Guidelines for the Management of Chemotherapy-induced Nausea and Vomiting

Policy Owner: Directorate of Cancer Services (Cancer and Tertiary Services)
Approved by: SACT Service Improvement Group
Version: 2
Issue date: January 2021
Review date: January 2023

Contents

Policy Statement
Guidelines for the Management of Chemotherapy-induced Nausea and Vomiting (CINV)

Scope of policy
The guidelines refer to the management of CINV in adults only.

Aims and Objectives
These guidelines aim to optimise drug selection for the prevention and control of CINV. The guidelines are issued on the understanding that they are the best available from the resources at our disposal at the time of preparation.

Clinical information

1. CINV prevention:
CINV is a common side-effect of many cancer treatments.

Efficient treatment of CINV results in increased quality of life for the patient, and better overall health of the patient and, due to better patient tolerance, more effective treatment cycles.

Choice of anti-emetics should be based on the emetic risk of the therapy (see appendix 5), prior experience with anti-emetics as well as individual patient factors.

Acute and delayed CINV are usually managed with standard prophylactic treatment. However, these may need to be adjusted for individual patients.

Risk factors that may put a patient at greater risk for CINV are included in the box below (see appendix 1 for CINV Risk Assessment Tool):

- Female sex
- Patient age (under 50 years old)
- History of no /light alcohol use
- History of previous CINV
- History of nausea and vomiting during pregnancy
- History of motion sickness

Risk factors that should be considered when prescribing dexamethasone as an anti-emetic

- History of diabetes
- Diagnosis of pancreatic cancer
- History of Whipples / PPPD surgery
- History of psychosis

Recommended Standard Anti-Emetics for the Management of CINV

For all patients metoclopramide 10mg tds for up to 5 days as required. Supplied by pharmacy on cycle **1 only**, nurse to assess at each cycle and provide further pre-packs if required. Patients under 25 years consider cyclizine 50mg tds instead of metoclopramide. Regimens lasting >5 days may also have cyclizine 50mg tds.

Emetic Risk	**Acute** *10 to 30 min prior to chemotherapy*	**Delayed** *After chemotherapy*	**Second line suggestions** *If 1st line fails or patient assessed as having higher risk of CINV*
Very High > 90% (**cisplatin based chemotherapy >50mg/m^2 only)**	Netupitant and palonosetron 300mg/0.5mg capsule oral 1 hour prior to chemotherapy Dexamethasone 8mg oral	Dexamethasone 8mg daily in the morning on days 2, 3 & 4	For an iv alternative consider fosaprepitant and palonosetron Do not add in ondansetron if first line fails
High > 90% includes anthracyclines and cyclophosphamide combination e.g. FEC. (Excludes CHOP & CVP) (Note, upper GI regimens may be managed as high due to the availability of liquid aprepitant)	Aprepitant 125mg oral 1 hour prior to chemotherapy Ondansetron 8mg mg oral Dexamethasone 8mg oral	Aprepitant 80mg oral days 2 & 3 Ondansetron 8mg oral 8 to 12 hours after pre-med Dexamethasone 8mg daily in the morning on days 2 & 3 **PLUS cycle 1 only** : Ondansetron 8mg oral 4 doses to be taken up to bd only if required.	Increase Ondansetron Fosaprepitant iv Palonosetron 500micrograms orally or 250micrograms iv Lorazepam – 1mg sublingual Cyclizine 50mg tds or 150mg over 24 hours via syringe driver Haloperidol 1.5 mg Levomepromazine 6.25mg up to bd or 6.25 to 25mg over 24 hours via syringe driver
Moderate 30-90% including cisplatin based chemotherapy ≤50mgh/m^2	Ondansetron 8mg mg oral Dexamethasone 8mg oral	Ondansetron 8mg oral 8 to 12 hours after pre-med Dexamethasone 8mg daily in the morning on days 2 & 3	Move up one level or add in 2nd line suggestions as per high risk
Low 10-30%	Dexamethasone 8mg oral	No additional routine prophylaxis required	Move up one level or add in 2nd line suggestions as per high risk
Minimal < 10%	No additional routine prophylaxis required	No additional routine prophylaxis required	Move up one level or add in 2nd line suggestions as per high risk

2. Management of antiemetic failure:

2.1 Breakthrough nausea and vomiting: occurring despite prophylactic treatment.

The general principle of breakthrough treatment is to add one agent from a different class to the current regimen, see appendix 3 for further considerations when selecting additional antiemetics.

To manage breakthrough CINV, first establish what the patient has already taken and consider adding in/changing to antiemetics from the table below

Treatment options for breakthrough nausea and vomiting (in no particular order)	**Comments**
Metoclopramide 10 mg PO tds up to 5 days	Add to current antiemetics
Cyclizine 50 mg PO tds or ondansetron 8 mg PO up to bd	Change metoclopramide to cyclizine if nausea only, otherwise consider adding in ondansetron (orodispersible versions are also available)) Do not add in ondansetron if netupitant and palonosetron 300mg/0.5mg capsule first line fails
Ondansetron 8 mg IV bd	Do not add in ondansetron if netupitant and palonosetron 300mg/0.5mg capsule first line fails
Levomepromazine 6.25 mg PO tds 6.25–12.5 mg SC (unlicensed route	Add to current antiemetics
Cyclizine 50 mg PO tds or 150 mg via syringe driver over 24 hours With or without: haloperidol 1.5 mg PO at night (can be increased to 5-10mg daily in divided doses – see BNF Prescribing in palliative care)	

Adapted from UKONS CINV policy

Prior to next cycle: ascertain that the best regimen is being administered for the emetic risk; consider giving either antiemetics as per 1 level higher in table 1 or anti emetics from second line suggestions in table 1.

Ensure sickness episodes, all extra anti-emetics given and their effectiveness are clearly documented on ChemoCare so that appropriate anti-emetics are given with all subsequent cycle(s).

2.2 Refractory nausea and vomiting: occurring during subsequent cycles when anti-emetics have failed in earlier cycles

Clinicians should re-evaluate emetic risk, disease status, concurrent illnesses, and medications.

2.3 Anticipatory nausea and vomiting: a learned or conditioned response that appears to be the result of previous experiences with that led to CINV, in which the brain associates the sights, sounds, and smells of the treatment area with vomiting.

Consider adding in lorazepam 1mg sublingually on night prior to and the morning of chemotherapy.

Also consider relaxation techniques and referral to Complementary Therapies.

3. Nausea and vomiting >7 days after chemotherapy:

Check for other causes of nausea and vomiting.

Some common reversible causes of nausea and vomiting include:

- Dyspepsia
- Uraemia
- Electrolyte imbalance - hypercalcaemia, hypomagnesaemia, hyponatraemia, hyperglycaemia
- Infection
- Constipation
- Gastrointestinal obstruction
- Cachexia syndrome
- Metastases
- Concomitant medication (e.g. antibiotics, antifungals, opioids)
- Vestibular dysfunction.

4. Other possible alternatives:

Although not routinely used the following drugs may be of use in patients who are not responding to standard antiemetics.

Olanzapine

Dose: 10mg stat then days 2 to 4.

Unlicensed indication delayed nausea and vomiting (in addition to ondansetron and dexamethasone) - especially useful for delayed nausea.

See unlicensed use page for more information on prescribing:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=988&pid=49207

Side effects: Sedation can be an issue in elderly/frail.

Interactions to note: Metoclopramide - may increase extrapyrimidal side effects so use alternative prn antiemetic e.g. domperidone

ESMO/MASCC https://www.annalsofoncology.org/article/S0923-7534(19)31641-2/pdf

"olanzapine seems to be useful in the prophylaxis of delayed nausea [superior to (fos)aprepitant] and equal to (fos)aprepitant in the prevention of acute symptoms. Olanzapine may be considered with a 5-HT3 RA plus dexamethasone, particularly when nausea is an issue, but using the 10 mg dose, patient sedation may be a concern"

ASCO https://ascopubs.org/doi/full/10.1200/JCO.20.01296
"Adults who experience nausea or vomiting despite optimal prophylaxis and who did not receive olanzapine prophylactically should be offered olanzapine in addition to continuing the standard antiemetic regimen"

Nabilone (synthetic Cannabinoid)

Dose: 1-2mg bd po

Indication: licensed for nausea and vomiting caused by cytotoxic chemotherapy, unresponsive to conventional antiemetics

Side effects: Drowsiness and dizziness occur frequently with standard doses.

Other Info: Schedule 2 Controlled Drug so paper prescriptions needed, not currently stocked in Singleton, contact pharmacy for more information.

ASCO https://ascopubs.org/doi/full/10.1200/JCO.20.01296

“ASCO recommend as option if already tried olanzapine for breakthrough n & v”

NICE Cannabis Based products https://www.nice.org.uk/guidance/ng144/chapter/Recommendations#intractable-nausea-and-vomiting

"NICE state that the evidence is limited, and of low quality using outdated antiemetics but that it could be an option as an add on where patients have nausea and vomiting despite optimised conventional antiemetics."

References

The following were used as the basis for these guidelines:

American Society of Clinical Oncology (ASCO)
Antiemetics: Clinical Practice Guideline Update 2011
http://jco.ascopubs.org/content/29/31/4189.full.pdf+html

Multinational Association of Supportive Care in Cancer (MASCC) and European Society for Medical Oncology (ESMO)
2016 Updated MASCC/ESMO consensus recommendations: Emetic risk classification and evaluation of emetogenicity of antineoplastic agents
Support Care Cancer published online 08 August 2016
http://annonc.oxfordjournals.org/content/27/suppl_5/v119.full

National Comprehensive Cancer Network (NCCN)
Antiemesis guidelines version 2.2014
http://www.nccn.org/professionals/physician_gls/recently_updated.asp

UKONS Acute Oncology Prevention and Management Guidelines: Chemotherapy-Induced Nausea and Vomiting
http:///www.ukons.org/contentimages/Treatment-protocol-A5-v7.pdf

Common Terminology Criteria for Adverse Events (CTCAE) v 4.03
http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE_4.03_2010-06-14_QuickReference_5x7.pdf

Appendix 1:

CINV Risk Assessment Tool

If the answer to any of the following questions is 'yes' it may increase the risk of CINV

Is the patient female?	Yes ☐ No ☐
Is the patient under 50 years of age?	Yes ☐ No ☐
Does the patient have a history of:	Yes ☐ No ☐
Low alcohol intake?	Yes ☐ No ☐
Motion sickness?	Yes ☐ No ☐
Nausea and vomiting in pregnancy?	Yes ☐ No ☐
Previous CINV with chemotherapy?	Yes ☐ No ☐

To assess for anticipatory nausea and vomiting consider the following questions in addition to those above

Does the patient have a history of sweating or generalised weakness after the previous cycle of chemotherapy?	Yes ☐ No ☐
Is the patient emotionally distressed?	Yes ☐ No ☐
Does the patient expect to experience side effects from the chemotherapy?	Yes ☐ No ☐

Adapted from CINV Risk Profile MSD

Appendix 2:
Grading Severity of Nausea and Vomiting

	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
Nausea	Nausea without alteration in eating habits	Oral intake decreased without significant weight loss, dehydration or malnutrition	Inadequate oral food or fluid intake requiring parenteral fluids / or TPN		
Vomiting	1 -2 episodes in 24 hours	3-5 episodes in 24 hours	6 or more episodes in 24 hours. IV fluids or TPN required	Life threatening consequences	Death

Adapted from the Common Terminology Criteria for Adverse Events (CTCAE) v4.03

Appendix 3:

Considerations when Selecting Additional Anti-Emetics

The following table is a summary of some of the different properties of some of the anti-emetics available. The recommended doses refer to use in CINV.

Please note limited prescribing information is given. For full details please consult the Manufacturer's Summary of Product Characteristics (SPC) (www.medicines.org.uk), the current edition of the BNF (www.bnf.org) or ask a pharmacist for advice.

Drug & forms available	**Recommended Doses**	**Class**	**Notes**	**Common side effects**
Netupitant and palonosetron 300mg/0.5mg capsule **(**Akynzeo™) Click here for SPC	Netupitant and palonosetron 300mg/0.5mg capsule oral 1 hour prior to chemotherapy	Netupitant is a NK-$_1$ antagonist Palonosetron is a 5-HT$_3$ receptor antagonist (potential risk of QT interval prolongation, caution in at risk patients or when used with other drugs that may increase QT interval, e.g. Domperidone)	Do not add in ondansetron as a rescue Netupitant is metabolized by CYP3A4 therefore care with interactions – see SPC	Constipation, likely to be worse than ondansetron alone. There have been reports of serotonin syndrome following concomitant use of 5-HT3 antagonists and other serotonergic medicinal products (including SSRIs and SNRIs)
Aprepitant 80mg & 125mg capsules Click here for SPC	125mg stat prior to treatment then 80mg od for 2 days	NK-$_1$ antagonist	EMEND is licensed for use with dexamethasone 12mg PRE MED & 8mg for days 2, 3 & 4 Metabolized by CYP3A4 therefore care with interactions – see SPC	Hiccups, GI disturbances (e.g. dyspepsia, diarrhoea or constipation, anorexia), asthenia, headache, dizziness

Dexamethasone 2mg tablets 2mg/5ml solution 4mg/ml injection	Depending on emetic risk – see table	Steroid	Patients on regimens which include high dose steroids e.g. CHOP or Paclitaxel, do not routinely require dexamethasone as part of their anti-emetic regimen. The dose specified by the treatment regimen overrides this policy. Caution prolonged use, e.g. multiple day regimens.	Increased susceptibility to infection Loss of diabetic control and precipitation of diabetes in susceptible patients. Insomnia Mental disturbances Dyspepsia Fluid retention Adrenal suppression
Cyclizine 50mg tablets 50mg/ml injection Click here for SPC	50mg tds	Antimuscarinic $^{++}$ H_1 antagonist^{++}	Anti-kinetic Blocks the peripheral effect of metoclopramide and domperidone	Drowsiness, blurred vision, dry mouth
Domperidone 10mg tablets	10mg tds oral Maximum 7 days	D_2 antagonist $^{++}$	Prokinetic Peripheral action blocked by cyclizine Click here for MHRA Drug Safety Update regarding prolonged QT interval.	Does not cross the blood brain barrier therefore no extrapyramidal effects Raised prolactin concentrations

Fosaprepitant 115mg injection Click here for SPC	115mg iv stat	NK-$_1$ antagonist	Prodrug of aprepitant	GI disturbances (e.g. dyspepsia, diarrhoea or constipation, anorexia), hiccups, asthenia, dizziness, headache
Haloperidol 500microgram & 1.5mg tablets 5mg/ml injection	1.5mg on or 1.5mg bd	D_2 antagonist $^{+++}$	Stronger affinity for D_2 than metoclopramide, therefore better in combination with cyclizine	Extrapyramidal effects, sedation, dry mouth, constipation
Levomepromazine 6mg & 25mg tablet 25mg/ml injection Click here for SPC	6mg on or 6mg bd	5HT$_2$ antagonist $^{+++}$ Antimuscarinic $^{+++}$ D_2 antagonist $^{++}$ H_1 antagonist^{+++}	Mixed action – effect on both vomiting centre and CTZ	Dystonic reactions, sedation, postural hypotension – dose dependant
Lorazepam 1mg tablets Click here for SPC	0.5to 1mg po stat dose	Benzodiazepine		Unlicensed indication Not for long term use
Metoclopramide 10mg tabs 5mg/5ml solution 5mg/ml injection	10mg tds Maximum 5 days	D_2 antagonist $^{++}$ 5HT$_4$ agonist $^{++}$ 5HT$_3$ antagonist^{+}	Prokinetic Peripheral action blocked by cyclizine Click here for MHRA Drug Safety Update	To be used with caution in patients suffering from epilepsy, since the frequency and severity of seizures may be increased. Dystonic reactions (high doses, young, female patients), extrapyramidal effects
Ondansetron 4mg & 8mg orodispersible films/tablets 2mg/ml injection 4mg/5ml syrup	CINV Patients age 75 years or older: maximum iv dose 8 mg. Adult patients younger than 75 years: maximum	5HT$_3$ antagonist $^{+++}$	Effective for acute phase but little role in delayed phase Ondansetron should be avoided in	Constipation headache

Click here for SPC	iv dose 16 mg.		patients with congenital long QT syndrome Click here for MHRA Drug Safety Update	
Palonosetron 500microgram capsule Click here for SPC 250micrograms/5ml injection Click here for SPC	500microgram po stat or 250microgram iv stat one hour prior to chemotherapy	$5HT_3$ antagonist^{+++}	Do not give with ondansetron Do not give a second dose within 7 days No dose adjustment required in hepatic or renal impairment Not recommended under 18years	Constipation, headache.

++ moderate affinity +++strong affinity

Appendix 4: Telephone advice for patients with CINV

Assess patient's symptoms according to the following criteria and give advice as indicated. (Remember to check if the patient is pyrexial)

	Grade 1	Grade 2	Grade 3	Grade 4
Vomiting	1 -2 episodes in 24 hours	3-5 episodes in 24 hours	6 or more episodes in 24 hours or need for parenteral rehydration	Dehydration and collapse or requiring parenteral nutrition
Nausea	Nausea without alteration in eating habits	Oral intake decreased without significant weight loss, dehydration or malnutrition	Inadequate oral food or fluid intake requiring parenteral fluids / or TPN	

Grade 1 and 2 toxicity:

Did the symptoms start within 2-4 days of receiving chemotherapy?

YES

Is the patient taking Capecitabine?

YES

Refer to capecitabine clinical review protocol

NO

Is the patient taking anti emetics as prescribed?

NO

If possible advise patient to take prescribed anti emetics regularly. To phone back if symptoms do not settle within 2-4 hours

YES

Refer to the 'guidelines for management of nausea and vomiting' on COIN for recommended rescue medication.
If GP to prescribe or administer SHO or senior nurse must contact GP to advise.

NO

Unlikely to be chemo related, needs medical assessment of symptoms

Grade 3 and 4 toxicity:

Require urgent medical review.
If referral to GP or another hospital is required this should be done by the triage nurse /medic

Appendix 5: Assigning Anti-emetics to a regimen

Emetic Risk of Intravenous SACT Drugs

Percentage risk is based on proportion of patients likely to experience emesis in absence of anti-emetics

Minimal Risk < 10%	Low Risk 10-30%	Moderate Risk 30-90%	High Risk >90%
Atezolizumab	Aflibercept	Alemtuzumab	Anthracycline/ cyclophosphamide combination
Avelumab	Blinatumomab	Arsenic trioxide	Carmustine
Bevacizumab	Bortezomib	Azacitidine	Cisplatin
Bleomycin	Brentuximab	Bendamustine	Cyclophosphamide
Busulfan	Cabazitaxel	Carboplatin	>1500 mg/m2
Cemiplimab	Carfilzomib	Clofarabine	Dacarbazine
2-Chlorodeoxyadenosine	Catumaxumab	Cyclophosphamide	Mechlorethamine
Cladribine	Cetuximab	<1500 mg/m2	Streptozotocin
Daratumumab	Cytarabine	Cytarabine	
Durvalumab	<1000 mg/m2	>1 g/m2	
Fludarabine	Docetaxel	Daunorubicin	
Ipilimumab (reduced)	Doxorubicin	Doxorubicin	
Nivolumab	liposomal	Epirubicin	
Obinutuzumab	Erbulin	Idarubicin	
Ofatumumab	Etoposide	Ifosfamide	
Pembrolizumab	5-Fluorouracil	Irinotecan	
Pixantrone	Gemcitabine	Oxaliplatin	
Polatuzumab Vedotin	Gemtuzumab	Thiotepa	
Ramucirumab	Ozogamicin	Trabectedin	
Rituximab	Inotuzumab		
Trastuzumab	Ozogamicin		
Vinblastine	Ixabepilone		
Vincristine	Kadcyla		
Vinorelbine	Methotrexate		
	Mitomycin		
	Mitoxantrone		
	Nab-paclitaxel		
	Paclitaxel		
	Panitumumab		
	Pegylated liposomal doxorubicin		
	Pemetrexed		
	Pertuzumab		
	Temsirolimus		
	Topotecan		

Adapted from MASCC and ESMO guidelines 2016, NCCN guidelines v2.2014

Emetic Risk of Oral SACT Drugs

Percentage risk is based on proportion of patients likely to experience emesis in absence of anti-emetics

Minimal or Low Risk < 30%		Moderate or High Risk >30%
Acalabrutinib	Lenvatinib	Abemaciclib
Afatinib	Lorlatinib	Bosutinib
Alectinib	Methotrexate	Ceritinib
Alpelisib	Neratinib	Crizotinib
Axatinib	Nilotinib	Cyclophosphamide
Brigatinib	Olaparib	Hexamethylmelamine
Capecitabine	Osimertinib	Imatinib
Chlorambucil	Palbociclib	Lenvatinib
Cobimetinib	Pabinostat	Lomustine
Dabrafenib	Pazopanib	Midostaurin
Dacomitinib	L-Phenylalanine mustard	Niraparib
Dasatinib	Pomalidomide	Procarbazine
Encorafenib	Ponatinib	Ribociclib
Entrectinib	Regorafenib	Rucaparib
Erlotinib	Ruxolitinib	Selinexor
Etoposide	Sorafenib	Temozolomide
Everolimus	Sunitinib	Vinorelbine
Fludarabine	Tegafur Uracil	
Gefitinib	Thalidomide	
Gilteritinib	6-Thioguanine	
Hydroxyurea	Topotecan	
Ibrutinib	Trametinib	
Idelalisib	Vandetanib	
Ixazomib	Vemurafenib	
Lapatinib	Venetoclax	
Larotrectinib	Vismodegib	
Lenalidomide	Vorinostat	

Adapted from MASCC and ESMO guidelines 2016, NCCN guidelines v2.2014

Combination Regimens
Antiemetic treatment for patients who receive combination chemotherapy should be determined according to the agent with the greatest degree of emetic risk (ASCO 2011)

Anthracyclines-cyclophosphamide combinations are reclassified as highly emetogenic (ASCO 2011).

Multi-day Regimens
It is suggested that antiemetics appropriate for the emetogenic risk class of the chemotherapy be administered for each day of the chemotherapy and for 2 days after, if appropriate (ASCO 2011)

Chemoradiotherapy Regimens
For patients who receive combination chemoradiotherapy, antiemetic therapy is dictated by the emetogenicity of chemotherapy, unless the emetic risk of radiation therapy is higher (ASCO 2011)

Appendix 6: Evidence based information

Emetic Risk	Acute	Delayed
Very High > 90% (cisplatin based chemotherapy >50mg/m^2 only)	Netupitant and palonosetron 300mg/0.5mg capsule oral 1 hour prior to chemotherapy MASCC and ESMO Dexamethasone 8mg oral or iv	Dexamethasone 8mg daily in the morning on days 2, 3 & 4
High > 90% including anthracyclines – cyclophosphamide combinations ASCO/MASCC	Aprepitant 125mg oral ASCO/MASCC Ondansetron 8mg mg oral or iv ASCO Dexamethasone 12mg oral or iv (if aprepitant omitted dexamethasone 20mg) ASCO/MASCC	Aprepitant 80mg oral days 2 & 3 ASCO/MASCC Ondansetron 8mg oral 8 to 12 hours after pre-med ASCO Dexamethasone 8mg daily in the morning on days 2 & 3 (if aprepitant omitted dexamethasone 16mg daily on days 2, 3 & 4) ASCO or Dexamethasone 8mg daily in the morning on days 2, 3 & 4 MASCC
Moderate 30-90%	Palonosetron oral or iv ASCO/MASCC Dexamethasone 8mg oral or iv ASCO/MASCC	Dexamethasone 8mg daily on days 2 & 3 ASCO MASCC (dex rec for days 2+3 but no dose in ref)
Moderate 30-90% If palonosetron is not routinely available ASCO/MASCC	Ondansetron 8mg mg oral or iv ASCO Dexamethasone 8mg oral or iv ASCO/MASCC	Ondansetron 8mg oral 8 to 12 hours after pre-med ASCO Dexamethasone 8mg daily on days 2 & 3 ASCO MASCC (dex rec for days 2+3 but no dose in ref)
Low 10-30%	Dexamethasone 8mg oral or iv ASCO Dex, ond or dom/met MASCC	No routine prophylaxis required ASCO/MASCC VCC: domperidone 10mg tds 7 days prn
Minimal < 10%	No routine prophylaxis required ASCO	No routine prophylaxis required ASCO

Key changes

Information on the possible use of Olanzapine or Nabilone (synthetic cannabinoid).

Upper GI regimens containing cisplatin to be managed as per high not very high due to the availability of a liquid aprepitant product.

COIN clinical online information network

Swansea Bay University Health Board

Authorisation Form for Publication onto COIN

PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED – IF NOT APPLICABLE PLEASE PUT N/A

COIN ID.	2794
Title.	Guidelines for the Management of Chemotherapy-induced Nausea and Vomiting
Name and Signature of Author/Chair of Group or Committee.	[redacted]
Name and Signature of Lead Pharmacist.	[redacted]
Please specify whether the document is New, Revised or a Review of a previous version.	Reviewed
Please specify the section on COIN where you wish the document to be published.	Specialties, Oncology, Hypersensitivity and Supportive Care.
Please sign to confirm that the document has been authorised by an approved governance process in a specialty or delivery unit.	SACT Improvement Group
Has NICE guidance been considered/referenced when producing this guidance? If yes, please state the title or reference number.	Yes
Is the document relevant to the GP Portal?	No
Equality Statement (Mandatory for Policies). (1)	N/A
Please specify keywords to assist with searching. (2)	Antiemetics, Chemotherapy, SACT, Sickness, Nausea, Vomiting, CINV.
Published.	May 2018
Last Review.	September 2025
Next Review/Expiry Date.	September 2026

(1) All policies need to comply with the Policy for the production, consultation, approval, publication and dissemination of strategies, policies, protocols, procedures and guidelines

(2) Relevant keywords will assist COIN users with searching for documents.