Fatigue in Palliative Care

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Why fatigue?

- Palliative care patients identify fatigue as a significant symptom.
- Fatigue is one of the most complex symptoms experienced by cancer patients (Potter, 2004).
- Has an impact on the quality of life for both patients and their carers, which is not always recognised by health professionals.
Main Points

- Definitions of fatigue.
- Causes of fatigue.
- Management of fatigue.
- Concluding points.
Incidences

• The European Association for palliative care describe fatigue as one of the most frequent symptoms in palliative care patients, reported in 80% of cancer patients and in up to 99% of patients following radiotherapy or chemotherapy (Radbruch I et al, 2008)
Fatigue is notoriously difficult to define as it is such an individual experience, affecting people in different ways. (Brown, 2004)
Fatigue is an unpleasant symptom, which incorporates total body feelings ranging from tiredness to exhaustion, creating an overall condition, which interferes with individuals ability to function to their normal capacity.(Ream and Richardson, 1996)
• The European Association for Palliative Care suggests that fatigue is a subjective feeling of tiredness, weakness or lack of energy (Radbruch L et al, 2008)
• Generally, cancer related fatigue cannot be attributed to a single cause, but has a multi-factorial aetiology. (Pederson et al, 2003)
Primary fatigue

Primary fatigue is thought to be related to the tumour itself. The cancer produces chemicals and hormones that make the patient feel tired have a feeling of fullness and can cause other complex problems.
Secondary fatigue

- Depression/emotional distress
- Insomnia
- Weight loss/poor nutrition/dehydration
- Infection
- Anaemia
- Electrolyte imbalance
- Side effects of medication
- Co-morbidities
Fatigue can be divided into two parts: physical and cognitive.

Physical prevents participation in activities and impedes activities of daily living.

Cognitive complicates activities such as reading, driving a car and thus prevents leisure activities.
The impact of fatigue on the patient’s quality of life.

• Fatigue has a strong negative impact on the patient’s daily life (Pederson, et al 2003)

• Coakley et al’s, (2002) study found fatigue influenced many areas of life, for those with advanced cancer, including mood, relationships, walking ability and enjoyment.
• The participants in Potters (2004) study describe their fatigue as global, affecting their physical, social and spiritual aspects of their lives, as they struggle to cope.
Social consequences

Psychological consequences

Physical consequences

Spiritual consequences

FATIGUE

Struggling to cope

Psychological consequences

Social consequences

Physical consequences

Spiritual consequences

Potter 2004
• NICE (2004) Guidelines state that the goal of palliative care, is the achievement of the best quality of life for patients and their families.
Management of fatigue

- All patients should be screened for fatigue.
- The severity and impact of fatigue on daily life should be assessed in every patient.
- Treatable causes of fatigue should be managed appropriately in an effort to reduce levels of fatigue. (Coakley et al, 2002)
• Anaemia ➔ Blood transfusion
• Infection ➔ Antibiotics
• Fever ➔ Antipyretic drugs
• Dehydration ➔ Hydration
• Cachexia ➔ Nutrition, anabolics (high protein drinks)
• Sleep disturbances ➔ Sleep hygiene/sedative
• Electrolyte imbalance ➔ Biphosphonates, Magnesium, blood sugars
Pharmacological approach

- Steroids - Dexamethasone
- Psycho-stimulants e.g. Methylphenidate. Initially 5mg BD – morning and lunchtime. Caution with cardiac disease.
- Modafinil
- (Seek specialist advice with these medications).
- Antidepressants
Non pharmacological approach

• Patient education – providing information and support and enabling patients to talk about fatigue, its meanings and implications.

  ▪ Exercise – consider referral to physiotherapy.

  ▪ Fatigue management – consider referral to the Occupational therapist.
• Modifying patients’ activity and rest patterns-help patients to prioritise activities, limit naps to 20-30 minutes, taking frequent short breaks rather than a long rest period.

• Access alternative therapies

• Psychosocial interventions – to help manage stress.

• Ensure adequate nutrition and hydration – consider dietician referral if appropriate
Exercise

• Aerobic exercise effectively alleviates fatigue in patients receiving cancer treatment (Radbruch et al, 2008).

• Exercise may not always be appropriate, or even possible in some palliative care patients (Coakley et al, 2002).
Concluding points

• Given the increasing recognition that fatigue is a multi dimensional phenomenon, it seems likely that the different aspects of fatigue may benefit from different treatment strategies (Pederson et al, 2003)
• It is important to remember that in the final stages of life, fatigue may provide protection and shielding from suffering for the patient and therefore treatment may be detrimental.

• Identification of the time point, where treatment of fatigue is no longer indicated is important to alleviate distress at the end of life Radbruch et al, (2008)
The promotion of sensitive communication, allowing patients time to discuss their fatigue in the context of living with a terminal illness, is perhaps the key to where the intervention should begin. (Potter, 2004)
The multi-professional approach

• A team approach allows health care professionals to share problems and co-ordinate different skills for the benefit of the patient. (Jeffrey, 1993)
Thank you for listening.

Any Questions?
References


• JEFFREY D (1993) “There is nothing more I can do” – *An Introduction to the Ethics of Palliative Care*. The Lisa Foundation Sainsbury Foundation, Penzance