# Modified Delphi Panel Consensus Guidance and Essential Strategies on the Prevention and Management of Nausea and Vomiting in Patients Treated With Zolbetuximab + Chemotherapy[5]

- An international RAND/UCLA modified Delphi panel included 15 clinicians
  - Panelists[a] were selected based on their experience in the zolbetuximab clinical trials

## Prior to and During First Infusion

Antiulcer medications (e.g., PPIs or $H_2$ blockers) or antacids are recommended for patients with dyspepsia who have not had a prior total gastrectomy. Administer PPIs or H2 blockers for a few days to 1 week prior to zolbetuximab treatment for maximal mucosal protection.

### Prophylaxis prior to first infusion

Provide one of the following National Comprehensive Cancer Network® (NCCN®)-recommended high-risk antiemetic drug regimens[7] (oral/IV antiemetics may be appropriate based on individual patient circumstances)

- NK-1 receptor antagonist + 5-HT3 receptor antagonist + dexamethasone + olanzapine
- or
- NK-1 receptor antagonist + 5-HT3 receptor antagonist + dexamethasone
- or
- 5-HT3 receptor antagonist + dexamethasone + olanzapine

### During first infusion, if the patient is experiencing

**Nausea alone**

Consider either making no modifications, or **stopping the infusion for 30-60 mins** and **restarting it at the same rate** as that prior to stoppage if symptoms improve

and

After the first hour (at an infusion rate of 200-265 mg/m²/hr), consider slowing the infusion rate without stopping it (Please see for additional information)

**Any vomiting (Please see ⓘ for additional information)**

Consider adding antiemetic treatment (e.g., rescue medications)[b]

**Stop the infusion for 30-60 mins** and restart it at a slower rate if symptoms improve (Please see for additional information)

**KEY**

- Zolbetuximab infusion rate
- Patient symptoms
- Antiemetic regimens

**Note:** If infusion was running at the PI rate, **slow the rate by 50%; if the infusion rate had already been slowed to 50%, slow by an additional 50% (i.e., 25% of the initial rate)**

**Note:** For vomiting, IV hydration may be appropriate depending on individual patient circumstances

## Second and Subsequent Infusions

- Adjust based on the patient's symptoms during previous infusions
- Begin infusions at the rate that was best tolerated during previous infusion
- The degree of nausea and vomiting is expected to diminish. In these cases, patients may tolerate titration of the infusion rate **by increments of 25% (e.g., if the infusion rate was slowed to 50% and the patient remained asymptomatic for 30-60 mins, consider increasing the rate to 75%) back to 100% or maximum tolerated rate**. Monitor the patient for recurrence of symptoms, and administer antiemetic medications as needed to manage symptoms

### Continuation of treatment

#### When planning for second or subsequent infusions, if the patient in previous infusion experienced

**Nausea alone or one episode of vomiting (Please see ⓘ for additional information)**

Rate recommended in PI

and

Make no changes or escalate the antiemetic regimen from previous infusion

**Repeated vomiting (Please see ⓘ for additional information)**

Slower than the recommended rate in PI (Please see for additional information)

and

Escalate the antiemetic regimen from previous infusion

#### During second and subsequent infusions, if patient is experiencing

**Nausea alone**

Make no modifications

**Any vomiting (Please see ⓘ for additional information)**

**Stop the infusion for 30-60 mins** and restart it at a slower rate if symptoms improve (Please see for additional information)

### Points to Note

- Consider administering antiemetics not used for prophylaxis in patients experiencing nausea and vomiting during the infusion
- Consider a scopolamine patch for refractory nausea or vomiting where premedication options have been escalated
- **Clinicians should avoid zolbetuximab discontinuation and retain flexibility for individual patient management**

[a]Experts from the US, Europe, Japan, and South Korea reviewed 382 scenarios, reaching an agreement in 85% (n=324). [b]Lorazepam, olanzapine, or metoclopramide.

**5-HT3 RA,** 5-hydroxytryptamine (serotonin) receptor subtype 3 antagonist; **AE,** adverse event; **C,** cycle; **D,** day; **Hrs,** hours; **H2,** histamine subtype H2 receptor; **HCP,** healthcare provider; **IRR,** infusion-related reaction; **IV,** ntravenous; **mFOLFOX6,** modified folinic acid, fluorouracil, and oxaliplatin regimen; **NCI-CTCAE v5.0,** National Cancer Institute Common Terminology Criteria for Adverse Events Version 5.0; **NK-1 RA,** neurokinin subtype 1 receptor antagonist; **OS,** overall survival; **PFS,** progression-free survival; **PI,** prescribing information; **PPI,** proton pump inhibitor; **RAND/UCLA,** RAND Corporation/University of California, Los Angeles; **TEAE,** treatment-emergent adverse event; **US,** United States.

**1.** Zolbetuximab placeholder reference for SmPC. **2.** Shitara K, et al. ASCO GI 2024. Abstract #372. **3.** Shitara K, et al. Lancet. 2023;401(10389):1655-1668. **4.** Shah MA, et al. Nat Med. 2023;29(8):2133-2141. **5.** KlempnerSJ, et al. ESMO Gastrointest Oncol 2025; 7: 100131. **6.** Common Terminology Criteria for Adverse Events (CTCAE) Version 5.0. Accessed January 20, 2025. **7.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Antiemesis V.2.2025. 