

FROM THE FAMILY PRACTICE INQUIRIES NETWORK

# What is a reasonable initial approach to the patient with fatigue?

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## ■ EVIDENCE-BASED ANSWER

Half of all patients presenting with fatigue have a psychological cause. Patients with a history of anxiety or depression or those with a duration of symptoms for more than 3 months are more likely to remain symptomatic 6 months later. Physicians should perform a physical examination, take a thorough history, and screen patients for depression using a validated primary care instrument, such as the Beck Depression Inventory or Prime-MD. Physicians may also consider a directed laboratory evaluation with sedimentation rate, blood count, and glycohemoglobin and thyroid stimulating hormone (TSH) levels, particularly in older patients.

**Grade of Recommendation:** C, based on case series and expert opinion

## ■ RECOMMENDATIONS FROM OTHERS

A guideline developed by a group of family physicians<sup>1</sup> provides the best overview of the topic. They recommend performing a detailed history and physical examination with further investigation reserved for patients with signs and symptoms of treatable causes of fatigue, such as anemia or hypothyroidism. They also recommend a somewhat more aggressive approach to investigation for patients older than 65 years.

## ■ EVIDENCE SUMMARY

Before evaluating a patient presenting with fatigue, we must know the differential diagnosis in primary care practice for this complaint. Approximately 10% of patients visiting a primary care practice report fatigue of at least 1 month's duration.<sup>2</sup> Ridsdale identified 220 British patients presenting to a general practitioner with a chief complaint of fatigue. Physicians performed a thorough history and physical; took a complete blood count; tested the levels of blood or urine glucose, electrolytes, sedimentation rate, TSH, and urea; and tested for mononucleosis (if younger than 40). Only 19 (8%) were given a diagnosis based on the laboratory evaluation: 8 had anemia, 3 were hypothyroid, 3 had mononucleosis, 3 had other infections, 1 had diabetes, and 1 had carcinomatosis.<sup>3</sup> shows results from 4 other series of fatigued patients.

Regarding prognosis, 59% of patients were still fatigued after 6 months.<sup>3</sup> Patients with a previous diagnosis of anxiety or depression (odds ratio [OR] =3.0; 95% confidence interval [CI], 1.4 - 6.1), those with symptoms for more than 3 months (OR= 2.1, 95% CI, 1.1 - 4.1), and those with more education (OR=3.5; 95% CI, 3.2 - 3.8) were more likely to remain fatigued at follow-up.<sup>3,7</sup>

To summarize, of 100 patients presenting to a primary care physician with fatigue, approximately 25 will be

depressed; 25 will have another psychiatric diagnosis, such as dysthymia or anxiety; 15 will have an infection, such as hepatitis, cytomegalovirus, or mononucleosis; 15 will have another physiological cause of fatigue, such as undiagnosed diabetes, anemia, or hypothyroidism; and 20 will remain undiagnosed.

A recent systematic review of case-finding instruments for depression in primary care found that most instruments are similar in accuracy (84% sensitive, 72% specific).<sup>8</sup> If applied to a group of fatigued patients with a 25% probability of depression, 50% of patients with an abnormal result on one of these case-finding instruments would be depressed compared with only 7% who had a normal or negative result. A primary care physician's clinical impression based on their interview of a patient has not been formally evaluated for its accuracy in the diagnosis of depression. A 2-question screen has good sensitivity but poor specificity (43% of nondepressed patients will be labeled as depressed by this instrument).<sup>9</sup>

#### CLINICAL COMMENTARY

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The evidence reviewed and the recommendations fit fairly well with my clinical impressions and approach to patients presenting with fatigue. However, I find that a substantial proportion have sleep deprivation, lack of adequate exercise, or their life is in some way out of balance (too much work, stress, or busyness with inadequate play, replenishment, or spiritual reflection and renewal). I am not convinced of the value of a routine sedimentation rate test unless the patient is elderly, has some other historical factor suggesting its utility, or has absolutely no other explanation for their symptoms. I seldom use depression-screening instruments since I simply take a history focused on depressive symptoms. Use of a depression screen before I enter the room would help focus and shorten the visit, and detect cases of depression I might otherwise miss. I will consider implementing such a practice for patients who present with fatigue or insomnia.

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