Weakness and Fatigue

Introduction
Fatigue is a persistent, subjective feeling of tiredness, weakness or lack of energy related to advanced chronic illness. It has many contributory causes, although the exact aetiology is poorly understood. Patients may use many terms to describe their experience of fatigue. Fatigue is a common symptom in progressive chronic disease. The severity and impact of fatigue may change in the course of the disease trajectory. It is frequently regarded as more distressing than pain by patients. It is often under-recognised by professionals. Fatigue may be unrelated to level of activity and not fully alleviated by rest or sleep. It is multidimensional, affecting physical function, cognitive ability, social, emotional and spiritual wellbeing. Reduced physical function limits participation in preferred activities and activities of daily living. Cognitive involvement limits activities such as reading, driving and social interaction. Fatigue can influence the patient’s decision-making about future treatment and may lead to refusal of potentially beneficial treatment. It is important to recognise that towards the end of life there will be a time point when intervention is no longer appropriate and may be distressing. At this stage, fatigue may provide protection and shielding from suffering for the patient.

Assessment
- All palliative care patients should be assessed for fatigue and its effects.
- Explore the person’s experience and understanding of fatigue.
- Acknowledge and validate the reality and significance of the symptoms.
- Be aware that patients may have multi-morbidities impacting on fatigue, for example cardiac/respiratory disease, renal or hepatic impairment, malignancy, hypothyroidism, hypogonadism, adrenal insufficiency, neurological conditions.
- Consider:
  - symptom pattern, duration
  - severity:
    - mild, moderate or severe
    - Patient-rated assessment on a 0–10 scale
  - impact on function and quality of life, for example everyday activities can seem impossible
  - impact on family or carers
  - contributing factors
  - general factors:
    - patient/family roles and responsibilities
- sleep disturbance
- nutrition – diet, absorption
- deconditioning due to reduced activity levels, fitness and/or muscle wasting
- over-exertion
- psychological factors, for example anxiety, fear
- depression

- condition-related factors:
  - metabolic abnormalities – consider checking sodium, potassium, calcium, magnesium, glucose, renal function, C-reactive protein, albumin
  - anaemia
  - infection
  - disease recurrence or progression – if weakness present, exclude malignant spinal cord compression (MSCC)
  - anorexia/cachexia – skeletal muscle wasting may be mediated by tumour necrosis factor, cytokines or both
  - Poorly controlled symptoms, for example pain

- treatment factors:
  - dialysis
  - biological therapy, for example interferon
  - surgery
  - prescribed medication, for example beta-blockers, sedating drugs, corticosteroids, opioids
  - over-the-counter medications
  - cancer treatments – radiotherapy, chemotherapy, hormone therapy.

**Management**

- The patient’s potential will be maximised through a combination of person-centred approaches in partnership with the multidisciplinary team.

- Treat potentially reversible factors if appropriate, for example blood transfusions may be helpful for some patients. Other symptoms and co-morbidities should be managed, and all medications reviewed.

**Non-pharmacological management**

- Diary – an activity/fatigue diary may help to identify precipitants and timing of symptoms.

- Energy conservation/restoration:
  - consider a self-management plan set priorities, delegate tasks
  - pace activities and attend to one activity at a time
  - schedule activities at times of peak energy and conserve energy for valued activities
  - eliminate non-essential activities
- occupational therapy referral for advice on minimising energy expenditure and appropriate aids/equipment.

- Physical activity and exercise:
  - an appropriate level of exercise can reduce fatigue and should be recommended
  - consider physiotherapy referral to ensure exercises are tailored to individual needs particularly for those patients who have advanced disease or are experiencing effects of treatments, for example anaemia, osteoporosis/bone metastases, falls.

- Psychosocial interventions – consider:
  - stress/anxiety management
  - relaxation/complementary therapy
  - sleep pattern advice, for example hot drink at night, avoid stimulants
  - offer appropriate verbal and written information.

**Pharmacological management**

- For patients with anorexia/cachexia-related fatigue, refer to Anorexia guideline.
- There is currently insufficient evidence to recommend pharmacological treatment, including the use of psychostimulants by non-specialists.

**Practice points**

As an ‘invisible’ symptom, fatigue is often misunderstood by patients, family, friends, colleagues and healthcare professionals. Open discussion should be encouraged. Often patients feel guilty about being no longer able to contribute fully to family life and this should be acknowledged.

People who have fatigue will have limited energy and may find it difficult to do simple everyday things that are usually taken for granted. The basis of managing fatigue is to ensure that the best levels of energy are available and used in the most efficient way. The Macmillan Get Active, Feel Good resource may be helpful.

For many patients, fatigue will be part of their experience of living with their illness. Through awareness and acknowledgement of the symptoms, consideration of lifestyle and the use of particular techniques, it is possible to manage fatigue and take steps to reduce the impact it has on daily life.

**Resources**

- Macmillan Cancer Support
- Macmillan Cancer Support, Coping with fatigue
- Macmillan Cancer Support, Get Active, Feel Good
- Cancer Research UK
- Cancer Research UK, Tiredness with cancer (fatigue)
References


