



Anorexia/Cachexia

Heart Failure Symptom Management Guideline For adults, age 19 and older in British Columbia

What is anorexia?

Anorexia is a syndrome characterized by some or all of the following symptoms: loss of appetite, nausea, early satiety, weakness, fatigue, food aversion, and significant physical and/or psychological symptoms. Causes of anorexia are multifactorial and include fatigue, dyspnea, medication side-effects, nausea, depression, anxiety and sodium restricted diets, which may all be found in patients with heart failure.

What is cachexia?

Cachexia is a syndrome characterized by severe body weight, fat and muscle loss and increased protein catabolism due to underlying disease. The prevalence of cachexia is 16–42% in the heart failure population and is associated with a 50%, 18 month mortality risk independent of variables such as ejection fraction, age and functional ability.

How is cachexia diagnosed?

Chronic condition with

- >5% weight loss in <12 months; or body mass index (BMI) <20kg/m²; and
- 3 out of 5 additional criteria:

1) Fatigue, 2) Decreased muscle strength, 3) Anorexia, 4) Low muscle mass, 5) Abnormal biochemistry

*Blood testing to diagnose cachexia in advanced stages of disease is not advocated.

Reminder: Malnutrition also affects prognosis in patients with heart failure and is often found in early transitions of the disease. However this symptom management guideline will focus on the assessment and treatment of anorexia and cachexia.

Approach to Managing Anorexia/Cachexia

Assessment

- History: When did weight loss begin? How much weight was lost? Obtain baseline (dry) weight. How is [the patients] appetite? What do they eat or drink on a typical day?
- How has weight loss affected mood?
- Ask about: nausea, early satiety, dyspnea, poor oral hygiene, dysphagia, malabsorption, bowel habits.
- Ask about: other factors causing anorexia/cachexia, e.g. cancer, hypothyroidism, severe liver disease, infections, depression.
- Use [Edmonton Symptom Assessment System \(ESAS\)](#) to rate appetite, nausea, fatigue, depression.
- Review medications known to contribute to anorexia/cachexia. eg. amiodarone, digoxin.
- Assess functional capacity for effects of early fatigue and muscle weakness

Tips

Comparing Malnutrition and Cachexia			
	Reversibility	Treatment Options	Other Therapies
Anorexia	Reversible	Preventative	Nutritional support/ Preventative strategies
Cachexia	Irreversible	Supportive symptom management as there is no cure	Focus on symptom management and psychological support
Malnutrition	Reversible	Increase nutrient intake	Nutrition support may help

- Focus interventions on treatment of symptoms and reduction of psychological burden for patient and family.
- Cachexia is not the same as starvation in that catabolism and subsequent weight loss can occur even if caloric intake is maintained or increased.
- Educate patient/family re difference between weight loss related to cachexia versus related to diuresis.
- Artificial nutrition in the setting of advanced cachexia is ineffective and will not improve quality of life.
- If patient is able, gentle physical exercise is recommended as it is known to improve peripheral blood flow, metabolism and neurohormonal abnormalities associated with cachexia.



Non-Pharmacological approach

Cachexia treatment options:

- Emphasis should be placed on maintaining and/or improving quality of life.

Anorexia treatment resources:

- Refer to a registered dietitian (RD); ensure dietitian aware of goals of care and focus of symptom management.
- Consider focus on maintenance of food and fluid intake for social and psychological benefits; liberalize dietary choices as much as possible (eg. low fat diet unnecessary).

Pharmacological Approach

- Standard heart failure therapies are known to improve quality of life and reduce symptoms and may reduce symptoms even at advanced stages of disease.
- Although many guidelines will refer to the use of appetite stimulants and steroids in the treatment of anorexia and cachexia, there is insufficient evidence of the benefit of these therapies. They are not recommended at the current time.
- Early satiety/nausea: Metoclopramide 10 mg PO or subcutaneous, 30-45 minutes prior to meals and at bedtime (hs) - (reduce dosage in renal impairment).
- Where concomitant depression/anxiety/insomnia is present, the antidepressant Mirtazapine may have the added benefit of increased appetite and weight gain. Starting dose of 7.5 mg may be up titrated to 30 mg at hs with consideration to sedative effects.