Anorexia and Cachexia in Palliative Care Settings

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Objectives

- Define and review anorexia and cachexia.
- Discuss common underlying etiologies for anorexia and cachexia in seriously ill patient populations.
- Identify appropriate clinical interventions for patients experiencing anorexia and cachexia.
Anorexia

- Reduction or loss of desire to eat or reduced caloric intake.
- Accompanies many common illnesses.
- Resolution.
- Weight lost may be replaced.
- Nutritional supplements or increased intake.
- Loss of fat (rather than muscle tissue).
Cachexia

- Complex syndrome
  - Anorexia.
  - Significant weight loss*, specifically muscle mass.
- May or may not include fat wasting.
- Generalized weakness.
- Increased protein catabolism and inflammatory response.
- Associated with the gravely ill.
- Possible in the absence of decreased appetite.
- Distinct from sarcopenia.
Anorexia Cachexia Syndrome

Cancer
Cachexia: Prevalence

- Varies widely in palliative care settings.
- Diagnostic criteria.
- Disease states.
- Comorbid conditions.
Pathophysiology

- Decreased Intake
- Metabolic Abnormalities
- Pro-Inflammatory Cytokines
- Systemic Inflammation
- Neurohormonal Dysregulation
- Tumor By-products
- Catabolic State
Anorexia Cachexia Syndrome (ACS)
Metabolic Alterations

- Common in advance disease
  - Systemic inflammatory response and cytokine production stimulation.
- Alterations include glucose intolerance, insulin resistance, increased lipolysis, increased skeletal muscle catabolism, increased basal energy expenditure.
- Genomics.
- Hormonally regulated feedback loops.
- Progressive worsening and survival.
Secondary ACS

Physical Symptoms
- Pain, ageusia, anosmia, stomatitis, dysphagia, dyspnea, malabsorption

Treatment Adverse Effects
- HAART, cytotoxic drugs, radiotherapy

Psychological/Spiritual Distress
- Anxiety, depression, suffering, cultural influences

Oral Issues
- Dentures, dental pain, infections, xerostomia
Assessment

- Appetite
  - Symptom assessment scales

- Nutritional intake
  - Retrospective (recall)
  - Prospective (calorie counting)
  - Risk factors for being unable to obtain or take in nutrients

- Basic nutritional status
  - Tools, lab values, functional assessments

- Physical exam

- Patient’s goals of care
  - Suffering or distress
  - Psychosocial evaluation concerning food
Cachexia Assessment

- Stores Depletion
- Muscle Mass & Strength
- Anorexia; Decreased Intake
- Catabolic Drivers
- Functional & Psychosocial Effects
Interventions

- Secondary symptom management
- Nutritional support
- Enteral and parenteral nutrition
- Pharmacologic interventions
- Psychosocial support

Improved Comfort + Decreased Distress
Nutritional Support

- Earlier in illness trajectories
- Mixed evidence
- Education and increased understanding
  - Patients
  - Families

- Quality of Intake
- Favored Foods
- Small Meals
- Taste, Textures & Temperature
- Different Liquids
- Timing Measures
Enteral and Parenteral Nutrition

- **Enteral** (i.e., nasoenteric tube, gastrostomy, jejunostomy)
  - Functional status.
  - Insufficient evidence.
  - Non-cancer patient populations.

- **Parenteral**
  - Controversial in palliative care settings.
  - Limited benefit with increased complications potential.
  - Functional gut → enteral preferred.
  - Parenteral nutrition only considered when aligned with goals of care, good underlying functional status, prognosis of at least 2-3 months, enteral feeding not possible.
## Pharmacologic Interventions

<table>
<thead>
<tr>
<th>Medications</th>
<th>Indications (ACS)</th>
<th>Adverse Effects and Pearls</th>
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</thead>
<tbody>
<tr>
<td><strong>Synthetic Progesterone</strong></td>
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<tr>
<td>Megestrol (160-800 mg/day)</td>
<td>Improves appetite, weight gain, and sense of wellbeing</td>
<td>Thromboembolic events, glucocorticoid effects, GI upset, heart failure, menstrual abnormalities, tumor flares</td>
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<tr>
<td><strong>Corticosteroids</strong></td>
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<tr>
<td>Dexamethasone (3-6 mg/day)</td>
<td>Improves appetite and sense of wellbeing</td>
<td>Immunosuppression, masks infection, HTN, myopathy, GI upset, increased ICP, electrolyte imbalances, anxiety, requires taper</td>
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<tr>
<td>Prednisone (20-30 mg/day)</td>
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<tr>
<td><strong>Cannabinoids</strong></td>
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<tr>
<td>Dronabinol (5-20 mg/day)</td>
<td>Increases appetite, decreases anxiety</td>
<td>Somnolence, confusion, dysphoria</td>
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<td>Medical marijuana*</td>
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<td><strong>Prokinetics</strong></td>
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<tr>
<td>Metoclopramide (10mg AC)</td>
<td>Improves gastric emptying, decreases early satiety, improves appetite</td>
<td>Diarrhea, restlessness, fatigue, drowsiness, EPS</td>
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</tbody>
</table>
Psychosocial Support

- Distress for patients and loved ones
- Body image
- Social dining
- Bereaved caregivers, guilt
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FOCUSED TRACKS:
Expert educators will conduct new tracks for home health, hospice, and compounding pharmacy along with outstanding sessions for hospital clinical and administrative leaders and facilities managers.
Thank you
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References


- Bruera E. Assessment and management of anorexia and cachexia in palliative care. In: *UpToDate*, Smith TJ (Ed), UpToDate, Waltham, MA. (Accessed May 2023).


