Chronic Fatigue in Family Practice

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Fatigue is the normal chaff of living. When young women were given diaries in which to record their symptoms, it was found that over 400 episodes of tiredness were recorded for every one episode that was brought to the physician.[1] Jerrett[2] prospectively studied those who complained of lethargy as a presenting or supporting symptom. He included patients with analogous symptoms, such as being "one degree under," "knackered," or "needing a tonic." Approximately 75 of 1000 patients complained of these symptoms each year. The General Practice Morbidity Survey[3] counts diagnoses, not symptoms. But symptoms that are unexplained at the end of the first consultation may be recorded in a "diagnostic" group that includes malaise, debility, fatigue, and tiredness. On the average, 12 out of every 1000 patients were so categorized in 1 year. The sex ratio is equal in childhood, but the recorded incidence doubles in adult women and increases for both sexes in old age.

It is customary for family physicians to formulate a problem along three axes: physical, psychological, and social. After a so-called diagnosis of fatigue has been made at the first encounter, a primarily physical cause has been found in 22% to 39%[2,4,5] of patients. In a retrospective study[4] in which fatigue was most frequently diagnosed in young adults, the most common cause was infectious mononucleosis. The second most common diagnosis, which was unexpected at first consultation, was pregnancy! Among older patients, fatigue is more likely to be due to circulatory disorders or, most important, to drugs prescribed by the physician.[2] Medical ward classics, such as anemia, uremia, and endocrine dysfunction, are less common causes of fatigue in general practice.[2,4,5]

In retrospective chart reviews, family physicians[4,5] posited a psychological cause for tiredness in 41% to 50% of patients. The duration of symptoms was, on the average, longer than the duration of symptoms in those given physical diagnoses.[4] Tiredness may be one of the cluster of physical and psychological symptoms that characterize a depressive episode.[6] Alternatively, tiredness may represent a physiological response to the social role of mothers of small children. The causes of fatigue may also span the physical and psychosocial dimensions, a striking case being the patient who is depressed, overworked, and postpartum.

Taking a physical and psychosocial history, including an inquiry into the patient's own ideas and concerns, is the most cost-effective physician response. This information, matched with knowledge of potential causes and their age-sex distribution, will help in deciding what systems to examine and what laboratory tests to choose. In one study laboratory tests were important in securing the diagnosis in only 8% of patients.[5] Management of physical causes is well defined. Diagnosis of psychological causes may be difficult. Goldberg and Bridges[7] have shown that physicians are most likely to overlook psychological distress when patients bring what appear to be physical symptoms, a real dilemma for general physicians who must constantly consider symptoms on at least two levels. When a patient is convinced that symptoms are organic, a reasonable response is to examine and investigate while opening up a discussion of psychosocial issues. The patient, relieved that the physician shares a concern to exclude bodily dysfunction, will sometimes piece together hidden worries, bringing them back for discussion at a later date. When a depressive episode is diagnosed in general practice, there is evidence that antidepressants given in recommended doses help.[8]

Social causes are more difficult to define and treat. Such questions arise as: When is fatigue a normal response to excessive hours of work? Why is it not presented more often? Why is it presented now? Often fatigue is presented by an individual whose responsibilities are difficult to define and organize and where the demarcation between home and work is unclear. It is an irony that these are features that characterize the conditions of work of both family physicians[9] and their women patients.[10] Stoical physicians sometimes overlook this parallel. A physician may trivialize or inappropriately medicalize a patient's complaint. When the diagnosis is not medical but existential,

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neither party need lose face if it is discussed with honesty, empathy, and warmth.[11] A counseling approach enables a patient to consider a variety of options and make new choices in the future.

A few patients in each practice complain of fatigue that continues for more than 6 months. Researchers are currently investigating the causes of chronic fatigue from different specialist perspectives. Some patients have immunological dysfunction.[12,13] British investigators have found some patients with raised antibody titers to enterovirus.[14,15] Surveys of fatigued patients in ambulatory care[16,17] suggest that the Epstein-Barr virus is only rarely responsible for chronic fatigue and that this entity has been overdiagnosed.

Until a specific causal agent is identified, it is inappropriate to use a diagnostic label that implies the etiology is known, and when investigators use different definitions, it is also difficult to compare their results. Holmes et al[18] have therefore proposed that agreed criteria and definitions be used by all researchers investigating chronic fatigue. Using these criteria, 67% to 72%[19,20] of patients with chronic fatigue have been shown to have a psychiatric disorder, depression in particular. Chronic fatigue may cause psychological distress, but patients with chronic fatigue are twice as likely to have a psychiatric disorder as those who have fatigue with peripheral neuromuscular disease.[20]

Stress,[21] psychiatric disorder, impaired immunity, and infection have all been identified as possible causes of chronic fatigue. Over time each of these factors may interact,[22,23] and much remains to be explained. The family physician works with specialists on the one hand and patients on the other. In this position it is sometimes reasonable to defer judgment. Scientific knowledge and the clinical picture will change. The physician can listen and wait, exercising tact and care.

A diagnostic label may reassure the patient and the physician. Physicians[24] and patients vary in their need for the certainty that a diagnosis implies. Although it is unlikely that the frequency with which tiredness is presented varies widely, the 222 physicians who participated in the General Practice Morbidity Survey varied greatly in their use of the diagnostic group that includes tiredness. Some physicians may infer that recording symptoms at the end of the consultation represents a failure of the clinical reasoning process. Others may prefer symptoms, unalloyed. Symptoms may presage recognizable disease in the future or nothing at all.

Little is known about the outcome of fatigue in family practice except that when a diagnosis of fatigue is made at the first consultation, patients consult, on the average, only 1.4 times.[3] Until recently, investigators tended to ignore "heartsink"[25] complaints. Chronic fatigue deserves investigative attention. It brings out the best and worst in family medicine. At worst the patient's complaint may give voice to some feeling the physician cannot face or cope with in himself, the very stuff of Balint[26] work. At best the physician and patient search for meaning. Frequently they accept fatigue as the normal chaff of living or, sometimes, as the harbinger of disease. But at the end of a search, the physician and patient may come full circle to the symptom, with all its uncertainty.

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