Loss of Appetite in Adults with Cancer: Screening and Assessment

Screen for loss of appetite at each visit and validate ESAS score. ESAS Score 1- 3 ESAS Score 4-6 ESAS Score 7-10

To support the diagnosis of anorexia vs. stage of cachexia recommend use of the following evidence-based assessment tools:

- Malnutrition Screening Tool
- Patient Generated Subjective Global Assessment
- Diet history, Physical Assessment and Laboratory investigations to support diagnosis of anorexia vs. stage of cachexia.
- Percentage of weight loss over time evaluates malnutrition

	V
Assessment using Acronym O, P, Q, R, S, T, U, V and W (adapted from Fraser Health)	
Onset	When did you notice your lack of appetite? Is it there all the time?
Provoking / Palliating	Is there a time of day when your appetite is better/worse? What do you think may cause your lack of appetite? Have you had any recent surgery or treatment that you think is affecting your ability or desire to eat? Are you taking any medications that are affecting your ability to eat?
Quality/Quantity	Compared to your normal food intake, are you eating the same amount? More than usual? Less than usual? Are you drinking enough fluid?
Related Symptoms	Are there other symptoms that affect your ability to eat? (e.g. nausea/vomiting, constipation/diarrhea, sore or dry mouth, taste changes, bothersome food odours, problems swallowing, early feelings of fullness, pain, shortness of breath, depression)
Severity	How much is the lack of appetite affecting your activities of daily living or ability to function?
Treatment	Are you doing anything to help manage your loss of appetite (e.g. any physical activity, medications, or changes to your diet)? Is it working?
Understanding / Impact on You	How is the lack of appetite affecting you and/or your family? Do you feel distressed about your inability to eat? Have you experienced feelings of pressure, guilt or relational stress with regard to food intake and weight loss?
Values	Are there any other views or feelings about this symptom that are important to you or your family?
Weight	Have you lost weight recently without trying? If yes, how much? What was the time frame? Have you been eating poorly because of a decreased appetite?

Mild Loss of Appetite Anorexia or Pre-Cachexia

- Weight loss <5% in past 6 months
- Treatment/medication related anorexia and/or weight loss
- No subjective report of dehydration

Moderate Loss of Appetite Anorexia or Cachexia

- Weight loss >5% in past 6 months
- Tumour/treatment/medication related
- C-Reactive Protein value indicating inflammation

Severe Loss of Appetite Refractory Cachexia

- Extreme sarcopenia
- Advanced disease, progressive loss of muscle mass with functional impairment (low Palliative Performance Score)

Interventions for all patients, as appropriate

- Early consultation with the palliative or supportive care team should be considered
- Screen, assess and manage potential causes of secondary cachexia (anti-cancer treatment, other medication and psychosocial factors).
- Consider stage of disease, progression of disease and Palliative Performance Scale (PPS), or functional status when determining goals of care and treatment plans.
- Provide emotional support to patient and family.
- Consider importance of food in the social context and impact on quality of life, cultural issues, patient's accessibility to food.
- Referral to other health care professionals where appropriate.

Loss of Appetite in Adults with Cancer: Care Map

Mild Loss of Appetite Anorexia or Pre-Cachexia Care Pathway Moderate Loss of Appetite
Anorexia or Cachexia
Care Pathway

Severe Loss of Appetite Refractory Cachexia Care Pathway

NON-PHARMACOLOGICAL TREATMENT

- · Suggest eating small, frequent meals and choosing high energy, high protein foods. See Patient Education tools below.
- Ensure adequate hydration, preferably through energy and protein containing liquids.
- Suggest making mealtimes as relaxing and enjoyable as possible.
- Suggest convenience foods, deli or take-out foods, Meals on Wheels® or catering services, Home Making services, or asking friends/family to help out.
- Taking medication with a high calorie / protein fluid such as milkshakes or nutrition supplements can also increase nutritional intake. This should be reviewed by a dietitian and/or pharmacist because of potential drug/nutrient interaction(s).

Nutritional Strategies: provide patient education tools

- Healthy Eating Using High Energy, High Protein Foods
- High Energy and High Protein Menu items
- Food ideas to help with poor appetite
- Increasing Fluid Intake
- Suggestions for Increasing Calories and Protein
- Eating Well When You Have Cancer
- Canada's Food Guide

Exercise:

- Encourage exercise, as tolerated by patient. Walking fifteen minutes a day can help regulate appetite.
- Patient should start the exercise regimen slowly, and gradually increase the intensity.
- Exercise can be initiated at most levels above PPS 30-40% but caution should be guiding principle, as well as presence of bony metastases and low blood counts.

Referral to Registered Dietitian

Referral to a Registered Dietitian may be based on criteria of weight loss, and/or the presence of significant symptoms that are affecting intake, and cannot be addressed adequately by self-management and/or general patient education tools.

- Consider PPS and ESAS scores to determine the appropriateness and aggressiveness of interventions.
- Educate that a person may naturally stop eating and drinking as part of the illness progression and the dying process, treatment may not be indicated
- Focus should be on patient comfort and reducing patient and caregiver anxiety
- Ice chips, small sips of beverages and good mouth care becomes the norm.
- Suggest alternate ways to nurture the patient (oral care, massage, reading, conversing).
- Consider symbolic connection of food and eating with survival and life.
- Consider consultation with Registered Dietitian, palliative care team, bioethicist, or spiritual counselor regarding the discontinuation of nutrition.

PHARMACOLOGICAL TREATMENT

Prokinetics

metoclopramide 10 mg q4 to 8h. OR domperidone 10mg TID to QID (The risk of serious abnormal heart rhythms or sudden death (cardiac arrest) may be higher in patients taking domperidone at doses greater than 30mg a day or in patients who are more than 60 years old).

Synthetic Progestogens

megestrol acetate: minimum efficacious dose = 160 mg daily and titrate to effect maximum dose = 480 mg/ day OR medroxyprogesterone acetate (MPA): 200 mg daily

Corticosteroids

Initial dose: dexamethasone 4mg daily OR prednisolone 30mg daily in the morning. Prescribe for 1 week, if no benefit, stop.

If helpful, increase or decrease to most effective dose; review regularly and withdraw if no longer improving symptoms.

Other Considerations: Assess need for a proton pump inhibitor (ie. pantoprazole, rabeprazole)

Follow-Up and Ongoing Monitoring with palliative/supportive care team is recommended

Disclaimer: Care has been taken in the preparation of the information contained in this Algorithm document. Nonetheless, any person seeking to apply or consult the guidance for practice document is expected to use independent clinical judgment and skills in the context of individual clinical circumstances or seek out the supervision of a qualified specialist clinician. Cancer Care Ontario makes no representation or warranties of any kind whatsoever regarding their content or use or application and disclaims any responsibility for their application or use in any way.