

# Fatigue in cancer

*Like pain, this is a symptom that physicians can and should manage*

A consensus is emerging among patients, caregivers, and oncologists that cancer related fatigue is the most important untreated symptom in cancer today. This fact is probably due to improved management options for other symptoms associated with cancer and its treatment such as pain, depression, and nausea and vomiting. However, though the problem is real, it is rarely discussed and seldom treated. Both patients and physicians may view cancer related fatigue as something to be endured rather than a symptom amenable to differential diagnosis and treatment. Research currently underway should begin to change this perspective and offer effective approaches to treatment.

This research has begun to focus both on the impact of fatigue on patients and on oncologists' attitudes towards fatigue as a symptom. In one recent study patients and oncologists agreed on the presence of significant fatigue in 75% of patients.<sup>1</sup> However, they disagreed on its importance. While 61% of patients reported that fatigue affected their lives more than pain, only 37% of oncologists thought this was true.

A follow up study confirmed the central importance of fatigue on patients' quality of life.<sup>2</sup> When asked which symptom most affected quality of life, fatigue was ranked first (60%), followed by nausea (22%), depression (10%), and pain (6%). The symptom had considerable economic impact: 75% of patients and 40% of caregivers had changed their employment status because of cancer related fatigue. This is not the fatigue associated with common experience, but a complete lack of energy and severe mental exhaustion.

Importantly, this study also confirmed the current discrepancy between the importance of fatigue to quality of life for patients and actual discussion and treatment of the symptom. Most patients assumed that fatigue was caused by the treatment or the disease and would be self limited. Physicians' response to learning of patients' fatigue was non-specific, with the most commonly recommended treatments being nothing (40%) or rest (37%).<sup>2</sup>

All this is beginning to change as cancer related fatigue is becoming recognised as a symptom which may be tackled through differential diagnosis and specific treatment. Published guidelines on evaluating and managing fatigue should be useful for the practising clinician.<sup>3</sup> A careful history should elicit the severity of the symptom, its duration, pattern and course, and exacerbating and palliating factors. A critical part of management is regular reassessment of the symptom during intervention.

As part of the history it is important to assess sleep hygiene. Frequent napping during the day can interfere with a restful, "restorative" night's rest. Regular bed and waking times should be established, and the patient should perform restful activities before going to bed.<sup>4</sup> Although rest is commonly advised as a useful approach to fatigue, there is some observational evidence that moderate aerobic activity is actually more effective in

reducing cancer related fatigue.<sup>5</sup> Exercise may also help improve sleep hygiene.

Obviously, correcting known causes of fatigue is the first step in management. Depression and fatigue often occur together in cancer, and, like fatigue, depression is both underdiagnosed and undertreated.<sup>6</sup> In patients with fatigue and a significant mood disorder a trial of antidepressants should be strongly considered. Though pain management has improved in cancer, centrally acting drugs such as opiates can also impair cognition. Narcotic analgesics should be titrated to alleviate pain without significantly altering mentation. If this is not possible, a trial of adjuvant psychostimulants is often helpful in reversing narcotic induced somnolence.<sup>7</sup>

Anaemia is common in patients with cancer, especially those with leukaemia or lymphoma or receiving regimens containing platinum. Data from randomised, placebo controlled trials convincingly show the ability of  $\alpha$  erythropoietin to maintain packed cell volume, reduce transfusion requirements, and improve overall quality of life.<sup>8</sup> Growth factor treatment with erythropoietin should be considered in patients whose fatigue may be secondary to moderate anaemia. Other physiological abnormalities, such as changes in serum electrolytes, should be screened for and corrected.

Palliative care in oncology has evolved from pain control and hospice placement to more comprehensive symptom management. Today fatigue is the commonest and most debilitating symptom in patients with cancer. Cancer related fatigue can have cognitive, psychological, and physiological causes, each of which is amenable to specific interventions. As cancer related fatigue becomes increasingly recognised as a treatable symptom, oncologists will make the same progress in its management as they have in controlling pain, depression, nausea, and vomiting.

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