**Mini-Chalk Talk: Nausea & Vomiting**

**METOCLOPRAMIDE** for gastric stasis. Starting dose 30mg/24hours via CSCI

Treat underlying causes- laxatives, treat oral thrush, consider ascitic drain.

Consider dexamethasone in bowel obstruction +/- hyoscine butylbromide, octreotide, NG tube

Learning points

1. Importance of taking a good history. Differentiate nausea/ vomiting/ retching. Review medical notes, drug chart and blood tests. Examine the patient for potential causes. Treat oral thrush, constipation, ascites, rationalise medications.
2. 1st step for drug management- cause specific. Consider haloperidol/ metoclopramide/ cyclizine. Think of route- SC/CSCI if vomiting.
3. 2nd line drug management- optimise the dose, revisit the cause. Consider switching to alternative antiemetic above. Consider switching to LEVOMEPROMAZINE.
4. 3rd line- Combine levomepromazine with 5HT3 antagonist

1st line**- HALOPERIDOL** 1mg stat dose or ON, or 1.5mg via CSCI reasonable starting doses. Consider lower doses in frailty, renal impairment.

**ONDANSETRON** used in chemotherapy induced nausea and vomiting

**CYCLIZINE** 100-150mg/24hours via CSCI 1st line for raised ICP/ cerebral metastases

**LORAZEPAM** for anticipatory nausea

Rarely seen in palliative care

**Cerebral**

Raised ICP

Anxiety

**Toxic**

Infection

Hypercalcaemia

Drugs- opioids, SSRIs

Chemotherapy

Infection
Renal failure

**Gastric causes**

Gastric stasis

Constipation

Bowel obstruction

Ascites

Hepatomegaly

Oral thrush

**Vestibular**

**Vomiting Centre**