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Domperidone – What is your experience?

August – September 2014

Number of responses = 61

1) For which indications have you previously prescribed domperidone for regular long term use (i.e. for more than 1 week) in your palliative care patients? (many_of)

answer	*votes*	*% of voters*
Nausea and vomiting	54	89
Upper gastro-intestinal dysmotility (due to gastritis and diabetic gastroparesis)	48	79
Gastro-oesophageal reflux	23	38
Vomiting and hypotension associated with anti-parkinsonian drugs	17	28
None of the above	3	5
Other (please state in comments section below)	1	2

2) How many years have you been working in palliative care? (one_of)

answer	*votes*	*% of vote*
Less than 1 year	0	0%
Between 1 and 5 years	8	13%
Between 5 and 10 years	19	31%
Between 10 and 15 years	17	28%
More than 15 years	19	31%

3) As a consequence of the EMA/MHRA recommendations, will you be changing your prescribing practice in terms of the *indications* for which you will prescribe domperidone in palliative care patients? (yes_no)

answer	*votes*	*% of vote*
Yes	14	23%
No	48	79%

3a) If yes, please indicate how you will change your prescribing practice in terms of the *indications* you will use domperidone for. (freetext)

I will be less likely to prescribe in patients with cardiac problems
Less likely to use it for gastro-oesophageal reflux, more aware of patients comorbidity-heart disease and also co-prescribed drugs - are they CYP3A4 inhibitors?
I am using metoclopramide for all the above indications except if there are contra-indications. If patients are admitted on domperidone, I do not change it if they have been on it for some time and prognosis short (as in months rather than years)
If one of the specific contraindications apply I won't be prescribing this drug for them
Will consider other medications now for nausea & vomiting & upper gastro-intestinal dysmotility, specifically in patients greater than 70years & with cardiac co-morbidities
I will think more carefully before prescribing it for patients with problems around early satiety and gastric dysmotility related to malignancy
Will limit my prescribing of domperidone to those without cardiac dysfunction and will use for shorter periods of time in lower doses
No change to indications but will have to spend time counselling patients and relatives to inform of risks

Management of dysmotility in patients on opioids (selected cases)
Reduce to 10 mg b.d. and not exceed this
I will use more metoclopramide
More cautions

4) As a consequence of the EMA/MHRA recommendations, will you be changing your prescribing practice in terms of the *dose* that you will prescribe for domperidone in palliative care patients? (yes_no)

answer	*votes*	*% of vote*
Yes	26	43%
No	35	57%

4a) If yes, please indicate how you will change your prescribing practice in terms of the *dose* of domperidone you will use. (freetext)

10mg t.d.s. rather than 10mg q.d.s.
Start with lower dose
Consider a smaller dose of 10 t.d.s. much less likely to use 20mg q.d.s.
Stick to 10mg t.d.s. if possible
More proactive attempts to keep to the lowest dose that mitigates symptoms
Start at low dose and build up (usually start high and reduce)
I will titrate the dose more carefully
Be more cautious in escalating dose
Lower dosing
Will start with 10mg t.d.s. rather than prescribing 10-20mg t.d.s.
More likely to limit dose to recommended maximum i.e. 10mg t.d.s.
Will now start all patients on 10mg t.d.s., rather than 20mg t.d.s./q.d.s.
I will not prescribe above 10mg t.d.s.
Lower dosing
Respecting the EMA recommendations which apply also in France, I will prescribe a lower dose
On occasion, patients have required domperidone 20mg q.d.s. for symptom control for short-term periods. I will now potentially only prescribe 10mg t.d.s. as a maximum dose, with rotation to an alternative antiemetic if this is ineffective
More cautious of higher dose in long term use - likely to review more proactively
Previously used to use a maximum of 20mg q.d.s. now reduce to 10mg t.d.s.
Decreased maximum dose from q.d.s. to t.d.s.
I will limit it to 10mg t.d.s.
Be careful with doses
Will not use domperidone
More caution

5) As a consequence of the EMA/MHRA recommendations, will you be changing your prescribing practice in terms of the *duration of use* that you will prescribe for domperidone in palliative care patients? (yes_no)

answer	*votes*	*% of vote*
Yes	18	30%
No	41	67%

5a) If yes, please indicate how you will change your prescribing practice in terms of the *duration of use* of domperidone. (freetext)

GPs will be reluctant to continue prescribing so I may need to decrease the duration
Review earlier but if still indicated then continue
If used, then more careful to assess response and stop if not really effective
More discussion of small risks
Try to stop it if the problem resolves on the drug whereas in the past, I may have continued it once problem e.g. vomiting resolved
Instigate regular review for all who are taking domperidone long term, but if still needed and effective unlikely to stop using
More mindful of trying to stop once symptom control achieved
Review after 5 days
Try and use shorter courses
Trial of withdrawal considered
Shorter duration
Fewer risks in palliative care considering the palliative situation
Will be more cautious at reviewing effectiveness and extra pyramidal side effects and stopping
Duration of use indefinite
I will review it after 7 days and consider carefully alternatives
Will not use domperidone
More caution

6) As a consequence of the EMA/MHRA recommendations, will you be changing your prescribing practice in terms of *using domperidone in patients with underlying cardiac disease or severe hepatic impairment* in palliative care patients? (yes_no)

answer	*votes*	*% of vote*
Yes	31	51%
No	29	48%

6a) If yes, please indicate how you will change your prescribing practice in terms of *using domperidone in patients with underlying cardiac disease or severe hepatic impairment*. (freetext)

Might select another anti-emetic but will consider each case individually
Be more wary but if the most appropriate medication I will discuss the risks with the patient and involve them in the decision-making
Perform an ECG before prescribing
Much more aware of drugs which can increase the QT and the implication of liver disease
Weigh the benefits risks more carefully - but still prepared to use
More discussion of small risks
I will consider if a more suitable drug is available
Yes, but recognise limitation of options for a disabling symptom
More aware of considering risk/ benefits and involving patients in discussion
Will be more cautious
Will consider alternatives first
Will be more wary
Probably not use
A little more caution
Would take this into consideration, but would still prescribe if I felt the benefits had the potential to outweigh the risks.

Will avoid if possible & try alternative anti-emetics first
I will be more cautious about prescribing in patients with cardiac disease but it may still be appropriate although I will use the lowest dose and for the shortest time possible. I will probably avoid in patients with severe hepatic impairment
Not using in these patients
Not sure - depends on quality of life issues and how impaired this is due to vomiting / gastritis / oesophageal reflux
Consider other anti-emetics first, otherwise lowest dose that achieves desirable effect and review frequently to see if still required
I will continue to weight up risk vs benefit
More caution when prescribing to patients with underlying cardiac disease, careful consideration of other drugs that may prolong QTc
I would be very unlikely to initiate domperidone. However, for patients already taking it, I am more likely to review and stop it if they have cardiac disease or liver failure
Control of ECG
Will not be using domperidone
More caution

11) Further comments. (freetext)

Need to ensure that other medications do not increase the risks further
Biggest impact is persuading primary care colleagues that it is okay to use domperidone. This is another situation where a patient needs to give informed consent to beyond label use
I already take these things into consideration and if on balance the least harm lies with the prescribing then I will do so.
I hardly ever use domperidone
I will continue to take account of the issues associated with domperidone as I do with all the medications I prescribe. I will be mindful of the new guidance and will inform patients so they if look it up they will already be informed and not anxious
I have good experience with domperidone and have never had any problems prescribing the lowest possible doses