Correspondence

Pancreatic insufficiency and weight loss in older patients

Sir,

Weight loss is an important independent predictor of increased mortality in the older population.\(^1\) We report three cases of weight loss secondary to pancreatic insufficiency in elderly patients with no previous pancreatic disease.

An 80-year-old widower, presented with a six month history of lethargy, anorexia and weight loss of 6 kg. He was suffering a prolonged bereavement reaction associated with recent alcohol excess following the death of his wife. He weighed 44.5 kg, haemoglobin was 13.5 g/dl. The patient’s mood and appetite improved on antidepressant therapy and alcohol withdrawal, but he failed to gain weight, and reported episodes of intermittent diarrhoea. Barium enema and coeliac screen were unremarkable. Pancreatic insufficiency was diagnosed with a positive pancreolauryl test of 14.4% (normal range >30%). The patient’s diarrhoea stopped and he gained 14 kg in 10 months following pancreatic enzyme supplementation.

An 80-year-old man presented with vomiting several hours after eating and weight loss of approximately 6 kg in one month. Haemoglobin was 12.4 g/dl. Endoscopy, upper gastrointestinal tract biopsy, barium enema, abdominal ultrasound and coeliac screen were unremarkable. Pancreolauryl test was positive at 12.2% and CT scan showed pancreatic atrophy, but no calcification. His symptoms resolved, and he gained 8 kg in one month following pancreatic enzyme supplementation.

A 78-year-old woman was admitted with a 5-day history of diarrhoea following antibiotics for a chest infection. She also reported weight loss and malaise over a 1 month period. She weighed 39.2 kg, haemoglobin was 10.0 g/dl, and serum ferritin 40 μg/l (15–300 μg/l). Barium enema, upper endoscopy, coeliac screen and abdominal CT scan were normal. Pancreolauryl test was positive at 9.2%, and she gained 6 kg in 3 months following pancreatic enzyme supplementation.

The underlying cause is not identified in approximately one quarter of subjects in studies of weight loss in older people, hence the term geriatric cachexia.\(^1\) It is unclear, however, whether pancreatic function has been investigated in these studies. Age-related morphological changes in pancreas including duct cell proliferation, cavity formation and adipose tissue invasion have been described at post mortem in Wistar rats and humans. Structural changes have been confirmed in living subjects using ultrasound and endoscopic retrograde pancreatography.\(^2\)

The effect of these structural changes on pancreatic exocrine function currently remains unresolved. The majority of physiological studies have consisted of relatively small sample sizes drawn from select populations. There have been no longitudinal studies of pancreatic exocrine function in humans. The ‘gold-standard’ for the diagnosis of pancreatic insufficiency is by direct testing, and requires double lumen gastric and duodenal intubation. Some investigators have reported no significant age-related decline in the volume of pancreatic juice secretion induced by intravenous cholecystokinin/secretin stimulation,\(^3\) while others have found reductions of approximately one third.\(^4\) The volume of pancreatic juice secreted in response to intravenous cholecystokinin/secretin increased linearly up to the third decade of life, and thereafter declined, in a cross-sectional study of 180 subjects aged 16–83 years.\(^5\)

Non-invasive investigations of exocrine pancreatic function, including the para-aminobenzoic acid (PABA) and pancreolauryl tests are now available. Between 1996 and 2003, the University Hospital of Wales performed 159 pancreolauryl tests on 155 individuals, mean age 51.16 years (95%CI 49.99–52.33). Given the high prevalence of weight loss with increasing age, this suggests the
pancreolauryl test is being under-used in the investigation of older patients. The prevalence of pancreatic insufficiency in the older population is unknown. It is now easy to investigate and treat with enzyme supplementation, and should be considered in the differential diagnosis of weight loss in older patients.

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Cost-effectiveness of cognitive behaviour therapy for patients with chronic fatigue syndrome

Sir,

In their economic evaluations of treatments for chronic fatigue syndrome (CFS), Severens et al.1 compared the cost-effectiveness of cognitive behaviour therapy (CBT) with those of other interventions, and found that the percentage of CFS patients who improved with CBT performed for 8 months was 31% vs. 9% and 12% for other treatments. Considering that, in one study, 28% of CFS patients treated with low-dose hydrocortisone over just one month virtually recovered,2 Severens et al.1 also should have compared the cost-effectiveness of CBT with that of low-dose hydrocortisone.

Treatment with low-dose hydrocortisone for CFS, besides being intuitively far less costly than CBT, is also better-founded clinically than any psychological therapy, because hydrocortisone corrects the hypocortisolism that characterizes at least some CFS patients.3 Given that ‘frank hypocortisolism’, rather surprisingly, was one of the exclusion criteria for enrolment in the trial of Cleare et al.,2 the percentage of CFS patients who can be effectively treated with low-dose hydrocortisone in day-to-day health care is likely to be higher than the 28% found in that trial.2

In view of the 42 clinical features that CFS shares with Addison’s disease,4 including all the physical and neuropsychological symptoms listed in the diagnostic criteria for CFS,4 this syndrome should be treated with the two classic drugs for Addison’s disease, namely, hydrocortisone in combination with fludrocortisone,5 not with CBT. This psychological treatment was of benefit only to some patients fulfilling arbitrarily modified criteria for CFS, which ignore the physical signs and symptoms that discriminate CFS from depression.4 Therefore, CBT may have actually benefited depressed subjects, rather than patients with CFS.4

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