Regarding cancer-related fatigue

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This is in response to the article "Cancer-related fatigue: a review", published in April 2011 by Campos et al.[1]. We have a few concerns regarding certain statements made by the authors.

The advances in oncology have rendered cancer from a universally lethal disease to a chronic condition for many and a curable illness for a few. Hence, the potential long-term adverse effects of supportive care interventions should be given due consideration.

Though the authors have mentioned the efficacy of amphetamines such as methylphenidate/dexmethylphenidate, no mention was made on the potential risks involved, such as the risk of addiction, increased blood pressure, cardiovascular risks, hyperthermia, muscle catabolism etc[2]. Given that cancer patients are expected to survive longer due to the improvements in oncology, we should exercise caution against the use of drugs with potential for abuse in cancer patients who are expected to survive for long periods. Regarding their statement that modafinil is effective only in patients with severe fatigue, we would like to state that there is no uniform consensus as to how fatigue can be graded as mild, moderate, and severe. Different scales exist, such as the Brief Fatigue Inventory, the Fatigue Severity Index etc. Scoring patterns are different and hence severity can vary with the questionnaire used. Moreover, modafinil is said to benefit patients with both moderate and severe fatigue[3] (rather than only severe fatigue). Modafinil can be especially beneficial in certain subsets of cancer patients, such as patients on radiation therapy (RT), since patients on RT are more likely to develop cancer-related fatigue at higher incidences and higher magnitudes when compared to cancer patients that are not on RT[4,5]. We opine that modafinil would be a better choice when compared to methylphenidate/dexmethylphenidate because of the lesser addictive potential and lower risk of toxicities.

We suggest that the use of erythropoiesis stimulating agents (ESA) such as erythropoietin and darbopoetin in patients with hemoglobin level < 10 mg/dL can be more dangerous compared to routine measures, such as the use of hematinics and blood transfusions, especially in patients who are on radical curative treatments with chemotherapy or radiotherapy. Not only do ESAs increase the risk of thromboembolisms, but also being growth factors, they may promote tumor growth and progression and hence may offset benefits of chemotherapy and radiotherapy. We suggest that ESAs should be reserved for terminally ill patients only.

We have minor concerns regarding the use of guarana. Since guarana extracts may work in a way similar to caffeine, we suggest that it may be used only after it has been tested for cardiovascular side effects, such as arrythmias[6], in a large population.

We are, however, very appreciative of the overall message of the article by Campos et al.[1], since it highlights a very important and often neglected topic.

References

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