

Anorexia: an Eating Challenge in Palliative Care

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Anorexia: un Desafío Alimentario en Cuidados Paliativos

Anorexia: um Desafio Alimentar em Cuidados Paliativos

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INTRODUCTION

Anorexia is a common and complex symptom in patients with advanced cancer, characterized by partial or total decrease of food intake or desire to eat. Food aversion¹ can be triggered by various metabolic and immunological disorders¹⁻⁵, in addition to emotional complications that may contribute to the worsening of the nutritional status and the general condition of the patients^{6,7}.

The relationship between cancer anorexia and poor prognosis and survival is factual due to weight loss that impairs the immune system, muscle mass with loss of strength and balance that may be associated with cachexia syndrome^{2,4,5}. Consequently, this can affect patients' quality of life^{1,3,6,5,8,9} and result in apathy, gradual disinterest in life and social isolation.

According to the World Health Organization, one of the pillars for palliative care is the quality of life of patients with chronic, evolutionary and even terminal diseases, including cancer.

Therefore, palliative care entails a set of practical assistance measures for advanced cancer patients who require special care for addressing serious, chronic, degenerative, progressive, and life-threatening illnesses¹⁰. It is an urgent humanitarian need worldwide due to a high level of late diagnosis, and poor survival rates. Furthermore, palliative care transcends traditional care models, bringing bioethics issues to the fore, including nutrition-related themes⁸.

Due to the multiple dimensions involved in caring for palliative patients -physical, social, psychological - a multidisciplinary approach is needed to provide proactive care, while ensuring previous management of several symptoms^{8,10}. Thus, multidisciplinary teams should

develop effective communication and patient-and family-centered care, although it may become quite challenging on account of the complexity of advanced cancer. Similarly, dietitians as healthcare providers involved in this setting have a great responsibility to employ all the necessary skills to provide comprehensive assessment for palliative care patients⁸.

Despite the relevance of the issue, it is surprising that palliative patients are neglected by the healthcare providers, and that a gap in the literature exists on nutritional intervention to prevent or mitigate anorexia. Therefore, in an effort to deepen this issue, this article addresses the importance of debating the eating challenges of these patients and emphasizes the dietitian's role in a multidisciplinary team.

NUTRITION AND ANOREXIA: A CRITICAL ISSUE

Nutrition is a set of metabolic processes, involuntary and dependent on a regular and satisfactory nutrients supply, whose purpose is nourishing the entire body and promoting fully functional systems in different physiological situations. Nevertheless - in progressive disease conditions - metabolic changes occur due to immune system imbalance, besides lipolysis, protein loss caused by hypercatabolism²

Malnutrition is a well-known problem as an independent risk factor for morbidity and mortality among cancer patients¹¹. Thus, an abnormal metabolic process is not able to maintain the functioning of all body organs and systems. Cancer anorexia and malnutrition include loss of lean mass, muscle weakness, fatigue, an impaired immune system, an impaired functional status, poor quality of life and patient survival^{11,12}.

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There is a close relationship between eating, nutrition and cancer^{1,3,6,8,9} due to the link among foods, health, hope and vitality. Overall, eating is understood as something good and healthful, although for advanced cancer patients who suffer from anorexia, it might be seen as a stressing factor^{6,8,9,13}. This perception is considered as worrying for palliative care patients, because a good outcome is not expected when facing a life-threatening disease even by individualizing the therapeutic plan^{4,5}. Furthermore, treatments side effects, like bad taste in the mouth, gastrointestinal disturbances and pain can worsen a patient's anorexia condition^{1,2,9} and food aversion¹. It should be noted that, some patients have experienced anorexia as an inconstant sensation of desire to eat. Yet, in other cases, patients complain of a sensation of early satiety and food aversion.

Several studies have shown that nutritional intervention plays a relevant and preventive role for the choice of the best means and feeding pathways and provisioning of proper nutrients for each phase of the illness^{5,8,12,13}. This intervention can help encourage the needed eating pattern changes, monitor the possible side effects of treatments and, as far as possible, prevent or delay the malnutrition process. Admittedly, every effort is made to ensure that the objectives of bringing quality of life and dignity for the patient in palliative care can be achieved^{5,8,9,12,13}.

NUTRITIONAL INTERVENTION AND THE ROLE OF DIETITIANS AND MULTIDISCIPLINARY TEAMS

Individualized nutritional intervention, through dietary counseling, bears positive effects on nutritional status and quality of life in palliative care patients^{5,8,9,12,13}. Dietitians can provide support to patients and families towards understanding new senses and meanings assigned to nourishment through dietary counseling^{5,12,13}. Hence, the latest guideline on nutrition for cancer patients, published by ESPEN, has highlighted dietary counseling as one of the approaches to cancer-associated malnutrition, although has been recommended in palliative care that "only after considering together with the patient the prognosis of the malignant disease and both the expected benefit on quality of life and potentially survival as well as the burden associated with nutritional care"⁵.

Dietary counseling has been described as "a dedicated and repeated professional communication process that aims to provide patients with a thorough understanding of nutritional topics that can lead to lasting changes in eating habits"⁵. This approach can help cancer patients and their families to deal with eating disorders found in progressive disease⁷, guide patients and their families on how to prepare new homemade recipes, explain about the rational use of oral nutritional supplements or

artificial nutrition and guide on gastrointestinal symptom management^{5,8,9,12,13}.

Oral intake should be a first choice; however, often foods and drinks can be changed in sensory properties such as taste, smell, appearance, color, texture to encourage and ameliorate the intake. At other times, a number of problems like swallowing disorders, gastric disturbance, constipation, also require new food changes, for instance: temperature, bland diet foods, limited food and drink amount, and limited fat and fiber content. In some cases, artificial nutrition could be indicated. Hence, the enteral route becomes a good option for feeding the patient who is unable to use the oral pathway^{5,8,9,12,13}.

Among advanced cancer patients, eating behavior dimensions have been examined by a number of investigators, which has shown that eating issues have a psychosocial as well as a physical component^{1,3,6,7,8}. Moreover, the presence of a food culture usually manifests itself in beliefs, convictions, and guided interventions in popular knowledge. Thus, in search of idealized "healthy eating", patients can live under dietary rules imposed in order to protect them^{6,8}. Although food assumes an important role in the social life of people, patients in palliative care may have eating habits changed for reasons inherent to the disease affecting nutritional status and quality of life^{5,7-9,12,13}.

The challenge for dietitians is to know how to improve nutritional intake through providing enough food on a timely basis to prevent or mitigate anorexia, delay weight loss and ameliorate a patient's functional status and quality of life¹². However, all decisions on nutritional interventions have to consider cancer prognosis, anticancer treatments, patient's nutritional status, and nutritional intervention goals, as well as a patient's desire, whether he/she is able to decide or whether the family agrees so. Still, these actions should be supported by effective communication to all healthcare providers, conveying trust and respect^{5,8}.

Respect for advanced cancer patients' autonomy is of fundamental importance within the palliative approach⁸. This bioethical condition is consolidated in human rights doctrines and resolutions, where human dignity is a core value. The fulfillment of these patients' desires and nutritional needs becomes an ethical concern for all healthcare providers; and at the same time, an achievement of human dignity for patients.

CONCLUSION

Eating challenges in palliative care should be faced as a critical issue for advanced cancer patients and anorexia-related eating disorders. Therefore, individualized

nutritional intervention shall be provided for all cancer patients, especially those in palliative care, which requires continuous care due to short-life expectancy. It is worth noting that effective nutritional intervention depends on a comprehensive assessment of individual needs by the dietitian to prescribe an integrated therapeutic plan, through patient-centered effective communication and shared decision-making, together with a multidisciplinary team.

CONTRIBUTIONS

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CONFLICT OF INTEREST

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