Management of NAUSEA and VOMITING in the last days of life: PAEDIATRIC AND NEONATAL Document 5

Assess the patient **a minimum of every 4 hours** to allow existing and emerging symptoms to be detected, assessed and treated effectively

- Use the *Comfort Observation Symptom Assessment: Paediatric & Neonatal (COSA: P&N)* to document assessments
- In addition to pharmacological measures, implement non-pharmacological measures. Environmental considerations may include: removal of strong odours, minimise movement, increase airflow (including handheld fan), decrease room lighting and noise, a cool facial cloth, the presence of parents/carers, music, books, favourite toys, electronics that are developmentally appropriate, provision of tissues and a vomit bag within easy reach. Consider patient comfort- reduce/stop artificial and oral nutrition replacing with regular effective mouth care/sips of water/ice if appropriate
- Consider other contributing causes such as constipation, raised intracranial pressure, severe gastritis and side effects or interactions of medications

Route of medication administration

- **Enteral:** Whilst patient is able to tolerate this, the enteral route (oral/buccal/gastrostomy/naso-gastric [NG]) is preferred. (NB: absorption will be slower with enteral administration in the last days of life). If patient experiences severe nausea or vomiting then subcutaneous (subcut) or intravenous (IV) route of administration is preferred
- **Subcutaneous (subcut)/Intravenous (IV):** consider using subcut route of administration or use IV access [Intravenous cannula (IVC)/ Central Venous Access Device (CVAD)] if available as per local policy
- Avoid intramuscular injections

IF YOU HAVE DOUBTS OR CONCERNS CONTACT A SPECIALIST PAEDIATRIC PALLIATIVE CARE SERVICE (SPPC) VIA ANY OF THE NSW CHILDREN'S HOSPITAL'S SWITCHBOARDS (INCLUDING OUT OF HOURS)

AS REQUIRED (PRN) antiemetic dosing

Pre-emptive enteral/subcut/intravenous medication should be prescribed even if the patient is not currently nauseated or vomiting

ENTERAL or SUBCUTANEOUS or INTRAVENOUS

First line: PRN ONDANSETRON
Dose 0.1 mg/kg every 8 hours prn for nausea/vomiting
Maximum 8 mg/dose
(Maximum 3 prn doses in 24 hours)
Seek advice SPPC if patient <4 weeks of age

Second line: PRN METOCLOPRAMIDE*
Dose: 0.15 mg/kg every 6 hours prn for nausea/vomiting
Maximum 10 mg/dose
(Maximum 3 prn doses in 24 hours)
Seek advice SPPC if patient <4 weeks of age

If 3 or more prn doses required in previous 24 hours, prescribe regular antiemetic

REGULAR antiemetic dosing

Regular antiemetic dosing should also include PRN options (enteral/subcut/IV)

ENTERAL or SUBCUTANEOUS or INTRAVENOUS

First line: ONDANSETRON
Dose: 0.1 mg/kg every 8 hours for nausea/vomiting
Maximum 8 mg/dose
(Maximum 3 doses in 24 hours)
PLUS prescribe **METOCLOPRAMIDE*** as PRN medication

Second line: METOCLOPRAMIDE*
Dose: 0.15 mg/kg every 6 hours for nausea/vomiting
Maximum 10 mg/dose
(Maximum 3 doses in 24 hours)
PLUS prescribe **ONDANSETRON** as PRN medication
OR
Infusion
Continuous **METOCLOPRAMIDE*** subcut/IV infusion
Dose: 0.4 mg/kg/24 hours (Maximum total dose in 24 hours = 30 mg)
(Dependent on local guidelines)
(Can be combined with Morphine and/or Midazolam infusion)
PLUS prescribe **ONDANSETRON** as PRN medication

If 3 or more prn doses are required in previous 24 hours increase regular and/or prn dose. **Seek advice from SPPC if additional dose guidance required e.g. alternative anti-emetics required**

*** Metoclopramide use for paediatric patients - watch for oculogyric crisis or acute dystonia or extrapyramidal side effects. Caution with abdominal colic. Do not use if bowel obstruction suspected. Use with caution and have benzatropine injection available for treatment of acute dystonic reactions**

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