



Complete Summary

GUIDELINE TITLE

Unintentional weight loss in the elderly.

BIBLIOGRAPHIC SOURCE(S)

University of Texas, School of Nursing. Unintentional weight loss in the elderly. Austin (TX): University of Texas, School of Nursing; 2006 May. 21 p. [38 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [May 2, 2007, Antidepressant drugs](#): Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

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SCOPE

DISEASE/CONDITION(S)

Unintentional weight loss

- Malnutrition
- Wasting Syndrome

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Nutrition

INTENDED USERS

Advanced Practice Nurses
Dietitians
Health Care Providers
Nurses
Patients
Pharmacists
Physician Assistants
Physicians
Students

GUIDELINE OBJECTIVE(S)

- To delineate a simplified criteria for the early identification and screening for unintended weight loss in the elderly
- To outline the standard for diagnosis and treatment of unintended weight loss in the elderly
- To strengthen the elderly patient's quality of life, vitality, and functional ability even with other comorbidities through a balanced nutritional status
- To evaluate and consolidate the newest research to capably direct the elderly patient with unintended weight loss
- To achieve the highest level of patient compliance and endorsement with therapeutic, non-pharmacologic and pharmacologic management

TARGET POPULATION

Individuals aged 65 to 79 years and 80 years and over

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Subjective assessment including present history, assessment of symptoms, past medical and surgical history, comorbidities, dietary and weight history, social and psychosocial history, and risk factors
2. Objective assessment – physical examination with emphasis on the oral exam, loss of subcutaneous fat, muscle wasting, and body mass index (BMI)
3. Diagnostic procedures:
 - Complete blood count (CBC)
 - Complete metabolic panel
 - Thyroid-stimulating hormone (TSH)
 - Liver enzymes
 - Lactate dehydrogenase level
 - Serum albumin, transferrin, prealbumin, retinol-binding protein, and cholesterol
 - 24-hour urinary creatinine/height ratio
 - Chest x-ray
 - Mini-Nutritional Assessment
 - Mini-Mental Status Examination
 - Geriatric Depression Scale if indicated

Management/Treatment

1. Non-pharmacological therapy
 - Recording weight monthly
 - Increasing caloric requirements and protein intake
 - Providing appropriate nutrient mix of carbohydrates, fat and protein.
 - Multivitamins, calcium, vitamin D, vitamin B, and folic acid; adequate hydration
 - Ensuring adequate oral health
 - Eating smaller meals more often
 - Add flavor enhancers, fats and oils to usual foods
 - Enhancing dietary environment
 - Providing mealtime assistance as needed
 - Offering a variety of nutritional supplements
 - Regular exercise
2. Pharmacological therapy
 - **Note:** Drugs should not be used as first line intervention in the elderly as there has been inadequate testing of appetite enhancement medication in this population.
 - Megestrol (Megace)
 - Tetrahydrocannabinol (Dronabiol, Marinol)
 - Oxandrolone (Oxandrin)
 - Mirtazapine (Remeron)
 - Human growth hormone (Somatotropin)

MAJOR OUTCOMES CONSIDERED

- Quality of life
- Functional ability
- Serum albumin levels
- Weight gain or weight stabilization

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature was searched through Pub Med, MEDLINE, EBSCO, CINAHL, CDC, and Cochran's Collaboration. Searches were limited to evidence in the literature published in the last five to seven years.

NUMBER OF SOURCE DOCUMENTS

Thirty-eight documents, articles and/or guidelines were pooled for guideline recommendations.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Subjective Review
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality/Levels of Evidence

- **Good:** Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.
- **Fair:** Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.
- **Poor:** Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Adapted from: U.S. Preventive Services Task Force Ratings: Strength of Recommendations and Quality of Evidence. Guide to Clinical Preventive Services, Third Edition: Periodic Updates, 2000-2003. Agency for Healthcare Research and Quality. Alexandria, VA: International Medical Publishing, Inc.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The literature was scrutinized by systematic review and analysis of the evidence with consensus of four Family Nurse Practitioner graduate students at the University of Texas at Austin, School of Nursing.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

These practice guidelines are extrapolated from the latest research and guidelines with group consensus following extensive literature review.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

- **A** – Strong recommendation that clinicians provide the service to eligible patients. There is good evidence that the service improves important health outcomes and concludes that benefits substantially outweigh harms.
- **B** – Recommendation that clinicians provide the service to eligible patients. There is at least fair evidence that the service can improve health outcomes but concludes that the benefits outweigh harms.
- **C** – No recommendation for or against routine provision of the service. There is at least fair evidence that the service can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.
- **D** – Recommendation against routinely providing the service to asymptomatic patients. There is at least fair evidence that the service is ineffective or that harms outweigh benefits.
- **I** – Conclusion that the evidence is insufficient to recommend for or against routinely providing the service. Evidence that the service is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Adapted from: United States Department of Health and Human Services (U.S. DHHS), Office of Public Health & Science. U.S. Preventive Services Task Force. Guideline to Clinical Preventive Services, (3rd ed.: Periodic Updates, 2000-2003), Alexandria, VA: International Medical Publishing, Inc.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The draft was originated by a group of family nurse practitioner students in their graduate program and was compared with the guidelines from other groups and adapted appropriately. The draft was then submitted for review to the family nurse practitioner faculty and revisions were made. An outside specialist favored the group with the final external review of the draft, which was subsequently revised. The amended and reorganized recommendations were then presented to the guideline committee.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (Good, Fair, and Poor) and recommendation grades (A-I) are defined at the end of the "Major Recommendations" field.

Diagnosis/Evaluation

Criteria for Diagnosis

- Significant weight loss of > 5% weight loss in 30 days or >10% weight loss in 6 months without trying to lose weight. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
- Interventions should begin when
 - a. The body mass index (BMI) is = < 21
 - b. > ¼ of food left uneaten at 2 of the 3 meals per day assessed over 7 days. **(Strength of Recommendation: B; Quality of Evidence: Fair)**

Subjective Assessment

1. Present history
2. Symptoms
3. Past medical and surgical history with identification of comorbidities
4. Dietary history
5. Weight history (significant weight loss is >5% weight loss in 30 days or >10% weight loss in 6 months)
6. Change in clothing size

7. Social and psychosocial history
8. Family support
9. Identification of risk factors
10. Description of functional status

Objective Assessment

Complete physical exam with emphasis on the oral exam, noting loss of subcutaneous fat, muscle wasting, and BMI.

Diagnostic Procedures

1. Complete blood count (CBC) (including total lymphocyte count)
2. Complete metabolic panel
3. Thyroid-stimulating hormone (TSH)
4. Liver enzymes including alkaline phosphatase and bilirubin
5. Lactate dehydrogenase level
6. Serum albumin
7. Serum transferrin
8. Serum prealbumin
9. Serum cholesterol
10. 24-hour urinary creatinine/height ratio
11. Chest X-ray (CXR)
12. Screening for insufficient food intake (Mini-Nutritional Assessment at www.mna_elderly.com) (Guigoz, Vellas, & Garry, 1994) **(Strength of Recommendation: B; Quality of Evidence: Fair)**
13. Screening for depression if indicated (Geriatric Depression Scale) (Yesavage et al., 1983) **(Strength of Recommendation: A; Quality of Evidence: Good)**
14. Screening for dementia if indicated (Mini-Mental Status Examination) (Folstein, Folstein, & McHugh, 1975) **(Strength of Recommendation: A; Quality of Evidence: Good)**

Management/Treatment

Non-Pharmacological Therapy

1. To restore a deficit, an increase up to a 100% of the recommended daily allowance (RDA) values in energy, protein, and micronutrients is required. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
2. To restore a deficit, caloric requirements should be 30 to 35 cal/kg/day. (Just to maintain their weight and activity, the elderly need 25% greater than the standard RDA calories.) **(Strength of Recommendation: B; Quality of Evidence: Fair)**
3. To restore a deficit, the protein intake should be 1.5 to 2 g/kg/day. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
4. After addressing the energy and protein requirements, the second goal is to provide the appropriate nutrient mix. Typically this consists of 50-60% carbohydrate, 25% fat and 25% protein. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
5. Excess carbohydrates should be avoided as this may lead to hyperglycemia. **(Strength of Recommendation: B; Quality of Evidence: Fair)**

6. Take multivitamin supplementation to keep up with the increased metabolism and restore deficiencies. **(Strength of Recommendation: B; Quality of Evidence: Good)** The micronutrients (water and fat soluble vitamins and trace minerals) may need to be increased to a dose of 5 to 10 times the RDA. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
7. The elderly also require increased calcium and vitamin D to prevent osteoporosis, along with Vitamin B and folic acid to counteract increased homocysteine and its cardiovascular effects. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
8. Adequate hydration is required to facilitate the transport of nutrients, remove by-products and maintain cardiovascular stability. The recommendations are:
 - a. 30 to 35 mL per kg body weight with a minimum of 1500 mL/day
 - b. 1 to 1.5 mL per calorie consumed
 - c. Replacement of added losses from disease or medications. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
9. In an acute catabolic insult, nutritional support should be initiated within 48 hours. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
10. Ensure adequate oral health. Poor oral hygiene, ill-fitting dentures, and dry mouth are risk factors for decreased oral intake through altered taste sensation and difficulty in chewing and swallowing. **(Strength of Recommendation: A; Quality of Evidence: Good)**
11. Include patients and families in the decisions about the extra food, protein, and supplements so that, with their own ideas and input, they may be more likely to comply with the treatment plan. Involvement in menu revision and food selection are also important. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
12. Provide favorite foods and snacks. Consider food preferences, consistency, and temperature along with ethnic food choices. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
13. Optimize energy intake with high energy foods at the best meal of the day. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
14. Eat smaller meals more often. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
15. Provide finger foods that are nutritious and easy to eat. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
16. Use flavor enhancers which increase the taste of the food, therefore, augmenting intake of food by counteracting the age-related increase in smell and taste thresholds. **(Strength of Recommendation: B; Quality of Evidence: Good)**
17. Add fats or oils to usual foods to increase weight gain through increased energy intake which may also help to avoid satiety-related limitations which can decrease energy intake. **(Strength of Recommendation: A; Quality of Evidence: Good)**
18. Avoid gas-producing foods which may lead to gastric distention with air and early satiety and, therefore, decreasing the total amount of food intake. **(Strength of Recommendation: I; Quality of Evidence: Poor)**
19. Minimize dietary restrictions. Salt and fat contributes to the taste in food, and a regular diet does not significantly affect glucose control. Both adjustments to the diet may make meals more delectable and savory and, therefore, increase overall food intake. **(Strength of Recommendation: B; Quality of Evidence: Fair)**

20. Enhance the dietary environment. Use innovative dining room interventions. Make meal times interesting which are anticipated with pleasure. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
21. Women eat more with men present. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
22. Both men and women eat more with family present. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
23. Eat in the company of others which leads to enhanced enjoyment of food and increased energy intake. 44% more food is eaten when eating in groups. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
24. Larger meals are eaten on the weekends and later in the day. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
25. More food is eaten if the meals-on-wheels delivery person stays while the recipient eats. **(Strength of Recommendation: A; Quality of Evidence: Good)**
26. Many older adults need assistance with their meals because of functional, physical, or cognitive disabilities. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
27. Increasing nutrition through food should be the first step, prior to initiating dietary supplements. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
28. If the patient's caloric needs cannot be met with 3 meals and 3 snacks per day, high energy and nutritionally dense supplements should be added. **(Strength of Recommendation: B; Quality of Evidence: Fair/Poor)**
29. Oral nutritional supplementation is associated with weight gain and reduced fatality. **(Strength of Recommendation: A; Quality of Evidence: Good)**
30. Protein/calorie supplements should be given between meals and not with meals to minimize appetite suppression and compensatory decreased intake of food at meal time. **(Strength of Recommendation: A; Quality of Evidence: Good)**
31. Have the patients sample the supplements and give them a variety. Presentation of the supplement should also be varied. **(Strength of Recommendation: B; Quality of Evidence: Fair/Poor)**
32. A liquid supplement in which the energy is supplied by glucose instead of fat is less likely to cause satiation. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
33. Use community nutritional support services to decrease the functional limitations related to supply, preparation, and consumption of good quality food. **(Strength of Recommendation: A; Quality of Evidence: Good)**
34. Participate in regular exercise which promotes muscle hypertrophy, gain in lean-body mass, and may stimulate appetite. **(Strength of Recommendation: C; Quality of Evidence: Poor)** The evidence of the research was unable to document increased overall weight gain but did document gain in lean body mass which makes regular exercise an important adjunct in the guideline.

Pharmacological Therapy

1. Drugs should not be used as first line intervention in the elderly as there has been inadequate testing in this population. Benefits are restricted to small weight gains without indication of decreased morbidity or mortality or

- improved quality of life or functional ability. **(Strength of Recommendation: B; Quality of Evidence: Fair)**.
2. **Megestrol (Megace)** is a synthetic progestational agent that is associated with weight gain. It may be effective in the elderly population at 800mg daily for three months. Persons receiving megestrol acetate should be monitored for adrenocortical insufficiency. **(Strength of Recommendation: B; Quality of Evidence: Fair)** Should not be used with bedfast patients related to DVT risk.
 3. **Tetrahydrocannabinol (Dronabinol – Marinol)** has not been adequately tested in underweight elderly men and women but has shown some potential benefits. Dronabinol could be used when weight loss occurs without an apparent cause, and when no reversible cause is present, but is associated with central nervous system toxicity. Dronabinol appears to be a good drug for end-of-life and palliative care because it stimulates appetite, has anti-nausea properties, decreases pain, and enhances general well-being. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
 4. Patients receiving **Megace** and **Dronabinol** usually gain weight, but the weight is primarily adipose tissue as opposed to lean body mass. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
 5. Consider use of exogenous anabolic hormones to increase net protein synthesis. **Oxandrolone (Oxandrin)** is the only oral anabolic steroid that is safe and effective for weight loss and PEM (protein energy malnutrition). Studies have not shown that they lead to weight gain **(Strength of Recommendation: C; Quality of Evidence: Fair)**
 6. **Mirtazapine (Remeron)** used for the treatment of depression has also been shown to increase appetite and weight gain. **(Strength of Recommendation: B; Quality of Evidence: Fair)**
 7. The short term use of **human growth hormone (Somatotropin)** may be promising in severely cachectic nursing home residents, but may be associated with increased mortality. **(Strength of Recommendation: C; Quality of Evidence: Fair)**

Definitions:

Rating Scheme for the Strength of the Recommendations

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Quality/Levels of Evidence

Rating Scheme for the Strength of the Recommendations

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CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document for Management of Weight Loss in the Elderly.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations" field).

The guidelines recommendations draw heavily and are based primarily on consensus statements and other national guidelines written about unintentional weight loss. The guideline standards submitted are synthesized from the

appropriate research references addressing the assessment and treatment of unintentional weight loss.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved early identification of elderly patients with unintentional weight loss
- Appropriate management and treatment of elderly patients with unintentional weight loss
- Decreased morbidity related to decreased nutritional status
- Enriched quality of life, vitality, and functional ability for elderly patients with unintentional weight loss regardless of their other comorbid conditions.
- Decreased cost of care

POTENTIAL HARMS

Adverse Side Effects of Medications

- *Megestrol (Megace)*. The most frequent side effects are pulmonary embolism, thrombophlebitis, cardiomyopathy, leukopenia, edema, constipation, delirium, hypogonadism, hyperglycemia, adrenal suppression, and impotence. Should not be used with bedfast patients.
- *Tetrahydrocannabinol (Dronabinol - Marinol)*. The most frequent side effects are dizziness, confusion, somnolence, difficulty concentrating, mood disturbances, anxiety, dry mouth, and ataxia.
- *Oxandrolone (Oxandrin)*. The most frequent side effects are hepatic necrosis, liver failure, hepatic tumors, congestive heart failure, severe edema, and polycythemia.
- Patients receiving *Megace* and *Dronabinol* usually gain weight, but the weight is primarily adipose tissue as opposed to lean body mass.
- *Mirtazapine (Remeron)*. The most frequent side effects are confusion, somnolence, dizziness, nausea, dry mouth, constipation, flu syndrome, edema, abnormal thinking or dreams, hypo/hypertension, elevated cholesterol or triglycerides, and asthenia. *Remeron* should be used with caution in elderly patients.
- *Human growth hormone (Somatotropin)*. The most frequent side effects are intracranial hypertension, pancreatitis, hypothyroidism, generalized edema, glucose intolerance, carpal tunnel syndrome, headache, arthralgias, myalgias, and gynecomastia.

Subgroups Most Likely to Experience Harm

Patients with hypersensitivity or allergy to the drug components or drug class of the medications in the recommendations. Bedfast patients should not be given Megace related to the deep vein thrombosis (DVT) risk.

CONTRAINDICATIONS

CONTRAINDICATIONS

- *Megace* is contraindicated in the presence of pregnancy, diabetes, thromboembolic disease, and impaired renal function.
- *Dronabinol - Marinol* is contraindicated in the presence of schizophrenia and hypersensitivity to sesame oil.
- *Oxandrin* is contraindicated in the presence of prostate and breast cancer, pregnancy, hypercalcemia, nephrosis.
- *Remeron* is contraindicated within 14 days of monoamine oxidase (MAO) inhibitor use and should not be used with alpha 2 agonists.
- Somatotropin is contraindicated in the presence of malignancy.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These guidelines are not intended for use outside the stated population. The independent skill and judgment of the health care provider must always dictate treatment decisions because individual patient circumstances vary and the treatment options which are appropriate also vary.
- These guidelines are provided for educational purposes, discussion, and as a decision-making tool both for clinicians, patients, and family members. It should not be relied upon or used without the supervision of a qualified physician.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Routinely screen all patients over 65 years of age for unintentional weight loss at every visit or once a month at home. If weight loss is greater than 5% in one month or greater than 10% in six months without trying to lose weight, begin implementation of recommendations included in the guideline as soon as possible. Using the implementation tool provided in the original guideline document will be extremely helpful in this process. (See "Availability of Companion Documents" field.)

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 May

GUIDELINE DEVELOPER(S)

University of Texas at Austin School of Nursing, Family Nurse Practitioner Program
- Academic Institution

SOURCE(S) OF FUNDING

University of Texas at Austin, School of Nursing, Family Nurse Practitioner Program

GUIDELINE COMMITTEE

Practice Guidelines Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: None available.

Print copies: Available from the University of Texas at Austin, School of Nursing,
1700 Red River, Austin, Texas, 78701-1499

AVAILABILITY OF COMPANION DOCUMENTS

An unintentional weight loss care flowsheet is available in the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 24, 2006. The information was verified by the guideline developer on November 14, 2006. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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