Lancashire and South Cumbria Integrated Care Board

Network Antiemetic Protocol For Patients Receiving Chemotherapy

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AMENDMENT HISTORY
(Complete for existing documents that need amendment within their 3 year life span)

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
	June 2025	4	Recategorised pemetrexed as minimal	

Category A: regimens with high risk (>90%) of emesis
Premedication:
Ondansetron 8mg IV bolus (given by IV infusion if age ≥ 65)
Dexamethasone 8mg IV
Olanzapine 5mg PO
Aprepitant 125mg PO

TTO:
Dexamethasone 8mg OD PO Day 2-4 (start the morning after chemotherapy)
Olanzapine 5mg OD PO Day 2-4 (taken in the evening)
Aprepitant 80mg OD PO Day 2 & 3
Metoclopramide 10mg TDS PO prn (28 tablets)

For diabetic patients consider reducing or omitting dexamethasone after the first cycle if no nausea or vomiting.

Category B: regimens with moderate risk (30-90%) of emesis
Premedication:
Ondansetron 8mg IV bolus (given by IV infusion if age ≥ 65)
Dexamethasone 8mg IV

TTO:
Dexamethasone 8mg OD PO Day 2-4 (start the morning after chemotherapy)
Metoclopramide 10mg TDS PO prn (28 tablets)

For diabetic patients, consider using aprepitant instead of dexamethasone.

Category C: regimens with low risk (10-30%) of emesis
Premedication:
Ondansetron 8mg IV (given by IV infusion if age ≥ 65)

TTO:
Metoclopramide 10mg TDS PO prn (28 tablets)

Category D: regimens with minimal risk (<10%) of emesis
No premedication routinely administered.

General notes:

- In patients aged 65 or older, ondansetron should be infused in 50-100ml 0.9% sodium chloride over at least 15 minutes).
- If nausea was not controlled, administer antiemetics from the next category up.
- If patients complain of symptoms suggestive of steroid withdrawal syndrome, give Dexamethasone as a reducing course (4mg BD for 2 days, 2mg BD for 2 days then 2mg OD for 2 days, then stop)
- Patients should be advised not to use metoclopramide continuously for more than 5 days.
- In patients with swallowing difficulties, aprepitant capsules may be opened and mixed with water for immediate administration. The granules should not be crushed.

Rescue Treatment:
If patients require admission for treatment of nausea and vomiting the following schedule is suggested:

Stop metoclopramide, start cyclizine 150mg/day SC via syringe driver
If symptoms not controlled after 24 hours, stop cyclizine and start levomepromazine 6.25 to 12.5mg over 24 hours SC via syringe driver (not to be given concurrently with olanzapine)

Interactions:
Aprepitant is a moderate inhibitor of CYP3A4 and will increase concentrations of drugs metabolised via CYP3A4
Ondansetron can prolong the QT interval. Exercise caution when used with other drugs that can prolong the QT interval.
Ondansetron may cause serotonin syndrome when used with serotonergic drugs (e.g., SSRIs and SNRIs).

Contraindications:
Metoclopramide is contraindicated in epilepsy and Parkinson's disease (use cyclizine instead)

Appendix 1:

Risk of Emesis of IV chemo agents

High (> 90%)
Cisplatin
Mechlorethamine
Streptozotocin
Cyclophosphamide ≥1500 mg/m2
Carmustine
Dacarbazine
Dactinomycin
NB: any combination of an anthracycline and cyclophosphamide is treated as high risk

Moderate (30 to 90%)
Oxaliplatin
Cytarabine ≥ 1g/m2
Carboplatin
Ifosfamide
Cyclophosphamide < 1500 mg/m2
Doxorubicin
Daunorubicin
Epirubicin
Idarubicin
Irinotecan

Low (10% to 30%)
Paclitaxel
Docetaxel
Mitoxantrone
Topotecan
Etoposide
Methotrexate
Mitomycin
Gemcitabine
Cytarabine < 1,000 mg/m2
Fluorouracil
Bortezomib
Cetuximab
Trastuzumab

Minimal (< 10%)
Bevacizumab
Bleomycin
Busulfan
2-Chlorodeoxyadenosine
Fludarabine
Pemetrexed
Rituximab
Vinblastine
Vincristine
Vinorelbine