PRIMARY CARE 10 TOP TIPS

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Vomiting in cancer

1 Causes are often multiple and may not be related directly to cancer – eg urinary tract or other infection, medication, the vomiting cycle of anxiety and distress.

2 It is often best to obtain control by parenteral route (syringe driver) and then convert to oral.

3 Opioids may initially cause transient nausea often related to gastric stasis. First line drug of choice is Domperidone or Metoclopramide (latter acts centrally as well as peripherally and may cause extrapyramidal effects).

4 Chemotherapy and radiotherapy induced nausea/vomiting are usually treated with Ondansetron (melts available) or Granisetron but these are constipating.

5 Cyclizine is recommended for nausea/vomiting related to raised intracranial pressure. It can be given subcutaneously but can cause skin irritation.

6 Haloperidol is used for chemical/metabolic causes of vomiting (eg uraemia and hypercalcaemia) and it may also ease distress and related vomiting cycle. If ineffective Levomepromazine may be used and both can be given orally. (25mg Levomepromazine tablets can be quartered for a starting dose of 6.25mg)

7 Intestinal obstruction not amenable to surgical intervention including stents may respond to use of Buscopan (to reduce secretions and colic) in combination with Cyclizine or Haloperidol for nausea and vomiting. If these are ineffective specialist team may recommend Octreotide +/- NG tube.

8 Always consider hypercalcaemia (and potential for reversal) when a cancer patient is nauseated/vomiting especially when there is confusion or constipation present.

9 Remember oro-pharyngeal candidiasis as a potential cause, treat with Nystatin for one week and if ineffective change to Fluconazole 50mg for one week and review.

10 Avoid using multiple anti-emetics unless there is a clear reason to do so but particularly avoid the following combinations if possible as they are antagonistic: Cyclizine or Buscopan with Metoclopramide or Domperidone.

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