



Emetic risk classification and evaluation of the emetogenicity of antineoplastic agents—updated MASCC/ESMO consensus recommendation

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Abstract

Purpose Our goal was to identify new anticancer agents approved by the US Food and Drug Administration (FDA) and the European Medical Agency (EMA) since the 2016 MASCC/ESMO antiemetic update and classify their emetic potential.

Methods The MASCC/ESMO Expert Panel classified the emetogenicity of the identified new antineoplastic agents based on nonsystematic reviews of randomized controlled trials, analysis of product labeling, and evaluation of emetic classification in other international guidelines and informal consensus. The emetogenic classification system for oral anticancer agents was revised into two emetic risk categories (minimal–low; moderate–high) to be consistent with the system reported by ASCO (American Society of Clinical Oncology) in their 2017 guideline update. The previously employed four emetic risk classification categories for intravenously administered antineoplastic agents were retained for this update.

Results From June 2015 to January 2023, 107 new antineoplastic agents (44 intravenously administered and 63 orally administered agents) were identified. The reported incidence of vomiting varied significantly across studies for many agents, especially for oral anticancer agents.

Conclusion The MASCC/ESMO Expert Panel acknowledges the limitations of our efforts to classify the emetic potential of anticancer agents, especially the imprecision associated with oral agents. However, we have attempted to provide a reasonable approximation of the emetic risk associated with new antineoplastic agents by searching the available literature and reviewing other available international antiemetic guidelines.

Keywords Emetogenicity · Nausea · Vomiting · Risk classification · Antineoplastic agents

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Introduction

In 1997, an emetogenic classification schema for anticancer agents was introduced and has formed the basis for subsequent antiemetic prophylaxis recommendations by guideline panels [4, 6]. Since the 2004 Perugia Antiemetic Consensus Conference, chemotherapy agents were divided into four categories based on the risk of emesis in the absence of antiemetic prophylaxis (Table 1) [9, 10]. Of note, nausea was not incorporated into this schema. Many new antineoplastic agents have been introduced since the last MASCC/ESMO antiemetic guideline update in 2016 [7, 11].

It remains a challenge to accurately define the emetic risk associated with antineoplastic agents [3, 8]. The data on emesis in various trials of anticancer agents are usually highly heterogenous (different tumor types, advanced versus non-advanced disease, systemic treatment naïve or previously treated, used alone or in combination with other agents, different antiemetic prophylaxis if given or not reported, different reporting system, e.g., CTCAE (Common Terminology Criteria of Adverse Events) all grades versus only grade 3/4). Oral anticancer agents provide additional challenges. Most oral agents tend to be used in extended regimens of daily use rather than the single bolus administration schedule commonly employed with intravenous agents. As these agents are typically administered continuously over protracted periods, traditional concepts of acute and delayed nausea and vomiting lose their relevance in these settings.

In the current update, the following questions related to antineoplastic agent emetogenicity were addressed:

1. Identify new antineoplastic agents approved by the FDA and/or EMA since the last update (time frame: June 2015 to January 2023).
2. Characterize the emetic potential of new intravenously administered antineoplastic agents and place them at an appropriate level in the four-level classification schema.
3. Modify the original four-level classification system for oral agents to a two-level system (minimal to low and moderate to high) [5] and place both prior and new oral antineoplastic agents into the appropriate level.

Methods

As the initial step, new antineoplastic agents approved by the FDA and/or EMA since the last update from June 2015 to January 2023 (data cut off) were identified by two independent reviewers. The data source was the FDA summary (<https://www.fda.gov/drugs/development-approval-process-drugs/new-drugs-fda-cders-new-molecular-entities-and-new-therapeutic-biological-products>) and the EMA summary (https://www.ema.europa.eu/en/medicines/field_ema_web_categories%253Aname_field/Human/search_api_aggregation_ema_therapeutic_area_name/Cancer/field_ema_public_date/%5B2022-05-31T22%3A00%3A00Z%20TO%202023-01-20T22%3A59%3A59Z%5D?sort=field_ema_computed_date_field&order=desc).

Next, information on the incidence of vomiting was obtained by (1) a nonsystematic review of randomized controlled trials, (2) a review of information available in the summary of product characteristics, and (3) through informal consensus of the panel members. In addition, a detailed comparison of emesis classification schemas in the updated ASCO and NCCN antiemetic guidelines was conducted. In cases where data was inconclusive, the corresponding pivotal key phase II/III studies of the respective antineoplastic agent were reviewed. If clinical studies of an antineoplastic agent showed broad differences in the incidence of vomiting, results of the “worst outcome” were selected.

The intravenous anticancer agents were classified as being at minimal, low, moderate, or high emetic risk in accordance with the summarized vomiting rates.

Oral anticancer agents were placed into one of two emetic categories, minimal–low risk and moderate–high risk (Table 2). Of note, the emetic risk classification only refers to adult patients.

Results

Within the defined time frame, 107 new antineoplastic agents were identified. The reported incidence of vomiting varied considerably across studies, especially for oral anticancer agents. The emetic potential of the oral anticancer

Table 1 MASCC/ESMO emetic risk groups 2016*

Intravenous agents	Emetic risk	Oral agents	Emetic risk
High	Risk in nearly all patients (> 90%)	High	Risk in nearly all patients (> 90%)
Moderate	Risk in 30 to 90% of patients	Moderate	Risk in 30 to 90% of patients
Low	Risk in 10 to 30% of patients	Low	Risk in 10 to 30% of patients
Minimal	Fewer than 10% at risk	Minimal	Fewer than 10% at risk

*Proportion of patients experiencing emesis in the absence of effective antiemetic prophylaxis. The incidence of nausea is not part of the risk classification

Table 2 MASCC/ESMO emetic risk groups 2023*

Intravenous agents	Emetic risk	Oral agents**	Emetic risk
High	Risk in nearly all patients (> 90%)	High/moderate	Risk in more than 30% of patients
Moderate	Risk in 30 to 90% of patients		
Low	Risk in 10 to 30% of patients	Low/minimal	Risk in fewer than 30% of patients
Minimal	Fewer than 10% at risk		

*Proportion of patients experiencing emesis in the absence of effective antiemetic prophylaxis. The incidence of nausea is not part of the risk classification

**The emetic potential of the oral anticancer agents is based upon a full course of therapy and not a single dose within the first cycle

agents was based upon a full course of therapy and not a single dose.

All agents in Tables 3 and 4 are listed in alphabetical order.

For intravenous agents No highly emetogenic intravenous agents were identified. Eight moderately emetogenic intravenous agents were identified (arsenic trioxide, cytarabine/daunorubicin liposomal, dinutuximab beta, irinotecan peg-liposomal, lurbinectedin, naxitamab, sacituzumab-govitecan, trastuzumab-deruxtecan). For sacituzumab-govitecan and trastuzumab-deruxtecan, the emetic potential appears to be at the high end of the moderate category, most closely resembling that of carboplatin. As such, those two new classified agents received an asterisk in the table to highlight this point.

Twenty-one intravenous agents were classified as low emetogenic (amivantamab, axicabtagene-ciloleucel, copanlisib, decitabine, elotuzumab, enfortumab-vedotin, gemtuzumab-ozogamicin, inotuzumab-ozogamicin, isatuximab, loncastumab-tesirine, margetuximab, melphalan-flufenamide, mirvetuximab-soravtansine, moxetumomab-pasudotox, necitumumab, nelarabine, tafasitamab, tagraxofusp, teclistamab, tisagenlecleucel, tisotumab-vedotin). Fifteen intravenous agents were classified as minimally emetogenic (asparaginase,¹ atezolizumab, avelumab, belantamab-mafodotin, cemiplimab, daratumumab, dostarlimab, durvalumab, emapalumab, ipilimumab, mosunetuzumab, obinutuzumab, polatuzumab-vedotin, ramucirumab, tremelimumab).

For oral agents Fourteen oral agents were identified as high–moderate (abemaciclib, adagrasib, avapritinib, cabozantinib, enasidenib, fedratinib, lenvatinib, lomustine, midostaurin, mobocertinib, niraparib, ribociclib, rucaparib, selinexor). Selinexor also received an asterisk to indicate the emetic potential to be at the higher end of the high–moderate risk

category. Forty-nine agents were classified as low–minimal (acalabrutinib, alectinib, alpelisib, apalutamide, asciminib, bexarotene, brigatinib, capmatinib, cobimetinib, dacomitinib, darolutamide, duvelisib, encorafenib, entrectinib, erdafitinib, estramustine, futibatinib, gilteritinib, glasdegib, infigratinib, ivosidenib, ixazomib, larotrectinib, lorlatinib, neratinib, nintedanib, olutasidenib, osimertinib, palbociclib, panobinostat, pemigatinib, pexidartinib, pralsetinib, relugolix, ripretinib, selpercatinib, sonidegib, sotorasib, talazoparib, tazemetostat, tepotinib, tivozanib, topotecan, trametinib, trifluridine/tipiracil, tucatinib, umbralisib, veneoclax, zanubrutinib).

Combination antineoplastic regimens For combination antineoplastic regimens, the emetic level is determined by identifying the most emetic agent in the combination. One exception to this rule remains the combination of cyclophosphamide and anthracycline (AC regimen). Both are moderately emetogenic agents; however, the regimen is highly emetic when coadministered. It has to be acknowledged that the studies defining the AC regimens as highly emetogenic were conducted almost exclusively in women with breast cancer. It is still a matter of debate whether AC used as a component of combination regimens such as the CHOP (doxorubicin plus cyclophosphamide, vincristine, and prednisone) regimen in patients with non-Hodgkin lymphomas is also highly emetic.

Discussion

Classifying antineoplastic agents according to their emetic potential remains imprecise and challenging. This process is hindered by the fact that the potential of an administered antineoplastic agent to cause emesis has been established rigorously for only a few agents. Due to limitations further discussed below, the third Antiemetic Perugia Consensus Conference decided to change from the original Hesketh classification schema from 1997 with five emetic risk groups

¹ asparaginase erwinia chrysanthemi (crisantaspase) and asparaginase (calaspargase pegol)

Table 3 Emetogenic potential of single intravenous antineoplastic agents

High	Anthracycline/cyclophosphamide combination ^a		
	Carmustine		
	Chlormethine (mechlorethamine)		
	Cisplatin		
	Cyclophosphamide ≥ 1500 mg/m ²		
	Dacarbazine		
	Streptozocin		
	Moderate	Alemtuzumab	Idarubicin
		Arsenic trioxide	Ifosfamide
		Azacitidine	Irinotecan
Bendamustine		Irinotecan peg-liposomal	
Busulfan		Lurbinectedin	
Carboplatin*		Naxitamab	
Clofarabine		Oxaliplatin	
Cyclophosphamide < 1500 mg/m ²		Romidepsin	
Cytarabine > 1000 mg/m ²		Sacituzumab-govitecan**	
Cytarabine/daunorubicin liposomal		Temozolomide ^b	
Daunorubicin		Thiotepa ^c	
Dinutuximab beta		Trabectedin	
Doxorubicin		Trastuzumab-deruxtecan**	
Epirubicin			
Low	Aflibercept	Ixabepilone	
	Amivantamab	Loncastuximab-tesirine	
	Axicabtagene-ciloleucl	Margetuximab	
	Belinostat	Melphalan-flufenamide	
	Blinatumomab	Methotrexate	
	Bortezomib	Mirvetuximab-soravtansine	
	Brentuximab-vedotin	Mitomycin	
	Cabazitaxel	Mitoxantrone	
	Carfilzomib	Moxetumomab-pasudotox	
	Catumaxomab	Necitumumab	
	Cetuximab	Nelarabine	
	Copanlisib	Paclitaxel	
	Cytarabine ≤ 1000 mg/m ²	Paclitaxel nab-albumin	
	Decitabine	Panitumumab	
	Docetaxel	Pemetrexed	
	Doxorubicin peg-liposomal	Pertuzumab	
	Elotuzumab	Tafasitamab	
	Enfortumab-vedotin	Tagraxofusp	
	Eribulin	Techistamab	
	Etoposide	Temsirolimus	
	5-Fluorouracil	Tisagenlecleucl	
	Gemcitabine	Tisotumab-vedotin	
	Gemtuzumab-ozogamicin	Topotecan	
	Inotuzumab-ozogamicin	Trastuzumab-emtansine	
	Isatuximab	Vinflunine	
	Minimal	Asparaginase [#]	Nivolumab
		Atezolizumab	Obinutuzumab
Avelumab		Ofatumumab	
Belantamab-mafodotin		Pembrolizumab	
Bevacizumab		Pixantrone	
Bleomycin		Polatuzumab-vedotin	
Cemiplimab		Pralatrexate	
Cladribine (2-chlorodeoxyadenosine)		Ramucirumab	
Daratumumab		Rituximab	
Dostarlimab		Trastuzumab	
Durvalumab		Tremelimumab	
Emapalumab		Vinblastine	
Fludarabine		Vincristine	
Ipilimumab		Vinorelbine	
Mosunetuzumab			

^aThe combination of an anthracycline and cyclophosphamide in patients with breast cancer is highly emetogenic

^bNo direct evidence found for temozolomide IV; as all sources indicate a similar safety profile of oral temozolomide, the classification was based on oral temozolomide

^cClassification refers to individual evidence from pediatric trials

*Emetic potential appears to be at the high end of the moderate category

**Emetic potential appears to be at the high end of the moderate category, most closely resembling that of carboplatin

[#]Asparaginase *erwinia chrysanthemi* (crisantaspase) and asparaginase (calaspargase pegol)

Table 4 Emetogenic potential of single oral antineoplastic agents*

High/moderate	Abemaciclib	Lenvatinib	
	Adagrasib	Lomustine	
	Avapritinib	Midostaurin	
	Bosutinib	Mobocertinib	
	Cabozantinib	Niraparib	
	Ceritinib	Olaparib	
	Crizotinib	Procarbazine	
	Cyclophosphamide	Ribociclib	
	Enasidenib	Rucaparib	
	Fedratinib	Selinexor**	
	Hexamethylmelamine	Temozolomide	
	Imatinib	Vinorelbine	
	Low/minimal	Acalabrutinib	Methotrexate
		Afatinib	Neratinib
		Alectinib	Nilotinib
		Alpelisib	Nintedanib
Apalutamide		Olutasidenib	
Asciminib		Osimertinib	
Axitinib		Palbociclib	
Bexarotene		Panobinostat	
Brigatinib		Pazopanib	
Capecitabine		Pemigatinib	
Capmatinib		Pexidartinib	
Chlorambucil		Pomalidomide	
Cobimetinib		Ponatinib	
Dabrafenib		Pralsetinib	
Dacomitinib		Regorafenib	
Darolutamide		Relugolix	
Dasatinib		Ripretinib	
Duvelisib		Ruxolitinib	
Encorafenib		Selpercatinib	
Entrectinib		Sonidegib	
Erdafitinib		Sorafenib	
Erlotinib		Sotorasib	
Estramustine		Sunitinib	
Etoposide		Talazoparib	
Everolimus		Tazemetostat	
Fludarabine		Tegafur/uracil	
Futibatinib		Tepotinib	
Gefitinib		Thalidomide	
Gilteritinib		Tioguanin (6-thioguanine)	
Glasdegib		Tivozanib	
Hydroxyurea		Topotecan	
Ibrutinib		Trametinib	
Idelalisib		Trifluridine/tipiracil	
Infigratinib		Tucatinib	
Ivosidenib	Umbralisib		
Ixazomib	Vandetanib		
Lapatinib	Vemurafenib		
Larotrectinib	Venetoclax		
Lenalidomide	Vismodegib		
Lorlatinib	Vorinostat		
Melphalan (L-Phenylalanine mustard)	Zanubrutinib		

*Classified emetic potential of oral agents based upon a full course of therapy and not a single dose within the first cycle

**Emetic potential appears to be at the high end of the moderate category

Table 5 Common terminology criteria: term vomiting

Adverse event	Grade				
	1	2	3	4	5
Vomiting*	1 – 2 episodes (separated by 5 min) in 24 h	3 – 5 episodes (separated by 5 min) in 24 h	≥ 6 episodes (separated by 5 min) in 24 h; tube feeding, TPN or hospitalization indicated	Life-threatening consequences; urgent intervention indicated	Death

*Definition: A disorder characterized by the reflexive act of ejecting the contents of the stomach through the mouth

to four broad emetogenic risk groups (high, moderate, low, minimal) [2, 6].

During the classification process, the following challenges noted during prior guideline updates were continuously present:

- A lack of specific information on nausea/vomiting in clinical trial publications,
- Listing only CTCAE grade 3/4 nausea and/or vomiting or the combination of both,
- Reporting all grades only of nausea and/or vomiting,
- Not specifying the observation period when the toxicity data were collected,
- Missing information on whether antiemetic prophylaxis or treatment was administered,
- Limited data for single antineoplastic agents as many agents are given as combination regimens,
- Inclusion of heavily pre-treated patient populations makes it difficult to differentiate whether the vomiting is due to the antineoplastic agent or due to advanced cancer itself (example: imatinib in CML, chronic phase imatinib is of low emetogenic potential, in blast crisis, imatinib is of moderate emetogenic potential),
- Lack of information about intercurrent illnesses or concomitant medications, which cause nausea and emesis,
- Failure to report the time frame of emetic outcomes, thus providing little basis to determine the potential of a new antineoplastic agent to induce acute or delayed nausea and vomiting or even anticipatory nausea and vomiting,
- No detailed information about patient-related variables in correlation to the incidence of nausea and vomiting, such as sex, age, anxiety, and history of alcohol consumption,
- The tendency to underestimate the incidence of emesis that occurs in the days after the patient has left the clinic and is no longer under direct observation.

The reported incidence of vomiting with three new antineoplastic agents (sacituzumab-govitecan, trastuzumab-deruxtecan, and selinexor) deserves special mention. The two intravenously administered agents (sacituzumab-govitecan and trastuzumab-deruxtecan) warrant classification in the high–moderate emetogenic range analogous to carboplatin.

The oral agent selinexor warrants classification in the higher end of the moderate–high-risk category.

Characterizing emetic potential for oral antineoplastic agents is especially problematic and challenging. These agents are typically administered chronically over protracted periods. Traditional concepts of acute and delayed nausea and vomiting lose their relevance in these settings.

One other limiting factor is the standard toxicity reporting systems. In clinical studies, the CTCAE criteria are often used (Table 5). For example, CTCAE grade 1 describes 1–2 episodes of vomiting in 24 h. Although this information would be critically important in evaluating the emetic potential of a given agent, grade 1 and 2 CTCAE toxicities are rarely reported in publications. The suggestion of the prior MASCC/ESMO guideline panel to record the frequency and intensity of nausea and vomiting using standard antiemetic methodology rather than the less informative Common Terminology Criteria was never adopted in clinical trials [2]. Further, the CTCAE criteria represent a classical clinician-reported outcome, and it is well-known that clinicians often underreport symptoms experienced by the patient [1]. In contrast, patient-reported outcomes usually identify a higher incidence and severity of treatment-related symptoms.

Finally, it should be acknowledged that the MASCC/ESMO antiemetic prophylaxis guideline recommendations at present can only be applied to intravenously administered antineoplastic agents, given the paucity of antiemetic trials specifically designed for orally administered antineoplastic agents.

Of note, several intravenous agents (carboplatin, sacituzumab-govitecan, trastuzumab-deruxtecan) are significantly more emetogenic than most moderate agents and may warrant consideration to be classified in a separate category between the moderate and high categories in the future. This may allow more precise antiemetic prophylaxis recommendations.

Acknowledging these limitations, we have attempted to provide a reasonable approximation of the emetic risk associated with systemic antineoplastic agents. Ultimately, this process will only improve if appropriate information on nausea, vomiting, and concomitant medication (e.g., antiemetic prophylaxis or treatment) is collected and reported for phase II and III clinical studies in new antineoplastic agents.

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