Guidelines for the Use of Anti-Emetics with Chemotherapy

The purpose of this document is to provide guidance on the rational use of anti-emetics for prevention and treatment of chemotherapy-induced nausea and vomiting in adult patients. It is not intended to address nausea and vomiting in palliative care. These guidelines provide a framework to support clinical practice, but they cannot cover every clinical situation and good common clinical sense and clinical experience will be required when approaching the management of individual patients.

Definitions of nausea and vomiting with chemotherapy

Acute: nausea and vomiting (n&v) experienced during the first 24-hour period immediately after chemotherapy administration.

Delayed: nausea and vomiting occurring more than 24 hours after chemotherapy and which may continue for up to 6 or 7 days.

Anticipatory: nausea and vomiting which occurs in the days to hours before the beginning of a new cycle of chemotherapy. It is either a learned response following chemotherapy-induced n&v on a previous cycle or an anxiety response. It is most common after 3 to 4 cycles of chemotherapy with very badly controlled acute or delayed symptoms.

Breakthrough: Development of nausea or vomiting despite standard anti-emetic therapy, and which requires treatment with an additional pharmacological agent.

Grading of Nausea and Vomiting

<table>
<thead>
<tr>
<th>Grade</th>
<th>Nausea</th>
<th>Vomiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Able to eat, but loss of appetite</td>
<td>1 episode in 24 hours</td>
</tr>
<tr>
<td>2</td>
<td>Oral intake decreased without significant weight loss</td>
<td>2-5 episodes in 24 hours</td>
</tr>
<tr>
<td>3</td>
<td>Inadequate oral caloric or fluid intake; IV fluids, tube feeding, or TPN indicated</td>
<td>≥ 6 episodes in 24 hours; IV fluids, tube feeding, or TPN indicated</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>Life-threatening consequences; urgent intervention needed</td>
</tr>
</tbody>
</table>

Optimal emetic control in the acute phase is essential to prevent nausea and vomiting in the delayed phase.

Anti-emetics should be administered regularly, prophylactically and orally where possible.

At equivalent doses for the prevention of acute emesis, 5HT₃ antagonists have equal efficacy and safety. Ondansetron is the 5HT₃ antagonist of choice within this Alliance.

See relevant chemotherapy protocol for agreed classification of emetogenicity of regimen, then follow guidelines below.
# First Line Anti-emetic Selection

<table>
<thead>
<tr>
<th>First Line Anti-Emetics</th>
<th>Acute Phase (the First 24 Hours&lt;sup&gt;a&lt;/sup&gt;)</th>
<th>Delayed Phase (24-72 hours post chemo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mildly Emetic Chemotherapy</td>
<td>No anti-emetic required routinely or Domperidone&lt;sup&gt;b&lt;/sup&gt; 10mg po before chemotherapy</td>
<td>Domperidone&lt;sup&gt;b&lt;/sup&gt; 10mg tds prn</td>
</tr>
<tr>
<td>Moderately Emetic Chemotherapy</td>
<td>Before chemotherapy: Dexamethasone&lt;sup&gt;e&lt;/sup&gt; 8mg po (or a single dose of ondansetron 8mg po)</td>
<td>Domperidone&lt;sup&gt;b&lt;/sup&gt; 10mg tds regularly for 3 days, starting on the day of chemotherapy, then 10mg up to tds prn</td>
</tr>
<tr>
<td>Highly Emetic Chemotherapy</td>
<td>Start before chemotherapy: Ondansetron 8mg po&lt;sup&gt;g&lt;/sup&gt; plus Dexamethasone&lt;sup&gt;c, d&lt;/sup&gt; 8mg po</td>
<td>Dexamethasone&lt;sup&gt;c, d&lt;/sup&gt; 4mg bd x 2-3 days (depending on cycle length), starting the morning after chemotherapy plus Domperidone&lt;sup&gt;b&lt;/sup&gt; 10mg tds regularly for 3 days, starting on the day of chemotherapy, then 10mg up to tds prn</td>
</tr>
<tr>
<td>Chemotherapy containing cisplatin ≥ 70mg/m² or Dacarbazine</td>
<td>Start before chemotherapy: Aprepitant 125mg po 20-60 minutes pre chemo plus Ondansetron 8mg po&lt;sup&gt;g&lt;/sup&gt; plus Dexamethasone&lt;sup&gt;c, d&lt;/sup&gt; 12mg po plus Olanzapine 5mg po plus, in the evening, Ondansetron 8mg po</td>
<td>Aprepitant 80mg po Day 2 and Day 3 plus Dexamethasone&lt;sup&gt;c, d&lt;/sup&gt; 4mg bd x 3 days, starting the morning after chemotherapy plus Olanzapine 5mg po once daily for 3 days, plus, after olanzapine completed, Domperidone&lt;sup&gt;b&lt;/sup&gt; 10mg up to tds prn</td>
</tr>
<tr>
<td>Patient considered at high risk of nausea and/or significant anxiety before treatment</td>
<td>In addition to the above: Lorazepam 0.5 - 1mg orally or sublingually, the evening before and the morning of chemotherapy</td>
<td></td>
</tr>
</tbody>
</table>

**Key:**

<sup>a</sup> Patients receiving fractionated chemotherapy will require the acute phase anti-emetics to be administered on each day that chemotherapy is given.

<sup>b</sup> Substitute domperidone with oral metoclopramide 10mg tds (max daily dose 30mg) if the patient is receiving cytotoxic therapy, or other medicines, known to prolong the QT interval e.g. crizotinib, dabrafenib, dasatinib, eribulin, nilotinib, sorafenib, erythromycin. Metoclopramide or cyclizine should also be considered as an alternative, in patients with cardiac conduction conditions or underlying cardiac disease, or receiving potent CYP3A4 inhibitors (e.g. clarithromycin, itraconazole, posaconazole), or with severe hepatic impairment.
Omit anti-emetic dexamethasone when steroids are included as part of the chemotherapy regimen or pre-medication, or when the patient is already on maintenance steroids equivalent to at least the required anti-emetic dose.

For haematology patients where a steroid is not desirable, consider substituting with a prolonged course of ondansetron, usually until 2-3 days after highly emetic chemotherapy is completed.

For haematology patients where a steroid is not desirable, consider substituting with ondansetron 8mg bd on the day of moderately emetic chemotherapy.

For patients who cannot swallow capsules, the aprepitant capsule may be opened and the contents sprinkled on the tongue and swallowed. For patients who have a feeding tube, it is not recommended to use the feeding tube for administration of the contents of the capsule. Instead, a single dose of fosaprepitant 150mg IV over 20-30 minutes is recommended immediately before chemotherapy.

For patients who cannot tolerate the oral route, ondansetron 8mg IV doses should be given in 50-100ml sodium chloride 0.9% (or glucose 5%) over at least 15 minutes.

Other points regarding dexamethasone:

- Dexamethasone is the most useful agent in preventing delayed emesis.
- For patients on maintenance steroids at a dose equivalent to less than the daily anti-emetic dexamethasone dose, the maintenance steroid should be omitted on each day that anti-emetic dexamethasone is prescribed, and re-started on the morning after anti-emetic dexamethasone is completed.
- For diabetics, be aware that dexamethasone will cause blood glucose to be raised, and should be used with extra monitoring if possible:
  - insulin-dependent diabetics may be able to adjust their insulin dose according to blood glucose results;
  - it is preferable for non-insulin-dependent diabetics to check their blood glucose morning and evening whilst on dexamethasone and to contact their GP if any concerns;
  - for patients who do not self-monitor their glucose, they should be advised to contact their GP if they become symptomatic (increased thirst, increased need to urinate).

Contact the diabetic team if concerned about an individual patient.

- If dexamethasone is contra-indicated for any reason, ondansetron may be prescribed / duration extended, as an alternative, for moderately emetic chemotherapy.
- For patients who develop indigestion on dexamethasone, omeprazole or ranitidine may be prescribed to cover the duration of steroid.
- Consider reducing the course length and dose of oral dexamethasone for patients on a weekly regimen (e.g. weekly carboplatin regimens may usually be managed with dexamethasone 2mg bd x 2 days)

Patients should be advised to contact the oncology/haematology hot-line if they start vomiting at home. Delayed vomiting may cause acute renal failure due to dehydration, which may exacerbate the nephrotoxicity of chemotherapy.
a) Immediate management

Patient presents to A&E, or telephones the oncology treatment hotline, with nausea & vomiting
Ask if patient is on chemotherapy, and when chemotherapy was administered**

**Other factors to consider:
- Check calcium levels, as hypercalcaemia can cause n&v
- Raised intracranial pressure can cause n&v
- Rule out abdominal pathology

Investigations: Check FBC / U&Es / LFTs / Bone profile
(N.B. patient also at risk of neutropenic sepsis)
Observations: Temp / pulse / blood pressure / resp rate / O₂ saturations
Check for allergies
Contact AOS or haematology team, as appropriate

Mild nausea, or 1 episode of vomiting in 24 hours (GRADE 1)

Is the patient already taking domperidone or metoclopramide?

No
Start regular domperidone or metoclopramide 10mg tds po
Review after 24 hours
If poor response, consider adding in levomepromazine 6.25mg bd, or olanzapine 5mg od or dexamethasone* 4mg bd

Yes
Start regular cyclizine 50mg tds po
Review after 24 hours

Moderate to severe nausea and vomiting (≥ GRADE 2)
Unable to eat and drink

Chemotherapy given < 24 hours ago
Acute emesis
Give ondansetron 8mg IV over 15 minutes
Consider giving levomepromazine 6.25mg bd, or olanzapine 5mg od po, if not received prophylactically
Consider giving dexamethasone* 8mg IV (check how much steroid already given)

Chemotherapy given > 24 hours ago
Delayed emesis
Give stat Cyclizine IV 50mg
Consider giving levomepromazine 6.25mg bd, or olanzapine 5mg od po, if not received prophylactically
Consider giving dexamethasone* 8mg IV (check how much steroid already given)

Start IV hydration if necessary
Review after 1 hour

Poor response
For severe intractable nausea and vomiting, subcutaneous infusion via syringe driver of either Cyclizine 150mg/24hr, OR Levomepromazine 6.25 – 12.5mg/day (twice as potent as oral route and therefore likely to be more sedating)

Good response and tolerating oral fluids and drugs.
If decision to discharge patient, please ensure given appropriate oral antiemetics to take home.

Continue to monitor FBC & U&Es, and give IV fluid and electrolyte replacement as required.

* DO NOT add dexamethasone for AML patients
b) Subsequent chemotherapy cycles

For patients with any breakthrough nausea or vomiting on the previous chemotherapy cycle, clinicians should re-evaluate emetic risk, disease status, concurrent illnesses, and medications, and check that the best anti-emetic regimen is being administered for the emetic risk.

- Evaluate how poor the emetic control was, including the timing and duration of nausea and vomiting, i.e. was it during the acute phase, and / or the delayed phase, or was it anticipatory?
- Ensure that the correct anti-emetic schedule was prescribed in the first cycle.
- Check patient compliance with the anti-emetics.
- Consider concurrent disease and medication factors.

**Any anxiety, or signs of anticipatory nausea and vomiting?**

Add in Lorazepam 0.5 - 1mg orally or sublingually the evening before and the morning of chemotherapy.
N.B. Lorazepam causes drowsiness; counsel patients not to drive when taking this medication.

**Nausea & vomiting within 24 hours of chemotherapy?**

Increase the anti-emetics in the first 24 hours to those recommended for the next level of emetogenic potential.

If already received ondansetron with the previous cycle, increase the ondansetron post chemo to:
Ondansetron 8mg po + 8 hours and + 16 hours after pre-chemo ondansetron (i.e. 3 doses in the 1st 24 hours)

For cisplatin-based chemotherapy (cisplatin ≥ 70mg/m²), or EC chemotherapy for breast cancer: consider adding in olanzapine 5mg od, starting before chemotherapy, and continuing olanzapine at the same dose on Days 2 – 4.

Addition of **aprepitant** may be considered as follows:

- The three-drug* combination of aprepitant, ondansetron and dexamethasone is approved for use in patients who have failed to achieve adequate acute phase anti-emetic control on ondansetron and dexamethasone, and are receiving the following chemotherapy:
  - breast cancer patients receiving anthracycline plus cyclophosphamide chemotherapy (mainly EC) who have experienced Grade 2+ nausea & vomiting on ondansetron and dexamethasone
  - patients receiving carboplatin ≥ AUC 4 or cisplatin < 70mg/m², and who have experienced Grade 2+ nausea & vomiting on ondansetron and dexamethasone
  - patients receiving any other highly emetic chemotherapy regimen and whose nausea and vomiting has resulted in a hospital admission (i.e. Grade 3 / 4 nausea and vomiting)

**Dosing:** Aprepitant 125mg po 20 – 60 minutes before chemotherapy starts, followed by 80mg po once daily on the morning of Day 2 and Day 3

*plus consider increasing the Day 1 dexamethasone dose to 12mg po
*aprepitant is not to be used as a substitute for ondansetron or dexamethasone.
Check for aprepitant interactions but ignore any recommendations to reduce dexamethasone dose.

- Aprepitant is contra-indicated with pimozide.
- It should not be prescribed for patients also prescribed fentanyl patches.
- As it may reduce the anticoagulant effect of warfarin, monitor INR closely for 2 weeks after each 3 day course of aprepitant.
- Contraceptive failure of hormonal contraceptives during and for 28 days following administration of aprepitant is possible. Alternative or back-up methods of contraception should be used during treatment with aprepitant and for 2 months after last dose.

**Delayed nausea & vomiting?**

- Increase the anti-emetics to the next level of emetogenic potential.

- Ensure future anti-emetics cover the full period of delayed nausea. Dexamethasone duration may be increased to 5-7 days if prolonged nausea beyond 72 hours.

- The MHRA maximum recommended adult dose for both domperidone and metoclopramide is 10mg three times a day.

  What to do if 30mg per 24 hours of dopamine antagonist is not sufficient:

  - Consider the substitution of domperidone / metoclopramide with levomepromazine 6.25mg po bd, or olanzapine 5mg po od.

  - Consider the addition of cyclizine 50mg po tds

**Action of anti-emetics on main receptor sites**

Drugs acting on the same receptor (e.g. domperidone and metoclopramide) should not be used together:

<table>
<thead>
<tr>
<th>Drug</th>
<th>D2 antagonist</th>
<th>H1 antagonist</th>
<th>ACh antagonist</th>
<th>5HT2 antagonist</th>
<th>5HT3 antagonist</th>
<th>NK1 inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoclopramide</td>
<td>++</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Domperidone</td>
<td>++</td>
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<tr>
<td>Ondansetron</td>
<td></td>
<td></td>
<td>+++</td>
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</tr>
<tr>
<td>Aprepitant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+++</td>
</tr>
<tr>
<td>Fosaprepitant</td>
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<td></td>
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<td></td>
<td></td>
<td>+++</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td></td>
<td></td>
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<tr>
<td>Olanzapine</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cyclizine</td>
<td>++</td>
<td></td>
<td>++</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>+++</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prochlorperazine</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td></td>
<td>+/++</td>
</tr>
</tbody>
</table>

Reason for Update: removed option to increase domperidone or metoclopramide above 30mg per day; olanzapine 5mg dose as standard; added lower dose cisplatin as eligible for 2nd line aprepitant; added dacarbazine-containing regimens for 1st line aprepitant

Approved by Chair of Alliance Chemotherapy Group: Dr J De Vos

Date: 19.9.19

Prepared by: S Taylor

Checked by: A Burgin
## Notes on anti-emetics

*N.B. These are not comprehensive; please refer to BNF or SPC for more information*

<table>
<thead>
<tr>
<th>Anti-emetic</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aprepitant and Fosaprepitant</strong></td>
<td>These are NK₁ receptor antagonists, which are licensed for prevention of nausea associated with highly emetic chemotherapy. They are used in combination with a corticosteroid and a 5HT₃ antagonist. Studies show that aprepitant augments the antiemetic activity of ondansetron and dexamethasone and inhibits both the acute and delayed process of cisplatin-induced emesis. Common side effects include headache, hiccups and fatigue.</td>
</tr>
<tr>
<td><strong>Cyclizine</strong></td>
<td>Cyclizine may cause antimuscarinic side effects such as dryness of the mouth and drowsiness. The elderly are more susceptible to these effects. Avoid repeated IV usage.</td>
</tr>
<tr>
<td><strong>Dexamethasone</strong></td>
<td>Corticosteroids can cause sleep disturbances, hyperactivity and excessive appetite. They also produce glucose intolerance; use with care in patients with diabetes mellitus. Patients may experience perineal discomfort if the drug is given by IV bolus. This can be avoided by administration via IV infusion.</td>
</tr>
<tr>
<td><strong>Domperidone</strong></td>
<td>Domperidone should not be used when stimulation of the gastric motility could be harmful, e.g. gastrointestinal haemorrhage, mechanical obstruction or perforation. Risk of QT interval prolongation; see note b in the Key on page 2.</td>
</tr>
<tr>
<td><strong>Levomepromazine</strong></td>
<td>Avoid in patients with liver dysfunction. Inhibits cytochrome P450. Common side effects are somnolence, lack of energy, dry mouth, hypotension, photosensitivity and skin reactions.</td>
</tr>
<tr>
<td><strong>Lorazepam</strong></td>
<td>Can cause drowsiness and may affect performance of skilled tasks, e.g. driving.</td>
</tr>
<tr>
<td><strong>Metoclopramide</strong></td>
<td>Can rarely cause agitation or the development of extra-pyramidal symptoms, particularly in young female patients. These can occur up to 24 hours after a dose and may vary from facial grimacing and dystonic movements to odd feelings in the mouth, restlessness, somnolence and irritability. Bowel transit time may be reduced and some patients experience diarrhoea. Should not be used when stimulation of the gastric motility could be harmful, e.g. gastrointestinal haemorrhage, mechanical obstruction or perforation.</td>
</tr>
<tr>
<td><strong>Olanzapine</strong></td>
<td>Should be avoided in patients with Parkinson’s disease. Common side effects are somnolence, lack of energy, dry mouth, hypotension, photosensitivity and skin reactions.</td>
</tr>
<tr>
<td><strong>Ondansetron</strong></td>
<td>Patients may complain of constipation or headache. These need to be advised accordingly, e.g. senna or lactulose to relieve constipation, and paracetamol to relieve headache. If severe, consider an alternative anti-emetic. Should be avoided in patients in bowel obstruction. Repeat intravenous doses should be given no less than 4 hours apart.</td>
</tr>
<tr>
<td><strong>Prochlorperazine</strong></td>
<td>Prochlorperazine should be avoided in patients with liver or renal dysfunction, Parkinson’s disease, hypothyroidism, cardiac failure, phaeochromocytoma, myasthenia gravis and prostatic hypertrophy. May cause drowsiness. Available in a buccal formulation.</td>
</tr>
</tbody>
</table>

*Reason for Update: removed option to increase domperidone or metoclopramide above 30mg per day; olanzapine 5mg dose as standard; added lower dose cisplatin as eligible for 2nd line aprepitant; added dacarbazine-containing regimens for 1st line aprepitant*

*Approved by Chair of Alliance Chemotherapy Group: Dr J De Vos*

*Version: 6  Date: 19.9.19*

*Supersedes: Version 5  Prepared by: S Taylor  Checked by: A Burgin*
Emetic Potential of Individual Cytotoxic Agents

Recent publications, including the 2017 ASCO guidelines for anti-emetics, have categorised the emetic potential of individual cytotoxics into four emetic risk groups according to the incidence of emesis without anti-emetics, as specified in the table below.

These 4 groups do not correlate totally with our grouping of Mildly emetic, Moderately emetic, Highly emetic, or Highly emetic, including aprepitant - our guidelines fit in with this categorisation as follows:
- Emetic Risk < 10%: follow guidelines for Mildly Emetic Chemotherapy
- Emetic Risk 10% - 30%: follow guidelines for Mildly Emetic Chemotherapy or Moderately Emetic Chemotherapy as indicated
- Emetic Risk 30 – 90%: follow guidelines for Highly Emetic Chemotherapy
- Emetic Risk > 90%: follow guidelines for Highly Emetic Chemotherapy +/- including aprepitant*

Please note: the emetogenicity of each chemotherapy regimen is specified within each Alliance chemotherapy protocol, which should be the primary point of reference for determining each regimen’s emetic potential.

<table>
<thead>
<tr>
<th>Emetic Risk &lt; 10% (equivalent to “Mildly”)</th>
<th>Emetic Risk 10 - 30% (equivalent to “Mildly” or “Moderately” as indicated)</th>
<th>Emetic Risk 30 - 90% (equivalent to “Highly”)</th>
<th>Emetic Risk &gt; 90% (equivalent to “Highly”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asparaginase</td>
<td>Mildly</td>
<td>Amsacrine</td>
<td>Carboplatin</td>
</tr>
<tr>
<td>Bevacizumab</td>
<td>Capecitabine</td>
<td>Azacitidine</td>
<td>Cisplatin*</td>
</tr>
<tr>
<td>Bleomycin</td>
<td>Cetuximab</td>
<td>Bendamustine</td>
<td>Cyclophosphamide ≥ 1.5g/m²</td>
</tr>
<tr>
<td>Busulfan PO</td>
<td>Cyclophosphamide</td>
<td>Caelyx</td>
<td>Dacarbazine</td>
</tr>
<tr>
<td>Chlorambucil PO</td>
<td>Fluorouracil</td>
<td>Cytarabine ≤ 1g/m²</td>
<td>Dactinomycin</td>
</tr>
<tr>
<td>Cladribine</td>
<td>Gemcitabine</td>
<td>Cabozantinib</td>
<td>Carboplatin</td>
</tr>
<tr>
<td>Daratumumab</td>
<td>Methotrexate 50-250mg/m²</td>
<td>Eribulin</td>
<td>Ceritinib</td>
</tr>
<tr>
<td>Fludarabine</td>
<td>Mitomycin</td>
<td>Etoposide IV</td>
<td>Streptozocin</td>
</tr>
<tr>
<td>Hydroxyurea</td>
<td>Paclitaxel</td>
<td>Cytarabine &gt; 1g/m²</td>
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<tr>
<td>Melphalan PO</td>
<td>Pemetrexed</td>
<td>Daunorubicin</td>
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<tr>
<td>Mercaptopurine</td>
<td>Pentostatin</td>
<td>Doxorubicin</td>
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<td>Methotrexate PO</td>
<td>Pertuzumab</td>
<td>Epirubicin</td>
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<td>Nivolumab</td>
<td>Topotecan IV</td>
<td>Idarubicin IV</td>
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<td>Obinutuzumab</td>
<td>Trastuzumab</td>
<td>Ifosfamide</td>
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<tr>
<td>Pembrolizumab</td>
<td>Trastuzumab emtansine</td>
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<td>Pixantrone</td>
<td>Trifluridine-tipiracil</td>
<td>Lenvatinib</td>
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<tr>
<td>Rituximab</td>
<td>Lomustine</td>
<td></td>
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<tr>
<td>Ruxolitinib</td>
<td>Leuplapan IV</td>
<td></td>
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<tr>
<td>Vinblastine</td>
<td>Methotrexate &gt; 250mg/m²</td>
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<tr>
<td>Vincristine</td>
<td>Oxaliplatin</td>
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<tr>
<td>Vindecin</td>
<td>Temozolomide</td>
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<tr>
<td>Vinorelbine</td>
<td>Thiotepa</td>
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</tbody>
</table>

* aprepitant approved for first-line use in patients receiving cisplatin ≥ 70mg/m²

Reason for Update: removed option to increase domperidone or metoclopramide above 30mg per day; olanzapine 5mg dose as standard; added lower dose cisplatin as eligible for 2nd line aprepitant; added dacarbazine-containing regimens for 1st line aprepiant

Approved by Chair of Alliance Chemotherapy Group: Dr J De Vos

Prepared by: S Taylor
Date: 19.9.19
Checked by: A Burgin
Assessing the Emetogenicity of a Regimen

For new combination regimens which do not have a protocol, the following is recommended:

- Aprepitant + olanzapine should be included for any regimen containing cisplatin ≥ 70mg/m².
- A regimen containing any other agent that has emetic risk 30–90% or > 90%, treat as Highly Emetic Chemotherapy.
- A regimen containing two or more Moderately Emetic agents, treat as Highly Emetic Chemotherapy.
- A regimen containing one Moderately Emetic agent from the 10-30% risk group plus any number of Mildly Emetic agents (whether from < 10% or 10-30% risk group), treat as Moderately Emetic Chemotherapy.
- A regimen containing one or more Mildly Emetic agents (whether from < 10% or 10-30% risk group) should be treated as Mildly Emetic Chemotherapy.

References:
- Roila, F et al; Annals of Oncology 2016; 27 (suppl 5): 119 – 133
- Navari, RM et al; NEJM 2016; 375: 134 – 142 (olanzapine)
- Hashimoto, H et al; JCO 2016; 34 (No 15 suppl): 10111 (olanzapine 5mg vs 10mg)