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Long-Term Care Survey Alert

Quality of Care: Resident Shedding Pounds Due To Poor Appetite? Target These 2 Often-Overlooked Causes

The answer to why a resident isn't eating may be easier than you think.

When a resident stops eating well or has a lackluster appetite, take a look at his mood and meds.

"Not eating is a major symptom of depression," says **John Schnelle, PhD**, a professor of medicine at **Vanderbilt University** who has done research on dining assessment in nursing homes. Thus, "we think people who are capable of eating who aren't should receive a consult for assessment of depression."

A desire to eat alone may also be a red flag: Schnelle notes that "some people may wish to be left alone during the meal." But if that's the case, "staff still has to be mindful that the person's desire to isolate himself may be due to depression -- and thus assess accordingly."

If antidepressant therapy alleviates the primary depression, then the individual may once again find food appealing, adds **Joseph Gruber, RPH, CGP, FASCP**, director of medication therapy management programs for **Omnicare Inc.**

Choose the right antidepressant for the person who has a poor appetite, however. "Some antidepressants can cause various degrees of appetite and weight loss, most notably fluoxetine and sertraline," Gruber cautions.

Other antidepressants, such as paroxetine and mirtazapine, may be beneficial for residents who have poor appetite and weight loss, he notes. Since paroxetine can pose problematic side effects for nursing home residents, he adds, nursing homes tend to use mirtazapine more widely for "depressed individuals exhibiting significant appetite suppression and weight loss."

Review the Residents' Meds

Various types of medications can cause appetite suppression, says Schnelle (see p. 31 for a list of routine meds, including those with the potential for an alternative). In addition, medications that have a direct irritating effect on the stomach can cause or contribute to poor appetite and weight loss, according to Gruber.

Examples: An oral nonsteroidal anti-inflammatory medication such as ibuprofen can cause direct GI injury, Gruber says. Also, "Alzheimer's medications such as acetylcholin-esterase inhibitors can cause significant nausea, vomiting and subsequent poor appetite and weight loss due to their chemical activity in the stomach." Rivastigmine seems to do this the most followed by donepezil and galantamine, he adds.

Memantine, which is in a different class of Alzheimer's drugs, usually doesn't have this effect. So why not just use memantine? Clinical studies show benefits from using an acetylcholinesterase inhibitor and "even increased benefits of combining them with memantine," Gruber explains.

Another option: If a person starts on an acetylcholinesterase inhibitor and stops eating to the point he or she is losing weight, back down on the dose until the person's stomach gets used to it, Gruber suggests. "Then titrate the dosage upward slowly." Sometimes you may need to switch to an alternative acetylcholinesterase agent or substitute memantine, he adds.

Clinical tips: If you can't substitute a med, get the interdisciplinary team involved, suggests **Marilyn Mines, RN, RAC-C, BC.** "The dietician can offer suggestions and help look at drug interactions along with the pharmacist," says Mines, manager of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. For example, if a resident taking a drug

that irritates his GI tract can't switch to another med, offer frequent servings of soothing foods and fluids, Mines suggests.