



## Chapter 1. The Complex Problem of Fatigue

It would be helpful, as we start out, to define what we mean by fatigue and to give it some context. Fatigue is a symptom, a subjective feeling. We say 'I feel tired.' Nobody else can see our tiredness; we have to tell them what it feels like. Similarly, when we feel pain or feel nauseous or feel dizzy, we are feeling things that others cannot see. Signs of disease, on the other hand, are the physical manifestations of illness. They are more objective, and other people can see them, especially those with a trained eye. Indeed, sometimes the patient cannot see the sign, they only feel the symptoms.

Jaundice, for example, is a definite sign of disease. It usually means there is something wrong with your liver. You can see the yellow in the eyes where there should be white. Similarly, the rash of meningitis, the swollen tonsils of a streptococcal throat, and the red streaming eyes of an allergic reaction are all signs that other people can see and which help doctors to make a diagnosis. Unfortunately, there are no signs of fatigue, only a dreadful feeling. This is the first reason why it can be such a difficult problem to diagnose.

When doctors are formulating a diagnosis, they take a detailed account of your symptoms (your feelings). Then they examine you for physical signs, and then, if need be, they order tests. These medical tests are simply another attempt to obtain objective evidence of disease. Thus a high blood sugar would suggest diabetes, and a kidney stone on X-ray would explain renal colic. Unfortunately, there are no laboratory tests that can diagnose or measure fatigue; and, in the vast majority of cases, all the investigations are normal. This is the second reason why fatigue is so difficult to diagnose. The third reason is this: fatigue may accompany virtually any disease state. It is truly a non-specific symptom.

Fatigue, therefore, is a subjective symptom that shows no signs of disease: it cannot be measured or confirmed by investigation, and it may be part and parcel of any disease you care to think of. To quote again from a British Medical Journal editorial, this is why the doctor's reaction to the fatigued patient 'is frequently one of frustration and helplessness, since they know the bewildering variety of causes, the many psychological factors, and the frequent impotence of medical treatment'.

I believe that the 'impotence of medical treatment' is not quite as bad as it used to be, but some of the old attitudes remain. In their frustration and helplessness, some doctors have fallen into a scientific trap, a professional comfort zone, so to speak. This is an arrogant and dark place where otherwise brilliant minds become unstuck through the limitations of their machines. If they cannot measure it objectively in the laboratory, they are inclined to dismiss it. This is why you might be told, 'There is nothing wrong with you.' What you should be told, of course, is: 'Our technology has not yet reached the point where we can explain your symptoms.'

OK, so let us now take a look at your fatigue. And let us start by putting it into some sort of perspective. To help us with this task, I suggest we conduct a hypothetical survey of an entire community. You will see that you are not alone in your fatigue.

#### Fatigue — a hypothetical community survey

For argument's sake, we will study a small town with a population of, say, 2,000 people, and we will ask each member of this community to fill out a health questionnaire. The first and obvious finding would be this: they would all know what it's like to feel tired. After all, they would say fatigue is a universal experience. But we are not interested in this 'normal tiredness'. We are more concerned with those who feel tired all or most of the time, and whose quality of life is significantly impaired as a result. One-fifth of the men and one-third of the women in this survey would admit to this sort of tiredness. In other words, some 500 of these 2,000 people would be feeling tired at any one point in time. Sadly, only one in five of these will go to a doctor for help. The others will struggle on as best they can.

It is likely that those who stay away from doctors do so because they are afraid their tiredness would be construed as trivial and that they would be quickly dismissed. Others may fear being told that their symptoms are 'all in your mind'. Finally, others may avoid going to the doctor in the belief that nothing can be done to help. It must be said, to our shame, that these fears and attitudes originated first in doctors, and that patients only learned of them afterwards through bitter experience. In any case, only 100 of our original 500 fatigued people will end up with the doctor. It is important to remember that these patients present with a chief complaint of feeling tired all the time, in other words, this is the primary reason they are going to see the doctor. You will see the relevance of this shortly.

#### Fatigue — 100 hypothetical patients

Let us now follow these patients and see what happens to them. What sort of diagnoses do they end up with? Let us also ensure that they are given the benefit of the very best medical evaluation. As alluded to above, this would include a detailed clinical history, followed by a physical examination and appropriate laboratory tests. They would also have an examination of their mental state to elicit any features of psychological distress. Finally, if necessary, the patient would be referred to a specialist for a second opinion.

Would you be surprised to learn that up to 70 per cent of our patients will be given an accurate psychiatric diagnosis? Depression is the most common disorder identified in those who present with fatigue. This is followed closely by anxiety, panic and phobic disorders. A much smaller percentage is found to have somatisation (hysteria) or some other psychiatric disorder. These are specific and positive diagnoses; they are made on the basis of firm evidence of psychiatric symptomatology, and many patients respond well to appropriate treatment. The outlook is excellent for most of them.

Reassuringly, less than 5 per cent of our patients will be given a physical diagnosis, such as a low blood count, an underactive thyroid, or worse. That leaves us with a full 25 per cent who cannot be classified into physical or psychiatric categories. Thus, we have what one researcher has called an 'irreducible minority' of patients whose fatigue cannot be explained by physician or psychiatrist. This is what we mean when we speak of chronic unexplained fatigue.

Five patients from this group could turn out to have a chronic fatigue syndrome; a similar number will have fibromyalgia (a related disorder); and the remainder will end up with the rather unsatisfactory label of idiopathic (we-don't-know-the-cause-of-it) fatigue. There is no contradiction in saying that some patients with unexplained fatigue have chronic fatigue syndrome or fibromyalgia, for we are still unable to explain these conditions. Nevertheless, the diagnostic labels are useful in that they allow us to recognise patients who have a specific cluster of symptoms and offer them some practical help towards recovery.

The results of our survey are summarised in Table 1. You will see that they give this book its basic structure. We will deal with each category in turn, starting with the psychological and psychiatric explanations of fatigue in Section 2(i) and the physical explanations in Section 2(ii). In Section 4 we will deal with chronic debilitating fatigue of unknown origin. But before we do that we will examine the treatable causes of fatigue that are frequently overlooked in the assessment of the fatigued patient. These appear in Section 3 under the general headings of sleep, diet, germs and chemicals. These explanations of fatigue do not appear in our survey because the researchers didn't ask about them! Perhaps these forgotten causes were hidden among those who were said to have idiopathic fatigue. We must remember, therefore, that fatigue can only remain idiopathic after all the other possibilities have been explored. We won't find an explanation for your tiredness if we don't look for one!

Do not accept the label of idiopathic fatigue until you are sure that all other possibilities have been considered.

Table 1.

Population of 2,000	•	All will have experienced transient fatigue.
Of these 2,000	•	500 complain of significant fatigue all or most of the time.
Of these 500	•	400 will struggle on as best they can and avoid doctors. 100 will seek medical help.
Of these 100	•	70 have a psychiatric diagnosis and do well with treatment.
	•	5 will have a physical condition, such as anaemia.
	•	25 will have a fatigue that defies explanation.
Of the 70 with psychiatric diagnoses	•	40 will have depression.
	•	25 will have anxiety, panic or a phobic condition.
	•	5 will have hysteria or a related disorder.
Of the 25 with unexplained fatigue	•	1–5 will have a chronic fatigue syndrome.
	•	1–5 will have fibromyalgia.
	•	The remainder will have idiopathic fatigue.

## Fatigue — one real life case history

So much for population studies, but how should we approach your specific case? We are faced with so many possible explanations. Well, as always in medicine, we start with the clinical history. Have a read through the following example. In many ways it is quite typical and, as you would expect, in some ways it is unique.

### Case history

Allison is a 20-year-old university student living away from home. Attractive, intelligent and well spoken, you would think she has everything going for her. Although her appearance belies the fact, she is actually quite unwell. She complains of feeling tired all the time, and is especially prone to exhaustion following exercise. Even tasks we all take so much for granted, like climbing the stairs or taking lecture notes, have become difficult.

Her problem started, out of the blue, some four years ago. One morning, returning from her daily swim, she felt exceptionally tired. After a few days it was clear that she was not improving, so she went to see her doctor who, finding nothing wrong, arranged her admission to hospital. All sorts of tests were carried out, but with the exception of one ambiguous result, which half-raised the possibility of a viral infection, they drew a blank. She was then sent to a psychiatrist who prescribed an antidepressant, but she stopped taking it because of intolerable side effects. Allison missed a full year of school, but when she did eventually return to her studies, she achieved good enough grades to secure a place in the science faculty at the university.

Although she has some relatively good days, Allison has never really recovered full strength. She is doing her best to complete the current academic year, but her memory and concentration are now affected. She is troubled with forgetfulness and describes herself as being ‘muddled’ in thought. Recently her fatigue has become more severe, causing her to miss a number of lectures. She is already older than her present classmates, and it’s beginning to look as if she might have to drop behind again.

She is, not surprisingly, depressed and weepy. When questioned further, she admits to a host of other symptoms: palpitations, premenstrual tension, painful periods, irritable bowel syndrome, muscle pains, mouth ulcers, indigestion, frequent sore throats and frequent colds. She also describes recurring episodes of feeling ‘faint and shivery’; these bouts are relieved temporarily by eating a bar of chocolate or some other sugar-laden food (to which she will readily confess addiction). She supplements this rather inadequate diet with two pints of milk every day and ten mugs of coffee. Her appetite is good and her weight stable, she does not smoke cigarettes or drink alcohol, and she has never taken illegal drugs.

She used to be a lively sort, enjoying the normal activities of teenage years, but that’s all changed now. She used to have a boyfriend, but he’s gone. He grew impatient. She feels guilty for being ill, for not being able to pull herself out of this dreadful pit, and she’s fed up with living at the receiving end of charity. Her family is anxious. They wonder what on earth is going on, and whether there will ever be an end to this nightmare. Allison and

those who love her have suffered a great deal. They are not alone in their plight. Neither are you.

No doubt you will have recognised some of your own symptoms here. As you read through the analysis that follows, you will start to pick up some of the clues that could explain your own fatigue.

### The analysis

Apart from some details that have been changed to protect her identity, this is sadly a true story. It may seem at first glance to be a hopeless case, but it is not. If we take a closer look at the details of her history, we will find a number of possible explanations for her fatigue, some of which, it must be said, do not appear to have been considered at all. In so doing, we may be able to offer her — for the first time ever — some real hope of a cure.

To start our search we should go back to the beginning, to the days and weeks before her symptoms first appeared. It turns out that she was under considerable stress at the time. She was preparing for an important examination that would determine her future career. She may have felt subject to undue pressure, from home or from within, to succeed academically. When she first came to see me, she was again facing exams — it would not be wise to dismiss this as mere coincidence. Stress of this sort can quickly lead to outright depression, and one of the main complaints of those who are depressed is a feeling of chronic fatigue. The psychiatrist who saw her initially thought that she was depressed. Perhaps she was, and perhaps she still is. She does cry a lot, her sleep pattern is disturbed, and she never did finish her course of antidepressants; but — and this is a very big ‘but’ — is her depression the cause of her symptoms, or the result of them?

On the other hand, it could be that all her trouble stems from a disturbed sleep pattern per se. We know that sleep deprivation has a profound effect on body and brain, and that it will inevitably induce fatigue. She does go to bed a bit on the late side, and it is a long time since she regularly enjoyed wholesome, restorative sleep.

The next thing we should look at is the possibility of a viral infection. You will remember that this prospect was raised early on in the course of her illness. Sometimes a virus can hide itself inside muscle (and other) cells and remain there undetected by both immune system, and laboratory tests for years. Similarly, some viruses disrupt cell function before they are beaten by the immune system, and this disruption can persist long after the virus has been cleared. This could explain her fatigue, muscle pains, exhaustion after exercise, recurrent sore throats and colds.

Her bouts of feeling ‘faint and shivery’ raise yet another possibility, that of reactive hypoglycaemia (low blood sugar). The clue here is that she craves sweet things. These give her a dramatic rise in blood sugar levels, and although she gets an energy boost from them, it lasts only a short time. When the blood sugar subsequently falls again, it does so precipitously, bringing on faintness, shivering and fatigue. The excessive caffeine she drinks serves only to aggravate the sugar swings, and may be contributing to fatigue in its own right.

Her great preference for milk may also be significant. Patients with food intolerance can become strangely fond of their culprit foods. The chances of fatigue being ‘allergic’ in origin are greatly increased when other possible symptoms of food intolerance are present. Irritable bowel symptoms, mouth ulcers and indigestion may each be induced by adverse reactions to food. Besides all this, her diet is nutritionally inadequate. It does not

supply her with the essential vitamins and minerals that are required for optimal health and energy. Finally — and this is an apprehension frequently voiced by those who have unresolved symptoms — it is possible that some serious disease has been overlooked by her doctor, or is not yet fully manifest.

In any case, whatever the original cause of her fatigue, she now has to cope with additional factors that are bound to have a compounding effect. A recent move away from home, a broken romance, the pressure of exams, the loss of a social life, or wondering whether she can cope with the future, will only worsen her fatigue.

As you can see, fatigue can be a complex dilemma. It is a difficult symptom to live with. It mars the enjoyment of life, interferes with performance, strains relationships, hinders potential and frustrates ambition. To get to its root, in this or in any other case, will require a committed and painstaking effort. This will involve looking at the problem, not just from one angle but from many, taking every possible influence into consideration. If it is going to yield at all, it will yield to patient enquiry.

