

EVALUATING THE 2023 MASCC/ESMO GUIDELINE UPDATE FOR THE
PREVENTION OF CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING AND ITS CLINICAL APPLICATION

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ABSTRACT

Beyond the recommendations of the updated MASCC/ESMO Antiemesis Guidelines in 2023, there are some issues in clinical practice that remain unanswered. Some of them are the following:

1. What individual risk factors mean MEC becomes HEC?
2. When should a second agent be added to patients receiving LEC?
3. How to manage CINV in patients treated with new ADCs?
4. How should long delayed CINV be managed?
5. How should CINV be managed in patients receiving oral agents?

ABBREVIATIONS

ADC	antibody-drug conjugate
CINV	chemotherapy-induced nausea and vomiting
HEC	highly emetogenic chemotherapy
5-HT ₃ -RA	5-hydroxytryptamine3-receptor antagonist
LEC	low emetogenic chemotherapy
MEC	moderately emetogenic chemotherapy
NK ₁ -RA	neurokinin-1 receptor antagonist



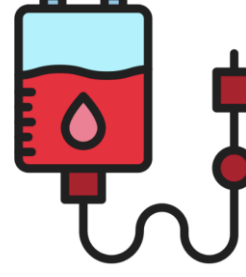


INTRODUCTION

The 2016 MASCC/ESMO guidelines for the prevention of chemotherapy- and radiotherapy-induced nausea and vomiting (CINV) were updated in 2023 by a Consensus Committee consisting of 34 multidisciplinary international health care professionals and three patient advocates. These Guidelines collect the last evidence of the main questions related to emesis. But there are some aspects that require an answer to help clinicians in daily clinical practice.

METHODS AND MATERIALS

Across a series of meetings, we evaluated these guidelines to identify any possible evidence gaps and unaddressed aspects in daily clinical practice which warrant further discussion. Five questions were identified and some recommendations were done.

RESULTS, DISCUSSION AND CONCLUSIONS

 <p>1. What individual risk factors mean MEC becomes HEC?</p>	 <p>2. When should a second agent be added to patients receiving LEC?</p>	 <p>3. How to manage CINV in patients treated with new ADCs?</p>	 <p>4. How should long delayed CINV be managed?</p>	 <p>5. How should CINV be managed in patients receiving oral therapies?</p>
<ul style="list-style-type: none">• A range of factors have been identified:<ol style="list-style-type: none">1. Age2. Female sex3. Anxiety4. History of motion sickness or nausea during pregnancy5. Prior treatments6. Inadequate sleep before chemotherapy7. Duration of CINV• Emesis risk calculators to estimate individual risk may be helpful	<ul style="list-style-type: none">• If CINV control is inadequate with initial monotherapy, switching to an alternative agent should be considered• In patients with poor control of CINV in the previous cycle, the prophylaxis regimen recommended for the MEC could be an option• Overtreatment may be a concern, and the addition of a second agent might only be considered if it addresses a particular issue	<ul style="list-style-type: none">• ADCs may be associated with a novel pattern of CINV, with onset of nausea at around 2-3 days and vomiting at around 10 days and the risk remaining high throughout each cycle• A two-drug regimen may be sufficient, although triple therapy of 5-HT₃-RA, a NK₁-RA and dexamethasone will be needed• Anti-emetics with longer half-life and/or longer protection may be an appropriate option	<ul style="list-style-type: none">• The entire CINV risk period and not just the initial 24 hours or even 120 hours should be considered• Properties of anti-emetics, such as half-life and duration of effect, may be relevant• Addition of an NK₁-RA to 5-HT₃-RA and dexamethasone may reduce CINV over a 7-day period versus 5-HT₃-RA plus dexamethasone	<ul style="list-style-type: none">• Data on the emetic risk potential of oral anticancer agents are very limited• Guidance is based on the use of on-demand antiemetics, typically, a combination of :<ul style="list-style-type: none">➤ 5-HT₃-RA (days 1–7)➤ dexamethasone (days 1–3)• If this is inadequate, consider the addition of an NK₁-RA• Multiple dosing could also be an option

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