Fatigue

BC's HEART FAILURE NETWORK
Quality care for quality life.

Heart Failure Symptom Management Guideline
For adults, age 19 and older in British Columbia

Fatigue is defined as a sustained sense of exhaustion with a decreased capacity for physical and/or mental work. Fatigue is also subjective and is the most disabling symptom in chronic heart failure. Studies show it is a multidimentional symptom with both clinical and psychological characteristics effecting patients' quaility of life.
A combination of pharmacological and self-management strategies are best employed to reduce and control symptoms of fatigue.

Approach to Managing Fatigue

Assessment

- Document history, physical examination, medications, sleep history, psychosocial assessment, environment assessment, review of laboratory and imaging studies.
- Assessment needs to focus on determining the cause, effect and impact on quality of life for the patient.

Fatigue tips

- Identify and treat the underlying cause as appropriate; consider co-morbid conditions such as anemia, chronic obstructive pulmonary disease, depression, dehydration, endocrine imbalances, hypercapnea, hypoxia, medications (eg. beta blockers, opioids, antidepressants), bradycardia, poor nutrition, poor sleep, sepsis, pain, diarrhea, nausea or vomiting, hypokalemia, hypernatremia, and hypomagnesaemia.
- Collect Edmonton Symptom Assessment System (ESAS) score to assist with monitoring and documenting symptomatic burden.
- A combination of pharmacologic and non-pharmacologic self-management strategies is most effective.

Non-pharmacological Approach

- Assess and give fluids as appropriate.
- Nurition counselling.
- Sleep, aromatheraphy.
- Massage, music.
- Exposure to natural enviornment.
- Pace activities to reduce severity of fatigue and help patient to adapt life to day to day condition.
- Prepare for exertional activities, including pre-medication as indicated (eg. Nitro, opioids).

Initial pharmacological Approach

Treat underlying causes: (content retrieved from FH's symptom guideline for fatigue available at) www.fraserhealth.ca/media/11FHSymptomGuidelinesFatigue.pdf)

- Depression – refer to provincial Depression symptom guideline http://www.bcguidelines.ca/guideline_mdd.html
- Rule out endocrine imbalances – (Diabetes management and thyroid hormone replacement).
- Hypokalemia – change loop diuretic to potassium sparing; may need potassium supplement.
- Insomnia – consider sedative or hypnotic medication (may have high risk of delirium).
- Sepsis – give antibiotics and antipyretics where appropriate.

Persistent Symptoms	
Psychostimulants Not first line therapy	**This medication class should be used in consultation with a palliative care physician and a physician experienced in heart failure care.** **Patients who are elderly, cachexic, debilitated, have renal or hepatic dysfunction may require reduced doses** http://www.bcguidelines.ca/submenu_palliative.html http://www.bcguidelines.ca/pdf/palliative2_fatigue_appendix_b.pdf

Persistent Symptoms				
Name	**Trade Name**	**Dose forms**	**Starting dose**	**Maximum dose**
Methylphenidate (Risk of arrhythmia and agitation…..should only be used in specific cases)	Ritalin	IR tabs 5, 10, 20 mg	Not recommended for patients over 65 years of age Age 18-65: 5mg PO BID (AM & noon) Frail patients: 2.5 mg PO BID	15 mg PO BID (AM and Noon)
	Biphentin	SR capsules 10, 15, 20, 30 mg	Once does is stabilized in IR give equivalent daily does as SR or XR once daily in AM	
	Concerta	XR tabs 18, 27, 36, 54 mg		
	Ritalin SR	SR tabs 20 mg		
Dextroamphetamine	Dexedrine	IR tabs 5 mg	Not recommended for patients over 65 years of age Age 18-65 2.5mg PO BID (AM then 4 to 6 hours)	20mg PO BID (AM then 4 to 6 hours)
		SR capsules 10,15 mg	Once dose stabilized on IR, give equivalent daily does as SR once daily in AM	
Modafinil	Alertec	Tabs 100 mg	Age over 65 years 100 mg PO QAM	Age over 65 years 100mg PO BID (AM and noon)
			Age 18-65 years 100 mg PO BID (AM and noon)	Age 18-65 years 200 mg PO BID (AM and noon)

Reference BCMA palliative care guideline