Anorexia/Cachexia

Introduction

Anorexia/cachexia syndrome is a complex metabolic process found in many end stage illnesses. This is characterised by the loss or absence of appetite (anorexia) with weight loss and muscle wasting (cachexia). This impacts significantly on quality of life and can cause anxiety and distress for patients, perhaps even more so for carers.

Assessment

The assessment is much more than the patient’s calorific intake versus their body weight. It is worth considering if recording the patient’s weight is necessary as this may result in increasing anxiety about their weight loss. Be aware that the ongoing loss of lean body mass may occur with or without loss of fat mass.

A nutritional assessment needs to be holistic and acknowledge the emotional, social, cognitive and biochemical aspects of nutrition and diet. Each assessment should be individualised taking the patient’s condition and stage of illness into consideration.

Look for any reversible problems that may exacerbate anorexia, including Pain, Breathlessness, Depression, Ascites, Nausea and Vomiting, Constipation, Dysphagia, Heartburn, Gastritis, Anxiety and Medication.

Oral problems: such as dry mouth, ill-fitting dentures, ulcers, candidiasis.

- Odours: cooking smells, incontinence, fungating lesions and fistulae can contribute to anorexia.
- Delayed gastric emptying (for example due to local disease, autonomic neuropathy) causing early satiety and vomiting of undigested foods that relieve nausea.
- Fatigue is commonly associated with anorexia/cachexia syndrome.

Ask the patient and the carer about their perspectives on weight, body image, nutrition and dietary intake.

Management

- The aims are prevention or early identification as well as the treatment of contributory symptoms. This includes acknowledging the psychological impact on the patient and carer, together with providing information and supportive care.
- In nutritional support, the emphasis is based upon eating within the limits of the patient’s condition and capability.
Non-pharmacological management

- Offer information and practical advice about nutrition, diet and managing anorexia in advanced illness.
- Address patient and carer concerns about the importance of providing nourishment.
- Encourage patients and their carers to focus on enjoying food and the social interaction associated with eating and drinking.
- Explain that a gradual reduction in oral intake is a natural part of the illness.

Medication

Pharmacological management

The following drugs are of limited or temporary benefit but worth considering as may improve quality of life. The potential side effects and risks of medication should be taken into account when prescribing.

Corticosteroids

- Established role in short-term improvement of appetite. Rapid effect but tends to decrease after 3 to 4 weeks.
- May also help to reduce nausea, improve energy and general feeling of wellbeing. However, there is often no significant effect on nutritional status.
- Starting dose: oral dexamethasone 4mg or prednisolone 30mg (given in the morning).
- Consider need for gastric protection, such as H2 receptor blocker (for example ranitidine) or proton pump inhibitor (for example omeprazole).
- Prescribe for 1 week and if helpful, reduce gradually to lowest effective dose. If no effect, stop.
- Assess and review dose regularly.
- Side effects: fluid retention, candidiasis, myopathy, insomnia, gastritis and steroid-induced diabetes.

Progestogens

- May stimulate appetite and weight gain in patients with cancer.
- May take a few weeks to take effect but benefit is more prolonged than steroids.
- More appropriate for patients with a longer prognosis.
- Megestrol acetate: starting dose 160mg/daily and then after 2 to 3 weeks assess and review. For appetite stimulation, lower doses are as effective as higher doses but for weight gain there does appear to be more of a dose-response relationship. There is no

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Indicates this medication is associated with QT prolongation ©
evidence for an optimal dose however the maximum dose is 800mg daily. Reduce dose gradually if it has been used for more than 3 weeks (adrenal suppression).

- Side effects: nausea, fluid retention and increased risk of thromboembolism.

**Prokinetics**

- Used for early satiety, delayed gastric emptying, gastroparesis or nausea.
- **QT† Metoclopramide 10mg or QT† domperidone 10mg** given three times a day, 30 minutes before meals.

**Practice points**

- Supplementary drinks are expensive but can help selected patients after careful assessment of nutritional status, prognosis and alternative options. (Refer to local formulary for recommended preparations and advice.)
- Previous dietary advice given regarding diabetes and high cholesterol may be relaxed.
- Consider referral to a dietitian if appropriate.

**Patient/carer advice points**

- Gently encourage the patient to take what they can manage. Provide small portions, attractively presented, offered frequently throughout the day.
- Offer soft, easy to swallow foods such as soup, pudding and nutritious drinks. If tolerated, increase intake of higher calorie foods such as butter, cream, cheese.
- Try not to talk about food all the time and try to keep the person involved in the social aspects of meals.

**Resources**

**Professionals**

Further information available at Macmillan Cancer Support.

Check local policies and guidelines for further advice and information.

**Patients**

Information booklets are produced by Macmillan Cancer Support and are available on their website [http://www.macmillan.org.uk](http://www.macmillan.org.uk) or via the helpline 0808 808 0000.

**NHS Inform**

**References**


