Section Scottish Palliative Care nausea and vomiting guideline

Comments received from external referees and others

All reviewers submitted declarations of interests which were viewed prior to the addressing of comments.

Open consultation			**Type of response and declared interests**
CGD		Yann Maidment, College Lead for Research submitting comments on behalf of the College of General Dentistry	*Group response.* *<u>Nature and purpose of your group or organisation</u>* Professional body comprising of registrant members of the whole dental team. To empower the public and patients to achieve and maintain good oral health through its professional community
ED	Emma Dymond	Consultant in Palliative medicine, Glasgow Royal Infirmary, NHSGG&C	*Individual response.* Nothing declared.
HB	Honor Blackwood	Specialist Nutritional Support Dietitian, NHS Forth Valley	*Individual response.* Nothing declared.
JG	Jennifer Gibson	GP, Lead GP for Palliative Care NHSL, former Palliative Care SAS doctor, NHS Lanarkshire	*Individual response.* Nothing declared.
JM	Jennifer McCraken	Highly Specialist Dietitian, The Royal Marsden	*Individual response.* *<u>Non-financial personal interests</u>* I chair the BDA palliative care subgroup, a special interest subgroup of the BDA Oncology specialist group. Feedback is therefore collated from dietitians with clinical and research experience in palliative care.
LC	Lucy Cogdell	Palliative Medicine Consultant, Roxburghe House Hospice, Aberdeen	*Individual response.* Nothing declared.

LH	Lucy Hetherington	Consultant in Palliative Medicine, Beatson, West of Scotland Cancer Centre	*Individual response.* *Non-financial personal interests* I have published a book chapter on substance use and palliative medicine - no financial remuneration
MT	Mandy Trickett	Physiotherapist/Practice Education Lead, NHS Highland	*Individual response.* *Non-financial personal interests* Published work in cancer rehabilitation when worked as a Palliative Care physiotherapist. *Any other interests of relevance* Passionate about high quality palliative care for all.
RCGP		Marcus Carslaw, Policy and Public Relations Officer submitting comments on behalf of the Royal College of General Practitioners Scotland	*Group response.* *Nature and purpose of your group or organisation* RCGP Scotland is the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.
RP	Rosemary Pengelly	Public Partner, Healthcare Improvement Scotland	*Individual response.* *Any other interests of relevance* University of Stirling as an unpaid community researcher.
SD	Siobhan Dobie	Hospital Medical Pharmacist, University Hospital Wishaw, NHS Lanarkshire	*Individual response.* *Financial personal interests* AstraZeneca educational events for COPD

Reviewer	Comment	Development group response	Editorial group response
General			
HB	Consider timing of medications e.g. pre meals so allows to alleviate nausea before eating.	We have added the following point to the management section: • Aim to time food for after antiemetics have taken effect	Changed to allow the bullets to flow better: • Timing food after antiemetics have taken effect.
LH	I wonder if it is worth mentioning a line of guidance re considering performing an ECG to check a QTc for patients on antiemetics where felt appropriate..... (I'm not sure if required - just a thought.	This has been added to the Assessment section: Consider if appropriate to perform an electrocardiogram (ECG) to measure QTc as many antiemetics risk QTc prolongation	Changed to: Consider the appropriateness of performing an electrocardiogram (ECG) to measure QTc as many antiemetics increase the risk of QTc prolongation.
MT	Appears relevant but unable to specifically comment and out with scope of practice. Keen to see importance of physical activity and regular postural/positional changes.	The following has been added to the Management section: • Positional changes may help depending on underlying cause, eg reducing intra-abdominal pressure	Changed to allow the bullets to flow better: Positional changes, depending on the underlying cause, eg reducing intra-abdominal pressure
CGD	The guidelines have been well produced and written. They are sufficiently general that no specific additional guidance appears to be necessary for the special area of general dental and oral health care beyond what appears elsewhere for special situations (e.g. oncology care). An old (Galen, 2nd century A.D) piece of guidance that "the extraction of teeth should not be undertaken - unless	Thank you	✓

	there is no alternative", still holds true - even more so in palliative care.		
RCGP	We welcome the updated guidelines for the care of palliative patients with nausea and vomiting. The College welcomes the succinct introduction to the nausea and vomiting guidelines; however, we note that it may be beneficial for the concept of 'total nausea' to be defined in the document. We welcome the inclusion of potential clinical scenarios as they offer context and good learning points. The inclusion of emerging therapies is welcomed, although we note that GPs are unlikely to use these therapies without first having consulted with specialist services.	Total nausea has been explained in para 2 of the introduction of the revised document. The need to consult specialist advice is emphasised throughout the document. It is hopefully clear that emerging therapies should not be trialled without consulting specialist palliative care.	✓ ✓
	The College welcomes the general and non-pharmacological advice sections; however, we note that it would be beneficial for these sections to be located towards the start of the guidelines, with signposting to relevant clinical scenarios.	The update will be translated into the SPCG toolkit on the Right Decision Service platform (RDS) The sections are clearer and easier to access there. The flow and order of the guideline has been revised.	✓
	The Scottish Palliative Care Guidelines are a useful resource for GPs treating palliative care patients and the updated guidelines offer an improvement on previous versions. The College feels it would be useful for the guidelines to be made available via an app to allow ease of access to the information via mobile devices on home visits. This	The update will be translated into the SPCG toolkit on the Right Decision Service platform (RDS) which is accessible online and via an app.	✓

	would be of particular benefit to doctors working in remote and rural areas where internet connectivity may be patchy or limited.		
RP	But there is nothing for the patient/carer on the nausea and vomiting guidelines. That is an omission, as it has to help ease things when the patient/carer is handled well and also informed on ways in which to handle nausea/vomiting (especially if the person is organising to die at home). The four guidelines seem to have an inconsistency, as getting the patient/carer 'onside' must help also with the easing of the patient and, separately, also the clinical options. Such inconsistency is a weakness, so please could there be some consistency across the four guidelines, ideally on the ethos as well captured within the breathlessness wording for patients/carers.	This guideline is written with the intended audience of healthcare professionals, but a link to separate advice for patients and carers has been included in the non-pharmacological management section. The need to consider holistic factors and effects on quality of life has been added to the guideline under good practice guides.	✓ ✓ Moved to top of assessment
Assessment			
JM	Assessment (p.1) • Possible nutritional assessment by dietitian • Personal assessment of interest and desire to eat - the goal should be to promote comfort	The importance of hydration and nutritional assessment is emphasised in the guideline. Dietitian assessment in the context of life-limiting disease is not typically conducted in practice. We have included the following:	✓

	• Assessment of the need for rehydration	Holistic assessment, including: • discussing goals and what matters to the patient, whether there is a desire to eat, whether goals are nutrition or eating for comfort, or simply relief from nausea and/or vomiting • effects on quality of life and social functioning • spiritual distress Consideration of hydration status and the need for rehydration is described in guideline.	✓ ✓
LH	re Regurgitation - 'consider seeking advice' who would this be from? does this need more elaboration.	We have added the following: Identify and treat reflux/regurgitation. If uncontrolled with medication, consider seeking advice from gastroenterology colleagues. Further interventions, such as endoscopy or stenting, can be considered.	✓ Changed to allow the bullets to flow better: ○ Reflux or regurgitation. Identify and treat and if uncontrolled with medication, consider seeking advice from gastroenterology colleagues. Further interventions, such as endoscopy or stenting, can be considered.
2. Motility disorders			
LC	I think a bit of work is needed on the motility section to clarify the difference between bowel dysmotility/ dysfunction and complete bowel obstruction. Important to add that if treating with a prokinetic causes increasing crampy	We have added greater clarity and signposting to the bowel obstruction guideline. The importance of considering cramping as a result of prokinetic drugs	✓

	pain then may need to be stopped and reviewed in case now has developed a complete bowel obstruction.	has been added to the assessment section. The following sentence is included in the motility section: • if there is large volume vomiting or colicky bowel pain, especially colic caused by a prokinetic agent, exclude complete bowel obstruction and refer to Bowel obstruction guideline.	✓
3. Intracranial disorders			
ED	Great guideline and resource- In ICP and motility disorder section- Unsure of evidence in timing of reducing steroids after 3 days - if no specific evidence may need to mention consideration may be needed on an individual patient basis around reduction 3-5 days after initiation depending on response and any associated side effects.	This has been amended to: Consider a corticosteroid to reduce intracranial pressure – †dexamethasone 8 mg to 16 mg daily. Aim to reduce the dose after 3 to 5 days depending on side effects and individual factors, aiming to stop or reduce to lowest maintenance dose. The appropriate starting dose should be discussed with a senior clinician.	✓
JG	Page 4 would suggest changing the wording of "levomepromazine* 2.5mg to 5mg by subcutaneous injection 12 hourly as needed or 5mg to 15mg in 24 hours by continuous subcutaneous infusion. May need to give subcutaneous injection more frequently initially, for example hourly, to control symptoms	The guideline explains that the 24-hour dose will be variable depending on response. A general comment about switching to the oral route has been added to the practice points section.	✓ ✓

	Consider change to oral route if symptoms resolve." to: "levomepromazine* 2.5mg to 5mg by subcutaneous injection - initially may need to give subcutaneous injection frequently e.g. hourly to control symptoms, then 12 hourly as needed once controlled. Alternatively, 5mg to 15mg in 24 hours by continuous subcutaneous infusion. Consider change to oral route if symptoms resolve." for purposes of clarity.		
4. Oral/pharyngeal/oesophageal irritation			
JM	Oral/pharyngeal/oesophageal irritation (p.7) • Thoroughly clean dentures once removed to help prevent possible infections • Running a room humidifier at night can relieve symptoms of dry mouth • Using artificial saliva products can help keep the mouth moist • Consider modified consistencies as needed	These points have been added to the Non-pharmacological section.	✓
5. Multifactorial			
ED	For the mutifactorial nausea section I wonder if prochlorperazine should be added as an option to consider also- our health board highlighted the cost a number of years back (would be good	Prochloperazine has been added as an option.	✓

	to check with a specialist pharmacist if high cost of levomepromazine tablets still a concern) and at that point plan was for use of prochlorperazine for palliative care patients requiring a second line antiemetic (guidance didn't change for chemo induced N+v)- suspect if cost still an issue this will impact all health boards in Scotland."		
6. Higher centres			
LH	Section 6 - Higher centres 'The 500mcg Lorazepam can't be absorbed by this route' immediately follows a sentence re subcutaneous administration so is misleading. Perhaps change to 'The 500mcg Lorazepam can't be absorbed subcutaneously'.	The sentence this pertains to has now been removed.	✓
General advice			
LH	Re caution in Parkinson's "Anti-dopaminergics should be avoided in patients with Parkinson's disease" This isn't technically true as domperidone is often first line as it doesn't cross the BBB. Would it be better to say 'Metoclopramide, haloperidol, prochlorperazine and levomepromazine should be avoided in patients with Parkinson's disease. Domperidone, cyclize and ondansetron could be considered..... or similar.	The sentence this pertains to is no longer in the guideline.	✓
SD	Under other management considerations: buccal or sublingual	The following has been added:	✓

	medication administration may be helpful but may trigger symptoms of nausea or vomiting in susceptible individuals.
	
	Could we elaborate to explain that in practice swallowing tablets can cause nausea/vomiting and some patients find they tolerate liquids/crushable forms much better. There are resources such as NEWT for swallowing difficulties and often gives advice regarding taste.
		• Consider the formulation of drugs and route of administration of medication as:
		  ○ the oral route may not provide adequate absorption or be available as a result of nausea (which inhibits gastric emptying) or vomiting
		  ○ when using the oral route, swallowing tablets may trigger nausea therefore liquids or crushable formulations may be preferred, additionally it may take longer for the medication to absorb as nausea is frequently associated with delay gastric emptying
		  ○ buccal or sublingual medication administration may be helpful
		  ○ alternatively, the transdermal or parenteral route may be used
		
		NEWT guidelines not mentioned specifically as this requires a subscription.	

Non-pharmacological management			

JM	Other management considerations - Non-pharmacological management (p.12) • Sip small amounts of fluids throughout the day • Avoid drinking and eating at the same time • Opt for foods served at room temperature • Choose comfortable, loose-fitting clothing to reduce discomfort around the waist • Evaluate oral nutritional supplement appropriateness • Weight monitoring / malnutrition screening • Ginger may help with nausea, suggest trying crystalized stem ginger or add freshly ground ginger to hot water to make a drink. • Suggest peppermint tea or sucking on mints. • Try cold fizzy drinks between meals, if tolerated. • Try plain biscuits / toast or crackers. Try eating after antiemetics taking effect	Many of these points have now been added to the guideline. The points mentioning food stuffs have not been added specifically, because the effect will be variable depending on the individual. However, there is advice to consider what the individual finds helpful or unhelpful.	✓
HB	Consideration of ginger products such as ginger biscuits, ginger tea etc	As above, specific food stuffs have not been mentioned in the guideline.	✓

	Little and often approach to eating		