

FACTSHEET: NAUSEA AND VOMITING

The following guidance is for management nausea and vomiting in patients with life-limiting illnesses, depending on cause and stage of life.

Common causes of nausea and vomiting (N&V) in palliative care

- Biochemical – e.g. hypercalcaemia, uraemia, hyponatraemia, organ failure
- Iatrogenic – medication side effects including opioids, antibiotics
- Central – cerebral metastases, vestibular disorders, visual changes
- Gastrointestinal – reflux, oesophageal candidiasis, delayed gastric emptying, gastric outlet obstruction, constipation, bowel obstruction
- Chemotherapy induced
- Psychogenic or anticipatory – e.g. anxiety, anticipatory nausea
- Multifactorial – multiple reasons from above

History of N&V

- Duration and circumstances at onset e.g. medication changes
- Timing:
 - Immediately after oral intake – suggests oesophageal or oropharyngeal cause
 - Shortly following oral intake – suggests gastric cause e.g. delayed emptying/outlet obstruction
 - On movement – suggests central or obstructive cause
 - With vertigo – suggests central
 - Early morning – suggests central
 - Spontaneous (suggests obstructive) or constant (suggests biochemical)
- Do vomits occur without nausea? – suggests obstructive cause
- Associated features – e.g. constipation, symptoms of raised ICP, reflux, dysphagia, hallucinations, opioid side effects

Assessment

Examination findings (including hydration state)

Medication review

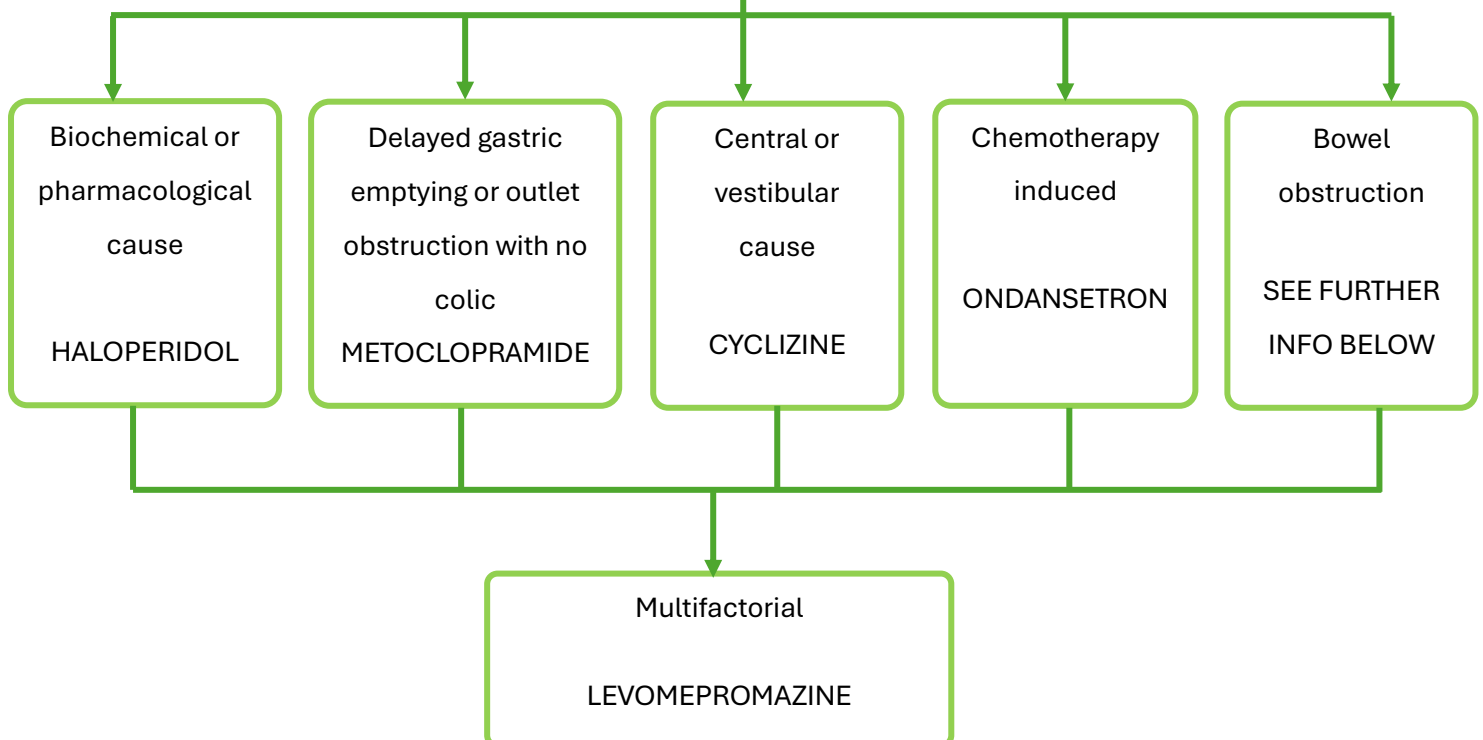
Blood tests (if appropriate) to include bone profile, U&E, LFT

Please see the BNF for up-to-date cautions and contraindications for the medications listed in this guideline

Initial management

- Check whether route of medications is appropriate – are medications being absorbed orally?
- Treat reversible causes e.g. reflux with PPI or famotidine, treat oral thrush with appropriate antifungal agent, address bowels, anxiety management strategies if this is contributing
- Treat raised intracranial pressure – with escalation of care or steroids depending on clinical scenario
- Consider how to administer other vital medications e.g. antiepileptics, analgesia, steroids
- Consider hydration status
- What is the escalation plan – if still having active/oncological management is hospital appropriate?

Choose antiemetic based on suspected cause



Bowel obstruction

Two main options:

- Active hospital management – surgery, Ryle’s tube, IV hydration
- Symptomatic management:
 - NO COLIC – encourage bowel to move with metoclopramide, gentle laxatives
 - COLIC – rest bowel with cyclizine, or combination haloperidol and hyoscine butylbromide

If above ineffective or if vomits are large volume, consider octreotide with palliative intent.

Doses and routes

Metoclopramide

Starting dose 10mg TDS PO or 30mg via syringe driver/24hrs

Maximum 60mg/24hrs unless advised otherwise by palliative care team

Do not co-prescribe with cyclizine

Haloperidol

Starting dose 0.5-1.5mg once daily PO or SC

Use lower doses in renal failure/elderly

Maximum 5mg/24hrs unless advised otherwise by palliative care team

Long half-life, OD dosing usually sufficient

Levomepromazine

Multiple receptor affinity so can treat multiple causes of nausea and vomiting

Highly sedative, reserve for use in palliative care

Starting dose 6.25-12.5mg OD PO or SC, typically in evening due to sedative effect

Long half-life so OD dosing usually sufficient

May cause site reactions when administered SC

Higher doses may be used for agitation and hallucination at the end of life

Cyclizine

Starting dose 50mg TDS PO or 75-150mg via syringe driver/24hrs

Maximum 150mg/24hrs

Do not co-prescribe with metoclopramide

Poor compatibility with other medications in syringe drivers, and may cause site reactions

Constipation and dry mouth common

Ondansetron

Generally reserved for chemotherapy induced vomiting

Highly constipating

Starting dose 4mg BD-TDS PO

Maximum 16mg/24hrs unless advised otherwise

Octreotide

Reduces volume and frequency of large volume vomits in intractable bowel obstruction when other measures have failed to resolve symptoms

Starting dose 500-1500mcg/24hrs via syringe driver

Listed as red drug for some indications but may be prescribed by GP if recommended by palliative care (as per BNF indications)

Limited compatibility with other medications via syringe driver

FOR FURTHER ADVICE

Please contact The Kirkwood 24 hour advice line on 01484 557910