

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

WEAKNESS/FATIGUE

INTRODUCTION

Fatigue is defined as, “a subjective feeling of tiredness, weakness or a lack of energy”. The pathophysiology of fatigue in palliative care patients is not fully understood and multiple factors may contribute to it. The causes of fatigue are:

- Cancer related - altered metabolism, anorexia-cachexia, cancer-induced cytokines and other substances, paraneoplastic syndromes - Eaton-Lambert and other myopathies
- Treatment related - chemotherapy, radiation therapy, surgery, dialysis, biological therapy, e.g. interferon
- Others - autonomic failure - postural hypotension, occasional syncope, fixed heart rate, gastrointestinal symptoms, cardiopulmonary disorders
- Reversible causes:
 - Endocrine - hypothyroidism, hypo-adrenalism (most often due to rapid withdrawal of corticosteroid medication), diabetes mellitus, Addison's disease, hypercalcaemia, hypokalaemia and hyponatremia, dehydration
 - Anaemia
 - Haemorrhage
 - Depression, anxiety
 - Drugs - opioids, antidepressants, phenothiazines, beta blockers, phenytoin, levothyroxine
 - Infection/sepsis
 - Hypoxia, hypercapnia
 - Others - poor nutrition, sleep disturbances, bedridden, uncontrolled symptoms, etc.

Fatigue is a multidimensional symptom affecting physical, emotional, social and spiritual well-being and quality of life. It is an extremely common problem in palliative care patients and causes significant distress. The impact of fatigue often is not recognized by physicians. It is important to try and differentiate it from depression.

The words asthenia and fatigue are often used interchangeably by health professionals. Patients and families use several words to describe fatigue: drowsiness, tiredness, weakness, lethargy, reduced alertness or energy. Fatigue does not always manifest physically. Cognitive fatigue can make activities like reading or other leisure activities extremely difficult. Fatigue is often associated with affective disturbances and patients may feel listless, depressed, irked or paralysed.

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Fatigue can influence the patient's decision-making regarding future treatment and may lead to refusal of potentially beneficial treatment. Treating fatigue vigorously in those patients who benefit and withdrawing or withholding assessment and treatment procedures from those patients who do not benefit, will help provide optimal care.

ASSESSMENT

- All palliative care patients should be routinely assessed for fatigue and its impact
- Assessment must determine the underlying aetiology of fatigue, effectiveness of treatment and impact on quality of life for the patient and their family (**refer to the Guideline - Symptom Assessment**)
- Use a subjective Symptom assessment scale - Edmonton Symptom assessment scale to assess the symptom and the therapeutic outcome and document the same
- Laboratory investigations (if appropriate) - See Table 1

Table 1: Laboratory Investigations
Haemoglobin, WBC count, serum sodium, potassium, calcium, magnesium, blood glucose, serum urea, creatinine, liver enzymes, triiodothyronine, thyroxine, drug levels (phenytoin, digoxin)

MANAGEMENT

Non-pharmacological Measures

- Acknowledge the distress due to the symptom
- Address and correct reversible or contributing factors
- Patient and family should be educated on what could and could not be corrected
- Work with patient and family to assess fatigue and identify management plans
- Help with pacing of activities - encourage the patient to plan periods of rest and periods of moderate physical activity
- Advise the patient to delegate tasks to others when he/she is unable to perform
- Encourage the use of physical aids (walkers, grab bars) to preserve mobility, as fatigue progresses
- Rehabilitation goals should be carefully weighed in patients with advanced disease with short life expectancy to assure that the rewards of treatment outweigh the burdens
- **Depression/anxiety disorders**
 - counselling
 - psychotherapeutic interventions such as dignity therapy

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- massage and aromatherapy
- attention restoring activities - music, exposure to natural environment
- **Prolonged immobilization** - moderate physical activity and exercise preserve muscle function and has been shown to have strong benefit
- **Sleep disturbances**
 - sleep therapy such as sleep hygiene (go to bed only when sleepy, get out of bed when unable to sleep, use the bed for sleep only, no reading or problem-solving in bed, arise at the same time every morning, avoid napping, regular exercise, quiet and comfortable dark room, avoid watching the clock)
 - stimulus control (avoid coffee, nicotine)
 - relaxation techniques (progressive muscle relaxation, autogenic training, imagery training, meditation)
 - cognitive therapy

Pharmacological Measures

- **Fatigue** - Methylphenidate start with 2.5 - 5mg bd (am and noon), increase by daily increments of 2.5 - 5mg bd, maximum of 20 - 40mg/24 hours
- **Anorexia/cachexia** - *refer to the Guideline for Anorexia/Cachexia*

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