Assess the likely cause for nausea to guide the anti-emetic most likely to relieve symptoms.
Review reversible causes (see boxes below)

Is the patient already established on an anti-emetic?

Yes

Patients who have previously been nauseated and established on an anti-emetic should have the anti-emetic reviewed.

If still appropriate, it should be converted to a subcutaneous route and reassessed after 24 hours. If still not controlling nausea and vomiting, change to an alternative and/or seek specialist advice.

No

Initial Treatment

Patients who become nauseated or start vomiting:
For gastritis, gastric stasis, functional bowel obstruction - Prokinetic anti-emetic:
Metoclopramide 10 mg TDS PO/SC or CSCI 30 mg/24 hours [above 30 mg with specialist advice] (*avoid in complete bowel obstruction—see guidance on bowel obstruction). There is an increased risk of neurological adverse effects at doses higher than 30 mg/24hours and if used for longer than 5 days.*

Domperidone 10mg BD - TDS PO
There is an increased risk of cardiac side effects at dose higher than 30mg/24hour and if used for longer than 7 days — see BNF for more information

For most chemical causes of vomiting (e.g. medication, hypercalcaemia, renal failure)
Centrally acting anti-emetic:
Haloperidol 500 micrograms - 1.5 mg at bedtime PO/SC or CSCI/24 hours (*monitor for undesirable effects when switching route at higher doses as some patients may require a dose reduction when switching from the oral route to SC)*
Metoclopramide also has a central action.

For vestibular symptoms - anti-emetic acting in vestibular system and vomiting centre:
Cyclizine 50 mg BD - TDS PO/SC or CSCI 75 mg - 150 mg / 24 hours

Sometimes it is necessary to convert to a broad spectrum anti-emetic
Broad- spectrum anti-emetic:
Levomepromazine 6.25 mg PO or 2.5 mg SC at bedtime, or 6.25 mg CSCI/24 hours — to maximum 25 mg/24h

Reversible causes of nausea, vomiting or regurgitation to be considered:

- Medication
- Hypercalcaemia
- Infection
- Constipation
- Reflux/Gastritis
- Uncontrolled pain
- Cough
- Anxiety
- Urinary retention causing renal impairment
- Oral/oesophageal candidiasis

Alternative anti-emetics may be more appropriate in certain circumstances

- **Bowel Obstruction:**

See guidance on bowel obstruction—page 12

- **Parkinson's Disease / Lewy Body Dementia:**

Avoid anti-emetics with a dopamine receptor antagonist effect e.g. haloperidol, levomepromazine and metoclopramide
Domperidone 10 mg BD - TDS PO first line — see caution above

- **Raised Intracranial Pressure (ICP):**

If taking oral dexamethasone for symptoms of raised ICP, this should continue to be given daily via the SC route.
Aim to maintain at the lowest maintenance dose that controls the symptoms of raised intracranial pressure.
Dexamethasone subcutaneously 3.3 mg - 6.6 mg OD - BD
All doses of dexamethasone should be given **before 2pm. *dexamethasone can raise blood sugar levels and capillary blood glucose levels should be checked as per local guidance. If there is a risk of seizures, e.g. in brain metastasis, use levomepromazine with caution as this can lower the seizure threshold**

- **Severe Heart Failure:**

Levomepromazine 6.25 mg PO or 2.5 mg SC at bedtime, or 6.25 mg – CSCI/24 hours.
Avoid anti-emetics with anti-muscarinic side effects, such as Cyclizine, that may cause tachy-arrhythmias.