

NEW ZEALAND DATA SHEET

1. PRODUCT NAME

DBL™ Cisplatin 1 mg/mL Solution for Injection

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

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

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Solution for injection

DBL Cisplatin Injection is a clear, colourless to pale yellow sterile solution.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

DBL Cisplatin Injection 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

Dosage

A variety of doses and schedules are used. To obtain optimum therapeutic results with minimum adverse effects, the dosage of cisplatin must be based on the clinical, renal and haematologic status of the patient.

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, 5-fluorouracil.

3. For treatment of head and neck cancer: bleomycin, methotrexate.

Dosage adjustment

Dosage should be reduced in patients with depressed bone marrow function.

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 4000/mm³).

A base line audiogram should be taken and the patient monitored periodically for auditory deterioration (see Section 4.4 Special warnings and precautions for use).

Hepatic impairment

Human studies show a high uptake of cisplatin in the liver. An elevated aspartate aminotransferase (AST) and alkaline phosphatase (ALP) with clinical signs of liver toxicity has been reported in some cases. The adult dosage should be used with caution in patients with pre-existing hepatic dysfunction.

Renal impairment

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.

Administration

- 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:** DBL Cisplatin Injection should be added to 1 litre of sodium chloride IV infusion 0.9%.

Aluminium containing equipment should not be used for administration of cisplatin (see Section 6.2 Incompatibilities).

- 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.

The product and its admixtures contain no antimicrobial agent. In order to reduce microbiological hazards it is recommended that further dilution be effected immediately prior to use and infusion commenced as soon as practicable after preparation of the admixture. Infusion should be completed within 24 hours of preparation and the residue discarded.

4.3 Contraindications

Use of cisplatin is contraindicated in the following conditions:

- Severe renal impairment (refer to Section 4.2)
- Hearing disorders (refer to Section 4.4, Ototoxicity).
- Bone marrow depression
- Generalised infections
- During pregnancy or lactation
- In patients with a history of hypersensitivity to cisplatin or platinum-containing compounds.

4.4 Special warnings and precautions for use

Cisplatin is a highly toxic drug with a relatively narrow therapeutic index, and a therapeutic effect is unlikely to occur without some evidence of toxicity. Cisplatin should be administered only under constant supervision by physicians experienced in therapy with cytotoxic agents and only when potential benefits of cisplatin therapy outweigh the possible risks. Appropriate facilities should be available for adequate management of complications should they arise.

To minimise the risk of nephrotoxicity, hydrate before, during and after therapy (see Section 4.2). Prior to initial therapy, then before subsequent doses, the following parameters should be monitored: renal function including Glomerular Filtration Rate (GFR), Blood Urea Nitrogen (BUN), serum creatinine and creatinine clearance; electrolytes (magnesium, sodium, potassium and calcium) to detect hypomagnesaemia or hypocalcaemia; auditory function; red blood cells, white blood cells and platelets; liver function and neurological status.

Renal function

Cisplatin is contraindicated in patients with severe renal impairment (see Section 4.3).

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 and a reduction in effective renal plasma flow.

Pre and post treatment hydration may reduce nephrotoxicity (see Section 4.2).

Renal function must return to normal before further doses are given (see Section 4.2).

Special care has to be taken when cisplatin-treated patients are given concomitant therapies with other potentially nephrotoxic drugs (see section 4.5).

Ototoxicity

Ototoxicity is cumulative and occurs mainly with high dose regimes. 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.

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. Clinically important deterioration of auditive function may require dosage modifications or discontinuation of therapy.

Myelosuppression

This may occur in patients treated with cisplatin. Haematological toxicity is dose-related and cumulative. The nadirs in circulating platelets and leucocytes generally occur between days 18 - 23 (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.

Peripheral blood counts should be monitored frequently in patients receiving cisplatin. Although the haematologic toxicity is usually moderate and reversible, severe thrombocytopenia and leucopenia may occur. In patients who develop thrombocytopenia special precautions are recommended: care in performing invasive procedures; search for signs of bleeding or bruising; test of urine, stools and emesis for occult blood; avoiding aspirin and other NSAIDs. Patients who develop leucopenia should be observed carefully for signs of infection and might require antibiotic support and blood product transfusions.

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.

Anaemia

Anaemia (decrease of greater than 2g/dL haemoglobin) occurs in a significant number of patients, usually after several courses of treatment. Anaemia occurs at approximately the same frequency but generally with a later onset than leucopenia and thrombocytopenia. Transfusions of packed red cells may be necessary in severe cases.

Rarely, the drug has caused haemolytic anaemia; Coombs-positive results have been reported in a few of these cases. Further courses with cisplatin in sensitised individuals may cause increased haemolysis.

A high incidence of severe anaemia requiring transfusion of packed red cells has been observed in patients receiving combination chemotherapy including cisplatin.

Nausea and vomiting

Marked nausea and vomiting occur in almost all patients treated with cisplatin and are occasionally so severe that dosage reduction or discontinuance of treatment is necessary.

Anaphylaxis

Reactions, 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 the necessary supportive equipment and medication should be readily available to treat such reactions.

Cardiovascular toxicity

Cisplatin has been found to be associated with cardiovascular toxicity (see section 4.8). 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).

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

Cisplatin is known to induce neurotoxicity; therefore, neurologic examination is warranted in patients receiving a cisplatin-containing treatment. Peripheral neuropathy, postural hypotension, myasthenic syndromes, seizures and visual loss may occur with cisplatin treatment. This appears to be more common after prolonged treatment. Since neurotoxicity may result in irreversible damage, the development of clinically significant symptoms should generally contraindicate further cisplatin usage.

Immunosuppressant Effects/Increased Susceptibility to Infections

Administration of live or live-attenuated vaccines in patients immunocompromised by chemotherapeutic agents including cisplatin, may result in serious or fatal infections. Extreme caution should be used where patients have recently been exposed to infections, particularly chicken pox and herpes zoster. Vaccination with a live vaccine should be avoided in patients receiving cisplatin. Killed or inactivated vaccines may be administered; however, the response to such vaccines may be diminished.

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.

Other

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.

Use in hepatic impairment

Liver function should be monitored periodically.

Paediatric Use

Cisplatin can also be used in children. Cases of delayed-onset hearing loss have been reported in the paediatric population. Long term follow-up in this population is recommended.

4.5 Interaction with other medicines and other forms of interaction

Cisplatin is mostly used in combination with antineoplastic drugs having similar cytotoxic effects. In these circumstances additive toxicity is likely to occur.

Other known drug interactions are reported below.

Nephrotoxic drugs

Potentially nephrotoxic drugs, e.g. aminoglycoside antibiotics and loop diuretics when given concurrently or within 1-2 weeks after cisplatin administration, may potentiate the nephrotoxic effects of cisplatin. Concomitant use of other potentially nephrotoxic drugs (eg amphotericin B) is not recommended during cisplatin therapy.

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

Ototoxic drugs

Concurrent and/or sequential administration of potentially ototoxic drugs, e.g. aminoglycoside antibiotics and loop diuretics, may potentiate the ototoxic effects of cisplatin, especially in the presence of renal impairment.

Ifosfamide may increase hearing loss due to cisplatin.

Renally excreted drugs

Literature data suggest that cisplatin may alter the renal elimination of bleomycin and methotrexate (possibly as a result of cisplatin-induced nephrotoxicity) and enhance their toxicity. 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.

Antigout agents

Cisplatin may raise the concentration of blood uric acid. Thus, in patients concurrently receiving antigout agents such as allopurinol, colchicine, probenecid or sulfinpyrazone, dosage adjustment of these drugs may be necessary to control hyperuricemia and gout.

Anticonvulsant agents

Plasma levels of anticonvulsant agents may become subtherapeutic during cisplatin therapy. In patients receiving cisplatin and phenytoin, serum concentrations of the latter may be decreased, possibly as a result of decreased absorption and/or increased metabolism. In these patients, serum levels of antiepileptics should be monitored and dosage adjustments made as necessary.

Anticoagulants

It is advisable to check the international normalized 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.

4.6 Fertility, pregnancy and lactation

Effects on fertility

Female

Based on non-clinical (see section 5.3) 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). 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.

Pregnancy – Category D¹

If the drug is administered during pregnancy or if the patient becomes pregnant whilst receiving the drug she should be advised of the hazard to the fetus. Cisplatin should only be used if the potential benefits outweigh the risk of therapy.

The safety of cisplatin in pregnancy has not been established. Cisplatin can cross the placental barrier. In mice and rats, cisplatin is teratogenic, embryotoxic and carcinogenic. Cisplatin is leukemogenic in rats. Cisplatin may be toxic to the fetal urogenital tract. Therefore cisplatin is considered to be potentially harmful to the fetus when administered to a pregnant woman and its use in pregnant women is not recommended. Patients should be advised to avoid becoming pregnant.

¹ *Category D: Drugs which have caused, are suspected to caused or be expected to cause, an increased incidence of human foetal malformations or irreversible damage. These drugs may also have adverse pharmacological effects.*

Women of childbearing potential/Contraception in males and females

Women of childbearing potential should use effective contraception during treatment with cisplatin and for at least 7 months 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 4 months after the last dose.

Lactation

Cisplatin and its active metabolites have been identified in human milk of treated mothers. Advise pregnant women not to breastfeed during treatment with cisplatin and for 1 month following last dose of treatment or to discontinue treatment, taking into account the importance of the drug to the mother.

4.7 Effects on ability to drive and use machinery

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

4.8 Undesirable effects

Infections and infestations

Infection (infectious complications have led to death), sepsis.

Blood and lymphatic system disorders

Thrombotic microangiopathy (haemolytic uraemic syndrome), bone marrow failure, neutropenia, Coombs positive haemolytic anaemia.

Myelosuppression often occurs during cisplatin therapy. Mild bone marrow toxicity may occur with both leucopenia and thrombocytopenia. These effects are usually reversible after ceasing treatment. Cisplatin may also induce anaemia: this is not clearly dose related and is occasionally caused by haemolysis. 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.

There have been rare reports of acute myelogenous leukemias and myelodysplastic syndromes arising in patients who have been treated with cisplatin, mostly when given in combination with other potentially leukemogenic agents.

Immune system disorders

Anaphylactic and anaphylactic-like reactions, consisting principally of flushing, facial oedema, wheezing, tachycardia and hypotension have been reported in patients previously exposed to cisplatin. The reactions usually occur within a few minutes of cisplatin administration and may be controlled by IV adrenaline, corticosteroids and/or antihistamines.

Metabolism and nutritional disorders

Cisplatin may cause dehydration in patients. Cisplatin may also cause serious electrolyte disturbances, mainly represented by hypomagnesemia, hypocalcemia, and hypokalemia, and associated with renal tubular dysfunction. Hypomagnesemia and/or hypocalcemia may become

symptomatic, with muscle irritability or cramps, clonus, tremor, carpopedal spasm, and/or tetany. Hypomagnesaemia and hypocalcaemia may develop during cisplatin therapy or following discontinuance of the drug. Other reported toxicities are hyperuricemia, hyponatremia, hypophosphataemia and syndrome of inappropriate antidiuretic hormone (SIADH). 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. Regular monitoring of serum electrolyte levels and replacement where necessary are advisable.

Nervous system disorders

Convulsion, leukoencephalopathy, reversible posterior leukoencephalopathy syndrome, hemorrhagic stroke, ischemic stroke, ageusia, cerebral arteritis, myelopathy.

Peripheral neuropathies occur infrequently with usual doses of the drug. They are generally sensory in nature (e.g. paraesthesia of the upper and lower extremities), but can also include motor difficulties, reduced or absent reflexes and leg weakness. Autonomic neuropathy, seizures, slurred speech, loss of taste and memory loss have also been reported. These neuropathies usually appear after prolonged therapy, but have also developed after a single drug dose. Areflexia and loss of proprioception and vibratory sensation may be seen, especially if cisplatin is given at higher doses or more frequently than recommended. In some patients they may be irreversible however, they have been partially or completely reversible in others following discontinuance of cisplatin therapy. Cerebrovascular accident has been reported in patients treated with cisplatin. Lhermitte's sign has been reported.

Eye disorders

Retinal toxicity manifests as blurred vision and altered colour perception. Optic neuritis, papilloedema and cortical blindness have been reported rarely following the administration of cisplatin. These events are usually reversible after drug withdrawal. Retinal pigmentation has also been reported.

Ear and labyrinth disorders

Unilateral or bilateral tinnitus and/or high frequency hearing loss (>4000Hz) has been observed in up to 31% of patients treated with cisplatin and is usually reversible. The damage to the hearing system appears to be dose related and cumulative, and it is reported more frequently in very young or very old patients. Auditory function should be monitored more closely during treatment.

Cardiac disorders

Cardiovascular abnormalities (coronary disease, congestive heart failure, postural hypotension, thrombotic microangiopathy, arrhythmia, bradycardia, tachycardia, myocardial infarction, cardiac arrest, cardiac disorder etc.)

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 uremic syndrome) or cerebral arteritis. Various mechanisms have been proposed for these vascular complications.

Respiratory, thoracic and mediastinal disorders

Pulmonary embolism.

Pulmonary toxicity has been reported in patients treated with cisplatin in combination with bleomycin or 5-fluorouracil.

Gastrointestinal disorders

Stomatitis, vomiting, nausea, anorexia, hiccups, diarrhoea.

Cisplatin induces severe nausea and vomiting in almost all patients. Severe nausea and vomiting usually begin within 1-4 hours after treatment and may persist for up to a week after treatment. These side effects are only partially relieved by standard antiemetics. The severity of these symptoms may be reduced by dividing the total dose per cycle into smaller doses given once daily for five days. Reported toxicity includes gingival platinum line.

Hepatobiliary disorders

Mild and transient elevations of serum AST and ALT levels may occur infrequently. Liver damage has also been infrequently reported.

Skin and subcutaneous tissue disorders

Mild alopecia. Rarely, urticarial or maculopapular skin rashes have also been observed.

Musculoskeletal and connective tissue disorders

Myalgia, muscle spasms.

Renal and urinary disorders

Acute renal toxicity, which was highly frequent in the past and represented the major dose-limiting toxicity of cisplatin, has been greatly reduced by the use of 6 to 8-hour infusions as well as by concomitant intravenous hydration and forced diuresis. Cumulative toxicity, however, remains a problem and may be severe. Renal impairment, which is associated with tubular damage, may be first noted during the second week after a dose and is manifested by an increase in serum creatinine, BUN, serum uric acid and/or a decrease in creatinine clearance. Renal insufficiency is generally mild to moderate and reversible at the usual doses of the drug (recovery occurring as a rule within 2-4 weeks); however, high or repeated cisplatin doses can increase the severity and duration of renal impairment and may produce irreversible renal insufficiency (sometimes fatal). Renal failure has been reported also following intraperitoneal instillation of the drug.

Reproductive system and breast disorders

Impairment of spermatogenesis and azoospermia have been reported (see Section 4.6).

General disorders and administration site conditions

Pyrexia, asthenia, malaise. Local effects such as pain, oedema, erythema, phlebitis, tissue cellulitis, fibrosis, and skin necrosis (following extravasation of the drug) may also occur. Extravasation may result from infusion of solutions greater than 0.5 mg/mL cisplatin.

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

Acute overdosage with cisplatin may result in an enhancement of its expected toxic effects (eg kidney failure, severe myelosuppression, intractable nausea and vomiting, severe neurosensorial toxicities, liver failure etc.). Death may also occur. No proven antidotes are known for cisplatin overdosage. Haemodialysis is only effective, even then partially, up to 3 hours after administration because of the rapid and extensive binding of platinum to plasma proteins. Signs and symptoms of overdosage should be managed with supportive measures. Patients should be monitored for 3 to 4 weeks in case of delayed toxicity. See Section 4.8 Adverse effects (undesirable effects) for possible complications.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Class

Antineoplastic agent.

Mechanism of action

Cisplatin is a platinum compound of which only the cis-isomer is active and has 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. Three hours after a bolus injection and two hours after the end of a three-hour infusion 90% of the plasma platinum is protein-bound.

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 and Excretion

The elimination of intact drug and various platinum-containing biotransformation products is via the urine.

Studies aiming at determining plasma elimination half-life of total platinum have shown a very large interindividual and interstudy variation. Most studies reported a half-life of total plasma platinum post cisplatin treatment of approximately 5 days or longer. The half-life of total platinum was observed at 1 to 240 hours in end-stage renal disease patients.

5.3 Preclinical safety data

In repeat dose toxicity models, renal damage, bone marrow depression, gastrointestinal disorders, ototoxicity, neurotoxicity, and immunosuppression have been observed.

Genotoxicity

Cisplatin is mutagenic in numerous *in vitro* and *in vivo* tests.

Non-clinical findings in mice showed that cisplatin caused direct damage to primordial follicle oocytes, leading to apoptosis, and ovarian depletion. Cisplatin causes testis damage and decreased sperm counts in mice, primarily through effects on differentiated spermatogonia. These findings suggest potential effects on male and female fertility.

Cisplatin is embryotoxic in mice and rats, at clinically relevant doses and in both species, deformities have been reported.

Studies in rodents have shown that exposure during pregnancy can cause tumors in adult offspring.

Carcinogenicity

In long term studies, it has been shown that cisplatin is carcinogenic in mice and rats.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol BP

Sodium chloride BP

Water for injection BP

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

24 months.

6.4 Special precautions for storage

Store between 15°C – 25°C. Do not refrigerate. Do not freeze. Protect from light. Single use only. Discard unused portion.

6.5 Nature and contents of container

<u>Strength</u>	<u>Pack Size</u>
10 mg/10 mL	1x 10 mL vial
50 mg/50 mL	1 x 50 mL vial
100 mg/100 mL	1 x 100 mL vial

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.

Handling Precautions

As with all antineoplastic agents, trained personnel should prepare Cisplatin Injection. This should be performed in a designated area (preferably a cytotoxic laminar flow cabinet). Care should be taken to prevent inhaling particles and exposing the skin to cisplatin. Protective gown, mask, gloves and appropriate eye protection should be worn while handling cisplatin. In the event of contact with the eyes, wash with water or saline; where solution accidentally contacts skin or mucosa, the affected area should be immediately washed thoroughly with soap and water and in both cases seek medical advice. Seek immediate medical attention if the drug is ingested or inhaled. It is recommended that pregnant personnel not handle cytotoxic agents such as cisplatin.

Luer-Lock fitting syringes and giving sets to avoid leakage are recommended. Large bore needles are recommended to minimise pressure and possible formation of aerosols. Aerosols may also be reduced by using a venting needle during preparation.

Items used to prepare cisplatin, or articles associated with body waste should be disposed of by placing in a double sealed polythene bag, and incinerating at 1100°C.

Spills and Disposal

If spills occur, restrict access to the affected area. Wear two pairs of gloves (latex rubber), a respirator mask, a protective gown and safety glasses. Limit the spread of the spill by covering with a suitable material such as absorbent towel or adsorbent granules. Spills may also be treated with 5% sodium hypochlorite. Collect up absorbent/adsorbent material and other debris from spill and place in a leak proof plastic container and label accordingly.

Cleanse the remaining spill area with copious amounts of water.

Cytotoxic waste should be regarded as hazardous or toxic and clearly labelled 'CYTOTOXIC WASTE FOR INCINERATION AT 1100°C'. Waste material should be incinerated at 1100°C for at least 1 second.

7. MEDICINE SCHEDULE

Prescription Medicine

8. SPONSOR

Pfizer New Zealand Limited
P O Box 3998
Auckland, New Zealand
Toll Free Number: 0800 736 363
www.pfizermedicalinformation.co.nz

9. DATE OF FIRST APPROVAL

27 August 1985

10. DATE OF REVISION OF THE TEXT

03 March 2023

™ = Trademark

Summary table of changes

Section changed	Summary of new information
4.6	Update to contraception duration for males and females. Removal of washout period information for patients with end-stage renal disease. Update to lactation advice.
5.2	Update to distribution pharmacokinetic properties. Update to elimination half-life.
5.3	Update to animal embryotoxicity information.

All	Minor editorial changes.
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