Part 2: Pain and Symptom Management

Fatigue and Weakness

Key Recommendations

• Except when a patient is dying, recognize that fatigue is a treatable symptom with a major impact on quality of life.

Definition

Fatigue is a subjective perception/experience related to disease, emotional state and/or treatment. Fatigue is a multidimensional symptom involving physical, emotional, social and spiritual well-being and affecting quality of life.¹

Assessment

1. Assess whether symptom is fatigue or weakness (generalized or localized).
2. Distinguish fatigue from depression.

Management

1. After treating reversible causes and providing non-pharmacological treatment recommendations, consider pharmacological treatment (refer to Appendix A: Medications Used in Palliative Care for Fatigue), if consistent with patient's goals of care.
Fatigue and Weakness Management Algorithm

**Fatigue and Weakness Management Algorithm**

Hyperlinks indicate additional information available in guideline sections above:

A = Assessment
M = Management

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**Muscle Weakness (A1)**

**Localized Weakness**
- Cerebral metastases
- Cerebral vascular accident
- Radiculopathy

**Generalized Weakness**
- Deconditioning
- Paraneoplastic syndrome
- Polymyalgia
- Polymyositis
- Steroid induced myopathy
- Steroid withdrawal, abrupt

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**Reversible Causes of Fatigue (A3)**

- Anemia
- Dehydration
- Hypokalemia
- Hyponatremia
- Hypomagnesemia
- Hypo/hypercalcemia
- Hypothyroidism
- Medicationinduced
- Alcohol/drug abuse
- Infection
- Sleep disorder
- Obstructive sleep apnea
- Chronic fatigue syndrome

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**Distinguish fatigue from depression**
See BCGuidelines.ca – Palliative Care Part 2 – Depression Management Algorithm

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**Fatigue Screen**

Numeric Rating Scale (0–10 scale)

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**Fatigue Assessment**

- History
- Physical Exam
- Labs

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**Assess for and treat persisting pain, dyspnea, and nausea contributing to fatigue**

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**Assess for other causes of fatigue and treat, if appropriate**

- Reversible causes of fatigue
- Depression
- Muscle weakness

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**Palliative Care Consult for refractory symptoms**

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**Non-pharmacological Treatments**

**General measures**
- Individualized graded exercise program
- Nutrition
- Assessment by Home and Community Care for support in home

**Education of patient and caregivers**
- Normalize
- Energy conservation
- Sleep hygiene
- Fatigue scale

**Stress management**
- Cognitive behavioural interventions
- Support groups

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**Pharmacological treatments (M1)**

- Terminal phase of illness?
  - Yes
    - Steroids (may be useful)
  - No
    - Methylphenidate OR Dextroamphetamine OR Modafanil (only if fatigue > 6/10)
References


Appendices

Appendix A – Medications Used in Palliative Care for Fatigue
Appendix A: Medications Used in Palliative Care for Fatigue

Tailor dose to each patient; those who are elderly, cachectic, debilitated or with renal or hepatic dysfunction may require reduced dosages; consult most current product monograph for this information: [http://www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index-eng.php](http://www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index-eng.php)

### PSYCHOSTIMULANTS

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Available Dosage Forms</th>
<th>Standard Adult Dose (note age specific recommendations)</th>
<th>Drug Plan Coveragea</th>
<th>Approx. cost per 30 days C</th>
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<tbody>
<tr>
<td>methylphenidate0</td>
<td>Ritalin®, G</td>
<td>IR tabs: 5, 10, 20 mg</td>
<td>Age over 65 years: Not recommended</td>
<td>Yes, LCA</td>
<td>$6–18 (G) $14–41</td>
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<td>Age 18 to 65 years:</td>
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<td></td>
<td></td>
<td></td>
<td>Start: 5 mg PO bid (AM and noon); use 2.5 mg</td>
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<td>for frail patients Max: 15 mg PO bid (AM and noon)</td>
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<td></td>
<td>Biphentin*</td>
<td>SR caps: 10, 15, 20, 30 mg</td>
<td>Once dose stabilized on IR, give equivalent daily dose as SR or XR form once daily in AM</td>
<td>No</td>
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<td></td>
<td>Concerta*</td>
<td>XR tabs: 18, 27, 36, 54 mg</td>
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<td></td>
<td>Ritalin-SR®, G</td>
<td>SR tabs: 20 mg</td>
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<td>dextro-amphetamine0</td>
<td>Dexedrine®, G</td>
<td>IR tabs: 5 mg</td>
<td>Age over 65 years: Not recommended</td>
<td>No</td>
<td>$18–134 (G) $24–188</td>
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<td>Age 18 to 65 years:</td>
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<td>Start: 2.5 mg PO bid (AM then in 4 to 6 h) Max: 20 mg PO bid (AM then in 4 to 6 h)</td>
<td>No</td>
<td>$33–135</td>
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<td>Special Authorityf, LCA</td>
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<tr>
<td>modafinil0</td>
<td>Alertec®, G</td>
<td>Tabs: 100 mg</td>
<td>Age over 65 years:</td>
<td>No</td>
<td>$30–60 (G) $45–90</td>
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<td>Start: 100 mg PO qAM Max: 100 mg PO bid (AM and noon)</td>
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<td>Age 18 to 65 years:</td>
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<td>$60–120 (G) $90–180</td>
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<td>Start: 100 mg PO bid (AM and noon) Max: 200 mg PO bid (AM and noon)</td>
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**Abbreviations:** caps capsules; G generics; h hours; IR immediate release; LCA subject to Low Cost Alternative Program; max maximum dose; PO by mouth; qAM every morning; SR sustained release; tabs tablets; XR extended release

a Refer to guideline and/or algorithm for recommended order of use.

b PharmaCare coverage as of October 2016 (subject to revision). Obtain current coverage, eligibility, and coverage information from the online BC PharmaCare Formulary Search page at [pharmacareformularysearch.gov.bc.ca](http://pharmacareformularysearch.gov.bc.ca)

c Cost as of October 2016 and does not include retail markups or pharmacy fees. Generic and brand name cost separated as indicated by (G).

d This indication (i.e. depression) used in practice, but not approved for marketing by Health Canada

e Special authority required to obtain coverage for Concerta® for ADHD as second line treatment

f Special authority required to obtain coverage for modafinil for patients with narcolepsy

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BCGuidelines.ca: Palliative Care for the Patient with Incurable Cancer or Advanced Disease