ABVD (Hodgkin's Lymphoma)

DRUG ADMINISTRATION SCHEDULE

Day	Drug	Dose	Route	Diluent	Rate
1 and 15	Ondansetron	8mg	IV bolus		
	Hydrocortisone	100mg	IV bolus		
	Doxorubicin	**25mg/m^2**	**IV bolus**	**via 0.9% Sodium Chloride Drip**	
	VinBLASTine	**6mg/m^2 (Max: 10mg)**	**IV infusion**	**50ml 0.9% Sodium Chloride**	**5 minutes**
	Bleomycin	**10,000 i.unit/m^2 (Max 15000 i.unit)**	**IV bolus**	**via 0.9% Sodium Chloride Drip**	
	Dacarbazine	**375mg/m^2**	**IV infusion**	**500ml 0.9% Sodium Chloride**	**60 minutes**

CYCLE LENGTH AND NUMBER OF DAYS
28 Day cycle, usually given for 2 to 6 cycles

APPROVED INDICATIONS
Hodgkin's Lymphoma

RECOMMENDED TAKE HOME MEDICATION
Ondansetron 8mg Twice Daily for 3 days.

INVESTIGATIONS / MONITORING REQUIRED
Prior to first cycle: CT Scan, FBC, U&Es, LFTs, ECG, Echo if indicated, PET Scan (where appropriate)

Prior to each cycle: U&Es, LFTs, FBC

ASSESSMENT OF RESPONSE
Measure palpable disease. Clinical review prior to each cycle. CT Scan mid-way through treatment and at the end of treatment.

REVIEW BY CLINICIAN/CLINICAL NURSE SPECIALIST
Prior to each cycle, unless being reviewed by a Nurse Specialist or Pharmacist under a locally agreed framework. Minimum consultant review annually.

NURSE / PHARMACIST LED REVIEW
As per locally agreed framework, or under share care with GP. 3 monthly review when stable**.**

ADMINISTRATION NOTES
- Patients requiring blood transfusion will require irradiated blood.

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- Vinblastine and Doxorubicin are both highly vesicant and care must be taken during administration.
- **Vinblastine is for intravenous administration only.** Administration by other routes may be fatal.
- Prior to starting vinblastine ensure the venous access device is sufficiently patent by flushing well with Sodium Chloride 0.9%. If there is doubt about the patency of the access device it must not be used.
- Vinblastine is to be given by intravenous infusion in 50ml of Sodium Chloride 0.9% over 5 minutes. (Rate: 600ml/hr = about 200 drops per minute on a 'standard' 20drop per ml IV giving set.). Administration should normally be 'free-flow' rather than via a volumetric pump.
- Vinblastine is highly vesicant – during administration a nurse should remain with the patient and observe the infusion site carefully for signs of extravasation. In the event that extravasation is suspected the infusion must immediately be stopped and appropriate treatment started (according to the extravasation policy).
- Following administration of vinblastine flush well with Sodium Chloride 0.9%
- Bleomycin can cause pulmonary fibrosis, pre-administration of hydrocortisone may reduce the risk. Bleomycin has a lifetime cumulative dose of 500,000 i.units
- Risk of pulmonary fibrosis can be reduced by avoiding GCSF.
- Screening using lung function tests should be considered in high risk patients
- Dacarbazine is highly light sensitive – the decomposition product causes pain on peripheral infusion. The infusion should be prepared as close to the time of administration as possible. Bags and giving sets should be protected from UV light. If the bag is tinted pink it should not be used. If pain occurs increasing the volume (or piggybacking with an additional bag of fluid) may help, however in many cases patients will require a PICC or other central line.
- Doxorubicin is cardio toxic and has a cumulative lifetime dose of 450-550mg/m^2. Patients with prior anthracycline exposure, or underlying cardiac disease should be considered for ECHO.
- Some units prescribe bleomycin by short intravenous infusion in 100ml Sodium Chloride.

TOXICITIES

Common: Myelosuppression (Moderate), Nausea / Vomiting, Fatigue, Immunosuppression, Constipation
Less Common: Flushing, Rash, Allergic reaction, paraesthesia, pulmonary toxicity, cardiac toxicity

DOSE MODIFICATION / TREATMENT DELAYS

Haematological Toxicity:

(Note: where haematological disease is affecting bone marrow function, lower treatment parameters may be acceptable. This should be clearly documented for the specific patient.)

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There is growing evidence that ABVD can be given without reference to neutrophil counts, nor the need for GCSF support. FBC monitoring may be appropriate as a marker of disease but WBC/ANC should no longer determine if treatment proceeds. Monitoring of PLTs remains appropriate.

If PLT > 100 x 10^9 /litre treatment can proceed as planned. If PLT 70 to 99 x 10^9 /litre consider reducing the dose of doxorubicin, vinblastine and dacarbazine to 66% and proceeding with treatment. If PLT < 70 x 10^9/litre treatment should be delayed to allow recovery.

Renal Function:

CrCl	Bleomycin Dose	Dacarbazine Dose
> 60ml/min	100%	100%
50 – 60ml/min	100%	80%
46 – 49ml/min	75%	80%
31 – 45ml/min	75%	75%
10 - 30ml/min	75%	70%
≤ 10ml/min	50%	70%

Hepatic Function:

Bilirubin	Vinblastine Dose	Doxorubicin Dose
< 20 µmol/l	100%	100%
20 – 51 µmol/l	100%	50%
>51 µmol/l	50%	25%

TREATMENT LOCATION

Suitable for administration in chemotherapy day units, under the supervision of haematology teams from Level 1 – 4 Haematology Services.

REFERENCES:

- Bonadonna G, *et al.* Combination chemotherapy of Hodgkin's Disease with adriamycin, bleomycin, vinblastine & imidazole carboxamide versus MOPP. Cancer: 36 252-259 (1975)
- Evens AM *et al.* G-CSF is not necessary to maintain over 99% dose-intensity with ABVD in the treatment of Hodgkin lymphoma: low toxicity and excellent outcomes in a 10-year analysis.British Journal of Haematology 137 (6) 2007, 545–552

Document Control

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Due for Review:	April 2016	
Summary of Changes	2.0a	Updated vinblastine for NPSA alert.
	3.0a	Updated to remove ANC limits for treatment. Range of cycles changed to 2 to 6 cycles.