

Fatigue after breast cancer and in chronic fatigue syndrome Similarities and differences

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Abstract

Objective: Fatigue is investigated in 57 severely fatigued disease-free breast cancer patients and in 57 gender- and age-matched patients with chronic fatigue syndrome (CFS) using multidimensional and multimethod assessment. A comparison between these groups of patients is important to determine whether a cognitive behavioural intervention to reduce fatigue in CFS patients would be appropriate as well for severely fatigued disease-free breast cancer patients. **Methods:** Measurement included computerised questionnaires and a standardised neuropsychological test. Furthermore, patients filled out a daily Self-Observation List (SOL) and wore an actometer during a period of 12 days. **Results:** In comparison to severely fatigued disease-free breast cancer patients, CFS patients score more problematic with regard

to the level of fatigue, functional impairment, physical activity, pain and self-efficacy. However, a subgroup of severely fatigued disease-free breast cancer patients reports the same amount of problems as CFS patients with regard to psychological well-being, sleep and concentration. Finally, CFS patients and severely fatigued breast cancer patients score equal on measures of social support. **Conclusion:** There seem to be some similarities but also many differences between severely fatigued breast cancer survivors and females with CFS. Therefore, cognitive behaviour therapy (CBT) to reduce fatigue after treatment for cancer should also differ in certain aspects from cognitive behaviour therapy as it has been developed for patients with CFS. © 2002 Elsevier Science Inc. All rights reserved.

Keywords: Chronic fatigue syndrome; Disease-free breast cancer patients; Fatigue

Introduction

Fatigue is a complaint that is often reported by cancer patients while they are undergoing treatment for cancer [1]. In the last few years, several studies have demonstrated that many patients also experience fatigue (long) after curative treatment for cancer has been terminated [2–11]. At this moment, little is known about the factors that may cause or perpetuate fatigue. However, it seems that characteristics of the disease and treatment are not related to the severity of fatigue long after treatment has ended. A treatment for fatigue long after treatment for cancer is not available.

Another patient population with severe fatigue complaints, for which up until now no physical explanation has been found, are patients with chronic fatigue syndrome (CFS). CFS is characterised by persistent or recurrent fatigue that lasts for 6 or more consecutive months. Fatigue is not the result of constant exertion, does not improve by rest and has led to substantial decrease of former standards of professional, social and personal functioning [12]. There is increasing evidence that cognitive behaviour therapy (CBT) is effective for patients with CFS [13,14].

Our research group has developed a multidimensional assessment method to measure fatigue in patients with CFS [15]. Factor analyses has identified nine dimensions, namely fatigue severity, functional impairment, psychological well-being, sleep disturbances, neuropsychological impairment, physical activity, social support, causal attributions and self-efficacy. These dimensions appeared to be relatively inde-

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pendent, meaning that each dimension uniquely contributes to the description of a patient.

Using this assessment method, we are able to examine to what extent a patient who experiences severe fatigue after treatment for cancer resembles a patient with CFS. The purpose of this study is to compare, where possible, a group of severely fatigued disease-free cancer patients with a group of CFS patients on the above-described dimensions. We added the dimension “pain” in this study, because pain is a frequent complaint, besides fatigue, of CFS patients. A comparison between these groups of patients is important to determine whether a cognitive behavioural intervention to reduce fatigue in CFS patients would be appropriate as well for severely fatigued disease-free breast cancer patients.

The specific research questions we would like to answer are the following:

1. How many severely fatigued disease-free breast cancer patients fulfill the criteria (severity of fatigue and functional impairment) for CFS?
2. Do severely fatigued disease-free breast cancer patients (those who fulfill the criteria for CFS and those who do not fulfill these criteria) differ from CFS patients on the dimensions self-efficacy, psychological well-being, sleep, concentration, physical activity, social support and pain?

Methods

Patients

In a longitudinal study investigating the course of fatigue after treatment for breast cancer, 150 disease-free breast cancer patients were included [33]. One of the inclusion criteria was that patients had to be treated according to the protocol of the Comprehensive Cancer Centre East in the Netherlands for premenopausal breast cancer patients. Furthermore, they had to be younger than 50 by the time of primary diagnosis and had to have completed treatment for breast cancer a minimum of 6 months and a maximum of 70 months before. Finally, they had to have no evidence of disease recurrence at the time of participation. On the basis of a cut-off score of 35 on the subscale “severity of fatigue” of the Checklist Individual Strength (CIS), 57 patients (38%) could be considered as severely fatigued 6–70 months (mean 2 years) after the end of treatment for cancer. Data of these severely fatigued disease-free breast cancer patients have been used for the present study.

In an intervention study, in which the effect of cognitive behaviour therapy on fatigue has been investigated, 270 patients with CFS participated ($n=270$) [14]. Participants had to be between the age of 18 and 60 years old. Furthermore, patients were selected for this intervention study on the basis of the operational criteria for CFS. This means a score of 40 or higher on the subscale “fatigue severity” of the CIS and a score of 800 or more on eight subscales of the Sickness Impact Profile (SIP-8). Finally,

patients were excluded if they had participated in previous CFS research. From this sample of 270 patients, we selected 57 patients matched on age and gender with the 57 severely fatigued disease-free breast cancer patients.

From both samples, baseline data are used for the current study. The collected data consist of computerised questionnaires. Patients were asked to complete the self-report questionnaires mentioned below by computer at our department. Furthermore, patients performed a standardised neuropsychological test and filled out a daily Self-Observation List (SOL) during a period of 12 days. They also wore an actometer during this 12-day period.

Measures per dimension

Fatigue severity has been measured by the “fatigue severity” subscale of the CIS and the “Daily Observed Fatigue” (DOF) of the SOL. The CIS [15,16] is a 20-item questionnaire. Each item is scored on a seven-point Likert scale. The questionnaire was designed to measure four aspects of fatigue during the last 2 weeks, namely fatigue severity (eight items; 7–56), concentration (five items; 5–35), motivation (four items; 4–28) and physical activity (three items; 3–21). High scores indicate a high level of fatigue, a high level of concentration problems, low motivation and a low level of physical activity. The CIS has good reliability (Cronbach’s α ’s varying from .83 to .92) and discriminative validity [15–17]. In the SOL, Daily Observed Fatigue is reported four times a day on a five-point scale (0–4). Total scores range from 0 to 16 [18].

Functional impairment has been measured with eight subscales of the SIP-8: home management, mobility, alertness behaviour, sleep/rest, ambulation, social interactions, work and recreation and pastimes [19,20]. The SIP is a widely used measure with good reliability and content validity [21].

Self-efficacy is measured with the Self-Efficacy Scale (SES) [22]. The SES consists of five questions that measure sense of control with respect to fatigue complaints. A total score ranges from 5 to 25, a higher score reflecting more sense of control. Cronbach’s α reliability coefficients range from .70 to .77 [14,22,23].

Psychological well-being has been measured with the Beck Depression Inventory for primary care (BDI-pc) [24] and with the subscales depression, anxiety, somatisation, interpersonal sensitivity and obsessive-compulsive behaviour of the Symptom Checklist (SCL-90) [25]. Lower scores reflect less problems in these subscales. The SCL-90 is widely used and the reliability and discriminating validity are good. The BDI-pc has seven items and is composed of cognitive and affective symptoms only. We used this shortened version of the BDI to prevent an overlap between the physical symptoms of chronic fatigue and the physical symptoms of depression. The BDI-pc has high internal consistency (Cronbach’s $\alpha=.86$) and displays convergent validity [24].

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