Palliative Management of Fatigue at the Close of Life: "It Feels Like My Body Is Just Worn Out"

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ON JANUARY 17, 2007, AUTHORS SRIRAM YENNArajalingam, MD, and Eduardo Bruera, MD, presented the case of Mrs D, an 82-year-old retired nurse with a history of interstitial lung disease, hypertension, coronary disease, osteoporosis, gastroesophageal reflux disease, and anemia, with a recent admission for pneumonia. Her surgical history included a colectomy secondary to a perforated diverticulum and gastrointestinal bleeding. Due to dyspnea, Mrs D became increasingly dependent on supplemental oxygen for her daily activities. She lived independently and had a living will; she had asked to not undergo resuscitation. Her daughter, with whom she was very close, was her durable power of attorney for health care.

Mrs D’s most pervasive complaint was fatigue—often profound, and debilitating to the point that it was functionally and cognitively limiting. Her primary care physician, Dr K, a palliative care specialist, suspected that her fatigue stemmed from a combination of factors. Mrs D’s goals of care generally focused on comfort; she declined to pursue diagnostic testing unless it would help to identify therapy that improved her quality of life. Dr K and Mrs D attempted a number of symptomatic interventions, including exercise/physical therapy, increased socialization, methylphenidate, megestrol acetate, blood transfusions, vitamin B12 replacement, treatment with sertraline (25 mg titrated upward to 100 mg daily) for 1 year, and an 8-month course of fluoxetine (10 mg titrated to 40 mg daily), as well as other therapies to control concurrent symptoms (eg, opioids for pain). Each yielded only partial and short-term relief.

As the authors describe, fatigue is the most common chronic symptom associated with cancer and other chronic progressive diseases. Clinical fatigue includes 3 major components: (1) generalized weakness, resulting in inability to initiate certain activities, (2) easy fatigability and reduced capacity to maintain performance, and (3) mental fatigue resulting in impaired concentration, loss of memory, and emotional lability. They describe the assessment and treatment of fatigue at or near the end of life including characterizing (often using scales) fatigue’s severity, temporal features (onset, course, duration, and daily pattern), exacerbating and relieving factors, associated distress, and impact on daily life, and identifying treatable causes. When discovery of the specific etiologic cause is not possible, as with Mrs D, treating the symptoms—often with a multidisciplinary team—should be the focus of care, including ceasing or adjusting the dose of opioids, treating anemia, depression, delirium or cognitive dysfunction, and correcting weight loss. An exercise regimen or physical therapy may also offer relief. Finally, continued access to the physician on short notice, continued assessment of symptoms, and excellent physician-patient communication are critical.

A Perspectives editor reinterviewed Dr K in December 2006.

DR K: Mrs D began receiving hospice in December 2005 after having been admitted to the hospital for back pain (due to spinal stenosis). She was discharged with a CAD pump (morphine) initially to a nursing home, then to her daughter’s home. She continued to receive home health care and palliative care. She died on March 6, 2006.

I am deeply humbled by my experience in caring for Mrs D. She taught me much about balancing “cure” and “care” in patients facing chronic and progressive illness. She reminded me that the challenge of providing genuine “patient-centered” care—care is fundamentally grounded in a patient’s goals and preferences—especially within the context of great uncertainty.

Mrs D also taught me much about managing fatigue in elderly persons with progressive illness. Although I seemed to achieve temporary success with treatments like antidepressants, exercise, and appetite stimulants, I truly believe my most important intervention was a willingness and commitment to listen to her frustrations, fears, and hopes around this troubling and refractory symptom. My treatment attempts, regardless of their efficacy, seemed to at least validate her illness experience. I hope this validation somehow lessened the distress and frustrations of Mrs D and her family.

While as chronic care providers we hope to “cure,” more often we partner with our patients on a journey embodied by moments of both glory and despair. When our technologies sometimes fall short, I hope our partnership and support make their journeys more bearable.

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