Dear Dr. Jeff,

As I make rounds in the nursing home, residents frequently complain of being tired all the time. The nurses report that these individuals sleep well at night and, when offered, usually refuse sleep aids, saying they sleep too much already. It doesn’t seem right to just write off their complaints as being related to age and general infirmity. Any suggestions?

Dr. Jeff responds: Fanny Lou Hamer, the spark plug of the Mississippi Freedom Democratic Party in the 1960s, was famous for saying she was “sick and tired of being sick and tired.” Your instinct is absolutely on the mark. The residents who complain to you are not simply a bunch of whiners unwilling to adjust to the reality of the aging process.

Our elderly residents rarely expect to have the stamina to run a marathon or even the energy and drive to pull an all-nighter when involved in an exciting project or a good book. But the sensation of being tired all the time is a profoundly negative quality-of-life factor that is inadequately addressed by American health care. This is not simply another nursing home issue, but a common complaint across the aging spectrum.

The National Cancer Care Network defines this symptom, medically labeled fatigue, as “physical, emotional, and/or cognitive tiredness or exhaustion” that is out of proportion to recent activity and that does not resolve with sleep. Far from being benign or the result of unreasonable expectations, fatigue is the most common symptom reported at the end of life across all life-limiting diseases.

Cancer-related fatigue is not simply a marker for terminal disease. It appears in people with early disease who appear to be responding in other ways to treatment, and it appears in cancer survivors as well. It is, moreover, the most common end-of-life symptom for renal disease, second-most common after dyspnea for heart failure and chronic obstructive pulmonary disease, second after pain for cancer, second after diarreal for HIV/AIDS, and third-most common after depression and sleep disturbance for end-stage liver disease. Patients often find fatigue more distressing than their pain.

Fatigue frequently overlaps with pain, depressed mood, sleeplessness or disturbed sleep, and anorexia. But each of these symptoms may be seen separately or in varying combinations. When they do coincide, they represent a symptom cluster for frailty and poor prognosis. Unfortunately, these distressing symptoms don’t break through into the realms of the Minimum Data Set, the Quality Indicator Survey, or the home care Outcome and Assessment Information Set (OASIS measures). As a consequence, fatigue is underreported, underevaluated, and underdiagnosed.

In 19th- and early 20th-century literature, we are treated of people who suffered from what was then called “neurasthenia.” It represented a complex of fatigue, headache, anxiety, depressed mood, and neuralgia. Although originally believed to represent a physiologic problem in the nervous system, it gradually transformed into a diagnosis of “nerves.” (You can still find it in the World Health Organization’s International Classification of Diseases.)

Neurasthenia was thought to be particularly prevalent in Americans. Indeed, William James, who was himself diagnosed with it, called it “Americanitis.” As the categorization gradually shifted from physical to psychological, physicians located the cause in the stresses of modern industrial society.

All in the Head

We can, in retrospect, recognize elements of anxiety, neurosis, depression, and posttraumatic stress disorder in many of the case histories. Many of these patients may actually have been suffering from a wide variety of undiagnosed conditions, from brain tumors to adrenal insufficiency, but the common belief has been that most suffered from psychiatric problems with somatization.

This history has certainly contributed to the tendency of many primary care physicians to write off patients with fatigue as complainers and for many physicians in long-term care to blame their patients’ fatigue on anxiety or depression. Certainly, evaluation by a competent mental health practitioner may be appropriate for some of these patients, but a good medical evaluation must consider multiple potential etiologies.

Particularly in our nursing home populations, medication side effects have to top the list of any differential diagnosis for fatigue. A veritable laundry list of commonly used medications can manifest fatigue as a side effect. Prominent among these are beta blockers, used for congestive heart failure, hypertension, angina, tremors, atrial fibrillation, and many other medications. In fact, many medications also interfere with melatonin release, producing the combination of fatigue and sleeplessness.

Many other cardiac medications can contribute to fatigue if they have negative inotropic effects. Rather surprisingly, the angiotensin-converting enzyme (ACE) inhibiting antihypertensive medications, usually regarded as the best-tolerated medications for hypertension in the elderly, have also been associated with fatigue. In fact, on one website where patients complain of medication side effects, the ACE inhibitor ramipril was the most cited medication under the category “fatigue.”

Diuretics can both deplete needed minerals and cause intravascular depletion of fluids, especially when used to treat venous insufficiency or any other condition not associated with fluid overload. The associated orthostatic hypotension contributes to activity limitation and a sense of weakness. Potent calcium-channel blockers, some beta blockers, and some antihypertensives, which many hospitals seem to dispense like vitamins, cause magnesium depletion, which in turn produces muscle weakness and fatigue. A recent article in the American Journal of Medicine indicates that statins can produce fatigue and decreased exercise tolerance, particularly among female patients. Antihistamines, including the commonly used medicize prescribed for vertigo, can also cause fatigue.

In a particularly confusing loop of cause and effect, while many clinicians ascribe fatigue symptoms to psychological causes, the very psychotropic drugs used in treatment, which include major tranquilizers, minor tranquilizers, and antidepressants, have all been causally associated with symptoms of fatigue.

If we didn’t already have compelling reasons to try to direct these medications to that narrow group of patients who genuinely benefit from them, this suggests yet another reason. At the least, any resident whose fatigue symptoms have gotten worse since a psychotrophic medication was initiated requires reconsideration.

Let’s Get Physical

A comprehensive evaluation of fatigue should include a physical examination and a limited number of laboratory tests. Chronic infectious diseases including chronic osteomyelitis, subacute bacterial endocarditis, and tuberculosis can all produce fatigue. Since many of these diseases’ typical presentations overlap with a variety of common conditions and physical findings in the elderly, the index of suspicion should be high.

An elevated serum C-reactive protein may be present without fever or leukocytosis. A complaint of restless leg syndrome can trigger a careful neurologic examination. Early Parkinson’s disease, particularly in the elderly, can present without any significant tremor. Patients may complain of fatigue, which is often exacerbated by the weakness associated with decreased muscle tone and slowed movements as well as significant sleep disturbance, also typical of early Parkinsonism.

In the general public, sleep apnea syndrome is a common cause of chronic fatigue. These patients report sufficient time in bed, as do most of our long-term care residents, but find their sleep unsatisfying. A recently published review by the Mayo Clinic found no real difference between young and older patients with sleep apnea. When nurses report that residents sleep, do they comment on snoring or episodes of snoring or restlessness at night? Sleep apnea syndrome is potentially very treatable, and treatment may lower blood pressure and protect against potentially fatal arrhythmias. Portable testing equipment, now available for home sleep studies, removes the need to transport frail patients to sleep centers.

With such an array of possible causes, fatigue syndrome defies a specific therapy. There have been trials of a variety of medications including steroids, androgens, and psychostimulants. A few small trials have suggested some modest effects, particularly for androgens in COPD patients recovering from surgery, but none that conclusively document improvement in chronic fatigue or in the fatigue associated with end-stage disease. A recent trial in breast cancer patients on hormonal therapy showed some improvement with fungal spores from traditional Chinese medicine. This is obviously far from FDA approval.

Many patients try to cope with their fatigue by taking additional naps or limiting their activity. This is an unsuccessful strategy. Limiting activity leads to a vicious cycle of muscle atrophy followed by worsened weakness and decreased exercise tolerance. Patients with fatigue need exercise. Even patients with advanced metastatic cancer benefit from a regular exercise regimen. Nursing home residents with declining function may benefit from a course of restorative physical therapy or the creation of an exercise schedule consistent with their abilities and limitations.

Yes, fatigue is a common complaint, both amorphous and, lacking urgency, easy to brush aside in medical settings geared to dramatic interventions. But we do our patients a profound disservice when we don’t listen and respond to their complaints. Fatigue is a thief, robbing our residents of life-affirming energy.

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