BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

Nutritional Guidelines for Symptom Management

ANOREXIA

DEFINITION: The loss of appetite. In cancer patients, this is a common contributing cause of poor nutritional status.

POSSIBLE CAUSES:

Tumour:
- metabolic abnormalities (e.g. increase in lactic acid, fatty acid mobilization, amino acid imbalances)
- hormonal abnormalities
- factors secreted by tumour (e.g. tumour necrosis factor/cachectin)
- taste and smell abnormalities
- food aversions
- pain
- gut involvement (e.g. intraluminal GI malignancy, gut atrophy, partial bowel obstruction, decreased production of digestive secretions, decreased peristalsis, constipation)
- malaise and asthenia (cycle can occur in which decreased intake leads to lethargy and weakness, leading to a further decrease in oral intake)

Treatment:
Chemotherapy- and radiation therapy-induced
- constipation
- cytotoxic effects on the gut
- dysphagia
- fatigue
- mucositis
- nausea
- pain
- taste and smell abnormalities
- xerostomia

Medication:
- narcotics
- antibiotics
- antifungal agents
- alternative diet therapy/supplements

Psychological factors:

- anxiety
- depression
- fear of eating because of possibility of making symptoms worse (pain, incontinence, diarrhea, constipation) or because of certain beliefs that eating will make the cancer, symptoms or health worse.

Socioeconomic factors*:*

- Lack of emotional, manual and financial resources/support

NUTRITIONAL GOAL

To facilitate the process of maintaining/improving the nutritional status of the cancer patient despite anorexia.

STRATEGIES FOR MANAGEMENT

General Strategies:

- Identify factors contributing to loss of appetite (listed above).
- Whenever possible, the underlying cause of the anorexia should be dealt with (e.g. elimination/replacement of the offending drug, control of symptoms).
- Refer to other health professionals (e.g. doctor, nurse, pharmacist, social worker, counsellor, home care, home making) where appropriate.

Assessment Strategies:

- Obtain **diet history** to assess adequacy of intake as well as any pattern of food avoidance/aversion.
- Ensure **adequate hydration**, preferably through energy- and protein-containing liquids that can be sipped throughout the day.
- Consider the **aggressiveness of nutritional intervention.** In palliative patients, the quality of life takes precedence over maintaining nutrition status when adequate nutrition intake becomes too difficult.
- **Consider pre-existing diets,** for example, a restrictive diet that limits high energy high protein foods necessary to help maintain his/her nutritional status. Diet restrictions previously prescribed for a medical condition (e.g. hyperlipidemia, diabetes, overweight, and hypertension), can usually be liberalized if the patient is finding it difficult to maintain his/her weight. For example, a patient with diabetes with a very poor appetite, may better tolerate small amounts of food (even if they contain simple sugars) often throughout the day rather than following his/her diabetic meal pattern.
- **Alternative diets** may require the elimination of many foods and/or the intake of a dietary supplement which has side effects and/or which interrupts with meals and snacks (e.g. has to be taken on an empty stomach several times daily). In these cases, various factors should be considered:
  - How does a patient feel about following this therapy? Who prescribed it?
  - Is this form of therapy/supplementation harmful (nutritionally, financially)?

- Look for ways to maintain nutritional status within the guidelines if the patient is to continue with the diet.

Psychosocial

- Food and eating have strong symbolic connection with survival and life. It is one area that family members feel they can contribute to the patient's wellbeing and recovery. They often encourage their loved one to eat and spend much time and effort to prepare favourite foods only to be disappointed when the patient takes only very small amounts of food. This can lead to feelings of rejection of the caregiver's love. It can also lead to feelings that the patient is not doing enough to keep well or recover. Food becomes a battleground perpetuating the emotional turmoil experienced by both the family and patient. In these cases it may be helpful to explain anorexia to the family. Caregivers should be encouraged to support the patient in his/her choices around food and eating.

- Be aware of the **cultural issues** re: food beliefs (e.g. Chinese "hot" and "cold" foods) as some foods may be deemed to be cancer promoting or "unhealthy". Knowing the types of acceptable high calorie, high protein comfort food/ideas that are specific to each culture may also be helpful.

Nutritional Strategies:

- Suggest **eating often and choosing high energy, high protein foods**. Limit low energy foods such as tea, coffee, low calorie broths, fruits and vegetables. When choosing lower calorie foods, the patient should be encouraged to enrich these foods with a high calorie / protein accompaniment, e.g. cream, protein or calorie powder supplement, cheese, cream sauce, egg swirl.
- Make a **list of high calorie/protein food ideas** that are best liked/tolerated. Recommend having larger meals when his/her appetite is best.
- **Consider how food is served.** If the **smell of food** during preparation nauseates or suppresses the patient's appetite, suggest cold, mild food odors or avoiding the kitchen during this time.
- Suggest making **mealtimes** as relaxing and enjoyable as possible. Making mealtime a social event (e.g. having lunch with the grandchildren, eating out) may help increase food intake. Also suggest making food more visually appealing.
- If **fatigue or meal preparation is a problem**, suggest convenience foods, deli or take-out foods, Meals on Wheels® or catering services, Home Making services, or asking friends/family to help out. Soft easy to chew foods also require less energy to eat.
- If few suggestions appeal to the patient, he/she may have an **aversion to food** in general. The patient may find it much simpler to meet his/her daily nutritional requirements by taking nutritional supplements in a medicinal manner (e.g. 5 tins of Ensure Plus or 3 tins of Nutren 2.0 per day plus other fluids). Taking medication with a high calorie / protein fluid such as milkshakes or nutrition supplements can also increase nutritional intake.

- If poor oral intake is long-standing and unlikely to improve even with nutritional counseling, and/or an **appetite stimulant,** tube feeding may be indicated depending on the situation. A **walk or fresh air prior to mealtimes** may also stimulate the appetite. Patients should check with their doctor before using a small amount of **alcohol** (e.g. wine or sherry) to stimulate their appetite before meals.
- It is important to remember that a person may naturally stop eating and drinking as part of the dying process. Encouraging intake at this time may not only be inappropriate but may also be harmful

PATIENT/CLIENT EDUCATION MATERIALS

- **High Energy, High Protein Ideas (BCCA)**
- **High Calorie, High Protein Diet (ADA/DC)**
- **Tips to Help Maintain Your Weight**
- **Make Every Bite Count**
- **High Energy High Protein Sample Menu and Recipes**
- **Healthy Eating Using High Protein High Energy Foods (BCCA)**

REFERENCES

1. Manual of Clinical Dietetics, ADA DC. Sixth Edition. 2000
2. Nutritional Management of the Cancer Patient. Abby Bloch. 1990.
3. Pharmacologic Management of Cancer Anorexia/Cachexia. Loprinzi, C.L. Oncology 7(11 Supplement): 101-103, 1993