## Definition and aetiology

Those affected by fatigue/tiredness describe symptoms with emotional, cognitive, physical and behavioural aspects. A range of biological, psychological and social factors, often in combination, play a role in causing fatigue/tiredness. These include clearly definable psychological and physical disorders or stressors; often, however, no definitive aetiology can be identified. This guideline addresses the symptom of fatigue/tiredness in adults.

## Potentially dangerous causes of fatigue/tiredness – specific challenges

- Mental illnesses requiring treatment, especially depression or anxiety disorders
- Sleep apnoea
- Post-exertional-malaise (PEM) in the context of ME/CFS (see dissenting opinion in long version of guideline, Chapter 5.7.5.)
- Treatable and severe physical illnesses are rare and nearly always associated with abnormalities in medical history and/or physical examination.
- Diagnostic testing fixed on biological causes ("tumour searches") lead to unnecessary stress for the affected patient and can contribute to the somatization of a mood disorder.

## Diagnostics in ambulatory settings

### Patient history A

- Symptom characteristics
- Associated complaints
- Is the fatigue/tiredness new or unusual?
- Level of impairment in daily life
- Patient perspective of potential causes and treatment strategies
- Symptoms of depression/anxiety
- PEM

- Somatic history:
  - Sleep
  - Body weight
  - Cardiac/respiratory/gastrointestinal/urogenital/CNS-functionality
- Medications and psychotropic
- Post-infectious chronic illness

- Social, familial, employment situation
- Exposure to chemical or noise pollution
- Similar symptoms in private/professional environment
- Snoring, excessive daytime sleepiness
- (Habitual) lack of sleep

### Physical examination A

- Dependent on abnormalities in the medical history!

If no indication of specific physical conditions:

- Abdomen
- Heart
- Circulation
- Respiratory tract
- Lymph notes, basic neurological exam including
- Muscle atrophy, strength, tone, reflexes
- Mucous membranes

### Laboratory testing A

- Dependent on abnormalities in the patient history and physical examination

If no indication of specific physical conditions:

- Blood glucose
- full blood count
- Blood sedimentation rate/CRP
- Liver transaminases/γ-GT
- TSH

Further laboratory or diagnostic testing only in the case of specific abnormalities in patient history or physical exam. **GCP**

## Therapy

| Follow-up care | Further options |
|---|---|
| ■ Structured, individual and flexible follow-up care based on the aetiology and specific patient situation, openness for patient-physician communication, planned follow-up visits, consideration of a wide range of biological, psychological and social factors **A** | ■ Symptom diary **0**<br>■ Symptom orientated activating measures **A/0***<br>■ Behavioural therapy **A/0*** |

## Diagnostic aids

- **Depression**
  Two screening questions based on the last 4 weeks
  - Have you often felt depressed/sad/hopeless?
  - Have you had little interest/pleasure in your activities?

  If both questions are answered in the negative, major depression can be ruled out with a high degree of certainty.
  If at least one question is answered in the affirmative, further questions about continuous symptoms (in addition to those about fatigue/lack of energy) should be asked based on the last 2 weeks:
  - Decreased concentration and attentiveness
  - Decreased self-esteem and self-confidence
  - Feelings of guilt and worthlessness
  - Negative and pessimistic outlook
  - Suicidal thoughts, self-harm or suicide attempts
  - Sleep disorders
  - Decreased appetite

  Major depression can be diagnosed if five or more criteria, including fatigue, are present (including the affirmative answer to at least one of the two screening questions)

- **Anxiety disorder**
  Screening questions based on the last 4 weeks
  - Nervous tension/anxiety/feeling out of inner balance
  - Worry or anxiety about many things
  - Anxiety attack(s)

- **Screening questions for sleep apnoea**
  - Loud snoring or pauses in breathing during sleep
  - Falling asleep unintentionally or in inadequate situations in the daytime

- **ME: Myalgic encephalomyelitis / CFE: Chronic fatigue syndrome**
  Multiple definitions exist for these conditions. This guideline uses the IOM criteria. In particular, PEM (post-exertional malaise, or prolonged worsening of symptoms after physical or cognitive exertion) must be present; this symptom should be asked about and addressed early in treatment in order to avoid overexertion and acute deterioration. Other typical symptoms include lack of refreshing sleep, cognitive impairment and orthostatic intolerance. A definitive diagnosis is only possible after 6 months. For detailed diagnostic criteria, e.g. based on NICE or CCC guidelines, see the long version of the guideline.

- **Common mistakes and pitfalls**
  - Abnormal laboratory values are too hastily accepted as sufficient explanation for fatigue/tiredness
  - Physical causes are ruled out before psychosocial aspects are addressed – by this point, a somatization disorder may have developed.
  - If a chronic illness is already known, fatigue/tiredness may be prematurely attributed to the illness
  - For information regarding pseudo-associations and self-fulfilling prophecies see the long version of the guideline, Chapter 5.8.
  - For information regarding iron deficiency and substitution, see the long version of the guideline, Chapters 5.3 and 6.2.

**Legend:** **A** strong (should); **B** intermediate (ought to); **0** weak recommendation (can); **GCP** good clinical practice
* according to symptom aetiology see long version of guideline, Chapter 6; for special notes regarding ME/CFS see Chapter 5.7

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