antagonists increase risk of cardiac arrhythmias and sudden cardiac death in those with QTc interval prolongation on electrocardiography (ECG). Surveillance ECG testing is advocated for some of these agents.

OTHER CLINICAL SETTINGS

Some cancer chemotherapies are intensely emetogenic **(Chap. 73)**. Combining a 5-HT_3 antagonist, an NK_1 antagonist, and a glucocorticoid can control both acute and delayed vomiting after highly emetogenic chemotherapy. Benzodiazepines like lorazepam reduce anticipatory nausea and vomiting. Other therapies with benefit in chemotherapy-induced emesis include cannabinoids, olanzapine, gabapentin, and alternative therapies like ginger. Most antiemetic regimens produce greater reductions in chemotherapy-induced vomiting than nausea.

Clinicians should exercise caution in managing nausea of pregnancy. Studies of the teratogenic effects of antiemetic agents provide conflicting results. Antihistamines like meclizine and doxylamine, antidopaminergics like prochlorperazine, and antiserotonergics like ondansetron demonstrate limited efficacy. Some obstetricians recommend alternative therapies including pyridoxine, acupressure, or ginger.

Managing CVS and CHS is challenging. Prophylaxis with tricyclic antidepressants or anticonvulsants (topiramate, zonisamide, levetiracetam) reduces the severity and frequency of CVS attacks in uncontrolled reports. Combining intravenous 5-HT_3 antagonists with the sedating effects of a benzodiazepine like lorazepam are mainstays for aborting acute flares. Small studies report benefits with aprepitant and injectable or intranasal forms of the 5-HT_1 agonist sumatriptan to manage acute CVS episodes. These treatments are reportedly less effective for CHS, but haloperidol and topical capsaicin cream may reduce acute CHS attacks.

INDIGESTION