Managing fatigue

1. Take a proper history of tiredness/fatigue (as you would for pain).

2. Try to quantify the problem. How does fatigue affect the patient and their life? What is it they can and can’t do because of the fatigue? Do they have unrealistic expectations about the speed of recovery or are they denying the seriousness of their illness?

3. Try to understand the meaning of the fatigue for the patient.

4. Is the concern about the physical limitations or the worry that the fatigue may indicate disease progression and death?

5. Try to determine the cause:
   - treatment (eg chemotherapy, radiotherapy or steroid associated)
   - disease progression, depression or anxiety
   - an unrelated problem.

To determine the cause you should take a detailed history of the fatigue. Consider:
   - A person history – previous personality and previous reaction to illness or adversity.
   - The disease history – consider the usual natural history of this tumour type and/or stage (eg prostate cancer without metastases is unlikely to cause fatigue, but lung or pancreatic cancer may cause fatigue).
   - The treatment history and natural history of adverse effects, one to two weeks following chemotherapy or radiotherapy fatigue is expected. It is unlikely to be getting worse after that unless the disease is progressing or another cause.
   - Consider the use of appropriate tests to assess disease progression eg full blood count (FBC), albumin, liver function tests (LFTs), urea and electrolytes (U&E), glucose, weight, tumour markers, x-ray or scan.
   - Consider other causes not directly related eg thyroid, diabetes etc.
   - Assess psychological causes. It can be difficult to separate appropriate sadness and true clinical depression. Rating scales are sometimes helpful but a pervasive loss of interest or joylessness may indicate depression.

6. Rest usually makes fatigue worse, while appropriate exercise usually helps. Consider the role of appropriate graded exercise (even bed and chair based exercise will prevent de-conditioning).

7. GPs tend to lose touch with patients receiving oncological treatments. Try to maintain contact – patients appreciate this hugely and then feel more ready to discuss issues. It also creates trust which will be hugely beneficial in the doctor/patient relationship.

8. Taking the symptoms seriously and validating them is therapeutic for the patient.

9. Use the symptoms as a cue – patients may wish to discuss disease progression and prognosis etc.

10. Referrals may be useful or appropriate. Your interest, support and willingness to discuss concerns and have those difficult but important conversations is an equally significant part of patient care.