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A Qualitative Analysis of Cancer-Related Fatigue in Ambulatory Oncology

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The purpose of this study was to describe patients' perceptions of the causes, relief, related symptoms, meaning, and suffering secondary to cancer-related fatigue (CRF). In total, 252 patients with breast, lung, colon, and prostate cancers were enrolled in a quasiexperimental study to test the effects of a clinical intervention on reducing barriers to symptom management in ambulatory care. Analysis of data reported in this article was derived from the Piper Fatigue Scale–Revised. Using qualitative research methods and content analysis, written statements related to the impact of CRF were coded using the following themes: patients' perceptions of CRF, causes, relief, related symptoms, meaning, and suffering. Comments were categorized and reviewed for content. Overall, CRF had a significant impact on physical, psychological, social, and spiritual well-being. CRF limited the ability of participants to function, socialize, and participate in enjoyable activities. Emotional issues as a result of CRF were common. The negative impact of CRF on patients' overall well-being alters the meaning and suffering related to the cancer experience. The assessment of personal meaning and suffering related to CRF is an important component of the multidimensional assessment of CRF and will enable nurses to better understand the suffering related to CRF.

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Cancer-related fatigue (CRF) is one of the most common and distressing symptoms experienced by patients with cancer (Berger, 2009; Hofman, Ryan, Figueroa-Moseley, Jean-Pierre, & Morrow, 2007). Many patients experience fatigue as a presenting symptom prior to their diagnosis of cancer, and about 70%–100% of patients with cancer experience CRF at some time during diagnosis and treatment (Berger, 2009). Prevalence rates vary from 25%–99%, depending on the type of treatment, dose and route of administration, type and stage of cancer, and the method and timing used to assess CRF (Mitchell & Berger, 2008). CRF can negatively affect all aspects of patients' quality of life (QOL) and can limit their ability to fully engage in activities that give meaning and value to their lives (Berger, 2009). Despite its frequency and its negative impact, CRF remains under-reported, underdiagnosed, and undertreated (Berger, 2009).

In patients receiving chemotherapy (CT), 80%–90% report CRF, and its prevalence rates and patterns over time may vary by the specific CT agent, its route of administration, and the frequency and density of treatment cycles. For example, a “roller-coaster” pattern of CRF over time is reported in women with early-stage breast cancer receiving 3–4 week CT cycles (Berger, 1998). Less is known about CRF's prevalence rates and patterns prediagnosis (Hofman et al., 2007). During radiation therapy (RT), CRF is an almost universal occurrence, with 70%–100% of patients experiencing a gradually increasing, cumulative pattern of CRF over time that usually peaks and plateaus at 4–6 weeks and gradually declines thereafter over time (Berger, 2009). Most RT studies address CRF in patients receiving external beam RT. Increased levels of CRF are reported when different therapies, such as RT and CT, are used as combination therapy (Woo, Dibble, Piper, Keating, & Weiss, 1998). Although