BRITISH MEDICAL JOURNAL

LONDON, SATURDAY 20 APRIL 1985

Lassitude

Loss of energy is a common presenting complaint to both the general practitioner and the hospital consultant, but it receives little attention in the medical press. The physician's reaction is frequently one of frustration and helplessness, since he knows the bewildering variety of causes, the many psychological factors, and the frequent impotence of medical treatment.

The cause of fatigue as the presenting symptom in general practice is said to be apparent in 80-85% of cases.[1] In another retrospective study of 176 patients with fatigue in whom a diagnosis was not possible after the first visit two fifths were found eventually to have physical causes, an equal proportion psychological, and the remainder an equal proportion of mixed causes and undetermined ones.[2]

A recent account of primary care evaluation of lassitude is essentially a distillation of the author's personal experience and, as he readily admits, lacks objective validation.[3] He has tabulated the various causes of lassitude, offered the inevitable algorithm, and assembled a useful table of the clinical features that have helped him differentiate the organic and psychological aetiologies of fatigue. This review gives practical advice on an approach which the author has found useful—but I doubt whether the search for mitral valve prolapse will be rewarding. A third of the patients with this not uncommon syndrome are said to have fatigue,[4] but a recent leading article in the *BMJ* suggested that the condition is usually benign.[5]

What, then, are we to do when faced with a patient whose main complaint is one of lethargy? Clearly a full clinical history is of prime importance and likely to be much more rewarding than laboratory investigations. This was certainly the experience of Hampton and his colleagues when they assessed the relative contributions of history taking, physical examination, and laboratory investigation to the diagnosis of medical outpatients.[6] Investigations are even less rewarding in the assessment of lethargy.[7] The medical history will permit the exclusion of physiological causes of fatigue such as inadequate rest, environmental noise, boredom, insomnia, and recent illness. It may disclose localising symptoms which the patient had regarded as unimportant or identify factors in the history that suggest a specific cause. It will also exclude iatrogenic causes, the most common of which are β blockers and diuretics. Alcoholism and drug abuse must also be excluded.

Nearly one half of the patients will be suffering from psychosocial problems, making it important to exclude depression and anxiety—but a psychiatric explanation of fatigue should be based on positive evidence and not be a diagnosis of exclusion. Screening questions about mood and the psychological response to illness are therefore necessary, but these add little time to the clinical assessment. Many depressed patients will confirm the clinical impression by admitting their feelings or breaking down when questioned about them. The tone of voice and speed of speech provide further diagnostic clues. None of the many screening tests have found general acclain in Britain, but I believe that the general health questionnaire is probably the best.[8]

Depressive illness is frequently related to interpersonal problems, unresolved grief, and depressive reactions to physical illness. The outlook is usually good: indeed, two thirds of patients with psychiatric problems presenting to the general practitioner recover without treatment.[9] Even in medical inpatients substantial psychiatric morbidity has been identified in over a fifth, with a predominance of depressive illness.[10] Failure to diagnose depression is usually due to failure to seek it rather than to any confusion in diagnostic symptoms; the reason is that most doctors have been trained to take a history of physical complaints and are less competent (and, perhaps, less interested) in the psychological or social aspects which may be related to the physical symptoms. Another factor is the conditions in which medical staff in the NHS operate,[11] and some physicians fear that inquiry into a patient's psychological response to illness may precipitate emotional distress. These attitudes lead to missing opportunities for relieving anxiety, and depression.

If the patient runs a fever the differential diagnosis is that of pyrexia of undetermined origin. Many patients with fatigue, however, will ascribe the onset of their symptoms to an infection even though they no longer have a fever. The lethargy that follows glandular fever and other viral infections is well recognised; it is most common in patients under the age of 40.[7] Some such patients have a true depressive

We apologise to readers for the late arrival of their journals. This is being caused by industrial action at the printers.

Readers are reminded that the *BMJ*'s current classified job advertisements are also available on Prestel.

illness, and their presentation and response to treatment are little different from those of any other form of depression. In the wider context of depressive illness in patients studied in acute medical admissions the cause of the depression was found to be the medical illness in 65%, while in the remainder it was related to other stresses and previous history.[12] The pattern of depression in patients with acute organic illness tended to show less suicidal tendency and greater anxiety, helplessness, and hopelessness than in patients in psychiatric wards. Investigations in patients who develop lethargy after an infection usually fail to explain their symptoms, and in the absence of depression the nature of their disease remains unexplained. The management of these patients is important though frustrating—there is often no effective treatment. The disorder is, however, usually self limiting, even though restoration of health may take several months. A single case report of a patient with prolonged postviral exhaustion who was studied with nuclear magnetic resonance showed abnormally early intracellular acidosis for the exercise performed, and the authors suggested that the cause was excessive formation of lactic acid resulting from a disorder of metabolic regulation.[13]

Physical examination of the patient is important not only to exclude a physical cause of the symptoms but to act as a reassurance. Laboratory investigation, though unlikely to establish a diagnosis, may provide further reassurance. A simple haematological and biochemical screen may occasionally show anaemia undetected by clinical examination; biochemical evidence of osteomalacia suggesting malnutrition; hypothyroidism—or even apathetic hyperthyroidism undetected by the clinical history and physical examination; uraemia; macrocytosis and raised liver enzyme activities unmasking alcoholism; hyperglycaemia indicating diabetes mellitus; or a high erythrocyte sedimentation rate suggestive of underlying organic disease.

When the history, physical examination, and laboratory investigation fail to establish a diagnosis the management of the patient is of the utmost importance. Mood disturbances hinder recovery from physical illness, so that both the mind and the body need care and attention.[14] There are no more common circumstances where the physician's attitude and lack of understanding may perpetuate disease. Patients consider themselves and their illnesses to be important, and they need to know that their physician thinks so too. The patient has come to the doctor because he feels ill. The physician is, therefore, being insensitive to tell the patient in whom there is no evidence of serious organic disease that "there is nothing wrong." The patient knows that something is wrong and wants an explanation. Even if there is no specific treatment once he understands the problem the patient can usually come to terms with it and adjust his life accordingly. It is not knowing what is wrong that is injurious. He also needs to know that he is not unique, and that the physician has met the problem before. An optimistic approach is essential—and justified; but there is no clinical problem more demanding of the art of medicine than the management of lassitude.

C W H HAVARD

Consultant Physician and Endocrinologist,
Royal Free Hospital,
London NW3 2QH

1 Rockwell DA, Burr BD. The tired patient. *J Fam Pract* 1974;**1**:62-5.
2 Morrison JD. Fatigue as a presenting complaint in family practice. *J Fam Pract* 1980;5:795-801.
3 Solberg LL. Lassitude. A primary care evaluation. *JAMA* 1984;**251**:3272-6.
4 Gonzales ER. The 'non-neurotic' approach to mitral valve prolapse. *JAMA* 1981;**246**:2113-20.
5 Oakley CM. Mitral valve prolapse: harbinger of death or variant of normal? *Br Med J* 1984;**288**:1853-4.
6 Hampton JR, Harrison MJG, Mitchell JRA, Pritchard JS, Seymour C. Relative contributions of history-taking, physical examination, and laboratory investigation to diagnosis and management of medical outpatients. *Br Med J* 1975;ii:486-9.
7 Jerrett WA. Lethargy in general practice. *Practitioner* 1981;**225**:731-5.
8 Goldberg DP. A comparison of two psychiatric screening tests. *Br J Psychiatry* 1976;**129**:61-9.
9 Goldberg DP, Blackwell B. Psychiatric illness in general practice. A detailed study using a new method of case identification. *Br Med J* 1970;ii:439-43.
10 Maguire GP, Julier DL, Hawton KE, Bancroft JHJ. Psychiatric morbidity and referral on two general medical wards. *Br Med J* 1974;i:268-70.
11 Nabarro JDN. Unrecognised psychiatric illness in medical patients. *Br Med J* 1984;**289**:635-6.
12 Moffic HS, Paykell ES. Depression in medical in-patients. *Br J Psychiatry* 1975;**120**:346-53.
13 Arnold DL, Radda GK, Bore PJ, Styles P, Taylor DJ. Excessive intracellular acidosis of skeletal muscle on exercise in a post viral exhaustion/fatigue syndrome. *Lancet* 1984;i:1367-9.
14 Cay EL, Vetter N, Phillip AE, Dugard P. Psychological status during recovery from an acute heart attack. *J Psychosom Res* 1972;**16**:425.

Practice nurses: an underused resource

In the mid-1960s near extinction of general practice in the United States left many rural areas without doctors. This manpower crisis, together with radical feminist ripples from the worldwide wave of student radicalism, overcame the resistance of the American Medical Association to nurse practitioners—for a time. By 1978 over 7000 of them were established in practice, mostly giving primary care for chronic illness and working in health maintenance or prevention in rural or poor communities.[1] In due course the performance of the nurse practitioner in primary care was subjected to randomised controlled trial at Burlington, Ontario, Canada. Within the limits of the trial they were found to diagnose, refer, and prescribe as well as the general practitioners with whom they worked—and perhaps a bit better than randomly selected general practitioners working alone.[2-4] But then medical school output rose, radicalism moved from left to right, and little is now heard of the nurse practitioner in North America, though she still seems to be beavering away.[5]

In this issue (p 1181) Isaac Marks reports a randomised controlled trial of behavioural therapy by psychiatric nurses, showing that their patients did better at follow up one year later than did those given routine treatment by their general practitioners—and that when those unsuccessfully treated by general practitioners were crossed over to treatment by nurses, these patients also improved. All preferred primary care by nurse therapists or general practitioners to hospital outpatient care by psychiatrists. As in the Burlington trial, these nurses had been trained appropriately for their work and had been given enough time to perform it. Also as in the Burlington trial the doctors with whom their performance was compared had not been trained appropriately for their work and were generally operating under greater pressure from time. Probably anyone with intelligence, honesty, and a social conscience can do any specified medical task provided they are trained for it, given enough time, and can maintain their skills by continued experience.

Divisions of labour in hospitals permit generally safer and more effective follow up of many chronic conditions such as hypertension, diabetes,[6] and childhood asthma[7] than that provided by general practitioners working alone, their actions prompted by demand by patients rather than their own planning. When general practitioners have a similar nursing and clerical staff, however, the care they provide is at least as good as that in outpatient departments, more convenient for patients, and more economic for the health service. Above all their care is more feasible when hypertension, diabetes, and childhood asthma affect about 10%, 2%,