Monitoring and Managing Common Adverse Events with Capivasertib: Practical Steps for US Oncology Teams

This infographic was funded by AstraZeneca and is intended for US Healthcare Professionals. **Please see full Prescribing Information, including Patient Information**, when making treatment decisions with capivasertib.

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Capivasertib (TRUQAP®) in combination with fulvestrant is indicated for the treatment of adult patients with HR-positive, HER2-negative locally advanced or metastatic breast cancer with one or more *PIK3CA/AKT1/PTEN* alteration as detected by an FDA-approved test following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy. Capivasertib can cause hyperglycemia, diarrhea, cutaneous adverse reactions, and fetal harm. For more details on safety and dosage modifications for adverse reactions, please see full Prescribing Information.

CAPIVASERTIB, A TARGETED AGENT FOR HR+/HER2– ADVANCED OR METASTATIC BC

Capivasertib is an oral AKT inhibitor approved with fulvestrant for HR+/HER2– advanced or metastatic BC with ≥1 *PIK3CA*, *AKT1*, or *PTEN* alteration following progression on endocrine therapy.[1]

In CAPItello-291*, capivasertib improved PFS (7.3 vs 3.1 months; HR: 0.50; p<0.001) in the biomarker-altered population, but also highlighted the need for proactive AE management.[2,3]

Diarrhea, rash, and hyperglycemia are the most common and clinically meaningful AEs and require structured, anticipatory management to maintain adherence and dose intensity.[4]

*Phase III RCT in women and men with HR+/HER2– advanced BC who had a relapse or disease progression during or after treatment with an aromatase inhibitor, with or without previous CDK4/6i therapy, randomized 1:1 to receive capivasertib + fulvestrant (n=355) or placebo + fulvestrant (n=353).[2,3]

PROPHYLAXIS AND MANAGEMENT STRATEGIES

Diarrhea

Incidence	Prophylaxis	AE management	Re-initiation
Occurs in 72% of patients (Grade ≥3 in 9%), with a median onset of 8 days.[2,3] Most cases are intermittent, short-term, and manageable with supportive care.[2-4]	**Step 1: Risk assessment**[4] • Baseline GI history • Concomitant meds (e.g., laxatives, metformin) • Renal function, hydration status **Step 2: Educate patients**[4] • Take capivasertib with food • Stool diary during **4 days on/3 days off** cycle • Dietary guidance: low fat, avoid irritants, maintain hydration • Have anti-diarrheal treatment available before starting capivasertib, and take anti-diarrheal treatment at the first sign of diarrhea	**Management Algorithm**[1,4] Grade 1: Maintain same dose*; Loperamide as needed Grade 2: Withhold until ≤Grade 1*; Loperamide (4 mg, then 2 mg q4h), consider diphenoxylate plus atropine if persistent Grade 3: Withhold until ≤Grade 1*; Loperamide (4 mg, then 2 mg q2h), consider octreotide if persistent Grade 4: Permanently discontinue*; Loperamide (4 mg, then 2 mg q2h), consider octreotide if persistent	✓Resume capivasertib when ≤Grade 1 ✓Recovery ≤28 days: Resume same dose or one dose level lower ✓Recovery >28 days: Resume at one dose level lower ✓Recurrent Grade 2 diarrhea: Resume at one dose level lower *In line with Prescribing Information recommendations.

Rash

Incidence	Prophylaxis	AE management	Re-initiation
Affects 38% of patients (Grade 3 in 12%), with a median onset of 12 days.[2,3] Rash is an on-target effect; 75% of events occur in the first cycle.[2-4]	**Step 1: Prophylaxis**[4] • Daily nonsedating H1 antihistamine on **Day 1** for the first 8 weeks • **Skin care**: emollients, fragrance-free cleansers, sun protection **Step 2: Educate patients**[4] • Educate patients to recognize capivasertib-associated rash and other symptoms that require enhanced supportive care • Ask patients to report any rash promptly	**Management Algorithm**[1,4] Grade 1 (<10%): Maintain same dose†; Escalate antihistamines; add topical corticosteroids Grade 2 (10–30%): Withhold until ≤Grade 1†; Add H2 receptor antagonists; consider oral steroids (prednisone 0.5 mg/kg)‡ Grade 3 (>30% or severe): Withhold until ≤Grade 1 or discontinue†; Intensify steroids (prednisone 1 mg/kg);‡ consider dermatology consult Grade 4: Permanently discontinue†; Intensify steroids (prednisone 1 mg/kg);‡ consider dermatology consult	✓Resume when rash improves to ≤Grade 1 ✓Recovery ≤28 days: Resume same dose ✓Recovery >28 days or persistent/recurrent Grade 2: Resume at one dose level lower ✓Recurrent Grade 3 rash: Permanently discontinue †In line with Prescribing Information recommendations. ‡Use with caution due to the potential for hyperglycemia, which may necessitate increasing frequency of glucose monitoring 1–2 days after initiation of steroids, and close follow-up thereafter.

Hyperglycemia

Incidence	Prophylaxis	AE management	Re-initiation
Occurs in 16.3% (Grade ≥3 in approximately 2.3%), with a median onset of 15 days.[2,3] Severe cases like DKA are rare (0.3%).[2-4]	**Step 1: Risk assessment**[4] • BMI ≥30 • Prediabetes or diabetes • Steroid use • Baseline fasting glucose and HbA1c **Step 2: Monitor and treat**[4] • Monitor fasting glucose on Days 3–4 of dosing weeks during early cycles, then monthly§ • More frequent checks for high-risk patients§	**Management Algorithm**[1,4] <160 mg/dL: Maintain same dose; Start or escalate metformin 161–250 mg/dL: Withhold until FG ≤160 mg/dL; Escalate metformin; consider adding SGLT2i/TZD 251–500 mg/dL: Withhold until FG ≤160 mg/dL; Escalate metformin; consider adding SGLT2i/TZD; consider insulin for FG >400 mg/dL >500 mg/dL: Withhold; Electrolyte management; consider insulin; optimize FG with metformin and second-line agents	✓Recovery ≤28 days: Resume same dose ✓Recovery >28 days: Resume at one dose level lower ✓FG ≥500 mg/dL persisting >24 h or DKA: Permanently discontinue ✓Optimize antihyperglycemic therapy before re-challenge §FG monitoring is recommended per the Prescribing Information.

KEY TAKEAWAYS: MDT CARE CHECKLIST

Before starting treatment[4]
- ✓ Baseline glucose, HbA1c, BMI
- ✓ GI history, dermatologic history
- ✓ Medication review
- ✓ Patient education on early symptoms

During treatment[4]
- ✓ Weekly symptom check-ins during the first two cycles
- ✓ Glucose monitoring per algorithm
- ✓ Reinforce hydration, stool diary use, skin care, and early reporting

When to escalate[4]
- ✓ Persistent Grade ≥2 symptoms
- ✓ Any Grade ≥3 event
- ✓ Atypical GI symptoms or rapid clinical decline
- ✓ Suspected DKA or severe rash

References
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2. Turner NC et al. N Engl J Med. 2023;388(22):2058-70.
3. Rugo HS et al. ESMO Open. 2024;9(9):103697.
4. Iyengar NM et al. NPJ Breast Cancer. 2025;12(1):16.

Abbreviations: AE: adverse event; AKT: protein kinase B; BC: breast cancer; BSA: body surface area; CDK4/6i: CDK4/6 inhibitor; DKA: diabetic ketoacidosis; FG: fasting glucose; GI: gastrointestinal; HER2–: human epidermal growth factor receptor 2-negative; HR+: hormone receptor positive; HR: hazard ratio; MDT: multidisciplinary team; PFS: progression-free survival; PTEN: phosphatase and tensin homolog; q2h: every 2 hours; q4h: every 4 hours; SGLT2i: SGLT2 inhibitor; TZD: thiazolidinediones; vs: versus.