



مركز الكويت لمكافحة السرطان
Kuwait Cancer Control Center

TOF (TRASTuzumab / OXALiplatin / 5-Fluorouracil)



Ministry of Health

Name: _____ **File #:** _____ **Ht (cm):** _____
Nationality: _____ **Civil ID:** _____ **Wt (Kg):** _____
Gender/Age: _____ **DOB:** _____ **BSA (m²):** _____

Indication(s): HER2 +ve metastatic gastric and gastro-oesophageal junction adenocarcinoma

Central line: Available NA

Allergies: NKA Yes, specify; _____

Parameters: Initiate treatment only if ANC \geq 1500; HB \geq 80; Plt \geq 75,000; CrCl $>$ 45 ml/min.
 Baseline ECHO and/or MUGA scan before initiation of Anti-HER2 therapy.
 Then, every 3 months during and upon completion of Anti-HER2 therapy.
 Then, every 6 months for at least 2 years following completion of Anti-HER2 therapy.

Pre-treatment Medications: (30-60 min before starting treatment)

Ondansetron 8 mg PO/IV
 Dexamethasone 10 mg PO/IV

Standard Protocol:

DRUG	DOSE	ADMINISTRATION	DAYS
TRASTuzumab	8 mg/kg (Loading dose)	IV in 250 mL NS over 90 min.	1st dose only
TRASTuzumab	6 mg/kg (Maintenance)	IV in 250 mL NS over 30 min.	D1
OXALiplatin	130 mg/m ²	IV in 500 mL D5W over 2 hr.	D1
5-FU (infusion)	1000 mg/m ²	For outpatient: continuous infusion via 5-FU pump or For inpatient: IV in 1000 mL NS over 46 hr	D1, 2
5-FU (infusion)	1000 mg/m ²	For outpatient: continuous infusion via 5-FU pump or For inpatient: IV in 1000 mL NS over 46 hr	D3, 4

To be repeated every 3 weeks for 6 cycles.

Special instructions: - The appropriate Dose Band INFUSOR for 5-FU will be applied accordingly.
 - Avoid ice chips.

Treatment Description:

Cycle	Day	Date	TRASTuzumab	OXALiplatin	5-FU (infusion)	5-FU (infusion)
C# __	D1					XXXXXXX
	D2		XXXXXXX	XXXXXXX		XXXXXXX
	D3		XXXXXXX	XXXXXXX	XXXXXXX	
	D4		XXXXXXX	XXXXXXX	XXXXXXX	

Physician (Stamp and signature)

Consultant (Stamp and signature)