Birmingham Children's Hospital NHS
NHS Foundation Trust

GUIDELINE FOR THE MANAGEMENT OF CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING.

Version:	1.0.0
Ratified by:	Drug & Therapeutics Committee
Date ratified:	21-09-2010
Name of originator/author:	Nigel Ballantine
Name of responsible committee/individual:	Chemotherapy Working Group (CWG)
Date issued:	27-09-2010
Review date:	Document to be reviewed not less than every two years – first review due September, 2012
Target audience:	Medical, nursing and pharmacy staff within the Haematology Oncology Specialty

Contents

Paragraph **Page**

1 Introduction

This guideline has been developed in order to ensure that the prophylaxis and treatment of chemotherapy-induced nausea and vomiting is provided in a manner which aims to take account of the emetogenic stimulus provided by the chemotherapy and the known actions of the individual anti-emetic drugs.

2 Purpose

This guideline aims to provide a logically consistent framework within which prescribing will be done, and other support to the patient provided.

It also addresses the issue of costs. Whilst Ondansetron is now off-patent and available as a generic preparation, expenditure on 5-HT_3 blockers is still considerable and requires appropriate management.

3 Duties

3.1 Duties within the Organisation

The lead officer for this document is identified on the title page.

3.2 Identification of Stakeholders

The following stakeholders have been identified within BCH: The Chemotherapy Working Group (CWG); the Cancer Locality Group; the Haematology Oncology Programme meeting; nursing and support staff within the Haematology Oncology specialty.

Outside BCH: The West Midlands Children's Cancer Network Group; Pan Birmingham Cancer Network Drug & Therapeutics Committee.

4 Method for development

4.1 Consultation and Communication with Stakeholders

The policy was drafted by Nigel Ballantine (Chair, CWG) and reviewed by the stakeholders previously identified. Comments and suggestions were incorporated until a final version was agreed by the CWG and ratified by the Head of Chemotherapy (HoC) and Lead Cancer Clinician (LCC).

5 Content

5.1 Background

No single agent, or combination of drugs, will totally abolish chemotherapy-induced nausea and vomiting in all patients.

All children should receive anti-emetic therapy which, as far as can be predicted, is appropriate to the emetic potential of the prescribed chemotherapy and their previous experience of receiving chemotherapy.

It is recognised that control of nausea and vomiting declines during a multi-day treatment block, despite appropriate and effective anti-emetic treatment on Day 1. Once control of nausea and vomiting is reduced or lost it is highly unlikely that additional interventions will be successful in regaining control within an individual treatment block.

Anticipatory nausea and vomiting may adversely affect the efficacy of anti-emetic treatment given with chemotherapy, perhaps because the anti-emetic treatment itself provides a further anticipatory stimulus. Adolescent patients, in particular, may benefit from pre-medication with benzodiazepines, e.g. lorazepam, to reduce the anticipatory aspect of their nausea and vomiting and maximise the efficacy of anti-emetic treatment.

Adding further drugs to anti-emetic regimes which are appropriate to the emetogenicity (potential to produce nausea and vomiting) of the chemotherapy being administered is unlikely to provide more than marginal additional benefit.

Other modes of treatment, such as play therapy, should not be overlooked.

Treatment failure:

Treatment is considered to have failed if:

- The patient vomits twice in an eight hour period.
- The patient experiences nausea which is prolonged, continuous and interferes with or prevents normal activities.

Policy:

It should be recognised by all those treating patients receiving cytotoxic chemotherapy that effective anti-emetic treatment is available.

However, it must also be understood, and older patients and parents counselled in this regard, that no anti-emetic regime can be relied upon to abolish nausea and vomiting completely.

Anti-emetic treatment appropriate to the emetogenicity of the chemotherapy is set out in the table which follows (see Standard Anti-emetic Regimes for Haematology Oncology). Ranking of the emetogenicity of drug treatment,

however, is based on single agent treatment. The emetogenic potential of the whole treatment block should be assessed, along with the response of the individual patient, and anti-emetic treatment prescribed accordingly.

The anti-emetic regime should only be escalated when treatment on the existing regime has failed according to the criteria defined above in para. 3.

No patient should receive more than three anti-emetic drugs concurrently except in exceptional circumstances.

5-HT_3 blockers should be given to cover the acute emetic stimulus of chemotherapy administration ONLY. Whilst it is well recognised that nausea, in particular, continues after chemotherapy has finished, there is good evidence that 5-HT_3 blockers are less effective against delayed nausea and vomiting than against the acute stimulus of chemotherapy administration.

For delayed nausea, dopamine antagonists, e.g. metoclopramide and domperidone, are more effective, with or without concurrent dexamethasone. **A 5-HT_3 blocker should only be given for delayed or continuous nausea and vomiting if these drugs have failed to provide relief by the criteria in para. 3 above.**

Anticipatory nausea and vomiting, and its effect on subsequent control during chemotherapy treatment, may be helped by the administration of lorazepam or other anxiolytic treatment for 48 hours prior to a treatment block, particularly in adolescent patients.

Distraction and play therapy should not be ignored in the management of nausea and vomiting in patients receiving chemotherapy.

Administration of Ondansetron:

On Day 1 of any in-patient chemotherapy ondansetron should be administered intravenously.

On Day 2, and any subsequent days of a single treatment block, ondansetron should be administered orally as tablets, Melt® tablets, or syrup according to the child's preference. Ondansetron should **not** be continued beyond the last day of chemotherapy administration.

Out-patients and day-case patients should receive a single dose of ondansetron parenterally prior to treatment, and subsequent doses orally, as above.

Ondansetron should **not** be provided to take home UNLESS the patient is returning on consecutive days to receive chemotherapy. As for in-patients, it should not be provided after the last day of chemotherapy administration.

Only those patients for whom parenteral treatment is the preferred option on the following **clinical** grounds should continue to receive intravenous ondansetron:

- The child vomits back oral medicines.
- Sore mouth and/or unable to swallow

It should be noted that ondansetron and granisetron may cause **constipation**, as may levomepromazine. Patients and parents should be questioned about bowel habit, and encouraged to push oral fluids. Lactulose or another suitable laxative should be considered as necessary.

Note on the administration of Ondansetron Melt® tablets:
These tablets are formulated to melt rapidly when placed on or under the tongue. This takes literally only a couple of seconds**. However, it is important to understand that the small volume of liquid which results must be swallowed for the Ondansetron to be absorbed.** It is **not** absorbed from the buccal cavity.

Normally the melted tablets are quite palatable, having a strawberry taste and leaving a slight bitter taste in the mouth, **but** patients may not have normal taste sensation in consequence of their chemotherapy.

Melt tablets are available in 4mg. and 8mg. strengths and may be halved in a tablet cutter, although they will start to melt if handled for other than a short period of time.

Drugs available:

For drug doses please refer to Appendix III

Dexamethasone:

Mechanism of action: Corticosteroid with predominantly glucocorticoid (anti-inflammatory) effects.

Notes on use:

- An effective anti-emetic most commonly combined with other specific therapy, e.g. 5-HT_3 or D_2 receptor antagonists.
- Particularly helpful in the treatment of delayed nausea and vomiting.

Dexamethasone should be given for a maximum of FIVE days whilst chemotherapy is being administered. It should only be started with the dose of anti-emetic immediately preceding the start of chemotherapy, and should be stopped within 24 hours of the completion of chemotherapy.

It should not be given to patients:

- *Concurrently receiving high-dose steroid therapy as part of their chemotherapy, or for other reasons,*
- *Receiving BMT, from the start of conditioning until at least two weeks post transplant.*
- *With brain tumours unless it has been demonstrated that their nausea and vomiting cannot be controlled using alternative treatment.*

Domperidone:

Mechanism of action: Antagonist of central dopamine (D_2) receptors.

Notes on use:

- Effective anti-emetic although its usefulness is limited by the lack of an injectable preparation.
- Effective for delayed nausea and vomiting.

Levomepromazine (previously known as methotrimeprazine):

Mechanism of action: A phenothiazine with effects at dopamine (D_2), histamine (H_1), muscarinic and 5-HT_2 receptors.

Notes on use:

- An effective anti-emetic, particularly by the parenteral route.
- Sedation is commonly significant
- Patients receiving ifosfamide should be carefully monitored since sedation may mask signs of encephalopathy.

Lorazepam:

Mechanism of action: A benzodiazepine anxiolytic.

Notes on use:

- Has minimal anti-emetic properties, but is considered useful for its amnesic and anxiolytic properties.
- Administration during chemotherapy may attenuate the memory of an unpleasant experience and administration immediately prior to a block of treatment (1-3 days) may be beneficial in reducing the anticipatory aspect of nausea and vomiting.

Metoclopramide:

Mechanism of action: Antagonist of central dopamine (D_2) receptors and, probably, 5-HT_3 receptors in the G.I. tract.

Notes on use:
- Effective anti-emetic. May be given in low-dose and high-dose regimes, the latter requiring concurrent administration of Promethazine to avoid extrapyramidal effects.
- Useful for delayed nausea and vomiting.
- Extrapyramidal reactions may be treated with procyclidine

Nabilone:

Mechanism of action: A cannabinoid drug with central actions at the level of the cerebral cortex.

Notes on use:
- Use is limited by the non-availability of formulations other than a capsule.
- Evidence suggests that the effect on vomiting may be greater than that on nausea.
- May be helpful in managing intractable vomiting and nausea uncontrolled by other treatment, but many patients find the adverse effects on mood and behaviour unacceptable.

Ondansetron:

Mechanism of action: 5-HT_3 (serotonin) antagonist.

Notes on use:
- This group of drugs have become the gold standard in the treatment of chemotherapy-induced nausea and vomiting.
- They are expensive and are not needed if patients are receiving only weakly emetic treatment.
- They are less effective against delayed nausea and vomiting, for which metoclopramide or domperidone are preferred.

Granisetron:

Mechanism of action: 5-HT_3 (serotonin) antagonist.

Notes on use:
- As for ondansetron, but needs to be given only twice a day.
- At the present time there is little local experience of its use, and place in treatment.

Cyclizine:

Mechanism of action: Antihistamine (H_1 receptors) with anti-muscarinic properties.

Notes on use:

- This drug **SHOULD NOT** be used for the treatment of chemotherapy-induced nausea and vomiting.
- Whilst it has been shown to be effective for nausea and vomiting with a labyrinthine origin, and is considered effective against opiate-induced nausea and vomiting, there is **NO** evidence in the literature that it is effective against chemotherapy-induced nausea and vomiting.
- The effects of cyclizine (antimuscarinic) and metoclopramide/domperidone (prokinetic) are also antagonistic which is a further argument against their concurrent use.

6 References

7 Equality Impact Assessment

See Appendix F

8 Approval, Dissemination and Implementation

8.1 Approval of document

This document has been approved by the CWG and ratified by the HoC and LCC.

8.2 Dissemination

A paper copy will be placed in the policy files within the Haematology Oncology Specialty.

Electronic copies will be provided via the Trust Intranet in the Oncology department and Trust policies folders.

8.3 Implementation

The policy is currently in use within the Haematology Specialty. This document brings the policy into Trust-approved format.

9 Monitoring Compliance With and the Effectiveness of the policy

9.1 Process for Monitoring Compliance and Effectiveness

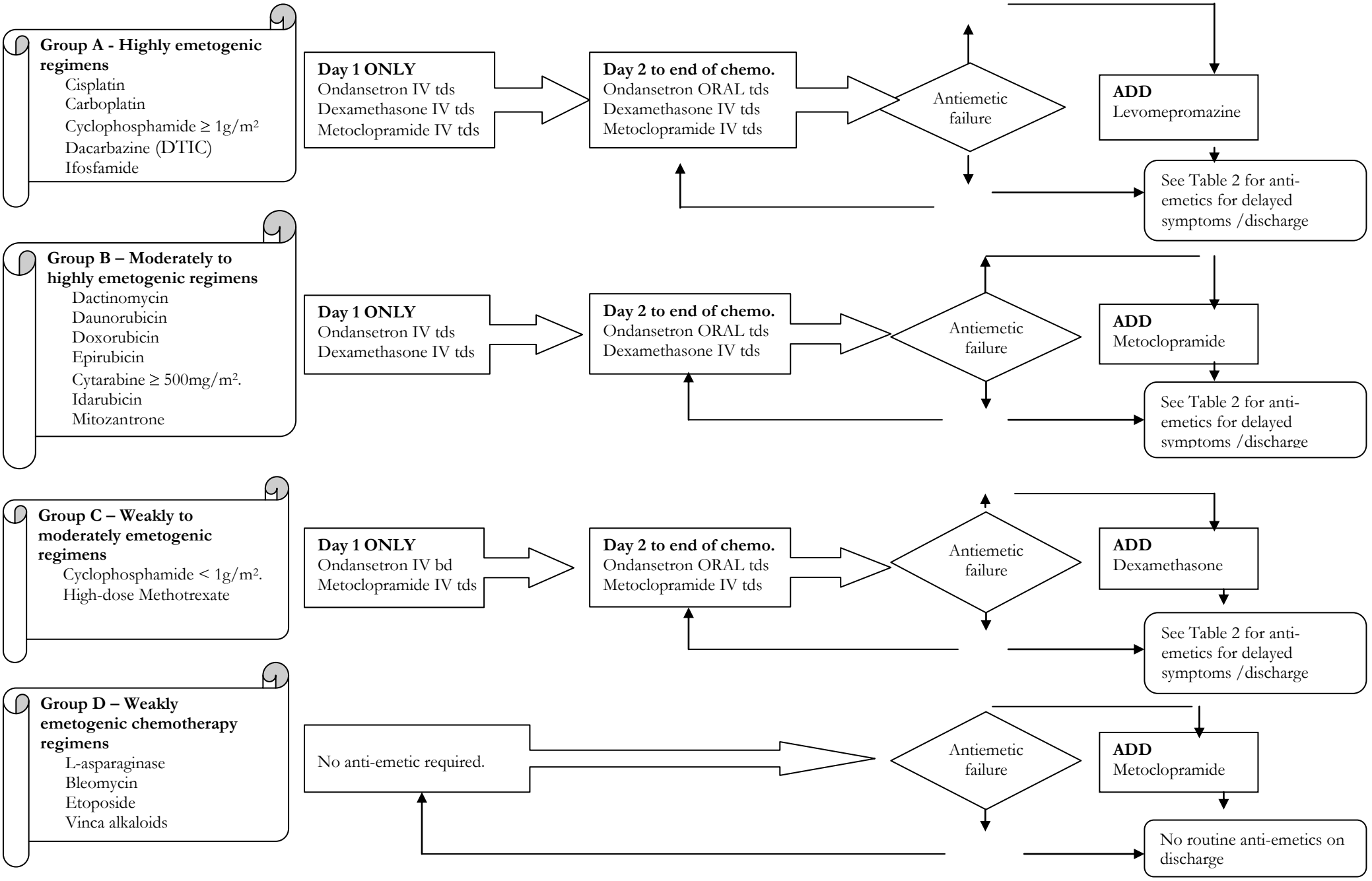
Routine audit of clinical areas.

9.2 Standards/Key Performance Indicators

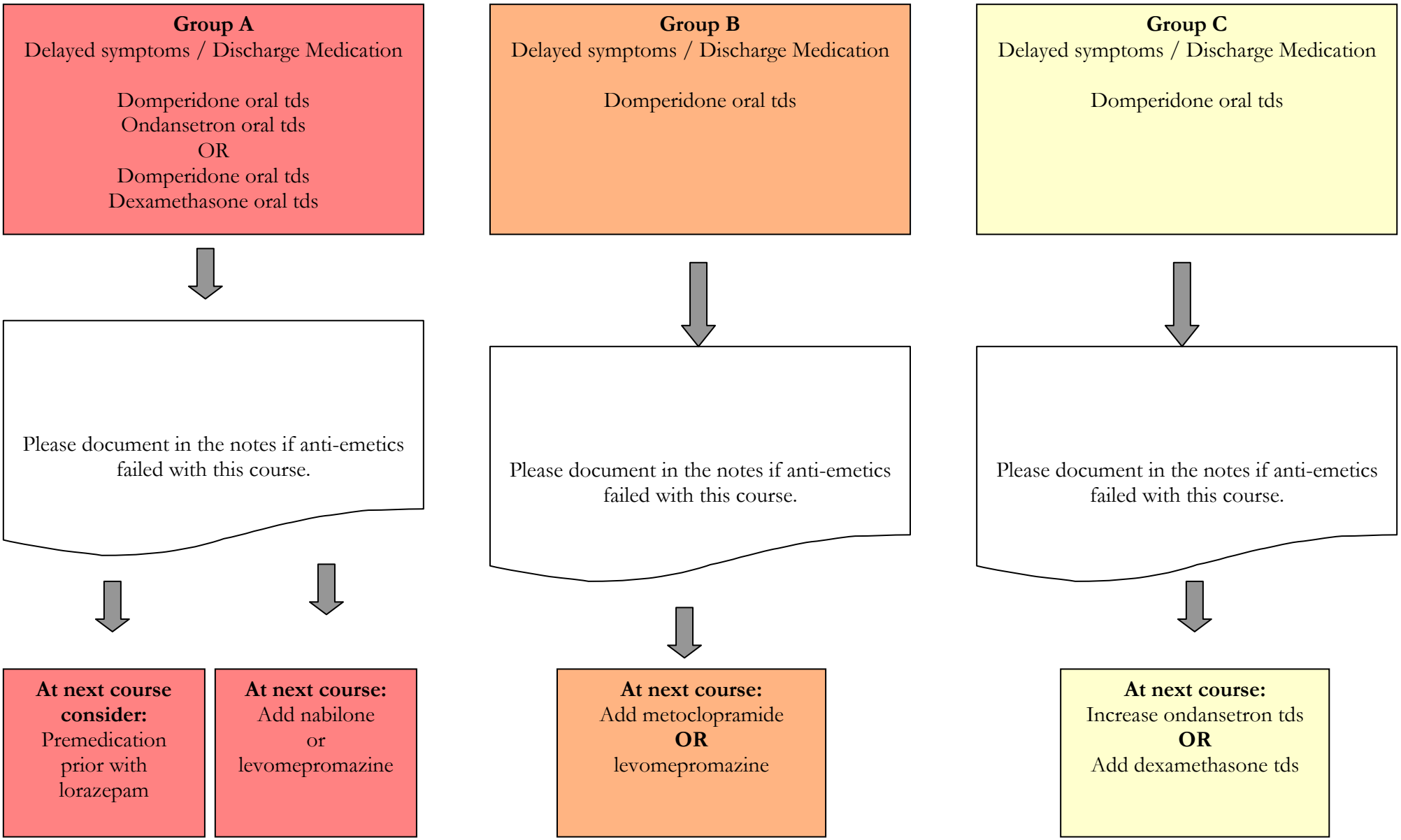
10 Associated Documentation

None

Appendix I: Summary of anti-emetic prescribing (in normal renal / hepatic function):



Appendix II: Treatment of delayed nausea and vomiting – discharge medication



Appendix III - ONCOLOGY HAEMATOLOGY ANTI-EMETIC POLICY – DRUG DOSES

FIRST LINE ANTI-EMETICS

DRUG Indication	Route	Times per day	DOSE N.B. Suggested dose is an individual dose unless otherwise stated. 0 - 4 weeks	4 weeks to 2 years	2 – 12 years	12 years and over	Availability	Comments	Dose ref
DEXAMETHASONE Supplementary antiemetic	I.V.	2 – 3, with ondansetron or granisetron	<= 15kg: 1mg. 16 – 25kg: 2mg. 26 – 35kg: 3mg. 36 – 45kg: 4mg. 46 – 55kg: 5mg. > 55kg: 6mg.				Injection: 4mg. in 1ml.	*Given for a maximum of FIVE days. Start with the dose of antiemetic given immediately before chemotherapy starts, and stop within 24 hours of completion of chemotherapy. Care in patients receiving concurrent steroid therapy (chemotherapy, or other reasons).* ***Consult prior to use in patients with brain tumours or receiving conditioning for BMT***	1
DOMPERIDONE Antiemetic	Oral	3 - 6		0.2 - 0.4mg/kg.		10 - 20mg.	Tablets: 10mg. Suspension (SF): 5mg. in 5ml.		3
LORAZEPAM Anxiolytic	Oral	1 - 2				1 - 2mg.	Tablets: 1mg, 2.5mg.		3
METOCLOPRAMIDE Antiemetic to supplement 5-HT_3 blocker	Oral I.V.	3 - 4			0.2mg/kg. Round dose to nearest 1mg.		Tablets: 10mg. Liquid: 5mg. in 5ml. Injection: 10mg. in 1ml.	Dystonic reactions more likely when daily dose exceeds 500 microgram/kg. Antidote: Procyclidine	1
ONDANSETRON Antiemetic	Oral I.V.	2 - 3		1 - 2mg.	2 - 4mg.	4 - 8mg.	Tablet: 4mg, 8mg. Melt® tablet: 4mg, 8mg. Syrup: 4mg. in 5ml. Injection: 2mg. in 1ml.	Twice daily dosing may be adequate to cover moderately emetogenic chemotherapy.	1

Appendix IV: SECOND-LINE ANTIEMETICS

DRUG Indication	Route	Times per day	DOSE N.B. Suggested dose is an individual dose unless otherwise stated. 0 - 4 weeks	4 weeks to 2 years	2 - 12 years	12 years and over	Availability	Comments	Dose ref
DOMPERIDONE Antiemetic	Rectal	Single dose			15 - 30mg.	30 - 60mg.	Suppositories: 30mg.	Usefulness likely to be minimal. Included for the sake of completeness.	3
LEVOMEPROMAZINE (METHOTRIMEPRAZINE) **(NOZINAN)** Refractory nausea and vomiting	I.V.	Continuous			0.25 - 0.5mg/kg/24 hours		Tablet: 25mg. Injection: 25mg. in 1ml.	Maximum dose: 25mg/24 hours. *Carefully monitor patients receiving Ifosfamide since sedation may mask signs of emcephalopathy.*	RMH
Antiemetic	S.C.	1 or 2 **or**			0.1mg/kg/day **OR** 0.05mg/kg. twice a day.			For twice daily dosing may be infused over 30 minutes in Sodium Chloride 0.9%.	UCLH
Sedative and antiemetic		Continuous infusion			0.5 - 3mg/kg/day				5, 8.2
NABILONE Antiemetic	Capsule	2			< 18kg: 0.5mg. > 18kg: 1mg	1mg.	Capsules: 0.25mcg. (SP), 1mg.		3
		3			> 36kg: 1mg				
GRANISETRON Antiemetic	Oral	2	Not recommended			1 - 2mg.	Tablets: 1mg, 2mg. Injection: 1mg. in 1ml. 3mg. in 3ml.		
	I.V.			40microgram/kg. (Maximum dose: 3mg.)		3mg. Max: 3 doses in 24 hours.			

APPENDIX V: STANDARD ANTI-EMETIC REGIMES FOR HAEMATOLOGY ONCOLOGY

Drug	Standard anti-emetic regime	Rescue therapy to be added to standard regime if required	Additional treatment if treatment failure with previous blocks.	Delayed symptoms / Discharge medication
Highly emetogenic drugs Cisplatin Carboplatin Cyclophosphamide >= 1g/m^2. Dacarbazine (DTIC) Ifosfamide High-dose Melphalan	Ondansetron, Dexamethasone[1] and Metoclopramide every EIGHT hours.	Levomepromazine	Nabilone or Levomepromazine	Domperidone ± Ondansetron or Dexamethasone. Lorazepam prior to next block
Moderate to highly emetogenic drugs Dactinomycin Daunorubicin Doxorubicin Epirubicin High-dose Cytarabine > 500mg/m^2. Idarubicin Mitozantrone	Ondansetron and Dexamethasone every EIGHT hours.	Metoclopramide	Metoclopramide or Levomepromazine	Domperidone
Weakly to moderately emetogenic drugs Cyclophosphamide < 1g/m^2. High-dose Methotrexate ChlVPP	Ondansetron every TWELVE hours and Metoclopramide every EIGHT hours	Dexamethasone	Increase Ondansetron to three times a day **OR** Ondansetron twice daily plus Dexamethasone	Domperidone
Weakly emetogenic drugs Asparaginase Bleomycin Etoposide Vinblastine Vincristine	No antiemetic required.	Metoclopramide	Metoclopramide	None

Notes: 1. Consult before using in patients with brain tumours or receiving conditioning for BMT

APPENDIX VI

CHANGE IN PRACTICE REGARDING ANTI-SICKNESS MEDICINES

Dear Parent or Carer,

This is to let you know that we are changing our practice with regard to the prescribing of anti-sickness medicines for the nausea and vomiting which is brought on by the giving of chemotherapy (at this time we are not making any changes to our practice if the nausea and vomiting have causes other than chemotherapy, although we may do so in future).

As I am sure you will understand, new information often becomes available about all aspects of the treatments your child is receiving, and we always try to ensure that our practice is as up-to-date as possible. This is the reason why we are making some changes now.

Whilst drugs such as ondansetron are very effective for treating the sickness caused by chemotherapy, there is now evidence from clinical studies that they are most effective when a child is receiving chemotherapy, but less so once the chemotherapy itself is finished. The nausea and vomiting which may continue after the chemotherapy has finished is better treated with drugs such as metoclopramide and domperidone, two drugs which have very similar actions and effects.

It is for this reason that we are now recommending that ondansetron or granisetron are only given during the administration of chemotherapy, and further treatment, if required, is given as metoclopramide or domperidone.

We are also recommending that ondansetron or granisetron are given my mouth whenever possible. In-patients will receive these medicines intravenously on the first day of treatment because of the greater intensity of treatment, but after that will be given their treatment orally. Out-patients will be given ondansetron or granisetron by mouth. These drugs are just as effective when swallowed, and we have tablets, tablets which melt on the tongue or liquid so that we can give the anti-sickness medicine to your child in the way they prefer. If they are too sick to take the medicine by mouth it will, of course, be given into their line.

Please be reassured that these changes are being made because there is good evidence that they will result in the best possible treatment for your child. If you have any concerns about the contents of this letter, or other questions about your child's treatment, please do not hesitate to speak with members of the medical or nursing staff.

Nigel Ballantine,
Lead cancer pharmacist.
23-10-2009

Appendix D - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	No	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			

Appendix F - Equality Impact Assessment

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

EQUALITY IMPACT ASSESSMENT FORM

SECTION 1:

Department: Haematology Oncology	**Assessor: Nigel Ballantine**
Policy/ Service Title: Guideline for the management of chemotherapy-induced nausea and vomiting.	**Date of Assessment:** 10-5-2010

1. Describe the purpose of this policy or function	The Children's Cancer Measures 2009 requires the PTC (principal treatment centre) to have a range of policies in place to support the safe and effective delivery of chemotherapy from the perspective of patients, carers and staff. This policy has been in place for a number of years and is being brought to Trust standard as part of the peer view process for cancer services.
2. Who is affected by this policy?	Medical, nursing and pharmacy staff within the Haematology Oncology specialty at BCH.
3. What are the outcomes or intended outcomes of this policy/ function?	This policy will ensure that staff caring for patients with chemotherapy-induced nausea and/or vomiting have available a clinical guideline for effectively managing such patients. Secondarily, compliance with Children's Cancer Measures 2009.
4. What consultation has been undertaken during the development of this policy/function?	Stakeholders identified in the policy
5. What information or evidence has been used to assess the potential impact across the equality strands?	This policy will have no implications with respect to Equality Impact

IMPACT		
1. What is the impact or likely impact, either positive or negative, of the initiative on individuals, staff, or the public at large? None		
2. Please complete the following list and identify if there is, or likely to be, an impact on a group		
a) Grounds of race, ethnicity, colour, nationality or national origins.	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
b) Grounds of sexuality or marital status	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
c) Grounds of gender	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
d) Grounds of religion or belief	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
e) Grounds of disability	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
f) Grounds of age	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
If you have stated that there is an adverse impact a Full Impact Assessment is Required. Complete Section 2.		

SECTION 2:

Modifications
1. If you stated that the policy/ function has or could have an adverse impact on any group, how could you modify it to reduce or eliminate any identified negative impacts?
2. If you make these modifications, would there be an impact on other groups, or on the ability of the policy to achieve its purpose?
Consultation **Under the Race Relations (Amendment) Act 2000 you are required to consult on the impact of new policies, functions and service change.**
3. How do you plan to consult on these modifications? Specify who would be involved, timescales and methods.

Decision Making
1. Who will make the decision?
2. What is the decision? ☐ Reject the policy/ function ☐ Introduce the policy/ function ☐ Amend the policy/ function ☐ Other (Please explain)

Monitoring and Review
1. How will the implementation of the policy/ function and its impact be monitored?
2. What are the overall learning points from this assessment?
3. What actions are recommended from this assessment?
4. When is the review date?

For advice in respect of answering the above questions, please contact the Equality and Diversity Officer on Ext: 8611. A completed form must be returned with your procedural document.

Appendix G - Version Control Sheet

Version	Date	Author	Comment (Identify any significant changes to the procedural document)

Appendix H - Plan for Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Guideline for the management of chemotherapy-induced nausea and vomiting.		
Date finalised:		**Dissemination lead: Print name and contact details:** Nigel Ballantine (NB)	BCH email Ext: 8673
Previous document already being used?	**Yes / ~~No~~** (Please delete as appropriate)		
If yes, in what format and where?	Paper copies in policy files in key clinical areas within the Specialty		
Proposed action to retrieve out-of-date copies of the document:	Review of all policy files		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
HaemOnc Policy files	NB	P/E	
Trust policies	NB	E	

Dissemination Record – to be used once document is approved.

Date put on register / library of procedural documents		**Date due to be reviewed**	

Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**