

NEW ZEALAND DATA SHEET

CISPLATIN ACCORD (CISPLATIN) SOLUTION FOR INJECTION

1 PRODUCT NAME

Cisplatin Accord 1 mg/1 mL solution for injection

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Cisplatin Accord 1 mg/1 mL is available as a 10 mg/10 mL, 25 mg/25 mL, 50 mg/50 mL and 100 mg/100 mL solution for injection.

For the full list of excipients, see **Section 6.1 List of Excipients**.

3 PHARMACEUTICAL FORM

Solution for injection

Cisplatin Accord injection is a clear, colourless to pale yellow sterile solution of cisplatin 1 mg/mL and sodium chloride 9 mg/mL in water for injections.

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Cisplatin Accord is indicated for the palliative treatment of:

- Metastatic non-seminomatous germ cell carcinoma;
- Advanced-stage refractory ovarian carcinoma;
- Advanced-stage refractory bladder carcinoma; and
- Refractory squamous cell carcinoma of the head and neck.

It may be used as a single agent or in combination with other chemotherapeutic agents.

It may be employed, in appropriate circumstances, in addition to other modalities, e.g. radiotherapy or surgery.

4.2 DOSE AND METHOD OF ADMINISTRATION

The usual dose in adults and children when used as single agent therapy is 50 - 100 mg/m² as a single IV infusion every 3 - 4 weeks, or 15 - 20 mg/m² as a daily IV infusion for 5 days every 3 - 4 weeks.

Combination therapy:

Cisplatin is commonly used in combination therapy with the following cytotoxic agents:

1. For the treatment of testicular cancer: vinblastine, bleomycin, actinomycin D.
2. For treatment of ovarian cancer: cyclophosphamide, doxorubicin, (adriamycin), hexamethylmelamine, fluorouracil.
3. For treatment of head and neck cancer: bleomycin, methotrexate.

Subsequent treatment with cisplatin:

A repeat course of cisplatin should not be given until:

1. The serum creatinine is below 140 micromol/L and/or the plasma urea is below 9 mmol/L, and
2. Circulating blood elements are at an acceptable level (platelets at least 100,000/mm³, WBC at least 4,000/mm³).

A baseline audiogram should be taken and the patient monitored periodically for auditory deterioration.

With impaired liver function

Human studies show a high uptake of cisplatin in the liver. An elevated SGOT has been reported in some cases and the adult dosage should be used with caution.

With impaired renal function

Cisplatin displays high tissue uptake in the kidneys, exhibits dose related and cumulative nephrotoxicity, and is excreted mainly in the urine. In addition, the plasma elimination half-life of cisplatin is prolonged in renal failure.

Caution should be exercised in patients with pre-existing renal dysfunction. Cisplatin is contraindicated in patients with serum creatinine levels greater than 0.2 mmol/L. Repeat courses are not advised until serum creatinine is below 0.14 mmol/L and/or blood urea below 9 mmol/L.

- a. Pretreatment hydration: Patients should be adequately hydrated before and for 24 hours after administration of cisplatin to ensure good urinary output and minimise nephrotoxicity. Hydration may be achieved by IV infusion of 2 litres of either sodium chloride IV infusion 0.9% or glucose-saline (e.g. glucose 4% in one-fifth sodium chloride IV infusion 0.9%) over a 2-hour period. During the last 30 minutes of the pretreatment hydration or after the hydration, 375 mL of 10% mannitol injection may be administered via a side-arm drip.
- b. Preparation of cisplatin infusion: Cisplatin injection should be added to 1 litre of sodium chloride IV infusion 0.9%.
- c. Treatment: Following prehydration, administer the cisplatin infusion over 1 - 2 hours. It has been proposed that a longer infusion time of 6 - 8 hours may decrease gastrointestinal and renal toxicities. The IV flask should be covered to preclude light.
- d. Post-treatment hydration: Adequate hydration and urinary output must be maintained during the 24 hours following infusion. It has been suggested that IV hydration continue after treatment with the aim to administer 2 litres of sodium chloride IV infusion 0.9% or glucose-saline over a period of 6 - 12 hours.

4.3 CONTRAINDICATIONS

Use of cisplatin is contraindicated in patients with a history of hypersensitivity to cisplatin or other platinum-containing compounds, in pregnancy or lactation and in patients with renal impairment. Cisplatin should not be used in patients with hearing impairment or myelosuppression.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Only individuals experienced in antineoplastic therapy should use cisplatin.

Renal function

Measurements of BUN, serum creatinine and creatinine clearance should be taken before initiating cisplatin therapy, and prior to subsequent doses, as toxicity is cumulative. Cisplatin is recommended to be given once every 3 - 4 weeks. Hydration is recommended to minimise nephrotoxicity.

Cumulative and dose-related renal insufficiency is the major dose-limiting toxicity of cisplatin. The most commonly observed change in renal function has been a fall in glomerular filtration rate reflected by a rise in serum creatinine. Renal function must return to acceptable limits (serum creatinine below 0.14 mmol/L and/or blood urea below 9 mmol/L) before further doses are given.

Ototoxicity

Tinnitus or occasional decreased ability to hear normal conversation are indications of ototoxicity, which have been frequently observed. Abnormalities of audiometric testing are more common and hearing loss can be unilateral or bilateral; frequency and severity increase with repeated doses, and may not be reversible, but mostly occur in the 4,000 - 8,000 Hz range.

As ototoxicity of cisplatin is cumulative, audiometric testing should be performed, if possible prior to initiation of therapy and at regular intervals thereafter, particularly if the clinical symptoms of tinnitus or hearing impairment occur. Radiotherapy may enhance ototoxicity.

Myelosuppression

This may occur in patients treated with cisplatin. The nadirs in circulating platelets and leucocytes generally occur between days 18 - 32 (range 7.3 - 45) with most patients recovering by day 39

(range 13 - 62). Leucopenia and thrombocytopenia are more pronounced at doses greater than 50 mg/m². Anaemia (decrease of greater than 2 g% haemoglobin) occurs at approximately the same frequency but generally with a later onset than leucopenia and thrombocytopenia.

Subsequent courses of cisplatin should not be instituted until platelets are present at levels greater than 100,000/mm³ and white cells greater than 4,000/mm³. A high incidence of severe anaemia requiring transfusion of packed red cells has been observed in patients receiving combination chemotherapy including cisplatin. Rarely, the drug has caused haemolytic anaemia; direct Coombs-positive results have been reported in a few of these cases.

Peripheral blood counts should be performed at regular intervals for the duration of cisplatin treatment.

Anaphylaxis

Reactions, possibly secondary to cisplatin therapy, have been occasionally reported in patients who were previously exposed to cisplatin. Patients who are at particular risk are those with a prior history or family history of atopy. Facial oedema, wheezing, tachycardia, hypotension and skin rashes of urticarial non-specific maculopapular type can occur within a few minutes of administration. Serious reactions seem to be controlled by IV adrenaline, corticosteroids or antihistamines.

Patients receiving cisplatin should be observed carefully for possible anaphylactic-like reactions and supportive equipment and medication should be available to treat such a complication.

Cardiovascular toxicity

Cisplatin has been found to be associated with cardiovascular toxicity (see **Section 4.8 Undesirable Effects**). Patients may experience clinically heterogeneous venous thromboembolic events, myocardial infarction, cerebrovascular accidents, thrombotic microangiopathy and cerebral arteritis. Cases of pulmonary embolism (including fatalities) have been reported (see **Section 4.8 Undesirable Effects**).

Hypomagnesaemia and hypocalcaemia

Hypomagnesaemia occurs quite frequently with cisplatin administration, while hypocalcaemia occurs less frequently. The loss of magnesium seems to be associated with renal tubular damage which prevents resorption of this cation. Where both electrolytes are deficient, tetany may result. It does not appear to be dose related. Monitoring of electrolytes is necessary.

Neurotoxicity and seizures

Peripheral neuropathy, postural hypotension and seizures may occur with cisplatin administration. This appears to be more common after prolonged administration. The development of clinically significant symptoms should generally contraindicate further cisplatin usage.

Dental

The bone marrow depressant effects of cisplatin may result in an increased incidence of microbial infection, delayed healing and gingival bleeding. Dental work should be avoided during cisplatin therapy.

Others

Liver function should be monitored periodically. Neurological examinations should also be performed regularly.

As patients undergoing treatment with cisplatin are at an increased risk of bleeding, bruising and infection, it is recommended that extreme care be used when performing necessary invasive procedures.

Alcohol and aspirin should be avoided because of the risk of gastrointestinal bleeding.

Extreme caution should be used where patients have recently been exposed to infections, particularly chicken pox and herpes zoster. Live virus vaccines should not be used in patients undergoing cisplatin therapy.

Paediatric population

Cisplatin can also be used in children.

4.5 INTERACTION WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION

Nephrotoxic drugs

Potentially nephrotoxic or ototoxic drugs, e.g. aminoglycoside antibiotics and loop diuretics, may potentiate the nephrotoxic and ototoxic effects of cisplatin.

The renal toxicity of ifosfamide may be greater when used with cisplatin or in patients who have previously been given cisplatin.

Ototoxic drugs

Potentially ototoxic drugs such as aminoglycoside antibiotics or loop diuretics may exacerbate the ototoxic effects of cisplatin.

Ifosfamide may increase hearing loss due to cisplatin.

Renally excreted drugs

Reduction of the lithium blood levels was noticed in a few cases after treatment with cisplatin combined with bleomycin and etoposide. It is therefore recommended to monitor the lithium values.

Anticonvulsant agents

Plasma levels of anticonvulsant agents may become subtherapeutic during cisplatin therapy.

Anticoagulants

It is advisable to check the international normalised ratio (INR) when oral anticoagulants such as coumarins/warfarin are used simultaneously with cisplatin.

Paclitaxel

Administration of cisplatin prior to an infusion with paclitaxel may reduce the clearance of paclitaxel by 33% and can therefore intensify neurotoxicity.

Cisplatin interacts with aluminium to form a black precipitate. Needles, syringes, catheters or IV administration sets that contain aluminium should not be used for the administration of cisplatin.

4.6 FERTILITY, PREGNANCY AND LACTATION

Pregnancy (Category D)

Patients should be advised to avoid becoming pregnant.

Women of childbearing potential should use effective contraception during treatment with cisplatin and for at least 26 weeks following the last dose. Men with female partners of childbearing potential should be advised to use effective contraception during treatment with cisplatin and for at least 14 weeks after the last dose.

For patients with end-stage renal disease, the washout period of cisplatin will be longer (up to 7 weeks); effective contraception for men is advised for at least 19 weeks and for female patients, for at least 31 weeks after the last dose.

If the patient becomes pregnant whilst receiving the drug she should be advised of the hazard to the foetus. Cisplatin should only be used if the potential benefits outweigh the risk of therapy

Breastfeeding

Cisplatin is excreted in breast milk. To avoid possible harmful effects in the infant, patients treated with cisplatin must not breastfeed.

Fertility

Female

Based on non-clinical (see **Section 5.3 Preclinical Safety Data**) and clinical findings, female fertility may be compromised by treatment with cisplatin. Use of cisplatin has been associated with cumulative dose-dependent ovarian failure, premature menopause and reduced fertility.

Male

Cisplatin can affect male fertility. Impairment of spermatogenesis and azoospermia have been reported (see **Section 4.8 Undesirable Effects**) - Reproductive System and Breast Disorders). Although the impairment of spermatogenesis can be reversible, males undergoing cisplatin treatment should be warned about the possible adverse effects on male fertility.

Both men and women should seek advice on fertility preservation before treatment.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

The effect of cisplatin on the ability to drive and use machinery has not been established.

4.8 UNDESIRABLE EFFECTS

Cumulative and dose-related renal impairment is the major limiting toxicity of cisplatin. Renal toxicity becomes more prolonged and severe with repeated courses of the drug. Regimes of IV hydration, mannitol diuresis and 6 - 8 hour infusions of cisplatin have been used to reduce the incidence and severity of nephrotoxicity.

Infections and infestations

Infection (infectious complications have led to death), sepsis

Neoplasms benign, malignant and unspecified

Secondary malignancies and acute leukaemia have been known to develop.

Blood and lymphatic system disorders

Thrombotic microangiopathy (hemolytic uremic syndrome), bone marrow failure, neutropenia, thrombocytopenia, leukopenia, anemia, Coombs positive hemolytic anemia.

Leucopenia and thrombocytopenia are dose-related and more pronounced at doses greater than 50 mg/m². Leucocyte and platelet nadirs generally occur between days 18 and 23 of treatment, with recovery in most patients by day 39. Anaemia occurs at approximately the same frequency.

Immune system disorders

Anaphylactic-like reactions, consisting principally of facial oedema, wheezing, tachycardia and hypotension have been reported in patients previously exposed to cisplatin. The reactions may be controlled by IV adrenaline, corticosteroids and/or antihistamines.

Other adverse effects to cisplatin which have been reported infrequently include cardiac abnormalities, elevated SGOT and liver damage. Secondary malignancies and acute leukaemia have been known to develop. Extravasation may result from infusion of solutions greater than 0.5 mg/mL cisplatin.

Endocrine disorders

Inappropriate antidiuretic hormone secretion has been known to develop.

Metabolism and nutritional disorders

Cisplatin may cause the following in patients: hyponatremia, hypomagnesemia, dehydration, hypokalaemia, hypophosphataemia, hyperuricemia, hypocalcemia, tetany

Nervous system disorders

Convulsion, neuropathy peripheral, leukoencephalopathy, reversible posterior leukoencephalopathy

syndrome, hemorrhagic stroke, ageusia, Lhermitte's sign, myelopathy, autonomic neuropathy, cerebrovascular accident, ischemic stroke, cerebral arteritis

Eye disorders

Vision blurred, color blindness acquired, blindness cortical, optic neuritis, papilloedema, retinal pigmentation

Ear and labyrinth disorders

Tinnitus and/or high frequency hearing loss has been observed in up to 31% of patients treated with cisplatin. Ototoxicity may be more severe in children and more frequent and severe with repeated doses.

Cardiac disorders

Arrhythmia, myocardial infarction, bradycardia, tachycardia, cardiac arrest, cardiac disorder

Vascular disorders

Raynaud's phenomenon

Venous thromboembolism

A significant increase in the risk of venous thromboembolic events has been reported in patients with advanced solid tumours and treated with cisplatin compared with non-cisplatin-based chemotherapy.

Vascular toxicity coincident with the use of cisplatin in combination with other antineoplastic agents have been reported rarely. The events are clinically heterogeneous and may include myocardial infarction, cerebrovascular accident (haemorrhagic and ischaemic stroke), thrombotic microangiopathy (haemolytic uraemic syndrome) or cerebral arteritis. Various mechanisms have been proposed for these vascular complications.

Respiratory, thoracic and mediastinal disorders

Pulmonary embolism

Gastrointestinal disorders

Stomatitis, vomiting, nausea, anorexia, hiccups, diarrhoea

Cisplatin induces severe nausea and vomiting in almost all patients. Nausea and vomiting usually begin within 1-4 hours after treatment and may persist for up to a week after treatment.

Skin and subcutaneous tissue disorders

Rash, alopecia

Musculoskeletal and connective tissue disorders

Muscle spasms

Renal and urinary disorders

Renal failure acute, renal failure, renal tubular disorder

Reproductive system and breast disorders

Abnormal spermatogenesis and azoospermia have been reported.

General disorders and administration site conditions

Pyrexia, asthenia, malaise, injection site extravasation (extravasation may result in local soft tissue toxicity including tissue cellulitis, fibrosis, and necrosis, pain, oedema, erythema)

Neurotoxicity, characterised by peripheral neuropathies, both sensory and motor, have occurred in some patients.

Myelosuppression may occur in patients treated with cisplatin.

Hyperuricaemia may occur in patients receiving cisplatin, principally as a result of drug-induced

nephrotoxicity. Hyperuricaemia is more pronounced with doses greater than 50 mg/m², with peak levels occurring between 3-5 days after administration of the drug. Allopurinol may be used to reduce serum uric acid levels.

Hypomagnesaemia and hypocalcaemia may develop during cisplatin therapy or following discontinuance of the drug. Hypomagnesaemia and/or hypocalcaemia may be manifested by muscle irritability or cramps, clonus, tremor, carpopedal spasm and/or tetany. Regular monitoring of serum electrolyte levels and replacement where necessary are advisable.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://nzphvc.otago.ac.nz/reporting/>

4.9 OVERDOSE

In the event of overdosage or toxic reactions, symptomatic or supportive measures should be taken. Patients should be monitored for 3 to 4 weeks in case of delayed toxicity.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764 766).

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Pharmacotherapeutic group: antineoplastic agent

ATC code: L01XA01

Mechanism of action

Cisplatin is an antineoplastic agent with biochemical properties similar to those of bifunctional alkylating agents. The drug inhibits DNA synthesis by producing intrastrand and interstrand crosslinks in DNA. Protein and RNA synthesis are also inhibited to a lesser extent. Cisplatin does not appear to be cell-cycle specific.

5.2 PHARMACOKINETIC PROPERTIES

Distribution

There is good uptake of cisplatin by the kidneys, liver and intestine. More than 90% of platinum-containing species remaining in the blood are bound (possibly irreversibly) to plasma proteins.

The clearance of total platinum from plasma is rapid during the first four hours after intravenous administration, but then proceeds more slowly because of covalent binding to serum proteins. Levels of unbound platinum fall with a half-life of 20 minutes to 1 hour depending on the rate of drug infusion

Elimination

The elimination of intact drug and various platinum-containing biotransformation products is via the urine. About 15 - 25% of administered platinum is rapidly excreted in the first 2 - 4 hours after administration of cisplatin. This early excretion is mostly of intact cisplatin. In the first 24 hours after administration, 20 - 80% is excreted, the remainder representing drug bound to tissues or plasma protein.

5.3 PRECLINICAL SAFETY DATA

Cisplatin is mutagenic in bacteria and produces chromosome aberrations in animal cells in tissue culture. In mice, cisplatin is teratogenic and embryotoxic. Cisplatin may be toxic to the foetal urogenital tract. Carcinogenicity of cisplatin is possible but not proven.

Non-clinical findings in mice treated with cisplatin (5 mg/kg intraperitoneally) showed that cisplatin caused direct damage to primordial follicle oocytes, leading to apoptosis.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

Sodium chloride
Hydrochloric acid
Sodium hydroxide
Water for injections

The solution does not contain any preservative.

6.2 INCOMPATIBILITIES

Cisplatin may interact with aluminium to form a black precipitate. Needles, syringes, catheters or IV administration sets that contain aluminium parts which may come in contact with cisplatin should not be used for preparation or administration of the drug. The stability of cisplatin is adversely affected by the presence of bisulphite, metabisulphite, sodium bicarbonate and fluorouracil.

6.3 SHELF LIFE

3 years

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Store below 25°C. Protect from light. Do not refrigerate or freeze.

If a precipitate has formed because of exposure to low temperatures, redissolve by storing at the recommended storage condition until a clear solution is obtained.

6.5 NATURE AND CONTENTS OF CONTAINER

Cisplatin Accord is available in four strengths: 10 mg/10 mL, 25 mg/25 mL, 50 mg/50 mL and 100 mg/100 mL, in Type I amber glass vials in packs of 1.

Not all presentations may be marketed.

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL AND OTHER HANDLING

Cisplatin 0.15 mg/mL in sodium chloride IV infusion 0.9% is chemically stable for 24 hours when stored at room temperature and protected from light. The solution does not contain any antimicrobial preservatives and to avoid microbial contamination hazards, infusion should be commenced as soon as practicable after preparation. Infusion should be completed within 24 hours of preparation and any residue discarded.

Chemical and physical in-use stability after dilution with sodium chloride IV infusion 0.9%, stored in PE bags, has further been demonstrated for the below concentrations and storage conditions:

Concentration after dilution	Temperature conditions	Other conditions	*Stability demonstrated for
0.01 mg/mL	2 to 8°C	Unprotected from light	21 days
	25°C	Unprotected from light	21 days
0.1 mg/mL	2 to 8°C	Unprotected from light	21 days
	25°C	Unprotected from light	21 days
0.4 mg/mL	25°C	Unprotected from light	21 days

*based on physico-chemical stability of the drug product after dilution

Syringe study: the undiluted solution is stable for 14 days at room temperature protected from light when stored in a syringe.

No microbiological claims are made in relation to the data above, and from the microbiological point of view the product should be used immediately. If not used immediately, in-use storage time and

conditions prior to use are the responsibility of the user and would not normally exceed 24 hours, unless dilution has taken place in controlled and validated aseptic conditions.

7 MEDICINE SCHEDULE

Prescription Only Medicine

8 SPONSOR

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10 DATE OF REVISION OF TEXT

20 August 2021

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Summary table of changes

Section changed	Summary of new information
All	Trade name update, editorial changes
1	Change to title
4.5	Added interactions
4.6	Added fertility and pregnancy information
4.8	Added azoospermia
5.3	Additional information added
6.1	Inclusion of all excipients that could be present
6.3	Shelf life updated
6.4	Added storage condition information
6.5	Editorial update
8	Update to sponsor details