

Anorexia-cachexia

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This issue's special feature, on which these questions are based, was commissioned from independent authors. The Life-long Learning scheme 2007 is supported by an educational grant from Martindale Specials but the company has no editorial input. The information in the box below should help readers to identify knowledge gaps and undertake continuing professional development. Readers are also invited to complete the questions overleaf to test their knowledge of the articles, and send their answers, together with a stamped and addressed C5 envelope, to:

Life-long Learning – Anorexia-cachexia
Hospital Pharmacist
 1 Lambeth High Street
 London SE1 7JN



Entries must be received by 22 October 2007. Results will be returned with a certificate of completion.

Name: _____

RPSGB registration number: _____

Address: _____

Post code: _____

Life-long Learning competition

This is the first set of questions of the next Life-long Learning competition, which will run until the November 2007 issue.

The entrant who achieves the highest marks in this series of three exercises will win registration and travel expenses (up to £200) for the *Hospital Pharmacist* conference in February next year. The runner up will receive complimentary registration to the conference.

Your name, address and scores will be held on a database for the purpose of awarding prizes. Should you not wish your details to be held in this way, please tick the box. If you do this, you will be sent a certificate, but you will be ineligible for a prize.

How to undertake continuing professional development

Identify knowledge gaps

- ◆ The causes of anorexia-cachexia and methods used for its detection
- ◆ The classes of drug used to manage the symptoms of anorexia-cachexia

Act

- ◆ Read the articles in this issue
- ◆ Test your knowledge by answering the multiple-choice questions overleaf

Evaluate

- ◆ What have you learnt?
- ◆ How has it added value to your practice?
- ◆ What will you do now and how will this be achieved?

The feature on anorexia-cachexia has been accredited by the College of Pharmacy Practice against the Royal Pharmaceutical Society's general and hospital practice areas of competence, which can be accessed via *Hospital Pharmacist* online (www.pjonline.com/links/hp)

Reading the feature and completing the questions will help readers to fulfil aspects of the following competency areas, depending on their area of practice and application of learning: G1, G5, G8, G9, HP1, HP2, HP4, HP5, HP10.

Completion of the questions entitles undergraduates to one point towards the

Professional Development Certificate, a joint initiative between the British Pharmaceutical Students' Association and the College.

The assistance of the College of Pharmacy Practice is acknowledged in producing the CPD elements of this month's special feature.

Further information on how hospital pharmacists are approaching the challenges of CPD can be found in articles in the February 2005 issue of *Hospital Pharmacist* (2005;12:65–72).



To answer the questions, tick either the True or False column

| | True | False | | True | False |
|--|------|-------|---|------|-------|
| 1. Anorexia-cachexia syndrome (ACS): | | | 6. Pharmacological treatment: | | |
| a) Is a life-threatening condition | | | a) Management of ACS focuses on treating the underlying causes | | |
| b) Only affects patients in the advanced stages of cancer | | | b) Topical corticosteroids treat, but do not prevent, ulcers | | |
| c) Is capable of impairing a patient's response to chemotherapy | | | c) A systemic antifungal agent is recommended to treat oral candidiasis | | |
| d) Occurs in over half of all cancer patients | | | d) Megestrol acetate has been shown to improve quality of life in patients with ACS | | |
| e) Is more common in breast cancer sufferers than lung cancer sufferers | | | e) Use of megestrol acetate is limited by its high incidence of severe side effects | | |
| 2. Causes: | | | 7. Use of corticosteroids: | | |
| a) Weight loss in ACS patients is purely a result of reduced food intake | | | a) Corticosteroids are not recommended to treat weight loss alone | | |
| b) Hypocalcaemia leads to a loss of appetite | | | b) Corticosteroids should not be used in patients with a poor prognosis | | |
| c) Chemotherapy can lead to a reduced calorie intake due to nausea and vomiting | | | c) Review of corticosteroid treatment is recommended two days after initiation of therapy | | |
| d) Voluntary energy consumption is likely to be reduced in cachexic illness | | | d) Corticosteroids may help reduce muscle proteolysis | | |
| e) Wasting in cachexic patients is partly explained by energy from the oxidation of food being released as heat, instead of being used for ATP synthesis | | | e) Corticosteroids can relieve compression secondary to oedema | | |
| 3. Biochemical abnormalities: | | | 8. Other pharmacological treatments: | | |
| a) Cytokines are thought to be the key mediators of ACS | | | a) The most common side effect of eicosapentanoic acid is constipation | | |
| b) In animals, chronic administration of cytokines such as interleukin-1 is associated with a reduction in food intake | | | b) Megestrol acetate may exert its effect centrally via stimulation of neuropeptide Y | | |
| c) Raised leptin levels in ACS stimulate feeding to reverse weight loss | | | c) Thalidomide has proved useful in treating symptoms such as insomnia and sweating | | |
| d) The Cori cycle, which provides tumours with energy, contributes to the development of cachexia | | | d) When used to treat ACS, thalidomide does not need to be supplied on a named patient basis | | |
| e) The production of lipid mobilising factor by tumours leads to a reduction of lipid levels in the bloodstream | | | e) Metoclopramide is beneficial in treating nausea and vomiting | | |
| 4. Detection: | | | 9. Treating dry mouth: | | |
| a) Rapid weight loss over a few days is a useful indicator for the development of ACS | | | a) Dry mouth in ACS patients may be caused by medication | | |
| b) The development of ascites could potentially prevent the detection of ACS | | | b) Artificial saliva substitutes have shown to be more effective than chewing gum | | |
| c) Tricep skinfold thickness is one of the sites commonly used as an indicator of body fat stores | | | c) Mucin-based artificial saliva is generally better tolerated than cellulose-based artificial saliva | | |
| d) Bioelectrical impedance analysis is based on the principle that lean tissue is resistant to electrical currents | | | d) A deficiency in zinc has been linked to altered taste in cancer patients | | |
| e) Creatinine measurement is a highly valuable method for measuring ACS progression | | | e) Pilocarpine is ineffective against dry mouth if there is no residual salivary tissue function | | |
| 5. Nutrition: | | | 10. Future developments: | | |
| a) An alcoholic drink can boost nutrition, as it has appetite-stimulating properties | | | a) Melatonin has been shown to increase toxicity in patients on chemotherapy | | |
| b) Parenteral nutrition helps maintain the gut mucosal barrier | | | b) The use of cannabinoids to treat weight loss may be limited by their side effects | | |
| c) Increasing portion size is a simple way of increasing food intake | | | c) Cyproheptadine is a serotonin agonist | | |
| d) Intensive parenteral nutrition does not increase lean tissue mass | | | d) Pentoxifylline has been shown to improve appetite in ACS patients | | |
| e) Although improving appetite is not associated with improved survival, it may improve a patient's quality of life and sense of well being | | | e) Gherlin has shown potential in the treatment of ACS | | |

Answers will appear in the November issue

