# The tired patient
## Part II

— B Sparks

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***Summary***

*This 2-part article discusses tiredness as a disease rather than a symptom in order to understand, diagnose and manage patients more effectively. Part II looks at different causes, physical and non-physical, as well as management of the tired patient.*

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To manage tiredness it is essential to find the cause. In most instances, this is possible, although not always easy.

### Physical causes of tiredness

From the studies in Table 3 it is evident that malignancy was rare as a cause of undiagnosed tiredness, occurring in only 9 out of 940 cases. No pathology was found in 3% of patients.

The cardiovascular causes in Table 4 included one half with previously undiagnosed hypertension and half as ischaemic heart disease.

**Table 4: Physical causes of tiredness**[6, 10, 12, 16, 17]
(Based on 5 Studies – in patients with single diagnosis)

| | No. of patients |
|---|---|
| Infection | 117 |
| Cardiovascular | 58 |
| Endocrine | 57 |
| Medications (iatrogenic) | 25 |
| Haematological | 23 |
| Neurological | 15 |
| Nutritional | 9 |
| Renal | 8 |
| Cancer | 7 |
| Gastrointestinal | 6 |
| Allergy | 2 |
| Connective tissue disease | 1 |
| Other | 17 |
| TOTAL | 345 |

An important group are those due to medications prescribed by their doctors. Over half of the patients are above 70 years and in all the cases lethargy was the presenting symptom. The majority of the patients were having regular repeats of their drugs. In another study the drugs were mainly Stemetil and beta-blockers.[18]

In middle-age, circulatory causes and, in old age, iatrogenic and circulatory causes were the commonest.

From these figures it is also evident that occult infections are the major physical conditions which we must attempt to elicit in undiagnosed tiredness, accounting for 34% of physical causes. The majority of infective causes are in patients under 40 years of age. The infections were distributed as in Table 5. The figures would probably not strictly apply in Southern Africa where bilharzia, tuberculosis, tropical parasites may influence the figures. Glandular fever, in these studies, seemed to produce tiredness of the longest duration. We have all seen patients complaining of lethargy for up to a year after severe mononucleosis.

**Table 5:**
**Infection as a cause of tiredness**[6, 10, 12, 16, 17]

| | No of patients |
|---|---|
| Influenza or influenza-like illness | 42 |
| Mononucleosis (proven or suspected) | 32 |
| Respiratory infection | 16 |
| Urinary tract infection | 6 |
| Hepatitis | 4 |
| Pulmonary tuberculosis | 4 |
| Sinusitis | 3 |
| Cholycystitis | 2 |
| Herpes Zoster | 2 |
| Syphilis | 1 |
| Dental Infection | 1 |
| Encephalitis | 1 |
| Labyrinthitis | 1 |
| Malaria | 1 |
| Streptococcal pharyngitis | 1 |
| TOTAL | 117 |

Endocrine conditions were also frequent in these studies. (Table 6). In the early studies the diagnosis of thyroid disease was based on basal metabolic rate, and not the more sensitive T3, T4 and TSH estimations. Possibly these figures should be higher.

With regard to the menopause, I feel there is an ever present danger of over-diagnosing menopause as a cause of tiredness in the menopausal age group, for more serious disease may well be

*Tiredness is one of the most common presenting symptoms in middle-age*

disregarded if the symptoms are ascribed to the "change of life". Tiredness should not be attributed to the climacteric unless accompanied by other symptoms such as hot-flushes, palpitations, parasthesias and arthralgias. It may be present as a result of some other cause such as secondary anaemia from menorrhagia or loss of sleep from nocturnal flushes and cramps. I also believe that many of the so-called menopausal symptoms are psychological in nature, being related to the "empty-nest syndrome" and the patient requires counselling and not hormones!

**Table 6: Endocrine causes of fatigue**

| | No of Patients |
|---|---|
| Hypothyroid | 13 |
| Hyperthyroid | 7 |
| Goiter | 1 |
| Diabetes mellitus | 14 |
| Hypoglycaemia | 7 |
| Menopause | 14 |
| Pregnancy | 4 |
| TOTAL | 60 |

## Non-physical causes of tiredness

An important statistic to emerge from the combined studies was that nearly two/thirds of the patients complaining of lethargy gave no positive histories nor abnormal findings on physical examination and blood investigations. Jerrett[17] found 187 patients of the 300 studied, to fall in this group, 149 being women. (Table 7). Lethargy was the presenting symptom in half the patients and, apart from the absence of physical signs, the only constant factor was sleep disturbance and the presence of stress factors in their lives. Well over half the patients were between the ages of 35 or 55 years. Boredom, worry about money, children and sick relatives figured predominantly in the anxiety states.

**Table 7: Problems apparent in men and women in whom no physical cause could be found (Jerrett)**

| Problem | No of Patients |
|---|---|
| **Men** | |
| Redundancy or work dissatisfaction | 7 |
| Insomnia related to shift work | 4 |
| Psychosexual problems - impotence | 4 |
| - "frigid" wife | 1 |
| Bereavement | 2 |
| Recent retirement | 3 |
| Tensions | 8 |
| Frank depression | 5 |
| Hectic life style | 2 |
| Alcohol problem | 2 |
| TOTAL MEN | 38 |
| **Women*** | |
| Anxiety state | 58 |
| Frank depression | 44 |
| Psychosexual problems | 32 |
| previous termination of pregnancy | |
| infertility | |
| impotent husband | |
| frigidity | |
| lack of satisfaction | |
| Bereavement | 9 |
| Dieting | 6 |
| TOTAL WOMEN | 149 |

* over half women were between 35 and 55 years.

## MANAGEMENT OF THE TIRED PATIENT

With this background into the classification and causes of tiredness, what then should be the approach to the tired patient.

When a patient complains of lassitude in a general practice, the following will usually be true.[12]

1. The patient and physician know each other, both this knowledge and their pre-existing relationship will affect the evaluation process.
2. The participants will probably have repeated future encounters. Thus a complete answer is not always necessary on the first visit for a complaint - the physician can make effective use of the test of time and can expect a patient to return if the initial plan doesn't seem to be working.

In a paper on fatigue as a presenting symptom, Friedlander[19] writes, "no satisfactory diagnostic guide exists but the perceptiveness of the physi-

cian." This statement is very true of this condition. Faced with a patient with fatigue, the doctor must choose from an array of available diagnostic studies.

In the management, the history and examination are of greatest importance. In addition to the information that is usually elicited in routine history and physical examination, certain special areas should be explored.

**History** (Refer to Table I, Part I for relevance)

- daily activities (assess physiological basis)
- sleep patterns
- symptom of tiredness
  - type – loss of interest?
    - desire/ability?
    - tired physically?
    - mental fatigue?
    - sleepy?
  - onset
  - duration
  - progression
  - effect of exercise
  - effect of sleep
  - diurnal variation (weekends)
  - relationship to meals, diet
- medications (elderly)
  - esp recent changes
  - potassium
  - beta blockers
- focus on infections
  - bd temps for 3 days
  - confusion in elderly ?UTI
  - exposure to bilharzia
- weather preference and other thyroid symptoms
- exclusion of pregnancy
- mental history
  - anxiety
  - depression
  - marital and sexual problems
  - self esteem
- relationships
- support systems – spouse & family
- previous functional problems

**Physical examination**

- to exclude infections
  - urine "Dipstick"
    - leucocytes
    - nitrites
    - urobilinogen/bilirubin
  - micro?
  - prostate check
- to exclude mononucleosis
  - glands
  - spleen/liver
- assess thyroid function
  - pulse
  - ankle reflex return

  (kneeling – slow in myxoedema)

The majority of physical problems would have been detected up to now. If an abnormality is isolated, and if you and the patient accept this as a possible cause of the tiredness then appropriate support, suggestions, and/or referrals should be pursued. The effective observation of body language will often assist in assessing if the patient has a psychological cause.

In the absence of a positive feature, including a primary psychogenic cause, then it may be appropriate to order further investigations. I personally find that simple reassurance at this stage is enough, and the patient is requested to return, should the condition not improve.

**Ulysses syndrome**

On the patient's return a few tests could be done realising the danger of producing a "Ulysses syndrome" if many unnecessary tests are performed. This syndrome results from possible slight abnormalities detected as a "bell-curve" effect

*There is a danger of over-diagnosing menopause as a cause of tiredness*

which create a syndrome consisting of multiple minor "abnormalities" which are in reality normal. Obviously the chance of such a syndrome increases with each additional over-investigation. The patient and the doctor are then caught in a progressive spiral of investigations, creating further fears and anxieties about this monster of a non-existent disease.

In fact Jerrett[17] states "that if the history and examination are negative for organic disease, there is no point in doing any routine investigations, even full blood count and urine testing, because they are most unlikely to accomplish anything apart from reassuring the doctor – but they may have the opposite effect on an already over-anxious patient.

The following investigations are suggestions but will obviously vary according to your own "gut-feeling" about the problem.

- FBC & ESR
- Fasting blood glucose (?HbA1C)
- T3, T4, TSH
- Urine for MC&S
- Stool for occult blood
- Bilharzial CFT & Cercarial FAT
- Ferritin

These tests help to establish or suggest the diagnosis of infection, anaemia, endocrine, renal or GIT causes of diseases, which are the major physical causes of isolated tiredness. Obviously we are looking for early undifferentiated disease at this stage – all more advanced disease has been

detected at an earlier stage.

Other tests at this stage could be:

- EB virus antibodies esp IgM in younger individuals
- Pregnancy test
- X-ray chest in older patients
- K+ if on diuretics
- Liver function tests
- Urea

If the patient returns and all these are negative then these tests may be indicated if:

- Calcium – especially if there is constipation which together with tiredness may be the only early signs of hyperparathyroidism
- Cortisol
- ECG
- WR
- Magnesium

At this stage, if you can't find indications of psychological, physical nor physiological cause for the isolated symptom, then referral for second opinion is justified if the patient is not prepared to use "tincture of time".

## TREATMENT

Potions for the treatment of fatigue have preoccupied man since early times, and Victorian and Edwardian patients were subjected to a host of "magnetic" and "electric" corsets, jolting chairs, shoes, soaps and other devices. (Fig 3).

Treatment in the first place should be for the individual condition isolated.

### Psychological cause assessment

As with the investigation of other conditions, a diagnosis of psychological cause should not be entertained merely because of an absence of abnormal physical findings and/or laboratory investigations. Rather an evaluation for depression, anxiety and stress in their own right should be undertaken in all cases. Some attempt should be made to assess the needs of the patient and whether they are fulfilled.

There are only 5 reasons why patients go to a doctor and these are basically if any of the following are threatened, and I find these reasons a simple model on which to base further discussions with the patient:

1. A sense of physical well-being
2. Adequate self-image
3. Some control of everyday life functions – eating, walking, sexual function, toilet etc
4. The ability to be creative and productive in a way that is meaningful to us, accepted by others – both in the home and in employment.
5. Membership in a supportive community – family and general community.

With the patient's consent these areas must be assessed especially in a patient with fatigue with its multi-factorial etiology. Patients must be asked how these factors are threatened in their lives, and counselled accordingly. I have often found that a psychosexual problem is at the root of the problem. In such a case the patient may well have each of these areas affected and it requires sensitive counselling of each aspect. If the appointment has become rather long, I usually suggest that the patient return to me for a further appointment when I can discuss the problems at length.

Antidepressive drugs may also be required often as a trial and adjunct to therapy but not purely as a cast-off of "try this, it will make you better". Further psychological counselling must be pursued as well.

### Conclusion

Tiredness, one of the most common presenting symptoms, can provide an interesting and challenging dilemma to the primary care physician. It requires all of such a physician's best attributes – a broad view of disease, a high degree of psychosocial sensitivity, and a good ongoing relationship with the patient.[17]

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