**Liposomal Cytarabine (DepoCyte®) INTRATHECAL and INTRAVENTRICULAR**

**INDICATION**

Treatment of lymphomatous meningitis. 
NB. Not routinely commissioned by NHSE. Individual funding request is required prior to treatment.

Discuss intraventricular route with local intrathecal lead.

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**ALL INTRATHECAL DRUGS TO BE ADMINISTERED IN ACCORDANCE WITH NATIONAL GUIDANCE AND LOCAL POLICY**

**TREATMENT INTENT**

Disease modification.

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**PRE-ASSESSMENT**

- Blood tests - FBC, coagulation screen.
- Stop/withhold anticoagulation as per local guidance.
- If platelets <40x10⁹/L give 1-2 pools of platelets (depending on prior platelet increments) just before/during procedure. Correct any coagulation abnormality.
- Treatment should be agreed in the relevant MDT.

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**DRUG REGIMEN**

**LIPOSOMAL CYTARABINE (DepoCyte®)** 50 mg INTRATHECAL or INTRAVENTRICULAR. 
Administer within 4 hours of preparation. In-line filters must not be used.

DepoCyte® should be administered by slow injection over 1-5 minutes directly into the cerebrospinal fluid (CSF) via either an intraventricular reservoir or by direct injection into the lumbar sac. Following administration by lumbar puncture, the patient should be instructed to lie flat for one hour after administration.
CYCLE FREQUENCY

Not more frequently than once every 14 days - see SPC for full details.

The following regimen of induction, consolidation and maintenance therapy is recommended:

**Induction therapy**: 50 mg administered every 14 days for 2 doses (weeks 1 and 3).

**Consolidation therapy**: 50 mg administered every 14 days for 3 doses (weeks 5, 7 and 9) followed by an additional dose of 50 mg at week 13.

**Maintenance therapy**: 50 mg administered every 28 days for 4 doses (weeks 17, 21, 25 and 29).

RE-STAGING

Review CSF WBC count and cytology at each LP; since DepoCyte®’s particles are similar in size and appearance to white blood cells, care must be taken in interpreting CSF examination following administration.

DOSE MODIFICATIONS

If neurotoxicity develops, the dose should be reduced to 25 mg. If neurotoxicity persists, treatment with DepoCyte® should be discontinued.

Schedule may need modification if the platelet count is very low or coagulation is abnormal.

INVESTIGATIONS

FBC – aim for platelet count of > 40 x 10⁹/L.

CONCURRENT MEDICATION

| Dexamethasone | 4 mg twice daily (PO/IV) for 5 days, beginning on the day of each DepoCyte® injection. |

EMETIC RISK

Minimal.
ADVERSE EFFECTS / REGIMEN SPECIFIC COMPLICATIONS

There is a significant risk of chemical arachnoiditis (16%), a syndrome manifested primarily by nausea, vomiting, headache and fever. If left untreated it may be fatal.

Inform patients about the expected adverse reactions of headache, nausea, vomiting and fever, and about the early signs and symptoms of neurotoxicity. Emphasise the importance of concurrent dexamethasone administration at the initiation of each cycle of DepoCyte® treatment.
Instruct patients to seek medical attention if signs or symptoms of neurotoxicity develop, or if oral dexamethasone is not well tolerated.

Administration of DepoCyte® in combination with other neurotoxic chemotherapeutic agents or with cranial/spinal irradiation may increase the risk of neurotoxicity.

On the basis of reported adverse reactions, patients should be advised against driving or using machines during treatment.

TREATMENT RELATED MORTALITY

< 1%

REFERENCES