

Cancer-related fatigue in the palliative phase

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Summary

Introduction

This guideline uses the definition of Cancer-related fatigue as given by the National Comprehensive Cancer Network: “it is a distressing, persistent, subjective sense of physical, emotional, and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and interferes with usual functioning”. Cancer-related fatigue differs from normal fatigue in its intensity, its duration and the distress it gives. Cancer-related fatigue is worse than the fatigue that people normally experience after exertion. It does not respond adequately to rest or sleep, and it is overwhelming in the sense that people cannot ignore it.

Aetiology

The aetiology of cancer-related fatigue is largely unknown. It is hypothesized that fatigue is primarily related to the underlying cancer due to the production of pro-inflammatory cytokines (primary fatigue). Besides the underlying cancer, various physical and psychosocial factors may contribute to the occurrence and the severity of fatigue in patients with cancer in the palliative phase, i.e.:

- tumour-induced complications;
 - comorbid disease(s);
 - anti-tumour therapy;
 - adverse effects of other medication;
 - physical symptoms;
 - psychosocial problems, including existential distress.
- Usually, various factors occur concurrently.

Assessment and evaluation

- Identify the presence of fatigue. Consider using the Distress Thermometer or the Utrecht Symptom Diary as a screening tool to facilitate identification.
- Identify fatigue and discuss the severity of fatigue with the patient:
 - at regular intervals during and after anti-tumour therapy;
 - when progressive disease is found;
 - at the transfer of a patient to another care setting.During the periods in which the disease is stable without active therapy, low-frequency screening usually is sufficient.
- Consider using a questionnaire such as the Multidimensional Fatigue Inventory (MFI) or the Checklist Individual Strength (CIS) to assess the dimensions and the severity of fatigue. A score of ≥ 35 on the sub-scale “Severity of Fatigue” of the CIS is considered as the cut-off point for severe fatigue.
- Explore the experience of fatigue and the possible contributing factors if fatigue is rated ≥ 4 on the Utrecht Symptom Diary. Take a complete medical history (including a heteroanamnesis) focusing on the physical, emotional and cognitive dimensions and the presentation of fatigue, assess concurrent symptoms, possible contributing factors and the impact of the fatigue on functioning in daily life and social interaction with relatives.
- Use the results of the Distress Thermometer or the Utrecht Symptom Diary for the assessment of problems contributing to the fatigue.
- Assess any existential problems.
- Consider using the Hospital Anxiety and Depression Scale (HADS) or the screening list Four Dimensional Symptom Questionnaire (4DSQ) for the screening on anxiety and

depression.

- Always conduct a physical examination.
- On indication, order further laboratory tests, imaging studies or functional tests if feasible and appropriate.

Integrated approach

EDUCATION

- Be attentive, have sympathy for and acknowledge the burden of cancer-related fatigue for patients during the palliative phase of their disease.
- Encourage discussion of fatigue and support the patient's self-insight.
- Provide information about the symptom fatigue in the palliative phase of cancer, and attune the information to the needs and preferences of the patient and his relatives.
- Support this oral information with written information and refer to specific websites with relevant information.

The central caregiver and the primary treating professional are responsible for providing information, but they can delegate this task, to a nurse for example.

- Provide information on how to cope with fatigue, such as:
 - stimulating physical activity, while taking physical limitations into account;
 - maintaining a regular sleep
 - pattern and a good sleep hygiene;
 - setting priorities with regard to activities;
 - pacing activities;
 - spreading out activities more evenly over the day and the week;
 - using distraction during periods of severe fatigue.
- Involve the patient's relatives in the information about cancer-related fatigue and how to cope with it.

SUPPORTIVE CARE

- Discuss the problems that may contribute to the fatigue with the patient and explore to which health care professionals with specific knowledge, experience and skills in cancer-related fatigue he may be referred to. Decide together with the patient taking his needs and preferences into account.
- Advise making contact with fellow patients (for the recognition and affirmation of feelings and experiences). This can be done through organisations such as a national federation of cancer patients or via a community support group.
- Advise support from/for the relatives/informal care givers.

CONTINUITY AND ORGANISATION OF CARE

- Consider using an individual care plan.
- If possible, ensure that the patient has one central caregiver. The central care giver is responsible for the coordination and continuity of care. Furthermore, he is the first to be contacted by the patient and the relatives in case of questions or problems.
- Ensure that throughout the disease trajectory it is clear who the primary treating professional is.
- Discuss with the patient and his relatives which care givers can be consulted for specific problems. Document the conclusions.
- Consider participation in a multidisciplinary meeting (e.g. a home palliative care group, an oncology network or a multidisciplinary meeting at a facility).
- Or ask a multidisciplinary palliative care consultation team for advice.
- In case of multiple and complex problems, consider referral to a rehabilitation physician or a specialist elderly care.

Management and interventions

TREATMENT OF CONTRIBUTING PROBLEMS

- Always ensure optimal symptom control.
- During the early palliative phase of advanced cancer, propose anti-tumour therapy if the fatigue seems to be caused by the underlying cancer, but weigh the expected benefit and the potential side effects against each other.
- Consider treatment of concurrent problems that may contribute to the experience of fatigue, taking into account the natural history of the underlying cancer, the comorbidity and the patient's preferences.
- Always consider symptomatic and, if appropriate, causal therapy of concurrent physical and psychosocial symptoms.
- Consider specific support in case of existential problems.

Non-pharmacological interventions

PSYCHOSOCIAL INTERVENTIONS

- Consider cognitive behavioural therapy or mind-body interventions (e.g. mindfulness or yoga) for patients who are treated with anti-tumour therapy or whose disease is relatively stable and when psycho-education is insufficiently effective for their fatigue.
- For these specific interventions, refer to professionals with specific expertise, especially in the field of oncology.

EXERCISE/PHYSICAL ACTIVITY

- Stimulate daily physical activity according to (inter)national physical activity guidelines thereby taking the patient's physical capabilities into account.
- Consider referral for an aerobic exercise intervention for patients with fatigue and functional limitations on exertion during the early palliative phase of cancer. Refer to a physiotherapist with specific knowledge, experience and skills in cancer-related fatigue.
- Advise a diet with sufficient calories, proteins and other nutrients to support an exercise intervention.
- Consider referral to a rehabilitation physician in case of complex functional limitations (multiple problems) during the early palliative phase of cancer.

Pharmacological interventions

CORTICOSTEROIDS

- Consider treatment with 8 mg of dexamethasone for severe fatigue occurring in the terminal stage of cancer when interventions for contributing problems are no longer available.
- Stop the corticosteroid treatment after one week if it is not effective.
- Weigh the desired effect of dexamethasone on fatigue and quality of life and possible side effects.

PSYCHOSTIMULANTS

- Consider treatment with methylphenidate in case of a concurrent depression and a short life expectancy for which treatment with regular antidepressants is not thought to be useful.
- Start with a dose of 5 mg twice daily; the dose may be increased every 3 days by 10 mg/day to a maximum dose of 40 mg/day.
- Carefully weigh the risk of side effects such as hypertension, tachycardia and restlessness.
- Do not prescribe psychostimulants for amelioration of fatigue unless there is a concurrent depression.

ANTIDEPRESSANTS

- Do not prescribe antidepressants for amelioration of fatigue unless there is a concurrent depression.