Cancer-Related Fatigue: An Immense Problem

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This issue of The Oncologist reports a new population-based survey that clarifies the profound impairments associated with cancer-related fatigue. It is another in a long series of epidemiologic studies that underscore the prevalence and adverse impact of this phenomenon. More than 75% of cancer patients experience fatigue [1-16], at least for a time, and many studies document the potential for chronic fatigue in those with active disease [2-7] and in survivors [17-22]. Most surveys demonstrate relationships between fatigue and functional limitations, negative mood, or sleep disturbance.

These data indicate that cancer-related fatigue is an immense problem associated with pervasive disturbances in quality of life. With an ever-increasing focus on the need for symptom control as part of comprehensive cancer care, the management of fatigue clearly should be part of the standard approach to all patients.

Unfortunately, this is not the case. Fatigue is seldom discussed by physicians and patients, and specific therapeutic approaches are seldom offered [1]. This lack of focus suggests that undertreatment is common. Undertreatment is also suggested by surveys that reveal limitations in the management of problems associated with fatigue. For example, depression is poorly recognized [23], and despite data that implicate a causal relationship between moderate anemia and fatigue [24], anemia is often untreated until other symptoms appear. Finally, the evidence that cancer pain continues to be undertreated [25, 26] despite a strong scientific basis for effective therapy gives little reassurance that a symptom with a still inchoative scientific literature will be well managed.

The lack of a scientific literature on fatigue deserves emphasis as one of the major barriers to improved management. Fatigue is a complex symptom [27]. Patients may characterize fatigue in terms of an overall lack of energy, cognitive impairment, somnolence, mood disturbance, or muscle weakness. Predisposing factors include the disease itself, antineoplastic therapies, metabolic disturbances, mood or sleep disorders, and other problems. Given the variability in the population affected by fatigue, it is likely to be a common outcome associated with several, and perhaps many, pathophysiologic processes. At this time, very little is known about any of them.

This limitation is compounded by other treatment barriers. Patients may not complain of the symptom [1], even if severe. This phenomenon is similar to the patient underreporting observed in those with cancer pain [28]. Limited assessment on the part of clinicians may be accompanied by inexperience in using some of the approaches that have been empirically recommended [27], including the stimulant drugs and nonpharmacologic therapies such as exercise and cognitive interventions. Constraints in the systems of care, including the lack of reimbursement for some of these recommended approaches, also contribute. This combination of clinician-related, patient-related, and system-related barriers has been highlighted in the area of cancer pain [26] and applies as well to the management of cancer-related fatigue.

The challenge at present is to improve the recognition of fatigue as a major issue in cancer care; develop a systematic approach to management based on clinical observation and the limited data extant; and pursue investigations that will ultimately identify the mechanisms responsible and the means to address them efficiently. An algorithm for
management can be developed now [29]. Although the overall effectiveness of such an approach remains to be tested, any strategy that calls for the treatment of potential contributing factors and symptomatic therapy using both pharmacologic and nonpharmacologic interventions is likely to improve the dismal situation that now exists.

Ironically, the history of cancer pain gives reason for hope. Although pain is still undertreated, there is a strong consensus that the quality of cancer pain management has improved during the past two decades. In the early 1980s, cancer pain was recognized as common, but excellence in pain care was not perceived to be central to oncology practice. Oncologists perceived that there were limited management options and no efforts had been made to address any of the barriers to better management. Over time, however, there was an explosion of research about pain, management guidelines based on consensus were developed, and a sustained effort to improve the education of clinicians began. The new standards for pain management promulgated by the Joint Commission on the Accreditation of Healthcare Organizations is the most recent indication of positive change. All these efforts have yielded results and more progress is anticipated.

In some ways, the situation surrounding cancer-related fatigue is reminiscent of cancer pain at the time progress began to accelerate. Recognition of the problem started to improve, and the literature can evaluate the epidemiology and provide sensible management guidelines. If the history of cancer pain is an indication, the future will bring research, clinician education, patient advocacy, and system change. Given the scope and impact of this problem, this progress will be long overdue.

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REFERENCES


