Protocol for Planning and Treatment

The process to be followed in the management of:

MALIGNANT MESOTHELIOMA

Patient information given at each stage following agreed information pathway

1. DIAGNOSIS

Patients may present with chest pain, dyspnoea, cough, and/or pleural effusion. Advancing disease causes respiratory insufficiency; chest wall pain; cardiovascular complications from pericardial effusion and invasion of the heart; ascites and growth in periotoneum; and general constitutional deterioration.
An accurate history of asbestos exposure should be sought.

2. STAGING

As per IMIG TNM Staging 1994

3. HISTOPATHOLOGY

Subclassified into:

Epithelioid
Sarcomatoid
Biphasic

Histological appearance appears to be of prognostic value, with most clinical studies showing that epithelial mesotheliomas have a better prognosis than sarcomatoid mesotheliomas.

4. INVESTIGATIONS

Chest X-ray usually shows a pleural effusion or pleural thickening.

CT thorax and upper abdomen delineates the extent of disease far more accurately than chest radiography.

Because many patients with mesothelioma present with a pleural effusion, they usually undergo thoracocentesis and pleural fluid pathology is positive in about one third of cases. It is difficult to differentiate metastatic adenocarcinoma from mesothelioma with cytology alone.

If the pleural space is totally or partially free, thoracoscopy is a preferred approach to diagnosis because is most likely to yield a diagnosis, can be done by a videoscopic assisted procedure (VATS) which is a limited surgical procedure, allows direct examination of clinically abnormal tissues and permits effective pleurodesis, and provides the pathologist with a good specimen obtained from an involved area.

If the pleural space is obliterated by adhesions or tumour, diagnostic limited thoracotomy may be required.

5. SURGERY

This should only be done in the context of a clinical trial.

Patients with epithelioid histology, clinical stage I or II disease, negative mediastinal nodes at mediastinoscopy and minimal costophrenic recess angle disease may be considered for trail entry.

6. RADIOTHERAPY

Palliative radiotherapy:

Indications:

Palliation of local symptoms particularly chest wall pain
Palliation of painful chest wall masses

Dose:

8Gy single fraction or 20Gy in 5 fractions over 5-7days

7. CHEMOTHERAPY

All patients with mesothelioma and performance status 0-1 should have the opportunity to discuss the merits and limitations of chemotherapy with a specialist experienced in the use of chemotherapy for malignant mesothelioma. Palliative chemotherapy may be offered following this discussion.

1st line palliative chemotherapy:

Indications:

PS 0-1 and selected 2
Adequate cardiac and renal function (GFR>50ml/min)
Non-resectable malignant mesothelioma.

Response monitoring:

Clinical assessment and chest X-ray each cycle
CT thorax after 2 cycles

Continue chemotherapy only if evidence of ongoing symptomatic benefit and no radiological or clinical evidence of progression.

2nd line palliative chemotherapy:

More than 6 months progression free:

If patient responds to first line chemotherapy and is progression free for more than 6 months, further chemotherapy can be considered at time of progression if patient remains of good performance status (PS0-1), using Carboplatin and pemetrexed.

Less than 6 months progression free:

If patient responds to first line chemotherapy and is progression free for less than 6 months, further chemotherapy can be considered at time of progression if patient remains of good performance status (PS0-1) Carboplatin and Vinorelbine.

Response monitoring:

Clinical assessment and chest X-ray each cycle
CT thorax after 2 cycles

Continue chemotherapy only if evidence of ongoing symptomatic benefit and no radiological or clinical evidence of progression

CONSIDER CLINICAL TRIALS

8. OTHER SUPPORTIVE MEASURES

Ensure:

Early referral to palliative care services.
Referral to benefits officer
Referral to Tayside Action for Asbestos

9. TREATMENT DEFINITIONS

1st line Regimen:

Day 1 pemetrexed 500mg/m^2 IV
Day 1 cisplatin 75mg/m^2 IV

Every 21 days for up to 6 cycles depending on response and toxicities

In those with poor renal function (GFR <50 ml/min) Carboplatin should be used instead of Cisplatin at a dose of AUC5 (EDTA GFR)

Pre-medication:

Dexamethasone 4 mg BD PO days -1, 0, and 1
Folic acid 400 micrograms PO starting 7-14 days pre-chemotherapy and continuing until 3 weeks after last dose of chemotherapy.
Vitamin B12 1000micrograms IM 7 days pre-chemotherapy and then every 9 weeks (dose should be doubled in the malnourished).

2nd line Regimen:

Carboplatin AUC 5 iv d1 q21 days
Pemetrexed 500mg/m^2 IV d1 q 21 days

Pre-medication:

Dexamethasone 4 mg BD PO days -1, 0, and 1
Folic acid 400 micrograms PO starting 7-14 days pre-chemotherapy and continuing for 4 weeks
Vitamin B12 1000micrograms IM 7 days pre-chemotherapy and then every 9 weeks

Other 2nd line Regimen:

Carboplatin AUC 5 iv d1 q21 days q 21d
Vinorelbine 25mg/m^2 iv d 1 q 21d
Vinorelbine 60mg/m^2 d8 q 21d

Author: …… Signature: …….. Date: ……

Chair: …… Signature: …….. Date: ……
(on behalf of OHMMG)

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