

Adjuvant abemaciclib + endocrine therapy

The usual abemaciclib starting dose is 150 mg twice daily; a lower dose or altered schedule may be prescribed. Abemaciclib is taken twice daily continuously for up to two years with endocrine therapy, unless recurrence or unacceptable toxicity requires an earlier change. A four-week dispensing block is not a rest cycle. Endocrine treatment normally continues beyond abemaciclib.

Discussion aid: review with the patient and complete the approved local consent process.

Purpose and plan

- ☐ Exact indication, treatment aim and uncertainty explained
- ☐ Expected duration and review / switch points discussed
- ☐ Alternatives and the option not to proceed discussed
- ☐ Patient priorities, capacity and support needs explored

Selected material risks

- ☐ Diarrhoea, dehydration and nausea
- ☐ Liver-test abnormalities
- ☐ Rare serious lung inflammation
- ☐ Vaginal dryness and sexual effects
- ☐ Clot and uterine risks with tamoxifen

Discuss the treatment aim, alternatives, benefit and uncertainty, important medicine-specific risks, reproductive precautions, symptom support and planned duration. Confirm the endocrine partner and any ovarian-suppression plan. The timeline does not authorise a restart or certify clinical review.

Practical safety

- ☐ Medicine, route, schedule and missed-dose instructions
- ☐ Menopause and ovarian-suppression requirements if relevant
- ☐ Pregnancy, contraception / fertility and breastfeeding
- ☐ Monitoring, symptom reporting and contact plan

- ☐ Low blood counts and infection
- ☐ Blood clots
- ☐ Hot flushes, joint or muscle symptoms
- ☐ Bone loss with AI / ovarian suppression

Individual benefit, alternatives and concerns

Agreed checks and next review

FBC, renal, liver and bone profile; ECG as clinically indicated. Confirm node-positive high-risk eligibility, definitive surgery and timing: within 16 months of resection and up to 12 weeks of endocrine treatment after the last non-endocrine treatment before starting. Assess VTE history, bowel function, all medicines, endocrine partner, ovarian suppression if using an AI before menopause, and bone/reproductive health. FBC, renal, liver and bone profile every two weeks for the first two months, monthly for the next two months, then as clinically indicated. More frequent liver monitoring for grade 2 or worse liver abnormalities. ECG is driven by clinical need; no routine ribociclib Day-14 ECG schedule. Early and ongoing diarrhoea review, hydration/intake, infection, clots, breathlessness and adherence; prompt action between appointments. Creatinine can rise through inhibited tubular secretion without a true fall in filtration; assess the clinical context and alternative renal measures if needed.

Clinician / date: _____ Patient discussion documented: _____

Consent is an ongoing conversation and may be reconsidered. This aid is not treatment authorisation.