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Community Pharmacists in Oncology Supportive Care

Evidence-Based Supplementation and Clinical Referral Pathways

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The Community Pharmacy Encounter with the Oncology Patient

The moment that defines the clinical value of community pharmacy in cancer supportive care



Why this encounter matters

- ~70% of oncology patients obtain supplements from community pharmacy — at the moment of initiation
- One of the earliest and most accessible healthcare encounters where supplement decisions can be intercepted before potential harm occurs

What the patient brings

- Active antineoplastic prescription + supplement query or self-initiated OTC product
- Uncertainty, internet-sourced beliefs, and often — undisclosed prior supplement use

What the pharmacist provides

- Structured screening, interaction review, evidence-graded counselling
- Triage of red-flag symptoms and structured referral to oncology MDT when indicated
- FIP (2024): community pharmacist is the most accessible healthcare professional for this role

FIP. Statement of Policy — People-Centred Pharmaceutical Care. FIP, 2024 | Velicer CM & Ulrich CM. J Clin Oncol 2008;26(5):869–876.



The Community Pharmacist in Oncology

FIP Cancer Care Handbook (2022) · FIP Statement of Policy (2024) · ISOPP Position Statement (2021)

FIP Statement of Policy (2024): *"Pharmacists, as the most accessible healthcare professionals, are uniquely positioned to support patients with cancer through medicines optimisation, patient education, supplement counselling and seamless interprofessional referral."*

FIP Cancer Care Handbook (2022) — five core roles

1. **Medicines optimisation**
   Oral antineoplastic safety checks, adherence monitoring, dose-modification liaison, toxicity detection — TKIs, CDK4/6i, PARPi dispensed from community pharmacy
2. **Patient assessment & education**
   Structured medication reconciliation including all OTC, herbal and supplement use; evidence-based patient and caregiver counselling throughout disease trajectory
3. **Supportive care & symptom management**
   Antiemetic optimisation, CIPN recognition, evidence-graded supplement counselling, fatigue and pain assessment — within community pharmacy scope
4. **Multidisciplinary integration & referral**
   Formal communication pathways to oncology MDTs; shared EHR access; referral protocols for supplement interactions and red-flag symptom recognition
5. **Cancer prevention, screening & early detection**
   Smoking cessation, vaccination, lifestyle risk-factor assessment — community pharmacy as the most accessible first-contact entry point

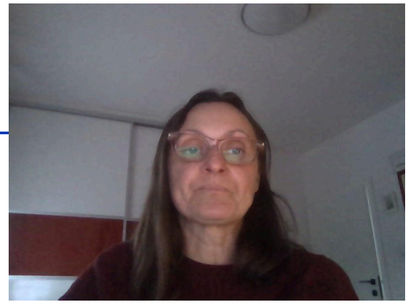
Why community pharmacy?

- Can contribute to a more complete medication history, including OTC medicines and supplements
- During home-based oral chemotherapy phases: community pharmacist is often the primary regular healthcare contact
- Role defined as risk recognition, interaction review, triage and structured referral — not independent oncological decision-making

ISOPP Position Statement (2021)

- "The Oncology Pharmacy Team is an integral component of the multidisciplinary healthcare team involved with ALL aspects of cancer patient care — from diagnosis to survivorship"
- Advocates best practices for anticancer medications dispensed outside cancer centres — including community pharmacies
- Coverage: treatment, supportive care, palliative care, survivorship — not limited to inpatient or infusion-day settings

FIP Cancer Care Handbook 2022 | FIP Statement of Policy 2024 | Holle LM et al. (ISOPP). JOPO 2021;27(5):1159–1200. DOI:10.1177/10781552211017199



FIP Cancer Care: A Handbook for Pharmacists (2022)

The primary international policy document defining pharmacist roles in oncology supportive care



Scope of the FIP Handbook

- Comprehensive guide covering pharmacist roles from diagnosis through survivorship — applicable to both hospital and community pharmacy settings
- Explicitly addresses community pharmacist contribution to oncology supportive care, medicines optimisation and patient education

Alignment with FIP Development Goals

- Linked to FIP DG15 (People-Centred Care), DG16 (Access to Medicines) and DG18 (Chronic Disease Management)
- Part of FIP's Practice Transformation Programme on Non-Communicable Diseases — cancer as a priority condition

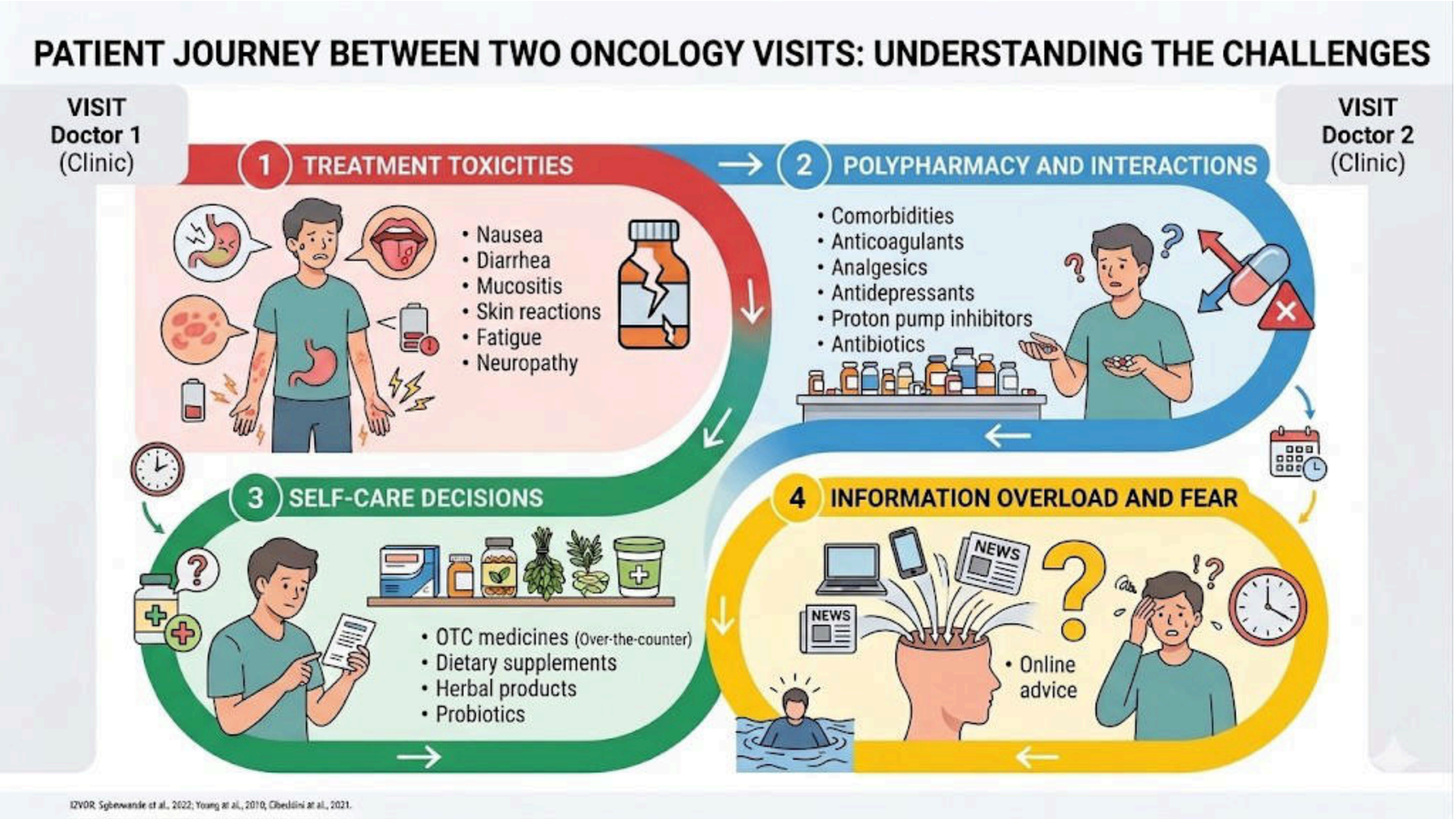
Key message

- Hospital and community pharmacy are not competing — they cover different phases of the patient journey
- Community pharmacy covers the outpatient home-treatment window; hospital pharmacy covers inpatient and infusion-day encounters
- FIP (2022) explicitly calls for structured communication between both settings to ensure continuity of care

FIP. Cancer Care: A Handbook for Pharmacists. The Hague: International Pharmaceutical Federation; 2022.

Patient Journey Between Two Oncology Visits

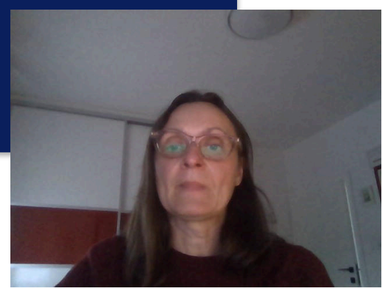
Where community pharmacy operates — the clinical gap it uniquely occupies

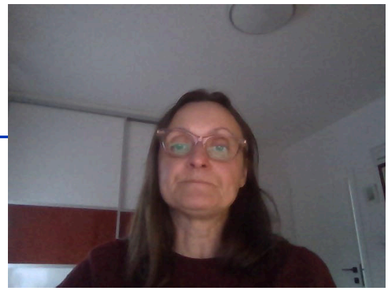


Community pharmacy clinical role in this journey

- Supplement screening at initiation (zone 3)
- Interaction triage with polypharmacy (zone 2)
- Red-flag symptom recognition and referral
- Adherence support during oral chemotherapy phases

Sgbewande et al. 2022 | Young et al. 2010 | Elbeddini et al. 2021 | FIP Cancer Care Handbook 2022





The Clinical Problem: Supplement Use in Your Oncology Patients

What happens between appointments — and who is watching?

40–80%
of cancer patients use supplements during active treatment
Range reflects heterogeneous populations, tumour types and CAM definitions

<50%
disclose supplement use to their oncology team
Reasons: fear of disapproval; “natural = safe” assumption

~70%
obtain supplements from community pharmacy
Only interceptable clinical encounter at initiation

#1 risk
St. John’s Wort and high-dose antioxidants
Most established pharmacokinetic and regulatory evidence base

The gap in your patient’s care

- Oncology patients commonly initiate supplement regimens between clinic visits — based on internet sources, family advice or pharmacy recommendations
- Hospital oncology pharmacists manage inpatient and infusion-day encounters, but the home-treatment window remains substantially underserved clinically
- Clinically relevant interactions — CYP3A4/P-gp induction, anticoagulant potentiation — may go undetected without systematic screening

✓ The community pharmacy opportunity

- Community pharmacists can collect the most complete OTC medication history: supplements, herbals, self-medication — information not captured in hospital records
- Repeated dispensing contacts during oral chemotherapy provide a screening window unavailable to the oncology clinic
- FIP (2024): community pharmacists uniquely positioned by access and frequency to support outpatient oncology supportive care

Velicer CM & Ulrich CM. J Clin Oncol 2008;26(5):869. DOI:10.1200/JCO.2007.13.5608 | FIP Statement of Policy 2024 | Antunac Golubić Z et al. Nutr Cancer 2023



Supplement Landscape: What Patients Use

Croatian cancer population data and patient motivation



62%
use daily dietary supplements

22%
each: vitamin D, B-complex, probiotics

56%
cite perceived health benefit

Croatian cancer population data (CROSBI 2023)

- 62% of oncology patients use daily dietary supplements — Antunac Golubić et al., Nutr Cancer 2023
- Most common: vitamin D (22%), B-complex (22%), probiotics (22%)
- Breast, prostate, colorectal and lung cancers most represented in supplement-use studies
- 56% of supplement users report perceived health benefit as primary motivation
- Majority obtain supplements from community pharmacies — pharmacist is first point of disclosure

Why patients self-supplement

- Improve quality of life and general well-being
- Reduce adverse effects of chemotherapy or radiotherapy
- Strengthen perceived immune function
- Physician, family or friend recommendation
- “Natural” products perceived as safer than medications
- Sense of active participation in own care and treatment

Antunac Golubić Z et al. Nutr Cancer 2023 | Velicer CM & Ulrich, Sys Rev 2020 | AESGP Consumer Survey EU 2024



Evidence-Based Supplementation — Vitamin D & Magnesium

Same supplement, different indication — the clinical context decides

	VITAMIN D (cholecalciferol)	MAGNESIUM (glycinate / citrate)
Evidence level	MODERATE — for deficiency correction (bone health, well-established) LOW / VERY LOW — antitumour benefit in unselected patients (not established)	HIGH — cisplatin-induced hypomagnesaemia (standard of care) LOW–MODERATE — CIPN prevention: ASCO 2020 does NOT recommend
Key evidence	VITAL (Manson JE, NEJM 2019): no significant cancer incidence reduction in general population. AMATERASU RCT — hypothesis-generating only.	Cisplatin hypomagnesaemia: standard clinical practice, well-supported. Oxaliplatin CIPN prevention (Mg/Ca infusions): ASCO 2020 — evidence insufficient to recommend.
Clinical role	Deficiency correction (25-OH-D <30 nmol/L): endorsed. Antitumour benefit in unselected patients: NOT guideline-endorsed — investigational only. Do not promote as oncological agent.	Replace documented hypomagnesaemia in cisplatin patients. Prevents neuromuscular complications of deficiency. NOT routinely for CIPN prevention or unspecified symptom management.
Dose	800–4,000 IU/day maintenance. 50,000 IU/week loading if 25-OH-D <30 nmol/L. NIH ODS: optimal for bone ≥50 nmol/L; >125 nmol/L may cause adverse effects.	Therapeutic: 300–400 mg elemental/day. Preferred: glycinate or citrate (superior bioavailability vs oxide).
Monitoring	Serum 25-OH-D at baseline & 3 months. Avoid >10,000 IU/day without supervision.	Serum Mg; urine Mg/creatinine ratio; renal function mandatory with cisplatin regimens.
Interaction	No significant interactions with standard chemo at therapeutic doses; caution with granulomatous disease.	May chelate fluoroquinolones, tetracyclines — separate dosing by 2 h; caution in renal impairment.
CP recommendation	● **GREEN for deficiency correction** ● **AMBER (caution) for antitumour claims — not supported**	● **GREEN for cisplatin hypoMg replacement** ● **RED — do not recommend for CIPN prevention (ASCO 2020)**

Manson JE et al. NEJM 2019. DOI:10.1056/NEJMoa1809944 | Urashima M et al. Nutrients 2021. DOI:10.3390/nu13061987 | NIH ODS Vitamin D 2024 | ASCO CIPN 2020. DOI:10.1200/JCO.20.01399

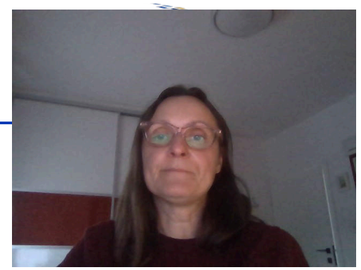


Evidence-Based Supplementation — Omega-3 Fatty Acids & L-Glutamine

GRADE-informed: indication-specific review — not universal oncology supplementation

	OMEGA-3 EPA/DHA	L-GLUTAMINE
Evidence level	MODERATE — for cancer cachexia (heterogeneous meta-analysis data). NOT high certainty for all oncology patients.	MODERATE — selected populations; single-centre RCT data. MASCC/ISOO: not universally recommended.
Key evidence	Lam CN et al. Nutrients 2024 (meta-analysis): modest lean mass preservation in cachectic patients; high heterogeneity (I^2>50%); no survival benefit demonstrated.	Tsujimoto T, Nutrients 2023: significant grade 3–4 mucositis reduction. Single centre — requires independent replication.
Clinical role	Anti-inflammatory; nutritional support for documented cachexia / anorexia. NOT antitumour. ESPEN 2021: conditional recommendation for nutritionally indicated patients — NOT for all patients.	Conditionally essential in catabolic stress; reduces RT-induced mucositis; maintains gut barrier integrity during chemoradiotherapy. Consider individually with oncologist agreement.
Dose	Cancer cachexia: EPA ≥2 g/day. General support: 1–2 g EPA+DHA/day. Pharmaceutical-grade fish oil preferred. NOT krill oil if anticoagulated.	0.3 g/kg/day in divided doses; typical: 10 g TID during active chemoradiotherapy. Powder or capsule formulations suitable for community dispensing.
Monitoring	Weight, lean mass, ECOG performance status; lipid profile; INR if anticoagulated; pause ≥5 days pre-surgery (high bleeding risk).	WHO mucositis grading; patient oral intake and weight. No specific lab monitoring required. Avoid in hepatic encephalopathy.
Interaction	Anticoagulant synergy (warfarin, apixaban) — INR monitoring recommended. Avoid high-dose (>3 g/day) during surgery or when anticoagulated.	Generally safe; theoretical concern with certain antiseizure medications; avoid in hepatic encephalopathy.
CP recommendation	• **CONDITIONAL (AMBER) — documented cachexia only** • Not for all oncology patients; heterogeneous evidence base	• **CONDITIONAL (AMBER) — H&N / thoracic chemoRT only** • Prior oncologist agreement recommended; not universally endorsed

Lam CN et al. Nutrients 2024. DOI:10.3390/nu16010104 | Tsujimoto T. Nutrients 2023. DOI:10.3390/nu15194117 | ESPEN 2021. DOI:10.1016/j.clnu.2021.02.005 | MASCC/ISOO Mucositis 2020



Evidence-Based Supplementation — Melatonin & Probiotics

Emerging evidence — study design limitations noted; not yet practice-standard for routine use

	MELATONIN	PROBIOTICS
Evidence level	MODERATE — emerging RCT data in cancer-related fatigue and sleep. Single RCT; exploratory endpoint. Hypothesis-generating — not yet practice-standard.	MODERATE — stronger evidence for chemo-induced diarrhoea with specific strains. CAUTION in severely immunocompromised patients.
Key evidence	Mukhopadhyay N et al. Oncologist 2024: DB-RCT, BCa radiotherapy — significant fatigue reduction vs placebo. Exploratory endpoint; single trial.	Benna-Doyle S et al. SAGE Cancer Support Care 2026: Lactobacillus rhamnosus GG and Saccharomyces boulardii significantly reduce chemo-induced diarrhoea.
Clinical role	Anti-inflammatory; sleep-wake cycle regulation; radiation-induced fatigue in early BCa; potential synergy with chemo (preclinical data only). Not antitumour.	Restore gut microbiome after chemo-induced dysbiosis; reduce antibiotic-associated diarrhoea. Potential immuno-oncology interaction via gut-immune axis — requires monitoring.
Dose	3–10 mg at bedtime; start 1–3 mg in elderly; licensed supplements preferred. Administer 30–60 min before sleep.	Lactobacillus rhamnosus GG: ≥10 billion CFU/day. Saccharomyces boulardii CNCM I-745 for antibiotic-associated diarrhoea. Strain-specific dosing essential.
Monitoring	Pittsburgh Sleep Quality Index (PSQI); fatigue NRS; watch for morning sedation and interaction with CNS medications.	Stool frequency (Bristol scale); CRP/WBC if immunosuppressed. Microbiome restoration 4–6 weeks post-chemo.
Interaction	Caution with anticoagulants, antidiabetics, immunosuppressants; CYP1A2 substrate — fluvoxamine increases levels significantly.	CONTRAINDICATED in severely immunocompromised (ANC <500). Use only pharmacist-verified strains; live cultures require refrigeration.
CP recommendation	• **MODERATE (AMBER) — selected cases, BCa radiotherapy** • Not yet routine recommendation; requires independent replication	• **MODERATE (AMBER) — strain-specific, chemo-induced diarrhoea** • Contraindicated in severely immunocompromised; verify ANC status

Mukhopadhyay N et al. Oncologist 2024;29:e206. | Benna-Doyle S et al. SAGE 2026

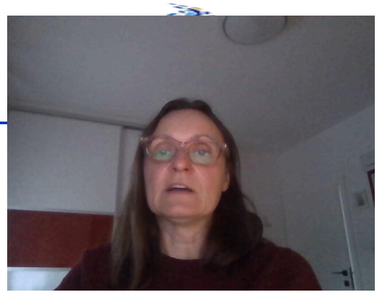


Supplement–Anticancer Drug Interaction Matrix

Risk level and clinical rationale — evidence quality specified; association distinguished from established causality

Supplement	Chemotherapy	Targeted therapy	Hormone therapy	Risk level
High-dose vitamin C	May protect tumour cells from ROS (biological plausibility — not proven clinically)	No major interaction documented	Generally safe	MODERATE
High-dose vitamin E	May antagonise platinum cytotoxicity (biological plausibility; association not proven causation)	Possible CYP3A4 induction at very high doses	Caution with aromatase inhibitors	MODERATE
St. John's Wort	No direct cytotoxic antagonism — but reduces irinotecan, docetaxel, taxane exposure via CYP3A4/P-gp	CYP3A4 induction → reduced TKI levels (imatinib: ~30% AUC reduction, DailyMed label)	Reduces tamoxifen AUC via CYP3A4; regulatory contraindication	CRITICAL — avoid
Omega-3 (>3 g/day)	Additive anticoagulation risk with platinum compounds (pharmacodynamic)	Generally compatible at therapeutic doses	Compatible	LOW–MOD (context)
Vitamin D (standard)	Compatible — no clinically relevant interaction at therapeutic doses	Compatible	Compatible — may support outcomes in deficiency	SAFE
Magnesium	Renal caution with cisplatin; replacement is standard supportive care	Compatible	Compatible	SAFE
Curcumin (high-dose suppl.)	Mixed evidence; anti-NF-κB activity; conflicting preclinical and clinical data	P-gp inhibition possible at high doses	Conflicting with tamoxifen — avoid high-dose supplemental form	LOW–MOD (oncologist review)
Melatonin	May improve chemo tolerability (single RCT, preclinical data; exploratory)	CYP1A2 substrate — check for significant interactions	Caution with hormone-sensitive cancer	LOW–MOD (single RCT)

DailyMed imatinib prescribing information | EMA HMPC Hypericum 2022 | NCCIH Herb-Drug Interactions 2024 | Natural Medicines Database 2024 | NIH ODS



High-Risk Agents Requiring Oncologist Notification

Evidence quality and causality status specified — pharmacokinetic evidence distinguished from observational association

Oncologist notification recommended before dispensing — evidence rationale specified per agent

High-dose antioxidants

Vitamins A, C, E; CoQ10; beta-carotene

EVIDENCE

SWOG S0221 (Ambrosone CB, JCO 2020): observational analysis within RCT cohort, n=1,134 breast cancer. Antioxidant use during chemo associated with HR 1.41 for recurrence — ASSOCIATION, not causation. Self-reported supplement use is a key limitation.

CAUSALITY / RATIONALE

Biological plausibility (ROS scavenging may protect tumour cells) provides independent rationale for caution during cytotoxic therapy — even in the absence of definitive causal proof.

RECOMMENDATION

Not recommended routinely during active cytotoxic therapy without oncological review. Low-dose multivitamin (≤100% RDA) generally considered acceptable. Reassess 4–6 weeks post-treatment.

St. John's Wort

Hypericum perforatum

EVIDENCE

Mechanism well-established: strong CYP3A4 + P-glycoprotein inducer. DailyMed imatinib label: concurrent use reduced imatinib AUC by ~30% in pharmacokinetic studies. Similar PK data for irinotecan, docetaxel, tamoxifen (NCCIH 2024).

CAUSALITY / RATIONALE

Causality status: PK mechanism established; clinical outcomes (treatment failure) limited to case series and observational data — causality plausible but not proven in controlled trials.

RECOMMENDATION

EMA HMPC: contraindicated with multiple antineoplastic agents. Recommend discontinuation; notify oncologist. PK rationale sufficient regardless of outcome data availability.

Curcumin — high-dose supplemental form

not dietary amounts

EVIDENCE

Phase I safety established at up to 8 g/day (Cheng et al.); anti-inflammatory activity (anti-NF-κB). At very high supplemental doses: potential P-gp inhibition and theoretical CYP interactions.

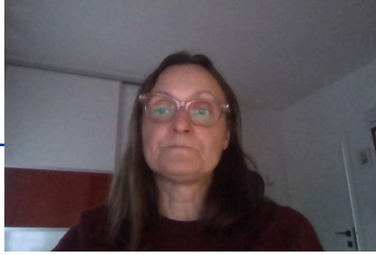
CAUSALITY / RATIONALE

Evidence for tamoxifen co-therapy: conflicting — some RCTs suggest benefit; some preclinical data raise concern. Insufficient high-quality evidence to support or oppose routine use.

RECOMMENDATION

Recommendation: dietary amounts (food use) are safe. High-dose supplemental form during active targeted or hormone therapy: requires oncologist review before dispensing.

Ambrosone CB et al. JCO 2020;38(8):804–814 | DailyMed imatinib label | EMA HMPC | NCCIH 2024



Proposed Structured Referral Pathway: Community Pharmacy → Oncology MDT

Closing the outpatient gap — a professionally operationalised algorithm, not a standalone clinical decision tool

1 Patient presents

Oncology patient at community pharmacy with supplement query, OTC request or symptom complaint during active home-based treatment

2 Structured enquiry

5-question structured tool:

1 Active antineoplastic agent?

2 Active chemo/RT ongoing?

3 Immune/ANC status expected?

4 Prior interactions documented?

5 Indication for supplement?

3 Risk classification

GREEN
evidence-based, acceptable safety → dispense with documented counselling

AMBER
context-dependent → dose/timing guidance or oncologist consultation

RED
significant interaction → decline + notify oncologist

4 Document & communicate

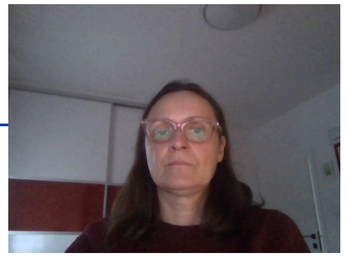
Structured EHR entry or referral letter: agent, dose, indication, clinical rationale, action taken → oncology team within agreed response time

5 Close the loop

Oncologist acknowledges and adjusts if indicated; documents in shared record. Pharmacist confirms at next dispensing contact.

Digital documentation (EHDS): The European Health Data Space was legally finalised as Regulation (EU) 2025/327 (OJ 5 March 2025; in force 26 March 2025), with phased application from 2027. This provides a structural framework for cross-border EHR interoperability; it does not eliminate local clinical and professional responsibilities. Shared supplement documentation is feasible within existing national EHR frameworks now.

Allen SM et al. J Oncol Pharm Pract 2024;30(1):263. DOI:10.1177/10781552231160654 | Malifarge L et al. JCO Oncol Pract 2024;20(3):386. DOI:10.1200/OP.23.00362 | Regulation (EU) 2025/327 (EHDS) | FIP GPP 2022



Key Messages for Oncology Practice

Three core pillars: ask — supplement selectively — formalise referral

I Ask about supplements — structured enquiry as standard practice

Patients are supplementing during active treatment — most are not telling us.

- Reporting rates <50% in European settings; structured pharmacist enquiry associated with increased disclosure in observational studies
- Structured supplement enquiry should be a standard component of every community pharmacist encounter with an oncology patient

II Supplement selectively, not routinely — indication drives the decision

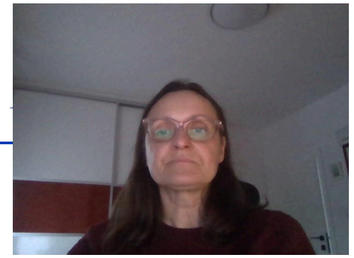
Targeted supplementation in documented indications: acceptable. Routine supplementation: not supported by evidence.

- St. John's Wort: PK mechanism established (CYP3A4/P-gp induction, ~30% AUC reduction imatinib). High-dose antioxidants: observational association (SWOG S0221) — not proven causation. Both warrant explicit MDT protocol.
- Vitamin D: correct documented deficiency (25-OH-D <30 nmol/L); antitumour benefit in unselected patients is NOT established (VITAL, NEJM 2019)
- Omega-3: may be considered in nutritionally indicated patients with documented cachexia (ESPEN 2021 conditional); NOT for all oncology patients
- Magnesium: replace documented cisplatin-induced hypomagnesaemia (standard of care); NOT recommended for CIPN prevention (ASCO 2020)

III Formalise referral — protocol

Community pharmacy occupies the outpatient monitoring window that oncology does not currently cover.

- Home-based oral therapy — where toxicity accumulates, adherence falters and supplements are initiated — is the most important undermonitored period. FIP (2022) identifies this explicitly as a priority gap.
- A one-page written protocol agreed between oncology unit and community pharmacy — referral criteria, communication channels, documentation standards — is the highest-impact, lowest-cost intervention available
- Evidence base for pharmacist-led oncology interventions: growing, but primarily observational and pilot data. Clinical rationale is strong. A call for both implementation and prospective research.



Three Things to Remember

1

Ask systematically about OTC medicines, herbals and dietary supplements.

2

Recommend supplements only when indication, evidence and safety are clear.

3

Refer early when red flags, high-risk interactions or uncertainty are present.

"The safest pharmacist's intervention may be preventing an unsafe recommendation."

Summary based on FIP Cancer Care Handbook 2022 | FIP Statement of Policy 2024 | ISOPP 2021 | ESPEN 2021 | ASCO CIPN 2020



Communication: Protecting Safety Without Losing Trust

How we say it determines whether the patient tells us the truth next time

✕ Avoid

- *"That is alternative therapy; do not use it."*
- *"It cannot do any harm."*
- *"Just ask your doctor."*
- *"There is no evidence, so it is useless."*

✔ Use instead

- *"Let us check whether it is safe with your therapy."*
- *"Natural products can still affect drug levels or bleeding risk."*
- *"I will explain what I am concerned about and when to contact your oncologist."*
- *"Please bring all products to the next oncology appointment."*

SUGGESTED SENTENCE

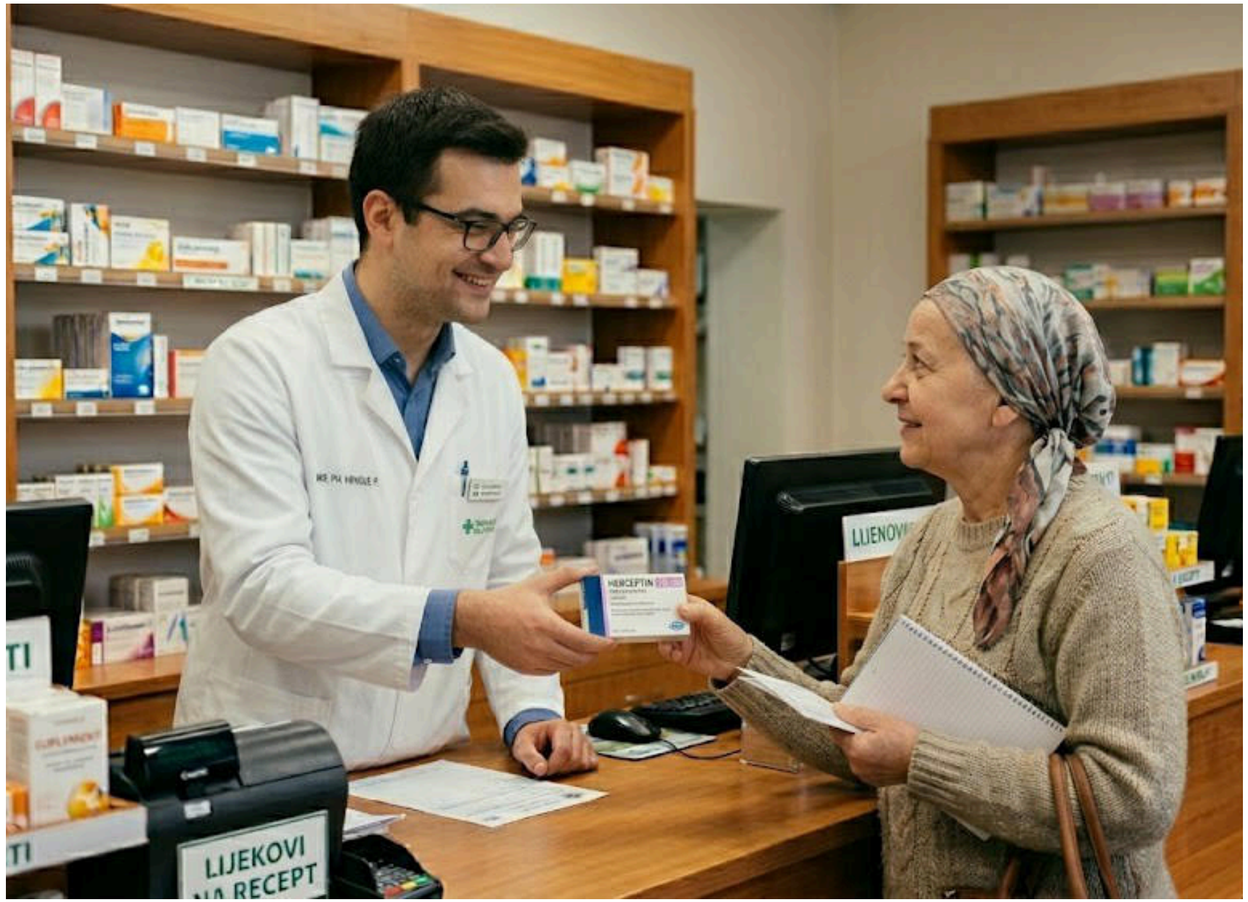
"I understand why you want to support your body; my role is to help you do that safely."

Sources: FIP, 2022; ESMO supportive and palliative care communication resources | FIP Statement of Policy 2024



Community Pharmacy: Where Oncology Supportive Care Continues After the Clinic

The outpatient monitoring window that community pharmacy uniquely occupies



What this picture represents

- Community pharmacist dispensing oral antineoplastic to an oncology outpatient
- Every dispensing encounter is an opportunity: supplement screen, toxicity recognition, adherence check, triage

The ask we make of oncologists

- Include community pharmacists in the MDT communication loop — not as decision-makers, but as the early-warning system for the home-treatment phase

FIP Cancer Care Handbook 2022 | FIP Statement of Policy 2024 | Regulation (EU) 2025/327 (EHDS) | Allen SM et al. J Oncol Pharm Pract 2024. DOI:10.1177/10781552231160654

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Thank you

Questions, comments and collaboration welcome

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