Musings on Cachexia and Anorexia

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The high prevalence of cachexia and anorexia in advanced cancer patients is well recognized, and has produced an increased interest in this area of patient management. Management suggestions include clarifying the goals of treatment, dietary counseling, enteral and parenteral nutrition, and a variety of pharmacological alternatives. However, cachexia and anorexia do not exist in isolation in any individual patient, and a careful and accurate assessment is essential for applying therapeutic options at our disposal. Decision making demands a rationale use of options given the background of supportive evidence for benefit and a careful application to the circumstances of specific individual patients and families.

As we consider these various aspects, there are underlying issues we need to keep in mind. Our current definitions of palliative care generally do not describe the certainties or acknowledge the ambiguities of the boundaries of palliative care (1). We do not limit palliative care to cancer populations alone, nevertheless the problems of cachexia and anorexia have most commonly been described in patients with advanced cancer, and to a lesser extent AIDS (2). Most of the research and literature on palliative care in this area has focused on the cancer population. While aspects of the approach developed may well be applicable to other palliative care populations, we need to keep in mind that the underlying pathophysiology may vary significantly (3). We also need to avoid having our use of treatment approaches hampered by the often quoted statement that "palliative care neither hastens nor postpones death" (1). As in other areas of palliative care, some of the potential therapeutic options in the management of cachexia and anorexia may well prolong life in a meaningful and important manner that has clear benefits for patients and families.

A simple definition of anorexia implies a loss of appetite and reduced caloric intake (2), while cachexia can be defined as an involuntary weight loss of more than 10% of premorbid weight, associated with loss of muscle and visceral protein and lipolysis (4). While these definitions may be reasonably clear, there are circumstances of clinical uncertainty. Patients and families do not always agree on the significance of decreased appetite and caloric intake. Similarly there are no firm criteria to define a diagnosis of cachexia where weight loss and alterations in laboratory values do not correlate.

We often refer to the "cachexia/anorexia syndrome" as one of the most frequent and devastating problems affecting patients with advanced cancer. However just as cachexia does not always correlate with tumor stage or burden, so cachexia may not correlate with anorexia (4). Cachexia may in fact occur before the patient or family notices any loss of appetite. The degree to which cachexia and anorexia drive from identical pathophysiologies is uncertain, and while in the latter

stages of advanced disease they are commonly associated, it would be unwise to assume that they always appear in tandem.

As the multidimensional aspects of the total pain experience have been well recognized for many years, so the multidimensional and associated problems of cachexia in advanced palliative care patients needs to be recognized. In addition to the well-recognized association with anorexia, other associations recognized include asthenia, chronic nausea and psychological issues. Less commonly acknowledged problems may be the interplay with oral complications, pain syndromes, and dyspnea. Given the diagnostic and therapeutic implications of these interactions, appropriate assessment and application of treatment options will require an attempt to clarify possible associations in individual clinical circumstances.

References:

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