

Cancer-Related Anorexia-Cachexia Syndrome

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Cancer-related anorexia-cachexia syndrome (CACS) is an under-recognized component of accelerated mortality and morbidity in patients with advanced cancer. The lack of desire to eat also can create tension and conflict between patients and their families. Advanced practice nurses play a vital role in ensuring early assessment and interventions for patients with CACS.

Mrs. T was a 60-year-old gravida 2, para 2 Caucasian patient with stage IIIC endometrial cancer who presented for her fifth cycle of paclitaxel and carboplatin chemotherapy. She was ambulating with a walker because of unsteady gait and reported nausea, fatigue, weakness, and decreased appetite. Mrs. T had occasional heart palpitations and reported dizziness and lightheadedness. She said that her sisters and husband were distressed and sometimes angry over her loss of appetite and desire to eat. Mrs. T feels guilty when she has difficulty or inability to eat food they have prepared for her. She has lost 6.6 kg since her last visit four weeks ago.

Mrs. T presented to her local hospital in May 2009 with complaints of weakness, decreased appetite, and right-side abdominal pain for three weeks. Computed tomography scan of her chest, abdomen, and pelvis revealed abnormal bilateral mediastinum and hilar nodes. Parenchymal, pre-, and infracarinal nodes; significant abdominal ascites; peritoneal caking with nodularity; and a large mass in the lower abdomen with one component measuring 8 x 13 cm and another measuring 9 x 13 cm also were present. Pelvic ultrasound revealed abdominal and pelvic ascites. Her CA-125 was 338 U/ml (normal value is less than 35 U/ml in most laboratories). Mrs. T was referred to gynecology-oncology for evaluation and treatment.

Mrs. T had had exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, appendectomy, posterior enteration, anterior resection of the rectosigmoid with primary anastomosis,

and left pelvic lymph node dissection. Surgical pathology report noted International Federation of Gynecology and Obstetrics grade 3, stage IIIC, undifferentiated endometrial adenocarcinoma with metastasis to the ovaries, omentum, colon, terminal ileum mesentery, and appendix mesentery. Mrs. T was prescribed six cycles of carboplatin at 175 mg/m² and an area under the curve of 6. Review of symptoms was negative, except for as stated previously.

In the past, Mrs. T had been diagnosed with metastatic endometrial cancer, diabetes mellitus type II, and open reduction and internal fixation of the left hip and ankle in 1983 after a motor vehicle accident. Her current medications included hydrochlorothiazide and triamterene, oxycodone and acetaminophen, docusate sodium, senna, pegfilgrastim, aprepitant, lorazepam, a multivitamin, metoprolol succinate ER, and promethazine. She had no known drug or food allergies. She had never undergone colonoscopy or mammogram, and her last Pap smear was performed in 1995. Mrs. T's father died at age 52 with myocardial infarction, and her mother died at age 76 with a positive history of diabetes mellitus type II. She had no known family history of carcinoma, hypertension, or cerebrovascular accidents.

Mrs. T was on disability for inability to perform job duties because of frailty

at the time of study. She previously had smoked 0.25 packs of cigarettes a day for two years but quit in 1970. She occasionally consumed alcohol and denied recreational drug use. She lived in a two-story private home with her husband of 42 years. She had two adult children who no longer lived at home.

Mrs. T exhibited no signs of acute distress. She was awake, alert, oriented, and cooperative, and her speech was clear and appropriate. She had moist and pink lips and oral mucosa, healthy gums, and a normal palate. Her posterior pharynx appeared normal. Mrs. T's respiration rate was normal as well, with no wheezing. Her lungs were clear bilaterally. Her heart rate and rhythm were regular with no extra sounds, and no heart murmur was appreciated. Her abdomen was symmetric with no visible herniations. Mrs. T's skin was warm and healthy, and a midline scar had healed. She had positive bowel sounds. Her abdomen was scaphoid, soft, nontender, and nondistended, with no palpable abdominal masses or hepatosplenomegaly. Mrs. T's external genitalia were normal, with no discharge at introitus. Her urethral meatus and urethra appeared healthy. Blood was not noted in her vaginal vault. Her cervix, uterus, and adnexa were surgically absent. Bimanual examination revealed no palpable masses or tenderness. She had no visible or palpable cervical, supraclavicular, subclavicular, or axillary lymphadenopathy.

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