MANAGEMENT OF PAEDIATRIC POSTOPERATIVE NAUSEA AND VOMITING (PONV)

Nausea and vomiting are often multifactorial in origin. Contributing factors include: -

- **surgery (especially intra-abdominal, eyes, ENT, dental)**
- **patient factors such as history of motion sickness, dehydration, prolonged fast, anxiety**
- **opioid administration (including PCA morphine), N2O**
- **gastric stasis, atony, ileus delayed return to enteral nutrition**
- **pain**
- **hypotension, hypoxia, hypercapnea, hypoglycaemia**

Management

1. Consider ceasing oral intake and commencing IV fluids (to rehydrate and prevent hypoglycaemia).

2. Consider reducing or stopping opioid administration but **ENSURE THAT** alternative analgesia is available and satisfactory.

3. Treat anxiety (consider a benzodiazepine if necessary. NB. This will increase any opioid-induced tendency to respiratory depression– therefore **MONITOR APPROPRIATELY**).

4. Administer an antiemetic PR, IV or orally.

- **An antiemetic prescription should accompany any opioid prescription, including Oramorph.**

- **ondansetron** **0.1mg/kg slow IV/PO*** (max. 4mg) **12 hourly**
- **cyclizine** **1mg/kg IV** (over 5 mins)**/PO** (max. 50mg) **8 hourly**
- **prochlorperazine** **1-11yrs if >10kg, 250micrograms/kg PO**
  12-17yrs: 5-10mg PO **8 hourly**
- **metoclopramide** **0.1mg/kg IV** (over at least 3 mins) **8 hourly**
  (contraindicated under 1 year and second-line only)

* consider *orodispersible ondansetron* 4mg

All except ondansetron may rarely cause dystonic reactions such as an oculogyric crisis. This is usually associated with high and repeated doses that are seldom, if ever, required to treat postoperative nausea and vomiting.