 1997; 16: abstract 55
Sonneveld, P et al (1995); JCO (13): 2530-2539