Weight loss, Unexpected

DEFINITION

Unexplained weight loss, or losing weight without trying — particularly if it's significant or persistent — may be a sign of an underlying medical or psychological disorder. The point at which unexplained weight loss becomes a medical concern is not exact. But many doctors agree that a medical evaluation is called for if patient lose more than 5 percent of body weight in six months to a year.

SIGNS & SYMPTOMS

- Decreased skin turgor
- Dry mucous membranes, thirst
- Sudden weight loss of 2% or greater
- Postural hypotension and/or low B/P
- Weak, rapid pulse
- Neck veins flat when client is supine
- Change in mental status
- Elevated BUN and Hct
- Decrease in urine output with increased specific gravity (reflects an actual rather than a potential fluid volume deficit).

ASSESSMENT:

- Monitor and document vital signs especially BP and HR.
- Assess skin turgor and oral mucous membranes for signs of dehydration.
- Monitor BP for orthostatic changes (changes seen when changing from supine to standing position). Monitor HR for orthostatic changes.
- Assess alteration in mentation/sensorium (confusion, agitation, slowed responses)
- Determine if patient showing signs of depression.
- Assess color and amount of urine. Report urine output less than 30 ml/hr for 2 consecutive hours.
- Monitor and document temperature.
- Monitor fluid status in relation to dietary intake.
- Auscultate and document heart sounds; note rate, rhythm, or other abnormal findings.
- Monitor serum electrolytes and urine osmolality, and report abnormal values.
- Weigh daily with same scale, and preferably at the same time of day.

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- Monitor active fluid loss from wound drainage, tubes, diarrhea, bleeding, and vomiting; maintain accurate input and output record.

Nursing Interventions

- Urge the patient to drink prescribed amount of fluid.
- Aid the patient if he or she is unable to eat without assistance and encourage the family or so to assist with feedings, as necessary.
- If patient can tolerate oral fluids, give what oral fluids patient prefers. Provide fluid and straw at bedside within easy reach. Provide fresh water and a straw.
- Provide comfortable environment by covering patient with light sheets.
- Monitor vital signs of clients with deficient fluid volume every 15 minutes to 1 hour for the unstable client and every 4 hours for the stable client. Observe for decreased pulse pressure first, then hypotension, tachycardia, decreased pulse volume, and increased or decreased body temperature.
- Check orthostatic blood pressures with client lying, sitting, and standing.
- Monitor for inelastic skin turgor, thirst, dry tongue and mucous membranes, longitudinal tongue furrows, speech difficulty, dry skin, sunken eyeballs, weakness, and confusion.
- Provide fresh water and oral fluids preferred by patient, provide prescribed diet; offer snacks, instruct significant other to assist patient with feedings as appropriate.
- Provide frequent oral hygiene, at least twice a day.
- Assist with ambulation if client has postural hypotension.
- Watch for signs of bulimia.

Patient Teaching

- Instruct patient to avoid rapid position changes, especially from supine to sitting or standing.
- Teach patient and family about appropriate diet and fluid intake.
- Teach patient and family how to measure and record intake and output accurately.
- Teach patient and family about measures instituted to treat hypovolemia and to prevent or treat fluid volume loss.
- Instruct patient and family about signs of deficient fluid volume that indicate they should contact health care provider.

Cultural considerations

- Assess for the influence of cultural beliefs, norms, and values on the patient's ideal of acceptable body weight and body size.
- Discuss with the patient those aspects of his or her diet that will remain unchanged, and work with patient to adapt cultural core foods.
- Validate the patient's feelings regarding the impact of current lifestyle, finances, and transportation on ability to obtain and prepare nutritious food.

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Coordinating Care with Nursing Assistant

- Assist with ambulation if patient has postural hypotension.
- Provide frequent oral hygiene, at least twice a day.
- Provide comfortable environment by covering patient with light sheets.
- Report any signs of depression.

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