Fatigue

Essential CME is a series of topics involving a continuous self learning and appraisal process in family practice for general practitioners, primary care physicians and generalist medical officers.

The five parts to the section are Benchmarks for the Busy GP, South African Rural General Practice, Teaching Old Docs New Tricks, MCQs and Resource section.

This is number twenty-two in the series and is on Fatigue.

Part 1

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Benchmarks for Busy GPs

This section is not a comprehensive review but a short selection of abstracts to help you focus on important aspects of the subject partly in the form of reminders and memory joggers.

Readers may find themselves bewildered by modern medical literature on the subject of fatigue.

There is the symptom of fatigue and there are syndromes featuring fatigue.

Fatigue may be a 'supporting' symptom or the main complaint.

Doctors vary widely in their approach to fatigue and in the way they categorise it. For instance, if you are a doctor who is a bit reluctant to accept uncertainty at the end of your clinical reasoning process you are more likely to try to find or create a specific diagnosis. If you are comfortable without a diagnosis then you will be able to leave the patient at the level of the symptom.

Many questions about fatigue remain unanswered (or have not been posed yet).

The language of fatigue is also a problem. Is 'fatigue' synonymous with tiredness, lack of energy, feeling unwell etc? What does it mean to the patient and does it have the same meaning to the doctor? When is it a social comment and when is it a symptom?

Along the road a lot of things happen to

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the symptom of fatigue and it may not end up as the 'end-of-consultation' diagnosis.

"One of the unnecessary difficulties patients suffering is from fatigue have to deal with is the inability of some physicians to believe that they are ill" *(McWhinney, 1889, p.270)*

Fatigue is also a difficult thing to measure. There is a fatigue questionnaire *(Wessely & Powell, 1989;Chalder et al, 1993, David et al, 1990, Pawlikowska et al, 1994).*

Most people attribute their fatigue to social or psychological factors. I have taken to wandering around the house complaining that 'I am burnt out' (my wife tells me I enjoy doing this).

The Coxsackie B virus theory

In 1988 Yousef and coworkers suggested that coxsackie B was a likely cause of chronic fatigue syndrome. Further studies have not confirmed this. About a quarter of patients with fatigue are found to be positive for coxsackie B as well as a quarter of normal matched controls. There is also a strong seasonal variation.

The different findings are partly thought to be due to different criteria used for selecting the patients and also the comparison group. (Ridsdale, 1995).

The symptom of tiredness

Tiredness is the second most common physical symptom after respiratory symptoms **in the community**. *(Hannay, 1978)*

But of all new symptoms presented to the general practitioner a loss of energy or tiredness was the fourteenth most frequent symptom (cough was the most frequent). UK figures *(Morrell, 1972)*

Tiredness, lack of energy, fatigue, or lassitude has also been recorded as the seventh most frequent presenting complaint in general practice. *(McWhinney, 1989, p.260)*

So it is not one of the most common symptoms presented (although on some days it may appear so!) but neither is it uncommon.

In virtually all studies, more women were found to be fatigued than men.

Women were particularly likely to report fatigue when they had children under six years of age.

Married women are more likely to be diagnosed as fatigued than their single counterparts.

This gender difference may be not so marked as more women than men were attending the general practitioners and when fatigue was the main complaint, the outcome for men was worse at six months.

About half of all the patients receive a psychological diagnosis, the commonest being depression.

Ten to 20% of patients remain undiagnosed.

FATIGUE AND DEPRESSION

In general practice depression is one of the most important and treatable conditions that we see and tiredness/fatigue is a common presenting symptom of depression. About half the patients presenting with fatigue to family physicians are suffering from psychogenic fatigue. A general practitioner sees about four new episodes of depression per month (UK figures). We see a different spectrum of depression to that seen by a psychiatrist. Our cases are milder with fewer of the classical manifestations and with many patients who are not obviously depressed. Forty per cent of depressives in general practice have

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some physical illness. Vaguer symptoms such as tiredness, irritability, sleep disturbance and just not feeling well are commoner complaints than the patient expressing that they are depressed or 'down'.

Other ways in which depression can present include:

* Frequent visits.
* Frequent visits with a child.
* After hours calls.
* Alcohol abuse.
* Impairment of memory.
* Chronic headache, abdominal pain, etc.

Addendum: How depression presents appears to vary in different cultures. I have found in my practice that women who ask "Don't you think it is my hormones, doctor, can I have a hormone test?" often turn out to be depressed (it can turn out to be both). It may be a local way of presentation of depression. Another presentation may be 'Can I have a tonic doctor?' or 'Can I have a vitamin injection?'

(Further information: McWhinney, 1989, p.262, Essential CME, Depression, January, 1995).

Fatigue caused by infection

Many types of infection or PUO can cause fatigue. Viral infections are common causes of fatigue. Remember to keep in mind infectious mononucleosis and viral hepatitis. Also pyelitis, subacute bacterial endocarditis, HIV, tuberculosis and bilharzia. Rickettsial infections may present as fatigue in South Africa as well as brucellosis.

Iatrogenic fatigue

Drugs such as the birth control pill, antihypertensives such as beta blockers and methyldopa, diuretics, tranquillisers, antidepressants and steroids can cause fatigue.

Endocrine and metabolic fatigue

Early pregnancy, menopause, hypothyroidism, diabetes, hypokalaemia, hypomagnesaemia may cause fatigue.

Interestingly anaemia even down to 8 grams does not necessarily cause fatigue symptoms (Ridsdale, 1995). I had always assumed fatigue and anaemia were inextricably linked. Perhaps it is the insidiousness of the anaemia that makes the patient unaware of their falling energy level. Iron deficiency is the most common deficiency disease in the world despite the fact that iron is the second most common element. A low serum ferritin is usually accompanied by fatigue.

Physiologic fatigue can be caused by overwork, insufficient sleep, too little activity, boredom, unhealthy eating patterns and obesity.

Fatigue in the elderly patient

"Always exclude depression"

Professor Helgard Meyer, Pretoria.

Consider hypothyroidism and diabetes. Also occult infections and malignancy. Also subacute bacterial endocarditis in elderly patients with recent onset of fatigue. Pernicious anaemia should also be remembered in older patients. Tuberculosis often goes unrecognised amongst the elderly especially in old age homes.

Neurological conditions such as Parkinson's disease and dementia may present with fatigue.

Lassitude and malaise

"Doctor, I've got malaise" or "I'm suffering from lassitude". Patients don't complain of malaise or lassitude so why put down in the notes that "the patient com-

PITFALLS IN THE DIAGNOSIS OF DEPRESSION

Not picking up that vague symptoms like fatigue may be 'masking' depression.

Failing to ask the most sensitive question 'do you feel depressed?'

Failing to ask this question in other ways if the answer is 'no', eg 'do you feel down in the dumps?', 'do you feel low in spirits etc?', 'how is your sleep, appetite etc?', 'Are you enjoying things you usually enjoy?', 'Are you crying more than usual?', 'do you have difficulty carrying on?'.

Depression occurs concurrently with physical disease. Watch for early carcinoma of the pancreas, hypothyroidism and pernicious anaemia.

Older patients with depression are at risk of having organic disease missed (especially women over the age of 65). A valuable test is an ESR for occult cancer or chronic infection.

Depression in the elderly may present with memory loss.

Fatigue and confusion in the elderly may be due to 'silent' infection such as pyelitis.

Depression is often overlooked in patients who have a disease that accounts for their illness such as osteoarthritis of the spine which 'explains' the backache or hiatus hernia on gastroscopy that 'explains' the abdominal pain.

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plained of malaise". He didn't. He complained of being tired. This is an example of 'semeiosis' which is making a construct out of a symptom. Another example of semeiosis is when the patient complains of 'coughing blood' and the doctor writes down haemoptysis in the notes. The symptom has been transferred to another level of significance (biomedical).

Rarer causes of tiredness

Tiredness is an important symptom of any malignant neoplasm and often precedes signs and symptoms (eg Hodgkin's disease, leukaemias and myelomatosis).

Addison's disease is characterized by fatigue, hypotension and pigmentation which caused the patient to be referred to as "a tired Turk".

Myxoedema and Simmonds disease (panhypopituitarism) are rare causes of tiredness.

It is said that patients presenting with early thyrotoxicosis do not complain of tiredness but of increased energy. Interestingly surgeons maintain that tiredness is one of the constant symptoms of thyrotoxicosis (Fowler, 1974, p.166). This may be due to the profile of a surgeon's practice who sees specific referred cases.

I wonder what physicians say and what the general practice presentation of thyrotoxicosis really is as we each see only a few cases. Perhaps it presents differently at different stages to different disciplines.

Chronic fatigue syndrome (CFS)

This syndrome has been defined in recent years. It means different things to different people and is an unclear topic. In South Africa it is seen by general practitioners but also by orthopaedic surgeons, neurologists and has enormous economic implications as it may end up with inappropriate viral studies (which cost R800-R900), bone scans and MRIs.

Increasing attention is being directed towards an abnormality in the hypothalamic-pituitary-adrenal axis with central neurotransmitter abnormalities (e.g serotonin) in these patients.

Diagnostic criteria for this syndrome have been laid down by the United States Centres for Disease Control (Holmes et al, 1988) and Clinical Guidelines have been put forward by the Committee for Science and Education, Medical Association of South Africa (S Afr Med J 1995; 85: 780-782). These criteria are designed "to improve the comparability and reproducibility of clinical research and epidemiological studies".

Another one of the main reasons for the guidelines is to help contain costs.

Sufferers are often very 'level-headed' people who are high achievers hence the term 'yuppy flu'.

One theory is that it may be an unconscious way of diminishing one's responsibilities or personal difficulties.
Chronic fatigue syndrome, depression and fibromyalgic syndrome share many similarities and criteria.

Forty to 50% of CFS sufferers are suffering from depression too and up to 70% have some form of mental disorder. About 70% of CFS patients also meet the criteria for fibromyalgic syndrome.

There is a lot of opinion that separates ME as a distinct entity from the CFS syndrome

We like to make one diagnosis only in a linear cause-effect way but chronic fatigue may be co-constituted or interrelated with other condi-

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frequency of the diagnosis of ME/chronic fatigue was 0,1% . Seventy per cent were females and 30% were males. The peak age group was 40-49 year group. The common duration of symptoms was two years after which it fell steadily. Only a few patients were ill for eight years or longer. Most GPs made the diagnosis between 1 and 2 years after onset. There was an even distribution between urban and rural practices. It was proposed that the patients who complain of intractable symptoms lasting many years may fall into a separate category.

Post-viral fatigue/post-infective fatigue

This concept is used with caution now as post-viral fatigue syndrome was used as synonymous with chronic fatigue syndrome which is now not considered to be caused by viruses.

It is the fatigue, weakness, inability to concentrate properly etc often seen after an infection and lasts less than six months.

Viruses can cause fatigue during the acute infection and afterwards (post-influenzal debility etc). Bacterial infections such as pneumonia can be followed by a long period of fatigue, hair loss and muscle pains. Post-infective fatigue may also follow minor infections such as a throat or skin infection. Some opinions suggest that it is an 'emotional' reaction in susceptible individuals triggered by infection.

What was neurasthenia?

Neurasthenia was a diagnosis given in 1869 for 'nervous exhaustion'. The chief symptoms were fatigue, headache, gastrointestinal disturbances and subjective sensations of all kinds. Neurasthenics looked fit and well nourished. It was put down to the stresses of industrialisation and blamed on 'modern civilisation'.

(Reference: Beard G. Neurasthenia or nervous exhaustion? Boston Med Surg J 1869;3:217-220. Wessely S, Hotopf M. Neurasthenia and ME: does history teach us anything? Psychiatry in Practice. 1994 June:27-31)

The message in the bottle

Is fatigue a metaphor or coded message in a bottle that is tossed into turbulent seas by the sufferer, in the hope that a passing navigator will retrieve the bottle and decipher the hidden meaning? Is it the unfulfilled expectations of modern society represented by the media as eternal youth and energy (the Salusa 45 phenomenon)? Fatigue may be expressing a mid-life crisis, the realization that one has not achieved or been promoted to what one aspired to or that one's marriage is not 'ideal'. It may represent a patient who is asking permission to withdraw or for time out. Fatigue may be a mask or protest or 'sickness strike' against social conditions, alienation or exploitation. *(Scheper-Hughes, 1994)*

A PROTOCOL/GUIDELINES FOR THE MANAGEMENT OF TIREDNESS

Excellent guidelines are laid down for the general practitioner.

There are nine areas to consider in initial assessment and management. In the absence of obvious disease there are twelve avenues to consider.

(Refer: Tiredness: S A Fam Pract Manual. No 10. (Common Conditions in Adults). Jun/Aug 1994: 10.53.)

A safe diagnostic strategy

Let us take a patient presenting with the symptom of fatigue and how one could approach it. A five question model can be applied:

1. What is the probability diagnosis?

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2. What serious disorders must not be missed?
3. What conditions are often missed?
4. Could this patient have one of the 'masquerades'?
5. Is this patient trying to tell me something else?

(Murtagh, 1992, p.212)

Masquerades

Syphilis and tuberculosis used to be the diseases that could masquerade almost in anyway. Common masquerades in this day are still tuberculosis and now AIDS in Africa. Malignant disease, alcoholism, side effects of drugs, endocrine disorders and the various manifestations of atherosclerosis can also masquerade and are often overlooked.

Take for instance a seemingly neurotic patient with tiredness, headache, constipation, loss of appetite, indigestion and backache etc. This patient might be suffering from one of the seven common masquerades (depression, diabetes, drugs, anaemia, thyroid, urinary infection, spinal dysfunction).*(Murtagh, 1992, 214)*

"Hallo, tiredness, my old friend"

(apologies to Simon and Garfunkle)

Tiredness can be seen as a positive thing (perhaps one could call it **eufatigue**). The tiredness after exercise or after the completion of a job well done would be in this category. Tiredness can also be useful as a refuge, a safety valve or warning sign. It can be a presentation of a natural withdrawal or hibernation.

It may represent a patient who has assumed a **sick role** or had a sick role imposed on him or her. This can have both negative and positive effects.

In contrast normal tiredness may be a negative thing (**dysfatigue** perhaps?) when things have not gone one's way, the day's objectives have not been met and interpersonal or work relationships have caused an emotional fatigue.

Tiredness may also be used for secondary gains, to mask hidden agendas or for the purpose of malingering.

Tiredness and hypotension

There has been a long standing debate over whether hypotension causes symptoms. British teaching used to state that hypotension was a clinical sign or finding which did not produce symptoms whereas the Continental schools taught that hypotension caused symptoms such as tiredness. It was perhaps part of a cultural divide where the British with magnificent chauvinistic disdain looked down on the weak-kneed hypotensive French.

Does the finding of hypotension in a patient with tiredness mean there is a direct cause/effect relationship?

Conundrum one: One finds hypotension in a patient who complains of tiredness and tells them that this is the cause and then prescribes the Effortil Perlongets. The patient returns for a repeat prescription. He or she feels much better. Is it the Effortil Perlongets, the natural history of a cycle in which the tiredness would have got better anyway or the placebo effect?

Conundrum two: How does one measure the outcome? We concentrate on the outcome for the patient but often ignore the outcome for the doctor, society or the practice of medicine.

Outcome one: The patient is satisfied and happy but poorer due to the cost of the medicine.

Outcome two: The doctor is happy with a satisfied customer.

Outcome three: The pharmaceutical industry is happy with the sale of medi-

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cines and society is happy with this as it provides employment in this industry.

Outcome four: Another part of society is not happy due to the cost of the medicine (the medical aid or the taxpayer).

Outcome Five: Was this 'good medical practice'? Is it 'evidence-based'? Did the tiredness improve yet the blood pressure stay low? Or did the tiredness and the blood pressure improve simultaneously? What do the randomised control trials say?

Conundrum Three: Once or twice a year new patients or patients I share with others* come in to see me and inform me that they suffer from low blood pressure which causes low energy and tiredness etc and could they have their prescription for Effortil repeated. This is almost an impossible situation to evaluate because the horse is already out of the stable. The self-fulfilling prophecy has been fulfilled and the seed has been planted and grown. A plausible reason has been given with a socially acceptable label to a common symptom. It would be interesting to follow the natural history of tiredness in a group of patients from whom one withheld the diagnosis of hypotension and compare it with a group after they had been informed about their hypotension. (See previous Essential CMEs on the effects of labelling.)

Conundrum Four: I have patients who have blood pressures of 90/60 mm/Hg or even lower who are completely symptomless and without complaints and others who have higher blood pressures of, say, 100/80 mmHg who complain of tiredness, dizziness etc.

Some answers to these conundrums are: Hypotension (like hypertension) is a clinical sign not a disease. There are dimensions other than the purely biomedical that should be addressed.

Much can be resolved by the three stage assessment which addresses not only the clinical findings but patients as individuals living in unique contexts.

Having said all this (which means I am about to contradict myself) recent trials (Pemberton, 1989; Wessely, 1990; Pilgrim, 1992; Rosengren, 1993) support the existence of a hypotensive syndrome of dizziness-giddiness and unexplained tiredness and have related hypotension to minor psychological dysfunction and poor self perceived wellbeing. In women, but not in men, a significant association has been found between low blood pressure and tiredness, but not dizziness-giddiness, which appears to occur in men. A 'readiness to cry' has been reported more often by those with low systolic blood pressure *(Bengtsson, 1987).*

In conclusion it seems that there are so many confounding factors associated with hypotension and symptoms **as seen in general practice** that the best advice would appear to be to be aware of the prevalent theories and treat the patient on an individual basis.

** 'Patients I share with others' is a dynamic in a coming Essential CME.*

Tiredness and body history

Through the ages the way in which man has considered his body has changed. In the early ages man is thought to have experienced his or her body in a more holistic and spiritual way whereas in this century the body has become medicalised in high technology (the so called 'high tec-low touch medicine'). In previous centuries the body was the domain of many agencies whereas in this century medicine has almost monopolised it in the pursuit of health. This is a continually changing process as society or an age regards its physical being in the contexts in which it lives. The patient with tiredness or pain visits the doctor in this century. In the last century he may have gone to a priest and in the next century he may visit a computer. *(Illich, 1986; Sosnowski 1994)*

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OPTION FATIGUE

Option fatigue (McClung, 1990) is an interesting concept that proposes that the affluent, consumer-driven culture of the twentieth century provides so many options and choices in our daily lives that having to make so many decisions causes fatigue.

One must choose what TV channel to watch, what party to vote for, what wine to drink, what colour condom to put on. Where option fatigue, it is proposed, exacts its greatest toll is in the area of spiritual and moral values, which have become relative instead of absolute.

The clauses of life are now full of 'ifs' and 'buts'. Choices over such issues as divorce, euthanasia and abortion use up one's emotional energy.

This excess of choice in daily life is said to lead to a lack of commitment and shallowness. Marilyn Monroe once said, "I just believe in everything – a little bit". *(Guinness, 1983).*

Choice and options also lead to boredom and eventually withdrawal.

NEXT ISSUES ARE:

February
Tuberculosis

March
Ugufa Kwabantu

April
Arthritis

May
ENT

June
The burnt out GP

July
Oncology

Part 2 South African Rural Practice

This section presents a problem orientated approach in the context of rural practice.

The context is the store at Eksteenfontein, Richtersfeld.

It is a remote rural GP or government clinic treating low income or poverty stricken patients. The roads to the clinic are difficult to travel on and may require a four wheel drive at times. There are no facilities for investigations, no X-ray facilities etc. The constraints of poverty and unemployment dictate that medicines that are dispensed are generic and cost effective and may be based on the essential drug list (see **Resource Section**).

Most patients that attend the clinic are illiterate and can only speak and understand their own vernacular language.

In this context the expression or complaint of fatigue may have a much wider interpretation than just that of bodily fatigue.

Western doctors may have difficulty in knowing exactly how to interpret the symptom and may look for physical causes only in a biomedical framework.

On the other hand there is an advantage of 'unfamiliarity' with the patient when patients of another culture are seen which may make the symptom of tiredness carry more weight than the same symptom in a 'familiar' patient especially if they have had the complaint before (the **familiarity cascade**). This is one of the few advantages that the one-off consultation has over continuity of care: there are fewer preconceptions.

Because there is no word for depression in African languages, the symptoms of depression are often 'carried' by words such as 'fatigue' or 'loss of energy' or the very expressive 'the whole body' (**wonke umzimba**) which is often said as though 'the whole world' was lying on the patient's shoulders.

One of the great misconception of the past was that Africans rarely suffered from depression. This was partly due, I believe, because there was no word for it and therefore the concept was not so sharply defined in their culture. If it does not have a label or a name or a culturally recognised form, it remains diffuse and cannot have a body of followers (or recognisers).

The Western cultural symptoms of depression are well defined and relate to Western lifestyle whereas the African expresses depression in a different idiom. As there is no word for it, it may not need to be expressed in words. It is, I believe, almost unconsciously expressed in these phrases of fatigue, loss of energy and the whole body.

The culturally recognised way of being depressed in the Western world is being more and more defined by the media and modern psychiatry. The older traditional worlds seemed to allow an inner withdrawal, a winter, a time of rest that enabled a renewal. 'Fatigue' is an expression of this need. Modern expressions of this older idiom are now 'stress', 'alcoholism', 'overdose', 'burn out'.

Many black patients are now torn between their own or their family's belief in traditional healing and their respect for the know-how of Western medicine.

In fact western patients rarely come out with the expression that they feel 'depressed' until they have been diagnosed as 'depressed'. This is because it is often difficult to put one's feelings into words and it might be assumed that it is the doctor's job to assess whether one is 'depressed' or not. The patient

WE NEED YOUR HELP

Your comments on this CME Section are welcome:

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We need help to provide an ongoing education that is appropriate to practice. We invite you to make up MCQs or ideas on benchmarks, rural practice etc.

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Part 2

may also be afraid of being labelled.

It is important to exclude physiological fatigue due to long hours of work, exhaustion from rising early, long journeys to work, inadequate meals and disturbed sleep from overcrowding and inadequate accommodation.

Exclude also fibromyalgic syndrome, which is common, presenting with fatigue, headaches, muscle pains in neck and back and legs.

Fatigue as the primary symptom may point more to depression or a problem of living whereas fatigue as a secondary symptom may be part of a complex of symptoms representing an infection, fibromyalgia or more serious conditions such as tuberculosis, malignancy etc,

Chronic fatigue syndrome (ME) has been assumed to be unique to developed countries (MacIntyre, 1989). I must admit I have never thought of this diagnosis in this context of rural (or urban) black practice.

Fibromyalgia, on the other hand, whose criteria and symptoms have a considerable overlap with chronic fatigue syndrome, is seen in black patients. It may be the commonest cause of widespread musculoskeletal pain.

Remember to check for 'physical' causes of fatigue such as tuberculosis, chronic infections, protozoan infections, HIV infection and malignancy.

In the days before chemotherapy, the prognosis was compared between patients with tuberculosis who presented with haemoptysis and those who presented with tiredness. Those presenting with tiredness had a worse prognosis than those presenting with haemoptysis which was promptly X-rayed and an early diagnosis made. Those presenting with tiredness were more likely to have advanced tuberculosis. (Fowler, 1974, p.165)

Part 3

Teaching Old Docs New Tricks

You are a general practitioner in your mid forties and have been in practice for fifteen years in a rural area of South Africa. You have attended some congresses but the work load of your practice and bringing up your family have left you with a need to update your knowledge. You decide to sit one of the postgraduate exams in family medicine. You have written the papers and now go for the oral examinations. The examiner explains that a revolution has occurred in family practice theory since you qualified and asks you the following question:

Question one: What do you do when a patient comes in armed with a self diagnosis of myalgic encephalitis? He has detailed information about the viral aetiology that he has just read in the *Fair Lady* in your waiting room. He has already formed entrenched views of what it is and he's **got it**.

Answer: Many GPs are sceptical of this diagnosis even if they do not express this openly. They may experience heart-sink in this situation. Given the guarded outcome of true chronic fatigue syndrome it is important to distinguish between **chronic fatigue** and **chronic fatigue syndrome**.

A way of removing your preconceptions is to take a detailed history. This is both therapeutic for you and the patient and helps in a non-judgemental approach.

Question two: The patient now produces incontrovertible evidence of his condition in the form of a photostat of a laboratory report done by his previous GP. It shows a positive Coxsackie virus titre. How do you proceed?

Answer: With caution, feeling your way as you go. Those patients who attribute their illness entirely to external causes such as a viral infection have a poor prognosis. Listen to the patient's story. He is telling you about many things. He is stating his beliefs but also asking many questions. You **accept** the patient's story as a unique gift.

Start from the beginning taking nothing for granted. Try to collate the previous reports and investigations. Taking the history in different ways and from different angles may reveal a long line of consultations with various agencies.

Try and elicit what he has been told by significant others about his condition, whose opinion he values.

You have now been consulting for 25 minutes, the waiting room is restless, you feel you have hardly started on this case.

Because you have given him one of your most valuable assets – time, and are interested (patient-centred) he will return.

Question three: Your receptionist has already rung through once to ask if you are still busy with a patient. You ask him to come back for another consultation. He says he cannot afford it. His medical aid has run out because of the treatments and investigations he has had and he cannot afford to take anymore time off work as he has been off a lot this year with fatigue and muscle pains. How do you proceed?

Answer: You need to have time yourself for **reflection** on this case. It cannot be a one-off consultation. You are being asked to do what is not possible. You have to set boundaries. You inform him that you have to **exclude** by history and examination that there is nothing 'treatable' or 'physical' wrong.

NB: In general never make use of the particular words 'there is nothing wrong'. Turn a 'negative physical' into a positive event. This can be done by your attitude.

You need to get his old notes so that investigations are not repeated and you may need to do further tests that are appropriate, history and examination driven, cost-effective, focused and which will be of use or add to the patient's management or treatment plan (probably none will be required if these criteria are applied). You have to go for a **negotiated settlement** as to the future management of this patient. Because of the associated psychiatric morbidity with chronic fatigue, you also have to explore this dimension with all patients.

Part 4 Multiple Choice Section (MCQS)

Multiple choice questions are intended to cover the factual clinical areas of general practice. They also test reasoning ability and understanding of basic facts, principles and concepts. The questions are of the true/false type. In some examinations marks are deducted for incorrect answers or failure to answer while in others marks are not deducted for incorrect answers. These questions are not set in an 'examining mode' but rather in an 'education mode'. Circle T for true or F for false.

Major criteria for Chronic Fatigue Syndrome are:

1. T/F Muscle discomfort or myalgia.
2. T/F New onset of fatigue causing 50% reduction in activity for at least six months.
3. T/F Generalised headaches.
4. T/F Exclusion of physical and all psychiatric conditions producing similar symptoms.

Social factors that may contribute to depression in women include:

5. T/F A severe life event in the last nine months.
6. T/F The lack of a confidant.
7. T/F Having three or more children at home and not being employed outside the house.
8. T/F The death of a woman's mother in childhood.

Characteristics of fibromyalgic syndrome that are present in the majority of patients:

9. T/F Restless legs.
10. T/F Non-refreshing sleep.
11. T/F Irritable bowel syndrome.
12. T/F Recurrent sore throat.

Infectious mononucleosis:

13. T/F Is often accompanied by fatigue.
14. T/F Occurs usually between the ages of 40 and 60 years.
15. T/F Fever, sore throat and enlarge cervical lymph nodes are common.
16. T/F It may be clinically indistinguishable from rubella.

Pathological causes of fatigue in the elderly include:

17. Hypothyroidism.
18. Occult neoplasm.
19. Hypomania.
20. Pernicious anaemia.

ANSWERS

1. False. Is minor criterion.
2. True.
3. False. Is minor criterion.
4. True.

5. True
6. True
7. True
8. True

9. True
10. True
11. True
12. False. This is a minor criterion of chronic fatigue syndrome

13. True
14. False. It usually occurs between the ages of 10 and 35 years.
15. True
16. True

17. True
18. True
19. False
20. True

Part 5

Sources and Resources

BOOKS THAT SOUTH AFRICAN GPs FIND MOST USEFUL TO KEEP IN THEIR ROOMS

The South African Family Practice Manual, published by South African Family Practice.

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