# 1.1 Anorexia

## Key Points

1. Anorexia is a manifestation of the underlying disease.
   Anorexia is not the cause of the patient's terminal condition. However, most families and physicians express this erroneous belief in statements such as, "If only he would eat, he would get better!"

2. Family and friends are often more concerned than the patient about anorexia.
   Providers can help family and friends find alternative ways to express their love and concern, so that eating does not become an area of conflict.

3. Anorexia may have multiple causes related to poor symptom control.
   The provider can look for reversible causes of anorexia, such as poorly controlled pain and other physical symptoms, and can seek the help of dietary professionals in selecting palatable foods. A "cardiac prudent diet" is probably no longer necessary.

4. Anorexia may respond to an appetite stimulant like dexamethasone.
   Dexamethasone is a preferred appetite stimulant. It is effective, inexpensive, and may have additional benefits such as serving as an adjunct for pain control, lifting the patient's mood, and addressing asthenia. Megestrol is expensive ($300–$500/month), not very effective, and results in no identifiable improvement in quality of life.

5. Anorexia, when severe, often results in the use of IVF, TPN, or tube feedings.
   These treatments may be very appropriate to bridge and support someone until normal eating can resume. For most people at the Life's End, these treatments can cause:
   1) iatrogenic harm because of infections, fluid overload, and aspiration pneumonia;
   2) pain and discomfort from the placement and maintenance of IV and tubes;
   3) increased use of restraints to protect IV lines and feeding tubes.

# Anorexia

## The Palliative Response

### Anorexia Is a Symptom

Anorexia is a common symptom at Life's End.

*Decreased intake is nearly universal in the last few weeks to days of life.*

### The Role of the Physician

- Look for reversible causes
- Consider the use of appetite stimulants
- Provide accurate and helpful information
- Help family members identify alternative methods of expressing love
- Ensure that any IV or tube feedings are safe, effective, and consistent with Goals of Care

### Dietary Management

- Involve the patient in menu planning
- Offer small portions of patient's favorite foods
- Offer easy-to-swallow foods
- Try sweets
- Avoid foods with strong smells, flavor, or spices, unless patient requests

### Responding to Family Concerns

- Family members and caregivers are more concerned about lack of appetite and may harass the patient about decreased intake
- Anticipate family concerns and initiate family discussion about decreased appetite
- Be prepared to discuss and review this symptom every time you meet with family
- Demonstrate willingness to look for reversible causes and to use appetite stimulants

### Educating Patient and Family

about progression of the underlying illness and its effect on appetite

- Anorexia is a symptom of the disease
- The patient is not starving
- Forced feeding often causes discomfort
- Artificial feeding usually does not prolong life and may shorten it
- Patients are usually not uncomfortable from decreased intake and can live for long periods on little food

## Reversible Causes of Anorexia

Differential Considerations

- Poorly controlled pain and non-pain symptoms
- Nausea and vomiting
- GI dysmotility (gastroparesis)
- Oral infections such as thrush or herpes simplex
- Xerostomia (dry mouth)

## Reversible Causes of Anorexia

Differential Considerations

- Constipation and urinary retention
- Medications such as iron supplements
- Chemotherapy and radiation
- Depression and anxiety
- Gastritis and Peptic Ulcer Disease

## Consider an Appetite Stimulant

Alcohol

- Wine, sherry, and beer have significant calories and are well-known appetite stimulants
- Consider using if consistent with culture and heritage and if no history of past alcohol abuse
- Many people who had used alcohol routinely before they became ill have the impression that they must now not drink alcohol at all

## Consider an Appetite Stimulant

Cyproheptadine (Periactin)

- This antihistamine has the side effect of weight gain
- Has been used to treat anorexia nervosa
- Not highly effective and may be more placebo effect than active drug
- Is not likely to be helpful at Life's End

## Consider an Appetite Stimulant

Megestrol (Megase)

- Approved for the treatment of AIDS wasting
- Dose for wasting is megestrol suspension 800mg QD
- Expensive—approximately $350/month
- Major side effects are Pulmonary embolism nausea and vomiting

## Consider an Appetite Stimulant

Megestrol (Megase)

- In patients with cancer, the use of megestrol was not associated with any documented improvement in QOL or survival
- Usually not recommend for anorexia at EOL

## Consider an Appetite Stimulant

Dexamethasone (Decadron)

- Dose of 2–4mg at breakfast and lunch
- Can tell within a few days to a week if effective
- Inexpensive
- May also have beneficial effects on pain, asthenia, and mood
- Causes less fluid retention than other corticosteroids

## Consider an Appetite Stimulant

Dexamethasone (Decadron)

- Use caution with history of diabetes mellitus
- Usually not concerned in the EOL setting about long-term complications of steroids
- May be a good choice in COPD patients who have become steroid dependent

## Consider an Appetite Stimulant

Dronabinol (Marinol)

- Usually used in young patients with past experience with marijuana
- Expensive—up to $500/month
- Requires DEA Schedule III
- Usually used in HIV or as part of treatment protocol with chemotherapy

## Artificial Nutrition at Life's End

Tube Feeding

- Tube feeding and forced feeding in terminally ill patients have not been shown to prolong life
- Nasogastric and gastrostomy tube feedings are associated with:

  *Aspiration pneumonia*

  *Self-extubation and thus use of restraints*

  *Nausea and diarrhea*

  *Rattling and increased respiratory secretions*

## Artificial Nutrition at Life's End

Total Parenteral Nutrition (TPN)

Meta-analysis of 12 randomized trials in cancer patients (1980s)

- Decreased survival
- Decreased response to chemotherapy
- Increased rate of infections

*Is anorexia ever a protective mechanism?*

## Artificial Nutrition at Life's End

Consider Potential Burdens

Tube feeding and IV hydration often increase secretions, ascites, and effusions, which require additional treatments.

*Always ask:*
*"Are these kinds of treatments in line with the Goals of Care?"*

## Selected Readings

**Myths, Theories, and Decision-Making**

Cross, K. L. "If He Would Just Eat, I Know He Would Get Stronger." *Quarterly Newsletter of the American Academy of Hospice and Palliative Medicine* 1 (2001): 12–14.

**Medical Management**

Bruera, E. "ABC of Palliative Care: Anorexia, Cachexia, and Nutrition." *British Medical Journal* 315 (1997): 1219–1222.

Jatoi, A. and C. L. Loprinzi. "Current Management of Cancer-Associated Anorexia and Weight Loss." *Oncology* 15 (2001): 497–509.

Jatoi, A., H. E.Windschitl, C. L. Loprinzi, J. A. Sloan, S. R. Dakhil, J. A. Mailliard, R. Pundaleeka, C. G. Kardinal, T. R. Fitch, J. E. Krook, P. J. Novotny, and B. Christensen. "Dronobinal versus Megestrol Acetate versus Combination Therapy for Cancer-Associated Anorexia: A North Central Cancer Treatment Group Study." *Journal of Clinical Oncology* 20 (2002): 567–573.