Nutrition Update: Anorexia and Cachexia

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Faculty Biography

Kristen Kreamer, AOCNP, APRN-BC, CRNP, MSN is Nurse Practitioner, Ambulatory Oncology at Fox Chase Cancer Center in Philadelphia, Pennsylvania.

Ms. Kreamer received her Masters of Science in Nursing from Yale University in New Haven, Connecticut and an Oncology Nurse Practitioner certificate from the University of Pennsylvania in Philadelphia, Pennsylvania.

Ms. Kreamer is a member of several academic and professional societies, including the National Oncology Nursing Society and Sigma Theta Tau. She is the author or co-author of several professional journal articles.
Cancer Anorexia-Cachexia Syndrome (CACS)

- A complex metabolic syndrome- includes both anorexia and cachexia
- CACS common among patients with cancer
- Many patients with cancer lose desire to eat (anorexia)
- Diagnosis of anorexia is based on reduced appetite, early satiety, taste alterations and nausea
- Anorexia is often associated with reduced food intake
- Cachexia includes physical wasting with loss of skeletal and visceral muscle mass resulting from negative protein and energy balance
- Anorexia contributes to cachexia, but cachexia can occur independently from anorexia.


Weight Loss

- Involuntary weight loss is very common among patients with cancer
- Weight loss is associated with poor tolerability of cancer treatment, reduced quality of life and survival
- Weight loss and malnutrition are not always synonymous with cachexia
- Often associated with anorexia, inflammatory process, insulin resistance and increased tissue protein turnover rates
- CACS is characterized by loss of lean body mass and fat
  - Cannot be reversed by conventional nutritional support
  - Leads to progressive functional impairment.

Cachexia

For cachexia there must be:

- At least 5% weight loss in 12 months
- Body mass index of <20 kg/m²
- Presence of a known chronic disease
- At least three of the following:
  - Loss of muscle mass
  - Asthenia (lack of energy)
  - Loss of body fat
  - Altered analytical parameters (albumin <3.2 g/dl or increased inflammatory parameters such as interleukin-6 >4.0 pg/ml or C-reactive protein >5.0 mg/l)


Cachexia

Cachexia also leads to emaciation, impairment of immune system, metabolic dysfunction and autonomic failure

Cachexia in the patient with cancer can lead to:

- Failure of anti-cancer therapy
- Increased toxicity from treatment
- Shorter survival
- Psychosocial distress

NCCN Guidelines for Palliative Care, Version 1.2016.
## Epidemiology of CACS

<table>
<thead>
<tr>
<th>Tumor Site</th>
<th>Incidence of weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreas</td>
<td>83%</td>
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<tr>
<td>Gastric</td>
<td>83%</td>
</tr>
<tr>
<td>Esophagus</td>
<td>79%</td>
</tr>
<tr>
<td>Head and neck</td>
<td>72%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>55-60%</td>
</tr>
<tr>
<td>Lung</td>
<td>50-56%</td>
</tr>
<tr>
<td>Prostate</td>
<td>56%</td>
</tr>
<tr>
<td>Breast</td>
<td>10-35%</td>
</tr>
<tr>
<td>General cancer population</td>
<td>63%</td>
</tr>
</tbody>
</table>

Tuca et al. (2013). Clinical evaluation and optimal management of cancer cachexia. Critical Reviews in Oncology/Hematology, 88(5-6).


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## Epidemiology of CACS

- **Overall prevalence of CACS:**
  - 40% at diagnosis
  - 70-80% in late stages of disease
- **Survival of patients with cachexia significantly shorter than those without cachexia** – in stomach, pancreatic, prostate, colon and breast cancer
- **Risk of CACS higher when treated with radiotherapy and chemotherapy in esophageal, lung, and head and neck cancers due to swallowing disorders and mucositis**
- **CACS can be direct cause of death in more than 20% of patients with cancer**

### Stages of Cancer-Related Cachexia

<table>
<thead>
<tr>
<th>Precachexia</th>
<th>Cachexia</th>
<th>Refractory Cachexia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Weight loss &lt;5% Anorexia and metabolic change</td>
<td>Weight loss &gt;5% or BMI &lt;20 and weight loss &gt;2% or sarcopenia and weight loss &gt;2%. Often reduced food intake, Systemic inflammation</td>
</tr>
</tbody>
</table>

Footnotes:

### Pathophysiology of Cancer Cachexia

![Pathophysiology of Cancer Cachexia Diagram]


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Pathophysiology of Cancer Cachexia

- Characterized by a persistently increased basal metabolic rate that is not compensated by increasing protein/calorie intake
- Digestive Factors:
  - The digestive factors that can significantly contribute to the onset of CACS include dysgeusia, nausea, dysphagia, odynophagia, mucositis, constipation, malabsorption, and intestinal obstruction.
- Humoral mediators of CACS include cytokines. Different cytokines intervene as humoral mediators of anorexia.
- The best known CACS-mediating tumor factors are proteolysis-inducing factor and lipid mobilization factor.
- Host – Tumor Interaction


Diagnosis and Assessment of CACS

- The most commonly used anthropometric values are weight loss and body mass index (BMI)
- The amount of weight loss that indicates a risk of CACS is:
  - more than 10% in the last 6 months OR
  - 5% in less than one month
- A BMI of less than 20kg/m2 is a criterion for malnutrition
- Biological values such as albumin, prealbumin, transferrin and C-reactive protein can provide valuable information about nutritional status
  - Albumin of less than 3.2 g/dl indicates protein depletion and risk of malnutrition
  - Prealbumin more sensitive than albumin. Prealbumin of <10 mg/dl indicates malnutrition
  - Transferrin-reduced in CACS and a value of <100 mg/dl indicates severe malnutrition
  - C-reactive protein > 5mg/l

Treatment of CACS

- Treatment of CACS based on 3 factors:
  - Oncologic therapy
  - Nutritional support
  - Pharmacological treatment


Nutritional Support

- Nutritional support includes:
  - Dietary advice
  - Nutritional supplements
  - Enteral diet

- Helpful recommendations:
  - Fractionated intake (small frequent meals)
  - Food chosen according to the patient’s preferences and ability to swallow
  - Avoiding strong smells
  - Carefully presented meals
Nutritional Support

- Eating calorie-rich, high protein supplements has been shown to stabilize weight
- Nutrition interventions may not impact weight gain or energy intake, but can improve quality of life.
- Parenteral nutrition may not be metabolized and can increase the suffering of dying patients

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Treatment of Anorexia and Cachexia

**FIX WHAT YOU CAN!**

- Reversible causes of anorexia should be addressed (e.g., management of oropharyngeal candidiasis)
- Treatment also includes management of symptoms that interfere with food intake
  - pain
  - constipation
  - nausea/vomiting
  - oral mucositis
  - dyspnea
  - depression

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Pharmacological Treatment of CACS

- Ideal drug in managing CACS should:
  - Increase the appetite
  - Promote weight gain
  - Improve quality of life
  - Not interfere with cancer treatment
  - Have an adequate tolerance profile

- Best way to treat CACS is to cure the cancer.

Pharmacologic approaches for managing CACS:
- To fight anorexia (stimulate appetite)
- Alter metabolic disturbances


Drugs with Proven and Potential Activity in CACS

- Include:
  - Drugs with confirmed efficacy:
    - Megestrol acetate (MA)
    - Corticosteroids
  - Likely effective drugs that require confirmation in more controlled clinical trials
    - Cannabinoids (dronabinol)
    - Bortezomib
    - Non-steroidal anti-inflammatory drugs
  - Drugs the efficacy of which has not been confirmed in controlled clinical trials
    - Prokinetic agents
    - Pentoxifylline
    - Cyproheptadine
    - Hydrazine sulfate

- Investigational drugs with good prospects for efficacy to be confirmed:
  - Ghrelin
  - Melanocortin antagonists
  - B2 agonists (formoterol)
  - Anti-IL-6 monoclonal antibodies
  - Selective androgen receptor modulators (SARMs)
  - Thalidomide
  - Oxandrolone

Use of Progestogens in CACS

- **Megestrol acetate (MA)**
  - A semi-synthetic progesterone derivative
  - Initially used in treatment of disseminated breast and endometrial cancer
  - Some patients treated with MA gained weight and had increased appetite as side effects
  - In 1993, FDA approved MA for CACS and cachexia associated with other chronic conditions (e.g., AIDS, geriatric cachexia).

- **MA Safety Profile**
  - Generally well-tolerated
  - **Toxicities: Fluid retention and thromboembolic events**
    - Some authors suggest weight gain may be largely due to fluid retention
    - One-in 4 treated with MA will have increase in appetite, 1 in 12 will have increase in weight; however, 1 in 6 will develop thromboembolic event and 1 in 23 will die.


Corticosteroids

- **Mechanism of action related to inhibition of IL-1, TNF-alpha and leptin and increase in neuropeptide Y levels**
- Various literature reviews indicate that glucocorticoids (dexamethasone 3-6 mg/day), prednisone (15 mg/day) methyl prednisolone (12 mg/day) increase appetite and cause weight gain
- **Effect short lived (4 weeks)**
- Causes more long-term side effects than placebo and MA (insulin resistance, fluid retention, steroidal myopathy, skin fragility, adrenal insufficiency, sleep and cognitive disorders)


Cannabinoids

- Dronabinol studied at doses from 2.5 mg to 20 mg/day
- Reduction of nausea, increased appetite and tendency to weight stabilization
- Main adverse events are:
  - Euphoria
  - Hallucinations
  - Vertigo
  - Psychosis
  - Cardiovascular disorders
- Contraindicated in patients with:
  - Allergy to sesame oil
  - History of substance abuse/misuse
  - Psychiatric disorders


Bortezomib

- An ubiquitin-proteasome system and NF-\(\kappa\)B transcription factor inhibitor used in the treatment of multiple myeloma and other hematologic cancers
- Promising initial data
- Clinical trial in CACS in pancreatic cancer showed no significant effect in weight gain
- While potentially active, further studies necessary

Antiserotonergic Agents

- Cyproheptadine is an antihistamine and antiserotonergic agent
- Efficacy in CACS not confirmed in clinical trials
- Pizotifen is an antiserotonergic drug used in treatment of anorexia from other causes- has not been studied in patients with cancer


Cytokine Inhibitors

- Omega-3 fatty acids, eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) inhibit PIF, TNF-α and IL-6.
  - Efficacy in CACS not fully confirmed in controlled clinical trials.
  - Weight gain of >10% was significantly more common in patients treated with MA.
  - Most authors conclude that ω-3 fatty acids could be potentially active in CACS but further research is required.
- NSAIDS- (Cox-2 Inhibitors)
  - Two controlled clinical trials in CACS show they are effective for gaining weight and muscle mass, especially when combined with MA.
- Pentoxifylline- efficacy in CACS not demonstrated

Cytokine Inhibitors

- Thalidomide
  - Evidence suggests this agent may increase appetite, weight and feeling of wellbeing in CACS
  - Need confirmation with additional trials
- Melatonin
  - An endogenous hormone secreted by pineal gland that is used in sleep disorders
  - Suggested that its effect can be due to cytokine and TNF-a inhibition
  - Recent study comparing melatonin versus placebo in CACS did not find differences between 2 groups


Anabolic Steroids

- Anabolic steroids studied in CACS:
  - Oxymetholone
  - Oxandrolone
  - Nandrolone
  - Fluoxymesterone (high levels of hepatotoxicity)
- Anabolic effect increases muscle mass with no changes in appetite or amount of food intake
- Ghrelin (natural ligand of growth hormone receptor)
  - Two studies have confirmed its efficacy in increasing appetite and weight in CACS patients
  - Two studies of anamorelin, a ghrelin receptor agonist, suggest that this agent may effectively increase body weight and CACS symptoms in patients with lung cancer
  - Requires additional studies

Anabolic Steroids

- Hydrazine sulfate
  - Has been studied as a treatment for cancer and for cancer-related anorexia and cachexia
  - Theorized that cachexia occurs because the cancer is using too much of the body’s sugar. This causes tissue to die and muscle to waste away and the individual loses weight
  - Also cancer cells have high levels of TNF-alpha that can cause loss of appetite, tiredness and breakdown of muscle tissue. Hydrazine can block the TNF-alpha and stop tumor growth and prevent cachexia.
  - Clinical trials have not confirmed its efficacy in CACS

- Beta-2-agonists
  - Have a known capacity to increase muscle mass
  - Currently in preclinical experiments in CACS

Prokinetic Agents

- Metoclopramide or cisapride
  - Are antidopaminergic agents with antiemetic and prokinetic effects
  - May relieve nausea and eating intolerance
  - Controlled trials have shown no efficacy in control of anorexia and weight loss

<table>
<thead>
<tr>
<th>Recommended for Practice</th>
<th>Likely to be Effective</th>
<th>Effectiveness Not Established</th>
<th>Effectiveness Unlikely</th>
<th>Not Recommended for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corticosteroids, Systemic Progestins</td>
<td>Oral Nutritional Interventions</td>
<td>Astragalus Radix Herbal Mix</td>
<td>Cyproheptadine, Ghrin, Herbal Medicine</td>
<td>Melatonin, Metazoline, MS 20 Soybean Extract, Multicomponent Rehabilitation Intervention</td>
</tr>
<tr>
<td>Carnitine/L-Carnitine</td>
<td>Cannabis/Cannabinoids</td>
<td></td>
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</table>

ANOREXIA/CACHEXIA

REASSESSMENT

Acceptable:
- Weight stabilization or gain
- Improvement in symptoms that interfere with intake
- Improved energy
- Resolution of metabolic or endocrine abnormalities

Continue to treat and monitor symptoms and quality of life

Ongoing reassessment

Unacceptable

- Intensify palliative care interventions
- Provide dietary consultation
- Consider clinical trial

PAL-13
Psychosocial Impact of CACS

- Self-image
- Social relationships – What social event doesn’t include food?
- Family relationships – tension, frustration, blaming
- Sexuality
Clinical Trials Regarding CACS Listed on clinicaltrials.gov

- Study of the relationship between clinical and para-clinical markers during situations of cachexia and pre-cachexia in patients over 70 years with colorectal surgery.
- The safety and efficacy of acupuncture for anorexia in patients with GI Tract and Lung cancers.
- Cannabinoid capsules as treatment to improve cancer related CACS in advanced cancer patients.
- Acupuncture for unintentional weight loss with GI cancer.
- Effect of Sipje-ondaebotang for cancer related anorexia in cancer patients.
- QOL after esophagectomy for cancer.
- Efficacy of parenteral nutrition in patients at palliative phase of cancer.
- Pilot study of safety and tolerability of nutrifriend in NSCLS cachexia.


Conclusion

- CACS is a complex metabolic syndrome
- Characterized by weight loss and loss of muscle mass that may include loss of fatty mass
- Associated with anorexia, inflammatory processes, insulin resistance and increase in tissue protein turnover.
- Associated with limited food intake due to tumor growth or the side effects of treatment
- Early diagnosis and a thorough assessment are important in the management of CACS
- Symptomatic treatment of CACS is based on nutritional support and drugs capable of modulating the cascade of metabolic disorders
- The drug most commonly used in CACS is MA.
- Future strategies for CACS include further research on drugs that are potentially effective in CACS.
Conclusion

- Nurses need to be aware of other symptoms that can impact the patient’s appetite and intake of food.
- Nurses need to be proactive in addressing other symptoms that can impact the patient’s intake.
- Nurses need to be aware of potential methods to enhance appetite for food.
- Nurses need to help patients and families understand the complexity of this syndrome and that the patient is not “giving up” because she is losing weight.