18.1 GENERAL PRINCIPLES

- Fatigue may be defined as: “a subjective, unpleasant symptom which incorporates total body feelings ranging from tiredness to exhaustion, creating an unrelenting overall condition which interferes with an individual’s ability to function to their normal capacity.”

- Fatigue is believed to be the most common and most debilitating symptom experienced by cancer patients. Surveys reveal a prevalence of > 75%. This can increase to > 90% when including patients after treatment with radiotherapy or chemotherapy.

- Despite the prevalence and impact of fatigue the problem has been neglected in clinical and research terms. Reasons for this may include failure of health care professional to offer interventions and patients' lack of awareness of effective treatments.

- Fatigue affects physical, psychological and social well-being.

- Although most of the research is for cancer-related fatigue, it is recognised that fatigue also has a major impact on the quality of life for patients with non-malignant disease.

- Fatigue is a multi-dimensional syndrome and rarely an isolated symptom. It often has multiple contributing causes.

- The multidimensional nature of fatigue makes systematic evaluation essential. All palliative care patients should be screened for the presence of fatigue. Assessment should include a fatigue history, physical examination and appropriate investigations.

- A fatigue history should establish the following information: severity, temporal features (e.g. onset, course, duration and daily pattern), exacerbating and relieving factors, associated distress and impact on daily life.

- The evidence supporting specific management strategies is limited and further research is required.

18.2 GUIDELINES

18.2.1 Assessment

- Assessment of fatigue should depend on self evaluation by the patient. This should only be replaced by estimations from professionals when patient self-assessment is not possible.

- There is no single preferred assessment tool, but it is suggested for clinical purposes, where time may be limited, that a numerical rating scale may be the most practical. This may take the form of a numerical 0-10 scale or a fatigue scoring system based on the Palliative Care Assessment tool (PACA).  

\[
\begin{align*}
0 & = \text{no fatigue.} \\
1 & = \text{fatigue present but not affecting daily life.}
\end{align*}
\]
2 = fatigue present and having moderate effect of daily life.
3 = fatigue present and having overwhelming effect on daily life.

- Reassessment and evaluation of interventions should take place at regular intervals as clinically indicated.\textsuperscript{5, 9} [Level 4]

18.2.2 Management

- The management of fatigue should be tailored to the individual patient using a multi-professional approach.\textsuperscript{5} [Level 4]
- Management strategies will vary and may need to be adapted depending on the stage of the illness. It is important to identify when treatment of fatigue is not a priority in order to alleviate distress at the end of life.\textsuperscript{7} [Level 4]
- Treatable causes of fatigue should be managed appropriately e.g. anaemia, infection, drug side effects, insomnia, depression.\textsuperscript{4, 7} [Level 2++]
- When specific causes of fatigue cannot be identified and corrected, non-pharmacological and pharmacological management should still be instigated if clinically appropriate.\textsuperscript{5} [Level 4]
- Figure 18.1 outlines a management strategy in relation to fatigue in palliative care patients.

18.2.3 Non-pharmacological management

- There is a stronger evidence base for non-pharmacological management strategies in the management of fatigue compared to pharmacological interventions.\textsuperscript{9, 10} [Level 4]
- Non-drug management may include:\textsuperscript{5, 10, 11}
  - Patient information leaflets, advice on diet, sleep and exercise. [Level 2++]
  - Occupational therapy. [Level 4]
  - Physiotherapy. [Level 2++]
  - Psychological support. [Level 2++]
- Exercise programmes have been shown to be of benefit in the management of fatigue, both during and after cancer treatment. Goal setting can also provide a useful focus for patients.\textsuperscript{5, 9, 10} [Level 1+] Further research is required to determine the optimal type, intensity and timing of an exercise intervention.\textsuperscript{10} [Level 4]
- Psychosocial interventions specific to fatigue have been shown to reduce the level of fatigue.
- These may include: educating patients about fatigue, provision of literature, teaching of coping strategies and learned activity management.\textsuperscript{5, 11} [Level 2++]

18.2.4 Pharmacological management

- Drug management of fatigue may include the use of corticosteroids, psycho-stimulants or antidepressants.\textsuperscript{4, 7, 12} [Level 2++] (see \textit{Guidelines on Psychostimulants, Depression and Corticosteroids}).
- The evidence for the effectiveness of corticosteroids in the management of fatigue is limited.
- Corticosteroids are often prescribed for co-existent symptoms such as pain and poor appetite. If considering a trial of corticosteroids, dexamethasone is the recommended corticosteroid of choice. The suggested starting dose is 4 mg daily, administered before 2pm. Patients should be reviewed after 5-7 days. If there is no evidence of improvement the corticosteroids should be discontinued. If there is evidence of improvement the patient should be maintained on the lowest effective corticosteroid dose.\textsuperscript{7, 9} [Level 4] (See \textit{Guidelines on Corticosteroids})
For psychostimulants, the strongest supporting evidence is for methylphenidate hydrochloride. It has been shown to improve cancer related fatigue in some small studies but more research is needed to confirm its role. 12 [Level 4] (See Guidelines on Psychostimulants).

Figure 18.1 Management of fatigue in palliative care patients 5, 6, 9 [Level 4]

- Evaluation of fatigue using PACA assessment tool

- **SCORE 0**
  - Continue to monitor

- **SCORE 1-3**
  - History, examination, investigations (if appropriate) e.g. urea and electrolytes, full blood count, calcium, liver function tests and infection screen
  - Is the cause potentially treatable?
  - **YES**
    - Treat any reversible causes e.g. anaemia, infection, anxiety, depression, insomnia, drug side effects etc.
  - **NO**
    - Symptomatic therapies

- **Pharmacological management**
  - Corticosteroids
  - Psychostimulants

- **Multi-professional non-pharmacological management**
  - Information / education;
  - Exercise therapy;
  - Psychological support

- Regular reassessment of interventions
18.3 STANDARDS

1. All palliative care patients should be screened for the presence of fatigue and the result documented in the case notes.3,4,5,7 [Grade D]

2. The severity and impact of fatigue on daily life should be assessed in every patient 3,4,5,7 [Grade D]

3. Patients commenced on corticosteroids for fatigue should be reviewed after 5-7 days.9 [Grade D]

4. Patient information leaflets regarding the aetiology and management strategies for fatigue should be readily available.9,11 [Grade C]

18.4 REFERENCES


18.5 CONTRIBUTORS

Lead Contributors

Dr G Whyte
Speciality Registrar in Palliative Medicine
Aintree University Hospitals NHS Foundation Trust
Liverpool
and
Clatterbridge Centre for Oncology NHS Foundation Trust
Wirral

Dr L Johnny
Speciality Registrar in Palliative Medicine
St Johns Hospice
Wirral

Dr K Groves
Consultant in Palliative Medicine / Medical Director
West Lancashire, Southport and Formby Palliative Care Services
NHS Sefton and Queenscourt Hospice

Mr D Galvin
Physiotherapist
Halton Haven Hospice
Runcorn

Mr R Case
Lead Nurse for the Community Specialist Palliative Care Team
Wirral

Mrs G Harthen
Team Manager
Macmillan Community SPC Service
Knowsley Integrated Provider Service

Mr A Dickman
Specialist Principal Pharmacist
Marie Curie Palliative Care Institute
Liverpool

External Reviewer

Dr E Marshall
Consultant in Medical Oncology
Clatterbridge Centre for Oncology NHS Foundation Trust
Wirral