**Key Points in the management of Nausea & Vomiting**

Key reference: <http://www.palliativecareguidelines.scot.nhs.uk/>

See also [www.palliativecareggc.org.uk](http://www.palliativecareggc.org.uk)/ for information / links

* Assessment is key
	+ History of disease and drug history
	+ Assessment of symptoms - is it nausea, retching, vomiting or combination?
	+ If vomiting, what was content and volume of vomit?
	+ How long have symptoms been present?
	+ Any associated symptoms? E.g. abdominal colic, constipation, neurological signs, headaches
	+ What is causing the patient to feel sick / vomit?
	+ Are there any investigations that would help? E.g. calcium levels, U/Es
	+ Is referral for other investigations required? E.g. do you need to contact oncologist re further imaging if patient has cancer?
	+ Is the patient likely to be dehydrated and need admission?
* Reverse any reversible causes e.g.
	+ Drugs e.g. Opioids, digoxin
	+ Correct biochemical upset e.g. Hypercalcaemia / bisphosphonate
	+ Treat constipation
	+ Steroids for RICP
* If an antiemetic is indicated:
	+ What mechanism is likely to be involved?
	+ What drug should work on that mechanism?
* In established vomiting avoid the oral route
* May need more than one antiemetic as often the symptoms of nausea and vomiting have more than one cause
* Haloperidol is likely to be the most effective for opioid sickness
* Levomepromazine has a long duration of action and can be given once daily
* Levomepromazine can be very sedating
* Levomepromazine is the broadest spectrum antiemetic
* Consider an antiemetic when starting an opioid in an opioid naive patient
* Suffering from nausea / vomiting is probably worse than suffering pain
* Remember that patients who are vomiting may not be absorbing their analgesia so add that to the syringe pump if need to set one up. The local hospice will provide you with compatibility data if not on palliative care guidelines.
* Avoid prescribing doses with decimal points!