MANAGEMENT OF POOR APPETITE IN PATIENTS WITH CHRONIC KIDNEY DISEASE

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Assessment

- Assess duration, change in oral intake, change in weight/lean body mass.
- Assess for presence of specific food aversions, early satiety, taste changes, dry mouth, swallowing problems.
- Assess and correct possible contributing factors:
  - Glycemic control
  - Fluid balance
  - Depression/anxiety
  - Nausea/constipation (see BCPRA Symptom Management Resources)
  - Inadequate dialysis prescription / under dialysis (if applicable)
  - Minimize/eliminate medications that may lead to poor appetite, taste changes, dry mouth

Non-pharmacological Strategies

- Liberalize diet restrictions (salt, phosphorus, potassium) if safe to do so.
- Eat frequent small, high calorie meals and snacks.
- Drink liquids between meals (not at meals) to avoid early satiety during meals.
- Encourage easy food preparation and use of meal/grocery delivery services.
- Consider oral lubricants to manage symptoms of dry mouth (e.g., Mouth Kote, Moi-Stir, Biotine).
- Encourage physical activity, as tolerated. Exercise can stimulate appetite.
- Consider oral nutrition supplements.

Consider goals of care. If goals are conservative:

- Educate patient and family that a reduction in appetite is part of the natural progression of CKD and/or aging.
- Focus on balancing oral intake requirements with quality of life.

See BCPRA patient teaching tool “Tips for People with Nausea and/or Poor Appetite.”

Pharmacologic Interventions

- Appetite stimulants, such as megestrol acetate, have not been clearly shown to be advantageous in the CKD population and are therefore not recommended.
  - For hemodialysis patients, intra-dialytic parenteral nutrition (IDPN) may be considered. Refer to: Please refer to www.bcrenalagency.ca/resource-gallery/Documents/Intradialytic%20Parenteral%20Nutrition%20(IDPN).pdf.

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Patients with CKD frequently experience poor appetite related to uremia, complications of CKD and other co-morbidities. Appetite may worsen with progression of kidney disease leading to malnutrition. As nutrition status is an important factor in dialysis and/or transplant outcomes, management of anorexia depends largely on the goals of care for each patient. While there is research demonstrating a relationship between the presence of appetite disorders in uremic patients and the consequences for nutrition status, no information is available to guide the treatment of anorexia in the CKD population. Guidelines from the management of poor appetite in cancer care were used to support this algorithm.

Supporting References

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   This systematic review concluded that the current evidence using megestrol acetate in dialysis patients is limited, safety beyond 24 weeks is unknown and its use is associated with significant adverse effects. Three randomized controlled trials (n=9-22) and 6 observational studies (n=9-32) involving dialysis patients were included. There are no studies involving non-dialysis CKD patients. The 3 RCTs studied megestrol acetate doses ranging from 80-800mg per day for a duration of 8 to 24 weeks. Two of the 3 studies reported a 1.7 to 5kg weight gain while 2 trials found a statistically significant increase in serum albumin and appetite. The only adverse effect reported was abnormal ACTH stimulation test. No deaths were believed to be drug related.

   The 6 observational studies used megestrol acetate doses ranging from 40 to 800mg per day over 12 to 24 weeks. Four of the 6 trials found a 1.5 to 4.6kg weight gain and a statistically significant increase in

serum albumin of 2.2 to 5.2 g/L. All patients reported increased appetite. Forty-three adverse effects and 21 discontinuations were reported, including overhydration/excessive fluid gain, diarrhea, hyperglycemia, excessive weight gain, decreased baseline cortisol levels, thrombophlebitis, nausea/vomiting, confusion/hallucinations, etc. No deaths were believed to be drug related.

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