The Evolution of Supportive Therapy of Emesis

It is axiomatic that state-of-the-art antineoplastic therapy calls for a multi-pronged strategy with an emphasis on integrating complementary and, hopefully, synergistic modalities. With the advent of more-precise molecular and genetic typing and the identification of responsive and resistant subgroups, this therapy is also becoming more customized; one size no longer fits all. The net result of this heterogeneous approach is a greater burden on the oncologist caregiver. The field has progressed far beyond the cookbook stage, when once we knew the tumor type, the treatment choice flowed somewhat automatically.

What is not so readily apparent, however, is that this complexity of management decisions also extends to the use of supportive care agents. In the not too distant past, the practicing oncologist had only a limited repertoire of interventions to manage such incapacitating and even limiting events as intractable chemotherapy-induced vomiting, but today a much broader array of interventions is available. This array of treatment options, in turn, has led to the increasing need to characterize the clinical aspects of the syndromes, to apply individualized treatments.

The science of emesis continues to evolve. Introduction of the 5-HT3 receptor inhibitors were a significant advance in managing the acute vomiting that follows closely after the administration of highly emetogenic agents, but control was certainly not complete. Two articles in this issue address the further refinements in the management of post-chemotherapy vomiting. Stoutenberg and Raftopoulos review the physiology and clinical effectiveness of a new class of antiemetic agents, the NK1 receptor antagonists, as exemplified by aprepitant. What makes this agent an important contributor in this supportive care scenario is not only that it adds to the acute control of vomiting, but that it also provides a new modality for the management of hitherto difficult-to-treat delayed vomiting. The compartmentalization of emesis into distinct clinical and pathophysiologic phases attests to the increasing sophistication in how these syndromes are managed.

The article by Roscoe et al. extends the field even further. What may be a conceptual surprise to some oncologists is that emesis and nausea may have different underlying physiologic triggers; they are not just differences in severity along the nausea-vomiting continuum. Specifically, nausea is viewed as a multidimensional experience that can be associated with a variety of causes. It follows, therefore, that curtailing emesis and nausea may require a different spectrum of approaches. As this review shows, there appears to be an evolving body of evidence that biobehavioral interventions may be the key to managing the nausea component of post-chemotherapy morbidity.

As these editorial pages seem to continuously point out: if one word must be applied to the practice of oncology, it should be dynamic. The management of emesis stands as a dramatic example.