Divide et Impera: by joint forces and disciplines alleviate suffering from cachexia

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Palliative care specific issues in cachexia research and management: do we have guidelines to offer?

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Definitions / Diagnosis	Palliative Care; Cachexia
Patients	
Key aspects Pall Care	
Diagnosis & Treatment	Neglect versus overtreatment
Does cachexia hurt?	Calman, Culture, Calories
Guidelines to offer?	Nutrition, Drugs, psychosocial, activity, …
Current approach	Cachexia elements, impact

Cancer Cachexia

Key components (domains) of cancer cachexia

- **Loss of weight >5% last 6 months, ongoing last 1-2 months**
  - **In most patients weight loss reflects loss of muscle mass**
  - **In patients with fluid retention, large tumor mass, or obesity (>30kg/m2), muscularity needs to be measured directly or weight loss is >15%/6 mts**
- **Anorexia** (central, taste, satiety, bowel) **/ reduced food intake**
- **Catabolic drive** (inflammation and/or tumor)
- **Decreased muscle mass** (depletion), **- strenght**

Impact

- **Psychosocial consequences** (eating-related distress)
- **Decreased physical function** (physical fatigue)

Severity

(Proposal)

Severity	0	1	1	2
Loss	No loss	No loss	Loss	Loss
Depletion	Store normal	Depletion	Store normal	Depletion

Consensual diagnostic criteria after Systematic Literature Reviews, cachexia expert focus groups, core cachexia experts, peer-discussion at Lofoten May 2008 → Delphi consensus clinical cachexia experts.

Palliative Care

Palliative care is the **active, total care** of the patients whose disease is not responsive to curative treatment. **Control of** pain, of other **symptoms**, and of **social, psychological and spiritual problems** is paramount. Palliative care is **interdisciplinary** in its approach and encompasses the **patient**, the **family** and the **community** in its scope. In a sense, palliative care is to offer the most basic concept of care – that of providing for the **needs** of the patient wherever he or she is cared for, either at home or in the hospital. Palliative care **affirms life** and regards **dying as a normal process**; it neither hastens nor postpones death. It sets out to preserve the best possible quality of life until death

EAPC. ***Eur J Pall Care*** **2007;14:109-114**

Patients

61-y man, cardia-carcinoma (uT3 uN1 M1)
Metastasis:liver, peritoneal, gluteal, bones
Day 1 second cycle chemotherapy (ECF)

45 kg, 2 mts ago 51 kg, 164 cm, BMI 19.6, oral intake ↘ 25% of normal, appetite 5/10

Stomatitis G1, h/o abd. Surgery, CRP 21 g/dl

Early satiety 6/10, nausea 4/10, dysphagia 1/10, fatigue 8/10, abdominal pain 3/10
Wife distressed what to cook, wants TPN

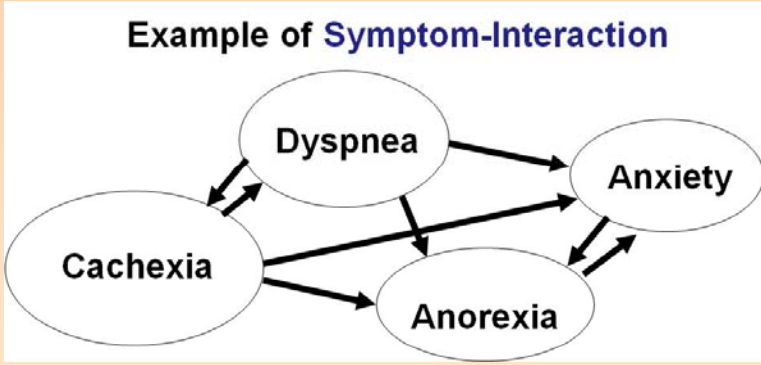
Acetaminophen, novamine, osmotic laxative

Patients

62-j family women, 3 children
advanced colorectal carcinoma M1, G2,
metastasis liver, peritoneal, lung
5-FU/LV/CPT-11 x 6 mts (PR, SD), after 3 mts
PD → Oxaliplatin/Capecitabine x 3 Mts, SD
→after 2 mts bowel obstruction and PD
Family requests parenteral nutrition

Multidimensional aspects of suffering

- **Pain-Syndromes** (80%)
- **Fatigue** (90%)
- **Loss of Appetite & Weight** (80%)
- **Nausea / Vomiting** (90%)
- **Anxiety** (25%)
- **Shortness of Breath** (50%)
- **Delirium-Agitation** (80%)
- **Depressive Symptoms** (30%)
- **Social / Family Distress** *(>30%)*
- **Existential Distress** *(>30%)*



Cachexia is one among other problems: prioritize
Cachexia causes (also) symptom interactions

Teunisen & Graeff, EAPC 2007. Volume 4 Topics Pall Care. Walsh D Supp Care Cancer 2000. Vainio A
J Pain Symp Manag 1996. Reuben DB Arch Intern Med 1988. Dewys WD Am J Med 1980

Unity of care involving families in care concepts

Family members are partners in care, involved in nursing, organisation, enhancing compliance (and pressure), …

Family members are suffering from losses, role change, misunderstandings, etc.

Cachexia involves typically the „whole“ family

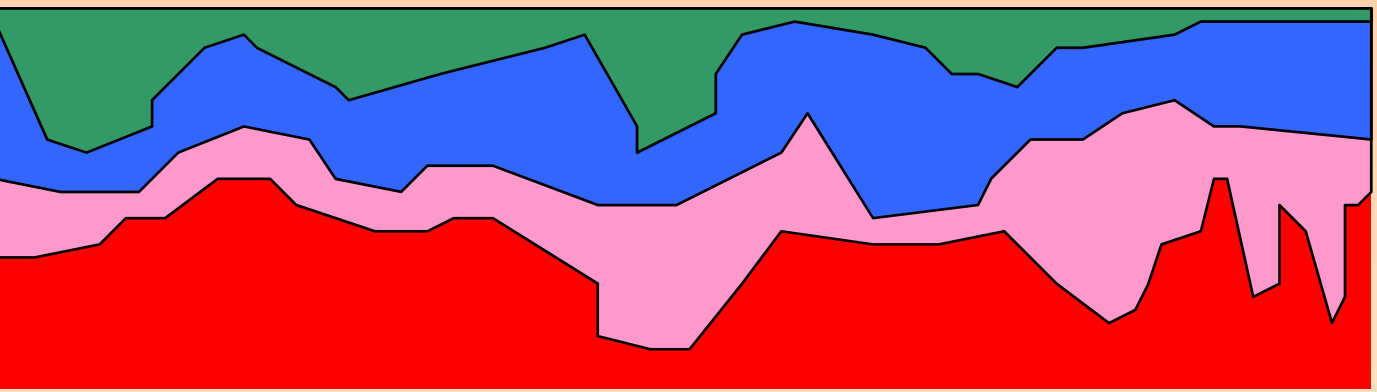
Goal-, and suffering-directed (not [only] disease-directed) diagnostic and therapeutic concepts

Screen for symptom, check impact, prioritize

- **Cause-directed treatments if reversible, and treatment appropriate**
- **Alleviate suffering from multi-dimensional consequences**
- **Empower patient and family to understand cachexia**

Diagnosis and multidimensional assessment of cachexia and its impact: far more than weight loss

Fluctuating trajectories of illness



Individual patient trajectories

- Information, communication
- Autonomy, Decisions
- Distress psychosocial
- Distress physical

In modern oncology (with phases of PD-SD-PR and treatments) cachexia‘s importance fluctuates

Limited life time implicating concurrent priorities until death and likelihood to reach “nutritional” goals

	Time to response		
	days	wks	mts
Weight loss - survival			
Loss of appetite			
Nutritional intake			
Body composition			
- Edema			
Function physical			
Quality of life			
- Fatigue (physical)			
Eating-related Distress			

Goals for cachexia treatment change of time

Specific symptoms and complications impacting nutrition

Nausea	Stomatitis
Vomiting	Dysgeusia
Constipation	Dental problems
Diarrhea	Difficulty chewing
Defecation after meal	Dysosmia
Pain	Xerostomia
Dyspnoea	Thick saliva
Fatigue	Dysphagia
Anxiety/depression	Epigastric pain
Sense of hopelessness	Abdominal pain

Secondary causes for impaired oral nutritional intake

Poster #170

Many frequent symptoms and complications in Palliativ Care can contribute to Cachexia

Eating-related suffering of patients and family members

Elements of eating-related distress[1]

- Contra-intuitive, unpredictable inability to eat and weight loss
- Existential distress (loss of weight and control)
- Change of cooking habits, cooking as expression of love
- Couples coping: trying, searching advice, pressure, accept

→ Item-bank development for assessment Poster EAPC 2008 #186

Emerging awareness of psychosocial consequences of cachexia: 12 papers identified in systematic literature review[2], EAPC 2008 #33, #62, #186

Psychosocial impact of Cachexia seems to matter

1 Strasser F et al. Palliative Medicine 2007;21:129-37

Delivery of care by multi-professional teams in various care settings

Cachexia assessment requires acknowledgment of multidimensional aspects.

Specialized approaches („cachexia“ clinics[1,2]) consist of multi-diciplinary teams covering nutritional, psycho-social-spiritual, physical, medical, and nursing aspects (among other)

Cachexia assessment & management is teamwork

1 Dalal S. et al., EAPC 2008 #396; 2 Strasser F et al. ESMO 2006

Diagnosis and treatment of cachexia

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→Should we treat these patients (and families)?
→ Which goals do we want to achieve?

Diagnosis and treatment of cachexia

Neglected ⟷ **Overtreatment**

Reversible cause of impaired nutritional intake (mucositis, pain, dyspnea, constipation, dysphagia, wrong food, etc.)

Multimodal approach (nutrition, exercise, inflammation, symptom control, distress, family) **not followed**

„Aggressive“nutrition lacking achievable goals

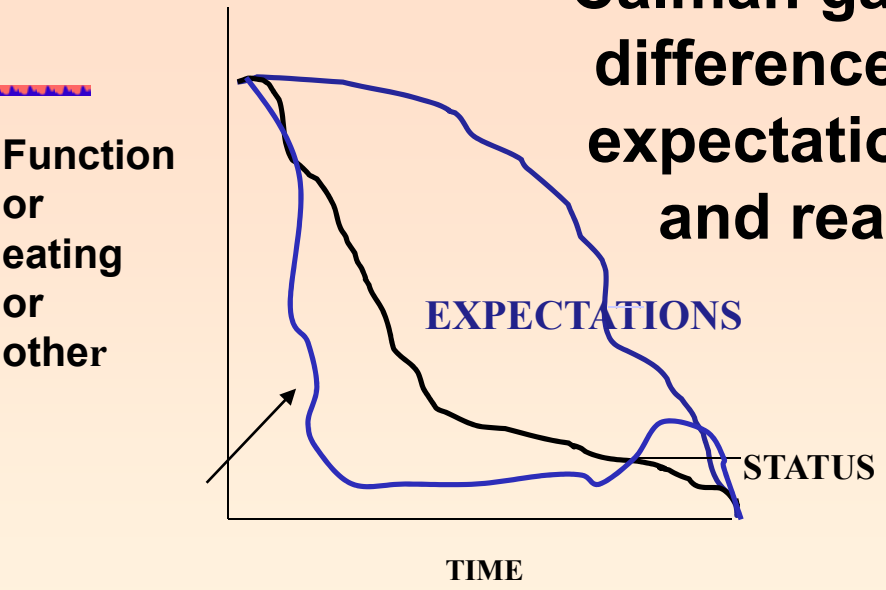
Misunderstanding of cachexia mechanisms

Lack of alternative interventions tackling meaning, hope, dignity, closure, etc.

→ No prospective research data

Does cachexia hurt?
Calman, Culture, Calories

Calman gap[1]: difference of expectations and reality



<u>Meaning of Eating</u>[2,3]

„my daily bred give me today“

Eating = life

Love → Eating

Cultural & religious differences

Misunderstanding of „what happens with me“: hurts

→ New meaning and hope with less function & food

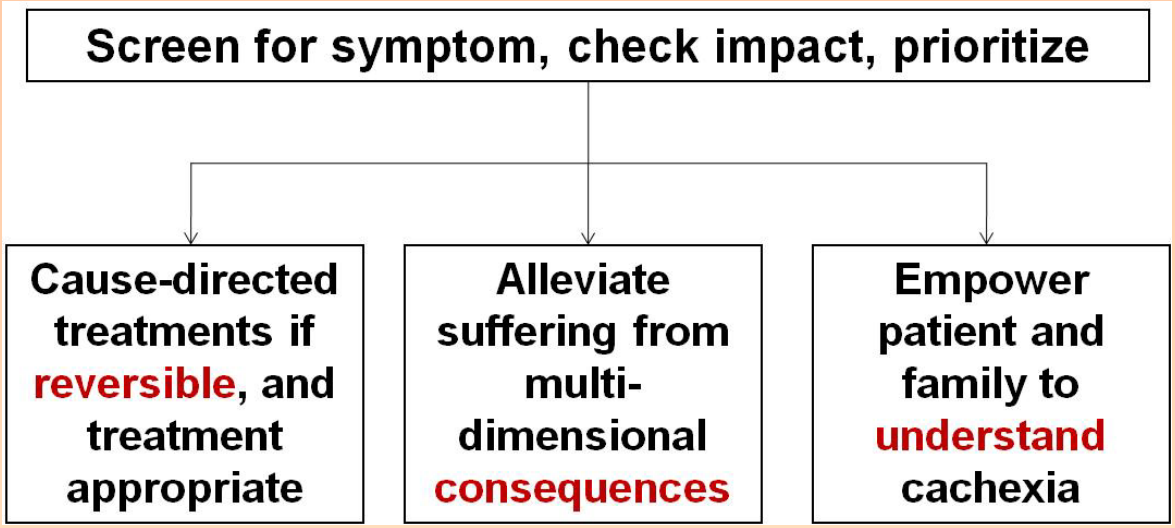
1: Calman KC. Quality of life in cancer patients-an hypothesis. J Med Ethics 1984; 10: 124-
2: Mintz S.W et al, The Anthropology of food and eating, 200
3: Salomonsson, Ethnologia Scaninavia 199

Do we have guidelines to offer?
Nutrition, Drugs, Counselling, etc.

Guidelines may be needed for:	**Needed!**
• **Diagnosis and classification of cachexia in the cancer palliative care context**	**EPCRC**
- Primary cachexia domains: Phenotype?	***EPCRC***
- Secondary causes of ▼oral intake	**EPCRC**
- Eating-related distress	**EPCRC**
• **Nutritional interventions incl. counselling**	**ESPEN** *EPCRC*
• **Anti-cachexia drugs, combinations**	**EPCRC**
• **Psychosocial interventions**	*EPCRC*
• **Physical activity interventions**	*EPCRC*
• **Prognostication and prioritisation**	*EAPC*

→ **EPCRC: www.epcrc.org YOU ARE INVITED!**

Current approach (St.Gallen Nutrition & Fatigue Clinic)



Interventions: nutritional, anti-cachexia drugs, counselling (understanding, calman-gap, meaning), secondary anorexia treatment, physical activity, oncological, social net.

- **ESAS**
- **MMSQ**
- **HADS**
- **SACS***
- **SIF***
- **2-d oral intake**
- **Diet type**
- **Social net**
- **FICA***
- **Coping**
- **ERD***
- **Function: FIM**
- **Preferred PA***

SACS: secondary anorexia & cachexia checklist; SIF: single-item fatigue domains; ERD: eating related-distress; PA: physical activities; FICA: Faith

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Conclusion:

New set of diagnostic criteria is under development by EPCRC → new assessment tool

Key questions on palliative care specific issues in cachexia → many are open (www.epcrc.org)

Collaborative efforts needed and welcomed