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Signs and symptoms of CHS:

- Cannabinoid use
- Intractable nausea and/or emesis
- Cyclical episodes of emesis of 24- 48 hours duration
- Compulsive hot water bathing
- Non-specific abdominal pain

Exclusion criteria:

- Patients < 12 years of age
- Pregnancy
- Concern for sepsis (see [Sepsis pathway](#))
- Concern for acute abdomen

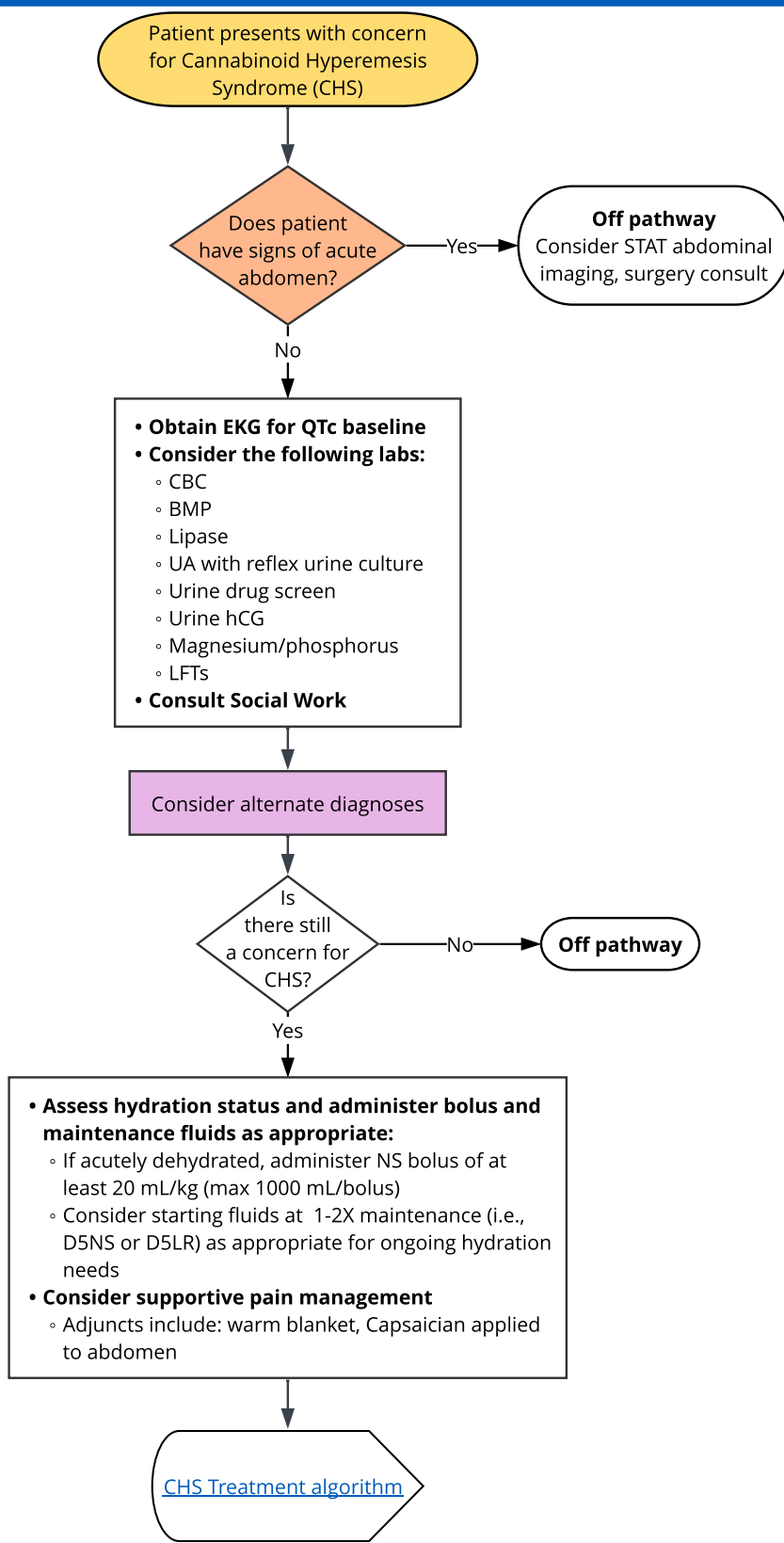
Signs of acute abdomen (any of these):

- Rigidity
- Guarding
- Non-distractable pain
- Distension
- Vital sign instability
- Fever

Possible alternate diagnoses*:

- Gastroenteritis (see [Acute Gastroenteritis pathway](#))
- Cyclic vomiting syndrome
- Rumination syndrome
- Eating disorder
- Cannabinoid withdrawal syndrome
- Increased intracranial pressure
- Gastroparesis
- Pelvic inflammatory disease

*Note: This list is not exhaustive





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Inclusion criteria:

- Patients with acute nausea and/or vomiting and suspected or confirmed CHS

Important Considerations:

- Opioids should be avoided in the treatment of abdominal pain in CHS, as they are often ineffective and may even worsen abdominal pain in CHS
- Consider admission for patients with recurrent CHS symptoms or multiple previous similar presentations

Haloperidol

- Before administration, assess risk for prolonged QT; may obtain ECG or start continuous cardiac monitoring if ECG is abnormal
- If the patient develops acute signs of akathisia, rigidity, bradykinesia, dysphagia, or tremor, stop haloperidol and administer IV diphenhydramine

When to consider GI/Toxicology consult:

- Persistent vomiting or pain despite 3rd-line therapy
- Abnormal laboratory findings suggesting alternative GI pathology (e.g., elevated lipase, significant LFT abnormalities, severe electrolyte derangement)
- Recurrent unexplained vomiting without clear improvement after cannabis cessation (GI consult / GI nonurgent ambulatory follow up)
- GI bleeding (hematemesis, melena):
 - See [GI Bleed pathway](#)
 - GI consult as required
- Significant weight loss or growth concerns (consider upper GI or CT scan for superior mesenteric artery syndrome)
- Refeeding syndrome concern
- Bilious emesis, or focal peritoneal signs (Surgery consult)

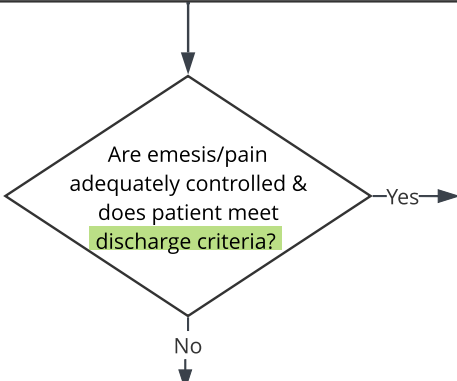
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Patient requires acute treatment for cannabinoid hyperemesis syndrome (CHS)

- Medication options:
 - 1st Line: Ondansetron: 4-8 mg IV or ODT (if no IV access)
 - If no response within 30 min, move to 2nd line
 - 2nd Line: **Haloperidol**: 0.05 mg/kg IM or PO, max dose 5 mg
 - If patient has known history of cannabinoid use, can consider for 1st line
 - If no response within 30 min, move to 3rd line
 - 3rd Line: Lorazepam: 0.025-0.05 mg/kg/dose (depending on mental status)
- Administer PO challenge
- Consider supportive pain management
 - Adjuncts include: warm blanket, Capsaicin applied to abdomen
- Consider repeat BMP to ensure electrolytes normalize



Discharge patient

- Counsel patients on cessation of cannabis use as the only definitive cure for CHS
- Provide [education](#)
- Social work will provide resources for substance treatment and discuss intervention with caregivers
- Consider documenting as a protected note based on patient preference

- Consider re-dosing ondansetron (q6h PRN)
- Consider re-dosing Haloperidol (q8h PRN) if EKG is normal and mental status is normal/near normal
- Consider **GI/Toxicology consult** for refractory symptoms or diagnostic uncertainty
- Reconsider **alternate diagnoses** and include other specialists as indicated
- Consider **hospital admission**

Discharge criteria:

- Able to tolerate PO intake
- Adequate pain control
- Adequate hydration
- Symptoms improve with initial therapies

Inpatient management:

- Follow medication guidance above as for patients in ED
- Reconsider **GI/Toxicology consult**

Admission criteria- any of the following despite 3rd line antiemetics:

- Intractable vomiting
- Dehydration and requirement for IVF
- Failed PO challenge
- Multiple ED visits without resolution
- Uncontrolled pain