NAUSEA AND VOMITING AFSOS GUIDANCE

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Disclosures

• Consultant / Advisory Boards / Speaker: Tesaro, Helsinn, Sanofi, Roche, MSD, TEVA, Norgine, Prostrakan, Leo pharma, Janssen, Hospira, Boehringer, AMGEN, Pierre Fabre Oncologie, Vifor Pharma

• Associations: ESMO, ASCO, MASCC, AFSOS, AESCO
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Introduction / context

- Chemotherapy Induced Nausea and Vomiting (CINV) are one of the side effects feared by patients who initiate cancer chemotherapy treatment.
- There is a gap between patients' and caregivers' perceptions that can be detrimental in optimizing antiemetic treatments.
- Poor control of NVCI has a major impact on quality of life, daily activities, professional activities, social and relational life.
- NVCI can cause serious metabolic complications: acute functional renal failure, chronic renal failure after sequella, ionic disorders, weight loss, denutrition.
Introduction : Warning

The members of the "Nausea and Vomiting Chemo-Induced (NVCI): Management" working group have chosen not to modify the emetogenic level of certain chemotherapy molecules or protocols as proposed in the updated international recommendations (ESMO-MASCC, ASCO, NCCN).

In particular, the group members chose to keep anthracycline-cyclophosphamide, carboplatin (AUC 4), epirubicin (> 90 mg/m2) and doxorubicin (> 60 mg/m2) as moderately emetogenic.

The reasons for this choice are primarily educational: so that there is no exception to the rule "The most emetogenic molecule gives the overall level of chemotherapy protocol".

On the other hand, the main motivation of the international recommendations for the modification of the emesis level of molecules seems to be to allow the introduction of an anti-NK1 in the prophylaxis of these same molecules. However, since 2013, AFSOS standards propose an anti-NK1 for all moderately emetogenic protocols.

Finally, by keeping these molecules as moderately emetogenic, there is no need to prescribe corticosteroids for primary prophylaxis (thus allowing cortisonic savings).

The members of the "Nausea and Vomiting Chemo-Induced (NVCI): Management" working group
## CINV Clinical Presentation

<table>
<thead>
<tr>
<th>Name</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated</td>
<td>Before Chemotherapy Administration</td>
</tr>
<tr>
<td>Acute</td>
<td>During the 24 hours after Chemotherapy</td>
</tr>
<tr>
<td></td>
<td>Administration</td>
</tr>
<tr>
<td>Delayed</td>
<td>After 24 hours Following Chemotherapy</td>
</tr>
<tr>
<td></td>
<td>Administration</td>
</tr>
<tr>
<td>Refractory</td>
<td>CINV Despite Right Treatment</td>
</tr>
</tbody>
</table>
## CINV Classification

<table>
<thead>
<tr>
<th>Grade</th>
<th>Nausea</th>
<th>Vomiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>Appetite Loss</td>
<td>1 Episode of Vomiting / 24h</td>
</tr>
</tbody>
</table>
| Grade 2 | Decrease in food intake  
No weight loss  
Without dehydration  
Without undernutrition | 2 - 5 Episodes of Vomiting / 24h |
| Grade 3 | Insufficient intakes (caloric and/or hydric)  
Nutrition by tube, parenteral and/or hospitalization required | ≥ 6 Episodes of Vomiting / 24h |
| Grade 4 | - | Life-threatening risk |
| Grade 5 | - | Death |

D’après le NCI-CTAE v 4.03  
(National Cancer Institute-Common Terminology Criteria for Adverse Events)
CINV Risk Factors

Emetogenic risk chemotherapy

Individual Risk Factors
- Age < 55-60 years
- Female sex
- Background:
  - Morning Nausea
  - Pregnant Nausea
  - Motion sickness
  - Early Nausea
- Sleep < 7 hours the day before chemo
- Anxious subject
- Subject who thinks he is at high risk for NVCI
- History of NVCI in previous chemotherapy cycles

Individual protective factors
- Alcohol Intake
## Management

<table>
<thead>
<tr>
<th>Name</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Prophylaxy</td>
<td>Preventive treatment put in place from the 1st cycle of chemotherapy</td>
</tr>
<tr>
<td>Secondary Prophylaxy</td>
<td>Preventive treatment put in place following the occurrence of NVCI during the previous chemotherapy cycle</td>
</tr>
<tr>
<td>Rescue Treatment</td>
<td>Treatment for NVCI despite well-managed prophylaxis</td>
</tr>
</tbody>
</table>
Drugs (cf. annexe)

- **Setrons** (Anti-5-HT3)
  - Antagonists of Serotonin Type 3 Receptor

- **NK-1 Inhibitors**
  - Antagonists of Neurokinin type 1 Receptors

- **Steroids**

- **Anti-D2**
  - Antagonists of Dopamin type 2 Receptors

- **Psychotrops**
  - Benzodiazepins
  - Neuroleptics
Advice for Patients
Hygieno-Dietetics Rules

- Promote hydration: prevention of kidney failure
- Splitting the diet: 6 to 8 small meals and/or snacks per day
- Offer small cold meals to avoid strong odours
- Avoid foods that are too fatty, fried or spicy
- Choose foods that are easy to digest
- Offer to eat slowly
- Offer drinks to patients' taste between meals: water, infusions, apple juice, Coca Cola® (degassed or not)...
- If necessary, use a straw in a closed cup to facilitate small sips and avoid odours.
- Maintain a sitting position for 30 minutes after eating; if lying down, prefer the right side to promote gastric emptying
Non-Drugs Solutions

Acupuncture

• In addition to well-managed drug prophylaxis (grade B recommendation)
  • Electrostimulation > simple acupuncture: reduces the incidence of acute vomiting
  • Acupressure reduces the severity of acute nausea
  • No data on delayed events
  • Points Used: 6MC +++ +/- 36E and 4Rp
  • Acupuncture session: the day before or qq hours after chemotherapy
  • Adverse reactions: all related to electrostimulation: transient rash, skin irritation at electrode points, electric shock, aggravation of paresthesia in patients with peripheral neuropathy.
Other Therapeutics

Low Level of Evidence:

- Ginger
- Desmodium
- Mint Alcohol
- Homeopathy
- ...

Warning with Drug-Drug Interactions
Implementation of management

At any time:
- Patient counseling
- Rescue Treatments
- +/- acupuncture

Primary Prophylaxis

Efficacy*

Is prophylaxis prescribed and taken?

- YES
  - Secondary Prophylaxis
- NO
  - Same prophylaxis

* = efficacy = Nausea ≤ grade 1 or < 2,6 mm on Analogic Numeric Scale and Vomiting grade 0
Define Primary Prophylaxis

1. Define the Emetogenic Level of Drugs

2. Define the Emetogenic Level of Protocol

3. Prophylaxis in Function the Emetogenic Level of Protocol

4. Adaptation according to the patient risk factors
1. Emetogenic Level of Drugs

IV Drugs

**High Emetogenic (90%)**

- Carmustine
- Cisplatin
- Cyclophosphamide (> 1.5 g/m²)
- Dacarbazine
- Mechlorethamine
- Streptozocine
# 1. Emetogenic Level of Drugs

## IV Drugs

**Moderate Emetogenic (30 to 90%)**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alentuzumab</td>
<td>Epirubicine</td>
</tr>
<tr>
<td>Azacitidine</td>
<td>Idarubicine</td>
</tr>
<tr>
<td>Bendamustine</td>
<td>Ifosfamide</td>
</tr>
<tr>
<td>Carboplatine</td>
<td>Irinotecan</td>
</tr>
<tr>
<td>Clofarabine</td>
<td>Oxaliplatine</td>
</tr>
<tr>
<td>Cyclophosphamide (&lt;1,5 g/m²)</td>
<td>Romidepsine</td>
</tr>
<tr>
<td>Cytarabine (&gt; 1 g/m²)</td>
<td>Temozolomide*</td>
</tr>
<tr>
<td>Daunorubicine</td>
<td>Thiotepa</td>
</tr>
<tr>
<td>Doxorubicine</td>
<td>Trabectidine</td>
</tr>
</tbody>
</table>

* Pas de données en IV / extrapolation avec le per os
# 1. Emetogenic Level of Drugs
## IV Drugs

<table>
<thead>
<tr>
<th>Low Emetogenic (10 to 30%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Afibercept</td>
<td>Gemcitabine</td>
</tr>
<tr>
<td>Atezolizumab</td>
<td>Ipilimumab</td>
</tr>
<tr>
<td>Belinostat</td>
<td>Ixabepilone</td>
</tr>
<tr>
<td>Blinatumomab</td>
<td>Methotrexate</td>
</tr>
<tr>
<td>Bortezomib</td>
<td>Mitomycine</td>
</tr>
<tr>
<td>Brentuximab</td>
<td>Mitoxantrone</td>
</tr>
<tr>
<td>Cabazitaxel</td>
<td>Nab-paclitaxel</td>
</tr>
<tr>
<td>Carfilzomib</td>
<td>Paclitaxel</td>
</tr>
<tr>
<td>Catumaxumab</td>
<td>Panitumumab</td>
</tr>
<tr>
<td>Cetuximab</td>
<td>Pemetrexed</td>
</tr>
<tr>
<td>Cytarabine &lt; 1 g/m²</td>
<td>Pertuzumab</td>
</tr>
<tr>
<td>Doxorubicine Liposomale Pegylatée</td>
<td>Temsirolimus</td>
</tr>
<tr>
<td>Docetaxel</td>
<td>Topotecan</td>
</tr>
<tr>
<td>Eribuline</td>
<td>Trastuzumab-emtansine</td>
</tr>
<tr>
<td>Etoposide</td>
<td>Vinflunine</td>
</tr>
<tr>
<td>5-Fluorouracile</td>
<td></td>
</tr>
</tbody>
</table>
### 1. Emetogenic Level of Drugs

#### IV Drugs

<table>
<thead>
<tr>
<th>Very Low Emetogenic (&lt; 10%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bevacizumab</td>
</tr>
<tr>
<td>Bleomycine</td>
</tr>
<tr>
<td>Busulfan</td>
</tr>
<tr>
<td>2-Chlorodeoxyadenosine</td>
</tr>
<tr>
<td>Cladribine</td>
</tr>
<tr>
<td>Daratumumab</td>
</tr>
<tr>
<td>Fludarabine</td>
</tr>
<tr>
<td>Nivolumab</td>
</tr>
<tr>
<td>Obinutuzumab</td>
</tr>
<tr>
<td>Ofatumumab</td>
</tr>
<tr>
<td>Pembrolizumab</td>
</tr>
<tr>
<td>Pixantrone</td>
</tr>
<tr>
<td>Pralatrexate</td>
</tr>
<tr>
<td>Ramucirumab</td>
</tr>
<tr>
<td>Rituximab</td>
</tr>
<tr>
<td>Trastuzumab</td>
</tr>
<tr>
<td>Vinblastine</td>
</tr>
<tr>
<td>Vincristine</td>
</tr>
<tr>
<td>Vinorelbine</td>
</tr>
</tbody>
</table>
### 1. Emetogenic Level of Drugs

**Oral Drugs**

<table>
<thead>
<tr>
<th>High Emetogenic (90%)</th>
<th>Moderate Emetogenic (30 à 90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hexamethylmelamine</td>
<td>Bosutinib</td>
</tr>
<tr>
<td></td>
<td>Cabozantinib</td>
</tr>
<tr>
<td></td>
<td>Ceritinib</td>
</tr>
<tr>
<td></td>
<td>Crizotinib</td>
</tr>
<tr>
<td></td>
<td>Cyclophosphamide</td>
</tr>
<tr>
<td>Procarbazine</td>
<td>Imatimib</td>
</tr>
<tr>
<td></td>
<td>Lenvatinib</td>
</tr>
<tr>
<td></td>
<td>TAS-102</td>
</tr>
<tr>
<td></td>
<td>Temozolomide</td>
</tr>
<tr>
<td></td>
<td>Vinorelbine</td>
</tr>
</tbody>
</table>
### 1. Emetogenic Level of Drugs

#### Oral Drugs

**Low Emetogenic (10 à 30 %)**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afatinib</td>
<td>Idelalisib</td>
<td>Regorafenib</td>
</tr>
<tr>
<td>Alectinib</td>
<td>Ixazomib</td>
<td>Sonidegib</td>
</tr>
<tr>
<td>Axatinib</td>
<td>Lapatinib</td>
<td>Sunitinib</td>
</tr>
<tr>
<td>Capecitabine</td>
<td>Lenalidomide</td>
<td>Tegafur Uracil</td>
</tr>
<tr>
<td>Cobimetinib</td>
<td>Olaparib</td>
<td>Thalidomide</td>
</tr>
<tr>
<td>Dabrafenib</td>
<td>Osimertinib</td>
<td>Trametinib</td>
</tr>
<tr>
<td>Dasatinib</td>
<td>Nilotinib</td>
<td>Vandetanib</td>
</tr>
<tr>
<td>Everolimus</td>
<td>Palbociclib</td>
<td>Vorinostat</td>
</tr>
<tr>
<td>Etoposide</td>
<td>Panobinostat</td>
<td>Venetoclax</td>
</tr>
<tr>
<td>Fludarabine</td>
<td>Pazopanib</td>
<td></td>
</tr>
<tr>
<td>Ibrutinib</td>
<td>Ponatinib</td>
<td></td>
</tr>
<tr>
<td>Ixazomib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lapatinib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenalidomide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olaparib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osimertinib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nilotinib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palbociclib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panobinostat</td>
<td></td>
<td></td>
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<tr>
<td>Pazopanib</td>
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</tr>
<tr>
<td>Ponatinib</td>
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<tr>
<td>Regorafenib</td>
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<tr>
<td>Sonidegib</td>
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<tr>
<td>Sunitinib</td>
<td></td>
<td></td>
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<tr>
<td>Tegafur Uracil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thalidomide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trametinib</td>
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<td></td>
</tr>
<tr>
<td>Vandetanib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vorinostat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venetoclax</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 1. Emetogenic Level of Drugs

#### Oral Drugs

<table>
<thead>
<tr>
<th>Very Low Emetogenic (&lt; 10%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorambucile</td>
<td>Pomalidomide</td>
</tr>
<tr>
<td>Erlotinib</td>
<td>Ruxolitinib</td>
</tr>
<tr>
<td>Gefitinib</td>
<td>Sorafenib</td>
</tr>
<tr>
<td>Hydroxyurée</td>
<td>6-Thioguanine</td>
</tr>
<tr>
<td>Melphalan</td>
<td>Vemurafenib</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>Vismodegib</td>
</tr>
<tr>
<td>Moutarde à la L-Phenylalanine</td>
<td></td>
</tr>
</tbody>
</table>
2. Define the protocol Emetogenic level

- Most emetogenic molecule gives the overall level of the chemotherapy protocol
- Emetogenic levels are not added
  - If protocol with 2 moderately emetogenic drugs then the protocol is moderately emetogenic.
3. Primary Prophylaxis of Acute and Delayed CINV
Several options (in no order of preference)

**High Emetogenic Chemo (HEC)**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Days 2,3,4</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Aprepitant 125 mg</td>
<td>✔ Aprepitant 80 mg (D2-D3)</td>
</tr>
<tr>
<td>✔ Setron (au choix annexe 1)</td>
<td>✔ Steroids</td>
</tr>
<tr>
<td>✔ Steroids</td>
<td>✔ Steroids</td>
</tr>
</tbody>
</table>

or

| ✔ Rolapitant 180 mg | ✔ Steroids |
| ✔ Setron (Optional Annex 1) | |
| ✔ Steroids | |

or

| ✔ Nepa* (Netupitant 300 palonosetron 0,5) | ✔ Steroids |
| ✔ Steroids | |

* : NEPA : in France for Cisplatin based regimen
3. Primary Prophylaxis of Acute and Delayed CINV
Several options (in no order of preference)

**Moderate Emetogenic Chemo (MEC)**

<table>
<thead>
<tr>
<th>Jour 1</th>
<th>Jours 2,3</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Aprepitant 125 mg</td>
<td>✓ Aprepitant 80 mg (J2-J3)</td>
</tr>
<tr>
<td>✓ Setron (Optional Annex 1)</td>
<td></td>
</tr>
<tr>
<td>✓ Steroids</td>
<td></td>
</tr>
</tbody>
</table>

or

| ✓ Rolapitnant 180 mg   |                        |
| ✓ Setron (Optional Annex 1) |                    |
| ✓ Steroids             |                        |
3. Primary Prophylaxis of Acute and Delayed CINV
Several options (in no order of preference)

Low Emetogenic Chemo (LEC)

<table>
<thead>
<tr>
<th>Jour 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Anti-D2</td>
</tr>
<tr>
<td>or</td>
</tr>
<tr>
<td>✓ Steroids</td>
</tr>
<tr>
<td>or</td>
</tr>
<tr>
<td>✓ Setron (Optional Annex 1)</td>
</tr>
</tbody>
</table>
Very Low Emetogenic Chemo (VLECs)

No Routine Primary Prophylaxis
4. Adaptation of prophylaxis serving patient risk factors
CINV Individual Risk Factors

**Individual Risk Factors**

- Age < 55-60 years
- Female sex
- Background:
  - Morning Nausea
  - Pregnant Nausea
  - Motion sickness
  - Early Nausea
  - Sleep < 7 hours the day before chemo
- Anxious subject
- Subject who thinks he is at high risk for NVCI
- History of NVCI in previous chemotherapy cycles

**Individual protective factors**

- Alcohol Consumption
4. Adaptation of prophylaxis

In Case of Many Risk Factors

« Upgraded » Prophylaxis:

- Application of primary prophylaxis at the upper emetogenic level ...
- From the first cycle
« Upgraded » Primary Prophylaxis

- **HEC**: HEC prophylaxis HEC + Olanzapine
- **MEC**: HEC prophylaxis
- **LEC**: MEC prophylaxis
- **VLEC**: LEC prophylaxis

HEC : High Emetogenic Chemo  
MEC : Moderate Emetogenic Chemo  
LEC : Low Emetogenic Chemo  
VLEC : Very Low Emetogenic Chemo
Secondary Prophylaxis

= Add a Drug
(without order of preference / not previously prescribed)

- Anti-NK₁
- Setron
- Steroids
- Anti –D₂
- Psychotropes :
  - Neuroleptics : Olanzapine / Haloperidol (Off Label Use)
  - benzodiazepines
- Cannabinoides (not available in France)
Rescue Treatments

During Chemo
- **Setron**: dose optimization (up to 16 mg single dose)
- **Anti D2**
  - Alizapride: 5 mg/Kg/jour 15 minutes IV
  - Or Metoclopramide: 30 mg 15 mn IV (max dose 0,5/Kg/j)
- **Steroids**: NO
- **Benzodiazepine**: if failure (per os or intravenous)

During the 24 first hours
- **Setron +/- Anti-D2 +/- Benzodiazepine**

In the Delayed Phase
- **Anti-D2 +/- Benzodiazepine**
Special cases
Continuous Chemotherapy

- Example: capecitabine
  - No long course steroids
  - Anti-D2 one hour before chemotherapy
  - If failure: daily setron
Special Cases

- **Trabectidine**
  - Primary Prophylaxis: setron (at choice) + Steroids

- **Ifosfamide**
  - Primary Prophylaxis: setron (at choice) + Steroids

- **Aprepitant**: to avoid absolutely with these 2 molecules because of the interaction and the increased risk of toxicity.

- **Rolapitant**: no published clinical data (ongoing studies). Pharmacological and preclinical data (1, 2) support a lack of interaction with these 2 molecules. Its use cannot be recommended as it stands but must be examined according to the intensity of the NVCI and the interest of the patient, in particular the prognosis.

---

Multi-Day Chemo (BEP or TPF)

- If aprepitant
  - 125 mg D1 then 80mg next days
  (continue 2 days after the last injection of HEC* ou de MEC**)

- No Data with NEPA, palonosetron ou rolapitant

* HEC : High Emetogenic Chemo
** MEC : Moderate Emetogenic Chemo
Task Force

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Jean-Baptiste REY (Reims)
Annex

Drugs Solutions
Sétrons (1/2)
Molécules, voies d’administration et posologies disponibles (IV = Per os)

- **Granisetron**
  - Comprimé pelliculé : 1mg, 2 mg (générique, KYTRIL®)
  - Solution injectable : 3 mg/3ml (générique, KYTRIL®)

- **Ondansetron**
  - Comprimé pelliculé : 4 mg, 8 mg (générique, ZOPHREN®)
  - Comprimé lyoc ou orodispersible : 4 mg, 8 mg (générique, ZOPHREN®)
  - Sirop : 4 mg/5 ml (ZOPHREN®)
  - Supposoire : 16 mg (ZOPHREN®)
  - Film orodispersible : 4 mg, 8 mg (SETOFILM®)
  - Solution injectable : 2 mg/ml (générique, ZOPHREN®)

- **Palonosetron**
  - Solution injectable : 250 μg (ALOXI®)
Sétrons (2/2)

- Antagonistes des récepteurs à la sérotonine de type 3

- Effets indésirables fréquents :
  - Constipation, céphalées (grades faibles)
  - Transitoire et asymptomatique des ASAT et ALAT

- Risque de torsade de pointe (QT)
  - ECG indispensable avant première cure de chimio
Antagonistes des récepteurs aux neurokinines de type 1

Molécules disponibles :

- **Aprépitant** : J1 : 125 mg + J2 et J3 : 80 mg
- **Nétupitant** (disponible uniquement en association avec palonosétron : NEPA) : J1 : 300 mg/0,5mg
- **Rolapitanton** : J1 : 180 mg

**Remarque** : Netupitant et Rolapitanton possèdent une longue demie vie. Leur prise unique à J1 permet une prophylaxie des NVCI retardés sur plusieurs jours.
Corticoïdes

- Molécule de référence : dexaméthasone (DXM)
- Pas de différences entre corticoïdes à posologies équivalentes (cf. infra)
- Prise unique / per os = IV
- Les corticoïdes utilisés dans le traitement des hémopathies malignes lymphoïdes pourront être administrés aux horaires des antiémétiques afin d’éviter une dose de corticoïdes trop importante.

<table>
<thead>
<tr>
<th>Corticoïdes</th>
<th>Posologie (mg)</th>
<th>Posologies (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexaméthasone</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Méthylprednisolone</td>
<td>64</td>
<td>44</td>
</tr>
<tr>
<td>Prednisone / Prednisolone</td>
<td>80</td>
<td>55</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td>320</td>
<td>220</td>
</tr>
</tbody>
</table>
Anti D₂

- Antagoniste de la dopamine
- Molécules disponibles :
  - Métoclopramide (per os, suppositoire, injectable)
  - Métopimazine (per os, suppositoire, injectable)
  - Alizapride (per os et injectable)

NB : Dompéridone à éviter car pas de données dans la littérature et risque de troubles du rythme cardiaque
Psychotropes

• Benzodiazépines (BZD)
  – Préférer les BZD à demi-vie courte (ex : alprazolam)

• Neuroleptiques
  – Olanzapine : 1 cp de 5 mg par jour pendant 5 jours
Coordination Mise à jour 2017
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Bibliographie

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Rolapitant
Rolapitant (suite)

NEPA

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