Fatigue:
Assessment and management in palliative care

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• Mr. HD

• Problem of fatigue in palliative care

• Fatigue Assessment

• Generic approaches to fatigue management

• Future directions

• Mr. HD

• Discussion
• Mr. HD

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• Discussion
Mr. HD

- 72 year old man with mesothelioma admitted to palliative care with increasing shortness of breath on exertion
- Diagnosed in March 2014 when presented breathlessness and weight loss
- He declined any treatments as he was concerned that living alone may compromise his ability to manage the adverse effects of chemotherapy
After being on the service for one month, a request was for admission to optimise palliation of breathlessness.

However, on admission, whilst bothered by breathlessness, Mr HD reported being most bothered by fatigue.

In fact, he tended to be quite irritable as he felt that the staff were only interested in pain and breathlessness.

In his own words, “don’t you people listen??”
• Mr. HD

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Fatigue in palliative care

• Fatigue in end of life care is common with reports ranging from 40 to 100% of people affected

• The wide variation in quoted rates reflect the lack of agreed diagnostic criteria

• However, despite this, there is general agreement that fatigue is a highly subjective, very personal experience and often very distressing problem

• Like pain, correlates with suffering

• May be a source of conflict
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- Discussion
Fatigue in advanced illness, unlike tiredness in otherwise healthy populations is remarkable for the fact that it is not improved by sleep and rest.

Fatigue may have numerous deleterious effects including on well-being:

- Physical
- Psychological
- Social
- Emotional

This not only impacts the patient but their family as well.
Assessing patient with fatigue

• Like any symptom, the assessment of a person with fatigue requires a comprehensive history and physical examination

• This must include an appreciation of the impact of the problem on the patient’s overall functioning

• The other main focus must be an assessment of whether there are features of this problem that may be reversible
Aetiology of fatigue in advanced cancer

- Tumour-related factors and complications such as:
  - Anaemia
  - Electrolyte abnormalities
  - Dehydration
  - Anorexia/cachexia
  - Thrombosis/pulmonary embolism
  - Renal, liver or heart failure
  - Hypoxia
  - Adrenal insufficiencies
  - Neurological deficit
  - Fever

- Comorbid conditions such as:
  - Hypothyroidism
  - Diabetes mellitus
  - COPD
  - Heart failure
  - Cardiovascular disease
  - Infections

- Iatrogenic factors relating to:
  - Chemotherapy
  - Immunotherapy
  - Small-molecule targeted therapies
  - Hormonal therapies
  - Radiotherapy
  - Surgery

- Physical symptoms associated with the underlying tumour or its treatment such as:
  - Pain
  - Dyspnoea
  - Difficulty swallowing
  - Appetite loss

- Side effects of other medications such as:
  - Opioids
  - Psychiatric drugs
  - Antihistamines
  - Beta blockers
  - Corticosteroids

- Psychological/behavioural factors such as:
  - Anxiety
  - Depression
  - Sleep disorders
  - Decreased physical activity

Cancer-related fatigue
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• **Generic approaches to fatigue management**
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Palliating fatigue: pharmacological interventions

<table>
<thead>
<tr>
<th>Cause of fatigue</th>
<th>Possible interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour</td>
<td>Systemic anti-cancer therapy (e.g., chemotherapy, hormonal therapy or targeted therapy)</td>
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<tr>
<td>Anti-cancer treatment</td>
<td>Consider reducing/delaying dose or stopping treatment (only if severe)</td>
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<tr>
<td>Other medications</td>
<td>Consider reducing dose/withdrawal of potential fatigue-inducing drugs (e.g., psychotropic drugs, anti-histamines, beta blockers, etc.)</td>
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<tr>
<td>Anaemia</td>
<td>If iron, folic acid or vitamin B12 levels are low, use supplements (oral/intravenous) as appropriate if haemoglobin levels are low, consider</td>
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<td>erythropoiesis-stimulating agents or whole blood/red blood cell transfusion</td>
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<tr>
<td>Electrolyte disorders</td>
<td>Hypercalcemia: intravenous sodium chloride and bisphosphonates</td>
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<td></td>
<td>Hyponatremia: fluid restriction and/or salt supplementation (oral/intravenous)</td>
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<tr>
<td>Dehydration</td>
<td>Rehydration with intravenous sodium chloride and depending on cause could include for example, discontinuation of diuretics, initiation of insulin</td>
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<td>treatment (if hyperglycemic), and treatments for fever/excessive sweating (e.g., clonidine, progestins, selective serotonin reuptake inhibitors,</td>
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<td>gabapentin if related to hot flushes)</td>
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<tr>
<td>Weight loss</td>
<td>If there are metabolic abnormalities resulting from anorexia-cachexia syndrome consider megestrol acetate or corticosteroids (depending on life</td>
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<td>expectancy)</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Depends on comorbidity present; check for hypothyroidism, adrenal insufficiency, diabetes mellitus, heart failure, cardiovascular disease, COPD,</td>
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<td>infections, etc., and treat according to findings</td>
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<td>Depression</td>
<td>Consider use of selective serotonin reuptake inhibitors</td>
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<td>Sleep disorders</td>
<td>Consider short-term short-acting benzodiazepine treatment if severe or unresponsive to non-pharmacological intervention. Sedating anti-</td>
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<td>histamines, antidepressants or antipsychotics may also be useful. Melatonin or methylphenidate may be beneficial if there is a disturbed day/</td>
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<td></td>
<td>night-time rhythm</td>
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<tr>
<td>Underlying symptoms</td>
<td>Pain or dyspnoea can cause fatigue and should be treated appropriately (e.g., non-steroidal anti-inflammatory drugs or opioids for pain, and</td>
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<tr>
<td></td>
<td>morphine, corticosteroids, bronchodilators or sedatives/anxiolytics for dyspnoea)</td>
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<tr>
<td>Unknown</td>
<td>Psychostimulants (e.g., dexamphetamine, dexamethasone, methylphenidate or modafinil) for symptomatic relief</td>
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Palliating fatigue: non-pharmacological interventions

Examples of possible non-pharmacological interventions for use in cancer patients experiencing fatigue.

<table>
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<tr>
<th>Category</th>
<th>Details</th>
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<tbody>
<tr>
<td>Energy conservation</td>
<td>Help patients to find a daily routine that balances activity and rest, which works for them based on their pattern of fatigue</td>
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<tr>
<td>Psychosocial support</td>
<td>This could include counselling/psychotherapy, cognitive behavioural therapy, etc. Can be provided in the form of group therapy as part of rehabilitation programmes or individually. Can also be sought through professional psychosocial oncology centres or through psychologists, counsellors, etc. Inform patient about the possibility of spiritual care. Advise distraction (e.g., reading, listening to music, walking, gardening, etc.) if appropriate to patient.</td>
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<td>Sleep therapy</td>
<td>Stimulus control, sleep restriction and sleep hygiene may be beneficial</td>
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<td>Complementary therapies</td>
<td>Relaxation therapy, massage, music, herbal remedies (e.g., American ginseng), yoga, and acupuncture may also provide relief</td>
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<tr>
<td>Other supportive care</td>
<td>Consultation with a dietician, physiotherapist or occupational therapist as required. Assist patient in gaining additional help at home from caregivers, volunteers, etc.</td>
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<tr>
<td>Physical activity</td>
<td>Encourage physical activity and provide information on any available training and/or rehabilitation programmes (supervised by a physiotherapist if fatigue is severe)</td>
</tr>
<tr>
<td>Self efficacy and self management</td>
<td>Encourage positive patient factors such as self efficacy, mastery and learned resourcefulness</td>
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Palliating fatigue

• Despite the myriad of suggestions, fatigue remains poorly palliated
• Reasons for this include:
  – Under diagnosed
  – Reversible causes not addressed
  – Impact of the problem underestimated
  – Disconnect between patient’s expectations that this will be discussed and hesitancy of health professionals to address and issue they perceive as insovable
Palliating fatigue

To date, expert recommendations suggest optimal approaches to best palliate this problem include:

- Cognitive treatments
- Supportive counselling
- Energy saving discussions
- Avoidance of pharmacological management unless this is targeted to reverse a specific curative cause
- Realistic goal setting
- Avoidance of harm
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Future targets to address fatigue?

- Aside from attempting to correct the reversible causes, little objective evidence exists to recommend definitive treatments.

- Possibilities from preliminary studies include:
  - Exercise programs
  - Psychostimulants
  - Online support groups
  - Modafondil
  - Modification of cytokine activity
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Mr. HD again

- Investigations did not reveal a readily reversible cause of Mr. HD’s fatigue

- He was reviewed by the OT and physio but he found himself too fatigued to engage

- After 2 weeks in the SPCU, it was clear that he was not able to self-care and although discussions regarding transfer to RACF were initiated, he died before these could be actioned
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• Reluctance to discuss fatigue

• Fatigue as a source of conflict

• Realistic goal setting conversations

• Clinician helplessness