

**Optimising CINV management:
applying evidence in clinical practice**

Petra Tesařová

Charles University Hospital

Prague, Czech Republic

Good afternoon, dear colleagues, and now let me share with you practical implications of introducing antiemetic treatment of our patients in daily practice.

Disclosures

These are my disclosures.

What are the current treatment options?

My previous speakers mentioned all the treatment options, and we are able and should follow standard recommendations of treatment for our patients.

...but how many situations are really standard?

However, many real situations are really far from standard.

Question 1

Here is my first question. Have you ever met a patient who is experiencing vomiting after chemotherapy even though a standard preventive treatment had been given?

Please vote.

Evidence from the “real world” clinical setting

We have evidence from “real-world” data published last year. You can see that among patients who underwent approximately 4000 chemotherapy regimens, nausea and vomiting occurred in more than 60% and grade 2 or higher vomiting and nausea in more than 40%.

Patient case: RL

Let me move to the first case. This lady is a 60-year-old female, with a new diagnosis of metastatic non-small cell lung cancer. She is a smoker and drinks one to two alcoholic drinks per week. She has had three pregnancies involving hospitalisation for morning sickness. She also had a significant medical history of depression, hypothyroidism, anxiety, impaired glucose tolerance, and gastro-oesophageal reflux.

She will receive platinum-based chemotherapy.

Question 2

What is the optimal tailoring approach to preventing nausea and vomiting?

Please vote.

CINV risk assessment tool for establishing overall emetic risk

In each individual case we need to consider not only regimen risk factors but also patient-related risk factors.

Regimen-specific risk factors: emetogenic potential of anticancer agents

Antiemetic prevention is intended for a patient treated by a regimen with high and moderate emetogenicity, and if we consider emetogenicity of a combined regimen, this is determined by that cytostatic that is associated with highest risk for nausea and vomiting.

Predictive factors for optimising selection of prophylactic antiemetics

However, we have a lot of other risk factors that emerged from clinical trials. For example, for Dranitsaris' trial, he mentioned eight risk factors: patient age; the first two cycles of chemotherapy; anticipatory nausea and vomiting; history of morning sickness; hours of sleep before chemotherapy; nausea in the prior cycle; patient self-medication; and use of platinum or anthracycline regimens.

Patient case: RL

I highlighted these risk factors in a case report. This lady is not so young. She is not teetotal. She suffered from morning sickness during pregnancy. She has a lot of comorbidities—depression, anxiety, impaired glucose tolerance, reflux, and we plan to treat her with cisplatin-based chemotherapy.

Question 3

What kind of antiemetic regimen would you choose for this lady?

Triplet setrons, plus dexamethasone, plus metoclopramide?

Setrons, plus NK₁ receptor antagonists, plus dexamethasone, plus lorazepam?

NK₁ receptor antagonists, plus dexamethasone, plus metoclopramide?

Please vote.

Recommended antiemetic assessment and treatment plan for RL: HEC

For this lady it is highly recommended to use in prevention triplet setron, NK₁ receptor antagonist and dexamethasone, and continue with dexamethasone and NK₁ receptor antagonists after chemotherapy.

Patient case: AS

This is my second case report. This lady is 42 years old. She is a teacher at a local elementary school. She presents with three-month history of fatigue and weight loss.

She has never smoked, does not drink alcohol. She has three children and in her history, morning sickness during pregnancy.

A colonoscopy revealed 8 cm of colon cancer and a biopsy confirmed this diagnosis of colorectal adenocarcinoma with KRAS mutation, and we plan for this lady treatment by FOLFOX6 in combination with bevacizumab.

Question 4

Based on the guidelines, which antiemetic regimen is recommended for this patient?

Doublet setron and dexamethasone?

NK₁ receptor antagonist, a proton pump inhibitor, and H1 antagonist?

Special institution-based protocol?

None of the above?

Please vote.

Recommended antiemetic assessment and treatment plan for AS: MEC

We consider the same way for doublet setron plus dexamethasone, but we slightly modified this treatment because we chose palonosetron due to longer half-life, and according to guidelines, it is possible to use granisetron with extended-release injection application.

Patient case: AS (cont.)

However, we have not been successful in prevention because our patient during cycle one continues to experience nausea and vomiting, and she reports unpleasant additional symptoms—weight loss, depression, and fatigue.

Question 5

Which is considered a risk factor for developing nausea and vomiting after chemotherapy in general?

Young age?

Anticipatory nausea and vomiting?

Nausea and vomiting in the previous cycle?

History of morning sickness during pregnancy?

All of the above?

Please vote.

How would you modify her antiemetic regimen?

How would you modify her antiemetic regimen for the next cycle?

It is possible and reasonable to add an NK₁ receptor antagonist, but this patient is really very busy. She has three children. She is a teacher and best quality of life for her is made convenient by NEPA single dose.

How can adherence to antiemetic guidelines be improved in your practice?

What about information about improving adherence to antiemetic guidelines? We have fresh data from an oncological nurse survey that are very important education for all providers—physicians, nurses, and pharmacists.

Using standardised protocols, improve patient teaching and also precise follow-up.

Message for clinical practice

This is my message for your clinical practice.

Prevention of CINV is better than symptomatic treatment.

Follow the guidelines for prevention based on the emetogenicity of chemotherapy regimens.

Additionally, take each patient's individual risk factors and comorbidities into account.

New therapeutic options offer the opportunity to improve guideline adherence and ensure a better quality of life. For example, fixed combination NK₁ receptor antagonists and palonosetron.

Applying effective therapeutic strategies as indicated for nausea and vomiting will result and improve adherence to cancer treatment.

The way is tailoring...

Please keep in your mind that to omit or to underestimate the prevention of nausea and vomiting for your patients could lead to a decrease in quality of life and irreparable damage of your patient.

Thank you for your attention. [*Applause*]

[*Ends*]

