

Part 2: Pain and Symptom Management Fatigue and Weakness

Effective Date: February 22, 2017

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.
- 3. Look for reversible causes of fatigue or weakness (refer to *Fraser Health, Hospice Palliative Care Symptom Guidelines, Fatigue,* available at www.fraserhealth.ca/media/11FHSymptomGuidelinesFatigue.pdf).

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

Hyperlinks indicate additional **Fatique Screen** information available in **Numeric Rating Scale** *quideline sections above:* (0-10 scale)A = AssessmentM = ManagementReversible Causes of Fatigue (A3) **Fatigue Assessment** Anemia History Dehydration · Physical Exam Hypokalemia Labs Hyponatremia · Hypomagnesemia · Hypo/hypercalcemia Assess for and treat persisting Muscle Weakness (A1) Hypothyroidism pain, dyspnea, and nausea Medicationinduced **Localized Weakness** contributing to fatigue · Alcohol/drugabuse Cerebral metastases Infection • Cerebral vascular accident Sleepdisorder Radiculopathy · Obstructive sleep apnea **Generalized Weakness** Assess for other causes of • Chronic fatigue syndrome fatigue and treat, if appropriate Deconditioning Paraneoplastic syndrome • Reversible causes of fatigue • Depression Polymyalgia Distinguish fatigue from depression Polymyositis Muscle weaknesss See BCGuidelines.ca - Palliative Care Part 2 -• Steroid induced myopathy Depression Management Algorithm • Steroid withdrawal, abrupt **Palliative Care Consult** for refractory symptoms **Non-pharmacological Treatments General measures Education of patient and** Stress management caregivers • Individualized graded Cognitive behavioural exercise program Normalize interventions Nutrition • Energy conservation • Support groups · Assessment by Home • Sleep hygiene and Community Care for Fatique scale support in home Pharmacological treatments (M1) No Yes Terminal phase of illness? Steroids Methylphenidate OR (may be useful) Dextroamphetamine OR Modafanil (only if fatigue > 6/10)

Resources

▶ References

1. Ferrell BR, Grant M, Dean GE, Funk B, Ly J. Bone tired: The experience of fatigue and impact on quality of life. Oncology Nursing Forum. 1996;23(10):1539-47.

Appendices

Appendix A – Medications Used in Palliative Care for Fatigue

For additional guidance on fatigue, see also the **BC Inter-professional Palliative Symptom Management Guidelines** produced by the BC Centre for Palliative Care, available at: www.bc-cpc.ca/cpc/symptom-management-guidelines/



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

PSYCHOSTIMULANTS ^A						
Generic Name	Trade Name	Available Dosage Forms	Standard Adult Dose (note age specific recommendations)	Drug Plan Coverage ^B		Approx. cost per 30
				Palliative Care	Fair PharmaCare	days ^c
methylphenidate ^D	Ritalin®, G	IR tabs: 5, 10, 20 mg	Age over 65 years: Not recommended	Yes, LCA	Yes, LCA	\$6-18 (G) \$14-41
			Age 18 to 65 years: Start: 5 mg PO bid (AM and noon); use 2.5 mg for frail patients Max: 15 mg PO bid (AM and noon)			
	Biphentin®	SR caps : 10, 15, 20, 30 mg	Once dose stabilized on IR, give equivalent daily dose as SR or XR form once daily in AM	No	No	\$23-59
	Concerta®	XR tabs: 18, 27, 36, 54 mg		No	Special Authority ^E	\$71–93
	Ritalin-SR®, G	SR tabs: 20 mg		No	Yes, LCA	\$9 (G) \$24
dextro- amphetamine ^D	Dexedrine®, G	IR tabs: 5 mg	Age over 65 years: Not recommended	No	Yes	\$18–134 (G) \$24–188
			Age 18 to 65 years: 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			
		SR caps : 10, 15 mg	Once dose stabilized on IR, give equivalent daily dose as SR form once daily in AM	No	Yes	\$33-135
modafinil ^D	Alertec®, G	Tabs: 100 mg	Age over 65 years: Start: 100 mg PO qAM Max: 100 mg PO bid (AM and noon)	No	Special Authority ^F , LCA	\$30-60 (G) \$45-90
			Age 18 to 65 years: Start: 100 mg PO bid (AM and noon) Max: 200 mg PO bid (AM and noon)			\$60–120 (G) \$90–180

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

 $^{^{\}rm A}\,$ Refer to guideline and/or algorithm for recommended order of use.

⁸ 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

^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