

# The tired patient

## Part I

— B Sparks



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### Curriculum vitae

In September 1987 Bruce Sparks became Professor and Head of the Department of Family Health at the University of the Witwatersrand. He came from a four-man group practice in Johannesburg and had been a part-time teacher in the Department of Medicine for some years. He is also the Secretary of the National Council of the Academy, a member of the College of Medicine of SA's Council and an examiner for the MFGP. His special interests are in family therapy, sexology, doctor-patient relationship and computer technology. Professor Sparks is married and they have 2 children.

**KEYWORDS:** Fatigue; Diagnosis;  
Incidence; Age factors; Sex factors

### Summary

*This article discusses tiredness as a disease rather than a symptom in order to understand its presentation, diagnosis and management. In Part I some definitions and studies are given; age, sex and socio-economic factors are discussed as well as organic vs psychological tiredness.*

S Afr Fam Pract 1987; 8 (11): 434-9

- "Dr I need a tonic to keep me going"
- "I'm so exhausted!"
- "... shattered!"
- "I just want to sleep all day!"
- "I'm so tired I can't face anything"
- "I feel so drained and tired all the time!"
- "I could literally sleep for a week"
- "All I need Doctor, is a 'good pick-me-up'!"
- "I feel so weak and drained"
- "I'm 'knackered' "

**I**n the average family practice we are presented each day with this sort of complaint. One of the most difficult tasks in medicine is to diagnose a serious disease in its early undifferentiated stage, when an imprecise complaint such as tiredness is the only symptom.<sup>1</sup>

Fatigue is a commonly experienced symptom which may be a component of virtually any disease and may have a physical, psychological and mixed origin. It is possibly the most common, yet least understood, and most neglected symptom in general practice, and words such as "tiredness" or "fatigue" are not even mentioned in the indices of major textbooks of medicine. Also, very few studies have been done, especially in recent years. Our modern high tech medical world hardly considers a simple topic such as tiredness but the physician of the 1940s and '50s certainly were prepared to philosophise, and it is in these years that one finds the most publications. I have been forced to glean most of the statistical data from early papers.

The military problems of the first World War gave considerable impetus to the study of fatigue. The special interest lasted a few years and then died away. The second World War again thrust the problem of fatigue on the medical profession and on

*How do I know that my youth is all spent?  
Well, my 'Get up and go' has 'Got up and went'.  
But I really don't mind when I think with a grin,  
Of all the grand places my 'Get up' has bin.*

ANON

psychologists. Wide variations in the ability of military recruits to withstand the stress of special army tasks led to a frantic effort to improve the methods of selecting men. Phrases such as "battle fatigue", "combat fatigue" or "pilot fatigue", entered the dictionaries and it was realised that psychological factors were a predominant influence on the etiology of these conditions.

In this article I discuss tiredness as a "disease" rather than a "symptom" in order to understand its presentation, diagnosis and management.

### *Tiredness is a WHOLE symptom*

#### Definition

There is no precise, reliable, quantifiable definition of fatigue or tiredness which is clinically useful. This absence of an overall definition of tiredness pre-empts any scientific basis for measuring the condition, because logically, that which can not be defined can not be measured, and is not understood.<sup>2</sup> It has been loosely defined as 'a sense of

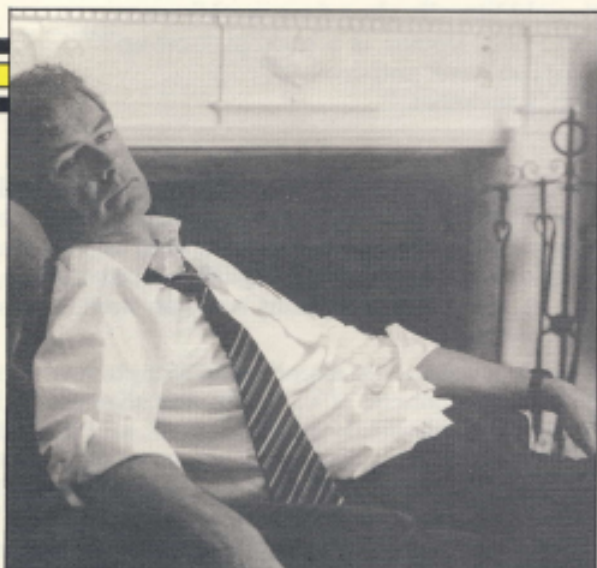
weariness described variously as exhaustion, low vitality, ... often accompanied by a subjective sensation of weakness and strong desire to rest or sleep'.<sup>1</sup> Others add a self-felt assessment of inadequacy and difficulty in concentration.<sup>3</sup>

#### Incidence

The incidence in the general population is difficult to estimate, but we are certainly not seeing all instances of the symptom, as the majority are being managed by self-help, usually by the use of self-prescribed vitamin "tonics", or life-style manipulation, such as jogging or going to a "gym". According to Banks,<sup>4</sup> only 1 in 456 symptom episodes of energy change will reach a doctor.

#### Location

Tiredness is a "whole" symptom much like the true "holistic" concept of JC Smuts.<sup>5</sup> It is felt throughout the patient's body and is not confined to regions, anatomical structures or specific physiological functions, but rather it emanates from the natural whole of the human body and mind. It is the interrelationship of these two that governs the consciousness of tiredness.<sup>6</sup>



**PATIENT  
PERFORMANCE  
NEED NOT BE AFFECTED BY  
ANTI-HYPERTENSIVE THERAPY.**

### Age distribution

Fatigue occurs at any age but is relatively rare in children under 15 years, (2,3% of the patients with fatigue in the 1975 National Ambulatory Medical Care Survey).<sup>7</sup> It is stated to be high in menopausal women and I have certainly found it to be a common symptom in young women.

*People tend to think that lack of energy means lack of vitamins*

### Sex ratio

Female : male = 2 : 1

A study of forty-year-old Danes found that 40% of women and 25% of men felt "tired at present".<sup>8</sup> It is thought that this may be due to the fact that women work harder at jobs with a less distinct endpoint in sight and fewer rewarded goals.<sup>9</sup> Some conditions are also more prevalent or exclusive to women such as menopause and pregnancy. Possibly the ratio may be a manifestation of visiting

patterns to doctors rather than differences in prevalence.

### Socio-economic status and race

These do not appear to be risk factors,<sup>1</sup> but no study has been done in RSA, and a transcultural study would certainly be an interesting and valuable exercise.

### Classification

Several classifications for fatigue have been suggested,<sup>1, 6, 10, 11, 12, 13, 14</sup> but the simplest scheme uses an etiological axis of physical, psychological and a mixture of both.

I prefer using the following classification (Fig 1).

- physiological (normal)
- physical (organic) — acute
- psychological — chronic

Fig. 1

Physiological tiredness is "that which can normally be expected in a mentally and physically healthy individual when an imbalance in exercise, rest or

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diet exists, such as would occur with prolonged mental stress or pregnancy'.<sup>10</sup>

I have attempted to illustrate this classification in a graphic model (Fig 2).

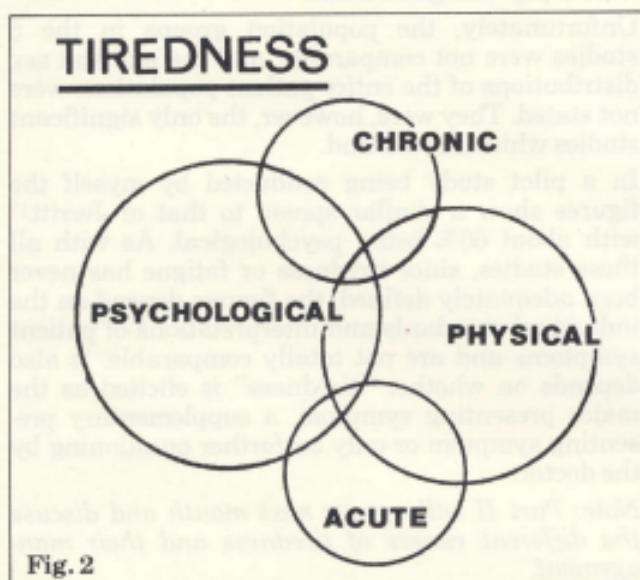


Fig. 2

### Organic vs psychological tiredness

A useful method of differentiating organic from psychological tiredness is illustrated in Table 1.

Features	Psychological	Organic
Presenting complainant	Usually patient	Usually family or friends
Physical appearance	Anxious/depressed /normal	Ill
Primary deficit	Desire	Ability
Duration	>4 months or recurrent	<2 months
Timing	Worse in morning/whole day	Worse in afternoon or evening
Course	Fluctuating	Progressive
Onset	Stress related	? related to onset of ailments
Effect of sleep or rest	Unaffected	Relieved
Relation to phys activity	Relieves symptoms	Worsens symptoms
Family and environment	Stressful	Supportive
Associated symptoms	Nonspecific and multiple	Specific and few
Previous health problems	Often functional	Usually organic

In organic disease the family or friends of the patient often contact the doctor due to their concern about his recent deteriorating health, stamina or appearance and they will be most supportive. In functional tiredness the patient who has a stressful family or work environment will present personally when experiencing a fatigue or lack of motivation of longer duration. The duration of psychological tiredness tends to be greater than 4 months while that of organic origin is usually shorter than 2 months.<sup>1, 14, 15</sup> (See Table 2).

Table 2 - Causes of fatigue related to duration for 141 patients with one diagnosis (Morrison JD<sup>16</sup>)

Duration of fatigue	Causes of fatigue	
	Psychological (no of pts)	Physical (no of pts)
Less than 1 month	16	39
One to four months	27	21
More than four months	29	9

Classically the person with psychological tiredness will complain of being tired when waking and often during the whole day, but feeling better after a game of squash or a session at the gym. She may also be feeling better in the evening. She also may have typical symptoms of depression (depressive sleep disturbance, irritability, lack of motivation, etc). On questioning, the patient will be able to differentiate the primary defect as either one of lack of desire for activity or one of wishing to do exercise but finding progressive weakness and exhaustion during the activity.

I discuss Table 1 with the patients and it assists them to understand their condition. The table should be used as a guide to give the doctor and the patient some direction for further action. It should also be remembered there are often features of both types, as in the mixed form.

### CAUSES OF TIREDNESS

#### Myths

- Public's misconceptions

In the mind of the public lack of energy tends today to mean lack of vitamins. This idea is exploited by the manufacturers of vitamin products - especially around exam time and during the winter months. In fact, in one study vitamin deficiency was encountered in only 1 of the 300 cases.<sup>12</sup> The concept of vitamin deficiency as a cause of lack of energy has surpassed the previous notion when I was a child that constipation or "poor elimination", was to blame!

Cancer, too, is frequently feared by patients when chronic ill health of any kind appears but in fact is generally found in only 0,7% of cases of tiredness.<sup>12</sup> Cancer seldom produces weakness unless it is so far advanced that anaemia, and cachexia has resulted.

*“If no cause is obvious then the patient must have a psychological problem” - a myth?*

• *What about doctors?*

Doctors rate anaemia high on the list of conditions often treated for tiredness. Generally it is accepted that the Hb must fall by 30% before symptoms of tiredness are evident, ie in chronic slow anaemia. I must say that I have found quite a few tired women who have had ferritin levels below normal and who have so far been able to sustain normal haemoglobin levels, who have responded quite well to iron.

A diagnosis of “low blood pressure” is often made when BP readings are in fact normal. Any young women will have low BPs, and will answer in the affirmative when questioned about postural effects on rising, but I often wonder whether it is justifiable to label them as having low BP and put them on Effortil. I have often seen them later when they are fine but the BP hasn't risen a jot, and in fact may be lower.

One myth to be aware of is “if no cause is obvious then the patient must have a psychological problem” and be consigned to what has been described as the clinical rubbish basket of neurotic ill-health. If one asks any patient including healthy ones, and even GPs, about stress factors in their lives, one will usually find some. The fact is that they may not be responsible for the condition. Rather an evaluation for depression or anxiety should be made in *all* cases and not by default, in those with apparently normal exam and investigations.

**What in fact are the causes of tiredness?**

From Table 3, which is a composite analysis of figures from five studies, it is evident that about 55 to 60% of patients with tiredness were thought to have a psychological cause.

Unfortunately, the population groups in the 5 studies were not comparable, and the age and sex distributions of the entire patient populations were not stated. They were, however, the only significant studies which I could find.

In a pilot study being conducted by myself the figures show a similar spread to that of Jerritt<sup>17</sup> with about 60% being psychological. As with all these studies, since tiredness or fatigue has never been adequately defined, the figures depend on the individual standards and interpretations of patient symptoms and are not totally comparable. It also depends on whether “tiredness” is elicited as the major presenting symptom, a supplementary presenting symptom or only on further questioning by the doctor.

*Note: Part II will appear next month and discuss the different causes of tiredness and their management.*

**References**

1. Valdini AF. Fatigue of Unknown Aetiology - a Review. *Fam Prac* 1985; 2(1): 48-53.
2. Eidelman D. Fatigue: Towards an analysis and a unified definition. *Med Hypotheses* 1980; 6: 517-26.
3. Bartley SH. Fatigue, Mechanism and Management. Springfield: Charles C Thomas, 1965: 52.
4. Banks MH, et al. Factors influencing demand for Primary Medical Care in women aged 20-44 years: A Preliminary Report. *Int J Epid*, 1975; 112: 60.
5. Smuts JC. Holism and Evolution. 3rd ed. London: Macmillan, 1936; 1.
6. Ffrench G. The Clinical Significance of Tiredness. *Can Med Assoc J* 1980; 82: 665-71.
7. National Ambulatory Medical Care Survey: 1975 Summary, Hyattsville, Md, National Centre for Health Statistics, 1978; 22-6.
8. Norreland N, Holnagel H. Fatigue among 40 year olds. *Ugeskr Laeger* 1979; 141: 1425-9.
9. Rhoads JM. Overwork. *JAMA* 1977; 237(24): 2615-8.

**Table 3 - Causes of fatigue**

	Number of patients	Psychological %	Physical %	Mixed %	Physiological %	No diagnosis %
Allan (1944) <sup>12</sup>	300	79,7	20,3	NR	NR	NR
Jerritt (1981) <sup>17</sup>	300	59,1	39,6	NR	1,3	NR
Morrison (1980) <sup>16</sup>	176	40,9	38,7	11,9	,6	7,9
Katerndahl (1983) <sup>10</sup>	59	35,6	37,3	NR	11,9	15,2
Ffrench (1960) <sup>6</sup>	105	26,7	71,4	NR	1,9	NR
TOTAL	940	57,1	36,7	2,2	1,6	2,4

NR = Not recorded

## Tired patient

10. Katerndal DA. Fatigue of Uncertain Etiology. *Fam Med Rev* 1983; **8**: 26-38.
11. Friedman HH. Fatigue. In: Problem Orientated Medical Diagnosis. Boston: Little, Brown & Co, 1975; 709.
12. Allan FN. The Differential Diagnosis of Weakness and Fatigue. *N Eng J Med* 1944; **231**(12): 414-9.
13. Muncie W. Chronic Fatigue. *Psychosom Med* 1941; **3**(3): 277-85.
14. Kaye PL. Fatigue: Pervasive Problem. *NY State J Med* 1980; **Jul**: 1225-9.
15. Solberg LI. Lassitude. *JAMA* 1984; **251**(24): 3272-6.
16. Morrison JD. Fatigue as a presenting complaint in family practice. *J Fam Pract* 1980; **10**: 795-801.
17. Jarrett WA. Lethargy in General Practice. *Practitioner* 1981; **225**: 731-7.
18. Edit. Fatigue as an unwanted effect of drugs. *Lancet* 1980; 1285-6.
19. Friedlander HS. Fatigue as a presenting symptom. *Curr Therap Res* 1962; **4**: 441-9.

## From the Journals

### Effect of a rapid diagnostic method on prescribing patterns and ordering of throat cultures for Streptococcal Pharyngitis

BEV LORRAINE TRUE, PharmD  
BARRY L CARTER, PharmD  
CHARLES E DRISCOLL, MD  
J DANIEL HOUSE, PhD

Iowa City, Iowa

*J Fam Pract* 1986; **23**(3): 215-9

The sensitivity and specificity of a rapid identification test for group A  $\beta$ -hemolytic streptococcus and its impact on prescribing antibiotics and ordering throat cultures were evaluated in a primary care office setting. The calculated sensitivity, specificity, positive predictive value, and negative predictive value were 82 percent, 92 percent, 76 percent, and 94 percent, respectively. Throat cultures were ordered for 98 percent of patients with acute pharyngitis regardless of the method of testing available. After use of the rapid identification test within the office, a reduction was observed in physician prescribing of antibiotics before the throat culture results were known. Physicians were more likely to initiate antibiotics immediately when rapid test results for streptococcal infection were positive and provide patient education regarding symptomatic treatment when the results were negative. The rapid identification test is an acceptable alternative to the standard culture technique in the family practice office. The rapid test was apparently responsible for the observed reduction in antibiotic prescribing and should reduce unnecessary cost and antibiotic exposure in the ambulatory setting.

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Further information is available on request from the Medical Department