THE VOMITING PATIENT

"What shall we do with the drunken sailor?"

Approach to nausea/vomiting:

- Look at the patient first!
- If vomiting, pass them a chuck bucket (emesis bag)
    - IV access ASAP, fluids asap
    - Antiemetics

Causes of nausea/vomiting

- Medications – particularly chemotherapy meds, analgesics
- Pregnancy
- AF/MI
- Hypotension
- Stress
- Organ dysfunction – liver, stomach, brain, ears
- Constipation
- Infection
- Underfilling – not a cause necessarily, but doesn't improve matters!

Freak-out causes of vomiting

- MI/AF
- Meningitis
- DKA
- Brain tumour
- Addison's crisis
- SBO/pancreatitis/cholecystitis/perforation of some previously functional organ

- Constipation
- Surgical problems
- Infections - urine

- GIT
- Organs
- Infection

- Pregnancy
- Stress

- UTI/infection
- Medications
- MI/AF
- Bowel/GIT

Diagnosis

- Every patient gets the following review:
    - Reason for admission
    - PMHx
    - ALLERGIES
    - Recent medication changes

- Every patient is asked about chest pain, dysuria, cough, SOB, fever, other pain.
- Every patient gets the following examination:
    - Eyeball: how do they look? Are they vomiting constantly, or every now and again? Do they look dry? Yellow?
    - Feel the pulse – regular? Irregular?
    - Listen to the heart – murmurs, gallop rhythm, pericardial rub, regularity
    - Listen to the chest – posterior if possible – infection? Collapsed lung?
    - Feel the abdomen – Distended? No bowel sounds? Peritonism?
    - Feel the calves – tender? Swollen?
- Consider taking bloods (LFT, CRP, EUC, FBE, CMP) and urine (BHCG, dipstick). ECG if you think the heart is a problem.
- *All females between the ages of 10 years and 70 years are both sexually active and pregnant until otherwise proven. If they're "not having sex", someone else may be having sex with them!!*

Treatment (adult doses only)

- Maxolon: 10mg tds PO/IV/IM. Can be given up to QID if pushed. Doesn't work for PONV. Do NOT use if bowel obstruction – it is a propulsive agent and will worsen the situation.
- Ondansetron: 4 or 8 mg bd PO/IV. Useful for chemotherapy patients, and post-op pts.
- Droperidol: 250-500mcg Q4H PRN. Watch for long QT, particularly with antiarrhythmics, antihistamines, TCAs.
- Dexamethasone: 4-8mg IV daily. A last resort, but can be very effective. Be wary of diabetics; it can play silly buggers with their sugars.
- Prochlorperazine: 20mg PO initially, then 5-10mg tds. Or 12.5mg IV/IM QID. For migraines, I like 12.5mg in bag of NS given stat.
- Haloperidol: 2mg IV. Not often used, but can be useful if you're desperate. Try dexamethasone first!
- FLUIDS: most patients with no history of heart or renal failure can take a bag of fluid stat. Assess fluid status of a patient. Many pts find that a quick bag of fluids makes them feel 100% better quickly, so flood young patients with a couple of bags.

If you think the patient has a bowel obstruction or is at risk of aspiration:

- Follow the protocol from the intranet
- Insert large NGT and request four hourly aspirations from the nursing staff.
- Put the patient on sips/chips/drips – sips of fluid only, ice chips for comfort, IVT.
- Order AXR to confirm/deny bowel obstruction, CXR if concerned about aspiration.
- Pantoprazole IV 40mg BD will reduce gastric secretions for comfort
- Write up replacement fluids for NGT (see my cheat sheet)
- Make sure patient is not lying flat if possible.
- Do NOT give maxolon (metoclopramide) to these patients – propulsive effect. Always work from the bottom (end) first!
- Surgical review, or review by senior if concerned.

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My head is pounding
Feeling waves of nausea
Even the light hurts.